Promising Policies And Practices To Address Tobacco Use By Persons With Mental And Substance Use Disorders

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People with mental and substance use disorders:

- Are approximately twice as likely as the general population to smoke cigarettes,[1]
- Are more likely to die from smoking-related illness than from their mental and substance use disorders (i.e. behavioral health conditions),[2,3] and
- Want to quit smoking and are able to do so successfully, which both reduces their risk of developing smoking-related diseases and may also improve their behavioral health outcomes.[4,5,6]

In 2016, among U.S. mental health services treatment facilities:

- 48.6% had a smoke-free campus,
- 48.9% screened clients for tobacco use,
- 37.6% offered tobacco cessation counseling,
- 25.2% offered nicotine replacement therapy (NRT), and
- 21.5% offered non-nicotine tobacco cessation medications.[7]

In 2016, among U.S. substance use disorder treatment facilities:

- 34.5% had smoke-free campuses,
- 64.0% screened clients for tobacco use,
- 47.4% offered tobacco cessation counseling,
- 26.2% offered NRT, and
- 20.3% offered non-nicotine tobacco cessation medications.[7]

In recent years, states have made significant progress in addressing tobacco use and secondhand smoke exposure in behavioral health treatment settings. This document highlights efforts by some states in implementing one or more of these policies and practices. It could serve as a resource for tobacco control and behavioral health programs as they prioritize potential actions to address tobacco use among people with mental or substance use disorders.

Example: New York Implements Tobacco-Free Campus Policies

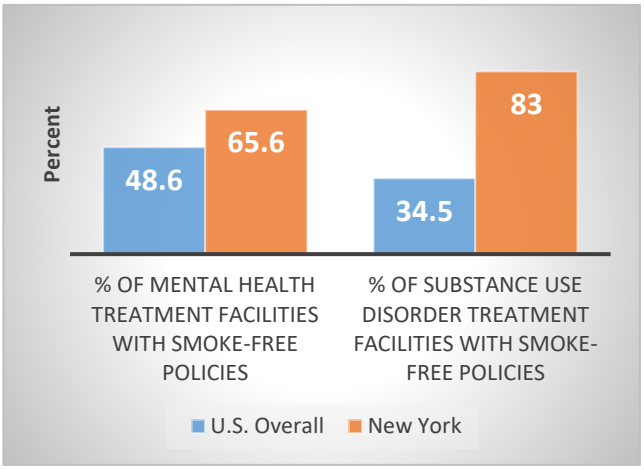
Strategy: Make Behavioral Health Treatment Settings Tobacco-Free

In 2008, New York became the first state to require that all state-funded or state-certified substance use disorder treatment programs (involving over 1,400 programs at the time) prohibit smoking on any property owned or operated by those programs, including outdoor areas.[8]

The counselors and clinical supervisors reported that, at first, they had some problems with implementing and enforcing the policy. However, policy implementation improved over time.[9,10]

About one year after the New York Office of Alcoholism and Substance Abuse Services (OASAS) implemented this policy, counselors and clinical supervisors noted that:

- Fewer clients were smoking,
- More clients were aware of the harms related to smoking, and
- More clients wanted to quit and knew about resources to help them quit.[9]



New York first addressed smoking at substance use disorder treatment facilities because of OASAS's interest and readiness, given its knowledge of the linkages between treating nicotine addiction and treating other addictions. After OASAS implemented its policy, the Office of Mental Health decided to take a similar—but not identical—approach to address the burden of tobacco use on its clients. The Office of Mental Health partnered with the State Department of Health Bureau of Tobacco Control to train mental health providers and Department of Health grantees to help mental health facilities adopt and implement tobacco-free campus policies. These policies prohibit the use of all types of tobacco products, including e-cigarettes, on the entire campuses of mental health facilities, including outdoor areas.

National Center for Chronic Disease Prevention and Health
Office on Smoking and Health

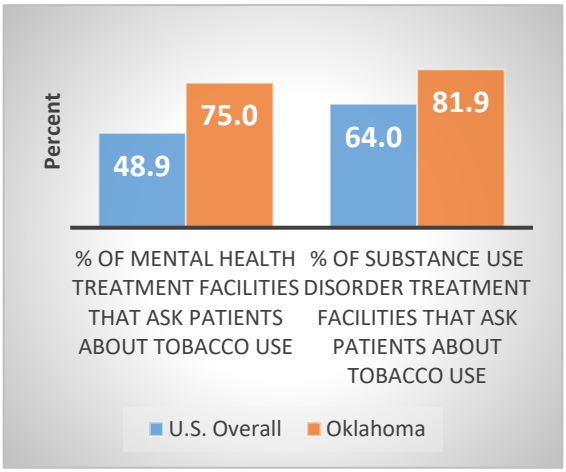
Bureau staff report that the tobacco-free campus policies have resulted in social norm change with respect to tobacco use, making it easier for behavioral health providers to screen for tobacco use and help clients quit. Tobacco-free campus policies can reinforce tobacco-free norms and also eliminate exposure to secondhand smoke. To further support efforts by behavioral health providers to address tobacco use, partner agencies in New York created a cross-walk chart summarizing tobacco-related requirements from several behavioral health regulatory agencies. The chart includes each agency's regulations and recommendations on screening and treating clients (including at discharge), training staff, and adopting tobacco-free campus policies.[11]

These efforts have likely contributed to recent research findings showing that New York is the state with the highest proportion of substance use disorder treatment facilities that have smoke-free campuses, screen for tobacco use, offer cessation counseling, and offer nicotine replacement therapy.[12]

Example: Grant Funding in Oklahoma Changes Systems for Assessing and Addressing Tobacco Use

Strategy: Integrate Screening for Tobacco Use into Behavioral Health Treatment

The Oklahoma Tobacco Settlement Endowment Trust (TSET) works to reduce tobacco use in the state using funds from the Master Settlement Agreement.[13] In 2011, TSET brought together Oklahoma's Department of Mental Health and Substance Abuse Services (ODMHSAS) and State Department of Health to develop a plan to address tobacco use among behavioral health clients and providers. After this meeting, facilitated by the Smoking Cessation Leadership Center, TSET awarded grants to health system partners to help put the plan in place.[14]



Over a five-year period, Oklahoma took the following steps:

- Trained behavioral health providers about tobacco and the state's plan to reduce tobacco use,
- Required state-funded behavioral health facilities to have tobacco-free policies for staff and clients and show plans for enforcing the policies,
- Required state-funded behavioral health facilities to implement the "5 A's" (five steps for clinicians to help people quit tobacco: Ask, Advise, Assess, Assist, and Arrange[15]) or to refer clients who use tobacco to the state quitline, and
- Required state-funded behavioral health providers to track the number of clients they referred to the quitline and increase the proportion of clients referred each year.

ODMHSAS staff say that these steps helped change the culture around tobacco use in behavioral health treatment settings in Oklahoma. After ODMHSAS took these steps, Oklahoma changed its behavioral health treatment regulations. Now Oklahoma law requires that the above measures be taken by all substance use disorder treatment facilities and all state-funded or state-certified mental health facilities. ODMHSAS is now focusing on reducing tobacco use among clients at all mental health facilities in the state – even if these facilities are not state-certified or state-funded – to help improve health.

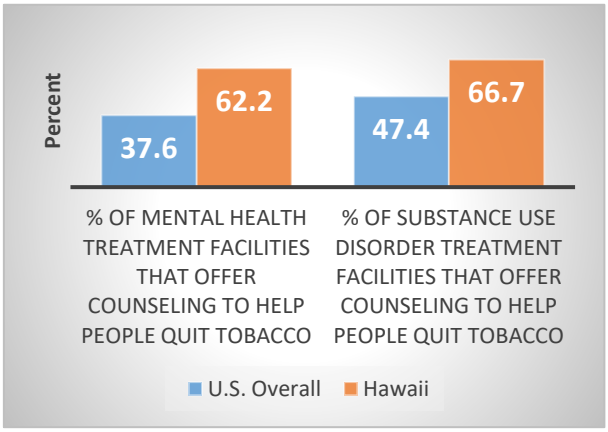
This effort appears to be making an impact: Oklahoma has the highest proportion of mental health treatment facilities offering cessation counseling, offering non-nicotine cessation medications, and providing smoke-free campuses in the U.S. ODMHSAS staff report that only 45% of persons with a mental health condition who were served by ODMHSAS smoked in 2017, down from 71% in 2011. During this same timeframe, the proportion of persons with a substance use disorder served by ODMHSAS that smoked fell from 77% to 51%.

Example: Provider Training Results in Hawaii Behavioral Health Facilities Providing Counseling to Help Clients Quit

Strategy: Counsel Behavioral Health Clients to Quit Using Tobacco

The Hawaii Department of Health Tobacco Prevention and Education Program (TPEP) surveyed behavioral health programs to learn more about their current cessation practices. Some steps that TPEP took to address tobacco use among persons with behavioral health conditions and increase counseling in Hawaii include:

- Partnered with the Hawaii Health Department's Adult Mental Health Division to provide a series of trainings on tobacco interventions to behavioral health clinical staff, case managers, and social workers,
- Conducted a workshop for those same participants with a national expert on addressing tobacco use among persons with behavioral health conditions, and
- Worked with the state Attorney General's Office to clarify that a state law allowing minors to consent to substance use disorder treatment without a parent's permission also applies to tobacco cessation treatment, resulting in the state quitline and health providers being able to offer nicotine addiction counseling to more youth.

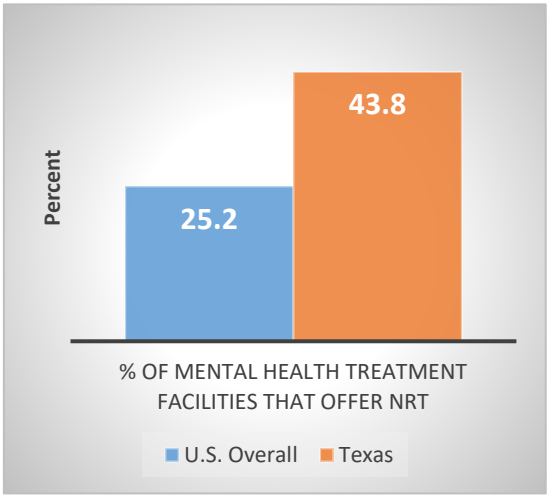


The SAMHSA surveys show that Hawaii has a high proportion of both mental health treatment facilities and substance use disorder treatment facilities offering tobacco cessation counseling to clients.[12]

Example: Texas Provides NRT as Part of a Range of Tobacco Cessation Measures in Mental Health Treatment Settings

Strategy: Offer Behavioral Health Clients Nicotine Replacement Therapy (NRT)

During 2013-2017, the Taking Texas Tobacco Free (TTTF) project, with funding from the Cancer Prevention and Research Institute of Texas, partnered with 22 community mental health treatment centers (representing over 250 individual clinics) to put comprehensive and sustainable tobacco-free programs in place in Texas. The goal was to reduce tobacco use and secondhand smoke exposure among employees, clients, and visitors by adopting tobacco-free campus policies, screening employees and clients regularly for tobacco use, and providing counseling and NRT to tobacco users who want to quit.



Over the four-year period:

- TTTF staff trained 5,172 mental health clinic employees (including those not providing direct clinical care) about tobacco use and its impact on persons with mental health conditions,
- TTTF staff trained employees providing direct clinical care about how NRT and non-nicotine cessation medication can help people quit tobacco,
- TTTF staff provided tobacco dependence training to 150 of the employees providing direct clinical care,
- Clinicians at these facilities screened for tobacco use over 120,000 times, and
- Over 15,000 individual boxes of nicotine patches, gum, or lozenges were provided to mental health treatment clinic clients and staff.[16]

Texas has the highest proportion of mental health treatment facilities that offer NRT.[12] The Texas Department of State Health Services Tobacco Prevention and Control Program has said that providing "starter supplies" of NRT to behavioral health centers has made a difference; it has been easier for these facilities to implement tobacco-free campus policies and put in place processes to consistently screen clients for tobacco use because they have cessation tools on hand to support quit attempts. TTTF is now implementing a similar program with 18 substance use disorder treatment centers.

Example: New York and Oklahoma Make it Easier for Persons with Behavioral Health Conditions to Access Non-Nicotine Cessation Medications

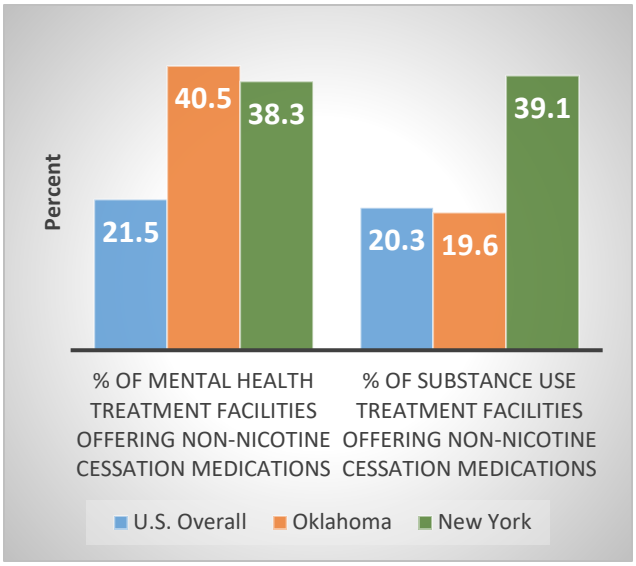
Strategy: Offer Behavioral Health Clients Non-Nicotine Tobacco Cessation Medications

Behavioral health facilities in New York and Oklahoma are national leaders in providing non-nicotine medications to help persons receiving treatment for mental or substance use disorders quit using tobacco.

Medicaid pays for mental health treatment for more persons in the U.S. than any other insurer, and its role in paying for substance use disorder treatment is growing.[17] State Medicaid programs are required to cover all seven medications, including two non-nicotine medications—varenicline and buproprion—approved by the Food and Drug Administration for smoking cessation.[18,19] As of June 30, 2017, 32 states covered all seven of these medications for all traditional (non-expansion) Medicaid enrollees.[20] However, barriers such as copayments, prior authorization, limits on the number of treatments allowed per year, or limits on how long treatment can be provided, may make it difficult for Medicaid enrollees to obtain these medications.[20]

New York's Medicaid program pays for non-nicotine cessation medications.[21] Because most people who smoke make multiple quit attempts before succeeding, New York does not cap the number of times each year it will pay for the medication for a client insured through Medicaid.[21] This may be especially beneficial for behavioral health clients who smoke as they tend to be heavier smokers and may need extra help following medication regimens.[12] With funding from New York's Bureau of Tobacco Control to promote universal provision of tobacco dependence treatment services, the Center of Excellence for Health Systems Improvement:

- Gathered information from the state Bureau of Tobacco Control, the Office of Alcoholism and Substance Abuse Services, and the Office of Mental Health,
- Outlined what each behavioral health regulatory body requires and recommends for providing tobacco cessation medication,[11] and
- Drafted a Tobacco Dependence Treatment Financial Modeling Tool that, once finalized, will be piloted by Department of Health grantees assisting health care organizations. The Tool is intended to help the health care organizations better understand the costs and benefits of taking a range of steps to help people who smoke quit, including providing cessation medications on-site.[22]



Similarly, Oklahoma's Medicaid program pays for non-nicotine cessation medications.[23] It does not limit the number of times each year a client insured through Medicaid can access bupropion, one of the two non-nicotine medications approved by the FDA for tobacco cessation.[24] The changes that were made to Oklahoma's Medicaid program to provide this coverage stemmed from a partnership between the Oklahoma Health Care Authority, the Oklahoma Tobacco Settlement Endowment Trust, and the Oklahoma State Department of Health. The group:

- Identified who was responsible for policy change,
- Gathered data about the costs of providing cessation medications, the number of people who would seek the medications, and the number of people who likely would quit using tobacco, and
- Showed what the return on investment would be if cessation medications were covered by Medicaid at no cost to the client.[25]

The proportion of Oklahoma mental health treatment facilities and the proportion of New York mental and substance use disorder treatment facilities providing non-nicotine medications to clients is nearly double the proportion of behavioral health treatment facilities doing so elsewhere in the U.S.[12]

Additional State Activities

The activities listed above are just some of the steps that states are taking to help people with behavioral health conditions quit tobacco. States are also taking other innovative steps in this area.

For example, in addition to providing cessation support to clients while they are receiving behavioral health treatment, state-funded and state-certified behavioral health treatment facilities in **OKLAHOMA** provide clients discharged from crisis, in-patient, and residential treatment facilities with a short-term supply of free NRT until they can obtain additional free NRT from the state quitline or another source. Behavioral health providers also check on clients' progress in quitting tobacco during a follow-up call which takes place within 30 days of discharge.

To increase cessation support in the community, **KENTUCKY** empowered pharmacists to provide tobacco cessation counseling and medications. Previously, pharmacists could not provide cessation medications on their own to help people quit using tobacco. In 2016, the Tobacco Prevention and Cessation Program within the Kentucky Cabinet for Health and Family Services worked with the state Pharmacy Board to help pharmacists and doctors enter into collaborative care agreements[26] allowing pharmacists to recommend cessation medications and provide brief cessation counseling. In late 2017, the Kentucky Pharmacy Board changed its rules to further empower pharmacists, allowing pharmacists to provide cessation medications and more extensive cessation counseling on their own.[27,28] This will allow persons with behavioral health conditions—and others—increased access to cessation services.

Other evidence-based strategies to address tobacco use among people with behavioral health conditions include:

- Adopting or changing health systems' screening processes and electronic health record systems to make sure that providers ask and counsel clients about tobacco use and, if appropriate, provide them with cessation medications.[12]
- Continuing to educate behavioral health providers about the evidence that people with behavioral health conditions who smoke want to quit and benefit from quitting, while acknowledging that they may require longer or more intensive cessation treatment than people without such conditions.[12,29]
- Working with state Medicaid programs to cover evidence-based cessation treatments (including individual, group, and telephone counseling and the seven FDA-approved cessation medications), to remove barriers to accessing these treatments, and to promote awareness of this coverage among Medicaid enrollees and their health care providers to increase use of these treatments. Removing barriers, such as copayments, prior authorization, limits on the number of treatments allowed per year, or limits on how long treatment can be provided, can make it easier for people to access cessation treatment and encourage smokers to follow through on a quit attempt.[20]
- Continuing to reduce the appeal, accessibility, and social acceptability of tobacco and tobacco use. Not only will this reduce tobacco use in the general population, it will also help support targeted efforts to reduce tobacco use among people with behavioral health conditions. Proven methods include implementing comprehensive smoke-free laws, increasing the price of tobacco products, and conducting high-impact media campaigns.[30] Ideally these campaigns can feature messages and testimonials specifically geared to persons with behavioral health conditions, such as Rebecca's story from the *Tips from Former Smokers*® Campaign.[31]

The activities described here are examples of some of the strategies that tobacco control and behavioral health programs have taken as they have worked together to reduce tobacco use among people with mental and substance use disorders. Quitting smoking not only improves physical health but may also improve behavioral health outcomes in this population. For this reason, behavioral health treatment facilities are important settings for delivering evidence-based tobacco cessation interventions.

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available at: https://www.samhsa.gov/data/sites/default/files/2016_NSSATS.pdf. Additional information about the survey results can be found at: Marynak K, VanFrank B, Tetlow S, et al. Tobacco Cessation Interventions and Smoke-Free Policies in Mental Health and Substance Abuse Treatment Facilities—United States, 2016. *Morbidity and Mortality Weekly Report*, 67(18):519—523, 2018. Available from: https://www.cdc.gov/mmwr/volumes/67/wr/mm6718a3.htm.

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