

INTRODUCTION

The BEA Expert Advisory Group reviewed the existing literature and survey data collected from professionals who provide tobacco dependence treatment to people with MI/SUD (see Section 5). The Advisory Group interpreted this information and developed the following key findings and general recommendations for adapting tobacco dependence treatment for people with MI/SUD.

KEY FINDING: SERVICES FOR TOBACCO USERS WITH MENTAL ILLNESS AND SUBSTANCE USE DISORDERS ARE COMPLEX.

Currently, tobacco dependence treatment is generally delivered in conjunction with other health care at health care facilities, medical clinics/offices, and hospitals; through programs and services that tobacco users seek out (quitlines and community cessation programs); and sometimes through referrals between these programs and services (e.g. health care to quitlines; quitlines to community cessation programs).

The types of tobacco dependence treatment provided in these settings vary by intensity. Services range from brief treatment, including simple advice to quit, prescriptions for medications and, referral to quitlines by primary care providers, to intensive treatment offered by trained tobacco treatment specialists.

BRIEF TREATMENT

Brief treatment, designed especially for busy primary care providers, is the most widely recommended and commonly used form of tobacco dependence treatment in medical settings. Most tobacco users, if they receive any treatment, are likely to receive brief treatment. The Public Health Service (PHS) Clinical Practice Guideline recommends that routine screening for tobacco use be included for all clinic visits and all tobacco users receive at least brief treatment (3 minutes or less) from their primary healthcare providers.³⁷

INTENSIVE TREATMENT

Intensive treatment is more complex, requiring specialized training and more time to provide. Intensive treatments that include coaching/counseling by trained professionals over several weeks or months coupled with appropriate cessation pharmacotherapies and follow-up consistently lead to better abstinence rates than brief treatment. Although reimbursement for and availability of intensive treatment is limited, the Guideline recommends that intensive treatment be offered to any tobacco user who is willing to participate.³⁷

QUITLINES

Quitlines are another resource. Treatment through tobacco quitlines is available in all 50 states and is helping to reach more tobacco users. Tobacco quitlines vary considerably in the services they provide. Most provide more than brief treatment and some provide fairly intensive treatment.³⁸

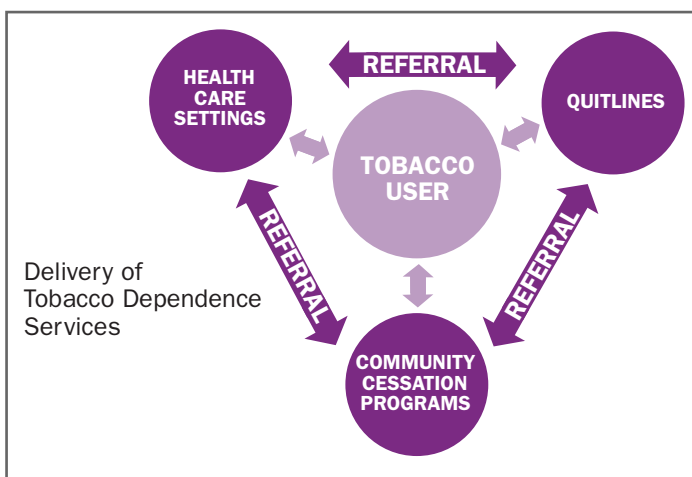


Figure 1 illustrates the range of tobacco dependence treatments by intensity and a broad estimate of their availability.

Figure 1: Estimate of tobacco treatment services available by treatment intensity

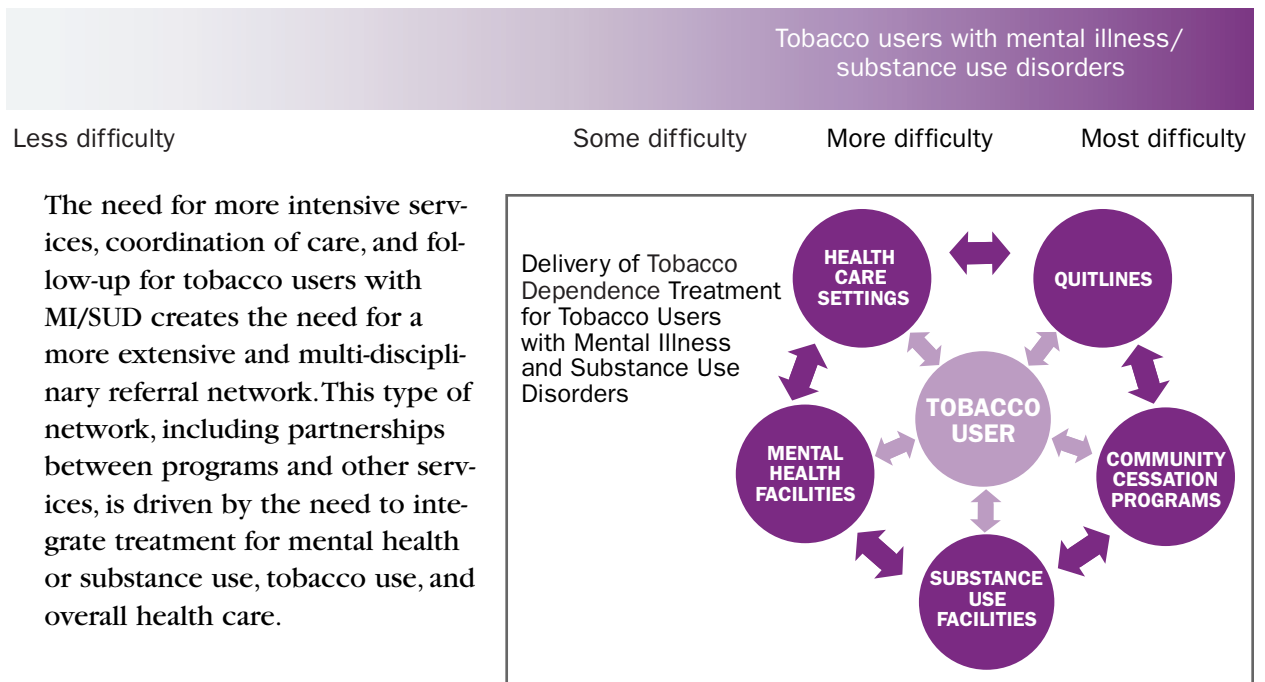
Self help/quit on own	Low intensity: E.g. Brief treatment in primary care	Medium Intensity: E.g. many Quitlines	High Intensity: E.g. Individual/group multi-session treatment with trained specialists and medical supervision
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TREATMENT SERVICES NEEDED FOR TOBACCO USERS WITH MENTAL ILLNESS AND SUBSTANCE USE DISORDERS.

Tobacco users with serious and persistent MI and/or with SUD have very high rates of smoking,³⁹ the highest average consumption of cigarettes,⁵ and have the most difficulty quitting. These smokers are more likely to be receiving care through mental health and substance use treatment facilities and some may also receive care from a primary care provider.⁴⁰ These smokers need to have tobacco dependence treatment integrated directly into their mental health or substance use care and, if needed, coordinated with primary care providers.

Compared to individuals with serious mental illness, a large proportion of tobacco users with MI/SUD are less functionally impaired, and are likely to receive their care in routine health care settings. These tobacco users will benefit from more tailored tobacco dependence treatment integrated with their usual health care. Like tobacco users in treatment facilities, these clients also have more difficulty quitting than those without MI/SUD and will need more intensive care than the brief treatment more common in routine health care⁴¹ (see Figure 2). Health professionals who routinely work with these tobacco users advise that services in routine healthcare will need to include more intensive follow-up, more medical management of both tobacco use and MI/SUD, and more monitoring of medications, to help these clients successfully quit.

Figure 2: Difficulty quitting for all tobacco users



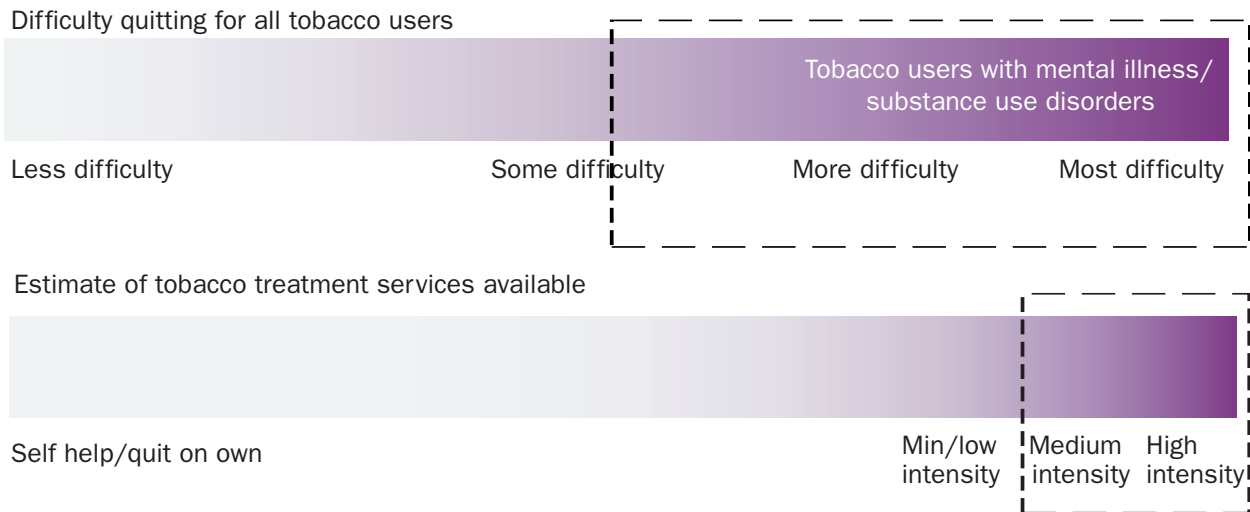
The need for more intensive services, coordination of care, and follow-up for tobacco users with MI/SUD creates the need for a more extensive and multi-disciplinary referral network. This type of network, including partnerships between programs and other services, is driven by the need to integrate treatment for mental health or substance use, tobacco use, and overall health care.

KEY FINDING: THERE IS A SIGNIFICANT GAP IN SERVICES.

Few tobacco dependence treatment programs have been adapted for clients with MI/SUD and the number of tobacco treatment specialists trained to deliver more complex interventions is limited (see competencies for Tobacco Treatment Specialists at www.attud.org). Many MI/SUD treatment providers do not regularly offer even brief treatment for tobacco users seen in treatment facilities. In some cases, when tobacco use is assessed, MI/SUD treatment providers may advise clients to quit but rarely assist them in making a quit attempt or follow up and help manage a quit attempt.^{42,43,44} In addition, few MI/SUD treatment programs have trained staff to deliver tobacco cessation services for clients, and few referral networks exist.

In order to improve treatment for tobacco users with MI/SUD, the gap between treatment services needed and treatment services available needs to be closed. To begin to close this gap, the BEA Expert Advisory Committee recommends that existing tobacco cessation services be tailored for each treatment setting and then additional services be created where they do not exist.

Figure 3: Gaps in Services



SIX RECOMMENDATIONS FOR ADAPTING TREATMENT PROGRAMS.

RECOMMENDATION 1: CHANGE EXISTING BELIEFS

Many providers and clients still believe that tobacco users with serious MI/SUD don't want to or can't quit. These beliefs are outdated and serve as barriers, even preventing treatment from being offered. There is ample evidence that they both want to and can quit.⁴⁵⁻⁴⁹

In a recent study of over 300 depressed smokers and their readiness to quit, 79% reported an intention to quit and 24% were ready to quit in the next 30 days.⁵⁰ In a 2006 study of smokers with psychiatric disorders, those who were treated and followed for 12 months were three times more likely to be abstinent than those who were not treated.⁵¹ In a study of smokers in a substance abuse facility, 75% accepted an offer for smoking cessation treatments.⁵²

Another recent study of clients with substance use disorders shows that many want to participate in treatment and many have tried to quit repeatedly including the year leading up to treatment for substance use.⁵³ In a 2004 review of clinical trials, 50% to 77% of clients in substance abuse treatment expressed interest in quitting smoking.⁵⁴