PRIORITY RESEARCH CENTRE
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THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Tobacco and TCs: Fraternising with the Enemy?

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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?

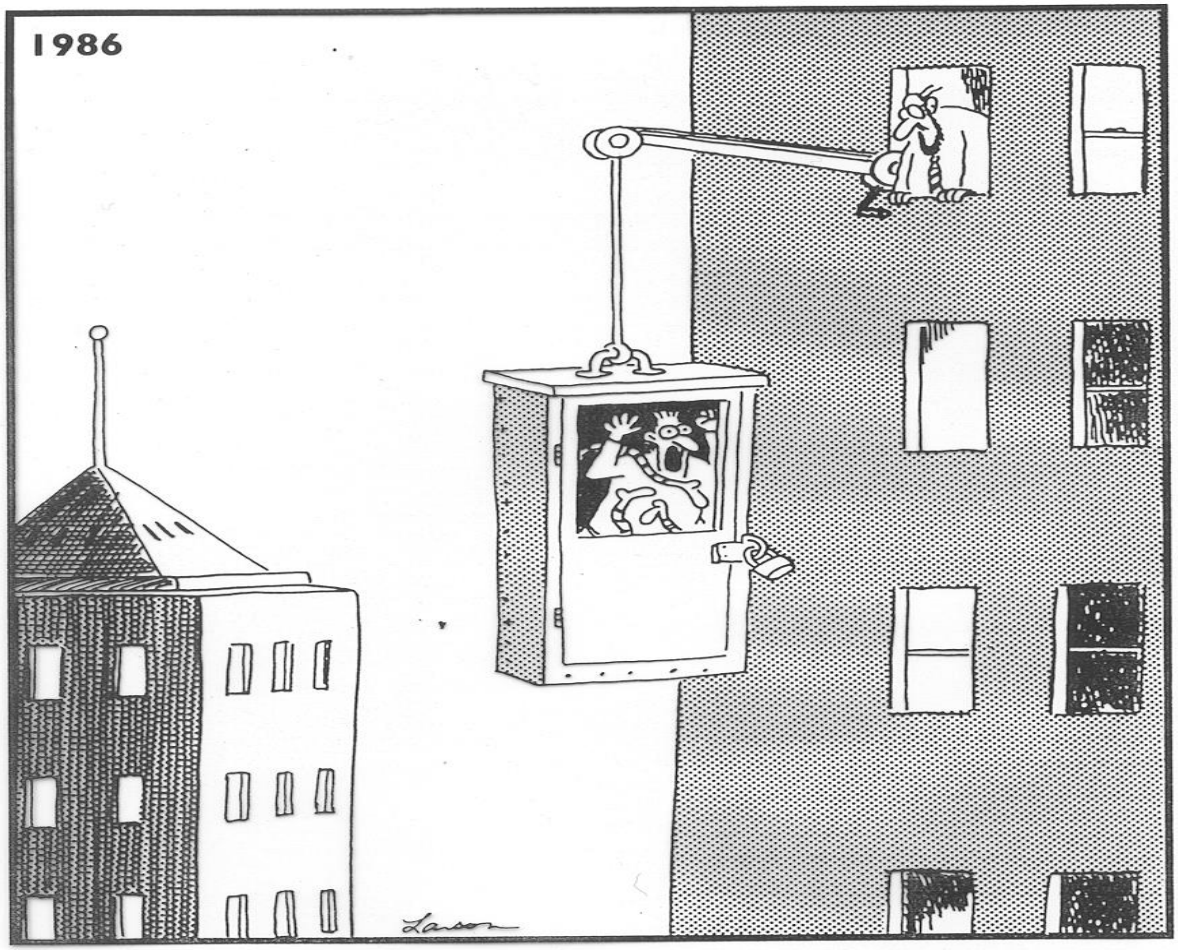
Why has tobacco dependence been treated differently to other substance dependence in treatment settings?

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”

National Mental Health Commission. A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention (2012)

- Life expectancy shorter
- Cardiovascular disease: single largest cause of the death

Leading causes of death

(AIHW 2012)

Men	%	Women	%
CHD	16.7	CHD	15.3
Lung cancer	6.6	Stroke	9.8
Stroke	6.2	Dementia	8.0
Respiratory	4.4	Lung cancer	4.4
Prostate cancer	4.3	Breast cancer	4.1

Unhealthy behaviours and leading preventable causes of death

(AIHW 2012)

Disease	Behaviour	Biomedical
CHD/ stroke	Smoking, Inactivity, Alcohol, Diet	Obesity, high BP, Cholesterol
Cancers	Smoking, Inactivity, Alcohol, Diet	Obesity
Respiratory	Smoking	

Health behaviours & health protection

(Khaw et al 2008)

Health Behaviour	How Scored
Smoking habit	Nonsmoker = 1
Fruit and vegetable intake	Five servings or more daily as indicated by blood vitamin C = ≥50 nmol/l = 1
Alcohol intake	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
Physical activity	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

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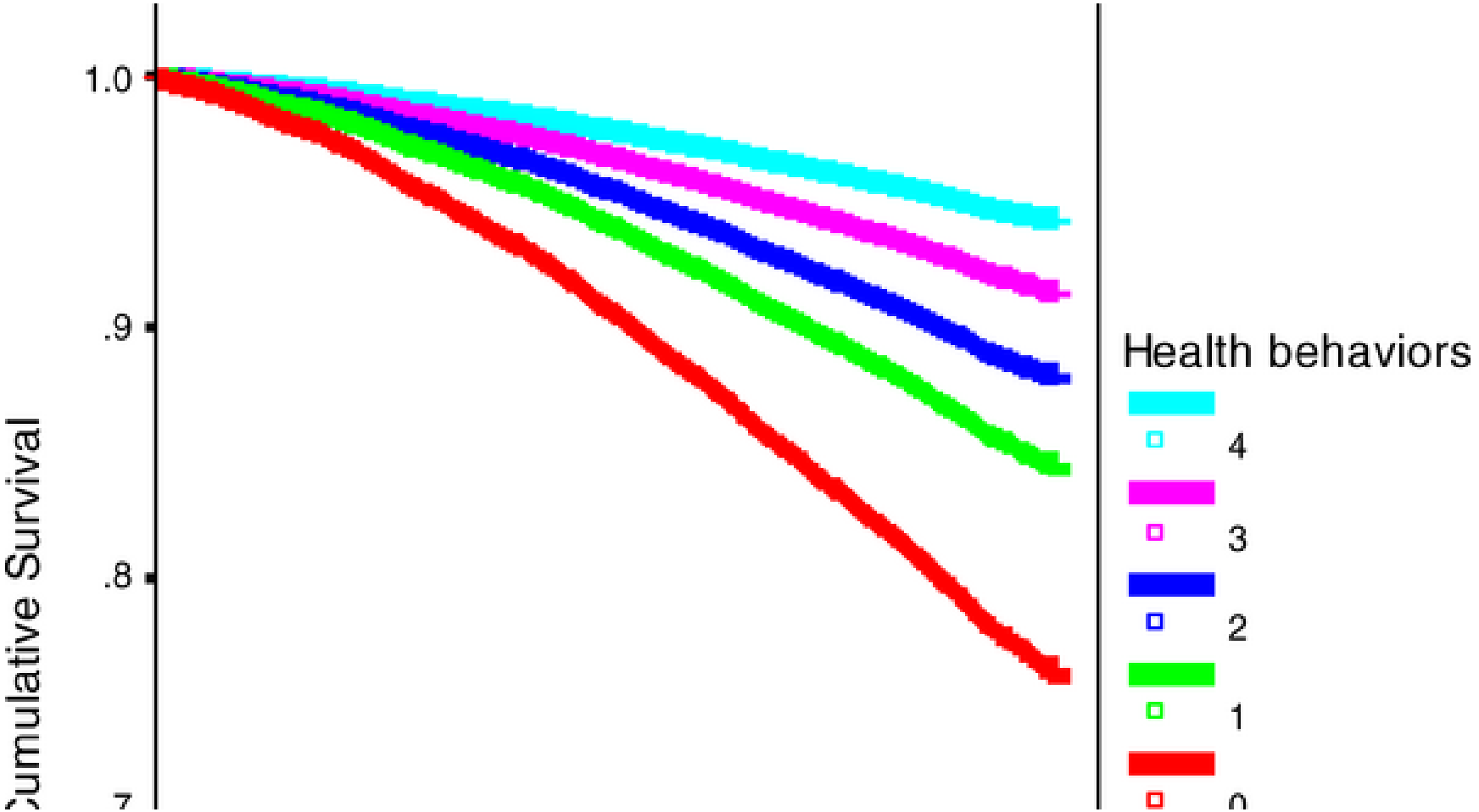
Health score of 0 vs 4 = 14 year difference in chronological age for mortality risk

(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)

Behaviour	Salvation Army Residential (n-228)	General
Smoking	74% men 90% women	18% men 15% women
Alcohol use disorder (lifetime)	59% (primary substance)	35% men 14% women
Insufficient physical activity	55.1%	62%
Insufficient fruit & vegetables	Not reported	94%

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)

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

AOD

- Prochaska, DeLucchi & Hall (2004)
  - 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 ↓ 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

Multiple risk profiles in inpatients

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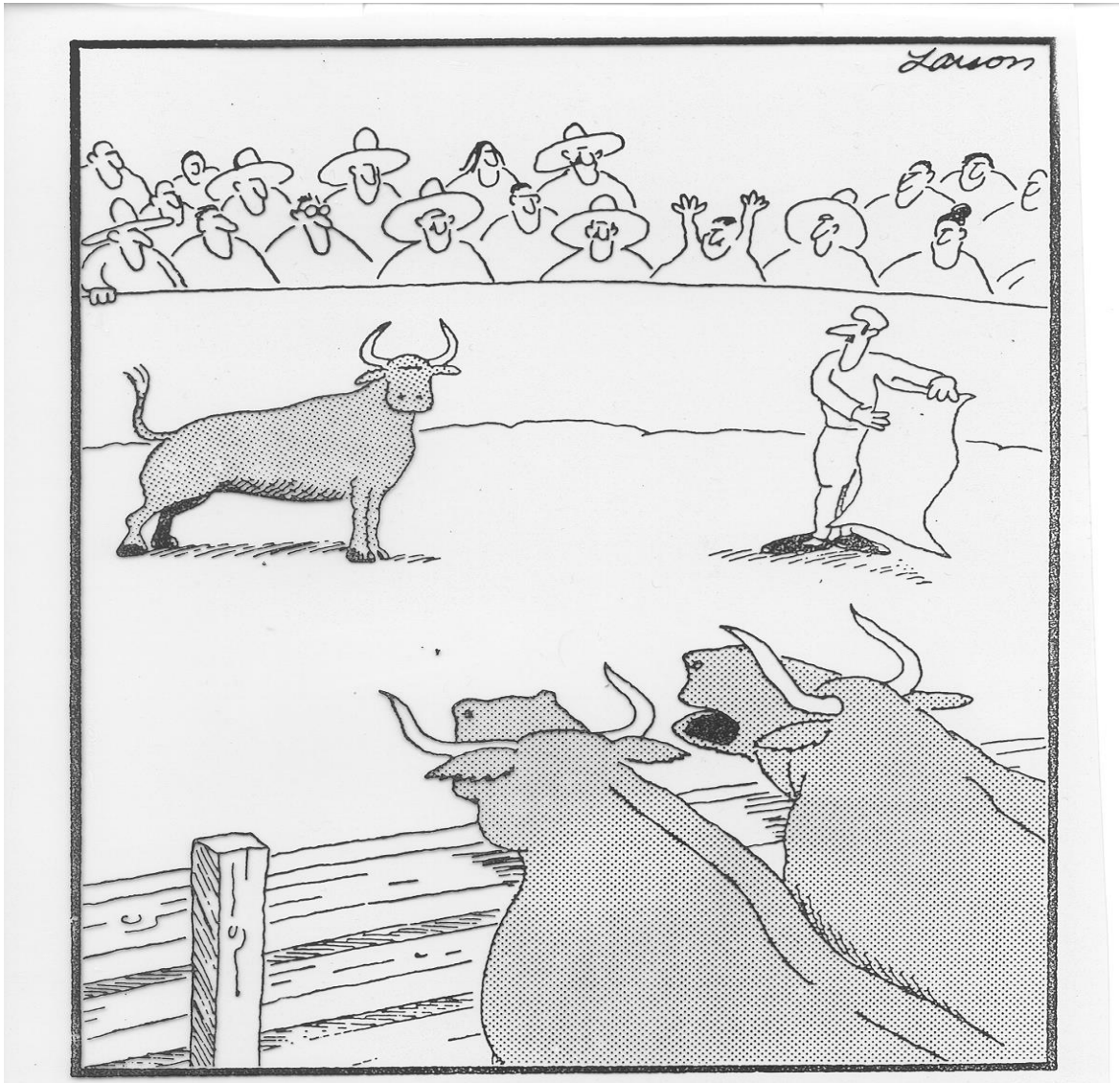
Efficacy Motivational Interviewing?

- Heckman et al 2010
  - Appears beneficial, including in smoking with mh problems
- Aveyard et al 2011

Offer advice and assist all




It doesn't matter what other people think - the important thing is that you believe in yourself
horacek

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