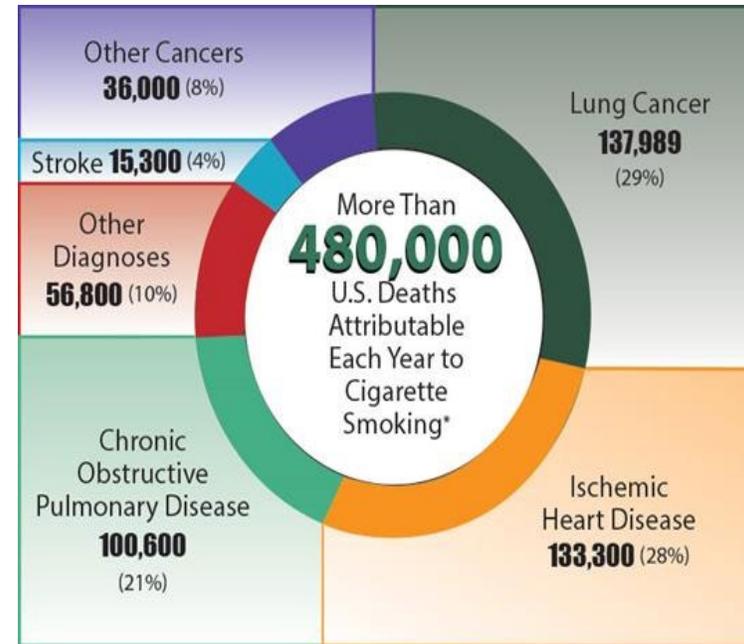




Hazards of Smoking

Smoking is the leading preventable cause of death and disability in the United States

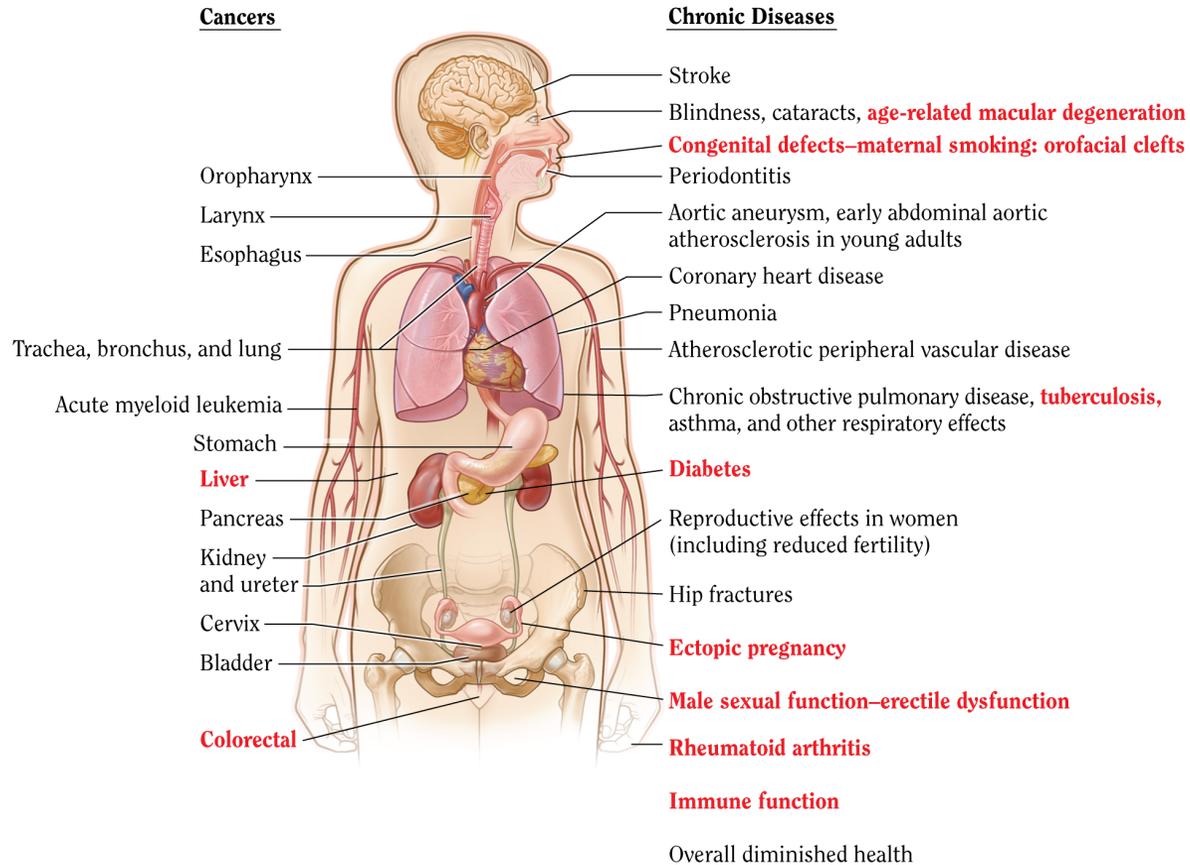
- Smoking causes more than 480,000 deaths each year
- About 1 in 5 deaths is related to smoking
- Smoking and tobacco use cuts the lifespan of individuals who have a mental illness by up to 25 years



Source: The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014



Hazards of Smoking

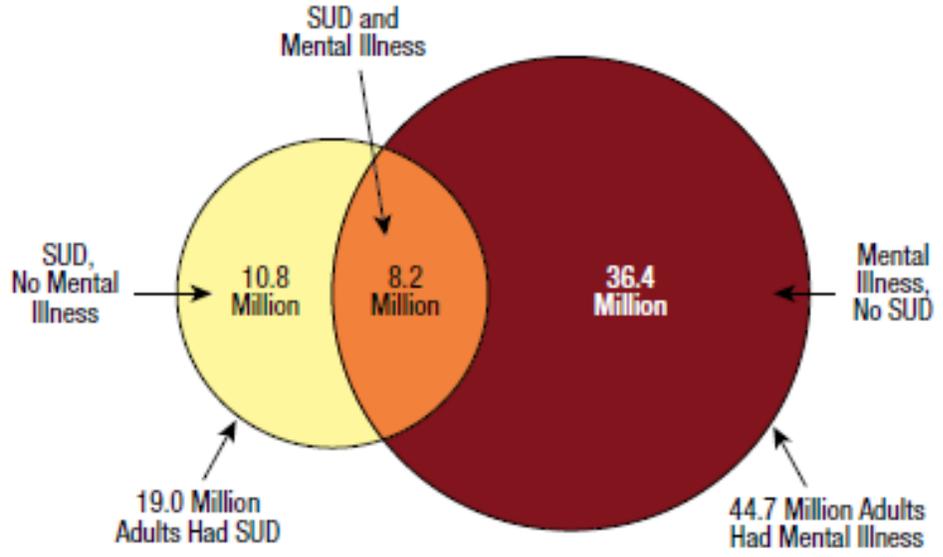


Smoking increases risk for:

- Cancers
- Heart disease
- Stroke
- COPD
- Diabetes complications

Co-occurring Substance Use + Mental Health Disorders

Figure 1. Past Year Substance Use Disorder (SUD) and Mental Illness among Adults Aged 18 or Older: Numbers in Millions, 2016

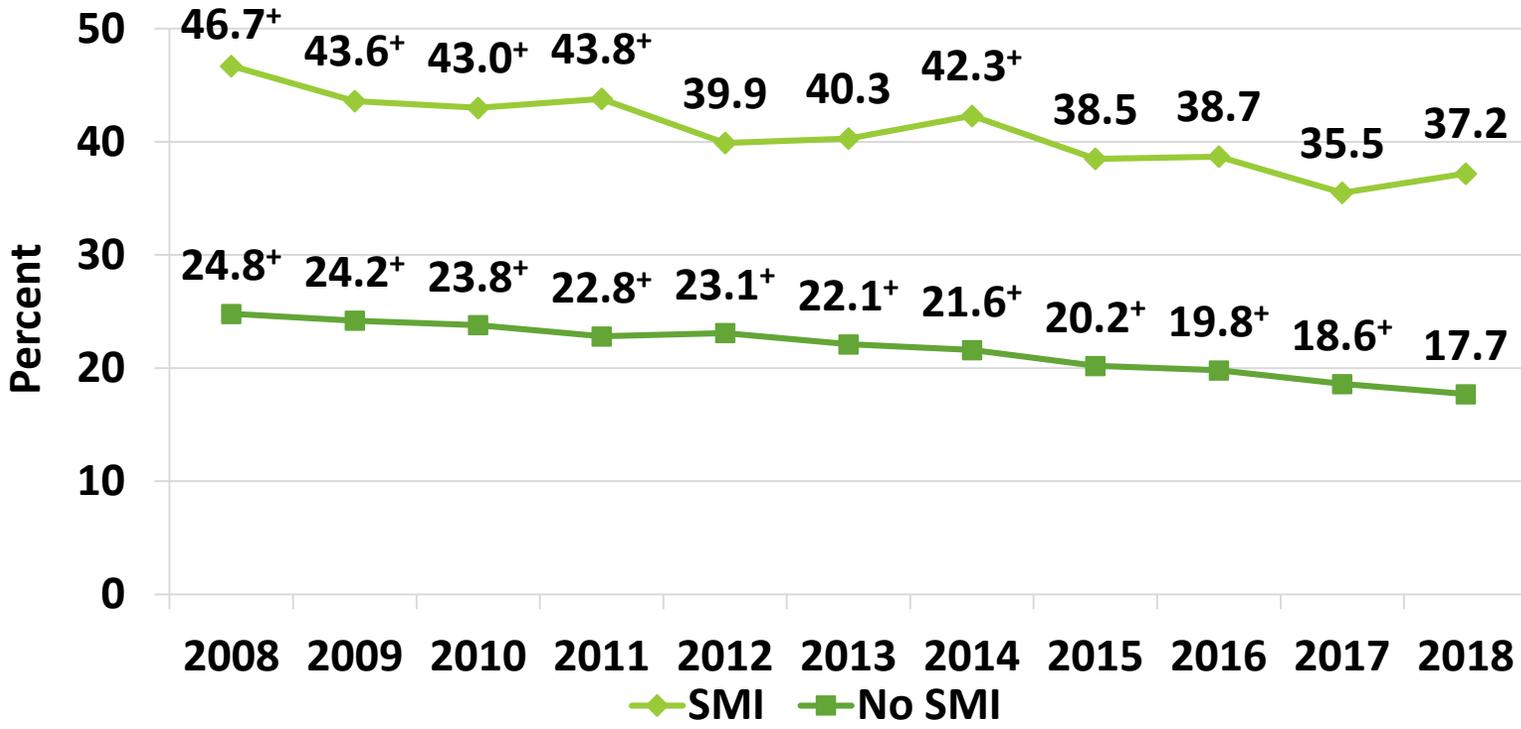


- Individuals with a (non-nicotine) substance abuse or mental health disorder represent about 25% of the United States population but consume about 40% of all cigarettes sold to adults.
- 175 **billion** cigarettes sold/\$39 billion annual profit

Graphic courtesy of: SAMHSA Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health, pg. 46.



Current Smoking among Adults (age ≥ 18) with Past Year Serious Mental Illness (SMI): NSDUH, 2008-2018



Current Smoking is defined as any cigarette use in the 30 days prior to the interview date.
Serious Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder resulting in serious functional impairment, based on the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
⁺ Difference between this estimate and the 2018 estimate is statistically significant at the .05 level.



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High Rate Among People with SUDs

70-87% of adults with substance use disorders (SUDs) smoke cigarettes. (Knudsen et al 2016; Guydish et al. 2011)

- Individuals with alcohol dependency are 3X more likely to smoke, and those with drug dependency are 4X more likely to smoke compared to the general population.

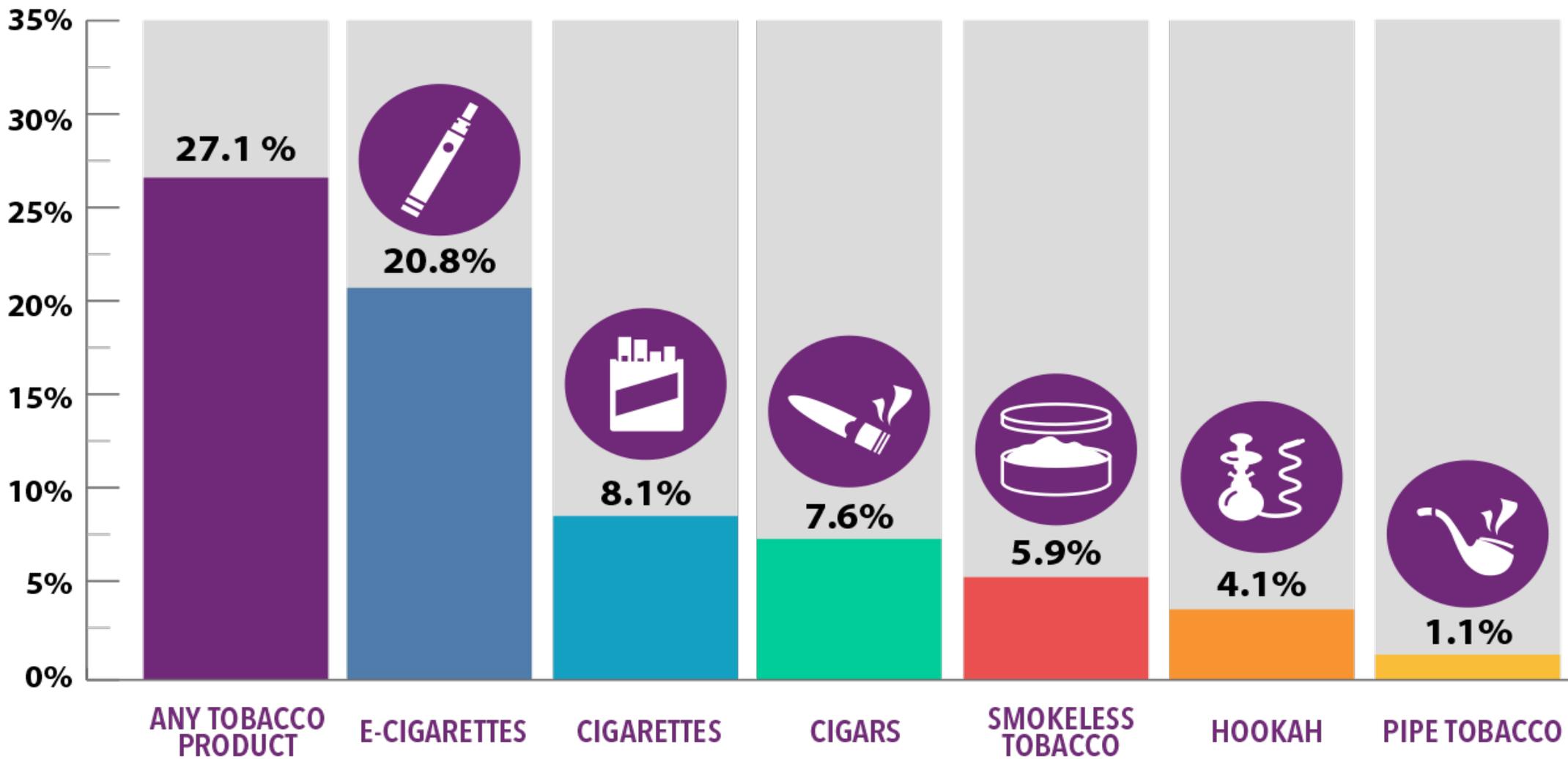
The strongest associations, however, are between opioid and tranquilizer use and nicotine

- Why? Smokers report the expectancy that smoking assists in coping with pain (e.g., via distraction), relief from pain-related boredom, anxiety, depression, anger, and frustration (i.e., negative reinforcement), and enjoyment derived from smoking (i.e., positive reinforcement).





Tobacco Products Use Among High School Students



Individuals with Intellectual & Developmental Disabilities (IDD)



Limited Data on tobacco use and individuals with IDD

- Men are more likely than women to use tobacco
- Individuals with intellectual and developmental disabilities and comorbid substance use disorders have lifetime tobacco use estimates of 83%
- Individuals with mild to moderate intellectual disabilities have higher smoking rates than those with more severe intellectual disabilities
- Even though individuals with IDD are more likely to see a doctor- they are not likely to receiving tobacco screening or intervention
- An individuals living in group home settings and living independently generally smoke more (20%) than people living with family members/significant others/friends (3 – 5%)





Treatment Modifications for Individuals with IDD

Intra-treatment support

- Enlist significant others (and treatment team if applicable) to express concerns about smoking and to listen to fears about quitting
- Identify roles for significant others to assist in efforts to quit if smoker were to make quit attempt

Practical counseling

- Be certain that any educational materials are understandable to client; use repetition to reinforce skills
- Clearly define terms such as *urge* or *craving* to smoke
- Be aware of length of counseling time smoker can tolerate
- Additional counseling sessions may be necessary
- Extra counseling sessions around “quit date”
- Allow time at end of counseling session to reinforce key concepts





High Rate of Smoking/Tobacco Use Among the Homeless

- Prevalence of smoking among homeless populations is between 60% and 80%
- Homeless adults spend a third of their monthly income on tobacco
- Homeless adults are targeted by the tobacco industry – nearby tobacco shops, discounted prices and low end tobacco products, free giveaways and samples at festival and events
- Homeless adults experience substance abuse and/or mental health concerns that can be exacerbated by heavy cigarette use
- Study done among clients from six homeless-serving agencies/shelters in Oklahoma City (N=396) indicated that rate of concurrent use of multiple tobacco products was high, at 67.2%.

Neisler et al., 2018



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High Rate of Smoking/Tobacco Use Among Sexual Minorities

- Disproportionate Impact Among LGBT
 - 20.5% of LGB adults smoke cigarettes compared to 15.4% of heterosexual adults
 - 2013 National Health Interview Survey: Modified from: Ward, Dahlhamer, Galinsky, & Joestl

(%) Current Cigarette Smokers	Both Sexes	Men	Women
Gay or Lesbian	25.8	25.8	25.7
Straight	17.6	20.3	15
Bisexual	28.6	28.8	28.5

*limited data for transgender adults

- Data from states is limited – only 6 states have published reports on tobacco use by sexual orientation
 - Arizona, California, Massachusetts, New Mexico, and Oregon/Washington (joint)

Source: CDC. Lesbian, Gay, Bisexual, and Transgender Persons Tobacco Use, 2018



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Why Such High Smoking Rates?

- Due to lower income:
 - Lack access to health insurance, health care, and help to quit
 - Often directly targeted for tobacco marketing*
- Chronic stress and ineffective coping skills*
- Environmental exposure and peer groups
- Lack social support systems
- Widespread misconceptions and myths about dual tobacco and substance use
- Are at higher risk because of perceived benefits of tobacco use on stress and anxiety reduction (CDC. Vital Signs, Feb. 2013)



*Will discuss in more detail later



Myths & Facts About Smoking Among People with SUD/Behavioral Health Conditions (BHC)



MYTHS:

- People with SUD/BHC:
 - do not want to quit smoking
 - are unable to quit smoking
 - will jeopardize their recovery by quitting smoking

FACTS:

- People with SUD/BHC:
 - are as motivated to quit as smokers without SUD/BHC
 - are able to quit, especially when offered proven treatments
 - who quit smoking have a lower risk of substance use relapse and decreased negative mental health symptoms

Source: CDC. Vital Signs, Feb. 2013; Prochaska et al, 2004; Taylor, 2014





Benefits of Quitting

Tobacco Use & Recovery



Quitting smoking does not jeopardize sobriety or treatment outcomes

- Smoking cessation interventions were associated with 25% increased likelihood of long-term alcohol and drug abstinence (Prochaska, 2004)
- In a recent review of quitting smoking programs on substance use, the majority of studies found:
 - For alcohol and other substances – decreased consumption, decreased relapse, and increased past year abstinence (McKelvey et al, 2017)
- Continued tobacco use can harm recovery and trigger other substance use (Williams, 2005; Kohut, 2017)

Not Treating Tobacco Dependence has Negative Treatment Outcomes



Treatment Outcomes for Smokers

- Increased opioid withdrawal
- Increased cravings
- Lower detox completion/ Methadone taper

Clinicians mistakenly believe smoking has positive psychological functions

- Use smoking as an indirect coping strategy
- Reinforces coping through addiction
- Perceived stress reduction is often relief of withdrawal symptoms

Smoking cessation (i.e., being abstinent from cigarette use after a period of withdrawal) is positively related to opiate and cocaine abstinence (Shoptaw et al, 2002)





Mental Health Improvements Associated with Quitting

- Quitting smoking is associated with significant decreases in anxiety, depression, and stress
- Increase in psychological quality of life and positive affect
- Associated improvements are greater than or equal to effect of antidepressants in depressive and anxiety disorders (Taylor et al., 2014)





Barriers to Intervention

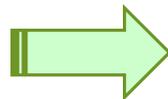
- Lack necessary knowledge and training about cessation treatments
- Reduced confidence in their abilities to deliver cessation treatments
- Persistent misconceptions and myths about the joint use of tobacco and other substances/mental illness and hinder recovery
- Fear that people will leave treatment
- Long standing permissive “culture of smoking”
- Clients report that “smoking helps with symptoms”
- Clients are under a lot of stress
- We don’t want to “police” tobacco use





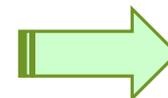
The 5 A's

ASK



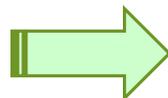
about tobacco USE

ASSESS



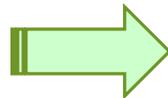
READINESS to quit

ADVISE



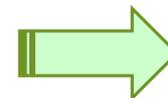
consumer to QUIT

ASSIST



with QUIT ATTEMPT

ARRANGE



FOLLOW-UP care





Why Use Nicotine Replacement Therapy?

NRT



- Helps relieve physical withdrawal symptoms
- Addresses a person's physiological need
- Delivers lower levels of clean nicotine



Nicotine from NRT = Nicotine from Tobacco

The amount of nicotine a person receives from their NRT should equal or be a little more than the nicotine they were receiving from their tobacco.

- People inhale approximately 1 mg of nicotine with every cigarette (regardless of brand; cigarettes are pretty standardized)
- There are 20 cigarettes in a pack of cigarettes
 - Little cigars or cigarillos are similar to cigarettes but have different packaging standards – may be sold individually, in packages or 2, 3, or 5 little cigars) – they are likely flavored as well.
- Spit tobacco (chew, snus, snuff) have differing nicotine concentrations and people use the products in many different ways.





Tobacco Treatment Medications

	Patches	Gum	Lozenge	Chantix (most effective)	Zyban/ Wellbutrin
Strength	21, 14, 7 mg	2, 4 mg		.5, 1 mg	150 mg
Dosing	1 patch/ 24 hrs	1 piece every 1-2 hours		<ul style="list-style-type: none"> • Days 1-3: .5 mg every morning • Days 4 - 7: .5 mg twice daily • Day 8 - end: 1 mg twice daily 	Days 1-3: 150 mg once in AM Day 4 – end: 150 mg twice daily
Advantages	Private Once a day	Offset cravings Reduces dependence		High success rates	Also treats depression
Adverse Reactions	Skin reaction Sleep Disturbance	Jaw tired/sore Hiccups	Indigestion Hiccups Insomnia	Nausea Abnormal, strange or vivid dreams Depressed mood, agitation, changes in behavior, suicidal ideation	Dry mouth Insomnia Do not use w/ seizure disorder or eating disorder



Two Week Cost Comparison

Nicotine Replacement Therapy

Nicotine patches

- Nicoderm CQ = \$41.99 (\$82.00 per month)
- Generic brand = \$27.49 (\$54.98 per month)

Nicotine gum

- Nicorette – 100 pcs = \$41.99 (\$82.00 per month)
- Generic – 100 pcs = \$25.99 (\$51.98 per month)

Nicotine lozenges

- Nicorette – 81 pcs = \$41.99 (\$82.00 per month)
- Generic – 81 pcs = \$23.99 (\$48.00 per month)

Cigarettes (one pack per day)

- Marlboro (@ \$5.76) x 14 days = \$80.64
- Camel (@ \$5.74) x 14 days = \$80.36
- Newport (@ \$6.99) x 14 days = \$97.86
- Kool (@ \$5.34) x 14 days = \$74.46
- Pall Mall (@ \$4.50) x 14 days = \$63.00
- Virginia Slims (@ \$6.58) x 14 days = \$92.12
- American Spirit (@ \$6.63) x 14 days = \$92.82

NRT is available in smaller quantities

- 72 count 4 mg lozenges = \$25.49
- 20 piece 2 mg gum (generic) = \$6.99
- 20 piece 4 mg gum (Nicorette) = \$9.99
- 10 piece 4 mg gum/lozenge (generic) = \$5.49



Great alternative
to purchasing a pack
of cigarettes



Medications for Tobacco Users - Summary

Medication Type	Availability
Nicotine Patch	Over the counter
Nicotine Gum	Over the counter
Nicotine Lozenge	Over the counter
Nicotine Inhaler	Prescription only
Nicotine Nasal Spray	Prescription only
Chantix / Varenicline	Prescription only
Zyban / Wellbutrin	Prescription only





Challenges of Psychotropic Medications & Tobacco Use

MEDICATIONS

- Lethargic
- Weight gain
- Insomnia, lack of concentration
- Nervous/anxiety

TOBACCO

- Boost energy
- Appetite suppressant
- Help focus, improves concentration
- Provides sense of relaxation/well-being

- Nicotine does provide some benefits to clients that may offset side effects from psychotropic medications.
- Nicotine replacement therapy can reduce anxiety attributed to nicotine withdrawal.
- Clients may use tobacco for the immediate relief of stress, but in the long-run, tobacco increases stress.
- This does not justify not helping clients quit tobacco.



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E-cigarettes and Electronic Nicotine Delivery Systems



Electronic Nicotine Delivery Systems (ENDS): To Vape or Not to Vape?

The National Academies of SCIENCES ENGINEERING MEDICINE



Evidence suggests ENDS are less harmful than traditional, combustible cigarettes, but not harmless

Research states:

- Presence of toxic substances (ie, fine/ultrafine particles, cytotoxicity, various metals, TSNA, and carbonyls), but lower levels than cigarettes
- Dual use of ENDS & combustible cigs common & is problematic
- Not effective method to quit smoking
- Long term health consequence of e-cigarette use unknown

Use of ENDS should be discouraged and not be used as a first line cessation method



*shown to demonstrate approximate scale

- a. Generic Combustible Tobacco Cigarette
- b. First Generation E-Cigarette
- c. Second Generation E-Cigarette
- d. Third Generation E-Cigarette

National Academies of Sciences, Engineering and Medicine. 2018. *Public health consequences of e-cigarettes*. Washington, DC: The National Academies Press

CA Cancer J Clin 2017;67:449-471. *Key Issues Surrounding the Health Impacts of Electronic Nicotine Delivery Systems (ENDS) and Other Sources of Nicotine*



Benefits of a Tobacco Free Policy

- Significantly reduces exposure to secondhand smoke
- Behavioral health providers have high smoking rates (between 30% to 50%)
- Does not impact client's willingness to seek treatment
- Benefits clients, staff, stakeholders, and community
 - Increases quit attempts and decreases number of cigarettes smoked per day
 - Increases effectiveness of medications
 - Promotes abstinence from other substances, lowers relapse rates
 - Lowers health costs
 - Reduces sick days of former smokers and their families





Engaging Tobacco Users on Tobacco-free Campus



- **Polite and Respectful:** Be empathetic & understanding
- **Listen to them:** Hear what they have to say
- **Educate:** Share information about the policy and why it is in place, inform them about cessation services, answer their questions
- **Be non-judgmental:** Don't make assumptions or criticize/blame people, be comfortable with yourself

<https://www.takingtexasobaccofree.com/copy-of-videos>





Resources

Clients:

- Quit Line 1-877-YES-QUIT
 - <https://www.quitnow.net/mve/quitnow?qnclient=texas> (click on the **Refer A Patient** in the upper right-hand corner).
 - Download the Texas QuitLine app (refer clients to the QuitLine from phone):
 - <https://www.uttobacco.org/our-programs/for-health-care-providers-and-emr-vendors>
 - <https://smokefree.gov/> (Text message quit programs for veterans, pregnant women, teenagers, Spanish-speaking people and older adults)
- Nicotine Anonymous (support groups, online, phone)
- Non-smoking AA & NA meetings (majority are smoke-free)
- On site NRT





Resources

Employees:

- EAP
- PCP co-pay and prescription reimbursement (spouses and eligible dependents included)
- Nicotine Anonymous, as well as non-smoking NA and AA groups
- On site NRT
- Quit Line 1-877-YES QUIT

