



Smoking Cessation for Persons with Mental Illnesses

In-Service Training on Smoking Cessation for People with Mental and Substance Use Disorders

Substance Abuse & Mental Health Services Administration

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University of Colorado
SCHOOL OF MEDICINE
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Colorado Department
of Public Health
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Objectives

- **The culture of the mental health community-**
 - **Barriers & Vulnerabilities**
- **The evidence base**
- **Tools for change**

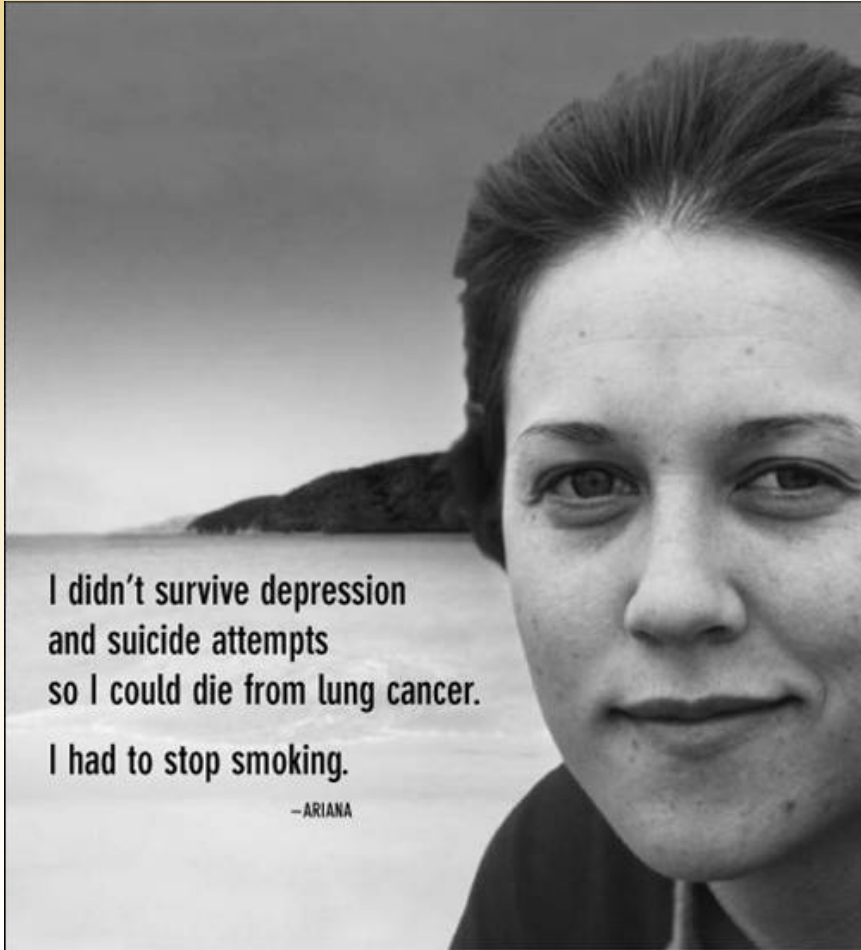
Some Guiding Principles

“... **Recovery** involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).”

The Olmstead Decision- supporting a meaningful life in the most integrated setting possible

A Wellness Philosophy

To assist consumers to lead meaningful lives in their communities, we need to promote behaviors that lead to health




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

—ARIANA

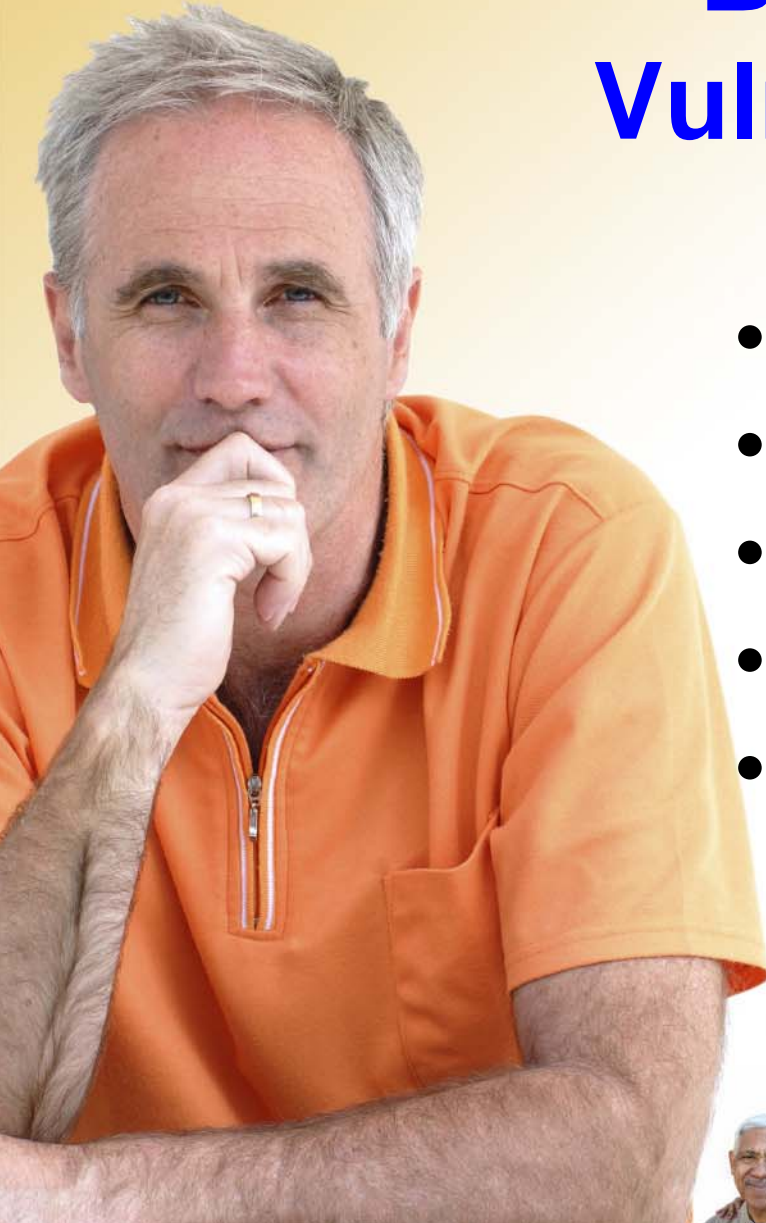
CIGARETTES ARE MY GREATEST ENEMY
TOBACCO CAUSES MORE DEATHS THAN AIDS, DRUGS, BREAST CANCER AND GAY BASHING COMBINED

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Barriers & Vulnerabilities

- Biological predispositions
- Systemic hurdles
- Stigma and provider beliefs
- Psychological and social factors
- Tobacco industry targeting



Biological Predisposition

- Persons with mental illnesses have unique neurobiological features that:
 - may 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

Smoking among Youth

- As many as 80% of tobacco users start smoking before they are age 18
- Adolescents who become regular smokers are more likely to report heightened levels of stress, depression, and anxiety

(Brown et al., 1996; Chassin et al., 1984; Escobedo et al., 1998; Koval et al., 2000; Patton et al., 1996; Pederson et al., 2000; Sonntag et al., 2000; Stein et al., 1996).

Barriers to Tobacco Interventions

Systems Factors

- Societal stigma
- Competing demands
- Tobacco as socialization activity, behavioral reward
- Staff acceptance, promotion
- Disruption of treatment milieu
- Financial revenues
- Reimbursement for services

Barriers to Tobacco Interventions

Clinician Factors

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

Barriers to Tobacco Interventions

Patient / Consumer Factors

- Expectation of failure
- Self-stigma
- Lack of recovery
- Fear of weight gain
- Fear of withdrawal symptoms
- Boredom
- Knowledge
- Coping with tension and anxiety
- Daily routines
- Smoking as social activity



“I’ve been schizophrenic since I was 14. I was told more or less when I went to the hospitals that cigarettes help control certain areas in my brain and the way we function out in society. I became more of a smoker because I was told it would help me with my illness. I was taught more about it helping my illness than I was about cancer and stuff like that.”

- Consumer focus group participant

Tobacco Industry Targeting

- Study analyzed previously secret tobacco industry documents (280 records).
- 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.

Prochaska JJ, Hall SM, Bero LA., 2007



What is the Evidence that Anything Works?



Myth: Persons with mental illnesses and substance abuse disorders are more addicted to nicotine and therefore are unable to quit smoking

Fact: These persons can successfully quit using tobacco



Myth: Persons with mental illnesses and substance abuse disorders enjoy smoking and don't want to quit

Fact: These persons want to quit smoking and want information on cessation services and resources

Smoking Cessation Results for 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)

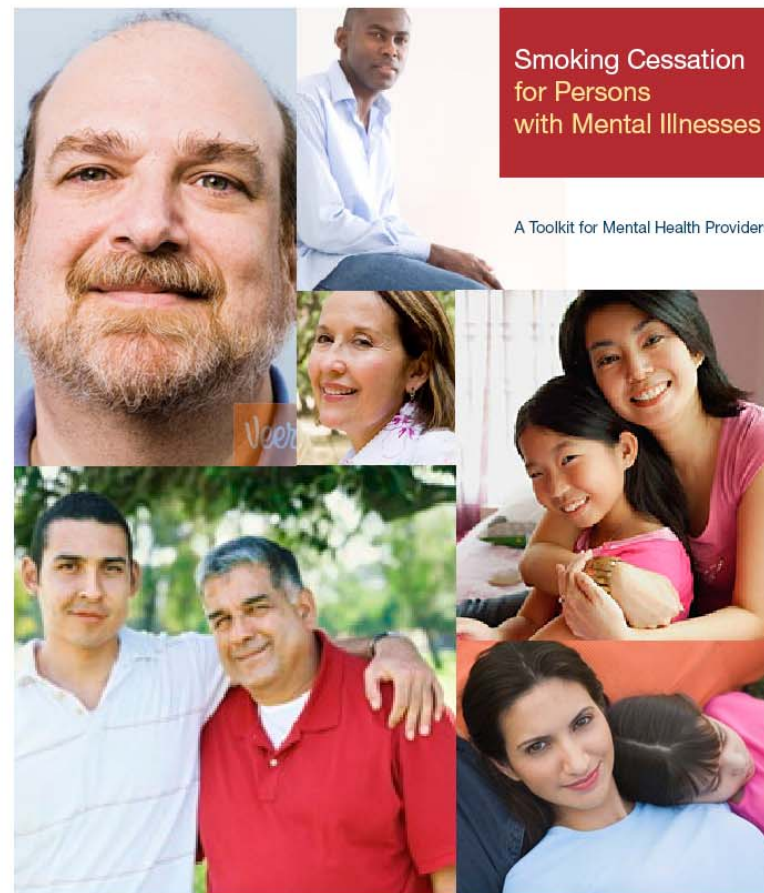
Tools for Change

- Cognitive-Behavioral Therapy (CBT) + nicotine replacement therapy (NRT) or other medications
- Individual counseling- >4 sessions
- Groups meeting 7-10 weeks
- Individualized treatments based on diagnoses
- Stress patient / client preference
- Peer-to-peer support
- Address psychosocial needs that might undermine tobacco cessation
- Monitor for side effects, weight gain & depression





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



PDF available at:
http://smokingcessationleadership.ucsf.edu/Downloads/MH/Toolkit/Quit_MHToolkit.pdf

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Consumer Brochures

Don't believe the myths
The truth about tobacco is scary enough

Top 5 myths about smoking

The Myth: To quit smoking, all you need is will power.
The Truth: Most smokers need help. Only three percent of people who try to quit "cold turkey" succeed. To quit, most smokers need help through counseling or nicotine replacement therapy or both.

The Myth: People with mental illnesses are more addicted to nicotine and are unable to quit smoking.
The Truth: People with mental illnesses can successfully quit using tobacco. Research studies show that nicotine replacement therapy and psychotherapies are effective in helping people with mental illness quit.

The Myth: "Light" or "low tar" cigarettes are safer than regular cigarettes.
The Truth: There's no such thing as safe smoking. "Light" and "low tar" cigarettes have the same cancer-causing agents as regular ones. Plus, studies have shown that people smoking "light" cigarettes smoke more often and inhale more deeply to get the same amount of nicotine.

The Myth: "Natural" tobacco such as American Spirit and clove cigarettes are a healthier choice than regular cigarettes.
The Truth: Smoking "natural" tobacco and clove cigarettes will increase your risk of cancer, heart disease and emphysema. There is no healthy smoking option. Natural or organic tobacco and clove cigarettes are just as unhealthy as regular cigarettes.

The Myth: Persons with mental illnesses should smoke because it helps reduce symptoms.
The Truth: There are effective ways to reduce symptoms that do not hurt your health like smoking does.



These materials are funded with proceeds from Colorado's tobacco tax.

You CAN quit tobacco
Tips for Preparing to Quit



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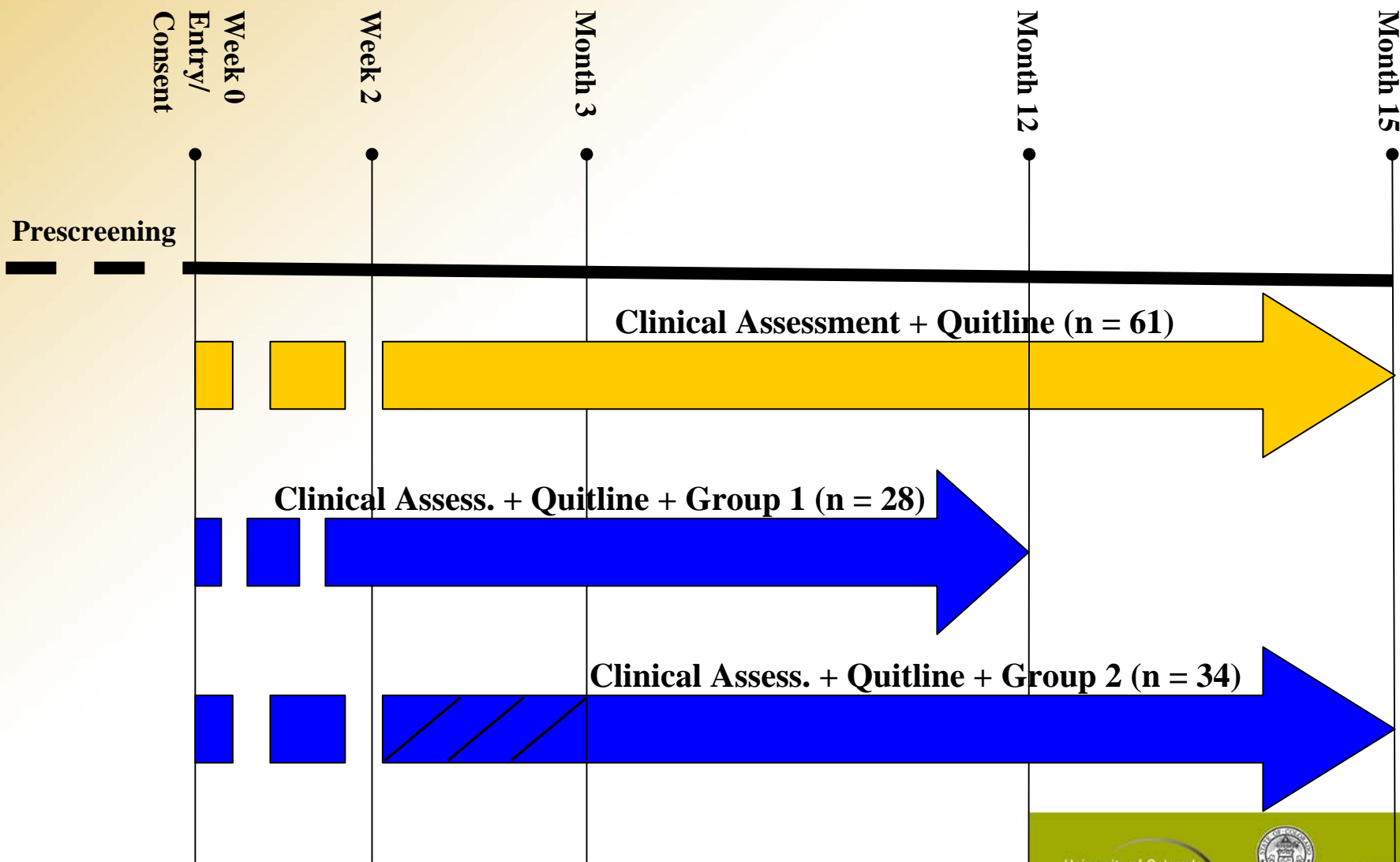
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Randomized Cessation Pilot Study Objectives

- *Aim 1:* Implement and test evidence based tobacco cessation strategies at community mental health centers and clinics.
- *Aim 2:* To establish a robust and sustainable infrastructure for tobacco cessation for persons with mental illnesses

The Study Intervention (N = 123)



Wellness Group

- Based on the SANE model
- Based on Motivational Interviewing and Cognitive Behavioral Techniques
- 10 sessions / group format
- Structured framework with homework activities

Wellness Group Sessions

- Session 1** Introduction to the program
- Session 2** Working with the positives (strengths)
- Session 3** How smoking affects your body
- Session 4** Building self-confidence
- Session 5** Dealing with stress and helping relationships
- Session 6** Healthy ways of dealing with feeling down
- Session 7** Dealing with strong negative feelings
- Session 8** Healthy Lifestyle (Diet and exercise)
- Session 9** Planning for high-risk situations
- Session 10** Celebrating the road to recovery

Baseline Characteristics

Demographic Characteristic	Group 1 N=61	Group 2 N=33	Group 3 N=29
Primary Psychiatric Diagnosis			
Schizophrenia	23.0%	30.3%	31.0%
Schizoaffective	None		
Other Psychotic Disorder	none		
Bipolar	36.1%	18.2%	37.9%
Depression	21.3%	15.2%	17.2%
Anxiety	Included in other		
Other	36.1%	42.4%	24.1%

6- Month Results Summary

- **Reduction often happens before cessation:** We had a significant decrease in self-reported average number of cigarettes per day across all groups.
- **Measured tobacco dependence is decreasing over time**
- **Cessation appears to increase over time:** Conservative Intent-to-treat cessation is 7%-13%, and is trending up.
- **Fears of increased symptoms are not being realized:** Scores on depression and psychosis measures showed a significant decrease in depressive and psychotic symptoms over time.
- **12-month analyses needed:** It is unclear if the wellness group augmentation of quitline counseling and NRT leads to better outcomes

Concluding Thoughts

- **Include a wellness philosophy in “transformation” activities**
- **Possibly a new Generation of SAMHSA/CMHS Evidence-Based Practice Toolkit?**
- **Block grant incentive and/or recommendations**
- **Stress that services for integrated care and co-occurring disorders includes tobacco (e.g., TIP 42)**
- **Partner on reimbursement models**
- **Support centers of excellence, training, and pilot programs**
- **Facilitate peer-to-peer interventions**

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