MDQuit.org

Treating Tobacco in Smokers with Substance Use Disorders Workshop

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MARYLAND RESOURCE CENTER
FOR QUITTING USE & INITIATION OF TOBACCO

Overview

- Nicotine: A Hidden Addiction in Substance Abuse and Mental Health Treatment
- Putting Smoking in Perspective
- Addressing Current Barriers
- Current Treatment Recommendations for Quitting Tobacco Use
- Creating the future: Integrating Smoking Cessation into Mental Health, Addiction,and Dual Diagnosis Treatment

The Big Picture – 2007 and beyond

There are 90.7 million ever smokers in the U.S.

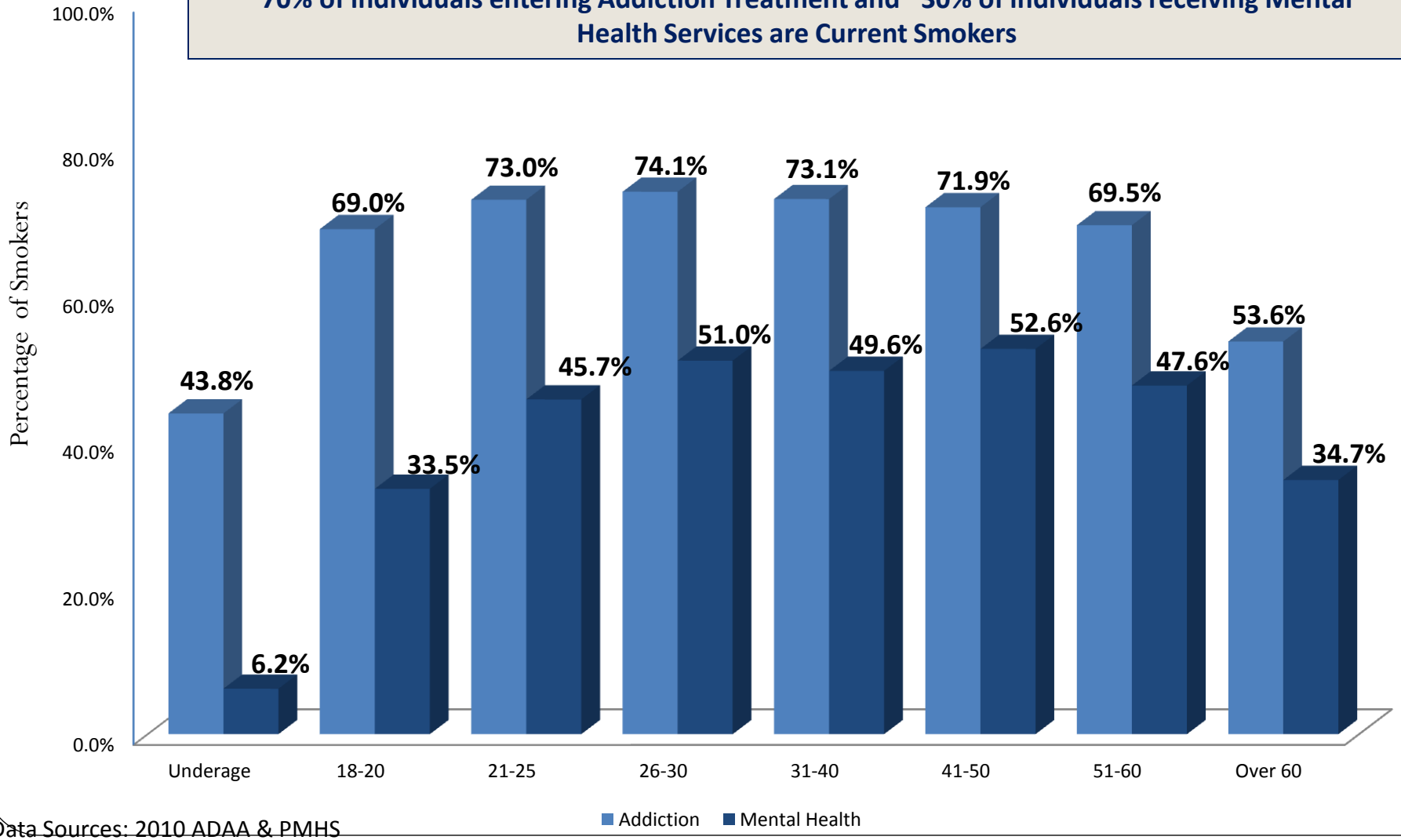
- Over 52% of these are now former smokers
- Prevalence has dropped from 42% in 1965 to under 20% in 2007
- In Maryland smoking rates dropped from 20.5% in 2000 to 15.2% in 2010.
- **There are over 45 million successful quitters**

43.4 million people are still smoking the U.S. in 2007 (19.8% of adults)

- 77.8 % of smokers smoke every day
- 38.4% stopped smoking for one day in the past year because they were trying to quit

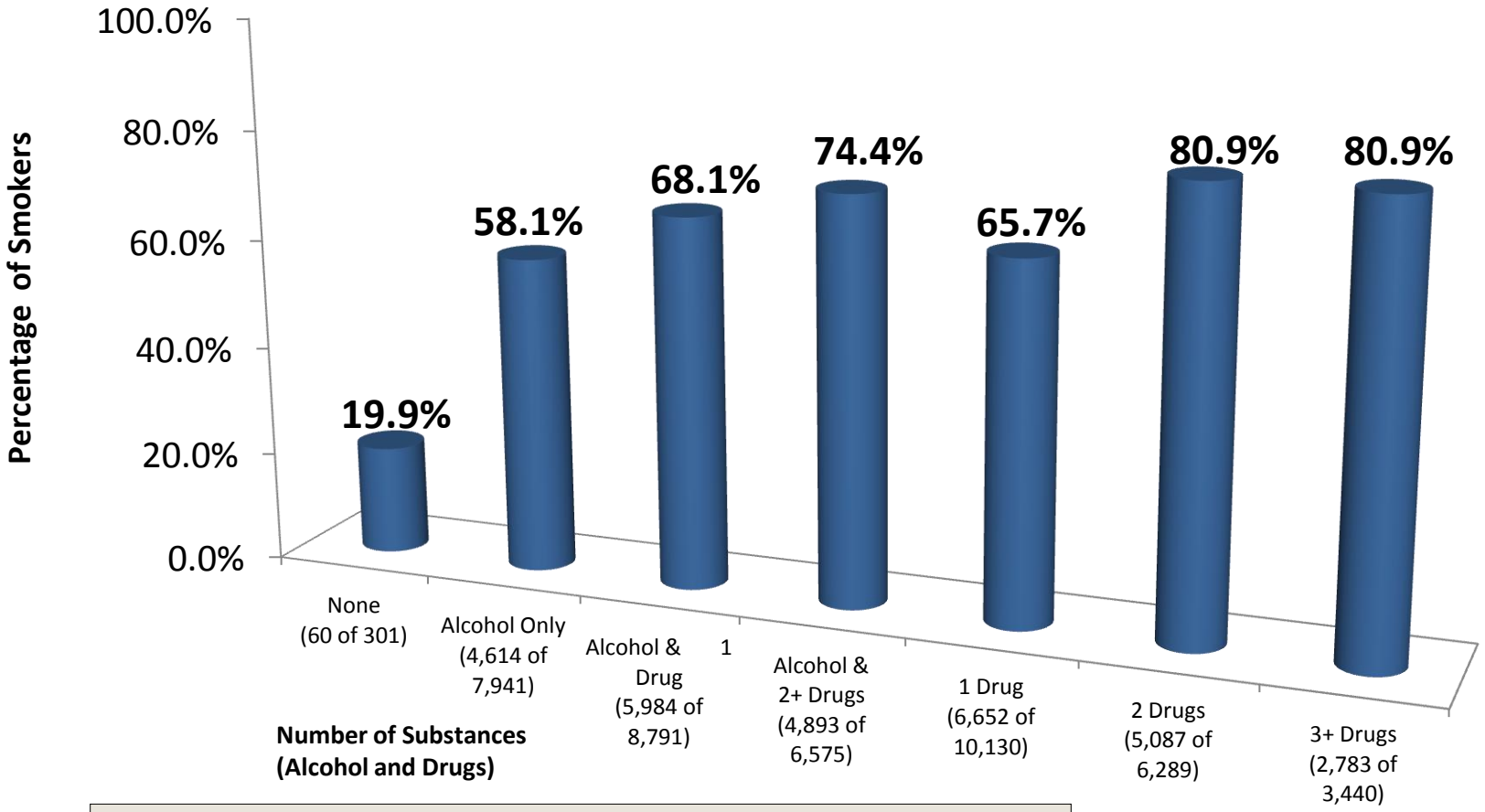
2010 Smoking Rates by Age Group in Maryland Addiction/Mental Health Clients

~ 70% of individuals entering Addiction Treatment and ~30% of individuals receiving Mental Health Services are Current Smokers



Data Sources: 2010 ADAA & PMHS

Alcohol, Drug Use and Current Smoking



Poly Substance Use by Persons Admitted to Addiction Treatment in Maryland is Related to an Increased Likelihood of Current Smoking

Source: 2010 ADAA
(N= 43,467 persons admitted to State-Funded Alcohol and Drug Abuse Treatment)

Behavioral Health and Smoking in Maryland

Maryland Behavioral Health Smoking Rates (CY 2010)

- Admissions to State-Funded Alcohol and Drug Abuse Treatment
  - **81.4% Inpatient**
  - **64.0% Outpatient**

(Source: ADAA SMART [State of Maryland Automated Record Tracking)] System)

National Behavioral Health and Smoking

- Over 70% of the BH population wants to quit

- Approximately 35-40% BH staff smoke vs. 20.4% general population

(Source: 2006 NASHMHPD Research Institute Survey on Smoking Policies)

What are the Benefits and Costs of Smoking for Substance Abusers

Cons for Quitting

- Benefits of Smoking
- Costs of Quitting

Pros for Quitting

- Costs of Smoking
- Benefits of Smoking

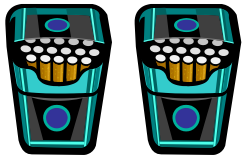
Synergy between tobacco use and alcohol or drug misuse?

- Daily and non-daily smokers:
  - drink more and for longer periods of time
  - find alcohol more reinforcing
  - Seem to be able to extend the Marijuana experience
  - Nicotine is a stimulant that can take the edge off the depressant effects of some drugs
  - Others that you have heard?

Cost of Smoking

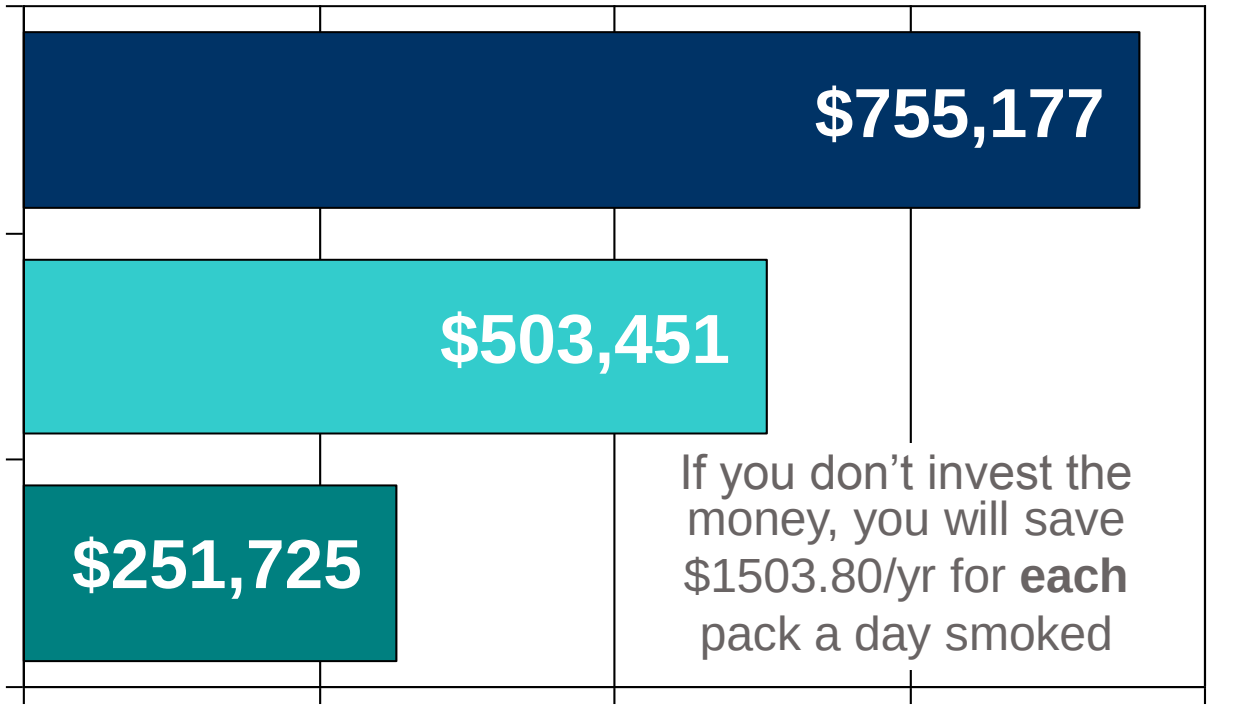
If you save the money you use to buy cigarettes for 50 years @ $4.32 per pack and earn 4% interest

3 Packs/day



2 Packs/day

1 Pack/day



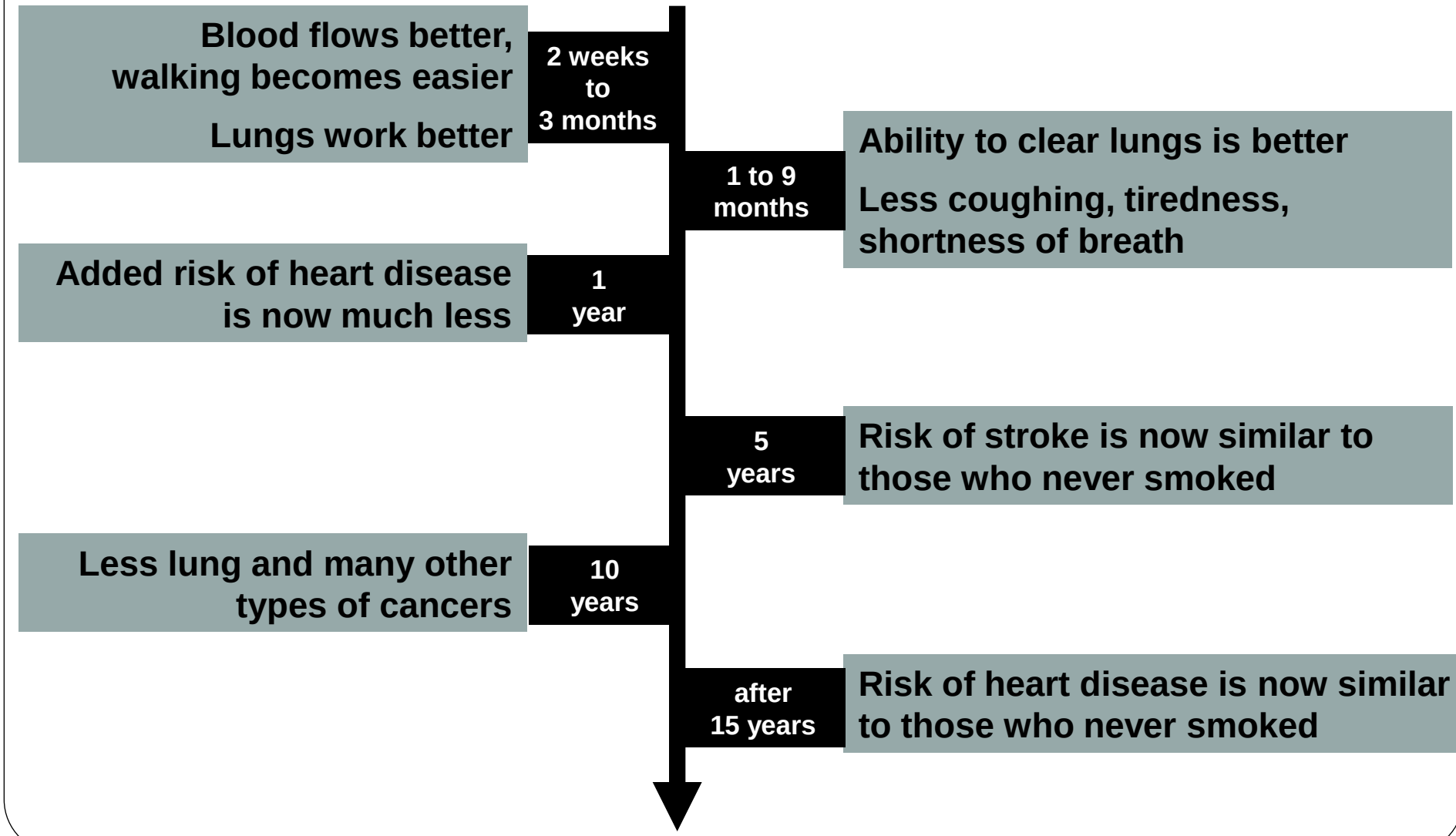
Non Communicable Diseases NCDs

- WHO report estimated that 36 MILLION people worldwide die EACHYEAR due to NCDs (63% of all deaths)
- Major causes: CVD, Cancer, Respiratory diseases, Diabetes, Other
- Leading factors contributing
  - Tobacco Use
  - Unhealthful Diet
  - Alcohol
  - Physical Inactivity

  - Sound like any substance abuse treatment clients?

Benefits of Quitting

Time Since Quitting

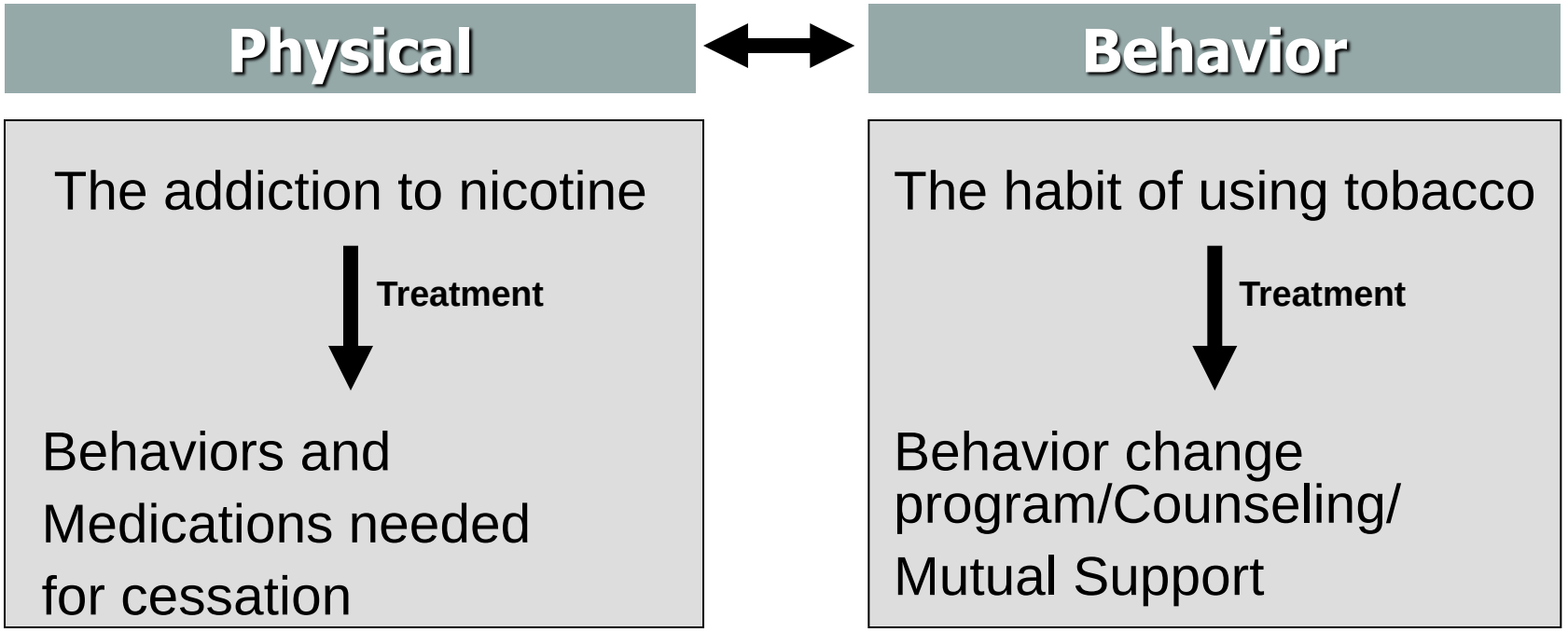


Drug Abuse Treatment Programs and Smoking Cessation

- Why should they be great at helping smokers quit?
- What could they do?
- What are the keys to getting more smoking cessation n drug treatment programs?
- What are the barriers?

Tobacco Dependence is Similar to Dependence on all Substances

Treatment should address both the physiological addiction and the habit.



Helping with the Physical Part: Medication

- Medications help with the physical part of quitting (addiction)
- Make people more comfortable when quitting
- Less irritable, better sleep and mood, less cravings, less weight gain
- Medications do not have the harmful ingredients in cigarettes
- Can focus on changing behavior

Helping with the Behavior Part: Counseling and Support

- Prepare to quit;
- Build Motivation
- Change the environment
  - Have tobacco-free home rules
  - Avoid smoke and things that remind you of smoking (ash trays, tobacco branded items)
  - Plan other activities for when you usually smoke
- Plan to quit: Pick a date to quit and develop a change plan
- Create Commitment
- Implement the Plan: Revise as needed
- Sustain energy and commitment to maintain cessation

Barriers to quitting

When quitting, people have a hard time because they…

- Fear weight gain
- Fear withdrawal symptoms
- Give up a social activity to do with friends
- Expect failure- maybe they failed in the past
- Think they cannot cope with tension and anxiety
- Do not know enough about the good parts of quitting
- Have a hard time changing daily routines that include smoking

A Personal Journey

- The journey into and out of nicotine addiction is a personal one marked by
  - Biological, psychological and social risk and protective factors
  - Social Influences (peers, media, tobacco companies, policies, current events)
  - Personal choices and decisions
  - A process of change that is common and unique

How Do People Change?

- People change voluntarily only when
  - They become ***interested and concerned*** about the need for change
  - They become ***convinced*** that the change is in their best interest or will benefit them more than it will cost them
  - They organize a ***plan of action*** that they are ***committed*** to implementing
  - They ***take the actions*** that are necessary to make the change and sustain the change

Stage of Change Tasks

- **Precontemplation**

- **Contemplation**

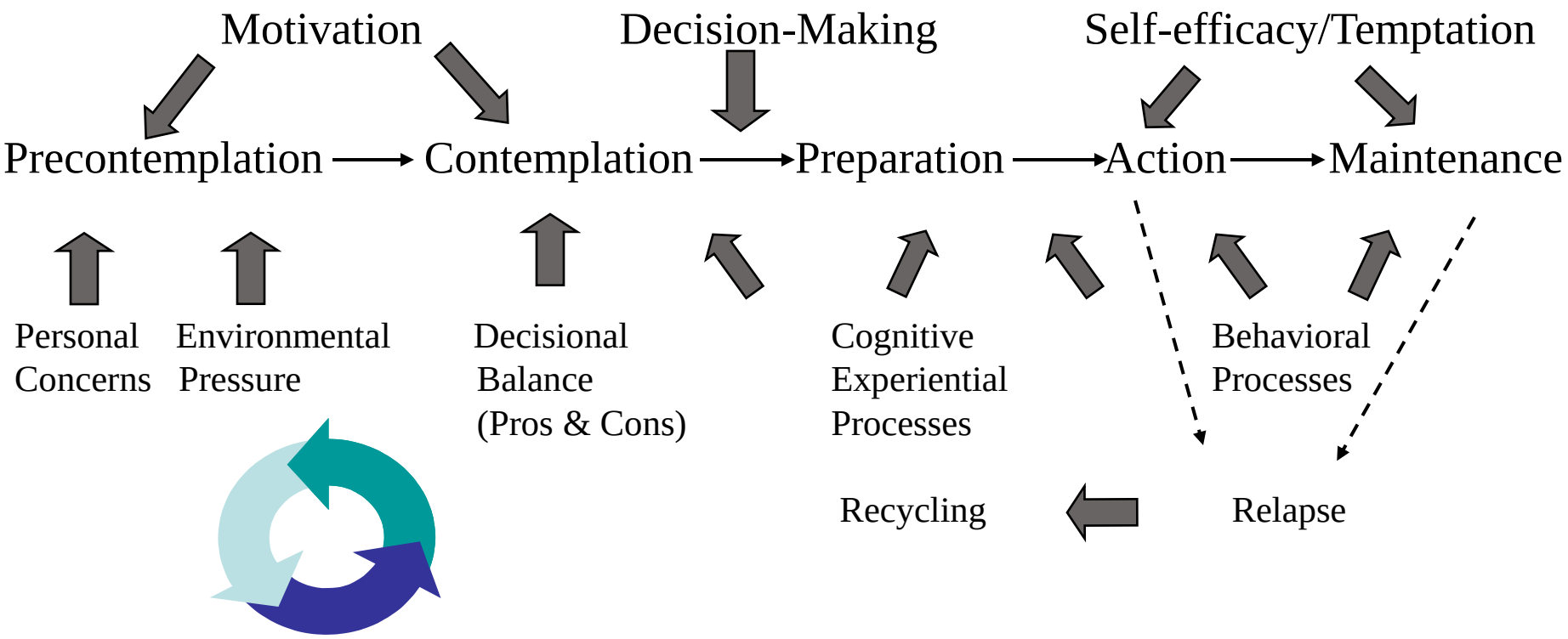
- **Preparation**

- **Action**

- **Maintenance**

- **Interested and Concerned**
- **Risk-Reward Analysis & Decision making**
- **Commitment & Creating an Effective/Acceptable Plan**
- **Implementation of Plan and Revising as Needed**
- **Consolidating Change into Lifestyle**

Theoretical and practical considerations related to movement through the Stages of Change



Selecting a Treatment: Triage Guidelines

- Steer patient to most appropriate treatment
  - Patient characteristics and preference
- Minimal self-help interventions are a good place to start for many smokers
- More intensive…if patient has made many prior attempts, is high on nicotine dependence and is ready and willing
- Treatment matching
  - Tailored materials
  - Pharmacological aids

Current Numbers of Smoking Cessation services in SA Treatment Facilities

- Unfortunately, there needs to be an increase in smoking cessation services offered as up to 60% of programs do not offer any formal cessation services (Knudsen, 2011).

- Studies have found that hospital affiliation, service breadth, the priority given to physical health, the availability of medication to treat addictive problems, assessment of cigarette smoking, and a greater perception of the proportion of patients who smoke were associated with the delivery of smoking cessation services (Friedman, Jiang, & Richter, 2008).

Barriers for Smoking Cessation in Substance Abuse Treatment

- Provider Myths
- Challenges to Facilities and Providers

Common Provider Myths

Smoking Cessation in Substance Abuse Treatment

Myth #1:

- **If someone in substance abuse treatment has to give up smoking too, they will just drop out or might have increased chance of relapse.**

Myth #2:

- **Health care professionals can help the general population quit smoking more easily than helping someone who is also quitting another substance as well.**

Myth #3:

- **People who are willing to address their substance use problems are probably less motivated to quit smoking.**

Myth#4:

- **If a person has substance abuse issues, their smoking is much more benign in terms of health risks and concerns and can be addressed later.**

Myth#1

- **If someone in substance abuse treatment has to give up smoking too, they will just drop out or might have increased chance of relapse.**
  - Inclusion of smoking as a target for intervention does not appear to reduce patients' commitment to broader addiction treatment.
  - Incorporating smoking cessation treatment into inpatient addiction treatment centers has not substantially reduced long term treatment completion (Sharp et al., 2003).
  - Smoking cessation interventions delivered during treatment actually increase the odds of abstinence (Prochaska, Delucci, & Hall, 2004).
  - Continued smoking post-treatment increases risk of substance abuse relapse, and quitting smoking reduces risk of relapse (Satre et al., 2007; Tsoh et al., 2011).

Myth #2

- **Health care professionals can help the general population quit smoking more easily than helping someone who is also quitting another substance as well.**
  - Dr. Ong and fellow researchers at UCLA (2011) found that with counseling from a physician, persons with a substance use disorder who also smoked had quit rates very similar to those who did not have a substance use disorder (31% compared to 34%).

Myth #3

- **People who are willing to address their substance use problems are probably less motivated to quit smoking.**
  - Actually, research has indicated that up to 80% of people in addiction treatment are interested in quitting smoking (Prochaska, 2004).
  - Recent studies suggest that drug treatment patients are interested in quitting smoking, have tried to quit repeatedly, and often have made a serious attempt within the last year (Richter and Arnsten, 2006).
  - In fact, one study showed that 70% were either contemplating quitting or preparing to quit in terms of their readiness to change (Nahvi, Richter, Li, Modali, & Arnsten, 2006).

Myth #4

- **If a person has substance abuse issues, their smoking is much more benign in terms of health risks and concerns and can be addressed later.**
  - Mortality statistics suggest that more people with alcoholism die from smoking-related diseases than from alcohol-related diseases (Hurt et al. 1996, Hser et al., 1994).
  - Many persons who abuse substances including alcohol also smoke putting them at high risk for tobacco-related complications including multiple cancers, lung disease, and cardiovascular disease (Richter, McCool, Okuyemi, Mayo, & Ahluwalia, 2002).

Challenges to Facilities/Providers

Smoking Cessation in Substance Abuse Treatment

1. Many clinicians smoke, and do not promote and/or implement smoking cessation interventions as much as clinicians who do not smoke (Knudsen & Studts, 2010; Rothrauff, 2011).

2. Clinicians are faced with insufficient financial reimbursement to properly administer tobacco cessation interventions to their clients (Rothrauff, 2011).

3. There is also a possible lack of access to smoking cessation services as well as insufficient training and educational tools for staff members to address tobacco dependence among patients (Knudsen, 2010; Knudsen & Studts, 2010; Williams, 2005).

Staff Smoking

- According to recent research literature, staff smoking in substance abuse treatment facilities ranges from 14-40% (Guydish, Passalacqua, Tahima, & Turcotte Manser, 2007)
- Recommendations (Williams, 2005) :
  - A smoke-free policy should be implemented on all grounds of the treatment facilities.
  - Promotes a drug-free environment for both patients in treatment and patients out of treatment.
  - Providing smoking cessation resources not only helps them quit but also provides them with essentials tools necessary to help substance abuse clients quit smoking.
  - Smoke-free policies can be successfully established by:
    - Providing tobacco education to all staff members.
    - Thoughtfully and carefully implementing the smoke-free regulations

Financial Reimbursement

- Barriers associated with financial issues faced while trying to administer proper smoking cessation interventions can be circumvented by opting for less expensive interventions such as:
  - Quitlines
  - Handouts with information on smoking cessation,
  - Referrals to nonprofit organizations that provide free services and/or Websites that provide additional information and self-help guidelines to quit smoking, etc. (SAMHA; MDQuit; smokingstopshere.com)
- Federal Medicaid policy states that smoking cessation benefits, such as counseling and drug therapy, are OPTIONAL benefits under Medicaid (except for children covered under Early Periodic Screening, Diagnosis and Treatment).
- Smoking cessation-counseling services may be provided under a variety of Medicaid benefit categories. However, smoking cessation medications are specifically classified as those drugs that may be excluded.

Brief Intervention for Tobacco: Private Payer Benefits

- HCPCS/CPT Codes:
  - **99406**: Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. *Short descriptor: Smoke/Tobacco counseling 3-10*
  - **99381-99397**: Preventive medicine services
  - **96150-96155**: Health & Behavior Assessment/Intervention (Non-physician only)
- Private payer benefits are subject to specific plan policies. Before providing service, benefit eligibility and payer coding requirements should be verified. AAFP, 2011

Increasing Access and Training to Providers

- Lack of knowledge and training has also been repeatedly shown to be a barrier in providing smoking cessation interventions during substance abuse treatment (Guydish et al., 2008; Knudsen, 2010; Knudsen & Studts, 2010; Williams, 2005).
- Recommendations:
  - Policy regulation, provision of NRT and training for treatment providers can help integrate smoking cessation programs into residential substance abuse treatment centers.
  - Treatment providers should be familiar with the PHS:TTUD guidelines as the Best Practices recommendations for smoking cessation with this population.

Treating Tobacco Use and Dependence: 2008 Update

- TTUD recommendations:
  - Smoking cessation for all health care settings including SUD treatment
    - All smokers should be offered treatment
  - Brief interventions (identify and engage)
    - Patients unwilling to quit be provided with brief intervention to build motivation
    - Patients willing to quit be offered evidence based treatment
  - Treatment services (treat nicotine addiction)
    - Counseling
    - Medications (NRT, Chantix®, Zyban®)

Evidence Based Treatments

- Efficacious Interventions for smoking with Substance Abusers:
  - Interventions:
    - 5 A's (willing to quit)
    - Brief Motivational Interviewing (not willing to quit)
    - Medications
    - Nicotine replacement therapy (NRT)
    - Cognitive-behavioral therapy
  - Formats:
    - Individual and/or group counseling

(Kalman, 2010; ahrq.com, Yahne & Baca, 2009)

Selecting a Treatment: Triage Guidelines

- Steer patient to most appropriate treatment
  - Patient characteristics and preference
- Minimal self-help interventions are a good place to start for many smokers
- More intensive…if patient has made many prior attempts, is high on nicotine dependence and is ready and willing
- Treatment matching
  - Tailored materials
  - Pharmacological aids

Effective Strategies

- Teachable Moments
- Various strategies used with individuals without mental illness will work with individuals with MI & SMI
  - Nicotine Replacement Therapy
  - CBT
  - Group Therapy
  - Quitlines

Brief Intervention for Tobacco: The 5 A's Approach

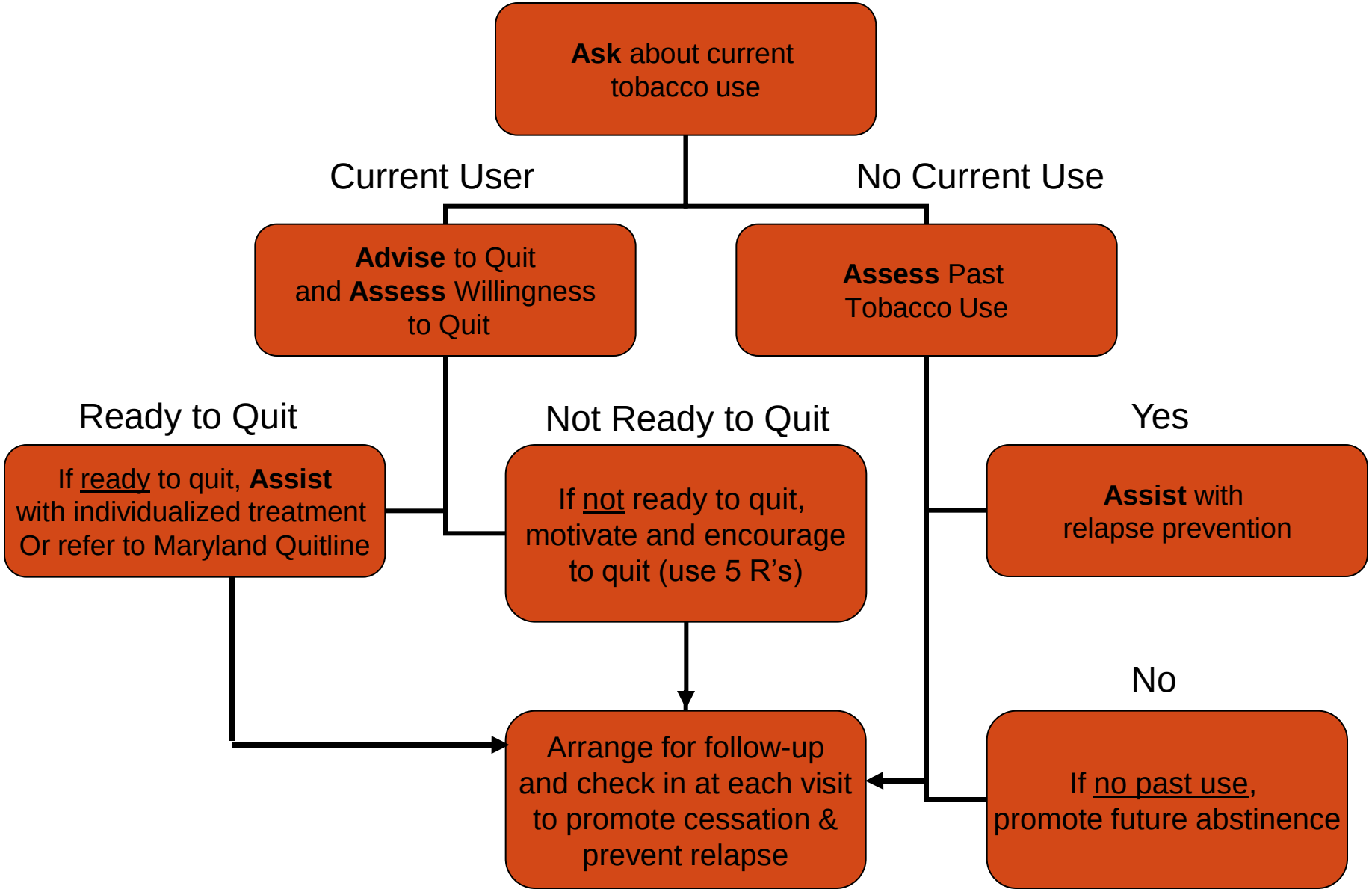
- The 5 A's approach is a simple, brief way to address tobacco use with every patient.
- Altogether, the 5 A's may take 1 – 5 minutes.
- They do not need to be applied in a rigid manner, and entire office/clinical staff should be involved.
- Clinical settings that implement the 5 A's fully show better results than those with partial use (Fiore et al., 2008).

The 5 A's:

1. Ask
2. Advise
3. Assess
4. Assist
5. Arrange

The 5 A's presented here are consistent with approaches recommended by the Agency for Healthcare Research and Quality, NCI, and the American Medical Association.

Treating Tobacco Using the 5 A's



Brief Motivational Interviewing

- Focus on exploring a tobacco user's feelings, beliefs, ideas, and values regarding their use in an effort to uncover any ambivalence about using tobacco.
- Once ambivalence in uncovered, the clinician selectively elicits, supports, and strengthens the client's change talk and commitment language.
- Four general principles:
  - Express Empathy
  - Develop Discrepancy
  - Roll with Resistance
  - Support Self Efficacy

Medications

- Bupropion SR
  - Approximately doubles the likelihood of long term (>5 month) abstinence from tobacco use as compared to placebo treatment.
  - Prescription only.
- Varenicline
  - Not recommended in combination with NRT
  - 2 mg dose triples the likelihood of a long term abstinence from tobacco use.
  - Prescription only.
- Encouraging all patients attempting to quit to use effective medications for tobacco dependence treatment except where contraindicated or for special populations in which there is insufficient evidence of effectiveness.

Information from the TTUD Clinical Practice Guideline: 2008 Update

Nicotine Replacement Therapy

- Nicotine Gum
  - Increases likelihood of long term (>5 month) abstinence by about 50% as compared to placebo treatment.
- Nicotine Inhaler
  - Approximately doubles likelihood of long term abstinence.
- Nicotine Lozenge
  - For highly dependent smokers, approximately tripled the odds of abstinence 6 months postquit.
- Nicotine Nasal Spray
  - Approximately doubles likelihood of long term abstinence.
- Nicotine Patch
  - Approximately doubles likelihood of long term abstinence.

NRT for Persons with SA, MI & SMI

- The patch may be the preferred nicotine replacement option for people with serious mental illness because of its high compliance rate and ease of use.
  - The patch is less helpful for immediate cravings, thus it is often coupled with nicotine gum, an inhaler or nasal spray
  - Combination of patch plus one of the short-acting forms may be most efficacious approach

Source: National Association of State Mental Health Program Directors Toolkit

Cognitive Behavioral Therapy

- When a person uses cognitive therapy to help quit smoking, the focus is on:
  - Increasing the patient's confidence in their ability to quit smoking.
  - Exploring any ambivalence about quitting.
  - Learning ways of coping with stress and urges to smoke.
- Cognitive behavior therapy is a goal-directed and problem-focused form of therapy.
- Clients learn rational thinking and self-counseling skills.

el-Guebaly, N., Cathcart, J., Currie, S., Brown, D., & Gloster, S. (2002). Smoking cessation approaches for persons with mental illness or addictive disorders. Psychiatric Services, 53(9), 1166-1170

Additional Support

- Nicotine Anonymous
- Peer Based Support
- Quitlines

Nicotine Anonymous

- For those who already attend AA or NA meetings, sometimes they offer smoke free meetings which do not have smoking during the breaks.
- There is also Nicotine Anonymous which promotes the same 12 step model as AA and NA, but is focused on the use of nicotine in all forms.
- They are free and run entirely by group members.
- (800) 642-0666 is a free, national number providing callers with meetings in their area.

Peer Based Support Programs

- Rx for Change is a tobacco use cessation program training clinicians Best Practices Techniques for smoking cessation interventions. It also has peer counselor training available.
  - Program is entitled "Peer to Peer: A Tobacco Cessation Program"
- "Choices" is a consumer driven program for smokers with additional Mental Illness.
- Peer support has been shown to be an additional help in reducing daily smoking and increasing motivation in adolescents to stay quit (Malchodi et al., 2003; Posovac, Kattapond, & Dew, 1999).

Quitting *IS* Possible!

- Within the general population, people who stop smoking, even at the age of 40-50, avoid more than 90% of the lung cancer risk associated with tobacco (Peto, Darby, Deo, Ilcocks, Whitley, & Doll, 2000).
- Drug treatment patients who quit smoking have been shown to improve their quality of life (McCarthy, Zhou, Hser, & Collins, 2002).
- In a national sample of active illicit drug users in the U.S., 1 in 5 (21%) were *former* smokers (Richter, Ahluwalia, Mosier, Nazir, & Ahluwalia, 2002).

Strategies for Increasing Cessation

- Know the Smoker
- Understand the Cessation Journey
- Treat the Smoker as a Consumer
- Create a continuum of care
- Develop collaborations and create synergy
- Take advantage of opportunities

Additional Resources

- Free Tobacco Cessation Training
  - Clinician Assisted Tobacco Cessation Curriculum -- www.rxforchange.ucsf.edu. This online comprehensive tobacco cessation education tool provides the knowledge and skills necessary to offer tobacco cessation counseling to clients who use tobacco. Has customized curriculums.
  - 2008 U.S. Public Health Service Guideline -- Treating Tobacco Use and Dependence: visit www.surgeongeneral.gov/tobacco for free resources and best practices for tobacco intervention.
- Free Tobacco Cessation Tool Kits
  - Bringing Everyone Along Resource Guide and Summary -- www.tcln.org/bea. Developed by the Tobacco Cessation Leadership Network, this guide and summary assists an array of health professionals to adapt tobacco cessation services to the unique needs of tobacco users with mental illness and/or substance use disorders.

Quitlines

- The Maryland Tobacco Quitline
  - Service provided by Free & Clear Inc.
  - Free reactive and proactive phone counseling services
  - Quit CoachesTM - Trained specialists
  - Provides individually-tailored quit plans
  - Referral to local county resources – cessation classes, in-person counseling and free medication
  - Operational seven days a week - 8:00am to 3:00 am
  - Free NRT (The patch or gum) 4 week supply

Fax Referral Program

- "Fax to Assist"- launched Dec. 2006 by
- On-line training & certification for HIPAA-covered entities
  - http://mdquit.org/fax-to-assist
- Providers can refer their patients or clients (who wish to quit, preferably within 30 days) to the Maryland Tobacco Quitline
- Tobacco users will sign the Fax Referral enrollment form during a face-to-face intervention with a provider
  - (e.g., at a doctor's office, hospital, dentist's office, clinic or agency site)
- The provider will then fax the form to the Quitline
- Within 48 hours, a Quit Coach™ makes the initial call to the tobacco user to begin the coaching process

Fax to Assist

What is Fax to Assist?
Fax to Assist is an exciting and convenient way for you to refer your clients to Maryland's Quitline to help them quit smoking.

Who is eligible to become Fax to Assist certified?
All Maryland healthcare providers who are employed by a HIPAA-covered entity are eligible and encouraged to use Fax to Assist to help their clients quit smoking.

How do I become Certified?
There are two options that are available:

Online Individual Training

Advantages:

- Training and certification can be completed in about 20 minutes!
- Instant feedback on the individual certification examination.
- Instant access to **Fax to Assist** referral forms and Quitline resources.
- **How do I start?** Follow the directions below.

On-Site Group Training
(for 3 or more providers)
Advantages:

- We come to you and provide a one hour training for your whole team!
- Training can be tailored to your setting and patient population.
- Same-day certification and Fax to Assist kits provided.
- **How do I start?** CLICK HERE and send us an email to sign-up for on-site training.

Fax to Assist

Our online certification program is now CME-approved! CLICK HERE to find out more about **Fax to Assist** and complete your training.

Center Specialists

If you are interested in resources, training, or other prevention and cessation information to help consumers, please call us at (410) 455-3628 or contact one of our MDQuit Resource Center Specialists:

- Preston Greene, M.A.
- Angela Petersen
- Shayla Thrash
- Onna Van Orden, M.A.

Most Searched Topics

- Cancer
- Cardiovascular Disease
- Cessation
- Cigarettes

Fax to Assist Provider Kits

When you complete the certification quiz, MDQuit will send you:

- Training CD-Rom with all 4 Modules
- 5A's Clipboard
- 5A's Mousepad
- MDQuit ink pen

Talking about smoking is not easy

- People have different feelings about smoking
- Some want to quit; others do not
- One way to start the conversation:
  - "I want to support you in living a healthy life. Tobacco use can make us unhealthy in many ways. People who get help are likely to quit. Do you want to quit smoking (or using other tobacco products)?"
  - (If yes) "I would like to support you in this process."
  - (If no) "Is it okay if I talk with you again in the future about your smoking?"

If a smoker asks you about your tobacco use…

- **If you have never smoked**, you may have a hard time understanding how hard it is to quit. Let them know that even though you haven't done it before, you will try your best to support them.
- **If you currently smoke** or **have quit**, you probably have a better idea about what it's like to be addicted to tobacco. You can share your experiences, but let them talk more.

If you smoke, what can you do?

- Keep cigarettes and other smoking related paraphernalia out of sight
- Smoke outside and away from the smoker trying to quit.
- Don't offer the quitter a smoke even as a joke.
- Make a quit attempt yourself

If the Smoker Slips or Relapses

- A slip is not a relapse so encourage the smoker that they can do it and that may need a change in the plan
- Remind them of reasons for quit and length of successful abstinence
- Don's belittle, nag, or make smoker feel guilty (interferes with recycling)
- Encourage them to try again

Remember:

- Regardless of the myths and barriers, there are successful, concurrent treatments for tobacco cessation in Substance Abuse Treatment.
- There are resources available to assist training staff to appropriately assist clients in quitting tobacco and other substance use.
- Using a combination of treatments, counseling styles, medications, and resources such as Quitlines is more effective than any alone.


I didn't go through
treatment; get clean
in recovery from
drug addiction
so I could die from
lung cancer
I had to stop smoking,
Tony