CONTRA COSTA
MENTAL HEALTH COMMISSION

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MENTAL HEALTH
COMMISSION
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Mental Health Commission
Quality of Care Committee Meeting
Thursday, February 18, 2021, 3:45-5:30 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**

V. **APPROVE minutes from January 18, 2021 Quality of Care Committee meeting**

VI. **REVIEW and DISCUSS list of Mental Health Services Act facilities, Behavioral Health Services owned and operated facilities and contracted facilities, including criteria for inclusion, types of sites included, and information tracked about the sites with Jennifer Bruggeman, Program Manager, Mental Health Services Act, and Jan Cobaleda-Kegler, Mental Health Program Chief, Adult and Older Adult Behavioral Health Services and Joseph Ortega, RN, IMD Liaison**

(Agenda continued on Page Two)

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

Quality of Care Committee Agenda (Page Two)

Thursday, February 18th, 2021 ◊ 3:45 pm - 5:30 pm

VII. DISCUSS information sources and needs for learning about programs for cessation of smoking in mental health treatment and recovery environments and congregant living

VIII. UPDATE committee on the outcome of the Site Visit adult questionnaire test

IX. DISCUSS HUME test timing and objectives and assign roles

X. DISCUSS Site Visit report template contents

XI. Adjourn

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

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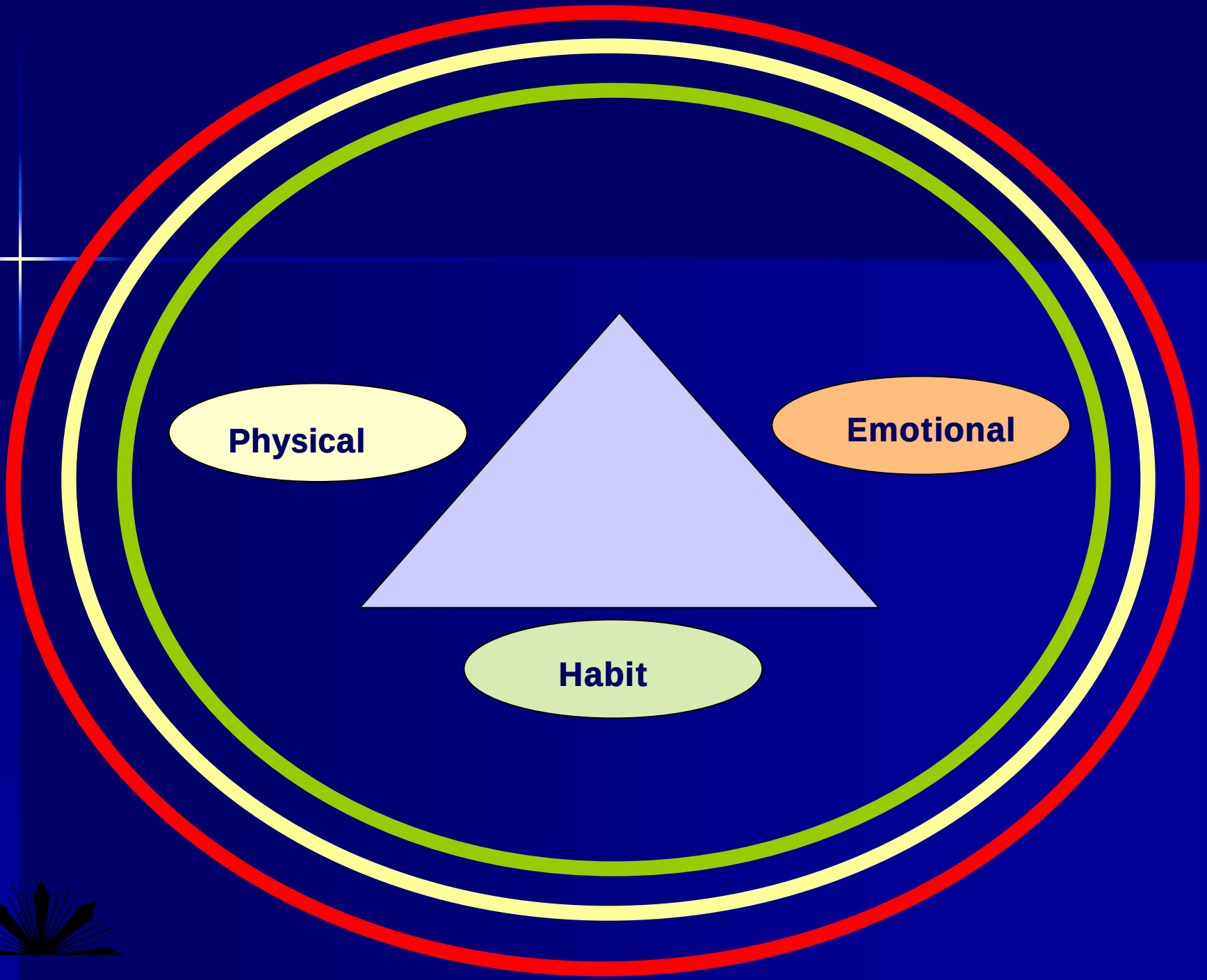
OBJECTIVES

- 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

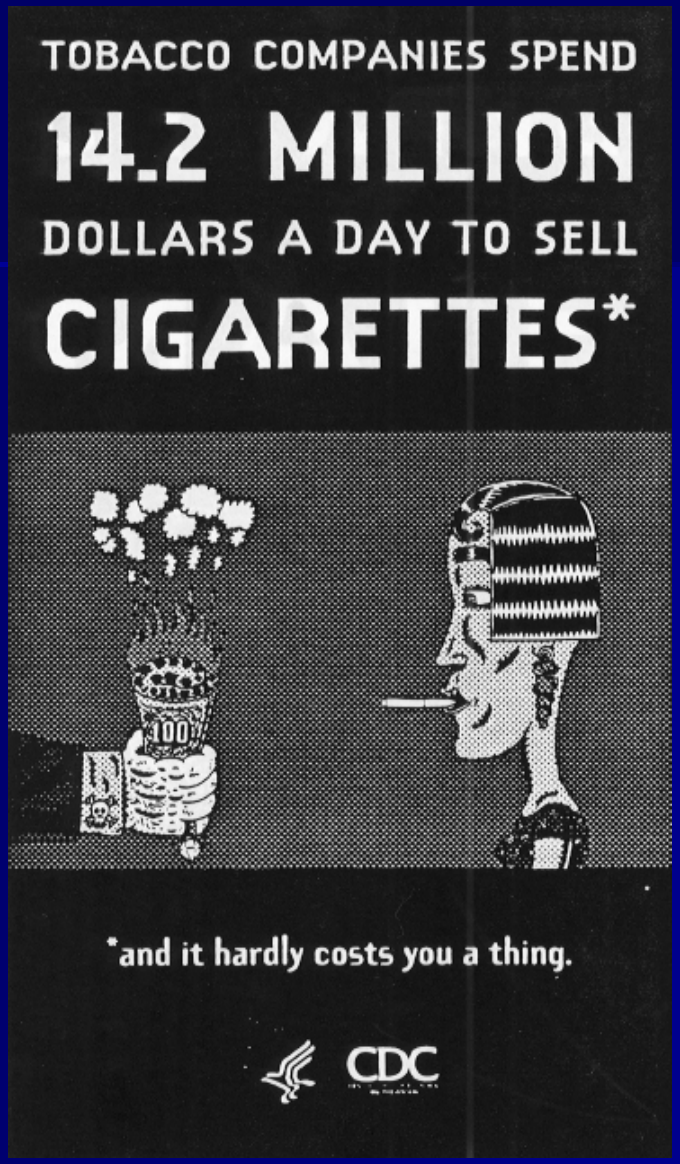
- Training - all staff 1 hour- clinical staff trained on tobacco addiction
- Prohibition in buildings, vehicles, property
  - No smoking of staff in sight of clients
  - Inform,orient,record violations,post
- Public Information-Signage-employee tobacco treatment benefits
- Divestment- no tobacco funds
- 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

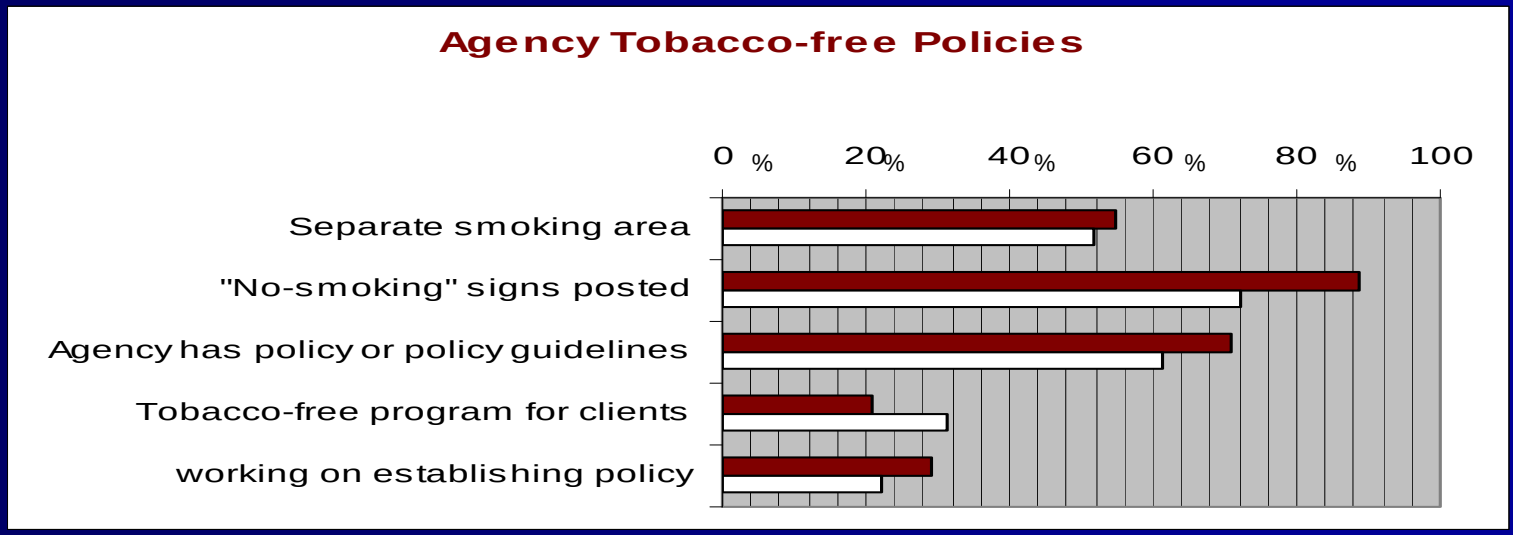
NASMHPD Key Messages

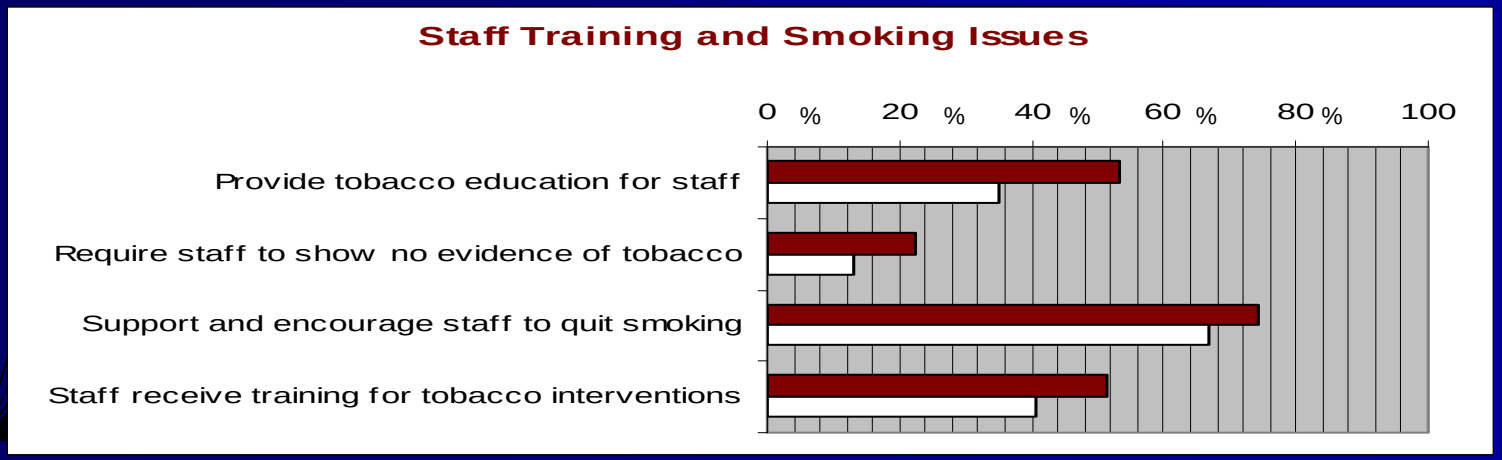
- 25 year mortality gap due largely to smoking
- Smokers with schizophrenia spend >1/4 income on on cigarettes
- Tobacco use interferes with psychiatric medications
- Although more than 2/3 of smokers want to quit only 3 percent are able to quit on their own-need help
- Even highly addicted smokers with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

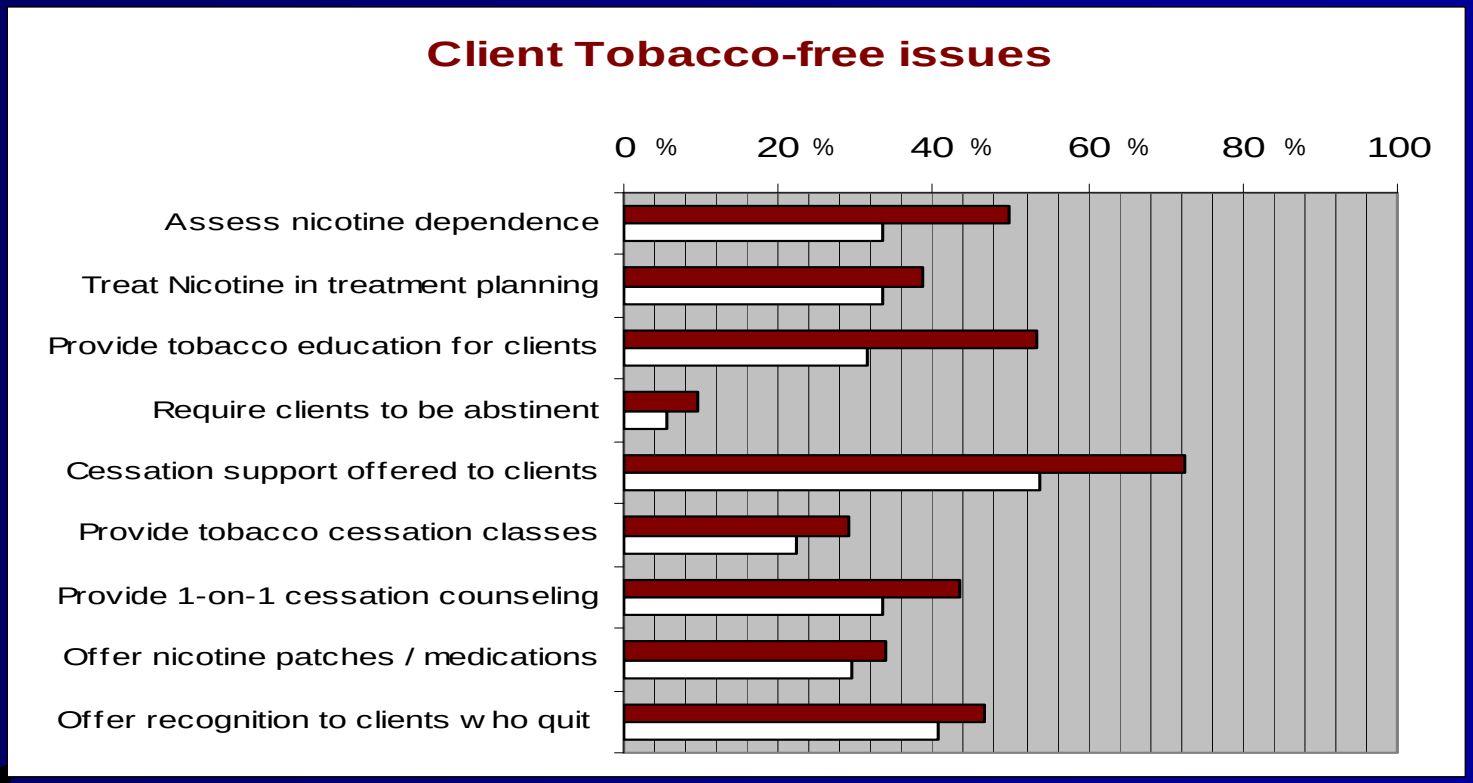
Baseline 1/03 few agencies had t-policies Evaluation 2005 (54/80) 2007 (62/110) Results of self report tobacco policy checklist



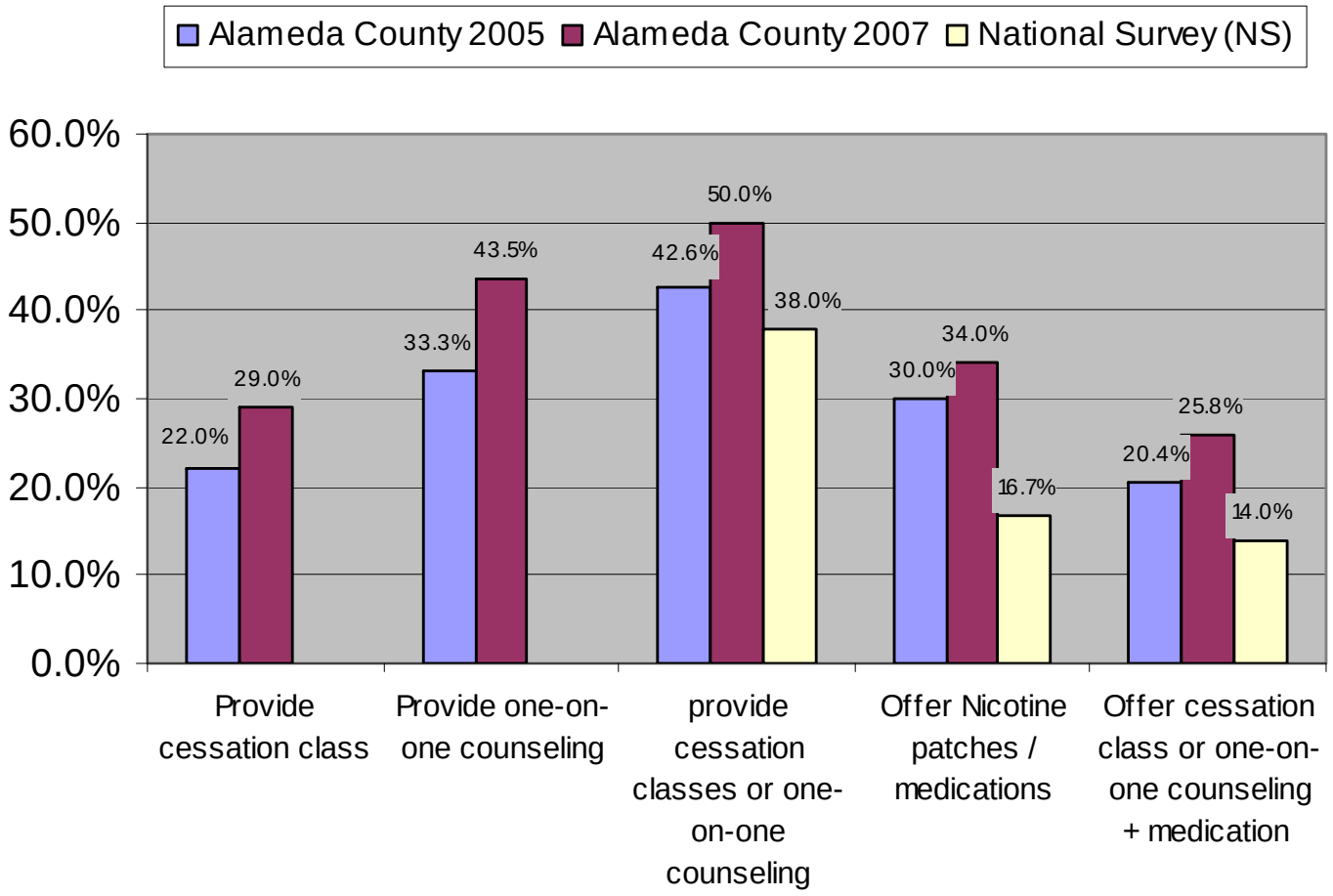


Baseline 1/03 few agencies had t-policies Evaluation 2005 (54/80) 2007 (62/110) Results of self report tobacco policy checklist

Client tobacco-free issues



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**

CONTRA COSTA MENTAL HEALTH COMMISSION

CLIENT SATISFACTION SURVEY

1. How long have you been in this program?

_____

_____

_____

2. Do you feel that you are getting better and that your quality of life is improving?

_____

_____

_____

3. Are there ways in which this program is different for you than other programs that you have participated in? How is different?

_____

_____

_____

4. Tell me a few things about this program that you like the best.

_____

_____

_____

5. In respect to making this program better, are there any recommendations that you would make to improve this program?

_____

_____

_____

6. Does the staff ask you for your input on services that you might need?

_____

_____

7. Does the staff help you use your personal strengths, skills, and capabilities in your recovery? (E.g. your leadership abilities, compassion for others, artistic talents, computer skills)

_____

_____

_____

8. Do you feel the services you receive are adjusted to your specific needs (e.g. gender, ethnicity, disability, language)?

_____

_____

9. Does the program provide or connect you with meaningful social opportunities or therapeutic activities? Any other type of activities that are important to you?

_____

_____

_____

10. Are you comfortable with us asking you questions about your behavioral health medications? Yes ☐ No ☐

Are you taking medications? (If "Yes", go to question "11a". If "No", skip remaining medication-related questions.)

Yes ☐ No ☐

a. Did a doctor or staff person talk to you about what the medications are for?

Yes ☐ No ☐

_____

b. Did a doctor or staff talk to you about the medications' side effects, including interaction with other medications you are taking?

Yes ☐ No ☐

_____

c. Did a doctor or staff talk to you about alternatives to medication such Cognitive Behavioral Therapy, Acupuncture, Yoga, or Mindfulness?

Yes ☐ No ☐

_____

d. Did the doctor or staff answer all of your questions about your medications?

Yes ☐ No ☐

_____

e. Do you feel the medications are helping you?

Yes ☐ No ☐

_____

f. If you had a problem with your medications, did the doctor or staff listen to your concerns? What did they do about your concerns?

Yes ☐ No ☐

_____

g. (*For female clients*): Did a doctor talk to you about the impact of medication on your hormones, menstrual cycle, menopause, pregnancy, or sexual function?

Yes ☐ No ☐

_____

h. (*For male clients*): Did a doctor talk to you about the impact of medication on your hormones or sexual function?
   Yes □ No □

_____

i. Where do you get your medications? Is it convenient for you?

_____

j. Did you sign any papers agreeing to take the medications?
   Yes □ No □

_____

k. Did you understand the papers?
   Yes □ No □

_____

11. How is your physical health? Do you have access to the physical health treatment and support that you need? Is your physical health accounted for in your treatment plan?

_____

_____

_____

12. Does the program provide ways for family members, caregivers, friends or other advocates to participate in your program? Are services are provided to support your family members?

_____

_____

_____

13. Do you have a Peer Provider? (*See description below.) What services or support do you receive from peer providers in this program?

_____

_____

_____

14. (Inpatients Only) Do you like your accommodations and your meals here? What about the common areas and therapy spaces, or any other aspects of the facility?

_____

_____

_____

15. How do you get to and from this program? How long does it take you to get here from where you live? Do you feel safe in this program's neighborhood?

_____

_____

_____

16. Is it easy to get appointments with your doctor, therapist, social worker or whoever else you want to meet with? Can you get appointments within a reasonable time-frame?

_____

_____

_____

17. ***(Will think about this question – Should we include)?***
Do you have children, elderly parents, or anyone else whom you are responsible to care for? What are some ways that this program helps you manage your caregiving needs? (E.g. providing toys and a play space for children?)

_____

_____

_____

18. Does this program provide you with other services, such as legal help, housing services, financial resources, medical expense resources, educational services, SNAP benefits (food assistance program known as CalFresh in CA), or other services?

_____

_____

_____

19. Consider the documents that you have signed. For example, HIPPA notice (privacy), financial responsibility, patients' rights.
Did you read the documents? Yes □ No □

---

a. Could you read them? Yes □ No □
b. Did you understand what you were signing? Yes □ No □

_____

20. Do you know your rights as a participant in this program? Confidentiality is a right, for example. Do you feel your rights are being respected?

_____

_____

_____

21. If you've ever had a concern or grievance with your treatment or some other aspect of the program, have you been able to address your concern successfully? What process did you follow? Did you use a grievance form?

_____

_____

_____

22. Do you know what a Patient's Rights Advocate is? (*See description below.) Do you know how to contact one?

_____

_____

_____

23. Do you have an Mental Health Advanced Directive, also known as a Psychiatric Advanced Directive? (***See description below.)

_____

_____

_____

24. If you had a magic wand and could change anything about this program, what would that be?

_____

_____

_____

* PEER PROVIDER
A peer provider is someone who draws on their own lived experience of disability, along with training and professional support, to provide services like counseling and coaching to people with the same type of disability.

** PATIENTS RIGHT ADVOCATE
An individual, such as an attorney, friend, nurse, ombudsman, physician, or social worker, who pleads for and preserves a patient's rights to health care. Patient advocates address many com mon and important health care issues, including the right to access a health care provider, the ri ght to obtain confidential care, and the right for the patient to work after diagnosis or treatment.

*** MENTAL HEALTH ADVANCED DIRECTIVE: Document developed voluntarily by a person with a mental health condition when the person is doing well to ensure that during periods, when the person lacks the capacity to make an informed decision about mental health care, their choices regarding treatment and services shall be carried out. The benefits of Mental Health Advance Directives include increasing treatment collaboration by improving communication between the individual and his/her treatment team; allowing for consumer- centered care and treatment planning; expediting crisis interventions; preventing unnecessary guardianship procedures; and promoting individual autonomy and empowerment in the recovery from mental illnesses.

Site Visit Report Instructions and Template

I. Instructions

The Site Visit report is the culmination of the site visit. It's a summary of the most important insights that the site review team has to share. Ultimately it will provide input into how the county mental health system of care can improve.

Suggestion: Write the report as soon as you can so that the information is fresh in your mind.

a. Organize and transcribe notes (Commissioners, Executive Assistant or volunteer Commissioner if help is needed)

For each interview, organize and type notes into a Word questionnaire template document (see Program Director, Staff, Consumer, Youth, Child, Family/Care-giver Interview questionnaires). They are now legible and accessible to everyone. Email copies to the Executive Assistant. In the case of Zoom interviews, if necessary, make use of the Zoom recording to fill in gaps. Note that the recordings should be viewed by the interviewers and scribes only???

b. Draft report narrative (Commissioners, Executive Assistant if help needed)

- Choose one person to write the report or assign different sections to different Commissioners
- Draft a narrative report using the Site Visit Report Template document to help stay organized and address the main points
- Keep the narrative report brief – readable in under five minutes??? and presentable in a meeting in under five minutes???. If the reader wants more detail they can refer to the interview notes
- If assistance is needed, contact the Executive Assistant for help – he or she may help or may connect you with a site visit volunteer Commissioner

c. Review and edit (Commissioners, Executive Assistant, Chair)

- Review and edit the report with the Executive Assistant and a site visit volunteer Commissioner who is available to assist
- Provide the MHC Chair with a review copy and update the report with any clarifications
- Sign off on the final draft

II. Template

(Note: This is a first pass brain dump. We have to look back at the surveys to map questions back to report template.)

Report date
Site name
Site visit date

1. Summary of Consumer Questionnaire Findings

Number and type of interviewees
__ Adults
__ Youths
__ Children
__ Family Members

General observations??? (This is typically the hardest thing for people to write. We could give examples of things to comment on. Or skip this and have "Other observations" and perhaps "Miscellaneous" at the bottom.) For example…

Strengths:
For example:

1. Description and example
2. Description and example
3. Description and example

Challenge areas:
For example

1. Description and example and suggestions by interviewee
2. Description and example and suggestions by interviewee
3. Description and example and suggestions by interviewee

Consumer magic wishes (big desires)???

Other observations (if no "General Observations")

Miscellaneous comments (is this necessary???)

2. Summary of Staff Survey Findings

Number and type of interviewees
__ Program Director

__ Clinical Director
__ Clinical staff and roles
__ Other staff and roles
__ Peers???

Strengths:

1. Description and example
2. Description and example
3. Description and example

Challenge areas

1. Description and example and suggestions by interviewee
2. Description and example and suggestions by interviewee
3. Description and example and suggestions by interviewee

Magic wishes???

3. Physical Site

Brief description:
Cleanliness
Comfort
Functional
Everything needed there e.g. furnishings, supplies
Well maintained
Food (if comments by consumers positive or negative)
Other: Calm, quiet, upbeat

4. Miscellaneous Issues???

General health of the organization???
Suggestions

5. Recommended areas for action plans
   1. Problem to solve: Description
   2. Problem to solve: Description
   3. Problem to solve: Description

Any situation requiring immediate attention by Program Director or CCBHS/CBO/CCRMC staff