

INTRODUCTION

The following section presents information from a key informant survey with health professionals who treat tobacco users with MI/SUD (A list of survey respondents may be found in Section 5). The advice in each section is based on the experience of these professionals as they apply evidence-based best practices in their respective settings. The advice provided by these professionals has not been separately evaluated. As more research and evaluation becomes available, this advice will likely need to be updated.

Four tobacco cessation treatment settings were identified as part of the survey:

- Programs in community settings;
- Tobacco quitlines;
- Services in mental health treatment settings;
- Services in substance abuse treatment settings.

A fifth setting, primary care clinics, was identified but a database of primary care providers was not available for the survey. A set of general recommendations for primary care providers is included based on the PHS Guideline³⁷ and advice from other health professionals.

Each set of recommendations is in four parts: 1) Intake assessment; 2) Treatment planning; 3) Treatment approach and follow-up; and 4) Summary advice.

TOBACCO DEPENDENCE PROGRAMS IN COMMUNITY SETTINGS

INTAKE ASSESSMENT

A thorough assessment is strongly advised to structure an effective treatment plan that takes into account co-morbidities and concurrent treatments/providers. Assessment questions are divided into several categories: 1) demographic characteristics, 2) tobacco use history, 3) current quit attempts, 4) social support, 5) current life situation, 6) current health history, and 7) screening for mental health or substance use disorders. See Section 4 for a description of tobacco dependence assessment questions and sample assessments.

MENTAL HEALTH AND SUBSTANCE USE ASSESSMENT ISSUES

Tobacco cessation professionals not trained in MI/SUD were concerned that clients seeking cessation services may be sensitive about sharing any MI/SUD history. These professionals preferred getting this information indirectly. There was also a concern about professional responsibility/liability for action if a client seeking cessation treatment disclosed a MI/SUD problem in a non-mental health/substance abuse setting. These concerns were not shared among professionals who had more training in MI/SUD. Instead, they recommended asking direct questions about MI/SUD in order to establish the most effective treatment plan possible.

The following outlines advice for both direct (recommended) and indirect approaches to obtaining client information on history of MI/SUD.

DIRECT APPROACHES

Programs with trained mental health professionals use a set of direct questions to determine any MI/SUD history. They assess whether a client has ever received counseling, treatment, diagnosis or medications for mental health, emotional or behavioral problems and ask separate questions about a history of substance abuse or dependence. Many of these programs obtain extensive information from clients on past and current mental health and medical conditions. They will often include standardized assessment instruments to better characterize current symptoms or level of functioning (e.g., Beck Depression Inventory⁶³, K6⁶⁴).

For substance use it was recommended that staff ask questions in a way that “normalizes” use, e.g.: asking, “How much do you drink?” rather than “Do you drink?” Standardized assessment questions can be used to help determine a general level of problem drinking and the potential need for referral (e.g.: CAGE test⁶⁵ C- “Ever Cut down on drinking?” A- “Ever get Annoyed when people ask about drinking?” G- “Ever feel Guilty about drinking?” E- “Ever have an Eye opener or morning drink?”).

Some tobacco dependence treatment programs receive client referrals from a mental health agency or a primary care provider. In this case the client should have signed a release of information, making them aware that any MI/SUD information will be shared. When both the client and the tobacco treatment professional understand that this information is shared, MI/SUD issues are more likely to be addressed directly rather than indirectly.

INDIRECT APPROACHES

Programs with staff not trained in MI/SUD, often approached assessment in a more conversational way. In this approach, the tobacco treatment professional works to establish rapport with the client through an interview tailored to the particular client. Most tobacco treatment programs ask at the intake assessment whether a client is currently taking any medications. If a client reports taking any psychotropic medications, the presence of a mental illness is assumed. Follow-up questions are asked during the interview as well as questions about any current or previous history in behavioral counseling, and about a counseling relationship with a MI/SUD provider, if disclosed. From there, follow-up questions help determine whether the client is presently working with a behavioral health care provider. If so, the client is reminded that tobacco abstinence could be disruptive to their day-to-day life and can alter the effects of any psychiatric medications they may be taking. These clients are referred to their primary provider to monitor any psychiatric symptoms and to make any necessary adjustments in medications dosages.

Additional questions can also be asked about whether any family members have a history of mental illness or substance use. Clients may be willing to discuss problems with family members more than their own problems. If there is a positive family history, the client may have similar problems. Through the interview process, the presence of MI/SUD use may be revealed by spontaneous report or become evident by observation of behavior. Appropriate referrals (if necessary and available) can then be made.

See Section 4 for a sample of both direct and indirect ways of asking clients mental health and substance use questions.

TREATMENT PLANNING

Our experts recommended that treatment planning be tailored based on the stability of a client’s MI/SUD or stability of their recovery process.

Clients who are not stable (e.g. active substance use, current depression, anxiety disorders) should be counseled to seek treatment from their primary care and/or mental health provider before or concurrently with pursuing quitting tobacco. If a client refuses to follow through on a referral, tobacco dependence treatment would not be withheld. But, ongoing encouragement and referrals for treatment should continue if the client is unable to maintain focus in quitting smoking due to these pre-existing conditions. An exception is when there are concerns about harm to self or others. In this case, any tobacco treatment is bypassed and an immediate referral to a hospital emergency room and/or the client’s primary provider (or 911) should occur immediately.

tobacco cessation pharmacotherapy is essential. Benefit coverage (e.g. Medicaid, Medicare) and easy and inexpensive access for cessation medications and client management while on drug treatment need to be addressed as part of the treatment plan.

If possible, tobacco treatment professionals will need to have access to prescribers or be able to make referrals to specific primary care providers familiar with mental health/substance abuse treatment and tobacco cessation treatment. Knowledge of health plan reimbursement policies is important for coordinating care, since many clients are enrolled in health plans. Referrals to quitlines that provide medications as part of their services can also help.

Programs without good access to prescribers will need to coordinate with the client's primary care provider or psychiatrist in the development of a tobacco treatment plan so that the tobacco treatment professional can help monitor symptoms and assist with follow-up as needed. Closer provider coordination improves the likelihood that management, monitoring, and adjustment of any concomitant medications during the client's quit attempt will occur.

APPROACHES TO TREATMENT AND FOLLOW-UP

Clients with less functional impairment can participate in a typical, structured treatment approach (e.g. specific quit day). Clients who are functionally impaired will need a less structured and more flexible treatment approach that links the quit date to client readiness. Flexibility with the quit date will require some adjustments to other components of a cessation program as well.

There are several reasons for the need for flexibility.

Clients with MI/SUD are likely to be more nicotine dependent, making it more difficult to quit. Clients with MI/SUD may have little previous or positive quitting experience and may need to do more preparation before they have sufficient confidence and skills to try. One survey respondent stated that everyone in her groups was encouraged to set a quit date, but that timelines varied. Another said that treatment was approached gradually—learning not to smoke in specific situations and waiting to set a quit date until later.

Expert Advisory Committee Caveat

It is important to be cautious about doing too much planning, or delaying a quit date more than necessary. While it is important to help match the pace of treatment to the needs of the client, it is also possible to inadvertently provide a reason to continue to postpone quitting. This is a difficult balance for any client, but particularly important for those with mental illness and substance use disorders.

Some clients may need to follow incremental steps that can be more easily accomplished. Breaking down the quitting process into smaller, more concrete pieces can help clients build skills and reduce the risk of failure in a given quit attempt. Flexibility in the duration of treatment is also important. Tobacco treatment professionals reported that there is often a need to reevaluate and increase the duration of cessation treatment compared to smokers without MI/SUD. Some programs also reported that clients continue to attend group sessions for ongoing support long after "formal" treatment ends. At the same time, many clients will have developed behavioral skills to cope with symptoms of MI/SUD and can use these same steps to successfully develop behavioral skills to stop smoking. Many also have long histories of participation in therapeutic and support groups, so they are knowledgeable and practiced in group dynamics.

SUMMARY OF PROFESSIONAL ADVICE

- Use a supportive, open, and flexible approach (e.g. flexible quit date), tailored to the individual.
- The more treatment options, such as group, individual, or combinations, the better.
- More treatment sessions are better and long-term follow-up is useful for relapse prevention.

- Pharmacotherapy is essential: work with client's prescriber to monitor medications and health status.
- Provide specific education to clients (and staff) about nicotine addiction and tobacco cessation medications. For example, some people have concluded that because they know smoking is harmful, it is nicotine that causes cancer.
- For group programs, clients who have been treated for addictions or been part of recovery support programs can be an asset in any group treatment setting. They can help solidify a group and make it more effective for those members who have little experience in therapeutic or support group settings. Clients with serious mental illness may do better in a group together. They may be more likely to find greater acceptance and understanding of their disorders as they attempt to quit smoking. However, programs need to provide enough flexibility so that clients could opt to be in general population groups, if they chose to.
- Supplementing group experiences with individual counseling time for additional support and skill development may improve client satisfaction and reduce anxiety.
- Level and type of training for professionals providing cessation services to this population is important to outcomes. A background in addiction, behavioral health (including group dynamics) in addition to tobacco dependence training can help professionals feel more competent and comfortable when working with these clients.
- The availability of a physician, medical director, or other health care provider embedded in the treatment team is an advantage. Most clients will have co-morbid medical conditions and a medical provider can help provide direct input into the cessation treatment plan.

TOBACCO QUITLINES

INTRODUCTION

Quitlines are mostly state funded, telephone-based services that provide counseling and support by trained professionals for tobacco users who want to quit. Quitlines represent the public health model of tobacco dependence treatment - low-cost effective interventions to a potentially large population of tobacco users. The general approach to quitline services is to first complete an initial screening for all callers to determine client needs and appropriate educational materials that can be mailed. Callers interested in quitting are then connected to a trained counselor. The trained counselor develops a quit plan, and then (depending on the resources of the quitline) may offer medications (e.g. nicotine patches) and provide several, proactive follow-up calls scheduled at specific times. Quitline services vary by state. Each state contracts with a quitline vendor and negotiates the protocol.

Some quitline counselors are professionally trained mental health or substance use specialists, although most are not. Some have had continuing education in this area and others have received training as part of their quitline training. The quitlines who responded to our survey all receive a significant number of calls from clients affected by a range of MI/SUD.

Some quitlines have modified their basic format to accommodate callers with MI/SUD. All quitlines agreed that they better serve clients who have less functional impairment than those with serious MI or callers in treatment for SUD. Three variations in services were identified from our survey: 1) Adding mental health and substance use questions to the initial assessment. Clients are then referred for adjunct treatment in the community if necessary; 2) Developing a proactive/ interactive network with mental health and substance use providers to link clients seen in either setting and sharing information about clients' tobacco dependence treatment; and