Center of Excellence for CHSI Health Systems Improvement

Literature Review:

Emerging Practices for Tobacco Dependence Interventions and Treatments for Individuals with Serious Mental Illness

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Promoting Health Systems Improvement for a Tobacco Free New York

A Project of CAI

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Background

Tobacco use is the leading preventable cause of morbidity and mortality in the United States, responsible for over 443,000 deaths per year, or nearly 1,300 deaths every day.[1] An estimated 25,400 of these deaths take place in New York State, where second-hand smoke is responsible for 2,600 deaths annually.[2] While there has been a steady decline in overall smoking prevalence in New York State in recent years, rates have remained stagnant among those with serious mental illness. More than 1 in 3 adults (36%) with any mental illness are tobacco users, compared to approximately 1 in 5 adults (21%) with no mental illness.[3] For those with severe mental illnesses, smoking rates are even higher, estimated to be at 59% for persons diagnosed with schizophrenia, 46% with bipolar disorder, and 38% with serious psychological distress.[4]

Tobacco-related illnesses including cancer, heart disease, and lung disease are among the most common causes of death among the mentally ill. Individuals with serious mental illness and substance abuse treated in the public health system die a startling twenty-five years earlier than those without mental illness.[5] Often, patients with mental illness have been smoking for more years and consuming more cigarettes per day than smokers in the general population. As a result, they may need more intensive treatment to help them quit and may benefit from longer durations of treatment.

Despite common misconceptions among mental health practitioners around the ability and willingness of patients with serious mental illness to quit smoking, this population is as capable of quitting successfully as other smokers, and are as likely to benefit from evidence-based cessation treatments as the general smoking population, although intensive and longer treatment sometimes is required.[6] The behavioral healthcare system is in an opportune position to address this need due to its ability to facilitate a continuous and prolonged relationship providing care and treatment to patients with serious mental illness. As such, there is a need for a rigorous examination and review of the literature on emerging practices for interventions and treatments for individuals with serious mentally illness within mental health settings.

Purpose of Literature Review

The aim of this literature review is to examine the literature on emerging practices for interventions and treatments for individuals with serious mental illness to inform the Health Systems for a Tobacco-Free New York program's objective of decreasing the smoking prevalence among this population. This examination will inform activities of the Statewide Stakeholder Workgroup and its Mental Health Sub-Committee, which seek to advance policy and protocol changes that promote sustainable tobacco-free norms within treatment settings for serious mental illness by purposefully integrating evidence-based practices and treatments, as well as the work of 10 regional contractors with inpatient and outpatient facilities serving individuals with serious mental illness in their catchment areas.

Methods

Studies published in peer-reviewed journals in the last five years (2009-present) were identified through a keyword search using the PUBMED database. Keyword search terms included: smoking, tobacco, treatment, serious mental illness, mental disorders, and smoking cessation. The studies selected for review included systematic reviews and meta-analyses, cohort studies, case-control studies, and commentaries that addressed smoking cessation and treatment among individuals with serious mental illness.

Summary of Literature

Fifteen studies were identified and included in the literature review. The majority of articles recommended multi-pronged strategies that called for simultaneous work across the following areas:

- Conducting innovative counseling and treatment approaches tailored to meet the needs of individuals with serious mental illness
- Integrating smoking cessation treatment across healthcare disciplines (primary care; mental health)
- Educating practitioners in evidence-based practices and building competencies in these areas
- Combining pharmacologic treatment with behavior change
- Implementing widespread smoke-free policies

- Dispelling myths associated with treating individuals with serious mental illness for tobacco

For the purposes of this literature review, the articles are summarized into the following five subcategories: review articles on evidence for treatment and commentary; tobacco treatment for individuals with serious mental illness; stages of change for individuals with serious mental illness; integrated care; and smoke-free grounds policies.

- **Review articles on evidence for treatment and commentary:** Six meta-analyses and commentary articles were included in the review.
    - In the Prochaska article (2011),[7] the author explains how consistent myths have led to persistently high smoking rates among the mentally ill, including myths that individuals with mental illness are not interested in smoking cessation, that they do not have the capacity to quit, and that efforts to quit may actually impede mental illness treatment. As a result of these prevailing myths, there have been few studies identifying the most effective treatments and services for decreasing smoking prevalence among individuals with serious mental illness. Within the studies Prochaska reviewed, researchers found smokers with serious mental illness to be highly motivated in quitting smoking, and amenable to treatments such as: behavioral counseling, nicotine replacement products, and e-cigarettes. In addition, these studies suggest that garnering health systems' support and implementation of smoke-free policies may lead to more supportive environments. See *Appendix B* for a summary of evidence from the Prochaska article.
    - A meta-analysis by Molina-Linde (2011)[8] concludes that, while specific recommendations are varied, all studies recommend the following as effective strategies for smoking cessation of adults with major depression, schizophrenia and psychosis: increasing and prolonging the treatment period; implementing joint education techniques with cognitive-behavioral therapy; and simultaneously using drug treatments that help with both tobacco relapse and baseline psychiatric symptoms. However, there is great heterogeneity in the specific recommendations given by the studies. The author emphasizes several conclusions, including that smoking should be approached in patients with serious mental illness because in

addition to tobacco use meaning a serious risk of morbidity-mortality, it significantly affects their quality of life.

- Cerimele, et al's (2014)[9] review found that individuals with depression effectively quit smoking without worsening of their depression symptoms, including pharmacologic treatments such as varenicline and bupropion. The authors recommend reframing tobacco use treatment as a way to reduce overall psychiatric symptom burden and improve the general health of patients. Such reframing may encourage clinicians to make tobacco use treatment a higher priority in the care of patients with serious mental illness. Cerimele, et al's review also includes select special considerations when treating people with serious mental illness for tobacco dependence based on the literature (see *Appendix B*).

- **Tobacco treatment for people with serious mental illness:** Six articles in this literature search examined specific treatment interventions**:**
  - Cummins, et al (2014)[10] conducted a national survey among individuals with mental health conditions, specifically examining their susceptibility to e-cigarette use. The findings reveal motivation, willingness, and capability to quit smoking among individuals affected by mental health conditions, and suggest e-cigarettes may help contribute to tobacco reduction among this population.
  - Strong, et al (2014)[11] examined the cessation treatments preferred by depressed smokers residing in inpatient settings. Participants demonstrated interest in quitting smoking, with 46% having attempted to quit within the previous year (though not necessarily with an evidence-based treatment), 86% showing interest in behavioral counseling, and 92% shoring an interest in nicotine therapy. These findings highlight how intention exists among this population, and that depressed smokers are comfortable using medication as treatment due to their familiarity with psychotropic drugs. Nonetheless, emotional barriers including weight gain concerns may prevent this population from quitting smoking. As such, the authors suggest that healthcare providers need to integrate smoking cessation into their overall therapy services.
  - Morris, et al (2009)[12] used focus groups and semi-structured discussions to examine how to adapt evidence-based cessation services used in the general population to those specifically with serious mental illness. Analyses were conducted with patients, mental health providers, and

administrators. A major finding is that persons with mental illnesses often desire to quit smoking, struggle to find assistance, and encounter barriers to effective tobacco cessation services within the public mental health system, including barriers accessing FDA-approved medications for tobacco cessation and knowledge deficits among their health and mental health care providers. The findings from this study were used to develop a provider toolkit aimed at mental health providers which includes treatment strategies and referral approaches.

- Parker, et al (2012)[13] studied the impact, barriers, and facilitators of a pilot project to reduce high smoking rates among individuals with serious mental illness through tailored tobacco cessation services in mental health facilities, including motivational interviewing, cognitive behavior therapy techniques, and combination nicotine replacement therapy (but not bupropion, or varenicline). Of the 110 patients that attended at least one support session, 31% made a quit attempt and 15% stopped smoking. Though the intervention had efficacy, it did not succeed in assisting a high percentage of the sample to ultimately quit. The authors attribute complex systemic barriers to these poor findings and call for improving education to providers and staff, elevating the importance of smoking cessation among these providers, as well as integrating performance indicators with financial incentives.
- In the Cochrane Database Systematic Review by van der Meer, et al (2013),[14] the authors examined the effectiveness of smoking cessation interventions among smokers with current or past depression, both with and without specific mood management components. The only intervention that increased long-term cessation for those with both current and past depression was adding a psychosocial component to the standard cessation intervention. Pooled results from four trials suggest that bupropion may increase long-term cessation for those smokers with past depression; however, there was no evidence to suggest the effectiveness of bupropion among smokers with current depression. There also was insufficient evidence on the use of antidepressants or NRT without specific mood management components among smokers with current or past depression.
- Tsoi, et al (2013)[15] evaluated different cessation treatments for smokers with schizophrenia in a Cochrane Database Systematic Review. The

authors found that bupropion increased smoking cessation among smokers with schizophrenia without jeopardizing their mental state. Varenicline also increased the likelihood of cessation within this population; however, evidence was inconclusive about possible adverse effects on patient mental state. Additionally, contingent reinforcement may help smokers with schizophrenia reduce tobacco-use in the short-term. There was no evidence to support the effectiveness of the other interventions examined in this review.

- **Stages of change (5 A's) for individuals with serious mental illness:**
  - Dixon, et al (2009)[16] published a paper on the effectiveness of the 5 A's (Ask, Advise, Assess, Assist, and Arrange) to help reduce smoking among individuals with serious mental illness at mental health facilities. While there was no reduction in smoking prevalence rates 6 months post-intervention, there was moderate cessation after 12 months. Thus, it could be that, when working with populations with serious mental illness, interventions may take additional time to show impact.
  - In a follow-up study, DiClemente, et al (2010)[17] examined progress over time using the stages of change among a subsample of the 2009 Dixon study. While the 2009 article reported modest quit rates, an examination of the stages of change mindset of the participants revealed that the 5 A's intervention was having an effect. This could indicate it takes longer for those with serious mental illness to move through the stages of change, and perhaps they would have moved beyond the precontemplation phase if given more time as part of the smoking cessation intervention.

- **Integrated care:**
  - Cerimele, et al (2014)[9] also discuss the important role primary care providers play in helping individuals with serious mental illness quit smoking since most patients with a psychiatric illness present initially to primary care rather than through specialty care settings. Therefore, primary care providers need to be well-versed in evidence-based tobacco cessation services and guidelines for those with serious mental illness, namely that the "principles of smoking cessation apply equally to the treatment of smokers with and without psychiatric illness" and appropriately identifying smokers through the 5 A's. The authors describe

how primary care providers should be equipped in addressing nicotine withdrawal, as individuals with serious mental illness may experience more acute withdrawal symptoms. Additionally, the authors recommend primary care providers using motivational interviewing and the 5 R's - Relevance, Risks, Rewards, Roadblocks, and Repetition - encouraging the same pharmacologic treatments that are recommended for non-psychiatric patients, and quit hotlines.

- Schwindt, et al (2014)[18] describe the effects of a tobacco education program geared towards nursing students on the delivery of tobacco cessation services for clients with serious mental illness. Educating nurses has important implications to treating individuals with serious mental illness because nurses are often on the frontline interfacing with these populations across fields (mental health, primary care, etc.); however, most nurses are ill-equipped to address treatment strategies. This educational program resulted in improved competence and motivation of nursing students to deliver cessation services to this population. Findings suggest that the underlying motivational processes of nursing students may influence their intentions to deliver cessation services, and that the availability of easy-to-use teaching resources facilitates the integration of tobacco education into existing curricula.
- In McFall, et al's (2010)[19] randomized control trial, the investigators demonstrated that integrating cessation treatment into mental health treatment for individuals with post-traumatic stress disorder resulted in better abstinence from smoking as compared to referring patients to specialized cessation treatment. Furthermore, the smoking cessation treatment did not impede in overall health or mental health care treatment for those who received integrated care.

- **Smoke-free grounds policy:**
  - Grant, et al (2014)[20] detailed an ethnographic study on the effects of institutional culture on the implementation of smoke-free grounds policies using observation, document review, and interviews with healthcare professionals and staff. Results demonstrate how successful smoke-free grounds policy implementation is affected by individual beliefs and attitudes and group norms, and that policy implementation most likely

occurs when there is strong leadership who both drives the mission and also consults with staff members.

- Hehir, et al (2013)[21] surveyed staff in a high-security mental health facility within an entirely non-smoking policy to understand the inner workings of a smoke-free inpatient mental health facility and assess any associated negative consequences. Facility staff positively reported working in a totally smoke-free environment, attributing positive outcomes to the health of their patients and themselves, as well as making it easier to deliver patient services. Additionally, only 20% of the respondents believed that the non-smoking policies resulted in their patients being more aggressive or difficult to manage.

Discussion

The literature revealed that while there can be increased barriers to accessing FDA-approved medications, smokers with serious mental illness are no less motivated or capable of smoking cessation than the general population[7, 10-12] There is also evidence to support the use of nicotine-replacement products or pharmacology over increased periods of time in combination with behavioral counseling as this is particularly effective among those with serious mental illness.[7, 8, 11, 14, 16, 17] In one randomized control trial, those who received tobacco dependence treatment integrated into treatment for post-traumatic stress disorder (PTSD) had higher rates of cessation than those who received the same treatment for PTSD but were referred to an external cessation program.[19]

Therefore, it is a matter of effective provision of tailored evidence-based treatment. Health systems support and smoke-free policies will only enhance and expedite this process.[7] In order to garner prioritization of tobacco dependence treatment at the systems-level in mental health and primary care settings, it is critical to connect tobacco use to general health and psychiatric burden when promoting the issue, and, when possible, integrating tobacco indicators into the facility's incentivized quality assurance measures.[9, 13]

Similarly, for those residing in in-patient facilities, quitting should be addressed in regular therapy to address patient concerns.[11] Since individual beliefs and attitudes and group norms effect smoke-free grounds policy implementation, it is critical for tobacco dependence prioritization at all levels, which is most successful when there is strong leadership driving the systems-level change and consulting with staff members.[20] One

study demonstrated positive health outcomes and easier service delivery for staff and patients in a high-security in-patient mental health facility after going smoke-free.[21]

Since those with serious mental illness can experience more acute withdrawal symptoms than the general population, it is important that any providers or staff addressing tobacco dependence with patients are well-educated and equipped to handle nicotine withdrawal.[9, 18] Effective strategies that can be used with those with serious mental illness are contingent reinforcement,[15] motivational interviewing, the 5A's (Ask, Advise, Assess, Assist, Arrange), and the 5 R's (Relevance, Risks, Rewards, Roadblocks, Repetition). [9, 16, 17] Staff can be educated in these concepts through the integration of the education into existing curricula or standards of care.[18]

In terms of specific tobacco dependence medication, bupropion and varenicline have shown to effectively help participants quit smoking without worsening their depression symptoms[9] and to increase cessation among participants with schizophrenia. Bupropion did not jeopardize the mental state of participants and results were inconclusive about the effect varenicline had on mental state among participants with schizophrenia.[15] E-cigarettes have also helped smokers with serious mental illness quit smoking in some cases.[10] Though research is currently examining the impact of tobacco cessation medication on specific serious mental illnesses, there is need for further evidence in order to define tobacco dependence treatment best practices by type of serious mental illness. Please see Appendix B for a summary of current findings on effective tobacco dependence treatment strategies for those with serious mental illness.[7]

Major findings from the articles included in this literature review support integrated care, including both FDA-approved tobacco cessation medication and counseling, systems-level change that impacts staff at all levels of mental health, including in-patient, and primary care facilities, the importance of garnering prioritization at all levels, and educating all staff who will provide direct services to patients. Though there is still substantial work to be done when it comes to defining best practices for specific tobacco cessation medication and people with serious mental illness, the recommendations above provide a good starting point for addressing systems-level change.

Appendix A. Table of Articles

Authors	Title	Journal/Publisher	Year	Topic
Prochaska JJ	Smoking and Mental Illness – Breaking the Link	New England Journal of Medicine	2011	Review of evidence on treatment and commentary
Molina-Linde JM	Effectiveness of smoking cessation programs for seriously mentally ill	Actas Españolas de Psiquiatra	2011	Review of evidence on treatment and commentary
Cerimele JM, Halperin AC, Saxon AJ	Tobacco Use Treatment in Primary Care Patients with Psychiatric Illness	Journal of the American Board of Family Medicine	2014	Integrated care (and includes a review of evidence on treatment and commentary)
Cummins SE, Zhu S, Tedeschi GJ, Gamst A, Myers MG	Use of e-cigarettes by individuals with mental health conditions	Tobacco Control	2014	Tobacco treatment for mentally ill
Strong DR, et al.	Utilization of evidence-based smoking cessation treatments by psychiatric inpatient smokers with depression	Journal of Addiction Medicine	2014	Tobacco treatment for mentally ill
Morris C, Waxmonsky JA, May MG, Giese AA	What Do Persons with Mental Illnesses Need to Quit Smoking? Mental Health Consumer and Provider Perspectives	Psychiatric Rehabilitation Journal	2009	Tobacco treatment for mentally ill
Parker C, McNeill A, Ratschen E	Tailored tobacco dependence support for mental health patients: a model for inpatient and community services	Addiction	2012	Tobacco treatment for mentally ill

Authors	Title	Journal/Publisher	Year	Topic
Van der Meer RM, Willemsen MC, Smit F, Cuijpers P	Smoking cessation interventions for smokers with current or past depression	Cochrane Database System Review	2013	Tobacco treatment for mentally ill
Tsoi DT, Porwal M, Webster AC	Interventions for smoking cessation and reduction in individuals with schizophrenia	Cochrane Database System Review	2013	Tobacco treatment for mentally ill
Dixon L, et al.	Is Implementation of the Mental Health Centers Effective for Reduction of Smoking by Patients with Serious Mental Illness?	American Journal on Addictions	2009	Stages of change for people with serious mental illness
Diclemente C, et al.	Stage movement following a 5A's intervention in tobacco dependent individuals with serious mental illness	Addictive Behaviors	2010	Stages of change for people with serious mental illness
Schwindt RG, McNelis AM, Sharp D	Evaluation of a theory-based education program to motivate nursing students to intervene with their seriously mental ill clients who use tobacco	Archives of Psychiatric Nursing	2014	Integrated care
McFall M, et al.	Integrating tobacco cessation into mental health care for posttraumatic stress disorder: a randomized controlled trial	Journal of the American Medical Association	2010	Integrated care
Grant LG, Oliffe JL, Johnson JL, Bottorff, JL	Health care professionals implementing a smoke-free policy at inpatient psychiatric units	Qualitative Health Research	2014	Smoke-free grounds policy
Hehir AM, Indig D, Prosser S, Archer VA	Implementation of a smoke-free policy in a high secure mental health inpatient facility: staff survey to describe experience and attitudes	BioMed Central Public Health	2013	Smoke-free grounds policy

Appendix B. Select Information from Key Articles

The following table is from Prochaska's article (2014) to highlight the ***evidence-base for treatments and interventions for smokers with serious mental illness:***

Recommended Treatments for Tobacco Dependence and the Evidence Base for Use in Smokers with Mental Illness.*

Treatment Strategy	Findings in Smokers with Mental Illness
Clinician advice to quit and referral	In one trial in clinically depressed smokers, yielded abstinence rate of 19% at 18 months of follow-up.[1]
Individual cessation counseling	At 18 months of follow-up, individual counseling with access to cessation pharmacotherapy achieved abstinence in 18% of smokers with PTSD[3] and 25% of those with depression.[1]
Group cessation counseling	Group counseling plus nicotine replacement achieved 19 to 21% abstinence at 12 months of follow-up in outpatients with serious mental illness; tailoring content for smokers with schizophrenia was equally effective.
Quit-lines	The nearly 25% of callers to the California quit-line who had major depression were significantly less likely than nondepressed callers to have quit smoking at 2 months of follow-up.
Nicotine replacement: patch, gum, lozenge, inhaler, nasal spray	One trial found nicotine gum particularly helpful among depressed (as compared with nondepressed) smokers (36% abstinence at 3 months). In acute care settings, nicotine replacement reduced agitation in smokers with schizophrenia and was associated with lower rates of leaving inpatient psychiatric settings against medical advice. Extended use of a nicotine patch reduced relapse risk among smokers with schizophrenia. A case series documented that nicotine nasal spray was used appropriately by smokers with schizophrenia and supported cessation.
Bupropion	An effective cessation aid in smokers with or without current or past depression. A meta-analysis of 7 trials in 260 smokers with schizophrenia showed significant effects at 6 months of follow-up.[4] According to a case study, two smokers with bipolar disorder quit smoking with no adverse effects on mood.
Varenicline	Three case series involving medically stable outpatients with schizophrenia reported significant smoking reduction, 8-to-75% quit rates, improvements on some cognitive tests, and no serious adverse effects; individual case reports reveal mixed effects in smokers with schizophrenia or bipolar disorder. Three randomized, controlled trials in smokers with schizophrenia or depression are in process.
Nortriptyline	Demonstrated efficacy in the general population and among smokers with a history of depression; no data on smokers with current mental illness.
Clonidine	Demonstrated efficacy in the general population; no data on smokers with mental illness.

* Information on recommended treatments for tobacco dependence is from Fiore et al.[5] Bupropion and varenicline include an FDA-mandated black-box warning highlighting the risk of serious neuropsychiatric symptoms, including changes in behavior, hostility, agitation, depressed mood, suicidal thoughts and behavior, and attempted suicide. Nortriptyline and clonidine are second-line cessation pharmacotherapies that have been identified as efficacious in the general population but are not FDA-approved. PTSD denotes post-traumatic stress disorder.

The following table from Cerimele, et al's (2014) review article describes some ***special considerations when treating smoking in patients with psychiatric illness:***

Tobacco smoke–medication Interactions	Tobacco smoke, but not nicotine, induces the metabolism of several psychotropic medications through the CYP1A2 enzyme. Medication doses for some psychotropic medications will need to be reduced if the patient achieves abstinence from smoking.
Nicotine withdrawal	Symptoms of nicotine withdrawal, such as irritability, sleep problems, fatigue, impaired concentration, and appetite changes, may mimic symptoms of psychiatric illness. Nicotine withdrawal can be alleviated with nicotine replacement therapy or with varenicline to some extent.
Persistence	Successful smoking cessation requires persistent efforts since most patients require more than one attempt to quit. Every attempt to quit provides opportunities for learning how to quit, and patients are more likely to succeed with each subsequent try.
Caffeine–tobacco smoke interaction	Tobacco smoke also induces the metabolism of caffeine. Smoking cessation without a reduction in caffeine intake may lead to symptoms of caffeine toxicity, including anxiety, restlessness, sleep problems, and irritability, which can mimic symptoms of psychiatric illness.

Appendix C. References

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