Tobacco Treatment Counseling with Behavioral Health Patients – Can It Be Done?

Thursday, March 4, 2021

Rethink Tobacco Indiana

Grant funded by the Indiana Department of Health's Tobacco Prevention and Cessation to reduce the prevalence of tobacco use among persons with mental health conditions, substance use disorders, or co-occurring disorders through the following activities:

- Technical Assistance
- Policy Development
- Education
- Specialized Training
- Resources

Indiana Department of Health | Tobacco Prevention and Cessation

www.in.gov/isdh/tpc

rethink tobacco indiana

www.RethinkTobaccoIndiana.org

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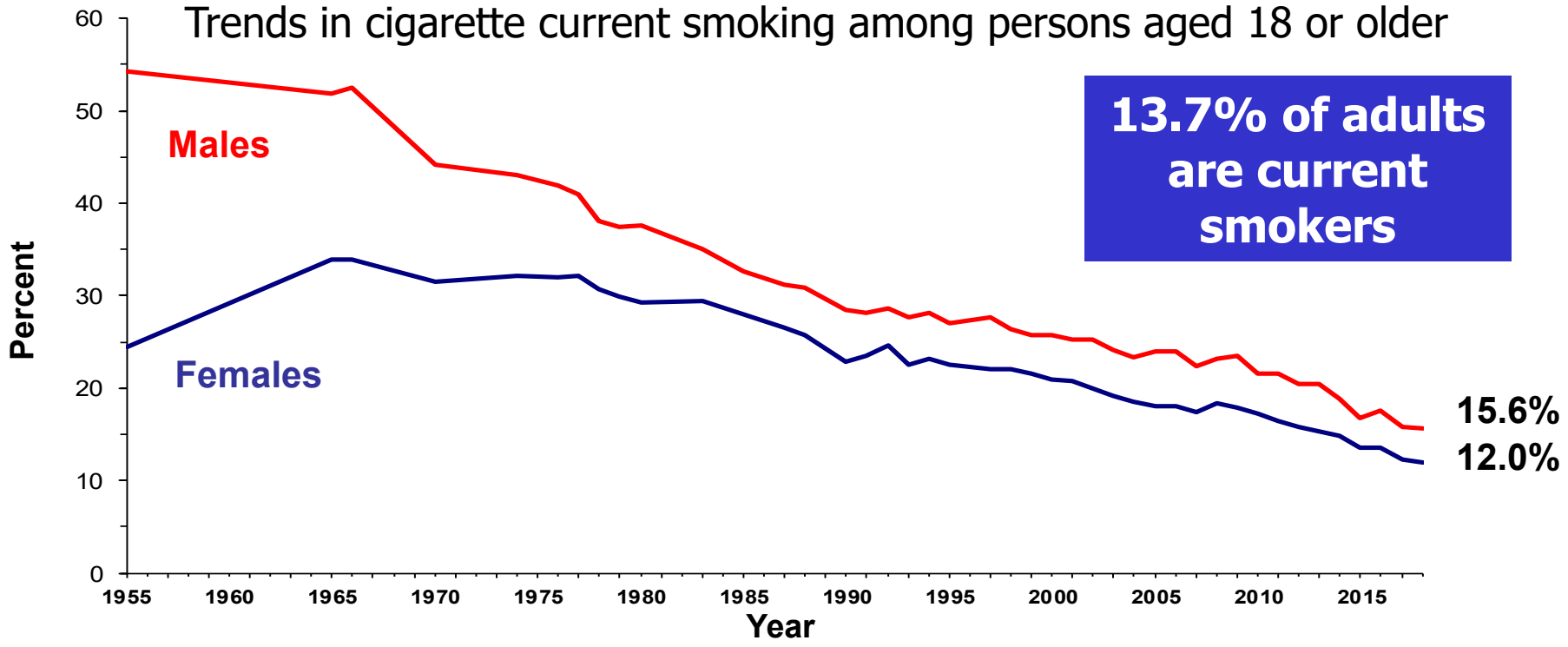
Tobacco Treatment Counseling with Behavioral Health Patients –

Can It Be Done?

Objectives

- Detail the impact of a behavioral health diagnosis on quitting smoking
- Summarize how clinicians can counsel behavioral health patients to successfully quit
- Provide a brief review of motivational interviewing techniques

TRENDS in ADULT SMOKING, by SEX—U.S., 1955–2018



68% want to quit
55% tried to quit in the past year

Graph provided by the Centers for Disease Control and Prevention. 1955 Current Population Survey; 1965–2018 NHIS. Estimates since 1992 include some-day smoking.

Behavioral Health Diagnosis/Smoking

- Nicotine dependence most prevalent substance use disorder among persons with psychiatric issues
  - Smoke nearly half of the cigarette consumed yearly in U.S.
- Adults living with psychiatric illness:
  - Smoke more cigarettes/month than persons without mental illness (326 vs. 284)
  - Have higher prevalence of past-month cigarette use (33.3% vs. 20.7%)
  - Account for nearly half of 480,000 annual tobacco-related deaths in U.S.

Lipari, R., & Van Horn, S. (2017). Smoking and mental illness among adults in the united states: The CBHSQ Report

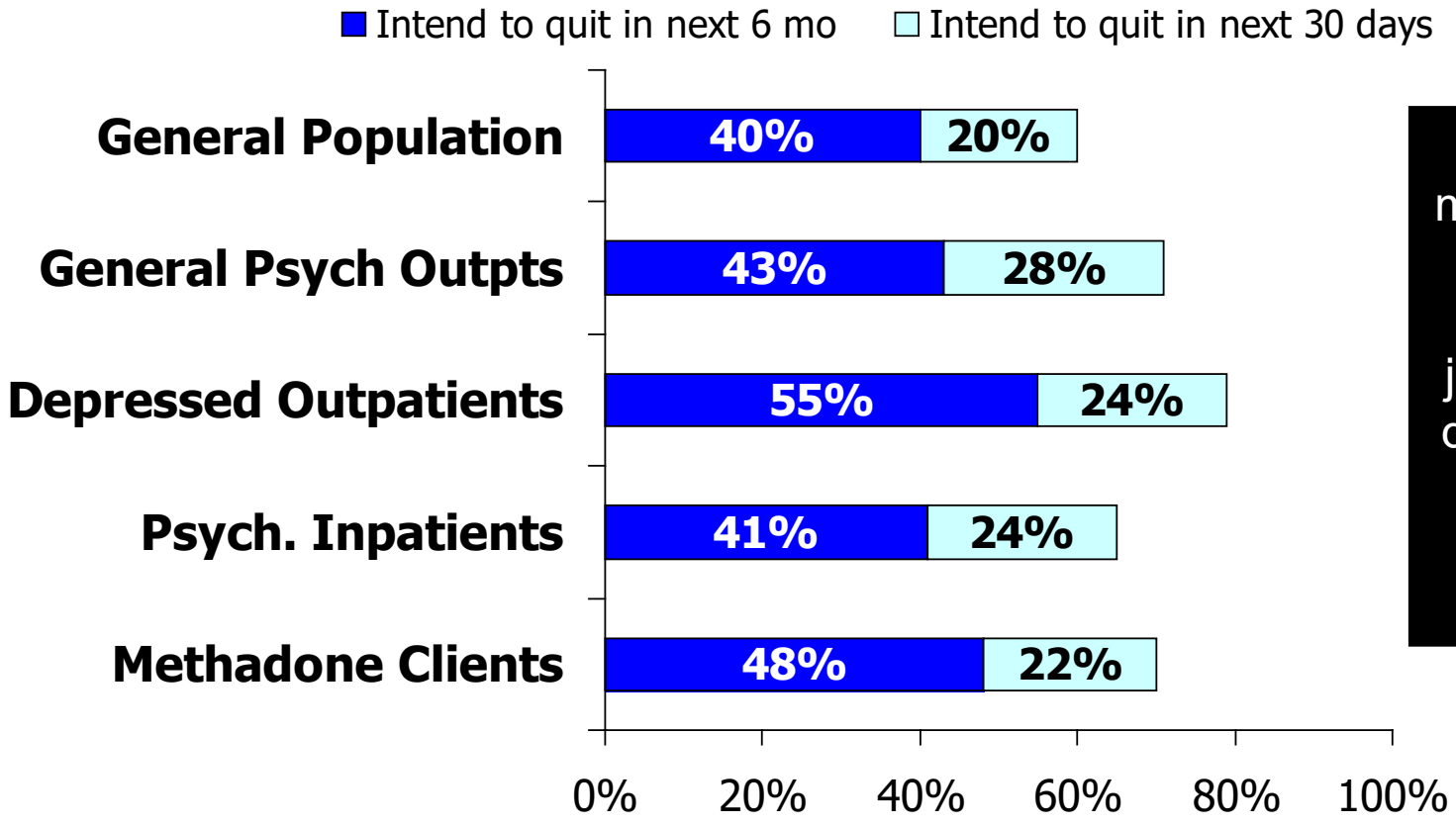
KEY POINTS

- 50% of deaths in persons living with depression, schizophrenia, or bipolar disorder are attributable to tobacco-related diseases
- Cessation is not associated with exacerbation of psychiatric symptomatology
- Some evidence that cessation might reduce risk of re-hospitalization

KEY POINTS (cont'd)

- Adult smokers living with a psychiatric disorder:
  - Are motivated to quit and engage in treatment when offered
    - Quit at same rates as general public
  - Studies show quitting actually improves chances of recovery

READINESS to QUIT *



Smokers with mental illness or addictive disorders are just as ready to quit smoking as the general population of smokers.

* No relationship between psychiatric symptom severity and readiness to quit.

Cessation Improves Recovery

"…Smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke."

Gemma Taylor, et al. BMJ 2014; 348

Barriers to Treatment

- Providers do not routinely screen for tobacco use
- Many psychiatric staff smoke
  - Use smoking as way to bond
- In addiction community, belief that "other" addiction is more important
- Cessation is "impossible" for this population

Barriers (Cont.)

- Smoking is used by psychiatric staff as behavior modifier/reinforcer
- Belief that cessation will cause relapse
- Many patients do not work:
  - Increased idle time
  - Use smoking to deal with boredom
  - Socialize with other smokers

Role of Big Tobacco

- Advertised cigarettes as a way:
  - To get rid of stress
  - Live a good life
  - To deal with your problems
- Gave away free cigarettes at psychiatric facilities or sold them cheaply
- Stopped many facilities from going smoke free

Centers for Disease Control and Prevention. Best Practices User Guide: Health Equity in Tobacco Prevention and Control.

Additional Psychological Factors

- Many psychiatric patients consider cigarettes:
  - A "core need"
  - Essential to their existence
  - More important than food
  - Prevent relapse of their psychiatric disorders

WHAT CAN YOU DO?

Systems Changes

- Screen all patient for tobacco use
- Make all facilities tobacco free
  - Address staff and volunteer smoking
- Stop use of cigarettes as a reward system
- Incorporate tobacco cessation into overall treatment plan
- Train addiction specialists in tobacco treatment

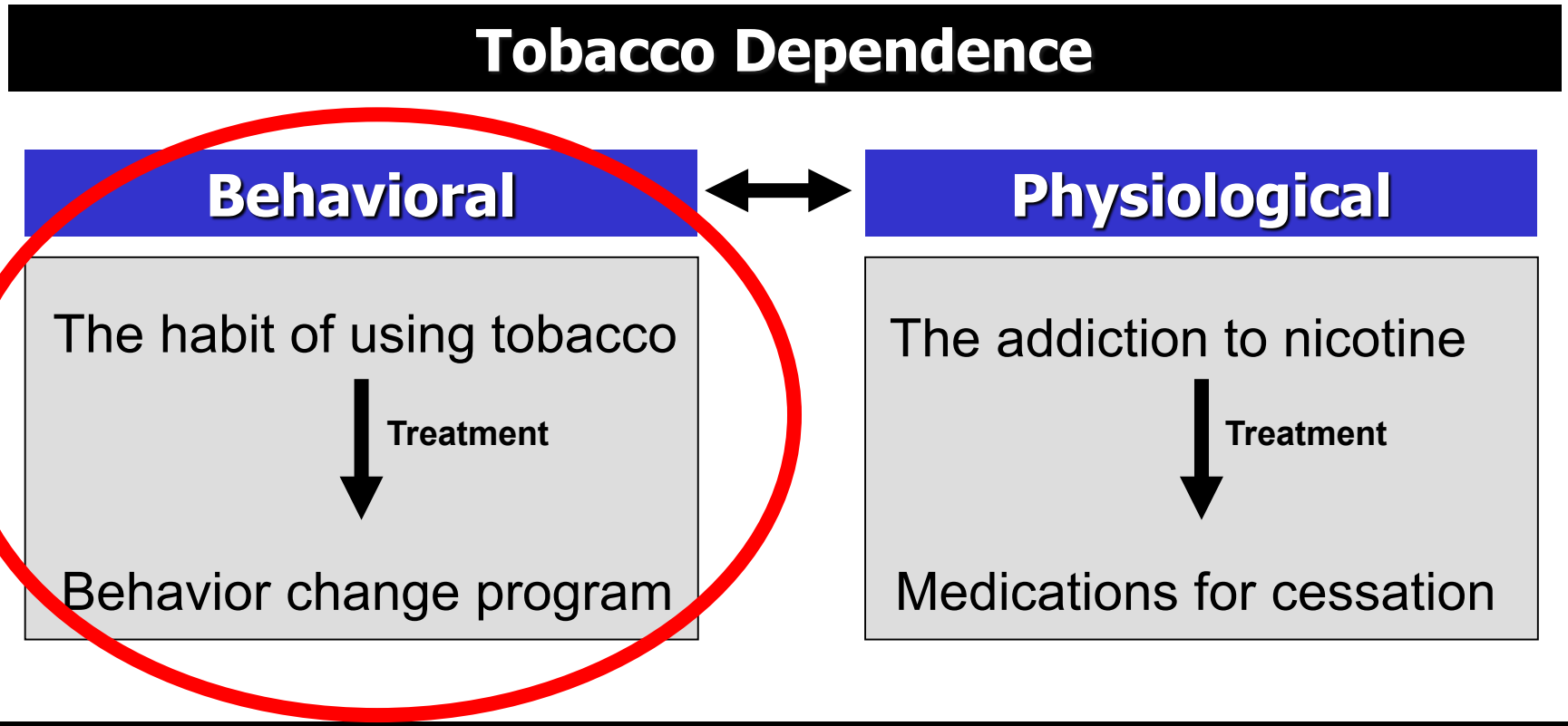
Smoking Bans

- Meta-analysis of 22 investigations into impact of smoking bans in psychiatric facilities showed:

  " No major longstanding untoward effect in terms of behavioral indicators of unrest or compliance."

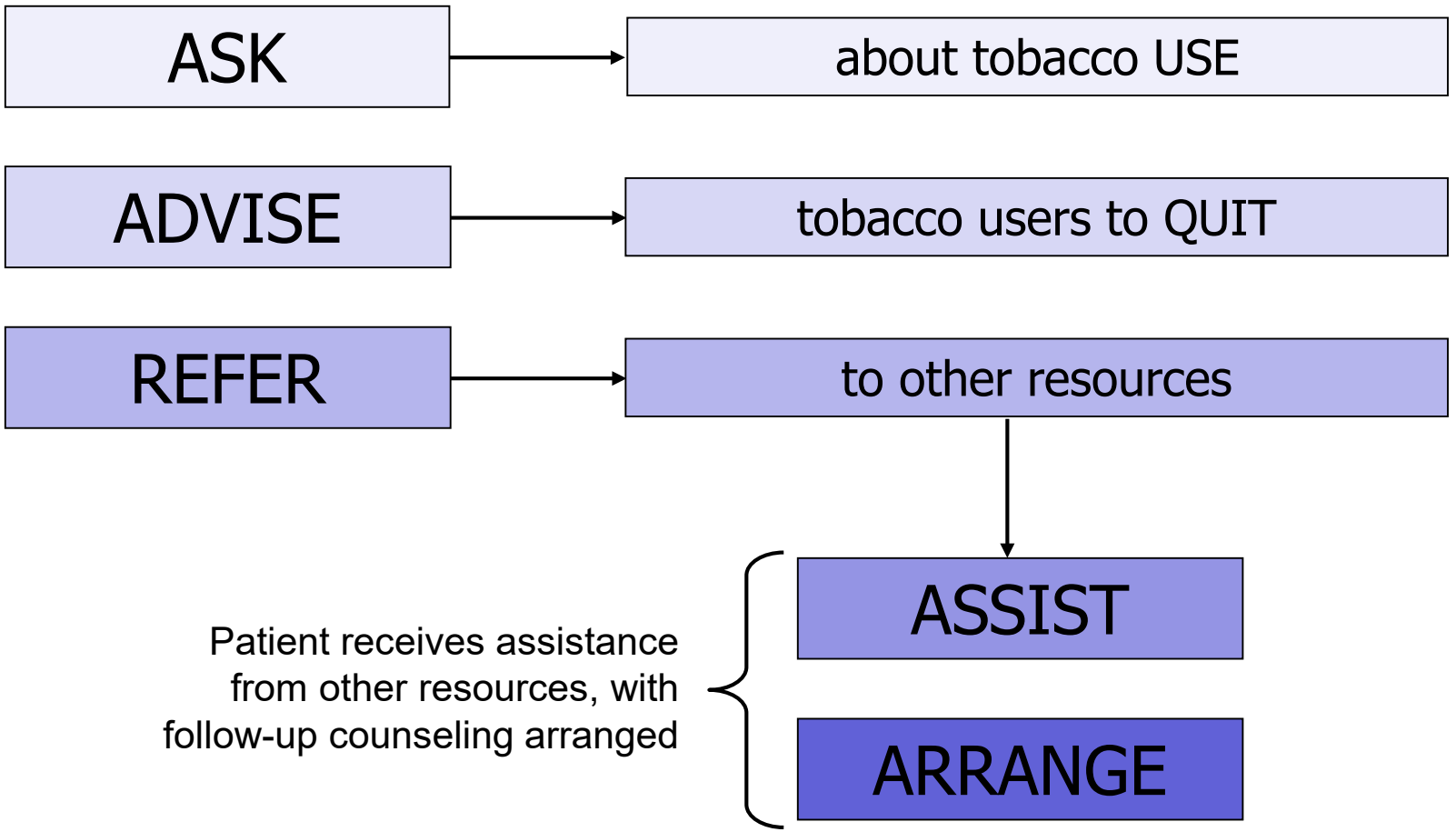
Nady, Psychiatr Serv 53:1617-1622

TOBACCO DEPENDENCE: A 2-PART PROBLEM



Treatment should address the physiological **and** the behavioral aspects of dependence.

BRIEF COUNSELING: ASK, ADVISE, REFER



The 5 A's (cont'd)

ASK about tobacco use; with a tone that conveys sensitivity, concern and is non-judgmental:

- "Do you smoke or use other types of tobacco or nicotine, such as e-cigarettes?"
  - "It's important for us to have this information so we can check for potential interactions between tobacco smoke and your other medicines."
  - "We ask all of our patients, because tobacco smoke can affect how well some medicines work."
  - "We care about your health, and we have resources to help our patients quit smoking."
- "Has there been any change in your smoking status?"

The 5 A's (cont'd)

ADVISE tobacco users to quit (clear, strong, personalized)

- "It's important for your health that you quit smoking, and I can help you."
- "Quitting smoking is the most important thing you can do to...[control your asthma, reduce your chance for another heart attack, better manage your diabetes, etc.]"
- "Quitting smoking is the single most important thing you can do to protect your health now and in the future."
  - "I can help you select medications that can increase your chances for quitting successfully."
  - "I can provide additional resources to help you quit."

How To Advise

Motivational Interviewing

"…..a skillful clinical style for eliciting from patients their own good motivation for making behavior change.."

In Other Words….

Guide

the patient to telling you that they

want to change

rather than you telling them they

have to change.

Avoid

- Forcing the change
- Intimidating
- Nagging
- Guilt

Benefits to This Approach

- Using MI:
  - Prevents frustrating conversations with "noncompliant" patients
  - Allows you to step away from the role of the parent scolding the naughty child for doing something wrong
  - Establishes a real sense of collaboration between you and the patient

How Do I Create Change?

To Begin With:

- Accept Ambivalence
- View change as a learning process
  - Understand that relapse is natural
- Elicit **Change Talk**

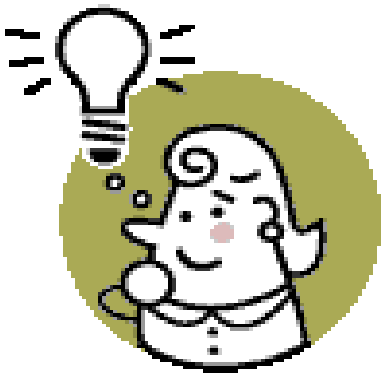
Goal of Change Talk

- Collaborate with the patient to:
  - Understand and explore their own motivations for change.
  - Help them view the "change" as more enticing than the status quo
  - Increase their belief that they can change!

Why Change Talk?

Change

is more likely to occur



when the idea comes from the individual

not from you!

Why Don't People Change?

- The "old" has importance and value
- They are comfortable with their current situation
- They are afraid of change
- They don't think they can change

Why Do People Change?

- The "new" has importance and value
- They are **un**comfortable with their current situation
- They are comfortable with the prospect of changing
- They feel they have skills/knowledge to change

How Do Individuals Change?

Generally behavior change

is a **process**

that occurs over time,

not a discrete one-time event

Stages of Change Model

- Pre-contemplation
- Contemplation
- Action
- Maintenance
- Slip
- Relapse

Creating Change Talk Through Motivational Interviewing

How To Elicit Change Talk

- Ask Permission
- Use Open Ended Questions
- Listen Reflectively
- Summarize Feedback
- Roll with Resistance/Ambivalence

Ask Permission

- "Do you mind if we discuss your smoking today?"
- "Can I tell you what concerns me about your smoking?"
- "Is it ok to talk about the possibility of quitting?"

Open Ended Questions:

Questions that do not invite

short or one word answers

Open Ended Questions (cont.)

- Most open-ended questions begin with:
  - WHAT
  - HOW

- What's wrong with WHY?

Examples of Open Ended Questions

- "What is prompting you to think about quitting now?"
- "What do *you* want to do about your smoking?"
- "How are you benefitting from smoking?"
- "How would your life be different if you were not a smoker?"

If Reluctant:

"What would have to happen to you for you to consider quitting?

The Importance Ruler

Importance

How **important** would you say it is for you to quit smoking? On a scale from 0 to 10, where 0 is not at all important and 10 is extremely important, where would you say you are?

0 1 2 3 4 5 6 7 8 9 10

Not at all important Extremely Important

The Confidence Ruler

Confidence

If you decided to quit now, how **confident** are you that you could do it? On the same scale of 0 to 10, where 0 is not at all confident and 10 is extremely confident, where would you say you are?

0 1 2 3 4 5 6 7 8 9 10

Not at all confident Extremely confident

How to Boost Confidence

"What accomplishment are you most proud of?"

"If you can do that you can quit smoking!"

Elicit Goals/Values

- "What is the most important priority in your life right now?"
  - "How does smoking help/prevent you from achieving that?"

- "What are your core values?"
  - "Where does a healthy lifestyle fit in?"
  - "What role does smoking play in your life?

Elaborate

- Get an "in-depth" understanding of the reason for change/situation
  - "Tell me more about……"
  - "Exactly what is prompting you to consider quitting now?"
  - "Explain to me in detail what happened when you relapsed back to smoking."

Ask About Extremes

- "Suppose you don't ever quit. What do you imagine will happen to you in the next year/two years?"

- "If you do quit for good, what do you think your life would be like? How would things be different?"

Listen Reflectively

- Use the patient's own words
  - "I hear you saying that the idea of quitting *is very scary*"
  - "I am getting the feeling that you don't think you can quit because *you have too much stress in your life.*"

Summarize your Feedback

- "We have agreed…..
- "So here are the steps that you said you would do…."
- "Let me summarize what we have just discussed……"

Roll with Resistance/Ambivalence

- "Can you help me understand….."
- "What specifically concerns you about…."
- "OK, I hear you saying that on one hand you want to quit, but on the other hand you are scared to do it."

Ambivalence

- A natural part of the change process
  - Both the old and new have value
- Getting stuck there is the problem
- Resolving ambivalence can be key
  - " The Decisional Balance Sheet"

Decisional Balance Sheet

SMOKE

PRO	CON

DON'T SMOKE

PRO	CON

Your Goal

- Establish a strong, clear, internal reason for quitting/losing weight/change:
  - Health
    - Clearly link presenting illness to smoking/obesity
    - Don't talk about DEATH
  - Money
  - Family
  - Social
  - Other

Support and Encourage

- Your belief that someone can change will help them change
- Accept the individual
  - Understand their perspective
  - This does not mean you endorse it
- Don't argue/push
  - Can backfire and reinforce the behavior

REFER

- Brief interventions have been shown to be effective
- In the absence of time or expertise:
  - Ask, advise, and refer to other resources, such as local group programs or the toll-free quitline **1-800-QUIT-NOW**

This brief intervention can be achieved in less than 1 minute.

WHAT ARE "TOBACCO QUITLINES"?

- Tobacco cessation counseling, provided at no cost via telephone to all Americans
- Staffed by highly trained specialists
- Up to 4–6 personalized sessions (varies by state)
- Some state quitlines offer pharmacotherapy at no cost (or reduced cost)
- 28.1% success rate for patients who use the quitline and a medication for cessation

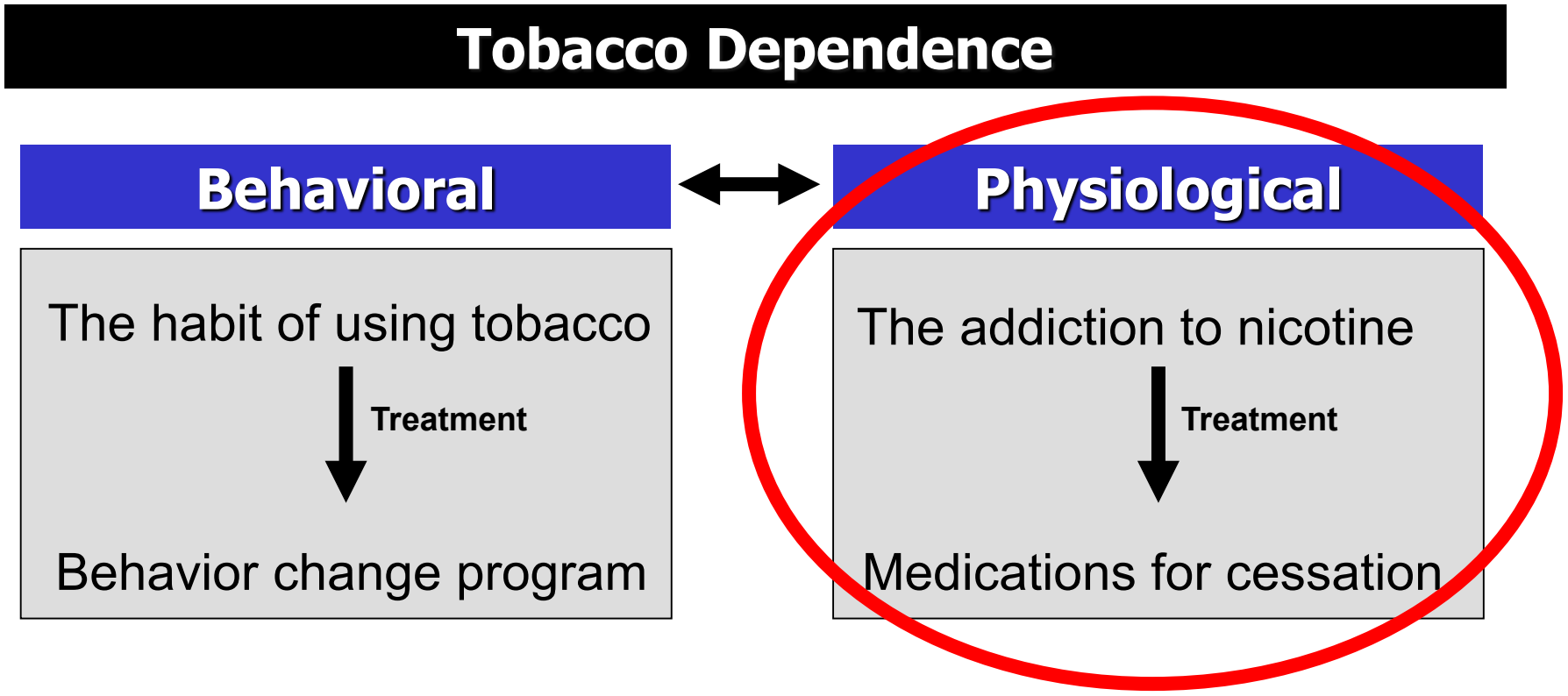
Most health-care providers, and most patients, are not familiar with tobacco quitlines.

WHEN a PATIENT CALLS the QUITLINE

- Caller is routed to language-appropriate staff
- Brief Questionnaire
  - Contact and demographic information
  - Smoking behavior
- Choice of services
  - Individualized telephone counseling
  - Quitting literature mailed within 24 hrs
  - Referral to local programs, as appropriate

Quitlines have broad reach and are recommended as an effective strategy in the 2008 Clinical Practice Guideline.

TOBACCO DEPENDENCE: A 2-PART PROBLEM



Treatment should address the physiological **and** the behavioral aspects of dependence.

PHARMACOTHERAPY: FIRST-LINE AGENTS

Nicotine gum*

- Nicorette (OTC)
- Generic nicotine gum (OTC)

Nicotine lozenge*

- Nicorette Lozenge (OTC)
- Nicorette Mini Lozenge (OTC)
- Generic nicotine lozenge (OTC)

Transdermal nicotine patch*

- NicoDerm CQ (OTC)
- Generic nicotine patches (OTC, Rx)

Nicotine nasal spray*

- Nicotrol NS (Rx)

Nicotine oral inhaler*

- Nicotrol (Rx)

Bupropion SR tablets

- Zyban (Rx)
- Generic (Rx)

Varenicline tablets

- Chantix (Rx)

These are the only medications approved by the FDA for smoking cessation.

** Nicotine replacement therapy (NRT) products.*

Final Reminders

- You can not make anyone change
- The more you push the more they'll resist
- Rather, help the patient want to change:
  - Increase displeasure with current behavior
  - Decrease fear of the new
- In the end, the patient:
  - Should present the reasons for change
  - Choose when and how to change

- **People with behavioral health problem can quit**

- Failure to address cessation tacitly implies that:
  - Quitting is not important
  - Continued smoking is ok

You just might be **the** person this particular patient will pay attention to.

Resources

- www.QuitNowIndiana.com
- www.CDC.gov/quit
- www.RethinkTobaccoIndiana.org
- www.in.gov/VapeFreeIndiana

Contact Information:

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