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# LIVING TOBACCO FREE

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RECOVERY & PREVENTION FOR  
OUR MENTAL HEALTH & WELLNESS

A Report on a Tobacco Prevention & Cessation Pilot  
Program Conducted by The Missouri Department of  
Mental Health in Conjunction with Crider Health  
Center, COMTREA, & Queen of Peace Center



February 2014

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## I. INTRODUCTION (NEED AND HISTORY)

The use of tobacco products is the leading cause of premature death for people with mental illness or addiction (*Williams & Ziedonis, 2004*) and contributes to persons with mental illness dying an average of 25 years earlier than the general population (*Parks et al., 2006*). Tobacco is responsible for greater morbidity than alcohol and all other drugs combined (U.S. Department of Health and Human Services, 2000) and, amazingly, is more deadly to substance abuse patients than their primary presenting substance of abuse (Baca and Yahne, 2009). Nationally, 44% of persons with serious psychological distress (SPD) smoke cigarettes, compared to 24% of the general population (*Substance Abuse and Mental Health Services Administration, 2007*). The use of tobacco products is reported at rates 2 – 3 times higher for individuals with mental illness and substance use disorders than in the general population (*Lasser et al., 2000*). Persons with mental illness or substance use disorders smoke 44% of all cigarettes smoked in the U.S. (*Grant et al., 2004*). The towering morbidity and mortality rates in this population are also propelled by chronic diseases associated with tobacco use. These include diabetes, COPD and asthma, hypertension, coronary heart disease, stroke, and cancer.

In Missouri the data on tobacco use are even more alarming. According to a 2008 Missouri Foundation for Health-funded study conducted for the Missouri Department of Mental Health (DMH) (Missouri Foundation for Health, 2010):

- Tobacco use is higher among Missouri consumers of psychiatric and substance abuse services than consumers nationally (64% vs. 44%).
- Tobacco use among consumers of alcohol and drug abuse and psychiatric services is more than double that of adult Missourians (64% vs. 24.5%) and more than three times the use rate of the general population nationally (64% vs. 21%).
  - Among these consumers, 87% reported daily use, with 95% smoking cigarettes, 18% smoking cigars and 9% using chewing tobacco.
  - 76% of consumers in residential psychiatric and/or alcohol and drug abuse settings, 61% in outpatient settings and 59% in community settings, reported regular use.

Of all the clients receiving psychiatric and/or alcohol and drug abuse services who reported regular tobacco use, 56% wanted to quit, compared to 74% of adults nationally (*Gallup, 2008*). Despite the significant proportion of persons with mental illness and/or substance abuse problems who want to quit, the above Missouri study also reported that “a lack of tobacco cessation programs at many mental health and substance abuse provider agencies” was an important factor contributing to this “high rate of tobacco use among Missouri consumers” (Missouri Foundation for Health, 2010). These are precisely the high rates that translate directly into greater morbidity and mortality among this population as was noted above.

DMH, the state mental health authority, has made a significant commitment to address tobacco dependence in its clients and agency staff. Missouri state hospitals and DMH offices have been tobacco-free for quite some time (Nov. 2007 and Jan. 2008 respectively), and DMH has been encouraging community-based agencies that provide state-funded services to both implement tobacco-free policies and provide smoking cessation supports to their clients and staff. In 2011-

2012 a series of “mini-grants” for up to \$8,000 were made available to CMHCs and substance abuse treatment providers to assist them in this endeavor.

DMH has also applied for and been awarded a progressive series of grants from the Missouri Foundation for Health (MFH).

- The first was for a needs assessment that included a survey of tobacco use by persons with mental illness and/or substance use disorders receiving DMH-funded services (*A Comprehensive Report: Tobacco Use Among Consumers of Services of the Missouri Department of Mental Health*, April 2010).
- A second MFH grant provided for the creation of a state plan (*Missouri Plan for Living Tobacco Free: Recovery and Prevention for Our Mental Health and Wellness*, September, 2010). This plan contained goals and strategies intended to reduce and prevent tobacco dependence and contribute to the recovery of persons receiving services mental illness and substance use disorders from DMH.
- The Living Tobacco Free Plan was followed by a third MFH grant-funded pilot project, the particulars of which are the content of this report. Titled Living Tobacco Free (LTF) its purpose was to implement practices recommended through the Plan that could be replicated in other agencies across the state. This pilot involves Missouri Department of Mental Health (DMH) in partnership with Community Treatment Inc. (COMTREA), Crider Health Center, and Queen of Peace Center, all three agencies in or near St. Louis. The three pilot agencies started the MFH-funded LTF project in November 2011 and continued providing grant funded services through December 2013.

It is the LTF Pilot Project that is described in this report. The LTF Pilot Project proposed two broad goals: (1) the creation tobacco-free campuses (buildings and grounds), including residential facilities, and (2) implementing comprehensive supports and programs to curtail tobacco use by both clients of the pilot agencies and their staff. In short, the project sought to build an organizational infrastructure to support tobacco cessation.

It is hoped that this description of what was done, how it was done, and an accounting of the successes and obstacles encountered will help other agencies in their efforts to both become tobacco-free and implement meaningful tobacco cessation activities aimed at clients and staff. We believe there are important lessons that can assist state-funded behavioral health providers to successfully implement tobacco cessation activities in community-based agencies.

## **Profile of Participating Agencies**

### **Crider Health Center (CHC)—**

Crider Health Center covers four counties: Lincoln, Warren, St. Charles, and Franklin. These counties are a mix of urban and rural communities.

Residential facilities:

Pathways Assisted Living Facility (ALF) (17 beds), O’Fallon.

C.H.O.I.C.E.S. (Independent Living Facility for persons with disabilities), St. Charles.

Three Adult Psychiatric Individualized Supported Living (PISL) facilities for three to four persons each.

Five Independent Supported Living (ISL) facilities with three to four residents each.

Clubhouses (Psychosocial Rehabilitation Centers):

Headway, St. Charles.

Harmony, Washington.

CHC was a Federally Qualified Health Center (FQHC) throughout the period covered by the pilot project.

Clients: CHC had about 5522 clients served through outpatient psychiatry. Of these, 303 were clubhouse members and 998 were community support recipients. It is estimated that overall about 64% of these clients used tobacco (*Report*, p.8).

Staff: 488. It was unknown how many staff used tobacco.

### **COMTREA (Community Treatment, Inc.)—**

COMTREA covers Jefferson County.

Residential facilities:

Keaton Center (24-bed assisted living facility), Festus.

A Safe Place (18-bed shelter for battered women and children), Jefferson County.

COMTREA became a Federally Qualified Health Center during the period covered by this pilot project. The Federal Health Resources and Services Administration (HRSA) designated COMTREA as an FQHC in July 2012.

Clients: Around 1,200, of which it was estimated that about 64% use tobacco (*Report*, p.8).

Staff: about 180. At the beginning of the grant COMTREA estimated that about 50%-60% of staff smoke.

### **Queen of Peace Center (QOPC)—**

Queen of Peace Center is an urban substance abuse provider serving person from St. Louis City and County. Queen of Peace Center brought an interesting aspect to the pilot because of the unique subpopulations served. For example, pregnant women were provided screening for tobacco use and augmented pregnancy-tailored counseling to tobacco users, which is strongly recommended by the USPSTF (2003, 2009).

Residential facilities:

St. Philippine Home (33-bed transitional facility for homeless women and children), St. Louis City;

Our Lady of Perpetual Help (24-bed residential treatment facility for pregnant and postpartum women and children); St. Louis City.

Clients: Over 300. QOPC estimated that the overwhelming majority smoke.

Staff: 99 full and part time employees. QOPC did not know how many staff used tobacco but estimated that it was significant.

## **I. PLANNING AND IMPLEMENTATION TEAMS**

Each of the three agencies created tobacco cessation planning and implementation teams. Teams were comprised of at least a consumer, a clinician, and an administrator. As the project matured other team members were brought in on an as needed basis. For example, when smoking cessation resources for staff were being considered, or staff policies governing procedures for sanctioning staff violations of an agency's tobacco-use policies, a Human Resources person was

essential. Additional consumers also became involved as tobacco use policies spread to residential facilities and clubhouses. One agency involved security personnel so they could enforce smoking prohibitions on the grounds of the main building.

The commitment of senior administrative staff was also key. The goals of this project required considerable commitment of both time and resources. If senior leadership were not fully committed the chances for organizational change would be sharply diminished. Before applying to the Missouri Foundation for Health (MFH) for the grant, the executive directors of each agency were contacted to determine their interest and commitment. However, one agency was transitioning to new leadership as the project started and another agency underwent a leadership change shortly into the grant period. Securing the commitment of the new leadership was important. The planning and implementation teams must have the full backing of senior administrative staff.

One of the first jobs of the team was to review current agency policies and practices, and start to determine what should be changed. In doing this each agency created a Living Tobacco Free Plan with specific action items, steps that needed to be taken, time frames, and an identification of staff responsible for overseeing the particular item.

The identification of staff responsible for a particular item is very important. One or two persons should not be responsible for everything, nor should the whole team be responsible. On the one hand making a small handful of people responsible is likely to be overwhelming, on the other, if responsibility is too diffuse it means that, in effect, no one is responsible. Identifying action steps and specific time frames was also important. Each agency's Living Tobacco Free Plan went through many changes and revisions over the 26-month period of the provision of services through the grant. In some cases ad hoc teams were created to deal with a particular action step, e.g., residential smoking plan, changes in assessment and treatment planning.

As the project started and continued through most of the first year, it was apparent that at least one or two agency staff persons needed to be dedicated to the tobacco-use project for at least a certain portion of their time. If an agency merely assigns a staff person to be a tobacco cessation "champion" and carry important leadership responsibilities on the planning and implementation team in addition to all their other regular duties, there will be problems adequately performing the new assignments. It is important that an agency's lead tobacco cessation champion(s) have some portion of their time dedicated to tobacco-use cessation. This means that perhaps 6-8 hours a week of a staff person's time be dedicated to the tobacco cessation effort. Once the plan is created and significant portions of it successfully implemented, this dedication time can be cut back. However, as COMTREA, CHC, and QOPC created their plans and started implementation, it became apparent that the regular duties of one or two persons be adjusted such that they could devote time to tobacco cessation planning and implementation.

This suggestion is based on observations of the project oversight group at DMH which helped to monitor the progress of the agencies and comments made by staff at the three participating agencies. The DMH group provided technical assistance to the three agencies, conducted monthly phone calls with each, conducted site visits, and received documents produced by the planning and implementation teams at each agency.

## II. DR. DOUGLAS ZIEDONIS CONSULTATION

Dr. Douglas M. Ziedonis, MD, MPH, is Professor and Chair of the Department of Psychiatry at the University of Massachusetts Medical School and UMass Memorial Health Care. Dr. Ziedonis is internationally regarded for his cutting edge research in co-occurring mental illness and addiction, including tobacco dependence. At UMass he works with and has helped develop the Addressing Tobacco Through Organizational Change (ATTOC) model. The Department of Mental Health arranged for Dr. Douglas Ziedonis to provide consultation for the tobacco cessation activities at the three agencies involved in the LTF pilot project.

Early in the grant period (June 2012) Dr. Ziedonis came to Missouri to review each agency's tobacco cessation efforts and provide feedback to them as to what they could be to be more effective. Dr. Ziedonis' consultation had huge impact on the direction of the LTF pilot project. Many of his recommendations were integrated into the change plans of each agency. Because of this, a brief summary of those recommendations is provided.

In the month before his visit Dr. Ziedonis received and reviewed the three agencies' change plans, written policies on tobacco (administrative and clinical), and any Human Resources benefits for staff. There was an initial conference call with the planning/implementation teams from all three agencies followed by a call with the team at each agency to become acquainted with what the teams were doing. These calls were followed by a one-day site visit at each agency in early June 2012.

During the site visits, Dr. Ziedonis conducted an environmental scan both inside and outside the agency facilities. He spoke with each executive director, the LTF planning/implementation teams, conducted chart reviews, and met with staff to summarize his findings and recommendations at the end of the day. Although some of his findings were unique to each agency, there were others that had more universal application. These recommendations included:

- Change plans should be organized around three broad goals: clients, staff, and environment. Strategies can be grouped under these goals. These goals can be aligned with a vision of wellness and recovery.
- Agencies should provide indoor signage and resources. These include brochures available in high traffic areas, signs and posters with pro-recovery and pro-wellness messages, information about the Missouri Quitline, and other tobacco cessation resources. Such messages should also be in residential facilities and day treatment areas.
- Be sensitive to how tobacco users may want help. They may want face-to-face individual or group supports, phone support, or internet chat rooms or programs on-line. Resources are available for each of these preferences. Agencies should match treatment to preference and use an array of tools, not just one. Tobacco cessation tools will be differentially effective for different tobacco users, that's why an array of tools is needed.

Tools can include: Freedom From Smoking (FFS) clinics, Learning about Healthy Living (LAHL) classes, Nicotine Anonymous (NicA), smoking cessation websites such as Become an Ex ([www.becominganex.com](http://www.becominganex.com)) and Quit Now ([www.quitnow.com](http://www.quitnow.com)), individual counseling, and others.

- The clinical records for all clients should clearly document tobacco use. Tobacco use should be on the problem list on treatment plans. Tobacco use should be part of screening, assessment, and treatment planning. Assessment should include at least age of onset and history of use, as well as information about severity level, motivation, and quit attempts.
- Develop Tobacco Treatment Specialists. They will have the ability to train others, including clinicians and administrative staff.
- Train physicians about tobacco. Many don't know much about tobacco cessation and they need to be part of the plan. Physician involvement is especially crucial when quitting tobacco use can change blood levels.
- Staff tobacco policies should include both 1) resources to help staff stop tobacco use, and 2) policies to require staff show no evidence of smoking. The latter point requires staff to have no odor of smoke on their breath or clothes, no visible tobacco products or paraphernalia, and no smoking on the job in any way that is visible to clients. HR should be involved with these policies.

As part of his visit, Dr. Ziedonis was filmed doing a presentation for clinicians on tobacco cessation resources and activities, prescribing tobacco cessation medications (including NRTs), and using a carbon monoxide (CO) monitor. DVDs of this presentation have been provided to the three MFH grant partner agencies and 35 additional DMH behavioral health providers. As a result of lessons learned from the LTF grant DMH has contracted with the Mayo Clinic to train TTSs and has also been training FFS facilitators for provider agencies across the state—each agency with a trained TTS and/or FFS facilitator has received a copy of this DVD.

### **III. GOING TOBACCO FREE**

With a goal of becoming completely tobacco free, each agency tried to restrict tobacco use to the greatest extent possible. However, the problems they faced and the way they did so vary considerably and reflect the unique situations that each faced.

#### **Crider Health Center**

CHC reviewed and updated their tobacco policies requiring that all buildings, grounds, and vehicles be tobacco free. They also created procedures to which staff could refer to enforce the policies. The basic CHC policy on tobacco stated that: “. . . all facilities, campuses, and vehicles owned or leased by Crider Health Center shall be tobacco free.”

CHC has a number of residential programs. These include Pathways, an 18-bed Assisted Living Facility (ALF)/Intensive Residential Treatment Service (IRTS) facility, and four Adult Psychiatric Individualized Supported Living (PISL) facilities for three to four persons each. By October 2012 three of four PISLs were tobacco free and Pathways was “almost” tobacco free (see below). No tobacco use was allowed in the Pathways facility, but some residents could smoke in a designated area outside.

Initially, as part of the LTF grant, CHC banned tobacco use anywhere, both in Pathways or on the grounds. However, during a licensure visit from the Division of Regulation and Licensure (DRL) (in the Department of Health and Senior Services) a resident complained to one of the licensure staff that they were no longer allowed to smoke on the grounds. The licensure individual told CHC that it was a violation of rule (per interpretive guideline) to not allow residents to smoke who had previously been allowed to. Licensure informed CHC that any residents who had been allowed to smoke in a designated area earlier must continue to be allowed to smoke there. Only new residents who were informed when admitted to the facility that no smoking was allowed anywhere on the premises could be barred from smoking.

The interpretive guideline cited by Licensure reads as follows:

If a facility changes its policy to prohibit smoking, it must allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents. Weather permitting; this may be an outside area. Residents admitted after the facility changes its policy must be informed of this policy at admission.

Unless CHC changed its smoking policy immediately, Pathways would be cited for a deficiency. CHC changed the policy to comply with DRL’s guidelines and “grandfathered in” current smokers. (See **Appendix B: Pathways and the Resident Right of Self-Determination and Participation** for a fuller presentation of the applicable rule, intent of the rule, and interpretive guideline used to monitor the rule.)

Crider Health Center also had two Clubhouses, Harmony (Washington, MO) and Headway (St. Charles, MO). In these Clubhouses members participate in consensus-based decision making regarding all important matters relating to the running of the Clubhouse. Because of this philosophy, each Clubhouse discussed the merits of becoming tobacco free. Harmony decided to go tobacco free on January 1, 2013. Headway is also discussing it but has not set a date.

#### E-Cigarettes

CHC was the only agency that encountered a problem with e-cigarettes. A number of clients started using e-cigarettes at the facility, arguing that CHC’s tobacco use policies did not include e-cigarettes because they did not contain tobacco. The receptionist at the front desk was under pressure and was not sure how to handle the situation. Crider decided to ban e-cigarettes. Their use constituted a temptation for others trying to quit, and they felt that the potential risks of e-cigarettes were not yet fully known. To make it clear that e-cigarettes were banned from the premises, CHC modified its policies and ordered new signage that included e-cigarettes in its ban on tobacco products. The new signs were put up both outside, in the parking lot, and inside where they were easily visible.

## **COMTREA**

COMTREA decided to go entirely tobacco free throughout their campus and residential facility. Tobacco use had been permitted outside in designated areas. The tobacco use policy was changed to include grounds as well as buildings. Their policy states: "Smoking or any other tobacco use is not allowed on any COMTREA property at any time for any reason." They erected signage around campus to inform people of this policy.

Like QOPC (see below), COMTREA created a script with various scenarios for staff to use when they saw someone using tobacco on COMTREA property. This script was a modification of the script written by QOPC.

## **Queen of Peace Center**

Queen of Peace Center struggled with the concept of becoming a tobacco free agency. Though wanting to become tobacco free, they encountered obstacles that prevented the agency from doing so. One of the problems was at their main site, Cathedral Tower. This site was shared by two agencies in addition to QOPC. One of these agencies was a residential care facility on the second floor. Both agencies permitted tobacco use under certain circumstances and QOPC could not change the other agencies' policies. Tobacco use was permitted in designated areas in back of Cathedral Tower. Although smoking was not permitted around the front entrance, signage was not well displayed and the policy was poorly enforced leading to groups of smokers congregating in front of the building and smoking, as well as smoking on their way back to the designated areas.

The tobacco cessation team at QOPC bought new signs and strategically located them where they were easily seen. Since QOPC could not control the other agencies in the building, they worked with them to tighten smoking policies. They designated the Tower as a "smoking restricted" facility and put up signs stating "This Is a Smoking Restricted Campus. Thank you for your cooperation." Two areas in back were labeled "designated smoking areas" and signs stating that the front is a "Smoke Free Zone" were put up. The designated smoking areas were for clients and staff and could only be used during four designated times during the day.

Enforcing the new policies also needed to be considered. Staff were hesitant to just walk up to people smoking in violation of the policies. To help mitigate this hesitancy, QOPC wrote suggested scripts for staff to use when they noticed violations of the smoking policies. The scripts covered several different scenarios. The security guards at the facility were also asked to enforce the smoking policy if they noticed people smoking in smoke free zones. The smoking restriction policies apply to clients, staff, and visitors. As clients go through intake each person is briefed on the tobacco policy and signs an agreement that they will follow the policy.

The women being treated by QOPC are expected to accept responsibility for being substance free on campus in accordance with QOPC's policies. The use of alcohol or other drugs on QOPC property is cause for immediate dismissal. After debate, this policy was also applied to the use of tobacco. A client agreement was written to be reviewed with the client and signed at intake. This agreement specified that the person understands "that failure to follow or comply with any Queen of Peace Center policy can and will lead to dismissal from the program." If tobacco was used on the premises in violation of policy, discharge from the program was a possibility. If a

client were to violate the tobacco use policy once, they were counseled by one of QOPC's TTSs. If a second violation occurred the person again received counseling and was asked to sign a "behavioral contract" that reiterates the QOPC's smoking policies and states that if the smoking policy is violated again, for a third time, within the next two months the individual would be dismissed from QOPC. During the course of the grant period, QOPC did dismiss clients from their program for multiple tobacco use violations as part of the overall policy concerning drug use on campus.

At QOPC's two residential facilities away from Cathedral Tower, other problems arose. Both of these facilities became tobacco free. Female residents wanting to smoke had to smoke off-site. Many of these women had small children and they had to take their children with them if they leave the facility to smoke off-site (staff did not care for unattended children if the mother was out). Since the facilities were locked for security reasons, staff must let the women back in when they came back from smoking. Staff couldn't keep doing this throughout the day and night, so QOPC set specific times when the women could leave to smoke. There were four smoking times throughout the day (the same as at Cathedral Tower).

Both residential facilities are in areas where crime has been a problem and both facilities have had shootings occur near the smoking women with their small children. For safety reasons the QOPC residential tobacco use policies are still in flux. There is consideration of allowing the women to smoke outside but on the residential facility grounds.

\* \* \* \* \*

In addition to the above changes all three agencies made various informational brochures about the effects of tobacco use, how to quit smoking, and the available smoking cessation resources. Quit smoking and healthy living signs were posted inside agency buildings, including residential facilities.

#### **IV. CLINICAL CHANGES AND SPECIAL CLINICAL TRAINING**

##### **Specific Clinical Changes**

All three agencies have made serious efforts to change their clinical process to better accommodate tobacco dependence treatment. CHC and COMTREA are grounding tobacco cessation in their health care homes, while QOPC is integrating tobacco cessation into overall wellness.

Clinical changes were made in all three agencies due to the adaptation of Freedom From Smoking clinics and the utilization of Tobacco Treatment Specialists. Those changes are described in their own sections.

Other clinical changes at each agency include:

##### **COMTREA**

Adult Psychiatric Services Programs:

- Intake assessment was changed to include language to screen for nicotine use.
- Behavioral Health Assessment (Brief Annual Evaluation) for all CPR Maintenance Clients was changed to add language to screen for nicotine use.
- Initial/Annual Psychosocial Assessment (yearly assessment for CPR clients) strengthened language to assess for nicotine use as part of the Substance Abuse section, including clients' motivation to quit and referrals provided.
- Treatment Plans (all clients) now require specific objectives and interventions regarding smoking cessation for clients that identify a desire to cut down or quit smoking.

Adult CSTAR Program—Substance Abuse Evaluation (CIMOR Assessment)—initial assessment required for all substance abuse clients:

- Assessors now note nicotine use, amount of use, and desire to quit.
- Diagnosis of Nicotine Dependence or Nicotine Abuse is now included in the initial diagnosis, as appropriate.
- Treatment Plans (all clients) now require specific objectives and interventions regarding smoking cessation for clients that identify a desire to cut down or quit smoking.

General Clinical Changes:

- Staff throughout all adult programs refer clients for smoking cessation resources.
- Staff assist clients in accessing NRTs through Medicaid or through the LTF grant.
- Staff psychiatrist reviews client charts so the NRTs are distributed with the correct dosage.
- Carbon monoxide monitors (purchased through the grant) to measure CO levels in smokers' blood are integrated into FFS, Learning About Health Living, general CSTAR groups, and Psychosocial Rehabilitation Day Programs.
- "Smoke breaks" were eliminated throughout the agency. Clients are no longer allowed to leave the building on breaks during any groups.
- Smoking cessation resources are available on the intra-agency website.
- Staff are being trained on nicotine use and cessation resources.
- Brochures are available with COMTREA resources and community resources for smoking cessation.
- Increasing coordination with Health Care Home staff to address nicotine use.
- Trained three Tobacco Treatment Specialists at the Center for Tobacco Treatment and Training, University of Massachusetts Medical School, Worcester, MA

### **Crider Health Center**

- Trained clinicians on how to assess for tobacco-dependency/abuse during the assessment process and to assess for motivation for smoking cessation when consumer identifies they are a smoker.
- Everyone is assessed for tobacco use both initially and annually.
- Adding specific objectives and interventions toward tobacco cessation into the treatment planning process when consumers identify a desire to quit or minimize current tobacco use.
- Added additional smoking screening questions to the Psychosocial Assessment to guide treatment planning.
- CHC built tobacco cessation into individual therapy. It was already embedded in group activities through FFS and LAHL.

## **Queen of Peace Center**

### **Intake**

- Consumers are given rules identifying QOPC's smoking restrictions.
- Assessors record each consumer's smoking history into the summary note of the Non-Emergency Medical Assessment section of the Initial Standardized Assessment Protocol (ISAP).

### **Treatment Plans**

- Treatment plan goals, objectives and interventions reflect consumer desires for smoking cessation.

### **Healthy Living**

- The Community Support Specialists organized "Healthy Lifestyle" weeks during which information on the effects of smoking, healthy eating and enjoyable physical activities are given alongside actual engagement in activities for the staff and consumers to promote healthier living.
- Healthy Lifestyle Committee members and other Quality Improvement Committee members send out healthy lifestyle facts to all of the staff in either fact sheet forms in the mailboxes or through email blasts.
- Learning About Healthy Living curriculum has been integrated into the group education schedule. These classes are ongoing.

## **Nicotine Replacement Therapies (NRTs)**

There are effective medications for tobacco dependence and clinicians should encourage their use by all patients attempting to quit smoking. All forms of nicotine replacement therapy improve 6-month quit rates by about 60% over placebo (yielding a 2%–8% improvement in the absolute rate) (Glick, 2009).

Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates and have been approved by the Food and Drug Administration for this purpose:

- Nicotine gum
- Nicotine inhaler
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine patch
- Varenicline
- Bupropion SR

Although any of these seven medications could have been utilized by the agencies participating in the LTF grant, the only medications actually used were the over-the-counter (OTC) NRTs. These were the nicotine patch, gum, and lozenge.

All three agencies were initially hesitant to provide OTC NRTs. During the first year or so of the grant NRTs were probably underutilized. Since the use of NRTs in conjunction with a behavioral intervention is an evidence-based practice, this was disappointing. Despite frequent urging to increase the use of NRTs, especially the patch, use remained low. It wasn't until staff

from each agency were trained as TTSs that the provision of NRTs for persons motivated to quit tobacco became more routine. Both the UMASS Medical School and the Mayo Clinic taught TTS students to make NRTs readily available to persons wanting to quit. Slowly, utilization began to pick up, especially at COMTREA.

### **Crider Health Center**

Crider Health Center initially limited tobacco users who could receive NRTs to those attending an FFS clinic. This meant that only a few persons motivated to try to quit and attending FFS could get an NRT. This kept NRT use very low. Later in the grant period CHC opened NRT use to any adult ready to quit and made more use of the patch.

A person has to request an NRT by filling out a request form. If insurance or MO HealthNet (Missouri Medicaid) doesn't provide it, CHC would provide the NRT through the LTF grant. The CHC NRT request form allowed consumers to designate the type of NRT they wanted (gum, including flavor and dosage; lozenges, including flavor and dosage; patches, including dosage). The Health Care Home Director (a nurse) would review the form and purchase the NRT per client/staff request.

### **COMTREA**

COMTREA also initially limited NRTs to persons attending FFS clinics. Like the other agencies they expanded NRT distribution from clients participating in FFS to any adult client 18 years of age or older wanting to quit smoking (with no medical contraindications for use). This was part of a written procedure for NRT distribution and fed into their NRT Request form. COMTREA did a good job as they continued to expand NRT distribution throughout the second year of the grant.

### **Queen of Peace Center**

Like CHC, QOPC was somewhat slow to use NRTs. QOPC developed an NRT request form and log. At one point NRTs were provided to clients on a daily basis instead of providing enough for a longer period of time. Like the other agencies, QOPC slowly expanded NRT use.

### **Dosing**

In addition to using NRTs, proper dosing for persons with mental illness can be a problem. This is because persons with mental illness often smoke differently than the general smoker. One cigarette is approximately equal to 1 mg of nicotine (though different brands can vary) given transdermally. This is why people who smoke one pack of cigarettes per day (20 cigarettes) normally start on a 21 mg nicotine patch. However, persons with mental illness may smoke deeper and faster. They get 2-3 mgs of nicotine per cigarette instead of the usual 1 mg which most smokers get. If a client is smoking a pack a day, they may be getting the same amount of nicotine that a lot of people get who smoke two packs a day. The client is getting perhaps 40 or more mgs of nicotine. If a 21 mg patch is used by that client they will still feel the effects of nicotine withdrawal, making their quit attempt much harder. They may, in fact, need two patches initially to help them quit. Some people also really miss that first cigarette in the morning or a cigarette at other times during the day, even if using a patch. It makes sense to provide gum or lozenges to help abate sudden cravings.

During the period of the grant there were few if any instances of clients being allowed to use multiple patches or more than one NRT. Toward the end of the grant period COMTREA's physician indicated his willingness to approve such dosing, but no actual instances of such a practice are known.

Dr. Ziedonis, among other clinicians working with mental health patients who smoke, recommend "off-label" dosing. The FDA recently made proper dosing easier by removing the warnings and limitations from the labels of OTC NRTs. Hence, the "off label" issue is no longer relevant. According to the FDA (FDA, April 2013):

- There are no significant safety concerns associated with using more than one OTC NRT at the same time, or using an OTC NRT at the same time as another nicotine-containing product—including a cigarette. If you are using an OTC NRT while trying to quit smoking but slip up and have a cigarette, you should not stop using the NRT. You should keep using the OTC NRT and keep trying to quit.
- NRT users should still pick a day to quit smoking, and begin using the OTC NRT product on their "quit" day, even if they aren't immediately able to stop smoking.
- Users of NRT products should still use the product for the length of time indicated in the label—for example, 8, 10 or 12 weeks. However, if they feel they need to continue using the product for longer in order to quit, it is safe to do so in most cases. Consumers are advised to consult their health care professional if they feel the need to use an OTC NRT for longer than the time period recommended in the label.

For further discussion of the issue of dosing and the use of multiple NRTs see the Toronto Center for Addiction and Mental Health at [http://knowledgex.camh.net/primary\\_care/toolkits/addiction\\_toolkit/smoking/Pages/faq\\_recommending\\_nrt.aspx](http://knowledgex.camh.net/primary_care/toolkits/addiction_toolkit/smoking/Pages/faq_recommending_nrt.aspx).

It is hoped that future projects will move faster to provide NRTs to persons who want to quit and that the issue of dosing and the provision of multiple NRTs is properly matched to each individual's needs.

### **Carbon Monoxide (CO) Monitors**

During Dr. Douglas Ziedonis' site visits in June 2012, he discussed the usefulness of CO monitors as a part of tobacco dependence treatment. Carbon monoxide is a colorless, odorless, and tasteless toxic gas that is a byproduct of smoking tobacco (among other things). Carbon monoxide reduces the blood's ability to carry oxygen, thereby depriving the heart, brain and other organs of oxygen. Carbon monoxide also decreases the release of oxygen to the fetus in pregnant women. This increases the risk of both underweight births and birth defects.

The CO monitor is an independent clinical tool that provides a quick, easy, non-invasive, and cheap way to identify, educate, assess and treat tobacco dependent individuals. It can become a routine part of screening and tracking tobacco use. It is also an effective way to create a

“teachable moment” to raise the motivation level of tobacco users. As a tobacco user blows into the monitor, the CO level in the person’s blood is conveyed as a numerical reading—the number goes higher and higher while, at the same time, a light changes color from green, to yellow, and finally red. There may also be an audio signal that rises in volume and pitch with the CO level. These indicators can be quite dramatic and can facilitate a tobacco user to connect the effects of smoking to the smoker’s blood and body.

With this knowledge, all three agencies purchased CO monitors shortly after Dr. Ziedonis’ site visits. The agencies developed policies for governing the use of the monitors, including when to use, training of staff, and logging. As staff at each agency got used to using the CO monitor, they purchased additional monitors to use at different sites. CO monitors were integrated into FFS classes, LAHL classes, general CSTAR groups, PSR Day Programs, and Crider Center’s clubhouses. Queen of Peace Center has a population of pregnant women with substance use disorders who also smoke. One of the two CO monitors they purchased measures both the CO levels in the blood of the smoking mother as well as CO levels in the blood of her fetus.

By the end of the service provision through the grant (December 2013), Crider Center had five CO monitors positioned around their service area, COMTREA had three—one at each site, and Queen of Peace Center was using two.

As staff at the three agencies discussed their CO monitors, they were in close agreement that CO monitors were a useful tool in facilitating tobacco cessation. CO monitors are not best used alone but should be integrated into a complete array of tobacco dependence interventions and treatments.

## **Staff Training**

In addition to these changes in the clinical processes aimed at integrating tobacco cessation into the assessment and treatment planning processes, there was also tobacco cessation training aimed at clinicians at each agency. (Note: The integration of CO monitors into each agency’s clinical processes is discussed in a section of its own. Discussion of FFS and TTS training are also available in sections devoted to these activities.)

- **General Training**  
Throughout the 26-month grant period, all three agencies conducted training to acquaint their staff with the dangers of tobacco use, why people should quit, and techniques for quitting. Much of this was general training directed at all staff. Some of it was done at lunch-and-learns over the noon hour and some of it was integrated into regular staff continuing training. However, several clinician trainings were aimed at specific groups and were required as a way to make tobacco cessation activities a routine part of the duties of particular clinical groups.
- **Community Support Staff Training**  
Toward the end of the LTF grant period, CHC conducted training for all of their Community Support Specialists (CSS). The curriculum was put together and trained by CHC’s three TTSs. This training was mandatory for all CSSs. The training was held on

three different dates so all staff could be trained. The first group was trained in November 2013, the second in December 2013, and the third in January 2014 (just after service provision under the grant ended). The training covered information about tobacco and its effects on health, a discussion of the seven FDA approved tobacco cessation medications, an overview of the brief counseling technique “Ask, Advise, Refer”. Especially useful is a discussion of how the CSS can help clients quit tobacco use by moving clients up the stages of change (pre-contemplation, contemplation, preparation, action, maintenance). Specific objectives and interventions that can be used by the CSS are included. PowerPoint presentation from this training is available at: <http://dmh.mo.gov/mentalillness/provider/tobaccotraining.htm> .

- **Physician Training**

Crider Health Center, the largest of the three agencies, encountered problems integrating physicians into the treatment of tobacco dependence. Physician involvement is crucial so that other medications can be monitored if there is an interaction between them and decreasing nicotine levels. CHC used physicians who worked on a contract basis. When they are taken out of exam rounds it becomes very expensive. It “hits the bottom line” as an administrator expressed it. Sometimes there was confusion between physicians, e.g., psychiatrists seeing clients would not prescribe NRTs themselves, instead they wanted their patients to go to their primary care physician for the prescription.

CHC scheduled a physician training in December 2013 that trained some of their contract physicians. The training was led by one of their house physicians and featured some of the slides from Dr. Douglas Ziedonis’ DVD (see Ziedonis Consultation). This training covered characteristics of tobacco use in persons with mental illness and substance use disorders, psychotropic medications and nicotine, and use of tobacco cessation medications. There will be a web version for physicians who can’t attend. The PowerPoint slides will be on the Missouri Coalition of Community Mental Health Centers web site for other agencies to use.

- **Treatment Planning**

In the Fall of 2013 tobacco treatment experts from all three agencies worked together to develop a joint training addressing tobacco use in treatment planning. This training covered the stages of change and how to properly match treatment to whatever stage a client might be in. A presentation of this training with accompanying PowerPoint slides was filmed at a studio at the Missouri Institute of Mental Health in October 2013. The filmed presentation is now available for training staff at all three agencies as well as being available to any agency across the state.

- **Wellness Coaching**

In 2012-13 the three participating agencies sent staff to DMH-provided Wellness Coaching training. Although the training was originally aimed at Community Mental Health Centers (CMHCs) QOPC was also allowed to train a staff person. This training was provided to assist with education for the management of chronic diseases and client wellness. This training helped agency staff develop skills needed to motivate individuals to create and follow through on health and wellness goals and which assist them in making behavioral changes that lead to positive lifestyle improvement. This training was provided by DMH through the University of Medicine and Dentistry of New Jersey, School of Health Related Professions. Each of the persons trained is now a trainer who

can teach other staff wellness coaching skills. All three agencies worked to train other staff in wellness coaching and to embed tobacco cessation in overall wellness and recovery.

QOPC was especially eager to integrate tobacco cessation into overall client wellness and recovery. QOPC's wellness coach and tobacco treatment specialist worked together to improve healthy lifestyles curriculum, client care, and environmental awareness. They provided wellness training to all the CSSs in the agency.

### **Nicotine Anonymous (NicA)**

Nicotine Anonymous is a 12-step program to help people help each other live nicotine-free lives. The primary purpose of Nicotine Anonymous is to help all those who would like to cease using tobacco and nicotine products in any form. The fellowship offers group support and recovery using the 12-steps as adapted from Alcoholics Anonymous to achieve abstinence from nicotine.

Residents at St. Philippines, a QOPC residential facility, started Nicotine Anonymous meetings in January 2013. Queen of Peace Center offers different types of 12-step group education and the initiation of NicA meetings was a good fit to their overall philosophy and programming. A client who had gone through FFS was particularly helpful in organizing these meetings with the cooperation of staff at St. Philippines.

### **Learning About Healthy Living (LAHL)**

This is a curriculum (Williams, J., Ziedonis, D., Speelman, N, et al., 2005) geared for persons with behavioral health disorders who are not yet ready to quit smoking. LAHL is a 20 session group treatment approach that is designed for smokers at different levels of motivation with different mental health problems. The goal of the intervention is to increase individuals' awareness about the risks of tobacco use, treatment options, enhance motivation to address tobacco, and to begin by making other healthy life choices. The curriculum is designed to be usable by a broad range of mental health professionals and paraprofessionals. In addition to tobacco, the curriculum addresses other aspects of healthy living, including diet, managing stress, and increasing activity. This course is ideal for persons for whom the more structured FFS course is not appropriate. This curriculum is free and may be downloaded from the internet. Agencies conducting LAHL classes for consumers participating in DMH programs may bill DMH for consumer participation in these classes.

Although the emphasis is on addressing tobacco cessation, the manual includes sections on other aspects of healthy living, including improved diet, increasing activity, and managing stress. Since many behavioral health and substance use treatment providers in the DMH system are increasingly focusing on increased wellness, content from this manual is readily integrated into programs already in place or being developed.

The LAHL manual is actually designed for two groups, the first, Learning About Healthy Living, is an educational and motivational intervention. It is open-ended, clients can start at any point

(there is a rolling admission) and it is not time limited. As people become motivated to quit tobacco use, they can go on to the second group. In Missouri, the first group, LAHL, was used in all three agencies and tobacco users who wanted to quit were transitioned into FFS.

All three agencies conducted LAHL groups at multiple sites. Because clients can start and drop out of the classes at any point, numbers of persons completing the classes are not available. However, all three agencies made heavy use of the course.

The emphasis on FFS probably discouraged use of the second section of LAHL which is aimed at persons motivated to quit smoking. This is the same group targeted by FFS. None of the agencies utilized this part of LAHL.

### **Freedom From Smoking (FFS) Clinics**

To help adult smokers quit, the American Lung Association (ALA) offers Freedom From Smoking clinics. The evidence-based program teaches skills and techniques that have been proven to help smokers quit. Many consider FFS as the “gold standard” in treating tobacco dependence. The FFS group clinic includes eight sessions and features a step-by-step plan for quitting smoking. Each session is designed to help smokers gain control over their behavior. The clinic format encourages participants to work on the process and problems of quitting, both individually and as part of a group. FFS is geared toward persons already motivated to quit tobacco use.

In order to offer FFS clinics facilitators must be trained and certified by the ALA. During the course of the LTF grant, three FFS facilitator training sessions were held. These were conducted by an ALA master trainer from the Plains-Gulf Region of the ALA with offices in St. Louis. These sessions, conducted in December 2011, March 2012, and March 2013, ultimately trained 37 staff from the three agencies: 9 from COMTREA, 17 from Crider Center, and 11 from Queen of Peace Center. (Two other persons were also trained as FFS facilitators: a state mental health professional at the first session who was to help the master trainer understand tobacco cessation issues unique to persons with serious mental illness and substance use disorders, and a person from ACT Missouri.)

The first FFS clinics were offered in the second quarter of the grant (February-April 2012) for consumers and staff. Almost immediately thereafter additional clinics were added for different sites and populations. Queen of Peace Center had trained six facilitators at the December 2012 training. COMTREA and CHC trained three and five respectively, and, as they expanded clinics, wanted additional FFS facilitators. The agencies felt that FFS clinics were sufficiently effective that they requested a second FFS facilitator training which was held in March 2012. As FFS clinics were offered the three agencies were able to bill for the clinics through either Enhanced Psychosocial Rehabilitation (PSR) (CHC and COMTREA) or Group Education (QOPC).

One of the problems with training FFS facilitators is that as new facilitators are needed, either through normal turnover or expansion of the number of FFS clinics being offered, a certified

ALA facilitator trainer must be employed to conduct the training. In an effort to work around this expensive and time consuming step, as an add on to the FFS facilitator training in March 2013, the Plains-Gulf ALA in St. Louis allowed their master trainer to train one person from each of the agencies to become an FFS ALA certified facilitator trainer. This meant that all three agencies had a clinician who could now train FFS facilitators in house—without incurring training costs and as the need arose. This was an important step toward building sustainability into the FFS program after funding from the grant ends. Becoming an FFS facilitator trainer requires that the person has been an FFS facilitator for at least one year and has taught at least two FFS clinics, and, like all FFS facilitators, be a nonsmoker. All three agencies are using their FFS facilitator trainers to train new facilitators in-house.

**Specifics:**

- COMTREA offered FFS clinics at Arnold, Festus, and High Ridge. COMTREA also referred staff to FFS clinics at the County Health Department.
- Crider Health Center offered regular FFS clinics at three sites: Wentzville, St. Charles, and Union. Later FFS was expanded to PSR programs in Washington and St. Charles. Crider Center also conducted FFS clinics for staff at their Wentzville office location. Their facilitator trainer had trained five clinical staff to be facilitators (through October 2013).
- CHC also trained all its Nurse Care Managers to be FFS facilitators.
- Queen of Peace Center offered FFS clinics at their residential sites, including St. Philippine Home and Our Lady of Perpetual Help. By April 2013 Queen of Peace Center had trained eleven FFS facilitators and was conducting ongoing clinics across the agency. Queen of Peace Center’s facilitator trainer had trained two clinical staff to be facilitators (through July 2013)

Although all three agencies were conducting FFS clinics, both COMTREA and Crider Center encounter problems with transportation—many clients had no way to come in for the clinics. Many of COMTREA’s and Crider’s clients were not on site. They could live anywhere throughout each agencies service area. Their clients could obtain transportation to get in to see their physician, but not to attend FFS clinics. Queen of Peace Center had clients on site at their residential facilities so transportation was not an issue. QOPC had some transportation resources to help clients get to classes at the main building (Cathedral Tower). This transportation problem was not solved during the grant period.

QOPC had problems just getting women who signed up for FFS clinics to come. Typically, only half or so of the persons committed to participating actually came. However, some women would come to the classes but not quit smoking and, later, enroll in another FFS clinic. QOPC reported that a number of women quit smoking after enrolling in several FFS clinics.

**Other Tobacco Cessation Curricula**

In addition to FFS there are other good smoking cessation curricula that are aimed at persons who are ready to quit tobacco use. The three pilot agencies did not become aware of these resources until late in the grant. These other curricula include:

- *SANE Smokefree Kit*, an Australian curriculum aimed specifically at person with mental illness. This resource includes information on the relationship between smoking and mental illness; a session-by-session guide to running a program (with handouts); and a copy of *SANE Guide to a Smokefree Life*, written for people with a mental illness.
- A curriculum aimed at persons ready to quit smoking contained in the Learning About Healthy Living free on-line manual; and
- A third curriculum contained in an important resource book, *The Tobacco Dependence Treatment Handbook: A Guide to Best Practices* (Abrams, et al., 2007). This latter resource also contains all necessary handouts for the eight-week curriculum.

These are resources that agencies might find useful if the \$30 FFS participant's manual is an expensive that cannot be sustained.

By the end of the grant period, each of the LTF partner agencies had been provided with copies of the *SANE Smokefree Kit* and they had also purchased *The Tobacco Dependence Treatment Handbook*. They have these resources if they decide to explore them.

### **Tobacco Treatment Specialists (TTS)**

At the start of the Living Tobacco Free grant, the Missouri behavioral health system did not use Tobacco Treatment Specialists. When Dr. Douglas Ziedonis consulted at the three partner agencies in June 2012, he strongly recommended that each agency develop staff that were trained as Tobacco Treatment Specialists.

TTSs are individuals with extensive expertise in tobacco treatment. Among other things, they:

- Understand the science behind tobacco addiction, nicotine withdrawal symptoms, and effective treatments for tobacco use;
- Develop individualized treatment plans using comprehensive, evidence-based assessments and treatment strategies, including both medications and behavioral treatment; and
- Serve as educational resources for organizations, healthcare providers, and the general public regarding tobacco use treatment issues.

Agencies training TTSs may be accredited by the Association for the Treatment of Tobacco Use and Dependence (ATTUD). ATTUD has developed national standards for TTS training programs.

Following the recommendation from Dr. Ziedonis, the Missouri Foundation for Health agreed to the use of grant funding to allow each agency to send a clinician to the Center for Tobacco Treatment Research and Training at the University of Massachusetts Medical School. The training consisted of an online course covering basic skills for working with smokers as a pre-requisite for an intensive four-day TTS core training conducted in Massachusetts. This program, like a few others in the United States, offers a certification process for clinicians completing the course. This training was conducted in September 2012.

As the agencies developed TTSs, they reported that they thought that TTS training is important for more than just clinicians. They believed that if administrators were to take the training, it

would be a “wonderful way to get agency buy-in for tobacco dependence treatment.” These administrators would also come away with many ideas as to how to better implement tobacco dependence treatment. People trained as TTSs also noted that they had “extra credibility” with all staff, including clinicians.

So valuable were the TTSs to the three agencies, that additional staff were trained. In March 2013 another person from each agency was trained to be a TTS by the University of Massachusetts Medical School. Each agency then had two TTSs on staff.

Much of the reason for the LTF grant was to pilot tobacco dependence treatment processes to determine what is effective and what might be less so. The development of TTSs (some of whom have already received their certification) was deemed so important that the Department of Mental Health (DMH) decided to begin offering TTS training to other agencies in the state. As part of an evolving state plan for tobacco cessation, DMH contracted with the Nicotine Dependence Center at the Mayo Clinic, Minnesota, to conduct TTS training in June 2013. The Mayo Clinic TTS training program covers much of the same material as that at the University of Massachusetts, but is a five-day training with no online module. The Mayo Clinic brought staff from the Clinic to conduct training for 30 persons in Jefferson City. The Mayo Clinic will conduct a second TTS training for DMH in March 2014 for another 30 attendees.

One additional staff person from CHC received TTS training from the Mayo Clinic at the June 2013 training. COMTREA then sent a third person to the University of Massachusetts Medical School in September 2013. CHC and COMTREA then had three TTSs each, while QOPC, a smaller agency, had two. Each agency then had sufficient TTSs to provide coverage at multiple sites, backup for each other, and supply and teach state-of-the-art educational and treatment strategies for their respective agency. These TTS act as an educator to both clients and staff and encourage clients to become more engaged to quit tobacco use through motivational interviewing.

During a conference call with TTSs and staff from all three agencies in April 2013, agencies agreed that it would have been very helpful to have staff trained as TTSs from the start of the grant.

### **Missouri Tobacco Quitline (1-800-QUIT-NOW).**

Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, clinicians and healthcare delivery systems should both ensure patient access to quitlines and promote quitline use (Tobacco Use and Treatment, PHS). Available 24 hours a day, seven days a week, the Missouri Quitline offers several levels of free telephone and online counseling as well as resource materials to assist individuals to quit smoking or chewing. Special services are available for pregnant women. Collaboration with the Quitline is especially important because agencies can receive useful feedback about persons referred to the Quitline. In Missouri, if persons are referred to the Quitline on a faxed referral sheet, the referring agency will receive feedback information regarding the status of the person referred. A further benefit of the Missouri Quitline is that callers can obtain a two-week supply of NRTs when they register with the Quitline.

All three agencies were encouraged to utilize the Missouri Quitline. Referrals to the Quitline were also recommended to each of the agencies by Dr. Douglas Ziedonis during his on-site consultations in June 2012. Quitlines have been empirically shown to be an effective tool in reducing tobacco use (Fiore M.C., et al., April 2009).

Each of the agencies reported that they referred clients and staff to the Quitline. Such referrals consisted of making the Quitline information readily available and encouraging clients to make a call. Since it was up to the individual to make the call, there are no numbers as to how many actually called the Quitline. None of the agencies used the referral form enabling them to obtain feedback. QOPC, in particular, feared there would be confidentiality issues by making such referrals. Also, all three agencies learned that the Missouri Quitline does not always have sufficient funding to provide the advertised two-week supply of NRTs on a regular basis. Funds for NRTs are provided to cover a specific calendar period. If the funds are exhausted before the end of the period, no NRTs can be provided until the next period. This creates an element of unreliability and is a problem that was not known at the beginning of the project. This diminished the potential value of making referrals to the Quitline, and, hence, probably served as a brake on utilization.

## V. TREATING AGENCY STAFF

CHC offered NRTs to any staff participating in FFS clinics. They also made benefits available through their Human Resources Office of up to \$100 to reimburse staff for purchasing smoking cessation products, prescription medications, and/or auricular therapy.

As of July 1, 2012 COMTREA stopped hiring persons who used tobacco. Current staff that use tobacco will be grandfathered in. Initially they had wanted to use blood tests to measure cotinine levels at hiring to check for tobacco use. Due to a lack of labs to do the tests, expense, and problems with a nonsmoker testing positive due to being exposed to secondhand smoke caused them to go to an honor system.

All three agencies conducted FFS clinics for staff. They struggled as to whether or not to include clients and staff in the same clinic. After determining that few staff wanted to participate in FFS clinics with clients, some FFS clinics were provided for staff only.

- COMTREA, a small agency, discovered that smoking staff were reluctant to take FFS from a peer. In an effort to get around this problem, COMTREA referred staff to FFS clinics conducted by the Jefferson County Health Department. However, COMTREA did offer FFS clinics to a few staff.
- Crider Health Center conducted a staff clinic in June 2012 with 10 participants, 4 of whom completed the course.
- Queen of Peace Center surveyed staff as to their interest in an FFS clinic. Only 5 responded: 1 was ready to quit, 1 was “on the fence”, and 3 replied that they knew the risks of smoking but were not interested in quitting.

## VI. SUSTAINABILITY AND THE FUTURE

There are an impressive array of assets that have been developed to enhance the sustainability of the activities, infrastructure building, and treatments that have been implemented as a result of the MFH LTF grant. Some are as follows:

### **HealthCare Homes.**

The development of HealthCare Homes in Missouri offer an exciting opportunity for continuing the tobacco cessation activities conducted through the LTF grant. Missouri is one of the few states in the nation to be developing HealthCare Homes that integrate behavioral and primary care in CMHCs. Both COMTREA and CHC have implemented such HealthCare Homes. The HealthCare Home initiative targets individuals enrolled in Medicaid with a serious mental illness and emphasizes assisting these individuals in accessing primary care services, managing chronic illness, and developing and maintaining healthy lifestyles. CMHC HealthCare Homes integrate Nurse Care Managers and Primary Care Physician Consultants into their psychiatric rehabilitation teams to assist in monitoring health status, coordinate care with the individual's PCP, help individuals understand and self-manage their chronic diseases, promote healthy lifestyles, reduce inappropriate utilization of emergency department services, and participate in hospital discharge planning. Statewide data show that of all the persons served in CMHC HealthCare Homes:

- 60% smoke;
- 25% have diabetes;
- More than 25% have COPD/asthma;
- More than 30% have hypertension; and
- 80% have a BMI>25.

HealthCare Homes are a natural place to anchor tobacco cessation activities and offer exciting possibilities for their implementation. Not all the persons with SMI and SUD issues are currently being served by HealthCare Homes, but the number is expanding and will continue to expand.

### **Freedom From Smoking (FFS)**

During the course of grant, each of the three agencies developed an FFS facilitator trainer. This person is certified by the ALA to train new facilitators who can conduct FFS clinics for clients and staff. These facilitator trainers will help sustain the FFS clinics at each agency.

### **Psychosocial Rehabilitation (PSR)**

Reimbursement on a per person basis for FFS clinics and LAHL classes can be obtained through this group treatment service. It allows CMHCs to be able to sustain these groups after the grant period is over. PSR does not pay for the cost of the participant FFS manuals, however.

### **Group Education**

Reimbursement for FFS clinics and LAHL classes on a per person basis can be obtained by substance abuse treatment agencies through a service called Group Education. Group Education does not pay for the cost of FFS participant manuals.

### **Motivational Interviewing (MI).**

With DMH assistance, all three agencies trained a substantial majority of their clinical staff in Motivational Interviewing (MI). This evidence-based process has been shown effective as a means for increasing the motivation of tobacco dependent consumers to quit (Tobacco Use and Treatment, PHS). MI is a key part of engaging clients and helping to move them up the readiness to change ladder.

### **Wellness Coaching.**

In September of 2012, all three agencies sent staff to DMH-provided Wellness Coaching training. Although aimed primarily at CMHCs, QOPC staff also were trained. These staff developed skills on motivating individuals to create and follow through on health and wellness goals and assist clients to make behavioral changes leading to positive lifestyle improvement. This training was provided by DMH through the University of Medicine and Dentistry of New Jersey, School of Health Related Professions. Each of the persons trained is now a trainer who can teach other staff wellness coaching skills. Embedding tobacco cessation in overall wellness and recovery is an important strategy for DMH.

### **NRTs**

Continuing to supply NRTs to all persons wanting to quit tobacco use may be something of a challenge, though there are some available resources. MO HealthNet (Medicaid) recipients are eligible for up to 24 weeks of NRTs and behavioral therapy. NRTs through MO HealthNet must be prescribed. In addition, DMH has been making some limited resources available to behavioral health provider agencies to provide NRTs for non-Medicaid clients. Lastly, there are very limited NRTs sporadically available through the Missouri Quitline. Supplying NRTs to all persons wanting quit tobacco use will be a challenge, but will not be a hopeless challenge.

### **TTSs**

Having trained Tobacco Treatment Specialists in each agency is force for sustainability. These persons have the expertise to continue to advocate for and implement state-of-the-art tobacco treatment interventions. That knowledge will be valuable in terms of individual client treatment as well as in advising each of the agencies as to how they can improve their tobacco cessation activities. DMH is contracting with the Mayo Clinic to provide TTS training to staff from provider agencies across the state. This DMH-funded training is ongoing. With the support of DMH, each agency will replace CTTSs as normal attrition occurs (through additional training of current staff or hiring a new CTTS from outside the agency). Their knowledge and skills will help each agency to continue to maintain their tobacco cessation efforts. As each of the TTSs acquires experience they may apply for and become certified as a TTS. The certification is available through the training agency (either UMASS Medical School or the Mayo Clinic).

### **Clinical Changes**

The clinical changes that each of the agencies made are also sustainable. Standing policies to ensure the assessment of all clients for tobacco dependence and readiness to quit have been implemented. Anyone ready to quit are being provided both behavioral and pharmacological supports (this includes use of the Missouri Quitline). Those not yet ready to quit are engaged by agency staff to enhance their motivation. Tobacco cessation activities are being included on

client treatment plans. These clinical changes are in place, have been trained, and will be ongoing.

**DMH Statewide Plans**

Tobacco cessation is being stressed by DMH across the whole state. There is an ongoing effort on the part of the Division of Behavioral Health to integrate tobacco cessation activities into the treatment of all clients being provided with state-funded services. This tobacco cessation effort includes both CMHCs and substance abuse treatment providers. Providing tobacco-free campuses, tobacco-free residences, and tobacco cessation treatment is a crucial part of HealthCare Homes and the wellness orientation are part of the DMH vision.

Essentially, DMH is creating an “arc” which, over time, will integrate behavioral and primary care within the context of a culture of wellness. This commitment has been expressed philosophically, but, even more important, with the expenditure of considerable resources to make it happen. DMH and the three agencies that participated in the LTF grant are committed to this. The lessons learned from this grant will resound across the state. DMH is also committed to prevent backsliding and to furthering efforts to improve the health and expand the lifespans of its clients.

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<http://www.tobaccoprogram.org/pdf/Learning%20About%20Healthy%20Living.pdf>.

## **Appendix A: Pathways and the Resident Right of Self-Determination and Participation**

This Appendix provides greater context and technical information to help persons understand the conflict over smokers' rights faced by CHC over the DHSS monitoring of Pathways ALF. As noted in the report above, DHSS licenses Pathways as an ALF and periodically monitors the facility for compliance with licensure standards. CHC, by not allowing smoking on facility grounds was found to be in violation of DHSS interpretive guidelines to state and federal regulations.

Below is language from the Code of Federal Regulation (CFR). Although Assisted Living Facilities (ALFs) aren't federally funded, the Department of Health and Senior Services (DHSS), the licensing agency, considers the resident right of self-determination and participation to be applicable since they are also rights listed under the Missouri Resident Rights section. Despite contacts with the Tobacco Cessation Office in the DHSS, this issue was not resolved by the end of the grant period.

Below are given the CFR governing this issue Pathways faced, the intent of that rule, and, most importantly, the DHSS interpretive guideline that DHSS used to monitor compliance with the rule.

### **§483.15(b) - Self-Determination and Participation**

The resident has the right to--

- (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;
- (2) Interact with members of the community both inside and outside the facility; and
- (3) Make choices about aspects of his or her life in the facility that are significant to the resident.

### **Intent: §483.15(b)**

The intent of this requirement is to specify that the facility must create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. This includes actively seeking information from the resident regarding significant interests and preferences in order to provide necessary assistance to help residents fulfill their choices over aspects of their lives in the facility.

### **Interpretive Guidelines: §483.15(b)**

Many types of choices are mentioned in this regulatory requirement. The first of these is choice over "activities." It is an important right for a resident to have choices to participate in preferred activities, whether they are part of the formal activities program or self-directed. However, the regulation at §483.15(f) Activities, F248 covers both formal and self-directed activities. For issues concerning choices over activities, use Tag F248.

The second listed choice is "schedules." Residents have the right to have a choice over their schedules, consistent with their interests, assessments and plans of care. Choice over "schedules"

includes (but is not limited to) choices over the schedules that are important to the resident, such as daily waking, eating, bathing, and the time for going to bed at night. Residents have the right to choose health care schedules consistent with their interests and preferences, and the facility should gather this information in order to be proactive in assisting residents to fulfill their choices. For example, if a resident mentions that her therapy is scheduled at the time of her favorite television program, the facility should accommodate the resident to the extent that it can. If the resident refuses a bath because he or she prefers a shower or a different bathing method such as in-bed bathing, prefers it at a different time of day or on a different day, does not feel well that day, is uneasy about the aide assigned to help or is worried about falling, the staff member should make the necessary adjustments realizing the resident is not refusing to be clean but refusing the bath under the circumstance provided. The facility staff should meet with the resident to make adjustments in the care plan to accommodate his or her preferences.

**NOTE:** For issues regarding choice over arrangement of furniture and adaptations to the resident's bedroom and bathroom, see §483.15(e)(1), Accommodation of Needs, Tag F246. According to this requirement at §483.15(b)(3), residents have the right to make choices about aspects of their lives that are significant to them. One example includes the right to choose to room with a person of the resident's choice if both parties are residents of the facility, and both consent to the choice.

If a facility changes its policy to prohibit smoking, it must allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents. Weather permitting, this may be an outside area. Residents admitted after the facility changes its policy must be informed of this policy at admission.

## **Attachments**

Attached are a number of documents that were produced by the agencies participating in the LTF grant. These are samples that may benefit other agencies that are trying to undertake tobacco cessation activities. The contexts for these Attachments are discussed in this report. Readers are urged to refer back to the report.

- The Smoking Cessation Resources brochure (**Attachment 1**) is something that can be used as a template by practically any agency. Only agency particulars need be changed.
- **Attachment 2** on the NRT Distribution Procedure and Request Form is something agencies may want to think about as they develop their own policies on the distribution of NRTs.
- The Enforcement Script (**Attachment 3**) is useful to help provide staff with some ideas as to how to enforce tobacco policies in different situations. Without staff becoming involved tobacco policies often are not enforced and soon become ignored by both clients and staff.
- The Crider implementation plan (**Attachment 4**) is an example of a plan as it had evolved fair late in the grant.
- The Queen of Peace Center implementation plan (**Attachment 5**) is an example of an earlier plan. The QOPC plan would continue to change as the grant progressed.
- The Tobacco Treatment Training for Community Support Staff (**Attachment 6**) is a PowerPoint presentation produced by CHC which they used over three training sessions to train all their CSSs on tobacco cessation.
- **Attachment 7**, the QOPC Campus Smoking Policy reflects the unique barriers QOPC faced as they discovered that their situation would not permit them to become a tobacco free agency.
- **Attachment 8**, the video was created and presented by staff at COMTREA, Crider Health Center, and Queen of Peace Center. The video addresses ways to best match appropriate tobacco cessation interventions to a client's readiness to quit tobacco use.

**ATTACHMENT 1: SMOKING CESSATION RESOURCES BROCHURE (COMTREA)**

## Are You Ready To Quit Smoking?

1. Do I want to quit smoking for myself?
2. Is quitting smoking a #1 priority for me?
3. Have I tried to quit smoking before?
4. Do I believe that smoking is dangerous to my health?
5. Am I committed to trying to quit even though it may be tough at first?
6. Are my family, friends, and co-workers willing to help me quit smoking?
7. Besides health reasons, do I have other personal reasons for quitting smoking?
8. Will I be patient with myself and keep trying if I backslide?

If you answered YES to 4 or more of these questions, then you are ready to quit smoking.

This brochure contains information regarding resources that you might find helpful.



Community Treatment, Inc

227 Main St., Festus, MO 63028  
636-931-2700

21 Municipal Dr., Arnold, MO 63010  
636-296-6206

1817 Gravois Rd., High Ridge, MO 63049  
636-376-0079

[www.comtrea.org](http://www.comtrea.org)



**Living Tobacco Free**  
A Missouri Department of Mental Health Tobacco Cessation Pilot

Funding provided by



*Funding for this project was provided in whole by The Missouri Foundation for Health. The Missouri Foundation for Health is a philanthropic organization whose vision is to improve the health of the people in the communities it serves.*



## Smoking Cessation Resources



**Do you want to quit smoking?  
Here are some resources that may help you!**

## Why Should I Quit?

As soon as you quit smoking, your body begins a series of healing or recovery changes that continue for years!

### 20 Minutes After Quitting

- Your heart rate drops to a normal level

### 12 Hours After Quitting

- The carbon monoxide level in your blood drops to normal

### 2 Weeks to 3 Months After Quitting

- Your risk of having a heart attack begins to drop
- Your lung function begins to improve

### 1-9 Months After Quitting

- Your coughing and shortness of breath decrease

### 1 Year After Quitting

- Your added risk of coronary heart disease is half that of a smoker

### 5-15 Years After Quitting

- Your risk of having a stroke is reduced to that of a nonsmoker's
- Your risk of getting cancer of the mouth, throat, or esophagus is half that of a smoker's

### 10 Years After Quitting

- Your risk of dying from lung cancer is about half that of a smoker's
- Your risk of getting bladder cancer is half that of a smoker's
- Your risk of getting cervical cancer or cancer of the larynx, kidney, or pancreas decreases

### 15 Years After Quitting

- Your risk of coronary heart disease is the same as that of a nonsmoker.

## Local Resources

### Freedom From Smoking Classes

- Freedom From Smoking is a seven week group program developed by the American Lung Association designed to provide you with tools, techniques, and support that will help you quit smoking successfully.
- The program has a positive focus to help participants learn proven strategies for changing their behavior and life style.

**COMTREA offers the Freedom From Smoking program for FREE to any current COMTREA adult clients.**

- New groups begin regularly at our Arnold, Festus, and High Ridge locations
- To register, speak with any COMTREA staff member for more information.

The Jefferson County Health Department offers the Freedom From Smoking program regularly for any Jefferson County resident at the Arnold and Hillsboro locations as well as at Jefferson Regional Medical Center.

- Call 636-797-3737 ext 268 for questions or to register

**Take the Freedom From Smoking course online at:** <http://www.ffsonline.org>

† AMERICAN LUNG ASSOCIATION.

*Freedom*  
FROM SMOKING®

## Other Resources

### Become an EX -

[www.becomeanex.org](http://www.becomeanex.org)

The EX Plan is a free quit smoking program, one that can show you a whole new way to think about quitting. It's based on personal experiences from ex-smokers as well as the latest scientific research from the experts at Mayo Clinic.

### Smokefree.gov - [www.smokefree.gov](http://www.smokefree.gov)

Smokefree.gov provides free, accurate, evidence-based information and professional assistance to help support the immediate and long-term needs of people trying to quit smoking.

### Nicotine Anonymous –

[www.nicotine-anonymous.org](http://www.nicotine-anonymous.org)

The Fellowship offers group support and recovery using the 12 Steps as adapted from Alcoholics Anonymous to achieve abstinence from nicotine.

### The Missouri Tobacco Quitline

**1-800-QUIT-NOW**

The Missouri Tobacco Quitline can help Missourians stop using tobacco. The Quitline offers telephone and online counseling and resource materials to assist individuals who want to quit smoking. The Quitline is free to anyone in Missouri.

### Smokefree QuitGuide – App

The Smokefree QuitGuide app for your smartphone is now available for download on iTunes!

This app is designed to help you prepare to quit smoking and support you in the days and weeks after you quit.

## **ATTACHMENT 2: NRT DISTRIBUTION PROCEDURE AND REQUEST FORM (COMTREA)**

### **Procedure for NRT Distribution (COMTREA)**

#### **Who is Eligible?**

- Current COMTREA client with DMH funding
- Adults 18 and over
- No medical contraindication for use of NRTs
- Clients must provide full list of medications upon request and the request must be reviewed by PCP or HCH Physician

#### **For Clients in Freedom From Smoking or Learning About Healthy Living:**

1. Group facilitator obtains completed NRT request form from client and submits to any HCH staff.
2. HCH staff pulls client's chart and reviews request and chart with Dr. Helton at weekly meeting or with client's PCP for appropriateness.
3. Once approval from Dr. Helton is obtained, requested NRTs are ordered for client and group facilitator is notified. If additional information is needed from client, facilitator is notified of that as well.
4. NCM attends FFS or LAHL group to distribute initial 2 week supply of NRT to client.
5. Additional 2 week supply is given as client continues to attend group. If client drops out of group, remainder of NRTs is provided on a case-by-case basis. At final group, the remainder of the 8-12 week supply is provided.

#### **For Adult clients not attending smoking cessation groups:**

1. Client completes NRT Request form.
2. Staff forwards request to HCH staff.
3. HCH staff pulls client's chart and reviews request and chart with Dr. Helton at weekly meeting or with client's PCP for appropriateness.
4. Once approved HCH staff will notify primary clinician (CSS, CCM, or therapist) of approval and to coordinate a time to meet with client and primary clinician.
  - a. Client is expected to meet with HCH NCM's to review NRT's prior to distribution
  - b. If client is open to Counseling only under a physician, client will be contacted directly by NCM to arrange a time for him or her to come to the office
5. Client will be provided with full recommended course of NRT at meeting with NCM.



**Living Tobacco Free  
Nicotine Replacement Therapy (NRT) Request**

ID: \_\_\_\_\_ Date: \_\_\_\_\_

Client or  Staff      Office preference:  South  Suburban  Northwest

**For Clients:** Does client have insurance coverage for NRTs?  Yes  No

If yes, reason client unable to utilize benefits provided by insurance: \_\_\_\_\_

**For Clients:** Does client reside in a RCF?  Yes  No

If yes, contact info for home: \_\_\_\_\_

**Desired NRT:**

Nicotine Gum                       Nicotine Patch

**Average number of cigarettes currently smoked daily?**

Less than 10       10-20       20 or more

**How soon do you smoke your 1<sup>st</sup> cigarette after waking each morning?**

More than 30 minutes       Less than 30 minutes

**List all current medications (prescribed and OTC):**

Medication Name	Dose (ex. 150 mg)	Times per day (ex. 2x daily)

**(Please attach list for any additional medications)**

**Please Note:** All participants are strongly encouraged to speak with their physician prior to starting any nicotine replacement therapy.

**There is important advice** to consider before beginning a nicotine replacement therapy.

- You should stop using a nicotine replacement product and call your health care professional if you experience nausea, dizziness, weakness, vomiting, fast or irregular heartbeat, mouth problems with the lozenge or gum, or redness or swelling of the skin around the patch that does not go away.
- Don't use any other product containing nicotine while using a nicotine replacement product.
- Women who are pregnant or breast-feeding should use these products only with approval from their health care professional.
- Talk to your health care professional before using these products if you have
  - diabetes, heart disease, asthma, or stomach ulcers
  - had a recent heart attack
  - high blood pressure that is not controlled with medicine
  - a history of irregular heartbeat
  - been prescribed medication to help you quit smoking
- If you take prescription medication for depression or asthma, let your health care professional know if you are quitting smoking; your prescription dose may need to be adjusted.

A full course of NRT will be provided to assist with smoking cessation. If an additional course is necessary, this may be requested and the request will be reviewed by Living Tobacco Free grant staff.

You agree to use the NRT only as directed and will not share the NRT with anyone. COMTREA is not responsible for any adverse effects from the use of the NRT.

---

**I acknowledge that I have read, understood, and agree to the above terms and wish to receive NRT. I agree to not smoke cigarettes or use any other nicotine containing product while using NRT. I will not hold COMTREA or any staff members responsible for any adverse effects from the use of NRT.**

Signature: \_\_\_\_\_

Date:

Witness: \_\_\_\_\_

Date:

---

**Program Use Only –**

---

NRT Provided:

- Nicotine Gum 4 mg       Nicotine Patch 21 mg  
 Nicotine Gum 2 mg       Nicotine Patch 14 mg  
 Nicotine Patch 7 mg

NRT provided: \_\_\_\_\_ Boxes: \_\_\_\_\_ Date Provided: \_\_\_\_\_ Staff:

\_\_\_\_\_ Boxes: \_\_\_\_\_ Date Provided: \_\_\_\_\_ Staff:

\_\_\_\_\_ Boxes: \_\_\_\_\_ Date Provided: \_\_\_\_\_ Staff:

NRT provided: \_\_\_\_\_ Boxes: \_\_\_\_\_ Date Provided: \_\_\_\_\_ Staff:

\_\_\_\_\_  
NRT provided: \_\_\_\_\_ Boxes: \_\_\_\_\_ Date Provided: \_\_\_\_\_ Staff:

\_\_\_\_\_

## **ATTACHMENT 3: LIVING TOBACCO FREE POLICY ENFORCEMENT SCRIPT (COMTREA)**

### **COMTREA Tobacco-Free Policy Enforcement Scripts**

COMTREA's Smoke-Free and Tobacco-Free Policy aims to minimize exposure to Environmental Tobacco Smoke (ETS) for clients, staff, visitors, contractors and volunteers across all agency programs. COMTREA strives to offer comprehensive treatment services for our community in a healthy, productive environment. Our policy states that the use of any tobacco product is not permitted at any COMTREA location and applies to all clients, staff, and visitors.

The purpose of this document is to provide COMTREA staff with guidance on how to support our clients to manage their nicotine dependence while in a smoke free environment. All staff at COMTREA share in the responsibility for supporting our clients in complying with the Tobacco-Free policy.

The interests of non-smokers and of those trying to quit, recently quit or thinking of quitting must absolutely be considered and these interests are served best by a strict, yet compassionate approach to smoke free policies.

The following scenarios and scripts are designed to assist COMTREA staff in the enforcement of this policy on the COMTREA campuses.

COMTREA expects all staff to be respectful and courteous when approaching someone using tobacco products on campus. If the tobacco user becomes agitated or hostile, please do not escalate the situation. Simply walk away.

Please keep in mind when addressing tobacco use with anyone:

- Be empathetic. The 3-5 minutes you spend with a person struggling with their need for tobacco could help their craving dissipate.
- Use common sense in every situation.
- Remember that the encounter should be supportive, not punitive.
- Share information about the policy in a non-judgmental way.

#### **Scenario #1:**

**Situation:** You see a person using tobacco products on COMTREA property.

**Response:** "Hello! I just wanted to remind you that COMTREA is committed to providing a smoke-free treatment setting. That means smoking is not allowed on our grounds. We appreciate your cooperation with this."

**Scenario #2:**

**Question:** “Where am I allowed to smoke?”

**Response:** “The use of tobacco products is not allowed anywhere on campus. We ask that you wait to smoke until after you have completed your visit at COMTREA for the day. If you need to smoke or use tobacco products, you will need to leave the campus. We appreciate your help with maintaining a tobacco free treatment setting.”

**Scenario #3:**

**Question:** “Do I have to quit smoking?”

**Response:** “No. COMTREA is not asking anyone to quit. This policy simply means that no one can use tobacco products on any COMTREA campus.”

**Scenario #4:**

**Question:** “Why don’t you have a designated smoking area?”

**Response:** “Designated smoking areas are not consistent with the tobacco-free policy. The aim of COMTREA’s tobacco-free policy is to create a healthy environment for clients and staff. Creating smoking areas sends a message that tobacco use is acceptable; rather, the COMTREA policy promotes healthy lifestyles and provides assistance for clients and staff who are ready to quit and for those who need to manage their addiction symptoms while here.”

**Scenario #5:**

**For prospective clients and their families prior to beginning services at COMTREA:**

“I’d like to let you know in advance that COMTREA strives to offer treatment services for our community in a healthy, productive environment. The use of tobacco products is not allowed on our property, grounds, or parking areas. I’d like to thank you in advance for respecting our policy.”

**Scenario #6:**

**For group facilitators, prior to allowing clients to have a break during group:**

“Please don’t forget, COMTREA is smoke-free on all our property. The break during group is a good time to get a drink, use the restroom, stretch your legs, or complete a UA if needed.”

**What to do if a client refuses to quit smoking on COMTREA property?**

1. Politely remind client of the tobacco-free policy.
2. Note to yourself a general description of the client.
3. Walk away.
4. Notify the office manager or front desk staff of the client's description and that you asked them to quit smoking and they refused.
5. Front desk staff will identify the client when they check in/out and then notify the primary clinician by email.
6. Primary clinician will address the matter with client as a treatment issue.

**ATTACHMENT 4: LIVING TOBACCO FREE IMPLEMENTATION PLAN (CRIDER HEALTH CENTER) (from late in the two-year grant)**

**Crider Health Center: Living Tobacco Free Plan with Time Frames:**

Action Items	Steps to Take	Completion Plan	Sustainability Plan
<p><b>Create tobacco cessation planning and implementation teams</b></p>	<p>Identify team members from across Crider Center programs. Members to include FFS facilitators, HCH staff, PSR, CS, Outpatient, Residential and Health and Safety Coordinator. Crider will also identify consumers to participate in the planning team. Core Team member will assist in transporting consumer representatives</p>	<p><b>Completed:</b> The planning team was formed in Jan. 2012</p>	<p>Following the MIMH grant the Nurse Care Managers and Director of Integrated Services will continue to focus on smoking cessation efforts started by the FFS core team. The TTS at Crider Health Center will provide training to each CSS regarding tobacco cessation and how to provide 1:1 support to consumers based on their stage of change.</p>
<p>Create tobacco cessation planning and implementation teams</p>	<p>Establish regular meetings and plan agenda for team meetings</p>	<p><b>Ongoing through Nov:</b> Team meets monthly beginning with 1-20-12 mtg</p>	<p>The Nurse Care Managers are embedded in the CMCH and Primary Care programs and will continue to bring smoking cessation communication, education, and discussions to team meetings following the conclusion of the MIMH grant. Specialized training will also be provided to CSS by TTS re: tobacco cessation</p>

**Crider Health Center: Living Tobacco Free Plan with Time Frames:**

Action Items	Steps to Take	Completion Plan	Sustainability Plan
<p>Create tobacco cessation planning and implementation teams</p>	<p>Divide planning team into smaller organized groups to focus on following areas: 1) Organize next round of groups, 2)Communication 3) Policy 4) Assessment and Treatment planning 5) CO Meters 6) Training and resources 7) Residential Smoking Plan</p>	<p>1. <b>Completed:</b> FFS groups are offered through FFS facilitator schedules 2.) <b>Ongoing:</b> used ADP and all agency emails, will utilize SLT in April to spread sustainability plans 3.) <b>completed:</b> developed enhanced tobacco use policies 4.) <b>completed:</b> Assessment updated <b>ongoing:</b> will provide additional training to staff re: tobacco use/cessation 5.) <b>completed:</b> CO Meters purchased <b>completed:</b> equipment use policy developed that includes the use of meters 6.) <b>Ongoing:</b> Crider treatment model training to include tobacco use/cessation 7.) <b>Completed:</b> Residential Facilities only one home has designated smoking area all others are smoke free</p>	<p>1.) Crider will have one staff member trained to complete facilitator trainings, this will enable Crider to continue to offer FFS groups and train additional facilitators as needed. All NCM have become FFS facilitators 2.) communication w/ staff and consumers re: smoking cessation and tobacco use through 1:1 appointments, FFS groups, staff meetings, and training. 3.) Policy will be completed and all staff will be updated 4.) All staff will receive training re: assessment and goal development 5.) Providers and NCM will all receive training on the CO Meters 6.) Agency to provide training and NCM to re-enforce trainings with teams</p>
<p><b>Develop and Implement plans for comprehensive tobacco cessation activities</b></p>	<p>Identify initial target areas for implementation- PSR, Residential, and Staff</p>	<p><b>completed:</b> target areas identified during 1-20-12 mtg</p>	<p>NCM assigned to programs throughout Crider and will continue to champion tobacco cessation efforts</p>

**Crider Health Center: Living Tobacco Free Plan with Time Frames:**

Action Items	Steps to Take	Completion Plan	Sustainability Plan
Develop and Implement plans for comprehensive tobacco cessation activities	Planning team meets monthly to review the Plan and Timeline to ensure Crider stays on target with goals	<b>ongoing:</b> Team meets monthly	NCM will continue to champion tobacco cessation efforts with their assigned teams
Develop and Implement plans for comprehensive tobacco cessation activities	Once programs are identified as areas to start groups, establish dates/time of FFS groups	<b>ongoing:</b> FFS groups offered at Wentzville, St. Charles and Union offices. Both PSRs utilizing Healthy Living groups with members	Will have one staff member certified to provide FFS Facilitator training to staff. All NCM are trained to offer FFS groups, in addition to interested staff across the outpatient clinic and CS teams to help co-facilitate
Develop and Implement plans for comprehensive tobacco cessation activities	Bring current Policy to planning team for review/revision	<b>completed:</b> Policy has been updated	All staff will be informed of policy developed by FFS team
<b>Policy written and implemented to require all buildings, grounds, and vehicles to be tobacco-free</b>	Complete review of written policy	<b>completed:</b> Policy has been updated	All staff will be informed of policy developed by FFS team
Policy written and implemented to require all buildings, grounds, and vehicles to be tobacco-free	Crider Center is currently tobacco free campus, need to create procedures for staff to have in order to enforce policy	<b>completed:</b> In addition to developing policy, scripts are also included in the policy to assist staff in enforcing the policy if someone is smoking on campus	All staff will be informed of policy developed by FFS team and will have scripts for talking to persons who are smoking on campus

**Crider Health Center: Living Tobacco Free Plan with Time Frames:**

Action Items	Steps to Take	Completion Plan	Sustainability Plan
<p><b>Develop and provide educational material and training on the effects of tobacco use and benefits of quitting</b></p>	<p>HH NCM to order educational materials to distribute to planning team for programs to distribute during appointments with consumers</p>	<p><b>ongoing:</b> FFS facilitators have utilized the FFS manual during groups and additional educational materials that have been helpful for group participants. Will share resources with staff for 1:1 appointments through the TTS training of CSS staff</p>	<p>NCM will provide educational materials to the teams they support as needed. CSS staff will also be provided training by TTS staff re: tobacco cessation support</p>
<p>Develop and provide educational material and training on the effects of tobacco use and benefits of quitting</p>	<p>Obtain FFS booklets for FFS group sessions for consumers/staff</p>	<p><b>completed:</b> FFS booklets were ordered for groups. Will reorder manuals as needed</p>	<p>FFS facilitators will discuss ordering needs with program director per program budgets</p>
<p>Develop and provide educational material and training on the effects of tobacco use and benefits of quitting</p>	<p>Provide training for clinicians on how to assess for tobacco dependency/abuse through assessments and how to add tobacco cessation into the ITP process</p>	<p><b>ongoing:</b> Crider Center has develop training model for all staff tobacco use/cessation will be covered in this training. Will be introduced in the Wellness Coach training and re-enforced through TTS training with CSS staff.</p>	<p>NCM will provide additional support to case workers as needed in team meetings and will provide ongoing tobacco trainings through team meetings. All NCM are trained in FFS and will use this to also re-enforce skills. TTS are available to teams for consultation/training as needed</p>

**Crider Health Center: Living Tobacco Free Plan with Time Frames:**

Action Items	Steps to Take	Completion Plan	Sustainability Plan
<p><b>Planning and implementation of tobacco cessation supports for residents</b></p>	<p>Develop detailed plan for provision of tobacco cessation for residents</p>	<p><b>completed:</b> Residential facilities became tobacco free in October. At this time, only one facility has designed area for tobacco use.</p>	<p>Continue to work with auditors/funders to have smoke free campus at residential locations per guidelines and continue to support designated smoking area at Station House.</p>
<p>Planning and implementation of tobacco cessation supports for residents</p>	<p>Offer FFS classes to residents</p>	<p><b>completed:</b> FFS was offered to residents and 2 house managers have been certified to offer FFS groups</p>	<p>continue to offer FFS groups to residents as needed</p>
<p>Planning and implementation of tobacco cessation supports for residents</p>	<p>Speak to residents and guardians about moving the residential facility to smoke free</p>	<p><b>completed:</b> Residential facilities became tobacco free in October. At this time, only one facility has designed area for tobacco use.</p>	<p>Continue to work with auditors/funders to have smoke free campus at residential locations per guidelines and continue to support designated smoking area at Station House.</p>
<p>Planning and implementation of tobacco cessation supports for residents</p>	<p>offer NRT to residents</p>	<p><b>completed:</b> residents were provided with NRT</p>	<p>Residents to obtain NRT as needed through providers, insurance, or 1-800 quit line</p>

Crider Health Center: Living Tobacco Free Plan with Time Frames:

Action Items	Steps to Take	Completion Plan	Sustainability Plan
<p>Planning and implementation of tobacco cessation supports for residents</p>	<p>Residential Programs (excluding 1 ISL) will become smoke free as of 10-1-2012</p>	<p><b>completed:</b> Residential facilities became tobacco free in October. At this time, only one facility has designed area for tobacco use.</p>	<p>Continue to work with auditors/funders to have smoke free campus at residential locations per guidelines and continue to support designated smoking area at Station House.</p>
<p>Planning and implementation of tobacco cessation supports for residents</p>	<p>Provide training for clinicians on how to assess for tobacco dependency/abuse through assessments and how to add tobacco cessation into the ITP process</p>	<p><b>ongoing:</b> Crider Center has develop training model for all staff tobacco use/cessation will be covered in this training. Will be introduced in the Wellness Coach training and re-enforced through TTS training with CSS staff.</p>	<p>NCM will provide additional support to case workers as needed in team meetings and will provide ongoing tobacco trainings through team meetings. All NCM are trained in FFS and will use this to also re-enforce skills. TTS are available to teams for consultation/training as needed</p>

**Crider Health Center: Living Tobacco Free Plan with Time Frames:**

Action Items	Steps to Take	Completion Plan	Sustainability Plan
<p><b>Incorporate tobacco issues into consumer education curriculum</b></p>	<p>Assess current consumer education efforts within programs in order to plan how to incorporate tobacco issues into treatment education</p>	<p><b>ongoing:</b> Crider Center has develop training model for all staff tobacco use/cessation will be covered in this training. Will be introduced in the Wellness Coach training and re-enforced through TTS training with CSS staff.</p>	<p>NCM will provide additional support to case workers as needed in team meetings and will provide ongoing tobacco trainings through team meetings. All NCM are trained in FFS and will use this to also re-enforce skills. TTS are available to teams for consultation/training as needed</p>
<p><b>Provide evidence-based tobacco cessation curriculum group courses (FFS)</b></p>	<p>Provide FFS groups to staff and PSR.</p>	<p><b>Completed:</b> PSR offered FFS groups to members but has found the Healthy Living Courses more successful in the PSR model</p>	<p>PSR will continue to offer Healthy Living courses at the request of member interest</p>
<p>Provide evidence-based tobacco cessation curriculum group courses (FFS)</p>	<p>Identify plans to expand groups to other programs</p>	<p><b>completed:</b> FFS groups have been offered to PSR, Residential, CS, and Outpatient consumers</p>	<p>Expand FFS efforts to primary care patients by training primary care NCM and BHS to offer FFS groups to medical patients. Continue to offer groups to CS, PSR, Residential, and Outpatient consumers</p>

**Crider Health Center: Living Tobacco Free Plan with Time Frames:**

Action Items	Steps to Take	Completion Plan	Sustainability Plan
Provide evidence-based tobacco cessation curriculum group courses (FFS)	Incorporate Healthy Life Styles into the FFS groups. Developed hand outs to provide to group members	<b>Completed:</b> PSR offered FFS groups to members but has found the Healthy Living courses more successful in the PSR model. Continue to offer FFS groups to CS and outpatient consumers	PSR will continue to offer Healthy Living courses at the request of member interest. Continue to use FFS model with CS and outpatient consumers
<b>Provide cessation incentives</b>	Explore incentive programs	<b>completed:</b> FFS Team decided not to pursue incentive programs	n/a
Provide cessation incentives	Identify incentives to be offered to participants of the FFS groups	<b>completed:</b> FFS Team decided not to pursue incentive programs	n/a
<b>Incorporate tobacco dependence assessment into the treatment plan</b>	Meet with Quality Management program to discuss/develop the ITP needs	<b>completed:</b> QM staff incorporated additional questions into assessment. <b>completed:</b> clinical staff to receive additional training on incorporating cessation into ITP per consumer's interest	NCM/TTS will provide additional support to case workers as needed in team meetings and will provide ongoing tobacco trainings through team meetings. All NCM are trained in FFS and will use this to also re-enforce skills

**Crider Health Center: Living Tobacco Free Plan with Time Frames:**

Action Items	Steps to Take	Completion Plan	Sustainability Plan
Incorporate tobacco dependence assessment into the treatment plan	Provide training for clinicians on how to assess for tobacco dependency/abuse through assessments and how to add tobacco cessation into the ITP process	<p><b>completed:</b> QM staff incorporated additional questions into assessment.</p> <p><b>completed:</b> clinical staff to receive additional training on incorporating cessation into ITP per consumer's interest</p>	NCM/TTS will provide additional support to case workers as needed in team meetings and will provide ongoing tobacco trainings through team meetings. All NCM will be trained in FFS and will use this to also re-enforce skills
Incorporate tobacco dependence assessment into the treatment plan	Added additional smoking screening questions to PSA to guide ITP process	<p><b>completed:</b> QM staff incorporated additional questions into assessment</p>	n/a
<b>Build tobacco cessation into individual therapy</b>	Assess current consumer education efforts within programs in order to plan how to incorporate tobacco issues.	<p><b>Ongoing:</b> clinical staff to receive additional training on incorporating cessation into treatment as appropriate to the therapy session.</p>	NCM/TTS will provide additional support to clinicians as needed in team meetings and will provide ongoing tobacco trainings through team meetings. All NCM will be trained in FFS and will use this to also re-enforce skills
Build tobacco cessation into individual therapy	Talk with programs delivering this service about building tobacco cessation into current service model	<p><b>completed:</b> FFS team leaders to discuss FFS grant and sustainability plans at SLT</p>	Ongoing support from program leaders re: importance of tobacco use education and cessation within current programs

**Crider Health Center: Living Tobacco Free Plan with Time Frames:**

Action Items	Steps to Take	Completion Plan	Sustainability Plan
<p><b>Build tobacco cessation activities into enhanced PSR/group education (ADA)</b></p>	<p>Meet with Independence Center to learn about their tobacco cessation programming as it relates to ICCD standards and incorporate into Crider programming</p>	<p><b>completed</b></p>	<p>n/a</p>
<p>Build tobacco cessation activities into enhanced PSR/group education (ADA)</p>	<p>Offer FFS groups to PSR members</p>	<p><b>Completed:</b> PSR offered FFS groups to members but has found the Healthy Living courses more successful in the PSR model. Continue to offer FFS groups to CS and outpatient consumers</p>	<p>PSR will continue to offer Healthy Living courses at the request of member interest. Continue to use FFS model with CS and outpatient consumers</p>
<p>Build tobacco cessation activities into enhanced PSR/group education (ADA)</p>	<p>Offer NRT to PSR members participating in FFS</p>	<p><b>Completed:</b> PSR offered FFS groups to members but has found the Healthy Living courses more successful in the PSR model. NRTs supplied to members participating in groups</p>	<p>NRTs to be provided through providers, insurance or referral to 1-800 Quit Line</p>
<p><b>Provide NRTs</b></p>	<p>Develop plan for educating staff on NRT</p>	<p><b>Ongoing:</b> Offer lunch and learn for all providers re: use of NRT through the use of Dr. Ziodonis training DVD</p>	<p>Request new providers view NRT video during training/orientation</p>
<p>Provide NRTs</p>	<p>Meet with Medical Directors to develop plan for prescribing practices of NRTs and expectations</p>	<p><b>ongoing:</b> Goal to complete development of NRT prescription plan by end of Nov.</p>	<p>Once plan is developed will be provided to new providers during training/orientation</p>

**Crider Health Center: Living Tobacco Free Plan with Time Frames:**

Action Items	Steps to Take	Completion Plan	Sustainability Plan
Provide NRTs	Discuss how to continue to provide NRT support to staff and clients after grant expires	<b>completed:</b> will encourage consumers/patients work with providers for scripts, educate them on insurance benefits, and referral to 1-800 Quit Line	continue to encourage consumers/patients work with providers for scripts, educate them on insurance benefits, and referral to 1-800 Quit Line
Provide NRTs through QOL	Speak to QOL Pharmacy to determine if NRT will be covered under 340B pricing and if QOL can supply NRT	<b>completed:</b> QOL does supply NRT for consumers/patients with prescriptions and can fill through insurance benefits	QOL to continue to supply NRT to consumers/patients with prescription through insurance benefits
Build tobacco cessation activities into health care homes	HCH services are embedded in existing programming. This step will happen naturally through the integrated care model	N/A	Healthcare Home NCM and Director of Integrated Services will champion smoking cessation efforts
Residential setting to become tobacco free	Identify possible site to be tobacco-free and introduce idea to staff and residents	<b>completed</b>	n/a

updated 10.4.13

**ATTACHMENT 5: LIVING TOBACCO FREE IMPLEMENTATION PLAN: (QUEEN OF PEACE CENTER) (fairly early in the two-year grant)**

Queen of Peace Center- Healthy Lifestyle Committee

Project Plan REVISED as of 2/28/2013

**GOAL: Queen of Peace Center will help clients attain a healthier lifestyle.**

Objective	Action Items	Estimated Implementation Date	Staff Person(s) Responsible
1. Create material to be distributed throughout the agency surrounding reduced smoking and living healthier lifestyles.	Create a brochure	August 1, 2012	Rosie
	Pick out posters with positive messages surrounding healthier lifestyles	August 1, 2012/ongoing In the process of remodeling 3 <sup>rd</sup> floor	Sharon/Cameron COMPLETED- working on getting some posters framed
	Create postcard sized fact sheet to place in employee mailboxes/residential areas with quick facts about effects of ATOD use, resources, and healthy tips (can be used for marketing blasts or to give to new clients)	August 1, 2012	Dorothy COMPLETED 8/20 along with Cameron's picture- will continue to do this once a month
2. Develop a Nicotine Anonymous meeting	Look into what it takes to start a NA meeting	August 15, 2012	Anna COMPLETED
	Create a small list of resources that can aid with reducing/quitting tobacco products that address different avenues one might seek help (i.e. telephone, face-to-face, internet)	August 15, 2012	Sara
3. Ensure each client has a signed statement of understanding of healthy lifestyles initiative and the designated smoking times at appropriate site(s).	Create a brief document that is a bright color to be placed in each client file to be sure that it is signed	August 1, 2012	Susan COMPLETED
	Have intake coordinator brief clients on initiative at intake into QOPC and have document signed at that time	Effective immediately, but will be ongoing	Intake Department (Carolyn) COMPLETED
4. Provide Freedom From Smoking classes and NRTs	Create schedule of when classes will be administered and by who	September 1, 2012	Margo COMPLETED 11/2/2012

	Complete simple survey of 5-6 questions to be administered as a baseline and follow up survey to evaluate how much classes/education/support affected daily tobacco use or propensity to engage in healthier activities	September 1, 2012	Sara
	Create a NRT tracking process to help monitor distribution and invoicing	September 1, 2012	Cassie COMPLETED
	Create guidelines to be used when administering or not administering NRTs for clients	September 1, 2012	Dorothy COMPLETED Sep 2012

**GOAL: Staff will be trained as to the best practices in addressing tobacco and the Center will support staff recovery.**

Objective	Action Items	Estimated Implementation Date	Staff Person(s) Responsible
5. Enhance staff training on healthier lifestyle initiative  *will discuss by next meeting on August 9, 2012	Identify areas of focus for training and curriculum/schedule of training • Screening, Assessment, Tx Planning	September 14, 2012	Healthy Lifestyles Committee
	Conduct training with staff	TBD*	TBD*
	Ensure follow up of training and reiteration of message at monthly department meetings	ongoing	All Program Supervisors
6. Create a CO meter plan	Produce a document with guidelines for use (i.e. when to use it, where to keep it, etc.) Submit to Dr. Cook before purchase	August 15, 2012	Lauren COMPLETED Sep 2012
	Purchase CO meter (one that measures levels of mom and baby)	TBD/September 1, 2012	Sara COMPLETED Sep 2012
7. Obtain a Tobacco Treatment Specialist that can be located at Cathedral Tower	Identify/Secure an existing staff person to become a TTS	July 20, 2012	Healthy Lifestyles Committee COMPLETED 8/27- Committee has

			chosen Molly Doolittle
	Create plan for how TTS will be utilized throughout agency and what the guidelines are	July 27, 2012 Will complete when Molly returns	Dorothy Molly
	Complete registration	August 15, 2012 September 4, 2012	TBD/person chosen to be TTS Molly
8. Create staff recovery plan	Send out an email asking that staff who smoke to please reply with if they would be interested in attending Freedom from Smoking classes	Would like to have all responses by August 3, 2012	Rosie COMPLETED- Discussed results on 8/9
	Based off of survey results, create a Freedom From Smoking class schedule and/or referral resources (i.e. organizations, internet, etc.)	<del>TBD based off of responses</del> Will not be starting at this time, see next cell for more information	Marge Email only had 5 staff respond, of those: 1 ready to quit, 1 on the fence, and 3 know the risks of smoking but not interested in quitting

**GOAL: Cathedral Tower will become a tobacco-restricted campus.**

Objective	Action Items	Estimated Implementation Date	Staff Person(s) Responsible
9. Obtain signage communicating Healthy Lifestyle initiative	Decide on template and lay out of signs	July 31, 2012	Sara, but approved by Committee/Administration COMPLETED 8/27
	Get quotes on signage	July 15, 2012	Jeanne COMPLETED
	Order signs	August 1, 2012	Susan Sara/Jeanne COMPLETED Nov 2012
	Map out campus of where potential signs could go and where we want to place the smoking areas	July 15, 2012	Healthy Lifestyles Committee COMPLETED- signs will be placed by front entrance, along walkway, one near PFK, and one sign at the Annex
	Post signs inside and outside	August 8, 2012	

		November 2012	Maintenance COMPLETED NOV 2012
10. Shape Healthy Lifestyle Policies for Queen of Peace Center sites	Meet with Building Committee of Cathedral Tower to gage buy in of Healthy Lifestyles Initiative among other Agency executives	July 15, 2012	Jeanne COMPLETED
	Find existing standards/regulations surrounding tobacco use and disciplinary action as it relates to our organization, Catholic Charities, Archdiocese, Council on Accreditation, and other accrediting bodies	July 15, 2012	Jeanne COMPLETED
	Create guideline/policy surrounding location for smoking and allowable times for use; defer to existing policies regarding insubordination of staff and clients	August 1, 2012	Sara COMPLETED- awaiting board approval
	Determine what amount of time is a "grace period" while beginning stages of initiative are being communicated throughout the agency	July 15, 2012	Healthy Lifestyles Committee COMPLETED
	Once grace period has ended and message has been relayed to clients and staff, enforce guidelines, policies, and corrective action regarding ATOD use	August 1, 2012	QOPC staff (Healthy Lifestyles Committee will follow up on enforcement) Enforcement started; will be ongoing
	11. Create a communication line	Produce a plan for what happens when clients are caught smoking outside of approved smoking areas	July 31, 2012
	Keeps up on consistent messaging/branding of the Healthy Lifestyles initiative throughout the organization	ongoing	Sara/Molly

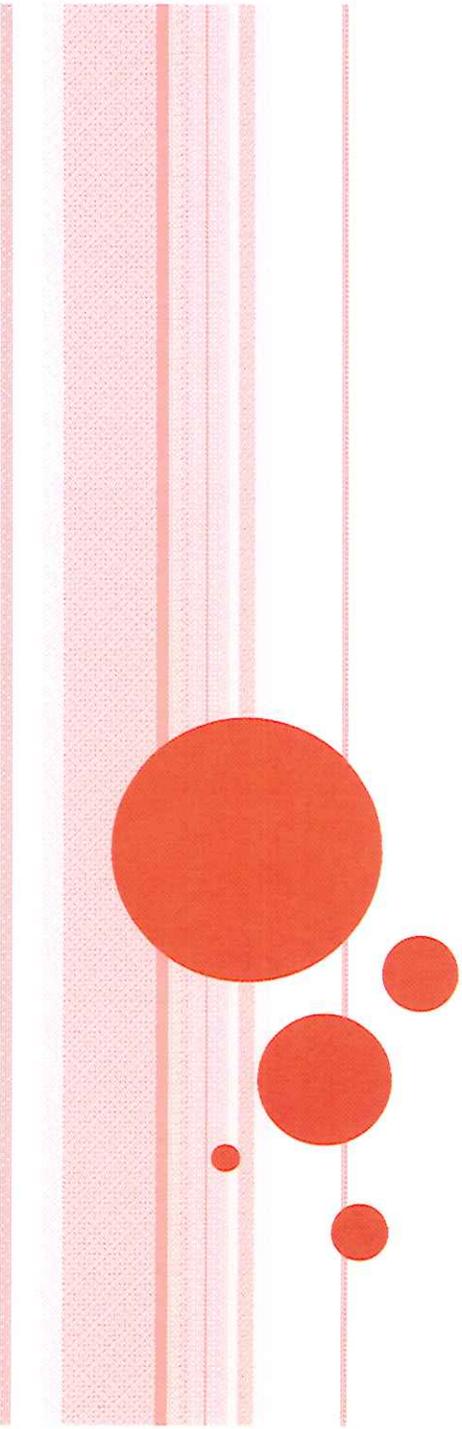
	Create a way to monitor and assess feedback from initiative that can be used to shape policy and how it is implemented throughout the agency	September 1, 2012	Sara/Molly ONGOING effort with Healthy Lifestyles Committee
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**GOAL: Queen of Peace Center's Healthy Lifestyles initiative will be sustainable.**

Objective	Action Items	Estimated Implementation Date	Staff Person(s) Responsible
12. Coincide with QOPC's client-centered approach with behavior change	Continue to incorporate Motivational Interviewing (MI) as part of intake and clinical services	Ongoing	Intake Department (Carolyn/Jess) and FFS Facilitators and Clinical Staff
13. Ensure QOPC clinical staff are able to keep Freedom From Smoking (FFS) classes on the group schedule	Have remaining adult counselors attend FFS training	March 29, 2013	Steve, Linda, Cristina, Gloria, & Rachel
	Have eligible staff person attend the FFS trainer training	March 29, 2013	Sharon
14. Solidify the Healthy Lifestyles Committee's place within QOPC	Hold refresher training on integration of tobacco use/dependence into existing services and treatment planning using modules on Tobacco Resource Recovery Exchange with QOPC staff	June 2013	TTS/FFS facilitators and Clinical Director
	Follow up with a brief fact sheet in employee mailboxes and email directory that can be used for reference and reminders	August 2013	TTS and FFS Facilitators
	Send email to QOPC staff email directory calling additional employees to join the Healthy Lifestyles Committee to ensure a larger representation of staff	August 2013	Sara

15. Create a living document that can guide QOPC's development of smoke free campuses	Continue to adjust and modify current procedure for tobacco use as QOPC's clients and services evolve	April 2013	Healthy Lifestyles Committee
	Discuss at monthly Healthy Lifestyle Committee the progress of clients that are utilizing tobacco cessation services	ongoing	TTS and FFS facilitators
16. Collaborate efforts of Wellness Staff within QOPC in order to improve Healthy Lifestyles initiative, client care, & environment awareness	Provide health assessments as part of intake into QOPC that will utilize the CO meter to educate clients on their levels and to promote tobacco cessation service option within the organization	March 2013	Dorothy
	Wellness Coach will train TTS	February-March 2013	Cameron
	Wellness training will help provide a system of tools that staff can assist clients with in setting and reaching their Healthy Lifestyle goals	ongoing	Wellness Staff and TTS
17. Ensure financial sustainability with grant funds ending November 1, 2013	Continue to partner with Family Care Health Center, where eligible women can receive patches if prescribed by their doctor, as well as attend FFS offered by their staff	Ongoing	Dorothy
	Near the end of project go over proper steps in ensuring grant related services and time once reimbursed through the grant are being coded properly in ClaimTrak in order for it to be billed under CSTAR contract	October 2013	Margo

**ATTACHMENT 6: COMMUNITY SUPPORT STAFF TRAINING POWERPOINT  
PRESENTATION (CRIDER HEALTH CENTER)**



# **TOBACCO TREATMENT TRAINING FOR CS STAFF**

**Debra Menne, Sabrina Tuttolomondo & Kendra Hines**

# COMPOUNDS IN TOBACCO SMOKE

An estimated 4,800 compounds in tobacco smoke,  
including 11 proven human carcinogens

## Gases

- Carbon monoxide
- Hydrogen cyanide
- Ammonia
- Benzene
- Formaldehyde



## Particles

- Nicotine
- Nitrosamines
- Lead
- Cadmium
- Polonium-210

Nicotine is the addictive component of tobacco products,  
but it does NOT cause the ill health effects of tobacco use.

# ANNUAL U.S. DEATHS ATTRIBUTABLE to SMOKING, 2000– 2004

		Percent of all smoking-attributable deaths
Cardiovascular diseases	128,497	<b>29%</b>
Lung cancer	125,522	<b>28%</b>
Respiratory diseases	103,338	<b>23%</b>
Second-hand smoke	49,400	<b>11%</b>
Cancers other than lung	35,326	<b>8%</b>
Other	1,512	<b>&lt;1%</b>

**TOTAL: 443,595 deaths annually**

# 2004 REPORT OF THE SURGEON GENERAL: HEALTH CONSEQUENCES OF SMOKING

## FOUR MAJOR CONCLUSIONS:

- Smoking harms nearly every organ of the body, causing many diseases and reducing the health of smokers in general.
- Quitting smoking has immediate as well as long-term benefits, reducing risks for diseases caused by smoking and improving health in general.
- Smoking cigarettes with lower machine-measured yields of tar and nicotine provides no clear benefit to health.
- The list of diseases caused by smoking has been expanded.

U.S. Department of Health and Human Services (USDHHS). (2004).  
*The Health Consequences of Smoking: A Report of the Surgeon General.*

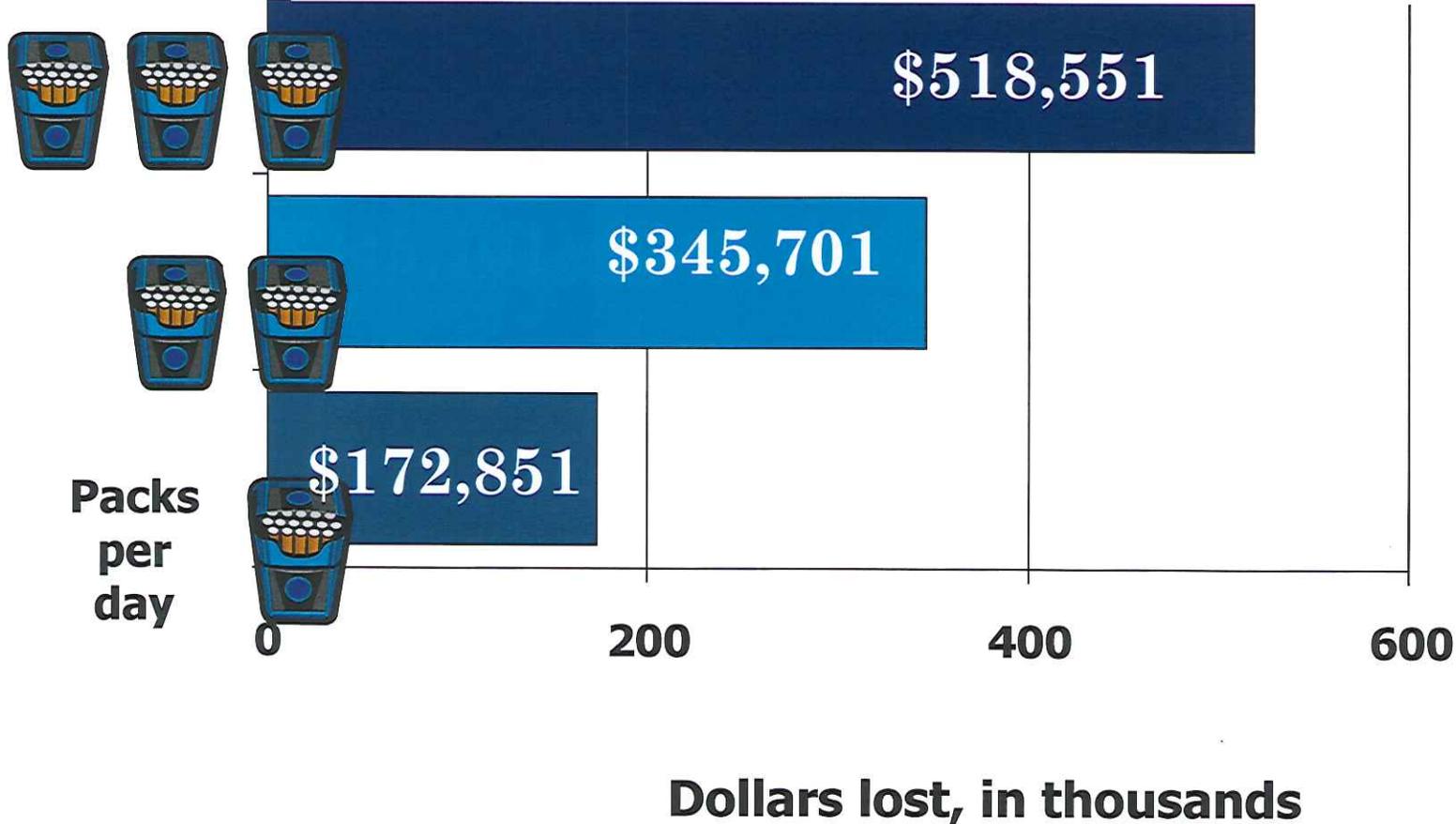
# HEALTH CONSEQUENCES OF SMOKING

- Cancers
  - Acute myeloid leukemia
  - Bladder and kidney
  - Cervical
  - Esophageal
  - Gastric
  - Laryngeal
  - Lung
  - Oral cavity and pharyngeal
  - Pancreatic
- Pulmonary diseases
  - Acute (e.g., pneumonia)
  - Chronic (e.g., COPD)
- Cardiovascular diseases
  - Abdominal aortic aneurysm
  - Coronary heart disease
  - Cerebrovascular disease
  - Peripheral arterial disease
- Reproductive effects
  - Reduced fertility in women
  - Poor pregnancy outcomes (e.g., low birth weight, preterm delivery)
  - Infant mortality
- Other effects: cataract, osteoporosis, periodontitis, poor surgical outcomes



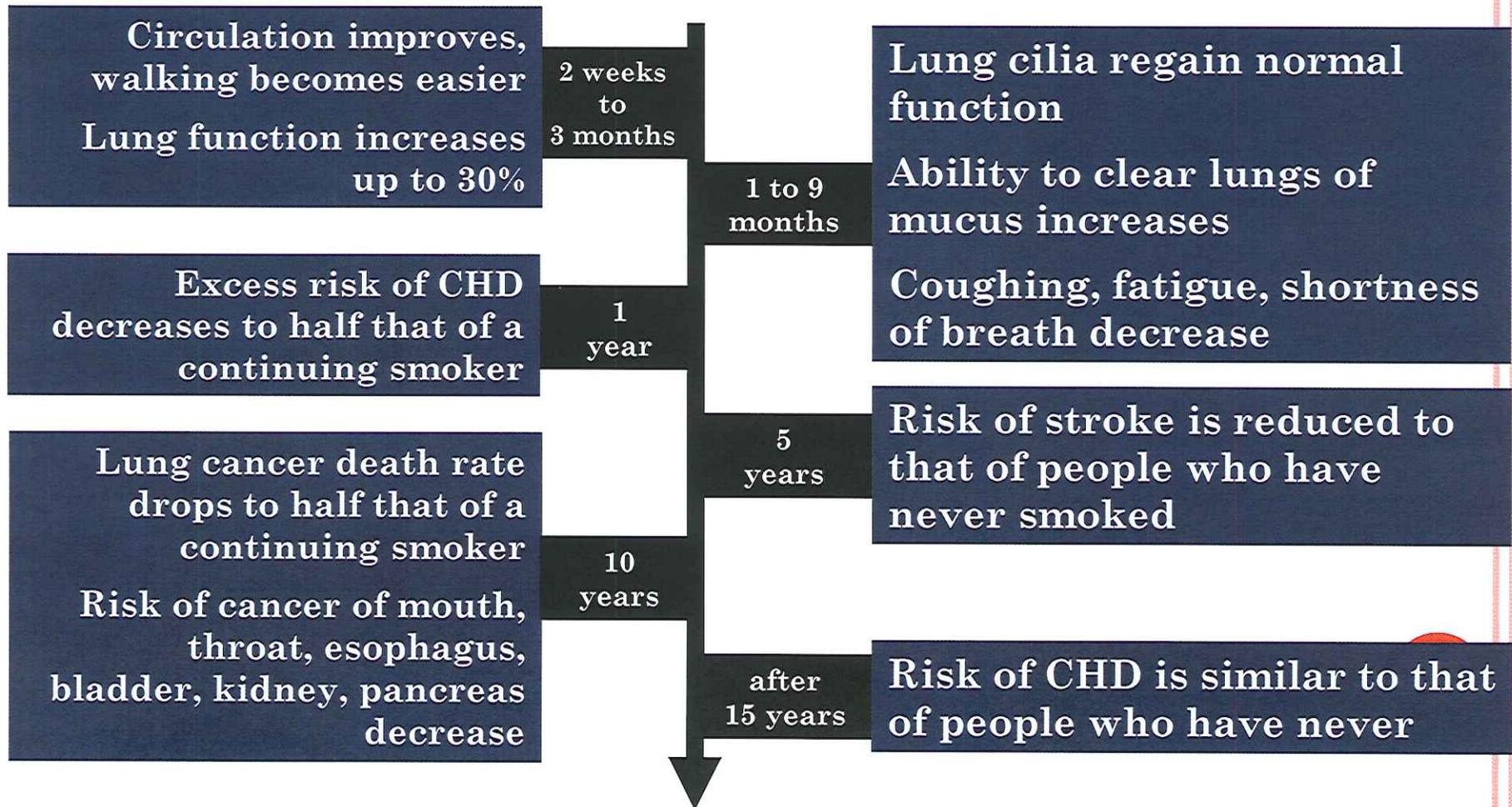
# FINANCIAL IMPACT OF SMOKING

Buying cigarettes every day for 50 years @ \$5.51 per pack  
Money banked monthly, earning 2% interest



# QUITTING: HEALTH BENEFITS

## Time Since Quit Date



# TOBACCO DEPENDENCE: A 2-PART PROBLEM

## Tobacco Dependence

### Physiological

The addiction to nicotine



Treatment

Medications for cessation



### Behavioral

The habit of using tobacco



Treatment

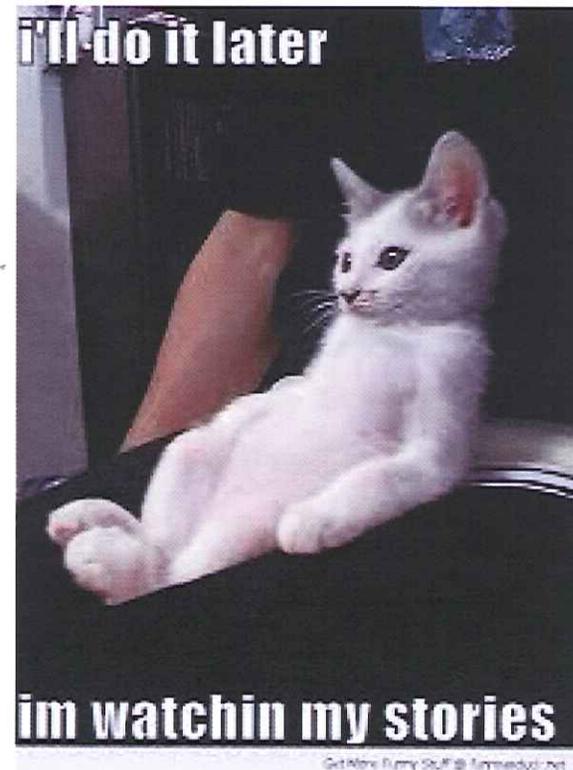
Behavior change program

Treatment should address the physiological **and** the behavioral aspects of dependence.



# OVERVIEW VIDEO-SMOKING CESSATION

- Video Time!



## TOBACCO COMES IN MANY FORMS

- **Cigarettes**- second hand smoke is unfiltered that everyone around them inhales
- **Cigars**-nicotine is absorbed in the mouth even though they don't inhale
- **Chew or Snuff** -nicotine absorbed and chemicals known to cause oral cancers



# HOOKAH (WATERPIPE SMOKING)

- Also known as Shisha, Narghile, Goza, Hubble bubble
- Tobacco flavored with fruit pulp, honey, and molasses
- Increasingly popular among young adults in coffee houses, bars, and lounges 7-10% of U.S. college students use hookah
- Nicotine, tar and carbon monoxide levels comparable to or higher than those in cigarette smoke



# ELECTRONIC CIGARETTES

- Battery operated devices that deliver vaporized nicotine
  - Cartridges contain nicotine, flavoring agents, and other chemicals
- Battery warms cartridge; user inhales nicotine vapor or ‘smoke’
- NOT labeled with health warnings
  - Preliminary FDA testing found some cartridges contain carcinogens and impurities (e.g., diethylene glycol)
  - No data to support claims that these products are a safe alternative to smoking



# STRATEGIES TO ADDRESS TOBACCO USE

- Multifaceted approach to address nicotine dependence
  - Routinely assessing consumers for tobacco use
  - Integrating tobacco-cessation into treatment plans
  - Relapse planning
  - Educational activities
  - Freedom from Smoking classes
  - Nicotine replacement therapies (NRTs)
  - Incentives for quitting
  - Building a strong “wellness” culture



# NICOTINE REPLACEMENT THERAPIES

- MO HealthNet covers 2 quit attempts of up to 12 weeks of intervention per lifetime
  - Nicorette Gum, Nicotrol Inhaler, Nicorette Lozenge, Nicotrol nasal spray, Nicoderm, Chantix, Zyban/Wellbutrin
  - To access coverage – Clients should call the Participants Services Unit at **1-800-392-2161**
- Medicare Prescription Drug Plans – Some plans offer coverage for smoking cessation
  - Dual Eligible clients may switch plans at any time to enroll in a plan which covers cessation aids.



## WHEN YOUR CLIENT WANTS TO QUIT

- Ask-Advise-Refer
- Integrate smoking cessation into treatment plans
- Assist with creating plan to quit
- Assist with obtaining NRTs
  - Refer to psychiatrist or PCP for assistance with prescription NRTs
- Refer to additional resources for support
  - Freedom from Smoking
  - Toll-free quit line: 1-800-QUIT-NOW
  - Online support programs



# FDA-APPROVED MEDICATIONS FOR CESSATION

## **Nicotine polacrilex gum**

- Nicorette (OTC)
- Generic nicotine gum (OTC)

## **Nicotine lozenge**

- Nicorette Lozenge (OTC)
- Nicorette Mini Lozenge (OTC)
- Generic nicotine lozenge (OTC)

## **Nicotine transdermal patch**

- NicoDerm CQ (OTC)

## **Nicotine nasal spray**

- Nicotrol NS (Rx)

## **Nicotine inhaler**

- Nicotrol (Rx)

## **Bupropion SR (Zyban)**

## **Varenicline (Chantix)**

**These are the only medications that are FDA-approved for smoking cessation.**

# USING THE NRT'S OR FDA APPROVED MEDS DOUBLE THE QUIT RATE

## Over the Counter NRT's:

**Nicotine patch in 3 strengths 21mg, 14mg and 7mg 1ppd smokers use 21mg for steady state of Nicotine**

**Nicotine Lozenge and gum come in 4mg and 2mg for cravings to use thru the day**

## Prescription needed for these NRT's and medications:

**Nicotine nasal spray fastest method of delivery but has a burning feeling in nose**

**Nicotine inhaler most like a cigarette but not as popular as others above**

**Bupropion SR (Zyban) also known as wellbutrin to reduce cravings for nicotine**

**Varenicline (Chantix) most effective but can produce vivid dreams and watch for SI**

- Reduces physical withdrawal from nicotine, these are **clean nicotine products**
- **Eliminates the immediate, reinforcing effects of nicotine that is rapidly absorbed via tobacco smoke**
- Allows patient to focus on behavioral and psychological aspects of tobacco cessation

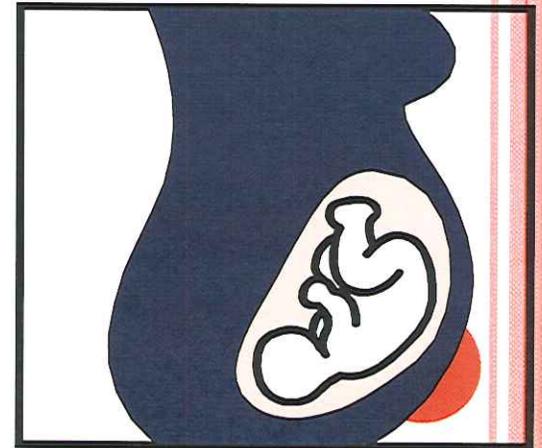


# PHARMACOTHERAPY: USE IN PREGNANCY

- The Clinical Practice Guideline makes no recommendation regarding use of medications in pregnant smokers
  - Insufficient evidence of effectiveness
- Category C: varenicline, bupropion SR
- Category D: prescription formulations of NRT

“Because of the serious risks of smoking to the pregnant smoker and the fetus, whenever possible pregnant smokers should be offered person-to-person psychosocial interventions that exceed minimal advice to quit.” (p. 165)

Fiore et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline*. Rockville, MD: USDHHS, PHS, May 2008.



# PHARMACOTHERAPY: OTHER SPECIAL POPULATIONS

Pharmacotherapy is **not** recommended for:

- Smokeless tobacco users
  - No FDA indication for smokeless tobacco cessation
- Individuals smoking fewer than 10 cigarettes per day
- Adolescents
  - Nonprescription sales (patch, gum, lozenge) are restricted to adults  $\geq 18$  years of age
  - NRT use in minors requires a prescription

**Recommended treatment is behavioral counseling.**

Fiore et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline*. Rockville, MD: USDHHS, PHS, May 2008.

# NICOTINE GUM

NICORETTE (GLAXOSMITHKLINE); GENERICS

- Resin complex
  - Nicotine
  - Polacrillin
- Sugar-free chewing gum base
- Contains buffering agents to enhance buccal absorption of nicotine
- Available: 2 mg, 4 mg; original, cinnamon, fruit, mint (various), and orange flavors



# NICOTINE LOZENGE

## NICORETTE LOZENGE AND NICORETTE MINI LOZENGE (GLAXOSMITHKLINE); GENERICS

- Nicotine polacrilex formulation
  - Delivers ~25% more nicotine than equivalent gum dose
- Sugar-free mint, cherry flavors
- Contains buffering agents to enhance buccal absorption of nicotine
- Available: 2 mg, 4 mg



# TRANSDERMAL NICOTINE PATCH NICODERM CQ (GLAXOSMITHKLINE); GENERIC

- Nicotine is well absorbed across the skin
- Delivery to systemic circulation avoids hepatic first-pass metabolism
- Plasma nicotine levels are lower and fluctuate less than with smoking



# NICOTINE NASAL SPRAY

## NICOTROL NS (PFIZER)

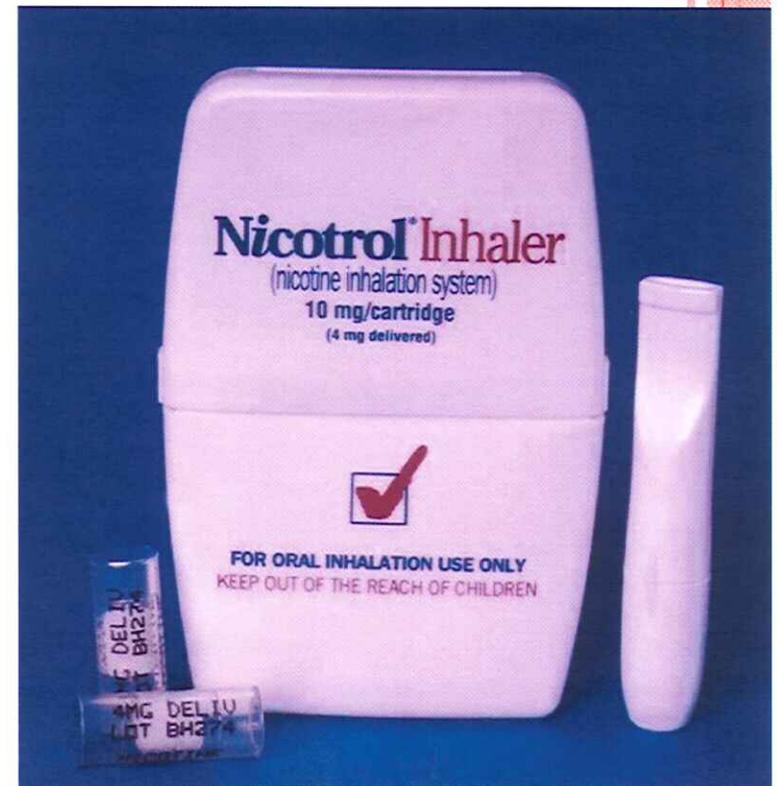
- Aqueous solution of nicotine in a 10-ml spray bottle
- Each metered dose actuation delivers
  - 50 mcL spray
  - 0.5 mg nicotine
- ~100 doses/bottle
- Rapid absorption across nasal mucosa



# NICOTINE INHALER

## NICOTROL INHALER (PFIZER)

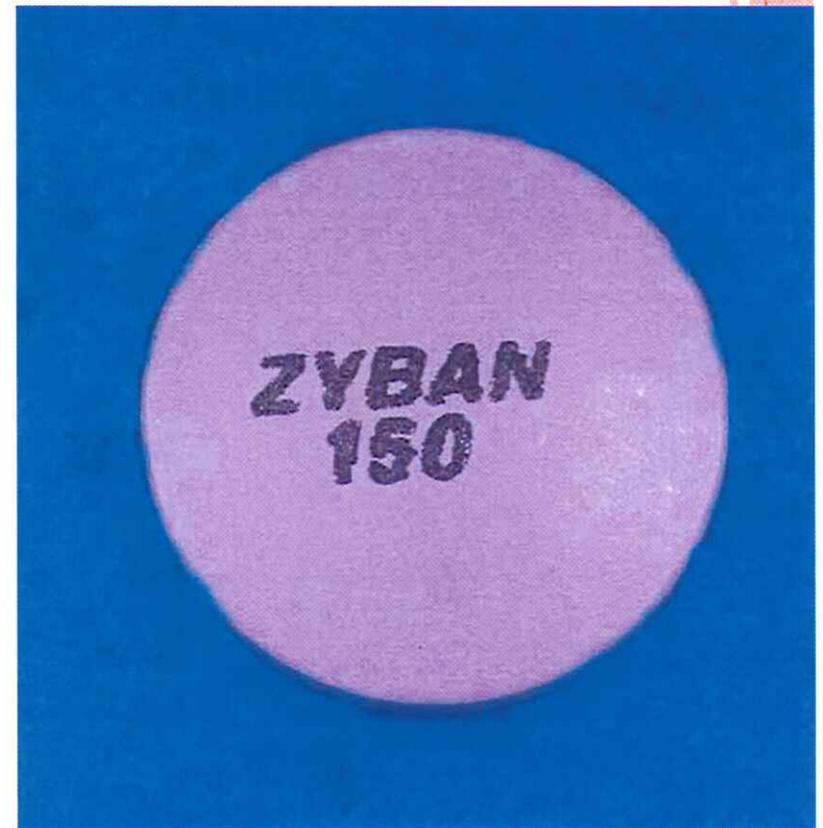
- Nicotine inhalation system consists of:
  - Mouthpiece
  - Cartridge with porous plug containing 10 mg nicotine and 1 mg menthol
- Delivers 4 mg nicotine vapor, absorbed across buccal mucosa



## BUPROPION SR

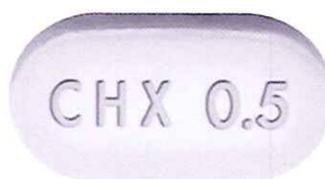
ZYBAN (GLAXOSMITHKLINE); GENERIC

- Nonnicotine cessation aid
- Sustained-release antidepressant
- Oral formulation



# VARENICLINE CHANTIX (PFIZER)

- Nonnicotine cessation aid
- Partial nicotinic receptor agonist
- Oral formulation



# COMBINATION PHARMACOTHERAPY

Regimens with enough evidence to be 'recommended' first-line

- **Combination NRT**

- Long-acting formulation (patch)

- Produces relatively constant levels of nicotine

**PLUS**

- Short-acting formulation (gum, inhaler, nasal spray)

- Allows for acute dose titration as needed for nicotine withdrawal symptoms

- **Bupropion SR + Nicotine Patch**



# COMPLIANCE IS KEY TO QUITTING

- Promote compliance with prescribed regimens.
- Use according to dosing schedule, NOT as needed.
- Consider telling the consumer:
  - “When you use a cessation product it is important to read all the directions thoroughly before using the product. The products work best in alleviating withdrawal symptoms when used correctly, and according to the recommended dosing schedule.”



## TOBACCO CESSATION REQUIRES BEHAVIOR CHANGE

- Fewer than 5% of people who quit without assistance are successful in quitting for more than a year.
- Few patients adequately PREPARE and PLAN for their quit attempt.
- Many patients do not understand the need to change behavior
- Patients think they can just “make themselves quit”

**Behavioral counseling is a key component of treatment for tobacco use and dependence.**

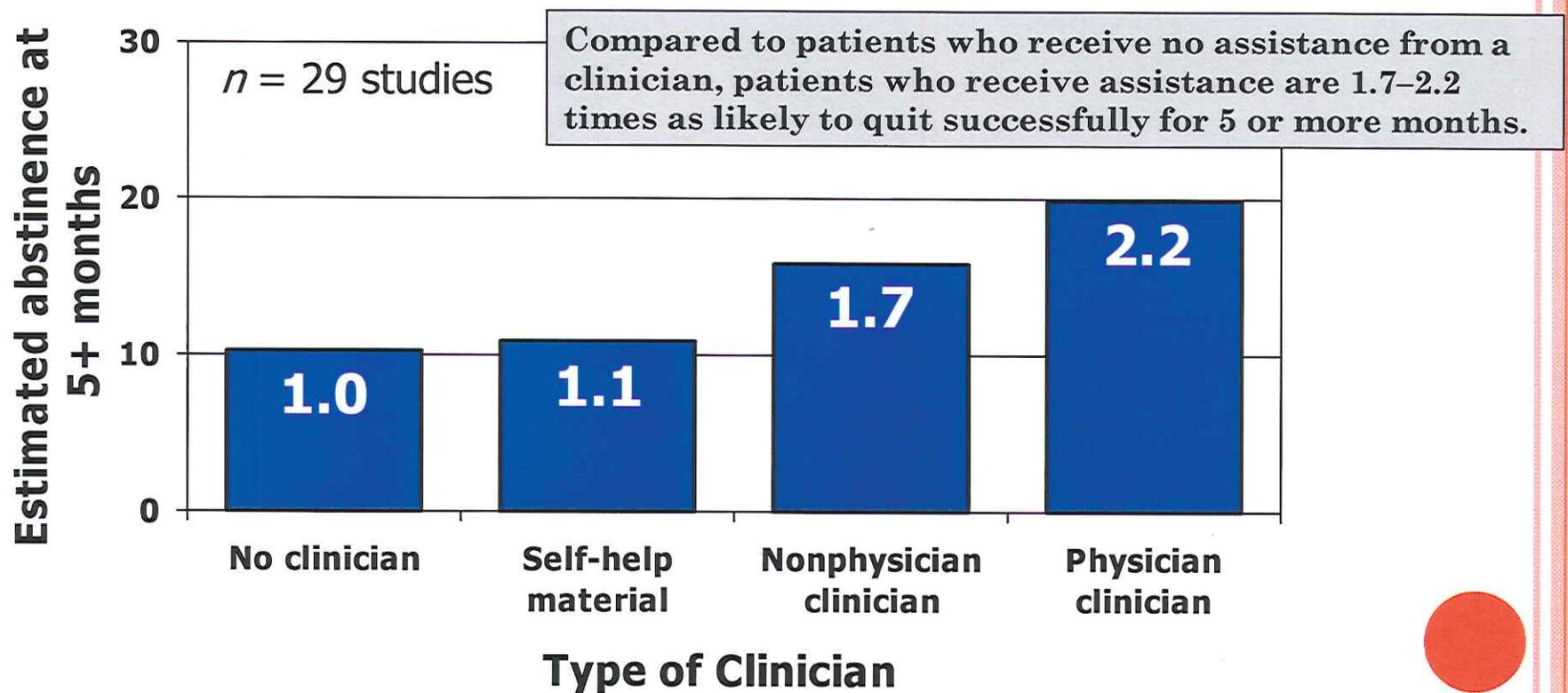
## CHANGING BEHAVIOR (CONT'D)

- Often, patients automatically smoke in the following situations:
  - When drinking coffee
  - While driving in the car
  - When bored
  - While stressed
  - While at a bar with friends
  - After meals
  - During breaks at work
  - While on the telephone
  - While with specific friends or family members who use tobacco
- Behavioral counseling helps patients learn to cope with these difficult situations without having a cigarette.



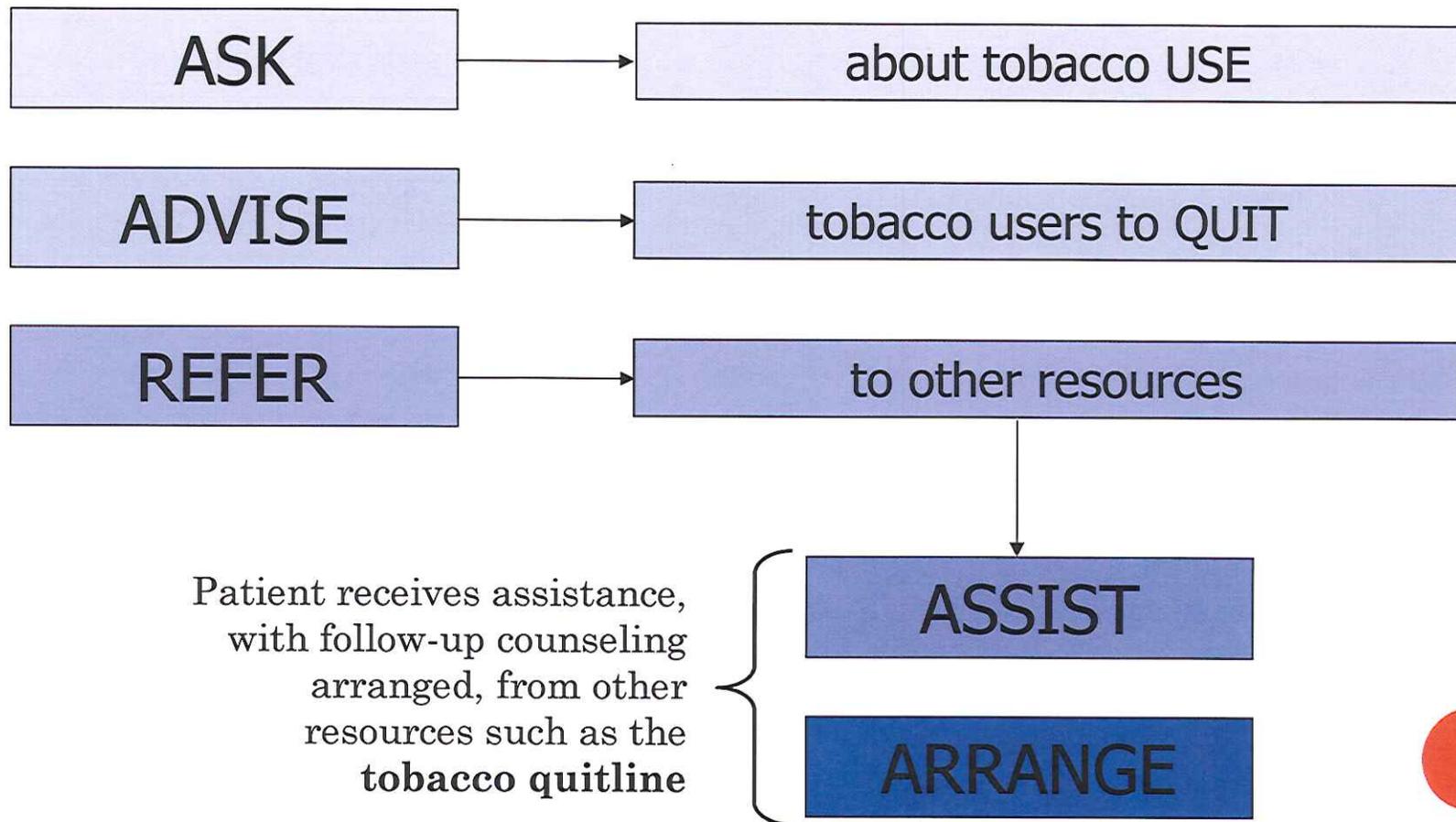
# CLINICIANS CAN MAKE A DIFFERENCE

With help from a clinician, the odds of quitting approximately doubles.



Fiore et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline*. Rockville, MD: USDHHS, PHS, May 2008.

# BRIEF COUNSELING: ASK, ADVISE, REFER



# STEP 1: ASK

- **ASK** about tobacco use
  - “Do you, or does anyone in your household, ever smoke or use any type of tobacco?”
    - “We like to ask our patients about tobacco use, because it has the potential to interact with many medications.”
    - “We like to ask our patients about tobacco use, because it contributes to many medical conditions.”



## STEP 2: ADVISE

- **ADVISE** tobacco users to quit (clear, strong, personalized)
  - “It’s important that you quit as soon as possible, and I can help you.”
  - “Cutting down while you are ill is not enough.”
  - “Occasional or light smoking is still harmful.”
  - “I realize that quitting is difficult. It is the most important thing you can do to protect your health now and in the future. I have training to help my patients quit, and when you are ready, I will work with you to design a specialized treatment plan.”

## STEP 3: REFER

- **REFER** tobacco users to other resources

### Referral options:

- A doctor, nurse, pharmacist, or other clinician, for additional counseling
- A local group program
- The support program provided free with each smoking cessation medication
- The toll-free telephone quit line: **1-800-QUIT-NOW**



## INTEGRATING ADDITIONAL TREATMENT TEAM MEMBERS

- Fewer than 5% of people who quit without assistance are successful in staying quit for more than 1 year.
- Compared to smokers who receive assistance from no clinicians, smokers who receive assistance from two or more clinicians are 2.4 times as likely to quit successfully for 5 or more months.
- Behavioral counseling and support is a key component of treatment for tobacco use and dependence.



# INTEGRATING ADDITIONAL TREATMENT TEAM MEMBERS

## Psychiatrists

- Nicotine can affect the efficacy of psychotropic medication.
- Signs of nicotine withdrawal, such as feeling irritable, angry, or restless, can be mistaken for an increase in psychiatric symptoms.
- It can be helpful to notify a psychiatrist PRIOR to quitting.



# INTEGRATING ADDITIONAL TREATMENT TEAM MEMBERS

## **Primary Care Physicians (PCPs)**

- Can assist in the prescribing of some NRTs, such as the nicotine nasal spray, inhaler and Bupropion SR and Chantix.
- Can advise on how staying quit can effect someone's quality of life, or other health conditions.



# INTEGRATING ADDITIONAL TREATMENT TEAM MEMBERS

## **Healthcare Home Nurse Care Managers**

- Nurses may be able to assist in providing support and encouragement as well as basic education regarding smoking cessation and NRTs.
- At some facilities, they may have access to CO meters or may run Freedom From Smoking Groups.



# INTEGRATING ADDITIONAL TREATMENT TEAM MEMBERS

## **Nursing Staff**

- May be able to assist a consumer in obtaining NRTs and can assist in educating about the safe and effective use of these tools.
- May also assist in providing education regarding how smoking cessation may affect an individual's other medications or any medical health concerns.



# INTEGRATING ADDITIONAL TREATMENT TEAM MEMBERS

## **Family Members**

- If a consumer lives with someone who smokes in a shared living space, that can make it difficult to be successful.
- Encouraging consumers to identify other members of support, to create a holistic approach, allows them the best chance at success.
- Freedom From Smoking and other evidence based treatment modalities encourage a consumer to identify a “quit buddy” from within their support system.



# WHY USE MOTIVATIONAL INTERVIEWING WITH SMOKING CESSATION

- Business as Usual Approach
- Motivational Interviewing Approach



# The Stage of Pre-contemplation



They may have no interest in quitting smoking.  
You may see denial, defiance, rationalization and lack of interest

**Counseling approach:** Use acceptance, patience and introduce ambivalence.

ASK questions like: Is there any way you would be better off if you quit smoking?

The goal here is to help move the Client to contemplation



## PDP OBJECTIVE AT THIS STAGE OF CHANGE

- **Objective**: Client will openly discuss tobacco use with CSS quarterly.
- **Intervention**: CSS will facilitate discussion and assess for change talk with client quarterly regarding tobacco use. CSS/NCM will offer educational materials regarding tobacco use.
- Responsible person(s): Client, CSS, NCM
- Frequency: Every 3 months
- Duration: 12 months
- Baseline: Client has not discussed tobacco use
- Start date: 00/00/0000



# The stage of Contemplation

Ambivalence is seen and you may hear:

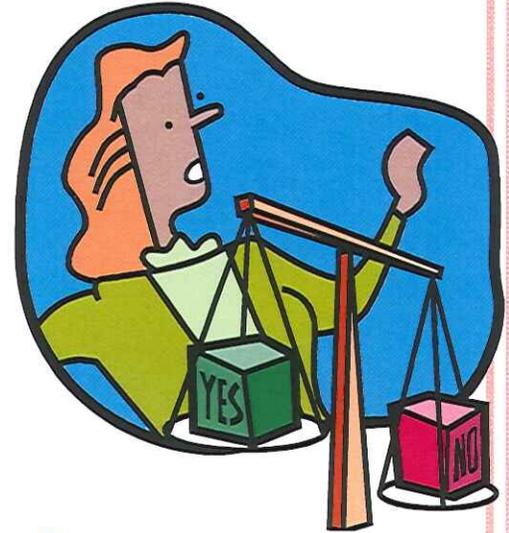
I want to quit but I like smoking.

**Counseling approach: acceptance, patience, identify resistance and explore both sides of ambivalence.**

Ask questions like:

What would you miss about smoking?

**The goal here is to move from contemplation to preparation**



## PDP OBJECTIVE AT THIS STAGE OF CHANGE

- **Objective**: Client will explore the pros and cons of smoking cessation with CSS monthly.
- 
- **Intervention**: CSS will offer educational materials in favor of smoking cessation. CSS will encourage client to schedule an appointment with NCM to discuss the benefits of smoking cessation. CSS will facilitate discussion and assess for change talk monthly regarding smoking cessation.
- 
- Responsible person(s): Client, CSS, NCM
- Frequency: Monthly
- Duration: 6 months
- Baseline: Client openly discusses tobacco use
- Start date: 00/00/0000



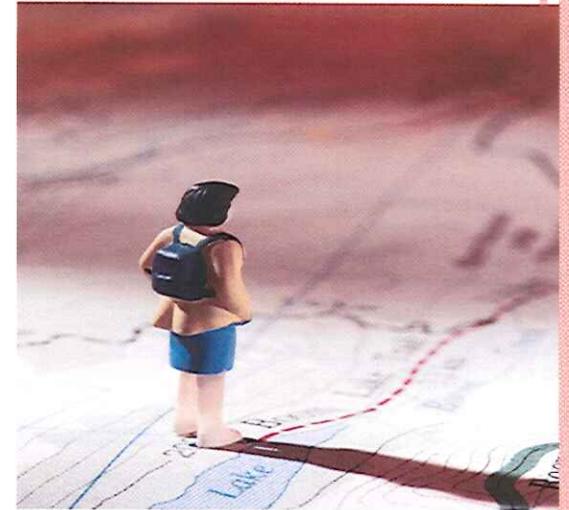
## RESPONDING TO CHANGE TALK

- Work with a partner
- Decide who will be the first speaker
- Speakers, will take on the “role” of a client, and speak to the listener about the following topic: “I can’t imagine not smoking, but the one thing I really hate about smoking is. . .”
- Listener’s task is to respond ONLY with reflective statements—try to complexify reflections and try to evoke some change talk
- Speaker responds to listener by continuing to elaborate
- Stay in your role. Do not discuss or break role until I tell you to switch.
- Switch and repeat exercise



# Stage of Preparation

They are ready to quit smoking



Counseling approach: directness, clarity, specific suggestions, Help them obtain the NRT's, Use approval, Offer them praise and encouragement, provide strategies for smoke cessation like groups, quit now line

Ask questions like: What problems do you anticipate?

Encourage use of a tool like pack tracks to monitor how much they smoke.



# PDP OBJECTIVE AT THIS STAGE OF CHANGE

- **Objective:** Client will develop a quit plan by 00/00/0000.
- 
- **Intervention:** CSS will encourage client to schedule an appointment with PCP and offer communication support in PCP appointment to discuss NRT use. CSS will educate client and encourage use of FFS groups offered at Crider Health Center Quarterly. CSS will educate and encourage use of 1-800-QUITNOW hotline. CSS will encourage client to schedule an appointment with NCM to create a quit plan. CSS will facilitate discussion and assess for change talk weekly regarding smoking cessation.
- 
- Responsible person(s): Client, CSS, NCM
- Frequency: 2x monthly
- Duration: 3 months
- Baseline: Client has never developed a quit plan before
- Start date 00/00/0000



# The Stage of Action



You may hear: I don't smoke anymore.

**Counseling approach:** Help to identify relapse triggers, provide support even if they have a slip but don't return to smoking as much as they had. Provide encouragement and watch for depression, Encourage peer support lines such as 1-800-quit now line or nicotine anonymous or FFS groups

Help eliminate relapse triggers and adapt new coping skills

Teach all the lifestyle changes to aid in success



## PDP OBJECTIVE AT THIS STAGE OF CHANGE

- **Objective:** Client will attend all 8 FFS groups and quit smoking 00/00/0000.
- 
- **Intervention:** CSS will support client to problem solve barriers to attending FFS groups. CSS will encourage client to utilize NCM, CSS, and 1-800-QUITNOW hotline when client needs to problem solve barriers to smoking cessation. CSS will facilitate discussion and assess change talk regarding smoking cessation weekly.
- 
- Responsible person(s): Client, CSS, NCM
- Frequency: Weekly
- Duration: 7 weeks
- Baseline: Client has enrolled in FFS group
- Start date 00/00/0000



## NICOTINE WITHDRAWAL

- Irritability/frustration/anger
- Anxiety
- Difficulty concentrating
- Restlessness/impatience
- Depressed mood/depression
- Insomnia
- Impaired performance
- Increased appetite/weight gain
- Cravings peak first few days & can last weeks



# Maintenance

You may hear: I am a non-smoker now

Counseling approach: Praise, reassurance, provide support and identify relapse potentials and plan to how to avoid them

The Client is open to information and feels a sense of success and self-righteousness even if they still have occasional cravings

The goal at this stage is to help the Client discover the truth about their life while promoting emotional growth



# PDP OBJECTIVE AT THIS STAGE OF CHANGE

- Objective: Client will abstain from use of tobacco for the next 12 months.
- Intervention: CSS will facilitate discussion with client quarterly regarding the benefits of abstaining from tobacco use. CSS will offer education and resources regarding the health benefits of continued abstinence from tobacco use. CSS will encourage client to utilize NCM, CSS, and 1-800-QUITNOW hotline when client needs to problem solve concerns regarding abstinence from tobacco use.
- Responsible person(s): Client, CSS, NCM
- Frequency: Quarterly
- Duration: 12 months
- Baseline: Client has been abstinent from tobacco since 00/00/0000
- Start date 00/00/0000



## JANE

- Seeking treatment for Major Depressive Disorder as well as crack cocaine use
- Smokes 2 packs of cigarettes per day
- “Sure I have some bad health stuff due to my smoking, who wouldn’t? But I don’t want to stop smoking cigarettes right now; I’m already trying to stop smoking crack. That’s too much at one time.”
- What stage of change in Jane in?



## JANE

- Jane meets consistently with CSS, who identifies and response to increased change talk
- Jane reports, “Maybe I need to cut down on my cigarette smoking because I have a family history of Cancer and COPD and I have some breathing problems.”



## JANE-GROUP ACTIVITY

- In groups of 4, identify 2 stage matched goals and interventions that you might use with Jane.  
Share your favorite one with the larger group.



# WHAT ARE “TOBACCO QUITLINES”?

- Tobacco cessation counseling, provided at no cost via telephone to all Americans
- Staffed by trained specialists
- Up to 4–6 personalized sessions (varies by state)
- Some state quitlines offer pharmacotherapy at no cost (or reduced cost)
- Up to 30% success rate for patients who complete sessions

**Most health-care providers, and most patients, are not familiar with tobacco quitlines.**

# WHEN A PATIENT CALLS THE QUITLINE

- Counselor or Intake Specialist Answers
  - Caller is routed to language-appropriate staff
- Brief Questionnaire
  - Contact and demographic information
  - Smoking behavior (e.g., cigarettes per day)
  - Choice of services



## WHEN A PATIENT CALLS THE QUITLINE (CONT'D)

### ○ Services provided

- Referral to local programs
- Quitting literature mailed within 24 hrs
- Individualized telephone counseling
  - Confidential
  - Professional, trained counselors

**Quitlines have broad reach and are recommended as an effective strategy in the 2008 Clinical Practice**

# **MAKE a COMMITMENT...**

## **ADDRESS TOBACCO USE**

WITH ALL PATIENTS.

## **AT A MINIMUM,**

MAKE A COMMITMENT TO INCORPORATE BRIEF TOBACCO INTERVENTIONS AS PART OF ROUTINE PATIENT CARE.

## **ASK, ADVISE, AND REFER.**



ANY QUESTIONS?



## ATTACHMENT 7: CAMPUS SMOKING POLICY (QUEEN OF PEACH CENTER)

### Queen of Peace Center Campus Smoking Policy\* Healthy Lifestyles Committee

#### ***Policy Statement***

Queen of Peace Center at Cathedral Tower promotes a smoking restricted campus in order to model and encourage healthy behaviors which are consistent with the Healthy Lifestyles Committee initiative. Smoking is only allowed in the designated area in the back of the building south of the Annex building during the designated times:

**7:00 am to 7:30 am**

**12:30 pm to 12:45 pm**

**5:30 pm to 5:45 pm**

**7:00 pm to 7:30 pm**

Queen of Peace Center sites at Our Lady of Perpetual Health (OLPH) and St. Philippine Home also promote a smoke free environment. Smoking and use of tobacco products on the property of these sites is strictly prohibited. All vehicles owned at operated through Queen of Peace Center are smoke free.

#### ***Reason for Policy***

The Healthy Lifestyles initiative at Queen of Peace Center was created through funding from The Missouri Department of Mental Health through a partnership implementation grant offered from The Missouri Foundation for Health to eliminate tobacco-related disparities.

The Healthy Lifestyles Committee was created in order to ensure compliance with grant tasks and obligations, as well as to create a healthier environment at Queen of Peace Center by focusing on the mind, body, and spirit. The Committee works to provide educational materials for staff and clients, as well as increase awareness on healthy lifestyle options.

The Campus Smoking Policy is designed to align the behavior of our staff and clients with policies that promote better health. The problem of secondhand hand smoke in the workplace has been well researched and documented. The policy also provides resources and treatment options for clients that are addicted to tobacco products. Queen of Peace Center can provide resources (including contacting their insurance provider at the number provided on the back of the insurance card) to employees that express interest in obtaining help to cease tobacco use; this will be done to ensure staff have opportunities available to them that are align with the Healthy Lifestyles initiative.

#### ***Entities Affected By This Policy***

Including, but not limited to: all Queen of Peace Center employees, clients, volunteers, vendors, contractors and visitors. All Queen of Peace Center campuses (Cathedral Tower, Our Lady of Perpetual Health, St. Philippine Home), buildings, vehicle and equipment apply.

#### ***Responsibilities***

Clients

Clients are responsible for complying with the Campus Smoking Policy. Failure to follow and comply with this policy and those set forth by Queen of Peace Center

can lead to dismissal from the program. Client violations of the Campus Smoking Policy will be handled in the following manner:

1<sup>st</sup> offense: Receive a verbal warning. Name and counselor information taken by staff person and sent to primary counselor. Client must contact counselor to meet within one week of the documented violation of the Campus Smoking Policy.

Failure to contact counselor will count as a second offense.

2<sup>nd</sup> offense: Client meets with counselor and is put on a behavior contract for two months. Violations made within this time frame will count as the 3<sup>rd</sup> offense.

3<sup>rd</sup> offense: Dismissal from Queen of Peace Center.

Clients will be provided the Healthy Lifestyles Agreement at intake. This acknowledges that they will abide by the designated smoking times outlined in the Campus Smoking Policy.

Clients will have additional resources available to them surrounding tobacco addiction and information to quit.

Clients are asked to report those they see breaking the Campus Smoking Policy to their assigned counselor and/or community support worker.

#### All Employees

Employees are responsible for executing safe practices including:

1. Learning and adhering to the Campus Smoking Policy, and any other policies and procedures associated/related to this policy through Queen of Peace Center, Catholic Charities, and the Archdiocese.
2. Reporting and documenting any violations of the Campus Smoking Policy by staff to their supervisor and clients to their appropriate counselor.
3. Adhering to the course of action for clients outlined in client responsibility.
4. Reporting any unsafe conditions related to the Campus Smoking Policy to their supervisor who can then relay the issue to Administration and the Healthy Lifestyles Committee.

Employees desiring to stop smoking shall be responsible for reviewing tobacco cessation benefits available through their health insurance provider.

Employees are not allowed to smoke with clients.

Employee violations of the Campus Smoking Policy will be treated with the same course of action as outline in the Employee Handbook.

#### Managers and Supervisors

Managers and supervisors are responsible for safe practices of employees including:

1. Ensuring staff receive appropriate orientation to the Campus Smoking Policy, including job-specific and area procedures meant to comply with the policy.
2. Monitoring compliance with this policy and procedures
3. Referring employees who have difficulties complying with this policy to Employee Assistance Program (EAP)
4. Enforcing this policy and dispensing appropriate action(s) as necessary and consistent with the HR policy on corrective action outline in the Employee Handbook.

5. Consulting with the appropriate HR staff prior to taking corrective action.

All managers and supervisors shall actively support and participate in the promotion and enforcement of the Campus Smoking Policy by informing visitors of the policy.

**Security**

Security staff who observe any individual violating this policy will notify/remind the individual of this policy.

**Employee Assistance Program**

Assistance is provided within EAP and can be contacted 888-629-3835.

**Human Resources**

Human Resources shall inform employees of this policy and shall make this written document available at time of hire. A discussion of this policy shall take place at all new employee orientations. HR will provide information and assist managers/supervisors with correction action procedures when notified of a violation.

**ATTACHMENT EIGHT: ADDRESSING TOBACCO USE IN TREATMENT PLANING  
(VIDEO)**

The following 31-minute video was created and presented by staff at COMTREA, Crider Health Center, and Queen of Peace Center. The video addresses ways to best match appropriate tobacco cessation interventions to a client's readiness to quit tobacco use. This project was funded by the Missouri Department of Mental Health and the Missouri Foundation for Health.

To access the video go to: <http://youtu.be/4SCj0UMPB8o>