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Creating a Tobacco-Free Residential Substance Abuse Treatment Facility: A Toolkit for Designing an Effective Intervention

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A Toolkit for Designing an Effective Intervention

Section I Introduction

Introduction

Summary

This toolkit was created specifically for residential substance abuse facilities treating an adult population. The goal of this toolkit is to assist organizations in becoming tobacco-free and implementing a full tobacco cessation program in order to promote health and recovery from all addictions, including nicotine.

This toolkit was created as a Capstone Project through Georgia State University's Institute of Public Health. The author, a Masters in Public Health Candidate, identified the need for additional resources to help residential substance abuse facilities become tobacco-free. These types of facilities face unique challenges in adopting such a policy change. One challenge is related to the comorbidity between substance abuse, mental illness and nicotine addiction. Clients and staff members of these organizations smoke at rates higher than the general population, often require multiple quit attempts, and are accustomed to being able to smoke in treatment as it has historically been accepted within this community. Common myths and concerns surrounding concurrent tobacco cessation and substance abuse treatment also play a role in the hesitancy of organizations in adopting such policies. This toolkit was created to help administrators and program planners access and navigate the existing tobacco-cessation resources while maintaining a focus on the specific needs of organizations treating substance abuse.

While this toolkit is written for organizations that treat substance abuse, the co-morbidity of substance abuse and mental illness is well-known and documented. Therefore both issues must be considered when working with this population. Research within this toolkit pertains to both substance abuse and mental health treatment and interventions. Information unique to substance abuse or mental illness is noted as such. There are several toolkits currently available specifically for mental health populations, but there are few resources unique to substance abuse populations. This toolkit helps to fill that void and provides information that is relevant to substance abuse facilities, which may also address mental health, and are considering a tobacco-free campus.

Figure 1

Why address Smoking Cessation in this population?

Facts about nicotine addiction among individuals with substance abuse and mental illness.
21% of the general U.S. population smoke cigarettes (CDC, 2010b).
Up to 80% of individuals with substance abuse and mental illness are smokers (Kalman, Morissette, & George, 2005).
More than 25% of staff members working in addiction and mental health facilities are smokers (Ratschen et al., 2009; Teater & Hammond, 2009).
The tendency of staff to encourage smoking cessation among clients is directly related to their smoking status. Current smokers are less likely to recommend clients consider cessation (Bobo & Davis, 1993).
Genetics, self-medication and environmental factors contribute to the higher proportion of substance abusers and the mentally ill who smoke (Kalman, Morissette, & George, 2005).
Substance addicted and mentally ill populations have higher rates of tobacco-related illnesses and death than the general population (Baca & Yahne, 2009).
Smoking cessation during treatment has been shown to enhance recovery and abstinence rates (Reid et al., 2008; Baca & Yahne, 2009).

Introduction

A rationale for the development of tobacco-free policies and tobacco cessation programs at residential substance abuse treatment facilities

Tobacco use is the number one cause of preventable illness, disability and death in the United States. It is responsible for more than 443,000 deaths annually and accounts for more than 30% of cancer deaths (Centers for Disease Control and Prevention, 2010b). One in five American adults are smokers and tobacco-related illness and death costs our nation over $193 billion annually in healthcare costs, lost productivity and premature death (Centers for Disease Control and Prevention, 2010a).

While 20.6% of the general population are smokers (Centers for Disease Control and Prevention, 2010b), this rate is 2-4 times higher among substance addicted and mental health patients (Kalman, Morissette, & George, 2005). Between 40% and 80% of substance addicted and mentally ill individuals are tobacco users. Individuals with substance abuse disorders and mental illness consume 44.3% of all cigarettes smoked in the United States (National Alliance on Mental Illness, 2010). Tobacco use is responsible for more deaths than alcohol and other drugs, and the combined effect of smoking and drinking is more harmful than either action alone (Baca & Yahne, 2009). Higher rates of tobacco use among substance addicted and mentally ill individuals can be explained by a combination of factors, including genetics, self-medication and environmental factors (Kalman et al., 2005). Although tobacco-use is very common among this population, only 30-40% of substance abuse treatment facilities offer smoking cessation resources (Baca & Yahne, 2009). Tobacco cessation during treatment is often avoided because providers incorrectly believe patients cannot quit tobacco successfully or that concurrent treatment will negatively impact their recovery goals (Hitsman, Moss, Montoya, & George, 2009).

However, recent research has proven that smoking cessation during substance abuse treatment does not negatively impact treatment goals and can, in fact, enhance recovery and abstinence rates. A study of 225 smokers in drug and alcohol programs were randomly assigned to a treatment as usual group or a group receiving smoking cessation support. Individuals in the smoking cessation treatment group experienced significant reductions in daily smoking rates (smoking approximately 75% less cigarettes daily) without any negative impacts on their substance abuse treatment (Reid et al., 2008). A literature review of 12 studies to measure tobacco cessation rates during substance abuse treatment found that smoking cessation success rates varied between interventions from 4.7% to 23.4% (Baca & Yahne, 2009). Results of this literature review indicate that concurrent tobacco and other substance addiction treatment does not jeopardize recovery goals and that concurrent treatment can improve drinking outcomes and abstinence from other drugs (Baca & Yahne, 2009).

There are many barriers to implementing a tobacco-free policy at a substance abuse and/or mental health facility. Common barriers include resource limitations, beliefs or myths within the field and the high prevalence of smoking among treatment staff (Guydish, Passalacqua, Tajima, & Manser, 2007). Barriers related to resource limitations include limited smoking cessation knowledge and training of staff members as well as a lack of staff time, smoking cessation services and funding. A number of common

myths and beliefs also impact the willingness of organizations to implement a tobacco policy change or offer cessation programs. These myths include the notion that smoking cessation will negatively impact recovery, that other addictions are more important to overcome than nicotine, that clients are not interested in smoking cessation, and that smoking is helpful in the recovery from alcohol and other drugs. The fact that many staff members are also smokers is an impediment to organizations implementing tobacco-free policies (Guydish et al., 2007). A facility must address all of these issues in order to successfully transition to a tobacco-free residential treatment facility. This toolkit serves as a resource manual for addressing these barriers and transitioning your organization to a tobacco-free facility through policy change, education and tobacco-cessation interventions.

Successful smoking cessation interventions during substance addiction treatment offer a variety of treatment options and require that staff members are educated about and aware of their role in the program. Interventions often provide a menu of treatment options that clients and staff members can select from (Baca & Yahne, 2009). These options allow an organization to offer multiple resources that fit within the budget and program design. A literature review by Baca & Yahne (2009) found five successful intervention strategies that should be considered by organizations, including:

- The U.S. Public Health Service's 5A's model (Ask, Advise, Assess, Assist, Arrange);
- Motivational Interviewing, an evidence-based practice related to client-centered goals;
- Psychotherapy, such as Cognitive Behavioral Therapy, which addresses the role of mental health in treatment and outcomes;
- Pharmacotherapy, such as Nicotine Replacement Therapy; and
- Telephone Support or Quit Lines, which are free supports providing counseling, follow-up and assistance connecting to cessation resources.

Additional evidence-based practices for concurrent treatment include contingency management and motivational enhancement therapy (Hitsman et al., 2009), which are familiar practices within substance abuse and mental health treatment. In general, successful smoking cessation interventions for addicted populations focus on building motivation to quit, assessing motivation to quit and helping individuals develop the cognitive and behavioral skills to successfully quit tobacco and manage withdrawal (Hitsman et al., 2009).

Staff involvement is crucial to the success of a smoking cessation intervention at a substance abuse treatment facility. Staff members working in substance abuse and mental health treatment facilities also smoke at rates higher than the general population. Various studies report between 25% and 63% of staff are smokers (Bobo & Davis, 1993; Knudsen & Studts, 2010; Teater & Hammond, 2009; Ratschen, Britton, Doody, Leonardi-Bee, & McNeill, 2009). Although the percentages vary, it is reasonable to assume that more than 25% of addiction and mental health staff members are current smokers. The percentage of smokers tends to be lower among doctors, physicians and qualified staff members than it is among non-qualified staff members (Ratschen et al., 2009). The smoking status of staff members impacts whether or not these individuals address tobacco cessation with clients. Addiction and mental health staff members who are current smokers are less likely than non-smokers or former smokers to urge clients to quit tobacco (Bobo & Davis, 1993). For a tobacco cessation intervention to be effective, it

is essential that staff members understand the importance of the program, their role in working with clients to quit tobacco and have a full employee tobacco cessation program available for their use (Ratschen et al., 2009; Baca & Yahne, 2009).

Residential substance abuse facilities that adopt a tobacco-free policy have much to gain in terms of quality of life and financial benefits. By providing substance abuse and mental health clients with tobacco cessation options, facilities are able to promote the health and recovery from all addictions. Smoking cessation during substance abuse treatment has been associated with up to a 25% increased likelihood of long-term abstinence from alcohol and other drugs (Prochaska, Delucchi, & Hall, 2004). Organizations implementing an employee cessation program stand to gain financially through decreased health insurance costs, employee sick time and lost productivity. In general, workplace wellness programs benefit the overall health of employees while saving money for corporations. A meta-analysis of 73 published studies found that health promotion programs in the workplace resulted in a 25% savings for companies (Chapman, 2003). A national study found that individuals who smoked a pack or more of cigarettes per day experienced twice as much lost productive time as nonsmokers (Stewart, Ricci, Chee, & Morganstein, 2003) and decreasing the number of cigarettes smoked per day increases worker productivity. All individuals who quit tobacco immediately experience health benefits (American Lung Association, 2010). Providing a tobacco-free work environment reduces exposure to secondhand smoke by 72% and therefore decreases illness among all employees (CDC, 2010d). Although secondhand smoke exposure has decreased in recent years, more than 88 million nonsmokers are exposed to secondhand smoke annually (CDC, 2010b). The high prevalence of client and staff smoking in substance abuse treatment facilities means that individuals are commonly exposed to secondhand smoke, and tobacco-free policies promote clean air in the workplace.

Tobacco-free regulations are becoming more and more common in our society. By implementing a policy at your organization, you are preparing your facility to be a leader within the recovery community while supporting the long-term health of your clients and staff. This toolkit will allow you to effectively implement a tobacco-free policy that promotes clean air, reduces second-hand smoke exposure and provides clients and employees with the best opportunity to take ownership of and change their tobacco habits. This program is designed specifically for residential facilities and the unique challenges these organizations encounter when implementing such a program.

Figure 2

National Statistics

Facts about substance abuse, mental illness and nicotine dependence in the United States
8% of the U.S. population (more than 20 million individuals) aged 12 and over have used illicit drugs within the past month.*
8.9% of the U.S. population (more than 22 million individuals) aged 12 and over were classified with substance dependence or substance abuse within the past year.*
4.4% of the U.S. population (almost 10 million individuals) aged 18 and over have a serious mental illness.*
25.2% of the U.S. population (2.5 million individuals) aged 18 and over with a severe mental illness also were also classified with substance abuse or dependence.*
44.3% of all cigarettes in America are smoked by individuals with a mental illness and substance abuse addiction.**

*U.S. Department of Health and Human Services, 2008
**National Alliance on Mental Illness, 2010

Creating a Tobacco-Free Residential Substance Abuse Treatment Facility

A Toolkit for Designing an Effective Intervention

Section II Program Design

Program Design

Requirements of an Effective Program

Policy Development

Introduction

Policy development is the critical first step for an organization transitioning to a tobacco-free environment. A tobacco-free policy at a residential substance abuse treatment facility indicates that the organization is committed to protecting the health of all employees and clients through the adoption of a clean air policy.

Secondhand smoke is dangerous to nonsmokers. Individuals exposed to secondhand smoke in their home or workplace experience a 25-30% increase in heart disease risk and a 20-30% increase in lung cancer risk (American Society of Addiction Medicine, 2005). More and more employers are now providing smoke-free workplace environments. In 1986, only 3% of the workforce was protected by smoking bans and clean air policies, but this number reached 64% in 1996 (National Cancer Institute, 2000). Restricting tobacco-use in the workplace is related to a decrease in the amount of cigarettes smoked per day by employees, results in increased cessation attempts, and leads to increased cessation success rates (National Cancer Institute, 2000). Tobacco-free policies are effective in reducing exposure to secondhand smoke in the workplace by an average of 72% and are most effective when combined with tobacco cessation resources and support (CDC, 2010d). As a health facility, it is important to protect the health and well-being of all individuals on your campus, and this can be accomplished through a tobacco-free policy and clean air campaign.

Traditionally, tobacco has been accepted within the recovering community and in treatment programs (Ziedonis et al., 2007). Individuals with substance addiction and mental illness smoke at rates higher than the general population (Kalman et al., 2005) and tobacco use has been accepted as a way of life. Within treatment, tobacco has been used as a reward, such as the “smoke break” being considered a reward for good behavior (Ziedonis et al., 2007). Also, it is common for staff members to smoke with clients and for this to be viewed as a bonding experience (Ziedonis et al., 2007). Attitudes and behaviors within the field of substance addiction and mental health treatment are shifting, and more organizations and clinicians are now addressing tobacco addiction as part of the client-centered treatment plan (American Society of Addiction Medicine, 2005). Adopting a tobacco-free policy shows an organization’s commitment to the health of its employees and supports the belief that individuals in recovery can learn to live without tobacco.

How to Develop a Policy

It is crucial to have a written policy addressing tobacco-use. A written policy makes it easier to explain the protocol to clients and employees and provides a clear position statement in case the policy is challenged. The written policy should document the policy change, expectations, available resources and enforcement practices related to the policy. It is common for residential substance abuse facilities to allow smoking outdoors, and sometimes indoors, as smoking has long been a norm within treatment. A successful tobacco-free policy must prohibit all smoking on campus rather than allow smoking in designated areas.

The Substance Abuse and Mental Health Services Administration (2010) provides tips for creating an effective drug-free workplace policy and recommended components of a tobacco-free policy include:

Background Information – Why was the policy developed (e.g. to provide a clean air environment, to protect individuals from secondhand smoke, to help clients quit tobacco)?; How was it developed (e.g. a leadership committee composed of individuals from various programs, staff, clients, smokers and non-smokers spearheaded the planning, research and development; staff and client input was solicited through surveys and focus groups)?

Goals – Does the organization have to comply with any tobacco-free regulations for accreditation or licensure standards? What does the organization hope to achieve through the policy change (e.g. reduced secondhand smoke exposure, increased overall health of employees and clients, an increase in worker productivity, decreased health insurance costs)?

Definitions – What substances and behaviors are not allowed on campus? Who does the policy apply to? When will the policy become effective? What locations on campus are impacted by the policy (e.g. all areas of campus, personal vehicles, indoors, outdoors)? Is the presence of tobacco products or tobacco paraphernalia a violation of the policy?

Enforcement – Who is responsible for making clients and employees aware of the policy? Who is responsible for enforcing the policy? How will violations be handled among staff members? How will violations be handled among clients? How will violations be handled among visitors or volunteers?

Many individuals believe that smoking is an individual choice. Additionally, tobacco-free policies and enforcement can impact the employment and treatment status of individuals. For these reasons, it is important that a legal advisor review a tobacco-free policy before it is implemented to ensure that the policy protects the rights of the employer, employees, clients and visitors.

Policy Announcement

It is important to consider how your organization will educate employees and clients about a changing tobacco policy. Notification of the policy change should occur well in advance of the date the policy becomes effective. When to begin notifying clients depends on the length of your treatment program. For example, if clients remain in treatment for up to 180 days, individuals considering admission into your residential treatment program should be made aware of the pending policy change in the six

months before the policy is implemented. Once a policy change is approved, staff members should be notified about the pending change and human resources should inform all potential employees about the changing policy.

Employee communication should occur through multiple channels. This can take place through staff meetings and orientation sessions for new employees. Employees should receive the information in an updated employee handbook and through outlets such as email, the organization's website, posters, banners, pay check flyers, etc. (See *Appendix A-2* for modifiable templates). Informing and educating employees about the policy change and available resources helps create buy-in and understanding for what can be a challenging transition.

The written policy and subsequent employee communication should answer the following questions for staff members (SAMHSA, 2010):

1. What resources will the organization make available to employees to help with the transition and with tobacco cessation?
2. How can employees express grievances and concerns?
3. How will the organization ensure tobacco users on staff are not singled out and are treated fairly during the transition?
4. How will policy violations be handled?
5. What are the procedures for determining if an employee has violated the policy?
6. How can an employee appeal a violation?

Policy Enforcement

A tobacco-free policy should clearly state how the policy will be enforced for both staff and clients and who is responsible for enforcing the policy. The policy must establish the consequences of violating the policy.

Staff enforcement of violations of the policy may include: a verbal warning for the first offense and a written note in the employee's human resources file for subsequent offenses. After multiple offenses, employees may be placed on probation, suspended or even terminated. The extent of the enforcement may also relate to how the violation occurred. For example, staff members caught smoking with clients may incur more severe penalties than those caught "sneaking" tobacco.

Client enforcement of the policy is difficult since violations could potentially lead to the individual ceasing treatment. Clients may be given verbal warnings for first offenses and written warnings for subsequent offenses, which could result in mandatory attendance of extra tobacco cessation programs or counseling. Rewards and incentives can also be used for clients complying with the policy, such as awarding extra house privileges to individuals compliant with the policy or providing a "tobacco-free" movie night to reward clients for their efforts.

The policy must clearly identify and describe who is responsible for enforcing the policy. A system should be created for documenting and reporting client and staff violations to supervisors.

Policy Adoption and Wording

Adopting a tobacco-free policy can be done in steps or all at once. Some organizations choose to adopt policy change and incorporate program changes over time. An organization interested in adopting specific changes before becoming tobacco-free might consider the following:

- Adopting the term "break" instead of "smoke break;"
- Incorporating clean-air walks during breaks for clients who do not desire to smoke;
- Restricting client and staff smoking together;
- Designating only specific areas for smoking; and
- Banning staff smoking on campus.

An organization can adopt these changes over time, address concerns as they arise and slowly transition into a tobacco-free organization.

New Jersey was the first state to require that all residential addiction treatment facilities incorporate tobacco-free standards, and it provides a great example of the success that can be achieved through policy change (Foulds et al. 2006). Initially, New Jersey required that all clients be assessed for and treated for nicotine dependence. The next step was to establish tobacco-free grounds, and this was accomplished over a three year time period to allow for transition (Foulds et al., 2006).

Making a tobacco-free policy change is not required in phases and with adequate time (6 months once the policy change is announced), an organization can fully transition to a tobacco-free campus that includes comprehensive indoor and outdoor smoking bans (Foulds et al., 2006).

Example of the definition of a tobacco-free facility:

"A tobacco free facility is defined as an environment free of tobacco use, including the use of smokeless tobacco, such as snuff and chewing tobacco. Tobacco use must be prohibited throughout the entire workplace with no exceptions, including, all indoor facilities, offices, hallways, waiting rooms, rest rooms, elevators, meeting rooms, community areas, and agency owned and/or leased vehicles. This policy applies to all employees, clients, contractors, and visitors" (Massachusetts Office of Health and Human Services, 2010).

Policy example from New York State's Office of Alcoholism and Substance Abuse Services:

Figure 3. New York Tobacco-Free Environment Policy Wording

I. PURPOSE

Use of any tobacco products is prohibited at the Addiction Treatment Centers (ATC's) at all times. This policy shall apply to *all persons* who may be at the ATC, regardless of their purpose for being there.

II. POLICY

No ATC Director, staff person, patient, group of patients or any other person or persons, has any authority to agree to allow the use of tobacco products anywhere in the designated space or program of an ATC. An ATC Director will establish a procedure for informing patients, staff, visitors, contractors, etc. of the ban on the use of tobacco products in, or on the grounds of the ATC, or at any time or anywhere during the patients' treatment at the ATC.

III. IMPLEMENTATION

Each ATC shall provide services to assist patients who desire to stop the use of tobacco products and such services will be included as part of his or her written comprehensive individual treatment plan. Tobacco possession and use will be dealt with and treated in the same fashion that other substances and alcohol are.

Employee assistance programs, as well as other programs, will be made available to staff who desire to stop smoking. However, neither smoking, nor programs to assist an employee to stop smoking, shall require an ATC Director or other supervisor to change the employee's work schedule, duty assignment, or work place.

A. Public Information about the Policy

The ATC Director shall arrange for placement of appropriate signs to inform all persons who enter the ATC that tobacco use is prohibited. Each sign shall clearly and directly convey the message that smoking and use of tobacco products is not allowed anywhere in the ATC by any person at any time. When appropriate and necessary, signs shall be in languages other than English.

Any informational materials, including brochures, patient handbooks, and employee handbooks, about the ATC and its rules shall specify that the facility maintains a tobacco-free environment. These materials shall include information on enforcement of the policy.

B. Enforcement

The ATC Director shall designate an individual(s) to be informed of violations of this policy. Such designee(s) shall include at least one employee to process allegations of violations by other employees. The individual(s) shall be informed of any incidents of use of tobacco products in the ATC. The designee shall inform the user that he or she is in violation of the Clean Indoor Air Act, Public Health Law Article 13-E and this policy, request that there be no other violations, and, as applicable, inform the user of the penalties for the violation.

If a patient violates this policy and uses a tobacco product while in treatment, it shall be considered in the context of his or her individual treatment plan and the program will respond in a manner consistent with policies regarding the possession and/or use of drugs and alcohol.

A visitor to the facility who violates this policy shall be asked to leave and reminded not to smoke, or use tobacco products, on future visits. If a violation is repeated on a future visit, such person shall be refused entry to the ATC for an appropriate period of time, determined by the Director and/or his/her designee.

Approved By:_____ Date:_____

Reproduced from New York State Office of Alcoholism and Substance Abuse Services. Model Policies and Procedures: Tobacco-Free Environment of Addiction Treatment Centers.
http://www.oasas.state.ny.us/tobacco/providers/modelplan.cfm

Additional Resources: Policy Development

To learn more about workplace policy development, call SAMHSA's Workplace Helpline at 1–800–WORKPLACE or visit - SAMHSA Drug-Free Workplace Kit

Examples of policy wording from Ohio – Ohio Policy Examples

Program Design

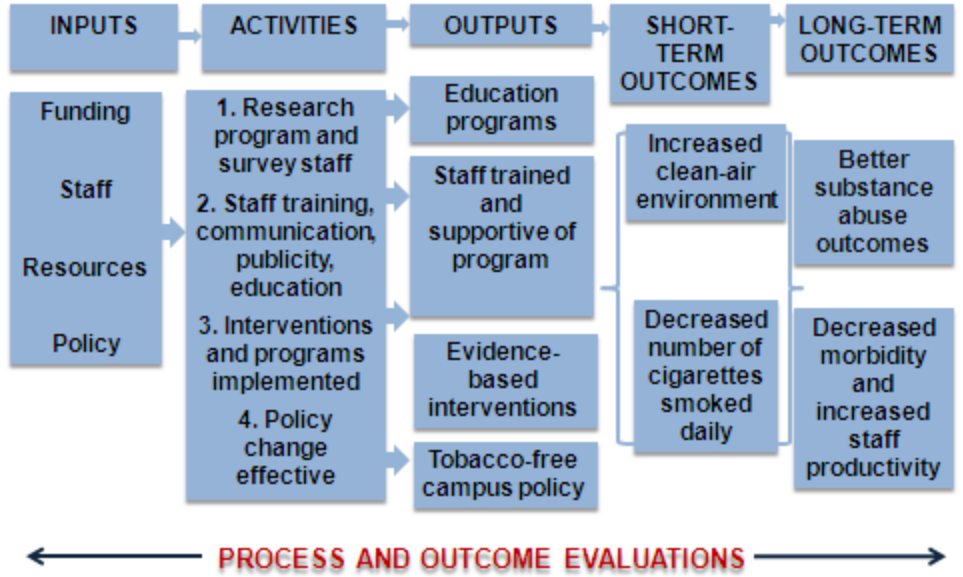
Requirements of an Effective Program

Logic Model

Creating a Logic Model is an important planning component for any program or health intervention. A logic model describes the inputs, activities, outputs, as well as short- and long-term program objectives. A logic model should be created early in the policy change and program planning process and can be used to enhance and evaluate the feasibility and effectiveness of the proposed program. Once implementation of a program has begun, the logic model should be revisited occasionally to ensure the program activities and goals are being achieved.

Figure 4 provides an example of a logic model for making a substance abuse facility tobacco-free. A modifiable template can be found in *Appendix A-1*.

Figure 4
Tobacco-Free Campus Logic Model



The first two steps in creating a logic model relate to the process of planning the program and determining what inputs are available and what activities will be involved. Begin by listing the inputs or resources that are available for program use, such as financial, staff and organizational resources. Next, list the categories of activities that will take place to create the policy change and implement a cessation program. Activities should correspond with how the resources will be used to achieve change. Outputs and outcomes relate to the ultimate results that the program or policy change intends to achieve. Outputs represent the results of the specific program activities. Policy and program changes will result

in both short- and long-term outcomes. Short-term outcomes should be evident as soon as the program is implemented. Long-term outcomes will typically occur a number of years after the program has been implemented (4-6 years) and relate to quality of life and health benefits that will be achieved by the policy/program change. The program evaluation should take place throughout all stages of the logic model. This is important because the evaluation must be considered in the planning process and revisited in each phase of implementation. Advance planning of how the evaluation will occur will result in the ability to obtain results and data that allow a thorough evaluation and analysis of how the program was implemented and how successful or unsuccessful it was in achieving the proposed outcomes (W.K. Kellogg Foundation, 2004).

Additional Resources: Creating a Logic Model

The CDC provides a Healthier Worksite Initiative to assist organizations in assessing the need and interest in a tobacco-free policy. Information can be accessed by visiting - CDC Assessing Need and Interest

Specific information about constructing a program logic model can be found at - CDC Logic Model Information

The Kellogg Foundation provides a detailed Logic Model Development Guide which explains the benefits of a logic model and provides steps for constructing a program-specific logic model - Kellogg Foundation Logic Model Development Guide

Organizational Change

Nicotine dependence is embedded within substance abuse recovery and mental health treatment. Traditionally, cigarettes have been part of the recovery culture, and smoking breaks are often presented as a reward for good behavior and achievement of treatment goals (Ziedonis et al., 2007). An organization's leadership must address the barriers of resource limitations, common myths and staff smoking in order to build staff buy-in and design an effective policy change plan.

Organizational change is created by educating staff members, providing evidence of successful interventions and by creating readiness for change. Education of staff members is further discussed in *Section II: Program Design*. Establishing organizational readiness for change is important and has been successfully implemented in substance addiction treatment facilities through the familiar 12 Step Approach (See Figure 5) (Ziedonis et al., 2007).

Figure 5

12 Step Approach to Addressing Tobacco Use Through Organizational Change*

Step	Organizational Change
1	Acknowledge that addressing tobacco use is challenging.
2	Establish a leadership committee. Ensure the organization's commitment to the project.
3	Create a change plan, timeline and measurable goals/objectives.
4	Begin by implementing changes that are easy and will be successful.
5	Conduct staff training and education. Provide ongoing staff supervision.
6	Provide interested staff members with tobacco treatment and cessation support.
7	Assess client nicotine use, dependence, previous treatments and quit attempts.
8	Educate clients about tobacco dependence.
9	Provide Nicotine Replacement Therapy for management of nicotine withdrawal.
10	Integrate tobacco dependence treatment groups into regular services.
11	Develop Nicotine Anonymous meetings on campus.
12	Create written policies to address tobacco use on campus.
* Adapted from Ziedonis et. al. 2007	

Creating organizational change based on the 12 step model allows for familiarity among staff, clinicians and clients (Ziedonis et al., 2007). One of the key factors in creating organizational change is to have high-level leadership embrace and endorse the program or policy change (Step 1). This is important as employees' perception of managerial support increases compliance (Knudsen & Studts, 2010).

Another key factor in creating organizational change is to establish a leadership committee (Step 2). Members of a leadership committee should represent the various sub-groups of employees at an organization (administration, clinical, medical, support staff, etc.), as well as high-level leadership who have the ability to make financial decisions and can motivate change among staff and clients (Ziedonis et al., 2007). This committee is tasked with the activities associated with the oversight of designing, implementing and evaluating the program (See *Section II: Program Design* for more information about

creating a tobacco-free timeline and suggested specific activities). A Program Administrator should be identified to handle the day-to-day program activities and correspondence. The leadership committee should provide oversight to the program, address staff and client concerns and make overall policy/program decisions.

Creating a written plan for change involves brainstorming the short- and long-term goals of a policy change and/or cessation program (Step 3). The leadership committee will be instrumental in determining the goals, objectives and evaluation criteria during this phase. Small changes should be implemented initially to ensure success and establish rapport for the program and committee (Step 4). Examples of small changes include updating client forms to assess nicotine dependence, creating a way to identify smokers in client charts, discontinuing the use of the term "smoke break," and mandating that staff members do not smoke with clients (Ziedonis et al., 2007). All staff members should be trained to assess client nicotine dependence, readiness to change, and should be prepared to discuss tobacco use and cessation with clients (Step 5) (See *Section II: Program Design* for additional information about staff training).

Since many staff members smoke, it is important to offer an employee cessation program to interested individuals (Step 6). An employee cessation program should provide staff members with similar resources and support as the client cessation intervention. Client forms and assessments will need to be updated in order to incorporate screening for tobacco use, measuring nicotine dependence and assigning cessation resources and materials (Step 7). Clients should receive tobacco information and support in the form of education (Step 8), nicotine replacement therapy (Step 9) and the integration of evidence-based practices that work for concurrent tobacco cessation and substance abuse/mental health treatment (Step 10). Additionally, the creation of nicotine anonymous meetings (Step 11) can be a useful resource and support for both clients and staff. Finally, policies should be updated to reflect the organization's stance on tobacco use (Step 12). If the campus is tobacco-free, the organization's policy should clearly state the expectations, rules and how violations will be handled (Ziedonis et al., 2007).

Budget

Before deciding to implement a tobacco-free policy, an organization should thoroughly explore the costs associated with various interventions. An educational program alone can be designed and implemented with minimal costs (staff time and resources being the most expensive items). More expensive interventions include the use of Nicotine Replacement Therapy (NRT), which has been shown to double an individual's chances of quitting successfully (Smokefree.gov, 2010). The best results are achieved through a cessation program that combines educational and medication components. Take time during the planning stage to price various NRT products, consider how many employees/clients would utilize such products and determine a budget.

Figure 6

Budget Considerations

Category	Considerations
Personnel	Who will run the program (a current or new employee, can an intern or masters student work on this as a special project/internship)?
Printing Costs	Costs associated with the policy change/announcement and education. When possible, utilize programs/resources that are already available.
Nicotine Replacement Therapy and Medication	What products will be offered to clients and/or staff? How many people do we anticipate to use these products? How many units are required per day per person (e.g. gum chewed every 2-3 hours; patch applied once every 24 hours)?
Other Possible Costs	Regular Gum, Peppermints, Stress Kits (forms of distraction for tobacco-users trying to quit); Carbon Monoxide Meters.

Resources for Determining a Budget and Reducing Costs:

A. Utilize existing resources and materials when possible.
    1. Surgeon General's 5 A's Program Recommendation
    2. Smokefree.gov Quit Guide and Resources
    3. Example Employee Wellness Toolkit
B. Compare prices for nicotine replacement therapy and consider how many individuals will utilize these services over a specific time period (See Figure 6).
    1. Consider purchasing in bulk.
    2. Consider purchasing generic products.
    3. Use coupons/manufacturer discounts/patient assistance programs
        i. Chantix Website
        ii. Nicoderm CQ Website
        iii. Pfizer Assistance Programs
C. Seek outside funding. Request gift-in-kind support from the organizations where you purchase nicotine replacement therapy. Identify charitable foundations tied to the retailers and vendors that your organization uses and explore grant making opportunities through the submission of a letter of inquiry or formal grant request.

Program Design

Timeline

Timeline Introduction

Providing sufficient advanced notice to employees, stakeholders and clients is vital to the success of implementing a tobacco-free policy in a residential substance abuse program since all individuals involved need time to adjust before the policy change is implemented. Since many staff members smoke themselves, it is essential to design an employee smoking cessation program as part of the intervention. Staff members need time to make the personal decision to quit or to determine how they will manage their habit given the new policy. Increasing staff buy-in for a tobacco-free policy is essential, and this is achieved through time, open communication and education. Most hospitals establish a 9-12 month timeline for tobacco-free policy implementation. A residential substance abuse/mental health facility can successfully adopt this new policy in six months. Timeline recommendations for program planning, implementation and evaluation activities are provided in Figures 7 and 8.

Figure 7

Program Planning Timeline

	Program Planning Activity	6	5	4	3	2	1
1	Notify board members, key staff, stakeholders	■					
2	Formal internal announcement of program (Appendix A-2)	■					
3	Establish Leadership Committee and program staff	■					
4	Create policy, program materials and website updates		■				
5	Communicate policy change to all employees		■	■			
6	Announce program on campus (Appendix A-5)			■	■	■	■
7	Finalize and order program materials and signage				■		
8	Finalize policy (Appendix A-3)				■		
9	Educate staff, clients, volunteers about program and policy					■	■
10	Establish schedule of available resources/program					■	
11	Deliver program materials to all departments						■
12	Announce program in the general media (Appendix A-4)						■
13	Organize campus-wide health celebration event						■
14	Post all signage and brochures						■

Explanation of Program Planning Sub-Activities

The program planning timeline outlines recommended activities for the six months prior to implementation. A discussion of sub-activities related to program planning follows.

Activity #3 – Establish a Leadership Committee and Program Staff. A leadership committee should be composed of an executive level individual who supports the program, the individual in charge of implementing the program, and smokers and nonsmokers representing various populations within the organization. Possible sub-activities within this category include:

a. Survey staff and clients – A survey should address current smoking habits and assess readiness to quit tobacco. Survey questions asking staff/clients to list or rate preferred cessation supports would be helpful in designing the program and establishing what resources will actually be utilized by smokers. (*See Section II: Program Design* for more information. *Appendix A-7* provides modifiable staff and client survey templates).

b. Establish program goals, objectives and evaluation methods –

   The **Program Goal** should be a brief overall explanation of the program. Example: The [Insert Program/Committee Name] has been established to implement a no-smoking campus policy at [Insert Company Name] in order to promote a clean air environment and to improve the health of clients and staff.

   The **Program Objectives** should be brief, specific and measurable. Example:

   Objective 1: 75% of smoking clients will receive cessation education and resources during their six month stay at [Insert Company Name].

   Objective 2: The overall number of cigarettes smoked daily by staff members will be reduced by 10% within a one-year period.

   The **Program Evaluation** should be considered during the program planning process. A program evaluation may assess if the program was implemented as planned (called a process evaluation) and if the program was effective in achieving the desired results (called an outcome evaluation). (*See Section IV: Policy/Program Evaluation* for more information).

c. Draft policy change – Ensure the policy wording is reviewed by the Executive Director, Board Members, Quality Improvement Director and legal advisors. (See *Section II: Program Design* and *Appendix A-3* for more information).

d. Research employee benefits – Determine if employee insurance and/or health benefits will be impacted by this program. Will healthcare costs decrease if people quit smoking? Will insurance cover any nicotine replacement therapy or education groups for staff?

e. Establish communication methods – Determine how and when the policy change will be explained to all staff members. Identify a contact person for the program who can address concerns, answer questions and report feedback to the leadership committee.

Activity #5 Communicate Policy Change – The policy change should be announced to all staff members by a high-level executive. The official announcement may occur at a meeting or in an email or memo to all employees (See *Appendix A-2* for modifiable staff communication templates). Human Resources should be instructed to inform all potential employees of the upcoming policy change. Employees should be instructed to inform all incoming clients of the policy change (the exact timing depends on the length of the program. If a client typically remains on campus for six months, this process should begin at least seven months before the policy is implemented). Once official notification is made, ongoing communication should be a priority of the leadership committee.

Activity #6 Announce Program on Campus – Both employees and clients should be aware of the pending policy change. It is important to ensure that staff members receive education about the effects of smoking, proven cessation methods and cessation during substance abuse treatment. Additionally, staff should be educated about what resources and programs will be available to smokers once the campus is tobacco-free. Education and communication may take the following forms: Email, FAQs, Scripts, Inclusions with Payroll Tickets, Toolkits, Lunch and Learn or other educational sessions. It is vital to fully explain to staff and clients how the program will be enforced. Scripts may assist in training staff with how to deal with unpleasant client/staff reactions to the policy change. (*See Section II: Program Design* for more information about staff training and *Appendix A-2* for modifiable templates related to staff communication).

Activity #11 Deliver Program Materials to Departments – All staff members should know how to access program materials. Materials may include assessment forms, schedules of education/cessation sessions, stress kits, peppermints/gum, nicotine-replacement therapy, toolkits, etc.

Figure 8

Program Implementation and Evaluation Timeline

	Implementation and Evaluation Activity	0	+1	ongoing
1	Official beginning of program			
2	Host campus-wide health event			
3	Remove all cigarette-butt receptacles on campus			
4	Enforce policy			
5	Process evaluation of policy change/program			
6	Program adjustments as necessary			
7	Outcome evaluation of policy change/program			

Explanation of Program Evaluation Sub-Activities

The program implementation and evaluation timeline above (Figure 8) documents activities that should occur during the implementation month (noted as "0"), one month after implementation (noted as "1+") and activities that are classified as "ongoing." A discussion of sub-activities within specific categories follows.

Activity # 5 Process Evaluation – This type of evaluation measures if the program was implemented as planned. This may include surveys or focus groups conducted with staff and clients. This helps to monitor the program, determine areas of confusion and make adjustments as necessary.

Activity #6 Outcome Evaluation – This type of evaluation measures if the program was effective. This may include pre- and post-test surveys of individuals who did or did not receive cessation services as part of the program and tracking the number of supplies used or distributed.

See *Section IV: Policy/Program Evaluation* for more information about process and outcome evaluations.

Program Design

Staff Training

Staff Training Introduction

Between 25% and 63% of substance abuse and mental health treatment staff are smokers themselves (Ratschen et al., 2009; Knudsen & Studts, 2010; Teater & Hammond, 2009; Bobo & Davis, 1993). The personal habits of these individuals, along with the mistaken beliefs that cessation interferes with recovery, that tobacco is the least worrisome addiction, or that cessation will be too stressful for clients, leads to the reluctance of staff members to address tobacco cessation with their clients (Teater & Hammond, 2009). All of these issues must be addressed in order to create a successful policy change.

Communication is a key step related to policy and program changes. It is important to ensure that all staff members are aware of the pending policy change. Staff buy-in is critical to the success of the program, and is established through open, advanced communication and training. *Appendix A-2* provides sample communication templates to inform employees about the policy change and available resources. The policy change should be initially announced by a high-level executive at the organization.

In addition to communicating the policy change to employees, it is important to train and educate staff members who will be working with clients about tobacco-use and cessation during substance abuse treatment. Additionally, it is important to note that the smoking status of employees impacts their beliefs about addressing smoking cessation with clients. A survey of 963 addiction treatment staff members found that the majority of employees, including current, former and non-smokers, agreed that agencies should address and treat tobacco dependence in their programs (Teater & Hammond, 2009). Despite this stated agreement, staff members who smoke are less likely to discuss cessation with their clients (Bobo & Davis, 1993; Ratschen et al., 2009). It is crucial that all staff members understand the program, its importance and are prepared to discuss tobacco dependence and cessation with clients.

Staff Education

As mentioned in the Program Rationale, there are many barriers to implementing a tobacco-free policy at a substance abuse and/or mental health facility. These barriers include resource limitations, common beliefs within the field and the large percentage of treatment staff who are also smokers (Guydish et al., 2007). All of these barriers must be addressed by the Leadership Committee and Program Administrator(s) in order to implement a successful program.

A review of 15 articles related to staff perceptions of providing smoking cessation during substance abuse treatment revealed a number of barriers including a lack of staff knowledge/training, limited staff time, the provision of few onsite smoking cessation services, as well as inadequate staff support and funding (Guydish et al., 2007). The most commonly reported barrier was related to the lack of staff knowledge and training, indicating an increased need in educational training before implementing a tobacco-free policy or cessation program. The leadership committee should plan to address the issues of staff time, available cessation services and funding during the planning stages of the program.

Figure 9

Staff Myths and Realities About Tobacco Cessation During Substance Abuse Treatment

Myth	Reality
Quitting smoking endangers abstinence.	Smoking cessation during substance abuse treatment has been associated with up to a 25% increased likelihood of long-term abstinence from alcohol and other drugs (Prochaska, Delucchi, & Hall, 2004).
Nicotine addiction is the least important addiction during recovery.	Substance addicted and mentally ill individuals experience greater smoking-related morbidity and mortality than the general population (Baca & Yahne, 2008). Individuals with a mental illness are more likely to be smokers and experience lower quit rates than individuals without a mental illness (Lasser et al., 2000).
Clients in recovery are not interested in quitting tobacco.	Approximately 70% of all smokers are interested in quitting tobacco (Fiore et al., 2008). Smokers in substance abuse treatment understand the dangers of smoking and are generally interested in quitting (Baca & Yahne, 2008).
Quitting tobacco during recovery is too stressful.	Nicotine addiction is an addiction like any other drug or alcohol (Teater & Hammond, 2009). Nicotine addiction should be addressed during recovery as it relates to addictive personalities, coping, etc.

A number of common myths and beliefs impact the success of implementing a tobacco-free policy. Figure 9 provides a list of myths identified by Guydish et al. (2007), as well as evidence citing the reality which should be explained to staff members in order to dispel myths and increase understanding of the importance of tobacco-free policies and programs.

Following are topics and talking points that should be addressed with employees and staff members so that they understand the importance of addressing tobacco cessation with clients during substance abuse treatment.

Topic: Co-Morbidity of Tobacco Use and Substance Abuse/Mental Illness

In 2008, 21% of American adults over the age of 18 were smokers (Pleis, Lucas, & Ward, 2009).
Smoking rates among individuals in substance abuse treatment are two to four times higher than the general population (Kalman et al., 2001, 2005), meaning up to 80% of individuals in recovery are smokers. Approximately half of individuals with a severe mental illness also have a diagnosis of substance abuse or dependence (National Alliance on Mental Illness, 2010). Tobacco use is the leading preventable cause of illness and death in the United States (National Institute on Drug Abuse, 2008) and individuals with mental illness and substance abuse die at earlier ages than the general population (National Association of State Mental Health Program Directors, 2007). It is important to educate staff members about the comorbidity of these addictions and the importance of quitting to improve overall health and recovery.

Topic: Substance Abuse Treatment Employees and Tobacco

Studies show that nearly half of employees working in substance abuse treatment are also in recovery (Bobo & Davis, 1993) and more than 80% of recovering staff members smoke (Knudsen & Studts, 2010). In general, more than 25% of addiction treatment staff smoke and the smoking status of employees impact their tendency to encourage clients to quit smoking. One study found that 55% of former smokers working in substance abuse treatment centers thought clients should be encouraged to quit smoking while only 23% of current smokers believed clients should be urged to quit (Bobo & Davis, 1993). Education of employees, open communication and an employee tobacco cessation program are critical to a successful policy change.

Topic: Motivation to Quit

More than 70% of all smokers would like to quit (Fiore et al., 2008). While the majority of tobacco users would like to change their habit, abstinence rates are lower based on certain variables (see Figure 10), including the comorbidity of substance abuse and mental health issues (Fiore et al., 2008). These individuals often require additional quit attempts, resources and support in order to successfully quit tobacco. As part of the education process, staff members need to understand the challenges that clients face in quitting tobacco and help clients learn more about their tobacco habits, assess readiness to change and motivate clients to consider quitting now or in the future.

Figure 10

Variables Related to Lower and Higher Tobacco Abstinence Rates

Variables Related to Lower Smoking Abstinence Rates	Variables Related to Higher Smoking Abstinence Rates
High levels of nicotine dependence.	High motivation to quit tobacco and high readiness to change.
Comorbidity of substance use and mental illness.	Moderate to high self-efficacy and confidence in his/her ability to quit.
Increased levels of stress and stressful life events (divorce, health problems, job change).	Strong support system.
Regular exposure to other smokers and/or presence of other smokers in the same household.	No exposure to smoking at the home or workplace and others do not smoke around the quitter.
Heavy smoker (20+ cigarettes per day) and first daily cigarette is within 30 minutes of waking.	Ready to quit tobacco within the next month.

Adapted from *Treating Tobacco Use and Dependence: 2008 Update* (Fiore et al., 2008)

Note that individuals with a substance abuse and/or mental health diagnosis exhibit many of the variables related to lower smoking abstinence rates. Therefore, it may seem harder for these individuals to remain tobacco-free. Educational sessions with staff members should prepare staff for the challenges clients will face when trying to quit tobacco.

Topic: Concurrent Tobacco Cessation and Substance Abuse Treatment

A national survey of more than 2,000 substance abuse counselors found that more than 60% of counselors perceived that smoking cessation interventions would improve the likelihood of clients achieving sobriety (Knudsen & Studts, 2010). Despite this, only 30%-40% of substance abuse facilities offer tobacco cessation resources (Baca & Yahne, 2009). Studies show that smoking cessation interventions in substance abuse treatment can benefit clients, but the success of these interventions is dependent upon staff's knowledge and understanding of the program, as well as managerial and leadership support for the program (Knudsen & Studts, 2010). Multiple studies show there is an increased need for educating staff members about cessation and the specific program being implemented (Ratschen et al., 2009; Knudsen & Studts, 2010). Tobacco cessation during recovery has been associated with a 25% increase in long-term sobriety (Prochaska et al., 2004), and it is important to educate staff members about current research relating to the benefits of concurrent tobacco cessation and substance abuse treatment. Additionally, be sure to solicit feedback from staff members and address specific concerns they might have about implementing a policy change and/or tobacco cessation program.

It is important to help employees understand what they are being asked to do and why what they are being asked to do is important. Conversations and education can take the form of scripts, lunch and learn sessions, large and small group meetings, etc. Ensure that all employees understand the importance of the program and the research behind the concept. The most successful program and policy changes at substance abuse and mental health facilities have included open communication, leadership committees, advanced planning, staff education, staff training, and evidence-based smoking cessation interventions.

Additional Resources: Training Staff Members

Free Online Tobacco Intervention Training for Health Professionals - Live Healthy Georgia

Toolkit from the National Association of State Mental Health Program Directors – Tobacco-Free Living in Psychiatric Settings: A Best Practice Toolkit

Quick Reference Guide for Clinicians: Treating Tobacco Use and Dependence – Surgeon General Guide

Program Design

Sample Data Collection Questionnaires

It is important to gather information from clients and employees about their current tobacco-use status, habits, readiness to change and past cessation attempts. This information can help design the program or intervention and is vital during the evaluation stage. Information should be collected prior to participation in the intervention and follow-up data should be collected after the intervention has been implemented to help determine the effectiveness of the program.

Measuring Client Nicotine Dependence

A form should be created that will gather general demographic information and document a client's current tobacco use. The Fagerström Test for Nicotine Dependence on Cigarettes is a common measure and is used in this toolkit (Mayo Foundation, 2003). The results of an assessment can be used by staff members to determine what type of resources might benefit a particular client and to recommend the appropriate type and amount of nicotine replacement therapy.

An example of a client assessment form is provided in Figure 11. See *Appendix A-6* for a modifiable template.

Figure 11. [ORGANIZATION NAME/LOGO]

Nicotine Dependence Assessment

Client Name: _____Date: _____

1. Does client use tobacco? (circle answer)

Yes (continue to question number 2)

No. Have you ever used tobacco? YES or NO.

If YES, when did you quit? _____.

2. How long has(did) client use(d) tobacco? _____ years _____ months

3. What form(s) of tobacco does(did) client use(d)? (circle answers)

Cigarettes Pipe/Cigar Chewing/Smokeless Tobacco Other: _____

4. Is client interested in quitting tobacco now?

Yes No Possibly/Would consider learning more

Items and Scoring for the Fagerström Test for Nicotine Dependence on Cigarettes

QUESTION	ANSWER	SCORE
How soon after you wake up do you smoke your first cigarette?	Within 5 minutes	3
	6 to 30 minutes	2
	31 to 60 minutes	1
	After 60 minutes	0
Do you find it difficult not to smoke in places where smoking is not allowed (ex. hospital, library, movies)?	Yes	1
	No	0
Which cigarette would you be the most unwilling to give up?	The first one in the morning	1
	All others in the day	0
How many cigarettes a day do you smoke?	More than 30	3
	21 to 30	2
	11 to 20	1
	10 or less	0
Do you smoke if you are so ill that you are in bed most of the day?	Yes	1
	No	0
	TOTAL SCORE	

Scoring: 0-2 Points: Mild Nicotine Dependence; 3-6 Points: Moderate Nicotine Dependence;
7-10 Points: Heavy Nicotine Dependence

Name of Staff Member Completing Assessment: _____

Next Steps/Referrals:

Scheduled Follow-Up:

Additional Resources: Measuring Nicotine Dependence

A copy of the Fagerström Test for Nicotine Dependence can be found at the Mayo Clinic's website - Fagerstrom Test of Nicotine Dependence

Staff Questionnaires

Staff questionnaires serve multiple purposes. They can gather information about the perception of a tobacco-free policy or employee cessation program, measure current tobacco-use among employees and assess what cessation resources might be utilized. Additionally, staff can help identify gaps in treatment support and can provide insight into the type and amount of education that staff members will require (Teater & Hammond, 2009). The Employee Opinion Survey in Figure 12 can be used to help design the intervention and gather pre-intervention data about current tobacco use.

See *Appendix A-7* for a modifiable template of the Employee Opinion Survey and an example Employee Follow-Up Survey.

Figure 12. [ORGANIZATION NAME/LOGO]
Employee Opinion Survey

The following survey is being conducted in conjunction with [ORGANIZATION NAME] becoming a SMOKE FREE CAMPUS on [DATE]. Please share your honest, anonymous opinion.

1. What barriers do you see that [ORGANIZATION NAME] would face if we adopted a 100% smoke free policy? *(Check all that apply)*

_____ Employees would not follow policy

_____ Clients/visitors would not follow policy

_____ Employees would seek jobs elsewhere

_____ Clients would seek services elsewhere

_____ Policy would be too hard to enforce

_____ Other, please specify: _____

2. Please indicate the extent to which you are bothered by secondhand smoke at work. *(Check all that apply)*

_____ Frequently bothered _____ Occasionally bothered

_____ Seldom bothered _____ Never bothered

3. If you are bothered by secondhand smoke at work, in what way are you bothered? *(Circle all that apply)*

_____ Eye, nose and throat irritation _____ Concern for your long-term health

_____ Interference with work performances _____ Headaches

_____ Pregnancy related concerns _____ Other, please specify _____

_____

_____

General Information:

1. Please indicate your current smoking status:

_____ Never smoked

_____ Currently smoke cigarettes

Cigarettes/packs *(please circle)* per day _____

Length of time you have smoked _____

_____ Currently smoke pipe/cigar. Amount smoked per day _____

_____ Used to use tobacco

How long since you last used tobacco? _____

For how long did you use tobacco? _____

Approximate amount of tobacco used daily: _____

How did you quit? _____

2. Are you **Male** or **Female**? (please circle one)

3. What is your age *(please circle one)*

_____ Less than 20 years _____ 20-30 years _____ 30-40 years

_____ 50-60 years _____ 60+ years

For current smokers only:

1. Do you smoke at work?

_____ Yes _____ No

2. Do you want to quit?

_____ I want to quit _____ I do not want to quit _____ Maybe / Unsure

3. Have you ever tried to quit before?

_____ Yes _____ No

4. Would you utilize a company-sponsored program to help you stop smoking?

_____ Yes _____ No _____ Maybe

5. If smoking were banned in the workplace, how would this affect the amount you currently smoke?

_____ It would not affect how much I smoke _____ I would smoke less

_____ I would smoke more at home _____ I would try to quit

6. What do you think would help you quit using tobacco? *(check all that apply)*

_____ Smoking cessation class _____ Quitting with a friend/spouse/co-worker

_____ Incentive program _____ Medication aids to help me quit

_____ 1-800 Quitline _____ Educational information on how to quit

_____ Nothing - I will quit on my own when I am ready

Thank you for your cooperation and for sharing your opinion!

****

Additional Resources: Data Collection Questionnaires

Staff Questionnaire provided by the Health Promotion Board - Employee Questionnaire.pdf

Creating a Tobacco-Free Residential Substance Abuse Treatment Facility

A Toolkit for Designing an Effective Intervention

Section III Program Implementation

Program Implementation

Components of a Tobacco Cessation Program

Introduction

Successful tobacco cessation interventions build motivation to quit, assess readiness to change, and assist tobacco users in developing the behavioral and cognitive skills required to manage the withdrawal process and successfully quit tobacco (Hitsman et al., 2009).

The U.S. Department of Health and Human Service's Clinical Guidelines for *Treating Tobacco Use and Dependence*: *2008 Update* (Fiore et al., 2008, 2009) was created for professionals in a variety of clinical settings, including substance abuse and mental health treatment facilities. The guide encourages all clinicians to address tobacco use with their clients and notes that:

- Even brief interventions (less than three minutes) are effective;
- The more involved an intervention, the better the tobacco cessation outcome;
- Interventions increase motivation and future quit attempts for clients who are not ready to quit tobacco; and
- Tobacco-cessation interventions are cost effective.

Additionally, *Treating Tobacco Use and Dependence*: *2008 Update* established 10 key findings that clinicians should be aware of (Figure 13) (Fiore et al., 2009).

Figure 13

10 Key Findings for Clinicians

Adapted from *Treating Tobacco Use and Dependence: 2008 Update* (Fiore et al., 2009)
1. Tobacco dependence is a chronic disease and cessation often requires multiple quit attempts, repeated interventions and ongoing support.
2. Health organizations and clinicians interacting with clients must consistently identify and document each client's tobacco use status and recommend support and resources for all tobacco users.
3. Tobacco dependence treatments are effective for many populations, including individuals in substance abuse and mental health treatment. Clinicians should encourage and assist all clients who are interested in quitting tobacco.
4. Even brief tobacco dependence treatment is effective.
5. Individual, group and telephone counseling are effective in assisting clients in quitting tobacco. The effectiveness of these interventions increases with the intensity and length of the treatment. Practical counseling (problem-solving/skills training) and social support are two effective components of counseling.
6. There are many effective medications for tobacco dependence and clinicians should encourage their use when appropriate. The following medications increase long-term smoking abstinence rates: Bupropion SR, Nicotine gum, Nicotine inhaler, Nicotine lozenge, Nicotine nasal spray, Nicotine patch, Varenicline.
7. The combination of counseling and medication is more effective than either alone.
8. Counseling through telephone quitlines is effective and should be recommended to patients.
9. If a tobacco user is unwilling to quit, clinicians should use the 5R's motivational intervention to help increase the chances of future quit attempts.
10. Tobacco dependence treatments are clinically effective and highly cost-effective.

Program Implementation

Components of a Tobacco Cessation Program

Addressing Nicotine Dependence

The importance of addressing tobacco cessation among substance abuse and mental health clients has now been established within this toolkit. The next step is for your organization to determine how it will address nicotine dependence with clients. A plan must be established to help clinicians identify and assess tobacco use and refer clients to the resources available at your organization and within the community. Since the needs of clients and the resources available to organizations will vary considerably, a menu of treatment options is provided to help your organization determine which interventions and resources are the most feasible to implement.

Assess tobacco use with all clients and measure nicotine dependence

All clients should be asked whether or not they are a current or past tobacco user. This can be accomplished in a simple manner by adding a sticker to the front of each chart or by adding an additional question to the intake questionnaire. A more elaborate questionnaire, such as the one in *Appendix A-6*, can be created to gather client demographic information, tobacco use status and to measure nicotine dependence using the Fagerström Test.

Staff members should be trained to discuss the issue of nicotine dependence with clients. Role playing can be helpful in building staff confidence, knowledge and comfort with this discussion. Further information about holding conversations with clients can be found in the following sections related to Assessing Readiness to Change and implementing the 5A's method.

Assess readiness to change

It is important to determine whether or not a client is ready to change their tobacco habit. Different interventions can be delivered to individuals who are ready to change now versus those who are not yet ready. The simplest way to assess readiness to change is by asking the following two questions:

1. Do you currently smoke?
2. If yes, what are your feelings and thoughts about quitting smoking?

An individual's response will indicate if he/she is in the precontemplation, contemplation, preparation or action phase of tobacco cessation. Knowing an individual's stage of readiness to change will allow staff members to provide resources and information in a manner the client is prepared to accept. The American Academy of Family Physicians (2000) provides examples of how an individual in each stage might respond to the above questions. Those conversation examples and explanations of the phases are provided in Figure 14.

Figure 14. American Academy of Family Physicians: Readiness to Change

Precontemplation

Patients in the precontemplation stage respond with a nonambiguous answer, indicating that they have no intention of changing. Some actual responses by smokers in this stage have been the following:

Anger: "Just get off my back, all right?"

Entitlement: "Who are you to tell me what to do?"

Ignorance: "I already smoke a low-tar cigarette, so there's no need to quit."

Denial: "Some people get lung cancer from smoking, but it won't happen to me."

Defiance: "I'll smoke if I want to."

The goal of counseling patients in the precontemplation stage is to introduce ambivalence, so they will begin to consider quitting; prescribing medication and strategies for cessation does not help these patients quit smoking.

Contemplation

Patients in the contemplation stage usually respond with two answers, one about wanting to quit and the other about wanting to continue smoking. Some actual responses by smokers in this stage have been:

"I want to quit smoking, but I don't think I'll be able to."

"I like smoking, but I'm concerned about this cough."

The goal of counseling patients in the contemplation stage is to explore both sides of their ambivalence (with the emphasis on how their lives will improve after quitting), which helps them resolve in favor of quitting.

Preparation

Patients in the preparation stage respond with a nonambiguous answer, indicating that they have reached a resolution. Even though they are still smoking, they have made the decision to quit. They typically respond with statements like these:

"You finally convinced me to quit smoking."

"I've heard there's some new medication out to help me quit."

The goal of counseling patients in this stage is to assess their previous attempts to quit and identify what worked before (to build on prior successes) and what were the barriers to success in the past.

Patients in the precontemplation stage and patients in the contemplation stage have not yet decided to quit smoking; only patients in the preparation stage have reached that point.

Action

The physician's responsibility is to guide patients one stage at a time toward the point where they actually stop smoking--which is the action stage. Although this transition takes some patients many years, others move from contemplation through preparation and into action within a single clinical encounter.

Reproduced from American Academy of Family Physicians: Assessing Nicotine Dependence (Rustin, 2000)

http://www.aafp.org/afp/20000801/579.html

Recommend resources based on tobacco use and readiness to change

Resources should be recommended based on the menu of options that your organization will provide to clients. An example menu of options is provided in the next section. Ideally, all organizations should provide various materials to promote tobacco education, awareness and cessation.

Additional Resources: Addressing Tobacco Use

American Academy of Family Physicians: CAGE Questionnaire and 4 C's Test for Nicotine Dependence

University of Rhode Island: General Change Assessment

Program Implementation

Components of a Tobacco Cessation Program

Menu of Options and Interventions

A literature review of smoking cessation interventions during substance abuse treatment indicates not only that concurrent treatment does not negatively impact substance abuse treatment, but that it can enhance recovery outcomes (Baca & Yahne, 2009). Baca & Yahne's (2009) analysis recommends providing a menu of treatment options for substance abuse clients. Providing a menu of services allows organizations with limited resources, such as funding and clinician time, to still provide basic and effective cessation services that fit within their organization's budget and culture of treatment. An example menu of successful interventions includes the following topics or interventions, which are further explained in this section:

1. 5A's (for individuals willing to quit)
2. 5R's (for individuals unwilling to quit)
3. Relapse Prevention (for former tobacco users)
4. Evidence Based Practices (Motivational Interviewing, Motivational Enhancement Therapy, Cognitive Behavioral Therapy, Contingency Management)
5. Pharmacological Options (Nicotine Replacement Therapy and Other Drugs)
6. Quitlines
7. General Wellness Programs (including Physical Exercise Program and/or Nutritional Program)

5A's

The U.S. Public Health Service's *Treating Tobacco Use and Dependence*: *2008 Update* recommends the 5A's strategy be used by all healthcare clinicians (Fiore et al., 2008, 2009). The process of **Ask, Advise, Assess, Assist and Arrange** provides a simple outline for conducting conversations with clients (Figure 15). All clients should be **asked** about their tobacco use status and this information should be recorded. Clinicians should **advise** all tobacco users to quit tobacco

Figure 15

Summary of 5A's

Adapted from *Treating Tobacco Use and Dependence: 2008 Update* (Fiore et al., 2009)
Ask about tobacco use. Identify and document tobacco use status of each client at every appointment or visit.
Advise to quit. Encourage all tobacco users to quit in a clear, strong and personalized manner.
Assess interest in quitting. For current tobacco users, is the individual interested in making a quit attempt now? For previous tobacco users, when did the individual quit and is he/she currently experiencing any challenges to remaining tobacco-free?
Assist in quitting. For clients willing to quit, offer resources available through your organization and the community, such as counseling support and medication. For clients not willing to quit, provide motivational interventions (such as the 5R's) that are designed to increase the likelihood of future quit attempts.
Arrange follow-up. Ensure all clients receive follow-up related to quit attempts and assessing their willingness to quit.

and **assess** their willingness to quit. Individuals interested in quitting should be **assisted** in the process and follow-up should be **arranged** to determine the success of a quit attempt (Morris, Waxmonsky, Giese, Graves, & Turnbull, n.d.).

An abbreviated version (Ask, Advise, Refer) can be adopted by organizations that do not offer cessation resources or if staff has very limited time to discuss tobacco cessation with clients. This process involves **asking** all clients about their tobacco use status and recording the information, **advising** all clients to consider quitting tobacco and **referring** clients to available cessation resources within the community (Morris, Waxmonsky, Giese, Graves, & Turnbull, n.d.).

See *Appendix B* for a detailed account of each step of the 5A's.

5R's

Figure 16

5R's for Tobacco Users Unwilling to Quit

Adapted from *Treating Tobacco Use and Dependence: 2008 Update* (Fiore et al., 2009)
Relevance. Ask each tobacco user why quitting is personally relevant. Ask the client to be as specific as possible and consider health status, family situation, personal barriers to quitting and past quit attempts.
Risks. Ask the client to identify negative personal consequences of tobacco use. Short-term risks include shortness of breath, asthma, bad breath. Long-term risks include heart attack, stroke, cancer.
Rewards. Ask the client to identify benefits of tobacco cessation. Examples may include improved health, sense of smell, physical appearance and financial savings.
Roadblocks. Ask the client to identify expected barriers to tobacco cessation and discuss options and treatments. Examples of barriers include nicotine withdrawal, mood instability, additional stress/anxiety, weight gain and being around other smokers.
Repetition. Repeat the 5R's each time a tobacco user unmotivated for cessation reappears in treatment. Remind clients that multiple quit attempts are often necessary to achieve cessation.

In assessing tobacco use, a clinician may determine that an individual is unwilling to quit tobacco at this point in time. In those circumstances, the *Treating Tobacco Use and Dependence*: *2008 Update* recommends the use of the 5R's strategy of **Relevance, Risks, Rewards, Roadblocks, Repetition** (Figure 16). The 5R's strategy lets the clinician introduce the topic of cessation and allows the client to openly address each topic. Open-ended questions and active listening on the part of the clinician are necessary with this approach (Fiore et al., 2008, 2009).

Relapse Prevention

In assessing tobacco use, a clinician may determine that an individual has quit tobacco in the past. In those circumstances, *Treating Tobacco Use and Dependence*: *2008 Update* recommends **assessing** the potential for relapse, **assisting** the individual with resources and encouragement and **arranging** follow-up for ongoing support (Figure 17) (Fiore et al., 2008, 2009).

Figure 17

Relapse Prevention for Former Tobacco Users

Reproduced from the 2008 Clinical Guidelines for Treating Tobacco Use and Dependence	
Action	**Strategies for Implementation**
Assess Relapse Potential. Ask each former tobacco user when he/she quit. Ask clients if they still crave tobacco and what cessation challenges they encounter.	Remind clients that most tobacco relapses occur within two weeks of quitting and that this risk decreases with time. Cessation challenges will remain for a long time and therefore the need for additional support should be assessed and clients should be connected to resources.
Assist and Provide Encouragement. Congratulate former tobacco users for abstinence and encourage continued cessation.	Ask open-ended questions to discuss the individual's successes. Ask questions about their personal benefits of cessation, challenges in quitting and additional resources that may be needed.
Arrange follow-up.	Determine areas of need and recommend additional support and resources. Schedule a time to follow-up with the client via a telephone call or at a future appointment.

Evidence-based models are the cornerstone of substance abuse and mental health treatment. These models identify treatment practices that are grounded in scientific research and provide clients with the best chances of success and recovery. Familiar models within the fields of substance abuse and mental health, such as Motivational Interviewing, Motivational Enhancement Therapy, Cognitive Behavioral Therapy and Contingency Management, have been successfully adapted and utilized for tobacco cessation.

Motivational Interviewing

Motivational interviewing (MI) is a form of client-centered counseling focused on setting goals, creating behavior change and resolving client ambivalence (National Registry of Evidence Based Programs and Practices, 2007b). MI addresses the contradictory attitudes preventing behavior change in substance abuse and mental health clients. MI focuses on establishing rapport with the client, reflective clinician listening and allowing clients to think about and provide their own answers. Clinicians trained in MI practices ask open-ended questions, affirm the statements made by clients and help clients recognize the discrepancy between their current behavior and future goals. Together, clients and clinicians set goals and establish a work plan for goal achievement (NREPP, 2007b). The conversation and interaction skills that clinicians use during motivational interviewing can be adapted to facilitate conversation with clients interested in tobacco cessation. The *Treating Tobacco Use and Dependence*: *2008 Update* provides MI strategies that are adapted to tobacco cessation and appropriate for individuals in substance abuse and mental health treatment. A summary of recommended clinician behavior and strategies are provided in Figures 18a and 18b (Fiore, et al., 2008, 2009).

Figure 18a

Motivational Interviewing Strategies

Adapted from *Treating Tobacco Use and Dependence: 2008 Update* (Fiore et al., 2009)	
Express Empathy	• Use open-ended questions to ask about the importance of addressing tobacco use, specific concerns about quitting and anticipated benefits ("How important is quitting to you?"). • Use reflective listening to help ensure the understanding of what is being said and to summarize client comments ("So you think smoking helps you maintain weight?"; "What I hear you saying is you enjoy smoking but it worries your boyfriend."). • Normalize feelings and concerns ("Many people worry about quitting cigarettes."). • Support the client's right to choose ("I hear you saying that you are not ready to quit now, but I am here when you are ready.").
Develop Discrepancy	• Highlight the discrepancy between the client's current behavior and their values and goals ("It sounds like family is your priority. How do you think smoking affects them?"). • Reinforce talk of change and commitment ("It's great you will quit when you move into your new apartment."). • Build commitment to change ("There are many options, such as NRT and counseling, that will help with withdrawal.").

Figure 18b

Motivational Interviewing Strategies (cont.)

Adapted from *Treating Tobacco Use and Dependence: 2008 Update* (Fiore et al., 2009)	
Roll with Resistance	• If the client expresses resistance, step back and use reflection ("Sounds like you are feeling pressured about your tobacco use."). • Express empathy ("I understand you are worried about managing withdrawal."). • Ask permission to provide information and support ("Would you like to hear about some strategies that can help address your concerns?").
Support Self-Efficacy	• Help the client identify and build on past successes ("So you were fairly successful in your last quit attempt."). • Offer options for achievable, small steps toward change ("You can always try calling the Quitline when you are tempted to smoke."; "Try reading about the benefits of and strategies related to quitting."; "Consider changing your smoking patterns, such as not smoking in the house or decreasing the number of cigarettes you smoke daily.").

Motivational enhancement therapy (MET) is an adapted version of motivational interviewing that includes client-feedback sessions where the clinician promotes the client's commitment to change. The goal of MET is to change behavior by encouraging motivational commitments from clients, and through the clinician's neutral reactions to client resistance (NREPP, 2007a).

A study of smokers with schizophrenia determined that individuals receiving one motivational interviewing/motivational enhancement session related to seeking tobacco cessation treatment resulted in an increase in the number of individuals seeking cessation support compared to those who received only brief education or no intervention (Steinberg, Ziedonis, Krejci, & Brandon, 2004). Participants received a feedback session where they were given information about their tobacco habits and dependence compared to the average population of smokers and nonsmokers. Additionally, they were provided with information about the amount of money spent on smoking, the importance of quitting and their individual confidence about quitting. All participants were encouraged to quit tobacco and were referred to a tobacco treatment program. While 69% of participants initially indicated that they had no intention to quit tobacco within six months, 32% of individuals receiving the MI intervention contacted a recommended cessation resource following the MI session. This study indicates that motivational interviewing is successful in helping mental health clients become more interested and engaged in tobacco cessation and treatment (Steinberg et al., 2004).

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is commonly used in substance abuse and mental health treatment and can be adapted to address tobacco cessation. CBT focuses on changing behavior through problem solving, thought modification and skills building (Beck, 2009).

The benefits of CBT for smoking cessation are well established, and CBT for cessation focuses on building motivation and confidence to quit, preparing for a quit attempt and coping with withdrawal symptoms (Perkins, Conklin & Levine, 2007). The cognitive aspect of CBT in smoking cessation for mental health

populations includes helping clients learn coping skills to manage withdrawal and mood changes while behavioral aspects focus on changing habits in order to build support systems and avoid the temptation to smoke (Hitsman et al., 2009). The benefits of CBT for smoking cessation have also been proven among a substance abuse population. Reid et al. (2008) found that a combination of nicotine replacement therapy (patch) and CBT resulted in a significant reduction of smoking rates among outpatient substance abuse patients. Additionally, abstinence rates for the primary drug being treated were unchanged between the "substance abuse treatment as usual group" and the "concurrent substance abuse and smoking cessation treatment groups", indicating that concurrent treatment does not negatively impact recovery. CBT can be delivered via individual or group counseling sessions and can vary in length from 15 to 60 minutes per session (Hitsman et al., 2009).

Contingency Management

Contingency management (CM) is an evidence-based practice that promotes treatment compliance by rewarding goal completion (NREPP, 2007c). CM has been very successful in substance abuse and mental health treatment, and this philosophy has been adopted for concurrent tobacco and substance abuse treatment.

One study of individuals in a residential drug treatment program compared the effects of a tobacco cessation intervention, including prize contingency management, with a control group that received only the tobacco cessation intervention. Participants in the CM group were able to receive prizes ranging in value from $1 to $100 and an individual increased his/her number of opportunities to win based on attendance and negative carbon monoxide (CO) and salivary tests. The study found a significant decrease in smoking rates among residential substance abuse clients in the CM group compared to those in the control group (Alessi, Petry, & Urso, 2008).

Pharmacological Options

There are several nicotine and non-nicotine medications proven effective in increasing tobacco quit rates. The combination of medication and counseling is more effective than either alone, and a program should provide both aspects whenever possible (Fiore et al., 2008). A brief explanation of the seven first-line medications approved by the FDA is provided below. See *Appendix C* for additional information about recommending specific medications to clients, dosing instructions, drug interactions and costs of use. It is important to pay special attention to medication recommendations when working with a substance addicted and mentally ill population. Pharmacological medications for tobacco cessation can be helpful, but careful research should take place before recommending clients use these options. This population needs to be aware of the danger of nicotine overdose, medication interactions and FDA drug warnings.

Nicotine Replacement Medications

The use of Nicotine Replacement Therapy (gum, patch, lozenge, nasal spray and inhaler) is effective in treating substance abuse clients interested in smoking cessation (Baca & Yahne, 2009). Substance abuse and mental health clients smoke at higher levels than the general population, and therefore have higher levels of nicotine dependence. Because of the high levels of dependence, nicotine replacement therapy can be especially helpful in managing withdrawal symptoms and slowly decreasing the body's dependence on nicotine.

Figure 19

Types of Nicotine Replacement Therapy (NRT)

Nicotine Replacement Therapy	General Information
Nicotine Gum	Over the counter medication. Available in 2 mg and 4 mg doses. Client chews up to 24 pieces a day for up to 12 weeks. Nicotine gum provides an immediate dose of nicotine that helps satisfy oral cravings.
Nicotine Patch	Over the counter medication. Available in 7 mg, 12 mg and 14 mg doses. One patch is applied per day and delivers 24 hours of consistent levels of nicotine. Can be used for a total of 8-10 weeks.
Nicotine Lozenge	Over the counter medication. Available in 2 mg and 4 mg doses. Client may use up to 20 lozenges per day for a total of 12 weeks. Lozenges must be allowed to dissolve over a thirty minute time period.
Nicotine Nasal Spray	Prescription medication. 0.5 mg dose of nicotine delivered in 2-4 sprays every hour. Maximum of 40 doses per day for a duration of 3-6 months.
Nicotine Inhaler	Prescription medication. 10 mg cartridge provides 4 mg of nicotine. A total of 6-16 cartridges can be used daily for up to 6 months. Client "puffs" on the cartridge and it may be helpful with clients who are used to having a cigarette in their hand/mouth.

National Association of State Mental Health Program Directors (2007).

Anyone discussing nicotine replacement therapy with clients should warn individuals of the potential of nicotine overdose and identify the signs of nicotine overdose (including nausea, vomiting, exhaustion, weakness) (Bentz, Gray, & Swan, n.d.). It is important that clients do not continue to use tobacco while on nicotine replacement therapy due to the risk of nicotine overdose.

Additionally, clinicians should discuss the signs of nicotine withdrawal with clients. These side effects can include (Bentz, Gray & Swan, n.d.):

- irritability
- restlessness
- fatigue
- difficulty concentrating
- anxiety
- hunger
- weight gain
- problems sleeping
- cravings for nicotine
- decreased heart rate

Non-Nicotine Medications (Providence Health and Services Toolkit)

Two non-nicotine prescription medications are available for use with tobacco cessation clients. These medications include Bupropion (Zyban) and Varenicline (Chantix). Both must be prescribed by a physician and require careful consideration of the client's medical history, current addiction or mental health status and medication status. Bupropion is an antidepressant used in the treatment of tobacco cessation and Varenicline is a cessation medication that blocks the effects of nicotine in the brain (PubMed Health, 2009a, 2009b). *Appendix C* provides additional information about these medications and their use with a mental health population. It is particularly important to pay special attention to substance addicted and mentally ill clients using these drugs. Only prescribe these drugs after researching FDA recommendations.

Quitlines

Many states and organizations offer tobacco cessation support and resources through quitlines. Quitlines provide telephone-based cessation services that are cost-effective and individualized (North American Quitline Consortium, 2009). Services and resources provided during a quitline session include counseling, self-help materials and general education, as well as medications and medication information. Currently, every state operates a quitline, and in 2006 more than 328,700 individuals utilized quitlines throughout the United States (North American Quitline Consortium, 2009). The effectiveness of quitlines has been researched, proven and is recommended in the *Treating Tobacco Use and Dependence*: *2008 Update.*

General Wellness Program

Increasing overall wellness can encourage clients to take ownership of their health and make decisions, such as tobacco cessation, that will improve their quality of life. In a residential setting, programs can add general wellness information and resources in formal or informal manners. An informal program would include starting an optional exercise program or walking group and encouraging tobacco users to consider exercise since it helps with nicotine withdrawal symptoms (Brunnhuber, Cummings, Feit, Sherman, & Woodcok, 2007). A basic nutrition program might appeal to clients who are concerned

about gaining weight when quitting tobacco. A more formal program would include scheduled educational sessions. The *Learning About Healthy Living: Tobacco and You* manual created by Williams et al. (2005) addresses overall wellbeing and health for clients with mental illness. This type of resource can be utilized to help implement a regular education and counseling program related to managing mental health, addiction recovery, overall health and tobacco cessation.

Additional Resources:

2008 Quick Reference Guide for Clinicians

U.S. Department of Health and Human Services - Treating Tobacco Use and Dependence

Quitlines

1-800-QUITNOW (1-800-784-8669). Toll-free number that connects you to cessation supports in your specific state and allows you to speak with a quit counselor.

Smokefree.gov Quitline FAQ

National Cancer Institute Quit Line Website

North American Quitline Consortium Website

General Wellness Programs

Mental Health Specific Toolkit - Learning About Healthy Living

Creating a Tobacco-Free Residential Substance Abuse Treatment Facility

A Toolkit for Designing an Effective Intervention

Section IV Policy/Program Evaluation

Policy/Program Evaluation

Introduction

The purpose of an evaluation is to assess and improve the quality of the program that was implemented and to determine its effectiveness (McKenzie, Neiger & Thackeray, 2009). An evaluation plan should be in place prior to initiating a policy change or tobacco-cessation program as the evaluation process is on-going and takes place throughout the design and implementation of a program. Once the goals of a policy change and tobacco-cessation program are determined, program planners need to decide how those changes will be measured. Data will need to be collected for at least three time periods – baseline, mid-term evaluation and final evaluation. It is appropriate for the mid-term evaluation to take place six months after the policy change/program implementation and for the final evaluation to occur 12 months after implementation (CDC, 2010c).

Process and Outcome Evaluations

Data collection at the baseline, mid-term and final evaluation points will be used to perform both a process and outcome evaluation.

A **process evaluation** determines if the policy change/program was implemented as planned and identifies areas that can be improved. This type of evaluation is not as time consuming as an outcome evaluation and involves more qualitative data, such as client and employee feedback and suggestions, which can be collected through surveys and focus groups (McKenzie, Neiger, & Thackeray, 2009).

The purpose of an **outcome evaluation** is to determine if the policy change/program was effective in producing the desired results. An outcome evaluation is more time consuming and data-dependent than a process evaluation (McKenzie, Neiger, & Thackeray, 2009).

Baseline, Mid-Term and Final Data Collection

The type of data collected during each evaluation period depends on the goals of your particular organization's policy change and cessation program. A general discussion of the purpose of each data collection period and examples of possible measures are provided below.

Baseline Data Collection- Baseline data may already be available through your organization or it may have to be collected prior to the program's beginning or the policy change. The purpose of gathering baseline data is to allow for a comparison to determine changes that have occurred over time as a result of the policy change/program.

Mid-Term Evaluation – A mid-term evaluation should be conducted six months following the policy change/program implementation. The process evaluation is important as there has been time to determine what went well and what did not go well during the implementation period and in the design of the program in general. Conducting a process evaluation at six months will allow your organization to

make changes in how the program is being run and to address any concerns and issues that have surfaced. An outcome evaluation at this time will serve as a "trial run" for the data that will be collected for the final outcome evaluation. It often takes longer than six months to see behavior change and financial benefits, but the mid-term evaluation should still attempt to collect data related to the outcome of the program.

Final Evaluation – The final evaluation should take place 12 months following the policy change/program implementation and should focus heavily on conducting an outcome evaluation to determine the effectiveness of the policy and program. An outcome evaluation is heavily data dependent and looks at numbers and facts in order to determine results.

Examples of Evaluation Measures

Below are four figures (20a-d) that provide examples of objectives that might relate to an organization's reasoning for implementing a tobacco-free policy and cessation program. A discussion of possible measures for each of the three evaluation points is included for each objective.

Figure 20a. Policy Change Objective: Increase Worker Productivity (CDC, 2010c)	
Baseline Evaluation	**Possible Measures**
	Use Human Resources data to determine the number of sick days employees used in the six and/or 12 months prior to the policy change.
	Administer an anonymous staff survey to determine the number of employees who use tobacco, the number of cigarettes smoked daily by employees, the number of smoke breaks daily and the average length of smoke breaks. (Note: self-reported data may not be reliable. Observations of staff smoking and/or a focus group might assist in determining if survey results are accurate measures of items such as number and length of smoke breaks).
Mid-Term Evaluation	**Possible Measures**
Process Evaluation	Conduct a focus group to discuss how smoking habits of employees have changed in the six months since the new policy was effective (e.g. compare number of smoke breaks per day, smoking habits, number of cigarettes smoked daily, etc. before and after policy change).
Outcome Evaluation	Use Human Resources data to determine the number of sick days employees used in the past six months. Survey employees about their illnesses/health, tobacco use and changes in smoking habits in the past six months.
Final Evaluation	**Possible Measures**
Process Evaluation	Conduct a focus group to discuss how smoking habits of employees have changed in the 12 months since the new policy was effective (e.g. compare number of smoke breaks per day, smoking habits, number of cigarettes smoked daily, etc. before and after policy change).
Outcome Evaluation	Use Human Resources data to determine the number of sick days employees used in the past 12 months. Survey employees about their illnesses/health, tobacco use and changes in smoking habits in the past 12 months. Relate results to staff time and money saved by the organization due to increased worker productivity.

Figure 20b. Policy Change Objective: Decrease Healthcare Costs (CDC, 2010c)	
Baseline Evaluation	**Possible Measures**
	Use Human Resources data to determine health care usage and costs related to tobacco use (e.g. employee costs associated with heart disease, cancer, and respiratory illnesses). Determine costs related to programs for reducing employee tobacco use (e.g. cessation programs, Nicotine Replacement Therapy, etc.)
Mid-Term Evaluation	**Possible Measures**
Process Evaluation	Survey staff members or conduct a focus group to determine if cessation resources are clear and easy to utilize.
Outcome Evaluation	Re-assess baseline measures for the past six months.
Final Evaluation	**Possible Measures**
Process Evaluation	Survey staff members or conduct a focus group to determine if cessation resources are clear and easy to utilize.
Outcome Evaluation	Re-assess baseline measures for the past 12 months. Determine changes in healthcare use and costs over 12 months. Compare healthcare use and costs of individuals who utilized cessation services vs. those who did not utilize cessation services.

Figure 20c. Cessation Program Objective: Decrease Tobacco Use Among Staff and Clients (CDC, 2010c)	
Baseline Evaluation	**Possible Measures**
	Survey staff and clients to determine how many use tobacco, amount used per day (e.g. number of cigarettes smoked daily), level of nicotine dependence and readiness to change. Survey staff and clients to determine knowledge of tobacco, dangers of tobacco and understanding of cessation options.
Mid-Term Evaluation	**Possible Measures**
Process Evaluation	Measure staff and client knowledge, awareness and utilization of available cessation services over the past six months.
Outcome Evaluation	Re-assess baseline measures over the past six months.
Final Evaluation	**Possible Measures**
Process Evaluation	Re-assess mid-term measures over the past 12 months.
Outcome Evaluation	Re-assess baseline measures over the past 12 months. Determine changes in the number of staff and client tobacco-users, the amount used daily, nicotine dependence levels and readiness to change over the past 12 months.

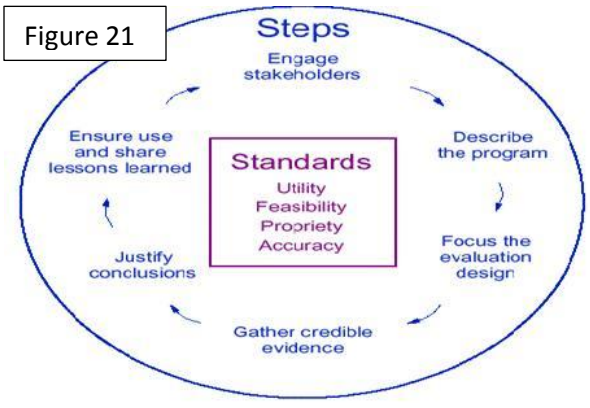
Figure 20d. Cessation Program Objective: Increase the Number of Staff and Clients Using Cessation Services (CDC, 2010c)	
Baseline Evaluation	**Possible Measures**
	Determine the number and type of cessation programs and services currently available to clients and staff. Measure the number of clients and staff who are currently trying to quit tobacco and/or using available resources. Document the number of community partnerships and referral resources currently available.
Mid-Term Evaluation	**Possible Measures**
Process Evaluation	Measure staff and client satisfaction with the amount and type of cessation resources available over the past six months. Determine additional resources that have been added over the past six months. Assess the barriers to receiving cessation support and resources over the past six months.
Outcome Evaluation	Re-assess baseline measures over the past six months. Determine if more resources are available and if the number of individuals accessing those resources has changed over the past six months.
Final Evaluation	**Possible Measures**
Process Evaluation	Re-assess mid-term measures and determine changes over the past 12 months. Determine changes in staff and client satisfaction and usage of cessation resources. Address barriers that have been identified by staff and clients.
Outcome Evaluation	Re-assess baseline measures and determine changes over the past 12 months. Document the number of cessation services and community referral sources that have been added to the program over the past 12 months. Determine changes in the number of staff and clients using cessation services and considering quitting tobacco over the past 12 months.

Conclusion

Once the evaluation is complete, the information should be distributed to stakeholders, staff members and clients. Stakeholders include the individuals and entities important to the organization, such as the Board of Directors, funding organizations and leadership personnel. The evaluation results should be used to determine if the policy change and cessation programs were effective in achieving their goals, if the program should be expanded and any costs/savings associated with the policy change/program.

Figure 21 from the CDC explains the components that should be included in the evaluation of a tobacco-free policy change and cessation program (CDC, 2010c). The final evaluation should describe the policy change and program that took place, explain the focus of the evaluation process, provide evidence gathered through the evaluation and explain the conclusions of the evaluation. Additionally, the evaluation should be used to share the lessons learned through the policy change/program and should be used to engage stakeholders about the policy change/program and its effects.

Figure 21



Creating a Tobacco-Free Residential Substance Abuse Treatment Facility

A Toolkit for Designing an Effective Intervention

Section V

Tobacco Policy/Program Changes Work

Tobacco Policy/Program Changes Work

Case Studies and Effective Programs

Introduction

A number of substance abuse and mental health facilities have adopted tobacco-free policies and/or tobacco cessation programs at their organizations. These organizations vary in the type of services they provide clients (long-term, short-term, residential, outpatient), the types of tobacco-free standards or cessation programs offered and the success of these interventions and policy changes. This section provides case studies of policy and program changes that have been implemented at substance abuse and mental health facilities throughout the United States.

New Jersey Residential Addiction Facilities Successfully Integrate Tobacco-Free Standards

In 1999, New Jersey became the first state to require that all residential addiction treatment programs adopt policies to establish tobacco-free campuses, as well as assess and treat client tobacco dependence among patients. The creation of a tobacco-free campus was initially encouraged but not required in order to provide organizations with additional time for planning and transition. The results from an evaluation of 33 treatment providers indicates that tobacco dependence treatment can be integrated into residential addictions programs through policy change, staff training and the provision of resources, such as Nicotine Replacement Therapy (Foulds et al., 2006).

Figure 22

New Jersey's Experience

Lessons Learned from Integrating Tobacco-Free Standards into Residential Addiction
1. Tobacco dependence treatment can be fully integrated into addiction treatment programs.
2. Most patients in addiction treatment programs want to change their tobacco use.
3. Treating tobacco dependence in the context of tobacco-free grounds does not lead to patients leaving treatment early.
4. The greatest resistance to implementing a tobacco-free policy typically comes from staff rather than patients (with staff who smoke but are in recovery from other addictions sometimes feeling that their sobriety is being challenged).
5. Thorough staff preparation and training, along with availability of Nicotine Replacement Therapy (for both staff and patients), are important components of implementation.
6. Implementation of a tobacco-free grounds is the most challenging aspect of the policy but also an important driver of other organizational changes (e.g. policies for staff tobacco use, availability of NRT).
7. Not enforcing tobacco-free policies can detract from their effectiveness.

Reproduced from Foulds et al. 2006

Initially, treatment providers and staff members were concerned that clients would forego substance addiction treatment and that the policy would negatively impact treatment outcomes through premature discharges and disruption of treatment. In preparation for the policy change, extensive training was provided to assist management and clinical staff in assessing tobacco use and providing treatment. Nicotine replacement therapy was made available to all patients, and later to all interested staff members (Foulds et al., 2006).

An evaluation of 33 treatment providers found the following about New Jersey's program (Foulds et al., 2006):

- Upon admission to a substance abuse program, 66% of patients had a desire to decrease or stop their tobacco use.
- Upon discharge, almost half of patients believed the tobacco-free policy assisted them in addressing their tobacco habit.
- The quantity and quality of tobacco dependence treatment in residential programs throughout the state increased significantly.
- Available staff trainings related to assessment, treatment planning and treatment (including NRT) were well attended by staff members.
- The rates of early discharge from residential programs did not differ between smokers and nonsmokers.
- There was no change in the percentage of smokers who entered residential treatment and there was not an increase in program discharges.

New Jersey's experience is unique in that there was a state-wide mandate for change and some resources were provided for training and nicotine replacement therapy. The New Jersey experience provides an excellent example of the success that can be achieved when addressing tobacco use concurrently with substance abuse treatment.

Staff Smoking Curbed in Oregon

A substance abuse treatment agency in Oregon had a policy prohibiting tobacco use on its campus for more than a decade. The policy was ignored by leadership, staff and clients alike, and smoking had become accepted in designated areas on campus. This particular substance abuse agency provides treatment for adolescents and adults, and both outpatient and residential services are offered on one campus. A policy was implemented to prohibit staff tobacco use on the campus and limit staff members to two 10 minute breaks per day (plus lunch). Clients were still allowed to smoke in designated areas on campus, and education and nicotine replacement therapy was available to interested clients. The agency implemented a program to provide nicotine replacement therapy for staff and clients, staff received training and education, and support groups were established on campus. A support group was created for individuals highly motivated to quit, and a lower motivation group was established to provide general education about tobacco use and cessation. Although staff reported concern and anxiety about the pending program, a staff survey following the policy change revealed a positive response. Another staff survey a year after the intervention showed that staff members were still positive about the program, that interest in staff cessation remained high and that more staff members were interested in the agency becoming completely tobacco-free. Effective communication and the establishment of a leadership committee were considered to be largely responsible for the effectiveness of this policy change and program (Ziedonis et al., 2007). This example of policy change in Oregon indicates the importance of addressing staff smoking and notes the ability of staff members to successfully quit, their interest in using available resources, and the ultimate acceptance and understanding of tobacco policy changes.

A Smoking Ban works at a North Carolina Psychiatric Program

A North Carolina psychiatric three-day crisis stabilization program implemented a campus-wide smoking ban. In advance of the policy change, patients were informed about the pending change and offered educational materials about nicotine addiction, cessation and withdrawal. All patients were offered nicotine replacement therapy in the form of patches and gum. In advance of the policy change, staff surveys showed concern and uncertainty about the changing policy. An evaluation three months after the policy change found that the number of admissions, as well as the daily census and the age of patients in the program were unchanged. Additionally, patient behavior was compared before and after the smoking ban, and behavior was unchanged in terms of the incidence of contraband, episodes of harm and the use of patient restraint. In regards to staff members, a follow-up survey showed staff members were more supportive of the program (Matthews et al., 2005). The experience in North Carolina supports the concept that a smoking ban does not negatively impact patients and that staff members become more supportive of such a program over time.

Figure 23

A Client's Story

Scott's Story of Tobacco Cessation, Relapse and Treatment

Scott was in addiction treatment in New York when the facility became tobacco-free. "Speaking for myself, I wanted to become tobacco-free. It often bothered me that for one as independent as me, it could be said that I was also owned by the tobacco industry because I was addicted to tobacco," said Scott. To assist with the change to tobacco-free, Scott and the other patients participated in educational groups to learn more about tobacco addiction and cessation.

Upon leaving the treatment center, Scott moved into a halfway house where he was the only person who did not smoke. "Tobacco use was such a social event, therefore I was lonely," commented Scott. After six months at the halfway house, Scott began smoking again in order to feel part of the group. He commented, "The price I paid was my re-addiction to tobacco."

Unfortunately Scott relapsed, but he returned to treatment two years later. He now "look[s] forward to restarting my life being clean, sober, and tobacco-free while addressing my mental health issues." (Bonneau, 2008).

Scott's story highlights the common use of tobacco in the recovering community, especially in residential programs, and the detrimental effects this can play on cessation attempts.

Adapted from Bonneau, 2008

Minimal Program in a Navy Alcohol Rehabilitation Program Decreases Client Smoking and Gains Staff Support

A 28-day inpatient Navy Alcohol Rehabilitation Program adopted a smoke-free policy. Staff members received three months advance notice of the policy change, and staff members attended one brief educational session about the effects of smoke-free policies in psychiatric and chemical dependency programs. Prior to the policy change, patients were allowed to smoke in all buildings and areas of campus and tobacco cessation was not addressed with clients. The new policy limited patient smoking to designated areas following daily meals. The program implemented a basic cessation intervention that made nicotine patches available to interested clients and offered a monthly one hour voluntary educational program focusing on the health effects of smoking, the benefits of quitting, and the combined use of alcohol and tobacco. Clients receiving alcohol treatment over an eight month period were surveyed before and after their treatment program. Approximately 12% of clients reported that the tobacco policy change helped their alcohol recovery, and 50% reported that the change had no effect on their recovery. A statistically significant reduction in the number of cigarettes clients smoked

daily occurred from admission (21 cigarettes per day) to discharge (17.8 cigarettes per day). Client reported advantages of the policy change included less secondhand smoke, a cleaner/healthier environment and the ability to quit smoking. Client reported disadvantages included increased stress/anxiety, less focus on primary addictions and increased rule violations (Patten et al., 1999).

This organization also surveyed staff attitudes before and after the policy change. Staff support of the policy change increased during the six months following the policy change and 84.6% of staff members thought the organization should remain tobacco-free. Staff reported advantages of the policy include a cleaner/healthier environment, improved work conditions and the application of a consistent approach to all addictions. Staff reported disadvantages include increased patient stress, increased patient rule violations and decreased focus on the primary addiction (Patten et al., 1999). The Navy Alcohol Rehabilitation Program shows that even minimal efforts and changes can reduce the amount that clients smoke and result in staff support for a tobacco-free policy.

Frequently Asked Questions

Q. What does a tobacco-free policy entail?

A tobacco-free policy at a residential substance abuse facility indicates that the organization is committed to protecting the health of all individuals on the campus through a complete smoking ban. This means smoking is not allowed anywhere on campus, including indoors, outdoors or in vehicles. This type of policy must be committed in writing and incorporated as part of the treatment culture in order to be successful.

Q. Why is it important to become completely tobacco-free rather than limit smoking to designated areas?

A complete smoking ban makes all of the grounds and buildings tobacco-free and therefore increases the chances of incorporating a policy that is complied with and decreasing smoking rates. Smoking is a common social activity in residential treatment settings. Without a full smoking ban individuals on the campus are still exposed to dangerous secondhand smoke and smokers will have a difficult time quitting if they are surrounded by individuals continuing to smoke, even if smoking is only allowed in designated areas.

Q. What are the keys to a successful policy change?

The most successful program and policy changes at substance abuse and mental health facilities have included open communication, leadership committees, advanced planning, staff education, staff training, and evidence-based smoking cessation interventions and resources.

Q. What are the biggest problems and challenges that residential addiction treatment facilities encounter when changing tobacco policies?

Common barriers to providing smoking cessation during substance abuse treatment are related to resource limitations (lack of staff training, staff time, onsite cessation services and funding), common beliefs (perceived risk to sobriety, belief that other addictions are more important than tobacco addiction, thought that clients don't want to quit) and the fact that many staff members are smokers themselves (Guydish et al., 2007). This toolkit addresses these barriers and provides strategies, information and resources for overcoming these challenges.

Q. What does my organization have to gain from implementing a tobacco-free policy?

Upon changing to a tobacco-free organization, you can market the concept that you promote the health and recovery of individuals from all addictions. If a staff cessation program is implemented, you will likely see long-term financial savings related to health care costs, decreased sick leave and increased productivity of workers. Tobacco-free is the wave of the future and accreditation and licensure agencies are increasingly demanding tobacco-free initiatives as part of the approval process. By considering this policy change now, your organization will be better prepared for future regulations and requirements.

Q. How long will it take to implement a tobacco-free campus and intervention?

Advance planning is critical for implementing this type of policy-change. Nicotine addiction goes hand in hand with substance abuse and mental illness. It is important that all employees receive education about smoking cessation, general educational materials and information about the policy change in advance of the start date. *Section II: Program Design* provides a six month timeline for preparation and implementation of a full tobacco-free policy. Organizations may wish to phase tobacco changes into their organization. Cessation programs can be implemented once all involved staff members are educated. In some cases, some substance abuse and mental health facilities have chosen to implement cessation programs, evaluate their success and then transition to a fully tobacco-free campus over an extended period of time.

Q. How do I get the staff on board?

A survey of more than 2,000 substance abuse counselors by Knudsen & Studts (2010) found that nearly half of counselors were in addiction recovery themselves. These individuals tend to smoke at rates higher than the general population (Ratschen et al., 2009) and the likelihood of staff members discussing smoking cessation with clients is linked to their smoking status (Bobo & Davis, 1993).

The high prevalence of tobacco use among treatment staff requires that organizational leadership quickly create staff buy-in for the program and that a full tobacco cessation program be offered to both clients and staff members. Staff buy-in can be created through:

A. Communicating the policy change openly to all staff members;
B. Conducting a survey or focus group with staff members to gather feedback;
C. Holding educational meetings to inform staff about the importance of discussing cessation with clients, as well as providing research related to the results of concurrent smoking cessation with addiction or mental health treatment; and
D. Providing an employee cessation program similar to the one offered to clients.

Q. Will clients quit using my facility and seek treatment elsewhere if we become tobacco-free?

A study of 33 residential addiction facilities that implemented a tobacco-free policy and program in New Jersey found that the number of smokers entering treatment and the number of early discharges did not change because of the intervention (Foulds et al., 2006). Some studies have found that negative client behavior was unchanged as a result of changed tobacco policies (Matthews et al., 2005), but other organizations have noted an increased incidence of contraband or rule breaking when clients are no longer allowed to smoke (Patten & Martin, 1999). In general, clients will not forego treatment because of a tobacco-free policy, but realistically there will be policy violations and issues that will have to be dealt with appropriately.

Q. How much will implementing a program cost?

The costs associated with implementing a tobacco-free policy and cessation program vary considerably. An organization can implement a brief program very cost-effectively or can implement a full, multi-option program that will be very costly. Implementing a brief intervention to **Ask** clients about tobacco use, **Advise** clients to quit and **Refer** clients to cessation and education resources can cost little (mainly

resources for staff training and printed materials/chart updates). A more intense program, and likely one with more successful outcomes, would combine nicotine replacement therapy with cessation education classes that were based on evidence-based practices. The costs of this type of program are more substantial and would include clinician training, creation and printing of materials, clinician time for researching/creating a counseling curriculum, the costs of nicotine replacement therapy, etc. Substance abuse treatment facilities adopting a tobacco-free policy are encouraged to incorporate a full employee cessation program including nicotine replacement therapy, further increasing the cost of the program.

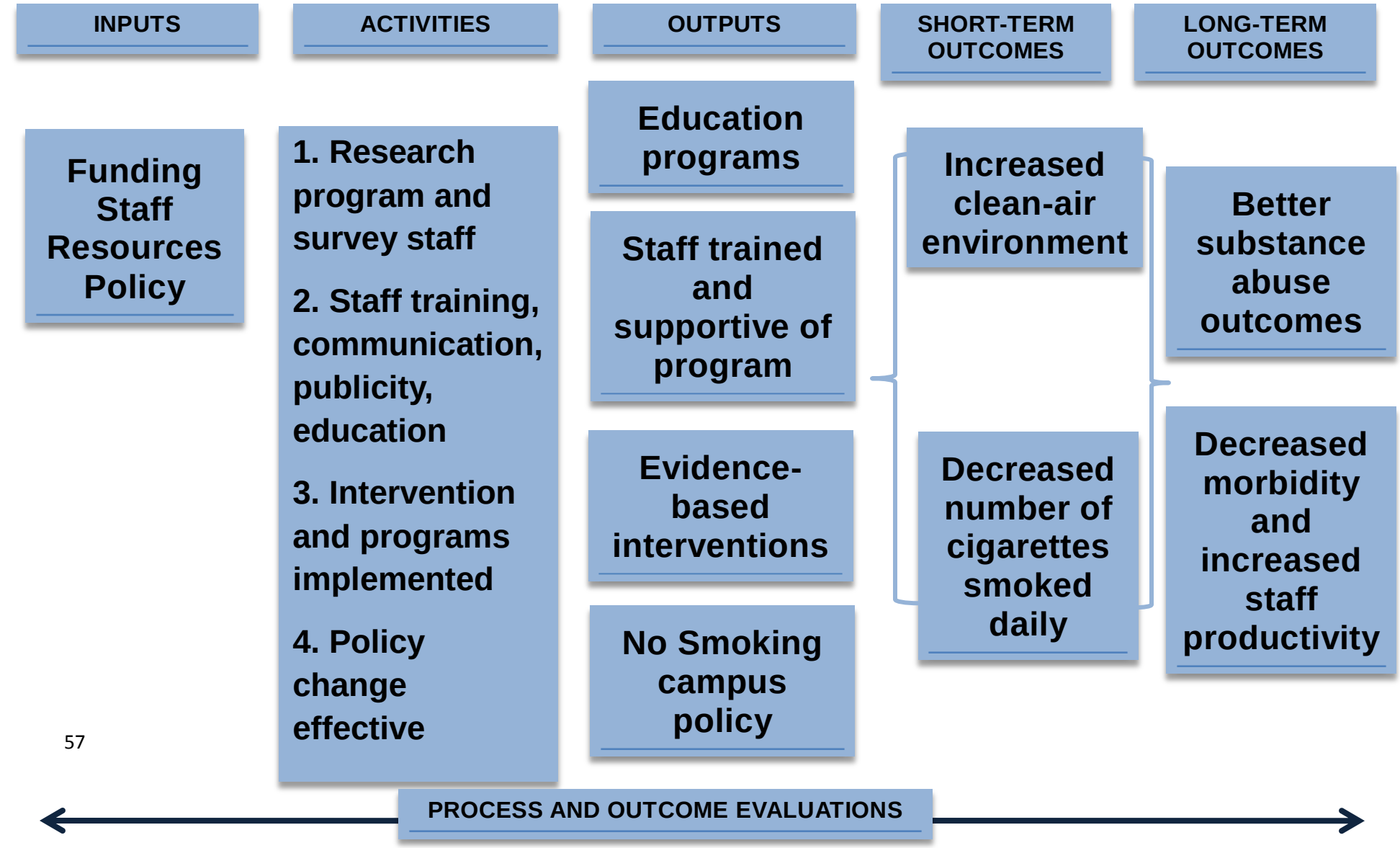
Creating a Tobacco-Free Residential Substance Abuse Treatment Facility

A Toolkit for Designing an Effective Intervention

Section VI Appendix

Appendix A-1

Tobacco-Free Campus Logic Model Template



Appendix A-2: Staff Communication Templates

General Memo to Employees about Policy Change

[DATE] **Program Contact: [NAME(S)], [PHONE #]**

New Tobacco-Free Policy at Substance Abuse Facility Paves the Way for Health and Recovery

On [DATE], [ORGANIZATION] will take an important step in supporting the health of individuals with substance addiction by adopting a tobacco-free policy to protect the rights of clients, employees and visitors' to breathe clean air. Individuals with a substance addiction smoke at rates two to four times higher than the general population and staff members also smoke at rates slightly higher than the general population. The commonality of smoking in our community means that individuals are exposed to secondhand smoke on a regular basis. Secondhand smoke exposure increases heart disease risk by 25-30% and lung cancer risk by 20-30%. Tobacco-free campus policies prohibit smoking on the entire campus and are effective in reducing secondhand smoke in the workplace by an average of 72%. As a health facility, it is important to protect the overall well-being of all individuals on our campus, and we will accomplish this in part through a tobacco-free policy promoting clean air.

Beginning [DATE], it is the responsibility of program managers to ensure that all staff members inform incoming clients or clients receiving an assessment about this policy change. Human Resources is responsible for informing any newly hired employees of this policy.

[ORGANIZATION] will offer a complete tobacco-cessation program for clients and employees. Services will include [PROVIDE FULL LIST OF SERVICES]. (*Examples include clinical assessment of tobacco-use status/readiness to change, educational materials, nicotine replacement therapy, cessation support groups, utilization of the 5A's program, 1-800 Quit Line, etc.)*. The policy change will be effective [PROVIDE DATE] and is anticipated to impact and promote health for [NUMBER] individuals annually.

Memo to Employees about Employee Cessation Program

[DATE] **Program Contact: [NAME(S)], [PHONE #]**

New Employee Tobacco-Cessation Program at [ORGANIZATION NAME]

As you know, [ORGANIZATION NAME] will become a tobacco-free campus on [DATE]. We are taking this important step in supporting the health of individuals with substance addiction by adopting a tobacco-free policy to protect the rights of our clients, employees and visitors to breathe clean air. Individuals with a substance addiction smoke at rates two to four times higher than the general population and staff members also smoke at rates slightly higher than the general population. The commonality of smoking in our community means that individuals are exposed to secondhand smoke on a regular basis. Secondhand smoke exposure increases heart disease risk by 25-30% and lung cancer risk by 20-30%. Tobacco-free campus policies are effective in reducing secondhand smoke in the workplace by an average of 72%. As a health facility, it is important to protect the overall well-being of all individuals on our campus, and we will accomplish this in part through a tobacco-free policy promoting clean air.

Beginning [DATE], staff members will not be allowed to use tobacco anywhere on campus, including indoors, outside of campus buildings and inside personal vehicles. All employees must abide by this policy and violators will be reported to their supervisor for enforcement. Warnings will be given for first violations, but any subsequent violations will result in [LIST ENFORCEMENT RULES/PUNISHMENT – *ex. required attendance at nicotine education sessions, suspension from work, etc.*].

To assist employees in this change, [ORGANIZATION] will offer a complete tobacco-cessation program for employees. Services will include [PROVIDE FULL LIST OF SERVICES]. (*Examples include clinical assessment of tobacco-use status/readiness to change, educational materials, nicotine replacement therapy, cessation support groups, 1-800 Quit Line)*. Thank you for helping us support and promote the health of all [NUMBER] employees at [ORGANIZATION NAME].

Paystub Reminder to Employees about Policy Change

IMPORTANT REMINDER

[ORGANIZATION NAME]

will become a tobacco-free facility and campus on

[DATE]

An employee cessation program is available to assist you in this change. Contact [PROVIDE CONTACT NAME AND INFORMATION] for more information about available resources.

This policy will be enforced by all managers and supervisors. Plan ahead for a smooth transition.

Appendix A-3: Policy Template

[INSERT COMPANY NAME AND/OR LOGO]

Policy Title: **Effective Date:**

POLICY: All facilities of [Insert Company Name] are free of tobacco, alcohol and illegal drugs. Use of any type of these products is prohibited anywhere on the campus, including buildings, bathrooms, automobiles, parking lots, sidewalks, grassy areas, etc.

PURPOSE: To ensure that all facilities are tobacco-free.
[Insert Company Name] desires to provide a treatment and work environment that is tobacco-free in order to support the health and well-being of all clients, employees and visitors.

PROCEDURES: TOBACCO-FREE ENVIRONMENT

1. All [Insert Company Name] facilities, including company owned vehicles, are tobacco-free facilities. Tobacco use is not allowed in any building or vehicle owned by [Insert Company Name]. Tobacco use includes the use of all tobacco products, such as chewing tobacco and cigarettes.
2. The use of any of these products in [Insert Company Name] facilities by clients constitutes a violation of program rules. Client violations will be handled in the following manner: [Insert Description of How Client Violations are Handled]. The possession of paraphernalia for these purposes is considered a violation of this rule.
3. The use of any of these products in [Insert Company Name] facilities (including personal or company owned vehicles) by staff members will result in disciplinary action. Employee disciplinary action includes [Insert Description of Disciplinary Action]. An employee smoking cessation program is available and offers [Insert Program Details].
4. Clients receiving services at [Insert Company Name] will be offered the opportunity to participate in a smoking cessation program. If interested, clients will receive smoking cessation brochures, resources and nicotine replacement therapy. Nicotine replacement therapy will be discontinued if a client continues to smoke when off campus (in order to prevent a dangerous nicotine overdose). Nicotine replacement therapy will be prescribed, documented and handled like other medications. All clients who use tobacco will be given the Fagerström Test for Nicotine Dependence.
5. When any new visitor arrives at the facility, staff should review the tobacco-free environment policy with the visitor. When any repeat visitor arrives at the facility, staff should remind the individual that [Insert Company Name] is a tobacco-free environment. Violation of the tobacco-free environment policy by a visitor may result in termination of visiting privileges. All visitors should be informed that clients cannot receive cigarettes or other nicotine products while in treatment.
6. When any staff person takes or accompanies a client off the grounds, it should be understood that a client may choose to smoke when not on campus, but may not smoke in [Insert Company Name] vehicles or personal vehicles. Clients indicating that they wish or intend to smoke when off grounds should be reminded of the value of maintaining abstinence from tobacco even when away from [Insert Company Name]. It should be noted in the client's chart that he/she is currently using tobacco and nicotine replacement therapy should not be provided to the client.
7. Persons contacting [Insert Company Name] for information on services will be advised prior to admission that all facilities are tobacco-free. Potential hires should be informed during the interview process.

Policy adapted from Freedom House Recovery Center's Organizational Policy and Procedures Manual, Chapel Hill, North Carolina.

Appendix A-4: Press Release Template

[DATE] **Contact: [NAME(S)], [PHONE #]**

New Tobacco-Free Policy at [ORGANIZATION NAME]

(CITY) -- On [DATE], [ORGANIZATION] will take an important step in supporting the health of individuals with substance addiction by adopting a tobacco-free policy to protect the right of clients, employees and visitors' to breathe clean air. Individuals with a substance addiction smoke at rates two to four times higher than the general population and experience increased mortality and morbidity rates related to smoking. Recent research indicates that quitting smoking while in recovery can increase the chance of long-term sobriety by 25%. Additionally, a large proportion of employees in substance abuse treatment facilities are smokers and therefore are less likely to discuss the benefits of tobacco-cessation with clients during treatment. The commonality of smoking in this population and community exposes many individuals to secondhand smoke. On average, tobacco-free workplace policies effectively reduce secondhand smoke exposure by 72%.

"The overall goal of a tobacco-free policy on our campus is to protect the health of our clients, employees and visitors while reducing health care costs and increasing employee productivity," said [ORGANIZATION REPRESENTATIVE]. "This is an important step in protecting the health of individuals who are heavily impacted by smoking related illness and exposed to dangerous secondhand smoke."

[ORGANIZATION] will offer a complete tobacco-cessation program for clients and employees. Services will include [PROVIDE FULL LIST OF SERVICES]. *Examples include clinical assessment of tobacco-use status/readiness to change, educational materials, nicotine replacement therapy, cessation support groups, utilization of the 5A's program, 1-800 Quit Line).* The policy change will be effective [PROVIDE DATE] and is anticipated to impact and promote health for [NUMBER] individuals annually.

[COMPANY LOGO]

WILL BECOME A TOBACCO-FREE CAMPUS

ON [DATE]

Tobacco use will not be permitted on the grounds, parking lot, vehicles or in the buildings.

[COMPANY LOGO]

IS TOBACCO FREE

Tobacco use is not permitted on the grounds, parking lot, vehicles or in the buildings.

Thank you for helping us protect the health of our clients, employees and visitors.

Double click the image below to access a double-sided brochure in Microsoft Publisher. A modifiable version of this template can be accessed through the following link: [Tobacco-Free Campus Brochure Template.]

Appendix A-6: Client Nicotine Dependence Assessment Template

[ORGANIZATION NAME/LOGO]

Nicotine Dependence Assessment

Client Name: _____Date: _____

1. Does client use tobacco? (circle answer)

Yes (continue to question number 2)

No. Have you ever used tobacco? YES or NO.

If YES, when did you quit? _____.

2. How long has(did) client use(d) tobacco? _____ years _____ months

3. What form(s) of tobacco does(did) client use(d)? (circle answers)

Cigarettes Pipe/Cigar Chewing/Smokeless Tobacco Other: _____

4. Is client interested in quitting tobacco now?

Yes No Possibly/Would consider learning more

Items and Scoring for the Fagerström Test for Nicotine Dependence on Cigarettes

QUESTION	ANSWER	SCORE
How soon after you wake up do you smoke your first cigarette?	Within 5 minutes	3
	6 to 30 minutes	2
	31 to 60 minutes	1
	After 60 minutes	0
Do you find it difficult not to smoke in places where smoking is not allowed (ex. hospital, library, movies)?	Yes	1
	No	0
Which cigarette would you be the most unwilling to give up?	The first one in the morning	1
	All others in the day	0

How many cigarettes a day do you smoke?	More than 30	3
	21 to 30	2
	11 to 20	1
	10 or less	0

Do you smoke if you are so ill that you are in bed most of the day?	Yes	1
	No	0
	TOTAL SCORE	

Scoring: 0 – 2 Points: Mild Nicotine Dependence

3- 6 Points: Moderate Nicotine Dependence

7-10 Points: Heavy Nicotine Dependence

Name of Staff Member Completing Assessment: _____

Next Steps/Referrals:

Scheduled Follow-Up:

Appendix A-7: Staff Survey Templates

Employee Opinion Pre-Implementation Survey

[ORGANIZATION NAME/LOGO]
Employee Opinion Survey

The following survey is being conducted in conjunction with [ORGANIZATION NAME] becoming a SMOKE FREE CAMPUS on [DATE]. Please share your honest, anonymous opinion.

1. What barriers do you see that [ORGANIZATION NAME] will face when we adopt a 100% smoke free policy? *(Check all that apply)*

_____ Employees will not follow policy

_____ Clients/visitors will not follow policy

_____ Employees will seek jobs elsewhere

_____ Clients will seek services elsewhere

_____ Policy will be too hard to enforce

_____ Other, please specify: _____

2. Please indicate the extent to which you are bothered by secondhand smoke at work. *(Check all that apply)*

_____ Frequently bothered

_____ Occasionally bothered

_____ Seldom bothered

_____ Never bothered

3. If you are bothered by secondhand smoke at work, in what way are you bothered? *(Circle all that apply)*

_____ Eye, nose and throat irritation

_____ Concern for your long-term health

_____ Interference with work performances

_____ Headaches

_____ Pregnancy related concerns

_____ Other, please specify

_____

4. Please indicate your current smoking status:

_____ Never smoked

_____ Currently smoke cigarettes

Cigarettes per day _____

Length of time you have smoked _____

_____ Currently use other form of tobacco. Type: _____ Amount used daily: _____

_____ Former tobacco user. How long since you last used tobacco? _____

For how long did you use tobacco? _____

Approximate amount of tobacco used daily: _____

How did you quit? _____

5. Are you **Male** or **Female**? (please circle one)

6. What is your age *(please circle one)*

_____ Less than 20 years _____ 20-30 years _____ 30-40 years

_____ 50-60 years _____ 60+ years

For current smokers only:

1. Do you smoke at work? _____ Yes _____ No

2. Do you want to quit?

_____ I want to quit _____ I do not want to quit _____ Maybe / Unsure

3. Have you ever tried to quit before? _____ Yes _____ No

4. Would you utilize a company-sponsored program to help you stop smoking?

_____ Yes _____ No _____ Maybe

5. If smoking were banned in the workplace, how would this impact the amount you currently smoke?

_____ It would not impact how much I smoke _____ I would smoke less

_____ I would smoke more at home _____ I would try to quit

6. What do you think would help you quit using tobacco? *(check all that apply)*

_____ Smoking cessation classes _____ Quitting with a friend/spouse/co-worker

_____ Incentive program _____ Medication aids (Nicotine Replacement Therapy)

_____ 1-800 Quitline _____ Educational information on how to quit

_____ Nothing - I will quit on my own when I am ready

Comments:

Thank you for your cooperation and for sharing your opinion!

****

Employee Opinion Post-Implementation Survey

[ORGANIZATION NAME/LOGO]
Employee Opinion Follow-Up Survey

The following survey is being conducted in conjunction with [ORGANIZATION NAME] becoming a SMOKE FREE CAMPUS on [DATE]. Please share your honest, anonymous opinion.

1. Please indicate your current smoking status:

_____ Currently smoke cigarettes

_____ Currently smoke pipe/cigar

_____ Former smoker (stopped **before** the smoking policy was adopted)

_____ Former smoker (stopped **after** the smoking policy was adopted)

_____ Never smoked

2. What is your opinion of the smoking policy at your workplace?

_____ Not strict enough _____ Reasonable _____ Too strict

3. What is your opinion of secondhand smoke? *(Check one)*

_____ Definitely harmful _____ Probably harmful

_____ Not harmful _____ Not sure

Please answer the following questions if you smoked at the time the smoking policy was implemented:

4. Have you enrolled in the smoking cessation program offered at [ORGANIZATION NAME]?

_____ Yes, I have enrolled. _____ No, I have not enrolled.

5. How has the smoking policy impacted your smoking? *(Check all that apply)*

_____ I smoke less overall. _____ I smoke more overall.

_____ I smoke less at work. _____ I smoke more at work.

_____ I smoke more at home. _____ I smoke less at home.

_____ It has not impacted me. _____ I quit smoking.

_____ I am trying to quit. _____ I only smoke outdoors.

6. What resources did you use? *(Check all that apply)*

_____ Cessation Classes/Support Group _____ Nicotine Replacement Therapy

_____ General educational materials _____ 1-800 Quit Line

7. What other resources/support would you find helpful? _____

Comments:

Thank you for your cooperation!
****

Appendix B

5A's Process and Procedure

Ask, Advise, Assess, Assist and Arrange

To be used with clients who are willing to quit tobacco.

Adapted from Morris, Waxmonsky, Giese, Graves & Turnbull, n.d. & Fiore, Jaén, Baker, et al., 2008

ASK	
Action	Strategies for Implementation
Ask every client at every visit if he/she smokes.	Systematically identify all tobacco users at every visit. Determine what form of tobacco is used. Determine frequency of tobacco use. Make note of consumers exposed to secondhand smoke.

ADVISE	
Action	Strategies for Implementation
In a clear, strong and personalized manner, advise every tobacco user to quit. Maintain a non-judgmental manner.	Provide advice that is: **Clear:** "I think it is important for you to quit smoking, and I can help you try." **Strong:** "I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future, and we are here to help you." **Personalized:** Tie tobacco use to current health/illness, its social and economic costs, stage of readiness to change, and/or the impact of tobacco use on others in the household. "Continuing to smoke makes your asthma worse, and quitting may dramatically improve your health."

Note: Refer is an optional stage for organizations that do not offer full cessation support or do not have the resources to implement the full 5A's program.

REFER	
Action	Strategies for Implementation
For consumers interested in quitting.	Provide information on local smoking cessation resources. Document the referral.

ASSESS	
Action	Strategies for Implementation
Assess each tobacco user's willingness to make a quit attempt in the near future (approximately one month). Assess readiness to change. Assess the specific pros and cons of an individual quitting. Assess past quit attempts and challenges encountered.	Assess readiness for change. "Are you willing to try quitting tobacco?" If the client is ready to quit, proceed to Assist (below) and arrange for more services to help with the quitting process. If the client is willing to participate in cessation treatment, provide information about the treatments available in your organization or make a referral to other services (Arrange). Discuss and establish a quit plan. Address concerns and refer individual to available resources.

ASSIST	
Action	Strategies for Implementation
Help the client create a quit plan. Recommend the use of Nicotine Replacement Therapy and counseling.	Ask the client to set a quit date (ideally within 2 weeks). Recommend the client tell family, friends, co-workers, roommates about the quit date and ask for their support. Tell the client to pay attention to the triggers that make him/her want to smoke and become aware of the challenges he/she anticipates with quitting. The client should think of other activities/distractions and stop smoking where he/she spends the majority of his/her time (home, car, work). Discuss Nicotine Replacement Therapy and how it increases the chances of successfully quitting and reduces withdrawal symptoms. Discuss counseling and other options for addressing behavioral changes.

ARRANGE	
Action	Strategies for Implementation
Schedule follow-up communication with the client via phone or in person.	Check in with the client within the first week following the quit date. Follow-up again within the first month and provide ongoing follow-up as needed. Follow-up can be in the form of a phone call or future appointment. If a client has relapsed and is using tobacco again, remind the client that quitting is hard, that many people make multiple quit attempts and help the client identify triggers/situations that have made quitting difficult. Help the client identify other ways he/she can deal with those triggers or situations. Assess whether or not NRT is being used and refer the client to additional resources. Focus on any successes and congratulate the client.

Appendix C

Prescribing Nicotine Replacement Therapy

Double click the image below to access a double-sided handout from the American Academy of Family Physicians. The handout provides information on Nicotine Replacement Therapy Formulations, Bupropion and Varenicline. The handout describes the product, precautions, dosing instructions, adverse effects, advantages, disadvantages and the anticipated daily cost of the product.

PHARMACOLOGIC PRODUCT GUIDE: FDA-APPROVED MEDICATIONS

	NICOTINE REPLACEMENT THERAPY (NRT) FORMULATIONS						BUPROPION SR	VARENICLINE
	GUM	LOZENGE	TRANSDERMAL PREPARATIONS[1]		NASAL SPRAY	ORAL INHALER		
PRODUCT	**Nicorette®, Generic** OTC 2 mg, 4 mg; original, FreshMint®, Fruit Chill®, mint, orange[2]	**Commit®, Generic** OTC 2 mg, 4 mg mint	**Nicoderm CQ®** OTC 24-hour release 7 mg, 14 mg, 21 mg	**Generic Patch** OTC/Rx (formerly Habitrol) 24-hour release 7 mg, 14 mg, 21 mg	**Nicotrol NS®** Rx Metered spray 0.5 mg nicotine in 50 µL aqueous nicotine solution	**Nicotrol Inhaler®** Rx 10 mg cartridge delivers 4 mg inhaled nicotine vapor	**Zyban®, Generic** Rx 150 mg sustained-release tablet	**Chantix®** Rx 0.5 mg, 1 mg tablet
PRECAUTIONS	▪ Pregnancy (Category D) ▪ Recent (≤2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Temporomandibular joint disease	▪ Pregnancy (Category D) ▪ Recent (≤2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris	▪ Pregnancy (Category D) ▪ Recent (≤2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris		▪ Pregnancy (Category D) ▪ Recent (≤2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis) ▪ Severe reactive airway disease	▪ Pregnancy (Category D) ▪ Recent (≤2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Bronchospastic disease	▪ Pregnancy (Category C) ▪ Concomitant therapy with medications or medical conditions known to lower the seizure threshold ▪ Severe hepatic cirrhosis **Contraindications:** ▪ Seizure disorder ▪ Concomitant bupropion (e.g., Wellbutrin) therapy ▪ Current or prior diagnosis of bulimia or anorexia nervosa ▪ Simultaneous abrupt discontinuation of alcohol or sedatives (including benzodiazepines) ▪ MAO inhibitor therapy in previous 14 days	▪ Pregnancy (Category C) ▪ Severe renal impairment (dosage adjustment is necessary)
DOSING	▪ *≥25 cigarettes/day:* 4 mg ▪ *<25 cigarettes/day:* 2 mg Week 1 – 6: 1 piece q 1 – 2 hours Week 7 – 9: 1 piece q 2 – 4 hours Week 10 – 12: 1 piece q 4 – 8 hours ▪ Maximum, 24 pieces/day ▪ Chew each piece slowly ▪ Park between cheek and gum when peppery or tingling sensation appears (~15 – 30 chews) ▪ Resume chewing when taste or tingle fades ▪ Repeat chew/park steps until most of the nicotine is gone (taste or tingle does not return; generally 30 min) ▪ Park in different areas of mouth ▪ No food or beverages 15 min before or during use ▪ Duration: up to 12 weeks	▪ *1st cigarette ≤30 minutes after waking:* 4 mg ▪ *1st cigarette >30 minutes after waking:* 2 mg Week 1 – 6: 1 lozenge q 1 – 2 hours Week 7 – 9: 1 lozenge q 2 – 4 hours Week 10 – 12: 1 lozenge q 4 – 8 hours ▪ Maximum, 20 lozenges/day ▪ Allow to dissolve slowly (20 – 30 minutes) ▪ Nicotine release may cause a warm, tingling sensation ▪ Do not chew or swallow ▪ Occasionally rotate to different areas of the mouth ▪ No food or beverages 15 minutes before or during use ▪ Duration: up to 12 weeks	▪ *>10 cigarettes/day:* 21 mg/day x 6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks ▪ *≤10 cigarettes/day:* 14 mg/day x 6 weeks 7 mg/day x 2 weeks ▪ May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) ▪ Duration: 8 – 10 weeks	▪ *>10 cigarettes/day:* 21 mg/day x 4 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks ▪ *≤10 cigarettes/day:* 14 mg/day x 6 weeks 7 mg/day x 2 weeks ▪ May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) ▪ Duration: 8 weeks	1 – 2 doses/hour (8 – 40 doses/day) One dose = 2 sprays (one in each nostril); each spray delivers 0.5 mg of nicotine to the nasal mucosa ▪ Maximum - 5 doses/hour - 40 doses/day ▪ For best results, initially use at least 8 doses/day ▪ Patients should not sniff, swallow, or inhale through the nose as the spray is being administered ▪ Duration: 3 – 6 months	6 – 16 cartridges/day; individualized dosing ▪ Initially, use at least 6 cartridges/day ▪ Best effects with continuous puffing for 20 minutes ▪ Nicotine in cartridge is depleted after 20 minutes of active puffing ▪ Patient should inhale into back of throat or puff in short breaths ▪ Do NOT inhale into the lungs (like a cigarette) but "puff" as if lighting a pipe ▪ Open cartridge retains potency for 24 hours ▪ Duration: up to 6 months	150 mg po q AM x 3 days, then increase to 150 mg po bid ▪ Do not exceed 300 mg/day ▪ Treatment should be initiated while patient is still smoking ▪ Set quit date 1 – 2 weeks after initiation of therapy ▪ Allow at least 8 hours between doses ▪ Avoid bedtime dosing to minimize insomnia ▪ Dose tapering is not necessary ▪ Can be used safely with NRT ▪ Duration: 7 – 12 weeks, with maintenance up to 6 months in selected patients	Days 1 – 3: 0.5 mg po q AM Days 4 – 7: 0.5 mg po bid Weeks 2 – 12: 1 mg po bid ▪ Patients should begin therapy 1 week prior to quit date ▪ Take dose after eating with a full glass of water ▪ Dose tapering is not necessary ▪ Nausea and insomnia are side effects that are usually temporary ▪ Duration: 12 weeks; an additional 12 week course may be used in selected patients

Creating a Tobacco-Free Residential Substance Abuse Treatment Facility

A Toolkit for Designing an Effective Intervention

Section VII References

References

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