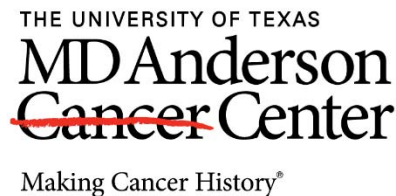


Project ECHO

Common Beliefs about Smoking Cessation in Psychiatric Patients

David P. Hunt, MPAS, PA-C



Outline

Where have we been ?

Where are we now ?

Where do we need to go and how do we get there ?

Cartoon characters advertised directly to children circa 1950's – 1960's



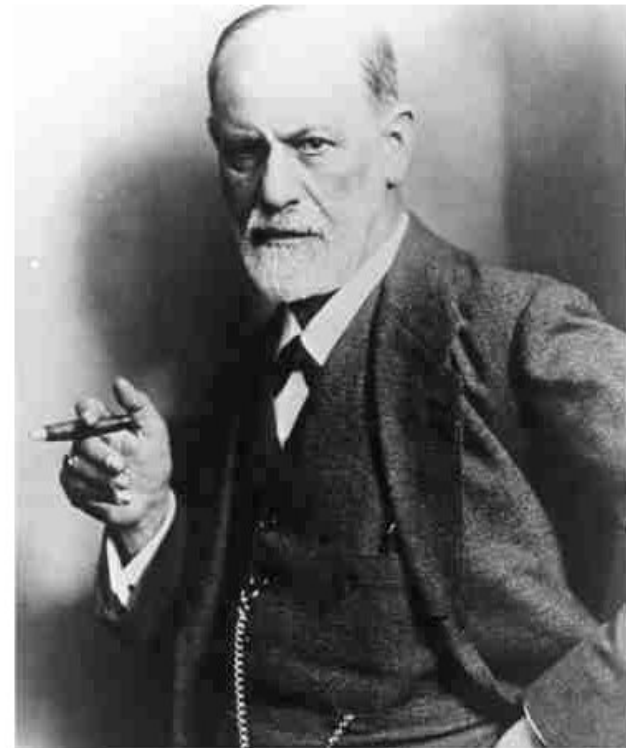


Family doctors, surgeons, diagnosticians, nose and throat specialists ... doctors in every branch of medicine were asked: "What cigarette do you smoke, Doctor?"

Three nationally known independent research organizations did the asking.

The answers came in by the thousands. Actual statements from doctors themselves. Figures were checked and re-checked! The results? Camels ... convincingly!

The culture of Psychiatry was historically connected to and associated with smoking.



A PRIMER FOR PSYCHOTHERAPISTS

BEHAVIOR DURING THE INTERVIEW 39

KENNETH : 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.

ADJUNCT IN PSYCHIA
FRANCISCO; CLINICA
STITUTE OF PSYCHOANALYSIS; FORMERLY LECTURER
IN PSYCHIATRY, DEPARTMENT OF SOCIAL WELFARE,
UNIVERSITY OF CALIFORNIA

1951

HOSPITAL SMOKING BANS

THE WALL STREET JOURNAL TUESDAY, OCTOBER 11, 1994

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.

Helen Konopka
Board of Directors



NAMI Alliance for the Mentally Ill
NAMI Friends and Advocates of the Mentally Ill
432 Park Avenue South, Suite 710, New York, New York 10016-3013
Hotline 212/684-7400 • Business 212/684-5305 • Fax 212/684-5354

*Philip Morris:
NAMI is fighting the City, HHC
and Bellevue Hospital bureaucracy.
The patients in the psychiatric inpatient
units, emergency units and admission
units need a discrete smoking area and
not be forced to go Ciled Lobby.
Helen Konopka*

The New York Times

SUNDAY, FEBRUARY 19, 1995

JCAHO ultimately "yielded to massive pressure from mental patients and their families, relaxing a policy that called on hospitals to ban smoking."

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.

RJR-MACDONALD INC. Research and Development /
Cigarette and Tobacco Division

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.

Outline

Where have we been ?

Where are we now ?

Where do we need to go and how do we get there ?

Why the Big Push for Smoking Cessation with Behavioral Health Patients?

U.S. Smoking Rates

General Population: 19.3%

Behavioral Health Population smoking rates: 32% - 98%

Because of the **Extreme Disparity of Smoking Prevalence** among those with **Mental Illness Compared** with the **General Population**.

Smoking Prevalence Among Those with Mental Illness

- Prevalence is 75% for those with either addictions and/or mental illness, as opposed to 19.8% for the general population
- In mental health settings, about 30-35% of the staff smoke

SMOKING PREVALENCE RATES BY DIAGNOSTIC CATEGORY ACROSS STUDIES

■ Major depression	■ 36-80 %
■ Bipolar disorder	■ 51-70 %
■ Schizophrenia	■ 62-90 %
■ Anxiety disorders	■ 32-60 %
■ PTSD	■ 45-60 %
■ ADHD	■ 38-42 %
■ Alcohol abuse	■ 34-93 %
■ Other drug abuse	■ 49- 98 %

(Morris et al., 2009)

Mental Health and Addictive Disorders: Special Considerations for Treating this Population

- Neurobiological factors reinforcing use of nicotine.
- MH patients often feel excluded from mainstream cessation programs.



Mental Health and Addictive Disorders: Special Considerations for Treating this Population (continued)

- Lower rate of successful quit attempts
- Higher tobacco relapse rates

Mental Health and Addictive Disorders: Special Considerations for Treating this Population (continued)

- Smoking is an accepted part of psychiatric culture
 - Clinicians may believe patients are not able or willing to quit
 - For those with chronic mental disorders
 - Major part of daily routine/structure
 - Alleviates boredom

Persons with Serious Mental Illness and Tobacco Cessation

- While overall smoking in the United States has decreased, the proportion of smokers with psychiatric diagnoses has increased.
- Nearly half of all cigarettes consumed in the United States are by individuals with a psychiatric disorder.

Persons with Serious Mental Illness and Tobacco Cessation (continued)

- Mentally ill clients may differ from other populations in the way they use tobacco because they often smoke their cigarettes close to the butt where nicotine levels are highest (Lyon, 1999), and inhale frequently, rapidly, and deeply (Olinicy, Young, & Freedman, 1997).

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; Himmelhoch 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).

Outline

Where have we been ?

Where are we now ?

Where do we need to go and how do we get there ?

Why should Behavioral Health take the lead in Tobacco Treatment ?

High prevalence of tobacco use / patient need

Tobacco Use Disorder is in DSM-5

We are trained in addictions

Best prepared to manage tobacco interactions with psych meds

Longer / more treatment sessions than medical encounters

Experts in psychosocial treatment

Closer relationship to Mental Health symptoms

TRUE OR FALSE?

- Question: Is tobacco necessary self-medication?
- FALSE: It is not. The tobacco industry has supported this myth.
- Question: People with mental health and/or addiction issues aren't interested in quitting.
- FALSE: The same percentage wishes to quit as in the general population.
- QUESTION: People with mental health/addictions can't quit.
- FALSE: The quit rates are the same or slightly lower than the general population.
- QUESTION: Quitting worsens recovery from the mental illness.
- FALSE: Quitting does not hurt recovery.
- QUESTION: Tobacco is a low-priority problem.
- FALSE: Smoking is the biggest killer for those with mental and/or substance abuse disorders.

Source: Prochaska, J. J. (2011). *New England Journal of Medicine*. July 21, 2011.

Alarming Statistic

About 200,000 of the 435,000 annual deaths from tobacco use in the U.S. occur among people with behavioral health conditions.



Alarming Statistic (continued)

Saul Levin, MD, MPA, CEO and Medical Director of the American Psychiatric Association
April 9, 2014

“Primary Care Physicians have high rates of asking their patients about smoking status and assisting them with quitting; Psychiatrists do not.”

Dr. Levin urges psychiatrists to pay more attention to one aspect of their patient's health that has long been ignored--helping them stop using tobacco products.

What Can Be Done to Reduce Smoking Among People with Mental Illness?



Mental Health Professionals

- Find out if patients smoke. Sometimes patients aren't asked whether they smoke when beginning mental health treatment.
- If they do smoke, offer to help patients quit by providing proven quitting treatments.

What Can Be Done to Reduce Smoking Among People with Mental Illness? (continued)

Mental Health Professionals

- Make quitting tobacco part of an approach to mental health treatment and overall wellness. Mental health professionals should be especially aware of the behavior changes that may occur when withdrawing from nicotine, and should make sure that their patients are aware of them.

What Can Be Done to Reduce Smoking Among People with Mental Illness? (continued)

Mental Health Professionals

- Medicines used to treat mental illness may need to be monitored and adjusted.

What Can Be Done to Reduce Smoking Among People with Mental Illness? (continued)



Mental Health Facilities

- Include tobacco cessation treatments as part of an overall mental health treatment strategy.
 - Make mental health facilities and campuses completely tobacco-free (no use of any tobacco product by anyone anywhere inside or outside at any time).
-

What Can Be Done to Reduce Smoking Among People with Mental Illness? (continued)

Mental Health Facilities

- Call attention to and stop practices that encourage tobacco use (e.g., providing cigarettes to patients, allowing smoking as a reward, selling tobacco products on site, and allowing staff to smoke with patients).

Tobacco-Free Living in Psychiatric Settings

- In the U.S., 440,000 people die each year from tobacco-related causes.
 - 8.6 million people are disabled from smoking-related diseases.
- We can reduce those numbers by transforming the mental health treatment milieu into one that discourages tobacco use and helps consumers and staff quit.

Tobacco-Free Living in Psychiatric Settings (continued)

- At any given time:
approximately 50,000 consumers are housed
in the 235 state public psychiatric facilities in
the U.S.
- Roughly 200,000 pass through these facilities
each year.

Tobacco-Free Living in Psychiatric Settings (continued)



- With comprehensive programs to curb tobacco use, we have the potential to help them choose to quit and learn new ways to live longer, healthier lives.

Considerations for Timing of Tobacco Cessation



- Is the patient about to undergo a new therapy?
- Is the patient presently in crisis?

Considerations for Timing of Tobacco Cessation (continued)

- What is the likelihood that cessation would worsen the non-nicotine psychiatric disorder?
- What is the individual's **ability to mobilize coping skills** to deal with cessation? If the coping skills are low, would the **patient benefit from individual or group behavior therapy?**

Important Factors to Consider



- >1 psychiatric Dx? May be more difficult and may need to consider and monitor effects on meds and sx's.
- Stability of psych condition, medication regimen (changes in past 3-6 months) This is but one parameter sometimes used in research settings for determining stability which must be correlated with clinical findings.

Important Factors to Consider (continued)

- Typical vs. Atypical antipsychotic Patients on
Typical antipsychotics don't do as well as patients
on atypical antipsychotics generally.
- Recent or current SI? Suggests psychiatric
instability and smoking cessation may take a
lower priority in this clinical context.

Important Factors to Consider (continued)

- Recent/Immediate Stressors, e.g. homelessness, divorce, unemployment, moving etc. May not be the best time to initiate smoking cessation attempt.
- Pt. feelings about possible wt. gain. May be cause for relapse if patient gains weight. May affect medication selection.

Additional Factors for Consideration

- Smokes within 5 - 10 minutes of awakening (suggests high level of physical dependence)
- Pregnancy— may be limited to NRT's
- Motivation Level – assessing this is very key to readiness. (Has patient developed Co-morbid cancer, pulmonary or cardiac disease etc.)

Additional Factors for Consideration

(continued)

➤ Patient's ability to access medication/s

