Smoking Cessation in Behavioral Health Workshop

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MARYLAND RESOURCE CENTER FOR QUITTING USE & INITIATION OF TOBACCO
Overview

- Nicotine: A Hidden Addiction in Substance Abuse and Mental Health Treatment
- Putting Smoking in Perspective
- Addressing Current Barriers
- Current Treatment Recommendations for Quitting Tobacco Use
- Creating the future: Integrating Smoking Cessation into Mental Health, Addiction, and Dual Diagnosis Treatment
- Breaking the Habit in Behavioral Health (BH2): New Hope for Clients Who Smoke
“Cigarette smoking is the chief, single, avoidable cause of death in our society and the most important public health issue of our time.”

~C. Everett Koop, M.D.  
former U.S. Surgeon General
The Big Picture – 2012

- In the U.S., **42.1 million people** currently smoke cigarettes (18.1% of adults). Of these…
  - 3 out of 4 smoke **DAILY** (78.4%), but
  - More than half of these smokers tried to quit in the past year (52.9%).

- Between 1965 and 2009 the **proportion of former smokers more than doubled**:  
  - In 2012, 55% of ever smokers are now former smokers. 
  - Smoking prevalence has dropped from 42% in 1965 to **18.1% in 2012**.

CDC, 2012
The Health Consequences of Smoking: 50 Years of Progress
A Report of the Surgeon General
Successes over the past 50 years

- *JAMA* – in 1965 42% of adults smoked; in 2012 18% of adults smoked.

- *JAMA* – Tobacco control measures adopted since 1964 have saved eight million Americans from death (average 160,000 year over 50 years).
  - Each of the 8 million gained an average of 20 years of life.
  - Total of 157 million years of lives saved.

- Report led to warning labels on cigarette packs, ban on TV ads, and eventual norm shift in smoking.
  - 1965 – congress passed legislation requiring SGR warnings on cigarette packs (took 6 years to implement).
  - 1971 – cigarette ads banned from TV.
Tobacco Disproportionately Impacts Substance Using Populations

- Smoking rates are estimated to be as high as 74% to 88% among individuals with substance abuse problems
  - Estimates range between 85% to 98% for individuals in Methadone-Maintenance programs

- Individuals who abuse substances...
  - Tend to start smoking at a younger age
  - Are more likely to be heavy smokers
  - Are more nicotine dependent
  - Experience greater difficulty with quitting

Kalman, 1998; Holbrook & Kaltenbach, 2011; Prochaska et al., 2004
Behavioral Health and Smoking in Maryland

Maryland Behavioral Health Smoking Rates (CY 2010)

- Admissions to State-Funded Alcohol and Drug Abuse Treatment
  - 81.4% Inpatient
  - 64.0% Outpatient

Source: ADAA SMART [State of Maryland Automated Record Tracking] System

National Behavioral Health and Smoking

- Over 70% of the behavioral health population wants to quit
- Approximately 35-40% behavioral health staff smoke vs. 20.4% general population

Source: 2006 NASHMHPD Research Institute Survey on Smoking Policies
Smoking in Addiction, Mental Health, and Statewide

Behavioral Health Consumers Smoke at Greater Rates than the General Population in Almost All Counties in Maryland.

Sources: Addiction (2010 ADAA), Mental Health Services (2010 PMHS); General Population (2010 BRFSS)
Smoking Rates by Education Level for Adults in Addiction Treatment vs. General Population

Sources: Addiction Treatment (2010 ADAA); General Population (2009 BRFSS)
The highest percentage of BH smokers are White, followed by Black and Hispanic. Within ethnic groups, there is little difference between males and females.

Sources: Addiction Treatment (2010 ADAA); Mental Health (2010 PMHS)
Annual Deaths Attributable to Smoking in the U.S.

For every 1 person who dies from tobacco use, another 20 suffer from one or more serious smoking-related illness — more than 8.6 million in the U.S.

(CDC, 2013)
Active Smoking

Cancers
- Oropharynx
- Larynx
- Esophagus
- Trachea, bronchus, and lung
- Acute myeloid leukemia
- Stomach
- Liver
- Pancreas
- Kidney and ureter
- Cervix
- Bladder

Chronic Diseases
- Stroke
- Blindness, cataracts, age-related macular degeneration
- Congenital defects—maternal smoking: orofacial clefts
- Periodontitis
- Aortic aneurysm, early abdominal aortic atherosclerosis in young adults
- Coronary heart disease
- Pneumonia
- Atherosclerotic peripheral vascular disease
- Chronic obstructive pulmonary disease, tuberculosis, asthma, and other respiratory effects
- Diabetes
  - Reproductive effects in women (including reduced fertility)
  - Hip fractures
  - Ectopic pregnancy
  - Male sexual function—erectile dysfunction
  - Rheumatoid arthritis
  - Immune function
  - Overall diminished health

Source: USDHHS 2014
Passive Smoking

**Children**
- Middle ear disease
- Respiratory symptoms, impaired lung function
- Lower respiratory illness
- Sudden infant death syndrome

**Adults**
- Stroke
- Nasal irritation
- Lung cancer
- Coronary heart disease
- Reproductive effects in women: low birth weight

*Source: USDHHS 2014*
Mortality: Tobacco and Behavioral Health

- Individuals with chronic mental illness die on average **25 years earlier** than the general population,
  - CVD, lung disease, and diabetes mellitus (top 3)

- In 20 year longitudinal study of individuals with alcoholism or SUDs,
  - Mortality rate = **48%**. Triple the expected 18%!
  - **HALF** the deaths were attributed to smoking!

- Each year, **200,000+** of the 443,000 deaths due to smoking are believed to be among individuals with mental health or substance use disorders.

Mauer, 2006; Hurt et al., 1996; Prochaska et al., 2013
**Benefits of Quitting**

**Time Since Quitting**

- **2 weeks to 3 months**
  - Ability to clear lungs is better
  - Less coughing, tiredness, shortness of breath

- **1 year**
  - Added risk of heart disease is now much less

- **1 to 9 months**
  - Blood flows better, walking becomes easier
  - Lungs work better

- **5 years**
  - Risk of stroke is now similar to those who never smoked

- **10 years**
  - Less lung and many other types of cancers

- **after 15 years**
  - Risk of heart disease is now similar to those who never smoked
Tobacco Cessation in Behavioral Health Populations
Tobacco Dependence has Two Parts

Treatment should address both the addiction and the habit.

**Physical**
- The addiction to nicotine
  - Treatment
  - Medications for cessation

**Behavior**
- The habit of using tobacco
  - Treatment
  - Behavior change program/
    Counseling
Helping with the Physical Part: Medication

- Medications help with the physical part of quitting (addiction)
- Make people more comfortable when quitting
- Less irritable, better sleep and mood, less cravings, less weight gain
- Medications do not have the harmful ingredients in cigarettes (E-Cigarettes?)
- Can focus on changing behavior
Helping with the Behavior Part: Counseling and Support

• Counseling helps with the Behavior part (Habit)

• **Prepare to quit:** Change the environment
  • Have tobacco-free home rules
  • Avoid smoke and things that remind you of smoking
    (ash trays, tobacco branded items)
  • Plan other activities for when you usually smoke
    (e.g., after dinner)

• **Plan to quit:** Pick a date to quit

• Decide why YOU want to quit: reasons
Barriers to quitting

When quitting, people have a hard time because they…

• Fear weight gain
• Fear withdrawal symptoms
• Give up a social activity to do with friends
• Expect failure—maybe they failed in the past
• Think they cannot cope with tension and anxiety
• Do not know enough about the good parts of quitting
• Have a hard time changing daily routines that include smoking
Effective intervention begins with understanding the journey into and out of addiction
How Do People Change?

- People change voluntarily only when
  - They become *interested and concerned* about the need for change
  - They become *convinced* that the change is in their best interest or will benefit them more than it will cost them
  - They organize a *plan of action* that they are *committed* to implementing
  - They *take the actions* that are necessary to make the change and sustain the change
Stage of Change Tasks

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

- Interested and Concerned
- Risk-Reward Analysis & Decision making
- Commitment & Creating an Effective/Acceptable Plan
- Implementation of Plan and Revising as Needed
- Consolidating Change into Lifestyle
Theoretical and practical considerations related to movement through the Stages of Change

- Precontemplation | Contemplation | Preparation | Action | Maintenance
- Motivation | Decision-Making | Self-efficacy/Temptation
- Personal Concerns | Environmental Pressure | Decisional Balance (Pros & Cons) | Cognitive Experiential Processes | Recycling | Behavioral Processes | Relapse

Recycling
Cyclical Model for Intervention

- Most smokers will recycle through multiple quit attempts and multiple interventions.
- However successful cessation occurs for large numbers of smokers over time.
- Keys to successful recycling
  - Persistent efforts
  - Repeated contacts
  - Helping the smoker take the *next step*
  - Bolster self-efficacy and motivation
  - Match strategy to patient stage of change
Journey of Smokers in Maryland

Stage-based analysis of 2000, 2002 & 2006 Maryland Adult Tobacco Surveys (MATS)
Stage of Change for Smoking Cessation

• Using the 2000, 2002, & 2006 Maryland Adult Tobacco Surveys (MATS) respondents were classified into 5 Stages of Smoking Cessation:

  • **Precontemplation** = Current smokers who are *not* planning on quitting smoking in the next 6 months

  • **Contemplation** = Current smokers who are planning on quitting smoking in the next 6 months but have *not* made a quit attempt in the past year

  • **Preparation** = Current smokers who are *definitely* planning to quit within next 30 days and *have made a quit attempt* in the past year

  • **Action** = Individuals who are not currently smoking and have stopped smoking within the past 6 months

  • **Maintenance** = Individuals who are not currently smoking and have stopped smoking for longer than 6 months but less than 5 years

*DiClemente, 2003*
<table>
<thead>
<tr>
<th></th>
<th>2000 (Wave 1)</th>
<th>2002 (Wave 2)</th>
<th>2006 (Wave 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Readiness to Change &amp; Intentions</strong></td>
<td>% yes</td>
<td>% yes</td>
<td>% yes</td>
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<tr>
<td><strong>Ever Seriously Considered Quitting</strong>&lt;sup&gt;a, b&lt;/sup&gt;</td>
<td></td>
<td></td>
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<tr>
<td>Precontemplation (PC)</td>
<td>75.2</td>
<td>72.4</td>
<td>68.6</td>
</tr>
<tr>
<td>Contemplation (C)</td>
<td>96.1</td>
<td>95.5</td>
<td>95.2</td>
</tr>
<tr>
<td>Preparation (P)</td>
<td>96.8</td>
<td>97.7</td>
<td>96.5</td>
</tr>
<tr>
<td>All Stages</td>
<td>84.7</td>
<td>85.2</td>
<td>79.7</td>
</tr>
<tr>
<td><strong>Number of Prior Quit Attempts</strong>&lt;sup&gt;b, c, †&lt;/sup&gt;</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Precontemplation (PC)</td>
<td>4.0 (7.6)</td>
<td>4.3 (6.5)</td>
<td>4.6 (11.2)</td>
</tr>
<tr>
<td>Contemplation (C)</td>
<td>5.1 (7.3)</td>
<td>4.4 (5.3)</td>
<td>5.7 (11.3)</td>
</tr>
<tr>
<td>Preparation (P)</td>
<td>7.6 (11.4)</td>
<td>6.7 (9.8)</td>
<td>10.3 (17.9)</td>
</tr>
<tr>
<td>Action (A)</td>
<td>6.5 (9.7)</td>
<td>5.6 (9.5)</td>
<td>4.7 (8.7)</td>
</tr>
<tr>
<td>Maintenance (M)</td>
<td>4.8 (6.9)</td>
<td>5.3 (7.7)</td>
<td>6.8 (14.2)</td>
</tr>
<tr>
<td>All Stages</td>
<td>5.1 (8.4)</td>
<td>5.2 (7.7)</td>
<td>5.8 (12.6)</td>
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<tr>
<td><strong>Rung</strong>&lt;sup&gt;a, b&lt;/sup&gt;</td>
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<tr>
<td>Readiness Ladder 1 (lowest) - 10 (highest)</td>
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<tr>
<td>Precontemplation (PC)</td>
<td>2.9 (2.6)</td>
<td>3.1 (2.7)</td>
<td>3.1 (2.9)</td>
</tr>
<tr>
<td>Contemplation (C)</td>
<td>5.0 (3.1)</td>
<td>4.8 (3.0)</td>
<td>5.4 (3.1)</td>
</tr>
<tr>
<td>Preparation (P)</td>
<td>6.5 (3.0)</td>
<td>6.4 (3.1)</td>
<td>6.7 (3.3)</td>
</tr>
<tr>
<td>All Stages</td>
<td>4.2 (3.2)</td>
<td>4.4 (3.2)</td>
<td>4.2 (3.3)</td>
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<tr>
<td>Table 4. Expectations about and utilization of cessation products and services in 2006 (%)</td>
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<td>---------------------------------------------------------------</td>
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<tr>
<td><strong>Around this time last year were you smoking cigarettes every day, some days, or not at all?</strong>^a</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Every day</td>
<td>Some days</td>
<td>Not at all</td>
</tr>
<tr>
<td>Precontemplation</td>
<td>75.2</td>
<td>20.1</td>
<td>4.7</td>
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<tr>
<td>Contemplation</td>
<td>70.7</td>
<td>20.9</td>
<td>8.5</td>
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<tr>
<td>Preparation</td>
<td>57.7</td>
<td>24.1</td>
<td>18.3</td>
</tr>
<tr>
<td>Action</td>
<td>59.9</td>
<td>18.0</td>
<td>22.1</td>
</tr>
<tr>
<td>Maintenance</td>
<td>9.9</td>
<td>10.2</td>
<td>79.9</td>
</tr>
<tr>
<td>All stages</td>
<td>59.0</td>
<td>18.6</td>
<td>22.4</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>IF YOU DECIDED TO GIVE UP SMOKING ALTOGETHER, HOW LIKELY DO YOU THINK YOU WOULD BE TO SUCCEED?^a</th>
</tr>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Precontemplation</td>
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<tr>
<td>Contemplation</td>
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<tr>
<td>Preparation</td>
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<tr>
<td>All stages</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you ever expect to quit smoking?^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>% yes</td>
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<tr>
<td>Precontemplation</td>
</tr>
<tr>
<td>Contemplation</td>
</tr>
<tr>
<td>Preparation</td>
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<tr>
<td>All stages</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Used an aid last time you tried to quit?^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>% yes</td>
</tr>
<tr>
<td>Precontemplation</td>
</tr>
<tr>
<td>Contemplation</td>
</tr>
<tr>
<td>Preparation</td>
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<tr>
<td>All stages</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Ever used NRT to quit?^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>% yes</td>
</tr>
<tr>
<td>Precontemplation</td>
</tr>
<tr>
<td>Contemplation</td>
</tr>
<tr>
<td>Preparation</td>
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<tr>
<td>Action</td>
</tr>
<tr>
<td>Maintenance</td>
</tr>
<tr>
<td>All stages</td>
</tr>
</tbody>
</table>

^aAll between-stage comparisons significant at p<0.05 level.
NRT, nicotine replacement therapy.
Why Intervene with Tobacco Users?

- Advice by health providers...
  - Makes a difference
  - Enhances motivation to quit
  - Increases the likelihood of a quit attempt (now or later)
- Results in greater satisfaction with health care
- Is *highly* cost-effective

Source: Treating Tobacco Use and Dependence (TTUD), 2008
Selecting a Treatment: Triage Guidelines

- Steer patient to most appropriate treatment
  - Patient characteristics and preference
- Minimal self-help interventions are a good place to start for many smokers
- More intensive...if patient has made many prior attempts, is high on nicotine dependence and is ready and willing
- Treatment matching
  - Tailored materials
  - Pharmacological aids
Options: Nicotine Replacement Therapy

- **Forms of NRT include:**
  - Gum*
  - Patch*
  - Nasal Spray

 (*Available OTC)

- Highly dependent smokers benefit from higher dosages (e.g., 4mg vs 2mg-gum) of NRT

- Smokers’ preference for a specific form of NRT depends on many factors, including:
  - Past experiences with NRT
  - Number/severity of side effects
  - Ease/convenience of use
  - Effect on craving/weight gain

- **Guided use** of NRTs is recommended to assist in the prevention of improper use of NRT.
Options: Medications

- Bupropion (Zyban; Wellbutrin SR)
  - Antidepressant

- Varenicline (Chantix)

  - Helpful for smokers seeking non-nicotine treatment and/or for those with comorbid depressive symptoms (i.e., Zyban)

- Prescription Needed
NRT for Persons with MI & SMI

- The patch may be the preferred nicotine replacement option for people with serious mental illness because of its high compliance rate and ease of use.
- The patch is less helpful for immediate cravings, thus it is often coupled with nicotine gum, an inhaler or nasal spray.
- Combination of patch plus one of the short-acting forms may be most efficacious approach.

Source: National Association of State Mental Health Program Directors Toolkit
Evidence of effectiveness of tobacco dependence interventions in specific populations

- Bupropion SR and NRT may be effective for treating smoking in individuals with schizophrenia and may help improve negative symptoms and depressive mood
  - Individuals on atypicals may be more responsive to Bupropion SR than those taking standard antipsychotics
- Meta-analysis (2008): bupropion SR and nortriptyline vs. placebo for individuals with past history of depression
  - Bupropion & nortriptyline both effective in increasing long-term cessation rates in smokers with history of depression (OR = 3.42)
### Things to Consider ...

**SMOKING CESSATION MAY INCREASE BLOOD LEVELS OF THESE MEDICATIONS**

<table>
<thead>
<tr>
<th>Category</th>
<th>Medication 1</th>
<th>Medication 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIPSYCHOTICS</strong></td>
<td>Haloperidol</td>
<td>Olanzapine</td>
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<tr>
<td></td>
<td>Chlorpromazine</td>
<td>Clozapine</td>
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<tr>
<td></td>
<td>Fluphenazine</td>
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<tr>
<td><strong>ANTIDEPRESSANTS</strong></td>
<td>Clomimpramine</td>
<td>Imipramine</td>
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<tr>
<td></td>
<td>Desipramine</td>
<td>Nortriptyline</td>
</tr>
<tr>
<td></td>
<td>Doxepin</td>
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</tr>
<tr>
<td><strong>MOOD STABILIZERS</strong></td>
<td>Carbamazepine</td>
<td></td>
</tr>
<tr>
<td><strong>ANXIOLYRICS</strong></td>
<td>Desmethyldiazepam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oxazepam</td>
<td></td>
</tr>
<tr>
<td><strong>OTHERS</strong></td>
<td>Heparin</td>
<td>Acetaminophen</td>
</tr>
<tr>
<td></td>
<td>Insulin</td>
<td>Caffeine</td>
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<tr>
<td></td>
<td>Theophylline</td>
<td>Propranolol</td>
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<tr>
<td></td>
<td>Tacrine</td>
<td>Warfarin</td>
</tr>
</tbody>
</table>

Tailoring to Special Populations: Comorbid Depression & Anxiety

- **Depression:**
  - Bupropion, an antidepressant, might be helpful for this group
  - May want to suggest combined NRT + behavioral intervention

- **Anxiety:**
  - Smokers with history of anxiety may be treated with NRT, bupropion (or both)—though bupropion may worsen anxiety symptoms in some
  - Smokers with a history of anxiety may need help:
    - Getting started on their quit
    - Tolerating and coping with withdrawal symptoms, reducing cessation fatigue
Tailoring to Special Populations: Comorbid Substance Abuse

- Nicotine dependence should be treated during treatment for other substance use issues
- Frequent monitoring & increased levels of support are important with this population
- Little evidence to guide choice of most appropriate form of pharmacological therapy
- This population tends to be more highly dependent on nicotine, so stronger dosages of NRT or combinations should be considered
Treatments Do Work

- Treatment for persons with MI that combine Nicotine Replacement Therapy (NRT) with Cognitive Behavioral Therapy (CBT) have been shown to be efficacious
- CBT programs with highest quit rates have
  - groups of approximately 8 to 10 individuals
  - meet once a week for 7 to 10 weeks

Source: Toolkit
Treatments Do Work

- For persons with schizophrenia, combining CBT with NRT and strategies to enhance motivation yield the highest success rates.
- Baker et al. (2006) found a significantly higher proportion of smokers with a psychotic disorder who completed all CBT treatment sessions remained abstinent at follow-up periods relative to controls who received usual care:
  - 3 months: 30.0% vs. 6.0%
  - 6 months: 18.6% vs. 4.0%
  - 12 months: 18.6% vs. 6.6%
Barriers for Smoking Cessation in Behavioral Health Treatment

- Provider Myths
- Challenges to Facilities and Providers
Common Provider Myths
Smoking Cessation in Behavioral Health Treatment

Myth #1:
- If someone in substance abuse treatment has to give up smoking too, they will just drop out or might have increased chance of relapse.

Myth #2:
- Health care professionals can help the general population quit smoking more easily than helping someone who is also quitting another substance or has a mental health problem as well.

Myth #3:
- People who are willing to address their behavioral health problems are probably less motivated to quit smoking.

Myth #4:
- If a person has behavioral health issues, their smoking is much more benign in terms of health risks and can interfere with recovery.
Myth#1

• If someone in substance abuse treatment has to give up smoking too, they will just drop out or might have increased chance of relapse.
  • Inclusion of smoking as a target for intervention does not appear to reduce patients' commitment to broader addiction treatment.
  • Incorporating smoking cessation treatment into inpatient addiction treatment centers has not substantially reduced long term treatment completion (Sharp et al., 2003).
  • Smoking cessation interventions delivered during treatment actually increase the odds of abstinence (Prochaska, Delucci, & Hall, 2004).
  • Continued smoking post-treatment increases risk of substance abuse relapse, and quitting smoking reduces risk of relapse (Satre et al., 2007; Tsoh et al., 2011).
Myth 2: Not interested in quitting
Do Behavioral Health Populations Have Intentions to Quit?

<table>
<thead>
<tr>
<th>Population</th>
<th>Intend to quit in next 6 mo</th>
<th>Intend to quit in next 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Population</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>General Psych Outpts</td>
<td>43%</td>
<td>28%</td>
</tr>
<tr>
<td>Depressed Outpatients</td>
<td>55%</td>
<td>24%</td>
</tr>
<tr>
<td>Psych. Inpatients</td>
<td>41%</td>
<td>24%</td>
</tr>
<tr>
<td>Methadone Clients</td>
<td>48%</td>
<td>22%</td>
</tr>
</tbody>
</table>

* No relationship between psychiatric symptom severity and readiness to quit

Smokers with mental illness or addictive disorders are just as ready to quit smoking as the general population of smokers.
Myth 3: Not able to quit
Smoking Cessation success & Psychotic Disorder

CBT programs with highest quit rates have:
- groups of approximately 8 to 10 individuals
- meet once a week for 7 to 10 weeks

Baker et al., 2006
MORE DEPRESSED SMOKERS QUIT WITH STAGED CARE INTERVENTION Among smokers in outpatient treatment for depression, more who participated in the Staged Care Intervention achieved abstinence at the 12- and 18-month followups compared with participants in the control group.

Myth 3: Not able to quit

• In a Randomized Controlled Trial of depressed smokers:
  • When treated with a combination of …
    • motivational counseling,
    • nicotine patches, and
    • behavioral therapy
  **depressed smokers** were much more likely than their counterparts who did not receive the interventions to be smoke-free at 12- and 18-month assessments

• Among opioid-dependent women, a 6-week smoking cessation intervention was associated with:
  • Decrease in daily cigarettes, at 3-month follow-up, by:
    • 49% among pregnant women
    • 32% among non-pregnant women

Hall et al., 2006; Holbrook & Kaltenbach, 2011
Myth 4: Interfere with recovery
Does quitting tobacco lead to an increase in mental health symptoms?

- **Among depressed patients who quit smoking:**
  - No increase in suicidality
  - No increase in psych hospitalization
  - Comparable improvement in number of days with emotional problems
  - No difference in drug use and less alcohol use among those who quit smoking

- **Among patients with schizophrenia who quit smoking:**
  - No affect on attention, verbal learning, working or verbal memory, executive function/inhibition, or clinical symptoms of schizophrenia
  - Bupropion: decreased the negative symptoms of schizophrenia
  - Varenicline: no worsening of clinical symptoms and a trend toward improved cognitive function

Prochaska et al., 2008; Evins et al., 2005; Evins et al., 2009; George et al., 2002
Myth 4: Interfere with recovery
Does quitting tobacco lead to relapses to other substance use?

- Incorporating smoking cessation into substance abuse treatment programming does not lead to increased risk of relapse and seems to promote abstinence from other substances of abuse!

- Smoking cessation interventions provided during addiction treatment were associated with a 25% increased likelihood of long-term abstinence from alcohol and illicit drugs.

Hughes & Kalman, 2006; Prochaska, Delucchi, & Hall, 2004
Multiple Levels of Factors Influence Clients Quitting

Client
- severity of dependence
- comorbidity
- motivation

Provider
- Knowledge
- Skills
- Resources
- Attitudes

Setting
- Policy
- Cost

Attitudes of Administration

Larger community

Goals of agency
Staff reported presence of smoke-free policies and cessation programs
Coping with Stress Reported as Top Reason for Difficulty Quitting

- Eases Symptoms
  - MHA: 22.1% Strongly Disagree / Disagree, 33.5% Don't Know, 44.6% Strongly Agree / Agree
  - ADAA: 25.2% Strongly Disagree / Disagree, 39.0% Don't Know, 35.8% Strongly Agree / Agree

- Eases Side Effects
  - MHA: 20.5% Strongly Disagree / Disagree, 43.0% Don't Know, 36.5% Strongly Agree / Agree
  - ADAA: 22.4% Strongly Disagree / Disagree, 41.9% Don't Know, 36.1% Strongly Agree / Agree

- Cope w/Stress
  - MHA: 57.3% Strongly Disagree / Disagree, 85.1% Don't Know, 8.0% Strongly Agree / Agree
  - ADAA: 52.4% Strongly Disagree / Disagree, 84.3% Don't Know, 5.2% Strongly Agree / Agree

- Provides Routine
  - MHA: 19.6% Strongly Disagree / Disagree, 27.5% Don't Know, 52.9% Strongly Agree / Agree
  - ADAA: 26.8% Strongly Disagree / Disagree, 27.2% Don't Know, 46.2% Strongly Agree / Agree

- Used by Peers
  - MHA: 57.3% Strongly Disagree / Disagree, 81.6% Don't Know, 13.4% Strongly Agree / Agree
  - ADAA: 52.4% Strongly Disagree / Disagree, 78.3% Don't Know, 13.7% Strongly Agree / Agree

Legend:
- Red: Strongly Disagree / Disagree
- Yellow: Don't Know
- Brown: Strongly Agree / Agree
Smoking Status of MHA & ADAA Providers

MHA
- Never: 63.0%
- Former User (< 6 mos): 23.0%
- Former User (> 6 mos): 10.0%
- Current: 4.0%

ADAA
- Never: 52.0%
- Former User (< 6 mos): 33.0%
- Former User (> 6 mos): 13.0%
- Current: 2.0%
Staff Smoking

- According to recent research literature, staff smoking in substance abuse treatment facilities ranges from 14-40% (Guydish, Passalacqua, Tahima, & Turcotte Manser, 2007)

- Recommendations (Williams, 2005) :
  - A smoke-free policy should be implemented on all grounds of the treatment facilities.
  - Promotes a drug-free environment for both patients in treatment and patients out of treatment.
  - Providing smoking cessation resources not only helps them quit but also provides them with essentials tools necessary to help substance abuse clients quit smoking.
  - Smoke-free policies can be successfully established by:
    - Providing tobacco education to all staff members.
    - Thoughtfully and carefully implementing the smoke-free regulations
Needed resources identified by both MHA & ADAA Providers
Brief Intervention for Tobacco: Private Payer Benefits

- **HCPCS/CPT Codes:**
  - **99406:** Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. *Short descriptor: Smoke/Tobacco counseling 3-10*
  - **99381-99397:** Preventive medicine services
  - **96150-96155:** Health & Behavior Assessment/Intervention (Non-physician only)

- Private payer benefits are subject to specific plan policies. Before providing service, benefit eligibility and payer coding requirements should be verified.

AAFP, 2011
Treating Tobacco Use and Dependence: 2008 Update

- TTUD recommendations:
  - Smoking cessation for all health care settings including SUD treatment
    - All smokers should be offered treatment
  - Brief interventions (identify and engage)
    - Patients unwilling to quit be provided with brief intervention to build motivation
    - Patients willing to quit be offered evidence based treatment
  - Treatment services (treat nicotine addiction)
    - Counseling
    - Medications (NRT, Chantix®, Zyban®)
Evidence Based Treatments

• Efficacious Interventions for smoking with Substance Abusers:
  • Interventions:
    • 5 A’s (willing to quit)
    • Brief Motivational Interviewing (not willing to quit)
  • Medications
    • Nicotine replacement therapy (NRT)
    • Cognitive-behavioral therapy
  • Formats:
    • Individual and/or group counseling

(Kalman, 2010; ahrq.com, Yahne & Baca, 2009)
Selecting a Treatment: Triage Guidelines

- Steer patient to most appropriate treatment
  - Patient characteristics and preference
- Minimal self-help interventions are a good place to start for many smokers
- More intensive...if patient has made many prior attempts, is high on nicotine dependence and is ready and willing
- Treatment matching
  - Tailored materials
  - Pharmacological aids
Effective Strategies

- Teachable Moments
- Various strategies used with individuals without mental illness will work with individuals with MI & SMI
  - Nicotine Replacement Therapy
  - CBT
  - Group Therapy
  - Quitlines
Behavioral Health Options for Addressing Tobacco Use
Interventions Available in MD

- For your agency
  - Brief Intervention (A³C)
  - Single Session Intervention
  - Multiple Session Intervention
- MD Quitline
  - Client direct calls
  - Fax to Assist Program
- County Health Departments
- Other Resources (medicaid, hospitals, etc.)
The Maryland Tobacco Quitline

- Free reactive and proactive phone coaching calls (4 calls)
- Certified Coaches™ provide individually-tailored quit plans
- Provides referrals to local county resources – cessation classes, in-person counseling and free medication
- Operates 24 hours a day / 7 days a week
- Free NRT (patch or gum) 4 week supply
- Fax to Assist program gives providers an opportunity to easily, quickly, and effectively connect patients with the Quitline.
The Maryland Tobacco Quitline

- Extended services for pregnant women
  - 10 sessions (Pre- & Post-Partum)

- Adolescent quit coaching
  - QL now serves 13 to 17 years

- Medicaid Match
Ask, Advise, & Connect (AAC)

- **Ask:**
  - Every patient about their smoking at every visit

- **Advise:**
  - Provide brief advice to quit

- **Assess:**
  - Use ruler to examine readiness to quit

- **Connect:**
  - Utilize our fax referral program to connect your patients directly to the MD Quitline!
  - Shown to significantly increase enrollment in QL services (13-fold!) in comparison to simple referral to QL (i.e., providing QL card)

(Visdine et al., 2013)
Steps 1-2: **Ask & Advise**

1. **Ask:**
   - Identify & document tobacco use for **EVERY** patient at **EVERY** visit
     - Example: “Tell me about your tobacco use.”

2. **Advise:**
   - In a clear, strong, personalized manner, advise **EVERY** tobacco user to quit.
     - Example: “As your smoking has increased, your breathing has worsened. Right now, quitting smoking is the best thing you can do for your health.”
Step 3: **Assess Readiness to Quit**

**Ask:** “On a scale of 1 to 10, with 10 being very ready, how ready are you to quit smoking?”

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>Low Readiness</td>
<td>Moderate Readiness</td>
<td>High Readiness</td>
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</tbody>
</table>

- **I don’t want to quit.**
- **Tobacco is not a problem for me.**
- **Trying to quit would be a waste of my time.**
- **I am thinking about quitting.**
- **I know that quitting would be good for my health.**
- **I am interested in hearing about ways to quit.**
- **I am ready to quit using tobacco.**
- **I would like help to quit using tobacco.**

This ruler is available for download at: [http://mdquit.org/sites/default/files/pdf_files/Readiness%20Ruler.pdf](http://mdquit.org/sites/default/files/pdf_files/Readiness%20Ruler.pdf)
Step 4: Connect to Quit

- Utilize MDQuit’s fax referral program to connect your patients directly to the MD Quitline!
  
  - Please view our *Fax to Assist* training module to learn more about:
    - The **free** cessation services provided by the Maryland Quitline
    - How you can connect your patients directly to the Maryland Quitline using MDQuit’s “**Fax to Assist**” program

- Utilization of fax referral programs have been shown to:
  
  - Significantly increase enrollment in Quitline services (13-fold!) in comparison to simple referral to Quitline (i.e., providing patients with the Quitline card)

(Vidrine et al., 2013)
Fax to Assist

What is Fax to Assist?
Fax to Assist is an exciting and convenient way for you to refer your clients to Maryland’s Quitline to help them quit smoking.

Who is eligible to become Fax to Assist certified?
All Maryland healthcare providers who are employed by a HIPAA-covered entity are eligible and encouraged to use Fax to Assist to help their clients quit smoking.

How do I become Certified?
There are two options that are available:

**Online Individual Training**
- **Advantages:**
  - Training and certification can be completed in about 20 minutes!
  - Instant feedback on the individual certification examination.
  - Instant access to Fax to Assist referral forms and Quitline resources.
  - **How do I start?** Follow the directions below.

**On-Site Group Training**
(for 3 or more providers)
- **Advantages:**
  - We come to you and provide a one hour training for your whole team!
  - Training can be tailored to your setting and patient population.
  - Same-day certification and Fax to Assist kits provided.
  - **How do I start?** CLICK HERE and send us an email to sign-up for on-site training.

Fax to Assist

Our online certification program is now CME-approved! CLICK HERE to find out more about Fax to Assist and complete your training.

Center Specialists
If you are interested in resources, training, or other prevention and cessation information to help consumers, please call us at (410) 455-3628 or contact one of our MDQuit Resource Center Specialists:

- Preston Greene, M.A.
- Angela Petersen
- Shayla Thrash
- Onna Van Orden, M.A.

Most Searched Topics
- Cancer
- Cardiovascular Disease
- Cessation
- Cigarettes
Important Things to Consider

- Providers are encouraged to arrange follow-up appointments to discuss the client’s progress towards cessation.

- The Fax to Assist referral may **ONLY** be used if the client gives their **written consent** on the form.

- In order to receive client feedback from the Quitline, your practice **MUST** be a HIPAA Covered Entity (e.g., doctor’s office, dentist’s office, hospital, clinic or agency site)
Quitline Satisfaction and Quit Rates
Year 4 Evaluation

- **98% of callers were satisfied with Quitline services**
  - Overall satisfaction rates were high for the MDQL services, with 97.5% of the respondents indicating that they were somewhat to very satisfied and 96.6% reporting that they would recommend the Quitline to others.

- **7 times the quit rates of non-assisted quit!**

- **35.4% had not used tobacco for one month or longer. (without counseling the quit rate is usually 4-7%).**
Quitline Evaluation

- 7 month follow-up for responders
  - 7-day point prevalence quit rates were 32%
  - 30 day quit rates were 27.9% compared to estimated rates of 3 to 10% for unassisted quit attempts.

- Statewide for 2010-2011
  - No significant differences between Blacks/African Americans and Whites/Caucasians on 7-day or 30-day quit status.
  - No differences found based on age or gender.
  - No differences for those with behavioral health symptoms.
BREAKING THE HABIT
in
BEHAVIORAL HEALTH

New Hope For Clients Who Smoke
Single and Multi-Session Groups

- **Single Session**
  - Single 90 minute session aimed at preparing BH clients to quit using tobacco. Content consists of discussion points, activities, & handouts.

- **Multiple Sessions**
  - **Four Session:**
    - 1: Thinking About Quitting
    - 2: Preparing to Quit
    - 3: Quit Week
    - 4: Strengthening the Quit Attempt
  - 8 session expands upon the topics covered in each of these 4 sessions, as needed
Preparing to Quit Single Session Overview

*Note: Can be delivered as group OR individual intervention

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Session Content Outline
- Module 1: Can Smokers Quit?
- Module 2: Nature of Addiction
- Module 3: Preparing to Quit
- Module 4: Become a Former Smoker!

Client Worksheets (Appendix A)
- Withdrawal Symptoms Information Sheet
- The Stages of Change
- My Most Recent Quit Attempt Worksheet
- Decisional Balance Worksheet
- Readiness Evaluator
- How Dependent am I?
- Identifying Triggers Worksheet
- Know Your Options
- Ready to Change Your Smoking?
- Smoking Tracker Cards

Additional Information (Appendix B)
- How Does Nicotine Affect the Body?
- Real People. Real Quit Stories.

Group Registration Sheet (Appendix C)

Client Evaluations (Appendix D)

Client Certificate of Completion (Appendix E)

Icon Key:
- **Handout:** You should discuss any worksheets referenced next to this icon. All of the worksheets you will need are listed in the handout checklist above.

- **Group Question:** When you see a question accompanied by this icon, pose the question to the group. Make sure you give group members a sufficient amount of time to answer and discuss responses.

- **Video:** This icon indicates that a video (or alternative) can be presented to the group to help explain important content. Videos can be found on the “Breaking the Habit in Behavioral Health” DVD provided by MDQuit.
Four Sessions: Outline

- Session 1: Preparation
  - Motivation and Decision to Change
- Session 2: Preparation
  - Triggers and ABCs
- Session 3: Quitting
  - Social Skills and Social Support
- Session 4: Maintenance
  - Coping and Relapse Prevention
- Follow up (by phone -or- in person):
  - Brief counseling and plan adjustment if necessary
Underlying Components

- In line with stage based approach:
  - Building motivation, decisional balance
  - Exploring components of change and skill building to increase self-efficacy
  - Supporting Action and change, building social support and changing environment to support change
Assessing Group Dimensions

- Either prior to group entry or in first session:
  - Ready, willing, and able?
  - Nicotine dependence and increased support
  - Symptom severity-MH and SUD
  - Cognitive abilities and possible impairment
How to Expand From Four Sessions

- For groups who are less ready or less confident, focus on the components in RED
- For groups who may have struggled with relapse and are highly dependent, focus on expanding sessions in YELLOW
- For groups struggling with mental health or addiction symptom severity expand sessions in YELLOW and GREEN

Keep in mind: If you expand, don’t expand indefinitely and lose site of the other components!
Style of Delivery:
Emphasizing a Motivational Enhancement Approach to Increase Engagement in the Change Process
MI in Groups

“While the MI approach with individuals has been described as waltzing, we think that using MI in groups is more like conducting a symphony. Each member plays an individual instrument and contributes to the collective melody of the group, and at the same time responds to the conductor. The conductor, in turn, gently guides the instrumental interactions, as well as the overall orchestral composition.”

(Velasquez, Stephens, & Drenner, 2013; p. 281)
Strategies for Increasing Cessation

- Know the Smoker
- Understand the Cessation Journey
- Treat the Smoker as a Consumer
- Create a continuum of care
- Develop collaborations and create synergy
- Take advantage of opportunities
Additional Resources

- **Free Tobacco Cessation Training**
  - **Clinician Assisted Tobacco Cessation Curriculum** --
    www.rxforchange.ucsf.edu. This online comprehensive tobacco cessation education tool provides the knowledge and skills necessary to offer tobacco cessation counseling to clients who use tobacco. Has customized curriculums.

- **2008 U.S. Public Health Service Guideline** -- Treating Tobacco Use and Dependence: visit www.surgeongeneral.gov/tobacco for free resources and best practices for tobacco intervention.

- **Free Tobacco Cessation Tool Kits**
  - **Bringing Everyone Along Resource Guide and Summary** --
    www.tcln.org/bea. Developed by the Tobacco Cessation Leadership Network, this guide and summary assists an array of health professionals to adapt tobacco cessation services to the unique needs of tobacco users with mental illness and/or substance use disorders.
For Additional Resources Visit
www.smokingstopshere.com
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 diseases. Smokers want to quit more than you may think. And they can. Talk to them about it. For more help, visit 1-800-NO-BUTTS. And visit www.nobutts.org/quit for free training, resources, and patient materials.