SMOKING & MENTAL ILLNESS
Addressing Myths and Barriers

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- NIMH R01
- NIDA P50 Component
- NIDA R34
- TRDRP Pilot CARA, Research Award
- Pfizer Investigator Initiated Research Award
The Death of a 56-Year-Old Man With Serious Mental Illness

- A 56-year-old, gay-identified Caucasian man
- >15 psychiatric hospitalizations over a 10-year span
- Severe depressive symptoms, suicidal ideation, and auditory hallucinations criticizing him and/or commanding him to commit suicide
- Tested positive for stimulants
- Diagnosed with schizoaffective disorder, major depression with or without psychotic features, posttraumatic stress disorder, and polysubstance or stimulant dependence

The Death of a 56-Year-Old Man With Serious Mental Illness

* Smoked 2 packs of cigarettes per day for 25 years
* 10 attempts to quit smoking, 2 in the past year
  * Each attempt was unassisted, without clinical support or use of FDA-approved cessation medications
* Longest period of being tobacco-free was 7 days
* No advice to quit smoking in the past year by a mental health or general medical provider

Died 20 years prematurely from complications of pulmonary emphysema due to smoking

Graph provided by the Centers for Disease Control and Prevention. 1955 Current Population Survey; 1965–2010 NHIS. Estimates since 1992 include some-day smoking.

19.3% of adults are current smokers

21.5% 17.3%

70% want to quit
SMOKING PREVALENCE by PSYCHIATRIC DIAGNOSIS

Source: Lasser et al., 2000 JAMA

National Comorbidity Survey 1991-1992

41.0% Overall

Panic Disorder
PTSD
GAD
Dysthymia
Major Depression
Bipolar Disorder
Nonaffect Psychosis
ASPD
Alcohol Abuse/Dep
Drug abuse/dep

- National Comorbidity Survey, Lasser et al. JAMA 2000
  - 1991-1992: 41%

- Healthcare for Communities survey, Ong et al. AJPH 2010
  - 2000-2001: 44%

- National Survey of American Life, Hickman et al. NTR 2010
  - 2001-2003: 45%

- CDC Vital Signs MMWR, 2012
  - 2009-2011: 36%
Sung, Prochaska, Ong et al. (2011) NTR
SMOKING in PSYCHIATRY: ADULTS in SAN FRANCISCO, CA

County Psych Inpatient: 60%
Private Psych Inpatient: 45% (M=21, SD=15)
Private Psych Outpatient: 28% (M=17, SD=12)
SF Adults: 14% (M=15)

Acton, Prochaska, Kaplan, Small & Hall. (2001) Addict Behav
Post-Mortem Study with Young Adults in Finland (N=1623)

Smoking Prevalence in Finland 18.6%

Launiainen et al. (2011) NTR
Menthol Use & Serious Mental Distress: National Sample

* 2008-2009 National Survey on Drug Use and Health (NSDUH)
* 24,157 adult smokers
* Severe psychological distress associated with menthol use: adj-OR = 1.23, p=0.02
  * Controlling for sociodemographic factors: ethnicity, SES, gender, age, education, marital, health insurance, cpd

Hickman, Delucchi, Prochaska (in press) Tobacco Control
Menthol Smoking in Two Adult Psychiatric Samples & the US

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>NSDUH (US)</th>
<th>County Psych Hosp</th>
<th>Private Psych Hosp</th>
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<tr>
<td>African Amer</td>
<td>82%</td>
<td>37%</td>
<td>67%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>82%</td>
<td>37%</td>
<td>66%</td>
</tr>
<tr>
<td>Latino</td>
<td>70%</td>
<td>30%</td>
<td>44%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>57%</td>
<td>29%</td>
<td>46%</td>
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<tr>
<td>Caucasian</td>
<td>36%</td>
<td>22%</td>
<td>36%</td>
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</table>
Menthol Smoking: Adolescents & Young Adults in MH Treatment

- **NSDUH (US)**
  - 12-17 yr olds: 46%
  - 18-25 yr olds: 33%

- **Outpt Mental Health**
  - 12-17 yr olds: 74%
  - 18-25 yr olds: 42%
Estimates that 44% to 46% of cigarettes consumed in US by smokers with psychiatric or addictive disorders (Lasser, 2000; Grant, 2002)

* 175 billion cigarettes and $39 billion in annual tobacco sales (USDA, 2004)
A PRIMER FOR
PSYCHOTHERAPISTS

BEHAVIOR DURING THE INTERVIEW

Should the therapist smoke during the interview? Why not? It will help drain the small amount of undischarged tension which is always present during an interview, and it contributes to the naturalness of his behavior.

KENNETH

ADJUNCT IN PSYCHIATRY; CLINICAL INSTITUTE OF PSYCHOANALYSIS; FORMERLY LECTURER IN PSYCHIATRY, DEPARTMENT OF SOCIAL WELFARE, UNIVERSITY OF CALIFORNIA

1951
Re: Research Proposal for July/83 – June/84
"Tobacco Smoking As a Coping Mechanism in Psychiatric Patients: Psychological, Behavioral and Physiological Investigations"
Phase I

These 3 studies, plus the remaining 3 planned for next year promise to bear fruitful findings. It is particularly interesting that the psychiatrists, who are medical professionals, are very aware of the role of tobacco use in patients and are very interested in these studies. If tobacco can be shown to be an efficient form of "self-medication" for these patients then this would be significant bonus for the tobacco industry.

Dr. Knott has been sponsored by CTMC for some years. Up to last year his own salary was paid by us - so he was totally dependent on CTMC funding. He became, however, a permanent member of the Royal Ottawa Hospital in 1984, and since then we only support the cost of his assistants.

The latest request is addressing the problems that restriction on smoking in the workplace or elsewhere may have on inducing stress on the smoker. Once again he seems to be looking at this from our point of view.
I am writing to request a donation of cigarettes for long-term psychiatric patients... because of recent changes in the DHHS regulations, Saint Elizabeth Hospital can no longer purchase cigarettes for them.

I am therefore requesting a donation of approximately 5,000 cigarettes a week (8 per day for each of the 100 patients without funds).
March 21, 1991

Lawrence Tilton
Tilton's Log Cabin
P.O. Box 657
Skowhegan, ME 04976

Dear Larry:

This letter is to inform you that the smoking in restaurants bill (L.D. 603) is now set for hearing on Wednesday, April 3, 1991, at 9:30 a.m. at the Elks Lodge in Augusta. In fact, the following smoking bills also have been set for hearing on that day:

LD 463 - An Act to Exempt Substance Abuse and Psychiatric Patients from the Prohibition against Smoking in Hospitals

3. LD 542 - An Act to Ban Smoking in Laundromats

4. LD 603 - An Act to Amend the Laws Concerning Smoking in Restaurants

5. LD 1134 - An Act to Protect Citizens from the Effects of Environmental Tobacco Smoke

With the above bills all scheduled on one day, it is difficult to know exactly when each of them will be reached. It is vital that you, or a representative, attend the hearing to speak on the legislation and we would appreciate it if you would either give me a call or my paralegal, Susan Mitchell.

Thank you.

Kind regards,

JON R. DOYLE

JRD/1m

cc: Kent Wall
HOSPITAL SMOKING BANS

Mental Patients Fight to Smoke When They Are in the Hospital

“It’s one of the very very few pleasures that schizophrenics and people with major depression have,” says Helen Konopka, a 71-year-old retired New York teacher who organized a tidal wave of letters and petitions to the Joint Commission. She says Ms. Konopka’s crusade is backed by the National Alliance for the Mentally Ill, an influential advocacy group of patients and their families. The group says it hasn’t had any contact with the tobacco industry.

JCAHO ultimately “yielded to massive pressure from mental patients and their families, relaxing a policy that called on hospitals to ban smoking.”
TOBACCO BANS & STATE PSYCHIATRIC HOSPITALS (2005-2011)

Percent of Smoke Free State Psychiatric Hospitals

- 2005: 20%
- 2006: 40%
- 2008: 60%
- 2011: 80%

Response Rate: 2005 - 55%, 2006 - 82%, 2008 - 75%, 2011 - 80%

NASMHPD Surveys 2005-2011
* Langley Porter, 100% smokefree since 1988
* N=100 smokers
* 70% used NRT during hospitalization
* 1 patient had tobacco on their treatment plan
* 2 were advised to quit smoking
* 3 received a DSM-IV diagnosis of Nicotine Dependence or Withdrawal
* 4 were provided NRT at discharge

RETURN to SMOKING: SMOKE-FREE ACUTE PSYCH HOSPITAL

FIGURE 1. Return to Smoking Following a Smoke-Free Hospitalization in Days Since Discharge

2006 AAMC Practice Survey: Psychiatrists

- **62%** Ask about tobacco & Advise to quit
- **44%** Assess readiness to quit
- **13-23%** Assist
  - NRT (23%), other Rx (20%), cessation materials (13%)
- **14%** Arrange follow up
- **11%** Refer to others

Psychiatrists least likely to address tobacco use with their patients relative to other specialties (family medicine, internal medicine, OB/GYN)
* Few reported a psychiatrist (27%), therapist (18%), or case manager (6%) ever advised them to quit smoking

Several reported *discouragement to quit* from mental health providers

Prochaska, Reyes, Schroeder, et al. (2011). Bipolar Disorders
Top Barriers to Treating Tobacco
2006 AAMC Survey with 701 Psychiatrists

- 89% -- Patients not motivated to quit
- 83% -- More acute problems to address
- 80% -- Few cessation programs available
- 75% -- Patients usually fail to quit
- 72% -- Other practice priorities
- 65% -- Staff are unfamiliar with tobacco treatments
- 61% -- Limited time with patients
- 58% -- Lack of provider knowledge in tobacco cessation
Top Barriers to Treating Tobacco
2006 AAMC Survey with 701 Psychiatrists

- **89%** -- Patients not motivated to quit
- **83%** -- More acute problems to address
- **80%** -- Few cessation programs available
- **75%** -- Patients usually fail to quit
- **72%** -- Other practice priorities
- **65%** -- Staff are unfamiliar with tobacco treatments
- **61%** -- Limited time with patients
- **58%** -- Lack of provider knowledge in tobacco cessation
Just as Ready to Quit Smoking as the General Population

- General Population: 40% intend to quit in next 6 mo, 20% in next 30 days
- General Psych Outpts (Acton et al., 2001 Addict Bx): 43% in next 6 mo, 28% in next 30 days
- Depressed Outpatients (Prochaska et al., 2004, Drug Alc Dep): 55% in next 6 mo, 24% in next 30 days
- Psych. Inpatients (Prochaska et al., 2006, Am J Addict): 41% in next 6 mo, 24% in next 30 days
- Methadone Clients (Nahvi et al., 2006, Addict Bx): 48% in next 6 mo, 22% in next 30 days

* No relationship between psychiatric symptom severity and readiness to quit
While 96% of current smokers believed they needed to be mentally healthy to quit, most ex-smokers were not in good or excellent mental health when they quit.
57% of ex-smokers described their mental health as in recovery compared to 40% of current smokers, $\chi^2(3) = 11.12$, $p = .011$
ADDRESSING MYTHS & BARRIERS

- Individuals with mental illness are just as motivated to quit smoking as the general population

- **83% -- More acute problems to address**
- 80% -- Few cessation programs available
- 75% -- Patients usually fail to quit
- **72% -- Other practice priorities**
- 65% -- Staff are unfamiliar with tobacco treatments
- 61% -- Limited time with patients
- 58% -- Lack of provider knowledge in tobacco cessation
Tobacco Kills

* Individuals with mental illness die, on average, 25 years prematurely (Colton & Manderscheid, 2006)
  * elevated risk for respiratory and cardiovascular diseases and cancer, compared to age-matched controls (Brown et al., 2000; Bruce et al., 1994; Dalton et al., 2002; Himelhoch et al., 2004; Lichtermann et al., 2001; Sokal, 2004).

* Current tobacco use is predictive of future suicidal behavior, independent of depressive symptoms, prior suicidal acts, and other substance use (Breslau et al., 2005; Oquendo et al., 2004, Potkin et al., 2003).
COMPARATIVE CAUSES of ANNUAL DEATHS in the UNITED STATES

Source: CDC

Individuals with mental illness or substance use disorders

Number of Deaths (thousands)

AIDS  Obesity  Alcohol  Motor Vehicle  Homicide  Drug Induced  Suicide  Smoking

Source: CDC
* Associated with greater AMA rates
  * Hospitalized smokers twice as likely to leave AMA, if withdrawal not treated with nicotine replacement (Prochaska et al., 2004)

* Poorer outcomes among smokers with schizophrenia
  * Greater psychiatric symptoms, more frequent hospitalizations, higher medication doses (Dalack & Glassman, 1993; Desai et al., 2001; Ziedonis et al., 1994)

* Decreases some psychiatric medication levels
TOBACCO IMPACTS TREATMENT

PHARMACOKINETIC DRUG INTERACTIONS with SMOKING

Drugs that may have a decreased effect due to induction of CYP1A2:

- Caffeine
- Clozapine (Clozaril™)
- Fluvoxamine (Luvox™)
- Haloperidol (Haldol™)
- Olanzapine (Zyprexa™)
- Phenothiazines (Thorazine, Trilafon, Prolixin, etc.)
- Propanolol
- Tertiary TCAs / cyclobenzaprine (Flexaril™)
- Thiothixene (Navane™)
- Other medications: estradiol, mexiletene, naproxen, phenacetin, riluzole, ropinirole, tacrine, theophylline, verapamil, r-warfarin (less active), zolmitriptan

Smoking cessation may reverse the effect.
75% of psychiatric patients who smoke report smoking most or all of their cigarettes while alone (Prochaska et al., 2005).

- Median of $142.40 per month spent on cigarettes among an outpatient sample of smokers with schizophrenia (Steinberg et al., 2004)
- 27% of their monthly incomes
• Individuals with mental illness are just as motivated to quit smoking as the general population
• Tobacco use is a leading cause of death for those with mental illness & smoking adversely impacts treatment

• 80% -- Few cessation programs available
• 75% -- Patients usually fail to quit
• 65% -- Staff are unfamiliar with tobacco treatments
• 61% -- Limited time with patients
• 58% -- Lack of provider knowledge in tobacco cessation
TOBACCO TREATMENT GUIDELINES

* All patients ought to be screened for tobacco use, advised to quit, and offered intervention
* All patients should be offered pharmacological treatment for quitting smoking, unless contraindicated
* There is a dose response relationship with the amount of contact provided

American Psychiatric Association, 2006; U.S. Public Health Service, 2008
Treatment should address the physiological and the behavioral aspects of dependence.
TOBACCO TREATMENTS with DEMONSTRATED EFFICACY

* Physician advice
* Formal smoking cessation programs
  * Individual counseling
  * Web and telephone counseling:
    * www.smokefree.gov
    * 1-800-QUIT-NOW (national toll-free quit line)
  * Group programs
* NRT, bupropion, varenicline, nortriptyline, clonidine, cytisine
Referring patients to a toll-free quit line is simple and easily integrated into routine patient care.

- Takes < 5 minutes
- Toll-free cessation counseling and many states over pharmacotherapy
* Nearly 1 in 4 callers met criteria for current major depression

* At 2-months, those with depression much less likely to be quit (19%) than callers without depression (28%)

* What are the unique challenges?

* How can we reach, engage, & best help smokers with current mental illness?

• **Individuals with mental illness are just as motivated to quit smoking as the general population**

• **Tobacco use is a leading cause of death for those with mental illness & smoking adversely impacts treatment**

• **Number of treatments are available including the quitline**

• **75% -- Patients usually fail to quit**

• **65% -- Staff are unfamiliar with tobacco treatments**

• **58% -- Lack of provider knowledge in tobacco cessation**
* Literature base of more than 8,700 research articles
* < 30 randomized clinical trials treating tobacco dependence in smokers with mental illness or addictive disorders

TREATING TOBACCO DEPENDENCE in DEPRESSED SMOKERS

322 depressed smokers recruited from four outpatient psychiatry clinics

Stepped Care Intervention
Stage-based expert system counseling
Nicotine patch
6 session individual counseling

Brief Contact Control

Hall et al., 2006. Am J Public Health
Intervention Components

- Stage-tailored Expert System @ Intake, 3 & 6 months
- Stage-tailored Manual
- Counseling Session 15 to 30-minutes
- 10 weeks Nicotine Patch
ABSTINENCE RATES by TREATMENT CONDITION

* p<.05 for group comparison
NO RELATIONSHIP

- Depression severity, as measured by the Beck Depression Inventory-II, was unrelated to participants’ likelihood of quitting smoking.
- Among intervention participants, depression severity was unrelated to their likelihood of accepting cessation counseling and nicotine patch.
Among depressed patients who quit smoking:
* No increase in suicidality
  * Quit: 0% vs Smoking: 1-4%
* No increase in psych hospitalization
  * Quit: 0-1% vs. Smoking: 2-3%
* Comparable improvement in % of days with emotional problems
* No difference in use of marijuana, stimulants or opiates
* Less alcohol use among those who quit smoking

Prochaska et al., 2008, Am J Public Health
TREATING DEPRESSED SMOKERS

* Stage-based tobacco treatment with CBT and NRT significant effects at 12 and 18 months
* No evidence of worsened psychiatric symptoms associated with quitting smoking
* Smoking can be treated concurrent with depression without adverse effects to mental health functioning
TREATING TOBACCO USE in INPATIENT PSYCHIATRY

* 100% smoke-free unit
* Stage-tailored expert system, stage-tailored manual, 10 wk nicotine patch vs. Usual care
* 224 patients enrolled
* Full range of psychiatric diagnoses
* 79% recruitment rate
* 81% retention at 18 months

Prochaska et al., in press, Am J Pub Health
Sample (N=224)

- Dx: 47% unipolar depression, 25% bipolar depression, 15% schizophrenia spectrum, 13% other
- 88% involuntarily admitted
  - Suicidal (75%), homicidal (2%), gravely disabled (10%)
- Functioning (SF12): mental health (M=28±13) physical health (M=49±13)
- Length of hospitalization, M = 7 days ± 6
- Regular smoker M = 20 years (±14)
- Cigarettes/day M = 19 (±13)
- 75% smoked ≤ 30 min of waking
ABSTINENCE RATES by TREATMENT CONDITION

OR=3.15, p=0.018 for condition in a GEE-based logistic regression
* 46% psychiatric re-hospitalization rate
  * CA data: 44% psychiatric re-hospitalization rate

* 234 Re-hospitalizations:
  * Unrelated to quit status
  * Related to African American race, psychosis symptoms at baseline, prior psych hospitalizations, unstable housing, & study condition
  * Significantly greater for control (140) than treatment (94) participants, p=.036
## Model Predicting Rehospitalization

<table>
<thead>
<tr>
<th>Parameter</th>
<th>OR (95% CI)</th>
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<tbody>
<tr>
<td><strong>Condition (usual care)</strong></td>
<td>1.92 (1.06, 3.49)</td>
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<tr>
<td><strong>Race (African American)</strong></td>
<td>3.04 (0.97, 9.58)</td>
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<td><strong>Psychotic Symptoms (BASIS-24)</strong></td>
<td>1.43 (1.09, 1.89)</td>
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<tr>
<td><strong>Education in years</strong></td>
<td>1.06 (0.97, 1.16)</td>
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<tr>
<td><strong>Unstably housed</strong></td>
<td>2.09 (1.12, 3.92)</td>
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<td><strong>Quit during 18-month trial</strong></td>
<td>0.56 (0.28, 1.14)</td>
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<td><strong>Psychiatric Hospitalization History</strong></td>
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<td>First hospitalization (reference)</td>
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<td>1 to 2 prior hospitalizations</td>
<td>1.60 (0.70, 3.63)</td>
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<td>3 to 7 prior hospitalizations</td>
<td>2.13 (0.95, 4.77)</td>
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<td>8+ prior hospitalizations</td>
<td>3.21 (1.37, 7.54)</td>
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Efficacious for smokers with clinical depression (N=322)
Efficacious for smokers hospitalized for severe mental illness (N=224)
Comparable quitting to general population
No harm to mental health recovery
Comparable effects in a diverse sample (N=100)

Hall et al. (2006) AJPH; Prochaska et al. (2008) AJPH
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<tr>
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<td>Recruitment Rate</td>
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<td>71%</td>
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<td>Education in years</td>
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<td>Private/self-pay</td>
<td>53%</td>
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CESSATION OUTCOMES:
Private & County Hospitals

- Intervention
  - Baseline: 0%
  - 3 mo: 3.2%
  - 6 mo: 6.5%
  - 12 mo: 14.4%

- Usual Care
  - Baseline: 0%
  - 3 mo: 7.3%
  - 6 mo: 12.5%
  - 12 mo: 26.2%
2 META-ANALYSES of BUPROPION FOR QUITTING SMOKING in PERSONS with SCHIZOPHRENIA

* 6 RCTs, N = 260 total (19 – 59)
* EOT: RR = 2.57 (95% CI 1.35, 4.88)
* 6 mo FU: RR = 2.78 (95% CI 1.02, 7.58)
* Gen Pop: RR = 1.69 (95% CI 1.53, 1.85)


Bupropion for quitting smoking found to be well tolerated in patients with schizophrenia who are stabilized on an adequate antipsychotic regime.
VARENICLINE USE in SMOKERS with SCHIZOPHRENIA

* 12wk open label trial, N=112 stable outpatients
  * 28-day continuous abstinence = 34%
  * Improved psychiatric, depressive & NW sxs
    * Pachas, Cather, Pratt et al. 2012 J Dual Diag

* 12 wk RCT
N=127 stable outpatients
varenicline was well tolerated
no evidence of sx exacerbation

Williams et al. (2012) J Clin Psychiatry
INTEGRATING TOBACCO TREATMENT within PTSD SERVICES

* RCT with 66 clients from VA Medical Center

* Integrated care (IC)
  * Manualized treatment delivered by PTSD clinician and case manager (3-hr training)
  * Behavioral counseling 1x a week for 5 weeks + 1 follow-up
  * Bupropion, nicotine patch, gum, spray

* Usual care (UC): referral to VA quit smoking clinic

McFall et al. (2005) Am J Psychiatry
INTEGRATING TOBACCO TREATMENT within PTSD SERVICES

* Cessation Medication Use
  * Integrated Intervention: 94%
  * Usual Care: 64%

* Counseling Sessions Attended
  * Integrated Intervention: $M=5.5$
  * Usual Care: $M=2.6$

* At all assessments, the odds of abstinence were 5 times greater for integrated care vs. usual care

McFall et al. (2005) Am J Psychiatry
INTEGRATING TOBACCO TREATMENT within PTSD SERVICES

* Multi-site RCT with 943 clients from 10 VA Medical Centers, train-the-trainer model

* Integrated care (IC) vs. Usual care (UC)

* Cessation outcomes: **2-fold increase in quitting**
  * 18-mo 7 day PPA: IC 18.2% vs. UC 10.8%

* Strongest predictor of tx effect: # of counseling sessions received

* Quitting had no detriment on PTSD symptoms

McFall et al. (2010) JAMA
Evidence for Dz Specific Tx

* No benefit of tailoring over traditional cessation treatments for smokers with schizophrenia (George et al., 2000)

* APA tobacco treatment guideline does not recommend tailoring by diagnosis

* High prevalence of co-occurring disorders
  * NIMH R01 trial (N=856, n=214 w/ schz spctrm)
  * M = 3.6 diagnoses (sd=1.6)
  * 10% of those with schizophrenia, sole dx
SUMMARY: TOBACCO TREATMENT in SMOKERS with MENTAL ILLNESS

* Support for currently available interventions
  * Treatments matched to motivation
  * NRT, bupropion, varenicline

* Tobacco treatment does not appear to harm mental health recovery

* Integration into mental health treatment settings increases receipt of care and abstinence rates
TAXATION for CESSATION

* Healthcare for Communities household survey
* Cross-sectional survey, 2000-2001
* N=7909
  * Smoking prevalence: 44% (MH) vs. 19% (non-MH)
* A 10% increase in cigarette prices associated with 18% less smoking participation among individuals with alcohol, drug, or mental disorders

Ong, Zhoum & Sung (2010) AJPH
• Individuals with mental illness are just as motivated to quit smoking as the general population
• Tobacco use is a leading cause of death for those with mental illness & smoking adversely impacts treatment
• Number of treatments are available including the quitline
• Smokers with mental illness can quit
• 65% -- Staff are unfamiliar with tobacco treatments
• 58% -- Lack of provider knowledge
Admin

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<th>Past 7 Days</th>
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Which of the following versions of Rx for Change do you plan to use?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask-Advise-Refer Rx for Change</td>
<td>4,874</td>
</tr>
<tr>
<td>The 5 A's Rx for Change</td>
<td>5,987</td>
</tr>
<tr>
<td>Psychiatry Rx for Change</td>
<td>2,471</td>
</tr>
<tr>
<td>Cancer Care Provider curriculum</td>
<td>1,138</td>
</tr>
<tr>
<td>Mental Health Peer Counselor curriculum</td>
<td>1,992</td>
</tr>
<tr>
<td>Surgical Provider curriculum</td>
<td>920</td>
</tr>
<tr>
<td>Cardiology Provider curriculum</td>
<td>619</td>
</tr>
</tbody>
</table>

What is your planned use for Rx for Change?

<table>
<thead>
<tr>
<th>Use</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance my own knowledge / skills</td>
<td>3,299</td>
</tr>
<tr>
<td>Teach health professional students</td>
<td>1,350</td>
</tr>
<tr>
<td>Teach licensed health professionals</td>
<td>1,814</td>
</tr>
<tr>
<td>Not sure (just checking it out)</td>
<td>752</td>
</tr>
</tbody>
</table>

How did you hear about the Rx for Change program?

<table>
<thead>
<tr>
<th>Source</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conference, meeting, or workshop</td>
<td>971</td>
</tr>
<tr>
<td>Faculty member / colleague</td>
<td>3135</td>
</tr>
<tr>
<td>Internet LISTSERV</td>
<td>453</td>
</tr>
<tr>
<td>Newsletter article or publication</td>
<td>371</td>
</tr>
<tr>
<td>Other</td>
<td>798</td>
</tr>
<tr>
<td>Surfing the internet</td>
<td>900</td>
</tr>
<tr>
<td>UCSF Smoking Cessation Leadership Center</td>
<td>458</td>
</tr>
</tbody>
</table>
ADDRESSING MYTHS & BARRIERS

• Individuals with mental illness are just as motivated to quit smoking as the general population
• Tobacco use is a leading cause of death for those with mental illness & smoking adversely impacts treatment
• Number of treatments are available including the quitline
• Smokers with mental illness can quit
• MH providers are interested in training to treat tobacco dependence and training improves practice
FUTURE RESEARCH

* How to better:
  * Disseminate the evidence base
  * Engage MH providers in treating tobacco
  * Sustain quit attempts
  * Work with additional diagnostic groups (e.g., bipolar, ADHD, eating disorders, panic disorder)
  * Broaden tobacco treatment to attend to clients’ additional risk factors (e.g., alcohol/drug use, inactivity, poor diet, stress, sleep, nutrition)
  * Achieve parity in smoke-free environments in psychiatry
  * Efficacy of reduce-to-quit, combination medications, extended treatment, and other treatment approaches
‘CIGARETTES ARE MY GREATEST ENEMY’

* Statewide social marketing campaign in California by Billy DeFrank Lesbian and Gay Community Center, the Center OC, & American Legacy Foundation

* Real-life triumphs over adversities to quit smoking

I didn’t survive drugs & alcohol so I could die from lung cancer.

I had to stop smoking.

— SELMA

I didn’t survive depression and suicide attempts so I could die from lung cancer.

I had to stop smoking.

— ARIANA