Tobacco and TCs: Fraternising with the Enemy?

Amanda Baker PhD
The challenge... Q & A
How common is smoking in substance use treatment settings?
In what ways has smoking been treated differently to other substances in treatment settings?
Why has tobacco dependence been treated differently to other substance dependence in treatment settings?
Tobacco

• Less behavioural disturbance

• Fears of patients not coping/aggression, worsening MH or AOD

• NRT widely available

Hughes & Weiss (2005)
Can we address smoking and substance use problems in treatment settings?

Professor Gallagher and his controversial technique of simultaneously confronting the fear of heights, snakes, and the dark.
“A national disgrace”

• Life expectancy shorter

• Cardiovascular disease: single largest cause of the death
## Leading causes of death

(AIHW 2012)

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>%</th>
<th>Women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td></td>
<td>16.7</td>
<td>CHD</td>
<td>15.3</td>
</tr>
<tr>
<td>Lung cancer</td>
<td></td>
<td>6.6</td>
<td>Stroke</td>
<td>9.8</td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td>6.2</td>
<td>Dementia</td>
<td>8.0</td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td>4.4</td>
<td>Lung cancer</td>
<td>4.4</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td></td>
<td>4.3</td>
<td>Breast cancer</td>
<td>4.1</td>
</tr>
</tbody>
</table>
Unhealthy behaviours and leading preventable causes of death
(AIHW 2012)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Behaviour</th>
<th>Biomedical</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD/Stroke</td>
<td>Smoking, Inactivity, Alcohol, Diet</td>
<td>Obesity, high BP, Cholesterol</td>
</tr>
<tr>
<td>Cancers</td>
<td>Smoking, Inactivity, Alcohol, Diet</td>
<td>Obesity</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Smoking</td>
<td></td>
</tr>
</tbody>
</table>
### Health Behaviours & Health Protection

(Khaw et al 2008)

<table>
<thead>
<tr>
<th>Health Behaviour</th>
<th>How Scored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking habit</td>
<td>Nonsmoker = 1</td>
</tr>
<tr>
<td>Fruit and vegetable intake</td>
<td>Five servings or more daily as indicated by blood vitamin C = ≥50 nmol/l = 1</td>
</tr>
<tr>
<td>Alcohol intake</td>
<td>One or more, but less than 14 units, a week = 1. One unit = approximately 8 g of alcohol; i.e., one glass of wine, one small glass of sherry, one single shot of spirits, or one half pint of beer</td>
</tr>
<tr>
<td>Physical activity</td>
<td>Not inactive = 1; i.e., if sedentary occupation, at least half an hour of leisure time activity a day; e.g., cycling, swimming; or else a nonsedentary occupation with or without leisure-time activity</td>
</tr>
</tbody>
</table>

doi:10.1371/journal.pmed.0050012.t001
Health score of 0 vs 4 = 14 year difference in chronological age for mortality risk
(Khaw et al 2008)
CVD risk behaviours in people with substance use problems vs general population
(Kelly et al, Drug & Alcohol Review, 2012; AIHW 2012)

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Salvation Army Residential (n=228)</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>74% men 90% women</td>
<td>18% men 15% women</td>
</tr>
<tr>
<td>Alcohol use disorder (lifetime)</td>
<td>59% (primary substance)</td>
<td>35% men 14% women</td>
</tr>
<tr>
<td>Insufficient physical activity</td>
<td>55.1%</td>
<td>62%</td>
</tr>
<tr>
<td>Insufficient fruit &amp; vegetables</td>
<td>Not reported</td>
<td>94%</td>
</tr>
</tbody>
</table>
Depression *(Kelly et al 2012)*

• Residential substance abuse treatment:
  – Self-reported previous diagnosis of depression

• Men: 33%

• Women: 50%
Health risk behaviours often co-exist
## Multiple risk profiles in inpatients

*(Prochaska et al 2014)*

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>% at risk</th>
<th>Behaviour</th>
<th>% prepared 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>100</td>
<td>Depression prevent</td>
<td>76</td>
</tr>
<tr>
<td>High fat diet</td>
<td>68</td>
<td>Stimulant use</td>
<td>74</td>
</tr>
<tr>
<td>F &amp; V</td>
<td>67</td>
<td>Stress management</td>
<td>69</td>
</tr>
<tr>
<td>Sleep hygiene</td>
<td>53</td>
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<td>69</td>
</tr>
<tr>
<td>Inactivity</td>
<td>52</td>
<td>Non-Rx opiate use</td>
<td>68</td>
</tr>
<tr>
<td>Cannabis</td>
<td>46</td>
<td>Binge drinking</td>
<td>57</td>
</tr>
<tr>
<td>Depression prevent</td>
<td>43</td>
<td>Inactivity</td>
<td>51</td>
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<td>Stress management</td>
<td>42</td>
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<td>Binge drinking</td>
<td>26</td>
<td>High fat diet</td>
<td>43</td>
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<td>Stimulant use</td>
<td>22</td>
<td>Cannabis</td>
<td>23</td>
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<tr>
<td>Non-Rx opioids</td>
<td>11</td>
<td>Tobacco</td>
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AOD

  - 18 RCTs in treatment or recovery; ns
  - Recovery: significant 77% increase in the likelihood of smoking abstinence among intervention versus control participants (ST)
  - A significant 25% increased likelihood of LT abstinence from AOD
  - Concluded smoking cessation enhances AOD outcomes
MMT

• Okoli et al 2010
  – Incentives (↑ MMT dose), CBT, counselling + NRT
  – Smoking cessation interventions were associated with a significant ↓ in smoking and expired CO but not abstinence
  – No study reported any worsening in AOD
  – Suggested integration of treatment for mental health issues such as depression may be important
Major Depressive Disorder

• Hitsman et al (2012)
  – 42 studies (past MDD)
  – Most combination CBT and pharmacotherapy
  – Past MDD associated with \( \downarrow \) abstinence rates
  – Recent MDD CBT self-help effective

  – Recommended CBT for mood management in those with past MDD to improve smoking outcomes
Summary Recommendations

• **Integration** of smoking cessation treatment into mental health or substance use treatment

• **Pharmacotherapy** of adequate dosage and duration

• Staff and management of treatment facilities should work further to develop **policies** conducive to smoking cessation to allow dissemination of evidence-based treatment into practice as new treatments emerge
Before you begin

• Assess your readiness and capacity

• Seek leadership buy-in

• Establish a tobacco working group / task force

(Jamie Ostroff, IPOS Conference, 2012)
• Michael Botticelli
  Acting Director of the White House Office of National Drug Control Policy

• Earlier this year, Botticelli wrote an article for the Huffington Post about the need to build a smoke-free life in recovery. In the article, he shared about his own struggle
(video):
link to Washington post
Essential Steps

• Ask about tobacco use @ initial & follow-up visits (mental health, D&A etc)

• Document current use and changes in tobacco use status in medical chart

• Provide personalised advice and education about cessation benefits and risks of continued use as a routine
Essential steps

• Provide cessation assistance and/or refer to tobacco treatment specialists

• Document changes in smoking status and analyze utilization trends and outcomes for continuous quality improvement

(ASCO, 2009)
Tobacco cessation

• Implement a comprehensive, evidence-based cessation & RP program for patients and employees
• Provide staff education
• Review and advocate for tobacco free policies and procedures
• Monitor and implement continuous improvement in standards of care for tobacco dependence *(Jamie Osteroff 2012)*
Assessment *(Hitsman et al, 2009)*

- Very similar as for non-AOD smokers
  - Cigarettes per day
  - Smoking history
  - Perceived benefits (social, psychol, physical)
  - Readiness to quit
  - History of serious quit attempts
  - Associated craving & withdrawal symptoms
  - Treatment history inc. longest period of abstinence
Assessment

– Psychiatric symptomatology, D&A craving during past quit attempts
– Perceived barriers to abstinence
– FTND & other qrs valid
How to start
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Efficacy Motivational Interviewing?

• Heckman et al 2010
  – Appears beneficial, including in smoking with mh problems
• Aveyard et al 2011
Offer advice and assist all

"The cape, Larry! Go for the cape!"
It doesn't matter what other people think - the important thing is that you believe in yourself.
Evidence Base *Hitsman et al (2009)*

- MI+CBT (delivered by a smoking cessation counsellor or a health care provider) +pharmacotherapy integrated into care

- Tobacco treatments do not have an adverse effect on AOD use or psychiatric symptoms
Multi-component interventions: feasible, effective, and more efficient (Spring et al 2010)
Evidence Base

- Smoking reduction as the initial treatment goal
- CBT: self-monitoring; avoidance of high risk situations; stress management; coping with craving; relapse prevention
- Chronic disease approach
- Pharmacotherapy: adequate dose and duration
- Integrated care
Video

• Consumer
• John
Every health worker
THANK YOU

Newcastle, Australia