



Tobacco Cessation and Behavioral Health

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Today's Objectives

- ▶ Why this? Why now?
- ▶ Morbidity and mortality
- ▶ Prevalence rates
- ▶ Unique challenges
- ▶ Case Study: California Smokers' Helpline
- ▶ Resources and tools



Why Now?

- ▶ Promotion of health
- ▶ Changing philosophy around addictions & co-occurring treatment
- ▶ Putting the “T” back in ATOD
- ▶ Increased treatment effectiveness
- ▶ A key component of the recovery process
- ▶ You are in the best position to offer these services




A Wellness Philosophy

A black and white close-up portrait of a woman, Ariana, looking directly at the camera with a slight smile. The background is a soft-focus outdoor scene.

I didn't survive depression
and suicide attempts
so I could die from lung cancer.
I had to stop smoking.
—ARIANA

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

Funded by the American Legacy Foundation, however, this does not necessarily represent the views of the Foundation, Pacer/Deen et al., or its Board of Directors
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To assist people to
lead meaningful
lives in their
communities, we
need to promote
behaviors that lead
to health



Alarming Statistics

A decorative graphic at the bottom of the slide consists of a solid purple shape that starts as a thin horizontal line on the left, gradually rises to a rounded peak in the middle, and then tapers back down to a thin horizontal line on the right.



Tobacco's Deadly Toll

- ▶ 200,000 of the 435,000 annual deaths are people with mental illness and substance use disorders
- ▶ For patients in treatment for alcohol and drug dependence, more than half die from tobacco-caused illnesses¹
- ▶ Among treated narcotic addicts, smokers' death rates are 4 times that of nonsmokers²

¹Hurt et al., 1996

²Hser et al., 1994; Lynch & Bonnie, 1994



Morbidity and Mortality

Thirteenth
in a Series
of
Technical
Reports

Morbidity and Mortality in People with Serious Mental Illness

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Morbidity and Mortality

- ▶ Persons with mental illnesses die up to 25 years earlier and suffer increased medical comorbidity
 - ▶ Often from tobacco related diseases
 - ▶ More likely to die from these diseases than from their alcohol use
- ▶ Smokers with mental illnesses have increased hospitalizations, and require higher dosages of medications

(Brown et al., 2000; Colton & Manderscheid, 2006; Dixon et al., 1999; Joukamaa et al., 2001; Osby et al., 2000; Dalack & Glassman, 1992; Desai, Seabolt, & Jann, 2001; Goff, Henderson, & Amico, 1992; Williams & Ziedonis, 2004; Ziedonis, Kosten, Glazer, & Frances, 1994).



Prevalence Rates



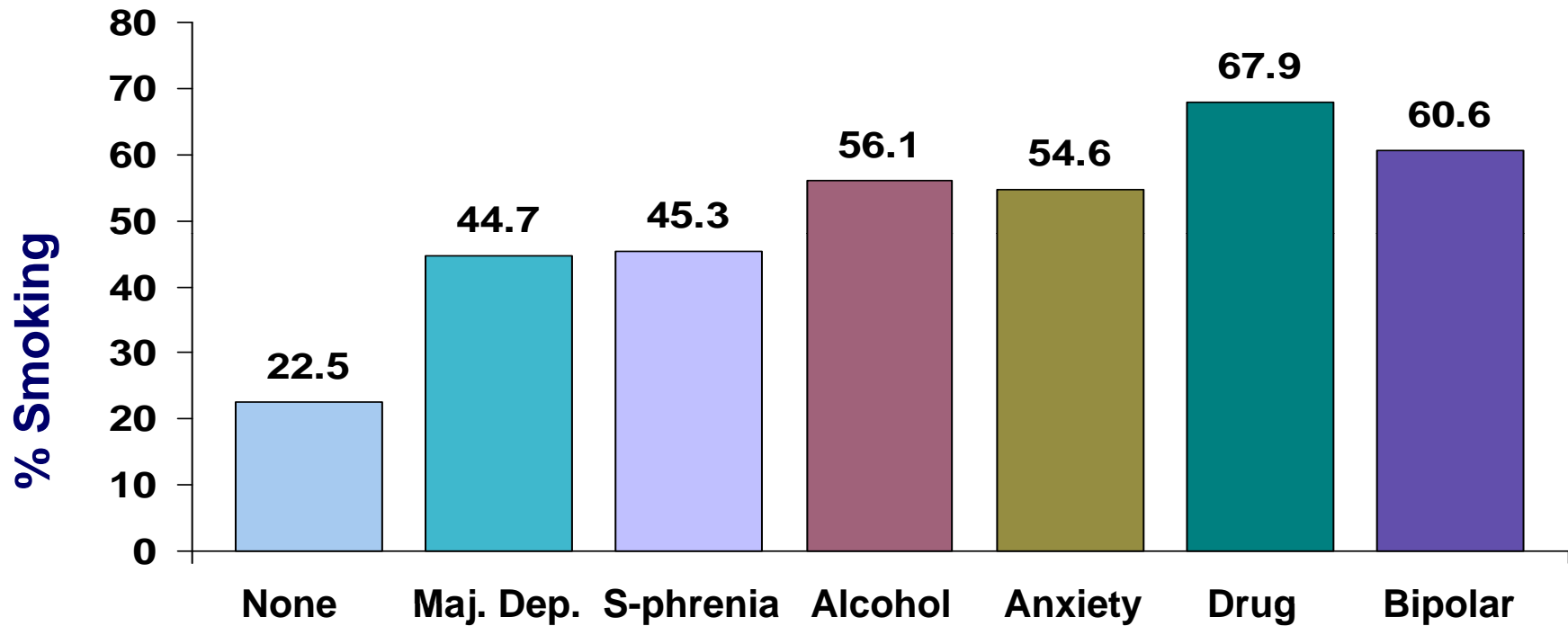


Smoking and Behavioral Health

- ▶ About 41% of people with mental illness & substance use disorders smoke.²
- ▶ Rates of smoking are 2-4 times higher than among the general population.¹
- ▶ 60% of current smokers report having had a mental health or substance use diagnosis sometime in their lifetime.¹
- ▶ This population consumes 45% of cigarettes smoked.³

1. Kalman, 2005 2. Lasser, 2000, 3. Breslau, 2003

Smoking by Diagnosis



Lasser et al., 2000





Smoking by Diagnosis (variety of surveys & settings)

Schizophrenia	45-88%
Bipolar disorder	51-70%
Major depression	36-80%
Anxiety disorder	32-60%
Post-traumatic stress disorder	45-60%
Attention deficit/hyperactivity disorder	38-42%
Alcohol abuse	34-80%
Other drug abuse	49-98%

Beckham et al., 1995; De Leon et al., 1995; Farnam 1999; Grant et al., 2004; Hughes et al., 1996; Lasser et al., 2000; Morris et al., 2006; Pomerleau et al., 1995; Stark & Campbell, 1993; Ziedonis et al., 1994



Why is This Population Vulnerable?



Barriers & Vulnerabilities

- ▶ Biological factors
- ▶ Barriers to tobacco interventions
 - Systems Factors
 - Clinician Factors
 - Client/Consumer Factors
- ▶ Tobacco industry targeting



Biological Factors

- ▶ Persons with behavioral health diagnoses may have neurobiological & genetic features that:
 - increase their tendency to use nicotine,
 - make it more difficult to quit, and
 - complicate the withdrawal phase.
- ▶ Nicotine enhances
 - concentration
 - information processing
 - learning
 - mood
- ▶ May reduce medication side effects



Barriers to Tobacco Interventions: Systems Factors

- ▶ Competing demands
- ▶ Tobacco as socialization activity, behavioral reward
- ▶ Staff acceptance and promotion
- ▶ Not part of current treatment milieu
- ▶ Lack of reimbursement for services



Barriers to Tobacco Interventions: Clinician Factors

- ▶ Expectation of failure
- ▶ Competing demands
- ▶ Fear of symptom exacerbation & relapse
- ▶ Lack of training
- ▶ Minimization



Smoking Prevalence Among Mental Health Providers

- ▶ 30% - 35% of mental health providers smoke as compared to-
 - Primary Care Physicians 1.7%
 - Emergency Physicians 5.7%
 - Registered Nurses 13.1%
 - Dentists 5.8%
 - Dental Hygienists 5.4%
 - Pharmacists 4.5%

Strouse, Hall, Kovac, 2004



Barriers to Tobacco Interventions: Client/Consumer Factors

- ▶ Expectation of failure
- ▶ Lack of knowledge
- ▶ Fear of withdrawal symptoms
- ▶ Fear of weight gain
- ▶ Concern about recovery
- ▶ Concern about stress management (tension, anxiety)
- ▶ Doubt about dealing with boredom
- ▶ Part of daily routines
- ▶ Integral to social activity



Tobacco Industry Targeting

- ▶ Monitored or directly funded research supporting the idea that individuals with schizophrenia were:
 - less susceptible to the harms of tobacco and
 - that they needed tobacco as self-medication
- ▶ Promoted smoking in psychiatric settings by:
 - providing cigarettes and
 - supporting efforts to block hospital smoking bans



Myths and Myth-breaking Evidence



Myth #1

- ▶ **Myth**: Persons with mental illness and substance use disorders don't want to quit.
- ▶ **Fact**: The majority of persons with mental illness and substance use disorders want to quit smoking and want information on cessation services and resources.



Interest in Quitting Results: Behavioral Health

- ▶ Study of 300 depressed smokers: 79% were interested in quitting. (Prochaska et.al., 2004)
- ▶ Study of 224 hospitalized psychiatric patients who smoke: 79% of eligible smokers recruited into the study (Prochaska et al., 2009)
- ▶ Review of clinical trials: 50% - 77% in substance use facilities were interested in quitting. (Joseph et.al., 2004)



Myth #2

- ▶ **Myth**: Persons with mental illness and substance use disorders can't quit smoking.
- ▶ **Fact**: Persons with mental illness and substance use disorders can successfully quit using tobacco.



Smoking Cessation Results: Mental Illnesses

Most combine meds & psycho-education +/- CBT

▶ Schizophrenia: 8 studies (n= 9-70)

Quit rates 35-56% post-treatment,
12% at 6-months

▶ Depression: 8 studies (n= 29-615)

Quit rates 31-72% post-treatment,
12-46% at 12 months

(el-Guebaly et al., 2002)



Does Abstinence from Tobacco Cause Recurrence of Psychiatric Disorders?

- ▶ For depressed smokers who quit :
 - No increase in suicidality, hospitalization, use of marijuana, stimulants, or opiates
 - Less alcohol use among those who quit (Prochaska et al., 2008)
- ▶ For smokers with schizophrenia who quit:
 - No worsening of attention, verbal learning/ memory, working memory, or executive function/inhibition, or clinical symptoms of schizophrenia (Evins et al., 2005)



Myth #3

- ▶ **Myth**: Smoking cessation will threaten recovery for persons with substance use disorders.
- ▶ **Fact**: Smoking cessation can enhance long-term recovery for persons with substance use disorders.

(Prochaska et al., 2004; Saxon, 2003; Signal Behavioral Health, 2008; Lemon et al. 2003; Gulliver et al 2006; Ziedonis et al, 2006; Baca & Yahne, 2009)



Smoking Cessation Results: During Addictions Treatment or Recovery

- ▶ Systematic review of 17 studies
- ▶ Smokers with current and past alcohol problems:
 - More nicotine dependent
 - Less likely to quit in their lifetime
 - As able to quit smoking as individuals with no alcohol problems

Hughes & Kalman, 2006, Drug Alc Dep



Does Abstinence from Tobacco Cause Relapse to Alcohol and Illicit Drugs?

- ▶ At > 6 months follow-up, tobacco treatment with individuals in addictions treatment was associated with a **25% increased abstinence** from alcohol and illicit drugs
- ▶ Caveat – one well done study looking at concurrent vs. delayed tobacco cessation treatment (n=499; Joseph, et al, 2004)
 - ▶ Comparable smoking quit rates at 18 months, but lower prolonged alcohol abstinence rates for concurrent treatment group at 6 months



What is Your Role?



Clinical Practice Guidelines

- ▶ Comprehensive, evidence-based approach for smoking cessation
- ▶ Released in June 2000 by the U.S. Public Health Service—updated version in 2008
- ▶ Systematic approach to tobacco cessation for all healthcare facilities



Clinical Practice Guidelines (cont.)

- ▶ All patients/clients should be screened for tobacco use, advised to quit and be offered intervention
- ▶ Those trying to quit should be offered pharmacotherapy, unless contraindicated
- ▶ There is a dose response relationship with the amount of contact provided



Evidence-Based Model: The 5 A's

Ask: Systematically identify all tobacco users at every visit

Advise: Advise tobacco users to quit

Assess: Assess each tobacco user's willingness to quit

Assist: Assist tobacco users with a quit plan

Arrange: Arrange follow-up contact



The 5 A's and A, A, R

Ask: Systematically identify all tobacco users at every visit

Advise: Advise smokers to quit

Assess: Assess each smoker's willingness to quit →

Refer to the California Smokers' Helpline and/or Peer-to-peer counselor

Assist: Assist smokers with a quit plan →

The Helpline provides behavior modification counseling (quit plan and quit date)

Arrange: Arrange follow-up contact →


The Helpline provides 5 follow-up calls – timing is based on the probability of relapse.



Case Study

The California Smokers'

Helpline





California Smokers' Helpline

1-800-NO-BUTTS

- ▶ Free statewide tobacco cessation program
- ▶ Funded by tobacco taxes
 - Propositions 99 & 10
- ▶ Scientifically proven to be effective
- ▶ All services available by telephone
- ▶ In operation since 1992
- ▶ Adults, teens, pregnant women and proxy
- ▶ Multiple languages



Multiple Languages

- ▶ English
1-800-NO-BUTTS (1-800-662-8887)
- ▶ Cantonese
1-800-838-8917
- ▶ Korean
1-800-556-5564
- ▶ Mandarin
1-800-838-8917
- ▶ Spanish
1-800-45-NO-FUME (1-800-456-6386)
- ▶ Vietnamese
1-800-778-8440



Available Services

- ▶ Self-help materials
- ▶ Referral lists of local cessation programs
 - ▶ Updated by each county's tobacco control program
- ▶ Individual telephone counseling
 - ▶ Confidential
 - ▶ One pre-quit call, multiple proactive follow-up calls
 - ▶ Trained counseling staff



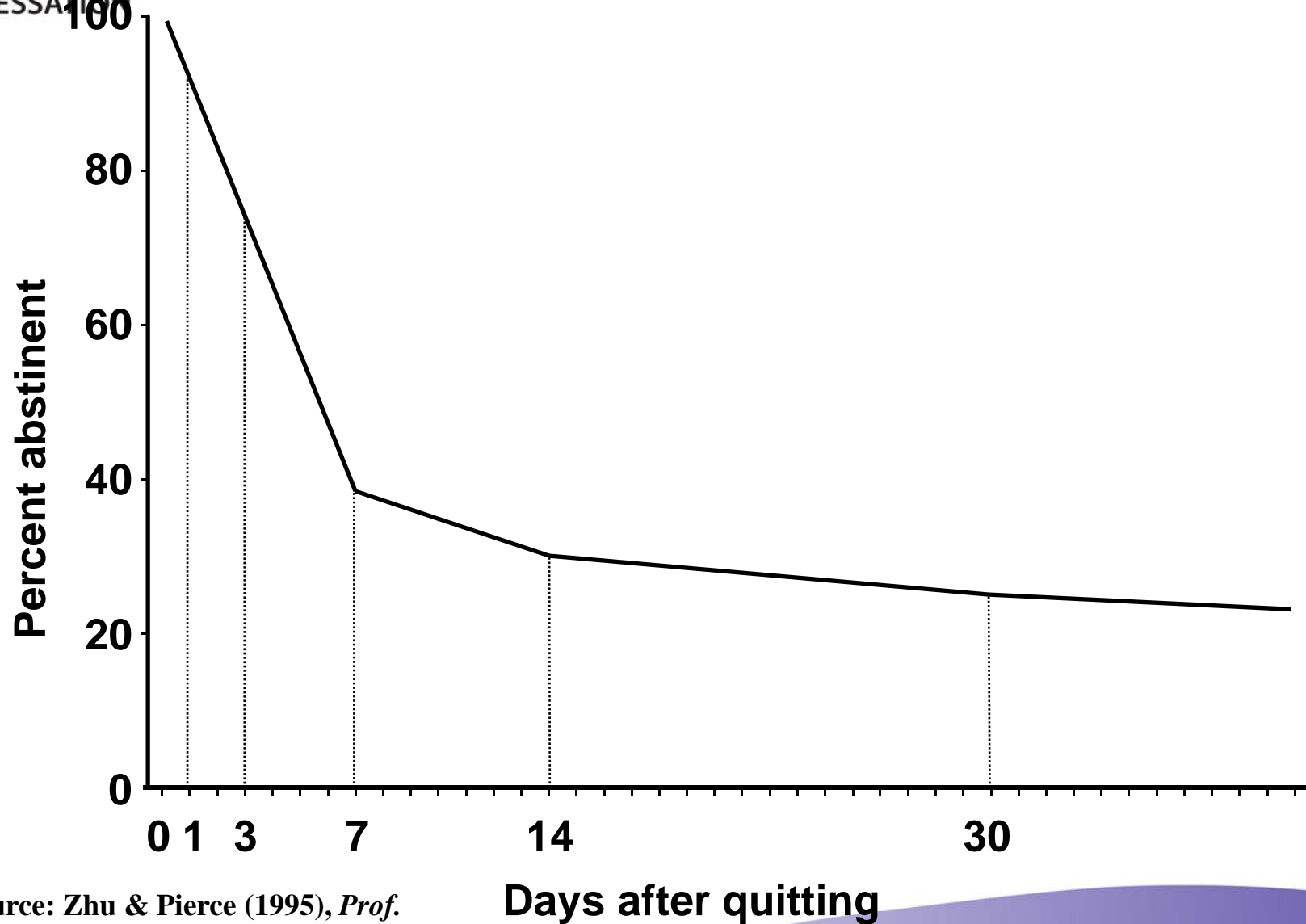
What Happens in Each Call?

- ▶ Initial session
 - Comprehensive, 30-40 min. call
 - Preparation to quit
 - Setting a quit date

- ▶ Follow-up sessions
 - Up to five 10-15 min. calls
 - Relapse prevention
 - Pharmacotherapy review



Relapse-Sensitive Scheduling



Source: Zhu & Pierce (1995), *Prof. Psych. Res. & Practice*, 26, 624-625

Days after quitting

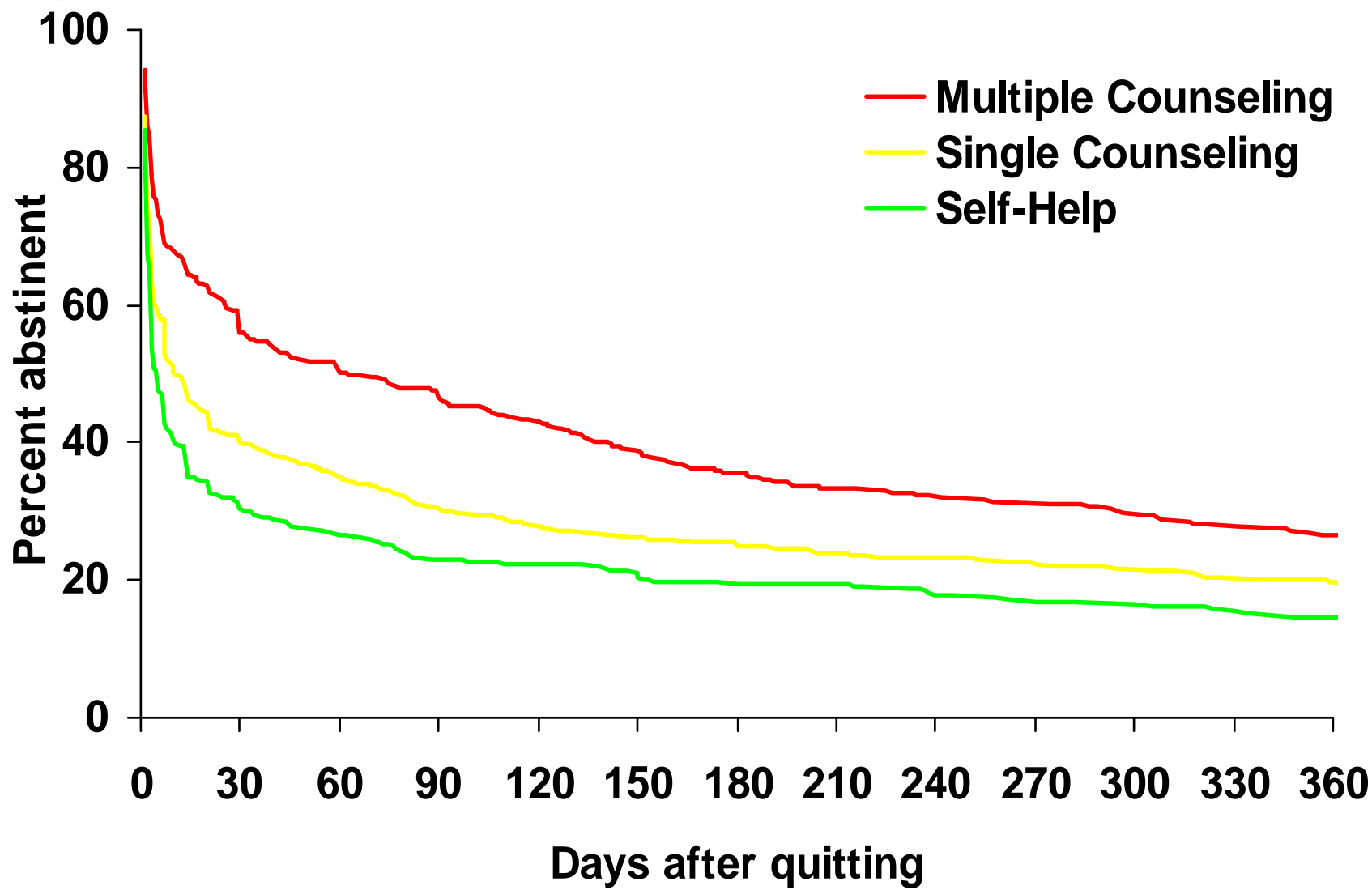


Helpline Intervention Summary

- Identify a strong reason (Motivation)
- Bolster belief in ability (Confidence)
- Develop a solid plan (Skills)
- Adopt a new view of self (Self-image)
- Keep trying (Perseverance)



Relapse Curves for the 3 Groups



Source: Zhu et al. (1996), *JCCP*, 64, 202-211



Helpline Callers with Behavioral Health Conditions



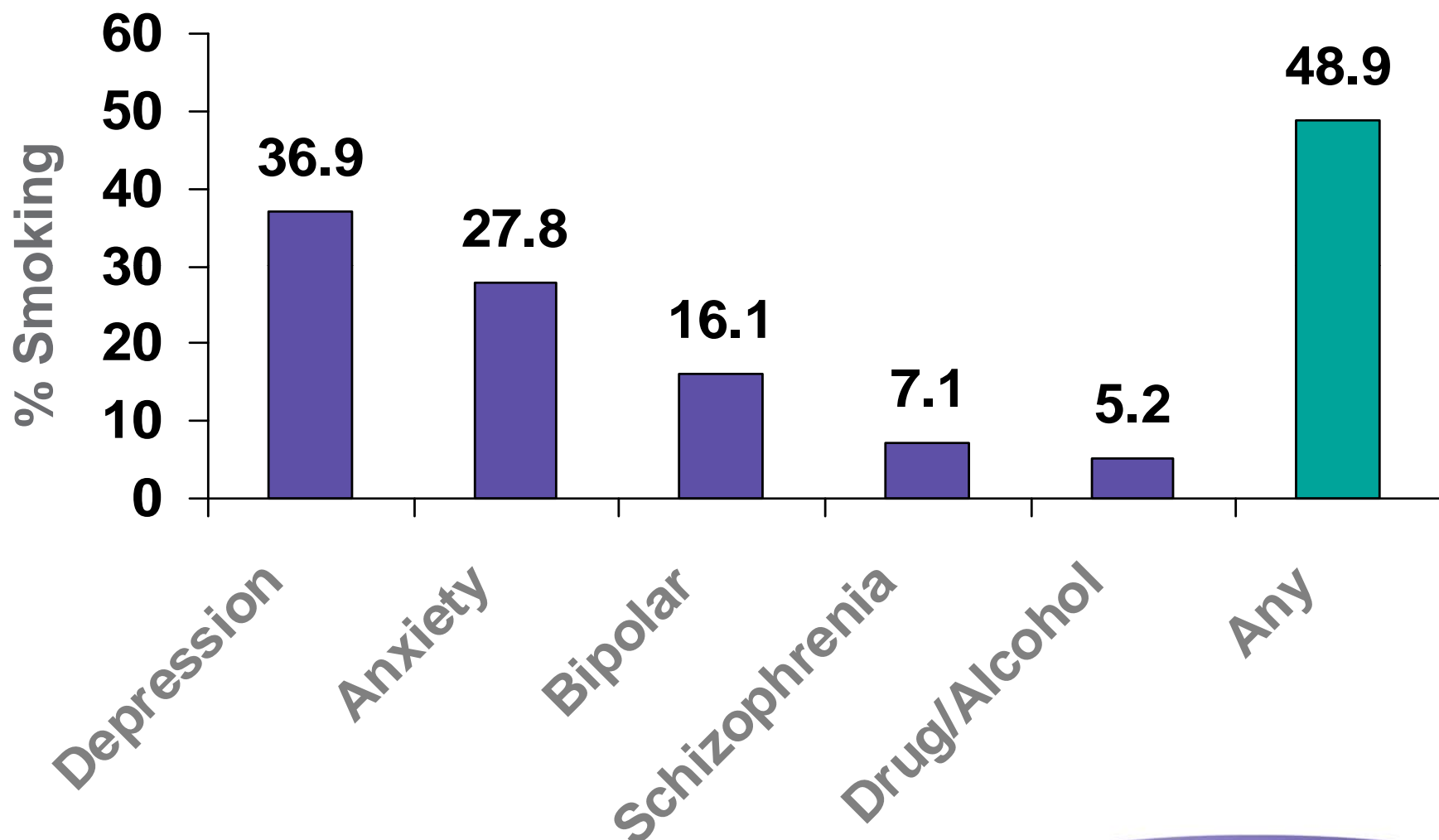


Self-Reported Behavioral Health Conditions Among Helpline Callers

- ▶ Do you have any current mental health issues such as:
 - An anxiety disorder?
 - Depression?
 - Bipolar disorder?
 - Schizophrenia?
 - Drug or alcohol problem?
 - ▶ If yes, have you been actively using/drinking in the last month?



Self-Reported Behavioral Health Conditions Among Helpline Callers



(Zhu, et al, 2009. Unpublished data)



Received Counseling

No Mental Illness	74.0%
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Mental Illness	84.0%
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(Zhu, et al, 2009. Unpublished data)





Use of Nicotine Replacement Therapy (NRT)

No Mental Illness 33.3%

Mental Illness 41.7%

(Zhu, et al, 2009. Unpublished data)






Quit Attempts

Quit in 2 Months (%)

No Mental Illness	53.1*
Mental Illness	56.4*

(Zhu, et al, 2009. Unpublished data)

* Descriptive data, not based on results of a randomized controlled trial






Quitting Success

30-Day Point Prevalence (%)
at 2 Months

No Mental Illness	20.8*
Mental Illness	19.0*

(Zhu, et al, 2009. Unpublished data)

* Descriptive data, not based on results of a randomized controlled trial





Conclusions from the Helpline

- ▶ Smokers with mental illnesses call in high numbers
 - Across all demographics
- ▶ They appear to be more motivated
 - More likely to get counseling & use NRT
- ▶ The motivation and use of treatment seem to compensate for the vulnerability associated with their mental health condition.
- ▶ As a result, they are equally likely to try to quit & succeed
- ▶ Randomized controlled trials are needed to determine efficacy of telephone counseling for smokers with mental illnesses

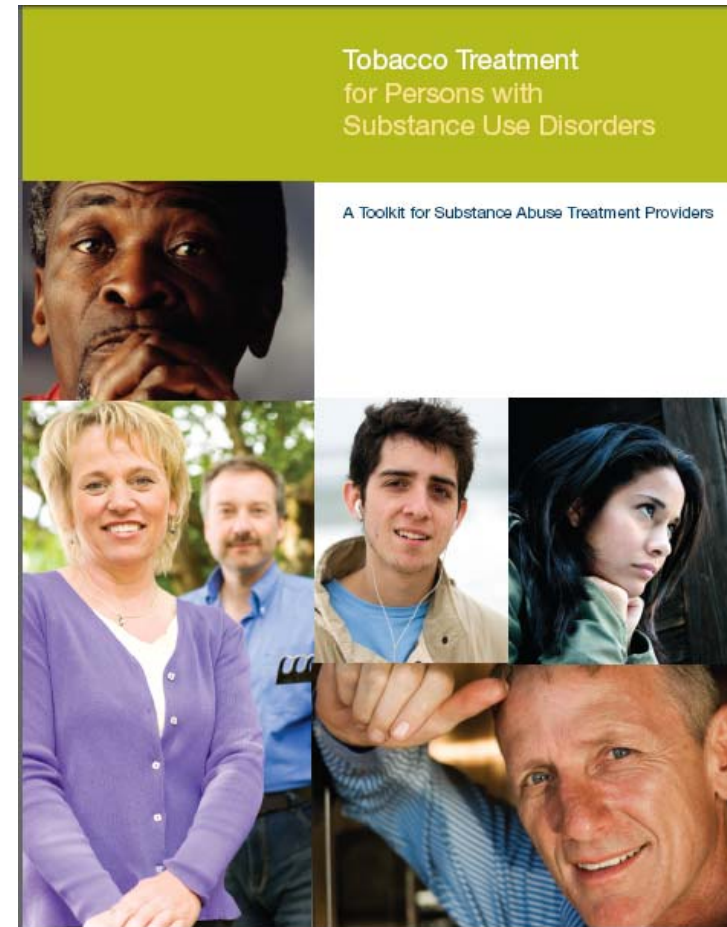
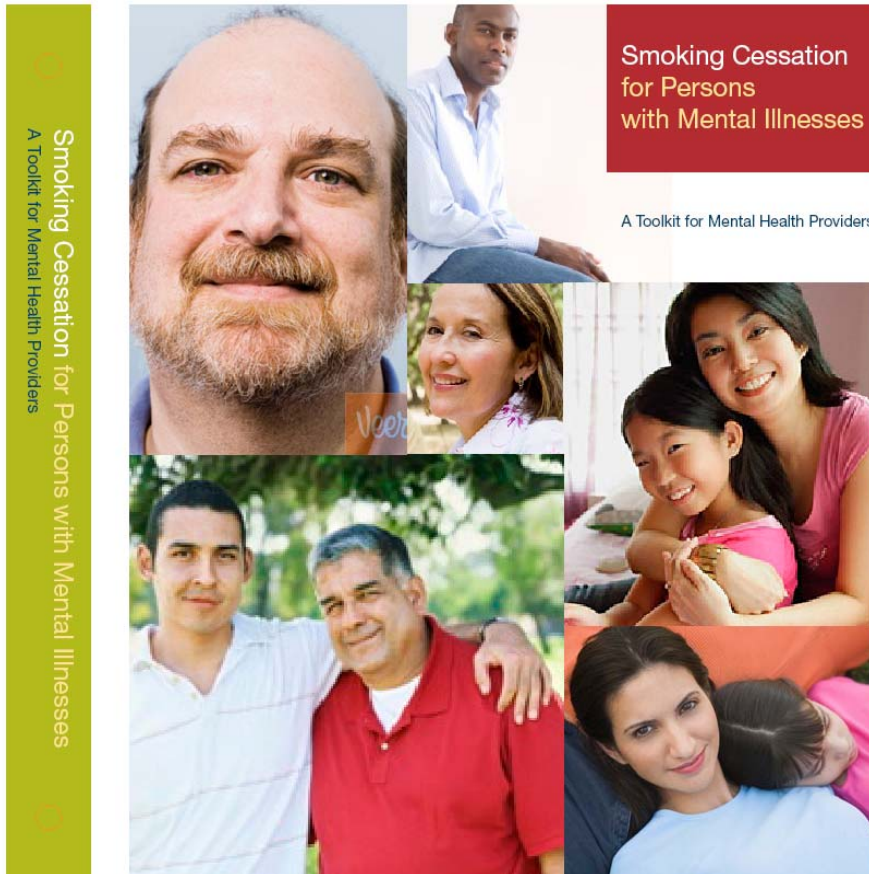


Key Treatment Considerations

- ▶ Psychiatric stability/level of functioning
- ▶ Quitting history & symptoms
- ▶ Biochemical factors
- ▶ Pharmacotherapy issues
- ▶ Session structure & content
- ▶ Clinician style
- ▶ Consultation with current providers
- ▶ Referrals as needed



Resources



For free copies go to:

<http://smokingcessationleadership.ucsf.edu/BehavioralHealth.htm>



Questions?

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