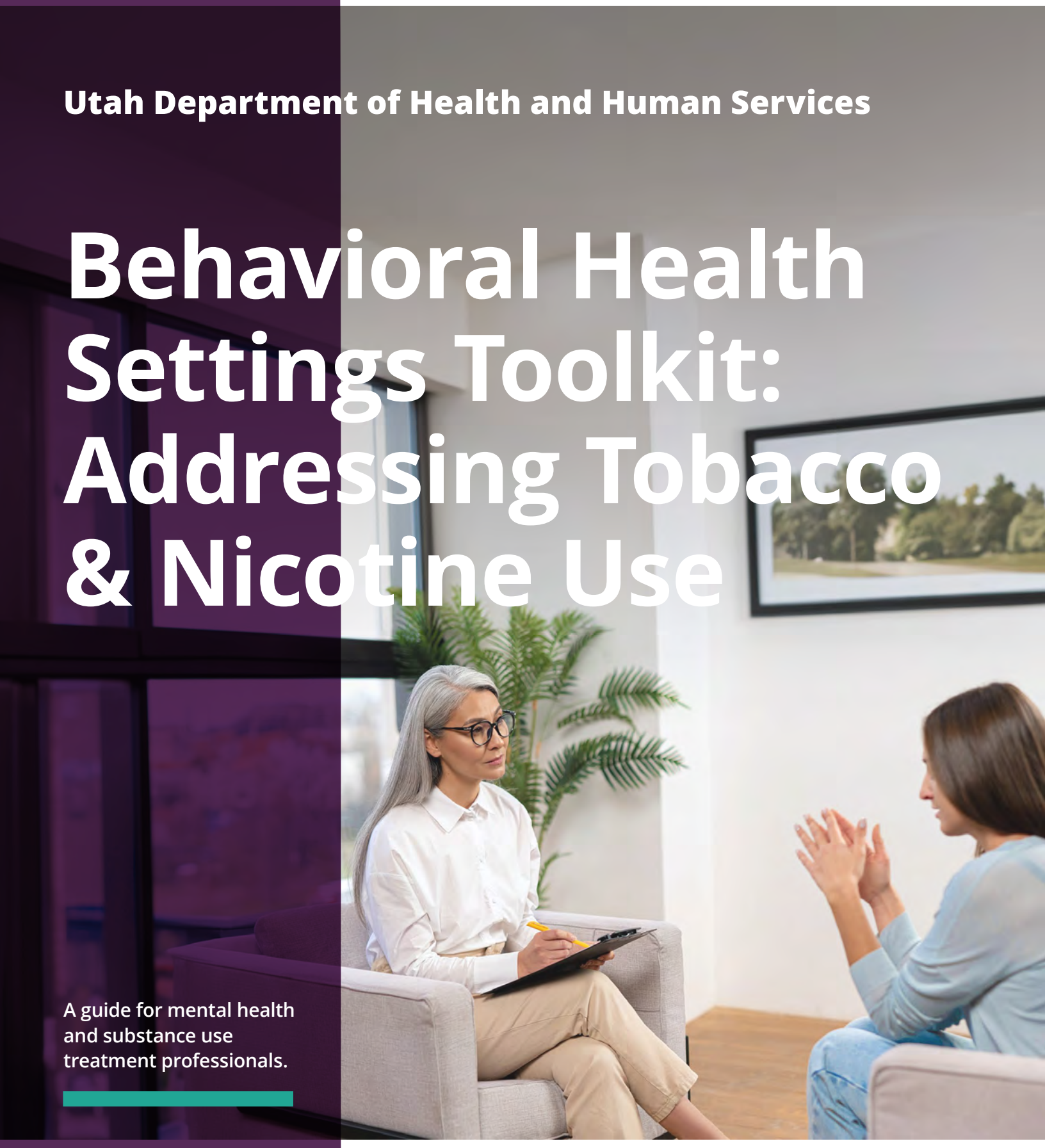
Utah Department of Health and Human Services

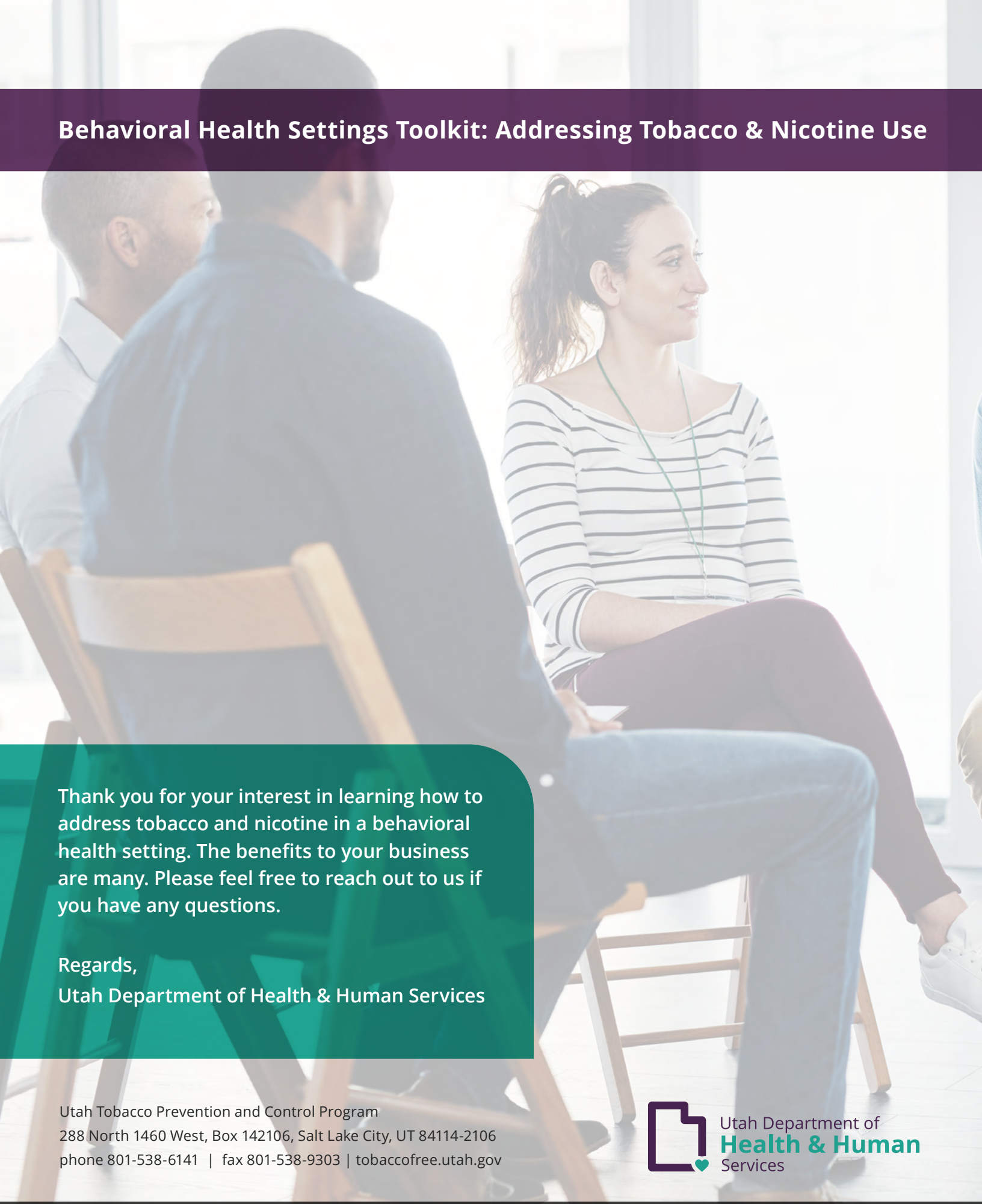
Behavioral Health Settings Toolkit: Addressing Tobacco & Nicotine Use



A guide for mental health and substance use treatment professionals.

Utah Department of Health & Human Services

Behavioral Health Settings Toolkit: Addressing Tobacco & Nicotine Use



Thank you for your interest in learning how to address tobacco and nicotine in a behavioral health setting. The benefits to your business are many. Please feel free to reach out to us if you have any questions.

Regards,
Utah Department of Health & Human Services

Utah Tobacco Prevention and Control Program
288 North 1460 West, Box 142106, Salt Lake City, UT 84114-2106
phone 801-538-6141 | fax 801-538-9303 | tobaccofree.utah.gov

Utah Department of Health & Human Services

Table of contents

Acknowledgments

The Tobacco Prevention and Control Program (TPCP) at the Utah Department of Health and Human Services (DHHS) is committed to improving the health of Utahns by reducing rates of commercial tobacco use and disease, death, and disparities. People with behavioral health conditions experience disproportionate societal pressure and stigma and access medical services less than the general population, particularly if they have co-occurring disorders. These challenges often lead people with behavioral health conditions to use nicotine at high rates. This toolkit was made for behavioral health professionals to implement policies and practices that help clients more easily quit tobacco and nicotine products.

Tobacco Prevention and Control Program,
Utah Department of Health and Human Services

A special thank you to the Public Health Law Center, Mitchel Hamline School of Law, and the Minnesota Department of Health. This toolkit was adapted with permission from the American Lung Association.

About this toolkit

Who is this toolkit for?

This toolkit was developed for a broad continuum of mental health and substance use treatment professionals. Materials are intended for direct providers, as well as administrators and behavioral health organizations. Many of the materials are also appropriate for primary care and other healthcare providers focused on substance use disorders.

How do I use this toolkit?

The toolkit contains a variety of information and step-by-step instructions about:

- ways to assess readiness to quit,
- tobacco and nicotine treatment,
- strategies for implementing a tobacco-free policy,
- strategies to increase cessation opportunities and success, and
- referral to community resources.

Providing tobacco cessation services

There are many ways to provide tobacco cessation services for both employees and clients. The Affordable Care Act requires insurance companies to provide some level of tobacco cessation support. However, not all private insurers offer a full range of services. If people who have insurance are interested in accessing tobacco cessation treatment, they should be encouraged to access benefits through their health plan. If your organization provides an employer-sponsored insurance plan, confirm what the coverage is, how services can be obtained, and at what cost to employees.

As of August 2010, the Centers for Medicare and Medicaid Services (CMS) began covering tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries. Although coverage differs depending on whether a tobacco-related diagnosis has been made, services are covered regardless of the patient's signs and symptoms of tobacco-related disease.[1] If the Medicare recipient has not been diagnosed with a disease caused or exacerbated by tobacco, Medicare treats tobacco cessation counseling as a preventative treatment. All Utah Medicaid plans cover nicotine replacement therapy (NRT) patches, gum, and lozenges, Bupropion and Varenicline—the NRT inhaler and nasal spray vary by plan. Individual counseling is covered for all members, and group counseling and phone counseling vary by plan. Coverage limitations including duration limits, annual limits, quantity limits, counseling requirements, prior authorization, and step therapy vary by plan. See Utah Medicaid Coverage of Tobacco Cessation Treatments chart for more details.

Waytoquit.org offers free and confidential tools for people trying to quit nicotine products regardless of insurance status. Some resources include quit coach sessions online or over the phone, NRT, a customized quit plan, educational materials, and text support.

Tobacco, in this document, refers specifically to the use of manufactured, commercial tobacco products and not the sacred, medicinal, and traditional use of tobacco by tribal nations and other groups.

Quick facts and statistics

The importance of addressing tobacco use

Using tobacco is the **No. 1** cause of preventable death in people with a mental illness.

75% want to quit compared to 60% of the general population who use tobacco products.

44% of the U.S. tobacco market is consumed by people with a mental illness and substance use disorders.

1 in 3 people who smoke in the United States have been diagnosed with a mental illness.

Behavioral health can take the lead

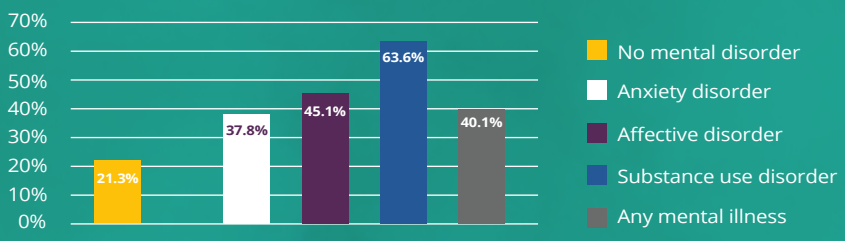
- There is a high prevalence of tobacco use and patient need.
- Providers are trained in treating addictions.
- **Tobacco interacts negatively with some psychiatric meds.**
- Tobacco use disorder is a behavioral health condition in the SDM-S.

=25% higher success rate

Treatment works!

Adults with serious mental illness (SMI), a tobacco-related diagnosis, had a median **age at 32 years** earlier than adults without an SMI and without a tobacco-related diagnosis.

U.S. smoking prevalence



The CDC says fewer than half of mental health and substance use treatment centers in the U.S. have tobacco cessation services: https://www.cdc.gov/tobacco/health-equity/behavioral-health/quitting-tobacco.html.

Why address the issue

Nicotine addiction: What it looks like in the brain

Tobacco use and mental illness

Smoking and mental illnesses: nicotine effects and other considerations

Why do clients use nicotine products more?

Researchers believe that a combination of biological, environmental, and social factors contribute to increased tobacco use among persons with mental illnesses. For example, people with mental illnesses:

- access general medical services and other community resources relatively infrequently
- struggle with stigma in many ways
- experience higher rates of morbidity and mortality than the overall population

Biological considerations

- Persons with mental illnesses have unique neurobiological features that may increase their tendency to use nicotine, make it more difficult to quit, and complicate withdrawal symptoms.
- Nicotine enhances concentration, information processing, and learning. This is especially important for persons with psychotic disorders for whom cognitive dysfunction may be a part of their illness or a side effect of antipsychotic medications.
- Other biological factors include nicotine's positive affects on mood and feelings of pleasure and enjoyment. Some evidence also suggests that smoking is associated with a reduced risk of antipsychotic-induced Parkinsonism.

Psychological considerations

- Tobacco use is perceived to relieve feelings of tension and anxiety and is often used to cope with stress.
- People develop a routine of smoking, which can add some daily structure.

70%-80% of clients receiving treatment for alcohol and other drug problems want to stop using tobacco.[9]

Tobacco and mental illness

Using tobacco is the No. 1 cause of preventable death in people with mental illness.

Environmental considerations

- People who live in areas with a large density of tobacco retailers are more likely to use tobacco and nicotine products.
- Experiences of trauma negatively affect health outcomes and make people more likely to develop or exacerbate behavioral health conditions.

Social considerations

- People may smoke to feel "part of a group." This can be especially true in residential and treatment settings.
- Smoking is often associated with social activities.
- The site of a social activity may support tobacco use.

Stigma

- Providers may think that people with mental illnesses are unable to quit smoking.
- Symptom management often takes precedence over preventive health measures.

Specific psychiatric and co-occurring disorders

What are some considerations for smoking cessation regarding mental disorders?

Depression

- Among patients seeking smoking cessation treatment, 25%-40% have a history of major depression and many have minor dysthymic symptoms.
- Depression has been shown to predict poorer smoking cessation rates. Consider starting or restarting psychotherapy or pharmacotherapy for patients who state that depression intensified with cessation or that cessation caused depression.
- Cognitive behavioral therapy and antidepressants have been found to improve smoking cessation rates in those with a history of depression or symptoms of depression.

Tobacco and mental illness

Schizophrenia

- People with schizophrenia who use tobacco or nicotine may experience fewer negative emotional symptoms (motivation, drive, and energy).
- Persons with schizophrenia who use tobacco or nicotine may be less interested in tobacco cessation, making strategies to enhance quitting motivation particularly important.
- When patients with schizophrenia do try to stop nicotine use, many are unsuccessful; intensive treatments are appropriate, even with early attempts.

Tobacco use and chemical dependency

Substance use connection

Tobacco use is strongly correlated with development of other substance use disorders such as the following:

- Early onsets of smoking and heavy smoking are highly correlated with the subsequent development of other substance use and psychiatric disorders.[1]
- People who smoke heavily have more severe of substance use disorders than do people who smoke moderately or not at all. [2]
- Tobacco use impedes recovery of brain function among clients whose brains have been damaged by chronic alcohol use. [3,4]

Chemical connection

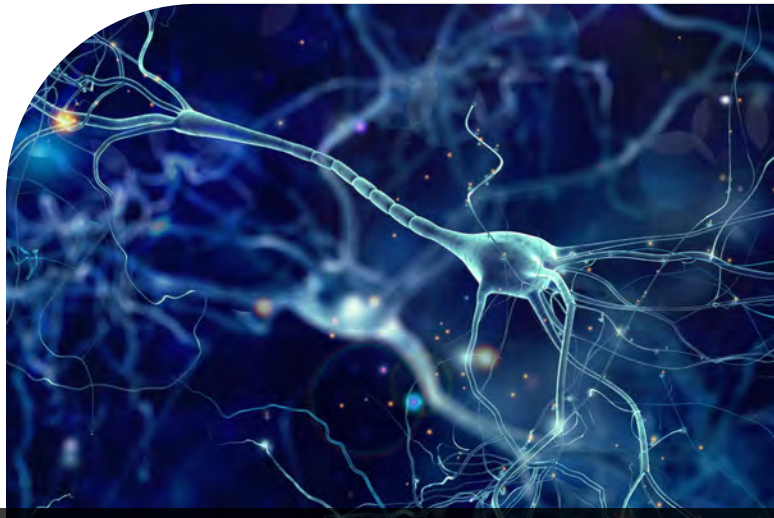
Nicotine affects neurotransmitters such as dopamine. Psychological effects and considerations include:

- nicotine positively affecting mood and feelings of pleasure and enjoyment.
- Tobacco use may temporarily relieve feelings of tension and anxiety and is often used to cope with stress.
- Nicotine appears to affect the same neural pathway—the mesolimbic dopamine system—as alcohol, opioids, cocaine, and marijuana.[5]
- Smoking can hinder the metabolism of some medications such as highly active antiretroviral therapy for persons with HIV/AIDS.[6]

Social connection

Smoking and nicotine use are often associated with social activities, “smoke breaks,” or treatment.

- People may use tobacco or nicotine products to feel “part of a group” and may be afraid that quitting tobacco will damage their social relationships.
- In substance use treatment settings, providing smoke breaks rather than healthy alternatives, such as walks or quiet times, can reinforce the social connection to tobacco.
- Persons who do not participate in many activities may become bored and use tobacco or nicotine products more to keep themselves busy.
- Workplace smoking restrictions lead to less smoking among employees.[7]
- Smoke- and tobacco-free workplace policies lead to reductions in daily consumption of cigarettes and increases in tobacco use cessation among workers.[8]



Myths

Treatment connection

Q **Clients who receive treatment for tobacco use are more likely to reduce their use of alcohol and other substances and have better treatment outcomes overall.[10]**

A Cigarettes are real drugs. They contribute to more illness and early death than any other drug, legal or illegal. And they are highly addictive—on par with heroin. When creating a healthier environment, train staff and clients about smoking, the quitting process, and how smoking impacts other addictions. Evidence suggests that smoking harms recovery from other drugs because it can be a trigger for using those substances.

Q **Clients will start using tobacco or nicotine products again once they are discharged. Why bother quitting?**

A Many clients may use tobacco or nicotine products again. It is not standard to refuse treatment for other addictions, even when it seems the client is not motivated to remain abstinent. Everyone should have the opportunity to detoxify while in treatment with the hope that they will choose a substance-free life. Quitting is hard, especially in environments where tobacco use is acceptable. By incorporating tobacco cessation in recovery philosophy, clients can learn refusal skills, identify triggers, and regain control if they relapse. This is an opportunity to be leaders, inspiring other community mental health facilities to ban tobacco use and open new doors to wellness and recovery.

Q **Nicotine calms down clients. When they can't use it, won't there be chaos?**

A Facilities that do not allow smoking report fewer incidents of seclusion, restraint, coercion, and threats among patients and staff. Uncomfortable nicotine withdrawal symptoms can be reduced by appropriately using nicotine replacement therapy and other medications.

Q **Nicotine calms down clients. When they can't use it, won't there be chaos?**

A The U.S. Food & Drug Administration's (FDA) Center for Drug Evaluation and Research has not approved any e-cigarette as a safe and effective method to help people quit tobacco and nicotine. There may also be potential harm to people exposed to secondhand emissions from e-cigarettes.

Q **Clients won't have support to continue quitting tobacco and nicotine once they are back home.**

A More and more multiunit housing developments are becoming smoke-free. As of February 3, 2017, U.S. Housing and Urban Development has issued a smoke-free rule ban for all Public Housing Authorities (PHA). Each PHA must implement a "smoke-free" policy banning the use of prohibited tobacco products in all public housing, living units, indoor common areas in public housing, and in PHA administrative office buildings. The smoke-free policy must also extend to all outdoor areas up to 25 feet from the public housing and administrative office buildings. This rule improves indoor air quality in the housing; benefits the health of public housing residents, visitors, and PHA staff; reduces the risk of catastrophic fires; and lowers overall maintenance costs. Supporting clients in their efforts to quit tobacco and nicotine will help them transition into a smoke-free lifestyle in their permanent residence.[14]

Tobacco products 101

Cigarettes
Tobacco rolled into a paper wrapping. The smoke produced by cigarettes contains 7,000 chemicals, 70 of which have been proven to cause cancer.

Light cigarettes
These may be labeled “low- tar,” “mild,” “light,” or “ultralight.” In 2010, the use of this terminology in labeling was banned.

Menthol cigarettes
These are cigarettes that contain a minty flavoring.

Cigars, cigarillos and little cigars
These are bundles of dried and cured tobacco rolled in leaf tobacco or any substance containing tobacco. They may come in flavors, making them appealing to youth and young adults.

Hookah
These products allow for the inhalation of smoke from flavored tobacco products and are also referred to as water pipes.

Snuff
A dry form of tobacco that can be inhaled through the nose.

Electronic cigarettes (e-cigs) or vapes
These produce an aerosol of nicotine and other chemicals that are inhaled. They can look like traditional cigarettes, cigars, pens, or even toys. The FDA’s Center for Drug Evaluation and Research has not approved any e-cigarette as a safe and effective method to help smokers quit.

Chewing tobacco
A smokeless tobacco placed between the cheek and gums. Tobacco juices are usually spit out, but some people may swallow them.

Nicotine products
Alternative nicotine or nontherapeutic products derived from tobacco or made synthetically. These include pouches, orbs, pellets, nicotine-laced food and beverages, etc.

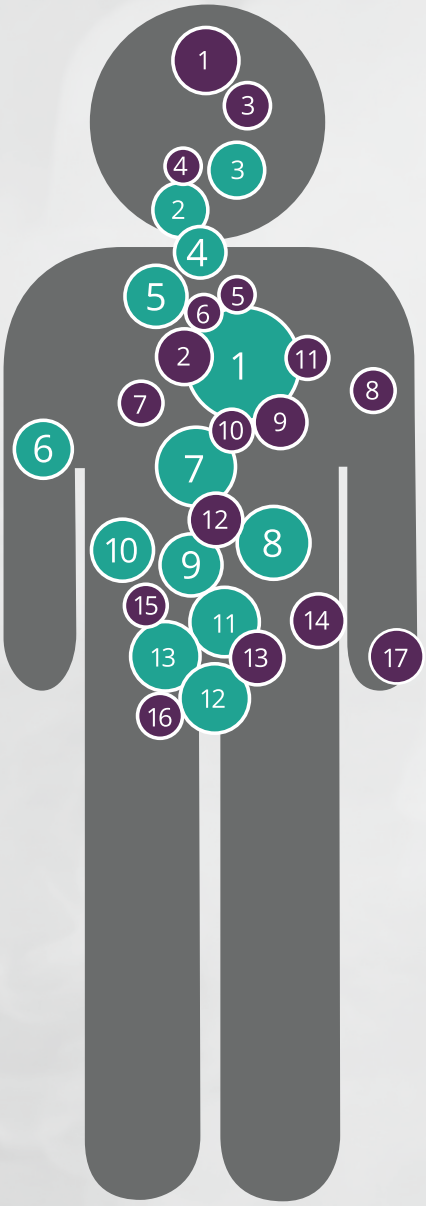
Snus
Moist snuff that is placed in a small pouch and placed between the cheek and gums. This product does not require the user to spit.

**None of the above items are safe alternatives to cigarettes and are not effective cessation tools.*

Source:
http://betobaccofree.hhs.gov/about-tobacco/index.html

Tobacco use affects almost every part of the body

People who use tobacco or nicotine are at risk for a long list of health conditions.



Tobacco use has been proven to cause the following cancers:[19]

1. Lung, Trachea, and Bronchus Cancer
2. Oropharynx Cancer
3. Cancers of the Lip and Oral Cavity
4. Laryngeal Cancer
5. Esophageal Cancer
6. Acute Myeloid
7. Leukemia
8. Stomach Cancer
9. Liver Cancer
10. Pancreatic Cancer
11. Kidney Cancer
12. Cervical Cancer
13. Bladder Cancer
14. Colorectal Cancer

Beyond cancer, tobacco use has also been proven to cause:

1. Strokes
2. Coronary heart disease
3. Vision loss due to cataracts and macular degeneration
4. Periodontitis (serious gum infection that can end in tooth loss)
5. Aortic aneurysm
6. Early abdominal atherosclerosis
7. Pneumonia
8. Atherosclerotic peripheral vascular disease
9. Chronic obstructive pulmonary disease (COPD)
10. Tuberculosis
11. Asthma
12. Diabetes
13. Reproductive health issues
14. Hip fractures
15. Ectopic pregnancy
16. Erectile dysfunction
17. Rheumatoid arthritis
18. Immune dysfunction
19. Heart disease

Consequences of tobacco use

In 1964, the surgeon general of the United States released a report stating that smoking cigarettes is a cause of both lung cancer and chronic bronchitis.[20] Today, more men and women die of lung cancer than any other cancer.[21] The effects of tobacco use do not end at lung cancer. Tobacco can negatively affect almost every organ of the body.[23]

Effects of secondhand smoke

People who don't smoke when exposed to cigarette smoke and vape aerosol can also suffer negative health effects. Secondhand smoke (SHS) has been proven to cause strokes, lung cancer, and coronary heart disease in adults who don't smoke.[19] Pregnant people exposed to SHS have an increased risk of delivering a low-birth-weight infant.[19] It is estimated that 42,000 Americans die each year from SHS exposure, with the majority of these being from lung cancer and heart disease.[19,24]

SHS also causes numerous health issues for infants and children. Infants exposed to SHS have an increased risk of sudden infant death syndrome (SIDS).[19] Children exposed to SHS are more likely to suffer from ear infections, coughing, sneezing, bronchitis, pneumonia, and shortness of breath.[25-26] Children with asthma who are exposed to SHS are more likely to suffer from severe asthma attacks.[25-26]

When people quit smoking

20 minutes — Heart rate drops.

12 hours — Carbon monoxide level in blood drops to normal.

2-12 weeks — Heart attack risk begins to drop. Lung function begins to improve.

1-9 months — Coughing, sinus congestion, fatigue, and shortness of breath decrease.

1 year — Increased risk of coronary heart disease is half that of someone who smokes.

5 years — Stroke risk is reduced to someone who doesn't smoke and use at 5 to 15 years after quitting.

10 years — Lung cancer death rate is about half that of someone who continues to smoke.

Risk of cancer of the mouth, throat, esophagus, bladder, kidney, and pancreas decrease.

15 years — Risk of coronary heart disease is back to that of someone who doesn't smoke.

Go smoke-free for a higher appraisal and happier tenants!

As a property manager contemplating smoke-free housing, you need essential information.

This overview covers everything from financial impacts, fire risks, health considerations, and legal aspects, and offers you clear next steps.

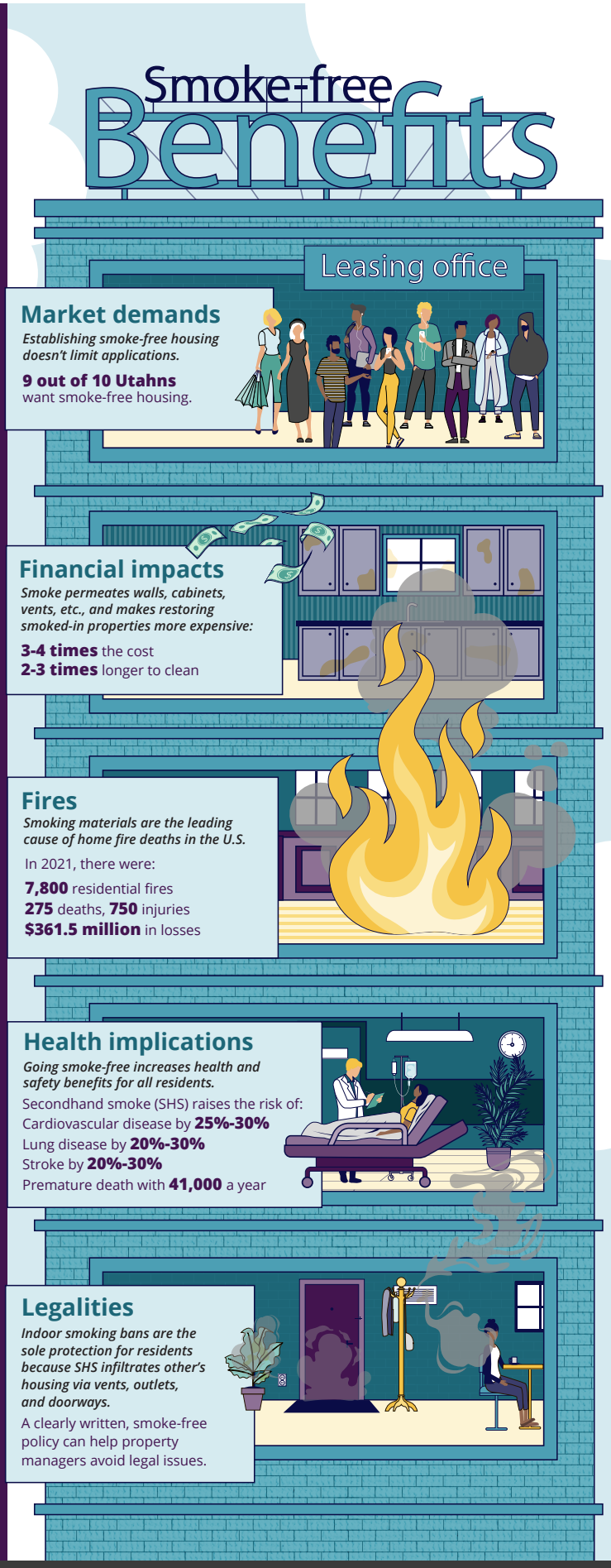
By considering these key points, you can make informed decisions that enhance property management and resident well-being.

Steps forward:

Go smoke-free today for a better future for you, your property, and Utah.

Open the camera on your phone and scan the QR code, or go to www.tobaccofree.utah.gov/muh-tools.

Utah Department of
Health & Human
Services



What tobacco costs employers

Tobacco-free policies help people quit

According to TPCP, tobacco-free worksite policies reduce nicotine use, increase quit attempts, increase successful quit attempts, and improve the health of clients and employees alike.

This is especially important because if people quit smoking before 30, they can almost eliminate their risk of premature death; if people quit before 40, they reduce their risk of early death by 90%.[19,28] Beyond this, quitting at any age will see health benefits and quality of life improvements.[28]

2.6 days

Increased absenteeism

It is estimated that smokers miss approximately 2.6 more days of work than their nonsmoking peers each year.[32]

1% less

Reduced productivity due to nicotine addiction

A smoker can start to feel withdrawal symptoms within 30 minutes of their last cigarette/tobacco use .19 These withdrawal symptoms, as a result of nicotine addiction, can interfere with an employee's ability to effectively perform his or her job. It is estimated that smokers are 1% less productive than nonsmokers.[32] In a worksite with many smokers, these productivity losses can add up!

5.5 days

Missed work time due to smoke breaks

While every person is different, a recent study estimated that the average smoker takes two 15-minute smoke breaks per day in excess of regularly scheduled and allowed breaks.[32] This results in 5½ days per year of paid time that an employee is not working.

8% higher

Increased healthcare expenses

A recent study estimated that the healthcare expenses of a person who smokes are approximately 8% higher than the expenses of someone who doesn't smoke.[32]

For employers that self-insure their employees, this can drastically increase the total amount spent on healthcare costs. Even employers who purchase private insurance are likely to see an increase in healthcare expenses due to employees who smoke.[32] A person who smokes is likely to have more insurance claims, and this could require employers to pay higher premiums.[32]

A recent study found that for every person who quits smoking, an employer can save between $2,885 and $10,125 annually.[32] The breakdown of these potential savings can be seen in the table below. Implementing a tobacco-free worksite policy can reduce business costs and help employees quit.

You can easily estimate the number of people who smoke at your worksite, the productivity losses of your business due to tobacco use, your excess healthcare costs due to smoking, and the total amount of money your company could save by helping all tobacco using employees quit. A cost calculator tool can be found here at **waytoquit.org**.

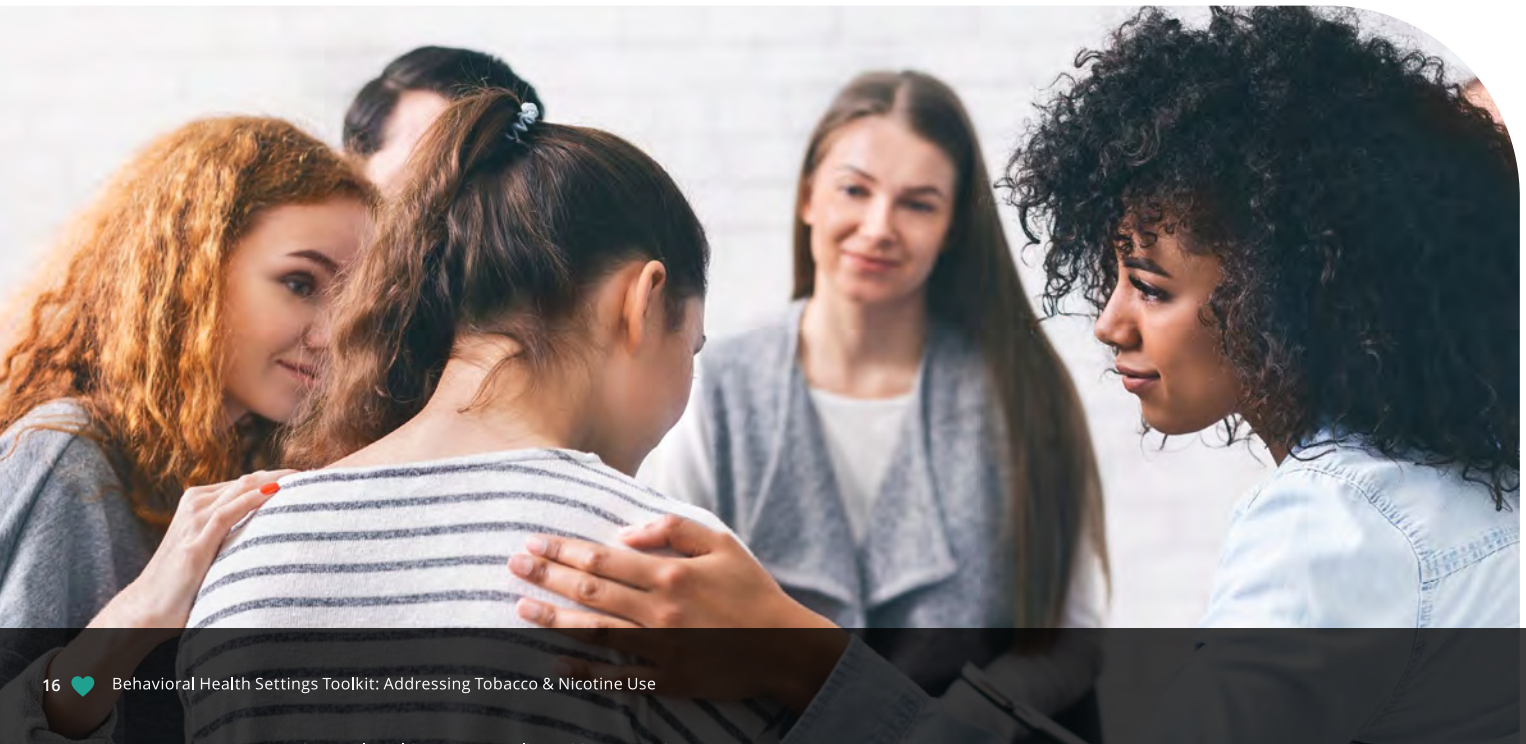
Improve the health of all employees and visitors

More people in the United States die prematurely due to tobacco use than any other cause.[19] Approximately 480,000 Americans die each year because of smoking and exposure to SHS.[18,19] Implementing a tobacco-free policy at your worksite can help people quit tobacco and nicotine products and extend their lives.

Policy

Policy menu:
A variety of policy options can reduce the harm of tobacco and nicotine.

Type of policy	Who is affected	Brief outline of policy
Tobacco-free grounds	Employees Patients Clients Visitors	Promotes the health and safety of organization's employees, clients, patients, and visitors. Use of tobacco products is prohibited on grounds and within business-owned vehicles.
Treatment plan	Patients	Intake/triage questions upon check-in Refer clients to resources available through your organization, their health plan, and/or the Utah Tobacco Quitline at waytoquit.org. (Referral options can be found in the Appendix.) Integrated Treatment Plan: Clients' providers are aware of cessation efforts.
Provide and promote interactive educational programming on tobacco cessation	Employees Patients	Providers will not distribute tobacco or nicotine products to clients and will actively encourage cessation or treatment plans.



1. Steps toward policy change

Assemble a tobacco-free or wellness committee

Depending on the organization's size, a tobacco-free committee or workgroup may be a crucial part of implementation. Committee or workgroup members can take responsibility for many activities and provide ongoing support after implementation.

You may also involve your wellness team or committees, if you have one. Large organizations may choose to break committee or workgroups into sub-committees or sub-groups based on the skills and expertise of members. For example, a worksite could assemble an education subcommittee, a marketing subcommittee, and a facilities subcommittee, and be overseen by a steering or advisory committee. If this structure is used, it is recommended that people who currently use tobacco and nicotine products and those who have quit be included within each subcommittee. In small organizations, committees may only have a few members. These individuals could include a human resources representative, a manager, and a business owner.

Additional steps for tobacco-free grounds policy

- Assemble a tobacco-free committee or workgroup.
- Assess tobacco attitudes, belief, and use.
- Develop a comprehensive policy.
- Select a timeline and implementation date.
- Determine compliance and enforcement strategies.
- Install adequate signage and remove any barriers in the implementation of this policy.
- Implementation date celebration.
- Evaluative effectiveness of policy.

Example of responsibilities by committees and subcommittees*

Steering/advisory committee

- Set policy implementation date
- Create overall timeline
- Determine subcommittees needed
- Select subcommittee chairs and help recruit participants
- Approval and oversight of committee activities
- Update affiliate office managers on progress of policy implementation
- Education subcommittee
- Create education subcommittee timeline
- Develop the tobacco-free policy
- Develop educational materials about the policy
- Identify community resources and decide how best to utilize them
- Provide resources for those who want to quit tobacco
- Work with public relations/marketing subcommittee to address communication to visitors

Public relations/marketing subcommittee

- Create public relations/marketing subcommittee timeline
- Create theme/campaign/logo
- Create messaging
- Create internal/external signage
- Media relations/press releases
- Business-to-business communication

Facilities subcommittee

- Create facilities' subcommittee timeline
- Remove any smoking huts, ashtrays, and receptacles
- Install signage on property

2. Access tobacco attitudes, belief, and use

During the early stages of implementation, it may be beneficial for committee members to conduct a broad assessment of the proposed policy. It will help to get a better picture of the current state of tobacco use with employees and prepare for future policy evaluation.

These suggestions can improve policy implementation process but are not required. Conduct strategies that are applicable to the worksite and possible with resources. Your local health department's staff members are happy to connect you with local resources to assist you in this process and help determine what is best for your worksite.

Ideas for gathering

1. Research current policies about tobacco and nicotine use. If changes have been made to these policies in recent years, see if information exists on the policy-change process. This may be informative on steps to take and possible issues.[33]

2. Research what tobacco cessation options are currently available to employees. This includes an analysis of current insurance benefits for coverage of cessation counseling and/or medications.[33]

3. If applicable, meet with union representatives to determine if there are contract issues that may impact the policy implementation process.[33]

A sample staff survey can be found in the Appendix. Incentives and confidentiality may help employees be more inclined to complete the survey.

Should you use this survey, or construct a survey of your own, your local health department can help you analyze the data you receive to build upon your existing tobacco and nicotine cessation efforts.

Ongoing

- Develop messaging on why you are implementing this policy.
- Develop and disseminate educational materials.

Remember that each organization is unique and has different needs. Some suggestions in this toolkit may not be applicable or feasible for all organizations. Focus on what is best for the clinic and staff. If additional assistance is needed, free resources are available to you. To connect with local resources, please contact your local health department. Contact information can be found at tobaccofree.utah.gov/community or on the second to last page of this toolkit.

3. Develop a comprehensive policy

See Appendix for a sample Tobacco-free Grounds Policy.

A comprehensive tobacco-free policy includes all tobacco and "look-alike" products and encompasses the entire property.

Tobacco and tobacco-like products that should be listed as prohibited substances include, but are not limited to:

- Cigarettes
- Electronic cigarettes
- Cigars
- Chewing tobacco
- Snuff
- Pipes
- Dissolvable tobacco products
- Snus

For a policy that includes tobacco-free grounds, it should apply to the following places:

- all buildings (including those owned, leased, rented, or maintained by your organization)
- all property grounds
- parking lots and ramps (including while inside privately-owned vehicles)
- plazas and contiguous sidewalks within 300 feet of the property
- company-owned vehicles

People who would be covered under a comprehensive tobacco-free policy include all those that step onto the property. These include, but are not limited to:

- Employees
- Visitors
- Patients (for healthcare facilities)
- Vendors
- Clients
- Contract workers
- Volunteers

Other important things to include in a comprehensive tobacco-free policy include:

- The sale or distribution of any tobacco products on the property is prohibited
- The procedures for the implementation of the policy
- The effective date for this policy
- Any new rules or regulations related to hiring new employees
- Plans for enforcement of the policy and consequences for violations
- Prohibiting activities such as providers smoking with clients
- Any new cessation benefits or options that will be made available to employees

4. Select a timeline and implementation date

Additional steps for tobacco-free grounds policy

Many organizations choose to make a policy change over a six-month or one-year timeframe. However, some may require more or less time. An implementation timeline should consider the number of individuals involved in making decisions related to the policy, the number of employees and locations that will be affected, the anticipated public impact, and more.

A six-month activity timeline and blank work plan have been provided in the Appendix of this toolkit.

Evaluate effectiveness of policy

Many decisions need to be made prior to drafting a tobacco-free policy by leadership and tobacco-free or wellness committees, if you have them. As input from employees, clients, and other interested parties is received, adjust and amend the policy as needed. Keep in mind that making changes based on feedback from all dissenting voices can weaken the policy. Be sure to match the policy with your intentions and goals. Regularly revisit your policy, even after implementation, to respond to changes within the organization or in tobacco use and cessation treatment.

1. **Conduct follow-up surveys of employees.**[35] If an employee assessment is conducted prior to policy implementation, a 6-month follow-up survey would be useful in analyzing changes. This could help determine the level of employee awareness about the policy and new cessation options, and be an opportunity to ask about concerns or suggestions.

2. **Conduct follow-up assessments of the organization.**[35] If you performed an organization assessment prior to policy implementation, observe and record changes based on the policy in a follow-up assessment of the organization.

3. **Work with a health insurance provider to compare healthcare costs prior to and following the policy implementation.**[35] Depending on how health insurance is provided to employees and what type of policy has been implemented (tobacco-free grounds, etc.), cost savings of the policy may be quantifiable. Begin by partnering with the insurance provider prior to policy implementation.

4. **Use a health-risk assessment to determine changes in tobacco use.**[33] If the clinic participates in annual health risk assessment activities, it may be used as a method for determining how many employees used tobacco and nicotine products before and after policy implementation.[35-36]

Ongoing tasks

Develop messaging on why you are implementing this policy

It is important to develop messaging on why the policy is being created early in the implementation process. Doing this sends a positive and consistent message to all impacted by the policy. Notifying employees, clients, vendors, and other community members early in the process allows them to express their opinions, get involved, and prepare for changes. This message should come directly from organizational leadership or by a letter of support from leadership.

Develop and disseminate educational materials

Before implementing a tobacco-free worksite policy, develop and disseminate educational materials for all impacted groups.

Strategies should be developed for reaching out to:

- employees
- visitors
- patients/clients
- job applications and new employees
- vendors and partners
- surrounding worksites
- general public, if applicable
- board of directors

Strategies for reaching audiences include:

- tobacco-free signage
- organization website
- organization's intranet
- email
- newsletters
- letter from company leadership
- pamphlets for visitors
- appointment card announcements
- social media
- job applications
- admittance forms or other check-in paperwork,
- posters and displays throughout worksite
- employee handbooks
- window clings on company vehicles
- discussion at staff meetings and trainings
- guest speakers
- new employee orientation
- mass media (press releases, articles, news features, news conferences, interviews, special events)

Tobacco treatment

Tobacco treatment and existing programs

When treating tobacco use disorder, medications are often necessary but not sufficient on their own. People do best with properly dosed pharmacotherapy and intensive tobacco dependence counseling. Tobacco dependence treatment combining cognitive behavioral therapy and multiple pharmacotherapies has shown the greatest efficacy for individuals with co-occurring substance use disorders and mental illnesses.

Peer recovery programs

Peer specialists have experience within a specific community, such as behavioral health, and are trained to support peers along their quit journey. Depending upon the setting, peers can be employees or clients who formerly used tobacco or nicotine. Peers uphold the values of recovery and resiliency, serving as role models for wellness, responsibility, and empowerment.

In their interactions, peers can communicate warmth, empathy, and nonjudgment while honoring the unique needs of peers quitting.

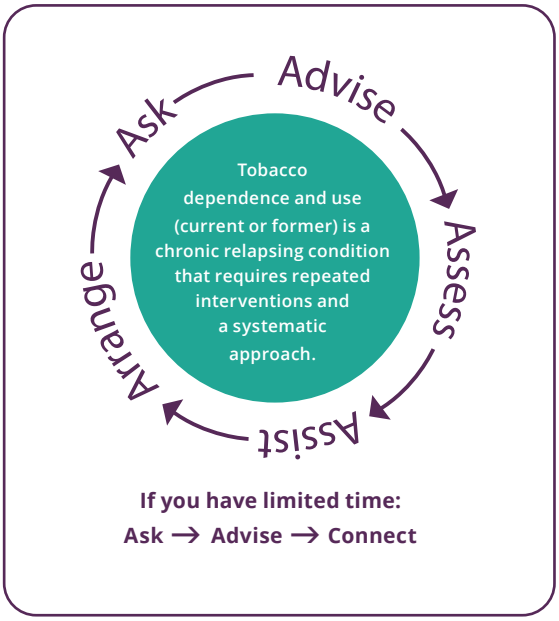
While precise job descriptions vary widely across agencies, peers focus heavily on identifying strengths, skill building, effective symptom management, and goal setting. They can also provide outreach, advocacy, education, and social and logistical support. Peers need specialized training to incorporate tobacco cessation interventions into their roles and responsibilities.

Stages of Change

- **Precontemplation:** No change is intended in the foreseeable future. The individual is not considering quitting.
- **Contemplation:** The individual is not prepared to quit at present, but intends to do so in the next six months.
- **Preparation:** The individual is actively considering quitting in the immediate future or within the next month.
- **Action:** The individual is making overt attempts to quit. However, quitting has not been in effect for longer than six months.
- **Maintenance:** The individual has quit for longer than six months.

Source: njchoices.org/pages/quit_tips

The 5 A's: ask, advise, assess, assist and arrange



The U.S. Public Health Service Clinical Practice

Guideline: Treating Tobacco Use and Dependence provides healthcare clinicians an onsite strategy for smoking cessation treatment that is built around the 5 A's (Ask, Advise, Assess, Assist and Arrange).

Knowing that providers have many competing demands, the 5 A's were created to keep steps simple.

Regardless of the patient's stage of readiness for a cessation attempt, the 5 A's should be utilized at every patient visit.

The Guideline recommends that all people entering a healthcare setting should be asked about their tobacco use status and that this status should be documented. Providers should advise all tobacco users to quit and then assess their willingness to make a quit attempt. Persons who are ready to make a quit attempt should be assisted in the effort. Follow-up should then be arranged to determine the success of quit attempts.

The full 5 A's model is most appropriate for agencies and organizations that have tobacco cessation medications and/or behavioral services available for persons with mental illnesses. For agencies and organizations that do not have tobacco cessation services readily available, we recommend using the first two A's (ask and advise) and then the agency can connect to available community services. (This is referred to as the 2 A's + C model).

TPCP has curated additional resources for addressing tobacco in behavioral health settings that you are free to use here.

Tobacco cessation health coverage in Utah

Treatment resources

For the best chance at a successful quit, use therapy and cessation aid(s) approved by the Food and Drug Administration:

Therapy:
- Individual
- Group counseling
- Telephone counseling

Cessation medications:
- Buproprion
- Varenicline

Nicotine replacement therapies:
- Patch
- Gum
- Lozenge

Medical Assistance and Utah Medicaid

The Utah Medicaid program covers:

- ☑ NRT gum
- ☑ NRT patch
- ☑ NRT lozenge
- ☑ Buproprion
- ☑ Group counseling *(coverage varies by plan)*
- ☑ Individual counseling
- ☑ Phone counseling *(coverage varies by plan)*

For more information, please call the Utah Medicaid Program at 800-662-9651 or 801-538-6155, or visit their website at medicaid.utah.gov.

State Employee Health Program Coverage

The state employees group insurance program covers:

- ☑ NRT gum
- ☑ NRT patch
- ☑ NRT lozenge
- ☑ Buproprion
- ☑ No tobacco surcharge
- ☑ Individual counseling
- ☑ Group counseling
- ☑ Phone counseling

Free with a prescription

COST: As of January 1, 2016, copays on medications were removed and individual, group, and phone counseling were added.

For more information, visit mn.gov/mmb/images/SoB-16-17.pdf.

Tobacco cessation health coverage in Utah

Resources to help you quit

way to quit

Way to Quit offers all Utahns free help to quit tobacco and nicotine.

Visit waytoquit.org or call 1-800-QUIT-NOW anytime to enroll.

Custom quit plans include any or all of the following:

- Text messaging— practical advice and encouragement to help you quit
- Nicotine replacement therapy (NRT)— free patches, gum or lozenges
- Email program—a series of emails with tips, advice, and encouragement to help you quit
- Calls with a certified quit coach to help you design a quit plan that works for you

Cost: free

Medications provided:

- ☑ NRT gum
- ☑ NRT patch
- ☑ NRT lozenge
- ☑ Buproprion

Private insurance coverage

The Utah Insurance Department released a Tobacco Cessation Requirements bulletin to Utah health plans in 2015 stating which benefits they are required to provide. However, cessation coverage in private health insurance plans vary by employer and/or plan. People who use tobacco and nicotine products with this type of insurance should contact their health plan by calling the number on the back of their insurance card.

References
Numbers 1-23

1. Degenhardt, L., Hall, W., & Lynskey, M. (2001). Alcohol, cannabis and tobacco use among Australians: A comparison of their associations with other drug use and use disorders, affective and anxiety disorders, and psychosis. Addiction, 96 (11), 1603-1614.

2. Marks, J.L., Hill, E.M., Pomerleau, C.S., Mudd, S.A., & Blow, F.C. (1997). Nicotine dependence and withdrawal in alcoholic and nonalcoholic ever-smokers. Journal of Substance Abuse Treatment, 14 (6), 521-527.

3. Durazzo, T., Cardenas, V., Studholme, C., Weiner, M., & Meyerhoff, D. (2007). Non-treatment-seeking heavy drinkers: Effects of chronic cigarette smoking on brain structure. Drug and Alcohol Dependence, 87 (1), 76-82.

4. Durazzo, T., Rothlind, S., Gazdzinski, P., Banys, D., & Meyerhoff, D. (2006). A comparison of neurocognitive function in nonsmoking and chronically smoking short- term abstinent alcoholics. Alcohol, 39 (1), 1-11.

5. Pierce, R.C. & Kumaresan, V. (2005). The mesolimbic dopamine system: The final common pathway for the reinforcing effect of drugs of abuse. Boston: Boston University School of Medicine.

6. Tobacco Cessation Leadership Network. (2008). Bringing Everyone Along Resource Guide. Portland, OR: Author.

7. Tobacco Cessation Leadership Network. (2008). Bringing Everyone Along Resource Guide. Portland, OR: Author.

8. Task Force on Community Preventive Services. (2005). The Guide to Community Preventive Services: What Works to Promote Health. New York: Oxford University Press.

9. Grant BF, Hasin DS, Chou SP, Stinson FS, Dawson DA. Nicotine Dependence and Psychiatric Disorders in the United StatesResults From the National Epidemiologic Survey on Alcohol and RelatedConditions. Arch Gen Psychiatry. 2004;61(11):1107-1115. doi:10.1001/archpsyc.61.11.1107

10. McCarthy, W.J., Collins, & C., Hser, Y.I. (2002). Does cigarette smoking affect drug abuse treatment? Journal of Drug Issues, 32 (1), 61-80.

11. Hurt, R. D. "Mortality following Inpatient Addictions Treatment. Role of Tobacco Use in a Community-based Cohort." JAMA: The Journal of the American Medical Association275.14 (1996): 1097-103. Web.

12. Richter, K.P., Ahluwalia, H.K., Mosier, M.C., Nazir, N., & Ahluwalia, J.S. (2002). A population-based study of cigarette smoking among illicit drug users in the United States. Addiction, 97 (7), 861-869.

13. Prochaska, J.J., Delucchi, K., & Hall, S.M. (2004). A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. Journal of Consulting and Clinical Psychology, 72 (6),1144-1156. Minnesota Adult Tobacco Survey. (2014). Tobacco Use in Minnesota. Retrieved March 31, 2016, from http://www.mntobacco.nonprofitoffice. com/vertical/Sites/%7B988CF811-1678-459A-A9CE- 34BD4C0D8B40%7D/uploads/MATS_Fact_Sheet_ FINAL_1_20_15.pdf

14. "Instituting Smoke-Free Public Housing." Federal Register. N.p., 05 Dec. 2016. Web. 15 Mar. 2017.

15. "Khat." SpringerReference (n.d.): n. pag. National Institute on Drug Abuse. Web.)

16. Lan, Yu-Ching, Y. Hser, Y. Ho, W. Tsai, J. Hsu, and J. Kang. "Patterns of Adolescent Chewing Betel Nut and Later Drug Use in Adults." Drug and Alcohol Dependence 140 (2014): n. pag. Web.)

17. Minnesota Center for Health Statistics (MCHS). Minnesota Student Survey-Center for Health Statistics. Minnesota Department of Health, Oct. 2016. Web. 1 Mar. 2017

18. Campaign for Tobacco-Free Kids. (2015). The Toll of Tobacco in Minnesota. Retrieved March 30, 2016, from https://www.tobaccofreekids.org/facts_issues/ toll_us/minnesota

19. U.S. Department of Health and Human Services. (2014). The Health Consequences of Smoking-50 Years of Progress. Atlanta, GA: U.S. Department of Health and Humans Services, Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion. Retrieved March 9, 2015, from http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf

20. Centers for Disease Control and Prevention. (2014b). History of the Surgeon General's Report on Smoking and Health. Retrieved March 9, 2015, from http:// www.cdc.gov/tobacco/data_statistics/sgr/history/

21. Minnesota Department of Health. (2014). Teen and Tobacco in Minnesota. Retrieved April 1, 2016 from http://www.health.state.mn.us/divs/chs/tobacco/youth. html

22. American Cancer Society. (2016). Cancer Facts & Figures 2016. Retrieved May 9, 2016 from http:// www.cancer.org/acs/groups/content/@editorial/ documents/document/acspc-044552.pdf

23. 23. Centers for Disease Control and Prevention. (2014a). Health Effects of Cigarette Smoking. Retrieved March 9, 2015, from http://www.cdc.gov/tobacco/data_statistics/ fact_sheets/health_effects/effects_cig_smoking/

References
Numbers 24-36

24. Centers for Disease Control and Prevention. (2014c). Tobacco-Related Mortality. Retrieved March 9, 2015, from http://www.cdc.gov/tobacco/data_statistics/fact_ sheets/health_effects/tobacco_related_mortality/

25. Centers for Disease Control and Prevention. (2015b). Secondhand Smoke (SHS) Facts. Retrieved March 9, 2015, from http://www.cdc.gov/tobacco/data_statistics/ fact_ sheets/secondhand_smoke/general_facts/#harm

26. U.S. Department of Health and Human Services. (2006). The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Retrieved March 9, 2015, from http://www.surgeongeneral.gov/library/ reports/secondhandsmoke/fullreport.pdf

27. Hopkins, D. P., Razi, S., Leeks, K. D., Priya Kalra, G., Chattopadhyay, S. K., Soler, R. E., & Services, T. F. o. C. P. (2010). Smokefree policies to reduce tobacco use. A systematic review. Am J Prev Med, 38(2 Suppl), S275-289. doi: 10.1016/j. amepre.2009.10.029

28. Jha, P., Ramasundarahettige, C., Landsman, V., Rostron, B., Thun, M., Anderson, R.N., Peto, R. (2013). 21st- century hazards of smoking and benefits of cessation in the United States. N Engl J Med, 368(4), 341-350. doi: 10.1056/NEJMsa1211128

29. Ripley-Moffitt, C., Viera, A. J., Goldstein, A. O., Steiner, J. B., & Kramer, K. D. (2010). Influence of a tobacco- free hospital campus policy on smoking status of hospital employees. Am J Health Promot, 25(1), e25-28. doi: 10.4278/ajhp.090223-ARB-78

30. Gadomski, A. M., Stayton, M., Krupa, N., & Jenkins, P. (2010). Implementing a smoke-free medical campus: impact on inpatient and employee outcomes. J Hosp Med, 5(1), 51-54. doi: 10.1002/jhm.473

31. Kim, B. (2009). Workplace smoking ban policy and smoking behavior. J Prev Med Public Health, 42(5), 293-297. doi: 10.3961/jpmph.2009.42.5.293

32. Berman, M., Crane, R., Seiber, E., & Munur, M. (2014). Estimating the cost of a smoking employee. Tob Control, 23(5), 428-433. doi: 10.1136/ tobaccocontrol-2012-050888

33. Centers for Disease Control and Prevention. (2010). Tobacco-Free Workplace: Assessing Need and Interest. Retrieved March 9, 2015, from http://www.cdc.gov/ nccdphp/dnpao/hwi/toolkits/tobacco/assessing.htm

34. Centers for Disease Control and Prevention. (2010). Tobacco-Free Workplace: Assessing Need and Interest. Retrieved March 9, 2015, from http://www.cdc.gov/ nccdphp/dnpao/hwi/toolkits/tobacco/assessing.htm

35. Centers for Disease Control and Prevention. (2010). Tobacco-Free Workplace: Evaluating Success. Retrieved March 9, 2015, from http://www.cdc.gov/ nccdphp/dnpao/hwi/toolkits/tobacco/evaluating.htm

36. Tobacco Free Florida. Benefits to Quit Worksite Toolkit: Strategies for Creating a Healthier Workforce and Bottom Line. (n.d.). Retrieved March 9, 2015, from http://www.tobaccofreeflorida.com/county/miamidade/ wp-content/uploads/sites/45/2014/11/Employer- Cessation-Toolkit-Benefits-to-Quit-metro-cover.pdf

Appendix

Fagerstrom Test for Nicotine Dependence*

Circle one number for each question.		
How soon after waking do you smoke your first cigarette?	Within 5 minutes 5-30 minutes 31-60 minutes	3 2 1
Do you find it difficult to refrain from smoking in places where it is forbidden? e.g. Church, Library, etc.	Yes No	**1** **0**
Which cigarette would you hate to give up?	The first in the morning Any other	**2** **0**
How many cigarettes a day do you smoke?	10 or less 11 - 20 21 - 30 31 or more	**0** **1** **2** **3**
Do you smoke more frequently in the morning?	Yes No	**1** **0**
Do you smoke even if you are sick in bed most of the day?	Yes No	**1** **0**
SCORE	**1- 2 = low dependence** **3-4 = low to mod dependence**	**5 - 7= moderate dependence** **8 + = high dependence**

Add up the scores from the questionnaire.

**This test is for cigarettes only. For e-cigarettes, use the Nicotine Dependence Clinic's Assessment.*

Scoring the Fagerstrom Test for Nicotine Dependence

To remind you of information (covered in module 1) about scoring the test:

Score of 1-2

A patient who scores between 1 and 2 on the Fagerstrom Test for Nicotine Dependence is classified as having a low dependence on nicotine. This suggests that they may not need nicotine replacement therapy, although it is recommended that they still be monitored for withdrawal symptoms.

Score of 3-4

A patient who scores 3 or 4 is considered to have a low to moderate dependence on nicotine and could be offered patches, inhaler, lozenges, or gum. Please check NRT recommendations chart.

Score of 5-7

A patient who scores 5 to 7 is considered moderately dependent on nicotine and can be offered patches, an inhaler, lozenges, or gum. They can also be offered the combined therapy of patches with lozenge and gum. Check NRT recommendations chart.

Score of 8 and over

A patient who scores 8 and over is considered highly dependent on nicotine and can be offered patches, inhaler, lozenges, and/or gum. They can also be offered the combined therapy of patches with lozenges or gum. Check the NRT recommendations chart (see the chart on the next page).

Appendix

Sample work plan templates

Tobacco use and recovery among individuals with mental illness or addiction

Organization goals

1. Incorporate ongoing tobacco education into staff orientation and training.
2. Provide parallel wellness services between clients and staff (including tobacco cessation).
3. Work toward standardizing client assessment and referral protocols. Include them in EMR system.
4. Work toward tobacco-free grounds policies.

Focus area: staff orientation and training

Objectives and action steps	Who	Timeline	Resources and support available/ needed		Potential barriers or resistance	Communications plan	Status
What needs to be done?	Who will take action?	By what date will the action be done?	Resources available	Resources needed (financial, human, political, other)	What individuals and organizations might resist? How?	What individuals and organizations should be informed about/ involved with these actions?	
Goal:							
Step 1: Identify survey needs		Begins Ends					
Step 2:							
Step 3:							
Goal:							
Step 1:							
Goal:							
Step 1:							

Appendix

Sample work plan templates

Focus area: tobacco-free grounds policies

Notes:

Objectives and action steps	Who	Timeline	Resources and support available/ needed		Potential barriers or resistance	Communications plan	Status
What needs to be done?	Who will take action?	By what date will the action be done?	Resources available	Resources needed (financial, human, political, other)	What individuals and organizations might resist? How?	What individuals and organizations should be informed about/ involved with these actions?	
Goal:							
Step 1: Identify survey needs		Begins Ends					
Step 2:							
Step 3:							
Goal:							
Step 1:							
Goal:							
Step 1:							

Appendix

Sample work plan templates

Focus area:

Notes:

Objectives and action steps	Who	Timeline	Resources and support available/ needed		Potential barriers or resistance	Communications plan	Status
What needs to be done?	Who will take action?	By what date will the action be done?	Resources available	Resources needed (financial, human, political, other)	What individuals and organizations might resist? How?	What individuals and organizations should be informed about/ involved with these actions?	
Goal:							
Step 1: Identify survey needs		Begins Ends					
Step 2:							
Step 3:							
Goal:							
Step 1:							
Goal:							
Step 1:							

Appendix
Sample policy language

Purpose

_____ is committed to providing safe and healthy work environments. Tobacco and nicotine use is a major cause of preventable disease and death. Smoking, tobacco use, and exposure to secondhand smoke have been found to cause heart disease, cancer, asthma, bronchitis, and other respiratory problems. Electronic delivery devices, more commonly referred to as electronic cigarettes, closely resemble and purposefully mimic the act of smoking. They produce a vapor of harmful aerosols and typically contain nicotine derived from tobacco, which is a highly addictive substance. Their use in locations where smoking is prohibited creates concern and confusion and makes policy enforcement more difficult.

_____ believes the use of tobacco and nicotine products, including electronic delivery devices, on its property is detrimental to the health and safety of its employees, clients, and other visitors.

Definitions

"All Times" means 24 hours a day, 7 days a week.

"Electronic Delivery Devices" or electronic cigarettes means any product that can be used by a person to deliver nicotine, lobelia, or any other substance through the inhalation of aerosol or vapor from the product. The term includes, but is not limited to, devices manufactured, distributed, marketed, or sold as e-cigarettes, vapes, e-cigars, e-pipes, or under any other product name or descriptor.

"Employee" means any person employed by _____ in a full- or part-time capacity, or any position contracted for or otherwise employed, with direct or indirect monetary wages or profits paid by _____, or any person working on a volunteer basis. The term includes, but is not limited to, personnel, contractors, consultants, and vendors.

"Property" means all facilities, grounds, and property (including vehicles) owned, leased, rented, contracted, used, or controlled by _____.

"Smoking" means inhaling or exhaling smoke from any lighted or heated cigar, cigarette, pipe, any other tobacco or plant product, or inhaling or exhaling aerosol or vapor from any electronic delivery device. Smoking includes being in possession of a lighted or heated cigar, cigarette, pipe, or any other tobacco or plant product intended for inhalation, or an electronic delivery device that is turned on or otherwise activated.

"Tobacco and Nicotine Products" means any product containing, made, or derived from tobacco or nicotine and is intended for human consumption, whether chewed, smoked, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means.

"Tobacco Use" means the act of smoking, the use of smokeless tobacco, or the use of any other tobacco product in any form.

"Visitor" means any person who is not an employee.

Appendix
Sample policy language

Policy
The use of tobacco products and electronic delivery devices is prohibited at all times in or on all property _____ has the authority to control regardless of location.

Employees are prohibited from using tobacco products and electronic delivery devices while on duty.

Applicability
This policy applies to all visitors and staff on _____ property.

This policy also applies to private vehicles parked on_____ parking lots.

Exception
It is not a violation of this policy to use a product that has been approved by the United States Food and Drug Administration for sale as a tobacco cessation product, as a tobacco dependence product, or for other medical purposes, and is being marketed and sold solely for such an approved purpose.

Dissemination
Signage will be posted at strategic locations to notify employees and visitors of this policy.

Cessation
_____ will identify and/or offer cessation programs and services to those ready to quit.

Compliance and enforcement
The success of this policy depends on the consideration and cooperation of both tobacco users and non- users. Enforcement is a shared responsibility of all staff. Individuals acting in violation of this policy will be reminded and asked to comply. Employees found to have violated this policy may be subject to disciplinary action. Visitors who violate this policy may be asked to leave the property.

Effective date
This policy shall take effect in full on _____ .

This publication was prepared by the Public Health Law Center at Mitchell Hamline School of Law, St. Paul, Minnesota and made possible with funding from the Minnesota Department of Health. The Public Health Law Center provides information and technical assistance on issues related to public health. The Public Health Law Center does not provide legal representation or advice. This document should not be considered legal advice. For specific legal questions, consult with an attorney.

Appendix
Utah tobacco recovery program and wellness survey

Thank you for taking the time to complete the survey! Your responses will be completely confidential. Your employer will not know if you participate, and we will not share your individual responses with your employer.

Tobacco use definition
Tobacco use in this document refers to smoking, use of smokeless tobacco products, and the use of unregulated nicotine products (e.g., "e-cigarettes"). It also refers specifically to the use of manufactured, commercial tobacco products, and not to the sacred, medicinal, and traditional use of tobacco by American Indians and other groups.

1. Please identify the site you work with most regularly.

- ☐ Location 1
- ☐ Location 2
- ☐ Location 3
- ☐ Location 4
- ☐ Location 5
- ☐ Other (please specify)

2. Which program do you spend most of your time working in:

- ☐ Program 1
- ☐ Program 2
- ☐ Program 3
- ☐ Program 4
- ☐ Other (please specify)

3. How long have you been at XXX?

- ☐ 0-1 Year
- ☐ 1-5 Years
- ☐ 5-10 Years
- ☐ 10+ Years
- ☐

Appendix
Utah tobacco recovery program and wellness survey

4. Please indicate the degree to which you disagree or agree with each of the following statements:

Objectives and action steps	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
Implementing tobacco-free ground policies at XXX would infringe on staff rights	❍	❍	❍	❍	❍
Continued tobacco use makes chemical dependency relapse more likely	❍	❍	❍	❍	❍
Stopping tobacco use increases cravings for alcohol and other drugs	❍	❍	❍	❍	❍
Eliminating the use of tobacco will not interfere with chemical dependency recovery	❍	❍	❍	❍	❍
Eliminating the use of tobacco may have health benefits	❍	❍	❍	❍	❍
Tobacco use decreases symptoms of mental illness	❍	❍	❍	❍	❍
Tobacco dependence should be treated in chemical dependence recovery programs	❍	❍	❍	❍	❍
Implementing tobacco-free grounds policies at XXX would infringe on client rights	❍	❍	❍	❍	❍
Implementing tobacco-free ground policies at XXX would infringe on staff rights	❍	❍	❍	❍	❍
Nicotine Replacement Therapy Products (gum, patch, lozenge) are safer than commercial tobacco	❍	❍	❍	❍	❍
Electronic Cigarettes are an effective tobacco cessation device	❍	❍	❍	❍	❍
In certain circumstances, it's okay for staff and clients to use tobacco together	❍	❍	❍	❍	❍
Providing clients access to tobacco treatment services is consistent with our mission to XXXXX	❍	❍	❍	❍	❍

Appendix
Utah tobacco recovery program and wellness survey

5. What do you believe is the biggest barrier to incorporating tobacco treatment into the way that XXXX provides services?

- ☐ Lack of client interest
- ☐ Lack of client ability
- ☐ Lack of staff interest
- ☐ Lack of staff training
- ☐ Eliminating the use of tobacco may negatively interfere with chemical dependency recovery
- ☐ Eliminating the use of tobacco may increase symptoms of mental illness
- ☐ Treatment is not effective for people with mental illness
- ☐ Other (please specify)

6. What tobacco dependence topics would you like more training and/or information about? (select all that apply)

- ☐ The basics – an understanding of the nature of tobacco dependence
- ☐ Tobacco treatment and recovery including withdrawal management
- ☐ Medical aspects of tobacco use
- ☐ How tobacco relates to other chemical use
- ☐ Psychosocial and other cultural aspects of tobacco use
- ☐ Marketing and advertising factors
- ☐ Tobacco use and mental health conditions
- ☐ Pharmacotherapy (interactions of medications with tobacco)
- ☐ Electronic cigarettes
- ☐ Use and impact of tobacco in diverse populations (e.g., hookah, American Indian)
- ☐ Other (please specify)

7. What wellness topics would you like more training and/or information about? (select all that apply)

- ☐ Finding medical providers that accept MA
- ☐ Understanding dental treatment plans
- ☐ Diabetes prevention and treatment resources
- ☐ Understanding medical records
- ☐ Specific coping skills for stress
- ☐ Understanding recommended dental procedures
- ☐ Benefits of different types of exercise and physical activity
- ☐ Understanding recommended health screenings
- ☐ Sexual health resources
- ☐ Other (please specify)

Appendix
Utah tobacco recovery program and wellness survey

8. How often do you start conversations with clients about the following topics?

	Never	Sometimes	Daily	N/A
Tobacco use	❍	❍	❍	❍
Exercise	❍	❍	❍	❍
Nutrition	❍	❍	❍	❍
Sexual health	❍	❍	❍	❍
Chronic pain	❍	❍	❍	❍
Body weight	❍	❍	❍	❍

9. Additional comments

Appendix

Activity timeline

Month 1 — Develop messaging on why you are implementing this policy

Month 1 — Assemble a tobacco-free committee or workgroup

Month 2 — Select a timeline and implementation date

Month 2 — Assess tobacco use at the worksite

Month 3 — Develop comprehensive tobacco-free policy language

Month 3 — Review insurance change options

Month 3 — Discuss compliance and enforcement strategies

Month 3 — Develop educational material

Month 4 — Finalize a comprehensive tobacco-free policy

Month 4 — Assess cessation options

Month 4 — Determine compliance and enforcement strategies

Month 5 — Disseminate educational material

Month 5 — Promote cessation options

Month 6 — Emplace enforcement strategies

Month 6 — Install adequate signage and remove any smoking huts, ashtrays, and receptables

Month 6 — Implementation day celebration

Ongoing activities:

- Disseminate educational material
- Promote cessation options
- Monitor and address hot spots
- Evaluate effectiveness of policy

Contact us

Utah Tobacco Prevention and Control Program

288 North 1460 West, Box 142106

Salt Lake City, UT 84114-2106

tobaccofree.utah.org

1-800-QUIT-NOW

phone 801-538-6141

fax 801-538-9303

Utah Department of Health & Human Services

way to quit.org

1.800.QUIT.NOW

way to quit