OVERVIEW

- Tobacco Treatment
  - Smoking Outcomes
  - Co-occurring Disorders
  - Integration
- Tobacco Prevention

TREATING SPECIAL POPULATIONS

RESEARCH on TOBACCO & DEPRESSION

- Most of the research has been conducted with people with a history of MDD, in free-standing smoking clinics
  - Greater tobacco abstinence with increased psychological support (Hall et al., 1994; Brown et al., 2001)
  - Individuals with recurrent MDD may be especially helped by CBT—mood management approaches
  - Individuals with a history of MDD may have more difficulty quitting and more severe withdrawal symptoms than those without MDD

READINESS to QUIT in SPECIAL POPULATIONS*

- General Population
  - 40% Intend to quit in next 6 mo
  - 20% Intend to quit in next 30 days
- General Psych Outpts
  - 43% Intend to quit in next 6 mo
  - 28% Intend to quit in next 30 days
- Depressed Outpatients
  - 55% Intend to quit in next 6 mo
  - 24% Intend to quit in next 30 days
- Psych. Inpatients
  - 41% Intend to quit in next 6 mo
  - 24% Intend to quit in next 30 days
- Methadone Clients
  - 48% Intend to quit in next 6 mo
  - 22% Intend to quit in next 30 days

ABSTINENCE RATES by TREATMENT CONDITION

- Stepped Care Intervention
  - Stage-based expert system counseling
  - Nicotine patch
  - 6 session individual counseling
- Brief Contact Control

322 depressed smokers recruited from four outpatient psychiatry clinics

Hall et al., 2006, Am J Public Health

* No relationship between psychiatric symptom severity and readiness to quit

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DEPRESSION SEVERITY & TOBACCO TREATMENT OUTCOME

- **NO RELATIONSHIP**
  - Depression severity, as measured by the Beck Depression Inventory-II, was unrelated to participants' likelihood of quitting smoking
  - Among intervention participants, depression severity was unrelated to their likelihood of accepting cessation counseling and nicotine patch

TREATMENT of PSYCHIATRIC INPATIENTS

- Using the same model...
  - Tobacco cessation treatment initiated during psychiatric hospitalization
    - 224 patients enrolled
    - Full range of psychiatric diagnoses
    - 79% recruitment rate
    - >80% retention at 18 months
    - Efficacy outcomes thru 18 months still being collected (trial will end August 2010)

TREATING SMOKERS with SCHIZOPHRENIA

- Treatments tailored for smokers with schizophrenia no more effective than standard programs (George et al., 2000)
- Atypical antipsychotics associated with greater cessation than typical antipsychotics

TWO RCTS of TOBACCO TREATMENT in PATIENTS with SCHIZOPHRENIA

- Case studies suggesting MDE recurrence after quitting smoking among those with a history of depression
  - Glassman, 2001: MDE recurrence in 6% (n=2) of those smoking vs. 31% (n=13) of those abstinent
    - Differential loss to follow-up: 5% (n=2/44) of quitters missing vs. 39% (n=22/56) of continued smokers
  - Tsah, 2001: N=308, no difference in rate of MDE among abstinent vs. smoking participants
    - Difference in rate of MDE by depression history: 10% among those with no MDD history vs. 24% if MDD+ history

Depression is a remitting and relapsing disorder

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MENTAL HEALTH OUTCOMES: DEPRESSED SMOKERS TREATED for TOBACCO

- Among depressed patients who quit smoking:
  - No increase in suicidality
    - Quit: 0% vs Smoking: 1-4%
  - No increase in psych hospitalization
    - Quit: 0-1% vs. Smoking: 2-3%
  - Comparable improvement in % of days with emotional problems
  - No difference in use of marijuana, stimulants or opiates
  - Less alcohol use among those who quit smoking

Prochaska et al., 2008, Am J Public Health

TOBACCO CESSATION & SCHIZOPHRENIA SYMPTOMS

- Tobacco abstinence (1-wk) not associated with worsening of:
  - attention, verbal learning/memory, working memory, or executive function/inhibition, or clinical symptoms of schizophrenia (Evins et al., 2005)
  - Bupropion: decreased the negative symptoms of schizophrenia (Evins et al. 2005, George et al. 2002)
  - Varenicline: no worsening of clinical symptoms and a trend toward improved cognitive function (Evins et al., 2009)

INTEGRATING TOBACCO TREATMENT within PTSD SERVICES

- RCT with 66 clients from VA Medical Center
  - Integrated care (IC)
    - Manualized treatment delivered by PTSD clinician and case manager (3-hr training)
    - Behavioral counseling once a week for 5 weeks + 1 follow-up
    - Bupropion, nicotine patch, gum, spray
  - Usual care (UC): referral to VA smoking cessation clinic

McFall et al. (2005) Am J Psychiatry

INTEGRATING TOBACCO TREATMENT within PTSD SERVICES

- Cessation Medication Use
  - Integrated Intervention: 94%
  - Usual Care: 64%
- Counseling Sessions Attended
  - Integrated Intervention: M=5.5
  - Usual Care: M=2.6
- At all assessments, the odds of abstinence were 5 times greater for integrated care vs. usual care

McFall et al. (2005) Am J Psychiatry

SUMMARY: TOBACCO TREATMENT in PSYCHIATRIC PATIENTS

- In general, currently available interventions show effectiveness
- Wide range of abstinence rates, with unknown determinants
- Evidence of deleterious effect on psychiatric symptoms or recurrence is weak
- Integration into mental health treatment settings increases abstinence rates

TOBACCO CESSATION DURING ADDICTIONS TREATMENT or RECOVERY

- Meta-analysis of 19 trials
  - 12 in treatment; 7 in recovery
- Findings: Tobacco Cessation
  - In Treatment Studies: Post treatment abstinence rates were intervention=12% vs. control=3%
  - In Recovery Studies: Post treatment abstinence rates were intervention=38% vs. control=22%
  - No significant effect for tobacco cessation at long-term follow-up (≥ 6 months)

Prochaska, Delucchi & Hall (2004) JCCP
TOBACCO CESSION DURING ADDICTIONS TREATMENT or RECOVERY

- Systematic review of 17 studies
- Smokers with current and past alcohol problems:
  - More nicotine dependent
  - Less likely to quit in their lifetime
  - As able to quit smoking as individuals with no alcohol problems

Hughes & Kalman (2006) Drug Alc Dep

DOES ABSTINENCE from TOBACCO CAUSE RELAPSE to ALCOHOL and ILLICIT DRUGS?

- At > 6 months follow-up, tobacco treatment with individuals in addictions treatment was associated with a 25% increased abstinence from alcohol and illicit drugs (Prochaska et al., 2004).
- Caveat: One well done study (N=499) of concurrent versus delayed treatment reported (Joseph et al., 2004):
  - Comparable smoking abstinence rates at 18 months (12.4% versus 13.7%)
  - Lower 6-month prolonged alcohol abstinence rates among those offered concurrent compared to delayed tobacco cessation treatment; NS at 12 and 18-months

SUMMARY: TOBACCO TREATMENT for SUBSTANCE ABUSING PATIENTS

- In general, currently available interventions show some effectiveness, at least for the short-term
- Range of abstinence rates, with unknown determinants
- Weak evidence of deleterious effect on abstinence from illicit drugs and alcohol
- Disorder specific data may eventually allow better tailoring of treatments

PREVENTION

- Problem of identification and developmental sequence, with a few exceptions:
  - ADHD
    - ADHD diagnosed prior to initiation of smoking
    - Smoking rates 2 to 3 times higher for adolescents with vs. without ADHD
    - Adults with childhood history of ADHD may have more difficulty in quitting smoking (Humfleet et al., 2005)
  - Children of parents with addiction problems
    - Sons more likely to be recent smokers than the general population (Schukit et al. 2004)

PREVENTION

- Drug Abuse Treatment Settings
  - Prospective study, N=649
    - At 12-month follow-up, 13% of the 395 baseline smokers reported quitting smoking and 12% of the 254 baseline nonsmokers reported starting/relapsing to smoking

Kohn et al. (2003) Drug Alc Dep

"Those who deliver mental health care often pride themselves on treating the whole patient, on seeing the big picture, and on not being bound by financial irrationality or by the biases of their culture; yet many fail to treat nicotine dependence. They forget that when their patient dies of a smoking-related disease, their patient has died of a psychiatric illness they failed to treat."

- John Hughes 1997

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