Program Manager Meeting

Children, Youth and Families | Behavioral Health Services
November 13, 2025| Zoom | 9:30 – 11:30 a.m.

Agenda

- **Welcome** - Emily Gaines
  - Gov Delivery registration: County of San Diego, California - BHS Provider Communications

- **QA Updates** *(SOC)* - Elaine Mills, Diana Daitch-Weltsch — 10 minutes
  - How to Complete the MH Non-Psychiatric SMHS Timeliness Record - 2023 CalMHSA
  - How to Complete the MH Psychiatric SMHS Timeliness Record - 2023 CalMHSA
  - MH Access Times FAQ and Tip Sheet - 6-17-25.pdf

- **Addressing Nicotine Addiction Among Youth** - Irene Linayao-Putnam — 30 minutes
  - Pages 3-30

- **System Collaboration Updates -** Shaun Goff, Cynthia Roman — 10 minutes
  - Special Population Identification
  - Page 55

- **Vista Hill ChildNET -** Annabel Mojica, LMFT, LPCC — 10 minutes
  - Pages 56-64

- **Early Childhood Emotional and Behavioral Services -** Leslie Manriquez, LMFT — 15 minutes
  - Pages 65-76

- **TBS Prior Authorization and referral process -** Christine Boyd, LMFT — 10 minutes
  - Pages 77-92

- **Assessment Summary -** Eileen Quinn O'Malley, LMFT — 5 minutes
  - Page 93-96

- **Our Safe Place – Good news highlights – PRIDE season -** Kate DeBerardinis, LCSW — 15 minutes
  - Pages 97-110

- **Networking with colleagues** - (If time permits) — 15 minutes

- **Announcements** *(SOC)*
  - Birth of Brilliance save the date and Call for Proposals – Melanie Morones and Vanessa Arteaga:
    - Birth of Brilliance 2026: Disrupt burnout. Reimagine rest. Submit today ✨🎤
    - Conference: February 26, 2026
    - Cultural Fair: Feb 27, 2026
  - Native American Heritage Month (Indigenous Tribe Map)
  - Holiday Closure
    - Page 111
  - MHSA to BHSA:
    - MHSA to BHSA Changes Chart
    - MHSA to BHSA County Funding Changes Graphic

- MHSA to BHSA Changes: What This Means

- BHSA Input Opportunities
  - Page 112
- National Voter Registration Act
  - Page 113
- Safer Spaces Training (flyer attached)
  - Page 114
- 211 Food Resources (flyer attached)
  - Page 115-116
- Incredible Years Training (flyer attached)
  - Page 117-118
- MCRT School Training Video
- Accessing past BHS Provider and GovDelivery communications: BHS Provider Communications

➢ **Next Meeting: January 8, 2026** | 9:30 - 11:30 a.m.

ADDRESSING NICOTINE ADDICTION AMONG OUTPATIENT 2 TEAM YOUTH

Irene Linayao-Putman, MPH Community Health Program Specialist
Public Health Services – Maternal, Child, & Family Health Services Branch
Chronic Disease & Health Equity Unit
County of San Diego Health & Human Services Agency

Presented On: 11/13/25

SANDIEGOCOUNTY.GOV/HHSA

OVERVIEW

- Introductions & Definitions
- Understanding Youth Tobacco Use Trends
- Meeting OP2 Needs
- Helping Youth Quit Vaping/Smoking
- Continuing to Collaborate
- Questions & Answers

Image Source: Shutterstock, 2024

INTRODUCTIONS & DEFINITIONS

TRADITIONAL TOBACCO

Tobacco and other plant mixtures that are grown or harvested with no added chemicals and have been used by American Indian and Alaskan Native nations for thousands of years as a medicine with cultural and spiritual importance. Traditional tobacco use varies with each tribe.

The common understanding is that traditional tobacco focuses on the process of tending, gathering, and using the tobacco in a respectful manner in accordance with Tribal guidance.

Traditional tobacco is:

- Sacred, ceremonial
- Rarely inhaled into the lungs
- Gathered or grown locally
- Prayerful
- Natural
- Deliberate, thoughtful
- Not addictive
- Healing, medicinal
- Process driven
- Respected
- Used as an offering

Source: Differences of Traditional vs. Commercial Tobacco. *Kick It California*, 2023

COMMERCIAL TOBACCO

Tobacco products that contain altered tobacco plants with added chemicals. Made by companies and sold in stores and online. These products include harmful toxins. Commercial tobacco is product and profit-driven, with no connection to spiritual or respectful use.

Commercial tobacco is:

- Recreational
- Inhaled
- Not sacred
- For profit
- Addictive, habitual
- Disease causing
- Processed
- Causal
- Product driven

Source: Differences of Traditional vs. Commercial Tobacco. *Kick It California*, 2023

UNDERSTANDING YOUTH TOBACCO USE TRENDS

TOP REASONS FOR VAPING AMONG U.S. ADOLESCENTS

48.7% Who vaped in the past year[1]

71.1% Who vaped near-daily[2]

To "Relax":

Connection between vaping and mental health concerns such as stress and anxiety.

48.7% Who vaped in the past year[1]

28.1% Who vaped near-daily[2]

To "Experiment":

Indicates curiosity as a primary driver among youth.

13.0% Who vaped in the past year[1]

42.7% Who vaped near-daily[2]

Because they were "hooked":

Rarely cited by occasional users.

[1]**Those reporting any past 12-month vaping:** n=5,082; respondents are a combination of 8th, 10th, and 12th grade students.
[2]**Near-Daily Vaping:** n=637; respondents are 12th grade students only (there were low levels of near-daily vaping among 8th and 10th graders).

Source: Patrick, M.E., Terry-McElrath, Y.M., Arterberry, B., & Meich, R.A. (2024). Reasons for Vaping Among US Adolescents. *Pediatrics, 154*(6). https://doi.org/10.1542/peds.2024-067856.

TOP REASONS FOR VAPING AMONG U.S. ADOLESCENTS

36.4% Who vaped in the past year[1]

42.8% Who vaped near-daily[2]

Because of "Boredom":

More common among 8th graders than older students.

34.0% Who vaped in the past year[1]

41.4% Who vaped near-daily[2]

For "Taste":

Flavors appeal to youth, often promoted in vaping marketing.

30.4% Who vaped in the past year[1]

20.9% Who vaped near-daily[2]

To "Have a Good Time with Friends":

Additionally, 13.1% of near-daily users[2] wanted to look cool, reflecting the influence of peer perceptions and social norms.

[1]**Those reporting any past 12-month vaping:** n=5,082; respondents are a combination of 8th, 10th, and 12th grade students.
[2]**Near-Daily Vaping:** n=637; respondents are 12th grade students only (there were low levels of near-daily vaping among 8th and 10th graders).

Source: Patrick, M.E., Terry-McElrath, Y.M., Arterberry, B., & Meich, R.A. (2024). Reasons for Vaping Among US Adolescents. *Pediatrics, 154*(6). https://doi.org/10.1542/peds.2024-067856.

TOP REASONS FOR VAPING AMONG U.S. ADOLESCENTS

33.1% Who vaped in the past year[1]

14.3% Who vaped near-daily[2]

Because of "Convenience":

E-cigarettes were more convenient than combustibles.

11.4% Who vaped in the past year[1]

18.5% Who vaped near-daily[2]

For "Weight Control":

This highlights a concerning trend due to potential body image pressures.

2.9% Who vaped in the past year[1]

8.9% Who vaped near-daily[2]

To "Quit Smoking":

Vaping was not commonly reported as a tool for smoking cessation.

[1]**Those reporting any past 12-month vaping:** n=5,082; respondents are a combination of 8th, 10th, and 12th grade students.
[2]**Near-Daily Vaping:** n=637; respondents are 12th grade students only (there were low levels of near-daily vaping among 8th and 10th graders).

Source: Patrick, M.E., Terry-McElrath, Y.M., Arterberry, B., & Meich, R.A. (2024). Reasons for Vaping Among US Adolescents. *Pediatrics, 154*(6). https://doi.org/10.1542/peds.2024-067856.

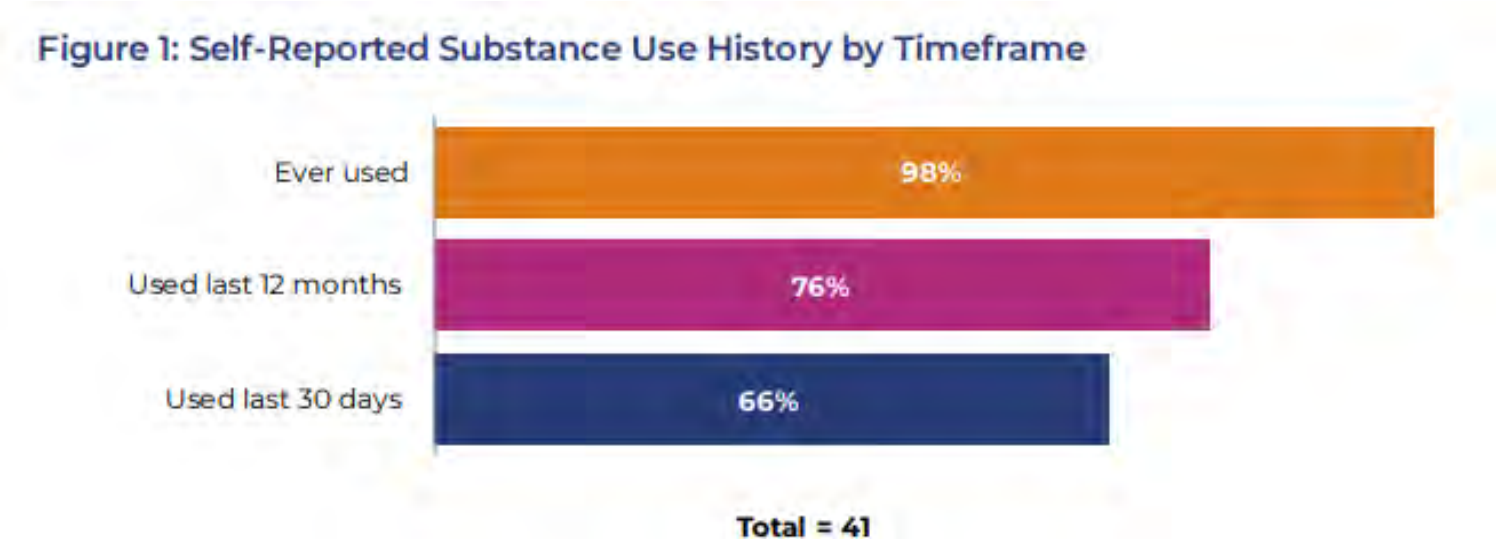
JUVENILE ARRESTEE DRUG USE

The information on the next slides come from the 2024 Juvenile Arrestee Drug Use in the San Diego Region (May 2025). For the full resource, please view here: 2024 Juvenile Arrestee Drug Use in the San Diego Region

To learn more, please visit the San Diego Association of Governments (SANDAG) website: www.sandag.org.

SANDAG CJ BULLETIN Research findings from the Criminal Justice Clearinghouse

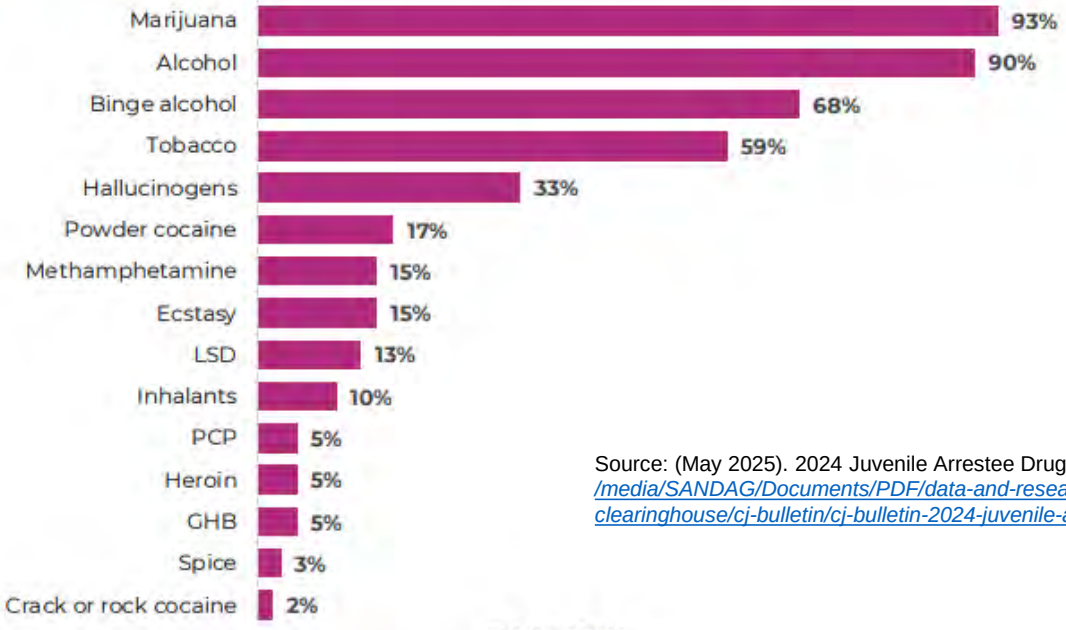
SUBSTANCE USE HISTORY



Source: (May 2025). 2024 Juvenile Arrestee Drug Use in the San Diego Region. SANDAG. *https://www.sandag.org/-/media/SANDAG/Documents/PDF/data-and-research/criminal-justice-and-public-safety/criminal-justice-research-clearinghouse/cj-bulletin/cj-bulletin-2024-juvenile-arrestee-drug-use-in-the-sd-region-2025-05-01.pdf*

RATES OF USE BY SUBSTANCE

Figure 2: Rates of Substance Use Among Interviewed Youth

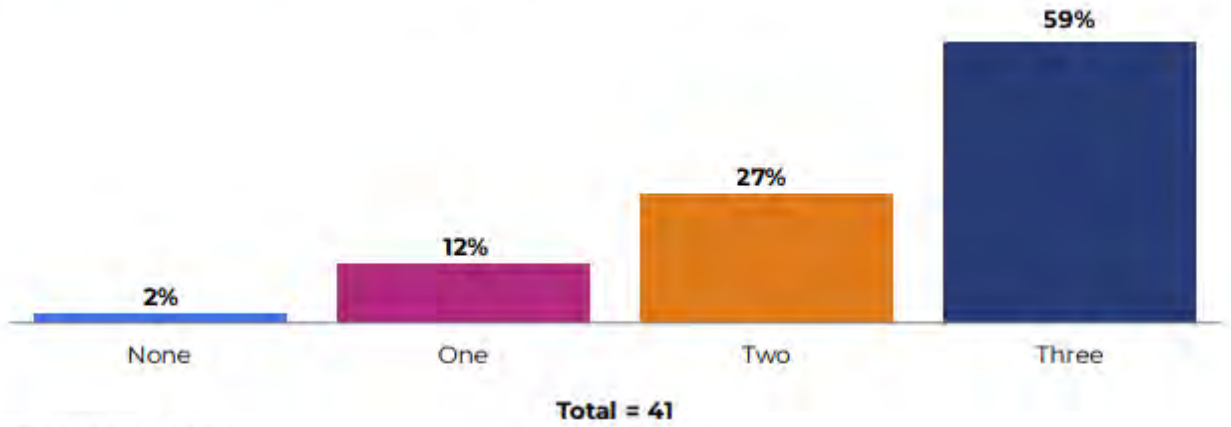


Note: Cases with missing information not included.
Source: SANDAG, 2024

Source: (May 2025). 2024 Juvenile Arrestee Drug Use in the San Diego Region. SANDAG. https://www.sandag.org/-/media/SANDAG/Documents/PDF/data-and-research/criminal-justice-and-public-safety/criminal-justice-research-clearinghouse/cj-bulletin/cj-bulletin-2024-juvenile-arrestee-drug-use-in-the-sd-region-2025-05-01.pdf

GATEWAY DRUGS: ALCOHOL, MARIJUANA, & TOBACCO

Figure 3: Number of Gateway Drugs Used Among Interviewed Youth

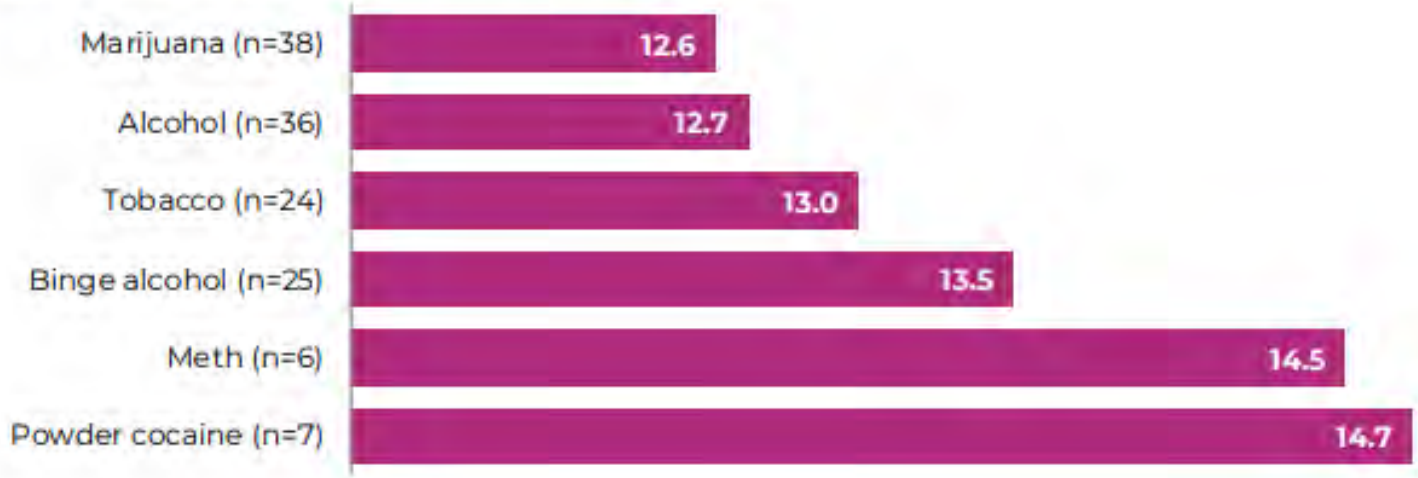


Source: SANDAG, 2024

Source: (May 2025). 2024 Juvenile Arrestee Drug Use in the San Diego Region. SANDAG. *https://www.sandag.org/-/media/SANDAG/Documents/PDF/data-and-research/criminal-justice-and-public-safety/criminal-justice-research-clearinghouse/cj-bulletin/cj-bulletin-2024-juvenile-arrestee-drug-use-in-the-sd-region-2025-05-01.pdf*

INITIAL SUBSTANCE USE

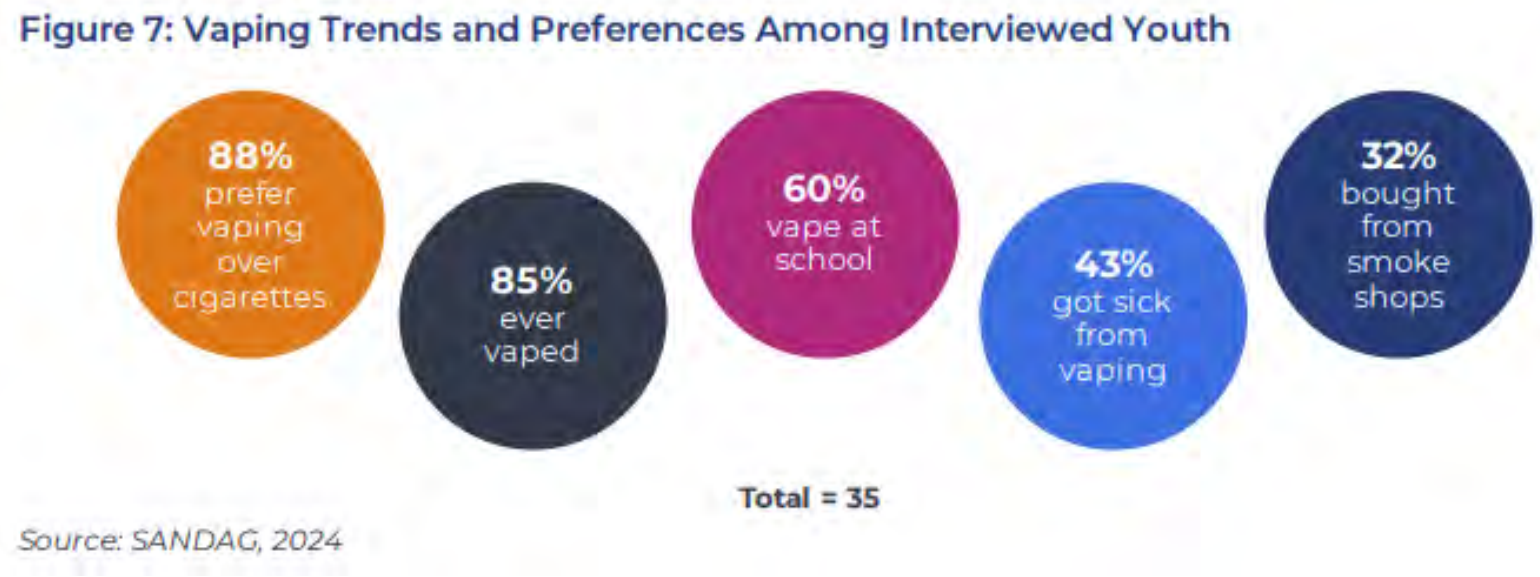
Figure 4: Average Age of Initial Substance Use



Note: Cases with missing information and/or a respondent size less than three are excluded from the figure.
Source: SANDAG, 2024

Source: (May 2025). 2024 Juvenile Arrestee Drug Use in the San Diego Region. SANDAG. *https://www.sandag.org/-/media/SANDAG/Documents/PDF/data-and-research/criminal-justice-and-public-safety/criminal-justice-research-clearinghouse/cj-bulletin/cj-bulletin-2024-juvenile-arrestee-drug-use-in-the-sd-region-2025-05-01.pdf*

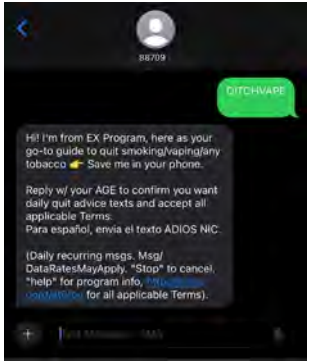
VAPE TRENDS & PREFERENCES



Source: (May 2025). 2024 Juvenile Arrestee Drug Use in the San Diego Region. SANDAG. *https://www.sandag.org/-/media/SANDAG/Documents/PDF/data-and-research/criminal-justice-and-public-safety/criminal-justice-research-clearinghouse/cj-bulletin/cj-bulletin-2024-juvenile-arrestee-drug-use-in-the-sd-region-2025-05-01.pdf*

MEETING NEXT OP2'S NEEDS

KEY EDUCATIONAL RESOURCES



[DITCHVAPE](#) to 88709 - a free text message program created with input from teens, college students, and young adults who have tried to quit or have successfully quit using e-cigarettes.

Stanford Medicine, 2025

[Stanford Cannabis Awareness & Prevention Toolkit](#) - an adaptable toolkit that fits your needs, from useful lessons, Power Point slides/notes, worksheets, and activities.

Stanford Medicine, 2025

[Stanford Tobacco Prevention Toolkit](#) - a curriculum with fun modules, quizzes, and downloadable materials like fact sheets and infographics.

California Youth Advocacy Network, 2018

[California Youth Advocacy Network](#) - an excellent source for educational materials. Developed with research on youth/young adult tobacco/vaping use.

HANDOUTS

- Tobacco and Behavioral Health
- Vaping Cessation Fact Sheet
- **Article:** “Nearly Half of Teen Vapers Have Recently Tried to Quit” – Medpage Today
- Fagerström Test for Nicotine Dependence Scale – Smokeless Tobacco
- Pharmacologic Product Guide – FDA-Approved Medications for Smoking Cessation

HELPING OP2 YOUTH QUIT VAPING/SMOKING

CESSATION INTERVENTIONS

Ask, Advise, Refer

Ask

Respectfully ask each patient if they use tobacco products.

> *"Do you smoke, vape, or use any other form of commercial tobacco?"*

Advise

Advise your patient on the benefits of quitting and the support available to them.

> *"Using tobacco can lead to asthma, heart and lung disease, and cancer. Programs and treatments can help you quit. Are you ready to try?"*

Refer

If they are interested in quitting tobacco, congratulate them!

Healthy Women, 2024

Source: Ask, Advise, Refer. *Tobacco Education Clearinghouse of California (TECC), 2024*

HELP TO QUIT

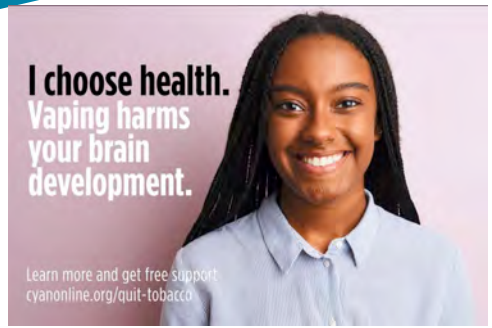

KICK/T
California
KICKITCA.ORG
ENGLISH
1-800-300-8086
SPANISH
1-800-600-8191
QUIT SMOKING ■ QUIT VAPING ■ QUIT SMOKELESS TOBACCO
KickItCa.org
Free, customized one-on-one coaching, grounded in science and proven to help you quit.
Automated Text Program
We'll text you helpful tips at critical points during your quit journey, and answer any questions you have within one business day.
Text "Quit Smoking" or "Quit Vaping" to 66819
Texto "Dejar de Fumar" o "No Vapear" al 66819
Speak with a Quit Coach
Monday-Friday 7 am to 9 pm
Saturday 9 am to 5 pm
1-800-300-8086 (English)
1-800-600-8191 (Spanish)
Mobile Apps
Download from the App Store & Play Store
no butts
no vape
Chat with a Quit Coach
kickitca.org/chat
Amazon Alexa
Say "Alexa, open Stop Smoking Coach" or "open Stop Vaping Coach"
Some clients may be eligible to receive free nicotine patches
Chat with a Quit Coach to see if you qualify.

ASK, ADVISE, REFER

Kick It California

[Kick It California Services Flyer]

CALIFORNIA YOUTH ADVOCACY NETWORK (CYAN)



CYANOnline

CONTINUING TO COLLABORATE

POLICIES ADOPTED 2020-2025

Carlsbad	• Smoke-Free Multi-Unit Housing	**Oceanside**	• Tobacco Retail Licensing
Chula Vista	• Flavor Ban	**San Diego**	• Flavor Ban
Encinitas	• Flavor Ban • Smoke-Free Outdoor Public Places	**San Marcos**	• Smoke-Free Outdoor Dining
Escondido	• Smoke-Free Outdoor Dining • Tobacco Retail Licensing	**Solana Beach**	• Flavor Ban
Imperial Beach	• Flavor Ban • Smoke-Free Outdoor Dining	**Vista**	• Smoke-Free Outdoor Dining
La Mesa **NATIONAL CITY**	• Smoke-Free Outdoor Public Places • Tobacco Retail Licensing • Tobacco Retail Licensing	**County of San Diego – Unincorporated Areas**	• Flavor Ban • Smoke-Free Outdoor Dining • Tobacco Retail Licensing

QUESTIONS & ANSWERS

The County of San Diego's Tobacco Control Resource Program supports the *Live Well San Diego* vision for healthy, safe, and thriving communities. For more information, visit LiveWellSD.org. ©2025. California Department of Public Health. Funded under contract #CTCP-21-37.

The Public Health Services department, County of San Diego Health and Human Services Agency, has maintained national public health accreditation, since May 17, 2016, and was re-accredited by the Public Health Accreditation Board on August 21, 2023.

CONTACT INFORMATION

Tobacco Control Resource Program

tinyurl.com/tcrpsandiego

tobacco@sdcounty.ca.gov

Irene.Linayao-Putman@sdcounty.ca.gov

The County of San Diego's Tobacco Control Resource Program supports the *Live Well San Diego* vision for healthy, safe, and thriving communities. For more information, visit LiveWellSD.org. ©2025. California Department of Public Health. Funded under contract #CTCP-21-37.

The Public Health Services department, County of San Diego Health and Human Services Agency, has maintained national public health accreditation, since May 17, 2016, and was re-accredited by the Public Health Accreditation Board on August 21, 2023.

THANK YOU

The Public Health Services department, County of San Diego Health and Human Services Agency, has maintained national public health accreditation, since May 17, 2016, and was re-accredited by the Public Health Accreditation Board on August 21, 2023.

Original Investigation

Cigarette Smoking During Recovery From Substance Use Disorders

Michael J. Parks, PhD[1,2]; Carlos Blanco, MD, PhD[1]; MeLisa R. Creamer, PhD[1] ; et al

Author Affiliations | Article Information

JAMA Psychiatry
Published Online: August 13, 2025
doi: 10.1001/jamapsychiatry.2025.1976

Key Points

Question Do changes in cigarette smoking predict substance use disorder (SUD) recovery over time, accounting for between-person confounders?

Findings In this longitudinal survey cohort study of 2652 participants, within-person transitions away from smoking were positively associated with SUD recovery in a nationally representative cohort; quitting smoking increased the odds of SUD recovery by 30% in fully adjusted models. Findings were robust in sensitivity analyses.

Meaning These results imply that quitting smoking is linked to better SUD recovery outcomes; smoking cessation could be a tool for assisting the recovery process among the millions of US adults with a current SUD.

Abstract

Importance Cigarette smoking is more prevalent among those with than without other substance use dis-

recovery.

Design, Setting, and Participants This cohort study was conducted among a nationally representative cohort of US adults with history of SUD from the PATH (Population Assessment of Tobacco and Health) Study. The PATH Study is an ongoing, nationally representative, longitudinal cohort study in the US. Analyses included adults (aged ≥18 years) in the wave 1 cohort (recruited in 2013/2014) assessed annually over 4 years until wave 4 (2016/2018). A second nationally representative cohort (from 2016/2018 to 2023) was also assessed in sensitivity analyses. Data analysis was completed from June 2024 to September 2024.

Exposure Cigarette smoking (never, former, and current use).

Main Outcomes and Measures The primary outcome was SUD recovery, assessed via the Global Appraisal of Individual Needs–Short Screener SUD subscale, measured as high lifetime SUD symptoms (4-7 symptoms) and zero past-year symptoms (sustained remission) or high lifetime SUD symptoms with any past-year symptoms (current substance use or SUD). Fixed-effects logistic regression assessed within-person change in smoking and its association with SUD recovery, accounting for between-person confounders.

Results Among 2652 adults from 2013/2014 to 2016/2018, 41.9% of participants (95% CI, 39.4%-44.4%) were female, and mean age was 39.4 years (95% CI, 38.7-40.3). By self-reported race and ethnicity, 17.0% of participants (95% CI, 15.3%-18.9%) were Hispanic, 13.9% (95% CI, 12.2%-15.6%) were non-Hispanic Black, 63.1% (95% CI, 60.4%-65.7%) were non-Hispanic White, and 6.0% (95% CI, 4.9%-7.4%) were another non-Hispanic race (Asian, Native American/Alaska Native, Native Hawaiian/Other Pacific Islander, more than 1 race). Within-person change from current to former smoking was positively associated with SUD recovery: year-to-year change to former cigarette use was associated with a 30% increase in odds of recovery (odds ratio [OR], 1.30; 95% CI, 1.07-1.57), accounting for time-varying covariates and between-person differences. This association remained significant after lagging predictor by 1 year (OR, 1.43; 95% CI, 1.00-2.05) and in the second cohort assessed from 2016/2018 to 2022/2023 (OR, 1.37; 95% CI, 1.13-1.66).

Conclusions and Relevance In this cohort study, within-person change from current to former smoking was associated with recovery from other SUDs. These results suggest that smoking cessation could be used as a tool to assist recovery processes and improve health among adults with an SUD.

Introduction

Despite declines in cigarette smoking,[1] smoking remains the leading preventable cause of morbidity and mortality in the US. Disparities in smoking also persist[2,3]—certain subgroups smoke at disproportionately high rates,[4,5] particularly individuals with nontobacco substance use disorders (SUDs).[6-10] Individuals with SUDs also have a disproportionately high likelihood of dying from tobacco-related causes.[11,12] There are renewed calls to treat tobacco use, particularly smoking, among those with SUDs.[8] However, tobacco use is undertreated and often untreated in health facilities that treat SUDs,[13-18] as treatment professionals may consider smoking a low priority.[8,16] Recent estimates show there are 48.5 million people in the US with an SUD in the past 12 months,[19] and 35.8% of those with an SUD currently smoke,[6] making recovery from SUDs and smoking public health priorities.

Previous research shows that smoking cessation is associated with improved outcomes for SUDs.[20-23] However, most studies are from population samples with data collected at least 20 years ago or from treatment studies,[24,25] and few studies examine how change in smoking status is related to SUD recovery over time using recent, nationally representative samples. Research designs that can account for confounding factors (eg, randomized clinical trials that isolate the experimental effect of smoking on SUD recovery) are typically not feasible at the population level, but quantitative methods applied to population-based data can approximate experimental conditions that remove the influence of confounders across individuals.[26-32] Using nationally representative samples would provide estimates that are generalizable to millions of US adults with an SUD, including those who do and do not receive treatment,[32] and using methods that account for confounding factors across individuals would provide more accurate estimates of how change in cigarette smoking is associated with SUD recovery over time.[31,32]

The purpose of this study was to assess smoking and SUD recovery over time using data from the US nationally representative PATH (Population Assessment of Tobacco and Health) Study,[33-37] focusing whether within-person transitions from current to former smoking were associated with SUD remission

odds of past 12-month SUD recovery increase in years when those with a history of SUD do not smoke relative to years when they smoke, accounting for differences across individuals that could influence the smoking-recovery association. Based on previous literature, we hypothesized that transitioning from current to former smoking would be associated with SUD recovery.

Methods

Data came from the PATH Study, which is an ongoing, nationally representative, longitudinal cohort study of adults and youth in the US. The PATH Study consists of individuals selected at the inception wave and 2 later replenishment waves. The PATH Study used a stratified address-based, area-probability sampling design that oversampled adults who self-reported tobacco use, young adults, and adults who identify as Black or African American. Study participants recruited at baseline between September 2013 and December 2014 formed the wave 1 (W1) cohort. Our primary analyses assessed the W1 cohort annually across 4 waves until W4 (December 2016 to January 2018). Data for W2 and W3 were gathered from October 2014 to October 2015 and from October 2015 to October 2016, respectively. PATH Study restricted-use files were analyzed,[33] and analyses focused on adults aged 18 years and older. Among adults selected during initial screening, 32 320 interviews were conducted at W1 (74.0% weighted response rate). The weighted W4 response rate for the W1 cohort, conditional upon W1 participation, was 73.5%, representing 27 757 adult respondents. Youth who aged up into the adult PATH Study at each wave between W1 and W4 were included. Further details regarding the PATH Study design and methods and the reliability and validity of responses are published elsewhere.[34-37] Details on interview procedures, questionnaires, sampling, weighting, and response rates are described in the PATH Study restricted-use files user guide.[33] The study was conducted by Westat and approved by the Westat institutional review board. All respondents aged 18 years and older provided informed consent. This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guidelines for cohort studies.

At W4, the first probability replenishment sample was selected from the US civilian noninstitutionalized population at the time of W4. More details on this replenishment sample have been published elsewhere.[37] Sensitivity analyses were conducted that assessed this second nationally representative cohort from W4, which included 4 waves of data across the COVID-19 pandemic: W5 data were collected from December 2018 to November 2019; W6 from March 2021 to November 2021; and W7 from January 2022 to April 2023.

Primary Analytic Sample

Inclusion criteria for being in the analytic sample included (1) being in the W1 cohort; (2) having longitudi-

2413, and 2565 respondents in waves 1 through 4, respectively. The analytic sample included 354 respondents with 2 waves (13.4%), 812 with 3 waves (30.6%), and 1486 with 4 waves of data (56.03%). eMethods 1 in the **Supplement** provides more details on the analytic sample, including those who were excluded because they had an SUD and did not change SUD recovery status during the study period and their smoking status.

Measures

SUD Recovery

A dichotomous recovery measure captured sustained remission from SUD symptoms, assessed via the Global Appraisal of Individual Needs–Short Screener (GAIN-SS) subscale for SUDs[38,39] (1 = sustained remission, 0 = current symptoms or substance use). Following past research,[38,39] sustained remission was measured as having high lifetime SUD symptoms (4-7 symptoms) but zero symptoms or use in the past 12 months, and current SUD or use was measured as having high lifetime SUD symptoms with any SUD symptom or use in the past 12 months.[38,39] The GAIN-SS measure is designed to measure annual change in recovery status via change in symptomology, akin to treatment outcomes of abstinence at 12 months postdischarge.[38] eMethods 2 in the **Supplement** provides wording for the GAIN-SS subscale for SUDs.

Cigarette Smoking

Cigarette smoking status was captured via a 3-level measure: never, former, and current. Former and current smoking included both experimental and established use. Current use (smoking some or all days in the past month) was used as the reference group.

Time-Varying Covariates

Time-varying covariates included mental health using the PROMIS Global Mental Health Subscale converted to T scores.[40] The subscale consisted of 4 items that assessed self-rated quality of life, mental health, satisfaction with social activities and relationships, and emotional problems. Each item ranged from 1 to 5, with high scores indicating better mental health. Other time-varying measures included educational attainment, which assessed highest level of education obtained via an ordinal measure (range: 1-4, with 1 = less than high school or GED, 2 = high school graduate, 3 = some college or associate degree, and 4 = bachelor degree or higher); medical treatment in the past 12 months based on whether respondents had seen a physician (1 = yes, 0 = no); and urgent care or emergency department visits in the past 12 months for a health problem (1 = yes, 0 = no). We also controlled for whether respondents used varenicline (Chantix) or bupropion (Wellbutrin, Zyban) in the past 12 months (1 = yes, 0 = no). Finally, a time-varying urban [illegible]al location covariate was included, which was based on geocoded addresses and a 4-category measure de-

We used fixed-effects logistic regression to test whether within-person, year-to-year change in smoking status was associated with SUD recovery over time. Fixed-effects regressions offer key advantages over conventional regressions, primarily in relation to omitted variable bias by removing potential effects of any time-invariant causes (measured or unmeasured),[31,41-44] similar to random assignment. Fixed-effects regressions remove effects of all time-invariant causes (all potential factors that could explain between-person differences in changes in SUD recovery over time, such as type of substances used at baseline or previous SUD treatment) at the person level and strictly examine within-person variance, allowing individual persons to serve as their own control by strictly making within-person comparisons over time.[31] Such methods are important for the current study because there are potential confounding factors across individuals that are difficult to measure or that do not change over time (eg, race, sex, genetic risk factors) in population-based surveys like the PATH Study. These potential confounding factors could affect changes in both smoking and SUD recovery.[32] Despite accounting for all differences across individuals, it is important to adjust for potential time-varying confounders in fixed-effects regression.[31,32] We adjusted for time-varying covariates previously mentioned. In our analysis, we estimated 2 models: a model that only included smoking status and no time-varying covariates and a model that adjusted for time-varying covariates.

Fixed-effects logistic regression models require that outcomes change within persons,[31] thereby reducing the sample to only individuals who experienced change in SUD recovery over the current study period (eg, smoking status could remain stable or change, but the binary measure of SUD recovery status was required to change in order to assess within-person change in the outcome). Consequently, the current study strictly focused on individuals with a history of SUD who experienced a change in SUD recovery over the study period (N = 2652 adults, with 9088 observations). Full-sample and replicate weights were used to account for the complex sample design, nonresponse, and attrition over time.

Since our primary research question did not address whether smoking status change preceded SUD recovery status change, we did not account for contemporaneous effects in primary analyses.[42,45] Smoking and recovery status were measured within the same 12-month period, and our primary research question addressed whether individuals had higher odds of recovery in years they did not smoke, accounting for all between-person differences. However, we conducted 2 sensitivity analyses. First, we tested whether there were differences in results after accounting for contemporaneous effects by lagging the SUD recovery outcome and main smoking predictor by 1 wave in dynamic panel data models.[42,45] The sample size for these analyses was reduced because participants needed to have changed SUD recovery status in 2 consecutive waves. Second, we tested the robustness of results by assessing the additional nationally represen[illegible] cohort generated at W4. Data for the second cohort were gathered at intervals that spanned longer than 1

Results

Descriptive Results

A total of 2652 individuals with 9088 observations were assessed, among whom 41.9% of participants (95% CI, 39.4%-44.4%) were female, and mean age was 39.4 years (95% CI, 38.7-40.3). By self-reported race and ethnicity, 17.0% of participants (95% CI, 15.3%-18.9%) were Hispanic, 13.9% (95% CI, 12.2%-15.6%) were non-Hispanic Black, 63.1% (95% CI, 60.4%-65.7%) were non-Hispanic White, and 6.0% (95% CI, 4.9%-7.4%) were another non-Hispanic race (Asian, Native American/Alaska Native, Native Hawaiian/Other Pacific Islander, more than 1 race).

Across the study period, being in SUD recovery vs not was nearly equal across observations (48.4%; 95% CI, 47.3%-49.4% vs 51.6%; 95% CI, 50.6%-52.7%, respectively). Current smoking was the most common smoking status (47.2%; 95% CI, 44.6%-49.8%), followed by former smoking (44.3%; 95% CI, 41.7%-46.9%) and never smoking (8.5%; 95% CI, 6.6%-10.9%). All other time-varying descriptive results are reported in **Table 1**.

View Large Download

Table 1. Weighted Estimates for Analytic Sample Across Wave 1 (2013/2014) to Wave 4 (2016/2018) of the PATH (Population Assessment of Tobacco and Health) Study[a]

Weighted Estimates for Analytic Sample Across Wave 1 (2013/2014) to Wave 4 (2016/2018) of the PATH (Population Assessment of Tobacco and Health) Studya

Fixed-Effects Logistic Regression Results

Regression results in **Table 2** showed that within-person change from current to former smoking was significantly and positively associated with being in SUD recovery. Year-to-year, within-person change to former cigarette use was associated with a 42% increase in the odds of being in recovery (odds ratio [OR], 1.42; 95% CI, 1.18-1.71; $P < .001$), accounting for all between-person differences. This association was reduced after adjusting for time-varying covariates but remained strong and statistically significant (adjusted OR, 1.30; 95% CI, 1.07-1.57; $P = .009$). There were statistically significant associations for time and [illegible]al health, indicating a positive trend in recovery over time (adjusted OR, 1.11; 95% CI, 1.05-1.17; $P < .001$) and a

Table 2. Weighted Fixed-Effects Logistic Regression Results for Substance Use Disorder Recovery and Within-Person Associations With Cigarette Smoking From Wave 1 (2013) to Wave 4 (2016) of the PATH (Population Assessment of Tobacco and Health) Study[a]

Weighted Fixed-Effects Logistic Regression Results for Substance Use Disorder Recovery and Within-Person Associations With Cigarette Smoking From Wave 1 (2013) to Wave 4 (2016) of the PATH (Population Assessment of Tobacco and Health) Studya

Additional models that removed the never-smoking category were examined. All results for all analyses remained identical for the transition from current to former smoking. The main results are based on the larger sample size that retained the never-smoking category.

Sensitivity Analyses

eTable 1 in **Supplement 1** reports results for dynamic panel data models that assessed within-person change but also lagged the recovery outcome and smoking predictor by 1 wave (4585 observations, 1686 individuals). The positive association between within-person change from current to former smoking and being in SUD recovery remained statistically significant and increased in magnitude in these sensitivity analyses (OR, 1.46; 95% CI, 1.03-2.07; $P = .03$). The association also remained statistically significant after accounting for time-varying covariates (adjusted OR, 1.43; 95% CI, 1.00-2.05; $P = .04$).

eTable 2 in **Supplement 1** reports results for the sensitivity analyses that assessed the W4 cohort (11 605 observations, 3340 individuals). The positive association between within-person change from current to former smoking and being in SUD recovery remained statistically significant in these sensitivity analyses (OR, 1.70; 95% CI, 1.40-2.05; $P < .001$). This association remained positive and statistically significant after adjusting for time-varying covariates (adjusted OR, 1.37; 95% CI, 1.13-1.66, $P = .002$).

Discussion

This study's finding that smoking cessation was associated with recovery from nontobacco SUDs can be used to help justify incorporating smoking cessation treatment into virtually all SUD treatment. Using data from the nationally representative cohort included in the PATH Study, year-to-year transitions from current to former cigarette smoking were positively linked to SUD recovery. Moreover, this within-person change in smoking and its positive association with SUD recovery existed after accounting for any potential

tion by approximating experimental conditions that minimize confounders across individuals. This is critical because between-person confounders could influence smoking status, SUD recovery, and their association, but methods used in the current study removed any (measured or unmeasured) between-person confounders,[31] with potential examples including whether individuals had ever received SUD treatment in the past or the type of substance used at baseline. Previous research has been limited because studies on this topic have often used data from single treatment centers or single cessation trials,[24,25] and previous research using nationally representative samples were from studies using data that were at least 20 years old and did not use methods to help provide highly specific tests for the association with SUD recovery.[32]

This study's results also showed that the association between within-person changes in smoking and SUD recovery remained robust in sensitivity analyses. After considering changes in smoking that preceded changes in SUD status and after analyzing a second nationally representative cohort studied over a longer and later period, the transition from former to current smoking was still significantly associated with SUD recovery. In sum, this study's hypothesis, which stated that year-to-year change from current smoking to former smoking would be positively associated with SUD recovery on a given year net of between-person confounders, was supported in primary and sensitivity analyses.

These findings reinforce the importance of addressing tobacco use among individuals with an SUD, including not only those who are actively receiving treatment, but also the millions of adults with an SUD who do not seek treatment.[19,32] Future research and practice should test ways to implement tobacco treatment for patients within the health care system.[8,46-50] Population-based approaches to cessation should also continue to be tested to reach individuals with SUDs outside of the health care system, including targeted cessation strategies and approaches to increase access to care.[51-53] Population-based policies geared toward helping individuals decrease or quit smoking, such as consistent and robust tobacco taxes and programs designed to increase tobacco quit line utilization,[53,54] could potentially help individuals in their recovery process. Future research should also consider other tobacco or nicotine products, such as e-cigarettes, in the SUD recovery process, both in terms of their link to smoking cessation and cessation from those products.

Limitations

Limitations to the current study include no direct measure of SUD treatment or medications, such as anti-craving prescriptions, but past-year medical visits and other potentially relevant medication use were accounted for. There could also be other time-varying variables that were not captured, and all meas were based on self-report data. Finally, abstinence was used as the measure of recovery, and resul er-

Cigarette smoking remains persistently high among individuals with a nontobacco SUD, despite declines in cigarette smoking among the US population.[6] Health care professionals and systems that treat SUDs are in an opportune position to address tobacco use,[8] but tobacco use is often untreated in health facilities that treat SUDs.[13,16] In this cohort study, smoking cessation was linked to better SUD recovery outcomes, and it could improve overall health among the millions of US adults with a current SUD. Results suggest that smoking cessation could be used as a way to assist recovery processes among adults with an SUD.

Article Information

Accepted for Publication: June 2, 2025.

Published Online: August 13, 2025. doi:10.1001/jamapsychiatry.2025.1976

Corresponding Author: Wilson M. Compton, MD, MPE, National Institutes of Health, NIH Mail Center, NIDA 3WFN MSC 6025, 16071 Industrial Dr, Dock 11, Gaithersburg, MD 20877 (wcompton@nida.nih.gov)

Author Contributions: Dr Parks had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Parks, Creamer, Kingsbury, Everard, Marshall, Kimmel, Compton.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Parks, Compton.

Critical review of the manuscript for important intellectual content: All authors.

Statistical analysis: Parks, Everard.

Obtained funding: Kimmel, Compton.

Administrative, technical, or material support: Parks, Creamer, Everard, Kimmel, Compton.

Supervision: Kimmel, Compton.

Conflict of Interest Disclosures: Dr Compton reported long-term stock holdings in 3M, General Electric, and Pfizer outside the submitted work. No other disclosures were reported.

Funding/Support: This manuscript was supported by federal funds from the National Institute on Drug

on Minority Health and Health Disparities, the National Heart, Lung, and Blood Institute, the National Institute on Alcohol Abuse and Alcoholism, the National Institute of Environmental Health Sciences, the Office of Behavioral and Social Sciences Research, the Office of Disease Prevention, the National Institute of Diabetes and Digestive and Kidney Diseases, and the National Library of Medicine. The PATH Study is supported with federal funds from NIH NIDA and FDA CTP, under contract to Westat (contract numbers HHSN271201100027C and HHSN271201600001C). Drs Blanco, Creamer, Kimmel, and Compton were substantially involved in providing scientific expertise and providing scientific management for contract numbers HHSN271201100027C and HHSN271201600001C.

Role of the Funder/Sponsor: The sponsors supported the authors, who were responsible for preparation, review, and approval of the manuscript and the decision to submit the manuscript for publication. The sponsor had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation of the manuscript; or decision to submit the manuscript for publication. The sponsors reviewed and approved the manuscript.

Disclaimer: The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the US Department of Health and Human Services or any of its affiliated institutions or agencies.

Data Sharing Statement: See Supplement 2.

References

1. Cornelius ME, Loretan CG, Jamal A, et al. Tobacco product use among adults – United States, 2021. *MMWR Morb Mortal Wkly Rep*. 2023;72(18):475-483. doi:10.15585/mmwr.mm7218a1 PubMed | Google Scholar | Crossref

2. Le TTT, Méndez D, Warner KE. New estimates of smoking-attributable mortality in the US from 2020 through 2035. *Am J Prev Med*. 2024;66(5):877-882. doi:10.1016/j.amepre.2023.12.017 PubMed | Google Scholar | Crossref

3. National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. US Centers for Disease Control and Prevention; 2014.

4. Drope J, Liber AC, Cahn Z, et al. Who's still smoking? disparities in adult cigarette smoking prevalence in the United States. *CA Cancer J Clin*. 2018;68(2):106-115. doi:10.3322/caac.21444

https://cancercontrol.cancer.gov/brp/tcrb/monographs/22/index.html

6. Han B, Volkow ND, Blanco C, Tipperman D, Einstein EB, Compton WM. Trends in prevalence of cigarette smoking among US adults with major depression or substance use disorders, 2006-2019. *JAMA*. 2022;327(16):1566-1576. doi:10.1001/jama.2022.4790
Article | PubMed | Google Scholar | Crossref

7. Han B, Einstein EB, Compton WM. Patterns and characteristics of nicotine dependence among adults with cigarette use in the US, 2006-2019. *JAMA Netw Open*. 2023;6(6):e2319602-e2319602. doi:10.1001/jamanetworkopen.2023.19602
Article | PubMed | Google Scholar | Crossref

8. Kleinman RA, Barnett BS. Smoking cessation as a priority for psychiatrists. *JAMA Psychiatry*. 2024;81(10):951-952. doi:10.1001/jamapsychiatry.2024.2162
Article | PubMed | Google Scholar | Crossref

9. Prochaska JJ, Das S, Young-Wolff KC. Smoking, mental illness, and public health. *Annu Rev Public Health*. 2017;38(1):165-185. doi:10.1146/annurev-publhealth-031816-044618
PubMed | Google Scholar | Crossref

10. Young-Wolff KC, Adams SR, Sterling SA, et al. Nicotine and cannabis vaping among adolescents in treatment for substance use disorders. *J Subst Abuse Treat*. 2021;125:108304. doi:10.1016/j.jsat.2021.108304
PubMed | Google Scholar | Crossref

11. Callaghan RC, Veldhuizen S, Jeysingh T, et al. Patterns of tobacco-related mortality among individuals diagnosed with schizophrenia, bipolar disorder, or depression. *J Psychiatr Res*. 2014;48(1):102-110. doi:10.1016/j.jpsychires.2013.09.014
PubMed | Google Scholar | Crossref

12. Callaghan RC, Gatley JM, Sykes J, Taylor L. The prominence of smoking-related mortality among individuals with alcohol- or drug-use disorders. *Drug Alcohol Rev*. 2018;37(1):97-105. doi:10.1111/dar.12475
PubMed | Google Scholar | Crossref

13. National Survey of Substance Abuse Treatment Services (N-SSATS): 2020: data on substance abuse treatment facilities. Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services.
https://www.samhsa.gov/data/sites/default/files/reports/rpt35313/2020_NSSATS_FINAL.pdf

15. Hall SM, Prochaska JJ. Treatment of smokers with co-occurring disorders: emphasis on integration in mental health and addiction treatment settings. *Annu Rev Clin Psychol*. 2009;5:409-431. doi:10.1146/annurev.clinpsy.032408.153614
PubMed | Google Scholar | Crossref

16. 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. doi:10.1016/j.drugalcdep.2010.03.002
PubMed | Google Scholar | Crossref

17. Das S, Hickman NJ, Prochaska JJ. Treating smoking in adults with co-occurring acute psychiatric and addictive disorders. *J Addict Med*. 2017;11(4):273-279. doi:10.1097/ADM.0000000000000320
PubMed | Google Scholar | Crossref

18. Bjørnestad ED, Vederhus JK, Clausen T. High smoking and low cessation rates among patients in treatment for opioid and other substance use disorders. *BMC Psychiatry*. 2022;22(1):649. doi:10.1186/s12888-022-04283-6
PubMed | Google Scholar | Crossref

19. Substance Abuse and Mental Health Services Administration. 2023 NSDUH Annual National Report. https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report

20. García-Rodríguez O, Secades-Villa R, Flórez-Salamanca L, Okuda M, Liu SM, Blanco C. Probability and predictors of relapse to smoking: results of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). *Drug Alcohol Depend*. 2013;132(3):479-485. doi:10.1016/j.drugalcdep.2013.03.008
PubMed | Google Scholar | Crossref

21. Weinberger AH, Platt J, Esan H, Galea S, Erlich D, Goodwin RD. Cigarette smoking is associated with increased risk of substance use disorder relapse: a nationally representative, prospective longitudinal investigation. *J Clin Psychiatry*. 2017;78(2):e152-e160. doi:10.4088/JCP.15m10062
PubMed | Google Scholar | Crossref

22. Blanco C, Okuda M, Wang S, Liu SM, Olfson M. Testing the drug substitution switching-addictions hypothesis. A prospective study in a nationally representative sample. *JAMA Psychiatry*. 2014;71(11):1246-1253. doi:10.1001/jamapsychiatry.2014.1206
Article | PubMed | Google Scholar | Crossref

24. Bertucci S, Schultz E, Stevenson B, Fu SS. An opt-out tobacco treatment group intervention within an intensive substance use disorders treatment program: initial outcomes in the Veterans Health Administration. *Nicotine Tob Res*. 2024;27(1):12-17. doi:10.1093/ntr/ntae134
PubMed | Google Scholar | Crossref

25. Holt AG, Hussong A, Castro MG, et al. Smoking policies of outpatient and residential substance use disorder treatment facilities in the United States. *Tob Use Insights*. Published online May 14, 2024. doi:10.1177/1179173X241254803
Google Scholar | Crossref

26. Maciejewski ML. Quasi-experimental design. *Biostatistics Epi*. 2020;4(1):38-47. doi:10.1080/24709360.2018.1477468
Google Scholar | Crossref

27. Shadish WR, Cook TD, Campbell DT. *Experimental and Quasi-Experimental Designs*. 2nd ed. Cengage Learning; 2002.

28. Cook TD, Shadish WR, Wong VC. Three conditions under which experiments and observational studies produce comparable causal estimates: new findings from within-study comparisons. *J Policy Anal Manage*. 2008;27:724-750. doi:10.1002/pam.20375
Google Scholar | Crossref

29. Rosenbaum PR. How to see more in observational studies: some new quasi-experimental devices. *Annu Rev Stat Appl*. 2015;2(1):21-48. doi:10.1146/annurev-statistics-010814-020201
Google Scholar | Crossref

30. de Vocht F, Katikireddi SV, McQuire C, Tilling K, Hickman M, Craig P. Conceptualising natural and quasi experiments in public health. *BMC Med Res Methodol*. 2021;21(1):32. doi:10.1186/s12874-021-01224-x
PubMed | Google Scholar | Crossref

31. Firebaugh G, Warner C, Massoglia M. Fixed effects, random effects, and hybrid models for causal analysis. In: Morgan S, ed. *Handbook of Causal Analysis for Social Research. Handbooks of Sociology and Social Research*. Springer; 2013:113-132. doi:10.1007/978-94-007-6094-3_7

32. Witkiewitz K, Pfund RA, Tucker JA. Mechanisms of behavior change in substance use disorder with and without formal treatment. *Annu Rev Clin Psychol*. 2022;18(1):497-525. doi:10.1146/annurev-clinpsy-072720-014802

Administration; Center for Tobacco Products. ICPSR36231-v21 Population Assessment of Tobacco and Health (PATH) study [United States] restricted-use files, user guide. *Inter-university Consortium for Political and Social Research*. November 21, 2019. Accessed July 8, 2025. doi:10.3886/ICPSR36231.userguide
Google Scholar

34. Hyland A, Ambrose BK, Conway KP, et al. Design and methods of the Population Assessment of Tobacco and Health (PATH) study. *Tob Control*. 2017;26(4):371-378. doi:10.1136/tobaccocontrol-2016-052934
PubMed | Google Scholar | Crossref

35. Piesse A, Opsomer J, Dohrmann S, et al. Longitudinal uses of the Population Assessment of Tobacco and Health study. *Tob Regul Sci*. 2021;7(1):3-16. doi:10.18001/TRS.7.1.1
PubMed | Google Scholar | Crossref

36. Tourangeau R, Yan T, Sun H, Hyland A, Stanton CA. Population Assessment of Tobacco and Health (PATH) reliability and validity study: selected reliability and validity estimates. *Tob Control*. 2019;28(6):663-668. doi:10.1136/tobaccocontrol-2018-054561
PubMed | Google Scholar | Crossref

37. Opsomer JD, Dohrmann S, DiGaetano R, et al. Update to the design and methods of the PATH Study, wave 4 (2016-2017). *Tob Control*. 2024;33(6):733-738. doi:10.1136/tc-2022-057851
PubMed | Google Scholar | Crossref

38. Dennis ML, Feeney T, Stevens LH. Global Appraisal of Individual Needs-Short Screener (GAIN-SS): administration and scoring manual for the GAINSS version 2.0.1. Chestnut Health Systems. Accessed July 8, 2025. https://www.assessments.com/assessments_documentation/gain_ss/GAIN-SS%20Manual.pdf

39. Dennis ML, Chan YF, Funk RR. Development and validation of the GAIN Short Screener (GSS) for internalizing, externalizing and substance use disorders and crime/violence problems among adolescents and adults. *Am J Addict*. 2006;15(Suppl 1)(suppl 1):80-91. doi:10.1080/10550490601006055
PubMed | Google Scholar | Crossref

40. Hays RD, Bjorner JB, Revicki DA, Spritzer KL, Cella D. Development of physical and mental health summary scores from the patient-reported outcomes measurement information system (PROMIS) global items. *Qual Life Res*. 2009;18(7):873-880. doi:10.1007/s11136-009-9496-9
PubMed | Google Scholar | Crossref

Google Scholar | Crossref

42. Allison PD. *Fixed Effects Regression Methods for Longitudinal Data Using SAS*. SAS Institute, Inc; 2005.

43. Raudenbush SW, Bryk AS. *Hierarchical Linear Models: Applications and Data Analysis Methods*. 2nd ed. Sage; 2002.

44. Wooldridge JM. *Econometric Analysis of Cross Section and Panel Data*. 2nd ed. MIT Press; 2010.

45. Moral-Benito E, Allison P, Williams R. Dynamic panel data modelling using maximum likelihood: an alternative to Arellano-Bond. *Appl Econ*. 2019;51(20):2221-2232. doi:10.1080/00036846.2018.1540854
Google Scholar | Crossref

46. White SA, Stone E, Murphy KA, Daumit GL, McGinty EE. Smoking cessation medication prescribing for smokers with and without mental illness. *Psychiatr Serv*. 2023;74(4):332-340. doi:10.1176/appi.ps.202100690
PubMed | Google Scholar | Crossref

47. Taylor GM, Lindson N, Farley A, et al. Smoking cessation for improving mental health. *Cochrane Database Syst Rev*. 2021;3(3):CD013522. doi:10.1002/14651858.CD013522.pub2
PubMed | Google Scholar | Crossref

48. Kleinman RA, Kendra MS, De Golia SG. Smoking cessation prescribing and referral practices among psychiatry residents. *Acad Psychiatry*. 2020;44(2):144-146. doi:10.1007/s40596-019-01104-z
PubMed | Google Scholar | Crossref

49. Streck JM, Regan S, Werner M, et al. Preliminary feasibility of integrating tobacco treatment into SUD peer recovery coaching: a mixed-methods study of peer recovery coaches. *Addict Sci Clin Pract*. 2023;18(1):25. doi:10.1186/s13722-023-00380-3
PubMed | Google Scholar | Crossref

50. McCuistian C, Lisha NE, Campbell B, Cheng C, Le J, Guydish J. Reducing tobacco use in substance use treatment: the California tobacco free initiative. *Addict Behav*. 2024;155:108025. doi:10.1016/j.addbeh.2024.108025
PubMed | Google Scholar | Crossref

51. Bailey SR, Marino M, Ezekiel-Herrera D, et al. Tobacco cessation in Affordable Care Act M[illegible]d expansion states versus non-expansion states. *Nicotine Tob Res*. 2020;22(6):1016-1022.

PubMed | Google Scholar | Crossref

53. Slater JS, Nelson CL, Parks MJ, Ebbert JO. Connecting low-income smokers to tobacco treatment services. *Addict Behav*. 2016;52:108-114. doi:10.1016/j.addbeh.2015.10.013
PubMed | Google Scholar | Crossref

54. Parks MJ, Kingsbury JH, Boyle RG, Choi K. Behavioral change in response to a statewide tobacco tax increase and differences across socioeconomic status. *Addict Behav*. 2017;73:209-215. doi:10.1016/j.addbeh.2017.05.019
PubMed | Google Scholar | Crossref

Smoking Cessation Leadership Center
UCSF
University of California San Francisco

Pharmacologic Product Guide: FDA-Approved Medications for Smoking Cessation

	Nicotine Replacement Therapy (NRT) Formulations				Bupropion SR	Varenicline
	Gum	Lozenge	Transdermal Patch	Nasal Spray		
Product	**Nicorette[1], Generic** OTC 2 mg, 4 mg original, cinnamon, fruit, mint (various)	**Nicorette[1],Generic; Nicorette[1] Mini** OTC 2 mg, 4 mg; cinnamon, cherry, mint	**Habitrol[2], NicoDerm CQ[1], Generic** OTC 7 mg, 14 mg, 21 mg (24-hr release)	**Nicotrol NS[3]** Rx Metered spray 10 mg/mL nicotine solution	**Generic** (formerly Zyban) Rx 150 mg sustained-release tablet	**Generic** (formerly Chantix[3]) Rx 0.5 mg, 1 mg tablet
Precautions	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Temporomandibular joint disease ■ Pregnancy[4] and breastfeeding ■ Adolescents (<18 years)	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Pregnancy[4] and breastfeeding ■ Adolescents (<18 years)	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Pregnancy[4] and breastfeeding ■ Adolescents (<18 years)	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis) ■ Severe reactive airway disease ■ Pregnancy[4] and breastfeeding ■ Adolescents (<18 years)	■ Concomitant therapy with medications/conditions known to lower the seizure threshold ■ Hepatic impairment ■ Pregnancy[4] and breastfeeding ■ Adolescents (<18 years) ■ Treatment-emergent neuropsychiatric symptoms[5] Contraindications: ■ Seizure disorder ■ Concomitant bupropion (e.g., Wellbutrin) therapy ■ Current or prior diagnosis of bulimia or anorexia nervosa ■ Simultaneous abrupt discontinuation of alcohol or sedatives/benzodiazepines ■ MAO inhibitors in preceding 14 days; concurrent use of reversible MAO inhibitors	■ Severe renal impairment (dosage adjustment is necessary) ■ Pregnancy[4] and breastfeeding ■ Adolescents (<18 years) ■ Treatment-emergent neuropsychiatric symptoms[5]
Dosing	*1st cigarette ≤30 minutes after waking: 4 mg* *1st cigarette >30 minutes after waking: 2 mg* Weeks 1–6: 1 piece q 1–2 hours* Weeks 7–9: 1 piece q 2–4 hours* Weeks 10–12: 1 piece q 4–8 hours* **while awake* ■ Maximum, 24 pieces/day ■ During initial 6 weeks of treatment, use at least 9 pieces/day ■ Chew each piece slowly ■ Park between cheek and gum when peppery or tingling sensation appears (~15–30 chews) ■ Resume chewing when tingle fades ■ Repeat chew/park steps until most of the nicotine is gone (tingle does not return; generally 30 min) ■ Park in different areas of mouth ■ No food or beverages 15 minutes before or during use ■ Duration: up to 12 weeks	*1st cigarette ≤30 minutes after waking: 4 mg* *1st cigarette >30 minutes after waking: 2 mg* Weeks 1–6: 1 lozenge q 1–2 hours* Weeks 7–9: 1 lozenge q 2–4 hours* Weeks 10–12: 1 lozenge q 4–8 hours* **while awake* ■ Maximum, 20 lozenges/day ■ During initial 6 weeks of treatment, use at least 9 lozenges/day ■ Allow to dissolve slowly (20–30 minutes) ■ Nicotine release may cause a warm, tingling sensation ■ Do not chew or swallow ■ Occasionally rotate to different areas of the mouth ■ No food or beverages 15 minutes before or during use ■ Duration: up to 12 weeks	<u>>10 cigarettes/day:</u> 21 mg/day x 4–6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks <u>≤10 cigarettes/day:</u> 14 mg/day x 6 weeks 7 mg/day x 2 weeks ■ Rotate patch application site daily; do not apply a new patch to the same skin site for at least one week ■ May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime); before recommending, rule out other factors that might be contributing (e.g., drug interaction between caffeine and tobacco smoke, other medications, and lifestyle factors) ■ Duration: 8–10 weeks	1–2 doses/hour* (8–40 doses/day) One dose = 2 sprays (one in each nostril); each spray delivers 0.5 mg of nicotine to the nasal mucosa **while awake* ■ Maximum - 5 doses/hour or - 40 doses/day ■ During initial 6-8 weeks of treatment, initially use at least 8 doses/day ■ Gradually reduce daily dosage over an additional 4-6 weeks ■ Do not sniff, swallow, or inhale through the nose as the spray is being administered ■ Duration: 12 weeks	150 mg po q AM x 3 days, then 150 mg po bid ■ Do not exceed 300 mg/day ■ Begin therapy 1–2 weeks prior to quit date ■ Allow at least 8 hours between doses ■ Avoid bedtime dosing to minimize insomnia ■ Duration: 7–12 weeks, with maintenance up to 6 months in selected patients ■ Dose tapering is not necessary	Days 1–3: 0.5 mg po q AM Days 4–7: 0.5 mg po bid Weeks 2–12: 1 mg po bid ■ Begin therapy 1 week prior to quit date ■ Take each dose after eating and with a full glass of water ■ Dosing adjustment is necessary for patients with severe renal impairment ■ Duration: 12 weeks; an additional 12-week course may be used in selected patients ■ May initiate up to 35 days before target quit date OR may reduce smoking over a 12-week period of treatment prior to quitting and continue treatment for an additional 12 weeks

	Nicotine Replacement Therapy (NRT) Formulations					
	Gum	Lozenge	Transdermal Patch	Nasal Spray	Bupropion SR	Varenicline
Adverse Effects	■ Mouth and throat irritation ■ Jaw muscle soreness ■ Hiccups ■ GI complaints (dyspepsia, nausea) ■ May stick to dental work	■ Mouth and throat irritation ■ Hiccups ■ GI complaints (dyspepsia, nausea)	■ Local skin reactions (erythema, pruritus, burning) ■ Sleep disturbances (abnormal or vivid dreams, insomnia); associated with nocturnal nicotine absorption	■ Nasal and/or throat irritation (hot, peppery, or burning sensation) ■ Ocular irritation/tearing ■ Sneezing ■ Cough	■ Insomnia ■ Dry mouth ■ Nausea ■ Anxiety/difficulty concentrating ■ Constipation ■ Tremor ■ Rash ■ Seizures (risk is 0.15%) ■ Neuropsychiatric symptoms (rare; see Precautions)	■ Nausea ■ Sleep disturbances (insomnia, abnormal/vivid dreams) ■ Headache ■ Flatulence ■ Constipation ■ Taste alteration ■ Neuropsychiatric symptoms (rare; see Precautions)
	■ Adverse effects more commonly experienced when chewing the lozenge or using incorrect gum chewing technique (due to rapid nicotine release): - Lightheadedness/dizziness - Nausea/vomiting - Hiccups - Mouth and throat irritation					
Advantages	■ Might serve as an oral substitute for tobacco ■ Might delay weight gain ■ Can be titrated to manage withdrawal symptoms ■ Can be used in combination with other agents to manage situational urges ■ Relatively inexpensive	■ Might serve as an oral substitute for tobacco ■ Might delay weight gain ■ Can be titrated to manage withdrawal symptoms ■ Can be used in combination with other agents to manage situational urges ■ Relatively inexpensive	■ Once-daily dosing associated with fewer adherence problems ■ Of all NRT products, its use is least obvious to others ■ Can be used in combination with other agents; delivers consistent nicotine levels over 24 hours ■ Relatively inexpensive	■ Can be titrated to rapidly manage withdrawal symptoms ■ Can be used in combination with other agents to manage situational urges	■ Twice-daily oral dosing is simple and associated with fewer adherence problems ■ Might delay weight gain ■ Might be beneficial in patients with depression ■ Can be used in combination with NRT agents ■ Relatively inexpensive (generic formulations)	■ Twice-daily oral dosing is simple and associated with fewer adherence problems ■ Offers a different mechanism of action for patients who have failed other agents ■ Most effective cessation agent when used as monotherapy
Disadvantages	■ Need for frequent dosing can compromise adherence ■ Might be problematic for patients with significant dental work ■ Proper chewing technique is necessary for effectiveness and to minimize adverse effects ■ Gum chewing might not be acceptable or desirable for some patients	■ Need for frequent dosing can compromise adherence ■ Gastrointestinal side effects (nausea, hiccups, heartburn) might be bothersome	■ When used as monotherapy, cannot be titrated to acutely manage withdrawal symptoms ■ Not recommended for use by patients with dermatologic conditions (e.g., psoriasis, eczema, atopic dermatitis)	■ Need for frequent dosing can compromise adherence ■ Nasal administration might not be acceptable or desirable for some patients; nasal irritation often problematic ■ Not recommended for use by patients with chronic nasal disorders or severe reactive airway disease ■ Cost of treatment	■ Seizure risk is increased ■ Several contraindications and precautions preclude use in some patients (see Precautions) ■ Patients should be monitored for potential neuropsychiatric symptoms[5] (see Precautions)	■ Patients should be monitored for potential neuropsychiatric symptoms[5] (see Precautions) ■ Cost of treatment
Cost/day[5]	2 mg or 4 mg: $2.97–$3.69 (9 pieces)	2 mg or 4 mg: $3.42–$4.05 (9 pieces)	$1.83–$2.84 (1 patch)	$10.88 (8 doses)	$0.46 (2 tablets)	$6.82 (2 tablets)

[1] Marketed by GlaxoSmithKline.
[2] Marketed by Dr. Reddy's.
[3] Chantix, formerly marketed by Pfizer, was voluntarily recalled and has been unavailable since 9/16/2021, due to the presence of N-nitroso-varenicline at levels exceeding the FDA's acceptable intake limit.
[4] The U.S. Clinical Practice Guideline states that pregnant smokers should be encouraged to quit without medication based on insufficient evidence of effectiveness and theoretical concerns with safety. Pregnant tobacco users should be offered behavioral counseling interventions that exceed minimal advice to quit.
[5] In July 2009, the FDA mandated that the prescribing information for all bupropion- and varenicline-containing products include a black-boxed warning highlighting the risk of serious neuropsychiatric symptoms, including changes in behavior, hostility, agitation, depressed mood, suicidal thoughts and behavior, and attempted suicide. Clinicians should advise patients to stop taking varenicline or bupropion SR and contact a health care provider immediately if they experience agitation, depressed mood, or any changes in behavior that are not typical of nicotine withdrawal, or if they experience suicidal thoughts or behavior. If treatment is stopped due to neuropsychiatric symptoms, patients should be monitored until the symptoms resolve. Based on results of a mandated clinical trial, the FDA removed this boxed warning in December 2016.
[6] Approximate cost based on the recommended initial dosing for each agent and the wholesale acquisition prices for generic and brand formulations from Red Book Online. Thomson Reuters, January 2025.

Abbreviations: MAO, monoamine oxidase; NRT, nicotine replacement therapy; OTC, over-the-counter (nonprescription product); Rx, prescription product.

For complete prescribing information and a comprehensive listing of warnings and precautions, please refer to the manufacturers' package inserts.

Rx for Change

Smoking Cessation Leadership Center
UCSF
University of California San Francisco

FREE HELP TO QUIT SMOKING | VAPING TOBACCO & NICOTINE

Many people need support to quit smoking. Kick It California has helped 1 million+ people over the past 30 years.

Scan QR code to enroll today.

There's a Quit Coach Ready to Help You.
Connect with us today.

Call a Quit Coach
Monday-Friday 7 am to 9 pm
Saturday 9 am to 5 pm
English **1-800-300-8086**
Spanish **1-800-600-8191**

Chat with a Quit Coach
Monday-Friday 7 am to 9 pm
Saturday 9 am to 5 pm
kickitca.org/chat

Enroll online
Learn about how KIC can help you or someone you care about quit.
kickitca.org/quit-now

Join our Texting Program
Receive texts tailored to help at critical points.
Text "Quit Smoking" or "Quit Vaping" to 66819
Message & data rates may apply

Watch Quit Smoking Vids
Tips for planning to quit, staying motivated, and handling cravings.
youtube.com/kickitca

Free Nicotine Patches*
Enroll now or call us to see if you're eligible to receive free patches.
Talk to a Quit Coach Today!
**Client eligibility applies. While supplies last.*

KICK IT
QUIT SMOKING | VAPING APP

5 ways our KICK IT app can help you.

- Check In Daily
- Track Progress
- Build a Quit Plan
- Crush Cravings
- Complete Missions
- FREE Download Today

Google Play | App Store

AYUDA *GRATUITA* PARA DEJAR DE FUMAR | VAPEAR TABACO Y NICOTINA

Mucha gente necesita apoyo para dejar de fumar. Kick It California ha ayudado a más de un millón de personas en los últimos 30 años.

Escanea el código QR para registrarte hoy.

Nuestros asesores están aquí para ayudarte.
¡Ponte en contacto con nosotros!

Habla con un asesor
Lunes-Viernes, de 7 am a 9 pm
Sábado, de 9 am a 5 pm

1-800-600-8191

Chatea con un asesor
Lunes-Viernes, de 7 am a 9 pm
Sábado, de 9 am a 5 pm

kickitca.org/es/chat

Regístrate en línea
Conoce como KIC puede ayudarte a ti y a tus más queridos a dejarlo.

kickitca.org/es/quit-now

Recibe mensajes de texto
Únete al programa de SMS para recibir apoyo en momentos clave.

Envía "Dejar de Fumar" o "No Vapear" al 66819

Pueden aplicarse tarifas de mensajes y datos.

Videos para dejar de fumar
Consejos para dejarlo, mantener la motivación y sobrellevar los antojos.

youtube.com/kickitca

Parches de nicotina gratis*
Comprueba si cumples con los requisitos para recibir parches gratis.

¡Habla con un asesor hoy!

**Sujeto a elegibilidad. Hasta agotar existencias.*

KICK IT
QUIT SMOKING | VAPING APP (solo disponible en inglés)

5 maneras como la app KICK IT app puede ayudarte.

- *Check-Ins* diarios
- Supera tus antojos
- Sigue tu progreso
- Completa misiones
- Plan para dejarlo
- FREE Descárgala hoy

Google Play | App Store

ASK, ADVISE, REFER

Tobacco/Nicotine Cessation Intervention

ASK

Ask about tobacco/nicotine use or exposure

Smoking

Smokeless/Oral

E-Cigarettes/Vapes

Have you ever used tobacco or nicotine products?

- If **YES**: "When was your last use?" If < 1 month, select "Current." If >1 month, select "Former."
- If **NO**: "Have you been regularly exposed to smoke or aerosol in the past couple of weeks?" If yes, select "Passive" exposure. If no, select "Never" user.

ADVISE

Advise to stop tobacco use or exposure

- "Quitting is one of the best things you can do for your health."
- "Smoke or aerosol causes inflammation to your heart and lungs."

REFER

Refer to support that doubles the chances of quitting

- "Kick It California is our free state quitline. They can help you with a free plan to quit and can tell you about medications covered by most insurance. They also may have special offers. Can they call you?
  - If **YES** to referral order: "Kick It California will call you in a couple days."
  - If **NO**: "Kick It California has a text program. Text 'QUIT SMOKING or 'QUIT VAPING' to 66819."

For more information, visit kickitca.org.
To submit a referral to Kick It California, click here

Graphic adapted from the American Academy of Pediatrics and Centers for Disease Control and Prevention.

KICK IT California

CA QUITS

Drug Interactions with Tobacco Smoke

Many interactions between tobacco smoke and medications have been identified. In most cases it is the tobacco smoke—not the nicotine—that causes these drug interactions. Tobacco smoke interacts with medications through pharmacokinetic (PK) and pharmacodynamic (PD) mechanisms. PK interactions affect the absorption, distribution, metabolism, or elimination of other drugs, potentially causing an altered response to those drugs. Most PK interactions with smoking result from induction of hepatic cytochrome P450 enzymes (primarily CYP1A2). People who smoke may require higher doses of medication that are CYP1A2 substrates. Upon cessation, dose reductions might be required. PD interactions alter the expected response or actions of other drugs. The amount of tobacco smoking needed to have an effect has not been established, and the assumption is that a person with any level of smoking is susceptible to the same degree of interaction. **The most clinically significant interactions appear in the shaded rows. Commonly available brand names are shown in parentheses.**

Drug/Class	Mechanism of Interaction and Effects
Pharmacokinetic Interactions	
Alprazolam (Xanax®)	• Conflicting data on significance, but possible plasma concentrations (up to 50%); ↓ half-life (35%).
Caffeine	• Metabolism (induction of CYP1A2); ↑ clearance (56%). • Caffeine levels likely ↑ after cessation; recommend reduction in caffein upon cessation
Cilostazol	• ↓ Plasma concentrations (by 20%)
Chlorpromazine (Thorazine®)	• ↓ Area under the curve (AUC) (36%); ↓ plasma concentrations (by 24%). • ↑ Levels upon cessation have been reported causing sedation and hypotension.
Clopidogrel (Plavix®)	• ↑ Metabolism (induction of CYP1A2) of clopidogrel to its active metabolite. • Clopidogrel's effects may be enhanced in people who smoke (≥10 cigarettes/day); may be dependent on CYP1A2 genotype; might also ↑ risk of bleeding. • Smoking cessation should still be recommended in the at-risk populations needing clopidogrel.
Clozapine (Clozaril®)	• ↑ Metabolism (induction of CYP1A2); ↓ plasma concentrations (by 18%). • ↑ Levels upon cessation may occur; closely monitor drug levels and reduce dose as required to avoid toxicity.
Duloxetine (Tarceva®)	• ↓ AUC (33%) • ↑ Dosage modifications not routinely recommended
Erlotinib (Clozaril®)	• ↑ Clearance (24%); ↓ trough plasma concentrations (2-fold).
Flecainide	• ↑ Clearance (61%); ↓ trough plasma concentrations (by 25%). • People who smoke may need ↑ dosages.
Fluvoxamine	• ↑ Metabolism (induction of CYP1A2); ↑ clearance (24%); ↓ AUC (31%); ↓ Cmax (32%); ↓ Css (39%). • Dosage modifications not routinely recommended but smokers may need ↑ dosages.
Haloperidol (Haldol®)	• ↑ Clearance (44%); ↓ plasma concentrations (by 70%); data are inconsistent therefore clinical significance is unclear.
Insulin, subcutaneous	• Possible ↓ insulin absorption secondary to peripheral vasoconstriction • Smoking is reported to cause insulin resistance. • PK & PD interactions likely not clinically significant, but people who smoke may need ↑ dosages.
Irinotecan (Camptosar®)	• ↑ Clearance (18%); ↓ AUC of active metabolite, SN-38 by 40% via induction of glucuronidation; ↓ systemic exposure resulting in lower hematologic toxicity and may reduce efficacy. • People who smoke may need ↑ dosages.
Methadone	• ↑ Metabolism (induction of CYP1A2 [minor pathway for methadone]). • ↑ Levels upon cessation have been reported causing sedation, confusion and labored breathing which required dosage reduction. Carefully monitor response upon cessation.
Mexiletine	• ↑ Clearance (25%); ↓ half-life (36%).

(continued)

Drug/Class	Mechanism of Interaction and Effects
Nintedanib (OFEV®)	• Decreased exposure (21%) in people who smoke, which may affect efficacy. • No dose adjustment recommended; however, avoid smoking during treatment.
Olanzapine (Zyprexa®)	• ↑ Metabolism (induction of CYP1A2); ↑ clearance (40%); ↓ plasma concentrations (by 12%). • People who smoke may need ↑ dosages.
Pirfenidone (Esbriet®)	• ↑ Metabolism (induction of CYP1A2); ↓ AUC (54%) and ↓ Cmax (32%) compared to people who don't smoke. • Decreased exposure in people who smoke may decrease efficacy.
Pomalidomide (Pomalyst®)	• ↓ AUC (32%) compared to people who don't smoke.
Propranolol (Inderal®)	• ↑ Clearance (77%).
Riluzole (Rilutek®)	• ↑ Elimination (20%) • Dosage modifications not routinely recommended.
Riociguat (Adempas®)	• ↓ Plasma concentrations (by 50-60%). • People who smoke may require dosages higher than 2.5 mg three times daily; consider dose reduction upon cessation.
Ropinirole	• ↓ Cmax (30%) and ↓ AUC (38%) in study with patients with restless legs syndrome. • People who smoke may need ↑ dosages.
Tasimelteon (Hetlioz®)	• ↑ Metabolism (induction of CYP1A2); ↓ drug exposure (40%). • People who smoke may need ↑ dosages.
Theophylline	• ↑ Metabolism (induction of CYP1A2); ↑ clearance (58–100%); ↓ half-life (63%). • Monitor levels if smoking is initiated, discontinued, or changed. Maintenance doses are considerably higher in smokers; ↑ clearance with second-hand smoke exposure.
Tizanidine (Zanaflex®)	• ↓ AUC (30-40%) and ↓ half-life (10%) observed in male individuals who smoke
Tricyclic antidepressants (e.g., imipramine, nortriptyline)	• Possible interaction with tricyclic antidepressants in the direction of ↓ blood levels, but the clinical significance is not established.
Warfarin	• ↑ Metabolism (induction of CYP1A2) of R-enantiomer; however, S-enantiomer is more potent and effect on INR is inconclusive. • Shown to impact INR. Consider monitoring INR upon smoking cessation.
Pharmacodynamic Interactions	
Benzodiazepines (diazepam, chlordiazepoxide)	• ↓ Sedation and drowsiness, possibly caused by nicotine stimulation of central nervous system.
Beta-blockers	• Less effective antihypertensive and heart rate control effects; possibly caused by nicotine-mediated sympathetic activation. • People who smoke may need ↑ dosages.
Corticosteroids, inhaled	• People who smoke with asthma may have less of a response to inhaled corticosteroids.
Hormonal contraceptives (combined)	• ↑ Risk of cardiovascular adverse effects (e.g., stroke, myocardial infarction, thromboembolism) in women who smoke and use combined hormonal contraceptives. Ortho Evra® patch users shown to have 2-fold ↑ risk of venous thromboembolism compared to oral contraceptive users, likely due to ↑ estrogen exposure (60% higher levels). • ↑ Risk with age and with heavy smoking (≥15 cigarettes per day) and is quite marked in women ≥35 years old.
Serotonin 5-HT_1 receptor agonists (triptans)	• This class of drugs may cause coronary vasospasm; caution for use in people who smoke due to possible unrecognized coronary artery disease.

Adapted and updated, from:
Zevin S, Benowitz NL. Drug interactions with tobacco smoking. Clin Pharmacokinet 1999;36:425–438, and Kroon LA. Drug interactions with smoking. *Am J Health-Syst Pharm* 2007;64:1917-21 and Li H, Shi Q. Drugs and diseases interacting with cigarette smoking in US prescription drug labelling. *Clin Pharmacokinet* 2015;54:493-501.
Information from individual drug package inserts is also used.
Abbreviations: AUC, area under the plasma concentration-time curve; Cmax, maximum plasma concentration; Css, steady-state plasma drug concentration; CYP, cytochrome P450; INR, international normalized ratio.

Special Population Identification KTA ICC/IHBS and ICC/IHBS & Documenting and Billing CFT Meetings in SmartCare

Excerpts from QA MH- Up to The Minute September 2024 &
Pathways to Well-Being County Webpage

QA MH - UP TO THE MINUTE
September 2024

Special Populations Selection for Children/Youth receiving ICC and/or IHBS Services

MHPs are obligated to provide ICC and IHBS through the EPSDT benefit to all children and youth under the age of 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for these services. Neither membership in the *Katie A.* class nor subclass is a prerequisite to consideration for receipt of ICC and IHBS, and therefore a child does not need to have an open child welfare services case to be considered for receipt of these services. All children and youth should be screened for ICC and IHBS services as part of the Assessment process, and these services should be provided to youth when medically necessary. (Medi-Cal Manual for ICC/IHBS/TFC Services Third Edition)DHCS no longer requires the identification of class or subclass when determining eligibility for ICC/IHBS services, however, counties are recommended to continue tracking of those youth who would have been subclass.

When ICC/IHBS services are assessed to be medically necessary, these youth should be entered into the appropriate Special Populations category in SmartCare – this will link the appropriate modifier for billing and tracking purposes when providing these services. How To Identify a Client as Katie-A or Other Special Population - 2023 CalMHSA

- Special populations "ICC/IHBS" is used for any youth receiving ICC/IHBS services.
- Special populations "Katie A ICC/IHBS" is used for any youth that would have been considered "subclass" under previous PWB criteria.

Documenting and Billing for CFT Meetings in SmartCare

Youth identified as being eligible for ICC and/or IHBS services are required to be provided CFT meetings at minimum of every 90 days. Providers should utilize **Procedure Code: CFT/MDT** when documenting a CFT meeting. This procedure code has been updated on the SmartCare Service Code Crosswalk. There have been no changes to the documentation or claiming requirements for CFT meetings. Each treatment team member that plans to bill for their time spent discussing the client with other treatment team members must create their own service note. Additional guidance on documenting CFT/Treatment Team Meeting: How to Document Treatment Team Meetings - 2023 CalMHSA

Providers should also ensure that youth receiving these services have been identified in the appropriate **Special Populations** category in SmartCare which will link the appropriate required modifier (HK) to the service for billing purposes as well allowing for tracking of these youth/services.

- Special populations "ICC/IHBS" is used for any youth receiving ICC/IHBS services.
- Special populations "Katie A ICC/IHBS" is used for any youth that would have been considered "subclass" under previous PWB criteria.

Vista Hill ChildNET

A SchooLink™ Program

Interim Program Manager: Annabel Mojica, LMFT, LPCC

Overview of ChildNET

- New program partnering with pre-schools and daycares specifically located in the North-Inland San Diego County Region (with future expansion to the North-Coastal Region of San Diego County)
- Currently, initial partnership with Escondido Union School District State Pre-Schools (7 sites)
- Plans to expand to additional pre-school and daycare settings in the Vista and Oceanside communities (with established MOU's)
- Serving children ages 0–5 and their families
- ChildNET Office location:

425 W. 5th Ave., Suite #101, Escondido, CA 92025

ChildNET Services Provided

- Focus on early childhood mental health and behavioral health.

<u>Services include:</u>

- Intake & CalAIM Assessment
- Individual Therapy, Family Therapy and Parenting Classes utilizing the Incredible Years® curriculum
- Small Group support services (Incredible Years®) for children
- Behavioral support for children
- Case management services and psychiatric services (if warranted and with parent permission)

Staffing: Licensed / Registered Clinician

- Completes comprehensive behavioral health assessments
- Works collaboratively with school team to support student in classroom setting and with the family to support student in home and community settings
- Provides Individual Therapy, Family Therapy and Group Therapy services

Staffing: Mental Health Rehabilitation Specialist (MHRS)

- Supports students through behavioral interventions and small group sessions
- Provides small group intervention using social-emotional skill building activities
- Facilitates parenting classes utilizing the Incredible Years® curriculum
- Connects families with the necessary community resources

Access to Psychiatric Support Services

- Clients have access to psychiatric evaluation and medication management as clinically indicated (and with parent consent)
- The program Psychiatrist collaborates with the Clinician and family to review progress and ensure continuity of care.

Current Established Partners (MOU)
Escondido Union School District (EUSD)

State Pre-School Sites:

- Central
- Glen View
- Juniper
- Lincoln
- Oak Hill
- Pioneer
- Rose

Contact Information

- Interim Program Manager : Annabel Mojica, LMFT, LPCC
- Phone Number: 760-258-5020
- Email: amojica@vistahill.org
- Address: 425 W. 5th Ave., Suite #101, Escondido, CA 92025

Thank You!

episcopal community services

Para Las Familias

EARLY CHILDHOOD EMOTIONAL AND BEHAVIORAL SERVICES

BUILDING STRONG FOUNDATIONS: INFANT & EARLY CHILDHOOD MENTAL HEALTH

LESLIE MANRIQUEZ-JIMENEZ
ASSOCIATE DIRECTOR OF CHILDREN'S BEHAVIORAL HEALTH
EPISCOPAL COMMUNITY SERVICES - PARA LAS FAMILIAS

WHAT IS INFANT & EARLY CHILDHOOD MENTAL HEALTH (IECMH)

IECMH REFERS TO THE DEVELOPING CAPACITY OF CHILDREN FROM BIRTH TO ABOUT 5 YEARS OF AGE TO:

- EXPERIECE, REGULATE, AND EXPRESS EMOTIONS,
- FORM CLOSE AND SECURE REALTIONS, AND
- EXPLORE THIER ENVIROMENT AND LEARN - ALL WITHIN THE CONTEXT OF THEIR FAMILY, COMMUNITY, AND CULTURAL EXPECTATIONS

(Source: Zero to Three, 2017)

WHY DOES IECMH MATTERS

EARLY BRAIN DEVELOPMENT SETS THE STAGE FOR LIFELONG HEALTH

RELATIONSHIPS ARE THE CORE OF EMOTIONAL DEVELOPMENT

EARLY MENTAL HEALTH SHAPES LATER OUTCOMES

WHY DOES IECMH MATTERS

ABOUT ECS - PARA LAS FAMILIAS

ECS PARA LAS FAMILIAS (PLF) IS AN OUTPATIENT CLINIC DEDICATED TO OFFERING A VARIETY OF BILINGUAL AND BICULTURAL MENTAL HEALTH SERVICES TO FAMILIES IN THE SOUTH BAY AREA OF SAN DIEGO. OUR SERVICES CATER TO FAMILIES WITH MEDI-CAL, PRIVATE INSURANCE, OR NO INSURANCE, SPECIFICALLY FOR CHILDREN AGED 0 TO 12 YEARS.

SERVICES OFFERED:

ELIGIBILITY SCREENINGS

BEHAVIORAL HEALTH ASSESSMENTS

ATTACHMENT-BASED FAMILY THERAPY

SCHOOL OBSERVATIONS

TEACHER/PROVIDER CONSULTATIONS

PARENTING CLASSES

ecs
episcopal community services
Para Las Familias

OUR FOCUS:

Children who receive treatment at PLF acquire essential tools to build healthy emotional connections with their parents or caregivers, enabling them to achieve social and emotional stability. By fostering a secure attachment, the child gains a relational safe haven that acts as a source of social-emotional support. This supportive mechanism also helps to mitigate behavioral challenges, alleviate anxiety, and cushion the impact of trauma and other stressors.

HOW DO WE DO IT:

By helping caregivers strengthen their parent-child relationship through teaching parenting skills, psychoeducation on attachment-based interventions, and providing corrective relational experiences between child and their caregivers in family sessions

PLF collaborates with various dedicated community organizations to connect clients and their parents with additional services. These partnerships aim to empower families, helping them reach their fullest potential and enhance opportunities for their children.

ecs
episcopal community services
Para Las Familias

THERAPEUTIC PROCESS: CIRCLE OF SECURITY

01

Increasing parent's observational skills from developmental perspective

02

Respond to child's needs for exploration and back to a safe-haven

03

Support reflective dialogue between therapist-caregiver to explore strengths and difficulties

THERAPEUTIC PROCESS: THERAPLAY

STRUCTURE

Creates a predictable world that organizes a child's experiences, fostering a sense of safety. Roles are clearly defined, allowing the child to exercise age-appropriate control.

Engagement

Connecting through playful interactions, a child experiences safety when their adult is able to enjoy with them. Play is a child's main language.

Nurture

Experiencing a sense of worthiness for love brings comfort and tranquility to the child. It reinforces the idea that love can be received without the need to "work for it" or "ask" for it.

Challenge

This supports children in feeling capable and fosters self-efficacy by encouraging them to take age-appropriate risks with the guidance of an adult.

GOALS OF TREATMENT:

- SUPPORT DEVELOPMENTAL PROGRESS
- IMPROVE AFFECT REGULATION
- DEVELOP TRUST IN HUMAN RELATIONSHIPS
- JOY IN EXPLORATION AND LEARNING
- ESTABLISH SAFE HAVEN

ecs
episcopal community services
Para Las Familias

FUNDING SOURCES & REFERRAL SOURCES

Funding sources:

- HDS First 5 funding
- San Diego County MHSA
- SAMHSA
- San Diego Foundation
- Donations/Fundraising

Referral Sources:

- Healthy Development Services
- CFWB & Foster Care System
- Early Head Start and Head Start
- Community Pediatricians
- San Ysidro Health
- Rady Children's
- 211 Info Line
- Word of Mouth
- Community Agencies

ecs
episcopal community services

Para Las Familias

THANK YOU VERY MUCH

619-565-2650

Leslie Manriquez-Jimenez

Lmanriquez@ECScalifornia.org

STRENGTHENING SBCS COMMUNITIES

San Diego Foundation

First 5 San Diego

SAMHSA
Substance Abuse and Mental Health Services Administration

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

THERAPEUTIC BEHAVIORAL SERVICES

Today's Focus

- **What is TBS?**
- **TBS eligibility and service delivery requirements**
- **Prior Authorization and Referral Process (Optum)**
  - How to complete referral
  - How to follow up on submitted referrals
- **TBS and SMHP Partnership**
- **FAQs**
- **TBS Referral, Brochure, and Contact information**

What is TBS?

- **An intensive**, home-based, short-term, behavioral modification program
- **Designed** to help youth reduce high risk behaviors
- **Supplemental** to therapy
- **Can serve youth in any home setting: homes, foster homes, STRTPs**
  - **School shifts** at times, if appropriate

Who Does TBS Serve?

- **TBS serves youth…**
  - who are up to the age of 21
  - who reside in San Diego County
  - with full-scope Medi-Cal
  - who meet <u>at least one</u> of the following criteria:
    - require support to maintain the current placement
    - require support to reduce the need for psychiatric hospitalization, and/or
    - require support to transition to a lower level of care
  - and who are working with a Specialty Mental Health Provider **(SMHP)**

The TBS Team

- **TBS Case Manager**
  - Manages youth's services
  - Develops TBS Cal-AIM Assessment and TBS Care Plan
  - Coordinates treatment team meetings
- **TBS Coach**
  - Provides one-to-one behavioral modification in the youth's environment
  - Implements individual interventions based on youth's TBS Treatment Plan & need
  - Includes everyone in the home to ensure lasting change
- **TBS Parent Partner (as needed)**
  - Works one-to-one with caregivers, teaching parenting techniques, self-care and provides them with resources

The Focus of TBS

→ To reduce Target Behavior(s)

- Target Behaviors are identified by the TBS Case Manager with client and family. A few of the behaviors we address:
  - Reactive Outburst Behaviors
  - Anger Outburst Behaviors
  - Depressive Behaviors
  - Unsafe Behaviors
  - Poor Social Skills
  - Sexualized Behaviors
  - Obsessive/Compulsive Behaviors
  - Anxious Behaviors

Eligibility and Service Delivery

- Youth has full-scope MediCal
- Youth receives consistent individual or family therapy from MediCal provider (SMHP)
- Youth and caregiver are available for intensive services (in home or in community). Caregiver present at all TBS coaching shifts, typically 2-3 hours.
  - Shifts available afternoon, evening, weekends
- SMHP available to collaborate with TBS Case Manager on regular basis

The Course of Services

1) SMHP completes Prior Authorization Request & Referral Form and sends to **OPTUM** for approval

2) Prior Authorization Request is processed by **OPTUM**, faxed to TBS Referral Specialist who then assigns referral to a TBS Case Manager

3) Case Manager provides intake and completes Cal-AIM Assessment

4) Case Manager identifies target behavior & creates TBS Care Plan

5) Case Manager conducts Implementation meeting to review Care Plan

6) TBS Coach(es)/ Parent Partners are assigned and TBS Coaching begins

7) Bi-Weekly & Monthly meetings with Treatment Team throughout coaching

8) The youth meets goals and has a TBS Graduation or Celebration of Learning!

How to Refer

1) Assess if youth meets criteria for TBS services
    a) Requires support to maintain the current placement
    b) Requires support to reduce the need for psychiatric hospitalization, and/or
    c) Requires support to transition to a lower level of care
2) Discuss TBS services with youth and family
3) Complete the *TBS Prior Authorization Request/Referral Form*
4) Fax the *TBS Prior Authorization Request/Referral Form* to Optum at (866) 220-4495
5) Contact Optum or our Referral Specialist with questions at (858) 256-2180 ext. 535

* Release of Information is not required to proceed with referral

TBS Referral Form

FAX TO: (866) 220 – 4495
Optum Public Sector San Diego
Phone: (800) 798-2254, Option 3, then option 4

THERAPEUTIC BEHAVIORAL SERVICES (TBS)
PRIOR AUTHORIZATION REQUEST & REFERRAL FORM

☐ Initial Request (submitted by SMHP) ☐ Continuing Request (6 mos.) (Submitted by TBS provider)

* Indicates a required section for Initial Requests

Youth Information*:

*Name: ____	*DOB: ____	*Medi-Cal or SSN: ____
*Current Address: ____		
School: ____	School District: ____	
*Parent/Caregiver Name: ____	*Parent/Caregiver Phone: ____	

Referring Party/Therapist Information*: *Please Note: Client must be receiving services from a Specialty Mental Health Provider (SMHP) billing Medi-Cal.*

*SMHP Name: ____	*SMHP Credential: ____
*SMHP Program Name: ____	*Address: ____
*Phone: ____	*Fax: ____

Additional Referring Party Information: *(If same as SMHP, please leave blank)*

Name: ____	Agency: ____	Relationship: ____
Address: ____		
Phone: ____	Fax: ____	E-Mail: ____

CWS/Probation Involved: ☐ Yes ☐ No CWS Contact Name: ____ Probation Contact Name: ____

Phone: ____	Fax: ____	E-Mail: ____

Other Party Involvement: *(i.e. CASA, Mentor, Attorney, Big Brother/Sister, etc.)*

Name/Relationship: ____	Contact Phone: ____
Name/Relationship: ____	Contact Phone: ____

Specific requests with regard to TBS Coach's language, culture, gender, etc.: ____

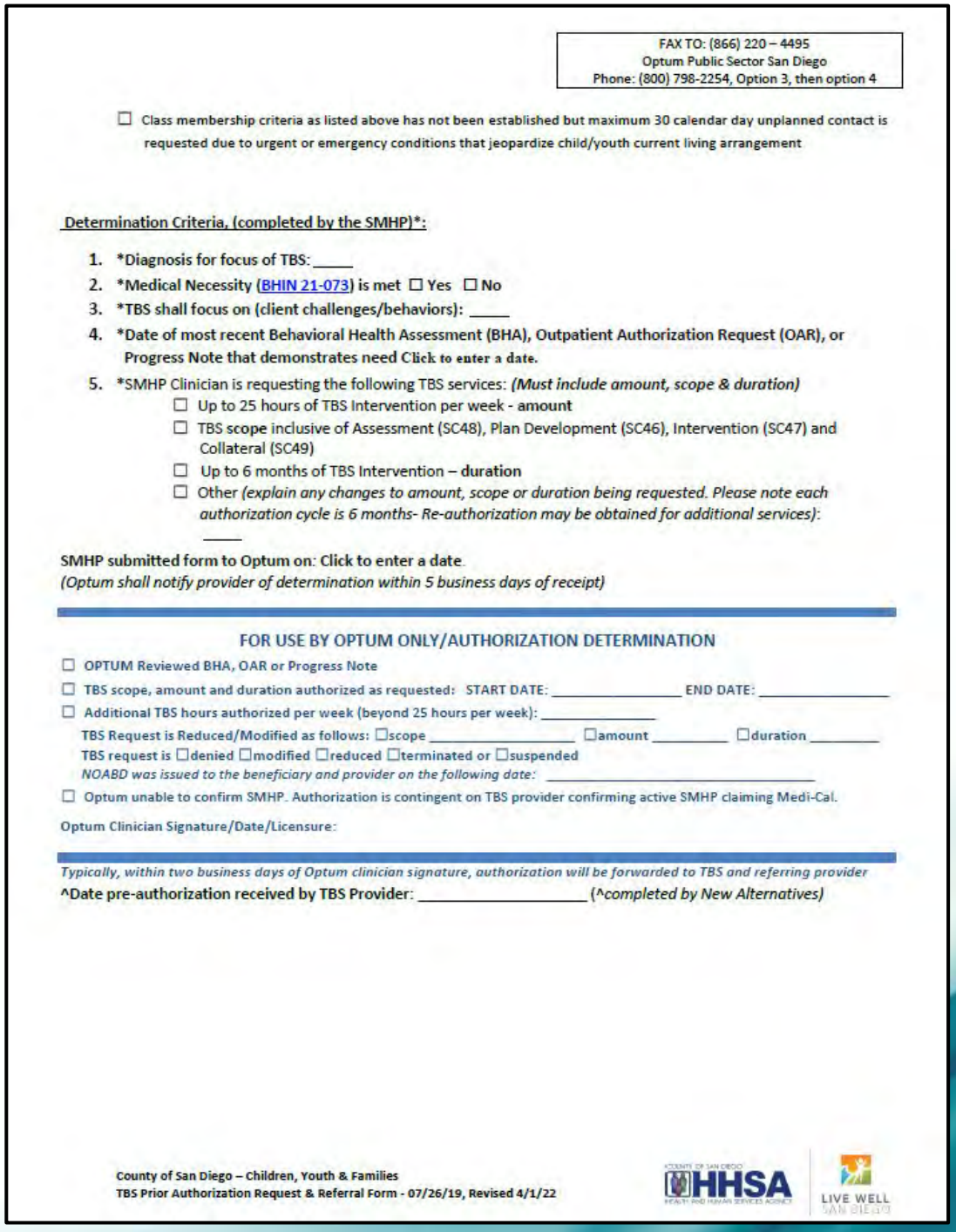
TBS Class Criteria / Eligibility Per DMH Information Notice NO: 08-38 (Completed by SMHP)* – *All questions below require completion.*

1. Is Youth a full-scope Medi-Cal beneficiary under age 21? ☐ Yes ☐ No **AND**
2. Is Youth receiving specialty mental health services from a Medi-Cal funded therapist/case manager? ☐ Yes ☐ No
3. Which of the following conditions have been met by the Youth? *(*Check all that apply, must check a minimum of 1)*
   - ☐ Youth is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option or has had at least one emergency psychiatric hospitalization within the past 24 months
   - ☐ Youth is placed in or being considered for placement in a group home facility of RCL 12 or above/STRTP or is in a locked treatment facility for the treatment of mental health needs
   - ☐ Youth may need out of home placement, a higher level of residential or acute care
   - ☐ Youth is transitioning to a lower level of care and needs TBS to support the transition
   - ☐ Youth has previously received TBS while a member of the certified class

County of San Diego – Children, Youth & Families
TBS Prior Authorization Request & Referral Form - 07/26/19, Revised 4/1/22

LIVE WELL SAN DIEGO

TBS Referral Form



FAX TO: (866) 220 – 4495
Optum Public Sector San Diego
Phone: (800) 798-2254, Option 3, then option 4

☐ Class membership criteria as listed above has not been established but maximum 30 calendar day unplanned contact is requested due to urgent or emergency conditions that jeopardize child/youth current living arrangement

Determination Criteria, (completed by the SMHP)*:

1. *Diagnosis for focus of TBS: ____
2. *Medical Necessity (BHIN 21-073) is met ☐ Yes ☐ No
3. *TBS shall focus on (client challenges/behaviors): ____
4. *Date of most recent Behavioral Health Assessment (BHA), Outpatient Authorization Request (OAR), or Progress Note that demonstrates need Click to enter a date.
5. *SMHP Clinician is requesting the following TBS services: *(Must include amount, scope & duration)*
   - ☐ Up to 25 hours of TBS Intervention per week - **amount**
   - ☐ TBS **scope** inclusive of Assessment (SC48), Plan Development (SC46), Intervention (SC47) and Collateral (SC49)
   - ☐ Up to 6 months of TBS Intervention – **duration**
   - ☐ Other *(explain any changes to amount, scope or duration being requested. Please note each authorization cycle is 6 months- Re-authorization may be obtained for additional services)*: ____

SMHP submitted form to Optum on: Click to enter a date.
(Optum shall notify provider of determination within 5 business days of receipt)

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ OPTUM Reviewed BHA, OAR or Progress Note
☐ TBS scope, amount and duration authorized as requested: START DATE: _____ END DATE: _____
☐ Additional TBS hours authorized per week (beyond 25 hours per week): _____
TBS Request is Reduced/Modified as follows: ☐scope _____ ☐amount _____ ☐duration _____
TBS request is ☐denied ☐modified ☐reduced ☐terminated or ☐suspended
NOABD was issued to the beneficiary and provider on the following date: _____
☐ Optum unable to confirm SMHP. Authorization is contingent on TBS provider confirming active SMHP claiming Medi-Cal.

Optum Clinician Signature/Date/Licensure:

Typically, within two business days of Optum clinician signature, authorization will be forwarded to TBS and referring provider
^Date pre-authorization received by TBS Provider: _____ *(^completed by New Alternatives)*

County of San Diego – Children, Youth & Families
TBS Prior Authorization Request & Referral Form - 07/26/19, Revised 4/1/22

Status of Referral Submissions

- Call Optum to ensure receipt of referral and authorization
  - (800) 798-2254 (select option 3 then option 4)
  - If Optum requires a correction, they will fax provider (no phone calls)
- Check Client Programs List Page in SmartCare
  - TBS will be listed as "Requested" in SmartCare when authorized and fax received at TBS office
- Call TBS directly once referral is authorized for referral assignment information

What is the role of the SMHP?

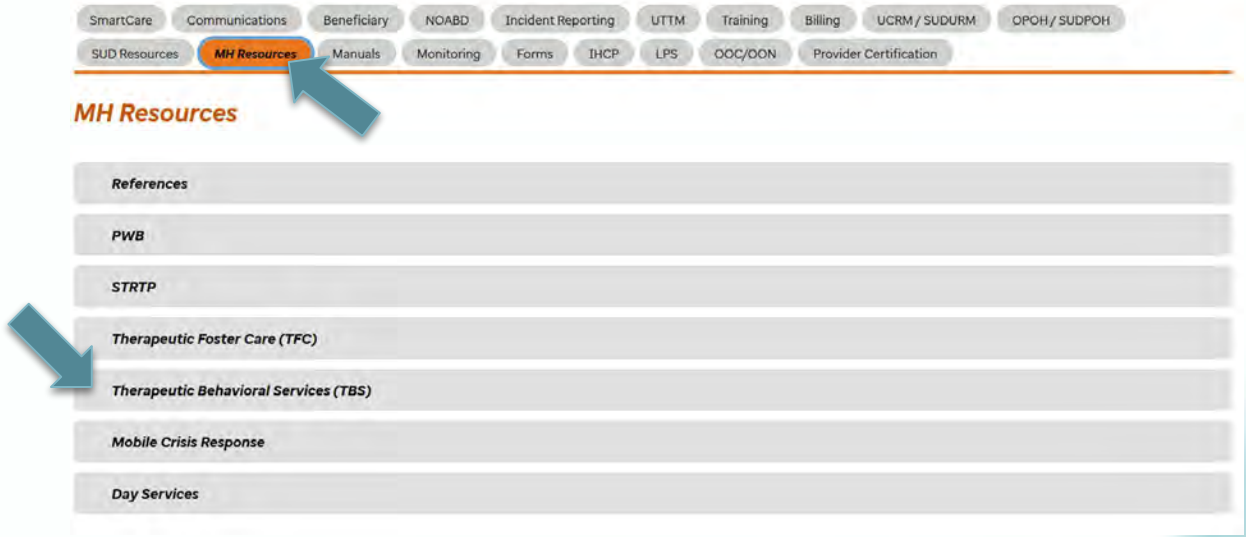
- Collaboration and Communication
  - Participation in TBS Meetings
    - Celebrate and maintain progress
    - Provide feedback
    - Advocate for engagement in TBS services
  - Feedback and collaboration with TBS Case Manager
    - Monthly at minimum aligning with update meetings
  - Support TBS interventions
- Maintain active therapy services with the TBS youth and family at least 2-4 times per month.

Eligibility and Service Delivery FAQs

- Client/caregiver have not heard from TBS. What happened?
- Can a client see a case manager instead of a therapist at the primary program?
- Can the primary program end services once TBS opens?
- What if client's family is not available for intensive services?
- What if the SMHP cannot collaborate with TBS? Can communication be email or voicemail only?

More Information

- **Visit the TBS info page on the County of San Diego Behavioral Health Services Website**
  - https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_children/therapeutic_behavioral_services.html
- **Access TBS MHP Provider Documents at Optum San Diego**
  - https://optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/smh-dmc-ods-health-plans.html



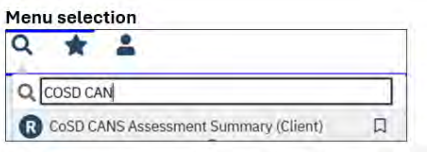
Questions?

Thank you!

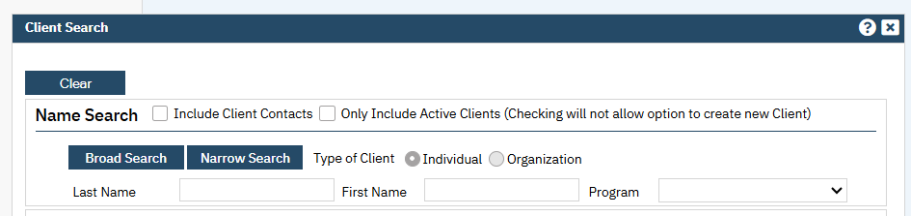
- **Christine Boyd, Program Manager**
  - christine.boyd@newalternatives.org
  - (858) 256-2180 x517
- **Jennifer Duran, Clinical Lead**
  - jennifer.duran@newalternatives.org
  - (858) 256-2180 x513
- **Kristina Crader, Referral Specialist**
  - kristina.crader@newalternatives.org
  - (858) 256-2180 x535

CANS Assessment Summary Report
New COSD SmartCare Report - SmartCare EHR

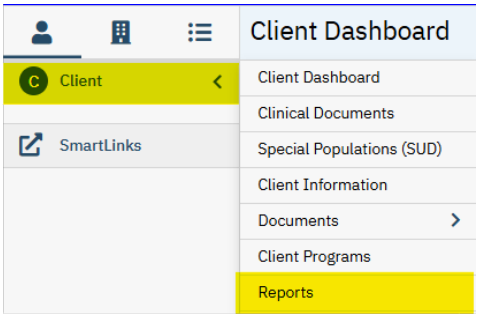
1. Select COSD CANS Assessment Summary in Menu bar



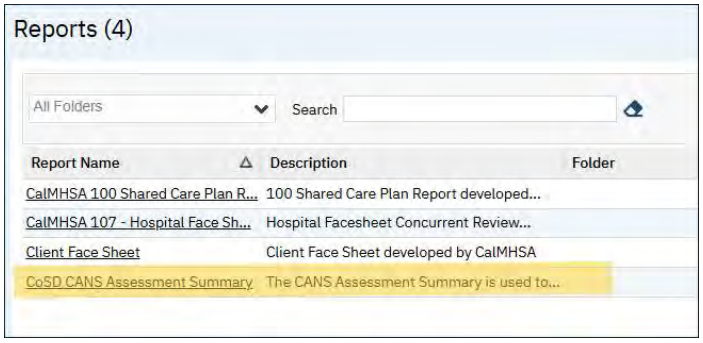
2. Enter client name (or ID) and program in Client Search and select



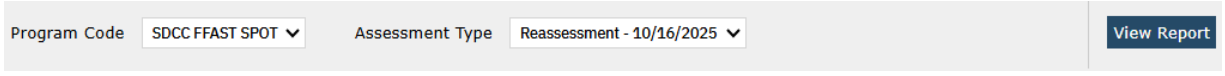
3. Toggle client icon and select Reports



4. Select CANS Summary Assessment Report



5. Enter Program Code and Assessment Type then select View Report



CANS Assessment Summary Report (4 pages)

Assessment Summary **Reassessment**

Name: [redacted] **Client ID** [redacted] **DOB:** [redacted]

Enrolled Date: 7/29/2025 **Discharge Date:** **Assigned Staff:** [redacted]

Program: SDCC FFAST SPOT

CANS Date: 10/16/2025 **Assessor:** [redacted]

Strengths to leverage to achieve goals

Strengths (item rated '0' or '1')	- Family Strengths - Talents and Interests - Natural Supports - Resiliency

Core Modules

	High Need: Act Immediately and/or Intensively (item rated a '3')	**Help is Needed: Address in Services (item rated a '2')**
Behavioral/Emotional Needs		- Anxiety - Adjustment to Trauma
Life Functioning		- Family Functioning - Living Situation - Social Functioning - School Behavior - School Achievement - School Attendance
Risk Behaviors		
Cultural Factors		
Caregiver Resources and Needs		
	# OF 'HIGH NEEDS' ITEMS = 0	**# OF 'HELP IS NEEDED' ITEMS** = 8

Follow-up Assessment Modules

Trauma Module Clinician endorsed 'Yes'	- Neglect - Witness to Family Violence - Disruption in Caregiving/Attachment Losses - Parental Criminal Behaviors

Parent PSC Respondent: Other

Parent PSC Date: 10/15/2025 **Staff:** [redacted]

PSC for Ages 6 and up

	Score	**Clinical Cutoff Score**
Attention Problems Subscale (0-10)[a]	1	Not At-Risk (Under 7)
Internalizing Problems Subscale (0-10)[b]	7	**At-Risk (5 or higher)**
Externalizing Problems Subscale (0-14)[c]	2	Not At-Risk (Under 7)
Total Scale Score (0-70)[d]	29	**Impaired (28 or higher)**

a. AT RISK - Children with scores of 7 or higher on this subscale usually have significant impairments in attention.
b. AT RISK - Children with scores of 5 or higher on this subscale usually have significant impairments with anxiety and/or depression.
c. AT RISK - Children with scores of 7 or higher on this subscale usually have significant problems with conduct.
d. IMPAIRED
- PSC Parent - Children ages 6-18 with scores of 28 or higher and children ages 3-5 with scores of 24 or higher usually have psychological impairment.

Strengths:

FAMILY STRENGTHS: Families who have strength in this area display qualities or behaviors that give hope to the family as a whole. This could include showing love and respect for one another. There is at least one member of the family who has a strong, loving relationship with the child and is able to provide support.

TALENTS/INTERESTS: Children who have strength in this area have a talent, interest, or hobby that makes them happy and feel good about themselves (for example, athletics or music).

NATURAL SUPPORTS: Children who have strength in this area have support from unpaid helpers outside the family (for example, neighbors) who help support the child's healthy development.

RESILIENCY: Children who have strength in this area are able to adapt to new situations, manage difficult challenges successfully, and identify as well as use their own strengths.

Child Behavioral/Emotional Needs:

ANXIETY: Children who need support in this area may seem nervous and fidgety. Even with support and coaching, they may avoid doing things children usually enjoy because they are too scared. Young children may have an especially hard time being away from their caregivers and may cling and cry more intensely or for longer than expected when they are away from their caregivers.

ADJUSTMENT TO TRAUMA: Children who need support in this area a) have experienced a stressful event that was perceived as having the ability to cause harm and b) show signs of difficulty coping with feelings that are triggered by the memory of that event. Some of these signs include nightmares, excessive clinginess, fear of things/people that remind them of the traumatic event, increased jumpiness, changes in their eating/sleeping/toileting habits, irritability, aggression to self and others, and difficulty calming down.

Life Functioning:

FAMILY FUNCTIONING: Children who need support in this area may struggle in developing or keeping positive relationships with family members. It may also refer to struggles with relationships within the family. It may look like the child or family member is cautious or uncertain when engaging in play with one other, the child or family member may struggle saying good-bye, or the child or family member may be hesitant to comfort or be comforted by one other. Relationships may not appear close. The child may become easily angered or hit, kick or throw things at the caregiver. In some cases, the relationship puts the child at risk of being emotionally harmed, physically injured, or sexually abused.

LIVING SITUATION: Children who need support in this area have problems in their current living situation. They may have inappropriate behavior, difficulty interacting with their caregiver, or may be at-risk for removal due to their difficult behavior.

SOCIAL FUNCTIONING: Children who need support in this area have difficulty making and keeping social relationships. They may have no friends or have constant conflict with others.

SCHOOL BEHAVIOR: Children who need support in this area behave in ways that cause problems at school (for example, they are disruptive and may have been suspended).

SCHOOL ACHIEVEMENT: Children who need support in this area have low grades, are falling behind in subjects, or have been held back a grade level.

SCHOOL ATTENDANCE: Children who need support in this area are frequently absent and the absences are interfering with their academic progress.

Trauma/Transition:

NEGLECT: Physical neglect happens when a child is not given the food, clothing, shelter, or supervision they need to grow and be safe. Medical neglect happens when a child does not get the medical care they need. Educational neglect happens when caregivers do not enroll a child in school or make sure that the child attends school and receives an education.

WITNESS TO FAMILY VIOLENCE: This occurs when children are exposed to violence in their home or in their family. A child may see the violence, they may hear sounds when it is happening, or they may later see things that happened because of the violence (for example, seeing broken furniture).

DISRUPTION IN CAREGIVING/ATTACHMENT LOSSES: This occurs when a child has had one or more major changes with their caregivers such as being separated because of separation or divorce, death of a caregiver or because a caregiver is being deported or sent to prison. Caregivers could be parents, grandparents, brothers or sisters, or other family members who help look after the child.

PARENTAL CRIMINAL BEHAVIORS: Actions and/or behaviors that parent/caregiver display which are criminal and have been witnessed by child.

How do BHS providers complete and utilize CANS results?

- CANS are completed at intake, every 6 months following the first administration, at 'triggering conditions' and at discharge from BHS SOC – 'One Youth, One CANS' which may mean that CANS are completed when youth is enrolled in different programs or through child welfare / juvenile probation departments
- The CANS tool provides a framework for developing and communicating a shared story and incorporates youth and family information to inform planning, support decisions and monitor progress
- The assessment process aims to create and establish an authentic partnership with youth and families, which promotes coordinated and integrated plans that are individualized to address the unique needs of each child / youth / family members
- CANS Assessment Summary when reviewed with the youth, family, and as appropriate with the Child and Family Team (CFT) can be utilized to:
    - Develop a cohesive care plan
    - Identify successful outcomes
    - Establish consensus ratings to support collaboration during CFT meetings and promoting a shared vision, transparency, and communication with partners

SAN DIEGO YOUTH SERVICES

Building futures for over 50 years

Our Safe Place

Celebrating 50 Years

SAN DIEGO YOUTH SERVICES

STRENGTHENING COMMUNITIES

SBCS

the YMCA

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Who we are:

5 Drop in Centers

Medi-Cal Clinic - Therapy

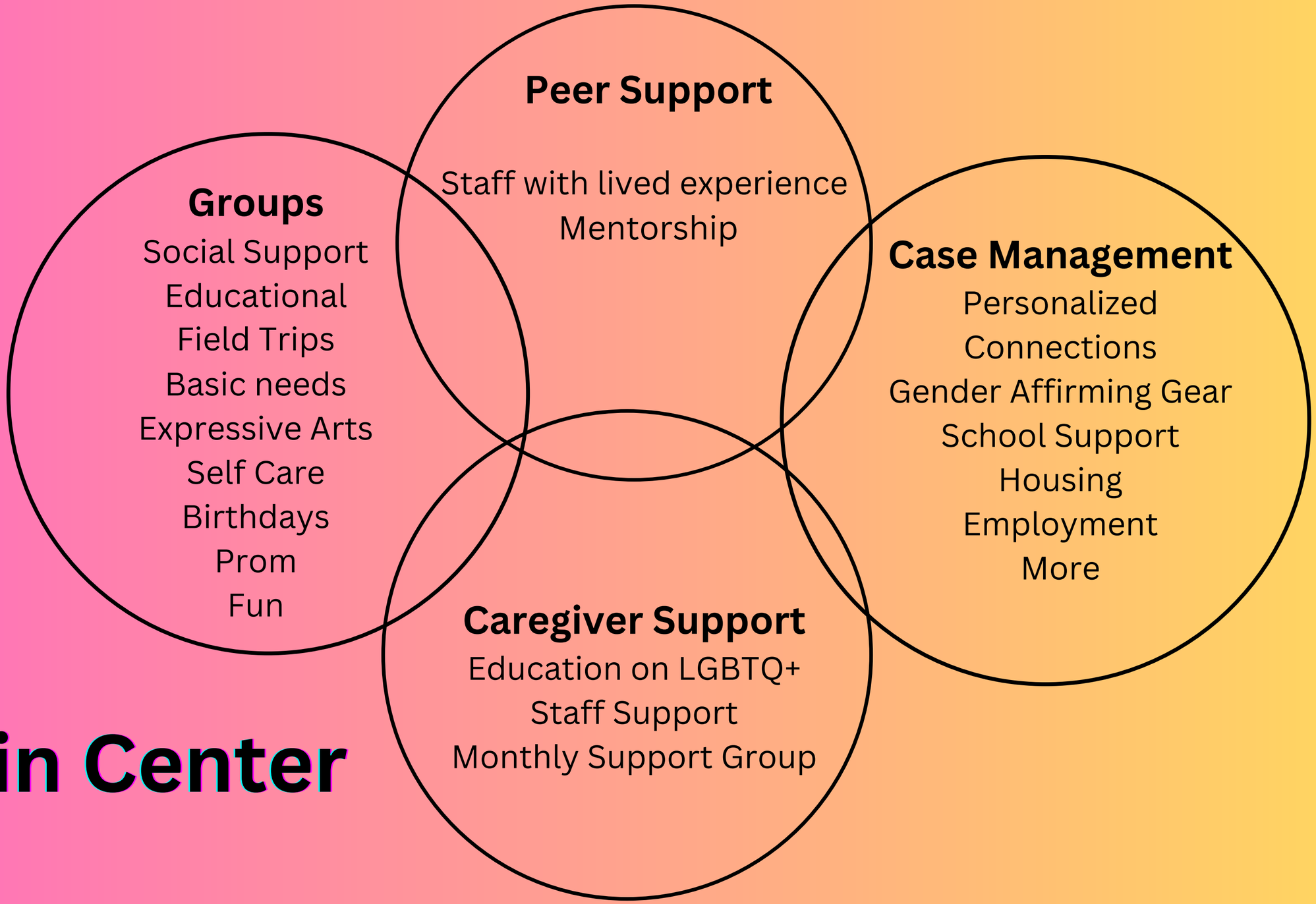
Psychiatry Services

Community Outreach and Trainings

Who Do We Serve:

- LGBTQ+ Young Folks
- Up to Age 21
- Caregivers

Drop in Center



Mental Health Clinic

Our current clinicians hold specialities and training In:

Individual, Group, Family

Meet clients where they're at:
School, DIC, Home, ETC

Telehealth

Psychodynamic
Psychoanalysis
Expressive Arts
Narrative Therapy
Drama Therapy
Movement Therapy
CBT
DBT
Neurolingistic Programming
EMDR
Internal Family Systems
Mindful Self Compassion
Ecosystem Family Therapy

3 Clinicians
1 Case Manager

Up to 6 months of treatments
with reassessment possible

Optional psychiatry with
Medication Prescriptions

Where we are:

SDYS OSP Clinic
3427 4th Ave, San Diego

Central - SDYS Golden Hill Youth Center
2220 Boardway, San Diego

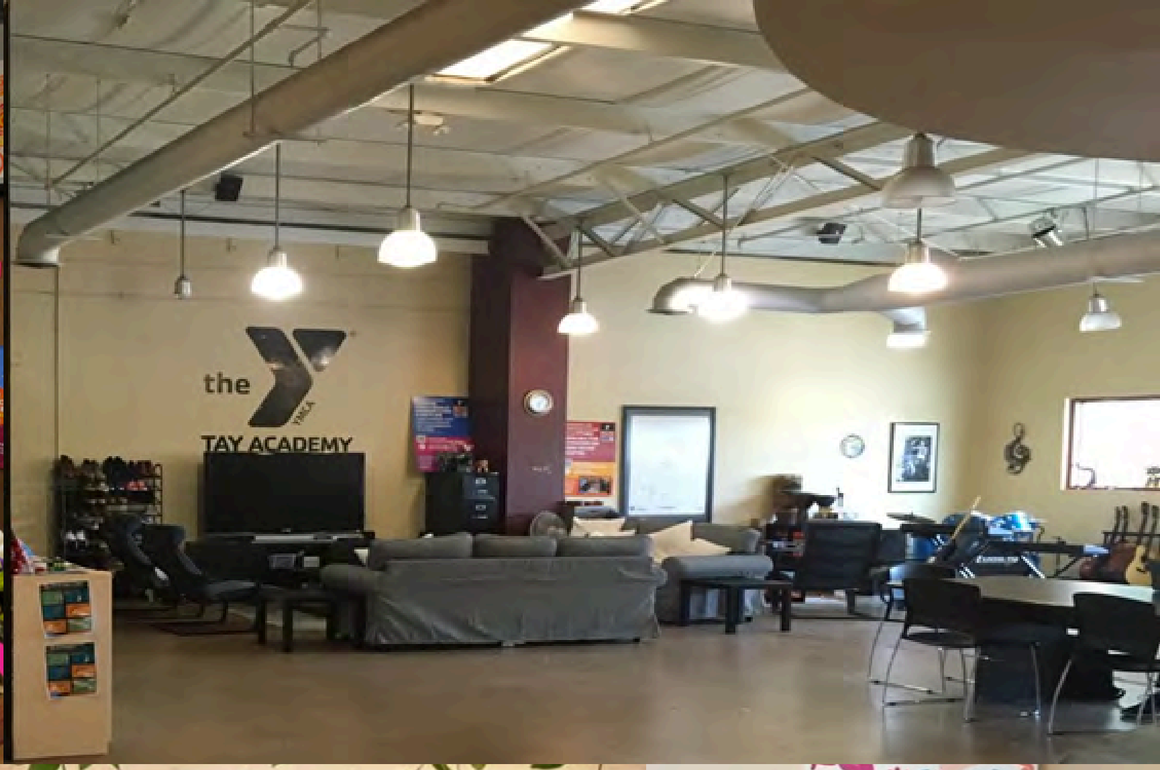
East - SDYS SVECC
3845 Spring Drive, Spring Valley

North - YMCA
150 La Terraza Blvd
Escondido

North - Oceanside YMCA
215 Barnes St, Oceanside

South -SBCS Trolley Trestle
746 Ada St Chula Vista


BLOOM


the
TAY ACADEMY


OSP


988
SUICIDE & CRISIS LIFELINE
Food Pantry


Astro Forecast
SUN PISCES
MOON GEMINI
MERCURY AQUARIUS

OSP Prom

Pride Season: June

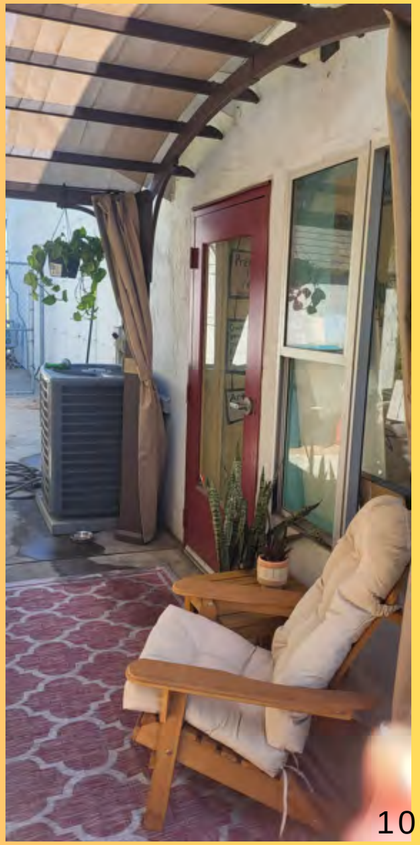
San Diego Pride Parade & Festival

UNBREAKABLE PRIDE UNSHAKEABLE POWER

Pride Season: July

Patio Grand Opening

Pride Season: August



Humble Horse: OSP Summer Series

Pride Season: June-Aug

Referring Youth:

- Can be referred by a provider, teacher, friend
- Can self refer
- Can visit first before intake or referral
- Clinic accepts: Medi-cal, Underinsured, or Uninsured
- Please consider youth safety and if they are out to caregivers

Who to Contact:

Clinic: kdeberardinis@sdyouthservices.org

Central & East: jbarnes@sdyouthservices.org

South : oursafeplace@csbcs.org

North: afavela@ymcasd.org

Email us if your interested in your group recieving this outreach presentation, our LGBTQ+ training, or if you would like to be added to our month activity calendar and newletter mailing list.

Thank you!

Holiday Closure

Holiday Closure Fiscal Year 2024-2025 for BHS Programs

County of San Diego – Health and Human Services Agency (HHSA)

Behavioral Health Services (BHS) – Contractor Information Notice

To:	**BHS Contracted Service Providers**
From:	**Behavioral Health Services**
Date:	**November 22, 2024**
Title	**Holiday Closure Fiscal Year 2024-2025 for BHS Programs**

Holiday Closures

As the holiday season approaches, please review the office closure protocol for holidays or organizational events provided below. Programs can locate specific program expectations in the contract Statement of Work and/or in the Substance Use Disorder Provider Operations Handbook (SUDPOH)/Organizational Provider Operations Handbook (OPOH).

- **Outpatient programs** generally follow the County of San Diego (County) holiday schedule, which is attached for reference.
- **Residential programs** remain open 365 days a year. If staffing is reduced during the holidays, required program activities such as group sessions, individual sessions, and/or assessments are expected to continue.

Programs requesting to have a closure that is not specified in the Statement of Work or provided for in the SUDPOH/OPOH need to proactively reach out to their Contracting Officer's Representative (COR) in advance of the requested closure to provide rationale and obtain written approval.

Office Closure Protocol

The standard closure procedures for outpatient programs include:

- All clients and/or caregivers to receive advance notice of closure.
- Stakeholders and referral sources to be notified of closure in advance.
- Visible and legible signs regarding closure to be displayed, minimally, at the entrance(s) of the building/program.
- Outgoing phone and email messages (such as out of office alerts) to inform callers of closure and available alternative resources (i.e., hotline numbers, cell phone numbers, or other emergency numbers).
- Proposed closures to be finalized only upon written approval from the COR.

The BHS team wishes your team and those you serve a happy and safe holiday season!

Attachment: County Observed Holiday Schedule FY 24-25

For More Information:

- Contact your Contracting Officer's Representative (COR)

1 of 1 2024-11-22

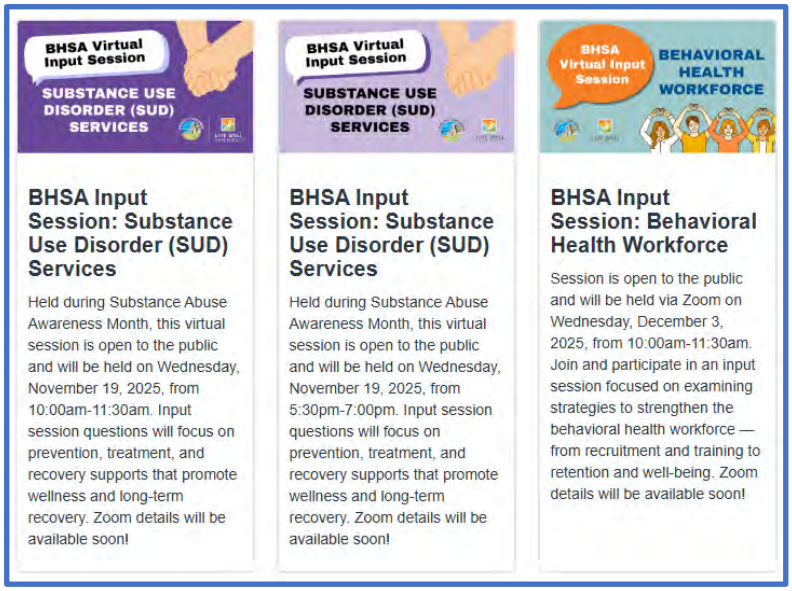
BHSA Input Opportunities

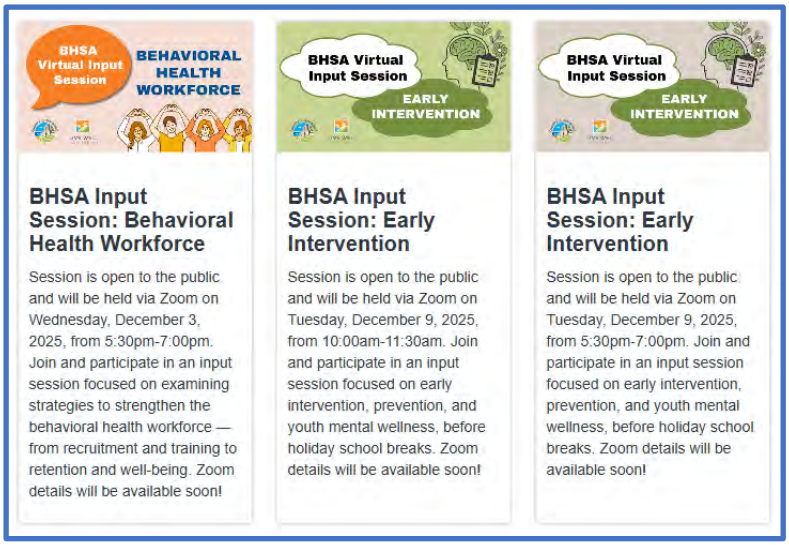
[Behavioral Health Services Act]

[Behavioral Health Services Act Online Input Form]

[Behavioral Health Services Act (BHSA) Updates Sign-Up Form]

[Engagement Activities]





- Ensure & Record that Staff Obtained Annual Training
- Make Required Forms Available at Required Intervals
  - An attached Voter Registration Form, General and State Instructions Form and DSS 16-64 form shall be included in all intake/admission packets
  - For Children's programs, voter registration services shall be offered to parents/guardians of clients less than 18 years of age
  - Submit any completed forms to state
- Document in SmartCare in intake note
  - Include in documentation: "Offered Voter Registration Forms" and notate any refusal to complete form

SPC LGBTQIA+ Safer Spaces 1.0 & 2.0 Training

2025 Training Dates:

- **1.0 Virtual- Oct. 28 & Oct.30 from 2 - 3:45 pm at**

  http://sdcoe.k12oms.org/918-272894

- **2.0 Virtual- Dec. 2 & Dec. 4 from 2 - 3:45 pm at**

  http://sdcoe.k12oms.org/918-272897

This training provides participants with the following:

1.0 Training:

- Relevant terms/concepts
- Lived experiences of LGBTQIA+ youth
- Federal and state laws protecting LGBTQIA+ youth
- Importance of inclusive curriculum
- How to be an ally to LGBTQIA+ youth
- Resources from the Suicide Prevention Council

2.0 Training:

- Review 4 pillars
- Reflections on your allyship and going beyond
- Intersectionality
- Inclusive sex education
- Transgender and gender non-binary experiences

NO COST!

Target Audience: All who have contact with K-12 students in an educational setting to create a safer learning environment.

In partnership with the San Diego County Suicide Prevention Council and the County of San Diego.

Questions? Contact: Elizabeth Campos

ecampos@sdcoe.net

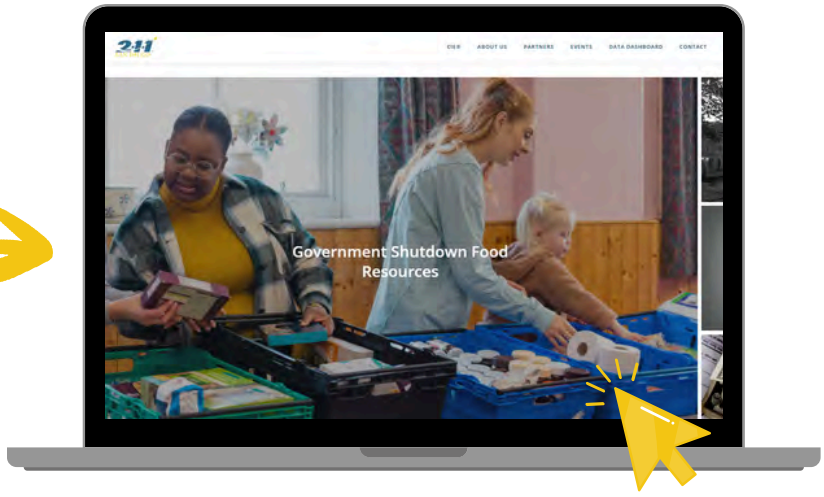
858-295-8992

Participants may be photographed for use in promotional and/or news materials.

Are You Impacted by the Government Shutdown?

Find Food Resources Near You!

> ***Visit 211sandiego.org***



SCAN ME!

You can find information about:

- CalFresh (aka SNAP, EBT, Food Stamps)
- Helpful FAQ's, including FREE Student Breakfast and Lunch
- How to Find Food Resources Near You
- ***And More!***

Don't have access to a digital device?

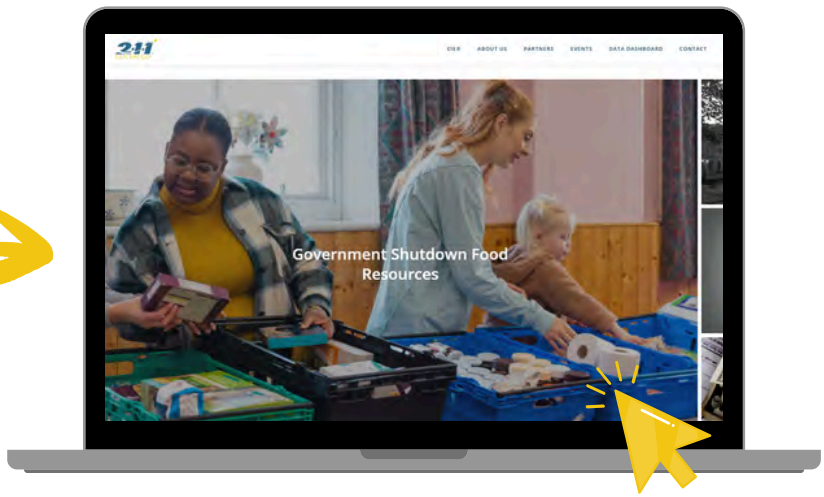
Call us by dialing 2-1-1.
Open 24 hours a day. In more than 200 languages.

¿Está Afectado

por el Cierre del Gobierno?

¡Encuentre Recursos Alimentarios Cerca de Usted!

Visite 211sandiego.org



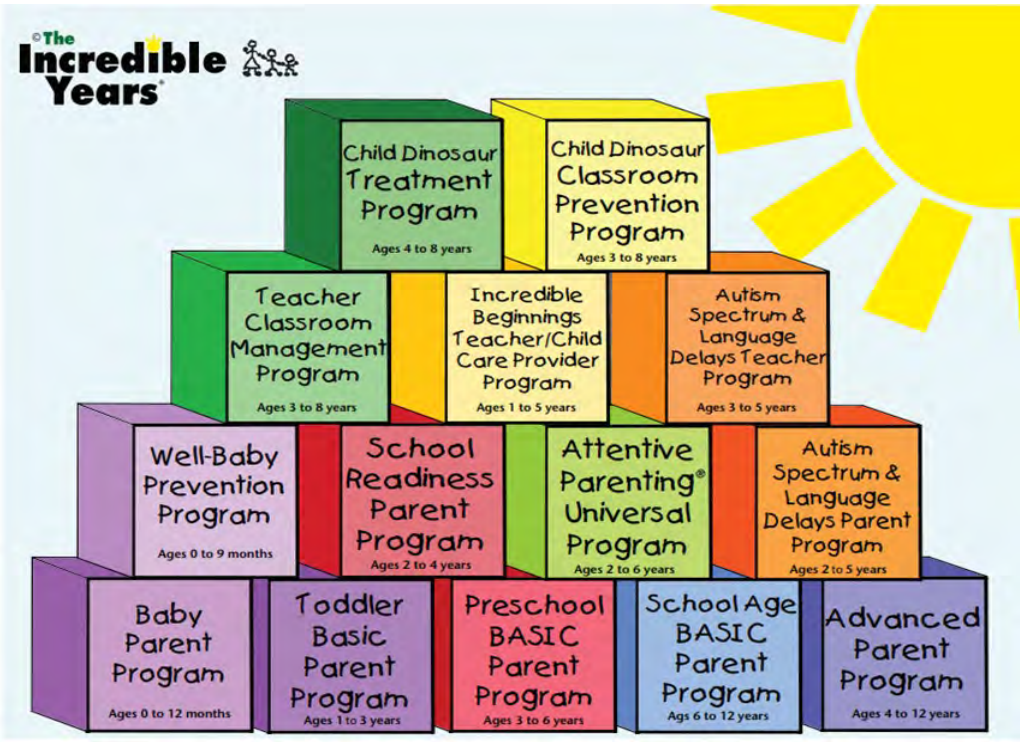
¡ESCANÉAME!

Puede encontrar información sobre:

- **CalFresh (también conocido como SNAP, EBT, Cupones de Alimentos)**
- **Preguntas Frecuentes de Ayuda, incluyendo Desayuno y Almuerzo GRATIS para Estudiantes**
- **Cómo Encontrar Recursos Alimentarios Cerca de Usted**
- ***¡Y Más!***

¿No tiene acceso a un dispositivo digital?

Llámenos marcando 2-1-1.
Disponible las 24 horas del día. En más de 200 idiomas.



The Incredible Years®
Parent Group Leader Workshop Agenda

Day 1

Morning

- Overview of the Webster-Stratton program
  - Family and child risk factors
  - Content of program
  - Research findings
  - Group leader roles
- Child-Directed Play Promotes Positive Relationships

Afternoon

- Descriptive Commenting, Academic & Persistence Coaching
- Emotional & Social Coaching
- Logistics: Getting your first group started (recruitment, location, leader preparation, child care, incentives)

Day 2

Morning

- Praise Program
- Tangible Rewards Program: (Routines & Rules, Limit Setting)

Afternoon

- Handling Misbehavior: Follow Through & Ignore
- Maximizing your results (partners, role playing, home assignments, buddy system, collaboration between home and school, "principle training," ensuring generalization, self-monitoring checklist, make-up sessions, ending the group)

Day 3

Morning

- Handling Misbehavior: Time Out to Calm Down
- Handling Misbehavior: Logical Consequences

Afternoon

- Problem Solving
- Weekly evaluations
- Self and peer evaluations
- Ongoing consultation
- Certification of group leaders

Two options for Incredible Years (IY) Training for BHS IY programs

- BHS IY programs will have option to send staff to (1) IY training course hosted by developers or (2) organized by Incredible Families (IF) program.
- Contingent on participation, IY training organized by IF program are projected to have lower cost.
- Cost per staff under option 2 will be calculated by number of BHS staff attending the training.

Option 1 – Directly from IY Developer

INCREDIBLE YEARS TRAINING COST:

EXAMPLE

Option 2 – Organized locally for BHS providers via the Incredible Families (IF) program annually

INCREDIBLE FAMILIES PROGRAM IY TRAINING COST:

Total training cost - $10,500.00 (includes training and trainer expenses)

Will be divided based on per staff cost: Min 15 staff and up to a max of 25 attendees

15 participants = $700 per staff
20 participants = $525 per staff
25 participants = $420 per staff