The Maryland Leadership Academy for Wellness and Smoking Cessation Summit

BWI Airport Marriott Hotel
Baltimore, MD
May 31 – June 1, 2011

ACTION PLAN

Background & Introduction

On the evening of May 31 and all day June 1, 2011, twenty-eight leaders in public health, behavioral health, and tobacco control came together for a first-ever Maryland initiative focused on reducing smoking prevalence among people with behavioral health disorders. The summit was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Smoking Cessation Leadership Center (SCLC) as part of the Leadership Academies for Wellness and Smoking Cessation. The purpose of the summit was to design an action plan for Maryland to reduce smoking and nicotine addiction among behavioral health consumers and staff, and to create an environment of collaboration and integration among the fields of public health (including tobacco control and prevention), mental health, and substance use prevention.

The summit began with dinner and a Gallery Walk on May 31, 2011. Renata J. Henry, M.Ed., Deputy Secretary, Behavioral Health and Disabilities, Maryland Department of Health and Mental Hygiene, welcomed participants. Ms. Henry stated, "We're happy and excited to have Maryland chosen to be among the SAMHS-SCLC Leadership Academies for Wellness and Smoking Cessation." She added, "Your invitation tonight is due to the fact that you are a leader. Expectations are high to institutionalize change. Change is something we know how to do. And we are going to do this!"

Maryland Secretary of Health and Mental Hygiene, Joshua M. Sharfstein, M.D., also spoke to summit attendees, adding, "Tobacco is a huge health problem for our clients. It's great that this conversation is happening. We should be prepared to do something different, and I look forward to seeing Action Plan that we will do. I thank you all for being here."

Participants represented federal, state, and local agencies, including mental health, addictions, consumer, community services, non-profit, academic, quitline, and chronic disease prevention organizations (*see Appendix A, participant list*). Leaders at the summit were well-aware that people with behavioral health disorders are disproportionately burdened by the harmful effects of smoking and tobacco use, and each partner committed to the work, target, and strategies established at the summit. In a discussion led by seasoned facilitator, Jolie Bain Pillsbury, Ph.D., each partner expressed their interests in the Academy summit. Themes that

emerged from the groups' interests were peer support, work with providers, integration of behavioral health and public health, cornerstone for change, and personal connections to the toll of tobacco (*see Appendix B*).

Douglas Tipperman, MSW, Public Health Advisor, Center for Substance Abuse Prevention, SAMHSA, attended on behalf of SAMHSA and also as a committed partner to the Maryland Academy. Mr. Tipperman noted, "SAMHSA is interested in knowing what we can do, and I look forward to coming back a year from now to see the difference we have made in Maryland. Fortunately, I live here and will be able to see that change happen."

Leadership = Make change, facilitate change, institutionalize change
-Renata Henry

On the morning of June 1, 2011, Frances B. Phillips, RN, M.H.A., Deputy Secretary of Public Health, Maryland Department of Health and Mental Hygiene, made another call to action. She noted that Maryland used to have a proud tradition of being a tobacco-growing state, but now, "We have a culture change in Maryland, and the state is ready for change with regard to tobacco use in mental health and substance abuse settings." Ms. Phillips added, "It's a lot more effective to save lives *millions at a time*, so be bold in pushing for what we want to accomplish in our state action plan."

Steven A. Schroeder, MD, Director, Smoking Cessation Leadership Center, presented on research on smoking prevalence, health effects, and innovations in the management of smoking cessation.

By the end of the summit, Maryland partners answered the following questions that framed the Action Plan.

1. ***Where are we now? (baseline)***
2. ***Where do we want to be? (target)***
3. ***How will we get there? (multiple strategies)***
4. ***How will we know if we are getting there? (evaluation)***

The following Action Plan details the group's baseline, target, recommended strategies, and next steps.

Question #1: Where are we now (baseline)?

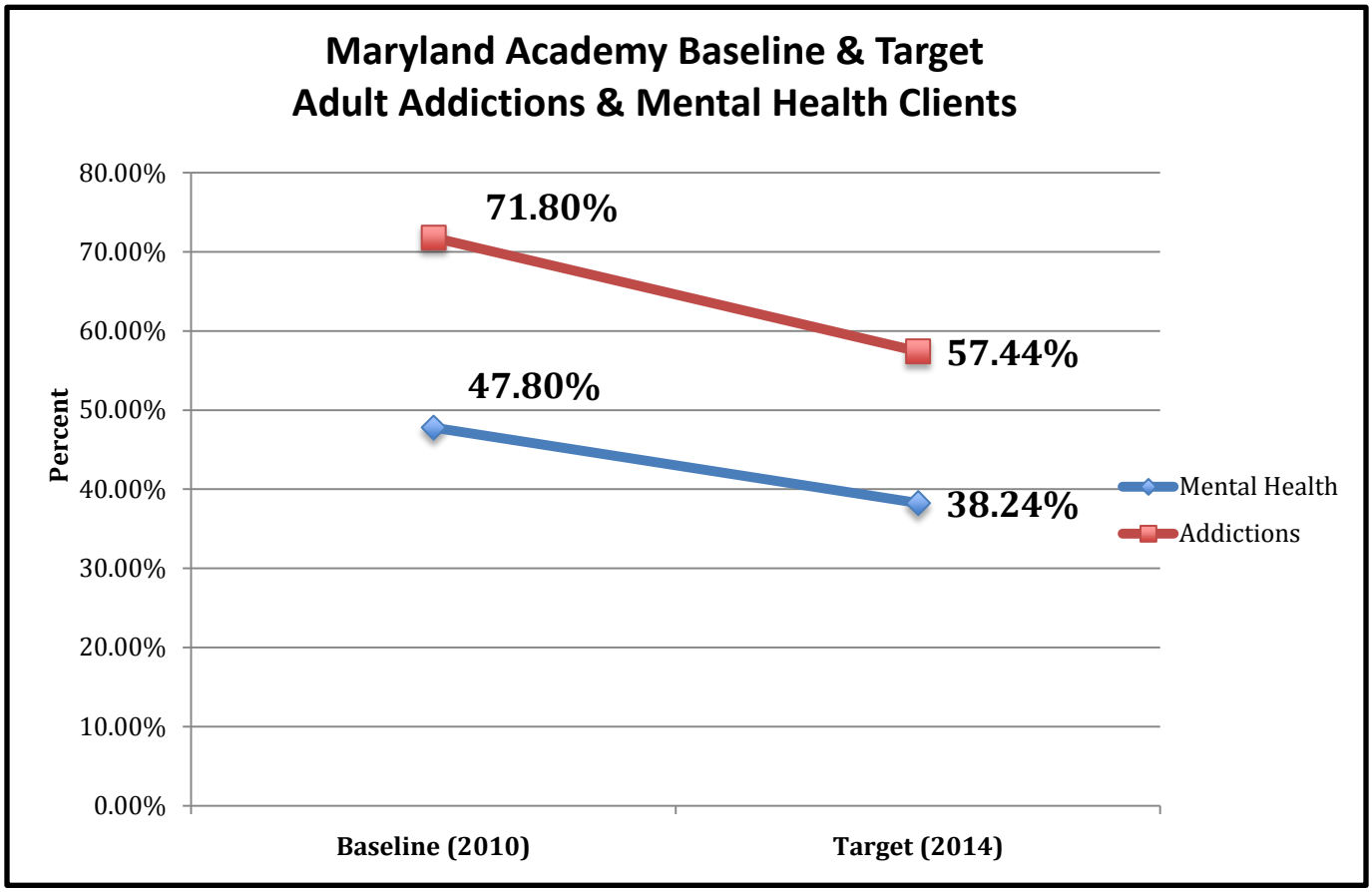
Partners adopted the baseline measure of smoking rate among Maryland adult mental health clients at 47.80% and 71.80% for addictions clients (*see Appendix C*).

Question #2: Where do we want to be (target)?

The partners adopted the **target to reduce smoking prevalence among adult mental health and addictions clients by 20% each by end-of-year 2014**.

Maryland Adult Clients	Mental Health	Addictions
Baseline (2010)	47.80%	71.80%
Target (2014)	38.24%	57.44%

Agreement: Addictions data are at admissions. Mental health data are throughout treatment.



Question #3: How will we get there? (multiple strategies)

Maryland partners adopted four overarching strategies to reach the target:

Adopted Strategy Groups
Peer Empowerment – Outreach, Educate, Train, Advocate
Clinical & Staff Support
Regulatory & Structural Strategy (policy, funding, mandates)
Training & Education

The following matrices outline each committee group's proposed strategies, commitments, timeline, and impact measurements. Committees will use these grids to track progress.

Strategy: **PEER EMPOWERMENT**

Outreach, Educate, Train, Advocate

Task Force Members: Clarissa Netter, Sarah Burns (co-chair), Janine Delahanty (co-chair), Stephen Stahley, Doug Tipperman, Jean Smith, Catherine Saucedo

WHAT	HOW	WHO	WHEN	IMPACT	MEASURE
EBBP BP smoking cessation trainings available to peer leaders	Establish a review committee, Review Rx For Recovery and others, adjust as needed, fit into SBIRT for S/A, MH, include motivational interviewing	Clarissa, Sarah, Janine, Stephen, Jean, Catherine, Carlos	End of September – Review, Edit, Revise	Create Curriculum, Build Capacity	A finished curriculum
Distribution of Training Information	Work with Value Options,andnetworkofcare.org, On Our Own of Maryland	Reimbursement Specialist – Clarissa Sarah	Upon completion of training material	Knowledge is shared	Number of peer leaders trained Pilot programs implemented (H.T.I.)

	ADAA NCADD	Linda Oney Carlos and Nancy			
Consumer-Driven Campaign	Create consumer demand by creating regional forums at WRCs, work with Miriam and Bunky, MDQuit Collect/Send existing materials	On Our Own of Maryland, Youth M.O.V.E., NAMI, Faces and Voices of Recovery, AA, NA Catherine	Start ASAP Complete by beginning of September ASAP	Consumer voice heard and curriculum reflects ideas that will work	Decreased smoking in BH and MH populations
Leverage Conferences	Use as platform to draw attention to BH MH and tobacco use (Introductory Workshop)	MD Quit - Jan MHA – May OOOMD – June Addiction Conf.	See “Who Box”	Raised awareness of disparity in BH and MH populations and tobacco use	More people aware of reality of tobacco use and BH and MH populations
Capitalize on existing BH and MH Recovery Resources	I.D. existing resources	Catherine	ASAP	More information	More thorough curriculum
I.D. Addiction Recovery Networks	Internet, Connections	Clarissa	ASAP	More Resources	Better distribution of material
Reimbursement for Certified Peer Support Specialist	Go to MHA meetings to keep it a priority Research other States	Clarissa, Brian Hepburn Catherine	As meetings happen	CPSS are paid for providing support	CPSS are successful in assisting in quitting smoking

Strategy: **CLINICAL & STAFF SUPPORT**

(1) Aid clinical and support staff to reduce tobacco use prevalence

(2) Provide tools for staff to aid behavioral health clinicians/staff and consumers in tobacco use cessation.

Task Force Members: Peter Cohen, Georgia Stevens (co-chair), Mildred Morse, Steven Schroeder, and Audrey Regan (co-chair)

WHAT	HOW	WHO	WHEN	IMPACT	MEASURE
Gather baseline data on the prevalence of smokers among the clinicians and staff.	If a HRA is available, use this. If not, implement a HRA. As a part of the licensing application, one must conduct an assessment of tobacco utilization among staff.	Community-based providers	2012	Start to create an employee smoke-free culture	*100% input as compliance with grant/contract award *(*Rethink mandating compliance with contract award.)*
Provide cessation tools and policies for clinicians and staff	1. Promote quit line 2. Promote cessation classes and counseling 3. Promote pharmaceutical coverage within benefit designs	Employers, who are told via the conditions of award.	FY13 by mandate and as may be encouraged in FY 12 on a voluntary basis	10 % access	Knowledge of prevalence of smoking among clinician/staff.
Identify and support champions within workplaces and agencies to assist in tobacco use cessation implementation measures	Administrative support for: (1) link employees to services; (2) link champions to champions (3) Allow and	Agency Administrators, Champions, Agency supervisors Clinicians/staff/consumers	2012 and beyond	*100% compliance as part of grant/contract award	Supervisor personnel evaluations

	encourage work time for tobacco support and cessation				
Include tobacco use prevention and intervention measures as a personnel evaluation criterion.	Via conditions of award. Support the benefits vs. punishment. Be respectful, inviting, and inspiring when working with personnel.	Employers	2012, yearly	Enforcing the importance of being smoke free.	Prevalence of smoking among staff.
Aid behavioral health clinicians/staff and consumers in tobacco use cessation.	4A's and referrals	Employer policies Supervision	2013 and beyond	100% informed 100% compliance	*Conditions of award and personnel evaluations.

Strategy: **REGULATORY/STRUCTURAL TASK FORCE**

Create a framework for policy and regulatory changes necessary to reduce smoking prevalence among DHMH behavioral health patients.

Task Force Members: Renata Henry, Lesa Diehl,
Tom Cargiulo (co-chair), Lawrence Carter (co-chair), Dawn Berkowitz (co-chair)

WHAT	HOW	WHO	WHEN	IMPACT	MEASURE
Require all new treatment plans to address smoking and second hand smoke as a goal, as appropriate.	Mandate through existing contracting processes. Incorporate into regulatory changes in both substance abuse and mental health Pre-training on how to integrate treatment plans and person-centered training. Build into medical records (EMR)	ADAA/Tom ADAA/MHA – Tom/Brian H.	FY 12 (July 1, 2011) Jan 1, 2012	28,000 people in substance abuse treatment will have a treatment plan that addresses smoking. Approx. 50k people in tx in DHMH programs will have a tx plan that addresses smoking.	80% compliance as evidenced by ADAA quarterly monitoring. EMR utilization data
Best practices must be incorporated in working with Behavioral Health Patients around smoking cessation.	Include in funding agreements with CSAs and local providers.	Renata Brian H.	July 1, 2011	40,000 people	80% of providers will deliver best practice services.
Incorporate prevalence data into State Stat	Develop the measure. Contact Thomas Kim	Tom, Brian H, Thomas Kim	October 1, 2011	50k	Inclusion of Data in State Stat
Develop an MOU between BH and FHA regarding this Initiative.	Cross-Agency meetings between ADAA, MHA	Renata Fran Phillips	October 1, 2011	50k	Formal MOU developed

	and FHA to develop MOU				
Develop a report card on smoking for publicly funded behavioral health providers (include smoke-free campuses). Explore the use of one-time monies, as available, to incentivize provider success.	Convene data group to develop and implement data collection efforts.	Tom/Brian H Data Collaborative	October 1, 2011	50k	Report Card Developed
Explore reimbursement changes needed to support smoking intervention activities.	Evaluate what smoking intervention activities are currently paid for under Maryland state employee insurance	Renata, BH, Medicaid	October 1, 2011	50k	Report out on findings
Requisite state agencies (ADAA/MHA) will have goal statements which reflect the inclusion of health and wellness as a guiding principle.	ADAA/MHA/Dep Secretary will revise current goal statements to include health and wellness	Renata/Tom/Brian Consumers, Stakeholders	December 31, 2011	People will reclaim health	New, revised goals will be available
Create a signage-campaign to promote smoke-free environments in publicly funded, community-based bh programs.	Expand upon existing Work with consumer-driven efforts (partner with peer empowerment task force)	DHMH BH/Ctr for Health Promotionn– Dawn, Lawrence, Tom, Brian			
Facilitate the implementation of identified strategies.	Form a committee of key stakeholders.	The Center for Health Promotion, MHA, ADAA and Deputy Secretary Henry, Deputy Secretary Phillips			

Strategy: **TRAINING & EDUCATION**

To provide information to optimize understanding, strategies, techniques, and resources, to promote tobacco prevention and cessation.

Target Groups: Consumers/patients, providers, family members/support, and policy-makers or legislators

Task Force Members: Mike Drummond, Sara Wolfe, Eugenia Conolly (co-chair), James Chambers (co-chair), Neil Grunberg, Adrienne Ellis, Carlo DiClemente

WHAT	HOW	WHO	WHEN	IMPACT	MEASURE
Integrate Smoking Cessation into PEER training program	Train the trainer model Partner with Peer Empowerment Task Force	MD Quit Peer Task Force	Over next 12 months	Change the norms and the culture- able to talk about smoking; identify champions and role models	Train all the PEERS
Educate Providers and Consumers to Resources Available	Facebook ads; google ads; smoking stops here and MD Quits websites; CSAs; Work with Peer Empowerment Task Force for messaging	MD Quit Peer Empowerment Task Force			
Provide presentation to Advisory Councils	State Drug Alcohol Abuse Council; Advisory Council on Mental Hygiene; Office of Integrated Affairs; Tobacco Coalitions in each county Engage Office of	MHA, ADAA	Over the next 12 mos		

	Consumer Affairs, peers, and tobacco county coalitions				
Provide and maintain an accessible list of resources	Updated websites: Smoking Stops Here Website; (consumers) MDQuit.org (providers); providers and stakeholder groups to link to these sites; MACSA	MD Quit			
Expand the number of people trained to become competent smoking cessation providers	use best practices but adapted to what is able to be done in the setting MD Quit Model; Train the trainer model; Link local health departments to provide training; partner the addictions and mental health providers to provide training; CEU credits; continue to look for other funding opportunities to expand the efforts	MD Quit; Tobacco Control;	Over the next 18 mos	Direct impact with consumers;	Number of people trained in smoking cessation best practices; Number of people participating in smoking cessation programs
Train providers about the importance of smoking cessation, to have conversations and make referrals	MHA conference; Value Options partnership; MADC partnership; MD ADDA management conference; Core Service Agency partnership; MPS partnership; Maryland Joint Council on Interprofessional Affairs	MD Quit; Tobacco Control; Adrienne; Georgia; MHA	Over the next 18 mos	Changing provider behavior; direct impact with consumers;	Number of providers reached;
Develop plan for use of technology for education and outreach in support of behavior	Continued team efforts to utilize best practices and enhance other			Reach larger geographic area;	Completed plan

change	efforts				
Develop and Implement Promotional Campaign	Media campaign; paid advertising; provider toolkits; Press Release; Sign up sponsors or organizations in support of the campaign; create templates key messages and facts for distributions to target audiences. Include wellness and recovery messages or posters	MD Quit; ADAA; MHA; Tobacco Control; MHAMD; Mike; SAMHSA; CQT; CSAs;	Over the next 12 mos	Change culture and behaviors	Number of sponsoring organizations; Number of kits ordered; Number of providers, wellness & recovery centers that have posters posted
Create Cross- Agency Task Force to oversee implementation of action plan and strategies	ADAA; MHA; MD Quit; Provider; Consumers; Advocates; policy-makers	Neil, Carlo			

Question #4: How will we know we are getting there?

Each task force identified process measures for each strategy. See measurement identified under each strategy above. Data will be shared with the task force members regularly. Data will be used to evaluate which strategies are or are not working, and to motivate partners whenever possible. The overall prevalence of smoking among adult mental health and addictions clients will be measured yearly till 2014.

Next Steps Timeline

Date/Month	Who	Key Milestones
JUNE	Renata, co-chair Public Health co-chair TBD	Establish Steering Committee for the 4 task forces to make implementation happen.
	Lawrence, Dawn (public health), co-chair	Co-chair, behavioral health and disabilities with public health. Discussion on shared responsibilities via pre-meeting.
	Task Force Chairs: • Janine/Sarah (Peer) • Georgia & Audrey (Clinician/Staff) • Jim & Eugenia (Training/Education) • Lawrence/Dawn/Tom (Regulation/Structural)	Establishment of Task force Chairs
	Renata, and Public Health co-chair	Interim Step – sit down with Dr. Sharfstein to help streamline the future work of the steering committee
JULY	Task Force members	Task force communication reinforced and implementation of action plan
AUGUST	Task Force members	Task force communication and implementation of action plan
SEPTEMBER	Peer Task Force	Beginning Sept - Evaluations from consumer groups re messaging and peer curriculum End of Sept – form curriculum and create first round of messaging from consumer-led campaign

Commitments & Appreciation

Name	Commitments & Appreciation
Peter	Commitment towards the group of teenagers who are most vulnerable to begin smoking. Think about teenagers AND their families.
Audrey	Excited to move forward to keep the process going
Steve	Good to be with you. We've set a very high bar. Good for everyone.
Georgia	For the clients we serve in recovery, it's been a great opportunity to help them reach their goal
Jean	Happy to work in the peer group
Catherine	Key to successful summit is momentum and speed. I will complete my tasks and help keep the work moving.
Clarissa	Offer my time and office as a resource to incorporate consumers using volunteer network throughout the state. Please contact my office to connect with recovery volunteers.
Sarah	Going to call at least 10 people to let them know what happened, to help move the tasks forward.
Janine	Stay in touch with the group regularly.
Steve Stahley	I have all the motivation I'll ever need.
Doug Tipperman	Being an MD resident, I look forward to seeing the change in MD and to seeing the movement in other State Academies. Will be presenting on a panel with Surgeon General, and MD will get coverage
Lesa	Bring back to health department and office and staff. One of the few to have direct services. Will begin implementation.
Dawn	WE've made great strides in the past day and a half. That a lone will help us lead the charge to reducing tobacco use among behavioral health populations.
Tom	Hope to come back in the next few years to say that 20% was not optimistic enough. Look forward to getting other partners in the table. Commitment to hit that 20% or more
Lawrence	Commitment to keep talking about it to staff, other people in the building. Promise to keep the conversation moving forward.
Sara	Commitment to keep sending out resources to you. Feel free to contact me to get resources available distributed to your clients. Make sure quitline is providing satisfactory services to clients, and highlight successes.
Mike	Create an environment of wellness and recovery. Promote this movement and goals of this organization to other providers. Promote to consumer, NAMI, and other organizations.
Eugenia	From April 4th to today, I have been able to participate in a planning and folks working together that have not been able to participate before. Great opportunity for the people that we serve for our patients and people we serve. Thank you to the SCLC folks. Committed today and moving forward.
Jim	Committed to improving the health care of those whom we serve.
Carlo DiClemente	Wonderful to move out of the silos. Wonderful to work with this group.

	Commit myself and MD Quit Resources to reach the target.
Neil	I am so inspired by the selflessness in the room for the people who don't have a voice. My hats off to all of you. Commit myself and graduate laboratory support, study help, analysis to help. I know MD can bring together behavioral health and preventative medicine. Delighted to provide contacts to make it happen national and globally.
Adrienne	Committed since email of June 1st at 7:45am. Committed to bringing my experience in outreach and campaign to move things forward.
Renata	Thank you Dr. Schroeder for coming all the way from San Francisco. So glad we're one of the 5 states. Thank you Doug Tipperman and to SAMHSA. Thank you to Planning Committee – Eugenia Conolly, Daryl Plevy, Lawrence Carter, Steve Stahley, Georgia Stevens, Dawn Berkowitz, Audrey Regan, Catherine Saucedo, Reason Reyes, Jennifer Matekuare, Teriyana Ruffin, and Jolie Bain Pillsbury.

Closing Remarks

Renata J. Henry, M.Ed., Maryland Deputy Secretary, Behavioral Health and Disabilities, DHMH, provided closing remarks. "We worked really hard, and I appreciate all of you in the room. It takes a big commitment to hold time on your calendar, to get here and stay the whole time. It has been a great opportunity for us to come together, and we will see this Action Plan through."

Appendices

Appendix A – Participant List

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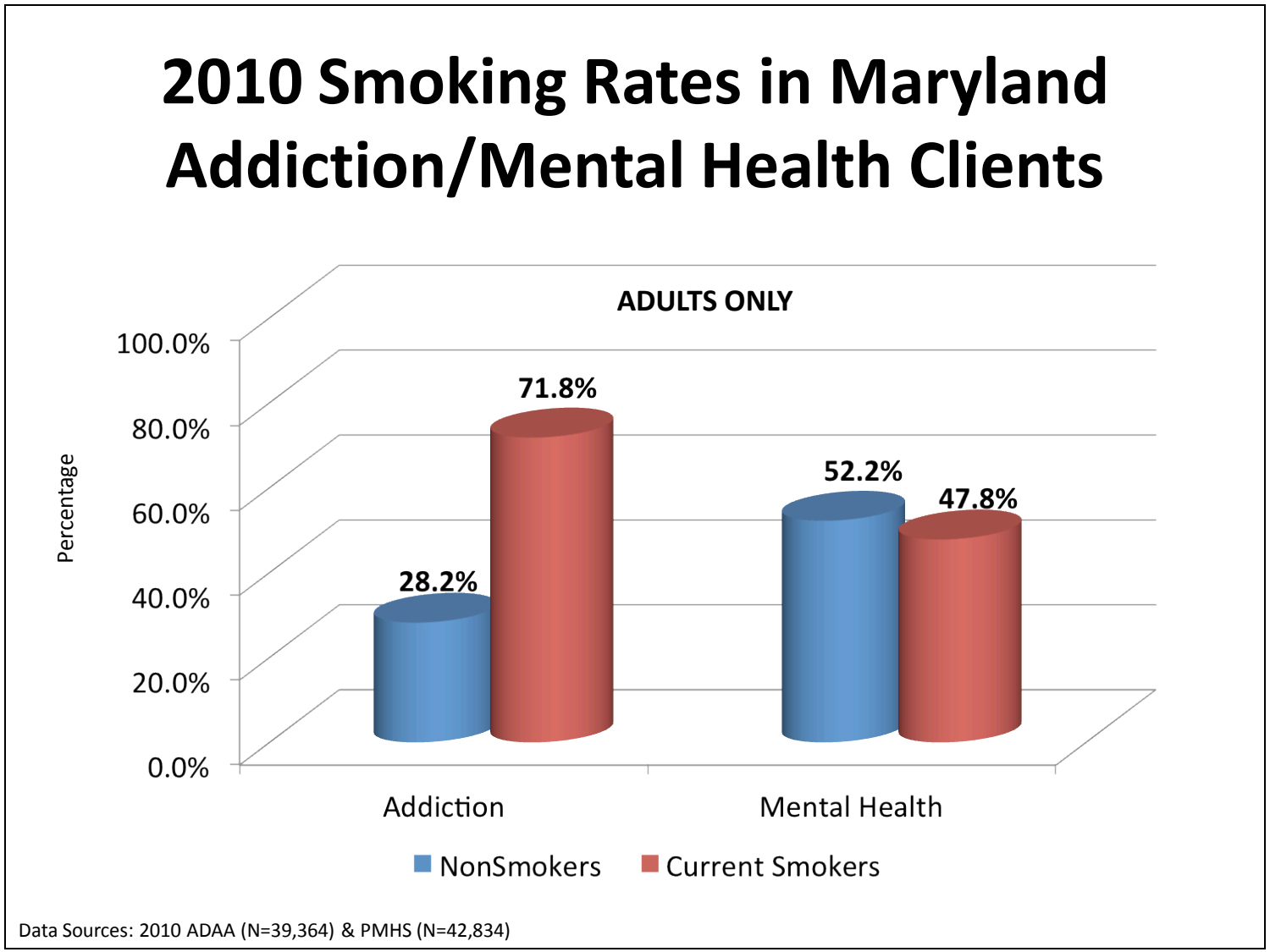
Appendix B – Interests

Partners' Interests in the Summit
Support for Peers in Recovery
As a person in long-term recovery, I acknowledge that programs for people who smoke and are in recovery is important; I want others to understand that tobacco is deadly.
Work with a number of recovery-related issues among MH consumers. MH consumers are burdened with smoking. Tobacco has a negative impact on their quality of life. I see quitting smoking and getting free from tobacco is integral in the work of recovery.
I have come to believe that people can get inspired in their future, and achieve things in life that they thought weren't possible. I really believe that if we can help people recover and in their recovery journey, we can help them quit smoking. My interest is to learn from all of you. I am honored to be with all of you. How can we create a culture to get people to achieve their goals and quit smoking?
Preventing and reducing the high rate among behavioral health population. Interested in learning what we can do.
Work with a lot of consumers in the state of MD. As we know in the consumer world, tobacco has been treated as a drug for many years in our population. I want to be in the forefront to reduce prevalence in behavioral health population. Smoking part of my background and touched by people I care about. We need to help patients make the right kind of choices.
Focused on outreach and education, and here to see how we can help with smoking cessation arena.
Work with Providers
Get providers (many in public health dept) in reaching out to other mental health and addiction providers to help patients quit smoking. Get providers to quit themselves. Important for staff to model to their clients.
Passion is to work with providers and peers to reduce smoking prevalence in MD.
Another passion is community-centered counselors in cessation. What I'm looking to see here is to learn what I can say to counselors to help peers quit smoking. We (counselors) don't have the education and training and resources to make appropriate interventions or referrals.
Data and Resources
Interested in data and resources. Interested in offering train-the-trainer models.
I work with various populations. My passion is about preventing and reducing. When I was asked to be part of this effort, I was surprised by the high rates of smoking. I'm here because I want to be able to learn from all of you, and get clear understand and steps to do to help people reduce quit smoking.
The data is here and we need to do better. Look at health care reform in 2014. We need to do a better job of this population. We need to treat nicotine the same way as we do with other drugs. Treat patients as well as staff.
I want people to understand that nicotine is not deadly but smoking is deadly. That is a very important distinction. Many of these people are self-medicating with the drug nicotine. I think there is a lot of misunderstanding around science. My teaching at the national level is better when I understand what's happening locally. Now I'm working with smoking and our troops, which has gone up dramatically in the last 10 years. Want to help our wounded soldiers.
Day job to help prevent stroke, heart disease, and diabetes. 80% can be prevented if people can quit smoking and have healthy weight. Very excited to be here.
When I think about the statistics that people with behavioral health disorders who smoke die 25 years younger, I think the time is now to address this issue. Glad to be here for us to come together and find solutions.
My interest is to look at behavioral health population's smoking prevalence. 44% of the nation's cigarettes are consumed by patients with behavioral health disorders.
I've done a lot of work in social work field. Interested in smoking cessation initiative for many years. The quitline has been my "baby," and glad to be back to help and make sure everyone has access to effective tobacco dependence treatment.
Integration of Behavioral Health and Public Health
My passion is related to the segregation and isolation of behavioral health from public health. When you look at a focus on reducing costs and improving quality of care. Reducing tobacco and smoking can help with reducing costs and improving quality of care. When I think of the rates of smoking in methadone

programs, we haven't come as far as we need to. When we talk about health promotion and prevention, I want it to integrate for everybody.
Done a "pathetic job" in Substance Abuse – we need to do better job with integration. Also need a focus on smoking for patients and staff.
Beforehand, worked in substance abuse and prevention. My interest is to formalize the working relationship between public health and behavioral health.
One of the things we talk about a lot is the integration of smoking in behavioral health for better health outcomes.
Keenly interested in integration of health, mental health, and cessation. I recognize that her smoking was motivated by her mental health status.
Cornerstone for Change
MD has pretty low smoking rates in the overall population, but we have so much to improve in the substance abuse arena. MD can get on the map with just a little more work. I'm here to help you take on that challenge.
We're in the business of creating culture change. Happy to be here.
The planning of the SAMHSA Academies is one of the cornerstone activities we (SAMHSA) are planning nationally.
Now interested in how we are going to roll it out in the multitude of programs.
Interested in hearing all your reflections. There was a lot I was thinking about that touches on tobacco. We can't go far with public health without dealing with tobacco.
Personal Connections
A new dad to a 4-year old and my son is old enough to know that tobacco is dangerous.
Two family members who died from smoking. My interest is paved by consumers and patients, 80-90% of them smoke. Very interested in knowing what works in systemic way.
Passion is towards a wellness and model. Smoking cessation is part of wellness. I have a family member who is trying to quit, but hasn't quit yet.
From a personal perspective, I just lost a client that could not kick the habit.
Big interest in public health

Appendix C – Updated Baseline Data



Appendix C – Group Conversations on "What do we know about Wellness and Smoking Cessation in Maryland?

TABLE	GROUP CONVERSATIONS
1	• We were struck at being good in terms of general population %, and more so how the numbers went up for MH and SA • 70% of people want to quit, but we have not tapped into that area to help people quit. STRATEGY ELEMENTS o Look at relapse not as failures, but as attempts and part of recovery. o Focus on smoking as the problem. o Regulations are on our side. Smoke-free settings used to get legislative push
2	• Taken by number of consumers vs. staff smoking implications. How do you help people when faced with something so glaring? • Institutions look at the problem in a punitive viewpoint or are puzzled by it. • Do you take a look at the harm reduction? Gradual? Global perspective? • 40-50% of Adults MH smoke; 70% adults SA • In 2014 data may be quite different as health care reform is implemented in terms of insurance and data • Low #s children under 18 who smoke, yet we know that that is when people start smoking. Data implications?
3	• MD at epicenter of health in our country. We should be leading in behavioral health, overall health, and smoking prevention. • MD has rich resources (NIH, etc) that can position the state to be a leader in smoking cessation
4	• Mental health smoking rates are lower than addictions rates. • Differences exist between jurisdictions in general population; but no distinction among behavior health between jurisdictions – all high. • Smoking rates higher among women than men; surprising. • Mental health smoking rates 3-5x higher than general population.
5	• We discussed past baselines from other summits. • Got into conversation of how we can make things happen. Will save strategies for tomorrow. • Possible baseline: "2010 Smoking Rates in MD Addictions/MH Clients" *(see slide)* o *Data clarification – slide includes all ages (6 to 65)* o New estimate for 18 to 65 year olds is 47.8% • Need staff data • County data good for monitoring process outcomes. • Are we talking about just smoking, or smoking & tobacco? *Group needs to decide.*

Appendix D – Overnight Reflections

Facilitated discussion on Wednesday, June 1, 2011, 8:30 a.m. about partners' overnight reflections from dinner

Overnight Reflections
Data
The data we talked about did include children. More accurate when have data on adults only.
Excited that we are able to get the revised data. Thank you, Janine. We now have more appropriate numbers for addictions and mental health.
Happy to see the revised data because it will frame our "Where are we now?"
Refocus on the number of 70% want to stop smoking. That's something we want to connect with. Also connect with staff who are smokers and offer them services so that they can believe in the change.
70% want to quit. That's exactly been my experience. Mental health consumers are passionate about stopping smoking. We need to help them.
Thrilled to Be Here
Glad to have some sleep last night. Thrilled we are doing this. We were talking last night about leadership and change. This is where it all starts with a group of people like this.
When I got up this morning, I really felt energized. All of you are great resources. You energized me to wanting to come back today.
We have to be passionate about setting a target. I'm most encouraged about the connections we have in these tables that we've not met face to face. Together, we can break down silos so that we can address the issue.
Priority Populations to Consider
Overnight, I was struck by number of children served in the MH arena. What types of prevention messages can we begin to make for this population at risk for smoking?
The prevalence among women and how it exceeds men – we need to focus on strategies for women.
Need to think about different strategies about the different subgroups, ie. People with depression, anxiety disorders, thought disorders, co-morbidity, etc.
I, too, thought about the 70% who want to quit. What can we do so that they have the opportunity to quit? Want to build more capacity and education for providers and community. What can we do to bring down the percentage of women who are smokers? I also agree this is a long-term initiative. We need to also evaluate so that we can demonstrate those good outcomes, and meanwhile get additional support in the process.
Now is the Time for Action
We all agree that we have to do something and do something fast in the behavioral health arena.
Had a vision of a smoke-free Maryland. Consumers are moving forward with their recovery in MD. With that, the recovery method will take place.
In our center, we have low incidence of smoking in mental health. 3 smokers. It's possible our center could be duplicated for other centers.
Read the materials with conference materials. We have been successful in getting smoke-free policy, need to spread it in the state.
There's a difference between "want" to do and "doing" it.
Commitments
The commitment to make the change is here. How will we did this? What are the implications for policy? I am thrilled with the true partnership with public health.
This is a long-term project. When you think about driving down the prevalence, we have to think about a long-term project. The other group we don't have data is on mental health providers. Doctors talk to their patients about smoking. I don't think it happens in the mental health community. Need to incorporate that group of people. The mantra here is low-cost, no-cost. There needs to be an understanding that there will be some cost to the system who will implement this; need to find resources to do the work we will say we'll do.
Resources
As we get out of the recession, where do we put our money and strategy? One thought is our adolescent research, where the next generation of smokers is coming from.

Appendix E – Partners' Resources and Leverage Suggestions

Strategy	Who	Leverage
Provider & Staff	Mildred	• Provider training
	Steve Schroeder	• Smoking cessation for staff
	Audrey	• Smoke-free campus; legal resource center • Work with businesses • "Healthy Maryland" • Prevention (cigar laws)
	Peter	• MA-PED, FP, Psych, SBIRT • Women/Children residential programs • Adolescent programs
	Georgia	• Groundwork; set committee • Interested in provider and peer strategies (training, technology, networking)
Peer	Catherine	• Free resources: • 800 Quit Now Cards • Tobacco Free Toolkits • Curriculum • training
	Steve Stahley	• Combatting new tobacco products • Remaining trans. Resources • Interest in topic area • Interested in provider and peer strategies (training, technology, networking)
	Janine	• MD quit • Data development • Interested in provider and peer strategies (training, technology, networking)
	Sarah Burns	• Peer smoking cessation groups • WRAP facilitation groups • Co-partner with 1-800-QUIT NOW
	Doug	• Consult on what works
	Clarissa	• Galvanize consumer leaders with resources, training, and partnering • Galvanize and support provider leaders with resources, training, and partnering • Galvanize and support family leaders with resources, training, and partnering • Galvanize and support youth with resources,

		training, and partnering
Regulatory & Structural	Lawrence	• Formal collaboration with mental health and substance abuse • Office assets
	Lesa	• Policy development • Training/education • Consensus building • Communication
	Renata	• Regulatory changes • Funding alignment • Policy changes • measures
	Neil	• Motivational DVD with CEU credit
	Tom	• Funding, regulations, and data dessimination
Training & Education (with outreach)	Adienne	• Working with health insurance plans • Outreach and communication • Relationships and networks
	Mike	• Peer to peer • Development groups for staff and consumers • Policy changes • Measures • Prevention
	Jim	• Buy-in from providers • Community med directors
	Carlo	• Training providers and peers • Program development/ implementation • Quitline connections • Bring in technology • Evaluation measures
	Eugenia	• Policy development • Capacity building • Training/education • Prevention/intervention • Communication network
	Sara Wolfe	• Resources for providers and consumers • Cataloguing in MD resources • Outreach to specific providers