

CDC Town Hall Teleconference

Adult Smoking and Mental Illness

February 12, 2013
2:00 pm–3:00 pm EST

Coordinator: Good afternoon and thank you all for holding. The lines have been placed on a listen only mode until the question and answer portion of today's conference, and I would like to remind all parties the call is now being recorded. If you have any objections, please disconnect at this time. I would now like to turn the call over to Rich Schieber. Thank you, sir. You may begin.

Rich Schieber: Hi. Good afternoon. Thank you. I'm Rich Schieber. I'm the CDC *Vital Signs* Program Coordinator and I'm very pleased that you could join us today for this conference call. Before we get started, let me go over a couple of housekeeping details. Please go online and download today's PowerPoint Presentation and that way you can follow along with the presenters and I'm going to give you the web address next. And the web address is www.cdc.gov/stltpublichealth. That's s-t-l-t public health, one word.

When we get to that page, there's a link directly to the Town Hall website under highlighted products and resources on the bottom right. And also on this page, you can review the bios for each of the presenters. And, also, this is where we'll add the audio recording and transcript for today's meeting later on. They should be available by next week.

So, that's it for housekeeping. Now today we're here to discuss the latest *Vital Signs* Report on Adult Smoking and Mental Illness. This is a very important public health topic. A disproportionate number of those with mental illness are dying from smoking and are at greater risk for developing chronic disorders.

Historically, not universally, but historically mental health practitioners have been reluctant to address nicotine addiction in conjunction, sorry, in conjunction with mental health treatment and also may have lacked the necessary resources. But in recent years, greater attention has been paid to shifting the culture within the mental health facilities to make them smoke-free. This not only helps the clients but also the staff as they transition from nicotine dependency to nicotine-free and, therefore, can help improve their overall health and life expectancy.

Today we're going to hear from four colleagues in Maryland, Massachusetts and Texas and one from CDC here in Atlanta. And the first speaker will be Dr. Shanta Dube. And Shanta is the Lead Health Scientist in the Office of Smoking and Health at CDC's National Center for Chronic Disease Prevention and Health Promotion. And Shanta will provide a summary of this month's *Vital Signs* report. Very good.

And then, without me interfering, Dr. Dube will hand the call over to Doug Tipperman. Doug is the Lead Public Health Advisor for the Center for Substance Abuse Prevention at SAMHSA, Substance Abuse and Mental Health Services Administration. And, Mr. Tipperman will share the information he has about the success of the 100 Pioneers for Smoking Cessation Campaign. And that has benefited seven states since 2010 and it's steadily expanding.

And again without interruption, Mr. Tipperman will then turn the call over to Dr. Doug Ziedonis. And Dr. Ziedonis is Professor and Chair of Psychiatry at the University of Massachusetts Memorial Medical Center and the University of Massachusetts Medical School.

Dr. Ziedonis will discuss an effective ten-step model known as Addressing Tobacco Through Organizational Change. And then Dr. Ziedonis will turn the

call over to Mr. Dale Mantey, pardon me, and Mr. Mantey is the Tobacco Cessation Service Coordinator in the Department of Health Promotion and Wellness at Austin Travis County Integral Care. And Mr. Mantey will talk about tobacco cessation initiatives that have been replicated state-wide there.

It's also contributed significantly to our helping making mental health facilities throughout Texas tobacco-free. There will be time for questions after our presentations and you can get in the queue to ask a question at any time during the teleconference by pressing star 1 and recording your name when prompted.

So if this works for everyone, I would like to turn the call over to Dr. Dube. Shanta, are you there?

Shanta Dube: I'm here. And, thank you, Dr. Schieber, and welcome everyone. Good afternoon. I'm very pleased to be able to present some findings from our *Vital Signs* which was released last Tuesday. The title is Current Cigarette Smoking Among Adults Eighteen Years With Mental Illness.

And, before I start, I want to recognize all of the co-authors on this report. In particular Joe Gfroerer at SAMHSA who was our collaborator on the report as well as Brian King, Bridgette Garrett, Stephen Babb, and Dr. Tim McAfee who is our Director in the Office on Smoking and Health. Just briefly, to go over the four goal areas of our office, we aim to prevent initiation of tobacco use amongst youth and young adults. We have a focus to eliminate secondhand smoke exposure. We also have a goal area around promoting cessation.

And, as you will see highlighted is a goal area to identify and eliminate tobacco-related disparities. This report was developed and reported as a means to address this particular goal area within the Office on Smoking and Health.

Just to recap the impact of smoking at a population level, approximately 8.6 million people in the US have at least one serious illness caused by smoking. Approximately 440,000 premature deaths among US adults occur annually due to smoking and secondhand smoke exposure. And smoking reduces life expectancy on average by about 14 years.

Here is a trend line of what we've seen in terms of current smoking amongst adults from 1995 to 2010. We have seen marked declines in current cigarette smoking amongst adults over time. However, one of the things that we have observed as well is that certain populations still have a high burden of smoking or high rates of smoking.

In particular, persons with mental illness have high rates of smoking. This has been documented whereby about 40% to 85%, depending on diagnosis, of those with mental illness currently smoke cigarettes.

We also know, based on an article by Bridget Grant, that those who are nicotine dependant smoke about 34.2% of cigarettes smoked in the US. And persons with mental illness may be smoking more heavier and more frequently than other smokers.

Because of all of these known facts around smoking behaviors in persons with mental illness, we in the Office on Smoking and Health in collaboration with SAMHSA realize that more surveillance and reporting of smoking in this population was necessary to do.

So our objective for this study was to assess the most recent national and state level estimates of cigarette smoking amongst adults 18 years and older with any mental illness. Again, our objective was to bring awareness of this issue to the broader audience.

Our methods, briefly, we utilize the 2009 to 2011 National Survey on Drug Use and Health. It was approximately, it included approximately 138,000 adults interviewed in 2009, 2010 and 2011. In terms of our statistical analysis, the data were weighted to adjust for differential probability of both selection and response and we used chi-square tests to look at significant differences at a (P) level of 05.

I'm going to briefly go over this slide. I realize there's a lot of information on here. But, in terms of how SAMHSA defines any mental illness, the Kessler-6 or K6, which is used to assess psychological distress was used as well as the World Health Organization Disability Assessment Schedule, also called the WHODAS.

Both of these were implemented in the survey respondents, amongst the survey respondents and then the scores on these two scales were used to determine any mental illness based on a statistical model which utilized clinical interviews on a representative subsample of the NSDUH respondents that assessed DSM-IV disorders.

In terms of our definition of smoking characteristics, current smoking was actually defined as current smoking in the past thirty days. We did not include 100 cigarettes and this will be corrected after this presentation and the corrected slides will be available.

Daily smoking was defined as smoking every day in the past 30 days. And our cessation indicator was a quit ratio, that is a percentage of adults who had ever smoked at least 100 cigarettes and you also reported no past month cigarette use.

So, our overall findings from the study, we found that approximately 19.9%, almost 20% of US adults had any mental illness. Smoking prevalence was 36%

for persons with any mental illness versus 21.4% for persons with no mental illness. And we also examined the prevalence of smokers with any mental illness and this was 30%.

Among smokers the average number of cigarettes smoked in the preceding month was higher at 331 compared with, for adults with AMI, compared with adults who did not have AMI. Among adults with any mental illness the quit ratio was 34.7% compared with those with no mental illness at 53.4%. In addition, we did look at variations across socio-demographic characteristics and across geographic regions.

Prevalence was highest amongst men, adults aged older than 45 years, those living below poverty level and those with less than high school educations. You know, what we want to point out here is what we see in terms of disparities overall in the general population. We see amongst those with any mental illness and it's very pronounced.

And by US regions, smoking prevalence among those any mental illness was lowest in the west and northeast and highest in the midwest and south. Across states, prevalence ranged from 18.2% in Utah to 48.7% in West Virginia. The conclusions and implications of this report lead us to be aware and understand that increased awareness about the high prevalence of smoking among persons with mental illness is still needed.

To that, we know that there are effective population based prevention strategies that can be extended to this population, and they include implementing tobacco-free campus policies, in mental health facilities, as well as, screening by primary care and mental health care professionals. They should be done routinely and practiced. And also, for health professionals, offering evidence based cessation treatments to those who use tobacco.

We know persons with mental illness who smoke are at risk for multiple adverse behavioral and health outcomes. And therefore, the benefits of cessation for this population should be underscored. And now I'm going to turn it over to Doug Tipperman at SAMSHA. Thank you.

Douglas Tipperman: Thank you Shanta. For those of you who are following the slides, we are now on slide 17. Today, I'll talk briefly about a couple of cornerstone federal initiatives to address the high rates of tobacco use by those with mental illness as well as those with substance abuse disorders. Although the data presented today concerns persons with mental illness, we know that a similar problem exists among those with substance use disorders, and the current state efforts tend to address both of these issues.

Then, slide 18. With that said, a key challenge faced in addressing these high tobacco use rates is that tobacco use has been accepted and even used as an incentive or reward for those being treated for mental or substance use disorders. Tobacco has been used as incentive or reward for taking medication, for following rules, or attending therapy. I have even heard of cases of staff members smoking with clients because they saw it as a bonding experience.

On this slide, I have the findings from a survey that was done back in 1999 and 2000 in Massachusetts. And they found that 22% of their mental health consumers reported that they started smoking in a psychiatric setting. On to slide 19.

Slide 19 is a letter that I don't expect you to be able to read, but I'm going to describe the letter to you. It came from one of the tobacco and street document archives. It's dated 1980, and it was sent by Dr. Fuller Torrey who was the

medical director at St. Elizabeth's Psychiatric Hospital in Washington DC. The letter was sent to R.J. Reynolds requesting a donation of cigarettes.

In the letter Dr. Torrey refers to smoking as one of the greatest pleasures for patients who have very few, if any, alternatives. He goes on to say that many staff have been providing clients with cigarettes out of their own pockets. Okay, slide 20.

Several years ago, my agency, SAMSHA, began an effort to help reverse these practices and to de-normalize tobacco use within behavioral health treatment and the recovery culture. On this slide, it mentions the Pioneers for Smoking Cessation Campaign. Beginning in 2008, SAMSHA, in partnership with the Smoking Cessation Leadership Center, launched the 100 Pioneers for Smoking Cessation Campaign.

The campaign provides support to behavioral health facilities and organizations to undertake tobacco cessation efforts. This support has included financial awards, technical assistance, networking, and training webinars.

On slide 21, beginning in 2010, SAMSHA and the Leadership Center expanded the Pioneers campaign by working with states through leadership academies for wellness and smoking cessation. The goal of the academies is to reduce tobacco use among those with mental illness as well as those substance use disorders.

Participating states bring together policymakers and stakeholders, and those include leaders in tobacco control, mental health, substance abuse, public health, and mental health consumers to develop a collaborative action plan. At the bottom of the slide, I've listed the states that have participated in leadership academies.

If you live in one of these states, you may have been involved in this effort, but if not and you're interested, I encourage you to contact the Leadership Center or actually the Smoking Cessation Leadership Center to find out the contact for your state. On slide 22, it—last year, federal efforts to address tobacco use among those with mental and substance use disorders increased greatly with the formation of a federal collaboration that we call the HHS working group on tobacco control and behavior health.

And I have here listed the federal agencies that participate in this collaboration. Matter of fact, the *Vital Signs* report being discussed today is an outgrowth of this collaboration. And finally, slide 23 is a summary of best practices to prevent and reduce tobacco use among persons with mental and substance use disorders. Some of these were mentioned earlier, such as adopting and implementing a tobacco-free facility and campus policy, having providers routinely ask their clients if they use tobacco, and providing evidence based cessation treatments to those who do.

We know that evidence based tobacco cessation treatments are effective with those with mental or substance use disorders. However, they may face challenges in trying to quit. They may benefit from additional counseling, longer use of cessation medications and monitoring as part of routine care.

We also know that those on psychiatric medications, some medications are actually affected by smoke. They metabolize faster, so when these patients quit, very often they can reduce those medications that are affected. So that would need to be monitored also.

The final point is that the effectiveness of tobacco cessation treatment can be significantly increased by integrating cessation services into the mental health or addiction treatment program and that's based on a study that was done by the VA

with persons suffering with PTSD. They found that when they integrated tobacco cessation into their care they were twice as likely to be successful in quitting as opposed to being referred to a tobacco cessation program. And that concludes my presentation and I'll turn it over to Dr. Douglas Ziedonis. Thank you.

Douglas Ziedonis: Thank you very much, and I also want to thank the CDC and SAMSHA and others for highlighting this very important topic. Those of us who are clinicians working in the trench know that for too long this has been an ignored topic, although there's been a lot of progress.

I'm going to be talking about addressing tobacco through organizational change, a model that I think a mentor, John Slade who was, who did seminal work in nicotine-free as drug-free which became a platform for the development of the current version of ATTOC.

On slide 25, you know, why should we address tobacco? I think it's been clear, the numbers that were presented by the CDC. Those of us who work in clinical settings actually see higher numbers. We tend to see 50% to 95% of our patients smoke. So this really should be an issue that we address in mental health settings routinely, all the time.

Increased morbidity and mortality, I was appreciative also to the disparities on tobacco both the rates of , high rates and the quitting, but really we're very focused on the health disparities—cardiac disease, lung cancer are the top two causes of death. Our state was the first to report the 25 year shorter lifespan for people with serious mental illness who are in the public sector. That's outrageous that any group of people in the United States would have that big a gap in lifespan.

This should be the headline of newspapers. We wouldn't tolerate it and if it wasn't for stigma towards mental illness, we would address it much more aggressively. The cost for people on fixed incomes is substantial.

Studies we've done, 25% of their income often goes up in smoke to address this topic, to smoke. It also affects their ability to have housing, discretionary income, employment, insurance, relationships. It really is now the time to address tobacco, even more. I see it every day. I wake up and I'm fighting stigma and health disparities. In mental health settings we tend to like the word wellness so that we're blending both the issues of obesity and smoking.

Obviously recovery, which has been a long standing word in substance abuse, addiction, recovery, and 12-step, is now front and center with the consumer movement. People with lived experience said recovery is also an important concept which is resonating for people to better address this topic.

There are lots of great evidence based treatments out there that we need to integrate; psychiatrist, nurses need to know how to prescribe the seven FDA approved meds. They need to be on our formularies. We also need to know psychosocial treatments both brief ones on engaging through motivational interviewing, a brief interventions, perhaps getting people to other resources that are available in the community.

We just haven't bridged to community resources and there are a lot out there that we should do. From my own experience, training's not enough. You can't change culture through just training.

It needs resources, it needs support, it needs to be put on the front stage of importance and so that's where organizational change strategies, continuous quality improvement projects need to be done at local sites. The National

Alliance for the Mentally Ill, the family members, they had a strong position statement, on slide 27, that people with mental illness and in recovery have the right to be smoke-free and tobacco-free.

It's almost amazing that we even have to say that as a statement. Part of it's due that one of the smokescreens; one of the barriers has been the overemphasis, in my opinion, of the self medication model. There's very little evidence other than high rates of smoking to support a self medication hypothesis versus the idea that people are addicted.

Quitting addiction is hard and particularly if everybody reinforces it and also you live in settings where smoking is tolerated and used as incentive or even if you live in a group home where many people smoke. So I think we have to appreciate it's an addiction first. There may be other minor issues in that area but there's very little data other than perhaps withdrawal is worse, and that's not surprising.

Other components of the National Alliance of the Mentally Ill, and they have a nice website, nami.org, that you can find the full policy, but they felt effective prevention and treatment should be a part of every mental health care treatment and recovery. They also supported a tobacco-free campus in all mental health settings. The model that we have that you could all put in your Google engine, UMASS, U-M-A-S-S, ATTOC, A-T-T-O-C and this would pop up.

You'll get a lot more details than I can present in ten minutes about our model. Again, as A Great Evolution with John Slade and the seminal work he did on nicotine-free is drug-free. So I've, we've been able to implement this model in probably about half the states in the nation and particular local programs.

We're now globally. China is where the United States was in the 50s in smoking, and interestingly their rates of smoking amongst people with schizophrenia

paralleled the gender difference and so it really raises another issue about self medication. About 5% of women in China smoke and only 5% of people with schizophrenia smoke who are women.

Seventy percent of the men smoke in China and 70% of the men who have schizophrenia smoke, so I think it's also important to look at global issues to perhaps help us understanding this issue. We focus on three key areas: patient, staff, and environment. How can we improve clinical services, screen better, document better?

If I could get one thing, get people to put it in their treatment plan because that means you've probably screened and assessed, and that means you probably have a treatment in mind. And then simply is it for lower motivated or higher motivated clients because then you have different strategies. It requires staff training. We haven't been trained.

Psychiatrists weren't trained in managing tobacco in their own training when they were going through residency programs. Also, if staff smoke and we have an unusually high rate of smoking amongst mental health staff. If they smoke, they're not going address tobacco so we have to also work with the staff. Remember in the 50s, 50% of doctors smoked and now only 3% of doctor's smoke.

We have to get rates like that with all mental health clinicians. Another area is policies either for, to restricted smoking on the grounds which is not the favored route, at least as a step towards tobacco-free grounds. We don't allow alcohol on grounds and it's a legal substance. Why would we allow tobacco on the substance, on our grounds?

It's not only the smoke that people breathe but it's the trigger when you see somebody smoking so we have to remember that important thing. The ten-step model that we have which, again, you can learn in much more detail through the internet and reading the details but we have basically three phases of planning, implementing and sustaining change. Any of you who've done an organizational change effort know the importance of communication. I suggest a written out change plan. What are you going to put on your website, what newsletters, what is your signage that you're going to have?

Also if you're monitoring a sustaining change you need to have a dashboard and track the key outcomes. Oftentimes people want to have some technical assistance and training because they don't have the in-house support and there's lots of resources available to help people in this area. And it's good to hear of all the activities.

On slide 29, this is typically what we've done which, again, helping people prep for, addressing tobacco, developing goals in the patient, staff and environment areas, identifying a champion, seeing if an agency will allow resources like a minimum of two hours a week that someone could do this work, having a leadership team - really walking through the campus, looking through the charting, seeing what's going on at the agency before you even develop it, what basic training will everybody get, what advanced training might you have for the specialists, creating work groups in this different areas.

Also more tobacco treatments specialists in mental health is needed. The model on slide 30, you can see those core five steps. I'm not going to go through those. You can download a lot more information on our website. On the implementation phase, that's the crux of it.

What are you going to screen and assess better, what kind of treatments can you bring in, how do you get consumers involved? Through our experience, the empowerment of peers and consumers really makes a big difference in change and there's a number of websites and information that are available in that area.

Next slide 32, you've have to document your changes through your policies. The biggest one is usually due process around if people are smoking, staff on campus, what are you going to do about it, standard operating procedures. There's a lot of strategies to sustain change because that's what we want to do ultimately.

So if you look at slide 33, typical things for a clinician assessing current use, use of CO meters. Most staff haven't even seen or heard of it, or cotinine levels is another way, although a little bit more expensive. How do you assess motivation for are you ready to quit and try something or not?

Slide 34, treatment can work. It has to be a little bit adaptive for our patients. They tend to be heavier smokers. They tend to also have mental illness and have psychiatric meds.

They care mostly about stress management and the weight concerns. They also worry about their family, significant others living with other people who smoke. We have to monitor psyche med blood levels as was described.

Blood levels will go up when you quit smoking so you might get side effects from the medications, particularly antipsychotics. The next slide is a picture of, 35, of a CO meter, one of the older versions. We found that to be very impactful in giving personalized feedback.

There's a, next slide has a free manual that you can get online, Learning About Healthy Living. Put that in your Google and you'll get it for free. I don't want to, we often in mental health put down quitlines online work, Nicotine Anonymous. Those are great resources.

I really encourage people. 1-800-QUIT-NOW, we've integrated into mental health centers and they use it. www.becomeanex.org through many other good online resources. Nicotine Anonymous has phone line meetings every day that you can engage in.

Some of the things that we've found using this model in Connecticut where I want to appreciate the Department of Public Health and their support with Communicare, our partner agency with 16 different behavioral health agencies. We were able to get people to put this into their treatment plan, make big changes, and outcomes for the patients.

They brought in treatment programs, learning about healthy living groups, quitters groups, got people access to the community resources. The staff in, get them in recovery if they were smoking, train them in the basics and advance. We've had mental health agencies go tobacco-free both inpatient as well as outpatient settings.

Now really is the time for us to address tobacco. I really appreciate the opportunity that all of us have put into this talk and hopefully this will be just one of many. On slide 40 there are a number of other resources that you'll be able to download about our work in clubhouses that the Genesis Clubhouse that has done a great thing through the legacy funding and foundation.

I mentioned the smoking cessation leadership group has a lot of great resources for this group, Steve Schroeder leading, that's an amazing person. RX for Change

has a ton of PowerPoints for free just dedicated for this group. Bringing Everyone Along (BEA), another great resource so there's tons of material out there.

It's a matter of putting it together and thinking of both training and organizational change. And so at this time I'll pass it on to Dale Mantey.

Dale Mantey: Hi there. My name's Dale Mantey. I'm going to be talking to you about the actual policy change, how to implement it, how to sustain it and what it can do, the good things, the bad things. If you look on slide 42, the prevalence we all know is alarming. As the good doctor was saying, some of our client groups, particularly all schizophrenics, will smoke at rates of 90% - 95%. And I'm glad he actually brought up the practitioners.

This is often kind of not talked about and we found in 2020 that our practitioners smoked about, or used tobacco products at about a rate of two times more than of the county we lived in. Now the barriers to treatment that come from tobacco we found, research has shown that biologically tobacco inhibits the absorption of psychiatric medications.

Therapeutically, research has also shown that an increase in positive outcomes comes at facilities that do not allow tobacco products and this has created public health ramifications that, you know, tobacco, of the 443,000 annual tobacco-related deaths, over 200,000 of them will have had a mental illness. Slide 43, a tobacco-free workplace. We got our start with the Communities Putting Prevention to Work grant. This created a coalition in Austin and Travis County to prevent tobacco use, decrease prevalence, what have you.

And that allowed us to create our tobacco cessation initiative which had three goals: policy implementation, decreased prevalence, and increase prevention. In

order to do those three goals we had to confront a mentality in the mental health world. Indifference is the biggest, is one of them. It's seen as a low priority. Our practitioners and our staff will say things like, we're just trying to keep our consumers out of jail, off the streets, on their meds, tobacco, I can't really be bothered with that.

Then there's the reluctance. They'll say it's too difficult, they'll say that the consumers have no interest in doing it, they'll say quotes like, 'if a person without a mental illness can't quit tobacco, what makes you think that someone with a mental illness can quit tobacco?'

Research shows that our patients want to quit and can quit the same rate as the general population. And then the resistance. This what everyone else has talked about. There's this myth of self-medication and there's nothing to back that up.

Now in terms of us actually creating and adapting our policy. Data collection was the first part of it. We assessed the prevalence among our staff and our consumers and then we've tried to find the attitudes and the support for tobacco-free workplace and a tobacco cessation initiative here at ATCIC.

We also remain in continuous and open dialog with our staff members. If anyone had an opinion, we wanted to hear it, we wanted to incorporate it, we wanted to understand any concerns and offer solutions before we even faced the problems. And externally we wanted to be in networks with every single tobacco cessation and tobacco prevention program and organization we could be in collaboration with.

Training, therapy and cessation techniques, mostly motivational interviewing. We found that's had one, some great success, a few others as well. And then, engagement strategies. This is referring people to our resources, to community

resources, letting them know that we're about to implement a tobacco-free policy, which I'll get into more. Basically, an engagement script to tell them how to - to inform them of our policy.

Now the resources I'm talking about we offered counseling to our consumers and to our staff, our staff members' families as well. We offered free nicotine replacement therapies. This came from a CPPW grant monies. This is patches, gums, lozenges, we've had great success with that. And we also offered employee prescription reimbursement program to those in our health care network.

Not only would we pay for the Chantix prescription, we would also reimburse them the co-pay of the doctor's visit. Now the tobacco-free workplace policy was approved in July of 2010 and implemented February of 2011. February 1 we just celebrated our two year anniversary. It was a comprehensive policy. No tobacco products were allowed on our campus.

There are no smoking areas and it is all tobacco products and it includes any person on ATCIC property for any reason. The program as a whole, we have education and training. Every new employee orientation we have one hour segments for, to teach the, what the policy is, what resources we can provide, so on and so forth.

And then we have a yearly training seminar. They've been in February previously and this year it'll be in April or May. The resources we've, our agency is dedicated to continuously providing NRTs. We find a way, it's expensive but we find a way.

And the tobacco use assessments, it's required at intake and then yearly after that for every single consumer that they are assessed for their tobacco use and it is

put on their treatment program. Staff surveys, we want to know exactly what our staff think. This allows them to let us know what's going on in the program from the macro, micro, and other levels.

Let them know any problems we have, how we can solve them. And then community based, we have partnered with housing programs to make apartment complexes smoke and tobacco-free here in Austin and Travis County, and we assist other mental health agencies in adopting and changing their policies regarding tobacco.

I'm on slide 48, staff prevalence. Six months prior to the program, our staff smoked, used tobacco at a rate of 28%. Six months after the program with the influx of training and resources, we got that number down to 11.6%. This is self reported surveys.

And of that 11.6%, 44% reported using less tobacco because of the policy. The staff support, six months prior to the implementation of the policy, only 60% of the staff supported it. Eighty-four percent supported it afterwards, six months afterwards. And staff training, 81.6% said they received training six months after the program.

The impact on consumers, we performed over 9,300 tobacco use assessments. Sixty-five hundred consumers were surveyed and 46.4% said that they felt positively impacted by our policy, positively impacted meaning they chose to quit, they continued to be a nonuser, or they were an ex-user who remained an ex-user.

And then the cultural shifts. Staff has begun to welcome the change. The initial resistance has subsided and now it's just another policy. And then similar mental health agencies all over the state of Texas and all over the country have asked us,

how did you do this, how do we implement this, what knowledge can you share with us?

And then the lessons we learned, first off, sustainability is crucial. You must remain visible and active. Stay incorporated with all of your staff members. Also invest in the things that will get you results. Use the best practices, have nicotine replacement therapies available - those are things that are going to get you the results you want.

And second, this policy lives and dies with the staff. You have to incorporate them in every single element. We kind of lived by the mantra of if you forced, you failed. And then stay committed. Your long-term goals will far outweigh the short-term resistance. And that would be it.

Rich Schieber: Thank you all for these excellent, excellent presentations.