National Addiction Treatment Week

UCSF Smoking Cessation Leadership Center | National Center of Excellence for Tobacco-Free Recovery

"Enhancing Recovery by Addressing Smoking During Addiction Treatment"

on Tuesday, October 19, 2021, at 1:00 pm EDT (60 minutes)

Speaker: **Brian Hurley, MD, MBA, DFASAM,** President-Elect, American Society of Addiction Medicine, Medical Director, LA County Department of Public Health's Substance Abuse Prevention and Control, and Volunteer Assistant Clinical Professor of Addiction Medicine at UCLA

I. Pharmacotherapy and drug interactions

Q: Can you say more about prescribing Chantix with NRT. Pfizer info says not to. ("You should not use CHANTIX while using other medicines to stop smoking. Using CHANTIX with a nicotine patch may cause nausea, vomiting, headache, dizziness, upset stomach, and tiredness to happen more often than if you just use a nicotine patch alone. Tell your healthcare provider if you use other treatments to quit smoking before starting CHANTIX. Talk to your healthcare provider to learn more about how to quit smoking.") Thank you!

A: Sure. Despite the manufacturer's warning, there is some mixed evidence that combining varenicline with NRT is effective (see below) and not really good evidence that this combination is routinely intolerable. Check out:

- Koegelenberg CF, Noor F, Bateman ED, van Zyl-Smit RN, Bruning A, O'Brien JA, Smith C, Abdool-Gaffar MS, Emanuel S, Esterhuizen TM, Irusen EM. Efficacy of varenicline combined with nicotine replacement therapy vs varenicline alone for smoking cessation: a randomized clinical trial. JAMA. 2014 Jul;312(2):155-61. doi: 10.1001/jama.2014.7195. PMID: 25005652. http://jamanetwork.com/journals/jama/fullarticle/10.1001/jama.2014.7195
- Chang PH, Chiang CH, Ho WC, Wu PZ, Tsai JS, Guo FR. Combination therapy of varenicline with nicotine replacement therapy is better than varenicline alone: a systematic review and meta-analysis of randomized controlled trials. BMC Public Health. 2015 Jul 22;15:689. doi: 10.1186/s12889-015-2055-0. PMID: 26198192; PMCID: PMC4508997. http://www.ncbi.nlm.nih.gov/pmc/articles/pmid/26198192

Q: I have encountered individuals who express smoking more when in MAT (Medication Assisted Treatment), how can we target this?

A: By consistently identifying and capitalizing on opportunities to treat patients who received medications for opioid use disorder. There are a few articles which discuss this dynamic:

- Nahvi S, Blackstock O, Sohler NL, Thompson D, Cunningham CO. Smoking cessation treatment among office-based buprenorphine treatment patients. J Subst Abuse Treat. 2014 Aug;47(2):175-9. doi: 10.1016/j.jsat.2014.04.001. Epub 2014 Apr 27. PMID: 24912863; PMCID: PMC4104355. http://www.ncbi.nlm.nih.gov/pmc/articles/pmid/24912863
- Streck JM, Kalkhoran S, Bearnot B, Gupta PS, Kalagher KM, Regan S, Wakeman S, Rigotti NA. Perceived risk, attitudes, and behavior of cigarette smokers and nicotine vapers receiving buprenorphine treatment for opioid use disorder during the COVID-19 pandemic. Drug Alcohol Depend. 2021 Jan 1;218:108438. doi: 10.1016/j.drugalcdep.2020.108438. Epub 2020 Nov 25. PMID: 33271434; PMCID: PMC7687365. http://www.ncbi.nlm.nih.gov/pmc/articles/pmid/33271434
- Hall SM, Humfleet GL, Gasper JJ, Delucchi KL, Hersh DF, Guydish JR. Cigarette Smoking Cessation Intervention for Buprenorphine Treatment Patients. Nicotine Tob Res. 2018 Apr 2;20(5):628-635. doi: 10.1093/ntr/ntx113. PMID: 28549161; PMCID: PMC7207071. http://www.ncbi.nlm.nih.gov/pmc/articles/pmid/28549161

Q: If a patient is undergoing elective surgery, should they discontinue nicotine replacement therapy?

A: Generally not. The only real time the patient should discontinue is during an acute myocardial infarction, but they can continue NRT through most elective surgeries, as a return to smoking is more threatening to normal healing than nicotine exposure.

Q: Should pain management be addressed prior to pushing for smoking cessation?

A: No. They should be addressed in parallel.

Q: What are the best non-NRT behavioral alternatives? (gum, tea, etc). And: What do you think about hypnosis, guided imagery and mindfulness based relapse prevention techniques?

A: I stick with evidence based strategies which include mindfulness. Check out the treatment section of the DIMENSIONS toolkit which has more information:
http://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Downloads/Toolkits/dimensions_tobacco_free_toolkit_hcp_0.pdf

Q: What is your take on prescribing an anxiolytics to aid cessation when the trigger is often anxiety?

A: I remind patients that quitting smoking will help their anxiety more than an anxiolytic and I generally try to get my patients to learn anxiety self-management without medications, but if the patient hasn't responded to these self-management tools, then I'd treat their anxiety syndrome with medications. This includes patients who use tobacco products.

Q: Would you be able to use these same strategies and NRT for individuals who use smokeless tobacco? I was told that the FDA has not approved the use of NRT to help people quit smokeless tobacco. How can we aid in that attempt?

A: Yes, the medication strategy is essentially the same. The key is to estimate their daily nicotine intake for the purpose of dosing NRT, but otherwise the medication is the same

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II. Policy and enforcement

Q: Do you suggest working with or offering tobacco cessation to employees who smoke, as a way of getting buy-in from staff who interact with patients/clients?

A: Yes, absolutely.

Q: Any data on whether people seeking SUD treatment are less likely to choose a smoke-free campus treatment center?

A: I can point to the New York State data which found no drop in enrollment when the whole state's SUD treatment programs went smokefree and a comparable finding in New Jersey:

- Guydish J, Tajima B, Kulaga A, Zavala R, Brown LS, Bostrom A, Ziedonis D, Chan M. The New York policy on smoking in addiction treatment: findings after 1 year. Am J Public Health. 2012 May;102(5):e17-25. doi: 10.2105/AJPH.2011.300590. Epub 2012 Mar 15. PMID: 22420814; PMCID: PMC3340008. http://www.ncbi.nlm.nih.gov/pmc/articles/pmid/22420814
- Pagano A, Guydish J, Le T, Tajima B, Passalacqua E, Soto-Nevarez A, Brown LS, Delucchi KL. Smoking Behaviors and Attitudes Among Clients and Staff at New York Addiction Treatment Programs Following a Smoking Ban: Findings After 5 Years. Nicotine Tob Res. 2016 May;18(5):1274-81. doi: 10.1093/ntr/ntv116. Epub 2015 May 25. PMID: 26014456; PMCID: PMC6407842. http://www.ncbi.nlm.nih.gov/pmc/articles/pmid/26014456
- Williams JM, Foulds J, Dwyer M, Order-Connors B, Springer M, Gadde P, Ziedonis DM. The integration of tobacco dependence treatment and tobacco-free standards into residential addictions treatment in New Jersey. J Subst Abuse Treat. 2005 Jun;28(4):331-40. doi: 10.1016/j.jsat.2005.02.010. PMID: 15925267. http://pubmed.ncbi.nlm.nih.gov/15925267

Q: Can you offer suggestions on connecting tobacco / nicotine cessation as part of addressing their co-occurring medical?

A: Yes. In general smoking treatment should be integrated into their other services, so the co-occurring treatment-relevant medications should include smoking cessation medications, that the co-occurring counseling should include smoking treatment, and their medical treatment should include medications and counseling to support smoking cessation.

Q: Could you contrast the completely tobacco free RESIDENTIAL program where clients have to not smoke while in treatment with med support as needed vs the comprehensive tobacco free but clients are not required to be tobacco free

A: Yes. In general, the more limited the opportunities to smoke, the more patients go into remission for their tobacco use disorder during treatment. Offering smoking treatment as part of treatment for other substance use disorders helps patients sustain the remission of their tobacco use disorder AND helps them remain in remission for their other substance us disorder.

Q: Do you have more data on the effect of smoking cessation on recovery from other substances? Example: with the residential data you presented, how well did they do related to the drug they sought residential treatment for?

A: Check out the articles:

- Tsoh JY, Chi FW, Mertens JR, Weisner CM. Stopping smoking during first year of substance use treatment predicted 9-year alcohol and drug treatment outcomes. Drug Alcohol Depend. 2011 Apr 1;114(2-3):110-8. doi: 10.1016/j.drugalcdep.2010.09.008. Epub 2010 Nov 2. PMID: 21050681; PMCID: PMC3062692. http://www.ncbi.nlm.nih.gov/pmc/articles/pmid/21050681 (check out Figure 1)
- Baca CT, Yahne CE. Smoking cessation during substance abuse treatment: what you need to know. J Subst Abuse Treat. 2009 Mar;36(2):205-19. doi: 10.1016/j.jsat.2008.06.003. Epub 2008 Aug 20. PMID: 18715746. http://pubmed.ncbi.nlm.nih.gov/18715746 (page 207)
- Hufnagel A, Frick U, Ridinger M, Wodarz N. Recovery from alcohol dependence: Do smoking indicators predict abstinence? Am J Addict. 2017 Jun;26(4):366-373. doi: 10.1111/ajad.12535. Epub 2017 Apr 4. PMID: 28376287. http://pubmed.ncbi.nlm.nih.gov/28376287 (check out Figure 1)

Q: Do you think the NY State model that prohibits smoking is less effective than the embedded counselor who is available should the client choose to learn more.

A: I think both are effective and should be used together: smokefree policies plus on-site smoking treatment.

Q: Have you seen smoking cessation treatment for parents/minors mandated in Child Welfare Juvenile Court cases? They treat all other addictions, why not tobacco?

A: They should!

There's a good article on this:

- Escoffery C, Kegler MC, Bundy L, Yembra D, Owolabi S, Kelley D, Mabry D. Evaluation of Smoke-free Foster Care Education for Foster and Adoptive Caregivers. Child Welfare. 2014;93(5):105-116. PMID: 29249835; PMCID: PMC5727377. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5727377

Usually the child welfare system inappropriately neglects addressing smoking among parents.

Q: It is difficult to consider discharging a client from SUD residential txt who is otherwise making progress that violates a no tobacco use policy repeatedly. What advice do you have in such situations?

A: To progressively limit their privileges until they can demonstrate an ability to navigate the facility's rules, which is part of their overall demonstration of recovery skills.

Q: Do most of these smoking cessation practices work for smokeless tobacco as well?

A: Yes.

Q: How do you address young adults with smoking tobacco?

A: With developmentally appropriate approaches (meds plus counseling and support), while paying attention to the young adult's peer circle, which often has the largest impact on their behavior.

Q: In my experience 12 step programs have not worked for tobacco cessation whereas we know they work well for other drugs. What are your thoughts are on the pros/cons of 12 step programs addressing smoking with these patients?

A: I think 12 steps could work really well if they focus on tobacco abstinence, and if the individual participating actually works the steps and gets support. Unfortunately, nicotine anonymous is not well studied (check out http://www.ncbi.nlm.nih.gov/pmc/articles/pmid/20019295). Most 12 step programs focused on alcohol and other drugs ignore tobacco, which expectedly leaves the program having no impact on tobacco product consumption. I think people attending 12 steps programs should have access to the full range of smoking treatments, including mutual self-help if they're interested.

Q: Most rehabilitation agencies don't promote tobacco cessation, although I'm assuming if those outlets (cigarettes) aren't available, their addiction tends to transition from their drug of choice to either food or caffeine, if not cigarettes or whatever is readily available that reduces the discomfort of withdrawal. But, how do you guide a client through the recovery process while also making sure they're not replacing their addiction with another addiction like food or cigarettes?

A: The same way I'd guide a patient without a tobacco use disorder entering early remission who often will binge on food or caffeine. I'd help support trigger identification and self-management with healthful habits. Their addiction to tobacco is simply one additional substance they'd learn to manage without.

Q: Thoughts on how to frame tobacco cessation with clients who are impoverished and they perceive smoking as their "only break or pleasure or time to themselves"? Despite living in poverty, the cost of tobacco products are not a prohibitive factor as in their mind this is a relatively cheap way to get some reprieve from compounded social problems (lack of education, underemployment, generational poverty, mental health symptoms, etc.) as opposed to obtaining more expensive elicit substances.

A: I'd start by using motivational interviewing and working to really understand what life is like for the patient. I've had patients in under-resourced settings usually start with "don't take my cigarettes from me" to which I'll usually reflect "cigarettes are a great source of comfort for you." If I have a decent therapeutic alliance I might offer an amplified reflection: "You're ready to increase your smoking since it's such a great source of comfort." If I've used an amplified reflection appropriately the next thing from the patient would be some statement like, "well, no, I can't afford any more cigarettes and even though they help me, I know they're bad for me" or some variation on their ambivalence.

I'd then reflect the change talk, such as "cigarettes are expensive and you'd like to feel better without needing to rely on cigarettes," and see what follows. The goal for patients not ready to quit is usually a plan to cut down, and I spend time planning, from the patient's perspective, what they are ready to do and when to get as much of a SMART goal together as possible (ranging from a certain CPD target or simply a willingness to discuss it at the next visit).

I don't spend a ton of time informing patients about the risks of smoking unless I have noticed a clear information deficit that the patient offers a readiness to address through learning more. Usually this ends up with the patient defending their cigarette consumption which is typically counterproductive.

Rather, I remain open to learning more about what the patient's thoughts are and readiness is even if their goals aren't abstinence and I have usually been able to evoke some modest change talk from most patients that can generate behavior change when the patient becomes ready. If I spend the whole time lecturing, this usually closes me off from participating with any of the patient's change process.

Q: What is your position on pharmacy practice expansion to prescribe all NRT's?

A: I support it. NRTs aren't particularly toxic and I think clinical pharmacists can capably prescribe all forms of NRT (and bupropion and varenicline).