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

"What Works: Developing Effective Partnerships to Treat Tobacco Addiction in Behavioral Health Settings" on Thursday, September 23, 2021, at 2:00 pm EDT (90 minutes)

Moderator: **Catherine Saucedo,** Deputy Director of Smoking Cessation Leadership Center, University of California, San Francisco

Speakers:

- **Christian Barnes-Young, MS, LPC,** Assistant Deputy Director, Division of Community Mental Health Services, South Carolina Department of Mental Health
- **Heath Holt Hayes, MA**, Chief Communications Officer, Oklahoma Department of Mental Health and Substance Abuse Services
- **Regina F. Smith, MS**, Director of Health Systems and Tobacco Cessation, Indiana Department of Health

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I. Outreach

Q: Are you seeing tobacco treatment services written into Child Welfare Services juvenile court reunification contracts for CPS parents that smoke?

A: (RS) That is an outreach area that we have talked about exploring. There are so many facets of welfare that would be great intersections i.e. transitional youth and vaping, Quitline promotion, foster parent training and expectations, case manager training, and incorporating contract language are strategies that we will introduce. Stay tuned!

A: (CB-Y) Not in SC, to my knowledge.

A: (HH) Oklahoma has recently begun Family Treatment Courts and for many of the reunification courts Behavioral Health Treatment is used. All of ODMHSAS' contracted behavioral health treatment providers have Tobacco Cessation as part of their contracts.

Q: I am a social worker in DC. Landlords are evicting people for smoking in smoke free and public buildings. Any suggestions?

A: (CS) Empathetic approach is best. Treat each "violation" as a teachable moment, refer to 1 800 QUIT NOW and refer to local community clinic services. Partnering with a community clinic, the quitline, and the PHA can prevent such drastic measures from happening in the first place. Visit smokefreePHA.org site and resources including webinars addressing such topics.

II. Challenges

Q: What is the biggest obstacle your state has faced in implementing your programs?
A: (RS) COVID, leadership buy-in, moving from talking about change to tangible results (moving partners to action)

A: (CB-Y) Gaining buy-in from staff. Having champions is critical to ensuring tobacco recovery services are readily available for patients to join when they express motivation. Routine screenings for tobacco use and motivational interviewing-type conversations have been helpful. It is important to be persistent.

A: (HH) I think the answer [below] applies to this- mainly buy-in, which we now have after educating our providers on the importance of tobacco cessation.

Q: What were the challenges to Oklahoma helpline/work?

A: (HH) In the past, probably buy in - Again with the issue of treatment staff sometimes being tobacco users, they can find it hard to encourage clients to stop tobacco use if they are users as well.

We also face the issue of provider staff not feeling like tobacco use is a priority given the other challenges that our clients are facing. Our clients have substance use and/or mental health challenges that can feel more pressing than getting them to quit tobacco although we know that in this population, tobacco use is the number one leading cause of preventable death. Typically, it takes several years before we actually start to see the health effects of tobacco use and it doesn't necessarily feel like a critical concern and the clients aren't in any imminent danger.

Additionally, being in the middle of a pandemic poses its own set of issues. People are stressed out right now and some are finding it harder than ever to quit, especially since many have been isolated.

Q: Did you find a barrier with needing an "order" from a doctor to dispense NRT in the residential setting?

A: (HH) No- physicians already prescribe a number of medications and this hasn't been any different or any more challenging.

III. Methods

Q: Where can I obtain good examples/templates for readiness assessments and workflow for a LHDP working on implementing E-referral into EHR system?

A: (CS) CAQUITS.org has great resources for providers. For EMR examples go to https://www.caquits.com/resources-providers and scroll down for Cerner and Epic information.

Q: How are you safely using carbon monoxide analyzers during Covid?

A: (CB-Y) The carbon monoxide analyzers have not been used during the COVID pandemic. Even before the pandemic, there was concern about multiple people using the devices. They devices we've been using come with disposable cardboard sleeves that go over the mouthpieces and the devices were sanitized between uses.

Q: How are follow ups done? I have found that a week supply does not have long term results. Previous discharged pts will come back on readmissions in less than a month smelling of cigarettes. The other issues is staff on breaks coming back smelling of smoke and taking care of patients trying to stop smoking. Or if they return to long term care which allow smoking, then they regress.

A: (HH) Follow up includes ODMHSAS staff calling the participants 30 days after discharge to see if they are still quit.

Addressing the supply question- We typically discharge clients with two weeks' worth of Nicotine Replacement Therapy, although with Medicaid expansion that amount may change. The goal is that because they are referred to the helpline while they are in treatment, we can discharge them with enough nicotine replacement therapy to last them until the helpline sends NRT to the client. Tobacco use is not permitted on ODMHSAS contracted or certified facility property. Although we do occasionally face the same issue of treatment staff using tobacco, we strongly discourage it and encourage provider staff to work with their own staff on their tobacco use so that they can better serve consumers.

Q: Does Oklahoma do coaching calls through the QuitLine that count as 'treatment hours' for the client in inpatient?

A: (HH) It would not count as treatment hours because they are conducted by the Quitline. If the facility is using an umbrella rate for the hours, they are inpatient the Quitline does not bill treatment hours, so this would not take away from the hours in the inpatient treatment facility. If the facility is fee for service, then the time used by the Quitline would not be billed. There are billing opportunities for interventions for those that have Tobacco Use Disorder by many levels of staff including physicians, nurses, therapists, case managers, wellness coaches, and peer recovery support specialists.

Q: One of my residential facilities allows their residents to have three cigarettes a day and if they are going to smoke they do not let them have NRTs. What are your thoughts on this? I notice an incredible amount of frustration for staff and residents with this approach.

A: (RS) I understood that it is counterproductive from a medical/science perspective to smoke and use NRT too, this may be the rationale? Not sure if its accurate, worth checking to confirm.

A: (CB-Y) Best practices teach that setback are to be expected and either/or approaches are not usually effective. I would encourage the facility to transition to a tobacco free setting. The attached document [see Additional Resources PDF] does a great job of summarizing the evidence about smoke-free psychiatric facilities.

A: (HH) Tobacco use should be prohibited on facility property.

Q: What would be the main preventive strategy to apply and educate Mental Health patients regarding the danger of Tobacco smoking and its impact on health?

A: (RS) Incorporating the stages of change, cost benefit analysis, brief action planning, providing quit materials that will address managing triggers and roadblocks.

A: (CB-Y) I need to defer to the prevention experts at Public Health and other agencies.

A: (HH) It would depend on the age of the clients. Somewhere around the ballpark of 85-90% of individuals do not pick up smoking if they are over the age of 18. If those over the age of 18 are not using tobacco, chances are they won't ever- it's not a habit that most people decide they would like to start one day.

Under the age of 18 I would continue to educate individuals on the dangers of tobacco use; what's actually in cigarettes, how it can damage every single part of the body, and how 50% of individuals who pick up tobacco use die from tobacco use. The remaining individuals live with chronic, irreversible health issues for the remainder of their lives.

Additionally, I would start to address tobacco use with those who are vaping who are not yet tobacco users. Research shows that those who use e-cigarettes and vaping devices typically go on to use tobacco, and we know that this is where teens are starting right now.

I would also address it as a social issue. Big Tobacco targets certain groups who they think are easy targets and have what would be considered to be higher stressors in their lives. They do this because they think, understandably so, that if they can get a group who is prone to high stress, addicted to their substance, they'll have a harder time quitting tobacco, and they're not wrong. If individuals feel like they're being harmfully targeted it may discourage them from engaging in tobacco use.