



Bringing *Everyone* Along  
Expert Advice for Providing Services for  
Tobacco Users with Mental Illness  
and Substance Use Disorders

**April 16, 17:**

**Clinical Solutions for Providing Tobacco  
Dependence Treatment for People with  
Mental Illness and Substance Use Disorders**

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## Presenters

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# Acknowledgements

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# Today's Objectives

- Learn about the unique tobacco treatment needs for persons with mental illness and substance use disorders (MI/SUD)
- Learn clinical solutions for assisting tobacco users with MI/SUD
- Learn quitline solutions for assisting tobacco users with MI/SUD
- Answer questions

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# Providing Tobacco Dependence Treatment: MI/SUD Fundamentals

- Demonstrated interest in quitting across populations
- Smoking cessation rarely jeopardizes stability of primary disorder or recovery
- Similar treatment/relapse prevention techniques

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# Intake Assessment Recommendations

- Past/current history of MI treatment and SUD recovery
- Current health history including medications
- Current life situation
- Social supports
- Tobacco use history
  - Determine current interest in quitting
  - If interested; determine readiness to quit

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## Assessment of MI/SUD: Direct or Indirect?

- Direct questions yield best information
  - Additional training may be needed to increase skills and comfort asking questions
  - Yields best treatment recommendations
- Indirect questions (e.g. cued from list of medications) can lead to information but can also miss information
  - Treatment recommendations may not be appropriate
  - May overlook problems that increase relapse rates

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# Determining Readiness to Proceed: Motivation and Stability

## ■ Motivation

- “Interested” is sufficient
- Don’t rule out initiating some type of intervention if not motivated to quit now

## ■ Stability

- Need to be psychiatrically stable-do not need to be in full remission
- No major medication changes
- No major life changes
- No active intoxication/withdrawal; consumer/client in recovery process

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# Unique Tobacco Treatment Needs

- Determine need for involvement from primary care/other health care providers
- Determine need for more intensive behavioral therapy
- Address psychotropic medication issues
- Tailor treatment plan based on
  - Current stability of symptoms/recovery
  - Functional status
  - Current psychotropic medications
  - Previous quit history

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# Treatment Planning Recommendations

- Plan tailored to stage of readiness
  - Wellness approaches for consumers/clients less stable or not ready to try quitting
  - Preparation techniques for consumers/clients who are interested in quitting
  - Reduced smoking/flexible quit dates for consumers/clients who are ready to try quitting
- Plan tailored to level of impairment
  - Quitline referral + pharmacotherapy for consumers/clients with little functional impairment
  - Cognitive behavioral therapy + pharmacotherapy for consumers/clients with greater functional impairment

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# Pharmacotherapy Principles for Tobacco Dependence Treatment in MI/SUD

- All smokers trying to quit should receive pharmacotherapy (PHS Clinical Practice Guideline)
- Dose level and duration of drug treatment individualized
- Many will need
  - Higher doses
  - Combination treatments
  - Longer duration of treatment

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# Pharmacotherapy Guidance

- Nicotine replacement therapy (NRT)
  - NRT alone rarely sufficient treatment
    - Many smokers may require higher dose (42 mg)
    - Choice of agent is primarily driven
      - patient preference
      - word-of-mouth
      - advertising
      - price
      - route of administration
      - perceived adverse effects

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# Pharmacotherapy Guidance

- ❑ Nicotine patches/CBT effective for smokers with Schizophrenia
- ❑ NRT/CBT effective for smokers with PTSD
- ❑ NRT/CBT has mixed results for smokers with Major Depression
- ❑ Efficacy of NRT in SUD enhanced by the inclusion of behavioral interventions

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# Pharmacotherapy Guidance

## ■ Bupropion (BUP)

- ❑ Effective in smokers with Major Depression but relapse high when treatment discontinued
- ❑ BUP not appropriate as only medication in Anxiety disorders
- ❑ Effective in smokers with PTSD (limited evidence)
- ❑ Effective in smokers with Schizophrenia but relapse high when treatment discontinued
- ❑ Limited published data on effectiveness in SUD

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# Pharmacotherapy Guidance

- Bupropion (BUP)
  - Contraindicated in seizure and eating disorders
  - Not recommended
    - Alcohol abuse/dependence
    - Bipolar disorder
    - Extended sleep deprivation
    - Past head trauma
  - Interferes with efficacy of protease inhibitors used for HIV/AIDS treatment

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# Pharmacotherapy Guidance

## ■ Varenicline

- Anecdotal reports of effectiveness for MI/SUD
  - One study in UK; positive results
  - Gap in the varenicline evidence base
- Post marketing adverse behavior and mood changes
  - Have been reported in all samples
  - Causal links have not yet been established
- Providers need to closely monitor mental status of anyone quitting smoking on varenicline

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# Pharmacotherapy Guidance

- Smoking induces CYP1A2 isoenzyme
- Approximately doubles clearance of
  - **Antipsychotics:**  
fluphenazine, haloperidol, olanzapine, clozapine, chlorpromazine
  - **Antidepressants:**  
amitriptyline, nortriptyline, imipramine, clomipramine, doxepin, fluvoxamine
- Cessation may produce rapid, significant increase in blood levels
- Need to monitor for increased side effects

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# Follow-up Guidance

- Variables predicting success
  - Compliance with psychotropic medications
  - Perceived ability to quit
- If non-adherence is related to instability, it is probably not the right time to quit
  - Need to address issues contributing to instability
  - Make sure treating tobacco is always included in Wellness planning for the future

# Clinical Monitoring Recommendations<sup>1,2</sup>

1. Patients should be seen 1 to 3 days after initiating smoking cessation
2. Monitor weekly for the 1st four weeks for MI/SUD relapse and the need to adjust medication levels
3. After 1st month, monthly review is suggested for 6 months
4. Communication between the primary care provider and mental health provider should occur
  1. During the initiation of the cessation attempt
  2. During the cessation period if any psychiatric complications occur

<sup>1</sup> Strasser, K., Moeller-Saxone, K., Hocking, B., Stanton, J., & Kee, P (2002). Smoking cessation in schizophrenia. General practice guidelines. Australian Family Physician, 31, 21-24. <sup>2</sup> Provincial Health Services.(2006). Tobacco reduction in the context of mental illness and addictions: A review of the evidence. Centre for Addiction Research of British Columbia



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Questions?

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# Treating Persons with MI/SUD on Quitlines

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# Quitlines

- Quitlines in the US collectively serve about 400,000 tobacco users a year.
- Quitlines represent a public health model of tobacco dependence treatment.
- Quitlines can act as a bridge between public health and clinical models
- Quitline counselors help callers devise an individualized plan to prepare to quit and, in many cases, make proactive follow-up calls for relapse prevention.

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## Quitline & MI/SUD callers

- Significant numbers of tobacco users with MI/SUD are calling quitlines.
- Quitlines are best able to help clients who are symptomatically stable and without functional impairment.

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# Comorbidity in Quitline Callers

- Depressive disorder
- Anxiety disorder
- Bipolar disorder
- Thought disorder
  - e.g., Schizophrenia
- Post traumatic stress disorder (PTSD)
- Other chemical abuse/dependency
  - e.g., Drug, alcohol

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# Prevalence of Comorbid Conditions Among Quitline Callers

- Not typically assessed at Quitlines
- Some idea of prevalence from California Smoker's Helpline (CSH) callers:
  - Percentages for related issues
  - Preliminary data from depression assessment

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## During an earlier CSH study.....

- 25% CSH smokers reported having been in counseling or recovery programs.
- Almost 15% CSH smokers reported taking some kind of psychotropic medication.

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## During a recent CSH study.....

- 25% smokers met the criteria for Major Depressive Disorder (MDD) using the PHQ-9.
- 70% of callers have at least mild depressive symptoms.
- 31% are currently in therapy and/or taking medication for depression
- 42% have been diagnosed by a health care provider as depressed in the past year

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# Key Questions

- Should we assess every smoker who calls for MI/SUD?
- What questions should we ask?
- What should we do with the answers?

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# Should We Assess Every Smoker?

- Persons with mental illness & substance abuse disorders:
  - smoke at higher rates than the general population
  - are at higher risk for tobacco related illness
  - present for treatment in substantial numbers
  - may not report psychiatric health issues

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# What Questions Should We Ask at Intake?

- Some quitlines ask **direct** questions about MI/SUD history.
  - “Do you have any mental health or emotional issues that might impact quitting.”
- Some quitlines assess **indirectly** during counseling part of call.
  - “Are you taking medications for any reason?”
  - “Do you attend meetings or counseling of any kind?” (Professional support or recovery programs).

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# What Should We Do With the Answers?

- Further assessment
  - Appropriateness of client for quitline setting
- Client contact with prescribing MD
  - Refer back to the primary physician
- Professional support & referral
  - Will often have to help clients identify support in their local area

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# Treatment Considerations

- Is the quitline an appropriate setting?
  - Level of functioning
  - Concurrent psychiatric treatment
- If yes, provide cessation treatment
  - Client contact with prescribing physician
  - Clinical supervision
- If no, provide referral for mental health treatment
  - Proactive follow-up
  - Reassessment

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# Treatment Protocols

- Quitlines adapt protocols to needs of MI/SUD clients.
- Some quitlines have more formal protocols and others informally adapt existing protocols:
  - Assess psychiatric stability/level of functioning
  - Review quitting history & symptoms
  - Discuss biochemical factors
  - Adapt counselor style
  - Vary call content, length & frequency

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# Treatment Protocols (cont.)

- Other considerations:
  - Deliver shorter calls, with more concrete content and smaller steps toward change.
  - Directly confer with current provider on treatment plan.
  - Recommend clients consult with providers before continuing in treatment.
  - Encourage use of pharmacotherapy as recommended in combination with other medications and behavioral treatment.
  - Limit use of written materials
  - Provide referrals as needed.

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# Quitline Innovations

- **Specialized protocol**
  - American Society of Addiction Medicine (ASAM) assessment is completed at intake
  - Counselor assigns low, medium or high rating and determines level of care in a 3-step care model
- **Quitline as a portal to other services**
  - Primary care and/or mental health provider
  - Mental health providers with expertise in addiction
  - Addiction medicine physicians
  - Referral lists for services in local area

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# Conclusion

- Clients with psychiatric health issues call Quitlines.
- Clients with psychiatric health issues have different levels of functioning.
- Quitlines can serve this clientele based on client level of functioning & local professional support:
  - Full protocol
  - Single session and referral
  - Referral

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Bringing Everyone Along

[www.tcln.org/bea](http://www.tcln.org/bea)

Next call: May 1

