A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

SMOKING CESSATION LEADERSHIP CENTER

ATTUD
Association for the Treatment of Tobacco Use and Dependence

WELCOME

Behavioral Health and Tobacco: The Final Frontier

Thursday, September 29, 2011 - 2:00 pm ET

During the Webinar

Tip: If you do not see the "Join Teleconference" popup box, please click on the "Audio" tab, then click "Join Teleconference".

- **Press *6 once to mute your phone line**
- **All phone lines will be muted during the presentation**
- **Do NOT put phone on hold**
- **Turn OFF your webcam by clicking on the camera icon** 
- **Webinar is being recorded**
- **Questions are encouraged throughout via the chat box**

Welcome

- **Alice Dalla Palu**
  - ***Moderator***
  - Executive Director, Tobacco Free Northeast PA@Burn Prevention Network
  - Chair, ATTUD Disparate Populations Committee

During the Webinar

Tip: If you do not see the "Join Teleconference" popup box, please click on the "Audio" tab, then click "Join Teleconference".

- **Press *6 once to mute your phone line**
- **All phone lines will be muted during the presentation**
- **Do NOT put phone on hold**
- **Turn OFF your webcam by clicking on the camera icon** 
- **Webinar is being recorded**
- **Questions are encouraged throughout via the chat box**

Agenda

- **Welcome**
  - Alice Dalla Palu, Moderator, Chair, ATTUD Disparate Populations Committee
  - Catherine Saucedo, Deputy Director, SCLC
- **Panel Presentation**
  - Chad Morris, PhD
  - Cathy McDonald, MD
  - Jill Williams, MD
  - Megan Piper, PhD
- **Questions & Answers**
- **Technical Assistance and Closing Remarks**

Disclosures: *Faculty speakers, moderator, and planning committee members have disclosed no financial interest/arrangement or affiliation with any commercial companies who have provided products or services relating to their presentation or commercial support for this continuing medical education activity.*

www.attud.org

Association for the Treatment of Tobacco Use and Dependence

ATTUD is an organization of providers dedicated to the promotion of and increased access to evidence-based tobacco treatment for the tobacco user.

www.attud.org

Goals of the Organization:

1. Provide forums (e.g. a listserve) for information exchange on best practices, innovations, etc
2. Promote evidence-based practices
3. Explore the need for credentialing of tobacco training programs, of treatment providers and of treatment organizations.

Goals (Continued)

4. Serve as a resource regarding implementation of evidence-based treatment
5. Advocate for increased access to evidence-based treatment modalities via policy, funding, and system changes.
6. Advocate both for smokers and for treatment specialists

Overview

- Over 350 members
- Established accreditation board for tobacco training programs
- Consultant to CMS, AHRQ, WHO, State of Florida, etc
- Very active listserv

Membership

Any individual who is currently active or has been historically active in the treatment of tobacco use and dependence, including:

- Health Care Providers (e.g. counselors, tobacco treatment specialists, physicians, nurses, etc.)
- Researchers
- Educators/Trainers
- Policy makers
- Students

For more information: www.attud.org

WELCOME FROM SCLC

Catherine Saucedo, Deputy Director
Smoking Cessation Leadership Center
University of California, San Francisco

Smoking Cessation Leadership Center

- Began in 2003 as a Robert Wood Johnson National Program Office with a $10-million 5 year grant
- Aimed at helping clinicians do a better job intervening with tobacco users
- Additional funding from VA, Legacy and ARRA
- Housed at UCSF

SCLC's Aim

- Help more people who want to quit smoking get help and support
- Changing norms among clinicians to make intervention everyday practice
- Broaden access to cessation tools and resources
- Improve coverage for treatment services

SCLC Partners with Many Groups

- National associations of clinicians
- Place based partnerships with cities, counties, states
- Federal agencies such as VA, SAMHSA, CDC, HRSA

Key Clinician Partnerships

- Nurses
- Dental Hygienists
- Diabetes Educators
- Pharmacists
- Family Physicians
- Emergency Physicians
- Physician Assistants
- Respiratory Therapists
- State Mental Health Program Directors
- Anesthesiologists
- Surgeons

Key Behavioral Health Partnerships

- American Psychiatric Nurses Association
- Depression and Bipolar Support Alliance
- CADCA
- Faces and Voices of Recovery
- NAADAC
- NAMI
- NASADAD
- NASMHPD
- The National Council
- Mental Health America
- University of Colorado Medical School at Denver
- SAMHSA

Work with SAMHSA

- Partnered with past and current SAMHSA administrators
- Created SAMHSA Tobacco-Free Initiative
- Trained SAMHSA staff in Washington
- Led to
  - ***100 Pioneers for Smoking Cessation Virtual Leadership Academy*** and
  - ***State-Level Leadership Academies for Wellness and Smoking Cessation***

In-Service Training Poster: July 7, 2008

Introduction of Presenter

- **Chad Morris, PhD**
  - Associate Professor
  - Director, Behavioral Health & Wellness Program

  University of Colorado Denver, Anschutz Medical Campus

  Department of Psychiatry

  chad.morris@ucdenver.edu

Introduction of Presenter

- **Cathy McDonald, MD, MPH**
  - Project Director
  - Alameda County Alcohol, Tobacco and Other Drug Provider Network;
  - Pediatrician and medical consultant, Thunder Road Adolescent Drug Treatment Program
  - cmcdonatr@aol.com

ATTUD ACTIONS TO TAKE: INTEGRATING TOBACCO TREATMENT WITHIN BEHAVIORAL HEALTH

The Disparate Populations Committee Objective

- Identify and address the needs of those disproportionately affected by tobacco use.
  - smokers with mental illnesses and addictions
  - pregnant smokers
  - low income populations

- The committee's initial focus was on persons with behavioral health conditions

Morbidity & Mortality

- **Persons with mental illnesses die up to 25 years earlier and suffer increased medical comorbidity**
  - **Smokers with mental illnesses have**
    - **more psychiatric symptoms,**
    - **increased hospitalizations, and**
    - **require higher dosages of medications**

(Brown et al., 2000; Colton & Manderscheid, 2006; Dixon et al., 1999; Joukamaa et al., 2001; Osby et al., 2000; Dalack & Glassman, 1992; Desai, Seabolt, & Jann, 2001; Goff, Henderson, & Amico, 1992; Williams & Ziedonis, 2004; Ziedonis, Kosten, Glazer, & Frances, 1994)

Prevalence of Tobacco Use

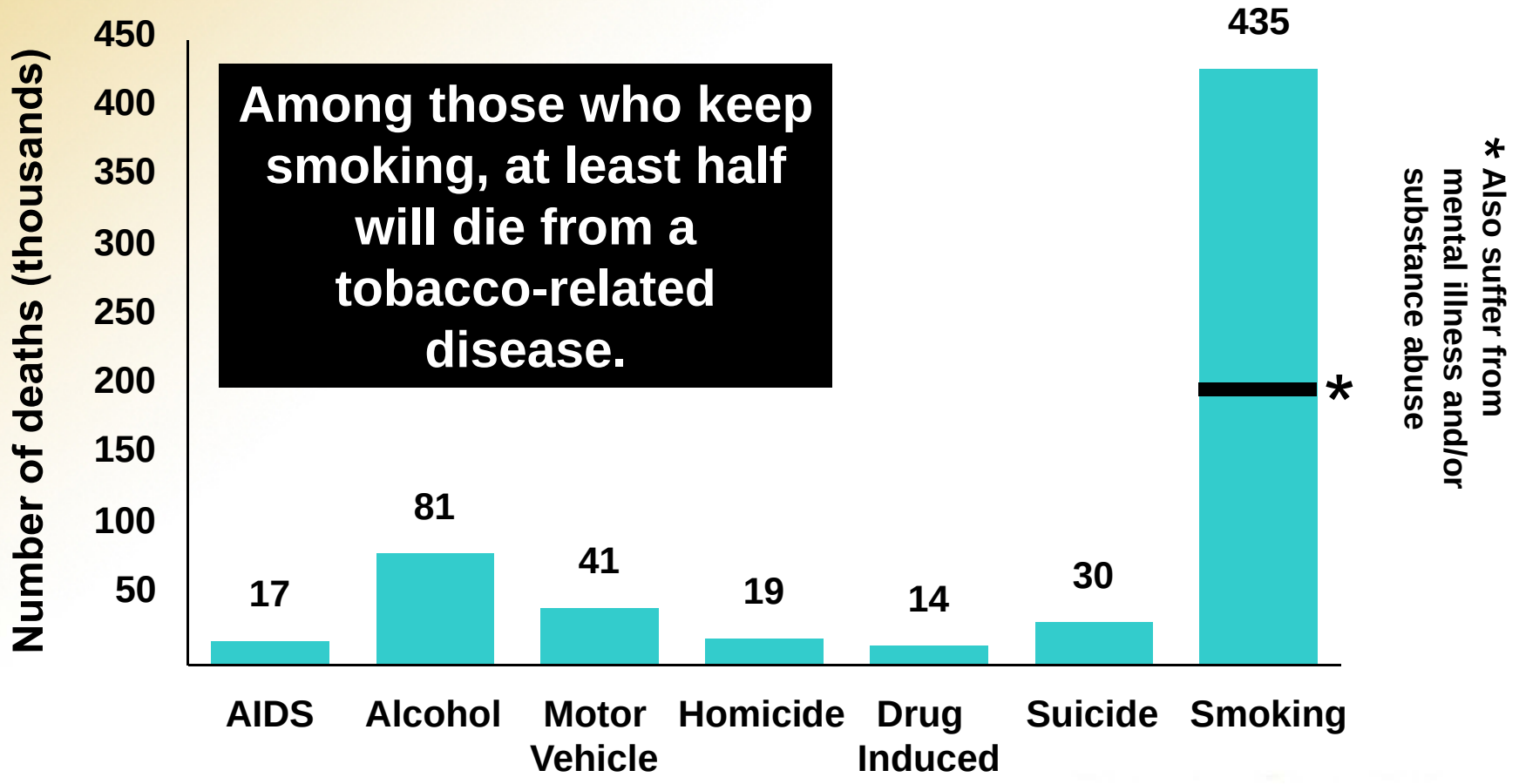
- **About 20% of U.S. adults are smokers**

While Persons with Mental Illnesses are:

- Nicotine dependent at rates **2-3 times** higher
- Represent over **44%** of the U.S. tobacco market
- Consume over **34%** of all cigarettes smoked

(Lasser K et al: JAMA 284:2606-10, 2000)

Comparative Causes of Annual Deaths in the U.S.

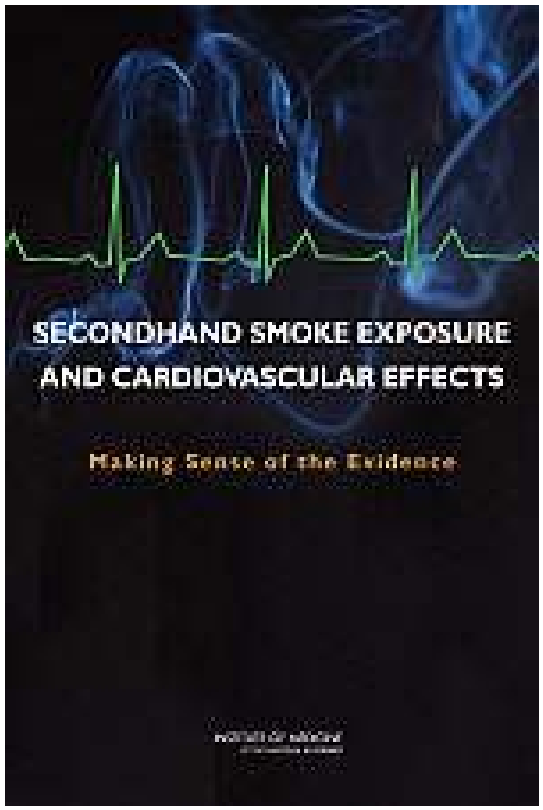


Behavioral Health and Wellness Program

Mokdad et al. (2004). *JAMA* 291:1238–1245.
Flegal et al., (2005). *JAMA* 293:1861–1867.

Secondhand Smoke

Nonsmokers who are exposed to secondhand smoke at home or work increase their heart disease risk by 25--30% and their lung cancer risk by 20–30%



http://www.cdc.gov/tobacco/basic_information/health_effects/heart_disease/index.htm

Community Behavioral Health Provider Integration of Tobacco Treatment

When faced with a patient who smokes, there are three acceptable responses:

1. Treat the patient yourself, according to the best evidence
2. Refer the smoker to a smoking cessation treatment facility
3. Refer the patient to a toll-free telephone "Quitline," accessed through 1-800-QUITNOW

A fourth alternative, doing nothing, is now unacceptable.

Schroeder, 2011

Review of Policy & Position Statements

- American Psychiatric Association
- American Psychiatric Nurses Association
- American Society of Addiction Medicine, Inc.
- NAADAC: The Association for Addiction Professionals
- NAMI: The National Alliance on Mental Illness
- NASMHPD: National Association of State Mental Health Program Directors
- NIDA: National Institute of Drug Abuse

Why Community Behavioral Health?

- Established rapport
- Integrated and health home models
- Access to high risk populations
- Community-based and patient-directed
- Complements other prevention and wellness activity
- Healthcare reform and new CMS regulations

All clinicians working with individuals with mental health or substance use disorders provide direct treatment to clients, develop professional capacity to do so, and fully integrate tobacco treatment into behavioral healthcare.

Implement Evidence-Based Interventions with all tobacco users

1) Screen Tobacco use and Dependence at intake with other chemical dependence

Do you use any tobacco?

2) Develop and implement tobacco treatment plans that address both behavioral and pharmaceutical treatment- How important is it to you to quit, 1-10?

Motivate those with low importance -Treat withdrawal if tobacco-free milieu - In action help prepare & treat with meds/counseling

Implement Evidence-Based Interventions with all tobacco users

3) Document tobacco diagnoses in client charts using DSM IV or ICD 9 criteria

DSM IV 305.10 Nicotine Dependence

292.0 Nicotine Withdrawal

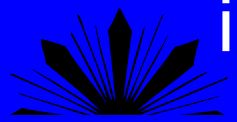
292.9 Nicotine Related Disorder not otherwise specified

ICD-9 305.10 Medical document-related medical conditions like COPD

Implement Evidence-Based Interventions with all tobacco users

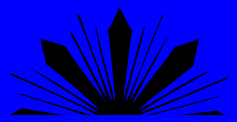
4) Use available billing procedures and codes to maximize reimbursement and sustain services -- Medicare/Medicaid

5) Provide discharge plans to facilitate care transitions and provide referrals for continued support. Consider referrals to state Quitlines: 1-800-Quit-Now; refer to continuing care that addresses tobacco; other local resources; Nicotine Anonymous; internet; etc.



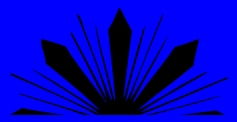
Enhance capacity of behavioral healthcare providers to provide effective client focused evidence-based tobacco treatment

1) Train Behavioral Health providers in the tobacco addiction process, diagnosis and evidence-based tobacco addiction management -- State or organization level or CTTS
1) Require staff treating tobacco dependence to demonstrate competency in providing evidence-based tobacco treatment
2) Provide ongoing continuing education opportunities for tobacco training



Fully integrate evidence-based tobacco addiction treatment into Mental Health & Addiction services

1) Address tobacco addiction with the same degree of commitment, resources & attention as other chemical addictions
2) Require counselors to perform & document tobacco assessment & treatment planning & incorporate into the client's overall care
3) Use systems for prompting routine & high quality care i.e., reminders, integration into electronic medical records & supervision



Fully integrate evidence-based tobacco addiction treatment into Mental Health & Addiction services

4) Regard tobacco addiction as a chronic condition requiring training in the management of tobacco addiction with: physician addiction medicine specialists, primary care physicians, clinical psychologists, psychiatrists & allied health professionals for a client-centered team approach

Fully integrate evidence-based tobacco addiction treatment into Mental Health & Addiction services

5) Advocate for client treatment reimbursement with insurers and employers commensurate with the burden of tobacco use in behavioral health populations which includes tobacco treatment counseling and pharmaceuticals.

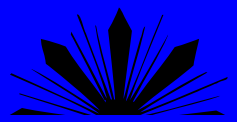
Require all mental health & substance abuse facilities and campuses to be tobacco-free to avoid undermining client and staff efforts to end tobacco dependence

1) Establish a tobacco-free policy for buildings, vehicles & grounds throughout the entire facility campus which applies to all clients, staff, volunteers & visitors.

   New York State - New Jersey - Oregon

2) Provide education and treatment support for staff and volunteers to gain buy-in, motivation and commitment

see Resource List



Introduction of Speaker

- **Jill Williams, MD**
  - Associate Professor Psychiatry
  - Director, Division of Addiction Psychiatry
  - UMDNJ-Robert Wood Johnson Medical School
  - williajm@umdnj.edu

Introduction of Presenter

- **Megan Piper, PhD**
  - Center for Tobacco Research and Intervention, University of Wisconsin, School of Medicine and Public Health
  - MEP@ctri.wisc.edu

Psychiatric diagnoses in smokers seeking treatment: Outcomes and treatment response

Megan Piper, Ph.D.

UW-CTRI
Center for Tobacco Research and Intervention
University of Wisconsin Medical School

uw-tturc
Transdisciplinary Tobacco Use Research Centers

Wisconsin Smokers' HEALTH STUDY

Acknowledgements

- Piper, M. E., Smith, S. S., Fleming, M. F., Bittrich, A. A., Brown, J. L., Leitzke, C. J., Zehner, M. E., Fiore, M. C. & Baker, T. B. (2010). Psychiatric disorders in smokers seeking treatment for tobacco dependence: prevalence and relations with tobacco dependence and cessation. *Journal of Consulting and Clinical Psychology, 78,* 13-23. PMCID: PMC2813467
- Piper, M. E., Cook J. W., Schlam, T. R., Jorenby, D. E., & Baker, T. B. (2011). Anxiety diagnoses in smokers seeking cessation treatment: Relations with tobacco dependence, withdrawal, outcome, and response to treatment. *Addiction, 106,* 418-427. PMCID: PMC3017215
- WSHS Students and Staff
  - More than 100
- These studies were conducted at the University of Wisconsin and supported by NIH Grants #P50-CA84724-05 and # P50-DA0197-06. Dr. Piper was supported by an Institutional Clinical and Translational Science Award (UW-Madison; KL2 Grant # 1KL2RR025012-01).
- Medication was provided to patients at no cost under a research agreement with GlaxoSmithKline.

uw-tturc

Wisconsin Smokers' HEALTH STUDY

UW-CTRI

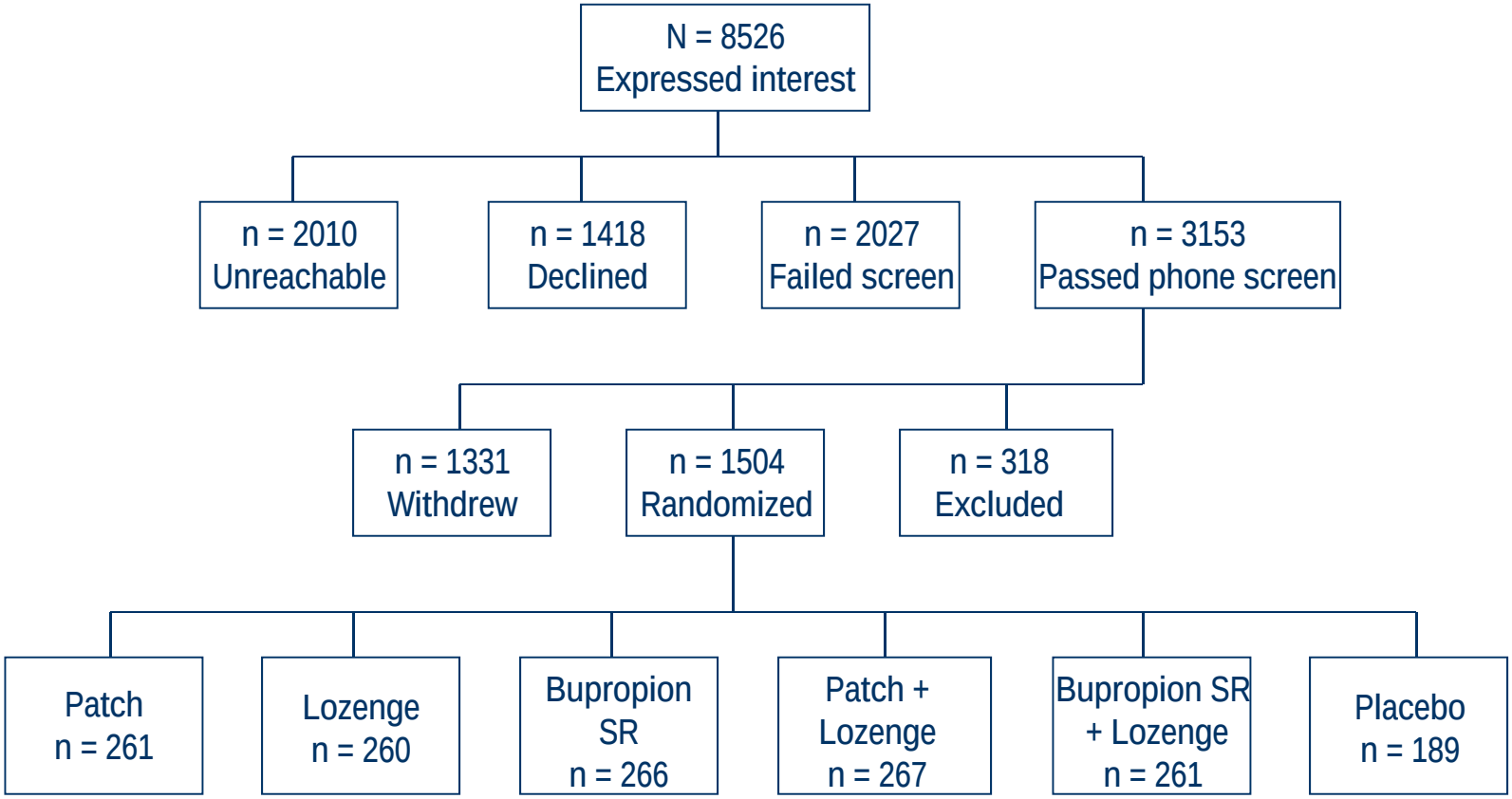
Research Questions

- Are there differences in cessation outcome among smokers with psychiatric comorbidities?
- Are there differences in treatment response among smokers with a history of anxiety?

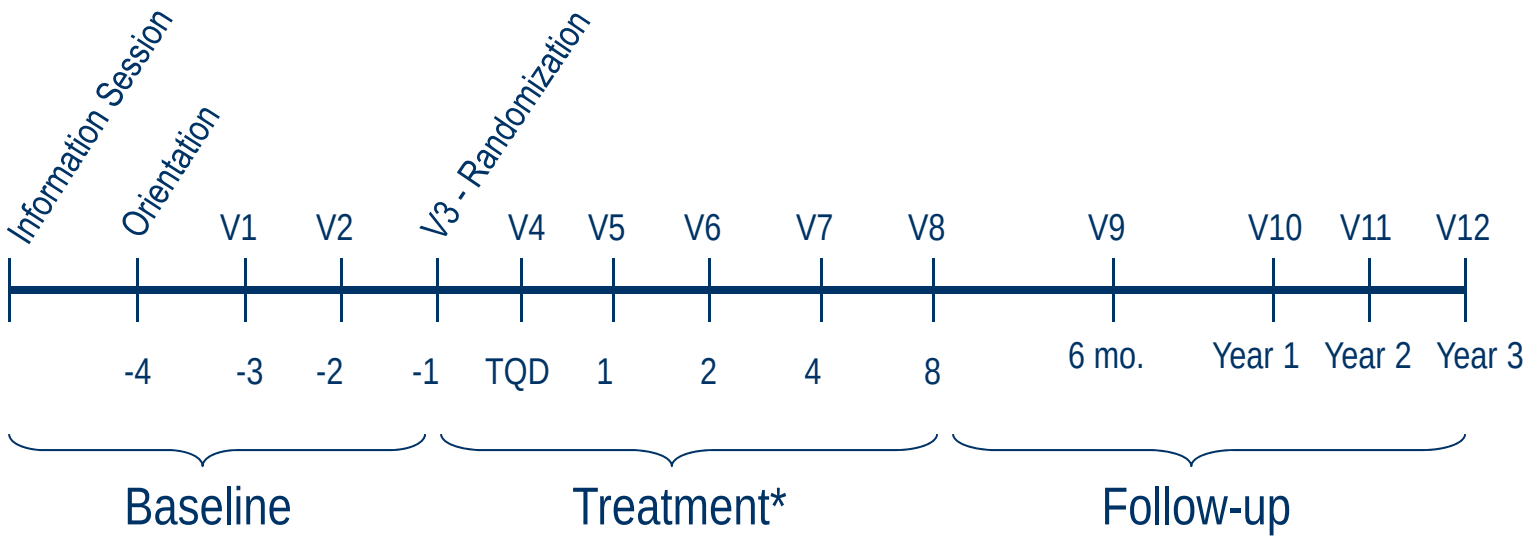
Recruitment and Inclusion/Exclusion Criteria

- Recruited in Madison and Milwaukee, WI
  - TV, radio and newspaper advertisements, community flyers
  - Earned media
- Inclusion criteria:
  - Smoking ≥ 10 cigs/day for the past 6 months
  - Motivated to quit smoking
- Exclusion criteria:
  - Contraindicated medications
  - Consuming ≥ 6 alcoholic beverages 6-7 days/week
  - Self-reported history of psychosis or bipolar disorder

CONSORT Figure



Study Timeline



*Counseling and medication

Psychiatric Assessment

- At Baseline and Years 1, 2 and 3
- World Mental Health Survey Initiative's Composite International Diagnostic Interview (WMH-CIDI; Version 20)
- 13 modules: Screening, Depression, Mania, Panic Disorder, Social Phobia, Generalized Anxiety Disorder, Substance Use, Services, Chronic Conditions, 30-day Functioning, 20-day Symptoms, and Attention Deficit Disorder
- Lifetime and past 12 month diagnoses
- Takes approximately 90 minutes

Participants

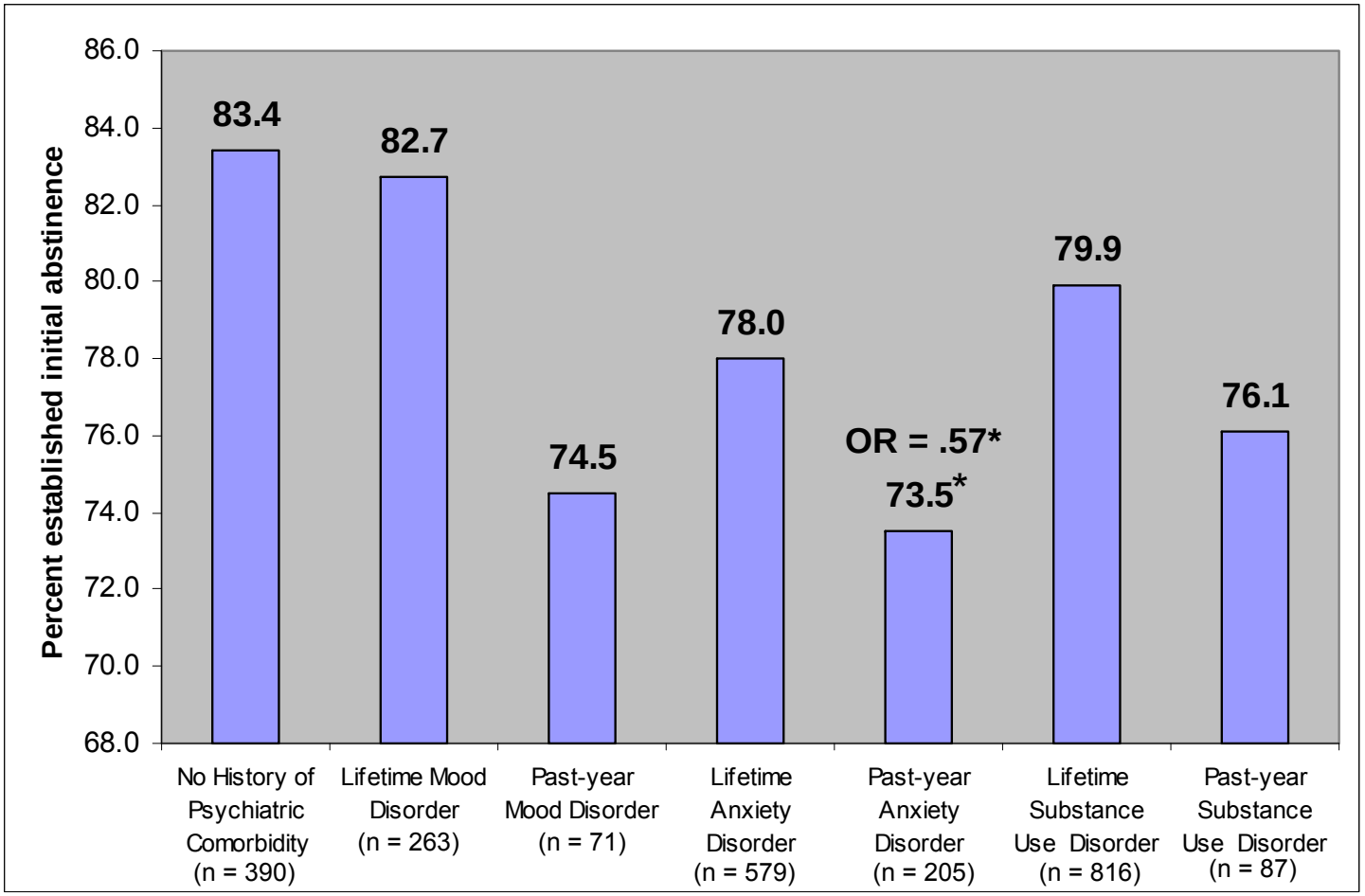
- N = 1504 (628 men, 876 women)
- Race/Ethnicity
  - 1258 (83.9%) White
  - 204 (13.6%) African-American
  - 42 (2.8%) parents of Hispanic origin
- 21.9% had a 4-year college degree
- Mean age = 44.67 (SD = 11.08)
- Mean cigs. smoked/day = 21.43 (SD = 8.93)
- Mean number of quit attempts = 5.72 (SD = 9.65)

Presence (%) of DSM Diagnoses

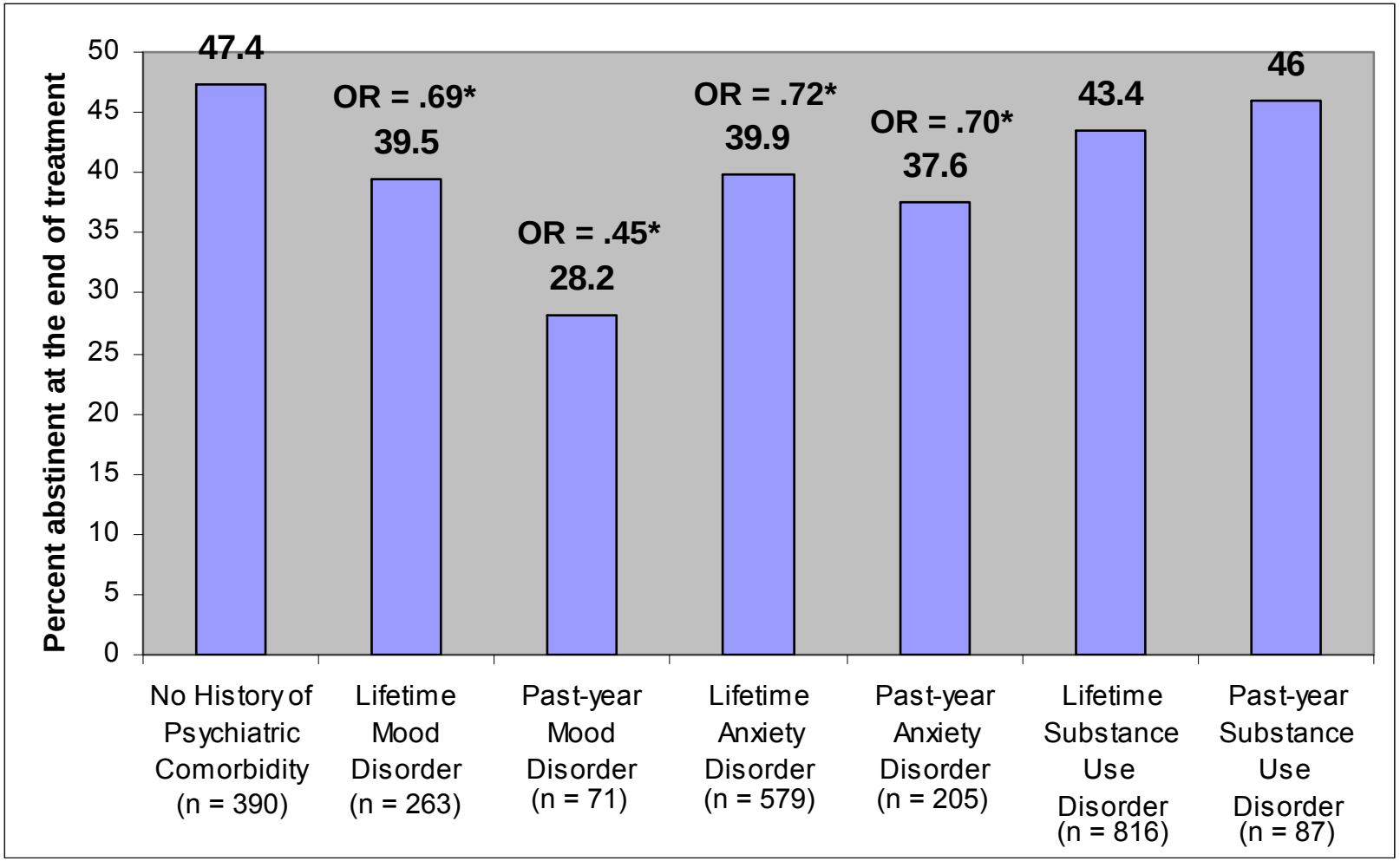
	Past-Year Diagnoses	Lifetime Diagnoses
No diagnosis	**1165 (79.3)**	**390 (26.5)**
1 diagnosis	**213 (14.5)**	**412 (28.0)**
2+ diagnoses	**92 (6.3)**	**668 (45.4)**

(N = 1470)

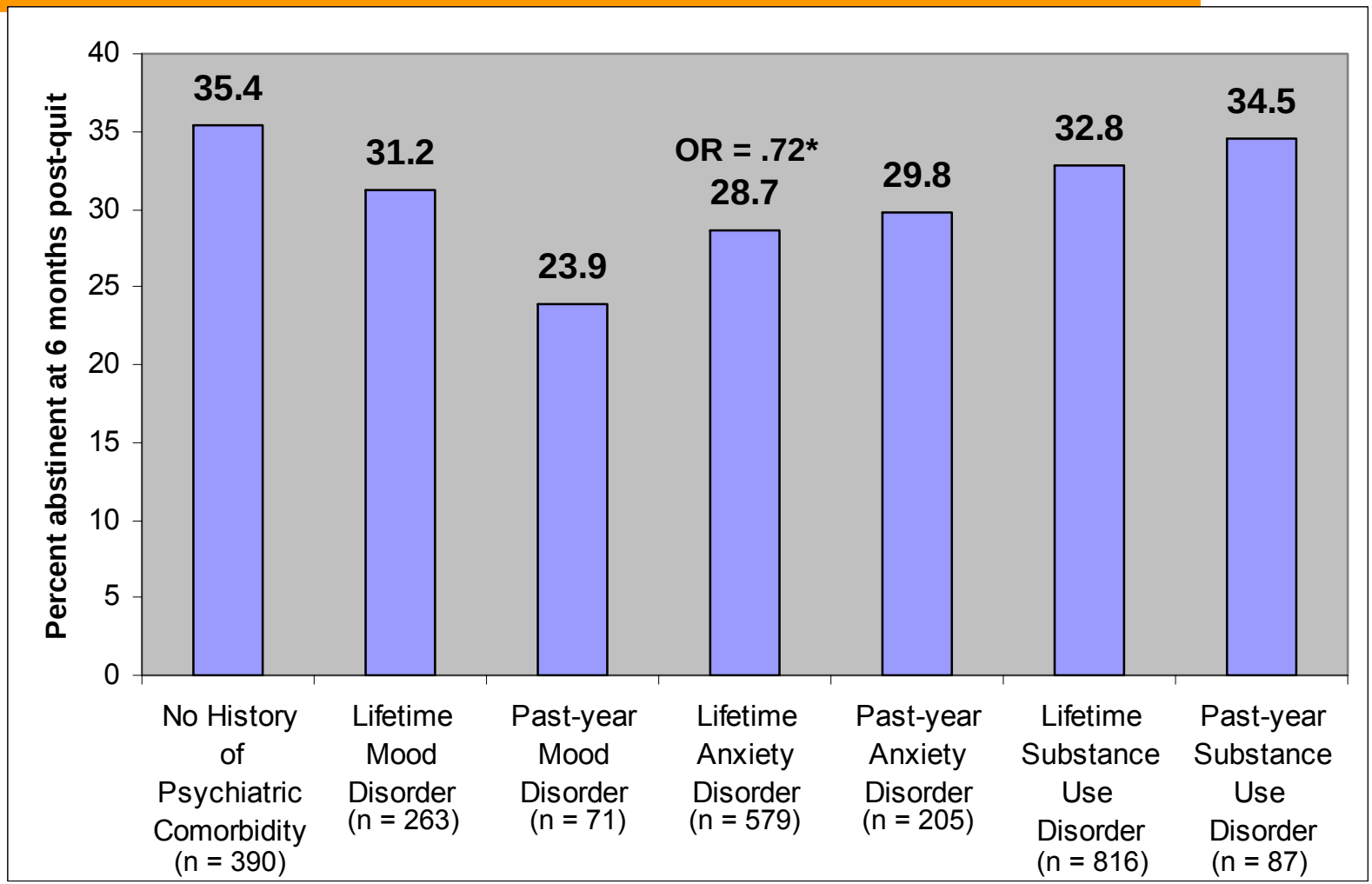
Initial Cessation



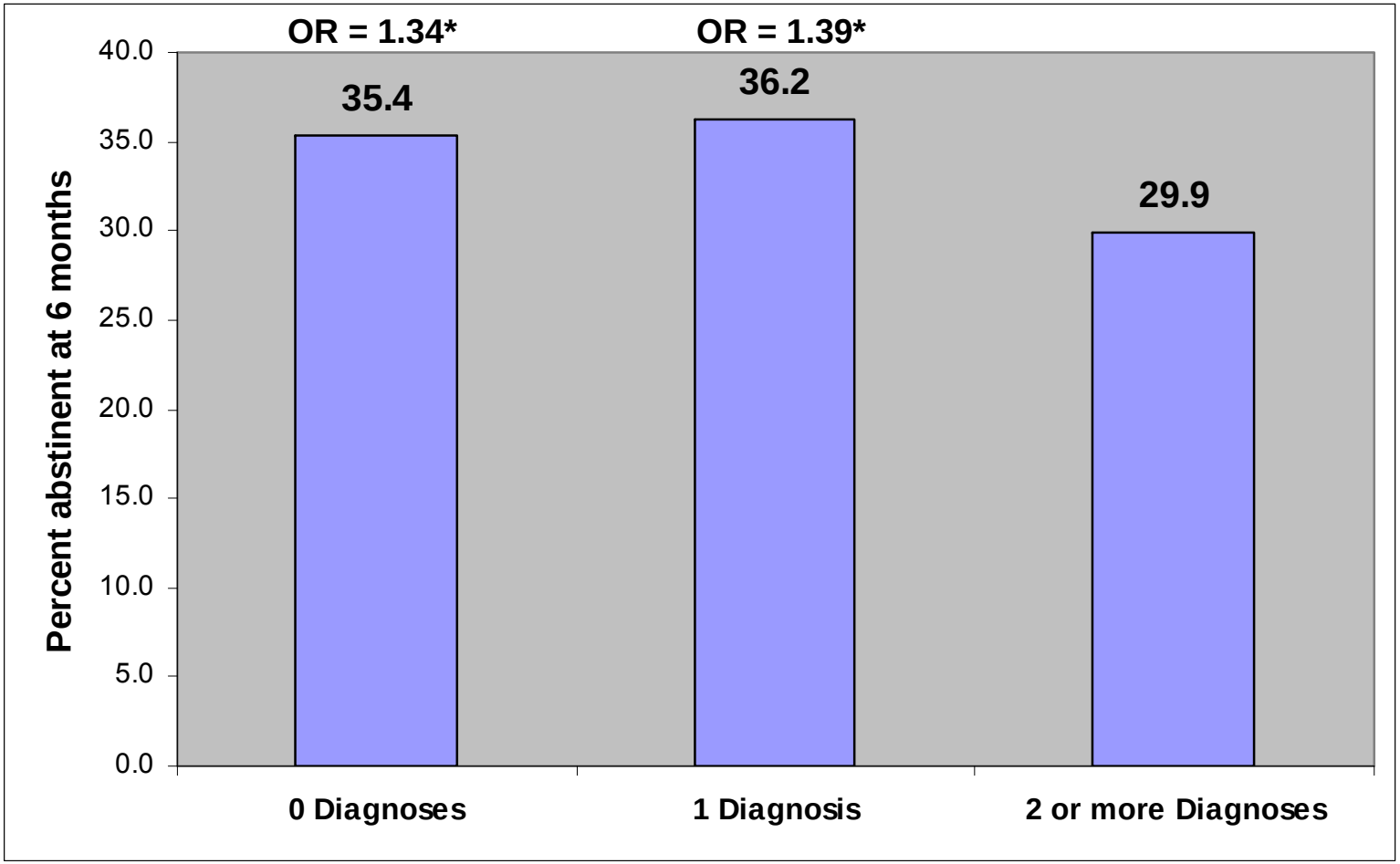
8 Weeks Post-Quit



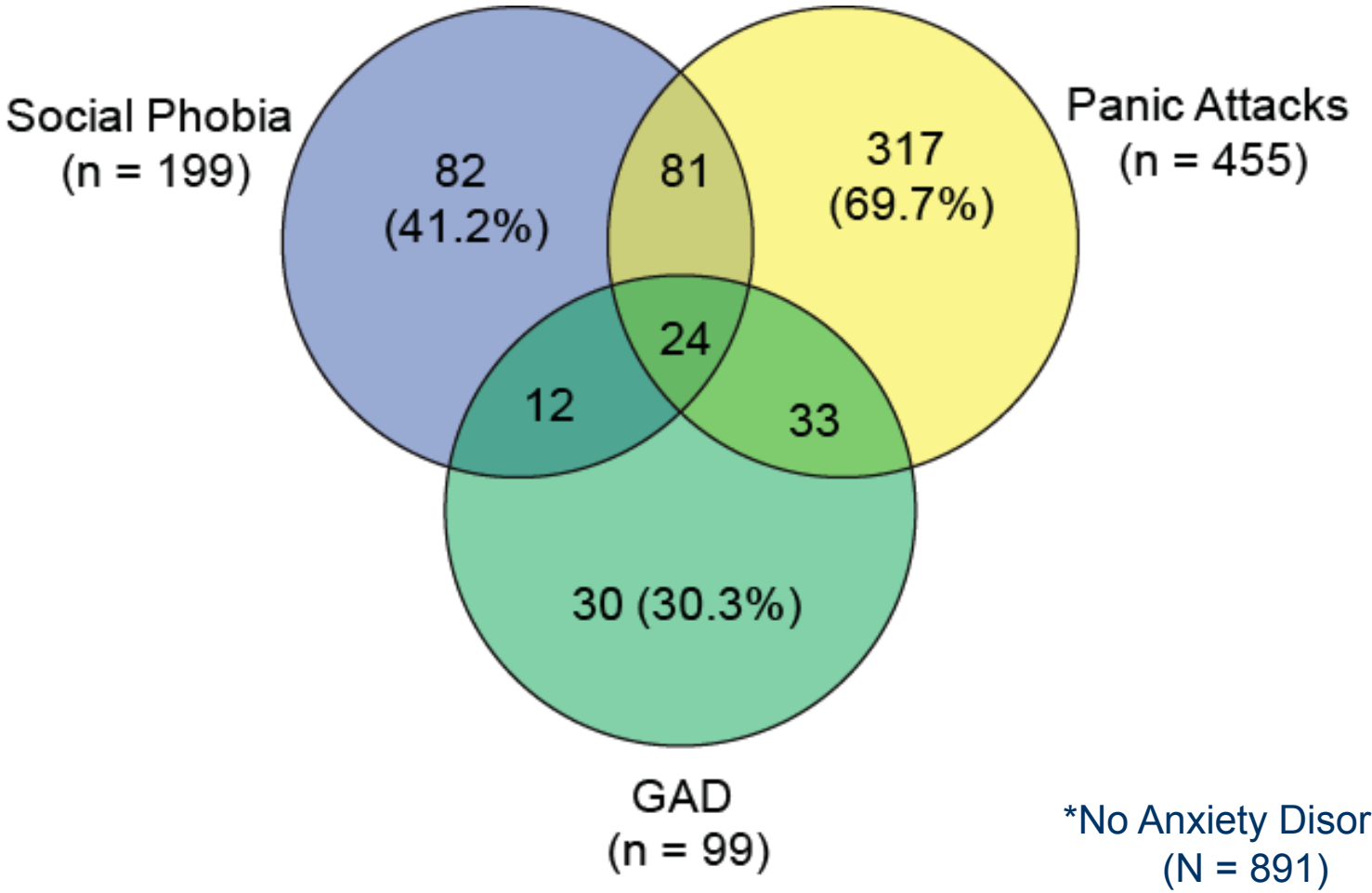
6-months Post-Quit



6-months Post-Quit

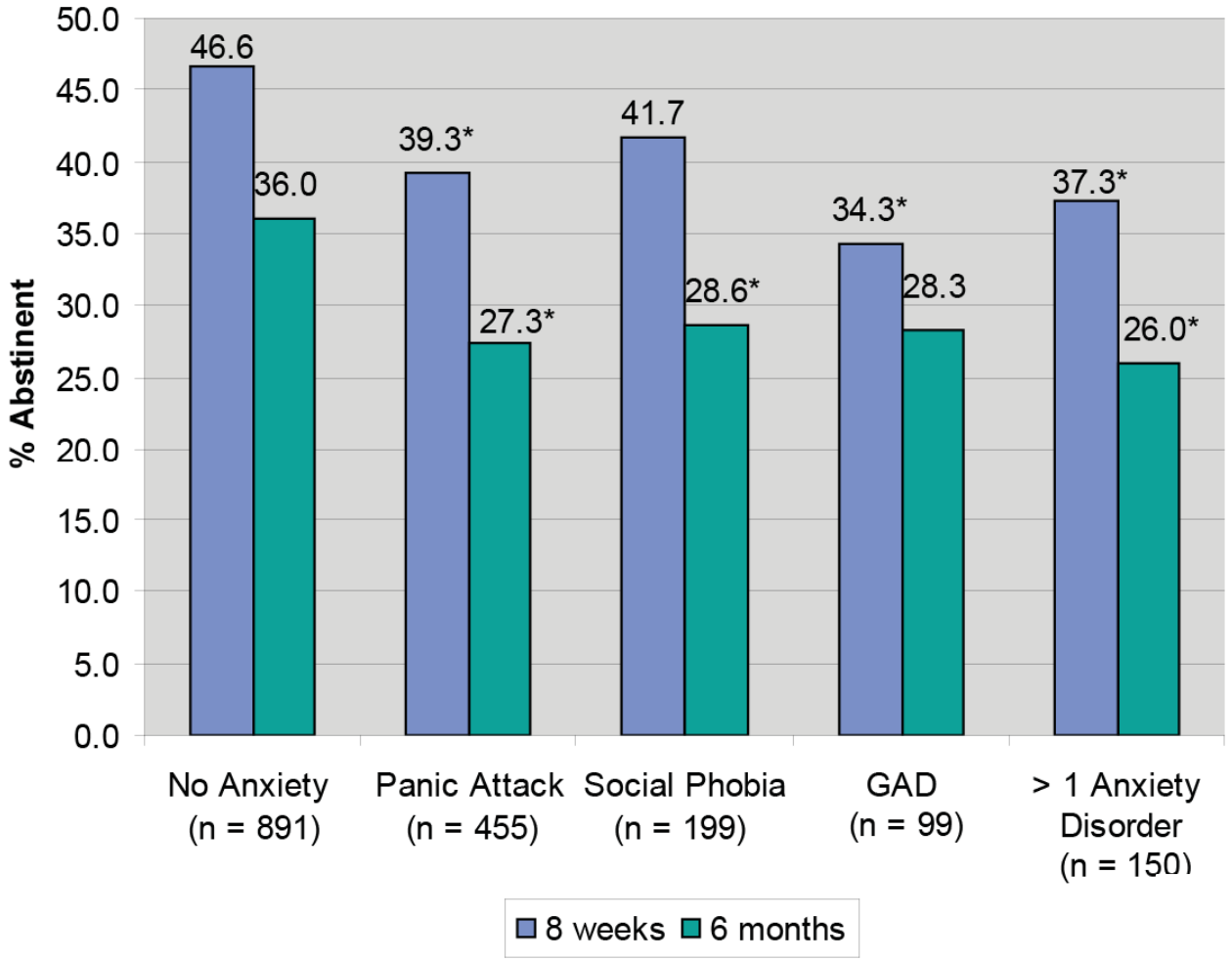


Anxiety Diagnoses (N=579; 39.4%)



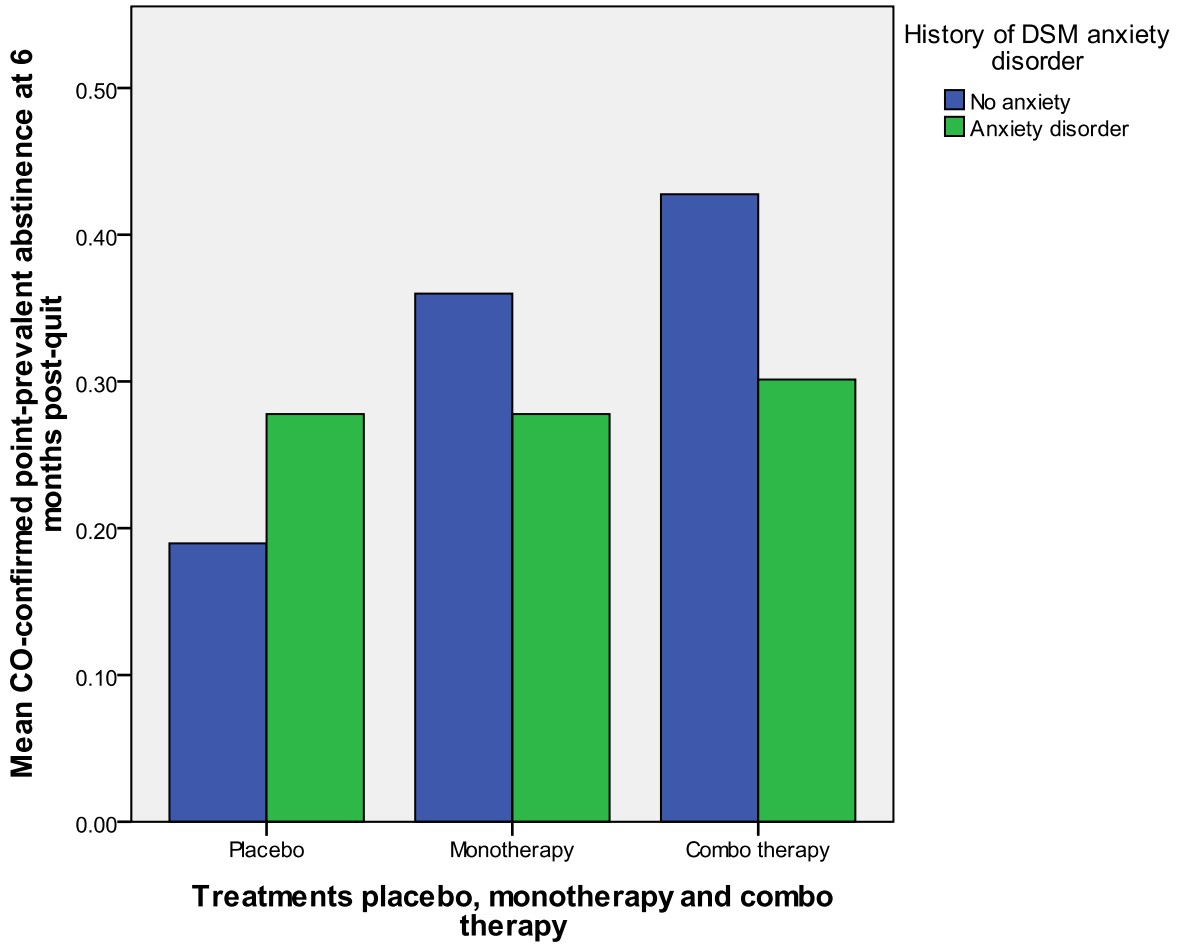
*No Anxiety Disorder
(N = 891)

Cessation Success

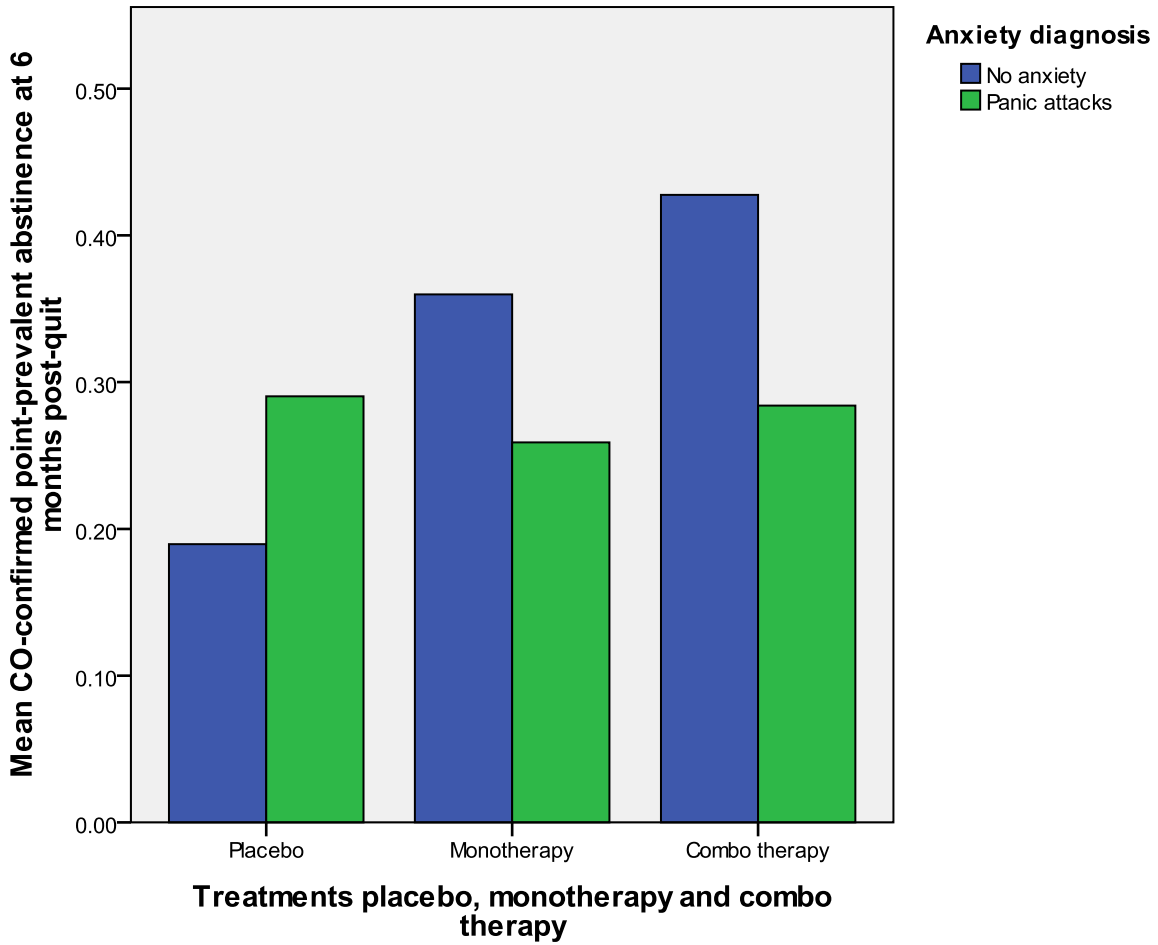


*** p< .05 compared to the abstinence rate for participants who never met criteria for an anxiety diagnosis**

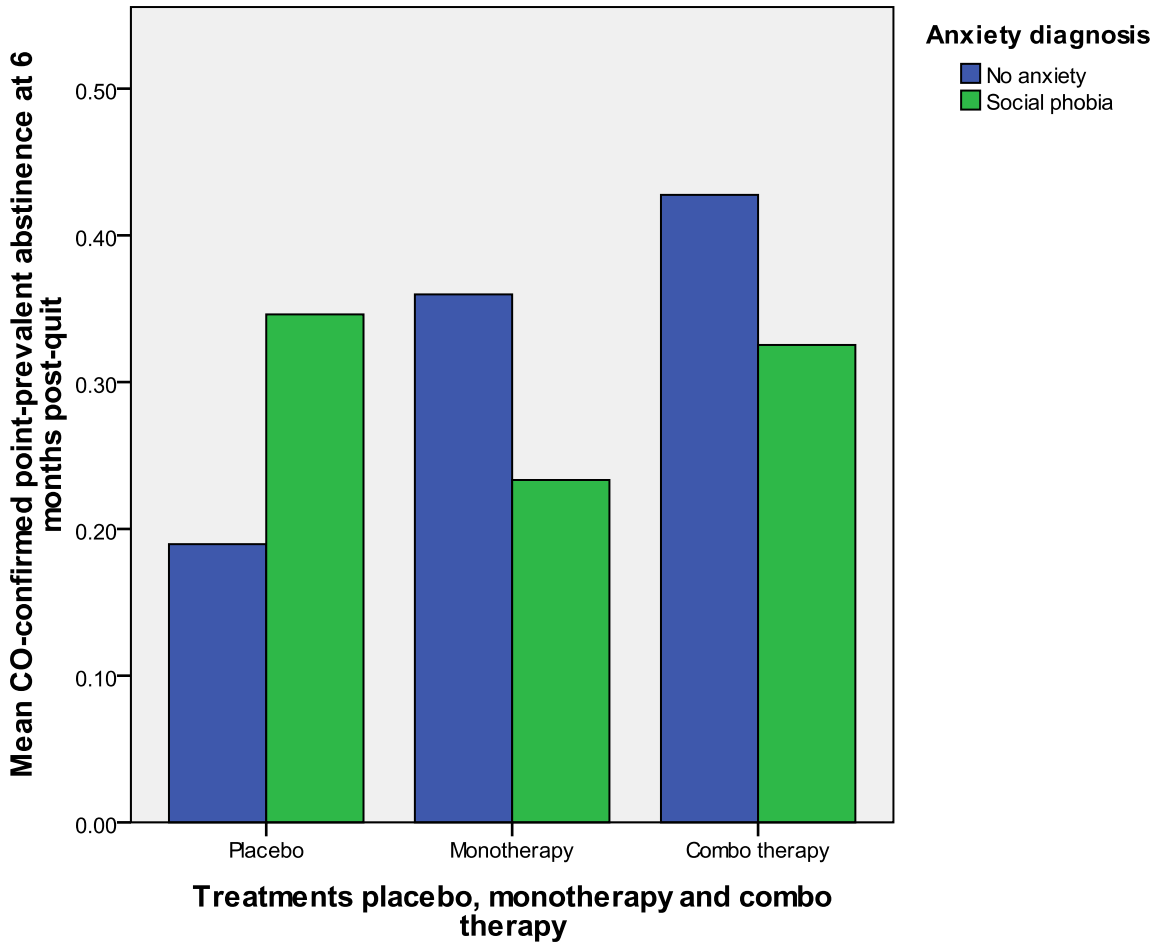
Anxiety and Treatment Outcome



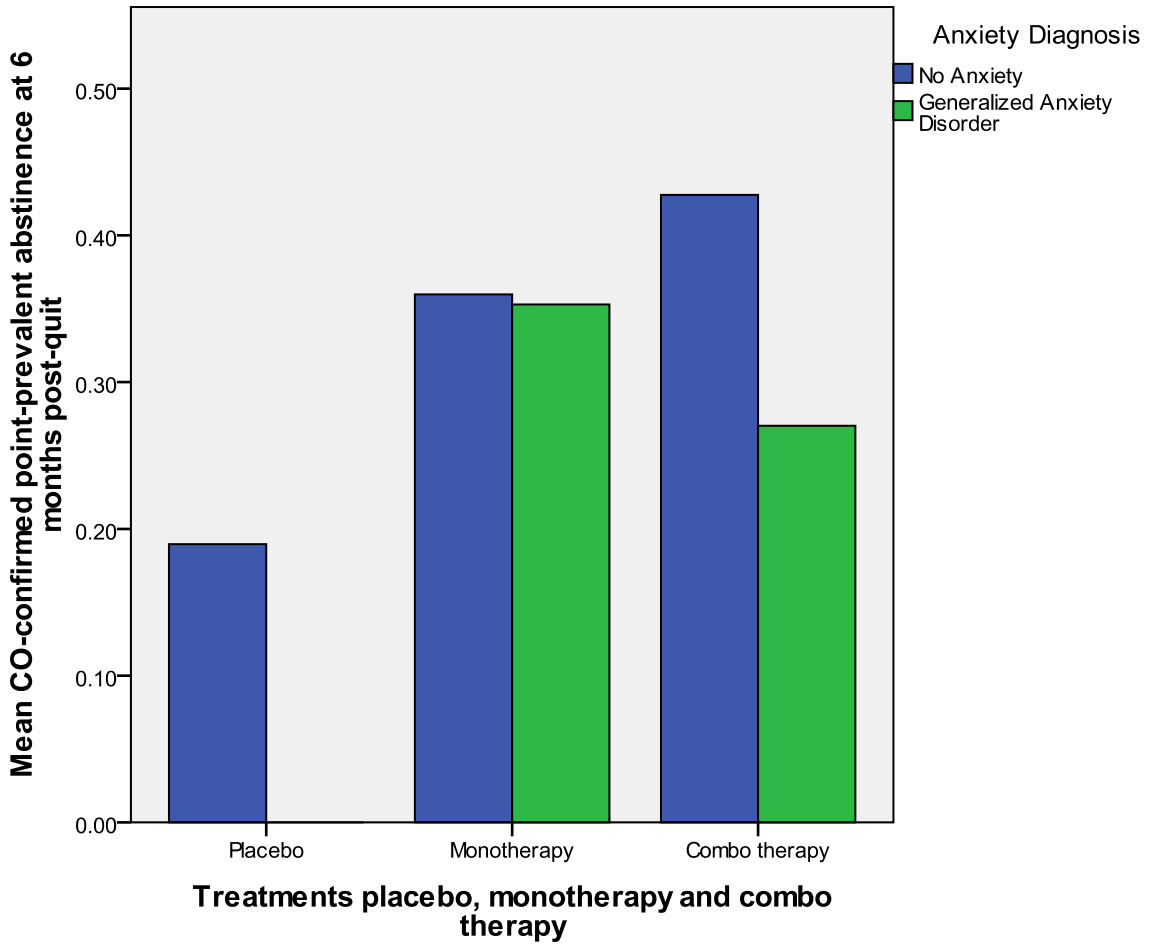
Panic and Treatment Outcome



Social Anxiety and Treatment Outcome



Generalized Anxiety and Treatment Outcome



Summary

- Treatment-seeking smokers have significant psychiatric comorbidity
- Internalizing disorders (mood and anxiety disorders) predict early cessation failure (end of treatment) but substance use disorders do not
- Lifetime history of an anxiety disorder and multiple lifetime diagnoses predict cessation failure at 6 months
  - Mood disorder in the last 12 months may predict cessation failure at 6 months, but the test was underpowered

Summary

- Smokers who have ever been diagnosed with panic attacks, social phobia or GAD are less likely to establish long-term abstinence.
- While smokers with no history of anxiety doubled their chances of quitting with combination NRT, compared to placebo, participants with a history of an anxiety diagnosis received no apparent benefit from pharmacotherapy.

Caveats

- This sample was limited to smokers motivated to quit
- Participants with serious mental illness and heavy drinkers were excluded
- Conducted in Wisconsin, the state with the highest binge drinking rates
- This study did not assess current or on-going diagnoses

Clinical Implications and Future Directions

- Even the lowest quit rates were above 20% at 6 months, suggesting that intensive counseling is effective among all smokers
- There is a need to develop new treatments, both pharmacologic and psychosocial, to address smokers with a history of anxiety
- There is a need for more research in the smokers with serious mental illness (e.g., bipolar disorder)

Questions & Answers

- Feel free to ask questions via the **chat box**.

Free Technical Assistance

Visit SCLC online:

http://smokingcessationleadership.ucsf.edu

Call SCLC toll-free:

1-877-509-3786

Closing Remarks

Please help us by completing the post-webinar survey.

Thank you for your continued efforts to combat tobacco.