focused, as opposed to facilitative and insight-oriented. Increased time for cognitive processing is needed, necessitating assignment of smaller tasks and less reading. Likewise, calls could be split into several, shorter calls rather than fewer, longer calls.

Characteristics of the therapeutic relationship, important for any client, are especially important for clients with MI/SUD. These include trust, message consistency, compassion, being non-judgmental, expressing confidence in the ability to quit, and help increasing support.

Clients were encouraged to use pharmacotherapy and referred to their primary prescriber for prescriptions. The possible need for dose adjustments of any psychiatric medications was also discussed. Some quitlines provide medications, primarily nicotine replacement therapy, and some advise clients to purchase cessation medications on their own.

SUMMARY OF PROFESSIONAL ADVICE

- Assess current participation in MI/SUD treatment and treatment compliance.
- Assess current level of functioning.
- Determine level of functioning for previous quit attempts.
- Encourage contact with current prescriber prior to and during the quitting process.
- Keep the approach brief, focused and concrete, especially for lower functioning clients with MI/SUD. More repetition may be necessary.
- Pay close attention to a client's cognitive processing. Calls may need to be shorter and not move too quickly.
- For lower functioning clients, limit the use of abstract or open-ended questions.
- Limit the use of written materials. Lower functioning clients may have difficulty processing much written information.
- Provide clients with mental health referrals in their local area, if needed.
- Provide ongoing training and supervision for quitline staff.

MENTAL HEALTH TREATMENT PROGRAMS

INTRODUCTION

The culture of mental health treatment facilities and services plays an important part in the success of tobacco dependence treatment for consumers. Because staff members help establish and support the social norms of the facility, when they smoke themselves and/or believe that smoking is an important part of treatment for consumers, tobacco dependence treatment programs can be undermined. Education outreach to staff members is needed to increase awareness about the harms of smoking and benefits of quitting, help reduce barriers to quitting, for promoting quitting among staff, and for ensuring more routine screening and treatment for tobacco use.

INTAKE ASSESSMENT

The initial mental health assessment conducted by a counselor, social worker, nurse, psychologist, or other psychotherapist, should include a standard set of questions to screen for tobacco use. The tobacco screening questions identify and assess a tobacco use status by asking about current use (what product, how much, how often, when), history of use, previous quit attempts, level of dependence (using Fagerström Test for Nicotine Dependence scale[69]) and interest in trying to quit (see Section 4 for examples). Mental health providers need to then act on the assessment information and offer treatment tailored to the consumer's needs. Consumers will need to continue to be screened and their tobacco use monitored throughout their treatment. Since

"vital signs" are not routine in the delivery of mental health care, chart reminders will need to be devised to facilitate ongoing screening. With the growth of policies restricting smoking in mental health facilities, smoking cessation is increasingly mandatory for these consumers and medications to manage withdrawal are often necessary. However, enrollment in tobacco treatment programs should continue to be voluntary.

TREATMENT PLANNING

After identifying an interest in tobacco treatment and assessing adequate stability of mental illness, treatment planning begins with an evaluation of a consumer's readiness to quit during an individual counseling session. The categories used to gauge readiness to quit are: 1) not thinking about quitting, 2) not prepared to quit now but thinking about quitting sometime in the next 6 months, 3) thinking about quitting in the next month. From there, consumers are helped to develop a treatment plan tailored to their specific needs and stage of readiness to quit. The treatment plan needs to consider the consumer's mental health status and treatment and level of functioning now and during any previous quit attempts along with corresponding sequelae.

Part of the initial counseling should include consumer education about the effects of smoking and quitting on other drugs they might be taking (e.g. psychiatric medications, see page 12). Quitting smoking may require a *reduced* dose of some medications. A potential positive bi-product of reducing psychiatric medication doses is a reduction in dose-related side effects. For some consumers, the potential of reducing side effects may increase motivation to try to quit.

Treatment plans could include a series of individual sessions with a case manager (if available), enrollment in a cognitive-behavioral group cessation program, a wellness program, or a combination of group program and individual counseling. Consumers should be encouraged to participate in groups when possible, but be permitted to opt out if they are uncomfortable. Most of the mental health professionals interviewed completed individual consultations with consumers then made decisions about whether a one-to-one setting, a group setting, or a combination of settings would be most appropriate.

CESSATION PHARMACOTHERAPY

Prescription buproprion, varenicline or non-prescription nicotine replacement therapy (NRT) is commonly recommended for consumers based on their diagnosis, existing medication regimen, and potential need to reduce risk. Different medications have been shown to be effective in consumers with different diagnoses. Bupropion has been shown to be most effective in consumers with depression, but relapse is high when treatment is discontinued.[69,70] Bupropion has also been effective in treating consumers with post traumatic stress disorder (PTSD)[71] but has adverse effects in consumers with bipolar disorder and eating disorders.[72] Programs using the nicotine patch have been moderately successful in consumers with schizophrenia.[73] Nicotine replacement therapy has been successfully used in consumers with PTSD.[74] Varenicline has been effective for many smokers but has not yet been tested in persons with mental illness. There have been two recent reports of psychotic exacerbations on varenicline,[56,57] and, post marketing adverse behavior and mood changes have been reported. No casual links have yet been established, but consumers and providers are warned to closely monitor psychiatric symptoms when quitting smoking.[59] For a more complete discussion of prescribing cessation medications for clients with mental illness, see Smoking Cessation for Persons with Mental Illness"[75] and "Tobacco-Free Living in Psychiatric Settings"[30].

TREATMENT APPROACHES AND FOLLOW-UP

A flexible approach using cognitive behavioral therapy is recommended. A group program format is about 8-10 people for 7-12 weeks. Typical content includes:[75]

- Introduction to tobacco history and prevalence of use.
- Education about the properties of nicotine, health effects of nicotine and tobacco use, and addictive nature of nicotine.
- Review of the reasons why people smoke.
- Education about how to quit smoking, use of medications, and developing a quit plan.

Consumers new to quitting will likely have fewer skills. These consumers may need to begin with a program focused less on setting a specific quit date and more on how to overcome obstacles to quitting. Peer support in the groups can help clients address common problems and be reassured that they are not alone in their efforts.

The University Medical and Dental School of New Jersey (UMDNJ) has developed a specific program called "Learning about Healthy Living" for low motivated smokers in mental health settings.[77] This program has a manual used with 20-week group sessions, carbon monoxide monitoring, information on medications and availability of treatment. The purpose of this program is to stimulate enough motivation in smokers to subsequently enter an eight to ten week treatment program.

INCREMENTAL STEPS

Consumers who are ready to quit will benefit from programs that are structured in incremental steps that are more easily accomplished. Breaking down the quitting process into smaller, more concrete pieces can help consumers build skills and reduce the risk of failure in a given quit attempt.

LONGER FOLLOW-UP

Program follow-up may be lengthy since consumers often maintain contact with case managers for an extended period of time. The extended follow-up is important for some consumers and will help them to reach complete cessation and prevent relapse. The ongoing follow-up also permits a smoother coordination of medications. It is not unusual for consumers to want to continue attending groups and remain on medications long after quitting for extra support.

Increasing motivation to quit

Motivation to quit and to remain abstinent can be improved through community outreach. An example is a program that does quarterly presentations on tobacco education at a mental health day treatment center so consumers who smoke can get information in a comfortable, low demand environment. This approach also provides opportunities for mental health consumers who have already quit to talk about their experiences and to encourage others to move toward quitting.

SMOKE-FREE POLICIES

Treatment is facilitated by the adoption of smoke-free policies, which prohibit smoking in or around the facility by both consumers and staff. Since staff and consumers have previously smoked side-by-side supporting one another in their nicotine dependence, smoke-free policies can significantly improve quitting support for everyone. Tobacco has also been used as a reward for good behavior in many mental health facilities. As more and more mental health facilities become smoke-free, both staff and consumers will benefit by supporting one another in quitting.

SUMMARY OF PROFESSIONAL ADVICE

- Ideally, a consumer's mental health provider and/or primary care provider should be involved in tobacco dependence treatment planning and medication management.
- Treatment plans need to be tailored to individual circumstances. A combination of cognitive-behavioral therapy with nicotine replacement therapy (NRT) or other medication (such as bupropion or varenicline) is important to cessation outcomes.

- Quitting may be a struggle for consumers and they will likely need more time to work towards their goals. The issue may not be *motivation* to quit but *confidence* that it can be done. Any reduction in cigarettes smoked in a day needs to be recognized as progress. For these reasons, quit dates need to be flexible and goals need to be frequently reevaluated.
- Group sessions can work very well. Consumers support one another in their quit attempts in the group and socially outside the group.
- Support for quitting is improved when the agency has smoke-free policies. Overall support by staff is invaluable to consumers, as is creating a social environment where nonsmoking consumers do not feel marginalized.
- To be successful, the staff in mental health facilities need to be educated, involved, and also helped to quit.

SUBSTANCE USE TREATMENT PROGRAMS

INTRODUCTION: THE SUBSTANCE USE TREATMENT CULTURE

Tobacco dependence is classified as an addiction and is the most common substance use disorder.[77] Even so, tobacco dependence is commonly ignored in substance use treatment programs.[78] Explanations for why this is the case are related to the ways in which the culture of recovery programs has developed and to the attitudes, skills, and knowledge of the staff.[78] The culture of substance use treatment programs typically supports tobacco use and can undermine tobacco dependence treatment. About 30 to 40% of staff in community-based treatment programs are tobacco dependent.[79] Many treatment program staff strongly believe that tobacco is not a "real" drug, that it is not as harmful as other drugs of abuse, and that quitting smoking is too stressful and would jeopardize recovery from other substances.[78]

Increasingly the data are showing otherwise. In a 10-year prospective study of graduates from an inpatient substance use treatment center, tobacco related illnesses caused significantly more deaths than alcohol related causes.[80] The death rate among narcotic addicts who received treatment was fourfold higher among smokers compared to non-smokers.[81] There is also evidence that smoking cessation may help clients already in recovery programs and may protect against relapse to the illicit drug of choice.[82] Alcoholics who quit smoking are more likely to succeed in treatment.[83] Smokers relapse back to alcohol and illicit drugs more often, more frequently and sooner than nonsmokers.[84]

Although the culture of treatment programs and treatment staff are slow to change, they are changing. Addiction treatment specialists are recognizing the importance of addressing mental illness and tobacco use during substance use recovery programs. And, treatment programs are recognizing the importance of assisting their staff members who use tobacco to quit. More training and ongoing supervision of staff is also helping to reinforce the importance of quitting, to address problems, and to build capacity and skills within treatment programs.

The substance use treatment programs that were included in our survey had undergone the cultural change from programs that supported tobacco use to programs that treat tobacco dependence. They all emphasized the importance of directly addressing the cultural and staff issues in order to better integrate effective tobacco dependence treatment into substance use treatment.

INTAKE ASSESSMENT

Tobacco use questions need to be incorporated into the standard substance use intake assessment and follow-up care, whether it is done in person or over the phone. Intake questions for tobacco use follow the same format as questions about other substances: frequency of use, his-