

# **The Unmet Needs of Smokers with Mental Illness or Addiction**

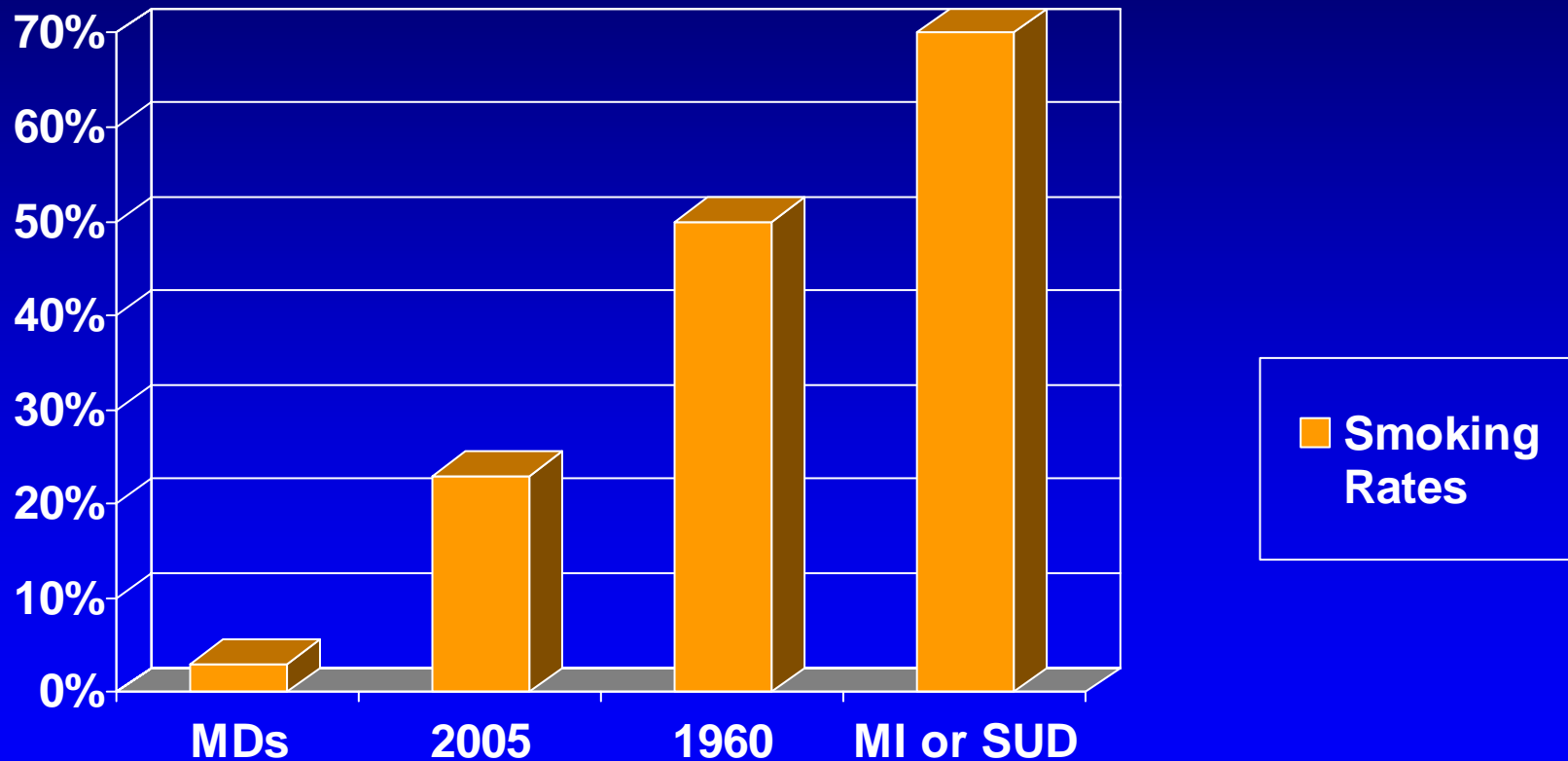
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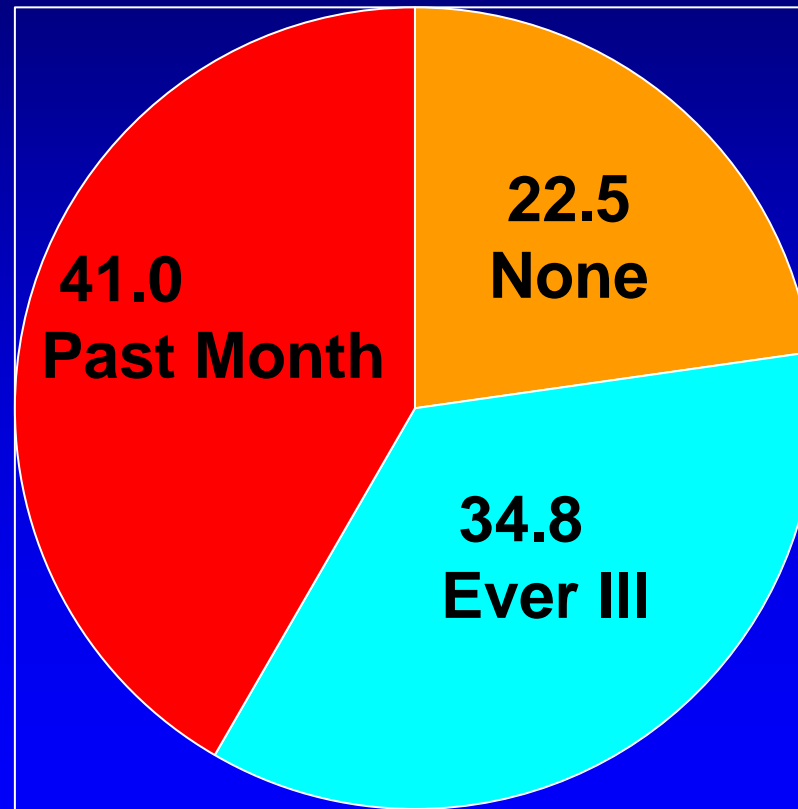
UMDNJ-Robert Wood Johnson Medical School

UMDNJ-School of Public Health

# Smoking Prevalence Rates



# Current Smokers by Mental Illness History



*Lasser et al, JAMA, 2000*

# Increased Smoking

	EVER/DAILY	HEAVY (>25)
Maj Depression	X	
Bipolar Disorder	X	X
Schizophrenia	X	X
Panic/agoraphobia	X	X
Alcohol Depend	X	X
Drug Depend	X	X
PTSD	X	X

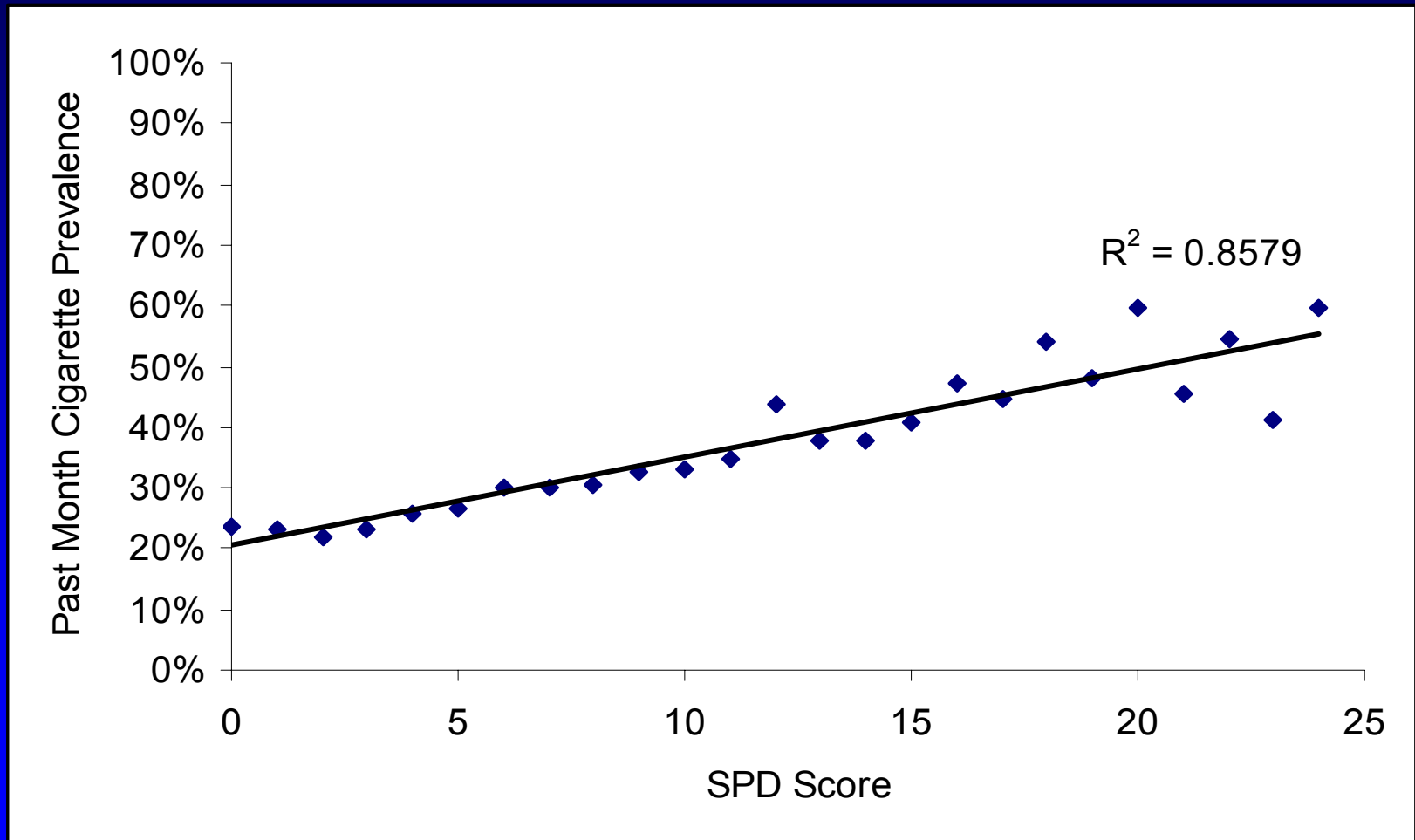
# SPD (K6) and Smoking

	<b>Yes</b>	<b>No</b>
	<b>Weighted %</b>	
<b>Daily Smoking</b>	<b>30.2</b>	16.7
<b>Lifetime</b>	<b>71.3</b>	59.9

Data from 2002 NSDUH

Hagman et al., 2007; Williams et al, in press

# Past month cigarette use by SPD severity



# Percent/Adjusted Odds Ratio for Past Month Cigarette Smoking, 2002 NSDUH

	%	AOR	(95% CI)
• SMI			
– YES	26.0	<b>1.82</b>	(1.61-2.06)
– NO	44.9	1.0	referent
• Alcohol/ Drug Use Disorder			
– YES	57.9	<b>3.09</b>	(2.78-3.45)
– NO	24.4	1.0	referent

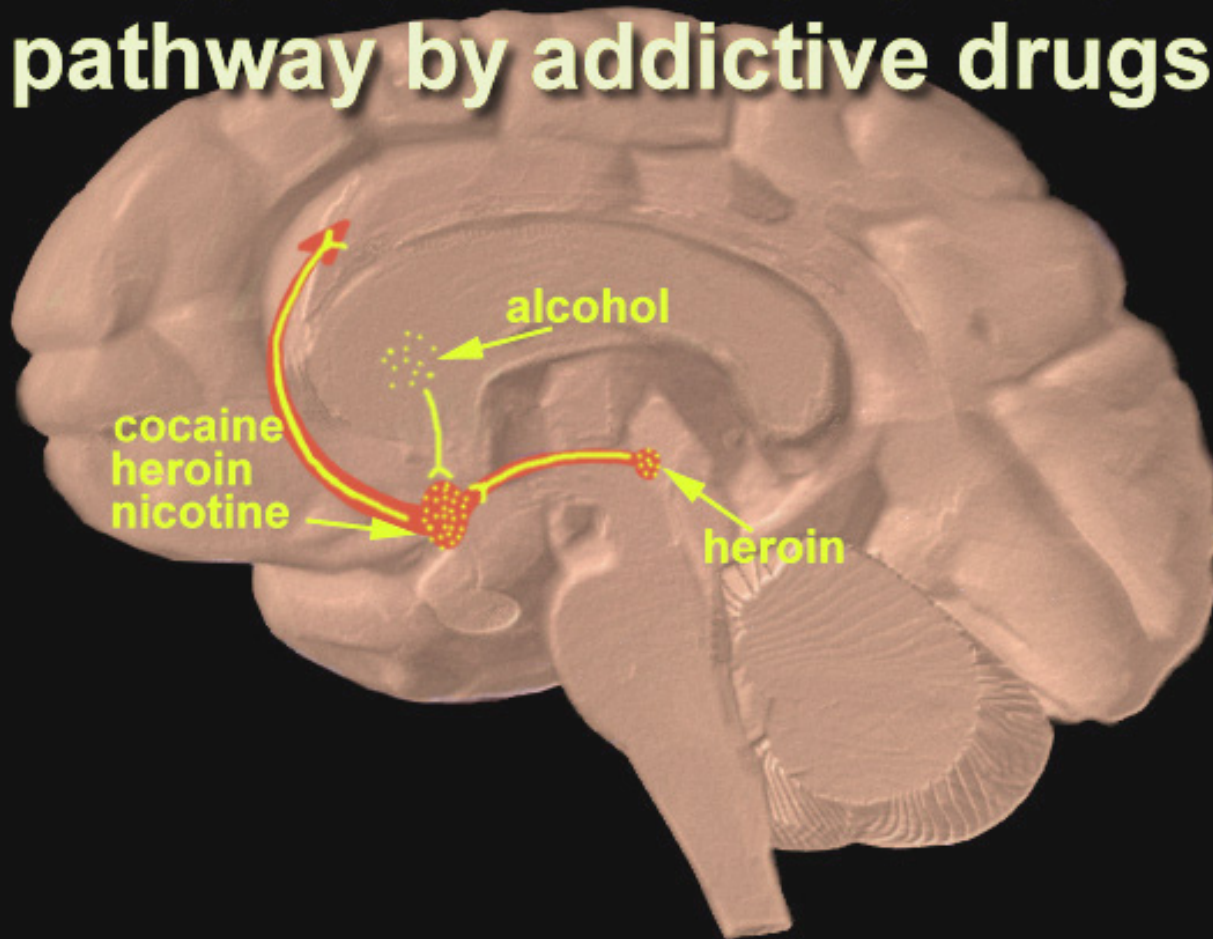
*Controlled for age, gender, race, education*

# Rationale Not to Treat Tobacco Dependence in SUD Patients

- Not a real drug
- Fewer consequences / Not as disruptive to patients' life
- Disruptive to SUD treatment
- Patients don't want tobacco treatment
- Patients can't quit smoking successfully
- Jeopardizes recovery from other substances

# Not a Real Drug

## Activation of the reward pathway by addictive drugs



# Fewer Consequences; Not Immediate

- More alcoholics die from smoking related diseases than from alcohol related diseases
- Synergistic effects of alcohol and tobacco  
↑ risk of developing pancreatitis and oral cancers
- Smoking reduces recovery from cognitive deficits during alcohol abstinence

Hurt et al, 1996; USDHHS 1982 Durazzo et al, 2007

# Disruptive to SUD Treatment

- No increase in irregular discharges when residential SUD settings when TF(NJ)
- ↑ Clients enrolled in treatment when facility went TF (Kotz et al, 1993)
- Longer LOS when patients enrolled in smoking cessation program (Burling et al., 1991).
- No increase in early discharges (Joseph, 1993).

# Patients Resistant to Tobacco Treatment

- Two-thirds of smokers wanted to stop (41%) or cut down on tobacco use (24%) at time of admission to residential addictions treatment  
Williams et al, 2005
- Patients highly interested in treatment and believe inpatient treatment is best time
  - Orleans & Hutchinson, 1993; Shoptaw et al., 2002; Richter et al, 2001; Nahvi, et al, 2006; Sees & Clark, 1993; Clemmey et al, 1997; Frosch et al, 1998; Clarke et al 2001; Joseph et al., 1990; Saxon et al., 1997; Joseph et al., 2002

# Patients with SUD Can't Quit Smoking

- Past h/o EtOH dependence no increased difficulty quitting (> 1 year sobriety) on a given attempt
- Usual treatments effective
- Smokers learned skills in recovering from alcohol that helped them quit smoking

# Lifetime Quitting

- Smokers with current alcohol problems, were less likely to have quit in their lifetime than smokers with no problems
- ? Fewer quit attempts

Hughes & Kalman, 2006

# Jeopardizes Recovery from other Substances

- Several studies show no adverse effects on abstinence

Bobo et al. 1996, 1998; Hurt et al., 1994; Cornelius et al. 1997, 1999; Prochaska et al. 2004; Lemon et al, 2003; McCarthy et al, 2002; Shoptaw et al., 2002

- Quitting smoking may help with long-term abstinence from alcohol and other drugs

# Concurrent vs Delayed Tobacco Treatment

- N= 1943 with AD or AA
- Concurrent or Delayed (6M) Tob Tx
- Concurrent more likely to participate
- Same success in cessation
- Worse alcohol outcomes in concurrent (30d, 6, 12, 18M)

TABLE 3. Alcohol treatment outcomes

	Intention to treat			Respondents		
	Concurrent ( <i>n</i> = 251)	Delayed ( <i>n</i> = 248)	<i>p</i> value	Concurrent	Delayed	<i>p</i> value
30-day alcohol abstinence						
6 months	51%	64%	.004	( <i>n</i> = 193) 67%	( <i>n</i> = 215) 74%	.12
12 months	46%	53%	.11	( <i>n</i> = 183) 63%	( <i>n</i> = 177) 75%	.02
18 months	48%	60%	.01	( <i>n</i> = 195) 62%	( <i>n</i> = 205) 72%	.03
6-month alcohol abstinence						
6 months	41%	56%	.001	( <i>n</i> = 193) 54%	( <i>n</i> = 215) 65%	.03
12 months	33%	42%	.06	( <i>n</i> = 183) 46%	( <i>n</i> = 177) 58%	.02
18 months	41%	48%	.14	( <i>n</i> = 195) 53%	( <i>n</i> = 205) 58%	.34

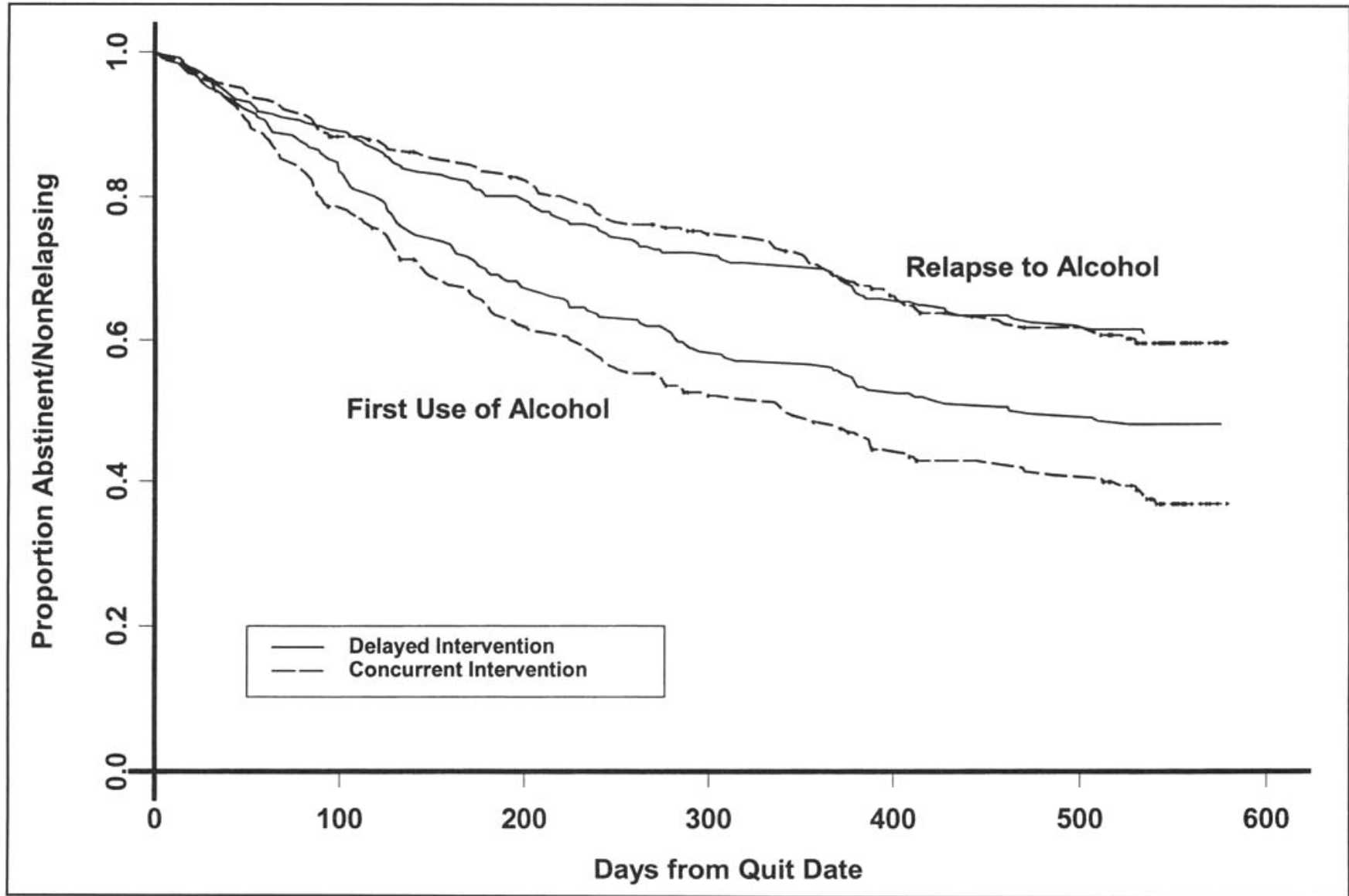


FIGURE 3. Time to relapse/time to first use

Time to first alcohol use shorter in concurrent group  
( $p=0.025$ )

# Tobacco Treatment Availability

- National survey of 550 OSAT units (2004–2005)
  - 88% response rate
- 41% offer smoking cessation counseling or pharmacotherapy
- 38% offer individual/group counseling
- 17% provide quit-smoking medication
- More likely : medically oriented, more comprehensive services, recognize the health burden of smoking

# Using the Co-Occurring Model for Treating Tobacco

- Continuous Assessment of Substance Use
- Motivational Interventions
- Integrated Treatment in Setting
- Psychopharmacology
- ? Housing (TF treatment setting)
- ? Case Management (Contribution by every provider)

# Principles of Co-occurring Disorders Treatment

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



- Consumers Helping Others Improve their Condition by Ending Smoking
- Positive Message: MH Consumers do have CHOICES

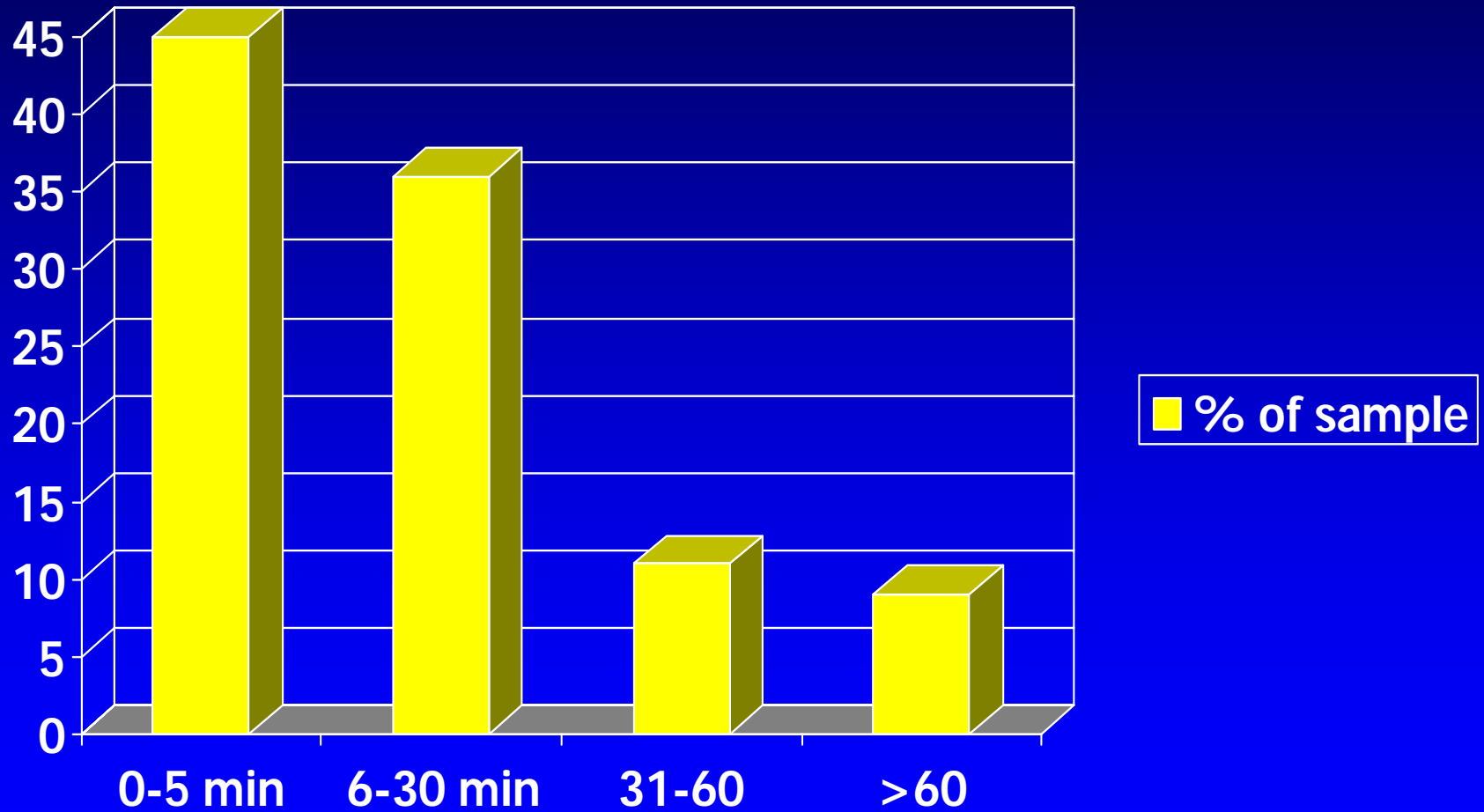
# Research Study

- RWJMS IRB approved
- Subset of smokers who receive feedback intervention (n=100)
- Incentive- phone card
- Baseline in-person survey
- 1 and 6 month follow-up phone survey
- Tobacco use; Changes in smoking, use of treatment
- Satisfaction with peer contact

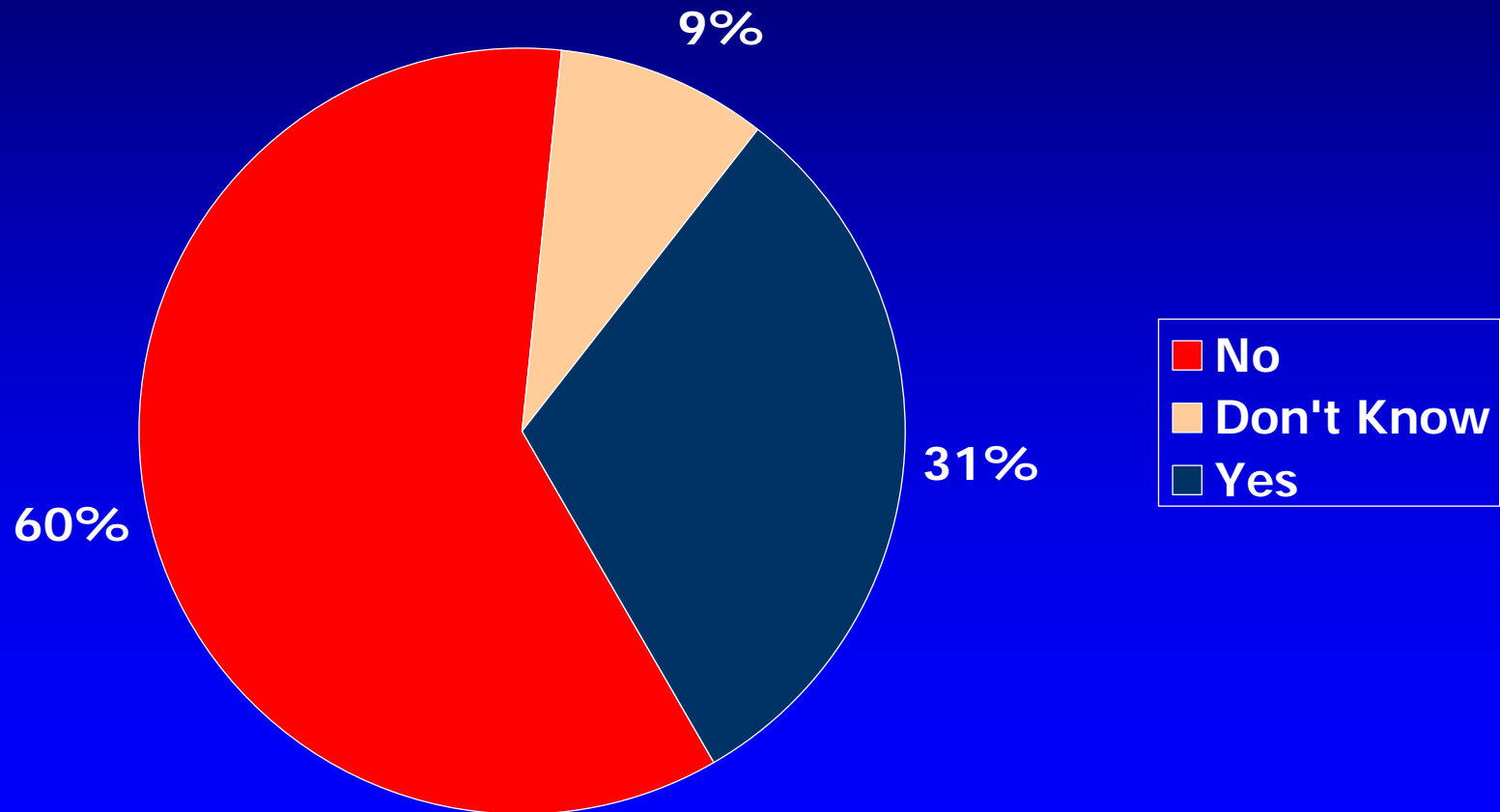
# Smokers in CHOICES Study (N=102)

Age	43
CPD	19 (4-70)
Years smoked	25
Age first smoked	15
Past quit attempts	3
Unemployed	91%
Family/friend buys tobacco for me	59%
Others in household are smokers	60%
Others smoke indoors in home	61%

# Time to First Cigarette of Day

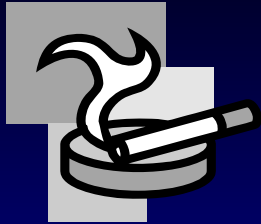


# Does your mental health program offer any tobacco treatment?



# 1 month Follow-up Results

- 86% response rate
- 30% reported trying to quit at 1 month follow-up
- 80% who had not tried to quit significantly reduced the number of cpd (11 vs 18;  $p < 0.000$ )



# Conclusions

Tremendous health care burden of tobacco use in patients with SUD

Treatment works

More access to treatment needed