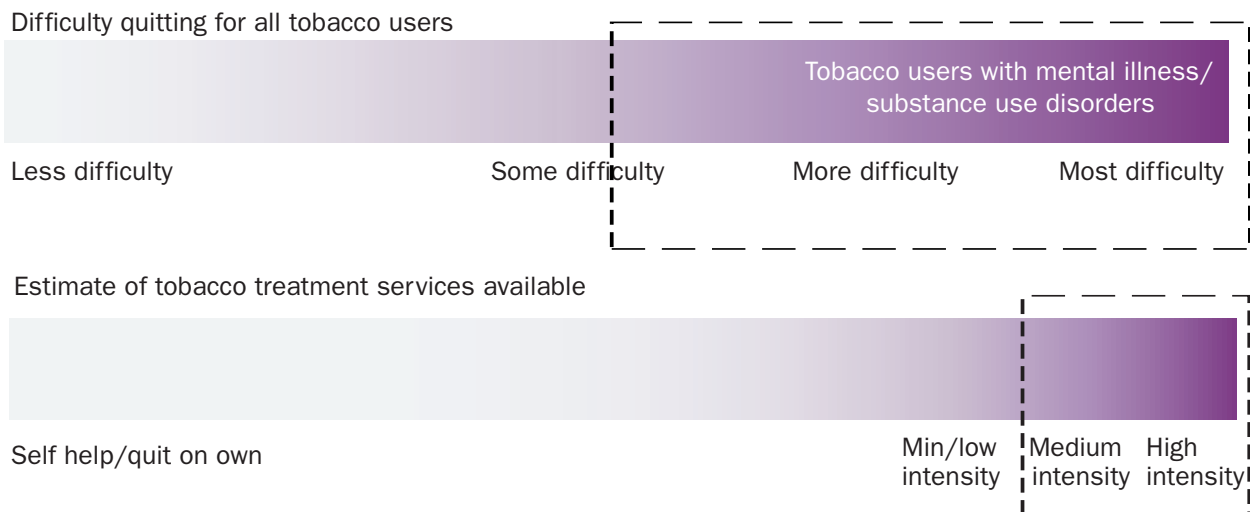


KEY FINDING: THERE IS A SIGNIFICANT GAP IN SERVICES.

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 These beliefs are outdated and serve as barriers, even preventing treatment from being offered.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

Surveys have shown that the majority of smokers (around 70 percent) want to stop smoking yet quit rates remain very low.⁵⁵ Among persons with mental illness and addictions there is evidence of a desire or motivation to quit smoking. But the cessation rates among these individuals are particularly low and they have many of the same concerns as other smokers (e.g. not being ready yet to quit).⁵⁶

RECOMMENDATION 2: PROVIDE TAILORED TREATMENT SERVICES

Tobacco users with serious MI/SUD respond to the same evidence-based treatment approaches as other tobacco users. However, programs and services do need to be tailored both behaviorally and pharmacologically to the specific needs of the client, their functionality, and usual treatment setting. Coordination among the key care providers is necessary so that tobacco cessation treatment can be integrated into ongoing treatment for MI/SUD. The availability of a referral network and/or partnerships between primary care providers, quitlines, tobacco treatment specialists, and mental health and substance use professionals is important to address the more complex needs of these tobacco users. With greater training and expertise of professionals within a specific program, there is less need to refer out for additional services.

RECOMMENDATION 3: USE RESULTS FROM A COMPREHENSIVE ASSESSMENT TO HELP TAILOR SERVICES

Determining how to tailor treatment services and what referrals/partnerships are needed for each client should be based on an initial individualized, detailed assessment. Professionals completing the assessment and treatment planning need to have adequate training to be prepared to complete the assessment questions and make appropriate treatment and referral decisions.

ASSESSMENT FOR TOBACCO TREATMENT PROFESSIONALS

The intake assessment should include questions regarding the client's mental health and substance use history. The emphasis for these questions is not to determine a diagnosis, but to assess current functional status and relative functional stability during previous quit attempts, and to identify potential referral needs. An assessment of current level of functioning and functioning at the time of any previous quit attempts can be a more informative guide for tailoring treatment than a diagnosis (See Section 4 for sample assessment questions.).

Clients are more likely to be successful and need less program tailoring if they are:

- Currently functioning adequately.
- Able to participate in treatment.
- Have a history of adequate functioning during previous quit attempts.
- Motivated.
- Ready to quit.
- Stable on any medications.

Those whose current level of functioning requires substantial support or who became less functional during a previous quit attempt may need more tailored and coordinated treatment management. These individuals may require additional monitoring by personnel with the clinical skills to assess levels of functioning and to monitor medications.

What is stable functioning?

Stable functioning of a client is defined by our Expert Advisory Committee as the absence of current acute major life or medication changes. In addition, the client is motivated and has support from care providers and others to quit. Stable functioning may be present while the client is recovering from other substance dependence, and such recovery should not delay attempts to quit smoking. Functional stability during a previous quit attempt means determining how well the client handled withdrawal, if there were any significant health or medication changes, any significant change in psychiatric symptoms or substance use, and the circumstances surrounding relapse.

ASSESSMENT FOR MENTAL HEALTH AND SUBSTANCE USE TREATMENT PROFESSIONALS

The intake assessment should include questions about present and past tobacco use, assessment of nicotine dependence, and an assessment of readiness to quit. Tobacco users with mental illness and substance use disorders may not know how to quit or have little prior quitting experience to draw upon. Assessing readiness to quit (questions usually included in typical tobacco intake assessments) is also important in tailoring tobacco treatment within MI/SUD services. Several toolkits that include appropriate assessment questions have been recently developed to assist MI/SUD professionals develop tobacco cessation treatment interventions within MI/SUD settings. Sample intake assessments and links to these toolkits can be found in Section 4.

RECOMMENDATION 4: PROVIDE CESSATION PHARMACOTHERAPY AND MONITOR PSYCHIATRIC MEDICATIONS CONCURRENTLY

Clients with MI/SUD are more highly nicotine dependent and will most often need cessation medications to manage withdrawal. Choice of medication should support any existing medication regimens and take the following into consideration: current/past MI/SUD history, client preference, previous levels of withdrawal when attempting abstinence from tobacco, the specific treatment environment, the treatment specialist's familiarity with cessation medications, availability of the medication to the client and the relative risk/benefit.

CESSATION PHARMACOTHERAPY

Dose level and duration of drug treatment will need to be tailored to individual needs. As recommended by the PHS Guideline, more dependent smokers, including those with psychiatric and substance abuse co-morbidities, may need higher doses of cessation medications, combination medications (e.g. nicotine patch + fast acting NRT such as nicotine gum or inhaler, NRT + bupropion) and for longer duration of treatment.³⁷ While increasing dose, combining medications, and lengthening treatment maybe clinically indicated, this has not been FDA approved. Clients should first discuss medication treatment options with their providers.

There are several other important considerations when treating clients with MI/SUD using bupropion or varenicline. History of bipolar symptoms should be assessed since bupropion can cause the onset of manic symptoms and is contraindicated. Experts have noted that tobacco users with alcoholism, eating disorders and substance use disorders have experienced difficulties such as agitation and seizures using burpropion and, while it is not contraindicated, it is not recommended. Smokers with HIV/AIDS on highly active antiretroviral therapy (HAART) do not receive the beneficial effects of the drugs due to smoking. Also, bupropion interferes with efficacy of protease inhibitors and other medications used by people with HIV/AIDS. Nicotine nasal spray is not recommended for people who abuse drugs intranasally. The safety of varenicline, the newest tobacco cessation medication, has not been well established for persons with mental illness. While our experts reported positive initial results with varenicline, there have been two recent reports suggesting a psychotic exacerbation in a person with schizophrenia and in a person with bipolar disorder who were taking varenicline.^{57,58} Additionally, post marketing adverse behavior and mood changes have been reported, but no casual links have yet been established.⁵⁹ A warning has been added to the varenicline package insert to monitor for psychiatric symptoms and report any symptoms to a healthcare provider. See chart in Section 4 for prescribing information.

PSYCHIATRIC MEDICATIONS

Psychiatric medications will need to be monitored and potentially adjusted for clients who significantly reduce or stop smoking. The tars in tobacco smoke can change the metabolism of a

variety of medications including some psychotropic medications. When tobacco users initially quit, their blood levels of these medications can rise, increasing the risk of adverse events seen with higher doses, even if dose levels remain constant.^{60,61}

Medications that Have Their Levels Affected by Smoking and Smoking Cessation ⁶²		
ANTIPSYCHOTICS	Chlorpromazine (Thorazine)	Olanzapine (Zyprexa)
	Clozapine (Clozaril)	Thiothixene (Navane)
	Fluphenazine (Permitil)	Trifluoperazine (Stelazine)
	Haloperidol (Haldol)	Ziprasidone (Geodon)
	Mesoridazine (Serentil)	
ANTIDEPRESSANTS	Amitriptyline (Elavil)	Fluvoxamine (Luvox)
	Clomipramine (Anafranil)	Imipramine (Tofranil)
	Desipramine (Norpramin)	Mirtazapine (Remeron)
	Doxepin (Sinequan)	Nortriptyline (Pamelor)
	Duloxetine (Cymbalta)	Trazodone (Desyrel)
MOOD STABILIZERS	Carbamazepine (Tegretol)	
ANXIOLYTICS	Alprazolam (Xanax)	Lorazepam (Ativan)
	Diazepam (Valium)	Oxazepam (Serax)
OTHERS	Acetaminophen	Riluzole (Rilutek)
	Caffeine	Ropinirole (Requip)
	Heparin	Tacrine
	Insulin	Warfarin
	Rasagiline (Azilect)	

RECOMMENDATION 5: TAILOR BEHAVIORAL TREATMENT

TREATMENT INTENSITY

More intensive behavioral treatment is often necessary to help clients with MI/SUD quit. More intensive treatment usually means more and sometimes longer sessions, particularly for higher functioning clients. For lower functioning clients, more sessions are often needed, but the sessions may need to be shorter and the content more focused and concrete. Compared to tobacco users in the general population, clients with MI/SUD may also need a longer preparation time prior to quitting. Preparation techniques such as discussing the pros and cons of reducing daily smoking and delaying the time between cigarettes may be needed before clients are ready to attempt significant reduction of smoking and quitting. This process could take a number of weeks or months before the client is ready to progress towards abstinence.

TREATMENT FLEXIBILITY

Behavioral treatment needs to be flexible enough to allow changes in the content of treatment and the schedule of appointments or meetings. Predetermined quit dates and follow-up schedules are often too limiting for this population. Clients may need more time to learn about tobacco use and to master adequate coping and quitting skills. Many tobacco dependence treatment services for a general population are based on the assumption that most clients who attend are ready to attempt total abstinence from tobacco in the first week or two. Lower functioning clients may have sufficient motivation to quit but lack confidence, self-efficacy, and the skills needed to quit on the same schedule.

TREATMENT APPROACHES

Motivational interviewing and skill development is currently a widely used approach to counseling for addictive behavior. Some of the aspects of motivational interviewing can also be helpful when working with these clients, especially those with substance use disorders. But, other aspects may be too open-ended for some clients with cognitive impairments. These clients may need a more concrete and directive approach with shorter, more specific steps. At the same time, many clients with serious mental illness are accustomed to learning and using an array of specific, personal behavioral survival skills to function in the broader community or in the treatment setting.

These can include such skills as:

- Basic self-care
- Social skills
- Time management
- Use of stress reduction techniques
- Enlisting support persons
- Knowing the importance of attending regular appointments
- Using medications faithfully
- Anger management
- Cognitive skills to envision life beyond smoking.

These same skills can also help clients develop greater self-efficacy for quitting and more hope about their eventual success. Learning, practicing, and internalizing concrete behavioral skills for quitting can be a natural extension of the skills acquisition process they have already developed and honed.

Clients with MI/SUD may participate in tobacco dependence treatment group programs geared to a broader population, but they may feel less welcome and/or feel misunderstood by other group members who do not share these disorders. Before recommending a group program, professionals may first need to assess whether clients are functionally able to benefit (e.g. able to participate in a group process for 1-2 hours). Additional attention by the group facilitator as well as an option for some one-to-one sessions outside the group time may be needed. On the other hand, tobacco users with experience in substance use disorders treatment programs and/or 12 Step recovery programs (e.g. Alcoholics Anonymous or Narcotics Anonymous) may be assets to the overall functioning of a tobacco treatment group since they are often familiar and comfortable with group treatment settings, group dynamics, and group process. They have also developed skills in making one life change that they can apply to becoming a non-smoker.

RECOMMENDATION 6: INCREASE TRAINING AND SUPERVISION FOR COUNSELING STAFF

Clinical training for tobacco treatment specialists is important. Any professional providing treatment for these populations will need to make treatment decisions, have more contact with healthcare providers, participate in case management, make referrals and help clients make connections between the different treatment services. In our survey, the approach to treatment loosely followed the type of background and professional discipline of the provider. The professionals interviewed who had little or no training in MI/SUD were more careful on the intake assessment when asking about symptoms and functioning. They were also more concerned about sensitivity issues and more likely to believe that asking questions about mental illness and substance use would be intrusive or offensive to their clients.

Professionals with more training and background in mental health and substance use were more comfortable in assessing symptoms and previous history. They were also careful to adhere

to the specific professional standards under their license, which helps protect the professional and helps ensure appropriate and ethical care for clients.

Professionals who had more clinical training reported that their clients were well aware of their problems and understood the need to have them discussed as part of the treatment plan. They added that when these issues are not discussed during the assessment, clients are not well served and the work to help them quit maybe undone. Further, not addressing these issues directly may inadvertently communicate that MI/SUD disorders should remain hidden. This, in turn, can have the unfortunate effect of reinforcing the stigma surrounding MI/SUD.

Increased and ongoing training and supervision is important for building skills and confidence for effectively addressing these issues and for improving treatment.