Tobacco Use Disorder: The Neglected Addiction

Presented by Andrée Aubrey, LCSW, CTTS, NCTTP

September 11, 2019

Andrée Aubrey
Contact info
Andrée.Aubrey@med.fsu.edu
Florida State University
College of Medicine
Area Health Education Center

Webinar Learning Objectives

1. Understand tobacco use prevalence rates for individuals with behavioral health conditions within a health disparities framework
2. Examine common barriers and strategic interventions for consistently integrating tobacco treatment along with other behavioral health services
3. Implement the guideline-based brief intervention which significantly improves client readiness to make a tobacco quit attempt
Tobacco Use Disorder: DSM 5

1. Use in larger amounts or longer than intended
2. Desire or unsuccessful effort to cut down
3. Great deal of time obtaining, using (chain-smoking) or recovering
4. Craving or strong urge to use tobacco
5. Role obligation failure at work, home, or school (interferes w/ work)
6. Continued use despite social/interpersonal problems
7. Sacrificing activities to use or because of use
8. Use in situations where impairment is physically hazardous
9. Continued use despite knowledge of having a physical or psychological problem caused or exacerbated by use
10. Tolerance: need increased amount or diminished effect
11. Withdrawal

Nicotine Withdrawal: DSM 5

Symptoms:
- Irritability, frustration, or anger
- Anxiety
- Difficulty concentrating
- Increased appetite or weight gain (4-7 lbs)
- Restlessness
- Depressed mood
- Insomnia
- Decreased heart rate

Associated Features:
- Craving sweet or sugary foods
- Impaired performance on tasks requiring vigilance
- Increased constipation
- Coughing
- Dizziness
- Dreaming/nightsmares
- Nausea
- Sore throat
Important Features of Tobacco Use Disorder

- Highly addictive but not intoxicating so use gets completely integrated in one's lifestyle
- Rapid rate of absorption (7-10 seconds) and high amount of nicotine delivered directly to the brain
- Releases dopamine to deliver a feeling of calm and pleasure
- Nicotine withdrawal starts within 60 – 90 minutes of last use
- Users experience withdrawal symptoms as "stress", use nicotine, and conclude smoking helps to deal w/ stress

The immediate psychoactive effects of nicotine are regarded as positive by users, and devastating physical effects seem more distant.

Tobacco Use in the General Population

CDC, National Health Interview Survey, 1966-2014

Tobacco Use in the Past Month Among People Aged 18 or Older, by Past Year Level of Mental Illness 2016

<table>
<thead>
<tr>
<th>Mental Illness Level</th>
<th>No Mental Illness</th>
<th>Mild Mental Illness</th>
<th>Moderate Mental Illness</th>
<th>Serious Mental Illness</th>
<th>Any Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23.6</td>
<td>27.8</td>
<td>32.7</td>
<td>43.3</td>
<td>40.9</td>
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<td></td>
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</tbody>
</table>

(Tobacco Use Products, Cigarettes, Smokeless Tobacco, Cigars, Pipe Tobacco)

(NSDUH 2017)

Behavioral Causes of Death in U.S

Substance Related Deaths in 2018
Alcohol & Tobacco

Cigarette smoking and excessive alcohol consumption are two of the leading preventable causes of premature death in the U.S. and the world (Danae, 2009).

Highly comorbid conditions (Grant, 2004; NIH NIAAA)
- Individuals with alcohol use disorders: smoking rates are 4X higher than general population
- Individuals with Tobacco Use D/O: alcohol use disorder rates 3X higher than general population

More alcoholics die of tobacco-related illness than alcohol-related illness

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**Smoking Rates on General U.S. Population Compared to Subpopulations (2014-2015)**

<table>
<thead>
<tr>
<th>Subpopulation</th>
<th>Percentage with Smoke</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>20.0%</td>
</tr>
<tr>
<td>Veteran</td>
<td>26.0%</td>
</tr>
<tr>
<td>Boroughized</td>
<td>28.0%</td>
</tr>
<tr>
<td>Metros</td>
<td>27.0%</td>
</tr>
<tr>
<td>Rural</td>
<td>30.0%</td>
</tr>
<tr>
<td>High School</td>
<td>31.0%</td>
</tr>
<tr>
<td>Col. Arrest</td>
<td>32.0%</td>
</tr>
<tr>
<td>Total Arrest</td>
<td>30.0%</td>
</tr>
<tr>
<td>Justice Involved</td>
<td>30.0%</td>
</tr>
<tr>
<td>Living in Poverty</td>
<td>32.0%</td>
</tr>
<tr>
<td>Substance Use Issues</td>
<td>33.0%</td>
</tr>
<tr>
<td>Lower Education Levels</td>
<td>32.0%</td>
</tr>
<tr>
<td>Blue Collar/Service Industry</td>
<td>30.0%</td>
</tr>
<tr>
<td>LGBTQ Population</td>
<td>31.0%</td>
</tr>
<tr>
<td>Rural Communities</td>
<td>31.0%</td>
</tr>
</tbody>
</table>

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**BIG TOBACCO WANTS YOU!**
About how many tobacco disparities groups would pertain to the clients you serve?

A. 1  
B. 2 or 3  
C. 4 or 5  
D. More than 5

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**Consequences of Tobacco Industry Targeting**

- 50% of all long-term users die from tobacco-related illnesses
- Tobacco contributes to more deaths than the primary behavioral health disorder
- Smokers with a mental illness have a cancer incidence rate that is 2.6 times higher than those w/o a MI (National Behavioral Health Network)
- Cancer is second leading cause of death in US and commercial tobacco use is the leading cause of preventable cancer/cancer deaths

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For every person who dies because of smoking, at least 30 live with a serious smoking-related illness.
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Why don’t we consistently assess tobacco use and treat this particular addiction?

- Releases dopamine to deliver a feeling of calm and pleasure
- Can act as a stimulant or depressant
- Increases the reinforcing effects of other drug stimuli
- Suppresses appetite
- Improves cognition and motor function

Tobacco is the problem, not a solution!

But “they” benefit from smoking, right?
Which of the following barriers to addressing Tobacco Use D/O seems to be the most influential at your organization or in your practice?

A. TUD considered less important than other SUD
B. Limited funding for tobacco treatment
C. Treatment culture that is amenable to tobacco use
D. Concerns cessation attempts will impede sobriety or stability of symptoms of mental health disorders

Clinical Barriers
- Failure to appreciate health consequences
- Lack of staff time and training
- Possible bias against use of cessation medications
- Symptoms of nicotine withdrawal may be misinterpreted as worsening of symptoms of mental illness

Organizational Barriers
- Limited funding for TUD treatment
- Ambivalence about establishing tobacco-free grounds
- Misbelief that there are no standards for TUD treatment
- Lack of resources for training staff
- Treatment culture that historically has been amenable to tobacco use
Benefits of Quitting

- Meta-analysis of 26 longitudinal studies
- Consistent evidence that stopping smoking is associated with improvements in:
  - Depression
  - Anxiety
  - Stress
  - Psychological quality of life, and
  - Positive affect compared to continuing to smoke. "The effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders." (Taylor 2014)

Quitting Smoking Improves Substance Abuse Treatment Outcomes

- Tobacco dependence treatment provided during addictions treatment was associated with a 25% increased likelihood of long-term abstinence from alcohol and illicit drugs.
- The preponderance of studies indicate that concurrent tobacco dependence treatment does not jeopardize SUD outcomes. (Prochaska 2004 meta-analysis of 19 RCT with folks in current treatment or recovery)
- Continued tobacco use is associated with:
  - Greater odds of SUD relapse
  - Increased depressive symptoms and suicidal risk behavior (Weinberger 2017)
  - Increased risk of new onset mood and anxiety disorders (Mojtabai and Crum 2013)
What is the estimated tobacco use prevalence rate among treatment staff compared to the general population?

A. Significantly lower  
B. Approximately the same  
C. Somewhat higher  
D. Significantly higher

Clinical Barriers

- Smoking rate among treatment staff is significantly higher than the general population
- Approx. 30-35% of the behavioral health workforce smokes vs. 1.7% of primary care physicians  
  (SAMHSA)
- Approx. 50-60% of addiction treatment clinicians smoke  
  (Friend & Levy 2004)

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Evidence Based Treatment for TUD

- 8700 peer-reviewed articles and 35 meta-analyses
- Available at https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html

What percentage of individuals with mental health and/or substance use disorders are interested in quitting smoking?

A. Less than 15%
B. Less than 25%
C. About 50%
D. About 70%

CDC; MMWR / January 6, 2017 / Vol. 65 / No. 52

- The most effective treatment for smoking cessation is the combination of counseling and pharmacotherapy
- All smokers should be offered pharmacotherapy when they are ready to make a quit attempt (with some exceptions)
- Brief interventions may be delivered by all clinicians and are effective in increasing client willingness to make a quit attempt
- The more intensive the counseling, the higher the long-term quit rate

Strategic Interventions

Brief Intervention

**Step 1 – ASK**
- Systematically identify all tobacco users at each visit
- Document Status
  - Record in in-take interview
  - Ask and record in psychosocial history
  - Add to problem list or treatment plan

**Step 2 – ADVISE**
- In a clear, strong, and personalized manner, urge every tobacco user to quit
  - Clear: “There are new treatments and medications available to help you quit.”
  - Strong: “I want to make sure you understand quitting is the most important thing you can do to improve your health.”
  - Personalized: “Continuing to smoke makes your depression worse and quitting will help dramatically.” OR “Quitting tobacco will reduce your risk of relapse from alcohol and other drugs.”
Step 2 – ADVISE
- Take advantage of “Teachable Moments”
- Acknowledge difficulty of quitting
- Stress the benefits of quitting rather than the risks of continuing
- Be caring, empathetic and positive
- Offer counseling and medications

Step 3 – REFER
- Local programs
- State or national quit lines (1-800 Quit Now)
- Private insurance plans may offer benefits
- Smokefree.gov (NIH- teens, women, veterans, Español, chat on-line)
- Espanol.smokefree.gov
- American Cancer Society, American Heart Association, American Lung Association

Guideline: PRACTICAL COUNSELING
- Provide Info
  - Tobacco Dependency
  - Treatment Options
  - Successful Quit Strategies
- STEP 2
  - Recognize “dangerous situations”
  - Cues and triggers to smoke
- STEP 3
  - Develop and strengthen coping skills
    - Cognitive
    - Behavioral
    - Psychological
    - Social
    - Spiritual
Over the Counter (OTC)

- Nicotine patch – long-acting
- Nicotine lozenge (short-acting)
- Nicotine Gum (short-acting)

Prescription Required

- Nicotine Nasal Spray
- Nicotine Inhaler
- Bupropion SR (Zyban)
- Varenicline (Chantix)

FDA Approved Pharmacotherapy:

Dept Health and Human Service; USPHS Clinical Practice Guideline 2008

NRT is extremely safe:

- Same drug client is already using
- Contains nicotine w/o the thousands of other chemicals and known carcinogens in cigarette smoke
- Not introducing a new drug into the body – nicotine is already interacting with the other medications a client may be taking (some caveats for psychotropic meds and caffeine – visit https://rxforchange.uscf.edu)
- Low potential for addiction

Nicotine Concentrations
You have not failed, you have just not finished the process!

Quitting isn’t about what you give up. It’s about what you get back.

Andrée Aubrey, LCSW, CTTS
Andree.Aubrey@med.fsu.edu
850-645-6439

Thank You!

Florida State University
College of Medicine
Area Health Education Center
https://med.fsu.edu/ahec/home