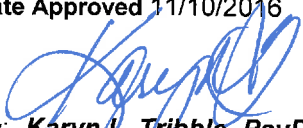
	<p>Date Approved 11/10/2016</p>  <p>By: <u>Karyn L. Tribble, PsyD, LCSW</u> Deputy Director, for</p> <p>Manuel J. Jiménez, Jr., MA, MFT Behavioral Health Director</p>
<p>POLICY TITLE</p> <p>Provider Tobacco Policies and Consumer Treatment Protocols</p>	<p>Policy No: 1901-1-1</p> <p>Date Effective: 11/10/2016 Date Revised:</p>

PURPOSE

This policy is intended to aid ACBHCS consumers/clients in quitting tobacco¹ which is in alignment with the SAMHSA 10 X 10 campaign to reduce the disparity in life-expectancy among behavioral health consumers/clients in comparison with the general population. The need for this policy is evidenced by the following:

- I. Cigarette smoking is the chief preventable cause of morbidity and mortality in the U.S. Research has found that people with serious mental illness die, on average, 25 years earlier than the general population. It is estimated that 40% of this is due to smoking cigarettes. ACBHCS supports the SAMHSA 10x10 Wellness Campaign (to increase life expectancy by 10 years for those with Serious Mental Illness).

Consumers/clients with mental health, substance use and, those with co-occurring conditions smoke at significantly higher rates (60-90%) than the general population. Tobacco/nicotine dependence is an addiction, that like all other addictions, can interfere with a consumer's ability to recover and live a healthy life. Mental health consumers/clients have been shown to have improved mental health once they quit smoking. Quitting smoking can increase opportunities for employment, housing and social contact; improves finances; and generally decreases stigma.

- II. ACBHCS is committed to addressing and treating Tobacco Use Disorder in all of our programs. Tobacco use is the number one killer of our consumers/clients and severely affects their health and well-being. Therefore, we believe that promoting and assisting with the process of quitting smoking/tobacco use for all consumers/clients/staff who use tobacco is integral to the mission of the Department and that the DSM diagnosis of Tobacco Use Disorder should be integrated into mental health and SUD treatment.

¹All references to tobacco in this policy refer to any and all types of tobacco products. Smoking means inhaling, exhaling, burning, or carrying any lighted, heated, or ignited cigar, cigarette, cigarillo, pipe, hookah, bidi, kretek, Electronic Smoking Device, or any plant product used for human inhalation. Tobacco products include smokeless products: snuff, snus, dip, spit, smokeless, dissolvable, chew, or dip. Electronic Smoking Device or E-cigarette means any device with a heating element, a battery, or an electronic circuit that provides nicotine or other vaporized liquids to the user in a manner that simulates smoking tobacco. This policy includes any tobacco product or nicotine delivery system that is yet to be invented except products specifically tested for safety and efficacy and approved by the FDA (Federal Drug Administration) for treatment of tobacco use disorder/tobacco cessation.

- III. These policies are intended to provide all consumers/clients (those who smoke/use tobacco and those who don't) with a welcoming smoke and vapor free environment while protecting consumers/clients and staff from harms of second hand smoke. They are also intended to protect non-smoking consumers/clients from starting or relapsing to tobacco and to support those interested in quitting to be successful.

AUTHORITY

BHCS is a recipient of some Tobacco Master Settlement Agreement funds, and as such, BHCS County staff and each CBO funded through BHCS are required to adopt, implement, and comply with a comprehensive tobacco control policy. BHCS has adopted the Tobacco Policies. CBOs funded through BHCS are required to adopt and implement the BHCS Tobacco Policies or their own version of Tobacco Policies that are approved by the BHCS Tobacco Control liaison.

SCOPE

These policies cover all ACBHCS county-operated programs in addition to entities, individuals and programs providing behavioral health services under a contract or subcontract with ACBHCS.

POLICY

This policy establishes standards regarding tobacco treatment for ACBHCS consumers/clients including protocols for staff training, Tobacco Use Disorder assessment and treatment, and requirements regarding tobacco free grounds and divestment.

PROCEDURE

I. Policies for Staff Conduct and Prohibitions

- a. ACBHCS shall prohibit smoking and tobacco use of any kind, including e-cigarettes, in all ACBHCS County owned and/or leased vehicles.
- b. Programs must abide by the minimum requirement in their city ordinance regarding restrictions of tobacco use, including e-cigarettes, near entrances and exits; unincorporated areas of the County must abide by the minimum in the County ordinance (at least 25 feet). Programs must post "No Smoking" signs in prominent locations. Additionally, the policy will be in place at all ACBHCS and ACBHCS contractor sponsored events – whether on or off the premises.
- c. Staff shall not smoke in sight of consumers/clients nor with consumers/clients; staff shall not display tobacco paraphernalia or wear clothing that displays tobacco logos during work. ACBHCS encourages agency mandated policies that staff comply with "no evidence of tobacco use at work."
- d. ACBHCS requires all agency directors to ensure that tobacco treatment (including medication and counseling) is included in the health services offered to employees and to notify all employees regarding this resource. Agency directors are to encourage all staff at least annually to take advantage of tobacco treatment services in order to role-model healthy, addiction-free lifestyles.

II. Tobacco Use Disorder Assessment

An assessment for tobacco use, passive tobacco smoke exposure, and vapor shall be conducted at the time of the initial intake and annually to identify people who start smoking or other tobacco use in treatment. Consumers/clients, who report tobacco use and/or who have quit in the last year, should be reassessed at every follow-up visit. If consumers/clients meet the DSM criteria they will be considered to have tobacco use disorder. See Appendix for tobacco use assessment criteria.

III. Treatment

Treatment shall consist of regular follow up of Tobacco Use Disorder in each Consumer/client's Treatment Plan. Additionally:

- a. Provide all consumers/clients who smoke information about smoking and advise consumers/clients to quit by using a clear, personal, relevant, supportive message. (e.g., Note the consumer/client's health problems, interference of tobacco use with psychotropic medications, negative psychosocial behaviors associated with tobacco use, healthy living and recovery issues, as well as the financial burdens of tobacco use.) This information must be included in all on-site Healthy Living/Wellness groups.
- b. Provide all consumers/clients who smoke with ongoing Tobacco Use Disorder treatment appropriate to their Stage of Change as part of the client/consumer's treatment plan. This includes the 5A's (Ask, Advise, Assess, Assist and Arrange), appropriate motivational interviewing and providing counseling and access to tobacco treatment medications which may be supplemented by referrals for those who want to quit.
- c. Involve and educate families about how to support teen and adult consumers/clients who are trying to quit smoking.
- d. Passive tobacco exposure of children, youth and adults shall be followed up by providing support to help caregivers who smoke to address tobacco use.
- e. Housing providers are expected to provide safe tobacco-free environments and support residents to quit smoking.
- f. Involve consumers/clients in decision-making related to addressing tobacco when possible.

IV. Staff Training

All service providers will develop the capacity to perform Tobacco Use Disorder treatment interventions in their program.

- a. Clinical staff will receive a minimum of six documented hours of training in evidence-based Tobacco Use Disorder treatment protocols, including how to use Nicotine Replacement Therapy and medications that can benefit consumers/clients to quit smoking/other tobacco use and achieve a fuller recovery. This training can be attained through webinars, classes or by county sponsored skill building tobacco training at ACBHCS. (See appendix for a list of training opportunities.)
- b. Clinical staff will become proficient in evidence-based Tobacco Use Disorder treatment interventions and provide services to consumers/clients using this knowledge.
- c. Providers will provide one to two hours of on-site Tobacco training for all staff each year. Training will include basic tobacco education and the effects of secondhand smoke and will address ACBHCS' tobacco policy and treatment protocols as

specified in this document. Trainings may also include staff skill building workshops to enhance capabilities to address and to treat client/consumer tobacco use. Trainings can be through webinars, classes or on-site training provided by the ACBHCS tobacco consultants. (See appendix for a list of training opportunities.)

- d. Trainers must be knowledgeable about and train staff to provide evidence-based tobacco treatment protocols as outlined in the guidelines provided by, but not limited to: SAMHSA, the US Public Health Service, the American Psychiatric Association, and the National Association of State Mental Health Program Directors (NASMHPD).

V. Procedures to be completed in the event of a breach

Refer to the policy on policies.

CONTACT

BHCS Office	Current as of	Email
Julie Mills, Tobacco Control liaison	1/8/16	jmills@acbhcs.org

DISTRIBUTION

Copies of this policy shall be distributed to all current and future employees, posted on County and contract provider premises and available for inspection upon request. Additionally, copies of this policy shall be distributed to all ACBHCS county employees, ACBHCS contract providers and their staff, along with consumers/clients.

This policy will be distributed to the following

- ACBHCS Staff
- ACBHCS County and Contract Providers
- Public

HISTORY

Original Author: Stan Taubman, Ph.D.

Original Date of Approval: 1/1/2003 by Barbara Majak, MPH

Revise Author	Reason for revise	Date of Approval by (Name)
Lupe Mariscal	In keeping with original plan to convert guidelines to policies, the guidelines were transitioned to policies in 2011.	7/1/2011
Julie Mills	In 2015 Leadership asked that the policies be revised to fit the new policy format and clearly designate which components are requirements.	TBD

In 2002, following a settlement from a multi-state lawsuit against the tobacco industry, all public and private entities receiving Master Settlement Agreement funds in Alameda County were required to implement and comply with a comprehensive tobacco control policy. BHCS is a recipient of some of these funds, and as such, BHCS County staff and each CBO funded through BHCS was required to adopt and implement the BHCS Tobacco Guidelines on 1/1/2003. Monitoring for compliance with the Tobacco Guidelines was implemented as part of the annual contract monitoring procedure conducted by BHCS.

In 2011, the policies were revised and became effective 7/1/2011. BHCS' Co-Occurring Change Agents' Steering Committee and Tobacco Committee; Alcohol, Tobacco and Other Drug (ATOD) Network; and the BHCS Executive team worked on the revisions of these policies which were then approved by the Executive Team.

In 2015, the policies were once again revised by the BHCS tobacco consultants and liaison and approved by the Executive team.

- I. There is evidence that with appropriate treatment of Tobacco Use Disorder, mental health consumers/clients are able to quit. Consumers/clients with a Substance Use Disorder (SUD) who are treated for Tobacco Use Disorder at the same time they are treated for other substances have a 25% decrease in relapse one year post treatment compared to consumers/clients who are not treated for tobacco. (Prochaska 2004). In residential/inpatient mental health settings, programs that became tobacco free experienced a decrease in violence. (NASMHPD)
- II. BHCS acknowledges nationally recognized agencies such as SAMHSA, the U.S. Public Health Services, and the National Association of State Mental Health Program Directors (NASMHPD) have all published documents that recommend aggressive Tobacco Use Disorder treatment for patients with mental health and substance use conditions. These documents include *SAMHSA TIP 42* and *SAMHSA Advisories on Tobacco Policies and Treatment in Substance Abuse Treatment 2011*, *USPHS Guidelines for Tobacco Dependence Treatment, 2008* and *the NASMHPD Tobacco Free Toolkit, updated 2010*.

DEFINITIONS

Term	Definition
Tobacco	All references to tobacco in this policy refer to any and all types of tobacco products. Smoking means inhaling, exhaling, burning, or carrying any lighted, heated, or ignited cigar, cigarette, cigarillo, pipe, hookah, bidi, kretek, Electronic Smoking Device, or any plant product used for human inhalation. Tobacco products include smokeless products: snuff, snus, dip, spit, smokeless, dissolvable, chew, or dip.
E-cigarettes	Electronic Smoking Device or E-cigarette means any device with a heating element, a battery, or an electronic circuit that provides nicotine or other vaporized liquids to the user in a manner that simulates smoking tobacco. See BHCS website's Tobacco Treatment Resources Tab for BHCS' statement on e-cigarettes approved 1/31/13. http://www.acbhcs.org/tobacco/docs/2013/Electronic_Cigarettes_statement.pdf

APPENDIX

Alameda County Behavioral Health Care Services (ACBHCS) Provider Tobacco Policies on Clinical Training and Consumer/Client Treatment Protocols

August 5, 2016

This Appendix is designed to assist providers in implementing the ACBHCS Tobacco Policies and is intended to offer suggestions on how the policies and consumer/client treatment protocols can be integrated into existing treatment programs with little or no additional cost. All providers are encouraged to go beyond these suggestions and/or create other ways to comply that are consistent with each program's operations.

Addressing and treating tobacco will greatly reduce consumer/client stigma and discrimination: Smoking is no longer a social norm in American culture. Consumers/clients who quit smoking will increase their opportunities for employment, housing and social interaction within the broader population. Encouraging and supporting consumers/clients to quit smoking will help reduce stigma and increase their chances of a better life and social inclusion.

The Appendix is correlated to the named and numbered sections of the Tobacco Policies.

PROCEDURE

I. Policies for Staff Conduct and Prohibitions

- a. Post policy.
- b. Comply with 25 foot minimum tobacco free area.
- c. Consider having every staff member sign an agreement that the individual understands and will comply with the tobacco-free policy.
- d. Have personnel manager provide all staff with a handout listing the tobacco treatment options covered under the agency's health insurance policies. Include resources for part-time staff and volunteers who may not be insured including referral to Alameda County Federally Qualified Health Clinics (FQHC) community clinics (e.g. Alameda Health System's Wellness Centers, Asian Health Services, Axis Community Health, La Clinica, LifeLong Medical Care, Native American Health Center, Tiburcio Vasquez Health Center, Tri-City Health Center, West Oakland Health Council, etc.) as well as the free California Smokers' Helpline.

II. Tobacco Use Disorder Assessment

An assessment for tobacco use, vaping and passive tobacco smoke exposure shall be conducted at the time of the initial intake and annually to identify people who start smoking or other tobacco use in treatment. Consumers/clients, who report tobacco use and/or who have quit in the last year, should be reassessed at every follow-up visit. If consumers/clients meet DSM criteria, they will be considered to have tobacco use disorder.

Assessment of Nicotine Use and Nicotine Dependence

- **(ASK)** Current and past patterns of tobacco use (including multiple sources of nicotine)
- Severity of tobacco dependence (Heaviness of Smoking index- see below)
- **(ASSESS)** Current Motivation to quit

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- **(ADVISE)** All tobacco users to quit using a personal, relevant motivational statement.
- Breath CO level or cotinine level
- Assess prior quit attempts (number of attempts and what happened in the more recent attempts, why the consumer/consumers/client quit, how long the consumer/client was abstinent, why the consumer/client relapsed, what treatment did the consumer/client use (how was it used and for how long)
- Assess withdrawal symptoms
- Psychiatric and substance use histories - be aware that depression, anxiety, suicidality, posttraumatic stress disorder and other psychopathology may be unmasked by tobacco cessation (per ASAM Criteria 2013 Tobacco Use Disorder)
- Medical conditions- especially those related to tobacco use
- Common triggers (car, people, moods, home, phone calls, meals, places and situations etc.)
- Perceived barriers against quitting and supports for treatment success
- Preference for treatment strategy
- Assess if consumer/client is using any of the psychotropic medications that are broken down by the hepatic cytochrome p450 cyp isoenzymes. Following is a list of these psychotropic medications:
 - Amitriptyline (Elavil)
 - Nortriptyline (Pamelor)
 - Imipramine (Tofranil)
 - Clomipramine (Anafranil)
 - Fluvoxamine (Luvox)
 - Trazodone (Desyrel)
 - Fluphenazine (Prolixin)
 - Haloperidol(Haldol)
 - Olanzapine (Zyprexa)
 - Clozapine (Clozaril)
 - Chlorpromazine(Thorazine)

Because cigarette smoke stimulates these enzymes, consumers/clients who are on these medications generally require higher doses while smoking and need these doses lowered about 3 weeks after quitting smoking cigarettes.

- **(ASSIST)** By providing treatment
- **(ARRANGE)** Follow up, use teamwork and note that consumers/clients with Co-Occurring Conditions usually benefit from frequent follow-up over time.

Heaviness of Smoking Index

Use the following test to score a patient's level of nicotine dependence once they have been identified as a current or recent smoker

Please tick (☑) one box for each question		
How soon after waking do you smoke your first cigarette?	Within 5 minutes 5-30 minutes 31-60 minutes 60+ minutes	<input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0
How many cigarettes a day do you smoke?	10 or less 11 – 20 21 – 30 31 or more	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
		Total Score
SCORE	1- 2 = very low dependence 3 = low to mod dependence	4 = moderate dependence 5 + = high dependence

(Adapted from Tip 42 on Co-Occurring Conditions page 340 section on Tobacco Treatment)

III. Treatment - Treatment shall consist of regular follow up of Tobacco Use Disorder in each consumer/client's Treatment Plan. Additionally:

- a. Provide all consumers/clients who smoke information about smoking and advise consumers/clients to quit by using a clear, personal, relevant, supportive message. (e.g., Note the consumer/client's health problems, interference of tobacco use with psychotropic medications, negative psychosocial behaviors associated with tobacco use, healthy living and recovery issues, as well as the financial burdens of tobacco use.) This information must be included in all on-site Healthy Living/Wellness groups.

Treatment plans should include tobacco use as a problem for all individuals who smoke, with cessation treatment support offered for those who smoke, and prevention for those who do not smoke. "Benefits of Quitting tobacco for people in Mental Health Recovery" handout can be accessed at http://www.acbhcs.org/tobacco/docs/2014/Benefits_Quitting_MH_Recovery.pdf This handout is also available in Spanish at www.acbhcs.org under the tobacco tab under references and resources under Spanish handouts.

- b. Provide all consumers/clients who smoke with ongoing evidence-based Tobacco Use Disorder treatment as indicated in consumers/clients' treatment plan. This includes providing counseling and access to tobacco treatment medications, which may be supplemented by referrals.

Suggestions for implementation of a and b:

- Advise all consumers/clients who smoke to quit and offer assistance to help them quit when they are ready.
- Support consumers/clients who do not smoke, not to start. Support consumers/clients who have quit, to guard against relapse.

- Include issues/concerns in consumer/client treatment plans.
 - Provide all consumers/clients who smoke with information about dangers of smoking and relevant individual rationale for this recommendation. (e.g., Note the consumers/clients' health problems, interference of tobacco use with psychotropic medications, negative psychosocial behaviors associated with tobacco use, healthy living and recovery issues, as well as the financial burdens of tobacco use). See Benefits of Quitting above.
 - Include this type of information in rehab groups such as psychosocial education, wellness programming, dual diagnosis, medication management and/or anger management groups. And document the need to reduce or stop tobacco use to improve mental health or substance use impairments.
 - Contact PEERS agency (510) 832-7337 to schedule a peer-to-peer tobacco education presentation for consumers/consumers/clients in your program to help motivate consumers/clients to quit smoking.
 - Implement tobacco-free environments in order to provide a supportive environment for consumers/clients to quit smoking, and also protect those who have quit from relapse.
 - Provide staff training on how to improve your tobacco interventions. BHCS Tobacco Consultants can provide this training and assistance on site free of charge.
 - Evidence-based tobacco treatment for those ready to quit consists of a combination of one or more of the seven FDA approved tobacco treatment medications (nicotine patch, gum, lozenge, inhaler, nasal spray, varenicline and bupropion) AND counseling. Consumers/clients should receive cognitive-behavioral counseling focused on the most effective types of counseling per the 2008 Treating Tobacco Use and Dependence Update: practical counseling and social support.
 - California Smokers Helpline is an additional useful free resource that provides relapse sensitive counseling. It often helps consumers/clients to be willing to use the Helpline when you explain that they have paid a lot for this service through tobacco taxes on their cigarettes and they deserve to use it.
 - All consumers/clients smoking at least 5 cigarettes per day should be informed of at least some of the FDA approved tobacco treatment medications that are proven to be safe and effective and strongly encouraged to use medication to help their quit attempt because of the high risk of significant withdrawal.
- c. Involve and educate families about how to support teen and adult consumers/clients who are trying to quit smoking.

Suggestion for implementation – Include these issues/concerns in consumers/clients' treatment plans:

- Provide tobacco education and information to families on how to support their teen to quit smoking. This may also include information on how family members can quit smoking, i.e. refer to the CA Smokers' Helpline (1-800-NO-BUTTS) or proactively web refer at <https://forms-nobutts.org/referral/> with the consumers/client's consent.
- Include this type of information in rehab groups such as psychosocial education, wellness programming, dual diagnosis, medication management and/or anger management groups. And document the need to reduce or stop tobacco use to improve mental health or substance use impairments.
- Implement tobacco-free environments in order to provide a supportive environment for consumers/clients to quit smoking, protect consumers/clients and staff who do not smoke, and also protect those who have quit from relapse and to protect staff and consumers/clients from the dangers of second hand smoke.

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- Contact PEERS agency (510) 832-7337 to schedule a peer-to-peer tobacco education presentation for consumers/clients in your program to help motivate consumers/clients to quit smoking.

d. Passive tobacco exposure of children, youth and adults shall be followed up by providing support to help caregivers who smoke to address tobacco use.

Suggestions for implementation:

- Regularly assess for exposure of child to tobacco smoke.
- Provide appropriate interventions with caregivers, to include encouraging them to take smoking outside, not to smoke in cars, and to consider quitting.
- If possible provide tobacco cessation resources to caregiver. This may include referral to CA Smokers' Helpline (1-800-NO-BUTTS) or proactively web refer at <https://forms-nobutts.org/referral/> with consumer/client's consent. As of August 2016 the Helpline provides free nicotine patches to caregivers of children 5 and under.
- Implement tobacco-free environments, in order to minimize exposure of consumers/clients to tobacco smoke, and provide a supportive environment for caregivers to quit smoking, or protect those who have quit from relapse.
- Provide staff training on how to work with families and children. BHCS Tobacco Consultants can provide this training and technical assistance.

e. Housing providers are expected to provide safe tobacco-free environments and support residents to quit smoking.

Suggestions for implementation:

- Implement tobacco-free environments, in order to provide a supportive environment for consumers/clients to quit smoking, or protect those who have quit from relapse. This includes tobacco-free grounds and enforceable limits where residents can smoke on the property.
- See the BHCS website <http://www.acbhcs.org> under the Tobacco tab in the section tobacco references and resources where you will find a section on Tobacco-Free Housing, Environments and Programs for articles and resources.
- BHCS Tobacco Consultants can provide this training and technical assistance to housing providers.
- Assess risk for difficulty following smoke-free guidelines at admission and encourage consumers/clients to ask doctor for Nicotine Replacement Therapy to help with compliance and protect living situation. Have incoming consumers/clients sign a smoke-free contract on admission.
- Request that consumers/clients being treated with tobacco treatment medications at referring agencies be provided with a one month supply of tobacco treatment medications at the time of discharge to your agency.

f. Involve consumers/clients in decision-making related to addressing tobacco when possible.

Suggestions for implementation:

- Provide tobacco education and encourage those who have quit smoking to share their experiences quitting in group settings.
- Contact PEERS agency (510) 832-7337 to schedule a peer-to-peer tobacco education presentation for consumers/clients in your program to help motivate consumers/clients to quit smoking.

- Involve consumers/clients in your program in decision-making processes when considering making changes, such as implementing stricter tobacco-free zones, and/or tobacco-free programs.
- Consider supporting a peer-led Tobacco Recovery program where consumers/clients support other consumers/clients to consider quitting smoking. Training in this program can be provided by the BHCS Tobacco Consultants.

IV. Staff Training

All service providers will develop the capacity to perform Tobacco Use Disorder treatment interventions in their program. This section offers suggestions to providers on how to meet the required 6 hours of clinical training on how to treat tobacco dependence disorder through evidence-based treatment modalities and protocols.

BHCS contracts and consults with the ATOD Network staff to provide skill-building workshops and on-site provider trainings and/or technical assistance to address and treat consumers/clients tobacco-use, and how to implement tobacco policies. We encourage providers to utilize this resource. The contact for the ATOD Network is Judy Gerard at atodnetjudy@aol.com, 510-653-5040 ext. 349. It is also available at <http://www.acbhcs.org> in the Tobacco Treatment Resources Tab under the Tobacco Training and Technical Assistance section.

Additional training can be obtained through excellent webinars provided through:

- Smoking Cessation Leadership Center (located at UCSF), provides regular webinars hosting national leaders and experts in treatment of tobacco dependence among those with SUD and mental health conditions and has a group of archived webinars available. Many are available for credit for a variety of providers. <http://smokingcessationleadership.ucsf.edu/webinars/cme>
- <http://rxforchange.ucsf.edu> Offers tobacco training curriculum, there is one training curriculum for psychiatrists and one for peer counselors.
- CA Smokers' Helpline (located at UC San Diego), provides regular webinars hosting national and state leaders and experts in treatment of tobacco dependence among those with SUD and mental health conditions <http://www.nobutts.org/online-training>
- Additionally, a special on-line interactive 2.5 hour course (CEUs and CMEs may be available for some licenses) on tobacco treatment in behavioral health can be accessed here. <http://info.nobutts.org/tobacco-dependence-treatment-and-behavioral-health>
- The Wisconsin Nicotine Treatment Integration Project (WiNTiP)-Training for Systems Change: Addressing Tobacco and Behavioral Health

Behavioral health treatment programs are becoming increasingly aware of the importance of integrating tobacco into their policies and treatment protocols. This awareness is based upon: the high prevalence of tobacco use by consumers/clients; the related disproportionate burden from tobacco-related diseases; and empirical evidence that treating tobacco dependence improves both consumers/clients' mental health and clinical outcomes. Practical guidance about how to integrate tobacco into policies and treatment protocols in an easy-to-access format is lacking. The Wisconsin Nicotine Treatment Integration Project (WiNTiP) is filling this gap with a free, on-line tutorial. This tutorial highlights the experience of behavioral health clinicians and administrators who have integrated tobacco treatment and policy. Their experience and guidance are presented in five panel discussions organized around specific integration topics:

1. The Integration Process
2. Providing Evidence-based Tobacco Dependence Treatment
3. What about Enforcement?
4. Does Setting Make a Difference?

5. How to Help Staff who use Tobacco

There are twelve modules in all. Each includes an optional opportunity to apply content to your setting and challenges. When the tutorial is completed, your responses are combined into a tailored Tobacco Integration Plan. To begin your tutorial, please follow this link:

<http://go.wisc.edu/4n5r36>

V. Additional Resources

- Utilize the BHCS website <http://www.acbhcs.org> under the Tobacco Treatment Resources tab. There are many resources, handouts, research articles, and toolkits for tobacco treatment and policy implementation.
- Participate in ongoing trainings sponsored by BHCS that help train provider clinical staff to develop and/or enhance their motivational interviewing and other tobacco intervention skills, along with other on-site training and technical assistance available through the ATOD Network. The contact for the ATOD Network is Judy Gerard at atodnetjudy@aol.com, 510-653-5040 ext. 349. It is also available at <http://www.acbhcs.org> under the Tobacco Treatment Resources Tab under the Tobacco Training and Technical Assistance section.
- Consider partnering with primary care services such as FQHC community clinics and Alameda Health Services ambulatory care clinics to refer consumers/clients for some cessation services when reasonable and appropriate. This can be especially helpful if your agency has not been addressing tobacco at all, or you do not have a medical professional on your clinical staff. This can be a valuable component as you begin to integrate treatment of this critically important addiction into your services.