



**New Initiatives for Reaching
Smokers with Mental Illnesses**

**Tobacco Cessation Leadership Network
Roundtable Discussion**

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The Colorado Model

- ◆ 2004 & 2006 Statewide Focus Groups
 - ◆ State administrators, providers, consumers
- ◆ Prevalence Studies
- ◆ Toolkit for Mental Health Providers
 - ◆ To be disseminated statewide
- ◆ Wellness Group Manual
- ◆ Randomized Study of Cessation Strategies
 - ◆ Partnership with National Jewish
- ◆ Peer-to-Peer Interventions



Persons with Mental Illnesses: Prevalence of Tobacco Use

- ◆ Based on sample of ~112,000, Colorado prevalence of tobacco use varies by diagnosis (Morris et al, 2005):
 - ◆ Schizophrenia = 62%
 - ◆ Schizoaffective = 57%
 - ◆ Bipolar = 51%
 - ◆ Depression = 36%
 - ◆ Anxiety = 32%



What Do We Know about Persons with Mental Illnesses?

- ◆ They can successfully quit (Evins et al., 2005; George et al., 2002).
- ◆ They want to quit and want information on cessation services and resources (Morris et al, 2006).
- ◆ They often require more quit attempts before achieving successful cessation.
- ◆ NRT or bupropion SR in combination with individual or group counseling that employs Motivational Interviewing or Cognitive-Behavioral strategies are most effective
 - ◆ (Note: bupropion SR should be used with caution for persons with bipolar disorder).
- ◆ They need to be monitored for more severe nicotine withdrawal, exacerbation of their psychiatric disorder (especially depression), and possible side effects due to cessation-induced increases in medication levels.



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



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, el-Guebaly, Campbell, Hodgins, & Addington, 1998; Baker et al., 2006)



Mental Health Provider Toolkit

- ◆ Assessment and Intervention Planning
- ◆ Readiness to Quit and Stages of Change
- ◆ Cultural Considerations
- ◆ Smoking and Psychiatric Illness: Nicotine Effects and Other Considerations
- ◆ Smoking Cessation Treatment for Persons with Mental Illnesses
- ◆ Behavioral Interventions for Smoking Cessation
- ◆ Prescribing Cessation Medications
- ◆ Relapse Prevention
- ◆ Local and National Tobacco Cessation Resources
- ◆ Toolkit References
- ◆ Literature Review

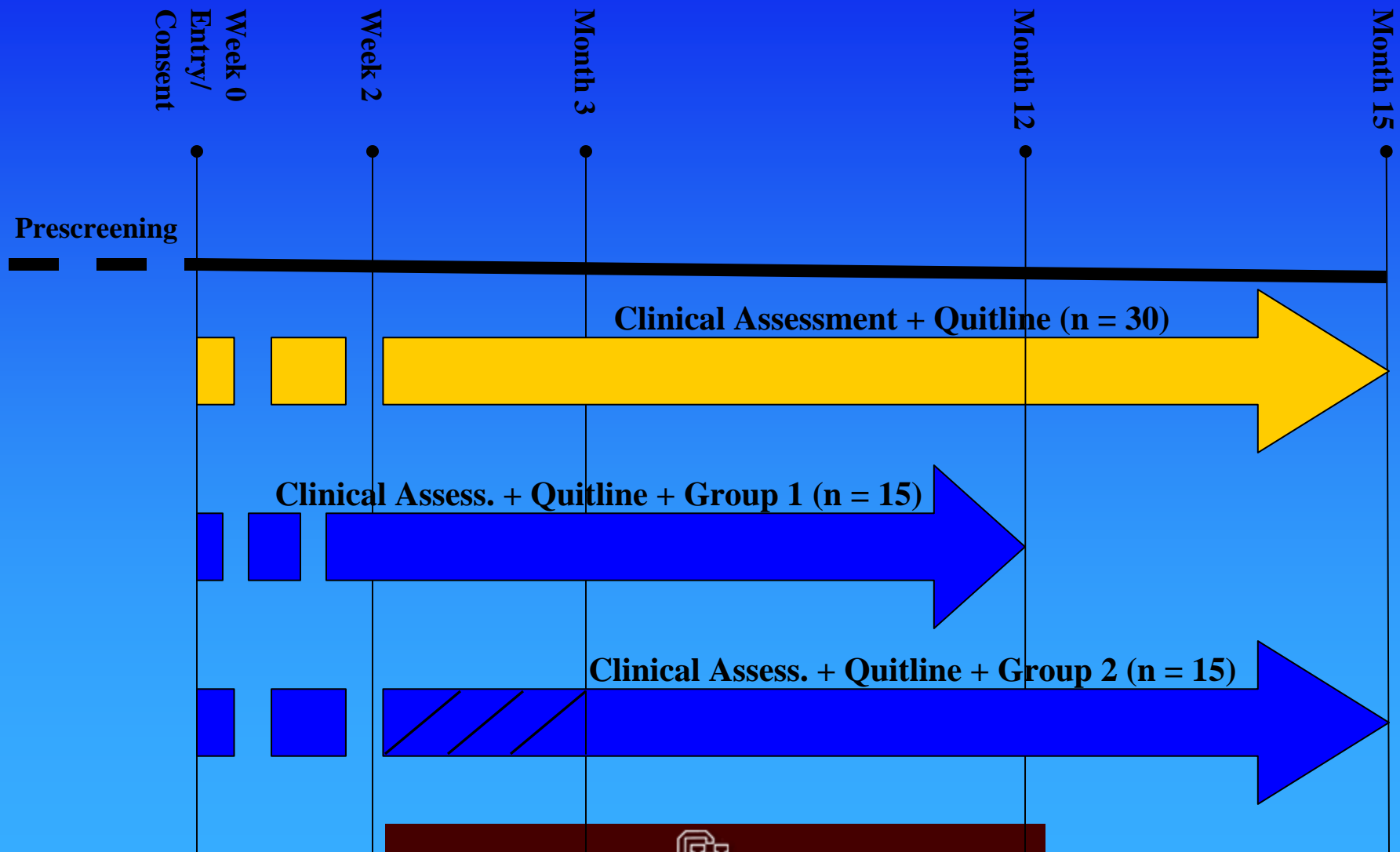


Rationale for Tobacco Interventions in Mental Health Settings

- ◆ Consumers who smoke have higher levels of nicotine dependence
- ◆ Smoking may alleviate negative symptoms, cognitive dysfunction, medication side effects
- ◆ The primary care sector is typically not equipped to address this population's needs



The Study Intervention (N = 240)



Wellness Group

- ◆ Based on the Australia SANE model for tobacco cessation for persons with psychotic disorders
- ◆ Based on Motivational Interviewing and Cognitive Behavioral Techniques
- ◆ 10 sessions / group format
- ◆ Structured framework with homework activities



Partnering with Quitlines: Training

- ◆ Introduction to mental illnesses
- ◆ Unique challenge tobacco presents for persons with mental illnesses
- ◆ Evidence-based guidelines and treatment
- ◆ Cessation study
- ◆ Dialogue around the issues Quitline staff face
- ◆ Ongoing Consultation



Communication Strategies for Quitline Staff

- ◆ Rapport
 - ◆ Validating
- ◆ Roles
 - ◆ Defining responsibility
- ◆ Rules
 - ◆ Structure upfront
 - ◆ Agenda and next steps
- ◆ Redirecting
 - ◆ Concrete, specific direction
 - ◆ Achievable steps
- ◆ Reminding
 - ◆ Positive reinforcement
- ◆ Referring
 - ◆ Internal / external



Thoughts on Moving Forward in Other Settings



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Barriers Include Stigma and Provider Beliefs

- ◆ Providers often think that persons with major mental illnesses are unable to quit smoking.
- ◆ Symptom management often takes precedence over preventive health measures.
- ◆ Competing demands.

"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

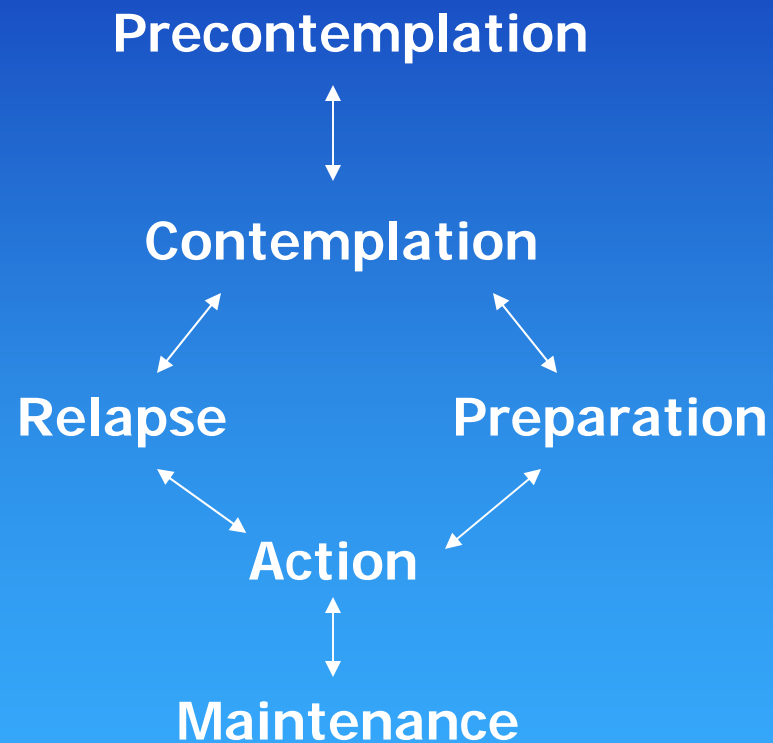


Other Barriers

- ◆ Lack of Provider Knowledge
- ◆ Uncomfortable with Mental Health Issues
- ◆ Liability Concerns
- ◆ Medication Complications
- ◆ Psychosocial Issues



Organizational Readiness for Change



Chronic Care Management

- ◆ Organizational Changes
 - ◆ Organizational commitment to tobacco cessation
 - ◆ Identification of community champions
 - ◆ Commitment to a smoke-free environment
 - ◆ Cessation opportunities for staff
 - ◆ Information feedback loop

- ◆ Delivery System Redesign
 - ◆ Optimal configuration of cessation services

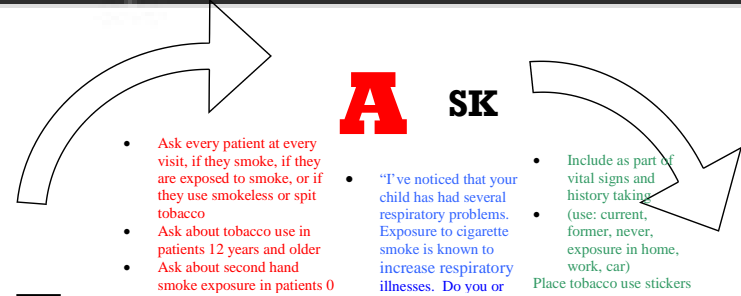
- ◆ Patient Self-Management
 - ◆ Manualized patient skills development
 - ◆ Individualized care management plan
 - ◆ Telephonic and/or face-to-face support and education
 - ◆ Psychoeducational groups



Chronic Care Management

- ◆ Clinical Information Systems
 - ◆ Real-time data collection and processing
 - ◆ Delivered in a way the provider finds most useful
- ◆ Decision Support through Expert Guidance
 - ◆ Tobacco cessation toolkit
 - ◆ A menu of reasonable options
 - ◆ Provider training
 - ◆ Ongoing technical assistance/ consultation
- ◆ Community Resource Mobilization
 - ◆ Specific role function
 - ◆ Linkage to community resources and partnerships





ASK

- Ask every patient at every visit, if they smoke, if they are exposed to smoke, or if they use smokeless or spit tobacco
- Ask about tobacco use in patients 12 years and older
- Ask about second hand smoke exposure in patients 0
- "I've noticed that your child has had several respiratory problems. Exposure to cigarette smoke is known to increase respiratory illnesses. Do you or
- Include as part of vital signs and history taking (use: current, former, never, exposure in home, work, car)
- Place tobacco use stickers

ARRANGE

- Assess smoking status at subsequent visits and, if the patient continues to smoke
- Ask every patient
- Ask every patient

ADVISE

- Strongly urge all tobacco users to quit
- Encourage reduction in exposure to second hand smoke
- "The most important thing you can do for your health is to quit smoking."
- "I highly recommend that you smoke outside to protect your child's health."

ASSESS/AGREE

- Assess readiness to quit within 30 days
- "Are you ready to quit within the next 30 days?"
- "Are you willing not to smoke in the house or car?"
- Have fax referral forms to the QuitLine in the exam room

ASSIST

- Ask every patient
- Zg l a r o b o a b (reverse side)
- Zg l a r o b o a b (reverse side)

This guideline is designed to aid the practitioner in addressing tobacco cessation and reduction of second hand smoke exposure within a planned care model- that of approaching tobacco use as a chronic condition, prone to relapse. Engagement of the patient within a supportive medical practice that uses a team approach will result in the most successful outcomes. Each element of the 5 A's model has 3 parts: the updated guideline, phrases for the clinician to use, and tips on how to integrate this guideline into everyday clinical work.

REFER

COLORADO QUITLINE
800.639.QUIT

To Order An Office Toolkit:

- Alksjdf;laksd;ghwqljg;ija s;ldjg;olij

For SHS Guidelines:

- Alksjdf;laksd;ghoiwqljg;ijas;ldjg;olijj

References:

- Asldckjf;slkdfowiajlkwej
- :lkajsd;l;foiwukj;ij;lkj;kjlk

Other topics:

- Asldckjf;slkdfowiajlkwej

Practice improvement ideas:

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www.coloradoguidentines.org

www.coloradoinstruct.org

www.cdphe.state.co.us/pp/tobac





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