THEME 1: Create Buy-In

• Disseminate Background Information to Understand Scope of Problem
• Understand consequences of tobacco use
• Begin to consider personal or systemic barriers to implementation

What is Buy-In? And why do we need it?
What is the smoking rate in the US (or your state)?

US Smoking Prevalence

16 million smokers with mental illness
~ 1/3 of 51 million smokers in the US

NCS-R 2001-2003; Diagnoses using CIDI
Prevalence of Smoking Not Decreasing in those with Poor Mental Health

Smokers with Behavioral Health Conditions are not Considered a Tobacco Use Disparity Priority Group?

Tobacco Use Rates in NJ Addictions Treatment Settings
Three Fourths of Smokers have a Past or Present Problem with Mental Illness or Addiction

Lasser et al., 2000: Data from National Comorbidity Study

Smoking is much more common in adults with mental illness than other adults.

MMWR Feb 5, 2013
It’s the Smoke that Kills
Cigarette smoke > 7000 compounds
Acetone, Cyanide, Carbon Monoxide, Formaldehyde
>65 Carcinogens
Benzene, Nitrosamines

Sources of Tobacco Toxins
Nicotine; nitrosamines
More than 600; Ammonia, cellulose acetate; flavors
Thousands; carbon monoxide; formaldehyde; benzene; arsenic, lead; PAH

Tobacco-Caused Illness
~90% of all lung cancers
~100% COPD
2X death from stroke/ CAD

Half of all smokers die from a tobacco-caused disease

CDC Surgeon General, 2004
Recent data from several states have found that people with SMI die, on average, 25 years earlier than the general population.

National Association of State Mental Health Program Directors
Medical Directors Council, July 2006; Miller et al., 2006

Cause of Death in Patients with Psychosis
For those aged 35-54 years, the odds of cardiac related death was increased by 12X in smokers vs. nonsmokers.

Kelly et al., 2009

Heavy smokers (1 pack daily; age 35-54) had approximately 170% increased risk of mortality vs. nonsmokers.

Reduction in CVD (%) from Each Risk Factor

50% of deaths in schizophrenia, depression and bipolar disorder attributed to tobacco

Callaghan et al., 2013
**Tobacco Consequences in SUD**

- More alcoholics die from smoking related diseases than from alcohol related diseases
- Synergistic effects of alcohol and tobacco ↑ risk pancreatitis and oral cancers
- Smoking ↓ recovery from cognitive deficits during alcohol abstinence


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**Smokers Suffer Financial Consequences and Lower Quality of Life**

- 73% Food
- 27% Shelter, Misc. Living Expenses

N=68 smokers with schizophrenia on disability income

Steinberg M., et al. Tobacco Control, 2004

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60% of Mental Health Consumers Report that Their Families Buy Them Tobacco
Persons with a mental disorder or SUD purchase & consume 30-44% of cigarettes sold in the US

Stigma: Smoking is a Barrier to Community Integration

Consumers want Jobs and Housing

Employers and landlords

highly stigmatize smokers

Why?

Smoke Free Housing

As much as 60% of airflow in multi-unit housing can come from other units

SHS infiltrates through air ducts, cracks, stairwells, hallways, elevators, plumbing, electrical lines

SHS is Class 1A carcinogen, in the same class as asbestos

In 2009, HUD issued PH Notice 2009-21 (revised in May 2012 as
PH Notice 2012-25), strongly encouraging PHAs to adopt smoke-free policies in some or all of
their public housing units. In 2010, HUD issued Housing Notice 2010-21 (revised in
November 2012 as Housing Notice 2012-22), encouraging Owners and Management Agents to
implement smoke-free housing policies in one or all of the properties they own or manage. The
benefits of smoke-free housing include reducing the exposure of residents to the harmful
components of secondhand smoke, reducing the risk of fires, and potentially reducing the costs
associated with maintenance at unit turnover. Smoke-free policies are increasingly being
adopted across the country by PHAs and Owners of both assisted multifamily housing and
market-rate rental housing.

Tobacco in the Environment

- 60% of mental health
  consumers report living with
  smokers AND smoking indoors
- Part of mental health culture
- Staff tobacco use

Williams et al., 2010; McNeill 2001

Smoke-Free Hospitals

- Hospitals with a psychiatric or substance
  abuse unit have lower compliance with 1992
  JCAHO tobacco standards
- Tobacco-free psych hospitals do no show
  increase in violence of incidents
- Policy supports treatment
- Psychiatric inpatients not given NRT were >
  2X likely to be discharged from the hospital
  AMA
- No Exemptions for behavioral health

Longo et al., 1998; Joseph et al., 1995; Prochaska 2004
**Suicide and Smoking**

- Daily smoking predicts suicidal thoughts or attempt (adjusted for prior depression, SUD, prior attempts; OR 1.82)

- Heavy smoking
  - Suicide completions
  - Attempts in adolescents (especially girls)

Breslau et al., 2005; Ostacher et al., 2006; Altamura et al., 2006; Iancu et al., 2006; Cho et al., 2007; Oquendo et al., 2007; Riia et al., 2006; Moriya et al., 2006

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**Benefits of Smoking**

**Cognition**
- Nicotine/ Nicotinic Receptors
  - Alzheimer's disease
  - Attention deficit disorder
  - Autism
  - Schizophrenia

**Depression**
- MAO Inhibitor Like Substance

- Tobacco ≠ pharmacological treatment
- Not a rationale for smoking

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**Activation of the reward pathway by addictive drugs**

Tobacco Dependence is an Axis I Disorder
**Tobacco Use Disorder**

Most tobacco users are addicted (2 or more)

- withdrawal
- tolerance
- desire or efforts to cut down/ control use
- great time spent in obtaining/using
- reduced occupational, recreational activities
- use despite problems
- larger amounts consumed than intended
- Craving; strong urges to use

*DSM-5*

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**Tobacco Withdrawal**

4 or more

Depressed mood
Insomnia
Irritability, frustration or anger
Anxiety
Difficulty concentrating
Restlessness
Increased appetite or weight gain

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**Reduced Access to Tobacco Treatment in Behavioral Health Settings**

- Nicotine dependence documented in 2% of mental health records
- Only 1.5% of patients seeing an outpt psychiatrist received treatment for smoking

*Less than half (44%) of clinicians in community mental health sites ask their patients about smoking*  

*Peterson 2003; Montoya 2005; Himelhoch 2014*
State Hospital Smoking Survey

2011; 206 Hospitals Surveyed; 80% response rate
Almost 80% no-smoking on premises
Less than 35% treatment

Less than Half of US Substance Abuse Facilities Treat this Substance
~ 88% response rate
41% offer smoking cessation counseling or pharmacotherapy
38% offer individual/group counseling
17% provide quit-smoking medication

Behavioral Health Staff Tobacco Attitudes and Practices
Helping patients stop smoking is part of the role of mental health professional 90%
Usually ask about smoking status 80%
Usually recommend NRT 34%
Usually prescribe pharmacotherapy to smokers 29%
Referred smokers to a quitline 26%
Felt well prepared from prior education to treat tobacco 12%
### Poor Baseline Tobacco Treatment Knowledge among Psychiatrists

50% correct: Evidence-based treatments; nicotine withdrawal; tobacco medications interactions.  
*Williams et al., JAPNA 2009*

### Primary Care

- Brief Intervention
- Shorter visits
  - 15 vs 30 min visits
- Access

### Behavioral Health

- Intensive
  - Addictions Experience
  - Addictions Training
  - More Visits
  - Experts Psychosocial Tx
- Assessment Mood
  
  *Counselors shouldn’t refer patients to others for counseling?*

### Which Approach to Take

- Implement current evidence based practices?
  - Public health model
  - Primary care
  - Brief strategies
  - Limited insurance coverage
  - Telephone counseling

- Develop tailored approaches?
  - Clinical/ co-occurring treatment model
  - Behavioral health
  - Face to face
  - Longer treatment
  - Expanded Medicaid and Medicare coverage for treatment
**Behavioral Health Should Take a Lead in Tobacco Treatment**

- High prevalence of tobacco use/patient need
- Nicotine Dependence in DSM-IV
- Trained in addictions
- Tobacco interactions with psych meds
- Longer and more treatment sessions
- Experts in psychosocial treatment
- Relationship to mental symptoms

*Williams & Ziedonis, Behavioral Healthcare 2006*

**Clinicians Belief** that patients were not interested in quitting was a major barrier to giving smoking cessation treatment

42% of patient charts in same study (49/117) Answered ‘yes’ to question Do you have an interest in quitting on their psychiatric assessment

*Williams et al., in press; Himelhoch et al., 2014*

**Removing Barriers to Providing Treatment**

- Training health professionals can ↑ delivery of tobacco treatments
- More favorable attitudes are associated with higher rates of tobacco treatments
- Nurses who use tobacco
  - provide cessation services
  - rate their ability to help patients as lower

*Slater et al., 2006; Braun et al., 2004; Reeve et al., 1996; Lancaster et al, 2008*
Specialized Tobacco Training Increases Treatment

Chart Review of 200 charts (20 clinicians trained at 2 day CME)

[Bar chart showing Pre and Post treatment discussions]

Williams et al., in press

Addressing Tobacco Requires Attention to Multiple Domains

- Neurobiological
- Psychological
- Social & Environmental
- Spiritual & Advocacy
- Treatment System & Institutional
- Greater dependence
- Poor coping; low confidence
- Live with smokers
- Seeing peers succeed; having hope
- Provider bias; No access to help

Williams et al, Administration & Policy in Mental Health and Mental Health Services Research, 2010

Mental Health Tobacco Recovery in NJ

[Diagram showing intersecting circles with Community, Clinical Treatment, and Environment]

Williams et al, Administration & Policy in Mental Health and Mental Health Services Research, 2010
Complete Wellness: Mental and Physical Health

Wellness & Recovery includes Addressing Tobacco

- Mental Health & Recovery Plan
- Healthy Food Choices
- Complete Wellness
- Regular Checkups
- Addressing Addictive Behaviors
- Balancing Relaxation & Stress
- Daily Physical Activity

Learning About Healthy Living

TOBACCO AND YOU

AVAILABLE FREE ONLINE
http://rwjms.umdnj.edu/addiction/

Conclusions

- It’s the smoke that kills
- Numerous consequences from tobacco for individuals with mental illness
- Mental health professionals MORE involved in tobacco treatment
- Treat it like a co-occurring disorder
- Program/Systems changes needed to support individuals/treatments

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Continue the conversation

Follow up Q&A Session:
Getting Started - Buy In and Barriers

Friday, April 11, 2014
3:00 - 4:00 PM EDT

To register:
https://www2.gotomeeting.com/register/878764482

Join us for our next webinar:

Introduction to Motivational Interviewing
Marc L. Steinberg, Ph.D., Associate Director, Division of Addiction Psychiatry, Rutgers Robert Wood Johnson Medical School

Wednesday, April 16, 2014 • 12:30pm – 2:00pm EDT

To register:
https://www2.gotomeeting.com/register/544114210

In this 90-minute webinar, Dr. Steinberg will discuss the following topics:
- Myths of Motivational Interviewing
- Definition of Motivational Interviewing
- Spirit of Motivational Interviewing
- Motivational Interviewing micro-skills
- The importance of “Change Talk”