TOBACCO CESSATION

Department of Veterans Affairs

VETERANS HEALTH ADMINISTRATION

Integrating Tobacco Cessation Treatment into Mental Health Care

A Preceptor Training Program to Improve Delivery of Tobacco Cessation Treatment for Veterans with Mental Disorders

Proceedings of the May 4-5, 2006 Conference

COSPONSORED BY

Public Health Strategic Health Care Group (13B)
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FORWARD

Veterans Health Administration (VHA) patients with mental disorders smoke at nearly twice the rate as persons without mental disorders, and they smoke more heavily. These patients bear a disproportionately heavy burden of disease and premature death that is surely linked to their tobacco use, as is their excessive utilization of medical services.

A number of efficacious tobacco use treatments are available that help 20 percent to 25 percent of individuals stop smoking. However, these treatments are only as useful as our ability to deliver them effectively to vulnerable populations who need them most. Despite VHA's progressive performance measures that promote screening and intervention, fewer than 20 percent of VHA patients who smoke report receiving desired tobacco cessation services. Similar shortfalls in tobacco cessation service delivery are mirrored at the national level, prompting our former Surgeon General to declare that "Our lack of progress in tobacco control is more the result of failure to implement proven strategies than the lack of knowledge about what to do."

VHA clearly needs a novel approach that improves initial *and* continuous access to effective tobacco cessation treatment for patients with mental disorders who suffer from comorbid chronic, relapsing tobacco dependence. One promising approach, called Integrated Care (IC), incorporates treatment for tobacco use delivered by mental health providers into routine psychiatric care. Mental health clinicians are uniquely positioned to serve as change agents for patients who use tobacco, as their frequent and enduring contact with patients is an ideal platform for continuous monitoring of tobacco use and "recycling" of patients who relapse after a quit attempt. IC overcomes many barriers to accessing tobacco cessation care for mental health patients and has been shown to be a clinically effective treatment for a variety of comorbid addictions, including tobacco dependence.

VHA initiated a preceptorship training program in 2003 to address the obvious need to improve access to effective tobacco cessation services for mental health patients. This program used a "train-the-trainer" model to: (1) teach VHA health care professionals evidence-based clinical practices for tobacco cessation, and (2) mentor their progress in implementing IC principles of tobacco cessation service delivery for mental heath patients at their host facilities. To date, over 160 preceptors—representing all 22 VHA Networks—have attended one of three national training conferences held in Seattle (2004), Chicago (2005), and Washington, D.C. (2006). Course faculty then provided follow-up monitoring of preceptors' progress in using IC strategies to implement effective home site tobacco cessation programs for mental health patients. Helping preceptors find solutions to institutional barriers to change was facilitated by disseminating peer-generated "best practices," recorded in monthly written site progress reports, and providing peer and faculty consultation during regular conference calls. Access to state-of-the-art patient health promotion materials and provider education documents were provided through video, hard copy, and web-based media.

This volume summarizes the course content from faculty presentations delivered at the third and final preceptorship training conference held in Washington, D.C. This conference brought together many national experts in tobacco cessation research and education who taught core concepts also covered in the 2004 and 2005 preceptorship training conferences. These core concepts included evidence-based treatments for tobacco use endorsed by the VA/DoD clinical practice guidelines, current scientific knowledge about tobacco use and outcomes of tobacco use treatment trials for smokers with mental disorders, and practical systems change

strategies for implementing tobacco cessation interventions in VHA mental health settings. In addition, the 2006 conference emphasized special topics, including: tobacco cessation treatment approaches for psychiatric inpatients and patients with concurrent substance use disorders, and tobacco cessation public health initiatives within the Department of Defense (DoD).

Miles McFall, Ph.D.
Northwest Mental Illness, Research, Education, and Clinical Center
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INTRODUCTORY REMARKS

Kim Hamlett-Berry, Ph.D.

This third preceptorship, based on a "train-the-trainer" model, was organized to equip VHA mental health service providers with the knowledge and skills they need to assist their patients to quit smoking. In fact this may be the most important thing providers can do to improve their patients' health and save their lives, in view of the illness and death associated with tobacco use.

The 2005 *Smoking and Tobacco Use Cessation National Report* indicated that 67 (42 percent) of all VA medical centers (VAMCs) have outpatient psychiatric programs, and 41 (26 percent) have specialty smoking cessation (SC) programs. So, the previous trainings in integrating smoking cessation into routine care for patients with psychiatric disorders clearly are affecting care for this population. However, a number of VAMC inpatient units and settings still have indoor smoking areas — which are clearly inconsistent with our core health mission. There is increasing evidence also suggests that the ventilation systems used in these indoor areas are not as effective as once thought in preventing secondhand smoke exposures, contributing to renewed concerns about potential health effects.

Changing the VAMC culture that supports smoking is nearly as challenging as getting patients to stop smoking. It will take time and education to dispel the myths about tobacco use among patients with serious mental illness. We know that many of these patients do want to quit and they benefit from smoking cessation interventions. The smoking behaviors of our veteran patients also need to be viewed in the larger context of the history of tobacco use among military populations. Preceptors will need to be patient while trying to promote much needed change and educating others in the system to be effective agents for change as well. Finally, it is also important to look beyond the traditional smoking cessation group format for creative ways to encourage and support smoking cessation in the context of mental health care services.

TOBACCO CESSATION SERVICE DELIVERY WITHIN VHA
Limitations and Proposed Solutions

Miles McFall, Ph.D.

Tobacco use is the most preventable cause of illness and death in the United States, accounting for 20 percent of all deaths (440,000) in the country each year. It is also the most lethal substance use disorder, killing more than four times as many Americans as alcohol use. Between 33 percent and 45 percent of smokers will die from tobacco-related illnesses. Smoking shortens men's lives by 13.2 years and women's lives by 14.5 years. Smoking also carries tremendous economic costs: an estimated $75 billion in tobacco-related health care expenses and $82 billion in lost productivity associated with tobacco-related illness and mortality.

Tobacco use is especially high among individuals affected by serious mental illness. About 50 percent of those with serious mental illness are smokers, compared with 23 percent for society at large. In fact persons with mental illness smoke half of all cigarettes produced — and are only half as likely to quit as smokers without mental illness. Those with multiple psychiatric diagnoses are likely to be heavy smokers. Smoking-related diseases and mortality are disproportionately high for veterans with mental disorders, owing in part to the high prevalence of smoking in this population.

Progress in VHA tobacco control

Fortunately, there are effective pharmacological and counseling treatments for tobacco use disorder. Success rates for quitting smoking range from 20 percent to 25 percent. Sixty percent of VA patients who smoke, including veterans with mental disorders, want to quit and are receptive to treatment.

VHA and the Department of Defense have developed clinical practice guidelines for tobacco cessation treatment for both primary care and smoking cessation clinic settings. VHA clinicians also are in high compliance with performance measures to identify and counsel tobacco users.

Tobacco cessation treatment options and barriers to care

There are four venues for delivering tobacco cessation treatment to VA patients: (1) Refer them to a smoking cessation program; (2) Treat them within the primary care setting; (3) Refer them to a telephone-based tobacco quitline; or (4) Integrate tobacco cessation treatment into mental health care, whereby mental health providers deliver tobacco cessation treatment to their patients rather than referring them to a tobacco cessation specialist.

Specialized smoking cessation clinics provide the care for 88 percent of VA smokers who receive smoking cessation treatment. They offer the most comprehensive, intensive tobacco cessation treatment available in VHA. But there is a high rate of non-compliance for smokers referred to these clinics: Between 48 percent and 87 percent fail to show for their initial session, and another 44 percent to 79 percent drop out after attending an initial session.

Primary care providers treat 12 percent of VA smokers receiving tobacco cessation treatment, while 31 percent are treated by both a primary care provider and a smoking cessation clinic. VA primary care providers who treat smokers meet high standards for screening patients for tobacco use (98 percent), advising patients to quit (95 percent), and inquiring about interest in treatment (76 percent). Despite meeting high standards for detection of smoking and giving advice to quit, primary care providers consistently show low rates of actual delivery of tobacco cessation treatments to smokers — particularly those with mental illness.

Deficiencies in the current system for delivering tobacco cessation treatment have resulted in the unfortunate situation where only 17 percent to 22 percent of VA enrollees who smoke and want to quit report receiving desired tobacco cessation treatment during the prior year [1]. A number of barriers contribute to VHA's failure to deliver tobacco cessation treatment to the majority of its patients who smoke and who desire treatment. Most importantly, the current model of providing brief, episodic tobacco cessation treatment is no match for a chronic, relapsing disorder like nicotine dependence that requires repeated interventions over a long interval of time in order to be effectively managed.

Second, providers have limited time to repeatedly monitor patients' status, respond to relapses, and pursue drop-outs. Third, many providers—particularly primary care medical providers—have insufficient training in tobacco cessation treatment for smokers who have mental illnesses. Fourth, VHA has limited resources to treat the large volume of VA smokers (33 percent of all patients) who want to quit. Fifth, many providers may harbor beliefs that tobacco cessation treatment is ineffective and they may become discouraged by the low quit rates resulting from their efforts at intervention. Finally, there may be other provider barriers, such as the low importance of smoking in the face of competing health care demands, the incorrect perception that patients are not interested in quitting, and fear of delivering a negative message to patients that may drive them away from treatment.

Why integrate smoking cessation treatment into mental health care?

Several studies have integrated interventions for substance abuse into treatment of mental disorders that is delivered by a single provider or provider team. Integrated models of care have been shown to improve engagement and retention in substance use treatment, reduce drug and alcohol consumption, and increase rates of remission from non-tobacco substance use disorders among patients with serious mental illness.

There are excellent reasons for extending principles of integrated care demonstrated in the substance abuse literature to tobacco cessation treatment for patients enrolled in mental health care:

1. Mental health providers already have advanced training in treating behavioral and substance abuse disorders, which can be readily applied to nicotine dependence.
2. Mental health providers can tailor cessation treatment to address the dynamic interaction of tobacco use and psychiatric symptoms (e.g., address the interface of mood disturbance as an antecedent to tobacco use or as a consequence of tobacco cessation).
3. The frequent, continuous nature of mental health care promotes ongoing monitoring of smoking status and reapplication of treatment. This feature of care is imperative because most successful ex-smokers require six to eight quit attempts and may require multiple episodes of intervention over an extended period of time. Mental health providers also are uniquely positioned to offer tobacco cessation treatment sessions of sufficient numbers and duration to obtain optimal abstinence results, given the known "dose-response" effect between treatment and smoking outcomes.
4. Mental health clinics have the potential to expand access to smoking cessation treatment for veterans who are otherwise underserved because of the limitations and barriers associated with specialty tobacco cessation clinics and primary care-based tobacco cessation treatment (discussed above). Also, providing "one-stop-shopping" that provides tobacco cessation treatment in the mental health care environment for psychiatric patients can overcome a number of logistical barriers to care that are associated with referral to a specialty provider.

[1] VHA Office of Quality and Performance, 1999 Large Veterans Health VHA Survey and Survey of Healthcare Experiences of Patients (2002, 2004).

Implementing integrated approaches to care must emerge from a clinic culture that supports abstinence from tobacco as a priority for both mental and physical health. This approach provides assessment and treatment for tobacco use disorder in all willing mental health patients who smoke. And it provides tobacco cessation interventions by all mental health providers on repeated occasions to patients who smoke.

Implementing effective systems for tobacco cessation treatment

This integrated approach to tobacco cessation treatment requires — and results in — a culture change that emphasizes the importance of repeated monitoring and intervention for the chronic, relapsing medical disorder of tobacco dependence. Such change can be created by implementing seven key steps:

1. Make recurrent staff training in tobacco cessation clinical skills a priority. Medical residents, psychology interns, and students are effective culture change agents and should be targeted for tobacco cessation training.
2. Identify local "clinical champions" who promote tobacco cessation at the clinic level, grow an institutional identity as a "go to" person for information about tobacco cessation, and look after a myriad of practical tasks associated with this role.
3. Enlist allies — facility leaders, pharmacists, patients who have been successful in quitting smoking — to promote culture change.
4. Organize oversight/steering committees of program directors who have the authority to leverage culture change and allocate resources necessary to expand tobacco cessation treatment services.
5. Develop promotional strategies to keep tobacco cessation "front and center" in visible ways (e.g., organize health promotion campaigns and fairs, mount inspirational posters readily available from public health organizations, etc.).
6. Provide logistical support, such as making patient educational materials and carbon monoxide monitors readily available for program clinicians.
7. Monitor smoking outcomes and provide clinician-specific feedback on tobacco cessation smoking performance measures and monitors.

The objective of implementing these change principles is to develop an effective system where *all* mental health patients are assessed for tobacco use and all willing patients are offered tobacco cessation treatment on repeated occasions. Ideally, all clinic staff—not just a few enthusiasts—participate in screening for tobacco use, educate patients about the benefits of quitting smoking, and incorporate tobacco cessation treatment interventions into their ongoing mental health care with patients.

Although smokers with concurrent mental illness most likely benefit most from intensive treatment for tobacco cessation, even brief approaches to treatment can be effective, using the Public Health Service model of the 5 "A's:"

- **Ask** about smoking status
- **Advise** quitting
- **Assess** willingness to quit
- **Assist** quit efforts
- **Arrange** post-quit follow-up

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TOBACCO USE AND MENTAL ILLNESS
Neuropsychiatric Links and Mechanisms

Andrew J. Saxon, M.D.

Increasing evidence points to a link between smoking and mental illness. For example, data indicate that some 45.4 percent of those with nicotine dependence also have alcohol dependence; 30 percent have major depression; 35.3 percent have mania; and nearly 40 percent have panic disorder.

Although we are at an early stage in our understanding of possible genetic predisposition for nicotine dependence, we do know that nicotine gets into and changes the brain very quickly. Smoking is temporally associated with the onset of schizophrenia, a stark example of the close relationship between nicotine dependence and schizophrenia.[2]

A Norwegian longitudinal study of 1,190 adults found that the risk of depression was four times as high for heavy smokers than for non-smokers.[3] Blood flow decreases in several brain areas in women grieving the breakup of a relationship.[4] Another study showed that nicotine infusions increase blood flow in the same areas of the brain deficient in blood flow in grieving women.[5]

Smoking has been linked to suicidal behavior. One study showed that daily smokers had 1.74 times the rate of suicidal behavior as nonsmokers, more than three times the rate of major depression and nearly one and a half times (1.48 percent) the rate of alcohol or drug use.[6]

Treatment for smokers with mental illness

Medication is very useful in assisting people to stop smoking, approximately doubling the quit rates over those who attempt to stop without it. But we don't know how well such drugs as bupropion work to assist persons with schizophrenia, for example, to quit smoking. One study found that short-term quit rates were higher with bupropion compared to placebo among schizophrenics, while bupropion did not worsen the clinical symptoms of schizophrenia and tended to improve patients' depressive and other negative symptoms.[7] Bupropion also may be useful for treating depression as well as smoking cessation.

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For dually diagnosed patients, studies suggest that many patients will attempt to quit smoking. Most of them can reduce their smoking, but few will actually quit even with weekly group therapy so we need to design better treatments. On the other hand, treatment for smoking cessation does not increase their other substance use. People prone to depression, for example, are likely to have greater problems from nicotine withdrawal.

Smoking and smoking cessation affect the metabolism of various psychotropic medications in different ways. It is the polycyclic aromatic hydrocarbons in cigarette smoke, rather than nicotine itself, which causes these effects on medication metabolism. With smoking, for example, medications that are metabolized by CYP 1A2 may require higher than usual doses, while the required dosage may be substantially decreased with smoking cessation.

Smoking decreases serum concentrations of such medications as chlorpromazine and other phenothiazines by 24 percent, clozapine by 28 percent, haloperidol by 70 percent, and fluvoxamine by 47 percent. On the other hand, it increases the clearance of caffeine by 56 percent, olanzapine by 98 percent, and propranolol by 77 percent.[8]

A meta-analysis of smoking cessation in substance abuse treatment or recovery suggests that some techniques used for smoking cessation can be applied to treating other substance use. Unlike other substances, however, fewer data suggest that simply reducing smoking improves health. This is why the goal of smoking cessation is complete abstinence.

[8] Zevin, S.,Benowitz, N. L., Drug interactions with tobacco smoking. An update. Clin Pharmacokinet 36:425-38, 1999.

ORIENTATION TO THE VA/DOD PRACTICE GUIDELINE
Recommendations for Tobacco Cessation Treatment

Scott Sherman, M.D., M.P.H.

VA patients smoke more (33 percent) than non-VA patients (23 percent), and are likelier to be heavy smokers (7.4 percent VA vs. 3.5 percent non-VA). More VA smokers are interested in quitting than non-VA smokers. In 1999, 65 percent of them quit at least one day within the previous year, compared to 34 percent of non-VA smokers. In 2002, 61 percent of VA smokers tried to quit within the previous year.

VA/DoD guidelines recommend that all patients interested in quitting tobacco use should receive: (1) **behavior therapy** (counseling); (2) **pharmacotherapy**, such as nicotine replacement therapy or bupropion; and (3) **follow-up.** Many providers also use self-help materials that the patient can take with him or her.

Approaches to treatment

VA/DoD recommend that provider and patient should discuss available treatment options, arrive at a *shared* decision, and choose the most intensive treatment option the patient is willing to attend.

A **minimal** strategy consists of only one counseling session, typically from a primary care or mental health care provider or other health care team member. An **intermediate** strategy includes two to three sessions, typically either from a primary care or mental health care provider or from a telephone quit line. An **intensive** strategy consists of four or more sessions, typically provided by a telephone quit line or a smoking cessation program.

Primary care-based treatment is the least effective, with success rates of only 10 percent to 20 percent short-term and seven percent to 10 percent long-term. Telephone quit lines and smoking cessation programs are equally effective, with 30 percent to 40 percent short-term effectiveness and 15 percent to 20 percent long-term.

Behavior therapy

In terms of counseling sessions, more sessions correspond with a greater rate of smoking cessation. According to June 2000 Public Health Service clinical practice guidelines for treating tobacco use and dependence, 12 percent of those who received one session were abstinent, while 25 percent of those who received eight or more sessions were abstinent. Sessions lasting 10 minutes or longer also showed greater success (22 percent) than those lasting less than three minutes (13 percent).

Three main approaches to counseling are supported by the scientific literature – intra-treatment social support, extra-treatment social support, and problem solving therapy. All are associated with an abstinence rate of approximately 15 percent.

Intra-treatment social support includes encouraging the patient in his or her efforts to quit, communicating caring and concern, and encouraging the patient to talk about quitting. **Extra-treatment social support** includes training patients to solicit support from others for their efforts to quit smoking. **Problem-solving** includes helping patients to recognize danger situations when they are likeliest to smoke, and to develop coping skills.

No evidence has been found to support such treatments as acupuncture, hypnosis, herbal medicines, or tapering. Tapering can potentially reinforce the addiction by making the individual think too much about smoking.

Pharmacologic therapy

Pharmacologic therapy is recommended for all patients who smoke, though there is little evidence it is useful for light smokers or adolescents. Treatment options include **bupropion** — starting one week before quit; **nicotine patches** — in 7 mg, 14 mg, and 21 mg dosages; **other NRTs** — such as nicotine lozenges, gum, and nasal sprays or inhalers; and other **new treatments** — including rimonabant, varenicline, and a nicotine vaccine.

Follow-up

Although VA providers do a great job asking patients about their smoking habits and advising them to quit, VA treatment rates are low. Only 28 percent of patients in a 1999 *VA Large Health Survey* report being treated or referred for smoking cessation. Eighty-three percent reported needing services to quit but not receiving them.

Only a minority of patients get treatment beyond being advised to quit smoking. A 2004 study reported that only seven percent of VA smokers reported receiving pharmacologic treatment for smoking cessation in the previous year. Given the fact that 65 percent of VA smokers express interest in quitting, this represents a tremendous missed opportunity.

Tobacco cessation treatment delivery through mental health care

For many patients, tobacco use is a chronic, relapsing disorder which can leave both patients and providers discouraged. Integrating tobacco cessation into mental health care may be the best way to get treatment to tobacco users with mental illness.

Many of these patients have much more contact with their mental health care provider than with their primary care provider. Most mental health care providers also already have the skills necessary for helping tobacco users to quit. For example, mental health care providers trained in treating post-traumatic stress disorder (PTSD) have advanced training in treating behavioral and substance abuse disorders that is applicable to treating tobacco use. They have continued, frequent contact with patients, which is important considering that it can take an average of six "quit attempts" to give up tobacco. PTSD providers are able to be there for the patient consistently throughout those attempts.

To provide this kind of integrated care, it will be important to develop a clinical culture that supports abstinence from tobacco, assess and treat tobacco use disorder in all willing mental health patients who smoke, and offer tobacco cessation interventions by all mental health care providers on repeated occasions.

Changing provider behavior and clinical culture requires emphasizing repeated monitoring and intervention for the chronic, relapsing medical condition of tobacco use. It requires identifying "clinical champions" who will make sure this issue is seen as important in the clinical workplace.

SMOKING AND SCHIZOPHRENIA
New Research Findings and Implications for Clinical Practice

Tony P. George, M.D.

There are reasons why some individuals are more susceptible to nicotine dependence than others. The pathophysiology of such disorders as schizophrenia, panic disorder, bipolar disorder increases the vulnerability of those suffering from them to nicotine dependence. Those with panic disorder and schizophrenia experience self-medicating affective and cognitive deficits associated with the disorders. Social factors, such as peer modeling, poverty, and stress, also put these individuals at greater risk for nicotine dependence.

Those with schizophrenia in particular tend to have a much higher prevalence of smoking (58 percent to 88 percent) compared to the general population. They have a harder time with smoking cessation. Higher rates of cardiovascular and lung disease also are associated with schizophrenic disorders. Genetic factors and cognitive deficits may explain these individuals' heightened nicotine dependence. In fact the same receptor in the brain that is believed to lead to schizophrenia seems to be stimulated by nicotine.

There may actually be potentially beneficial effects of nicotine/smoking for persons with schizophrenia. Nicotine seems to "turn up the brakes" in the brain, and turn down the over-active reward pathway, effectively normalizing these abnormal loops. Nicotine also seems to improve neuropsychological deficits in schizophrenia.

Treating nicotine dependence in those with schizophrenia

It is clearly important to recognize that people with schizophrenia smoke more because they receive the positive benefits of nicotine's normalizing effects. Nicotine patches do not have the same beneficial effects as cigarettes — something that has to be considered in developing treatment. The data suggest there may be benefits to developing nicotine-like drugs (nicotonic receptor stimulators) for all smokers, particularly those with schizophrenia.

Individuals with schizophrenia who are highly motivated to quit and have lower levels of tobacco dependence are most likely to successfully stop smoking. The ability to quit smoking in the first week predicts successful cessation. Other factors in smoking cessation for those with schizophrenia include behavioral treatment that is tolerable ("more is less"), higher doses of NRT or bupropion, lack of prefontal cortex-related neuropsychological deficits, and treatment with atypical antipsychotics. Older antipsychotic drugs blocked dopamine, causing side effects, while newer ones allow dopamine to do what it does while allowing treatment with fewer side effects.

It is possible to assist persons with schizophrenia who are heavily dependent on nicotine to quit smoking by using a combination of pharmacologic and behavioral therapies, but poor long-term outcomes suggest that treatments must be of longer duration to be helpful. Progress seems to depend on further developing pharmacologic and behavioral treatments that take into account the pathophysiological relationships between schizophrenia and nicotine addiction.

BRIEF COUNSELING AND PSYCHOPHARMACOLOGICAL INTERVENTIONS

Douglas E. Jorenby, Ph.D.

Tobacco dependence is a chronic disease, requiring ongoing rather than short-term care. It exhibits the classic characteristics of drug dependence in that nicotine causes physical dependence, characterized by withdrawal symptoms when someone quits; is psychoactive; and produces tolerance. Relapse is part of the chronic nature of dependence — and not an indication of personal failure by either the patient or clinician.

There are effective clinical interventions for tobacco dependence, though they are best understood in the context of treating a chronic, rather than acute, illness. The Public Health Service's Clinical Practice Guideline *Treating Tobacco Use and Dependence*, published in 2000, outlines effective, evidence-based treatments.[9]

The "Five A's"

Effective treatment for tobacco dependence can be framed in terms of five areas for care providers:

- **Ask** every patient at every visit about his/her tobacco use.
- **Advise** patients who use tobacco to quit because even brief advice to quit results in greater quit rates. Advice should be clear, strong, and personalized for the individual patient.
- **Assess** patients' willingness to quit after providing a clear, strong, personalized message about quitting.
- **Assist** patients' development of a quit plan by providing practical counseling and intra-treatment social support, helping them obtain extra-treatment social support, and recommending pharmacotherapy (except in special circumstances).
    - **Developing a quit plan**: This includes setting a quit date (such as a birthday, anniversary, or another meaningful date); reviewing past quit attempts (which may have lasted weeks or months before they relapsed); anticipating challenges to quitting; removing tobacco products, and urging the patient to avoid alcohol use (a major relapse factor) and exposure to tobacco.
    - **Practical counseling:** Even short-term (three minutes or less) interventions are useful in increasing abstinence rates — though the PHS Guideline notes that longer, more intensive interventions are more effective than shorter, less intensive interventions and should be used whenever possible. It is important to provide basic information to patients (such as about the withdrawal symptoms of nicotine and health changes after quitting); help them recognize danger situations (such as after a meal, first thing in the morning, with coffee, in the car, during transitions between activities, or while using other substances); and develop coping skills.
    - **Intra-treatment social support:** Encourage patients to talk about the quitting process, and let them talk honestly. Communicate caring and concern.
    - **Extra-treatment social support:** Train patients to solicit support from others, such as family and friends.
    - **Recommend pharmacotherapy:** Using the pharmacotherapies found to be effective and suggested in the PHS Guideline can double or triple patients' chances of abstinence. These include bupropion and NRTs such as nicotine gum, lozenge, inhaler, nasal spray, and patch.

[9] Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.

- **Arrange** follow-up contact within one week after the quit date, whether telephone contact or referral to a telephone quit line. Most relapse occurs within the first two weeks of quitting.

For patients who are not ready to make a quit attempt, "Five R's" are useful:

- **Relevance:** Tailor advice and discussion to each patient.
- **Risks:** Outline the risks of continued smoking.
- **Rewards:** Discuss the benefits of quitting.
- **Roadblocks:** Identify barriers to quitting.
- **Repetition:** Reinforce the motivational message at every visit.

INTEGRATING TOBACCO CESSATION TREATMENT INTO MENTAL HEALTH CARE FOR PTSD

Miles McFall, Ph.D.

Smoking is prevalent among veterans with post-traumatic stress disorder (PTSD), with rates of current smoking in the range of 53 percent to 63 percent. PTSD increases the odds of smoking four-fold over smoking rates for individuals exposed to trauma without PTSD. Moreover, veterans with PTSD are more likely to be heavy smokers compared to veterans without PTSD (48 percent vs. 28 percent) and are only half as likely to quit as are smokers without PTSD in the general population.

The heavy smoking among veterans with PTSD likely contributes to the high rates of medical care utilization and health care costs established for patients with PTSD. Research shows that trauma cues evoke nicotine withdrawal symptoms in smokers with PTSD, who smoke specifically to relieve anxiety and tension.

Finally, smoking cessation may exacerbate depression in smokers with PTSD, which may contribute to their high rates of relapse. In combination, these factors underscore that veterans with PTSD are a population at risk for tobacco use and related diseases, prompting research into methods that may improve smoking quit rates in this population.

A randomized, controlled clinical trial of integrated care to improve smoking quit rates in veterans with PTSD

At VA Puget Sound Health Care System, a randomized, controlled clinical trial was conducted that aimed to improve smoking quit rates in veterans with PTSD by testing a novel method for tobacco cessation service delivery. The objective of the study was to compare the effectiveness of brief Integrated Care (IC) versus VA's Usual Standard of Care (USC) for nicotine dependence in veterans undergoing mental health treatment for PTSD.

The study design randomized 66 patients with PTSD to one of two study conditions: IC where PTSD program clinicians delivered tobacco cessation treatment in the context of ongoing mental health care (n = 33), versus USC which consisted of referral to the facility's specialized smoking cessation clinic (n = 33). Patients were included if they smoked at least 10 cigarettes/day, and excluded if they used other forms of tobacco or had unstable psychosis or bipolar disorder.

The IC intervention involved six weekly 20-minute behavioral counseling sessions, pharmacotherapy for tobacco use (nicotine replacement therapy and/or bupropion), self-help readings, and relapse prevention/ recovery and maintenance. Additional discretionary behavioral counseling sessions were provided for patients who required additional relapse prevention or management interventions beyond the six "core" counseling sessions. Treatment followed the principles of the five "A's" published by the U.S. Public Health Service clinical practice guideline for tobacco use. Specifically, participants assigned to IC were assessed for their nicotine dependence and prior abstinence, educated about the benefits of quitting, and advised to quit. They were provided with motivational interventions, behavioral counseling and problem-solving advice, supported within sessions and assisted in identifying support between sessions, and prescribed a tobacco cessation pharmacologic regimen.

Patients in both treatment conditions had access to the same smoking cessation medications and comparable amounts of tobacco cessation behavioral counseling sessions. However, patients randomized to the IC

intervention actually received significantly more tobacco cessation treatment than patients in the USC condition: 61 percent in the IC group received bupropion, compared with 48 percent in the USC group; 94 percent in the IC group were given transdermal nicotine, compared with 67 percent in the USC group; 88 percent of patients in the IC group used nicotine gum, compared with 42 percent in the USC group; and patients in the IC group participated in twice the number of counseling sessions than patients in the USC condition (5.2 compared with 2.6) of treatment sessions than the USC group.

Patients in the IC group made more attempts to quit smoking than USC patients (4.29, compared with 3.5 in the USC group). The patients also reported that their satisfaction with the **amount** of treatment was significantly greater for the IC group (3.9 on a 1-5 scale) compared to the USC group (3.5). Those in the IC group also were significantly more satisfied with the **quality** of their treatment than patients in the USC condition (3.7 on a 1-5 scale for the IC group, compared with 3.4 for the USC group).

Patients randomized to the IC group showed substantially higher smoking quit rates than patients in the USC condition. At two months post-randomization, the seven-day point prevalence abstinence rate for IC participants was 42 percent vs. 13 percent for USC participants, a highly statistically significant difference. At nine months post-randomization, seven-day point prevalence abstinence rates declined to 18 percent for the IC condition and 7 percent for the USC condition, but the difference between study conditions remained statistically significant.

Translating research findings on IC into clinical practice: Outcomes from a practice-based approach of IC

An open clinical trial was conducted at VA Puget Sound Health Care System to determine whether findings from the randomized research trial would generalize to clinical practice. In this project, 107 veterans with PTSD received IC from their mental health providers in the facility PTSD program, using the same treatment approach employed in the randomized, controlled trial reported above.

Outcomes using seven-day repeated point prevalence abstinence rates were 28 percent, 23 percent, 25 percent, and 17 percent at measurement periods taken at two, four, six, and nine months post-treatment onset, respectively. The repeated point-prevalence abstinence rate (indicating sustained abstinence) for participants who were abstinent across the last three assessment intervals was 15 percent.

Extending the practice of IC to general mental health clinic settings

The success of IC in the PTSD clinic setting prompted us to conduct a clinical demonstration project where we trained all mental health providers at VA Puget Sound Health Care System in principles of IC. Mental health provider teams were educated in how to deliver brief tobacco cessation treatment, using the five "A's" model, by integrating this treatment into their ongoing psychiatric care of patients.

Outcomes from this training were measured by monitoring prescriber practice patterns in terms of the percentage of smokers in their caseload who received nicotine replacement therapy. Results showed that providers were more than five times as likely to prescribe nicotine replacement therapy for smokers in their caseloads during the year after training compared to a 12-month baseline period before training. Prescribers who received training at the Seattle division of VA Puget Sound Health Care System also were more likely to prescribe nicotine replacement therapy for smokers in their caseload compared to providers who had not received training at the American Lake division of VA Puget Sound Health Care System.

Conclusions

These studies indicate it is feasible and more effective to incorporate practice guideline-based smoking cessation treatment into routine mental health care delivery for patients with PTSD. The greater effectiveness of IC is likely due to the fact that patients who get IC are more likely to accept tobacco cessation treatment and receive a therapeutic "dose" of this treatment compared to the usual standard of care involving referral to tobacco cessation specialists.

IC is likely a better vehicle than specialty tobacco cessation treatment for delivering cessation treatment of sufficient intensity and duration to mental health patients who smoke. The frequent, continuous nature of mental health care promotes ongoing monitoring of the patient's smoking status and reapplication of treatment to encourage "recycling," which may also contribute to the success of IC. Principles of IC can be readily incorporated into clinical practice and can be effectively generalized to clinic settings for general mental health outpatients.

Suggested readings

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IDENTIFYING AND ADDRESSING BARRIERS TO THE INTEGRATED CARE MODEL

Timothy P. Carmody, Ph.D.

Integrating smoking cessation interventions into mental health settings is an innovation that, like all innovations, first requires an articulation of its potential **benefits**. Before it can be implemented, the **barriers** obstructing it must be identified. **Strategies** must be defined to ensure integration. Staff must be given **training**, planning conducted, team meetings held, and support and collaboration provided to ensure **diffusion** of the integrated model throughout the system.

Benefits

D.M. Berwick in 2003 identified five attributes of innovation that make new ways of doing things most likely to be adopted:

1. **Perceived benefit** - a balance of risks and gains.
2. **Simplicity** - of proposed changes and flexibility of implementation.
3. **Compatibility** - with the values, beliefs, history, and current needs of staff and patients.
4. **Trialability** - ability to try innovation in a small-scale way before adopting changes in all possible settings.
5. **Observability** of innovations.

In the area of substance abuse treatment, Simpson (2002) proposed four steps to adopting innovation that are relevant to smoking cessation treatment in the context of mental health services:

1. **Exposure** - training, facility resources, motivation for change.
2. **Adoption** - intent to try innovation, perceptions of helpfulness, and compatibility with accepted approaches.
3. **Implementation** - trial period, requiring institutional support, encouraging organizational climate.
4. **Practice** - incorporation of innovation into regular clinical practice.

Integrating tobacco cessation treatment into mental health care offers a number of benefits — for both patients and providers. Among them:

1. **Mental health providers have advanced training in the treatment of behavioral and substance use disorders that can be applied to nicotine dependence.** They already have established relationships with their patients, and may be better positioned than unknown providers to positively influence their patients' behaviors.
2. **Providing tobacco cessation treatment in the context of standard mental health care is more convenient for patients.** It may therefore expand access to smoking cessation treatment to veterans who would otherwise be underserved. Specialized smoking cessation clinics have high no-show and drop-out rates (42 percent to 87 percent) for veterans with mental illness.
3. **Smoking cessation is considered the "gold standard" in cost-effectiveness.** The cost per quality-adjusted year of life saved from smoking cessation efforts ranges from $1,108 to $4,542.

A recent economic analysis showed the VA can expect to save $853 per person (over a seven-year period) for each smoker who quits because of a significant reduction in heart attacks and strokes.

Barriers

A number of sources describe the potential barriers to integrating tobacco cessation into mental health services — including literature on health services research; dissemination of empirically supported mental health treatments in clinical and community settings; organizational change and diffusion of innovation; and ICM preceptor conference survey data, suggestions, and follow-up.

Patient barriers

- Belief that trying to quit will only complicate other mental health efforts.
- Belief that smoking improves abstinence from other substances.
- Concern that quitting will result in increased depression, anxiety, or other symptoms.
- Belief that it is "too late" to quit.
- Passive suicidality.
- Concern about weight gain. Reliance on tobacco use for socialization and/or entertainment.

Provider barriers

- Belief that patients will be offended by intervention efforts.
- Belief that interventions are complex and time-consuming.
- Concern that quitting smoking will compromise other abstinence goals for substance-abusing patients.
- Belief that tobacco cessation inevitably leads to increased distress.
- Expectation that banning smoking breaks will result in a staff and patient backlash.
- Low outcome expectations.
- Low self-efficacy.
- Perceived lack of patient interest.
- Low priority given to tobacco cessation among competing health care needs.
- Resistance to use of treatment manuals when implementing more intensive interventions.
- Being a current smoker.

Programmatic barriers

- Leadership fails to publicly support staff who regularly provide tobacco cessation treatment.
- Lack of tobacco cessation educational materials.
- VA pharmacy discourages or prohibits open prescriptions of appropriate tobacco cessation medications.
- Leadership allows staff and patients to use tobacco products inside buildings and/or near public doorways.
- Units maintain smoking areas on inpatient wards or hospital grounds.

Strategies

There are a number of specific strategies that are useful in integrating tobacco cessation treatment into mental health care settings. Those in the tables below were derived from earlier preceptor trainings.

Strategies
Send the right message
• Emphasize to staff the simplicity and brevity of the integrated care model. • Anticipate resistance from staff, and openly acknowledge it, validate them, and provide corrective information. • Appeal to various staff motivations: Taking pride in showing improved performance data for the clinic; noting that patients who quit smoking become more responsive to other mental health treatments; saving clinician time and energy because smoking cessation interventions compliment other treatments.
Increase access and convenience
• Use "drop-in" or "walk-in" formats for individual and group sessions. • Use a V-tel system. • Use quit lines and telephone-delivered counseling. • Offer evening groups. • Require a brief tobacco cessation counseling session for all patients in mental health or substance abuse treatment programs. • Provide quick-order options for tobacco cessation medications.
Make support materials available
• Mass produce patient education materials. • Store materials in a central, easily accessed, visible location (e.g., near mailboxes, lunchroom). • Delegate such tasks as: asking media to design/print posters; identifying a secretary who will track and replenish supplies of patient materials; asking a mental health administrative officer to track prescription practices and put together easily readable reports. • Put all materials from the preceptor training conferences onto the mental health shared drive.
Change the clinic culture
• Place smoking cessation visuals (e.g., posters, desk tents, 'I want to stop smoking' cards, no-smoking signs) conspicuously throughout the clinic. • Replace smoking rewards with abstinence rewards: replace smoking breaks with "fresh air" breaks; collect and prominently display photos or testimonials from former smokers in the clinic. • Emphasize the number of patients who have quit versus those who smoke.

Strategies

Target employee smoking

- Target employee smoking cessation.
- Provide employees with cessation support services.
- Create an employee wellness day or health fair.
- Publicize low-cost NRTs for non-veterans.
- Create a confidential employee-only cessation program.
- Use e-mail announcements to publicize employee cessation support services.

Use reminders effectively

- Ask the mental health Automated Data Processing Application Coordinator (ADPAC) or Clinical Applications Coordinator to create a medication ordering template in CPRS.
- Establish a clinician reminder system that is acceptable to clinicians.
- Invite staff to generate ideas for reminders in a group discussion, and implement popular ideas.
- Ask administrative staff to tell all patients to give their providers the "I want to stop smoking" card.
- Make periodic appearances at staff meetings to encourage continued use and expansion of the integrated care model.
- Send friendly e-mail reminders or acknowledgments of success.
- Use the Great American Smoke Out as a reminder for staff support.

Generate support at all levels

- Establish leadership support early on.
- Recruit support from administrative staff wherever possible.
- Concentrate on enthusiastic staff; resisters may come around once they see others successfully use the integrated model.
- Recruit support from preceptor faculty whenever and wherever possible.

Strategies

Make systemic changes

- Promote hospital policies that are consistent with tobacco cessation (e.g., remove smoking porches, replace smoke breaks with "fresh air" breaks, etc.).
- Place no-smoking signs and smoking cessation materials in conspicuous places.
- Document tobacco use disorder for all patients.
- Document all tobacco use interventions, no matter how short or simple.
- Use your clinical champion for support.

Training and education

The steps in providing training and education to mental health care staff are built on reporting to leaders and eliciting top-down support for integrating smoking cessation treatment into mental health care services. **Team meetings** are needed to provide inspirational education and introduce the treatment protocol. It is also essential to track both short- and long-term changes, and provide (and receive) regular feedback and adjust efforts accordingly.

Keys to successful training

- Include non-clinical staff in trainings because clinic and practice norms are only successfully changed when all staff are onboard.
- Involve non-clinical staff in:
  - Checking out appointments
  - Making short-notice prescriber appointments
  - Cueing providers on missing clinical reminders
  - Maintaining waiting-room materials
  - Answering patients' questions about clinic care, recommended treatments, etc.
- Schedule multiple staff trainings at different times of day over several weeks or months.
- Schedule special and brief trainings specifically for medication recommendations.
- Meet individually with key players (hospital leaders, department chiefs, smoking cessation lead clinicians) and supporters among the general staff.
- Target residents and interns whose enthusiasm and knowledge can serve to inspire more resistant staff.
- Meet with Employee Education and arrange CEUs and CMEs for training.
- Recruit the Public Affairs department to advertise trainings.

Team meetings

Clarify protocol purpose

- Describe the relationship between smoking and mental health.
- Highlight the benefits of addressing smoking in the course of standard treatment.
- Highlight the simplicity of smoking cessation treatment.
- Dispel erroneous beliefs most commonly or rigidly held in your clinic.

Define clinic goals

- Note higher goals, emphasize minimal standards.
- Clarify differences between required mandates and voluntary goals.
- Screen all mental health patients for tobacco use at least once.
- Enter tobacco use disorder as an official diagnosis in CPRS for all smokers.
- Advise all smokers to quit, and ask about their motivations to quit at least **3** times per year.
- Provide all smokers who are motivated to quit with brief interventions.

Define clinic roles

- Communication must be explicit.
- **Emphasize benefits of repetition.**
- **Smoking status screening**: All mental health providers.
- **Entering diagnosis in CPRS**: All mental health providers.
- **Motivation screening:** All mental health providers.
- **Counseling:** All mental health non-prescribers.
- **Setting up Rx appointments:** All mental health non-prescribers.
- **Pharmacotherapy:** All mental health providers.
- **Maintaining patient materials:** Clinical champion.
- **Providing regular feedback/training:** Clinical champion.

Define target audience

- **Smoking status screening:** All patients who are new to mental health or established patients for whom smoking status is not known.
- **Motivation screening:** All mental health patients who smoke.
- **Counseling:** All mental health patients who smoke and want to quit, whether or not they are already enrolled (or have been previously enrolled) in the specialized smoking cessation clinic.
- **Pharmacotherapy:** All mental health patients who smoke and want to quit, whether or not they are already enrolled (or have previously been enrolled) in the specialized smoking cessation clinic.

Define clinic procedures

- Provide a copy of brief guidelines to clinicians, make longer manuals available if requested, address concerns about "manualized straightjacket"
- Tell clinicians where to access patient self-help materials.
- Tell clinicians how to order appropriate medications.
- Inform clinicians, with team leader and support staff guidance, on how medication appointments will be scheduled.
- Inform clinicians how change will be tracked and communicated.

Diffusion

Berwick has identified five main character types who respond in different ways to innovation:

- **Innovators** — more venturesome, tolerant of risk, fascinated with novelty, willing to learn, and with a marginal status in the organization.
- **Early adopters** — opinion leaders, well-connected socially, generally testing several innovations, more influential and largely drive decisions to adopt an innovation.
- **Early majority** — learn mainly from people they know well, more risk-adverse than early adopters, readier to try innovations that meet their immediate needs than those that are simply interesting ideas.
- **Late majority** — adopt innovations that appear to be the new status quo, watch for local proof.
- **Laggards** — traditionalists.

Berwick also defined the ways to diffuse innovation:

- Find and support innovators.
- Find ways to facilitate interactions between innovators and early adopters.
- Make early adopter activities observable.
- Trust and enable reinvention.
- Create time and space for change.
- Lead by example.

Henggeler, Lee and Burns (2002) defined specific organizational factors in mental health settings that are important in diffusing innovation:

- **Collective vs. directive decisions:** Authoritarian decisions lead to faster diffusion of innovation, but collective decisions increase the likelihood that innovations will be sustained.
- **Perspectives of opinion leaders vs. innovators:** Opinion leaders are more influential than innovators and largely drive decisions to adopt an innovation.
- **Organizational norms:** The culture of the organization influences decisions to adopt innovations.

Innovations are more likely to be adopted and sustained in organizations in which opinion leaders support the innovation, staff at various levels have contributed to the decision to adopt, and the innovation is consistent with organizational culture.

Simpson (2002) provided a task analysis for planning diffusion of innovation, following these steps:

- Identify co-champions.
- Establish goals for integrating tobacco use cessation interventions into mental health settings.
- Identify steps to accomplish goals.
- Target mental health programs to initiate innovation.
- Identify potential collaborators.
- Schedule meetings with potential collaborators and facility leaders.
- Develop a plan for tracking progress toward goals.

IDENTIFYING AND ADDRESSING SYSTEMIC BARRIERS
Report-backs from Small Group Discussions

Preceptor trainees were split into nine groups to discuss specific barriers they see as preventing smoking cessation treatment from being integrated into mental health care services. In general all agreed that the best way to address these barriers is to provide training — possibly making it mandatory or with yearly updates — for physicians and other providers.

They identified quite a few barriers, noted below:

- Lack of training for providers
- Limited provider time, infrequent provider visits
- Lack of systematic follow-up with inpatients, no-shows
- Lack of collaborators at specific sites
- Lack of knowledge of the "Quit Smart" program
- Territoriality within the system
- Prescribing procedures and availability of nicotine replacement medications
- Hard for clients to keep appointments
- Staff and administrators who smoke in front of patients
- Staff beliefs that vets with mental illness can't change and won't recover
- Stigma of having mental illness or of not smoking when most peers do
- High turnover rates of primary care providers inhibit relationships with patients, prevent timely prescription/refills of nicotine replacement medications
- Uncertainty about when to integrate tobacco cessation with other mental health treatments
- Faulty assumptions about seriousness of smoking as a problem, whether education is the answer, the ability of those with mental illness to recover, and about whose "problem" it is to address smoking cessation
- Administrative costs
- Staff involvement and attitudes
- Patient resistance, e.g., complaints about "hearing about smoking cessation too many times"
- Culture of smoking in the area, among staff
- Resistance to implementing a new program

DEPARTMENT OF DEFENSE (DOD)
Smoking Cessation with Active Duty Personnel and New Veterans

Major Christine Hunter, Ph.D., A.B.P.P.

Tobacco kills more Americans each year than alcohol, car accidents, illegal drugs, suicide, homicide, AIDS, and fires *combined*. Nearly as many Americans die each year (400,000) from tobacco-related causes as have died (440,000) in all the country's conflicts since 1900; but smoking and tobacco use are especially widespread in the military.

A biennial survey given to active service members looks at trends in tobacco use across time. From 1992-1998, there was good progress in terms of declining cigarette use in the Department of Defense. But there has been an increase since 1998. There is a high rate of smoking among younger individuals in particular: 45 percent of those under age 20, and 43 percent of those 21- to 25-years-old have smoked in the last 30 days. By grade, officers tend to smoke less — while about 49 percent of the most junior enlisted members (E1-E3) smoke.

Smoking has a huge cost impact on the military. Medical care related to smoking in 1995 cost an estimated $584 million, and lost productivity because of smoking-related illness cost the services another $346 million. This is comparable to an entire U.S. Air Force base with 3,573 full-time staff remaining idle for a year.

Tobacco use degrades warfighter performance in a number of ways:

- 20 percent to 50 percent decrease in night vision for smokers
- Rapid nicotine withdrawal affects cognitive function and visual acuity
- Significant decrement in tracking and longer reaction times
- Young Active Duty (AD) have more hospitalizations and lost work
- Degrades physical fitness tests
- Decreased concealment
- More likely to sustain musculoskeletal injuries
- Associated with early discharge

Addressing tobacco use and cessation effectively requires a focus on the community because:

- **Health is only partially delivered by medical treatment facilities (MTFs)**: Health behaviors are heavily influenced by an individual's social and work environments, so there need to be prevention opportunities outside of MTF.
- **Changes in community norms are key to widespread, long-term changes in health:** Intended and unintended messages are important.
- **Personnel in leadership positions should not use tobacco themselves.**
- **Policies must translate into unit-level practice and be enforced.**

Approaches to change

Four distinct, yet interconnected approaches are needed to change the culture of smoking within the military: (1) Policy, (2) Environmental change, (3) Prevent initiation, and (4) Wider-reaching interventions.

Policy

The Air Force's tobacco policy is similar to that of other service branches. It features two instructions that provide specific guidance for tobacco control efforts (AFIs 40-101, 40-102). Affirming that tobacco is seen as a community problem, one instruction (AFI 90-501) provides structure and process for addressing community problems through a cross-functional, collaborative effort involving leadership, base agencies, and the larger community. Another instruction (AETCI 36-2216) restricts tobacco use for airmen in training. Finally, a November 2000 DoD pricing policy required U.S. Exchanges to survey and set cigarette prices no more than five percent below the lowest local competitor in their area.

Air Force policy and programs provide free tobacco cessation classes, including behavioral and pharmacological support, at every installation. Smoking is not allowed in Air Force facilities, during basic and early tech training. Tobacco products cannot be advertised in service publications. DoD chartered Alcohol and Tobacco Advisory Council advance policies to reduce tobacco consumption. All Basic Military Trainees receive a tobacco use prevention intervention, and there are specific tobacco cessation programs targeting Military Training Instructors/Leaders.

Environmental change

Environmental targets are important in changing the culture of smoking in the military, and policy is a key strategy for changing them. The Air Force has proposed a new policy that would prohibit smoking by any member in uniform or by civilian supervisors during duty hours. It would also require smoke-free facilities, limited breaks, no smoking in training, and no smoking in dorms.

Other environmental factors also contribute to initiating and continuing smoking. For example, military publications, such as *Army Times*, are not controlled by the military and are therefore able to carry tobacco advertising that appeals to the macho military culture of tobacco. Whether a roommate smokes is hugely influential on initiating, reinitiating, quitting, or abstaining. Leaders who smoke are also influential role models to those in their command.

Prevention

Within one year after basic military training (BMT), 7.8 percent of those in a study initiated smoking, 25.5 percent experimented with smoking, and 42.8 percent returned to smoking. Another study showed that most new smokers are ambivalent about their smoking. Sixty-five percent said they were seriously considering quitting in the next six months; 49.8 percent were seriously considering quitting in the next 30 days; 38.5 percent had tried to quit since BMT.

Both smokers and nonsmokers are very aware that tobacco use is bad for their health. Current smokers obviously feel much more strongly about what they perceive as the positive values of smoking: helps them relax (77 percent); reduces stress (70 percent); calms anger (69 percent); improves social comfort (56 percent); relieves boredom (51 percent); makes them feel good when they are down (47 percent); keeps them focused (45 percent); keeps weight down (43 percent).

Smoking is a highly refractory behavior, so prevention is key. Education is necessary but may not be sufficient to keep someone nicotine-free. Messages about health risk are not salient to younger people who don't tend to think about long-term consequences of their behavior. This means that targeted messages are needed that will appeal to young adults, provide positive alternatives to tobacco use, and reflect a realistic understanding of the relationship between the addictive properties of tobacco and the efforts of the tobacco industry to market its product. A policy that parallels the one on fitness may be a useful incentive to prevent smoking initiation. Other incentives for being tobacco-free also could be useful preventives.

Wider-reaching interventions

Current tobacco cessation treatment is only moderately effective and has a low impact. In fact it is not making a dent in the needs of the smoking DoD and veteran populations. There are barriers to treatment — it is time-consuming, locations of cessation programs may be unfamiliar, and there is stigma attached to quitting.

Studies show that cessation increases as person-to-person contact increases. Those who received minimal (less than three minutes) of contact showed a 13.4 percent cessation rate, while those who received 10 minutes or longer of counseling showed a 22.1 percent quit rate.

Primary care physicians and dentists are candidates for brief cessation: 70 percent to 80 percent of civilians see one or both of these health care providers at least once annually. For active duty, that number is almost 100 percent annually. Despite this seeming opportunity, most health care providers don't consistently or effectively identify or intervene with tobacco users. They frequently recognize the problem, but often don't feel they have the skills or time to address it, and patients' return to smoking can be discouraging.

To be effective, health care providers need appropriate training or inclusion of qualified team members to whom they can "handoff" cessation. Additionally, research needs to establish how evidence-based interventions can be best translated to fit the health care environment with minimal cost and resources.

PHARMACY
Questions and Answers on National and Local Policy

Mark Geraci, PharmD, BOCP

The VA's Pharmacy Benefits Management (PBM) team oversees the system's pharmacy policies and centralized dispensaries. The PBM's key national functions include:

- Drug benefit design
- Professional pharmacy practice
- Pharmacy policy
- Centralized prescription processing (CMOP)
- Staff education (CE/CME)
- Patient safety (drug safety Center-VAMedSafe, Adverse Drug Event (ADE) reporting modernization, post-marketing surveillance)
- Data management (provide end-user access to facility-specific drug utilization data via the VA Intranet
- Evidence-based formulary management (pharmacologic management, algorithms, guidelines, reviews New Molecular Entities (NMEs), etc.
- DoD collaboration (contracting for pharmaceuticals, algorithm/guideline development, CMOP pilot)
- Utilization management (outcomes assessment, pharmacoepidemiology, national drug use evaluations).

The VA formulary process features a number of key objectives:

- Promote appropriate drug therapy and discourage inappropriate drug therapy.
- Reduce the geographic variability in utilization of pharmaceuticals across the VA system.
- Initiate patient safety improvements.
- Improve the distribution of pharmaceuticals.
- Reduce inventory carrying costs, drug acquisition costs and the overall cost of care.
- Promote portability and uniformity of the drug benefit.
- Design and carry out relevant outcomes assessment projects.

Formulary management draws from certain principles:

- Safety is the first priority.
- Effectiveness is the second priority.
- After safety and effectiveness are addressed, cost is considered.

- Formulary decisions are evidence-based, not preference-based.
- Decisions are made after review of the drug group by experienced staff from Pharmacy Benefits Management (PBM) group; monograph development in conjunction with member(s) of the Medical Advisory Panel (MAP); and extensive discussion at monthly teleconference or quarterly, two-day meeting with PBM staff and MAP.

NMEs are defined as "medication containing an active substance that has never before been approved for marketing in any form in the United States." They include drug and biologic products, but do not include supplies and devices.

PBM monitors NMEs, tracking new approvals from the Food and Drug Administration (FDA). PBM also compiles and maintains a list of NMEs and their review status (available at VA Intranet: http://vaww.pbm.va.gov).

PBM uses a lengthy process to review NMEs, featuring: Multi-disciplinary review of the document; contact with MAP and/or subject matter experts; incorporating suggestions, comments, or changes from these individuals or groups; presentation to both MAP and VISN Formulary Leaders (VFLs) committees for approval of the document; final posting of the document on the VA Internet (http://www.pbm.va.gov) and Intranet (http://vaww.pbm.va.gov).

Access and utilization of NMEs depend on approved recommendations from the MAP and VFLs committees. Monitoring may be based on adherence to criteria the committees develop. In the current national formulary, the following four nicotine replacement drugs are dispensed according to the noted guidelines: nicotine patch (restricted to VA/DoD guidelines); nicotine gum (restricted to VA/DoD guidelines); nicotine lozenge (restricted to guidelines and for those unable to use or tolerate gum); and bupropion IR.

Yun Russ, RPh, BCPP

It is important for mental health care providers to identify and work with a supportive pharmacist, either within the facility or locally, who will be an ally in supporting patients' efforts to quit smoking.

Ms. Russ, a pharmacist with the VA Puget Sound Health Care System, in Seattle, WA, noted that her office is next to the receptionist where patients check in for mental health care services. Often providers will bring their patients interested in smoking cessation to her. She asks the patient three basic questions:

1. How long have you smoked?,
2. How much do you smoke?, and
3. What is your motivation for quitting today?

She sees her role as facilitating patients' ease of access to the medications they need — including nicotine patches, gums, and lozenges.

For facilities that don't have a pharmacist, Ms. Russ suggested finding a local pharmacist who will see it as an important endeavor to help veterans quit smoking. The pharmacist also can follow up with patients to reinforce their effort to quit smoking, assess how much of the NRT they are using, and assess their supply.

INPATIENT PSYCHIATRY
Integrating Tobacco Treatment and Substance Abuse Day Programs

Louis Stokes Cleveland VAMC

P. Eric Konicki, M.D.

Given the high rate of cigarette smoking in the military, providing or withholding smoking breaks and cigarettes often have been used to encourage or punish certain behavior. Several policy changes of the last two decades have cut into the military's smoking culture. A 1987 policy change banned all smoking in training commands. In 1996, President Clinton extended this policy to the entire U.S. military. That year the president also eliminated the military's practice of subsidizing tobacco products for service members.

In the U.S., 7.1 percent of the population are nicotine-dependent and have a comorbid psychiatric disorder — yet consume 34.2 percent of all cigarettes smoked in the country. The question comes down to this: Is there a high prevalence of drug abuse, including nicotine dependence, in the mentally ill — or is there simply a high prevalence of mental disorders in those who abuse drugs?

Barriers to smoke-free inpatient units and VAMC

Inpatient units frequently still allow smoking because of outdated ways of thinking. For example, there is often the belief that smoking is patients' "only pleasure in life," and that getting patients to quit will deprive them of this one "good" thing. There is also a fear that denying cigarettes to patients will exacerbate their symptoms and lead them to act out in other destructive or self-destructive ways. The use of cigarettes to reward desired behavior is a further impediment to smoking cessation and smoke-free clinics; and, finally, there is the fact that disease-specific factors can decrease a patient's interest in quitting.

There are specific laws and policies that hinder efforts to create smoke-free facilities and keep the VAMC overall from becoming smoke-free. Public Law 102-585, the Veterans Health Care Act of 1992, required "access to an area established and maintained . . . consistent with medical requirements and limitations, for patients or residents of the facility who are receiving care or services and who desire to smoke tobacco products."

The language of VHA Directive 2003-035, the Smoke Free Policy for VA Health Care Facilities, covers not only patients but also employees and visitors. Moreover, the December 22, 2005, Federal Services Impasses Panel determined that unions have the right to continue to have smoking rooms at their work facility, in this specific case the Department of Army Rock Island Arsenal.

These policies meant that employees must be allowed to smoke on hospital grounds — and that becoming a smoke-free medical center is not possible at this time.

Solution: Smoke-free units/medical center

At the Louis Stokes Cleveland VAMC, where Dr. Konicki works, there is one urban hospital and one suburban hospital. Smoking is allowed in the urban, but not in the suburban, inpatient unit. Patients have been dissatisfied with the different rules when they have been transferred from the urban to the suburban unit.

Efforts to move toward smoke-free units have been assisted by management support, a desire to offer one standard of care, rotation of staff between the urban and suburban units, providing an "environment of care," and making nicotine replacement therapy (NRT) available.

Smoking cessation was made a mental health priority in Cleveland. All psychologists have been given NRT prescribing privileges. All mental health patients are counseled about tobacco use at each and every visit. If the patient is interest in quitting and gets NRT, the facility has made it easy to order and fill prescriptions for NRT. The smoking cessation nurse then follows up with a phone call a week later to see how the patient is doing.

Performance measures show that while 98 percent of mental health patients received counseling on smoking cessation in the last year, only 49 percent used smoking cessation-related services

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VA Palo Alto Health Care System

Robert Zeiss, Ph.D.

Why try to help patients stop smoking?

While Dr. Zeiss was co-director of inpatient psychiatry, staff wanted to help patients quit smoking. The co-directors were bothered by the fact that by allowing smoking on the inpatient units they were aiding a clearly unhealthy behavior; they also wanted to encourage and promote health. They were aware of the high levels of agitation and potential for violence around smoking issues, particularly around questions of who was allowed to go on escorted "smoke breaks."

But staff and patients alike were held back by the question: Why bother to quit? Both staff and patients tended to accept such stereotypes as "psychiatric patients will never quit," "all schizophrenics smoke," "it's their one source of pleasure." Staff felt they couldn't interfere with patients' "right" to smoke. They also feared that patients who stopped and then resumed smoking risked relapse because it would cause neuroleptic levels to decrease.

What are the data?

The National Comorbidity Survey (NCS), conducted from 1990-1992, analyzed and reported in 2000[10] (Lasser et al., 2000), noted that 22.5 percent of adults with no mental illness are current smokers with a 42.5 percent quit rate.

Of adults with current nonaffective psychosis, 45.3 percent are current smokers. Of those with a history of nonaffective psychosis, 49.4 percent are current smokers with a 27.2 percent quit rate. Although the latter group has twice the smoking rate of those without mental illness, they still comprise fewer than one-half the total of those with nonaffective psychosis. That is, more than half of individuals with current psychosis do not smoke.

Among adults with bipolar disorder, 60.6 percent are smokers with a 25.9 percent quit rate. It is important to note that, like those with psychosis, more than 25 percent have quit smoking.

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[10] Lasser K, Boyd JW, Woolhandler S, Himmelstein DU, McCormick D, Bor DH. Smoking and mental illness: A population-based prevalence study. JAMA 2000 Nov 22-29;284(20):2606-10. [PMID: 11086367].

Evolution of a smoke-free environment

The smoke-free inpatient environment has evolved over the past two decades. The 1983 *Inpatient Psychiatry Handbook* limited smoking to day rooms and restrooms between the hours of 6 a.m. to 11 p.m. Smoking was allowed in group rooms with staff supervision. Patients were not allowed to carry matches, and staff would light their cigarettes. The *Handbook* noted that "no more than one pack of cigarettes per day" would be provided by staff for each indigent patient.

The 1993 *Handbook* prohibited smoking on the inpatient unit. Patients could earn smoking "privileges" whereby they would be escorted off the unit to smoke. One unit had a locked, enclosed courtyard; patients from other units were escorted to the facility grounds.

Experience with smoke breaks — six to eight escorted breaks per day — showed they took a large amount of nursing time. Patients were in a state of constant nicotine withdrawal between breaks. Only patients with good behavioral control were allowed smoking privileges to go out to smoke. There were high levels of agitation and frequent restraint use around smoking breaks, and a police presence was frequently required. Patients were hostile, especially toward nursing staff. There was frequent smoking on the unit, with associated risk of fire, and patients often fled the facility during smoking breaks.

The first attempt to change one unit to smoke free status was in January 2001. It failed, probably due to insufficient preparation and failure to convince the facility administration and union that a smoke-free unit was needed. Staff reported being highly fearful of increasing assaults and agitation if patients were "deprived" of cigarettes. After only two days, administration ordered the unit to reinstate "smoking rights."

Based on a literature review, the staff in June 2001 proposed a "trial" smoke-free unit. Administration and union agreed to this trial. Two months of positive experience and supportive data allowed the concept to be exported to other units.

The current situation

Today, patients are not allowed to smoke while hospitalized. On admission, all patients surrender smoking materials, matches, and lighters. A search of patient belongings decreases the likelihood of contraband being brought onto the units. Nicotine patches are used liberally to prevent patients from experiencing major withdrawal.

One impressive change was in the psychiatric intensive care unit, where the smoke-free policy brought a dramatic reduction in use of restraints and number of urgent calls to the police. In this way, the smoking-reduction program also became a workplace violence-reduction program.

Key elements of success

The experience in Palo Alto indicated several key steps for successful implementation of a smoke-free policy for inpatient units:

- Take time to build administrative and union support.
- Recognize that this is a program for health promotion, workplace violence reduction, and reduction of missing patient episodes.
- Develop a limited demonstration program if there is resistance.

- Set a target date for implementation.
- Treat your patients well, involve them in planning, and provide adequate nicotine replacement therapy — which may make the inpatient stay easier than being on a limited number of cigarettes and putting the patient in a constant state of withdrawal.
- Keep data on key outcome variables.

OUTPATIENT PSYCHIATRY
Integrating Tobacco Treatment into Substance Abuse Day Programs

VA Connecticut Healthcare System

Judith L. Cooney, Ph.D.

The VA Connecticut Healthcare System's effort to integrate smoking cessation treatment into its addiction services program is a work in progress. It has evolved since major system changes in 1996, when the smoking cessation clinic was moved from the Health Psychology to Substance Abuse domain.

The move put smoking cessation treatment up against the barriers of prevailing attitudes, particularly from psychiatry leadership who saw smoking cessation as unrelated to addiction treatment, optional, and a low priority for which it was not worth providing resources.

Top-down support is essential

Getting support from department leadership was an essential first step. Their concern that smoking cessation activities would be expensive and divert resources from other substance abuse treatment had to be addressed. The most effective response was to show them that the smoking cessation clinic was efficient and had economic and administrative value.

Line staff — including nurses and substance abuse staff — had their own concerns about tobacco treatment for substance abusers. Some felt that focusing on smoking cessation took the focus off patients' "real" work of recovery from other substances. Nicotine addiction was seen as benign. Often staff who smoke did so with patients, and even considered this part of the therapeutic process.

It became clear that staff were not knowledgeable about tobacco use disorder or smoking cessation treatment. Line staff frequently felt substance abuse patients were not interested in quitting smoking, or that trying to quit smoking would set patients up for failure. There was a belief that substance abuse patients "needed" cigarettes to cope with urges to drink — and that nicotine withdrawal would increase these urges.

Strategies to deal with barriers and implement services

Through an educational series that included in-service presentations and literature, staff were educated about tobacco treatment. Their concerns were addressed in one-to-one meetings, which produced fruitful, respectful conversations. It was especially useful to work closely with staff who shape co-workers opinions. These efforts all focused on emphasizing that tobacco treatment is a legitimate, feasible part of the staff's work as substance abuse treatment providers.

It was also useful to point out the risks and rewards of smoking and quitting — including the fact that voluntary smoking cessation does not harm, and may in fact help treat, alcohol abuse.

Changing the clinical culture to support integrated smoking cessation

The integrated program is valuable in offering opportunities for research and evaluation, which in turn inform the work of the clinic. An empirical approach addresses staff concerns, changes their beliefs, and breaks down barriers. Non-funded evaluation directly involves clinical staff, empowers ownership and involvement, and helps integrate the research and clinical programs.

Integrating smoking cessation and substance abuse treatment services required a culture shift. This included changing clinic policy to endorse a non-smoking environment. It meant disallowing indoor smoking, not making tobacco products available for sale, discouraging clinical and clerical staff from smoking with patients, offering (discreetly) smoking cessation treatment to staff who smoke, and no longer calling breaks "smoking breaks."

With the integrated program, every patient visit becomes an opportunity to provide smoking cessation treatment. In the changed clinical culture, nicotine is understood as a drug and smoking cessation as a viable and important part of addiction treatment. There, tobacco treatment is now embedded in routine patient care, and not seen as an additional burden. There is a team effort to address tobacco at multiple points through treatment.

All patients who smoke are offered a range of easily accessed tobacco treatment options. They are encouraged to receive the highest intensity treatment possible. Options range from brief advice from substance abuse providers, patient education materials, and smoking cessation medications; to intensive smoking cessation groups; to participating in clinical research trials.

Providers are trained in providing brief advice — including direct skills training, modeling, and feedback. There are in-service trainings, VA/DoD Clinical Practice Guidelines are distributed, and a pamphlet called *VetQuit: Tips to Stop Smoking* is given to providers to guide brief interventions and educate patients.

Lessons in diffusing barriers

Several lessons for addressing barriers from the VA Connecticut Health Care System's experience are useful for others considering integrated smoking cessation/substance abuse treatment services:

- **Support from managers:** economic, mandate compliance
- **Support from providers:** relevance to patients, practice feasibility, empirical approach allows staff to challenge assumptions
- **Training:** direct, skills training needed, ongoing, pamphlets to guide brief interventions
- **Smoking cessation treatment must be feasible:** simple, supported by smoking cessation clinic follow-up
- **Smoking cessation clinic:** new opportunities in training, complex care
- **Culture shift:** work in progress

WHERE DO WE GO FROM HERE?
Successful Tobacco Control Strategies

Scott E. Sherman, M.D., M.P.H.

This presentation aimed to help participants develop a tobacco control plan and review available VA tobacco cessation best practices. It recommended a five-step approach to change:

1. Form a "gang";
2. Develop a plan for delivering treatment;
3. Meet with top administration;
4. Put the plan in place; and
5. Measure and report results.

Form a "gang"

There will be staff, administrators, patients, and others interested in developing and implementing smoking cessation efforts in the VA mental health services setting. They bring different perspectives, and their input is important to keep up the momentum for change. Their sense of investment in the program's success is essential to creating change.

Develop a plan for delivering treatment

It is essential first to choose a goal for treatment. It may be to increase treatment within the mental health care setting, to increase referrals to telephone counseling, or increase treatment within the primary care setting. Next, choose strategies to accomplish your goal — preferably from among evidence-based strategies and based on best practices of what is known already to work.

Strategies for success

Several sources are available from which to find proven strategies — including Medline/PubMed, VA and NIH-funded research, abstract presentations from public health conferences, and VA best practice repositories. Another source is looking at the work of leading clinicians and other expert opinion.

Patient-level strategies may include sending unsolicited mailings to patients, which have been found to produce an unexpectedly high response; offering financial incentives for patients; and providing Web-based information and tobacco interventions.

Strategies at the staff and clinic level include auditing and providing feedback to the providers, computer support for treatment, telephone counseling, and hospital-based cessation programs.

System-level strategies can spur the most change. These include mandating that nicotine replacement medications be available in primary care, removing co-payments from treatment for tobacco cessation, and tracking performance measures for the rates of providers offering counseling and meds to patients.

Telephone counseling works

Studies indicate that having an on-call counselor was helpful in referring patients to a smoking cessation program. It doubled (from 7 percent to 14 percent) the percentage of patients who attended a smoking cessation program. The bachelors-level counselor proved popular with providers and clinic staff, and offered an easily reproducible intervention.

Telephone counseling is increasingly used to provide patients with simple referrals, proactive counseling, medication management, and follow-up contact. Studies at the VA Greater Los Angeles Healthcare System and VA Palo Alto Healthcare System showed high rates of referrals (45 percent connected to a helpline) and excellent success rates (25 percent abstinence at six-month follow-up). Telephone counseling accounted for 8 percent of all counseling calls for the California Smokers Helpline and the largest source of referrals from health care. It is now the standard of care for 10 VA sites in Los Angeles.

GENERATING GOALS FOR HOME FACILITIES
Group and Panel Discussion

After the preceptor trainees broke into discussion groups, they reported back to the larger group the plans and strategies they felt would make improvements in their facility and that could be useful in other facilities. These included:

- Start with the mental health clinic, reviewing charts, focusing on performance measures.
- Address executive committee that will define appropriate organizational goals and strategies for achieving them.
- Talk with those in power and control — service chiefs, heads of mental health councils — and show how integrated smoking cessation can be incorporated into routine mental health care with minimal time and staff burden.
- Form a steering committee — with representatives of nurses unions, pharmacy, primary care, dental — to talk about barriers and solutions to promoting tobacco cessation among patients and staff.
- Provide nicotine replacement medications — lozenges, gum, etc. — and push the integrated model.
- Follow-up with discharged patients, including linking counseling with quick orders, making low cost patches and gum available in canteens and from pharmacies.
- Involve case managers.
- Survey providers to find out who is doing smoking cessation counseling, and get pharmacists, mental health providers, and others excited about the integrated model so they will get others excited.
- Educate fellow staff about the integrated model.
- Offer grand rounds education, "lunch and learn" programs, notices in employee bulletins.

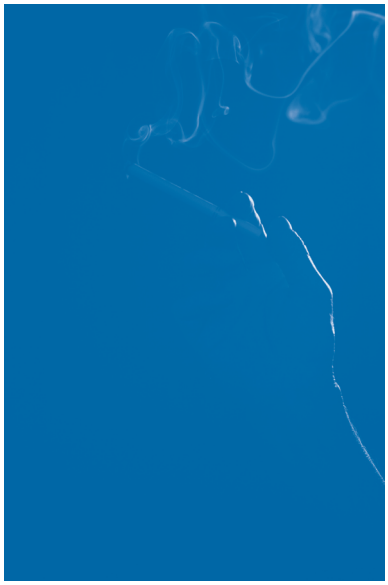
REVIEW OF LONG-TERM SUPPORT PLAN AND CLOSING REMARKS

Ruth Ann Tsukuda, Ed.D. MPH

Dr. Tsukuda explained that she will be the primary contact person for the preceptors. Monthly check-in calls and informal summaries via e-mail will be used to gauge progress and look at ideas that can be disseminated to others. The first progress report would be due May 29, 2006.

A telephone conferencing group, the Mental Health Smoke Line Preceptors, and an e-mail group will be available to increase dialogue among preceptors and VA sites.

The important thing for preceptors is to think in terms of small, strategic steps aimed at changing systems and the culture of smoking within the VA system.



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INTEGRATING TOBACCO CESSATION TREATMENT INTO MENTAL HEALTH CARE

Conference Summary

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