Welcome Pioneers for Smoking Cessation

Practical Clinical Strategies for Delivering Evidence-based Tobacco Dependence Interventions

Wednesday – September 15, 2010 – 1:00 pm ET

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Welcome

- **Reason Reyes**
  - *Moderator*
  - **Technical Assistance Manager**

    Smoking Cessation Leadership Center

    University of California, San Francisco

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Agenda

- Welcome
  - Reason Reyes, Technical Assistance Manager, moderator
- Presentation from Daryl Sharp, PhD, APRN, BC, FNAP
  - Questions & Answers
- Technical Assistance and Closing Remarks

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Today's Presenter

- **Daryl Sharp, PhD, RN-CS, NPP**
  - **Director, Doctor of Nursing Practice Program**
  - **Associate Professor of Clinical Nursing & in the Center for Community Health**
  - **University of Rochester Medical Center**

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Practical Clinical Strategies for Delivering Evidence-based Tobacco Dependence Interventions

September 15, 2010
SAMHSA/SCLC Webinar

Daryl Sharp, PhD, RN-CS, NPP
Associate Professor of Clinical Nursing & in the Center for Community Health
Director, Doctor of Nursing Practice Program

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Objectives

- To describe the epidemiology of tobacco dependence and mental illness
- To describe the neurobiological processes underlying tobacco dependence
- To discuss evidence-based pharmacologic & counseling strategies for those who are tobacco dependent
- To identify interpersonal approaches that strengthen motivation to stop smoking

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Smoking in Perspective

- Kills more than 435,000 Americans each year
- 21% of adult Americans smoke
- 4,000 12-17 year olds smoke first cigarette every day
- 1,200 become daily cigarette smokers
- Causes cancer, CHD, stroke, pulmonary disease, and adverse pregnancy outcomes- shortens life expectancy 14 years
- One-third of all tobacco users in U.S. will die prematurely

(Rigotti et al 2008)

Where are we?

(Schroeder & Morris, 2009)

- We have made significant progress ***BUT***:

  TOBACCO DEPENDENCE REMAINS THE LARGEST PREVENTABLE CAUSE OF DEATH & DISABILITY WORLDWIDE

- Smoking is concentrated in subpopulations of those with mental illnesses and/or substance use disorders

The Scope of the Epidemic

- Approximately 200,000 of 435,000 annual US deaths from smoking occur among those with mental illnesses and/or substance use disorders (Morris et al., 2009)

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Prevalence rates by diagnostic category across studies (Morris et al., 2009)

• Major depression	• 36-80 %
• Bipolar disorder	• 51-70 %
• Schizophrenia	• 62-90 %
• Anxiety disorders	• 32-60 %
• PTSD	• 45-60 %
• ADHD	• 38-42 %
• Alcohol abuse	• 34-93 %
• Other drug abuse	• 49- 98 %

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Factors linked with high smoking rates

Counseling Points ™, (2010), Vol 1, No. 1: http://www.apna.org/i4a/pages/index.cfm?pageid=3578

- Genetic predisposition
- Nicotine effects
- Boredom
- Smoking part of culture
- Used as a reward in some psychiatric settings
- May negate some antipsychotic agents' side effects
- Increased sensitivity to nicotine withdrawal
- Lack of social support
- High unemployment rates & poverty
- Relatively low education levels

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Environmental Tobacco Smoke

(National Cancer Institute, 2010)

- The combination of smoke given off the end of a burning tobacco product & exhaled smoke
- Kills 1 person, for every 8 killed by primary smoking
- Causes many of the diseases that primary smoke does
- 50,000 premature deaths each year
  - Conclusion of 3 independent scientific reports
  - Platelet activation is predominate mechanism
  - Banning ETS led to a 10-40% reduction in MI's

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Electronic cigarettes*

***e-Cigarettes**
(*BMJ* 2010; 340:c311; FDA, 2010)

- Widespread & increasingly popular
- Potential safety concerns:
  - Toxic chemicals
  - Labeling inaccuracies
- September 9, 2010: FDA cited 5 electronic cigarette distributers: violations of the Federal Food, Drug, & Cosmetic Act (FDCA) including unsubstantiated claims & poor manufacturing practices

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Any exposure = HARM

"There is no level of cigarette smoking or exposure to cigarette smoke that does not make the cells in your lungs sick; don't think that smoking one or two cigarettes a week means you are home free."

Dr. Ronald Crystal
Weill Cornell Medical Center, NY, NY

(Strulovici-Barel et al., 2010, *Am Journal of Respiratory & Critical Care Medicine*)

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Estimated cost burden

- Tobacco dependence costs nation more than $96 billion/year in direct medical expenses; $97 billion in lost productivity (CDC, 2007)

- Nearly ½ US cigarettes smoked by those with psychiatric disorders (Grant, 2004; Lasser, 2000)
  - In sample of 78 people with schizophrenia, participants spent nearly 1/3 (27.36%) of monthly public assistance income on cigarettes (Steinberg et al., 2004)

Cost-effectiveness

(Fiore et al., 2008)

- Tobacco use treatments (including medication & specialist-delivered intensive programs) are cost-effective compared to:
  - **HTN**
  - **Hypercholesterolemia**
  - **Routine screening: Mammography**

- Tobacco use treatment is highly cost-effective even given modest quit rates

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Health Benefits of Cessation

- **After 20 minutes,** heart rate drops; BP lowers
- **After 12 hrs,** carbon monoxide level in blood returns to normal
- **At 2 wks - 3 months**, lung function begins to improve & heart attack risks begin to drop
- **After 1 year,** CHD & stroke risk is half of a continued smoker's
- **After 5 years,** oral & esophageal cancer risks are halved
- **After 10 years,** lung cancer death rate is half of a smoker's

Bottom line: health benefits begin to accrue immediately!

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The same interventions that help the general population are likely to help those with mental illness especially if provided at greater intensity and for longer periods of time

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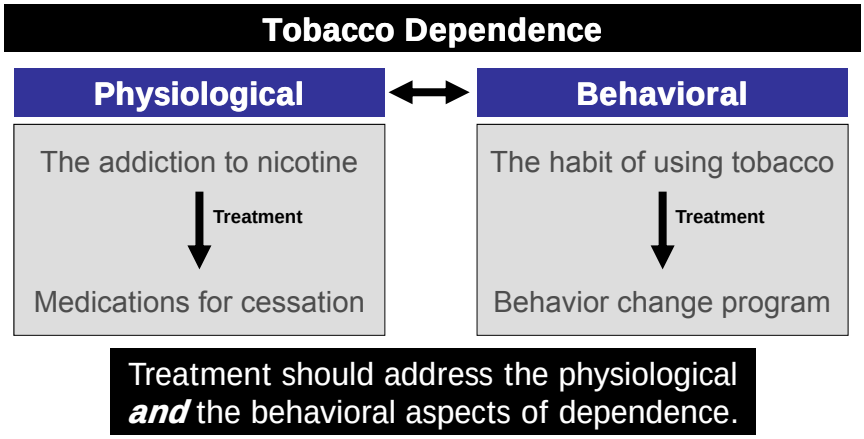
Tobacco Dependence Treatment



Treatment should address the physiological ***and*** the behavioral aspects of dependence.

Fiore et al. 2008; rxforchange/ucsf

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How Nicotine Replacement Therapies (NRT) Work

- Smoking stimulates α4β2 receptors
- Receptors become desensitized within minutes (~one cigarette)
- Receptors re-sensitize after 45 minutes
  ➡ WITHDRAWAL symptoms
- NRT alleviates re-sensitization of nicotinic α4β2 receptors responsible for withdrawal
- 20 cig/pack

Stahl, 2008

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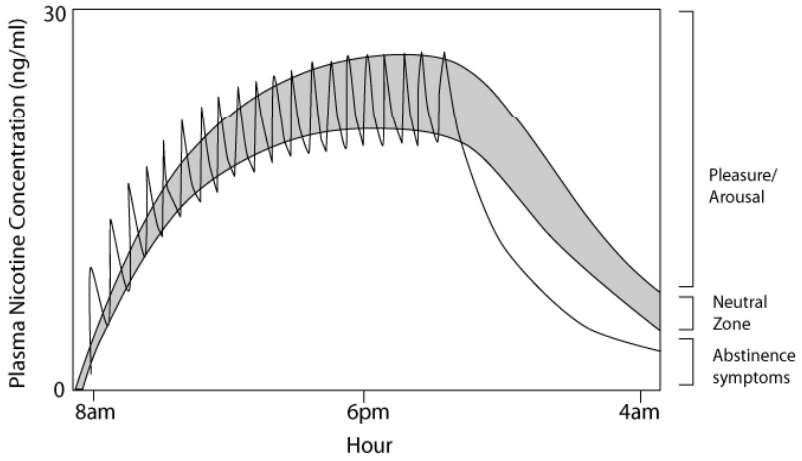
Nicotine Addiction Cycle

(Benowitz, 1992)



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Nicotine Patch

- **Advantages:**
  Easy to use, private, one per day, helps with early morning cravings
- **Disadvantages:**
  Skin reactions, not orally gratifying, vivid dreams, insomnia
- **Dosage**: 4 weeks - 21mg/24hrs.
  then 2 weeks - 14mg/24hrs.
  then 2 weeks - 7mg/24 hrs.
- **Costs:**
  $4.24/day

Fiore et al., 2008

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Nicotine Gum

- **Advantages:**
  Orally gratifying, useful to offset cravings
- **Disadvantages:**
  Poor taste, mouth soreness, dyspepsia, hiccups
- **Dosage:** Maximum dose: 24 pieces/day
  patient smokes < 25 cigs/day: 2mg
  patient smokes > 25 cigs/day: 4mg
  must use correctly: chew & park
- **Costs:**
  $6.25/day **(about 10 pieces)**

Fiore et al, 2008

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Nicotine Inhaler

- **Advantages:**
  Mimics smoking, keeps hands & mouth busy
- **Disadvantages:**
  Mouth & throat irritation, coughing, rhinitis,
  Less effective below 40° F
- **Dosage:** 6 – 16 cartridges/day
  One cartridge lasts 20 min. continuous puffing
  Good for 24 hours if not used completely
- **Costs:** **$6.00 -16.00/day**

Fiore et al., 2008

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Nicotine Nasal Spray

- **Advantages:**
  Higher nicotine levels, fast relief for heavy smokers, rapid delivery of nicotine
- **Disadvantages:**
  Nasal irritation, sneezing, coughing, runny nose
- **Dosage: 1 – 2 doses/hour (in each nostril)**
  minimum dose: 8 doses/day
  maximum dose: 40 doses/day
- **Costs: $5.00 -15.00/day**

Fiore et al., 2008

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Nicotine Lozenge

- **Advantages:**
  Keeps mouth busy, easy to use in social situations
- **Disadvantages:**
  Mouth/throat irritation, heartburn, indigestion, hiccups & nausea
- **Dosage:** minimum dose: 9 lozenges/day
  - 2mg: smokes 1st cigarette after 30 min. of waking
  - 4mg: smokes 1st cigarette within 30min.of waking
- **Costs:**
  $4.50/day

Fiore et al., 2008

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NRT: Precautions

- **Patients with underlying cardiovascular disease; package inserts recommend caution:**
  - **Recent myocardial infarction (within past 2 weeks)**
  - **Serious arrhythmias**
  - **Serious or worsening angina**
  - ***There is no evidence of increased cardiovascular risk with NRT***
- **Other precautions**
  - **Active temporomandibular joint disease (gum only)**
  - **Pregnancy/Lactation**

Fiore et al., 2008

Additional NRT Guidelines

- **Combining the nicotine patch & *ad libitum* NRT (nicotine gum/nicotine nasal spray) is more efficacious than a single form of NRT**
- **FDA has not approved combination NRT strategy**
- **Certain groups of smokers may benefit from extended use of NRT**
  - **Continued use of medication is clearly preferable to a return to smoking with respect to health consequences**
- **Risks/benefits analysis and consumer preferences should inform pharmacotherapy choices**

Bader, McDonald, & Selby, 2009; Fiore et al., 2008

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A Person-Centered Approach to NRT Dosing

- **Estimate amount of nicotine person is getting from smoking**
  - **Generally about 1 mg.+ of nicotine/cigarette**
- **Cover with comparable NRT (often helpful to use a continuous + intermittent form of NRT) mindful that NRT is more slowly absorbed than nicotine from cigarettes; higher peak levels of nicotine result in higher subjective effects of nicotine; often need higher doses of NRT to achieve same effects**
- **Review signs/symptoms of potential side effects including information that combination NRT is not FDA approved/discuss risks & benefits**

Benowitz & Dempsey, 2004; Williams, G.C. et al., 2006

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A Person-Centered Approach to NRT Dosing

- **Teach person signs/symptoms of nicotine withdrawal & nicotine toxicity**
- **On a scale of 0-3 (0=none; 1=mild; 2= moderate; 3= severe)**
  - ***Signs of withdrawal***:
    - Anxiety
    - Irritability
    - Difficulty concentrating
    - Cravings for cigarettes
  - ***Signs of toxicity***
    - Nausea
    - Sweating
    - Palpitations

Williams, G.C., et al., 2006

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Bupropion SR

- **Advantages:**

  Antidepressant, less weight gain,
  FDA approved for maintenance therapy (6mos)

- **Disadvantages:**

  May disrupt sleep, possible headaches, &
  dry mouth, seizure risk

- **Dosage:** Begin 1-2 weeks prior to quit date

  150mg q am for 3 days
  Increase to 150mg b.i.d. (at least 8 hours apart)

- **Costs:** $3.25/day

Fiore et al., 2008

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Varenicline

Partial agonist selective for the nicotine acetylcholine receptor

- **Advantages:**
  - Dual mechanism of action: agonist and antagonist effects
- **Disadvantages:**

  Nausea, insomnia, vivid dreams, headaches; use with caution in patients with renal dysfunction
- **Dosage:** Begin 1 week prior to quit date to minimize nausea/insomnia
  Days 1 – 3: 0.5 mg qd
  Days 4 – 7: 0.5 mg bid
  Days 8 – 28: 1 mg bid

  An additional 12 wks recommended for those who quit
  Adjust dose for real insufficiency 0.5 mg/d for GFR < 30

  *Should be taken after eating and with full glass of water
- **Costs:** $3.30/day

Fiore et al., 2008

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Varenicline: Public Health Advisory

- **FDA WARNINGS and PRECAUTIONS (February 2008)**
  - Serious neuropsychiatric symptoms
    - Changes in behavior
    - Agitation
    - Depressed mood
    - Suicidal ideation
    - Attempted and completed suicide
  - **Developed during Chantix therapy and during withdrawal of Chantix therapy**
  - **May cause recurrence or exacerbation of psychiatric illness**

Fiore et al., 2008

Combination Pharmacotherapy

- Bupropion SR + NRT can be safely combined; considered a first line medication combination
- NRT should **NOT** be combined with Varenicline
- The safety of combining Bupropion & Varenicline has **NOT** been established

Fiore et al., 2008

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When people stop smoking

- May be at risk for medication toxicity
- The tar in smoke enhances P450 enzyme system
  - Increased 1A2 isoenzyme activity
- Smoking can increase metabolism of meds (decreased serum levels)
- Those who smoke tend to be on higher medication doses

Stahl, 2008

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Drugs potentially affected by smoking

- **Watch for signs of toxicity**
  - **Caffeine**
  - **Theophylline**
  - **Fluvoxamine**
  - **Olanzapine**
  - **Clozapine**

Not a problem with NRT!

Fiore et al., 2008

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Medications are often necessary but not sufficient:

People do best with properly dosed pharmacotherapy AND intensive tobacco dependence counseling

Fiore et al., 2008

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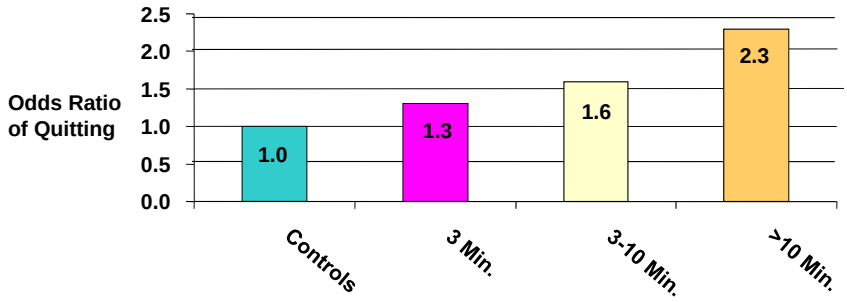
Quitting Increases with Counseling

Strong dose-response relation between counseling intensity & cessation success
(Fiore et al., 2008)



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Practical Counseling:

Skills building/problem solving and mobilizing social support

- Developing Quit Plans
  - Problem-solving
  - Skills building
  - Identifying sources of social support
    - Intratreatment (treatment team)
    - Extratreatment (family/friends; not included in 2008 PHS Guidelines)

Fiore et al., 2008

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Process of Counseling

- Studies have shown that the way in which you counsel makes a difference in how successful people are in changing health behaviors
- The ***PROCESS*** of counseling is as important as the ***CONTENT*** of the intervention

Ryan et al., 2008; Williams et al., 2006

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Smoker's Health Study

(Geoffrey Williams, MD, PhD, PI; funded by NIMH/NCI)

- Randomized Controlled Trial
- N = 1006 adults who smoked
  - Relatively disadvantaged (poor/undereducated)
  - More than half not initially ready to stop smoking
- Intervention
  - Integration of PHS guidelines/SDT
  - Targeted smoking and LDL cholesterol
- Sample excluded people with psychosis/bipolar disorder

Williams et al., 2006

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Self-determination theory

(Deci & Ryan, 1985; Ryan et al., 2008)

- Human beings intrinsically motivated toward health

Three psychological needs:

- Autonomy
- Competence
- Relatedness

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Self-determination theory

(Deci & Ryan, 1985; Ryan et al., 2008)

- Autonomous motivation:
  - Sense of volition
  - Self-initiation
  - Personal endorsement of behavior
- Controlled motivation:
  - Pressured by interpersonal or intrapsychic force

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Self-determination theory

(Deci & Ryan, 1985; Ryan et al., 2008)

Autonomy supportive care environments:

- Understand person's perspective
- Acknowledge feelings
- Offer choices
- Provide relevant healthcare information

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Self-determination theory

(Deci & Ryan, 1985; Ryan et al., 2008)

Autonomy supportive environments **enhance** autonomous motivation

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Self-determination theory

(Deci & Ryan, 1985; Ryan et al., 2008)

- Controlling care environments:
  - Pressure people to act in certain way
  - Threaten with information

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Self-determination theory

(Deci & Ryan, 1985; Ryan et al., 2008)

Controlling environments **inhibit** autonomous motivation

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Smoker's Health Study

(Geoffrey Williams, MD, PhD, PI; funded by NIMH/NCI)

- The clinical endpoint of the intervention was to guide the person to making a clear choice about whether he wanted to change or not (***support person's autonomy need***)
- If the person wanted to stop smoking or change diet then the clinician provided competence training on how to reach that goal (***support person's competence & relatedness needs***)

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Smoker's Health Study

(Williams et al., 2006)

- ***Results***:
  - Those who received the autonomy supportive intervention (process), which also was based on the PHS guidelines for treating tobacco use and dependence (content) had significantly higher quit rates at 6 & 18 months than those in the comparison condition (who were encouraged to work with their primary care providers and community agencies)

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Mobilizing Motivation:

Autonomy Support/Motivational Interviewing

- **Stay mindful of importance of basic psychological need satisfaction**:
  - Autonomy
  - Competence
  - Relatedness
- **Counselor-consumer relationship is a partnership (not expert/recipient)**
- **Elicit and acknowledge the person's perspective**
  - Listen well and reflect

Miller & Rollnick, 2002; Williams et al., 2006

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Mobilizing Motivation:

Autonomy Support/Motivational Interviewing

- **Advise person about the importance of stopping smoking to health in a clear but non-controlling manner**
  - Do not use information as a weapon/threatening manner
- **Provide health risks/benefits information; pharmacotherapy & quit plan options when invited/person signals readiness**
  - Ask permission
  - Check in with people about how they are hearing the information
  - Provide rationale for suggestions you offer
- **Avoid willfulness and maintain neutrality**
- **Support person's initiatives for change**

Miller & Rollnick, 2002; Williams et al., 2006

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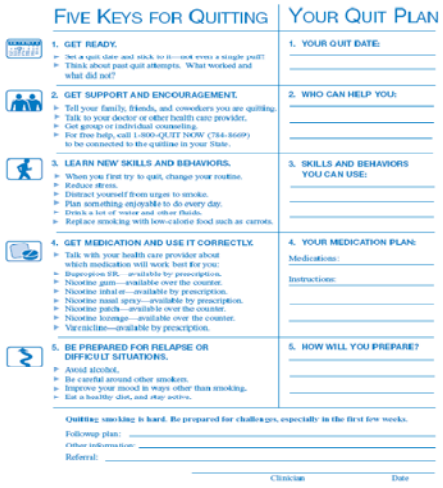

FIVE KEYS FOR QUITTING

1. GET READY.
   - Set a quit date and stick to it—not even a single puff!
   - Think about past quit attempts. What worked and what did not?
2. GET SUPPORT AND ENCOURAGEMENT.
   - Tell your family, friends, and coworkers you are quitting.
   - Talk to your doctor or other health care provider.
   - Get group or individual counseling.
   - For free help, call 1-800-QUIT NOW (784-8669) to be connected to the quitline in your State.
3. LEARN NEW SKILLS AND BEHAVIORS.
   - When you first try to quit, change your routine.
   - Reduce stress.
   - Distract yourself from urges to smoke.
   - Plan something enjoyable to do every day.
   - Drink a lot of water and other fluids.
   - Replace smoking with low-calorie food such as carrots.
4. GET MEDICATION AND USE IT CORRECTLY.
   - Talk with your health care provider about which medication will work best for you:
   - Bupropion SR—available by prescription.
   - Nicotine gum—available over the counter.
   - Nicotine inhaler—available by prescription.
   - Nicotine nasal spray—available by prescription.
   - Nicotine patch—available over the counter.
   - Nicotine lozenge—available over the counter.
   - Varenicline—available by prescription.
5. BE PREPARED FOR RELAPSE OR DIFFICULT SITUATIONS.
   - Avoid alcohol.
   - Be careful around other smokers.
   - Improve your mood in ways other than smoking.
   - Eat a healthy diet, and stay active.

YOUR QUIT PLAN

1. YOUR QUIT DATE:
2. WHO CAN HELP YOU:
3. SKILLS AND BEHAVIORS YOU CAN USE:
4. YOUR MEDICATION PLAN:
   Medications:
   Instructions:
5. HOW WILL YOU PREPARE?

Quitting smoking is hard. Be prepared for challenges, especially in the first few weeks.

Followup plan:
Other Information:
Referral:

Clinician Date

USDHHS. (2010). At: http://www.ahrq.gov/clinic/tobacco/tearsheet.pdf

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AND DON'T FORGET ANOTHER IMPORTANT COUNSELING RESOURCE!

1-800-QUIT NOW!

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Case Study #1:

Tobacco free X 3 weeks

- History: 44 y/o male with schizoaffective disorder; generalized anxiety disorder
- 20-30 CPD X 31 years
- Meds:
  - Risperidone
  - Abilify
  - Depakote
  - Ativan
  - Lipitor
- Successfully quit for 3 months using: 21mg. patch + 7 mg. patch + 6-7 doses of nasal spray
- Relapsed
- Unsuccessful trial of Varenicline
- Current NRT:
  - 21 mg. Patch
  - 7 mg. Patch
  - 4 mg. gum (5-6 pieces)
  - Nasal spray (6-7 doses)

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Case Study #2:

Smokes 2-4 cigarettes over the weekend only

- Hx: 48 y/o female with paranoid schizophrenia; 2 PPD X 34 years
- Received tobacco dependence counseling in group home
- Varenicline: 1 mg. BID (prescribed by PCP)
- Is tobacco free during week; smokes 2-4 cigarettes on weekends with mother; has had a few 2-4 week periods of abstinence
- Used 2 mg. gum over the weekends after feeling "deprived"
- Discontinued gum and continues on Varenicline X 9 months
- No adverse effects reported although person eager to discontinue ASAP: PCP advised her that she needed to be abstinent 3 months prior to d/cing Varenicline

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Case Study #3:

Tobacco free X 10 weeks

- Hx: 24 y/o male with schizoaffective disorder; seizure disorder and learning disability; alcohol dependence; 1 PPD X 4 years
- Meds:
  - Depakote
  - Lamictal
  - Geodon
  - Effexor
- Stopped smoking 6.5 weeks: January '08 using Nicotrol inhaler (5-6 cartridges a day) + 21 mg patch
- Called AA sponsor when tempted to use ETOH; advised to take a cigarette instead
- Bought chewing tobacco as did not want to smoke but then relapsed
- 8 weeks tobacco free using Nicotrol inhaler (3-4 cartridges) + Commit lozenge (4 mg.): up to 10 daily
- Psychiatrist then prescribed Varenicline/client used lozenges while building level in Week I
- Not currently smoking

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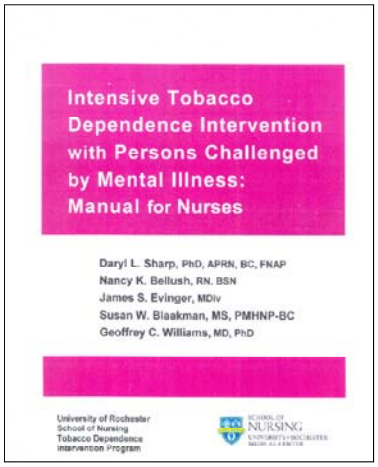
APNA Tobacco Dependence Information Center

http://www.apna.org/i4a/pages/index.cfm?pageid=3643



Summary

Tobacco dependence is an addictive disorder

- **Long term & chronic**
- **Characterized by periods of relapse & remission**
- **Requires ongoing vs. acute care**
- **Calls for ongoing support, counseling, education & pharmacotherapy**

Fiore et al., 2008

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Questions/Thoughts

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Acknowledgements

Smoking Cessation Leadership Center:
http://smokingcessationleadership.ucsf.edu/

Substance Abuse & Mental Health Services Administration:
http://www.samhsa.gov/

American Psychiatric Nurses Association:
http://www.apna.org/

And thank you, too, for your attention!

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Questions & Answers

- Ask questions

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Closing Remarks

- **Please help us by completing the post-webinar survey.**
- **Thank you for your continued efforts to combat tobacco!**

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