Improving Tobacco Treatment for People with Serious Mental Illness:

A Role for Academic Detailing?

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Disclosures

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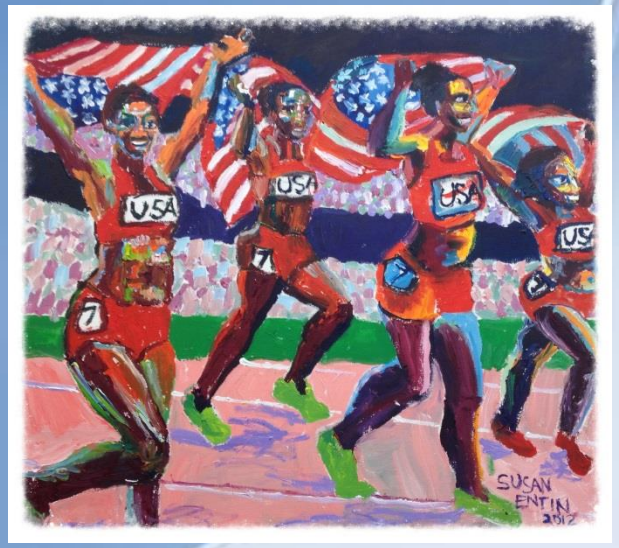
Outline

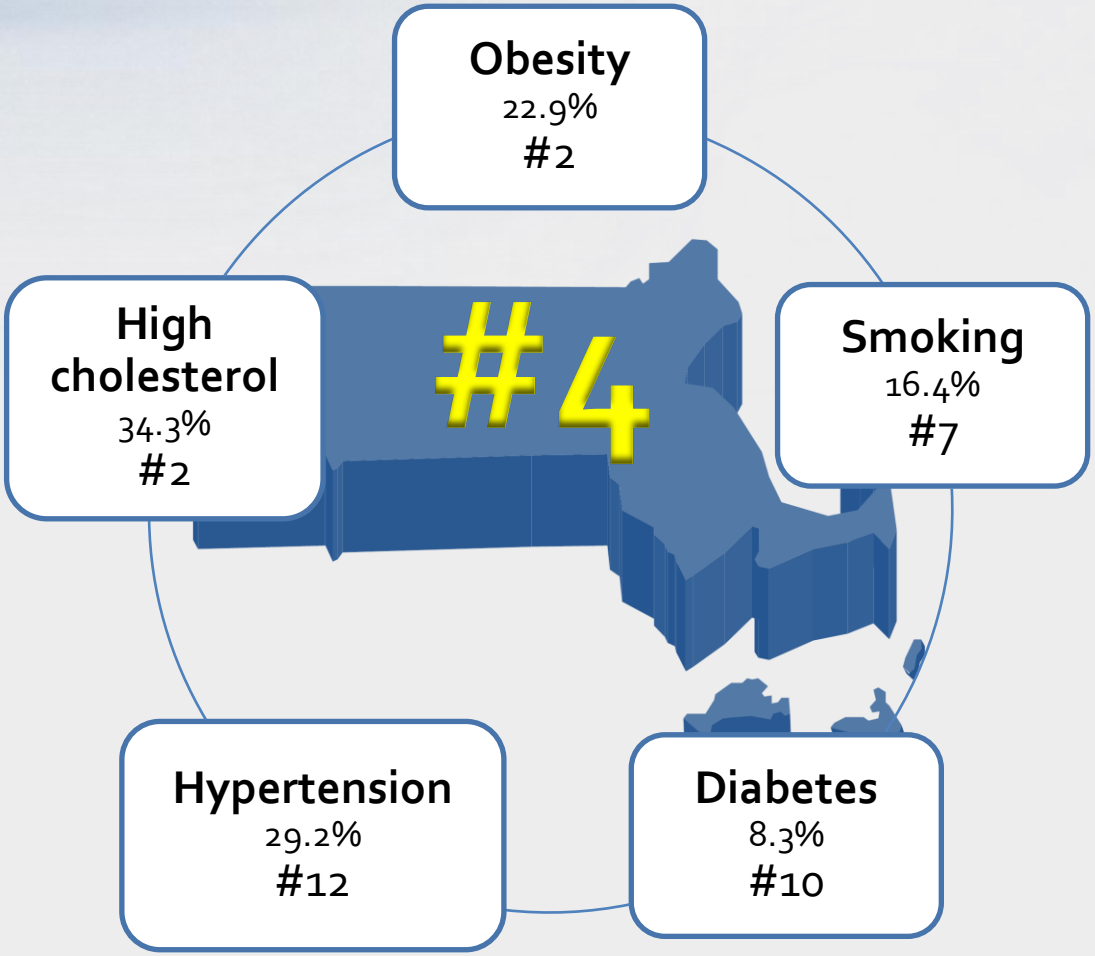


- A compelling need
- Academic detailing idea
  - Collaborative design
  - Intervention
  - Experience
- Program assessment
  - Pilot Results

MA Mental Health Center (MMHC)

- Department of Mental Health CMHC in Boston
- 1,100 outpatients
- All have a serious mental illness
  - 50-60% schizophrenia-spectrum
  - 60-80% with chronic medical conditions
  - Co-morbid substance use disorders common
- 80% below 200% of federal poverty level
- Nearly all publicly insured
- Ethnically diverse

How healthy is Massachusetts?



Americashealthrankings.org

How healthy is MMHC?

Obesity
47%

Smoking
47%

Diabetes
20%

Hypertension
46%

Dyslipidemia
59%

A Compelling Need

- People with SMI die 25 years earlier than the general population
- Nearly half of all deaths in people with SMI are due to tobacco-related illnesses
- 45% of people with SMI smoke, twice the rate of the general population
- Heavy smoking and high levels of nicotine dependence are common in people with SMI

Colton 2006, Callaghan 2014, CDC 2013, Williams JM 2011,

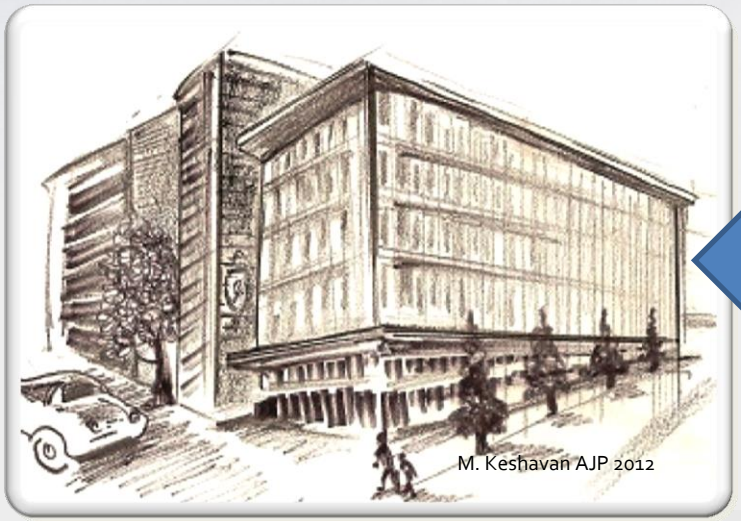
The Good News

- Most smokers with SMI want to quit
- Effective treatments exist
- Quitting doesn't worsen psychiatric outcomes
- Psychiatrists and mental health centers are well-positioned to intervene

Prochaska 2011, Tsoi 2010, Evins 2015

Integrated Care

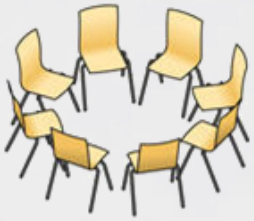
MENTAL HEALTH



PRIMARY CARE

Smoke Free Program Services

Education



Groups

- *Learning about Healthy Living*
- *Stop Smoking Group*

Care Coordination

Peer coaching

1:1 Cessation Counseling

Cessation medications

- **Text messaging**
- **Smartphone Apps**
- **Online programs**

Let's Talk about Smoking Website

Quitline referrals

WaRM Center Smoke Free Program

MMHC Provider's Role

ASK • ENGAGE • ACT

Connect Client with the Smoke Free Program

Genesis of NaRCAD Collaboration

- Provide unbiased, evidence-based information about treating tobacco use disorders in people with SMI
- Counter misinformation
- Invest providers in the cause

Implementation Plan

- Have two staff physicians split the detailing of all psychiatric prescribers (~10)
- 30 minute session covering:
  - Burden of tobacco use
  - Effectiveness of treatments
  - Availability of smoking cessation support services at MMHC

Creating the detail aid

1. Consolidate evidence base
2. Identify key messages
3. Synthesize messages and evidence into a "detail aid" which contains relevant information that can be referenced by the physician in the future with the goal of behavior change

Creating the detail aid

- Cutting-edge, evidence-based information in clear language with colorful graphics
- Highlights our three “asks”
  - Ask about tobacco use
  - Engage smokers in a discussion
  - Act by referring patients to the Smoke Free Team

Tobacco treatment for people with serious mental illness (SMI)

An opportunity to close the mortality gap

Mass DMH Department of Mental Health
Massachusetts Mental Health Center

NoRCAD
National Resource Center for Academic Detailing

A compelling need

45% of people with SMI smoke- twice the rate in the general population[1]

People with SMI die **25 years** earlier than people in the general population[2]

Reducing tobacco use among people with SMI can be the single most powerful intervention for reducing mortality and morbidity in this group

50% of all deaths among people with SMI are tobacco-related[3]

Myths vs. **Facts**[4]

Myth: People with SMI don't want to quit smoking.

Fact: Most smokers with SMI want to quit[5], at the same rates as the general population (60-70% in contemplation or preparation stage of change).[6]

Myth: People with SMI aren't able to quit smoking.

Fact: Long-term smoking quit rates across strategies are roughly 30%, similar to the general population and for other addictions.[7] Every quit attempt helps people move towards permanent abstinence.

Myth: Quitting smoking interferes with recovery from mental illness.

Fact: Smoking itself actually interferes with recovery and can affect drug metabolism, reducing efficacy of psychotropic medications. It can hamper a person's ability to find work and housing[4] and is financially burdensome, consuming 1/3 of monthly disability income for people with behavioral health conditions who smoke.[7]

Myth: Tobacco treatment isn't a psychiatrist's job.

Fact: Tobacco use releases dopamine in the nucleus accumbens to activate reward pathways in a manner similar to other substances of abuse.[7] Psychiatrists routinely treat addiction and encourage behavior change, so they CAN and SHOULD do so for nicotine addiction.

Tobacco treatment works for people with SMI

Studies in people with schizophrenia and major depressive disorder have found that tobacco treatment interventions using bupropion or varenicline are effective and safe, with no exacerbations of the underlying mental health condition.[8,9]

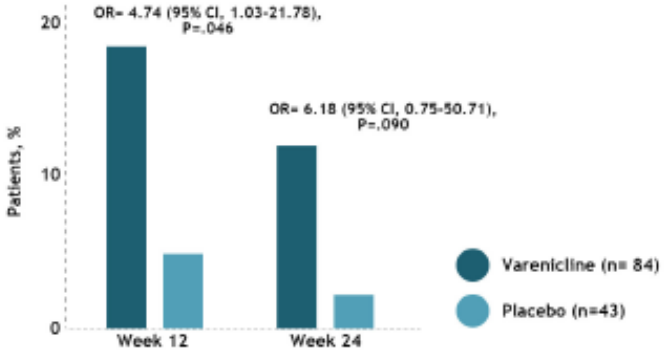


Figure 1. Abstinence at 12 and 24 weeks among patients with schizophrenia or schizoaffective disorder treated for 12 weeks with varenicline vs. placebo[9]

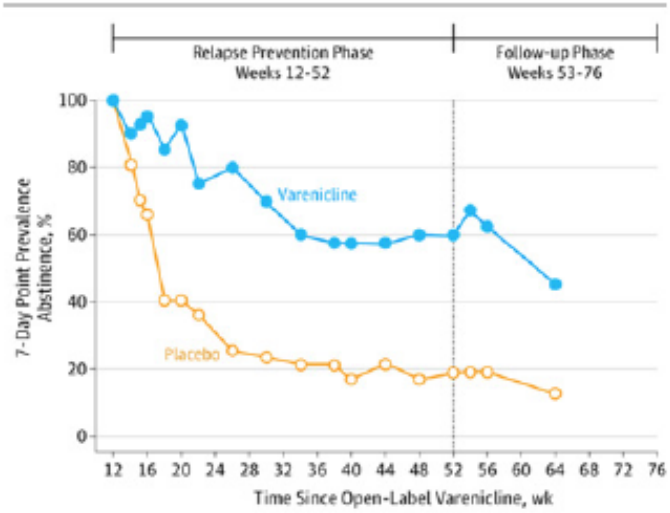


Figure 2. Point-prevalence abstinence rates during maintenance treatment with varenicline vs. placebo in people with SMI[10]

Side effect rates in the general population for selected smoking cessation treatments[12,13]

	Patch	Patch + lozenge	Bupropion	Bupropion + lozenge	Varenicline	Placebo
Nausea	4.3%	7.9%	4-16%	5%	52%	16-19%
Sleep disturbances or abnormal dreams	11%	9%	12-17%	11%	15%	20-22%
Local irritation	Skin (15%)	Throat (2-7%)	Throat (2%)	Throat (2-7%)		
Irritability			11%		12%	10%

The bottom line for schizophrenia

- Treatment for at least three months with either bupropion (+/- NRT) or varenicline, combined with behavioral support, increases abstinence rates.
- Behavioral treatment alone may have a lower impact on these patients than the general population.
- Maintenance treatment with varenicline for up to 40 weeks after a successful quit attempt may be needed to support abstinence.

The bottom line for bipolar disorder

- Although data are limited, people with bipolar disorder face the same risks of smoking-related mortality as people in the general population. Initiating treatment with single or combination NRT prior to weighing the risks and benefits of other medications is supported by indirect evidence and may help patients quit.

The bottom line for major depressive disorder (MDD)

- Psychosocial treatments for smoking cessation may be more effective in people with MDD than those with schizophrenia spectrum or bipolar disorders.
- Any of the available smoking cessation treatment options can be tried, unless specifically contraindicated.

Make smoking cessation happen!

Step 1: Ask

- Ask if your patient uses tobacco

Step 2: Engage

- If patient uses tobacco, advise them to quit
- Assess level of motivation for quitting

Step 3: Act

- Refer the patient to the Smoke Free Team via phone or email
- Prescribe tobacco treatment medications to increase success rates
- Monitor and adjust specific psychiatric medications as needed

The MMHC Smoke Free Program can help!

We can connect patients with:

- Integrated, collaborative, team-based care
- Individualized assessment and treatment planning
- Personalized motivational enhancement strategies
- Patient-centered decision support tools
- Evidence-based treatment options (individual and group counseling, medication consultations, and more)
- Ongoing monitoring and support

Masschusetts Mental Health Center Smoke Free Team
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MMHCSmokeFreeTeam@massmail.state.ma.us

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These are general recommendations only; specific clinical decisions should be made by the treating physician based on an individual patient's clinical condition.

Assessment of Intervention

- Pre- and 2 month post-survey to assess:
  - Knowledge regarding tobacco treatment
  - Comfort with prescribing cessation medications
  - Current practices
  - Acceptability and utility of AcD visit (post)

Survey Development

- Reviewed literature
- Got input from NaRCAD and others working on tobacco interventions
- Piloted surveys with residents and modified based on feedback
- Assessed practices, beliefs, behaviors
- 5 point Likert-type scale
  - Behaviors: 1 Never to 5 Always
  - Beliefs: 1 Strongly disagree to 5 Strongly agree

Structure of Detailing Visit

- Conducted by a psychiatrist or internist (both trained at NaRCAD Academic Detailing Training)
- 20-30 minutes in prescriber's office
- Begin with open ended question about successes and challenges in addressing tobacco use
  - Celebrate successes; validate challenges
- Pivot from challenges to key messages that may help them address these issues with greater success
- Conclude by reviewing steps the prescriber can take to increase their success related to tobacco treatment
- Leave prescriber with detail aid and high-yield references

Response to detailing

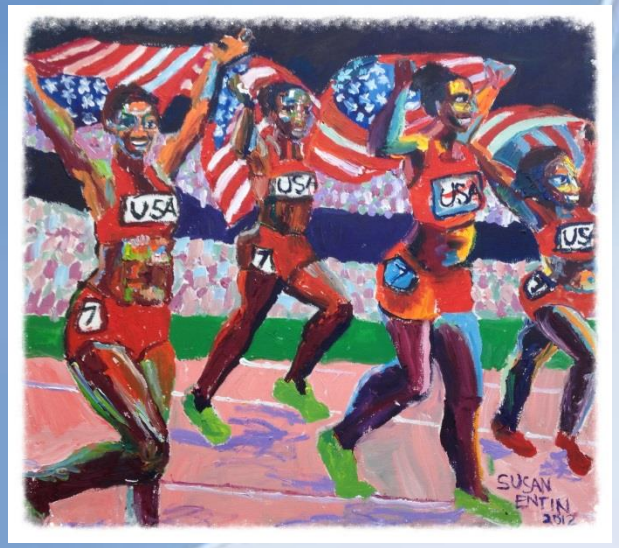
- Overwhelmingly positive
  - Most providers were invested in the issue
- Bidirectional information exchange
- Appreciation of program information
- Opportunity to express concerns and questions about program

Barriers that emerged

- Time
  - to sit down for a detailing visit
  - to talk with clients about smoking
- Competing priorities
- Limited knowledge of resources
- Hopelessness

Preliminary Results

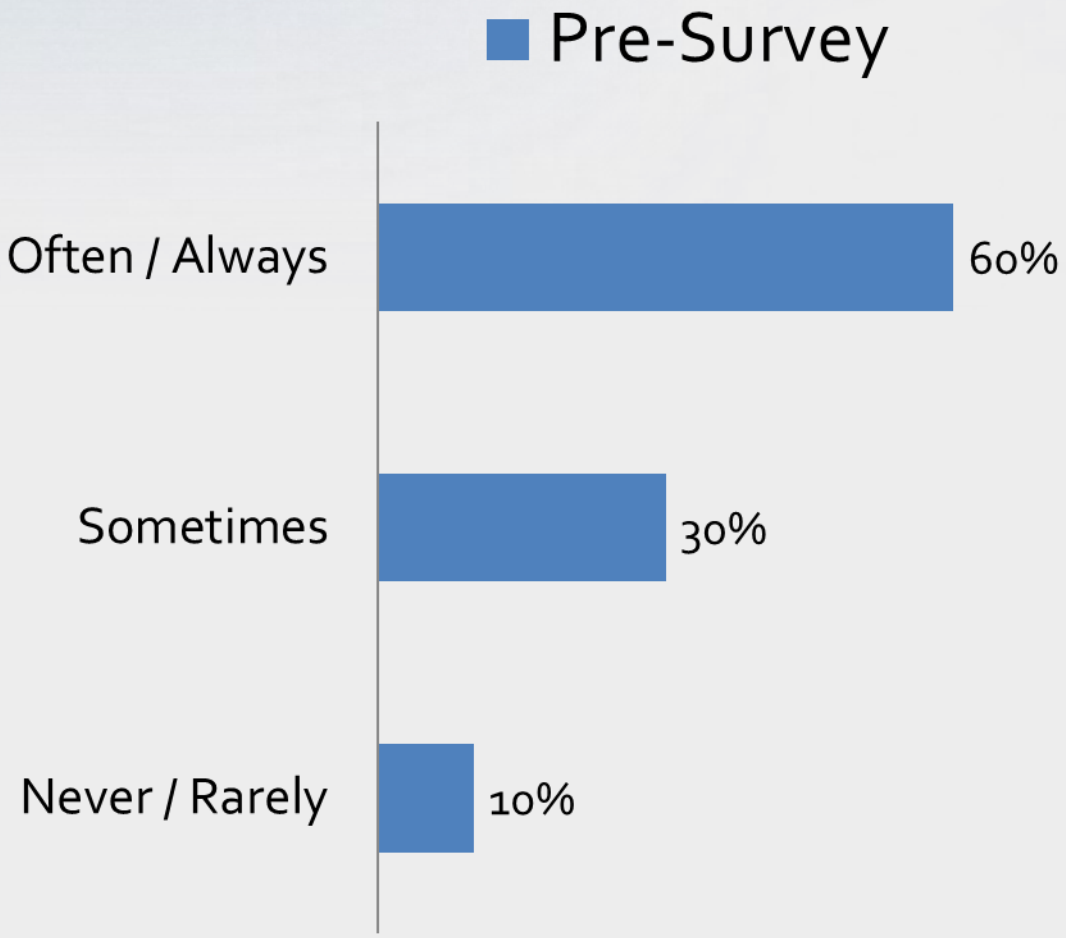
- 10 prescribers were detailed
- 10 completed pre and post surveys



Survey

Assessing Practices

Does your typical patient encounter include a question about tobacco use?



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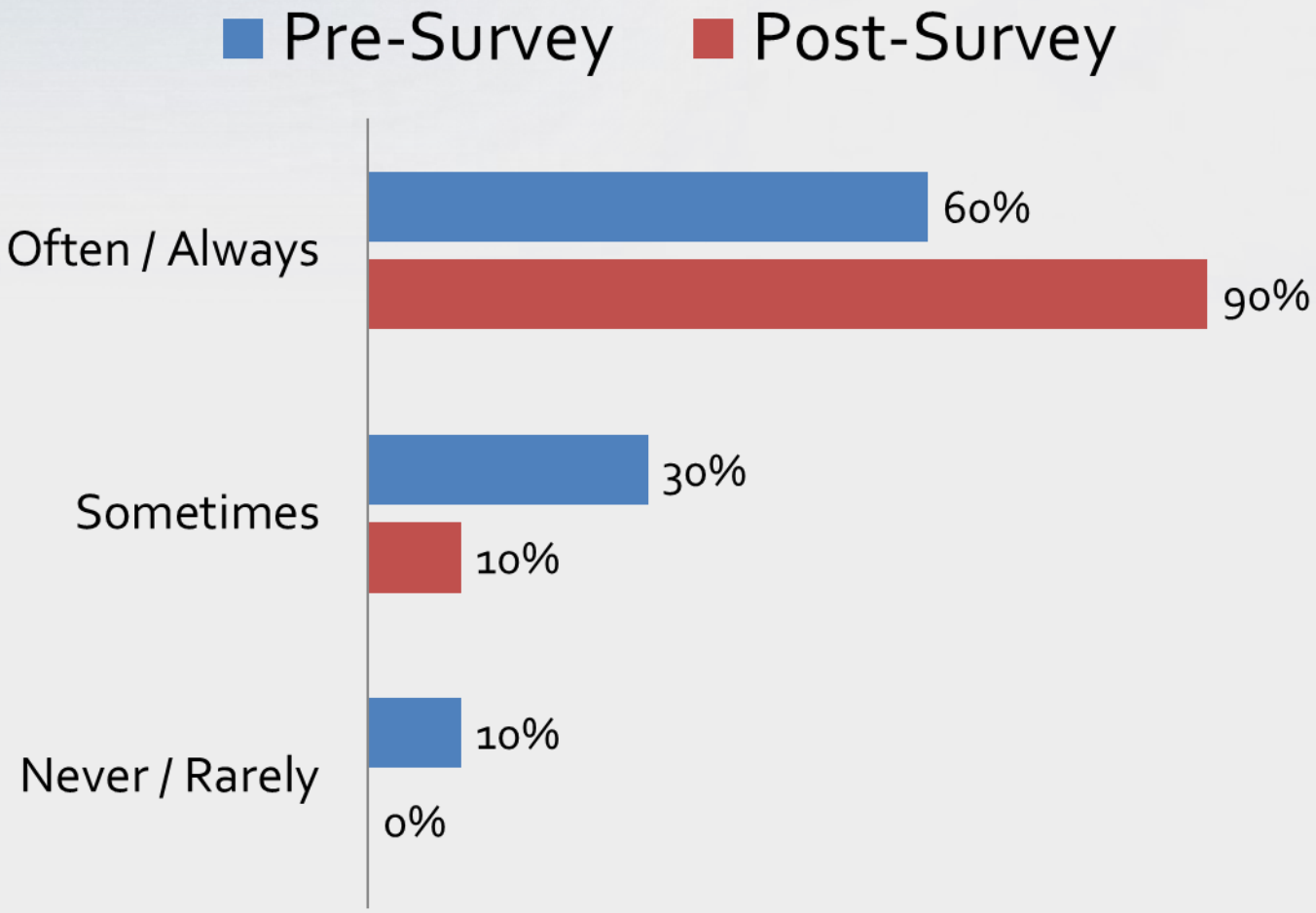
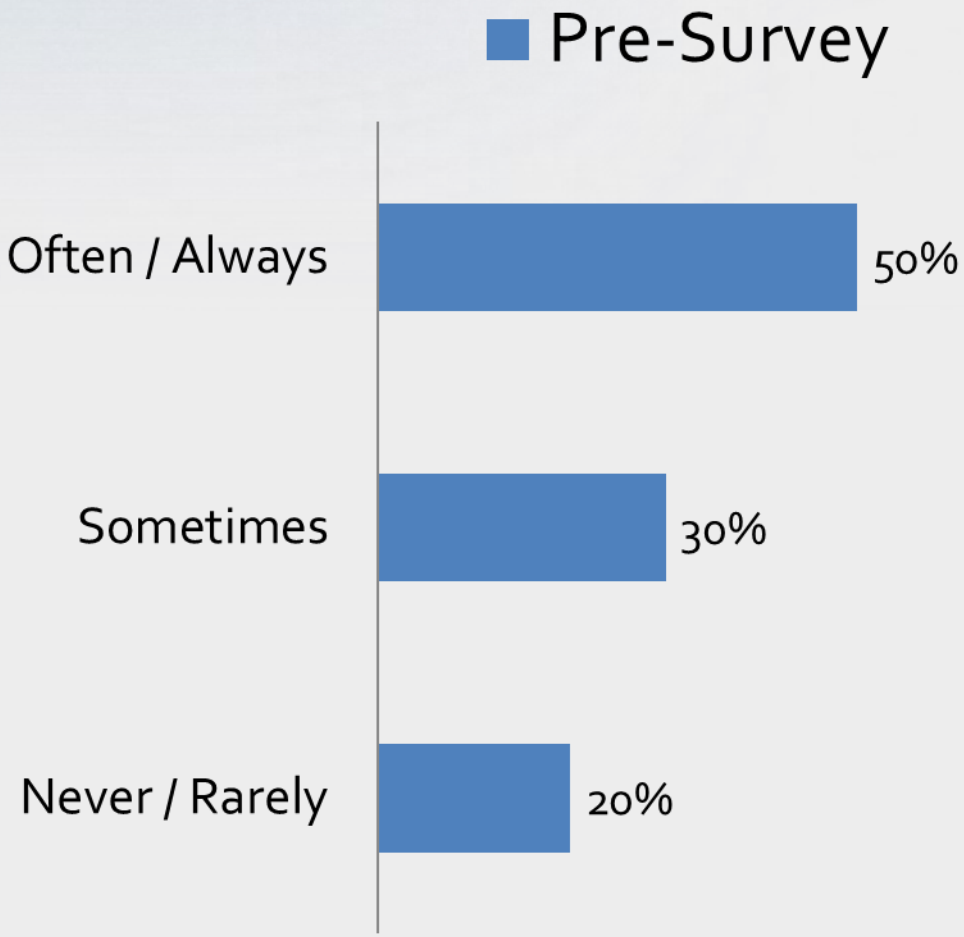


Does your typical encounter include assessment of readiness to quit?



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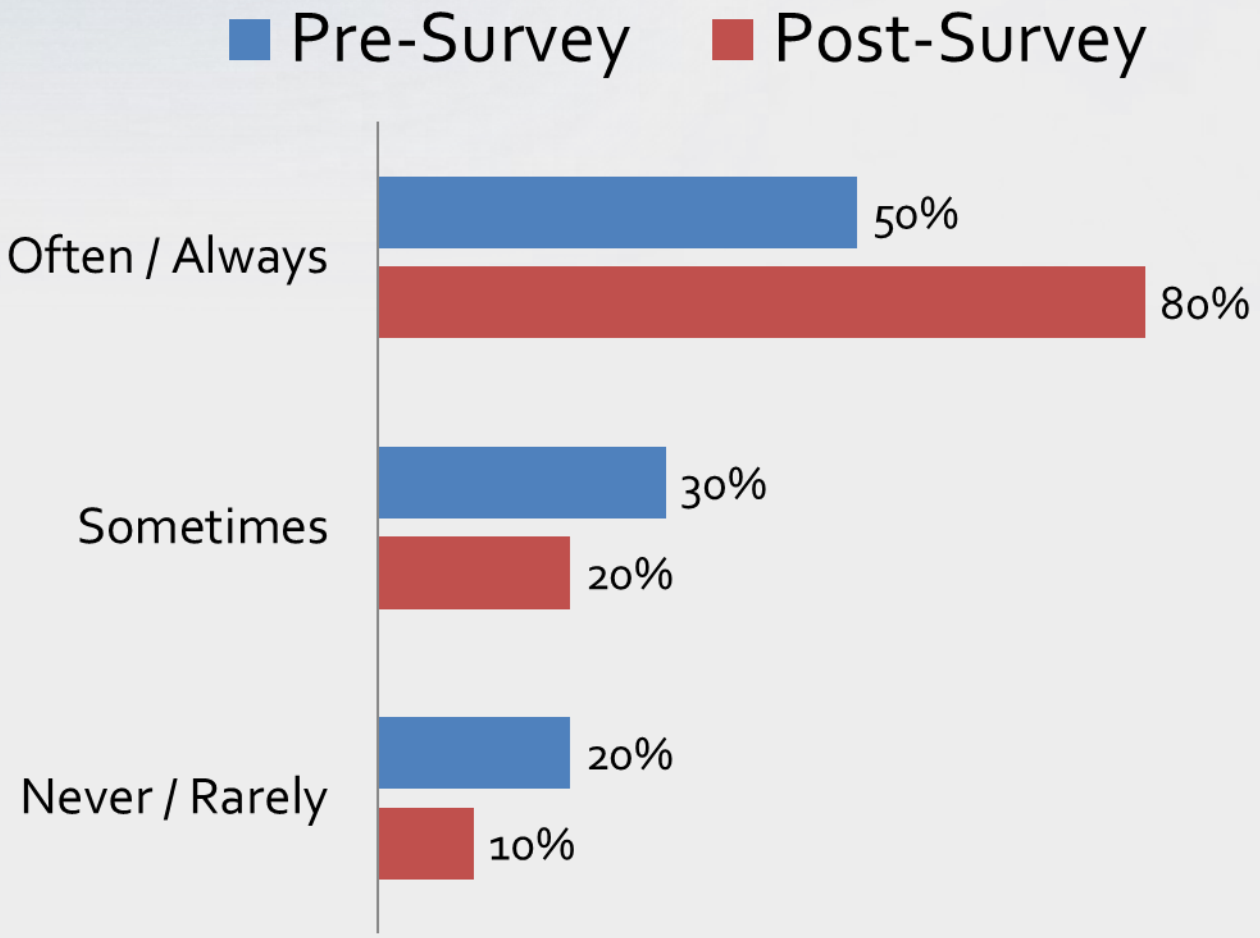
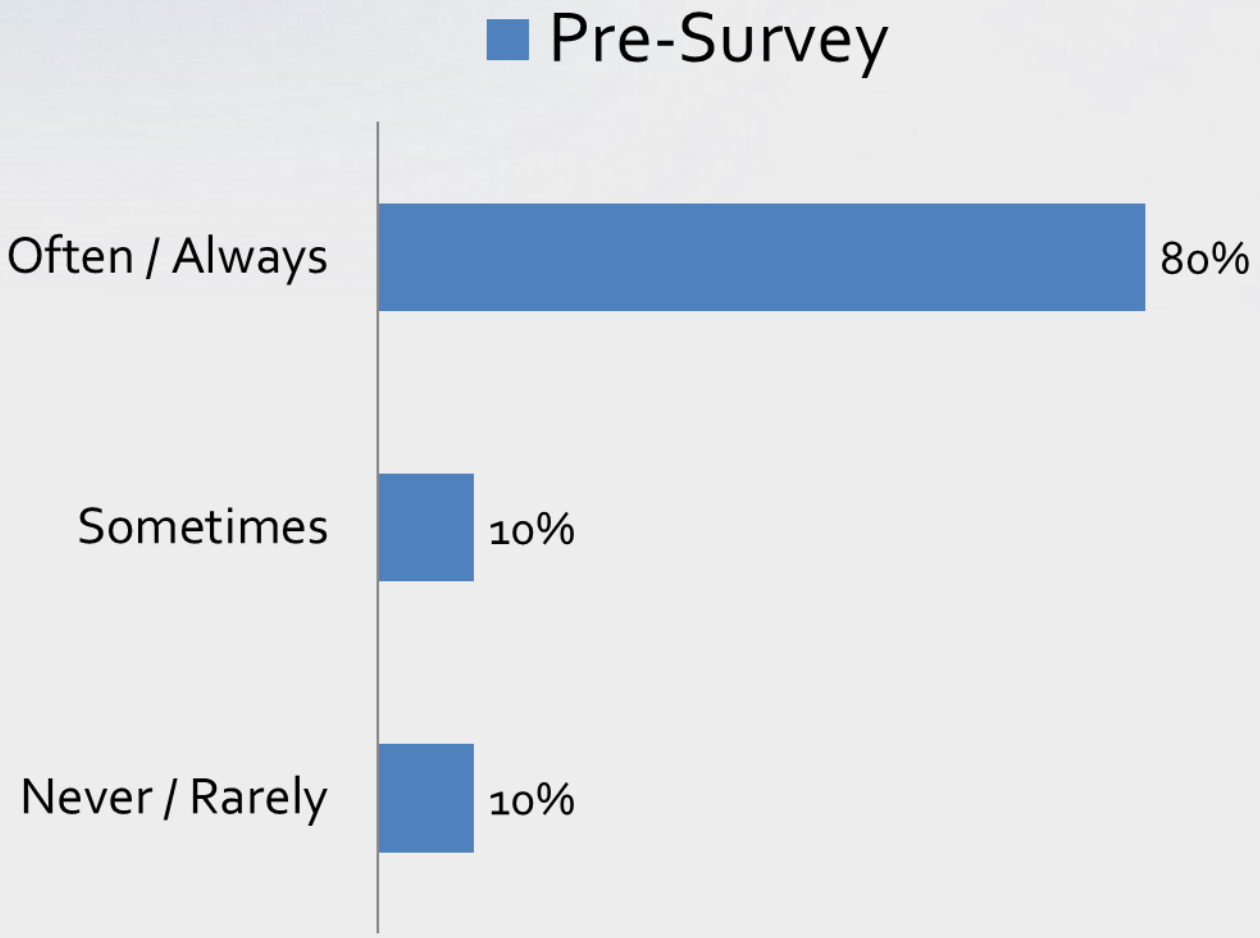


Do you refer the patient for services?



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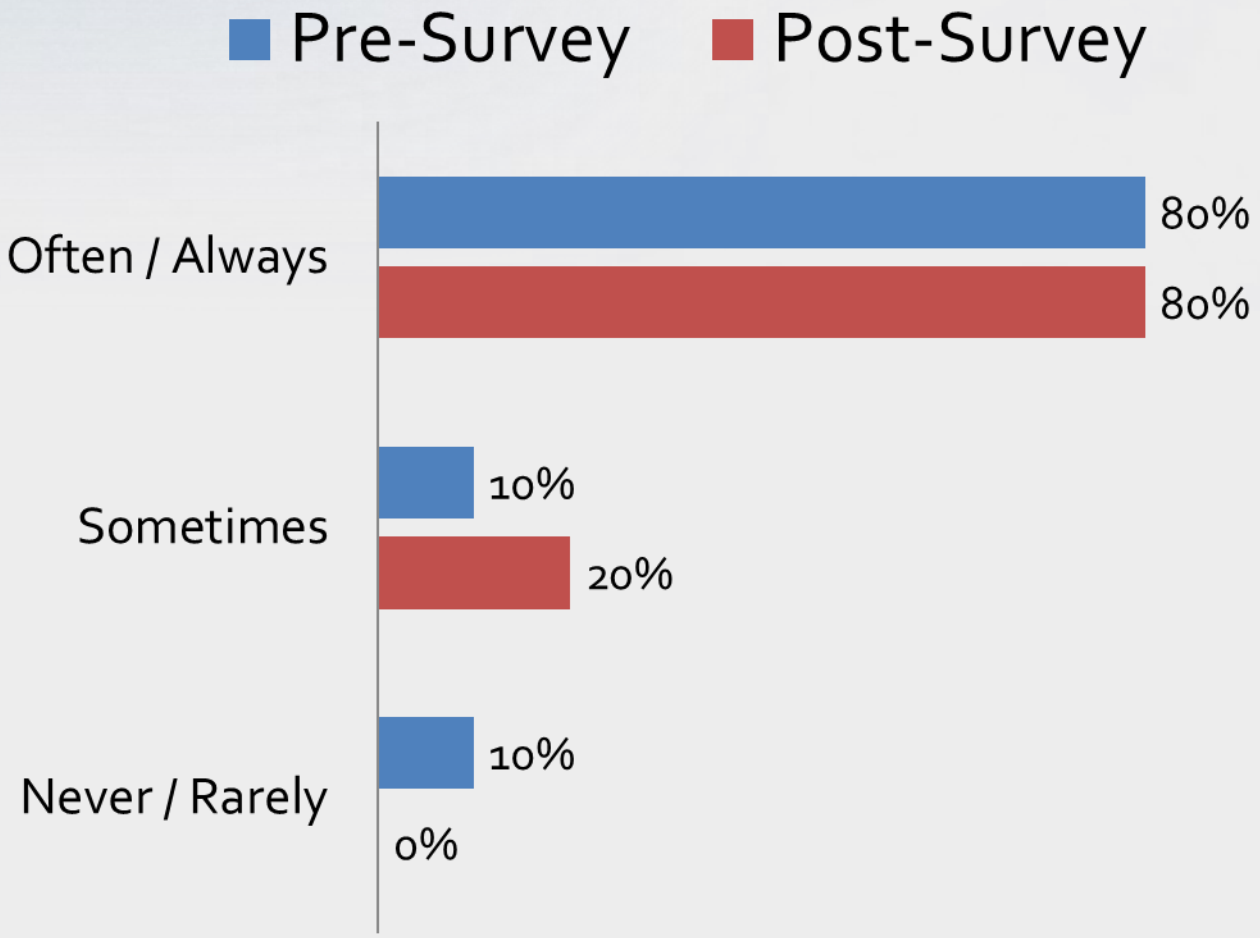
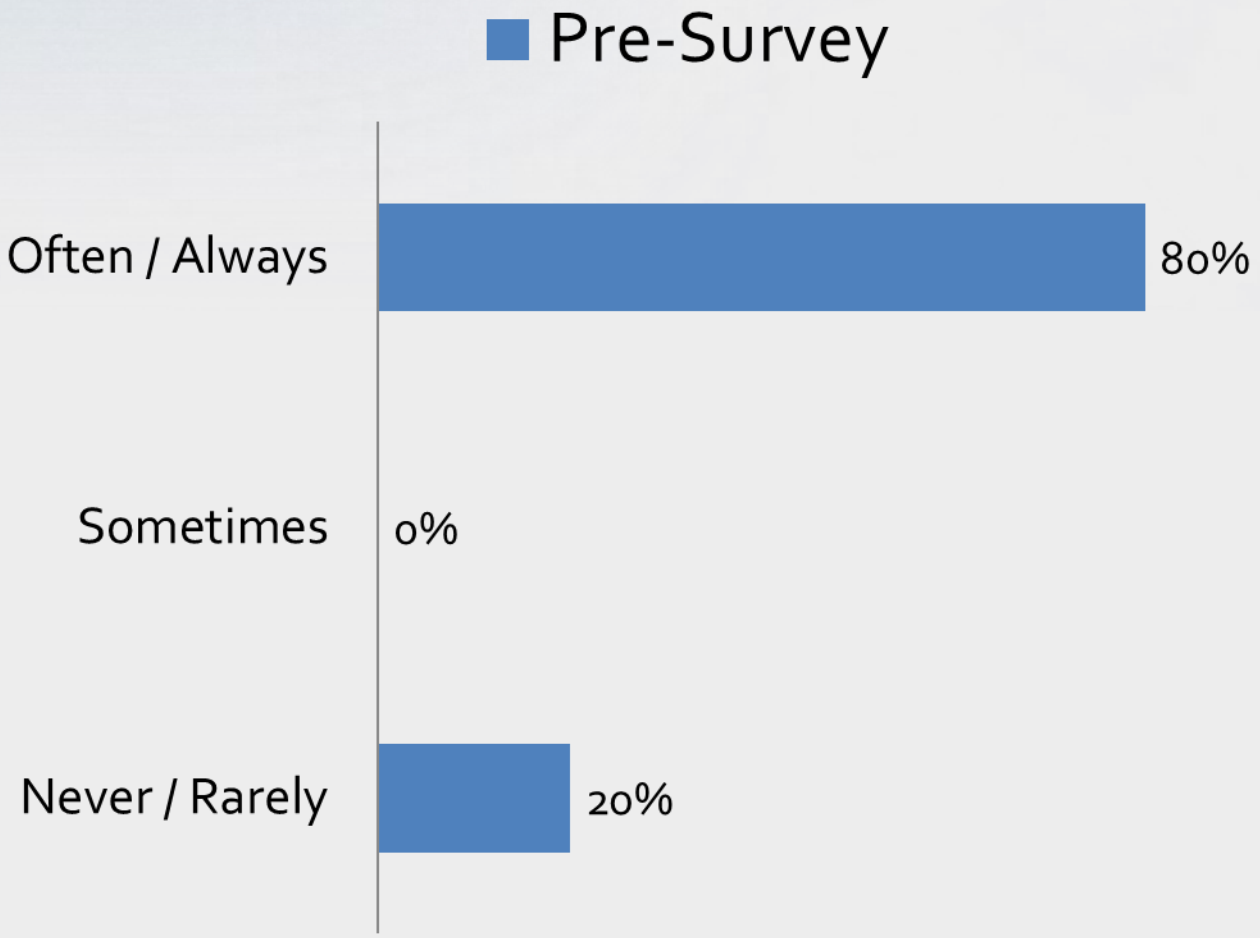


Do you discuss tobacco treatment medications?



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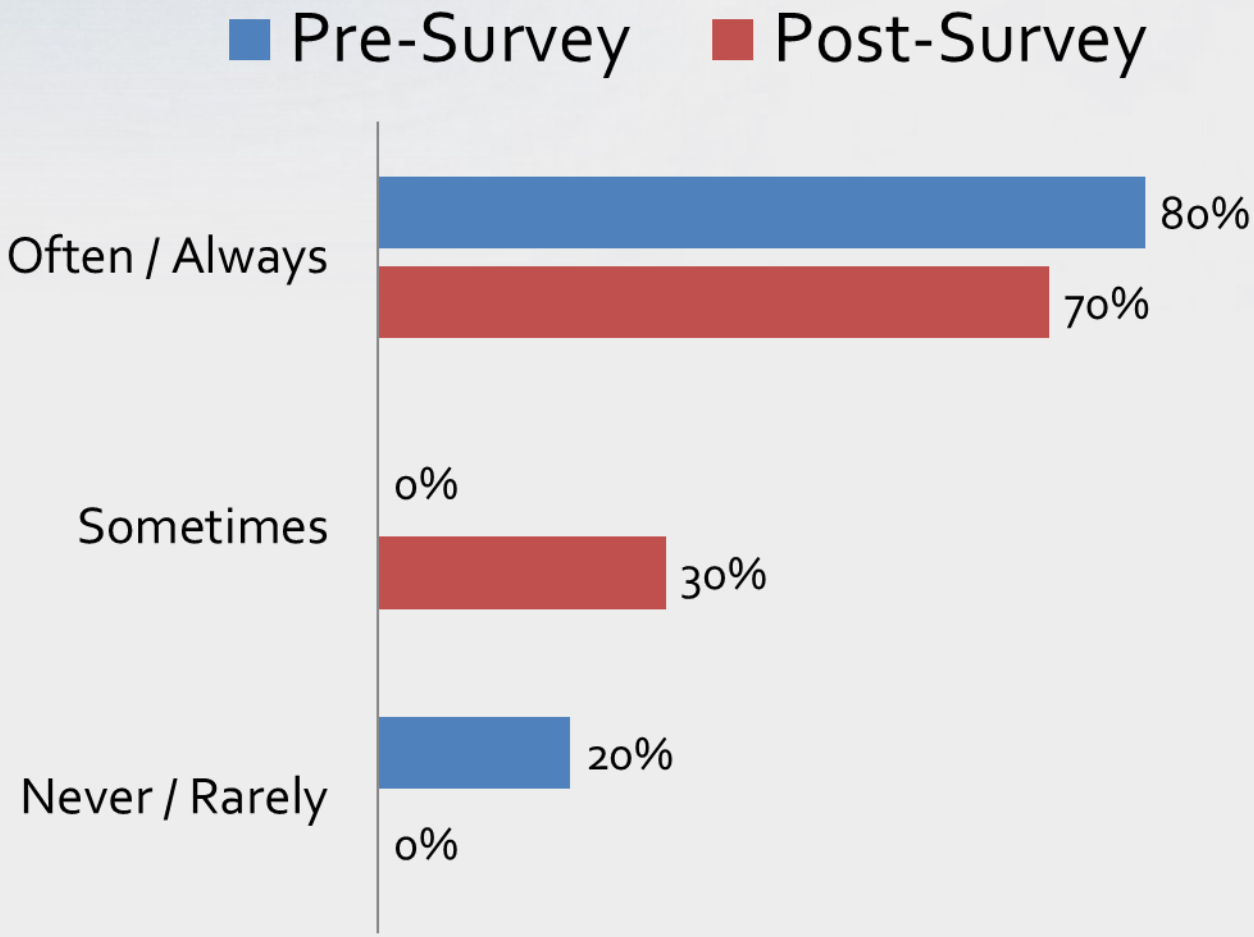

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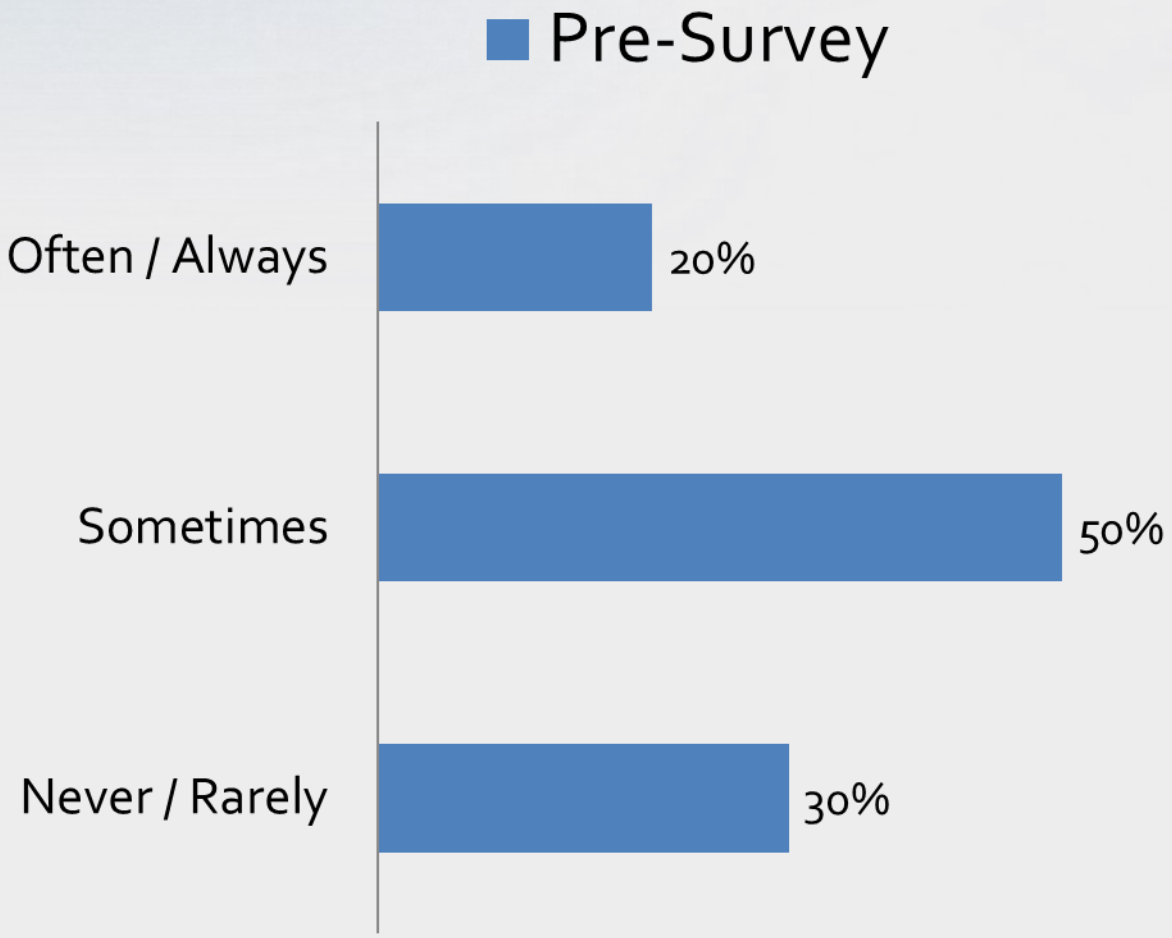

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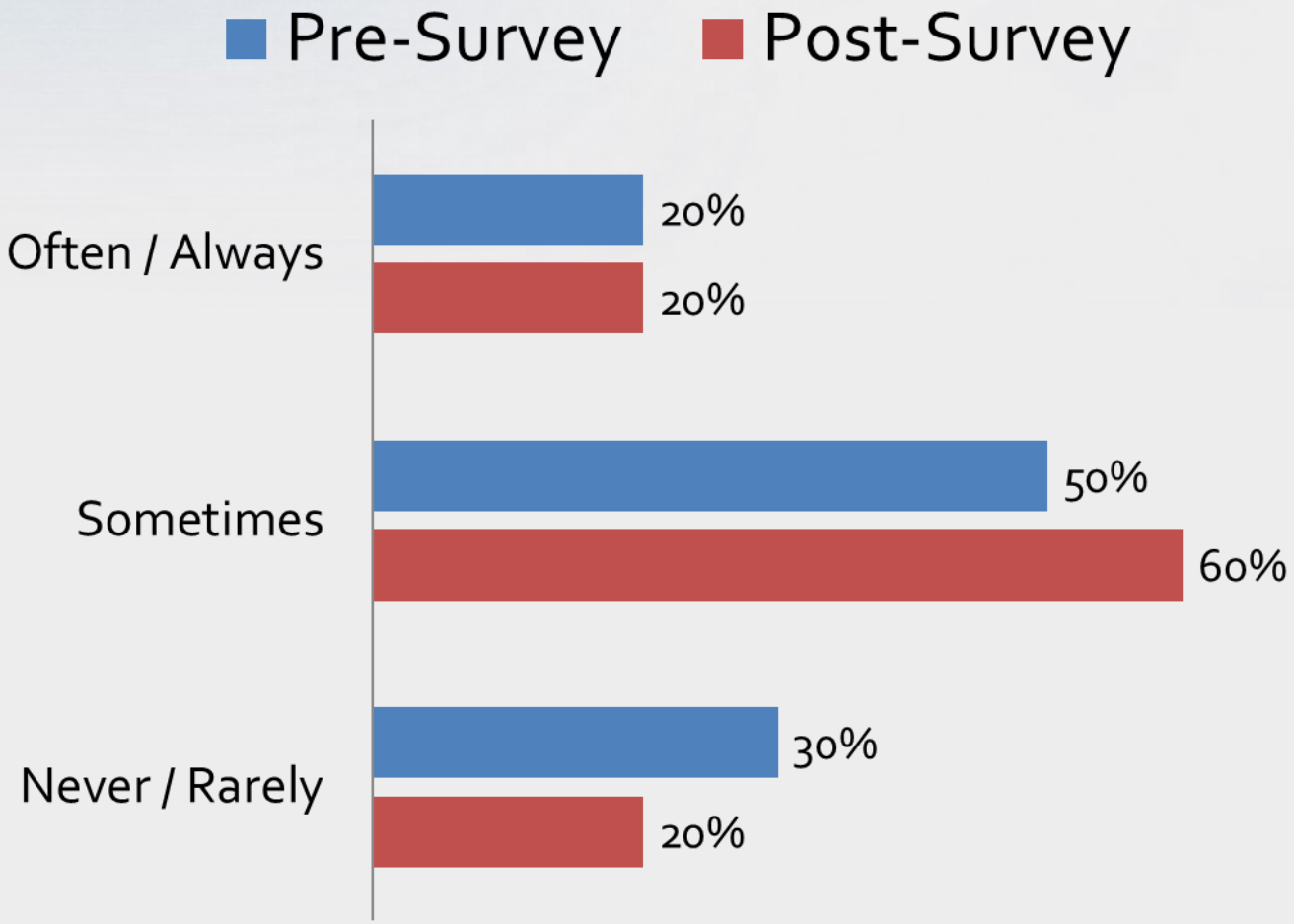

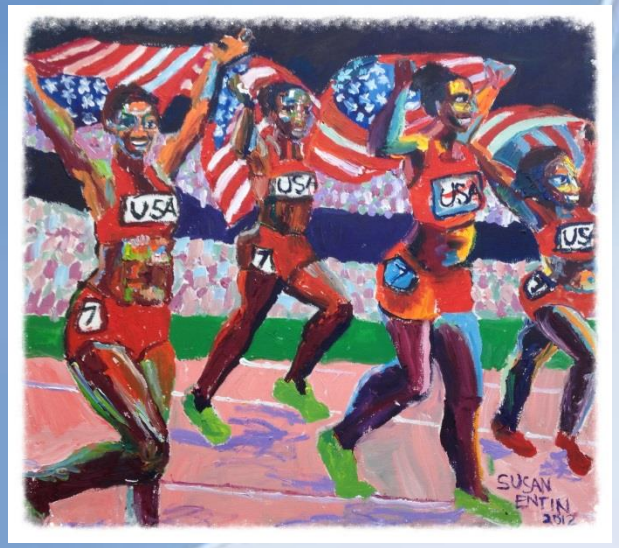

Survey

Assessing Beliefs

Survey – Assessing beliefs

- The assessment and treatment of tobacco use disorders falls under the psychiatrist's/mental health prescriber's scope of practice.

  Pre: 90% Agree or strongly agree →

  Post: 100%

- I am confident in my ability to treat tobacco use disorders in patients with serious mental illness.

  Pre: 70% Agree or strongly agree →

  Post: 90%

Acceptability and utility of AcD

2 months post-visit:

- I found the academic detailing visit useful

  100% Agree or strongly agree

- I made at least one change to my practice because of the academic detailing visit

  90% Agree or strongly agree

General Findings

- Prescribers more actively engaged in referral and treatment collaboration
- Increase in referrals
- Increase in use of tobacco cessation medication

Q & A