NYC TCTTAC
Tobacco Cessation Training & Technical Assistance Center

Program Tobacco Dependence Treatment Self-Evaluation Tool[1]

This tool is intended to stimulate goals as part of a quality improvement process for programs interested in implementing tobacco dependence treatment.

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.
- The response alternatives are behaviorally anchored, identifying measurable elements of tobacco dependence treatment.
- 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 imbedded 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 Housler, LMSW).*

POLICY AND ADMINISTRATIVE

1. **Tobacco use policy:**
   1) There is **no** written policy prohibiting tobacco use on grounds and in vehicles.
   2) There is **no** written policy prohibiting tobacco use on grounds and in vehicles, although there is an informal policy that is communicated to staff and consumers verbally.
   3) There is a written policy prohibiting tobacco use on grounds and in vehicles, although staff and consumers are **not informed** of the policy in writing.
   4) There is a written policy prohibiting tobacco use on grounds and in vehicles; staff and consumers are informed of the policy in writing **some of the time** (less than 80% of the time).
   5) There is a written policy prohibiting tobacco use on grounds and in vehicles; staff and consumers are informed of the policy in writing **most of the time** (at least 80% of the time).

2. **Tracking outcomes:**
   1) The program does **not** track outcomes data.
   2) The program tracks **mental health** related outcomes data.
   3) The program tracks **both** mental health and tobacco related outcomes data.
   4) The program tracks mental health and tobacco related outcomes data and uses the data to **identify** program strengths and challenges.
   5) The program tracks mental health and tobacco related outcomes data and uses the data to identify program strengths and challenges and to **make program improvements**.

ENVIRONMENT

3. **Availability of educational materials (e.g., visible in waiting areas, orientation materials, family visits, etc.):**
   1) Mental health related education materials **are** available and routinely offered.
   2) Mental health related education materials are available and routinely offered. Tobacco related materials are available but are **not** routinely offered.
   3) Mental health related education materials are available and routinely offered. Tobacco related materials are available and routinely offered **only to consumers who express an interest** in tobacco dependence treatment.
   4) Mental health related education materials are available and routinely offered. Tobacco related materials are available and routinely offered to **all** consumers who use tobacco products, **regardless of current interest in quitting**.
   5) Mental health related education materials are available and routinely offered. Tobacco related materials are available and routinely offered to all consumers who use tobacco products, regardless of **current interest in quitting**, and these materials are **matched to the consumer's stage of change**.

4. **Signage:**
   1) Signage re: "no tobacco use" on agency/program grounds or in vehicles is **not posted and/or the program grounds are not tobacco free**.
   2) Signage re: "no tobacco use" is posted **inconsistently**.
   3) Signage re: "no tobacco use" is posted **somewhat consistently**.
   4) Signage re: "no tobacco use" is posted **consistently**.
   5) Signage re: "no tobacco use" is posted **very consistently**.

SCREENING & ASSESSMENT

5. **Routine screening methods for tobacco use:**
   1) Intake screening based on consumers self-report about current tobacco use only. Decision based on practitioner's inference from consumer
   2) Intake screening includes 1-2 questions about current and lifetime tobacco use
   3) Routine set of standard interview questions for current and lifetime tobacco use using generic framework
   4) Screen for current and lifetime tobacco use using standardized formal instrument with established psychometric properties - completed at intake only
   5) Screen for current and lifetime tobacco use using standardized formal instrument with established psychometric properties - completed at intake and every six months for all consumers

6. **Tobacco use screening documented:**
   1) Tobacco use screening is **not** documented in records.
   2) Tobacco use screening is documented for some consumers but is **sporadic or variable** by staff (i.e., <50% of the records).
   3) Tobacco use screening is documented **somewhat consistently** (in 50-69% of the records).
   4) Tobacco use screening/rescreening is documented **consistently** (in 70-89% of the records).
   5) Tobacco use screening/rescreening is documented **very consistently** (in at least 90% of the records).

7. **Assessment of severity of tobacco use disorder (upon positive screen for tobacco use):**
   1) Assessment of severity of tobacco use disorder is **not** documented in records.
   2) Assessment of severity of tobacco use disorder is documented for some consumers but is **sporadic or variable** by staff (in < 50% of the records).
   3) Assessment of severity of tobacco use disorder is documented **somewhat consistently** (in 50-69% of the records).
   4) Assessment/reassessment of severity of tobacco use disorder is documented **consistently** (in 70-89% of the records).
   5) Assessment/reassessment of severity of tobacco use disorder is documented **very consistently** (in at least 90% of the records).

8. **Tobacco related diagnoses in relevant records:**
   1) Tobacco related diagnoses are **not** made or documented.
   2) Tobacco related diagnoses are present in some records but are **sporadic or variable** by staff (in <50% of the records).
   3) Tobacco related diagnoses are made and documented **somewhat consistently** (in 50-69% of the records).
   4) Tobacco related diagnoses are made and documented **consistently** (in 70- 89% of the records).
   5) Tobacco related diagnoses are made and documented **very consistently** (in at least 90% of the records).

9. **Assessment of Stage of Change for both mental health disorders and tobacco use:**
   1) Assessment of Stage of Change is **not** documented for either mental health disorders or tobacco use.
   2) Assessment of Stage of Change is documented for some consumers for either mental health disorders or tobacco use but is **sporadic or variable** by staff.
   3) Assessment of Stage of Change via **individual staff assessment** is routinely documented and focuses only on the motivation for addressing mental health disorders.

4) Assessment of Stage of Change using **formal measures** is routinely documented and focuses only on the motivation for addressing mental health disorders.
5) Assessment of Stage of Change using formal measures is routinely documented and focuses on the motivation for addressing **both** mental health disorders and tobacco use.

TREATMENT

10. Treatment Plans:

1) Tobacco use is **not** addressed in treatment plans.
2) Treatment plans addressing tobacco use are **sporadic or variable** by staff.
3) Treatment plans routinely address both mental health disorders and tobacco use, although there is a primary focus on mental health disorders. Tobacco related disorders are treated as **secondary** with vague/generic interventions.
4) Treatment plans routinely address both mental health disorders and tobacco use with equivalent focus. **Informal systems** (e.g., caseload tickler systems, calendar reminders, stickers, etc.) to remind staff at regular intervals to revisit interest in wellness related goals/objectives or reassess quit positions are present but used **sporadically or variably** by staff.
5) Treatment plans routinely address both mental health disorders and tobacco use with equivalent focus. **Formal systems** (e.g., tickler systems developed by the program, even if they are "low-tech") to remind all staff at regular intervals to revisit interest in wellness related goals/objectives or reassess quit positions are **routinely** used with follow-up (e.g., during clinical supervision, administrative meetings, etc.).

11. Interventions matched to Stage of Change for mental health disorders and tobacco use:

1) Documentation does **not** reflect Stage of Change.
2) Documentation reflecting Stage of Change is present in some records but is **sporadic or variable** by staff.
3) Documentation reflecting Stage of Change is **routinely** present, but there are no specific stage-wise interventions for either mental health disorders or tobacco use.
4) Documentation planning reflecting Stage of Change is routinely present; the awareness of matching services/interventions to Stage of Change is **general** and related to mental health disorder
5) Documentation reflecting Stage of Change is routinely present; the awareness of matching services/interventions to Stage of Change is **detailed** and related to both mental health disorders and tobacco use

12. Group Treatment for both mental health and tobacco use disorders:

1) 0%- 20% of consumers with a tobacco use disorder regularly attend an integrated mental health and tobacco use disorders group
2) 20% - 34% of consumers with a tobacco use disorder regularly attend an integrated mental health and tobacco use disorders group
3) 35% - 49% of consumers with a tobacco use disorder regularly attend an integrated mental health and tobacco use disorders group
4) 50% - 65% of consumers with a tobacco use disorder regularly attend an integrated mental health and tobacco use disorders group
5) >65% of consumers with a tobacco use disorder regularly attend an integrated mental health and tobacco use disorders group

13. Group curricula:

1) The program does **not** contain any standardized group curriculum for tobacco dependence treatment.
2) The program **contains** a standardized group curriculum for tobacco dependence treatment **for the general public** (i.e., it is not customized for people with serious behavioral health conditions).
3) The program **contains** a standardized group curriculum for tobacco dependence treatment which is **customized** for the serious behavioral health population and includes adaptation of evidence-based addiction treatment (e.g., motivational interviewing, relapse prevention, stage-based treatment, etc.). **but it is not used**
4) A standardized group curriculum for tobacco dependence treatment which is customized for the serious behavioral health population and includes adaptation of evidence-based addiction treatment (e.g., motivational interviewing, relapse prevention, stage-based treatment, etc.) is used **sporadically or is variable** by staff.
5) A standardized group curriculum for tobacco dependence treatment which is customized for the serious behavioral health population and includes adaptation of evidence-based addiction treatment (e.g., motivational interviewing, relapse prevention, stage-based treatment, etc.) is used **routinely**.

14. Medications to treat tobacco dependence:

1) Program does not offer tobacco dependence treatment medications.
2) Program offers **sporadic** access to tobacco dependence treatment medications available without a prescription (e.g., free nicotine patches).
3) Program offers **sporadic** prescriptions for tobacco dependence treatment medications (< 50% of consumers with tobacco related conditions who are interested in quitting)
4) Program offers **variable** prescriptions for tobacco dependence treatment medications (50%-75% of consumers with tobacco related conditions who are interested in quitting)
5) Program offers **routine** prescriptions for tobacco dependence treatment medications (> 75% of consumers with tobacco related conditions who are interested in quitting)

STAFF

15. Availability of a prescriber to treat tobacco dependence (e.g., with options including tobacco dependence therapies and medications):

1) There is **no** formal relationship with a prescriber for tobacco related conditions.
2) There is a relationship with a prescriber for tobacco related conditions (consultant/contractor, **off-site**).
3) There is a relationship with a prescriber for tobacco related conditions (consultant/contractor, **on-site**).
4) Program staff include an on-site prescriber for **clinical** matters only.
5) Program staff include an on-site prescriber for clinical matters, **clinical supervision, integrated team, etc.**

16. Access to clinical supervision/consultation:

1) Clinical staff do **not** have access to tobacco clinical supervision or consultation.
2) Clinical staff have variable access to tobacco clinical supervision or consultation (**off-site**).
3) Clinical staff have variable access to tobacco clinical supervision or consultation (**on-site**).
4) Clinical staff have routine access to tobacco clinical supervision or consultation by a **staff member** (on-site).
5) Clinical staff have routine access to tobacco clinical supervision or consultation by a staff member (on-site); there is a focus with a **focus on interventions specific to stage-wise treatment such as motivational interviewing and CBT** .

17. Tobacco related support for staff:

1) The agency/program does **not** provide tobacco dependence treatment or referrals for interested staff.
2) The agency/program provides **sporadic** or off-site tobacco dependence treatment or referrals for interested staff.
3) The agency/program provides **routine**, on-site tobacco dependence treatment or referrals for interested staff.
4) The agency/program provides routine, on-site tobacco dependence treatment or referrals for interested staff. Benefits include access to tobacco dependence therapies and medications **restricted** by co-pays, utilization limits, etc.
5) The agency/program provides routine, on-site tobacco dependence treatment or referrals for interested staff. Benefits include **unrestricted** access to tobacco dependence therapies and medications.

18. Peer employees:

1) Program staff includes **no** peer employees.
2) Program staff includes peer employees with **mental health** related lived experience only.
3) Program staff includes peer employees with **both** mental health and tobacco related lived experience.
4) Program provides peer employees with formal **training** in working with mental health conditions.
5) Program provides peer employees with formal training in working with **both** mental health and tobacco related conditions, as co-occurring disorders.

TRAINING

19. Tobacco dependence treatment training for clinical staff:

1) Training is **not** provided to clinical staff (0%).
2) Training is provided to some clinical staff but is **variably** provided/is sought out by individual staff (1-24% trained).
3) Training is systematically provided to staff who provide **tobacco** related services (25-50% trained).
4) Training is variably provided to **many** clinical staff (not just staff providing tobacco related services) (51-79% trained).
5) Training is systematically provided to **most** clinical staff, including new hires, and is monitored by an agency strategic training plan (at least 80% trained).

20. Tobacco dependence treatment training for prescribers:

1) Training is not provided to prescribers (0%).
2) Training is provided to some prescribers but is **variably** provided/is sought out by individual prescribers (1-24% trained).
3) Training is systematically provided to prescribers who provide **tobacco** related services (25-50% trained).
4) Training is variably provided to **many** prescribers (not just prescribers who provide tobacco related services) (51-79% trained).
5) Training is systematically provided to **most** prescribers, including new hires, and is monitored by agency strategic training plan (at least 80% trained).

Next Steps:

NYC TCTTAC will provide your program with a detailed report based upon your self-assessment. If desired, programs may develop their tobacco dependence treatment Implementation Plan according to the strengths and needs identified in that report.