Smoking Cessation Leadership Center

UCSF

University of California San Francisco

Enhancing Recovery by Addressing Smoking During Addiction Treatment, co-hosted by the American Society of Addiction Medicine

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, UCLA

October 19, 2021

October 18-24, 2021

National Addiction Treatment Week

National Addiction Treatment Week highlights the critical gap between the number of patients who need addiction treatment and qualified medical professionals available to treat patients using evidence-based approaches.

This year, we are inspiring the next generation of the medical professionals, including medical students, residents, and fellows, to learn about and treat addiction.

#treatmentweek

Our patient's **tobacco smoking and vaping** during addiction treatment is **too frequently overlooked. Treating tobacco product addiction** during addiction treatment **enhances our patient's recovery.**

Dr. BrianHurley
President-Elect
American Society of Addiction Medicine
Medical Director
LA County Department of Public Health's Substance Abuse Prevention and Control

National Addiction Treatment Week

- Addiction is a chronic disease, treatments are available, and recovery is possible.
- Sharing evidence-based approaches to addressing smoking during addiction treatment supports the medical community's efforts to provide critical care to patients with addiction.
- Encourage medical professionals to treat addiction. Use #treatmentweek to share your story about why treating addiction is important. Follow us on @TreatmentWeek!

Moderator

Catherine Saucedo

Deputy Director

Smoking Cessation Leadership Center
University of California, San Francisco

A National Center of Excellence for Tobacco-Free Recovery

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Disclosures

This UCSF CME activity was planned and developed to uphold academic standards to ensure balance, independence, objectivity, and scientific rigor; adhere to requirements to protect health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and include a mechanism to inform learners when unapproved or unlabeled uses of therapeutic products or agents are discussed or referenced.

All speakers, planning committee members and reviewers have disclosed they have no relevant financial relationships to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Anita Browning, Christine Cheng, Brian Clark, Brian Hurley, MD, MBA, DFASAM, Jennifer Matekuare, Ma Krisanta Pamatmat, MPH, Jessica Safier, MA, Catherine Saucedo, Steven A. Schroeder, MD, and Aria Yow, MA.

Thank you to our funders

truth initiative
INSPIRING TOBACCO-FREE LIVES

Robert Wood Johnson Foundation

California Department of PublicHealth

American Cancer Society®

SAMHSA
Substance Abuse and Mental Health Services Administration

National Behavioral Health Network
For Tobacco & Cancer Control

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- Please **make sure your computer speakers are on** and adjust the volume accordingly.
- If you do not have speakers, please click on the link, **'Listen by Phone'** listed on the left side of your screen, for the dial-in number.
- **This webinar is being recorded** and will be available on SCLC's website, along with a PDF of the slide presentation.
- Use the **'ASK A QUESTION' box** to send questions at any time to the presenter.

CME/CEU Statements

Accreditations:
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 *1.0 AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the webinar activity.

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California Behavioral Science Professionals: University of California, San Francisco School of Medicine (UCSF) is approved by the California Association of Marriage and Family Therapists to sponsor continuing education for behavioral health providers. UCSF maintains responsibility for this program/course and its content.

Course meets the qualifications for 1.0 hour of continuing education credit for **LMFTs, LCSWs, LPCCs, and/or LEPs** as required by the California Board of Behavioral Sciences. Provider # 64239.

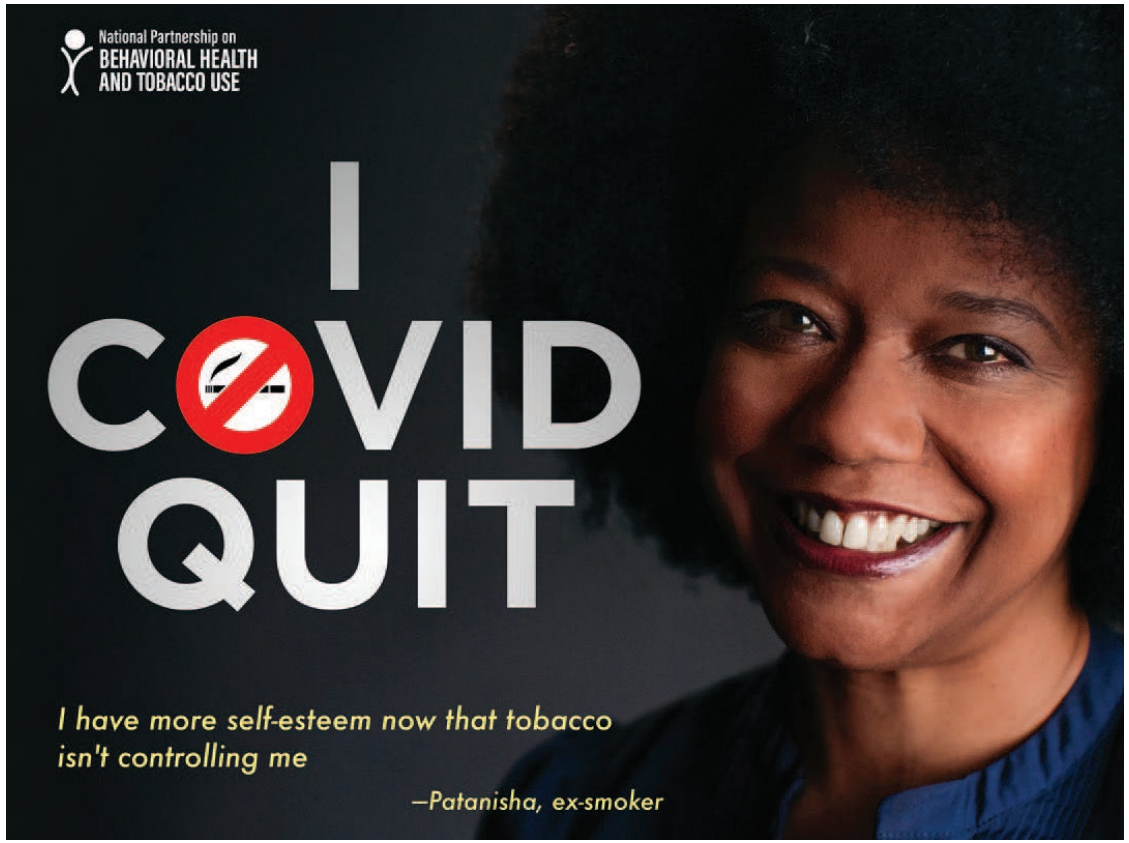
Respiratory Therapists: This program has been approved for a maximum of 1.0 contact hour Continuing Respiratory Care Education (CRCE) credit by the American Association for Respiratory Care, 9425 N. MacArthur Blvd. Suite 100 Irving TX 75063, Course # 186091000.

California Addiction Counselors: The UCSF Office of Continuing Medical Education is accredited by the **California Consortium of Addiction Professional and Programs (CCAPP)** to provide continuing education credit for California Addiction Counselors. UCSF designates this live, virtual activity, for a maximum of 1.0 CCAPP credit. Addiction counselors should claim only the credit commensurate with the extent of their participation in the activity. Provider number: 7-20-322-0722.

- **Free CME/CEUs** will be available for all eligible California providers, who joined this live activity thanks to the support of the California Tobacco Control Program (CTCP)
- For our California residents, SCLC offers regional trainings, online education opportunities, and technical assistance for behavioral health agencies, providers, and the clients they serve throughout the state of California.
- For technical assistance please contact (877) 509-3786 or Jessica.Safier@ucsf.edu.
- Visit CABHWI.ucsf.edu for more information

I COVID QUIT!

- Launched March 31



- SCLC's own campaign funded by Robert Wood Johnson Foundation
- Real people sharing their UNSCRIPTED experiences of improved mental health after quitting smoking—and they did it during the COVID-19 pandemic!
- FREE videos, digital images and toolkit for your use at ICOVIDQUIT.org
- We continue to seek and share more stories, particularly from those who represent underserved communities! Please email anita.browning@ucsf.edu if you would like to share a story

UCSF

Today's Presenter

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

Volunteer Assistant Clinical Professor of Addiction Medicine, UCLA

Enhancing Recovery by Addressing Smoking During Addiction Treatment

Brian Hurley, M.D., M.B.A., DFASAM

Medical Director for Substance Abuse Prevention and Control, Los Angeles County Department of Public Health

President-Elect, American Society of Addiction Medicine

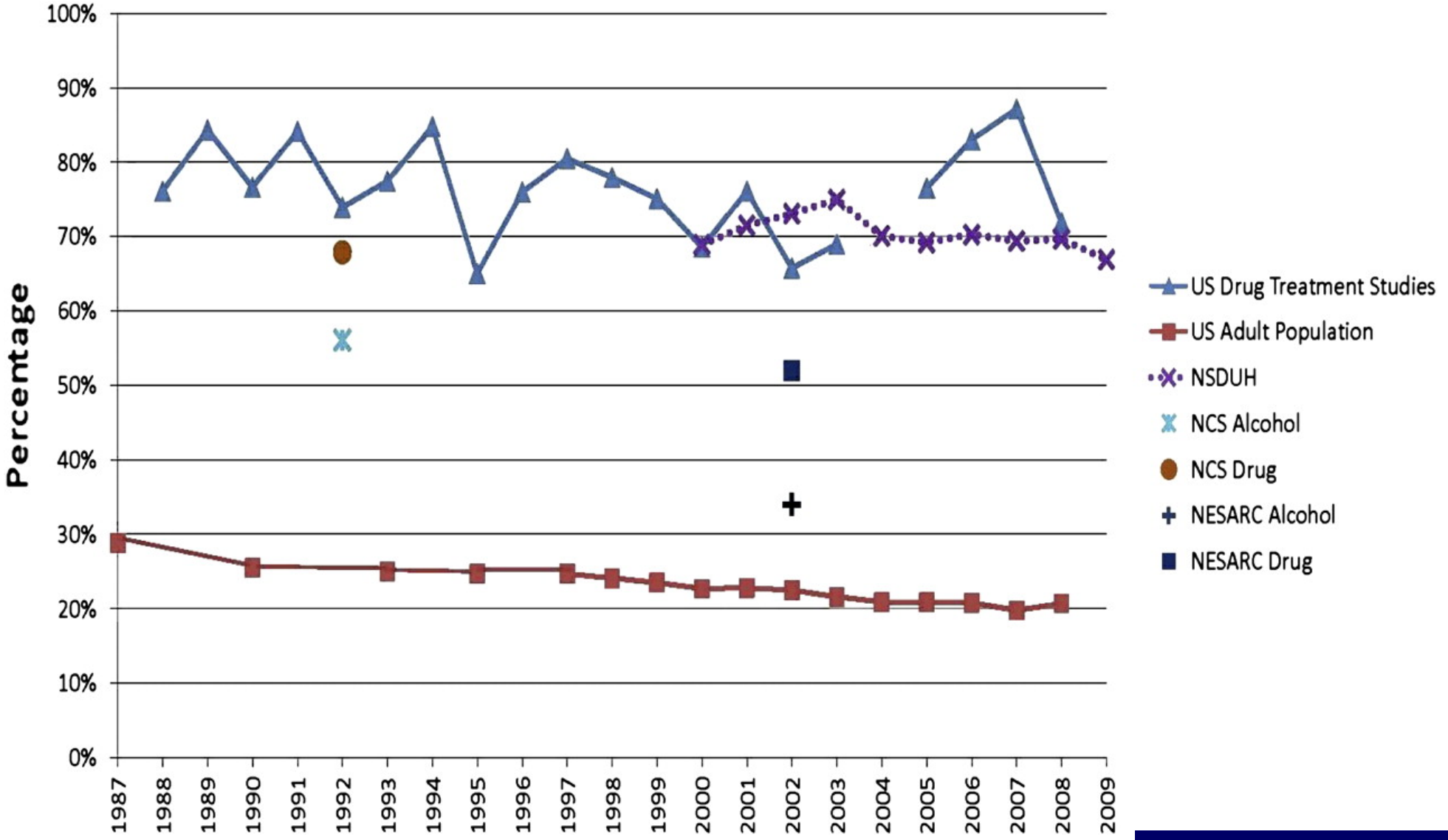
#TreatmentWeek

Learn more at treataddictionsavelives.org.

Disclosures

- Dr. Hurley has no financial conflicts of interest to disclose

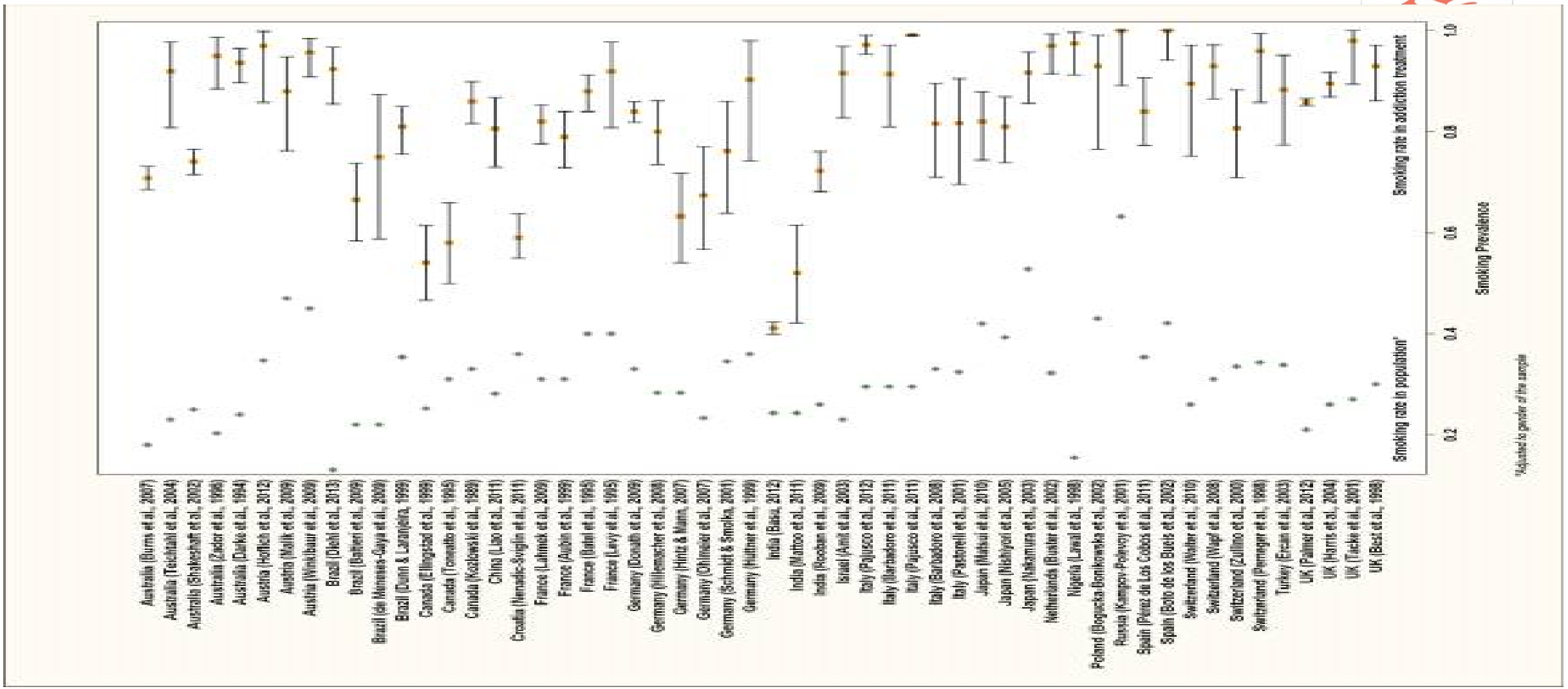
Comparing smoking prevalence



Guydish et al, Smoking prevalence in addiction treatment: a review. Nicotine Tob Res. 2011 Jun;13(6):401-11.

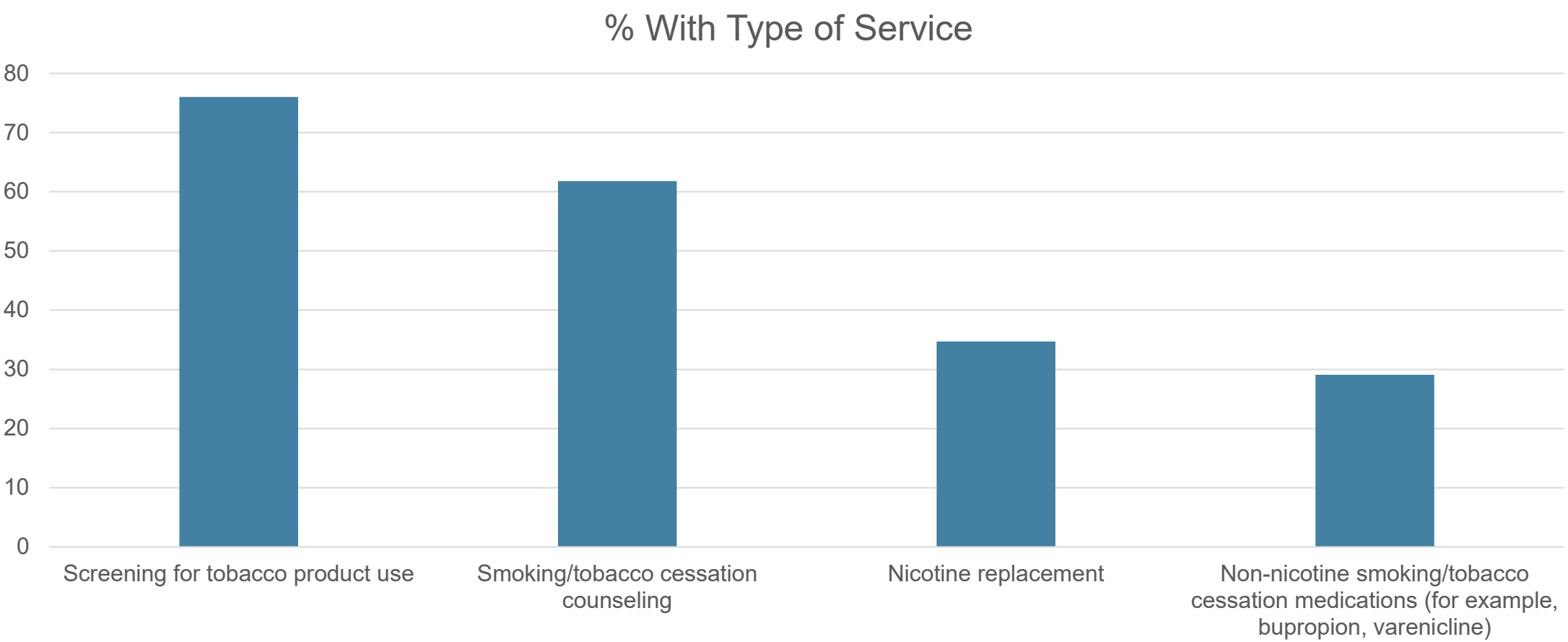
Nicotine & Tobacco Research

Smoking Prevalence Internationally



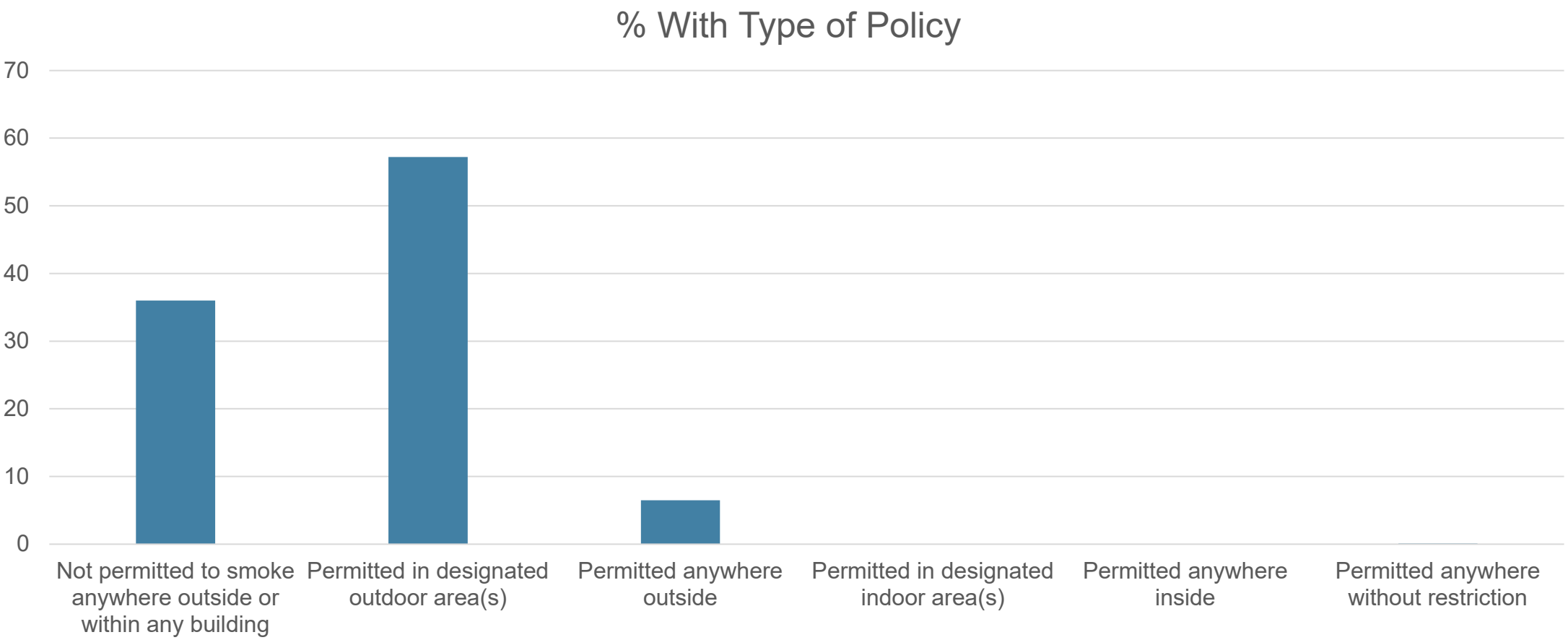
Guydish J, Passalacqua E, Pagano A, Martínez C, Le T, Chun J, Tajima B, Docto L, Garina D, Delucchi K. An international systematic review of smoking prevalence in addiction treatment. Addiction. 2016 Feb;111(2):220-30. doi: 10.1111/add.13099. Epub 2015 Sep 22. PMID: 26392127; PMCID: PMC4990064.

US Addiction Treatment Program Facility Smoking Services



Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2020. Data on Substance Abuse Treatment Facilities. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.

US Addiction Treatment Program Facility Smoking Policies



Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2020. Data on Substance Abuse Treatment Facilities. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.

Study: Adoption of Smoking Cessation Services

- 2006-2008 telephone survey of 1,145 US Addiction treatment organizations

Intake Procedures	
Ask all patients if they are current smokers	85.8%
Advise current smokers/tobacco users to quit	42.4%
Assess willingness to quit	43.5%
Use motivational techniques with unready patients	25.4%
Develop a quit plan for patients willing to make a quit attempt	35.2%
Program has adopted bundle of all five intake procedures	14.6%

Knudsen HK, Studts JL, Boyd S, Roman PM. Structural and cultural barriers to the adoption of smoking cessation services in addiction treatment organizations. J Addict Dis. 2010 Jul;29(3):294-305. doi: 10.1080/10550887.2010.489446. PMID: 20635279; PMCID: PMC2922688.

Study: Adoption of Smoking Cessation Services

- 2006-2008 telephone survey of 1,145 US Addiction treatment organizations

Smoking Cessation Services	
No formal services	57.8%
Formal counseling without medications	5.8%
Medications without formal counseling	25.2%
Formal counseling without medications	11.2%

Knudsen HK, Studts JL, Boyd S, Roman PM. Structural and cultural barriers to the adoption of smoking cessation services in addiction treatment organizations. J Addict Dis. 2010 Jul;29(3):294-305. doi: 10.1080/10550887.2010.489446. PMID: 20635279; PMCID: PMC2922688.

Reasons We Do Not Address Smoking

- 2006-2008 telephone survey of 1,145 US Addiction treatment organizations:
- Lack of clinical skills related to smoking cessation
- The cultural norm about smoking not being viewed as an important addiction treatment issue

Knudsen HK, Studts JL, Boyd S, Roman PM. Structural and cultural barriers to the adoption of smoking cessation services in addiction treatment organizations. J Addict Dis. 2010 Jul;29(3):294-305. doi: 10.1080/10550887.2010.489446. PMID: 20635279; PMCID: PMC2922688.

Reasons We Do Not Address Smoking

- Not part of addiction treatment culture
- Patient lack of readiness (or resistance)
- Lack of resources to implement tobacco cessation services
- Staff smoking and attitudes toward smoking
- Environmental barriers: physical layout and location

Pagano A, Tajima B, Guydish J. Barriers and Facilitators to Tobacco Cessation in a Nationwide Sample of Addiction Treatment Programs. J Subst Abuse Treat. 2016 Aug;67:22-9. doi: 10.1016/j.jsat.2016.04.004. Epub 2016 May 5. PMID: 27296658; PMCID: PMC4911699.

Reasons We Do Not Address Smoking

- Cross-sectional survey of staff and patients in seven community and residential addiction services in Europe:
  - Staff rate smoking treatment significantly less important than treatment of other substances ($p < 0.001$)
  - Only 29% of staff thought smoking should be addressed early in a patient's primary addiction treatment (compared with 48% of patients)

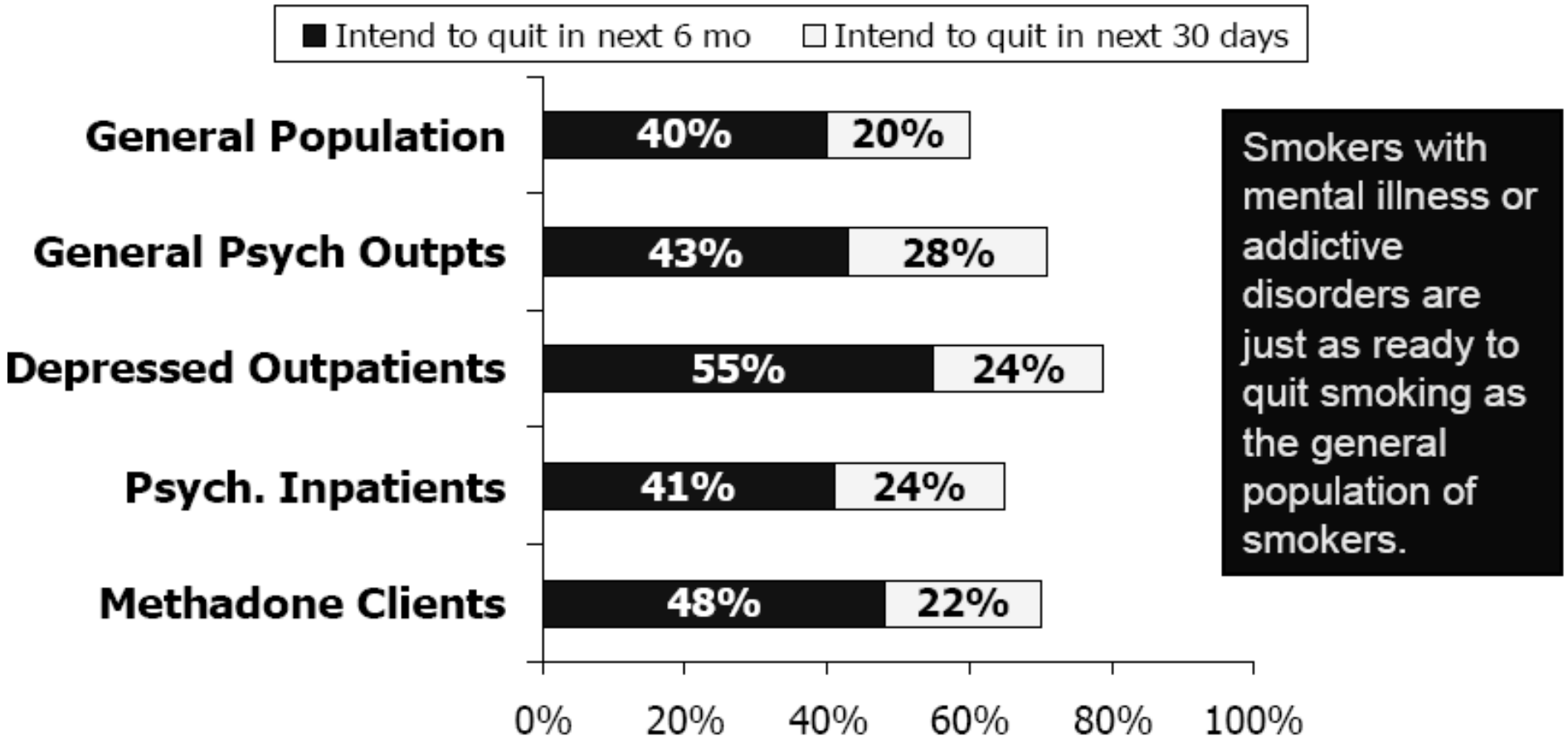
Cookson C, Strang J, Ratschen E, Sutherland G, Finch E, McNeill A. Smoking and its treatment in addiction services: patients' and staff behaviour and attitudes. BMC Health Serv Res. 2014 Jul 14;14:304. doi: 10.1186/1472-6963-14-304. PMID: 25017205; PMCID: PMC4108960.

Addiction Treatment Programs Have the Opportunity to Ask and Act

- 70% of tobacco users want to quit
- Without assistance only 5% are able to quit
- Most tobacco users try to quit on their own; more than 95% relapse
- Using evidence-based programs can more than double the quit rates

Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff. A clinical practice guideline for treating tobacco use and dependence: 2008 update. A U.S. Public Health Service report. Am J Prev Med. 2008 Aug;35(2):158-76. doi: 10.1016/j.amepre.2008.04.009. PMID: 18617085; PMCID: PMC4465757.

READINESS to QUIT in SPECIAL POPULATIONS



Smokers with mental illness or addictive disorders are just as ready to quit smoking as the general population of smokers.

*** No relationship between psychiatric symptom severity and readiness to quit**

Slide Courtesy J Prochaska; Acton 2001; Prochaska 2004; Prochaska 2006; Nahvi 2006

People with addiction are motivated to cease smoking

- Combined data from nine studies suggests:
  - More than half of all smokers may be contemplating quitting within 6 months or preparing to quit within 30 days.
  - Not dissimilar from general population.

Siru, Ranita et al. Addiction 104.5 (2009): 719-733.

Smoking in SUD populations

- The majority of patients enrolled in treatment for SUDs also smoke tobacco
- Smoking associated with poorer treatment outcomes compared to non-smokers
- Without smoking cessation treatment, smokers in SUD treatment do not reduce or quit smoking

  McClure, Erin A., et al. Journal of substance abuse treatment 53 (2015): 39-46.

Smoking in SUD populations

- Meta-Analysis of Smoking Cessation Interventions With Individuals in SUD Treatment or Recovery:
- 25% increased likelihood of long-term abstinence from alcohol and illicit drugs.
- Smoking cessation interventions during addictions treatment enhanced long-term sobriety

  Prochaska et al. Journal of Consulting and Clinical Psychology, Vol 72(6), Dec 2004, 1144-1156.

Smoking in SUD populations

- Smoking cessation during substance use disorder treatment:
- Does not impair outcome of the presenting substance abuse problem
- Enhances substance use disorder treatment outcomes

Baca, et al. Journal of substance abuse treatment 36.2 (2009): 205-219.

Quitting in Addiction Treatment?

- Recovery from alcohol dependence: Smoking indicators predict abstinence:
  - Method: N=300 w/ AUD (74.9% smoking) from two inpatient detoxification units in Germany. Alcohol consumption was prospectively followed for 1 year.
  - Smoking increased the risk for alcohol relapse (hazard ratio = 3.962, 95% CI 1.582–9.921).
  - Smoking reduced the probability of maintaining alcohol abstinence significantly
    - However, higher number of cigarettes smoked daily diminished the increased risk of alcohol relapse in alcohol-dependent patients.

Hufnagel, et al. The American Journal On Addictions. April 2017.

Quitting in Addiction Treatment?

- Stopping smoking during first year of substance use treatment predicted alcohol and drug treatment outcomes:
  - 1 year: 14.1% smokers stopped, 10.7% of the non-smokers started.
  - Smokers who stopped were more likely in remission from SUD, OR 2.4 (year 1 data).

Tsoh, et al. Drug and alcohol dependence 114.2 (2011): 110-118.

Addiction Treatment Should Take the Lead

- High prevalence of tobacco use disorders
- Knowledge about addictive disorders
- Tobacco interactions with psychotropics
- Longer and more treatment sessions
- Experts in psychosocial treatment
- Tremendous patient need
- Relationship to other addictions

Slide courtesy of Williams JM, 2012 AAAP Workshop on Tobacco Use and Cessation, December 7, 2012

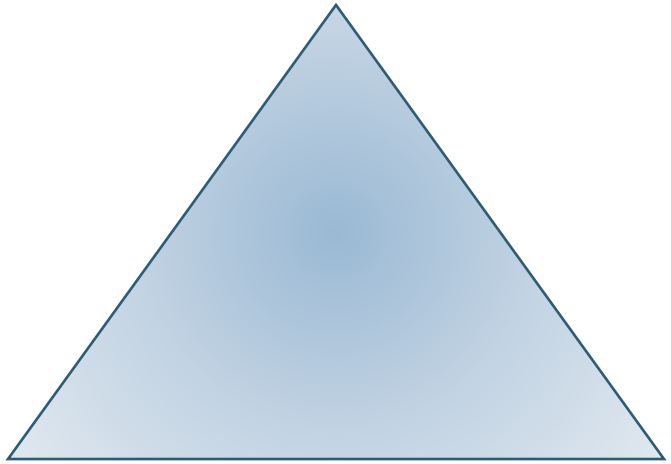
The 5 A's: Patient Readiness to Change

- **ASK** about tobacco use
- **ADVISE** to change tobacco use
- **ASSESS** willingness to make a change attempt
- **ASSIST** in attempt to cut down or quit
- **ARRANGE** for follow-up

Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff. A clinical practice guideline for treating tobacco use and dependence: 2008 update. A U.S. Public Health Service report. Am J Prev Med. 2008 Aug;35(2):158-76. doi: 10.1016/j.amepre.2008.04.009. PMID: 18617085; PMCID: PMC4465757.

Core Components of Addiction Treatment

*Medications



*Counseling

*Support

*When appropriate

Source: http://www.samhsa.gov/treatment

The 5 R's: Motivating Patient Readiness

- **RELEVANCE** of tobacco use from the patient's perspective
- **RISK** seen by the patient of continuing to use tobacco
- **REWARDS** seen by the patient of changing tobacco use
- **ROADBLOCKS** predicted by the patient during change attempt
- **REPETITION** each visit

Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff. A clinical practice guideline for treating tobacco use and dependence: 2008 update. A U.S. Public Health Service report. Am J Prev Med. 2008 Aug;35(2):158-76. doi: 10.1016/j.amepre.2008.04.009. PMID: 18617085; PMCID: PMC4465757.

Smoking Counseling

Practical Counseling

- Problem Solving and Skills Training:
- Build on past smoking change experiences
- Recognize danger situations
- Develop coping skills
- Education about successful smoking treatments
- Abstinence from intoxicants

Social Support

- Encourage the patient in a change attempt
- Communicate caring and concern
- Encourage the patient discuss their change attempt
- Other smokers in the treatment program and in the patient's household

Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff. A clinical practice guideline for treating tobacco use and dependence: 2008 update. A U.S. Public Health Service report. Am J Prev Med. 2008 Aug;35(2):158-76. doi: 10.1016/j.amepre.2008.04.009. PMID: 18617085; PMCID: PMC4465757.

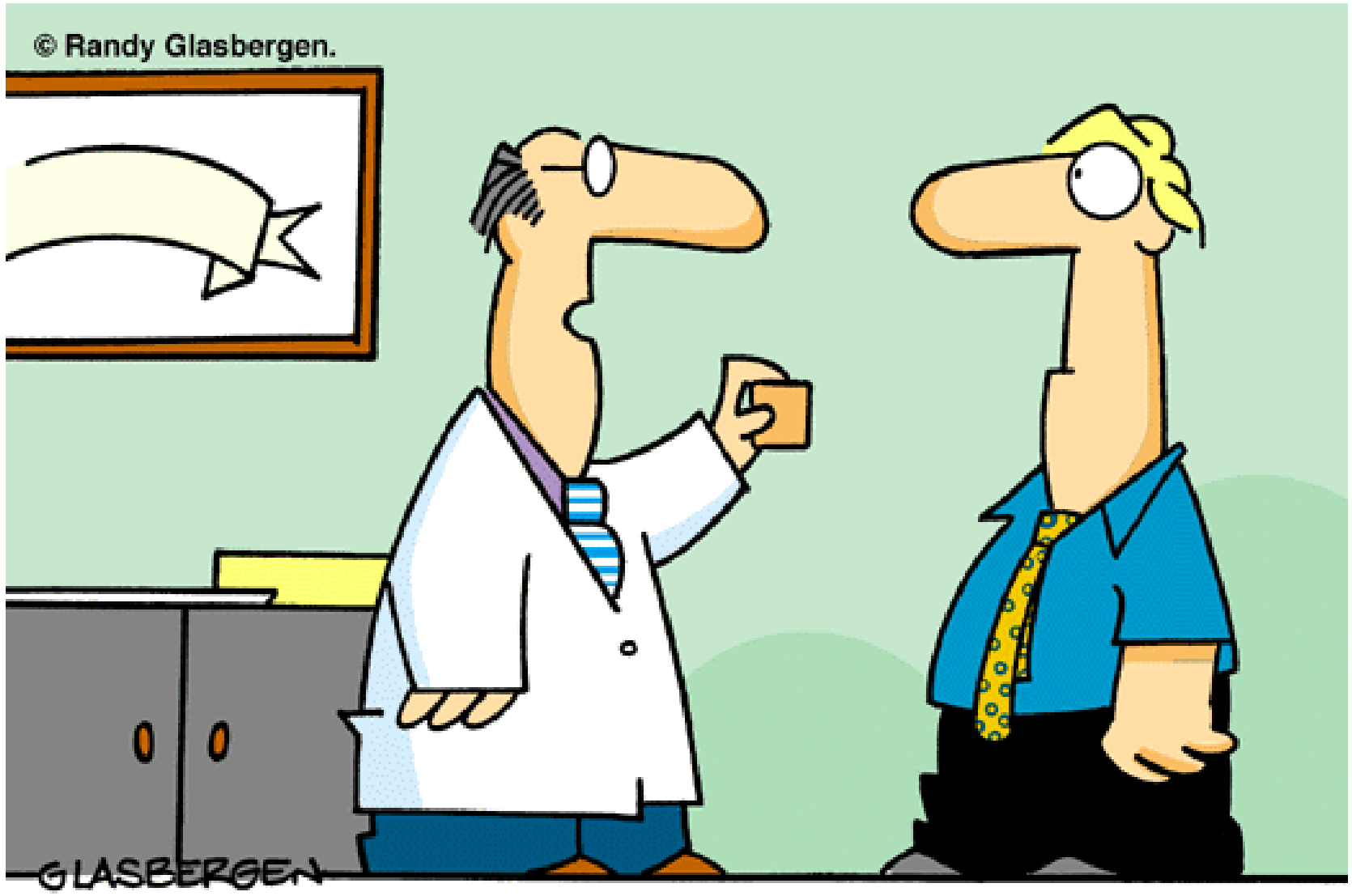
Tobacco Use Disorder Pharmacotherapy

- Nicotine Replacement Therapy → nicotinic acetylcholine receptor agonist
- Varenicline → nicotinic acetylcholine receptor high affinity partial agonist
- Bupropion → norepinephrine-dopamine reuptake inhibitor, norepinephrine releasing agent, and nicotinic acetylcholine receptor antagonist

PHARMACOLOGIC PRODUCT GUIDE: FDA-Approved Medications for Smoking Cessation

	NICOTINE REPLACEMENT THERAPY (NRT) FORMULATIONS					BUPROPION SR	VARENICLINE
	GUM	LOZENGE	TRANSDERMAL PATCH	NASAL SPRAY	ORAL INHALER		
PRODUCT	**Nicorette[1], Generic** OTC 2 mg, 4 mg original, cinnamon, fruit, mint	**Nicorette[1], Generic** **Nicorette[1] Mini** OTC 2 mg, 4 mg; cherry, mint	**NicoDerm CQ[1], Generic** OTC (NicoDerm CQ, generic) 7 mg, 14 mg, 21 mg (24-hr release)	**Nicotrol NS[2]** Rx Metered spray 10 mg/mL nicotine solution	**Nicotrol Inhaler[2]** Rx 10 mg cartridge delivers 4 mg inhaled vapor	**Zyban[1], Generic** Rx 150 mg sustained-release tablet	**Chantix[2]** Rx 0.5 mg, 1 mg tablet
PRECAUTIONS	• Recent (≤ 2 weeks) myocardial infarction • Serious underlying arrhythmias • Serious or worsening angina pectoris • Temporomandibular joint disease • Pregnancy[3] and breastfeeding • Adolescents (<18 years)	• Recent (≤ 2 weeks) myocardial infarction • Serious underlying arrhythmias • Serious or worsening angina pectoris • Pregnancy[3] and breastfeeding • Adolescents (<18 years)	• Recent (≤ 2 weeks) myocardial infarction • Serious underlying arrhythmias • Serious or worsening angina pectoris • Pregnancy[3] and breastfeeding • Adolescents (<18 years)	• Recent (≤ 2 weeks) myocardial infarction • Serious underlying arrhythmias • Serious or worsening angina pectoris • Underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis) • Severe reactive airway disease • Pregnancy[3] and breastfeeding • Adolescents (<18 years)	• Recent (≤ 2 weeks) myocardial infarction • Serious underlying arrhythmias • Serious or worsening angina pectoris • Bronchospastic disease • Pregnancy[3] and breastfeeding • Adolescents (<18 years)	• Concomitant therapy with medications/conditions known to lower the seizure threshold • Hepatic impairment • Pregnancy[3] and breastfeeding • Adolescents (<18 years) • Treatment-emergent neuropsychiatric symptoms[4] **BOXED WARNING REMOVED 12/2016** **CONTRAINDICATIONS:** • Seizure disorder • Concomitant bupropion (e.g., Wellbutrin) therapy • Current or prior diagnosis of bulimia or anorexia nervosa • Simultaneous abrupt discontinuation of alcohol or sedatives/benzodiazepines • MAO inhibitors in preceding 14 days; concurrent use of reversible MAO inhibitors	• Severe renal impairment (dosage adjustment is necessary) • Pregnancy[3] and breastfeeding • Adolescents (<18 years) • Treatment-emergent neuropsychiatric symptoms[4] **BOXED WARNING REMOVED 12/2016**
DOSING	*1st cigarette ≤30 minutes after waking:* 4 mg *1st cigarette >30 minutes after waking:* 2 mg Weeks 1–6: 1 piece q 1–2 hours Weeks 7–9: 1 piece q 2–4 hours Weeks 10–12: 1 piece q 4–8 hours • Maximum, 24 pieces/day • Chew each piece slowly • Park between cheek and gum when peppery or tingling sensation appears (~15–30 chews) • Resume chewing when tingle fades • Repeat chew/park steps until most of the nicotine is gone (tingle does not return; generally 30 min) • Park in different areas of mouth • No food or beverages 15 minutes before or during use • Duration: up to 12 weeks	*1st cigarette ≤30 minutes after waking:* 4 mg *1st cigarette >30 minutes after waking:* 2 mg Weeks 1–6: 1 lozenge q 1–2 hours Weeks 7–9: 1 lozenge q 2–4 hours Weeks 10–12: 1 lozenge q 4–8 hours • Maximum, 20 lozenges/day • Allow to dissolve slowly (20–30 minutes) • Nicotine release may cause a warm, tingling sensation • Do not chew or swallow • Occasionally rotate to different areas of the mouth • No food or beverages 15 minutes before or during use • Duration: up to 12 weeks	*>10 cigarettes/day:* 21 mg/day x 4–6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks *≤10 cigarettes/day:* 14 mg/day x 6 weeks 7 mg/day x 2 weeks • Rotate patch application site daily; do not apply a new patch to the same skin site for at least one week • May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) • Duration: 8–10 weeks	1–2 doses/hour (8–40 doses/day) One dose = 2 sprays (one in **each** nostril); each spray delivers 0.5 mg of nicotine to the nasal mucosa • Maximum – 5 doses/hour or – 40 doses/day • For best results, initially use at least 8 doses/day • Do not sniff, swallow, or inhale through the nose as the spray is being administered • Duration: 3 months	6–16 cartridges/day Individualize dosing; initially use 1 cartridge q 1–2 hours • Best effects with continuous puffing for 20 minutes • Initially use at least 6 cartridges/day • Nicotine in cartridge is depleted after 20 minutes of active puffing • Inhale into back of throat or puff in short breaths • Do NOT inhale into the lungs (like a cigarette) but "puff" as if lighting a pipe • Open cartridge retains potency for 24 hours • No food or beverages 15 minutes before or during use • Duration: 3–6 months	150 mg po q AM x 3 days, then 150 mg po bid • Do not exceed 300 mg/day • Begin therapy 1–2 weeks **prior** to quit date • Allow at least 8 hours between doses • Avoid bedtime dosing to minimize insomnia • Dose tapering is not necessary • Duration: 7–12 weeks, with maintenance up to 6 months in selected patients	Days 1–3: 0.5 mg po q AM Days 4–7: 0.5 mg po bid Weeks 2–12: 1 mg po bid • Begin therapy 1 week **prior** to quit date • Take dose after eating and with a full glass of water • Dose tapering is not necessary • Dosing adjustment is necessary for patients with severe renal impairment • Duration: 12 weeks; an additional 12-week course may be used in selected patients • May initiate up to 35 days before target quit date OR may reduce smoking over a 12-week period of treatment prior to quitting and continue treatment for an additional 12 weeks

https://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/pharmacologic-guide.pdf



"I'm prescribing a patch to help you quit smoking. Wear it over your mouth."

Slide Credit: Hilary Connery, M.D., Ph.D.

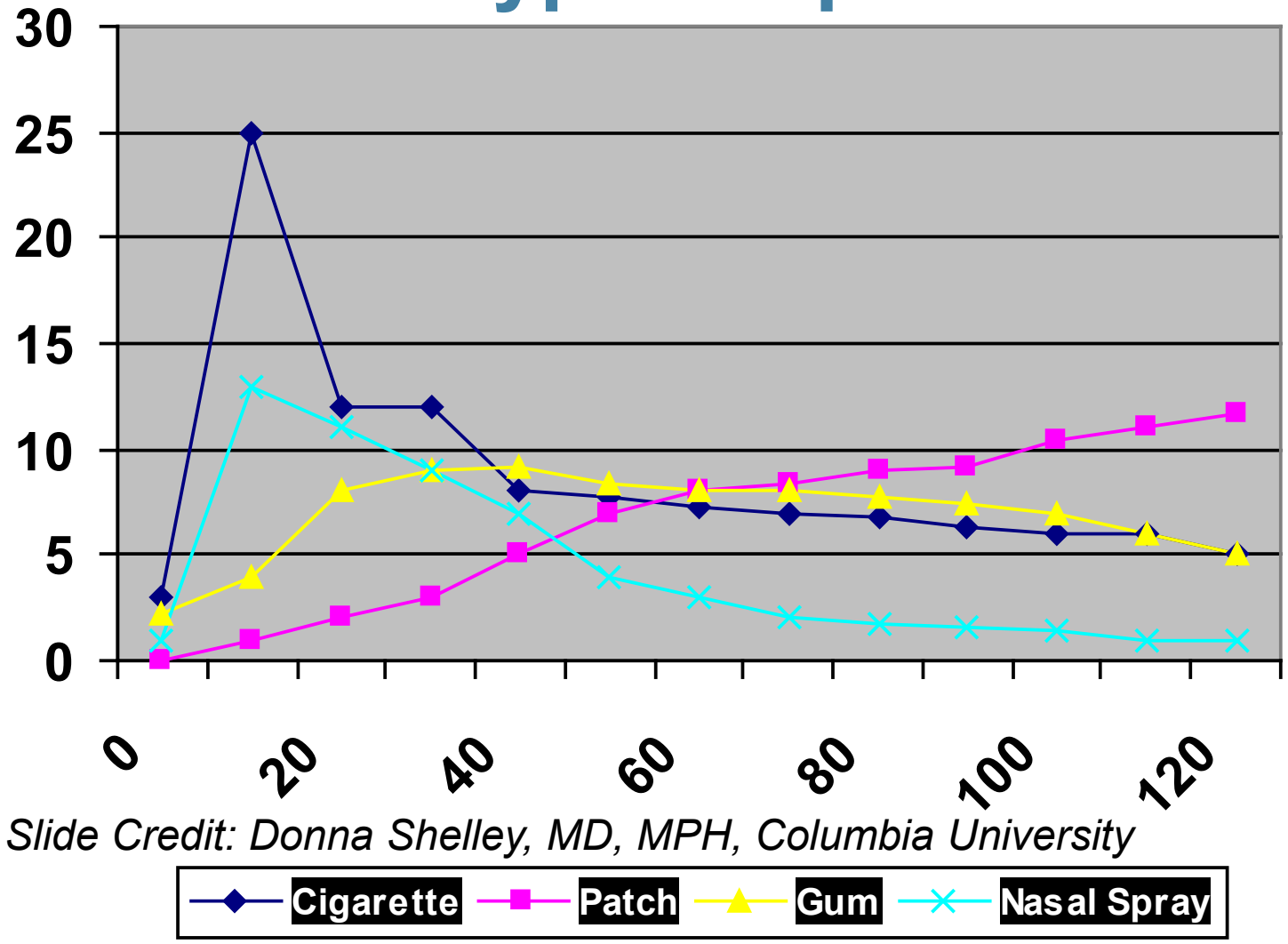
Prescription Status of Smoking Rx

Nicotine Gum	No Prescription
Nicotine lozenge	No Prescription
Nicotine patch	No Prescription *(some prescription versions)*
Nicotine nasal spray	Prescription Required
Nicotine inhaler	Prescription Required
Bupropion SR tablets	Prescription Required
Varenicline tablets	Prescription Required

Factors to Consider When Choosing a Medication Strategy

- Patient preference
- Clinician familiarity with the medications
- Contraindications for selected patients
- Previous patient experiences with a specific agent (positive or negative)
- Patient characteristics (concern about weight gain, history of depression)

Plasma nicotine levels after a cigarette vs. different types of pharmacotherapy



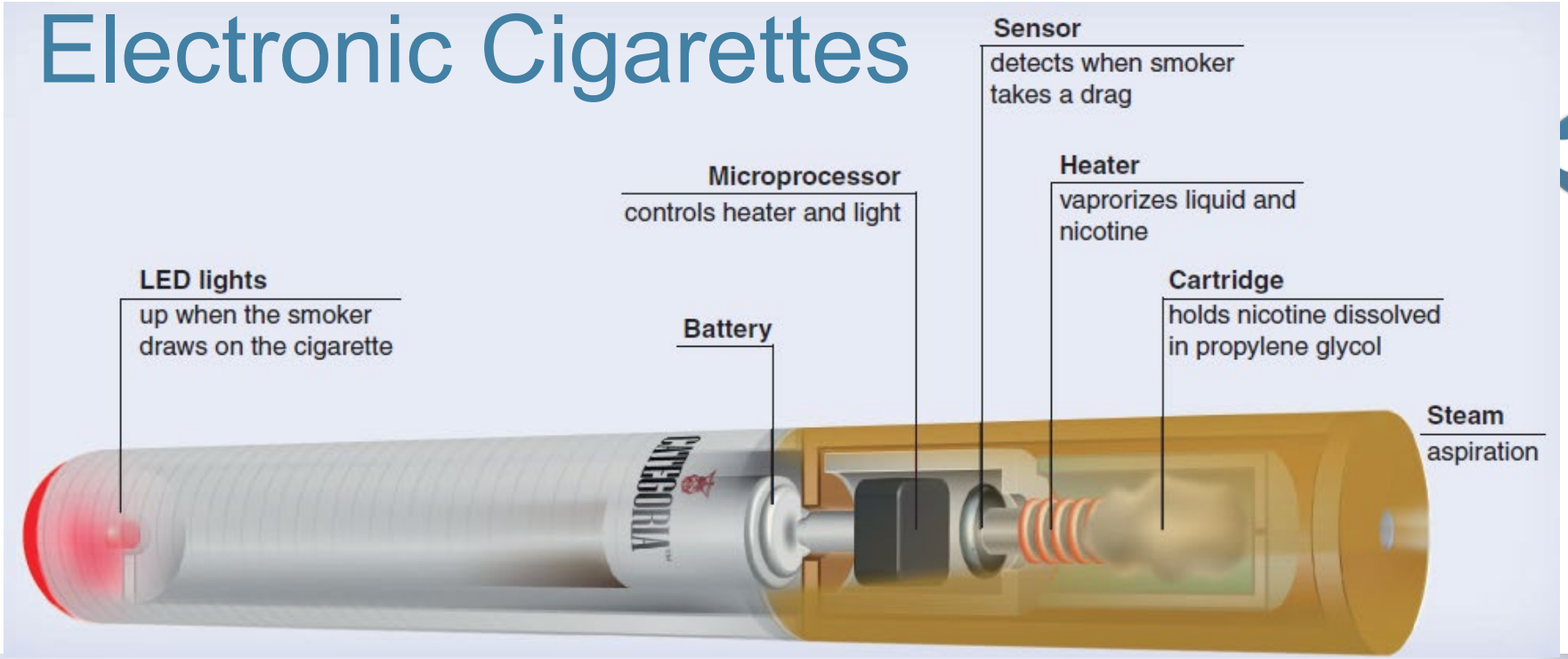
Slide Credit: Donna Shelley, MD, MPH, Columbia University

Patients With Addiction

- Most will need medication
- May need higher doses, longer duration of treatment and combination of medications
- Patients undergoing alcohol / sedative withdrawal management should only receive bupropion once their seizure risk has been managed
- Each agent is effective for patients with addictions

PHS Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update*
Signal Behavioral Health Network and the Colorado State Tobacco Education & Prevention Partnership (STEPP). *Smoking Cessation for Persons with Mental Illness: A Toolkit for Health Providers.* 2009

Electronic Cigarettes



Electronic cigarette contains:

Propylene glycol, glycerin, nicotine and food flavoring

Traditional cigarette contains:

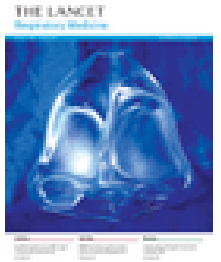
Nicotine, benzene, formaldehyde, lead, tar, methanol, hydrogen cyanide, butane, ammonia, chloroform, carbon monoxide, acetone, nitrosamines, aluminum, carbon dioxide, cadmium, arsenic, ethanol, vinyl chloride, radon, +3500 more chemicals and +50 known carcinogens

The American Cancer Society is awaiting further research on this topic, and has not taken a position on whether electronic cigarettes should be banned from the US market.

–cancer.org, Last Revised: 09/09/2013

Caponnetto et al 2012,

THE LANCET
Respiratory Medicine
Volume 4, Issue 2, February 2016, Pages 116-128



Articles

E-cigarettes and smoking cessation in real-world and clinical settings: a systematic review and meta-analysis

Sara Kalkhoran MD [a], Prof Stanton A Glantz PhD [a, b]

E-cigarettes are associated with significantly less quitting among smokers.

Kalkhoran, S., & Glantz, S. A. (2016). E-cigarettes and smoking cessation in real-world and clinical settings: a systematic review and meta-analysis. *The Lancet Respiratory Medicine*, *4*(2), 116-128.

Setting the Context: Policies

- Tobacco control policies (access to smoking treatment and tobacco-free campus policies) within addiction treatment promotes tobacco cessation:
- 2019 study of patients in residential addiction treatment exposed to a comprehensive tobacco control environment (vs. usual care)
  - 80% less likely to use tobacco during treatment
  - 35% decrease in the average number of days patients used tobacco
  - 27% decrease in the average number of cigarettes used per day

Romano I, Costello MJ, Ropp C, Li Y, Sousa S, Bruce D, Roth D, MacKillop J, Rush B. Evaluating the short-term impact of a tobacco-free policy in an inpatient addiction treatment setting. J Subst Abuse Treat. 2019 Dec;107:50-59. doi: 10.1016/j.jsat.2019.09.007. Epub 2019 Oct 22. PMID: 31757265.

Tobacco Policy Checklist – Part 1

- Tobacco-Free Environment (for patients, Staff and Visitors)
  - Program Buildings (indoors)
  - Program campus/grounds
  - Vehicles
  - Program Sponsored events
  - Specifically prohibits staff and patients from smoking together
- Enforcement (for patients, Staff and Visitors)
  - General enforcement
  - Identifies specific enforcement consequences
  - Mention of cessation and/or education
  - Establishes designated individual(s) for enforcement

UCSF Smoking Cessation Leadership Center's California Behavioral Health & Wellness Initiative. Tobacco-free Toolkit for Behavioral Health Agencies. (2019) http://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Downloads/Toolkits/362577_CABHWI_Toolkit_020420_WEB2.pdf - Accessed August 7, 2020

Tobacco Policy Checklist – Part 2

- Screening, Education and Treatment Services
  - Screening for tobacco use at intake
  - Removes tobacco products from patient possession at intake
  - patient education curriculum mentioned
  - Staff training mentioned
  - General cessation mentioned
  - Referral to outside cessation services mentioned
  - Onsite cessation program mentioned
  - Specific behavioral treatment services mentioned
  - Specific pharmacotherapy treatment services mentioned
- Policy Organization
  - Communication of the policy
  - Printed Materials
  - Signage
  - Rationale given for health or environmental consequences
  - Policy indicates all tobacco products, including e-cigarettes, preferably using the state definition of tobacco products
  - Applicable enforcement/adoption date
  - Individual(s) identified to review and/or update the policy

UCSF Smoking Cessation Leadership Center's California Behavioral Health & Wellness Initiative. Tobacco-free Toolkit for Behavioral Health Agencies. (2019) http://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Downloads/Toolkits/362577_CABHWI_Toolkit_020420_WEB2.pdf - Accessed August 7, 2020

Setting the Context: 2008 NYS Policies

1. Define the facility, vehicles and grounds which are tobacco-free
2. Prohibits patients, family members, and other visitors from bringing tobacco products and paraphernalia to the service
3. Requires all patients, staff, volunteers and visitors be informed of the tobacco-free policy including posted notices and the provision of copies of the policy
4. Prohibits staff from using tobacco products while at work, during work hours
5. Establishes a tobacco-free policy for staff while they are on the site of the service
6. Establishes treatment modalities for patients who use tobacco
7. Describes training on tobacco use and nicotine dependence available to staff including clinical, non-clinical, administrative and volunteers
8. Describes tobacco and nicotine prevention and education programs made available by the service to patients, staff, volunteers and others
9. Establishes procedures, including a policy to address patients who relapse on tobacco products.

TOBACCO-FREE SERVICES TITLE 14 NYCRR PART 856. [Statutory Authority: Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.21(b), 19.21(d), 32.01, & 32.07(a)] http://oasas.ny.gov/system/files/documents/2019/05/14%20NYCRR%20Part%20856%20%281%29_0.pdf - Accessed October 10, 2021

NYS Policies: Findings After 1 Year

- Patient smoking decreased from 69.4% to 62.8% ($P = .044$)
- While outpatient programs showed no significant changes on any of the staff and patient survey measures, in methadone programs, staff use of tobacco-related practices increased ($P < .01$) and patient attitudes toward tobacco treatment grew more positive ($P < .05$), and patients received more tobacco-related services ($P < .05$).
- Residential patients were more likely to report having quit smoking after policy implementation (odds ratio = 4.7)

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.

NYS Policies: Findings After 5 Years

- Staff smoking prevalence decreased from 35.2% in 2008 to 21.8% in 2013 (*P* = .005)
- Among patients who smoked, mean cigarettes per day decreased from 13.7 (*SD* = 8.38) to 10.2 (*SD* = 4.44; *P* < .001).
- Patient's and staff tobacco-related attitudes increased cessation services provided.
- Methadone program scores tended to rise (become more positive) throughout the study period.

Pagano A, Guydish J, Le T, Tajima B, Passalacqua E, Soto-Nevarez A, Brown LS, Delucchi KL. Smoking Behaviors and Attitudes Among patients 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.

Smoke-Free Policies and Smoking

- Patients in 25 CTN Addiction Treatment programs surveyed, comparing program with smoke-free policies to those without:
- Smoking prevalence decreased (92.5% v. 67.6%, p = .005)
- Rate of staff and patients smoking together decreased (35.6% v. 4.2%, p = .031)
- CPD decreased (10.62 v. 8.24, p < .001)
- Tobacco services received by patients increased (2.08 v. 3.05, p < .001).

Guydish J, Yip D, Le T, Gubner NR, Delucchi K, Roman P. Smoking-related outcomes and associations with tobacco-free policy in addiction treatment, 2015-2016. Drug Alcohol Depend. 2017 Oct 1;179:355-361. doi: 10.1016/j.drugalcdep.2017.06.041. Epub 2017 Aug 1. PMID: 28844012; PMCID: PMC5600495.

Resources: DO's and DON'Ts

- http://www.smokefree.gov
- http://www.nicotine-anonymous.org/
- http://smokingcessationleadership.ucsf.edu/BehavioralHealth.htm
- http://bh4tobaccofree.org
- DON'T recommend:
- "light" cigarettes or "natural" cigarettes
- Smokeless tobacco (carcinogenic, just as addictive)
- E-cigarettes: antifreeze, expensive, not proven safe or effective
  Int J Gen Med. 2011 Feb 1;4:115-20.

Slide Credit: Hilary Connery, M.D., Ph.D.

PERSISTENCE

THANK YOU!

Slide Credit: Hilary Connery, M.D., Ph.D.

Questions?

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Q&A

- Submit questions via the **‘Ask a Question’ box**

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with Drs. Danielle Shpigel and Andrea Weinberger

- **Thursday, December 9, 2021, 1-2:00 pm EST**
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