INPATIENT PRACTICE

More Training Needed on Smoking Cessation

Too many mental health professionals view the treatment of psychiatric patients who smoke as a primary care issue, according to a leading researcher in the field.

"But our patients do not necessarily receive regular primary care," says Judith J. Prochaska, Ph.D., of the department of psychiatry at the University of California, San Francisco. Furthermore, "primary care doctors may think our patients are too stressed out and too complicated to address tobacco with them."

Because of her concern about the care of these patients, Dr. Prochaska and colleagues conducted a national survey of psychiatry residency programs and found that only half of the programs offer smoking-cessation training. Of those that do offer such training, the median duration of training was just 1 hour (Acad. Psychiatry 2006;30:372-8).

A couple of years earlier, she reviewed the records of 250 inpatients hospitalized from 1998 to 2001 at San Francisco's Langley Porter Psychiatric Institute, which became 100% smoke-free in 1988—one of the first psychiatric hospitals in the country to do so. In that review, Dr. Prochaska found that patient smoking status was not included in the treatment planning of any of the 105 patients who were smokers. Just over half (56%) of patients who smoked had been given nicotine replacement in the hospital, but only one patient had been encouraged to quit, referred for cessation therapy, or given nicotine replacement on discharge.

One particularly interesting finding was that the smokers who were not given nicotine replacement were more than twice as likely as nonsmokers and those given nicotine replacement to leave against medical advice (Psychiatr. Serv. 2004;55:1265-70). The study led to the hospital's interest in doing more to address nicotine dependence among its patients.

Tobacco use in psychiatry is an issue that is moving increasingly to the fore. The American Legacy Foundation has funded the Smoking Cessation Leadership Center to direct a plan aimed at increasing access to smoking-cessation services for people with mental illness. The leadership center already has put together a coalition of nearly 30 organizations, including the American Psychiatric Association.

CLINICAL PSYCHIATRY NEWS recently spoke with Dr. Prochaska about the importance of smoking-cessation treatments for patients with mental illness, particularly in the inpatient setting.

CLINICAL PSYCHIATRY NEWS: How important are smoking-cessation efforts on inpatient units?

Dr. Prochaska: They are critical. Our patients smoke at high rates and tend to be heavy smokers. With a smoke-free unit, the effective management of patients' nicotine withdrawal is critical. But in general, [encouraging cessation] is not something that inpatient staffers consider. They see a patient who is agitated, depressed, anxious, or cannot sleep, and they think it is a psychiatric disturbance. They do not think "this is a pack-a-day smoker who no longer has access to cigarettes."

CPN: How do you respond to arguments that smoking has benefits for individuals with mental illness and, in fact, helps hospitals manage inpatients?

Dr. Prochaska: Psychiatric hospitals that permit patient smoking report upward of 4 hours per day managing the smoking breaks, dealing with fights over cigarettes, and cycling patients through the discomfort of nicotine exposure and withdrawal. What insurance company wants to pay for this staff time? What liability do hospitals face if patients initiate smoking during this acute time of vulnerability?

When units have gone smoke-free, they have not seen all the unrest that people anticipated—such as the increased use of medications, restraints, seclusion, or against-medical-advice discharges—when nicotine withdrawal is managed.

Units can go smoke free effectively. These are hospitals. Smoking is not at all consistent with the mission of a medical setting.

CPN: You have found that few psychiatry residents receive any training in smoking cessation. Why do you think this kind of training is not taking place more often?

'Tobacco should be addressed just like any other self-destructive behavior.'

DR. PROCHASKA

Dr. Prochaska: Psychiatrists have not viewed tobacco as their issue. Well, if the survival and well-being of patients are their concerns, then tobacco use must be considered and addressed. Tobacco should be addressed just like any other self-destructive behavior, with effective coping strategies brought into play.

Interestingly, tobacco use is also an important marker for future suicidality. Several well-designed, prospective studies with adolescents and adults have shown that.

CPN: What kinds of elements does an inpatient smoking-cessation plan need?

Dr. Prochaska: First, and consistent with clinical practice guidelines, all hospitalized patients who smoke should be offered nicotine replacement upon admission, unless there are clear contraindications. Furthermore, I would recommend making sure the patients' withdrawal is maximally addressed. If they smoke more than one pack a day, a 21-mg nicotine patch is not likely going to cover their withdrawal symptoms.

Bupropion, a medication approved by the Food and Drug Administration for smoking cessation, unfortunately is not likely to act quickly enough to address those initial withdrawal symptoms; it takes about a week for it to be effective. But for a patient interested in staying off tobacco after the hospitalization, bupropion could be combined with nicotine replacement.

Beyond pharmacotherapy, there should be planning for discharge from the hospital. Patients should be reinforced for the number of days they've been smoke free in the hospital; family members should be brought in to support cessation efforts; and there should be nicotine replacement available.

CPN: Recently, you reviewed tobacco industry documents and reported that tobacco companies had engaged in research with schizophrenia patients, and blocked efforts by hospitals to go smoke free. What are some of your specific findings?

Dr. Prochaska: Initially, I was surprised. But then, as I became more aware of how pervasive the tobacco industry's influence has been, it was just simply appalling. We found that companies provided cigarettes on a tax-free basis and gave damaged cigarettes to inpatient units or other programs for the mentally ill. We found letters from psychiatry units asking tobacco companies for cigarettes as a form of patient treatment as recently as 2000. We found that the industry had funded prominent researchers in this area.

CPN: Who is funding your current research, and what is its focus?

Dr. Prochaska: The research we are conducting is funded by the National Institute on Drug Abuse, as well as the California Tobacco-Related Disease Research Program (Proposition 99 funds). Our current research focuses on a tobacco-cessation treatment initiated in the inpatient psychiatry setting that is tailored to patients' motivation to quit, combined with behavioral counseling and the nicotine patch. The more we work with these patients and see the successes they are having, the more I believe that access to evidence-based treatments and systemic changes are at the heart of curing the tobacco problem in psychiatry. ■

By Timothy F. Kirn, Sacramento Bureau.

Send your thoughts and suggestions to cpnews@elsevier.com.

Medical Costs Are Much Higher in OCD Than Depression

BY MIRIAM E. TUCKER
Senior Writer

PITTSBURGH — Medical costs and use of outpatient medical services are much greater among people with obsessive-compulsive disorder than among those with depression, according to the findings of a study that examined the differences in Florida Medicaid patients over a 9-year period.

The study, funded by Jazz Pharmaceuticals, looked at only those patients with "pure" OCD—that is, OCD uncomplicated by depression, bipolar disorder, or psychosis—and "pure" depression—depression in the absence of OCD, bipolar disorder, or psychosis. The findings suggest that much of the care for patients with OCD occurs in outpatient medical settings, said Cheryl S. Hankin, Ph.D., president and chief scientific officer of BioMedEcon Health, Economics, and Outcomes Research, Moss Beach, Calif.

Anecdotally, such OCD patients have appeared in a variety of medical settings, including primary care, dermatology (patients who compulsively pick at their skin or pull their hair), and in obstetrics (pregnant women who fear contamination or other harm to their unborn children), Dr. Hankin noted.

Of approximately 2.9 million Florida Medicaid enrollees during 1997-2006, 16,055 met the criteria for pure depression and 156 for pure OCD. Of those, 135 of the pure OCD patients were matched to 1,511 pure depression patients for sex, race/ethnicity, medical illness severity (Charlson index), and age/year at initial diagnosis.

During the 2 years after diagnosis of OCD or depression, median overall health care costs were more than three times higher in those with pure OCD ($25,666) than those with pure depression ($7,832). The differences were greater for pure OCD for both overall medical costs ($24,799 vs. $7056) and for overall psychiatric costs ($3390 vs. $943). Total inpatient costs did not differ between the two groups ($8,932 for pure OCD, $5,791 for pure depression). There were no psychiatric inpatient stays in either group, Dr. Hankin noted.

Despite matching for medical illness severity, total outpatient costs ($5,139 vs. $2,687) drove the cost differential, with most of that difference coming from outpatient medical costs ($4,820 vs. $2,525). Outpatient psychiatric costs between pure OCD ($220) and pure depression ($224) did not differ significantly. Total pharmacy costs were also significantly higher for the pure OCD patients ($5,741 vs. $2,548), the difference being driven mainly by psychiatric medication costs ($3,294 vs. $818), while the difference for other medical pharmacy costs did not differ significantly ($1,810 for pure OCD vs. $1,346 for pure depression).

Dr. Hankin and her associates are now investigating whether the pharmaceutical treatment of OCD is appropriate in primary care medical settings. Some data have suggested that 40%-50% of patients are treated inappropriately, either with the wrong drugs, for too short a duration, and/or at too low a dose. ■