CONTRA COSTA
MENTAL HEALTH COMMISSION

CONTRA COSTA
MENTAL HEALTH
COMMISSION
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Mental Health Commission (MHC)

Wednesday, February 3rd, 2021 ◊ 4:30 pm - 6:30 pm

VIA: Zoom Teleconference:

https://cchealth.zoom.us/j/6094136195
Meeting number: 609 413 6195
Join by phone:
1 646 518 9805 US
Access code: 609 413 6195

AGENDA

I. Call to Order/Introductions

II. Public Comments

III. Commissioner Comments

IV. Chair Comments/Announcements

V. APPROVE January 6th, 2021 Meeting Minutes (5 minutes)

VI. RECEIVE presentation on the Contra Costa Health Tobacco Prevention Program and DISCUSS potential applications in Contra Costa County, Isabelle Kirske, Senior Health Education Specialist, Contra Costa Health Tobacco Prevention Program (30 min)

VII. DISCUSS potential 2021 Commission-wide goals beyond 2020 goals still in progress; candidate goals are (20 min):

- CONTRIBUTE TO CRISIS INTERVENTION EFFORTS: Track on and contribute in a significant way to the county-wide efforts to develop a new Crisis Intervention model.
- CREATE PLAN FOR VALUE STREAM MAPPING EVENT TO INCREASE NUMBER OF BEDS: Work with Health Services and Behavioral Health Services to create a plan for a Value Stream Mapping event focused on significantly increasing the number of placements available to house AND treat consumers along the continuum of mental health care provided by the County. This includes placements from the most restrictive and intensive care environments down to community housing with supports. This goal moves forward the Commission's 2020 motion to recommend a "Housing That Heals" Value Stream Mapping event to the Behavioral Health Service Director.

(Agenda continued on Page Two)

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

Mental Health Commission (MHC) Agenda (Page Two)

Wednesday, February 3rd, 2021 ◊ 4:30 pm - 6:30 pm

- CREATE PLAN FOR SMOKING CESSATION: Work with Behavioral Health Services and the Tobacco Prevention Program to create a plan for eliminating smoking in Behavioral Health Services- and CBO-operated programs, services. and congregant living.
- CREATE PLAN FOR VALUE STREAM MAPPING EVENT FOR CONSERVATORSHIPS: Work with Health Services and Behavioral Health Services to create a plan for a Value Stream Mapping event focused on significantly improving the functioning, accountability and transparency of the process of creating and managing LPS conservatorships. This goal moves forward efforts by the Justice Committee to 1) define the issues and challenges faced by parents and other guardians in seeking a conservatorship for their adult children; and 2) define the problems faced by the County conservatorship process, including a lack of treatment beds and lack of oversight.
- PERFORM SET NUMBER OF SITE VISITS: Perform six to eight site visits in 2021.

VIII. RECEIVE Behavioral Health Services Director's Report, Dr. Suzanne Tavano (20 minutes)

IX. VOTE on proposed by-law change regarding mandatory attendance of Mental Health Commission meetings (10 minutes)

CURRENT LANGUAGE:

a) "Regular attendance at Commission meetings is mandatory for all Commission members."

i) "A member who is absent from four (4) regularly scheduled Commission meetings in any calendar year shall be deemed to have resigned from the Commission."

PROPOSED LANGUAGE (IN BOLD):

a) "Regular attendance at Commission meetings is mandatory for all Commission members."

*i) "A member who is absent from four regularly scheduled full Commission meetings in any **consecutive twelve month period, as opposed to calendar year**, shall be deemed to have resigned from the Commission."*

X. VOTE on proposed new By-law change regarding mandatory Committee membership and attendance (20 minutes):

a) "Regular attendance of one standing Commission Committee, with the exception of Executive Committee, is mandatory for all Commission members."

i) "A member who is absent from four (4) regularly scheduled Commission Committee meetings in any calendar year shall be deemed to have resigned from the Committee. In such event the former Committee member's status will be noted at the next scheduled Committee meeting and shall be recorded in the Committee's minutes. The resigned member shall choose a different Committee on which to serve."

XI. Adjourn

MENTAL HEALTH COMMISSION
MONTHLY MEETING MINUTES
January 6, 2021 – Draft

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Cmsr. G. Wiseman, Mental Health Commission (MHC) Chair, called the meeting to order @ 4:33 pm Members Present: Chair- Cmsr. Graham Wiseman, District II Vice-Chair, Cmsr. Barbara Serwin, District II Cmsr. Candace Anderson, District II Cmsr, Douglas Dunn, District III Cmsr. Laura Griffin, District V Cmsr, John Kincaid, District II Cmsr. Kate Lewis, District I Cmsr. Kira Monterrey, District III Cmsr. Alana Russaw, District IV Cmsr. Geri Stern, District I Members Absent: Cmsr. Leslie May, District V Cmsr. Joe Metro, District V Cmsr. Gina Swirsding, District I Other Attendees: Dr. Suzanne Tavano, (Director, Behavioral Health) Colleen Awad Isenberg Fouzia Azizi Angela Beck (Mental Health Commission – Administrative Support) Jaspreet Benepal Cathy Botello Jennifer Bruggeman (Mental Health Services Act Program Manager) Jessica Hunt Lynda Kaufman Isabelle Kirske Anna Lubarov Audrey Montana (Mental Health Services Act Senior Clerk) Carolyn Obringer Akindele Omole Rona Popal Christy Pierce Dom Pruett (Representative of Supervisor Candace Andersen) Haji Razmin Stephanie Regular Ryyn Schumacher Robert Thigpen	Meeting was held via Zoom platform
II. PUBLIC COMMENT: • Lynda Kaufman (Psynergy Programs): Wanted to give report on the COVID and the congregate settings. Psynergy (Contra Costa County contractor) has one facility in Greenfield has been a hotspot. The other three facilities remain COVID-free. Just starting to get communications about vaccines rolling out to our communities. It will be the Residential Care facilities for older adults first, followed by the adult residential facilities.	

III. UPDATE on 4D status, Jaspreet Benepal, Chief Nurse, Contra Costa Regional Medical Center:

- 4D has opened the 20 bed, inpatient psychiatric unit, mainly to decompress Psychiatric Emergency Services (PES) during the COVID-19 environment, to have the minimum impact on the congregate close living in the locked unit.
- Working on increasing the censu. Happy to say we are open to accept any number of patients that have an admission requirement to be held on 4D. Started with 6 patients, increased to 12 and now ready to take more patients.
- This was all due to staffing upload issues – staffing, orientation, training take time and the main reason to go slow and ramp up.
- No COVID patients on 4D or 4C. COVID patients needing psychiatric care have been admitted on medical units and providing services where it has been best suited to serve them. Examination of our surge in COVID patient population rising, needed to prepare to take care of patient in need of psych services (who are also COVID positive) to admit them to the PES unit.
- Staff is being trained in a refresher course on how to manage COVID.
- Created a temporary partition on 4D to maintain social distance so we do not have COVID patients mingle with non-COVID patients.

Comments and Questions:

- What is the capacity on 4D? 20 beds. Hired nursing staff which is a difficult task nationally. Able to secure several RNs and training/orientation at present to take care of patients.
- (J. Kincaid) – Are you able to rely on registry nurses or were you able to recruit through civil service? Hired registry nurses and trying to fill positions by hiring temp/permanent/per diem – any qualifications to serve patients, we hire.
- (J. Kincaid) – Problems around the country (anti-ligature measures, etc.), can you give us an update on where you are with that? 4D was expedited, we did work with regulatory bodies and are on board, we update frequently requesting for us to continue to serve and keep the unit open while making the unit ligature resistant. 4C PES has been completed but 4D is still in process. CDPH is on board and in close communication with us. Any notification/documentation needed we provide current status. For mitigating purposes to make sure staff/patients are safe, we do staffing based on patient acuity.
- (J. Kincaid) – You are in process and in compliance because of status granted but do you have any idea when that will be completed? Work is going on and it took several months for other units to be ligature resistant because of the back order from manufacturers (not just California, nationally). If we have the documentation and in compliance in providing the information to California Department of Public Health (CDPH), so they know our current status. We keep requesting the waiver and they keep approving it. Most hospitals are going through similar challenges.
- (B. Serwin) – What has the population been like? Are you at capacity and needing more beds? No, actually, we have had a few beds everyday that we can admit more, and we evaluated our psych emergencies to see who may needs admission and we do admit them, but we haven't been full on 4D as yet.
- (B. Serwin) – But 4C? 4C is frequently in 19-23 and we try to ensure we are utilizing 4D beds also and not keeping anyone in PES that requires admission.
- (B. Serwin) – So you fill out 4C first and then move to 4D? No, we assess and evaluate where it would be best for the patients to come and admit in the appropriate unit.
- (J. Kincaid) – Can we then conclude this has been successful and has taken some pressure off PES and the fact that we have a few beds open is a good thing? Yes, it has been a positive impact on PES, we have been able to

decompress PES, at times when we have patients, we have beds and then PES doesn't have to manage at increased volume as they did before.	
IV. UPDATE on the mental health needs of Afghan refugees in Contra Costa County, Commissioner Kate Lewis, Commissioner Kira Monterrey; Lisa Mulligan, Refugee Mental Health Coordinator, Jewish Family and Community Services - East Bay; Fouzia Azizi, Department Director, Jewish Family and Community Services - East Bay; Rona Popal, Executive Director, Afghan Coalition. • Chair Graham Wiseman - Lisa Mulligan unable to attend today's meeting and will present at a later date. • Rona Popal, Executive Director, Afghan Coalition Presentation (share) Afghan Coalition founded in 1996 to address the needs of the Afghan community in the south county. ▪ Challenges of an immigrant community; combating isolation and promoting integration. ▪ The Afghan community is very isolated and vulnerable, especially in Contra Costa County (CCC). ◊ Very social but only within their culture. ◊ Not very aware of services and programs available. ◊ Affects quality of life and health. ▪ The causes of isolation: language, culture, fear, trauma. All because when they arrived in the US due to the Russian invasion, the wars within Afghanistan, then the Taliban; almost 40 years of war. How do we help? ◊ Translations services, education, culture counseling, cultural prevention counseling and empower as a group with support groups, skills and resources, such as starting their own businesses. Especially from home, as a lot of women cannot leave home due to caring for children and the culture does not allow them to get out of the home. There are many small business opportunities (i.e. making jewelry or cooking) so they can be empowered from home. ◊ Support groups for men and women, leadership training and mental health. Mental health is one of the most important we are running at present. ◊ Meeting their needs: Translation services, cultural counseling is very important and how to use the system as they are coming from a very different system and culture. There is no system of resources in Afghanistan. There is a fear they will lose their children, their name, culture and faith. ◊ Addressing trauma and isolation ◊ Addressing stigma from the culture. ◊ ESL and other educational help (adult school, as well as traditional) ◊ Community kitchen is an important social support group. ◊ Financial literacy help is provided ◊ New program: Elderly outreach to learn social media. Hired workers to help learn computer programs such as Zoom and other platforms. Go to homes and help set up / learn how to use platforms to navigate getting help with programs, not be so isolated at home. Every week, there is a support group, and they receive links to get in touch with program representatives and to help reach family members. This program is timely, went online during COVID. People are home, bound to home and cannot leave and some living with their abuser. It has helped them talk to us and reach out so we are able to help provide services for those in abusive situations to help provide services such as shelter and counseling they would otherwise be fearful to reach out for help. ◊ Help with legal aid, Immigration attorney	

- ◊ The youth program: The youth in the community learn English well and do not communicate with parents; believe their parents do not know anything, do not follow parents/family rules and the family are hearing they will lose their children if they discipline. The programs are helping to connect to legal services, social services.
- ◊ Small food program, every Friday for those who have lost their jobs.
- ◊ Provide job assistance (online application) help.
- ◊ Provide prevention counseling, psychotherapy.
- ◊ Looking to the future to expand program.

- Haji Razmin, Board member, Afghan Coalition in Alameda and Contra Costa County for 15+ years. Living in Contra Costa for more than 24 years, very familiar with the family conditions. There are over 10,000 families in Central/East Contra Costa County (Concord, Antioch, Pittsburg, Brentwood). The community needs help/services, especially the older members as they are still living in trauma and combined with the cultural differences, they cannot enjoy living in this free country.
  - The Coalition is trying to coordinate our efforts with CCC to establish offices in the county so that we are able to provide the help to them in their language.
  - There are many barriers, cultural stigmas that it is hard for community members, especially older community members to reach out and be open to discussing with therapists and reach out for doctors and other services.
- Cmsr. Kate Lewis reached out to some members of the Afghan community and some of the resources that help support the Afghan community for Behavioral Health Services (BHS) in Contra Costa. Very pleasantly surprised to receive an immediate response after reaching out. Rona responded the same day, set up a call and shared all the information in this presentation and more. Very interesting to hear, especially how much their program supports many Afghan refugees when they first come in. The issues with mental health stigma, interpersonal and partner violence and how that stigma creates boundaries and barriers to receive that kind of behavioral/mental health care they need. Also, that a surprising number of Contra Costa Afghan residence reach out to the Alameda site for the services and connecting to resources and services. If there was potential for expanding the resources into Contra Costa, it is a much-needed resource for community members and residence that are living in contra costa, but also there is an expected influx of Afghan refugees coming to this area, as well. As preparation for supporting the transition for these community members. Speaking with Lisa Mulligan from the Jewish Family and Community Services (JFCS), clarified they are located in Concord and do a lot of counseling and sees a lot of Afghan community members and does help with placement and resources. There are a few 'case managers' that are members of the Afghan community that are very helpful and had a very split opinion regarding the lack of Afghan behavioral health employees. The reason being, because of the huge stigma, often the residents would prefer to speak to someone that was not of their community. Often, one of the things we struggle with being a support person in a mental health capacity is being of the same culture and having the same understanding and background. However, the stigma sometimes prevents someone from accessing care. For that reason, the case managers in Concord are the go to 'resource builders' and the actual mental health providers do not speak the language. The biggest hurdle at her site is language barrier issues and access to resources that do have appropriate language options for Afghan residence. Farsi interpretation but might be in need of Dari or Pashto and it does not have the same communication ability. Impressed with the incredible work Lisa and Rona are doing.

- Comment (G. Wiseman) Being an immigrant, born in Iran with Farsi upbringing, understands the communication difficulties and language/cultural differences. There are many barriers within the different languages which makes it even more difficult to discuss how one feels and to share that with the language difficulties. It is important to communicate how we feel clearly.
- Cmsr. Kira Monterrey interviewed a young man in the community (male, 20's) currently earning a doctorate in psychology, so works in the mental health field, as well. He identified that anxiety, depression and PTSD are high among the population (older and younger). What he sees as the biggest barrier is stigma and lack of knowledge regarding mental health services and lack of acceptance, especially among the older generations. Many members of the community do not believe in mental health therapy. Lack of mental health knowledge and resources is a big issue. He believes addressing the stigma and putting more information out there could be helpful, especially for the younger population as he believes to be more willing to access mental health resources. He identified there are large student clubs, very active on social media and that could be a way to put information out to help reduce stigma. He identified there is a strong sense of community and banding together. Another issue identified during the interview is that suicide is a problem, but many families try to handle this problem on their own rather than resorting to hospitalization. This is attributed to stigma, fear of embarrassment / pride, as well. Mentioned some strong organizations that have potential to be helpful as information is being put out as resourceful such as the Afghan Women's Coalition Center and the Afghan Football Support Organization is a huge organization that a lot of younger people are members. There is also a new mosque in Concord that could be a nice hub for information. He did identify there are a lot of members in this community but most of the resources are found in Alameda county. Another barrier is the clash of world views between younger and older generations. Younger generation is more willing to seek help with mental health, but the older generation looks down on this.

Comments and Questions:

- (Ronal Popal) Due to our culture, there are two things that have not been accepted yet. (1) Personal relationships-having a boyfriend/girlfriend. The young generations hide this, whatever they do, who they date is kept from the family. (2) Gay/Lesbian, identifying as and having relationships-this is something against the belief/culture. That has caused the youth to run away/suicide. They are unable to come out to their families and community.
- (G. Wiseman) What do you think the MHC and BHS in Contra Costa can do to help address some of these issues? (R. Popal) Really need to resource for the Afghan community in Contra Costa County. Mosques are not a place for talking about problems, it is a place to pray. That is an issue with the community, putting all the resources on mosques as it is what they believe, their spiritual guidance. However, it is not a place, especially for young people to address mental health and interpersonal issues. Need resources in Contra Costa that provides more culturally competent programs. Our offices provide a space that reminds them of 'home' the way they are greeted, the surroundings – it makes them feel comfortable to open up. The program needs to be culturally competent for them to feel comfortable to open up and ask what they need.
- (G. Wiseman) Understanding how faith and culture play a role in addressing mental health issues, the stigma and family shame. Services that do not conflict with these issues to help people in need. Youth in the community are more open to communicate and seek help. The key is communication.
- (B. Serwin) Many of the services being utilized are in Alameda. Is that because there are more services available in Alameda? Do the case managers have

more relationships there? Are we tapping out the resources we do have here? Are they using our clinics? How do we get a handle on what kind of resources we need for the mental health component of it? (Dr. Tavano) Within a few years of the passage of the Mental Health Services Act, we did identify a significant and growing population of Afghan population in Contra Costa. It was a bigger portion of JFCS and really look to them to provide services. Unaware of the language capacity now but it was not uncommon we would call upon them if someone spoke Farsi and did not have a Farsi speaking clinician. We have been aware of the growing population. Fremont has a rather large population (Alameda County) and believe that is where the resources have grown. We will need to research data on the numbers.

- (J. Bruggeman) Barbara, Correct. JFCS, MHSA Prevention and Early Intervention (PEI) contracts with CCC and the population is under their Refugee and Immigrant program. The population they work with varies over time, depending on where they are coming from. In recent years, they have been working a lot with the Afghan community. Opportunity to visit program and meet case managers. Believe there are four case managers and one behavioral health clinician.
- (B. Serwin) Feel it is hard to get a handle on what is the unmet need, if we have people going to Alameda? Is JFCS completely tapped out? That is something (Rona and Haji) would be helpful to learn more about. What needs are being met and not met? (R. Popal) There are a lot of issues and we need more resources in CCC. **Need** support, speaks language.
- (D. Dunn) Alameda County, through MHSA Funding has funded quite a few different culturally specific community centers. Is that something that would be helpful here in CCC? (R. Popal) Yes, something like HUME center with staff and counselors that speak their language and doctors of same culture. Bring all those resources under one roof to help and support the community.

V. RECEIVE Behavioral Health Services Director's Report, Dr. Suzanne Tavano

- COVID Report: Go to cchealth.org website shows what phase and tier we are in to gauge the roll out. We are currently at Phase 1a – Tier 1, 2, & 3 within 1a. As soon as that tier is wrapping up, it goes to Phase 1b, 1c and when it goes to Phase 2 is when the general population will be eligible to receive the vaccination. There is no calendar, it is based on the vaccine being received and people being vaccinated as soon as possible.
- On December 20th received call for BHS to set up its own vaccination clinics for staff. Week of 21st planning the three vaccination clinics and opened the week of the 28th. First week was a short 3-day week. It is anticipated by Friday, 1/8, we will have vaccinated approximately 1000 BHS staff. On track with what we estimated we could do. Goals are being reached.
- Update on Reopening Don Brown Friday/Monday to re-open 6 bed availability for those stepping down from PES/MHRC. Prior to it was long-term, new model it is recuperative care (4-6 week stay). This will be a transition for them to find long-term.
- Lynda Kaufman from Psynergy rethinking how we can make referrals to the program and update we have moved quite far in the contract with Everwell in the Central Valley which will expand our capacity further for enhance board and care. Everwell is a different model, a bit more comprehensive.
- COVID spike a few weeks ago, really watching PES. Felt we needed to make some changes in order to keep PES viable. Patients come to the clinic, are tested at the door and if positive are either going to emergency or admitted to a medical/surgical unit and provided mental health/psychiatric support. Still concerned as we have one PES for the entire county and did not want to close due to an outbreak. Worked with emergency medical services to implement a process to help protect the viability of PES. Anyone calling 911 on a voluntary

basis are taken to closest emergency department and then PES works with them there. **Comments and Questions:** • (C. Pierce) Regarding Don Brown. Will people released from the jail be able to start going there? (Dr. Tavano) No final decision. Need to watch closely as beds are very limited and, if we know clients/had contact. NEED to be COVID negative. We will have to see how that goes • (G. Wiseman) Want to thank you Suzanne and show appreciation for all we are doing to address COVID in CCC. Also working with Youth Mental Health, the last three weeks we have lost 7 youths to suicide. Want to thank you for all the effort within the county to address and help parents and students as we go through a very difficult time. • (Alana Russaw) Working with the state, how do we identify who is essential who is not? I am working from home, so of course doctors and nurses to go ahead in vaccinations. How is it determined who is in particular tiers? (Dr. Tavano) Federal CDC Guidelines and then each state determines priority populations and each county has its ethical decisions committee that has its ethical decisions committee that has broad representation throughout the community and that is factored in the determination. All must be consistent with the general CDC guidelines. If you go to the website and look at the tiers, it will tell you who is up next. We don't know exactly when. Refer to: https://www.coronavirus.cchealth.org/vaccine-es	
VI. RECEIVE suggestions for 2021 Commission-wide goals beyond 2020 goals in progress • Cmsr. John Kincaid – Involvement in the new office of Racial Equity and Social Justice. • Cmsr. Kira Monterrey – Mental health crisis with COVID and going to require a lot of resources: Divorce, suicide, kids/teens hurting, depression, isolation, how it is impacting mental health problems as time goes on, domestic violence, sexual assault in home, molestation. There is going to be more mental health issues to follow for a long time due to the pandemic and we should look at this. (G. Wiseman) agree. • Cmsr. Doug Dunn – Capacity of BHS to deal with mental health issues. Monitor ability to provide the care needed for these issues moving forward. • Cmsr. John Kincaid – Participation in budget process.	
VII. RECEIVE report on Community Planning Meeting of the County Office of Racial Equity on Social Justice (Dec 16th, 2020) Commissioner Barbara Serwin • Cmsr. Barbara Serwin – Summary of Meeting. December 16, first meeting of the Community Planning of the newly founded office of Racial Equity on Social Justice. Attended by several commissioners: Cmsrs. Kincaid, Stern, May, Russaw. Link to recording, key documents can be found on the MHC website for background. In November of 2020, the Board of Supervisors voted unanimously to accept a proposal by Supervisor Gioia and Glover to create the office. The purpose to promote equity and eliminate disparities and harm in Contra Costa County, with the initial priority to eliminate structural racism. Second purpose to enable the county, working with the community including community organizations and leaders, cities and school districts, better coordinate strength and expand the county's existing work on equity and inclusion. Lastly, to allow the County to better partner with the community in prioritizing and implementing this work. • To date, $250,000 has been raised from foundations and endowments to fund a community planning phase for determining the structure, the operation and	

priorities. The county has already approved a $600,000 budget for three (3) full-time positions, a director of program analysis and administrative support and for that to kick in once the community engagement and planning process has been brought to a close and solid plans are in place moving forward. • First meeting went well, 2 hours, 222 participants with the majority representing community organizations with a stake in pursuing racial equity and social justice. Very successful outreach effort, pulling together multiple community groups to build a broader coalitions, which is one of the top priorities of the group. With so many efforts in place, this office is wanting to bring them together and develop more momentum and more effectiveness as a group. • There were several planned and impromptu speakers including Supvs. Glover and Gioia and those that presented were outlining the challenges and the needs, goals and strategies of the community in fighting for racial equity and social justice. The second main approach was personal testimony, many individuals spoke regarding the forms of racism experienced in their lives and a great deal of support for those individuals through the chat as well. • Overall theme was to engage people to acknowledge, discuss and disrupt the persistent pervasiveness of white supremacy and anti-black movement in our systems and organizations, specifically in our county. Mental health was not a planned topic of the meeting. It is too early to tell whether mental health will become a part of the offices set of interest, but as suggested, we need to launch into this and lobby for this.	
VIII. APPROVE December 2, 2020 Meeting Minutes • December 2, 2020 Minutes reviewed. **Motion:** J. Kincaid moved to approve the minutes as written. Seconded by D. Dunn. **Vote: 8-0-1** **Ayes:** G. Wiseman (Chair), B. Serwin (Vice-Chair), C. Anderson, D. Dunn, L. Griffin, J. Kincaid, K. Lewis, A. Russaw Abstain: K. Monterrey	**Agendas and minutes can be found at:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php
IX. COMMISSIONER COMMENTS • D. Dunn Update from Pat Godley re: budget process, has anyone received an update? (B. Serwin) We were going to touch base in early December. We have a meeting later in January with Pat Godley, Dr. Tavano, Cmsrs Dunn and Wiseman and will receive an update from there. • D. Dunn – Smoking cessation issue will be on February agenda. Alameda County has moved forward in discreet stages over the past five year (possibly Santa Clara county is doing something like this and will have information in the February meeting on that issue).	
X. CHAIR COMMENTS/ANNOUNCEMENTS: • Wanted to share that I was on vacation the last two and a half weeks in Florida, which gave me a different perspective on how deal with Corona within the community. On the last two days of my vacations, I was inundated with emails from multiple parents in multiple school districts regarding student deaths. Before I left, there were ten student deaths I was dealing with. These are children who have given up. Children who have thought the pain is too intense, I am going to hit the reset button. As I was gone, I was hoping this was going to calm down. As someone who is involved in youth mental health, I know that June is the peak of student suicide, but what I am seeing is we are reaching that peak NOW in December and January. We are reaching a peak where our children are giving up and thinking the pain is too hard to endure and are opting for suicide. When I got back, I had six messages from six school districts of youth suicides. Four in our own county. I think we are facing	

something we do not want to admit to. I think we are facing something that is going to become overwhelming. Our young people not understanding how to deal with stress, isolation and remoteness of going to school just on Zoom. As the chair, I just want to share, I think 2021 is going to be a tough year. I think we need to look forward on how we can support our children, our youth, our parents as we go forth into a year that is really kind of touched by uncertainty. How can we support these young people thinking the only way out is to die? Most of you know I lost my son Colin as a sophomore to suicide. He felt the pain was more than he could endure. I really think as we go forward, we need to address as a mental health commission in our county, not only how this COVID is affecting all of us, but more importantly, how it is affecting our use. Those involved in suicide prevention know that the biggest obstacle is: 'you are not alone'. We are all struggling with this. We are all struggling is how do we deal with this as a mental health commission. How do we deal with what is going on in our lives? So as the new chair, I want to thank you all for voting and electing me as your chair. As we go into 2021, mental health is even more important than it has ever been in the last hundred years. We need to keep in touch with our community, our parents, our students, our elderly… how can we help? As we go forward, I want to adjourn this meeting with hope that 2021 is a year where we connect with students, parents and the community and help people understand. • (Cmsr Laura Griffin) I would really like to see us put emphasis on removing the stigma. It stops them from getting help, it stops them from talking to others about it, from feeling normal, that they are not alone. You don't want to tell your employer. You don't want to tell your friends. How do we get rid of the stigma? It is one of the biggest problems there is. People don't come forward when they need help. Emotional issues, no one wants to admit to, why? Stigma.	
XI. Adjourned Meeting at 6:36 pm	

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The Tobacco Prevention Coalition & The Tobacco Prevention Program Presents:

TOBACCO RETAILER LICENSING POLICY INPUT WORKSHOP

Part 1

Take this opportunity to provide input on Tobacco Retailer Licenses (TRL) Policies for communities within Contra Costa County! This is the first of two sessions focused on TRL. You will have a chance to contribute to shaping policies for our work over the next few years on the topics of:

- Tobacco-free Pharmacies and Health Care Providers
- No Sale of Tobacco Products
- Removing Exemption(s) Clause(s)

Click here to register.

If you have any questions email:
tobaccopreventioncoalition@gmail.com

THURSDAY, FEBRUARY 4, 2021
3:00PM - 5:00PM VIA ZOOM

The Tobacco Prevention Coalition & The Tobacco Prevention Program Presents:

CESSATION & ASSETS INPUT WORKSHOP

Join us for this exciting opportunity to provide input on tobacco cessation as we are planning the next few years of tobacco control efforts. We will discuss the extent to which evidence-based, culturally, linguistically, and age appropriate tobacco cessation services are available in the community focusing on:

- Cessation Services
- Youth Engagement in Tobacco Control
- Community Engagement in Tobacco Control

Click here to register.
If you have any questions email:
tobaccopreventioncoalition@gmail.com

THURSDAY, FEBRUARY 25, 2021
1:00PM - 3:00PM VIA ZOOM

SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

IMPLEMENTING TOBACCO CESSATION TREATMENT FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS:

A QUICK GUIDE FOR PROGRAM DIRECTORS AND CLINICIANS

Why Implement Tobacco Cessation Treatment for Individuals with Serious Mental Illness (SMI)?

▪ Individuals with SMI die several years earlier compared to those without mental illness, and smoking is a major contributing factor. Quitting tobacco use would substantially reduce high rates of morbidity and mortality due to cancers, cardiovascular conditions and respiratory diseases among individuals with SMI.

▪ Quitting smoking is one of the most important choices that one can make at any age. The physical health benefits begin almost immediately and grow over time.

▪ Quitting smoking has been found to have mental health benefits such as reduced depression, anxiety, and stress, as well as increased positive mood and quality of life.

▪ Tobacco use can interfere with psychiatric treatment, in part because some components of tobacco smoke accelerate the metabolism of most antipsychotic medications; as a result, therapeutic levels of drugs established in smoke-free hospitals become sub-therapeutic when clients resume smoking on discharge.

▪ Quitting smoking can increase clients' sense of mastery, helping them focus on taking additional steps toward a positive lifestyle.

Call to Action

1. Do you work in a mental health treatment facility such as a residential treatment program, or an outpatient treatment program?

2. Do you want to take action to reduce the use of tobacco products and tobacco-related diseases among your clients with SMI?

If you answered "yes" to these two questions, this guide can help you implement a tobacco cessation program for individuals with SMI. This objective will require staff time and resources, and it may also require a culture shift within your agency. It is worth the investment, however, because of the clear benefits that will accrue to your clients, their families, and your staff.

Overview of the Problem

▪ **Cigarette smoking is widespread among individuals with SMI.** The prevalence of smoking among individuals with SMI is nearly twice that of the general U.S. population -- 35.5 percent vs. 18.6 percent (SAMHSA, 2018). Individuals with SMI smoke more cigarettes, smoke more intensely, have greater nicotine dependence, and experience greater withdrawal symptoms when attempting to quit (McClave et al, 2010).

▪ **Smoking shortens life expectancy among persons with SMI.** Individuals with SMI die several years earlier, on average, compared to individuals without mental illness, and smoking is a major contributing factor. Fifty percent of deaths among individuals with SMI are due to cardiovascular conditions, cancers, and respiratory diseases, conditions that can be caused and/or worsened by smoking (Olfson et al, 2015; Callaghan et al, 2014; Kelly et al, 2011).

▪ **Less than half of all mental health treatment facilities offer tobacco cessation services.** In 2017, only 39 percent of mental health treatment facilities in the United States provided cessation counseling. Only about 25 percent of these facilities offered nicotine replacement therapy and/or other tobacco cessation medications. Furthermore, only one-half of mental health treatment facilities had smoke-free policies both inside and outside their facilities (SAMHSA, 2017). Providing clients who smoke with cessation counseling and medication significantly increases their odds of quitting, especially when they are provided together (Das and Prochaska, 2017; Tidey and Miller, 2015).

▪ **Individuals with SMI who smoke want to quit, and can be successful in quitting.** Research confirms that individuals with SMI who smoke are as likely as the general population to want to quit smoking, and are able to quit when a tailored tobacco cessation intervention is integrated into their mental health treatment. Individuals with SMI who smoke are as ready to quit as those without SMI, and can do so without jeopardizing their mental health recovery (Prochaska, 2011; Gilbody et al, 2019).

Adverse Impact of Tobacco Use on Mental Health

▪ **Heavy smoking is a significant risk factor for major depression.** Depression is twice as common in smokers compared to nonsmokers, and four times as common in heavy smokers (Klungsoyr et al, 2006). In fact, heavy smoking has been reported to predict the onset of major depression (Khaled et al, 2012).

▪ **Daily tobacco use is associated with an increased risk of psychosis and an earlier age at onset of psychotic illness.** The overall prevalence of smoking in individuals having their first episode of psychosis was three times higher compared to non-smokers (Gurillo et al, 2015). Individuals with first-episode psychosis have a high prevalence of tobacco use compared to non-smokers, having smoked for approximately 5 years on average prior to the onset of psychosis, with daily smoking predicting more psychotic episodes (Myles et al, 2012; Bhavsar et al, 2018).

▪ **Tobacco use is significantly associated with increased suicidal behavior.** Studies have found current smoking to be significantly associated with suicide ideations, suicide attempts, and completed suicides (Evins et al, 2017; Han et al, 2017). In fact, longer lifetime smoking (>40 years vs. <10 years) was associated with a two-fold higher odds of suicide (Balbuena and Templer, 2015).

▪ **Tobacco use can interfere with psychiatric treatment.** Smoking affects medication levels of several psychotropic medications. Components of tobacco smoke accelerate the metabolism of certain psychiatric medications, resulting in lowered blood levels and the need for higher medication doses (Prochaska, 2011). In addition, tobacco smoke also impacts the metabolism of medications used to treat opiate use disorder, such as methadone (Wahawisan et al, 2011). This chart shows drug interactions with tobacco smoke: *https://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Documents/FactSheets/Drug%20Interactions%20with%20Tobacco%20Smoke.pdf.*

Benefits of Providing Tobacco Cessation Interventions

▪ **Tobacco cessation is associated with positive mental health outcomes.** A meta-analysis of 26 studies found that smoking cessation was associated with reduced depression, anxiety, and stress, as well as improved positive mood and quality of life when compared with continuing to smoke (Taylor et al, 2014). The meta-analysis found that "the effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders." In addition, studies have shown that neither a reduction in smoking nor use of smoking cessation medications such as varenicline appear to result in a worsening of psychiatric symptoms in individuals with stable, treated SMI (Evins et al, 2015).

▪ **Tobacco cessation at any age is associated with physical health benefits.** Quitting smoking is one of the healthiest choices any smoker can make. Quitting has the following immediate and long-term benefits of quitting smoking:

- o Within 2 weeks to 3 months of quitting, the chance of having a heart attack begins to drop. Lung function begins to improve.
- o Within 1 to 9 months, coughing and shortness of breath decrease.
- o Within 1 year of stopping smoking, the risk of coronary heart disease is half that of a smoker.
- o Within 2 to 5 years, the chance of having a stroke is reduced to the same as that of a non-smoker.
- o Within 10 years, lung cancer risk is half that of a smoker, and
- o Within 15 years, the risk of coronary heart disease is the same as those who never smoked (CDC, 2014).

Implementation of Tobacco Cessation Treatment

▪ **Identification, counseling, and medication are evidence-based practices to treat tobacco dependence.** The combination of medication and counseling is more effective at treating tobacco use and dependence than either treatment alone. Clinicians should encourage all individuals attempting to quit to use both counseling and medication (Fiore et al, 2008).

▪ **Tobacco cessation treatment includes five key steps.** Train all members of the healthcare team in the 5A's model (Ask, Advise, Assess, Assist, and Arrange) for treating tobacco use and dependence. Healthcare Teams: Identify and treat every tobacco user seen in a mental health program using the 5A's model as recommended in the Clinical Practice Guideline Treating Tobacco Use and Dependence, developed by the Public Health Service of the Department of Health and Human Services (Fiore et al, 2008), as follows:

ASK about tobacco use. Identify and document tobacco use status for every client at every visit.

ADVISE to quit. In a clear, strong and personalized manner, urge every tobacco user to quit.

ASSESS willingness to make a quit attempt. Is the client willing to make a quit attempt at this t time?

ASSIST in quit attempt. For the client willing to make a quit attempt, offer medication and provide or refer for counseling or additional treatment to help the client quit. For clients unwilling to quit, provide interventions designed to increase future quit attempts (e.g., motivational interviewing).

ARRANGE follow-up. For the client willing to make a quit attempt, arrange follow-up contacts, beginning with the first week after the quit date. For clients unwilling to make a quit attempt, address tobacco dependence and willingness to quit at their next clinic visit.

Counseling. Tobacco cessation counseling can be delivered in individual, group, or telephone-based sessions. The effectiveness of the counseling is correlated with treatment intensity. When working with clients making a quit attempt, clinicians can offer practical counseling and social support, as described below (Fiore et al, 2008):

1. **Practical counseling** (problem solving/skills training) can include conveying basic information (e.g., nicotine addiction, withdrawal symptoms, quitting techniques, including use of cessation medications). Clinicians can help clients identify high-risk situations (e.g., triggers for smoking) and practice coping strategies for when they are in a high-risk situation.

2. **Social support** delivered as part of treatment can include encouragement and expressions of caring and concern (e.g., expressing belief in the client's ability to quit, acknowledging the difficulty of quitting, and noting that support is available from others and through cessation medications). Telephone quitline counseling is effective with diverse populations and has broad reach. All states have quitlines that are staffed by trained counselors to help smokers quit. This free telephone service can be reached at 1-800-QUIT-NOW (1-800-784-8669). In addition:

- For Veterans, support is available at 1-855-QUIT-VET (1-855-784-8838) and https://www.publichealth.va.gov/smoking/quitline.asp.
- For Hispanic Americans, support is available at 1-855-DÉJELO-YA, and
- For Asian Americans, support is available at http://www.asiansmokers.quitline.org/

Smokefree.gov offers tips, plans, text messaging programs, apps for 24/7 support, and other ways to get ready to quit and be smokefree for good. Tailored information and resources are offered for smokers who are pregnant, veterans, teens, Spanish speakers, or older adults. These resources can be found at www.smokefree.gov.

Motivational interviewing (MI) can be useful for smokers who are not ready to quit or who are ambivalent about quitting. Clinicians should advise all tobacco users to quit and assess a client's willingness to make a quit attempt. For clients who are not ready to make a quit attempt, clinicians can use MI techniques to encourage quitting tobacco use. This supportive and nonjudgmental approach is based

on engaging the client; focusing on a mutually agreed-on agenda that promotes change; evoking client motivations for change; and developing a change plan (Miller and Rollnick, 2013). MI is a directed, person-centered counseling style that is effective in helping clients change their substance use behaviors. The core MI skills of asking open questions, affirming, using reflective listening, and summarizing can enhance client motivation and readiness to change. Counselor empathy, which is shown through reflective listening and evoking change talk, is another important element of MI's effectiveness, and is associated with positive client outcomes. MI has been adapted for use in brief interventions and across a wide range of clinical settings and client populations.

Smoking Cessation Medications. There are seven FDA-approved medications for smoking cessation.

Five are nicotine-replacement therapies:
- Nicotine patch (over the counter)
- Nicotine gum (over the counter)
- Nicotine lozenge (over the counter)
- Nicotine nasal spray (prescription)
- Nicotine inhaler (prescription)

Two are non-nicotine medications:
- Bupropion (Zyban®, by prescription only)
- Varenicline (Chantix®, by prescription only)

Healthcare providers should check prescription labeling information of the smoking cessation drugs available at Drugs@FDA to determine if there are any potential drug interactions (e.g., some patients using varenicline experienced a decreased tolerance to alcohol) or possible risks for specific populations (e.g., women who are pregnant or breastfeeding, individuals with diabetes, heart disease, asthma, or stomach ulcers). Healthcare providers should also review the product labels for drug warnings. For details, visit Drugs@FDA at https://www.accessdata.fda.gov/scripts/cder/daf/.

Note: E-cigarettes are not approved by the FDA as a quit smoking aid. More information on e-cigarettes is available at https://www.cdc.gov/tobacco/basic_information/e-cigarettes/index.htm.

Implementation of a Tobacco-Free Environment

Having a tobacco-free workplace (a) where all tobacco products (cigarettes, cigars, smokeless tobacco, chewing tobacco, e-cigarettes) are prohibited, (b) where smoking is prohibited on all facility premises (indoors and outside), and (c) where the policies apply to clients, visitors, and employees, sends the message to staff and clients that the organization's leadership and administrators are committed to the health and wellness of everyone. It also creates a supportive environment for those who want to quit using tobacco. Two steps in establishing a tobacco-free workplace are:

1. **Once you have implemented tobacco cessation programs, establish the policies and procedures required in a tobacco-free workplace.** Tobacco-free workplace policies should be clear and concise. They should clearly explain tobacco restrictions and how the policies will be enforced.

2. **Communicate the policies to all affected parties.** The tobacco-free workplace policies should be announced and communicated to all substance abuse treatment program staff, clients, and volunteers, as well as to visitors to the facility and grounds.

While many people fear that implementing a tobacco-free environment will be very difficult, the literature suggests that these fears are largely unfounded. In fact, the subsequent outcomes after implementation are typically quite favorable for both staff and clients.

Tobacco Cessation Integration Tips. SAMHSA recommends that mental health facilities adopt policies for tobacco-free facilities and grounds and integrate tobacco treatment into the care they provide. The following tips can help to ensure successful integration of these recommendations:

▪ **Obtain the commitment of senior leadership and management.** Having the commitment and support of the Board of Directors and senior management is paramount in successfully implementing a tobacco cessation program and a tobacco-free policy. Garnering their support prior to the start of the program is essential to promote and implement the program within the organization and in the community.

▪ **Identify a program champion.** This individual should be a dedicated staff member who can coordinate your agency's tobacco cessation and tobacco-free policy efforts.

▪ **Create a planning committee and involve staff.** This committee will develop written policies, procedures, and an implementation plan. It should include representation from staff members across the organization and across disciplines in order to address their concerns and leverage their clinical experience. Including medical team members is important so that medications for tobacco cessation can be made available as part of treatment. The committee can also troubleshoot issues that arise during implementation.

▪ **Implement an office-wide documentation system.** This ensures that tobacco use status is queried and documented for every client at every clinic visit. Expand vital signs documentation to include tobacco use (see example below).

VITAL SIGNS:

Blood Pressure: Pulse: Weight:
Temperature: Respiratory Rate:
Tobacco Use (circle one): Current Former Never

- **Assist staff members who want to quit tobacco use.**

- **Look for opportunities to celebrate success.**

- **Set a start date for when the new policies will go into effect.** The date should be far enough in advance to allow for staff training, raising awareness about the new initiative, offering and promoting cessation services, incorporating new treatment protocols into records, obtaining tobacco-free signage, and other necessary preparations. However, the start date should not be so far in the future that momentum is lost or that commitment to implementing the new policies can wane.

- **Roll-out awareness activities.** Before and after the start date, use a variety of information channels (e.g., agency emails, staff meetings, signage, client brochures, social media) to share information on new policies, procedures, and related items. Prior to the start date of the tobacco-free policy, implement a series of countdown activities to promote the changes and build awareness.

- **Track progress.** Measure progress against objectives by collecting data on tobacco use screening, cessation treatment utilization, and tobacco use status at discharge, as well as compliance with the tobacco-free policy.

- **Ensure collaboration with all members of an individual's care team.** For certain medications, which may include psychotropic medications, medications to treat opiate use disorders, or some medications for physical health conditions, the levels of medication in the blood stream will shift as the individual reduces their tobacco use. It is important that all providers, including substance use providers, psychiatrists, and primary care providers, are aware that the client plans to quit using tobacco so that they can support their cessation efforts and monitor the need for changes in doses and treatments.

Conclusion

Tobacco use is widespread among individuals with SMI, and the high prevalence of tobacco-related mortality among them is well-documented. Research shows that individuals with SMI who smoke are as interested in quitting as those without SMI and can do so without jeopardizing their mental health recovery. Quitting smoking is one of the most important choices that anyone can take to improve their health, and is beneficial for both physical and mental health. Furthermore, quitting smoking can have a broader positive influence on individuals with SMI; as they learn effective skills and techniques for smoking cessation, their sense of mastery and self-efficacy to make other healthy lifestyle changes can increase as well.

Tobacco cessation treatment should be an integral part of treating individuals with SMI. There is a critical need to engage mental health program directors and clinicians in efforts to increase access to evidence-based tobacco treatment for these individuals. For the numerous reasons cited within this guide, SAMHSA recommends the adoption of tobacco-free facilities/grounds policies and the integration of tobacco cessation treatment into the care provided to clients with SMI who smoke or use other tobacco products.

Resources

Addressing Tobacco through Organizational Change (ATTOC) Approach
(https://medschool.ucsd.edu/som/psychiatry/research/ATTOC/approach/Pages/default.aspx)
University of California School of Medicine
Provides agencies with a 10-step process for improving tobacco use disorder treatment services.

Behavioral Health and Wellness Program
(www.bhwellness.org/toolkits/Tobacco-Free-Toolkit.pdf)
University of Colorado Anschutz Medical Campus, School of Medicine
Offers DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers.

FDA 101: Smoking Cessation Products
(www.fda.gov/ForConsumers/ConsumerUpdates/ucm198176.htm)
U.S. Food and Drug Administration
This is a consumer brochure that provides information on smoking cessation products.

Final Recommendation Statement, Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions
(https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1)
U.S. Preventive Services Task Force
Provides recommendation grades for smoking cessation.

The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General
(www.surgeongeneral.gov/library/reports/50-years-of-progress/fact-sheet.html)
Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health
Offers a history of U.S. tobacco use and prevention and control efforts. Details the evidence for the health effects of cigarette smoking.

Million Hearts® Tobacco Cessation Protocols
(https://millionhearts.hhs.gov/tools-protocols/protocols.html)
Centers for Disease Control and Prevention
Provides a template and implementation guidance document to help institutions integrate tobacco cessation protocols into their clinical workflows.

Smokefree Apps
(www.smokefree.gov/tools-tips/apps)
Get 24/7 support with a Smokefree app for your smartphone. These free apps offer help just for you based on your smoking patterns, moods, motivation to quit, and quitting goals. Tag the locations and times of day when you need extra support.

Smokefree.gov
(www.smokefree.gov)
U.S. Department of Health and Human Services
Provides smokers who want to quit with free or low cost, evidence-based smoking cessation information, quit smoking tools, and on-demand support.

SmokefreeTXT
(www.smokefree.gov/smokefreetxt)
SmokefreeTXT is a six-week test messaging intervention with one week of preparation messages based on U.S. Public Health Service Clinical Practice Guidelines for Treating Tobacco Use and Dependence.

Smoking Cessation Leadership Center/National Center of Excellence for Tobacco-Free Recovery
(https://smokingcessationleadership.ucsf.edu)
University of California, San Francisco
Offers presentations, publications, toolkits, factsheets, and videos including one on motivational interviewing in the context of tobacco cessation.

Stay Quit Coach
(www.mobile.va.gov/app/stay-quit-coach)
Stay Quit Coach is an app that is designed to help with quitting smoking. It is intended to serve as a source of readily available support and information for adults, who are already in treatment to quit smoking, to help them stay quit even after treatment ends. The app guides you in creating a tailored plan that takes into account your personal reasons for quitting. It provides information about smoking and quitting, interactive tools to help users cope with urges to smoke, and motivational messages and support contacts to help you stay smoke-free.

Tobacco Cessation FAQ Videos for Providers and Clients
(www.bhthechange.org/resouces/tobacco-cessation-faq-videos-providers-clients)
National Behavioral Health Network for Tobacco & Cancer Control
National Council for Behavioral Health
Provides 12 short videos that can be used for educational and informational purposes when providing tobacco treatment services to consumers.

Tobacco Recovery Resource Exchange
(https://tobaccorecovery.oasas.ny.gov/)
New York State Department of Health Tobacco Control Program
Offers training and technical assistance to support chemical dependence service programs to implement tobacco-free environment policies and to provide tobacco-dependence education and treatment interventions.

Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians, 2008 Update
(www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/quickref/tobaqrg.pdf)
U.S. Department of Health and Human Services
Provides updated strategies and recommendations for addressing tobacco use.

What Are the Best Ways of Helping People with Serious Mental Illnesses Quit Tobacco?
(https://smiadviser.org/knowledge_post/what-are-the-best-ways-of-helping-people-with-serious-mental-illnesses-quit-tobacco/)

SMI Adviser, a Clinical Support System for Serious Mental Illness
American Psychiatric Association and SAMHSA
Provides information on smoking cessation products that are helpful in achieving abstinence from tobacco dependence in people with serious mental illness, and do not worsen underlying psychiatric symptoms.
Wisconsin Nicotine Treatment Integration Project
(https://uwmadison.co1.qualtrics.com/jfe/form/SV_essYyhGhb4TT5o9)
University of Wisconsin Center for Tobacco Research and Intervention
Offers "Training for Systems Change: Addressing Tobacco and Behavioral Health," a 12-module, online, interactive tutorial that highlights the experience of behavioral health clinicians and administrators who have integrated tobacco treatment and policy.

1-800-QUIT-NOW (1-800-784-8669)
(www.cdc.gov/tobacco/quit_smoking/cessation/pdfs/1800quitnow_faq.pdf)
National Cancer Institute
Connects individuals directly to their state's tobacco quitline.

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Quitting takes hard work and a lot of effort, but –

You Can Quit Smoking

– Support and Advice

A Personalized Quit Plan for: _____

Want to Quit?

- ✔ Nicotine is a powerful addiction.
- ✔ Quitting is hard, but don't give up.
- ✔ Many people try 2 or 3 times before they quit for good.
- ✔ Each time you try to quit, the more likely you will be to succeed.

Good Reasons for Quitting:

- ✔ You will live longer and live healthier.
- ✔ The people you live with, especially your children, will be healthier.
- ✔ You will have more energy and breathe easier.
- ✔ You will lower your risk of heart attack, stroke, or cancer.

Tips to Help you Quit:

- ✔ Get rid of ALL cigarettes and ashtrays in your home, car, or workplace.
- ✔ Ask you family, friends, and coworkers for support.
- ✔ Stay in nonsmoking areas.
- ✔ Breathe in deeply when you feel the urge to smoke.
- ✔ Keep yourself busy.
- ✔ Reward yourself often.

Quit and Save Yourself Money:

- ✔ At $3.00 per pack, if you smoke 1 pack per day, you will save $1100 each year and $11,000 in 10 years.
- ✔ What else could you do with this money?

U.S. Department of Health and Human Services
Public Health Service

You Can Quit Smoking

Five Keys for Quitting

1. Get ready.

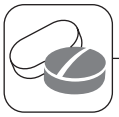
- ✔ Set a quit date and stick to it – not even a single puff!
- ✔ Think about past quit attempts. What worked and what did not?

2. Get support and encouragement.

- ✔ Tell your family, friends, and coworkers you are quitting.
- ✔ Talk to your doctor or other health care provider.
- ✔ Get group, individual, or telephone counseling.

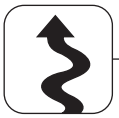
3. Learn new skills and behaviors.

- ✔ When you first try to quit, change your routine.
- ✔ Reduce stress.
- ✔ Distract yourself from urges to smoke.
- ✔ Plan something enjoyable to do every day.
- ✔ Drink a lot of water and other fluids.



4. Get medication and use it correctly.

- ✔ Talk with your health care provider about which medication will work best for you.
  - Bupropion SR – available by prescription.
  - Nicotine gum – available over-the-counter.
  - Nicotine inhaler – available by prescription.
  - Nicotine nasal spray – available by prescription.
  - Nicotine patch – available over-the-counter.



5. Be prepared for relapse or difficult situations.

- ✔ Avoid alcohol.
- ✔ If you are around other smokers, try not to stay around them too long.
- ✔ If you are angry, upset, sad or frustrated, don't smoke! Try other things to feel better, like taking a walk.
- ✔ Eat a healthy diet and stay active.

Your Quit Plan

1. Your Quit Date:

_____

2. Who can help you?

_____

_____

3. Skills and behaviors you can use:

_____

_____

4. Your medication plan:

Medication: _____

Instructions: _____

_____

_____

5. How will you prepare?

_____

_____

Quitting smoking is hard. Be prepared for challenges, especially in the first few weeks.

Follow-up Plan: _____

Other Information: _____

Referral: _____

_____

Clinician Date

U.S. Department of Health and Human Services
Public Health Service

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

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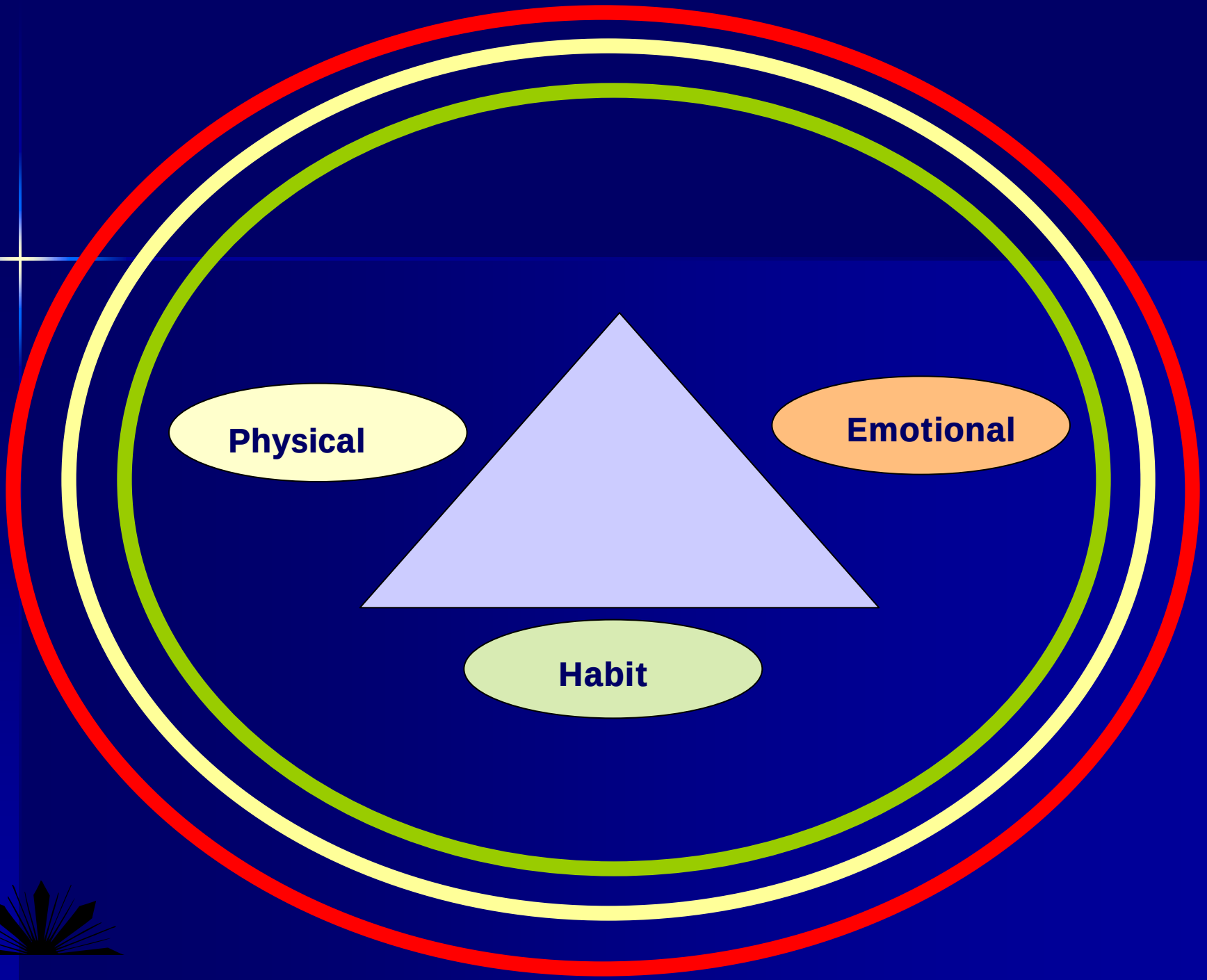
OBJECTIVES

- 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

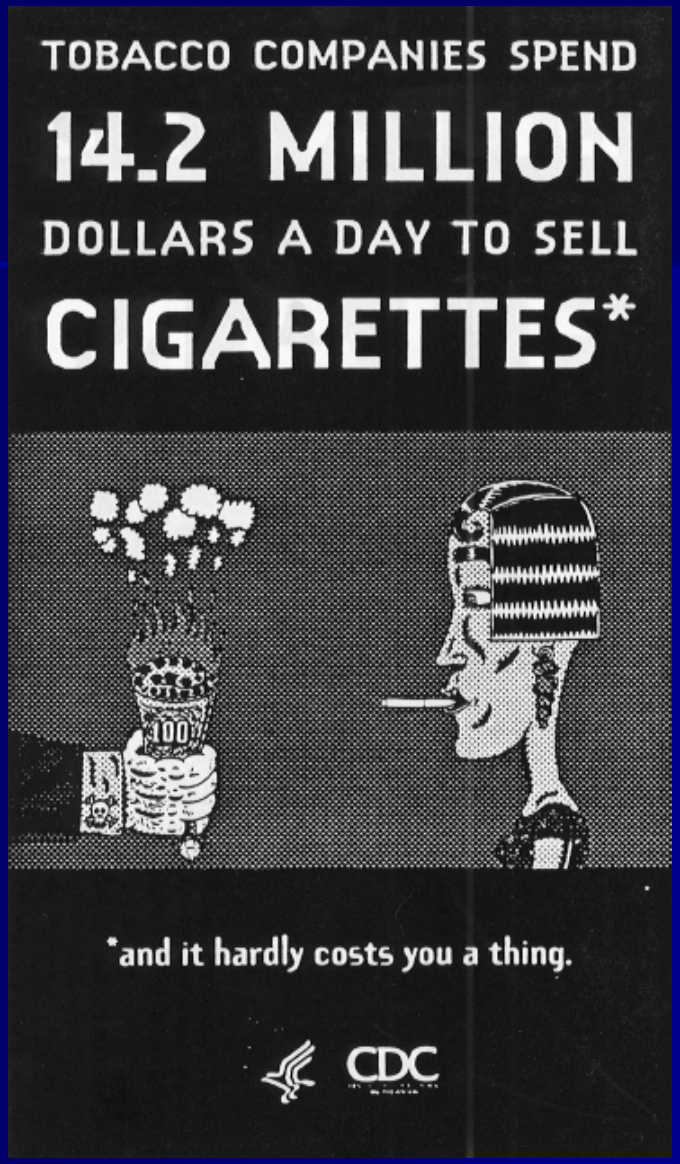
- Training - all staff 1 hour- clinical staff trained on tobacco addiction
- Prohibition in buildings, vehicles, property
  - No smoking of staff in sight of clients
  - Inform,orient,record violations,post
- Public Information-Signage-employee tobacco treatment benefits
- Divestment- no tobacco funds
- 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*
100
*and it hardly costs you a thing.
CDC

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]

KS

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

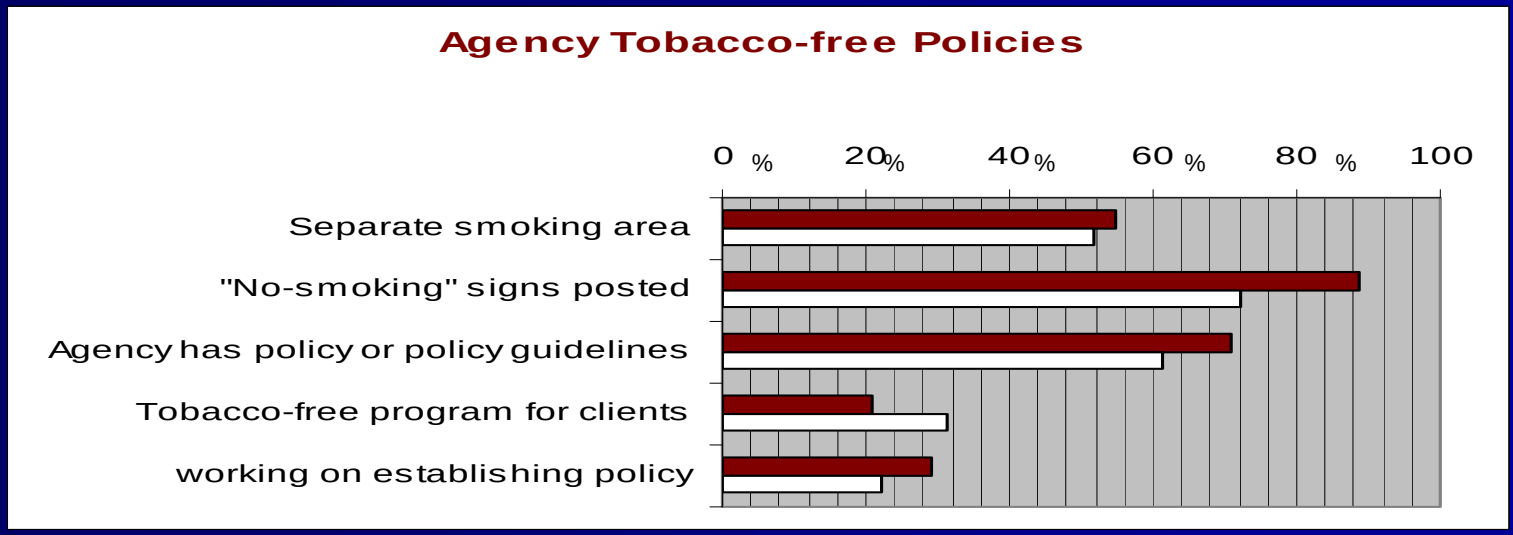
NASMHPD Key Messages

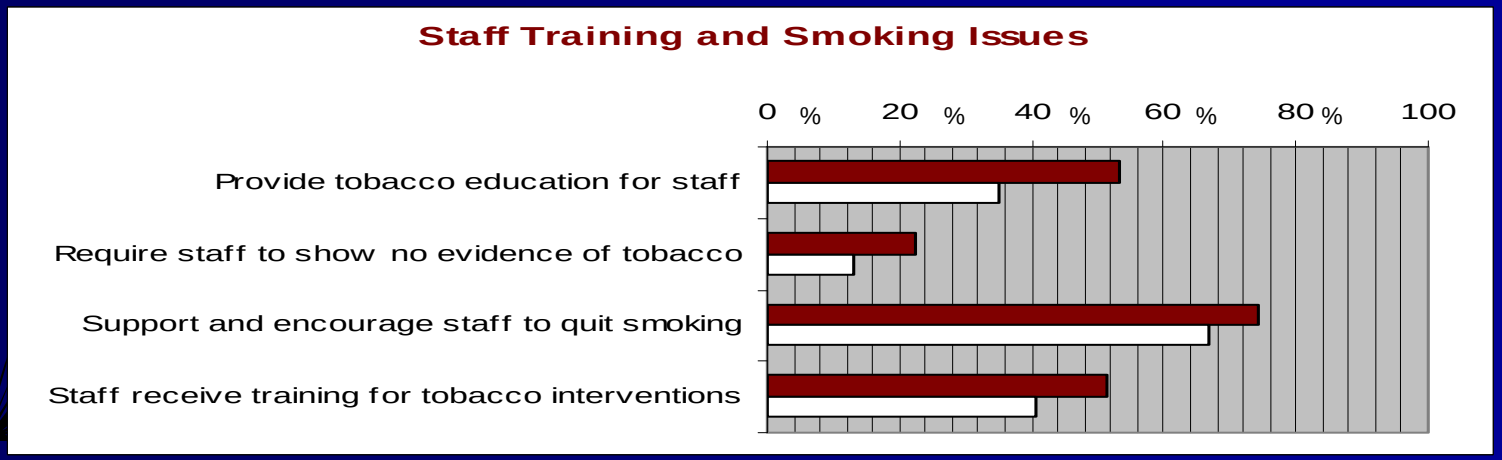
- 25 year mortality gap due largely to smoking
- Smokers with schizophrenia spend >1/4 income on on cigarettes
- Tobacco use interferes with psychiatric medications
- Although more than 2/3 of smokers want to quit only 3 percent are able to quit on their own-need help
- Even highly addicted smokers with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





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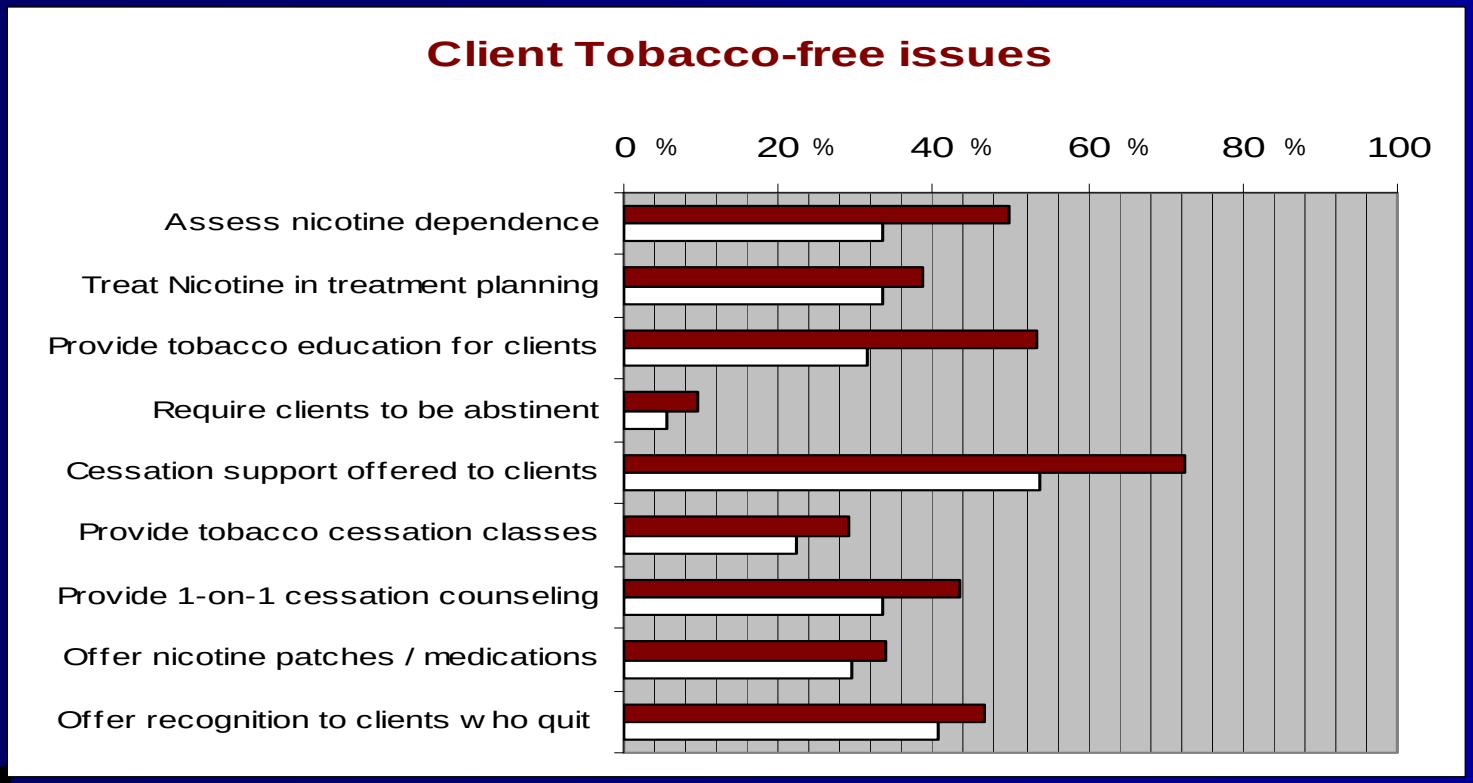
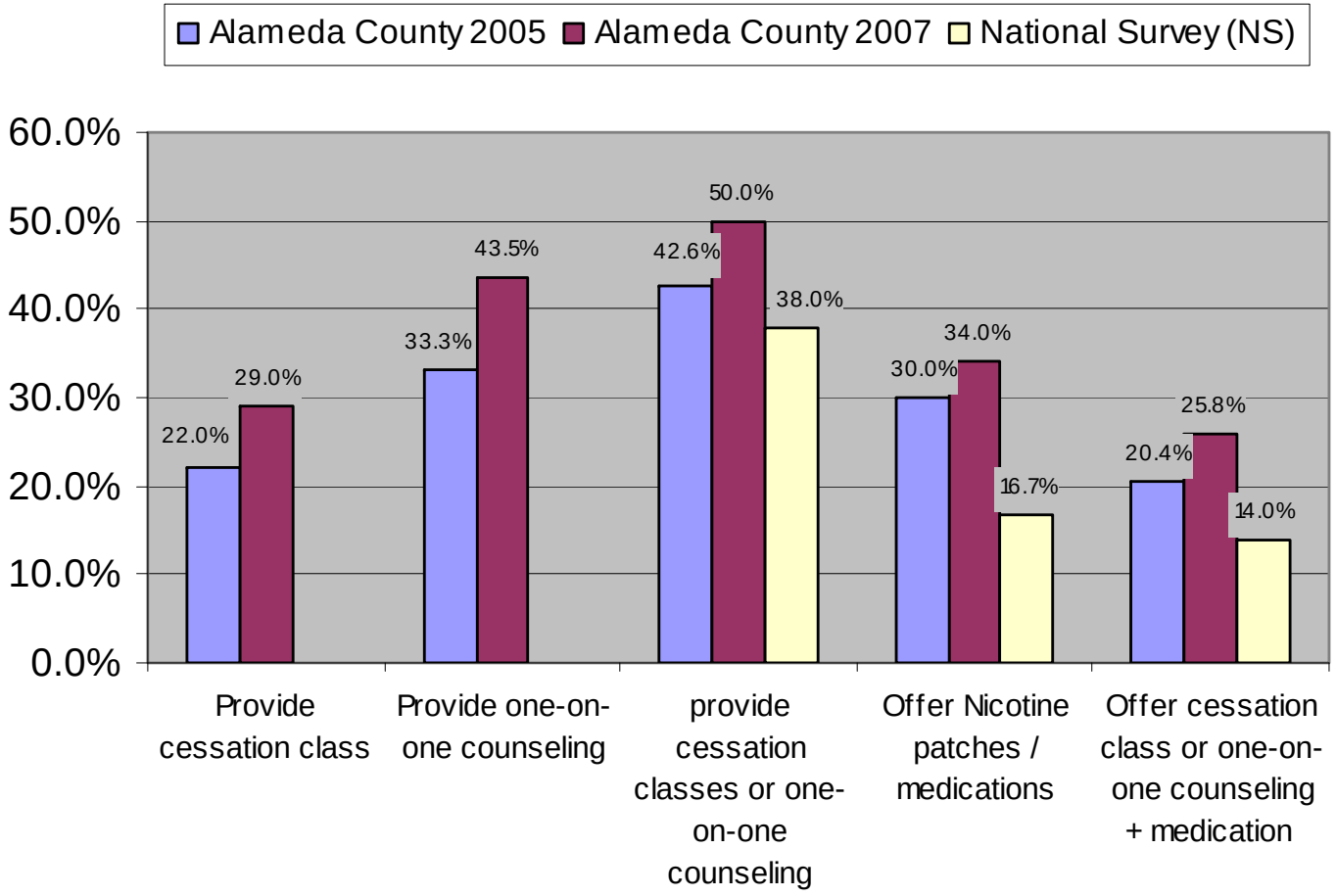
Client tobacco-free issues



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**