# Tobacco Recovery & Wellness Initiative (TRWI)

- Formed in November 2013
- Collaboration between:
  - Philadelphia Department of Public Health Tobacco Policy and Control Program (TPCP)
  - University of Pennsylvania's Comprehensive Smoking Treatment Program (CSTP)
  - Department of Behavioral Health and Intellectual disAbilities (DBHIDS)

# Goal of TRWI

- To improve the emotional, behavioral, physical and environmental health of people in recovery by placing tangible and effective tobacco dependence treatment tools in the hands of DBHIDS/CBH providers

# TRWI:  Key Objectives

- Recognize tobacco use as a core behavioral health issue deserving attention and resources

- Transcend care from a symptom reduction approach by promoting wellness as a key component of all treatment and support services.

- Establish policies which create tobacco-free treatment environments and alter the culture of smoking in treatment settings

# TRWI: Key Objectives

- Provide support to behavioral health staff who want to quit

- Provide treatment decision supports to providers

  - Safe and effective use of FDA- approved pharmaco therapies

  - Effective counseling and follow-up with tobacco-using consumers

  - Key cessation resources

# TRWI:  Key Objectives

- Address biases and frequently asked questions that can present a barrier to offering consistent tobacco use disorder treatment

- Provide training opportunities for behavioral health providers to treat tobacco use disorders

- Reduce smoking and smoking-related morbidity and mortality among Philadelphians with behavioral health problems

# TRWI: Success to Date

- Learning collaborative formed
- Implemented tobacco free environments in all network inpatient psychiatric units in Dec 2015
- Staff trained as champions through provider detailing and other formal trainings
- Programs saw no decreases in admissions
- Episodes of agitation decreased after implementation of tobacco free facilities
- Tracking smoking prevalence
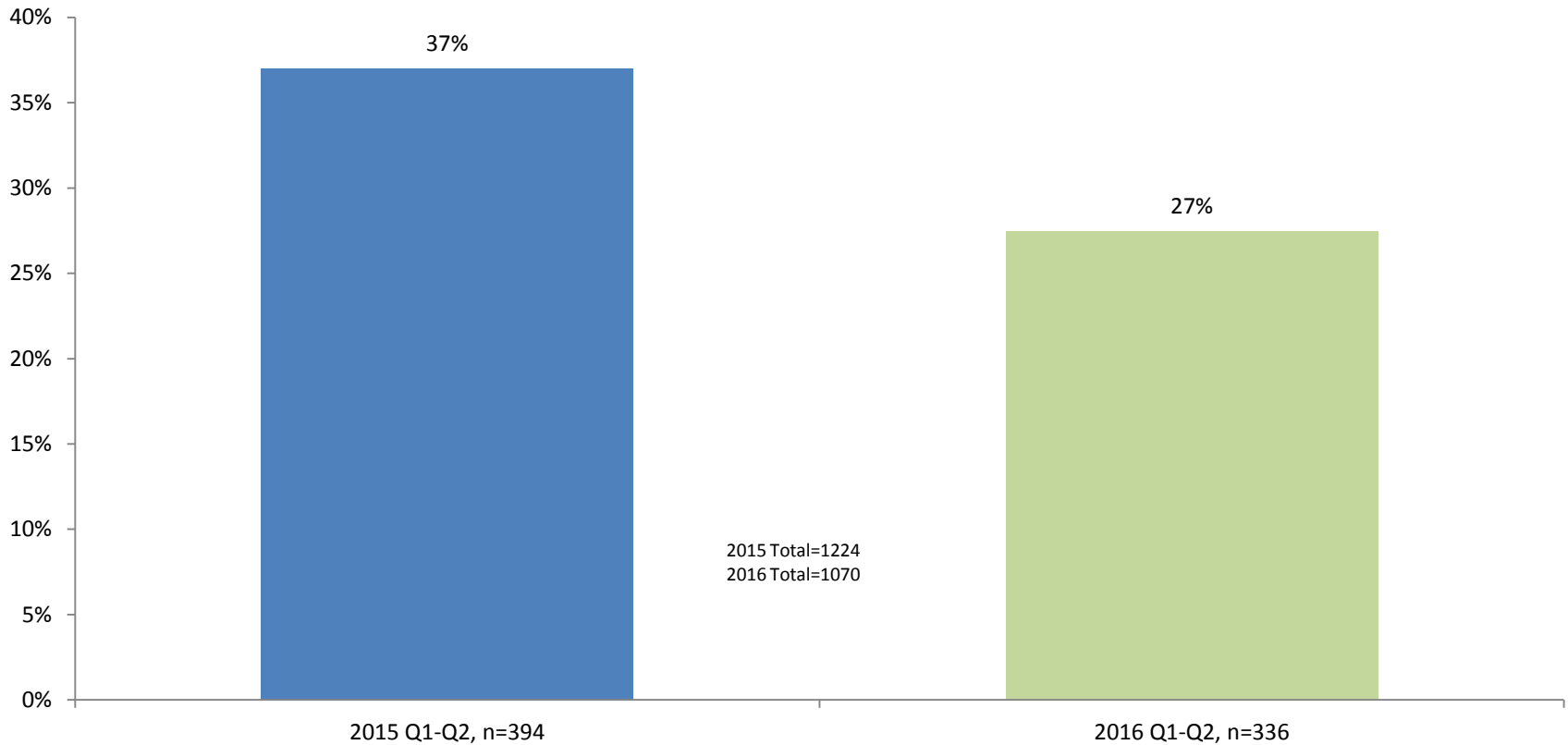
# Smoking Prevalence:  AIP in Philadelphia
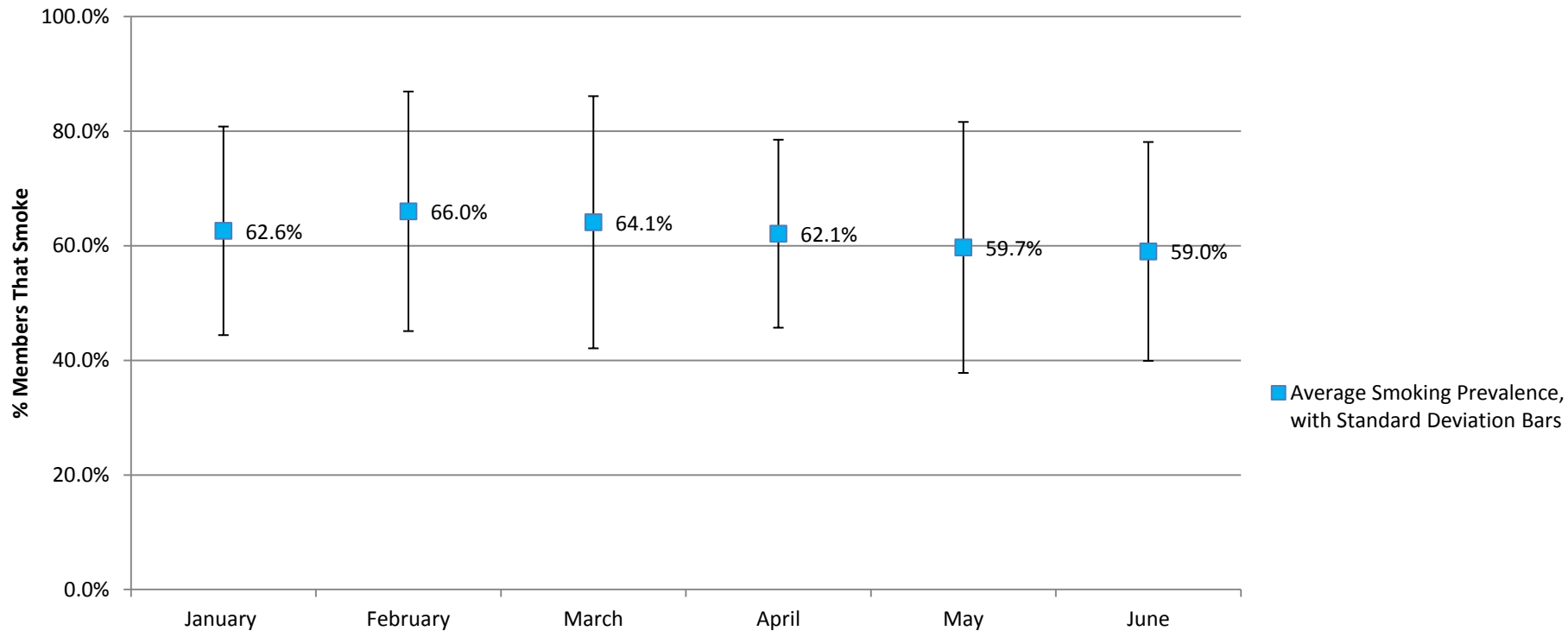
# Smoke Free Inpatient Facilities Saw No Reduction in Voluntary Admissions

## Percent of 302 Admissions out of Total Admissions*
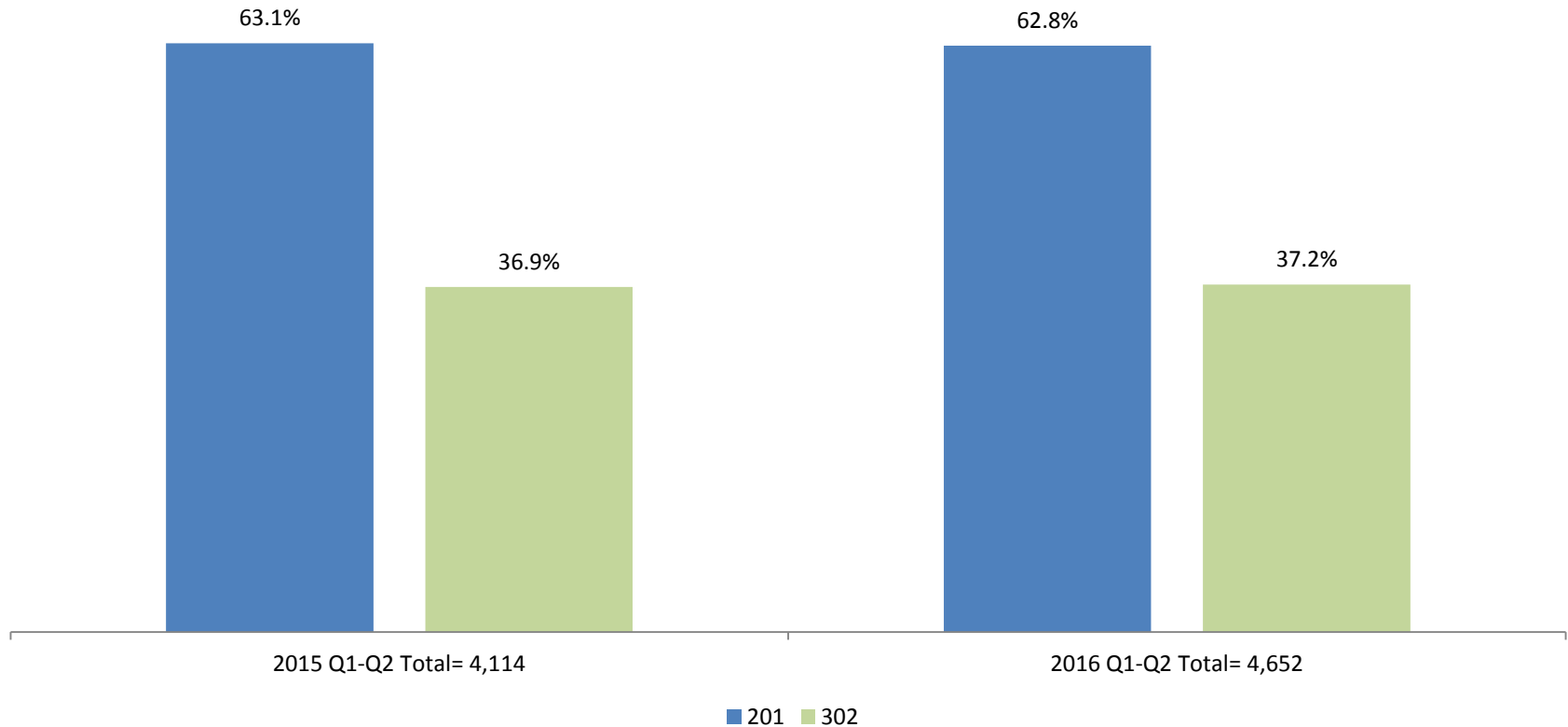
# Smoke Free Inpatient Facilities Saw No Increase in Episodes of Agitation

**Percent of Restraints & Seclusions
Out of Total Incidents**



2015 Total=1224
2016 Total=1070

37% — 2015 Q1-Q2, n=394

27% — 2016 Q1-Q2, n=336

## The First 90 Days of Tobacco-Free Campus at Friends Hospital: A Recovery Milestone

Philadelphia, PA—March 10, 2016—This March, Friends Hospital is celebrating the milestone of 90 days as a tobacco-free campus. This initiative involved providing support for tobacco-free recovery for patients, and encouragement for our staff members who chose to quit. In addition to smoking cessation aids such as nicotine gum and patches, hospital staff offer a variety of other options to help patients cope with tobacco cravings.

Staff work to empower patients in their health choices – and recovery overall – by providing a variety of leisure options for the patients to choose as an alternative to smoking. Expressive Art Therapy Director **Maureen Ciolko** notes that patients have access to art supplies, and many have chosen to make art to display on the units as a form of relaxation. The hospital provides journals, stress balls, and a music room to use as stress relief. Board games, word puzzles, Sudoku, and playing cards have become a routine for the patients during their breaks between groups or as a way to socialize in the evenings on many units. Regular outdoor breaks have been maintained, with a focus on activities instead of smoking. Many patients now throw footballs and frisbees with staff, and play basketball when they used to smoke. As the weather gets warmer, unit staff are planning to collaborate with patients to identify additional outside activities.

Friends Hospital's unit staff and administration have kept a close eye on the transition to a tobacco-free campus, and are pleased to report the transition occurred smoothly, without many major incidents. At a recent employee town hall meeting, Chief Clinical and Innovation Officer **Dr. Peter Vernig** presented data on this transition to the hospital staff. He reported that the hospital has not seen an increase in restraints or psychiatric emergencies, nor has there been any decrease in patients' agreeing to remain in treatment.

**Soon to be an EX-SMOKER**

**My HERO is Quitting Smoking!**

**TIM FASSNACHT**
"Superhero"
HR Department, Friends Hospital

**When did you start smoking?**
I started smoking when I was a sophomore in college.

**How did you start smoking?**
A friend of mine that I always hung out with was a smoker, one day he asked me if I wanted to try one and I did.

**How many times did you try to quit?**
I tried on four separate occasions, the longest I went was the last time where I quit for nine months when I found out my wife was pregnant with our first child.

**How many cigarettes did you smoke per day and for how many years?**
Originally, I would just bum a cigarette every so often. Gradually, I moved into...

Buying my own pack of cigarettes and it would last me a day or two.

**QUIT DATE OCT 2015**

**When did you decide that you will quit?**
It was during this past summer, my wife and I were talking about my son, and it came up that he was getting to an age when he was starting to imitate certain things we did. It was obvious that he had seen me smoking and we didn't want him to "want to be like dad" in that kind of way and my wife asked me if I was ever going to quit.

**What is your reason for quitting?**
I want to be healthy so that I am a good role model for my son and to create a healthy environment for my family.

**What strategy do you think would work for you?** I think some sort of nicotine replacement will help, but I will also be using my son and my family as an inspiration.

Because I know they love me and want me to be healthy so I can be with them as long as I can be.

"My son is my life and I would not want anything to be in the way of my time with him and my family. Cigarettes just aren't worth it. I feel better and am proud that I was able to make the right decision to quit cigarettes and not quit on my family."

FRIENDS HOSPITAL SAMPLE WILL BECOME TOBACCO-FREE ONETHING DECEMBER 4, 2015

**FRIENDS** HOSPITAL

C B H

# Today's Objectives

- Increase understanding of the impact of tobacco on the health status and recovery of the population served in addiction treatment settings

- Dispel myths about addressing tobacco in addiction treatment settings

- Learn how tobacco interventions can support individuals in their recovery

- Take the first steps towards creating tobacco free environments in addiction treatment facilities

# Tobacco Recovery and Wellness in Residential Addiction Treatment Settings

# Tobacco Recovery

- Supports the overall recovery and wellness of individuals served in addiction treatment settings

- Aligns with the DBHIDS population health approach

  – Improving health and wellness of the population

  – Addressing smoking as a significant contributor to physical and behavioral health outcomes

  – Up-streaming of individuals at risk to prevent major sequelae of long term smoking

  – Changing culture norms to counter targeting efforts of tobacco industry on vulnerable individuals

# TRWI Next Phase

- Expand TRWI efforts to include residential drug and alcohol treatment facilities

- New provider agreement language will be in effect **January 1, 2018**

- Requirements will include creating smoke free facilities, conducting comprehensive assessment and provision of interventions for tobacco recovery

# TRWI: Provider Agreement

- CBH provider agreements for residential addiction treatment facilities will be updated:
  - providers shall maintain a tobacco-free environment in which smoking and the use of tobacco products is prohibited on the campus accessible by CBH enrollees.
  - (i) CBH members are not permitted to be taken off of campus to smoke or use tobacco products.
  - (ii) CBH members will be screened for tobacco use disorders and provided smoking cessation treatment options while admitted to the campus.

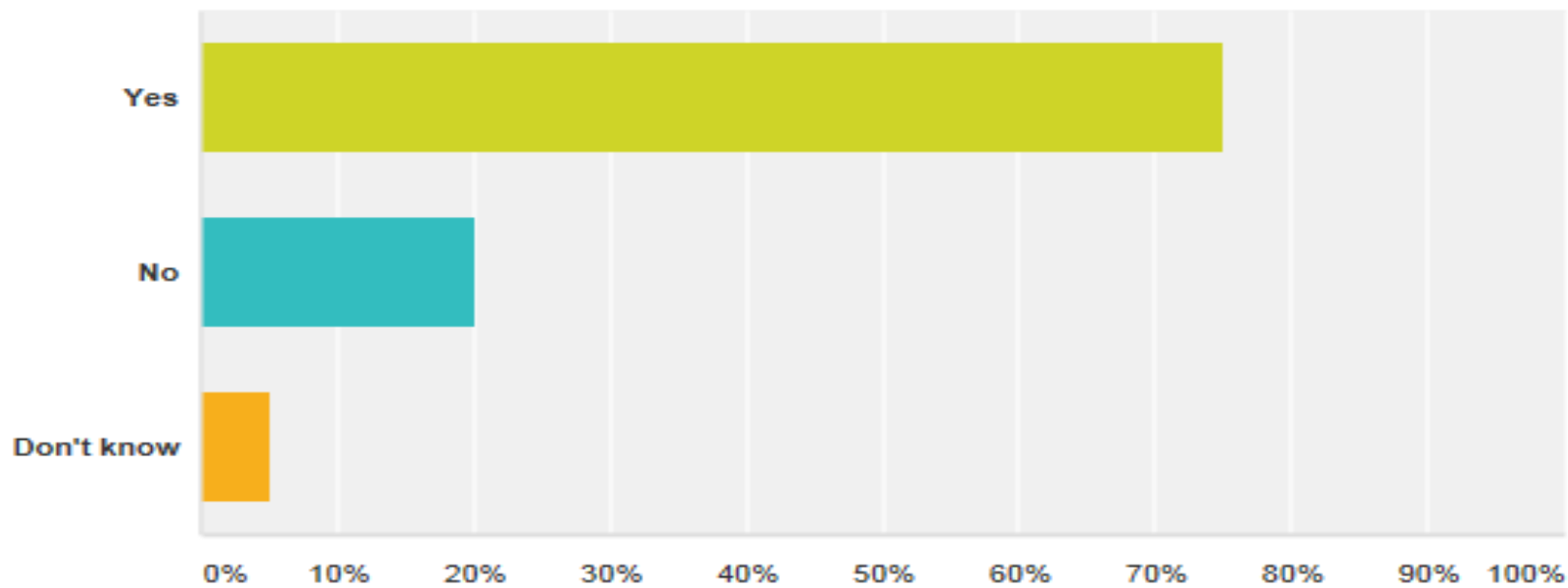# My agency currently routinely assesses for tobacco use

Answered: 20    Skipped: 0
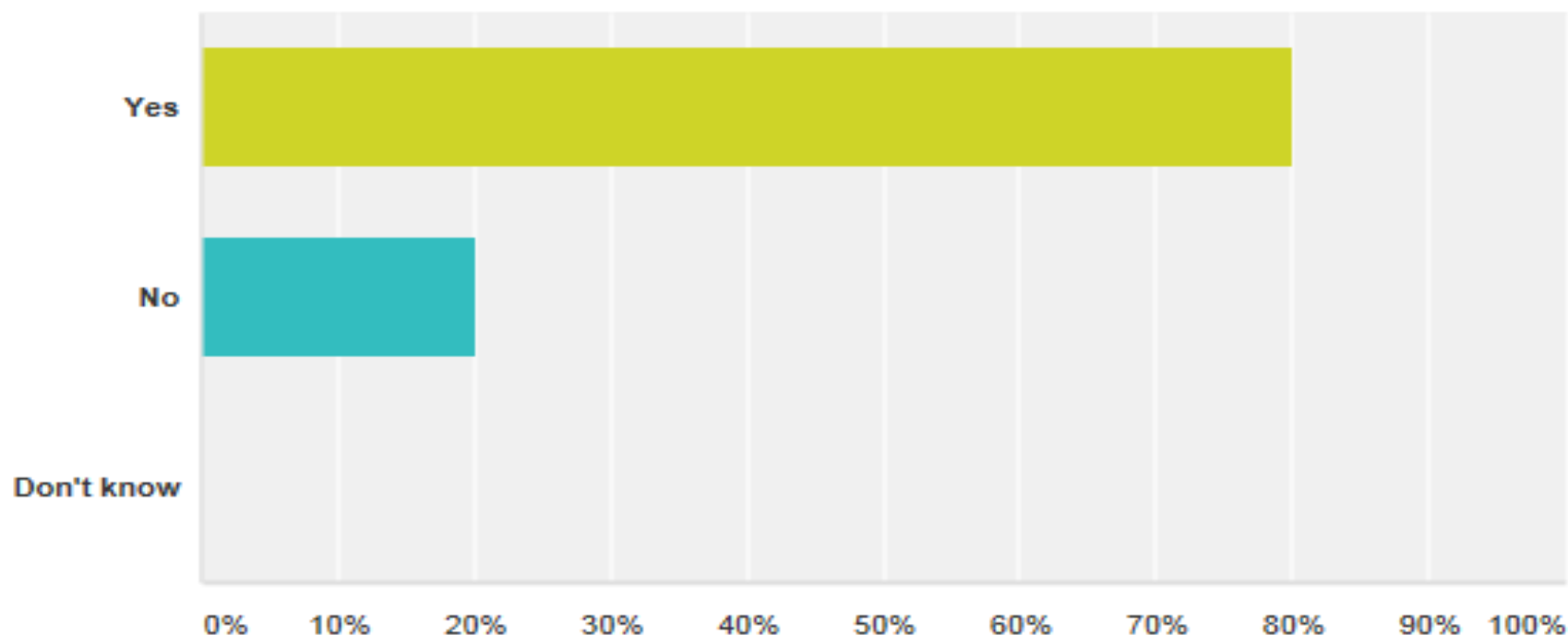


| Answer Choices | Responses | |
|---|---|---|
| Yes | 80.00% | 16 |
| No | 20.00% | 4 |
| Don't know | 0.00% | 0 |
| Total | | 20 |

# Has your organization's leadership considered implementing a tobacco-free policy?
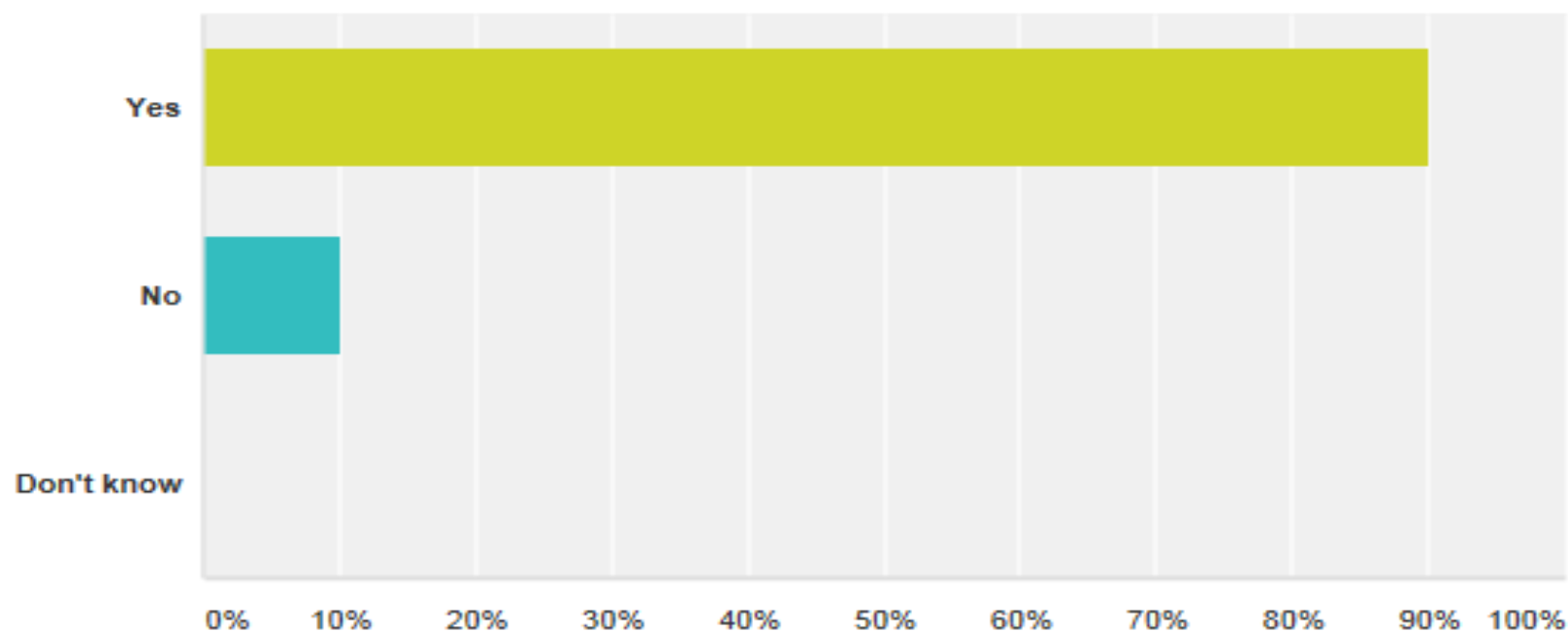
Answered: 20    Skipped: 0



| Answer Choices | Responses | |
| --- | --- | --- |
| Yes | 75.00% | 15 |
| No | 20.00% | 4 |
| Don't know | 5.00% | 1 |
| Total | | 20 |

Comments (0)

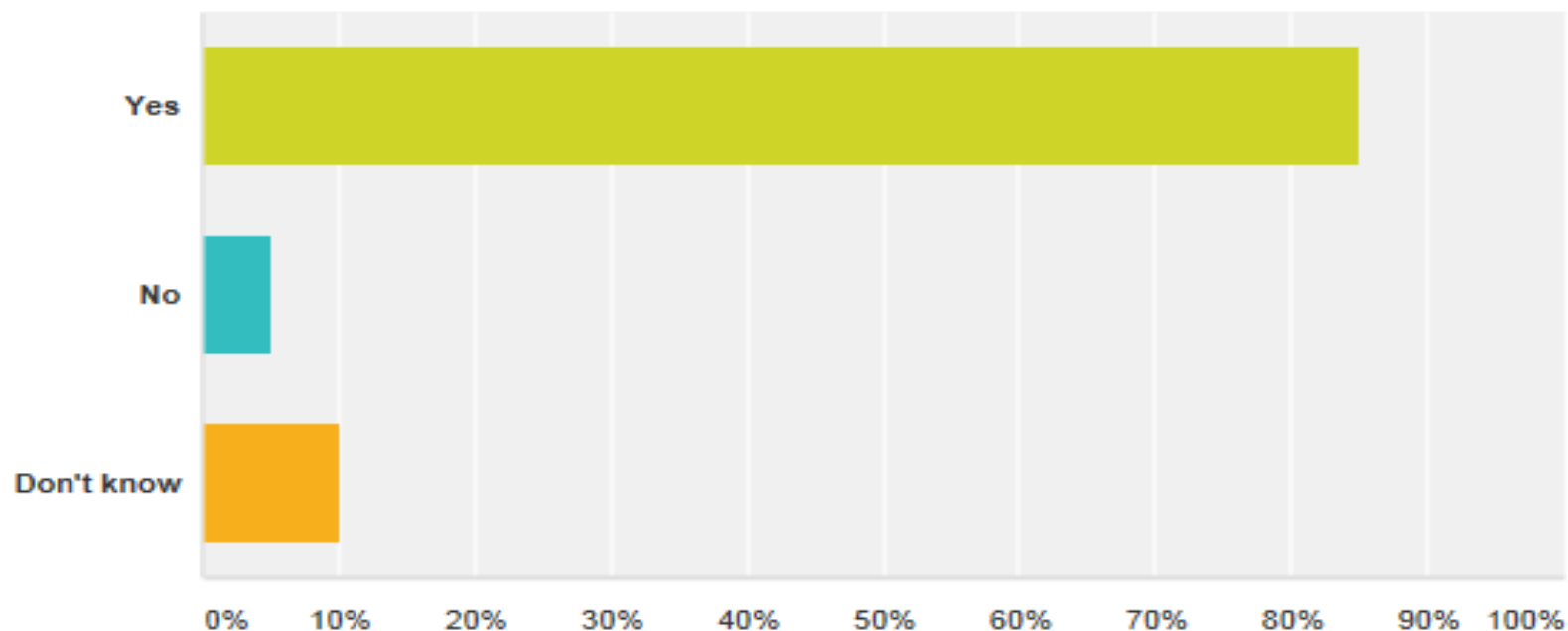# Does your organization currently have policies that prohibit the onsite use of alcohol and/or drugs?

Answered: 20    Skipped: 0



| Answer Choices | Responses | |
|---|---|---|
| Yes | 90.00% | 18 |
| No | 10.00% | 2 |
| Don't know | 0.00% | 0 |
| Total | | 20 |

# Is a tobacco-free policy consistent with your organization's mission and values?
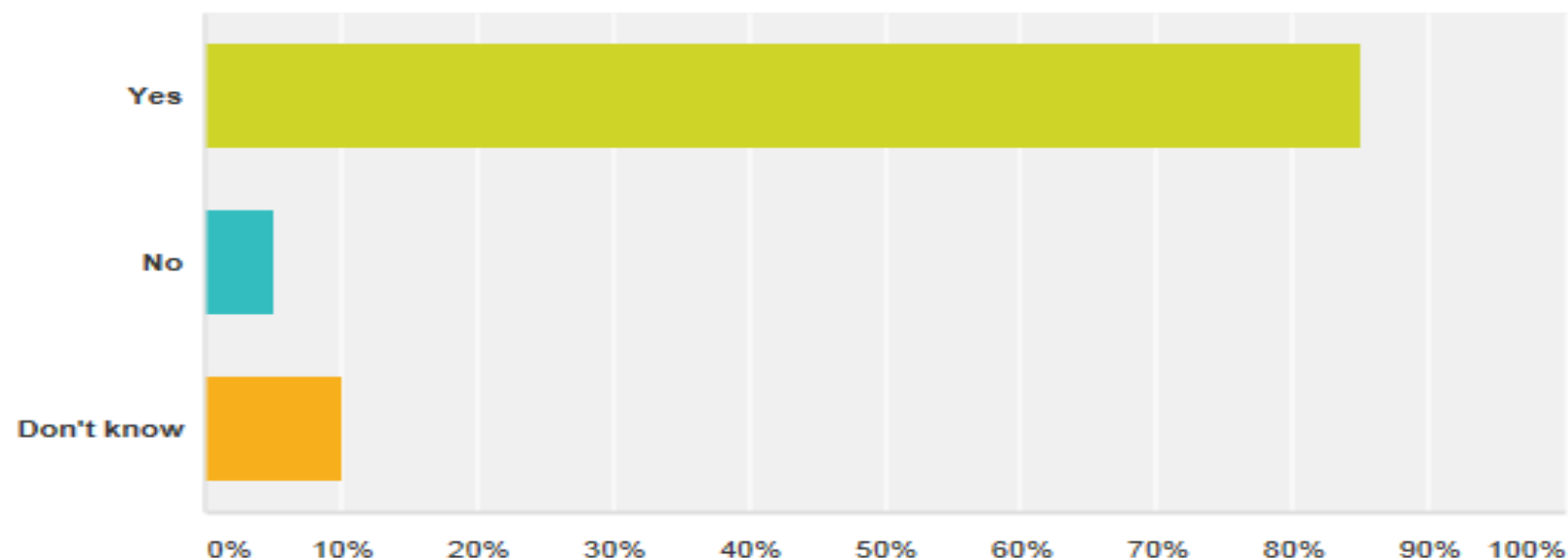
Answered: 20    Skipped: 0

| Answer Choices | Responses | |
|---|---|---|
| Yes | 85.00% | 17 |
| No | 5.00% | 1 |
| Don't know | 10.00% | 2 |
| Total | | 20 |

Comments (0)

# Do you believe your organization's policies can have a positive effect on the behaviors of your employees and the people they serve?

Answered: 20   Skipped: 0



| Answer Choices | Responses | |
| --- | --- | --- |
| Yes | 85.00% | 17 |
| No | 5.00% | 1 |
| Don't know | 10.00% | 2 |
| Total | | 20 |

Comments (1)

# Are there benefits to the implementation of a tobacco-free policy at your organization?
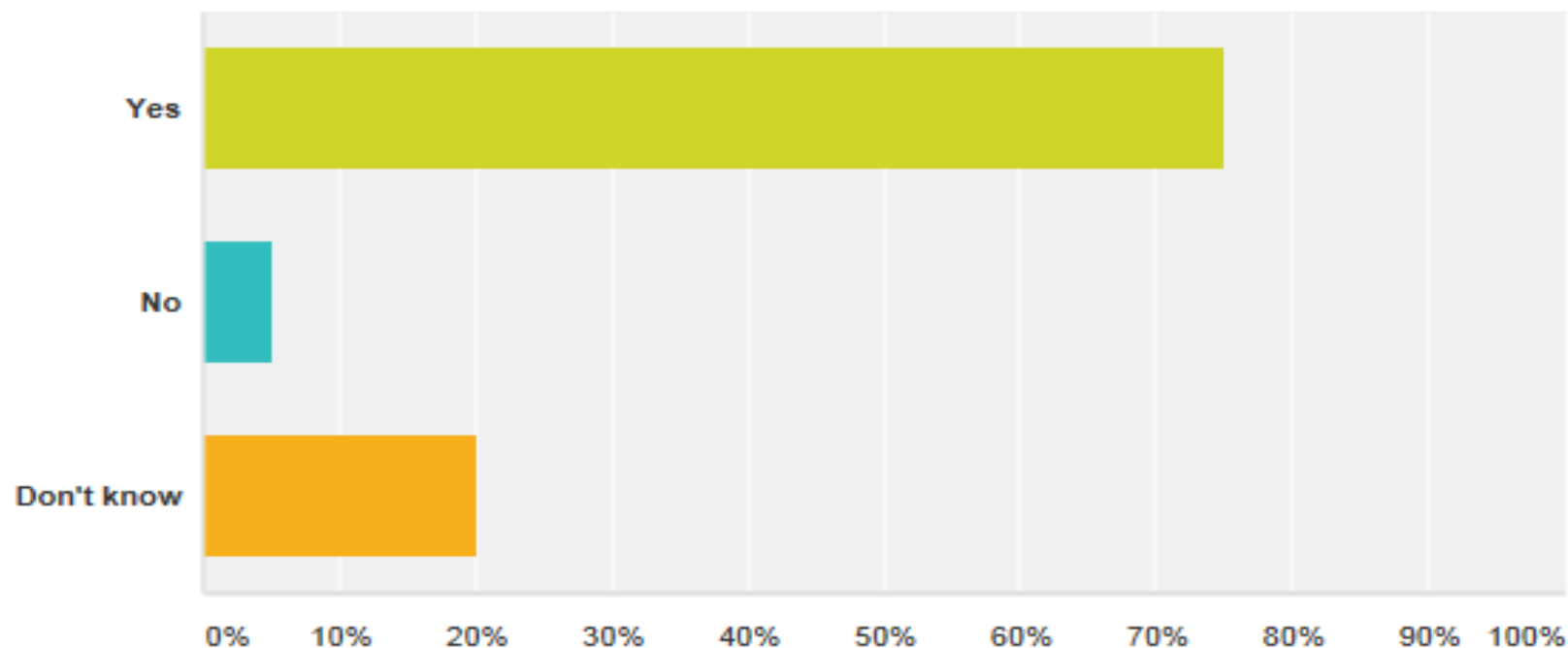
| Answer Choices | Responses | |
|----------------|-----------|------|
| **Yes** | 75.00% | 15 |
| **No** | 5.00% | 1 |
| **Don't know** | 20.00% | 4 |
| Total | | 20 |

# Do the benefits of implementation of a tobacco-free policy at your organization currently outweigh the perceived barriers?

Answered: 20    Skipped: 0
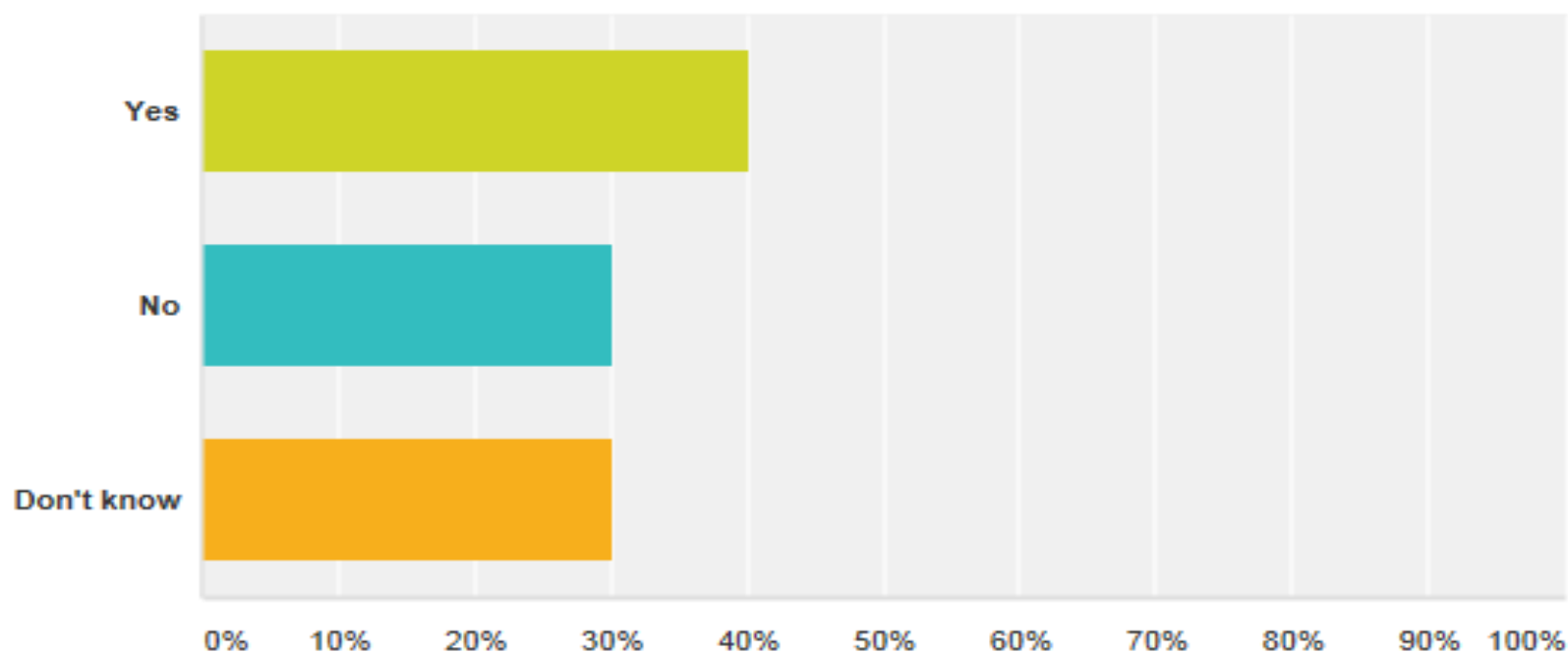


| Answer Choices | Responses | |
|---|---|---|
| **Yes** | **40.00%** | 8 |
| **No** | **30.00%** | 6 |
| **Don't know** | **30.00%** | 6 |
| Total | | 20 |

# Perceived Barriers

- Large number of staff smoke
- Individuals will choose to leave treatment
- Tobacco may be needed to help individuals quit other substances
- Early in recovery may not be the right time to address quitting smoking
- Smoking is a cultural norm in facilities and in 12 step meetings

Adding the "T" to the "AOD": Separating Fact from  Fiction

Ryan Coffman, MPH, CHES ,CTTS-M, FS (Retired)

Tobacco Policy and Control Program Manager

Philadelphia Department of Public Health

# Learning Objectives

- Separate the fact and fiction to address tobacco use in substance use disorder treatment settings (SUD)

- Relate the importance of resetting the norm to address tobacco use in SUD treatment settings to your clients and colleagues

- Describe opportunities to reset the tobacco norms at your agency

**SURGEON GENERAL WARNING:**

This presentation may be hazardous to your perceptions
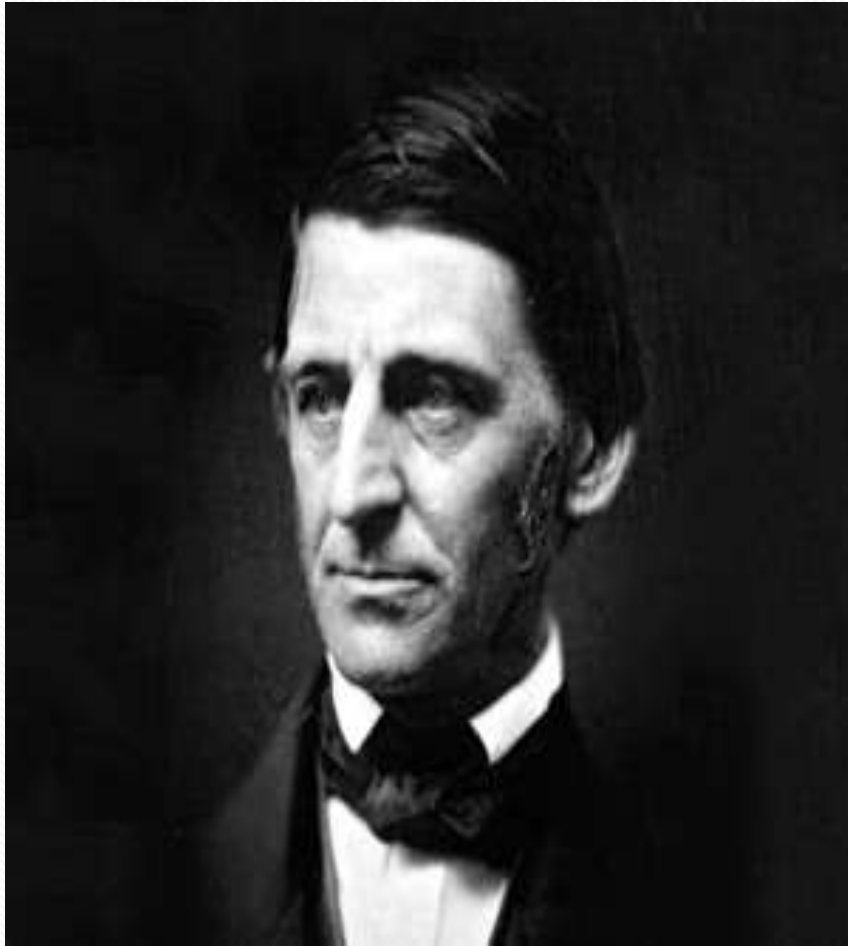
"The believing we do something when we do nothing is the first illusion of tobacco."

~Ralph Waldo Emerson

# Fiction

- "Quitting smoking is the lesser of two evils. Smoking is a habit and it's a legal product. At least my patient/client isn't using drinking or drugging."

# Fact

| | | Source |
|---|---|---|
| **Smoking among general Philadelphia population** | 22.4% (2014/5) | PHMC HHS[2] |
| **Among those ever with a substance abuse problem** | 69% (2012) | PHMC HHS |
| **Among those with problem alcohol use[3]** | 48% (2012) | PHMC HHS |
| **Among those with a diagnosed mental health condition** | 33.5% (2014/5) | PHMC HHS |

# Smoking kills more than **3x** as many people as drugs and **8x as** many as homicides

Deaths in Philadelphia due to tobacco, firearm homicide, and overdose
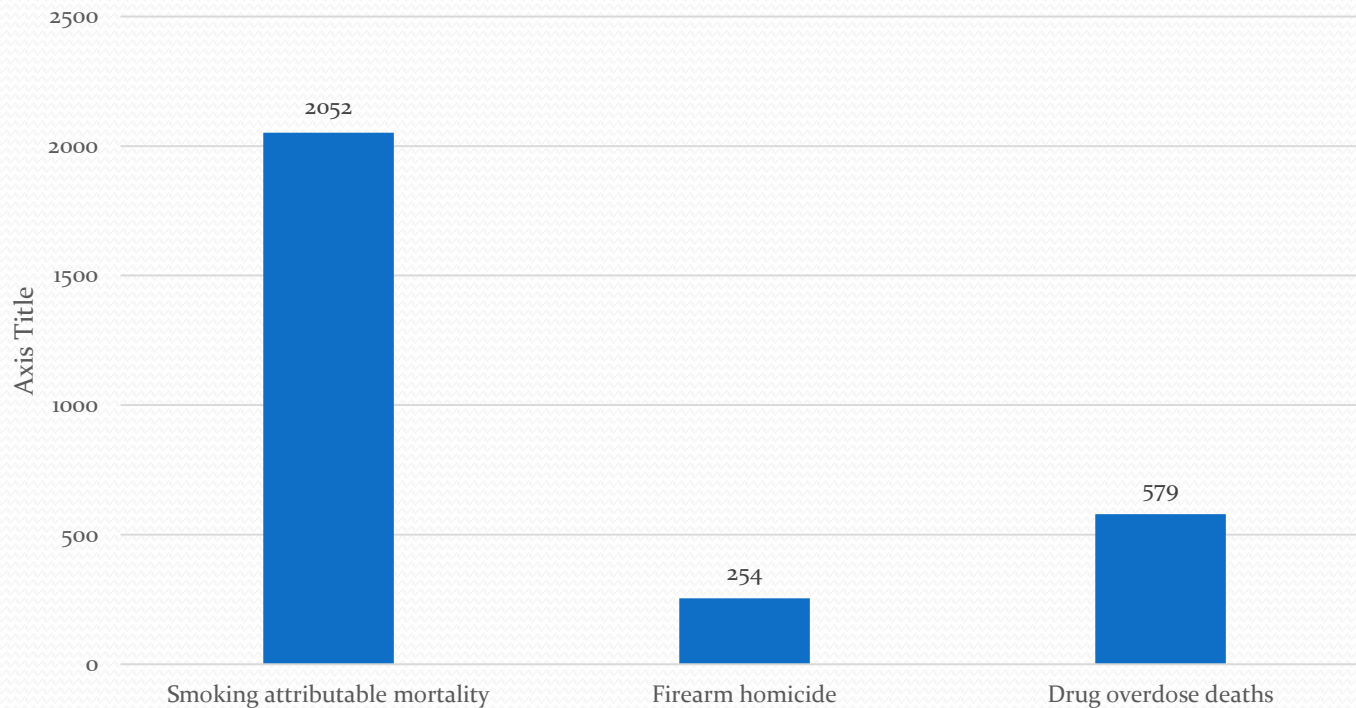
Smoking-attributable mortality calculated using SAMMEC methodology. Data source: Philadelphia Department of Public Health, Vital Statistics Report, 2012.
Firearm homicide data and Drug Overdose death data from the Philadelphia Medical Examiner's Office.

# From the Source

- "Different people smoke for different reasons. But the primary reason is to deliver nicotine into their bodies. ...Similar organic chemicals include nicotine, quinine, cocaine, atropine and morphine."

  Philip Morris, 1992

# From the Source

- "A cigarette as a 'drug' administration system for public use has very, very significant advantages: Speed. Within 10 seconds of starting to smoke, nicotine is available in the brain...Other 'drugs' such as marijuana, amphetamines, and alcohol are slower and may be mood dependent."

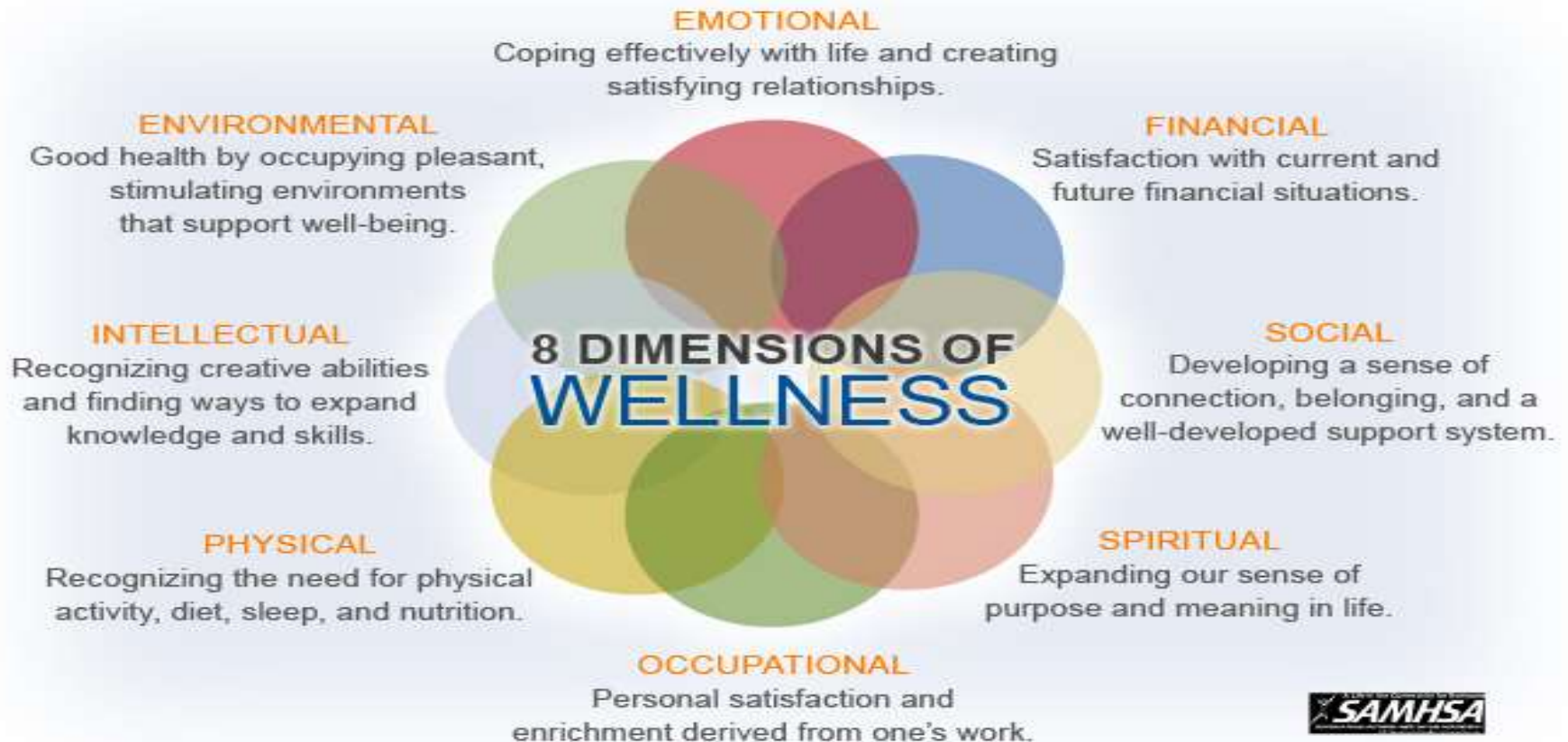  - British American Tobacco, 1985

# The First Thought

# Corner Offices vs. Street Corners
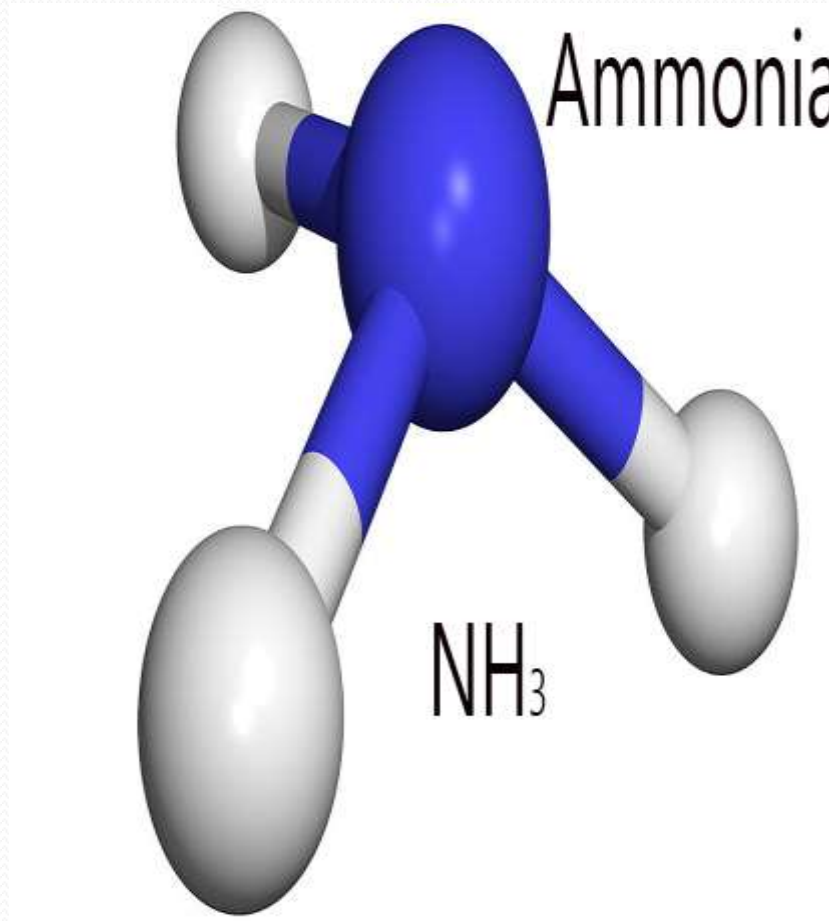
# The Secret and Soul of Marlboro

- Used to enhance uptake of nicotine to the blood

- Ammonia is added to increase the alkalinity of smoke and increase amount of nicotine in a 'free' form rather than in a 'bound' form of nicotine salts.

- "The secret of Marlboro is ammonia."
  - Brown & Williamson, 1989

# Tobacco use negatively impacts every dimension of wellness



**EMOTIONAL**
Coping effectively with life and creating satisfying relationships.

**ENVIRONMENTAL**
Good health by occupying pleasant, stimulating environments that support well-being.

**FINANCIAL**
Satisfaction with current and future financial situations.

**INTELLECTUAL**
Recognizing creative abilities and finding ways to expand knowledge and skills.

**8 DIMENSIONS OF WELLNESS**

**SOCIAL**
Developing a sense of connection, belonging, and a well-developed support system.

**PHYSICAL**
Recognizing the need for physical activity, diet, sleep, and nutrition.

**SPIRITUAL**
Expanding our sense of purpose and meaning in life.

**OCCUPATIONAL**
Personal satisfaction and enrichment derived from one's work.

SAMHSA

# = $3,877 per year

- 25 credit hours at Community College of Philadelphia

- Monthly trail pass for 38 months

- ~3 months rent for a 1 bedroom apartment in Philadelphia

- Average Philadelphia water bill for 55 months

- Average phone bill for 82 months

- Groceries for a family of 2 for 5 months

# Fiction

- "Our clients have to smoke. It is a legal product. Quitting smoking will jeopardize my patient's recovery from alcohol and/or other drugs."

# Fact

- People with mental illness and/or substance abuse disorders account for **<u>40%</u>** of the domestic cigarette market

- More individuals with alcohol dependence die from smoking related disease than alcohol related disease

- Quitting tobacco use in recovery can increase long-term abstinence rates by **25%** from alcohol and other drugs

# ~90% of smokers started before the age of 18.

- Developmentally and biologically susceptible to nicotine addiction

- Before the legal age of consent
  - Military service
  - Ability to vote
  - Entering into a legal contract
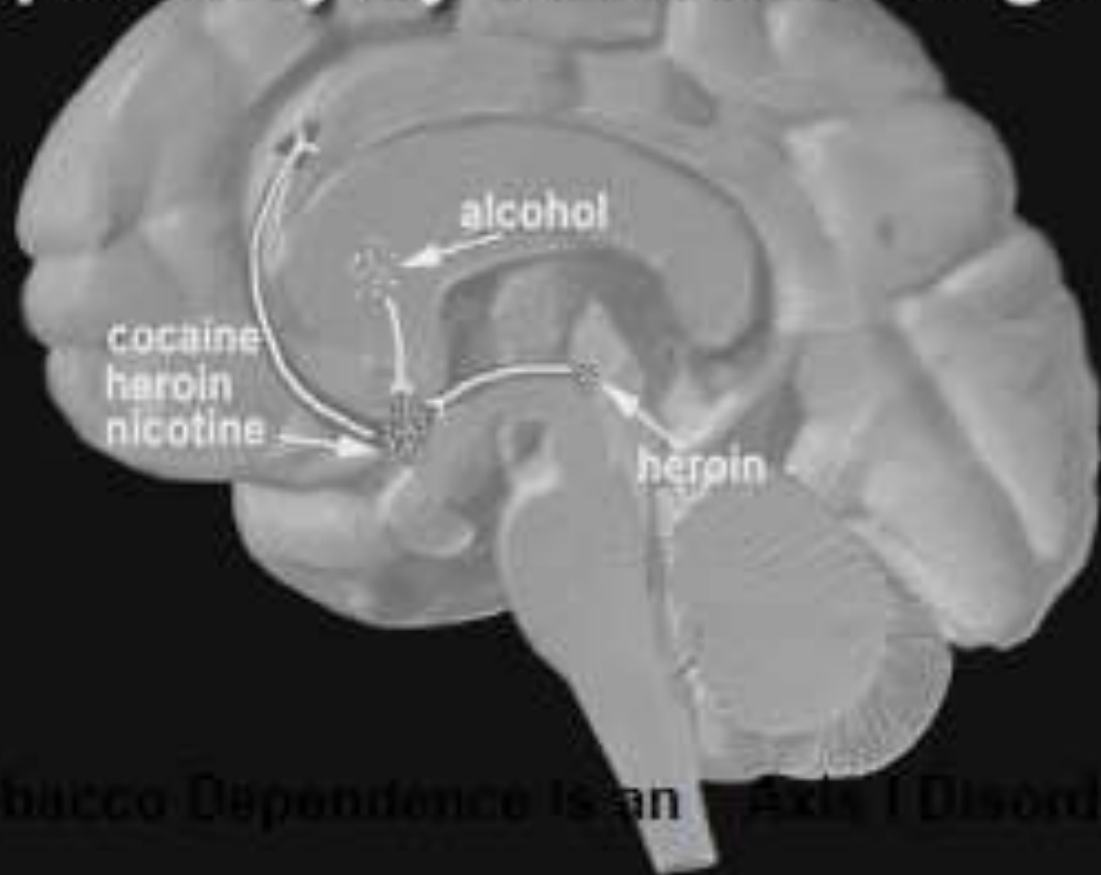
- "The cigarette should not be construed as a product but a package. The product is nicotine. . . Think of a puff of smoke as the vehicle of nicotine."
  - Philip Morris,  memo by William Dunn

- "The absorption of nicotine through the lungs is as quick as the junkie's 'fix'."
  - Brown and Williamson, 1973

# The Vehicle and The Drug

# Fact

- Individuals with SUD are far more likely to die of tobacco use than their SUD

- More individuals with alcohol use disorder die from tobacco-related illness than alcohol-related illness

- Quitting tobacco use in recovery can increase long-term abstinence rates by **25%** from alcohol and other drugs

# Tobacco Withdrawal

- Tobacco Withdrawal (4 or more)
  - **Depressed mood**
  - Insomnia
  - **Irritability, frustration or anger**
  - **Anxiety**
  - Difficulty concentrating
  - **Restlessness**
  - Increased appetite or weight gain
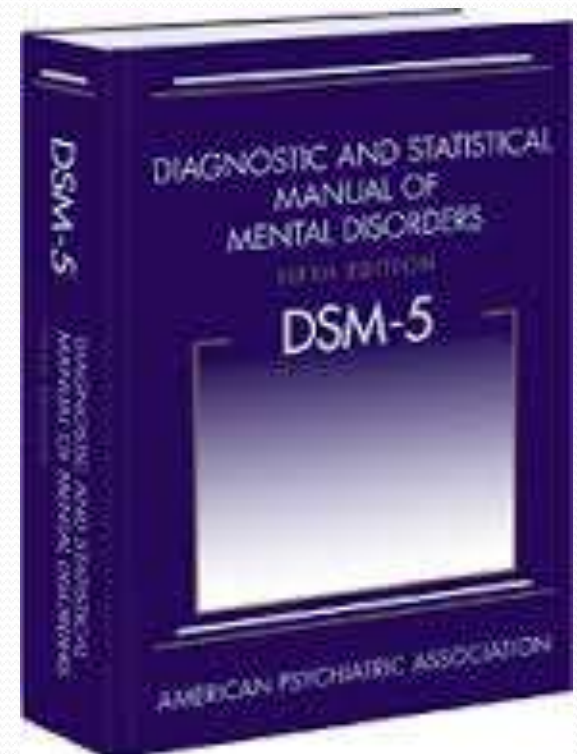
# Tobacco Use Disorder

- **Tobacco Use Disorder (2 or more)**
  - **Withdrawal**
  - **Tolerance**
  - Desire or efforts to cut down/ control use
  - Great time spent in obtaining/using
  - **Reduced occupational, recreational activiti**
  - **Use despite problems**
  - Larger amounts consumed than intended
  - Craving; strong urges to use
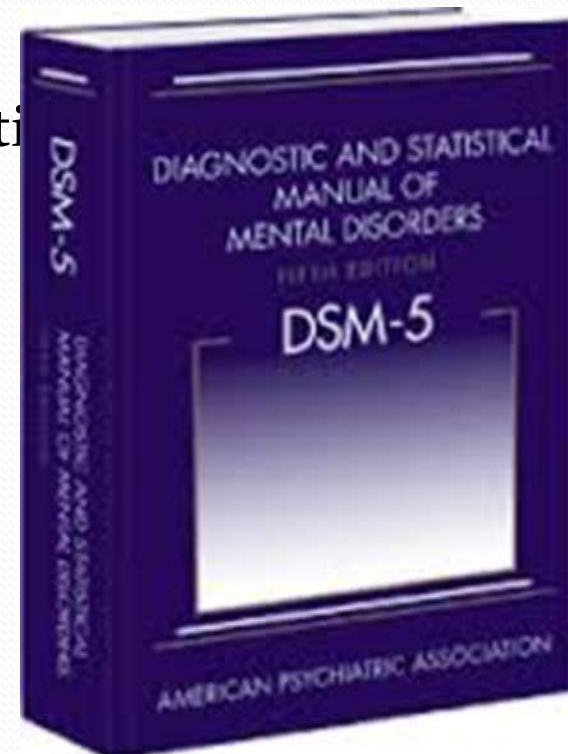
# Fiction

- "Staff do not have the training or the time to help our clients with tobacco use."

# Tobacco Use Disorder:
## A Chronic Disease and a Substance Use Disorder

- *Treatable,* chronic, relapsing condition

- Relapse can be a part of recovery or management

- Multiple management attempts

- Relapse
  - Intensify treatment
  - Not treatment failure

- Medication + Behavior Treatment

- Offer treatment even if individual is less motivated

# Fact

- Staff who are tobacco-free
  - Do not use tobacco with patients
  - More supportive of tobacco-free policies
  - More likely to offer clients tobacco treatment
  - Have more time available time and health, recovery, and wellness activities

- Staff are interested in
  - Resources, training, support to address and become tobacco-free

*Williams et al., 2010 ; McNeill 2001, Resnick, Bosworth, 1989; Brooks, 2004*

- Staff who use tobacco
  - May be in recovery themselves
  - 18 days a year on smoke breaks

  - Absent from work 26% more often than non tobacco-users

  - Higher health care costs

  - Can negatively impact staff and patient interactions

# SUD Treatment Providers Uniquely Positioned to Help

- Integrated mental health and addiction services
- Interventions matched to motivational level
- Longer and more intensive treatment perspective

- Psychopharmacology
- Case management
- Addictions Experience and Training
- Experts in Psychosocial treatment
  - Individual, group, etc.

# The Toll of Tobacco in the SUD Treatment Provider Community
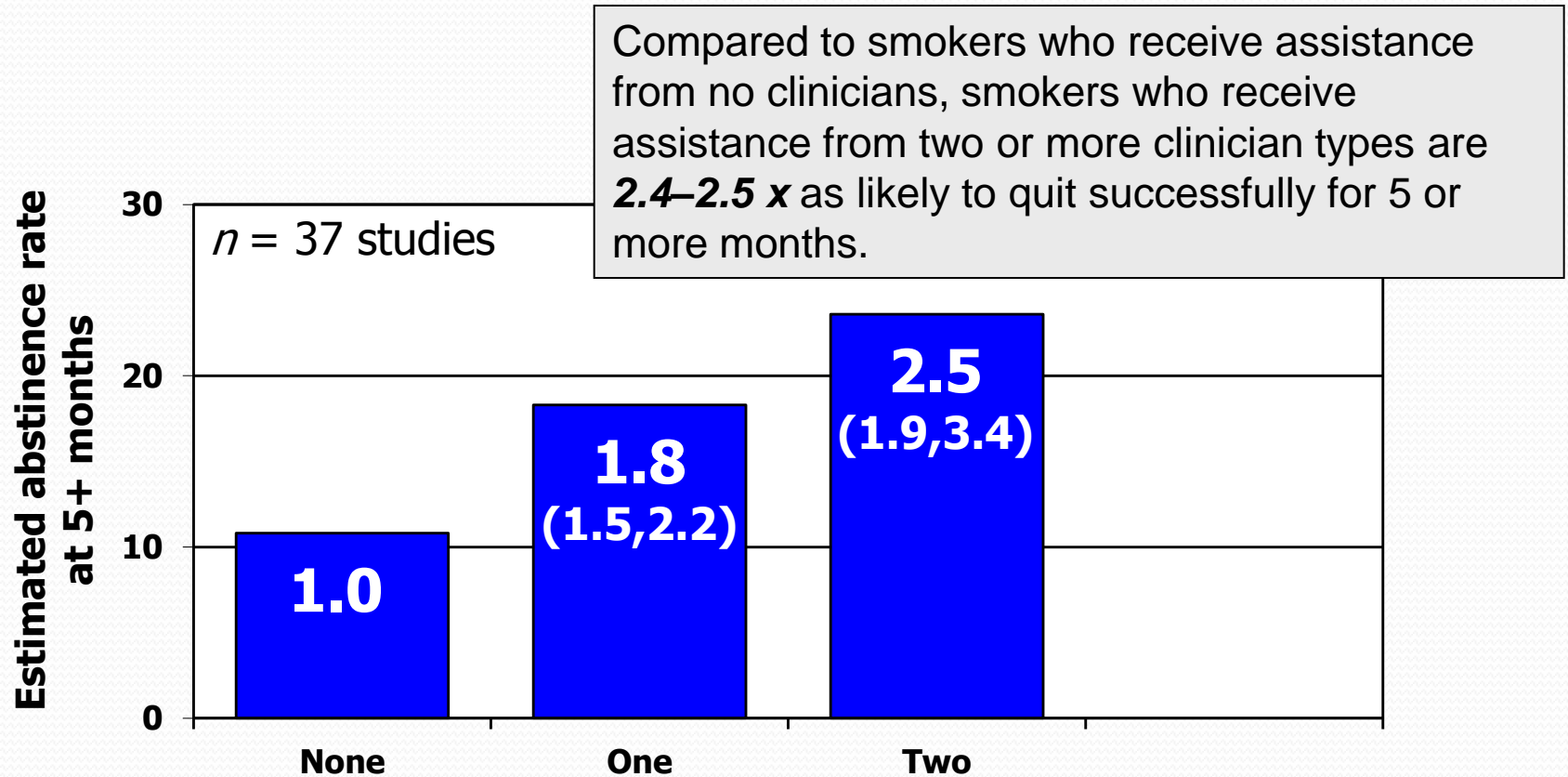
- Dr Bob and Bill W (AA)
- Danny C and Jimmy K (NA)
- Marie Nyswander (Methadone Maintenance)

- Charles Dederich (Syanon)
- Senator/Governor Harold Hughes (Society of Americans in Recovery)

# Fiction

"Tobacco treatment is the client's primary care provider's responsibility."

# Fact



Compared to smokers who receive assistance from no clinicians, smokers who receive assistance from two or more clinician types are *2.4–2.5 x* as likely to quit successfully for 5 or more months.

*n* = 37 studies

Estimated abstinence rate at 5+ months

30

20

10

0

1.0

1.8
(1.5,2.2)

2.5
(1.9,3.4)

None    One    Two

Number of Clinician Types

Fiore et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline.* Rockville, MD: USDHHS, PHS, May 2008.

# Fiction

- "Our clients are not interested in quitting."

# Fact

- 44% -80% of individuals in addiction treatment are interested in quitting their tobacco use

- Smoking cessation rates for individuals with SUD are comparable with the general population



McGarry, & Gogineni, 2001; Ellingstad, Sobell, Sobell, Cleland, & Agrawal, 1999; Irving, Seidner, Burling, Thomas, & Brenner, 1994; Richter, Gibson, Ahluwalia, & Schmelzle, 2001; Rohsenow et al., 2003; Sees & Clark, 1993; Zullino, Besson, & Schnyder,
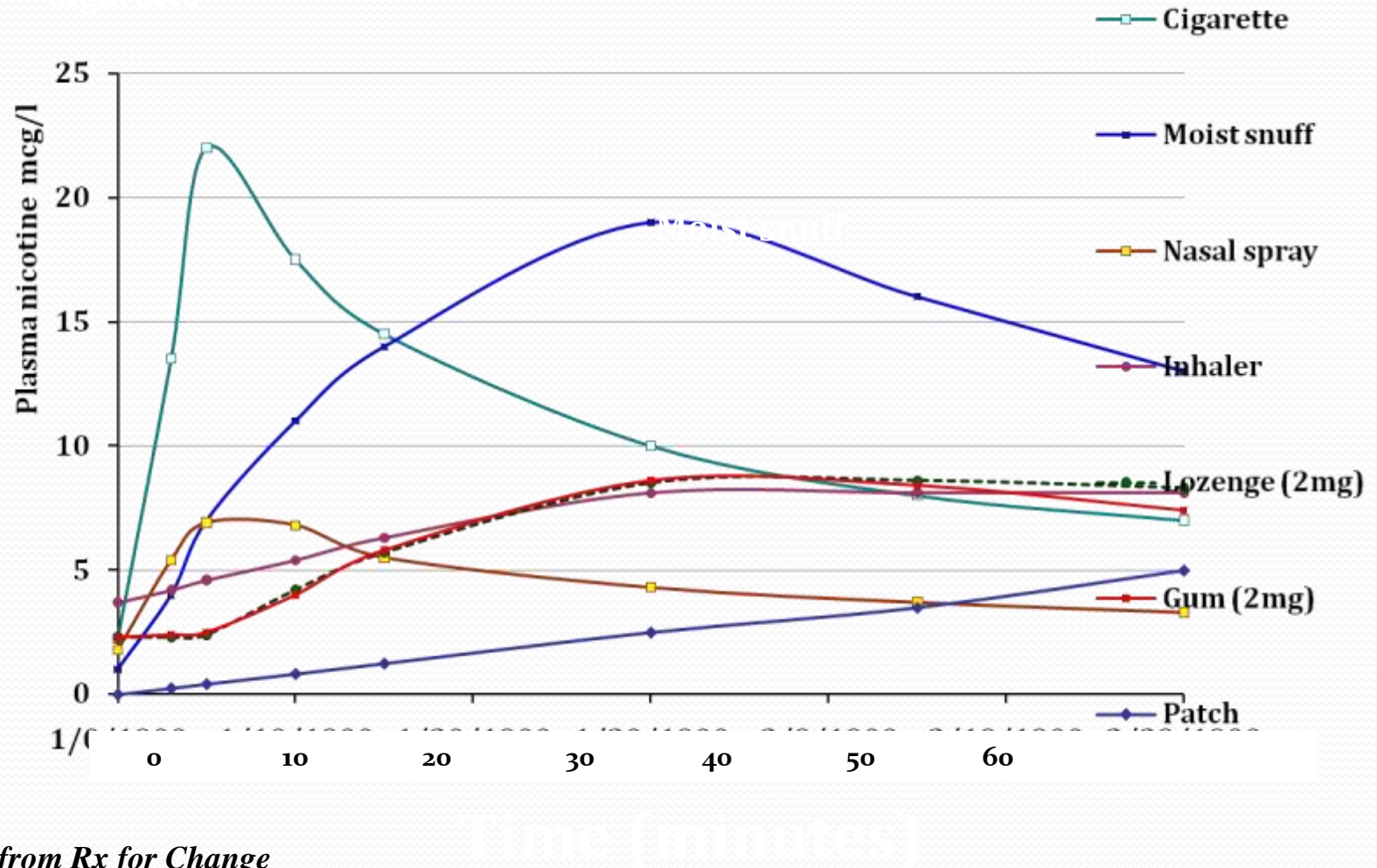
# Fiction

- "Quit smoking medications just substitutes one addiction for another."

# Fact

- Deliver nicotine in lower, slower, and more evenly that tobacco products

- Manage nicotine withdrawal or for tobacco treatment

- Increases chances of abstinence, even in individuals not motivated towards recovery

- Much lower abuse liability compared to tobacco products

# Comparison of Nicotine Levels in Tobacco Products and Nicotine Replacement Therapy



*Adapted from Rx for Change*

# Fiction

- "Smoking with clients give us a chance to talk about things we can't talk about in group."

# Would we?

# Fiction

- "Even if tobacco use is a problem, we don't know what to do for our population"

# Fact

- **Patient**
  - Every patient is screened, assessed, treated, and discharged with medication and behavioral treatment
    - FDA-approved pharmacotherapies
    - Individual, group, telephonic

- **Environment**
  - Indoor and Outdoor tobacco-free policies
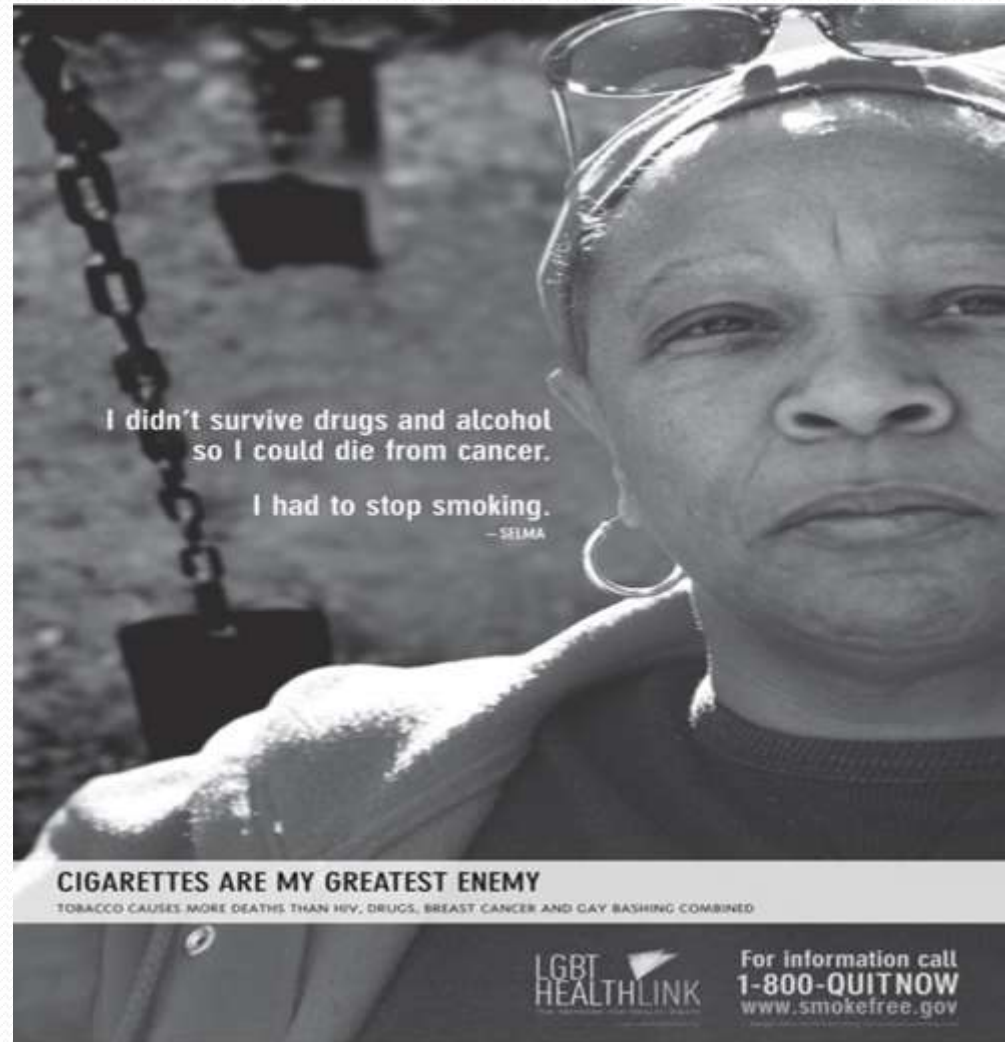  - Written and virtual communications
- **Staff**
  - Training
  - Recovery

# Organizational Support

# Resetting the Norm

- Recovery vs. Addiction

- Inclusion vs. Marginalization

- Wellness vs. Death/Disability

- Resiliency vs. Poor MI/SUD management



I didn't survive drugs and alcohol so I could die from cancer.

I had to stop smoking.
—SELMA

**CIGARETTES ARE MY GREATEST ENEMY**
TOBACCO CAUSES MORE DEATHS THAN HIV, DRUGS, BREAST CANCER AND GAY BASHING COMBINED

LGBT HEALTHLINK

For information call
1-800-QUIT NOW
www.smokefree.gov

# Redefine



ONE NIGHT
TRADE MARK
COUGH SYRUP

EACH OUNCE CONTAINS
ALCOHOL, (less than 1%) - - - - - - - 4¼ m.
CANNABIS INDICA, F.E., - - - - - - - 4½ m.
CHLOROFORM, - - - - - - - - - - - - 2⅕ m.
MORPHIA, SULPH, - - - - - - - - - - ⅛ gr.

SKILLFULLY COMBINED WITH A NUMBER
OF OTHER INGREDIENTS

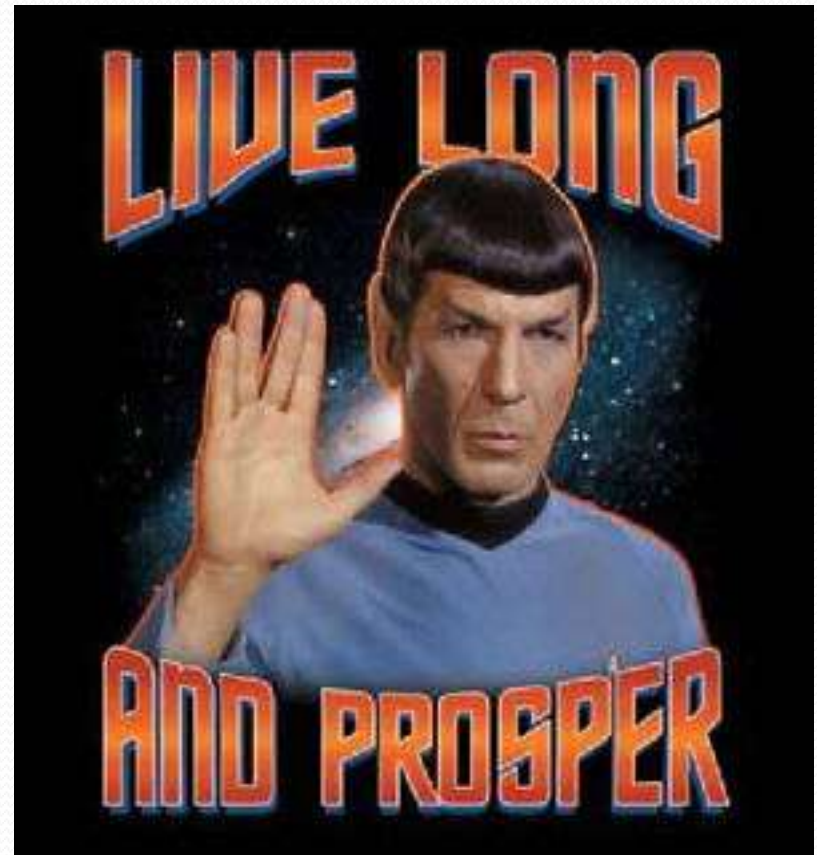# *Stay in touch!*

www.smokefreephilly.org
www.foodfitphilly.org

Be Tobacco-Free and....

Ryan Coffman

Tobacco Policy and
Control Program Manager

215-685-5620

ryan.coffman @phila.gov



Leonard Nimoy 1931-2015

# *RECOVERY-ORIENTED MESSAGE*

## *Working Definition of Recovery*

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**Substance Abuse and Mental Health Services Administration**
**www.samhsa.gov**

# PHILADELPHIA'S RECOVERY DEFINITION

Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in ones community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.
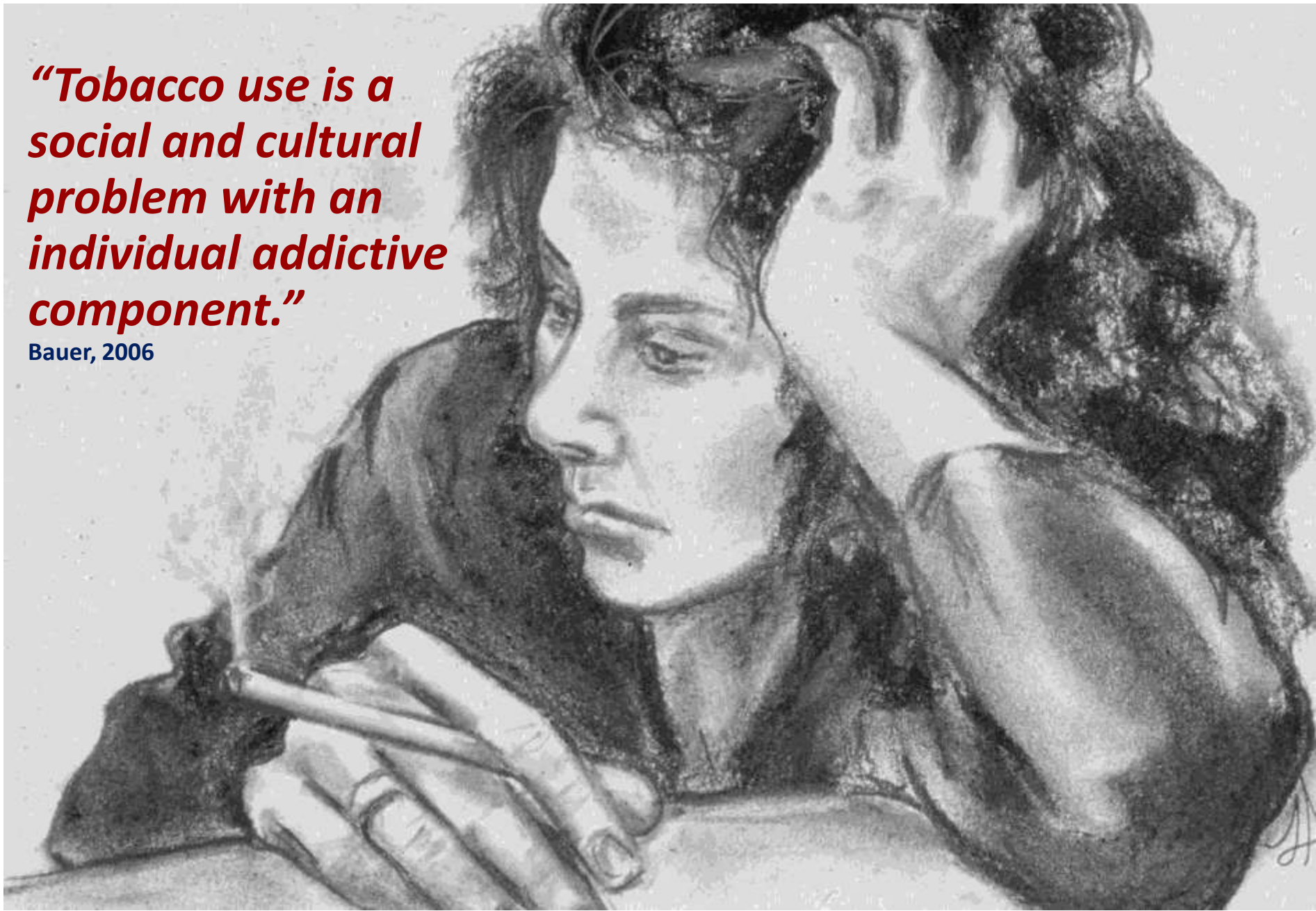
# Embrace Recovery!

## Be Physically and Emotionally Healthy.... Be Alcohol, Tobacco & Drug-Free

*"Tobacco use is a social and cultural problem with an individual addictive component."*
Bauer, 2006

# TOBACCO INTERVENTIONS

## Two Fundamental Goals:

- "Denormalize" tobacco use within the treatment & recovering community culture.

- Provide treatment to assist patients to establish and maintain tobacco abstinence as part of "a day at a time" recovery.

# *CULTURAL ADAPTATION*

**Goal: To accommodate the cultural beliefs, values, attitudes, and behaviors of the target population**

## Modify Evidence-Based Treatment

- Design
- Treatment components
- Approach to delivery
- Nature of the therapeutic relationship

**Take into account: Historical, Environmental & Social Forces**

Hawkins, Kreuter et al., 2008

# SURFACE & DEEP STRUCTURE

- **Surface Structure**: match intervention materials and messages to observable social and behavioral characteristics.

- **Deep Structure**: incorporate the core cultural values of the target group to increase saliency of the message and program impact.

  Changes in both facilitate participants' experience of self-reference and identification with the message, which increases the likelihood that they will identify discrepancies between their actual and ideal behaviors.

Resnicow et al., 2000

# Cultural Adaptation Process

**Change in Surface & Deep Structure**

## PHASE I:
### Data Collection

- Quantitative Data
- Qualitative Data
- Community Based Participatory Research Methods
- Community Advisory Board
- Develop Culturally Appropriate and Valid Measures
- Ensure Health Literacy of Materials
- Cultural Translation if Needed

## PHASE II:
### Treatment Modification

- Treatment Content
- Treatment Modality
- Treatment Intensity
- Treatment Delivery

## PHASE III:
### Pilot Test

- Acceptability
- Social validity
- Feasibility
- Satisfaction
- Comprehension
- Credibility
- Self-Reference
- Therapeutic Alliance
- Preliminary Efficacy

## PHASE IV:
### Outcomes

- Treatment Entry
- Treatment Attendance
- Therapeutic Alliance
- Treatment Adherence
- Treatment Response
- Maintenance of Treatment Response

Borrelli, B. (2010). Smoking Cessation: Next Steps for Special Populations Research and Innovative Treatments. *Journal of Consulting and Clinical Psychology, 78*(1), 1-12.

# REFRAME LANGUAGE

*Use language consistent to recovery culture, 12-Step teachings and therapeutic community principles*

**Public Health/Medical Terms**

- Smoking
- Quit Date
- Cessation

**Preferred Terminology**

- Tobacco Use, Hit, Fix
- Recovery Start Date
- Tobacco Treatment, Recovery

*The language we use is fundamental in creating environments conducive to a recovery process.* **– William White**

# TOBACCO INTERVENTIONS

*Two Levels of Behavioral Counseling to Match Intervention to Client Stage-Readiness:*

## Tobacco Awareness
### Cognitive
- Engagement
- Develop Interest
- Highlight Importance
- Advance Stage-Readiness

## Tobacco Recovery
### Behavioral
- Learn Coping Skills
- Elevate Confidence
- Embrace Lifestyle Change
- Always with Pharmacotherapy

# SUGGESTED ENGAGEMENT TOPICS

- Highlight and thoroughly explore the role that tobacco plays within alcohol and drug use rituals
- Share information on how cigarettes have been "re-engineered" to make them more addicting
- Acknowledge how continued tobacco use increases the probability of alcohol and drug relapse
- Discuss the traditional use of tobacco in the recovering community, i.e. coffee and cigarettes at 12-Step Meetings
- Explore how tobacco use behavior parallels or can maintain behavior associated to other drug use

# *Case Example*

- Therapeutic Community
- Harlem NYC
- 45 – 50  Adult Males
- Community Meeting
- Tobacco Awareness Group

Odyssey House

Where Recovery Lives

# *THE PARADOX*

- As one walks through a drug recovery process, the cigarette is often the last thread of a tangible link to one's old identity (person active in addiction) while developing a new identity (person in recovery).

- Tobacco use provides a sense of familiar comfort, yet often inhibits growth to key objectives of recovery: cognitive and behavioral change to redefine self and lifestyle.

# CHANGE STRATEGIES

- Anchor the rationale for addressing tobacco to the organization's mission.
- Highlight the topic as a recovery issue communicated through treatment philosophy.
- Develop a written *Alcohol, Tobacco and Other Drug* policy.
- Integrate tobacco treatment into existing programming.
- Strategically address the resistance to social change.
- Provide targeted staff training <u>after</u> completing a needs assessment; match training to agency stage-readiness.
- Use language consistent with treatment and recovery culture.
- Cultivate a consensus of <u>all</u> stakeholders.
- Utilize Quality Improvement Process and Clinical Supervision to sustain clinical interventions.

# SYSTEM CHANGES

|  | Current System | Change | Related Tasks |
|---|---|---|---|
| **Assessment** | | | |
| **Intake/Orientation** | | | |
| **Treatment Planning** | | | |
| **Program Therapies** | | | |
| **Psychoeducation** | | | |
| **Case Review/QI** | | | |
| **Discharge Planning** | | | |

# CHANGE STRATEGIES

Think parallel process for clients <u>and</u> staff

- Meet people where they are
- Strive to understand staff perspective
- Wherever possible, offer options
- Roll with resistance non-reactively
- Avoid willfulness
- Support staff initiatives for change
- Partner with staff to tailor interventions for their practice context

Miller & Rollnick, 2001; Williams et al., 2006

# *ENVIRONMENTAL SUPPORT*

## *Alcohol, Tobacco, & Drug-Free Policy*

# SUMMARY

## *Why an Integrated Recovery-Oriented Tobacco Intervention?*

- An integrated, recovery-oriented tobacco intervention is consistent with provider mission and improves quality of care
- Our models of care are already designed to treat substance use disorders
- Practitioners are highly competent in providing psycho-social treatments
- We can maintain fidelity to EBP while tailoring the protocol to accommodate the cultural beliefs, values, attitudes, and behaviors of those we serve in our programs

# *Thank You*

*When I stopped living in the problem and began living in the answer, the problem went away.*

*Big Book of Alcoholics Anonymous*
**Page 449**

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# Objectives

- Discuss the neuropharmacologic model of nicotine dependence and treatment.

- Establish the "Imperative to Treat Tobacco" within Addiction Treatment settings.
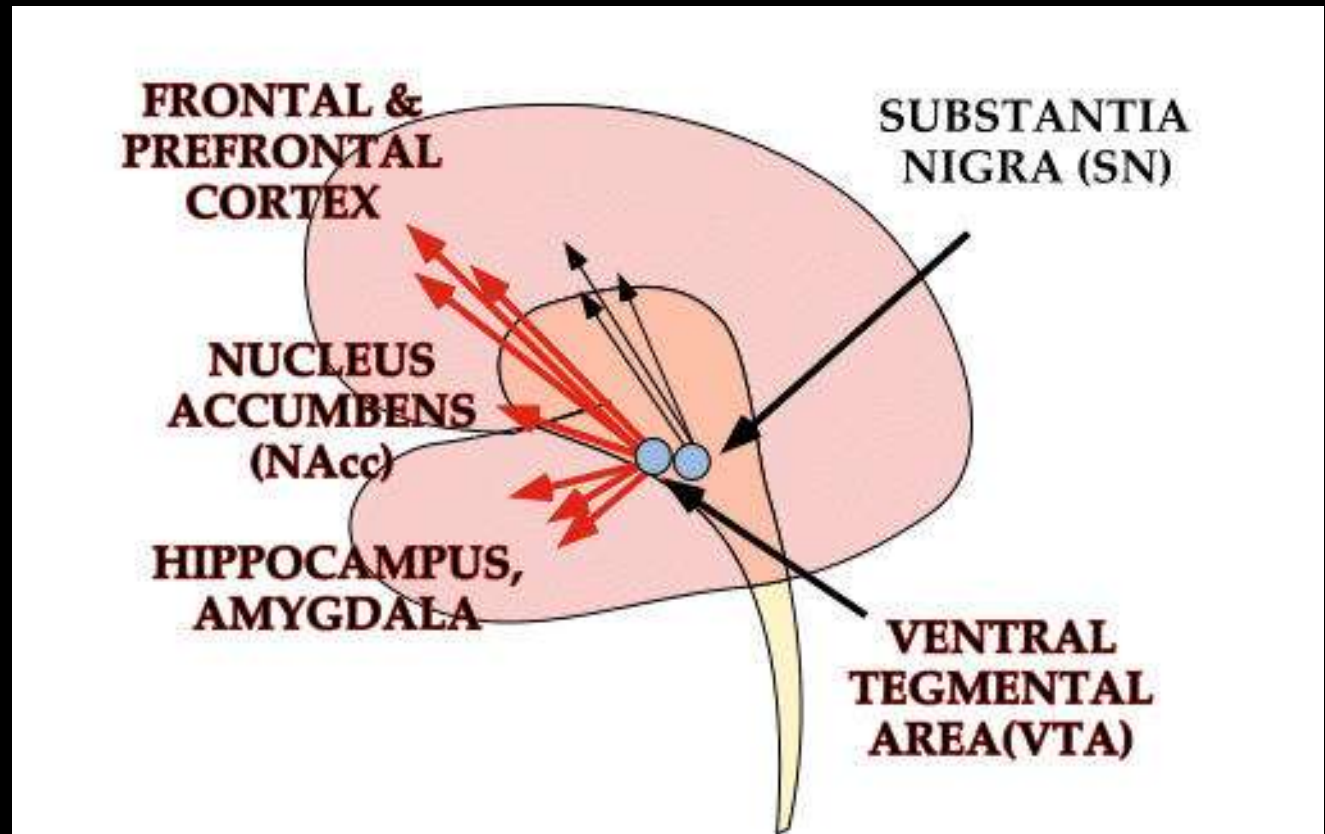
# Nicotine Dependence Itself a Chronic Illness



*"There's someone in my head, but it's not me."*   - Pink Floyd 1982

# Mesolimbic Dopaminergic system
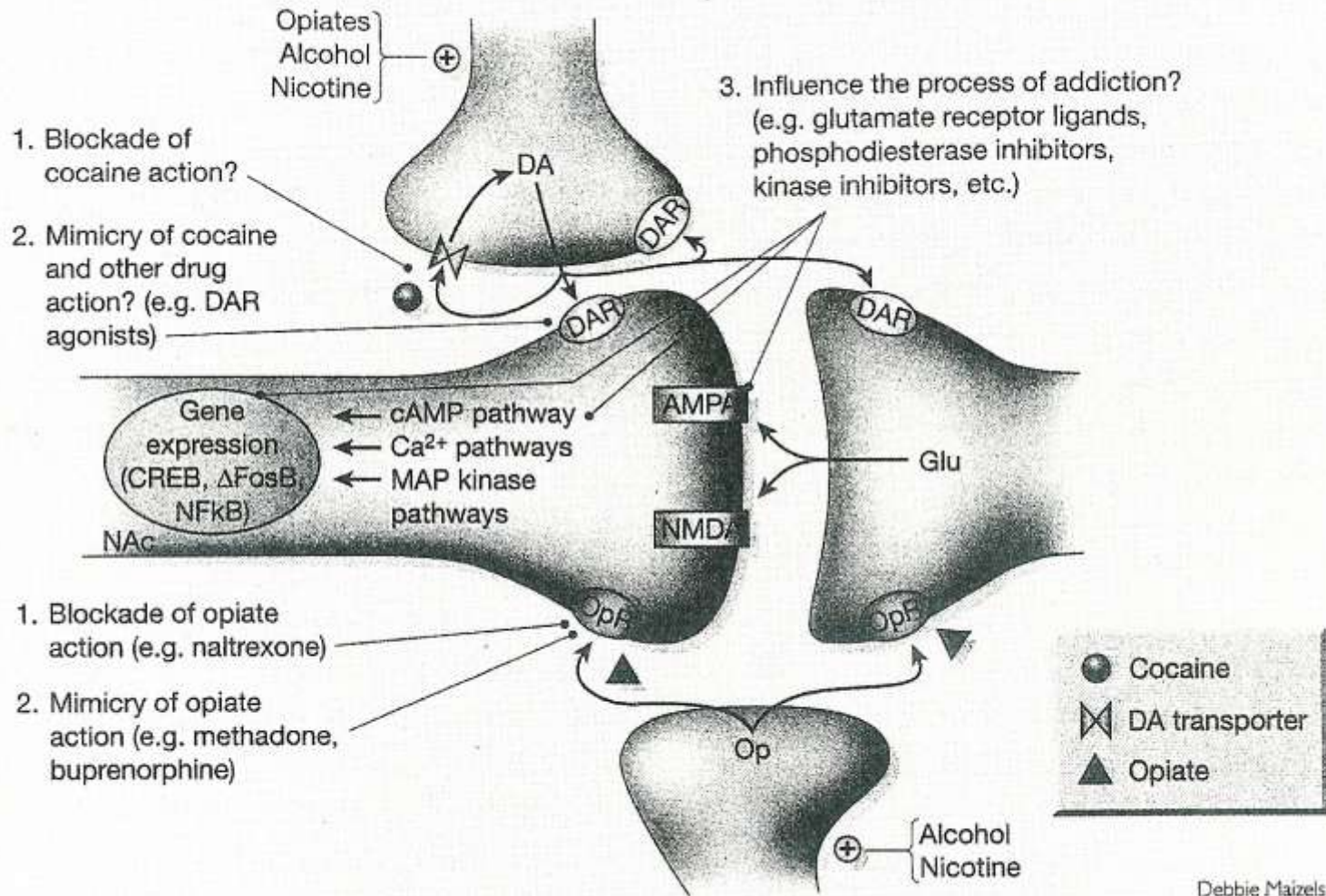
Emotion

Motivation

Memory

# Long term changes

- Increased neuronal arborization
- Increased density of nicotinic receptors
- Increased sensitivity of receptor ion channels
- Changes gene expression
  - Neuronal protein synthesis increases
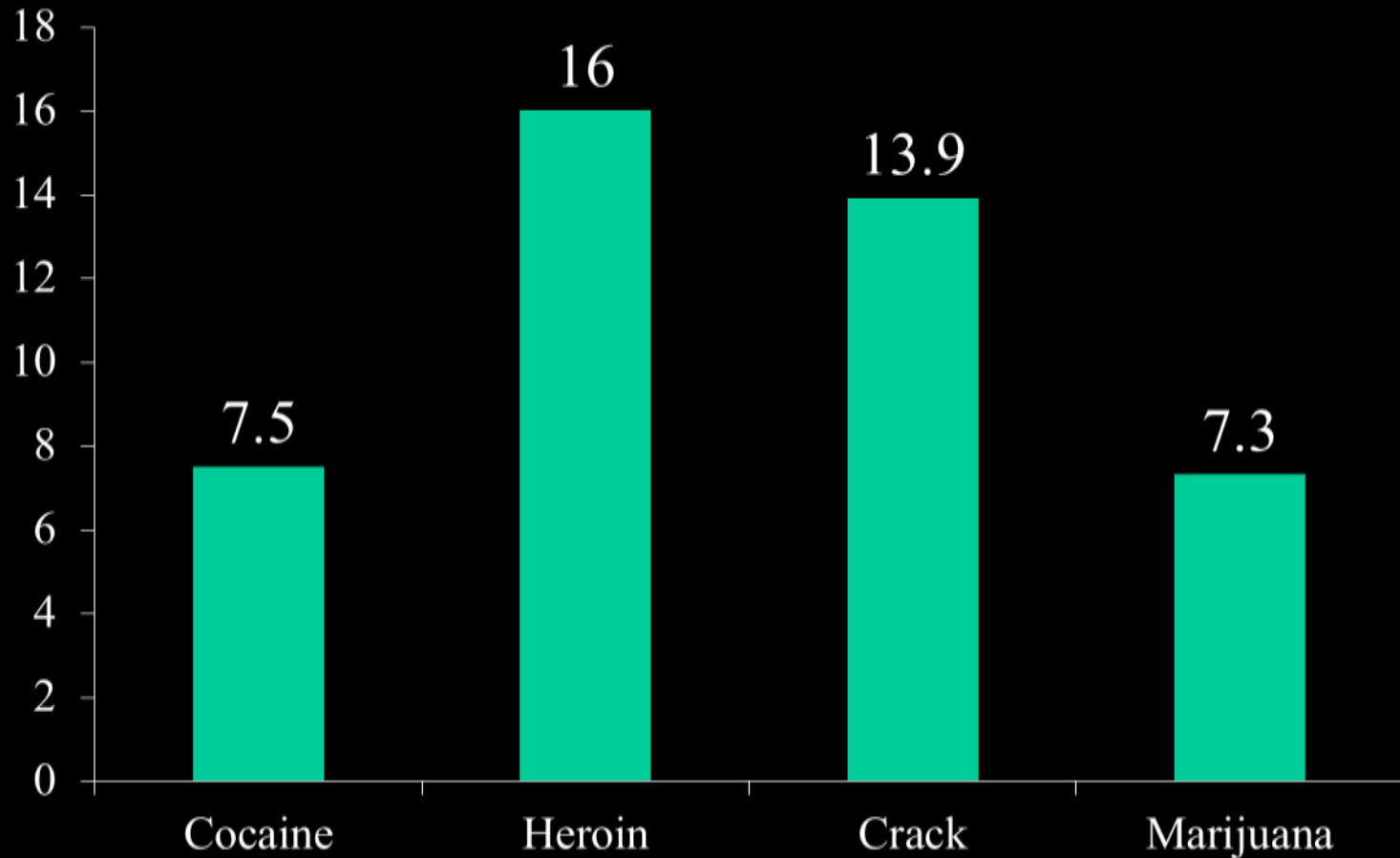  - Neurotransmitter synthesis increases

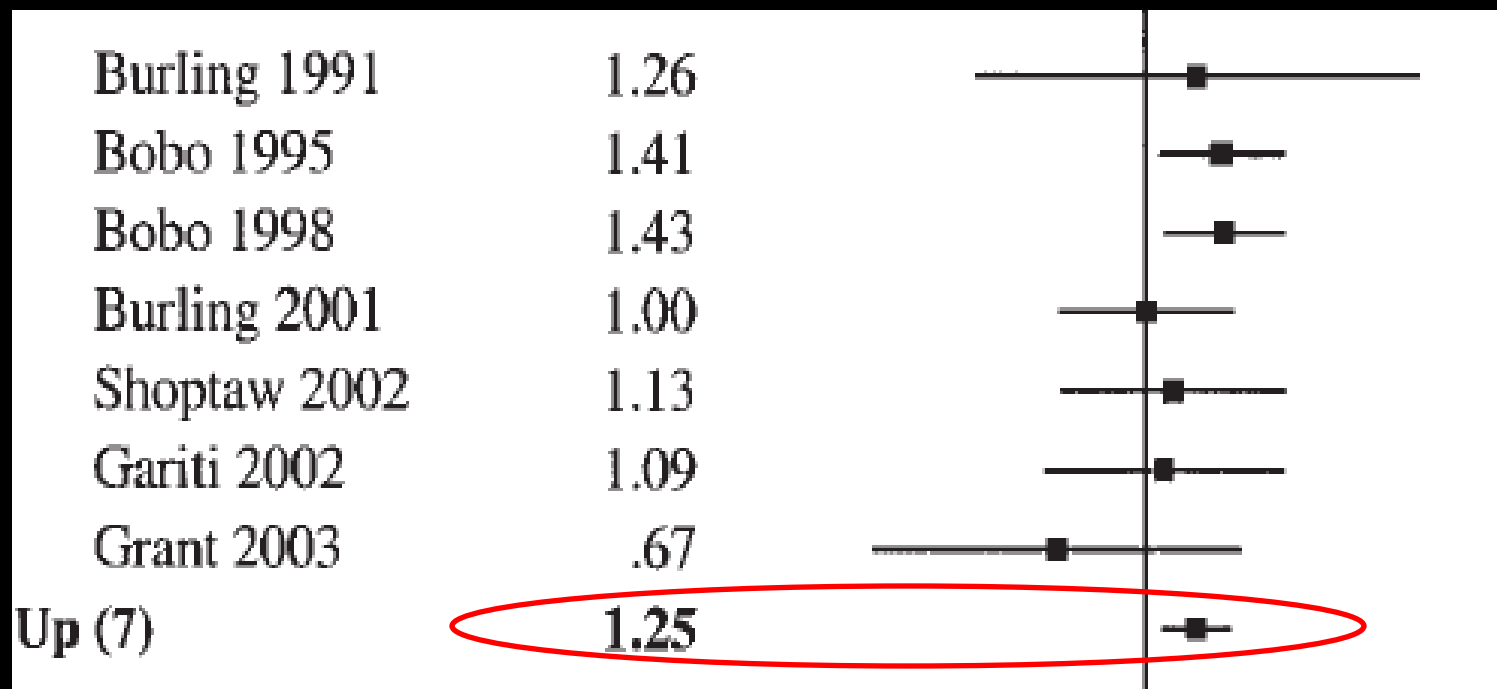# What the future holds



Debbie Maizels

# A Nobel-Worthy Model

# Substance Abuse Among Smokers



Lai. J Addic Dis 2008. 19: 11-24

# Smoking and Sobriety

*Among individuals in addictions treatment, smoking cessation interventions were associated with a significant increase in longterm sobriety relative to the control condition.*

| | | |
|---|---|---|
| Burling 1991 | 1.26 | |
| Bobo 1995 | 1.41 | |
| Bobo 1998 | 1.43 | |
| Burling 2001 | 1.00 | |
| Shoptaw 2002 | 1.13 | |
| Gariti 2002 | 1.09 | |
| Grant 2003 | .67 | |
| Up (7) | 1.25 | |

Prochaska. J Con Clin Psych 2004

# Points to Remember

- Smoking is the behavioral manifestation (cardinal sign) of a disturbance in brain biology induced by exposure to nicotine.

- Persistence of those changes are a function of activation of the FosB gene.

- Other drugs overlap with nicotine via impact on FosB metabolism.

- Simultaneous recovery from nicotine improves outcomes of substance abuse treatment and average of 25%.

*"If we always do what we've always done, we'll always get what we've always gotten."*

- Anonymous

Comprehensive Smoking Treatment Program

1-888 PENN STOP

*Community Behavioral Health*
*December 8, 2016*

*Recovery-Oriented Tobacco Interventions for Individuals with Substance Use Disorders*

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# TRWI: Next Steps

- New agreement language will be in effect **January 1, 2018**

- Planning and implementation of smoke free treatment facilities has begun

- Join the learning collaborative

- Opportunities for staff training, detailing

- Site visits

- [www.smokefreephilly.org](http://www.smokefreephilly.org)

# TRWI Implementation Timeline

| | Title/Name of Phase | Milestone(s) |
|---|---|---|
| **September 2016** | Project Start | Project Kick-Off Event |
| **Oct 1- Dec 31, 2016** | PHASE 1: Establish a Shared Vision | Provider Forums, Consumer Forums, Multiple Presentations |
| **Jan 1- Mar 31, 2017** | PHASE 2: Establish a Baseline | Clinical, Administrative & Environmental Assessments |
| **Apr 1- Jun 30, 2017** | PHASE 3: Engage, Educate, & Develop Shared Direction | Provider training opportunities, detailing visits |
| **July 1, 2017** | Provider Policy Drafts Due | PDPH and CBH provide feedback |
| **Jul 1- Dec 31, 2017** | PHASE 4: Consultation/Technical Assistance | Ongoing support with policy readiness and development |
| **November 1, 2017** | Provider Final Policy Drafts Due | PDPH and CBH provide feedback |
| **January 1, 2018** | Tobacco-free Policy Implementation Effective Start Date | Project Close Date |