TOBACCO INTERVENTIONS
What Can You Do?

Center for Evidence-Based Practices
Case Western Reserve University
Cleveland, Ohio
CENTER FOR EVIDENCE-BASED PRACTICES

at Case Western Reserve University

A partnership between the Jack, Joseph and Morton Mandel School of Applied Social Sciences & Department of Psychiatry at the Case Western Reserve School of Medicine

www.centerforebp.case.edu
A Technical-Assistance Center

Providing consultation, training, and evaluation for the implementation of integrated behavioral healthcare services
Service innovations for people with mental illness, substance use disorders

SAMI
SUBSTANCE ABUSE & MENTAL ILLNESS strategies for co-occurring disorders

IDDT
INTEGRATED DUAL DISORDER TREATMENT the evidence-based practice

DDCAT
DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT an organizational assessment & planning tool

DDCMHT
DUAL DIAGNOSIS CAPABILITY IN MENTAL-HEALTH TREATMENT an organizational assessment & planning tool

ACT
ASSERTIVE COMMUNITY TREATMENT the evidence-based practice

SE/IPS
SUPPORTED EMPLOYMENT/INDIVIDUAL PLACEMENT & SUPPORT the evidence-based practice

IPBH
INTEGRATED PRIMARY & BEHAVIORAL HEALTHCARE

MI
MOTIVATIONAL INTERVIEWING the evidence-based treatment

TRAC
TOBACCO: RECOVERY ACROSS THE CONTINUUM a stage-based motivational model

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Learning Objectives

1. Describe a stage-wise approach for effective interventions to reduce the dependence of tobacco products on mental health and/or substance related symptoms and recovery.

2. Describe the effects of tobacco products on pharmacological treatment for people with mental disorders.

3. Identify 5 considerations for improved treatment efficacy with behavioral health consumers considering tobacco cessation.
Engaging People in Discussions about Health-Related Behavior Changes
The facts:

• What’s the big deal about tobacco and people with Serious Mental Illness?

• 68% of people with schizophrenia are “heavy smokers” (smoke 25 or more cigarettes per day)

• More toxic exposure for patients who smoke (more cigarettes, larger portion consumed)

Lasser et al, 2000; Williams and Zeidonis, 2000; McCreadie, 1999; George TP et al. 2003
Morbidity and Mortality

• People with SMI have higher rates of suffering and death from:
  – Heart disease, breathing/respiratory diseases, diabetes, overweight/high BMI, cancers

• These conditions can be either directly or indirectly related to and/or exacerbated by tobacco use
Effects on Addiction and Relapse

• Smoker = Incr. rates of AOD Dependence

• People with an AOD addiction who also smoke experience a higher rate of relapse in their AOD use ....AND...

• AOD Tx + Tob. Cess. Programs = up to 25% more likely to achieve long-term abstinence; reduction in alcohol use with simultaneous tobacco cessation

(Smeltz, 2007; Friend & Pagano, 2005)
Nicotine Pharmacology

Pharmacology depends on delivery route
Reaches brain in 10 sec
Half-life 2 hours
Metabolized to cotinine in liver
Nicotine Dependence - Genetics

- Twin studies have revealed an inherited component to tobacco use and dependence
- Familial transmission of smoking across generations has been repeatedly observed
- Multiple genetic and environmental factors are involved in nicotine dependence
Nicotine- Pathophysiology

• Nicotine activates brain nicotinic acetylcholine receptors (nAchRs).
• nAchR activation leads to increased secretion of dopamine (DA) in the nucleus accumbens.
• High concentrations of nAch receptors are found in the mesolimbic system (pleasure/reward) and the locus ceruleus (attention/cognition)
Nicotine- Pathophysiology

• Nicotine leads to the release of a number of neurotransmitters in the CNS:
  · Dopamine
  · Norepinephrine
  · Glutamate
  · Vasopressin
  · Serotonin
  · Gamma-aminobutyric acid/GABA
  · Beta-endorphins

• Results in a complex combination of effects: stimulating, calming, and reinforcing
Neurobiological Connection (critical component)

• Smoking may interfere with the metabolism of psychotropic medications
  – Potentially higher doses needed for therapeutic effect
  – Side effects may increase as tobacco decreases

• Implications for reduction/cessation

Williams and Ziedonis, 2006, Snyder, 2006
Smoking Cessation May Increase Levels of Psychotropics and Other Medications

- Haloperidol
- Olanzapine
- Chlorpromazine
- Clozapine
- Fluphenazine
- Clomipramine (dep, ocd)
- Imipramine
- Desipramine
- Nortriptyline (dep, pain)
- Doxepin (depression)
- Carbamazepine (seizure, pain)
- Desmethyldiazepam
- Oxazepam
- Heparin (anticoagulant)
- Acetaminophen
- Insulin
- Caffeine
- Theophylline (asthma)
- Propranolol (hbp)
- Tacrine (Alzheimer’s)
- Warfarin (anticoagulant)
- Others
Summary: Tobacco use and SMI

• Contributes to morbidity and mortality
• Smoke more / get more toxic exposure per cigarette
• Impacts pharmacological treatment
• Neurobiological connection
• Direct implications for intervention
What percent of cigarettes smoked in the US are smoked by people with a psychiatric condition?

A. 5%
B. 16%
C. 30%
D. 36%

National Center for Chronic Disease Prevention and Health Promotion, 2013
Tobacco Interventions

• Screening and Assessment
  .....as intervention
• Stage-based interventions
• Pharmacological interventions
Individuals change voluntarily when they. . .

• Become **interested in or concerned** about the need for change

• Become **convinced** that the change is in their best interests or will benefit them more than cost them

• Organize a **plan of action** that they are **committed** to implementing

• **Take the actions** that are necessary to make the change and sustain the change
Stages of Change

• Precontemplation
• Contemplation
• Preparation
• Action
• Maintenance/Relapse Prevention
• [Relapse]

Prochaska and DiClemente, 1982
Stages of Change Model

- **Pre-contemplation**: Increase awareness of need to change, interest, and concern.
- **Contemplation**: Motivate and increase confidence in ability to change; risk/reward analysis.
- **Preparation**: Negotiate a plan.
- **Action**: Implement plan, reaffirm commitment and follow-up.
- **Maintenance**: Encourage active problem-solving; life-style changes.
- **Relapse**: Assist in Coping.

The cycle continues back to Pre-contemplation, indicating a continuous process of change and adaptation.
Stage of Change
Pre-contemplation

• No intention to change behavior - may “wish” - “want to want to change”

• Unaware/lack awareness of problems

• Others are aware of problem

• Present for help under pressure

• May demonstrate change under pressure - though then return to behavior

• **Hallmark** = resistant to change
Stage of Change
Contemplation

- Aware of problem & thinking about overcoming it
- No commitment to take action
- May remain “stuck” here for many years
- Knowing where one wants to go yet “not quite ready”
- Weighing pro’s and con’s of problem/solution
- **Hallmark** = ambivalence
Stage of Change
Preparation (Determination)

• Intend to take action soon (perhaps again), may have done so in the past
• Some reduction in problem behavior
• Decision-making stage
• **Hallmark** = small steps toward action
Stage of Change

Action

• Individuals modify behavior, experiences, or environment to overcome problems

• Requires considerable commitment of time and energy

• Change is visible and recognized

• Hallmark = visible modification of behavior
Stage of Change
Relapse Prevention/Maintenance

• Work to consolidate gains attained
• A continuation of change for at least 6 months
• Remains free of problem behavior
• **Hallmark** = stabilizing behavior change & avoiding relapse
Understanding Stage-wise Treatment
SUCCESS

WHAT PEOPLE THINK IT LOOKS LIKE

SUCCESS

WHAT IT REALLY LOOKS LIKE
Components of Change

Resistance
Ambivalence
Motivation
Common Complications:
(Ways to Create Resistance and Strategies to Avoid Them)

6 Complications
1. Question & Answer
2. Be the expert
3. Information Overload
4. Labeling
5. Blaming/shaming
6. Arguing for change
7. Premature focus

6 Ways to Engage
1. Ask and Listen
2. Shared Responsibility
3. Check Understanding
4. Person-Centered/strengths
5. Acceptance of Person
6. Change is the Person’s Decision/empower
7. Follow the person

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Employing Motivational Interviewing

• Collaborative, goal-oriented style of communication
• Pays specific attention to the language of change
• Elicits and strengthens a person’s own motivation and reasons for change
• Occurs within the context of clinician acceptance and compassion
Video

It’s not about the Nail........

www.youtube.com/watch?v=-4EDhdAHrOg
So why haven’t we addressed it?

• Too busy: ...too many other “more important” problems to deal with
• Pessimism: “most won’t quit anyway”
• View of smoking as “habit” rather than nicotine addiction needing treatment
• Culture of mental health community/treatment community – the “last” pleasurable habit they have
• “Respect” for patient’s choices and privacy
• Patients are “self-medicating” with nicotine
• I smoke and have not been able to quit
• Lack of training or expertise
• NOT REIMBURSED
Tobacco: Recovery Across the Continuum of stages, of treatment, of life
TRAC Model Principles

1. Organization wide effort
2. Integrated approach
3. Ongoing assessment
4. Stage-based approach
5. Motivational Interventions
6. Group and individual services
7. Strong interdisciplinary communication
8. Psychopharmacological interventions
9. Implementation and intervention monitoring
10. Involving natural supports
The 5 A’s (potentially not stage-wise)

<table>
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<th>Ask</th>
<th>Identify and document tobacco use status for every patient at every visit.</th>
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<td>Advise</td>
<td>In a clear, strong, and personalized manner, urge every tobacco user to quit....(skip if not ready)</td>
</tr>
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<td>Assess</td>
<td>Is the tobacco user willing to make a quit attempt at this time?</td>
</tr>
<tr>
<td>Assist</td>
<td>For the patient <strong>willing</strong> to make a quit attempt, use counseling and pharmacotherapy to help him or her <strong>(move toward the decision to)</strong> quit.</td>
</tr>
<tr>
<td>Arrange</td>
<td>Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date.</td>
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http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.html
Making the 5 A’s Stage-appropriate: The 5 R’s

For people with low readiness to quit:

- **Relevance:** Help the individual identify why quitting tobacco is relevant to him/her. (importance)
- **Risk:** Encourage the individual to verbalize possible negative outcomes of tobacco use.
- **Rewards:** Help the individual identify the possible benefits of quitting tobacco use.
- **Roadblocks:** Help the individual to identify possible obstacles to quitting, including (the perceived benefits of use) and obstacles from his/her past quit attempts.
- **Repetition:** It might likely take more than just one brief intervention before a tobacco user becomes ready to quit.

http://mdquit.org/cessation-programs/brief-interventions-5
Screening & Assessment
...as interventions
Do psychiatric patients really want to quit smoking?

YES!

• In one 1994 study, 90% of state hospital patients smoked.

• Nurses believed that 88% were not interested in stopping.

• But two-thirds said they would use help from a nurse if it was available.

Buchanan, 1994
Assessment: “Severity” of Use

Fagerström Test for Nicotine Dependence (FTND)

• Adult (Heatherton, et. al., 1991)

• Modified for Adolescents (Prokhorov, et. al., 1996; Prokhorov, et. al., 1998)

• Smokeless Tobacco (FTND-ST) (Boyle, et. al., 1995)
Assessment:

Heaviness of Smoking/Use

(../from Fagerstrom)

1. How soon after you wake, do you have first cigarette?
   a) Within 5 min (3 pts.)
   b) 6-30 min. (2 pts.)
   c) 31-60 min. (1 pt.)
   d) After 60 min. (0 pts.)

2. How many cigarettes per day?
   a) 10 or fewer (0 pts.)
   b) 11-20 (1 pt.)
   c) 21-30 (2 pts.)
   d) 31 or more (3 pts.)

SCORING (“addiction”):
0-2 = low   3-4 = moderate   5-6 = high
Assessment:
Heaviness of Smokeless/Use

1. How soon after you wake, do you place your first dip?
   a) Within 5 min (3 pts.)
   b) 6-30 min. (2 pts.)
   c) 31-60 min. (1 pt.)
   d) After 60 min. (0 pts.)

2. How many cans/pouches per week do you use?
   a) More than 3 (2 pts.)
   b) 2 – 3 (1 pt.)
   c) 1 (0 pts.)

SCORING ("addiction"):  
0-1 = low    2-3 = moderate    4-5 = high
How soon after waking... (n=1849)
Assessment: Stage of Change Readiness

Which of the following best describes you:

• I currently use a tobacco product and am
  – Not seriously thinking about quitting
  – Seriously thinking of quitting in next 6 mos.
  – Seriously thinking of quitting in next 30 days
• Quit tobacco within the last 6 mos.
• Quit tobacco more than 6 mos. ago
Assessment: 
Stage of Change Readiness

Which of the following best describes you:

• I currently use a tobacco product
  – Not seriously thinking about quitting [precontemplation]
  – Seriously thinking of quitting in next 6 mos. [contemplation]
  – Seriously thinking of quitting in next 30 days [contemplation or preparation (if quit attempt in last yr)]

• Quit tobacco within the last 6 mos. [action]

• Quit tobacco more than 6 mos. Ago [maintenance]
Stage of Change Readiness

(N=2,113)
What does your tobacco use do to your...
Differential Diagnosis in assessment

- Anxiety
- Depression
- Drowsiness
- Trouble sleeping
- Bad dreams and nightmares
- Headaches

- Feeling tense
- Restless
- Easily frustrated
- Problems concentrating
- Increased appetite
- Weight gain
Stage-Based Interventions
Precontemplation

• Assess use and readiness to change
• Identify individual goals/motivators
• Brief motivational conversations during “any” encounter related to health behaviors
• Offer practical help
• Relationship building
• Utilize natural discussion opportunities
Contemplation

• Develop motivation for change
• Understand the person’s goals
• Help tip ambivalence toward change
• Structured health-based curriculum
• Assess/build self-efficacy (confidence=small steps)
• Ongoing assessment
• Peer support
## Decisional balance

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<th>Good (pro)</th>
<th>Not so (con)</th>
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<td>Continuing to use tobacco</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Quitting tobacco</td>
<td>?</td>
<td>?</td>
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</table>
1. On a scale of 0 - 10 how important is it for you to ________ (exercise more)?...how confident are you about _____?

2. Why are you at a ____ and not a zero?

3. What would it take for you to be at a _____ (one number higher than they are)?
Preparation

• Tell your supports your plans
• Make it “uncomfortable” to use
• Education about tobacco use
• Discuss alternatives to use
• Skip one cigarette / chew / dip…(small steps)
• Delay “most hate to give up”
• Setting a quit date
Action/Maintenance

- Tobacco-specific group and individual skills training
- Pharmacological management
- Relapse prevention
- Practice refusal skills
- Social support / peer support
- Quitline
- Contingency management (reward abstinence)
4 D’s – for getting through a craving

• Delay
• Deep breathe
• Drink water
• Distract yourself / do something else
  – Music, walk, wash dishes, call someone, do “anything” healthy!
Relapse Management

• Help the person learn from relapse
• Assess current use and readiness to change and recycle
  – through the stages of contemplation, preparation, and action
• Do NOT talk about re-occurring use as a “failure”
Structured Health-Based Curricula

- Illness Management and Recovery (IMR)
- Wellness Management and Recovery (WMR)
- Team Solutions
- “Health Group”
- “Fitness Group”
- Disease-specific group (e.g. Diabetes)
Group Curricula


Learning About Healthy Living

Jill Williams, MD
Douglas Ziedonis, MD, MPH
Nancy Speelman, CSW, CADC, CMS
Betty Vreeland, MSN, APRN, NPC, BC
Michelle R. Zechner, LSW
Raquel Rahim, APRN
Erin L. O’Hea, PhD

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tobaccoprogram.org/pdf/Learning%20About%20Healthy%20Living.pdf

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Section 5

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Learning About Healthy Living Education Group

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Carbon Monoxide Meter

A carbon monoxide meter measures the amount of carbon monoxide in your body.

My Carbon Monoxide Level is = ___
0-8 Normal or Very low smoking
8-12 Concern
12-25 Warning
25-40 Danger
over 40 Severe Danger

If I quit smoking, my Carbon Monoxide Level will go down to: ___
Evidence-Based Pharmacotherapy for Tobacco-Related Disorders
Pharmacological Treatment

Rationale

– Reduce or eliminate withdrawal
– Block reinforcing effects of nicotine
– Manage negative mood states
– Unlearn smoking behaviors
– Cost-effective treatment
Pharmacological Treatments: FDA-Approved

Nicotine Replacement
- Patch
- Gum
- Lozenge
- Inhaler
- Nasal Spray

Bupropion

Varenicline

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It’s the Smoke that Kills

Cigarette smoke > 4000 compounds

- Acetone, Cyanide, Carbon Monoxide, Formaldehyde

> 60 Carcinogens

- Benzene, Nitrosamines

(CDC 2003)
Nicotine Safety

Confusion about safety/efficacy of nicotine

• Not a carcinogen
• Not a significant risk factor for cardiovascular events

Risk-benefit ratio supports nicotine medications over using tobacco
Nicotine Replacement Therapy (NRT)

- Nicotine absorption poorer than cigs
- Lower dose delivered
- Poorly orally absorbed; ↑ first pass metabolism
- Less rewarding than smoking
- **Under dosing common**
- Worsened by poor compliance
### Dosing Nicotine Replacement

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<th>Patch dose</th>
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<td>&lt; 10</td>
<td>7-14 mg/day</td>
</tr>
<tr>
<td>11-20</td>
<td>14-21 mg/day</td>
</tr>
<tr>
<td>21-40</td>
<td>21-42 mg/day</td>
</tr>
<tr>
<td>&gt; 40</td>
<td>42+ mg/day</td>
</tr>
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</table>

The patch should generally be continued at this dose for 2-6 weeks, then tapered at two week intervals until discontinued at the discretion of the treating physician and in collaboration with the patient.
Nicotine Patch

- Pick a time of day (morning is usually best)
- Rotate your patch placement (above the waist) daily.
- If you have trouble sleeping with the patch on, remove it at night.
- Replace with a new patch daily.
- Never cut the patch.
Nicotine Gum

- Nicotine Gum
  - FDA approved OTC medication
  - Slowly chewed over 30-60 minutes ("chew and park")
  - Starting dose:
    - 2 mg up to hourly for mildly dependent
    - 4 mg up to hourly for more heavily dependent
    - No more than 20 4mg pieces or 30 2mg pieces/day
  - Side effects: mouth soreness, indigestion, sore throat, tachycardia
  - Usually reserved for those with allergy to nicotine patch
  - Can be used to supplement nicotine patch in some circumstances
Nicotine Gum

• Not like normal gum
• Continue to “chew and park” until the gum loses its peppery flavor:
  – about 30 minutes per piece (or about 10 chews)
• Use only one piece of gum at a time
• Avoid drinking (esp. coffee, juices, or pop) for 15-30 minutes before and after each piece
• Do not swallow nicotine gum
Nicotine Lozenge

• Nicotine Lozenge
  – FDA approved OTC medication
  – Dissolved in mouth by sucking on the lozenge over 30 minutes
  – Starting dose:
    • 2 mg up to hourly for mildly dependent
    • 4 mg up to hourly for more heavily dependent
    • No more than 5 lozenges in 6 hours or 20/day
  – Side effects: mouth soreness, indigestion, sore throat, tachycardia
  – Usually reserved for those with allergy to nicotine patch
  – Can be used to supplement nicotine patch in some circumstances
Nicotine Lozenges

• If smoke 1st cig. w/in 30 min. of waking up, use 4 mg (otherwise, 2mg)

• Do not chew, bite, or swallow the lozenge

• Similar to “chew and park”

• Occasionally move the lozenge from side to side (usually lasts about 20 to 30 minutes)
Nicotine Lozenges

- Do not take more than 1 lozenge at a time
- Do not take 1 lozenge immediately after another
- Use at least 9-10 lozenges a day for the first 6 weeks
- Do not use more than five lozenges in 6 hours or more than 20 lozenges a day
- Do not drink or eat while using a lozenge
- Don’t eat or drink 15 minutes before and after using
Nicotine Inhaler ("puffer")

- By Prescription Only
- Comes with a mouthpiece and cartridges
- 6 to 16 cartridges/day during the first 3 to 6 weeks of treatment
- Maximum 16 cartridges/day
- Puff to the back of the throat
- Do not inhale into the lungs
- Puff frequently for about 20 minutes, until the cartridge is used up
- You do not have to complete an entire cartridge in one sitting
Simple Instructions

• For oral NRTs (gum, lozenge, and/or inhaler)
  – Stress nicotine absorbed through the mouth
  – Encourage use on a set schedule (not “as needed for cravings”) – to break addictive behavior
Nicotine Nasal Spray

• By Prescription Only
• Rec. starting dose: 1 to 2 doses/hr – maximum 5/hr
  – 1 dose is equal to 2 sprays—1 in each nostril
  – Minimum 8/day
  – Maximum 40/day
• Tilt head back
• Spray once in each nostril
• Do not breathe while spraying
• Wait a little while before breathing through nose again
• Wait 2 to 3 minutes before blowing nose
Summary: Nicotine Replacement Therapy (NRT)

• Recent practice guidelines have advised the use of NRT for all patients attempting to stop smoking

• Studies have consistently demonstrated that the addition of NRT to behavioral interventions doubles the quit rates

• **Extended combination treatment (12 mos.) has led to quit rates as high as 50%**

Bupropion for Smoking Cessation

- Most helpful if given 1-2 weeks before quitting
  - Not of much help when started at the time of quitting
- Dosage: 150 mg daily for 3 days, then 150 mg twice daily
- Requires rx
Bupropion SR

• Nonsedating/ activating
• Affects NE and DA, nicotine receptor
• Don’t use if: seizure disorder / eating disorder
• Side effects: insomnia, dry mouth, headache, activation, weight loss
• Marketed as antidepressant (Wellbutrin) and as smoking cessation aid (Zyban)
Buproprion SR

- Effect is independent of depression, gender, or race
- Works in those who failed prior NRT
- Retreatment is effective!
  - Works in those who failed prior buproprion
- Best results when combined with nicotine replacement
Varenicline (Chantix)

- Nicotinic partial agonist at the $\alpha_4\beta_2$ nicotinic acetylcholine receptor
- 1mg BID dose superior to placebo or bupropion in 12 week trials
  - Additional 12 weeks prevented relapse
- Most common side effects
  - Nausea, headache, insomnia, abnormal or vivid dreams, constipation, gas, vomiting
- Discontinuation rate similar to placebo

Gonzales et al., 2006; Tonstad et al., 2006; Jorenby et al., 2006
Varenicline (Chantix)

- Start medication 1 week before the quit date
  - Day 1 to 3 → take 0.5mg daily
  - Day 4 to 7 → take 0.5mg twice a day
  - Day 8 to end of tx → take 1mg twice a day
- Take after eating and with 8 oz. of water
- If on dialysis or have kidney problems, may need to reduce the dose
- Has not been studied in pregnant or breastfeeding women
Varenicline (Chantix)

• Continue for 3 months (even if not smoking) and up to 6 months
• Do not use NRT with varenicline
• Varenicline in SMI populations (RCT/Placebo and open-label trial):
  – Better outcome (quit rate)
  – No exacerbation of psych. sxs
  – Similar adverse event profiles

Pachas, et. al., 2012; Williams et al., 2012
Varenicline: FDA Warnings

- May 2006: FDA approves Chantix
- November 2007: FDA Early Communication
- February 2008: FDA Public Health Advisory
- July 2009: FDA Boxed Warning on serious MH events (Chantix and Zyban)
Varenicline: FDA Warnings

• Some had Sx due to nicotine withdrawal, but some were taking Varenicline and had not yet discontinued smoking

• Serious neuropsychiatric symptoms, including:
  – changes in behavior
  – agitation
  – depressed mood
  – suicidal ideation
  – attempted and completed suicide
  – vivid dreams
Varenicline: Update

• Reanalysis of data from 17 RCTs (N=8,027)
  – Varenicline did not increase rates of suicidal events, depression, or aggression/agitation
  – Significantly increased abstinence by 124% vs. placebo and by 22% vs. buproprion
  – ↑ Risk of neuropsych events equal in both treated and placebo patients if current/past psych illness

• Analysis of DOD data set (N=35,800)
  – Overall rate of neuropsych disorders lower for varenicline (2.28%) vs. NRT (3.16%)
Long-term (≥6 month) Quit Rates (each method compared to placebo)

Summary: Tobacco use and SMI

• Contributes to morbidity and mortality
• Smoke more / get more toxic exposure per cigarette
• Impacts pharmacological treatment
• Neurobiological connection
• Direct implications for intervention
Summary: Treatment

• Pharmacological treatment doubles quit rate (compared to placebo)
• Combination treatments improve outcomes
  – Bupropion and lozenge
  – Patch and lozenge
• Higher doses and/or longer duration of use may be beneficial
• Individual preference, cost, and tolerability will guide decision-making
Tobacco intervention: “It’s everybody’s job!”

Winner of the "Not My Job" Award - ADOT
Litchfield Park, AZ 85
Summary

• Assess readiness, importance, and confidence
• Explore person’s health-related concerns
• Listen for statements about their own motivation for change
• Share small amounts of information
• Check understanding
• Convey hope and optimism
Wrap-up

• Screening, Identification, and Psychosocial interventions for tobacco-related disorders:
  – Assess use, severity, and readiness to change
  – Be stage-wise

• Evidence-based pharmacotherapy for tobacco-related disorders:
  – Pharmacotherapy may double the quit rate
  – NRT Dosing: 1 mg per cigarette
Helpful Resources

• Office of the U.S. Surgeon General
  – www.surgeongeneral.gov/tobacco
  – Has numerous helpful resources for clinicians and consumers

• Ohio Tobacco Quitline
  – www.ohioquits.com
  – 1-800-QUIT-NOW (Telephone Quitline)

• American Lung Association
  – www.lungusa.org
  – 1-866-QUIT-YES (Telephone Quitline)

• National Cancer Institute
  – www.nci.nih.gov
  – 1-877-44U-QUIT (Telephone Quitline)
Helpful Resources (cont.)

• Ohio Medicaid prescription coverage check:
  – http://medlist.ohio.gov/main_domain/home.jsf
• CDC, NCI, NIH and DHHS resource:
  – www.smokefree.gov
• Ohio Department of Health
  – www.odh.ohio.gov
• UMDNJ Tobacco Dependence Program
  – www.tobaccoprogram.org
• Smoking Cessation Leadership Center
  – Smokingcessationleadership.ucsf.edu
• Rx for Change (free training curriculum—must register to use)
  – Rxforchange.ucsf.edu
Contact Us

Patrick Boyle, PhD, LISW-S, LICDC-CS

Center for Evidence-Based Practices (CEBP)
Case Western Reserve University
10900 Euclid Avenue
Cleveland, Ohio 44106-7169
216-368-0808