Clinical Performance Standards:

Tobacco Use Disorder

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Community Behavioral Health
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TABLE OF CONTENTS

1. INTRODUCTION

The Tobacco Use Disorder (TUD) Performance Standards support the integration of TUD interventions in drug and alcohol treatment services to maximize substance use treatment outcomes, strengthen the probability of long-term recovery, and reduce tobacco-related health disparities.

1.1. Genesis

The TUD Standards were developed in response to a CBH Provider and Member Survey that identified gaps between providers' expressed priorities and their current capacity to deliver TUD Treatment services. The results of the survey, along with lessons learned, are available for review in the attached Appendix.

1.2. Goals

- Encourage comprehensive TUD assessment and promote language change away from an excessively authoritative "cessation-oriented" to an empathic "person-centered" approach.
- Promote the identification and documentation of a formal DSM-5 diagnosis of Tobacco Use Disorder when appropriate.
- Promote the use of pharmacotherapy to help members' address TUD and prevent tobacco withdrawal.
- Promote the integration of TUD recovery-oriented behavioral interventions to advance replacement coping skills.
- Promote a therapeutic environment that provides for the safety of members and staff while signaling respect for interpersonal boundaries.
- Provide for the continuation of TUD services following discharge or return to the community.

1.3. Recommendations

- Use person-centered, recovery-oriented language when discussing tobacco.
- Provide education as to what a member can expect throughout the duration of his or her stay at the facility.
- Document a comprehensive tobacco use history.
- Assess and document problematic patterns of tobacco use.
- Use the DSM-5 criteria to establish the diagnosis of TUD (when appropriate).
- Evaluate and document the potential for tobacco withdrawal at intake.

- Offer medication treatment to all members with confirmed TUD.
- Integrate tobacco-related concepts into existing therapeutic routines.
- Explore and document associations between tobacco use behavior and other substance use.
- Promote a safe, tobacco-free therapeutic environment.
- Refer all CBH members with TUD to online or telephonic tobacco recovery resources.
- Refer CBH members receiving TUD pharmacotherapy to ongoing pharmacologic management resources.
- Perform a systematic quality assessment.

CBH providers are encouraged to request free technical assistance with TUD standard implementation.

2. PURPOSE

The TUD Performance Standards describe the expectations for quality in service delivery for CBH members who use tobacco, or who are at risk for tobacco use disorder, and whose services are funded through CBH or the City of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). The standards are intended as a guide that providers can use to develop and monitor their tobacco interventions and for CBH to evaluate these services.

The TUD Standards support member resilience by providing utilization of evidence-based practice including comprehensive assessment and documentation of tobacco use disorder, individualized treatment planning comprised of pharmacotherapy, behavioral and social supports, and discharge planning. They reflect the core values and principles of DBHIDS and aim to promote continuous quality improvement and evidence-based practice, increase consistency in service delivery, and improve outcomes for all members who engage CBH-funded services. The standards are consistent with the principles articulated in the American Society of Addiction Medicine's ***Integrating Tobacco Use Disorder Interventions in Addiction Treatment: A Guide for Addiction Treatment Clinicians and Programs***, and align with CBH's **Clinical Practice Guidelines** for Treatment of TUD.

TUD Standards emphasize the need for a person-centered longitudinal care model and a supportive clinical milieu for recovery. An important aim for the standards is to ensure providers have the capacity to engage members at all stages of change for tobacco abstinence. For example, members should *never* be discharged from residential treatment solely based on continued tobacco use. Implementation of these standards will help providers to identify pathways for pharmacological and behavioral interventions appropriate to a member's stage readiness. They were developed in response to a CBH Provider and Member Survey identifying gaps between providers' expressed priorities and their current capacity to deliver these services (See Appendix). The resulting standards are a response to provider observations about the current practice environment and may be amended in the future as conditions in the field evolve.

3. SCOPE OF SERVICES

TUD Standards are used to guide tobacco use disorder assessment and treatment delivered in all levels of care. CBH considers these standards to be the minimum practice necessary for providing high-quality, person-centered TUD treatment.

All CBH-funded drug and alcohol treatment services utilize evaluation methods to develop medication support, behavioral therapies, and environmental change to appropriately meet the needs of the member. The overarching goal of treatment is to produce socially significant improvement in behavior in a growth-promoting, recovery orientation. Rather than approaching tobacco use disorder from the more traditional abstinence-only/cessation perspective, the standards are implemented in a therapeutically integrated fashion, to help members progressively adapt behavioral and social skills necessary to advance "tobacco recovery."

4. RECOMMENDATIONS

4.1. Comprehensive Assessment

4.1.1. Intake Messaging

Entering treatment for a substance use disorder (SUD) can be a daunting proposition. Disruptions in tobacco use routines can significantly compound uncertainty and create an unsettling circumstance. The intake process should be designed to help ease anticipatory anxiety related to tobacco. Intake staff should avoid using cessation-oriented language when discussing tobacco during the intake process. Instead, providers should use person-centered, recovery-oriented language. Therapeutic language choices are an effective way to express empathy, reduce anxiety, and focus the member on the evolving life-enhancing process of recovery. For example:

Language That Conveys a "Cessation Orientation"	*Preferred Recovery-Oriented Language*
✗ Do you want to quit smoking?	✓ Would it be okay if we talk about your tobacco use? I'd like to ask you some questions to determine how we can best offer you help to stop cigarette craving. Interested?
✗ Smoking is bad for you.	✓ Learning coping skills to stop smoking is achievable and would help you to breathe better.
✗ You're not allowed to smoke while you're here.	✓ We strive to create a safe treatment setting free of triggers for all substances, including tobacco.
✗ If you don't stop smoking, you're not in recovery.	✓ We're here to support you in achieving your recovery goals. Have you heard that learning tobacco-free coping skills while in treatment greatly reduces the probability of relapse to other substances and promotes long-term recovery?

Common Terminology	*Preferred Terminology*
✗ Smoking	✓ Tobacco Use Disorder
✗ Smoker	✓ Person with Tobacco Use Disorder
✗ Cessation	✓ Tobacco Treatment and Recovery
✗ Quit Date	✓ Tobacco Recovery Start Date

Intake staff should be well-informed about the availability of tobacco recovery resources to help members manage Tobacco Use Disorder, prevent tobacco withdrawal, and be prepared to provide education as to what a member can expect throughout the duration of his or her stay at the facility.

Once the comprehensive intake evaluation is complete, the treatment staff helps the member to get oriented to the tobacco policies of the facility and in collaboration with the member develops an individualized tobacco treatment plan. Ensuring an empathic, person-centered approach to treatment planning can help ease anxiety and ensure a more therapeutic interaction.

4.1.2. Tobacco Use History

Admission screening and assessment includes an exploration of possible Tobacco Use Disorder in all members who report using tobacco products. The evaluation is face-to-face with a qualified health professional and when indicated results in a DSM-5[1] TUD diagnosis. It includes consideration for the potential need for medication interventions aimed at addressing tobacco withdrawal. The evaluator documents a comprehensive tobacco use history that includes:

- Type(s) of tobacco products used
- The quantity consumed in a typical day
- Environmental and emotional triggers to tobacco use
- Presence (or absence) of social supports for tobacco recovery
- Past quit attempts

[1] *American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.*

- Pharmacologic interventions utilized
- Circumstances of relapse (if relevant)

4.1.3. Tobacco Use Disorder Assessment

The evaluation includes assessment and documentation of any problematic patterns of tobacco use leading to clinically significant impairment or distress, as manifested by at least two of the following DSM-5 criteria, occurring within a 12-month period:

1. Loss of control (inability to stop using)
2. Persistent desire/unsuccessful efforts to stop using
3. Craving (a strong desire to use the substance)
4. Failure to fulfill major role obligations due to use
5. A great deal of time is spent obtaining, using, and recovering from the use of substances
6. Continued use of substances despite having social or interpersonal problems caused or made worse by the use
7. Important activities are reduced or given up because of the use
8. Substance use in situations where it is physically hazardous
9. Continued use of substances despite having physical or psychological caused or made worse by the use
10. Tolerance
11. Withdrawal

Providers will use the DSM-5 criteria to establish the diagnosis of TUD and will document the appropriate diagnoses in the record along with the ICD-10 codes used for billing and tracking purposes. Elements of a DSM-5 diagnosis classification differs from DSM-IV nicotine dependence in that it includes both craving and impaired control elements, a lower threshold for diagnosis, and severity levels where Mild is the presence of 2-3 criteria, Moderate 4-5 criteria, and Severe 6 or more criteria.

4.1.4. Tobacco Withdrawal Assessment

Circumstances that elevate the risk for tobacco withdrawal are common and may occur upon abrupt cessation of tobacco use or when reducing amount of tobacco consumed. At intake, an evaluation of the potential for tobacco withdrawal is performed and documented. Signs and symptoms of tobacco withdrawal include:

- Irritability, frustration, or anger

- Anxiety
- Difficulty concentrating
- Increased appetite
- Restlessness
- Depressed mood
- Insomnia

All members with confirmed TUD are offered medication treatment (see also Section B.1.) as determined by the evaluator's awareness of observable signs and symptoms of tobacco withdrawal, an estimation of the severity of these findings and a plan for monitoring for the exacerbation / resolution of these signs during treatment. Medication interventions for TUD are consistent with the principles outlined in CBH's **Clinical Practice Guidelines** for Treatment of TUD.

The assessment should begin the process of tobacco-related discharge planning and ensure continuity of care.

4.2. Treatment Implementation

The treatment of TUD follows basic principles of learning replacement coping behavior while reducing the interfering effects of tobacco withdrawal. Evidence-based pharmacologic and skill acquisition interventions are developed in collaboration with the member. Maintenance of treatment outcomes are promoted by ensuring a therapeutic environment during the treatment period and facilitating continued care and follow-up post-discharge.

4.2.1. Pharmacotherapy

All members with TUD are offered first-line U.S. Food and Drug Administration (FDA)-approved TUD medications. Pharmacologic treatments to manage tobacco craving and withdrawal may be used by members in the short-term to be comfortable while in a tobacco-free setting or as a part of a tobacco recovery plan to advance sustained abstinence. All pharmacotherapy recommendations are consistent with the principles outlined in the CBH Clinical Practice Guidelines for Treatment of Tobacco Use Disorder and are documented in the member's medical record. Useful evidence- based guidelines outlining effective approaches to pharmacotherapy in this population include those produced by the **U.S. Public Health Service** and the **American Thoracic Society**.

Like any other medication intervention, staff are responsible for monitoring the effectiveness of medication interventions for TUD and reporting observations which may indicate the need for medication adjustment to the appropriate ordering staff member. Examples include recognizing when members may be experiencing tobacco withdrawal despite using pharmacotherapy, or circumstances where the specific form of pharmacotherapeutic support may not align precisely with the member's individual needs. These observations are documented in the member's record.

4.2.2. Behavioral Interventions

Behavioral health providers are encouraged to integrate tobacco-related concepts into their existing therapeutic routines. Inclusion of the neurobiological and psychosocial aspects of tobacco use in existing member education topics elevates the relevance for addressing tobacco in drug and alcohol treatment.[2] Exploring tobacco use behavior can easily be integrated into discussions on dopamine reinforcement, internal and external drug cues, mood-regulation, etc. For example, the counselor may explore the intersect and influence of tobacco use within the context of alcohol and drug use rituals.

Members embrace new ideas through consensus building achieved by sharing their lived experiences. Best facilitated in a small group, tobacco awareness counseling utilizes motivational interviewing to promote a peer-to-peer discussion where group members share insight into their tobacco use behavior. The objectives of this group are to identify ambivalence towards tobacco use and elicit change talk to advance stage readiness. The facilitator maintains a neutral position, demonstrating an interest in the member's perspective on the topic using reflective listening, clarifying questions, and summarizing the key points being made. Opportunities for teachable moments are realized to share pertinent information within the context of SUD recovery. Associations between tobacco use behavior and other substance use should be routinely explored and documented in the member's record.

The **DBHIDS LMS Learning Hub** offers a *Tobacco Recovery in Behavioral Health Services eLearning Series* for provider education and training on pharmacotherapy and behavioral interventions.

4.2.3. Therapeutic Environment

The therapeutic environment is an essential consideration when implementing best practices for SUD recovery. Note that the therapeutic environment becomes a determinative factor well before a person is seen for services. In fact, as members approach the parking lot, lobby, or other common space, the environment can have a significant impact on how the person will perceive the experience. The therapeutic environment is interpersonal; SUD recovery requires an atmosphere of acceptance, empathic understanding, and unconditional positive regard within which the member feels free to verbalize and consider their thoughts, behaviors, and emotions.

Creating a therapeutic environment takes a conscious and intentional effort by clinicians and should account for the needs of *all* clients receiving SUD treatment. A variety of considerations go into creating a therapeutic environment. For example:

- The physical, environmental, and emotional safety of members is paramount.
- Respect for interpersonal boundaries facilitates engagement and communication.

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[2] *Kotyuk E, Magi A, Eisinger A, Király O, Vereczkei A, Barta C, et al. Co-Occurrences of Substance Use and Other Potentially Addictive Behaviors: Epidemiological Results from the Psychological and Genetic Factors of the Addictive Behaviors (PGA) Study. J Behavioral Addiction 2020 June 26; 9(2): 272–88.*

- Aspects of the physical space and movement within and outside the location can promote safety and emotional growth.

Overt or conspicuous tobacco use by members engaged in SUD treatment services can undermine the therapeutic nature of the environment by triggering members to engage in substance use behaviors, exacerbating healthcare and social disparities experienced by CBH members, signaling disrespect for the recovery needs of others, and by creating unsafe air quality for staff and members.

Treatment providers augment the therapeutic value of the recovery environment by regulating the use of tobacco in such a manner that the need to minimize the conspicuous use of tobacco is balanced by the need to avoid promoting covert tobacco use. The specifics of setting may fundamentally alter this balance. For example, treatment facilities may find it feasible to promote a tobacco-free environment without concern for covert use, while other facilities may find it necessary to identify a designated smoking area to avoid member high-risk behavior.

All CBH-funded facilities promote a safe, tobacco-free therapeutic environment by maintaining fidelity to the following principles:

- Indoor use of combustible tobacco (including cigarettes, cigars, hookah) or use of electronic smoking devices such as vape pens, pods, mods, tanks, e-cigarettes, e-cigars, e-pipes and e-hookah are prohibited in a manner consistent with Philadelphia's 2006 **Clean Indoor Air Worker Protection Law**.

- Facilities prohibit tobacco use in public-facing (e.g., front door) locations. Member education materials explicitly state that this restriction is an effort to account for the needs of *all* members receiving SUD treatment, and to foster a therapeutic recovery experience.

- The organization strictly prohibits staff smoking in the presence of members.

- Any designated smoking areas are open air and monitored routinely to ensure a safe and pleasant environment.

- The facility's policy is clearly written in plain language and visibly posted in common areas within the facility.

- Infractions of the organization's tobacco policy *per se* are never treated as the sole justification for administrative discharge. Rather, staff are encouraged to engage the member therapeutically by treating the infraction as an opportunity for a focused behavioral intervention.

4.3. Discharge/Continuity of Care

SUD treatment routinely includes an estimation of the member's anticipated needs upon treatment completion or when transferring into another level of care. Disposition recommendations include identifying community recovery supports, safety planning, and reducing risk for relapse. Since continued tobacco use following discharge significantly elevates the risk return to other substance use, a complete discharge plan includes the member's tobacco use status, recovery plan and community resources.

4.3.1. Community Resources

All CBH members with a diagnosis of TUD are referred to online and telephonic tobacco recovery resources to extend counseling and support services.

- **Pennsylvania's Department of Health Free Quitline** (1-800-QUIT-NOW/1-800-784-8669 and 1-855-DEJELO-YA/1-855-335-3569) provides coaching over the telephone or online in English and Spanish and technology-based support including email, text, and chat. CBH providers may connect members to the Quitline services via telephone or fax referral.

- **Nicotine Anonymous** provides online video conference meetings, internet, and phone meetings. NicA offers 12-step tobacco recovery online books and pamphlets. The literature is available in 17 languages.

- CBH Member Services Hotline (888-545-2600 or TTY: 888-436-7482) may offer additional community resources as they become available.

CBH members receiving pharmacotherapy for a diagnosis of TUD may be referred for ongoing pharmacologic management.

- **The University of Pennsylvania Comprehensive Smoking Treatment Program** (1-888-PENN-STOP/1-888-736-6786) offers in-person and telehealth visits to manage a personalized tobacco treatment plan. Translation is available for most languages prevalent within the CBH member community.

4.3.2. Written Discharge Plan

The discharge plan is individualized and strengths-based, building on support and capacity for resilience. The tobacco discharge plan includes diagnoses, outcomes of any structured tools, identification of community resources and medication instructions. Members are discharged from the facility with a prescription to last until their next medication appointment, preferably scheduled for a date no more than 30 days following discharge.

The plan is developed in collaboration with the member and any appropriate caregivers at the time of discharge, as well as other key people identified by the member. It is forwarded to the next treatment provider, PCP, and any other relevant parties. Recipients of the discharge plan are documented.

4.4. Follow-Up/Outcome

The 30-day period following discharge is a critical time for successful acclimation to placement or next level of care. To ensure high-quality care, providers are encouraged to adopt post-discharge self-monitoring strategies. CBH-funded facilities should perform a systematic quality assessment at least annually, to ensure that care processes remain consistent with the TUD standards and are aligned with current evidence-based guidelines. Organizational administrators assess and document threats to sustainability and provide feedback to CBH as issues are identified. CBH providers are encouraged to request free technical assistance with TUD standards implementation.

APPENDIX

Residential Drug and Alcohol Provider Tobacco Recovery Learning Collaborative Survey

Survey Name	*Knowledge, Attitudes, and Practice: Efforts to Integrate Tobacco Interventions into Behavioral Health Treatment*
Date of Survey	February 18 through March 7, 2022
CBH Providers	24 Questions/Statements N=107
CBH Members	9 Questions/Statements N=239

Key survey results that helped to inform Tobacco Use Disorder (TUD) performance standards:

Comprehensive Assessment

When comparing member interest for tobacco abstinence to provider perception of member interest a knowledge and practice gap were identified. 74% of CBH Member Survey respondents reported a conditional interest in tobacco abstinence as follows:

- "I want to stop smoking but don't think that I can" (16%),
- "I really want to stop smoking, but I don't know when I will" (37%),
- "I really want to stop smoking and intend to in the next month" (9%), and
- "I really want to stop smoking and intend to in the next 3 months" (12%).

Concurrently, a supermajority (81%) of provider respondents did not recognize or were uncertain of members' interest in changing their smoking behavior. Only 19% of CBH Provider Survey respondents agreed that members have an interest in tobacco abstinence.

Practice Gap

The provider perspective on tobacco appears to be abstinence-oriented with focused attention on response values (i.e., ready to quit vs. not ready to quit) at the time of assessment as opposed to identifying stage of readiness for behavior change. The member perspective demonstrated by 74% of the respondents suggests an expression of ambivalence, characteristic of individuals with substance use disorders (SUDs), where we find an interest in behavior change ("I really want to stop…") countered by an underlying reluctance to change (poor self-efficacy).

Lessons Learned

1. Alignment of perspective is a prerequisite to appropriately assess the member's stage readiness for tobacco abstinence.

2. Accepting the member's expressed ambivalence as a common characteristic of SUD allows providers to focus on the member's intrinsic desire for change in a person-centered manner.

3. Language choices and therapeutic goals related to TUD should reflect the member's desire to move toward change, rather than an abstinence only cessation-related perspective.

Documented DSM-V Diagnosis

75% of CBH Provider Survey respondents agree that members should be offered pharmacotherapy to treat tobacco withdrawal, although only 20% routinely document a DSM-5 diagnosis of TUD into the member's treatment plan.

Practice Gap

Even though behavioral health providers obtain relevant history and related information from the member to establish eligibility and appropriateness of services, questions pertaining to the psychosocial aspects of tobacco use during the assessment interview are not being asked to warrant documenting a DSM-5 TUD diagnosis. The result is an underutilization of TUD pharmacotherapy and behavioral interventions.

Lessons Learned

1. Recognition of tobacco withdrawal does not necessarily result in documentation of the problem, likely due to lack of adequate staff training, limited TUD treatment resources[3], and an under-appreciated focusing effect bias.[4]

2. Lacking formal documentation of a TUD diagnosis, treatment planning is less likely to include an integrated evidence based TUD intervention.

3. Left unaddressed, ongoing TUD significantly increases the odds of drug and alcohol relapse[5] and reduces the member's probability of achieving long term recovery[6].

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[3] *Ziedonis DM, Guydish J, Williams J, Steinberg M, Foulds J. Barriers and Solutions to Addressing Tobacco Dependence in Addiction Treatment Programs. Alcohol Res Health. 2006;29(3):228–35.*

[4] *Prochaska JJ. Failure to treat tobacco use in mental health and addiction treatment settings: a form of harm reduction? Drug Alcohol Depend. 2010 Aug 1;110(3):177–82.*

[5] *Weinberger AH, Platt J, Esan H, Galea S, Erlich D, Goodwin RD. Cigarette smoking is associated with increased risk of SUD relapse: A nationally representative, prospective longitudinal investigation. J Clin Psychiatry. 2017 Feb;78(2):e152–60.*

[6] *Tsoh JY, Chi FW, Mertens JR, Weisner CM. Stopping smoking during first year of substance use treatment predicted 9-year alcohol and drug treatment outcomes. Drug Alcohol Depend. 2011 Apr 1;114(2):110–8.*

Discharge/Continuity of Care Plan

73% of CBH Provider Survey respondents agreed that "cigarette smoking is often fundamental to the behavioral rituals of using alcohol and other drugs and 51% agreed that "tobacco use may serve as a stimulus to opioid use and other substances." In addition, 41% agreed that "establishing tobacco abstinence during SUD treatment is linked to an increase in long-term recovery."

Practice Gap

Despite having an awareness of the relationship of tobacco use to other substances and that TUD interventions improve treatment outcomes, less than 50% of respondents routinely included tobacco use status and TUD management instructions in a member's discharge plan.

Lessons Learned

1. Inclusion of instructions for continued TUD treatment is a critical component of maximizing long term recovery probabilities.

2. Discharge plans that include instructions for addressing the member's Tobacco Use Disorder align with staff's professional understanding of the impact TUD can have on treatment outcome.

3. System barriers, inadequate treatment policy and procedures, or a lack of staff training may serve to omit tobacco discharge planning.