




Smoking Cessation for Persons with Mental Illnesses



**“We want to quit smoking,  
We need to quit smoking,  
We CAN quit smoking”**



*A Practical Mental Health Consumer  
Data Driven Model*



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## Why Focus on Persons with Mental Illnesses?

In Order for Mental Health Patients to  
Lead Meaningful Lives-  
We Need to Promote Behaviors that  
Lead to Health

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## Today’s Objectives

- Discuss the unique challenges facing persons with mental illnesses who smoke
- Review the model for community participation
- Discuss qualitative study findings
- Review lessons learned and recommendations

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## Alarming Statistics



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## Morbidity & Mortality

- Persons with mental illnesses die young  
    **20% shorter life span**
- Greatly elevated risk
  - Cardiovascular disease**
  - Respiratory disease**
  - Lung cancer**
  - Infections**
  - Diabetes**

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## Prevalence of Tobacco Use

- 20% of Americans have mental illnesses at any point in time
- Nicotine dependent at rates 2-3 times higher than the general population
- Represent 44.3% of the U.S. tobacco market
- Represent 7.1% of the total U.S. population but consume 34.2% of all cigarettes smoked  
(Lasser K et al: JAMA 284:2606-10, 2000)


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### Tobacco Use by Psychiatric Diagnosis

Schizophrenia	65-85%
Bipolar disorder	55-70%
Major depression	50-60%
Anxiety disorders	45-60%

Lasser K et al: JAMA 284:2606-10, 2000; NASMHPD 2006



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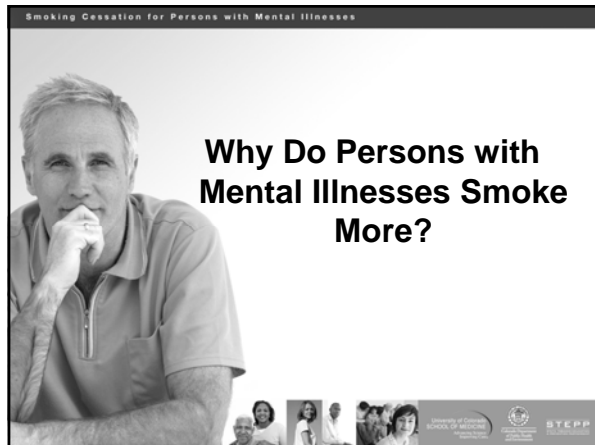
### Colorado Tobacco Use Study


N = 11,984


Schizophrenia <sup>1</sup>	62%
Schizoaffective <sup>1</sup>	57%
Bipolar disorder <sup>1</sup>	51%
Depression <sup>2</sup>	36%
Anxiety	32%
Other	30%


<sup>1</sup>P < 0.001 for all diagnostic categories compared to "other"  
<sup>2</sup>P < 0.01 for depression compared to "other"

Morris et al., 2006

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- ### Unique Challenges
- Biological predispositions
  - Psychological and social factors
  - Stigma and provider beliefs
  - Tobacco industry targeting
- 



- Smoking Cessation for Persons with Mental Illnesses
- ### Biological Predisposition
- Nicotine enhances
    - concentration
    - information processing
    - learning
  - Enhances mood
  - May reduce medication side effects
- 

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- ### Psychological Predisposition
- People smoke to relieve tension and anxiety
  - Helps cope with stress
  - People develop daily routines
    - they smoke during certain activities of the day
- 

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## Smoking As a Social Activity

- People may smoke to feel “part of a group”
- Smoking is associated with social activities
- To combat boredom
- Institutional support of tobacco use

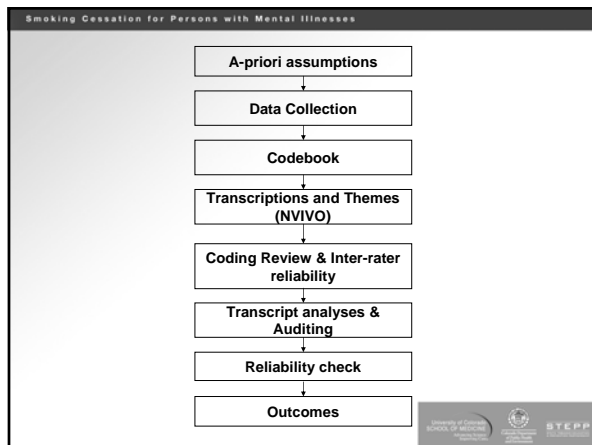



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## What do Persons with Mental Illnesses Need to Quit Smoking?

Mental Health Patient and Provider Perspectives






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## Focus Group Discussion Guide: Consumer


- *What information and resources do you or others you know need to stop smoking?*
- *Please review these materials. What suggestions do you have for improving them?*
- *How can mental health providers be of most help in assisting persons with mental illnesses to quit smoking?*



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## Focus Group Discussion Guide: Provider


- *Please take a few minutes to review the draft toolkit. Would this toolkit be helpful to you? How can we improve upon the current materials?*
- *What barriers do you encounter in trying to provide tobacco cessation services to your patients?*
- *What prevents persons with mental illnesses from quitting? What has worked?*



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## Focus Groups

- 10 Groups
  - 5 with mental health consumers
  - 5 with mental health providers
- Groups were held in Denver, Pueblo, Fort Collins, and Grand Junction
- Participants
  - 62 Consumers
  - 22 Providers



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## Consumer Participation

Tobacco User w/ Quit Attempt	21
Tobacco User: No Quit Attempt	11
Successful Quitter	9
Never Smoker	2
Data Not Collected	19
<b>Total</b>	<b>62</b>

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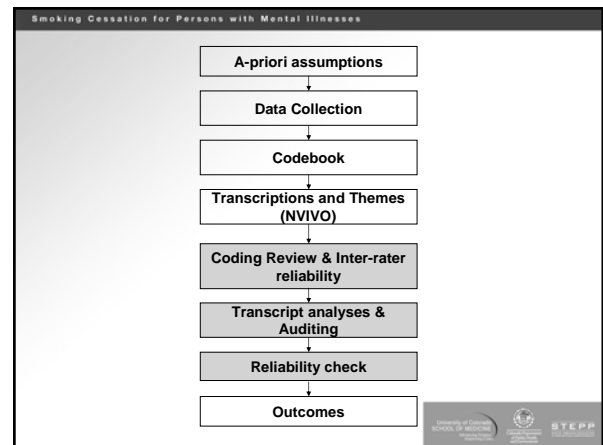
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## Provider Participation

Case Manager	3
Heath Educator	2
Psychiatrist	4
Psychologist	2
Registered Nurse	2
Social Worker	3
Other Mental Health Worker	4
Other	2
<b>Total</b>	<b>22</b>

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- ## Qualitative Data Analysis
- Focus groups recorded using a digital recording device
  - Group discussions transcribed verbatim into Word Documents
  - NVIVO 7 Qualitative Data Analysis software
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- ## Results
- 5 Thematic Categories:
- **Barriers to treatment**
    - lack of resources
    - provider stigma
    - negative patient attitudes
  - **Implementation**
    - resources
    - infrastructure
  - **Negative influences on smoking behavior**
  - **Knowledge deficits**
  - **Treatment needs**
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- ## Barriers to Tobacco Interventions
- Stigma
  - Competing demands
  - Tobacco as socialization activity, behavioral reward
  - Staff acceptance, promotion
  - Financial revenues
  - Reimbursement for services
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## Stigma and Provider Beliefs

"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 more or less 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



## Implementation

- Systematic identification and assessment of smokers
- Strategic partnerships
- Provider education
- Positive expectation

*"Quitting smoking is something that you just keep coming back to. You talk about it every single time you see the consumer"*



## Negative Influences on Smoking Behavior

- Smoking to control symptoms
- Stress, tension, and anxiety
- Boredom
- Smoking as a social activity

*"Give me something to occupy my time. There is nothing to do...except smoke, sleep, and shower."*



## Knowledge Deficits

- Knowledge deficits exist among consumers and providers

*"I don't inhale all the way. I just puff on it. It doesn't go fully into the lungs"*

*"I found out that my uncle was smoking clove cigarettes, they aren't really bad for you and not really addictive"*

*"They (mental health consumers) don't really care how much they spend on cigarettes. Their cigarettes are so important to them, it doesn't matter"*



## Treatment Needs

- Education
- Pharmacotherapy
  - Nicotine replacement therapy
  - Psychotropic medications
- Behavioral strategies
  - Individual or group counseling
- Peer support

*"I think support groups would be helpful. The more people that are trying to quit you can feed off each others' need to quit, or motivation to quit"*



## Notable Quotables


***I'd Love to quit, I just don't know how***  
*or*  
***I am sick and tired of being sick and tired of smoking***

*or*  
***Stress is a big trigger for me, I don't know how to deal with stress***


*or*  
***I think having information out there can induce you to quit, or want to quit***



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## Interventions: What is the Evidence That Anything Works?




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## Cessation Rates

Although quit rates for persons with mental illnesses are less than the general populations, smoking cessation rates are still substantial.

Major depression- up to 38% (Lasser et al., 2000)

Schizophrenia- between 10-30% (Addington et al., 1998; Baker et al., 2006)



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## Smoking Cessation Systematic Review

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



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## Treatment Recommendations


- Cognitive-Behavioral Therapy (CBT) + nicotine replacement therapy (NRT)
- Groups of approximately 8-10 individuals that meet once/week for 7-10 weeks
- Individualized treatments based on diagnoses
- Stress consumer preference
- Address psychosocial needs that might undermine tobacco cessation



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## Treatment Recommendations

- More person-to-person contact = better outcomes
- Intensive interventions are more effective
- If non-adherence is related to instability, it is probably not the right time to quit
- Cessation may produce rapid, significant increase in medication blood levels
- Monitor for side effects, weight gain
- Variables predicting success are current use of psychiatric medications and perceived ability to quit
  - e.g., Coping Skills for Stress, and Anxiety, Dealing with High Risk Situations




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## Pharmacotherapy

All smokers trying to quit should receive pharmacotherapy  
(US Clinical Practice Guidelines)

- Nicotine replacement therapy (NRT)
- Bupropion SR
- Varenicline (Chantix—Pfizer)
- Clonidine\*
- Nortriptyline\*

\*Not FDA-approved for tobacco cessation




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## Quitlines

Telephonic counseling and nicotine replacement therapy at no cost


- Only 4.5% of Colorado smokers quit smoking without Colorado QuiLine assistance (CDPHE, 2003)
- 27% (2,561 or 9,514 participants) of individuals who exited the QuitLine telephonic counseling program reported being tobacco free (National Jewish Medical and Research Center, 2006)



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## Recent Developments & Tools



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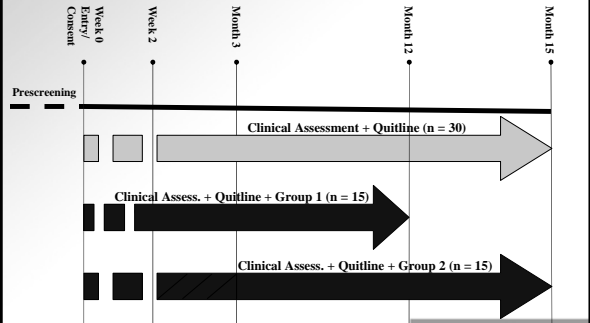
## The Colorado Model

- 2004 & 2006 Statewide Focus Groups
- Prevalence Studies
- Toolkit for Mental Health Providers
- Wellness Group Manual
- Randomized Study of Cessation Strategies
- Peer-to-Peer Interventions
- Primary Care
- Other Disparities Groups

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## The Study Intervention (N = 240)



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## Study Inclusion Criteria


- “Interested” consumer is good enough—don’t r/o based on “motivation”
- In most cases, you will start with harm reduction
- Psychiatrically stable—not full remission
- No major medication changes going on
- No major life changes going on
- No active intoxication / withdrawal



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## Wellness Group


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



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## Wellness Group Sessions

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



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

**Top 5 myths about smoking**

**Myth 1:** To quit smoking, all you need is willpower. The truth: Quitting without help is the most common reason why people fail to quit. You're not alone. There are many ways to quit, and you can get help. The truth: Research shows that people who use nicotine replacement therapy are more likely to quit.


**Myth 2:** There are no side effects to quitting. The truth: There are some side effects, but they are usually temporary and go away on their own. Research shows that people who use nicotine replacement therapy are more likely to quit.

**Myth 3:** "Light" or "low tar" cigarettes are safer than regular cigarettes. The truth: There are no safe cigarettes. All cigarettes contain nicotine and tar, which can cause serious health problems.


**Myth 4:** "Addict" status is a weakness. The truth: Nicotine is an addictive drug, and it's not your fault. You can get help to quit.

**Myth 5:** Quitting is too hard. The truth: Quitting is hard, but it's not impossible. There are many ways to quit, and you can get help.


**You CAN quit tobacco**  
Tips for Preparing to Quit



**Ready to Set Quit**



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




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## Next Steps

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- ➔ Peer to Peer Interventions
- ➔ Latinos and Smoking Cessation
- ➔ Women and Smoking Cessation
- ➔ QuitLine / Wellness Group
- ➔ International




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*"Even though this is hell, I still want it to be a healthy environment. So no, you can't smoke."*

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