Tobacco-Free Recovery

A Guide to Help Behavioral Health Facilities Go Smoke-Free.

Department of Public Health

Fresno County Tobacco-Free Coalition

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ACKNOWLEDGMENTS

The Fresno County Tobacco Prevention Program would like to thank its administrative staff for being strong leaders in the fight for smoke-free policies.

Thank you to all of the behavioral health facilities who will adopt smoke-free policies in the future. Your decision to do so will help more people on the path to live healthier lives.

Thank you to all of the staff members for all their hard work and time taken to review the many drafts of this toolkit.

OVERVIEW

Why a Tobacco Cessation Toolkit is Needed

Although the rates of tobacco use have decreased among the general population, there are still vulnerable subpopulations where the rate of use has increased. Unfortunately, individuals with behavioral health disorders are one of the subpopulations disproportionately affected by tobacco use.

This enormous problem has become an accepted part of life in treatment facilities. It is imperative to those with these disorders that this problem is no longer ignored, that the stigma is not allowed to block education efforts, and that common myths are no longer permitted to stop cessation efforts. Healthcare providers need to make tobacco use a priority issue, as they are on the frontlines of treatment. Tobacco is a chronic addiction and every individual deserves to be offered treatment.

The gap needs to be bridged between behavioral health communities and tobacco control. The problem should be addresses at the front lines by developing policy. Placing prevention efforts into facilities and by offering treatments.

Everyone deserves to live healthy tobacco-free lives, regardless of diagnosis.

Why Go Tobacco-Free?

Many benefits come from the implementation of a tobacco-free policy, including benefits to a facility's bottom line. Going tobacco-free reduces the risk of fires and accidental injuries[22] from tobacco use. This can reduce insurance costs. Businesses have successfully negotiated lower property insurance premiums after going tobacco-free.[23]

An obvious benefit is to the patients health. Patients have better reactions to medicatons, surgical outcomes and increase life expectancy.

Another benefit is the reduction in the potential legal liability. Non-smokers who have been harmed from secondhand smoke at work have successfully won lawsuits against employers.[24] The American Productivity Audit also found that tobacco use is a leading cause of lost time in workers' productivity. Therefore, quitting smoking improves productivity.[25] Companies have also found that employees who were smokers had more hospital admissions than non-smokers. Smokers also paid a higher average insurance premium.[26]

About This Toolkit:

This toolkit is intended for behavioral health and substance use care providers, administrators, and other care organizers.

The toolkit includes information about:

- Tobacco use facts
- How to assess readiness to quit tobacco use
- Tools to help staff and patients quit
- Relapse prevention
- Possible treatments
- Community resources

QUICK FACTS & MYTHS ABOUT BEHAVIORAL HEALTH CLIENTS AND TOBACCO USE

50-90% of behavioral health patients are tobacco dependent. Rates vary among diagnosis and facility setting[1]

25% of adults in the U.S. have a behavioral health disorder, and they **smoke 40% of all cigarettes** in the United States[1]

Those diagnosed with behavioral health disorders account for **16 million smokers in the U.S**.[2]

The incidence of **cancer is 2.5 times greater** than the general population.[2]

They **die 25 years sooner**, compared to the general population, due to tobacco related illnesses[2]

200,000 of the **443,000 premature deaths** In the U.S., from tobacco use are from this subpopulation[1,2]

22% of smokers reported they started smoking in facilities or while hospitalized.[2]

They are **2-4 times** more likely to be tobacco dependent than the general population.[1]

40-50% are heavy smokers and smoke more than 25 cigarettes per day.[1]

They account for **41%** of deaths from tobacco annually in the U.S.[1,2]

Quitters show lower rates of bronchitis and pneumonia.[7]

MYTH	FACT
They don't want to quit.	Studies show 50% to 79% of patients are interested in quitting.[3]
Quitting will threaten recovery.	Those who treat tobacco addiction along with other addictions simultaneously are 25% more likely to sustain their recovery.[4]
Smoking is helpful to the person's management of the symptoms of their mental disorder.[27]	Individuals with mental disorders that smoke have better long-term mental health when they quit smoking.[28]
They can't quit.	Research has shown they have almost equal quit rates as the general population with access to cessation services.[5]
It's too late.	All smokers benefit from quitting. After 20 minutes of cessation, heart and blood pressure drop.[6] After 2 weeks, circulation and lung function improve.[7]
Smoking builds relationships.	Smoking can be isolating. 75% of smokers with behavioral health disorders reported smoking all or most of their cigarettes alone.[8]
It's necessary for self-medication.	Tobacco does not control symptoms; it affects the brain's cognitive processes and counters some medications used in treatment.

Why does this subpopulation use tobacco?

THERE ARE A COMBINATION OF FACTORS TO CONSIDER THAT INCREASE THE USE OF TOBACCO AMONG THOSE WITH BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDERS.

Biological

- Some behavioral health disorders have neurobiological factors that can increase use and make it more difficult to quit nicotine. For example, nicotine positively affects mood, concentration, and attention span in those with schizophrenia and attention deficit disorders.[9]
- Nicotine briefly improves the sensory processing systems in some disorders, offering temporary relief from some symptoms caused by behavioral health disorders.[9]

Psychological

- The daily habit of use can be difficult to break.
- Tobacco use temporarily relives feelings of anxiety and tension. The behavioral health population typically uses tobacco to deal with stressors since their coping strategies may be limited.[9]

Social

- Smoking is an accepted part of the treatment center culture.
- It is a shared activity that may make smokers feel like they belong to a group.
- Smoking may have been used as a way to fill time and reduce boredom and loneliness.

The tobacco industry has historically targeted behavioral healthcare facilities through giveaways, donations, direct funding of studies, and through support to block hospital smoking bans.[10]

Tobacco Use By Diagnosis

Schizophrenia	62-90%
Major Depression	36-80%
Bipolar Disorder	51-70%
Attention Deficit/Hyperactivity Disorder	38-42%
Anxiety Disorders	32-60%
Post-Traumatic Stress Disorder (PTSD)	45-60%
Alcohol Abuse	34-93%
Other Drug Abuse	49-98%

*Morris, Chad D., et al. “What Do Persons with Mental Illnesses Need to Quit Smoking? Mental Health Consumer and Provider Perspectives.” Psychiatric Rehabilitation Journal, vol. 32, no. 4, 2009, pp. 276–284., doi:10.2975/32.4.2009.276.284.

ASSESSMENT AND PLANNING FOR CHANGE

The choice to implement a tobacco-free policy can be a daunting decision. Your agency will have to take into consideration many perspectives, opinions, and other factors. Viewpoints will come from various groups of people and other organizations, including: leadership, staff, patients, partners, neighbors, and your community. Other considerations your agency will reflect on are the long-term effects, resources needed, and financial repercussions from implementing a tobacco-free policy. A tobacco-free policy requires that people do not use tobacco on the organization's facilities and grounds. A model policy can be found on page 17.

Many agencies fear the implementation of a tobacco-free policy will adversely affect their bottom line. They are concerned about how their staff will respond and if there will be some turnover. They wonder how and who will take care of adherence and enforcement. The stress from challenges and concerns are common and experienced by others as well.

Many facilities nationwide have already successfully implemented tobacco-free and smoke-free policies with little to no impact to their bottom line. In 2012, the Utah Tobacco Prevention Program helped implement a statewide initiative that required mental health treatment and substance abuse treatment programs that receive public funding to be tobacco free. That same year, King County, Washington implemented a policy that required all contracted behavioral health and recovery providers to provide tobacco cessation treatment and become tobacco-free.

Trilogy Behavioral Healthcare, Inc, located in Chicago, Illinois, decided to improve clients overall health by going smoke-free. Their journey also began in 2012. They faced challenges, learned lessons through implementation, and saw successes.

There are always obstacles to overcome with any change. This section of the toolkit will provide your facility with an idea of where it currently is in the change process and steps on how to implement a tobacco-free policy.

STAGES OF CHANGE

It is important to assess your agency's readiness for change when considering the implementation of a tobacco-free policy. Change does not happen in one simple step; change happens through a progression of different stages. Your agency will move through The Stages of Change Model while on your way to the adoption of a tobacco-free policy. The table below may be helpful in identifying what stage your agency is in and to determine what next steps you should take to ensure the successful adoption and implementation of a smoke-free policy.

Stage of Change	Definition	Action
Pre-contemplation	Agency has not yet considered implementing a tobacco-free policy	Educate and inform leadership to create buy-in and support for a tobacco-free policy
Contemplation	Agency is considering implementing a tobacco-free policy	Identify individuals to serve in wellness committee, form wellness committee
Preparation	The tobacco-free policy will be implemented in the next 6-8 months	Gather information and ideas from staff and patients through surveys, meetings, and focus groups. Announce implementation date, notify all staff and patients of date, begin training and education.
Action	The tobacco-free policy has been implemented, but has only been in effect for a short period of time	Address any issues with policy adherence, continued support, and education to staff and patients
Maintenance	The tobacco-free policy has been in effect for 6 months or more	Continue support and education, conduct an evaluation of the policy, amend as needed

ASSESS YOUR AGENCY

A "**Yes**" answer indicates that your agency currently supports tobacco-free policy implementation. A "**No**" answer indicates that more research and thought need to be done before implementation of a new tobacco-free policy. A "**Don't Know**" answer indicates your agency may need to research tobacco-free policies further.

Question	Yes	No	Don't Know
Has your agency ever considered the implementation of a tobacco-free policy?			
Does your agency's leadership support implementation of a tobacco-free policy?			
Does your agency have a wellness committee, curriculum, or policy?			
Do you believe tobacco-free policies can have a positive impact on your agency?			
Does your agency currently have any tobacco policies?			
Does your agency restrict tobacco use by time and place?			
Is your agency interested in learning more about a tobacco-free policy?			

IMPLEMENTATION STEPS

Step 1	Create a wellness committee
Step 2	Establish a timeline
Step 3	Create the message
Step 4	Draft the policy
Step 5	Develop an open line of communication
Step 6	Educate and train
Step 7	Offer cessation services
Step 8	Launch the policy
Step 9	Monitor and evaluate

STEP 1
CREATE A WELLNESS COMMITTEE

Wellness committees promote healthy behaviors, help motivate staff, and bring healthy changes to the workplace. The committees provide structure to put policy and programs into action. They are goal oriented and result driven. The wellness committee will move your agency through the steps of the policy implementation process.

Select Wellness Committee Members

The committee must consist of the right amount and mix of members.

The size of the committee will be based on the size of the agency. Keep in mind, less can be more but if the committee is too small they may feel overwhelmed by the workload. It is recommended that the committee be composed of 3-12 staff members.

A cross-section of employees should be represented in the committee. It should consist of all levels of the agency so everyone is represented, and there will be a diverse representation of voices from all departments.

Candidates for the committee should be respected, trusted, and dependable, have a desire to help, and have good communication skills. Potential committee members can be recruited by letters, in-person, flyers, emails, and staff newsletters.

Establish Procedures and Rules

Schedule regular reoccurring meetings once or twice a month, for 30 minutes to one hour. A formal agenda, minutes taken, and any supporting documents must be prepared for each meeting. Working agreements should be created and should include: be prompt, courteous, listen and be respectful of others' ideas, and be dependable.

Plan an Initial Meeting

Send invites to committee members and senior staff, two weeks before meeting date.

A framework will be set on how members will work together and how the planning in the committee will be done.

The focus of the initial meeting should be to elect a chairperson (who will coordinate future meetings), and identify which member will take minutes. A mission and vision statement, goals, objectives, program strategy, and an implementation plan should be created during this first meeting.

Develop Goals

The committee will create short, intermediate, and long-term goals. In this case, the first long-term goal will be to implement a tobacco-free policy for the agency. After the goal is created, steps to achieve this goal should be established. The goal should be measurable and the steps should be clear to everyone in the committee.

STEP 2
ESTABLISH A TIMELINE

To help your agency become tobacco-free, it is important to have a timeline. It is recommended that your planning and implementation timeline be 6-8 months.

Month	1	2	3	4	5	6	7	8
Create a wellness committee								
Perform an assessment								
Create buy-in from staff								
Develop a timeline								
Draft policy and acquire opinions from staff								
Host meetings with staff and patients								
Announce the policy and start launch countdown								
Educate staff, patients, visitors, vendors, community, and neighbors								
Acquire cessation materials								
Train staff on policy								
Place signage								
Launch the policy at a kick-off event								

STEP 3
CREATE THE MESSAGE

You will have to explain why you want to implement a tobacco-free policy in your agency.

- "We are implementing this policy because we support an environment where employees, patients, and visitors are not exposed to the harmful effects of tobacco."
- "Studies show that smoking bans have no negative effects on behavioral health symptoms or management of substance abuse treatment."
- "Tobacco-free policies improve the health of everyone."
- "On (DATE), our facility will become tobacco-free and we will no longer permit the use of any tobacco products on our grounds."

A sample message is included at the beginning of **Appendix 1**, labeled "**background and intent**", in the sample tobacco-free policy. This message can be amended to fit your staff and agency's needs.

STEP 4
DRAFT THE POLICY

A strong tobacco-free policy will contain clear reasoning, definitions, and procedures. When drafting a policy, your agency will have to take into account staff views, human resource policies, and if your agency will offer or facilitate access to cessation classes and medications.

See **Appendix 1** for a sample tobacco-free policy which can be amended to fit your staff and agency's needs.

STEP 5
DEVELOP AN OPEN LINE OF COMMUNICATION

Now is the time to inform staff and patients of the implementation timeline. Clear open communication is key to avoiding confusion and easing anxieties. It is important that your statements are consistent to reinforce your message. Initial communication will consist of announcements of the policy to staff and patients, as tobacco users among these groups will need time to prepare and adjust.

Please see **Appendix 2** and **3** for sample announcement letters to staff and patients. These letters can be amended to fit your staff and agency's needs.

Your agency might also want to consider informing neighbors of the new tobacco-free policy. Issues may arise with neighbors and should be addressed accordingly. Patients and staff may litter and loiter in the neighborhood after your tobacco-free policy has been implemented. Plenty of notice should be given to neighbors and a personal contact should be offered in case issues do arise.

Appendix 4 contains a sample letter to neighbors, which can be amended to fit your agency's needs.

Be sure to respond to staff and patient' concerns. Hold separate meetings with staff and patients to allow for an open line of communication and discussion.

STEP 6
EDUCATE AND TRAIN

Offer educational seminars to staff and patients. Staff should also receive refresher training on an annual basis. Training will provide the knowledge necessary to assess and treat tobacco dependence. Information will include:

- Trends among smokers with behavioral health and/or substance use disorders
- Factors in treatment facilities that affect tobacco use in behavioral health and/or substance use populations
- Screening and assessment tools
- Evidence-based treatment for tobacco dependence
- Resources

Each patient should be assessed and offered information on tobacco cessation services regardless of their readiness for cessation.

STEP 7
OFFER CESSATION SERVICES

Because tobacco use is a chronic addiction that is difficult to quit, provide cessation medication and counseling to help staff and patients in their quit attempts. Within the general population, 4-7% of unaided quit attempts are successful. Cessation interventions have been proven to work, with quit rates as high as 30-40%.[11] Persons with schizophrenia whom seek treatment have also shown success with quit rates of 11-50%.[20] Quit rates in those with substance use disorders who have received cessation services range from 60-70%.[21] Cessation aids will be necessary for staff and patients to have successful quit attempts and ease withdrawal symptoms.

Cessation services should include: tobacco screening, assessment, motivational interventions, individual and group counseling, FDA approved cessation medications, and referrals to quit lines. All of these services are covered further on page 18 in the Assessment and Treatment section.

If your facility is not able to provide any of the services listed above, then they can refer patients to the many tobacco cessation resources currently available. Page 33 provides a list of local tobacco cessation resources and page 32 provides a list of nationally available programs for patient referrals.

The Affordable Care Act (ACA) requires most health insurance plans to cover some type of tobacco cessation treatment. Patients should check with their health insurance plan to confirm what types of treatments are covered.

STEP 8
LAUNCH THE POLICY

Before the implementation date, make certain all signage is posted in key areas. Key areas to focus on should be: building entrances, strategic areas around the property, and places where staff and patients previously assembled to smoke. Make sure signage represents all languages patients speak at the facility.

Confirm that all visitors and patients are aware of the implementation date by informing them both directly through reminders about the date and indirectly through brochures, posted signage, and removal of ash trays.

Hold a kick-off party on launch day to celebrate your facility's tobacco-free status and its commitment to health.

STEP 9
MONITOR AND EVALUATE

After implementation, the tobacco-free policy will have to be monitored and reevaluated as needed. You can expect some push back and negative reactions from patients as well as staff. Negative reaction from staff is driven mainly by anticipation and anxiety. Staff may worry how the policy will affect the agency, how it will affect the patients, and their relationships. All of these concerns can be alleviated through continual education.

ASSESSMENT AND TREATMENT OF PATIENTS

It is important to know the stage of readiness your patients are in when beginning the cessation discussion. Interventions need to be tailored to the patient based on their readiness for change. The Stages of Change Model can be used to help your patients in their tobacco cessation journey:

Stage of Change	Definition	Action
Pre-contemplation	Patients in this stage are not considering quitting. They often become defensive if asked about their smoking behaviors. At this stage, patients are not likely to be receptive to messages about cessation.	Educate and inform
Contemplation	Patients in this stage are considering quitting in the near future but are not quite ready to quit. They can be more receptive to receiving information about smoking and are aware of the consequences.	Encourage and motivate
Preparation	In this stage, patients are getting ready to quit. They have made the decision and are ready to stop smoking in the near future.	Help with setting goals
Action	Patients are actively trying to quit smoking. This stage can last about six months.	Provide support and assist with barriers
Maintenance	The patient has been in their quit attempt for longer than six months. They have remained a non-smoker by learning to handle their temptations. Slip-ups may occur, but they are used as learning opportunities.	Continued support, set new goals if necessary when ready

5 A'S – ASK, ADVISE, ASSESS, ASSIST, ARRANGE

The Treating Tobacco Use and Dependence guideline recommends providing brief interventions (less than 10 minutes). Evidence states that providers can make a difference even with small interventions (less than 3 minutes). Interventions can even help when patients/clients are not willing to make a quit attempt at that time. The intervention can help with motivation of future quit attempts.[14] The five major components (5 A's) of brief interventions are listed below.

The subsequent material is modified from Treating Tobacco Use and Dependence: 2008 Update. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html

ASK ABOUT TOBACCO USE

Action	Strategies for Implementation
Implement a system that guarantees that all patients are **asked** about tobacco use status at every visit. Use should also be documented.	Include tobacco use status in the recording of vital signs TOBACCO USE (circle one): Current Former Never

ADVISE THE PATIENT/CLIENT TO QUIT

Action	Strategies for Implementation
In a clear, strong, and personalized manner, **advise** every tobacco user to quit.	Clear: "It is important that you quit smoking, and I can help you." Strong: "I need you to know that quitting smoking is the most important thing you can do for your health." Personalized: Tie tobacco use to current symptoms and health issues, social/economic cost, and the impact on other persons in the household.

ASSESS THE WILLINGNESS TO MAKE A QUIT ATTEMPT

Action	Strategies for Implementation
Assess every tobacco user's willingness to make a quit attempt.	"Are you willing to give quitting a try?" • If the patient is willing, provide assistance. • If the patient is unwilling, provide further interventions to motivate future quit attempts.

ASSIST IN THE QUIT ATTEMPT

Action	Strategies for Implementation
Assist the patient with their quit plan.	Set a quit date. The quit date should be within the next 2 weeks. Tell family, friends, and coworkers about quitting, and request their support and understanding. Anticipate triggers and challenges to the upcoming quit attempt, including nicotine withdrawal symptoms. Remove tobacco products from the environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g. home, auto, work). Make your home smoke-free.
Recommend FDA approved nicotine replacement therapy (NRT) with counseling or other behavioral therapies.	Recommend the use of medications. Explain how these medications increase quitting success and reduce nicotine withdrawal symptoms.
Provide supplemental materials, including information on support and quit phone lines.	California Smokers' Helpline 1-800-NO-BUTTS

ARRANGE A FOLLOW UP

Action	Strategies for Implementation
Arrange for follow-up contacts.	Follow-ups should begin during the first week after the set quit date. A second follow-up should be scheduled within the first month. Identify problems encountered by the patient and anticipate future challenges. Assess medications. Remind patients of support and quit lines. Address tobacco use at next visit. Congratulate patients on successes. If the patient has used tobacco again, review the circumstances when they smoked, and use as a lesson. Elicit a recommitment to abstinence.

AAR - ASK, ADVISE, REFER

If the 5 A's model cannot be used due to time or lack of resources, briefer interventions, like the AAR method, can also be used to encourage and enhance a tobacco users' motivation to quit.

This method is similar to the longer intervention above, except for the last step. Instead of assessing, assisting, and arranging, the provider can refer patients to tobacco cessation programs. They have the option to refer to quit lines, websites, and local cessation programs.

MOTIVATIONAL INTERVIEWING

(Adapted from Treating Tobacco Use and Dependence: 2008 Update. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html)

Once your patient is identified as a tobacco user and you've determined the stage of change the patient is currently in, then motivational interviewing can be used to help motivate them towards quit attempts. Motivational Interviewing (MI) is a patient-centered counseling technique used to help people to make positive behavioral changes. This type of counseling helps patients explore and overcome their ambivalent feelings towards their harmful tobacco-use behaviors.

Many people with an addiction to nicotine do not realize that it may require several attempts before they finally quit. MI has been used to successfully help with promoting changes in patient's tobacco use and smoking cessation attempts. MI is also helpful with patients who are currently unwilling to make a quit attempt.

THE SPIRIT OF MOTIVATIONAL INTERVIEWING

Motivational interviewing is based on three key concepts: collaboration vs. confrontation, drawing out instead of imposing ideas, and autonomy rather than authority.

- **Collaboration** – based on a partnership between the patient and healthcare provider rather than confronting the patient and imposing your views upon them. When rapport and trust are built, a mutual understanding can result.
- **Evocation** - the healthcare provider works to draw out the patient's thoughts and feelings rather than imposing their opinions. Change is most likely to occur when the patient draws out their own reasons for change and aren't told what to do or why to do it.
- **Autonomy** – MI recognizes that the power to make change lies with the individual. It gives the individual responsibility for their actions.

THE PRINCIPLES OF MOTIVATIONAL INTERVIEWING

There are four different principles that guide MI. The healthcare provider needs to embrace these principles throughout treatment.

1. **Express empathy** – The interaction with the patient should be based on understanding. An empathic approach provides the foundation for a safe space where a patient feels they can share, be heard, and understood.

Use open-ended questions to explore the importance of addressing tobacco use and the patient's concerns and benefits to quitting: "How important do you think..." "What might happen if..."

Use reflective listening to gain a shared understanding, reflect words and meaning, and summarize what you have heard: "So you think..." "What I have heard..."

Normalize feelings and concerns: "Many people..."

Support the patient's right to choose or reject change: "I hear you saying..." "I'm here to help..."

2. **Develop discrepancy** – MI works to help patients examine the inconsistency of their current behaviors and their future goals. It is the healthcare providers responsibility to help the patient identify the mismatch between "where they are and where they want to be" and help them gradually move toward their goals.

Highlight the discrepancy between the patient's behaviors and expressed goals and priorities

Reinforce and support "change talk" and "commitment" language

Build and deepen commitment to change: "There are proven effective treatments..." "I would like to help you..."

3. **Roll with resistance** – It is important to not confront the patient's resistance, as opposing resistance tends to reinforce it. The idea here is to diminish and avoid any negative interaction, to just "roll with resistance." Avoid imposing your own way of thinking and the "righting reflex." If a patient is led to discover their own problems and develop their own solutions then there is little to fight against.

Use reflection and back off when resistance is expressed: "Sounds like..."

Express empathy: "You are worried..."

Ask permission to provide further information: "Would you like to hear..."

4. **Support self-efficacy** – Healthcare providers should support self-efficacy by highlighting successes, skills, and strengths. Belief that change is possible is important in the MI process.

Help patients to identity and build on past successes: "You were successful with..."

Offer options to achieve small steps to change: quit lines, benefits and strategies to quitting, and asking the patient for their ideas about quitting

5 R'S – RELEVANCE, RISKS, REWARDS, ROADBLOCKS, AND REPETITION

The areas that are addressed in motivational interviewing can be captured by the 5 R's. Research suggests the 5 R's enhance motivation to quit attempts.[15]

Relevance – Motivational Interviewing has a better impact if it is relevant to the patient's social situations, health concerns, age, gender, and other personal characteristics. Encouraging a quit attempt should be personally relevant and as specific to the patient as possible.

Risks – Patients should be asked to identify negative consequences of their tobacco use. The most relevant risks should then be highlighted.

Rewards – The patient should be asked to point out benefits of quitting tobacco. The benefits that are most relevant to the patient should then be emphasized.

Examples of rewards:

- Improved health
- Enhanced taste
- Better sense of smell
- Saving money
- Home, car, clothes and personal items will smell better
- Better overall health
- Whiter teeth

Roadblocks – The patient should also be asked to single out potential roadblocks and provide treatment options that could help with those barriers.

Barriers might include:

- Withdrawal symptoms
- Weight gain
- Depression
- Lack of support
- Relationships with other tobacco users

Repetition – Motivational interviewing should be repeated at every visit for patients who are currently unwilling to make a quit attempt. Those patients who have had previous failed attempts should be reminded that most people have several quit attempts before they are successful.

(Adapted from Treating Tobacco Use and Dependence: 2008 Update. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html)

Treatment Information

(Adapted from Treating Tobacco Use and Dependence: 2008 Update. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html)

All patients should be offered for tobacco use treatment. However, with this population, special consideration needs to be taken on when to offer treatment. Treatment should be given when the patient is not in a crisis situation or at a time when symptoms from their disorder are not severe.

Research has shown that tobacco cessation does not interfere with recovery from other substances.[17]

Because each patient is unique, treatments must be tailored to each individual. There are many options available to help become tobacco-free. The current, most effective approaches combine different treatment strategies. Interventions include: medications, counseling and behavioral therapies, education, and referrals to tobacco cessation resources and support systems.

Generally, persons with behavioral health disorders are prescribed a combination of treatments, including nicotine replacement therapy or other medications with counseling or behavioral therapy.

Studies have shown that more intensive counseling, which includes longer therapy sessions and a higher number of counseling sessions, relate to an increase in abstinence rates.[18] This social support is especially needed early on in quit attempts.[19]

Cessation Medication

The clinical guidelines for prescribing FDA-approved cessation medications have contradictions, warnings, precautions, as well as other concerns. Please refer to FDA prescribing information and package inserts for each medication. It is important that cessation medication be used and prescribed correctly. If they are misused or incorrectly prescribed, they can be rendered ineffective.

The seven FDA-approved nicotine-replacement therapy medications that have been proven effective in helping people stop using tobacco are:

Pharmacotherapy	Prescribing Information
NICOTINE GUM	Available over the counter. The most common reported side effects are mouth soreness, dyspepsia, jaw ache and hiccups. The recommended dosage for those who smoke 1-24 cigarettes/day is 2 mg gum. For those who smoke more than 25 cigarettes/day, it is 4 mg gum. The gum should be chewed slowly until the user can taste the nicotine or feel a tingling sensation in your mouth. The user should then stop chewing and park the piece of gum between their cheek and gums. After about a minute, when the tingling is almost gone, start chewing again. Repeat this process until the tingle is gone (about 30 minutes). The gum should be used for up to 12 weeks with no more than 24 pieces to be used per day.

NICOTINE PATCH	Available over the counter and by prescription. The most common reported side effects are local skin reactions, insomnia, and vivid dreams. The recommended step-down dosage is at 21 mg/24 hours for 4 weeks, 14 mg/24 hours the next 2 weeks, 7 mg/24 hours the next 2 weeks. The recommended single dosage is both a 22 mg/24 hours and 11mg/24 hours (for lighter smokers). Doses are available in a one-step patch regimen. The patch should be applied once a day upon waking. One patch helps relieve cravings all day. Treatment of 8 weeks or less has been shown to be effective as longer treatment periods.
NICOTINE INHALER	Available by prescription only. The most common reported side effects are local irritation of the mouth and throat. The recommended dosage is 6-16 cartridges/day; puff cartridge for up to 20 minutes, each cartridge is 4 mg, over 80 inhalations. It is recommended that the inhaler be used for up to 6 months, with gradual reduction in use over the last 6-12 weeks of treatment. Frequent puffing of the inhaler and the use of at least 6 cartridges/day has been shown to produce the best effects. Recommended duration of therapy is up to 6 months.
NICOTINE LOZENGES	Available over the counter. The most common reported side effects are mouth and throat soreness and dyspepsia. The recommended dosage is: Weeks 1-6, 1 lozenge every 1-2 hours; weeks 7-9, 1 lozenge every 2-4 hours; weeks 10-12, 1 lozenge every 4-8 hours. Use the 4 mg dose if smoking first cigarette within 30 minutes of waking. Use the 2 mg dose if smoking first cigarette after 30 minutes of waking. Smokers should use at least 9 lozenges per day in the first 6 weeks. The lozenge should be used for up to 12 weeks, with no more than 20 lozenges to be used per day.

BUPROPION-SR	Available by prescription only. The most common reported side effects are insomnia and dry mouth. Patients should begin treatment 1-2 weeks before their quit date. The recommended dosage is 150 mg every morning for 3 days, then 150 mg two times a day. Dosage should not exceed 300 mg per day. Dosage should continue for 7-12 weeks. Precautions should be taken for people who have a history of seizures, history of eating disorders, diagnosis of bipolar disorder, and monoamine oxidase inhibitors (MAOI) within 2 weeks.
VARENICLINE	Available by prescription only. The most common reported side effects are nausea, trouble sleeping, abnormal dreams, and constipation. Patients should start treatment 1 week before quit date; 0.5 mg a day for 3 days, then increase to 0.5 mg twice a day for 4 days, then increase to 1 mg twice a day for 3 months. Patients should be instructed to quit smoking on day 8 when dosage is increased to 1 mg/twice daily. Precautions should be taken for people who have psychiatric illness, significant kidney disease, and individuals who drive or operate heavy machinery.

*ALWAYS CONSULT FULL PRESCRIBING INFORMATION BEFORE INSTRUCTING PATIENTS/CLIENTS TO START ANY NRTS.

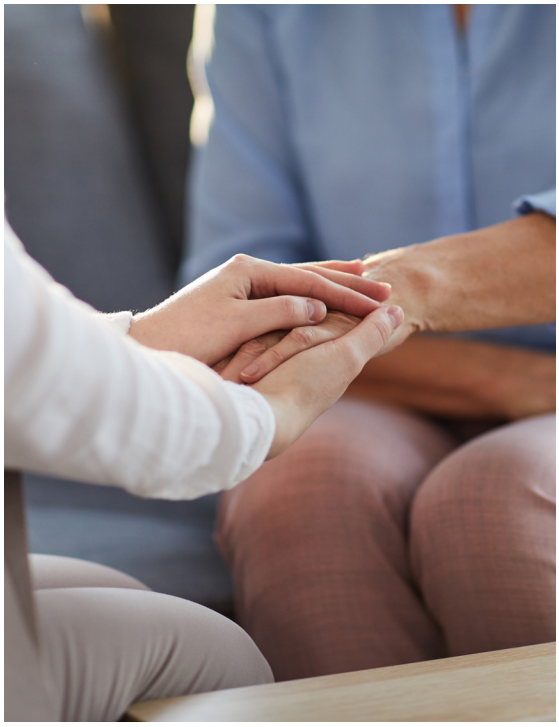
It is important that providers understand how tobacco interacts with psychiatric medications. Adjustments and monitoring of medication levels need to happen as a patient quits tobacco usage. As tobacco interacts with these medications to decrease their effectiveness, dosages of psychiatric medications may need to be changed as tobacco use stops. It is important that your patient not have high medication levels as their tobacco use decreases -- this will cause adverse effects.

THE FOLLOWING MEDICATIONS NEED TO BE MONITORED:

ANTIPSYCHOTICS	Chlorpromazine (Thorazine) Fluphenazine (Permitil) Mesoridazine (Serentil) Thiothixene (Navane) Ziprasidone (Geodon)	Clozapine (Clozaril) Haloperidol (Haldol) Olanzapine (Zyprexa) Trifluoperazine (Stelazine)
ANTIDEPRESSANTS	Amitriptyline (Elavil) Desipramine (Norpramin) Duloxetine (Cymbalta) Imipramine (Tofranil) Nortriptyline (Pamelor)	Trazodone (Desyrel) Clomipramine (Anafranil) Doxepin (Sinequan) Fluvoxamine (Luvox) Mirtazapine (Remeron)
MOOD STABILIZERS	Carbamazepine (Tegretol)	
ANXIOLYTICS	Alprazolam (Xanax) Diazepam (Valium)	Lorazepam (Ativan) Oxazepam (Serax)
OTHERS	Acetaminophen (Requip) Caffeine Heparin Insulin	Rasagiline (Azilect) Riluzole (Rilutek) Ropinirole Tacrine

COUNSELING AND BEHAVIORAL THERAPIES

Two counseling approaches are often used to help patients stop their tobacco use: practical and supportive counseling. Practical counseling teaches problem solving and relapse prevention skills, provides skills training, basic information about the harmful effects of tobacco, the benefits of quitting, and nicotine withdrawal symptoms. Supportive counseling provides support in the treatment program or a referral to a smoking cessation program. It provides encouragement, gives examples of success stories, and communicates caring and concern.



Counseling treatment formats include individual, group, and telephonic. Patients should be asked which type of treatment format they prefer and should be encouraged to use pharmacology along with behavioral interventions. If counseling treatment cannot be offered in person, a patient's quit attempt can still be supported by referring them to the CA Smokers' Helpline. Quit line information can be found on the Cessation Resources page of this toolkit.

RELAPSE PREVENTION

(Adapted from Treating Tobacco Use and Dependence: 2008 Update. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html)

For most people, quitting is not something that happens overnight, quitting is a journey. Relapse is a common occurrence on that quitting journey. Though most relapses occur in the first few days after quitting, some relapses occur months or years after a person's quit date. Many smokers may need repeated assistance to maintain abstinence over the course of their lifetime.

It is important to remember that a lapse is not a failure but an opportunity to learn useful information. A lapse can provide critical insight on triggers: when, why, and how it occurred. It can provide insight on how to anticipate any future occurrences so a relapse prevention plan can be developed.

Relapse prevention interventions are essential to help patients maintain smoking cessation over time. Approaches to relapse prevention are diverse and can be personalized to each individual.

Minimal interventions can be utilized at every encounter with the patient. Congratulate every former tobacco user on any successes during relapse prevention. Strongly encourage them to remain tobacco-free. Encourage discussions on: the benefits of quitting, success during the quit attempt, and any problems encountered during the quit attempt.

More intensive interventions can be used when a patient has expressed a problem that threatens their abstinence. Potential responses for common problems can include:

Lack of support for cessation:

- Schedule visits/calls
- Identify support sources
- Refer to local support groups
- Urge the patient to call the CA Smokers' Helpline

Negative mood or depression:

- Provide counseling
- Appropriate medications
- Referrals

Strong or prolonged withdrawal:

- Verify dosage of medication
- Extend use of medication
- Add other medications (combined therapy)

Weight gain:

- Encourage physical activity
- Discourage strict dieting
- Longer pharmacotherapy

Reduced motivation:

- Reassure
- Recommend rewarding activities
- Educate

Stressful event or interpersonal stress

- Identify short-term management skills
- Develop lifestyle changes

FREQUENTLY ASKED QUESTIONS

1 Why are we establishing a tobacco-free policy?

As healthcare providers, we are dedicated to improving the health of our staff, patients, and community. A tobacco-free policy will give us the opportunity to show our commitment to creating a safer and healthier community for all.

2 Do we have a right to smoke (use tobacco)?

No, no one has a legal right to smoke. Our organization does have a right to create a tobacco-free environment within our buildings and on our grounds.

3 How will we inform patients, visitors, and vendors of our new tobacco-free policy?

The tobacco-free policy will be announced through informational materials, trainings, and posted signs. The policy will be discussed with staff, to prepare for the change. Neighbors will also be informed through letters about the policy change.

4 How will this new policy be enforced?

To achieve maximum compliance, the policy will be enforced through communication. Everybody needs to be consistently reminded of the policy. Staff who witness infractions, of any kind, are asked to remind the person of the policy using a scripted phrase. If staff is uncomfortable with approaching and reminding any parties that are violating the policy, they can inform a supervisor of the violation.

While the policy is not meant to be enforced punitively, repeated violations could result in disciplinary action.

5 Will people be allowed to smoke on public property adjoining our property, such as the public sidewalk?

We must be respectful of our neighbors, so we are asking that staff, as well as patients, do not loiter near our organization's property to smoke. This includes public places like sidewalks and bus stops.

6 Can I smoke in my car?

Smoking inside your car is permitted if your car is parked off grounds and not located in a parking lot that is on the organization's property.

7 Who needs to follow this policy?

Everyone, including but not limited to: staff, clients, visitors, and vendors on the organization's property needs to follow the policy.

8 Can I use FDA-approved nicotine replacement therapy (NRT) products at work?

Yes, we encourage the use of FDA-approved NRT to help manage cravings while on-site.

NATIONAL TOBACCO CESSATION RESOURCES

AMERICAN CANCER SOCIETY
www.cancer.org

AMERICAN HEART ASSOCIATION
www.heart.org

AMERICAN LUNG ASSOCIATION
www.lung.org/stop-smoking/

AMERICAN PUBLIC HEALTH ASSOCIATION
www.apha.org

ASSOCIATION FOR THE TREATMENT OF TOBACCO USE AND DEPENDENCE
www.attud.org

CENTERS FOR DISEASE CONTROL AND PREVENTION
www.cdc.gov/tobacco/

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS
www.nasmhpd.org

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)
https://www.drugabuse.gov/drugs-abuse/tobacconicotine-e-cigs

NICOTINE ANONYMOUS
www.nicotine-anonymous.org

QUITLINE 1-800-QUIT-NOW
www.smokefree.gov/quitlines-faq.aspx

SMOKING CESSATION LEADERSHIP CENTER
http://smokingcessationleadership.ucsf.edu/

SOCIETY FOR RESEARCH ON NICOTINE AND TOBACCO
www.srnt.org

U.S. SURGEON GENERAL
www.surgeongeneral.gov

LOCAL TOBACCO CESSATION RESOURCES

GROUP SETTING

SAINT AGNES MEDICAL CENTER PLAZA - FREEDOM FROM SMOKING

Location: Medical Center Plaza, 1111 E. Spruce Ave., Leopard Room, 2nd Floor, Fresno, CA 93720

When: Meets in person from 10:00AM - 2:00PM

Other Languages: Spanish

(559) 450-2673

SAINT AGNES MEDICAL NORTHWEST - FREEDOM FROM SMOKING

Location: Northwest Building 4770 W. Herndon Ave., Fresno, CA 93720

When: Meets in person on Wednesdays, September 5-24 from 6:00PM-8:00PM & Wednesdays, October 31 to December 19 from 6:00PM-8:00PM.

Other Languages: Spanish

(559) 450-2673

PHONE-BASED

CA SMOKERS' HELPLINE

Languages: Available in English, Spanish, Vietnamese, Korean, Mandarin & Cantonese

A text messaging service is also offered. Registration is on the CA Smokers' Helpline website. The service provides extra support through tailored messages. Questions can also be sent to counselors through the messaging system.

Providers can also refer their clients online through a web-based referral interface. It is a quick and easy way to refer patients to the free cessation services.

1-800-NO-BUTTS
WWW.NOBUTTS.ORG

SMOKEFREE.GOV

Cost: No charge

Other Languages: Spanish

Other Information: Educational resources and live help through instant messaging. Text messaging service is also available. Text "Quit" to iQuit (47848)

1-800-QUIT-NOW
WWW.SMOKEFREE.GOV
WWW.ESPANOL.SMOKEFREE.GOV
WWW.WOMEN.SMOKEFREE.GOV
WWW.TEEN.SMOKEFREE.GOV

WEB-BASED

FREEDOM FROM SMOKING
American Lung Association

Cost: No charge for basic membership. Premium membership is $99.95 for 12 months.

1-800-LUNGUSA
WWW.FFSONLINE.ORG

BECOME AN EX
Robert Wood Johnson Foundation

Cost: No charge

Other Information: Program contains educational resources and strategies

BECOMEANEX.ORG

MEMBERS ONLY

NO BUTTS PROGRAM
CalViva Health

Cost: No charge to CalViva Health members

Other Languages: Spanish

Other Information: For Medi-Cal members only. Clients are referred to the No-BUTTS programs for additional information and assistance.

1-800-804-6074
CALVIVAHEALTH.ORG

QUIT TOBACCO
Kaiser Permanente

QUIT FOR LIFE
Kaiser Permanente

Cost: No charge to members

Other Languages: Spanish

Other Information: In-person counseling. Registration required.

(559) 448-4415

1-800-462-5327
QUITNOW.NET/KPWA

VETERANS SERVICES

VA TOBACCO QUITLINE

Other Languages: Spanish

Other Information: Quitline counselors offer continued support through follow-up calls and counseling

1-855-QUIT-VET

SMOKEFREEVET

The SmokefreeVET text message program will provide you with daily advice and support

TEXT VET TO 47848
SMOKEFREE.GOV/VET OR

SPANISH: TEXT VETESP
TO 47878
SMOKEFREE.GOV/VETESPANOL

TRAIN TO QUIT
Veterans Affairs

Cost: No charge to members with Tricare

Other Information: For military personnel and families. Interactive web-based support that tracks your progress and prepares you to quit tobacco for good. Also phone-based. Has 24/7 online live chat service.

703-693-8619
WWW.UCANQUIT2.ORG

STAY QUIT COACH

This mobile app was designed to help you quit smoking. Use it to develop a customized plan, taking into account your personal reasons for quitting. It will provide information, motivational messages, interactive tools for dealing with urges, and support to help you stay smoke-free.

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APPENDIX 1

SAMPLE TOBACCO-FREE POLICY

As of [DATE], [ORGANIZATION] will implement a 100% tobacco-free environment policy. No use, sale, or bartering of any tobacco products will be allowed by any employees, clients/patients, visitors, volunteers, and vendors on any of [ORGANIZATION]'s facilities or grounds.

It is required that people do not use tobacco on [ORGANIZATION]'s facilities and grounds or use tobacco products during paid work time. Employees will not be allowed to smoke or use any tobacco products during their paid work time (breaks) and are encouraged not to use tobacco products during their unpaid work time (lunch).

Background and Intent:

[ORGANIZATION] recognizes that the use of tobacco products on our grounds is harmful to the health and safety of everyone. We support an environment where employees, clients/patients, and visitors are not exposed to the harmful effects of tobacco use and are supported in their efforts to live 100% tobacco-free. Tobacco use continues to be the leading cause of preventable death in the United States. Those with behavioral health conditions and substance abuse disorders account for 44% of all cigarettes smoked in the United States.[1] People with serious behavioral health conditions die 25 years earlier than those without these conditions, often from tobacco-related illnesses including cancer, heart disease, and lung disease.[2] The death rates among tobacco users with substance abuse disorders is also four times higher than that of non-tobacco users.[3] Quitting tobacco is a desirable and achievable goal for behavioral health and substance abuse disorder clients/patients to improve their health and add years to their lives.

Definitions:

Tobacco products – Any product containing, made, or derived from tobacco or nicotine that is intended for human consumption, whether smoked, heated, chewed, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, including, but not limited to cigarettes, cigars, little cigars, chewing tobacco, pipe tobacco, snuff; and any electronic device that delivers nicotine or other substances to the person inhaling from the device, including, but not limited to, an electronic cigarette, electronic cigar, electronic pipe, or electronic hookah.

Notwithstanding any provision of subsections (1) and (2) to the contrary, "Tobacco Product" includes any component, part, or accessory intended or reasonably expected to be used with a Tobacco Product, whether or not sold separately. "Tobacco Product" does not include drugs, devices, or combination products authorized for sale by the United States Food and Drug Administration, as those terms are defined in the Federal Food, Drug and Cosmetic Act.

Facilities or grounds – Facility-affiliated buildings, organization-owned or leased grounds, parking lots, organization-owned or leased vehicles, sidewalk or streets within [ORGANIZATION] property lines, personal vehicles used in the course of work whenever other employees or another person is in the vehicle for work-related reasons, and clients/patients attending off-site activities. As well as, properties where off-site work activities are taking place and employees are representing [ORGANIZATION].

Employee and Volunteers – Any person who is employed or retained as an independent contractor by any employer in consideration for direct or indirect monetary wages or profit, or any person who volunteers his or her services for an employer.

Procedures:

All [ORGANIZATION] employees are required to be familiar with this policy. It is also required that all employees, clients/patients, visitors, volunteers, and vendors adhere to this policy.

1. **Employees and Volunteers:** Job announcements for all positions will include a notice that [ORGANIZATION] has a tobacco-free environment policy. All prospective volunteers and employees will receive reminders of the policy during the first interview, prior to hire, and at orientation. All current employees and volunteers will receive a copy of this policy and will be provided refresher training annually as needed.
2. **Clients/Patients:** Will be assessed and screened for history and current use of tobacco at admission as part of their initial assessment. This must also be recorded in their record. History and use will include: age of onset, duration of use, dosage of use, methods of use, previous attempts to stop, nicotine replacement therapy and FDA approved medications used, and previous cessation education.

   A tobacco treatment plan will be developed for all clients/patients with tobacco dependence. The plan will include appropriate evidence-based tobacco dependence treatment. If a patient is not yet ready to quit, this will include specific interventions designed to increase motivation to quit. Discharge plans will include a plan to remain tobacco-free and, should relapse occur, a specific plan for the re-establishment of tobacco dependence treatment.
3. **Visitors and Vendors:** Any new visitor will be informed of this policy from the employees before they are allowed to visit with the client/patient. New visitors and vendors will be handed a brochure with information about the tobacco-free policy, as well as, quitline information. Repeat visitors and vendors will be reminded about the tobacco-free policy and to not provide any tobacco products to clients/patients.

Accountability:

It is the shared responsibility of all [ORGANIZATION] employees to enforce the tobacco-free policy by encouraging compliance from all. Employees should communicate the policy to clients/patients, visitors, and others with respect and courtesy. The policy will also be communicated through a variety of other methods, including signs that will be posted at entrances and other selected locations outside the facility and grounds.

1. **Employees and Volunteers:** Repercussions for policy violations may include, progressive discipline culminating in corrective or disciplinary action as defined in Human Resources and Employee policies. Volunteers who continually violate the policy will be relieved of duty until they agree to comply.

Violation	Action
FIRST	Verbal intervention – Review the policy. Give clear expectation that it is not to reoccur. Review cessation materials and provide other resources (counseling, medication, and quitline information) and support to help with compliance.
SECOND	Repeat first offense interventions. Document discussion in supervisory log. Refer to first coaching to make expectation clear in writing. Sign and have employee sign the written warning. Review resources and support to help with compliance.
THIRD	Present the employee with a Performance Improvement Plan clearly stating the expectation and consequences if the policy is violated again. Clarify that violation will affect performance review and may result in further corrective action including suspension.
FOURTH	Document the new infraction and forward all previous documentation to the appointing authority for consideration of a meeting for corrective or disciplinary action including status, or tenure, or possible termination.

2. **Clients/Patients:** Violation of policy is a treatment issue to be addressed by the treatment team and as a disciplinary issue if violations persist.

Violation	Action
FIRST SECOND THIRD	Verbal Intervention – Review the policy with client/patient. Inform treatment team to provide assistance with NRT and alternative therapies to continue with compliance.
FOURTH	Treatment team should meet with leadership to discuss appropriate further actions, including discharge

3. **Visitors and Vendors:** Anyone who persists in violating this policy will be asked to leave the premises and may return when they are willing to comply with the policy. Violators may be reported to [NAME OF APPROPRITE DEPARTMENT OR PERSONNEL]. [DEPARTMENT OR PERSONNEL] will respond to the situation, as appropriate. Repeated violations may result in termination of visiting privileges.

Violation	Action
FIRST SECOND THIRD	Verbal Intervention – Review the policy and perimeter of the facility and grounds.
FOURTH	Report to appropriate personnel or security. The appropriate personnel will respond to the situation, as appropriate. Actions may include termination of visiting privileges.

Resources and Support:

Those tobacco users who are interested in quitting will be given information regarding tobacco treatment resources and support. [ORGANIZATION] understands that people who use tobacco need support to live tobacco-free lives. Because of this, resources will be offered to both employees and clients/patients to aid them in their process of quitting tobacco. This may include tobacco cessation counseling and quitline information, as well as, facilitation to where and how to receive cessation medication.

Resources and Support:

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APPENDIX 2

SAMPLE ANNOUNCEMENT TO STAFF

To all Staff Members,

All of us at [ORGANIZATION] are committed to improving the health of our patients and staff. We all are aware that tobacco-use creates health issues. Therefore, to promote health and create a healthy environment, our grounds will become tobacco-free on [DATE].

This policy will create an environment where no tobacco-use will be permitted. Staff is free to continue smoking on their own time, off [ORGANIZATION]'s grounds. Those who are considering quitting may decide to do so at this time, and we are committed to helping any staff who needs support in their quit efforts.

To assist those who want to quit, [ORGANIZATION] will provide cessation resources. The Fresno County Department of Public Health's Tobacco Prevention Program also has more information on cessation classes and other quit-smoking resources. The California Smokers' Helpline also offers telephone counseling free of charge at 1-800-NO-BUTTS.

Over the next months, look for information and details on the Tobacco-Free Campus Initiative. If you have any questions about the policy, please contact [NAME] in Human Resources, at (000) 000-0000.

Signatures of:

APPENDIX 3

SAMPLE LETTER TO PATIENTS

To all of Our Patients:

Beginning on [DATE], [ORGANIZATION] will be adopting a campus-wide, tobacco-free policy. This policy means that all patients, visitors, and staff are prohibited from using any tobacco products anywhere in [ORGANIZATION] buildings or on outside grounds.

We have joined treatment facilities across the country that have become tobacco-free. We are committed to providing the healthiest possible environment for patients, employees, and visitors.

Upon your admission, our staff will ask about tobacco-use. This information will be used to help you quit, provide tobacco-cessation products, and discuss other resources available to you.

Thank you for your cooperation with the Tobacco-Free Campus Initiative and for helping us maintain a healthier environment for everyone.

If you choose to quit or cut back on tobacco-use, we are happy to talk with you about your quit effort. The California Smokers' Helpline also offers telephone counseling free of charge at 1-800-NO-BUTTS.
Sincerely,

[NAME]

APPENDIX 4

SAMPLE LETTER TO NEIGHBORS

Dear [NEIGHBOR],

Effective [DATE], our organization will take a stance on the major public health issue of tobacco use. As an organization, we will be implementing a tobacco-free policy at [LOCATION]. The tobacco ban will apply to all employees, patients, visitors, and vendors. Our tobacco-free policy will prohibit the use of tobacco of any kind on [Organization]'s grounds.

We are not asking our employees or patients to stop using tobacco, rather we are creating a healthy environment by asking them to refrain from use on our property. To assist with the creation of a healthier, supporting environment for cessation, [ORGANIZATION] is developing programs and providing other resources for employees and patients.

Though we do not approve of it, some employees and patients may leave the grounds to use tobacco products. We have asked them to take you and your property into consideration during this process. If you notice any problem behaviors related to tobacco-use or not, please reach out to us at the contact information below.

As an organization, we are committed to eliminating the use of tobacco in our community. Our mission is to protect and promote health. Implementing a tobacco-free policy allows us to take steps towards completing that mission.

We appreciate your help during this process.

Sincerely,
[NAME OF CONTACT PERSON]
[TITLE]
[CONTACT INFORMATION, PHONE, EMAIL ADDRESS]