

AAHD

American Association on Health and Disability
110 N. Washington Street • Suite • 340-A Rockville, MD 20850

RESEARCH PERTAINING TO SMOKING CESSATION AND PEOPLE WITH DISABILITIES

DEAF AND HARD OF HEARING YOUTH SMOKERS

Do deaf and hard of hearing youth need antitobacco education?

Berman BA, Streja L, Bernaards CA, Eckhardt EA, Kleiger HB, Maucere L, Wong G, Barkin S, Bastani R. Division of Cancer Prevention and Control Research, School of Public Health and Jonsson Comprehensive Cancer Center, University of California, Los Angeles (UCLA), USA. Am Ann Deaf. 2007 Summer;152(3):344-55.

Little research has focused on tobacco use among deaf and hard of hearing youth. Findings are reported from a first-ever tobacco-related survey, completed by 226 California middle and high school students using either a written questionnaire or the Interactive Video Questionnaire, an interactive multimedia computer video technology. Rates for current smoking (3.1%), ever smoking (45.1%), and multiple types of tobacco use (10.6%) were found to be lower than among high school students generally; mainstreamed students were likelier to have ever tried smoking than their deaf school peers (57.8% vs. 31.8%). No statistically significant associations were found between ever smoking and race/ethnicity, gender, school performance, or prelingual vs. postlingual deafening; a quarter of the sample experienced occasional peer pressure to use tobacco products. Tobacco use covariates, exposure to cigarette marketing and antismoking programming, and tobacco education needs of deaf and hard of hearing youth are discussed.

Is tobacco use a problem among deaf college students?

Berman BA, Bernaards C, Eckhardt EA, Kleiger HB, Maucere L, Streja L, Wong G, Barkin S, Bastani R. Division of Cancer Prevention and Control Research, School of Public Health and Jonsson Comprehensive Cancer Center, University of California, Los Angeles (UCLA), USA. Am Ann Deaf. 2006 Fall;151(4):441-51.

College students' tobacco use poses a significant public health problem. Effective intervention requires understanding of this behavior among race/ethnic, cultural, and linguistic collegiate subgroups, including deaf and hard of hearing collegians. Findings from a first-ever tobacco-related survey among this understudied population are reported. The authors used written questionnaires and the Interactive Video Questionnaire, a multimedia computer technology developed for use with the deaf and hard of hearing, to interview 241 volunteers on seven California college campuses. They found lower self-reported current smoking prevalence (14.5%) relative to collegians in

the general population, but considerable ever smoking (65.1%) and multiple types of tobacco use (37.3%). The authors report on factors associated with tobacco use and on students' exposure to cigarette marketing, gaps experienced in receipt of antitobacco messages and services, and students' antitobacco intervention recommendations. Limitations of the research are described, including possible underreporting of participants' tobacco use.

DEPRESSION, SMOKERS WITH

A controlled trial of bupropion added to nicotine patch and behavioral therapy for smoking cessation in adults with unipolar depressive disorders.

Evins AE, Culhane MA, Alpert JE, Pava J, Liese BS, Farabaugh A, Fava M.
Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, Harvard Medical School, Boston, MA 02114, USA.
a_eden_evins@hms.harvard.edu J Clin Psychopharmacol. 2008 Dec;28(6):660-6.

Although there is a strong relationship between depression and smoking, most nicotine dependence treatment trials exclude depressed smokers. Our objective was to determine whether bupropion improves abstinence rates and abstinence-associated depressive symptoms when added to transdermal nicotine replacement therapy (NRT) and group cognitive behavioral therapy (CBT) in smokers with unipolar depressive disorder (UDD). Adult smokers with current (n = 90) or past (n = 109) UDD were randomly assigned to receive bupropion or placebo added to NRT and CBT for 13 weeks. In the primary analysis, with dropouts considered smokers, 36% (35/97) of those on bupropion and 31% (32/102) on placebo attained biochemically validated 7-day point prevalence abstinence at end of treatment (not significant). Because of a high dropout rate (50%) and a significant difference in abstinence status at dropout by treatment group, a traditional intent-to-treat analysis with last observation carried forward imputation of abstinence status was performed. In this secondary analysis, 56% (54/97) of those on bupropion and 41% (42/102) on placebo met criteria for abstinence at end of trial, $\chi^2 = 4.18$, $P = 0.04$. Nicotine replacement therapy usage and absence of a comorbid anxiety disorder predicted abstinence. Abstinence was associated with increased depressive symptoms, regardless of bupropion treatment. Thus, in the primary analysis, bupropion neither increased the efficacy of intensive group CBT and NRT for smoking cessation in smokers with UDD nor prevented abstinence-associated depressive symptoms. Bupropion seemed to provide an advantage for smoking cessation for those who remained in the trial. The dropout rate was high and was characterized by a higher prevalence of current comorbid anxiety disorder. Given the high abstinence rate achieved with CBT plus NRT, a ceiling effect related to the high level of intervention received by all subjects may have prevented an adequate test of bupropion.

The impact of depressive symptoms on alcohol and cigarette consumption following treatment for alcohol and nicotine dependence.

Kodl MM, Fu SS, Willenbring ML, Gravely A, Nelson DB, Joseph AM. Center for Chronic Disease Outcomes Research, Minneapolis VA Medical Center, Minneapolis, Minnesota 55417, USA. Molly.Kodl@va.gov Alcohol Clin Exp Res. 2008 Jan;32(1):92-9. Epub 2007 Dec 12.

BACKGROUND: Although depression is common among alcohol and tobacco dependent patients, its impact on treatment outcomes is not well established. The purpose of this study was to examine the impact of depressive symptoms on abstinence from tobacco and alcohol after treatment for alcohol dependence and nicotine dependence.

METHODS: The Timing of Alcohol and Smoking Cessation Study (TASC) randomized adults receiving intensive alcohol dependence treatment, who were also smokers, to concurrent or delayed smoking cessation treatment. The sample consisted of 462 adults who completed depression and substance use (alcohol and smoking) assessments at treatment entry and 6, 12, and 18 months posttreatment. Longitudinal regression models were used to examine the relationships between depression and subsequent abstinence from alcohol and tobacco after baseline characteristics, including alcohol and smoking histories, were considered.

RESULTS: Depressive symptoms were prospectively related to nonabstinence from alcohol. Depressive symptoms at the previous assessment increased the odds of drinking at the subsequent time point by a factor of 1.67 (95% CI 1.14, 2.43), $p < 0.01$. Depressive symptoms were not significantly related to subsequent abstinence from cigarettes.

CONCLUSIONS: Depression is an important negative predictor of the ability to maintain abstinence from alcohol within the context of intensive alcoholism and smoking treatment. It may be important to include depression-specific interventions for alcohol and tobacco dependent individuals to facilitate successful drinking treatment outcomes.

Acceptance of nicotine dependence treatment among currently depressed smokers.

Haug NA, Hall SM, Prochaska JJ, Rosen AB, Tsoh JY, Humfleet G, Delucchi K, Rossi JS, Redding CA, Eisendrath S. Department of Psychiatry, School of Medicine, University of California, San Francisco, USA. nahaug@itsa.ucsf.edu Nicotine Tob Res. 2005 Apr;7(2):217-24.

This study reports on baseline characteristics associated with acceptance and refusal of available smoking treatment among currently depressed smokers in a psychiatric outpatient clinic who were enrolled in a larger clinical trial. The sample (N=154) was 68% female and 72% White, with a mean age of 41.4 years and average smoking rate of 17 cigarettes/day. All participants were assigned to a repeated contact experimental condition; received a stage-based expert system program to facilitate treatment acceptance; and were then offered smoking treatment, consisting of behavioral counseling, nicotine patch, and bupropion. Acceptors (n=53) were defined as those

accepting behavioral counseling and pharmacological treatment at some point during the 18-month study, whereas refusers (n=101) received only the expert system. The number of days to treatment acceptance was significantly predicted by stage of change, with those in preparation entering treatment more quickly than contemplators or precontemplators. In a logistic regression, the variables most strongly associated with accepting treatment were current use of psychiatric medication and perceived success for quitting. Severity of depressive symptoms, duration of depression history, and history of recurrent depression were not related to treatment acceptance. Findings have implications for the psychiatric assessment and treatment of smokers in clinical settings. Psychiatric medication may play a significant role in smoking cessation treatment acceptance by currently depressed smokers.

DISABILITIES, SMOKERS WITH

Disparities in smoking behaviors among those with and without disabilities from 2001 to 2005.

Becker H, Brown A. The University of Texas at Austin School of Nursing, Austin, Texas 78701, USA. heatherbecker@mail.utexas.edu Public Health Nurs. 2008 Nov-Dec;25(6):526-35.

OBJECTIVES: Past research has suggested smoking disparities among individuals with disabling conditions. We contrasted smoking behaviors of those with and without disabilities from 2001 to 2005.

DESIGN: Descriptive correlational study.

SAMPLE: Telephone interviews were conducted in all states with noninstitutionalized adults. Half were female; most were Anglo (70.5%) and had at least a high school education (90%). Their average age was 45 years. Approximately 19% of the sample reported being disabled.

MEASUREMENT: We analyzed 4 years of data from the population-based Behavioral Risk Factor Surveillance System.

RESULTS: While individuals with disabilities were more likely to report ever having smoked than nondisabled respondents, current smoking behaviors were more similar in the 2 groups, and the difference was not statistically significant when demographic factors were included in the model. Smoking behavior decreased somewhat for nondisabled persons between 2001 and 2005, but remained fairly constant for those with disabilities. However, those with disabilities were more likely than those without disabilities to have attempted to quit smoking in all years.

CONCLUSIONS: Findings underscore the importance of smoking cessation programs tailored to people with disabilities. The role of the public health nurse in addressing smoking cessation at the individual, system, and community level is discussed.

State-level prevalence of cigarette smoking and treatment advice, by disability status, United States, 2004.

Armour BS, Campbell VA, Crews JE, Malarcher A, Maurice E, Richard RA. Division of Health and Human Development, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention, 1600 Clifton Rd, NE, MS E-88, Atlanta, GA 30329, USA. barmour@cdc.gov Prev Chronic Dis. 2007 Oct;4(4):A86. Epub 2007 Sep 15.

INTRODUCTION: To our knowledge, no study has determined whether smoking prevalence is higher among people with disabilities than among people without disabilities across all U.S. states. Neither do we know whether people with disabilities and people without disabilities receive the same quality of advice about tobacco-cessation treatment from medical providers.

METHODS: We analyzed data from the 2004 Behavioral Risk Factor Surveillance System to estimate differences between people with and people without disabilities in smoking prevalence and the receipt of tobacco-cessation treatment advice from medical providers.

RESULTS: We found that smoking prevalence for people with disabilities was approximately 50% higher than for people without disabilities. Smokers with disabilities were more likely than smokers without disabilities to have visited a medical provider at least once in the previous 12 months and to have received medical advice to quit. More than 40% of smokers with disabilities who were advised to quit, however, reported not being told about the types of tobacco-cessation treatment available.

CONCLUSION: Ensuring that people with disabilities are included in state-based smoking cessation programs gives states an opportunity to eliminate health disparities and to improve the health and wellness of this group. Ways to reduce unmet preventive health care needs of people with disabilities include provider adoption of the Public Health Service's clinical practice guideline for treating tobacco use and dependence and the provision of smoking cessation services that include counseling and effective pharmaceutical treatment.

INTELLECTUAL OR DEVELOPMENTAL DISABILITIES, SMOKERS WITH

Tobacco use among individuals with intellectual or developmental disabilities: a brief review.

Steinberg ML, Heimlich L, Williams JM. Department of Psychiatry, Robert Wood Johnson Medical School, New Brunswick, NJ, USA. marc.steinberg@umdnj.edu Intellect Dev Disabil. 2009 Jun;47(3):197-207.

Tobacco use is the leading preventable cause of death in the United States. Although few tobacco control efforts target individuals with intellectual and/or developmental disabilities, this population may be especially vulnerable to the deleterious effects of tobacco use and dependence. Individuals with intellectual and developmental disabilities suffer from the health, financial, and stigmatizing effects of tobacco use. The present review examined the current literature with respect to the prevalence and patterns of tobacco use in individuals with intellectual and developmental disabilities, the importance of addressing tobacco use in these smokers, and policies surrounding tobacco use in this population. Suggestions for additional avenues of inquiry as well as modifications to current cessation treatments are proposed.

MENTAL HEALTH PROVIDERS AND SMOKING

Community mental healthcare providers' attitudes and practices related to smoking cessation interventions for people living with severe mental illness.

Johnson JL, Malchy LA, Ratner PA, Hossain S, Procyshyn RM, Bottorff JL, Groening M, Gibson P, Osborne M, Schultz A. The Centre for Nursing and Health Behaviour Research and NEXUS, School of Nursing, University of British Columbia, Vancouver, BC, Canada. Joy.Johnson@ubc.ca Patient Educ Couns. 2009 Nov;77(2):289-95. Epub 2009 Apr 23.

OBJECTIVE: This study aimed to describe mental healthcare providers' attitudes about tobacco use, their personal smoking status, their confidence in offering smoking cessation support to clients living with severe mental illness, and the extent to which they incorporated smoking cessation interventions into their practice. The study also aimed to determine whether the providers' attitudes, smoking status, and confidence were associated with offering smoking cessation support to clients.

METHODS: Self-administered questionnaires were distributed within community-based mental health agencies to those who provide care and support to adults living with severe mental illness. Outcomes measured included respondents' smoking status, attitudes related to the provision of smoking cessation support, confidence in providing smoking cessation intervention, and smoking cessation practices. We conducted multivariate analyses using logistic regression analyses to examine the factors associated with the providers' tobacco-related practices.

RESULTS: In total 282 of 871 care providers responded to the survey, 22% of whom were current smokers. The providers who held sympathetic attitudes about their role and their clients' role in smoking cessation, who were never or former smokers, who were healthcare professionals rather than paraprofessionals, who had relatively more confidence, and who had more experience working in the mental health field were more likely to engage their clients in tobacco-related interventions.

CONCLUSIONS: In this study the healthcare providers working in community-based mental health have a smoking prevalence rate that exceeds that of the region's general population and did not provide optimal smoking cessation support to their clients.

PRACTICE IMPLICATIONS: Interventions that bolster the confidence of providers to engage in smoking cessation activities and that support a shift in attitudes about the role of tobacco use in mental health are required.

What do persons with mental illnesses need to quit smoking? Mental health consumer and provider perspectives.

Morris CD, Waxmonsky JA, May MG, Giese AA. University of Colorado Denver, Department of Psychiatry, Aurora, CO 80045, USA. Chad.Morris@UCDenver.edu Psychiatr Rehabil J. 2009 Spring;32(4):276-84.

OBJECTIVES: Forty-one percent (41%) of persons in the U.S. who reported having recent mental illnesses also smoke cigarettes. Tobacco use among this population is associated with up to 25 less years of life and excess medical comorbidity compared to the general population. While research demonstrates that tobacco interventions can be effective for persons with mental illnesses, they are not commonly utilized in clinical practice. The current study explored how to adapt evidence-based tobacco cessation interventions to meet the unique physiological, psychological, and social challenges facing persons with mental illnesses.

METHODS: Ten focus groups were conducted utilizing a semi-structured discussion; 5 for adult mental health consumers (n = 62) and 5 with mental health clinicians and administrators (n = 22). Content analysis was used to organize themes into categories.

RESULTS: Five thematic categories were found: (1) Barriers to treatment, (2) Resources and infrastructure, (3) Negative influences on smoking behavior, (4) Knowledge deficits, and (5) Treatment needs.

CONCLUSIONS: These findings are instructive in developing appropriate tobacco cessation services for this population. Specifically, these data have been incorporated into a mental health provider toolkit for smoking cessation and have informed the development of a tobacco cessation intervention study.

Survey of clinician attitudes toward smoking cessation for psychiatric and substance abusing clients.

Weinberger AH, Reutenauer EL, Vessicchio JC, George TP. Program for Research in Smokers with Mental Illness (PRISM), Department of Psychiatry, Yale University School of Medicine, New Haven, CT 06519, USA. andrea.weinberger@yale.edu J Addict Dis. 2008;27(1):55-63.

The current study examined mental health clinician attitudes regarding smoking cessation for psychiatric and substance abusing patients. Participants included n = 15

never smokers, n = 12 former smokers, and n = 7 current smokers. There was a trend (p = 0.08) for current smokers as compared to former and never smokers to be less likely to encourage their clients to stop smoking. Overall, clinicians strongly agreed that an individual's motivation is the most important determinant of success in quitting. Clinicians were concerned that smoking cessation would initiate a relapse to substance abuse. We suggest that mental health clinicians can be instrumental in providing information, encouragement, and opportunities for their patients to attempt smoking cessation.

Psychiatrists' smoking cessation activities with Ohio community mental health center patients.

Price JH, Ambrosetti LM, Sidani JE, Price JA. Department of Public Health, University of Toledo, 2801 W. Bancroft St., Toledo, OH 43606, USA. jprice@utnet.utoledo.edu
Community Ment Health J. 2007 Jun;43(3):251-66. Epub 2007 Jan 19.

This study describes a survey of Ohio community mental health center psychiatrists' perceptions and practices regarding smoking cessation activities using the 5A's method of smoking cessation. Of the 150 psychiatrists surveyed, 80 (53%) were returned. The majority of psychiatrists reported asking their patients about cigarette smoking status as well as giving advice to quit. However, the practice of actually facilitating quit attempts (i.e. with social support, nicotine replacement therapy, referrals, and follow-up visits) was lacking. This demonstrates that although cigarette smoking in individuals with mental illness is recognized as a major problem by adult psychiatrists, too little is being done to adequately address the issue.

MENTAL ILLNESS, SMOKERS WITH

Varenicline use in patients with mental illness: an update of the evidence.

Purvis TL, Nelson LA, Mambourg SE. VA Sierra Nevada Health Care System, 1000 Locust Street, Reno, Nevada 89502, USA (775) 786-7200 ext. 1074, (775) 328-1838; tara.purvis2@va.gov. Expert Opin Drug Saf. 2010 Feb 18. [Epub ahead of print]

Importance of the field: Patients with a psychiatric diagnosis have a higher prevalence of smoking compared to the general population. Varenicline is a first-line pharmacotherapy option to assist in smoking cessation. Clinical trials during drug development excluded patients with active psychiatric illnesses leaving the risks associated with varenicline use in this patient population unknown. Areas covered in this review: Literature published in English up to December 2009 were identified and include neuropsychiatric adverse drug events reported in pre-marketing trials and post-marketing surveillance, varenicline case reports, evidence surrounding the use of varenicline in patients with psychiatric diagnoses, and varenicline and suicidality.

What the reader will gain: Although the risk of potential neuropsychiatric events is evident through voluntary reporting systems and reported cases in the literature, multiple studies and case reports support the use of varenicline in the mental health population.

Reviewing the literature will enable clinicians to optimize patient care by weighing the risks and benefits associated with varenicline use against the risk of continued smoking.

Take home message: Cautious treatment initiation, patient education, and close follow-up, monitoring for mood and behavior changes during therapy are recommended, especially in the psychiatric setting.

Smoking expectancies and intention to quit in smokers with schizophrenia, schizoaffective disorder and non-psychiatric controls.

Tidey JW, Rohsenow DJ. Center for Alcohol and Addiction Studies, Brown University, Providence, RI, USA. Jennifer.Tidey@brown.edu Schizophr Res. 2009 Dec;115(2-3):310-6.

Cigarette smoking expectancies are systematically related to intention to quit smoking in adult smokers without psychiatric illness, but little is known about these relationships in smokers with serious mental illness. In this study, we compared positive and negative smoking expectancies, and examined relationships between expectancies and intention to quit smoking, in smokers with schizophrenia (n=46), smokers with schizoaffective disorder (n=35), and smokers without psychiatric illness (n=71). In all three groups, reduction of negative affect was rated as the most important smoking expectancy and intention to quit smoking was systematically related to concerns about the health effects and social consequences of smoking. Compared to the other groups of smokers, those with schizoaffective disorder were more concerned with social expectancies and with the immediate negative physical effects of smoking. Results of this study suggest that challenging positive smoking expectancies and providing more tailored information about the negative consequences of smoking might increase motivation to quit smoking in smokers with schizophrenia and schizoaffective disorder, as has been found with non-psychiatric smokers.

**Silver and Bronze Achievement Awards 2009 APA Achievement Awards
Silver Award: CHOICES, UMDNJ–Robert Wood Johnson Medical School, New Brunswick, New Jersey—Peer Support to Promote Smoking Cessation**

Williams JM (contact person for CHOICES) Division of Addiction Psychiatry, UMDNJ–Robert Wood Johnson Medical School, 317 George St., Suite 105, New Brunswick, NJ 08901 williajm@umdnj.edu Psychiatric Services. ps.psychiatryonline.org 2009 Oct; 60(10) (No abstract of this article is available—full text of the article can be found at <http://www.psych.org/Departments/HSF/PsychServcsAxchvmntAwrds/Psych-Services-article-CHOICES.aspx>)

There is evidence that the mentally ill population has less access to tobacco treatment services than the general population. One model for systems change is to target consumers directly to boost the demand for tobacco cessation services. One way of doing so is to involve persons with mental illness in talking with peers with mental illness who smoke and who may have low motivation to address their tobacco use. In the CHOICES program, patients are the peer providers. Peer-delivered services are in

keeping with the recovery model's goal to provide services via people who have experienced the condition themselves. To those fearful of change, peers are less threatening than professionals. Mental health consumers also report high satisfaction with peer-delivered services. The CHOICES program, based at the Robert Wood Johnson Medical School of the University of Medicine and Dentistry of New Jersey, takes a unique consumer-driven approach to addressing tobacco dependence among people with mental illness. The full name behind CHOICES—Consumers Helping Others Improve Their Condition by Ending Smoking—symbolizes empowerment and personal choice in recovery. CHOICES employs mental health peer counselors to deliver the message to smokers with mental illness in the community that addressing tobacco use is vital to their health and to motivate them to seek treatment. CHOICES mental health peer counselors, or consumer tobacco advocates (CTAs), serve as consultants to consumers to assist them with linkages to treatment, referrals, advocacy, and support and to provide educational materials.

A Wellness Approach to Addressing Tobacco in Mental Health Settings: Learning About Healthy Living

Williams J, Ziedonis D, Vreeland B, Speelman-Edwards N, Zechner M, Williams M, Rahim R, Karimi L, Molnar M, Eilers R University of Medicine and Dentistry of New Jersey (UMDNJ)-Robert Wood Johnson Medical School; UMDNJ-School of Public Health, Tobacco Dependence Program, New Brunswick, New Jersey, USA; University of Massachusetts Medical School, Worcester, Massachusetts, USA; UMDNJ-University Behavioral Health Care, Piscataway, New Jersey, USA; UMDNJ-School of Health Related Profession, Scotch Plains, New Jersey, USA; New Jersey Department of Human Services, Division of Mental Health Services, Trenton, New Jersey, USA American Journal of Psychiatric Rehabilitation, 2009 Oct 12(4):352-69.

OBJECTIVE: Treatments are needed for smokers with serious mental illness (SMI) who are not ready to quit.

METHODS: This article describes a 20-session group wellness treatment (Learning About Healthy Living [LAHL]) designed to provide information on tobacco use and other issues to enhance healthy living—nutrition, physical activity, and stress management. Goals are to increase awareness about tobacco and the benefits of treatment to enhance motivation for improving health.

RESULTS: LAHL was successfully pilot-tested for feasibility in nine community treatment programs; feedback from staff and consumers was positive.

CONCLUSIONS: LAHL is a feasible treatment model for addressing tobacco that is consistent with wellness and recovery in mental health settings and should be studied further.

Tobacco use and cessation in psychiatric disorders: National Institute of Mental Health report.

Ziedonis D, Hitsman B, Beckham JC, Zvolensky M, Adler LE, Audrain-McGovern J, Breslau N, Brown RA, George TP, Williams J, Calhoun PS, Riley WT. University of Massachusetts Medical School and UMass Memorial Health Care, Worcester, MA01655, USA. ziedonid@umhc.org Nicotine Tob Res. 2008 Dec;10(12):1691-715.

The National Institute of Mental Health (NIMH) convened a meeting in September 2005 to review tobacco use and dependence and smoking cessation among those with mental disorders, especially individuals with anxiety disorders, depression, or schizophrenia. Smoking rates are exceptionally high among these individuals and contribute to the high rates of medical morbidity and mortality in these individuals. Numerous biological, psychological, and social factors may explain these high smoking rates, including the lack of smoking cessation treatment in mental health settings. Historically, "self-medication" and "individual rights" have been concerns used to rationalize allowing ongoing tobacco use and limited smoking cessation efforts in many mental health treatment settings. Although research has shown that tobacco use can reduce or ameliorate certain psychiatric symptoms, overreliance on the self-medication hypothesis to explain the high rates of tobacco use in psychiatric populations may result in inadequate attention to other potential explanations for this addictive behavior among those with mental disorders. A more complete understanding of nicotine and tobacco use in psychiatric patients also can lead to new psychiatric treatments and a better understanding of mental illness. Greater collaboration between mental health researchers and nicotine and tobacco researchers is needed to better understand and develop new treatments for cooccurring nicotine dependence and mental illness. Despite an accumulating literature for some specific psychiatric disorders and tobacco use and cessation, many unstudied research questions remain and are a focus and an emphasis of this review.

A placebo-controlled trial of bupropion combined with nicotine patch for smoking cessation in schizophrenia.

George TP, Vessicchio JC, Sacco KA, Weinberger AH, Dudas MM, Allen TM, Creeden CL, Potenza MN, Feingold A, Jatlow PI. Centre for Addiction and Mental Health, Faculty of Medicine, University of Toronto, Ontario, Canada. Tony_George@camh.net Biol Psychiatry. 2008 Jun 1;63(11):1092-6. Epub 2007 Dec 21.

BACKGROUND: Individuals with schizophrenia smoke at higher rates (58%-88%) than the general population (approximately 22%), and have difficulty quitting. We determined whether the combination of sustained-release (SR) bupropion (BUP) with the transdermal nicotine patch (TNP) was well-tolerated and superior to placebo (PLO)+TNP for smoking cessation in schizophrenia.

METHODS: A 10-week, double-blind, placebo-controlled trial of BUP (300 mg/day) in combination with TNP (21 mg/24h) for 58 outpatient smokers with schizophrenia was conducted. Primary outcome measures were continuous smoking abstinence in the last 4 weeks of the trial (Days 43-70) and 7-day point prevalence abstinence at 6 months post-target quit date (TQD) (week 26).

RESULTS: Smokers assigned to the BUP+TNP group (n = 29) were more likely to achieve continuous smoking abstinence (8/29, 27.6%) than the PLO+TNP group (n = 29, 1/29, 3.4%) [Fisher's Exact Test, p < .05]; at 6-months post-TQD, 4/29 (13.8%) versus 0/29 (0.0%) achieved 7-day point prevalence smoking abstinence (p = .11). Neither bupropion SR nor smoking abstinence significantly altered the positive or negative symptoms of schizophrenia. The combination was well-tolerated in smokers with schizophrenia.

CONCLUSIONS: Combination therapy with bupropion SR+TNP versus placebo+TNP is well-tolerated and significantly improved short-term smoking abstinence in smokers with schizophrenia.

Outcome from a community-based smoking cessation program for persons with serious mental illness.

Currie SR, Karllyn J, Lussier D, de Denus E, Brown D, El-Guebaly N. Department of Psychiatry, Mental Health Information and Evaluation Unit, Calgary Health Region, Mental Health and Psychiatric Services, 206, 301-14th Street NW, Calgary, AB, Canada, T2N 2A1. scurrie@ucalgary.ca Community Ment Health J. 2008 Jun;44(3):187-94. Epub 2007 Nov 30.

Six and 12-month outcomes are reported on 79 mentally ill persons attending either a 4- or 8-session community-based smoking cessation group. Quit rates at post, 3-, 6-, and 12-month follow-ups were 16, 19, 16, and 19%, respectively, with no significant effect of program length. These success rates are comparable to outcomes reported following group-based treatment with mentally healthy smokers. The majority of quitters used nicotine replacement therapy. Psychotropic medication dosages did not vary over time in quitters or non-quitters. No reductions in smoking were observed among non-quitters. Quitting smoking had no untoward effects on symptoms of mental illness or general functioning.

Use of smoking cessation therapies in individuals with psychiatric illness : an update for prescribers.

Kisely S, Campbell LA. Departments of Psychiatry, Community Health & Epidemiology, Dalhousie University, Halifax, Nova Scotia, Canada. s.kisely@griffith.edu.au CNS Drugs. 2008;22(4):263-73.

Individuals with mental illness are particularly disadvantaged by their use of tobacco, spending as much as 40% of their income on cigarettes. They also have increased mortality from cardiovascular and respiratory disorders. The most effective interventions to help psychiatric patients stop smoking are similar to those that are effective in the general population. These include psychological treatments, nicotine replacement therapy (NRT), bupropion and nortriptyline, at least in the short term. Most studies agree that these gains can be achieved in the absence of significant adverse effects in terms of psychological morbidity. Effects diminish over time, but these findings also apply to the general population. The best long-term results have come from extended prescription

and psychological interventions, and apply equally to patients with and without a history of psychiatric disorder, such as major depression. In spite of this, clinicians are not fully exploiting opportunities to help psychiatric patients stop smoking. It is not possible to plan a programme to help individuals stop smoking in mental health settings unless factors such as demographics, diagnosis and concurrent medication are taken into account.

A 12-week double-blind, placebo-controlled study of bupropion sr added to high-dose dual nicotine replacement therapy for smoking cessation or reduction in schizophrenia.

Evins AE, Cather C, Culhane MA, Birnbaum A, Horowitz J, Hsieh E, Freudenreich O, Henderson DC, Schoenfeld DA, Rigotti NA, Goff DC.
Schizophrenia Program, Massachusetts General Hospital, Boston, MA 02144, USA.
a eden evins@hms.harvard.edu J Clin Psychopharmacol. 2007 Aug;27(4):380-6.

The objective of this study was to examine whether there is a benefit of adding bupropion SR to high-dose combination nicotine replacement therapy (NRT) and weekly group cognitive behavioral therapy (CBT) for smoking reduction or cessation in schizophrenia. Fifty-one adult smokers with schizophrenia were randomly assigned to a 12-week trial of bupropion SR 300 mg/d or placebo added to transdermal nicotine patch, nicotine polacrilex gum, and CBT. The treatment goal was smoking cessation. The primary outcome measure was biochemically confirmed 7-day point-prevalence of 50% to 100% smoking reduction at week 12. Secondary outcomes were biochemically confirmed tobacco abstinence and change from baseline in expired air carbon monoxide (CO) and psychiatric symptoms. Subjects on bupropion + NRT had a greater rate of 50% to 100% smoking reduction at weeks 12 (60% vs. 31%; $P = 0.036$) and 24, a lower expired air CO in the treatment and follow-up periods, ($F = 13.8$; $P < 0.001$) and a greater continuous abstinence rate at week 8, before NRT taper, (52% vs. 19%; $P = 0.014$). However, relapse rates in subjects on bupropion + dual NRT were 31% during NRT taper (weeks 8-12) and 77% at the 12-month follow-up. Abstinence rates did not differ by treatment group at weeks 12 (36% vs. 19%), 24 (20% vs. 8%), or 52 (12% vs. 8%). Because abstinence rates were high during treatment with combination pharmacotherapy and relapse rates were very high during taper and after discontinuation of treatment, study of longer term treatment with combination pharmacotherapy and CBT for sustained abstinence is warranted in those who attain initial abstinence with this intervention.

The acceptability of physical activity programming within a smoking cessation service for individuals with severe mental illness.

Faulkner G, Taylor A, Munro S, Selby P, Gee C. Faculty of Physical Education and Health, University of Toronto, Toronto, Canada. guy.faulkner@utoronto.ca Patient Educ Couns. 2007 Apr;66(1):123-6. Epub 2006 Dec 20.

OBJECTIVE: There is a high prevalence of smoking and physical inactivity among individuals with severe mental illness (SMI). The current study assessed the acceptability of introducing physical activity, including perceived advantages and disadvantages, as an adjunct to a smoking cessation service within this population.

METHODS: 109 participants with SMI who were receiving smoking cessation treatment completed a survey assessing perceived interest in physical activity and a 24-item decisional balance questionnaire reflecting potential advantages and disadvantages of becoming more physically active.

RESULTS: The majority of the participants reported being interested in assistance in becoming more active [63% (69/109)]. The highest rated advantages reported were 'It would improve my health or reduce my risk of disease' and 'It would improve how I feel about myself'. Cost, and being active by oneself were the most frequently reported barriers.

CONCLUSION: This study suggests that many individuals with SMI seeking treatment for smoking cessation may also be receptive to assistance in becoming more physically active. Such individuals endorse both advantages and disadvantages more frequently than those not interested.

PRACTICE IMPLICATIONS: This study provides preliminary support for the acceptability of adding physical activity as a smoking cessation strategy with SMI individuals. Addressing salient barriers will be critical to integrating physical activity within this smoking cessation service.

Cigarette smoking and overweight/obesity among individuals with serious mental illnesses: a preventive perspective.

Compton MT, Daumit GL, Druss BG. Department of Psychiatry and Behavioral Sciences, Family and Preventive Medicine, Emory University School of Medicine, Atlanta, 30303 GA, USA. mcompto@emory.edu Harv Rev Psychiatry. 2006 Jul-Aug;14(4):212-22.

BACKGROUND: Cigarette smoking and lifestyle factors underlying overweight/obesity (such as unhealthy diet and physical inactivity) appear to play a major role in the excess medical morbidity and mortality among persons with serious mental illnesses. The literature on the prevalence, etiology, prevention, and treatment of these two risk factors, in the context of serious mental illnesses, are reviewed following a preventive approach.

METHODS: The review relied upon searches of the MEDLINE database, from 1996 through April 2006, restricted to the English language. Original research, review articles, and clinical guidelines relevant to the topics of cigarette smoking, unhealthy diet, physical inactivity, and overweight/obesity among individuals with serious mental illnesses were identified.

RESULTS: Compared to those without a mental illness, individuals with a current mental illness are more than twice as likely to smoke cigarettes and more than 50% more likely to be overweight/obese, presumably the product of unhealthy diet and physical inactivity. Various biological, iatrogenic, and social factors place psychiatric patients at risk for these and other adverse health behaviors. Studies suggest that many of the same preventive approaches developed for general medical populations are likely to be effective in persons with serious mental disorders, though specialized approaches also are needed. Domains of prevention include primary prevention (population-based strategies to reduce the incidence of these adverse health behaviors), secondary prevention (early detection and treatment), and tertiary prevention (pharmacological and psychosocial treatments to reduce the burden of illness among those with the behaviors in question). However, mental health clinicians commonly lack the training or expertise to provide these services.

CONCLUSIONS: The high prevalence, adverse effects, and efficaciousness of treatments for smoking and obesity in persons with serious mental illnesses suggest the importance of addressing these problems in this population. Both further research and dissemination efforts are needed to ensure that patients with serious mental illnesses receive the appropriate preventive and clinical services for these two adverse health conditions.

Serious mental illness and smoking cessation.

Snyder M. University of Illinois at Chicago, College of Nursing, Chicago, IL 60612-7350, USA. SnyderM@uic.edu Issues Ment Health Nurs. 2006 Jul;27(6):635-45.

Persons with serious mental illness (SMI) are faced with substantial challenges to their health. This population is two to three times more likely to smoke cigarettes than persons who do not suffer from mental illness. In particular, young adults are at high risk for vulnerability to both SMI and cigarette smoking. Although there are proven methods for smoking cessation, both pharmacologic and non-pharmacologic interventions show limited usefulness for SMI who smoke. Alternative health care options as well as support groups and physical exercise are discussed as methods that may be useful in smoking cessation. Finally, integration of smoking cessation programming into existing mental health treatment services may offer the greatest opportunity for client success.

MENTAL ILLNESS AND SUBSTANCE ABUSE DISORDERS, SMOKERS WITH

Confronting a neglected epidemic: tobacco cessation for persons with mental illnesses and substance abuse problems.

Schroeder SA, Morris CD. Department of Medicine and Smoking Cessation Leadership Center, University of California, San Francisco, California 94143-1211, USA.

schroeder@medicine.ucsf.edu Annu Rev Public Health. 2010 Apr 21;31:297-314 1p following 314.

Tobacco use exerts a huge toll on persons with mental illnesses and substance abuse disorders, accounting for 200,000 of the annual 443,000 annual tobacco-related deaths in the United States. Persons with chronic mental illness die 25 years earlier than the general population does, and smoking is the major contributor to that premature mortality. This population consumes 44% of all cigarettes, reflecting very high prevalence rates plus heavy smoking by users. The pattern reflects a combination of biological, psychosocial, cultural, and tobacco industry-related factors. Although provider and patient perspectives are changing, smoking has been a historically accepted part of behavioral health settings. Additional harm results from the economic burden imposed by purchasing cigarettes and enduring the stigma attached to smoking. Tailored treatment for this population involves standard cessation treatments including counseling, medications, and telephone quitlines. Further progress depends on clinician and patient education, expanded access to treatment, and the resolution of existing knowledge gaps.

Treatment of smokers with co-occurring disorders: emphasis on integration in mental health and addiction treatment settings.

Hall SM, Prochaska JJ. Psychiatry Department, University of California-San Francisco, CA 94143, USA. shall@lppi.ucsf.edu Annu Rev Clin Psychol. 2009;5:409-31.

This article reviews the research on the treatment of cigarette smoking in individuals who have comorbid mental illnesses or non-nicotinic addictions. The prevalence of smoking in mentally ill and substance-abusing populations is presented, as well as reasons for this high prevalence. The historical role of cigarettes and tobacco in mental illness and addiction is reviewed to help the reader better understand the pervasiveness of smoking in these disorders and the relative absence of intervention efforts in mental health and addiction treatment settings. The article then discusses the several reasons for integrating smoking treatment into mental health and addiction settings. The outcome research for adult and adolescent comorbid smokers is reviewed, and barriers to treatment are discussed. The review closes with a brief discussion of models of integration and thoughts about prevention.

Treatment of tobacco dependence in mental health and addictive disorders.

Hitsman B, Moss TG, Montoya ID, George TP. Department of Preventive Medicine, Northwestern University, Chicago, Illinois 60611, USA. b-hitsman@northwestern.edu Can J Psychiatry. 2009 Jun;54(6):368-78. Comment in: Can J Psychiatry. 2009 Jun;54(6):353-5 and Can J Psychiatry. 2009 Dec;54(12):854-5; author reply 855-6.

People with mental health and addictive (MHA) disorders smoke at high rates and require tobacco treatment as a part of their comprehensive psychiatric care. Psychiatric care providers often do not address tobacco use among people with mental illness, possibly owing to the belief that their patients will not be able to quit successfully or that

even short-term abstinence will adversely influence psychiatric status. Progress in the development of treatments has been slow in part because smokers with current MHA disorders have been excluded from most smoking cessation trials. There are several smoking cessation treatment options, including psychological and pharmacological interventions, that should be offered to people with an MHA disorder who smoke. Building motivation and readiness to quit smoking is a major challenge, and therefore motivational interventions are essential. We review the treatment options for people with tobacco dependence and MHA disorders, offer recommendations on tobacco assessment and tailored treatment strategies, and provide suggestions for future research. Treatment efficacy could be enhanced through promoting smoking reduction as an initial treatment goal, extending duration of treatment, and delivering it within an integrated care model that also aims to reduce the availability of tobacco in MHA treatment settings and in the community.

Addressing smoking in community drug abuse treatment programs: practical and policy considerations.

Brigham GS, Schroeder G, Schindler E. Maryhaven, Columbus, OH 43207, USA.
Gbrigham@maryhaven.com J Psychoactive Drugs. 2007 Dec;39(4):435-41.

Smoking is the leading cause of preventable death in the United States. This public health problem is of particular concern among individuals with substance use disorders in that they smoke at a greater rate than the general public. Smoking-related illness represents a major source of preventable death in persons with drug dependencies. Substance abuse treatment programs have access to persons with substance use disorders and the opportunity to intervene on their smoking; however, nicotine dependence has historically not been viewed in the same light as other drug dependencies by the treatment field. As a result, many persons in these treatment program settings do not receive opportunities to address their smoking. When substance abuse treatment organizations consider implementing smoking policies and services, many questions and choices arise. In practice, a range of approaches has been developed from simple assessment and referral for smoking cessation treatment to implementing smoke-free grounds and requiring that patients stop smoking concurrent with addressing their other drug dependencies. Smoking cessation policy decisions have the potential to directly affect the patients, the workforce, the referral network, and other major stakeholders related to these organizations. The authors consider a range of both practical and policy issues facing treatment organizations and conclude that advances in smoking policy are possible with current resources.

MULTIPLE SCLEROSIS, SMOKERS WITH

Smoking rates and smoking cessation among individuals with multiple sclerosis.

Friend KB, Mernoff ST, Block P, Reeve G. Brown Medical School and Pacific Institute for Research and Evaluation, Decision Sciences Institute, Providence, Rhode Island 02906, USA. kfriend@pire.org Disabil Rehabil. 2006 Sep 30;28(18):1135-41.

PURPOSE: Adults with physical disabilities tend to smoke at higher rates than smokers in the general population. No study to date, however, has assessed smoking prevalence and cessation among individuals with multiple sclerosis (MS). Such information is critically needed because smoking is more deleterious for individuals with MS than for smokers without MS and increases MS risk.

METHOD: Questionnaires were sent to 700 National Multiple Sclerosis Society Rhode Island Chapter members.

RESULTS: Based on a 50% response rate, results demonstrated a 15.2% current smoker prevalence rate, which is lower than USA and Rhode Island general adult population averages. Individuals who smoked, however, tended to be heavy smokers, consuming 20 - 30 cigarettes daily, and had been smoking 10 years or longer. Smokers varied in their interest in quitting but seemed confident in their ability to do so. Respondents reported that it was difficult to quit because smoking was pleasurable; smoking was helpful in coping with boredom and with having MS; withdrawal symptoms were unpleasant; and treatment for tobacco dependence was expensive.

CONCLUSIONS: Efficacious smoking cessation interventions for smokers with MS should be developed to address a critical health need for a population of highly nicotine-dependent smokers who face numerous obstacles to quitting.

MULTIPLE SCLEROSIS, VETERAN SMOKERS WITH

Smoking among veterans with multiple sclerosis: prevalence correlates, quit attempts, and unmet need for services.

Turner AP, Kivlahan DR, Kazis LE, Haselkorn JK. VA Puget Sound Health Care System, Seattle, WA, USA. Arch Phys Med Rehabil. 2007 Nov;88(11):1394-9.

OBJECTIVE: To describe the prevalence and correlates of smoking as well as quit attempts and unmet need for smoking cessation services in a national sample of veterans with multiple sclerosis (MS).

DESIGN: Cross-sectional cohort study linking computerized medical record information to mailed survey data from 1999.

SETTING: Veterans Health Administration (VHA).

PARTICIPANTS: Sixty-four percent (2994/4685) of veterans with MS who received services in VHA and also returned survey questionnaires, as well as a 20% random subsample (n=569) who completed a more extensive assessment of smoking.

INTERVENTIONS: Not applicable.

MAIN OUTCOME MEASURES: Items assessing smoking, quit attempts, and unmet need for smoking services.

RESULTS: Among all survey respondents with MS, 28.5% (95% confidence interval [CI], 26.9-30.2) endorsed current smoking. Of extended survey respondents, 54.5% (95% CI, 46.6-62.1) reported a quit attempt in the past year, and 59.0% (95% CI, 51.1-66.4) reported not getting needed services for smoking in the past year. In fully adjusted logistic regression, smoking was associated with younger age, lower levels of education, being unmarried, higher levels of physical pain, and poorer mental health. A quit attempt was associated with higher levels of education and greater pain intensity.

CONCLUSIONS: Smoking among veterans with MS is common, with rates similar to those for other veterans. There is substantial need for cessation services. Cessation interventions should address correlates of smoking including pain, poorer mental health, and social isolation.

POSTTRAUMATIC STRESS DISORDER, SMOKERS WITH

Reasons for quitting smoking prior to a self-quit attempt among smokers with and without posttraumatic stress disorder or other anxiety/mood psychopathology.

Marshall EC, Vujanovic AA, Kutz A, Gibson L, Leyro T, Zvolensky MJ.

Department of Psychology, University of Vermont, Burlington, Vermont 05405-0134, USA. Am J Addict. 2009 Jul-Aug;18(4):309-15.

The present investigation examined intrinsic and extrinsic reasons for quitting among daily cigarette smokers with posttraumatic stress disorder (PTSD) as compared to clinical daily smokers with other anxiety and mood disorders (AM) and daily smokers with no current Axis I psychopathology (C) prior to a self-guided quit attempt. It was hypothesized that (1) the PTSD group would report greater intrinsic (ie, self-control and health concerns) reasons for quitting smoking, and (2) among those with PTSD, anxiety sensitivity (fear of anxiety; AS) would predict greater intrinsic reasons for quitting smoking. Participants were 143 (58.7% female; M(age) = 29.66 years, SD = 11.88) daily cigarette smokers. Partially consistent with prediction, the PTSD group reported significantly greater self-control intrinsic reasons for quitting, but not health concern intrinsic reasons, than the C group ($p < .01$). The PTSD group also reported greater immediate reinforcement extrinsic reasons for quitting than the C group ($p < .05$). The PTSD and AM groups did not significantly differ on any reasons for quitting. Also partially consistent with hypotheses, higher levels of anxiety sensitivity in daily smokers with Axis I psychopathology (both PTSD and AM groups) significantly predicted greater self-control intrinsic reasons for quitting. AS did not significantly predict immediate reinforcement extrinsic reasons for quitting. The current findings suggest that individuals

with PTSD and other psychopathology may have unique motivations for quitting smoking that could be usefully explored within smoking cessation treatment programs.

Impact of Posttraumatic Stress Disorder on early smoking lapse and relapse during a self-guided quit attempt among community-recruited daily smokers.

Zvolensky MJ, Gibson LE, Vujanovic AA, Gregor K, Bernstein A, Kahler C, Legues CW, Brown RA, Feldner MT. Department of Psychology, University of Vermont, 2 Colchester Avenue, Burlington, VT 05405, USA. Michael.Zvolensky@uvm.edu Nicotine Tob Res. 2008 Aug;10(8):1415-27.

The present investigation examined whether daily smokers with posttraumatic stress disorder (PTSD), as compared to daily smokers with either anxiety psychopathology or no current Axis I psychopathology, have decreased success in the early phases of a self-guided smoking quit attempt. Participants were 140 daily smokers (81 women; M (age) = 29.5; SD = 11.9; range = 18-65 years); approximately one-third of the sample met criteria for current PTSD (n = 47), one-third met criteria for other current anxiety disorders (without PTSD; n = 33), and one-third did not meet criteria for any current Axis I disorder (n = 60). Consistent with prediction, membership in the PTSD group, compared to membership in the other anxiety disorders group and the group with no current Axis I psychopathology, was associated with increased risk of lapse during the first week following quit day. Additionally, daily smokers with PTSD and other anxiety disorders were at significantly increased risk of relapse during the first week post-cessation compared to persons without Axis I psychopathology. However, the PTSD group and the other anxiety disorders group did not differ from one another in terms of relapse. Results suggest that PTSD is associated with increased risk of smoking lapse and relapse compared to smokers with no current Axis I psychiatric problems, and increased risk of early smoking lapse but not relapse, as compared to those with other anxiety disorders. Findings provide novel evidence that PTSD, and perhaps anxiety disorders more generally, may be important factors in reducing the odds of successful unaided quit attempts in the early phases of cessation.

POSTTRAUMATIC STRESS DISORDER, VETERAN SMOKERS WITH

Integrating smoking cessation into mental health care for post-traumatic stress disorder.

McFall M, Saxon AJ, Thaneemit-Chen S, Smith MW, Joseph AM, Carmody TP, Beckham JC, Malte CA, Vertrees JE, Boardman KD, Lavori PW. Veterans Affairs Puget Sound Health Care System, Seattle, WA 98108, USA. miles.mcfall@va.gov Clin Trials. 2007;4(2):178-89.

BACKGROUND: Post-traumatic stress disorder (PTSD) is associated with a high prevalence of smoking, heavy cigarette consumption and low cessation rates.

PURPOSE: This manuscript describes the design of a randomized, multisite effectiveness trial to test whether integrating smoking cessation treatment into mental health care (integrated care) improves prolonged abstinence rates among veterans with PTSD, compared with referral to specialized smoking cessation clinics (usual standard of care). Secondary objectives are to assess the cost-effectiveness of integrated care relative to usual standard of care, identify treatment variables that mediate differences between conditions in outcome and determine whether smoking cessation is associated with worsening PTSD and/or depression.

METHODS: Following randomization, subjects (projected n = 1400) from 10 Veterans Health Administration (VHA) medical centers complete follow-up assessments every three or six months for up to four years. Endpoints include 1-year prolonged abstinence at 18 months postrandomization, 7- and 30-day point-prevalence abstinence and measures of depression, PTSD and economic outcomes.

RESULTS: This study is unique in providing the largest scale test of the feasibility and effectiveness of having mental health clinicians implement evidence-based smoking cessation treatment in psychiatric care settings for veterans with PTSD. It incorporates methodological features that are desirable for cessation treatment trials, including: a) assessment of clinically meaningful long-term smoking outcomes; b) a manual guiding delivery of the experimental intervention; c) independent ratings of clinician competence and treatment adherence and d) methods for training clinicians that would enhance implementation of tobacco cessation treatment in large health care systems.

LIMITATIONS: Use of an exclusively VHA sample with few females limits generalizability.

CONCLUSIONS: The process for meeting challenges in designing this study may provide planning of other large-scale clinical effectiveness trials in tobacco control. Findings have potential to initiate system-wide change in clinical practice patterns for tobacco cessation treatment involving patients with mental disorders.

Improving the rates of quitting smoking for veterans with posttraumatic stress disorder.

McFall M, Saxon AJ, Thompson CE, Yoshimoto D, Malte C, Straits-Troster K, Kanter E, Zhou XH, Dougherty CM, Steele B. PTSD Programs (S-116 MHC), VA Puget Sound Health Care System, 1660 S. Columbian Way, Seattle, WA 98108, USA. miles.mcfall@med.va.gov Am J Psychiatry. 2005 Jul;162(7):1311-9.

OBJECTIVE: Smoking is highly prevalent and refractory among people with posttraumatic stress disorder (PTSD). This study aimed to improve the rate of quitting smoking for veterans with PTSD by integrating treatment for nicotine dependence into mental health care.

METHOD: Smokers undergoing treatment for PTSD (N=66) were randomly assigned to 1) tobacco use treatment delivered by mental health providers and integrated with

psychiatric care (integrated care) versus 2) cessation treatment delivered separately from PTSD care by smoking-cessation specialists (usual standard of care). Seven-day point prevalence abstinence was the primary outcome, measured at 2, 4, 6, and 9 months after random assignment. Data were analyzed by using a generalized estimating equations approach following the intent-to-treat principle.

RESULTS: Subjects assigned to integrated care were five times more likely than subjects undergoing the usual standard of care to abstain from smoking across follow-up assessment intervals (odds ratio=5.23). Subjects in the integrated care condition were significantly more likely than subjects in usual standard of care to receive transdermal nicotine and nicotine gum. They also received a greater number of smoking-cessation counseling sessions. Stopping smoking was not associated with worsening symptoms of PTSD or depression.

CONCLUSIONS: Smoking-cessation interventions can be safely incorporated into routine mental health care for PTSD and are more effective than treatment delivered separately by a specialized smoking-cessation clinic. Integrating cessation treatment into psychiatric care may have the potential for improving smoking quit rates in other populations of chronically mentally ill smokers.

SUBSTANCE ABUSE TREATMENT, YOUTH IN

Smoking among adolescents in substance abuse treatment: a study of programs, policy, and prevalence.

Chun J, Guydish J, Chan YF. Institute for Health Policy Studies, University of California, San Francisco 94118, USA. Jongserl.chun@ucsf.edu J Psychoactive Drugs. 2007 Dec;39(4):443-9.

The study was designed to: (1) identify smoking policies and interventions in adolescent residential treatment settings; (2) examine the prevalence of smoking among adolescents in these settings; and (3) assess relationships between program-level smoking policies and client-level smoking. The Center for Substance Abuse Treatment funded 17 sites to evaluate the effectiveness of Adolescent Residential Treatment (ART) programs for substance abuse. To describe program smoking policies and interventions, we conducted phone interviews with one key informant at each program (N=12). To describe client smoking behaviors, we conducted a secondary data analysis of baseline data for adolescents (N=912) entering ART programs. All sites had no smoking indoors and 75% of the site had tobacco-free grounds for adolescents. Forty-two percent provided their youth with nicotine replacement therapy, and 42% provided counseling for smoking cessation. Also, 33% did not allow staff smoking on and off campus. The prevalence of any smoking in the past month was 66%, and 22% of current smokers were daily smokers at admission. Where smoking was allowed on grounds, adolescents more often reported recent smoking. Smoking behavior is prevalent among adolescents in residential drug treatment, and should be addressed in all such programs through policy implementation and client-level smoking cessation intervention.

2010 American Association on Health & Disability

American Association on Health and Disability (AAHD) provides the materials and links for general information, education and disease awareness purposes only. Although every effort is made to assure that information is accurate and current, knowledge in the field of disability is changing often, and all data is subject to change without notice. AAHD makes no representations or warranties and assumes no responsibility or liability as to the accuracy, completeness, reliability or usefulness of any information contained in this document. Neither AAHD nor any parties, who supply information to AAHD, make any warranty concerning the accuracy of any information in this document.

This publication was made possible, in part, by a grant from the Department of Health and Human Services, Centers for Disease Control and Prevention (U59/CCU321860-04).