BEA

Bringing *Everyone* Along

RESOURCE GUIDE SUPPLEMENT

CASE STUDIES FOR INTEGRATING
TOBACCO DEPENDENCE TREATMENT
AND TREATMENT FOR MENTAL ILLNESS
AND SUBSTANCE USE DISORDERS

July 2009

A project of the Tobacco Cessation Leadership Network

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INTRODUCTION

The Bringing *Everyone Along Resource Guide Supplement* has been developed to assist tobacco control and cessation program administrators, managers, and treatment specialists, mental health and substance use program administrators, managers, and treatment specialists, and other health professionals to implement changes needed to integrate tobacco cessation services for persons with mental illness and substance use disorders (MI/SUD). The Supplement compliments the *BEA Resource Guide* by summarizing implementation advice and strategies used in four of the state programs initially surveyed for the BEA project.

The purpose for developing the *Supplement* came out of the many questions raised by health professionals as they sought to develop programs to assist tobacco users with MI/SUD. Among the most common questions are: "How do we get started and where can we find start-up funding? How can we gain the support of our partners in mental health and substance use treatment? What kind of training is needed and how can tobacco dependence treatment services be integrated into the delivery of mental health and substance use treatment? How do we approach medication issues? What about reimbursement and sustainability?

These questions were posed in follow-up interviews with BEA key informants in four states: Wisconsin, Colorado, New York, and Indiana. A summary of responses to these questions and full case studies from these states are presented in Section 2 of this Supplement. In each state, interviews were conducted with tobacco control program leaders and with the participating leaders from the mental health and substance use communities.

The Supplement is divided into three sections:

Section 1: Summary of common strategies for implementation

Section 2: Case studies and "Lessons Learned"

Section 3: Resources, web links, and acknowledgements.

It is our hope that the *Bringing Everyone Along Resource Guide and Supplement* together will help tobacco dependence treatment, mental health treatment, and substance use treatment professionals better integrate their services. And by working together, help fill the gap in service needed for the many tobacco users with mental illness and substance use disorders who need them.

ESTABLISHING PARTNERSHIPS AND START-UP FUNDING

Each of the four states featured in the case studies began by establishing partnerships between state mental health leaders and agencies, state substance use treatment leaders and agencies, and state tobacco control program leaders. The impetus for these partnerships differed, typically beginning informally with initial conversations and meetings between program leaders, who were often colleagues. Programs began to take shape as ideas were discussed and other leaders were invited to participate. A beginning step was to come to a mutual understanding of needs and program possibilities. While identifying and eliminating tobacco-related disparities is among the primary goals of state tobacco control programs,[1] tobacco control leaders were often unaware of the unique needs in the mental health and substance use communities and how their programs could help. Likewise, leaders from substance use and mental health agencies were often unfamiliar with how tobacco control programs are organized and how their needs could fit into tobacco control strategic plans. Through discussion and mutual understanding, innovative approaches emerged.

COLORADO

The partnership between the Colorado State Tobacco Education and Prevention Partnership (STEPP) and the mental health community grew out of a foresighted decision to conduct an assessment to identify gaps in services. Subsequently, persons with mental illness and substance use disorders were included among the 10 priority populations identified in the state strategic plan for funding to reduce disparities. Additionally, as recipients of CDC disparities strategic planning pilot funding, the STEPP program convened strategic planning groups to translate the needs assessments into program planning. When Colorado funding was cut in 2003, these programs were temporarily suspended. Funding was later restored in 2005 with an increase in the tobacco tax. The legislation passed to increase the tax included a requirement to use a portion of the revenue for programs to serve disparate populations. With new funding, a strategic plan was developed, multiple partners were involved in the working groups, and a variety of programs were funded. The mental health partners involved in strategic planning process continued as an ongoing advisory committee. They serve as strong and ongoing advocates for programs and funding within the STEPP program, helping to both direct and sustain the integration of services in Colorado.

WISCONSIN

The partnership between the Wisconsin Tobacco Prevention and Control Program and the mental health communities and substance use community began first as separate efforts later merged into a joint collaboration. In 1999-2000, leaders within the substance use and mental health communities began a grassroots advocacy effort to draw attention to the need for integrating tobacco dependence treatment into recovery programs. As part of their advocacy, they joined the Tobacco Dependence Treatment task force of the state Tobacco Control Program, to promote integration of treatment as a strategic goal. In 2002-2003, this informal advocacy effort gained momentum as several organizations representing Wisconsin addiction providers, clinicians and advocates each adopted a resolution to "support policies that lead to the integration of evidence-based nicotine treatment into addiction and mental health services." Meanwhile in 2001, the Wisconsin Tobacco Control Program received CDC funding to

1 The CDC recommendations for a comprehensive state tobacco control program include four overall goals: 1) Preventing the initiation of tobacco use, 2) Promoting tobacco cessation, 3) Eliminating exposure to secondhand smoke, and 4) Identifying and eliminating tobacco related disparities.

develop a state strategic plan for addressing disparities related to tobacco. The resulting disparities strategic plan included integrating tobacco dependence treatment into treatment for mental illness and substance use disorders. With advocacy from both the Tobacco Dependence Treatment and Disparities workgroups, the 2005–2010 Wisconsin Tobacco Control Program strategic plan added integration activities into their goals for eliminating tobacco related disparities Adding integration activities to the strategic plan led to the funding for a project to develop a statewide integration plan, the Wisconsin Nicotine Treatment Integration Project (WiNTiP).

INDIANA

The partnership between the Indiana Tobacco Prevention and Cessation Program (ITPC) and the mental health and substance use communities evolved from a successful statewide initiative to promote 100% tobacco free hospital campus policies across the state. With 75% of Indiana hospitals adopting smoke-free policies, and the emerging national information on the problem of tobacco use among persons with mental illness and substance use disorders, the ITPC established new goals within the strategic plan for establishing smoke-free policies in mental health and substance use facilities. Knowing that such an initiative would require a partnership with mental health organizations, ITPC reached out to the Indiana-based organization for Mental Health America and proactively helped them submit a proposal for funding to develop a strategic plan. At the same time, ITPC funded Clarian Health, in partnership with Affiliated Service Providers of Indiana, Inc. (ASPIN), to offer provider training and systems change technical support for ASPIN's behavioral health provider network. Between these two projects, an informal but active grassroots "Mental Health Collaborative" emerged involving representatives from a variety of mental health and substance use agencies. ITPC is working to expand the early development of the Collaborative and to help continue the funded projects to sustain development of a strategic integration plan for mental health and technical assistance.

NEW YORK

The partnership between the New York State Department of Health Tobacco Control Program (NYTCP) and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) began informally in 2003 with meetings among OASAS staff, Tobacco Control Program staff and the organization of Alcoholism and Substance Abuse Providers (ASAP). These groups met to explore the possibility of expanding a pilot project that had been underway in Western New York in which three Addiction Treatment Centers had successfully implemented tobacco-free policies. From this informal discussion, a four-year strategic plan was developed based on information gathered from key stakeholders through a series of five statewide forums. From these forums, two substantial barriers emerged: the need for training and the need for free access to nicotine replacement. Start-up costs for providing training and free NRT were estimated and a plan was presented to the New York Tobacco Control Program. Recognizing the opportunity to reach an important population of smokers, the director of the Tobacco Control Program brought the funding request to the state appointed Tobacco Control Program Board for approval. Once underway, the NYTCP and OASAS have continued a close partnership sharing training resources and merging systems for accessing NRT through the quitline and for other resources.

GAINING SUPPORT

All of the states used educational outreach programs to help bring both evidence-based and practical information to mental health, substance use, and tobacco control audiences. Each state program experienced initial skepticism and often outright resistance to early proposals for introducing smoke-free policies and for integrating tobacco dependence treatment into mental health and substance use treatment. As a result of the education outreach, each state also experienced a ready shift in attitudes and willingness to collaborate once information was presented, a common understanding of the problems emerged, and information about how other programs found solutions was shared.

Education sessions presented during meetings at individual facilities, as part of larger conferences, via conference calls, or accessed online all helped increase acceptance and support. The state programs found perhaps the most effective approach to be a peer-to-peer forum in which professionals listen to and learn from each other.

TRAINING PROGRAMS

All four states found that training programs were needed and each provided training tailored to their audiences. An important training message is that the behavioral and counseling skills used by mental health and substance use professionals easily translate for use in tobacco dependence treatment. Additional training needs include instruction on appropriate assessment steps and how to integrate tobacco dependence treatment into case management and group based treatment plans. For example, the Colorado training is focused on training quitline staff as well as integrating tobacco dependence treatment into community wellness group programs. Training in Wisconsin, New York, and Indiana, helps integrate tobacco treatment into individual treatment plans (See Section 3 for links to training resources).

SEPARATE TRAINING FOR PRESCRIBERS

Each state found that prescribers need a separate training to better understand: 1) the effect of smoking cessation on psychiatric medications, 2) how to prescribe the smoking cessation medications for patients with a variety of diagnoses, and 3) how to assess withdrawal symptoms verses. adverse drug events in their patients attempting to cut down or quit smoking.

EFFECT OF SMOKING CESSATION: The tars in tobacco smoke can change the metabolism of a variety of medications including some psychotropic medications. When tobacco users initially quit, their blood levels of these medications can rise, *increasing* the risk of adverse events seen with higher doses, even if dose levels remain constant. At the same time, patients trying to quit or reducing use will be experiencing common withdrawal symptoms. To the extent possible prescribers will need to try to distinguish expected withdrawal symptoms from potential medication toxicity. To do so, prescribers need to know which medications are most likely to be affected (see chart on page 12 of the Resource Guide) and to be prepared to monitor symptoms and make dose adjustments if needed.

Prescribing stop smoking medications for specific diagnoses: Smoking cessation medications need to be tailored based on individual conditions. For example, bupropion is contraindicated in those with seizure disorders and those with any history of bulimia or anorexia nervosa due to increased seizure risk. Bupropion is also contraindicated in those with recent exposure (in the last 14 days) to monamine oxidase inhibitors (MAOIs) such as phenelzine, tranylcypromine etc. Bupropion is not approved for use in those with bipolar depression, due to potential risk of precipitation of a mixed/manic episode.[2] BEA experts advise that tobacco users with alcoholism, eating disorders and substance use disorders have experienced difficulties such as agitation and seizures using burpropion. While bupropion is not contraindicated, it is not recommended for these patients. Smokers with HIV/AIDS on highly active antiretroviral therapy (HAART) do not receive the beneficial effects of the drugs due to smoking. Also, bupropion interferes with efficacy of protease inhibitors and other medications used by people with HIV/AIDS.

Nicotine nasal spray is not recommended for those with a history of abusing drugs intranasally. The safety of varenicline, the newest tobacco cessation medication, has not been well established for persons with mental illness. While our experts reported positive initial results with varenicline, post marketing adverse behavior and mood changes including suicidal ideation and suicide attempts have been reported. Because it is unclear if these events are drug related, close monitoring of clients on varenicline is recommended.

MEDICATION ACCESS ISSUES

Clients with MI/SUD are more highly nicotine dependent and every state program recognized the need for easy access to cessation medications to treat withdrawal. In New York, the lack of access to medications for clients in recovery programs was identified as a substantial barrier to moving forward with their program. In response, the New York Tobacco Control Program agreed

2 Wellbutrin XL United States Package Insert, 2007

to fund access to medications for these clients. In other states, clients find medications through state-funded quitlines, or through their insurer, especially through Medicaid programs. The Medicaid programs in each of these four states cover smoking cessation medications as do Medicaid programs in most states, although there are some limits on specific medications covered, and duration of treatment. Clients need information and often help with the specific steps that will link them more directly with Medicaid covered smoking cessation medications.

REIMBURSEMENT AND PROGRAM SUSTAINABILITY

Each program acknowledged that their program sustainability was linked to reimbursement. Once training and start-up is completed, usually with funding from tobacco control programs, a transition to a more sustainable format is needed. Because so many of these clients are covered through Medicaid, each state program is exploring options for reimbursement through Medicaid. Each state has its own rules about which medications are covered and which ones need to be prescribed by a Medicaid licensed provider. If over-the-counter (OTC) nicotine replacement therapy (NRT) is covered under Medicaid, it is common to require a prescription for accounting purposes. Psychiatrists and primary care providers are licensed providers and are the ones who typically prescribe for these Medicaid clients. Compared to primary care physicians, psychiatrists may have less experience in prescribing smoking cessation medications, have patients with more complex concomitant medication issues and may benefit from provider training.

Reimbursement for behavioral counseling through Medicaid is less common. When counseling is covered, it is often restricted to licensed healthcare providers. Because mental health and substance use services are funded separately from medical services, reimbursement for providers of medical services does not overlap with reimbursement for mental health and substance use providers. One solution is for Medicaid programs to expand the providers that can be reimbursed under medical coverage, since this is how most tobacco dependence treatment is presently covered. For example, in Indiana, Medicaid will reimburse any Medicaid licensed provider if tobacco dependence treatment falls within their scope of practice. Another solution is to include reimbursement for tobacco dependence treatment as part of mental health and substance use services. For example, in Colorado, certified addictions counselors can bill Medicaid for tobacco dependence treatment under the inhalant provision of addictions treatment.

SUMMARY

Establishing strategic partnerships between tobacco control, mental health, and substance use programs can lead to funded integration projects. Resistance to integrating treatments and smoke-free policies is common. Educational outreach to mental health and substance use providers helps build support and promotes collaboration. Training (and treatment) for staff members is necessary. Existing behavioral skills are readily applied for tobacco dependence treatment. Separate training is needed for prescribers, especially for psychiatrists who may be less familiar with tobacco cessation and tobacco cessation medications.

Easy access to stop smoking medications is necessary. Many smokers with mental illness and substance use disorders are covered under state Medicaid programs and most state Medicaid programs cover stop smoking medications. Changes in the administration of Medicaid pharmacy benefits may be needed to facilitate reimbursement for prescribers of mental health and substance use services.

COLORADO

COLORADO STATE TOBACCO EDUCATION AND PREVENTION PARTNERSHIP (STEPP) MENTAL HEALTH DISPARITIES PROJECT

PARTNERSHIP DEVELOPMENT

The Colorado State Tobacco Education and Prevention Partnership (STEPP) is situated within the Colorado Department of Public Health and Environment. STEPP is currently funded through revenue from tobacco taxes. The STEPP program provides tobacco control leadership in Colorado by mobilizing organizations and individuals to work together to support tobacco-free lifestyles and environments.

STEPP's program goals are to prevent youth from starting to use tobacco; help people who use tobacco to quit; assist in the reduction of and protection from secondhand smoke; and reduce tobacco use among groups that are disproportionately affected and/or at high risk. STEPP identifies 10 disparate groups that receive attention and funding for programs: African-Americans, Latinos/Latinas, Asian-Americans/Pacific Islanders, Native Americans, people in treatment for substance abuse, people in treatment for mental illness, people with disabilities, spit tobacco users, the gay, lesbian, bisexual, transgender community, and persons with low socioeconomic status.

In 2001, the tobacco control program, funded at that time by proceeds from the Master Settlement Agreement, conducted a population based survey to better understand what the tobacco issues were in Colorado and to identify needs and gaps in services. This survey revealed a significant need among disparate populations and separate needs assessments were funded for six of these populations, including persons with mental illness. During this same time, a statewide strategic planning workgroup was convened with subgroups working on strategic planning for disparate populations. As the survey work and strategic planning was getting underway, Colorado experienced a budget crisis and the tobacco control MSA funding was cut by over 90%. Because of the severe funding restrictions, a decision was made to discontinue the tobacco disparities needs assessments and strategic planning.

In November, 2004 Colorado voters approved a constitutional amendment to increase the tobacco tax by $.64. The amendment included language allocating 16% of the new revenue to the Department of Public Health and Environment for the Tobacco Education, Prevention and Cessation Grant Program and further stipulating that at least 15% of that funding be used to address tobacco use disparities. During this time, the Centers for Disease Control and Prevention was also awarding grants to states to engage in strategic planning projects to address tobacco disparities. Colorado applied for and was awarded one of these grants and used the funding to help facilitate a strategic planning process. The strategic planning process included a workgroup with representatives from the University of Colorado, Department of Psychiatry. The UCD psychiatry group was subsequently funded to complete the needs assessment and strategic plan for persons with mental illness.

PLANNING PROCESS

The University of Colorado Denver Department of Psychiatry group brought together a team to develop and administer the needs assessment and to propose a strategic plan. Based on the needs assessment, the primary goal of the strategic plan is to integrate tobacco dependence treatment into mental health settings. The primary means of integration is to provide eductional outreach, training, and technical support. These activities were undertaken, by the University of Colorado, Denver, Behavioral Health & Wellness Program (BHWP).

BHWP team members also participated on the statewide tobacco disparities strategic planning work group. The goals of the strategic plan for disparate populations were integrated into the overall statewide strategic plan, helping to keep the issue of tobacco use and mental illness an ongoing priority in overall tobacco control planning.

IMPLEMENTATION PROCESS

The strategic plan was initially rolled out with an educational outreach and training program. An early outreach effort was with the Colorado QuitLine. The quitline counselors were reporting some difficulty providing services for callers with mental illness. The UCD team arranged to participate in some of the quitline counseling sessions, later developing a training program specifically for quitline counselors. Through this specific training and education program, the quitline counselors became more comfortable and skilled in responding to callers with mental illness and better able to direct them to appropriate resources.

Another early effort was the development and publishing of a training toolkit to assist providers of mental health services to integrate tobacco cessation interventions into treatment. The toolkit (Smoking Cessation for Persons with Mental Illness: A Toolkit for Mental Health Providers available at: http://smokingcessationleadership.ucsf.edu/Downloads/MH/Toolkit/Quit_MH Toolkit.pdf) has been widely disseminated to providers in Colorado and has been adapted for use nationally by the Smoking Cessation Leadership Center.

Site specific education and training programs have been offered to help staff in behavioral health and primary care facilities integrate tobacco dependence treatment into practice. A focus of the training programs is to show staff how they can apply their existing skills and expertise in behavioral counseling for substance abuse to address tobacco and incorporate tobacco treatment into existing treatment services (e.g. wellness initiatives). A 3-state pilot (including Colorado) is underway to test a peer-to-peer tobacco cessation model as a means of augmenting provider-driven treatment. In this pilot, persons with current or past behavioral health disorders are trained to provide cessation services to their peers.

Another focus of the training programs is to identify, train, and support internal champions who can continue to lead and help sustain the integration effort and advocate for tobacco-free policies. To that end, a new interactive tobacco-free forum for behavioral health organizations has been introduced to share innovations, information and resources. The statewide forum features perspectives from facility administration, providers, and consumers.

Equally important to implementation is the sustained effort at the state tobacco control program level. A decision was made to continue a sub-committee on disparities, which has helped bring a stronger advocacy voice to ongoing tobacco control strategic planning and funding appropriation. This, in turn, is keeping the attention on mental health disparities high on the list of priorities. Addressing priority populations affected by tobacco is now an imperative activity for agencies applying for any STEPP grants. Attention to disparate populations, including mental health, has increasingly been infused into all tobacco control programming activities with specifically tailored programming, coalitions, and networks for each disparate population.

CHALLENGES IDENTIFIED

The process of establishing tobacco-free policies and administrative policies for provision of tobacco dependence treatment is a challenge in every state, including Colorado. The Colorado team is approaching these challenges by persistent outreach and education, presenting models of how these policies can be developed and implemented, building support in each of the facilities and in the state agencies, and through the interactive forum for discussion and problem-solving. For policy change to be successful, a cultural shift needs to occur both in each facility and across the state.

Finding the resources to get started is a challenge for some facilities. In Colorado, the education, training and technical support is provided through state tobacco control funds. Models are provided for how to incorporate treatment into existing systems, including provision of medications through existing benefit coverage, including the Colorado QuitLine. (The Colorado QuitLine provides up to four weeks of free nicotine patches.) In this way, mental health facilities need few additional start-up resources to integrate tobacco treatment. Although with recent and expected budget cuts, the ability of STEPP to fully fund the QuitLine and other training/technical support may be significantly curtailed.

Reimbursement for treatment services and for medications for consumers is another challenge. Work is underway in Colorado to establish partnerships with Medicaid and other large health plans to expand options for covering persons with mental illness. While some options exist,

(e.g. substance use counselors can bill for tobacco dependence treatment, there is a once in a lifetime treatment option under Medicaid) more and better options are needed.

Many providers of mental health services are not aware of what is already covered, so these existing benefits are not being well utilized. Increasing awareness of these options is part of the ongoing Colorado educational campaign.

The BHWP training team found that psychiatrists, primary care physicians and other prescribers often need specialized training on the use of tobacco cessation medications and the effect of smoking cessation on psychiatric medications. Few of these professionals have had training on tobacco cessation and pharmacologic interventions and have unfounded fears about the use of nicotine replacement therapy or other medications. The Colorado training program has carved out a specific training for prescribers and offers it separately from the more general training provided for other staff.

LESSONS LEARNED

1. Start with the data and information that you have for your state. It is difficult to ignore the need for action when looking at the tobacco use prevalence rates for this population and the lack of access to services. Persons with mental illness are clearly a disparities group.
2. Set aside funding for the needs assessments and strategic planning for how to get services to agencies and organizations.
3. Help institutionalize a focus on disparities. Including language in the legislation now obliges the state tobacco control review committee to make sure that funding goes to disparately affected populations. Through institutionalization, discussion is supported by funding.
4. Make sure there is a sustained planning process. The Colorado strategic planning process brought organizations together that don't usually collaborate. This broadens the investment made by multiple groups and facilitates getting the program underway. Colorado made the mistake of stopping the process just as it was getting underway when funding was cut in 2002. It is important to keep people involved. The ongoing advisory committee on disparities keeps the issue in the forefront. The advocacy and recommendations from this group are a driving force, asserting the community need for tobacco prevention and cessation.
5. Build support across facilities and agencies. Education outreach and training help to prepare facility staff to undertake implementation.

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REACHING SMOKERS WITH MENTAL ILLNESS AND SUBSTANCE USE DISORDERS IN INDIANA

PARTNERSHIP DEVELOPMENT

The Indiana Tobacco Prevention and Cessation Program (ITPC) is funded through the Indiana Tobacco Use Prevention and Cessation Trust Fund, established with proceeds from the Master Settlement Agreement. The ITPC is directed by an Executive Board whose vision is to significantly improve the health of "Hoosiers" and to reduce the disease and economic burden that tobacco use places on Hoosiers of all ages. The Executive Board allocates resources from the Trust Fund to support six goals:

- Change the cultural perception and social acceptability of tobacco use in Indiana
- Prevent initiation of tobacco use by Indiana youth
- Assist tobacco users in cessation
- Assist in reduction and protection from secondhand smoke
- Support the enforcement of tobacco laws concerning the sale of tobacco to youth and use of tobacco by youth
- Eliminate minority health disparities related tobacco use and emphasize prevention and reduction of tobacco use by minorities, pregnant women, children, youth and other at-risk populations.

As part of the strategic plan, ITPC has undertaken a major and successful statewide initiative to promote 100% tobacco free hospital campus policies across the state. With 75% success for this initiative and the emerging national information on the problem of tobacco use among persons with mental illness and substance use disorders, the ITPC began to establish new goals within the strategic plan for establishing smoke-free policies and treatment services in the facilities serving these populations.

The ITPC regularly issues a request for proposals (RFP) to help implement its strategic plan. Knowing that any initiative in Indiana with the mental health community would require a partnership with mental health organizations, ITPC reached out to the Smoking Cessation Leadership Center (SCLC) to help identify potential partnerships with mental health organizations in Indiana that could respond to the then current RFP. The SCLC helped link the ITPC with the Indiana-based organization for Mental Health America. Through this connection, the ITPC proactively helped the Mental Health America Indiana (MHAI) develop a proposal to establish a strategic plan for the mental health community in Indiana.

Through this process the MHAI proposal was funded and the "Rethink Tobacco" project was launched. The partners in Rethink Tobacco include local & state health department, MHAI chapters, local mental health centers, Clarian Health, and the Division of Mental Health & Addictions.

At the same time, Clarian Health, in partnership with Affiliated Service Providers of Indiana, Inc. (ASPIN), submitted a proposal to offer provider training and systems change technical support for ASPIN's behavioral health provider network. ASPIN is a non-profit organization that offers access to clinical providers in over 50 locations throughout the state of Indiana to develop, promote, and provide quality, cost effective behavioral healthcare services throughout a network of qualified providers.

PLANNING AND IMPLEMENTATION

Between these two projects, an informal but active grassroots "Mental Health Collaborative" has emerged involving representatives from a variety of mental health and substance use agencies. The Rethink Tobacco project has helped to assess provider knowledge, attitudes and beliefs and has established steering and stakeholder committees. Bringing Indiana Along, a project of Clarian Health, has offered educational presentations for providers, presentations on the need for systems changes and the steps to succeed, technical support to assist organizations with sys-

tems changes, and a monthly peer-to-peer conference call. Collectively, the Collaborative then helps to link organizations together, sharing information and resources and, through the lobbyists in various agencies, offers advice and direction to advocate for policy and legislative changes. ITPC is working to expand the early development of the Collaborative and to help continue the funded projects to continue development of a strategic plan for mental health and technical assistance. ITPC is also working collaboratively with the Indiana Division of Mental Health & Addictions, a long-time partner, who independently set goals for all state mental health hospitals to adopt tobacco-free policies.

The momentum from the Division of Mental Health & Addictions has had an impact, significantly increasing policies adopted by local mental health centers. ITPC is helping add to the momentum by requiring that all ITPC local grantees include activities promoting tobacco-free policies. This requirement is not specific to community health centers and mental health facilities, but local grantees are encouraged to include working with these facilities in their work plans. This requirement is based on the statutory mission of ITPC who is responsible for meeting the needs of those most disparately impacted by tobacco use in Indiana. Because there has been substantial progress with smoke-free policies in Indiana, all local grantees will eventually be working on policies for these facilities.

CHALLENGES IDENTIFIED

The projects in Indiana are in their early stages and are just beginning to move into the "new frontier" of integrating services. Although meetings and discussions are underway, more discussion and education is needed to continue building momentum and promoting change. There have been several "shining stars" that are modeling changes to tobacco free grounds. Sharing the process of making changes in these agencies is also helping other agencies to move forward.

Until now, ITPC has primarily focused on policies restricting second hand smoke. With the move towards changing smoke-free policies in mental health and substance use treatment facilities, ITPC is addressing the simultaneous need to provide more tobacco dependence treatment services for both staff and clients. Robust quitline services are more recently available but funding for more cessation services is limited. Although there is a growing need in mental health and substance use facilities for stop smoking medications, ITPC funded is limited to the starter kits provided through the Indiana quitline.

The Medicaid program in Indiana covers all FDA approved medications and provides some reimbursement for counseling by Medicaid licensed providers. ITPC is working on expanding the providers who can bill under Medicaid to include mental health and substance use service providers, helping clients access these benefits and services more seamlessly. ITPC is also exploring how the Indiana quitline can be reimbursed for providing counseling services.

Indiana has been fortunate to have a champion psychiatrist advocating for policy changes within Medicaid. This advocacy has helped to improve the benefits available to all recipients as well as those with mental illness and substance use disorders.

ITPC has encountered some resistance from consumer groups who were not included in the funding from the Master Settlement Agreement. The lingering sense of injustice creates barriers some to collaboration.

Treatment facilities initially believed that making policy and treatment changes couldn't be done. The training and technical support provided through Clarian is helping to address these barriers, providing the information and resources needed to get started. Once underway, each facility reports that making changes was much easier than expected and that even clients were quitting, which didn't seem possible.

LESSONS LEARNED

1. Everyone needs to be on board from the top of the organization down. In some organizations, the impetus came from the Human Resources department. In others, from the clinical director, or administrators who were concerned about the business case for making changes. Wherever the impetus comes from, all levels of the organization need to support the change.

2. Psychiatrists need to understand the connection between smoking and psychiatric medications. Once they understand this relationship, they are much more likely to be supportive of providing treatment.

3. Good staff training is important for successful integration. Mental health and substance use providers already have the necessary skills and techniques, they just need to apply them yet to tobacco treatment. Once this is emphasized, tobacco dependence treatment is more easily incorporated.

4. When treatment providers are helped to reframe "smoking cessation" as "tobacco dependence treatment," it is easier for them to see how tobacco dependence treatment is a natural and equal addition to substance treatment and recognize the potential for reimbursement.

5. Treatment providers need specific information about Medicaid coverage, who can bill and how to bill (e.g. correct billing codes).

6. Treatment for staff members needs to be available, preferably at the time the announcement of the new tobacco-free policy is made. In this way, the initial resistance that is common among staff can be addressed, and staff members have time to address their own dependence. It is common for staff to first want to try to quit themselves even when resources are available. Once they try, they are more likely to reach out for help.

7. Everyone starts out believing that changes will be difficult and finds it much easier than expected. The whole experience has been very rewarding.

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NEW YORK OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES: TOBACCO INDEPENDENCE PROJECT

PARTNERSHIP DEVELOPMENT WITH TOBACCO CONTROL

In July 2008, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) enacted a new regulation prohibiting smoking in all treatment facilities and on facility grounds, requiring inclusion of tobacco dependence treatment in client treatment plans, and provision of the necessary staff training.

Implementation of the policy was the result of a four-year planning process that began informally in 2003 with meetings among OASAS staff, Tobacco Control Program staff and ASAP, the organization of Alcoholism and Substance Abuse Providers. These groups met to discuss the possibility of expanding a pilot project that had been underway in Western New York in which three Addiction Treatment Centers had successfully implemented tobacco-free policies. The first step in the planning process was for OASAS to conduct a series of five forums around the state, inviting key stakeholders to discuss a proposed regulation and identify potential barriers.

OASAS

OASAS oversees the nation's largest and most diverse addiction prevention and treatment system. Its mission is to improve the lives of New Yorkers by leading a premier system of addiction services through prevention, treatment, recovery. OASAS plans, develops and regulates the state's system of chemical dependence and gambling treatment agencies. This includes the direct operation of 13 Addiction Treatment Centers, which provide inpatient rehabilitation services to 10,000 persons per year. In addition, the Office licenses, funds, and supervises some 1,300 local, community-based programs, chemical dependence treatment programs, which serve about 115,000 persons on any given day in a wide range of comprehensive services.

Two barriers emerged from these forums: 1) the need for training for all staff and 2) access to free nicotine replacement products for clients. The estimated start-up cost was $8 million over two years. With a clear plan in hand, OASAS approached the Commissioner for approval for the new regulation and the Tobacco Control Program for funding for training and NRT. The Director of the Tobacco Control Program, recognizing the opportunity to reach an important population of smokers, requested the funding from the Tobacco Control Program board. The funding request was approved with $4 million for NRT and $4 million for training over two years.

However, the then Commissioner for OASAS was not prepared to approve the new regulation and the plan was temporarily stalled. In 2007, a new Commissioner took office and immediately approved the new regulation. In July 2007, OASAS announced that the regulation would be implemented in July 2008, launching a year of preparation.

GAINING SUPPORT FROM FACILITY ADMINISTRATION AND STAFF: OUTREACH AND TRAINING

The announcement of the new regulation was met with resistance among some of the OASAS treatment providers. Like agencies in other states, many of these providers were recovering from other addictions and many continued to smoke. The new regulation challenged the addiction recovery culture that had evolved over time and challenged some accepted treatment approaches such as including tobacco use as a behavioral incentive. Despite this resistance, OASAS was firmly committed to following through on the new regulation and launched an outreach program to help build support. In the first year, OASAS staff presented to more than 4000 people, describing the rationale and answering questions. A website was also launched with resources and workbooks that could be completed for credit www.oasas.state.ny.us/tobacco/provider.

In 2007, the Tobacco Control Program $4 million training grant was awarded to the Professional Development Program at Rockefeller College at New York State University at Albany to provide statewide training and technical assistance. The Professional Development Program established The Tobacco Recovery Resource Exchange (www.tobaccorecovery.org), offering addiction professionals classroom training, technical assistance, and web resources. Five mini-grants from the Professional Development Program were awarded to other providers to conduct the training.

Before the $4 million dollar training contract began, the substance use providers who wanted to begin implementation of the regulation sought support from the Tobacco Control Program Cessation Centers. The 19 Cessation Centers located across NYS and who were training health care providers in the 5 A's protocols were able to provide training and TA to substance use providers. Once the training grant was up and running in 2008, Cessation Centers began referring substance use providers to the Professional Development Program.

ACCESSING MEDICATIONS

Over-the-counter (OTC) Nicotine replacement therapies (NRTs) such as nicotine patches, gum, and lozenges are available to OASAS certified facilities at no cost through a contract with the New York State Department of Health, Partners in Corporate Health. Partners in Corporate Health is the agency that distributes the NRTs for the New York State Quitline. OASAS facilities set up an online account with Partners in Corporate Health and order NRT as needed. Initially, there were no limits on ordering. Because of current budget restrictions, the ordering is being monitored more closely and clients are urged to take advantage of any coverage they may have through their health insurance (e.g. Medicaid).

CHALLENGES AND SOLUTIONS

In the first six months of implementation, the Addiction Treatment Centers when through a significant adjustment. Regular communication was needed to resolve issues as the new policy became integrated into each facility.

In the first month, admissions to the facilities declined by 8%, subsequently returning to former levels. The biggest challenges were with the residential treatment facilities and the 816 medical withdrawal services centers. Stories emerged of behavior problems attributed to the new policy in both types of facilities.

To help address these problems, several steps were taken. Monthly meetings with the residential association were initiated to discuss issues and solutions. While compliance with the new tobacco policy was added to the requirements for licensing, the requirement was waived for the first 6 months and technical assistance was offered to improve implementation. At the end of the first 6 months, a decision was made to waive the requirements for an additional 6 months.

Finally, to help improve ownership of the new policy and innovation in its full implementation, the Treatment Centers were also given more latitude in the first year to experiment with alternative strategies. In two cases, the alternative strategy involved granting their clients permission to continue some smoking early in their admission, under strict guidelines, and then requiring them to quit completely. Such transition strategies have reportedly helped both staff and clients in these facilities to adjust more easily to the new policy.

The NRT program also produced some challenges. Because the packaging for the nicotine lozenges retains some of the nicotine, they are treated as hazardous waste. The addition of this packaging to the other hazardous waste generated by the centers exceeded the required limits. Once this was discovered, the nicotine lozenges were removed from the order list.

An additional challenge to the NRT program is the across the board budget cuts imposed by the state government to address their budget shortfall. This, in turn, has

reduced the funding available for the program. OASAS is working to compensate for the drop in funding by monitoring orders for NRT more closely and encouraging the Treatment Centers to work through their outpatient client insurance to cover medications whenever possible.

Finally, the training program has posed challenges. There was a lengthy delay in the start up of the training program because of administrative issues with getting the contract underway. Now underway, the training will continue through 2010, but after new funding will be needed to continue the online training once the training grant has ended.

The successful implementation in New York has generated interest in other states looking to begin the process of creating smoke-free policies and integrating tobacco dependence treatment in their addiction facilities.

LESSONS LEARNED:

- Top-level support and firm commitment was very important to counter resistance and to successfully move the policy from planning through implementation.
- Securing program and funding support from the New York State Tobacco Control Program was necessary for the initiative to move forward.
- Delaying implementation for a year and providing training and technical support helped prepare the treatment centers for implementation.
- Because the treatment centers have different circumstances and are located in different surroundings, ongoing problem-solving and adjustments helped make implementation smoother.

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WISCONSIN NICOTINE TREATMENT INTEGRATION PROJECT (WINTIP)

PARTNERSHIP DEVELOPMENT

The partnership between the Wisconsin Tobacco Prevention and Control Program and the mental health community and substance use community began as separate efforts that merged into a collaboration. Beginning in 1999-2000, leaders within the substance use and mental health communities launched a grassroots advocacy effort to bring attention to the need for integrating tobacco dependence treatment into recovery programs. As part of their advocacy, they became involved in the *Tobacco Dependence Treatment Task Force* of the state Tobacco Prevention and Control Program, promoting integration of treatment as a strategic goal. In 2002-2003, this informal advocacy effort gained momentum as members of the mental health community became involved and as several organizations representing Wisconsin addiction providers, clinicians and advocates each adopted a resolution to move forward. The resolution stated that each organization "supported policies that led to the integration of evidence-based nicotine treatment into addiction and mental health services." As a result of this resolution, these participating organizations proceeded to include integration of treatment services into their respective strategic plans.

Meanwhile, in 2001, Wisconsin was among the CDC funded pilot projects to develop a state strategic plan for addressing disparities related to tobacco. The strategic plan was developed by the *Wisconsin Tobacco Prevention and Control Disparities Strategic Planning Workgroup* including representatives from 13 separate organizations, including leaders from the mental health and substance use communities. The disparities strategic plan also called for integrating tobacco dependence treatment into treatment for mental illness and substance use disorders.

With advocacy from both the Tobacco Dependence Treatment Team and from the Disparities workgroup, the 2005–2010 Wisconsin Tobacco Control program strategic plan incorporated integration activities into their goals for eliminating tobacco related disparities.

In 2007, funding for developing a statewide integration plan was approved and the Wisconsin Nicotine Treatment Integration Project (WiNTiP) was launched in January, 2008 (WiNTiP www.wisconsinwintip.com). The goal of the WiNTiP project is to "save Wisconsin lives by integrating evidence-based nicotine dependence treatment into alcohol and other drug dependence and mental health services."

PLANNING PROCESS

The goal of the 2008 planning year was to "develop a plan that, when implemented, would increase the amount of success of nicotine dependence treatment delivered by mental health and substance abuse providers to their patients." Additional funding for 2009 was then approved to "address barriers, develop policies, plan for implementation, develop administrative code changes, develop provider training curriculum and implementation plan, develop a RFP for technical assistance, measure success of integration efforts, and develop a plan for future funding."

An important planning activity in 2008 was to gather survey data about treatment polices from agencies in 21 states, from mental health and substance use providers, and from consumers through focus groups.

Among the 21 state agencies surveyed, only 12% reported that they had not yet taken any action to integrate services. The remaining states named a range of activities including forming a committee, developing a plan, meeting with tobacco prevention leaders, offering training, funding pilot projects, and pursuing regulation changes that would support integrating services.

Among providers, one-third reported that they do not provide any treatment for tobacco dependence, about half reported that they provided treatment some or all of the time, and the remaining reported that they only provide treatment when asked.

Among consumers, getting assistance in quitting when engaged with treatment (inpatient care for example) was considered important, although they believed that assistance should be available also during non-stressful times, a variety of quit methods should be available, and that peer-to-peer assistance was highly valued.

CHALLENGES IDENTIFIED

The agencies that were surveyed identified a number of challenges they faced including determining how integration would work, how treatment would be provided, where the resources would come from, how adding tobacco dependence treatment would affect their workload, and how they would be reimbursed. There was also a belief expressed that tobacco dependence is a minor problem compared to the treatment needs for mental illness and substance abuse.

In addition to the challenges posed by the agencies, there have been challenges from the senior administration at both the agency level and the state level. Because the WiNTiP project began as more of a grassroots advocacy effort, it has taken time for administrative support to develop. Inviting more ad- ministrative representatives from the state mental health and substance use agencies to collaborate with the tobacco control committees has helped to increase higher level support.

GOALS GOING FORWARD

1. Address provider barriers identified
2. Develop smoke-free policies and plan for their implementation
3. Develop administrative code changes that mandate tobacco free facilities and tobacco dependence treatment and plan for implementation of regulations
4. Develop provider training curriculum and implementation plan
5. Develop and send out an RFP for technical support
6. Develop a proposal for a mini-grant program that encourages, recognizes and develops champions of best practices
7. Develop a proposal for meaningful consumer roles for integration
8. Plan to measure the success of integration efforts
9. Develop a plan for securing funding for ongoing years from grant and government sources
10. Develop a public/private plan for helping those with mental health and sub stance dependence disorders under the care of a primary care physician rather than a specialist

LESSONS LEARNED

1. Gain top level support. Grassroots advocacy is important in helping move the initiative forward. But, top down administrative support is necessary to achieve the policy changes and resources necessary for integration to occur.
2. Provide education and outreach to gain administrative support. Outreach can mean going to organizations to deliver information or inviting representatives from organizations to come to programs and forums for information and networking. Participating in these programs can empower people to return to their organizations with the information and tools necessary to start the integration process. It also helps to do outreach at both the bureau chief level and practitioner levels. Identifying "early adaptors" and helping to support them as champions in their organizations, will help them advocate for changes among their colleagues.

3. Support clinician champion leaders in each setting. In order to effectively integrate treatment, some expertise in tobacco dependence is needed in each setting. In this way, for example, people receiving outpatient services will have access to tobacco dependence treatment while being seen in the mental health clinic rather than being referring to their primary care provider.
4. Having a champion as a consultant to other clinicians helps develop skills and confidence, especially with complex patients. Having an "expert" provide integration of treatment facilitates integration process.
5. Work towards sustainability of the program, looking for funding beyond the tobacco control program funding. This can be facilitated through more engagement of the mental health and substance use agencies, and working through the state regulatory process to improve reimbursement.

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TOOLKITS

BEA Resource Guide (2008): 60 page PDF document that includes research recommendations and clinical advice for adapting services in tobacco dependence treatment pro-grams,tobacco quitlines,mental health treatment programs,substance use treatment programs,and primary care settings.Available at http://www.tcln.org/pdfs/BEA_Resource_Guide-web.pdf

BEA Resource Guide Summary (2008): 9 page PDF summary of highlights from the Resource Guide.Available at http://www.tcln.org/pdfs/BEASummary-Web.pdf

Smoking Cessation for Persons with Mental Illness: A Toolkit for Mental Health Providers (2009). Developed by the University of Colorado, School of Medicine and revised for nation-wide use to meet the needs of a broad continuum of behavioral health providers and clinicians. http://smokingcessationleadership.ucsf.edu/Downloads/catolgue/MHtoolkitJan_2009.pdf

Tobacco-Free Living in Psychiatric Settings: A Best-Practices Toolkit Promoting Wellness and Recovery (July 2007, Updated September 2007). Developed by the National Association of State Mental Health Program Directors (NASMHPD). Provides practical tips for converting facili-ties to smoke-free status.Available at: http://www.nasmhpd.org/general_files/publications/NASMHPD.toolkitfinalupdated90707.pdf

Tobacco Treatment Toolkit for Substance Abuse Treatment Providers (2009). Educates substance abuse professionals about specific guidelines to use in reducing tobacco use among people in treatment for substance abuse disorders. Developed by Tobacco Use Recovery Now! (TURN), a project of Signal Behavioral Health Network.Available at: http://www.cohealth-providers.com/data/files/STEPP%20SAToolkit.pdf.

TRAINING AND TECHNICAL ASSISTANCE RESOURCES

New York State Tobacco Dependence Resource Center aims to provide New York's chemical dependency service providers, policy makers, and researchers with cutting-edge scientific resources and support on integrating tobacco dependence interventions into chemical depend-ency treatment. www.tobaccodependence.org/.

Meeting the Challenge of Tobacco Cessation for Persons with Mental Illness and Substance Use Disorders. Online CME program sponsored by the Tobacco Cessation Leadership Network.Website: www.tcln.org

Smoking Cessation Leadership Center (SCLC).The SCLC website provides a list of mental health resources, including a series of powerpoint presentations to the Substance Abuse and Mental Health Services Administration (SAMHSA) and a toll free number for technical assistance 1-877-509-3786. http://smokingcessationleadership.ucsf.edu/.

SANE Australia. SANE Australia is a national charity working for a better life for people affected by mental illness Website includes a factsheet about smoking and mental illness with a link to the SANE smoke-free Kit. http://www.sane.org/; http://www.sane.org/information/factsheets/smoking_and_mental_illness.html

Tobacco Recovery Resource Exchange is the online training and technical support resource for the New York Office of Alcoholism and Substance Abuse Services (OASAS) Tobacco Independence program. www.tobaccorecovery.org

WiNTiP for WiNTiP resources visit www.wisconsinwintip.com. For the full WiNTiP story visit: http://web.mac.com/creativerep/WiNTiP_Site_1/Blog/Entries/2009/6/23.html

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Clinical Solutions for Providing Tobacco Dependence Treatment for People with Mental Illness and Substance Use Disorders & Treating Persons with MI/SUD on Quitlines. TCLN Roundtable Discussion Topic, *Clinical Solution in Providing Tobacco Dependence Treatment for People with MI/SUD*, held on April 16 & 17, 2008. Available at: http://www.tcln.org/schedule/docs/041608/conf_call-presentations.pdf

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Tobacco Dependence Treatment Programs and Specialist Training. TCLN Roundtable Discussion Topic, *Tobacco Free Policy Issues and Adapting Tobacco Treatment Programs*, held on May 1 & 19, 2008. Available at: http://www.tcln.org/schedule/docs/050108/TobaccoDependenceTreatmentPrograms_SpecialistTraining.pdf

The Evolution of the NYS Tobacco-Free Initiative – How We Got There and What Happened After July 24, 2008. TCLN Roundtable Discussion Topic, *Implementing Statewide Tobacco Dependence Treatment Programs for Persons with Mental Health and Substance Use Disorders*, held on April 16, 2009. Available at: http://www.tcln.org/schedule/docs/041609/NYS_TobaccoFreeInitiative.pdf

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Smoke Alarm: The Truth About Smoking and Mental Illness (2007): The New York State Department of Health funded a project conducted by the Clubhouse of Suffolk, Inc., a private not-for-profit psychiatric rehab agency to tailor intervention for patients who struggled with tobacco addiction. The outcomes of the project are documented in the video. http://www.clubhouseofsuffolk.org/SmokeAlarm.cfm

WEBSITES

Centers for Disease Control and Prevention, Office on Smoking and Health. The CDC Office on Smoking and Health website has many free tobacco use prevention and cessation resources for professionals and clients, including posters, videos/DVD's, and pamphlets. Many materials are available in Spanish. www.cdc.gov/tobacco/

Consumers Helping Others Improve their Condition by Ending Smoking (CHOICES). The goal of this consumer driven organization is to increase awareness of the importance of addressing tobacco use and to create a strong peer support network that encourages mental health consumers to make a positive healthy lifestyle change by addressing smoking and tobacco use. Website: www.njchoices.org/index.htm.

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Program for Research in Smokers with Mental Illness (PRISM). This research program is directed towards understanding reasons for the high rates of tobacco use among individuals with major psychiatric disorders. Website: http://prism.yale.edu/.

North American Quitline Consortium (NAQC). The NAQC website provides information about quitline services available in all 50 states, the District of Columbia, Canada, and Mexico. Website: www.naquitline.org.

UMDNJ Tobacco Dependence Program (TDP) The tobacco dependence program is dedicated to reducing the harm to health caused by tobacco use. The TDP particularly aims to provide expertise on quitting smoking for those who need it most and has several resources for tobacco users with mental illness and substance use disorders. Website: www.tobaccoprogram.org.

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BRINGING EVERYONE ALONG FACTSHEET

WHAT IS THE RATIONALE FOR INTEGRATING TOBACCO DEPENDENCE TREATMENT INTO TREATMENT FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS?

- There is a demonstrated interest in quitting across populations.
  - 75% of clients believe tobacco treatment should be offered while in addictions treatment.[1]
  - 50% - 77% of clients in substance abuse treatment expressed interest in quitting.[2]
  - 79% of depressed smokers reported an intention to quit; 24% within 30 days.[3]
  - 75% of clients in a substance abuse facility accepted an offer for smoking cessation treatment.[4]
- Research is showing that treating tobacco use does not jeopardize stability of primary disorder or recovery.
  - Does not negatively affect abstinence from other substances. [5, 6, 7, 8, 9, 10, 11, 12]
  - Combining smoking cessation with other substance abuse treatment has been associated with a 25% greater likelihood of long-term abstinence from alcohol and other drugs.
  - Mental health symptoms do not worsen and may actually improve as individuals attempt to quit.[13, 14, 15]
- Treatment for tobacco dependence uses similar treatment/relapse prevention techniques.
  - Harm reduction approaches
  - Habit reversal and other cognitive-behavioral strategies
  - Importance of support systems
  - Stages of Change framework: factors affecting initiation, abstinence, and relapse to the use of tobacco, alcohol, and opioids are similar in nature.
  - Acknowledge and work with ambivalence

WHAT ARE THE CHALLENGES IN PROVIDING TOBACCO DEPENDENCE TREATMENT?

- Neurobiological factors reinforce the use of nicotine.
  - May increase tendency to use nicotine, make it more difficult to quit, and complicate withdrawal. "Self medication" with nicotine.
  - In the short term, nicotine enhances concentration, information processing, learning and mood. Nicotine may also reduce psychiatric medication side effects. Together, creates greater vulnerability for dependence
- Clients with mental illnesses and substance use disorders may feel excluded from mainstream cessation programs.
  - Staff in mainstream tobacco treatment programs typically do not have specific training and may be uncomfortable with working with these individuals.
  - Tobacco treatment programs may not address coexisting behavioral health disorders.
  - Written materials may be too complicated for those with cognitive deficits.
- Lower rate of quit attempts in the past
  - These persons have often not been advised to quit or provided opportunities to quit.
  - In many cases, they were actually told that smoking would help them.
- Higher tobacco relapse rates than in general population.

WHAT ARE THE BENEFITS IN PROVIDING TOBACCO DEPENDENCE TREATMENT?

- Addressing tobacco use is pro-recovery and pro-wellness; BENEFITS patients, clients and consumers.
  - Emerging evidence that morbidity is reduced.
  - May enhance abstinence from other substances.
  - Reduced financial burden.The average cost for smokers is about $2,000 per year. Disabilities benefits often do not even cover monthly rent and food.
  - Reduction in psychiatric medication burden. Smoking induces CYP1A2 isoenzyme, approximately doubling clearance of some psychiatric medications. Quitting smoking can decrease doseages needed and side effects.
  - Increased self confidence. Self-efficacy around health may generalize to other areas of life.

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A PROJECT OF THE TOBACCO CESSATION LEADERSHIP NETWORK

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