Addressing Tobacco in Co-occurring Condition Initiatives
Alameda County, CA

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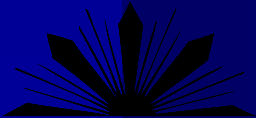
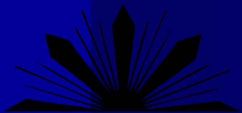
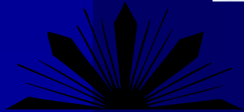


OBJECTIVES

- Participants will learn the 12 steps to developing tobacco-free agency policies (Hoffman and Slade 1993-Stuyt et al 2003)
- Participants will learn key steps in integrating tobacco treatment into county-wide Behavioral Health programs and or co-occurring initiatives

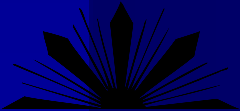




Physical

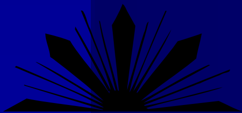
Emotional

Habit



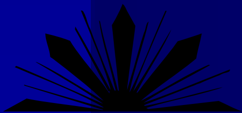
12 steps to Tobacco-free Treatment

- Acknowledge the Challenge
- Establish lead group/committee
- Develop policy
- Establish time-line -goals & Obj
- CONDUCT STAFF TRAINING
- Offer Treatment for nic-dep staff



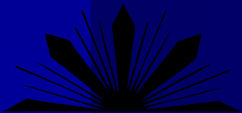
12 steps to tobacco-free treatment

- Assess & Diagnose nic-dep clients
- Include in patient education
- Discuss with referral resources
- Require staff “no evidence” t-use
- Establish t-free facility & grounds
- Implement nic -dependence treatment throughout program



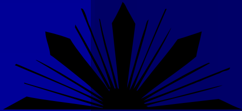
Agency example
Policy at Thunder Road Residential Teen Drug RX

- 7/94 “Smoke” breaks
- Nicotine Team/Chair non-administrator
- Staff airing of draft policy/training
- Client no smoking 7/96
- offer training and staff support
- 8/96-12/96 ongoing smoking/smuggling
- AWOLing/more training
- 11/96 Management absorbs Nicotine team



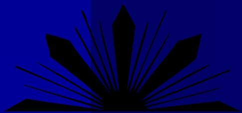
Evolution of TR Nicotine Policy 2

- 12/96 - Clear consequences for client smoking, restrict after-care contact
- 7/97 - Staff notified no smoking on grounds 8/97
- 5/98 –8/98 - Training/CMT planning/network, notify “no evidence” 8/99 // staff support
- 8/99 - “no evidence” for staff
- 1/01 - Nicotine highest priority for CMT
- Tobacco Free Zone –Thanks for your support!
- 9/01 - Nicotine treatment plans required Nicotine Workshop for families



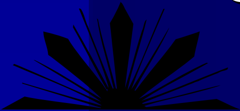
Framework for County Level Change
Alameda County, CA
(BHCS) Behavioral Health Care Services

- County Tobacco Settlement (MSA) $ tied to tobacco policies
- 12/02 BHCS develops cautious tobacco policy guidelines for 110 agencies
  - Population 1.5 million, clients 26,000
- Training & TA thru MSA grant ‘03-’08 <1 FTE works with BHCS agency liaison
- 2120 staff trained 75 agencies receiving TA



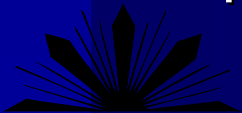
A County BHCS Tobacco Policy Guidelines Jan '03

- Training - all staff 1 hour- clinical staff trained on tobacco addiction
- Prohibition in buildings, vehicles, property
  - No smoking of staff in sight of clients
  - Inform,orient,record violations,post
- Public Information-Signage-employee tobacco treatment benefits
- Divestment- no tobacco funds
- Add on-address and treat if can't be treated in primary care.
- Guidelines at :http://BHCS.co.alameda.ca.us



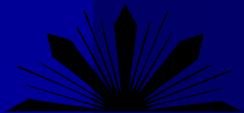
Essential Training components to enlist Mental Health and Alcohol and Drug Staff

- Tobacco 101
- Developing Tobacco Free Policies- staff issues
- Role of MH/AOD Programs in promoting smoking
- Tobacco effect on medication levels including psychotropic medications
- 25% increase in sustained abstinence associated with tobacco treatment in AOD
- Systematic tobacco assessment, counseling and pharmacotherapy
- Inclusion in treatment planning and relapse prevention



Essential Training components to enlist Mental Health and Alcohol and Drug Staff

- Examples of what was covered in the training
- High frequency of smoking in MH/AOD clients
  60%-90% smoke
- High Frequency of smoking among Staff
- Initially resistance to tobacco training has completely turned around over time. Now it is met with interest and enthusiasm by most groups.

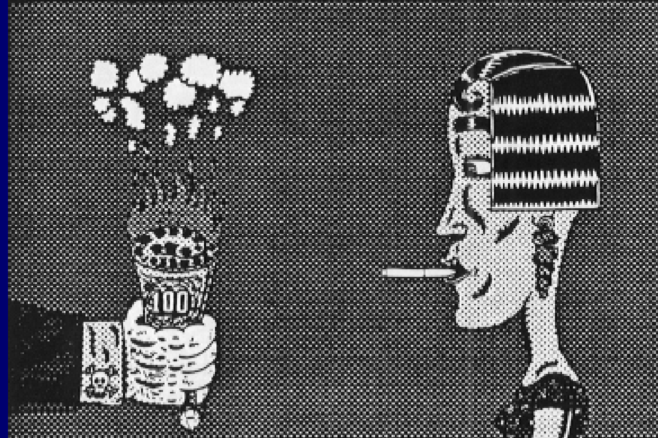


TOBACCO COMPANIES SPEND

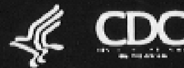
14.2 MILLION

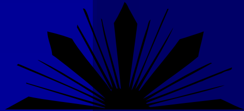
DOLLARS A DAY TO SELL

CIGARETTES*



*and it hardly costs you a thing.



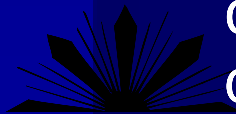


Tobacco Industry "subculture urban marketing" "Project SCUM." 1990's

Target for ads-gays in Castro & homeless in the tenderloin

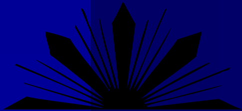
"This is a hate crime, plain and simple," Kathleen DeBold, (directs Project for Lesbians With Cancer) a group thinks of gays and lesbians as "scum,' and then targets us with something that kills?"

S F Supervisor Daly "It's racist, it's classist, it's oppressive. And it is really disheartening to hear. But I can't say that I am surprised. Low-income communities and people of color have always been derided and taken advantage of."



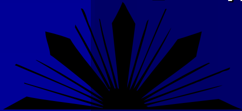
Why address tobacco in Behavioral Health

- Saves lives improves quality
- Saves health dollars
- Improves employee productivity and health
- Nicotine dependence DSMIV dx
- Smoking disproportionately affects behavioral health clients
- Williams J. Ziedonis D. Behavioral Health Care May 2006



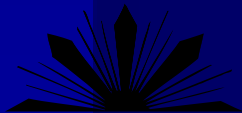
Why address tobacco in Behavioral Health

- Tobacco dependence and MI are SAMHSA co-occurring disorders
- Behavioral providers have more time for psychosocial RX
- Tobacco use alters psych meds
- Fits into wellness and recovery
- Reimbursement is improving
  - Williams J. Ziedonis D. Behavioral Health Care May 2006



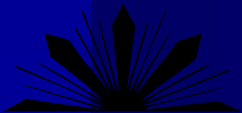
Why Treat Tobacco in MH/AOD

- **Recent data from several states have found that people with serious mental illness served by our public mental health systems die, on average, at least 25 years earlier than the general population.**



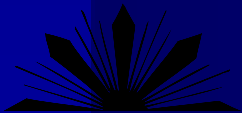
Why Treat-Meta Analysis of Treating tobacco in Drug treatment

- Right after treatment clients treated for tobacco had 1.10 greater chance of being clean and sober (9 studies)
- After 12 months t-treated clients had a 1.25 greater chance of being clean and sober (7 studies) J Prochaska 2004



Quit Rates for Mentally ill

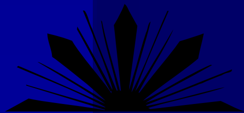
- 43% no hx Mental illness
- 37% lifetime Mental illness
- 31% past-month Mental illness
- Increased quitting with atypicals
- ALA model successful with schizo
- Mood manage for hx/depression
- Source: Lasser K. JAMA Nov. 22/29 2000 Hall/Zeidonis



How successful are people at quitting-at 6 months ?

- Self quitting 5%
- Physician advice 10%
- Group behavior 20%
- Nicotine replacement + advice 20%
- Nicotine replacement + group 30-40%
- Zyban 23%
- Zyban + patches 35%
- Varenicline 30%

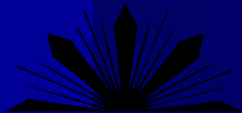
(Adapted from J. Hughes, Jorenby, NEJM 1999; and Hurt, NEJM 1997)



How successful are people at quitting after 6 month-meds only

- Self quitting 5% - 10% Physician Advice
- Placebo 13.8%
- Nicotine patch 6-14 weeks 23.4%
- Zyban 24.2%
- Patch + Paxil or Effexor 24.3%
- Patch + Zyban 28.9%
- Chantix 33.2%
- Nicotine patch >14 weeks + gum or spray 36.5%

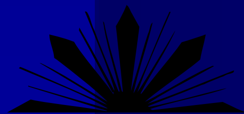
Meta analysis page 109 from Treating tobacco use and dependence 2008.
References at www.surgeongeneral.gov/tobacco/gdlnrefs. htm



Quitting is Possible

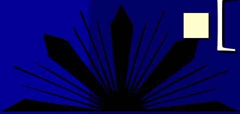
- New and better treatment approaches provide even more success
- MH/AOD clients often benefit from more intense innovative treatment.
- MH/AOD benefit when the milieu and systems support treatment
- EVIDENCE BASED TREATMENT =

  Counseling and medication



Some Facilities Treat, But Most Don't Offer Evidence-Based Treatment

- Survey of 408 methadone facility directors
- In the 30 days prior to taking the survey:
  - 73% provided brief advice to quit to at least 1 client
  - 18% offered individual or group counseling
  - 12% provided some form of NRT
- Among 550 U.S. outpatient facilities of all types
- 40% offer individual or group counseling
- <20% offer medication
- [Richter et al, 2004; Friedmann et al., 2007]



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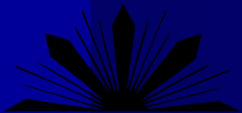
National signals help change paradigm

- SAMSHA Tip 42 Co-occurring includes tobacco

- SAMSHA 100 tobacco-free pioneers



National Association of State Mental Health Hospital Program Directors (NASMHPD)

"Silently and insidiously ...tobacco smoking became an accepted way of life..in our public mental health treatment facilities"

smoke breaks for staff and patients

when what and how one of the few choices allowed

used as (+) & (-) reinforcers to control behavior

while taking alcohol and drug use seriously a more deadly substance used much more-largely ignored

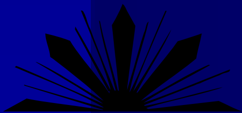
tobacco kills those with MI more often and earlier

Commit to educating, leadership to create smoke free systems, work to ensure that those who want to be tobacco free have access to continued cessation treatment and support in the community.

NASMHPD Tobacco Toolkit 2007- Appendix A

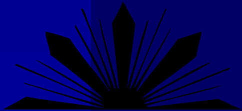
NASMHPD Key Messages

- 25 year mortality gap due largely to smoking
- Smokers with schizophrenia spend >1/4 income on on cigarettes
- Tobacco use interferes with psychiatric medications
- Although more than 2/3 of smokers want to quit only 3 percent are able to quit on their own-need help
- Even highly addicted smokers with mental illness can quit and are more likely to succeed with medications and behavioral therapy

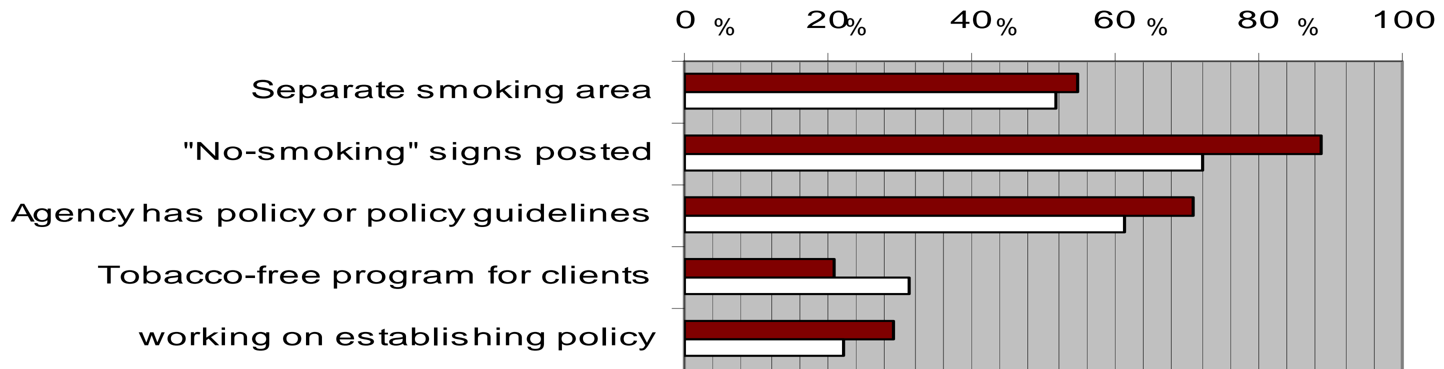


Major state level changes

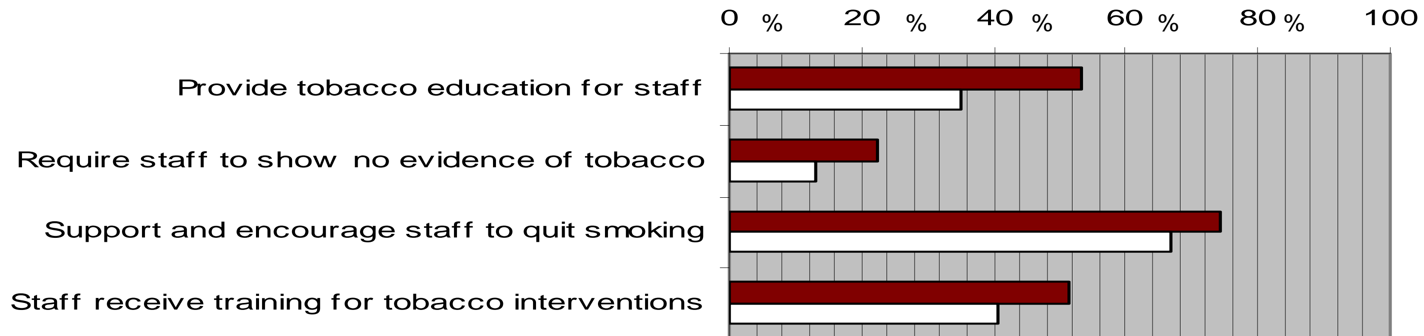
- New Jersey Requiring all residential programs to address tobacco on par with alchol and drugs 2001
- New York requiring all AOD programs to address tobacco on par with alcohol and drugs July 2008



Baseline 1/03 few agencies had t-policies Evaluation 2005 (54/80) 2007 (62/110) Results of self report tobacco policy checklist



2005
2007



Baseline 1/03 few agencies had t-policies Evaluation 2005 (54/80) 2007 (62/110) Results of self report tobacco policy checklist

Client tobacco-free issues

Client Tobacco-free issues

0 % 20 % 40 % 60 % 80 % 100

Assess nicotine dependence

Treat Nicotine in treatment planning

Provide tobacco education for clients

Require clients to be abstinent

Cessation support offered to clients

Provide tobacco cessation classes

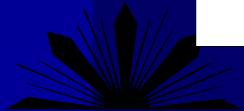
Provide 1-on-1 cessation counseling

Offer nicotine patches / medications

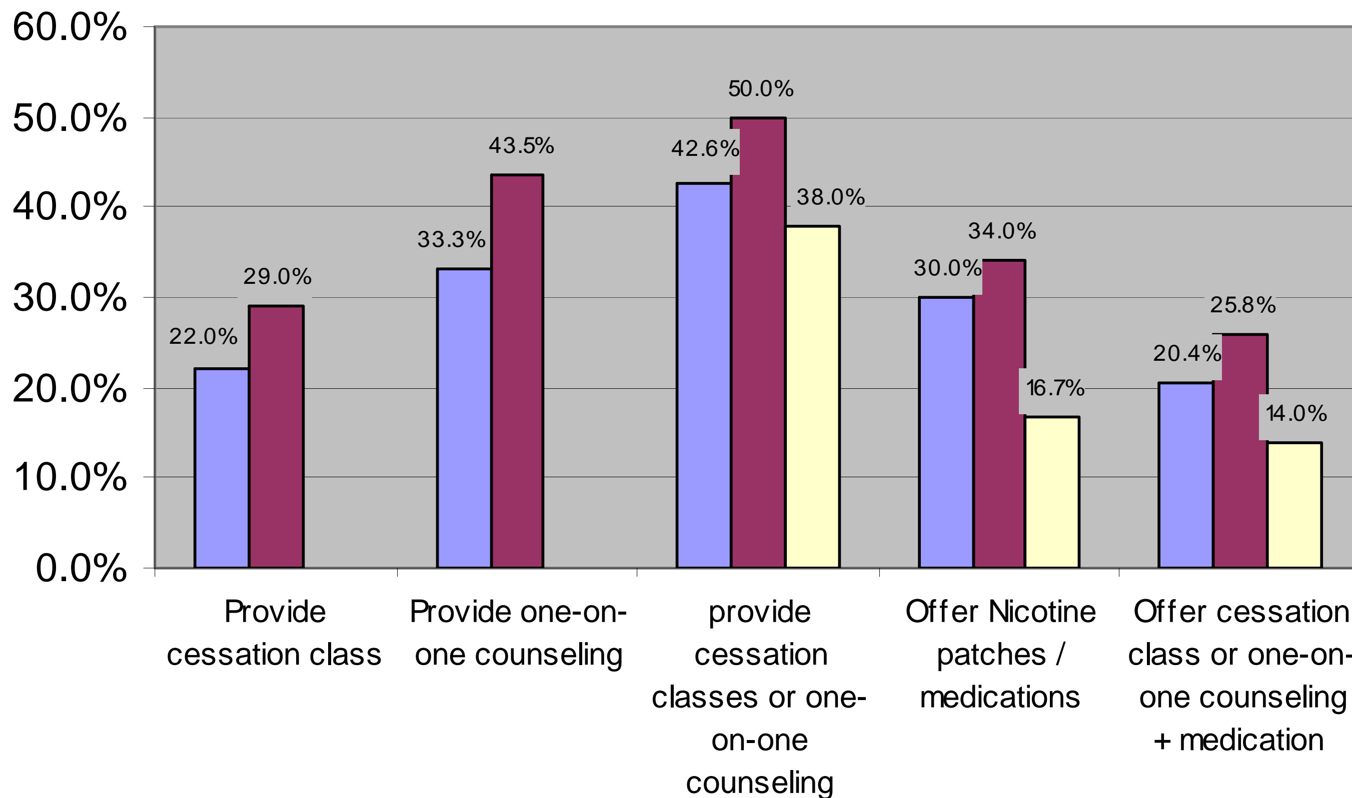
Offer recognition to clients w ho quit

2005

2007

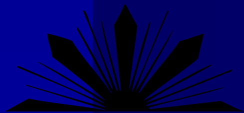


Comparison of Alameda County Tobacco Policy Surveys (2005 & 2007) and Outpatient AOD National Survey (2007)



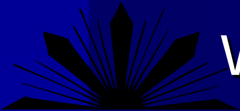
2009 survey results

- 70 programs responded
- 50% report assessing clients for tobacco
- 63% report offering cessation support
- 43% offer one on one counseling or group
- 20% offer evidence based treatment counseling and medications
- 16 agencies requested TA



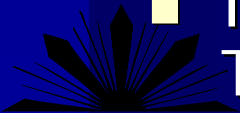
Alameda County-Treat Tobacco in MH/AOD

- Tobacco #1 Co-occurring condition-60-90% use tobacco
- Many states and counties have co-occurring or dual diagnosis initiatives in which they are trying to blend Mental Health and Substance Abuse Services so there is no wrong door (rarely include tobacco)
- Tobacco is highly addictive and the leading cause of death for those with MH/AOD
- A Co-occurring Initiative is not complete without addressing tobacco



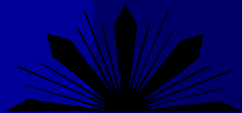
Alameda County-Treat Tobacco in MH/AOD

- 2008-2009 Behavioral Health Care Tobacco Training and TA program previously funded by Tobacco Control is funded by County BHCS !!!
- Continued training and technical assistance to agencies- mini tobacco grants for MH/AOD
- Tobacco integrated into Co-occurring Initiative (CCISC) model (Minkoff and Cline/ZiaPartners) as Number 1 Co-occurring Condition- Nicotine integrated into Compass eval tool.
- Change agents working to change system begin to see addressing tobacco as part of their work
- Initiative distributes Tobacco Dependence Treatment Syllabus to change agents



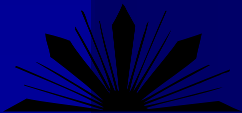
MINI GRANTS

- Mental Health agency implemented a tobacco information group 9 and Learning about Healthy Living- attendance increased from 0- 13 at LAHL
  - 20 LAHL and 5 education groups
  - 41 clients received incentives
  - 50% talking with psychiatrist about quitting
- AOD agency implemented free NRT program following protocol modeled after Massachusetts
  - 152 clients went to MI group
  - 21 quit attempt & received free NRT 2-8 weeks
  - 9 quit
  - 6 were quit for 10 weeks when program ended



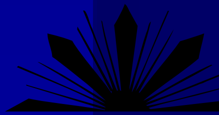
Consumer surveys

- 99 clients surveyed
- 32% interested in quitting
- 76% believe their program should offer support and treatment to help clients to quit



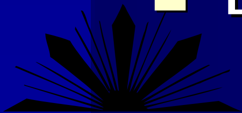
Addressing Tobacco in MH/AOD Policies

- Policy Guidelines '03 revised to draft "Tobacco Policies" mandating agencies have substantive tobacco programs with training and conduct guidelines for staff and integrate T- treatment into care for clients. To be finalized by review of key staff committees. Goal to incorporate into contracts with compliance follow-up in 2011.
- ACBHCS Website Co-Occurring description to be changed from "MH and Substance Use" to "MH and Substance Use (Alcohol, Tobacco and other drug)" - other materials



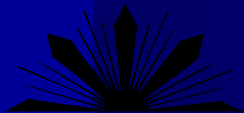
Addressing Tobacco in MH/AOD- On going training

- Training of psychiatrists on addressing tobacco and how to access treatment meds through existing systems and leap over barriers. TA from county pharmacist and state pharmacy consultant.
- Training of Staff
- Training of Consumers and Consumer advocates
- Training of Board and Care providers
- Efforts to develop peer support



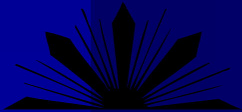
Discussion at 11/08 Psychiatric Practices Committee

"It is important to hold the idea of reward and optimism about this and encourage clients with every small success"



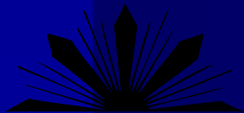
Alameda County Addressing Tobacco in MH/AOD

- Two Way Street
- Alameda County is the first of many ZiaPartner Co-Occurring initiative programs to address tobacco. This concept and it's importance will be shared with others from numerous states and counties at a national meeting in October 2009.
- Program does ongoing advocacy at the state level to promote a state MH/AOD Tobacco Initiative



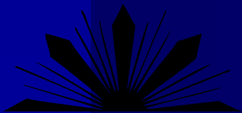
What makes it happen at the county level

- County admin requiring comprehensive tobacco policies :
  - Training staff regarding tobacco
  - Addressing staff tobacco use
  - assessing every client for tobacco use, educate clients
  - offering tobacco dependence treatment to every tobacco user
  - Establishing tobacco free grounds



What makes it happen at the county level

- Allocating resources to support programs in implementation of tobacco policies- training/consultation
- Allocating $ for small grants $2000 per agency. Rewards the pioneers/solidifies commitment
- Continued monitoring and quality assurance assessment to assure that programs are progressing with policies and implementation



What's the pay off of tobacco policies?

- Help clients stay free of drugs and alcohol
- Help clients live longer
- Help clients have higher quality of life- face problems without a drug
- Help clients recover from nicotine dependence
- QUALITY OF CARE /CONSISTENT WITH MISSION