What is the smoking rate in US (your state)?

~18%

Smokers with Behavioral Health Comorbidity (Mental Illness and Addiction) are Becoming a Sizeable Percentage of Smokers Left in the US
US Smoking Prevalence

51 Million Smokers in US Today
At least one third have a mental illness
~ 16 Million Smokers with Mental Illness

Prevalence of Smoking Not Decreasing in those with Serious Mental Illness

SAMSHA CBHSQ Report; July 18, 2013
Current Smokers by Mental Illness History

- 41% Past Month
- 23% None
- 35% Ever Ill

NCS 1992-1993
Lasser et al. 2000

Three Fourths of Smokers have a Past or Present Problem with

Mental Illness or Addiction

Smoking is much more common in adults with mental illness than other adults.

Vital Signs
Adult Smoking

1 in 3
Mental Illness

1 in 10
Smoking

1 in 5
Mental Illness and Smoking

MMWR Feb 5, 2013
It’s the Smoke that Kills
Cigarette smoke > 7000 compounds
Acetone, Cyanide, Carbon Monoxide, Formaldehyde
>65 Carcinogens
Benzene, Nitrosamines

Sources of Tobacco Toxins
Nicotine; nitrosamines
More than 600; Ammonia, cellulose acetate; flavors
Thousands; carbon monoxide; formaldehyde; benzene; arsenic, lead; PAH

Smoking is the #1 Cause of Death in People with Mental Illness or Addiction
Tobacco = #1 Cause of Preventable Death in US

30% OF ALL CANCER DEATHS

50% of deaths in schizophrenia, depression and bipolar disorder attributed to tobacco

Callaghan et al., 2013

People with SMI die, on average, 25 years earlier than the general population.

National Association of State Mental Health Program Directors
Medical Directors Council, July 2006; Miller et al., 2006
Counseling on medication provided and side effects of antipsychotic
Heat and sun safety precautions reviewed
Patient advised to make healthy food choices, drink adequate water and include fiber in daily diet
No mention tobacco despite advanced CV disease
Tobacco Consequences in SUD

- More alcoholics die from smoking related diseases than from alcohol related diseases
- Synergistic effects of alcohol and tobacco ↑ risk pancreatitis and oral cancers
- Smoking ↓ recovery from cognitive deficits during alcohol abstinence


Smoking Keeps Consumers from Achieving Recovery:
- Being Financially Stable
- Getting Jobs
- Securing Housing
- Being in Community

Recovery (SAMHSA) = process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential
Smokers Suffer Financial Consequences and Lower Quality of Life

N=68 smokers with schizophrenia on disability income

- Food Shelter
- Misc. Living Expenses
- Cigarettes

73% 27%


Smoke Free Housing

As much as 60% of airflow in multi-unit housing can come from other units

SHS infiltrates through ducts, cracks, stairwells, hallways, elevators, plumbing, electrical line

SHS is Class 1A carcinogen, in the same class as asbestos


Recreation is Tobacco-Free

NO SMOKING IN POOL AREA

SMOKE FREE BOWLING

Smoke Free Campus

This Park is Tobacco-Free

(iQUNETA)

This Home is 100% Smoke Free

A 100% smoke free home proves that smoking does not belong in your home. For more information visit www.100percentsmokefree.org
Tobacco in the Environment

- 60% of mental health consumers report living with smokers AND smoking indoors
- Part of mental health culture
- Staff tobacco use

Williams et al., 2010; McNeill 2001

Tobacco Use May Worsen Behavioral Health Outcomes and Cessation Doesn’t Worsen BH Outcomes

Suicide and Smoking

Daily smoking → predicts suicidal thoughts or attempt
(adjusted for prior depression, SUD, prior attempts; OR 1.82)

Breslau et al., 2005; Ostacher et al., 2006; Alimura et al., 2006; Iancu et al., 2006; Cho et al., 2007; Oquendo et al., 2007; Riala et al., 2006; Moriya et al., 2006
**Improved Mental Health with Quitting Smoking**

- Meta-analysis 26 studies (14 gen pop, 4 psychiatric, 3 physical conditions, 2 psychiatric or physical, 2 pregnant, 1

![Table 1: EFFECT OF SMOKING CASSETTE ON MENTAL HEALTH](image)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>No. of studies included</th>
<th>Original effect estimate</th>
<th>Standardized mean difference (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>4</td>
<td>-0.07 (-0.16 to -0.02)</td>
<td>-0.31 (-0.61 to -0.01)</td>
</tr>
<tr>
<td>Depression</td>
<td>9</td>
<td>-0.29 (-0.43 to -0.16)</td>
<td>-0.35 (-0.57 to -0.12)</td>
</tr>
<tr>
<td>Mixed anxiety and depression</td>
<td>4</td>
<td>-0.36 (-0.59 to -0.14)</td>
<td>-0.31 (-0.47 to -0.16)</td>
</tr>
<tr>
<td>Psychological quality of life</td>
<td>4</td>
<td>0.17 (-0.12 to 0.40)</td>
<td>0.22 (0.09 to 0.36)</td>
</tr>
<tr>
<td>Positive affect</td>
<td>1</td>
<td>0.08 (0.24 to 0.12)</td>
<td>0.40 (0.29 to 0.51)</td>
</tr>
<tr>
<td>Stress</td>
<td>2</td>
<td>-0.20 (-0.39 to -0.01)</td>
<td>-0.27 (-0.49 to -0.06)</td>
</tr>
</tbody>
</table>

*Taylor et al, BMJ, 2014*

**?? Benefits of Smoking**

**Cognition**

- Nicotine/ Nicotinic Receptors
  - Alzheimer’s disease
  - Attention deficit disorder
  - Autism
  - Schizophrenia

**Depression**

- MAO Inhibitor Like Substance

- Tobacco ≠ pharmacological treatment
- Not a rationale for smoking

**Addressing Tobacco in SUD**

**TREATMENT** - No negative impact on SUD treatment

- Same LOS
- No worsening of craving or abstinence rates

Smoking Cessation Interventions Provided during Addictions Treatment Associated with

**25% INCREASED LIKELIHOOD OF LONG-TERM ABSTINENCE FROM ALCOHOL AND ILLICIT DRUGS**

*Brown 2012; Williams 2004; Prochaska JCCP 2004*
Tobacco Use Disorder is a Behavioral Health Condition in the DSM-5

Tobacco Dependence is in the DSM-5

Tobacco Use is Still Part of Behavioral Health Culture and We're not Doing Enough and Treatment Works
Smokers with Behavioral Health Comorbidity are a Tobacco Disparity Group

Williams et al., AJPH, 2013

Tobacco-Related Disparities

Although cigarette smoking has declined significantly since 2004, disparities in tobacco use remain across groups defined by race, ethnicity, educational level, and socioeconomic status and across regions of the country.

Population Groups and Tobacco Use

- African Americans
- American Indian/Alaska Natives
- Asian Americans/Pacific Islanders
- Native Hawaiians
- Hispanics/Latinos
- Puerto Rican Hispanics and Transgender Persons
- People of Low Socioeconomic Status

NAMI

Strong Advocacy Effort Needed to Help Smokers with Mental Illness

In February, the Centers for Disease Control and Prevention (CDC) in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a report about the need for expanded efforts to address the treatment of mental illness. The report finds that 50 percent of adults with a mental illness are regularly smokers, compared with only 25 percent of adults who do not have a mental illness. Due to the significant proportion of smokers with mental illness, the need for increased emphasis on this topic remains critical.

This report is important for many reasons, but the most significant is that it brings attention to the needs of people managing mental illness by our health system. Now that we recognize this needs—both individuals with mental illness and those who assist them—our response must be strong, focused, and forceful.
What to Bring to Addiction Treatment

Treatment Program Website
Once you are scheduled to our program and before you arrive, our staff will give you a list of items you will not be permitted to bring with you. Detoxification clients may bring only 5 days’ worth of clothes. You may not bring books, magazines, cell phones, radios, portable music devices, or gum.

Important note regarding cigarettes: Clients who want to smoke cigarettes should bring cigarettes with them when they arrive.

Mental health and chemical dependency counselor Joan Ayala. Joan has a dual diagnosis of mental illness and addiction. During her lifelong battle she has learned coping skills to sustain her and end her addiction and cope with her mental illness.

USA TODAY; December 22, 2014

Only 1 in 4 Mental Health Treatment Facilities Offers Quit Smoking Services


N-MHSS Report, Nov 2014
State Hospital Smoking Survey
2011; 206 Hospitals Surveyed; 80% response rate
Almost 80% no-smoking on premises
Less than 35% treatment

Schacht et al., NASMHPD Research Institute, Inc. 2012

Less than Half of US Substance Abuse Facilities Treat Tobacco

Which Approach to Take
Implement current evidence based practices?
- Public health model
- Primary care
- Brief strategies
- Limited insurance coverage
- Telephone counseling

Develop tailored approaches?
- Clinical/ co-occurring treatment model
- Behavioral health
- Face to face
- Longer treatment
- Expanded support for treatment (Medicaid/ Medicare/ SAMHSA)
Behavioral Health

Brief Intervention
Shorter visits
15 vs 30 min visits

Access

ASAM Addiction Levels of Care

~90% of tobacco treatment occurs < level 1

Behavioral Health Should Take a Lead in Tobacco Treatment

- High prevalence of tobacco use/patient need
- Tobacco Dependence in DSM-V
- Trained in addictions
- Tobacco interactions with psych meds
- Longer and more treatment sessions
- Experts in counseling
- Relationship to mental symptoms and other addictions

- Undervalue tobacco use as a problem
- Consumers/families minimize the health risks of tobacco
- Professionals/systems have been slow to change in addressing tobacco
- Lack the knowledge about effectiveness of treatment
- Lack of advocating for treatment
- Poor reimbursement
- Higher smoking among staff
22.7 million individuals need treatment for an drug or alcohol use problem. 51 million use cigarettes. 11% Access 1% Use Quitlines. 12% received intensive outpatient (IOP).

NJ Fails in Tobacco Control

NJ Fails Tobacco Users

- FY2013 State Funding for Tobacco Control Programs: $0
- No Medicaid counseling coverage
- Medicaid Barriers to Medications
- Limits on duration, annual or lifetime limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.
NJ Tobacco Prevalence Varies by Region

Mortality Difference: County Vs. State Largely Driven By Lung Cancer Differences

Medicaid is the single largest payer for mental health services in US and is playing a larger role in the reimbursement of SUD
Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit

In 2013 Medicaid spent $103 million on cessation medications —less than 0.25 % of the estimated cost to Medicaid of smoking related diseases.

Armour 2009; Ku et al., 2016

Recommendations for ideal Medicaid benefit

• Coverage of all 7 FDA approved meds
  – No PA
  – No requirement to be in counseling
  – No stepped care
  – No time limits
  – Banning combinations

• Coverage of multiple options for counseling

• Access to several courses of meds/ year

• Access to multi-session counseling/ year

• Low or no co-pay

ALA; PFP; Action to Quit 2010

Obama says tackling opioid abuse as important as combatting threat of terrorism

President Obama Proposes $1.1 Billion in New Funding to Address the Prescription Opioid Abuse and Heroin Use Epidemic

Tuesday, March 29, 2016

President Barack Obama hugs Crystal Durtle after a panel discussion at the National Rx Drug Abuse and Heroin Summit
Causes of Death in Opioid Using Population

- Cancer
- Cardiac
- COPD

Accidents or suicide: 5%
HIV: 15%
Drug or alcohol: 20%
Tobacco: 40%

Veldhuizen et al., 2014

Smokers with MI or SMI Reduced Quitting over Lifetime

\[ E = N \times S \]

Exsmokers = (number trying to quit) x (success of attempts)

Former

- Smokers with MI (MI)
- Smokers with SMI (SMI)
- Non-SMI
- Non-MI

W West, 2013

Hagman 2007; McClave 2010; Lasser 2000; Pratt & Brody 2010

Poor Baseline Tobacco Treatment Knowledge among Psychiatrists

50% correct: Evidence-based treatments; nicotine withdrawal; tobacco medications interactions.

Williams et al., JAPNA 2009
Clinician Self-Reported Compared to Baseline Practices

Specialized Tobacco Training Increases Treatment

Addressing Tobacco Requires Attention to Multiple Domains

- Neurobiological
- Psychological
- Social & Environmental
- Spiritual & Advocacy
- Treatment System & Institutional
- Greater dependence
- Poor coping; low confidence
- Live with smokers
- Seeing peers succeed; having hope
- Provider bias; No access to help
Is this Treatment Planning?

Problem 2
THERE WAS AN INCIDENT OF CLIENT HARASSING FEMALE PEERS FOR CIGARETTES.

Staff Intervention
CLIENT INFORMED AND COUNSELED TO PURCHASE HIS OWN CIGARETTES AND NOT TO BOTHER ANYONE IF HE DOESN'T HAVE ANY.

[Tobacco dependence not listed on problem list or treatment plan]

Treatment Plan

• Nicotine Dependence
  — DEFERRED
  — Nicotine dep is deferred at this time.

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
Treatment Planning in the Behavioral Health Setting

- Add Tobacco Use Disorder to Problem List and Treatment Plan
- Complete Assessment – Identify level of dependence and motivation to change
- Identify measurable long-term and short-term goals

Complete Wellness: Mental and Physical Health

Wellness & Recovery includes Addressing Tobacco

CCBHC

- Certified Community Behavioral Health Clinics
  - Improve behavioral health by providing improved community-based mental health and substance use disorder treatment
  - Advance behavioral health care to the next stage of integration with physical health care
  - Utilize evidence-based practices on a more consistent basis
Scope of CCBHC Services

1. Crisis mental health services
   - 24-hour mobile crisis teams
   - Emergency crisis intervention services, and
   - Crisis stabilization

2. Screening, assessment and diagnosis, including risk assessment

3. Person and Family-centered treatment planning

4. Direct provision of outpatient mental health and substance use disorder services

5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk

6. Targeted case management

7. Psychiatric rehabilitation services

8. Peer support and counselor services and family supports

9. Intensive, community-based mental health care for members of the armed forces and veterans

Evidence-based Practices

- CCBHCs will provide evidence based practices and treatments (EBP/Tx) prioritized based on gaps identified by the CCBHC Steering Committee and NJ DMHAS
- CCBHCs will be provided with training in implementing EBPs
- CCBHCs are planning to offer:
  - Illness Management and Recovery (IMR)
  - Family Psycho-education
  - Supported Education/Supported Employment Services
  - Integrated Dual Disorder Treatment
  - Medication Management and Education
  - Cognitive Behavioral Therapy (CBT)
  - Medication Assisted Treatment (MAT)
  - Motivational Interviewing (MI)
  - Dialectical Behavior Therapy (DBT)
  - Trauma Informed Care (TIC)
  - Nicotine Replacement Therapy (NRT) and Medications
  - Learning About Healthy Living: Tobacco and you (LAHL)

Behavioral Health Systems Change - Creating a Tobacco Free Environment
Why Do Policy Change?

- Works
- Cost-Effective
- Restricting Tobacco Use
  - Protect nonsmokers from secondhand smoke
  - Motivate and help tobacco users quit
  - Prevent initiation of tobacco use
  - Workplace
- Mandates Assessment, Treatment
  - EMR, Meaningful Use, Quality Improvement

Terms: Tobacco Free better than Smoke-Free

- Tobacco =
  all cigarettes, cigars, ecigs, pipes, tobacco and smokeless tobacco. Lighters, rolling papers and matches are paraphernalia.
- Tobacco free =
  prohibits tobacco products within all buildings and on the grounds of facilities. Applies equally to patients and staff
  - Staff may not be identifiable as tobacco user (or visible from property using tobacco)

- Why Should Treatment Facilities be Tobacco-Free?
- What are the Most Common Obstacles?
- Are there Negative Consequences to Patients or Agency?
- What are the Recommended Steps?
- What Have Other Places Done?
- What Do Feds Say About This?
Why Should Treatment Facilities be Tobacco-Free?

- Stop rewarding good behavior with smoking/smoke-break
- Restricted smoking may ↑ withdrawal
- Wasted time due to tobacco distribution/bartering
- Consistent message: treat other addictions
- ↑ Access to medication and counseling
- Start smoking in treatment/relapse or cue
- Health care facility Smoker’s Lounge

Exemptions = Stigma

- Exempting mental health hospitals from smoke-free laws may worsen health inequalities for people with mental illness and further their stigmatization.

Patients with mental illnesses deserve the same protection from tobacco exposure that benefits the rest of the public.
What about Smokers’ Rights?

- The legal precedent for support of smokers’ rights has been almost non-existent.
- Courts have deemed tobacco not be a right but a privilege that can be restricted when it is detrimental to others.
- There is little legal support for the continued use of addicting substances in a supervised treatment setting that is being paid for by public funds.

CT Court does not Find in Favor of Right to Smoke at Psych Hospital

Lawsuit was filed by 9 patients vs. state hospital in Connecticut, claiming a violation of their civil rights by the restriction of smoking at the facility planned for Oct 2007. Claimed violation of ADA and CT Patient Bill of Rights.

"the question before the Court is whether a complete ban against smoking and tobacco products at Connecticut Valley Hospital violates a federal constitutional right. After careful thought and consideration, the Court concludes that it does not."

GIORDANO v. CONNECTICUT VALLEY HOSP.
Decision Dec 2008

Threat of Lawsuit

- The mere threat of legal or political action has been effective in getting states to rescind or exempt psychiatric or addictions treatment facilities from tobacco-free policies.
Are there Negative Consequences to Patients or Agency?

<table>
<thead>
<tr>
<th>Inpatient Psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NO increase in disruptive behaviors</td>
</tr>
<tr>
<td>• NO increase in AMA discharges</td>
</tr>
<tr>
<td>• NO additional seclusion and restraints</td>
</tr>
<tr>
<td>• NO increase in use of PRN medications</td>
</tr>
</tbody>
</table>

Substance Abuse

| • NO increase in AMA discharges |
| • Clients ARE interested in treatment |
| • NO reductions in admissions (NYOASAS) |

NASMHPD 2006; Patten et al., 1995; Halter et al., 1996

Williams 2004; Reid et al., 2008

OASAS

New York State
Office of Alcoholism & Substance Abuse Services
Addiction Services for Prevention, Treatment, Recovery

- All 1419 substance abuse treatment sites tobacco-free since 2008
- No reduction in admissions
- More than 80% in compliance (2010)
- Positive behavior change
  - less smoking, ↑ intentions to quit, ↑ awareness about smoking
- Negative behaviors
  - addict behaviors (lying, selling)
  - enforcement problems

Eby et al., NTR, 2012

No Reduction in SUD Program Admissions

Total For All Major Program Types OASAS NY
Tobacco-Free Implementation - July 2008

# Admissions

0 3,500 7,000 10,500 14,000 17,500 21,000 24,500 28,000 31,500 35,000


OASAS.ny.gov
Least Tobacco Treatment in Private SATP

Figure 3: Substance Abuse Treatment Facilities Offering Tobacco Cessation Services, by Facility Operation: 2010

Is addiction an unfair sales tactic?

What are the Recommended Steps?
What Have Other States Done?
Twelve Steps to Addressing Tobacco

1. Acknowledge the Challenge (Address the Barriers)
2. Establish a Leadership Group and Make a Commitment to Change
3. Create a Change Plan and Realistic Implementation Timeline
4. Start with Easier Program and System changes
5. Conduct Staff Training
6. Assess and Document in charts tobacco use, dependence, and prior treatments
7. Incorporate Tobacco Issues into all client education curriculum
8. Provide Medications for Tobacco Dependence Treatment
9. Provide Treatment or Recovery Assistance for Interested Tobacco Users
10. Integrate Motivation-Based Treatments throughout the Program
11. Establish Ongoing Communication with 12-Step Recovery Groups, Professional Colleagues, and Referral Sources about system changes
12. Consider additional Addressing Tobacco Policies, including Tobacco-Free Grounds

Hoffman and Slade, 1997

Next Steps

• Tobacco use has many negative consequences to consumers and is a barrier to recovery
• Ensure adequate Medicaid coverage for treatment to increase access
• Policy and treatment together are most effective approach
• Build advocacy to support initiatives
  jill.williams@rutgers.edu