Identifying and Addressing Health Disparities Related to Tobacco Use Among Individuals with Mental Health and Substance Use Disorders

AN IMPLEMENTATION TOOLKIT FOR STATEWIDE TOBACCO CONTROL PROGRAMS

This toolkit addresses the use of commercial tobacco and not the sacred, medicinal and traditional use of tobacco by some American Indian communities.

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

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The National Council for Behavioral Health is the unifying voice of America's health care organizations that deliver mental health and substance use disorder treatment services. Together with more than 3,326 member organizations serving more than 10 million adults, children and families living with mental illnesses and substance use disorders, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

The National Council, with funding from the Centers for Disease Control and Prevention's (CDC) Office on Smoking and Health (OSH), operates the National Behavioral Health Network for Tobacco & Cancer Control (NBHN) to address tobacco and cancer-related health disparities impacting individuals with mental health and substance use disorders (MH/SUD) identified by OSH and CDC's Division of Cancer Prevention and Control. NBHN empowers and prepares a wide range of stakeholders, including public health, mental health and addiction recovery, primary care, community-based and education, to prevent and reduce tobacco use and cancer among individuals with MH/SUDs.

The National Council's NBHN team is available to support statewide tobacco control in advancing their mental health and substance use-related tobacco control priorities through a diverse set of training and technical assistance offerings. NBHN can also connect organizational leaders and staff with peers who can share their experiences and expertise. To learn more and connect with the network for assistance, visit www.bhthechange.org.

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ABOUT THIS TOOLKIT

PURPOSE

Identifying and Addressing Health Disparities Related to Tobacco Use Among Individuals with Mental Health and Substance Use Disorders: An Implementation Toolkit for Statewide Tobacco Control Programs encourages a strengthened focus in identifying and addressing tobacco-related health disparities among individuals with MH/SUDs. The guidance included in this toolkit is informed by 10 national cohorts of statewide tobacco control programs participating in six-month tobacco cessation communities of practice hosted by NBHN and more than 80 MH/SUDs providers from across the country.

While the toolkit itself does not provide comprehensive guidance on implementing evidence-based tobacco control interventions in MH/SUDs settings, it provides practical, applied support for addressing the high rates of tobacco use among individuals with MH/SUDs and links to resources that NBHN believes to be most valuable. Specifically, the toolkit outlines evidence, implementation considerations and tools for answering three critical questions:

1. How can statewide tobacco control programs best support **implementation of tobacco-free campus policies** in mental health and substance use treatment settings?
2. How can statewide tobacco control programs best support **increased tobacco use and dependence screening** in mental health and substance use treatment settings?
3. How can statewide tobacco control programs best **support tobacco cessation treatment** assistance to clients in mental health and substance use treatment settings?

AUDIENCE

The primary target audience for this toolkit is statewide tobacco control programs housed within public health departments. The goal is to encourage and support this audience in developing, implementing and evaluating actionable plans aimed at reducing tobacco use prevalence rates among individuals with MH/SUDs. For ease of reading, the term "statewide tobacco control programs" is used throughout the toolkit.

The toolkit may also be useful for a wide range of mental health and substance use organizations that wish to partner with statewide tobacco control programs and other public health organizations to strengthen their own tobacco control policies and practices.

LANGUAGE CLARIFICATION

Knowing what is meant by certain terms used in this toolkit will be essential when setting out to implement any of the three priority strategies addressed. Ensuring a shared language with stakeholders from different systems is critical for developing trust and transparency. It will inspire confidence in a statewide tobacco control program's ability to understand a specific mental health and substance use treatment setting's needs, concerns, strengths and culture. Key term definitions are called out throughout the toolkit.

- **Mental health:** The wide range of mental health conditions that affect mood, thinking and behavior.
- **Substance use disorder:** The disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal substance or medication.
- **Mental health and substance use system:** The collection of public and private organizations that provide services and supports to individuals with MH/SUDs as their primary mission. In some places these are embedded in Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC) and local health departments.

- **Statewide mental health and substance use agency:** State-level government agency or agencies responsible for administering a variety of MH/SUD programs for children, youth and adults.
- **Mental health and substance use organizations:** The full range of organizations with a MH/SUD-focused mission. The term includes those focused on treatment to clients as well as those that serve the needs of MH/SUD providers, such as membership and advocacy organizations.
- **Mental health and substance use treatment settings:** Facilities where treatment is provided, as well as the grounds upon which these facilities sit.
- **Mental health and substance use treatment facilities:** Indoor places where MH/SUD treatment is provided. This term is most often used when citing references that only measure smoking indoors.

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CALL TO ACTION

Over the past 20 years, there has been much progress at federal, state and local levels to reduce the burden of tobacco use in the general population. Most of this progress is a result of implementation of evidence-based tobacco control policy, systems and environmental change. However, there is still much work to do to address the significant tobacco-related health disparities that remain – especially among individuals with MH/SUDs.

- **Tobacco-related health disparities:** The ways specific populations (e.g., individuals with MH/SUDs) remain at higher risk for tobacco use and exposure and continue to bear the disproportionate burden of tobacco-related illnesses and deaths despite the significant progress made in tobacco control in the general population.

Individuals with MH/SUDs die between five and 25 years earlier[1] than those without MH/SUDs and many of these preventable deaths are caused by smoking.[2, 3] Though only 25% of U.S. adults have some form of a MH/SUD, individuals with MH/SUDs account for 40% of all cigarettes smoked by adults.[4] This is attributed, in part, to individuals with MH/SUDs who smoke having less access to tobacco cessation treatment than the general population and delayed screening and treatment for tobacco use in mental health and substance use treatment settings, as well as across the health care services spectrum. Less than half of all MH treatment facilities offer tobacco cessation counseling (41%) and only 50% have smoke-free campus policies.[5]

- **Tobacco cessation treatment:** The range of activities that address tobacco use including providing counseling and prescribing medications.
- **Tobacco cessation counseling:** An intervention by a trained provider that helps tobacco users develop a plan to quit, address barriers and triggers to quitting, seek support and manage withdrawal symptoms and stress to prevent relapse. The term is used in the toolkit when referring to studies or surveys that are reporting only on this specific intervention.
- **Smoke-free campus policies:** Policies that prohibit smoking on all grounds of a mental health and substance use treatment setting – inside and outside.
- **Smoke-free policies:** Policies that prohibit smoking inside mental health and substance use treatment facilities.

Much of the literature cited in the toolkit measure where smoking is permitted or not among MH and SUD treatment facilities. However, it important to note that ideal policy language not only prohibits smoking cigarettes, but all forms of tobacco and addresses not only indoor use but use on the grounds of a facility – thus the goal of tobacco-free campuses. For specific articles cited in the toolkit, we use the term that reflects the type of policy measured in the study.

For these reasons and others (e.g., unfair targeting by the tobacco industry and increased risk owing to early childhood trauma exposure) explored throughout the toolkit, statewide tobacco control programs are uniquely positioned to address tobacco use among individuals with MH/SUDs within their state. Most statewide tobacco control programs have years of health systems change experience to draw from when turning their attention to collaborating with mental health and substance use health systems. In fact, their unique position combined with a long-held value that tobacco control is a social justice issue, demands leadership and strategic action on this mounting tobacco-related health disparity. *Identifying and Addressing Health Disparities Related to Tobacco Use Among Individuals with Mental Health and Substance Use Disorders: An Implementation Toolkit for Statewide Tobacco Control Programs* exists to support efforts in doing so.

MAKING THE CASE FOR A STATEWIDE TOBACCO CONTROL PROGRAM'S FOCUS ON INDIVIDUALS WITH MENTAL HEALTH AND SUBSTANCE USE CONDITIONS

LEADING WITH FACTS

There are many myths and misconceptions about tobacco use and cessation in the MH/SUD population.[6] In fact, even individuals with MH/SUDs who smoke have misconceptions about the impact of their tobacco use on their own overall health and ability to successfully quit. To compound these myths, which were heavily funded for decades by the tobacco industry, organizations (including public health) charged with serving the health and well-being of individuals with MH/SUDs may be hesitant to implement tobacco-free policies and tobacco cessation treatment programs because of misinformation about the challenges related to doing so. Instead of repeating common myths that are later likely to be misremembered as true,[7] be sure to lead with facts on disproportionate use, exposure and health harms when engaging leadership, stakeholders and mental health and substance use systems and providers. However, take time to explain the drivers of these tobacco-related disparities and why and how they exist and persist.[8]

Need help with talking points tailored to specific stakeholders? See Appendix A

Myth busting is not all it takes to establish a new belief. In fact, working only to bust myths can actually reinforce a person's old belief as they restate something they have heard before.[8] Instead of pointing out that something is untrue when busting myths, try reframing statements to reinforce something that is true.

STATE GOVERNMENT STAKEHOLDERS	COMMUNITY STAKEHOLDERS
• Medicaid • Public health department staff (make sure to include key personnel from tobacco control and comprehensive cancer control programs and your states' cancer control coalition partners) • Mental health and substance use department staff (e.g., substance use staff, mental health staff) • Human services department staff (if applicable and separate from the public health department) • Title V staff (these programs focus significantly on addressing smoking during pregnancy and postpartum and often address critical women's MH/SUD programming)	• Mental health and substance use state associations • Mental health and substance use organizations (SAMHSA) • Pharmacies • Primary care providers • Hospitals • Schools • Faith-based organizations • MH/SUD advocacy organizations • Other community-based organizations (e.g., community centers) • Peers/peer-led organizations and persons with lived experience (adult and youth)

Facts That Matter

- Tobacco is more harmful than any other substance and leads to more deaths than all other substances, including alcohol, that mental health and substance use providers and other health systems may focus on as a priority. Long-term tobacco use leads to chronic illnesses more so than any other substance.[4] The most common causes of death among individuals with MH/SUDs are heart disease, cancer and lung disease – which can be caused by smoking.[9]
- Individuals with MH/SUDs are interested in quitting at the same rate as the general population and can quit successfully at the same rate when given evidence-based tobacco cessation treatment options to support them.[10]
- Studies have shown that as many as 80% of clients in treatment are interested in tobacco cessation.[11]
- Tobacco cessation can have significant positive impacts on other treatment efforts for individuals with MH/SUDs (e.g., prevents death, improves health, optimizes psychiatric medication effects, reduces isolation, saves client money, increases satisfaction with care, increases self-efficacy). Quitting tobacco during substance use treatment is linked to a 25% increase in long-term recovery.[12]
- There is an association between cigarette smoking and increased anxiety, and any information around alleviation of anxiety symptoms usually relates to the immediacy of satisfying nicotine withdrawal by smoking – not an individual's actual anxiety.[13]
- Prevention and early intervention are critical. Trauma in childhood is associated with early initiation of tobacco use, adult tobacco use and duration and intensity of use.
- Smoking in adolescence is also associated with a greater risk of psychiatric disorders in adulthood, including panic disorder, generalized anxiety disorder and agoraphobia, depression and suicidal behavior, substance use disorders and schizophrenia.[14, 15, 16, 17]

EXPLAINING THE INDUSTRY'S ROLE IN CREATING THE DISPARITY

The tobacco industry has a long and deception-shrouded history of courting individuals with MH/SUDs through targeted advertisements,[4, 18] providing free or cheap cigarettes to psychiatric facilities,[2] blocking preventive smoke-free facility policies and funding research that perpetuates the myth that cessation would be too stressful and negatively impact overall mental health and substance use outcomes.[4, 18] There are many examples of tobacco companies falsely marketing cigarettes as both sedatives that allay anxiety and stimulants that provide an energy boost. These advertisements were followed by active relationship-building with psychiatric facilities in the 1980's and 90's which resulted in product promotions and giveaways to an already vulnerable population. A letter written in 1995 by a residential treatment center in North Carolina references the cigarette donations the facility received over the course of many years from Lorillard, the parent company of Newports, Mavericks, Kents and more.

> In the past, your company has made our clients a lot happier during the holidays by providing us with several cases of cigarettes, so that "Santa" can slip a few packs in their Christmas bags!"
>
> — **MARY ANN HARVEY,** *Executive Director*

Unfortunately, mental health and substance use providers across the country, also subject to the tobacco industry's deception, have historically accepted and perpetuated messaging and further facilitated tobacco use by rewarding clients with cigarettes and smoke breaks to encourage treatment compliance. In some cases, providers smoked with clients as a way of establishing rapport.

THE LINKS BETWEEN TOBACCO USE AND TRAUMA

Well established research and studies have shown that early initiation of tobacco use, adult tobacco use, duration and intensity of use and increased risk of smoking in adulthood is highly correlated to past trauma experienced by individuals, including adverse childhood experiences (ACEs) and post-traumatic stress disorder (PTSD). Trauma results from an event, series of events or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being.[19] Traumatic experiences can include events such as physical or emotional abuse, neglect, household dysfunction, violence and natural or manmade disasters. Long-term side effects of trauma can include other MH/SUDs, such as depression and anxiety, and use of tobacco products may occur as a result of negative coping mechanisms and self-medication.

The pleasurable and distress-reducing effects of nicotine on the brain make it a particularly dangerous and addicting substance for individuals who have experienced trauma. In addition to a dose-response relationship between ACEs and adult smoking, reports have shown that exposure to trauma in early adulthood is associated with up to a twofold increased risk of smoking. This rate may be higher in individuals who experience PTSD who have been shown to have current cigarette smoking and nicotine dependence rates two to three times higher than the general population.[20] Similarly, in individuals who have experienced ACEs, the number of events experienced (or ACEs score) directly correlates with increased smoking prevalence.[21] Studies have also associated specific types of ACEs, such as childhood abuse, with more severe nicotine withdrawal and dependence, suggesting that some experiences may make tobacco cessation more difficult.[22] Individuals who have been exposed to trauma also smoke more cigarettes resulting in higher nicotine content.[23]

As a result of these findings that demonstrate a clear link between tobacco use and trauma, statewide tobacco control programs should be aware of the following key best practices to best serve populations with trauma histories.

- Using a trauma-informed approach in all tobacco cessation treatment services.
- Teaching providers about the connection between trauma and smoking.
- Implementing peer-to-peer interventions.
- Applying trauma-informed motivational interviewing to tobacco cessation treatment.
- Infusing trauma-informed principles and sensitive practices into policies and interactions.
- Using a recovery-oriented system of care that incorporates a universal experience of trauma to ensure all individuals are treated in a trauma-informed fashion.

Despite smoking rates decreasing in the general population, there is still a need for statewide tobacco control programs to address tobacco use among individuals with MH/SUDs. To highlight disparities beyond those made evident by national data, statewide tobacco control programs should:

- Look up and share state tobacco use prevalence rates for the general population and for individuals with MH/SUDs and how these compare to national prevalence, if applicable.
- Look up and share the proportion of mental health and substance use treatment settings that have implemented tobacco-related policies and practices.
- Ask questions about the differences between the tobacco-related policies and practices in traditional health care settings versus those found in mental health and substance use treatment settings.

Doing so will make clear the level of attention placed on addressing the tobacco-related disparities in individuals with MH/SUDs and exactly where the greatest attention should be placed.

IMPLEMENTING TOBACCO-FREE CAMPUS POLICIES IN MENTAL HEALTH AND SUBSTANCE USE TREATMENT SETTINGS

THE SITUATION

The tobacco industry has a long and deceptive history of courting individuals with MH/SUDs, as well as the professionals and systems that serve them. Unfortunately, mental health and substance use providers across the country have not been immune to this deception. Those responsible for treating individuals with MH/SUDs have accepted and perpetuated tobacco industry messaging and further facilitated tobacco use by rewarding clients with cigarettes and smoke breaks to encourage treatment compliance and, in some cases, even smoking with clients as a way of establishing rapport.

Aggressive and targeted marketing by the tobacco industry, barriers to care, a lack of tobacco-free policy protections and the spread of misinformation have all contributed to the disproportionate number of individuals with MH/SUDs who use tobacco when compared to the general population. A 2018 national survey of MH treatment facilities and SUD treatment facilities found that about a third of SUD treatment facilities (34%) and half of MH treatment facilities (50%) reported that smoking was not permitted anywhere outside or within any building, illuminating ample opportunity for statewide tobacco control programs to correct this long-standing disparity in protection from smoke-free air.[24,5] It is important to note that the 2018 survey only asked if and where smoking was permitted. It did not ask about other types of tobacco use. This could point to another opportunity for statewide tobacco control programs to strengthen existing policies and all types of tobacco use.

THE SOLUTION

Research shows that smoke-free environments overall, supported by smoke-free policies and laws that prohibit smoking in public spaces, help improve the health of workers and the general population.[25] Not only is this evidence-based strategy effective, in many cases the benefits are apparent shortly after implementation (e.g., reductions in hospital admissions for heart attacks).[7]

In mental health and substance use treatment settings, tobacco-free campus policies are associated with increased attempts to quit, decreased frequency of use and decreases in disruptive behaviors and aggression.[26] Studies also show that staff encounter fewer problems with implementation than initially anticipated.[9] Tobacco-free policies also benefit staff. One study showed that employees who worked in places that maintained or implemented smoke-free policies were nearly twice as likely to quit smoking as employees who worked in places that allowed smoking.[27]

Facilitating and supporting implementation of tobacco-free campus policies in mental health and substance use treatment settings is a worthwhile investment of effort for statewide tobacco control programs when considering strategies for effectively addressing a health disparity through policy change. Tailored education, technical assistance, model policy language and support are specific ways to engage mental health and substance use treatment settings to build and maintain healthy environments for clients and staff through tobacco-free policy implementation.

The following links to helpful policy-change toolkits may prove useful and include model policy language. While the target audience for each toolkit is not statewide tobacco control programs, being familiar with the readiness, planning implementation and enforcement processes outlined in each toolkit will help prepare statewide tobacco control programs for the work they will need to do in collaboration with mental health and substance use partners in guiding and supporting tobacco control policy, systems and environmental change.

- NAMI-Kansas and Public Health Law Center, Kansas Tobacco Guideline for Behavioral Health Care: An Implementation Toolkit
- American Lung Association in Minnesota's Toolkit to Address Tobacco Use in Behavioral Health Settings
- University of Colorado, Anschutz Medical Campus, School of Medicine, Behavioral Health and Wellness Program's Dimensions: Tobacco-Free Policy Toolkit
- University of California, San Francisco, Smoking Cessation Leadership Center, Destination Tobacco Free: A Practical Tool for Hospitals and Health Systems

THE LANDSCAPE

While there are many successes and challenges in tobacco control efforts around the country, each state has a unique set of strengths and opportunities that position them to successfully guide, support and encourage tobacco-free mental health and substance use treatment settings. Having a keen awareness and understanding of the mental health and substance use landscape and climate for policy change will inform and drive decision-making, stakeholder engagement and action planning. To guide landscape assessment for tobacco-free campuses, questions are listed below. A worksheet to help capture findings is in Appendix B.

Understanding the Population

1. **What is the tobacco use prevalence rate for individuals with MH/SUDs in the state?**
    a. Are there differences for rural versus urban individuals with MH/SUD?
    b. Are there differences for individuals of different races or ethnicities with MH/SUD?
    c. Are there differences for individuals with lower socio-economic status with MH/SUD?
    d. Are there differences for LGBTQIA2+ individuals with MH/SUD?
2. **How do these rates compare with that of the general population?**
3. **What percentage of individuals with MH/SUDs are covered by Medicaid in the state?**
4. **Where do the majority of individuals with MH/SUDs receive treatment?**
5. **Who are the mental health and substance use treatment facilities, providers and partners in the state?**

    Here's a tip: The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Behavioral Health Treatment Services Locator (BHTSL) may assist in this effort. The resource is updated monthly with all new facilities that have completed a survey and met all qualifications.
6. **What are current best practices for tobacco-free campus policies in the state?**
7. **Are there other programs within the statewide health department that have an intentional focus on improving the health and well-being of individuals with MH/SUDs?**

    Here's a tip: If so, meet with the people leading these efforts. They will have a lot of guidance to share and connections to offer.

Understanding the Systems

1. **How many mental health and substance use treatment settings are in the state?**
2. **How many private mental health and substance use treatment settings are tobacco-free? Public mental health and substance use treatment settings that are tobacco-free?**
3. **How many people would be impacted by tobacco-free campus policy change efforts? (Don't forget this includes staff and consumers/clients.)**
4. **Was there statewide tobacco control program support for implementation efforts among public housing locations that recently went smoke-free? If so, were there lessons learned that should be applied to this effort?**
5. **Have there been past/successful efforts to implement tobacco-free policies within mental health and substance use treatment settings within the state? If so, what were the primary drivers and barriers? Which organization or agency led the effort? Was it led internally or externally?**
6. **Is there a statewide association that represents the interests of the mental health and substance use system and/or professionals?**
    a. If so, who are key members of their staff?
    b. When is their annual meeting/conference?
    c. What are their strategic objectives and priorities?

    Here's a tip: Go to the National Council's membership page to view their network of state and regional associations and departments that serve the interests of community mental health and substance use health care provider organizations in their states or regions.
7. **For public settings, which state agency is responsible for contracting, licensing and oversight? Is there more than one?**
    a. What is the specific department/program within the agency or agencies responsible for contracting and oversight?
    b. Who are the staff and what are their roles?
    c. Is there a committee that makes recommendations to the agency regarding regulations? What is important to know about the decision-making authority of this group?
    d. Are there current quality improvement measures they are responsible for? What are they? Could tobacco-free campuses support their quality improvement efforts?

AN IMPORTANT IMPLEMENTATION DRIVER

Organizations have had success with increasing tobacco cessation rates among clients and staff after going tobacco-free. Offering tobacco cessation treatment in tandem with implementation of a tobacco-free policy can enhance the therapeutic relationship, since clients expect their health care providers to address tobacco use and their satisfaction increases when this occurs.[28, 29]

WHERE IS IT WORKING?

New York

INCREASING TOBACCO USE AND DEPENDENCE SCREENING IN MENTAL HEALTH AND SUBSTANCE USE SETTINGS

THE SITUATION

Statewide tobacco control programs have long been a partner to health care systems working to integrate tobacco cessation treatment into routine clinical care. These health systems change initiatives strive to ensure that every patient is screened for tobacco use, tobacco use is documented in every chart and all tobacco users are advised to quit and provided with evidence-based treatment options. Statewide tobacco control programs have trained health care providers, created provider decision support tools, developed clinical workflow and helped modify electronic health records – encouraging changes to the system to make tobacco cessation screening and treatment standard practice among all individuals served by the system.

CDC-OSH's Using Health Systems Change to Increase Tobacco Cessation responds to frequently asked questions about health systems change.

However, statewide tobacco control programs' health systems change efforts within mental health and substance use settings have not been as robust. In 2018, tobacco screening was the most commonly implemented tobacco-related practice[5,24] with 53% of all mental health treatment facilities and 67% of SUD treatment facilities offering tobacco screening for their clients.

- The National Mental Health Service's (N-MHSS) Data on Mental Health Facilities provides in-depth information about MH treatment facilities in a specific state and their tobacco use screening, tobacco cessation counseling and smoke-free policies as of 2018.
- The National Survey of Substance Abuse Treatments Service's (N-SSATS) Data on Substance Abuse Treatment Facilities provides in-depth information about SUD treatment facilities in a specific state and their tobacco use screening, tobacco cessation counseling and smoke-free policies as of 2018.
- Search both documents using the word "tobacco" to easily find the relevant data.

A study by Ashton, et al. (2010) found that only 26% of MH treatment facility staff raised the issue of tobacco use with patients often or as part of the assessment. These statistics are especially concerning considering that approximately 80-90% of MH and SUD treatment clients smoke cigarettes.[30] Most importantly, studies have shown that as many as 80% of clients express an interest in tobacco cessation treatment. One study found that 52% of individuals seeking treatment for cocaine dependency, 50% of individuals seeking treatment for alcohol dependency and 42% of individuals seeking treatment for heroin dependency were interested in quitting smoking at the time they started treatment for their other substance use disorders.[31]

THE SOLUTION

Individuals with MH/SUDs have far less access to tobacco cessation treatment options across all health care systems than tobacco users in the general population. Therefore, statewide tobacco control programs' support of mental health and substance use providers (the primary treatment provider for individuals with MH/SUD) screening and treating tobacco use of their clients is critical to addressing this disparity. We know that screening practices, such as expanding the vital signs to include tobacco use status, significantly increase rates of clinician intervention, allowing screening to be an important first step in a process to also improve access to tobacco cessation treatment.[32]

Every client seeking mental health and substance use treatment services should be asked if they use tobacco. This screening for tobacco use should occur at treatment intake, concurrently with assessment for other chemical dependencies. A tobacco use diagnosis should be noted in client charts using Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) criteria. However, simply educating mental health and substance use providers on the importance of asking about tobacco use at intake and charting the assessment is not enough. There must be systems-level changes to ensure routine and ongoing screening by all staff for all clients at every visit. Specific strategies may be recording tobacco-use status as a vital sign or using electronic health records (EHR) that include prompts to allow clinicians to screen for tobacco use and nicotine dependence.

Screening Adolescents For Early Intervention

The Screening to Brief Intervention (S2BI) Tool has been validated for distinguishing among clinically relevant risk categories of adolescent (ages 12–17) substance use.[28] When used as part of the evidence-based approach, Screening, Brief Intervention and Referral to Treatment (SBIRT) can facilitate prevention and early intervention of tobacco use in youth.

THE LANDSCAPE

Increasing screening for tobacco use within mental health and substance use treatment settings demands a key understanding of this system, as the focus is on systems-level change, not simply changing the behavior of individual providers. Understanding the mental health and substance use landscape will help in determining where to place specific effort, guide which efforts must be tailored and to whom and inform who must be at the table when decisions are being made. The following questions guide landscape assessment.

Understanding the Landscape (individual providers within treatment settings)

1. **How many mental health and substance use treatment settings are there in the state?**
2. **How many clients does each of these settings provide services to?**
3. **How many of these settings are public? Privately funded?**
4. **How many treatment settings include screening for tobacco use status in their protocols already?**

   Here's a tip: The SAMHSA's Behavioral Health Treatment Services Locator (BHTSL) may assist in this effort.
5. **Are there annual meetings/conferences attended by treatment providers?**
   a. Has tobacco ever been a priority during these meetings/conferences?
   b. If so, what was the response?
6. **If there is a statewide association that represents the interests of mental health and substance use treatment facilities and/or professionals? Have they ever published policy or practice improvement objectives?**
   a. If so, what would it take to get tobacco on their radar screen? If the objectives already include tobacco screening measures, how are facilities/providers doing? If improvement is needed, is that an area for training support from the statewide tobacco control program?
7. **Has the statewide tobacco control program engaged in any activities targeted to this community (providers in mental health and substance use treatment settings) in the past?**
   a. If so, what was the response?
   b. Is there important historical context to be aware of?

Here's a tip: Often, tobacco use screening and tobacco cessation treatment is not prioritized in mental health and substance use treatment settings because of the critical nature of primary-presenting needs and symptoms of individuals with MH/SUD. Knowing that five years ago the statewide tobacco control program trained 100 mental health and substance use providers and there was momentum for engaging in systems-level changes before a funding cut eliminated the program or decreased a payment rate for a longer clinical visit to include tobacco cessation counseling, provides helpful context. There may need to be added emphasis on provider education and supporting expanded coverage for providers in order to begin. There may need to be an acknowledgement of mental health and substance use providers' hesitation to embark on another partnership with the program in addition to so many other competing priorities. A pilot or a less intensive effort to rebuild trust may be needed.

Understanding the Systems (Mental Health and Substance Use Treatment Settings)

1. **What are the possible attitudinal, institutional and organizational barriers to implementing a routine system ensuring screening for tobacco use in mental health and substance use treatment settings in the state?**
    a. What additional information or expertise is needed to address these potential barriers?
2. **For publicly-funded treatment settings, which statewide agency has authority for regulations, standards and quality improvement?**
    a. Is there a connection to this agency and the program specifically tasked with oversight?
3. **Are mental health and substance use treatment settings using EHR? If so, which platform are they using?**

    Using the Electronic Health Record (EHR) to Support the Delivery of Tobacco Dependence Treatment Services in Health Care Settings is a guide that describes the process of planning and implementing tobacco cessation treatment services integration using EHR.
4. **What are the best opportunities to build screening questions into existing workflows or standard operating procedures for selected system/settings?**

AN IMPORTANT IMPLEMENTATION DRIVER

Staff at all levels of a mental health and substance use treatment setting should be involved from the very beginning. Their diverse perspectives are needed in the planning process. This is especially true when it comes to staff who use tobacco. When these staff feel supported and heard about their own tobacco use, they are more confident, empowered and motivated to support tobacco screening and treatment for the people they serve.

Consider these examples for engaging staff who use tobacco:

- Host a listening session.
- Offer to support a staff tobacco cessation treatment group.
- Promote the quitline or provide education to staff on their already-covered tobacco cessation treatment benefits.
- Include them in developing a policy to address staff tobacco use.
- Share staff success stories.[33]

WHERE IS IT WORKING?

Oklahoma

SUPPORTING TOBACCO CESSATION TREATMENT ASSISTANCE TO CLIENTS IN MENTAL HEALTH AND SUBSTANCE USE TREATMENT SETTINGS

THE SITUATION

Individuals with MH/SUDs want to quit and can quit at the same rates as the general population.[10] Of individuals who smoke, 20-25% report that they intend to quit smoking in the next 30 days and another 40% say they intend to do so in the next six months. Remember, less than half of all MH (40.5%) and half of all SUD treatment (49.8%) facilities offer tobacco cessation counseling. Additionally, 27% of MH and 28% of SUD treatment facilities offer nicotine replacement therapy (NRT) and 24% of MH and 22% of SUD treatment facilities offer non-nicotine replacement therapies.[24,5] Mental health and substance use providers should offer individuals with MH/SUDs every opportunity to succeed and live long, healthy lives and offering tobacco cessation treatment assistance goes a long way in doing this.

Not only is tobacco cessation treatment a potentially lifesaving or life-altering service for individuals with MH/SUDs, it is also one of the most cost-effective preventive services with as much as a $2 to $3 return on every one dollar invested.[34] According to SAMHSA, Medicaid is the single most important financing source of mental health services in the U.S., covering nearly 27% of all mental health care and accounting for nearly half of the public mental health spending.[35] Considering the number of individuals with MH/SUDs insured by Medicaid, it is wise to learn more about what tobacco cessation treatment coverage is required – federally and in the state. The state's Medicaid agency may be a natural partner in supporting increased demand for tobacco cessation treatment among individuals with MH/SUD.

Medicaid: A Tobacco Cessation Primer is a resource to learn more about treatment benefits.

THE SOLUTION

Once individuals with MH/SUD who use tobacco are identified through screening, offering tobacco cessation treatment is the natural next step. The role of the statewide tobacco control program will be to offer guidance and support to mental health and substance use organizations as they determine how best to do this.

The U.S. Preventive Services Task Force identifies the 5 A's mental health and substance use counseling framework as a strategy for initiating conversations about tobacco use and cessation.[36] The Food and Drug Administration (FDA) has approved seven nicotine replacement and non-nicotine replacement therapies for tobacco cessation as well. Evidence indicates that NRTs increase the rate of quitting by 50-70%.[37]

Maryland's Tobacco Resource Center provides more information about the 5 A's model.

A Conversation Guide for Delivering a Trauma-informed Brief Intervention may also be useful in engaging providers in this work, especially considering the importance of using a trauma-informed care approach.

Mental health and substance use providers are uniquely positioned to address tobacco use with their clients. They often have regular, close contact with clients, making it an ideal setting to deliver ongoing tobacco cessation treatment support. In addition, clients expect their health care professionals to encourage them to quit using tobacco and improves client satisfaction.[28,29] In fact, individuals who have the help of a physician clinician are 2.2 times more likely to quit than those without this support. Similarly, those who have the help of a nonphysician clinician are 1.7 times more likely to quit.[38] When tobacco cessation treatment is an option for a client, the treatment plan should address this addiction as it would any other. Recent studies have shown a strong link between tobacco cessation and substance use treatment success. Individuals with alcohol use and/or other substance use disorders who also stop using tobacco products are up to eight times more likely to remain abstinent than those who do not.[39]

There are a wealth of resources that provide mental health and substance use providers with guidelines for effective tobacco cessation treatment practices. It is important to note that counseling and pharmacotherapy must be tailored to the unique needs of each individual client. Individuals with MH/SUDs often need more time to prepare to quit, enhanced medication treatment protocols, more intensive follow-up and closer medication monitoring. Being aware of these considerations can inform curriculum development and help ensure tailored training for mental health and substance use providers.

UCSF Smoking Cessation Leadership Center provides a list of tobacco cessation training curricula for mental health and substance use providers.

THE LANDSCAPE

Bringing tobacco cessation treatment to individuals with MH/SUDs where they receive the majority of their physical and mental health and substance use care is a critical part of the strategy to increase treatment access, provision and utilization. Encouraging and supporting mental health and substance use treatment settings to provide this assistance to clients involves engaging clients, providers and the community to increase understanding that addressing tobacco use is of utmost importance to addressing the leading cause of preventable and premature death in individuals with MH/SUD. In addition, training in evidence-based treatments and motivational interviewing is essential for providers and client-facing staff who may also play a role in screening and assessment, counseling, treatment, referral (if no treatment is provided) and follow-up supports. Statewide tobacco control programs need to understand the clinical, administrative and mental health and substance use consumer/client landscape before moving forward in engaging mental health and substance use providers in this strategy.

Understanding the Landscape

1. **How many mental health and substance use treatment settings in the state offer tobacco cessation treatment as a standard of care?**
    a. Are there settings that would be able to provide a case study of their process and/or provide presentations to encourage support?
2. **How many mental health and substance use providers are also certified tobacco cessation treatment specialists? Or have these specialists in their organization?**

3. **How many mental health and substance use providers refer to the state quitline? At what rate? In addition to providing treatment, or as a referral instead of providing treatment?**
4. **What progress has been made in screening state quitline callers for MH/SUDs?**
    a. If the state quitline screens all callers for mental health and substance use conditions, is there data to pinpoint where the majority of referrals come from?
    b. Is there a champion who could be highlighted to encourage increased referrals?
    c. Is there room to increase education to mental health and substance use providers about the quitline and the services offered?

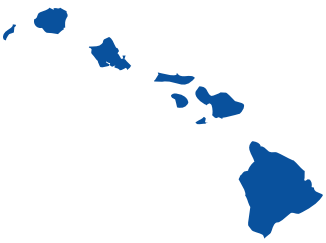
    If quitline callers are not being screened for mental health and substance use conditions, Smokers with Self-reported Mental Health Conditions is an article that can help make the case for doing so.
5. **Are there client advocacy groups that serve individuals with MH/SUD? How could these organizations be engaged to increase consumer demand for tobacco cessation treatment?**

Understanding the Systems

1. **For the mental health and substance use providers selected, what is the process for offering/providing staff training? What are the main barriers to providing staff training?**
2. **Is there existing capacity and/or infrastructure that could be leveraged to expand training?**
3. **Are there "early adopters" around tobacco-free campuses and expanding tobacco cessation treatment support in mental health and substance use treatment settings who could provide guidance and share progress with peers?**
4. **Are there state or federal mental health and substance use treatment settings that have quality improvement measures related to tobacco that could use support through training and technical assistance?**
5. **What does Medicaid coverage for tobacco cessation treatment services look like in the state? Who can bill for services and why? Who can't bill for services, and how does this impact treatment provision? Could stronger relationships with Medicaid be built to focus on increasing coverage of services and provider types? How can Medicaid and mental health and substance use providers be encouraged to expand knowledge and use of existing tobacco cessation treatment benefits?**
6. **Could quitline protocols for individuals with mental health and substance use conditions, including enhanced protocols, NRT provisions and pharmacological supports, be funded and implemented?**

AN IMPORTANT IMPLEMENTATION DRIVER

Peer support can transform mental health and substance use services and many mental health and substance use treatment settings already utilize peer specialists and/or recovery coaches for wellness initiatives. Having peers who have already quit tobacco engage with individuals interested in quitting can provide enhanced engagement, stronger support and better cessation outcomes. Tobacco cessation treatment can also be integrated into existing peer support programs. Learn more about how New Jersey's CHOICES program is doing this.



WHERE IS IT WORKING?

Hawaii

TOOLS AND TIPS FOR IDENTIFYING AND ENGAGING STAKEHOLDERS

Now that there is a clearer picture of the landscape of mental health and substance use treatment settings in the state for the specific strategy a statewide tobacco control program has chosen to focus on, the next step is to determine who the critical players are in moving this policy or practice change forward and how best to engage them. Their needs and concerns and the statewide tobacco control program's needs and concerns must be explicitly and honestly communicated to truly align agendas. This is especially true when working with those for whom tobacco control is not a top priority. When it comes to tobacco-free mental health and substance use treatment settings, not only will policy or practice change be the goal, but an organizational culture will be changing as well – this can be hard, if not impossible, work to do alone.

The stakeholders engaged in relationship building will depend on the specific policy or practice-change strategy being used. Encouraging support for change via a statewide association of providers? Engaging the statewide agency responsible for facility regulations to enact a statewide policy change for public facilities? Engaging privately-funded facilities that may serve a high percentage of individuals with MH/SUDs in the state? Being strategic at this point in stakeholder development will save time and energy in the long run. Engaging stakeholders outside of tobacco control and mainstream public health organizations is critical to the success of any initiative.

Stakeholders: Groups or individuals directly impacted by the decisions and actions of an organization. Stakeholders may or may not agree with what is being done.

Power mapping is a methodology employed to determine who has power in a system being changed and identifying what might encourage people who make up that system to support tobacco-free mental health and substance use treatment settings, screening for tobacco use or the provision of tobacco cessation treatment. Completing this exercise will lead to additional stakeholders – especially individuals and organizations who are likely to align with the initiative's priorities and have the ability to influence others. It will also clarify who might oppose the plan and who is ambivalent.

Appendix C provides a power mapping tool.

Another tool for ensuring a strategic approach to relationship-building is a Power/Influence Grid where stakeholders are grouped based on their level of power and influence. Knowing where a person or organization falls on the grid helps guide and tailor communication and engagement.

Insights gleaned from power mapping stakeholders and completing a power/influence grid will also guide communications and determine where to place time and attention (e.g., if a stakeholder is ambivalent and has little authority and few connections to essential partners, consider not spending precious time and resources trying to convince them of the importance of the work). It is often the case that valuable time is wasted on those who have neither power nor influence – another reason that taking time to conduct a stakeholder assessment is so valuable.

Partners: Organizations with whom there is a working relationship and who contribute to the effort through shared resources.

No matter what strategies are planned, take time to establish relationships with organizations and professionals across the state that are successfully implementing tobacco-related policies and leverage their success to inform others. These systems and providers will serve as champions for the cause and increase momentum. Need help finding success stories? Contact the National Behavioral Health Network for Tobacco and Cancer Control.

Finally, building connections among and between stakeholders will bolster trust that will be needed throughout the planning and implementation phases – especially among stakeholders who become partners in the work. Consider initiating one of the following examples to foster these connections:

- Host a CDC and SAMHSA-supported State Strategy Summit to help define the state's priorities and develop an action plan to address tobacco use among individuals with MH/SUDs.
- Host a provider meeting. This can include state Medicaid and mental health and substance use providers from both the public and private sectors. Consider engaging the health department's medical director as a champion or identify someone in the mental health and substance use community to co-chair the meeting.
- Invite identified champions working to address tobacco use among individuals with MH/SUDs to present at larger statewide agency meetings or annual conferences where there is a diverse cross-sector audience base.
- Host a peer-to-peer meeting for interested allies focused on developing policy around tobacco-free settings.
- Identify the leadership and mental health and substance use provider meetings that state Medicaid and managed care organizations might host. Attend these meetings, encourage participation by other allies or ask to give a presentation.

During the process of power mapping and placing stakeholders on a power/influence grid, potential stakeholders and partners may be missed. There should always be a deliberate process to cast a wider net to determine if there are missing or excluded voices from the table; to assess gaps in expertise, lived experience or perspective. Once gaps are identified, work with existing partners to develop an engagement strategy for communicating with and encouraging participation by those who may be new to this particular effort but have clear and necessary strengths to contribute.

TOOLS AND TIPS FOR ACTION PLANNING

Once key stakeholders (those with high power/high interest) and partners (those who will help do the heavy-lifting) are identified, engage them in the next step of any policy or practice-change process: action planning.

CONVENE A WORKGROUP

Convening a workgroup with representatives from the state health department, mental health and substance use state agency, mental health and substance use organizations and community-based organizations is an important first step in action planning. It is essential to include a variety of cross-sector stakeholders with diverse experience and perspectives to ensure the approach is comprehensive, reflects best and promising practices, and adequately addresses the challenge. Complex issues require complex solutions. Whenever possible, include people with lived experience (individuals with MH/SUDs) to confirm specific strategies will resonate with and prove effective for the intended audience. Consider engaging stakeholders and partners from the following:

STATE GOVERNMENT STAKEHOLDERS	COMMUNITY STAKEHOLDERS
• Medicaid • Public health department staff (make sure to include key personnel from tobacco control and comprehensive cancer control programs and your states' cancer control coalition partners) • Mental health department staff (e.g., substance use staff, mental health staff) • Human services department staff (if applicable and separate from the public health department) • Title V staff (programs that focus significantly on addressing smoking during pregnancy and postpartum; they often address critical women's MH/SUD programming)	• Mental health state associations (NPC) • Mental health and substance use organizations (SAMHSA) • Pharmacies • Primary care providers • Hospitals • Schools • Persons with lived experience (adult and youth) • Faith-based organizations • MH/SUD advocacy organizations • Other community-based organizations (e.g., community centers) • Peers/peer-led organizations

During a stakeholder assessment, an existing workgroup may be identified as a natural place to join, instead of creating yet another workgroup with many of the same faces sitting around the table. If so, there may be a need for some additional strategizing to learn how agendas align and how best to "make the case" for shared goals.

Need help creating a statewide workgroup? Apply for a State Strategy Summit to receive individualized technical assistance from the National Behavioral Health Network and Smoking Cessation Leadership Center.

Due to the strong causal links between tobacco and cancer,[25] one of the most important stakeholders (and possibly partners) is the statewide cancer control program. All states have comprehensive cancer control plans and funding to support meeting the identified deliverables for these plans. Consider collaborating with statewide cancer control program personnel to determine shared goals and objectives, the opportunities that exist to share or align resources, leverage expertise and coordinate for greater impact.

Create a Vision Statement

Before developing an action plan, the workgroup should agree upon a strategic vision for the initiative. The vision statement should be clear, data-informed, future-oriented and aspirational.

Sample Vision Statement
In 12 months, the XYZ Treatment Facility will be a 100% tobacco-free campus with overwhelming support from administration, staff and clients and will also secure dedicated funding of $15,000 to improve access to tobacco cessation treatment within the facility.

DEVELOP AN ACTION PLAN

The workgroup will need to reach consensus on the following questions in the early stages of action planning:

- What is the long-term goal?
  - Reduce the prevalence of tobacco use in individuals with MH/SUDs?
  - Increase access to evidence-based tobacco cessation treatment?
  - Become a 100% comprehensive tobacco-free campus?
- How will progress toward this goal be measured and evaluated? Is this possible with existing resources?
- What are the intermediate and short-term goals?
  - Increase provider buy-in for integrating tobacco cessation treatment with current services?
  - Build momentum for tobacco-free treatment settings across the state?
- How will progress toward intermediate and short-term goals be measured and evaluated? Is this possible with existing resources?
- Are roles and expectations for each member of the workgroup clearly defined?
- What expertise or skill is missing from the workgroup that is needed?

The data gathered to understand the state's particular landscape will also inform identification of strategic priorities. Effective action plans are challenging, especially when working across diverse sectors. They are also achievable and should contain the following elements:

- **SMART objectives:** Objectives should be specific, measurable, achievable, realistic and time-bound.
- **Action steps:** Tangible activities that must be completed to reach objectives. Each action step should detail what needs to take place, who is responsible for doing it, the resources they will need and the performance indicator that will let the rest of the group know if they are taking the right path toward the long-term goal – a compass.
- **System for continuous monitoring:** Progress on all activities and objectives should be continually monitored and evaluated to ensure goals are achieved and that the group remains aligned. This system should also facilitate accountability for all partners.

Remember to be flexible. It is important to have a plan in place but just as critical to respond to emerging needs. Maintain a continual loop of gathering data, assessing progress, checking in with stakeholders and partners and using information to make data-informed decisions and adjustments as needed. Sometimes data (including process data) reveal unanticipated results so be prepared to respond accordingly. For example, recent quitline data suggest fewer individuals with MH/SUDs are calling than originally believed. Is there now a need to develop tailored quitline promotional materials that better resonate with mental health and substance use organizations and individuals with MH/SUDs?

For an action plan template, see Appendix D.

For a menu of concrete workgroup activities, see Appendix E.

Any action plan should include performance measures for all proposed activities. Don't forget to revisit the performance measures regularly and use them to track progress. The data will reveal aspects of the initiative that are going well and aspects that may need to be modified to realize long-term goals.

For a workgroup performance measure worksheet, see Appendix F.

TOOLS AND TIPS FOR FRAMING THE MESSAGE

Framing messages is difficult, strategic work. It is difficult because while using stories of individuals who will be affected by a tobacco-free campus or by offering tobacco cessation treatment seems like an effective method for building support, individually framed messages can mask systemic approaches and solutions.

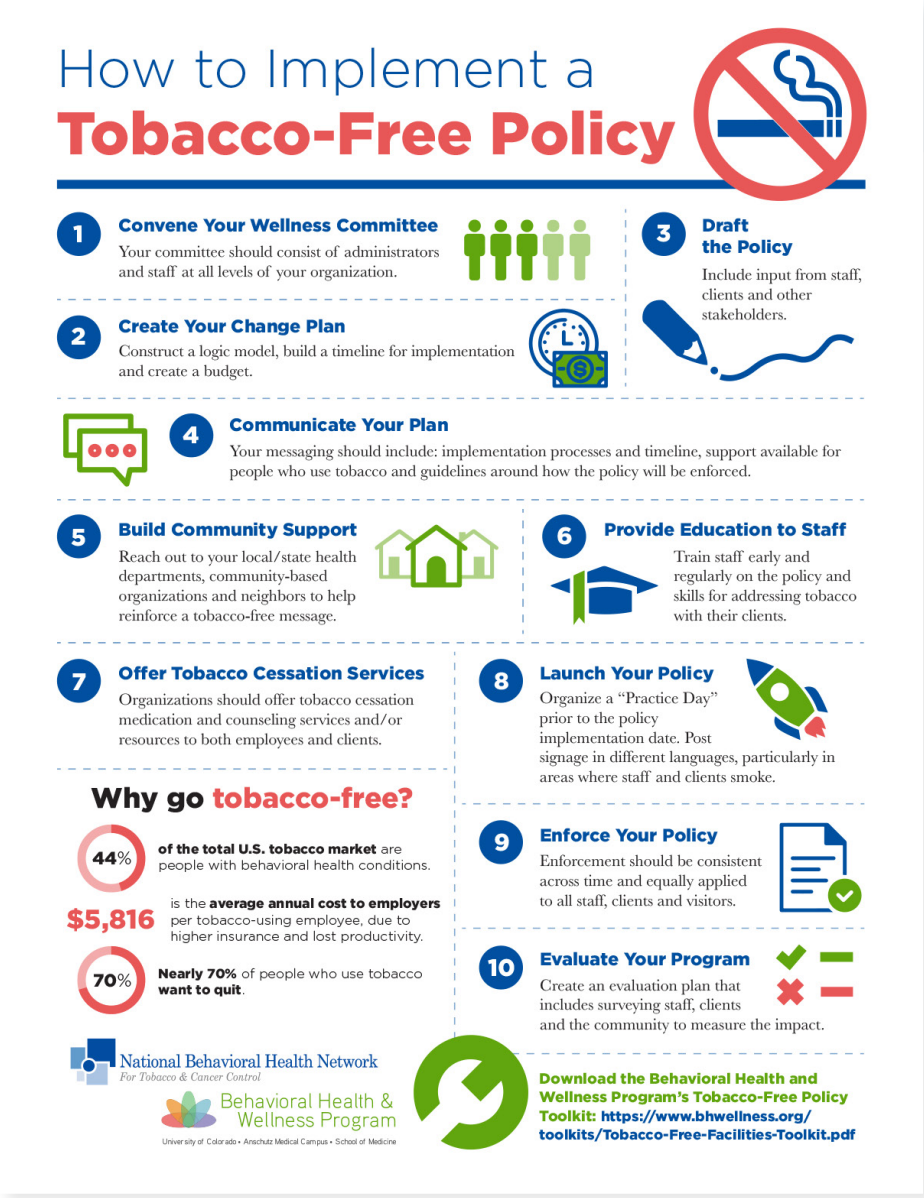
Individual message framing can also invoke a counterproductive mental frame that is associated with one "side" of the issue, polarizing those who you are trying to reach. Framing a tobacco-free campus policy or tobacco cessation treatment initiative can change how people understand and respond to it. A growing body of research indicates that because frames filter people's perception of an issue or problem, changing the frame changes the response.[8] In fact, frames can be much more powerful than facts.

The order in which various pieces of a message are presented also matters. When executed well, it has the power to engage an audience and challenge them to think about tobacco control in a new way. When executed poorly, it could disengage an audience and reinforce inaccurate beliefs.

1. Captivate an audience by answering their top question, "Why does this matter to me and my organization?"
2. Educate an audience by answering the question, "Why and how do disparities occur?" Help organizational leaders and other stakeholders understand disparities by providing additional context. To adopt tobacco control policies and practices, decision-makers must understand the cause of the tobacco use disparities among individuals with MH/SUDs, the dire health consequences and disproportionate use of tobacco products and the array of proven evidence-based practices to help people quit. In the absence of context to explain the cause of the problem, statistics about disparities are likely to be misunderstood or misinterpreted. It is important to encourage decision-makers to consider the systemic and structural factors that drive inequity and foster disparities – especially when working to encourage the need for tobacco control policy, systems and environmental change. Statewide tobacco control programs are in an ideal position to provide this education to other service providers, community-based organizations and clients. If done well, the result will raise awareness of the problem, decrease emphasis on "personal choice" solutions and increase emphasis on the role that policy and social conditions play in the issue, and hope that they can help make a difference.
3. Reinforce a message by sharing statistics that answer the question, "How bad is the problem?" Sharing references for these statistics will confirm that the source is reliable and trusted.

ChangeLab Solutions offers an important new resource for framing health disparities.

For frequently asked questions with suggested responses about tobacco-free campus policies, screening for tobacco use and offering tobacco cessation treatment support, see Appendix G.



This infographic produced by the National Behavioral Health Network outlines key tobacco-free campus policy implementation steps for mental health and substance use treatment settings. It will be useful in supporting efforts to educate allies on the process.

Implementing any new policy or practice can be a lengthy, challenging process. Mental health and substance use treatment settings, with guidance and support from statewide tobacco control programs, need to develop a system for ongoing staff training, routine data collection, stakeholder and client engagement activities and messaging to maintain staff, client and leadership buy-in. Be prepared to answer questions at all points in the process in a way that assists critical partners with moving from resistance to engagement. There will need to be support long after implementing changes in policy or practice. There may be issues with staff retention, competing organizational priorities and implementation challenges that prevent lasting adherence to new system changes. Ensure that the statewide tobacco control program commits to regular, ongoing communications to sustain and improve policy, screening and treatment efforts within mental health and substance use treatment settings and encourages providers to keep up their good work.

A FINAL THOUGHT

Statewide tobacco control programs have a unique and vital role to play in addressing tobacco-related health disparities among individuals with MH/SUDs. It is a role that requires tobacco control expertise, influence and resources and requires programs to intentionally seek out and acknowledge the expertise and influence of a community they may not know well. In fact, utilizing community-based expertise in every step of the process to implement a specific policy or practice change is the most important thing to ensure success and sustainability. This work cannot be accomplished from behind a desk. This work cannot be accomplished by selecting the solution first and going to community second. This work cannot be accomplished without acknowledging the intentional historical, contemporary and structural decisions that have contributed to the disparities, including those made by public health institutions and influenced by racism and inequity. This work cannot be accomplished alone, but it can be accomplish together. The National Council stands ready to support statewide tobacco control programs as they begin these efforts.

ADDITIONAL TOOLS AND RESOURCES

There are a wide variety of resources to support the full breadth of mental health and substance use organizations seeking to improve tobacco control initiatives for individuals with MH/SUDs. The following chart includes resources that address topics such as provider and public education, electronic nicotine delivery systems (ENDS), tobacco cessation treatment services, data and evaluation, billing, advocacy and policy. These resources will be helpful in leading, guiding, inspiring and supporting various stakeholders.

RESOURCE TITLE	PRIMARY AUTHOR	TOPIC(S) COVERED
Quitting Tobacco: Help Your Client to a Healthier Life	SAMHSA	Provider education
HIV and Tobacco Use: Pharmacological and Behavioral Methods to Help Your Patients Quit	Mountain Plains AIDS Education and Training Center	Provider education
Pharmacologic Product Guide: FDA-Approved Medications for Smoking Cessation	American Academy of Family Physicians	Provider education, tobacco treatment
Tobacco Cessation Provider Toolkit	Los Angeles Care Health Plan	Provider education
Clinician's Guide to Treating Tobacco Dependence	American Association for Respiratory Care Tobacco-Free Lifestyle Roundtable	Provider education
Billing Guide for Tobacco Screening and Cessation	American Lung Association	Provider education, billing
Billing Guide Addendum for Behavioral Health	American Lung Association	Provider education, billing
Tobacco Use Prevention and Cessation Counseling: Coding Reference	American Academy of Family Physicians	Provider education, billing
Smoking Cessation for Persons with Mental Illnesses: A Toolkit for Mental Health Providers	University of Colorado Denver	Provider education
Toolkit for Delivering the 5A's and 5R's to Brief Tobacco Interventions in Primary Care	World Health Organization	Provider education
What's in Your Vape? Toolkit for Parents, Grandparents & Caregivers	Alliance of Coalitions for Healthy Communities	Public education, ENDS
E-Cigarettes: A Growing Concern	University of Wisconsin (UW) Population Health Sciences	Public education, ENDS
Vaping and Electronic Cigarettes (E-Cigs)	UW Center for Tobacco Research and Intervention	Public education, ENDS
Electronic Cigarettes Prevention Toolkit: Know the Facts	United Way of Broward County Commission on Behavioral Health and Drug Prevention	Public education, ENDS, advocacy
Reduce Vaping Among Youth and Young Adults	SAMHSA	Public education, ENDS
Integrating Tobacco Cessation into Electronic Health Records	American Academy of Family Physicians	Practice

Dimensions: Peer Support Program Toolkit	Behavioral Health and Wellness Program	Practice
Program Infrastructure in Tobacco Prevention and Control	Centers for Disease Control and Prevention	Practice
Treating Tobacco Dependence Practice Manual: A Systems-change Approach	American Academy of Family Physicians	Practice
Destination Tobacco Free: A Practical Tool for Hospitals and Health Systems	University of California San Francisco: Smoking Cessation Leadership Center	Practice
Hospital Community Benefits and Tobacco Cessation Toolkit	American Lung Association	Practice, data, evaluation
Kansas Tobacco Guideline for Behavioral Health Care: An Implementation Toolkit	Public Health Law Center	Practice, provider education, billing
Implementing Tobacco Cessation Programs in Substance Use Disorder Treatment Settings: A Quick Guide for Program Directors and Clinicians	SAMHSA	Practice
Enhance Your State's Tobacco Cessation Efforts Among the Behavioral Health Population	SAMHSA	Practice, data, evaluation
Tobacco-Free Living in Psychiatric Settings	National Association of State Mental Health Program Directors	Practice
Tobacco-Free Toolkit for Community Health Facilities	Department of Health and Human Services, Los Angeles County Department of Public Health	Policy
Creating a Tobacco Free Campus: A Policy Guide	Public Health Seattle and King County	Policy
Regulating Tobacco Use Outdoors	Tobacco Control Legal Consortium	Policy
Keeping Your Hospital Property Smoke-Free: Successful Strategies for Effective Policy Enforcement and Maintenance	The Joint Commission	Policy
Policy Strategies: A Tobacco Control Guide	Tobacco Control Legal Consortium	Policy
Adopting Tobacco-free Policies on Campuses	Tobacco Control Legal Consortium	Policy
Dimensions: Tobacco-Free Policy Toolkit	Behavioral Health and Wellness Program	Policy
Recommendations and Guidelines for Policies & Procedures in Tobacco-Free Facilities in Wisconsin's Substance Use & Mental Health Treatment Programs	Wisconsin Department of Health Services	Policy
Toolkit to Integrate Tobacco Treatment and Policies into Montana's Behavioral Health Systems	Montana Department of Public Health and Human Services	Policy, practice
Smoke-Free Policies: Establishing a Smoke-Free Ordinance to Reduce Exposure to Secondhand Smoke in Indoor Worksites and Public Places	Partnership for Prevention	Policy

For more information and up to date resources, visit **https://www.BHtheChange.org/**

APPENDICES

APPENDIX A Talking Points

APPENDIX B Data Planning Worksheet

APPENDIX C Power Map Tool

APPENDIX D Action Plan Template

APPENDIX E Action Plan Menu of Options

APPENDIX F Performance Measures for Addressing Mental Health and Substance Use Tobacco-related Disparities

APPENDIX G Frequently Asked Questions and Suggested Responses

APPENDIX A

Working with Behavioral Health Systems to Address Tobacco-related Disparities: Talking Points

It is important to have a messaging approach in mind before speaking to organizational leaders, behavioral health treatment providers and community stakeholders about the benefits of going tobacco-free, increasing screening for nicotine dependence and supporting tobacco cessation treatment and counseling. The following talking points succinctly provide persuasive facts that are tailored to each audience, giving stakeholders information they need to make informed decisions about the role they would like to play in the initiative.

FOR INTERNAL STATE HEALTH DEPARTMENT LEADERSHIP

State health department leadership may need to better understand the rationale for moving into what may be viewed as "another agency's lane." This can be especially true when a state behavioral health program sits within a different state department or agency than the statewide tobacco control program. If this is the case, these points are important to make clear:

- Collaborating across multiple sectors allows the health department to more readily and cost-effectively address health disparities, promote healthy communities and ensure quality clinical and community preventive services. Partnering with behavioral health on tobacco control reflects a commitment to addressing disparities and promoting health equity.
- Successful efforts to improve the health and wellbeing of the state's residents must be made in partnership with other sectors. The tobacco control program strongly believes that it will take the unique expertise of public health combined with the unique expertise of behavioral health to adequately achieve [insert tobacco control priority here].
- It will be a win for the tobacco control program and the health department to be viewed as an asset to other organizations – those within and outside of state government. The aim will be to understand others' priorities and processes and see how we can fit in.

FOR BEHAVIORAL HEALTH LEADERSHIP

Organizational leadership is often interested in retaining clients and staff, offering high-quality services and maintaining the fiscal health of the business. In addition to these points, it would be helpful for them to know:

- Tobacco cessation is one of the most cost-effective preventive services, with as much as a $2 to $3 return on every dollar invested.
- Tobacco cessation treatment services are reimbursable through Medicaid and most private insurance plans. [Be sure to know exactly what state Medicaid covers for clients and reimburses for providers.]
- Clients expect their health care professionals to address tobacco use and their satisfaction is linked to this expectation. There is no realistic or documented long-term risk of losing clients if we adopt a tobacco-free campus policy.
- Organizational change can be difficult for clients and staff; however, it is no different than any other change the organization has taken on. Employing change management techniques will help engage staff and clients in a transparent process that will assist in retaining staff and clients and improve their health.

FOR BEHAVIORAL HEALTH PROVIDERS

Providers might wonder how they could integrate tobacco screening and tobacco cessation treatment into their practices given all their other organizational obligations. Highlight the following:

- It is our moral and professional obligation to address tobacco use, as we would address any other behavioral health issue. If you are providing substance use services, you can easily incorporate tobacco cessation.
- Even though there is anticipatory implementation anxiety, tobacco-free campus policies lead to more attractive treatment environments for both clients and employees.
- Tobacco can be built into a whole-health initiative and marketed to the agencies' advantage. Tobacco cessation and tobacco-free environments are critical to recovery.
- Integration is the new norm and tobacco services are a mandated component of integrated health services. You don't have to reinvent anything; there are ample resources for training that already exist.
- Workflow examples exist for integrating tobacco into screening, assessment and daily practice.

FOR COMMUNITY STAKEHOLDERS

Community members and businesses are interested in being good neighbors and protecting the interests of their business. Recruit partners by communicating the following:

- As health care providers, we are committed to improving the health and quality of life of the people we serve. By becoming completely tobacco-free, we are acknowledging that tobacco use is the number one cause of preventable disease in our community.
- It is important for us to be tobacco-free because it encourages people to adopt a healthier tobacco-free lifestyle and protects people from the hazards of secondhand smoke. A tobacco-free campus sets an example for healthy behavior and promotes a healthy community.
- We are implementing/have implemented a tobacco-free campus policy, which means that clients and staff cannot use tobacco on the premises. This could cause unintended consequences, for example, people moving off our property to nearby businesses to use tobacco. Our intention is to support our neighbors in experiencing similar benefits of maintaining tobacco-free environments and have sample signage and messaging and policy language to share if you are interested in going tobacco-free.

APPENDIX B

Data Planning Worksheet

The goal of this worksheet is to improve the collection and use of data among statewide tobacco control programs when working to address tobacco-related health disparities among individuals with mental health and substance use disorders.

SECTION A: PROGRAM CAPACITY

1. Currently, how would you rate the capacity of your program *to collect* tobacco-related data specific to the behavioral health population? Please choose one number rating on the 0 to 10 scale below.

0	1	2	3	4	5	6	7	8	9	10
Very Low					Average					Very High

2. Currently, how would you rate the capacity of your program *to use* tobacco-related data specific to the behavioral health population to tailor and/or target interventions? Please choose one number rating on the 0 to 10 scale below.

0	1	2	3	4	5	6	7	8	9	10
Very Low					Average					Very High

3. About how often does your program use data to measure or monitor tobacco burden and disparities for the behavioral health population in your state? Choose the one option that most closely describes the frequency of your data usage.

Less than once every 5 years	Biennially (approximately every other year)
Approximately every 5 years	Each year (annually)
Approximately every 3-4 years	More than 1 time each year

SECTION B: DATA SOURCES

4. What data sources does your program *regularly use to measure, monitor and evaluate* tobacco-related outcomes for the behavioral health population in your state?

National Data Sources

National Youth Tobacco Surveys	National Health and Nutrition Examination Survey
National Adult Tobacco Surveys	National Survey and Drug Use and Health Survey
National Health Interview Surveys	Current Population Survey
Youth Risk Factor Surveillance Systems	Other National Data (please specify:

State Data Sources	
State Behavior Risk Factor Survey	Youth Tobacco Surveys
State Medicaid Data	State Health Interview Surveys
State Quitline Data	Youth Risk Factor Surveillance Systems (YRBS)
State Youth Tobacco Surveys	State Health and Nutrition Examination Survey
State Adult Tobacco Surveys	State Survey of Drug Use and Health
Other State Data (please specify:	
Local or Other Data Sources	
Special Population Risk Factor Survey	Qualitative Data (focus groups, interviews, photovoice)
Hospital Data	System Assessments (quality, readiness, capacity)
EHR Data	Other Data (please specify:

5. What data sources does your program *want to have available to measure, monitor, and evaluate* tobacco-related outcomes for the behavioral health population in your state?

National Data Sources	
National Youth Tobacco Surveys	National Health and Nutrition Examination Survey
National Adult Tobacco Surveys	National Survey and Drug Use and Health Survey
National Health Interview Surveys	Current Population Survey
Youth Risk Factor Surveillance Systems	Other National Data (please specify:
State Data Sources	
State Behavior Risk Factor Survey	Youth Tobacco Surveys
State Medicaid Data	State Health Interview Surveys
State Quitline Data	Youth Risk Factor Surveillance Systems (YRBS)
State Youth Tobacco Surveys	State Health and Nutrition Examination Survey
State Adult Tobacco Surveys	State Survey of Drug Use and Health
Other State Data (please specify:	

Local or Other Data Sources	
Special Population Risk Factor Survey	Qualitative Data (focus groups, interviews, photovoice)
Hospital Data	System Assessments (quality, readiness, capacity)
EHR Data	Other Data (please specify:

SECTION C: DATA COLLECTION

6. What question(s) do you have related to tobacco use or tobacco control with behavioral health populations in your state? *What would you like to know in order to effectively plan, monitor, or evaluate your efforts?*

7. What types of data do you need to answer these questions? *What is on your data wish list?*

8. What specific questions or indicators would you ideally have data available for when planning, monitoring or evaluating?

APPENDIX C

Power Mapping Tool

This tool is derived from a power mapping activity and a tool for utilizing networks to help identify key stakeholders for engagement.

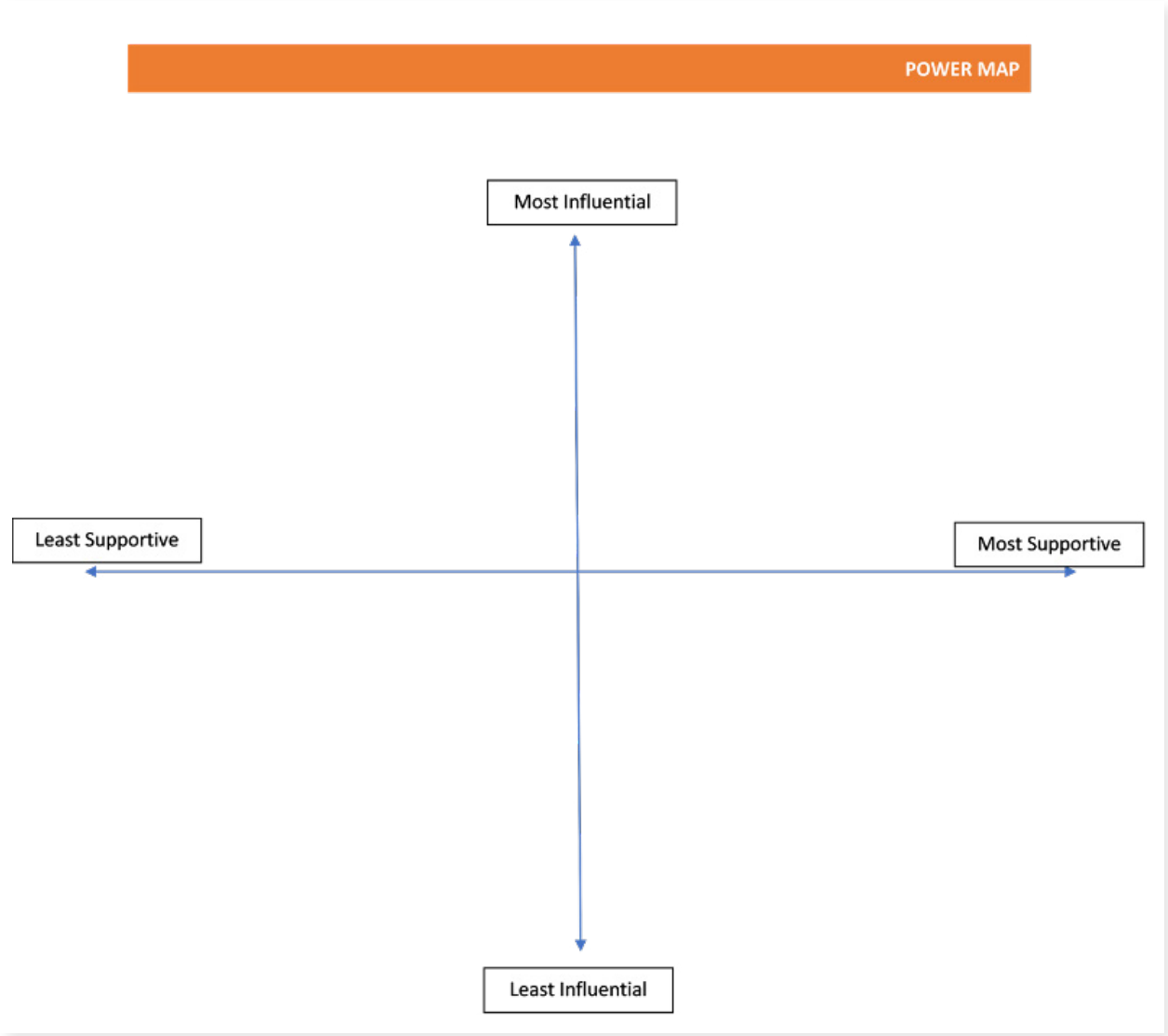
Materials Needed: Chart paper/markers or whiteboard/markers, sticky notes

Who Participates: Current partners

STEPS:

1. Clearly identify the desired goal or outcome you are working to achieve. If there are multiple goals or outcomes, you may want to create one map for each.
2. Brainstorm a list of key stakeholders you need to engage to achieve your goal/outcome. Write each name/role/organization on a sticky note.
3. Consider which organizations are essential to achieving your desired outcome/goal? Be sure to include those already involved in the effort.
    - Who has the expertise required to achieve the desired outcome?
    - Who has the resources required to achieve the desired outcome?
    - Who do we already have buy-in from?
    - Who needs to be supportive but isn't?
    - What other organizations may be impacted by our efforts and may or may not be supportive?
4. Using chart paper or a whiteboard:
    - Draw a simple X and Y axis.
    - Label the X axis from left to right "Least Supportive" and "Most Supportive."
    - Label the Y axis from top to bottom "Most Influential" and "Least Influential."
    - Write desired goal/outcome at top of chart paper or whiteboard.
5. Plot each sticky note on your power map. To determine best placement, your group should consider the following:
    - To what extent does this person/role/organization have influence to affect the desired outcome/goal?
    - What is this person/role/organization's level of support towards the desired outcome/goal?
6. As a group, discuss the following to help you prioritize your next steps:
    - Is there a key perspective missing from our efforts?
    - Do we need to find and engage this perspective?
    - Do we have a specific "ask" of them?
    - Do we need to keep them in our communication loop?
    - Do we do nothing?

7. Discuss how you will prioritize reaching out to new partners. Consider:
   - Who to engage.
   - Key message and specific "ask."
   - Method of communication.
   - Frequency of communication.
   - Person responsible.



APPENDIX D

Action Plan Template

Instructions: Develop 3-4 SMART objectives (Specific, Measurable, Attainable/Achievable, Relevant and Time-bound) focused on tobacco control and systems-level change. Write them into the appropriate boxes.

SMART OBJECTIVE 1:					
Action Step	**Action Step Lead**	**Targeted Completion Date**	**Resources Needed**	**Measure & Performance Indicator**	**Status Update**
1.					
2.					
3.					
4.					
5.					

On a scale from 1-10, how confident are you about achieving this objective? 1=no confidence, 10=extremely confident	Confidence score:
On a scale from 1-10, how committed are you to achieving this objective? 1= no commitment, 10=extremely committed	Commitment score:

SMART OBJECTIVE 2:					
Action Step	**Action Step Lead**	**Targeted Completion Date**	**Resources Needed**	**Measure & Performance Indicator**	**Status Update**
1.					
2.					
3.					
4.					
5.					

On a scale from 1-10, how confident are you about achieving this objective? 1=no confidence, 10=extremely confident	Confidence score:
On a scale from 1-10, how committed are you to achieving this objective? 1= no commitment, 10=extremely committed	Commitment score:

SMART OBJECTIVE 3:					
Action Step	**Action Step Lead**	**Targeted Completion Date**	**Resources Needed**	**Measure & Performance Indicator**	**Status Update**
1.					
2.					
3.					
4.					
5.					

On a scale from 1-10, how confident are you about achieving this objective? 1=no confidence, 10=extremely confident	Confidence score:
On a scale from 1-10, how committed are you to achieving this objective? 1= no commitment, 10=extremely committed	Commitment score:

APPENDIX E

Working with Behavioral Health Systems to Address Tobacco-related Disparities: Action Plan Menu of Options

Developing an action plan with behavioral health partners to implement tobacco-free campus policies, including strengthening tobacco use and dependence screening and supporting tobacco cessation treatment options, may feel like an overwhelming process. Setting achievable and concrete goals can help to ensure incremental progress.

The following menu provides concrete activities that could be pursued collaboratively with behavioral health partners to implement tobacco-free policies, engage staff, use data for quality improvement, enhance partnerships, improve cessation services and sustain progress. Be sure to consider the unique needs of behavioral health partners while choosing activities. It is okay to start with a few – not every issue will be addressed overnight. Success will require consistent engagement and effort, and progress is possible.

ESTABLISH AND/OR ENHANCE PARTNERSHIPS

- Increase and/or enhance partnerships with intentionally selected behavioral health treatment providers.
- Build relationships with behavioral health system administrators. For some states, this may mean increasing trust between the statewide tobacco control program and the state-level behavioral health agency. It could also mean building trust between statewide tobacco control program staff and a leadership team of a specific behavioral health treatment system with multiple campuses across the state.
- Identify shared goals and co-benefits across sectors.
- Fund existing or potential initiatives/programs prioritized by behavioral health partners (e.g., through grants or shared-funding mechanisms) or leverage funding from complementary programs to support cross-agency efforts.
- Host peer-learning opportunities for behavioral health treatment providers.
- Tailor campaign and/or marketing efforts so behavioral health partners don't have to. Better yet, engage partners and their clients in determining how best to tailor campaign messages.
- Build a coalition dedicated to policy change within treatment settings.
- Expand tobacco control education and resources in behavioral health treatment settings through webinars, workshops and classroom trainings.
- Host a summit, symposium or panel discussion on a topic prioritized by behavioral health partners.
- Collaborate with large insurers in the state to encourage eliminating the cost burden for those seeking tobacco cessation treatment services (e.g., eliminating or minimizing copays or deductibles for counseling and medications).

IMPLEMENT AND/OR ENHANCE EXISTING POLICIES

- Assess current behavioral health system climate (attitudes and beliefs; support and opposition) surrounding tobacco cessation treatment, prevention, and policy change.
- Collect information about current tobacco-related policies and practices in a specific behavioral health treatment setting to identify strengths, gaps and potential opportunities to leverage.
- Determine essential resources, including key stakeholders and potential partners, that will be necessary for planning and implementing a tobacco-free campus policy effort.

- Establish a customer relationship management tool to track key partnership information and activities surrounding planning and implementation milestones.
- Implement a tobacco-free campus policy or a smoke-free air policy that provides a completely tobacco-free indoor environment with tobacco-free buffer zones. An infographic of next steps can be found here: https://www.bhthechange.org/wp-content/uploads/ 2018/11/NBHN_TobaccoFreePolicyInfographic.pdf.
- Update a current tobacco-free behavioral health campus policy.
  - Does the current policy include e-cigarettes?
  - Could the current policy extend the exterior distance?
- Support a behavioral health treatment setting in updating their smoke-free air policy by engaging in discussion or providing training/assistance on tobacco-free campus policies, for example.
- Maintain or improve the effectiveness of a current tobacco-free campus policy:
  - Organize a refresher training with staff to avoid the natural drop-off in enforcement that occurs with passing time and staff turnover. Consider including role-playing exercises. Examples can be found on page 10 in the Tobacco-Free Initiative Information Kit.
  - Add more signage to remind clients and staff about policies and procedures.
  - Add more client-facing materials to waiting and exam rooms (e.g., quit cards).

Develop a script that behavioral health treatment setting staff can use to remind individuals that they are on a tobacco-free campus; encourage staff to practice the script in staff meetings, in board meetings, and in group meetings.

Develop a "we are tobacco free" card that provides details about campus polices for staff to use when verbal confrontation is not appropriate.

INCREASE AND/OR ENHANCE STAFF ENGAGEMENT AND EDUCATION

- Provide resources or incentives for behavioral health treatment setting staff who are attempting to quit (including counseling and medication).
- Conduct or host training for behavioral health treatment setting staff on:
  - Tobacco and behavioral health disparities
  - Clinical best practices, including counseling and medications (NRTs and non-NRTs)
  - The state quitline
  - Tobacco and recovery outcomes
  - Tobacco cessation billing codes (inpatient/outpatient)
  - 5 A's (Ask, Advise, Assess, Assist, Arrange)
  - 5 R's (Relevance, Risks, Rewards, Roadblocks, Repetition)
  - Motivational interviewing
  - Screening, Brief Intervention, and Referral to Treatments
- Provide staff with continuing education unit (CEU) credits or other incentives for trainings. Promote the Smoking Cessation Leadership Center's free trainings offered for up to 20 CEUs annually through support from Substance Abuse and Mental Health Services Administration (SAMHSA).

- Establish a wellness committee that addresses overall staff health.
- Support staff in receiving Tobacco Treatment Specialist credentialing.
- Designate physician champions in local hospitals and clinics to encourage provider peers to seek knowledge on new tobacco treatment models and become advocates for change within in their health care system.
- Disseminate clinical guidelines on best practices for counseling clients on their tobacco use.
- Work with experts in the field to deliver training and information (e.g., communities of practice, advisory boards, consultants, technical assistance providers, quality improvement organizations, research institutions).
- Make performance feedback an integral part of treatment.

INCREASE USE OF EVIDENCE-BASED INTERVENTIONS

- Develop a standardized method for conducting screening, brief intervention, and referral to treatment.
- Redesign the clinical delivery system for tobacco cessation treatment and services (workflows and responsibilities).
- Embed a reminder system into services for both clients and providers (e.g., apps, emails, phone calls, patient portals).
- Update electronic health records to include information on clients' smoking status and/or include a cessation component.
- Ensure providers address language barriers by using a teach-back method when explaining tobacco cessation treatment options or other cessation services.
- Offer in-house tobacco cessation counseling services (e.g., longer visits/sessions, follow-up calls, telehealth, individual and group counseling).
- Support state quitline capacity and promotion of quitline referrals.
- Make tobacco cessation treatment services more accessible (internet-based, self-help, telehealth).
- Promote or support coverage of tobacco cessation treatment services for uninsured clients.
- Promote access to tobacco cessation treatment options by offering FDA-approved first-line tobacco-dependence pharmacotherapies to all tobacco users who are trying to quit.
- Provide NRTs to tobacco cessation group counseling members before starting sessions or assist with increased access for NRTs for group attendees.
- Offer samples or other incentives to increase patient use of NRTs.
- Make opportunities for combination therapies available to clients (e.g., nicotine patch plus bupropion).
- Increase use of the "5 A's" model (Ask, Advise, Assess, Assist, Arrange).
- Implement a peer-based approach to counseling (e.g., peer specialists/tobacco treatment specialists).
- Integrate motivational interviewing in all treatment/tobacco cessation treatment services.

USE DATA FOR CONTINUOUS QUALITY IMPROVEMENT

- Develop a behavioral health treatment provider contact list for a local community, county, or state. Identify baseline data and develop an evaluation plan that answers the following questions:
  - Client level
    - How many clients actively use tobacco?
    - How many clients have been provided with evidence-based tobacco cessation treatment interventions in the past year (including screening, counseling, and medications).
    - How often are clients screened and rescreened for tobacco use?

  - Organizational level
    - How many facilities have smoke-free air policies? Tobacco-free campus policies?
    - How many people would be impacted by tobacco-free campus policies?
    - Where are the smoking locations on campuses?
    - What else could these areas be turned into to better use public space?

- Design electronic health record systems to assess and document the tobacco use status of all adult and young adult clients, inclusive of high school students.
- Conduct an assessment of current tobacco-related policies in private and public behavioral health treatment settings (see sample survey from New Jersey).
- Conduct an assessment of the implementation of evidence-based tobacco cessation treatment interventions in private and public behavioral health treatment settings.
- Update an existing assessment of the implementation of evidence-based tobacco cessation treatment interventions in private and public behavioral health treatment settings.
- Evaluate quality of care in behavioral health treatment settings and general hospitals by incorporating tobacco cessation treatment assessment as a measure for standard of care and staff performance evaluations.

APPENDIX F

Performance Measures for Addressing Behavioral Health Tobacco-related Disparities

This worksheet will assist statewide tobacco control programs in assessing current capacity and needs related to four performance measures: partnerships, evidence-based interventions, comprehensive smoke-free strategies and quit attempts. If data are not currently available, or are never available, please check the box indicating that option. Try not to skip or leave any section blank. Use the notes field to explain or describe your assessment of your program, as needed.

PARTNERSHIPS — *Number of agency or partner relationships focused on addressing tobacco-related disparities among the behavioral health population.*

Program Measure	Data Source and Year	Check the types of groups/ organizations that are current partners for addressing disparities among the behavioral health population (check all):	Check the types of groups/ organizations that your program NEEDS to develop relationships with to improve your efforts to address disparities among the behavioral health population (check all):	Check this box if these data are not yet available for your state
# of Partner Organizations		Other state health programs State human service programs Medicaid/Medicare Health plans Health/hospital systems Cancer centers Community behavioral health Organizations Professional associations Patient advocacy groups Coalitions/advisory groups Federal agencies Academic/research Institutions Other:	Other state health programs State human service programs Medicaid/Medicare Health plans Health/hospital systems Cancer centers Community behavioral health Organizations Professional associations Patient advocacy groups Coalitions/advisory groups Federal agencies Academic/research Institutions Other:	Not available or unknown

Notes on current partnerships:

EVIDENCE-BASED INTERVENTIONS (EBIs) — *Number of evidence-based interventions (EBIs) supported or led by your program that are targeted to reach and impact behavioral health populations through state, tribal, territorial or local organizations.*

Program Measure	Data Source and Year	List the types of existing tobacco prevention and control EBIs in your state targeted to reach and impact behavioral health populations.	List the types of tobacco prevention and control EBIs to reach and impact behavioral health populations that your program NEEDS help developing or implementing with partners.	Check this box if these data are not yet available for your state
Total # of EBIs				Not available or unknown

Notes about evidence-based interventions:

COMPREHENSIVE SMOKE-FREE STRATEGIES — *Number of persons covered by 100% comprehensive smoke-free laws.*

Program Measure	Data Source and Year	List the types of smoke-free facility policies currently protecting behavioral health populations in your state.	How does your state collect or compile these data?	Check this box if these data are not yet available for your state
# of Behavioral Health Facilities with Smoke-free Policies				Not available or unknown

Program Measure	Data Source and Year	List the types of smoke-free policies currently protecting behavioral health populations in your state.	How does your state collect or compile these data?	Check this box if these data are not yet available for your state
# of Persons Covered/ Occupancy of Facilities with Smoke-free Policies				Not available or unknown

Notes about smoke-free policies:

QUIT ATTEMPTS — *Number of adults with behavioral health concerns who have attempted to quit tobacco using state quitline.*

Program Measure	Data Source and Year (most recent)	Behavioral health population defined or identified by:	How often does your state collect or compile these data?	Check this box if these data are not yet available for your state
Total # of individuals with behavioral health concerns enrolled in quitline services per year		Ever diagnosed by doctor with depression 14 or more days of poor mental health in past month Binge drinking Heavy drinking ICD-10 Code Other:		Not available or unknown

Notes about evidence-based interventions:

APPENDIX G

Working with Behavioral Health Systems to Address Tobacco-related Disparities: Frequently Asked Questions and Suggested Responses

WHAT POSITIVE OUTCOMES CAN BE EXPECTED AFTER IMPLEMENTING A TOBACCO-FREE CAMPUS POLICY?

Organizations have had success with increasing cessation rates among clients and staff after going tobacco-free. Offering tobacco cessation treatment services in tandem with policy implementation can enhance the therapeutic relationship, since clients expect their health care providers to address tobacco use and their satisfaction increases when this occurs.

OUR CLIENTS HAVE ALREADY GIVEN UP SO MUCH (E.G., ALCOHOL, OTHER SUBSTANCES). HOW CAN WE ASK THEM TO GIVE UP SMOKING, TOO?

You will not be asking your clients to give up a right – smoking is not a protected right. In fact, we now know that much of the language around "rights" and tobacco use has been created by the tobacco industry to ensure ongoing consumption. You will be engaging in a process of motivational interviewing where the client comes to their own conclusion that quitting is their best option for a healthy future. Treat this as you would any other behavioral health condition that you approach from a motivational interviewing perspective. You work with clients on a daily basis to address some very challenging behaviors and thought patterns, and tobacco is no different. Many individuals with mental health or substance use disorders want to quit and can quit.

MY CLIENTS SAY SMOKING HELPS WITH THEIR ANXIETY. IF THEY TRY TO QUIT, WON'T THAT CAUSE AN INCREASE IN ANXIETY AND NEGATIVELY IMPACT RECOVERY OUTCOMES?

Smoking can actually worsen mental health symptoms and have adverse interactions with medications. The "anxiety" a person may experience during a quit attempt is actually nicotine withdrawal, which subsides within two to four weeks.

WE SCREEN FOR TOBACCO USE BUT AREN'T ABLE TO OFFER TOBACCO CESSATION TREATMENT SUPPORT IN-HOUSE. IF MY CLIENTS INDICATE TOBACCO USE, THEN WHAT OPTIONS DO I HAVE TO OFFER THEM?

Tobacco cessation treatment is an important component of therapy; therefore, clinicians have a responsibility to address this issue. If time or expertise is lacking, you can refer your clients to the state quitline that provides free cessation counseling and often offers additional supports, depending on the state. If appropriate, you can also weave discussions about coping strategies into your interactions by identifying triggers to use, identifying alternate activities or routines and educating them on the many nicotine replacement therapies (NRTs).

WE OFFER CESSATION SUPPORT GROUPS, BUT NO ONE SHOWS UP. WHY KEEP OFFERING THE GROUPS IF NO ONE ATTENDS? HOW CAN WE RECRUIT PEOPLE TO COME AND STICK WITH THE GROUP?

Some programs have seen success by improving access to NRTs upon arrival to the group session to allay cravings. Support groups are just one component of a comprehensive cessation program, so organizations should offer a number of services that address the behavioral and physiological components of quitting tobacco.

WILL WE LOSE CLIENTS TO OTHER FACILITIES WHERE SMOKING IS STILL ALLOWED?

Although this is a common concern, research has not shown it to be a reality. Clients expect their health care professionals to address tobacco cessation and many want to quit and are capable of quitting. Explain that because some clients may be trying to quit, you are giving them every opportunity to succeed by removing triggers, such as having to walk by a cloud of smoke to enter the building where they receive treatment.

WHAT ABOUT E-CIGARETTES AND VAPING IN OUR TOBACCO-FREE POLICY? SHOULD WE INCLUDE THEM IN OUR POLICY?

Yes, your policy should be written to address all electronic nicotine delivery systems. Though e-cigarettes and vaping have been marketed as a tobacco cessation approach, it is not an FDA-approved cessation tool. The long-term effects of e-cigarettes and vaping are also unclear, though we do know that their delivery methods often include harmful chemicals.

ISN'T TOBACCO USE A RIGHT?

Tobacco use and individuals who use tobacco are not a protected class or a protected right. In addition, no health care provider should condone tobacco use by clients or staff on the premises during treatment or during the workday. Behavioral health treatment providers have an obligation to provide treatment and recovery services, and to afford their clients every opportunity to succeed. That includes making the campus a safe and healthy environment for everyone, including clients who do not use tobacco and those attempting to quit.

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