What Helps People with a Mental Illness **Stop Smoking?**





L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

uOttawa

L'Université canadienne Canada's university



INSTITUT DE CARDIOLOGIE DE L'UNIVERSITÉ D'OTTAWA

Learning Objectives

- To describe the 'Ottawa Model' for Smoking Cessation, and an emerging model of collaboration between the University of Ottawa Heart Institute, the Canadian Mental Health Association-Ottawa Branch, and the University of Ottawa.
- 2. To provide an overview of tobacco use and health effects for people who have a serious mental illness and are homeless or vulnerably housed. To address the systemic, historic and educational barriers to providing smoking cessation interventions, and to identify how tobacco use contributes to specific health disparities in this population.
- 3. To outline successful smoking cessation approaches for individuals with serious mental illness. Medical directives for high doses of nicotine replacement therapy will be presented. Discussion of a current research study in Ottawa will demonstrate what can be achieved through collaboration in both clinical practice and at a system's level.

It's complicated.....

A health care system – even the best health care system in the world – will be only one of the ingredients that determine whether your life will be long or short, healthy or sick, full of fulfillment, or empty with despair.

The Honourable Roy Romanow, 2004

Ottawa Model for Smoking Cessation

0



Smoking is a leading cause of hospitalization

Smoking is a leading cause of <u>REHOSPITALIZATION</u>

Smoking is The Leading Preventable Cause of Disease and Death¹

Cardiovascular

Ischemic heart disease (#2)* Stroke – Vascular dementia² Peripheral vascular disease³ Abdominal aortic aneurysm

Active Smoking

Respiratory COPD (#3)* Pneumonia Poor asthma control

Other

Adverse surgical outcomes/ wound healing Hip fractures Low bone density Cataract Peptic ulcer disease[†]

Reproductive

Low birthweight Pregnancy complications Reduced fertility SIDS

*Top 3 smoking-attributable causes of death. [†]In patients who are *Helicobacter pylori* positive. COPD = chronic obstructive pulmonary disease; SIDS = sudden infant death syndrome. I. Surgeon General's Report. *The Health Consequences of Smoking*; 2004. 2. Roman GC. *Cerebrovasc Dis.* 2005;20(Suppl 2):91-100. 3. Willigendael EM et al. J Vasc Surg. 2004;40:1158-1165.

Cancer Lung (#1)* Oral cavity/pharynx Laryngeal Esophageal Stomach Pancreatic Kidney Bladder Cervical Leukemia

Intensive smoking cessation intervention reduces hospital readmission and all-cause mortality



44% relative risk reduction in hospital readmission

77% relative risk reduction in mortality

Mohiuddin, S. M. et al. Chest 2007;131:446-452



Smoking and Institutional Practice

There is a need to ensure that cessation efforts are coordinated, systematized, and integrated into <u>all</u> health settings.

"The Ottawa Model" Identification Documentation **Strategic Advice** Pharmacotherapy Long-term follow-up

Reid RD, Pipe AL, Quinlan B. Can J Cardiol 2006;22:775-780

Transforming







Organizational Practices Professional Behaviours

Patient Care



Transforming Professional Standards

Expected behaviour of hospital staff

- ∵ Ascertainment of smoking status of all admitted patients
- ∵ Provision of smoking cessation counseling to all smokers along with educational materials
- Provision of smoking cessation medications to smokers experiencing withdrawal and/or intending to quit smoking
- :: Entry into database
- ∵ Enrollment in follow-up system

Health Outcomes

Increased long-term cessation among hospitalized smokers



Changing practice is a multi-step process



Growing Community of Practice...

Year	2007	\rightarrow	2012
Sites	17	\rightarrow	130+
HCPs trained	680	\rightarrow	5100+
Smokers reached	5645	\rightarrow	22,725+

Over <u>70,000</u> smokers have been reached through OMSC programs across Canada



Is telephone counselling a useful addition to physician advice



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Robert D. R William A. I

Abstract

Background: T selling by a apy in helpi Methods: The t tal of 396 v assigned to teleph degree vice C 3 o therapy. Ter after the tars after the targ Results: The pa tween the c quit rates di 12 and 26 w Interpretation: apy, can he phone coun of assistance selected by

Robert Reid, PhD, N Monika Slovinec D'A

PURPOSE: Smokin

RESULTS: Stepped

CONCLUSIONS: A

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Stepped Care Approach to Smoking

HEALTH OUTCOMES/PUBLIC POLICY

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Promoting smoking corection during hospitalization NicotinNicotine:& TobacconResearch Advance Access published November 10, 2009

for c

Robert D Reid Ph

Original Investigation

Smoking cessation for hospitalized smokers: An evaluation of the "Ottawa Model" Campbell et al. Implementation Science 2011, 5:108

http://www.implementationscience.com/content/6/1/108



Abstract

Introduction: Interventions for hospitalized crease long-term smoking cessation rates. Th for Smoking Cessation (the "Ottawa Model") of the "5 A's" approach to cessation, customiz-Ottawa Model in 9 hospitals in eastern Ontario

Methods: The RE-AIM (Reach, Efficacy, A mentation, and Maintenance) framework was the intervention. Trained outreach facilitators tals to implement the Ottawa Model; program monitored over a 1-year period using admini data from a follow-up database. A before-and conducted to gauge the effect of the Ottawa M cessation rates 6 months after hospitalization smoking cessation were biochemically confirr sample of patients, and all cessation rates w potential misreporting.

Results: Sixty-nine percent of the expected nu received the Ottawa Model intervention. Cont tal, the confirmed 6-month continuous abs higher after, than before, introduction of th (29.4% vs. 18.3%; odds ratio = 1.71, 95% CI 2.43; $I^2 = 0\%$; p = .02). The intervention was accomplish counseling for smokers than delive or postdischarge follow-up. Attitudinal, manage mental challenges to program implementation



setting. This study evaluated the impact of is sharon Canobed", Koren Pieters', Rent-Anne Mullert, Robin Reecel and Robert D Rect

Abstract

Background: The Ottawa Model of Smoking Cestation (OMSC) is a hespital-based smoking is expanding across Canada. While the short-term effectiveness of hospital cessialion progra documented, less a known about long-term sustainability. The purpose of this exploratory understand how hospitals using the CMSC were addressing sustainability and determine if factors or issues that should be addressed as the program expanded

Methods, 5ix hospitals that differed on GMSC program activities ildentify and document to provide medication, and offer follow-up) were intentionally selected, and two key informat interviewed using a semi-structured interview guide. Key informants were usked to reflect implement the OMSC, the current implementation process, and perceived antianability of analysis of the interview transcripts was conducted and themes related to problem definiti influence, and pisgram features emerged.

Results: sustainability was operationalized as higher performance of OMSC activities than -Identified in the literature as important for sustainability, such as program design, difference organizational characteristics, and the community environment did not explain differences sustainability. Instead, key informants identifiest factors that reflected the interaction betwee problem was defined by stakeholders, how priorities and concerns were addressed, frature

mortality. Effec but they often : RD Reid, AL Pipe, B Quinlan. Promoting sm care interventic during hospitalization for coronary artery disease smoking cessa 2006;22(9):775-780. refers to the pr intervention an BACKGROUND: Quitting smoking is the most e

intense interve tion to reduce mortality in patients with coronary a smoke. Guidelines for the treatment of tobacco de METHODS: To addr mend that health care institutions develop plans to s hospitalized with tent and effective identification and treatment of to The participants University of Ottawa Heart Institute (Ottawa, On intensive stepp mented an institutional program to identify and therapy) or no a admitted to the Institute. abstinence mea

OBJECTIVES: The objectives of the present pape core elements of this program and present data cor and effectiveness.

PROGRAM DESCRIPTION: The goal of the prog the number of smokers who are abstinent from sm after a coronary artery disease-related hospitalization. the program include: documentation of smoking a admission; inclusion of cessation intervention on p individualized, bedside counselling by a nurse counse ate and timely use of nicotine replacement therapy phone follow-up; referral to outpatient cessation training of medical residents and nursing staff. Pr effectiveness were measured over a one-year period. RESULTS: Between April 2003 and March 2004, a ers were identified at admission, and 91% received help them guit smoking. At six-month follow-up, 44% CONCLUSIONS: Hospitalization for coronary as vides an important opportunity to intervene with sn motivation to quit is high. An institutional approa importance of smoking cessation in this patient increases the rate of smoking cessation. Posthospital should be a benchmark of cardiac program performar

Key Words: Coronary disease; Health care deliv Smoking

Robert D. Reid, Kerri-Anne Mullen, Monik Patricia M. Haley, Christine A. McLaughli RESEARCH

Ottawa Model Effectiveness in 9 Ontario Hospitals



(OR = 1.71; 95% CI = 1.11, 2.64; Z = 2.43; I2 = 0%; P = 0.02).

Reid RD, Mullen KA, Slovinec D'Angelo ME, Aitken DA, Papadakis S, Haley PM, McLaughlin CA, Pipe AL. *Nicotine Tob Res.* 2010 Jan; 12(1): 11-8





Saving bed days



Over 450 bed days saved at UOHI in 2009 with a \$200,000 investment (ROI = 355%)

Developing Regional Smoking Cessation Systems

- I. Creating partnerships
- 2. Creating knowledge exchange opportunities
- 3. Increasing access for smokers and creating seamless program linkages

Regional Smoking Cessation Programs

Inner City Health

Hospitals

Community

Mental Health

Agencies

Primary Care Central Registration

Smoking Cessation Continuing Challenges ... and Opportunities!

How would we define a 'vulnerable population' or a 'special population' of smokers?



Defining Underserved Populations in Smoking Cessation

 I0% higher smoking prevalence than general population
Disproportionate tobacco related health disparities
Lack of access or barriers to treatment
Understudied (lack of clinical trials)

(Borrelli, 2010)

Is modification of the Evidence Based Tx (AKA 'cultural adaptation') required for all underserved groups?



Avoiding the "Russian Doll" syndrome

Criteria for Considering if Adaptation or Modification of the Smoking Cessation EBT for the Underserved Group is Warranted

Are there differences from the general population in:

- I. Rates & patterns of smoking
- 2. Burden of tobacco-related health diseases
- 3. Predictors of smoking behavior (mediators)
- 4. Risk factors for treatment failure (moderators)
- 5. Protective factors (those that aid quitting)
- 6. Treatment engagement (participation, attrition)
- 7. Treatment response
- 8. Social validity of the EBT (accessible, acceptable)

Rates & Patterns of Smoking

 Up to 85% of individuals with severe mental illness continue to use tobacco products

(Harris, Parle & Gagne, 2007)

40% smoke more than forty cigarettes a day

(Horsfall, Clearly, Hunt & Walter, 2009)

 2003 Health Care for the Homeless User Survey determined smoking prevalence to be 73% (Baggett & Rigotti, 2010)



Prevalence of Smoking in the MHA Population



General Population vs Persons with Psychiatric Disorders

Kalman et al (2005) Am J Addict 14(2): 106-123

Smoking Prevalence Data at CMHA Ottawa (2010)









These practices increase the likelihood of ingesting infectious agents and toxins trapped in filters and tobacco remains.

Burden of Tobacco-Related Health Diseases

Individuals with severe mental illness die <u>25 years</u> earlier than the general population with 60% of premature deaths due to cardiovascular, respiratory and infectious diseases.

(Parks, Svendsen, Singer, & Foti, 2006)

• Coronary heart disease is the primary cause of premature death for individuals with Schizophrenia resulting in a 20% reduced life expectancy



(Hennekens, 2007)

How this contributes to inequitable Health Outcomes

Probability of survival to age 75 among homeless / vulnerably housed:

- 32% for men and
- 60% for women

Some of the largest differences in the mortality rates were for smoking related heart and respiratory diseases.



(Hwang et al., 2009, p. 1 of 9)

Predictors of smoking behaviour: Why do individuals with a mental illness smoke?

Literature cites:

- > Neurobiological vulnerabilities
- Psychosocial factors, theories of stress and reduced coping capacity
- > High co-occurrence of substance use disorder with mental illness & in homeless population, high cooccurrence of both mental illness and substance use disorder
- Lack of pleasant activities, physical activity, boredom

Risk factors for treatment failure

Factors related to the Mental Health System:

- Individuals with serious mental illness are less likely to even be offered information or support to address their tobacco use (Johnson et al., 2009)
- MH practitioners are less likely to treat tobacco addiction than other health providers

(Hall & Prochaska, 2009; Johnson et al., 2009)

Psychiatrist provided smoking cessation counseling in 12% of visits versus 38% of GP visits

(Ziedonis et al., 2008)



Why would this be?

- Prioritization of mental health treatment
- Belief among clinicians:
 - Persons with mental illness are not able or willing to quit
 - Smoking provides a singular source of pleasure for clients who have few material comforts
 - Quitting smoking will worsen the symptoms of mental illness and interfere with the ability to maintain abstinence from alcohol or drugs
- Staff safety concerns and fear of escalation of violence in in-patient settings


- Smoking cessation interventions do not endanger abstinence (Currie, Nesbitt, Wood & Lawson, 2003)
- Do not increase psychiatric symptoms (Banham & Gilbody, 2010; Hall & Prochaska, 2009)
- Facilities that continue to permit smoking have significantly higher incidents of conflict related to smoking than nonsmoking facilities

(Lane, Werdel, Schacht, Ortiz & Parks, 2009; Harris et al., 2006)



Additional risk factors for treatment failure

- medical co-morbidities
- poverty
- high unemployment
- lack of social support
- unstable housing
- unsupportive environments

Comorbidity High in Seriously Mentally III

A study in Maine comparing an age-matched sample of Medicaid enrollees with and without serious mental illness (SMI) found that the disease rates for the SMI group exceeded those of the non-SMI group in every disease category and that the SMI group had a higher rate of multiple medical conditions.



Source: "Morbidity and Mortality in People With Serious Mental Illness," NASMHPD, October 2006

Homeless and Vulnerably Housed: Chronic Health Conditions

(Housing Vulnerability and Health: Canada's Hidden Emergency, 2010)

- Arthritis 33%
- Hepatitis B & C 30%
- High Blood Pressure 18%
- Diabetes 8%
- Reported mental health problem 52%
- CÓPD 18%
- Asthma 23%
- HIV 6%
- Cancer 5%
- Cirrhosis 6%

Additional Material:

"40 is too young to die" (Early onset illness and mortality work group, 2011)

http://mainstayhousing.ca/PDF/40isTooYoungtoDiepaper.pdf



Protective Factors that Facilitate Quitting

Smokers with psychiatric disorders have similar levels of expressed desire to quit or reduce smoking as the general population

(Siru, Hulse & Tait, 2009; Hall & Prochaska, 2009; Moeller-Saxon, 2008)



Treatment Engagement (participation, attrition, adherence)

 In the U.S., only forty-one percent of state psychiatric facilities are smoke free

(NASMHPD, 2007, p. 15)

• Thirty percent of Canadian hospitals continue to have separate smoking policies for psychiatric patients

(Bardell & Brown, 2006)

 In residential programs for substance abuse treatment in Canada, only ten percent of reported providing on site smoking cessation treatment (Hall & Prochaska, 2009)

Surgeon General's WARSING Smoking Causes Lung Causers, Heart Disease, Englishers and May Complicate Programs. 7.

Tobacco industry and the mentally ill.....

- Individuals with mental illness comprise 44.3% of the U.S. tobacco market (Lasser et al., 2000)
- The tobacco industry has engaged in direct specific commercial marketing of cigarettes to homeless and mentally ill populations

(Apollonia & Malone, 2005)

 Identification that 'downscale' populations tended to smoke more: specific marketing approaches for the "Sub Culture Urban Marketing" smoking campaign, internally dubbed "Project SCUM" (NASMHPD, 2007)

Treatment Response: What does the Evidence Tell Us?

- Tailored smoking cessation interventions in addiction and/or mental health settings suggests positive outcomes (Aubin et al, 2012; Khara & Okoli, 2011; Selby et al, 2010)
- A systematic review of the efficacy and safety of buproprion in individuals with schizophrenia found significantly higher abstinence rates "without jeopardizing their mental state".

(Tsoi et al, 2010)

 Varenicline has been found to be "equally safe and effective in those with and without mental illness".

(Stapleton et al., 2007)

• A review of twenty-four studies assessing the effectiveness of smoking cessation for individuals with mental illness found that at the twelve month follow-up, quit rates were only marginally lower as compared to the general population.

(el-Guebably, Cathcart, Currie, Brown, & Gloster, 2002)

Social Validity of EBT's (EBT's are accessible, and viewed as helpful,

acceptable and relevant)

- Dose and intensity of the intervention required for this population (Medications & psychosocial interventions)
- Cost of treatment for those living in poverty
- Systemic 'silos' of treatment (Mental health, primary health care, addictions)

Potential Modifications of EBT for individuals with mental illness

- Integration of smoking cessation treatment within the mental health system
- Training to address systemic attitudinal barriers plus SC treatment for staff working in the MH system
- Tailoring of dose & intensity of interventions (pharmacotherapy & psychosocial interventions)
- NRT is cost prohibitive for those living in poverty. This is a medical intervention that needs to be available through Provincial health care plans
- For such heavily addicted populations harm reduction approaches need to be explored
- A new research and evaluation agenda needs to be developed that monitors the state of tobacco use for this population and begins to systematically evaluate population health interventions as they become more accessible to this population.

The "Take a Breath" Team at CMHA Ottawa





Fagerström Test For Nicotine Dependence

How soon after you wake up do you smoke your first cigarette?	3 = Within 5 minutes 2 = 6 to 30 minutes 1 = 31 to 60 minutes 0 = After 60 minutes	
Do you find it difficult to refrain from smoking in places where it is forbidden?	I = Yes 0 = No	
Which cigarette would you hate most to give up?	I = The first one in the morning0 = All others	
How many cigarettes per day do you smoke?	3 = 31 or more 2 = 21 to 30 1 = 11 to 20 0 = 10 or fewer	
Do you smoke more frequently during the first hours after waking than during the rest of the day?	I = Yes 0 = No	
Do you smoke if you are so ill that you are in bed most of the day?	I = Yes 0 = No	

8-10: Very High dependence 6-7: High 5: Medium 3-4: Low 0-2: Very Low



Level of Nicotine Dependence

Thinking About Quitting? Take A Breath....

Are you interested in participating in a program designed to help you quit or reduce your use of tobacco?

- Canadian Mental Health Association Ottawa Branch is conducting a study to help figure out what clients find helpful in reducing or quitting smoking
- **CMHA Clients** who are eligible for the study will be randomly assigned to 1 of 2 different treatment options
- **FREE** nicotine replacement therapy (NRT) available weekly if you qualify (after an initial physical health assessment by our Nursing team)
- FREE bus tickets to participate in the study

Want more information?

Talk to your worker & come to one of our information sessions.

Individual Client Appointment with RN/ NP

- CO monitoring
 - For validation, motivation and education
- Monitoring psychiatric and physical symptoms
 - Referral to physician/psychiatrist as necessary
- Dispensing NRT weekly encourages commitment
 - Opportunity to ask questions privately
- Adequate NRT dosing, longer term
 - Partnership with Ottawa Heart Institute for 'off label' medical directives

SMOKE FREE UTURE

A

A Day in the Life of Blood Nicotine

Subject smoking 1 cigarette per hour Transdermal patch.

Transdermal patch. Blood levels will vary with dosage and type of patch 21 mg, 24 hour

4mg chewing pieces (peak at 12 ng) drops to 0 at 6 am

Comfort zone for nicotine dependent smoker



Guide your Patients to a Smoke Free Future. CCSH. 1991

Nicotine Replacement Therapy: Patch

Dosing Strategy (24 hour continuous use):

- 7mg < 10 cigarettes
- 14mg 10-20 cigarettes
- 21mg > 20cigarettes
- 28mg > 30cigarettes
- 42mg > 40cigarettes

Titration/Combination



University of Ottawa Heart Institute Primary Care Smoking Cessation Program Nicotine Replacement Therapy (NRT) Protocol

Smokes >30 minutes of waking	Smokes within 30 minutes of waking	Treatment Plan	Instructions
<10		 7 mg for 6 weeks OR; use gum, lozenge or inhaler alone	:. Apply the patch to a clean, dry, non hairy area on the upper part of your body (arms, chest, back).
10-19	<10	14mg daily for 6 weeks then;7mg daily for 2 to 4 weeks	
20-29	10-19	 21mg daily for 6 weeks then; 14mg daily for 2 weeks then; 7mg daily for 2 weeks or longer 	:. Replace the patch with a new one every 24 hours.
30-39	20-29	 28mg (21mg + 7mg) daily for 6 weeks then; 21mg daily for 4 weeks then; 14mg daily for 2 weeks then; 7mg daily for 2 weeks or longer 	 Be sure to remove the old patch before putting on a new one. If you have difficulty sleeping remove your nicotine patch at bedtime.
	30-40	 35mg (21mg + 14mg) daily for 6 weeks then; 21mg daily for 4 weeks then; 14mg daily for 2 weeks then; 7mg daily for 2 weeks or longer 	
40+		 .42mg (21mg x 2) daily for 6 weeks then; . 35mg (21mg + 14mg) daily for 2 weeks then; . 21mg daily for 2 weeks then; . 14mg daily for 2 weeks or longer 	

Contraindications for Implementing the NRT Medical Directive

- Patient has had a previous adverse reaction to NRT
- Patient is using Varenicline/Champix
 - check with physician before prescribing
- Pregnant/breastfeeding patients
 - check with physician before prescribing
- Adolescents
 - check with physician before prescribing

Selecting the Initial Dose

Selecting an NRT treatment plan to match a smoker's unique needs is required to enhance success with smoking cessation:

- exposed environmental cues to smoke, OR
- have experienced difficulty with withdrawal when quitting in the past, OR
- smoke within 30 minutes form waking will require less NRT than other smokers.

Also consider: Patient preference and experience

NRT Titration

- There are slow and fast metabolizers and individuals may react differently to NRTs
- Monitor patients in the days and weeks following quitting to ensure the dose selected meets their needs.
- Titration of nicotine (up or down) is often required in order to tailor the treatment plan.
- Many patients will require the use of NRTs beyond the standard 10 to 12 weeks in order to be successful with quitting.

Managing Cravings

- If after 24 hours of starting NRT you are still experiencing moderate to severe withdrawal symptoms, try adding a short acting NRT like gum or the inhaler.
- If this is not enough, add one 7 mg patch to your treatment plan.
- Call the RN/NP if symptoms persist 24 hours following this change.

Addressing Myths Around NRT Use

(Zwar et al., 2006)

- Reluctance to use high-dose NRT because of possible side effects
 - Results in delaying smoking cessation
 - Offer trial quit date
- "Clean nicotine", safe
- Low abuse potential

However,

Sleep disturbances common with NRT

Smoking While Using NRT

(Fagerstrom & Hughes, 2001; Ferguson et al., 2012; Kozlowski et al., 2007; Schnoll et al., 2010)

Concurrent NRT & tobacco is safe

- Better to keep the patch on while smoking
- Misperceptions lead to relapse

"Reduce to quit" strategy

- Learning to manage cravings increases motivation and confidence to quit
- Gets person engaged in the process of quitting smoking
- Reduction in stress for setting quit date

The "Treatment Resistant" Smoker

(Bittoun, 2007)

Varied Response to NRT due to:

- Mental health status, depression
- Determinants of Health
 - socioeconomic status, education
- Pharmacogenetics (McClure & Swan, 2006)
 - Particularly CYP2A6 but likely many other relevant genes that are unknown at this time
- Race, ethnic and gender differences in nicotine metabolism through CYP2A6 gene



Effect of Smoking Cessation on Psychotropic Meds

- Blood levels of some antipsychotics can increase with smoking cessation
 - eg: clozapine, olanzapine, fluphenazine, haloperidol
 - Fluvoxamine inconsistent findings
- Polycyclic aromatic hydrocarbons
 - PAHs products of incomplete combustion
 - Potent inducers of hepatic cytochrome P450 IAI & IA2
- Metabolism of risperidone and quetiapine does not appear to be affected
 - (Morris, Waxmonsky et al., 2007, University of Colorado; Kroon 2007)

Effect of Smoking Cessation on Psychotropic Meds

- Must monitor medication side effects and psychiatric symptoms
 - Especially the first month after quitting
 - Ensure that antidepressant medications are at a therapeutic level before initiating smoking cessation

Schizophrenia:

• Nicotine withdrawal can mimic akathesia, depression, poor concentration, and insomnia

(Morris, Waxmonsky et al., 2007, University of Colorado)

Smoking Cessation What is Working Well

Meaningful Activities

- Communities and CMHA activities
- Volunteering, "giving back"
- Integrated Treatment Approach
 - Support from CMHA worker, housing, psychiatry, primary health care
 - Access to concurrent disorders and DBT groups
 - Supportive attitude from CMHA staff who have received education around smoking cessation

Integrated Treatment Approach at CMHA



Smoking Cessation What is Working Well

- Six month duration
- Adequate dose and combination NRT at no cost
 - "I could never do this without the patch"
- Participants offer possible solutions from their personal experience
 - "what worked for me was..."
 - Peer Facilitator trained in Advanced MI

Consistent use of **Motivational Interviewing Strategies...**

OARS

Open ended questions Affirmations Reflective listening Summaries, and....

Autonomy and Empathy

...are associated with increased levels of **Change Talk**

This change talk **predicts better outcomes** for:

- ~ people who consume alcohol
- ~ adolescents who are homeless & use drugs
 - emergency room patients

(Moyers et al, Baer et al, Gaume et al)

- Visualization/ Reframing:
 - "I'm a non-smoker now"

What people are telling us....

- "It feels good. I'm more aware of when I'm smoking and I'm not giving into the cravings anymore. I could never imagine stopping cigarettes but now I can."
- "Breathing is easier. I don't need as much Ventolin as I used to"
- "The sensation in my fingertips has improved"
- "It's incredible. I don't wake up in the middle of the night to smoke anymore."
- "Smoked: 0 cigarettes in 53 days, 13 hours and 6 minutes; Money saved: \$420.00; Cigarettes not smoked: 1070 or 50 packs." (from her iphone app)


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