

CDC Town Hall Teleconference
Adult Smoking and Mental Illness
Q&A

February 12, 2013
2:00 pm–3:00 pm EST

Rich Schieber: Let me remind you that you can get in the queue to ask a question by pressing star 1. You'll need to record your name when prompted and then you'll be announced into the conference by Elan, our operator, when it's your turn to ask a question. So I encourage you to take this opportunity to talk with each other and ask the experts and share lessons learned and challenges. So operator, we're ready for questions.

Coordinator: Okay. Our first question today is from Bernice Carver. Bernice, your line is open. Please check your mute feature.

Bernice Carver: Hello, can you hear me?

Coordinator: Yes, now we can hear you.

Bernice Carver: Okay. I was wondering if your tobacco-free policies include e-cigarettes and how you deal with that.

Dale Mantey: At the moment, this is Dale, at the moment we haven't actually addressed that situation. We've talked about it a lot in meetings, kicked the idea around, but at the moment we haven't addressed it.

Rich Schieber: Operator?

Coordinator: Would you like to take the next question? Our next question is from Mark Potuck.

Mark Potuck: Yes. Hi, everybody. Actually, one of my questions was the e-cigarette. I was wondering if, Dale, you had dealt with that or anyone else. But I also have another question and that was to, I forget which Doug mentioned about Nicotine Anonymous and I have not had good luck getting in touch with them. I had wanted to check into the possibility of establishing a local chapter. But you say there is a daily chat or something? I kind of missed that point. Hello, is anybody there?

Rich Schieber: The moderator is here.

Mark Potuck: Oh, okay.

Dale Mantey: Dale Mantey is here. We help with, we use Nicotine Anonymous as well. I'm sure I wasn't the person you were directing the question to.

Mark Potuck: Oh, no. That's okay, Dale. Any...

Dale Mantey: Yeah...

Mark Potuck: ...information about them I would be, I'd love to get in touch with them. I just have not...

Dale Mantey: Yes. They are, there's one main, prominent, local chapter here in Austin and they meet not too far from our big university, the University of Texas. And they, I mean, I can get you in touch with them to see if they know anyone in your area.

Mark Potuck: Oh, that would be great.

Dale Mantey: Yes, I mean, my email is at the end of my slide presentation. Just shoot me an email and then I'll forward you their information.

Mark Potuck: I will do that. Thank you so much.

Dale Mantey: I'm happy to help.

Coordinator: Thank you. Our next question is from Elizabeth Ortiz de Valdez.

Elizabeth Ortiz de Valdez: Thank you and greetings. I have a question that's specific among best practices for Hispanic Latinos, especially those with limited proficiency English.

Rich Schieber: Somebody want to take that on?

Dale Mantey: Am I the only one here? This is Dale again. Am I the only one here? What we...

Rich Schieber: Are the other speakers on the line?

Coordinator: Yes, they're all still connected.

Rich Schieber: Okay, good. Well, go ahead, Dale.

Dale Mantey: Well, I was actually hoping someone else could answer, well, we've used, and here in Texas and especially, particularly in Austin we do have a fairly high

rate of Hispanics, particularly Mexican-Americans. And what we found is we use similar tactics. We just also are lucky enough, we're blessed to have a large number of our staff be Spanish fluent and proficient.

And we've pretty much just used the same kind of things, made it a little culture specific, but pretty much just used the same tactics, just, versus English, we use it in Spanish. That's what we've done.

Doug Ziedonis: Hi. This is Doug Ziedonis. Still on addressing it for Latino Americans?

Elizabeth Ortiz de Valdez: Yes, or limited English proficiency.

Doug Ziedonis: Okay. You might want to check out UMDNJ, the Robert Wood Johnson, if you put in www.tobaccoprogram.org you'll, they have had a whole program dedicated for this and they changed the rate of getting people into their program from 3% to 35% of their patients. And they did a lot of changes. Not only linguistically but adapting to the culture, working with community leaders to develop a sense of that this could be a good topic to address. But they also have materials on their website.

Elizabeth Ortiz de Valdez: Yes. And also is there data regarding mental health and tobacco among Hispanic Latino population?

Rich Schieber: I...

Shanta Dube: Hi, yes, this is Shanta Dube at CDC. In our *Vital Signs* report, we did report that amongst persons with mental illness, 31.6% overall Hispanics were smokers versus 19.8% were not. So in other words, 31.6% of Hispanics with any mental illness were smokers versus 19.8% of those Hispanics without,

with no mental illness were smokers. And we have that in our actual MMWR report as well as the vital, excuse me, *Vital Signs* fact sheet.

Elizabeth Ortiz de Valdez: Where can we get the website? Sometimes it's hard to reach all your data.

Shanta Dube: Oh, I, Rich, I believe the URL is going to be disseminated to everyone. Is that correct?

Rich Schieber: Yes. And you can look right now at www.cdc.gov/vitalsigns

Elizabeth Ortiz de Valdez: Okay.

Rich Schieber: ...and if you go through that you'll see all kinds of resources.

Elizabeth Ortiz de Valdez: Perfect. Thank you.

Coordinator: Thank you. Our next question is from (Alia Bassy).

Lea Bacci: Hello. I was wondering, this, my question is for Dale. And we have a tobacco-free policy on our campus, we're a local health department, and we do have one, however, we, as part of the tobacco team, we're having some trouble with enforcement and how to go about it. I noticed you had about seven months from when the policy was approved to when it was implemented and what kinds of barriers maybe did you face and how did you overcome that with both, just general staff because we do have an outpatient clinic.

And then, also, how did you address that, you know, did you do staff trainings and then with the mental health and addictions counselors, what kind of enforcement did you have to go through?

Dale Mantey: We kind of handled it in a number of ways. One is the training. We continuously train. We kind of stress, we emphasize everything. We always get the higher-ups in the administration kind of to, like, say, well, we need to follow this policy so that always helps.

And the trainings as well. The other thing we have is, I mean, no one likes this part of it, but you know there are write-ups to HR that our supervisors have been conducting and writing that works. A few other things is we kind have a compliance report done quarterly.

Lea Bacci: Okay.

Dale Mantey: And when, and then whenever the compliance reports come out, they're kind of made public. Every, it almost becomes this, we've kind of created this competition on who is in compliance, who isn't. I mean, that just kind of worked for us. I'm not sure if it would work for your agency. I know that there's some differences. We have about 36 different actual buildings and campuses all over the city.

Lea Bacci: Right.

Dale Mantey: About, what's the size of yours?

Lea Bacci: We do have different locations. Our main concern where we see the majority of our mental health and addictions clients is one location. So that would really be the primary focus for us.

I think our issue is actually we do have staff compliance with not smoking on the campus. That we know for sure. But it's, you know, clients and visitors and encouraging the staff who are in and out of the buildings to say, 'I'm sorry, you can't smoke here.'

I think it's the approaching, you know, having to approach an individual that you don't know and ask them to quit. So I didn't know if you had any tools that you guys use that maybe we could, you know, use.

Dale Mantey: Yes, definitely. We created an engagement script and we made sure...

Lea Bacci: Okay.

Dale Mantey: ...to train our staff on that each quarter actually because it can almost be scary and intimidating to do that for a lot of our staff members.

Lea Bacci: Yes.

Dale Mantey: And as such, you know, as many, as much training and tools as you can offer them. The engagement script has been the best tool. And, I mean, I'd be happy to share ours with you if you could just follow up with me. Shoot me an email and I can share ours.

Lea Bacci: Definitely.

Dale Mantey: Yes.

Lea Bacci: That's great. Thank you so much.

Doug Ziedonis: This is Doug Ziedonis. I would just add of that, when we started our phase it was more educational oriented and so, also if you have, people have clarity of why you're doing it when you engage with them. Also if you're going to provide treatment resources, letting people know that those are available as far as that.

But everybody, the secretaries through the housekeeping, through the clinicians, everybody needs to be able to do their part and not have it be like speeding on the highway where only the cops are watching out so you really have to make sure everybody is a part of the team to address it. The biggest problem probably is due process, which is a lot easier to do with staff but often still doesn't happen.

Lea Bacci: Right.

Doug Ziedonis: But sometimes unions can be great and very supportive, particularly since they're now appreciating that smoking cessation should be part of their benefit package and that really they'll have better employees who are less sick and lower health insurance, live longer lives. So it can often be a very pro union thing, although some unions haven't been educated about these issues so you might have to deal with that.

Lea Bacci: Okay. Thank you very much.

Coordinator: Thank you. Our next question is from Lorna Schmidt.

Lorna Schmidt: Hi. I have a couple questions actually. The first is more for Shanta in regards to cessation. Do you have any information on what type of treatment, if any, individuals receive to aid them in quitting smoking?

And in terms of the actual success rates, were there any gender differences?
And then the other question that I had is more general. I'm wondering if anybody has an estimate as to what percent of mental health facilities in the United States are currently smoke-free.

Shanta Dube: So if I understood the first question correctly, you're, it sounded like you were asking about quit rates or quit ratios by gender. Is that correct?

Lorna Schmidt: Yes.

Shanta Dube: Yes. We did not calculate those, but I can certainly check in with Joe Gfroerer at SAMHSA and get back with you on any estimates calculated from SAMHSA's end on that.

Lorna Schmidt: Okay.

Shanta Dube: We did not include those in the report.

Lorna Schmidt: Okay. And then did you collect any information on, you know, in terms of, you know, access to NRT or more like behavioral coping strategies?

Shanta Dube: In the national survey on drug use and health, there aren't any measures around cessation. The only specific way to look or to measure cessation is

through the quit ratio as we did. But there are no questions on there around the cessation treatment.

Lorna Schmidt: Okay, thank you.

Doug Ziedonis: This is Doug Ziedonis. There is a very nice NIMH report that summarizes the literature because your questions are probably best answered and known through clinical trials that were done for these populations.

And I think what you would see in general is that they're, because they, the individuals tend to be heavy smokers, are more aggressive treatment, probably gives you a better outcome. But that all the seven FDA approved products can work. The rates just might be slightly lower and integrating psychosocial treatment, behavioral therapy is important.

We haven't as a field made enough referrals to quitline, although the VA has a study in the northeast about a quitline they developed specifically for patients with psychiatric disorders. But we've, through clinical experience, I would say patients engage and do well in the 1-800-QUIT-NOW and become the next dot org another sites like that and the local groups.

There's papers out about Learning About Healthy Living which is the lower motivated group getting them engaged to quit and quitter groups that are more like behavioral therapy, so there's great evidence out there. I would look through the NIMH website and some of the others that we've given you.

Lorna Schmidt: Thank you.

Coordinator: And Dr. Schieber, we do have a question in the room.

Rich Schieber: Yes, I wanted to ask, do we know anything about relapse rates after quitting between those with mental illness and those without?

Rich Schieber: ...well, that's something we can look into. Next question, please.

Coordinator: Our next question is from Jane Parker.

Jane Parker: Good afternoon. I have a question for Dale and Doug. Doug, you mentioned that patients may, these patients may benefit from longer use of cessation medications. And, Dale, you mentioned that you provided free nicotine replacement therapy for the patients. I'm wondering what, how long did you provide the nicotine replacement therapy? Or what would you recommend for length of nicotine replacement therapy for these patients?

Doug Ziedonis: Well, this is Doug Ziedonis. And as a physician and psychiatrist, someone who prescribes, you know, the PDR and the FDA have recommendations that are probably one-third of what clinicians would do routinely, but they recommend an 8 to 12 week.

But in clinical practice probably people will go off label and use for a longer period of time. And it really then depends on the individual patient, what was their, how much were they smoking when they started, when the treatment and, by the, I would say in general it's usually two to three times the length of what is recommended. And it's more aggressive and where you have to watch out is when you stop the medication, you know, that is a good time to have some booster, coaching, or peer support or something where they have a little bit of extra help or otherwise you will see relapse rates as opposed to quitting the medication.

Jane Parker: And we're talking about, I'm talking about over the counter.

Doug Ziedonis: Yes, I am too. The nicotine replacement, the patch, the gum, the lozenge, the three that are available over the counter.

Jane Parker: Okay.

Dale Mantey: Yes, and this is Dale. We found about the same. It was kind of patient specific. We usually found that it was often 12 weeks, sometimes more. We also found out that as they went down from step 1 to step 2 to step 3, we'd advise, because we would use the patch in collaboration with either the gum or the lozenge and we would find that once they got off step 3, they would like to remain on the lozenge for a brief amount of time, so that kind of goes, that kind of have to factors into the amount of time as well.

Doug Ziedonis: And those steps he just mentioned are the patches. The different dose is 21, 14, and 7 milligrams.

Jane Parker: Right, right. Well, thank you.

Coordinator: Thank you. Our next question is from Amy Raulerson.

Amy Raulerson: Hi, this question is for Dale. We're working with a mental health facility that has long-term and short-term residential care and the issue came up that the clients living on site wanted to have their cigarettes held for them, like at the front desk so that when they were able to go offsite, which they need a pass, they need to earn a pass to get off site, they wanted to be able to take their cigarettes offsite and smoke.

Well they just implemented a tobacco-free campus, so they're not allowed to have cigarettes on campus. So you can imagine how well that's going over. And I was just wondering if you could speak to that if you have residential facilities, how that applies to the residents.

Dale Mantey: We do and we've encountered that problem as well. We, a lot of our staff members that I met with, they've said that they almost, it was kind of standard operating procedure that we would hold the cigarettes and it kind of kept our clients from running out. It kept people from bartering with them, things of that nature. And those are concerns we've had.

The way we've kind of addressed it now is in a way, I mean, we haven't really come around with a good solution. It's kind of one of those unintended consequences, I guess. I know the way we are handling it and I don't like it. We kind of just tell them no tobacco at all and it might have our senses down just a little bit, but I mean that's pretty much how we're handling it. We're just sticking to the policy.

Amy Raulerson: Right. Yes, that's what we're, I mean that's what we've recommended them to do, just stick with the policy, but it's kind of escalating to the point where the residents are getting very upset. So we're trying to look for other input, maybe the way other people are doing it, so.

Dale Mantey: Yes, we're definitely trying to address it. We have kind of some of our minds in, we're bouncing ideas off of each other. We're trying different things at different facilities. If you don't mind me asking, when you say short-term and long-term, can you kind of clarify on that? How short-term are we talking?

Amy Raulerson: You know, I'm like the third party. I just consult with them...

Dale Mantey: Okay.

Amy Raulerson: ...so I'm not sure, but it's my understanding that maybe they're there for a limited time, like two or three weeks and then there are long-term care facilities where they might live there for a year or two or more.

Dale Mantey: Okay.

Amy Raulerson: And where we're having the issue is where they live there.

Dale Mantey: Okay. Some of the issues we faced, at one facility we have, it's a respite facility so they're there for a short period of time usually not more than a week or two on average. I mean some stay longer, some stay shorter. But they're actually not even allowed, I mean they can walk outside but they can't actually leave the campus for the first 24 hours I believe.

And what we do is we push the nicotine replacement therapy. We also allow the cessation groups there. And that's how we've been handling it so far. The clients are kind of resistant to it at first, but because we offer the patch it kind of gets their cravings down and because we have the groups, it kind of curbs their behavior a little bit. But it doesn't solve the problem long-term.

Amy Raulerson: Well, they...

Dale Mantey: Oh, keep going.

Amy Raulerson: ...maybe you can speak this. The issue that we're having now is one client in particular his health advocate is pushing him to pursue the avenue that it is

interfering with his mental health treatment because he has the right to smoke, he's an adult, you know, but because he lives on this facility, he can't. So they're saying that this policy is interfering with his treatment. Do you have any thoughts on that?

Dale Mantey: I'm sure I have thoughts on it. I can't really comment on it though.

Amy Raulerson: Okay.

Doug Ziedonis: This is Doug Ziedonis. I would say that the issue of rights to smoke is one that is a commonly raised one in mental health settings. The, one of the journals, Tobacco Control, had a whole issue on the ethics of this topic that you might want to access. If you, probably if you put it in your internet search engine, the words 'ethics and tobacco control,' you'll see the information on that, that's a guide. But basically it comes down to the fundamental issue of group rights versus individual rights.

And that's what the leverage that you would have to enforce these rules and if people are eligible to move to some other kind of setting or housing where they cannot affect other's rights to not smoke and not have to breathe and not be triggered, you know, that's usually the leverage. And then you can engage in where groups like NAMI that are very, you know, fighting for rights for people with mental illness.

They recognize that all of the risks to others, so if it wasn't a group issue people could live in their own house and do whatever they want.

Amy Raulerson: Okay, thank you.

Rich Schieber: One last question, I think.

Coordinator: And our final question is from Linda Hartung.

Linda Hartung: Thank you. I was interested in enforcement and you answered my question earlier. Thank you.

Rich Schieber: Well then let me take that spot and just ask one final question. What do we tell the person who's treating someone with mental illness to say to their patient but, doc, it helps me to smoke?

Dale Mantey: I think you have to address the issue of what's the counter and in what way do they think it's helping? It's just like sometimes when I treat cocaine addicts, they might say cocaine helps their mood, but that's not a great antidepressant.

So there are other options to help people and it may be that you just have to engage and talk with them and it will take a little bit longer. Not everybody's going to immediately say 'oh you're right doc, I'll quit.' So there are lots who want help and are actually, when I've worked with a psychiatrist and mental health specialists, they're actually surprised.

Oh, my goodness, I offer an option and people want to take it. But there will be some who you're going to have to work with over time and provide a lower motivated kind of group and that's why we created that learning about healthy manual, because it's just for this kind of person.

Rich Schieber: That's a very cogent message. Thank you. You know, I'm reminded that typical long-term quitter requires 11 quit attempts on average. So this group might even be more, a higher number than that, I don't know.

Well, listen, thanks to our presenters and thanks especially to our participants, all 286 of you. I really appreciate everybody spending this hour helping us learn about this and sharing our experiences. And if you have questions after we hang up shortly then to the individual presenters, their emails are embedded in their PowerPoint presentations.

So with this let me end and say thank you all very much and we will see you next month when we talk about teen pregnancy. Take care, bye-bye.

Coordinator: Thank you and this does conclude today's conference. You may disconnect at this time.