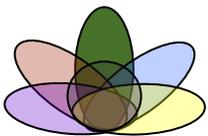


Do Quitlines Have a Role in Serving the Tobacco Cessation Needs of Persons with Mental Illnesses and Substance Abuse Disorders?

A Background Report - 2010



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Executive Summary

Individuals with addictions and mental health disorders are among those with the highest smoking prevalence. Persons with behavioral health disorders smoke at a rate of at least double that of the general population and these individuals represent an estimated 44 percent of the U.S. tobacco market. Almost half of all annual U.S. deaths from smoking are persons with addictions and mental health disorders.

The Quitline Behavioral Health Advisory Forum was created by quitlines, behavioral health providers, and tobacco cessation organizations interested in how quitlines might best serve the needs of callers with diagnosed or undiagnosed mental health and/or substance abuse disorders. Forum activities include:

- Ongoing expert advice, emerging practices and research ideas/ collaborations
- Cataloguing practices and resources for this population
- Reviewing screening and/or reporting questions and associated protocols
- Raising community awareness of quitline services
- Creating partnerships with community behavioral health providers
- Identifying referral resources for quitline callers that have behavioral health issues, including referrals back to health plans
- Recommending needed research and core competencies for quitline staff working with callers with behavioral health issues
- Creating training modules for quitline staff working with this population

There are real and perceived barriers to providing smoking cessation services to this population. Forum members met throughout 2009 to evaluate the potential issues that arise when quitlines serve persons with behavioral health disorders and to offer recommendations for moving forward.

This report provides a brief introduction to the evidence base and expert opinion regarding:

- The association between tobacco use and behavioral disorders
- Morbidity and mortality
- Neurobiological, psychological, social, and systemic barriers to tobacco cessation
- The desire and ability of these individuals to quit
- Quitlines' effectiveness serving this population

There is growing evidence that a significant number of quitline callers have addictions and mental health disorders. Quitlines are already serving this population.

Pragmatic suggestions are made in the following areas:

Screening	It is recommended that if quitlines are screening for chronic care conditions for all callers, that behavioral health issues be included. Screening will allow for further characterization of quitline clients, and is a necessary first step toward pilot interventions. One common strategy is to include 1-2 questions regarding callers' history of behavioral health issues and then another question tracking callers' perceptions of how behavioral health issues will impact quit attempts.
Treatment	Generally, persons with mental illnesses and substance abuse disorders benefit by the same interventions as the general population. Therefore, a combination of counseling and pharmacotherapy should be used whenever possible. Further guidelines are provided for persons with cognitive difficulties or current psychiatric symptoms.
Staff Training and Supervision	Tobacco treatment specialists should receive regular training on behavioral health issues. It is important that quitline staff have a working understanding of how addictions and mental health issues are associated with tobacco use and impact tobacco cessation efforts. This advisory group is working collectively to develop a standardized training curriculum for quitline tobacco treatment specialists.
Evaluation and Research	Additional studies are needed to investigate strategies in actual clinical settings for persons with behavioral health disorders, including quitlines. There's a need to collect more information about this population and then determine most effective means of intervening. The report provides specific areas of potential study. Quitlines are encouraged to work together to develop studies where findings are generalizable across settings, and to determine the best means of rapidly disseminating findings through national organizations and/or professional associations.
Community Referral	An interlinking network of cessation options is needed for persons with behavioral health disorders. Forum members recommend that quitlines develop bi-directional referral relationships with mental health and substance use providers/treatment programs. A potential strategy would be to utilize NAQC's quality improvement initiative to develop a toolkit or guidebook to provide practical guidance to quitlines on how to establish effective care coordination with community behavioral health providers.
Policy	At the organizational level, quitlines are encouraged to develop initiatives that target populations disproportionately affected by tobacco use- persons with behavioral health disorders being one such population. Such direction from leadership creates an environment conducive to raising awareness regarding health disparities and implementing novel strategies for standardized screening of behavioral health issues, treatment interventions, staff training, and coordination with community behavioral health agencies.

All clients, including quitline callers with diagnosed or undiagnosed behavioral health disorders, deserve access to proven treatments that significantly enhance the odds of cessation (Mottillo et al., 2008). The full report of the Quitline Behavioral Health Advisory Forum provides detailed support for the above recommendations and the role that quitlines might play in best assisting the many callers who have mental illnesses and substance abuse disorders.

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I. Purpose and Aims

The Quitline Behavioral Health Advisory Forum was created by quitlines,¹ behavioral health providers, and tobacco cessation organizations interested in how quitlines might best serve the needs of callers with diagnosed or undiagnosed mental health and/or substance abuse disorders. Forum activities include:

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Clients with behavioral health disorders (defined as mental illnesses and/or addictions) call quitlines in substantial numbers, but many questions remain regarding quitlines' role in identifying and serving these persons. This report is a critical appraisal of the potential issues that arise when quitlines serve persons with behavioral health disorders. A brief introduction to the evidence base is provided. And just as importantly, forum members identify salient gaps in evidence, and necessary further research, policy, and partnerships.

II. The Existing Knowledge Base

How Big is the Issue?

At least one in five people has a diagnosable psychiatric disorder during the course of any given year (U.S. Department of Health and Human Services, 1999). Although significant progress has been made, tobacco use remains the largest preventable cause of death and disability in the United States and worldwide (Schroeder, 2008). Because smoking is concentrated among persons with mental illnesses and/or substance abuse disorders, effective treatment strategies are key to achieving desired reductions in smoking prevalence (Schroeder, 2009).

While the tobacco use prevalence rates in the general population decreased over the last decade, this is not the case for individuals with substance abuse and mental health disorders (Schroeder & Morris, 2009). These individuals represent a surprising 44% of the U.S. tobacco market (Lasser et al., 2000). Although smoking varies greatly by diagnosis, rates can be as high as 90% among persons with psychotic disorders or alcohol and drug addictions (Degenhardt, Hall, & Lynskey, 2001; De Leon & Diaz, 2005; Grant et al., 2004; Krejci, Steinberg, & Ziedonis, 2003; Marks, Hill, Pomerleau, Mudd, & Blow, 1997). Over 75% of alcohol- and drug-dependent persons in early recovery smoke cigarettes (Gullilver et al., 2000; Hughes, 1995; Richter, Gibson, Ahluwalia, & Schmelzle, 2001), and tend to be heavy, highly

¹ The term quitline is used throughout the document but also refers to helplines. These terms are used interchangeably.

nicotine-dependent smokers (Kalman et al., 2004). Not only are individuals with substance abuse and mental health disorders more likely to smoke, they also smoke more cigarettes daily and smoke them down to the filter more than other smokers (D’Mello, Bandlamundi, & Colenda, 2001; Lasser et al, 2000).

Table 1. Tobacco Use by Diagnosis

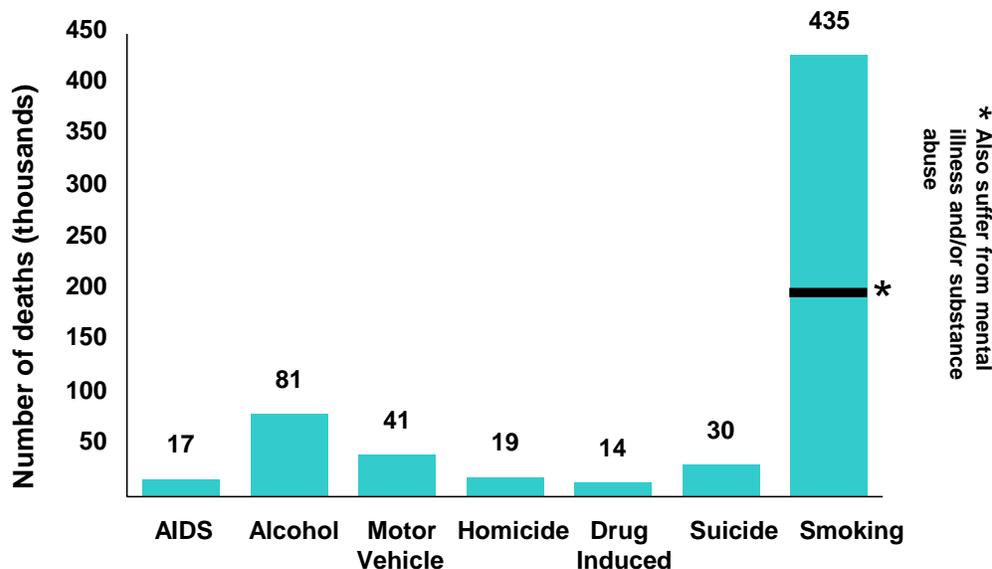
Schizophrenia	62-90%
Bipolar disorder	51-70%
Major depression	36-80%
Anxiety disorders	32-60%
Post-traumatic stress disorder	45-60%
Attention deficit/ hyperactivity disorder	38-42%
Alcohol abuse	34-80%
Other drug abuse	49-98%

(Beckham et al., 1995; De Leon et al., 1995; Grant et al., 2004; Hughes et al., 1986; Lasser et al., 2000; Morris et al., 2006; Pomerleau et al., 1995; Stark & Campbell, 1993; Ziedonis et al., 1994)

Morbidity and Mortality

Tobacco use represents a significant risk factor affecting health, quality of life, and morbidity for persons with behavioral health illnesses, with about 200,000 of the 443,000 premature deaths from smoking in the United States estimated to occur among these persons (Mauer 2006; Schroeder, 2009). These individuals die up to 25 years earlier and suffer increased medical co-morbidity, compared to the general population (Brown, Inskip, & Barraclough, 2000; Colton & Manderscheid, 2006; Dixon, Postrado, Delahanty, Fischer, & Lehman, 1999; Hurt et al., 1996; Joukamaa et al., 2001; Mauer, 2006; Osby, Correia, Brandt, Ekbohm, & Sparen, 2000). If not dying, these individuals are often severely disabled due to tobacco related diseases. They are at greater risk of developing metabolic syndrome and cardiovascular diseases, as well as other tobacco related illnesses such as lung cancer and chronic obstructive pulmonary disease (BarChanna et al., 2008; Brown et al., 2000; Dalack, Healy, & Meador-Woodruff, 1998; Joukamaa et al., 2001). The relative risks of developing cancers of the mouth and throat are seven times greater for tobacco users, six times greater for those who use alcohol, and 38 times greater for those who are both alcohol and tobacco dependent (U.S. DHHS, 1998a). Smokers with addictive and mental health disorders also have more symptoms, increased hospitalizations, and require higher psychiatric medication dosages (Desai, Seabolt, & Jann, 2001; Goff, Henderson, & Amico, 1992; Williams et al., 2004; Ziedonis, Kosten, Glazer, & Frances, 1994).

Figure 1. Comparative Causes of Annual Death in the U.S.



Mokdad et al. (2004). *JAMA* 291:1238–245.
Flegal et al., (2005). *JAMA* 293:1861–1867.

Barriers to Recovery

The neurobiological, psychological, social, and systemic variables associated with high tobacco use and barriers to quitting among persons with behavioral health disorders have been well documented (Desai et al., 2001; Forchuk et al., 2002; Harris & Edlund, 2005; Freedman & Leonard, 2001; Mauer, 2006; Prochaska, Hall, & Bero, 2007; Ziedonis, Williams, & Smelson, 2003).

Neurobiological. Some disorders have associated neurobiological features that increase the tendency to use nicotine, make it more difficult to quit, and complicate the withdrawal phase of tobacco cessation (Freedman & Leonard, 2001; Leonard et al., 2001; Martin & Freedman, 2007). Tobacco appears to affect the same neural pathway – the mesolimbic dopamine system – as alcohol, opioids, cocaine, and marijuana (Pierce & Kumaresan, 2006). The effects of nicotine and opiates on the brain’s reward system are equally potent in a key pleasure-sensing area of the brain, the nucleus accumbens (Britt & McGehee, 2008).

Psychological. Just as in the general population, smoking is a coping strategy for anxiety and boredom for persons with behavioral health disorders (Gurpegui et al., 2007; Smith et al., 1996; Van Dongen, Kriz, Fox, & Haque, 1999). Many of these persons have impaired functioning, and limited social and vocational opportunities.

Social. Smoking represents a means by which to break up daily monotony and is a prime means of connecting to others (Goldberg, Moll, & Washington, 1996; Strasser et al., 2002).

Systemic. Existing biological, psychological, and social barriers are compounded by inadequate support from providers (Himmelhoch & Daumit, 2003; Murali & Oyebode, 2004; Robson & Gray, 2007; Hinshaw & Stier, 2008). Although national organizations such as the National Association of State Mental Health Program Directors (NASMHPD) and the Substance Abuse and Mental Health Services Administration

(SAMHSA) are now making tobacco use a priority issue, the culture of substance abuse and mental health treatment has historically reinforced tobacco use in treatment settings, residential facilities, and supportive housing (Breslau, Novak, & Kessler, 2004; Naegle, Baird, & Stein, 2009; Solway, 2009). Providers have utilized cigarette privileges to encourage client compliance and medication adherence (Mester, Toren, Ben-Moshe, & Weizman, 1993; Jochelson, 2006). A further impediment to tobacco cessation efforts is the high tobacco use prevalence (30-35%) among behavioral health providers (Gorin, 2001; Mester et al., 1993; Morris, Waxmonsky, May, & Giese, 2009; Trinkoff & Storr, 1998).

Behavioral health professionals rarely ask clients if they smoke or provide cessation counseling (Zvolensky et al., 2005). As one telling example, psychiatric patients receive cessation counseling in only 38% of their visits to primary care physicians and a mere 12% of their visits to psychiatrists (Thorndike, Stafford & Rigotti, 2001). As the largest provider of substance abuse and mental healthcare in the nation, the rates of tobacco dependence among clients treated in the Veterans Administration (VA) is also a serious issue. Veterans have high rates of tobacco use. Public behavioral health treatment programs, including the VA, historically have not addressed tobacco dependence as a substance use disorder and failed to incorporate tobacco treatment into the available services (Rustin, 1998; Knapp, Rosheim, Mesiter, & Kottke, 1993). The belief is common among mental health and substance abuse providers that tobacco cessation is unrealistic for their clients. Smoking is often presented as “one of the last personal freedoms remaining” (Morris et al., 2009). “Why would we (providers) want to take that away?” Providers and administrators warn that forbidding smoking will disrupt the treatment milieu, dramatically increase behavioral problems, and result in premature or irregular discharges (Ziedonis et al, 2006). Tobacco use is viewed by many providers as a lesser problem than the immediate consequences of other substance abuse (Foulds et al., 2006).

Do Persons with Behavioral Health Disorders Want to Quit Smoking?

Although faced with multiple barriers to quitting tobacco, persons with mental illnesses are aware of the health consequences of their tobacco use, and express the desire to quit at a similar frequency to the general population of tobacco users (Addington, el-Guebaly, Addington, & Hodgins, 1997; Prochaska, Rossi et al., 2007; Siru, Hulse, & Tait, 2009). Studies find that 77-79% of persons with behavioral health disorders intend to quit, many in the next month (Joseph, Willenbring, Nugent, & Nelson, 2004; Prochaska et al., 2007).

Can Persons with Behavioral Health Disorders Quit Smoking?

Although brief smoking cessation interventions are widely recommended in medical settings (Fiore et al, 2008), they are seldom used in behavioral health settings. Few behavioral health clinicians ask patients about smoking or advise them to quit (Himmelhoch & Daumit, 2003; Prochaska, Gill, & Hall, 2004; Thorndike, Stafford, & Rigotti, 2001; Zvolensky et al., 2005). Moreover, the resources that are available are often not tailored to meet the intensity of services required by persons with substance abuse and mental health disorders (Tobacco Cessation Leadership Network, 2008; Zvolensky et al, 2005).

Despite opinions to the contrary, there is growing evidence that tobacco cessation interventions are effective for persons with addictive and serious mental health disorders (Baker et al., 2006; Currie et al., 2008; Smith et al., 2007). While aided quit rates for persons with behavioral health disorders are lower than for general populations, they are still substantial. A review of tobacco cessation studies found that quit rates ranged from 7%-60% directly after treatment and from 13%-27% at 12 months (el-Guebaly, Cathcart, Currie, Brown, & Gloster, 2002). In a large study of community-based cessation for persons with non-acute psychotic disorders, Baker and colleagues (2006) utilized a motivational interviewing and cognitive behavioral therapy intervention. They found that a significantly higher proportion of smokers who completed all treatment sessions, as compared to those who did not complete the treatment

sessions, stopped smoking at each of the follow-up occasions (point-prevalence rates: 30% at 3 months, 18.6% at 6 months, 18.6% at 12 months) (Baker et al., 2006).

As in the general population, the most effective cessation strategies for persons with behavioral health disorders is a combination of nicotine replacement therapy (NRT) or other cessation medications and individual or group counseling (U.S. DHHS, 2008). Unless medically contra-indicated, all persons with mental illnesses and substance use disorders should be encouraged to use the full range of cessation medications. Successful cessation counseling typically includes problem solving, skills training, cognitive-behavioral therapy and motivational interviewing strategies (Baker et al., 2006; Drake et al. 2001). Effective services to be considered also include telephonic quitlines, the efficacy of which have been widely demonstrated (Anderson & Zhu, 2007; Stead, Perera, & Lancaster, 2007; Zhu et al., 2002).

There are several special clinical considerations when working with persons with behavioral health disorders. **Due to the very high levels of tobacco dependence among persons with addictive and mental health disorders, they do often require a higher intensity of services consisting of a greater duration of treatment, frequency of counseling, and higher doses and/or combinations of cessation medications (U.S. DHHS, 2008; Ziedonis et al., 2008).** Throughout interventions, persons with behavioral health disorders who make quit attempts should be carefully assessed and monitored for depressive symptoms, particularly if they have a depression history (Haas et al., 2004; Kahler et al., 2003). Even sub-clinical depression symptoms predict poorer maintained abstinence (Kahler et al., 2002; Lerman et al, 2002; Niaura et al., 2001).

The existing evidence base and expert opinion suggests that individual or group counseling strategies used for the general population are also effective for persons with mental illnesses and addictions, but several issues require emphasis. Interventions should address both patients' misconceptions regarding tobacco use and realistic fears about quitting, including weight gain and withdrawal symptoms. Persons with mental illnesses are at heightened risk for obesity and metabolic syndrome, a group of risk factors for cardiovascular disease associated with the high prevalence of second-generation antipsychotic medication use (Brown, Inskip & Barraclough, 2000; Newcomer, 2007; Sherman, 2005; John et al., 2005). It is imperative that they learn healthy coping strategies, including good nutrition and exercise. Some will also benefit from alterations to standard cessation protocols due to cognitive impairments. **Lower cognitively functioning clients may have difficulty processing abstract concepts. Rather than focus on insight-oriented treatment, counseling might include cognitive behavioral therapy and concrete strategies for developing basic coping skills (Buckley, Pettit & Adams, 2007; Haas et al., 2004; National Association of State Mental Health Program Directors, 2007; Zvolnesky et al., 2003).**

Do Tobacco Dependence Services Adversely Affect Other Treatment?

Behavioral health providers commonly believe that they are putting clients' recovery from other addiction and mental health disorders at risk if they also treat tobacco dependence. Contrary to this view, there is mounting evidence that clients who receive treatment for tobacco use are more likely to reduce their use of alcohol and other drugs, have less psychiatric symptoms, and enjoy better treatment outcomes overall (McCarthy et al., 2002; Shoptaw et al., 2002). Data from the large Project MATCH clinical trial for alcoholism indicates that alcohol-dependent smokers can quit smoking cigarettes without putting their sobriety at risk. Those who quit smoking during the program drank less than those who did not quit smoking and significantly reduced their alcohol intake for six months after quitting smoking (Friend & Pagano, 2005). **A meta-analysis of 18 studies found that treating the tobacco use of clients improved their alcohol and other drug outcomes by an average of 25 percent (Prochaska et al., 2004).** Similarly, studies have found that smokers in the process of quitting smoking demonstrate no exacerbation of psychiatric symptoms (Baker et al., 2006; Hall et al., 2006; Morris, 2009). Inpatient treatment centers that have gone tobacco-free report improved health of patients and cleaner grounds/environment. Banning smoking reduced seclusion and restraint, decreased coercion and threats

among patients and staff, and increased availability of tobacco cessation medication (National Association of State Mental Health Program Directors, 2007). Studies from multiple countries substantiate this U.S. study in finding that smoking bans have no negative effect on psychiatric symptoms or management in treatment units (Iglesias, López & Alonso, 2008; Kitabayashi et al., 2006; Lawn & Pols, 2005).

Tobacco Use Reduction

Some persons with behavioral disorders will be ready to set a quit date; for others, cutting down before eventual cessation may be more realistic. There have not been tobacco reduction studies for persons with behavioral health disorders, but several reviews of studies for the general population found that a gradual approach to cessation which included counseling and medications led to later cessation (Cincirpini, Wetter & McClure, 1997; Fagerström, 2005; Hughes & Carpenter, 2006). Greater future cessation rates have also been found among smokers who switch from daily to non-daily use (McDermott, Dobson, & Owen, 2008). None of the studies reviewed found that reduction undermined later cessation. A Finnish study followed adult twins across a 15-year period to determine if reduction in tobacco use predicted later smoking cessation (Broms, Korkonen, & Kaprio, 2008). The study concluded that individuals who reduced use by 25% over a 5 year period were more likely to quit 10 years later, a finding which is consistent with several similarly designed studies (Falba, Jofre-Bonet, Busch, Duchovny, & Sindelar, 2004; Hughes, Cummings, & Hyland, 1999).

The Evidence for Quitlines

Quitlines are a primary tobacco cessation resource with demonstrated effectiveness (Anderson & Zhu, 2007; Stead, Perera, & Lancaster, 2007; Zhu et al., 2002). These telephonic services are widely available to all tobacco users in the U.S. and Canada, and generally offer some combination of counseling and cessation medications. In 2008, 70% of U.S. quitlines provided cessation medications (NAQC, Unpublished Data). Quitlines improve cessation rates by increasing the percentage of smokers making a quit attempt and reducing the probability of relapse (Cummins, Bailey, Campbell, Koon-Kirby, & Zhu, 2007a; McAfee, 2007; Zhu, et al., 2002). A recent Cochrane Review shows a pooled odds ratio of 1.41 for quitline counseling compared to self-help materials (Stead, et al., 2007). Quitlines attract clients across a range of ethnic, socio-economic, geographic, and psychiatric backgrounds, including clients at various stages of recovery from chemical dependency.

Quitlines have demonstrated the potential to overcome common barriers to access such as transportation and cost (Zhu, Anderson, Johnson, Tedeschi, & Roeseler, 2000), and have successfully extended the reach of more traditional programs (Zhu, Rosbrook, Anderson et al., 1995). That said, barriers to using quitlines do still exist, and far too few smokers avail themselves of this free service (Gilpin et al., 2001). In Fiscal Year 2009, 1.2% of tobacco users accessed telephone quitlines, and a median of 0.7% of tobacco users received evidence-based services through quitlines (i.e., counseling or medications). (2009 NAQC Annual Survey). Funding is clearly an issue. With the recent poor economic climate, many quitlines have faced significant cuts resulting in less funding for promotions and services. In addition to funding limitations, a recent study of the general population found that many people did not use the quitline due to a distrust of the quitline staff's intentions (Solomon et al., 2009). This suggests a need to address the credibility of quitlines and/or demystify quitline staff's work.

Many quitlines acknowledge that a significant number of the over 400,000 U.S. callers every year have either diagnosed or undiagnosed mental illnesses. The prevalence of current mental illness among quitline callers ranges from 19%- 50% (Canadian Smokers' Helpline, 2009 unpublished data; Hrywna et al., 2007; Kreinbring & Dale, 2007; McAfee, Tutty, Wassum, & Roberts, 2009; Tedeschi, Zhu, & Herbert, 2009). The California Smokers Helpline found that approximately half (48.9%) of callers report having at least one mental health issue, broken down as follows: Depression (36.9%), Anxiety (27.8%), Bipolar Disorder (16.1%), Schizophrenia (7.1%), and Drug/Alcohol (5.2%) (Zhu et al, 2009 unpublished data). Preliminary findings from a recent study of the Canadian Smokers' Helpline found a strikingly similar breakdown of diagnoses among those reporting mental health disorders- the most common disorders were clinical depression (39%), anxiety (26%), bipolar (11%), drug/alcohol abuse (7%), and schizophrenia (5%) (Canadian Smokers' Helpline, 2009 unpublished data for Ontario).

While there have been no published studies exploring the effectiveness of quitlines in treating smokers with behavioral health issues, there have been a handful of abstracts that suggest that quitlines can significantly intervene with this population. Several quitline studies have found self-reported 7-day abstinence rates for persons with mental illnesses to be equivalent to general callers at the end of treatment and at 6 months (Hrywna et al., 2007; Kreinbring & Dale, 2007; Tedeschi et al., 2009). Interestingly, callers to the California Smokers' Helpline reporting mental health issues received counseling and used NRT at higher rates (84% vs. 74% received as least one counseling call; 41.7% vs. 33.3% used NRT). There was no difference in quit attempts (56.4% for mental health callers vs. 53.1% for non-mental health callers) or quitting success using 30-day point prevalence at 2 months (19% for mental health callers vs. 20.8 % for non-mental health callers) (Zhu et al, 2009 unpublished data). Recent data from Colorado also found that persons with mental illnesses use the quitline and NRT at a greater rate than the general population, but also self-report that they have a lower chance of quitting (Colorado Department of Public Health and Environment, 2009 unpublished data). A randomized study of persons treated in public mental health systems showed that quitline counseling plus nicotine replacement therapy led to a significant reduction in self-reported number of cigarettes smoked per day (Morris et al., 2009). Another recent study by Free and Clear Inc. asked callers to answer a two-item measure regarding depression (Patient Health Questionnaire 2), as well as the question "do you have emotional or mental health challenges that you think will make it hard for you to quit tobacco?" Those who endorsed the emotional or mental health challenges question were less likely to be quit at six months (14.7 vs. 25.3%), but answers to the PHQ-2 were not predictive of quit status. Those who answered "yes" to the emotional/mental health question and who also had moderate or greater depressive symptoms reported very low 30-day abstinent rates, compared to participants who said "no" to the question but had mild or less depressive symptoms (9.1% vs. 23.9%) (McAfee et al., 2009).

Although more research is warranted, preliminary data suggest that persons with behavioral health disorders may be more apt to use quitline services. Moreover, the effectiveness of quitline services for these individuals are very similar to outcomes demonstrated for all quitline callers.

III. Salient Issues

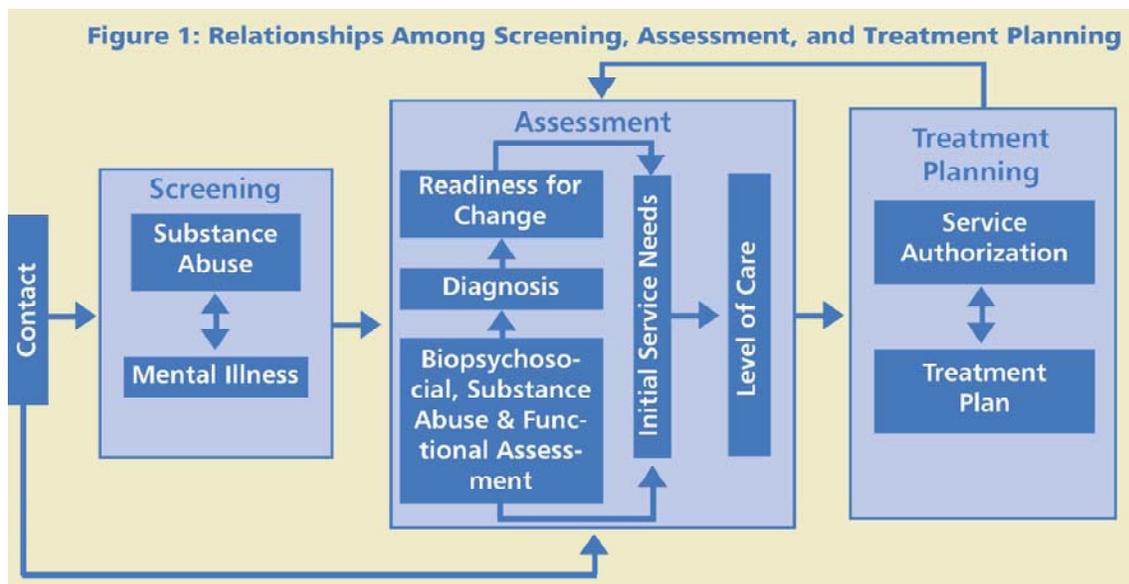
Screening

Forum members reported potential pros and cons regarding quitlines' screening for behavioral health conditions. At a general level, there first has to be consensus regarding how screening is defined. "Screening" can denote a diagnostic measure, while for others it may also refer to simple self-report. Other potential concerns regarding screening are: 1) Quitline tobacco treatment specialists may be unprepared to handle identified behavioral health issues, 2) There may be associated licensure and scope of practice issues, 3) Quitline staff may not refer persons screened positive for behavioral health issues to needed community resources (e.g., crisis lines, community mental health centers), 4) Screening questions may be improperly used, 5) There may be uncertainty regarding the duty to treat individuals when behavioral issues are identified, and 6) Both quitline staff and callers may feel burdened by additional questions. We address many of these concerns below.

As a foundation for further discussion, "screening" and related terms are operationalized. Several key definitions assist in differentiating between terms (Center for Substance Abuse Treatment (CSAT), 2005):

- **Screening** is a formal process that typically is brief and occurs soon after the client presents for services. It determines the likelihood that a client has a behavioral health disorder or that presenting signs, symptoms, or behaviors may be influenced by substance abuse and/or mental health issues. The screening process does not necessarily identify what kind of problem the person might have or how serious it might be, but determines whether or not further assessment may be warranted.
- **Assessment** gathers in-depth information and engages in a process to establish (or rule out) the presence or absence of a disorder.
- **Treatment (Service) Planning** develops a comprehensive set of staged treatment interventions adjusted as needed to take into account issues related to multiple disorders (e.g., tobacco dependence concurrent with other behavioral health issues). The plan is matched to the individual needs, readiness, preferences, and personal goals of the client.

Screening, assessment, and treatment planning are not stand-alone activities (COCE, 2007). Clients are best served when screening, assessment, and treatment planning are integrated, addressing both tobacco dependence and other behavioral health disorders. *Figure 2* provides an overview of this relationship



Substance Abuse and Mental Health Services Administration (SAMHSA), 2007

There was consensus among forum members that, outside of tobacco dependence, quitline tobacco treatment specialists should not be assessing (i.e., diagnosing and/or treating) behavioral health disorders. Diagnosis would fall outside of quitline tobacco treatment specialists' scope of practice and might also have licensure implications. At the same time, there are seldom any legal or professional restraints on who can be trained to conduct a screening (SAMHSA, 2007). **A wide spectrum of healthcare professionals screen for behavioral health issues in community settings. Similarly, with proper training, quitline tobacco treatment specialists are able to appropriately screen for behavioral health disorders.**

The North American Quitline Consortium (NAQC) recommends that the initial call include a minimum data set that assesses, among other things, basic demographics, smoking status, and tobacco dependence (Campbell, Ossip-Klein, Bailey, & Saul, 2007). While these questions are important for helping callers get the tobacco related services they need, they do not specifically address behavioral health status. Although quitline personnel have not reached consensus on the best way to assess for mental health issues, several quitlines have developed protocols which include either direct or indirect inquiry. Indirect inquiry, with questions such as, "Are you taking medication for any reason? Are you currently attending counseling or recovery meetings?" can yield useful information but may not provide the most accurate mental health picture. Direct inquiry, which involves adding one or more specific questions on psychiatric health to the standard intake procedure, can provide more accurate information. There is clearly a need to balance how many questions might be proposed with the demands extra questions place on callers and quitline resources. Recent research has shown that one- or two-item screeners are effective in identifying those at risk for behavioral health disorders (Brown & Papasouliotis, 2001; Canagasaby & Vinson, 2005; Fleming, 2004/2005; Kroenke, Spitzer, Williams, 2003). Because the screener questions can be answered in seconds, they can be asked during routine calls. Computerized screeners can also be effective when time is limited. **Table 2** presents the multiple strategies for quitlines.

Table 2. Brief Screening Strategies for Behavioral Health

Strategy or Instrument	Description	Screening Questions
Self report of major conditions	Broad questions regarding conditions that might affect callers' ability to quit. This might include a list of chronic conditions	<p>"In the last year have you received treatment for (specific chronic care condition)?"</p> <p>"Do you have (or have you had) a mental health issue (such as depression)?"</p>
<p>Patient Health Questionnaire (PHQ) (Spitzer, Kroenke, & Williams, 1999)</p> <p>Alcohol & Drug Screen (Brown et al, 2001)</p> <p>Drug Abuse Problem Assessment for Primary Care (DAPA-PC) (Holz, Landis, Nemes, Hoffman, 2001; Nemes et al., 2004)</p>	<p>The PHQ is a self report measure of depression. There are multiple versions of the PHQ that use 2, 8, or 9 questions</p> <p>The DAPA-PC is an 12-item Internet-based, self-administered screener for alcohol and drug use that scores patient responses, generates a patient profile for the healthcare provider, and offers motivational strategies</p>	<p><u>PHQ-2</u> "Over the past 2 weeks, have you felt down, depressed, or hopeless?" and "Over the past 2 weeks, have you felt little interest or pleasure in doing things?"</p> <p><u>Alcohol & Drug</u></p> <p>In the last year: 1) Have you ever drunk alcohol or used drugs more than you meant to? 2) Have you felt you wanted or needed to cut down on your drinking or drug use?</p> <p>Item examples: 1) Have you felt that you use too much alcohol and/or other drugs? 2) Have you tried to quit, control, or reduce your drinking and/or other drug use?</p>
Current Functioning	Questions of present functional status or expectation of how quit attempts will affect functioning.	"Do you have any mental health issues that might affect your quitting, such as an anxiety disorder, depression, schizophrenia, bipolar disorder, alcohol or drug problem?"

Quitlines have found that asking callers brief questions at first contact (intake) about their mental health was acceptable in a real world treatment setting (Morris et al., 2009). Thus far, it appears that questions tracking callers' perception of how behavioral health issues will affect the ability to quit have the strongest association with quit rates (e.g., McAfee et al., 2009). Because callers may not expect mental health questions from a tobacco quitline, it is important to make clear that the reason for asking is the known

relationship between smoking and mental health, and that the answers to these questions will equip quitline staff to offer the most appropriate services possible.

When screening for specific diagnoses, quitlines have often chosen to focus on depression (see *Table 2*). Due to the high expected prevalence of depression among callers (Breslau et al., 1998), this approach makes sense, but is also limited. In comparison to the general population, callers will also be expected to have high prevalence of other affective disorders (e.g., bipolar disorder), anxiety, psychotic disorders, and alcohol and drug dependence. Depression screening, when utilized alone, will miss these other common chronic disorders.

There are potential abuses and appropriate uses of screening findings. The potential exists that quitlines could use screening as a means of identifying and excluding persons with behavioral disorders from the range of services available to the general pool of callers. This is fear that some quitline callers may have and is a practice with which forum members strongly disagree. Screening might be appropriately used to inform quitline counseling and/or community referral, both of which are discussed below.

Counseling

If callers have diagnosed or undiagnosed behavioral health issues, there are implications for telephonic interventions. Even if clients are not currently in psychiatric distress, it is vital to reinforce their existing support base and to help them build support for quitting. It has been forum members' experience that clients with stable symptoms who have sufficient professional or personal support are most appropriate for the quitline setting. **However, all motivated callers, even those lacking psychiatric stability, should still receive counseling and pharmacotherapy to the degree possible.**

A key factor in counseling is current reported level of functioning, particularly psychiatric stability. Stable functioning, as defined by the expert advisory committee for the Bringing Everyone Along project (Tobacco Cessation Leadership Network, 2008), is "the absence of current acute major life or medication changes" (p. 10). Tobacco treatment specialists can determine psychiatric stability during calls through open-ended questions such as, "How stable are your mental health symptoms currently? Are you currently in any mental health or substance abuse treatment? How is the treatment going for you? How often are you in touch with your health care provider?" If clients exhibit psychiatric health concerns such as severe depression or symptoms of psychosis, then quitline staff must help to connect these clients to a health care provider in the same manner that referrals would be made for physical health or chronic care concerns. Past experience with quit attempts will also inform counseling. By asking "When you quit smoking before, what changes, if any, did you notice in your mental health symptoms or substance abuse?", tobacco treatment specialists might open a collaborative discussion with callers for effective planning. Clients and tobacco treatment specialists can then devise strategies for trigger situations that were problematic in the past.

Services may need to be tailored to individual needs and functioning. Some persons with behavioral health issues may benefit from alterations to standard quitline protocols. For example, callers with impaired cognitive functioning may have difficulty processing abstract concepts. Rather than focus on insight, counseling for this clientele might address the development of basic life skills or assistance with pre-existing skills. Gradual pacing, visual aids, and repetition are helpful (CSAT, 2005). It is beneficial to ask reasons for any non-adherence such as increased side-effects, and then to follow with problem-solving. These individuals, like all quitline callers, need reminders to use cessation medications and also benefit by regular discussion of the rationale for both counseling and cessation medications. It is expected that life functioning, for the better or worse, will often change after intake. Quitlines might consider asking questions regarding changes in behavioral health functioning since enrollment, such as "Since you began receiving quitline services have mental health issues or alcohol/drug use changed?"

Other alterations may better serve clients with psychotic disorders. A recent Cochrane review suggests that a cognitive-behavioral approach, as compared to a supportive therapy approach, is efficacious for these clients, though the authors caution that more research is needed (Buckley, Pettit, & Adams, 2007). Quitline counseling usually relies heavily on behavioral change strategies that include cognitive techniques. For clients with psychotic disorders, quitline staff might start by addressing only two main ideas, motivation and planning, using a cognitive-behavioral approach. Rather than discussing insight-oriented issues such as underlying reasons for behaviors, quitline staff can keep the focus on identifying a clear reason to quit and on planning specific strategies (including pharmacotherapy) to deal with cravings and triggers. During planning, staff can also stress the need for clients to be in touch with primary health and mental health care providers for added support and monitoring.

Brief interventions are very appropriate for this population (Bernstein et al., 2005; Lang, 2003; Whitlock et al., 2004), and may have the best chance for success. For general populations, pre-quit calls range from 30-40 minutes and usually end with the tobacco treatment specialist helping the client to set a quit date. Follow-up calls usually last only 10-15 minutes. The mean number of planned quitline sessions nationally is around five, although the average completed calls is approximately two (Cummins, Bailey et al., 2007). However, our experience is that cessation calls may need to be shorter and more frequent for clients with psychiatric health issues, especially for lower functioning clients. Reviewing too many topics during any one session may overwhelm the client. Focusing on just a few topic areas increases the client's chances of retaining the information and applying it as intended. Furthermore, pushing a client with psychiatric health issues to set a quit date during the first call could be counterproductive. A protracted schedule with more frequent calls prior to and during the quitting process may be more appropriate. Still, working toward a quit attempt must remain the goal. It is also worthy of note, that many individuals with behavioral health disorders have difficulty accessing phones, and more frequent calls might compound this issue.

Staff Training and Supervision

Quitlines will each need to decide how much specific attention to pay to behavioral health disorders versus other chronic conditions when developing interventions. But attention to staff training and supervision needs regarding callers with mental illnesses and substance abuse disorders can minimize barriers to effective service. Quitline staff should not be expected to diagnose, but rather to build quit strategies which match the functional abilities and motivational readiness of callers. Anecdotally, many quitline tobacco treatment specialists consider clients with reported or apparent psychiatric disorders time consuming and challenging: many of these clients need longer and more frequent calls, and they may have lower motivation or ability to follow through. At the same time, quitline staff, consisting of both professionals and paraprofessionals, may have little mental health background. Some quitline tobacco treatment specialists are professionally trained behavioral health providers or recipients of continuing education related to working with these clients, but most are not. Mental health and substance use counseling skills are typically not hiring criteria at quitlines. Even tobacco treatment specialists with behavioral health experience can find the telephone setting different from previous work environments. These gaps can leave staff at a loss when callers present with psychiatric symptoms and/or substance abuse. Additional skills and approaches are often necessary to work effectively with such persons. Targeted training may not only improve client outcomes, but also increase staff morale.

Initial staff training should be augmented by continuing education and supervision. Such training should include:

- Basic understanding of the interaction between mental illnesses, substance abuse and tobacco dependence,
- Orientation to how persons with behavioral health disorders present on calls,
- Brief screening tools,

- Motivational and cognitive behavioral therapy strategies,
- Procedures for making referrals to community resources.

This is consistent with Center for Substance Abuse Treatment (2005) recommendations for continued competency work for dual disorders. Potential areas of emphasis are integrated treatment planning, engagement and education, and integrated treatment methods. At a basic level, quitline tobacco treatment specialists are often personally uncomfortable with working with persons with behavioral health issues. **Tobacco treatment specialists generally need practice in talking about these disorders in a matter-of-fact way—as treatable conditions—to put the patient at ease and encourage cooperation.** There is often a fear that asking questions about behavioral issues will cause exacerbation of symptoms and even suicidality, but this has not been found to be the case (Gould et al., 2005). Tobacco treatment specialists will be most effective when displaying patience, persistence, and optimism.

Ongoing supervision is needed to help staff develop skills in creating and maintaining rapport and building realistic quit goals. Quality improvement strategies might include periodic role-playing and shadowing to assist quitline workers in continuing to develop skills in working with persons with mental illnesses. Live call monitoring and recorded call review by behavioral health experts may also be helpful. Supervisors will also need to insure that quitline materials are appropriate to the literacy and cognitive levels of the individuals served (Anderson & Zhu 2007).

Evaluation and Research

A full program of formative and summative evaluation should be conducted for quitline programs treating callers with behavioral health disorders. Formative evaluation aims for program improvement and can include both process and outcome evaluation. Potential topics for process evaluation include assessing whether strategies were implemented as planned and if the anticipated outputs were produced. Process evaluations often focus on the context of a program, including intervening events, the program's path of development, its costs, and monitoring of program operations and implementation. Outcome evaluations monitor program effectiveness. Summative evaluation, in contrast, only examines the effects of a program – in terms of intended or unintended outcomes, cost-effectiveness or cost-benefit analysis, etc. Specific evaluation questions may include determining the optimal number of contacts, length of average calls, effective content for calls, and satisfaction for both callers and quitline staff.

The North American Quitline Consortium (NAQC) has established some guidelines for the evaluation of Quitline programming that may be used as a template for conducting evaluations of interventions of callers with behavioral health disorders. Adding evaluation elements specific to treating callers with behavioral health disorders to NAQC's recommendations may be an important intermediate goal, once evidence from process and outcome evaluations of tobacco cessation treatment interventions for callers with behavioral health disorders has been accumulated. Future additions might include a standardized optional screening question at intake, as well as a question on the follow-up survey.

Organizational data infrastructure is needed to support the process and outcome evaluations described above. As with other chronic care programs, clinical information systems for quitlines are a key component that drive decision support (Wagner, et al., 2001). Information technology, data, and evaluation sections must accommodate new screening and follow-up domains and have the capacity to report back to the quitline and possibly to community providers.

Community Referral

Quitlines are most effective when working in coordination with other providers. Studies suggest that formal partnerships and referral mechanisms may decrease client ambivalence, give clinicians more confidence in clients' follow through, and lead to a ten-fold increase in quitline utilization (Cummins, Zhu, Tedeschi, et al., 2002; Sherman, Takahashi, Kalra, & al, 2004). Collaborative treatment is aligned with the principle of "no wrong door" (CSAT 2000). This is the notion that providers across all sectors of health service have a responsibility to be a point of access for each person's healthcare needs. For quitline callers presenting with other chronic conditions including behavioral health disorders, this would involve effectively guiding callers to appropriate community services. Use of mechanisms such as fax referrals from community providers allows quitlines to call potential clients proactively (Borland & Segan, 2006). Formal linkages with behavioral health providers also further assure quitline personnel that comorbid mental health and substance abuse issues are being monitored appropriately, making quitline programming for this population more attractive. It must be noted, that many callers are uninsured and the community healthcare services for these individuals are typically limited and difficult to access. Although quitlines can aspire to make appropriate referrals, the state of national healthcare coverage will often dictate what is possible.

Organizational Implications

Organizational concerns exist among quitlines that are contemplating an increased focus on callers with behavioral health conditions. A common concern is that quitline staff may begin to operate outside their scope of practice. There is also some trepidation regarding how identification of behavioral health issues may increase legal exposure, lead to mission drift, or incur greater program costs.

Scope of practice issues must be addressed. This can be accomplished through continuing education that clearly defines quitline staff roles and how these roles are differentiated from behavioral health counseling. For example, in addition to requesting cessation strategies, callers in distress may indirectly or directly request behavioral health services from quitline tobacco treatment specialists. Quitline staff must be prepared to clarify service limitations and provide referrals as appropriate. Quitline tobacco treatment specialists can be assured that if they remain within their defined scope of practice, they would not be considered psychiatric providers of record, any more than they would be considered cardiac care specialists for callers with a recorded history of heart disease.

Quitline personnel must weigh program change against the organization's mission and strategic plan. Although persons with mental illnesses and substance abuse disorders are clearly already using quitline services, the creation of specialty programming may call for alterations to the organizational mission. Explicitly including specialty populations in the mission statement can help to ensure that when quitline staff identifies members of this population, assessment and specialized intervention will follow. This has been the case with other target populations, such as youth and pregnant tobacco users (Cummins, Tedeschi, Anderson, Quinlan-Downs, Harris et al., 2007; Tedeschi, Zhu, Anderson, Cummins, & Ribner, 2005). Nationally, the average number of quitline calls per client is approximately two. Given the limited use of available services, quitlines need to determine how to integrate any new treatment content in a small number of contacts or increase the overall number of calls per client.

What is the legal exposure for a program that identifies problems in the screening process for which the program cannot provide treatment, and do we need additional permission to ask behavioral health questions? Being a new area of interest, there are no known legal precedents to address this concern. If we base assumptions on current quitline operations, telephonic programs are not expected to be able to treat every type of disorder, even if those disorders are identified by the program's screening and assessment procedures. Screening questions for behavioral health can be approached in the same manner, and with parity to, screening and procedures for other chronic care conditions. There is also the common perception that callers with behavioral health disorders have greater potential for suicidality

and/or homicidality. While there is no evidence to suggest that these callers have higher rates of suicide or homicide risk when compared to the general population of callers, many quitlines do and should have related emergency protocols in place.

With 45 million uninsured persons in the U.S. (Institute of Medicine, 2003), many callers with behavioral health disorders will not have primary care providers, much less specialty psychiatric or substance use care. To avoid negative legal consequences and fulfill ethical obligations to clients, the Substance Abuse and Mental Health Services Administration (SAMHSA) recommends that agencies that screen then refer to appropriate services (SAMHSA, 2007). While a few quitline programs have developed special protocols for callers with mental illnesses and substance abuse, most are just beginning to consider approaching behavioral health conditions just as they do other chronic conditions. Quitlines can partner with behavioral health treatment programs, just as they do with chronic disease programs to treat tobacco users who have diabetes, asthma, cancer, heart disease, stroke, and other conditions (North American Quitline Consortium, 2007). Quitlines can also work closely with state Medicaid and Medicare offices to insure that tobacco cessation services are a covered benefit for these individuals, and that information regarding quitline services is being disseminated.

As the scale of the health disparities of persons with behavioral health issues becomes increasingly evident, a compelling case can be made based on the dramatic morbidity and mortality statistics presented above. However, the potential cost effectiveness of quitlines diverting resources to treat persons with mental illnesses has yet to be studied. Many of these individuals are high utilizers of services (e.g., Chapman, Perry, & Strine, 2005; Moon & Shin, 2006; Thomas, Waxmonsky, Gabow, Flanders-McGinnis, et al., 2005). Though smoking prevalence rates in the general population continue to decrease, they remain high for persons with mental illnesses (Lasser, et al., 2000). There appears to be a “hardening of the target,” in which the remaining tobacco users are concentrated in the lower socioeconomic classes, are more nicotine dependent, and have more medical and psychiatric comorbidities (Lasser, et al., 2000; Schroeder, 2007).

Table 3. Current Quitline Practices Regarding Callers with Behavioral Disorders

Quitline Comparison Table						
Quitline	Screening Procedure	Specialty Treatment or Referral	Specialty Staff Counseling Training	Perceived Strengths of Strategies	Perceived Risks of Strategies	Data Elements Collected
Arizona Smokers' Helpline (ASHLine)	Yes. Included in the chronic illness assessment. Treatment for chronic illness in the last year. Is the person using medications to control symptoms.	<ul style="list-style-type: none"> Usual treatment for most clients. Assignment to one of the behavioral health specialists for harder to serve clients. 	<ul style="list-style-type: none"> Licensed behavioral health therapists on the call staff. General training regarding behavioral health issues and tobacco quitlines for all tobacco treatment specialists. 	<ul style="list-style-type: none"> Availability of BH Staff Increased Engagement Increased Retention 	None	<ul style="list-style-type: none"> Treated for mental health issue in last year. Currently using medications for mental health symptoms.
California Smokers' Helpline	Yes – anxiety, depression, bipolar disorder, schizophrenia, alcohol or drug problem, drinking in the last month	<ul style="list-style-type: none"> Encourage engagement with PCP Referral to county mental health and/or crisis/suicide hotline as clinically appropriate 	<ul style="list-style-type: none"> A clinical psychologist is on staff. New hires receive 2-3 hours of training including a review of major behavioral health diagnoses, myths & facts, psychiatric stability & treatment, quitting history & symptoms, biochemical factors, call content, length & number, tobacco treatment specialist style, and referral procedures 	<ul style="list-style-type: none"> Alerts tobacco treatment specialists to use screening questions Encourage clients to see PCP Tobacco treatment specialists assist with the referral process by providing contact information for mental health services or directly making a connection via three-way call 	<ul style="list-style-type: none"> Clients may only opt out of service referrals Mental health status in recorded at intake but this information does not trigger additional services for those who do not engage in telephonic counseling (e.g., callers requesting materials only) 	<ul style="list-style-type: none"> Yes – self-reported MH issues; Received at least one counseling call; NRT use; Number of quit attempts

Quitline Comparison Table						
Quitline	Screening Procedure	Specialty Treatment or Referral	Specialty Staff Counseling Training	Perceived Strengths of Strategies	Perceived Risks of Strategies	Data Elements Collected
Ontario Smokers' Helpline	Yes- asks about mh conditions. if "drug/alcohol abuse" is selected then the additional question "Have you been actively using/drinking in the last month" is asked.	<ul style="list-style-type: none"> • If the caller is having cognitive difficulty or being tangential, the counseling is simplified to 1-2 goals • Referral to the Canadian Mental Health Association if they do not already have mh providers. • If requested and available, callers are also referred to a database of community resources maintained by the Canadian Cancer Information Service for local cessation related services. 	<ul style="list-style-type: none"> • Staff receives training at orientation and as continuing education regarding working with persons with mental illnesses. • Regular training is provided to address staff turn-over. • Protocols are in place to manage high utilizers/ habitual callers, many of whom have mh disorders. 	<ul style="list-style-type: none"> • Staff is better informed of client condition(s) that may affect their quitting. • Can reinforce the need for client to consult their physician prior to quitting (in case medications need to be adjusted or if ongoing monitoring is required). • Reinforce precautions around using certain cessation medications (e.g. Champix.) • Callers are better informed of community resources. • Preliminary data suggests that these callers are doing just as well as other callers and may use more counseling sessions. 	<ul style="list-style-type: none"> • There is the possibility that once mh is screened for, some staff could be biased against these individuals. However, staff training addressing tobacco treatment specialist bias can help to minimize this risk. 	<ul style="list-style-type: none"> • Track number of callers with current anxiety, bipolar disorder, clinical depression, drug/alcohol abuse, eating disorder, schizophrenia, and other.

Quitline Comparison Table						
Quitline	Screening Procedure	Specialty Treatment or Referral	Specialty Staff Counseling Training	Perceived Strengths of Strategies	Perceived Risks of Strategies	Data Elements Collected
Free & Clear Inc.	No – but conducting a pilot with depression items and a functional question	<ul style="list-style-type: none"> Encourage coordination with health care providers Deliver local resource information 	<ul style="list-style-type: none"> A clinical psychologist and two physicians are on staff. A series of mental health trainings are provided to tobacco treatment specialists Long-standing, effective crisis protocol that addresses mental health situations such as severe depression, suicidal thoughts and intent. 	<ul style="list-style-type: none"> Training of tobacco treatment specialists helped them become more comfortable Real-time protocol for tailoring support and referring to resources Support in line with scope and practice of the tobacco treatment specialist role 	<ul style="list-style-type: none"> Limited impact on mental health symptoms and quit outcomes Heighten awareness of mental health symptoms among participants without access to mh resources Greater volume of callers with behavioral health issues 	<ul style="list-style-type: none"> Emotional and mental health challenges to quit; Depressive symptoms (PHQ2); Therapeutic alliance (Empathy Scale); Call length, Number of calls completed, 6-month cessation rates

Quitline Comparison Table						
Quitline	Screening Procedure	Specialty Treatment or Referral	Specialty Staff Counseling Training	Perceived Strengths of Strategies	Perceived Risks of Strategies	Data Elements Collected
National Jewish Health	Yes – one question for one State client- “In the past 12 months, have you received counseling, treatment or medication for a mental health, emotional or behavioral problem?”	<ul style="list-style-type: none"> Encourage engagement with PCP 	<ul style="list-style-type: none"> Specialty Training for Tobacco treatment specialists from the University of Colorado, Behavioral Health & Wellness Program A licensed psychologist and two physicians are on staff A crisis protocol addresses emergency situations such as gravely disabled callers, and suicidal and homicidal thoughts and intent 	<ul style="list-style-type: none"> A licensed psychologist attends to mental health concerns Addressing the needs of individuals who are in danger of harm to self or others by making appropriate referrals 	<ul style="list-style-type: none"> Awareness of the large number of mental health concerns among callers and the limited resources for those callers 	For some contracts- <ul style="list-style-type: none"> Depressive symptoms (PHQ2) An additional question regarding whether or not mental health issues may affect callers' ability to quit

Quitline Comparison Table						
Quitline	Screening Procedure	Specialty Treatment or Referral	Specialty Staff Counseling Training	Perceived Strengths of Strategies	Perceived Risks of Strategies	Data Elements Collected
Healthways QuitNet	<p>None in place for current state clients.</p> <ul style="list-style-type: none"> Gallup-Healthways Well-Being Assessment emotional well-being questions (stress, depression, anger, health perception) asked of many employer and health plan populations. Have proposed both PHQ2 and a current functioning question to current state clients. 	<ul style="list-style-type: none"> Encourage participation with PCP Refer to local mental health programs Referral to online support group community Specialized coaching within broader well-being programs (no quitline clients currently participate in these programs) 	<ul style="list-style-type: none"> General training includes education on co-morbidities of behavioral health issues and tobacco use/abuse Crisis protocol for suicidal ideation 	N/A	N/A	N/A

IV. Current Practices

Table 3 provides description of some of the current practices of quitlines that participated in this report or answered a call for information from NAQC in early 2010. In addition interested quitlines provided the below short descriptions of current practices:

California Smokers' Helpline

Since November 2008 intake staff at the California Smokers' Helpline has asked callers a self-report question about behavioral health. Each caller is asked if they have a current mental health issue such as an anxiety disorder, depression, bipolar disorder, schizophrenia, and drug or alcohol problem. If a caller endorses drug or alcohol problem staff follows up by asking if the caller has been actively using/ drinking in the last month. For clients who go on to counseling, behavioral health status does trigger assessment for symptom stability, mental health treatment history, medication use, and current treatment compliance. They also ask about previous quit experience as it relates to clients' psychiatric symptoms as that gives some idea of what clients will face in the current quit attempt. The Helpline encourages clients to reconnect with their primary care provider during the quitting process (or seek treatment if needed), and advises clients who are taking medications to talk with their prescribing physician before quitting, to address how changes in smoking status might impact blood levels and potency of certain medications. As a rule, for lower functioning clients, each call is somewhat abbreviated, concrete, supportive-therapy focused, and done with the recommendation for concurrent contact with a primary health care provider. New hires receive 2-3 hours of training on behavioral health and smoking cessation issues for a quitline setting and veteran staff receive continuing education and case reviews provided by the clinical director, a licensed psychologist. These clients may also receive more calls over a longer period of time as the quit process can be protracted. California is now considering development of materials for clients with behavioral health issues and looking to use the PHQ-8 to screen for depression and then explore treatment outcomes for those who have a positive screen compared to callers who do not.

Arizona Smokers' Helpline

Arizona's Bureau of Tobacco and Chronic Disease (BTCD) and the Division of Behavioral Health Services (DBHS) have begun an alliance to increase the awareness of the impact of tobacco on those with chronic mental health diagnosis. The two agencies met to discuss how changes could be implemented in the public behavioral health system to reduce tobacco use and increase health indicators for those served through the public health system. BTCD and DBHS in partnership with the Arizona Smokers' Helpline (ASHLine) convened a workgroup of decision makers from each of the Regional Behavioral Health Authorities (RBHA's) and the Arizona State Hospital to begin to develop a strategic plan to begin to include tobacco cessation services into the public behavioral health system. The ASHLine Outreach staff have begun meeting with individual providers under each of the RBHA's to discuss their commitments to increasing tobacco cessation services and utilizing the quitline as a primary treatment option for the people being served at their facilities. DBHS made a commitment to include tobacco cessation as one quarterly health indicator in 2010 and ask all funded facilities to increase awareness of the dangers of tobacco and services available through the ASHLine for all clients. This led to meetings with funded facilities including two large Consumer Service Agencies to discuss policy changes to increase tobacco cessation services onsite and include the ASHLine referral program in assessments. Efforts will increase to make consumers of services aware that quitting tobacco is a treatment issue, not a lifestyle choice, and any consumer may ask to have tobacco cessation added to

their Individual Service Plan. At the ASHLine, funds have been acquired to focus on providing more services to this vulnerable population. The enrollment process will change to capture mental illness as one of the chronic illnesses that are screened at intake. The ASHLine has also partnered with the Medication Management Program at the University of Arizona's College of Pharmacy to provide medication assessments for client and professionals who would like a review of medications and recommendations for medication adjustments for any client who is quitting tobacco and concerned about medication problems. The primary goal of focused efforts in Arizona's partnership with BTCD, DBHS and the ASHLine is to help behavioral health facilities acknowledge the dangers of tobacco, provide support to clients who indicate they wish to quit, and implement policy to include assessment and referral as a standard part of practice for all those who wish to quit. Efforts are also under way to make cessation medications easily accessible to this population.

Free & Clear Inc.

Free & Clear Inc. is not currently screening for behavioral health as a part of routine care, but will begin doing so in 2010. The quitlines did conduct a pilot program (n=500) in 2009 to assess for depression and tracked 6 month quit outcomes. This pilot included a functional question in addition to two depression measures (PHQ2 and OQ5). Findings showed that those who responded "yes" to the functional question (emotional or mental condition likely to interfere with their ability to quit and stay quit) and were symptomatic were significantly less likely to be quit at 6 months. Free & Clear provides training to staff on mental health conditions and their relationship to tobacco use and quitting. Tobacco treatment specialists are trained on communication "indicators" that may suggest the person has a mental health condition. Among others these may include a flat affect, tangential communication, etc. Tobacco treatment specialists are trained not to diagnose anyone based on these indicators but to take this information into consideration in developing their communication style and quit plan with each participant. Participants who self report a mental health condition are advised to inform their mental health provider of their intention to quit smoking and to have any mental health medication monitored to determine if dosage adjustments are necessary after quitting. Free & Clear provides medication decision support for all FDA approved quit medications. This process includes a screening for common mental health problems for those interested in using either bupropion SR (Zyban or Wellbutrin) or varenicline (Chantix).

National Jewish Health

National Jewish Health, in Denver, Colorado, collaborated with the University of Colorado Behavioral Health & Wellness Program in a study to evaluate smoking cessation for persons with mental illnesses who were provided QuitLine services in addition to their usual care. As part of this study, a team of National Jewish Tobacco treatment specialists were provided training in identifying and providing tobacco cessation support for those with mental illness who desire to reduce or eliminate their tobacco use. From this base of knowledge, National Jewish is now working with the Department of Health in Ohio to implement a program to identify callers to the Ohio Tobacco Quitline with mental illness utilizing a short questionnaire and to triage these individuals to appropriate local mental health care when needed. This program will help to identify the magnitude of callers to the Quitline with mental health problems. Another program which National Jewish is playing a role related to identifying those with mental health issues is with the ClearWay Helpline in Minnesota. That program utilizes a single question to screen callers. Our experience since September, 2009 with the single question (In the past 12 months, have you received counseling, treatment or medication for a mental health, emotional or behavioral problem?) for ClearWay indicates that close to 25% responded affirmative to this question. We will continue to evaluate the best ways to identify and respond to those tobacco users with mental health issues.

Healthways

Since January 1, 2008, Healthways has partnered with the Gallup Organization in administering the Gallup-Healthways Well-Being Index, a community-based survey which asks mental health questions of over 800,000 participants. Survey questions, which focus on depression issues and quality-of-life evaluation, are asked at quitline intake by some of our employer clients. Healthways QuitNet is not currently providing mental health screening for any of our state clients, though one of them will begin asking a 'current functioning' question beginning in July 2010; information gathered will help coaches interact more effectively with participants and make proper referrals when and if needed. All our quitline coaches receive training on co-morbidity, focusing primarily on the special obstacles confronting smokers with mental health issues.

V. Recommendations

There is growing evidence that a significant number of quitline callers have addictions and mental health disorders. We know that quitlines are already serving this population. The question is—“How can quitlines most effectively serve these individuals?” Based on the available empirical evidence, as well as the expert opinion of forum members, the below recommendations are being made. Additional research will inform other recommendations. Therefore, these recommendations are offered as a means toward further inquiry rather than the end goal. We anticipate that the direction offered below will need to be updated on a regular basis.

Screening

Quitlines are typically large public health programs that serve a large number of clients. Many quitline service providers have contracts with multiple states and organizations. Any added screening methods need to be practical and of high utility. The types of screening questions employed will be dependent upon the intended use. **It is recommended that if quitlines are screening for chronic care conditions for all callers, that behavioral health issues be included.** A behavioral health history can be general or include specific diagnoses (e.g., depression), with the expectation that available call time will limit the size of any screening instruments. Screening will allow for further characterization of quitline clients, and is a necessary first step toward pilot interventions.

It is recommended that a question or set of questions be developed and proposed to the NAQC Minimal Data Set workgroup for consideration as a standard optional question(s) for the Minimal Data Set. Adoption of such a question(s) would allow for interested quitlines to assess for behavioral health issues in a standardized way, which could provide an opportunity for conducting pilot or observational studies to address many of the research questions identified above. **One common strategy is to include 1-2 questions regarding callers' history of behavioral health issues and then another question tracking callers' perceptions of how behavioral health issues will impact quit attempts** (see *Table 2*). An example of this screening tool is:

1. “In the last year have you received treatment for (specific chronic care condition)?”
2. “Do you have (or have you had) a mental health issue (such as depression)?”
3. “Do you have any mental health issues that might affect your quitting, such as an anxiety disorder, depression, schizophrenia, bipolar disorder, alcohol or drug problem?”

Treatment

There have been no published studies regarding the effectiveness of quitline interventions tailored to persons with behavioral health disorders. Even so, assumptions can be made from the general knowledge base regarding tobacco cessation treatment among persons with behavioral health disorders and co-occurring or dual disorders treatment. **Generally, persons with mental illnesses and substance abuse disorders benefit by the same interventions as the general population. Therefore, a combination of counseling and pharmacotherapy should be used whenever possible, and the rationale for combined counseling and pharmacotherapy should be regularly stressed during treatment.** Some persons with behavioral disorders have cognitive difficulties or may exhibit psychiatric symptoms such as tangential thinking. This forum will continue to identify pragmatic strategies for most effectively working with these individuals. These suggestions will be integrated into future guidelines for tobacco treatment specialist training.

Staff Training and Supervision

Tobacco treatment specialists should receive regular training on behavioral health issues. It is important that quitline staff have a working understanding of how addictions and mental health issues are associated with tobacco use and impact tobacco cessation efforts. Provider training and accurate patient information must address unfounded but common concerns about potential interactions between cessation medications and other psychiatric medications, the fear that cessation attempts interfere with mental health or substance abuse recovery, and the inaccurate belief that tobacco cessation cannot occur concurrently with other substance abuse and mental health treatments. In addition to solo pharmacotherapy tobacco treatment specialists should understand the principles of guidelines-based combination pharmacotherapy and be able to discuss these with patients. They should also be aware of the effects of smoking and smoking cessation on commonly used psychiatric medications.

It is important to note that a current or lifetime mental health or addictions diagnosis does not equate with a certain functional status at any given point in time. Most persons with behavioral health disorders have full decision making capacity the majority of the time. Diagnoses such as anxiety and depression, which are often viewed as less serious than illnesses like schizophrenia and bipolar disorder, can actually lead to just as many functional deficits for longer periods of time. It is therefore important that quitline staff do not assume that persons who screen positive for specific behavioral health issues will have lower functioning and capacity to benefit by quitline services in comparison to the average caller. A positive screen does suggest that more assessment is necessary to determine what individualized quit strategies might be most effective (see *Figure 2*).

Quitline staff must have clear roles and responsibilities, and understand that their job does not involve diagnosing or treating behavioral health issues other than tobacco dependence. Due to natural staff turnover, sustainable training models should be explored, possibly with some combination of a train-the-trainer model and web-based continuing competency. **In the near future, this advisory group will work collectively to develop a standardized training curriculum for quitline tobacco treatment specialists.**

Evaluation and Research

Additional studies are needed to investigate strategies in actual clinical settings for persons with behavioral health disorders, including quitlines (Fiore et al., 2008; Flay et al, 2005; Ziedonis et al., 2008). There's a need to collect more information about this population and then determine most effective

means of intervening. Forum members encouraged pilot studies to increase the knowledge base in the following areas:

- Most effective means of screening for behavioral health disorders, as well as potential repercussions of screening for behavioral health disorders,
- Best means of preparing quitline staff to work with callers with substance abuse and mental health issues,
- Enhanced protocols for the behavioral health population and/or for specific diagnostic groups tested against standard care,
- Most effective nicotine replacement therapy and/or medication strategies for this population,
- How callers might be motivated to use a greater number of counseling sessions and pharmacotherapy,
- Recommended quitline service outcomes and indicators for this population (e.g., functional status),
- Treatment coordination with community providers.

There are additional unresolved questions regarding potential organizational and community change to support intervening with this population- some of these being:

- How can more clinical champions be recruited to promote the cause of smoking cessation?
- What is the proper balance between motivating smokers to quit while avoiding further marginalization of those who are unable to stop?
- What could be done to create robust advocacy groups around this issue?

Targeted pilot study will potentially accelerate the transfer of science to service for persons with behavioral health disorders. **Quitlines are encouraged to work together to develop studies where findings are generalizable across settings, and to determine the best means of rapidly disseminating findings through NAQC, SAMHSA, NASMHPD, and other national and/or professional associations.**

Community Referral

An interlinking network of cessation options is needed for persons with behavioral health disorders (Tobacco Cessation Leadership Network, 2008). Cessation services are delivered by primary care, mental health and substance abuse agencies, quitlines, and specialty cessation programs. Successful cessation interventions depend on community support of cessation attempts. Presently, quitlines typically receive referrals, but few make referrals out to services other than tobacco cessation programs. **Forum members recommend that quitlines develop bi-directional referral relationships with mental health and substance use providers/treatment programs.** It is to be expected that callers' follow through on community referrals will be low. Therefore, coordinated referrals are more likely to succeed.

Some of the principal organizations to consider are state mental health and substance abuse authorities, state councils of mental health and substance abuse agencies, advocacy groups (e.g., Mental Health

America, National Alliance on Mental Illness), community mental health and substance abuse clinics, local crisis/ suicide hotlines, and relevant university and college departments. Due to their high levels of dependence, smokers with addictive and mental health disorders may especially benefit from cessation medications. They may, however, have poorer access than most smokers and quitlines should consider providing information on resources for cessation medications including quitline benefits, state-specific Medicaid coverage, and pharmaceutical drug assistance programs. **A potential strategy would be to utilize NAQC's quality improvement initiative to develop a toolkit or guidebook to provide practical guidance to quitlines on how to establish effective care coordination with community behavioral health providers.**

Policy

At the organizational level, quitlines are encouraged to develop initiatives that target populations disproportionately affected by tobacco use- persons with behavioral health disorders being one such population. Such direction from leadership creates an environment conducive to raising awareness regarding health disparities and implementing novel strategies for standardized screening of behavioral health issues, treatment interventions, staff training, and coordination with community agencies.

Nicotine dependence is a chronic, relapsing disorder often requiring multiple attempts before individuals quit for good. Only 4-7% of unaided quit attempts (i.e., going cold turkey) are successful (Fiore et al., 2008). All clients, including quitline callers with diagnosed or undiagnosed behavioral health disorders, deserve access to proven treatments that significantly enhance the odds of cessation (Mottillo et al., 2008). This report offers background and recommendations for the role that quitlines might play in best assisting the many callers who have mental illnesses and substance abuse disorders.

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