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2018-09-04

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# A Qualitative Evaluation of Mental Health Clinic Staff Perceptions of Barriers and Facilitators to Treating Tobacco Use

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## Abstract

**Introduction:** Veterans with mental health disorders smoke at high rates, but encounter low rates of tobacco treatment. We sought to understand barriers and facilitators to treating tobacco use in VA mental health clinics.

**Methods:** This qualitative study was part of a trial evaluating a telephone care coordination program for smokers using mental health services at six VA facilities. We conducted semi-structured interviews with 14 staff: 12 mental health clinic staff working at the parent study's intervention sites (n = 6 psychiatrists, three psychologists, two social workers, one NP), as well as one psychiatrist and one psychologist on the VA's national tobacco advisory committee. Interviews were transcribed and inductively coded to identify themes.

**Results:** Five "barriers" themes emerged: (1) competing priorities, (2) patient challenges/resistance, (3) complex staffing/challenging cross-discipline coordination, (4) mixed perceptions about whether tobacco is a mental health care responsibility, and (5) limited staff training/comfort in treating tobacco. Five "facilitators" themes emerged: (1) reminding mental health staff about tobacco, (2) staff belief in the importance of addressing tobacco, (3) designating a cessation medication prescriber, (4) linking tobacco to mental health outcomes and norms, and (5) limiting mental health staff burden.

**Conclusions:** VA mental health staff struggle with knowing that tobacco use is important, but they face competing priorities, encounter patient resistance, are conflicted on their role in addressing tobacco, and lack tobacco training. They suggested strategies at multiple levels that would help overcome those barriers that can be used to design interventions that improve tobacco treatment delivery for mental health patients.

**Implications:** This study builds upon the existing literature on the high rates of smoking, but low rates of treatment, in people with mental health diagnoses. This study is one of the few qualitative evaluations of mental health clinic staff perceptions of barriers and facilitators to treating tobacco. The study results provide a multi-level framework for developing strategies to improve the implementation of tobacco treatment programs in mental health clinics.

## Introduction

People with mental health conditions are significantly more likely to smoke than people in the general population.[1–3] The American Psychiatric Association's (APA) practice guidelines for the treatment of nicotine dependence recommends routine tobacco screening of psychiatric patients and offering treatment to those interested in quitting.[4] Unfortunately, national rates of tobacco screening and treatment in mental health settings are low,[4,5] and lack of support from health care providers is a major barrier to abstinence in smokers with mental health conditions.[6]

To address the limited provision of tobacco treatment in mental health settings, we previously conducted a study evaluating the implementation of a telephone care coordination program for smokers receiving mental health care at Veterans Health Administration (VA) facilities (the "TeleQuitMH" trial).[7] Mental health clinic staff could refer their patients to the program using a quick consult in the electronic medical record (EMR). The program proactively reached out to patients to offer mailed cessation medications and telephone counseling (either specialized multisession counseling designed for patients with mental health disorders or warm-transfer to a state quitline for counseling). Long-term quit rates were good in both groups (26% in the specialized arm, 18% in the quitline arm), yet referrals from providers were lower than expected. Most providers did not refer any patients, and among those who did refer, 45% referred only one patient.

Prior research has examined barriers and facilitators to implementing tobacco treatment in mental health and substance use treatment programs. At the policy or organizational level, Muilenburg et al. found that the presence of financial incentives to treat tobacco and that having fewer organizational obstacles to tobacco treatment were associated with greater adoption of tobacco treatment in addiction treatment programs.[8] In a qualitative study, Pagano et al. found that addiction treatment program directors reported multiple organizational barriers to providing tobacco treatment, including limited resources (eg, insurance coverage for NRT), structural and environmental obstacles (eg, smoking sheds nearby), and a lack of attention to tobacco use in addiction treatment culture.[9] Additional research has similarly found that organizational cultures that value smoking cessation enhance the likelihood of tobacco treatment programs being implemented and sustained in mental health or substance abuse programs.[6,10,11]

At the visit or individual level, a national study of tobacco use screening and treatment by outpatient psychiatrists in the United States found that as visit length increased, the odds of being screened for tobacco increased.[5] Consistent with this finding, Knudsen et al. found that competing demands for staff time reduced odds of sustaining tobacco services in addiction treatment programs,[12] and Malte et al. reported that time limitations was the most common barrier reported by providers to integrating tobacco treatment into routine care for posttraumatic stress disorder.[13] Individual provider knowledge, beliefs, and attitudes have also consistently been shown to impact the implementation of tobacco treatment in mental health and substance use treatment settings. Provider factors associated with reduced implementation or provision of tobacco treatment include views that tobacco is a low priority for their patients,[14] limited training or self-efficacy in addressing tobacco,[11,15] fear that tobacco cessation will negatively impact mental health or substance use,[11,16] and the perception that patients are not interested in quitting.[9,17]

The majority of research examining factors that enhance or impede the delivery of tobacco treatment for mental health patients has been conducted in addiction treatment settings and has used quantitative methods, with potentially predictive factors chosen by investigators. In response to the low number of referrals received in the TeleQuitMH trial described above, we conducted qualitative interviews with VA mental health clinic staff and tobacco leadership to learn their perspectives about challenges and potential facilitators to addressing tobacco in VA mental health clinics.

## Methods

### Setting

The parent trial's tobacco care coordination program was implemented at six VA facilities in the Northeastern United States. These VA facilities function as staff-model managed care organizations. Each facility included one or more medical centers and community outpatient clinics. The facilities use a common electronic medical record (EMR) that includes reminders for smoking cessation screening and treatment. Each facility is held accountable for their performance on the clinical reminders, but at most sites the primary care provider is responsible for completing the smoking cessation reminder. The current interview sub-study was approved by the Institutional Review Board (IRB) and the Research and Development Committee at the parent study's main site, where the interview procedures were conducted.

### Participants and Recruitment

Purposeful sampling[18] was used to identify and recruit participants working in specific roles related to mental health care and tobacco at the VA. We were interested in interviewing four main categories of mental health clinic providers at the parent study's intervention sites: psychiatry, psychology, social work, and mental health nursing. We were also interested in speaking with national VA mental health care leaders and mental health providers who serve on the VA's national tobacco advisory committee (which helps provide direction and set tobacco policy at the VA) to understand the perspectives of VA mental health care and tobacco leadership.

Potential interviewees were identified using mental health clinic staff lists at three of the parent study's intervention sites: the site with the largest number of referrals, the site with the lowest number of referrals, and a site in the middle in terms of referral rates. From these lists, we invited five psychologists, five psychiatrists, one nurse practitioner, and two social workers to participate in an interview. We used the membership list for the VA's tobacco advisory committee to identify a psychiatrist and a psychologist to invite for an interview. We used the organizational chart for the VA's national mental health care leadership committee to identify six members to invite for interviews (four psychologists, two psychiatrists). The positions and titles of the members of the VA tobacco and mental health leadership committees invited to participate are not reported here to protect their identities.

Staff were invited to participate in an interview via institutional email, with up to three follow-up emails for non-respondents. Table 1 shows the interview response rates. Eighty percent of mental health clinic staff invited to participate completed an interview, and both invited members of the VA's tobacco advisory committee completed an interview. No members of the VA's national mental health leadership agreed to participate. The two who provided a refusal reason cited that they did not feel they had a role in addressing tobacco.

**Table 1.** Interview Response and Participation Rates

|  | Invited | Non-response | Refusal | Completed interview | Participation rate |
|---|---|---|---|---|---|
| **National Mental Health Leadership** | | | | | |
| Psychologist | 4 | 2 | 2 | 0 | 0% |
| Psychiatrist | 2 | 2 | 0 | 0 | 0% |
| **National Tobacco Leadership** | | | | | |
| Psychologist | 1 | 0 | 0 | 1 | 100% |
| Psychiatrist | 1 | 0 | 0 | 1 | 100% |
| **Mental Health Clinic Staff** | | | | | |
| Psychologist | 5 | 0 | 1 | 4 | 80% |
| Psychiatrist | 5 | 0 | 0 | 5 | 100% |
| Nurse Practitioner | 1 | 0 | 0 | 1 | 100% |
| Social Worker | 2 | 0 | 0 | 2 | 100% |

The final interview sample (*N* = 14) included six psychiatrists (one female, five male), five psychologists (two female, three male), two social workers (one female, one male), and a female mental health nurse practitioner who worked at the study's intervention sites. The sample also included one psychiatrist and one psychologist (both male) on the VA's national tobacco advisory committee. We anticipated further sampling if needed after our initial round of coding and analysis. However, the 14 interviews were similar in content and emergent themes, and we believe additional interviews would not have generated new insights.

## Interview Procedures

Interviews were conducted by two investigators (ESR, CG) and three graduate students. Interviews were conducted in-person for local staff or over the phone for remote staff. To minimize interviewee burden, interviews were designed to take no more than 20 minutes. We developed a semi-structured interview guide that assessed interviewee perceptions toward the importance of treating tobacco in mental health patients, the role of mental health providers in treating tobacco, and barriers and facilitators toward screening and treating tobacco in VA mental health treatment settings. Interviews were digitally recorded and transcribed verbatim.

## Analyses

We used a three-step group coding process to analyze the transcripts.[19] Investigators first read four transcripts together and used open-coding to develop an initial codebook with code names, meanings and examples. The investigators then applied the codebook to the remainder of the transcripts and held discussions to achieve consensus on coding and update the codebook. Once all transcripts were coded using the initial codebook, the investigators completed more focused coding to identify code clusters, relationships among codes and common themes. Once themes were identified, we developed a conceptual framework representing the barrier themes at three levels (eg, system, provider, visit/patient) and how the themes interact to influence tobacco screening and treatment delivery.

## Results

### Barriers

Figure 1 shows the conceptual representation of the barrier themes that emerged during the interviews. These barriers and their interactions are discussed in detail below (in order of their frequency reported during interviews).

### Theme 1: Competing Clinical Priorities and Immediate Patient Crises during a Visit

The most common tobacco treatment barrier—endorsed during 13 interviews—was the issue of competing priorities during a patient visit. Staff expressed that it is not always feasible or appropriate to spend time on tobacco when patients are facing immediate threats to safety (eg, homelessness, suicidality) or urgent psychiatric needs (eg, psychosis). One psychiatrist spoke of the conflict between believing that tobacco is important and the need to respond to psychiatric emergencies: "*I think that [addressing tobacco] is important but is probably a different level of priority depending on the patient. If you are seeing a patient because they are psychotic and suicidal…you know that their use of tobacco is less pressing.*" Similarly, a social worker expressed that: "*The day to day-ness of it all just means that only the immediate priorities and crises are what people are focused on and [tobacco] is just going to recede.*" We heard from one psychiatrist that competing priorities can be especially challenging in a walk-in mental health treatment setting where patients are more likely to be facing a psychiatric emergency.

In addition to competing patient priorities that occur during a visit, three interviewees reported competing priorities at the organizational level that determine what must be covered during the visit. For example, a psychiatrist expressed that they are held accountable by the facility for non-tobacco performance, such as completing depression and suicide screens. Once staff have finished addressing patient emergencies and the performance measure responsibilities, they feel they do not have time to address tobacco.

### Theme 2: Patient Challenges and Resistance to Quitting and/or to Treatment

The second most common theme endorsed during nine interviews was the perception of patient barriers to tobacco treatment. These barriers included patient use of smoking to relieve symptoms or improve mood, lack of patient interest in quitting, and patient refusal of treatment when offered. Four staff reported that mental health providers may be reluctant to address tobacco because they fear it would negatively impact mental health or substance abuse. For example, a social worker said: "*Our culture is that we have a lot of Vets with substance abuse problems and they are just so difficult and require so much work that no one really wants to jeopardize that. They all figure they can confront smoking in the future.*" A psychologist gave a patient example of his concerns: "*You know [patient] has nothing in his life, is having such a hard time, but smoking calms him down, says smoking calms him down, you know rather smoke than take another medication.*"
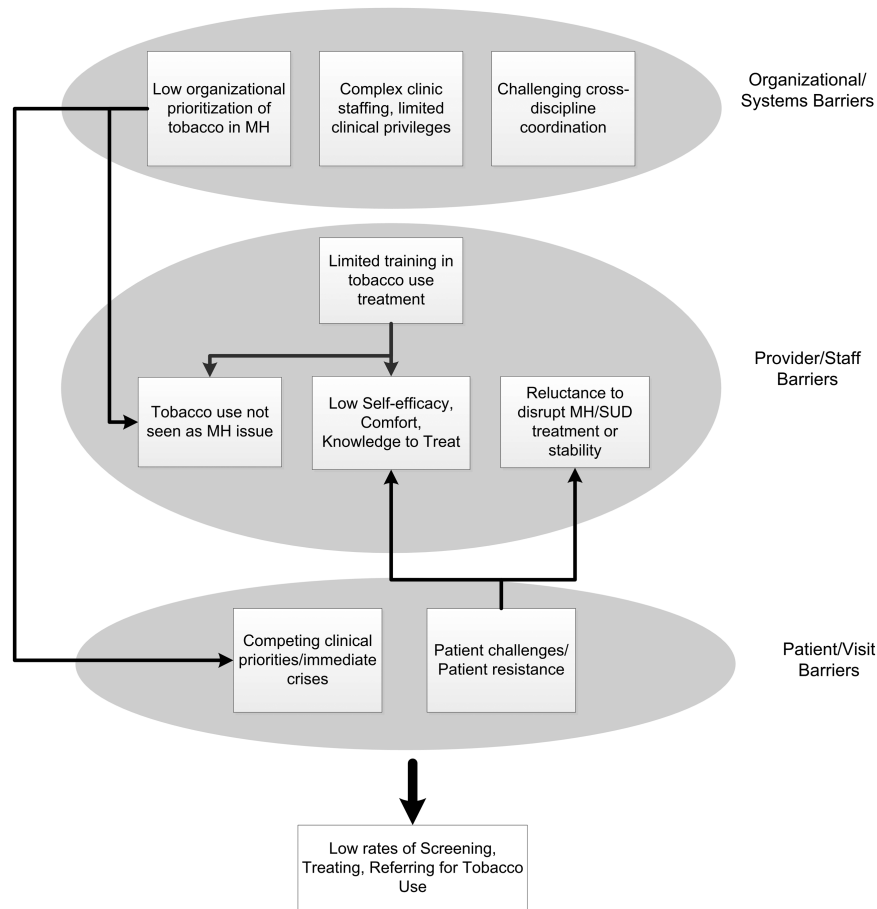
**Figure 1.** Conceptual framework of multi-level barriers to tobacco treatment in VA mental health clinics.

Eight interviewees expressed that even when providers broach the topic of tobacco and quitting, some patients are not interested in trying to quit, find the prospect of quitting to be too challenging, and refuse assistance. Four interviewees discussed patients with serious mental illness (eg, schizophrenia) or substance abuse as being especially challenging to engage in treatment or to help quit. A social worker said: "*The acute inpatient folks have been smoking for a very, very long time. They are constantly offered smoking cessation services but always opt out. And then those with other substance abuse – those are the hardest. Along with those with serious mental illness. Just the very nature of living makes it very, very hard to tackle smoking in the midst of these of these challenges. They are just in the business of staying alive and putting one foot in front of the other.*" This patient resistance and provider experience with this resistance was causing providers to refrain from addressing tobacco and was harming provider self-efficacy in helping their patients. One psychiatrist noted that providers can experience "*referral fatigue,*" such that they grow weary of offering tobacco treatment after years of patient refusals.

### Theme 3: Complex Clinic Staffing, Privileges and Cross-Discipline Coordination

A third major theme that emerged during 10 interviews was the issue that mental health clinics have diverse and complex staffing, which poses a barrier to creating a single, comprehensive tobacco treatment approach for the clinic. A clinic can be comprised of psychiatrists, psychologists, social workers, peer counselors, nurses, and non-clinical staff such as housing or employment specialists. We heard that some staff (eg, social workers, vocational specialists) do not use the EMR in their work and therefore would not see tobacco screening reminders or document when they know a patient is a smoker, and many staff do not have the ability to generate treatment consults (eg, psychologists). Additionally, three interviewees reported that staff may not interact or communicate with staff outside of their discipline. A psychologist expressed that: "*To some degree we need better communication and more integration between our psychologists, psychiatrists, and rehab-focused staff. Certainly the idea of medications may seem foreign to many. And so many don't do anything in [the EMR] at all and just are not going to be comfortable making referrals or putting in orders.*" Therefore, initiating and coordinating guideline-concordant tobacco treatment (eg, screening, medications, behavioral counseling) would require some mental health clinic staff to learn and use new procedures, as well as coordinate with psychiatrists or nurse practitioners for medication prescriptions. This coordination process was perceived as burdensome or confusing for four interviewees, as one social worker told us: "*I really can't even begin to think about medications. One more thing for me to have to follow-up on, and I'm not sure how the psychiatrists will review and monitor.*" These discipline and coordination factors appeared to contribute to some of the participants' discomfort in addressing tobacco and especially to reinforce the shared belief that tobacco cessation was not an essential function of their jobs.

### Theme 4: Mixed Staff Perceptions about whether Tobacco is a Mental Health Care Responsibility

A fourth theme that was expressed during nine interviews is the culture or perception that mental health staff often view tobacco as a medical issue, not within a mental health provider's scope of practice. Of note, the two providers on mental health leadership whom actively refused interview participation shared this perception when providing their reason for refusal. Six interviewees reported that mental health providers recognize that tobacco use is an addiction, and thus could be within the scope of mental health care, yet view tobacco use as different than other addictions. A psychiatrist told us that: *"Tobacco in general doesn't itself cause as many psychiatric sequelae as other drugs and that maybe part of why mental health people don't really see [tobacco] as much as their domain."* Five staff reported that they viewed tobacco as something primary care providers are addressing or should be addressing—or at least that tobacco use is a *"shared responsibility"* between mental health and primary care. The fact that the facility was only holding primary care providers accountable for completing tobacco use screenings and treatment referrals reinforced the perception that tobacco is not a mental health clinic responsibility.

On the other hand, five interviewees viewed tobacco as something that mental health providers should *"absolutely be doing."* For example, a psychiatrist told us that mental health providers are in a *"unique position to be able to help their patients stop smoking,"* because of the comorbid nature of mental health and smoking, as well as their addictions training and often more frequent visits with patients than a primary care provider.

### Theme 5: Limited Staff Training and Comfort in Tobacco Use Treatment

Lastly, four interviewees reported that mental health staff lack formal training in treating tobacco use and this lack of training contributed to the perception that tobacco was not within their domain and to discomfort in treating tobacco. A psychiatrist told us: *"I don't think I ever had a class on treating tobacco use disorder in residency, and so because of that mental health providers may feel less comfortable doing it…and just because it wasn't modeled as part of their responsibility when they were training, they go on to not really see part of their responsibility when they are full-fledged providers."* The training gap was not unique to psychiatrists. A social worker reported that, *"We have a diverse staff – lots of peer specialists and vocational rehab folks, employment specialists. And they tend to have even less of a health background or perspective."*

## Facilitators

The interviews revealed some common themes regarding factors that may facilitate tobacco treatment programs in mental health clinic settings, many of which are directly related to the barriers described above.

### Theme 1: Reminding Staff about Tobacco Screening and Treatment

Twelve interviewees believed that tobacco treatment facilitation should start with methods for reminding providers to screen and refer to tobacco treatment, because current priorities and workflow cause providers to forget about tobacco. One psychologist suggested that: *"The best way – it's just hard to imagine anyone opposed to, against it – is to keep it on the radar. What's going to stop them from making referrals is just forgetting about it….The motivation and intention is there, but people just forget."* However, two providers reinforced that more reminders will not be enough or may impose a burden on providers, because—as one psychiatrist put it—*"with all the [existing] reminders, we can't even handle what we already have."*

### Theme 2: Staff Belief in the Importance of Treating Tobacco Use in Mental Health Patients

Ten interviewees believed in the general importance of treating tobacco use in mental health patients and therefore that implementation efforts do not need to focus on changing attitudes about patient need to quit smoking. Although (as discussed above) 13 staff reported that they experience conflicting priorities that distract from the ability to address tobacco during a visit or care plan, no interviewees expressed that they believe their patients should smoke.

### Theme 3: Designating a Cessation Medication Prescriber

Related to the barriers that many mental health staff are not prescribers, lack comfort with cessation medications, and face competing priorities to coordinate care, nine interviewees expressed that having designated cessation medication prescribers would make comprehensive tobacco treatment easier in mental health settings. We heard from staff and tobacco leadership that tobacco programs can be successful by identifying providers who agree to prescribe cessation medications for patients receiving behavioral cessation treatment from non-prescribers. For example, a psychologist at our study's main site told us know that the primary care-based tobacco program has a single physician who prescribes for all patients who attend the program and that *"has worked well."* This reduces the need for staff to identify and coordinate with a different prescriber for each patient.

### Theme 4: Linking Tobacco Use and Mental Health Outcomes/Priorities

We heard from four interviewees that linking tobacco use and cessation to mental health treatment and outcomes could activate more mental health providers in the tobacco treatment process. Doing so would align tobacco treatment with disciplinary norms and staff perceptions of their role and skillset. For example, one social worker told us that focusing on substance abuse recovery would be *"a natural fit"* because *"after all, nicotine is a substance."* A psychiatrist suggested that we generate interest among psychiatrists by linking smoking cessation to metabolic syndrome associated with atypical anti-psychotics, because providers *"have so little success dealing with this issue, that to begin able to remove at least one contributing agent (smoking) would really be great."*

### Theme 5: Limiting Provider and Staff Burden

We heard from six interviewees that efforts to implement tobacco treatment need to limit provider and staff burden. A social worker reported that: *"I wonder if we should try to do as much of this as possible outside the visit. Then I'd be happy to remind them and reinforce and then check back in with them."* A psychiatrist and psychologist liked that our parent study's telephone program had an easy consult process through the EMR, because—as the psychiatrist put it—*"when things get really busy, there are not extra hoops [to refer]."*

### Additional Suggestions

Although not recurring themes, two interviewees provided suggestions to improve the implementation of tobacco treatment in mental health clinics. The mental health nurse practitioner suggested that efforts could be made to motivate patients to request treatment from their mental health providers, so that tobacco treatment programs do not rely only on providers to initiate the conversation. She recommended that: *"You could definitely do something to get the patients to ask about [treatment]. I've used the plasma TV for health education things and it's actually ended up being helpful – patients actually watch that and then come in and ask about what they saw."* Lastly, one social worker suggested that tobacco treatment programs could employ VA peer specialists who *"have a history of mental illness and are now embedded in mental health clinics, substance abuse clinics, and residential programs."* She suggested that *"peers are more effective in talking to the veterans about stopping drinking and drugging, or about coming into appointments and following up… perhaps this model can also be used for smoking cessation."*

### Discussion

This study identified five major themes related to barriers to treating tobacco use in VA mental health clinics. Similar to results found by Malte et al.[13] and others[12,14,20] the most common barrier was competing priorities or lack of time. Interviewees reported that competing priorities were especially challenging in an environment where administrators and/or mental health care cultures do not prioritize tobacco treatment. Of note, our recruitment process found that the two VA mental health leaders who actively declined an interview did so because they did not feel they have a role in addressing tobacco – reinforcing the interview finding that VA mental health providers do not view tobacco treatment as falling within the scope of routine mental health practice. The VA prioritizes treating tobacco use nationally[21] but places the responsibility in primary care. Therefore, while interviewees' organizational setting (ie, the VA) prioritizes tobacco, their immediate work environment (ie, the clinic) does not—suggesting that the immediate work environment had a greater impact on tobacco treatment behaviors than the broader organizational culture and policies.

Our interviews also found that mental health staff experience or perceive patient resistance to quitting and to treatment—a barrier that has been reported previously[9,17,20] and that can negatively impact providers' willingness or ability to address tobacco. Providers' willingness and ability to address tobacco was further hindered by lack of training in treating tobacco, which is consistent with prior research.[12,15,22] Our interviews revealed that this training deficit extends beyond psychiatrists to include non-clinical staff who frequently interact with mental health patients but may lack training in health care. A recent systematic review of barriers to quitting among mental health populations concluded that smokers with mental health conditions would benefit from their providers being better trained in tobacco assessment and treatment;[6] thus implementing tobacco training for mental health clinic staff is likely to be welcomed by both staff and patients.

While some findings are consistent with existing literature, the study also produced new insights. Interviewees expressed that the diversity of mental health clinic staffing poses problems in providing comprehensive tobacco treatment to patients, such that some clinic staff do not use the EMR, are unable to electronically refer patients to tobacco treatment, do not have the ability to prescribe cessation medications, and do not have routines for coordinating with medical staff. Therefore, a single mental health clinic may require multiple strategies for implementing tobacco treatment, depending on the work practices and clinical privileges of different staff.

The overall pattern of results suggests that mental health clinics face multiple *interacting* barriers to treating tobacco (Figure 1) and that implementation strategies targeting just one barrier will likely not be sufficient. For example, although competing priorities/time constraints was the most common treatment barrier noted by interviewees, there were multiple determinants of these competing issues, including provider (lack of training, comfort), organizational (mental health care priorities, culture) and patient (crises, lack of interest in quitting) factors. The pattern of findings is similar to those found in addiction treating settings, both in the U.S. and internationally, suggesting that there is remarkable pervasiveness and persistence in challenges to systematic implementation of tobacco treatment for persons with mental health diagnoses.

Our findings have implications for future research and development of strategies to implement tobacco treatment in mental health care settings. At the organizational level, mental health clinics should clarify the role of clinic staff in the tobacco treatment process and resolve provider concerns about competing priorities; for example, as has been successful in primary care, incorporating reminders to address tobacco use in EMR-driven and non-EMR-driven clinic workflow and include tobacco screening in staff performance measurement.[23] Clinics may also benefit from systems that allow staff without treatment privileges to easily refer patients to tobacco treatment and to coordinate with medical providers for cessation medications. In our discussion of potential treatment facilitators, interviewees reported that designating a cessation medical prescriber for the clinic may help alleviate barriers to providing cessation pharmacotherapy and alleviate non-prescriber concerns about medication responsibilities and management. In this study, mental health staff often viewed tobacco as a primary care responsibility. Future efforts may benefit from learning whether primary care providers would appreciate having more tobacco treatment involvement, support, and expertise from mental health providers, and how these two disciplines can work together to treat tobacco.

At the provider level, clinics can implement staff training on tobacco treatment, such as the evidence-based training curriculum for psychiatrists (*Psychiatry Rx for Change*) that could also be adapted for non-psychiatrist staff.[24,25] Our findings about potential treatment facilitators suggest that trainings may be enhanced by leveraging staff's existing positive attitudes about tobacco cessation, linking cessation to mental health treatment norms and outcomes, countering misperceptions about the inability or harms of patients with severe mental illness or substance abuse to quit,[26] and teaching methods for engaging resistant patients into treatment. Patient engagement in treatment and quitting (and therefore provider willingness to treat) may be enhanced by addressing barriers to quitting identified by mental health patients, such as stress management, symptom management, self-efficacy, and identity/belonging.[6] Additionally, for patients who were dealing with immediate crises during their visit that precluded a discussion about tobacco, clinics can implement strategies to engage the patients into tobacco care when they are stable, such as through proactive telephone outreach between visits.[27]

The overall pattern of results also supports the implementation of proactive tobacco treatment programs that do not rely on referrals from mental health providers.[27] Proactive tobacco treatment has been shown to increase population-level abstinence rates in primary

care[28] and socioeconomically disadvantaged populations.[29] A recent secondary analysis of proactive tobacco treatment in VA primary care found that primary care patients with a mental health diagnosis did not have significantly different abstinence rates than patients receiving usual care. However, authors noted that patients a mental health diagnosis in their sample had frequent medical visits and reported receiving recent cessation advice and treatment.[28] In mental health clinics, in contrast, where patients do not routinely receive tobacco cessation advice and treatment, proactive tobacco treatment may benefit smokers with a mental health diagnosis by overcoming many of the barriers identified in the current study.

### Limitations

Limitations of the study include the fact that interviews were only conducted with VA staff, and results may not generalize outside the VA. Interviewees were salaried staff in an integrated health care system. Private practice providers may encounter different experiences and motivations for treating tobacco, such as bonus payment opportunities for meeting federal smoking cessation quality measures.[30] Another limitation is the lack of representation of VA mental health leadership in the interview sample. Findings may reflect provider *perceptions* about organizational culture and priorities, and the study does not have data on mental health leadership views or information about executive-level barriers/facilitators to tobacco treatment. Lastly, we did not collect information about the smoking status of interviewees, which may impact their views toward treating patients for tobacco use.[9,15]

## Conclusions

VA mental health staff struggle with knowing that tobacco use in patients with mental health conditions is important, but they are conflicted on their role in the cessation process, encounter patient resistance to treatment, lack training and comfort in addressing tobacco, and face competing demands for their time. Implementation interventions are needed that address these multi-level, interacting treatment barriers to improve the delivery of tobacco treatment to this high-risk population.

## Funding

## Declaration of Interests

*None declared.*

## References

1. Lasser K, Boyd JW, Woolhandler S, Himmelstein DU, McCormick D, Bor DH. Smoking and mental illness: A population-based prevalence study. *JAMA*. 2000;284(20):2606–2610.
2. Mackowick KM, Lynch MJ, Weinberger AH, George TP. Treatment of tobacco dependence in people with mental health and addictive disorders. *Curr Psychiatry Rep*. 2012;14(5):478–485.
3. Cook B. Trends in smoking among adults with mental illness and association between mental health treatment and smoking cessation. *JAMA*. 2014;311:172–182.
4. American Psychiatric Association. Practice guideline for the treatment of patients with nicotine dependence. *Am J Psychiatry*. 1996;153(suppl 10):1–31.
5. Rogers E, Sherman S. Tobacco use screening and treatment by outpatient psychiatrists before and after release of the American Psychiatric Association treatment guidelines for nicotine dependence. *Am J Public Health*. 2014;104(1):90–95.
6. Twyman L, Bonevski B, Paul C, Bryant J. Perceived barriers to smoking cessation in selected vulnerable groups: a systematic review of the qualitative and quantitative literature. *BMJ Open*. 2014;4(12):e006414.
7. Rogers ES, Smelson DA, Gillespie CC, et al. Telephone Smoking-Cessation Counseling for Smokers in Mental Health Clinics: A Patient-Randomized Controlled Trial. *Am J Prev Med*. 2016;50(4):518–527.
8. Muilenburg JL, Laschober TC, Eby LT. Organizational factors as predictors of tobacco cessation pharmacotherapy adoption in addiction treatment programs. *J Addict Med*. 2014;8(1):59–65.
9. Pagano A, Tajima B, Guydish J. Barriers and Facilitators to Tobacco Cessation in a Nationwide Sample of Addiction Treatment Programs. *J Subst Abuse Treat*. 2016;67:22–29.
10. Fuller BE, Guydish J, Tsoh J, et al. Attitudes toward the integration of smoking cessation treatment into drug abuse clinics. *J Subst Abuse Treat*. 2007;32(1):53–60.
11. Okoli CTC, Otachi JK, Kaewbua S, Woods M, Robertson H. Factors Associated With Staff Engagement in Patients' Tobacco Treatment in a State Psychiatric Facility. *J Am Psychiatr Nurses Assoc*. 2017;23(4):268–278.
12. Knudsen HK, Muilenburg J, Eby LT. Sustainment of smoking cessation programs in substance use disorder treatment organizations. *Nicotine Tob Res*. 2013;15(6):1060–1068.
13. Malte CA, McFall M, Chow B, Beckham JC, Carmody TP, Saxon AJ. Survey of providers' attitudes toward integrating smoking cessation treatment into posttraumatic stress disorder care. *Psychol Addict Behav*. 2013;27(1):249–255.
14. Ziedonis DM, Guydish J, Williams J, Steinberg M, Foulds J. Barriers and solutions to addressing tobacco dependence in addiction treatment programs. *Alcohol Res Health*. 2006;29(3):228–235.
15. Glover M, Fraser T, Bullen C, Wallace-Bell M, McRobbie H, Hadwen G. Transition to a smoke-free culture within mental health and drug and alcohol services: A survey of key stakeholders. *Int J Ment Health Nurs*. 2014;23(2):183–191.
16. Wye P, Bowman J, Wiggers J, et al. Total smoking bans in psychiatric inpatient services: a survey of perceived benefits, barriers and support among staff. *BMC Public Health*. 2010;10:372.
17. Brown CH, Medoff D, Dickerson FB, et al. Factors influencing implementation of smoking cessation treatment within community mental health centers. *J Dual Diagn*. 2015;11(2):145–150.
18. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Adm Policy Ment Health*. 2015;42(5):533–544.
19. Auerbach CF, Silverstein LB. *Qualitative data: an introduction to coding and analysis*. New York: New York University Press; 2003.
20. Wilson AJ, Bonevski B, Dunlop A, et al. 'The lesser of two evils': A qualitative study of staff and client experiences and beliefs about addressing tobacco in addiction treatment settings. *Drug and Alcohol Review*. 2016;35(1):92–101.
21. Hamlett-Berry K, Davison J, Kivlahan DR, Matthews MH, Hendrickson JE, Almenoff PL. Evidence-based national initiatives to address tobacco use as a public health priority in the Veterans Health Administration. *Mil Med*. 2009;174(1):29–34.
22. Prochaska JJ, Fromont SC, Louie AK, Jacobs MH, Hall SM. Training in tobacco treatments in psychiatry: a national survey of psychiatry residency training directors. *Acad Psychiatry*. 2006;30(5):372–378.
23. Papadakis S, McDonald P, Mullen KA, Reid R, Skulsky K, Pipe A. Strategies to increase the delivery of smoking cessation treatments in primary care settings: a systematic review and meta-analysis. *Prev Med*. 2010;51(3-4):199–213.
24. Prochaska JJ, Fromont SC, Hudmon KS, Cataldo JK. Designing for dissemination: development of an evidence-based tobacco treatment

curriculum for psychiatry training programs. *J Am Psychiatr Nurses Assoc*. 2009;15(1):24–31.

25. Prochaska JJ, Fromont SC, Leek D, et al. Evaluation of an evidence-based tobacco treatment curriculum for psychiatry residency training programs. *Acad Psychiatry*. 2008;32(6):484–492.

26. Prochaska JJ. Failure to treat tobacco use in mental health and addiction treatment settings: a form of harm reduction? *Drug Alcohol Depend*. 2010;110(3):177–182.

27. Rogers ES, Fu SS, Krebs P, et al. Proactive outreach for smokers using VHA mental health clinics: protocol for a patient-randomized clinical trial. *BMC Public Health*. 2014;14:1294.

28. Fu SS, van Ryn M, Sherman SE, et al. Proactive tobacco treatment and population-level cessation: a pragmatic randomized clinical trial. *JAMA Intern Med*. 2014;174(5):671–677.

29. Fu SS, van Ryn M, Nelson D, et al. Proactive tobacco treatment offering free nicotine replacement therapy and telephone counselling for socioeconomically disadvantaged smokers: a randomised clinical trial. *Thorax*. 2016;71(5):446–453.

30. American Psychiatric Association. Quality Measures for 2017 MIPS Quality Category Reporting. https://www.psychiatry.org/psychiatrists/practice/quality-improvement/quality-measures-for-mips-quality-category. Accessed May 4, 2017.