RUTGERS
THE STATE UNIVERSITY OF NEW JERSEY

Integrating Tobacco and Nicotine Treatment into Substance Use Disorder Recovery

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Learning Objectives

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- Discuss how individuals with a Substance Use Disorder are a key disparity group for addressing tobacco and suffer many consequences from this addiction
- To understand changing patterns of tobacco use including vaping and co-use with cannabis
- Summarize the benefit of integrated approaches for addressing tobacco in SUD clinics and recovery homes
- To review brief updates in tobacco treatment with an emphasis on individuals with SUD

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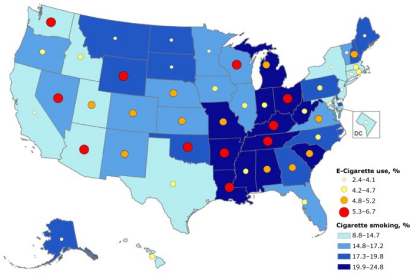
What is the smoking rate in US?



US 11%
in 2022; NHIS

E cigs ~ 6%

Mental Health ~ 30%

SUD ~ 40-60%

SUD Staff ~ 30%

Centers for Disease Control and Prevention, 2015; Guydish 2022

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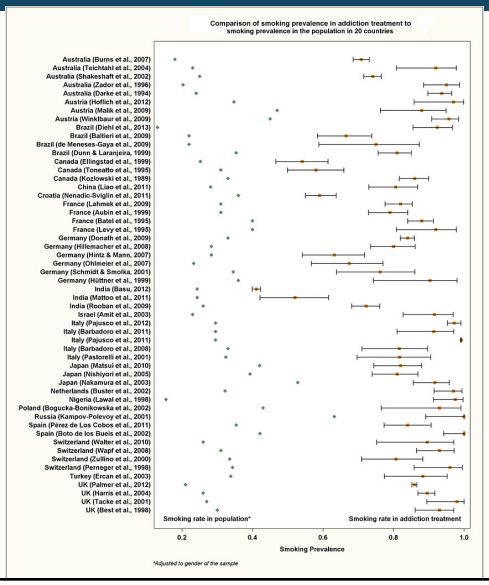
Higher Smoking Rates in SUD Internationally



Rates 2-4 times higher

US 60-70%

Guydish et al., 2015

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Smoking is a Social Justice Issue

www.thetruth.com

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Less Than Half of US Mental Health Treatment Facilities Screen for Tobacco Use

Tobacco Related Policies and Practices (2016 data)

Mental health treatment facilities (%)	Substance abuse treatment facilities (%)	*Marynak et al., MMWR, 2018*
48.9	64.0	Reported screening patients for tobacco use
37.6	47.4	Offered tobacco cessation counseling
25.2	26.2	Offered nicotine replacement therapy
21.5	20.3	Offered non-nicotine cessation medications
48.6	34.5	Had a smoke free campus policy

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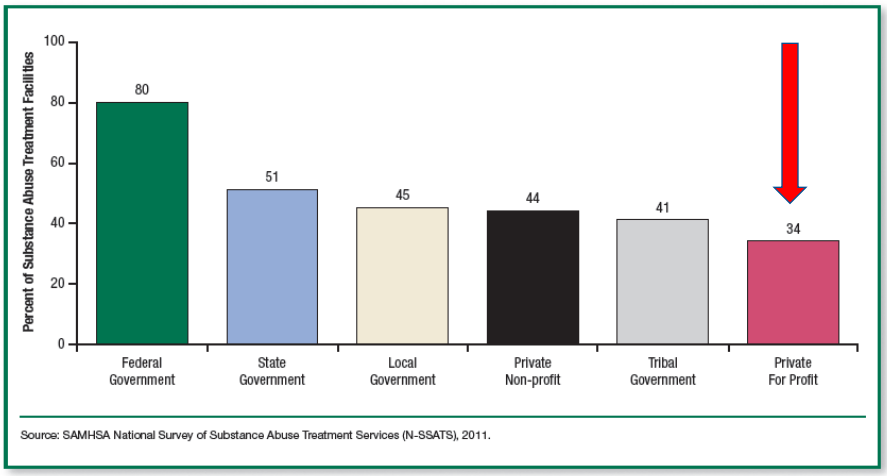
Least Tobacco Treatment in Private SATP

Figure 3. Substance Abuse Treatment Facilities Offering Tobacco Cessation Services, by Facility Operation: 2011



Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2011.

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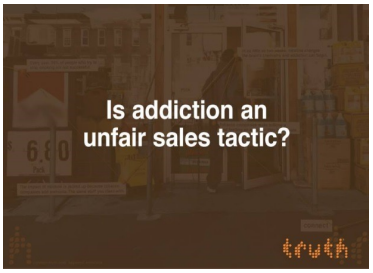
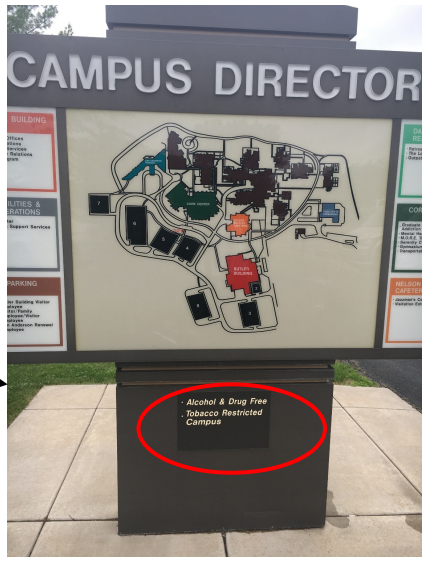


Alcohol Free
Drug Free

Not
Tobacco
Free



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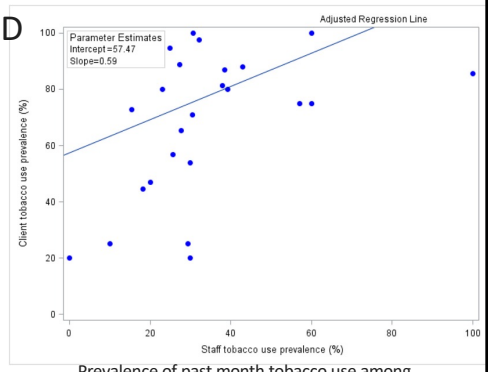
Staff Smoking

Higher staff smoking in SUD Programs

- More client smoking
- Lower client receipt of tobacco counseling
- Worse staff beliefs about having clients quit while in SUD treatment
- Lower staff self-efficacy to assist clients with quitting.



Prevalence of past month tobacco use among both staff and clients in 24 programs. The program at bottom left had 0% of staff and 20% of clients reporting recent use of tobacco products. The program at far right had 100% of staff and 86% of clients reporting use of tobacco products.

Guydish et al., 2022

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Barriers in SUD Programs

Rationale Not to Treat Tobacco Dependence in SUD Patients (Hurt & Slade 2001)

- Not a real drug
- Fewer consequences / Not as disruptive to patients' life
- Disruptive to SUD treatment
- Patients don't want tobacco treatment
- Patients can't quit smoking successfully
- Jeopardizes recovery from other substances

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Barriers in SUD Programs

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Hurt & Slade 2001; Williams et al., 2003

BARRIERS

- SUD recovery culture
- Low stakeholder engagement/ client resistance
- Organizational culture
- Lack of reimbursement for smoking cessation services
- Staff smoking
- Lack of workforce expertise/ lack of resources

Fokuo et al 2022; Pagano et al., 2016

BARRIERS

- Beliefs that clients need to smoke to relieve the stress of recovery
- Patients are disinterested in quitting
- Fears that concurrent treatment would jeopardize substance use
- Limited education/ training resources

Britton et al., 2023

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Predictors of Quality Tobacco Treatment

National survey of tobacco practices in US Drug Treatment Facilities

- Our facility has a policy that requires staff to offer treatment for clients' tobacco dependence
- Our staff has dedicated time for treating clients tobacco dependence
- Our staff has the skills to treat clients tobacco dependence
- Our staff has received training specifically for treating tobacco dependence

Commitment and Resources

Richter KP et al. 2017

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Survey of SUD Program Directors

- Several factors that would support tobacco treatment in SUD.

- Financial support
- Enhanced leadership
- **State mandates** against smoking in addiction treatment programs.

Pagano et al., 2016

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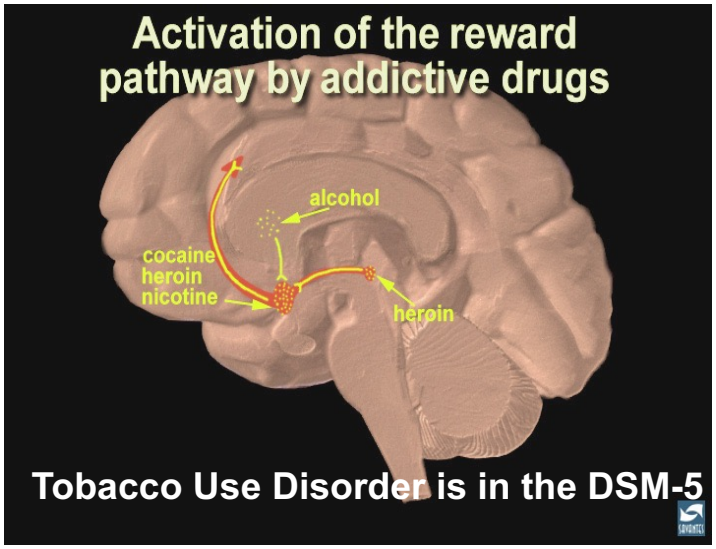
It is a Real Drug



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Addiction

- Reward Deficit + Excess Stress

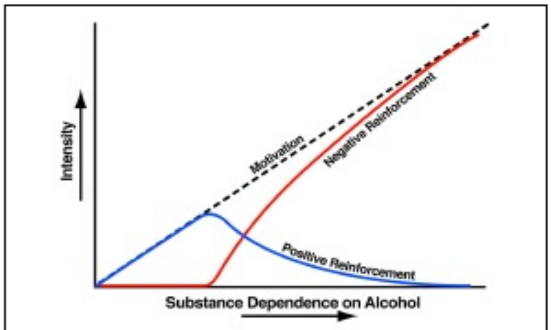

FIGURE 1 | Theoretical framework relating addiction cycle to motivation for drug seeking. The figure shows the change in the relative contribution of positive and negative reinforcement constructs during the development of substance dependence [taken with permission from Ref. [61]].

Drug withdrawal
Depression
Abuse/ Trauma
Neglect/Poverty/
Social Deprivation

Koob 2013

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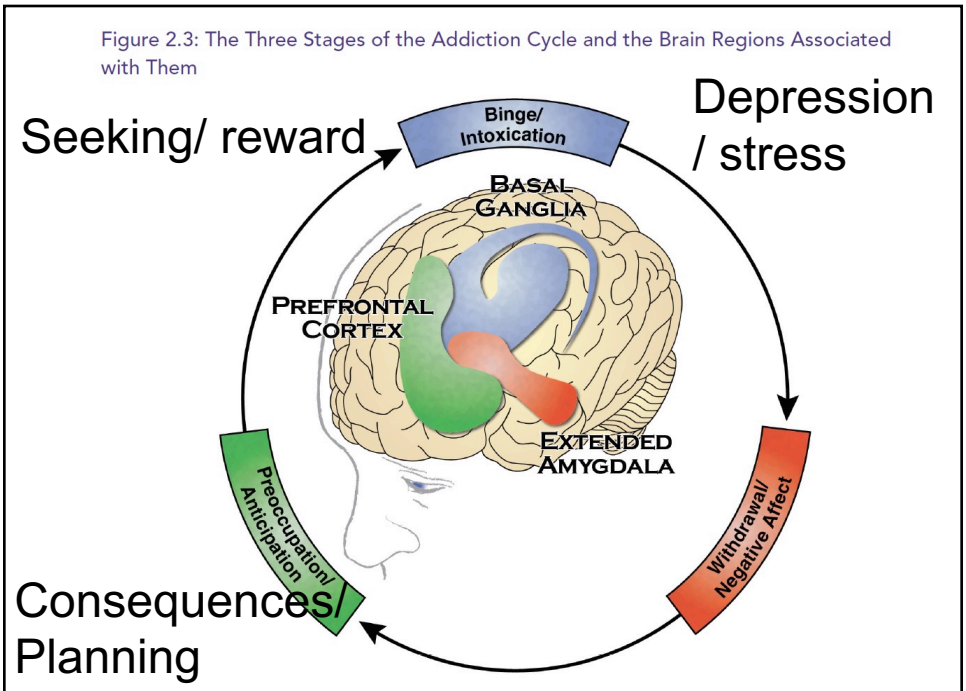
Figure 2.3: The Three Stages of the Addiction Cycle and the Brain Regions Associated with Them



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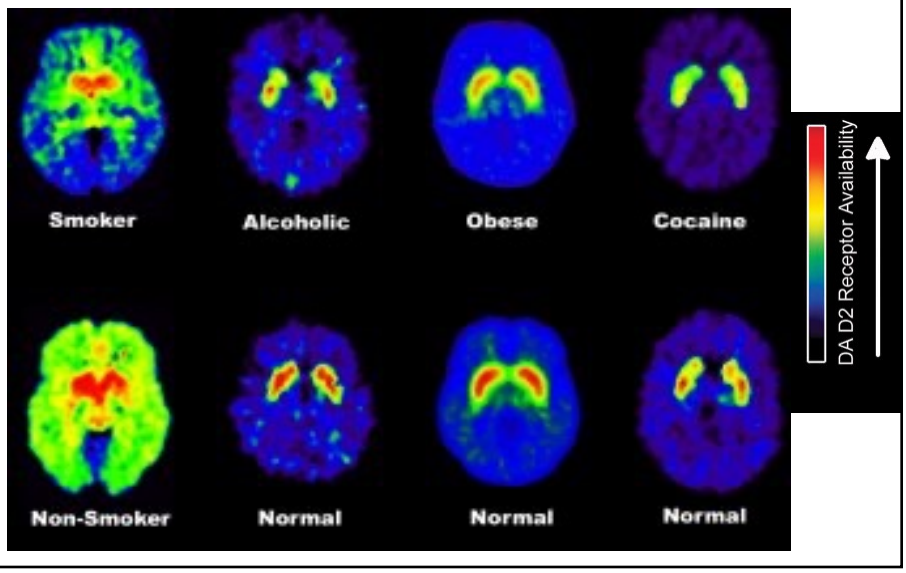
Dopamine D2 Receptors are Lower in Addiction



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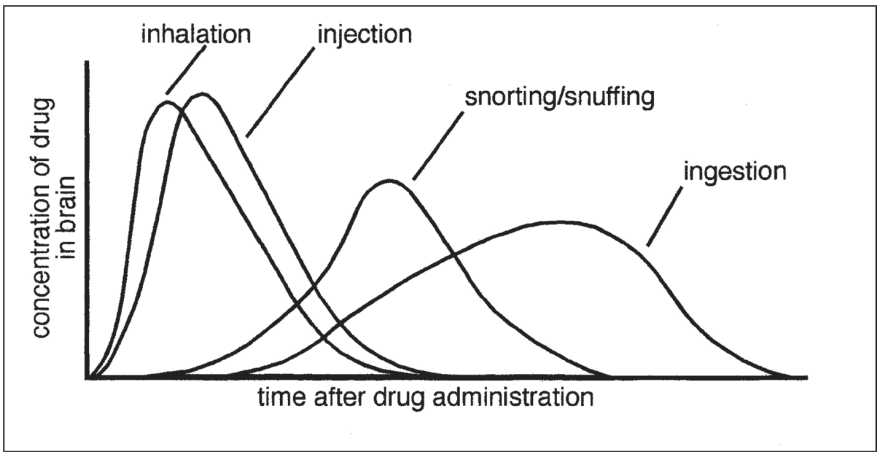
Smoking is Fastest Route of Drug Administration



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Are Drug Use Behaviors Related?

How does tobacco use behavior pattern *mimic* or *maintain* drug use behaviors?

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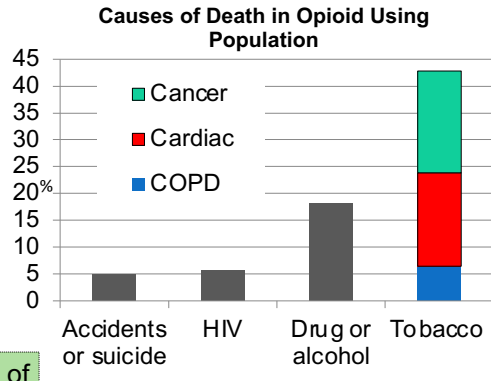
It Causes Real Consequences:
Tobacco is Number One Cause of Death

- Schizophrenia
- Depression
- Bipolar Disorder
- Accountable for 50% of all deaths



N=68,066 hospitalized in CA for opioid 1990-2005

More with alcohol use disorder die of smoking (caused diseases) than die of alcohol (caused disease)

Callaghan 2013; Hurt et al., 1996; Veldhuizen et al., 2014

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Consequences of Tobacco

Major Health Consequences

- Premature Death
- Heart Disease
- Lung Disease
- Cancer
- Others
- Severe COVID illness

Others/ Barrier to Recovery

- Financial Hardships
- More Employment Difficulties
- More Housing Difficulties
- Poorer Mental Health
- More Suicidal Ideation, Attempts
- More Relapse to Drugs and Alcohol
- Social Stigma
- Poorer Appearance
- More Fires in Home

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Tobacco Consequences in Alcohol Use Disorder (AUD)

- More die from smoking related diseases than from alcohol related diseases[1]
- Synergistic effects of alcohol and tobacco ↑ risk pancreatitis and oral cancers[2]
- Smoking ↓ recovery from cognitive deficits during alcohol abstinence[3]

[1]Hurt et al, 1996; [2]USDHHS 2007; [3]Durazzo et al, 2007

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It is Not Disruptive to SUD Treatment and Improves Other Abstinence Outcomes

- vs TAU (Winhusen et al., JCP 2016) in stimulant use disorder
  - Increased abstinence from stimulants at 6 months
  - More quitting smoking
  - Does not contribute to patient drop outs
- Does not negatively effect drinking or drug outcomes (Romano 2021; Apollonio 2016)
- Associated with 25% increased likelihood of long term abstinence from alcohol or drugs (Prochaska 2004)
- No increase in irregular discharges when residential SUD settings went TF(NJ; Williams 2005)

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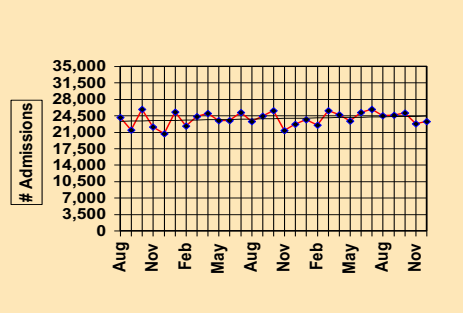
OASAS Improving Lives.
NEW YORK STATE OFFICE OF ALCOHOLISM & SUBSTANCE ABUSE SERVICES
Addiction Services for Prevention, Treatment, Recovery

- All 1419 substance abuse treatment sites tobacco-free since 2008
- No reduction in admissions
- More than 80% in compliance (2010)
- Positive behavior change
  - less smoking, ↑ intentions to quit, ↑awareness about smoking
- Negative behaviors
  - addict behaviors (lying, selling)
  - enforcement problems

No Reduction in SUD Program Admissions



Total For All Major Program Types OASAS NY Tobacco-Free Implementation - July 2008

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Smoking and SUD Relapse

- NESARC (2 surveys, 3 years; n>5000); SUD remission >1 year

  Controlled for sociodemographic and psychiatric covariates
- 82 % still smoking at Wave 2
- Wave 1 NS who started smoking, ↑ Wave 2 substance use and SUD relapse (vs stayed nonsmokers W2)
- Wave 1 S, ↑ Wave 2 substance use and SUD relapse (vs quit smoking W2)
- **Both continued smoking and new-onset smoking—is associated with an increase the likelihood of relapse to SUD**

Weinberger et al., JCP, 2017

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Quitting Smoking Reduces Anxiety and Depression

Meta-analysis 26 studies (14 gen pop, 4 psychiatric, 3 physical conditions, 2 psychiatric or physical, 2 pregnant, 1 post-op)

Table 1| Effect of smoking cessation on mental health. Sensitivity analysis after removal of studies of low quality (medium-
Newcastle-Ottawa scale)

Outcome	No of studies included	No of studies excluded	Standardised mean difference (95% CI)	
			Effect estimate	Original effect estimate
Anxiety	4	0	−0.37 (−0.70 to −0.03)	−0.37 (−0.70 to −0.03)
Depression	9	1	−0.29 (−0.42 to −0.15)	−0.25 (−0.37 to −0.12)
Mixed anxiety and depression	4	1	−0.36 (−0.58 to −0.14)	−0.31 (−0.47 to −0.14)
Psychological quality of life	4	4	0.17 (−0.02 to 0.35)	0.22 (0.09 to 0.36)
Positive affect	1	2	0.68 (0.24 to 1.12)	0.40 (0.09 to 0.71)
Stress	2	1	−0.23 (−0.39 to −0.07)	−0.27 (−0.40 to −0.13)

Taylor G, McNeill A, Girling A, Farley A, Lindson-Hawley N, Aveyard P. Change in mental health after smoking cessation: systematic review and meta-analysis. Bmj. 2014 Feb 13;348.

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Smoking and Anxiety

- Smoking → Panic
- Smokers 3X panic attacks/ disorder
- Anxiety D/o reduced success quitting and more withdrawal symptoms
- More negative affect (smoking to improve mood), anxiety sensitivity, more withdrawal symptom sensitivity

Tobacco Withdrawal

Depressed mood
Insomnia
Irritability, frustration or anger
Anxiety
Difficulty concentrating
Restlessness
Increased appetite or weight gain
Craving

Piper 2010; Bakhshaie 2016; Johnson et al., 2000; Isensee et al., 2003

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Why So Hard to Quit?

- Smoking a drug is highly addicting
- Easy access to drug
- Normalization in behavioral health settings
- **Treatment options**
  - Limited (brief) counseling support
  - No levels of care
- **Utilization of treatment is poor**
  - Most don't use counseling
  - Medications-too low dose, not enough time

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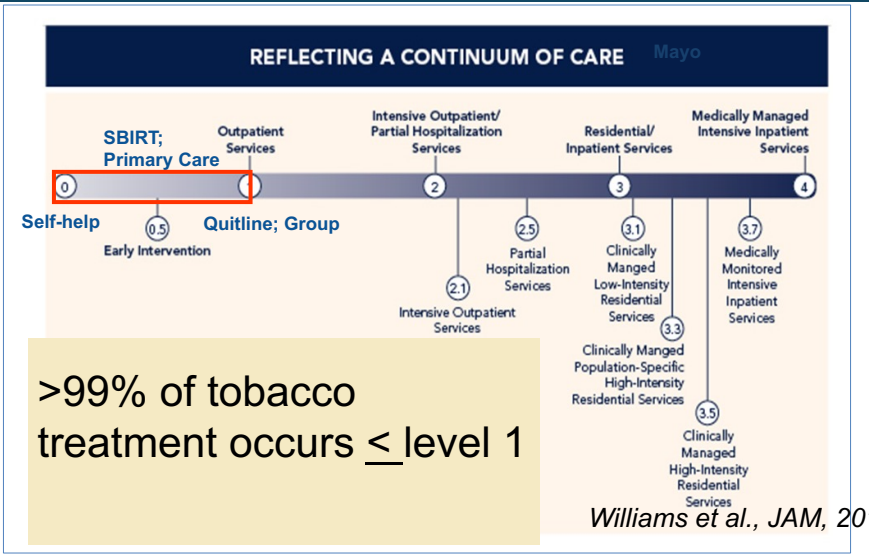
ASAM Addiction Levels of Care



>99% of tobacco treatment occurs < level 1

Williams et al., JAM, 2016

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Multidimensional Assessment

Biopsychosocial Severity and Level of Function

ASAM identifies 6 dimensions

√ 1. Acute intoxication and/or withdrawal potential

√ 2. Biomedical conditions and complications

√ 3. Emotional, behavioral, or cognitive conditions or complications

√ 4. Readiness to change

√ 5. Relapse, continued use, or continued problem potential

√ 6. Recovery/living environment

Each scored 0=none to 4=severe

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E= N x S

Exsmokers =(number trying to quit) x (success of attempts)

R West, 2013

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Treatment for Tobacco Use Disorder Works

Call it Treatment, Not Cessation

Tobacco Use is a Co-Occurring Disorder

- Brief Assessment
- Work with all Motivational Levels
- Engagement/ Motivational Approaches
- Counseling + Medications

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Smokers with mental illness

Compared with smokers without mental illness
(US, UK, Australia, Germany)

- More likely to try to quit
- Same or higher motivation
  - 50% considering quitting in next 1-6 months
- Higher rate of health professional's advice to quit, use of counseling and/or medication
- More quit attempts/ more **unsuccessful** attempts

Brose et al, BMJ, 2020; Siru 2009; Babb MMWR, 2017

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ATOD Orientation

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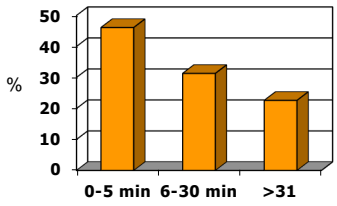
Heaviness of Smoking Index Best Measure of Dependence

Smokers in SUD Treatment are Moderately to Severely Tobacco Dependent



N=1882 smokers in addiction treatment,
Williams et al., 2005

AM Time to first cigarette (TTFC)

- ≤ 30 minutes = moderate
- ≤ 5 minutes = severe

Heatherton 1991

Implications for Treatment Outcome
Need for Medications
Implications for Dose

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Tobacco Withdrawal

Emerge hours after last cigarette
Can last up to (4) weeks

- Depressed mood
- Insomnia
- Irritability, frustration or anger
- Anxiety
- Difficulty concentrating
- Restlessness
- Increased appetite or weight gain
- Cravings

DSM5 2013

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FDA Approved Pharmacological Treatments

Nicotine Replacement (NRT)

Patch
Gum
Lozenge

Available OTC but are often covered with prescription with state Medicaid

Nasal Spray

Bupropion (Wellbutrin)

Varenicline (Chantix)

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Effectiveness of First Line Medications

Results from meta-analyses comparing to placebo (6 month F/U)

Medication	No. Studies	OR	95% CI
Nic. Patch (6-14 wks)	32	**1.9**	1.7-2.2
Nic. Gum (6-14 wks)	15	**1.5**	1.2-1.7
Nic. Inhaler	6	**2.1**	1.5-2.9
Nic. Spray	4	**2.3**	1.7-3.0
Bupropion	26	**2.0**	1.8-2.2
Varenicline (2mg/day)	5	**3.1**	2.5-3.8

2008 PHS Guideline Update; Hartmann-Boyce et al., 2013

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Recommendations for Increasing Smoking Cessation in US

- **Varenicline or combination NRT + behavioral support should be considered first line**

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Combination NRT

- Long acting (patch) + short acting (gum/lozenge/inhaler)
- Delivers higher dose
- Immediate withdrawal and craving relief

	OR
Patch + gum or spray	**1.9** (1.3-2.7)
Patch + bupropion	**1.3** (1.0-1.85)

2008 PHS Guideline Update; *Carpenter et al., 2013*

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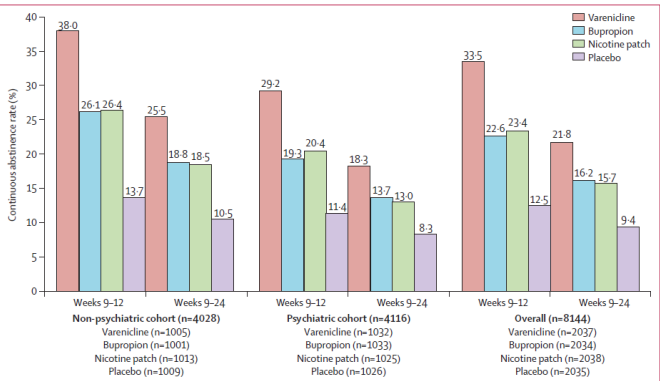
Neuropsychiatric Safety and Efficacy Varenicline, Bupropion, Nicotine Patch Smokers with and without Psych Disorders (EAGLES)

Varenicline superior to BUP and NP in psych and nonpsych cohorts

- 8144 (4416 psych and 4028, non psych by SCID)
- Triple dummy
  - Varenicline 1mg BID
  - Bupropion 300mg
  - 21mg Nicotine patch
  - 3 placebos
- Largest smoking cessation study



Anthenelli et al., 2016

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Neuropsychiatric Safety Varenicline

- Meta analysis 39 RCT (10,761 participants)
  - **No** increased risk of suicide, suicidal ideation, depression, irritability, aggression
- RCT. MDE, Schizophrenia, Bipolar
  - No worsening illness (MADRS, PANSS)
- EAGLES study : N= 8144 (4416 stable, psych outpatients)
  - No increased risk of moderate/ severe adverse effects vs NP or Bup or Placebo
    (Anxiety/ Panic, Depression, Feeling abnormal, Hostility, Agitation, Aggression, Delusions, Hallucinations/ Paranoia/ Psychosis, Homicidal ideation, Mania, Suicidal ideation or behavior)
- VAR ↓ mortality, serious CV events and neuropsych events (vs NRT) US Health insurance claim database (> 600k)
  VAR (20%) or BUP (25%) less likely hospitalized CV problem in last 12 mos (vs NRT)
  VAR: 35% ↓hospitalized psychiatric illness in last 12 mos (vs NRT; BUP ↑)

Carney et al., NTR, 2021 ; Anthenelli et al, 2016,Thomas et al., 2015

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Mental Health Populations

- Treatments work and well tolerated
- Overall cessation on a given attempt can be less than populations without mental illness
- Many studies- no worsening of depression, psychosis in quit attempt
- No worsening of neuropsychiatric: varenicline
- Modified counseling approaches with pharmacotherapy

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Tobacco Treatment in SUD

- 35 studies , 5796 participants
- **Pharmacotherapy appeared to increase tobacco abstinence** (RR 1.60, 95% CI 1.22 to 2.12, 11 studies, 1808 participants)
- **Combined counselling and pharmacotherapy increased abstinence** (RR 1.74, 95% CI 1.39 to 2.18, 12 studies, 2229 participants,) at follow-up, 6 weeks to 18 months.
- **Counselling interventions did not significantly increase tobacco abstinence** (RR 1.33, 95% CI 0.90 to 1.95)
- Interventions worked for both people in **treatment** (RR 1.99, 95% CI 1.59 to 2.50) and people in **recovery** (RR 1.33, 95% CI 1.06 to 1.67), and for **alcohol** (RR 1.47, 95% CI 1.20 to 1.81) and **other drug** dependencies (RR 1.85, 95% CI 1.43 to 2.40).
- Offering tobacco cessation therapy to people in treatment or recovery for other drug dependence **was not associated with a difference in abstinence** rates from alcohol and other drugs (RR 0.97, 95% CI 0.91 to 1.03, 11 studies, 2231 participants). Does not reduce other abstinence.

Apollonio, Cochrane, 2016

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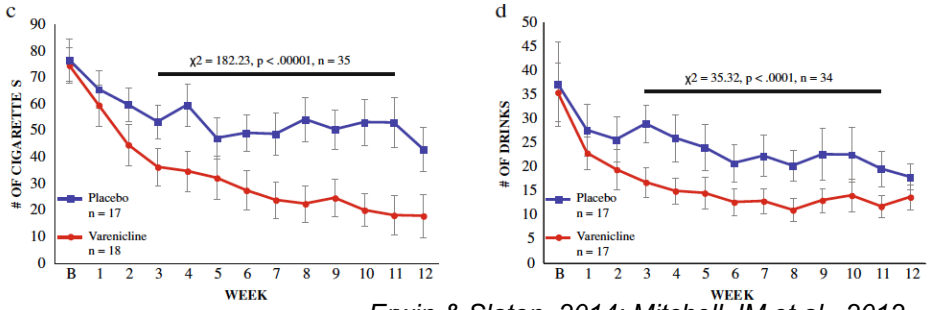
Varenicline and Alcohol

- a4B2 may modulate rewarding effects of alcohol
- Varenicline reduces alcohol consumption & craving
  - In heavy drinkers
  - In smokers trying to quit smoking
  - In lab studies of animals and humans



Erwin & Slaton, 2014; Mitchell JM et al., 2012

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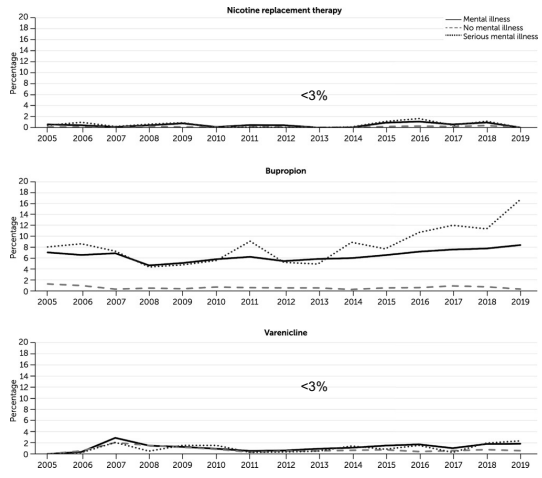
Access to Treatment Still Limited



The most common barrier to providing smoking cessation treatment noted by general internists (60%) and psychiatrists (80%) was patients' perception of **smoking as a coping mechanism for their mental illness**.

White et al., 2022, Psych Serv
Medical Expenditure Panel Survey (MEPS) data (2005–2019)

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Should we use medications for people who aren't ready to quit?

- Yes.
- Lessen dependence
- Minimize withdrawal/ Temporary abstinence
- Harm reduction
- Smoke less
- Higher OR for future quitting/ Reduce to Quit

Fiore et al., 2008. PHS Guideline

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Reduce to Quit (Cochrane)

- 51 trials with 22,509 participants
- Low-certainty evidence that reduction-to-quit interventions may be more effective when **pharmacotherapy** is used as an aid, particularly fast-acting NRT or varenicline (moderate-certainty evidence).
- Reduction-to-quit may be equivalent to abrupt quitting for fast-acting NRT or varenicline but not for nicotine patch, combination NRT or bupropion (abrupt quitting may be better)

Lindson et al, Cochrane, 2019

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Trends Through 2016

Figure 3. Past Month Cigarette Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2016

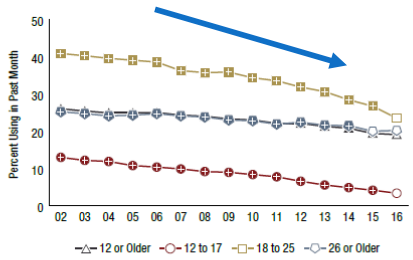
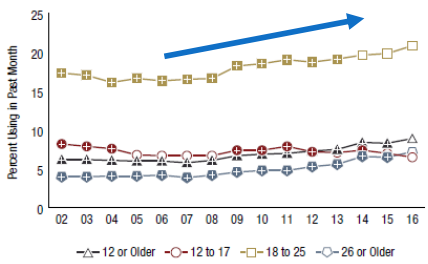


Figure 17. Past Month Marijuana Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2016



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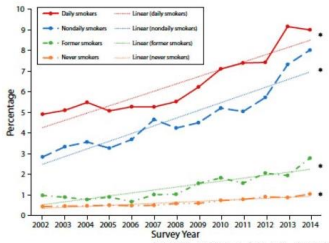
Cannabis and Tobacco

- Trends
  - Combustible vs Vaping/Ecigs
  - Co-Use Delivery
  - Legalization vs Medical
- Impact of Co-Use
  - Mental Health
  - Physical Health
  - Quitting tobacco
  - Quitting cannabis
  - Pregnancy
- Policy and Public Health Implications
  - Indoor Air/ Public Spaces
  - Industry/ Tax

Daily cannabis increased in last decade in smokers



NSDUH; Goodwin RD et al., AJPH 2017

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Vaping Cannabis and Tobacco

- 1 in 10 high school students reported ever vaping cannabis (e-cigarette device with marijuana, THC or hash oil, or THC wax)
- Higher odds of adolescents ever vaping cannabis, if (all past 30 days)
  - **cigars** (adjusted OR (aOR) 3.76)
  - **waterpipe** (aOR 2.32)
  - **e-cigarettes** (aOR 3.18)
  - *None smokeless, comb cigs*

Different Methods of Use (Concurrent, sequential or mixed)

- Spliff (tobacco rolled in with marijuana)
- Blunt (cannabis wrapped in tobacco leaf)
- Vaporizer

Kowitt et al., BMJ Open, 2019

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Tobacco and Cannabis Co-Use

- More psychiatric problems
- More health risks
- Higher risk for SUD of other
- More difficulty quitting (both)
- Desire/importance quit tobacco> cannabis
- ?Drug substitution
- ?Interventions for both

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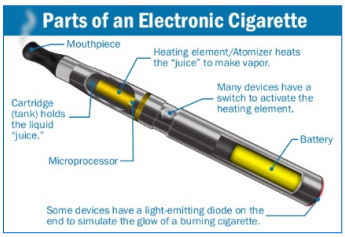
E-Cigarettes and Vaping

- Concern over youth uptake
  - **E-cigarette use is associated with increased risk for cigarette initiation and use, in low-risk youths**
- Controversy - older smoker for cessation
- Non- combustible
  - Safer than smoking doesn't mean safe?
- Not regulated/ Wide variability
- Nicotine addiction: ? same treatments
- Vaping culture- co use with THC/ cannabis
- Most EVALI cases: THC
- Public health support – UK, others
  - Continuum of risk ?



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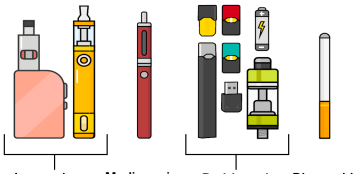
Tobacco and Nicotine Products

- Combustible

Hookah

- Non- Combustible



Snus, chew and nicotine pouches

- Medicinal

Nicotine Replacement Therapy (NRT)

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Controversies

Increasing Adult Cessation

Prevent Youth Uptake

Policy Agenda

- Decreasing the addictiveness of combusted tobacco products while ensuring the availability of reduced-risk nicotine products
- Imposing large taxes on combustible products and smaller taxes on e-cigarettes
- Limiting the sale of all tobacco/nicotine products to adult-only retailers
- Developing communications that accurately portray e-cigarettes' risks to youth and benefits for adult smokers

Warner et al., 2022

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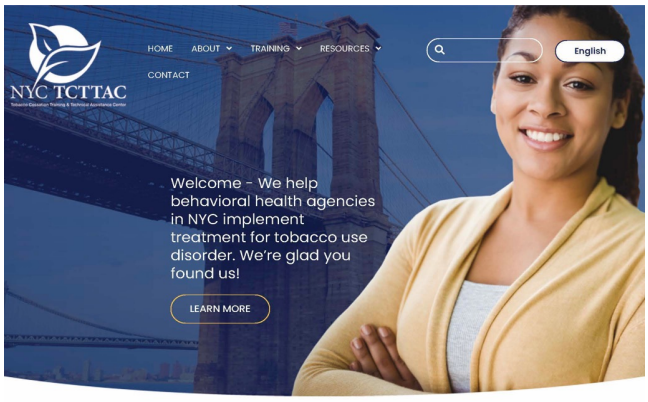
www.nyctcttac.org



583 providers **167** programs **61** agencies

from NYC completed our comprehensive training program since 2017, improving their capacity and expertise to treat tobacco use disorder.

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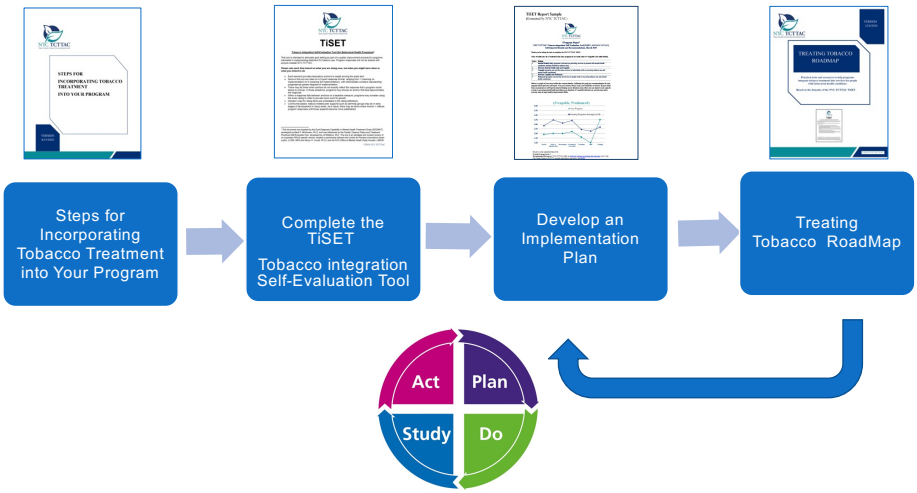
Implementing Change



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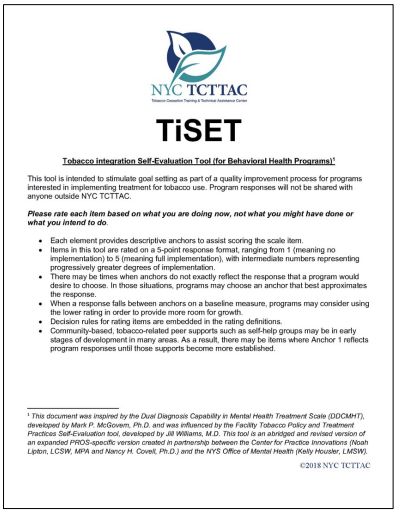
Tobacco Integration Self-Evaluation Tool (TiSET) for Behavioral Health Programs

- This tool is intended to stimulate goal setting as part of a quality improvement process for programs interested in implementing treatment for tobacco use
- Based on the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) index[1]
- Twenty items across Six domains:
  - POLICY AND ADMINISTRATIVE
  - ENVIRONMENT
  - SCREENING AND ASSESSMENT
  - TREATMENT
  - STAFF
  - TRAINING
- Items rated on a 5-point response, ranging from 1 (no implementation) to 5 (full implementation).



NYC TCTTAC

TiSET

Tobacco integration Self-Evaluation Tool (for Behavioral Health Programs)[1]

This tool is intended to stimulate goal setting as part of a quality improvement process for programs interested in implementing treatment for tobacco use. Program responses will not be shared with anyone outside NYC TCTTAC.

Please rate each item based on what you are doing now, not what you might have done or what you intend to do.

- Each element provides descriptive anchors to assist scoring the scale item.
- Items in this tool are rated on a 5-point response format, ranging from 1 (meaning no implementation) to 5 (meaning full implementation), with intermediate numbers representing progressively greater degrees of implementation.
- There may be times when anchors do not exactly reflect the response that a program would desire to choose. In those situations, programs may choose an anchor that best approximates the response.
- When a response falls between anchors on a baseline measure, programs may consider using the lower rating in order to provide more room for growth.
- Decision rules for rating items are embedded in the rating definitions.
- Community-based, tobacco-related peer supports such as self-help groups may be in early stages of development in many areas. As a result, there may be items where Anchor 1 reflects program responses until those supports become more established.

[1] *This document was inspired by the Dual Diagnosis Capability in Mental Health Treatment Scale (DDCMHT), developed by Mark P. McGovern, Ph.D. and was influenced by the Facility Tobacco Policy and Treatment Practices Self-Evaluation tool, developed by Jill Williams, M.D. This tool is an abridged and revised version of an expanded PROS-specific version created in partnership between the Center for Practice Innovations (Noah Lipton, LCSW, MPA and Nancy H. Covell, Ph.D.) and the NYS Office of Mental Health (Kelly Houster, LMSW).*

[1]Gotham HJ, Brown JL, Comaty JE, McGovern MP, Claus RE. Assessing the co-occurring capability of mental health treatment programs: the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index. The journal of behavioral health services & research. 2013 Apr;40(2):234-41.

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Doing an Agency or Program-Level Self-Assessment

- What is our capacity for treating tobacco today?
- How can we increase our capacity for treating tobacco over time?
- How do we develop and implement a plan to increase capacity?
- How do we know our changes have been successful?
- Process explores the organization's policies, clinical practices, and workforce capacities.
- Provides specific feedback/priority areas.

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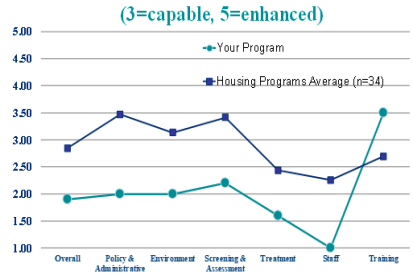
The Self-Evaluation (TiSET) Report



POLICY AND ADMINISTRATIVE
Overall Average Score: 2
Recommended Resources: NYC TCTTAC offers an archived webinar on tracking data outcomes. New York City Treats Tobacco (NYCTT) can help with tobacco use policy, see HERE.

Item	Recommendation
1. Tobacco Use Policy	Your program scored a 2 on this item. Congratulations on having an informal policy; consider developing a written policy prohibiting tobacco use on grounds and in vehicles, with the eventual goal of informing most (at least 80%) staff and people you serve in writing.
2. Tracking Outcomes	Your program scored a 2 on this item. Congratulations on tracking mental health outcomes; consider ensuring that the program tracks both mental health and tobacco related outcomes data, with the eventual goal of using this data to identify program strengths and challenges and to make program improvements.

- Used to develop an implementation plan
  - includes goals, objectives, interventions, responsible persons, and projected dates
- Can be repeated to measure progress in targeted areas

Covell et al., CMHJ, 2021

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Conclusions

- Approach tobacco use as a co-occurring disorder
- Improve implementation evidence based treatment
- Systems interventions/ policy mandates
- More resources: support for staff, training, time
- Varenicline OR Combination NRT two very good medication options
- More harm reduction

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