



Debunking Myths

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Today's Objectives

- ▶ Why Now?
- ▶ Why is This Population Vulnerable?
- ▶ Myths and Myth-breaking Evidence
- ▶ What is Your Role?
- ▶ Case Study: California Smokers' Helpline
- ▶ Treatment Considerations
- ▶ Provider Campaign



Why Now?

- ▶ 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



Why Now? (cont.)

- ▶ 100% of California state psychiatric facilities are smoke-free
 - Napa – 7/08
 - Coalinga – 8/08
 - Atascadero – 11/08
 - Patton – 4/09
 - Metro – 4/09
- ▶ Of the US state psychiatric facilities 41% do not permit smoking at their facility or grounds. Of the remaining 59%, half have plans to go tobacco-free.
 - Banning smoking reduced seclusion and restraint, decreased coercion and threats among patients and staff, and increased availability of tobacco cessation medication.



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



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



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
- ▶ Concerns about facilities going smokefree



Barriers to Tobacco Interventions: Clinician Factors

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

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)
- ▶ Survey of 685 smokers with bipolar disorder: 74% expressed a desire to quit (Prochaska et al., 2011)
- ▶ 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 Illness

New England Journal of Medicine (Prochaska, 2011):

- ▶ Stepped-care intervention tailored to depressed smokers' readiness to quit – 25% abstinent rate at 18-month follow-up.¹
- ▶ Cessation intervention integrated into treatment for PTSD doubled patients' odds of quitting smoking.²
- ▶ Meta-analysis of several randomized trials using bupropion for smokers with schizophrenia – 3-fold increase in abstinence rates 6 months after treatment.³

(1. Hall & Prochaska, 2009; 2. Mcfall, et al., 2010; 3. Tsoi, et al., 2010)

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



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?



Treating Tobacco Use & Dependence: Clinical Practice Guideline 2008

- ▶ 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
- Advice:** 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 Team Approach

- ▶ The Team
 - Primary care physician, pharmacist, dentist, behavioral health, quitlines, cessation programs, public health...
- ▶ Behavioral health providers are uniquely qualified
 - Behavior change
 - Addiction principles
 - Networks



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



Available Services

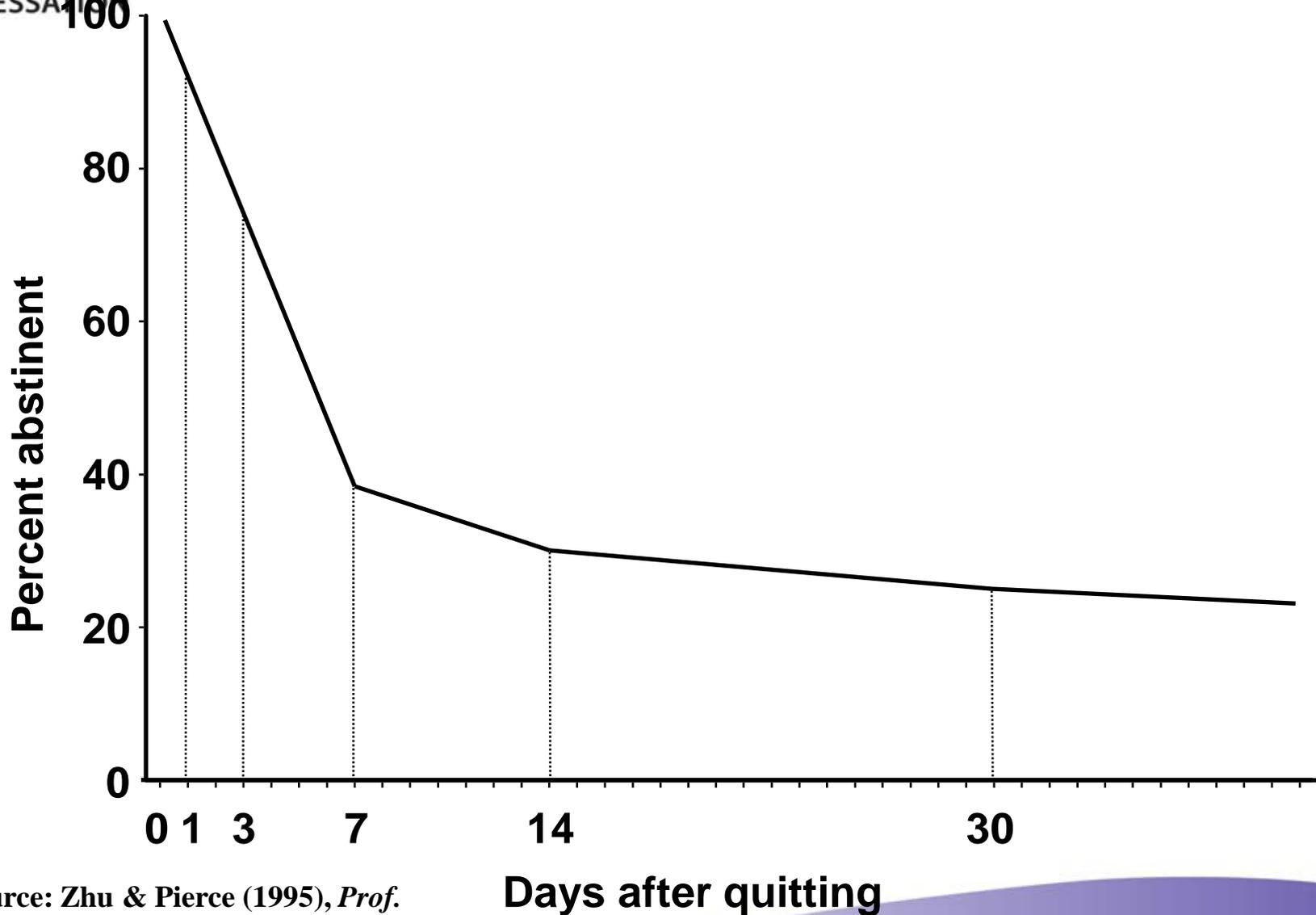
- ▶ Self-help materials
- ▶ Referral lists of local cessation programs
- ▶ Individual telephone counseling
 - ▶ Confidential
 - ▶ One pre-quit call, multiple proactive follow-up calls
 - ▶ Trained counseling staff



Types of Calls

- ▶ Intake session
 - 5-7 call to determine client needs
- ▶ Initial counseling session
 - Comprehensive, 25-30 min. call
 - Preparation to quit
 - Setting a quit date
- ▶ Proactive follow-up sessions
 - Up to five 10-15 min. calls
 - Relapse prevention
 - Pharmacotherapy review

Relapse-Sensitive Scheduling



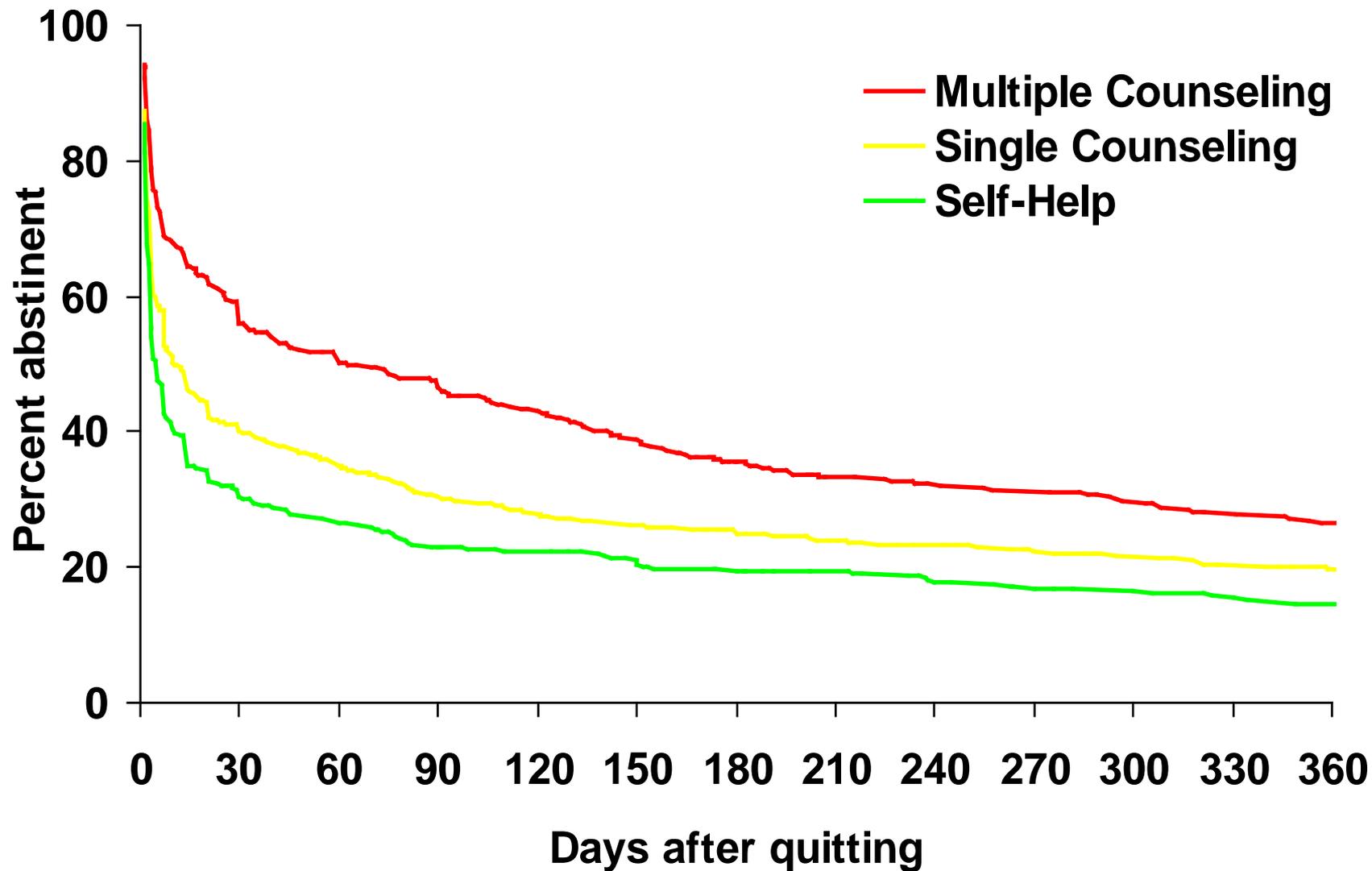
Source: Zhu & Pierce (1995), *Prof. Psych. Res. & Practice*, 26, 624-625



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



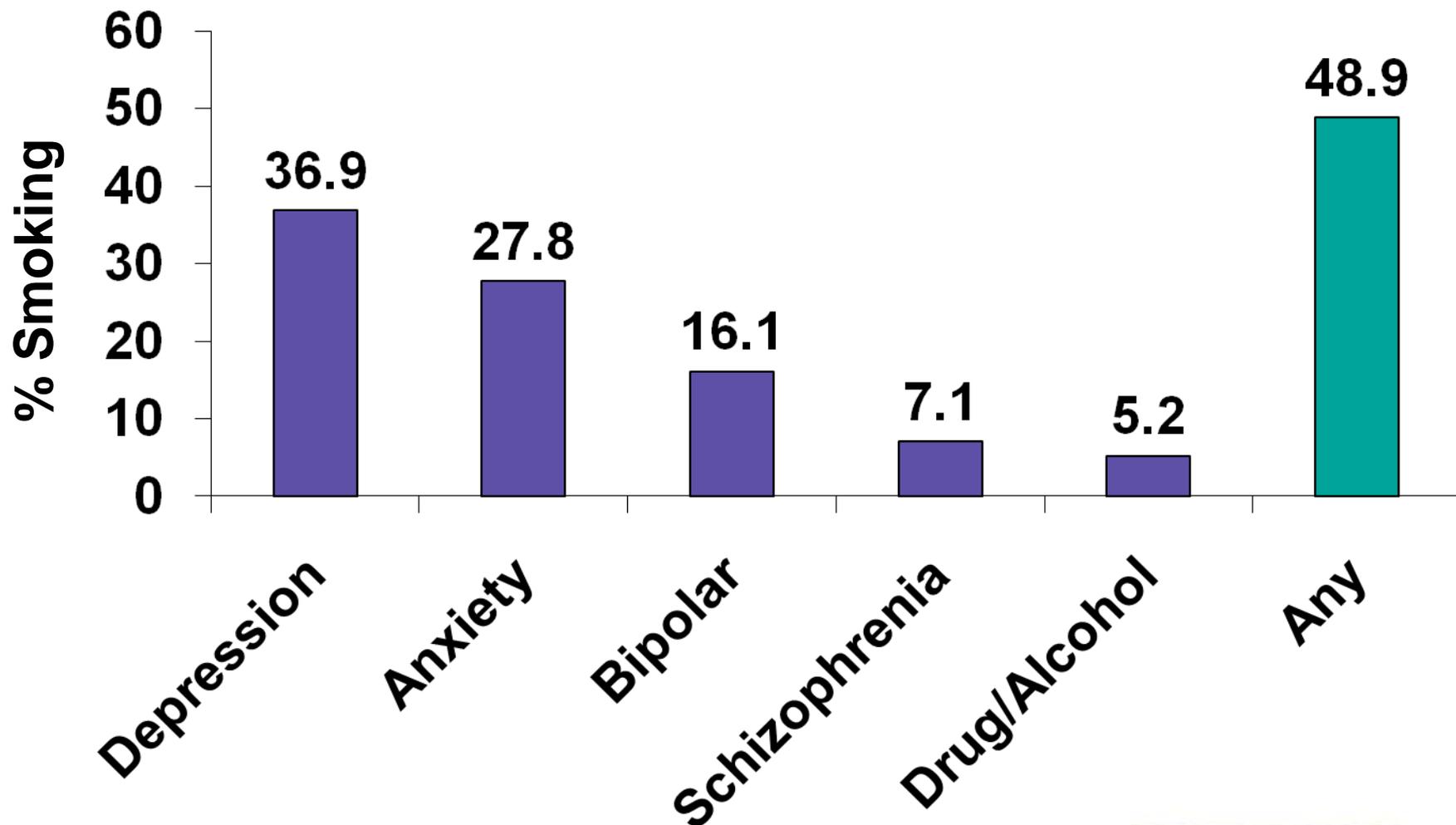


Helpline Callers with Behavioral Health Conditions

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





Received Counseling

No Mental Illness 74.0%

Mental Illness 84.0%

(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



Points 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



Treatment Considerations



Treatment: MI/SUD Fundamentals

- ▶ Demonstrated interest in quitting across populations
- ▶ Smoking cessation rarely jeopardizes stability of primary disorder or recovery
- ▶ Similar treatment/relapse prevention techniques

Determining Readiness to Proceed

- ▶ Motivation
 - “Interested” is sufficient
 - Not ruling out some type of intervention, even if motivation to quit now is low¹
- ▶ Stability
 - Need to be psychiatrically stable-do not need to be in full remission

¹ Steinberg, Ziedonis, et al., 2004)

Counseling Considerations

- ▶ Psychiatric stability
 - How are the client's symptoms?
 - Is the client in treatment?
 - How consistent is the client with treatment & how is it working?
- ▶ No major life changes
- ▶ No major medication changes
- ▶ No active intoxication/withdrawal from other substances



Counseling Considerations (cont.)

- ▶ Quitting history & symptoms
 - Past quit attempts are helpful indicators of what to expect.
 - What changes in symptoms were noticed?
- ▶ Biochemical factors
 - Nicotine acts much like a psychotropic medication on brain chemistry.
 - The blood levels of some the medications can increase dramatically when quitting.
 - Medications may need to be adjusted.



Counseling Considerations (cont.)

- ▶ Content, length, & number of calls
 - Based on level of functioning and professional support
- ▶ Counselor style (direction vs. facilitation)
 - Based on level of functioning



Counseling Considerations (cont.)

- ▶ Client contact with prescribing MD
 - Refer back to the primary physician
- ▶ Professional support & referral
 - May need to help clients identify support options

Pharmacotherapy



Pharmacotherapy Options

- ▶ Nicotine Replacement Therapy (NRT)
 - Nicotine Patch (OTC)
 - Nicotine Gum (OTC)
 - Nicotine Lozenge (OTC)
 - Nicotine Inhaler
 - Nicotine Spray

- ▶ Medication
 - Bupropion SR (Wellbutrin SR, Zyban)
 - Varenicline (Chantix)

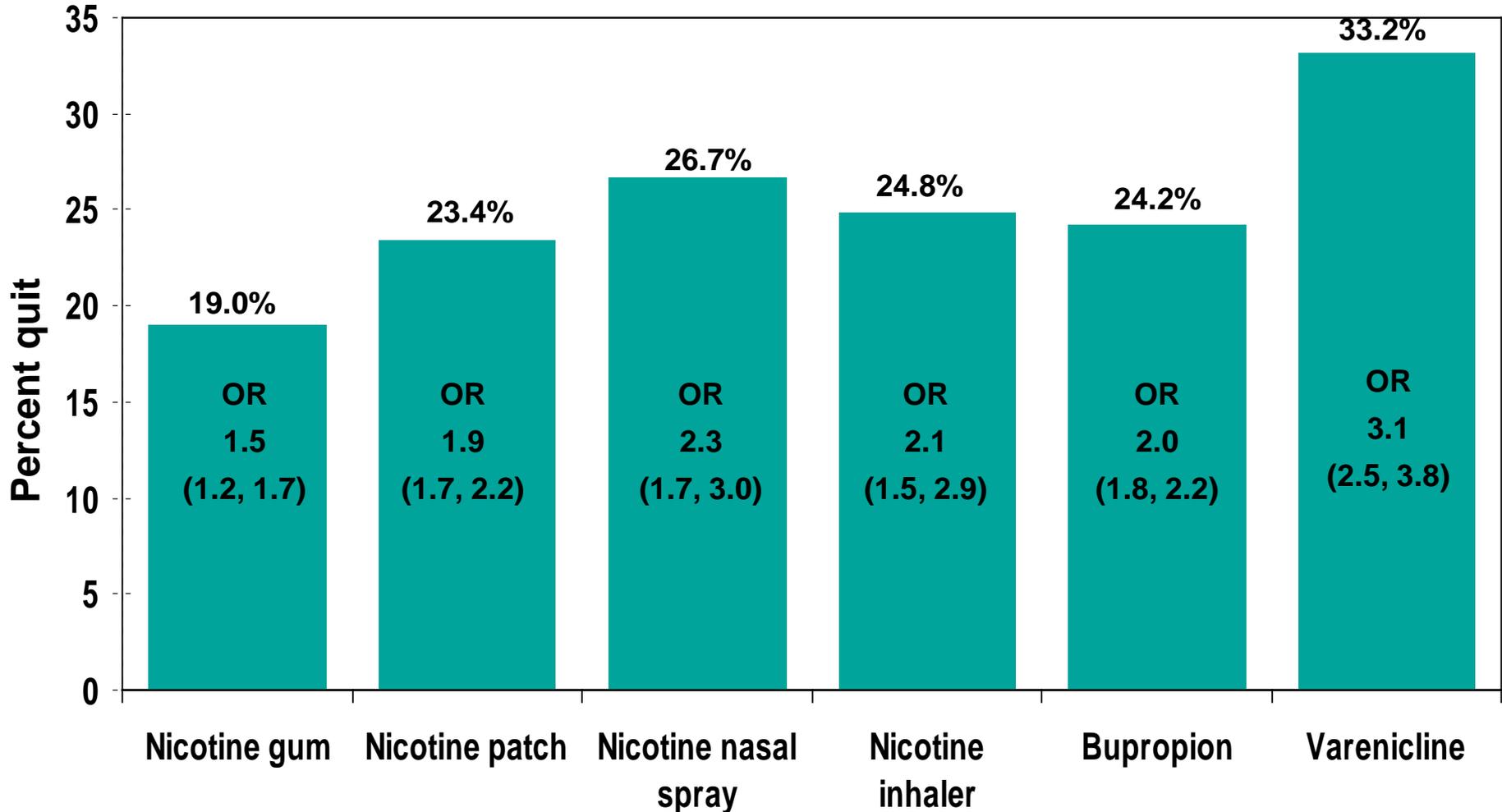


Boxed Warning for Chantix & Zyban

- ▶ July 1, 2009 – FDA announced it is requiring manufactures to use a Boxed Warning
- ▶ It highlights the risk of serious issues including:
 - Changes in behavior
 - Hostility & agitation
 - Depressed mood
 - Suicidal ideation, behavior, & attempts
- ▶ Summer, 2011 – Chantix associated with a small, increased risk of adverse cardiovascular events in patients with cardiovascular disease
- ▶ The FDA also stated - the risk of serious adverse medication events must be weighed against significant health benefits of quitting smoking



Six Month Point Prevalence Quit Rates for FDA-Approved Cessation Medications



Nicotine lozenge: (single study results) 2 mg = OR 2.0 (1.4, 2.8) 4 mg = OR 2.8 (1.9, 4.0)

*PHS Clinical Practice Guideline, May 2008.



Pharmacotherapy Guidance for Behavioral Health

- ▶ Smokers with behavioral health diagnoses who are trying to quit should receive pharmacotherapy (PHS Clinical Practice Guideline, 2008)
- ▶ Dose level and duration of drug treatment individualized.
- ▶ Many will need
 - Higher doses
 - Combination treatments
 - Longer duration of treatment

Bupropion SR

- ▶ Effective in smokers with Major Depression but relapse can be high when treatment discontinued
- ▶ Some evidence of effective in smokers with PTSD
- ▶ Effective in smokers with Schizophrenia

Bupropion SR (cont.)

- ▶ Contraindicated in seizure and eating disorders
- ▶ Not recommended:
 - Alcohol abuse/dependence
 - Bipolar disorder
 - Extended sleep deprivation
 - Past head trauma
- ▶ Interferes with efficacy of protease inhibitors used for HIV/AIDS treatment

Varenicline

- ▶ Anecdotal reports of effectiveness for MI/SUD
 - One study in UK - positive results
 - Individual case reports for smokers with schizophrenia & bipolar disorder – mixed results
 - Gap in the varenicline evidence base
 - Three randomized, controlled trials in smokers with schizophrenia or depression - in process
- ▶ Providers need to closely monitor mental status of anyone quitting smoking on varenicline

Pharmacotherapy Guidance

- ▶ Smoking induces CYP1A2 isoenzyme
- ▶ Approximately doubles clearance of
 - **Antipsychotics:** Prolixin (fluphenazine), Haldol (haloperidol), Zyprexa (olanzapine), Clozaril (clozapine), Thorazine (chlorpromazine)
 - **Antidepressants:** Elavil (amitriptyline), Aventyl (nortriptyline), Jaminine (imipramine), Anafranil (clomipramine), Sinequan (doxepin), Fluvox (fluvoxamine)
- ▶ Cessation may produce rapid, significant increase in blood levels
- ▶ Need to monitor for increased side effects



Clinical Monitoring Recommendations

- ▶ Patients should be seen 1-3 days after initiating smoking cessation
- ▶ Monitor weekly for the 1st 4 weeks for MI/SUD relapse and the need to adjust medication levels
- ▶ After 1st month, monthly review for 6 months
- ▶ Communication between the primary care provider and MI/SUD provider(s) should occur
 - During the initiation of the cessation attempt
 - During the cessation period if any psychiatric complications occur



Provider Campaign



Overview

- ▶ Provider in-person trainings and webinars
 - Working with SAY San Diego to help two local behavioral health outpatient units go tobacco-free
- ▶ CTCP behavioral health trainings
- ▶ Online, CME/CEU-approved training
- ▶ Digital and print ad campaign for behavioral health providers



Ad Campaign Summary

- ▶ **Objectives** - Designed to increase awareness of tobacco cessation considerations for patients with mental illness and substance use disorders:
 - The prevalence of tobacco use;
 - The negative health impacts of tobacco use;
 - The desire and ability to successfully quit smoking; and
 - The positive impact of quitting tobacco use on recovery efforts.



Ad Campaign Summary

▶ Target Audiences

- Drug and alcohol counselors
- Psychiatric nurses
- Licensed clinical social workers
- Marriage and family therapists
- Licensed clinical psychologists
- Physicians
 - Family practice
 - Internal medicine
 - Psychiatry

▶ Core Message

- "People with mental illness/substance use disorders want to quit smoking, can quit successfully, and you can help them quit."

Many
addictions
shatter lives.
This one is
more likely
to end them.



More than half of patients in drug and alcohol treatment will die from tobacco-related disease. Smokers want to quit more than you may think. And they can. Talk to them about it. For more help, refer them to 1-800-NO-BUTTS. And visit nobutts.org/mhd for free training, resources, and patient materials.



California
Smokers'
Helpline
1-800-NO-BUTTS

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You know
he smokes.
What you
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how badly
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People with serious
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25 years earlier, often
from tobacco-related
disease. Their desire
to quit is stronger than
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1-800-NO-BUTTS. And
visit info.nobutts.org/wh1
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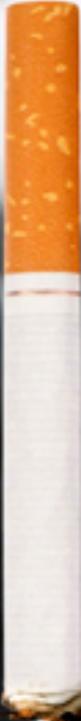


California
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1-800-NO-BUTTS

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California
Smokers'
Helpline
1-800-NO-BUTTS

Ad Campaign Vehicles

▶ Print Publications

- The California Psychologist
- Addiction Professional

▶ Digital Publications

- American Psychological Association Website
- Addiction Professional e-Blasts
- Advance for Nurses e-Blasts
- National Association of Social Workers e-Newsletter
- Nurse.com e-Blast
- MedScape Website
- Wiley Online Library Websites

▶ Direct Mail

- National Association of Social Workers member list
- American Association of Marriage and Family Therapists member list

▶ Added Value

- Addiction Professional – bonus e-blast
- Advance for Nurses – one news article and one tile ad for website
- California Psychologist – one news article and one tile ad for website
- NASW – two news articles for website
- Nurse.com—1,000 additional e-mail list subscribers per e-blast send

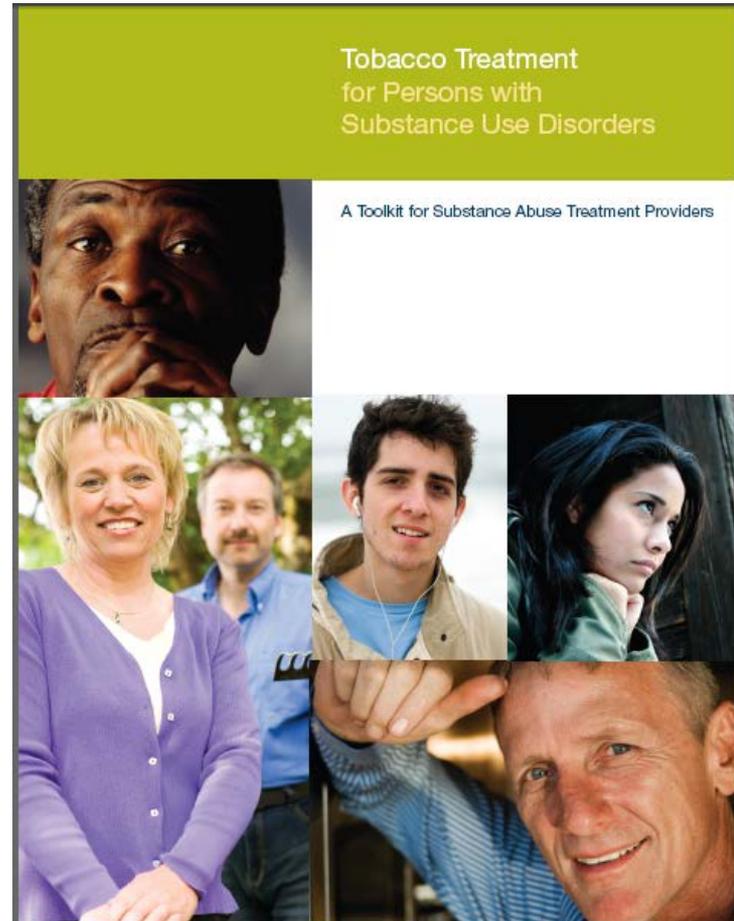
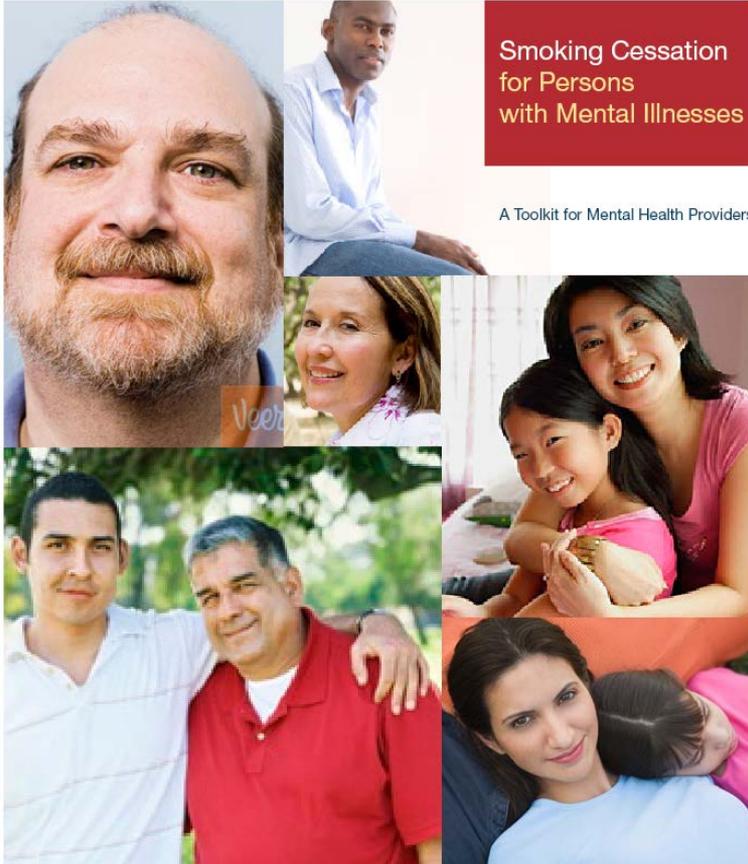


Ad Campaign Additional Offers

- ▶ Smoking Cessation Kit for Health Professionals
- ▶ Webinars
- ▶ Online CME Self-Study Course
- ▶ Plan to make ads widely available next year through the CDC Media Campaign Resource Center

Resources

Smoking Cessation for Persons with Mental Illnesses
A Toolkit for Mental Health Providers



<http://www.bhwellness.org>



Thank you!

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