# *Engaging clients with mental illnesses and behavioral health challenges in tobacco treatment = Enhancing Evidence Based Practice!*

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College of Nursing
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MANAGED BY UK HEALTHCARE

# Goals of this presentation

- Describe tobacco dependence in persons with a mental illness or substance use disorder (MI/SUD) compared to the general population
- Describe treatment options and considerations when providing tobacco dependence services to persons with MI/SUD
- Discuss when and how to adapt tobacco cessation treatment for a person with a MI/SUD

# Mental Disorders are Prevalent


- **18.1% have any mental disorder**
- **4.1% suffer from a serious mental illness (SMI)**

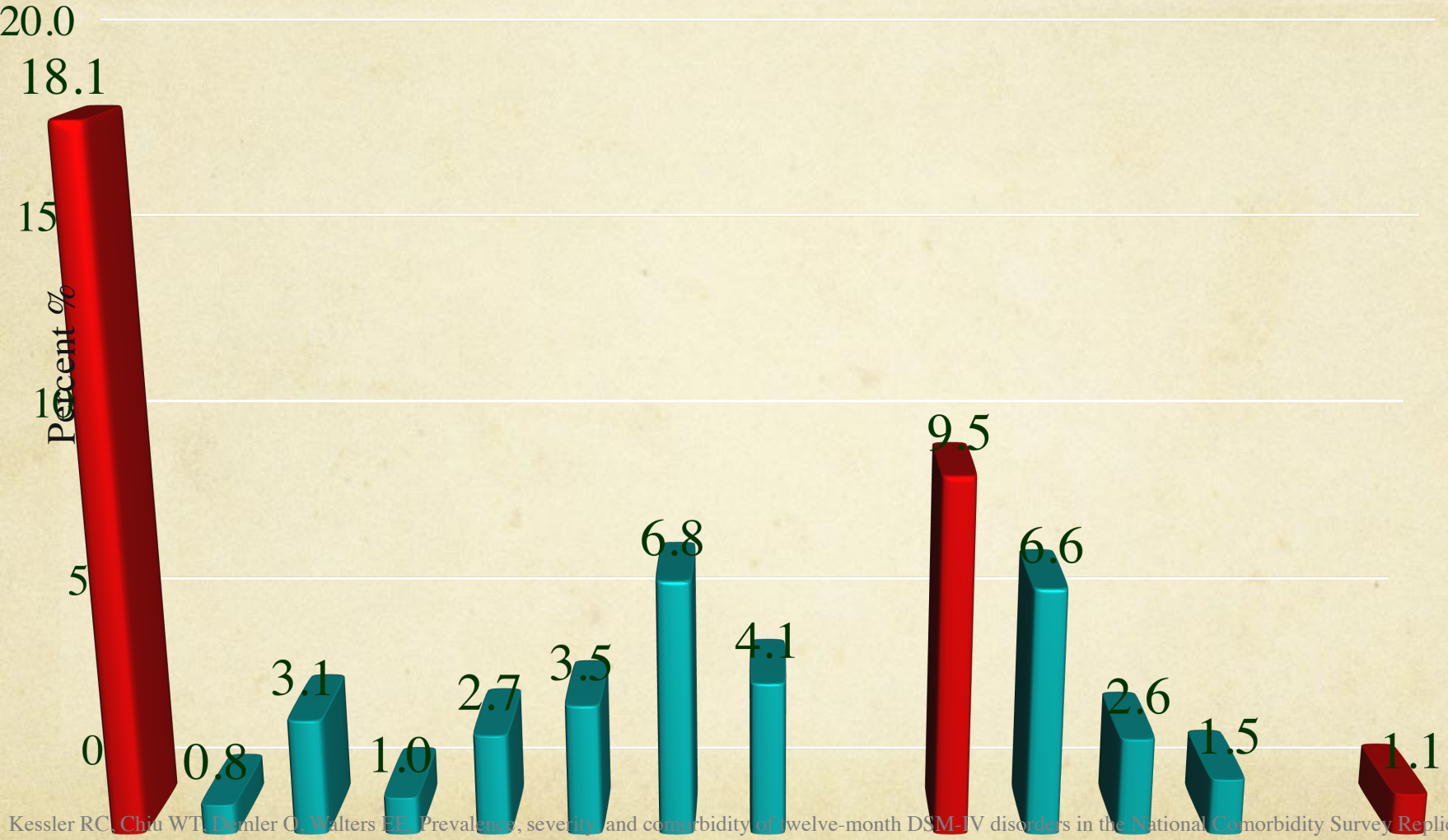
**2015 National Survey on Drug Use and Health:** http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf

# DSM V mental disorders

- Neurodevelopmental Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Elimination Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse Control, and Conduct Disorders
- Substance-Related and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilic Disorders
- Other Mental Disorders
- Medication-Induced Movement Disorders and Other adverse Effects of Medication
- Other Conditions That May Be a Focus of Clinical Attention

American Psychiatric Association. (2013). DSM 5. American Psychiatric Association.

# PAST YEAR MENTAL DISORDERS IN THE U.S.
# BY TYPE OF DISORDER (ADULTS ≥18 YRS)




Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry. 2005 Jun;62(6):617-627.

**2014 National Survey on Drug Use and Health:** http://www.samhsa.gov/data/sites/default/files/NSDUH-MHDetTabs2014/NSDUH-MHDetTabs2014.htm

Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. Archives of General Psychiatry. 1993 Feb;50(2):85–94.

# What About Substance Use Disorders?

# Substance use Disorder

**Problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:**

- The substance is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Craving, or a strong desire or urge to use the substance.
- Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
- Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
- Recurrent use of the substance in situations in which it is physically hazardous.
- Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
  - A markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for that substance (as specified in the DSM- 5 for each substance).
  - The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.


American Psychiatric Association. (2013). DSM 5. American Psychiatric Association.

# Classes of substances of abuse

**Opioids/Narcotics**

- Fentanyl
- Heroin
- Hydromorphone
- Methadone
- Morphine
- Opium
- Oxycodone

**Hallucinogens**

- Ecstasy/MDMA
- K2/Spice
- Ketamine
- LSD
- Peyote & Mescaline
- Psilocybin
- Marijuana/Cannabis
- Steroids
- Inhalants

**Stimulants**

- Amphetamines
- Cocaine
- Khat
- Methamphetamine
- Alcohol (low dose)
- Nicotine (high dose)

**Depressants**

- Barbiturates
- Benzodiazepines
- GHB
- Rohypnol®
- Alcohol (high dose)
- Nicotine (low dose)

**Drugs of Concern**

- Bath Salts or Designer Cathinones
- DXM
- Kratom
- Salvia Divinorum

Drug Enforcement Administration. (2011). Drugs of Abuse: 2011 Edition. A DEA Resource Guide. US Dept of Justice. www. justice. gov/ dea/ drugs_ of_ abuse_.

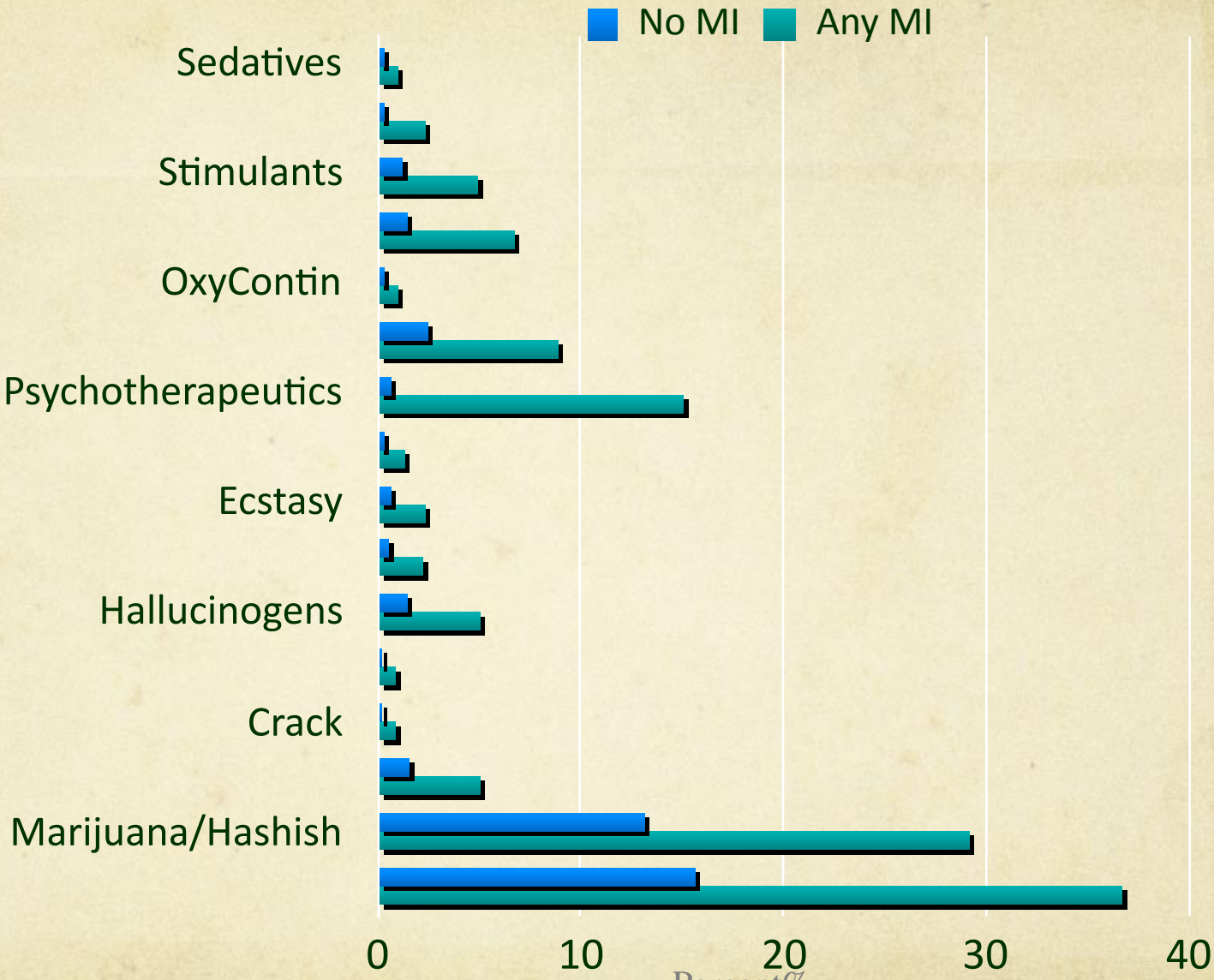
# Psychoactive effects of substances

| Substance | Sensory effects | Negative effects |
|---|---|---|
| OPIOIDS/NARCOTICS | Reduces tension, anxiety, and aggression | Drowsiness, inability to concentrate, apathy |
| HALLUCINOGENS | Perceptual distortions of thought associated with time and space | Respiratory depression, coma, convulsions, seizures |
| STIMULANTS | Exhilaration, enhanced self-esteem, improved mental and physical performance, extended wakefulness | Agitation, hostility, panic, aggression, suicidal/homicidal tendencies, paranoia |
| DEPRESSANTS | Sleep, relieve anxiety and muscle spasms, and prevent seizures | Amnesia, reduced reaction time, impaired mental function and judgement, and cause confusion, respiratory depression |

Drug Enforcement Administration. (2011). Drugs of Abuse: 2011 Edition. A DEA Resource Guide. US Dept of Justice. www. justice. gov/ dea/ drugs _of _ abuse .

# What About Co-Occurring MI & SUD?

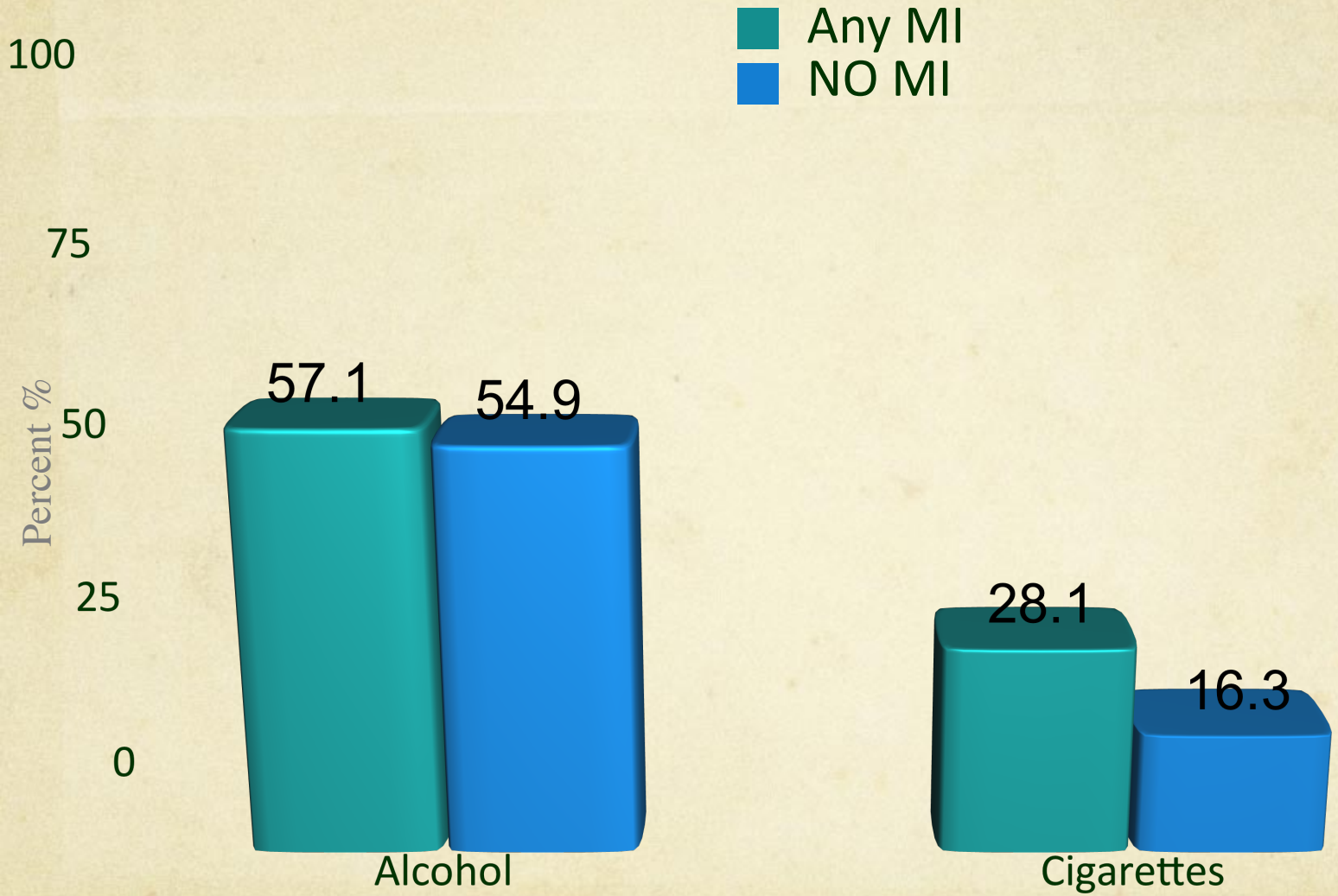
# Past year use of illicit drugs by MI status (adults ≥ 18 yrs)




2018 National Survey on Drug Use and Health: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetTabsSect8pe2018.htm

# Past month alcohol and tobacco use by MI status

(adults ≥ 18 yrs)




2018 National Survey on Drug Use and Health: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetTabsSect8pe2018.htm

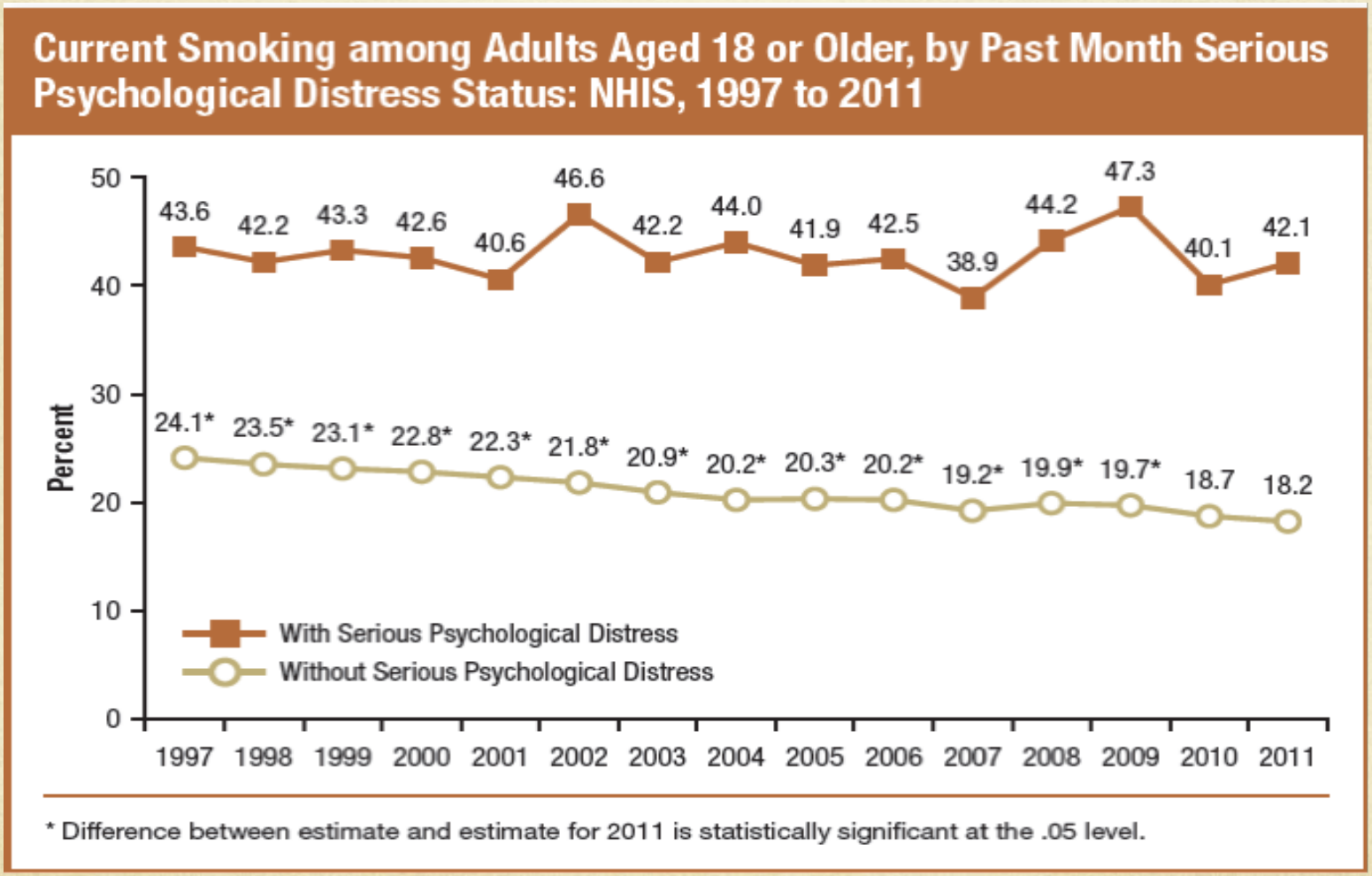
# Why Engage Persons with MI/SUD in Tobacco Treatment?

# Tobacco use and Mental Illness

Higher rates of tobacco use among individuals with mental illness or substance use disorders as compared to those without!

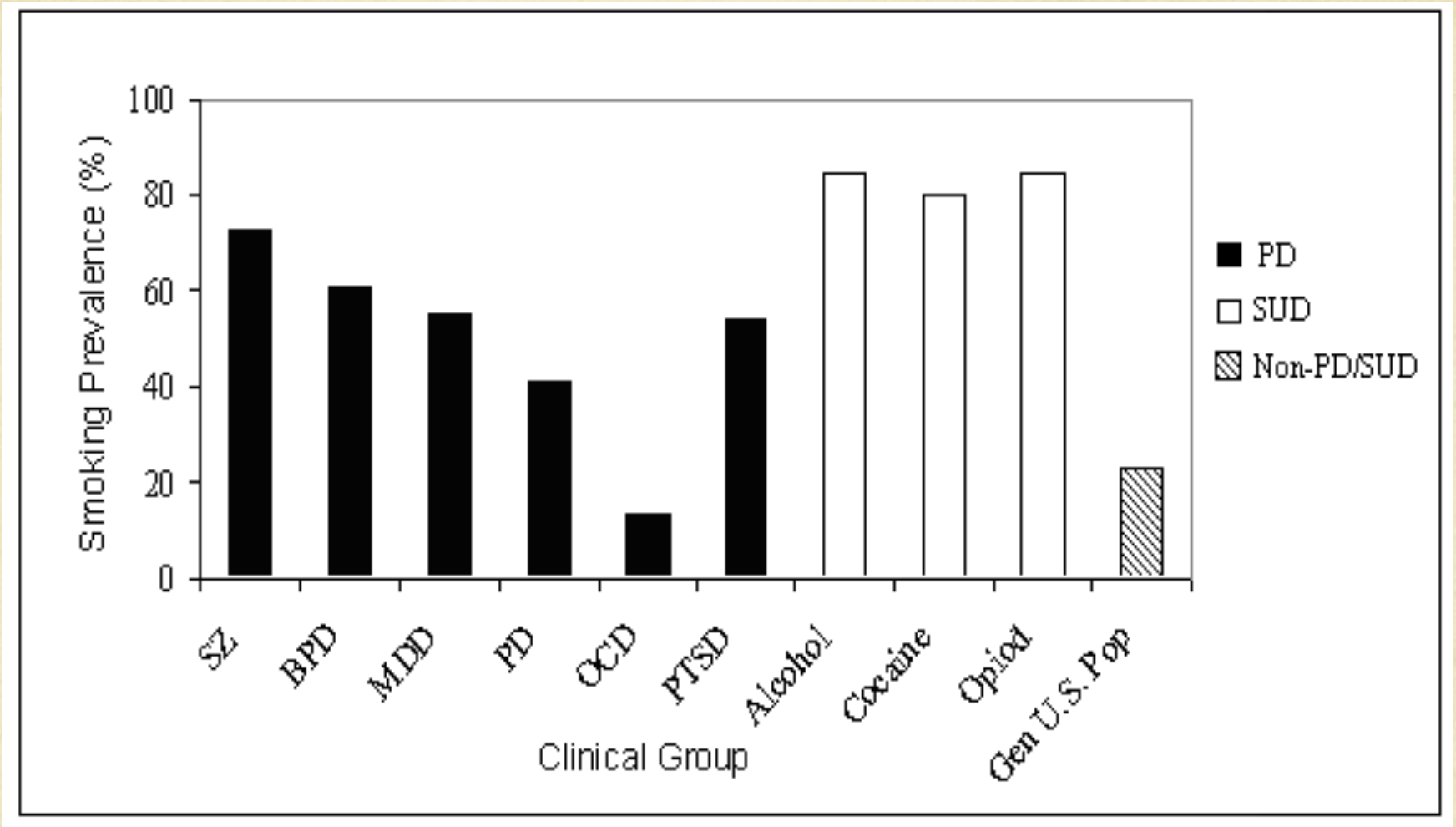

Centers for Disease Control and Prevention. Current Cigarette Smoking Among Adults—United States, 2005–2014. Morbidity and Mortality Weekly Report 2015;64(44):1233–40

# Little decline in smoking prevalence among those with mental illnesses




US Department of Health and Human Services. (2014). The health consequences of smoking—50 years of progress: a report of the Surgeon General. Atlanta, GA
Data from the National Health Interview Survey. Current smoking is defined as those who had smoked 100 cigarettes in their lifetime and smoked daily or some days at time of the interview. This illustration was obtained with permission from the SAMHSA CBHSQ Report, July 18 2013:http://www.samhsa.gov/data/sites/default/files/spot120-smokingspd_/spot120-smokingSPD.pdf

# Prevalence of smoking by MI/SUD disorder




Kalman, Morissette, & George. "Co-Morbidity of Smoking in Patients with Psychiatric and Substance Use Disorders." The American journal on addictions / American Academy of Psychiatrists in Alcoholism and Addictions 14.2 (2005): 106–123. PMC. Web. 7 Mar. 2016

# Effects of smoking among persons with MI/SUD

**Smokers with MI/SUD:**

- Die 10-25 years earlier
- Have more depression and anxiety
- Have more substance use problems
- Have more cardiovascular and cardiopulmonary problems
- Are more likely to commit suicide
- Have sexual problems

**Nonsmokers with MI/SUD:**

- Have better health
- Live longer
- Need less medication
- Have less depression
- Save more money

Parks, Svendsen, Singer, Foti (2006). Morbidity and Mortality in People with Serious Mental Illness.
National Association of State Mental Health Program Directors (NASMHPD). Medical Directors Council www.masmhpd.org

# Smoking is the leading cause of death in individuals with mental illness and substance use disorders!

Smoking tobacco causes more deaths among clients in substance abuse treatment than the alcohol or drug use that brings them to treatment. A seminal 11-year retrospective cohort study of 845 people who had been in addictions treatment found that 51 percent of deaths were the result of tobacco-related causes.[1] This rate is twice that found in the general population and nearly 1.5 times the rate of death by other addiction-related causes. Despite these statistics, most substance abuse treatment programs do not address smoking cessation.

Hurt, R. D., Offord, K. P., Croghan, I. T., Gomez-Dahl, L., Kottke, T. E., Morse, R. M., & Melton, L. J. (1996). Mortality following inpatient addictions treatment: Role of tobacco use in a community-based cohort. Jama, 275(14), 1097-1103.

# Why do people with MI/SUD use tobacco?

# Factors associated with tobacco use among persons with mental illness

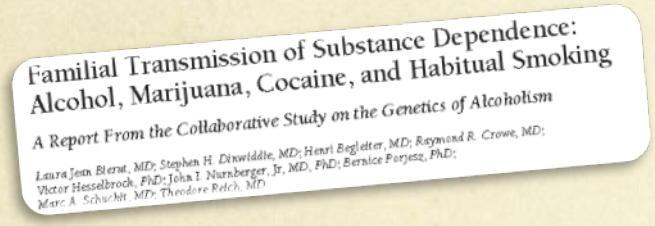
# Factors promoting SUD in populations with MI

- **Common factor models**
  - **Comorbidity is due to shared risk factors across SUD and MI**
- **Secondary substance use disorder models**
  - **MI increases the chances of developing SUD**
- **Secondary psychiatric disorder models**
  - **SUD increases the chance of developing MI**
- **Bidirectional models**
  - **Either disorder increases risk for the other disorder**

Mueser, K. T., Drake, R. E., & Wallach, M. A. (1998). Dual diagnosis: a review of etiological theories. Addictive behaviors, 23(6), 717-734.

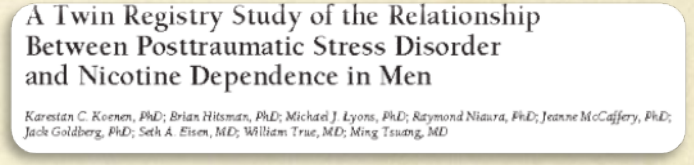
# Common factor models

- Genetic
  - **Genetic factors contribute to the development of MI/SUD and tobacco use**
    - **Shared familial transmission of substance use disorders**
    - **Shared genetic effects between alcohol and nicotine**
    - **Shared genetic factors for PTSD and Schizophrenia and tobacco use**

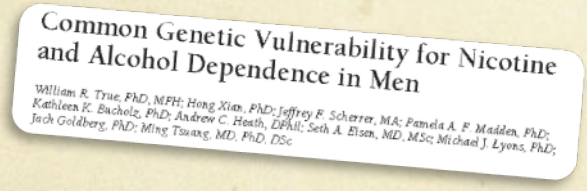

Familial Transmission of Substance Dependence: Alcohol, Marijuana, Cocaine, and Habitual Smoking

A Report From the Collaborative Study on the Genetics of Alcoholism

Laura Jean Bierut, MD; Stephen H. Dinwiddie, MD; Henri Begleiter, MD; Raymond R. Crowe, MD; Victor Hesselbrock, PhD; John I. Nurnberger, Jr, MD, PhD; Bernice Porjesz, PhD; Marc A. Schuckit, MD; Theodore Reich, MD


A Twin Registry Study of the Relationship Between Posttraumatic Stress Disorder and Nicotine Dependence in Men

Karestan C. Koenen, PhD; Brian Hitsman, PhD; Michael J. Lyons, PhD; Raymond Niaura, PhD; Jeanne McCaffery, PhD; Jack Goldberg, PhD; Seth A. Eisen, MD; William True, MD; Ming Tsuang, MD


Common Genetic Vulnerability for Nicotine and Alcohol Dependence in Men

William R. True, PhD, MPH; Hong Xian, PhD; Jeffrey F. Scherrer, MA; Pamela A. F. Madden, PhD; Kathleen K. Bucholz, PhD; Andrew C. Heath, DPhil; Seth A. Eisen, MD, MSc; Michael J. Lyons, PhD; Jack Goldberg, PhD; Ming Tsuang, MD, PhD, DSc


A Novel Permutation Testing Method Implicates Sixteen Nicotinic Acetylcholine Receptor Genes as Risk Factors for Smoking in Schizophrenia Families

Stephen V. Faraone[a,b] Jessica Su[b] Levi Taylor[c] Marsha Wilcox[c] Paul Van Eerdewegh[c,d] Ming T. Tsuang[a,b,c,e]


Gershon, E. S., Hamovit, J., Guroff, J. J., Dibble, E., Leckman, J. F., Sceery, W., Targum, S. D., Nurnberger, J. I., Jr., Goldin, L. R., & Bunne, W. E., Jr. (1982). A family study of schizoaffective, bipolar I, biopolar II, unipolar, and normal control probands. Archives of General Psychiatry, **39**, 1157–1167.

Koenen KC, Hitsman B, Lyons MJ, et al. A Twin Registry Study of the Relationship Between Posttraumatic Stress Disorder and Nicotine Dependence in Men. Archives of General Psychiatry 2005; 62:1258-1265

Faraone et al. (2004). A novel permutation testing method implicates sixteen nicotinic acetylcholine receptor genes as risk factors for smoking in Schizophrenia families

Bierut LJ, Dinwiddie SH, Begleiter H, et al. Familial Transmission of Substance Dependence: Alcohol, Marijuana, Cocaine, and Habitual Smoking: A Report From the Collaborative Study on the Genetics of Alcoholism. Archives of General Psychiatry 1998; 55:982-988

# Common factor models

- **Socioeconomic status (education, income, occupation)**
  - **Associations between SES, SUD, and MI**

Neighborhood disadvantage and early exposure to substance use may present an 'exposure opportunity' for subsequent substance use.


Substance Use and Mental Illness Communities…have encouraged tobacco use in the past or at best not discouraged it…and… isolated from smoking cessation approaches in the larger network community

Hawkins, D. J., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. Psychological Bulletin, **112**, 64–105.
Wagner FA, Anthony JC. Into the world of illegal drug use: Exposure opportunity and other mechanisms linking the use of alcohol, tobacco, marijuana, and cocaine. Am. J. Epidemiol. 2002; 155:918-925
Crum RM, Lillie-Blanton M, Anthony JC. Neighborhood environment and opportunity to use cocaine and other drugs in late childhood and early adolescence. Drug and Alcohol Dependence 1996; 43:155-161
Kawachi I, Berkman L. Social ties and mental health. Journal of Urban Health 2001; 78:458-467

# Secondary substance use disorder models

- **Psychosocial risk factor models**
  - **Self-medication hypothesis**: Specific substances are selected by individuals to ameliorate effects of specific internal states of dysphoria
  - **Alleviation of dysphoria**: Persons with MI are prone to heterogeneous dysphoric experiences (i.e., anxiety, depression) that make them more likely to use psychoactive substances to alleviate the dysphoria

Mueser, K. T., Drake, R. E., & Wallach, M. A. (1998). Dual diagnosis: a review of etiological theories. Addictive behaviors, 23(6), 717-734.

# Support for secondary substance use disorder model?

**Cognition**

- **Nicotine improves the P50 "gating" and sensory overload**

**Mood**

- **Some unknown psychoactive component of tobacco smoke (possibly acetaldehyde) acts as a monoamine oxidase inhibitor and COULD have antidepressant effects**

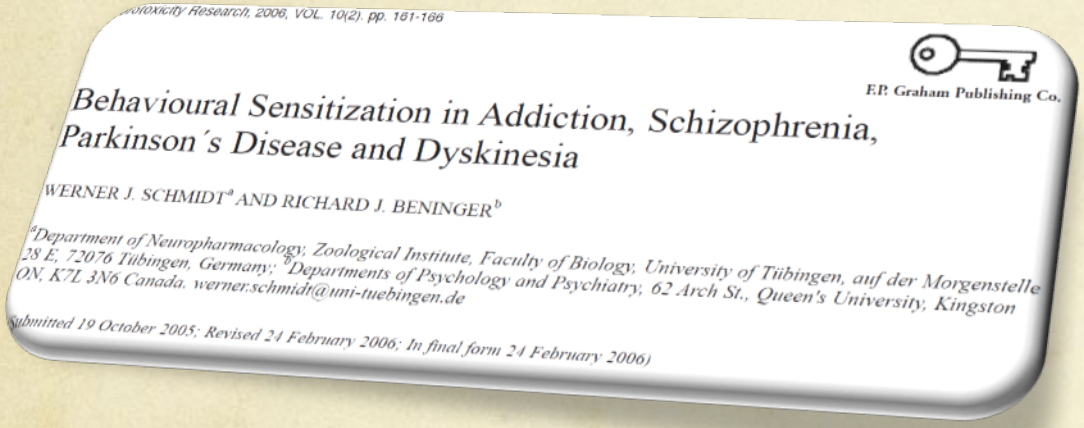
**Tension**

- **People with anxiety may find smoking reduces anxiety**

**NIDA NOTES:** http://archives.drugabuse.gov/NIDA_Notes/NNVol13N3/tobacco.html
Morissette, S. B., Tull, M. T., Gulliver, S. B., Kamholz, B. W., & Zimering, R. T. (2007). Anxiety, anxiety disorders, tobacco use, and nicotine: a critical review of interrelationships. Psychological bulletin, 133(2), 245
Talhout, R., Opperhuizen, A., & van Amsterdam, J. G. (2007). Role of acetaldehyde in tobacco smoke addiction. European Neuropsychopharmacology, 17(10), 627-636.
Anderson, S. M., & Brunzell, D. H. (2012). Low dose nicotine and antagonism of β2 subunit containing nicotinic acetylcholine receptors have similar effects on affective behavior in mice. PLoS One, 7(11), e48665.

# Secondary psychiatric disorder models

**Behavioral Sensitization:** Continuous stimulant administration can lead to increased sensitivity of response




**–Implicated in the development of positive symptoms in schizophrenia, through increased activity of dopamine receptors**

**Study in Finland found that heavy smoking adolescents are 3 times more likely to develop psychosis than non-smoking**


Schmidt, W. J., & Beninger, R. J. (2006). Behavioural sensitization in addiction, schizophrenia, Parkinson's disease and dyskinesia. Neurotoxicity research, 10(2), 161-166.
Mustonen, A., Ahokas, T., Nordström, T., Murray, G. K., Mäki, P., Jääskeläinen, E., ... & Niemelä, S. (2018). Smokinhot: adolescent smoking and the risk of psychosis. Acta Psychiatrica Scandinavica.

# Bidirectional models

- Ongoing, interactional effects between MI and SUD account for increased rates of comorbidity
- SUD may trigger MI in vulnerable persons, which is then maintained by continued SUD due to socially learned cognitive factors (i.e., such as beliefs, expectancies, and motives for substance use)

Graham, H. L. (1998). The role of dysfunctional beliefs in individuals who experience psychosis and use substances: Implications for cogitive therapy and medication adherence. Behavioural and Cognitive Psychotherapy, **26**, 193–207

# Myth Busters for Not Providing Tobacco Treatment….

# “these patients don’t want to quit”

- However….80% of participants in a methadone maintenance program and 75% of participants in an alcohol abuse program endorsed a desire to quit

(Richter KP et al., 2001; Ellingstad TP et al, 1999)

- In a review of 9 studies of motivation to quit smoking among individuals with psychiatric disorders at least 50% are contemplating cessation

(Siru, Hulse & Tait, 2009).

# *"these patients are unable to quit"*

- Meta-analysis (n = 19 studies) of smoking cessation among individuals in addiction treatment and recovery found increased cessation at end of 12 weeks treatment

  (Prochaska JJ et al, 2004).

- Another recent study found end-of-treatment (between 8 to 26 weeks) smoking cessation rates of 40% among individuals with SUD and/or PD who completed an intensive tailored smoking cessation intervention that provided no-cost pharmacotherapy combined with behavioural counseling

  (Khara and Okoli, 2011)

# *"these patients will relapse (to other substances) if they try to quit"*

- Smoking cessation improves MENTAL HEALTH SYMPTOMS

*"Smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke" (Taylor et al, 2014)*

- Smoking cessation ENHANCES long-term sobriety

*"Contrary to previous concerns, smoking cessation interventions during addictions treatment appeared to enhance rather than compromise long-term sobriety" (Prochaska et al., 2004)*

Taylor, G., McNeill, A., Girling, A., Farley, A., Lindson-Hawley, N., & Aveyard, P. (2014). Change in mental health after smoking cessation: systematic review and meta-analysis. Bmj, 348, g1151.

Prochaska JJ, Delucchi K, Hall SM. A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. Journal of Consulting and Clinical Psychology 2004; 72:1144-1156

# EFFECTS OF SMOKING CESSATION ON MENTAL HEALTH

# Our responsibility

"All smokers with psychiatric disorders, including substance use disorders, should be offered tobacco dependence treatment, and clinicians must overcome their reluctance to treat this population….

Treating tobacco dependence in individuals with psychiatric disorder is made more complex by the potential for multiple psychiatric disorders and multiple psychiatric medications."

(*Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline)*


Fiore M, Jaén C, Baker T, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. ;2008

# Recommendations for tobacco treatment among individuals with MI & SUD

# Key Recommendations

- Screening tools
- Timing of Treatment
- Type of treatment
  - Pharmacotherapy
  - Behavioral therapy
- Duration of treatment

# Screening for Depression in Smokers

- PHQ-2 Screening for Depression
- A quick way of screening patients for depression is to ask patients these two questions:
- During the past month, have you often been bothered by:
- 1. Little interest or pleasure in doing things? Yes___ No ____
- 2. Feeling down, depressed or hopeless? Yes___ No____
- If the patient's response to both questions is " No" the screen is negative.
- If the patient responded "yes" to either question, consider asking more detailed
- questions or using PHQ-9 patient questionnaire,

- Other tools for screening
  - PHQ-2 and PHQ-9
  - Zung Depression Scale
  - Beck Depression Inventory (BDI)

# ASSESSING SEVERITY OF SUBSTANCE USE (CAGE)

1. Have you ever felt you should cut down on your drinking? Yes___ No____

2. Have people annoyed you by criticizing your drinking? Yes___ No___

3. Have you ever felt bad or Guilty about your drinking? Yes___ No____

4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener) ? Yes___ No___

Each yes = 1.

A score of 2 or greater is clinically significant.

# Timing of treatment

## For those with MI

- Delay treatment until symptoms are in remission. For example
  - set quite date in future
  - refer for treatment…coordinate with physician and/or therapist
  - be aware of increased suicide rate for depressed smokers
- Monitor MI symptoms
  - Anticipate potential increase in side-effects of medications after initiating smoking cessation

## For those with SUD

- Concurrent treatment of tobacco and substances is safe. However,
  - Those using marijuana may have even harder time quitting
  - Treatment should account for synergistic use of substances
- Monitor Withdrawal symptoms
  - Anticipate higher report of withdrawal symptoms

| Medications that Have Their Levels Affected by Smoking and Smoking Cessation [60] | | |
|---|---|---|
| ANTIPSYCHOTICS | Chlorpromazine (Thorazine) | Olanzapine (Zyprexa) |
| | Clozapine (Clozaril) | Thiothixene (Navane) |
| | Fluphenazine (Permitil) | Trifluoperazine (Stelazine) |
| | Haloperidol (Haldol) | Ziprasidone (Geodon) |
| | Mesoridazine (Serentil) | |
| ANTIDEPRESSANTS | Amitriptyline (Elavil) | Fluvoxamine (Luvox) |
| | Clomimpramine (Anafranil) | Imipramine (Tofranil) |
| | Desipramine (Norpramin) | Mirtazapine (Remeron) |
| | Doxepin (Sinequan) | Nortriptyline (Pamelor) |
| | Duloxetine (Cymbalta) | Trazodone (Desyrel) |
| MOOD STABLIZERS | Carbamazepine (Tegretol) | |
| ANXIOLYTICS | Alprazolam (Xanax) | Lorazepam (Ativan) |
| | Diazepam (Valium) | Oxazepam (Serax) |
| OTHERS | Acetaminophen | Riluzole (Rilutek) |
| | Caffeine | Ropinirole (Requip) |
| | Heparin | Tacrine |
| | Insulin | Warfarin |
| | Rasagiline (Azilect) | |

# Recommend Cessation Pharmacotherapy

- Nicotine replacement therapy:
  - Combination therapy (patch + a short acting NRT) more effective than monotherapy (just the patch alone or just short acting alone)
  - Nasal spray not recommended for intranasal drug users
- Bupropion:
  - May be a good choice for individuals with depressive disorders
  - Contraindicated for those with a seizure history; monitor carefully among those with alcohol use disorder and eating disorders
- Varenicline:
  - Most effective medication for smoking cessation
  - Contraindicated for those with kidney problems

Tidey & Miller. (2015). Smoking cessation and reduction in people with chronic mental illness. Bmj, 351(1), h4065.
Anthenelli, Benowitz, West, St Aubin, McRae, Lawrence, ... & Evins (2016). Neuropsychiatric safety and efficacy of varenicline, bupropion, and nicotine patch in smokers with and without psychiatric disorders (EAGLES): a double-blind, randomised, placebo-controlled clinical trial. The Lancet, 387(10037), 2507-2520.
Sterling, L. H., Windle, S. B., Filion, K. B., Touma, L., & Eisenberg, M. J. (2016). Varenicline and Adverse Cardiovascular Events: A Systematic Review and Meta−Analysis of Randomized Controlled Trials. Journal of the American Heart Association, 5(2), e002849.

# Aspects of Behavioral Treatment

- **Flexibility** is key because of greater nicotine dependence and fewer positive past quit attempts.
- Confidence and skill building may be needed before setting a quit date.
- Breaking down quitting into smaller, more concrete pieces may be needed.
- Individual and group and a combination may help and the duration may be extended to increase maintenance.

# Conclusions

- People living with MI/SUD use tobacco at higher rates than the general population.
- Tobacco use among people living with MI/SUD is associated with disproportionate rates of illness and death.
- Tobacco treatment approaches are successful in these populations; they need to be more intensive
- Behavioral health care providers need to be more aggressive in offering treatment for tobacco use in these populations
- We are here to help enhance the health and quality of life of those living with MI/SUD by supporting them in tobacco treatment

# Tobacco Dependence Treatment Resources are Available

- Resources for helping smokers with a Mental Illness are available
  - Learning About Healthy Living group program for people with mental illness. http://ubhc.umdnj.edu/nav/LearningAboutHealthyLiving.pdf
  - **Smoking Cessation for Persons with Mental Illness: A Toolkit for Mental Health Providers (2007).** Developed by the University of Colorado at Denver and Health Sciences Center and funded by the Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership (STEPP), Colorado Department of Public Health and the Environment.

    http://www.cdhs.state.co.us/dmh/providers_ebp.htm
  - NASMHPD Technical reports on Smoking and Mental Illness and a Toolkit for Smoking Cessation in Mental Health Facilities http://www.nasmhpd.org/publicationsmisc.cfm

# Tobacco Dependence Treatment Resources are Available

- Best New Resources for helping smokers with a Mental Illness or Substance Use Disorder

- National Mental Health Partnership For Smoking Cessation and Wellness http://smokingcessationleadership.ucsf.edu/MentalHealth.html has guidelines for consumers, physicians, other treating professionals

- **2011, "*A Hidden Epidemic: Tobacco Use and Mental Illness."*** *Legacy* http://www.legacyforhealth.org/PDF/A_Hidden_Epidemic.pdf.

- **2011 "Tobacco Use Cessation During Substance Abuse Treatment Counseling",** SAMHSA Advisory, Volume 10, Issue 2, www.samhsa.gov HHS Publication No. SMA) 11-46Clin