Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
The views expressed in this training do not necessarily represent the views, policies, and positions of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA) or the U.S. Department of Health and Human Services (HHS).
Tobacco Use and Treatment for Smokers with Mental Health Diagnoses

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Anything can be dangerous, so what’s so special about cigarettes?
Comparative Causes of Annual Deaths in the U.S.
(In Thousands of Deaths)

Centers for Disease Control, Tobacco Information and Prevention Source (TIPS) 2000.
Comparative Causes of Annual Deaths in the U.S.
(In Thousands of Deaths)

- AIDS
- Alcohol
- Motor Vehicle
- Homicide
- Drug Induced
- Suicide
- Smoking

Centers for Disease Control, Tobacco Information and Prevention Source (TIPS) 2000.
Tobacco use kills more than the equivalent of three Boeing 747 Jumbo jet crashes / day.
Smokers with Mental Illness?
Adult Smoking
Focusing on People with Mental Illness

1 in 3
More than 1 in 3 adults (36%) with a mental illness smoke cigarettes, compared with about 1 in 5 adults (21%) with no mental illness.

3 in 10
About 3 of every 10 cigarettes (31%) smoked by adults are smoked by adults with mental illness.

1 in 5

Cigarette smoking is the leading preventable cause of disease, disability, and death in the US. Despite overall declines in smoking, more people with mental illness smoke than people without mental illness. Because many people with mental illness smoke, many of them will get sick and die early from smoking.

Recent research has shown that, like other smokers, adults with mental illness who smoke want to quit, can quit, and benefit from proven stop-smoking treatments. Some mental health providers and facilities have made progress in this area, while others are now beginning to address tobacco use. The 2006 Surgeon General’s...
Quit Ratio

34.7% 53.4%

Centers for Disease Control, MMWR, 2013

Any mental illness  No mental illness
Smoking prevalence in New Jersey for those reporting good mental health 2001 – 2010

Greater smoking prevalence was found in those with poor mental health as compared to those without poor mental health, after adjusting for age, sex, race, income, and education ($OR = 2.001$ [95% CI: 1.836 – 2.181], $p < 0.0001$).

Isn’t smoking the least of their problems?!!
Fewer than 15% of people with stage 3 lung cancer live 5 years.

Dr. Williams

This is from my doctors told me I have lung cancer so I don't know when I will see you next, but please don't give up on me, please give me refills on my nasal spray and gum as far as smoking I still smoke 3 or 4 cigarettes a day.

Sincerely
Negative Consequences (Physical Health)
People with SMI die several years earlier than the general population.¹

- Compared to non-smokers with schizophrenia, smokers with schizophrenia experience up to 12 times the risk of cardiac-related death.²

- Compared to those without SMI, cancer incidence is 2.6X higher in those with schizophrenia and bipolar disorder.³

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Negative Consequences (Medications)

- Increases metabolism of some medications
  - Induces the hepatic microsomal enzymes P450 system
    - Specifically the 1A2 isoenzyme is increased secondary to polynuclear aromatic hydrocarbons
  - Greater medication doses and side effects

- Nicotine (including NRT) does not change medication blood levels
Negative Consequences (Finances)

27% of public assistance income for cigarettes

Negative Consequences (Stigma)

- Tobacco use is stigmatized
- Poor mental health is stigmatized
Motivational Interviewing
N=32
Assessment
Intervention
Referral for Treatment
Psychoaeducation
N=34
Assessment
Intervention
Referral for Treatment
Minimal Control
N=12
Assessment
---
Referral for Treatment

One week and one month post-intervention follow-up by R.A. blind to treatment condition

78 Smokers with Schizophrenia / Schizoaffective Dx
At least 10 cigarettes per day
Not currently in tobacco dependence treatment

Figure 1. Percentage of participants receiving each intervention following up on referral to tobacco dependence treatment at one-week and one-month post-intervention.

An Adaptation of MI Increases Quit Attempts in Smokers With Serious Mental Illness

(follow-up study: similar design as previous)

- MI vs. Interactive Education (N = 98)
  - Enhanced educational control group
  - Dropped minimal control
  - Included Schizophrenia, Schizoaffective, Bipolar

- Carefully evaluated treatment integrity
- Evaluated treatment seeking and quit attempts

Funded by National Institute on Drug Abuse (K23DA018203)

Motivational Interviewing produced more quit attempts, but not greater formal treatment seeking.

Motivational Interviewing produced more quit attempts, but not greater formal treatment seeking.

Clinical Implications

- MI appears to be a better strategy than more commonly utilized techniques.
- Indicates this population can benefit from brief interventions.
- Should offer brief interventions to engage in treatment and initiate quit attempts.
What about those not interested in quitting?

- Discuss tobacco regularly with all smokers
- Motivational Interviewing
  - Increase desire to quit and self-efficacy
  - Build motivation for later
- Use *Learning About Healthy Living* manual
What you fail to say sends a powerful message too.
Only 5% of smokers making a 24-hour quit attempt receive any psychosocial treatment.

Behavioral health providers have the required skill set

- You already help your patients with:
  - Problem-solving
  - Coping with difficult situations / emotions
  - Social skills training
  - Making better choices
  - Avoiding high risk situations
## Combined approaches

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Risk Ratio</th>
<th>95% CI</th>
<th>Sample Size</th>
<th># of Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacotherapy + behavioral interventions vs. Usual care / self-help/brief advice&lt;sup&gt;8&lt;/sup&gt;</td>
<td>1.82</td>
<td>1.66 - 2.00</td>
<td>15,021</td>
<td>40</td>
</tr>
<tr>
<td>Increased behavioral support + pharmacotherapy vs. Less or no behavioral support + pharmacotherapy&lt;sup&gt;9&lt;/sup&gt;</td>
<td>1.16</td>
<td>1.09 - 1.24</td>
<td>15,506</td>
<td>38</td>
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</tbody>
</table>

Empirical Evidence:
Psychosocial approaches

## Psychosocial approaches

<table>
<thead>
<tr>
<th>Treatment Comparison</th>
<th>Risk Ratio</th>
<th>95% CI</th>
<th>Sample Size</th>
<th># of Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group therapy vs. self-help only</strong></td>
<td>1.98</td>
<td>1.60 - 2.46</td>
<td>4,375</td>
<td>13</td>
</tr>
<tr>
<td><strong>Individual Counseling vs. minimal contact control</strong></td>
<td>1.39</td>
<td>1.24 - 1.57</td>
<td>9,587</td>
<td>22</td>
</tr>
<tr>
<td><strong>Physician advice to quit vs. No advice / Usual care</strong></td>
<td>1.76</td>
<td>1.58 – 1.95</td>
<td>22,240</td>
<td>26</td>
</tr>
<tr>
<td><strong>Motivational Interviewing vs. Brief advice / Usual care</strong></td>
<td>1.27</td>
<td>1.14 - 1.42</td>
<td>10,538</td>
<td>14</td>
</tr>
<tr>
<td><strong>Proactive phone counseling (multi-session) vs. self-help or brief counseling</strong></td>
<td>1.37</td>
<td>1.16 – 1.50</td>
<td>24,904</td>
<td>9</td>
</tr>
</tbody>
</table>

Quitline

- Assessment
- Toll-free telephone counseling
- Scheduled calls from “Quit Coach”
- Good for transportation issues
- Empirically supported in general population
Quitline Concerns

- Phone minutes\(^1\)
- Privacy issues\(^1\)
- Uneasiness with receiving calls\(^1\)
- RCT indicated specialized quitline > traditional quitline for smokers with mental illness\(^2\)

1. Steinberg, Drummond, Williams, Cooperman. Quitline use for smokers with serious mental illness. Presented at National Conference on Tobacco or Health, Kansas City, MO, August 2012.
2. Rogers et al. Telephone Smoking-Cessation Counseling for Smokers in Mental Health Clinics: A Patient-Randomized Controlled Trial. (unpublished manuscript)
Empirical Evidence: Specific Psychosocial components

- Supportive Treatments
- Practical Counseling
Supportive Treatment

- Encourage
  - Demonstrate your belief your patient can quit
  - Note all the available options
  - Note that ½ of all smokers have been able to quit
  - Note that you’ve helped others quit

- Communicate caring / concern
  - “How do you feel about quitting?”
  - “I’m here to help you”
  - “I know this is tough”
Supportive Treatment (continued)

- Talk about the quitting process
  - Learn why patient wants to quit
  - Learn about previous successes
  - Learn about previous difficulties (just enough to avoid them this time)
Practical Counseling

- Provide basic information
  - Addiction, not just a “habit”
  - Withdrawal
  - Meds
- Recognize high-risk situations
  - The treatment program
  - Stress, other smokers, alcohol
  - Smoking paraphernalia, availability of cigarettes
Practical Counseling (continued)

- Develop coping skills
  - Anticipate and avoid temptations & triggers
  - Cognitive & behavioral strategies for:
    - Reducing stress/negative affect
    - Coping with smoking urges

- Choose a quit date and prepare
Prepare for Quit Date

- Education re: medications
- Clear out paraphernalia
- Clean the house / car / clothes
- Plan tobacco purchases carefully
- Tell everyone!
- Disassociate smoking from common activities
  - Coffee → cigarette
  - After meal → cigarette
  - Transportation → cigarette
Quit Date

- Set exact date
  - Possibly after reduction (i.e., flexible quit date)
- Multiple sessions before quit date
- Choose a weekday
- No tobacco use after midnight
- Celebrate quitting
- Check in – early abstinence is important
Unique Issues for People with Mental Illness

- Persistent psychiatric symptoms
- Poor social skills
- Cognitive limitations
- Difficulty forming a therapeutic alliance
Unique Issues for People with Mental Illness: Psychiatric Symptoms

- Assess psychiatric symptoms each session
- Assess concerns about smoking and their symptoms
- Address symptoms specific coping
- Collaborate with treatment team
Unique Issues for People with Mental Illness: Social Skills

- Drug refusal
- Problem solving
  - Reduce anger
  - Facilitate conversations
- Asking for social support
- Letting family / friends know they are quitting
  - Avoid “Happy Birthday! Here’s a carton of cigarettes”
Unique Issues for People with Mental Illness: Cognitive Limitations

- Take extra time when warranted
- Use repetition
- Assess understanding of topics
- Enhance self-efficacy
  - Cognitive limitations may inflate OR deflate self-efficacy
Unique Issues for People with Mental Illness: Therapeutic Alliance

- Show empathy – quitting is hard!
- Utilize underlying perspective of MI
  - Partnership
  - Acceptance
  - Evocation
  - Compassion
- Use engaging skills of MI
Conclusions

- Too few patients receive psychosocial treatments for tobacco
- Combinations of medications and psychosocial treatments will likely be most effective
- Behavioral health professionals have requisite skills!
Thank You!

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SAMHSA’s Program to Achieve Wellness
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