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CLINICAL PRACTICE GUIDELINES

Treatment of Tobacco Use Disorder (TUD)

Updated November 11, 2025

Community Behavioral Health

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1. BACKGROUND

Tobacco use is the leading preventable cause of disease, disability, and death in the United States, disproportionately affecting individuals with behavioral health disorders (mental health and substance use conditions). Compared to the general population, rates of tobacco use are two to three times higher among individuals with behavioral health disorders. Consequently, they experience greater nicotine dependence, more significant withdrawal symptoms when discontinuing tobacco use, and lower rates of tobacco use abstinence. In addition to the high rates of tobacco use disorder (TUD), individuals with behavioral health disorders experience excess morbidity and mortality from tobacco use, dying on average 25 years prematurely, with leading causes being tobacco-related chronic diseases.

Tobacco use negatively impacts behavioral health treatment. Tobacco use has been associated with increased depressive symptomatology, increased risk for hospitalization and suicidal thoughts and attempts, and greater risk of relapse to alcohol and illicit drug use.

Nicotine use through electronic cigarettes is on the rise, particularly among youth. Nicotine use during adolescence can interfere with brain development, increasing the risk of mood disorders, anxiety, and addiction later in life. Addressing this issue is crucial for early intervention and prevention efforts that support long-term mental and emotional well-being.

Despite the high rates of tobacco use and excess morbidity and mortality attributable to tobacco use, individuals with behavioral health disorders have less access to tobacco use treatment. Several factors contribute to the reduced access to evidence-based tobacco treatment in behavioral health settings, including targeted tobacco industry marketing to individuals with mental illness, lack of provider knowledge about evidence-based treatment for TUD, and provider misconceptions about the impact of tobacco abstinence on behavioral health outcomes. Many tobacco users with behavioral health conditions are motivated to stop tobacco use and can benefit from evidence-based tobacco treatments. As such, Community BH is committed to ensuring its beneficiaries have access to comprehensive tobacco use treatment across behavioral health settings.

2. PURPOSE

The TUD Clinical Practice Guidelines aim to disseminate evidence-based interventions for the identification and treatment of tobacco use, such that these interventions become the standard of care across Community Behavioral Health (CBH) Levels of Care. Integrating evidence-based interventions for tobacco use abstinence into behavioral health settings is a recognized strategy to increase tobacco use treatment utilization. Additionally, it promotes recovery and enhances outcomes for individuals with behavioral health conditions. These guidelines derive from multiple sources, including the U.S. Public Health Service (USPHS), the U.S. Preventive Services Task

Force (USPSTF), the American Society of Addiction Medicine (ASAM), the American Psychiatric Association (APA), and the Association for the Treatment of Tobacco Use Disorder (ATTUD).

3. DEFINITIONS

- ***Nicotine:*** The primary psychoactive and addictive chemical in tobacco products.
- ***Tobacco Use:*** Tobacco use refers to the use of any tobacco product, including but not limited to cigarettes; e-cigarettes and other electronic nicotine delivery systems (ENDS); cigars, cigarillos, and filtered cigars; smokeless tobacco (including snuff pouches); pipe tobacco; dissolvable tobacco in the form of strips, sticks, or lozenges; or tobacco smoked through a hookah or waterpipe (see **Diversity of Tobacco Products Appendix**).
- ***Tobacco Use Disorder (TUD):*** Consistent with other substance use disorders, these guidelines conceptualize TUD as a chronic, compulsive disorder requiring long-term management and intensive treatment approaches.
- ***Tobacco Withdrawal:*** Withdrawal syndrome occurs when individuals abruptly stop tobacco use or reduce the amount of tobacco use. Withdrawal symptoms include irritability/anger/frustration, anxiety, depressed mood, difficulty concentrating, increased appetite, insomnia, and restlessness.

4. PRACTICE GUIDELINES

4.1. Screening

All members who are thirteen or older should be asked if they use tobacco products and should have their tobacco use status documented regularly (see **Sample Screening Appendix**).

Clinic-based identification systems, such as adding tobacco use as a vital sign in the Electronic Health Record (EHR), have been shown to increase the likelihood that tobacco use is assessed and documented consistently. Suggested timeframes for screening include the following:

- All new members at admission/intake
- Quarterly for tobacco users
- Monthly for tobacco users attempting to cease tobacco use
- Annually for non-tobacco users

4.2. Assessment

Once tobacco use is identified, the tobacco use history should be assessed. When assessing tobacco use history, routine questions about tobacco use and the use of standardized, evidence-based instruments (e.g., questionnaires) should be employed.

- Key questions when gathering a tobacco use history may include the following: types of tobacco products used most frequently; amount of tobacco use regularly; age of tobacco use onset; any recent changes in tobacco use; previous quit attempts, including most recent attempt, duration of attempt, and methods tried on previous quit attempts; withdrawal symptoms experienced; and reason(s) for relapse.

- Assess for tobacco withdrawal. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision (DSM-5-TR™)* outlines the diagnostic criteria for tobacco withdrawal (see **Diagnostic Criteria Appendix**).

Interventions for all tobacco users should be categorized as either treatments for tobacco users who want to stop tobacco use or motivational treatments for those not interested in quitting tobacco use (see the **Treatment Algorithm Appendix**).

Screening and assessment results should be documented in the member's medical record.

4.3. Diagnosis

Formal establishment of a TUD diagnosis is vital, as many individuals with behavioral health disorders may qualify for a diagnosis of TUD. Tobacco-related diagnoses thus should be documented in the member's medical record, consistent with the *DSM-5-TR™* and the *International Classification of Diseases Diagnostic, Tenth Revision (ICD-10)*.

A TUD diagnosis should be included in the problem list, overall treatment plan, and discharge plan.

4.4. Treatment

All tobacco users with behavioral health conditions should be offered TUD treatment. Because individuals with behavioral health conditions experience higher rates of TUD, more intensive interventions are recommended, including increasing the length and number of treatment sessions.

Intensive interventions combining pharmacotherapy and counseling (behavioral interventions) are more effective for tobacco use abstinence than either pharmacotherapy or counseling alone. Counseling should be offered to all members, and counseling and pharmacotherapy should be available to members 18 years of age and older. Simply encouraging members to stop smoking is insufficient.

Counseling interventions should be tailored to the member's stage of change and offered in person or via telephonic sessions, individually or in groups. Counseling and behavioral therapies should involve practical counseling (problem-solving/skills training) and emphasize the development of social supports. Evidence-based counseling approaches to tobacco use include motivational interviewing and cognitive-behavioral therapy.

Pharmacotherapy is an effective evidence-based TUD treatment for individuals 18 and older with behavioral health conditions. Pharmacotherapy can facilitate tobacco use abstinence by reducing nicotine withdrawal symptoms, reducing the reward effects of nicotine from smoking by blocking nicotine receptors, and temporarily providing an alternative source of nicotine. All adult tobacco users should be offered first-line U.S. Food and Drug Administration (FDA)-approved abstinence medications when indicated (see **FDA-Approved Medications Appendix**).

TUD treatment should be documented in the member's medical record.

4.5. Aftercare Planning/Discharge

Tobacco use status should be integrated into the discharge plan. The discharge plan will vary depending on the level of care and the progress made toward tobacco use recovery. Planning should include a clear and specific follow-up plan at the next recommended level of care.

The discharge plan should be documented in the member's medical record.

4.6. Tobacco-Recovery Environment Policy

Behavioral health settings can establish a tobacco-free environment to promote recovery and create safer, healthier environments for members, staff, and visitors. CBH expects providers to meet members where they are in their recovery, in a supportive and non-punitive manner, and to adopt a therapeutic, clinically based approach. For more information on the therapeutic environment, refer to **Clinical Performance Standards for TUD, Section 4.2.3. Therapeutic Environment**. Relevant provider notifications can be found below:

- **CBH Provider Bulletin 21-19: Tobacco Recovery Policy Update: Residential Drug and Alcohol Levels of Care**
- **Provider Notice: Administrative Discharges from Residential Drug and Alcohol Treatment Settings**

5. MONITORING

CBH providers are expected to follow the guidelines outlined above for TUD. CBH monitoring and oversight will assess adherence to the standards, including those of the Quality, Clinical, and Compliance Departments. CBH encourages its providers to maintain internal quality management

programs to ensure treatment adheres to these and other applicable guidelines. CBH will continue to develop systematized strategies to support high-quality care within the network, including tracking valid quality of care metrics for various elements of treatment. In certain instances, CBH may request medical records to be reviewed for quality-of-care concerns. In addition, CBH will be tracking and sharing the following performance metrics with relevant providers:

CPG Component	Metric	Data Source	Numerator	Denominator
Screening	Percentage of CBH members screened for tobacco use in the last 12 months.	CBH Data Informatics	CBH members who were screened for tobacco use at least once within the last 12 months.	All unduplicated CBH members.
Diagnosis	Percentage of CBH members who have a TUD Diagnosis	State Public Health Claims/ CBH Provider Coding	Members with a TUD diagnosis	All unduplicated CBH members
Counseling	Percentage of CBH tobacco users who were provided TUD counseling.	CBH Data Informatics	CBH members who screened positive for tobacco use and were provided tobacco counseling at their last visit.	All CBH members who have a TUD diagnosis in the past 12 months.
Pharmacotherapy	Percentage of CBH tobacco users that are 18 years or older who were provided pharmacotherapy (NRT or medication).	CBH Data Informatics	Adult CBH members who screened positive for TUD and were treated via pharmacotherapy at their last visit.	All adult CBH members who have a TUD diagnosis the past 12 months.

6. APPENDICES

6.1. References

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6.2. Diversity of Tobacco Products

Product	Definition	Types	Nicotine Levels
Cigarette	Tobacco rolled in paper for smoking	A typical cigarette weighs <1 g; regular length (70 mm long), king (84 mm), 100s (100 mm), and 120s (120 mm)	Average in rod, 13.5 mg (range: 11.9–14.5 mg); nicotine yield to the smoker: 1–1.5 mg/cigarette
E-Cigarettes, Vapes, and Other Electronic Nicotine Delivery Systems	Electronic devices that use an "e-liquid" that usually contains nicotine derived from tobacco, as well as flavorings, propylene glycol, vegetable glycerin, and	Vapes, vaporizers, vape pens, hookah pens, electronic cigarettes (e-cigarettes or e-cigs), e-cigars, and e-pipes	Typical concentrations of free-base nicotine e-liquids are 3-24 mg/mL, while nicotine salt e-liquids are available in concentrations of up to 100 mg/mL

Product	Definition	Types	Nicotine Levels
	other ingredients. The liquid is heated to create an aerosol that is inhaled.		nicotine. Popular vapes can easily have the nicotine content of three cartons or 600 cigarettes.
Blunt	Cannabis filled in a hollowed-out cigarillo shell		Nicotine intake much lower than from cigarette or cigar smoking, but, based on animal studies, could enhance rewarding effects of delta 9-tetrahydrocannbinaol
Smokeless Tobacco or Nicotine Pouches	Tobacco inserted between lip and gum or snorted into the nose rather than smoked by the user	Snuff (ground tobacco), snus (ground tobacco in a tea bag–like pouch), chew (shredded tobacco)	Nicotine concentrations vary, range of 0.2 to 34 mg/g, the more alkaline products are capable of delivering higher levels of nicotine
Waterpipe/Hookah	Charcoal-heated flavored tobacco passed through a water-filled chamber that cools the smoke	Water tobacco is a mixture of dried fruit, molasses and glycerin, and conventional tobacco leaf	Average of 1.13 mg/g and high of 3.30 mg/g for product containing nicotine; nicotine-free for herbal (nontobacco) varieties

6.3. Sample Screening

- Adolescent Tobacco Use Screening Questionnaire
- Adult Tobacco Use Questionnaire

6.4. Diagnostic Criteria for Tobacco Withdrawal

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR™) outlines that the following four points should be checked off for a tobacco withdrawal diagnosis to be made:

1. The individual has used tobacco daily for a minimum of several weeks or more
2. Tobacco use has been reduced or abruptly discontinued, and four or more of the following symptoms have been experienced within the 24 hours since:
    - Feeling irritable, angry, or frustrated
    - Feeling anxious
    - Finding it difficult to concentrate
    - Feeling restless

- » Experiencing increased appetite
- » Feeling depressed
- » Having trouble sleeping

3. The symptoms experienced (mentioned above) must be causing the individual significant distress or affecting essential areas of their life, such as social interactions or work.

4. The symptoms cannot be attributed to another medical condition or mental disorder, including intoxication or withdrawal from another substance.

6.5. Algorithm for Treating Tobacco Use Disorder

Does the member use tobacco?

Yes ↓		No ↓	
Is the member willing to quit?		**Did the member once use tobacco?**	
Yes ↓	No ↓	Yes ↓	No ↓
Provide appropriate TUD treatments	**Provide motivational enhancement therapy and offer pharmacotherapy**	**Prevent relapse***	**Encourage continued abstinence**

**Relapse prevention interventions may not be necessary when the member has not used tobacco for many years.*

6.6. FDA-Approved Medications for Tobacco Use Abstinence

Product	Description	Dosing
Gum	➡ Nicorette; Generic; OTC ➡ 2 mg; 4 mg ➡ original, cinnamon, fruit, mint	Based on time of first cigarette: ➡ ≤30 minutes after waking: 4 mg ➡ >30 minutes after waking: 2 mg ➡ Weeks 1-6: 1 piece q 1-2 hours ➡ Weeks 7-9: 1 piece q 2-4 hours ➡ Weeks 10-12: 1 piece q 4-8 hours ➡ Maximum: 24 pieces/day ➡ Duration: up to 12 weeks

Product	Description	Dosing
Lozenge	➡ Nicorette; Generic; Nicorette Mini; OTC ➡ 2 mg; 4 mg ➡ cherry, mint	Based on time to first cigarette of the day: ➡ <30 minutes = 4 mg ➡ >30 minutes = 2 mg ➡ Weeks 1-6: 1 lozenge q 1-2 hours ➡ Weeks 7-9: 1 lozenge q 2-4 hours ➡ Weeks 10-12: 1 lozenge q 4-8 hours ➡ Maximum: 20 lozenges/day ➡ Duration: up to 12 weeks
Nasal Spray	➡ Nicotrol NS; Prescription Metered spray ➡ 10 mg/mL ➡ nicotine solution	➡ 1-2 doses/hour (8-40 doses/day) ➡ Maximum: 5 doses/hour or 40 doses/day ➡ Initially use at least 8 doses/day ➡ Duration: 3 months
Transdermal Patch	➡ NicoDerm CQ1; Generic; OTC (NicoDerm CQ, generic) ➡ 7 mg, 14 mg, 21 mg ➡ 24-hour release	➡ >10 cigarettes/day: » 21 mg/day for 4-6 weeks » 14 mg/day for 2 weeks » 7 mg/day for 2 weeks ➡ ≤10 cigarettes/day: » 14 mg/day for 6 weeks » 7 mg/day for 2 weeks ➡ Rotate patch application site daily; do not apply a new patch to the same skin site for at least one week. ➡ Duration: 8-10 weeks
Bupropion SR	➡ Wellbutrin, Generic ➡ 150 mg sustained release tablet	➡ 150 mg po q am for 3 days, then 150 mg po bid (do not exceed 300 mg/day) ➡ Begin therapy 1-2 weeks prior to quit date ➡ Dose tapering is not necessary ➡ Duration: 7-12 weeks, with maintenance up to six months in selected patients
Varenicline	➡ Generic ➡ 0.5 mg;1 mg tablet	➡ Days 1-3: 0.5 mg po q am ➡ Days 4-7: 0.5 mg po bid ➡ Weeks 2-12: 1 mg po bid ➡ Begin therapy one week prior to quit date. ➡ Dose tapering is not necessary.

Product	Description	Dosing
		➡ Dosing adjustment is necessary for patients with severe renal impairment. ➡ Duration: 12 weeks; an additional 12-week course may be used in selected patients. ➡ May initiate up to 35 days before target quit date OR may reduce smoking over a 12-week period of treatment prior to quitting and continue treatment for an additional 12 weeks