Free&Clear
the healthy behaviors company

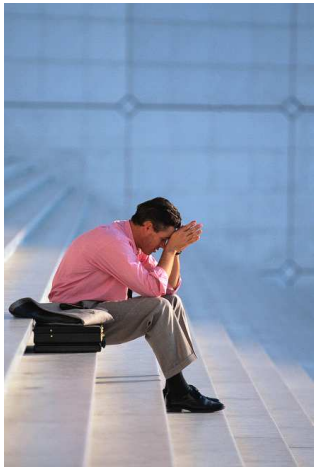
Mental Health and Quitlines: QL Perspectives and a QI Functional Assessment Project

Tim McAfee, Steve Tutty, Ken Wassum, Andrew Roberts
Free & Clear
206-876-2551
tim.mcafee@freeclear.com

Perspectives

Do people with a mental health diagnosis have access to quitlines? Should they?

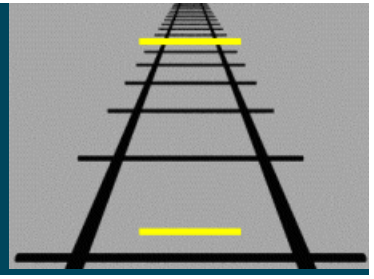
-Superficial answer = "Yes"



Drill-down questions:

- "Are they *aware* of QL services?"
- "Are they *referred* by MH providers?"
- "Are they *calling* at similar rates?"
- "Are they *receiving* condition-appropriate care?"
- "Are they *quitting* at similar absolute or relative rates?"
- "Would service be better if we *screened*?"

Challenges

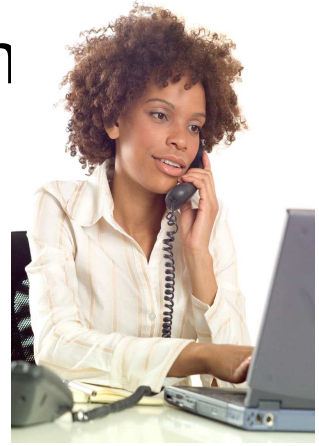


- Will altering cessation treatment for people with MH conditions help, hurt, or have no effect on quit or mental health outcomes?
  - Evidence base slim
  - How should we alter?
  - If more or different treatment is ineffective, providing it is not an improvement
- There is not one MH population
- Quitline staffing

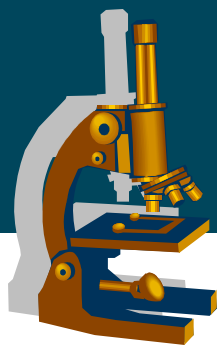
Pre-evidence recommendations

We SHOULD require that:

- QLs are accessible and REACHING MH populations
  - Monitor utilization
- QL personnel are competent to work with callers with MH conditions
  - Address prejudices and misinformation
  - Increase referral awareness



Pre-evidence recommendations



We should CONSIDER & EXPERIMENT with:

- Mental health functional status/other questions
- Varying the nature, style, intensity, timing, and duration of treatment

We should NOT require:

- MH screening for all QL callers in MDS
- QL personnel to *diagnose* MH conditions
- A different treatment approach (until evidence this improves outcomes)

Mental Health Improvement Plan

Assumption: Tobacco dependent callers with MH disorders want to quit, and can quit.

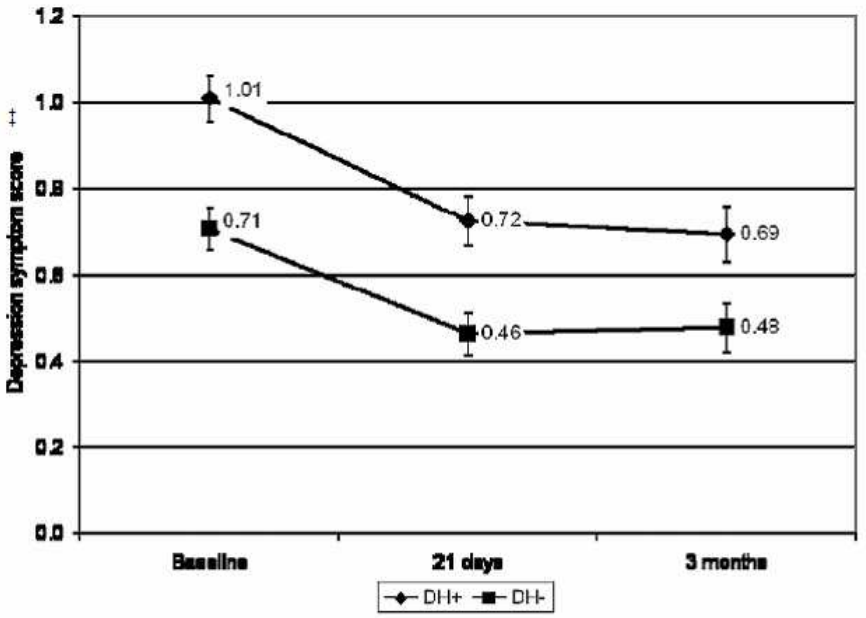
- Training curriculum for coaches
  1) Understand co-morbidity
  2) Tailor cessation support
  3) Relapse prevention
  4) Cmty & provider support
- QI pilot of a brief screening tool
- Measure impact

COMPASS study depression results

- 1200 participants – all received varenicline
- Depression history reviewed
- DH+ = higher rate of depression and stress symptoms - symmetric
- No difference in quit rates!!!

McClure et al. J Gen Intern Med. 24(5).563-9 (GSwan PI)

Figure 1. Change in Depression Score from Baseline to Follow-up*



*Scores reflect unadjusted means, with 95% confidence intervals indicated for each data poi
Adjusted mean change from baseline to each follow-up is presented in the text and was significantly greater for DH- participants at each follow-up.
† DH + participants indicated a probable history of prior major depression at baseline. DH – participants denied symptoms suggestive of a probable lifetime major depression episode.
‡ Depression symptom scores range from 0 to 4 and reflect symptoms over the past month. Higher scores indicate greater depression.

QI Screening Project

- ~500 commercial callers asked to answer additional MH-related questions at intake
- 99% consented
- Asked functional MH question:

  "Do you have emotional or mental health challenges that you think will make it hard for you to quit tobacco?"
- Asked PHQ-2 & OQ-5 (Depression screen)
- Correlating with 6-month quit status

Patient Health Questionnaire – 2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems:

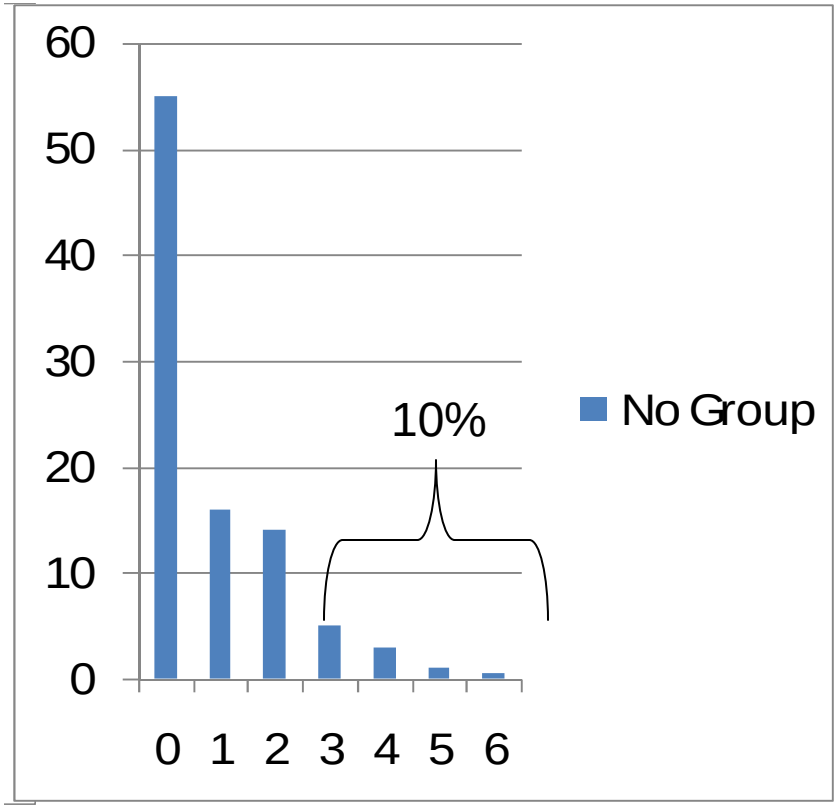
- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless

0=Not at all, 1 = Several Days, 2= More than half, 3 = Nearly every day

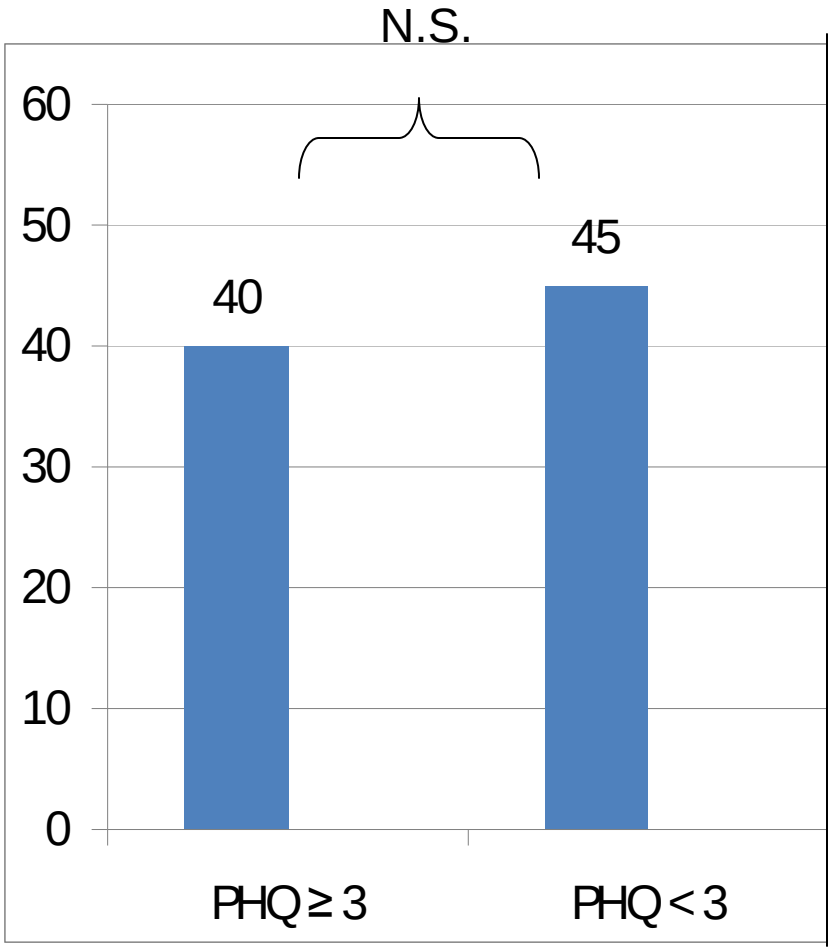
Baseline Valid Responses

	PHQ ≥ 3 (Yes depression)	PHQ < 3 (No depression)	
Yes to emotional challenges	8%	22%	30%
No to emotional challenges	7%	63%	70%
	15%	85%	N = 441

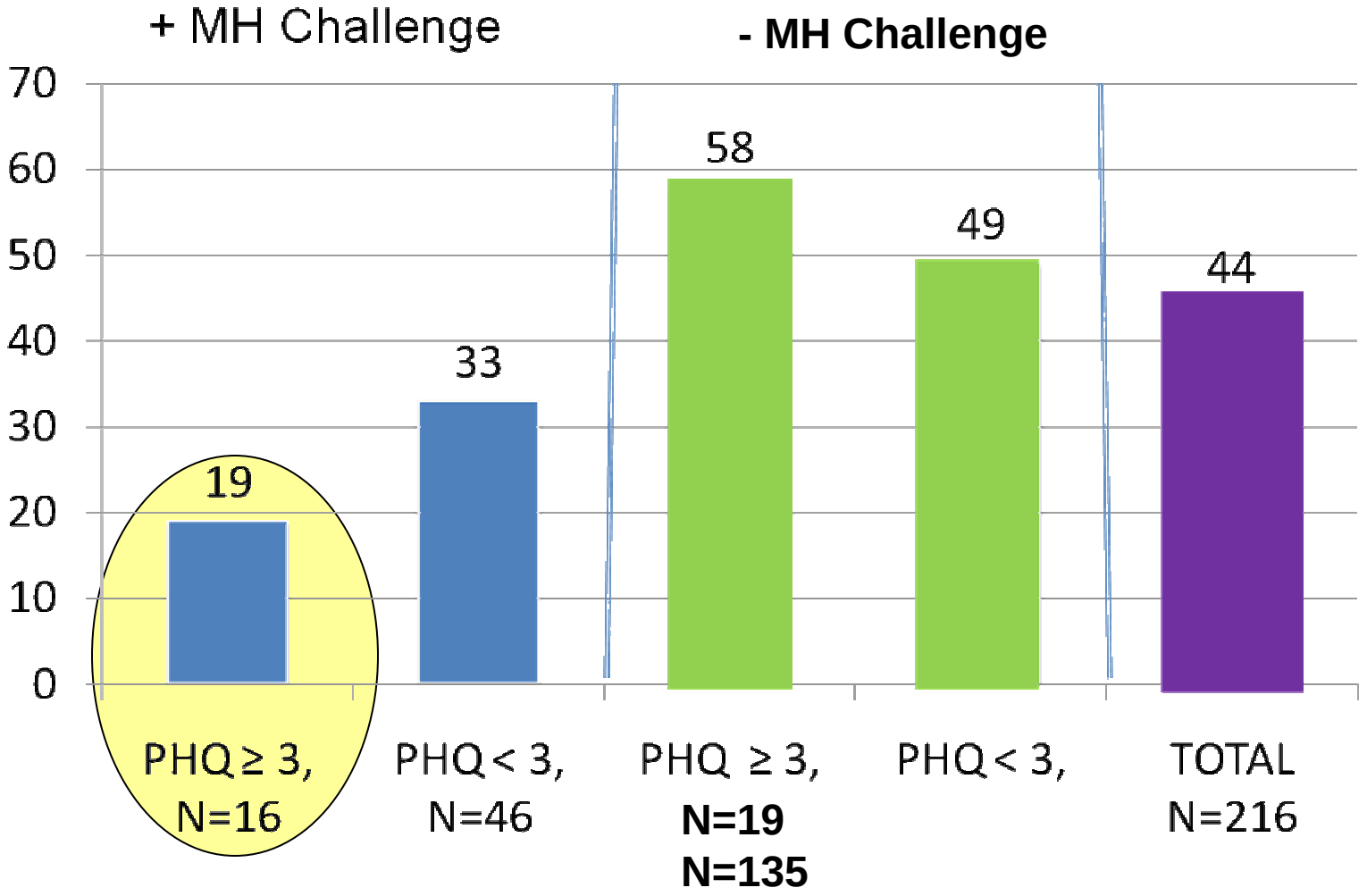
PHQ – 2: Distribution by “MH Challenge”



Responder Quit Rates (%):
≥ 30 days abstinent @ 6 months (N=216)

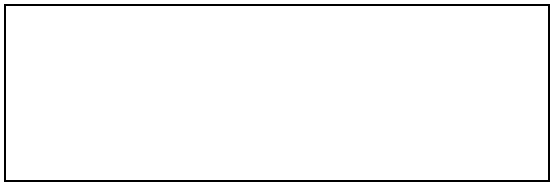


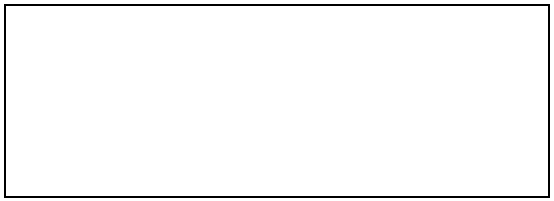
Responder Quit Rates (%):
≥ 30 days abstinent @ 6 months

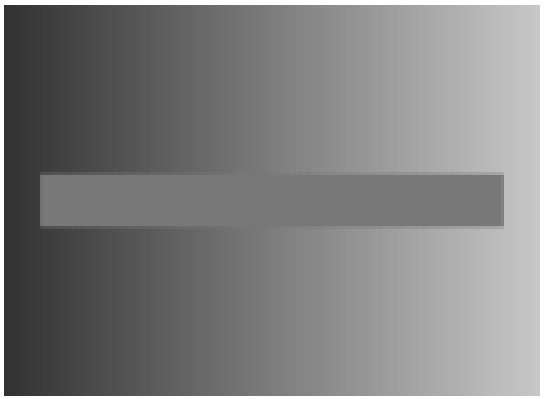


Caveats

- Commercial population
- Non-adjusted
- Moderate sample size
- Even if quit rates are lower, groups may be getting equivalent *relative* benefit



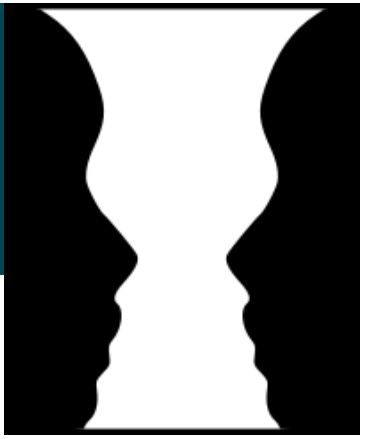




QI Pilot Summary

- 30% report emotional/MH challenges they expect will interfere with their ability to quit
- 15% screen positive on depression screen (PHQ)
- Those answering “yes” to MH challenges are ~3 times more likely to screen positive for depression
- Those screening + for depression are ~3 times more likely to answer “yes” to MH challenges
- PHQ-2+ does *not* predict lower quit rate
- MH Challenge+ screen is associated with a 40% decrease in quit rate.

Conclusion – Perspectives



- More research and evaluation needed
  - Prevalence/outcomes
  - Pros/cons of screening (functional assessment!)
  - Pros/cons of varying treatment
- We *don't* need more research before encouraging QL use in MH population
- We *don't* need more research to ensure QL staff are empathic and educated about MH

Responder Quit Rates: (Abstinent >30 days @ 6 mos)

	PHQ ≥ 3 Yes depression	PHQ < 3 No depression	
Yes to emotional challenges	16 3/16 quit (19%)	46 15/46 quits (33%)	62 18/62 quits (29%)
No to emotional challenges	19 11/19 quit (58%)	135 66/135 (49%)	154 77/154 quits (50%)
	35 14/35 (40%)	181 81/181 (45%)	N = 216 95/216 quits (44%)