Community Health Workers (CHWs) Increase Tobacco Cessation Among Adults with Serious Mental Illness (SMI)

Eden Evins, MD, MPH

Corinne Cather, PhD

Kristina Schnitzer, MD

Massachusetts General Hospital

April 26, 2022

SAMHSA
Substance Abuse and Mental Health Services Administration

MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Housekeeping Information

Participant microphones will be muted at entry

If you have questions during the event, please use the chat

This session is being recorded and it will be available by the next business day.

If you have questions after this session, please e-mail: newengland@mhttcnetwork.org.

Acknowledgment

Presented in 2022 by the Mental Health Technology Transfer Center (MHTTC) Network.

This presentation was prepared for the New England Mental Health Technology Transfer Center (MHTTC) Network under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA).

At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D, served as Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the Administrator of the Substance Abuse and Mental Health Services Administration.

The opinions expressed herein are the view of TTC Network and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this document is intended or should be inferred.

This work is supported by grants #1H79SM081775 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Presented 2022

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Community Health Workers (CHWs) Increase Tobacco Cessation Among Adults with Serious Mental Illness (SMI)

Listening Session – Tuesday, April 26

Eden Evins, MD, MPH

Corinne Cather, PhD

Kristina Schnitzer, MD

Overview

1. **Background –** Tobacco use in SMI
2. **Study Description** – *"A Randomized Trial of Provider Education and Community Health Worker Support for Tobacco Cessation for Adults with Serious Mental Illness"*
3. **Education** - myths/bias, practical tools for helping patients with SMI quit smoking
4. **Review pre-session survey**
5. **Discussion**

Background

- High rates of tobacco use disorder (TUD) in people with SMI drives a 25-30year mortality disparity
- <5% of smokers with SMI quit smoking with behavioral treatments alone
- In people with SMI who smoke, varenicline works, 19 - 42% short-term quit rates, is well tolerated, and is under-prescribed.

We tested the effect of 2 years of:

PE: education to primary care providers,

CHW: community-based CHW support, and

PE+CHW their combination

On Smoking Cessation rates at 2 years (biochemically-verified, 7-day point-prevalence tobacco abstinence)

and use of first-line TUD medication in a group of adults with SMI who qualified for psychiatric rehabilitation services, smoked tobacco, and didn't necessarily want to quit smoking.

Question

- When clinicians know the importance of providing effective TUD medication, can CHWs:
  - ✓ provide health education to raise the priority of smoking cessation as a goal,
  - ✓ reduce barriers to care from adverse social determinants of health,
  - ✓ assist with care navigation in fragmented treatment systems, and
  - ✓ promote treatment adherence and patient follow up?

- All adults with SMI from two large DMH-contracted psychiatric rehabilitation service agencies in Boston who smoked tobacco were eligible irrespective of desire to quit smoking.
- Primary care clinics were randomized to receive education to their clinical staff or not.
- Participants whose clinic received education were then randomized to CHW or no CHW.
- Thus, there were 3 arms: provider education + CHW, provider education alone, or treatment as usual

What did CHWs Do?

- Met with participants on a mutually determined schedule in their homes or neighborhoods to:
  - build trust and support identification of smoking cessation as a goal / alliance
  - assist with participant identified needs often associated with social determinants of health (rides, negotiating/paying bills, library card, groceries)
  - educate participants on safety and efficacy of smoking cessation medications
  - encourage trying TUD medications even if not sure they could quit
  - offer practical support for cessation, give rides to group meetings, assist at pharmacy, help initiate a home routine to improve medication adherence, etc
  - accompany to physician visits to help with communication

Results

- Participants randomized to PE + CHW were more likely to attain abstinence than those assigned to usual care (absolute difference 7%) or PE alone (absolute difference 5%)
- **Participants offered a CHW were >3x more likely to use varenicline, which nearly doubled the odds of year-two abstinence**.
- If tried varenicline with CHW, 21% chance of quitting.
- If tried varenicline without a CHW, 7% chance of quitting (same as no medication).

Impact of CHW on medication use and abstinence rates

CHW	Medication use[a]	# of participants		Observed Year 2 abstinence rates		Model-based predicted abstinence rates[b]
		N	%	%	n	%
No	None	331	64%	6%	20	7%
N=515	NRTs	123	24%	4%	5	5%
Includes PE	Varenicline	31	6%	7%	2	7%
and usual care	Varenicline and NRTs	30	6%	7%	2	7%
Yes	None	135	54%	6%	8	7%
N=251	NRTs	47	19%	15%	7	16%
Includes	Varenicline	27	11%	26%	7	27%
PE + CHW	Var. and NRTs	42	17%	21%	9	23%

Provider Education

A Public Health Crisis

64%
of individuals with
Schizophrenia
smoke

44%
of individuals with
Bipolar Disorder
smoke

15%
of the
General Population
smoke

Mortality for patients with SMI is

3.7x higher

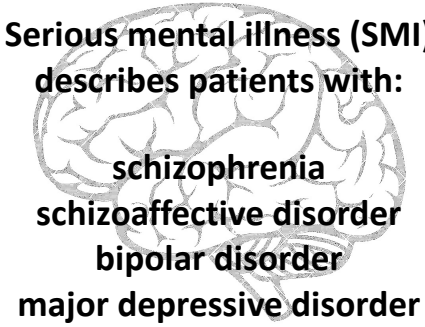
than for the general population[2]

Patients with SMI have a

25-year mortality gap

compared to the general population[3]

What is SMI?

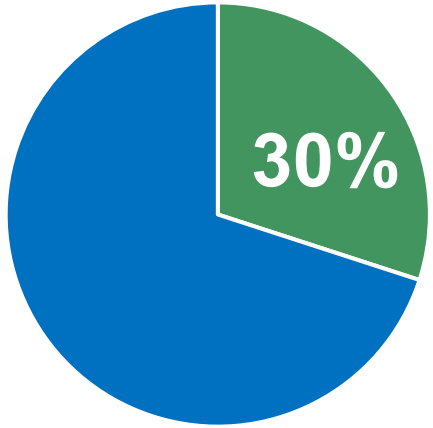


Serious mental illness (SMI) describes patients with:

schizophrenia
schizoaffective disorder
bipolar disorder
major depressive disorder

Opportunities to save lives

Long-term smoking quit rates across strategies for smokers with SMI are roughly 30%, similar to the general population.[4]

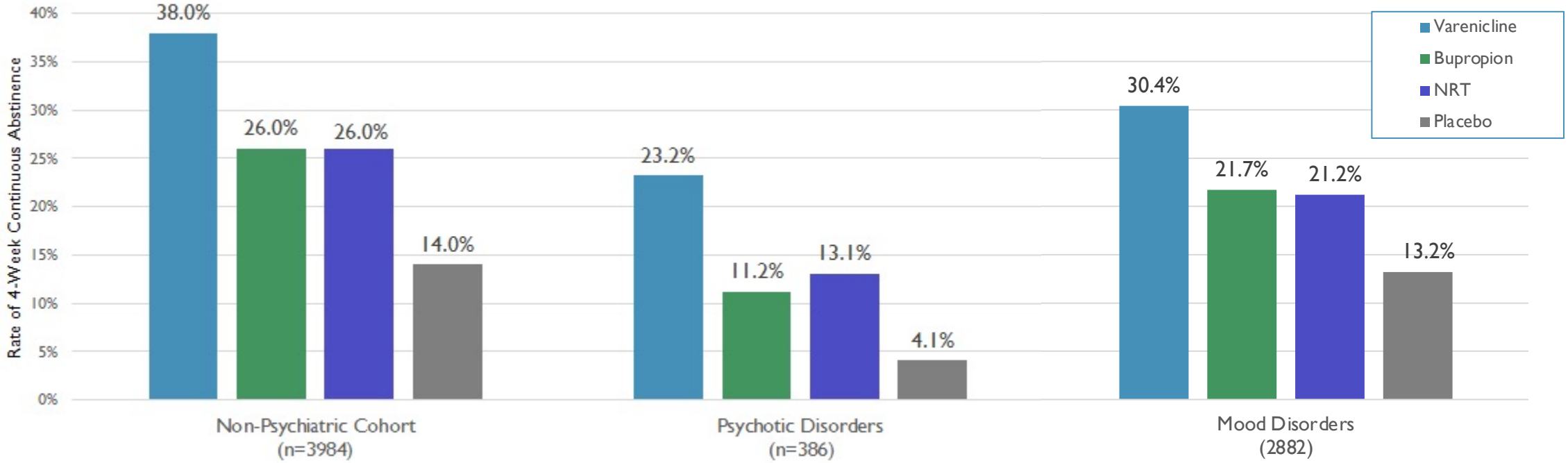


Every quit attempt helps people move towards permanent abstinence.

EFFICACY Comparative efficacy data based on EAGLES[2]

Varenicline was superior to bupropion, NRT and placebo, while bupropion and NRT were superior to placebo for biochemically-confirmed tobacco abstinence.‡

Continuous Abstinence During Weeks 9 Through 12 in Adult Smokers Without or With a History of Psychiatric Disorder

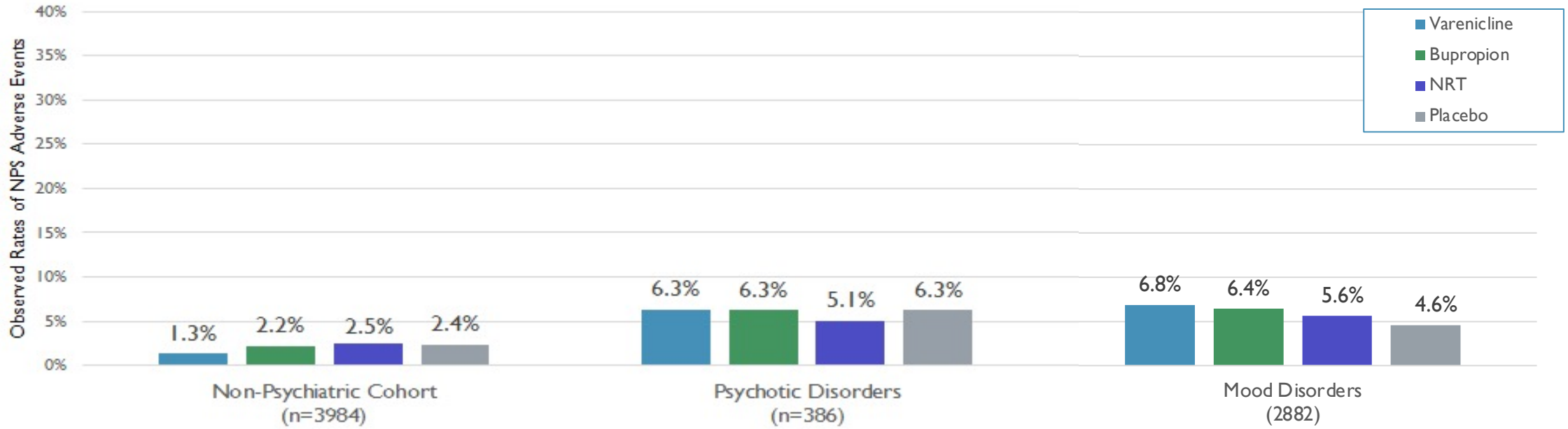


‡ "N" and analyses based on all-randomized populations in the EAGLES trial published in *The Lancet* (2016).

SAFETY

Varenicline Does NOT Increase AEs

Observed rates of neuropsychiatric adverse events in Adult Smokers Without or With a History of Psychiatric Disorder



Non-psychiatric cohort (n=3984)				Psychotic disorders (n=386)				Mood disorders (n=2882)			
Varenicline (n=990)	Bupropion (n=989)	Nicotine patch (n=1006)	Placebo (n=999)	Varenicline (n=95)	Bupropion (n=96)	Nicotine patch (n=99)	Placebo (n=96)	Varenicline (n=731)	Bupropion (n=716)	Nicotine patch (n=713)	Placebo (n=722)

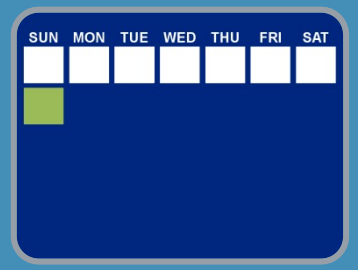
Neuropsychiatric (NPS) safety data based on EAGLES (Evaluating Adverse Events in a Global Smoking Cessation Study)[1,2], an FDA required trial to evaluate NPS safety in over 8000 smokers with and without a psychotic, anxiety or mood disorder†

MYTH	People with SMI don't want to quit smoking	Quitting worsens psychiatric symptoms	Medications don't help people with SMI stop smoking	Medications should only be prescribed for smokers ready to quit completely
FACT	**60-70% of smokers with SMI want to quit**	**Stopping smoking improves depressive symptoms (like anti-depressant medication)**	**Smokers with SMI are 3-6x more likely to quit when prescribed medication** (Only 4% quit without a medication)	**"Flexible quit" and "gradual quit" after starting medications are validated ways to quit**

Three Ways to Quit Smoking:
All Start with Smoking Cessation Medication

Fixed Quit

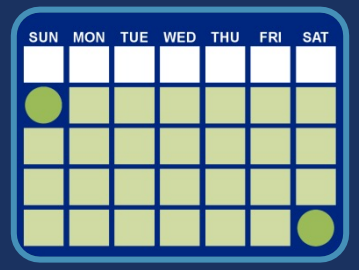
For people who want to quit smoking in a week



- Set a target quit date that is 1 week after starting smoking cessation medication
- Can keep smoking for the first week while they prepare to quit
- Take smoking cessation medication for 12-24 weeks

Flexible Quit

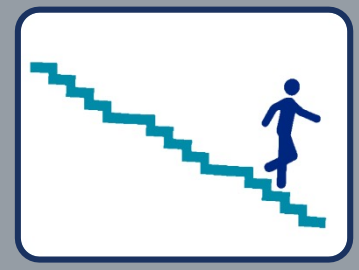
For smokers with serious mental illness (SMI)



- Start taking smoking cessation medication and pick a quit date 8 to 35 days after starting treatment
- *Can keep smoking for up to a month on smoking cessation medication while they prepare to quit*
- Take smoking cessation medication for 12-24 weeks

Gradual Quit

For patients who are not able/willing to quit abruptly



- Start taking smoking cessation medication and reduce smoking by 50% over 4 weeks, by an additional 50% in the next 4 weeks, and continue reducing with the goal of quitting by 12 weeks.
- Continue smoking cessation medication for an additional 12 weeks, for a total of 24 weeks

Next steps

- Can we take what we've learned through provider education and the CHW role and expand to other mental health providers?
- Can there be a role for psychiatric rehabilitation specialists in promoting tobacco cessation?

Survey Results

- Organizational

  Providing tobacco treatment mixed - whether emphasized at organizational level. Majority agree or strongly agree that tobacco treatment should be a part of the mission of their organization.

- Client-related

  Concerns that quitting tobacco could make psych symptoms worse.

  Concerns that if clients are using other drugs, quitting smoking at same time would be too much. Some noted that tobacco less harmful than other drugs they could be using.

  Smoking helps clients cope with stress in their lives.

- Personal

  Majority agree that treating tobacco should be a part of their work.

  Majority are moderately – extremely worried about health consequences of smoking for clients.

  Majority feel confident in helping but are strongly interested in learning tools, techniques, and resources.

  Burnout common.

Discussion

- How important is helping your clients with their physical health / quality of life? Is this currently part of your professional role?
- How would you like tobacco cessation to be prioritized in your role? What do you think is feasible given other demands of the job?
- How might experiencing making a substantial positive impact on your clients' physical health affect your job satisfaction?

Discussion

- What roadblocks have you encountered in working on smoking cessation with individuals with SMI?
- What tools or trainings would be most helpful to you in your work addressing smoking cessation for individuals with SMI?
- Is additional training to allow for tobacco treatment specialist and CHW certifications appealing to you?

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

The purpose of the MHTTC Network is technology transfer - disseminating and implementing evidence-based practices for mental disorders into the field.

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the MHTTC Network includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office.

Our collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. We work with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals. Our services cover the full continuum spanning mental illness prevention, treatment, and recovery support.

SAMHSA

Substance Abuse and Mental Health Services Administration

CONNECT WITH US

MHTTCnetwork.org

Sign-Up for Newsletter

MTTC News