# Enhance Your State's Tobacco Cessation Efforts Among the Behavioral Health Population

A Behavioral Health Resource

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# Introduction

The message is spreading across the country. State program planners, behavioral health service providers, insurers, and other stakeholders are becoming increasingly aware of this disparity: compared with the general population, people with mental or substance use disorders (M/SUDs) are more likely to smoke, buy cigarettes, and get sick or die of tobacco-related causes.

After decades of myths and misconceptions, people involved in planning state behavioral health and tobacco programs are stepping up prevention and cessation programs focused on these vulnerable populations, particularly in the health settings they turn to for services.

Using research findings and data—and with the backing of federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC) and partners such as the University of California's Smoking Cessation Leadership Center (SCLC)—these stakeholders are joining with clinical staff, behavioral health agencies, and associations to increase their state's tobacco use prevention and cessation efforts for the behavioral health population.

Is your state in the early stages of forming these types of partnerships? Then this resource will provide scientific data and evidence to help you make the case for integrating tobacco use prevention and cessation in behavioral health services. It will highlight the disparities between the general and behavioral health populations (see adjoining graphic). And it will demonstrate that cessation efforts produce positive SUD and mental health recovery outcomes.

Has your state already achieved buy-in and formed action-oriented collaborations? Then this resource will help you capture your progress by providing examples of how other states are using accurate baseline and continuing prevalence data on tobacco use and cessation.

**MAKE YOUR CASE:** POINT OUT THE DISPARITIES

**1** Tobacco smoking causes more deaths among clients in substance use treatment than the alcohol or other drug use that brings them to treatment.[1]

**51%** of deaths were the result of tobacco-related causes. That rate is ...

**>2x** the rate found in the general population.

**2** Smokers with serious mental illness...[2]

Have increased risk for cancer, lung disease, and cardiovascular disease.

Die several years sooner, on average, than Americans without serious mental illness.

**3** Smoking rates (1997 through 2011)...[3]

Decreased steadily among adults WITHOUT serious psychological distress (SPD) (from 24.1 to 18.2%).

**BUT**

Remained high and steady among adults WITH SPD (43.6% in 1997 and 42.1% in 2011).

**4** From 2009 through 2011, adults with any mental or substance use disorder...[4]

Represented **25%** of adults but used **40%** of all cigarettes smoked by adults.

[1] Hurt et al. (1996), a seminal 11-year retrospective cohort study of 845 people who had been in addictions treatment (described in SAMHSA, [2011]).
[2] Prochaska (2011).
[3] SAMHSA, Center for Behavioral Health Statistics and Quality (2013).
[4] SAMHSA (2013b).

# BACKGROUND

## *SAMHSA Tobacco Cessation Efforts in Behavioral Health*

SAMHSA has done extensive work with several states to lay the groundwork for expanded tobacco use prevention and cessation efforts. Beginning in 2009, partnering with SCLC, SAMHSA launched the 100 Pioneers for Smoking Cessation Campaign. The Campaign provided support to behavioral health facilities and organizations to address tobacco use among people with mental and substance use disorders (Santhosh et al., 2014).

To create broader reach, in 2010, SAMHSA and SCLC began to convene Leadership Academies for Wellness and Smoking Cessation summits. The summits were held with the goal of mobilizing policymakers and stakeholders (including leaders in tobacco control, mental health, SUD prevention and treatment, Medicaid, and public health, as well as behavioral health services consumers) to develop and implement collaborative state-specific action plans to reduce smoking rates among behavioral health services consumers and staff.

In 2014 and 2015, SAMHSA and SCLC held two Policy Academies on Tobacco Control in Behavioral Health. The Policy Academies were an opportunity to invite multiple states to learn about the issue and how they could conduct their own Leadership Academy for Wellness and Smoking Cessation summits.

As of September 2015, 10 states have convened Leadership Academy summits: Arizona, Arkansas, Hawaii, Maryland, Massachusetts, Mississippi, New York, North Carolina, Oklahoma, and Texas. Each summit has produced a comprehensive and fluid action plan based on a Performance Partnership Model focused on finding answers to four questions:

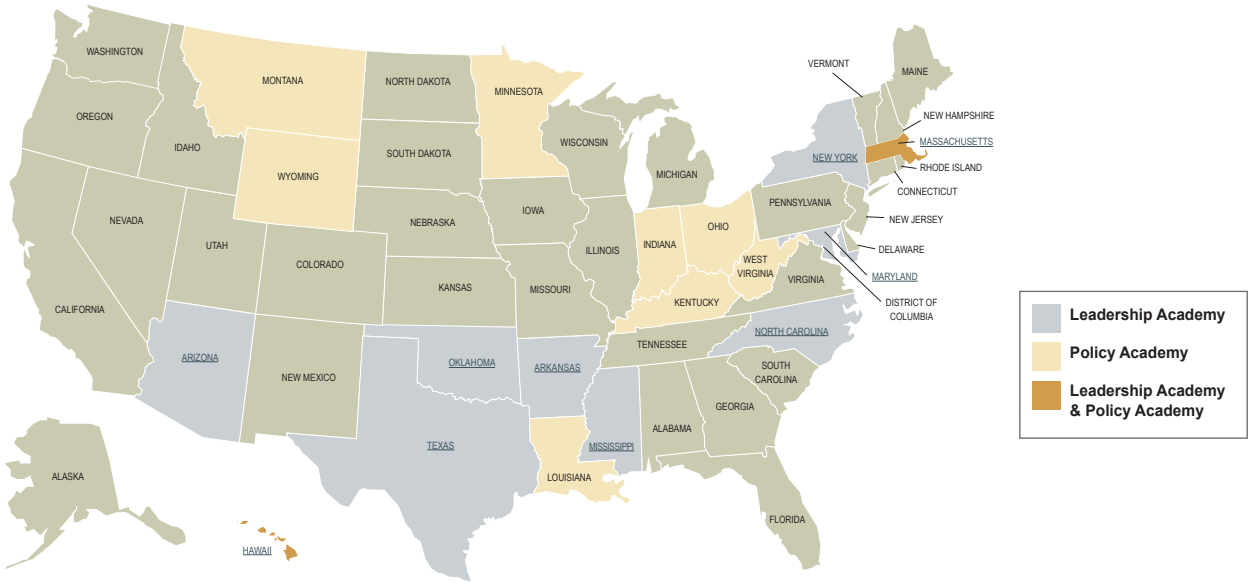
- **Where are we now?** (Baseline)
- **Where do we want to be?** (Target)
- **How do we get there?** (Multiple Strategies)
- **How do we know we are getting there?** (Evaluation)

## *The Academy Experience Can Apply to Other States*

Beyond resulting in concrete action plans, the Leadership Academy summits held to date launched new relationships within states—collaborations that can aid in accomplishing the action plans.

**LEADERSHIP AND POLICY ACADEMY STATES**

(Click on the links in the "blue" states to view Leadership Academy summit action plans)



**A TYPICAL POSTSUMMIT SCENARIO**

- **Several behavioral health services leaders meet at the summit. They form a committee to develop a smoking cessation curriculum.**
- **The state behavioral health department provides funding to train behavioral health services providers in the curriculum.**
- **Meanwhile, another committee that formed at the summit is working on a regulation that would require state-licensed treatment facilities to be tobacco free, both inside and on the outside grounds.**

*That's how a summit can catapult an action plan into some amazing results over a short timeframe.*

You don't have to be in an Academy state to form these kinds of bonds. Just capture the essence of a summit: bring people together, take them out of their silos, and help them realize that they share a unified vision.

## MAKE YOUR CASE WITH SCIENCE-DRIVEN DATA

Are you trying to persuade leaders and stakeholders in your state to adopt tobacco-free facility/grounds policies and to integrate tobacco treatment in behavioral healthcare? Or are you inviting new partners—such as insurance companies and Medicaid representatives—to join your existing efforts? In either scenario, you can use research-based data to make your case in several ways:

**Point out the need.** Use the above-depicted statistics about health and usage disparities between people with mental or substance use disorders who smoke and the general population of smokers.

**Refute any prevailing myths.** Numerous research studies have focused on debunking many myths that are counterproductive to the wellness of the behavioral health population. Five of them are shown in the graphic on the next page.

For example, researchers note that the tobacco industry actually fostered one of those myths—that people with mental illness need tobacco to self-medicate. On the contrary, smoking is associated with poor clinical outcomes, such as greater depressive symptoms (Khaled et al., 2012), greater likelihood of psychiatric hospitalization, and increased suicidal behavior (Berlin et al., 2015). Furthermore, smoking can complicate treatment by accelerating the metabolism of certain psychiatric medications, resulting in the need for higher doses to get the same therapeutic benefit (Prochaska, 2011).

Apollonio and Malone (2005) point out how the industry specifically targeted behavioral healthcare facilities and people with mental or substance use disorders by using promotional giveaways and making charitable donations. Prochaska (2011) lists additional industry leaders' activities to support the self-medication hypothesis: they funded research and presentations; they supported opposition to the smoking ban by the Joint Commission; they published articles in the press; and they marketed cigarettes to people with mental illness.

**Explain the value of continuing data.** Show how your state can incorporate accurate baseline and outcome data on tobacco use and tobacco cessation into its strategic planning. Data can be used both to motivate and to monitor progress. If something isn't working, it will show up in the data. If something is working, the data can be used as a motivator.

**Focus on gaining momentum.** Point to the number of states and facilities that have already responded to the need by offering smoking cessation services to behavioral health services consumers—and how many states and facilities are currently being persuaded by federal, state, and peer leaders to become part of this trend.

**Highlight progress in other states.** Success breeds success. Many states have already developed action plans and are currently implementing them. They are in various stages of initial success. Whether or not your state has embarked on this journey, it is useful to study what other states have done. Consider emulating their strategies or adapting them to your state's specific needs.

**KEEP DEBUNKING THE MYTHS**

**5** Prevailing Myths: **DEBUNKED**

1. **MYTH:** Tobacco is a **necessary** self-medication for people with mental illness.

   **FACT:** Not only is tobacco ineffective as a treatment for mental disorders, but psychiatric disease makes the brain **MORE SUSCEPTIBLE TO ADDICTION**.

2. **MYTH:** People with mental illness are **not interested** in quitting smoking.

   **FACT:** Patients in outpatient and inpatient psychiatric settings are **ABOUT AS LIKELY** as the general population to want to quit smoking.

3. **MYTH:**: People with mental illness **cannot quit** smoking.

   **FACT:** Randomized treatment trials and systematic reviews involving smokers with mental illness document that **SUCCESS IS POSSIBLE**.

4. **MYTH:** Smoking is a coping strategy. Quitting **interferes with recovery** from mental illness and leads to decompensation.

   **FACT:** Smoking cessation **DOES NOT EXACERBATE** depression or PTSD symptoms or lead to psychiatric hospitalization or increased use of alcohol or illicit drugs.

5. **MYTH:** Smoking is the **lowest priority** concern for patients with acute psychiatric symptoms.

   **FACT:** People with psychiatric disorders are **FAR MORE LIKELY TO DIE FROM TOBACCO-RELATED DISEASES** than from mental illness.

Sources: Prochaska (2011); see also Apollonio & Malone (2005); Berg, Sentir, Cooley, Engleman, & Chambers (2013); Chambers (2013 ).

**Describe positive health outcomes.** Recent research findings demonstrate an association between smoking cessation and positive behavioral health outcomes, as described below.

## DESCRIBE POSITIVE BEHAVIORAL HEALTH OUTCOMES

There is strong evidence demonstrating the benefits of providing tobacco cessation and prevention programming for behavioral health services consumers. Several key studies have found an association between smoking cessation and positive behavioral health outcomes:

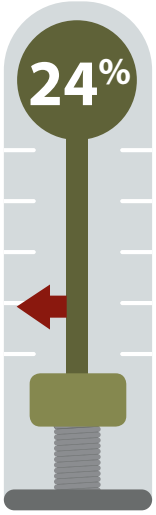
**Positive substance use outcomes:** Smoking cessation interventions may help with long-term abstinence. In a meta-analysis of 19 randomized controlled trials with individuals in current SUD treatment or recovery, smoking cessation interventions provided during treatment were associated with a 25 percent increased likelihood of long-term abstinence from alcohol and illicit drugs (Prochaska, Delucchi, & Hall, 2004).

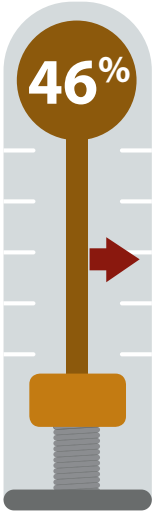
**Positive mental health outcomes:** A systematic review and meta-analysis of 26 studies produced some startling findings: compared with continued smoking, smoking cessation was associated with reduced depression, anxiety, and stress—and it

**OPPORTUNITY FOR CHANGE!**

We are off to a good start. With your help, we can make it all the way!

**MENTAL HEALTH FACILITIES.**
**In 2010, nearly one-quarter (about 24%) of the nation's 9,048 mental health treatment facilities that responded to the survey question about smoking cessation programs actually offered services to quit smoking.**




**SUBSTANCE USE DISORDER TREATMENT FACILITIES.**
**In 2012, nearly half (46%) of the nation's 14,311 facilities offered counseling or medications to help clients quit tobacco use. About 39% offered counseling, 22% offered nicotine replacement medication, and 16% offered non-nicotine medication.**

Sources: SAMHSA (2013a, 2014a, 2014b).

improved mood and quality of life (Taylor et al., 2014; Taylor et al., 2015).

**Positive mental health/substance use outcomes:** Data suggest that smoking cessation is associated with risk reduction for mood/anxiety or alcohol use disorders—even among smokers with a preexisting disorder. By applying statistical analyses to data from the longitudinal National Epidemiological Study of Alcohol and Related Conditions, Cavazos-Rehg et al. (2014) arrived at two conclusions:

- Among smokers with a prior history of a mood or anxiety disorder, smoking cessation was associated with a lower likelihood of recurrence or persistence of the disorder.
- Among smokers with preexisting alcohol use disorder, a recurrence or continuation of the disorder was less likely if they quit smoking.

## CAPTURE YOUR PROGRESS: ACCESS THE DATA YOU NEED

Different states pull their data from different sources. You can choose from a wide variety of benchmark sources to access national- and state-level tobacco use data on both adults and youth:

### *Data About Adults*

- SAMHSA's National Survey on Drug Use and Health (NSDUH) is the primary source of information on the prevalence, patterns, and consequences of alcohol, tobacco, and illegal drug use and mental disorders in the U.S. civilian, noninstitutionalized population, age 12 and older. The survey generates estimates at the national, state, and substate levels.
- SAMHSA's National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual census of all known substance abuse treatment facilities in the United States, both public and private. It includes multipurpose data that you can use in assessing the nature and extent of services provided in your state and in forecasting treatment resource requirements. National-level and state-specific reports provide data on services offered—including nicotine replacement, smoking cessation medications, and smoking cessation counseling programs—and smoking policy.
- SAMHSA's National Mental Health Services Survey (N-MHSS) is an annual survey of all known mental health treatment facilities in the

United States, both public and private. You can find national-level and state-specific reports that provide data on services offered, including smoking cessation services, and smoking policy.

- The Behavioral Risk Factor Surveillance System (BRFSS), sponsored by the Centers for Disease Control and Prevention (CDC), is a system of health-related telephone surveys that collect state data about U.S. residents' health-related risk behaviors, chronic health conditions, and use of preventive services. Its site offers several useful features, including a Prevalence and Trends Tool that allows you to produce different state-level data sets and customize your own charts and graphs by health category, including tobacco use.
- The CDC's National Adult Tobacco Survey (NATS) assesses the prevalence of tobacco use, as well as the factors promoting and impeding tobacco use among adults. NATS also establishes a comprehensive framework for evaluating both the national and state-specific tobacco control programs.
- The National Health Interview Survey (NHIS), an annual survey sponsored by CDC's National Center for Health Statistics (NCHS), collects data on a broad range of health topics, including adult tobacco use, through personal household interviews conducted by the U.S. Census Bureau.
- The Population Assessment of Tobacco and Health (PATH), cosponsored by the National Institute on Drug Abuse (NIDA) and the Food and Drug Administration (FDA), is a large nationally representative longitudinal study of tobacco use and how it affects the health of people in the United States. The study is looking at how and why people start using tobacco, quit using it, and start using it again after they've quit. PATH is examining changes in tobacco use-related attitudes, behaviors, and health over time and looking at differences among various demographic groups.
- Medicaid.gov provides statistics such as return-on-investment dollar figures for tobacco cessation programs, examples of states whose cessation programs have produced high returns on their investments, numbers of adults on Medicaid who smoke, percentage of Medicaid expenditures attributable to smoking, and more.
- The Robert Wood Johnson Foundation (RWJF) County Health Rankings & Roadmaps program measures the health of nearly all counties in the nation and ranks them within states. Its site allows you to select a measure, such as adult smoking, within your state, and gives you a county-by-county breakdown of statistical data. It also compares your state's overall adult smoking rate with the national median.
- RWJF's Interactive Tobacco Map provides the latest data on state smoking laws. It gives state-by-state breakdowns on smoke-free laws, cigarette tax rates, and total tobacco control spending. The breakdowns show population, timeline, and other information to help present a complete picture of each state's efforts.
- The North American Quitline Consortium (NAQC) collects information each year from quitlines across North America. You can use its interactive map and its Quitline Profiles to find state-by-state survey results, including the types of services offered, financing, and utilization of services. Quitline metrics include number of direct calls, number of tobacco users receiving services, number of referrals to the quitline, and NAQC standard quit rate. In many cases, state quitline data include callers' behavioral health status.

### *Data About Youth*

- The CDC's Youth Risk Behavioral Survey System (YRBSS) monitors six types of health-risk behaviors—including tobacco use—that contribute to the leading causes of death and

disability among youth and adults. For example, its results page includes a "Compare State and National Results" section that provides state-by-state breakdowns of current, past, and first-time tobacco use among high school students.

- The CDC's Youth Tobacco Survey (YTS) of students in grades 6 through 12 measures knowledge and attitudes regarding tobacco use, presence of tobacco prevention and control programs in school curriculums, cessation attempts and successes, prevalence of other tobacco products, and other components. It can enhance your state agency's or organization's capacity to design, implement, and evaluate programs to prevent young people from using tobacco and to help current users quit. It offers data for some, but not all, states. (Not all states were able to report both high school and middle school data; some states' data are omitted because the states failed to achieve response rates greater than or equal to 60 percent.)

## USE DATA FOR MAKING DECISIONS

Once you obtain state-specific data from any of these sources, you are one step closer to effecting policy change and initiating strategies aimed at preventing and reducing tobacco use among people with behavioral health conditions. First, it might be useful to see the policies and strategies being implemented by other states.

### *States Are Using Data To Promote Policy Change*

Around the country, states have been using data successfully to effect changes in policy. Perhaps the most dramatic of these changes involves policies mandating tobacco-free behavioral healthcare settings. New York, North Carolina, Oklahoma, and Texas are examples of states that have recently adopted tobacco-free policies as a result of increasing awareness—via data—of the health benefits to their behavioral health clients.

### *States Are Using Different Strategies To Achieve Their Goals*

Once states have determined which data to use for their baseline measures, they are employing a variety of strategies to achieve measurable goals. These strategies include holding trainings and conferences to advance the integration of tobacco cessation services; increasing access to tobacco cessation medications; and developing quitline promotional campaigns.

**Training and conferences** are effective strategies that many states use to achieve their data targets, as in the following examples:

- **Maryland:** As part of a multi-year project (from December 1, 2012, through June 30, 2015), 470 treatment providers from mental health and

**EXAMPLES OF POLICY PROGRESS IN SAMPLE STATES**

**OKLAHOMA:** All state-operated behavioral health services facilities were impacted by a February 2012 Tobacco Free Workplace executive order.

**NEW YORK:** 22 out of 24 behavioral health campuses are tobacco free; this policy is expected to become systemwide soon for all state-operated campuses.

**TEXAS:** 18 local mental health authorities have adopted a 100% tobacco-free campus policy.

**NORTH CAROLINA:** As of July 1, 2014, the use of tobacco products, including e-cigarettes, was prohibited anywhere on the grounds of state-operated healthcare facilities.

SUD programs were trained to deliver tobacco cessation services for their clients.

- **New York:** A Leadership Academy follow-up project is developing four sets of training events and modules: (1) four integrated-care distance-based learning modules for all mental health services providers statewide; (2) a consumer module available online to all consumers with severe mental illness; (3) a 2-day CME training for mental health services providers (sponsored by Rutgers University) that is being delivered to all state-operated community service facilities (six trainings over 3 years covering roughly 500 providers); and (4) a psychiatrist-focused module under development at the Center for Practice Innovations (CPI) at Columbia University College of Physicians and Surgeons, Department of Psychiatry.
- **North Carolina:** Plans are underway for a second statewide conference focused on reducing the prevalence of tobacco use in the behavioral health community.
- **Texas:** Under a 3-year grant funded through the Cancer Prevention Research Institute of Texas, the Taking Texas Tobacco Free (TTTF) project provided 218 tobacco treatment and education trainings to 4,600 staff members during the first 2 grant years.

**Tobacco cessation medications** are being supported by legislation in some states and by grants in others.

- **New York:** With the advent of Medicaid Managed Care as of October 1, 2015, in Manhattan, and in early 2016 for the rest of the state, plans are required to provide all forms of FDA-approved cessation medications, such as varenicline (CHANTIX®), without any time limitations for all covered people being treated for a mental disorder (though preauthorization is required).
- **Texas:** During its first 2 grant years, TTTF personnel shipped 504 boxes of nicotine patches and 288 boxes of nicotine gum to participating centers for free distribution to healthcare recipients and employees.

**Quitline promotional campaigns,** developed and launched in several states, have already started producing results:

- **Maryland:** The Maryland Tobacco Quitline offers a variety of free print and downloadable materials, including posters, brochures, factsheets, and a toolkit to help behavioral health services staff educate their patients and clients about the dangers of smoking. (Two sample posters are shown below.)

### Maryland Tobacco Quitline Posters

- **North Carolina:** Efforts to promote QuitlineNC have included several strategies: disseminating QuitlineNC information; making special promotions (such as free cessation medications) to behavioral health services providers and to the National Alliance on Mental Illness of North Carolina (NAMI NC); and placing a print ad on six billboards in the Triad area during 3 weeks in June 2014.

## States Are Reaching—and Surpassing!—Their Targets

**MARYLAND:**

Smoking prevalence for people with M/SUDs

dropped from **71.8%** in 2010 to **56.5%** in 2014

—even lower than the original target of 57.44%!

Between FYs 2013 and 2014, the number of callers to the quitline increased **9%** (from 6,778 to 7,479). for callers with behavioral health issues (including people with SUDs)

and **11%** (from 6,114 to 6,917). for behavioral health callers (excluding callers with SUDs).

Source: Maryland Leadership Academy information obtained by the SCLC.

**OKLAHOMA:**

Self-reported smoking prevalence for consumers with SUDs

dropped from **74%** in 2009 to **47.7%** in 2014

—even lower than the original target of 60%!

The state's national ranking in adult smoking prevalence dropped from **49th** to **39th** place in 3 years.

Provider referrals to the Oklahoma Tobacco Helpline increased from **380** consumers in 2012 to **4,070** in 2015.

Source: Oklahoma Leadership Academy information obtained by the SCLC.

### *States Are Seeing Measurable Progress*

The various strategies are paying off in some states, such as Maryland and Oklahoma. The numbers tell the story.

## GET INSURANCE GUIDANCE ON TOBACCO USE CESSATION

Once your state has chosen its data sources, set its targets, and agreed on its strategies, it's time to figure out how to make sure everyone has coverage for any services involved in implementing those strategies.

The news is encouraging. You have more options than ever to help in your tobacco cessation efforts: insurance companies are now required to cover tobacco cessation services under specific guidelines, and the American Lung Association (ALA), under a CDC grant, is available to provide technical assistance to states and the tobacco control community on tobacco cessation coverage policy and health systems change.

### *Learn More About Services That Health Plans Are Required To Provide*

Evidence-based tobacco cessation treatments are becoming increasingly available to people with mental or substance use disorders. Health plans are required to cover the following essential health benefits (EHB) to comply with the Affordable Care Act (ACA) preventive services requirements:

- Screening for tobacco use
- Cessation treatment for two quit attempts per year

In addition, plans are not allowed to include cost-sharing for these treatments. Furthermore, they cannot require prior authorization for any of these treatments.

**GET MORE DETAILS ABOUT INSURANCE COVERAGE**

- **Want to know more about how "quit attempts" are defined?**
- **Want to know more about which health plans are required to cover tobacco cessation as a preventive service?**

*Check out Q5 of the guidance FAQs issued by the U.S. Departments of Health and Human Services, Labor, and Treasury on May 2, 2014.*

## *Learn More About Essential Health Benefits in Your State*

Every state is different. In order to cover the EHB, each plan sold in state health insurance marketplaces must model its coverage after a state benchmark plan.

States initially chose their benchmark plans in 2013. In a rule published in early 2015, the U.S. Department of Health and Human Services (HHS) gave states the chance to update their choice of benchmark plans for the 2017 plan year. The states have done so, and on August 28, 2015, HHS published information about each benchmark plan.

How much bearing do these benchmark plans have on what tobacco cessation coverage is offered in any given marketplace plan? The answer remains unclear.

**LEARN ABOUT YOUR STATE'S ESSENTIAL HEALTH BENEFIT BENCHMARK PLAN**

**The Center for Consumer Information & Insurance Oversight (CCIO) site offers several resources, including:**

- **A summary of the plan's coverage.**
- **Supporting plan documents that provide more detail (a new feature, not provided in 2013).**
- **State-by-state information for 2017.** *(Click on the third bullet under your state's name and open the zip file.)*
- **The number of smoking cessation medications your state's benchmark plan covers.** *(In your state's zip file, search for "smoking.")*

*For more information, contact the American Lung Association, Washington National Office, 1301 Pennsylvania Ave., Suite 800, Washington, DC 20004. Phone: 202-785-3355.*

First of all, the EHB mandate allows plans a lot of flexibility to meet their benchmarks. Secondly, tobacco cessation is a subcategory of preventive services coverage.

The earlier May 2014 cessation guidance FAQs mentioned above, which applies to any plan sold through a marketplace, offers a tougher, more comprehensive standard than the benchmark plans. However, in some states whose benchmark plans do not offer a good cessation benefit, tobacco control personnel have a harder time convincing plans to offer a comprehensive benefit.

## *Get Insurance Companies Involved*

Insurance companies are an important player in state cessation efforts. Several Leadership Academy states, most recently Massachusetts, included insurers at their Leadership Academy as a way to engage them early on in the process and gain their buy-in to providing cessation services. The summit offers a real-time opportunity to make your case to insurance companies by demonstrating the return-on-investment benefits of tobacco cessation programs.

## *Learn How To Expand Medicaid Cessation Coverage in Your State*

If you are working to establish comprehensive tobacco cessation coverage under your state's Medicaid program, check out how Maine did it: the tactics they used, the obstacles they encountered, and the lessons they learned.

**MAINE ESTABLISHES NEAR COMPREHENSIVE TOBACCO CESSATION COVERAGE UNDER ITS MEDICAID PROGRAM**

**The case study* *Comprehensive Medicaid Tobacco Cessation Coverage in Maine: A Case Study in Legislative Action to Improve Health* is available on the American Lung Association public website.**

## ARE YOU READY TO TAKE THE NEXT STEPS?

Where does your state stand in the journey toward the goal of reducing smoking among people with M/SUDs? Has your state just gotten out of the starting gate? Did your state have a head start—like some of the success stories described above—and is it beginning to catch a glimpse of the finish line? Or is your state somewhere in between?

No matter where your state finds itself in this journey of forming partnerships, establishing baseline measures, setting goals, developing action plans, implementing strategies, and producing measurable outcomes—the real question is: Are you ready to take the next steps in your journey?

If you need help in taking those next steps, SAMHSA is here for you. For advice and suggestions, feel free to contact the Office of Policy, Planning, and Innovation (OPPI) Tobacco Policy Liaison.

## ADDITIONAL RESOURCES: FREE PRODUCTS

A wide range of tobacco cessation and prevention products have already been developed by public and private entities. These resources—including toolkits, curriculums, webinars, presentations, and publications—are freely available to you.

- The Smoking Cessation Leadership Center's (SCLC's) "Behavioral Health" web page has free presentations, publications, toolkits, factsheets, and more.
- Free continuing education units (CEUs) are still available for select webinars (archived and live) on SCLC's website.
- Maryland has developed a four-page toolkit that promotes their quitline and features eye-catching and motivational infographics about the health and economic costs of smoking.
- Maryland's SmokingStopsHere website offers free print and downloadable cards, brochures, and posters on a range of smoking cessation topics.
- The National Alliance on Mental Illness (NAMI) developed Hearts and Minds, an online, interactive educational initiative.
- Smoking Cessation for Persons with Mental Illnesses is a toolkit for mental health services providers developed by the University of Colorado Denver.
- Tobacco Treatment for Persons with Substance Use Disorders is a toolkit for SUD treatment providers developed by Tobacco Use Recovery Now! (TURN).
- The Rx for Change: Clinician-Assisted Tobacco Cessation curriculum equips health profession students and licensed clinicians with state-of-the-art knowledge and skills for assisting clients and patients with quitting.
- The Tobacco Recovery Resource Exchange, developed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), offers a free downloadable modular curriculum and implementation toolkit.

- The University of Colorado Behavioral Health & Wellness Program offers free toolkits for healthcare providers and supplementary services for priority populations, including tobacco cessation treatment for persons with behavioral health conditions.
- The Vermont Health Promotion Training Center has archived webinars on a variety of subjects, including tobacco and behavioral health.

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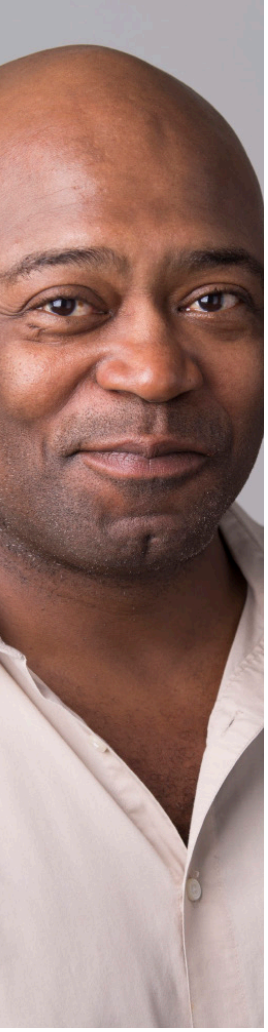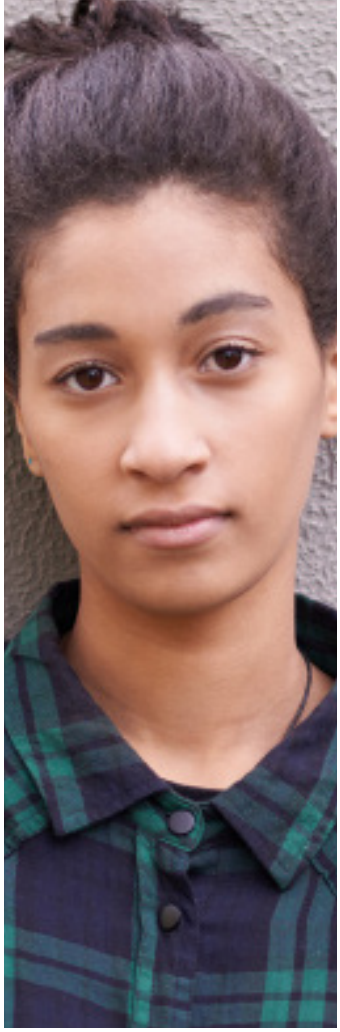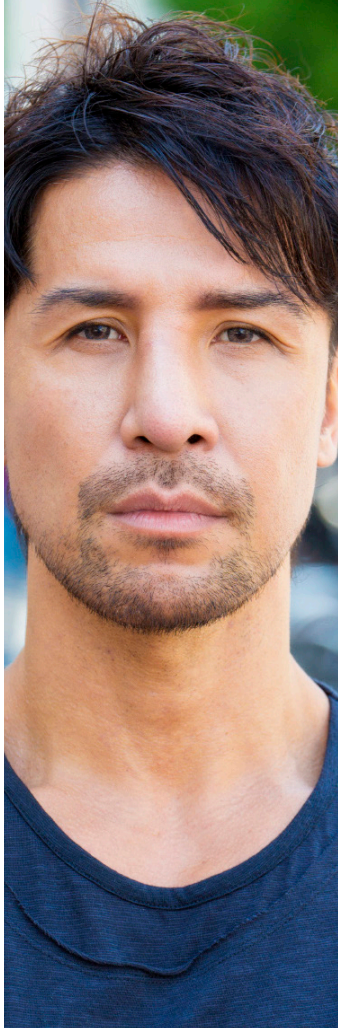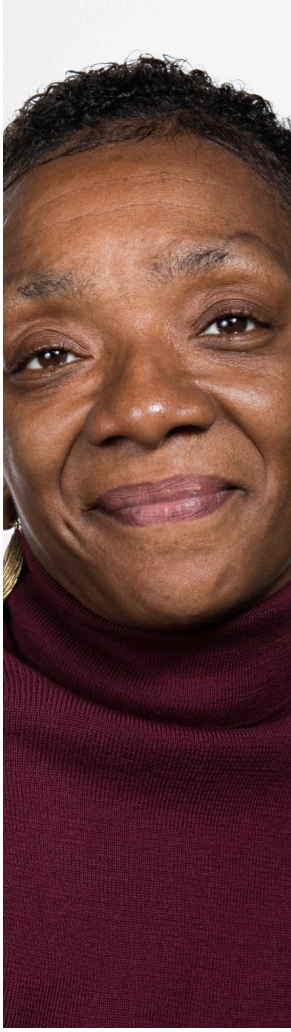
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