Nicotine Treatment Work Done in Other States

Oregon Nicotine Treatment and Recovery

Prepared by Rede Group, September 2022

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Terminology:

OHA	Oregon Health Authority
SUD	Substance use disorder
NRT	Nicotine replacement therapy
NiTR	Nicotine Treatment and Recovery
TTS	Tobacco Treatment Specialist

Introduction

Between December 2021 and January 2022, Rede interviewed nine key informants from agencies across different states in the United States who Rede identified as having strong programs reducing nicotine use among behavioral health populations. The purpose of these interviews was to gain a better understanding of tools and strategies other states use that could be adopted by Oregon to better serve our communities.

Interviewee information

Agencies

Key informants from nine agencies were interviewed. These agencies included:

1. Hawaii State Department of Health's Tobacco Prevention and Control Section
2. Montana Tobacco Use Prevention Program
3. Project Filter (Idaho)
4. Rethink Tobacco Indiana
5. Oklahoma Department of Mental Health and Substance Abuse
6. University of Houston
7. Integral Care (community behavioral health center) (Texas)
8. Florida Department of Health
9. Colorado State Tobacco Control Program

Services

A range of services were provided by agencies that Rede interviewed. All interviewees were from a facility that provided curriculum, training, and/or technical assistance for nicotine cessation to clients or staff members. Almost all provided some sort of cessation service (referrals and/or direct services) - with the most common service being referrals to a Quitline. Most also provided information on tobacco-free campus policies.

The following table shows services provided by the agencies interviewees worked with.

Type of service		Agencies providing the service (n=9)
Cessation		8
	NRT	4
	Quitline/Phone Quit	6
	Group Quit	1
Curriculum/training/technical assistance		9
Tobacco-free Policy		7
In-house treatment at BH and SA centers		2
Website		2
Other		4 (behavioral health advisory group, social media, working for CDC grants, legislation advocacy)

Overview of nicotine treatment and recovery work in behavioral health programs

Providers were asked a series of questions related to their work with behavioral health populsations, including their greatest successes, most surprising partners, and the most important considerations for this work.

Successes

The most frequently mentioned success was having **more buy-in from providers and stakeholders**; who were recently seeing it was possible for patients with behavioral health diagnoses to quit nicotine while undergoing substance use disorder or mental health treatment. Interviewees mentioned behavioral health providers having a **shift in beliefs to be more supportive of this work, understanding the importance of tobacco cessation,** and **implementing cessation programs in their facilities** (such as Group Quit). One interviewee shared that their agency's biggest success was that their **treatment strategies were never static**, and one shared that they have been successful in reducing tobacco use in behavioral health populations.

Surprising partners in nicotine treatment and recovery work

Two interviewees shared that they had surprising partners in this work. Those partners were **members of their advisory board** who were previously resistant and a **peer recovery association.**

Important considerations for this work

Interviewees gave a range of responses when asked about the most important consideration for improving nicotine treatment and recovery for people with behavioral health conditions. Three interviewees mentioned the **importance of provider and leadership buy-in**. These interviewees shared that tobacco cessation programs could not be successful without buy-in. Two interviewees mentioned that making progress in **this work takes a lot of time**, and two mentioned the importance of providing a **full suite of services** (such as counseling *and* NRT).

"I think... getting administrative buy-in, I don't think you can truly be successful unless you do that. When we work with centers, we have the CEO sign a memorandum of understanding, and agree on the steps they're going to take." -Key informant interviewee

"It's really kind of surprising how quickly a culture within an organization changes, once you start really focusing on this." -Key Informant Interviewee

Education, training, and resources specifically for behavioral health providers

Many interviewees provided training and resources specifically for behavioral health providers. Providing these resources and training was an important way for facilities to highlight the importance of treating nicotine dependence within behavioral health populations.
Specific trainings that were mentioned included

- Rx for Change
- Webinars
- Credential training
- Tobacco Treatment Specialist Training (TTS).

"Nicotine addiction doesn't present as a primary cause of engaging with these participants, [so] it's often lost in the mix, even though many in [the behavioral health] community are dying of chronic conditions, that's not what they're really being helped for." -Key informant interviewee

Three interviewees mentioned that they provided treatment services for staff, including their suite of services being available to staff members, providing information about the state's Quitline, and offering onsite classes just for staff).

Treatment interventions for behavioral health populations

Referring clients to a Quitline and **providing a client with information about pharmacotherapy options** were the most commonly recommended treatment interventions. Additional cessation interventions included brief interventions (5As, 5Rs), motivational interviewing, and specific curriculum (Learning about Healthy Living).

Peer to peer models

Six interviewees recommended or have implemented peer to peer models for providing nicotine treatment and recovery; three did not. The only specific model mentioned was the Dimensions Model from the Behavioral Health & Wellness Program at the University of Colorado[1]. One interviewee mentioned training their wellness coaches to serve as peer recovery coaches as well.

Culturally specific services and resources

The majority of key informants (7/9) shared that their agency provided/supported culturally specific resources; the most frequently mentioned group was LGBTQ+. Some types of resources mentioned included training for providers specific to these populations and population specific quitlines. Other organizations partnered with community groups who served priority populations in order to connect community members to resources, like their state's quitline.

Specific population	Interviewees that mentioned this population
Houseless	1
Tribes	3
Intellectually or developmentally disabled	2
Black	3
LGBTQ+	4

[1] Behavioral Health & Wellness Program. (n.d.). Trainings. Retrieved July 5, 2022, from https://www.bhwellness.org/trainings/

Other	6 (low SES, youth, Native Hawaiian, pregnant women, young adults, substance use disorders)

Data sources used

Interviewees were asked to share what data sources they use in their programs to understand and monitor the scope of nicotine dependence and treatment. Although many agencies reported that they use **state-specific data sources**, over half of interviewees also shared that they used **Behavioral Risk Factor Surveillance System (BRFSS) data**.

Data source	**Interviewees whose organizations use the source**
BRFSS	5
State survey	6
SAMHSA	3
Other	7- Relias, CDC MMWR, reporting and tracking Integral Care through electronic health record system, Quitline reports, National Substance Use Disorder Survey, State Tobacco Control Community of Practice, NRT data

Ideas to reduce disparities for behavioral health populations

Interviewees were asked what they felt would be effective at reducing tobacco-related disparities if resources were not a concern. The two most frequently mentioned ideas were **investing in behavioral health partners/providers** and **providing more TTS trainings**. Two interviewees said that including nicotine dependence treatment as a topic in behavioral health education would be helpful. Two interviewees said that making sure providers had NRT available on site for clients when they were ready to make a quit attempt would help. Other comments related to reducing commercial tobacco-related disparities for this population included: needing billing help for reimbursements, reimbursing providers for this work, awarding money to organizations only if they have a tobacco-free campus, going to behavioral health facilities in person to help providers implement programs, and having separate agencies responsible for doing tobacco cessation work.

When addressing this question, interviewees mentioned barriers that prevented them from reducing tobacco-related disparities for behavioral health populations:

- Two mentioned that behavioral health care staffing and retention was an issue that, if addressed, could provide more time and bandwidth for tobacco cessation programs
- Behavioral health providers had a lot on their plates and tobacco treatment was not their priority, which explained some of this work not getting done

A couple themes that emerged were that providers may not have had the capacity to provide nicotine dependence treatment, or did not understand the importance of commercial tobacco cessation. Widely, there was a need to expand training on the importance of cessation, particularly for behavioral health populations.

"I really think we need to invest more in our behavioral health partners and providers. There's still just… I don't see it as reluctance, but there are so many other priorities that they have that tobacco never rises to the top." -Key Informant Interviewee

"There's such an incredible barrier in getting staff members to go to the CTTS trainings, just increasing knowledge and competence within our professions. That has to happen if we're going to make some of these changes." -Key Informant Interviewee

Other comments

Lastly, interviewees were given the opportunity to share anything else they thought was important. One interviewee shared **the importance of prevention** in this work - as it's much harder to quit than to abstain. The importance of using **data** was also mentioned. Lastly, one interviewee mentioned they wanted to provide materials that appealed to the larger amount of people across the behavioral health spectrum, but that those with severe behavioral health conditions smoked at much higher rates than people with mild depression (which was a higher portion of clients).

"We spend a tremendous amount of time and energy and money on people dying from suicide, which is an equally tragic death, but we have five times more people dying from tobacco related illness than we have from suicide in our comunities… And this is why we have to take this seriously, because our tobacco users, they're not living past 62 years old." -Key Informant Interviewee