

# Welcome

Please stand by. We will begin shortly.

***“What’s Smoking Got to Do with It? Improving the Health of Priority Populations by Treating Tobacco Use”***

Tuesday, January 27, 2015 · 1pm ET (60 minutes)



SMOKING CESSATION  
LEADERSHIP CENTER



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

# Disclosure

Dr. Westley Clark, Dr. Lula A. Beatty, and Catherine Saucedo have disclosed no financial interest/arrangement or affiliation with any commercial companies who have provided products or services relating to their presentation or commercial support for this continuing medical education activity.

# Moderator



## Catherine Saucedo

- Deputy Director,  
Smoking Cessation Leadership  
Center, University of California,  
San Francisco
- **[csaucedo@medicine.ucsf.edu](mailto:csaucedo@medicine.ucsf.edu)**

# Thank you to our funders



Robert Wood Johnson Foundation



**LEGACY**  
FOR LONGER HEALTHIER LIVES

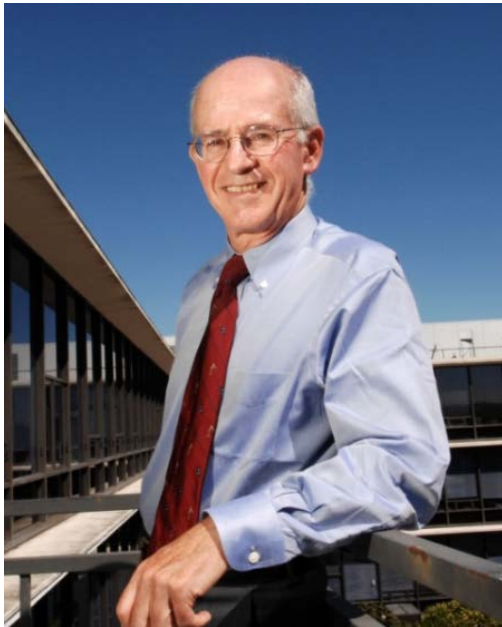


NATIONAL BEHAVIORAL  
**HEALTH NETWORK**  
FOR TOBACCO & CANCER CONTROL

# Housekeeping

- All participants will be in **listen only mode**.
- Please **make sure your speakers are on** and adjust the volume accordingly.
- If you do not have speakers, please request the dial-in via the chat box.
- **This webinar is being recorded** and will be available on SCLC's website, along with the slides.
- **Use the chat box to send questions** at any time for the presenters.

# Introduction by Dr. Schroeder



## **Steven A. Schroeder, MD**

- Director, Smoking Cessation Leadership Center
- Distinguished Professor of Health and Health Care, Department of Medicine, UCSF

# Today's Speaker



**Lula A. Beatty, PhD**

Senior Director, Health Disparities,  
at the American Psychological  
Association


# Today's Speaker



## **H. Westley Clark, MD, JD, MPH, CAS, FASAM**

Dean's Executive Professor of Public Health, Santa Clara University, Santa Clara, California and former Director of the Substance and Mental Health Services Administration's Center for Substance Abuse Treatment





# American Psychological Association (APA)

HEALTH DISPARITIES INITIATIVE

# American Psychological Association

- ▶ Established in 1892
- ▶ Largest association of psychologists in the world
- ▶ Our mission is to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives.

# Health Disparities Initiative

- ▶ In 2011 the APA identified Health Disparities as one of its Strategic Initiatives
- ▶ Goal 2. To expand psychology's role in advancing health; to promote psychology's role in decreasing health disparities
- ▶ Focus on stress, obesity and **substance use and addiction** as major underlying causes of poorer health and less productive and shorter lives in health disparity populations.
- ▶ Tobacco is the most commonly used substance and the leading cause of preventable illness and death

# Smoking and Tobacco Health Disparities

- ▶ December 2012 Conference on Strengthening Psychology's Role in Reducing Tobacco Health Disparities
- ▶ Recommendations: (1) Awareness, Education & Training, (2) Partnerships and Collaborations, (3) Materials, Resources, Publications and Presentations, (4) Research, (5) Advocacy and Policy, and (6) Funding and Reimbursement
- ▶ Agency for Healthcare Research and Quality funding received in 2013 to disseminate information on best practices in smoking cessation with health priority populations



# Upcoming

- ▶ Free smoking app for professionals on smoking in health priority populations
- ▶ Health Ambassadors program to support dissemination activities
- ▶ Webinar on dissemination strategies

Contact me at [lbeatty@apa.org](mailto:lbeatty@apa.org)

# What's Smoking Got to Do with It? Improving the Health of Priority Populations by Treating Tobacco Use

H. Westley Clark, MD, JD, MPH, CAS, FASAM  
Dean's Executive Professor of Public Health  
Santa Clara University

A Webinar presented by the:



SMOKING CESSATION  
LEADERSHIP CENTER

and



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

# Webinar Objectives

- Describe smoking in health priority populations including prevalence and risk factors
- Discuss reasons professionals may not attend to smoking in health priority populations and the consequences of not attending to smoking
- Identify and discuss evidence-based practices effective with health priority populations
- Specify that behavioral health professionals routinely screen their clients, and treat or refer them to treatment



# Priority Populations

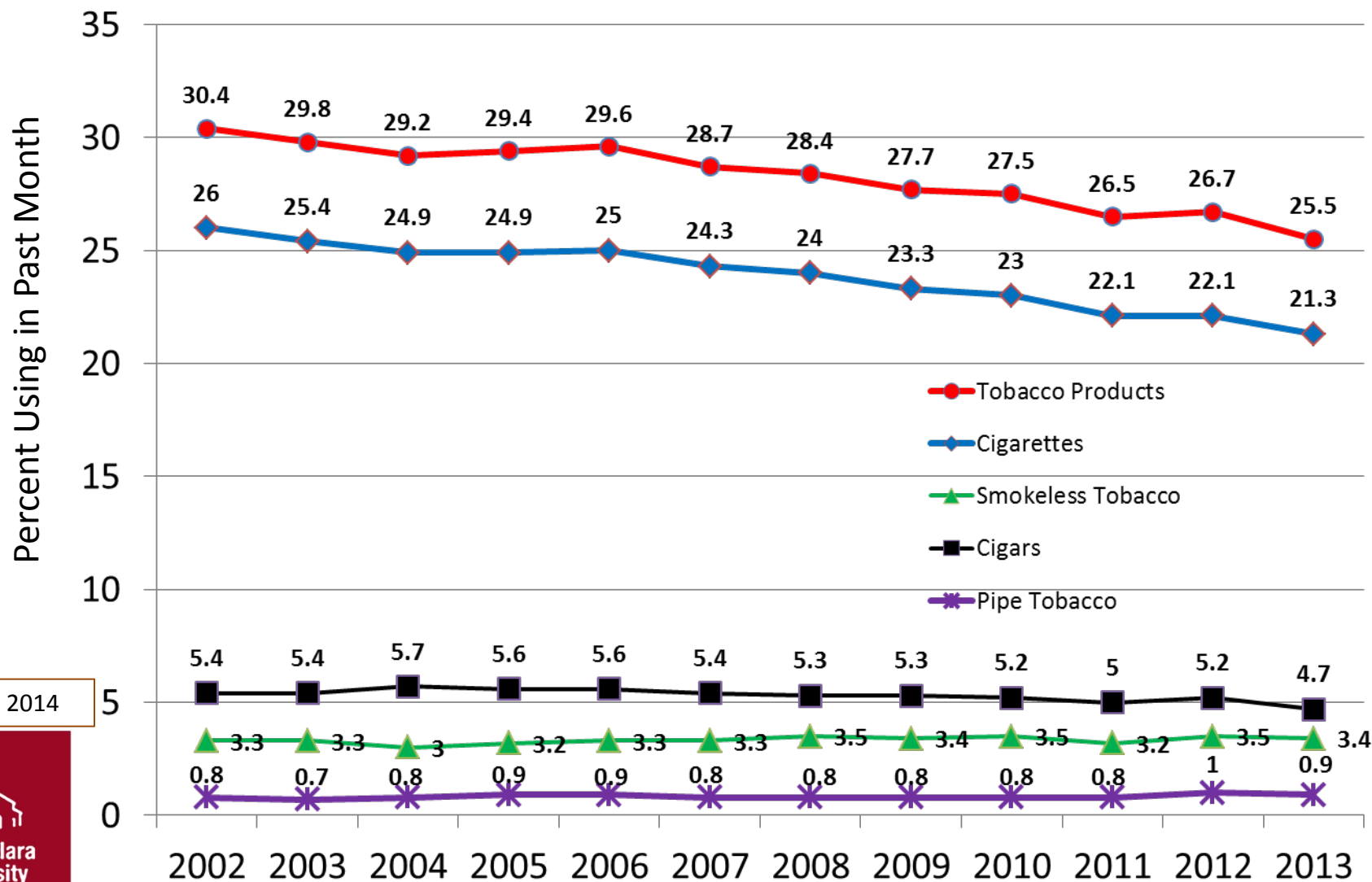
- Serious Mentally Ill
- Substance Users
- Racial/Ethnic Minority
- Persons with Disabilities
- Adolescents
- LGBT
- Girls and Women
- Persons Living with HIV/AIDS
- Low-Income
- Rural



# The Challenge

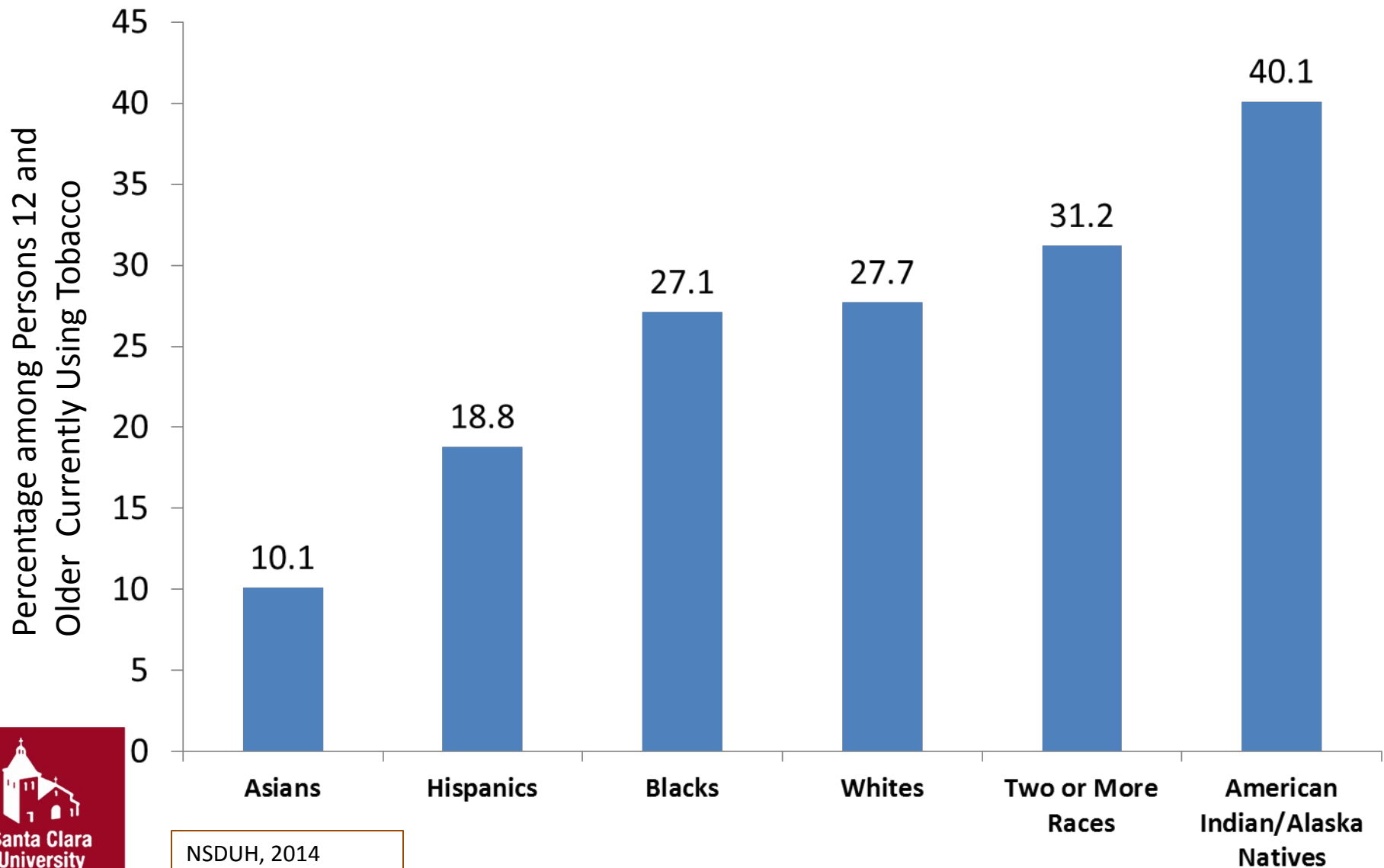
- In 2013, an estimated 55.8 million Americans aged 12 or older were current (past month) users of a tobacco product – approximately 21.3% of the population in that age range.
- 24.1% of past month cigarette smokers reported current use of an illicit drug, compared to 5.4% of persons who were not current cigarette smokers.
- Over half of the youths -- 750 thousand youths 12-17 years -- who smoked cigarettes in the past month also used an illicit drug (compared to 6.1% of youths who did not smoke cigarettes).

# Past Month Tobacco Use among Persons Aged 12 or Older: 2002-2013

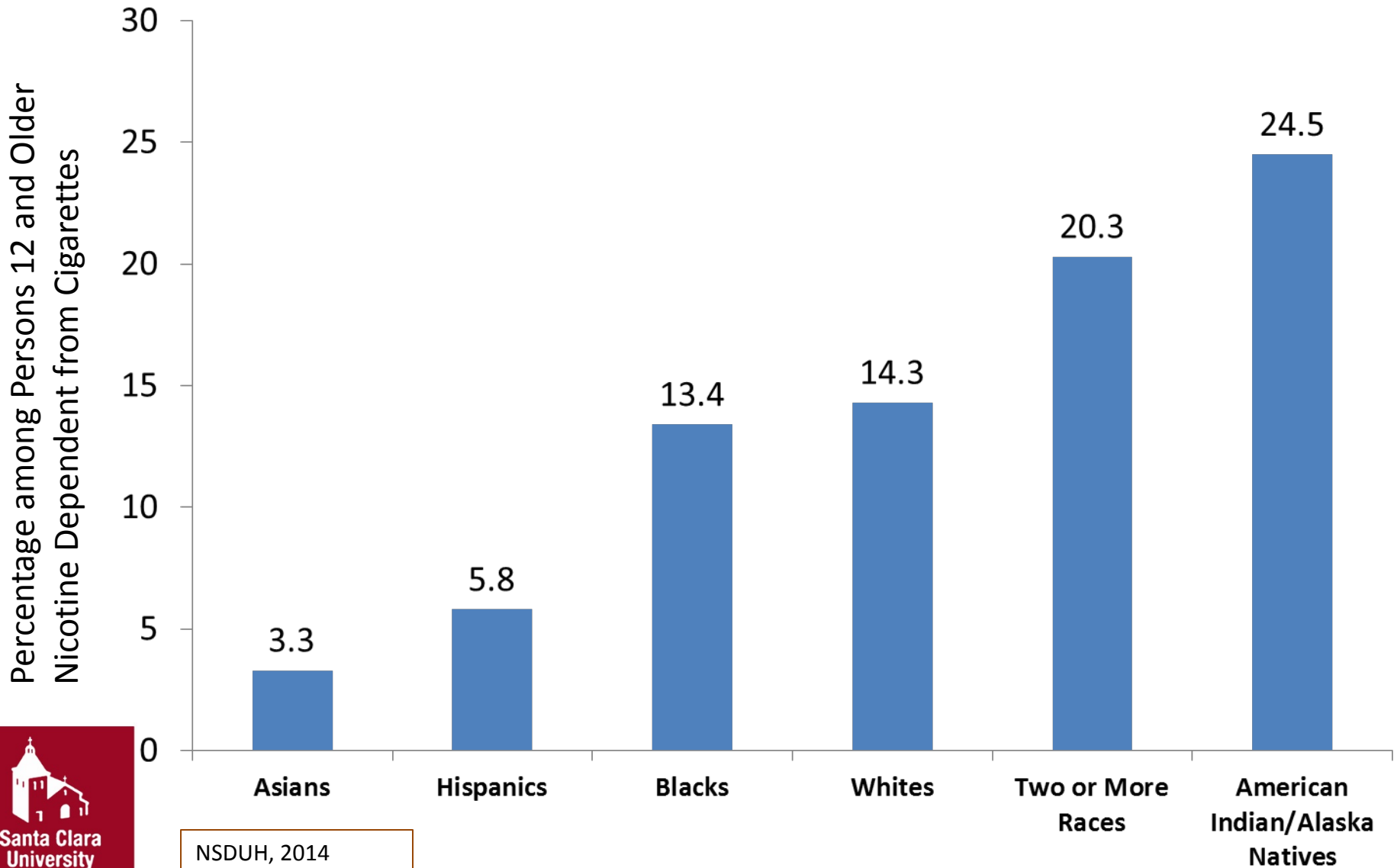


NSDUH, 2014

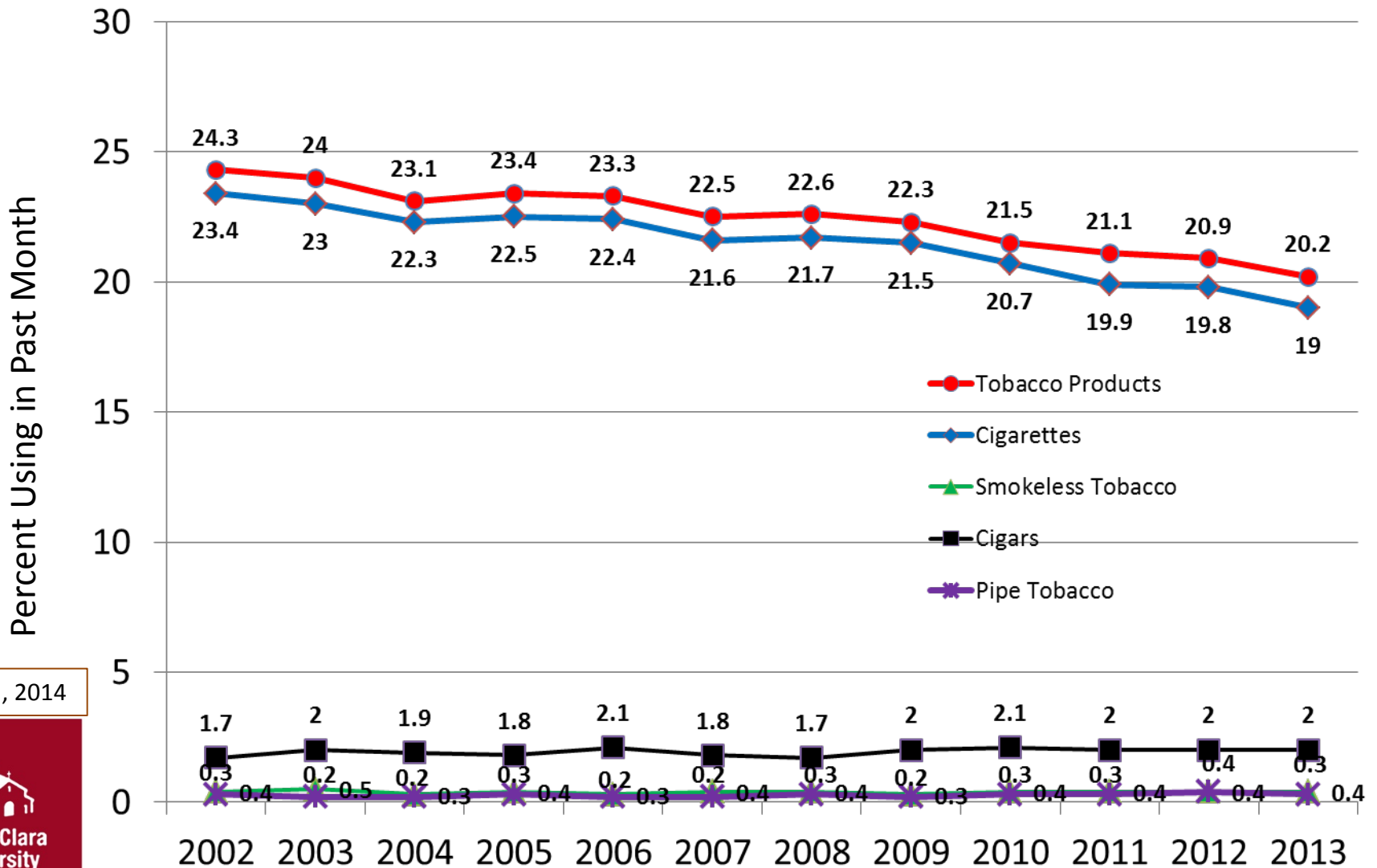
# Current Tobacco Use: Race/Ethnicity, 2013



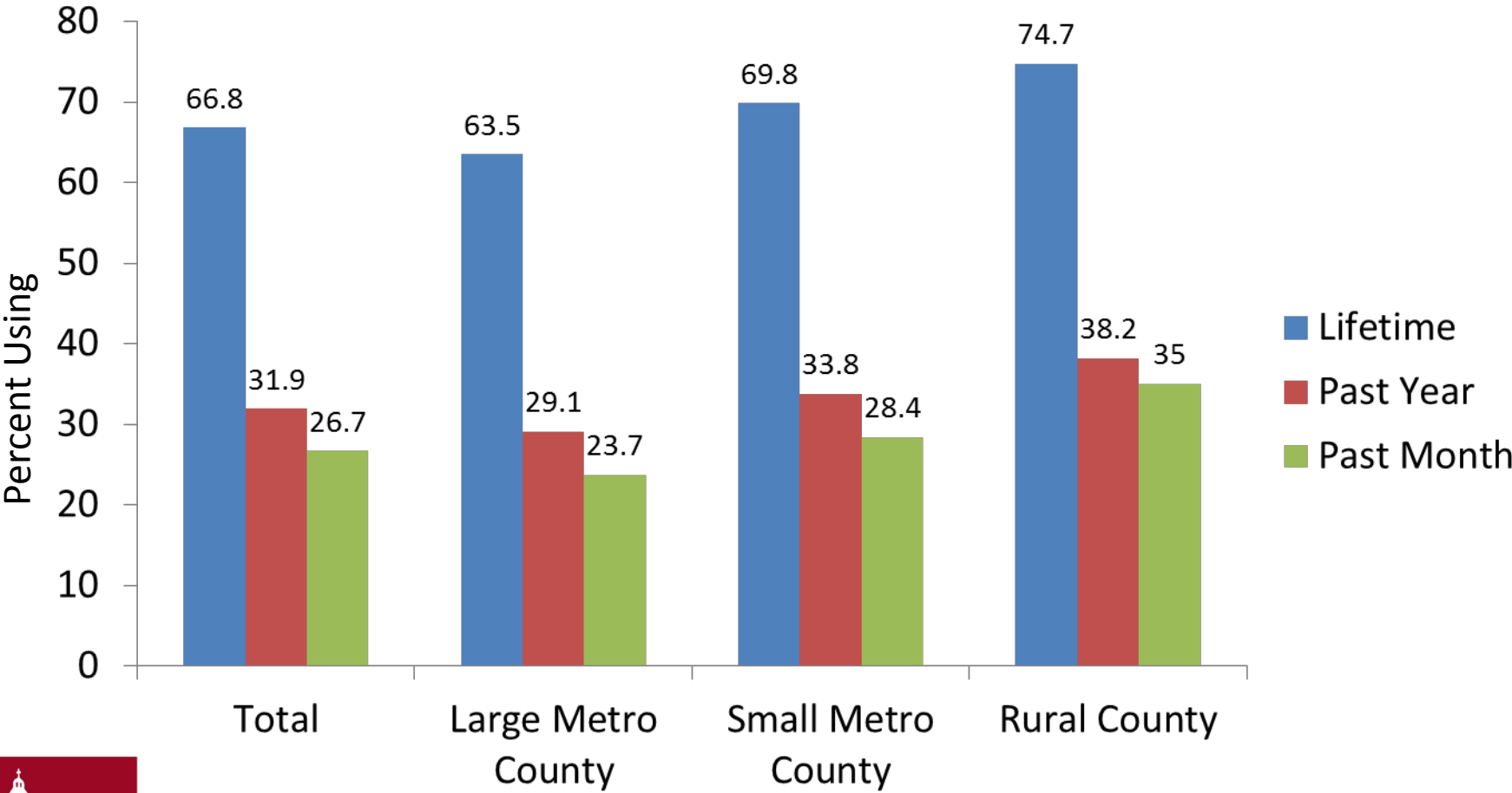
# Nicotine (cigarette) Dependence in the Past Month among Persons 12 or older: Race/Ethnicity, 2013



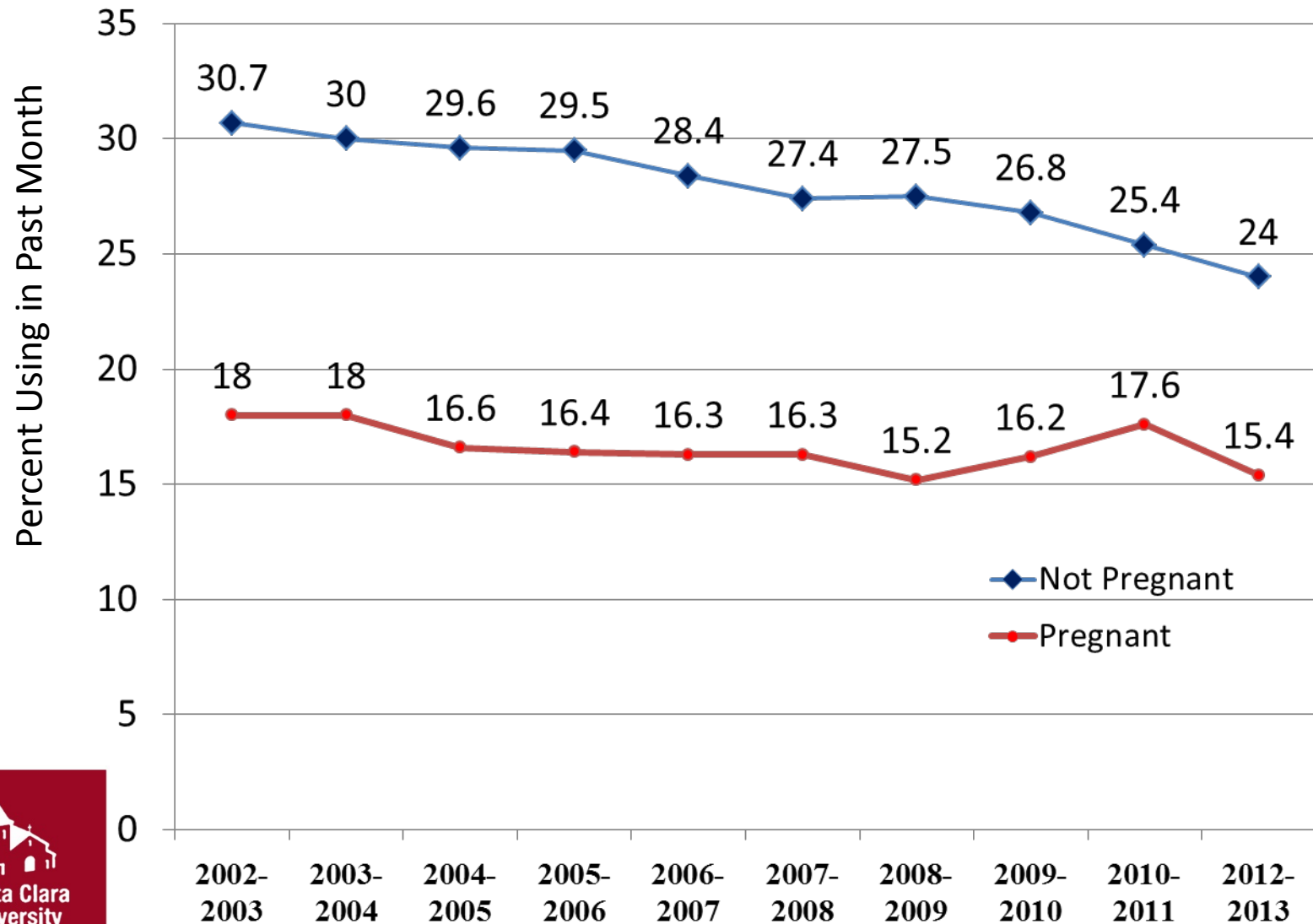
# Past Month Tobacco Use among Females Aged 12 or Older: 2002-2013



# Tobacco Product Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older, by Geographic Characteristics: Percentages, 2012



# Past Month Cigarette Use among Women Aged 15 to 44, by Pregnancy Status: Combined Years 2002-2003 to 2012-2013

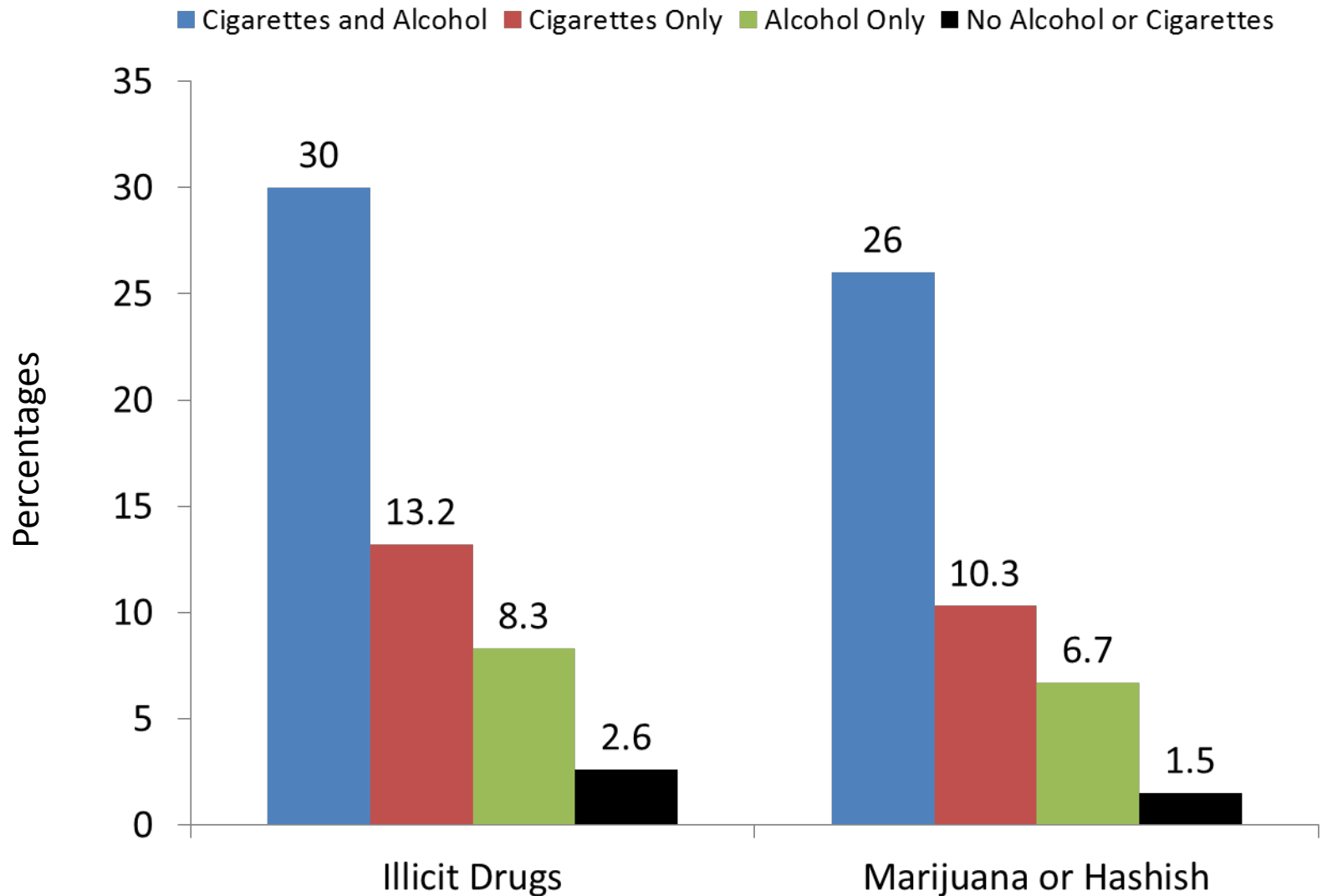


# Alcohol and Cigarettes

Alcohol Use Persons 12+ years	Current Cigarette Smokers	Current Non-Cigarette Smokers
Past Month Alcohol Use	65.2	48.7
Binge Alcohol Use	42.9	17.5
Heavy Alcohol Use	15.7	3.8

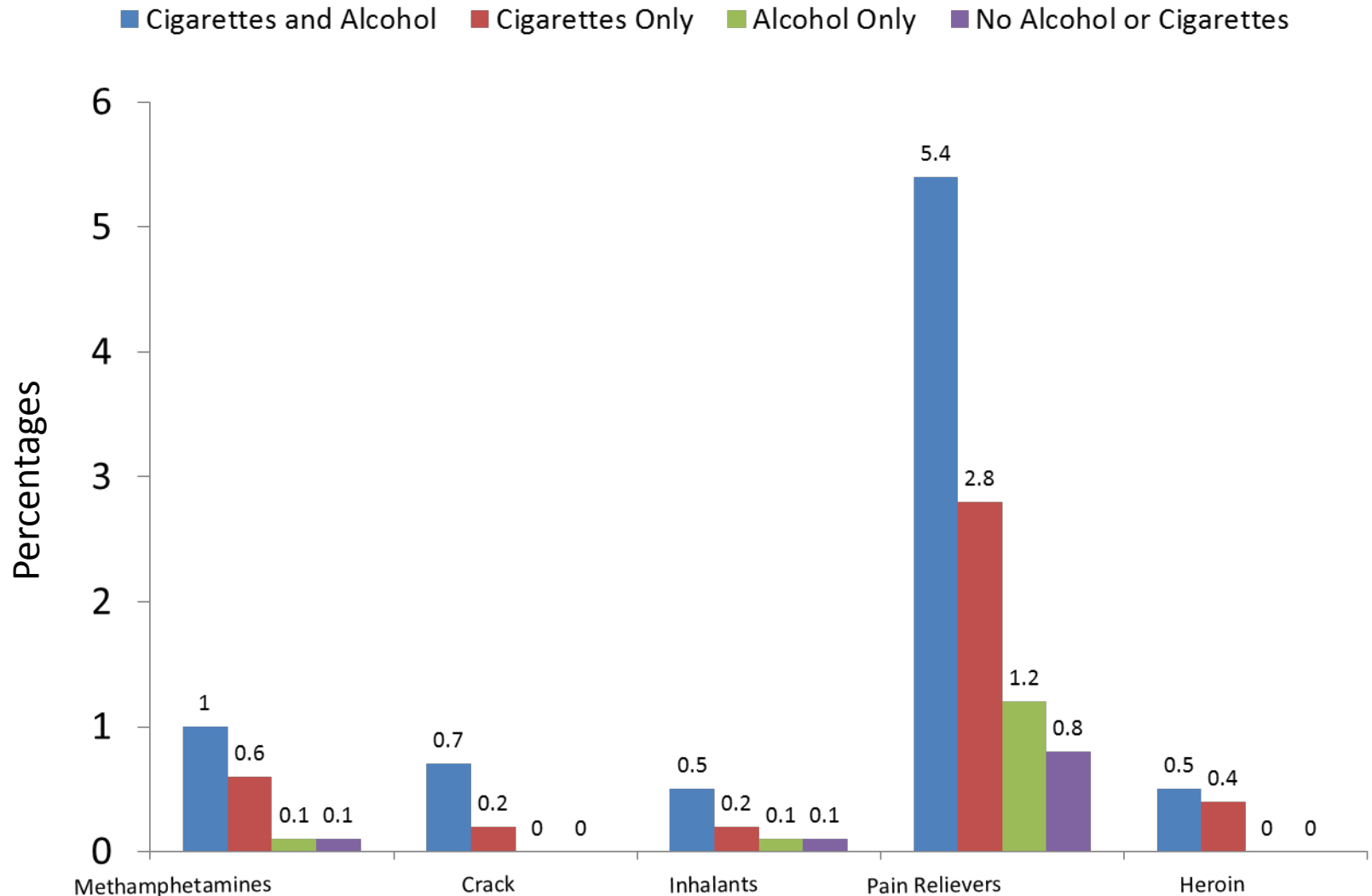


# Illicit Drug and Marijuana Use in the Past Month among Persons Aged 12 or Older, by Past Month Cigarette and Alcohol Use: Percentages, 2013



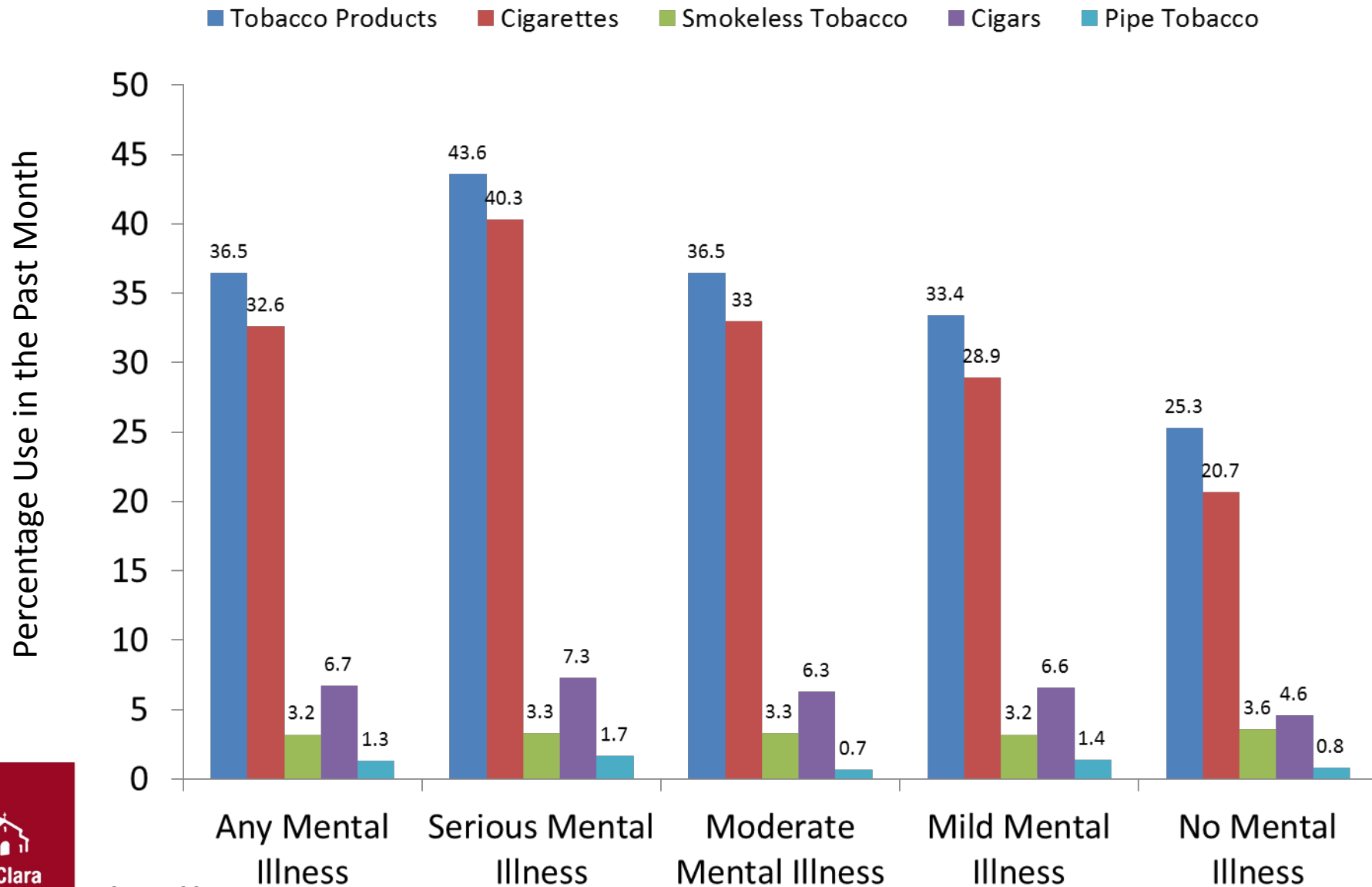
NSDUH, 2014

# Type of Illicit Drug Use in the Past Month among Persons Aged 12 or Older, by Past Month Cigarette and Alcohol Use: Percentages, 2013



NSDUH, 2014

# Tobacco Product Use in the Past Month among Persons Aged 18 or Older, by Past Year Level of Mental Illness: Percentages, 2013

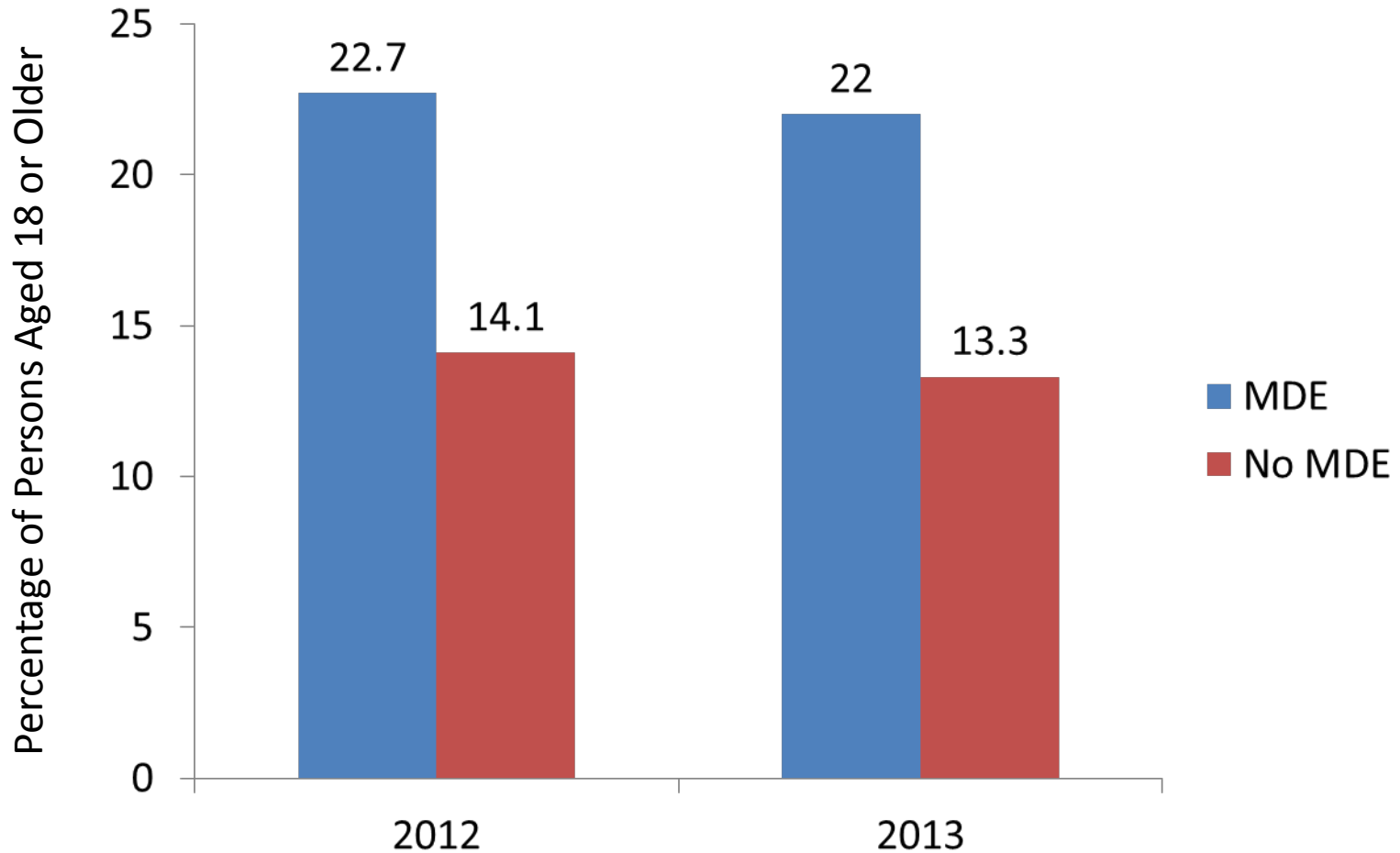


NSDUH, 2014



Santa Clara University

# Percentage of Past Month Daily Cigarette Use among Persons Aged 18 or Older by Major Depressive Episode (MDE), 2013



# Smoking and Attention-deficit Hyperactivity Disorder (ADHD)

Compared to the general population or nondiagnosed controls, individuals diagnosed with attention-deficit hyperactivity disorder (ADHD) are more than twice as likely to smoke; initiate smoking at an earlier age and progress to regular); and have more difficulty quitting .

Even after accounting for psychiatric comorbidity, ADHD is an independent risk factor for smoking. Further, subclinical ADHD symptoms confer an increased risk for lifetime smoking.

# Smoking During Adolescence as a Risk Factor for Attention Problems

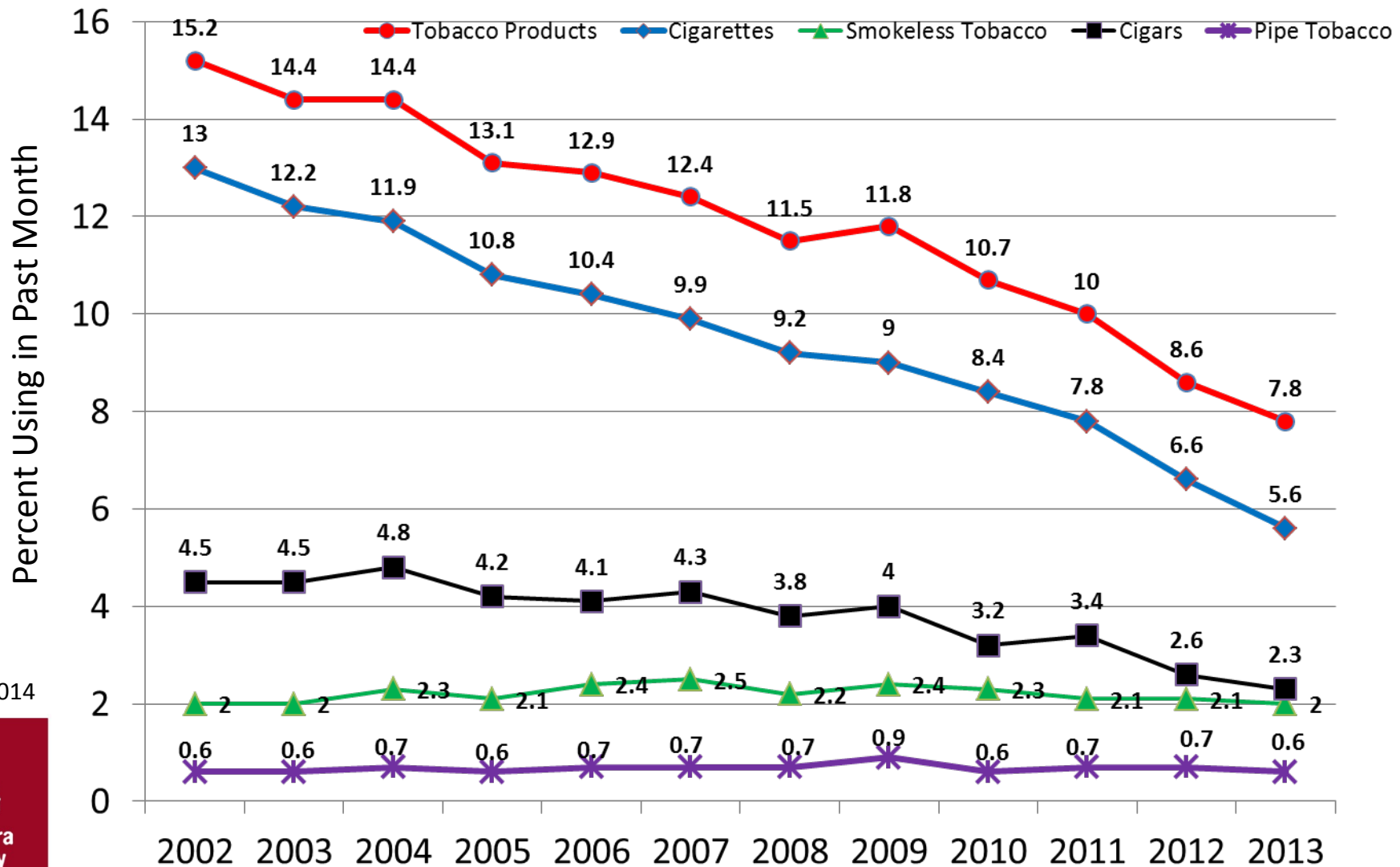
“Adult twins who ever smoked reported significantly more attention problems than their never-smoking co-twin. Longitudinal analyses showed a larger increase in attention problems from adolescence to adulthood in smoking twins than their never-smoking co-twin ( $p < .05$ ).

In childhood and adolescence, smoking twins had more attention problems than their never-smoking co-twin, whereas scores were similar before smoking was initiated or after both twins started smoking (not significant in all groups).

Results from this genetically informative study suggest smoking during adolescence leads to higher attention problem scores, lasting into adulthood.”

Jorien L. Treur et al, Biological Psychiatry, 2014

# Past Month Tobacco Use among Adolescents, Aged 12 to 17: 2002-2013

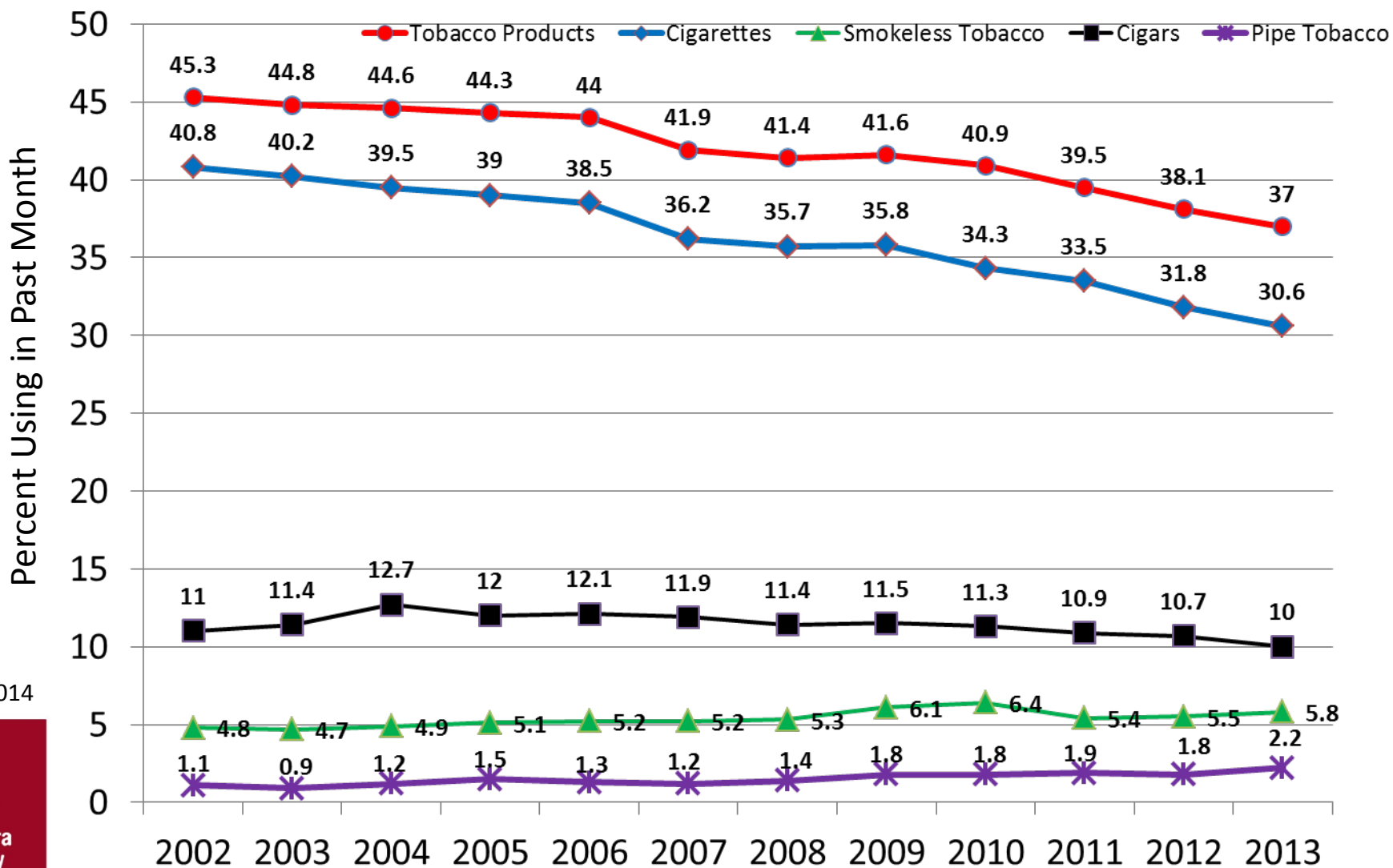


NSDUH, 2014



Santa Clara University

# Past Month Tobacco Use among Young Adults, Aged 18 to 25: 2002-2013

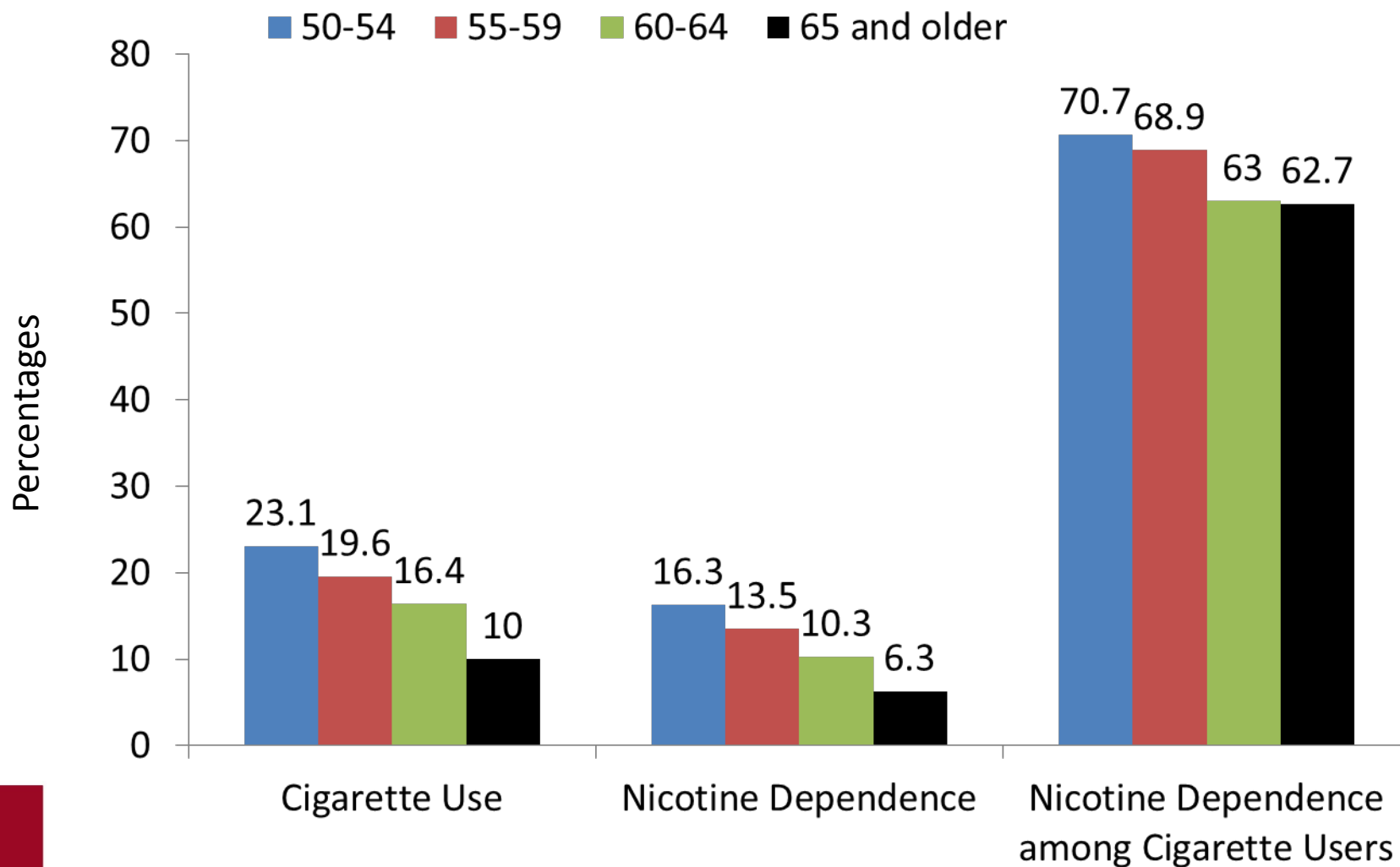


NSDUH, 2014





# Cigarette Use and Nicotine (Cigarette) Dependence in the Past Month among Persons Aged 50 and Older by Age Category, Percentages, 2013



NSDUH, 2014

# Trauma, PTSD, and Smoking

Trauma exposure and posttraumatic stress disorder (PTSD) are risk factors for tobacco addiction. In the U.S., 45% of individuals with PTSD smoke and there is a two- to five-fold increased risk of PTSD or nicotine dependence given the occurrence of the other.

Individuals with PTSD smoke more heavily, experience more severe withdrawal symptoms, and have lower quit rates than those without PTSD

Multiple mechanisms likely contribute to PTSD-smoking comorbidity, including overlapping neurobiological systems involved in stress response, PTSD, and drug reward and shared genetic liability). Further, individuals with PTSD may attempt to self-medicate PTSD symptoms (e.g., hyperarousal, re-experiencing)) or reduce negative affect by smoking.

Smoking among individuals with PTSD contributes to their poorer physical health and greater healthcare costs .

K.C. Young-Wolff et al. / Addictive Behaviors 39 (2014) 1231–1234

# Smoking Cessation Treatment, PTSD care and Veterans

When smoking cessation treatment was delivered as part of PTSD care for veterans, they engaged more with treatment (i.e., attended more sessions, used cessation medications) and had two to five-fold greater smoking abstinence as compared to clients referred to the VA outpatient quit smoking clinics.

K.C. Young-Wolff et al. / Addictive Behaviors 39 (2014) 1231–1234

# PTSD symptomatology and readiness to quit smoking among women with serious mental illness

In a diverse sample of 376 women smokers with serious mental illness recruited from acute psychiatric units, Young-Wolff et al found that PTSD symptoms were common (43%) and associated with worse substance use and mental health problems.

However, they also found a greater readiness to quit smoking, based on Prochaska's stages of change model. They subsequently argue for intervention practices that concurrently address trauma recovery and tobacco cessation.

# Smoking Prevalence: LGBT Populations

When controlling for age, race, education, income, and geographic region, Fallin et al found that being a bisexual woman versus heterosexual woman was significantly associated with younger age at first cigarette, smoking intensity, decreased past quit attempts and increased nicotine dependence. Bisexual women were approximately 1.4 years younger when they smoked their first cigarette. Bisexual women smoked 6.7 cigarettes more per day than heterosexual women, and lesbians had 2.3 times increased odds of being nicotine dependent when compared to heterosexual women. They also found that sexual minority males had a higher prevalence of smoking than their heterosexual counterparts.

Amanda Fallin et al, Preventive Medicine (2014)

# Suicidal Behavior and Smoking

Smoking is a well-established correlate of suicidal behavior in adolescents and young adults. Compared with never-smokers, both former and current smokers are more likely to report suicidal ideation. The severity of smoking is associated with suicidal behavior. Regular smoking is associated with a greater risk of suicide attempt than smoking experimentation and the association is still stronger in current smokers than in ever-smokers

Kessler et al. (2009) suggest that only nicotine dependence and not less severe smoking phenotypes remains significantly associated with suicide plans after adjusting for potential confounders.

Heaviness of smoking is associated with suicide with evidence of a dose–response relationship between cigarettes smoked per day and risk for suicide attempt and completed

Jeffrey F. Scherrer et al, *Nicotine & Tobacco Research*, Vol 14(4): 415-424, (2012)

# Smoking Prevalence among Adults by Lifetime Mental Illnesses Compared to General Population

<b>Schizophrenia</b>	<b>59.1%</b>
<b>Bipolar Disorder</b>	<b>46.4%</b>
<b>Serious Psychological Distress</b>	<b>38.1%</b>
<b>Attention Deficit Disorder</b>	<b>37.2%</b>
<b>Dementia</b>	<b>35.4%</b>
<b>Phobias or Fears</b>	<b>34.3%</b>
<b>General Population</b>	<b>20.6%</b>

Source: McClave et al: Smoking characteristics of adults with selected lifetime mental illnesses: results from the 2007 National Health Interview Survey. *American Journal of Public Health*. 2010; 100:12.

# Smoking Prevalence among Individuals with Substance Use Disorders

Individuals attending substance abuse treatment 77%\*

Opioid-dependent individuals 92%\*\*

An estimated 44% of cigarettes sold in the U.S. are sold to smokers with mental illness or substance use disorders.\*\*\*

Sources: \*Kelly et al: Drug and Alcohol Review. 2012;31;638-644.

\*\*Brooner et al: Arch Gen Psychiatry. 1997;54:71-80.

\*\*Strain EC: Clin J Pain. 2002;18:514-527.

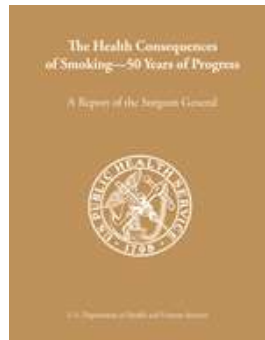
\*\*\* Lasser et al, JAMA. 2000;284(20):2606-2610.



# The Federal Government Efforts to Reduce Tobacco Use

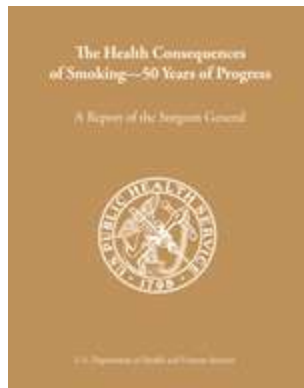
Over the last 50 years, the federal government has:

- Documented the lethal and addictive nature of tobacco products
- Supported state and community tobacco control efforts
- Required cigarette and smokeless tobacco products to carry warning labels
- Banned certain tobacco advertisements from television and radio
- Banned smoking from air travel
- Worked to educate the public about the lethal nature of secondhand smoke
- Supported education and research initiatives to prevent tobacco use and facilitate quitting

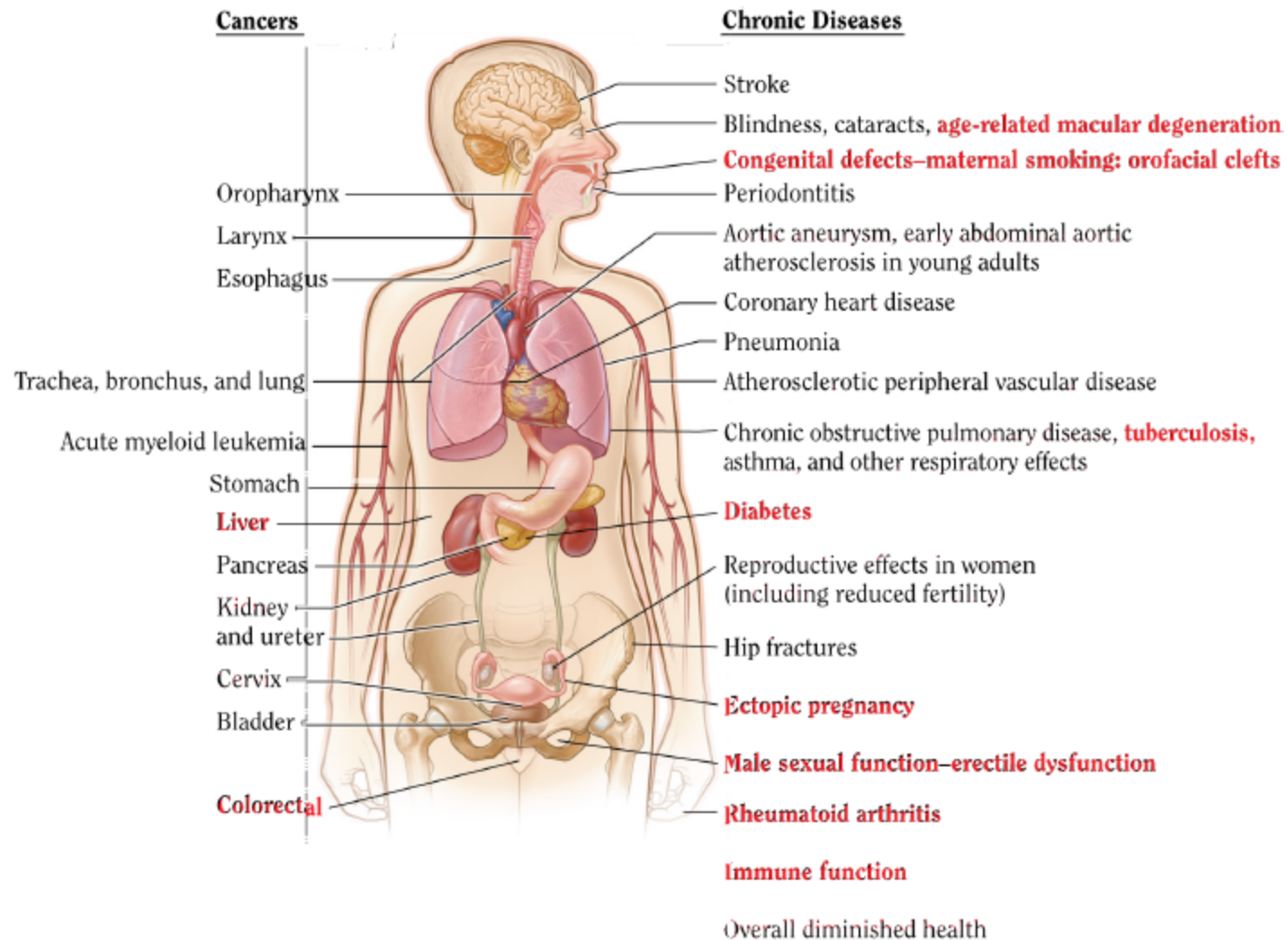


# Physical Health Consequences of Smoking

Figure 1.1A The health consequences causally linked to smoking



Chapter 1, Page 4



Source: USDHHS 2004, 2006, 2012.

Note: The condition in red is a new disease that has been causally linked to smoking in this report.

# Screening for and Assessing Readiness to Quit Among Priority Populations

- Up to 20% of patients presenting to the offices of primary care clinics report problems related to tobacco or other substance use. These problems are closely associated with serious medical problems.
- One promising approach is screening and brief intervention (SBI), and where appropriate referral to a specialty addiction treatment program (SBIRT)
- Brief Intervention (BI) is a time-limited, client centered counseling session designed to reduce substance use. Average duration is 5 to 20 minutes. BI does not seem to be linked to a patient's "readiness to change" and can work in precontemplation, as well as persons who are ready to change.

# Screening for and Assessing Readiness to Quit Among Priority Populations

*The U.S. Preventive Services Task Force (USPSTF)* recommends routine SBI to reduce alcohol “misuse” by adults, including pregnant women in primary care settings (Grade B), and strongly recommends that clinicians screen all adults, including pregnant women, for tobacco use and provide tobacco cessation interventions for tobacco users (Grade A). The USPSTF concludes though the evidence is insufficient to recommend for or against routine SBI to prevent or reduce alcohol misuse or tobacco use among children and adolescents. The USPSTF has found insufficient evidence to recommend universal SBI for illicit drug use.

*Most professional medical organizations*, including the American Medical Association (AMA), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Surgeons (ACS), have adopted policies calling on their members to be knowledgeable, trained, and involved in all phases of prevention and SBI for alcohol, tobacco, and other drug problems

# Clinical Approach to the SBI Services in Primary Care Settings

- The NIDA guide provides guidelines for the SBI delivery for alcohol, tobacco, and drugs in the general medical settings. The NIDA recommendations are consistent with the clinical guidelines for alcohol and tobacco SBI, as well as the Medicare and other insurance companies' requirements for SBI coding and billing .
- Existing guidelines recommend the Five A's (Ask, Advise, Assess, Assist, Arrange) approach for the SBI services:

# Clinical Approach to the SBI Services in Primary Care Settings

- *Ask* refers to *screening and assessment* of the risk level: “Screen, then intervene.” *Intervention* may then include all remaining “A’s” and is tailored to the screening results and determined risk level.
- *Advise* indicates for a direct personal advice about substance use. The goal of the clinician’s advice is for the patients to hear clearly that a change in their behavior is recommended as based on medical concerns (review results with the patient), and to learn about their personal substance use and its effects on health (provide advice). Presentation of the facts in an objective way, using strong and personalized language, by a knowledgeable and trusted professional, has been shown to facilitate change.

# Clinical Approach to the SBI Services in Primary Care Settings



Assess refers to evaluating the patient's willingness ("readiness") to change the unhealthy behavior (reduction of use or quitting), after hearing the clinician's advice. If the patient is not willing to change his or her substance use, the clinician should restate the substance use–related health concerns, reaffirm a willingness to help when the patient is ready, and encourage the patient to reflect about perceived "benefits" of continued use versus decreasing or stopping use and barriers to change.

# Clinical Approach to the SBI Services in Primary Care Settings

- *Assist* involves helping the agreeable patient develop the treatment plan following the patient's personal goals. Using behavior change techniques (e.g., motivational interviewing [MI]), the clinician should aid the patient in achieving agreed-upon goals and acquiring the appropriate skills, confidence, and social/environmental support. It is helpful if the plan describes in concrete terms the specific steps the patient elects to take to reduce/quit drinking, for example, the maximum number of cigarettes per day or week and how to prevent and manage high-risk situations or establish a support network. Starting with "small steps" while working toward a larger goal (abstinence or safe use) may be most reasonable and achievable for many patients.
- *Arrange* refers to the consideration of a follow-up visit and specialty referrals. A follow-up appointment should be *arranged* for all patients who screened positive to provide ongoing assistance and adjust the treatment plan as needed. Optimally, all patients should also receive educational materials to take home.



# Single Question Screen

"Ask" Single-Question Initial Screen for Substance Abuse (NIDA Quick Screen)		
In the past year, how often have you used the following:	Never 	Other Responses <sup>a</sup> (+ Initial Screen)  Proceed to Step 2 (Detailed Assessment)
Alcohol (heavy drinking <sup>b</sup> )		"Yes": Proceed with the NIAAA Clinician's Guide recommended assessment
Tobacco products (any use)		"Yes": Proceed with the "Helping a Smoker Quit" recommendations
Prescription drugs for nonmedical reasons (any use)		"Yes": Proceed with the NIDA-recommended assessment (NIDA-Modified ASSIST survey)
Illegal drugs (any use)		
Only "never" responses: negative screen. Praise and reinforce. SBI is completed.		

<sup>a</sup>Possible responses: "once or twice," "monthly," "weekly," or "daily or almost daily."

<sup>b</sup>Heavy drinking: five or more (for men) or four or more (for women) drinks in a day

# Positive Quick Screen for Alcohol or Tobacco

- Positive Quick Screen warrants a more detailed evaluation though. In case of alcohol (“yes” to heavy drinking) or tobacco (“yes” to any tobacco use), the NIDA guide recommends proceeding with alcohol or tobacco SBI and provides links to the appropriate Web sites. Because any tobacco use places a patient at risk, all tobacco users should receive strong, unambiguous advice to quit (*“Quitting tobacco is the most important thing you can do to protect your health”*) .

[http://www.drugabuse.gov/sites/default/files/resource\\_guide.pdf](http://www.drugabuse.gov/sites/default/files/resource_guide.pdf)

# Effective Prevention Policies

Policies proven to prevent young people from using tobacco:

- Make tobacco products less affordable.
- Restrict tobacco marketing.
- Ban smoking in public places (workplaces, schools, restaurants, hotels, parks, etc.)
- Require tobacco companies to label tobacco packages with large, graphic health warnings.

Source: Preventing Tobacco Use among Youth and Young Adults, a Report of the Surgeon General, CDC, July 2012.

# Effects of Increased Cigarette Prices

Increases in cigarette prices lead to significant reductions in cigarette smoking.

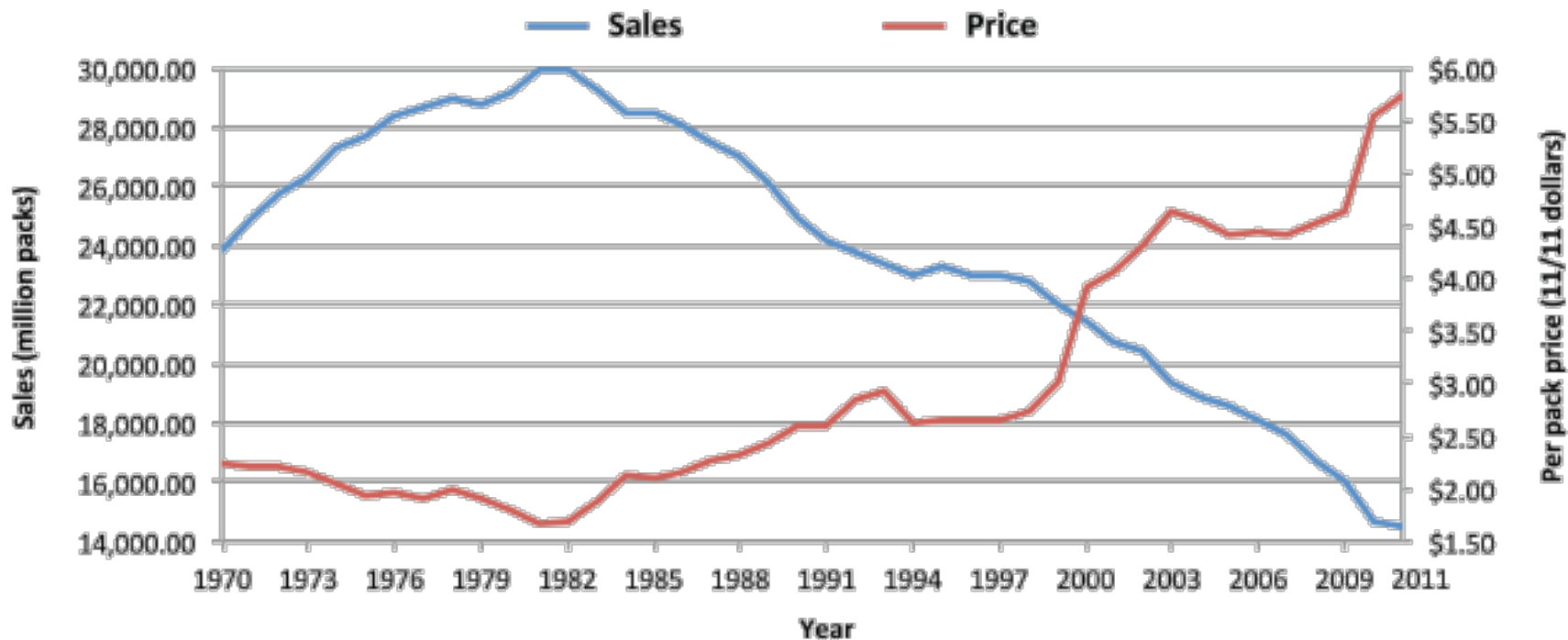
- A 10% increase in price has been estimated to reduce overall cigarette consumption by 3-5%
- Research on cigarette consumption suggests that both youth and young adults are two to three times more responsive to changes in price than adults.

Source: CDCP, Economic facts about U.S. tobacco production and use.

([http://www.cdc.gov/tobacco/data\\_statistics/fact\\_sheets/economics/econ\\_facts/index.htm](http://www.cdc.gov/tobacco/data_statistics/fact_sheets/economics/econ_facts/index.htm); accessed 01/10/15)

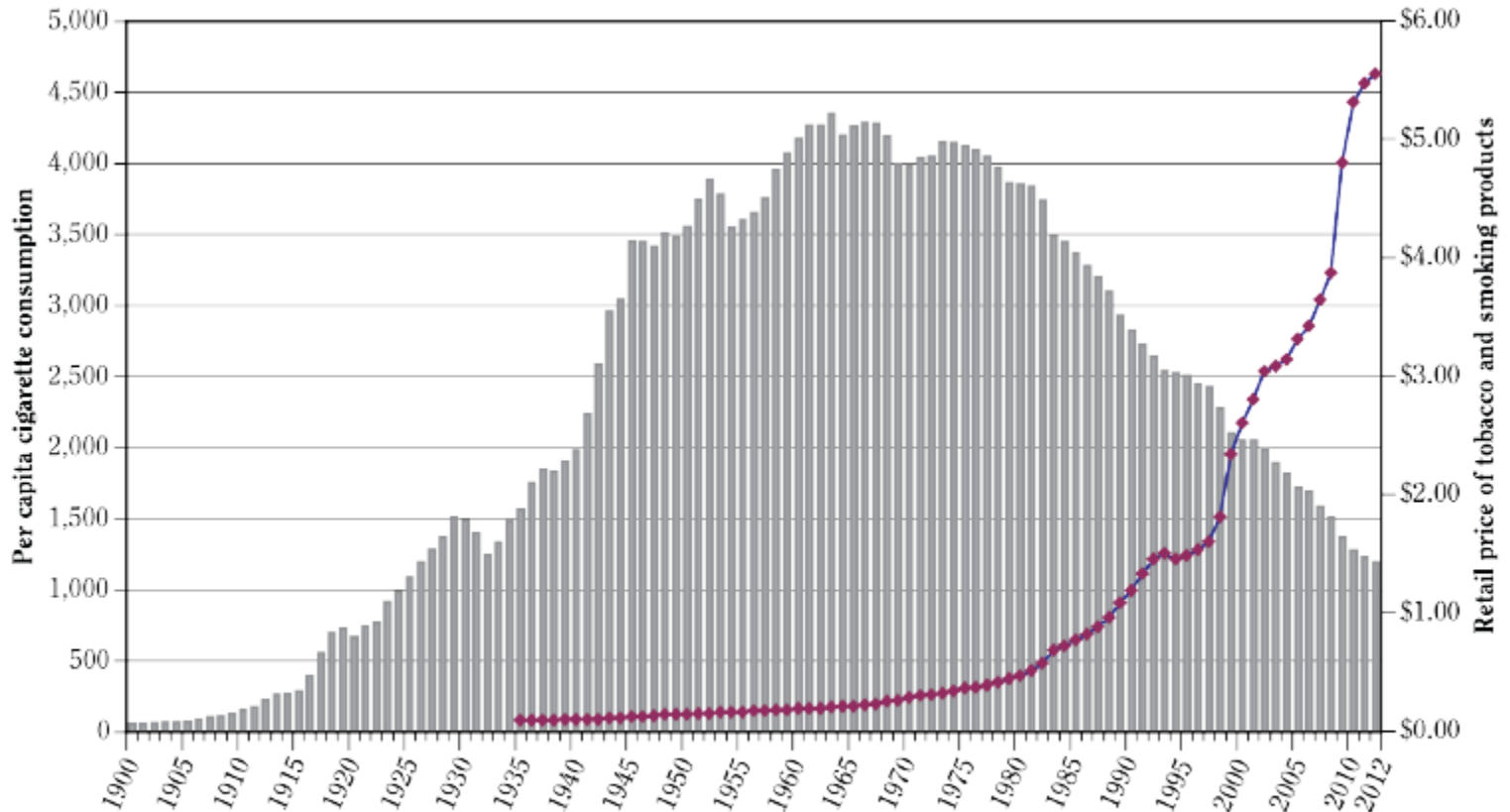
# Cigarette Prices and Cigarette Sales, 1970-2010

**Cigarette Prices and Cigarette Sales, United States, 1970-2010**  
**Cigarette Prices and Cigarette Sales, United States, 1970-2010**



U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Office on Smoking and Health, 2012. Data from Orzechowski and Walker 2011; author's calculations.

# Annual Retail Tobacco Price Index and Per Capita (18+) Cigarette Consumption- US, 1900-2012



Source: Orzechowski and Walker 2013; U.S. Bureau of Labor Statistics (BLS) 2013; U.S. Department of Agriculture 2013; U.S. Department of the Treasury 2013.

Note: U.S. Bureau of Labor Statistics (BLS) Tobacco and Smoking Product Index was converted to average retail price per pack using BLS Fiscal Year (July–June) 2011 Index (825.49) and Orzechowski and Walker (2013) average annual price for 2011 (\$5.55) values.

# 5 Federal Laws with Tobacco Control Requirements

- American Recovery and Reinvestment Act (2009)
- Children's Health Insurance Program Reauthorization Act (2009)
- Family Smoking Prevention and Tobacco Control Act (2009)
- Prevent All Cigarette Trafficking Act (2009)
- The Patient Protection and Affordable Care Act (2010)

# The American Recovery and Reinvestment Act (2009)

→ Invested \$200 million to support local, state, and national tobacco prevention and control efforts, thus mitigating decreases in state tobacco control budgets.



# Children's Health Insurance Program Reauthorization Act (2009)

- ➔ The Act included an unprecedented 62-cent increase in the federal excise tax on cigarettes to \$1.01 per pack.
  - Public Law 111-3, Title VII, § 701(2009)
- ➔ For every 10% increase in the price of tobacco products, consumption falls by approximately 4% overall, with a greater reduction among youth.

# Family Smoking Prevention and Tobacco Control Act (2009)

- This law granted the Food and Drug Administration the authority to comprehensively regulate thousands of tobacco products for the first time in history.
- It facilitated the creation of the Center for Tobacco Products to regulate the manufacture, distribution, and marketing of tobacco products to protect public health.

# Family Smoking Prevention and Tobacco Control Act (2009)

- This law requires cigarette packages to have larger and bolder health warnings, including graphic images.
- Mandates tobacco companies to disclose harmful constituents in their products.
- Prohibits false or misleading labeling and advertising for tobacco products.
- Requires the tobacco industry to submit an application to the CTP for new products.

# Tobacco Control Act (cont'd.)

- New health warning labels will convey the harms of tobacco.
- The new warning photographs on cigarette packs hold the promise of stimulating even further attempts by smokers to quit, if the recent legal ruling suppressing their use can be overturned.



# Prevent All Cigarette Trafficking Act (2009)

- The law reduces the illegal sale and transport of cigarettes and other tobacco products.
- It will reduce and prevent smoking by blocking access to underpriced and untaxed cigarettes and smokeless tobacco products.
- It will help curtail online and mail order sales to underage youth by requiring sellers to verify a customer's age prior to sale by checking databases.

# FDA Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco to Protect Children and Adolescents

Among other things, the rule:

- Prohibits the sale of cigarettes or smokeless tobacco to people younger than 18,
- Prohibits the sale of cigarette packages with less than 20 cigarettes,
- Prohibits distribution of free samples of cigarettes,
- Restricts distribution of free samples of smokeless tobacco, and
- Prohibits tobacco brand name sponsorship of any athletic, musical or other social or cultural events

<http://www.fda.gov/TobaccoProducts/ProtectingKidsfromTobacco/default.htm#>

# FDA Warning Letters

A Warning Letter is the agency's advisory action that is used to achieve prompt voluntary compliance with the law. FDA generally issues Warning Letters, displayed in a [searchable database](#), to tobacco retailers generally the first time violations are observed during a compliance check inspection.

[Find all other Warning Letters issued by CTP](#) at FDA's main Warning Letters page.

<http://www.fda.gov/TobaccoProducts/GuidanceComplianceRegulatoryInformation/ucm232109.htm>

# Examples of Retailers Receiving FDA Issued Warning Letters to Tobacco Retailers for Violations Observed During A Compliance Check Inspection

Date Stamp on Letter	Retailer Store Name	Retailer City	Retailer State
12/04/2014	Allsup's/Conoco	Shamrock	Texas
12/04/2014	Angelo's Party Store of Coloma	Coloma	Michigan
12/04/2014	Casey's General Store	Boonville	Indiana
12/04/2014	Cenex	Clinton	Missouri
12/04/2014	Chevron	Seattle	Washington
12/04/2014	Chevron	Medford	Oregon
12/04/2014	Citgo/Food Mart	Orange	Texas
12/04/2014	Coborn's Superstore	Mitchell	South Dakota
12/04/2014	Honey Plus Convenience Store	New London	Connecticut



# FDA Civil Money Penalty Complaints

A Civil Money Penalty (CMP) Complaint is used to initiate an administrative legal action against a retailer that can result in the imposition of a fine, called a Civil Money Penalty.

FDA generally issues Civil Money Penalty Complaints, displayed in a [searchable database](#), to tobacco retailers when subsequent violations are observed during a compliance check inspection.

Civil Money Penalty Complaints issued during the past 45 days can be downloaded below. Earlier Complaints can be found in the [searchable database](#).

# Examples of FDA Civil Money Penalty Complaints filed Against Retailers

Date Issued	Retailer	Civil Money Penalty Sought
11/03/2014	16 <sup>th</sup> Street Minute Mart	\$5,000
11/03/2014	Ramira Corporation	\$250
11/03/2014	Alvarez Auto Center	\$250
11/03/2014	Gill Petroleum	\$500
11/03/2014	Cascardo Oil	\$500
11/03/2014	Casey's Marketing	\$250
11/03/2014	Farmer's Union Oil	\$500
11/03/2014	Boeing Field Chevron	\$250
11/03/2014	Clauss Liquors	\$250
11/03/2014	9MM Liquor	\$250
11/03/2014	TJ Store	\$500
11/03/2014	HD Market and Deli	\$2,000

<http://www.fda.gov/TobaccoProducts/GuidanceComplianceRegulatoryInformation/ucm232109.htm>

# The Affordable Care Act (2010)

As part of its emphasis on prevention and health promotion, the law:

- Requires private insurance plans to cover tobacco cessation treatments, including medications that help people quit smoking
- Expands smoking cessation coverage for pregnant women who receive Medicaid
- Provides Medicare beneficiaries with an annual wellness visit that includes referrals for tobacco cessation services

# HHS Strategic Action Plan for Tobacco Control

*Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan for the U.S. Department of Health and Human Services, November 2010.*

“The Strategic Action Plan prescribes proven, practical, achievable actions that can be implemented at the federal, state, and community levels.”

# Four Tobacco-Related Objectives

*The Strategic Action Plan* charts a framework designed to achieve four tobacco-related objectives of *Healthy People 2020*:

- Reduce tobacco use by adults and adolescents
- Reduce the initiation of tobacco use among children, adolescents, and young adults
- Increase smoking cessation success by adult smokers
- Reduce the proportion of nonsmokers exposed to secondhand smoke

# Nicotine has no established role for helping people experiencing severe mental illness

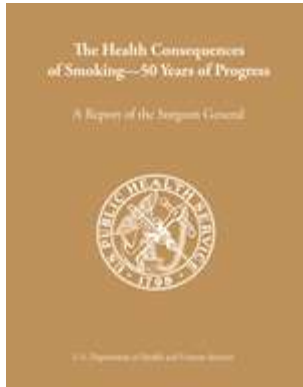
Tobacco industry documents indicate that the industry funded research for the specific purpose of perpetuating the belief that smoking improves symptoms in schizophrenic patients, advocated for exceptions for smoking in hospitalized psychiatric patients, and funded studies to medicinal uses of nicotine analogs to treat mental illness.

Chapter 5, page 124,

All tobacco products contain toxicants, so all tobacco product use poses some health risks. Because of the potential for fetal and adolescent nicotine exposure to have long-term detrimental effects on brain development, measures should be taken to ensure that nicotine is not perceived by the public as a cognitive-enhancing substance. It also does not have an established role in the management of people with a severe mental illness.

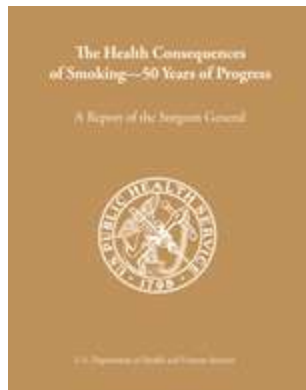
Chapter 5, page 126

The Health Consequences of Smoking-50 Years of Progress:  
A Report of the Surgeon General Report (2014)

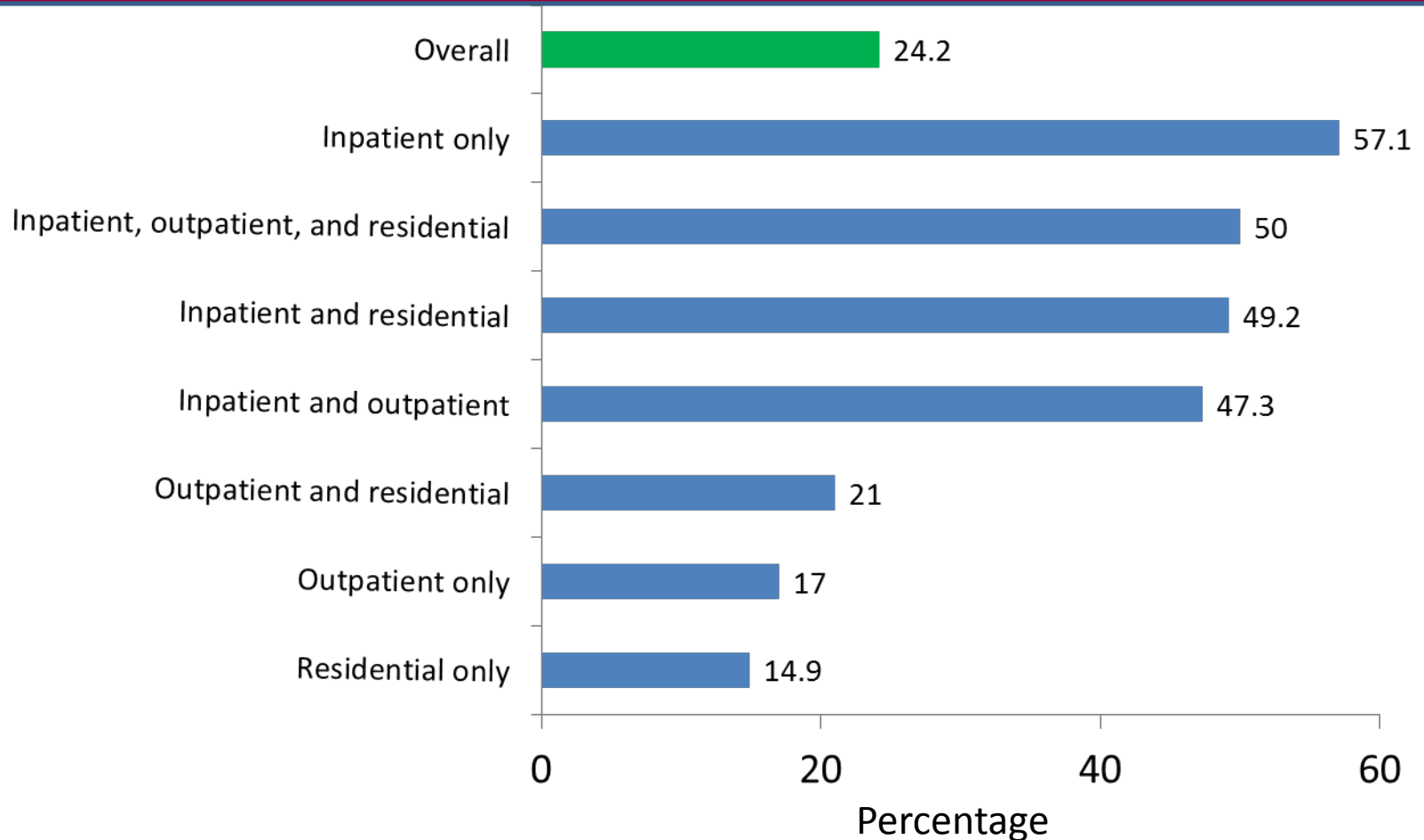


# Maternal Smoking and Neurobehavioral Disorders of Children: A Need for More Research

- The evidence is suggestive, but not sufficient, to infer a causal relationship between maternal prenatal smoking and disruptive disorder, and attention deficit hyperactivity disorder in particular, among children
- The evidence is insufficient to infer the presence or absence of a causal relationship between maternal prenatal smoking and the following conditions in children:
  - Anxiety and depression in children
  - Tourette syndrome
  - Schizophrenia
  - Intellectual Disability



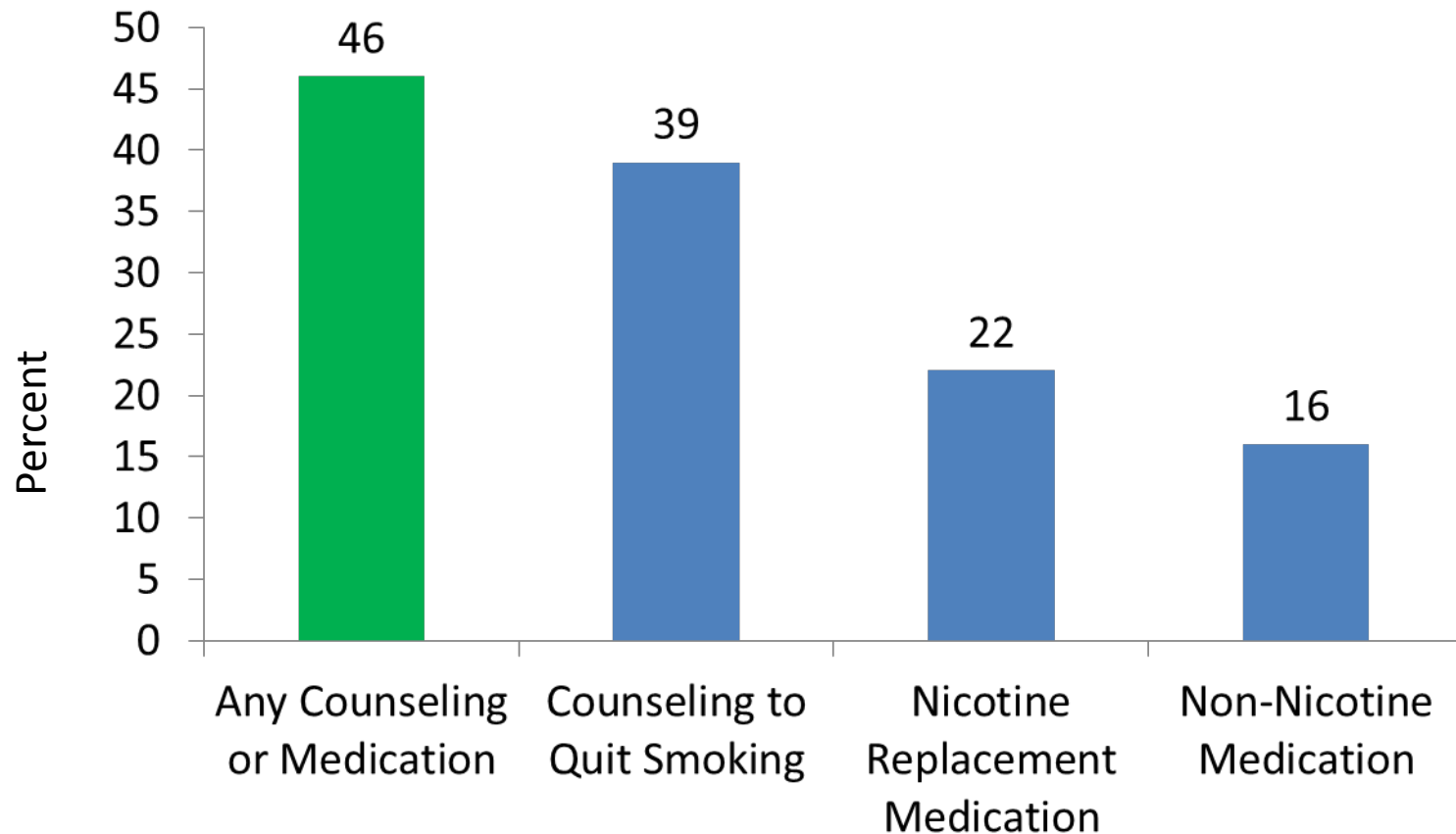
# Mental health treatment facilities offering services to quit smoking, by treatment setting: 2010



**NOTE.**—Inpatient settings include 24-hour psychiatric care in a hospital setting. Outpatient settings also include day treatment or partial hospitalization. Residential settings include 24-hour, overnight, psychiatric care in a residential nonhospital setting.



# Substance Abuse Treatment Facilities Offering Services to Quit Tobacco Use: 2012



Source: 2012 Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey of Substance Abuse Treatment Services (N-SSATS). N-SSATS is an annual survey of all substance abuse treatment facilities in the United States, both public and private, that are known to SAMHSA. N-SSATS is one component of the Behavioral Health Services Information System (BHSIS), an integrated data system maintained by the Center for Behavioral Health Statistics and Quality, SAMHSA. Information and data for this report are based on data reported to N-SSATS for the survey reference date March 30, 2012. For more information on N-SSATS, see [http://www.samhsa.gov/data/DASIS/NSSATS2012\\_Web.pdf](http://www.samhsa.gov/data/DASIS/NSSATS2012_Web.pdf).

# Summary of Barriers to Providing Smoking Cessation in Substance Abuse Treatment Settings

Source	Resource Limitations		Beliefs		Other Factors
	Lack of staff knowledge or training	Lack of staff time	Perceived risk to sobriety	Other addiction is more important	Staff are smokers
<b>Staff Surveys</b>					
Bobo & Gilchrist (1983)					✓
Bobo et al. (1995)	✓				✓
Hahn et al. (1999)	✓			✓	✓
Gill & Bennett (2000)	✓		✓		✓
Olsen et al. (2005)		✓	✓		
Fuller et al. (2007)					
<b>Director Surveys</b>					
Knapp et al. (1993)	✓		✓		
Willenbring et al. (2004)	✓	✓			
McCool et al. (2005)	✓			✓	
Richter (2006)			✓	✓	
<b>Director &amp; Staff Surveys</b>					
Walsh et al. (2005b)	✓	✓	✓		✓

Source: Guydish, J., Passalacqua, E., Tajima, B., & Turcotte Manser, S. (2007). Staff smoking and other barriers to nicotine dependence intervention in addiction treatment settings: A review. *Journal of Psychoactive Drugs*, 39(4), 423-433.

# Priority Populations and Smoking Cessation Therapy

- A Repeated Theme in the literature is that individuals within Priority Populations who smoke are often motivated to quit smoking but under utilize empirically validated cessation treatment options
- Reluctance to Quit Smoking varies by health status and levels of distress but offers unique opportunities for professionals to engage members of priority populations in active treatment or to employ motivational methods to help facilitate entry into smoking cessation treatment
- Increasing the availability of telehealth , mobile, and computer assisted interventions may also be of great importance to those priority populations without access to appropriate care; such strategies allow for increasing access to geographically restricted clients



# SAMHSA Tobacco Initiatives

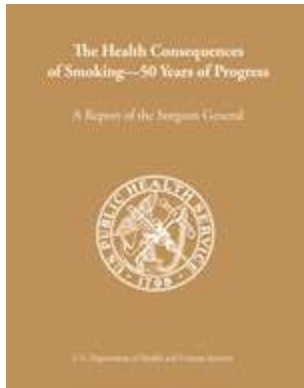
- Primary and Behavioral Health Care Integration (PBHCI) Grant Program
  - (95%) of Grantees offer Smoking Cessation Services
- Smoking Cessation for Persons with Mental Illnesses: A Toolkit for Mental Health Providers
  - [http://www.integration.samhsa.gov/Smoking Cessation for Persons with MI.pdf](http://www.integration.samhsa.gov/Smoking_Cessation_for_Persons_with_MI.pdf)
- DHHS's Million Hearts Campaign, a national initiative to prevent 1 million heart attacks and strokes by 2017
  - Includes Smoking Assessment and Treatment as a Clinical Quality Measure
  - <http://millionhearts.hhs.gov/aboutmh/achieving-goals.html>
- Supervisor Guide: Peer Support Whole Health and Wellness
  - Includes focus on smoking cessation
  - [http://www.integration.samhsa.gov/Supervisor Guide to Peer Support Whole Health and Wellness -c- 2013.pdf](http://www.integration.samhsa.gov/Supervisor_Guide_to_Peer_Support_Whole_Health_and_Wellness_-c-_2013.pdf)
- SAMHSA's National Registry of Evidence-Based Programs and Practices
  - Includes 8 interventions that can be used for smoking cessation
  - <http://nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=smoking%20cessation>

# Barriers to Progress

- The tobacco industry continues to aggressively promote tobacco use and fuel addiction among consumers.
- Cigarette manufacturers spend \$9.94 billion each year, or \$27million each day, on advertising and promotions to attract new youthful users, retain current users, increase consumption, and generate favorable attitudes toward tobacco use.

# Looking to the future

- Tobacco control needs to be shaped to address an increasingly heterogeneous pattern of use of tobacco products.
- Some of the highest prevalence rates are among persons of lower socioeconomic status, some racial and ethnic minority groups, sexual minorities (including individuals who are gay, lesbian, bisexual and transgender, and individuals with same-sex relationships and/or attraction), high school dropouts, persons with mental illness and alcohol and substance abuse disorders, American Indians and Alaska Natives, as well as recent immigrants from high-prevalence countries and people with complex comorbid medical illnesses (e.g., HIV/AIDS and cardiovascular disease).
- There is also substantial geographic variation with the highest prevalence rate in Appalachia and the South.



# THANK YOU!!!

- Cigarette and other tobacco product use are a major problem for health priority populations and for others.
- Numerous medical and psychological problems are associated with cigarette smoking
- Behavioral health and primary health providers are in a unique position to screen for tobacco product use and offer appropriate behavioral or medication assisted therapy (such as nicotine replacement therapy)
- Serious prevention strategies are needed to work in concert with screening and treatment.

# Questions and Answers



- Submit questions via the **chat box**



# Contact SCLC for technical assistance



**FREE CME/CEUs of up to 1.0 credits are available to all attendees of this live session. Instructions will be emailed after the webinar.**

- Stay tuned for our next webinar on **February 19, 2015 at 2pm ET**, “Big Marijuana: Lessons from Big Tobacco”

# Contact SCLC for technical assistance

## Visit us online

- <http://smokingcessationleadership.ucsf.edu>

## Call us toll-free

- 1-877-509-3786



# CME/CEU Statement

## **Accreditation:**

The University of California, San Francisco (UCSF) School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

UCSF designates this live activity for a maximum of *1.5 AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the webinar activity.

**Nurse Practitioners and Registered Nurses:** For the purpose of recertification, the American Nurses Credentialing Center accepts *AMA PRA Category 1 Credit™* issued by organizations accredited by the ACCME.

**Physician Assistants:** The National Commission on Certification of Physician Assistants (NCCPA) states that the *AMA PRA Category 1 Credits™* are acceptable for continuing medical education requirements for recertification.

**California Pharmacists:** The California Board of Pharmacy accepts as continuing professional education those courses that meet the standard of relevance to pharmacy practice and have been approved for *AMA PRA category 1 credit™*. If you are a pharmacist in another state, you should check with your state board for approval of this credit.

**Social Workers:** This course meets the qualifications for 1.5 hours of continuing education credit for MFTs and/or LCSWs as required by the California Board of Behavioral Sciences. If you are a social worker in another state, you should check with your state board for approval of this credit.