

The Role of Behavioral Health Care in Tobacco Dependence Treatment: Why Us? Why Now?

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Why should we become involved?

- Saves lives
- Saves healthcare dollars
- Improves productivity
- Nicotine Dependence is a DSM-IV Disorder
- Disproportionate in the mental health population
- Tobacco dependence and mental illness are co-occurring disorders
- Behavioral practitioners practice psycho-social treatments
- Tobacco interferes with psychiatric medications
- Consistent with wellness and recovery approaches
- Reimbursement for treatment is improving

Williams and Zeidonis, 2006

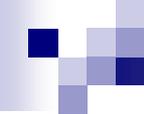


Tobacco Dependence and Mental Health Care

- Traditionally permissive attitude
 - Tobacco has traditionally been a reward in mental health settings
 - Management incentive on Inpatient units
- Nicotine Dependence: most common substance abuse disorder among individuals with schizophrenia

Improved Substance Abuse Recovery Rates

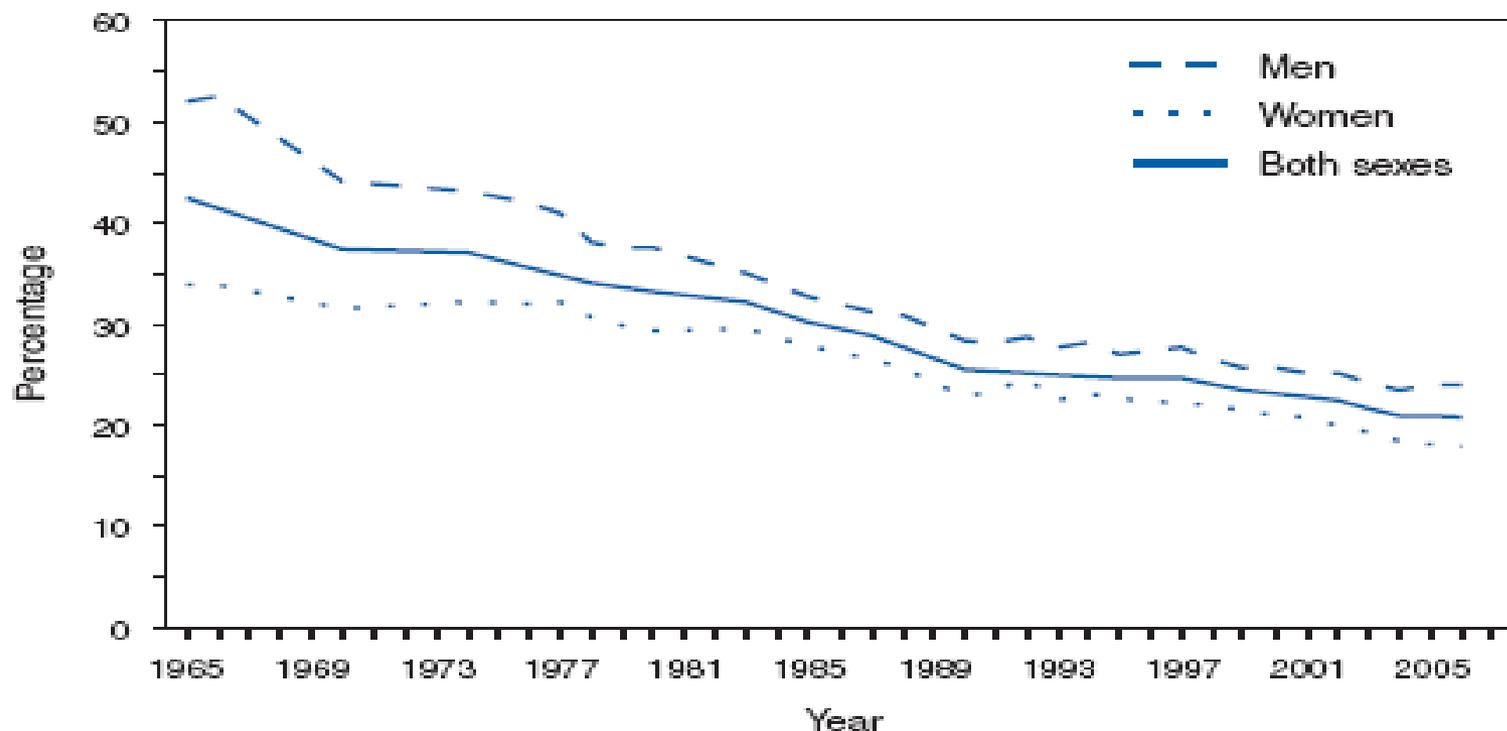
- Quitters 3 x as likely not to use cocaine as their peers who smoke. Frosch et al, 2000
- Alcoholics more likely to maintain long term abstinence. Bobo et al, 1987; 1989 Sees & Clark, 1993
- Alcoholics who quit were less likely to relapse to drinking MA Med Society, 1997
- Strong Associations between tobacco & opiate and cocaine use Frosch et al 2000



Who owns the problem?

- Mental health population represents a wide spectrum
- Smoking has a high prevalence across the continuum (Only 22% of smokers have not had a diagnosable mental illness)
- Common factor: high prevalence of desire to quit across the population
- However: not all segments of the mental health population are equally successful with traditional quit-smoking interventions

FIGURE. Estimated percentage of persons aged ≥ 18 years who were current smokers,* by sex — National Health Interview Survey, United States, 1965–2006



* During 1965–1991, current smokers were defined as persons who reported smoking at least 100 cigarettes during their lifetimes and who, at the time of interview, reported smoking (“Have you smoked at least 100 cigarettes in your entire life?” and “Do you smoke cigarettes now?”). In 1992, the definition changed to more accurately assess intermittent smoking (i.e., smoking on some days) and included persons who reported they smoked either every day or some days (“Do you now smoke cigarettes every day, some days, or not at all?”)

SMI-Reduced Life Expectancy

- 20% shorter life span
- Poor health care
- Increased coronary heart disease largely smoking related (remains when controlled for weight/bmi) *goff 2005*
- Increased mortality rates (above general population)
 - Cardiovascular disease 2.3 x
 - Respiratory disease 3.2 x
 - Cancer 3.0 x



Tobacco Control Techniques

- Current public health model for tobacco control
 - Focus on workplace outreach---misses many of SMI population
 - Very little to no preventative efforts
 - Allocation of resources: very little driven through Mental Health treatment venues

Schizophrenia and Smoking

- Very high prevalence: 80% (65-85)
- Smoke more
 - quantity of cigarettes
 - amount of draw per cigarette
- Smoking topography studies
- Half as successful in quit attempts
- Smoking produces therapeutic benefit
- Smoking ameliorates medication side effects

Tobacco (nicotine): psycho-active agent

- Effect of Nicotine on illness symptoms
- Effect of Nicotine on side effects of psychotropic medications
- Effect of Nicotine on social and psychological well-being
- Impact of tobacco smoking on P-450 system
- Impact of quitting smoking (and quit/relapse cycles) on other medications

Medication for Tobacco Dependence

- First-line Tobacco Dependence Medications (FDA Approved)
 - Nicotine Replacement
 - Gum, lozenge, inhalers, spray, patch,
 - Bupropion (Zyban; Welbutrin)
 - Varenicline (Chantix)

Jill Williams: Treating Tobacco Dependence in Mental Health Settings

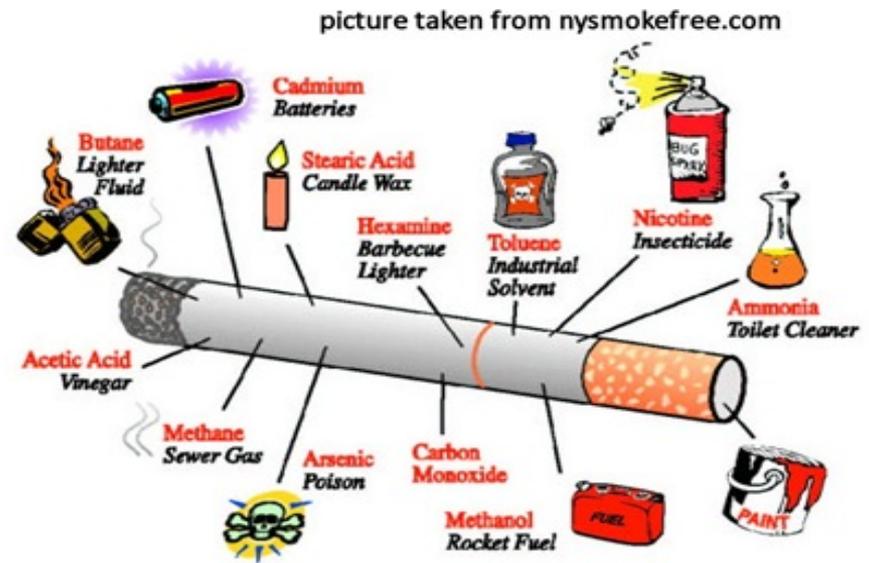
It's the Smoke that Kills

Cigarette smoke > 4000 compounds

Acetone, Cyanide, Carbon Monoxide, Formaldehyde

>60 Carcinogen

Benzene,
Nitrosamines

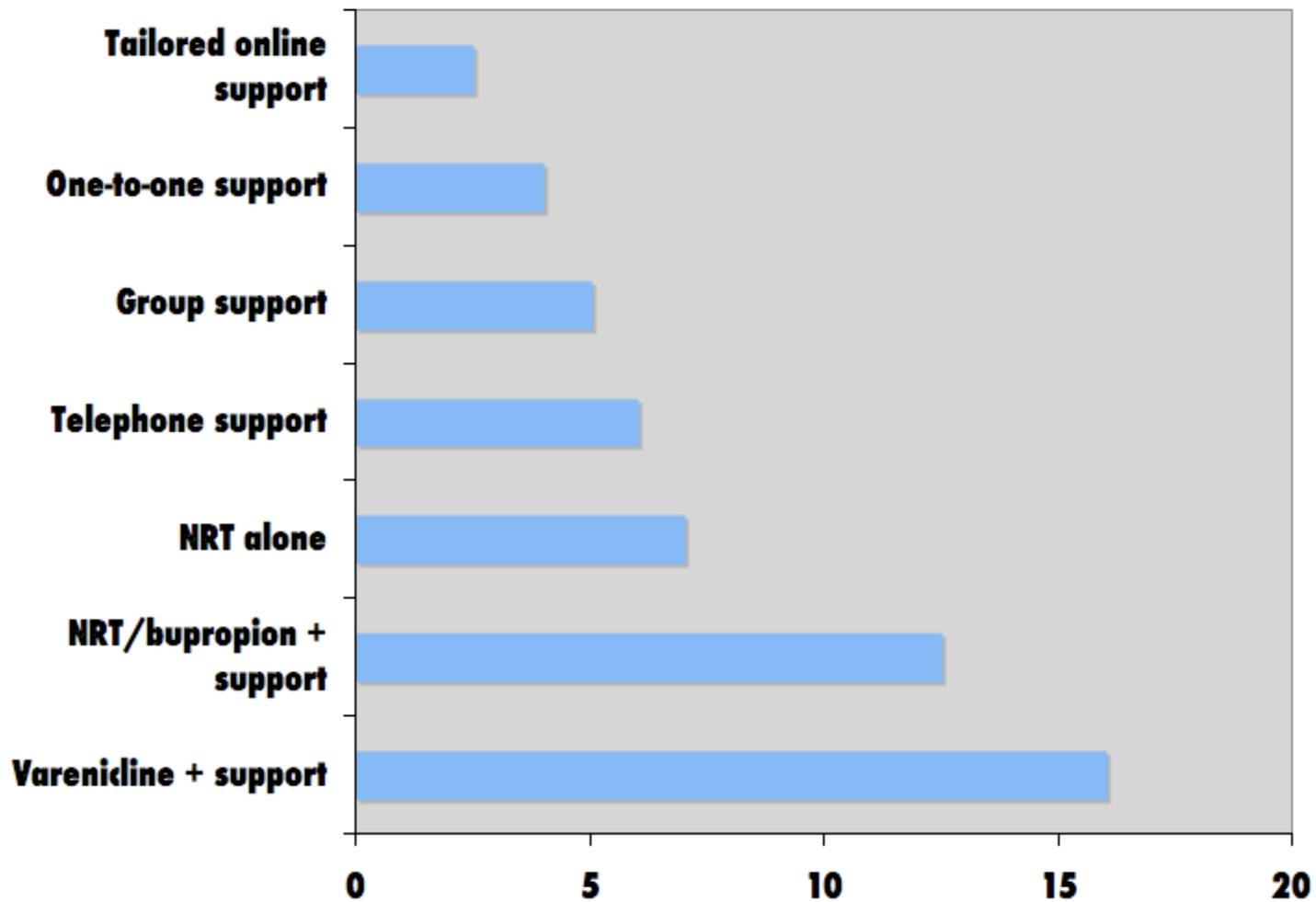


Myth Busting about Nicotine Replacement

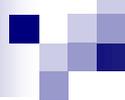
- Nicotine is not a carcinogen
- Patients tend to self dose
- Scheduled is better than PRN
- Period of treatment: may be crucial factor in SMI
- OK to combine with bupropion
- OK to combine with each other
- Very few contraindications
- Little to no drug-drug interactions

More myth busting regarding NRT

- Nicotine and patients with MI / Cardiac Disease
 - No reason not to use
 - Not introducing a “new drug”
 - Safer nicotine delivery vs smoking

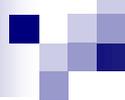


Westman/ Schiff, 2010 based on Cochrane Review Data



Principles of Co-occurring Disorders Treatment

- Integrated mental health and addiction services
- Comprehensive services
- Treatment matched to motivational level
- Long-term treatment perspective
- Continuous Assessment of substance use
- Motivational interventions
- Psychopharmacology
- Case management
- Housing



Principles of Co-occurring Disorders Treatment

- Dual diagnosis patients develop stable remission at a rate of about **10-15% achieving remission per year**
- Programs need to take a long term, outpatient perspective

Drake & Mueser, 2001; Drake 2000

The FIVE A's

- Ask
- Advise
- Assess
- Assist
- Arrange

Regardless of the client's stage of readiness for a cessation attempt, the 5 A's should be utilized at every visit.

*The U.S. Public Health Service Clinical Practice
Guideline: Treating Tobacco Use and Dependence 2008*



Counseling

- Motivational Interviewing/ Stages of Change
- CBT Approaches
- Individual/ Group/ Combination
- Integrated into treatment plan
- Consideration of needs specific to SMI:
 - Relapse
 - Medication impact of quitting and relapse
 - Impact of Weight Gain
 - Attention to depressive symptoms



Intensive Treatment for People with SMI

- **A general rule regarding smoking cessation efforts for SMI: more is better.**
 - **More intensive treatment frequency/ duration**
 - **More intensive pharmacotherapy**
 - **Increased dose**
 - **Increased combinations**
 - **Longer duration**
- **Involving more than one type of provider leads to greater success.**

SMI and Tobacco Dependence

- Tobacco Dependence Medications must be part of the psychopharmacologic treatment plan
 - Consideration of the need to deviate from “standard” treatment
 - How and why (logic of plan)
 - Thoughts about next steps
 - Cost benefit considerations
 - Important aspect of plan whether or not prescribing is done by the psychiatrist or by primary care
 - Difficult to quit patients need focused and aggressive treatment planning around smoking dependence treatment

SMI and Tobacco Dependence

- Assessment and counseling
 - Every patient who smokes/ every visit
 - Included in every treatment plan for smokers
 - Integrated into every format
 - Access to tools:
 - Five A's; Fagerstrom; toolkits, etc..
 - Planning for quitting is crucial for SMI
 - Meds
 - Relapse prevention
 - Weight gain



New York State Performance Partnership for Change

- Goal: Decrease number of SMI smokers in NY State by 10% in 3 years
- Disseminate training to all mental health providers
- Identify best practice early adopters for integrated services
- Create network of stakeholders
- Engage recipients and advocates



Conclusions

- It's the smoke that kills
- Mental health professionals MORE involved in tobacco treatment
- Treatments increase the success rates in making a quit attempt and should be used in all smokers
- Policies such as tobacco free psychiatric hospitals support treatment initiatives

Toolkits

- **OMH Wellness Initiative: LifeSPAN**
- http://www.omh.state.ny.us/omhweb/adults/wellness/lifespan/smoking_cessation/
- **UMDNJ Learning About Healthy Living Manual**
- <http://ubhc.umdj.edu/nav/LearningAboutHealthyLiving.pdf>
- **University of Colorado Smoking Cessation in People with mental Illnesses**
- <http://smokingcessationleadership.ucsf.edu/Downloads/catalogue/MHtoolkitJan2009.pdf>
- **APNA Tobacco Dependence Intervention Manual for Nurses**
- <http://www.apna.org/files/public/TobaccoDependenceManualforNurses.pdf>
- **NASMHPD Tobacco-Free Living in Psychiatric Settings**
- http://www.nasmhpd.org/general_files/publications/NASMHPD.toolkit.FINAL.pdf

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