Questions Asked During Live Webinar Broadcast on 9/11/19

Tobacco Use Disorder: The Neglected Addiction

Presenter: Andree Aubrey, MSW, LCSW, CTTS

You mentioned training options for SUD treatment staff, could you share a couple?

A: The Smoking Cessation Leadership Center offers lots of webinar training, including archived webinars, newsletters that address policy and provide resources, and information about vulnerable populations. Both the CDC and SAMHSA websites provide many resources. The University of Wisconsin – Center for Tobacco Research and Interventions offers training and other resources through their web-page (https://ctri.wisc.edu/providers/behavioral-health/). www.Rxforchange.ucsf.edu is another excellent training resource.

To those residential treatments that offer the clients 10 smoke breaks per day, how many smoke breaks do you think should be given to the clients?

A: Your question addresses the central theme of neglecting tobacco use as an addiction. How are breaks given for non-tobacco users? Would the program consider "fresh air breaks, healthy-snack breaks (or not so healthy snack breaks), or stretch breaks? Let's encourage treatment professionals and individuals in recovery to discover healthy breaks that address stress and not rely on an addictive behavior for a break.

Could you please review why the initiation of NRT for MI's is 2 weeks?

A: The physiological effects of nicotine include increased heart rate, cardiac output and blood pressure, and vasoconstriction of coronary arteries. A cardiologist may weigh the risk/benefit of allowing use of NRT vs. having a patient with an MI in the past two weeks return to cigarette use.

I have read recently that there is more push to make Cigarette packs less colorful and attractive and putting more warnings on the box. Do you think that would be an actual deterant ?

A: Yes, that has been the experience of other countries such as Australia.

I am attempting to identify training for tobacco cessation in Virginia. Do you have any insight on this?

A: I have copied the URL for the list of programs accredited to provide the Tobacco Treatment Specialist training. https://ctttp.org/accredited-programs/ Unfortunately, none of them are located in Virginia. You might also check with the heath professions associations and your state Department of Health.

You mentioned that the most effective treatment is medication in conjunction with face-to-face counseling. I facilitate tobacco cessation groups that both offer NRT and do not offer NRT. I see a big decline in consistency of attendence in the groups that do not have NRT. How much of that would you attribute to the lack of providing NRT?

A: Providing NRT is a great motivator for coming to a group. We do see this in FL too.

Is going to a smoke free treatment center a barrier to people coming into treatment.

A: This can be a concern expressed by organizations who are concerned they will lose business. "About half of mental health (49%) and a third of substance abuse treatment facilities (35%) reported having smoke-free campuses in the 50 states, Washington, D.C., and Puerto Rico, according to a new report from the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA)." I did a quick review of research literature and it seems there are mixed results about tobacco-free policies affecting census or clients leaving treatment early.

Tobacco-free policies can also be a motivator for quitting tobacco. When a facility goes smoke-free or tobacco-free, it is important to provide treatment – NRT (or another FDA approved medication) and counseling support. When we work with

treatment programs, we first offer treatment for staff who are using tobacco.

I hear from clients who have been inpatient or in other programs that even on their intake professionals have stated they should not try to stop all addictions at one time and put smoking to the side. How do you handle this?

A: The recommendation to delay addressing TUD is a strong myth that is not supported by the evidence (see slides 26 and 27). When smoking is "put to the side", it often does not get addressed again and clients are not offered treatment. Remember, about 70% of people who are smoking are interested in quitting and this holds true for individuals receiving behavioral health services as well as the general population.

I think the best strategy is offering to provide training for program staff. Our AHEC program at FSU submits abstracts and offers workshops at statewide conferences so we can reach professionals. SAMHSA has a nice infographic for addictions professionals that documents the safety and improvements in long-term abstinence for other SUD when incorporating treatment of TUD along with other services. You could share the infographic with program staff and supervisors. It's funny though, we never tell people to keep drinking while they deal wth other addictions. General advice is to quit all substances at one time.

If scare tactics don't work, why is that so prevalent in commercials for quitting?

A: You have a good point here. The CDC research does support "scary" ads as effective on a population level for increasing calls to quit lines. In my experience on an individual level it is easy for the person to dismiss this type of intervention, because most people already know smoking is bad for them. An early mentor in my professional development always told me "You have to say things in a way the other person is able to hear." My recommendation is to target interventions to the person's stage of behavioral change and focus on the positive, personal benefits of quitting. If it is a concern to the individual, asking a person about their personal health risks of continuing to smoke could be appropriate. (Think about the MI exploration of the good and not so good aspects of a behavior.)

I've had people tell me that the government inflates the # or deaths. Do you know how these deaths calculated?

A: Copied from the CDC web-site:

The following table lists the estimated number of smokers aged 35 years and older who die each year from smoking-related diseases.[1]

Related Mortality in the United States, 2005–2009

Disease	Male	Female	Total
Cancer			
Lung cancer	74,300	53,400	127,700
Other cancers[a]	26,000	10,000	36,000
Subtotal: Cancer	**100,300**	**63,400**	**163,700**
Cardiovascular Diseases and Metabolic Diseases			
Coronary heart disease	61,800	37,500	99,300
Other heart disease[b]	13,400	12,100	25,500
Cerebrovascular disease	8,200	7,100	15,300
Other vascular disease[c]	6,000	5,500	11,500
Diabetes mellitus	6,200	2,800	9,000
Subtotal: Cardiovascular and Metabolic	**95,600**	**65,000**	**160,000**
Respiratory Diseases			
Pneumonia, influenza, tuberculosis	7,800	4,700	12,500
COPD[d]	50,400	50,200	100,600
Subtotal: Respiratory	**58,200**	**54,900**	**113,100**
Total: Cancer, Cardiovascular, Metabolic, Respiratory	**254,100**	**183,300**	**437,400**
Perinatal Conditions			
Prenatal conditions	346	267	613
Sudden infant death syndrome	236	164	400
Total: Perinatal Conditions	**582**	**431**	**1,013**
Residential Fires	**336**	**284**	**620**
Secondhand Smoke			
Lung cancer	4,374	2,959	7,333
Coronary heart disease	19,152	14,799	33,951
Total: Secondhand smoke	**23,526**	**17,758**	**41,284**
TOTAL Attributable Deaths	**278,544**	**201,773**	**480,317**

Annual Cigarette Smoking-

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For Further Information

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health
E-mail: tobaccoinfo@cdc.gov
Phone: 1-800-CDC-INFO

For the 2004 Prochaska study, is the 25% increased likelihood of long-term abstinence, is that for alcohol and illicit substances, NOT tobacco? Also what is considered long-term, 6 months?

A: Yes, for alcohol and illicit drugs. Long term was defined as equal to or more than 6 months post-treatment.

Is there a priming effect of nicotine that increases likelihood of relapse?

A: Nicotine causes functional and structural changes in the brain which induce craving. (There are some good YouTube videos that demonstrate what happens in the brain in response to nicotine exposure.) Cravings may persist for several months, especially among individuals who are heavilty addicted. The role of euphoric recall, psychologically based craving, social norms of the peer group, and a deeply established behavioral habit also play a role in relapse.

Would completely banning smoking in TX centers violate the ethical principle of Autonomy?

A: I do not believe so and recognize others may think differently about this. Would banning the use of alcohol (a legal product) or marijuana cause the same concerns with violating the principle ot autonomy?

Wouldn't it be better to offer a pregnant woman NRT rather than have her continue smoking?

A: Good point. This is a risk/benefit analysis that the obstetrician, nurse practitioner, or midwife might consider. There is risk to a fetus exposed to nicotine in any form which is why I would defer to the medical practitioner and would not recommend NRT without a formal consultation.

Chantix has quite terrible side effects (speaking from experience). How do you help encourage people to stick with it in spite of the negative side effects?

A: If a person is experiencing side effects, especially terrible ones, I think it is better to consider another PDA approved cessation medication.

I am interested in receiveing materials and info about reimbursement for TUD treatment.

A: There is a great variability in private insurance reimbursements so you would have to check with commercial insurance

companies with whom you are working. The American Lung Association has an excellent billing guide for tobacco screening and cessation.
https://www.lung.org/assets/documents/tobacco/billing-guide-for-tobacco-1.pdf

You talk about tobacco use and mental health. Can you speak specifically to the link between trauma and nicotine addiction?

A: This information was obtained from PubMed Central, the National Library of Medicine's full –text repository. It is an open-access resource available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4275370/:

Trauma Exposure and Cigarette Smoking: The Impact of Negative Affect and Affect-Regulatory Smoking Motives

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J Addict Dis. Author manuscript; available in PMC 2015 Oct 1.
Published in final edited form as:
J Addict Dis. 2014; 33(4): 354–365.
doi: 10.1080/10550887.2014.969622

PMCID: PMC4275370
NIHMSID: NIHMS633747
PMID: 25299617

From the article's abstract:

Rates of cigarette smoking, in particular among trauma-exposed individuals, are nearly double the rates of non-psychiatric individuals [5], and these smokers tend to smoke more heavily and have higher levels of nicotine dependence than non-trauma-exposed smokers [6,7].

A google search will provide other HHS public access articles on the link between trauma and tobacco use.

The behavioral health community has a more frequent contact rate than the medical community. We may see clients 3x/week. The EBP recommends an Ask at every visit, but that seems like overkill for our population. What "Ask" interval would you recommend with such a high level of engagement?

A: The ask at at every visit was developed for primary care settings and has been adopted for behavioral health. The pupose is to continue to offer treatment resources and identify former smokers who may have relapsed. I think you should use your clinical judgement to determine the interval that seems right for the frequency of your contacts with the population you are serving.

Do you think that there is a less urgency of addressing Tobacco use because most of its effects are considered physiological and a medical problem, rather than a consequence of Tobacco use?

A: Yes, I do believe this is a factor. However, many clients see their behavioral health counselor more frequently than a primary care provider so opportunites to offer "new medications and treatment" that significantly improve success with quitting are missed.

Any statistics on those that struggle with substance use disorder and still smoke versus quitting smoking and relapse ties to this. In other words, most in early recovery still smoke and give up their drugs of choice, but if they gave up smoking how much less likely would they be to relapse?

A: Please refer to slide 27 which summarizes the 2004 Prochaska meta-analysis which found treatment for TUD "provided

during addictions treatment was associated with a 25% increased likelihood of long-term abstinence from alcohol and illicit drugs."

In regards to 70% of SUD patients wanting to quit smoking, do you have a citation for that percentage? Can this be found within the Tobacco Use 2008 Guideline?

A: Yes, this statistic is included in the guideline.

Centers for Disease Control and Prevention (CDC). Quitting smoking among adults – United States, 2000-2015. Morbidity and Mortality Weekly Report. 2017;65(52):1457-1464.

The truth initiative documents this statistic at https://truthinitiative.org/research-resources/quitting-smoking-vaping/what-you-need-know-quit-smoking You may download a report from this site which leads to a fact sheet and infographic.

Chewing tobacco is now the big thing as well as vaping. What can you do with a client who thinks bringing a bottle to spit in a session? We say no tobacco at all, but SUD was the main reason for treatment.

A: Spit or chewing tobacco delivers large amounts of nicotine and is just a different method of delivering nicotine. The no tobacco policy may need review to insure spit tobacco is included and consequences for tobacco use on the treatment organization's property are articulated.

Response to the Vaping Questions:

As I mentioned during the webinar, I consulted with my colleague Karen Geletko, MPH, who is a faculty member in the Department of Behavioral Sciences and Social Medicine at FSU Collegge of Medicine and has expertise in vaping and ENDS. Ms. Geletko has done research in this area, teaches medical students about vaping and related issues and is the faculty member who developed and teaches the "Other Tobacco Products" module for our Tobacco Treatment Specialist course. Rather than responding to individual questions, we have prepared this summary and reference list for the webinar participants as vaping cannot be characterized as either beneficial or harmful.

There are particulates in ENDS aerosol which include nicotine, additives (propylene glycol, glycerine, and flavoring compounds) and carcinogens and toxic chemicals (tobacco-specific nitrosamines, formaldehyde, acetaldehyde, acrolein and heavy metals (tin, silver, iron, nickel, aluminum, silicate). The toxins in vapor are significantly lower than those found in cigarette smoke.

FDA Regulations: E-cigarettes and other Electronic Nicotine Delivery Systems (ENDS) are not approved for tobacco cessation, are deemed a tobacco product, are banned for sale of those under 18 y/o, and require warning statements. Manufactures must register and list products with the FDA.

National Academies of Sciences, Engineering, and Medicine published Public Health Consequences of E-Cigarettes (2018), a report based on a comprehensive review of independent scientists.

Key Findings from the report:

- Contain and emit numerous potential toxins, increase airborne particulate matter, highly variable in nicotine delivery
- Completely switching reduces exposure to numerous toxicant and carcinogens and results in reduced short-term adverse health outcomes
- Youth users are more likely to transition to use of combustibles but e-cigarettes might also increase adult cessation of combustibles

American Heart Association

Position Statement:

- If a patient has failed initial treatment, has been intolerant to or refuses to use conventional smoking cessation medication, and wishes to use e-cigarettes to aid quitting, it is reasonable to support the attempt.
- Tell patients "although e-cigarette aerosol is likely to be much less toxic than cigarette smoking, the products are unregulated, may contain low levels of toxic chemicals, and have not been proven to be effective as cessation devices."
- Advise the patient to consider setting a quit date for their e-cigarette use and not to plan to use it indefinitely.

American Cancer Society
Position Statement:

- Some smokers, despite firm clinician advice, will not attempt to quit smoking cigarettes and will not use FDA approved cessation medications. These individuals should be encouraged to switch to the least harmful form of tobacco product possible; switching to the exclusive use of e-cigarettes is preferable to continuing to smoke combustible products.
- Clinicians should support all attempts to quit the use of combustible tobacco and work with smokers to eventually stop using any tobacco product, including e-cigarettes.

American College of Cardiology
Position Statement:

- E-cigarettes have the potential for benefit if they help smokers to quit smoking combustible cigarettes, especially smokers who have not been willing or able to quit using current treatments.
- This potential benefit must be balanced against e-cigarettes' long-term health risks, which are largely unknown at this time.
- This potential benefit must be balanced against the potential for e-cigarettes to attract youth and young adults who might not otherwise smoke to take up their use and perhaps increase the uptake of cigarettes.

American Lung Association
Position Statement:

- The ALA is very concerned that we are at risk of losing another generation to tobacco-caused diseases as the result of e-cigarettes. The Lung Association remains extremely troubled about the rapid increase of youth using these products.
- While much remains to be determined about the lasting health consequences of e-cigarettes, there's evolving evidence about the health risks of e-cigarettes on the lungs—including irreversible lung damage and lung disease.

General recommendations for speaking with adults: Vaping is not FDA approved for cessation, is not harmless, the long-term impact is unknown, secondhand exposure is a concern and using exclusively is preferable to smoking.

General recommendations for speaking with youth: Vaping is not recommended for youth usage under any circumstance, is not safe and contains toxins, contains nicotine and is addicting, and youth nicotine use may cause lasting developmental impairment.

References for vaping/ ENDS:

- The October issue of Nicotine and Tobacco Research journal (@NTR_Journal on Twitter) is dedicated to this topic
  https://academic.oup.com/ntr/issue/21/10

- Specifically, you might be interested in reading the open access editorial **"Viewing E-cigarette Research Through a Broad Lens"**, written by Tessa Langley, from the UK Centre for Tobacco and Alcohol Studies, Division of Epidemiology and Public Health, University of Nottingham https://academic.oup.com/ntr/article/21/10/1297/5547765

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