Smoking and Mental Illness – Break the Connection:
What Every Prescriber Needs to Know!

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Why should we become involved?

- Saves lives
- Saves healthcare dollars
- Improves productivity
- Nicotine Dependence is a DSM-IV Disorder
- Disproportionate in the mental health population
- Tobacco dependence and mental illness are co-occurring disorders
- Behavioral practitioners practice psycho-social treatments
- Tobacco interferes with psychiatric medications
- Consistent with wellness and recovery approaches
- Reimbursement for treatment is improving

*Williams and Zeidonis, 2006*
Tobacco Dependence and Mental Health Care

- Traditionally permissive attitude
  - Tobacco has traditionally been a reward in mental health settings
  - Management incentive on Inpatient units

- Nicotine Dependence: most common substance abuse disorder among individuals with schizophrenia
Improved Substance Abuse Recovery Rates

- Quitters 3 x as likely not to use cocaine as their peers who smoke.  Frosch et al, 2000
- Alcoholics more likely to maintain long term abstinence.  Bobo et al, 1987; 1989  Sees & Clark, 1993
- Alcoholics who quit were less likely to relapse to drinking  MA Med Society, 1997
- Strong Associations between tobacco & opiate and cocaine use  Frosch et al 2000

Jill Williams  Treating Tobacco Dependency in Mental Health Settings
Who owns the problem?

- Mental health population represents a wide spectrum
- Smoking has a high prevalence across the continuum (Only 22% of smokers have not had a diagnosable mental illness)
- Common factor: high prevalence of desire to quit across the population
- However: not all segments of the mental health population are equally successful with traditional quit-smoking interventions
Current Smokers by Mental Illness History

Lasser, et.al. 2000

- None, 23%
- Ever Ill, 35%
- Ill during past month, 42%
FIGURE. Estimated percentage of persons aged ≥18 years who were current smokers,* by sex — National Health Interview Survey, United States, 1965–2006

* During 1965–1991, current smokers were defined as persons who reported smoking at least 100 cigarettes during their lifetimes and who, at the time of interview, reported smoking (“Have you smoked at least 100 cigarettes in your entire life?” and “Do you smoke cigarettes now?”). In 1992, the definition changed to more accurately assess intermittent smoking (i.e., smoking on some days) and included persons who reported they smoked either every day or some days (“Do you now smoke cigarettes every day, some days, or not at all?”)
Quit Attempts in Total Population

- About 2/3 of all current smokers have tried to quit.
- Majority of quit attempts whether or not successful, occur without organized assistance.
- Some evidence that more nicotine dependent/multiple relapses may respond better to organized cessation.

Fiore et. al  JAMA May 23/30, 1990
Smoking and Mental Illness

- Depression and Anxiety compared to Schizophrenia:
  - Depression and Anxiety:
    - About 50% as likely to make a quit attempt
    - When engaged in treatment success rates are similar to general population
  - Schizophrenia:
    - About 5-10% make a quit attempt on their own
    - Engagement in tobacco cessation programs: only ½ as likely to have a successful quit attempt
  - Most people with SMI wish they could stop and many have made attempts though they are highly prone to relapse
  - Patients report that they would participate in tobacco treatment groups and activities if available

Jill Williams: Treating Tobacco Dependence in Mental Illness
Suicide and Smoking

- Daily smoking → predicts suicidal thoughts or attempt (adjusted for prior depression, SUD, prior attempts; OR 1.82)
- ↑ risk in schizophrenia and bipolar disorder
- 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; Riala et al., 2006; Moriya et al., 2006
SMI

- Serious Mental Illness
  - About 6% of population
    - Bipolar Disorder: 2.6%
    - Schizophrenia and schizoaffective disorders: 2%
    - Others: 1.4%
Tobacco Control Techniques

- Current public health model for tobacco control
  - Focus on workplace outreach---misses many of SMI population
  - Very little to no preventative efforts
  - Allocation of resources: very little driven through Mental Health treatment venues
Schizophrenia and Tobacco Dependence Treatment

- Motivated to quit
- But less successful with conventional treatment
  - Less likely to engage outside of Mental Health settings
  - Less likely to respond to treatment that is driven through purely verbal means
  - Less likely to respond to traditional pharmacologic support
Schizophrenia and Smoking

- Very high prevalence: (65-85 %)
- Smoke more
  - quantity of cigarettes
  - amount of draw per cigarette
- Smoking topography studies
- Half as successful in quit attempts
- Smoking produces therapeutic benefit
- Smoking ameliorates medication side effects
Tobacco (nicotine): psycho-active agent

- Effect of Nicotine on illness symptoms
- Effect of Nicotine on side effects of psychotropic medications
- Effect of Nicotine on social and psychological well-being
- Impact of tobacco smoking on P-450 system
- Impact of quitting smoking (and quit/relapse cycles) on other medications
It’s the Smoke that Kills

Cigarette smoke > 4000 compounds

Acetone, Cyanide, Carbon Monoxide, Formaldehyde

>60 Carcinogen

Benzene, Nitrosamines
Myth Busting about Nicotine Replacement

- Nicotine is not a carcinogen
- Patients tend to self dose
- Scheduled is better than PRN
- Period of treatment: may be crucial factor in SMI
- OK to combine with bupropion
- OK to combine with each other
- Very few contraindications
- Little to no drug-drug interactions

Jill Williams: Tobacco Dependence in Mental Health Settings
More myth busting regarding NRT

- Nicotine and patients with MI / Cardiac Disease
  - No reason not to use
  - Not introducing a “new drug”
  - Safer nicotine delivery vs smoking

Jill Williams: Tobacco Dependence Treatment in Mental Health Settings
Intensive Treatment for People with SMI

- A general rule regarding smoking cessation efforts for SMI: more is better.
  - More intensive treatment frequency/duration
  - More intensive pharmcotherapy
    - Increased dose
    - Increased combinations
    - Longer duration
- Involving more than one type of provider leads to greater success.
Medication for Tobacco Dependence

- First-line Tobacco Dependence Medications (FDA Approved)
  - Nicotine Replacement
    - Gum, lozenge, inhalers, spray, patch,
  - Bupropion (Zyban; Welbutrin)
  - Varenicline (Chantix)

Jill Williams: Treating Tobacco Dependence in Mental Health Settings
Conclusions Regarding NRT

- Treatments increase the success rates in making a quit attempt and should be used in ALL smokers
- Nicotine treatments are effective and well tolerated
- Dose aggressively
- Patient education about nicotine use
- SMI: May need increased dosing; combinations and longer term treatment for success

Jill Williams: Tobacco Dependence Treatment in Mental Health Settings
Other Treatments

- Anti-depressants
  - Bupropion

- Varenicline (Chantix) First Line Treatment
  - Concerns regarding psychiatric symptoms
  - Success rate: 14-21%, better than bupropion and NRT.
Westman/ Schiff, 2010 based on Cochrane Review Data
Smoking and Psychotropic Medications

- Stabilized on inpatient unit: No-smoking
- Drug levels drop when discharged and return to smoking
- Quitting: Might result in increased blood levels. Closely observe at the least
Principles of Co-occurring Disorders Treatment

- Integrated mental health and addiction services
- Comprehensive services
- Treatment matched to motivational level
- Long-term treatment perspective
- Continuous Assessment of substance use
- Motivational interventions
- Psychopharmacology
- Case management
- Housing
Principles of Co-occurring Disorders Treatment

- Dual diagnosis patients develop stable remission at a rate of about 10-15% achieving remission per year

- Programs need to take a long term, outpatient perspective

Drake & Mueser, 2001; Drake 2000
SMI and Tobacco Dependence

- Tobacco Dependence Medications must be part of the psychopharmacologic treatment plan
  - Consideration of the need to deviate from “standard” treatment
  - How and why (logic of plan)
  - Thoughts about next steps
  - Cost benefit considerations
  - Important aspect of plan whether or not prescribing is done by the psychiatrist or by primary care
  - Difficult to quit patients need focused and aggressive treatment planning around smoking dependence treatment
The FIVE A’s

• Ask
• Advise
• Assess
• Assist
• Arrange

Regardless of the client’s stage of readiness for a cessation attempt, the 5 A’s should be utilized at every visit.

The U.S. Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence 2008
SMI and Tobacco Dependence

- Assessment and counseling
  - Every patient who smokes/ every visit
  - Included in every treatment plan for smokers
  - Integrated into every format
  - Access to tools:
    - Five A’s; Fagerstrom; toolkits, etc..
  - Planning for quitting is crucial for SMI
    - Meds
    - Relapse prevention
    - Weight gain
Counseling

- Motivational Interviewing
- CBT Approaches
- Individual/ Group/ Combination
- Integrated into treatment plan
- Consideration of needs specific to SMI:
  - Relapse
  - Medication impact of quitting and relapse
  - Impact of Weight Gain
  - Attention to depressive symptoms
Conclusions

- It’s the smoke that kills
- Mental health professionals need to be MORE involved in tobacco treatment
- Tobacco Free policies at behavioral health services support tobacco cessation for recipients
- Treatments increase the success rates in making a quit attempt and should be used in all smokers
- Policies such as tobacco free psychiatric hospitals support treatment initiatives
• OMH Wellness Initiative: LifeSPAN
  • http://www.omh.state.ny.us/omhweb/adults/wellness/lifespan/smoking_cessation/
• UMDNJ Learning About Healthy Living Manual
  • http://ubhc.umdnj.edu/nav/LearningAboutHealthyLiving.pdf
• University of Colorado Smoking Cessation in People with mental Illnesses
• APNA Tobacco Dependence Intervention Manual for Nurses
• NASMHPD Tobacco-Free Living in Psychiatric Settings
  • http://www.nasmhpd.org/general_files/publications/NASMHPD.toolkit.FINAL.pdf
References

  John Hughes, M.D., and Fagerstrom, K. Interventions for treatment-ressistnt smokers. Fagerstrom Consulting
Tobacco Dependence Treatment Modules Available Through CPI’s FIT Initiative

- Practitioner tools for treating tobacco dependence
- Understanding the use of medications to treat tobacco dependence
- Implementing tobacco dependence treatment
- Now under development – module designed for consumers and family members about tobacco dependence treatment
Practitioner tools for treating tobacco dependence

This training module will help practitioners learn how to screen and assess tobacco use and dependency among individuals with serious mental illness. Practitioners will learn intensive counseling strategies to help the tobacco dependent client quit and appropriate documentation for assessment and treatment planning.

After viewing this module, practitioners will be able to create a comprehensive Tobacco Treatment Plan through appropriate screening, assessment and intervention strategies that have been identified in this module.
Understanding the use of medications to treat tobacco dependence

This training module educates both prescribers and non-prescribers on how smoking affects the metabolism of psychiatric medications. Prescribers and non-prescribers will learn about the three categories of first-line medications that are safe and effective treatment for tobacco dependence.

After viewing this module the practitioner will be able to provide brief education and instruction on the types of safe and effective medications for treating tobacco dependence in people with serious mental illness.
Implementing tobacco dependence treatment

This training module provides an overview of the epidemiology of tobacco use among individuals with serious mental illness; effective methods for tobacco dependence treatment, and information to help program leaders create, implement and maintain a tobacco free culture in mental health settings.

After viewing this module, practitioners will be able to describe the epidemiology and impact of tobacco use among individuals with serious mental illness; define effective methods for tobacco dependence treatment; and begin discussing how to implement and integrate tobacco dependence treatment in their mental health settings.
Integrating Health and Wellness in PROS: Wellness Self-Management

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Center for Practice Innovations

NYAPRS PROS Academy
November 15, 2012
Agenda

• The problem
• What is WSM and why is it important?
• WSM+
• WSM resources available through CPI
• Open Discussion, questions and answers
The Problem

Persons diagnosed with serious mental illness are now dying 25 years earlier than the general population.

The Problem

Increased Morbidity and Mortality Associated with Serious Mental Illness (SMI)

- Increased Morbidity and Mortality Largely Due to Preventable Medical Conditions
  - Metabolic Disorders, Cardiovascular Disease, Diabetes Mellitus
  - High Prevalence of Modifiable Risk Factors (Obesity, Smoking)
  - Epidemics within Epidemics (e.g., Diabetes, Obesity)

The Problem

What are the Causes of Morbidity and Mortality in People with Serious Mental Illness?

While suicide and injury account for about 30-40% of excess mortality, about 60% of premature deaths in persons with schizophrenia are due to “natural causes”

– Cardiovascular disease
– Diabetes
– Respiratory diseases
– Infectious diseases

The Problem

Schizophrenia: Natural Causes of Death

- Higher standardized mortality rates than the general population from:
  - Diabetes 2.7x
  - Cardiovascular disease 2.3x
  - Respiratory disease 3.2x
  - Infectious diseases 3.4x
- Cardiovascular disease associated with the largest number of deaths
  - 2.3 X the largest cause of death in the general population


The Problem

Access and Quality of Care

SMI may be a health risk factor because of:

- Patient factors, e.g.: amotivation, fearfulness, homelessness, victimization/trauma, resources, advocacy, unemployment, incarceration, social instability, IV drug use, etc.
- Provider factors: Comfort level and attitude of healthcare providers, coordination between mental health and general health care, stigma
- System factors: Funding, fragmentation

Question

Are these findings consistent with your experience and observations?
Question

What is your PROS program currently doing to address this issue?
Wellness Self-Management

Wellness Self-Management

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at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.
What is Wellness Self-Management?

• Curriculum based practice designed to assist adults to effectively self-manage serious mental health and related problems

• The topics covered include a number of research informed approaches that are organized into a comprehensive and coordinated set of practices

• Integrates 3 key areas:
  • Recovery
  • Mental health wellness and relapse prevention
  • Physical health
What is Wellness Self-Management? Continued

Based upon several sources:

- Dartmouth/SAMHSA *Illness Management and Recovery* materials and implementation resource kits
- OMH Bureau of Recipient Affairs revision of Dartmouth materials
- Eli Lilly NTTP materials
- Feedback from focus groups involving consumers, practitioners, and experts on cultural competency
Eight Goals of the Program

• Learning about recovery and what it can mean for you

• Making the best use of your mental and physical health services

• Learning how mental health and physical wellness will help you to achieve your goals and support your personal recovery

• Staying well by decreasing symptoms of a mental health problem
Goals of the Program (continued)

• Learning how to manage day-to-day stress and prevent relapse
• Staying well by connecting with others
• **Staying well by living a healthy lifestyle**
• Recognizing and building on your cultural values and experiences to support your personal recovery
WSM: The Personal Workbook

- 57 lesson curriculum
- Integrates concepts of Recovery, Mental health wellness and Physical health
- Structured lesson format
  - Important information
  - Discussion points
  - Personalized worksheet
  - Action step planning
- Non-prescriptive language
WSM: Logistics

- Group or individual format
- Meets at least once a week for 45+ minutes
- Group meets around a table
- Optimally closed group with 8-10 members
  - Successfully employed in open groups
- Optimally co-led with a peer counselor
- May be customized to setting and population (Selected chapters and lessons)
2010 SAMHSA Science & Service Award
Goals Identified by Consumers at the Beginning of the WSM Program
(n = 409)

- Being confident I can handle my mental health problems
- Improving my physical health
- Enjoying hobbies, leisure and recreational activities
- Being hopeful about my future
- Using medication in a way works for me
- Working at a paid job
- Living in a place that I like and can manage
- Engaging in creative activities
- Stopping or reducing my use of alcohol, drugs or cigarettes
- Working towards an academic degree
- Contributing to my community in a useful way
- Add your own goal
- Having a good relationship with family members
- Socializing with friends
- Improving my spiritual/religious side

Percent of Consumers

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Personal Assessment of Progress at the End of the Program

- Stopping or reducing my use of alcohol, drugs or cigarettes (n = 259)
- Using medication in a way works for me (n = 309)
- Having a good relationship with family members (n = 110)
- Socializing with friends (n = 110)
- Enjoying hobbies, leisure and recreational activities (n = 330)
- Living in a place that I like and can manage (n = 289)
- Engaging in creative activities (n = 292)
- Being confident I can handle my mental health problems (n = 339)
- Improving my physical health (n = 339)
- Improving my spiritual/religious side (n = 99)
- Contributing to my community in a useful way (n = 233)
- Being hopeful about my future (n = 322)
- Working at a paid job (n = 296)
- Add your own goal (n = 129)
- Working towards an academic degree (n = 243)
WSM Summary

- Winner of 2010 SAMHSA Science to Service Award
- Offered throughout NYS in inpatient and community services programs
- Over 100 programs have used WSM
- Over 4000 consumers have benefitted
- Online training course and workbook materials available
WSM+

- Collaboration among OMH, OASAS and CPI
- 57 lesson workbook -- adaptation of WSM workbook
- Emphasis on mental health and substance use issues throughout the entire workbook
- Pilot learning collaborative with 30+ programs (OMH and OASAS) – 2010-2011
WSM+ Personal Assessment of Progress at the End of the Program

Data as of 11/28/2011

- Stopping or reducing my use of alcohol or drugs (n=28)
- Add your own goal (n=9)
- Enjoying hobbies, leisure and recreational activities (n=29)
- Using medication in a way works for me (n=26)
- Engaging in creative activities (n=21)
- Having a good relationship with family members (n=31)
- Being confident I can handle my mental health problems (n=31)
- Living in a place that I like and can manage (n=30)
- Being hopeful about my future (n=28)
- Socializing with friends (n=27)
- Working towards an academic degree (n=19)
- Improving my physical health (n=27)
- Improving my spiritual/religious side (n=24)
- Contributing to my community (n=18)
- Working at a paid job (n=21)
Available Resources

CPI’s website (www.practiceinnovations.org) offers:

- Electronic version of WSM and WSM+ workbooks, free of charge
- WSM workbooks translated into Spanish, Chinese and Korean
- Bound, paper copies of WSM and WSM+ workbooks
- Electronic version of informational brochure
- Promotional videos (on our website)
- Practitioners’ Quick Guide to implementing WSM
- Online training module, free of charge within NYS

Contact Information for WSM

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