Welcome

Please stand by. We will begin shortly.

8 and Counting: SAMHSA State Academies for Smoking Cessation Foster Change

Tuesday, September 24, 2013 · 2pm Eastern Time (90 minutes)

Housekeeping

- All participants will be in **listen only mode**.
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8 and Counting: SAMHSA State Academies for Smoking Cessation Foster Change

Webinar objectives

- Learn about the Leadership Academy State successes and challenges in reducing the prevalence of tobacco use within the behavioral health field
- Examine recent state tobacco treatment and prevention policies and the strategies used for implementation
- Identify two tobacco dependence treatment training programs for behavioral health providers available for use
- Examine the evaluation of two statewide behavioral health tobacco use reduction projects and understand the important role data plays in creating change
- Understand the importance of peer participation in tobacco dependence treatment

Moderator

Jennifer Matekuare

- Operations Manager, Smoking Cessation Leadership Center, University of California, San Francisco
- **jmatekuare@medicine.ucsf.edu**

Agenda

- **Welcome**
  - Jennifer Matekuare, Operations Manager, SCLC, moderator
- **Update on SAMHSA and HHS**
  - Doug Tipperman
- **Special Introduction on Smoking and Behavioral Health**
  - Steven A. Schroeder, MD
- **Presentations from the 8 State Academy Representatives**
  - **Provider Education**
    - Stephen Michael, MS (Arizona)
    - Margaret Brake, MHA (North Carolina)
  - **Peers and Priority Populations**
    - Kimalesha Brown, MPPA (Mississippi)
    - Rebekah Young, MPA, CHES (Mississippi)
    - James Allen, MPH (Oklahoma)

Agenda (cont.)

- **Presentations from the 8 State Academy Representatives**
  - **Policy**
    - Julie Meyer, MPS (Arkansas)
    - William T. Wilson, DrPH (Texas)
  - **Evaluation**
    - Carlo DiClemente, PhD (Maryland)
    - Dawn Berkowitz, MPH, CHES (Maryland)
    - Gregory Miller, MD (New York)
- **Questions and Answers**
- **Closing Remarks**

Disclosure: Faculty speaker, moderator, and planning committee members have disclosed no financial interest/arrangement or affiliation with any commercial companies who have provided products or services relating to their presentation or commercial support for this continuing medical education activity.

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Welcome from SAMHSA

Doug Tipperman, MSW

- Lead Public Health Advisor, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration (SAMHSA)

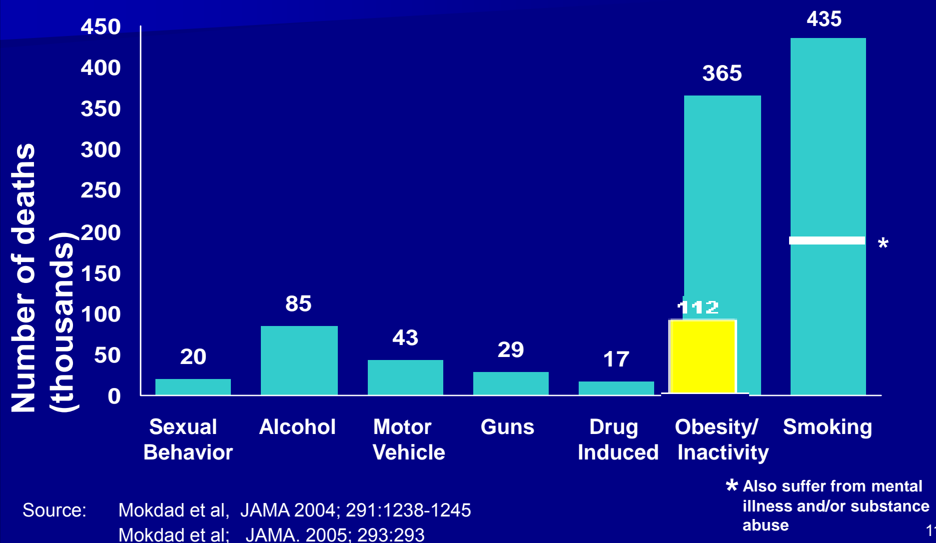
Special Introduction on Smoking and Behavioral Health

Steven A. Schroeder, MD

- Director, Smoking Cessation Leadership Center
- Distinguished Professor of Health and Health Care, Department of Medicine, UCSF

Tobacco's Deadly Toll

- 443,000 deaths in the U.S. each year
- 4.8 million deaths world wide each year
- 10 million deaths estimated by year 2030
- 50,000 deaths in the U.S. due to second-hand smoke exposure
- 8.6 million disabled from tobacco in the U.S. alone
- 45.3 million smokers in U.S. (78% daily smokers, averaging 15 cigarettes/day, 2010)



Smoking and Mental Illness: The Heavy Burden

- 200,000 annual deaths from smoking occur among patients with CMI and/or substance abuse
- This population consumes 40% of all cigarettes sold in the United States
  - -- higher prevalence
  - -- smoke more
  - -- more likely to smoke down to the butt
- People with CMI die earlier than others, and smoking is a large contributor to that early mortality
- Social isolation from smoking compounds the social stigma

Today's speaker

Stephen Michael, MS

- Director, Arizona Smokers' Helpline (ASHLine)

Everyone can quit.

You can help.

We can show you how.

Provider Training in Mental Health Settings in Arizona

Stephen S. Michael, MS
Director, ASHLine

Context

2010 ASHLine Funded through CPPW funds to work with behavioral health providers to adopt policy that makes referrals to quitlines standard operating procedure (SOP).

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Context

Combined effort:

Arizona Dept of Health Services Bureau of Tobacco and Chronic Disease:

Division of Behavioral Health Services;

University of Arizona's ASHLine;

Magellan Healthcare;

Community Partnership of Southern Arizona.

Tobacco Free Arizona

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Core Components

Reduce the impact of persistent myths about tobacco and those with mental illnesses through:

- Provider education
- Peer involvement and persuasion
- Policy change to include 2 A's & R
- Culture change (tobacco-free agencies)

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Provider Training

Two trainings with Dr. Jodi Prochaska:

- Front line staff in behavioral health facilities
- Prescribers in behavioral health facilities

Onsite trainings with the ASHLine Referral Development team:

- Focus on 2 A's & R plus policy change

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Two Models

- Magellan Healthcare followed a true systems change model:
  - Built a stop measure into the EHR;
  - Measure is a 2A's & R (Ask, Advise, Refer);
  - Required all funded agencies to use the EHR.
- CPSA used an individual agency model:
  - Medical directors designed and implemented the model in collaboration with the ASHLine.

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Thank You

Stephen S. Michael, MS
Arizona Smokers' Helpline (ASHLine)
Zuckerman College of Public Health
University of Arizona
(520) 320-6819
smichael@email.arizona.edu

THE UNIVERSITY OF ARIZONA.
Mel and Enid Zuckerman College of Public Health

Today's speaker

Margaret Brake, MHA

- Acting Team Lead for the Prevention and Early Intervention Team, Division of Mental Health, Developmental Disabilities, & Substance Abuse Services, North Carolina Department of Health & Human Services

Provider Training: Breathe Easy, Live Well

Margaret Brake, MHA
NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, DHHS

Breathe Easy, Live Well

- 15 week program – focus on wellness and smoking cessation
- Developed by the Southeastern Regional AHEC and the NC Health and Wellness Trust Fund
- Originally piloted in NC Clubhouses (PSRs)
- Evaluated by the UNC Tobacco Prevention and Evaluation Program

Breathe Easy, Live Well Results

- Clubhouse staff and members viewed the groups as effective, beneficial, and successful
- Staff reported new policies limiting tobacco use, and participating members reported substantial interest in tobacco-free spaces and quitting or reducing tobacco consumption at the end of the program.
- Participating members also reported high levels of knowledge about the harms of tobacco use and the perception of increased discussions about tobacco with medical providers

Breathe Easy, Live Well Expansion

- Trained 25provider staff in BELW curriculum and implementation strategies in March 2013
- Training focused on Tobacco and Mental Health; Sociological, Behavioral and Biological Components of Tobacco Dependence; FDA Approved Pharmacotherapy; BELW Toolkit; Motivational Interviewing & Stage-Wise Treatment
- Division of Public Health developing a BELW module based on the curriculum that will become the sixth module to an online tobacco dependence treatment training that will be piloted with SA treatment providers

Breathe Easy, Live Well Expansion

- Program will be piloted and evaluated in group home settings over the next year
- Staff will be available to provide training and technical assistance to implement the program in group homes and clubhouses
- Group Homes Pilot is an initiative under NC's state leadership academy

Breathe Easy, Live Well
Contacts For More Information

- Margaret Brake, NC DHHS
  Margaret.Brake@dhhs.nc.gov
- John Bigger, SR AHEC
  John.Bigger@sr-ahec.org
- Olaunda Green, Governor's Institute on Substance
  olaundagreen@att.net

Today's speaker

Mississippi State Department of Health
Office of Tobacco Control

Kimalesha Brown, MPPA

- Special Projects Officer, Office of Tobacco Control, Mississippi State Department of Health

Today's speaker

Institute for Disability Studies

Rebekah Young, MPH, CHES

- Health Educator/Researcher for the Tobacco Control Strategies Project for Mississippians with Disabilities, Institute for Disability Studies, The University of Southern Mississippi

Outreach and Consumer Education

- Representatives from service groups and consumer advocacy groups, government agencies, and the community
- Connect with peers to provide tobacco education
- "Nothing About Us Without Us"

Getting the Word Out

- Identify all consumer advocacy and services organizations
- One-Page Fact Sheet
- Resource Directory
- Annual consumer newsletter

The Fact Sheet

Tobacco Facts and Resources for Mississippi's Mental and Behavioral Health Consumers

Did you know...?

- Every year, 443,000 people in the U.S. die from smoking.
- These deaths can be prevented.
- 200,000 of the 443,000 people in the U.S. who die from smoking every year have mental illness and/or a substance abuse disorder.
- In 2011, almost 44 million people in the U.S. smoked cigarettes.
- Every year, 50,000 people in the U.S. who do not smoke die because they breathe in smoke from other people's cigarettes.
- People with mental illness smoke almost 31% of all the cigarettes made in the U.S.
- 40% of all the cigarettes made in the U.S. are smoked by people who have mental illness and/or a substance abuse disorder.
- 1 out of every 3 people with mental illness smokes cigarettes. 1 out of every 5 people without mental illness smokes cigarettes.
- People with mental illness smoke more cigarettes than people without mental illness and are less likely to quit smoking.
- People with mental illness or substance abuse disorders usually die 5 years earlier than people without these disorders.
- Up to 75% of people with serious mental illness and/or substance abuse disorders smoke cigarettes.
- 30-35% of people who provide mental health and substance abuse treatment services smoke.
- 12% of people in the U.S. who smoke say that they also use illegal drugs. 5% of people who do not smoke say they use illegal drugs.
- People who smoke cigarettes are more likely than people who do not smoke to drink alcohol.
- Even though we hear that people with mental illness and/or substance abuse disorders do not want to quit smoking, it is **NOT** true! They want to quit and want to get information that can help them quit.
- In one study, 52% of cocaine addicts, 50% of alcoholics, and 42% of heroin addicts said they wanted to quit smoking when they started getting treatment for their other addictions.

Is that true?[12]

- MYTH: Tobacco use is seen as a necessary self-medication.
- FACT: It is not. The tobacco industry has supported this myth.
- MYTH: People with mental health disorders and/or addictions aren't interested in quitting.
- FACT: The same percentage wishes to quit as in the general population.
- MYTH: People with mental health/addictions can't quit.
- FACT: The quit rates are the same or slightly lower than the general population.
- MYTH: Quitting worsens recovery from the mental illness.
- FACT: Quitting does not hurt recovery.
- MYTH: Tobacco is a low-priority problem.
- FACT: Smoking is the biggest killer for those with mental and/or substance abuse disorders.

Want more information or need help quitting?

Here are some resources in our state that can help:

- ACT Centers—Provides tobacco education, prevention and treatment and conducts research to learn more about helping people quit using tobacco
  http://act2quit.org/
  1-601-815-1180
- Generation Free—Program for students in grades 7-12 that promotes living a tobacco free life
  http://www.generationfree.com/
  1-601-420-2414
- Healthy Opportunity for Transition (HOT)—Program that provides education and support to help youth with disabilities learn to live independently
  http://www.lifeofms.com/what-we-do/healthy-opportunity-for-transition/
  1-601-969-4009 **Voice or TDD:** 1-800-748-9398
- Institute for Disability Studies (IDS)—Provides programs and connections to resources that can help make life better for Mississippians with disabilities
  http://www.usm.edu/disability-studies
  1-601-266-5163 **TTY:** 1-(888) 671-0051
- Mississippi Tobacco Free Coalitions—Provides tobacco education, promotes services to help people quit, and encourage communities to be smoke-free
  http://www.tobaccofreems.org/
- Mississippi Tobacco Quitline—Provides telephone and online support to any Mississippian ready to quit using tobacco
  http://www.quitlinems.com/
  1-800-QuitNow (1-800-784-8669)
- Reject All Tobacco (RAT)—Program for children in grades K-6 that provides education about the harmful effects of smoking and how to make healthy decisions
  http://www.gorat.com/
  1-601-991-6050
- Tobacco Control Strategies for Mississippians with Disabilities—Program at IDS that provides support and education to individuals with disabilities who are interested in quitting
  http://www.usm.edu/disability-studies/tobacco-control-strategies-mississippians-disabilities
  1-601-266-5163 **TTY:** 1-(888) 671-0051

Today's speaker

James Allen, MPH

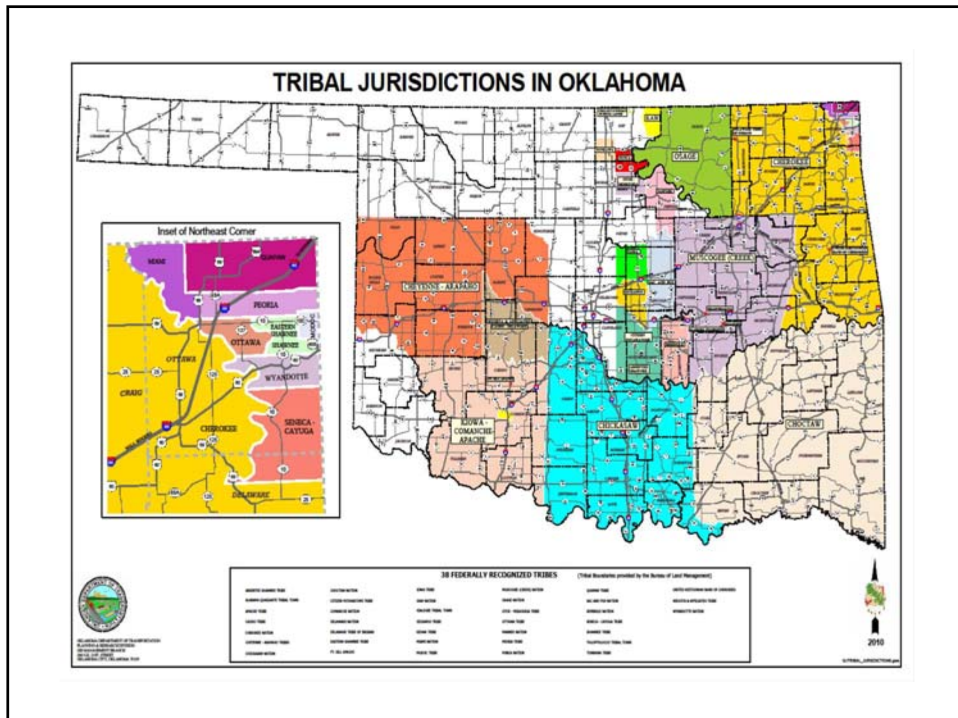
- Cessation Systems Coordinator,
  Center for the Advancement of Wellness,
  Oklahoma State Department of Health

Tobacco Cessation among American Indian People of Oklahoma

James Allen, MPH
Center for the Advancement of Wellness
Oklahoma State Department of Health

American Indian Tribes in Oklahoma

- Diversity of tribes as a result of forced removal from their homelands in other regions of the U.S.
- Oklahoma Tribal Nations do not live on reservations (except for the Osage Nation) but rather have trust lands next to privately owned property.
- Oklahoma recognizes tribal sovereignty and works as "government to government".



Honor What is Sacred

- Some tribes consider tobacco to be sacred and use it as part of sacred ceremony. This is distinct from *commercial tobacco use*.
- Cessation efforts need to take this distinction into account. Current work with tribes has produced the Honor What is Sacred campaign.
- Cessation services include the Tobacco Dependence Clinical Practice Guidelines but with messaging tailored specifically to American Indian people – with meaningful input from tribal partners.

Other Cessation Systems Initiatives

- Behavioral Health
- Hospitals
- Medicaid (SoonerCare)
- County Health Departments

Today's speaker

Julie Meyer, MPS

- Director of Policy and Research, Division of Behavioral Health Services, Department of Human Services

PRELIMINARY DRAFT

Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

Behavioral Health Transformation – Tobacco Cessation
September 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

PRELIMINARY WORKING DRAFT; SUBJECT TO CHANGE

Key facts in behavioral health for the Medicaid population

Early facts in Arkansas

Total Medicaid behavioral health beneficiaries	~110,000 recipients
"Core" behavioral health spend (38% IP, 62% OP)	~$550 M
"Halo" spend	~$380 M
Pharmacy spend of behavioral health clients (BH and halo)[2]	~$150 M

Definitions of key terms

"Core" behavioral health spend[1]:
- Includes behavioral health services delivered to the client, (e.g., services for ADHD or depression)
- Does not include direct dementia or DD costs, but does includes BH spend from these populations

Halo:
- Includes non-behavioral health services (e.g., medical, support services) delivered to people who also use BH services

NOTE: Does not include those funded solely from state general revenue. Analysis underway to incorporate broader behavioral health programs
1 Details of BH spend: ICD9 291 – 314 excluding autism (299) and dementia codes in 294, excludes pharmacy
2 Pharmacy includes some spend from some DD and dementia clients that has not yet been excluded
SOURCE: 2011 Medical claims for behavioral health diagnosis codes. Does not include pharmacy, crossover or third party liability

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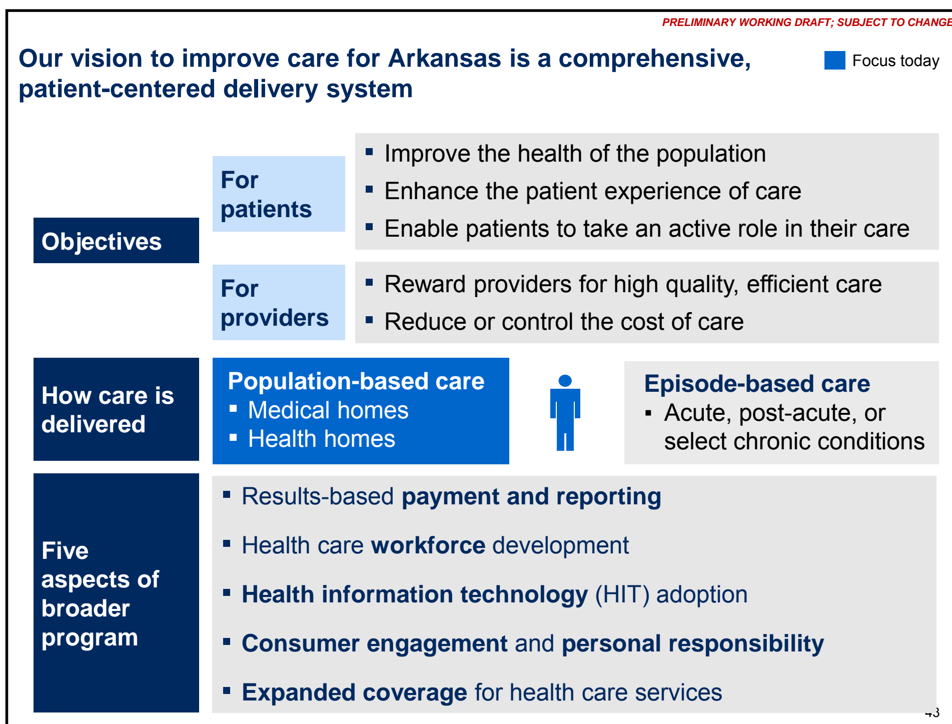
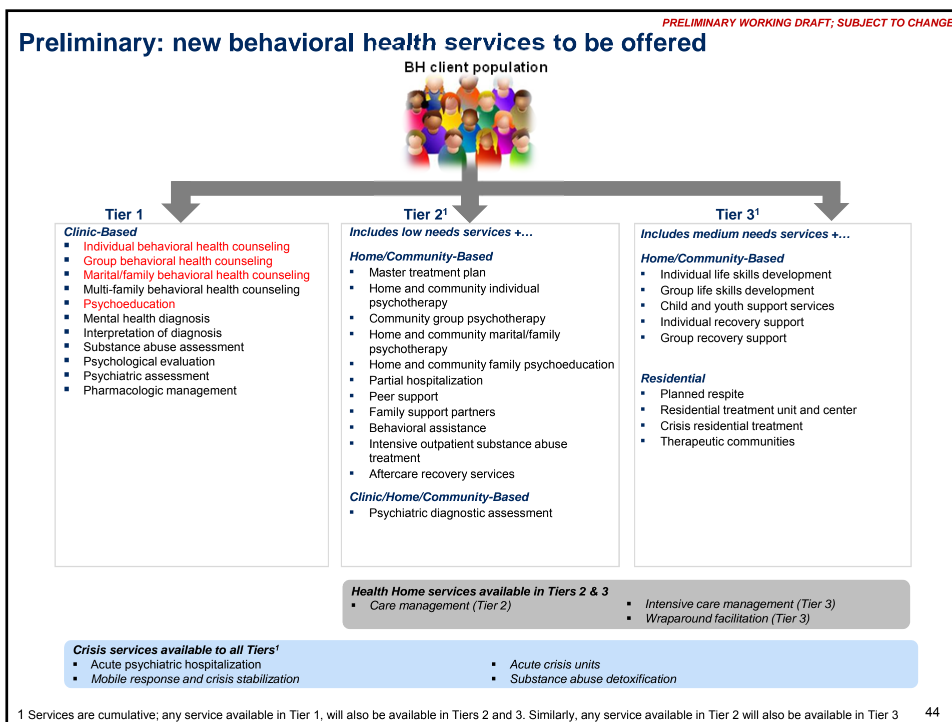

PRELIMINARY WORKING DRAFT; SUBJECT TO CHANGE
Our vision to improve care for Arkansas is a comprehensive, patient-centered delivery system
Focus today
Objectives
For patients
Improve the health of the population
Enhance the patient experience of care
Enable patients to take an active role in their care
For providers
Reward providers for high quality, efficient care
Reduce or control the cost of care
How care is delivered
Population-based care
Medical homes
Health homes
Episode-based care
Acute, post-acute, or select chronic conditions
Five aspects of broader program
Results-based payment and reporting
Health care workforce development
Health information technology (HIT) adoption
Consumer engagement and personal responsibility
Expanded coverage for health care services
43


PRELIMINARY WORKING DRAFT; SUBJECT TO CHANGE
Preliminary: new behavioral health services to be offered
BH client population
Tier 1
Clinic-Based
Individual behavioral health counseling
Group behavioral health counseling
Marital/family behavioral health counseling
Multi-family behavioral health counseling
Psychoeducation
Mental health diagnosis
Interpretation of diagnosis
Substance abuse assessment
Psychological evaluation
Psychiatric assessment
Pharmacologic management
Tier 2¹
Includes low needs services +…
Home/Community-Based
Master treatment plan
Home and community individual psychotherapy
Community group psychotherapy
Home and community marital/family psychotherapy
Home and community family psychoeducation
Partial hospitalization
Peer support
Family support partners
Behavioral assistance
Intensive outpatient substance abuse treatment
Aftercare recovery services
Clinic/Home/Community-Based
Psychiatric diagnostic assessment
Tier 3¹
Includes medium needs services +…
Home/Community-Based
Individual life skills development
Group life skills development
Child and youth support services
Individual recovery support
Group recovery support
Residential
Planned respite
Residential treatment unit and center
Crisis residential treatment
Therapeutic communities
Health Home services available in Tiers 2 & 3
Care management (Tier 2)
Intensive care management (Tier 3)
Wraparound facilitation (Tier 3)
Crisis services available to all Tiers¹
Acute psychiatric hospitalization
Mobile response and crisis stabilization
Acute crisis units
Substance abuse detoxification
1 Services are cumulative; any service available in Tier 1, will also be available in Tiers 2 and 3. Similarly, any service available in Tier 2 will also be available in Tier 3
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PRELIMINARY WORKING DRAFT; SUBJECT TO CHANGE

Tobacco Cessation

INDIVIDUAL BEHAVIORAL HEALTH COUNSELING: Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in DSM-IV or subsequent revisions. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration. ***Additionally, tobacco cessation counseling can be included as a component of this service.***

GROUP BEHAVIORAL HEALTH COUNSELING: Group Behavioral Health Counseling is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. ***Additionally, tobacco cessation counseling can be included as a component of this service.***

PSYCHOEDUCATION: Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and ***tobacco cessation***, and teaches problem-solving, communication, and coping skills to support recovery. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Multifamily groups usually consist of five to eight beneficiaries and their families, allowing them a more cost-effective method. Due to the group format, beneficiaries and their families are also able to benefit from peer support and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

MARITAL/FAMILY BEHAVIORAL HEALTH COUNSELING: Marital/Family Behavioral Health Counseling is a face-to-face treatment provided to one or more family members in the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. ***Additionally, tobacco cessation counseling can be included as a component of this service.***

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Today's speaker

William T. Wilson, DrPH

- Director of Health Promotion and Wellness, Austin Travis County Integral Care

Integrating Tobacco Cessation Into Behavioral Health Treatment

Strategies for Imbedding Tobacco Cessation into an Integrated Health Model

September 23, 2013

Bill Wilson, DrPH, CTTS
Director, Health Promotion & Wellness

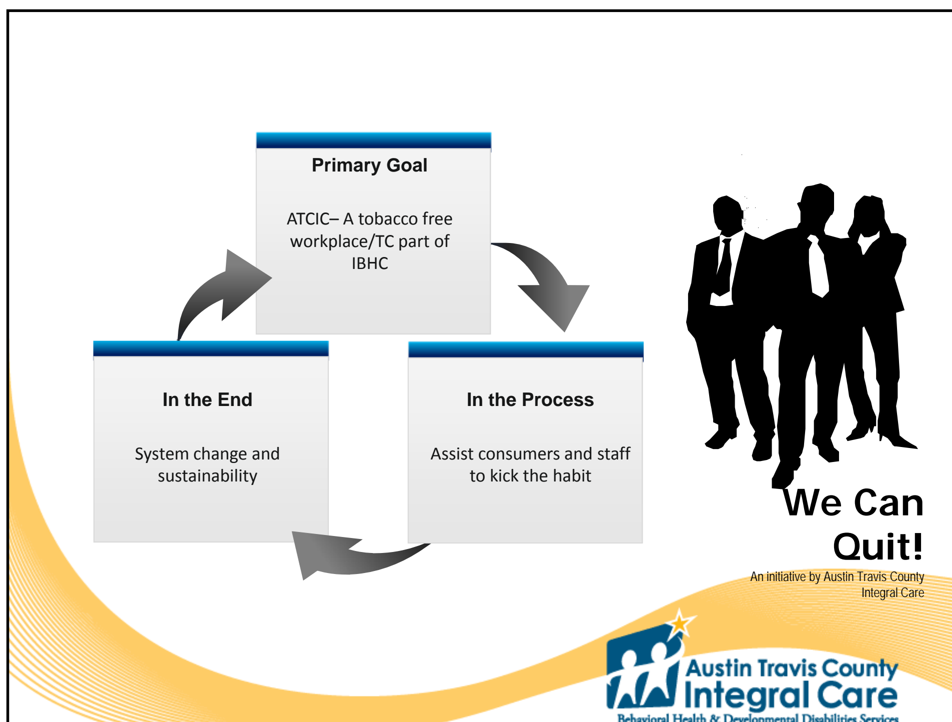
The Health Disparity

- The system in which people with MH and SA diagnoses receive care currently **does little** to change tobacco use
- The behavioral health system **needs large systemic changes** to address this problem
- Tobacco control has to date largely **ignored this issue**
- Designating smokers with behavioral health comorbidity a priority group will bring much-needed attention and resources
- Nicotine dependence is documented in only 2% of the medical records in MH/SA programs

Peterson, 2003

Policy

- Comprehensive (before during and after) policy developed and approved by BOD
- Tobacco Free date set
- Focus groups, communication strategy activated
- Point prevalence established through survey of consumers and staff
- EHR changed and staff training begins
- Signage and cleanup



FOUR PILLARS
STRATEGY

Multi-Modal Communication Strategy

- **Internal** – We Can Quit initiative –Intranet webpage, memorandums, email, success stories, flyers, signage, brochures, scripts, FAQ's
- **External** - FOCUS, consumer gazette, memo to contractors & leased properties, Internet webpage, media launch event, meetings

Train the Staff

- ALL STAFF – 5A's, 5R's plus plus
- Scripts for engaging clients & staff
- Tobacco Screening Tool (TUA) part of HER

Make Resources Available for Consumers/Staff

- Nicotine replacement therapy, Chantix, Wellbutrin
- Groups/individual counseling
- Community resources

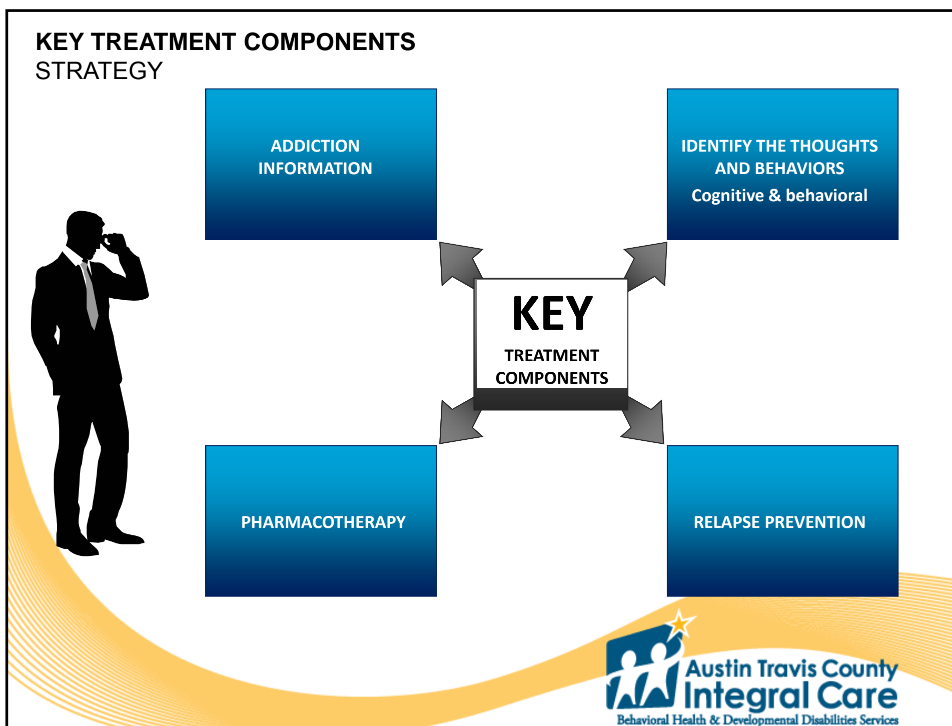
Austin Travis County
Integral Care
Behavioral Health & Developmental Disabilities Services

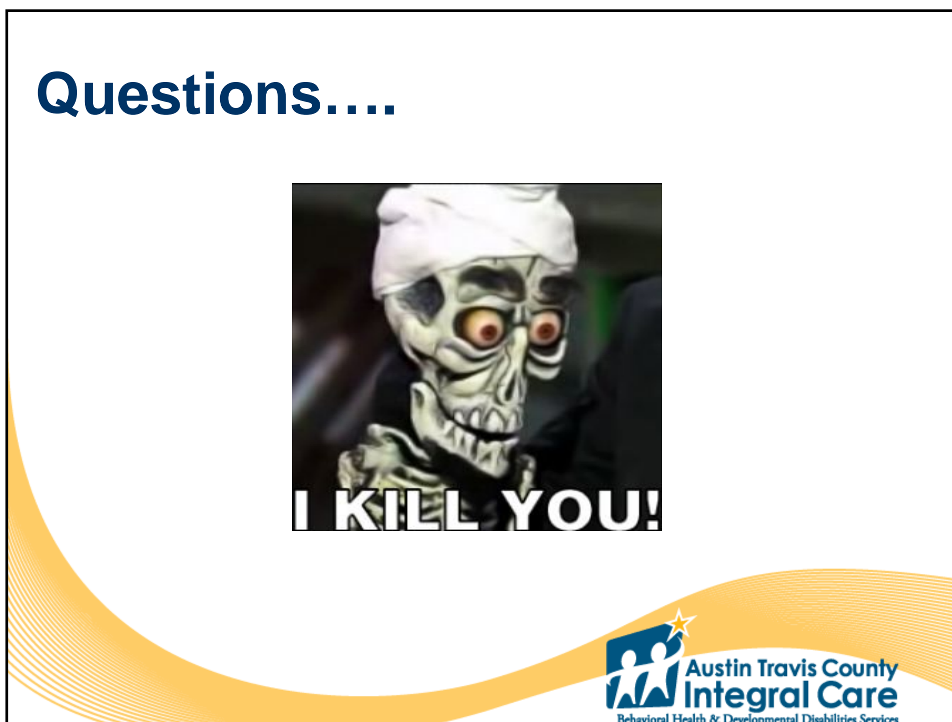
5 A's – Quick Guide
Helping Tobacco Users Willing to Quit!

Ask	Ask about tobacco use at every visit
Advise	Advise all tobacco users to quit
Assess	Assess patient's willingness to quit
Assist	Assist consumer in quitting
Arrange	Arrange a follow-up

5 R's – Quick Guide
Helping Tobacco Users **NOT** Willing to Quit!

Relevance	Help identify personally relevant reasons to QUIT
Risk	Invite consumer to discuss negative consequences of tobacco
Reward	Invite the patient to name personally relevant benefit
Roadblock	Ask patient to identify barriers to quitting and suggest treatment for specific barriers
Repetition	Repeat the above motivational techniques every time an unmotivated consumer visits


KEY TREATMENT COMPONENTS
STRATEGY
ADDICTION INFORMATION
IDENTIFY THE THOUGHTS AND BEHAVIORS
Cognitive & behavioral
KEY
TREATMENT COMPONENTS
PHARMACOTHERAPY
RELAPSE PREVENTION
Austin Travis County
Integral Care
Behavioral Health & Developmental Disabilities Services


Questions….
I KILL YOU!
Austin Travis County
Integral Care
Behavioral Health & Developmental Disabilities Services

Today's speaker

Carlo DiClemente, PhD

- Director, MDQuit Tobacco Resource Center; Director, Center for Community Collaboration; Professor, Department of Psychology, University of Maryland, Baltimore County

Today's speaker

Dawn Berkowitz, MPH, CHES

- Chief, Division of Federal and Special Tobacco Control Initiatives, Maryland Department of Health and Mental Hygiene

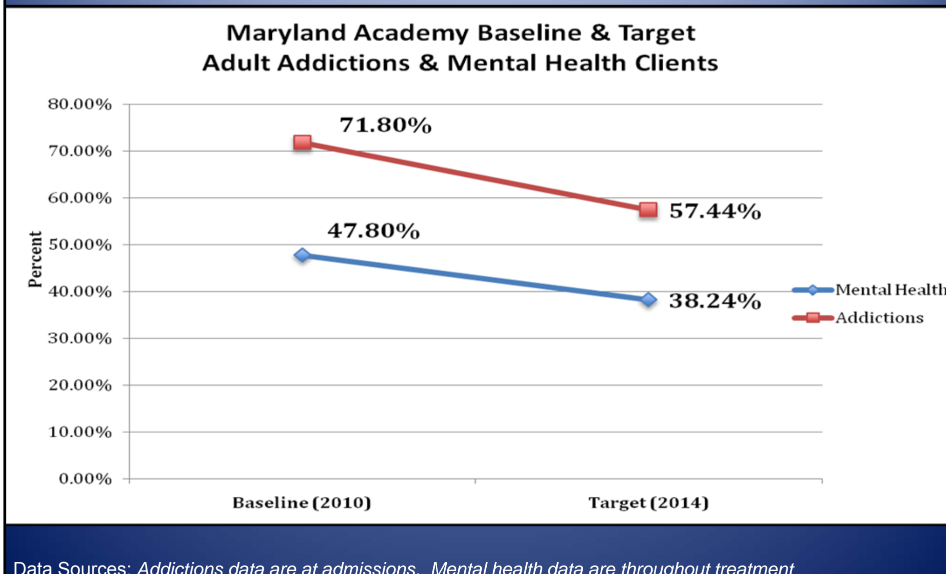
SAMHSA State Academies for Smoking Cessation: The Maryland Experience

September 24, 2013

Carlo C. DiClemente, PhD
Director, MDQuit Resource Center, UMBC

Dawn S. Berkowitz, MPH, CHES
Director, Center for Tobacco Prevention and Control, Maryland DHMH

Ambitious Goals for Smoking Reduction Rates in Maryland Addiction / Mental Health Clients



Data Sources: *Addictions data are at admissions. Mental health data are throughout treatment*

Governor's "State Stat" Initiative

- In January 2012, Governor O'Malley launched a revamped State Stat system
  - Provides for transparency and accountability by/from all state agencies
  - Highlights issues of importance
- Tobacco measures were modified to include behavioral health measures – initial measures only included services provided by the Maryland Tobacco Quitline
  - Added goal – reduce tobacco use among individuals with behavioral health disorders
  - % of adolescents/adults discharged from substance abuse treatment who used tobacco in 30 days prior to admission
  - % of adolescents/adults receiving mental health treatment who report smoking during their most recent interview
- Data reported monthly with 30-(MH) or 90-(SA) day lag

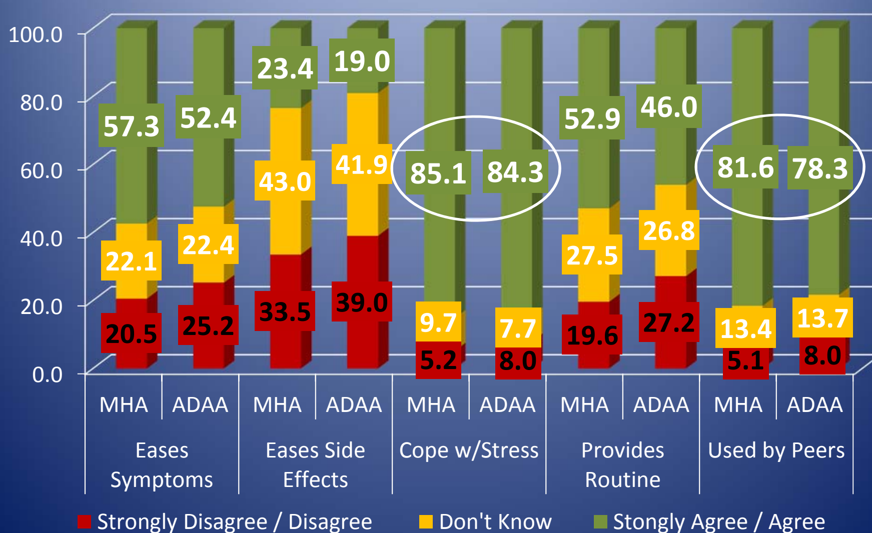
Next Steps

- Data thus far relatively unchanged
  - Needed additional resources and training to support policy changes and build capacity at the provider level
- As condition of award for state funding, documentation that BH patients screened and provided cessation services
- New MOU between Behavioral Health and MDQuit
  - Onsite training and technical assistance for behavioral health programs to implement multisession group treatment program
  - Cessation and resources infused into existing therapeutic framework
  - Targeted outreach to begin with providers with clients with highest tobacco use rates
  - Strong evaluation component included
- Working between Tobacco Control, Mental Health, and Substance Abuse to re-assess current measures
  - Change measures to compare admission vs discharge data

BH Surveys: ADAA and MHA Clinics Statewide

- Regional sampling strategy by agency type to ensure coverage across the entire state
- Selected a sampling of
  - 83 (of 160) Mental Hygiene Administration (MHA) clinics with 556 provider responses
  - 63 (of 155) Alcohol and Drug Abuse Administration (ADAA) clinics with 340 provider responses
- Examined provider knowledge of policy and programs and views of client smoking

Coping with Stress Reported as Top Reason for Difficulty Quitting



Summary of Findings

- Most MHA & ADAA providers indicated their clinics have smoke-free policies
  - Almost three-quarters of ADAA providers, but only 39% of MHA providers reported having programs to address smoking
- Stress was the top reported reason for why *both* consumers and providers continue to smoke
- On the positive side providers wanted information, materials and training to assist them in addressing smoking and many are former smokers who could be role models

Today's speaker

Gregory Miller, MD

- Medical Director, Adult Services,
  New York State Office of Mental Health

Medications for Tobacco Dependence Treatment

- Nicotine Replacement (NRT)
  - Combination
- Bupropion (Welbutrin; Zyban)
  - Can be used as an anti-depressant
- Varenicline (Chantix)
  - Neuro-psychiatric risk doesn't seem to be as serious as was thought.

Tobacco dependence pharmacology and SMI

- What do we know
  - Medications can improve successful cessation
  - More of what works for non-SMI
    - Combination
    - Increased doses
    - Longer duration in some instances
  - FDA is currently modifying recommendations to accommodate more flexible use of NRT
  - Even when not used in a quit attempt, meds can start the process of helping people with SMI to quit:
    - Example: NRT used to help patients live in tobacco free environments.

Policy Considerations

- Successful tobacco dependence treatment MUST involve evaluation and assessment for medication treatment
- EASY Access to prescribing by willing and informed prescribers is a must
- Medicaid reimbursement must reflect what we know:
  - More
  - Longer

Questions and answers

- Feel free to submit questions via the **chat box**

Contact SCLC for technical assistance

CME/CEUs of up to 1.5 credits are available to all attendees for a fee of $25 per certificate. Instructions will be emailed after the webinar.

Visit us online

- **http://smokingcessationleadership.ucsf.edu**

Call us toll-free

- **1-877-509-3786**

Closing remarks

- Please help us by completing the post-webinar survey.
- Thank you for your continued efforts to combat tobacco.
- Registration is now open for SCLC's next webinar on Thursday, October 3rd at 1pm ET, "To Hire or Not to Hire: Smokers and the Workplace."