



DEPARTMENT OF THE NAVY  
BUREAU OF MEDICINE AND SURGERY  
7700 ARLINGTON BOULEVARD  
FALLS CHURCH, VA 22042

IN REPLY REFER TO  
BUMEDINST 6200.12A  
BUMED-M3  
4 Dec 2012

BUMED INSTRUCTION 6200.12A

From: Chief, Bureau of Medicine and Surgery

Subj: COMPREHENSIVE TOBACCO CONTROL FOR NAVY MEDICINE

Ref: (a) through (n), see enclosure (1)

Encl: (1) References  
(2) Acronyms  
(3) Tobacco Cessation and Pregnancy  
(4) Expectations of Health Promotion and Wellness  
(5) Expectations of Pharmacy  
(6) Expectations of Dental Providers  
(7) Expectations of Substance Abuse Rehabilitation Program Providers  
(8) Expectations of Mental Health Providers

1. Purpose. To provide guidance governing tobacco use (to include smoked, smokeless, and electronic nicotine delivery devices) and tobacco cessation (TC) services within Navy Medicine.
2. Cancellation. BUMEDINST 6200.12 and BUMED Memo of 26 Aug 2008 "NAVMED Policy 08-017."
3. Scope. This instruction applies to all Navy Medicine regions, medical treatment facilities (MTFs), and dental treatment facilities (DTFs) ashore and afloat. This instruction does not take precedence over other instructions where tobacco use is controlled because of the potential for fire or explosion, health hazards, or other specific health and safety considerations. This instruction does not override provisions of existing civilian collective bargaining agreements until their expiration. Before implementing this policy for civilian employees, activities must, where applicable, discharge their labor relations obligations. Assistance and guidance may be obtained from regional offices of the Office of Civilian Personnel Management. In these negotiations, the concern is for the health of employees and beneficiaries.
4. Background. The United States Surgeon General has determined that tobacco use is the single most preventable cause of illness and death. The use of tobacco products adversely impacts the health and readiness of the entire Navy family. The impact of tobacco use affects mission capability (night-vision, combat and operational stress control, etc.), healing from battle-related injuries (wound healing, infection rates, heat injury, etc.) and can create a financial

hardship on the Service member and their family. Research has consistently shown that the use of tobacco products increases the risk of cancer, heart disease, and other major illnesses. Recent studies demonstrate that second-hand tobacco smoke also causes an increase in heart attacks and stroke among non-smokers. Furthermore, exposure to smoking residue increases risk for respiratory problems in highly susceptible populations.

5. Policy. Department of Defense (DoD) and Department of the Navy policies as articulated in references (a) through (n), discourage the use of tobacco products, educate personnel about the danger of tobacco use, and provide encouragement and assistance to tobacco users who wish to quit in order to establish a healthy work environment. As health care team members, Navy Medicine has a responsibility to provide leadership in encouraging programs and procedures that shall decrease tobacco use.

a. Navy Medicine shall become tobacco-free. Information to assist with tobacco-free locations can be found at the Navy and Marine Corps Public Health Center (NMCPHC) Web site: [http://www.nmcphc.med.navy.mil/Healthy\\_Living/Tobacco\\_Cessation/tobacco\\_MTF\\_TobaccoFreeCampus.aspx](http://www.nmcphc.med.navy.mil/Healthy_Living/Tobacco_Cessation/tobacco_MTF_TobaccoFreeCampus.aspx). Uniformed and civilian personnel within Navy Medicine are prohibited from using tobacco products while in the presence of patients or while in their working environment per reference (g). The heads of executive agencies are authorized to evaluate the need for further tobacco use restrictions and make adjustments per references (m) and (n). Because of the risk of second- and third-hand smoke, Navy Medicine personnel, while in a duty status, shall demonstrate no visual or olfactory evidence of tobacco products use.

b. Tobacco use shall occur during break periods designated by supervisors as based on staffing and per Federal law, personnel policy, and union contracts. Break periods, if used for tobacco, shall be the same, (in quantity, length, etc.) as for non-users. Should conflicts arise between the rights of tobacco users and non-tobacco users, the right to a tobacco-free space shall prevail. Tobacco use is prohibited during time authorized for physical fitness training and conditioning.

c. Based on Federal direction, the use of tobacco products, including all forms of smokeless tobacco and electronic nicotine delivery devices, are banned at all Bureau of Medicine and Surgery (BUMED) facilities in addition to Navy Medicine sponsored activities such as conferences, training, off-sites, and unit social functions.

d. The sale of tobacco products within BUMED controlled facilities is prohibited.

e. All Navy Medicine designated tobacco use areas, per reference (d), shall not encourage tobacco use. Designated tobacco use areas shall be located to limit visibility of tobacco use and exposure to second-hand smoke. The Navy and Marine Corps are required to prominently display tobacco use warnings and availability of TC programs in all designated tobacco use areas per reference (g).

f. Navy Medicine shall foster a culture of awareness supporting TC. All students, to include recruits scheduled for “A” school, shall be aware of continued tobacco abstinence after Boot Camp. Staff members assigned to Navy Medicine training programs shall be aware of tobacco abstinence among staff.

g. Navy Medicine’s TC model is the DoD/Veterans Affairs (VA) Clinical Practice Guideline (CPG); including the 5 A’s of intervention (Ask, Advise, Assess, Assist, and Arrange) and the 5 R’s of motivation (Relevance, Risks, Rewards, Roadblocks, and Repetition). This model reaches the entire Navy/Marine Corps population (active duty and reserve), family members, retirees, and civilian employees regarding the concerns of tobacco use. This model is available at: <https://www.qmo.amedd.army.mil/smoke/smoke.htm>.

h. Addressing TC in an operational setting is of paramount importance to ensure and maintain mission readiness and agile forces. It is essential that Navy and Marine Corps Operational Forces have unrestricted access to appropriate medications and other TC program elements in theater.

## 6. Responsibilities

a. All Navy Medicine regions, MTFs, and DTFs will offer TC services per references (h) and (i). All MTFs, including Branch Health Clinics, shall appoint a Clinical Champion to be the advocate for a TC program. All Champions shall coordinate the TC program and monitor the data. The Champion shall be part of a multidisciplinary team to support and advocate for TC across the command.

b. All Navy Medicine regions, MTFs, and DTFs are responsible for developing local TC guidelines. Enforcement guidelines and consequences for non-compliance shall be created and administered by the commander, commanding officers, and officers in charge of facilities. Enclosures (1) through (7) are provided for specific communities. Other communities such as Medical Home Port, Nursing, Command Fitness Leaders, Hospital Corpsmen, Primary Care, Allied Health Providers, and Specialty Medicine Providers can obtain information at: [http://www.nmcphc.med.navy.mil/Healthy\\_Living/Tobacco\\_Cessation/tobacco\\_CliniciansProviders.aspx](http://www.nmcphc.med.navy.mil/Healthy_Living/Tobacco_Cessation/tobacco_CliniciansProviders.aspx).

c. MTF based Health Promotion (HP) programs have a shared responsibility for coordinating and facilitating tobacco use prevention, education and treatment services per references (a) through (e). All members of the medical and dental health care teams shall take an active role in a multi-disciplinary approach to TC counseling, intervention, referral, and prescribing of medications. This multidisciplinary team approach to TC is defined in enclosures (2) through (7) and references (b) through (f).

(1) TC medications are relatively inexpensive per reference (i). Consequently, it is cost effective for all Navy Medicine regions, MTFs, and DTFs to make these medications available to as many individuals as possible, who have demonstrated the desire to quit tobacco. Medications shall not be restricted to only those individuals who attend HP programs.

(2) Providers familiar with the current DoD/VA CPG shall be allowed to prescribe TC medications. Policies should not restrict prescription authority to only a subset of providers as it greatly impairs the patient's access to timely and appropriate care.

d. Providers shall be aware that populations with specific qualification and disqualification standards exist within the Navy and Marine Corps. Inadvertently prescribing certain psychotropic medications such as bupropion or varenicline can adversely affect the command mission and duty status of aviation, undersea, special operations, and personnel reliability program personnel, among others. Therefore, providers shall accurately and completely document in the medical record prescribed medication(s), a discussion of side effects, and the necessity for the Service member to notify their command. It is the responsibility of the active duty member to notify their command as to their medications and treatment. References (b) through (f) provide amplifying information and guidance.

e. Medical and dental providers shall be familiar with the current DoD/VA CPG and prescribe TC medications accordingly. Based on the DoD/VA CPG, and using a population health and continuum of care model, patients shall be provided interventions based on clinical assessment, individual needs, and demonstrated commitment to succeed in TC. Providers will recognize those patients who are not benefiting from medication alone and who would require more intensive intervention, to include mental health and substance abuse clinics. When providing consultations, medical and dental health care staff shall:

(1) Ask and document the patient's tobacco use status during medical and dental examinations. This includes, but is not limited to: routine office visits, physicals, dental examinations, preventive health assessments, peri-operative visits, prenatal and well-woman visits, mental health, and substance abuse and rehabilitation program encounters.

(2) Emphasize to all pregnant patients and their family members the special risks to the fetus caused by any tobacco use to include exposure to second-hand smoke and residue per enclosure (2).

(3) Advise tobacco users of the risks associated with tobacco use and the benefits associated with quitting. Assess patient's readiness to quit and, if amenable, provide TC intervention and arrange follow up; refer them to locally available TC programs and/or provide them with TC resources.

(4) Medical, dental, and pharmacy health care staff shall remove barriers to evidenced-based pharmacotherapy by not restricting, limiting, or requiring medication use via participation with formal group intervention.

f. The NMCPHC and HP shall provide educational resources for the multidisciplinary health care teams to assist with tobacco use, prevention, and cessation efforts. These clinical resources include materials for providers, patient education, marketing, and educators and staff training. The NMCPHC Web site is located at: <http://www.nmcphc.med.navy.mil>.

4 Dec 2012

g. The NMCPHC will serve as the subject matter expert resource to assist MTFs in their tobacco cessation efforts and for tracking overall Health Promotion and Wellness (HPW) department-based Tobacco Program effectiveness metrics. Each MTF must submit their Tobacco Program metrics semiannually to the NMCPHC, per references (o). Program metrics will be reported by the NMCPHC to the respective Navy Medicine Region commander and BUMED. The BUMED HPW Program will provide program policy management based in part on these metrics.

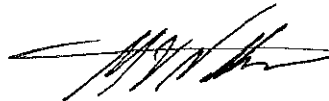
h. TRICARE offers a TC benefit to augment MTF resources. Information about this benefit can be found at: <http://www.tricare.mil/mybenefit/home/overview/HealthyLiving>. Patients can also receive help via the TRICARE UCANQUIT2 program at: <http://www.ucanquit2.org>. Additional help can be found at the United States National Quit Line at 1-800-QUITNOW (1-800-784-8669) or at: <http://www.smokefree.gov>. Guard and Reserve members should contact the National Quit Line to see what resources, to include medications, may be available in their state of residence.

i. Navy Medicine civilian employees are encouraged to use their Federal employee health insurance which now includes a TC benefit. Information about this new benefit is available at: <http://www.opm.gov/insure/health/nosmoking/index.asp>.

7. Action. Commands covered in the scope paragraph must ensure adherence to this instruction and guidelines set forth. Clinical staff of all Navy Medicine regions, MTFs, and DTFs must familiarize themselves with information about the availability of TC programs conducted in house, by other MTFs, and by additional DoD, state, Federal, and non-profit organizations.

8. Records Management. Records created as a result of this instruction, regardless of media and format, shall be managed per reference (g).

9. Report. The reporting requirements for this instruction are exempt from reports control per SECNAV M-5214.1 of December 2005, paragraph 7p.



M. L. NATHAN

Distribution is electronic only via the Navy Medicine Web site at: <http://www.med.navy.mil/directives/Pages/default.aspx>

## REFERENCES

- Ref:
- (a) 32 CFR 85
  - (b) CENTCOM MOD 10, Individual Protection and Individual Unit Deployment Policy
  - (c) MANMED, NAVMED P-117, Chapter 6 and Chapter 15
  - (d) OPNAVINST 6100.2A
  - (e) OPNAVINST 3591.1E
  - (f) MILPERSMAN 1300-318
  - (g) SECNAVINST 5100.13E
  - (h) NDAA 2009 TRICARE Benefit
  - (i) U.S. Department of Health and Human Services “Reducing Tobacco Use: A Report of the Surgeon General” Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000
  - (j) BUMEDINST 6110.13A
  - (k) 5 USC § 7901
  - (l) Executive Order 13058, "Protecting Federal Employees and the Public from Exposure to Tobacco Smoke in the Federal Workplace"
  - (m) FMR Amendment 2010-03
  - (n) OPNAVINST 6000.1C
  - (o) NAVMED POLICY 08-017

**ACRONYMS**

BUMED	Bureau of Medicine and Surgery
CPG	Clinical Practice Guideline
DoD	Department of Defense
DoD/VA CPG	Department of Defense/Veteran Affairs Clinical Practice Guide
DTF	Dental Treatment Facility
HP	Health Promotion
MTF	Medical Treatment Facility
NMCPHC	Navy and Marine Corps Public Health Center
TC	Tobacco Cessation
VA	Veteran Affairs

## **TOBACCO CESSATION AND PREGNANCY**

1. Only 14 percent of women who smoke while pregnant attempt to quit upon discovering they are pregnant. Of those who do manage to quit, as many as 90 percent shall relapse within 1 year post-partum. While pregnancy itself may act as a motivator for abstinence from smoking, its effect appears to only be temporary.
  
2. The concept of harm reduction involves lessening any given health risk to both the mother and the fetus. The American College of Obstetricians and Gynecologists (ACOG) recommends that medications should be considered if behavioral therapies have failed. ACOG further states that if the increased benefit of smoking cessation outweighs the unknown risk of nicotine replacement (and known risk of tobacco use), pharmacotherapy may be considered. The most current research shows little risk to the mother or fetus from either nicotine replacement therapy (NRT) or bupropion (Zyban®). In fact, studies looking at NRT use in pregnant women showed reduced carbon monoxide levels, reduced fetal heart rate, and increased uterine blood flow, thereby increasing nutrient and oxygen levels available to the fetus. Studies of the Zyban® Pregnancy Registry show that bupropion use during pregnancy does not increase risk of intrauterine growth retardation. The registry has also shown that only trace amounts of bupropion are found in post-partum breast milk samples, making it safe to use in lactating women. Varenicline (Chantix®) is a new medication used as an alternative to bupropion and NRT; however, Varenicline has not been tested in women who are pregnant or lactating, and therefore lacks the necessary level of evidence for recommending use (Class C medication).
  
3. The following recommendations are made regarding tobacco use and pregnancy.
  - a. All women who are pregnant or are contemplating pregnancy should receive strong advice from their health care providers to quit any and all tobacco use before, during and after pregnancy.
  
  - b. In the event of a pregnancy, women should first be offered assistance with tobacco cessation (TC) via counseling and support. Additionally, support is available via all Navy Medicine regions, medical treatment facilities, and dental treatment facilities or Semper Fit health promotion services.
  
  - c. Based on consultation with their provider, pregnant women who cannot quit tobacco use without medications should be offered NRT and bupropion (Zyban®/Wellbutrin SR ® 150mg), as per the Department of Defense/Veterans Affairs Management of Tobacco Use Clinical Practice Guidelines. In general, the risk of tobacco far exceeds that of NRT or bupropion.
  
  - d. Women shall be encouraged to continue tobacco abstinence post-partum in order to provide their newborn with a healthy, smoke-free environment. If relapse happens after delivery, the full spectrum of TC medications can then be considered.



e. Due to the increased risks of pneumonia, asthma, bronchitis, and ear and upper respiratory infections, mothers with infants and other children should also insist on a smoke-free environment for their family.

f. Since tobacco use is often used to self-medicate for depression, these new mothers should be considered at risk for post-partum depression and screened accordingly at post-partum and well-child visits per reference (n).

4. The most current research shows if behavioral therapy fails, risk to the mother or fetus from either the NRT or the Zyban may be acceptable, but the decision for using tobacco cessation medications during pregnancy is between the woman and her provider.

## **EXPECTATIONS OF HEALTH PROMOTION AND WELLNESS**

1. Health Promotion (HP) plays an instrumental role in a clinic's ability to provide Tobacco Cessation (TC) services to patients. HP serves as the chief advocate for tobacco prevention, education, and cessation services and efforts in the Department of the Navy. Additionally, the HP team often facilitates tobacco prevention, education, and cessation programming at all Navy Medicine regions, medical treatment facilities (MTFs), dental treatment facilities (DTFs), and the surrounding military community.
2. HP staff at each MTF provides tobacco prevention and cessation services as part of the wellness efforts and programs.
3. Navy Medicine recognizes that any individual department is incapable of providing the necessary TC support for their respective beneficiaries. The HP staff (along with their Semper Fit colleagues) shall partner and work collaboratively with others in the MTFs, on base, and with community groups (local, state, federal) to provide tobacco prevention and cessation programs.
4. Bureau of Medicine and Surgery (BUMED) encourages all members of the health care team (medical, dental, pharmacy, Substance Abuse Rehabilitation Program providers, and health promotion) to take an active role in tobacco cessation, including counseling with the 5 A's of intervention (Ask, Advise, Assess, Assist, and Arrange) and the 5 R's of motivation (Relevance, Risks, Rewards, Roadblocks, and Repetition), referral and the prescribing of medications when needed.
5. The HP team shall provide population and evidence-based tobacco programming including, but not limited to:
  - a. Evidence-based, clinically proven options and a continuum of care for cessation from all forms of tobacco use including spit, dip, snuff, chew, cigarettes, cigars, pipes, electronic nicotine delivery devices, and hookahs.
  - b. Continuum of care options that shall include at a minimum: promoting self-help approaches, use of state and national quit lines, Web-based programs, brief interventions, clinical interventions, educational programs, and intensive group interventions. This continuum of care approach should include referral to intensive, formal TC programs if the less intense interventions are unsuccessful.
  - c. Facilitation of partnerships between HP and the health care team by providing consultation, training, and TC services to clinics and patients as part of a multidisciplinary team effort.

d. Development of partnerships with other commands and organizations on base (Morale, Welfare, and Recreation; Semper Fit, Command Fitness Leaders, Fleet and Family Support Center, Marine and Family Services, and schools) as well as at the community, state, and national levels to prevent tobacco use initiation and promote cessation.

e. Provision of a patient-centered TC approach which includes appropriate, timely, and preferred TC when and where it is needed.

f. Improvement of access to care by offering TC interventions, both individual and group, at times and places (deck plates, worksites, community locations) convenient for the beneficiary.

g. Encouragement of use and implementation of the Department of Defense and Department of Veterans Affairs Clinical Practice Guideline at all Navy Medicine regions, MTFs, and DTFs.

h. The Navy and Marine Corps Public Health Center (NMCPHC) will serve as the subject matter expert resource to assist MTFs in their tobacco cessation efforts and for tracking overall Health Promotion and Wellness (HPW) department-based Tobacco Program effectiveness metrics. Each MTF must submit their Tobacco Program metrics semiannually (when looking for a date each year i.e., 15 Jan and 15 Jul) to the NMCPHC, per guidance at: <http://www.nmcphc.med.navy.mil/downloads/tobacco/TobaccoMetricsOnline Instr.doc>. Program metrics will be reported by the NMCPHC to the respective Navy Medicine Region commander and BUMED. The BUMED HPW Program will provide program policy management based in part on these metrics.

i. Engagement in creative ways of reaching the cognizant population as well as high-risk groups through e-mails, internet, displays, presentations, and other outreach efforts to address prevention, awareness, and cessation.

j. Development of materials and packages for key accession points (for example: Periodic Health Assessment, Deployment Health Clinics, Dental, Inpatient Wards, Outpatient Clinics, and Command Indoctrination), which allows for documentation of productivity and outreach.

k. Assistance with MTF-based performance measures such as ORYX (The Joint Commission's performance measurement and improvement initiative) data and The Joint Commission compliance by providing inpatient consults to tobacco users or arranging for follow-up prior to their discharge.

l. Collaboration with the local Substance Abuse Rehabilitation Program and/or the Consolidated Substance Abuse Counseling Center to present education and treatment options for the clients of their treatment program, to assist with the simultaneous treatment of dual addiction.

## **EXPECTATIONS OF PHARMACY**

1. Pharmacy plays an important role in Navy Medicine's ability to provide tobacco cessation (TC) and overall patient care. The pharmacy staff supports the clinician and facilitates patient care by providing comprehensive patient TC education for prescribed therapies, ensuring compliance based on medication usage and refill history, and via physician-pharmacist collaborative practices in which credentialed pharmacists utilize prescriptive authority to both support and increase patient access to care within all Navy Medicine regions, medical treatment facilities (MTFs), and dental treatment facilities (DTFs).

2. Pharmacy should assist and participate in developing local MTFs TC prescribing policy. In developing such a policy, the pharmacy shall ensure that:

a. TC pharmacotherapy shall be made available to include, at a minimum, nicotine replacement therapy in the form of gum and patch, bupropion SR, and varenicline pursuant to local MTF protocol.

b. MTF policy shall encourage:

(1) Step therapy in regards to pharmacotherapy use with the understanding that medication selection must be based on patient-specific factors. These factors include, but are not limited to: patient contraindications, documented failure of a previous TC pharmacotherapy, history of mental health illness, and job qualification standards. The recognition of those job positions in which medications such as varenicline and bupropion are considered psychotropic medications and may ultimately disqualify the member from performing their duty (aviation, weapons, subsurface, special operations, personnel reliability program, etc.) negatively impacting the mission.

(2) That the patient be evaluated and provided a TC pharmacotherapy determined to maximize compliance based on the patients' individual needs.

(3) That the patient utilize the selected medication for an adequate period of time per manufacturer recommendations to ensure therapeutic levels of medication are achieved and maintained, allowing for an adequate trial of TC pharmacotherapy.

(4) That upon TC pharmacotherapy failure, the patient is re-evaluated in terms of continued commitment to TC prior to initiation of additional or alternative TC pharmacotherapy.

c. Quantities of TC medications dispensed at one time are not excessive, so that more frequent follow-up visits are required.

3. All Navy Medicine regions, MTFs, and DTFs must take advantage of their local pharmacists' clinical and pharmaceutical knowledge in addition to their relative ease of access, utilizing their pharmacists in a position that expands beyond their traditional role of dispensing medications

and augmenting the education initially provided by the patient's provider. Pharmacists can play an instrumental role as both TC facilitators and clinical pharmacist practitioners, enhancing patient center care via the medical home port model. Thus, pharmacists shall assume more active roles by becoming TC facilitators and teaching health promotion and wellness TC classes, acting as physician extenders through a clinical practice agreement, or tending to patients throughout their course of TC pharmacotherapy.

**PROVIDER INFORMATION AND SUGGESTED USE OF VARENICLINE  
(CHANTIX®) FOR TOBACCO CESSATION WITHIN NAVY MEDICINE**

1. Varenicline is indicated for tobacco cessation (TC) as an alternative to bupropion (Zyban®) and nicotine replacement therapy (NRT). Varenicline has not been tested in individuals under 18 years' old or pregnant women, and therefore is not recommended for use in these groups. Women currently breastfeeding should also avoid this product since varenicline may pass into the breast milk, leading to unknown effects on the child. Caution is warranted in certain patient populations as individuals with a history of depression, psychosis, substance abuse other than nicotine, bipolar disease, panic disorder, or eating disorders were also excluded from initial testing and therefore have not been studied by the manufacturer.

2. As a recent medication, varenicline has not yet achieved the level of evidence similar to other TC medications. Based on its limited evidence track record, the following recommendations are made:

a. Based on the current Department of Defense and Department of Veterans Affairs Clinical Practice Guidelines for Tobacco Use Cessation, patients should be offered medications per their needs. Bupropion has been shown to decrease nicotine withdrawal symptoms in many patients and may be used in conjunction with both nicotine gum and the patch. The nicotine patch allows for steady-state waking hour delivery of nicotine while nicotine gum is often provided for ad lib use as needed. Consequently, these medications should be considered the first line of cessation support.

b. Varenicline has its place in a step therapy protocol, and varenicline should be considered for the subset of individuals who have not benefited from, or have contraindications to, the regimen of bupropion and/or NRT. Patients who have relapsed on the combination therapy above, or are unable to utilize or tolerate one or all of the standard cessation medications, may be considered for Chantix® therapy per local medical treatment facility policy and formulary requirements.

c. Chantix® is classified as a psychotropic medication; prescribers should carefully evaluate the patient prior to use. Additionally, prescribers should be aware that certain Navy specialties are restricted from utilizing psychotropic medications in order to maintain qualifications for their specific duties. It is the responsibility of both the provider and the patient to ensure adequate communication occurs to discern any potential reasons for why varenicline may not be an adequate tobacco cessation therapy.

3. Navy Precautions

a. Those patients who serve in areas of special concern such as aviation, weapons, subsurface, and special operations must be screened before using this medication. They should

also receive proper clearance by their specialty medicine area. In most cases, personnel assigned to the above mentioned special groups must be placed in a “down” status while using certain types of medications to include those psychotropic medications (bupropion and varenicline) associated with TC.

b. Patients with a history of mental health issues should be carefully screened before being prescribed varenicline. For these individuals, it is highly recommended that TC be addressed in coordination with their mental health provider.

c. Those individuals using Chantix® must have regular follow-up with their health care provider. It is strongly recommended that patients be seen at least every 14 to 28 days. Patients should be advised to watch for side effects involving changes in thought, mood, or behavior when taking this medication and to contact their health care provider if these occur. Patients should also be advised to stop taking the medication and seek help immediately if they have thoughts of harming themselves or others.

d. Health care professionals should monitor patients taking Chantix® for behavior and mood changes. Patients taking this product should report behavior or mood changes to their doctor and use caution when driving or operating machinery until they know how quitting smoking with Chantix® may affect them.

## **EXPECTATIONS OF DENTAL PROVIDERS**

1. The Bureau of Medicine and Surgery encourages all members of the health care team (medical, dental, pharmacy, and health promotion) to take an active role in tobacco cessation (TC), including counseling intervention (5 A's: Ask, Advise, Assess, Assist, and Arrange), referral and the prescribing of medications when needed.
2. As part of the Navy's health care team, Navy dentistry plays an important role in TC interventions since: tobacco use directly and adversely affects oral health, TC counseling can be directly incorporated into annual dental readiness encounters per Navy policy, and additional opportunities exist for tobacco counseling with specific dental procedures often associated with tobacco use.
3. Opportunities for dental providers to take the lead in TC interventions arise due to the damage that tobacco causes, in all of its forms, in the oral cavity. The damage of tobacco use is first seen in the mouth due to staining and other aesthetic issues. Tobacco use has also been linked to increased risk of tooth decay, periodontal disease, tooth loss, and oral cancer.
4. Current Navy Dental Operational Dental Readiness standards stipulate that every Navy and Marine Corps member, active or reserve, is required to have an annual dental examination per reference (c). Navy policies state that during this examination members must be asked about tobacco use and, if using tobacco, they must be counseled about the hazards of tobacco use, the benefits of quitting, and opportunities within the medical treatment facility (MTF) for cessation support. If the tobacco-using patient is pregnant, additional counseling is also mandated regarding harm to the fetus per reference (g).
5. Members seeking care in the Dental area expect to receive dental health education as part of their dental visit. The harm generated from the use of tobacco is easily integrated into this dental health message. This is especially true for such procedures as dental prophylaxis, intraoral hard and soft tissue regeneration, teeth bleaching and implants.
6. The Department of Defense (DoD) Tobacco Use Cessation (TUC) and Clinical Practice Guidelines (CPG) provides guidance for implementing evidenced-based TC interventions. Based on the DoD TUC CPG, Navy dentistry has the following options for helping patients with their desire to quit their tobacco use. These include:
  - a. Ask, Advise, Assist, Assess, and Arrange: This is for the provider (dentist or dental hygienist) who has the training and the time during the clinical appointment to help address their patient's tobacco use. In this scenario, the patient shall receive individualized:
    - (1) Assessment of their tobacco use.
    - (2) Evidence-based counseling and materials which cover the cessation process.



(3) Evidenced-based medications to support their cessation attempt.

(4) Appropriate follow-up appointments to allow adequate evaluation of the cessation process.

b. Ask, Advise, and Refer: This is for the provider (dentist or dental hygienist) that does not have the time, during the clinical appointment to help address their patient's tobacco use. In this scenario, the patient shall be:

(1) Asked about their tobacco use.

(2) Advised about the benefits of quitting and asked if they would like to quit.

(3) Referred to an established TC resource.

7. The Navy dental team has other opportunities to address tobacco use. Working with the local TC programs at their MTF, they can:

a. Facilitate partnerships between Health Promotions and the health care team by providing consultation, training, and tobacco services to clinics and patients as part of a multidisciplinary team effort.

b. Develop partnerships with other commands and organizations on base (Moral Welfare and Recreation, Semper Fit, Command Fitness Leaders, and schools) as well as at the community, state, and national levels to prevent tobacco use initiation and promote cessation.

c. Improve access to care by offering TC interventions, both individual and group, at times and places (deck plates, worksites, community locations) convenient for the beneficiary.

d. Develop materials and packages for key accession points to include periodic dental examinations, dental waiting rooms, and command indoctrination.

## **EXPECTATIONS OF SUBSTANCE ABUSE REHABILITATION PROGRAM PROVIDERS**

1. Heavy tobacco use is prevalent in patients demonstrating both substance and alcohol dependence. Statistically, active duty Service members use alcohol and tobacco at significantly higher rates than their civilian counterparts. Studies have found that people who smoke are three times more likely to drink and people who drink are four times more likely to smoke. This co-addiction to multiple drugs results in escalated alcohol and tobacco co-morbidity and diminished intervention effectiveness. Offering tobacco cessation (TC) to individuals in alcohol recovery is cost-effective. Since heavy tobacco and alcohol use very often go hand-in-hand, the Substance Abuse Rehabilitation Program (SARP) has a unique opportunity to address both issues concomitantly. Quitting tobacco use during or soon after treatment for alcohol abuse can actually increase chances of staying sober by as much as 25 percent.
2. Since SARP staff members may not all be trained specifically in counseling related to TC, it is recommended that they should, at a minimum:
  - a. Have a basic knowledge of the interactions between alcohol and tobacco, and encourage treating patients simultaneously for their dual addictions.
  - b. Assess and strongly encourage treatment of all dual-dependent patients who are in the outpatient and intensive outpatient setting for TC. Assessments shall be performed at least three times (initial, during, and end) during an individual's treatment program.
  - c. Become familiar with the Department of Defense and Department of Veterans Affairs (DoD/VA) Management of Tobacco Cessation Clinical Practice Guidelines to include the 5 A's of Intervention (Ask, Assess, Advise, Assist, and Arrange) and the 5 R's of Motivation (Relevance, Risks, Rewards, Roadblocks, and Repetition).
  - d. Have a working system in place to treat their dual-dependent clients for tobacco use to include access to both counseling and pharmacotherapy options. Patient-centered counseling should be provided using motivational interviewing techniques. When necessary, SARP directors should liaison with clinical champions or providers to prescribe medications. If TC services are not provided by alcohol and/or substance abuse counselors, then clients need to be referred to other available TC services.
  - e. Invite their local Health Promotions Coordinator to their treatment program to offer education and treatment options to their clients.
  - f. As addiction specialists, consider providing TC services (tertiary care) as staffing and clinic access permits for the small cohort that desire referral upon patient relapse after health promotion counseling and/or medications.

BUMEDINST 6200.12A  
4 Dec 2012

3. We encourage SARP directors and staff members to consider a tobacco-free environment since it greatly enhances the success of the SARP program.

## **EXPECTATIONS OF MENTAL HEALTH PROVIDERS**

1. In addition to the known adverse health consequences of tobacco use, continued smoking among individuals who have psychiatric conditions can lead to progression of these conditions and can complicate their treatment. Individuals who have mood disorders, psychoses, anxiety disorders, developmental disorders, and substance use disorders are more likely to be addicted to nicotine than people without these disorders. Significant findings among those patients with mental health issues are highlighted below:

a. Studies suggest that as many as 90 percent of individuals with diagnoses of schizophrenia are smokers.

b. Smoking prevalence rates among individuals with psychiatric diagnosis (depression, anxiety disorders, and psychotic disorders) are significantly higher than persons without mental illness. Overall rates range from two to three times higher and may be higher among certain disorders (Bipolar Disorder and Schizophrenia).

c. Persons with mental health and substance abuse disorders use 45 percent of cigarettes sold in the United States. This group is the only population that has not demonstrated any decline in smoking rates over the past four decades.

d. The costs associated with not treating tobacco use in the mental health system include increased mortality and morbidity, increased use of health care resources, decreased quality of life, and increased societal costs.

e. One out of three current tobacco users are using nicotine to treat an undiagnosed major depressive disorder. Depressed smokers have higher suicide rates than depressed non-smokers.

f. Individuals who are exposed to a traumatic event are twice as likely to develop post traumatic stress disorder (PTSD) if they are tobacco users.

2. Most smokers and smokeless tobacco users want to quit. Tobacco cessation (TC) treatments have demonstrated efficacy across populations and settings, from individuals to groups, outpatient to inpatient, and includes all Navy Medicine regions, medical treatment facilities, dental treatment facilities, and the U.S. Department of Veterans Affairs (VA) health care system.

3. Although persons with psychiatric conditions can stop smoking using standard pharmacologic and behavioral interventions, they seldom achieve long-term abstinence. Studies have shown that TC counseling or cognitive behavioral therapy alone were not effective for adults with a history of major depressive disorder (MDD). Individuals who have a history of MDD may have more difficulty quitting smoking and more severe nicotine withdrawal symptoms than those who do not have MDD.

4. Smokers with psychiatric disorders often feel excluded from mainstream cessation programs. This population's high rate of recidivism and their complex medication regimen often requires the expertise and collaboration of the mental health provider.
5. The above noted difficulties in treating nicotine dependence in patients with mental health issues possibly account for the reluctance by mental health professionals to address nicotine use and dependence. The lack of training and support may also account for inadequate treatment in the mental health setting.
6. The American Psychiatric Association, the Department of Defense, and VA have developed clinical practice guidelines that provide guidance on implementing evidence-based treatment and interventions for those with nicotine dependence and mental health conditions.
7. TC treatments – pharmacotherapy, behavioral, and counseling components – may be effectively incorporated into the mental health setting and have been found to be more successful than referral to specialty (TC) clinics. Providing tailored, individualized, and intensive services to meet the specific needs of patients is important. Recommended use of the 5 A's (Ask, Advise, Assess, Assist, and Arrange) and the 5 R's (Relevance, Risks, Rewards, Roadblocks, and Repetition) has been validated and found to be useful in standard mental health care. The use of nicotine cessation medications is also an essential complement to providing care for this complex patient population.
8. Nicotine replacement therapy has been shown to benefit cessation for those patients who also receive behavioral therapy. The use of non-nicotine medications for TC pharmacotherapy should be monitored closely by mental health providers and primary care providers. Recent findings have shown that pre-existing mental health illness can be potentially exacerbated by tobacco withdrawal and/or TC medications. Patients with a history of previous closed head trauma and eating disorders may require further evaluation prior to using bupropion. The Food and Drug Administration has released recent guidance in regards to the use of varenicline (Chantix®) in patients with mental health disorders.
9. The following recommendations are made regarding tobacco use and mental health:
  - a. Screening for all forms of tobacco use should be performed as part of the standard of care for mental health services.
  - b. All individuals who desire to quit tobacco should have a TC intervention incorporated into their overall mental health treatment plan. Those patients that aren't ready to quit should be reassessed at subsequent visits with the 5 R's.

c. Recognize that tobacco users may be self-medicating to treat undiagnosed mental health disorders. Therefore increased screening for depression and other mental health issues are warranted for high risk populations to include PTSD, perinatal, post-deployment, and substance abuse.