# COUNSELLING SMOKERS WITH MOOD DISORDERS

## GENERAL TIPS AND GUIDELINES

# BACKGROUND

- The prevalence of smoking among individuals with major depressive disorder ranges from **40-60%** across populations [1] and the prevalence of depression is **three times** higher among smokers than non-smokers.[2]
- There is evidence to support that tobacco interventions can improve depressive symptoms, anxiety, and stress, and enhance positive mood and quality of life.[3]
- Integrating mood management into smoking cessation treatment can improve long-term quit success rates among smokers with current/past depression [4], and is a step toward optimizing client health. [5]

# SCREENING & ASSESSMENT TOOLS FOR MOOD DISORDERS

Given that comorbid mood symptoms are common in individuals using tobacco/making a quit attempt, all patients should be screened for mood disorders.[5]

- The table below provides examples of screening and assessment tools for depression:[5],[6],[7],[8],[9]

| Patient Health Questionaire (PHQ-2 and PHQ-9) | • Self-reported screening-tool used to assess depression severity during quit attempt<br>• Scores each of the 9 DSM-IV criteria<br>• PHQ-2 is a first-step screen for frequency of depressed mood and anhedonia |
|---|---|
| Beck Depression Inventory (BDI) | • Self-reported 21-item tool to assess attitudes and symptoms of depression<br>• Only requires fifth/sixth grade reading level<br>• No formal training required to administer tool |
| Hamilton Depression Rating Scale (HAMD-7) | • 7-item scale to assess depression<br>• Higher score associated with greater depression severity<br>• Click **here** for more information |

# COMMON ELEMENTS OF BRIEF INTERVENTIONS [10]

| Identify events, stressors, or activities that increase the risk of smoking or relapse | • Negative mood<br>• Being around other smokers<br>• Drinking alcohol or using drugs<br>• Being under time pressure |
| --- | --- |
| Develop and practice coping or problem solving skills | • Learning to anticipate and avoid tempation<br>• Learning cognitive strategies that will reduce negative moods<br>• Lifestyle changes to reduce stress and improve the quality of life |
| Provide basic information about smoking and successful quitting | • Any smoking (even a single puff) increases the likelihood of a full relapse<br>• Withdrawal typically peaks withing 1-3 weeks after quitting<br>• Information on the addictive nature of smoking |

# ETHICAL CONSIDERATIONS WHEN ADDRESSING MOOD DISORDERS

As previously mentioned, there is strong evidence to support the integration of mood interventions as part of smoking cessation programming. However, ethical issues may arise at any point during treatment, including those that compromise your patient's well-being, conflicts of interest, and issues regarding consent and decision making. [11] As a health care provider, you must make a decision based on your profession's standards, your organizations policies/expectations and your personal values.

Below is a list of factors to consider when making ethical decisions regarding treatment: [5]

**Autonomy:** patients have the right to make their own decisions.

**Dignity:** Patients should be treated with compassion and respect.

**Client-centred:** Use an approach that centers around the client's best interest and values.

**Equity:** Ensure that access to care is equitable and barriers to treatment are reduced.

**Transparency:** Treatment options and decisions should be discussed clearly and timely.

**Diversity:** Support diversity among clients.

# GENERAL TIPS WHEN COUNSELLING SMOKERS WITH MOOD SYMPTOMS

**Compassion:** Support your patients regardless of the choices they make. You want your patients to succeed in quitting tobacco. Look for opportunities to provide affirmations to emphasize any changes or commitment you notice.

**Acceptance**: Patients use tobacco for many reasons. Our role is not to judge but to accept that tobacco plays a role in helping patients cope. Our goal is to help them find alternative ways of coping.

**Partnership:** You will work collaboratively with patients to determine the treatment goal and together develop a plan that meets each patient's unique needs. Encourage your patient to set goals and provide frequent feedback.

**Evocation**: Patients will bring varied experience with respect to their tobacco use or mental illness. They will have likely tried many things to stop using substances. They know what works and what doesn't. Focus on eliciting these strengths and barriers from the patients through reflective listening.

**Integrated approach:** Patients often present with multiple issues and may be ambivalent about addressing all of the issues together. Guide the patient in understanding the relationship between their mood disorder, tobacco use, and other health behaviours.

**Accommodate:** Our treatment protocols may be overwhelming for patients who experience cognitive impairments or disordered thinking. You may have to adjust your strategy and use alternate techniques such as repetition and simplified examples while working with these patients.

**Communication:** Be clear, concise, and consistent with your communication to the patient. Ask one question at a time, avoid compound questions, and give the patient lots of time to respond. Reflect and provide summaries frequently to bring important pieces of the conversation together.

# ADDITIONAL RESOURCES

- Smoking Cessation for Persons with Mental Illnesses. A Toolkit for Mental Health Providers: **https://www.integration.samhsa.gov/Smoking_Cessation_for_Persons_with_MI.pdf**
- TEACH Specialty Course: *Tobacco Interventions for Clients with Mental Illness and/or Substance Use Disorders:* **https://www.nicotinedependenceclinic.com/English/teach/Pages/Courses/Online-Courses.aspx**

## Webinars:

1. Increasing the Likelihood of Quit Success: Integrating a Mood Intervention into Smoking Cessation Programming (Part 1) **https://camh.adobeconnect.com/_a829238269/pgz12g059zp8/?proto=true**
2. Increasing the Likelihood of Quit Success: Integrating a Mood Intervention into Smoking Cessation Programming (Part 2) **https://camh.adobeconnect.com/_a829238269/pffrud3pkgtt/?proto=true**
3. Boiling the Ocean: working with clients with multiple behavior change goals **http://camh.adobeconnect.com/pckyxaffso36/**

# BIBLIOGRAPHY

1. Kalman, D., Baker-Morissette, S., George, T.P. (2005). Co-morbidity of smoking in patients with psychiatric and substance use disorder. American Journal on Addiction, 14: 106-23.

2. Lembke, A., Johnson, K., DeBattista, C. (2007). Depression and smoking cessation: Does the evidence support psychiatric practice? Neuropsychiatr Dis Treat. 3(4): 487-493.

3. Taylor, G. McNeill, A., Girling, A., Farley, A., Lindson-Hawley, N. & Aveyard, P. (2014). Change in mental health after smoking cessation: Systematic review and meta-analysis. BMJ, 348.

4. Van der Meer, R.M., Willemsen, M.C., Smit, F., Cuijpers, P. (2013). Smoking cessation interventions for smokers with current or past depression. Cochrane Database of Systematic Reviews, 21(8).

5. Barker, M., Dragonetti, R., Abate, T., & Selby, P. (2015). Tobacco interventions for clients with mental illness and/or substance use disorders: Course Manual. Toronto, ON: Centre for Addiction and Mental Health.

6. D'Souza, L., Lingam, M., Bantoto, B., Dragonetti, R., Selby, P. (2017). Integrated Chronic Disease Management and Prevention: A person-centred approach to addressing tobacco and other modifiable risk factors. Toronto, ON: Centre for Addiction and Mental Health.

7. American Psychological Association (2015a). Patient Health Questionnaire (PHQ-9 & PHQ-2). Retrieved from: http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health.aspx

8. McDowell, I., & Newel, C. (1996). Measuring Health. A Guide to Rating Scales and Questionnaires (2nd ed.). New York, NY: Oxford University Press.

9. Farinde, A. (2013). The Beck Depression Inventory. The Pharma Innovation Journal, 2(1), 56-62.

10. Morris, Chad, et al., et al. (2009). Smoking Cessation for Persons with Mental Illnesses. *A Toolkit for Mental Health Providers.*

11. Canadian Medical Association. CMA Policy. Ottawa, Canada: Canadian Medical Association; 2015. CMA code of ethics. Last reviewed 2015. Available at: http://bit.ly/1Wrbo5H.