UCSF Smoking Cessation Leadership Center | National Center of Excellence for Tobacco-Free Recovery

"The Great State Update: Effective Partnerships to Treat Tobacco Addiction in Behavioral Health Settings"
on Thursday, May 26, 2022, at 2:00 pm EDT

Speakers:

- **Carlo C. DiClemente, Ph.D. ABPP,** Director, Maryland Tobacco Control Resource Center (CdiC abbreviation below)
- **Reba Mathern-Jacobson**, **MSW**, Specialist, Public Policy and Advocacy, American Lung Association
- **Pat McKone, BA,** Senior Director Public Policy and Advocacy, American Lung Association
- **Dana Moncrief, MHS, CHES**, Director, Center for Tobacco Prevention and Control, Maryland Department of Health

Q: What is the explanation why addiction/SUD providers have excluded tobacco use disorders/TUD from the treatment services they offer those with other SUD's?

A: There are many myths and misconceptions about tobacco in SUD treatment providers. For years tobacco was thought as the lesser evil and helped manage the stress of withdrawal and recovery. This is not correct. Many providers are smokers and former smokers who do not want to tell individuals not to smoke. The biggest is that quitting tobacco would interfere with recovery. Research has also debunked this myth and there is some evidence that if a person with SD can quit tobacco it enhances recovery. (CdiC)

Q: What is defined as "tobacco dependence treatment" at Sheppard-Pratt? Does that mean they have received at least one session of tobacco treatment or that they were referred to the quitline, or some other specific treatment?

A. This is what I understand at present about the program. At Sheppard-Pratt there is a dedicated smoking cessation provider who talks with each and provides counseling and support services while in the hospital. The campus is smoke free so the patients use NRT and cannot smoke while hospitalized. There are attempts to connect with the quitline or an outside referral on discharge. There are also some research ongoing to see if the legacy quit smoking program on line can be adapted to be used by individuals with serious mental illness. (CdiC)

A: Sheppard Pratt defined "tobacco cessation treatment" as tobacco cessation counseling or both tobacco cessation counseling and provided NRT. 9,000 patients received tobacco cessation counseling (one or more); however, not all of them accepted use of NRT. Sheppard Pratt only referred to the Quitline at patient discharge to provide continued support for their quit attempts. (Maryland)

Q: Please share information on how to connect with a peer cohort. Thanks!

A: We have reached out to the behavioral health administration that has created training and certification programs for peer specialists to engage them in how to incorporate tobacco treatment in their training or continuing education programs with some success. There are a lot of training requirements and we have not been able to include tobacco treatment in the core yet. We also have reached out to large treatment programs to offer training to staff who are largely peer specialists and addiction counselors. Getting a list of peers to advertise to would also be helpful. We have peers who sign up for our BH2 training when we send the notices around. (CdiC)

Q: Do you see a movement with language from "cessation" to "treatment"?

A: I think the biggest change that can help is the broadening focus on recovery as a process of change that enables the person to lead a self-directed life and focuses on wellness and health as SAMHSA has done. Tobacco is a core consideration and should be an integral part of any wellness plan so that would be a great shift in emphasis and make tobacco a part of recovery. (CdiC)

Q: For data collection of tobacco use prevalence rates in the behavioral health population, what methods and/or data points were used?

A: For Maryland, we currently use the Behavioral Risk Factor Surveillance System (BRFSS) data set. (Maryland)