Connecting People with Mental Illnesses to Cessation Services
Introduction

Tobacco Use among People of Low Socioeconomic Status

Despite reduction in overall smoking rates, additional work is needed to engage populations most impacted by tobacco use. Individuals of low socioeconomic status (SES) are a priority population that experiences tobacco-related disparities. In the US, adults with lower educational attainment and those who live below the poverty line tend to smoke at a greater rate than the general population. In Minnesota, adults who have a household income of $35,000 or less make up 41.2% of all current smokers. A key strategy to reach priority populations and to promote equity is to partner with organizations that have established relationships with the community they serve.

Mental health organizations that serve a low-SES population can act as key partners in addressing tobacco disparities in individuals with mental illnesses, another priority population. Adults living below the poverty line are more likely to have a serious mental illness than those living at or above the poverty line, and adults with mental illness use tobacco at a disproportionately high rate in the US. Multiple factors drive the disparity, including people with mental illnesses’ need for additional cessation assistance and provider attitudes toward tobacco use and cessation among people with mental illnesses. Partnerships with mental health organizations provide opportunities to combat the factors causing high rates of tobacco use in this population.

ClearWay MinnesotaSM Community Engagement Grant Initiative

ClearWay Minnesota created a community-based granting initiative to address the issue of disproportionate rates of smoking in low-SES adults. The primary goal was to connect adult, low-SES smokers to existing tobacco cessation services, such as ClearWay Minnesota’s QUITPLAN® Services or established community cessation programs. A secondary goal was to build the grantee organization’s capacity to continue to connect clients to tobacco cessation services after the end of grant funding.

Four organizations that provide treatment, supportive services, education, and advocacy for individuals with mental illnesses received grants from ClearWay Minnesota between 2015 and 2016: Mental Health Resources (MHR), NAMI Minnesota (NAMI), RESOURCE, Inc. (RESOURCE), and Touchstone Mental Health (Touchstone).

Methods

Professional Data Analysts, Inc. (PDA) was hired by ClearWay Minnesota to conduct an independent evaluation of the first year of its community engagement grants. Data sources include individual and group interviews conducted by PDA and grantee reports submitted to ClearWay Minnesota.

* www.quitplan.com
Grantee Profiles
Organization Overview

Mental Health Resources (MHR)* provides case management, housing services, community treatment, and other supportive services to individuals with mental illnesses, primarily in metro Minneapolis-St Paul. All of their clients are adults of a low-SES. Prior to the grant, MHR worked with ClearWay Minnesota on other projects and knew that the two organizations aligned on their approach to tobacco cessation for people with mental illnesses. The grant was a natural match for their ongoing tobacco cessation initiative planning and allowed them to more fully support individuals with mental illnesses.

Grant Goals

- Change the way to report tobacco use status in clients’ health records.
- Link clients with cessation services, both within the agency and the community, and raise awareness of the availability of nicotine replacement therapy (NRT).
- Provide incentives to tobacco users who take an action toward quitting.

Grant Strategies

Workflow and EHR modifications. MHR made changes to their Electronic Health Record (EHR) to assess tobacco status as part of routine workflow at each visit and to make and document referrals within the system along with other health measures. MHR now screens clients for tobacco use every six months to better understand overall tobacco use. These screening reports allowed MHR to track the number of smokers along with how smokers feel about quitting and what they believe will happen if they continue to smoke at the same rate.

Staff trainings. Alongside the workflow and EHR modifications, MHR made comprehensive changes to build their internal capacity, which were part of broader organizational tobacco cessation efforts not funded by ClearWay Minnesota. Through ClearWay Minnesota funding, they built on previous staff training by a leader in tobacco cessation and mental health with small group training throughout the organization. The training focused on ways to integrate conversations about tobacco cessation into client treatment and also helped to identify champions who could lead changes and act as the primary contact for their department. All new staff continues to receive training.

Client engagement. MHR used several client engagement strategies to improve outcomes. They offered and distributed incentives to clients who elected to receive a cessation referral or took steps to quit on their own. The incentive was valued at $25 and contained a string backpack, stress relievers, an aromatherapy inhaler, a piggy bank, a pedometer and materials, and a water bottle. They also purchased carbon monoxide (CO) monitors and trained staff on how to use them to educate clients about the hazards of smoking and to motivate change. In addition, MHR mailed postcards to patients enrolled in outpatient services which described the incentive and the safety and coverage of NRT.

* www.mhresources.org
Mental Health Resources

Accomplishments

- MHR shared that EHR system upgrades went smoothly and started being used within a month. They attributed the easy implementation to the fact that they could make changes to their EHR in collaboration with their internal IT department within a couple of days, rather than having to work with an external vendor.

- The new focus on EHR and workflow increased their opportunities to address tobacco with their high-risk mental health community. With those changes, the percentage of clients with a recorded tobacco status increased from 40% to over 60% (see Tobacco Screening Tool on right).

- One hundred and ninety MHR staff attended a one-day training, and follow-up sessions were conducted with treatment teams.

- The focus on tobacco and additional training created a culture change in which staff incorporated tobacco conversations and cessation services into their thinking and their procedures.

- MHR distributed 158 incentives to clients who made efforts toward quitting. MHR reported that using incentives motivated their staff to continue addressing tobacco use with clients.

- MHR assessed 55 clients’ CO levels with CO monitors to educate them on the impact of tobacco use.

- The 2,500 postcards that were mailed describing the incentives and other services have received positive response.
Organization Overview

National Alliance on Mental Illness Minnesota (NAMI)* is a non-profit organization operating throughout Minnesota that provides education, support, and advocacy for individuals living with mental illnesses and their families. NAMI strives to eliminate the pervasive stigma of mental illness, affect positive changes in the mental health system, and increase public and professional understanding of mental illness. Many of the individuals that NAMI serves are considered low-SES.

Grant Strategies

Partnership and capacity building. NAMI focused on developing partnerships with 17 organizations, including public housing authorities, clubhouses (community-based support centers for people with mental illnesses), social service programs, and Veterans homes and health systems. They then provided support to build the capacity of those partners. NAMI provided tobacco cessation materials, trained partner staff, advocated for tobacco policy changes in mental health organizations, and offered to provide workshops to individuals with mental illnesses and their family members. NAMI also worked towards enacting smoke-free grounds policies at a drop-in center and a county mental health center.

Client engagement. NAMI developed and conducted workshops for individuals with mental illnesses and their families. Topics covered during the workshops included: background on tobacco, tobacco addiction, how to create a quit plan, medication choices, coping skills, and information about mental illness and cessation. At the end of the workshop, NAMI shared community resources where people can get services and medications, including QUITPLAN Services, Nicotine Anonymous groups, a local clinic’s tobacco treatment program, and websites.

Grant Goals

- Develop and implement workshops to reach people living with mental illness to educate them about cessation options and promote referral to smoking cessation services.
- Incorporate information on tobacco cessation into existing NAMI programs.
- Work with external partners to promote organizational change around tobacco cessation for people with mental illnesses.

Accomplishments

- NAMI established a contract with a public housing authority to deliver workshops in all public housing buildings in a large city.
- NAMI delivered their one-hour workshop 32 times to community organizations, such as community mental health centers and public housing authorities, reaching over 225 people with mental illnesses and their family members.
- Staff also helped a mental health center draft a smoke-free policy and start planning for implementation as a strategy to promote linkages to cessation services.

* www.namihelps.org
**Organization Overview**

RESOURCE, Inc. (RESOURCE)* provides employment support, career-based education, and chemical and mental health treatment and recovery services to people with mental illnesses and co-occurring substance use disorders in the metro Minneapolis-St. Paul area and in Princeton, Minnesota. RESOURCE’s mission is “to empower people to achieve greater personal, social and economic success.” They serve individuals with complex, chronic issues who face multiple barriers to recovery and self-sufficiency. Most of their clientele are of a low-SES, are people of color, and use tobacco. Tobacco use is particularly common among their clients with chemical dependencies.

**Grant Strategies**

**Workflow and EHR modifications.** RESOURCE adapted their EHR to track tobacco cessation referrals within the system. They worked toward integrating an organization-wide tobacco assessment at client intake, though they were unable to include a modification during the grant period.

**Staff trainings.** RESOURCE formed and maintained a ClearWay Minnesota Committee that led their tobacco cessation referral initiative. RESOURCE implemented a series of staff trainings around the issue of tobacco cessation for individuals with mental health/substance use disorders. A large group training conducted by an outside tobacco cessation expert provided staff with information on tobacco use among people with mental illnesses and chemical dependencies and with tools and information on how to work most effectively with clients. These trainings were followed by small group meetings. These meetings fostered peer-to-peer conversations and were instrumental in increasing commitment and learning, which helped staff support the initiative.

**Grant Goals**

- Create a tool to assist staff in identifying clients who use tobacco and connecting them to cessation services.
- Create and implement a multi-level training program to educate staff on tobacco cessation for people with mental illnesses and substance use disorders and on use of new tools to connect clients to cessation services.
- Track and monitor referrals and outcomes for clients who use tobacco.

* [www.resource-mn.org](http://www.resource-mn.org)
Accomplishments

- More than 130 staff attended the large-group training and approximately 100 staff also participated in the one hour small group meetings.

- They established short (10 minute) quarterly check-ins with the teams on tobacco cessation, as the teams requested ongoing follow-up and support.

- RESOURCE added a code within the EHR to track tobacco cessation referrals.
Touchstone Mental Health

Organization Overview
Touchstone Mental Health (Touchstone)* provides housing, residential treatment, therapy, case management, fitness, and other supportive services to individuals with serious mental illnesses in the Minneapolis-St Paul metro area. Touchstone serves adults with a low socioeconomic status. Touchstone strives to help people in their community connect to services and to improve the healing and well-being of their clients.

Grant Goals
- Improve organizational processes and educate staff to support tobacco cessation for clients.
- Identify clients who use tobacco and provide education.
- Provide clients with tobacco cessation referrals to increase access to existing services and NRT.

Grant Strategies

Workflow and EHR modifications. Touchstone integrated four easy questions to assess tobacco use into progress notes, housed in their EHR. Touchstone also updated their EHR so that referrals were captured in client progress notes. They worked with on-site IT staff to find simple solutions, and the Touchstone IT Director made the change in the system.

Staff trainings. A staff member completed Tobacco Treatment Specialist (TTS) training and created a tobacco cessation training module for in-person and online trainings. Staff completed either an online training or an in-person training, which included question and discussion time. They also implemented a protocol requiring newly hired staff to complete the tobacco cessation training module.

Client engagement. For clients interested in quitting, a staff member referred them to services or connected them to their psychiatrist, or other healthcare provider. The staff member who referred them to treatment would inform their colleagues of the client’s plan so that the full team could provide support to the client as they tried to quit. Touchstone also purchased CO monitors and trained staff on their use. The new CO monitor helped engage community members and clients at residential treatment sites.

* www.touchstonemh.org
Accomplishments

- Touchstone reported 582 conversations about tobacco cessation with their clients.

- The Touchstone EHR was updated to track client tobacco use and cessation referrals in their progress notes (see Tobacco Prompts on right).

- Touchstone was successful in having 100% of their direct service staff complete tobacco cessation information training.

- Every new employee providing direct services is required to complete the training and all direct service staff will be required to view the training annually.

- Six individuals have stopped smoking during the grant period and eight more are using NRT and staff and/or group support to stop smoking.
Facilitators, Challenges, and Barriers
Client Engagement Facilitators

Client attitudes toward tobacco use and quitting. As the grantees broached tobacco use with clients, they found that many had a high motivation to quit and frequently made quit attempts. Quitting smoking was on a lot of the clients’ minds. When the staff brought up the topic, many clients responded with: “Finally someone is asking about this!” Clients wanted to know why there were not cessation groups before because they had a desire for them.

Clients reported shame for their inability to quit, and it impacted their self-esteem. Hearing that their tobacco use was an addiction helped to validate their struggle with quitting and made them feel less ashamed. One organization provided incentives for any step toward quitting, which made an impact on client readiness because it pushed them toward action.

Teaching new skills for coping and gradual change. Grantees noted that the majority of tobacco cessation strategies focus on the general population, but they need strategies tailored to people with mental illnesses and substance abuse issues. Smoking is a coping mechanism within this community, so it is important to focus on other strategies and skills for the client to use to cope. People need to take time to practice new coping mechanisms and to be patient as they learn coping skills.

Harm reduction is a strategy widely used by grantees to address client issues, including other addictions or harmful behaviors, though reducing tobacco use does not necessarily reduce the damage done by tobacco. Because of clients’ familiarity with harm reduction strategies, grantees found that those who were reluctant to quit often would be willing to discuss reducing their tobacco use. Staff used their openness to start conversations and gave resources to people who were not ready to quit. They tried to talk to clients about where they are in their tobacco usage and find ways it is negatively impacting their lives, then move to problem solving. This strategy, as opposed to sending the simplistic message that tobacco is harmful and that they should quit, helped clients feel heard and ensured that the client and staff understood one another as the client made changes.

While it might feel like nothing’s changed, choices like these add up over time.

You don’t have to give up cigarettes to rethink tobacco! Small changes in your daily habits now can make a big difference in your future.

- Try nicotine patches, lozenges, or gum instead of cigarettes once in a while (it’s ok to use them together!)
- Start testing out new ways to deal with stress so that cigarettes aren’t your only tool
- Use a pedometer to measure how far you walk each day; gradually work to increase your walking as you work to decrease cigarettes
- Try the 4 Ds to cope with cigarette cravings: Deep Breathing, Drinking Water, Distraction Yourself, and Delay the cigarette
- Attend one of MHR’s Healthy Lifestyle Groups to learn more about tobacco

“Congratulations! You’ve taken a step to rethink tobacco.”

“We have seen the need in the community, and have had wonderful conversations with people living with mental illnesses who may not have gotten any information on smoking cessation without this program.”
Client Engagement Facilitators

Encouraging peer support. Peers who had quit were the biggest champions, so it was helpful to provide outlets for them to tell their stories to staff members and clients/peers. They shared tips and stories and served as mentors. Support groups for tobacco cessation also were well received. Grantees reported that their clients knew a lot and had a lot to say about the topic. Grantees also mentioned that referrals to support groups may be particularly appropriate for their clients who have familiarity and experience with group treatment. In addition, residential treatment or supportive housing provided a good opportunity for built in support systems for their clients.

Offering a variety of quit methods. The interest in the different methods of quitting varied widely. Clients at residential sites had more interest in support groups, whereas others expressed interest in connecting through their provider or community clinics with existing cessation services. Some clients connected to QUITPLAN Services, particularly those who wanted to pursue cessation independently. Staff who worked with higher need clients reported that their clients experienced more barriers to quitting tobacco and required more support than a quitline alone could provide.

Leveraging client relationships with primary care providers. Grantees reported particular success connecting their clients through primary care channels, because their clients found it easiest to turn to their primary care providers. The connections to primary care and other healthcare providers were made through various methods – clients would call and ask directly for NRT, grantee staff would call providers directly, or staff would attend appointments with the client. The staff supported clients in talking with their providers and ensured they received proper instructions for using cessation medications. Staff often needed to educate providers on tobacco cessation aids for their clients, but grantees reported that the work had been going well.
Client Engagement Challenges and Barriers

Individual struggles with quitting. Clients often lacked confidence to quit, even when they wanted to quit. As mentioned above, many clients used smoking as a coping mechanism. While teaching the clients a new skill was helpful, it was a difficult process and required time for the client to get used to being tobacco free. In addition, grantees explained that smoking is typically a social experience for their clients, a time to connect with friends and converse. Taking away smoking meant taking away an established socialization time for an often-isolated community.

“Smoking is their coping mechanism—it’s it.”

Complicated coverage for NRT. Grantees often faced challenges securing NRT for their clients when connecting them to a provider through their insurance. While Minnesota has fewer barriers to NRT access for people with Medicaid than other states, there are still hurdles. Many clients did not understand how to get the prescription or that a prescription was necessary. The steps involved with procuring a prescription were also a barrier: finding a provider, ensuring the provider will prescribe NRT (many have the misconception that it is not safe), going to the pharmacy to fill a prescription, which introduced transportation barriers, and for some clients, paying a minimal amount for their NRT, if they had not satisfied their deductible.

Another complication is that pharmacies were often not successful in submitting insurance claims for people with Medicaid and Medicare, which represent a sizable portion of the grantees’ clientele. The prescription would have to be submitted numerous times for it to be filled. The organizational staff had to coach pharmacies on how to use/access the benefit. Some pharmacies rewrote their computer code so that they could access the benefit, but if they did not, they continued to encounter problems.

Services and materials geared toward the general population. Some individuals had difficulty accessing or navigating cessation services that have only phone or web-based modes, particularly people who were homeless or very low income, which is prevalent among people with severe and persistent mental illnesses. Some clients did not have a reliable address, phone number or email address, which made using QUITPLAN Services very difficult.

Multiple organizations reported that using QUITPLAN Services was challenging for clients with the most severe and persistent mental illnesses, especially those with additional cognitive difficulties. They noted that the number of steps and questions involved in web and phone registration was too complicated for their clients. Many clients needed help from the staff to complete the process, but staff did not always have time to do this. Overall staff felt phone coaching was not a good fit for many clients, who found it frustrating and stressful. In addition, the grantees reported that the standard time it took to receive NRT after ordering it was a barrier: “They want to do it right now!” To address this issue, one organization used separate funds to provide free NRT onsite.

Traditional quit strategies and motivations, such as Mini-Quits, staying busy, and financial pressure, have not worked as well for the clients served by the grantees. For example, strategies that encourage smokers to use savings from quitting for a major purchase, such as a vacation, may not be as applicable for clients who have very low incomes. Typically, the grantees’ clients find butts, “bum”, share, or roll their own, rather than buy packs of cigarettes. Because the clients save only a few dollars versus $9 to $20 a day, this message has less of an impact.
Organizational Facilitators

Aligning tobacco cessation service linkages with ongoing work. Grantees reported that aligning tobacco linkages with their existing priorities and activities facilitated the uptake of the grant-funded work. For example, prior to the grant, a few organizations had initiated tobacco training and programs. The new efforts to link clients to cessation services were in line with the organizations’ prior activities, so the integration of additional training or documentation was easier. For organizations where tobacco cessation was a new topic, they found it helpful to frame it as part of their mission to promote health for the whole person and the bigger picture of social justice and health disparities for their population.

“Have [tobacco treatment] be a part of your strategic plan; have it be a value of your agency.”

Securing leadership and staff buy-in. Grantees noted that it is critical to “start with the staff” and to get buy-in from leadership on all activities – from training to policies. In one organization, the executive director believes addressing tobacco use in the mental health population is important, so it will remain a priority, even with other barriers. “It comes down to staff wanting to [help clients quit] and being supported to do it,” particularly from their supervisors and leadership.

Methods to promote staff buy-in included sharing stories about clients who have successfully quit and having outside leaders and authorities as partners. Education and training also were key to securing staff buy-in. Through grantee efforts to promote buy-in, they reported that the primary change was that “staff have second thoughts when they do not want to prioritize tobacco; they second guess themselves. They now have the information that shows that tobacco is an important issue for their clients, as it is a leading cause of death. They think twice before dismissing it.”

Another facilitator of staff buy-in was the increased attention given to mental health and substance abuse communities by the tobacco control field. A grantee explained, “Nobody gives much time or energy to people who have substance use or mental illness, so I think it has gotten people’s attention. It has started to change the culture.” Highlighting the growing focus on behavioral health in the tobacco control field facilitates staff and leadership buy-in when making organizational changes.
Organizational Facilitators

Educating and training staff promotes successful organizational changes. Grantees discussed the importance of general tobacco education, cessation strategies, and how to connect clients to existing cessation services. Prior to the grant activities, many staff did not understand the extent that tobacco harms clients or know about the high tobacco use rates in the mental health community compared to overall tobacco use rates. Mental health providers needed to learn about these disparities, but also to hear the message that there is hope. Specific training on available cessation services and procedures helped staff connect clients to cessation services and build organizational capacity. It was also important to teach staff how to start conversations about tobacco by connecting these conversations to their existing Motivational Interviewing skills. The focus on training was received well, and grantees reported that their staff was grateful for the information.

"Knowing the facts surprises people."

Training structure impacts success. Beyond the content, grantees found that certain structures and processes facilitated the impact of training. It was important to make the training required to guarantee high staff attendance. In addition, creating a curriculum for training new hires and requiring that they complete the training ensured that all staff would have basic information about tobacco and referrals. The required training also showed new hires that tobacco treatment is an important part of the organization’s work.

Organizations also had success with a tiered training model in which staff attended a large group training followed by smaller group trainings. The large group training was a one time, baseline effort to provide staff with information. It served as a call to action and was particularly successful when it was delivered by an outside leader in the field who could win over staff and show them that there was more to learn. Smaller group trainings followed the large group training. The smaller trainings were an opportunity for staff to talk about their concerns around the changes and to troubleshoot issues, such as pushback from providers who did not want to prescribe NRT or group homes that did not allow NRT use. They also discussed myths about harm reduction – for example, that certain brands of cigarettes and tobacco are less harmful. Some small groups focused on procedural topics, such as protocols for CO monitors and how to access outside services.

The small group trainings also uncovered what staff were already doing to support clients who use tobacco and facilitated a peer coaching experience for participants. Some sites found it helpful to build in quarterly visits to maintain visibility. The trainings improved conversations and referrals, and were a key part of the solution.
Organizational Facilitators

Identifying champions and designating ongoing roles. A key facilitator mentioned by all grantees was the identification of champions. They noted that it was helpful to find champions early in the process of organizational change and to identify multiple champions when there is high staff turnover. Two grantees formed formal committees made up of champions to facilitate the implementation of their initiatives. To identify internal champions, grantees watched for someone who asked a lot of questions and appeared to be the most interested. For organizations that worked with outside partners, they found that the person who initially invited them to work with their organization was a champion.

Once staff members were trained, champions acted as resources for troubleshooting, rather than solely relying on one or two individuals who organized the initiative. It was helpful for one organization to have their champion be trained as a Tobacco Treatment Specialist (TTS). The champion then went on to speak with clients and to work with providers to effectively prescribe medications. Champions who provided information to their peers were important, because information coming from peers can be more impactful on staff. Champions showed that cessation is about bringing up a conversation without shame or judgement and providing examples of success, which combatted fears and misinformation among staff.

Integrating tobacco assessment, conversations, and referrals into documentation and systems. Grantees reported that it was important to ask everyone about tobacco usage and to ask regularly. Regular screening started a lot of conversations and provided an opportunity for staff to learn as well. To accomplish this and follow it up with referrals and connections to services, it was important to integrate the changes into staff’s daily activities, such as requiring updates in progress notes, reports, referrals, and follow-ups. These changes also served to remind staff that tobacco was a priority. Integrating the questions into a place where they already asked clients about other substances, such as alcohol and drugs, was helpful. This was the most logical, least disruptive place to include the question so that it is asked and recorded with every assessment. Making tobacco cessation part of the staff’s existing routine also made the additional tobacco screening and follow-up feel like less of a burden.

The EHR/EMR was considered the best place to integrate the reminders, questions and referrals. Sites that had internal IT departments had the most success with fast, smooth changes to the EHR/EMR. Having the information in electronic records allowed the organizations access to the data so they could understand more about their clients’ tobacco use and how it is being addressed. Electronic referrals also made it easier for staff to link the client to existing services.
Organizational Challenges and Barriers

Systemic tobacco and mental health treatment cultural issues. The overall culture of mental health treatment facilities still does not include tobacco control efforts to the extent that physical health facilities have. While most buildings are smoke free, many sites with permanent housing still provide a dedicated smoking area. Some leadership teams fear that going smoke free will drive clients away or lead to an unwelcoming atmosphere for a population that is stigmatized and struggles to find welcoming places. For organizations that do not own their building or control their building policy, it is difficult to implement smoke-free policies when the ownership does not prioritize tobacco cessation. These challenges made it difficult for the grantees to execute the culture changes necessary to promote linkages to cessation services for clients.

Staff hesitation and misinformation. Staff misinformation about tobacco use and treatment, as well as high variability in attention to tobacco issues among staff, posed a problem. There were a number of factors that drove staff attitudes and behavior. Grantees reported that they encountered providers who continue to believe that smoking is a good method of symptom control for people with mental illnesses. Some grantee staff still saw other issues as priorities, particularly within chemical health treatment settings. Staff who are tobacco users made it harder to integrate cessation into their work. They felt they were not in a place to encourage clients to quit smoking when they were still smoking. Other staff were concerned that clients would become upset if they brought up tobacco use because it was too personal, though the grantees found this to be largely unfounded.

There was also resistance to training and new systems. Mental health providers believed they knew all cessation options and how to do cessation work with clients. Other staff resisted integrating tobacco because they saw the assessments and referrals as additional work in their already busy schedule. Staff who had negative experiences with existing cessation services or with providers who did not properly handle tobacco addiction felt uncomfortable referring clients to outside services.

"It isn’t because clients aren’t interested in quitting. It’s because of our lack of actions in addressing tobacco. It’s important to get resources to clients who lack the confidence in their ability to change."

Addressing tobacco in conjunction with mental health treatment is a relatively new topic for mental health practitioners. Grantees report that part of the challenge is the limited integration of mental and physical health, which includes tobacco. While screening for chemical health and substance abuse is common, tobacco use is not regularly assessed or addressed. For example, most health plans used by their low-income clients do not have screening paperwork that contains tobacco-related questions. Without assessment, conversations and connections to services are less likely to take place. People are interested in hearing about tobacco, but grantees report that real integration is not yet complete.
Organizational Challenges and Barriers

**Reaching clients in the community.** Case managers and staff who were going into the communities and to individual’s homes, rather than supporting clients in shared living facilities, had more difficulty supporting them because the clients did not necessarily have the additional support or the regular encouragement of peers and other staff. In addition, community work presented challenges for physical resources, like CO monitors. Planned programming and scheduling use of the CO monitors helped one organization integrate them into their work. They created a 4-session program that structured how the monitor was used and how information was recorded.

“This is a health disparities issue and should be treated like one.”

**Interactions with other healthcare providers.** Staff faced a challenge when linking clients to other healthcare providers for tobacco cessation. Staff often had to combat misinformation that clients received from other healthcare providers, such as previous therapists who recommend that clients not quit smoking because it would not be good for their mental health, or providers who do not want to prescribe cessation medications because they do not think it is safe or effective. Some encouraged patients to keep smoking if it helped them “get through” a difficult period.

In addition to supporting and referring clients, staff had to provide assistance to outside healthcare providers who did not know how to engage with clients who want to quit. They sometimes worked to educate therapists and psychiatrists that smoking is not helpful in the long run for patients; many had never seen an example of cessation success and therefore did not know it was possible.
Lessons Learned

For Mental Health Providers

- Recognize that clients want to quit tobacco and are open to discussing cessation options.

- Capitalize on mental health providers’ existing Motivational Interviewing and behavior change skills to encourage clients to connect with cessation services.

- Provide a variety of options for linkages to tobacco cessation services, including quitlines, community support groups, and healthcare providers.

- Train staff and secure leadership support and buy-in from the onset to encourage organizational change and make tobacco a priority.

- Provide multiple opportunities for training and discussion on general tobacco information, cessation services, and new organizational protocols when introducing tobacco initiatives at mental health organizations.

- Integrate assessment and referral into existing systems, such as screening or notes in an EHR or EMR, for sustainable change around tobacco conversations and connections.

For Cessation Service Providers

- Tailor cessation services to better meet the needs of those living with mental illnesses.

- Continue to evaluate and implement improvements to quitline services to better serve the mental health community.

- Make a concerted effort to build relationships with mental health service providers to increase providers’ trust in available cessation services, identify opportunities to tailor services, and improve utilization.

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References


