



BEA

Bringing *Everyone* Along

**RESOURCE GUIDE
SUMMARY**

FOR HEALTH PROFESSIONALS
PROVIDING TOBACCO CESSATION SERVICES FOR
PEOPLE WITH MENTAL ILLNESS
AND SUBSTANCE USE DISORDERS

January 2008

A project of the Tobacco Cessation Leadership Network

INTRODUCTION

The number of smokers who have mental health and substance use disorders (MI/SUD) is substantial. Many of these smokers lack basic information about the harm of smoking and benefits of quitting, are unaware of existing tobacco dependence treatment that can help them, and may have limited access to services that meet their unique needs. As more smokers with MI/SUD seek and are offered help, current treatment services will need to be adapted, and additional services added and promoted in order to better assist these smokers to quit.

The *Bringing Everyone Along Resource Guide* has been developed to assist an array of health professionals to adapt tobacco dependence treatment to the unique needs of smokers with mental illness and substance use disorders. These include:

- Tobacco dependence treatment program directors.
- Tobacco treatment specialists.
- Mental health and substance use treatment program directors.
- Mental health and substance use treatment specialists.
- Primary care providers.

The Resource Guide aims to be a practical resource based on existing research, insights and advice obtained through key informant surveys of professionals who serve these smokers, and the interpretation and recommendations of an Expert Advisory Committee. For a full copy of the Guide, visit www.tcln.org/bea.

This Summary highlights:

- Key findings and recommendations by the Expert Advisory Committee based on an analysis of the key informant surveys.
- Advice from the key informant surveys for adapting tobacco treatment for MI/SUD clients in: 1) tobacco dependence treatment programs available in the community, 2) tobacco quit lines, 3) mental health treatment programs, 4) substance use treatment programs, and 5) primary care settings. *(We did not have access to a database of primary care providers for the survey. Advice for primary care providers is based on the Public Health Service Clinical Practice Guideline 5A's and advice from health professionals in other settings.)*

We hope that the *Bringing Everyone Along Resource Guide* and *Summary* will serve to help health professionals begin to fill the gap between services available and services needed for smokers with mental illness and substance use disorders.

ABOUT MI/SUD

There is a spectrum of mental illness and substance use disorders that varies considerably by severity. All are overrepresented among smokers. Compared to a 20.6% smoking prevalence in the general population¹ it is estimated that prevalence is 35% for people with panic disorders, 49% for people with depression, 80% for people with alcohol dependence, and 88% for people with schizophrenia and bipolar disorder.² Professionals in every treatment setting will and regularly do encounter smokers with MI/SUD. All are likely to have difficulty quitting and will need more assistance.

ABOUT TERMS

Information for the Resource Guide has been synthesized from multiple disciplines. Each discipline uses somewhat different terms. "Client" is used here to identify patients of medical providers, consumers of mental health services, and clients of quitlines, tobacco treatment programs and substance use programs. The terms "mental illness and substance use disorders" (MI/SUD) are used together to include the spectrum of diagnoses.

The term "serious mental illness", as defined by the National Alliance on Mental Illness, includes major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.)

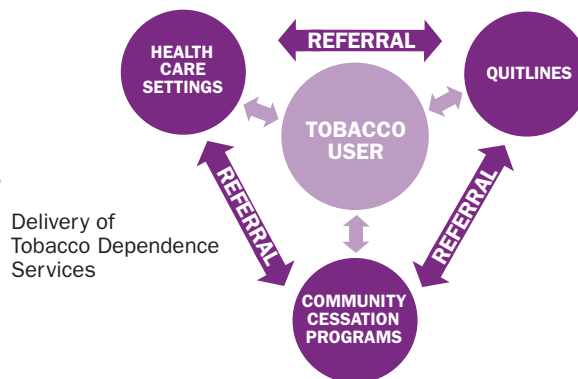
EXPERT ADVISORY COMMITTEE KEY FINDINGS AND RECOMMENDATIONS

KEY FINDINGS

Providing tobacco dependence treatment for people with mental illness and substance use disorders is more complex than for other tobacco users.

Tobacco dependence treatment for general populations:

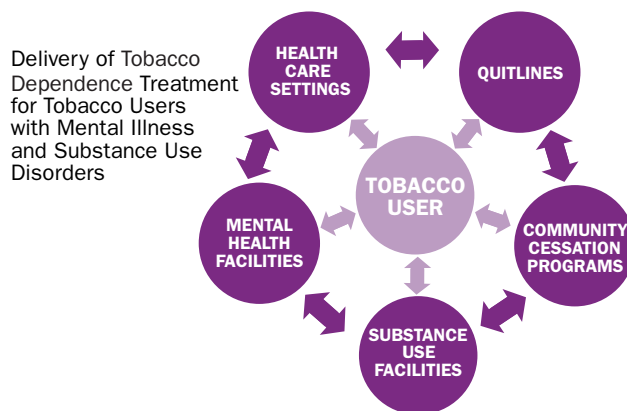
- Usually delivered in conjunction with health care at health care facilities, medical clinics/offices and hospitals, and through programs and services that tobacco users seek out (quitlines and community cessation programs).
- Services sometimes include referrals between these programs (e.g. health care to quitlines; quitlines to community cessation programs).
- Services vary by intensity from brief treatment, including simple advice to quit, prescriptions for medications and, often, referral to quitlines by primary care providers, to intensive treatment offered by trained tobacco treatment specialists.



Tobacco dependence treatment for people with MI/SUD

Determining where services are needed depends on the seriousness of the MI and treatment for SUD.

- People with serious and persistent MI and/or have a SUD problematic enough to require treatment, and have functional impairment:
 - Have very high rates of smoking,³ the highest average consumption of cigarettes,⁴ and the most difficulty quitting.
 - If receiving care, it is likely to be through mental health or substance use treatment facilities. Some may also receive care from a primary care provider.⁵
 - Need to have tailored tobacco dependence treatment integrated directly into their mental health or substance use care and, if needed, coordinated with primary care providers. Quitlines are not recommended for these smokers.
- People with MI/SUD and less functional impairment:
 - Are the largest proportion of MI/SUD clients.
 - If they receive care, it is likely to be in routine health care settings. Quitlines may be appropriate.
 - Have more difficulty quitting.
 - Need more intensive care than brief treatment common in routine health care.⁶ (Includes more 1) intensive follow-up, 2) medical management of both tobacco use and MI/SUD, and 3) monitoring of medications.)



All clients with MI/SUD need a more extensive and multi-disciplinary referral network to coordinate their treatment.

A significant gap exists in tobacco dependence treatment for MI/SUD.

- Few tobacco dependence treatment programs have been adapted for clients with MI/SUD.

- The number of tobacco treatment specialists trained to deliver complex interventions for MI/SUD clients is limited (see competencies for Tobacco Treatment Specialists at www.attud.org).
- Many MI/SUD treatment providers do not offer even brief treatment in facilities. When tobacco use is assessed, clients may be advised to quit but not receive assistance to quit.^{7,8,9}
- MI/SUD treatment programs have few trained staff in tobacco cessation and few referral networks exist.

SIX RECOMMENDATIONS

1. Change existing beliefs.

- Beliefs still exist among providers, clients, and family members that tobacco users with mental illness and substance use disorders don't want to or can't quit.
- There is ample evidence that clients with MI/SUD both want to and can quit.^{10,11,12,13,14,15}
- These beliefs serve as barriers to treatment, even preventing treatment from being offered.

2. Provide tailored and more intensive treatment programs.

- Evidence-based tobacco dependence treatment programs are effective for clients with MI/SUD.
- Programs and services need to be tailored both behaviorally and pharmacologically to the specific needs of the client and to their usual treatment setting (e.g. mental health or substance use facilities, community programs, primary health care).
- Coordinating care among the key care providers is necessary.
- Referral networks and/or partnerships between primary care providers, quitlines, tobacco treatment specialists, and mental health and substance use professionals are important for addressing the more complex needs of tobacco users with MI/SUD.

3. Use results from a comprehensive assessment to help tailor treatment services.

- Tailoring treatment services and referrals is based on an initial individualized, detailed assessment. (See complete Resource Guide for examples of comprehensive assessments at www.tcn.org/bea.)
- Treatment professionals need to be able to complete a comprehensive assessment and make appropriate referrals.

4. Recommend cessation pharmacotherapy; monitor psychiatric medications.

- Clients with MI/SUD are more highly nicotine dependent.
- Clients with MI/SUD should receive cessation pharmacotherapy to manage withdrawal, unless contraindicated.
- Stopping smoking changes metabolism resulting in changes in the effect of some psychiatric medications.
- Monitoring of both nicotine withdrawal and psychiatric symptoms is important. Dose adjustments may be needed.

5. Tailor behavioral treatment.

Clients with MI/SUD:

- Often need more intensive behavioral treatment, e.g. more sessions with more frequent and longer term follow-up, and with content and pacing adjusted for functional level.

WHAT IS STABLE FUNCTIONING?

Our Expert Advisory Committee defined stable functioning as the absence of current acute major life or medication changes. In addition, the client should be motivated and have support to quit from care providers and others. Stable functioning may be present while the client is recovering from other substances, 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.

- Often need a longer preparation time prior to quitting. Clients may need more time to learn about tobacco use and quitting, and to master adequate quitting and coping skills.
- Need program flexibility; fixed quit dates and follow-up schedules may be too structured.

6. Increase training and supervision for counseling staff.

- The Bringing Everyone Along key informant survey of tobacco cessation professionals shows that:
 - Professionals with more MI/SUD training were more comfortable and confident in assessing functionality, symptoms, and previous history and making treatment recommendations.
 - Professionals with little or no MI/SUD training were more careful in how they asked assessment questions, were more concerned about being too intrusive or offensive to their clients, and were more likely not to discuss the effect of MI/SUD on tobacco cessation efforts.
- To provide quality care for tobacco users with MI/SUD, many tobacco cessation professionals will need to have increased training on screening for a history and symptoms of MI/SUD, assessing client functional stability, making some treatment decisions, coordinating care with healthcare providers, participating in case management, making referrals, and helping clients make connections between treatment services.

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Advice for Tailoring Services by Treatment Setting: At-A-Glance Summary*

Program area	Tobacco Dependence Treatment Programs	Tobacco Quitlines	Mental Health Treatment Programs	Substance Use Treatment Programs
Intake and Assessment*	<ul style="list-style-type: none"> • Presence of MI/SUD assessed indirectly through assessment of meds and observation of behavior. • Normalize use of substances in intake process to increase comfort in disclosing (not “if” but “how much.”) • Direct questions recommended; more possible with training. • Need multiple formats to help tailor to client. • Need to coordinate with PCP or mental health provider for medication management. • Cessation pharmacotherapy essential. 	<ul style="list-style-type: none"> • Can assess MI/SUD indirectly through verbal cues or med use. • Direct questions recommended • Training on MI/SUD is needed. • Need to establish that quitline is not mental health provider. • Important to determine MI/SUD stability before proceeding. • Important to link client with current provider for medication management. • Cessation pharmacotherapy essential. 	<ul style="list-style-type: none"> • Add tobacco use and dependence questions to existing intake process. • Determine readiness to quit or next step – many not ready to quit. • Normalize use of substances in intake process to increase comfort in disclosing (not “if” but “how much”). 	<ul style="list-style-type: none"> • Add tobacco use and dependence questions to existing intake process. • Determine readiness to quit or next step – many not ready to quit. • Normalize use of substances in intake process to increase comfort in disclosing (not “if” but “how much”).
Developing Treatment Plan	<ul style="list-style-type: none"> • More sessions help; longer follow-up. • Option for flexible quit date – may need more preparation. • Content more flexible. • Build confidence with smaller steps. • Supplement group time with individual sessions for more support. 	<ul style="list-style-type: none"> • Treatment plan needs to be more concrete and focused if clients are functionally impaired. • Open-ended facilitative questions (often used with Motivational Interviewing) are less helpful for lower functioning clients. • May need more, shorter and more frequent follow-up calls. 	<ul style="list-style-type: none"> • Treatment plan is tailored to include tobacco at stage of readiness. • Treatment may need to begin with information and preparation. • Education about metabolic effects of quitting on medications needs to be included. • Cessation pharmacotherapy essential. 	<ul style="list-style-type: none"> • Outpatients programs: services offered; interest/acceptance – based on readiness to quit. Can provide concurrently with SUD treatment. • Provide Motivational Interviewing to move to next step if not yet interested. • Add tobacco dependence treatment to residential treatment if smoke-free. • Provide education on nicotine dependence – new info and counter to conventional SUD treatment (may leave out tobacco) and help identify support.
Treatment Approach and Follow-up	<ul style="list-style-type: none"> • Additional training is important. • Background in addiction or behavioral health improves comfort of treatment specialist and outcomes. 	<ul style="list-style-type: none"> • Treatment from case manager or refer to tobacco specialist – individual or group program; also wellness groups. • Need more than quitline services. • First priority is MH stability. • More extensive preparation needed (incremental steps) – based on readiness. • Reduced smoking more common than abstinence. • Smoke-free policies support cessation and reduction. • More support and longer follow-up. 	<ul style="list-style-type: none"> • Provide individual counseling + group support. • Need more than quitline services. • Aggressive cessation pharmacotherapy may be needed. • Long-term support is important for some. • Smoke free policies in treatment facilities help support cessation. 	<ul style="list-style-type: none"> • Provide individual counseling + group support. • Need more than quitline services. • Aggressive cessation pharmacotherapy may be needed. • Long-term support is important for some. • Smoke free policies in treatment facilities help support cessation.
Written Materials	<ul style="list-style-type: none"> • May not be very helpful to clients, are infrequently used. • If used, must be simple and concrete. 	<ul style="list-style-type: none"> • Infrequently used by clients, value to them is uncertain. • Therapeutic relationship more important than materials. 	<ul style="list-style-type: none"> • Sometimes used to help with learning. • Need to be appropriate to level of functioning. 	<ul style="list-style-type: none"> • All types of materials widely used, except those produced from the tobacco industry. • Need range of language and literacy needs. • Include family (likely also smokers).
Training and Supervision	<ul style="list-style-type: none"> • Additional training is important. • Background in addiction or behavioral health improves comfort of treatment specialist and outcomes. 	<ul style="list-style-type: none"> • Special training on tobacco treatment and help to quit for staff is important. • Belief in benefit of quitting is very important. 	<ul style="list-style-type: none"> • Additional training and continuing ed in tobacco dependence important. • Belief in benefit of quitting important. • Clinical supervision + team meetings and case review. 	<ul style="list-style-type: none"> • Additional training and continuing ed in tobacco dependence important. • Belief in benefit of quitting important. • Clinical supervision + team meetings and case review.

MH-mental health; SUD – substance use disorder; PCP – primary care provider

*See full Resource Guide for details at www.tcn.org/bea

ONLINE RESOURCES

TOOLKITS

Smoking Cessation for Persons with Mental Illness: A Toolkit for Mental Health Providers (2007). Developed by the University of Colorado at Denver and Health Sciences Center, funded by the Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership (STEPP), Colorado Department of Public Health and the Environment. To order copies visit www.steppitems.com

Tobacco-Free Living in Psychiatric Settings: A Best-Practices Toolkit Promoting Wellness and Recovery (July 2007). Developed by the National Association of State Mental Health Program Directors (NASMHPD). Provides practical tips for converting facilities to smoke-free status. Available at: www.nasmhpd.org/general_files/publications/NASMHPD.toolkit.FINAL.pdf

CONSUMER INFORMATION

Quitting for Good. An informative article published by www.schizophreniadigest.com. Available at: www.njchoices.org/smokingforschizophreniadigest.pdf

Facts about Smoking and Mental Health Disorders (2007). Tobacco Cessation Leadership Network. Available at: www.tcln.org.

Smoking and Mental Illness (2006). Fact sheet developed by SANE. SANE Australia is a national charity working for a better life for people affected by mental illness - through campaigning, education and research. Available at: www.sane.org/information/factsheets/smoking_and_mental_illness.html

Williams JM, Ziedonis DM, Speelman N, Vreeland B, Zechner M, Rahim R, O'Hea E. *Learning about Healthy Living: Tobacco and You Manual*. Revised June 2005. Supported by a grant from the NJ Division of Mental Health Services. Available at: <http://rwjms.umdnj.edu/addiction/LAHL.htm>

Key Assistance Report, Focus on Smoking Cessation (Date Posted: March 27, 2007). National Mental Health Consumers' Self-Help Clearinghouse. The Clearinghouse is supported by a grant from the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration, and the Center for Mental Health Services. Available to download from the Clearinghouse website at: www.mhselfhelp.org.

You CAN Quit: Tips for Preparing to Quit (2007). A brochure that educates persons with mental illnesses about the dangers of smoking. Developed by the University of Colorado at Denver and Health Sciences Center and funded by the Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership (STEPP), Colorado Department of Public Health and the Environment. Available at: www.steppitems.com.

You CAN Quit (2007). A poster that educates persons with mental illnesses about the dangers of smoking. Developed by the University of Colorado at Denver and Health Sciences Center and funded by the Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership (STEPP), Colorado Department of Public Health and the Environment. Available at: www.steppitems.com.

WEBSITES

Consumers Helping Others Improve their Condition by Ending Smoking (CHOICES). The goal of this consumer driven organization is to increase awareness of the importance of addressing tobacco use and to create a strong peer support network that encourages mental health consumers to make a positive healthy lifestyle change by addressing smoking and tobacco use. www.njchoices.org/index.htm.

Program for Research in Smokers with Mental Illness (PRISM). This research program is directed towards understanding reasons for the high rates of tobacco use among individuals with major psychiatric disorders. Website: <http://prism.yale.edu/>.

Smoking Cessation Leadership Center (SCLC). The SCLC website provides a list of mental health resources. To view these resources and learn about the SCLC's Mental Health Partnership for Wellness and Smoking Cessation, go to: <http://smokingcessationleadership.ucsf.edu/>.

New York State Tobacco Dependence Resource Center aims to provide New York's chemical dependency service providers, policy makers, and researchers with cutting-edge scientific resources and support on integrating tobacco dependence interventions into chemical dependency treatment. You will first have to register to obtain these resources. Website: www.tobaccodependence.org/.

North American Quitline Consortium (NAQC). The NAQC website provides information about quitline services available in all 50 states, the District of Columbia, Canada, and Mexico. www.naquitline.org.

UMDNJ Tobacco Dependence Program (TDP) The tobacco dependence program is dedicated to reducing the harm to health caused by tobacco use. Website: www.tobaccoprogram.org.

VIDEO

Smoke Alarm: The Truth About Smoking and Mental Illness (2007): The New York State Department of Health funded a project conducted by the Clubhouse of Suffolk, Inc., a private not-for profit psychiatric rehab agency to tailor intervention for patients who struggled with tobacco addiction. The outcomes of the project are documented in the video. Contact Lindsey von Busch at 732-288-0629 to obtain a copy.

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PARTICIPATING ORGANIZATIONS

Tobacco Cessation Leadership Network

The mission of the Network is to help increase the capacity in every state to establish effective, sustainable, and affordable cessation services to help tobacco users quit and stay quit. We seek to do this by linking state and national cessation leaders together to share information, resources and strategies, thereby enabling programs in each state to become more comprehensive and successful. www.tcln.org.

Association for Treatment of Tobacco Use and Dependence (ATTUD)

ATTUD is an organization of providers dedicated to the promotion of and increased access to evidence-based tobacco treatment for the tobacco user. www.attud.org.

North American Quit Line Consortium

The North American Quitline Consortium (NAQC) seeks to unite health departments, quitline service providers, researchers and national organizations in the United States and Canada to enable these quitline professionals to learn from each other and to improve quitline services. www.naquitline.org.



Tobacco Cessation
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