U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Chronic Disease and Health Promotion
Office on Smoking and Health

Public Meeting of the Interagency Committee on Smoking and Health

Behavioral Health and Tobacco Control

Wink Hotel DC, New Hampshire Ballroom
1143 New Hampshire Avenue, NW, Washington, DC 20037

June 14, 2018, 9:00 a.m. – 4:00 p.m.

Record of the Meeting

Opening announcements/welcome by
Simon McNabb, Designated Federal Official
Office on Smoking and Health (OSH)
Centers for Disease Control and Prevention (CDC)

Simon McNabb: Welcome and thank you for participating. This is a public meeting and in addition to the public who are in attendance, other members of the public are listening on the phone. I will ask the committee members and speakers to speak clearly into the microphone, and please remember to identify yourself for the record each time you speak.

While this is a public meeting, the conversation and questions will be confined almost entirely to the committee and presenters. We do have time on the agenda for the committee members to ask questions of the presenters after the presentations. We have also designated specific times in the schedule for general discussion.

There is also an opportunity for public comment this afternoon at 3:00 p.m. We welcome these comments, but we will not respond to public questions during this period or at any other time during the meeting. Those interested in making a public comment must sign up at the registration table. Those on the phone who would like to make a public comment should indicate that by hitting Star 1 on your phone. We will make a list of people to make public comments in the order that they sign up. We have limited time for public comment, so we cannot guarantee that everyone who signs up will have a chance to speak.

If you have any questions during the meeting on logistics, we have several folks from the Office on Smoking and Health at CDC to help. Monica Swann is with the OSH office here in Washington. Beth Reimels and Kristy Marynak are from the Office on Smoking and Health in Atlanta. They're here to help on substance matters related to tobacco control, but can also help direct you to the right source if you have logistics questions.

Information for the public to attend the meeting in person and/or teleconference was published in the Federal Register in accordance with FACA regulations and rules. The meeting is open to the public (Attachment 1: Participants' Directory).

We will now introduce the committee members and presenters. I ask the committee's public members to please disclose if you have any conflicts of interest. [No conflicts of interest were identified.]

Simon McNabb: We have a quorum. Our first speaker is Dr. Anita Everett. Dr. Everett is the Chief Medical Officer at the Substance Abuse and Mental Health Services Administration, or SAMHSA. She is also the Director of the Office of the Chief Medical Officer. Dr. Everett has extensive experience in the delivery and leadership of psychiatric services.

Opening statement by
Anita Everett, M.D., Chief Medical Officer
Substance Abuse and Mental Health Services Administration (SAMHSA)

Dr. Anita Everett: I want to say thank you to the members of the Interagency Committee on Smoking and Health, and the committee chair and Surgeon General, Dr. Adams, who will be with us later, for focusing today's meeting on addressing tobacco use by persons with behavioral health conditions.

As you know, tobacco use takes a heavy and disproportionate toll on persons with mental and substance abuse disorders. This toll includes not only dying years earlier and living more years with tobacco-related disabilities, but research also indicates that smoking contributes to poor behavioral health outcomes. Research also shows that quitting may improve mental health and addiction recovery outcome.

My own career spans 30 years of work, the majority in various levels of local, state, and federal government. I've always maintained a small clinical practice, most recently in Baltimore, in the inner city where smoking is a major issue among persons living with serious mental illness. My career also spans a time, early in my internship experience, when smoking was openly allowed in inpatient units, particularly psych units. There were large open wards where smoking was very common and quite often staff would smoke with the patients as sort of a way to bond.

Moving forward 30 years, I think all of us in this room can understand and appreciate that we've made dramatic changes. Now I'm at a point in my own clinic where I have experiences with patients discussing optimal smoking cessation techniques. I want to just give a perspective that in this last 20 to 30 years we've experienced tremendous movement in this area.

As part of this progress, SAMHSA has been committed to working with behavioral health providers and systems to promote the adoption of tobacco-free policies and integration of tobacco cessation treatment into behavioral healthcare. A key strategy has been to focus on state efforts through the Leadership Academies for Wellness and Tobacco-Free Recovery. This effort has been a collaboration between SAMHSA, the Smoking Cessation Leadership Center, and the

National Council for Behavioral Health. In addition, SAMHSA is part of the National Partnership on Behavioral Health and Tobacco Use, which you will hear more about later this morning.

These efforts are about to be significantly expanded through a new grant opportunity. Later this year, SAMHSA will award a five-year grant to establish a National Center of Excellence for Tobacco-Free Recovery. In addition to convening additional Leadership Academies, this Center of Excellence will also provide training and technical assistance nationally to push the envelope with the remaining individuals who still smoke and also have comorbid behavioral health conditions.

Today's presentations and discussions are intended to help identify additional federal actions we can take to address the disparities in tobacco use, particularly among those persons with mental and substance use disorders. I look forward to learning from your feedback how we can improve our efforts. I want to summarize my remarks by suggesting or asking "Are we at a tipping point with regard to the particular influence that smoking cessation can have on persons with behavioral health conditions?" Thank you very much. I'm looking forward to being with you all morning, and I appreciate your convening this quite exceptional committee today.

Simon McNabb: Dr. Everett, thank you very much, and we're very glad to have you. I'm now going to introduce our first presenter, Dr. Corrine Graffunder. Dr. Graffunder is the Director of the Office on Smoking and Health within the National Center for Chronic Disease Prevention and Health Promotion at the CDC. She is responsible for providing broad leadership and direction for all scientific, policy, and programmatic issues related to tobacco control and prevention.

Dr. Corinne Graffunder, Dr.P.H., M.P.H.
Director, Office on Smoking and Health

Dr. Corinne Graffunder: Good morning, everyone. It's wonderful to be here with you all. I'm going to give the 60,000-foot level overview that is intended to whet your appetite for today's deep dive into issues related to smoking cessation among persons with mental health and substance abuse disorders. I'm going to tee up a range of issues and topics, then we're going to have the entirety of today to address and focus on them in detail. I appreciate all of you being here and look forward to today's discussions.

What I'm going to cover briefly this morning is the extent of tobacco use in behavioral health populations. I'm going look at why behavioral health populations use tobacco. What can we do about tobacco use in these populations? And then, ultimately, what are some of the implications of this tobacco use?

Whenever I talk about tobacco control, I always like to start with the good news. The good news is that we know that the rates of cigarette smoking are way down, and continue to move in the direction that we want to see them moving in. We've spent decades working to address cigarette

smoking, and we are seeing tremendous progress in this area, but we know there's another side of the good news story. While we have made tremendous strides at the population level, we are definitely not having the same level of success within all population groups.
There are populations that continue using tobacco products, especially cigarettes, at much higher rates than the norm. These include populations that are identified by certain races and ethnicities, have lower levels of education or income, or have lower levels of insurance coverage. Included are individuals with certain disability status and limitations, or who identify as having certain sexual orientation, or those with mental health or substance abuse disorders and higher smoking rates. Today, of course, we will focus on the disparity that we know exists among the behavioral health population.

What do we know about current smoking within the past year among adults with behavioral health conditions? Well again, there's a bit of good news here. Like smoking prevalence overall, the trends in this population are going in the right direction. But again, there's a disparity here. We're not making the same progress with those living with behavioral health conditions as those who do not have behavioral health conditions. And, in fact, we know that adults with mental health or substance abuse disorders represent only 25% of the population, but they account for 40% of all cigarettes smoked by US adults. That is reflected in their high smoking prevalence, which, at 34%, is double the prevalence among adults without past-year behavioral health conditions.

Within the behavioral health population, there is a co-occurrence of illicit drug use with cigarette smoking. What the data show us is that overall, if there is any illicit drug use, there is a much greater chance that those individuals will also be cigarette users. Nearly 20% of adult smokers engaged in some form of illicit drug use in 2013, compared to less than 5% of adult non-smokers. You can also look at the relationship between smoking and alcohol use. Again, there's a disparity: smokers are more likely to drink than nonsmokers, with 65% of smokers vs. less than half of nonsmokers reporting alcohol use. The disparity gets even greater when you look at binge drinking and heavy drinkers. Nearly 43% of smokers report binge drinking, compared to 17% of nonsmokers.

From a public health perspective, why do we care about this? Why should it matter? It matters because of the significant adverse health effects. The adverse health effects from smoking are no different for smokers with behavioral health issues than from the adverse health effects for every other smoker in the world. But when you look at some of the data, there are differences amongst the behavioral health population in terms of their experience with the adverse health effects.

We know that smokers will die prematurely. In fact, our data suggest that people with mental illness and substance abuse disorders die five years earlier than those without these disorders. And tobacco is a contributor to that. It's not singularly the reason, but certainly tobacco use, and the rates of tobacco use, are a contributor to that.

Likewise, the most common causes of death among this population are the same causes that the majority of Americans die from. They’re heart disease, cancer, and lung disease – the leading

causes of death. But when you look at this population, you find that they are dying earlier because their smoking rates are higher. The same is true for drug users. Drug users who smoke cigarettes are four times more likely to die prematurely than drug users who do not smoke cigarettes. We're looking at a significant impact here in terms of health.

So how does nicotine play into adverse health effects? There are relationships between nicotine as a drug and some of the symptoms commonly experienced by the behavioral health population. Dr. Judith Prochaska and others, I'm sure, will touch on this area in a lot more depth in terms of the actual behavioral and physiological impacts of tobacco use.

And then, finally, tobacco smoke can interact with and inhibit the effectiveness of certain medications. This is not exclusive to medications that are used by the behavioral health population. This is true of medications used by patients in other health areas. But it's certainly a concern and I am always struck by how little I hear us talking about this idea that people who are being treated for a variety of conditions and who continue to smoke, that their success or the effectiveness of their medications may be altered in some way.

We also are going to touch on quitting today. You're going to hear from professionals who've been working in this field for a very long time to really understand quitting and quitting behavior amongst the behavioral health population. My bottom line is that what we know from the data that yes, people with mental illness are less likely to stop smoking. But it's not because (1) they don't want to quit or (2) because they're not capable of it. We have solid evidence that they do want to stop smoking and that they can and will succeed, but we really need to think about what it looks like to support that behavior change in the context of other things going on.

The next question which I find very intriguing is why behavioral health populations continue to use tobacco at such high rates. What I will share from a population health perspective is that in addition to understanding individual factors, we need to understand some of the other contributors. We need to recognize the role that the industry has played in targeting this population and in using very specific strategies to encourage initiation of cigarette smoking in this population and then sustain tobacco use in this population. These strategies, these tactics are not particularly unique to how the industry works to continue to recruit new smokers and maintain current and existing smokers. There’s evidence that these things have occurred and have been directed toward the behavioral health population.

That includes everything from making financial contributions to organizations that work with mentally ill patients, to funding research that really helps to create a body of evidence that will indicate that it's too stressful – that you can't possibly expect someone who's being treated for cocaine addiction or heroin addiction to also give up their cigarettes and give up nicotine. How could you possibly do that? There's also been research that shows providing free or cheap cigarettes to facilities has been funded by the industry. You heard about what it was like 30 years ago to be on a ward or be in a facility. And there's been tremendous progress, no doubt. But today, you'll hear some of the experts indicate where we still need to make more progress.

Certainly, there continues to be active efforts to block policy work and to try to dissuade policy work, and the marketing plans that have been around to look at how best to reach and market to specific populations. A Camel ad from way back specifically links happier moods to smoking. An ad selling Merit cigarettes used the word "schizophrenic" as its headline to promote the product's "big taste and lower tar, all in one." And many cigarette ads, including one for Newport, focused on "light" versions of the product. This was at a time when the industry was saying that low tar cigarettes that taste good may be better for you. This was the idea of selling health, selling a healthy lifestyle, and selling well-being as part of a cigarette ad.

We also have evidence of targeted distribution of tobacco products. Industry documents record distributions and giveaways to employees and patients at mental health facilities, and these types of marketing practices by tobacco companies have contributed to some of the disparities with the populations that we're concerned with.

I'm going to move now to what we can do about tobacco use in these populations. One of the ways that I personally like to talk about is the tobacco control vaccine. It would be wonderful if we could develop a vaccine to prevent smoking – like the flu shot. But in medicine and public health, things are rarely that easy. The good news, however, is that we actually have a tobacco control vaccine. Like a flu vaccine, it comprises multiple components, but it can be effective when it's administered correctly.

The tobacco control vaccine includes things that are proven to work – like increases in tobacco prices. To help control against smoking, a total price of $10 a pack is most effective. Another component of the vaccine is smokefree policies. To be really effective, they need to cover all indoor spaces nationwide. The majority of smokers want to quit, but they need to have access to cessation help, including counseling, nicotine replacement, and medications. That means all health insurance plans, including Medicaid, should cover all elements of tobacco dependence treatment. And hard-hitting media campaigns that can move smokers toward a desire to quit and point them in the direction of help that's available to help them quit are essential.

When I talk about tobacco control, I always start by saying that we know what works. But we need to be sure that we bring to scale those things that work. In part, we are failing to reach some populations that are disproportionately affected by tobacco use because we're not able to bring to scale the things that work in the same way we can do it in the larger population. The tobacco control vaccine allows me and allows you all and I hope allows professionals across the spectrum of different fields to understand that it's not just individual strategies that work. We know that these things all work in combination with one another in a really complex way – much more complex than we can cover today. The important message is that all of these components of the vaccine work in conjunction with one another. If you are providing the very best cessation access for a current smoker and that person has to go to work in a work place where they're still smoking, or they're being treated in a facility that is not completely tobacco- or smoke-free, that increases the challenge that that person is facing in terms of their own efforts to try to quit smoking.

Raising tobacco excise taxes is one strategy that has been found to be a powerful way to influence smoking in this country. At the beginning of this century, only a handful of states had excise tax rates of more than 50 cents a pack, and only three states taxed at a dollar a pack or more. Today, only a handful of states have taxes that are under 50 cents a pack, and at least 13 tax at $2 a pack or higher. In some of the major metropolitan areas, there are additional county or city taxes that help raise the price of cigarettes, and we continue to see progress on the state level. We know that the behavioral health population does respond to price and that their smoking rates go down as cigarette prices go up. A 10% increase in cigarette prices has been associated with an 18% decline in smoking.

Regarding smokefree policies, we'd like to thank SAMHSA for the recommendations they've made on this. The recommendation that the spectrum of behavioral health service organizations and facilities adopt total tobacco-free facility and ground policies is very powerful. This is the best practice that we promote and really advocate for - a complete, total tobacco-free policy campus-wide.

On the issue of access to cessation help, SAMHSA also has recommendations around the integration of tobacco treatment into behavioral health care. This is important because while there has been progress, we are not where we would like to be in terms of the actual interventions within mental health and substance abuse treatment facilities. For example, only about a quarter of mental health and substance abuse treatment facilities offer nicotine replacement therapy and only about one in five prescribe non-nicotine cessation medications.

Quitlines are interesting in that we know they reach a very small percentage of the overall population of smokers. But they reach low-income smokers and there are, in fact, callers who will self-report behavioral health conditions. More and more state quitlines are now asking about this – and today, 90% of state quitlines screen for behavioral health conditions at intake. The data they are collecting help us understand the extent of the issue. In fact, we now know that nearly 43% of quitline callers who receive cessation help reported having a behavioral health condition.

In the last several years, we've had multiple agencies fielding powerful media campaigns. CDC is in the seventh year of the *Tips From Former Smokers* campaign. We continue to be so proud of this campaign, and we've seen the same kind of response this year that we've seen throughout the life of this program. It's a dose-response relationship. When we run these ads, when we do this work, the number of calls to the quitlines doubles or triples. That's just one very crude marker that's not capturing all the other ways that people are responding to these ads, but it gives you an idea of how powerfully motivating the effect is from the stories of former smokers who are living with smoking-related disease and disability. One of our new ads, featuring a former smoker named Rebecca focuses on mental health - her depression and the relationship between her depression and her smoking, and how she began to take a holistic approach to addressing all of the things that she was struggling with in her personal life.

We did this ad in collaboration with our colleagues, particularly colleagues from SAMHSA and other federal sister agencies. The ad directly targets the providers themselves, asking the providers to really think about how they can engage their clients in smoking cessation conversations. This ad was coupled with an advertorial that takes the science that's available to try to counter the myths around integrating cessation in mental health care.

I want to close with a couple of points. One is that we at CDC are very proud of the infrastructure that we have in place through our National Tobacco Control Program, which reaches every state, 12 tribal support organizations, US territories, and eight national networks, one of which is represented here, the National Behavioral Health Network for Tobacco and Cancer Control.

But this infrastructure is insufficient. This infrastructure can't be successful without the kind of regulatory work that FDA is doing, the kind of science and support that NCI does or what SAMHSA does, what CMS can and should be doing, what DOD is doing. The role that all of the parties can play is critical to the overall success of tobacco control in the US. Our national program is a nugget of infrastructure that can help at the state and local level, but it really does take everyone else doing their part.

The last thing in my closing is this question, what are the implications for public health practice of cigarette smoking within the behavioral health population? Well the good news is I'm not going to even try to answer this question this morning. This is what you all are here for today. This is what you're here to help us understand.

What I will say is we know persons with behavioral health conditions are disproportionately higher users of tobacco products. We know that the industry has used multiple strategies to market products to them. We know that these conditions help make it more challenging for people to stop smoking even when they want to quit, and we absolutely know what works. When we know all these things, what I would say to you and what I would charge to you is it's now time to take action. We've got the information. We've got the knowledge. We now need to take action. I look forward very much to hearing the conclusions and the recommendations that you all make throughout the day. Thank you very much.

Simon McNabb: Thank you. Before we move into the Q&A, I'm very happy to be able to introduce our chair and I'm going to do that in a second. I'm just going to note I've asked Dr. Adams to hold off his formal comments until after the break. But I'm going to introduce him, so he'll say welcome and then we'll go to Q&A. And then we'll take our break.

It's my pleasure to introduce Dr. Jerome Adams, the 20th Surgeon General of the Unites States. Dr. Adams is a board-certified anesthesiologist. He served as Indiana State Health Commissioner from 2014 to 2017. (Dr. Adams) is a Maryland native, and has bachelor's degrees in both biochemistry and psychology from the University of Maryland, Baltimore County. He has a Master of Public Health degree from the University of California at Berkeley and a medical degree from Indiana University School of Medicine.

Vice Admiral Jerome Adams: Thank you so much, Simon, and thank you to all of you for being here. This is very important convening with some amazing partners, and I'm looking forward to a robust discussion today. I'll save my formal remarks, but for now let me say I'm just so thankful for the opportunity to participate. This issue is critically important to me.

I've got three little kids at home. That's not in my bio that folks usually read. But I'm very much interested from a personal point of view in the outcomes of the discussion that you have today. I'll share a little bit more about my personal story and family connection with tobacco, but we all have one. We've all got a story about a family member who died, about kids whom we want to keep safe. And so, again, I say that because I think it's important that we remember why we're here. And yes, it's to talk at a high level about federal policy, about the science and the evidence, but it's also really about making sure we're protecting the individuals that we care about and we love, who are exposed to tobacco and who are preyed upon by some of the folks out there each and every day.

Simon McNabb: Thank you Dr. Adams. And as is the Chair's prerogative, I will toss you the first opportunity to ask Corrine a question. Dr. Everett also gave us some opening remarks we're very grateful for.

Discussion 1

Vice Admiral Jerome Adams: Corinne, as a former state health commissioner, I'm interested to know what's the one CDC tool that you think is most beneficial or most underutilized by the states? As you mentioned, the CDC offers a lot of support to folks. And from a state point of view it's hard to figure out which ones to go after, which ones give you the most juice for the squeeze.

Dr. Corinne Graffunder: I will answer this question in two ways. One is that the states continue to be very resource-challenged. For example, we spent 48 hours with one state that asked me if we could turn off *Tips* for a couple of weeks because they were running out of money to fund their quitline. What this shows, and what we see time and time again, is that the demand exists. We have ways to reach smokers who want to quit. Yes it's hard, and yes, it's woefully inadequate in some ways in terms of the breadth and depth of everything that is available.

We know it is a challenge for the states to figure out how they can do all the things that work. You've heard me talk about the tobacco control vaccine before. So how do the states keep working on smokefree policies? How do they keep working on using effective media campaigns? And how do they make sure that they have the right relationships and the right support for the smokers that do want to quit.

On the point of the relationship, I do think with the very best of intentions, there are still challenges with getting the relationships. As a former state health official, you know what

the bureaucracies are like. You know how separated oftentimes the different parts are from one another. And getting those meaningful relationships and having them exist in a way that allows for actual genuine progress to be made is not always easy. For example, the CMS, the Medicaid and Medicare programs - those continue to be real challenges for the states. Part of it is bandwidth, but part of it is infrastructure and structurally there are not good supports to make that happen. I think the SAMHSA example of the institutes is a nice example of a very concrete step that can be taken that creates that bridge among state agencies and between state and federal partners.

Dr. Michele Bloch: I think there is general agreement in this field, and I'm looking at Dr. Warner, who I think would second this: the single most powerful tool the states have is raising the price of tobacco products, as it lowers use across all populations and it also reduces disparities. That was a key conclusion of a recent monograph. Of course, this requires a lot of political will. The second most powerful tool is smokefree policies and the extent to which they can generate interest in smokefree homes both in single family homes and multiunit housing. I think those strategies would have tremendous, powerful effects on reducing and changing social norms.

Dr. Susan Curry: Do we have data on cumulative reach of quitlines?

Dr. Corinne Graffunder: I think we do have some data on it, we could get that data.

Dr. Susan Curry: My other question is that public health practice is different from public health action. Do we look into public and private partnerships?

Dr. Corinne Graffunder: We do try to pursue a variety of different public/private partnerships. We partner more with nongovernmental organizations: our national network is an example of a relationship with nongovernmental organizations. Under the Surgeon General's leadership, there's been interest in figuring out how public health can interact more with the business sector and with true private industry and private partners. The CDC has a mixed history in that space and we have to be very careful, being a federal agency, but we are looking at some emerging opportunities.

Dennis Henigan: There's impressive evidence about the effectiveness of the *Tips* campaign generally. I'm wondering if it is possible to measure the impact of the *Tips* campaign on this population that we're talking about, given that some of the campaign is actually targeted at that population and whether that's something you've thought about.

Dr. Corinne Graffunder: There probably would be a way to lay out an evaluation plan for what that would look like; we would have certain (far from perfect) measures that we could look at and data that we could collect. We are always looking at the national quit line data warehouse and the data we collect. Some of the behavioral health data that I mentioned is actually newer; it has recently been added to what quitlines are collecting.

Dr. Steven Schroeder: This is a wonderful summary of progress that's been made but what is missing even now with this progress is urgency. There are 200,000 to 240,000 people with behavioral health conditions still dying from smoking. There is so much else going on: the obesity epidemic, opioid epidemic, so this has fallen to the bottom of the public agenda. And a latest example is the CMS, which was previously asking psychiatric hospitals to identify smoking in their populations and help them to quit. Now CMS wants to water down those recommendations to relieve the regulatory burden. The question is how can we make this more of an urgent issue? It's been around for so long that we've accepted it, and it's a national tragedy.

Dr. Corinne Graffunder: The MMWRs are a great way to at least elevate the issue. What I think we need to do more of is to include action steps, or available tools and resources in MMWR articles. This way, we state that there is a problem, but we also provide things that can be done or share some solutions to the problem. But I agree with you, I have probably told you (Schroeder) the number of times that I have people say to me: Tobacco's not even a problem anymore. That has been the most surprising thing since I have come back into this field.

Dr. Steve Schroeder: One anecdote, I think the people in this room are living in a "gated community" in regard to smoking. And as an anecdote, when we were married, we got a number of nice wedding presents, some of which were fancy ashtrays. To our knowledge, we have not had a person who smokes in our home in 25 years. What's happened is that smoking has become an invisible problem to many of the people who make decisions about allocations of federal and state budgets.

Vice Admiral Jerome Adams: I want to add something else to that, too. Corinne talked about my push to try to better engage the business community. The level of urgency on this issue was brought up. When you look at what people vote on, Democrat or Republican, rural or urban, black or white, the number 1 issue people vote on is jobs and the economy. I can tell you as a former state health official who stood in front of state legislatures and had to push for higher prices, for clean-air laws, what happens is you end up being pushed into choosing a side: You're either pro-smoking cessation and prevention or you're pro-business. It's created as an either/or argument.

One of the things that I'm trying to do is put out a Surgeon General's Report on health and economic prosperity, showing the link between healthy communities and lower absenteeism rates, greater productivity, better ability to recruit a work force to your town. And I know the evidence is there, but if we can put the Surgeon General's stamp of approval on that evidence to say that caring about clean-air policies, hearing about the price of tobacco, caring about the smoking rates in your community, is directly related to your bottom line, we can be more successful. And we need to get Amazon, get Walmart, get Berkshire Hathaway to show up at the state house and push for clean-air laws to counteract the mom and pop bars, to counteract the casinos, to counteract the gas stations

that are saying what you guys are pushing for is bad for business. Then we'll be much more successful and will create that urgency.

We're never going to get that urgency when we're coming at it from a health point of view when the polls state that people never, ever vote for health. And again, it's not a value judgment, it's just what the facts say. They vote for jobs and the economy and we've got to learn to speak in that language and get the folks who represent that community to carry our water for us.

Capt. Kimberly Elenberg: We've been going through about seven different states looking at the communities that have the highest population segment of military service members and have the lowest health-related quality of life. We've been trying to assess what is contributing to that low health-related quality of life, and I can tell you that smoking comes up high on the list. We were at a meeting in Baltimore yesterday with several of the state health commissioners. Each of the county health representatives confirmed there is a correlation between the use of tobacco and the opioid use rates and alcohol misuse.

So, one of the things the Defense Department is considering is to address our behavior change campaigns to be comprehensive. For example, if you are misusing alcohol, if you are struggling because of addiction to your opioid medication or other illicit drug use, or if you're using tobacco, you shouldn't have to go to separate platforms to find assistance. Because of that, we're building a behavioral change campaign that addresses each of those things and addresses pain. Usually pain is a driver for using these substances; psychological pain, social pain, physical pain.

We're really looking toward integrated resources and we are doing that through public/private partnerships. And to your point, Dr. Adams, regarding how we increase economic job opportunities: In Cecil County, there is a perceived barrier to getting jobs which contributes to some of the depression, anxiety and substance misuse because of the bridge tolls. The thing is, there's actually a program to help commuters with those tolls, but people just don't know about it. If we don't link the resources we have to the efforts that we have in transportation, in housing, in economic development, and in health provider and public health resources, we're going to miss the boat. There's such a strong link among all of them. I look forward to your thoughts on our attempt to provide a single platform for addressing these issues.

Dr. Corinne Graffunder: I think what you're suggesting is that when we talk about cessation, we need to make it clear that we're talking about nicotine addiction, drug addiction. We're not talking about a habit. When you look in our current health system, smoking cessation is often in the health and well-being side of what is provided to even an insured population, right? It's in your wellness provision. It doesn't fall under a clinical condition that needs to be treated.

Vice Admiral Jerome M. Adams, M.D., M.P.H., U.S. Surgeon General
U.S. Department of Health and Human Services

Vice Admiral Jerome Adams: First I'd like to thank the members of the Interagency Committee on Smoking and Health for your commitment, and especially our public members; Patricia Nez Henderson who couldn't be here in person today, Dennis Henigan, Kenneth Warner, Susan Curry, and Steven Schroeder. I think it's important that we recognize that this is (Susan) and (Steve)'s final meeting with the Interagency Committee, so please give them both a round of applause. Today was my first opportunity to meet you in person, but I know of the work that both of you have been doing from my long history in public health. And again, you all are true servants and we're really grateful for all of our public members and their willingness to serve.

We meet here today because smoking remains the leading cause of preventable deaths and disability in the United States, despite long-standing declines in the number of people who smoke. I know all of you know that but it's important that you hear your Surgeon General of the United States say that - that I know and that I believe that cigarette smoking remains the leading cause of preventable deaths and disability in the United States.

We have made great progress, but we're here today because there's still much more work to be done. The Office of Surgeon General has symbolized tobacco prevention ever since 1964 when the first Surgeon General's Report warned the public and the public health community of the health hazards of smoking. As Chair of the ICSH, I want you all to know that I'm committed to tobacco prevention and will continue to speak on and release Surgeon General's Reports on the topic. Smoking is the Number 1 preventable cause of disease and death and we need to help folks remember that. But as a public institution we also have to remember that the media cycle is short. And as we discussed earlier, we've got to continue to find ways to help folks remember that tobacco is intimately interconnected with many of the other things that folks care about.

I've had a lot of folks in the tobacco world say don't forget about us as you're talking about opioids, but I don't think it's either/or. I think there's a tremendous opportunity. Two, three years ago, I never would have been able to go to a community and get a mayor, the CEO of the largest corporation in that town, the local sheriff, the local faith-based leader, the school superintendent, the head of the public health department, all in a room to talk about any health issue; smoking, diabetes, pick one. Any issue, I wouldn't have been able to get all those folks in a room. Now, all those folks are not only in the room, but there's a line out the door waiting to talk to me about opioids.

If we can use that wind in our sails to talk about the broader umbrella of addiction – to talk about the folks with behavioral health disorders who go down the pathway of self-medicating with any number of different products – to talk about the upstream proximate causes and the lack of health and wellness in our communities that lead to these different outcomes – then we'll all be better for it. See this as an opportunity and not as a challenge to be overcome so that we can put tobacco back on the top of the list of diseases that we're worried about.

You know, the landscape of tobacco products has changed drastically over the last 54 years, but one constant remains. We're a healthier, stronger, and more resilient nation – a nation where fewer folks misuse opioids, where fewer folks have diabetes, where fewer folks are dying from all illnesses – when Americans are not smoking.

As your Surgeon General, I want you all to know I'm focused on promoting health, preventing disease, and most importantly leading with the science. But there's a saying that I commonly bring up. People need to know that you care before they care what you know. While I'm always going to lead with science, you can't beat people over the head with science from a public policy point of view. We've got to be motivational interviewers. We've got to be servant leaders. We've got to go in and gain trust from the others in that conversation so that we can then inject the science into the conversation.

By using the communication platform of my office to create cultural and behavioral change, I hope to create a healthier America. But we need to reach out beyond our silos to our counterparts in the business community and the military and law enforcement communities. Our nation is smoking and that is a contributor to the fact that seven out of ten of our youth are ineligible for military service right now. Our nation's poor health isn't just a matter of chronic disease 20 or 30 years down the road. We are a less safe nation right now because we're an unhealthy nation.

Engaging with the business community is critically important in any number of ways. I told you the Number 1 issue people vote on is jobs and the economy. The Number 2 issue they vote on is safety and security. Engaging our DOD partners and having them carry our water for us makes sense. I'd much rather have a four-star general going to the state house and arguing before the legislature that we need clean-air laws because we know that high smoking rates mean we have fewer young people who are physically fit enough to qualify for military service, and the smoking rates in the military are much higher than they are in the general public, than I would to have my health commissioner arguing that same thing. They know what I'm going to say when I walk into the state house. I tell folks. They roll their eyes. Oh, here comes the no-fun Surgeon General. He's coming to tell us we can't do anything that we like to do. But if we can have those business partners, those military partners carrying our water, it will change things in a way that we never before imagined. Look at the faith-based community. Another person I'd rather have standing in the community preaching my health message than a doctor, is a local pastor. In church every Sunday, we have a local pastor standing up there saying we need to lower our smoking rates because it is a plague on our community. That's going to get a lot more traction. But how many of you all have reached out to your local faith-based leaders and incorporated them into your programs and your plans? We need to make sure we're not only sharing science-based recommendations, but we're putting those recommendations in context with the priorities and values of our partners in the communities that we're seeking to reach.

We're lucky to have some wonderful presenters with us today. One of the things I always do when I'm coming to a meeting is look at the agenda and see who's talking. One of the things I always get upset about is that I don't get a chance to sit in for all the talks. But I'm going to be fortunate enough to spend some time with you through lunch today

Throughout today's meeting we'll consider how we can reduce the impact of tobacco on behavioral health populations as part of our national goal to reduce tobacco use overall. I mentioned my kids. I didn't mention that my grandfather died from complications due to his lung cancer. Didn't mention that my uncle smoked his whole life and died at a very young age from metastatic prostate cancer that, from a medical point of view, was almost surely exacerbated, accelerated by his smoking. Didn't tell you that my brother sits in state prison about ten miles from here right now due to his substance use disorder and crimes he committed to support his addiction. He self-medicated with tobacco. And that was part of his journey.

And even now I have to deal with my parents and with people around him saying, "Well, we might as well let him smoke because if we take that away from him, then he's going to go back to doing something else." We know that's not true. But I have lived through the stigma. I've lived through the challenges. I've lived through the heartache that tobacco brings to all of our families.

I'd like to challenge each you to join me in thinking in an innovative way about what is needed to support science-based interventions specifically at the federal level, so we can reach our shared goals of a tobacco-free generation and tobacco-free families. You already heard from Dr. Everett and from Dr. Graffunder of the CDC. A great example of innovative science-based intervention is the National Center of Excellence for Tobacco-Free Recovery that Dr. Everett alluded to today. We need to give folks tool kits like this to help them succeed.

Remember when I said don't beat people over the head with science? From a health care point of view as a doctor, I know there may be 10 different ways to do things, but when I come in, I want the Number 1 or Number 2 best ways. I don't want the Number 9 way. But from a health policy point of view, we've got to realize that in public policy, the key word is public, and that communities change. And so we've got to do a better job of giving people tool kits - of saying, "Here is the list of best practices" and giving them choices among those best practices, and I am really supportive of SAMHSA's Centers of Excellence. It's also very important that we address disparities and that we fully understand and address the unique issues that people in these communities face. I know you've already started an engaging discussion about tobacco use disparities among people with mental illness and substance use disorders. I'm very gratified that you will continue to look at that issue throughout the day and look forward to your feedback on it.

One of the other problems with tobacco, as you've heard, is we live in our bubbles. I don't see people smoking anymore. One of the more interesting things about being in my job and traveling around the country is I go to places and walk into a restaurant and you immediately think, "Are they smoking in here?" We're shocked when we encounter that because we live in our bubbles. And we've got to get outside of those bubbles sometimes and see that our beliefs about the culture of smoking and tobacco based on where we live and who we are, are not shared by a lot of our country. And we do face some significant challenges, particularly in minority communities. And I define minority widely including people with behavioral health issues, people who speak different languages, people in urban areas, inner city areas, and all sorts of different special populations that the industry has very specifically targeted with their products.

That's why it's truly critical to sincerely engage people from priority populations and to fully engage them as partners as we work to reduce tobacco use. Following my remarks will be my good friend Dr. Jodi Prochaska of Stanford University. We met in February when I addressed the SRNT at their annual conference. That was a wonderful convening – a great opportunity to give a shot in the arm to the folks who are doing the research that allows us to then go out and say, "We know this works, community, and you should put it in your tool kit." I actually brought two kids up on stage with me at that conference, embarrassed them a little bit, and had them pledge to a lifetime of research and science in front of a packed audience. It was one of the cool things about being Surgeon General.

Then after Jodi, we'll hear from Cliff Douglas of the American Cancer Society. He's going to review the National Partnership on Behavioral Health and Tobacco Use. This is yet another great example of public/private partnerships, and I look forward to his presentation because that's how we're going to take this thing to the next level, with public/private partnerships. And lastly Cliff's presentation is going to be followed by notes from the field led by an all-star group of health professionals reviewing promising practices.

I'd be remiss if I didn't take just a minute to discuss the opioid epidemic. I just left a meeting sponsored by the American Cancer Society where we were talking to folks about the opioid epidemic. There are 2.1 million people struggling with opioid use disorder including my own brother. And although the current focus has been on our nation's growing opioid epidemic, we have a unique opportunity, as I mentioned, to talk about nicotine addiction. The larger conversation must include and emphasize tobacco cessation as part of a comprehensive addiction treatment strategy. And I use every opportunity to talk about not either/or, but both. We must remember that with our help, smokers can and do quit smoking.

I want to close by stating that every single one of you in this room is seen as a leader in your community. And that's what this is about. It's not about having a conversation today. It's about taking all this back home to our communities. You have an opportunity and I would dare say an obligation to lead by example. Our job is to change the environment so that people no longer face a lifetime of addiction to a product that will give them cancer, heart disease, or COPD. And I'm a big believer in personal responsibility. But I also believe that the choices people make are 100% dependent on the choices that they have or that they perceive that they have. Our job is to make the HEALTHY choice also be the EASY choice for everyone in every single community.

It's within our power to reduce smoking to zero by accelerating our efforts to make the use of cigarettes and other tobacco products a thing of the past. And it's imperative that we use our platforms to maximum effect and be better partners by doing it with humility. Be servant leaders. I encourage you to commit to a day of rich dialogue aimed toward lasting solutions for tomorrow's generation, my three kids that I'm talking about, my 13-year-old, my 12-year-old who is literally graduating from sixth grade right now and my 8-year-old, all of whom know about the danger of cigarettes and all of whom have been offered e-cigarettes in their schools. I'm not going to go down that rabbit hole yet, but I hope you all have a conversation about that,

too. Because again, that's another thing that's not either/or. It's got to be both and finding out where the pendulum should appropriately swing.

But they're all depending on it. There's no time to waste. As Dr. Schroeder mentioned, we have to be better partners, we have to be better communicators, so we can bring that urgency back to the discussion about tobacco cessation, about the dangers of nicotine products, especially to our children. I'm so excited to be here and to be a part of this conversation today. And I want to leave you all with the knowledge that your Surgeon General is committed to tobacco. I may not always be out there leading with tobacco because again, I'm a communicator and I've got to talk in a way that resonates. But know that it's always on my mind. Always in my heart. And I truly believe that there's nothing that I'm going to talk about out there that I can't bring up tobacco in the context that we're working in. Even though we're passionate about tobacco we need to be better about bringing it up in the context of other priorities so that we can continue to bring that urgency back. Thank you very much.

Simon McNabb: Thank you Dr. Adams. It's now my pleasure to introduce Dr. Judith Prochaska. Dr. Prochaska is an associate professor of medicine with the Stanford Prevention Research Center and a member of the Stanford Cancer Institute. She's a principal investigator on multiple research awards from the National Institutes of Health and the State of California Tobacco Related Disease Research Program.

Impact of Tobacco Use on Behavioral Health Populations
Judith Prochaska, Ph.D., M.P.H.,
Associate Professor of Medicine, Stanford University

Dr. Judith Prochaska: Thank you Simon. I don't know about the not-so-fun Surgeon General. My kids would not agree. They think you are very cool. I'm so thrilled to be here today. I appreciate the invitation. You have gathered the most important partners in terms of moving things forward. And as much as I love research, if it only goes into journals and into publications, that's not enough. It's so important that we see action here. (Steve Schroeder) made an incredibly important point about the urgency, about this being a serious issue that continues to need our attention.

I'll start off talking about what we mean by behavioral health populations. That's important because in research, people define that in different ways and that can lead to some differences in what the findings are. I'll look at the epidemiology, but I'll do that fairly briefly. I'll dive into behavioral health settings and look at the extent to which tobacco has been attended to in these settings. I will talk about the tobacco industry efforts because it's not just the product, it's also the marketing around the product. I'll talk about tobacco treatment and I'll dive into the evidence base – what we are seeing in terms of what works for treating tobacco addiction in these populations. And then I'll summarize and the last two slides are my most important, so I want to

make sure I get to those because they cover what I see as potential action steps, both for preventing the uptake of tobacco use in these populations, as well as treating to reduce use.

Okay, so what do we mean by behavioral health population? One measure is psychiatric diagnoses based on a very extensive diagnostic interview that takes a lot of time. Another is substance abuse diagnoses, also based on extensive diagnostic interviews. And then, behavioral health populations also can be defined in terms of serious psychological distress, and the Kessler scale is a common measure that's used there. I also want you to think about less severe conditions. People can have depressive symptoms and maybe not have a depressive disorder. People can misuse alcohol and maybe not have a substance use disorder. And those individuals can also be at risk for tobacco use.

Other people move between conditions. They may have a mental health diagnosis for a period, then not have it. It's not a permanent condition necessarily. I also want you to think broadly about this population. These are people we know. This may be us. When I worked in psychiatric facilities, sometimes yes, these individuals may be homeless. They may be living on the street, smoking heavily. They also may be COOs at technology companies. They may be artists. They may be writers. So again, think broadly here and please don't get a narrow focus.

These behavioral health populations tend to use tobacco at higher prevalence and also to smoke more cigarettes per day. As Corrine Graffunder mentioned, they're estimated to consume about 40% of cigarettes sold in the US. It's a substantial market for the tobacco industry. It equates to about 175 billion cigarettes per year, with about $39 billion in annual sales. And there are significant tobacco-related health consequences for this group: higher rates of cancer, lung disease, heart disease, and premature death.

Tobacco is the most prevalent substance use disorder. Data from the NSDUH show that there are 40 million adult smokers in the US. It's adult use in the last month. While we have had great progress and success in reducing smoking prevalence over time, the actual number of tobacco users in the country has stayed relatively stable over the last 50 years, because of population growth.

Of the 40 million US smokers, at least half of those are addicted, compared to about 2 million individuals with opiate addiction. Surgeon General Adams' remarks about how opiate use and tobacco are related to each other, not having it be two distinct camps, and how to bridge that together with the renewed focus on opiates, is a very important message.

Tobacco is the leading cause of preventable death. About half a million individuals die every year from tobacco or exposure. As Steve Schroeder mentioned, about 200,000 to 240,000 of those individuals have mental illness or substance abuse disorders. Compare that to about 33,000 who die from opioids. Tobacco is 15 times that number in terms of its effects on our nation. That's one in five US deaths, one in three cancer deaths. That's 1,300 lives lost every day. And there's no therapeutic indication for tobacco use. Opiates are used in a clinical way to treat pain,

and they do have effects that are helpful. Tobacco, when used as directed, will kill about two out of three long-term users.

There is an image of a crowded train moving down the tracks, with passengers hanging onto the sides and standing on the top. Dr. Nora Volkow, who I respect greatly as a scientist and as a leader of NIDA, did grand rounds at Stanford that focused on the opioid crisis. She included remarks around tobacco and she mentioned that the train has already left the station for tobacco use. Her point was that it's important to address opioid use now, early, before that train leaves the station. But it's important for us to remember that there are strategies to get the tobacco train back into the station.

I was asked to talk a little bit about the research on genetics and smoking. Looking at nicotine and opioid use, both have profound effects on the brain and stimulate the release of the neurotransmitter dopamine in the midbrain, including the ventral tegmental area (VTA), the nucleus accumbens, and the prefrontal cortex. Dopamine induces feelings of euphoria and pleasure. Stimulation of dopamine in this reward pathway reinforces the behavior so that it will be repeated. When they've looked at the genetics of the opioid receptor (Mu 1), it's not associated with nicotine dependence. They're not seeing a genetic interrelationship there. There is limited support for genetic influences for smoking and mental illness. The most notable is that those with schizophrenia are showing a cognitive effect with gating, being able to shut off other sensory stimulation when they're using nicotine. That doesn't mean that they have to get the nicotine from tobacco, but it can suggest a reason why you see such high use rates of tobacco use and difficulty with quitting in this population.

There are specific genes that appear to affect responses to nicotine. We see that with metabolism of nicotine. The nicotine metabolism ratio is being used in research and, hopefully, clinically, to guide which treatments would be most efficacious in terms of pharmacotherapy. And there's variance in the (CYP2A6) gene that influences the rate of nicotine clearance.

In terms of prevalence in adults, we've seen significant declines in smoking prevalence over time. But large epidemiologic studies consistently show, across the decades, very high use of tobacco among those with current mental illness. Karen Lasser's study came out in *JAMA* in 2000 and it shows the smoking prevalence for different diagnostic groups. Forty-one percent of those with current mental illness were smoking, and the rates were highest for those with drug abuse and dependence, reaching around 70%. Those with bipolar disorder also had very high rates, over 60%. There is very little research in the field on smokers with bipolar disorder.

For those with psychosis and schizophrenia, only about 45% were smokers, but haven't we heard people say that 90% of people with schizophrenia smoke? Simon Chapman was interested in this and did a meta-analysis to see if he could identify the overall magnitude of tobacco use in those with schizophrenia. He found the prevalence to be 62%, but with a very wide range, from 14 to 88%. And why is that so broad? It's because it depends on where you sample.

If I go to a state psychiatric hospital where there's still smoking allowed, and the counselors are smoking with patients, there's a lot of down time, a lot of boredom. They're using cigarettes as a way to reinforce behavior for compliance with treatment. In those settings, you will see rates of about 88%. But with Karen Lasser's work she did with community dwelling individuals, it was more like 45%. Chapman also found that research studies that quoted a higher number are more likely to be cited. And so that number gets promulgated more and more in the literature. And he also found that that was mirrored on the Internet. This 90% figure was more likely to be found when you do a search on Google. The benefits of saying a high number? It draws attention to it. But the problem with promoting a 90% number is that it seems inevitable. All these individuals must have to use tobacco, so the inference is that it must be genetically determined.

In terms of substance use, one in four nicotine-dependent smokers have an alcohol use disorder. Three in four diagnosed with an alcohol disorder smoke. Three in four with past marijuana use smoke tobacco. And nine out of ten with a drug use disorder smoke. You see higher rates of tobacco use across all products among those with serious psychological distress, but by far the most commonly used product in this population is cigarettes.

There hasn't been a lot of research looking at menthol use, but a few studies consistently show that among smokers, those with mental health conditions have a higher prevalence of using menthol cigarettes than nonmenthol cigarettes. As a policy, banning flavors, including menthol in cigarettes, could have a potential positive effect on those with mental health conditions.

I do clinical work at Stanford as well as research. The third most popular brand of cigarettes in California is Natural American Spirit. Judge Kessler in 2006 ruled that use of low tar, light, ultra-light and natural cigarette branding is misleading for consumers. In 2009, the terms were banned in tobacco advertising and branding. People think that cigarettes with these terms provide a healthier way to smoke, and rather than quitting smoking, they switch to health-oriented marketed brands, gaining no health benefit, but sustaining tobacco industry sales and profits. Natural American Spirit is in this category. Natural as a cigarette branding term is banned, yet allowed to be retained in the Natural American Spirit brand name. These are data that we have under review for publication. Among nearly a thousand individuals with mental illness in California, we found that 15% identified Natural American Spirit as a top brand. This compares to about 2% nationally. And we found that those who preferred Natural American Spirit tended to be younger. They tended to be better educated. And they also reported eating a low-fat diet and being in better overall health. At the same time, the new warning label says this product contains nicotine and that nicotine is an addictive chemical. A critically important message to get out to individuals is that nicotine is addictive. Buying this product very likely will create an addition for you.

A number of studies funded by the NIH are looking at reducing the content of nicotine in the rod of cigarettes. This is not your light, ultra-light attempt by the industry. This is actually reducing the amount of nicotine available in the rod, bringing it down to below .5 milligrams of nicotine per gram of tobacco. You've heard, I'm sure, Commissioner Scott Gottlieb talk about this being something that the FDA is interested in pursuing. And there have been studies done on smokers

with psychiatric disorders, as well as alcohol use disorders and cannabis use, that have found that these cigarettes are less reinforcing, so users start smoking less. These same studies have not found that using cigarettes with less nicotine worsened people's depression. And there's very minimal compensatory smoking found in the studies.

We also see higher use of e-cigarettes among those with mental health conditions. In one of my clinical trials, in 2009, we were not hearing about e-cigarettes at all. But after 2013, one in four participants in my study said that they had tried an e-cigarette. There was a quote in a newspaper, The *Guardian*, suggesting that giving psychiatric patients access to e-cigarettes, particularly on closed wards, is definitely something to consider. Okay, do we have any research on that? No. Do we know what impact that would have in terms of uptake on individuals who come into the ward who may not even be smokers? No. Do we know anything about second-hand smoke exposures with vaping on these units? No. But for some reason, in this article, it seems like this would be a good idea. You know, they're not recommending offering e-cigarettes to the maternity wards, or the oncology wards – only to psychiatric wards. And it was a psychiatrist I respect who made that quote.

This is a quote from Andrew Chambers, a very creative basic scientist who does basic research with preclinical work. In one of his papers, he said, "How is it that our mental health research and clinical communities focus so exclusively on beneficial effects of smoking in populations who suffer the most from it?" The research on this question centers on smoking as self-medication. Behavioral health patients need this. It's bringing them benefit. We're treating them differently, asking different questions that we do of the general population.

I'll go back in time a little bit here. A 1951 handbook from the University of California asks, Should the therapist smoke during a patient interview? The response – "Why not? It will help drain the small amount of undischarged tension which is always present. And it contributes to the naturalness of his behavior." Also, an early version of AA's Big Book study guide for the 12 steps had a story about a man in early recovery whose wife pushed him to stop over-indulging in coffee and cigarettes. This finally threw him into a fit of anger and he got drunk. Later the wife sees she was wrong to make a burning issue out of his smoking when his more serious illness was being rapidly cured. Tobacco was treated very differently, not as a problem, not as a health problem, not as an addiction, but as something that was needed therapeutically.

Moving forward, in 1980, 16 years after the first Surgeon General's Report on the harms of tobacco, the Medical Director of Saint Elizabeth Hospital in Washington, DC, wrote to RJ Reynolds requesting a donation of cigarettes for their long-term psychiatric patients because the hospital was no longer allowed to purchase cigarettes for them. He asked for 5,000 cigarettes a week to supply 100 patients who didn't have funds to buy cigarettes. I'm not pointing the finger at anybody. I'm just showing how pervasive and part of the culture it has been to encourage smoking for behavioral health patients in clinical settings.

What do we know about tobacco use in psychiatric treatment settings in terms of exposure to secondhand smoke? A very interesting study was done in psychiatric facilities. It found that if

there's a smoking room and you sample the air quality in that room, there are very high levels of particulate matter, raising the risk of cardiopulmonary and lung cancer mortality. Only full indoor and outdoor smoking bans offer protection from this increased risk.

Yet new data out of the CDC show that less than half of mental health and addiction treatment facilities have a total tobacco-use ban. Screening patients for tobacco use happens at 64% of addiction treatment settings, but less than half of mental health treatment facilities screen. Even fewer substance abuse and mental health facilities offer NRT, pharmacotherapy, or cessation counseling.

Indoor and outdoor smoking bans happen at widely varying rates across the country, and the rates between mental health treatment settings and addiction treatment settings are not necessarily correlated. So just because a state has done really well in getting smoking bans in addiction treatment facilities, it doesn't mean that the same thing is happening in mental health facilities. If you do have a smokefree facility, does that mean that you're providing treatment? No. Among smokefree facilities nationwide, a small majority provide cessation counseling, but only about a third offer NRT, and only about a quarter offer cessation medication. This just indicates how important it is to have partners around the table to get this movement to happen in a concerted, comprehensive way.

What does it mean to be tobacco-free? Doug Ziedonis and Joe Guydish have done great work addressing organizational change to help addiction treatment facilities become tobacco-free. It's not just saying no more smoking. It's also saying no more evidence of tobacco use among staff. It's also saying we'll treat tobacco use in staff. We will train staff how to treat tobacco dependence in their clients. We'll do assessments. We'll do treatment planning. We'll do referrals. So again, it's important not just to ban the tobacco. That can look prohibitive and punishing to the client. You've got to provide the caring, the counseling, and the treatment around it.

If you fail to treat tobacco dependence in mental health and substance abuse settings, you see initiation. You see relapse to use. Kaiser, which has a fantastic chemical dependency recovery program, was not treating tobacco dependence in their program, but they were curious about how tobacco use changed during the course of drug treatment. Did clients just naturally stop on their own? And they found that some – about 13% of smokers – did quit smoking. But they also found that 12% of the baseline nonsmokers, who were never smokers or former smokers, started or relapsed to tobacco. So even if clients have quit smoking, there is a real risk for relapse during substance abuse treatment.

UCSF might be the first psychiatric unit to go tobacco-free. I did a study to see whether people were being treated for tobacco use. Seventy percent used NRT during hospitalization, which is good. But only one patient out of a hundred had tobacco use included on the treatment plan. Only two were advised to quit smoking. Only three were diagnosed with nicotine dependence or withdrawal. And only four were provided NRT at discharge. And some of the participants told us that they were told to take the patch off when they were leaving, because the clinical team knew that they were going to go smoke and they didn't want them to smoke on the patch. What

happened when they left? They did return to smoking because they weren't being treated for it during the hospitalization. What we found is that most of them smoked within 5 minutes of hospital discharge**;** they were smoking on the sidewalk outside the hospital. It led me to develop an inpatient intervention in this setting that I'll talk about in a little bit.

Steve Schroeder already mentioned this earlier this morning, but there is an opportunity to make public comment to CMS on their proposal to remove tobacco screening and treatment and referrals, specifically in psychiatric facilities, which I do believe would be a step back. When you ask psychiatrists, many say that they do ask their clients about tobacco use. Far fewer say that they treat it. In fact, psychiatrists are the least likely to treat tobacco use in their patients relative to other medical specialties. When we asked individuals with bipolar disorder if their psychiatrist advised them to quit, only about 27% said yes. You also hear that some are discouraged from trying to quit smoking by their mental health providers. There was a meta-analysis looking at psychiatry providers' beliefs about smoking. The big one is that they don't believe their clients want to quit. They also have permissive attitudes toward smoking and believe that quitting smoking will be too stressful for these patients.

Is it true that mental health and substance abuse patients don't want to quit? No. The research and the studies in my lab, as well as in other groups, show that those with mental health conditions or substance use disorders are just as ready to quit as the general population. Is it everybody? No. But about one in four are ready to quit in the next month. And about 60 to 70% do want to quit smoking at some point. And even if they don't want to quit smoking, it doesn't mean there's nothing to do. There are proven evidence-based interventions that you can take to move people toward a desire to quit.

Further, we also found that there was no relationship between the severity of the psychiatric symptoms and the readiness to quit. It can make sense to clinicians to feel like their clients are too overwhelmed to quit smoking, so they don't want to bring it up. But we encourage clinicians to at least ask the question. There may not ever be that perfect window of time where all stress is gone, and symptoms are perfect and now is the time to quit. Ask them where they're at.

As you heard from Corinne, there are medications that are affected by tobacco smoke. It's not the nicotine. It's the smoke. I got a call about one of my studies. A psychiatrist was interested in referring patients to me and asked if they should stop giving out cigarettes. I asked if they were prescribing olanzapine. Yes. Well, tobacco smoke cuts the levels of lanthopine by 80 to 90%. It cuts Haldol levels by half. So yes, smoking is not consistent with your treatment. If you're asking people to adhere to these medications, then why are you reducing their adherence by having them smoke?

In another study we found that if you didn't offer NRT to patients during a smokefree psychiatric hospitalization, they were twice as likely to leave the hospital against medical advice. If you're not addressing tobacco use in the hospital, it can impact clinical care because patients may be less likely to stay to receive it.

Is quitting too stressful? There's a really nice meta-analysis done by Taylor showing that in smokers in the general population**,** as well as those with mental health conditions, former smokers are less depressed than current smokers. Former smokers are less stressed out, less anxious, and have better quality of life than current smokers. So quitting smoking actually has been shown to improve mental health, not worsen it.

What's happening upstream? This is where we'll look at the industry. There is co-marketing of tobacco use and substance use. There has been co-ownership of alcohol and tobacco use among the major brands. In San Francisco, there was a move to bring tobacco into head shops, again, cobranding across drugs. You can buy cigars that taste like all kinds of alcohol flavors. You can buy e-cigs and smokeless tobacco as well that taste like all kinds of alcohol flavors.

Philip Morris developed a CEO issues book outlining how to fight regulations related to tobacco. Focus on the user. Smoking is a free choice, it's not that the product is constraining choice through addiction. Focus on aberrant users who excessively use. It's not our product's addictive quality that's contributing to heavy use. These strategies have been used both for tobacco and alcohol and, again, the major tobacco players have owned alcohol brands as well.

Industry documents show that the industry funded research on tobacco use and behavioral health that looked at self-medicating effects of nicotine. They did not fund research that looked at high smoking prevalence and harmful effects of smoking on this population. The industry was also very interested in schizophrenia and the idea that those individuals might be immune to lung cancer. They proposed that those who denied or repressed grief were more likely to develop cancer than those who expressed emotion. Their view was, and this is a quote, that "long-term schizophrenics, outwardly calm, have no capacity for the repression of significant emotional events and no need to contain emotional conflict," and that's why they were not getting cancer. It wasn't that they were dying decades earlier before they'd get cancer. This research was called into question for its lack of scientific integrity and the industry got worried that if this research became public, it might show them to be creating an immense smoke screen. Moving forward, the industry funded researchers who wrote articles for clinical journals suggesting that nicotine could be helping those who help themselves, again the self-medication idea.

Another issue is retail density. We've been working with individuals in smoke-free hospital settings who then go home. We're interested in the extent to which their environment is contaminated by tobacco retailers, how dense their environments are with tobacco retailers. What we found in the San Francisco Bay area is that those with serious mental illness lived in areas that were twice as dense in terms of tobacco retailers than the general population. We also found the more tobacco retailers around the individual, the greater their psychotic symptoms, self-harm symptoms, interpersonal problems, nicotine dependence and then, also, their lowered perceived ability to quit and their lower readiness to quit.

Even though the tobacco industry outspends the states 18 to 1 in marketing of tobacco vs. tobacco countermarketing, there have been some countermarketing efforts focused on those with mental health and addiction. The Truth campaign did a great job partnering on some ads related

to these issues during the VMA awards. And many of you at the table here were a part of the process of working on the *Tips* ad that Corrine mentioned and that features Rebecca, who talked about how smoking affected her depression. We did an evaluation, a national survey, to see the extent to which it reached individuals with mental health conditions compared to those without. We found that of those with mental health conditions, a majority watched TV at least three hours a day and 41% used the Internet three or more hours per day. These mass media campaigns are a very effective way to reach these individuals, as well as to reach all smokers. What we found in the evaluation is that a majority of respondents had seen the Rebecca ad. This evaluation is a longitudinal study. Respondents were surveyed before the *Tips* campaign, and then afterwards. And they also saw the other *Tips* ads in addition to Rebecca's. What we found was a dose response: the more often individuals saw the Rebecca ad, if they had mental health conditions, the more likely they were to make a quit attempt and the more likely they were to report their intention to quit. The *Tips* ad dealing with mental health raised both motivation and then also behavior to making a quit attempt. For smokers without mental health conditions, the general ads also increased their likelihood of making a quit attempt. These data are under review currently.

All right, jumping into clinical practice guidelines, there are a lot of gaps. Individuals in behavioral health populations tend to be excluded from clinical trials. A research review that I collaborated on found that in a literature base of more than 8,700 related research articles, fewer than 30 randomized clinical trials addressed treatment of tobacco dependence in smokers with mental illness or addictive disorders. There have been calls saying this is an inefficient use of scarce research dollars and that it presents ethical problems if we don't get an evidence base for this population. And since 1995, research in this area has grown significantly, and that's fantastic. However, the research has been primarily descriptive, with far fewer experimental intervention studies.

Of the smokers who call quitlines, about 40% have a behavioral health condition. Of the callers to California quit lines, those with current major depression were less likely to quit than those without depression, 19% versus 28%. But still, 19% quitting within that population level intervention is fantastic. It's a very important referral source. Our colleagues in the VA tested a more tailored quitline for those with mental health conditions, one with more of a concierge approach that included proactive outreach, warm handoffs to other resources, and coordination of medications; they boosted the quit rates up to 26%. That's fantastic.

I've done some work in treatment of tobacco use in inpatient psychiatry for a range of psychiatric diagnoses. Only about 60% of clients who smoked were preparing to quit in the next 30 days, yet with treatment, we found significant quit effects at 18 months, with 20% of clients who received tobacco cessation treatment quitting compared to about 8% in the control group.
Further, we found that we didn't hurt their mental health recovery. They actually had fewer psychiatric rehospitalizations if they received the tobacco treatment than if they were in the control group. And it was also highly cost-effective, less than $500 per patient.

One of my post docs, Norman Hickman, took this intervention to the county hospital, where the clientele is very ethnically diverse with a very low socioeconomic status, and he replicated the

findings. We did another study where we added a more intensive intervention. Nearly 1,000 individuals were offered NRT during hospitalization. They're using it. We're offering it to treatment participants when they leave. They're asking for it. If they get NRT when they leave, they're more likely to make a 24-hour quit attempt. They're more likely to be quit at one week.

These are the quit rates: about 20% of those who received tobacco treatment quit compared to about 12%, 12-1/2% in the control group. We're seeing consistent quit rates across diagnoses. It's interesting to note that those with schizophrenia are not doing worse than other groups. We do see a lot of serious adverse events in these populations overall, however. We have about 30 deaths in the study and we have a lot of repeat hospitalizations. It's not easy research to conduct but it's important research to conduct. But what happens is that in these populations, there is a revolving door. They do come back into the hospital for treatment. But we're not seeing evidence that this syndrome is related in any way to our providing tobacco cessation treatment or to their quitting smoking.

There are also similar effects with depressed smokers at 18 months. Sharon Hall's work found that tobacco treatment didn't hurt their mental health recovery and didn't lead to them using other substances. These data have been replicated. Among those who were dually diagnosed, there were also significant treatment effects. Tobacco dependence treatment didn't hurt their substance use outcomes. Miles McFall's work in the VA system, integrating smoking cessation into PTSD care, showed a doubling of the likely quit rate without hurting client PTSD recovery, and also showed cost effectiveness.

Varenicline has been used in smokers with depression, with significant treatment effects over time and no significant difference in serious psychiatric adverse events. Varenicline has been used in those with schizophrenia. Jill Williams is the lead author on one study showing significant effects post-treatment and a six-fold increase in cessation at 24 weeks. Eden Evins did a great study on patients with schizophrenia, continuing the varenicline longer and seeing the quit rate after Week 76 showing significant effects at all time points.

The data from the Eagles study of patients with different psychiatric disorders showed that varenicline, bupropion, and the nicotine patch outperformed the placebo in all of the different diagnostic groups and showed no uptick in mental health symptoms over time. A 2010 meta-analysis looked at bupropion use in those with schizophrenia and found a relative risk of 2.78 for the treatment effect.

It's better than even the general population. Is it that Bupropion is so much better in that group than in the general population? No. It's that if you give a placebo to somebody who has schizophrenia who smokes, they're not going to quit.

In addiction treatment and recovery, a meta-analysis I conducted some time ago showed significant treatment effects at the end of treatment for tobacco dependence. It was not sustained at long-term follow-up, but we also did not see harm to recovery. And we actually saw a 25% increase in abstinence from alcohol and illicit drugs.

There was a systematic review done more recently, in 2016, and a variety of different treatments worked in some studies, but they didn't work in other studies. So there really is some inconsistency and we need a better understanding of these data. For example, in a recent trial, we continue to see paying people to quit **as** working and paying them to stay quit, but then quit rates go down when the payments stop. Varenicline did better than the patch initially at three months, but then that was gone at six months and that was among smokers with substance use disorders.

A pilot tobacco treatment element within methadone treatment, using information-motivation-behavioral skills intervention, is showing good acceptability, showing some promise with quit attempts and abstinence. The results have not proved to have significant effects but they are showing some promise. Sharon Hall's work recently in opioid-addicted individuals who are on buprenorphine documented increased quit attempts, increases in their abstinence goals, and furthered their movement through stages of change, but did not affect their quit rates. We definitely need more research in this population.

So overall, research shows that yes, we can do it. The standard treatments for smoking cessation work for behavioral health populations. They are not hurting the mental health recovery process. Integration of cessation treatment within mental health and substance abuse treatment improved access to smoking cessation, supported movement through the stages of successful cessation, and proved to be highly cost effective.

I figure the reason I might have been asked here today is to help. Maybe it's presumptuous of me to offer some action steps to this impressive committee, but if I had a position of power that many of you do around the table, this is what I would like to see happen. I'd like to see graphic warnings about addiction on tobacco cigarettes, banning the use of the word "Natural" in tobacco branding and marketing, and banning the sale of flavored tobacco, including menthol, in all tobacco products. A recent effort to enact such a ban in San Francisco was successful. I'd like to reduce nicotine in all tobacco products to nonaddictive levels, raise tobacco taxes, prohibit tobacco retailers within 500 to 1,000 feet of behavioral treatment settings, and adopt tobacco-free campuses in treatment settings as well as bars and restaurants, because that also reduces smoking in behavioral health populations. I'd also like for all of us to stay vigilant.

In terms of action points for treatment, I think including behavioral health populations in countermarketing campaigns, especially *Tips*, is very important. They've done that in the most recent *Tips* campaign, which is fantastic. Including behavioral health populations in treatment research and reporting on subgroup effects is also very important. I'd like to see tobacco use treatment for frontline behavioral health staff, tobacco cessation treatment integrated into behavioral health treatment, and treatment of tobacco use covered under behavioral health CPT codes. And I'm hopeful that Jill will mention this during the panel because often it's covered under education codes rather than behavioral health codes, which is not consistent with other addictions. Finally, I'd like to see mental health consults integrated within quitlines and a Surgeon General's Report on tobacco use in behavioral health populations.

I know we've covered a lot this morning, but this is a very important topic. Thank you for your attention and for inviting me to be a part of this meeting.

The National Partnership on Behavioral Health and Tobacco Use
Cliff Douglas, J.D., Vice President, Tobacco Control
American Cancer Society

Simon McNabb: So now, keeping us moving, I'd like to introduce Cliff Douglas. Cliff Douglas is the Vice President for Tobacco Control and Director of the Center for Tobacco Control at the American Cancer Society, Inc. He is an expert on a wide range of tobacco-related health, regulatory and legal issues developed over a 30-year career serving in a variety of policy, advocacy, leadership**,** and academic positions.

Cliff Douglas: First of all, let me thank you for the opportunity to be part of this meeting and also let Surgeon General Adams know I just tweeted a quote from you from today which I thought was wonderful. It was that people need to know that you care before they care what you know. Wonderful, simple while complex guidance for all of us. Thanks.

I also want to thank Jodi Prochaska. I was an English major, so I appreciate your help with the science. And I want to thank the committee and again Dr. Adams for this special opportunity to tell you about the work of the National Partnership on Behavioral Health and Tobacco Use. What I'm going to do in the next few minutes is break this down into eight parts, but they are simple. First of all, I'm going to tell you just a little bit about the American Cancer Society's work overall, but particularly with attention to this issue. Second, I'm going to talk about our work with partners and the importance of partnerships. Third, our collective recognition of the problem which has already been laid out very nicely and our launch of the new initiative and who is involved. Fourth, our prevalence goal for 2020. Fifth, what our many partners are doing, and Sixth, the progress that we have collectively made in the last couple of years. Seventh, the goal that we have of eventually forming a national roundtable. And then finally, what our federal partners can do, which was one of our asks for today and we appreciate that opportunity to humbly share some thoughts.

First of all, let me just touch on the American Cancer Society's priorities and what we are committing our time and resources to these days. We formed our new Center for Tobacco Control in the summer of 2015. I came to the society to help launch the center. We established the center to combat tobacco-related disparities in communities suffering from higher tobacco use rates and a disproportionate incidence of tobacco-caused morbidity and mortality. These communities include**:** individuals with mental health and substance use disorders, low SES status, racial and ethnic minorities, LGBT individuals, and the homeless, among others. One of the top priorities is supporting people with mental health and substance use, or behavioral health disorders. We focus overall on disparities, and many of these communities overlap. For example, we've commissioned research on the homeless where, needless to say, overlapping with these other populations is not uncommon. They have very high smoking prevalence.

We have come to emphasize, as was emphasized in the 2014 Surgeon General's Report, the need to focus on combatting combustible tobacco use because we know that of all the tobacco product usage in our society, cigarettes alone are responsible for something on the order of 98% of all of the tobacco-related deaths in the United States. Clearly this class of tobacco products deserves special attention. Earlier this week, ACS released our two-years-in-the-making Public Health Statement on Ending Combustible Tobacco Use in the United States. And I commend your attention to some of our thoughts there and the science that we presented in support of taking this priority approach on combating smoking in particular.

At the ACS Center for Tobacco Control, we are emphasizing partnerships. One that's particularly relevant today is our wonderful collaboration with the Smoking Cessation Leadership Center at UCSF led by (Steve Schroeder) and supported by the great team there. We established this partnership in 2015, focusing on reducing tobacco use among smokers with behavioral health disorders. I want to particularly recognize the leadership of Steve and also of my boss, Rosie Henson, who for many years was at CDC and in the Office of the Assistant Secretary for Health, HHS, in launching this collaboration. Without your vision, I wouldn't be standing here talking about this today. Thank you again, Steve.

ACS and the Smoking Cessation Leadership Center agreed that national leaders from the tobacco control/public health community and the behavioral health sector should be brought together to develop a plan to expand and accelerate efforts to combat disparities in smoking prevalence and promote tobacco use treatment for those with mental health and substance use disorders. I'd like to note that this involves, as I will be laying out in more detail, a combination of the public and private sectors –federal and advocacy groups, provider associations, as well as the pharmaceutical industry. Having the behavioral health and public health communities in the same room makes this a first-of-its-kind endeavor.

When we look at all of the tobacco-related disparities, the behavioral health population is arguably the most significant in our society. Data from SAMHSA's National Survey on Drug Use and Health from 2008 through 2015 show that smoking prevalence among adults with behavioral health conditions is consistently about double the prevalence among adults with no behavioral health condition. Based on the urgent need to address tobacco use in this population, ACS and SCLC organized the first national summit in October of 2016. The participants included senior leaders of health professional organizations and our federal partners, not-for-profit health organizations, and a number of experts in behavioral health and in tobacco prevention and cessation. Some of them are here today. If I had time, I would recognize each one individually, but thank you for everything you've been doing for and with us throughout this time.

The summit produced a rather detailed national action plan that set forth practical strategies in the areas of networking, education, and clinical guidance to strengthen tobacco use prevention, to increase cessation, and ultimately to reduce prevalence among behavioral health populations. And based on that success and the progress that many of the participants have been making, we have determined that we are going to hold Summit number two this November, again in Atlanta.

We're very much looking forward to that because we know people will be coming with good news and optimism at the same time that we will be addressing ongoing and significant challenges before us.

We have about two dozen partners involved in this collaboration. One of our more recent additions is the Robert Wood Johnson Foundation. It's a remarkably diverse collaboration. This is a detailed list of everyone who is involved in this effort:

American Academy of Family Physicians
American Cancer Society
American Cancer Society Cancer Action Network
American Lung Association
American Psychiatric Association
American Psychological Association
Centers for Disease Control and Prevention's Office on Smoking and Health
National Alliance on Mental Illness
National Association of State Mental Health Program Directors
National Council for Behavioral Health
North American Quitline Consortium
Optum
Pfizer, Inc.
Robert Wood Johnson Foundation
Substance Abuse and Mental Health Services Administration
Smoking Cessation Leadership Center
Tobacco Control Legal Consortium
Truth Initiative
U.S. Department of Housing and Urban Development
U.S. Department of Veterans Affairs
United Health Group
University of Wisconsin—Center for Tobacco Research and Intervention

We agreed that we would aim for an ambitious, but we do believe an attainable, target for 2020, to reduce the smoking prevalence among the overall population of people with behavioral health disorders from 34.2% in 2015 to 30% by 2020. We've already given it a hashtag, "30 by 20," and we're looking forward to finding out from SAMHSA sometime this year how we're doing so far. What this amounts to, to put it in dramatic but realistic terms, is a campaign for a million lives. With roughly 22 million smokers in the behavioral health population in the U.S., if we reduce prevalence from 34. 2% to 30%, we would be down to about 19.5 million smokers in this population. That would predictably result in roughly 2.5 million fewer smokers and could thereby, because we know how this works, avert more than one million smoking-related deaths over time. Appreciation goes to (Steve Schroeder) for having conceptualized this initially and really putting in simple terms the enormous opportunity that we have in pursuing this.

And I think this short-term campaign highlights the landmark nature of this meeting, and I again thank the Surgeon General and CDC for having us here to focus on this today.

I heard the term “tipping point” used earlier today by Dr. Everett. We believe that through all of these efforts we are at a tipping point, and that through the national partnership initiative and working with all of you as reflected in this meeting, we're accelerating progress and we are on our way to achieving the significant gains that we suggest here.

When we held the summit in October of 2016, we developed an agenda for action. Every participating organization and agency made commitments to take specific actions to educate and guide their constituencies of professionals and consumers and also to expand their work on these issues with the public. These are the action areas in a nutshell: peer education, data, research, policy, systems change, and provider education.

Next, I’d like to take a look at what's been happening and give credit where it's due, which is in many places. I'm going to try to walk through this relatively quickly. I believe you have these details before you as well.

The National Association of State Mental Health Program Directors issued their policy statement on tobacco cessation in all behavioral health settings in recent months, calling on all of the behavioral health facilities in the US to go tobacco-free and provide cessation services to their clients.

Optum is one of the leading quitline providers in the United States, and they finalized development of a Tobacco Cessation Behavioral Health Program supporting about 1,300 participants with behavioral health conditions. Following successful evaluation of this program, they partnered with four states to offer the program to state quitline callers who reported behavioral health conditions. I would also note that Optum plans to launch a pilot in 2019 that will combine quitline coaching with in-person counseling specifically focused on behavioral health.

The VA executed a collaborative agreement with the American Cancer Society to further cessation efforts throughout the VA system for their behavioral health population.

The National Alliance on Mental Illness has added cessation to peer education and will offer 2,000 1-800-Quit-Now cards at their annual conference within the next few weeks here in Washington.

The American Lung Association has been a leading partner in this space for a long time. I tip my hat to Pat McKone and team for all of the work that you have been doing. Recently, ALA has been working with Easter Seals to promote cessation for the staff and clients at 11 local affiliates, four of which specifically have focused on the behavioral health population.

The American Academy of Family Physicians has disseminated its own new educational materials on tobacco use and behavioral health.

SAMHSA has done a number of things: made presentations on tobacco use in behavioral health to HRSA and before the HHS tobacco control steering committee and in other places. It is also funding the creation of a center of excellence – I believe it is the first of its kind – for tobacco-free recovery.

The APA is developing promotional materials, including a video focused on eliminating smoking in mental health facilities, among other actions.

And, as reflected in the visual, the CDC has done more than I can even begin to summarize. Of course, CDC deserves particular thanks for recommending the focus of this meeting today. You expanded the focus to smokers with behavioral health conditions as a priority population, and seeing this priority need addressed in the *Tips* campaign is fabulous. We hope to see that expand going forward.

Pfizer is active in this space as well, working with ALA and the National Alliance on Mental Illness to focus on behavioral health and tobacco use. I hate giving short shrift to any of our partners, but I am sure you have gotten the clear idea that there are many ongoing individual organizational efforts, and each one of our partners is contributing to the very real progress that has been, and will be made.

I would just add that, with regard to the American Cancer Society, our decision from the beginning was to maintain our financial and staffing commitment to sustain the National Partnership on Behavioral Health and Tobacco Use and to support the involvement of the Smoking Cessation Leadership Center as our expert secretariat.

Considering all of our collective effort and the progress we are making, I am reminded of what Corrine Graffunder noted earlier about the best practices approach to tobacco control. When you pull all of these efforts together, not only is each of them impactful individually, but we are also accomplishing great synergy. Indeed I think we are reaching critical mass, and that is why we are at a tipping point now where the social norms among practitioners and in public attitudes are starting to shift more rapidly.

As I noted at the outset, we established the goal of elevating and expanding this effort to roundtable status. That's a special status in ACS that serves as a way to elevate and strengthen our efforts in a given area and develop a longer-term, sustained infrastructure for conducting activities. The establishment of a roundtable would strengthen our networking and coordination. The American Cancer Society has a number of roundtables, in collaboration with CDC and other partners, and has met with great success through this vehicle.

Let me conclude with this, because a particular focus of today's meeting is on what your agencies can do to strengthen efforts in this area. We have a series of recommendations, some of them

fairly specific. They come from our partnership and I was delighted to get a lot of input from our partners. The first recommendation is directed to the Surgeon General, and that is to serve as a public spokesperson for the issue of tobacco use and behavioral health. Dr. Adams has already addressed the second recommendation very nicely, which is to address co-occurring tobacco use when talking about the opioid epidemic. Thank you for accomplishing this, Dr. Adams. But we do look forward to working with you on incorporating messages around tobacco use wherever possible for the reasons that you stated so eloquently. And we do appreciate your making it a high priority to serve as a public spokesperson for the issue of tobacco use in behavioral health.

The NIH, we think, could do some other things that would be of value, including supporting more research on smoking cessation medications for the behavioral health population and, potentially, trials of e-cigarettes for cessation in this population. We know that's an area of great interest and more research is needed when it comes to the potential for e-cigarettes or other electronic nicotine delivery systems to be used in connection with cessation. And, currently, these have not been reviewed or approved for cessation by the FDA. There have been a number of studies. The data are mixed. They might work. They might not. They might even be detrimental. They might help a lot. We are looking for some more help in that scientific area and participation by NIH could be of great value.

With the VA, we recommend that cessation be promoted particularly to student veterans who smoke and customized cessation services be provided within community colleges and universities. At many college and technical schools, students are young adults who use their GI bill for school after service; this also ties in nicely with our own national Tobacco-Free Generation Campus Initiative, supported by the CVS Health Foundation. We are focused on supporting the increased adoption and effective implementation of 100% smokefree and tobacco-free policies on college and university campuses around the country.

With DOD and the VA, we would encourage addressing the relationship between PTSD and smoking, and specifically looking at whether cessation helps in the treatment of PTSD. For NIDA, we would encourage strengthening treatment approaches for co-occurring opioid and tobacco use as well as marijuana and tobacco use, which is a burgeoning area of interest for obvious reasons. And then, finally, we think that HRSA could design a smoking cessation program specifically targeted to behavioral health populations, create incentives for more integrated care clinics (behavioral health and primary care), and set a goal to help all FQHCs develop a system for bidirectional quitline referrals.

The Department of Housing and Urban Development is on the cusp of implementing one of the more significant federal regulatory schemes in many years that promises to further reduce smoking and tobacco use in this country when public housing authorities go smokefree at the end of July. We think it would be helpful to develop or solicit the production of new smoking cessation resources tailored for public housing residents and to provide opportunities for funding to support execution of the new smokefree housing rule.

HUD's Healthy Homes program already offers a toolkit and other downloadable material. It is

wonderful material and (Peter Ashley) is here and we thank you for your leadership for so many years in getting us to this point. What might be helpful in addition to those materials would be to offer additional training for PHA administrators, health educators, and others in this area.

At CDC, well you're really doing a lot. We think it would be valuable to produce more *Tips* campaign ads, especially for smokers with co-occurring substance abuse, which has not received as much attention. At SAMHSA, making tobacco use and behavioral health an even greater priority would be valuable, as would improving the access that states have to NSDUH and NSATS, the two large databases managed by SAMHSA. I understand that it can be cumbersome to get into them. BRFSS has been highlighted as an example of access that is easier, with the data being more accessible to researchers.

With CMS, the National Quality Forum, Steve Schroeder and others highlighted this earlier and we agree and encourage CMS to not remove the screening or other measures for tobacco and alcohol that are collected during psychiatric inpatient hospitalization. It's not a time to pull back. It has made a difference in the right direction and we should keep going. A number of groups will be submitting some detailed substantiated comments to the agency about this issue.

Finally, to all agencies, this would be our overarching message. Please, in partnership with all of us, do engage in robust public education about the relative harms of combustible tobacco products versus other products including e-cigarettes. Again, I commend your attention to the American Cancer Society's new scientific position statement in that area. And overall, we ask other agencies to give the attention that's needed to help roughly half of our smoking population who are dealing with behavioral health disorders to overcome their dependency on combustible tobacco products and, where necessary, to take on the tobacco industry for the role it plays in encouraging and enabling these comorbid conditions. Let’s not forget that this is an epidemic with a vector. Just as malaria has mosquitos, we have the tobacco companies, without which we would not be facing this deadly epidemic.

Thank you very much.

Simon McNabb: Thank you, Cliff. Thank you, Jodi. We're going to open up for some dialogue and questions before lunch.

Discussion with Committee and Presenters

Vice Admiral Jerome Adams, Jodi, and Cliff, thank you so much. Cliff thank you so much for bringing up Malcom Gladwell and the Tipping Point. I tend to think of my job as to create tipping points, to create those discussions that lead to a change in social norms, especially if people stop doing bad things and start going good things. I challenge folks to think about that. Gladwell talks about the three ingredients: you can be a connector, an information specialist, or a salesman, but you need all three of those

ingredients to change a social norm. Think about how each of you can play your part in changing the bad norms and creating the good norms.

A quick question for Cliff or for anyone else: Do we know the percentage of those with behavioral health conditions who are employed? And digging even further, employed and covered by their employer? Because interestingly enough, when I was in Indiana, we went to Fort Wayne. We were looking at their overdoses and we were shocked to find that 70% of their overdose deaths were among employed people. It shows the stigma that even we can have in terms of trying to figure out which populations we affect. My worry is that we tend to think of folks with behavioral health conditions as being institutionalized and unemployed. I don't know the answer to this question, but I would guess that the majority of the people we're trying to reach actually are employed.

When you talk about employers, they control the environment that folks are in; they control the coverage that folks have for different services, the services we're trying to help provide for them if they have insurance. They can certainly control the policies in their communities in a way that we can't**,** and they're the ones who are bearing the burden of the cost of smoking. I think it's critical that we at least know to what degree they are bearing the burden and ways to intentionally engage them if we're moving forward and that we don't exclude them, because I know at least some of the folks with behavioral health conditions are employed and as employees are covered. And I would dare say that probably the majority of the folks that we're talking about are employed.

I'd love Cliff's or others' thoughts, and for Jodi, two quick things. You talked about the FDA's efforts to get combustible cigarettes down to nonaddictive levels of nicotine. I know there's a lot of debate in the scientific community about whether that's even a real or valid term. We know the response relationship between levels of nicotine and addictiveness. Is there such a thing as a nonaddictive level of nicotine? And are we creating a dangerous and slippery slope by suggesting that there is a non-addictive level of nicotine. I would love your thoughts on the research on that.

And then finally, I'd love your thoughts on the research on best practices of integration and co-quitting. I go to my tobacco folks and they're out talking about nicotine replacement therapy and how we can get doctors to incorporate it into their practices and best practices, but they know nothing about MAT. And then I go with my addiction folks and they're out getting doctors to learn about how to become MAT providers and get data waivers and they know nothing about nicotine replacement therapy. It's easy for us to say that we need to treat the two as the same, but in my own personal experience, the folks don't have the experience on how to integrate both of them. And they're coming at the same providers and the same community resources from different areas. I just don't know that there's a lot of research and best practices out there on how to do both together.

Cliff Douglas: To the first issue you brought up, employment, I don't know if those data are available. Perhaps others in the room would know and if not, it points toward some good research questions.

Unemployment overall is at three point something percent. Now you can have a very high percentage of folks - half the smoking population - dealing with these issues who are actually in the work place. And that in many ways presents us with an opportunity for intervention, for support, for reaching them and in the many ways that will evolve. You know insurance coverage has to be addressed in one category and all of the wellness programs, etc., supporting folks.

I think one thing that people will also understand here, particularly from the behavioral health community, particularly those who are dealing with certain behavioral health conditions - those with bipolar illness for example or chronic depression – have difficulty in the work place, they face stigma. That's a whole area of focus in the field. They are not experiencing the same types of life within the work place that other people not dealing with those issues are.

But what it means on the positive side is that if they are seeking support, if they're seeking treatment, it adds another element of opportunity to work with them on their smoking status. We have to think about it in those terms. Before I turn it over to Jodi, I thought I would just add that I've been working on the potential goal of reducing nicotine to nonaddictive levels since about 1992. I editorialized about it in *Tobacco Control* in 1998.

What we know now, because we have a lot more science at our fingertips, is that our lead researchers like Dorothy Hatsukami, Neil Benowitz, Eric Donny**,** and others have looked at the addictive threshold and they have studied smokers. This is what FDA is looking to and relying on to determine that, if you reduce nicotine below a certain threshold, it just becomes impossible or close to impossible for most smokers to sustain their addiction using those products. And while it's complex, it means it can enhance our efforts to intervene with cessation options and/or to use products that will not likely kill them that may be down on the other end of the continuum of risk. We can look at it that way. But I think**,** clearly, there is that scientific option of rendering those products not addictive. Jodi can probably say more about it.

Dr. Judith Prochaska: I hesitate to say this, but there's a lot of research out there. I really appreciate your focus on partnership with employers and looking at employability. There's a line of research that I've been doing with unemployed individuals who smoke and are seeking employment. We are using that as an opportunity for intervention for those low on resources in terms of finances**,** but we've shown that those who smoke have a much harder time getting re-employed compared to nonsmokers.

Even when people are employed, you see disparities in terms of what the environments are like. California was the first to have smoking bans in the work place, '94. But there were still a number of loopholes that were left open. If an individual worked in construction, warehouse facilities, or hospitality, they were much more likely to be exposed to tobacco. We have challenges with people who are on the Stanford health plan who are trying to get coverage for smoking cessation. A lot more needs to be done to create that level playing field in terms of access to treatment.

With the nonaddictive levels of nicotine, there is very little compensatory use with these reduced nicotine cigarettes. Could we bring nicotine down to zero? Would that be even better? Absolutely, but there were negotiation processes in the regulatory issue, so that can't be done. With the research that's been done, it's been with research cigarettes and it's very likely that if commercialized, the industry would make their very low nicotine cigarettes more attractive by adding more sugar, ammonia**,** or other features and marketing them in different ways than the basic packaging of research cigarettes. So I think it's very important that the regulatory steps are vigilant in overseeing and evaluating new and adapted products proposed for market.

I want to thank you. You are on our RX for Change curriculum that we have, and we have focused on that with health providers, psychiatric providers**,** as well as addiction treatment providers. The training piece is key. When I've done trainings, the big message has been that most providers know what to do. They know how to treat depression or anxiety or alcoholism and those strategies are essentially what you need for treating tobacco. It's really not that different. But breaking down that barrier, making it a priority, making it part of the job is really key to getting it to happen.

Dr. Susan Curry: I found an article on the employment status of people with mental illness. Data from 2009 and 2010**:** the number does decrease with increasing mental illness severity. But if you have none, it's 76%, mild 67%, moderate 63%, serious 54% employed. So that's still over half.

I want to give a shout-out to Jodi for the work that she does, and I want to add that if you want to get research into practice, you have to get practice into research. And I think the work that you and others do shows a commitment to doing that. The bar for dissemination is lower when you've partnered with the organization that you want to have evidence-based interventions to disseminate.

There's a point in time where you reach an age that could be called a déjà vu age, and I'm having a little bit of that. Back in 2002, I was on a subcommittee to this committee. Mike Fiori, who's in the audience, chaired it and we released a report called *Preventing 3 million Premature Deaths and Helping 5 Million Smokers Quit, a National Action Plan*. It still exists and I want to put out a suggestion to not forget to bring the past into the present because there's a list of federal actions in that plan, some of which have been operationalized, but some haven't, mostly due to lack of political will. I cannot find a

single statement in there about disparities or priority population. I mean, it was focused at the broad population.

In the report, there was the suggestion to raise the federal excise tax on tobacco products and use the proceeds from that to establish a fund. That fund would be used to increase the reach and effectiveness of interventions. If we were to reconvene that group, the fact that we've made progress over the last 16 years or so is evident. But the disparities haven't gone away and I think we would quickly get to that. So I just want to make sure that with the ACS initiatives and so forth, we don't lose the great work that's been done.

Denny Henigan; Thanks to Jodi and Cliff for really outstanding presentations. Jodi**,** I want to particularly refer to your list of the federal agenda that you would like to see advanced because I can't think of a better presentation of a federal agenda that could make a huge difference.

There's been discussion of FDA's initiative towards establishing a product standard for cigarettes that would lower the nicotine in cigarettes to nonaddictive levels. Obviously, that could have historical consequences. Another aspect of Commissioner Gottlieb's comprehensive plan that hasn't gotten as much attention, is the effort by FDA to revisit the way the agency has addressed the whole issue of medicinal nicotine. That brings to mind a question: Among this behavioral condition population, what is the prevalence of use of FDA approved cessation products? Not just NRTs but all approved products. There was some reference to the use of those products in institutional settings, but I'm wondering what the overall prevalence may be?

And also, keep in mind that FDA has established a Nicotine Steering Committee which is assigned the task of reevaluating the agency's approach to this in a very comprehensive way. I'm wondering if the speakers could comment on the importance of that committee actually taking into account this population, as well as the importance of ensuring that this population**,** as well as the general smoking population**,** get access and greater use of more effective cessation medicines.

Dr. Judith Prochaska: The best data would be from CDC. There was a report done in 2017, I believe, that looked at use of different treatments for quitting smoking. It was in the general population, but they certainly would have the ability to carve out for those with SAD's or psychological distress**,** and I don't think that report did at the time. The report found that the majority were quitting cold turkey; the general population. Nicotine replacement therapy and e-cigarettes were pretty comparable in prevalence of use. And then varenicline and bupropion were less prevalent. But that would be really interesting to see. Thank you.

Dr. Jill Williams: I agree with Jodi. I don't think anybody's really looked at that specifically. But remember that that's limited by access and in many states, people can't access these medications. I'm going to present a brief case this afternoon. Someone with

schizophrenia who received Medicaid as his insurance had cancer twice and yet New Jersey Medicaid would not allow him to use nicotine replacement. So it's hard to know when we're counting, what we're really counting because there are so many barriers that still exist.

Denny Henigan: Right, and the public health community, I think, has been concerned for a number of years that even among the smokers who very much wanted to quit and were trying to quit, few actually used these FDA-approved medications. We have been urging FDA to look at various barriers that may exist to introduce these products and to encourage greater use of these products.

Dr. Jill Williams: This is a population that in many ways is not biased against medications in the same way that the general population might be because they already may be taking medications. So I haven't seen that to be a tremendous barrier, people are usually open to medications. Being able to get them is the challenge.

Dr. Kenneth Warner: Thank you. Just one comment to follow-up with on the use of medications. One of the problems with over-the-counter nicotine replacement therapy is that people don't use it properly. I've spoken before a dozen or more groups of primary care physicians and when I asked them if they know how nicotine gum is supposed to be used, the basic answer is I have yet to find a single member of one of those audiences who understands you're not supposed to chew the gum. Now that's frightening to me because that's the simplest of all messages. I mean obviously it was a misnomer to name it gum in the first place. But the fact that we can't get a basic message like that across to doctors, yet we expect people who are smokers to be able to figure out how to use this stuff.

Like Sue**,** I have some history with this committee. I've only been a member of it for a couple of sessions now, but I have spoken before it 20, 30 years ago a few times. And I'm giving away a dirty little secret here that I suspect everybody in the room knows. Please forgive me, I tend to be kind of direct on occasion. This committee has a long history of discussing important issues and coming up with some terrific ideas and then having zero follow-up. I can't tell you how many of the meetings that I have personally attended where there's some terrific suggestions for the various agencies, but they just never materialize. And what strikes me about this meeting is that we're talking about something very important here. It may be the most important thing in smoking because let's face it, the rates of smoking are plummeting and that's a great thing. Smoking cessation rates have gone up in the last few years. That's a great thing. But it does mean that we're going to be left with more and more of the disparity rather than less of it.

We've had two speakers here who I thought had great talks. I particularly liked the way Cliff laid out an agenda for what each of the agencies could do. And I realize this is probably not very realistic, but I would love to see the outcome of this meeting be a

specific agenda of to-do items, realistic to-do items for each of the agencies here and a follow-up meeting planned and some follow-up to make sure things actually get done.

I mean Cliff has been in the field 30 years. I've been in it 40 years. We've seen too many instances of good ideas just not getting traction because they don't get engaged by the agencies that need to do it. So I hope we'll come with something more than the usual here's the agenda, for the future.

Simon McNabb: I think that we can commit to take the suggestions that we received and what I'd like to do is consult with the public members and say**,** "this is what the committee heard, this is what the committee set forth." And then I think that I work with Dr. Adams, then from Dr. Adams and the DFO, this can go to the agencies.

And I think that the challenge with this is that we are created by statute. And the statute created us to advise and gave us no specific mandate to act. And so your descriptions are accurate. And so it's up to all of us to take what we hear back and be leaders in our own agencies.

Dr. Wilson Compton: Thank you for the opportunity to highlight what I think the National Institute of Health, in particular the National Institute on Drug Abuse, has already been doing to address some of these disparities. We've had an initiative in conjunction with NCI and NIMH to develop new treatments for persons with schizophrenia who smoke. We're waiting to see the results of some of those studies. This is a major priority for the National Institute on Drug Abuse. I was really pleased to see laid out some of the opportunities for us to continue to contribute in this area with better treatments for a population that has not always been well-served by our current treatment.

I had a question for the two speakers related to this. Because both of you highlighted NIH and NIDA (and for some reason NIDA was singled out like we weren't part of NIH, but we are) around the importance of randomized trials for smoking cessation. My sense is that to a certain extent, we don't always need different treatments, we need implementation of what we know works for a population that's been ignored. What do you see is the balance between efficacy research versus the implementation of things we already have a pretty good idea will work in a population that hasn't had the benefit of them?

Dr. Judith Prochaska: I would say I singled out NIDA because you've led in this area, but the grants that I presented today have been funded by NIDA, NCI, NIMH and the VA; so many agencies contribute to this effort. I didn't hear if NIMH is here today at the table, which I would encourage.

In terms of effectiveness, trials are absolutely needed, and I would totally agree that we have evidence-based treatments**,** and a big issue is that they've not reached the populations that clearly need it. Going into psychiatric settings, addiction treatment

settings, going to implement development departments, going to the settings where these individuals are presenting is key. In terms of implementation science, it's a challenge to get funded. I've had that experience through that review committee. I've tried that, and I would love to try again, but it's a challenge.

Capt. Kimberly Elenberg: I just I wanted to let you know that as a result of this Federal advisory committee, the Department of Defense was able to do the first comprehensive DOD tobacco strategy ever. I'm sitting next to my colleagues from housing, and we now have a no-smoking policy in multiunit housing as a result of this guidance. I wanted to share that all of the policies that came forward are in the back of the book, and it couldn't have happened without the connections here. Today specifically, some of the contributions and the comprehensive addictive strategy that we've talked about that has been reinforced today, we've already reached out. The VA and DOD are going to follow up. We're looking at ways in which we could potentially work on a comprehensive strategy that potentially addresses tobacco, opioid, and alcohol misuse.

I learned from you, ma'am, that we really need to go back to our clinical providers and find out what are they suggesting? Are they screening for tobacco use? What's the cultural belief that they hold? And do we need to address that through the DOD Psychological Health Readiness Group and through the Addictive Substance Misuse Advisory Committee? Lastly, the data on cumulative research that you asked about, you're 100% right. One of the things we are working closely with is to find out if you are treating reserve components and National Guard members?

I know we don't have a formal means for measuring the impact of these meetings or what's spoken about at these meetings, but I wanted to bring to the table a very tangible impact that this group has specifically had on the Department of Defense**.** I want to take the time to look around at my partners and thank you all for bringing the research - for sharing the research or sharing your experience and sharing your wisdom and your guidance.

Dr. Steven Schroeder: Cliff**,** it is so great that ACS is setting such a high profile because the brand of ACS is just so strong. Hats off to you. And to the comment on employment**:** if you come to a job interview at most places and your fingernails are brown and your clothes smell of tobacco, you're not going to get hired. (Jodi) I want to ask you a question about e-cigarettes in the behavioral health population. What's your sense? I know there's not a sufficient amount of research, but is this promising? Is it questionable? Come back to that.

And then**,** finally, a couple of policy options that I either didn't hear emphasized or didn't hear. One is getting menthol out of cigarettes. And the second is for CMS: We talked about getting the measures in psychiatric hospital, but more behavioral health smokers come to general hospitals because of their heart disease, cancer**,** or their COPD. I know CMS has been thinking about instituting incentives to put those measures into general

hospitals**,** but haven't done that yet. That would help behavioral health smokers more than doing it in the mental hospitals. I wanted to get your comments on those policy options.

Dr. Judith Prochaska: Thank you Steve, you are a wonderful mentor as well, so thank you. In terms of menthol, absolutely, take it out. San Francisco recently did do that. They banned all flavors including menthol. Oakland did as well. San Mateo County, and I'm helping in Marin County with that. I'd be happy to have you join us on the efforts in Marin.

In terms of e-cigs, to do research on e-cigs for cessation, I left suggestions to fund research – to do research on e-cigs for cessation, but it takes more than money these days to do that in the US. There's regulatory restrictions on what can be done. Some of the issues that Denny raised around how medications are regulated by the FDA, that's how e-cigs are concerned here as well.

As a researcher, even if I scored really well on a grant to test e-cigs or cessation, I can't do that study unless I have an approved indication to use that drug, to have it cross state lines and, for me to give it to patients and to test it for that indication. Unless an e-cigs company has the means to have the data, the animal data to bring it to CDER to get that Investigational New Drug application (IND).

It is possible for e-cigs companies to do it. The question that has been raised is why do we need animal data when people are using these devices in such large numbers? Clearly they're not instantly killing people so they can't be that harmful. So there's been questions to try to loosen up the restrictions at FDA to allow researchers to see if these devices help people quit. Are people using them? Absolutely. Adults, kids and so forth. Can they help people quit? Maybe, but we need control trials to fully answer that question.

Dr. Steven Schroeder: What about the general hospital?

Dr. Judith Prochaska: Are you saying the joint commission does go to hospitals and they do need to ask and have meaningful use criteria around tobacco? I say it's done better in the general hospitals than in the psychiatric facilities.

Dr. Steven Schroeder: CMS has not yet created incentives the way it did in the psych hospitals.

Dr. Joe Parks: The rest of the issue here is that there is a bonus incentive payment for making the performance indicator that you screen people from tobacco and then you offer them cessation in the hospital and discharge including a prescription. That applies to psych units in general hospitals currently, to general psych**,** and to free-standing psych hospitals. It is in comment currently to take that indicator out. CMS has considered in its request for comments that they believe it to be unduly burdensome because it requires a

chart abstractor. They are taking that stance with just about every measure that requires chart abstractors.

Second, they're sayings it's duplicative of another measure where you're required to list every problem in the discharge summary and address it in some manner. They're saying this would get listed with the rest of them where appropriate. You know, I have yet to see a general hospital discharge summary off a non-psych unit list with smoking written on it. So certainly that standard does not work for the parts of general hospitals where it does not apply now. It's, kind of, a fantastic assertion.

Dr. Steven Schroeder: My comment is not only that we shouldn't get the measurements out of the psych hospitals, but we should put them into the hospitals where most of the behavioral population goes**,** which is the general population hospital.

Dr. Joe Parks: You might consider making an assertion that you should at least keep the ground you've gained before trying to gain more ground. You're about to lose ground that you gained.

Simon McNabb: We are over time. I'm going to give the last question to Dr. Curry.

Dr. Susan Curry: Because this is being recorded and I misspoke about the report from the subcommittee. It does mention disparities and so I just want to make sure that it's on the record. We were not as unenlightened as I thought we were.

I'm going to make one other point that I thought was important around the insurance and employment. I want to be careful that we don't assume that people who are employed have insurance because a large proportion of the population are employed by small-to medium-sized businesses who either do not provide insurance or provide very reduced coverage. So just keep that in mind.

Notes from the Field: Promising Practices
Moderator: Douglas Tipperman, M.S.W., Tobacco Policy Liaison Office of Policy, Planning, and Innovation, SAMHSA

Deidre Stenard, Peer Counselor
NJ CHOICES

Jill M. Williams, M.D., Division of Addiction Psychiatry
Rutgers University-Robert Wood Johnson Medical School

Joe Parks, M.D., Medical Director
National Council for Behavioral Health

Pat McKone, Senior Director
American Lung Association

Simon McNabb: All right, good afternoon. Thanks everyone. I hope everyone had a good lunch. We are rejoining our meeting and we are going to go switch gears a little bit and hear from several presenters. After we hear their presentations we will engage in a panel discussion with them.

I'm very happy that my colleague and friend Doug Tipperman is going to moderate this panel. Doug is the tobacco policy liaison for the Substance Abuse and Mental Health Services Administration, SAMHSA. He coordinates SAMHSA's tobacco-free campaign which focuses on reducing tobacco use by persons with mental and/or substance use disorders.

Doug Tipperman: Thank you Simon. This morning we got a good overview of the science as well as a major national initiative that ACS and the Smoking Cessation Leadership Center are doing. This afternoon, we want to focus on work that is happening in this field. We'll look at best practices, but also at the barriers that impact this work. We're calling this session Notes from the Field: Promising Practices.

We have four panel members with four different perspectives who will speak for about ten minutes. I'll ask them some questions and then after the break, you'll have a chance to interact and ask your own questions of the panel. I'll just briefly introduce each panel member. Their bios are in your packet. First, I'd like to introduce Ms. Deidre Stenard. Ms. Stenard is a peer advocate with the New Jersey Choices program, a consumer-driven program for smokers with mental illness. She has offered to share her own experience in quitting and also talk about the Choices program. Welcome Ms. Stenard.

Deidre Stenard: Hi, I'm Deidre. I'm with the Choices program. My story is that when I was 14, I was already addicted to a pack a day. I wanted to be cool and I wanted to fit in and smoking really helped. I was smoking before school and between classes.

After school I'd smoke, too, and it helped me socialize and connect with other people.
I was also doing other substances on a daily basis and drinking on the weekends, as was very common with teenagers back in the '70s. When I graduated from high school, my life took a nose dive and I was diagnosed - dually diagnosed, which meant that I had a mental illness and I suffered from substance abuse addiction. I really took my treatment to heart and I quit drinking**,** and I quit doing substances.

What happened, though, was that slowly I got addicted to both cigarettes and coffee. And that's what I would do any time social occasions would come up. I was there with my cigarettes and my coffee, and both of those – especially the cigarettes – were really powerful enough to change your mood and you felt – I felt in control. So that addiction lasted me for years, and I just kept smoking more over time to deal with life's events.

Later on, I got interested in computers and I moved out to the West Coast to take a job at a software development firm. For seven years I was smoking two packs of cigarettes a day along with a lot of coffee. I would just go to the convenience store, buy the two packs, and that was it. My favorite thing was to sit at the table and chairs they had outside or go inside Starbucks and sit there for ten minutes while I smoked cigarettes and drank coffee.

By the time I came back to New Jersey, I was smoking three packs of cigarettes a day and I had to deal with the consequences of that. I had a horrible cough. My lungs hurt, in fact they rattled, and I was wheezing. I would take a drag off of a cigarette and I'd cough uncontrollably for at least a minute. Then I started to really be concerned that I could be a candidate for lung cancer and emphysema.

I reached out for help and ended up at the quit center in New Brunswick, New Jersey. Before I even got in the counselor's office, I had to fill out an application which told them all about my smoking history. I noticed a bunch of things right away. There were many doctors working there and I felt pretty privileged. The counselor there gave me a carbon monoxide reading. He also gave me a free box of patches. In total, I used the nicotine patches, the inhaler and nasal spray. I didn't have to pay anything for those services, but they led me to quitting successfully after eight tries.

I quit on September 12, 2007, and over a 10-year period I saved $150,000. Not only that, but quitting saved my life. My body started to heal itself**,** and I could breathe again. My cough stopped. I could smell and taste things I never could before when I was a smoker. It was just a really great experience, and I went to that group for a couple of years, probably two or three years.

Dr. Williams recruited met to work for Choices. At the time I was between jobs and I was bouncing around not really belonging anywhere. After being in California and having this great career, I just didn't have anything yet. The job at Choices was a part-time paid position. Choices employs four consumer tobacco advocates, of which I'm one. We travel all over New Jersey with handouts, carbon monoxide meters, and tar and phlegm jars about three to four times a week. We go to mental health centers, community wellness centers, hospitals, partial care programs**,** and health fairs. We do a group presentation consisting of smoking education, smoking stories**,** and CO readings.

What's so interesting is that if we go someplace where they haven't seen us, i.e., the four of us, they are surprised we are mental health consumers. Most of us have had other jobs before. We're very professional. And people really warm up to us when they find out we're mental health consumers. They're interested in the fact that we've stopped smoking and that we got tired of smoking and the consequences and everything. We really wanted to quit, and the deal was, at least I can speak for myself, I had the opportunity of getting treatment at the tobacco dependency program in New Brunswick. Unfortunately, that program lost funding. We need funding for that program again. Choices is nice, and I think we do a great job with the grant that we have from

the state. But it would really be nice to have more quit centers around New Jersey that we can send people to when they want to quit.

Doug Tipperman: Thank you Deidre. All right let's move on. Next, we have Dr. Jill Williams. Dr. Williams is a Professor of Psychiatry and Director of the Division of Addiction Psychiatry at the Rutgers University, Robert Johnson Medical School. She's also the medical director and cofounder of the Choices Program that you just heard about.

Dr. Jill Williams: Lucky for me I get to follow Deidre, who is pretty impressive, and hear about all the good work that she and the team are doing. Thanks to Simon, the CDC, and the committee for pulling this meeting together today and, of course, to the Surgeon General, Dr. Adams, for being here and really stressing the importance of the issue. This is a very important meeting and I'm grateful to be part of it.

I'm going to speak to two specific pieces of this issue and problem. First, I'm going to speak to what can be done in the behavioral health treatment system. That's really been the focus of where my efforts have been. Although we've heard a lot this morning about the larger public health efforts, I'm really going to focus in on that that issue in particular. I am an addiction psychiatrist. I am a clinician. I am a MAT provider. I do conceptualize this. Similar to what you said, (Dr. Adams), in terms of integrated care and treatment models, I think that that really is the way to go, and that's the way I organized my practice.

I'm also going to speak about the issue as a tobacco treatment specialist. For people who work in tobacco treatment, we, sort of, feel like we're the stepchild of tobacco control. I want to really give a shout-out to treatment and treatment specialty. One issue related to that, just in terms of language and framing the issue, is I think we should stop saying cessation. I'm not the first to say that. My mentor (John Slade) wrote an article about 25 years ago. It might seem trivial to you, a change in language. But I think it really speaks to the need to treat smoking like a medical condition. We need to treat it like a substance use disorder**,** and in my practice I don't offer bipolar cessation. Or alcohol cessation. And there's a finality and a negative charge to some language that we use that I think turns populations away.

So just in terms of thinking of the big picture, I'm going to focus on these two issues briefly in the time I have today. Why are these populations not quitting? It's a very complicated question. Jodi spoke to some of these issues this morning. But I'm just going to focus on two brief parts of the problem. One is the neurobiological. There is tremendous evidence that these populations have higher levels of dependence on tobacco than other tobacco-using populations. We have to be vigilant to that if we're going to have an impact. And I said I would speak to the behavioral health treatment system because we're still not doing a good enough job.

There's been a lot of evidence through different studies that patients with behavioral health conditions have very high levels of tobacco dependence. As many as 50% of these populations meet criteria for severe dependence**,** smoking in the first minutes of waking up in the morning, which speaks to the tremendous need for medication and intensive treatments. We did a study

that found that people with schizophrenia smoke in such a way that they get more drug per cigarette. They have higher nicotine levels even from a single cigarette in a lab study than other populations. There are very high levels of dependence in these populations that we have to be mindful of if we're going to have an impact.

Now I'm going to focus on treatment and just put this into perspective. We don't do so well with substance abuse treatment. We reach about 11% of the population who needs substance abuse treatment. But we do worse than that for tobacco. Estimates show that quitlines are reaching about 1% of smokers with cessation assistance. Of course, that's not the entire effort, but it's one way to look at the problem and show that access to treatment is very limited in this country.

In fact, we wrote a paper to compare treatment for tobacco dependence to the way we look at other substance use disorders. We assess people with substance use disorders in multiple domains to understand the level of care that they need. This is referred to as the ASAM levels of care. It's widely used in substance abuse and behavioral health treatment and it ranges from self-help care all the way through a variety of modalities to the locked hospital unit.

What's interesting about tobacco is that all of the interventions fall below a Level 1. When you think about what we do for tobacco, we do self-help. We tell people go home and quit on your own. Sometimes your primary care doc gives you three minutes of counseling and says you ought to quit smoking, and this is why. And that's considered a .5, an expert-type intervention. And if you're really lucky, you receive an outpatient service like a quitline or a group. Those don't exist everywhere.

Beyond that, there's really no level of care. You might have failed your smoking cessation effort 99 times and we still say, well just go home and try it again. We don't increase your level of care like we do for every other medical condition. And in fact, if you look at the dimensions that we rate people for substance use disorders, in order to come up with that conceptual framework of where's the best level of care for them, you can imagine that smokers with behavioral health conditions score very highly in terms of need. They justify the need for a higher level of care. Fact: You could make that argument for someone with cancer – that the urgency and the high level of medical comorbidity would speak to them needing a higher level of care to address their tobacco addiction, yet there's nowhere to actually access that.

I thought I would also keep it real as a clinician this afternoon and very briefly mention a few cases, just to give you an example of what it's really like. I see patients as an addiction psychiatrist, many of whom do not come to me for tobacco treatment. They don't know that I do that. I tell them it's a bonus for them. This is an interesting case. A gentleman was referred to me for treatment of depression. He was smoking ten cigarettes a day at the time I saw him, and it was his first entry into any type of behavioral health care at the age of 58. He had never been in behavioral health care before. He also had chronic pain and was on opioids. He'd had more than 20 vascular surgeries in this life. He has been in contact with hundreds if not thousands of physicians and health care providers over his life span. I tried to write up a financial estimate of what 20 vascular surgeries cost and it's more than $5 million. Because this is fun for me, I read

some of the medical records for those episodes of care to see if anybody had really helped him to address the tobacco since that's the Number 1 reason for vascular disease. Very briefly at the end of these 10-page notes, it said stop smoking. There was one person I could find in a massive chart that said call the quitline.

It also turned out this gentleman was a pretty complicated guy. He had severe childhood trauma, PTSD. So, you know, when you come see me I treat you for depression and trauma and tobacco and all the problems rolled up into one. We talked about it. He was initially resistant. You know, by the third or fourth time I had seen him, he was willing to get treatment. I treated his depression. Put him on patches, gum, bupropion and duloxetine for his mood disorder. By his fifth time seeing me, he quit smoking, which is amazing because he had been in the system for decades, interacting with other medical professionals. He made a quit attempt around the fifth time I saw him, and he's now been 18 months tobacco-free. That's an example that I would show behavioral health providers, to say you can do this too. It's not magical. It's a matter of just including it in the treatment plan.

This case I briefly told some of you. A patient and his mother came to see me because they wanted him to stop smoking. He was highly motivated. He had severe chronic schizophrenia. And the reason they came to see me was because his psychiatric provider said I don't do that. I'm not going to help you. Obviously, that's a big part of this problem. They were lucky enough to get to see me. He wanted nicotine replacement. Medicaid wouldn't pay for it. Ironically that's changed since this happened, but we couldn't get him nicotine replacement, which was his first choice, even though Medicaid had paid for two episodes of care for cancer.

So why does insurance want to keep paying for chemotherapy and not for tobacco treatment? Again, he was highly motivated. We put him on varenicline, or Chantix because we couldn't get nicotine replacement. He did really well. He quit. But after six months Medicaid said that's it. You're done. You're not approved for more varenicline, even though he wanted to continue, and it probably would have benefited him. Then the rules had changed, and we were able to get him the gum and he's been maintained on the gum and is tobacco-free now for more than a year.

These are the kinds of barriers we experience in the field. This is where the rubber meets the road and people get treatments or they don't. And again, this is the model that I fall back on the most in terms of bringing this message to behavioral health providers. We already have models in mental health treatment for addressing co-occurring disorders. How do we treat addictions in the mental health setting? And these are the rules or principles of that treatment model and it works well for tobacco. It says we do integrated comprehensive services. It says we address the substance use disorder even when the person doesn't want to quit. They still get treatment.

What does that mean? Well, we take a long-term perspective.We have a long-term goal of abstinence. We do assessments. The things that work include motivational interventions, medications**,** and isn't it interesting that involving the overall treatment team and the support services like the case manager and the housing system lead to better outcomes? It's a really nice model and it works really well for tobacco.

I'm going to switch a little bit and say a lot of my efforts have been in educating this workforce. This is a huge work force that's untapped in terms of providing tobacco treatments. I think that we can bring them along, but when we give them a test of knowledge, they score really poorly. I've been doing this for ten years and I can tell you psychiatrists don't know the evidence-based treatments for tobacco. And they don't really know any more than the social workers or the nonmedical people that they work with.

There's a huge need for education. Education works, and in our studies, we've shown that when you educate behavioral health professionals and you do blinded chart reviews, six months later, they actually provide more treatment. There is a hope through educational efforts to drive more treatment efforts. I'm doing a big project right now in New York City with Columbia funded by the City of New York to disseminate some of that effectiveness work Wilson spoke about. You know, getting treatments out. Translating things. Putting things into practice.

But my last point, if I wanted to make a recommendation, I think what one of the major things holding us back is the lack of billing. I'm a psychiatrist. I can get paid to treat any addiction A to Z except T. I can't get paid to do tobacco work. I just do it because it's my passion. And we really need to treat it. I think Jodi mentioned this this morning. Most behavioral health codes opt out for the diagnosis of nicotine dependence. I wouldn't get paid for doing that treatment the same way I would get paid for alcohol or other substance use disorders.

Tobacco, I'm sorry, it grew up in primary care. The billing that has been developed really is for a primary care doc and says that if you're seeing somebody for COPD, you can add $14 or $27 to your bill by adding tobacco counseling three to ten minutes. That's not a bad thing. It's great for primary care. It doesn't really help us in behavioral health where we have a different approach. We want to do more integrated treatments and there aren't billing mechanisms to do that.

It would actually be simple in some ways to say tobacco actually is a substance use disorder from the perspective of SAMHSA and other agencies like Medicaid, so that it's not an opt out. So that we could do group psychotherapy, for example, and bill for the diagnosis of tobacco dependence. I want you to know that in the United States you really can't do that. I can't have a group and bill tobacco dependence as a diagnosis and get paid. So that's a huge barrier in terms of holding us back. An army of tobacco treatment specialists has been educating themselves and getting ready for this work in the last 20 years. I'm a part of that movement. But they're being held back because they can't get paid to do the good work they know how to do.

My conclusion is that there are promising practices that include viewing tobacco dependence as a co-occurring disorder and including it in an integrated treatment model. I think this is a very useful model for framing this in behavioral health. The barriers include provider education and provider buy-in. There are myths that still perpetuate in communities and these validate the need for education. The billing restrictions, not seeing tobacco dependence as a substance use disorder, are holding us back in terms of language and treatment frame and billing.

Doug Tipperman: Thank you Jill. Next, we have Dr. Joe Parks. Dr. Parks is the Medical Director for the National Council for Behavioral Health and is a distinguished research professor of science at the Missouri Institute of Mental Health with the University of Missouri, St Louis.

Dr. Joe Parks: Thank you very much. It's a pleasure to be here. The other perspective I'm speaking from is for about 20 years I was the Medical Director for the Missouri Department of Mental Health. And for the last three years, I was the Medicaid Director there and made some changes related to covering these treatments within the Missouri Medicaid program. There is a lot that can be done. I'm going to speak mostly about the changes through the health care system and payment systems.

The National Council is a contractor with CDC for the National Behavioral Health Network for Tobacco and Cancer Control. One of the projects we're really excited about is we supported Pittsburgh Mercy Health Systems in developing and implementing 100% tobacco-free policy at 60 campuses serving 33,000 people. Also, we did work with 89 different community behavioral health organizations, helping them to implement tobacco-free campuses and impacting another 100,000 people. This is agency by agency work among the willing. These are agencies that said yes, me. I'm ready to go there. And we need to keep on funding these kinds of things for the willing. But we need to do more to build the motivation in those that aren't saying me. You know, that's motivational theory of change. If somebody's not ready to change, you build dissidence.

I did that with Steve Schroeder when I was with the National Association of State and Mental Health Program Directors. We took the state hospitals in this nation from being 80%, 85% smoking on campus down to being just 20%. We flip the numbers and we did that by first saying that it was the standard of care to not have smoking on campus and to offer treatments. And then second, what we haven't done yet in the behavioral health community is we individually benchmarked states and we individually benchmarked hospitals. We did a repeated survey every two years and if you were one of those superintendents of the hospitals that hadn't changed their policy yet, you got a letter saying here's the result of the new survey. You're still among those that aren't meeting the current standard of practice and here's another copy of the tool kit to change. You can't just say it's a good thing to do. You need to send a letter to the CEO saying here's how you rate. And by the way, we listed it on a list, so he could see how everybody else rates. And that lets him know that all his peers know how he rates.

This could be done with the SAMHSA survey data that we saw reported in the Morbidity and Mortality Weekly Report because you have the results of, what, 12,000 mental health agencies, 14,000 substance abuse treatment agencies. Those could be made into individual, state-specific reports saying who was where. You could do a five-star system, one star for smokefree campus, one star for MA or nicotine replacement, one star for meds, you know, for the five things that are measured in that report, and list each individually.

We're part way to a consensus. We have the NASMHPD we saw in the earlier presentation saying this is the standard, not to have smoking on your campuses. SAMHSA has said that. It

would be helpful if NIDA would say the standard of treatment is to be smokefree on campus and to offer these treatments. It would be helpful if the Surgeon General's office would say that. After all, the standard of practice is a consensual decision that's agreed to among experts and people in authority. That's what we get to do. And then we can say you're not in compliance with the standard of practice. That rings bells with the people who run stuff if you tag them individually. I think that would be a big help.

I got into this field when I was first a hospital medical director in a state hospital in Ohio. One of the first cases I had, I had a 400-bed state hospital, 12-bed infirmary. I had a man in his 50s who was smoking three packs a day and he was psychotic pretty much all the time. He had COPD and advancing emphysema. If he continued to smoke, he was turning blue and passing out. If we stopped him from smoking he became violent and we had to fight him all the time. The choices were to let him smoke, but we couldn't put him on oxygen with a lit cigarette – or tie him down all the time. And I really got into the smoking cessation business because I didn't like that choice.

The second reason I learned not to like that choice is when I was medical director of a state hospital in Illinois. I was starting to build an understanding of what the advantages of going smokefree were. What we haven't talked about here is how allowing smoking in these facilities poisons and prevents treatment. There are significant advantages in not allowing smoking in closed environments like substance abuse residential treatment – the opiate centers we're opening where you have to stay there all the time.

I surveyed state hospitals in Ohio, Illinois, and New York, and we surveyed the nonsmokers. We asked them how often they saw staff coerce patients using access to cigarettes. If you're not good and do what I say, you don't get to smoke. How often did the nonsmokers see smokers threaten each other or exchange cigarettes for sexual favors? Sixty percent. The going price for sexual favors in those years was about three cigarettes. You think that isn't happening in some of these residential substance abuse treatment places where it's closed access? That needs to be surveyed. It needs to be looked at. It needs to be publicized. This is going on. What are we going to do about it?

When I was in Medicaid, we did open up the smoking treatment code completely. We have no prior authorization, no prescription limits on the medications. We have no limits on counseling events. Our rates are super low, we're Missouri and we're Medicaid. We don't pay enough. But I did not get nearly the utilization I wanted.

The message here**,** that could be done through CMS per se, would be to look at the states that have opened up their benefit like New York has, like Missouri has, like Oklahoma has. We see in the Morbidity and Mortality Monthly Report what a state needs to do. They need to do what Oklahoma did. They need to take the controls off. They need to say no, you need to be smokefree on campus if you're getting a state contract. And you need to offer treatment, both medication and nonmedication.

What a Medicaid Director needs to see is how did the other guy write the codes and what was the dollar volume? And let me tell you, the increase in expense in Missouri Medicaid was trivial. It was dust. It cost about what it costs me to treat three people with Hepatitis C to offer that whole benefit to the whole state. Now this is really bad news, because it's horribly underutilized. It's really good news if you want another state Medicaid Director to open up those codes because they don't cause budget issues. And that's what they need to know is they don't have a budget issue with tobacco dependence treatment. The amount of money it takes to open these codes, given the underutilization in a Medicaid program, is trivial. It is politically trivial. It is administratively trivial. It's within day-to-day fluctuations in pharmaceutical prices.

I think the other thing we can do is we can benchmark prescribers. We have claims data on the Medicaid CMS side. We know which doctors prescribe these medications and which ones don't. We routinely have pharmacy feedback projects where you let doctors know if their patients are taking opiates or not, if they're adhering to other medications. You could do the same thing with underutilization. Say Dr. Parks, you know, you treated this percentage of your patients with an illness associated with smoking. But you never write for any of these cessation medications. Here's the one-pager telling you how to do it. It makes a difference if you call people out individually. Whether that's a state mental health director saying hey, you're still allowing this in your contracted facilities or whether it's an individual prescriber or the head of a facility, it makes a difference.

The one other thing we did is we sent out mailings and publicized throughout Missouri which Medicare Part D plans did cover these medications, and which didn't. We encouraged our mental health case managers to get their patients on the plans that cover tobacco treatment medications. I also think we don't market the medications enough to the individual patients and say you should go ask for this. Here's a page to hand to your doctor saying I need this. We are very much more likely as prescribing physicians to respond to our patients. I respond to my patients more readily than to something a physician asks of me or that my medical director, who just sent me a nasty email for things I'm not doing, asks of me. Thank you very much.

Doug Tipperman: Thank you Joe. Next up is Pat McKone. Ms. McKone is Senior Director for the American Lung Association. She has been with the American Lung Association for 40 years. Ms. McKone founded the Minnesota Leadership Academy to facilitate statewide collaboration between mental health, substance abuse**,** and tobacco control leaders working to address tobacco use by those with behavioral health conditions.

Pat McKone: Thank you and I'll give my disclaimers right now. I'm not a scientist. I'm an activist. I'm an advocate. I'm passionate and I'm as urgent on this as you. My father was an alcoholic and a smoker, and he died at age 47. My passion for social justice is long, deep**,** and hard. I was raised in public housing. My only sister was developmentally disabled. I'm the grown-up version of some of those emojis and the pieces that I saw earlier this morning.

I do want to talk about how this issue of tobacco use in the behavioral health population first came to my attention. And I really do appreciate the opportunity to share that with you. I was

working on smokefree housing and in my community, Duluth, Minnesota**,** they implemented a menthol and other flavored tobacco products restriction this week, taking those products down from 85 locations to 4. I was working with the housing authority and I knew that there were potential issues with Legal Aid. I met with a friend who worked for Legal Aid and I said, "Here's the reason we're promoting smokefree housing. And she said to me, "Well, Pat, 80 to 90% of the people I work with smoke." And I said, "Gwen, that can't be possible.**"** I knew tobacco and I knew the highest rates are in the American Indian population in our community and that's 40 to 50%, not acceptable either. But I hadn't heard 80 or 90, which goes back to Dr. Prochaska's number.

A few short weeks later I went to a conference at Mayo that they do for tobacco treatment and I heard a one-hour presentation from Dr. Williams**,** and I was in shock. I thought this can't be possible. I've been in tobacco control 30 plus years and I have not heard that behavioral health is a priority population or they're smoking at these rates. This can't be true.

Advocate that I am, I thought I've got to find out more and then when I found out more, I thought I have to do more because this population, and I'm going tell you very frankly, hasn't been a traditional priority for tobacco control. It just hasn't. And that's changing. I do feel that tipping point. I am a stars and moon kind of girl. And I heard this morning on CBS a quote from (Maya Angelou) that said, "When we know better, we do better." And I want to say I hope when we know better, we do better. And today we know better. And we have to do better.

My model for change is first to educate people. I want to get that education and that buy-in or understanding. You may not agree, but I hope that you understand. And then I think we can do something about it. I can motivate you that there's something that can be done rather than it's all over, and then activate you to be part of the change. And Deidre, kudos to you for being here and being that motivator and activator. I love it. And you have been inspiring.

Our mission with the American Lung Association is a world free of lung disease. We are motivated and activated to get something done here on this and to save lives, all lives. I believe we're largely isolated from the problem of smoking. We don't see it, and yet there are populations who are struggling with it every day, but when we know it and do something about it, we will prevent lung disease.

I want to talk about bringing our two systems together, tobacco control and behavioral health because we're mostly advocates. When I walk in a room that's Alcohol, Tobacco and Other Drugs and I say I'm from tobacco control, it's like oh god, no, what is she going to put out there that we should do, that we're afraid to do, that we don't want to do. We need to get away from those siloed systems. I'm still trying to learn all the acronyms in this room, how they integrate and how we can do better together. Limited funding. That's not news to anybody. But I do take that charge that we need to come in the side door, the back door, the chimney, however we get in the room, to get our message out - and not to be preachy and judge**,** but we have to be there because we have a moral obligation to address this issue.

We have competing priorities. We've got Tobacco 21. We've got menthol and other flavorings. We've got the patch. We've got opioids. We've got funding. We've got access to care. And this one falls. This one gets through the cracks. We need more data. I know we've got a lot here, but we need more, more data, more sophisticated data.

We think we have best practices, but I would encourage you to think about all those best practices this population has lived under – taxes being raised, and smokefree air – and yet we haven't seen the same decline in their prevalence. Let's raise tobacco prices and let's dedicate that money to treatment and care, and not just say it's more for the coffers. We absolutely have to bust the myths around the impact of tobacco, the history of tobacco.

The Surgeon General recommended a tool kit. We've got one. But you can give a person a tool kit and they may not know how to work it. They're not motivated to work it. We've got to do more than that. We have to talk about things we talked about this morning, provide resources, provide networking so those leaders in behavioral health don't feel like they're out on a limb and taking a risk.

The risk is --- not doing anything. We have to integrate this population into tobacco plans and here's a shout-out to the Minnesota Department of Health. Because of the networking that we started, we actually have behavioral health providers at the table in developing the framework for tobacco control in Minnesota for the next five years. These are behavioral health, substance use, mental health use providers, business members are there discussing how you impact that, making a difference, and taking ownership of what they can do. Clear recommendations were put in this document**,** and it's a living document. And we did bring partners together through the SCLC and we came back to Minnesota, but we were not done.

Now what are we going to do? Through funding from the Center for Prevention at Blue Cross Blue Shield Minnesota, we have been able to come together for the last three years, annually at first**,** and then guess what people in the room said? We need to come together more often. When's the last time you heard that? In addition**,** to create new strategies to integrate tobacco dependence treatment within behavioral health treatment, our goal is to expand the type of health workers who provide tobacco dependence treatment and update the reimbursement system.

We also developed a portfolio of products that integrates tobacco control messaging with other issues that are not typical of those you see. For example, people know tobacco use is not healthy, but do they know that it could harm their pets? Do they know that it can create side effects or alter the effectiveness of their medications? We also coupled smoking messages with its effect on housing, staying sober, and looking for work – issues that are relevant to the behavioral health population. These messages are meant to be conversation starters, not to create guilt.

We are very excited that three large mental health and substance use providers that have worked together over the last two years in Minnesota, mentoring each other, sharing their change process together, are going tobacco free at the end of July. They've integrated treatment. They've integrated assessing the staff, addressing staff concerns, and addressing myths and beliefs around

tobacco use in the behavioral health population. Their theme was rethinking tobacco**,** and we worked together with them to develop their signage and their public information campaign that we designed with them, not for them.

I have to talk about North Dakota because I also worked there and I can do that accent. We were doing some education and training there and the substance use providers said they could not treat nicotine addiction because it wasn't in their licensing. I thought, oh come on, this is two years ago, you've got to be kidding. The language in the state's licensing law defined addiction counseling as the provision of counseling or assessment of persons regarding their use of alcohol or controlled substances. We asked the Attorney General if tobacco was a controlled substance and he said no so we helped them change the law. That's what we do. We do change. North Dakota is also going smokefree on all the campuses that DHS owns, operates, or leases from.

So how can the federal government support change? The first thing is to make this population a priority. Updating the Public Health Service Guidelines to add interventions for behavioral health is a good first step. We want to encourage the Centers for Medicare and Medicaid to enforce the preventive services provisions in the Affordable Care Act. We want to see the Joint Commission Tobacco Measures included in CMS's payment rule. We need sustained research funding so we can sustain change.

The federal government can also use the bully pulpit to encourage state actions. States need encouragement and support to expand their reimbursement system, expand the type of workers who can provide tobacco dependence treatment, and increase the price of tobacco – and ideally to use those tax revenues for funding treatment and access to care.

With that, I want to thank you and say let's work together to make a world free of lung disease.

Simon McNabb: Let me thank the four presenters. Those were wonderful progress reports. We're going to take a break and when we come back (Doug) is going to moderate a panel discussion with our four presenters. That panel will morph into a larger discussion with the committee members.

Panel Discussion Presenters

Simon McNabb: Unfortunately Dr. Adams has to leave early but we have a few minutes with him so I'd like to turn the floor over to him.

Vice Admiral Jerome Adams: Thank you to the panelists, that was just tremendous on all counts. I'm actually going to meet with the First Lady of New York City who is passionate about mental health**,** and we're going to talk about her new mental health initiative. This is the perfect conversation for me to have going in my discussions with her. We can talk about the need to emphasize tobacco cessation amongst that community**,** and I can find out from her what their commitment is going forward.

A couple of things I wanted to leave you with. Pat, I love your comments about integrating messaging because that's exactly what we do here. That's motivational interviewing. That's trying to find a new way to look at the problem instead of doing what Einstein said is insanity, the same thing over and over again, and expecting different results.

Deidre, I just wanted to say thank you much for your remarks. They really hit home to me. I was tweeting about you while you were talking. The final thing I want to leave you all with, and I encourage you have to a hearty discussion about this, is that all of the speakers talked about the funding. The last three speakers in particular, all of you I wrote down something about expanding the reimbursement system, new codes.

Here's my concern and I would love for you all to discuss this. No matter what happens, we're going to be dealing with a limited sized pot, a finite amount of money, and expanding the reimbursement system, changing the code means that oftentimes you're robbing from Peter to pay Paul.

Additionally, we believe, and I say "we" in terms of the administration, but I was also at the American Medical Association – most folks looking at health care reform believe that the system is broken, so expanding the code in many ways is doubling down on a broken system. Secretary Azar submitted to reforming the reimbursement system, so as was mentioned earlier, instead of paying for chemotherapy, we're paying for prevention. So I know that we have to have a glide path. It's not one day we do one thing and the next day we do another. You have to have a transition and that may involve adjusting codes to transition us over to prevention.

But with that said, my concern is if we keep doubling down on a broken system, we end up getting the codes that are codes in name but ultimately aren't funded. Those of you who live in this world have seen that happen over, and over, and over again. It's a code that nobody pays for because there's no money to pay for it**,** but we go that route instead of looking at models where we pay for income. And we actually say, instead of paying you for treating this person's substance use disorder and paying for you to treat this person's tobacco use disorder, how about we pay you overall based on whether or not you're preventing this person from coming back into the hospital for any reason.

So again, it's not to say that there's anything wrong with demanding payment for the services that you're providing. But let's think about how we can reform the system so that it works better for everyone and focuses on prevention instead of continuing to support and double down on what most people agree is a broken way of reimbursing providers for the services that they give to the folks that we care about.

With that said, it's really been great to spend so much time with you all. I wish I could stay here for the rest of the day**,** but please know your Surgeon General is passionate

about this, wants to continue to engage with you, to interact with you, and I'm glad that you all had so many recommendations that were geared specifically toward actions that I can take. I'm going to take all those back to HHS.

And I hope you all continue with your passion for this mission and for this population.

Doug Tipperman: I'm going to direct some questions to our panelists and each of you can respond to ones that you resonate with. For the first question, knowing the scope of the problem, what strategies have the greatest potential of being scalable, strategies that can be broadly implemented**,** and will have a population-wide impact? If you can each give an example of a strategy that you believe can be scaled and have a population wide impact.

Dr. Jill Williams: I think some of this has been brought up already today. I think systematic at the state level, tobacco-free policy is an important step and supporting that at the national level. We can see from the MMWR report that the action that states have taken, like Oklahoma and New York, is reflected in their higher rates of success in the overall report and that's why that data is so valuable.

We know that these things work. I spoke to this already, but I think more insurance to support the work force that staffs behavioral health facilities, and also more education for them, are important. We have a 40-year tradition in tobacco control of educating health care providers, but it's been largely focused on primary care and we need an effort now focused on behavioral health.

Dr. Joe Parks: I think we should give specific detailed solutions to the individual policymakers responsible. By that, I mean creating a sheet of what Oklahoma and Missouri did and what their experiences were with increased costs when they opened up the benefit and sending that through NAM, The National Association of Medicaid Directors, or CMS, Medicaid Directors, saying, look, here's how these two or three states did it and here's how much it cost them. State Medicaid agencies don't have a lot of staff. They don't have the bandwidth. Unless you give them that level of specificity, they'll have to prioritize, and this won't be high-priority stuff.

I think similarly for a state and mental health agency. One thing I didn't mention is we simply sent out letters of guidance on what was billable under our existing codes. All state mental health agencies for the seriously mentally ill have codes for psycho-education, which is a cognitive behavioral educational training with licensed or trained staff and based on an annualized curriculum about things that are directly related to their serious mental illness and how to manage it.

We've certainly seen enough evidence here that this level of smoking is directly related to mental illness. It falls within the billing code and an existing billing code with an existing rate. All the state agency has to do is send out a letter, this falls within the billing code.

Here's a list of the appropriate and analyzed intervention. But it has to be a specific instruction to the specific people that have that discretion, whether that's the mental health director or the Medicaid director. So you save them the staff work because they have short and narrow bandwidth.

Pat McKone: I think about the *Tips* campaign including a patient with mental health. Every time someone says to me, but smoking helps me relax, that's because you're in withdrawal. We just need that basic myth busting and education for the general public, too, because that's where the momentum is also going to keep increasing.

Doug Tipperman: In your work to reduce the burden from tobacco use, what strategies work well? What strategies help you achieve success?

Dr. Jill Williams: I don't necessarily have data on this**,** but I've been doing trainings for behavioral health professionals for ten years and as I did them over the years, I realized that I needed less time on the content and more time on the buy-in. Now I spend the first two hours of the morning trying to convince the audience of behavioral health professionals that they do, in fact, know how to do this. If they just put it in the bucket of substance use disorders, and I convinced them it's a substance, it's an addiction, they do know what to do and then the content that they need to learn is small.

Dr. Joe Parks: What helped me most was selling the decision maker based on their values and priorities, not on my values and priorities. I think that the tobacco efforts focus too much on health, everybody knows that. Everybody expects us to talk about that. The decision makers already have their excuses in their head. We got a lot further with the state hospital superintendents by giving them information around how they were increasing their rates of seclusion and restraint because people would get in fights over access to smoking material.

We got a lot more from decision makers when we added up all the time it took in treatment to do smoke breaks. If it takes 20 minutes to do a smoke break, 20 minutes to hand out the smoking stuff, 20 minutes to take it back, you do three or four of those a day, plus meals three times a day, when in the heck is anybody getting treated?

Now, the same is true for any behavioral health setting that sees people for a protracted period of time. That would be day treatment programs, that would be intensive outpatient, and that would be residential treatment programs. If you have a residential substance abuse treatment program that does three smoke breaks a day and three meals a day when are people in groups, when are they in individuals?

As a payer I would like to pay less if they're getting less treatment. Maybe we should pay lower rates to the facilities that have smoke breaks because we're not buying as much treatment. I think that's one thing that SAMHSA could fund, CDC could fund: a time study of a selection of long-treatment programs of those that allow smoking on campus

and therefore have breaks versus those that don't and see what the relative amount of treatment time is. That kind of information will change minds more than talking about illness.

Deidre Stenard: The approach I use when I'm working for Choices is just a systems approach. In other words, every six months, we're supposed to visit certain sites and I just make sure it's been six months. If we miss one, we can always get it on the next go around.

Dr. Joe Parks: That would be the best study for NIDA because NIDA has an interest in seeing people get the full degree of treatment for their opioid addiction. They also have an interest in tobacco. You should be interested in looking at if you get the same amount of treatment in an opioid program that has smoking on campus versus what you get in one that does not. Or are you systematically getting less treatment?

Wilson Compton: Remember that we're a grant funder, so if you have that idea, share it with the university in your local area. They're welcome to apply to us for support. Coach them on it.

Pat McKone: Building a coalition, a true coalition takes time. It takes sustained work and funding. It takes energy but it has worked. Last year, I would have told you we're struggling with that momentum. We met a week ago and I left thinking, oh my gosh, they're leaving us, they're doing it. And that is important.

I think framing the issue under social justice has been very helpful for us. I think that again, here I come**,** the tobacco control hero. I do think there's that friendly competition when you bring people together; if one group is doing it then we should do it**,** too. All of that builds for success and for that momentum.

I hope you have fewer people to treat because of our advocacy strategy and that we're talking differently in the future. I also want to share, I think stories of the day help. One example is the romaine lettuce comparison. I don't want to minimalize it, some people died, some people got sick, but nobody objected to taking that lettuce off the market. Nobody said the farmers are going to suffer, what are we going to do? Nobody said it's a legal product, let's just put a label on it and let people make a choice.

People get that when you make analogies about how we treat other public health issues and yet the products that we're talking about are still on the shelf. That's a different argument but it just gets people thinking in a different way.

Dr. Steven Schroeder: I have a social justice story with resonates with what you just said, Pat. San Francisco, as you know, is a very liberal city. I see a weekly group of UCSF medical students who are idealistic. One is doing a project to try to get psychiatric patients in San Francisco General Hospital to stop smoking. Some of the psychiatrists

don't think that's relevant. I gave her articles by Jodi and she went back and they said, oh, it's a social justice issue, let's do it.

Pat McKone: Doug, I want to make a follow-up comment on this because this has not come up yet today. We have evidence now showing that private facilities are the least likely to intervene for tobacco. They are the least likely to have tobacco-free grounds and do treatment. That's really the behavioral health industry's dirty little secret: Some places continue to use tobacco to lure people into treatment. I mean, what a compelling message for someone with a substance use issue to come here to pricey and often famous facilities in this country where they still allow and endorse all of this smoking behavior. There's a differential where public facilities are doing it and private are really holding us back in many ways. I think that has to be outed.

Doug Tipperman: In your work, what challenges have you encountered and how have you overcome these challenges?

Pat McKone: The baggage we bring to the table about each other, what we already believe in, how we work and don't work together, what our roles are, and what our roles aren't, I think that's a challenge. I think DHS licenses these places to help differently. They don't want to step on toes. They think tobacco control is aggressive and we're not ready for that. That baggage definitely takes time to unload**,** and I think we've got to get used to it or make use of it to bring about authentic conversations. I can't tell you how many people have told me that after they met me, oh, you're not as scary as I thought you were at first. I think, let's have those conversations because those divisions are deep and that baggage is old and new is here.

Dr. Jill Williams: With almost 20 years doing this, I'll say it's been mostly challenges. I won't use all my time to detail that but I'll say that I've been so frustrated at times that systems have not changed, that providers are so difficult to change. In fact, that was the genesis of the Choices program: Forget providers, they're hopeless, let's just bring the power and the message to the people because every time I stand in front of an audience of mental health consumers, they want to hear about this. They're interested. They want to sign up. When I offered treatment, I never had any shortage of people wanting to come see me.

So one model is a stronger consumer message to reach the audience. Now, we really need partners who now have the advocacy to successfully do that**,** but they've been sort of ambivalent over the years. I think if patients wanted it in huge numbers there'd be a lot of change.

Dr. Joe Parks: I basically agree with Dr. Williams. The biggest challenge is for the health care provider to find time in the visit to address this issue. Most see patients in 15 to 20 minute increments, how do they fit this in among their other complaints. But if the patient comes in and complains about it, we'll find a way to fit it in. So I think it might be

more marketing to let smokers know that it's treatable, they deserve treatment and they're getting gypped. Tell them they're getting gypped, get them angry a little.

Doug Tipperman: We have heard that many organizations, both governmental and non-governmental are involved in these efforts. Are there any groups that haven't been mentioned that you have partnered with?

Dr. Joe Parks: The groups that I found very helpful are the National Association of State Mental Health Program Directors. We**,** of course**,** are very helpful at the National Council, we'd love to help you more, come talk to us. Also, I think the National Association of Medicaid Directors could be of great assistance. These are the people that run systems that do the policy.

NASDAD, The National Association of State Drug and Alcohol Directors would be another good place to get at the health system level policy changes around access. They would be the key groups to message and to get information from.

Pat McKone: To echo what I said before about bringing in more advocacy organizations, interestingly, we've outreached all of them and we had the most buy-in from the organizations that represent the individual mental health consumer rather than the family of the mental health consumers. Groups like Mental Health America, for example, better reflect the individual**,** and not their family**,** as the advocacy lead and they've been more approachable and more likely to get on board.

Dr. Jill Williams: I would agree that Mental Health America and physician leaders, just individual physician leaders are a strong voice. We don't have enough Deidres. We really need more of those voices of those most impacted by how neglected this has been.

Doug Tipperman: Are there any groups that we haven't talked about that could be potential partners?

Deidre Stenard: When we refer people to places to go to get treatment for quitting, the most promising are either Nicotine Anonymous, which costs basically nothing, or CVS. They have the Minute Clinics and Start to Stop programs. That gets people started. That's some place to go. Other than that, most of the quit centers in New Jersey have been closed and there's two skeleton crews left at the ones that are still open.

Dr. Jill Williams: What Deidre is referring to, in case you're not familiar with it, is for a while New Jersey adopted the specialty tobacco treatment clinic model, which is a model used in the U.K. And it was actually wildly successful until New Jersey decided not to fund tobacco control eight years ago and they've all been dismantled. But we published on the results of the success rate in the specialty tobacco treatment centers and they're quite high, similar to the U.K.

Dr. Joe Parks: Among the most effective interventions are those done by mental health peer specialists. These include people in recovery from serious mental illness that we often use for individual support and psychosocial education and they have more credibility talking to a person that's currently suffering. They can say, that's what I did, and that's what happened to me; I was like you five years ago. It's more credible than what I could say.

An increasing number of agencies employ peer specialists. So, I think you would get some support from the National Depression and Mania Association. Clubhouse International might also be worth talking to, Clubhouse did a phenomenal job in Missouri. They went smokefree before a number of our hospitals and clinics did, and we're proud of it.

Dr. Jill Williams: Social workers, trusted care givers and providers, community health workers, parish nurses, and the faith community are going to the homes of many of these individuals and working on other health issues with them**.** Parish nurses are a really wonderful network of caring individuals.

Doug Tipperman: I'm actually presenting at the National Association of Social Workers Conference next week. I know that some of you addressed this in your presentation, but in your view, what can be done at the federal level that can meaningfully impact the problem of smoking among those with behavioral health issues?

Dr. Jill Williams: There's so many things I could say but I'm going to focus on two. I would like to see big efforts by CMS in terms of increasing access to funding for cessation services as well as SAMHSA. SAMHSA spends a lot of money. The majority of their budget goes to substance abuse treatment and on the list of substances that they treat or that you could apply for a grant for, tobacco is an exclusion. So both through SAMHSA and CMS, I think there could be tremendous access to treatment.

Again, tobacco at the highest federal level is a problem of prevention, it's in the Office of Prevention. Providers always feels like it's a little bit of a disservice to treatment. We don't view every other disease with only a prevention lens. We do cancer screenings and we should always be making those better, but we don't deny people cancer treatment. This is substance use disorder. People need treatment and we need it funded through the usual methods.

Dr. Joe Parks: I would certainly ask for the continued support from CDC for their National Behavioral Health Network for Tobacco and Cancer Control. Expand it if you can, it's been effective. I told you about the organizations that have been able to change because of that support.

I think on SAMHSA's side, there is a lot of data and a lot of power out front. They said that they've made an appropriate statement about supporting tobacco-free environments.

That's different than letting individual facilities get block grant funding that are not tobacco-free. We want you to know you're not tobacco-free and we support tobacco-free. Not a mandate**,** but it does cause a lot more action.

If possible, make the Morbidity and Mortality Weekly Report data available and give individualized feedback to the people that completed the survey. Show people - here is how everybody else answered and we support this. That would be 12,000-14,000 letters. That's a doable mailing. I've done mailings that size in Missouri many times.

If SAMHSA reaches out and says, here's what you told us and we would like to see you change this thing, along with a toolkit to go with it, I think things would change. Lastly, I think we need broader consensus on behavioral health. We hear individual agencies taking a stance that behavioral health organizations should survey, should have tobacco-free campuses, should offer the treatment. We've heard it from NASMHPD. I think it would be helpful to get a group of multiple agencies, SAMHSA, NASMHPD, National Council, perhaps NIDA and anybody else.

A key term is to say what the standard of practice is. That makes people more anxious and motivates them more than saying we support or we recommend. And if you get enough people at the table, the Joint Commission would support that. I think we could get enough partners and do an expert consensus panel in a day and a half or so that came out with a pretty impressive list saying the standard of practice is these five things. That would create momentum.

Dr. Jill Williams: One more thing, I don't want to let CDC off the hook. I think CDC does a lot in setting the tone for the country and that then trickles down to each state level. So I think language, framing the problem by not using the term "cessation" and framing it as treatment. Also, really giving the states the message that people need access to a range of treatment services. There has to be a range of services with more inclusion of some of the more intensive services. I think just changing the language and the recommendation at the top will trickle down and be effective.

Pat McKone: Think futuristic. I can't tell you the last time I called a phone number and got a real person. I think, how are people getting their information? How should we be providing services? I think we need a social media campaign. We need a presence where people are and it's probably not in the clinic and not on the phone, but they're on devices or they're talking through devices to get information. And we're always behind, the nature of what we're doing is playing catch-up. Let's think future.

Doug Tipperman: Perfect lead-in to the final question. If we hold another industry meeting on the topic five years from now, what would be the optimistic vision of this issue? In other words, what would success look like?

Pat McKone: My vision would be that the number of people requiring treatment will have gone down in this population. I'm really intrigued by the idea that there's personalized treatment at your voice. You can ask Google, or Alexa, or whatever the device is in five years. You can say: "I'm really stressed, I want to smoke, help me." The device could walk you through the steps, encourage you, connect you. It can be that customized.

My husband is a Type 1 diabetic. I ask Alexa how many carbs are in a blueberry muffin, and she tells us how many carbs there are. Programming and that. We're talking end game**,** and we're not talking harm reduction. We're talking health.

Dr. Joe Parks: I think in five years, it would be reasonable to have a target – 25% of the people with an addiction or mental illness quit being smokers. I'd go lower than the 30% actually. I think it would be a given that if we were able to flip the page of state hospitals from 80% allowing smoking to 80% not allowing it in five years, I don't see why that shouldn't be achievable for addiction treatment on campuses and for other mental illness treatment campuses. Those would be my two major markers.

Dr. Jill Williams: I'm not going to answer your question**,** but turn it the other way and say that in five years, if we're not doing widespread policy and reimbursement then we've really failed.

Deidre Stenard: I would like to see more funding from the federal government to the states that are interested in developing programs like Choices. There are other states who are on the verge of doing it, but they need funding.

Member Discussion

Simon McNabb: Thank you Doug and thank you panelists. I'd like to open it up for questions among the committee**,** and we're about to move into a large discussion.

Dr. Ken Warner: The one thing I'm not sure I heard was medical education and other forms of health care practitioner education. It's really shocking when you look at both medical school and residency, and see how little physicians are taught about smoking. Probably other substance use disorders as well, I assume.

Dr. Jill Williams: I just want to add, the other system we didn't talk anything about is our prison system. So much mental illness within the prison system.

Dr. Ken Warner: I have two terminology questions for Dr. Williams. You said we should no longer be using the word cessation because terms matter so much. I'd like to know what the alternative word would be. The other piece of the question is, as someone who is not from the behavioral health field, why do we call it behavioral health? That's always struck me as an absurd term for what we're discussing here. That should be

dealing with obesity and a number of other issues that have nothing to do with mental health.

Dr. Joe Parks: That's an attempt for the mental health crowd and the addiction treatment to accommodate each other in one term without somebody feeling slighted and without saying mental illness and addiction, which sounds kind of long. In retrospect, it's a huge failure because it creates an automatic connotation. When I talk about your behaviors, I'm not talking about something good. I don't say let's note Dr. Warner's health behaviors. Or Dr. Warner, we really appreciated your behaviors at this committee meeting. You don't feel good about that. So I think we should use mental illness and addiction and give it up. But it's a historic attempt to be inclusive.

Dr. Jill Williams: Your other question I think is fairly simple. We should just call it treatment. You could call it tobacco treatment. You could call it tobacco use disorder treatment, which is a little long, but that reflects at least the DSM-5 most current language, getting away from nicotine dependent language, identifying there's a problem and the drug is tobacco. Then simply framing it as treatment and what you will find is that patients are typically not resistant to treatment. You'd have a lot fewer patient barriers.

Dr. Ken Warner: So you don't object to the word cessation? You object to the word cessation in the context of treatment because most cessation is taking place outside of treatment, right? Or do you prefer quitting to cessation?

Dr. Jill Williams: I'm not a big fan of the Q word either.

Dr. Ken Warner: I agree with you that there's so much emphasis on prevention, maybe not enough on treatment. But if I had to put my limited resources into treatment versus policy, for example, to get to cessation or quitting, I'd do policy every day of the week because I think that's what's worked and we've got good evidence it's worked on a mass scale.

Dr. Jill Williams: Well, it's worked at a population level and that's why now we need a more disparity-driven approach, I would argue.

Dr. Ken Warner: I agree with that, but the point is that I think you need an alternative to treatment, which refers only to the patient health professional interaction.

Dr. Jill Williams: I think that's fair. In terms of thinking about other substances, people say abstinence. You could say tobacco-free. There's other ways you could frame it that are not necessarily linked to treatment.

Pat McKone: Also, people don't always hear you when you say cessation. But what I'm hearing from (Jill) is that it's an absolute mark that you're coming in to quit and that can

be an overwhelming hurdle for people who see you. If they're coming in to get treatment, that's more of a process, you're helping them through addiction. It also makes it more clinical. For the education piece one way to get some inroads there is to get more items on tobacco treatment into the Board.

Cliff Douglas: I mentioned earlier this morning I was an English major, so this is a fascinating discussion. Now, you're on my playing field. A parallel goes back to when we were working on the airline smoking ban, back in the late '80s. It was around that time that we decided to change our language and we stopped calling it a ban. We called it a smokefree law or policy**,** and it's really a parallel to what you're talking about right now. We don't tell people we would like to help them ban their smoking, but we talk to them about going smokefree or tobacco-free and I think that's the kind of language that we're moving toward.

I do wonder about the evolution that may proceed now in terms of trying to remove the community reference to cessation. That's kind of hard to imagine, but we can pick our spots and do our best.

Dr. Jill Williams: Just my personal opinion, it depends on the lens that you're looking through. We did a lot of work with young adults trying to get them to quit. They don't want treatment**,** but they do want cessation. So, depending on the population and the context, the language may need to be different. I think we want to be mindful that just as you don't want to say ban this or ban that, we want as much flexibility to have as big a tent as possible.

Dr. Steven Schroeder: I have a question for the panel and one for Jill. There's a Sherlock Holmes story about the dog that didn't bark. There's a dog that didn't bark today. Many of the people who work in these settings themselves smoke, the staff. I didn't hear anything about that. Do you have any recommendations from the panel?

The question for Jill is that in the behavioral health population, not only has smoking prevalence declined by the number of cigarettes smoked per day**,** but those who continue to smoke have declined. I've got to think that a lot of people with a behavioral health problem are not smoking two packs a day. They may be smoking five cigarettes, they may be an occasional smoker.

Do you treat them definitely? Do they come in to see you? Does your prescription change for them? What do you think about that? So those are two different sets of questions.

Dr. Jill Williams: We feel that they're dependent. That's not the best measure, frankly, of how addicted they are. It's somewhat of a measurement**,** but somewhat crude. I agree with you that populations are smoking less**,** but in terms of the inability to quit, if you measure that at the level of dependence, they're still quite dependent because they are unable to quit. In many ways we do approach them with the same type of treatment.

Maybe if somebody was an infrequent smoker, less than five cigarettes a day, we wouldn't go right to combination nicotine replacement. But in many other ways, it's the same and the treatments are certainly effective and necessary even for people who smoke a few cigarettes per day.

Dr. Joe Parks: I don't have near Dr. Williams' experience. What I do in terms of treatment is I heap huge amounts of praise on them from going from two packs a day to half a pack a day. And then I up their dose of Wellbutrin, which is what I would have done if they were still at two packs. They do deserve huge heaps of praise and that's very helpful.

From our experience with the hospitals and campuses that go smokefree, you have to offer the workforce treatment and support. We did that mostly through EAP programs and one-pagers reminding them of what was in their insurance business. Most hospitals started holding employee smoking support groups, quitting support groups. Pretty much time limited measures during that transition**,** but it was very important to address that.

It turned out the states that had the most problem doing conversions were the ones with the strongest union contracts. The biggest roadblock was how the union felt about it more than anything else. The states that were not a bargaining unit were able to move a lot quicker. This is one place where the unions were a disservice to their members.

I would mention also that organizations that went smokefree also saw their housekeeping bills go down and their furniture replacement charges go down. You don't get holes burned in things and you don't get as many fires. There were a lot of benefits that were good for the staff. The staff did notice also that they were getting hit less often when there were arguments that came to physical blows. I think in outpatient, you have to offer treatment to the staff, and that's with your insurance benefit with EAP and with some smoking support groups.

Dr. Jill Williams: I want to add one additional comment. We know that people with schizophrenia get more nicotine out of their cigarettes. We were very purposeful to use control subjects that were matched on poverty level because we think poverty is a driver of that as well. If you only have money for five cigarettes a day, you probably smoke them in a way that you maximize your nicotine intake.

So that's the assumption, that people are more addicted than you think, even on low numbers of cigarettes per day. That's been shown a bit in the U.K. where they've looked at cotinine and special deprivation, and those studies are hard to do in this country because we don't have a class system supposedly. NIDA could pursue that work and show evidence of higher levels of dependence even in people who are smoking fewer cigarettes per day and then justifying the need for treatment.

Dr. Joe Parks: I think that the Cancer Society, Lung Association would do well to have some posters that emphasize the cost issue. My patients are extremely price sensitive**,** and I think many would be more persuaded to quit if they saw the dollar amount they spend on smoking each year (depending on location and tax structure). Show them what they could have purchased instead. This could be a more motivating message for many people than the health concerns, especially very young people.

Dr. Jill Williams: Joe, you mentioned that you wish we had handouts of the medications to give to consumers in order to educate them, and you wish someone would talk about how much money people spend. That's exactly what Deidre's job is. We actually have handouts of exactly those things to use as educational tools.

Dr. Donald Shell: I appreciate the panel's comments. I've got two questions for Dr. Williams. One thing that's been troubling me all day, we know that individuals are self-medicating with nicotine. I keep thinking about health care providers who continue to smoke, even though they're working in the field. What are your thoughts on how we substitute something else for the benefit that individuals receive to address their stress? One of the presentations from Stanford talked about masking symptoms of mental illness and the role of tobacco in stress. If we want someone to not self-medicate with nicotine, then what do we offer the masses as something else to help them with the benefit that they're getting from nicotine?

And then the second question is the outcomes of the specialty tobacco treatment centers**;** you talked about funding being cut in New Jersey. I wonder if anyone has looked at the other tangential benefits**:** reduced hospitalizations, reduced vascular disease, reduced heart attacks for your patients that have reduced cost. Because your patients who have stopped smoking at the specialty centers have probably reduced health care costs for other diseases, comorbidities of tobacco use. I don't know if anybody has looked at the overall savings from patients who have benefited from your centers and looked at that as a reason to promote continued funding for those types of centers.

Dr. Jill Williams: We have not done the cost effectiveness specifically. They were state funded programs, which have a limited ability to do research. But there's tremendous evidence already that shows this is a cost-effective intervention and many other studies have already shown that. It's going to be a cost saver. Studies show again, and again, and again, the health care costs always go down when you invest and expand tobacco treatment. It's a cost in this year's budget**,** but if people could get beyond that, it's a major cost saver.

Donald Shell: But ROI, from a policy perspective, return on investment is an approach that can be taken. I wondered if that's a blind thought for cutting the funding, not really looking at the real true return on investment that the programs provide.

Dr. Jill Williams: Right. Massachusetts did a big study where they greatly expanded their Medicaid access for tobacco, they educated providers, they educated the public that the benefit was available**,** and they got a three-to-one return on investment. It saves health care dollars and drives down the cost of Medicaid.

We didn't specifically do that but many other agencies and organizations have already done it. You asked how we can replace the reward of smoking and the truth is, although there's some data that nicotine impacts the brain in a positive way, it is quite modest. The illnesses where there's the best evidence are attention deficit disorder (ADD) and schizophrenia. That's not the vast majority of people with depression and anxiety where it's not clear that there's so much benefit, certainly from nicotine.

So how do we help people rebuild without drugs? Well, that's what substance abuse treatment is. That's recovery. That's life. And that may sound trivial but I get quite angry when behavioral health professionals say it's all they have. I say, what's your job then? Your job is to help people rebuild their life truly drug-free. It's challenging. People have multiple difficulties**,** but that's our job.

Pat McKone: Self-medication, a commonly used term, is something that's been promoted by the tobacco industry. I would say that tobacco self-medicates nicotine withdrawal. So there's an addiction there. It treats the stress of withdrawal. There is a company that's spun off from RJ Reynolds called Targacept that has patented nicotine analogs to be used for schizophrenia, for Parkinson's, for Tourette's, for depression and they have not survived Phase 2 testing. So nicotine has very transient effects on the brain. It doesn't last very long and then you go into withdrawal.

Denny Henigan: This question is primarily for Dr. Williams, but the other panelists may want to offer a view. I was intrigued with the commentary about the physicians of the mental health advocacy community. You indicated there are some groups that are lukewarm towards this whole tobacco issue. Can you give us some idea of why that is and how that might be overcome?

Dr. Jill Williams: As a person who studies human behavior, I can tell you that although we want our patients to change, we seem reluctant to change ourselves. So physicians don't want to change, systems don't want to change. It's hard to overcome the status quo. If we have more people in our field who are addicted to this drug, that's a tremendous barrier to progress**;** it would make sense that we would have more tobacco users in our field because we have a tradition of hiring people who are in recovery themselves. I think that's a barrier that's holding us back.

Dr. Steven Schroeder: When you see a turtle on a fencepost, it didn't get there by itself. There's usually a reason why things are how they are. In 2007, when our Center began to take on this issue, we convened a summit at Lansdowne and we invited all the representatives of major agencies to come. An obvious group was NAMI.

I went to visit the leadership of NAMI and they asked why I was there and I explained, we're going to try to start a movement. You're a very powerful organization. You have the capacity to kill this movement, I'm asking you not to kill it. They said, our organization is very conflicted about this because there are relatives who say, poor old Uncle Joe. He's got severe chronic mental illness, smoking is his is his only pleasure.

But the counter argument is you're exposing little Timmy to secondhand smoke and you're going to cut years off his life, and you're going to injure his family income. So finally, they said, we won't support it but we won't fight it. Over time, they have become much more supportive.

They issued a video called Hearts and Minds and it addresses the very high rate of heart disease that occurs among people with mental illness because they're more sedentary, overweight, and don't eat as well. The video, in 1999, didn't mention smoking. We then helped them to update that with a small grant in 2009. The lead segment is Dr. Ivins of Mass General saying, "The most important thing you can do is not to smoke and here's how you stop." So NAMI used to be in that category.

The exposure to secondhand smoke, the social stigma, the difficulty of recovering, all of that has tilted the balance. I think it's less of an uphill fight than it was. Jill, do you want to comment on that?

Dr. Jill Williams: I think your perspective is correct. I think there is some ambivalence still, but less. It will be interesting to see how they would respond to this meeting today.

Public Comments

Dr. Anne Thompson: My name is Dr. Anne Thompson. I'm a child neurology resident at the University of Virginia and I'm currently in Washington, D.C., interning. The views expressed today are my own. I had two topics of interest to ask the committee about today. First, I think in looking at the harmful effects of tobacco, we are most commonly looking at really downstream, chronic, long-term effects of tobacco use among adult users. But certainly, we know that most cigarette smokers initiate smoking in adolescence and that was certainly a statistic that was illustrated by Deidre's story today, but is also commonly cited in the literature as many as 90% initiated smoking in adolescence.

I felt like adolescence came up and young adults came up on the periphery today and just how that segment of the population has influenced the Interagency Committee's thinking about this problem and how that will impact future policy. And then secondarily, I wanted to express concern about the position that the American Cancer Society stated about focusing on combustible tobacco products compared to other products. But in the past 10 years, CDC has released really alarming rates in terms of the increasing number of calls to poison control centers about the harmful effects of e-cigarette exposure and

liquid nicotine exposure in children. I just wondered if there could be further comments on that as well.

Member Discussion (Continued)

Dr. Peter Ashley: This is Peter Ashley from HUD's Office of Lead Hazard Control and Healthy Homes. I didn't introduce myself this morning and I wanted to be on record that I'm here. But Pat brought up an issue of working with tribal populations and at HUD we do have an Office of Native American Programs. Of course, our support is with housing, block grants. But if you want to find a population that really needs help and intervention, that would be one, wouldn't it? One of the highest in the country in terms of behavioral health issues from what I understand, prevalence, and smoking rate. So I just wanted to throw this question out to the folks at the table here. What are other federal agencies, NIH, et cetera, doing with the tribal populations in terms of helping with tobacco control in the context of behavioral health? I know Lung Association, you've been very active.

Pat McKone: Peter, that was a great lead-in because I want to share a story of what happens when you collaborate and you provide that voice. Our lead organizer, Deb Smith, engaged the American Indian Community in authentic conversation on this, honoring sacred tobacco and commercial tobacco.

The American Indian Community Housing, ACO it's called in our community, has just recently purchased a local market in a low-income neighborhood where they want to start selling healthier foods, teach folks how to cook, and also serve as a market source for corner markets in the community. They called us and told us that through their collaboration, through the report that we were doing, that they are not going to sell commercial tobacco in that neighborhood market. I don't like to say to people, "how can I help you." That's not empowering them. How can we work together, what can we do together? And when that happens, it creates further trust and collaboration. Also, honoring that tobacco is a sacred part of many tribal communities is important.

Dr. Michael Toedt: Dr. Michael Toedt, Chief Medical Officer, Indian Health Service. I am a family physician and I'm also a trained freedom from smoking facilitator. So tobacco use amongst American Indian and Alaskan Natives continues to be a persistent problem. I appreciate everyone for highlighting the disparity among ethnic groups and races.

With certain conditions, the Indian Health Services has had great success. The special diabetes program for Indians, which was established in 1977, has produced a 50% reduction in diabetic eye disease rates, a 54% decrease in kidney failure rates and diabetes, and it's been the largest decrease in both of those among any racial or ethnic group. The SDPI, Special Diabetes Program for Indians, also focused on tobacco cessation as part of its program.

The CDC reported in 2002 to 2005 that there was a 37.1% rate of tobacco use amongst American Indians and Alaska Natives. In the interim, the Indian Health Service implemented a tobacco-free policy in 2006 for our facilities. We continue to provide culturally sensitive basic tobacco intervention skills training, basic skill certification for instructors and for providers. We host best practices, promising practices, and tobacco webinars.

However, in the next reporting period, 2010 through 2013, the rate increased from 37% to 38% and now, American Indians and Alaska Natives are the only racial or ethnic group that has an increase in tobacco use. So I took the recommendations that are there for all federal agencies and the recommendations that you provided specifically for HRSA, looking at those as possible recommendations the Indian Health Services can implement.

I was particularly intrigued by the bidirectional tobacco quit line suggestion. I had a question about success of electronic integration of the medical record and whether or not there's any data to show that that is worth the bang for the buck. As you know, electronic medical records and changes to those interfaces are very expensive and cost-prohibitive.

I want to make sure that we are investing our scarce resources wisely.
I like the recommendations that you provided about use of community health workers. We**,** of course**,** are a strong supporter of integrated care, motivational interviewing, but for other issues like housing, I'd like to know what recommendations you would have for progress among tribal communities.

Pat McKone: I'm not sure if you're aware that Minnesota has recently launched a quitline that is focused on American Indians in collaboration with the American Indian cancer line in Minnesota. It just launched, but even marketing is being directed by the native community itself.

Dr. Joe Parks: If your pharmaceutical reimbursement claim system is using National Drug Codes (NDC) (I know in some states, the Indian Healthcare System is not using those yet) then you're able to see which of your prescribers are prescribing medications for treatment of tobacco and you probably should message those that are not using it and ask them why. Then, point out that their colleagues are**;** try offering them some CME (Continuing Medical Education) credits and go after underutilization of treatment if you have a way of tracking who is getting nicotine replacement therapy and the other medications.

Dr. Jill Williams: When we think about tobacco use in high-risk populations, whether that's pregnant women, youth, Native Americans, if you scratch below the surface there's also a behavioral health issue. And so if our approaches are limited to tobacco only, maybe this is why they're not optimal.

And I think that that's really true for pregnant smokers. People have just started now, to reveal in studies, high rates of depression and high rates of anxiety. One study showed 30% of pregnant smokers were using marijuana for the duration of pregnancy. I think if we're not taking a more overall holistic integrated approach that may be why our intervention seems to sometimes fail.

Capt. Kimberly Elenberg: In the VA we have the same issue of basically doing what we need to do in terms of electronic clinical reminders and electronic health records, but experience the same challenges of what's going to make a difference. And I think from a national policy perspective, there were two things that really did help drive up utilization of smoking cessation medication. One was basically a sort of HEDIS measure for health care systems for outpatients. They were asked once a year if they were a current tobacco user and received a brief message about quitting, counseling**,** and medications.

Just by including an offer to patients saying, "Are you interested in quitting and would you like medications today, including over-the-counter nicotine replacement therapy?" really drove up utilization of smoking cessation medications over time in our system. We use that a little bit as a marker to determine if we were doing a better job of delivering evidence-based treatment.

The other thing that has been discussed by the panel, training, is incredibly important. One thing that I think is critical is not just training of the primary care providers, the mental health providers, but also training pharmacists. Engaging pharmacists in our federal health care system is important because they look at the bottom line as opposed to looking at what is it going to cost us in terms of this increased utilization of smoking cessation medications. More understanding of what is it going to save us shows pharmacists can be engaged as prescribers under their scope of practice for dispensing smoking cessation medications. That enhanced training makes a huge shift in terms of looking at what happened with primary care in outpatient mental health populations getting medications.

Dr. Michele Bloch: We've talked about "behavioral health" very broadly, but obviously, it's a great spectrum from relatively modest to incredibly involved. And also, it combines both the psychiatric and substance abuse. I wondered if we are looking at different therapies, or is it all handled by the same cluster of providers? I just think it's been one big ball of wax when it really seems to comprise many different entities.

Simon McNabb: It's unfortunate that Dr. Prochaska left because I think she did touch on this briefly.

Dr. Jill Williams: I think the answer to your question is complicated because it's both yes and no. There are some diagnoses that really stand out and truly seem different, like schizophrenia, but a lot of other problems probably sort more by severity than they do by the name of the diagnosis. So I agree, in some ways**,** it's limiting to keep coming back to

just one big umbrella and imagining everybody is the same. There are subtle differences**,** but the general approach is probably okay for all I would say.

Dr. Joe Parks: And the general approach is better than no approach at all. We would be thrilled if people with schizophrenia who do benefit from higher doses of NRTs and longer durations of treatment uniformly have the general approach. People should have their care managed and be treated in the care setting that sees them most often.

If you see your health center more than anybody else, I actually would be holding them accountable for your blood pressure and blood sugar, as well as for your smoking because you have more opportunity to impact their health in general. So if you go to substance abuse treatment more often**,** then they should be the lead on your smoking. I'm a psychiatrist working in primary care. I see plenty of people with bipolar disorder and schizophrenia who get all their care at the primary care clinic and something is better than nothing. Wherever you are is a good place.

Dr. Antonello Punturieri: Dr. Williams touched on populations such as pregnant women. Since the data presented was aggregated by sex, should there be a difference of treatment by sex in this population? And my second question is in general to the panel, in regard to (Deidre's) story when she started smoking in high school. What is your position on going in that direction in terms of prevention?

Dr. Jill Williams: I'm not a pregnancy expert. I'm a simple psychiatrist. Certainly, there could be a bigger role for a different approach based on gender. My comment was just to say that among the other tobacco disparity population, what they have in common often is a behavioral health component. When we spoke before about who's missing, you could make the argument that pediatricians and child psychiatrists are missing. So people think it makes sense for me as an addiction psychiatrist to do this, and I always say, where are the child psychiatrists? This is an illness where the child lives disordered. So I think that that's a very reasonable idea.

Dr. Joe Parks: The prevention approach is really all about adolescents and young adults. You have an insignificant chance of being tobacco dependent if you don't smoke before 28. We probably shouldn't spend money on them at all given the relative risk to the younger population and our limited resources. The public commenter was absolutely correct. The prevention end of it**,** certainly**,** and early treatment is all downhill. We haven't said anything about school clinics and shame on us.

Simon McNabb: Harkening back to Corinne Graffunder's presentation on basic tobacco control**,** and we do see it as a vaccine, all those aspects play a part, and prevention is a big part. We'd love to see no need to have anyone in treatment for tobacco use. As (Ken) said, the power of this vaccine is population-level policies. We**,** among the tobacco-control community**,** can argue amongst ourselves of the impact of the various components; there's a lot of data. Ultimately all components need to be implemented.

Denny Henigan: Now that the discussion has drifted towards prevention, maybe this comment is appropriate. I just want to remind everyone that the FDA is currently considering a proposal to make cigarettes nonaddictive. And if you go back to the question, Where will we be in five years?, imagine if cigarettes are nonaddictive by that time. Imagine what that means for prevention. Imagine what that means for treatment. Imagine what that means for adolescents who may experiment with cigarettes**,** but don't get addicted or adults who are addicted and want to quit.

It simply has profound implications. And I just wanted to remind everyone that FDA is right now receiving public comments on that idea in an advanced notice of proposed rule-making. FDA extended the comment period by about a month. I think it expires mid-July. So the opportunity to comment exists right now on this historic proposal, whatever your perspective is. I believe federal agencies can comment themselves. It's government agencies themselves that can be heard**;** I imagine this committee could be heard.

So I just wanted to remind people of that because as we discussed, the day-to-day addressing of this issue in the field and elsewhere, there is this proposal lurking that would change everything.

Simon McNabb: Let's come back to the issue that Ken raised. How do we carry this forward? How do we ensure we have a large impact? I think we have a great opportunity because of our presenters. Several of them have given us feedback and answered that question of what needs to be done.

So what I propose is we take the things that we heard, and we certainly can lift them right from the presentations. We will review the transcript and collect any recommendations for action. I will work with the public members to validate and prioritize the recommendations.

Then, we will engage in a conversation with the Surgeon General on how to advance the recommendations and at the very least we will send them to every federal member of the committee. We will explore also sending it up the chain to HHS leadership, which is charge of the ICSH to advise the Secretary and the Director of the CDC. That is a modest proposal and let me put that out on the table to see if anyone has any reaction.

Dr. Ken Warner: I like what you're proposing. The comments I made earlier were actually very useful and it led to a couple of other conversations off the regular session between people discussing things they've done that others may not know about. And obviously, there's material in here that we can all learn from in that respect as well.

There were a lot of very specific suggestions, and (Cliff) for example, outlined them. I think it would be really useful to find proposals for each of the agencies and see how we can work together to address them, ask them to respond to them. Maybe some of the

proposals are nonsensical and maybe some of them have already been addressed successfully, and we just don't know about it. Get some interaction with each of the individual agencies based on some of these suggestions. And then come back to the group with the results of that discussion.

Simon McNabb: I'm sure everyone has read the bylaws of the committee, which means that silence means acceptance. I think we have a proposal and we will try to make that happen. Unfortunately, the Surgeon General isn't here. I referred to this proposal to him before he left. I think he's very open to this idea because one of his first questions about the ICSH was what tangible outcomes do committee meetings produce. He's committed to carrying any messages that come from this meeting and we left it to be determined what vehicle with which to best do that.

I want to ask one more question for any of the federal members that are present here, is there anything that you'd like to share, is there anything that you'd like to share from your agency, from your department on this topic**,** specifically**,** that you think hasn't come up or you think the committee should know?

Dr. Deirdre Kittner: I'm from the Center for Tobacco Products. Denny, thank you for bringing up the fact that we have dockets out to receive comments on the Commissioner's plan to reduce nicotine. I just wanted to let everyone know that it's helpful to hear conversations in the hall, comments, and emails to me or whoever you're sending them to. But the docket really is the official record for submitting comments to the FDA, data that you think we might find useful.

I want to remind you and encourage you to use this document submission process so that we can actually see your comments and so other people can see your comments. In addition to the one on nicotine, we also have one open on flavors including menthol**,** as well as premium cigars.

Dr. Corinne Graffunder : About three years ago, or maybe even longer than that, one of the things that CDC did is include in the notice of grant making used to fund our state tobacco control program that the states basically were required to include in some way work to address the behavioral health population. The states vary in terms of their capacity and in terms of where they do place their priorities.

But there are a number of activities, and actions, and collaborations that are occurring all across the country in the states, some of them led by the state tobacco control program, some of them where the state tobacco control program may just be a partner in that work. So I don't know how it might fit into informing anything moving forward, but I do know that this is occurring and I do know that we probably haven't invested the resources to cull that and try to share it in any real substantial way. But we could certainly take a look at where**,** maybe**,** there are some interesting case studies about things that are being done.

And to the extent that may or may not be something of interest or helpful, at least know that there is probably more going on out there than we are able to even represent to you right now.

Wilson Compton: One thing that wasn't addressed is the common risk factors when we think about developmental trajectories and some of the evidence for risk-factor based prevention having an impact on multiple outcomes, including tobacco use and behavioral health or mental illnesses generally. For example, an NCI study under (Michele's) leadership and participation, SAMHSA and NIDA funded, looked at middle school universal prevention, addressing risk factors that had had a whole host of positive outcomes, including reduced externalizing disorders as well as tobacco use, just as one example. And while that isn't a major theme here that's at least one other topic that touches on the relationship of mental illness and tobacco use.

Doug Tipperman: The public members who come to this meeting, this is their only opportunity with the federal government, meeting and talking about this issue. There's actually a monthly coordination meeting among the federal government. Some people were surprised to hear that and this conversation has happened a few times over the past few years. People don't realize that we have these meetings. (Simon), maybe it would be good for you to talk about that meeting, what they do, what happens in those meetings, et cetera.

Simon McNabb: Thank you, Doug. Eight years ago, under the leadership of the HHS Assistant Secretary for Health Howard Koh an initiative was begun to coordinate the tobacco control activities across HHS. The first product was a comprehensive tobacco control action plan that contained specific proposals the agencies could undertake. (https://www.hhs.gov/sites/default/files/ash/initiatives/tobacco/tobaccostrategicplan2010.pdf)

Cliff was also part of that team at the time and worked very closely with us. It's now eight, nine years old but it's a great summary if you want to know what HHS does on tobacco control; it is still very relevant. It was in the early days of FDA's authority over tobacco products, so it only scratches the surface of what FDA could do.

But what Doug is specifically referring to is the HHS Tobacco Control Steering Committee. This committee made up of HHS agencies, most of whom are also members of the ICSH, meets monthly to share information and coordinate our respective activities on tobacco control. The Surgeon General is our chair.

And then a subset of that group is the HHS cessation workgroup. It is a less formal workgroup chaired by CDC and NCI. Erik Augustson and Mike Fiore, over there in the audience, help lead it. The VA is a member in addition to the HHS agencies. come and they are a welcome member of it. Both DOD and HUD have participated at various times as well. It's a wonderful way for us to address the cessation issue and carry it forward.

Cliff Douglas: It has to be somewhat dated at this point, but the strategic action plan that we developed and issued in 2010, took a year to produce, and many people in this room, Wilson Compton, Doug Tipperman, Michele Bloch and others actually were involved in the committees that led to the development of it. It is online, that was my punch line here; I just looked it up. I'm holding it up here on my screen and it's called Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan for the U.S. Department of Health and Human Services. It detailed the work of all of the agencies and the collaboration that had been developed and continues to this day, the steering committee at HHS led by the Surgeon General, etc.

Simon McNabb: I will note that adult prevalence at that time was hovering around 20% and right now, it's hovering between 15% and 16%.

Peter Ashley: I wanted to mention that we also have a monthly call about smokefree housing with agencies that are interested in helping us implement our smokefree housing rule. EPA is on it, as well as CDC and NCI. So if any of you want to reach out, please do. Last month, we had ~~a~~ representative**s** from Robert Wood Johnson and the ALA talk about their grants to help us implement the policy that's in public housing.

Dr. Antonello Punturieri: I want to refer everybody to a couple of numbers. I work mostly in COPD and we launched the National Action Plan in 2017. This year, we went a little bit deeper and looked at the difference between rural and urban America.

As mentioned, we are doing really well in urban America. For adolescents 12 to 17 this is the national household survey on drug abuse. We have an average of 7% of smokers in 2010 in large urban areas. Instead, in rural areas, it's about 12%; almost double. For adults, it's kind of the same story: It's about 15 to 16% in urban and about 28% in rural areas.

Simon McNabb: Tony, thank you, you're right. That brings us back to**,** of course**,** the purpose of this meeting. Several people used the term bubble, it's certainly true that we are seeing tobacco use confined to certain populations.

I would like to officially thank the members of the committee, the federal members, the public members, and especially thank our speakers who are still present and let's give them one last hand. I will convey the conclusions of this meeting to the Surgeon General. He greatly appreciated all of you and he appreciated being here. Thank you very much.

CHAIR'S CERTIFICATION

I hereby certify that to the best of my knowledge, the foregoing minutes of the proceedings are accurate and complete.

_____ _____

Date

VADM Jerome M., Adams, M.D., M.P.H.
U.S. Surgeon General
Chair, Interagency Committee on Smoking and Health

Attachment 1: Participants List

Committee Chair
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U.S. Department of Health and Human Services

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Dennis Henigan, J.D.
Campaign for Tobacco-Free Kids

Steven Schroeder, M.D.
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Kenneth Warner, Ph.D.
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Advisory Committee Members Absent
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Black Hills Center for American Indian Health

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Deidre Stenard
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