Rhode Island Leadership Academy Virtual Summit
Tobacco, Mental Health and Substance Use Challenges

Welcome!

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Thank you for your commitment to this work and for being here today!

National Council for Mental Wellbeing

Founded in 1969, the National Council for Mental Wellbeing is a membership organization that drives policy and social change on behalf of nearly 3,500 mental health and substance use treatment organizations and the more than 10 million children, adults and families they serve.

- We advocate for policies to ensure equitable access to high-quality services.
- We build the capacity of mental health and substance use treatment organizations. We promote greater understanding of mental wellbeing as a core component of comprehensive health and health care.
- Through our Mental Health First Aid (MHFA) program, we have trained more than 2.5 million people in the U.S. to identify, understand and respond to signs and symptoms of mental health and substance use challenges.

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A Note on Language & Terminology

Mental wellbeing: thriving regardless of a mental health or substance use challenge.

Commercial tobacco use/tobacco use: The use of commercial tobacco and nicotine products (including electronic nicotine devices, otherwise known as ENDs).*

***All references to smoking and tobacco use is referring to commercial tobacco and not the sacred and traditional use of tobacco by some American Indian and Alaskan Native communities.**

1. What Has Caused the Disparity?

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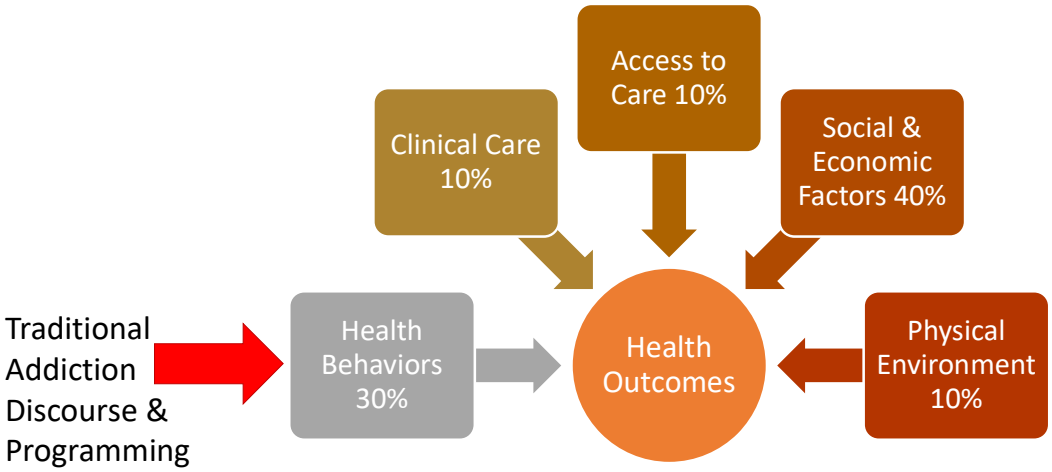
The Determinants of Health



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Tobacco & Behavioral Health: *What has caused the disparity?*

The overall rate of cigarette smoking among adults has been falling decreasing, but individuals with mental health challenges have been neglected in prevention efforts, environmental and clinical interventions.

This disparity can be attributed in part to predatorial practices by tobacco companies which included:

- Targeted advertisements
- Providing free or cheap cigarettes to psychiatric clinics
- Blocking of smoke-free policies in behavioral health facilities
- Funding research that perpetuates the myth that cessation would be too stressful and negatively impact overall behavioral health outcomes

- **High rate of ACEs/Trauma**
- **Limited access to high quality care (delays in care, lower quality of care, and more)**

50 Years Later…More Findings Emerged

Today we know that tobacco use can lead to many more types of cancers and chronic conditions other than those directly related to the lung thanks to the 2014 Report of the Surgeon General on Smoking and Health. Key findings from this report included:

- Smoking harms nearly every organ in the body
- Quitting smoking has both short- and long-term benefits for health
- Exposure to secondhand smoke causes cancer, respiratory and heart disease, and adverse health effects among children
- The list of diseases caused by smoking continues to grow

Yet for individuals with behavioral health conditions, prevention of smoking related illnesses often takes a back seat to the individual's mental illness leading to delayed diagnosis.

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What Changed in the General Population?

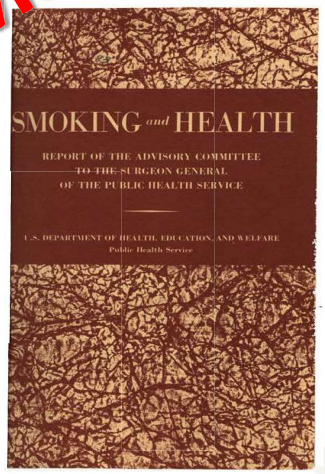
ACCESS
EDUCATION
SOCIAL NORMS
POLICIES
FUNDING

The 1964 the U.S. Surgeon General released the first report to examine the health consequences of tobacco use. This report changed the American perception, health care and public health attitudes towards tobacco use. From this report tobacco use was found to be….

The most important cause of chronic bronchitis

A cause of lung cancer and laryngeal cancer in men

A probable cause of lung cancer in women



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Race/Ethnicity

31.8% American Indians/Alaska Natives

16.6% White

Education Level

40.6% GED

4.5% Graduate degree

Poverty Status

25.3% Below poverty

14.3% At or above poverty

Health Insurance

28.4% Uninsured
25.3% Medicaid
11.8% Private

Disability/limitation

21.2% Yes

14.4% No

Sexual orientation

20.5% Lesbian/Gay/Bisexual

15.3% Heterosexual

Serious Psychological Distress

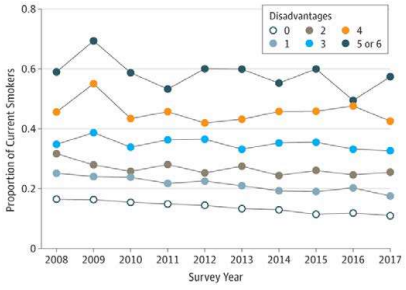
35.8% Yes

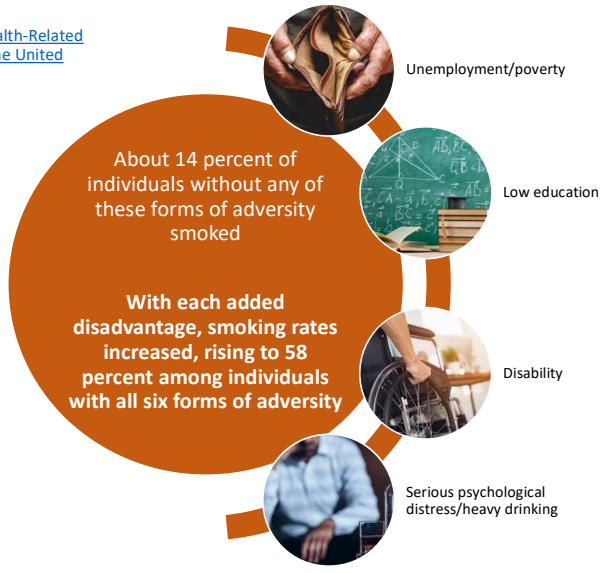
14.7% No

Source: slide courtesy of CDC; Jamal A, Phillips E, Gentzke AS, et al. Current Cigarette Smoking Among Adults — United States, 2016. MMWR Morb Mortal Wkly Rep 2018;67:53–59.

Examining Risk:
Poverty, other disadvantages tied to higher smoking risk

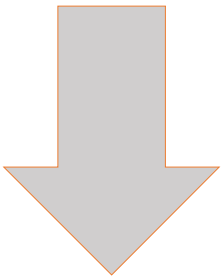
Source: Association of Cumulative Socioeconomic and Health-Related Disadvantage With Disparities in Smoking Prevalence in the United States, 2008 to 2017 (Leventhal, Bello, Galstyan, et al.)





"Disadvantage is a common denominator in smoking in the U.S. today, and if you face more disadvantages, your liability to smoking increases.

Disparities in smoking are explained by disadvantaged populations being more likely to start smoking and less likely to quit smoking."



Source: https://www.medscape.com/viewarticle/912195?src=wnl_edit_tpal&uac=245377DJ&impID=1948009&faf=1

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Race, Tobacco and Behavioral Health

- Black and Latinx adults and adults with psychiatric disorders experience smoking-related health disparities and have lower smoking quit rates than White adults and adults without psychiatric disorders.
- Racial/ethnic minority adults and adults with psychiatric disorders have been under-represented in smoking-related research.
- We have to pay more attention to and support for promising interventions, in addition to new engagement and different attempts at reaching these populations through conventional interventions to best address these disparities.

Sources: American Psychological Association, APA Working; Group on Stress & Health Disparities, 2017; Drope et al., 2018 ; Webb Hooper & Kolar, 2015; Williams et al., 2013; Dickerson et al., 2009; CDC, 2013, Shpigel 2021

Race, Tobacco and Behavioral Health

- In the U.S., 34% of adults with psychiatric disorders who smoke identify as Black and 32% identify as Latinx. Together this accounts for the majority of adults with psychiatric disorders who smoke cigarettes in the U.S. **Tobacco control work must be intersectional.**

- There is imited research on trauma and stress and smoking among adults who are either racial/ethnic minorities or have psychiatric disorders, and even less is known about adults who are members of both of these priority groups.

- Research around smoking patterns and smoking cessation among adults with psychiatric disorders is limited, and what has been done has included samples that are largely White.

Source: CDC, 2013, Shpigel 2021

Let's Talk About One Reason People Start Smoking: *Prevalence of Trauma in Behavioral Health Treatment Settings*

•Majority of adults and children in inpatient psychiatric and substance use disorder treatment settings report a trauma history (Lipschitz et al., 1999; Suarez, 2008; Gillece, 2010).

•43% to 80% of individuals in psychiatric hospitals have some form of experienced physical or sexual abuse.

•51% to 90% "public mental health clients" are exposed to trauma (Goodman et al., 1997; Mueser et al., 2004).

•2/3 of adults in SUD treatment report child abuse and neglect (SAMHSA, CSAT, 2000).

•A survey of adults in SUD treatment found that more than 70% had a history of trauma exposure (Suarez, 2008).

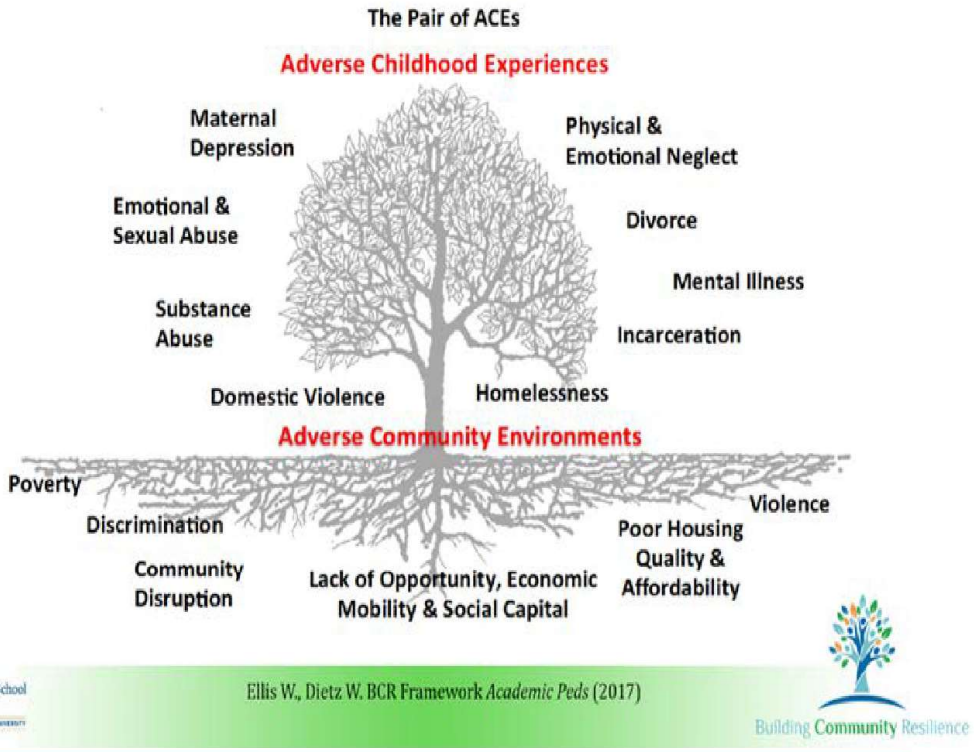
Gabor Mate's Definition of Addiction

Any behavior that a person is not able to give up and is associated with:

- Craving and temporary relief
- Long-term negative consequences

Early emotional loss is the template for all addictions

Mate, Gabor, *(2010). In the realm of the hungry ghosts.* Berkley, CA: North Atlantic Books. Print.



Life-Long Physical, Mental & Behavioral Health Outcomes Linked to ACEs

- Alcohol, tobacco & other drug addiction
- Auto-immune disease
- Chronic obstructive pulmonary disease & ischemic heart disease
- Depression, anxiety & other mental illness
- Diabetes
- Multiple divorces
- Fetal death
- High risk sexual activity, STDs & unintended pregnancy
- Intimate partner violence—perpetration & victimization
- Liver disease
- Lung cancer
- Obesity
- Self-regulation & anger management problems
- Skeletal fractures
- Suicide attempts
- Work problems—including absenteeism, productivity & on-the-job injury

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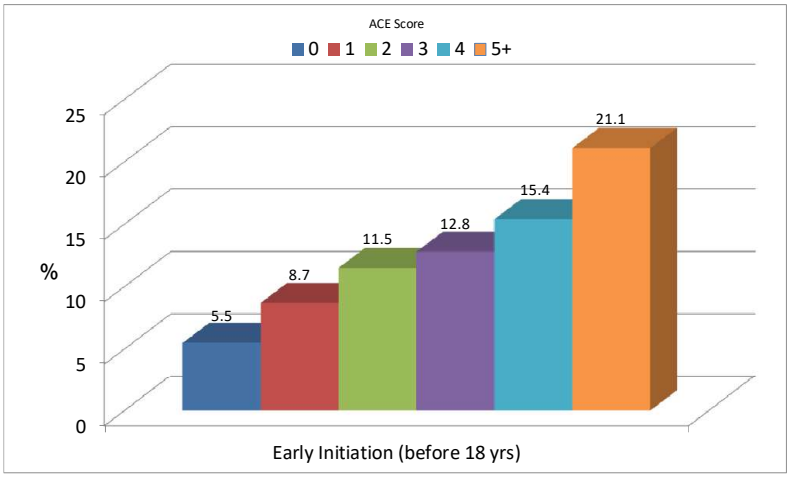
Smoking: Age at First Use



Anda, R. F., Croft, J. B., Felitti, V. J., Nordenberg, D., Giles, W. H., Williamson, D. F., & Giovino, G. A. (1999). Adverse childhood experiences and smoking during adolescence and adulthood. *Journal of the American Medical Association*, 282, 1652–1658.

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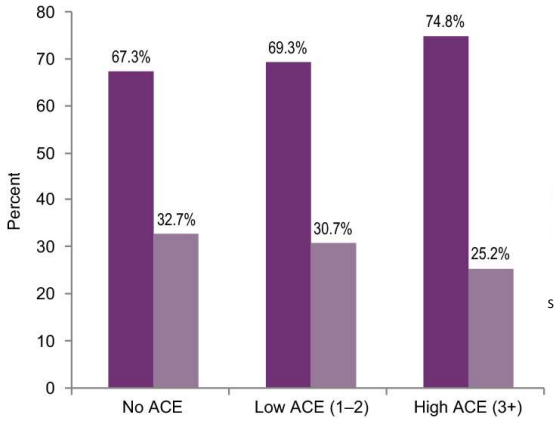
ACEs and Smoking Prevalence

Figure 1.
Prevalence of Daily and Non-daily Smoking by Adverse Childhood Experiences (ACE) Study Groups



Source: Austin, E. The Effect of Adverse Experiences on the Health of Current Smoker. 2012.

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ACEs ➡ Health Risk Behaviors ➡ Long Term Health Consequences

Individuals with a history of severe trauma are **twice** as likely to develop a smoking dependence

- **45**% of adults with a PTSD diagnosis smoke
- **73%** of those smoke 1+ pack of cigarettes per day

Source: Austin, E. The Effect of Adverse Experiences on the Health of Current Smoker. 2012.

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2. What is the Disparity?

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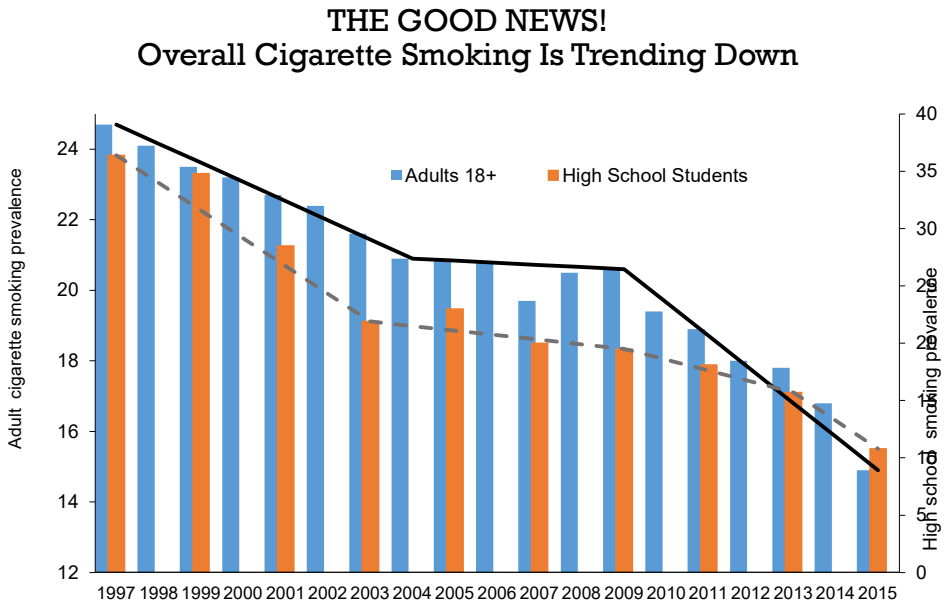
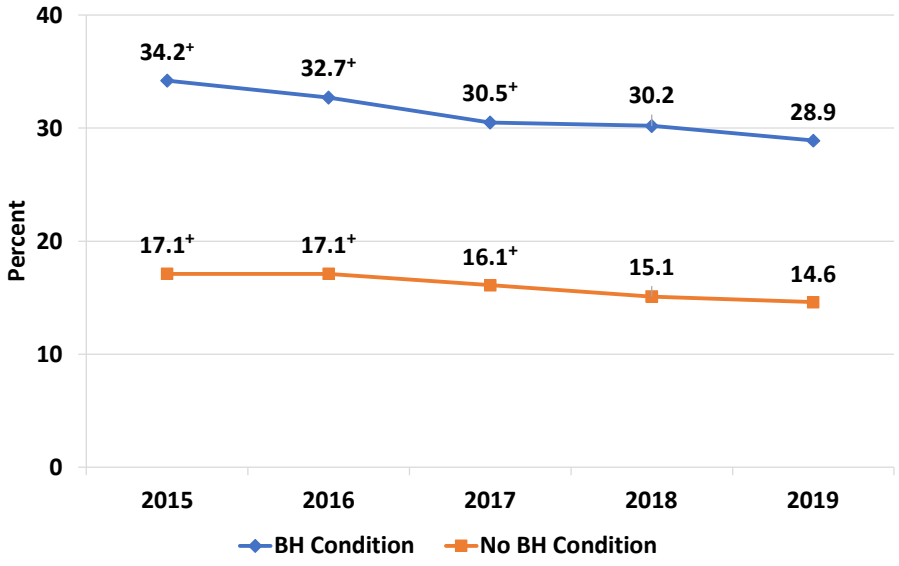


Source: slide courtesy of CDC; Adult cigarette smoking prevalence data are from the National Health Interview Survey (NHIS); 2015 data based on NHIS Early Release data for January-June. High
Source: data are from the National Youth Risk Behavior Survey.

Current Smoking among Adults (Age ≥ 18) with a Past Year Behavioral Health (BH) Condition: NSDUH, 2015-2019



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Current Smoking is defined as any cigarette use in the 30 days prior to the interview date.
Behavioral Health Condition includes Any Mental Illness (AMI) and/or Substance Use Disorder (SUD).
+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

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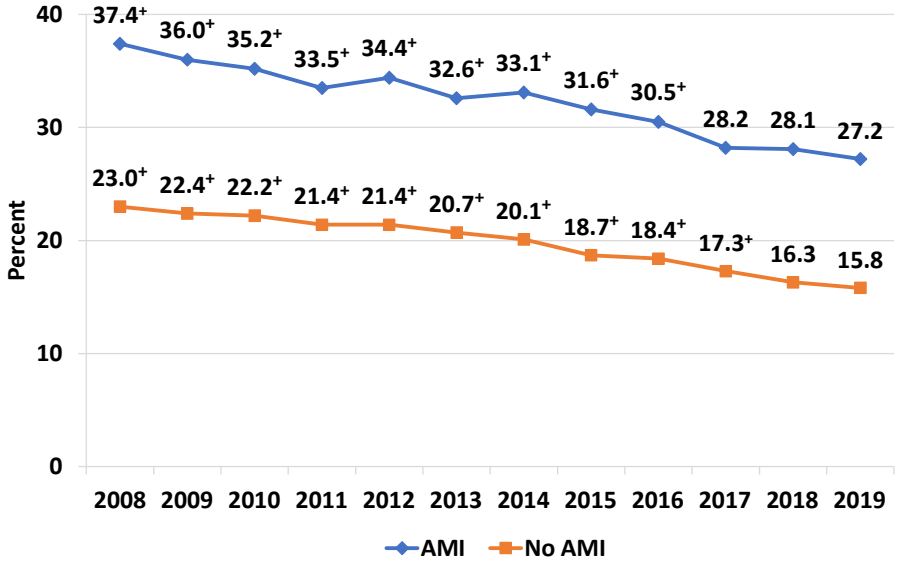
Current Smoking among Adults (Age ≥ 18) with Past Year Any Mental Illness (AMI): NSDUH, 2008-2019



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Current Smoking is defined as any cigarette use in the 30 days prior to the interview date.
Any Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, based on the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

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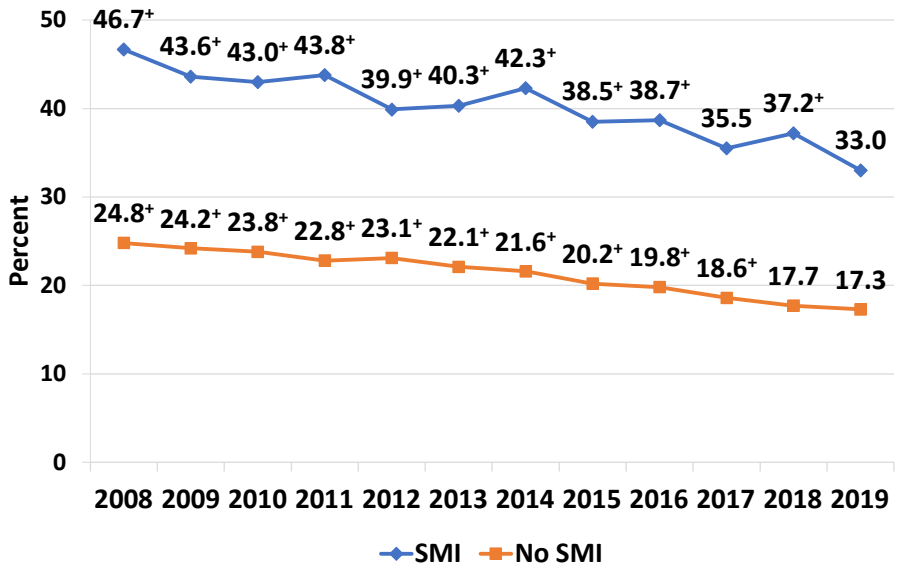
Current Smoking among Adults (Age ≥ 18) with Past Year Serious Mental Illness (SMI): NSDUH, 2008-2019



Current Smoking is defined as any cigarette use in the 30 days prior to the interview date.
Serious Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder resulting in serious functional impairment, based on the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

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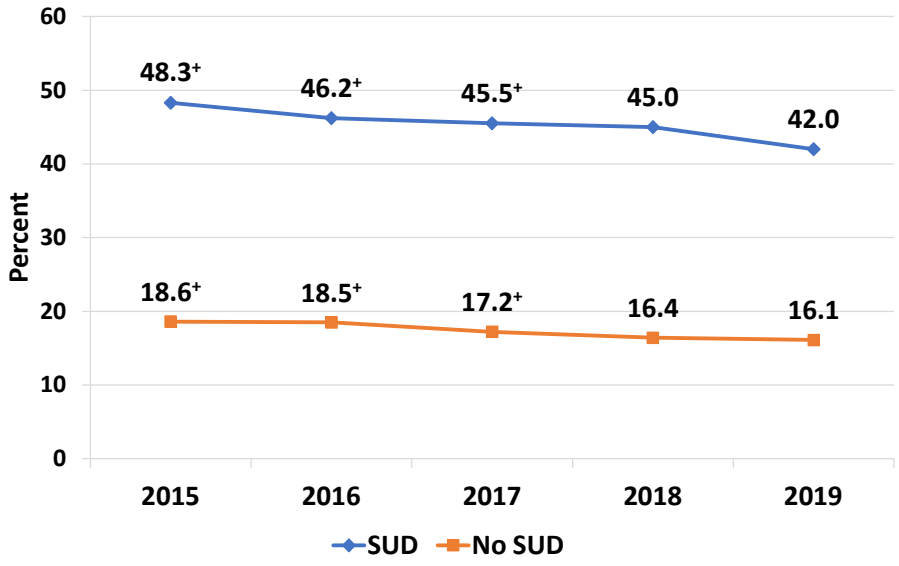
Current Smoking among Adults (Age ≥ 18) with a Past Year Substance Use Disorder (SUD): NSDUH, 2015-2019



Current Smoking is defined as any cigarette use in the 30 days prior to the interview date.
Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

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How are we doing when it comes to tobacco interventions?

Intervention	Mental Health Tx Facilities	Substance Abuse Tx Facilities
	2018	2018
Tobacco Use Screening	52.8%	67.0%
Cessation Counseling	40.5%	49.8%
Nicotine Replacement Therapy	26.6%	28.0%
Non-nicotine Cessation Medications	24.1%	22.3%
Smoke-free Building/Grounds	50.1%	34.5%

Sources: *National Mental Health Services Survey (N-MHSS): 2018. Data on Mental Health Treatment Facilities; National Survey of Substance Abuse Treatment Services (N-SSATS): 2018. Data on Substance Abuse Treatment Facilities.*

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- Most persons with mental illness and substance use disorders want to quit smoking. [1,2]
- **Smokers are more than 2x likely to quit for good with the help of tobacco cessation medications and counseling services.**
- **Smoking cessation can enhance long-term recovery for persons with substance use disorders.** For example, if someone quit smoking at the same time they are quitting [4]

Sources: [1] Acton et al. Depression and stages of change for smoking in psychiatric outpatients. Addictive Behaviors. 2001; 26(5):621-31. [2] Prochaska et al. Return to smoking following a smoke-free psychiatric hospitalization. Am J Addiction. 2006; 15(1):15-22. [3] Heiligenstein E, Smith SS. Smoking and mental health problems in treatment-seeking university students. Nicotine & Tobacco Research. 2006;8(4):519-23 [4] Prochaska, Judith J; Delucchi, Kevin; & Hall, Sharon M. A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery.. Journal of consulting and clinical psychology. 2004; 72(6), 1144 - 1156. Retrieved from: http://escholarship.org/uc/item/0r8673wv

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3. What Can We do to Address the Disparity?

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Recommendations on Addressing Tobacco Use with Individuals with Mental Health and Substance Use Challanges

- ✓ Adopt tobacco-free facility/grounds policies
- ✓ Integrate tobacco treatment into behavioral healthcare
  - ✓ 5 A's
  - ✓ NRTs
  - ✓ Pharmacological supports
- ✓ Utilize the Quitline and other evidence-based interventions
- ✓ Engage peer models
- ✓ Provide Trauma- Informed Care
- ✓ Think beyond cessation to RECOVERY

Source Slide Courtesy of SAMHSA: Substance Abuse and Mental Health Services Administration." Tobacco and Behavioral Health: The Issue and Resources," https://www.samhsa.gov/sites/default/files/topics/alcohol_tobacco_drugs/tobacco-behavioral-health-issue-resources.pdf [accessed 2018 May 11].

Implement and Strengthen Tobacco-free Organizational Policies

- Step 1: Convene a Tobacco-Free Committee
- Step 2: Create a Timeline
- Step 3: Craft the Message
- Step 4: Draft the Policy
- Step 5: Clearly Communicate your Intentions
- Step 6: Educate Staff and Clients
- Step 7: Provide Tobacco Cessation Services
- Step 8: Build Community Support
- Step 9: Launch the Policy
- Step 10: Monitor the Policy and Respond to Challenges

Slides Courtesy of Smoking Cessation Leadership Center - SAMHSA National Center of Excellence for Tobacco-Free Recovery

Implement and Strengthen Tobacco-free Organizational Policies

- Sample Policy Language from the American Lung Association in Minnesota's *Toolkit to Address Tobacco Use in Behavioral Health Settings*
- NAMI-Kansas and Public Health Law Center, *Kansas Tobacco Guideline for Behavioral Health Care: An Implementation Toolkit*
  - Policy Development Checklist
  - Model Tobacco-Free Policy for Behavioral Health and Substance Use Treatment Providers
  - Sample Tobacco-Free Policy: Tobacco Use Violations and Enforcement Measures
- Infographic on *How To Implement a Tobacco-Free Policy* from NBHN and Behavioral Health and Wellness Program

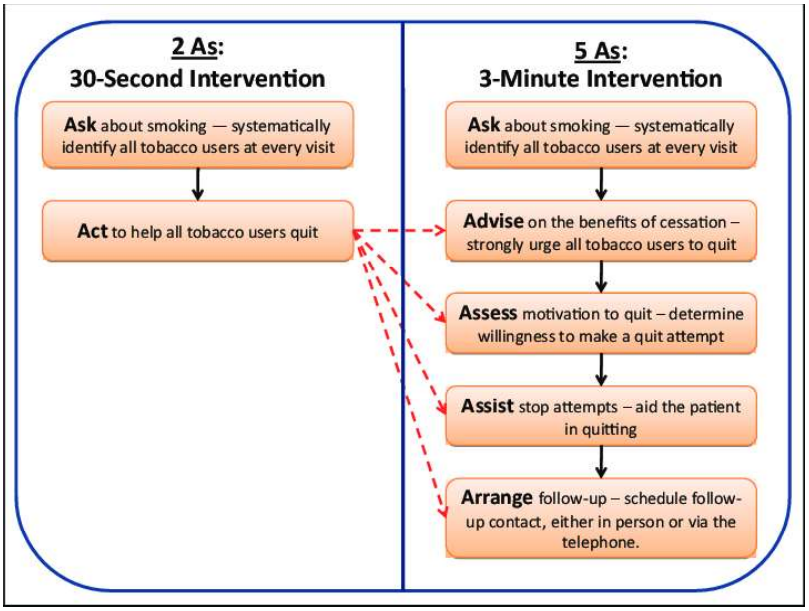
COVID-19 Windows of Opportunity

- Seismic shift in entire field: from in-person to telehealth treatment
- Building organizational capacity for telehealth:
  - Infrastructure
  - Practice
  - Financing
  - Workforce development
  - Policies and procedures, etc.
- Potential workload increase with increased access and influx of new clients
- Updated telephone technology must be addressed for access by certain populations (e.g., homeless, rural, senior citizens)

Windows of Opportunity (Cont.)

- Opportunities to "re-open" as tobacco free-facilities
  - Utilize more space and outdoor space for social distancing
  - Reduce risk overall of COVID-19 among clients who use tobacco
  - Reduce overall risk of COVID-19 spread and staff and patient infection through greater risk for individuals who use commercial tobacco.
  - Transition time for updating facilities and policies
  - Enhancing tobacco cessation supports

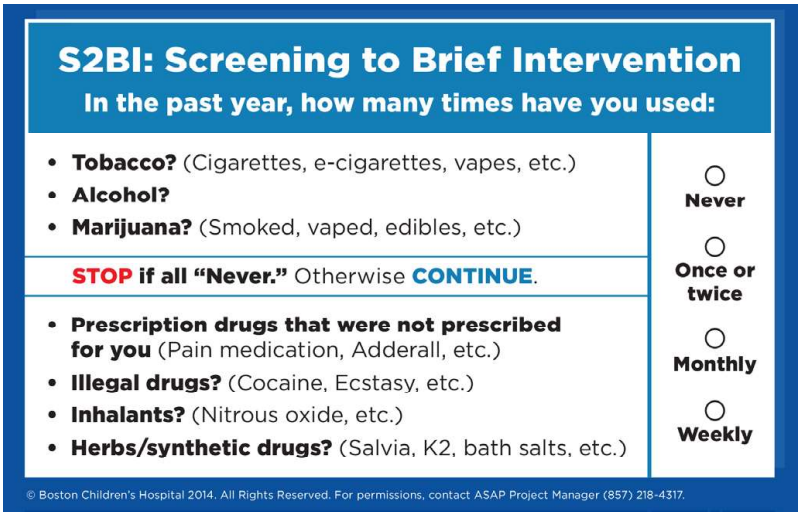
5 A's and 2 A's



Source: McLvor, A. et al. (2009) Best Practices for Smoking Cessation Interventions in Primary Care. Canadian respiratory journal: journal of the Canadian Thoracic Society 16(4):129-34. DOI:10.1155/2009/412385

SBIRT: An evidence-based approach to the delivery of early intervention and treatment services

- Screening: quickly assesses the severity of substance use and identifies the appropriate next steps
- Brief Intervention: focuses on motivation toward changing behavior and increasing insight and awareness regarding substance use
- Referral to Treatment: facilitates access to and coordinated care for patients that identified as needing more extensive treatment



Integrating Tobacco Cessation Treatments

- More than three out of five U.S. adults who have ever smoked cigarettes have quit.
- **Although a majority of cigarette smokers make a quit attempt each year, less than one-third use cessation medications approved by the U.S. Food and Drug Administration or behavioral counseling to support quit attempts**
- Cessation medications approved by the U.S. Food and Drug Administration and behavioral counseling increase the likelihood of successfully quitting smoking, particularly when used in combination. Using combinations of nicotine replacement therapies can further increase the likelihood of quitting.

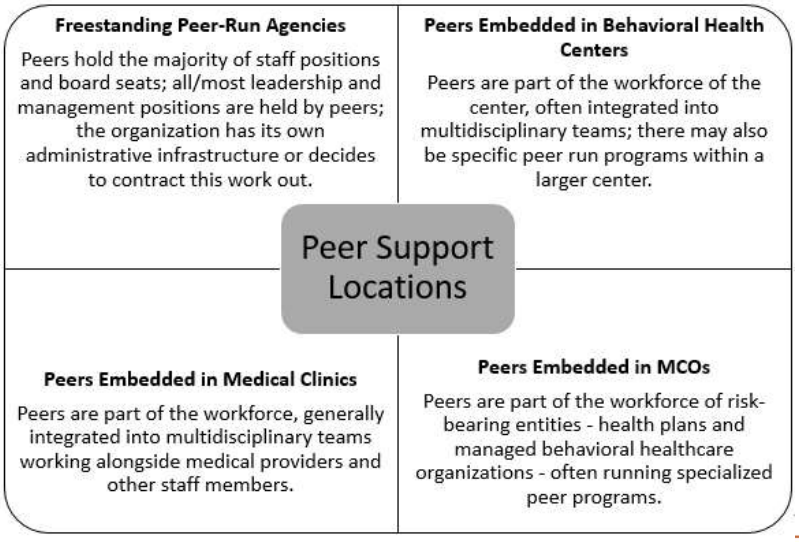
Source: U.S. Surgeon General's Report on Smoking and Tobacco Use, 2020

Leveraging Quitlines

- Free or subsidized cessation coaching and medications
- Coaching delivered primarily by telephone
- Expanding into web, chat, texting etc.
- Since July 2020 major quitline providers Optum and National Jewish have implemented behavioral health protocols for individuals with mental illness and/or substance use disorders
- Quitlines are funded by various methods:
  - State or local funds
  - CDC grants
  - Tobacco taxes
  - Master Settlement Agreement (MSA)
  - Public-private agreements

Incoming calls to the state quitline increased by an average **77%** during the 2020 *Tips*® campaign.

Engaging Peers to Support Tobacco Cessation



Peer Support:

The process of giving and receiving nonprofessional, nonclinical assistance from individuals with similar conditions or circumstances to achieve long-term recovery from psychiatric, alcohol, and/or other drug-related problems

Benefits:

- Informational support
- Emotional support
- Linkage to resources

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What is a Trauma-Informed, Resilience-Oriented Approach?

Realizes	• Realizes widespread impact of trauma and understands potential paths for recovery
Recognizes	• Recognizes signs and symptoms of trauma in clients, families, staff, and others involved with the system
Responds	• Responds by fully integrating knowledge about trauma into policies, procedures, and practices
Resists	• Seeks to actively resist re-traumatization

Substance Abuse and Mental Health Services Administration. 2014.

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Two Important Tenets of a Trauma-Informed, Resilience-Oriented Approach

We change the question from
"What is wrong with you?"
to
"What happened to you?"

_____

We assume everyone is doing the best they can

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Let's Reframe the Outcomes and *Continue the Good*

Messaging that Cessation is POSSIBLE and IMPROVES Behavioral Health Outcomes

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I hear your concerns and fears. Let's talk through them.

- Most people (clinicians and clients) assume/perceive that it is overwhelming to quit more than one substance at a time, and as a result, many clinicians believe going tobacco-free at a treatment facility, or co-treatment is unfeasible.
    - **Addressing tobacco use during substance use treatment can increase abstinence and long-term rates from both smoking and substances of treatment.**
- Perceived barriers among staff include fear of causing patients to leave early. This is unfounded, and there is no evidence of this. (Amansama et al., 2019)
- **Comprehensive tobacco control policy interventions within inpatient addiction treatment hospitals promote tobacco cessation**.
- Patients exposed to a more comprehensive tobacco control environment:
    - Were over 80% less likely to report having used tobacco during treatment, compared to patients exposed to usual care
    - Receiving treatment in this setting also contributed to a 35% decrease in the average number of days patients used tobacco compared to usual care
    - Reported a 27% decrease in the average number of cigarettes used per day compared to usual care (Romano, 2019)

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I hear your concerns and fears. Let's talk through them.

- **Client census levels and completion rates have NOT been shown to decrease in treatment facilities that go tobacco free**
    - Studies show no decrease in census data, and in fact the rates of treatment increased in facilities studies (Richney et al., 2017)
    - Studies show that no individuals report leaving treatment prematurely after a tobacco-free policy was implemented Richney et al., 2017)
    - Eliminating tobacco use in a residential treatment program leads to NO decline in patient interest and program utilization
- Tobacco users ARE still **just as likely to seek addictions treatment** and are interested in tobacco cessation
    - Up to 75% of dual tobacco and substance users report wanting to quit both tobacco and other substances (Flasch & Diener, 2004).
- **Clients ARE able to successfully quit tobacco**
    - Tobacco dependence treatment in substance abuse treatment centers has led to cessation rates ranging from 5% to 23% (Baca & Yahne, 2009).
    - This is similar to the rates reported for the general population (Fiore et al., 2008).
- Clients **relapse rates ARE REDUCED** for alcohol or drug use if they attempted to quit tobacco simultaneously
    - Treatment of tobacco dependence and other addictions produces better long-term abstinence for the primary addiction for which patients sought treatment (Baca & Yahne, 2009; Prochaska et al., 2004).

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I hear your concerns and fears. Let's talk through them.

- Tobacco-free policies can be enforced.
  - Compliance approaches work in every other healthcare and social service sector, as well as general spaces and place in society, from hospitals to clinics to airplanes, airports and restaurants.
  - Training staff and the peer workforce on verbal and nonverbal compliance methods can be effective.
- **Policies can help staff too**, reduce costs on health coverage AND productivity increases
  - Staff have heightened workplace health risks due to secondhand smoke exposure that you reduce by going tobacco free.
  - Staff time calculation show a decrease in non-labor law compliant smoke breaks which increases overall productivity and creates equity approach that doesn't exclude nonsmokers from breaks.
  - Overall healthcare costs can decrease tremendously for an organization.
  - No healthcare facility has reported reduction in staff quitting owing to an organization becoming tobacco free.
  - Staff can be very effectively trained to provide evidence-based interventions to the top of their license or role.
  - Training staff and the peer workforce on verbal and nonverbal compliance methods can be effective.

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Sources: Friedmann, Jiang, & Richter, 2008; Guydish et al., 2011; Schroeder & Morris, 2009)

Continuing the Good

- Provide the best clinical care to the best of our ability
  - Administering EBI at recommended times every time regardless of preconceived notion of outcomes.
- Work with health equity in mind
  - Tobacco in the number one cause and contributor to death amongst individuals with a behavioral health condition
  - Individuals with a behavioral health condition smoke at 2X the rate of the general population
- Ensure client centered care
  - Supporting those clients who want to quit
  - The good news: 7 out of 10 smokers want to quit smoking
- Ensuring no clients increase tobacco use while in care
  - 27% of the tobacco users reported increased tobacco use during treatment.
- Ensuring no client initiate use while in care
  - Of the nontobacco users admitted, 5% reported initiating tobacco use while in treatment.

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Remember Recovery

- "Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential."
- "Recovery is what people experience themselves as they become empowered to manage their mental illness and/or substance use disorder in a manner that allows them to achieve a meaningful life and a positive sense of belonging in their community."2

1. Recovery Emerges from Hope
2. Recovery is Person-Driven Recovery
3. Recovery Occurs via Many Pathways
4. Recovery is Holistic
5. Recovery is Supported by Peers and Allies
6. Recovery is Supported Through Relationship and Social Networks
7. Recovery is Culturally-Based and Influenced
8. Recovery is Based on Respect
9. Recovery is Supported by Addressing Trauma
10. Recovery Involves Individual, Family, and Community Strengths & Responsibility

Source: SAMHSA and https://www.internationalcredentialing.org/resources/Documents/Peer_Study_Guide.pdf

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Takeaways

1) Individuals with mental health and substance use challenges have disproportionately higher rates of tobacco use.
2) Individuals with mental health and substance use challenges are less likely to stop smoking than those without such conditions; however, **many smokers with mental health and substance use challenges want to quit.**
3) **We Know What Works**. Proven interventions, including counseling, FDA-approved medication, and tobacco-free policies, can help reduce tobacco use among behavioral health populations.

Join TODAY at BHtheChange.org!

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National Behavioral Health Network for Tobacco & Cancer Control

- Jointly funded by CDC's *Office on Smoking & Health & Division of Cancer Prevention & Control*
- Provides resources and tools to help organizations reduce tobacco use and cancer among people with mental illness and addictions
- 1 of 8 CDC National Networks to eliminate cancer and tobacco disparities in priority populations

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