Clinical Guidelines:

Treatment of Tobacco Use Disorder

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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, 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.

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 tobacco use disorder, 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 may benefit from evidence-based tobacco treatments. As such, CBH is committed to ensuring its beneficiaries have access to comprehensive tobacco use treatment across behavioral health settings.

2. PURPOSE

The Tobacco Use Disorder Clinical Practice Guidelines aim to disseminate evidence-based interventions for tobacco use identification and treatment 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***: Consistent with other substance use disorders, these guidelines conceptualize tobacco use disorder 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 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, tobacco use history should be assessed. When assessing tobacco use history, routine questions about tobacco use and standardized, evidence-based instruments (e.g., questionnaires) should be used.

- 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 tobacco use disorder diagnosis is vital as many individuals with behavioral health disorders may qualify for a diagnosis of tobacco use disorder. 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 tobacco use disorder 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 tobacco use disorder treatment. Because individuals with behavioral health conditions experience higher rates of tobacco use disorder, 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. Both counseling and pharmacotherapy should be offered to members. Simply encouraging members to stop smoking is insufficient. All members who use tobacco should be provided with evidence-based treatment, including pharmacotherapy, to help them abstain.

Counseling interventions should be matched to the member's stage of change and offered in person and telephonically, 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 tobacco use disorder treatment for individuals 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 tobacco users should be offered first-line U.S. Food and Drug Administration (FDA)-approved abstinence medications when indicated (see **FDA-Approved Medications Appendix**).

Tobacco use disorder 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 may institute a tobacco-free environment to promote recovery and create safer and healthier environments for members, staff, and visitors. CBH expects providers to meet members where they are in their recovery in a supportive, non-punitive manner and to adopt a therapeutic, clinically-based approach. For more on the therapeutic environment, see **Clinical Performance Standards for Tobacco Use Disorder, 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 above guidelines for tobacco use disorder. CBH monitoring and oversight will assess adherence to the standards, including Quality, Clinical, and Compliance Department protocols. 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 over age 13 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 13 years of age or older.
Counseling	Percentage of tobacco users who were provided tobacco use disorder counseling.	CBH Data Informatics	CBH members who screened positive for tobacco use and were provided tobacco counseling at their last visit.	All members who have a tobacco use disorder diagnosis in the past 12 months.
Pharmacotherapy	Percentage of tobacco users who were provided pharmacotherapy (NRT or medication).	CBH Data Informatics	CBH members who screened positive for tobacco use disorder and were treated via pharmacotherapy at their last visit.	All members who have a tobacco use disorder 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
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	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
Heated Tobacco	Electronic devices that heat reconstituted tobacco sticks treated with a glycerin humectant to deliver an aerosol	IQOS, Glo, Ploom Tech	Nicotine delivery can match that of conventional cigarettes
E-Cigarettes	Electric devices that produce an aerosol from a liquid that typically contains nicotine, propylene glycol, vegetable glycerin, and flavorings	Cigalikes/e-pens, tank systems, pods/nicotine salts (e.g., benzoate and lactate)	E-liquid nicotine content from 0-100 mg/ml. Nicotine delivery can match that of conventional cigarette but varies by device design (heating temperature), e-liquid nicotine content, and user behavior

6.3. Sample Screening

- Adolescent Tobacco Use Screening Questionnaire
- Adult Tobacco Use Questionnaire

6.4. Diagnostic Criteria for Tobacco Withdrawal

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR™) Tobacco Withdrawal Diagnostic Criteria

The 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:
    a. Feeling irritable, angry, or frustrated
    b. Feeling anxious
    c. Finding it difficult to concentrate
    d. Feeling restless
    e. Experiencing increased appetite
    f. Feeling depressed
    g. 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 tobacco use disorder 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
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	1-2 doses/hour (8-40 doses/day) Maximum: 5 doses/hour or 40 doses/day

Product	*Description*	*Dosing*
	nicotine solution	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-hr 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. 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