Fundamentals of Tobacco Interventions
WELCOME!

• Please take a few minutes to complete Learning Assessment 1 (in your folder)
• The purpose of this activity is to assess your perceived levels of feasibility, importance, and confidence in using the tools and interventions we will cover in this workshop
• This will not be collected, it is a self-reflection tool
These materials (and any other materials provided in connection with this presentation) as well as the verbal presentation and any discussions, set out only general principles and approaches to assessment and treatment pertaining to tobacco cessation interventions. They do not constitute clinical or other advice as to any particular situations and do not replace the need for individualized clinical assessment and treatment plans by health care professionals with knowledge of the specific circumstances.
Disclaimer

The recipient of the funding is in compliance with the CMA and the CPA guidelines / recommendations for interaction with the pharmaceutical industry.
Learning Objectives

At the end of this course, you will be able to:

– Describe why clinicians should implement tobacco cessation interventions
– Implement a structured, adaptable cognitive behavioral approach to smoking cessation
– List the pharmacotherapies that increase the odds of quitting
– Integrate cessation interventions into your clinical practice
Learning’s Quicker with a Clicker!

– Periodically throughout the course you will be invited to respond to a question with your iclicker.
– After everyone has input their answer, the screen at the front will display aggregate answers (no individual answers are shown).
– You will then be invited to discuss the question in a small or larger group.

Participants aren’t being graded, and there are no wrong answers.
Please remember to leave clickers on your table at the end of each day!
I-Clicker Tips

• I-Clickers are anonymous, fun learning tools which you will be using throughout the course
• I-clicker icons will cue you for an I-clicker question
• Faculty will read the multiple choice questions and you answer by pressing a correlating letter. Countdown of time shown on screen.
• Feel free to change your answer mid-question!!

1. Turn I-clickers on (green/red light tells you it’s on)
2. Keep I-clicker in safe spot for the full day (leave on table whenever not in use)
How long would it take the average person to count to a billion?

a. A day  
b. A month  
c. A year  
d. 10 years  
e. 100 years
“If you can count your money, you don’t have a billion dollars.”

-J Paul Getty

a. A day  
b. A month  
c. A year  
d. 10 years  
e. 100 years
Modules 1 • 2 • 3

1 Environment
2 Behaviour
3 Medication
Do you feel Tobacco is a gateway drug?

a. Yes, a high percentage of people who smoke cigarettes will be users of one or more substances
b. Yes, I think tobacco can lead to the use of other substances, but not for the majority
c. I think Tobacco can act as a gateway drug, but I also think other substances can lead to abuse of other drugs
d. No, I don’t think cigarette smoking leads people into trying other substances
e. University was my gateway into drugs
“Fast facts” on Tobacco Use in Canada

- Tobacco kills 1 in 5 Canadians, or 45,000 people every year (more than deaths due to traffic accidents, suicides, homicides, drug abuse and HIV-AIDS combined) (Physicians for a Smoke-Free Canada, 2003)
- Economic impact of smoking estimated at $17 billion every year (Rehm et al., 2006)
- 90% of people who smoke became addicted before age 18 (Fiore et al., 2008)
- Tobacco-related disease accounts for at least 500,000 hospital days each year in Ontario alone (MHP, 2009)
- 18% of Canadians age 15 and over are current smokers (CTUMS, 2008)
- Rates of smoking are much higher among sub-populations: e.g., 90% - people with schizophrenia, 90% - people with opioid dependence (Kalman, Morissette and George, 2005; NIDA, 2008)

Key Points
- Smoking is the leading cause of preventable death in Canada.
- It is a chronic relapsing disease with pediatric onset (90% of people become addicted before adulthood).
- Tobacco does not affect all Canadians equally. In fact, the most vulnerable Canadians are the ones most affected by smoking: marginalized populations such as people with mental illness, First Nations and Métis populations, LGBT populations, Canadians with lower education and income etc have higher smoking rates

References:
Why should health professionals get involved?

- Tobacco is the leading cause of preventable death in the developed world
- 70% of smokers want to quit, and the remaining 30% would likely choose to not start, or would not want their child to smoke (Fiore et al., 2008)
- Just 3-5% of unassisted quit attempts are successful, compared with up to 20% success for those receiving cessation counselling and medications (Fiore, Baker et al., 2008)
- Outcomes of evidence-based cessation interventions are comparable with other chronic disease management (hypertension, asthma, diabetes) (West and Shiffman, 2007)

Key Points
- The management of patients who use tobacco requires a chronic care model and a long-term view of treatment.
- All health care professionals should be encouraged to promote smoking cessation; it is a reasonable and cost-efficient treatment.
- For every 100 people you briefly intervene with, 2 will quit smoking.
- The cost of cholesterol interventions is approx $25,000-$50,000 per year and saves approx 6-7,000 lives – vs. smoking cessation, which costs approx $2,000 per year and saves 20,000+ lives.
- This is a treatable condition – few other medical treatments can yield such benefits.

Background
- Tobacco use/dependence is a chronic remitting/relapsing disorder similar to other chronic diseases such as asthma, congestive heart failure, and depression.
- Because tobacco use is ingrained into the lives of individuals, quitting is a challenging process that tends to cycle between smoking abstinence and relapse, and therefore resemble a chronic disease.
- Managing patients who use tobacco involves a long-term view of treatment and requires a chronic care model that includes counselling and advice interventions.1,2
- However, it is encouraging to know that appropriate interventions can produce successful, permanent results. (According to the CDC) in the United States, over half of those individuals who have ever smoked had successfully quit by 2004.3 In Canada, 52% of ever smokers in Canada have successfully quit smoking by 2004.6

References
5. CTUMS 2006.
What percentage of your client base smokes cigarettes and is dependent on one or more other substances?

a. more than 75%
b. 60 – 75%
c. 45 – 60%
d. 30 – 45%
e. less than 30 %
People with substance abuse problems are more likely to experience tobacco-related diseases than the general population

a. True
b. False
c. It depends on the substance they are abusing.

C. 50%
Understand tobacco dependence as a chronic disease and the need for a paradigm shift

► Key Points
These photos speak to the strength of the addiction, and the overwhelming loss of control that many smokers experience. Although the serious health consequences related to smoking are understood, many people are still unable to stop smoking.
Key Points

- Almost one billion men in the world smoke – about 35 percent of men in high-resource countries and 50% of men in developing countries. There are approximately 250 million women smokers worldwide: 22% of women in high-resource countries; and 9% of women in low and middle-resource countries.

- Male smoking rates have now peaked, and trends in low- and middle-resource countries indicate slow but sure declines. Tobacco is killing about 5 million men every year. Women smoking rates are declining in high-resource countries, but stable or increasing.

Interesting Fact

China consumes more than 37% of the world’s cigarettes, with 60% of the male population smoking. If the women of the world were to begin smoking at the same rate as men, this would be a global public health disaster. Preventing increases in smoking, in particular among women in low and middle-resource countries, will have greater impact on global health than any other single intervention.

Reference:
What percentage of Canadians are current smokers?

a. 13 %

b. 17 %

c. 22 %

d. 34 %

e. 41 %

Health Canada’s Canadian Tobacco Use Monitoring Survey (CTUMS) is a very good source for prevalence data.

17 (or 17.3%) is the correct answer
The Smoking Environment in Canada

- 17% of Canadians (~5 million) 15 years or older are current smokers
- 27% are former smokers
- 56% never smoked
- 55.1% of daily smokers have their 1st cigarette within 30 minutes of waking up. 75% within the hour!

CTUMS, 2009

Key Points

- From 1999-2009, while the number of Canadians aged 15 years and older has risen by 12% (about 24.3 million in 1999 to 27.3 million in 2008), the number of current smokers* has fallen by 20% (about 6.1 million in 1999 to 4.9 million in 2008).
- In 2008, 18% of the Canadian population aged 15 years and older (about 4.9 million Canadians) were current smokers. This represents the first statistically significant decrease since 2004 (20%).
- 55.1% of current smokers have their first cigarette within 30 minutes of waking up indicates a high level of addiction to nicotine.

* current smokers = daily plus occasional smokers
When does a person’s risk of developing lung cancer becomes more than 10 times the risk of a non-smoker?

a. Up to 10 cigarettes per day  
b. Between 10-19 cigarettes per day  
c. 20 cigarettes per day  
d. Between 21-31 cigarettes per day  
e. More than 31 cigarettes per day

► Key Points

■ Although there is a significant range of what is agreed to as the exact number of Canadians who die from smoking each year, the point is that it’s a very large, and concerning number.
  • 35,000-48,000 is equivalent to a small town disappearing every year  
  • Metaphor: A jumbo jet crashing twice a week for a year would be equivalent to the number of smokers that die each year in Canada.  
  • Cigarettes used as they are intended by their manufacturers will kill 50% of their consumers.

☼ Background

■ The 48,000 figure is the upper confidence bound. Some people believe a more accurate figure is about 35,000 deaths/year. Showing the estimate as a range between 35,000 to 48,000 deaths per year is most accurate, depending on assumptions made for the estimate.

Reference:

WHO Report on the Global Tobacco Epidemic  
Differences by Province

Average Number of Cigarettes Smoked Per Day (Ages 15+)

- Newfoundland and Labrador: 14.1
- Prince Edward Island: 14.7
- Nova Scotia: 15.5
- New Brunswick: 15.5
- Quebec: 14.9
- Ontario: 15.5
- Manitoba: 13.6
- Saskatchewan: 14.8
- Alberta: 14.2
- British Columbia: 14.1

CTUMS, 2008

► Key Points

• The average number of cigarettes smoked per day across the provinces is between 13 and 16 cigarettes, with the national average at 14.9 cigarettes per day.

• Also worth noting is the prevalence rate of current smoking among Canadians aged 15 years and older was higher in rural communities (21%) in Canada compared to urban communities (17%), however, a much larger number of smokers live in urban communities (about 3.7 million smokers) versus rural communities (about 1.0 million smokers).

* CTUMS currently does not collect data on smoking rates in the Territories; CTUMS 2008 is the most recent annual data available at press time.

Reference:
What is the province with the highest smoking prevalence?

a. Newfoundland and Labrador  
b. Quebec  
c. Saskatchewan  
d. Manitoba  
e. Alberta

Answer: Saskatchewan
**Key Points**

- This shows the comparison between the number of current smokers from 1999 to 2008.
- You will notice that all provinces have reduced the prevalence of smoking in this 9 year time frame. This is likely due to many factors including increased cessation strategies and population based approaches such as increased taxation and stricter by-laws.
- Manitoba has seen the smallest reduction in smoking prevalence, which may be due to a weaker tobacco strategy unable to help with both population and clinical based strategies.
- British Columbia has led the trend with the least consumption. They are also leaders in bringing forth smoke-free laws.
Key Point
- There is a negative correlation between socio-economic status and smoking levels: people with lower education and income are more likely to smoke.

Reference:
Gender Differences

- Males smoke more than females (18.9% vs. 15.7%)
- Men 23-24 have the highest smoking rates (27%)
- Men smoke more cigarettes consumed per day
  - Male 14.3
  - Female 12.3
- Young men smoke more than young women (15-19)
  - Male 15.6%
  - Female 11.8%

► Key Points

- This slide compares gender differences in the numbers of cigarettes smoked per day (cpd).
- The gender gap is much less than it was decades ago when it was not as socially acceptable for women to smoke. We can see with the younger generation that the gap is even less evident between the genders.
- However, men and women sometimes smoke – and quit smoking - for different reasons, which emphasizes the need for a tailored quit plans. For example, women may be more likely to seek out help.
- Given their complex anatomy and physiology, women are also more susceptible to health issues than men from smoking.
Levels of Interventions

• Minimal / Brief Contact
  – Delivered during the course of a regular health care encounter in less than 3 minutes.
    i.e.: 5A’s

• Intensive Interventions
  – Multi-session counselling programs involving extensive contact with a health care provider/counsellor
  – Inpatient programs (Mayo Clinic)

• Self Help


► Key Points

• Brief interventions can be effectively utilized by such professions as dentists, pharmacists, respiratory therapists, laboratory technicians etc., as they may see clients for short periods of time where a 2-3 minute intervention is both effective and reasonable to provide.

  • The intervention can be as simple as asking: “Are you a smoker? Have you ever tried to quit?” followed by a referral to a quitline or another health care professional for more intensive support.

• Keep in mind the way that questions are asked. Don’t approach a smoker (with above-mentioned questions) with an accusatory tone. Stay open and non-judgemental.

• Health care professionals who see clients for long durations over a longer period of time may be in a good position to offer intensive interventions along with the other services that they provide.

• There are many online websites, quit lines, books and self-help groups available for clients who prefer to quit on their own or in a peer-led forum. More about these options is available in the appendices.

References:
Available online at: http://www.ahrq.gov/clinic/tobacco/tobaqrg.htm
People with concurrent substance use disorders and tobacco use need to address the other substance use first in treatment?

a. True
b. False
Smokers who abuse alcohol are ___ % less likely to quit smoking

a. 95%
b. 60%
c. 45%
d. Smokers who abuse alcohol have similar patterns of quitting as non alcohol-dependent smokers

B. 60%
The most prevalent attitude that impedes addiction or mental health clients from receiving tobacco interventions is:

a. It's a violation of the client's human rights.

b. These clients cannot quit smoking, nor do they want to quit smoking.

c. Taking cigarettes away would be eliminating their last pleasure.

d. Treating the tobacco issue is not a priority- there are too many other issues to worry about.

e. All of the above.

E. All of the above.
Brief Cessation Interventions: The “5As”

- Ask about tobacco use
- Advise to quit
- Assess willingness to make a quit attempt
- Assist in quit attempt
- Arrange follow-up

Fiore et al. 2008.

► Key Points

• A brief cessation intervention (the 5 A’s) is key to ensure that as a clinician you are matching the appropriate interventions with what the client needs (treatment matching).

• Not all clients will need intensive interventions – but some will. Being well versed in both will enable health care professionals to effectively manage resources. Make sure that all clients/patients are asked about their smoking or tobacco use, and then arrange next steps. This ‘check in’ should be routine, and can take as little as 3 – 10 minutes in a doctor’s office.

• What are the disadvantages of this framework? We know that quitting smoking may be extremely hard and can be a chronic and relapsing addiction.

• Does it make sense to offer brief interventions for such a chronic condition? Evidence suggests it can make a significant impact in increasing quit attempts.
Quitting Smoking at any Age Can Increase Life Expectancy

Increased Life Expectancy

<table>
<thead>
<tr>
<th>Age stop smoking by</th>
<th>Life years gained</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 years</td>
<td>10</td>
</tr>
<tr>
<td>&lt;40 years</td>
<td>9</td>
</tr>
<tr>
<td>&lt;50 years</td>
<td>6</td>
</tr>
<tr>
<td>&lt;60 years</td>
<td>3</td>
</tr>
</tbody>
</table>

Quitting smoking before the age of 30, normal life expectancy

Doll R et al. 2007

► Key Point

• The positive impact of quitting smoking is now well established. Clinical benefits include increased life expectancy.

Reference:
Effective Amount of Contact Time

<table>
<thead>
<tr>
<th>Total Contact Time</th>
<th>Estimated Abstinence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>11.0 %</td>
</tr>
<tr>
<td>1 – 3 minutes</td>
<td>14.4 %</td>
</tr>
<tr>
<td>4 – 30 minutes</td>
<td>18.8 %</td>
</tr>
<tr>
<td>31 – 90 minutes</td>
<td>26.5 %</td>
</tr>
<tr>
<td>91 – 300 minutes</td>
<td>28.4 %</td>
</tr>
<tr>
<td>&gt; 300 minutes</td>
<td>25.5 %</td>
</tr>
</tbody>
</table>

Need to consider resources available

Fiore et al., 2008

► Key Point

- Clinicians need to take into consideration the resources they have that are available. The treatment provided should be assessed and match each clients’ needs and readiness to take action, accordingly.
Smoking as an Addiction
Have you ever been skinny-dipping?

a. Yes, but only once
b. Yes, but only a couple times when I was younger
c. Yes, I went last night
d. Never
Tobacco and Nicotine

- Tobacco is a plant that contains nicotine
- Nicotine is one of the major addictive components in tobacco
- It has both stimulant and depressant effects

Nicotine is not known to lead to any diseases such as COPD or cancer. It is the 4,000 other chemicals in cigarette smoke that contributes to these diseases.

► Key Points

- Other plants belonging to the nightshade family (e.g. eggplants, tomatoes, potatoes and red peppers) also contain nicotine – however their nicotine levels are much lower than what is found in tobacco. Nicotine likely acts as a natural insecticide for the plant itself – and indeed tobacco leaves can be used to brew an organic insecticide to use against bugs attacking other plants.

- In Canada, not many chemicals are added to cigarettes. Nonetheless, chemicals are released when the cigarette is burned – including more than 50 that cause cancer – resulting in a combination of particulate and gaseous matter which we collectively call ‘tar’ that provides flavour and other taste sensations.

- Many of our clients believe that nicotine is the harmful chemical in cigarettes and therefore are resistant to trying NRT. It is important to educate clients about how nicotine works, and that the other chemicals involved in burning tobacco and the paper found in a cigarette are responsible for the morbidity and mortality of smoking.

References:
Which of the following chemicals can be found in cigarettes?

a. Arsenic - a deadly poison, used in insecticides
b. Formaldehyde - used to preserve dead bodies
c. Cadmium - a highly poisonous metal used in batteries
d. Shellac - wood varnish when mixed with a form of alcohol
e. All of the above

Answer: E
Tobacco and Carcinogens

- More than 60 carcinogens are in cigarette smoke
- A minimum of 16 carcinogens are in unburned tobacco


► Key Points
- There are 4000 chemicals in cigarette smoke.
- Cigarette smoking is the single largest preventable cause of death and disability in developed countries
- More than 50 known carcinogens are in cigarette smoke. These carcinogens vary in their potency and concentration within cigarette smoke.
- The smoke produced by a single cigarette contains 1 to 3 mg of carcinogens and 0.5 to 1.5 mg of nicotine.
- Because most carcinogens are formed during combustion, unburned tobacco has fewer carcinogens than cigarette smoke. However, use of oral tobacco products is associated with certain kinds of cancer.

References:
Tobacco is a legal product.....

Key Point
• This product, used exactly as intended, kills about half of its users. If it were a new product just introduced today, no government would allow it to be sold. And unlike any other consumer product on the market, it is exempt from declaring its contents.

- Carbon Monoxide – an odourless, tasteless & poisonous gas
- Formaldehyde- used to preserve dead bodies
- Hydrogen Cyanide- a deadly poison
- Ammonia- found in cleaning fluids
- Urethane* - found in upholstery foam, plastics, carpets, etc.
- Hydrazine *- used in rocket fuel (for air bags, etc.)
- Nickel- corrosion resistant & has a slow rate of oxidation
- Arsenic-a potent poison used in insecticides, chemical warfare and wood preservation
- Cadmium * used in batteries, steel and as a plastic stabilizer
  • * = also carcinogenic

Facilitator Tip
Use the questions below to initiate a discussion with participants:
• Why do you suppose that is so?
• What do you think of the tobacco industry's role in positioning cigarettes as a 'lifestyle choice' instead of drug delivery system? Philip Morris in 1972: "Think of the cigarette as the dispenser for a dose unit of nicotine, and the pack as a storage container for a day's supply of nicotine." (2)
• Would banning cigarettes work? What can we learn from the US's prohibition of alcohol in the 1930s?
• What do you think that the impact might be if there was some sort of 'Nicotine Regulatory Agency' that would subject all tobacco products to the same sort of safety standards that all other consumer products are subjected to? (Probe – might this help to inform people of what they are exposing themselves to when smoking tobacco, and debunk the myths and deceptions of 'light and mild' and remind them that there is no safe cigarette?)

References:
2. Bates et al., 1999
Key Points

- Filters have been standard since 1954 following a spate of concerns by MDs that smoking was associated with lung cancer.
- Only a portion of the tobacco comes from the leaf. A significant amount comes from “reconstituted tobacco”, also known as “homogenized sheet tobacco”, which is made from the pulp of mashed tobacco stems and other waste from the tobacco plant. This is sprayed and impregnated with nicotine and approximately 600 additives.
- Ammonia aids in the delivery of nicotine and chocolate masks the bitter taste of tobacco. This is sliced to resemble shredded leaf tobacco.
- Puffed or expanded tobacco allows companies to produce more cigarettes per pound of tobacco grown.
- Tobacco leaf is saturated with freon and ammonia before being freeze dried. This expands the tobacco to at least double its natural state.

Background

A cigarette is a highly engineered drug delivery device designed to get nicotine to the brain as rapidly as possible (the faster the drug hits the brain, the greater the potential for addiction). Strategic holes in the filter dilute the smoke when tested by conventional ‘smoking machines’, but smokers tend to cover them up when smoking with their lips or fingers. This is a tactic that the tobacco industry is aware of that allows them to post seemingly low tar and nicotine ratings on the package. When actually smoked, such products can easily deliver higher tar and nicotine levels when the holes are blocked by the smoker.

The concentric rings also known as “burn rings” correspond to two different thicknesses of paper that slow the rate of burning when the smoker is not inhaling, but speeds it up as the smoker inhales. The paper is impregnated with a host of chemicals including titanium oxide that acts as an accelerant. The chemicals account for many cigarette-caused fires.

Cigarette paper is also carefully designed to control the burn rate when smoked – and to remain lit so that it will continue to burn away when sitting in an ashtray not actively smoked. This helps to increase the number of cigarettes used and maintains tobacco sales.

Reduced propensity cigarettes (RIP) will stop burning when left idle.
How familiar are you with the delivery system and the immediate effects of cigarette smoking on the body?

a. Very familiar – I could give this talk myself!

b. Somewhat familiar – I have a pretty good grasp of it.

c. Not very familiar – I know some bits and pieces.

d. Speak slowly…This will be new info for me!
Key Points

- Addictive drugs activate the reward system via increasing dopamine neurotransmission.

- In this slide, the reward pathway is shown along with several drugs that have addictive potential. Just as heroin (morphine) and cocaine activate the reward pathway in the VTA and nucleus accumbens, other drugs such as nicotine and alcohol activate this pathway as well, although sometimes indirectly. While each drug has a different mechanism of action, each drug increases the activity of the reward pathway by increasing dopamine transmission.

- Because of the way our brains are designed, and because these drugs activate this particular brain pathway for reward, they have the ability to be abused. Thus, addiction is truly a disease of the brain. As scientists learn more about this disease, they may help to find an effective treatment strategy for the recovering addict.

Facilitator Tip

- Point to the globus pallidus, an area activated by alcohol that connects to the reward pathway.
How many people do you need to immunize to prevent 1 person from getting the flu?

a. 3  
b. 7  
c. 14  
d. 24  
e. 100

Answer:
How many smokers do you need to intervene with to get one (1) quit?

a. 4  
b. 9  
c. 18  
d. 45  
e. 100

You need to intervene with 9 smokers.
Break Time 15 minutes
BEHAVIOUR
What type of vacation would you like to take next?

a. Adventure
b. Beach
c. City
d. Stay-cation
e. Cruise
“Why do people smoke . . . to relax; for the taste; to fill the time; something to do with my hands. . . . But, for the most part, people continue to smoke because they find it too uncomfortable to quit”

Philip Morris, 1984

References:
Assessing Tobacco Dependence
Assessment

- Components of Assessments
  - History of smoking and quit attempts
  - Level of Nicotine dependence
  - Withdrawal
  - Reasons for smoking, reasons for wanting to quit
  - Social environment
  - Co morbidities – psychiatric, and/or other substance use
  - Intrinsic Motivation and self-confidence
  - Client’s goals, views of treatment, preference for treatment

Abrams et al, 2007

Key Points

- Here we see components of a thorough tobacco use assessment – to be undertaken with each client seeking help to quit.
- Recall that assessments may be structured or unstructured, and certain aspects such as smoking triggers, withdrawal, social environment and motivation can change and therefore should be reviewed from time to time.
- The outcomes of your assessments will guide you towards the appropriate course of treatment. Research suggest that the above major areas to evaluate in order to create an optimal treatment plan:
  - We will be discussing specific tools that you can use shortly – and these tools and scales are included in your Appendices and on the CD-Rom.
  - Prochaska and DiClemente’s Stages of Change theory originated in the 1980s and has been applied to many behaviour changes other than smoking cessation. It has also come under some debate over the past few years.
    - There is little research showing that movement through the stages is orderly or that these stages are not mutually exclusive. Even though this model is important in terms of self-awareness, issues about the authority of evaluating stages restrict its practicality.
    - It is just one tool to help you understand your client’s relationship with their tobacco use, how receptive they might be to certain approaches you take, and how you can tailor your approach to be most acceptable to your client’s readiness to change.
- The Stages of Change theory has been subject to criticism on theoretical and empirical (research) grounds. This will be discussed further in upcoming slides.

References:
Do you ask each client about their tobacco use?

a. All the time, this is a key component to their assessment
b. Most of the time
c. Not as often as I would like to
d. Occasionally- mainly when it is obvious the client is a smoker
e. Almost never– smoking is minor compared to the other issues my clients face
Screening for Tobacco Use

• Screening for tobacco use is a critical component of treating tobacco use
• In a primary care setting treating tobacco use through brief intervention necessitates the fulfillment of the 4 A’s model similar to that used for unhealthy alcohol use
• CDC guidelines recommend expanding the vital signs to include tobacco use, using tobacco stickers on all patient charts, or indicating tobacco use status either through the physician’s electronic medical record or any other form of computerized reminder system employed by the physician
• Such a system would ensure systematic identification of all tobacco users at every visit
# Fagerstrom Test for Nicotine Dependence

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How soon after you wake up do you smoke your first cigarette?</td>
<td>Within 5 minutes</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>6 to 30 minutes</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>31 – 60 minutes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>After 60 minutes</td>
<td>0</td>
</tr>
<tr>
<td>2. Do you find it difficult to refrain from smoking in places where it is forbidden such as the library, or movie theatres?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>3. Which cigarette would you hate most to give up?</td>
<td>The first one in the morning</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>All other</td>
<td>0</td>
</tr>
<tr>
<td>4. How many cigarettes do you smoke? (20 in a pack)</td>
<td>10 or less</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>11-20</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>21-30</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>31 or more</td>
<td>3</td>
</tr>
<tr>
<td>5. Do you smoke more frequently during the first hours after waking than the rest of the day?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>6. Do you smoke if you are so ill that you are in bed most of the day?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>
# Fagerstrom Scoring

<table>
<thead>
<tr>
<th>Score</th>
<th>Addiction Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>Very Low Addiction</td>
</tr>
<tr>
<td>3-4</td>
<td>Low Addiction</td>
</tr>
<tr>
<td>5</td>
<td>Medium Addiction</td>
</tr>
<tr>
<td>6-7</td>
<td>High Addiction</td>
</tr>
<tr>
<td>8-10</td>
<td>Very High Addiction</td>
</tr>
</tbody>
</table>
Calculate Pack History

# of cigarettes / day  X  # of years smoked

______________________________________________________________________

20

= 

___ pack years
Brief Tobacco Interventions

• CDC guidelines recommend brief interventions to assist patients with smoking cessation
• The CDC guidelines demonstrate a dose-response relationship between session length and abstinence rates, an increase in abstinence rates with increasing “total amount of contact time” up to a maximum of 90 minutes, and a dose-response relationship between number of session and treatment effectiveness
Practice Guidelines

• Among the most authoritative resources regarding the treatment of tobacco use is the CDC Clinical Practice Guidelines Treating Tobacco Use and Dependence (2008, Fiore et. Al.).

• This extensive document covers the assessment of tobacco use, clinical interventions for tobacco use and dependence, intensive interventions for tobacco use and dependence, systems interventions, evidence and recommendations, and specific populations, as well as additional topics of interest.

• Available at:
  http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf
From your experience, how motivated are your clients to quit smoking while in recovery for another substance?

a. Very motivated
b. Slightly motivated
c. Reluctant about the idea
d. Not motivated at all, cigarettes help them get through the day
All Smokers Benefit From Proactive Assistance to Quit

- Motivation to quit does not predict response to treatment
  - Motivation can increase when effective treatment is offered
- Smokers with low motivation can achieve high continuous abstinence rates
- Irrespective of motivation, all smokers should be actively offered assistance to quit

Key Points
- Motivation is not a personality trait or inherent to someone’s character, it is a dynamic state that can be a product of how the clinician engages the client.
- First and foremost the clinican needs to examine his/her own beliefs about change and convey the belief to all clients that change is possible. Without communicating this, the clinican could become the client’s first barrier to change.
- Both client and clinician should remember that quitting smoking is a process, not a linear event.
The Spirit of Motivational Interviewing

• Ambivalence is a normal human condition

• Underlying spirit: collaborative, evocative, supporting autonomy

► Key Points
• Be wary of the ‘yes, but…’ when you provide suggestions (where the client has a reason why each suggestion won’t work). Consider who is more invested in making this change
• This response is a function of ambivalence towards change. The clinician’s goal is to organize the conversation so that the client argues for change and actively struggles to identify ideas for change (instead of us taking on the role of champion for change).

♫ Facilitator Tips
• Ask the participants if they have ever felt like they are working really hard with their clients, making lots of helpful suggestions, based on years of clinical experience, and the client consistently shoots down their suggestions?
• Give concrete examples of therapist statements and client responses, e.g., a client who is not responding to ways to access nicotine replacement.
When prompted, a client says she is smoking a pack a day, has no plans to quit any time soon and does not want to talk about it. How do you proceed?

a. Speak about the aids of counselling and medication to ease in a quit attempt
b. Emphasize the importance of quitting, and suggest choosing a quit day
c. Acknowledge what she has told you and move on, leaving the door open for future discussion
d. Coax her into going over assessment tools such as the Decisional Balance Sheet to establish how she feels about her smoking
e. With caution!

Opinion poll.
Key Points

• Change is a process, which both relapse and ambivalence can be a part of. But, it’s important to remind the client that even periods of abstinence from smoking can have health benefits.

• A clinician’s long term goal may be to encourage the client to make a quit attempt, but our short term goal may simply be helping the client get ready to make a change by working with ambivalence.
Key Points

- **Precontemplation**: Increase salience of potential risks and problems.
  As clinicians, we may see clients for reasons other than smoking, though it could be an opportunity for a teachable moment, to gently engage or educate clients about smoking (e.g. talking about light vs. mild).
- **Contemplation**: “Tip the balance” toward change.
  A decisional balance helps to bring out all the pros and cons of smoking. It is important to spend time with clients on what they like and do not like about smoking and validating those items. The process of putting all these reasons down on paper is helpful as it makes them less abstract. Hanging the decisional balance sheet on the fridge or somewhere visible so they can be reminded of their reasons for wanting to reduce or quit may be a good idea.
- **Determination/Preparation**: Reinforce reasons for change and provide practical advice.
  Making a commitment helps clients work towards their goal. Many people may be fearful of setting a quit date. A less intimidating alternative could be setting a “trial quit day”, where the client commits to one day of no smoking. Often clients do well on this one-day attempt which increases their confidence level. Help the client design a quit day so they have a plan in place for difficult situations. Now that they’re ready, will the client be attending groups? What supports are they looking for?
- **Action**: Provide practical advice on how to change, explore and respond to potential relapse.
  The client could discuss positive changes they may experience during quitting eg. breathing easier, saving more money, etc. Reinforce that quitting is not a one-day event but a process that is going to take some time to go through. Celebrate the successes.
- **Maintenance**: Assess the strategies that have been successful reinforce benefits of continued change.
  Acknowledge all the hard work the client has done to get to this stage. Continue to talk about relapse prevention.
Most people who smoke want to stop; fewer than what percentage of unassisted attempts last one year or more?

a. 0 – 4%
b. 5%
c. 25%
d. 50%
e. 75 – 100%

b. 5%
Change is not something you do to people, but with people.

► Key Point

• The core philosophy of Motivational Interviewing (MI) is to work in a respectful, collaborative way with our clients. Although it would be nice if clients always followed our advice, we know from hard-earned experience that this is seldom the case. In effect, MI affirms a very real truth: that change is only in the hands of the client, and we are simply along for the journey with them.
DSM-IV Diagnostic Criteria for Nicotine Dependence

In the DSM-IV 3 or more of the following criteria are required for a diagnosis of Nicotine Dependence:

1. Tolerance
2. Withdrawal. Requires daily use for at least several weeks. A minimum of 4 withdrawal symptoms are required. The withdrawal symptoms must “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.”
3. The substance is used in larger amounts or over a longer period than was initially intended.

► Key Point

• In the Diagnostic and Statistic Manual of Mental Disorders (DSM-IV, American Psychiatric Association), nicotine dependence is included under the general definition of substance dependence. The essential feature of substance dependence is a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. The DSM definition of nicotine dependence has seven criteria, four of which concern the impact of the substance use (criteria 2, 5, 6, 7).

Reference:
DSM-IV Diagnostic Criteria for Nicotine Dependence cont.

4. Unsuccessful efforts to cut down, regulate, or discontinue use.
5. A great deal of time spent obtaining the substance, using the substance, or recovering from its effects.
6. Important social, occupational, or recreational activities may be given up or reduced because of substance use.
7. Substance use continues despite the individual’s realization that the substance is contributing to a psychological or physical problem.
### DSM-IV Criteria Dependence

<table>
<thead>
<tr>
<th>Persistent desire or inability to stop</th>
<th>Most smokers want to stop, fewer than 5% of unassisted attempts last a year or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued use despite harmful consequences</td>
<td>Most smokers are aware of health risks and want to stop because of them, but feel unable to do so</td>
</tr>
<tr>
<td>Withdrawal syndrome</td>
<td>Experienced by majority of smokers</td>
</tr>
<tr>
<td>Use of more of the drug or use for longer than intended</td>
<td>Many smokers try to cut down but cannot maintain reduction; many learning to smoke believe they will stop before the damage is done but few manage to do so</td>
</tr>
</tbody>
</table>


> **Key Points**

- The first two points speak to the level of dependence in those people you may see smoking outside a hospital in a hospital gown, with an IV pole attached to their arm, and it's -30.
- Many smokers are unaware of withdrawal symptoms, they might confuse alleviation of withdrawal with a cigarette's ability to reduce anxiety and/or stress. Smoking might help them feel better when they feel edgy or uncomfortable, but really they may have alleviated early onset of withdrawal symptoms by smoking when the nicotine levels in their blood dropped below the comfort zone.
- The point about “Use of drug longer than intended” could refer to a young person who decides to try smoking at the age of 11 or 12 and smokes intermittently for months or years. They have not consciously made a decision to become a pack a day smoker for the next 30 years because they had the perception of “control” for the first weeks, months or even years of smoking.

**Reference:**
DSM-IV Criteria Dependence (2)

<table>
<thead>
<tr>
<th>Important activities forgone because of the drug</th>
<th>Heavily dependent smokers may give up or interrupt activities in non-smoking areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tolerance; diminished effect with continued use</td>
<td>In the case of nicotine, tolerance is mainly to the aversive effects</td>
</tr>
<tr>
<td>A lot of time spent obtaining the drug, using it or recovering from its effects</td>
<td>Criterion related mainly to illicit drugs or those that impair function (intoxicating drugs)</td>
</tr>
</tbody>
</table>


Key Points
- As smokers get more and more dependent many activities like physical exercise, walking up the stairs or jogging around the block becomes too unpleasant to bear.
- Many people don’t love their first cigarette and people don’t start smoking by smoking a whole pack over the course of one day. Tolerance and dependence gradually increases over time.
- Some people may not be able to afford brand name cigarettes, which may result in picking butts up off the streets, asking strangers for smokes, or buying contraband.

Facilitator Tip
- Ask participants if anyone has any specific examples from their clients that would illustrate these points? E.g. smokers giving up plane trips because they can’t smoke while flying etc.
### Daily Diary - Baseline

Think back to the last week starting today and make a note when you engaged in the current behaviour(s).

<table>
<thead>
<tr>
<th>Date</th>
<th>Behaviour</th>
<th>Describe the situation (e.g., were you alone or with others, at home or in a social setting, etc.)</th>
<th>Thoughts and Feelings (What were you thinking and feeling in this situation?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
<td></td>
<td></td>
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<td>Wednesday</td>
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<td>Thursday</td>
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<td>Friday</td>
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<td></td>
</tr>
<tr>
<td>Saturday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

► **Key Point**

- The Daily Diary is a way to have clients identify their tobacco use, without asking them to change. The Daily Diary can help clients to become more conscious of their smoking behaviour and see patterns that they may not have been aware of.
Tools / Scales to Consider

- Fagerstrom Test for Nicotine Dependence
- Heaviness of Smoking Index
- Beck Inventory of Depression
- Beck Anxiety Inventory
- Why you Smoke Scale
- Reasons for Quitting Questionnaire
- Minnesota Withdrawal Scale
- QSU – Questionnaire of Smoking Urges
- Cigarette Withdrawal Scale
- Coping with Temptations Inventory (CWTI)
- Smoking Consequences Questionnaire

► Key Points

• These tools and scales have been developed to help collect information to help both you and your client learn about the role that smoking plays in your client’s life, and to provide some insight as to what issues should be addressed to help them reduce or eventually quit smoking.

• Fagerstrom Test for Nicotine Dependence was originally used to determine dose of NRT.

• Heaviness of Smoking: two questions form the Fagerstrom.

• Beck Inventory of Depression: used to monitor mood in the quit process, not to diagnose. Evidence suggesting that people who score ten or higher will have a more difficult time quitting smoking.

• Beck Inventory of Anxiety: many anxiety symptoms overlap with nicotine withdrawal.

• Minnesota Withdrawal Scale, QSU, Cigarette Withdrawal Scale: all equally valid, no scale has significant advantages over the others. Minnesota Withdrawal has the advantage of brevity.

• Samples of each are in your appendices and on the CD-Rom so that you can make multiple copies to use and distribute as needed.

• We will also be using some of them in activities later today.

• Base your selection to use upon what seems most appropriate for the client. They all contribute towards understanding smoking behaviour, levels of addiction, and decisions about medications.
What do you plan to do after this course, with respect to tobacco assessment?

a. I will ask every client if she or he uses tobacco
b. I will use structured tobacco assessment tools with every client
c. I will ask some clients, but not every client
d. I will use structured tobacco assessment tools with some clients but not all clients
e. I will let the person self-identify her or his use of tobacco (I will not ask directly)
Behaviour Change Roadmap: THE 4 POINT PLAN
What is your smoking history?

a. Never smoked
b. Former smoker
c. Current, regular smoker
d. Current, occasional smoker

It’s important to reflect on how our smoking history informs our attitude towards smoking and tobacco users.
4 steps to stopping destructive behaviours and leading a healthier life:

1. STRATEGIZE
2. TAKE ACTION
3. OPTIMIZE
4. PREVENT RELAPSE (PERSEVERE)

► Key Points

- The STOP acronym describes four psychosocial intervention steps to follow in sequence, to change behaviour and adopt a healthier lifestyle.
- The tools themselves that we will be presenting are not all specific to tobacco alone. They help guide the client towards quitting smoking, but can be used for other behaviour changes as well.
Setting the Stage

• Important aspects to consider
  – Quitting is a process
  – Automatic behavior: not always a conscious process
  – A pack/day = 110,000 hand to mouth repetitions/year
  – Linked with many behaviors: meals, alcohol, waking up, coffee, environment – group homes, smoking rooms in hospitals
  – Linked with social relationships: breaks at work, parties, friends houses

► Key Points
• Smoking is an automatic/ritualistic behaviour. Some clients may not even remember lighting their cigarettes, and could have two going at once.
• Using Cognitive Behavioural Therapy (CBT), we aim to make smoking a more deliberate, conscious process using the behavioural strategies we teach our clients, which we will review later (eg. smoking outside, tracking sheets).
• The significance of the hand-to-mouth repetitive behaviour cannot be overemphasized. Smokers probably don’t do anything more a day other than blinking.
• Clients may need to be encouraged to replace the cigarette with another object like a straw, elastic, worry beads, rubix cube etc., as many are so used to smoking that they can be at a loss when they have nothing to do with their hands.
Symptoms          | Duration | Prevalence |
------------------|----------|------------|
Irritability / Aggression | < 4 weeks | 50%        |
Depression        | < 4 weeks | 60%        |
Restlessness      | < 4 weeks | 60%        |
Poor concentration| < 2 weeks | 60%        |
Increase appetite  | > 10 weeks | 70%        |
Light-headedness  | < 48 hours | 10%        |
Night-time awakenings| < 1 week | 25%        |
Constipation       | > 4 weeks | 17%        |
Mouth ulcers      | > 4 weeks | 40%        |
Urges to smoke    | > 2 weeks | 70%        |

Key Point

• This is a sample guideline of the duration of common nicotine withdrawal symptoms. Notably, not every person who quits may experience any or all of these symptoms in any given order. Heaviness of smoking may play a role in amount and intensity of withdrawal symptoms experienced, where those who smoke more than 10 cigarettes per day may notice more salient symptoms. These signs may be interpreted as a positive signal as your body’s way of healing itself of the chemicals absorbed from smoking cigarettes.

Reference:
http://www.quitsmokingsupport.com/withdrawal1.htmX
What is your experience in facilitating cessation groups?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>I have run tobacco cessation treatment groups</td>
</tr>
<tr>
<td>b.</td>
<td>I have run tobacco cessation psycho-educational groups</td>
</tr>
<tr>
<td>c.</td>
<td>I have run treatment groups for other substances/issues</td>
</tr>
<tr>
<td>d.</td>
<td>I have run psycho education groups for other substances/issues</td>
</tr>
<tr>
<td>e.</td>
<td>I have limited experience cessation facilitating groups</td>
</tr>
</tbody>
</table>
Step 1: STRATEGIZE
1. Strategize

- Can take 1 session or can happen over several
- Involves developing a quit plan:
  → Tracking smoking
  → Quit date
  → Triggers, coping skills, plan for high-risk events
  → Problem solving and coping skills
  → Support plan
  → Pharmacotherapy plan

► Key Points

• This is the first component of a tried and true brief treatment approach to quitting smoking. (These steps are used by CAMH in their Nicotine Dependence Clinic.)

• It can provide useful input in structuring a program as each of the elements listed above need to be addressed as the client develops their quit plan. These same points are addressed in individual client sessions as well as in group programs.
Strategize: Psychological

• Identify all positive supports
  – Partner, family, friends, colleagues
  – Professionals – physician, pharmacist, dentist, nurse, etc
  – Other support – Smokers’ Helpline, groups, websites, self-help
• Identify all negative influences
  – Other smokers (partner, family)
  – People who don’t want client to quit smoking
  – Unhelpful “encouragement” to quit

► Key Points
• Supports are crucial in the quitting process. Note that what the clinician and the client define as support can differ; however it’s the latter’s definition that matters.
• Encourage the client to avoid those people that make them feel guilty or who are ambivalent about them quitting smoking. Help them focus on drawing support from those who are ready, willing, able and have a positive outlook.
Strategize – Cognitive/Affective

- Personal relationship with cigarettes
- Describe cigarettes as friend or lover
- Can experience sense of loss when quitting
- Help reframe this thinking… abusive friend or lover
- Acknowledge these emotions

Key Points
- Be prepared to acknowledge the deep feelings and sadness often expressed by clients as they quit smoking. For many, cigarettes have been a constant companion and a crutch to be relied upon. It will likely take concerted effort to re-position them as something harmful, and part of your client’s past.
- You can assist in helping them to manage their grief by acknowledging their feelings, and helping them to understand that these are normal reactions experienced by many people when quitting smoking. Eventually they will pass, and be replaced by the health benefits and rewards of becoming an ex-smoker.
Strategize – Behavioural

- Relaxation strategies
- Physical activity
- Groups
- Rewarding accomplishments
- Tracking sheets / Self-monitoring
  - Increase awareness of smoking behaviour
  - Identify triggers, challenges
  - Suggest which cigarettes will be easy and which will be more difficult
  - Begins to break the automatic smoking behaviour and possibly reduces the number of cigarettes smoked

► Key Points

- Other techniques that address the biological aspects of quitting include gaining an increased awareness about their individual smoking patterns by recording each cigarette smoked, and replacing the perceived benefits gained through smoking with other activities.
- Participating in physical exercise helps to release the “feel good” endorphins and helps prevent weight gain.
- Support groups that help can be found both online and in person.
- Don’t forget to recognize successes – even cutting out one cigarette starts the process of controlling the behaviour side of smoking, and contributes towards building self-efficacy in quitting.
Strategize - Environmental

- **Smoke-free environments**
  - Make home and vehicle smoke-free
  - Explore areas of home to restrict smoking behaviour if entire home cannot go smoke-free
  - Work environment – avoiding smoking areas
  - Other

▶ **Key Points**
- Structuring the environment by removing cues to smoke is another step towards planning for success.
- Suggest making it more difficult to smoke: go outside for the cigarette. The idea is to make having each cigarette a conscious activity that requires purposeful effort, and to break the association with smoking as an automatic response.
- Smoke-free workplaces help smokers to reduce their daily consumption, and encourages them to quit.
- A 2002 review of 26 studies concluded that a complete smoking ban in the workplace reduces smoking prevalence among employees by 3.8% and daily cigarette consumption by 3.1 cigarettes among employees who continue to smoke. (**reference???)

♫ **Facilitator Tip**
- Ask participants for more ideas. Probe for tips like removing ashtrays, keeping cigarettes in trunk of car etc.

Reference:
Strategize - Biological

• Pharmacotherapy
  • If client is interested in medications, refer to physician/pharmacist or provide information
  • How much do they know about what is available?
  • What are the pros and cons of pharmacotherapy?
  • Who will help monitor this part of the quit plan?

▶ Key Points
  • All clients should be offered medications – except when contraindicated for special populations where there is insufficient evidence. This includes light smokers smoking fewer than ten cigarettes a day, adolescents with erratic smoking behaviours etc. (Treating Tobacco Use and Dependence 2008)
  • Recall the Fagerstrom and Heaviness of Smoking tests to assess client’s level of addiction and how appropriate NRT, or other aids like varenicline and buproprion, might be.
  • Identify someone who will monitor pharmacotherapy. Medications can be doubled if needed.
Reasons for Change

Making a commitment to meeting your goal is important to your success. Sometimes, it’s easy to forget why you’re making the change, so write down your reasons and use this as a reminder to yourself when things seem tough!

The most important reasons why I want to change are:

1

2

3

► Key Points

• This is a resource to use with your clients to help them commit to the idea of change.

• If needed, the text can be modified so that it reads “The most important reasons I might want to change are…” if the idea of wanting to change appears to be too frightening and/or difficult for the client.

• These reasons should be very concrete and specific, so that they make sense when the client looks back upon them as an important reminder as to why they decided to quit.
Key Points

Another tool is the 'Decision to Change' worksheet. Here, the client articulates both the benefits and the costs of changing their behaviour by writing down their own assessments of how quitting will affect them. It is particularly useful for people in the pre-contemplative phase, and is a fair, equitable process to undertake because it examines both the positive and the negative aspects of change.
Strategize – Set a Goal

• **Setting a quit date:**
  • Provides specific date/goal to work toward
  • Prevents delay in quitting
  • Allows time to reduce, practice, refine quit plan
  • At a minimum, plan to meet with client 1 – 2 weeks before quit date and 1 – 2 weeks after quit date

► Key Points

• Setting the quit date outlines the timeframe for action.

• Realizing that there will never be a perfect, stress-free and totally ideal time to quit, encourage the client to select a quit date when they will not be subject to additional pressures. This quit date should be within the next few weeks.

• If this is too intimidating, the clinician can suggest a trial of an experimental quit date – or a smoking holiday, or a partial quit day. The idea is to spend time practicing to be without cigarettes, and then build on that success.
Goal Statement

The behaviour I want to/need to change is:

What is your goal now?

START DATE: ____________________________

ACHIEVEMENT DATE: ____________________

► Key Points

• This tool helps the client focus on their overall behaviour change, and asks them to identify a specific goal for the present, with a start and end date.

• It is a strategy to build self efficacy as the client breaks up the overall behaviour change of quitting smoking into small, attainable steps. Keep these tools for reference later on. You can always revisit them and make revisions if needed.

♪ Facilitator Tip

• Ask participants what a small goal might be. One example might be to not smoke in the car, or to not smoke for a three hour period each day for a week. Any others?
Readiness Ruler

People usually have several things they would like to change in their lives – this may be only one of those things. Answer the following three questions with respect to the goal you have set.

How **important** is it to change this behaviour?

How **confident** are you that you could make this change?

How **ready** are you to make this change?

► **Key Points**

- Once the client has set their goal of quitting smoking, ask them to rate themselves using the readiness ruler that captures the importance, their confidence and how ready they are to change.
- Follow up by asking:
  - Why did they choose the number they did? Why not a number higher (or lower)?
  - What would it take for them to want to move the scale up in importance, or confidence, or readiness?
For Reflection: “Readiness Ruler”

What are 3 reasons you are at _____ and not zero?

1. 

2. 

3. 

► Key Points

• After you have discussed their results on the Readiness Ruler scale, ask them to complete this tool and write down three reasons why they are at the number they indicated, and not at zero.

• This exercise helps to highlight the positive things going on in their life as they embark on the path to change their behaviour and quit smoking.
STRATEGIZE
Identifying Barriers and Risky Situations
Identifying Barriers and Solutions to Change

Possible Barriers:  

Proposed Solutions:  

► Key Points

• The final component to plan their strategy for change is to consider possible barriers and solutions that might be encountered along the way.

• Note that there may not be just one solution for each barrier. Encourage the client to propose as many solutions that resonate for them, for each barrier.
Step 2:
TAKE ACTION

▶ Key Point
• Step 2 in our 4: Point Plan is to Take Action and help your client plan to manage triggers and high risk situations.
Take Action

• Discuss problems and potential strategies
  • Changes in mood – what support is needed?
  • Withdrawal symptoms – re-assess pharmacotherapy plan
  • Low motivation – decisional balance, review reasons to quit
  • Weight gain – recommend physical activity, healthy eating, additional support
• Lapses/slips – explore

► Key Point
• This is a good opportunity to review the progress made to date in preparing to quit. Stress the importance of planning for situations that require extra attention, and where seeking extra help might be needed.
Take Action (2)

• Continue identifying triggers, stressful situations
• Continue self-monitoring
• Maintain smoke-free environments
• Can be one session or several sessions
• Reset quit/reduce date if needed
• Congratulate your client for coming back

► Key Points

• Each of the strategies identified in the tools completed during the previous sessions should be optimized to achieve maximum benefit. Revisit the information on the forms completed. Check for relevance to see if anything has changed, and spend time with the client to identify anything that needs revising.

• Always end your sessions on a positive note of congratulations. It is hard for the client to keep coming back to work on changing entrenched behaviour, and such diligence should be rewarded.
Triggers and Consequences

• Identify high-risk situations
• Describe high-risk situation
• Describe types of triggers usually associated with the situation
• Describe the types of consequences associated with the situation
• How often does this type of situation occur?

► Key Points
• Engage the client in a discussion about when they feel most vulnerable to give in to the temptation to smoke. Explore all these different aspects of the situation, and then capture the details on the following work sheet.

' Facilitator Tip
• Summarize all the points on the slide briefly so they are emphasized in the participants’ minds as you move to the next slide.
Triggers and Consequences Worksheet

High-risk situation: _______________________

1. Briefly describe one of your most serious high-risk situations.

2. Describe as specifically as possible the types of triggers usually associated with this situation.

3. Describe as specifically as possible the types of consequences usually associated with this situation (immediate and delayed consequences, and positive and negative consequences).

4. How often did this type of situation occur in the past year? What percentage of your total behaviour over the past year occurred in this type of situation? _____________%

Key Points

• On this worksheet the client can respond to specific questions regarding the information discussed previously about managing high risk situations.

• The more details that clients capture on this worksheet, the better prepared they will be. It is much easier for them to follow a plan that has already been developed, instead of being caught unaware when they find themselves in this difficult situation.

• Suggest that the client plan more than one way to manage high risk situations, so that they have another ‘fire escape’ plan alternative at the ready if the first one doesn’t work.
### Triggers and Coping Skills – Sample Plan

<table>
<thead>
<tr>
<th>Triggers</th>
<th>Coping Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoke with colleague every day at breaks</td>
<td>Tell colleague I am quitting</td>
</tr>
<tr>
<td>After meals</td>
<td>Chew gum after meals, get up from table right away</td>
</tr>
<tr>
<td>Stress at work gets too much on some days</td>
<td>Plan to take walks when stress is high</td>
</tr>
</tbody>
</table>

► Key Points

- This slide demonstrates what a sample plan of triggers and coping skills might look like.
- Note that all plans are different and geared to the individual’s particular situation.
- Some people feel a fear of failure and disappointing their friends if they have failed to quit in the past. They may be reluctant to tell friends that they are quitting. Others derive benefit from the support and encouragement of their friends.
- Take the lead from your client to plan to manage triggers and coping mechanisms that would work best for them.
Three Options to Cope with Triggers

1. Avoid the triggers or situations
2. Change the trigger or situation
3. Find an alternative or substitute for the cigarette in response to the trigger or situation

► Key Points
• The client’s task is to break the associations they have made that trigger the desire to smoke by trying the above three options.
• For example, while quitting -- the client might decide to:
  1) Avoid coffee.
  2) Try herbal tea.
  3) Use NRT.
Change Plan Worksheet

The changes I want to make are...

The most important reasons why I want to make these changes are.....

The steps I plan to take in changing are...

The ways other people can help me are...

I will know that my plan is working if...

Some things that could interfere with my plan are...

► Key Points

• This Change Plan Worksheet lays out the specific items to address, and helps the client prepare for success. When completing this worksheet with different clients you may note gender differences with regard to Cognitive Behavioural Therapy (CBT): men seem to prefer graphs and charts, while women tend to prefer narratives.

• It helps the clients to take ownership of this process by completing this form themselves – either during a session or on their own at home, and then bringing it back for discussion and review at the next session.
Step 3: OPTIMIZE YOUR PLAN
Doing a 360: Asking for Feedback

- SOCIAL SUPPORTS (FAMILY MEMBERS, FRIENDS, COLLEAGUES)
- PROFESSIONALS (MD, RN, PHARMACIST, OTHERS)

  - FEEDBACK ON MY PLAN?
  - THINGS MISSING?
  - WATCH FOR SABOTEURS AND ENLIST SUPPORTERS

► Key Points

- Social supports and professionals can provide additional help and resources as needed. Encourage your client to seek their opinions.
- Do not be surprised if you hear: “I feel accountable to you and don’t want to disappoint.”
- Remind the client that this is their journey and reassure them that your role is non-judgmental and supportive. Reassure them that you are here to guide them towards achieving their goal of quitting – and that you are prepared to work together with them, and to keep on trying.
We have come to Step 4 in our STOP plan.
Prevent Relapse

- Client has quit or reduced
  - Congratulate on changes made
  - Review benefits from quitting/reducing
  - Identify remaining challenges
  - Maintain plan to cope with triggers, challenges, events
  - What will they do when faced with an obstacle and want to smoke?

► Key Points
- Reassure your client that relapse is not uncommon.
- Clinicians don’t want to position their client to anticipate failure, but do want them to be prepared to realize that comprehensive plans to quit smoking take the possibility of lapses and relapses into consideration. One relapse does not mean that trying to quit is over – it contributes to a learning experience that can be applied to the next quit attempt.
If I were to relapse...

…it would most likely be in the following situation:

____________________________________________________________________

____________________________________________________________________

What coping strategies could I use to avoid this relapse?

____________________________________________________________________

____________________________________________________________________

► Key Points

• This worksheet demonstrates forward thinking. Allow the client to anticipate how they would feel if they relapsed?

• It is another tool that can help prepare the client to avert relapse as it helps them to anticipate high risk situations and plan alternate strategies
Prevent Relapse (2)

- Were there any slips/relapses? What happened?
- What can be done in those situations again so things are different?
- Which options worked and what more needs to be done?

► Key Points

- Support the client to build in techniques for relapse prevention as part of their overall quit plan. Encourage them to imagine any situations that may tempt them in the future, and plan how to cope without reaching for a cigarette.
- Remind clients that understanding what led them to relapse should be factored into their next quit attempt. Now they have a chance to be better prepared for high risk situations. They are more able to deal with the warning signs signaling a lapse, without falling into the trap of smoking.
Example: Getting Together with Friends on Saturday Night

• Avoid the triggers or situations
  – Miss this event while I’m trying to quit smoking

• Change the trigger or situation
  – Ask friends to smoke outside b/c I am quitting

• Find an alternative or substitute for the cigarette
  – When someone lights up, get support from other friends
  – Get up and get glass of water or move to another part of the room
  – Might use nicotine gum or inhaler

► Key Points

• Here is an example of how a client might plan in advance to manage a situation when they might be tempted to smoke.

• Three specific actions have been identified to: avoid the trigger, change it, and find an alternative. These three aspects should be addressed to prepare for every high risk situation anticipated by the client.
Visual Aid for Clients

• Clients often become very discouraged with slips
  – Use life line as a concrete tool to show progress
• Life Line
  – 25 cig/day x 40 years = 365,000 cigarettes
  – Approx 4,380,000 hand-to-mouth repetitions

Key Points
• This technique creates a personalized lifeline of the client’s smoking habit to demonstrate to them the number of hand-to-mouth repetitions they have to learn to live without when they quit. Base the calculations upon the number of cigarettes they smoked per day, multiplied by the number of years that they have smoked.
• Another visual depiction of the enormity of the client’s task is to use toothpicks in a jar to represent how many cigarettes are smoked in a year – or in a month. It’s no surprise that it takes a great deal of effort.
• The message can be conveyed to clients much better if it’s represented in a visual way. Remind the client: “If you quit quitting, you’re never going to quit”.

AGE 13  AGE 53
Prevent Relapse (3)

- Pharmacotherapy – long term use for those that would benefit
- Staying engaged in treatment / counselling / groups when possible
- What other supports will remain available beyond treatment?
- Planning for relapse
  - What situations/triggers might lead to a slip or relapse?
  - Is there a plan on how to deal with those situations?

► Key Points

- Review the options listed here to augment the client’s efforts at being smoke-free. Try to encourage ongoing support groups as alternatives to going it alone if extra support is needed.
When you started the change process, you completed a “Decisional Balance” of anticipated costs and benefits of changing and of continuing the behaviour in the same way. Now that you have made some changes, complete the decisional balance again noting the actual costs and benefits that you have experienced, as well as things that you didn’t anticipate as costs or as benefits. Then go back and compare your responses with your previous Decisional Balance.

### Revisiting the Decision to Change Worksheet

When you started the change process, you completed a “Decisional Balance” of anticipated costs and benefits of changing and of continuing the behaviour in the same way. Now that you have made some changes, complete the decisional balance again noting the actual costs and benefits that you have experienced, as well as things that you didn’t anticipate as costs or as benefits. Then go back and compare your responses with your previous Decisional Balance.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Continuing the behaviour in the same way</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs</td>
<td></td>
</tr>
</tbody>
</table>

**Key Points**

- Revisiting this worksheet after a relapse is an opportunity for the client to add in the true costs and benefits of changing their behaviour, not just the anticipated costs and benefits when this sheet was first completed. Compare the original worksheet to the revised one to learn more to see if anything has changed.
Readiness Ruler

Now that you have successfully made some changes, where would you rate the importance of sustaining these changes? How confident do you feel now in maintaining change? How ready are you to continue the journey of change? After you have completed this sheet, go back and compare your responses with the one you completed previously.

<table>
<thead>
<tr>
<th>How <strong>important</strong> is it to change this behaviour?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How <strong>confident</strong> are you that you could make this change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How <strong>ready</strong> are you to make this change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

▶ Key Points

- Now that the client has more experience in quitting smoking, ask them to complete the readiness ruler as it relates to **maintaining** change – not just **making** the change as they did before. The results can be compared with earlier versions of these tools to see any similarities, or differences.
Concluding Thoughts on Relapse Prevention

- Follow-up calls
  - Evaluation and counselling calls
- How can the client re-engage quickly in treatment if he/she relapses?
- What are the red flags/warning signs that a client might relapse?
  - “One won’t hurt”
  - “I’m sure I can smoke socially now that I’ve quit”
  - “I’m stressed. Just this once to help me get through this”
  - “I’ve been quit for long enough that I have control over this”

Key Points

- The clinician can build a framework to help prevent relapse by letting the client know to expect follow-up calls at certain times between sessions, and/or after sessions end, both for evaluation purposes and to offer more support as needed.
- Be sure to clarify what steps the client needs to take to come back for more treatment if needed.
- If the client starts to justify some reasons for a cigarette, it can be an indication that they may relapse.
  - Help the client develop a plan to avoid the temptation, or ask them to come back and reset the quit date.
  - Discuss how each of these ‘red flags’ could impact on their ultimate success in quitting, and how they would feel if they found themselves back to the same smoking pattern. What can they do in advance to avoid falling into these traps?
Current Motivation and Next Steps

Where were you when you started this process, and where are you now?

What do you need to do to continue to make positive changes?

What is your next step?

► Key Points

• Completing this worksheet allows the client to gain perspective on quitting smoking.
• They are asked to reflect on how their entire journey has gone from starting to think about behaviour change, to continuing these efforts, and to write down the next step that they need to take moving forward.
• This gives them the chance to feel proud about the progress made to date, gain confidence, and to realize that even if they have had a relapse – they are still farther ahead than when they first started.
Additional resources that can support me…

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▶ Key Point

• Encourage your client to keep this list handy. It can have names, contact information, websites, favourite quotes etc – whatever resonates with the client.
Small Group Discussion

How could you use the clinical tools you apply to other substance use issues with your clients who smoke?
Even people who quit intermittently have substantial health benefits over those who continue to smoke.

► Key Point

- We know that relapse is part of the process of change. Yet, it’s important to remember that even periods of abstinence from smoking can have health benefits.
Small Group Case Discussion
Kelly A.

- You are in the midst of completing a comprehensive psychosocial assessment for a new client named Kelly who is seeking treatment in your addiction program. Kelly is 25 and she is seeking outpatient treatment for cocaine use. She reports smoking crack 2-4 times per week, mainly on weekends. Kelly is becoming concerned around her crack use because she feels like she is “losing control” of this weekend activity. Over the past 5 months, she has begun to use during the week and she has started to miss work, acquire debt, and her employer has expressed serious concern about her attendance and job performance.

- Furthermore, during this initial assessment, when you inquire about her current use of all substances, you notice that she reports higher than average levels of alcohol use. Kelly reports drinking 2-4 glasses of wine daily, “to unwind after work” and she reports heavier drinking levels on the weekends. On Friday and Saturday nights she reports drinking 6-9 cocktails per occasion. She mentions that she likes to party and has an active social life, so she typically goes to a party or a nightclub with friends every weekend. The client reports that this has been her normal drinking pattern for the past 7 years. She does not self-identify alcohol as a “substance of concern”, nor does she express any intention to change her alcohol use while she seeks treatment around her cocaine use.
Case Discussion

1. How would you further explore Kelly’s secondary substance use? Please explain the rationale behind your decision. What concerns you about her secondary substance use?

2. Please find a partner and role play the initiation of a discussion that further explores Kelly’s secondary substance use. One person is Kelly, the other person is the therapist who has “flagged” Kelly’s secondary substance use and has some concerns about the information Kelly provided.

3. Based upon the outcome of your role play how does “Kelly” respond to the “flagging” of her secondary substance? Is she willing to explore and/or potentially address her secondary substance use? How did your discussion impact her treatment plan?

Why did they flag this substance use- what is the therapist concerned about- what are the potential risks if this behaviour is not addressed?

Did anybody not flag this issue-?
Role play- ask people for examples of how the issue was further explored/ Did anybody experience resistance from the client?
Treatment plan- if Kelly is willing to explore this issue- then how will it be addressed- concurrently with her cocaine use, sequentially?
Kelly S

- You are in the midst of completing a comprehensive psychosocial assessment for a new client named Kelly, who is seeking treatment in your addiction program. Kelly is 25 and she is seeking outpatient treatment for cocaine use. She reports smoking crack 2-4 times per week, mainly on weekends. Kelly is becoming concerned about her crack use because she feels like she is “losing control” of this weekend activity. Over the past 5 months, she has begun to use during the week and she has started to miss work, acquire debt, and her employer has expressed serious concern about her attendance and job performance.

- Furthermore, during this assessment, when you inquire about her current use of all substances, you notice that she reports daily smoking. Kelly reports smoking 20-30 cigarettes daily. She mentions that smoking helps her “unwind especially after work” and cope with stress and anxiety. She reports smoking 20 cigarettes per day Monday through Thursday and she notes that she tends to smoke more on the weekends. On Friday, and Saturday nights she reports smoking 25-30 cigarettes per day. She mentions that she likes to party, and hang out with her friends; moreover, her friends all smoke. The client reports that this has been her normal smoking pattern for the past 7 years. She reports that she began smoking at the age of 14, but that she didn’t begin smoking daily until she was 16. Kelly does not express any concerns around her tobacco use. She does not self-identify it as “a substance of concern” nor does she express any desire to change her tobacco use while she seeks treatment for her cocaine use.
Case Discussion

1. How would you further explore Kelly’s secondary substance use? Please explain the rationale behind your decision. What concerns you about her secondary substance use?

2. Please find a partner and role play the initiation of discussion that further explores Kelly’s secondary substance use. One person is Kelly, the other person is the therapist who has “flagged” Kelly’s secondary substance use and has some concerns about the information Kelly provided.

3. Based upon the outcome of your role play how does “Kelly” respond to the “flagging” of her secondary substance? Is she willing to explore and/or potentially address her secondary substance use? How did your discussion impact her treatment plan?

Why did they flag this substance use- what is the therapist concerned about- what are the potential risks if this behaviour is not addressed?

Did anybody not flag this issue-?
Role play- ask people for examples of how the issue was further explored/ Did anybody experience resistance from the client?
Treatment plan- if Kelly is willing to explore this issue- then how will it be addressed- concurrently with her cocaine use, sequentially?
Comparing Cases

- In the Kelly S case, where tobacco was presented as the “secondary substance”, was tobacco treated differently?
- Beyond Kelly’s cocaine use, where was the overlap in these two cases and what similarities did you notice?
- Why do you think some clinicians treat tobacco differently? Why do you think some clients treat tobacco differently?
- How can we level the playing field?

Pros and cons of each drug

Thoughts, observations

Was it easier (more straightforward, automatic) for clinicians to address alcohol, incorporate it into the treatment plan vs incorporating/ addressing tobacco

How did the client’s use of tobacco impact the clinician’s approach to this case and/or the treatment plan itself?

Was one secondary substance more of a priority to address than another (Ie was alcohol viewed as more serious, important to address)
Comments and Questions?
Lunch!
Checking in half-way:
How is the course going so far?

a. Excellent
b. Very good
c. Good/Neutral
d. Fair
e. Awful
Implementing Tobacco Cessation Interventions in Addiction Settings

Will Elliott, Addictions Counsellor, Westover Treatment Centre
Tobacco and Aboriginal Health
Objectives

• Provide brief overview of Aboriginal issues as they relate to tobacco cessation
• Enhance understanding of Aboriginal healing as it relates to tobacco
• Discuss how non-Aboriginal partners can work as allies with Aboriginal peoples and communities to address tobacco cessation
Overview Of Presentation

• Limits to Presentation
• Tobacco and Aboriginal Health
• Questions and Answers
Limits to Presentation

- Inuit and Metis views will be highly underrepresented
- The term Aboriginal will be used as often as possible in an effort to be inclusive, but it is a broad general term that includes an incredibly diverse set of communities and peoples – BEWARE OF GENERALIZATIONS
FURTHER LIMITS TO PRESENTATION

- Epidemiological paradox (Reading et al. 2007: 8)
  - Aboriginal people need to raise profile of their suffering, so that they get help
  - Raising profile of suffering perpetuates racist stereotypes of Aboriginal peoples as suffering drains on health care system

Reference:
Money going down the drain; Image retrieved on Oct. 24, 2008 from http://www.tomgpalmer.com/images/Money%20Down%20the%20Drain.jpg
Response to Paradox

• A challenge …
  – To speak of hope without hiding pain that needs to be addressed
  – To speak of pain without hiding the hope behind it
“Traditional Tobacco is a gift that was given to Indigenous people by the Creator and it has a spiritual place within our communities. When Tobacco is burned the smoke rises which provides a link to all the spirits beyond the earth. Tobacco in its original form had honour and purpose. Traditional Tobacco did not contain all the chemicals that are now put inside. What is sold today has been tampered with for business and profit, taking away from its spiritual purpose.” - ROYTH BENEDICT, ELDER, MOOCHO'S NATION
Traditional Tobacco Use

- Traditional tobacco has been used by many Aboriginal people to:
  - Pray;
  - Give thanks to the Creator and Mother Earth;
  - Communicate with the spirits; and
  - Purify the mind and heal the body.
Ceremonial Use of Tobacco

- During ceremonial and spiritual activities, tobacco is not always burned or smoked (Daniels, 2002).
  - Some methods of use include simply placing it on hot coals or throwing it into a fire.
  - Other times it is held in the bare hand, then placed on the ground or on water.
  - When some Aboriginal people take plants or animals for sacred use, tobacco is traditionally left in the place where the plant or animal was taken from as an offering and sign of respect and gratitude.
CAUTION

- Not all Aboriginal cultures share the same teachings about tobacco
  - Some have never had tobacco teachings
  - Some communities are highly Christian
  - When meeting new communities, request to meet with an Elder and learn that communities teachings about tobacco
It’s still not okay to generalize!

• But in those Aboriginal communities who do have tobacco teachings, respect for tradition and culture can be an incentive to quit.

• Challenges to this notion:
  – Many traditional people smoke as well
The Creators Form of Tobacco

- This is *Nicotiana rustica*, the original form of tobacco used by Aboriginal people
  - Many Aboriginal communities will likely have their own spirit names for it (e.g., semma)
- It spread from South America into North America according to archeologists
- However, many Aboriginal communities will have teachings about how the Creator gave tobacco as a gift – be respectful of those teachings
Commercial Tobacco

- Most commercial tobacco is now grown from *nicotiana tabacum*
- The body reacts differently to the smoke from this plant
- It doesn’t produce the same gag reflex that *nicotiana rustica* does
  - The Creators medicine has been modified
Commerical Tobacco Use

• Many Aboriginal communities have high rates of commercial tobacco use
Commercial Tobacco Smoking Rates

- The First Nations and Inuit Health Branch of Health Canada reports the following facts on smoking rates in First Nations and Inuit communities:
  - Sixty percent of on-reserve First Nations people between the ages of 18 and 34 currently smoke;
  - Seventy percent of Inuit in the north between the ages of 18 and 45 currently smoke;
  - Almost half of Inuit (46%) who smoke started smoking at age 14 or younger; and
  - The majority of on-reserve First Nations people who smoke (52%) started smoking between the ages of 13 and 16.
- These statistics are from the 2004 Baseline Study among First Nations On-reserve and Inuit in the North, Environics Research Group.
Inuit Tobacco Use

- The Inuit's history with tobacco is very different from that of other indigenous people in Canada.
  - Because of extremely cold temperatures in the far north, cultivation of any crops, including tobacco, wasn't viable.
  - Tobacco was therefore not used in the far north until it spread from Europe, through extensive trading between the Inuit and both the Hudson's Bay Company and the North West Company.

Reference:
Image retrieved on July 2, 2010 from www.naho.ca/inuit/itn/
Why Quit Smoking?

• Winter (2001) notes the increasing rates of commercial tobacco use by Native youth and the rising rates of death among North America’s indigenous peoples from lung cancer, heart disease, and other tobacco-related illnesses.

Reference:
Image retrieved on July 2, 2010 from http://www.netwellness.org/healthtopics/smoking/shsmokeadults.cfm
Impact of Tobacco Use

- Retnakaran, Hanley, Connelly, Harris and Zinman (2005) found that cigarette smoking at an early age may be a factor contributing to the high prevalence of cardiovascular disease amongst Aboriginal youth in Canada.

Reference:
More impact of tobacco use

- The Aboriginal Cancer Care Unit (ACCU) (2008a) provides a provincial context for tobacco misuse: the use of tobacco products kills 16,000 people in Ontario every year, making rates among Aboriginal youth 15-17 years old triple those of 15-17 year olds in the general Canadian Population.

Reference:
Tobacco and Poverty

• Economic costs of tobacco use are devastating.
  – Higher medical costs
  – Businesses, families and individuals suffer in a similar fashion from lost earnings due to illness and disease.
  – Often, it is a family’s main wage-earner who is cut down early due to tobacco-related disease or death.
• In Canada, Aboriginal people living on reserves generally experience worse social, economic and environmental conditions than those of non-Aboriginal people. (Canadian Population Health Initiative, 2004)
• Lower socioeconomic status corresponds to a higher rate of cigarette use in First Nations (Environics Canada, 2004)
Interesting Note

- Many of these stats apply to youth – many future Aboriginal leaders are smoking
  - There are also many who don’t smoke and/or smoke in a traditional manner

Reference:
Image retrieved on July 2, 2010 from http://thunderstone.jcmultimedia.com/uploaded_images/4b482c9b23e5f5b3aacc26902e4a3034.jpg
The Sacred Balance: Many Aboriginal People are Smoking; Many Aren’t

• Some studies suggest that Aboriginal peoples themselves are more concerned about the ill effects of smoking.
  – Hayward, Campbell and Sutherland-Brown (2007) conducted an exploratory, comparative study of the utilisation and effectiveness of tobacco cessation quitlines among Aboriginal and non-Aboriginal Canadian smokers.
  – This exploratory analysis shows that even without targeted promotion, Aboriginal smokers do call Canadian quitlines, primarily for health related reasons.
Hayward, Campbell and Sutherland-Brown (2007)

• Six months after intake, Aboriginals and non-Aboriginals had taken similar actions with 57% making a 24-hour quit attempt.
  – Quit rates were higher for Aboriginals than for non-Aboriginals, particularly for men.
  → The 6-month prolonged abstinence rate for Aboriginal men was 16.7% compared with 7.2% for aboriginal women and 9.4% and 8.3% for non-Aboriginal men and women, respectively.
DISCUSSION

• Why might so many Aboriginal youth and adults be smoking? Consider:
  – culture (Aboriginal and non-Aboriginal)
  – community
  – family
  – nation
  – media
  – advertising
  – economic benefits of tobacco
  – accessibility of tobacco
  – other factors identified by group
Economic Impacts of Tobacco

- Purchase of contraband cigarettes has risen, especially in southern reserves (to both Aboriginal and non-Aboriginal consumers)
- Increase in organized crime and cross-border smuggling

**RCMP Cigarette Seizures - 1994 to 2008**
Positive Economic Impacts of Tobacco

- *Aboriginal Business* magazine, in its Winter 2006-7 edition, reported that GRE is the second largest single site private employer of Aboriginal people in the province, second only to Casino Rama.
- Proceeds from tobacco sales have been used to fund sovereignty movements, arts, sports, community development, etc.
Note

- Economics, population health, etc. are being talked about concurrently with individual health
- There is a reason for this …
Medicine Wheel (Lavallee)

- North – Mental/Intellect
  - White – Sweetgrass
  - Bear – Healing

- West – Emotional
  - Black – Sage
  - Buffalo – Insight

- South – Physical
  - Red – Cedar
  - Deer – Relationships

- East – Spiritual
  - Yellow – Tobacco
  - Eagle – Vision

SELF
DIVERSITY OF MEDICINE WHEEL TEACHINGS

• Medicine Wheel teachings will vary from community to community; some Aboriginal peoples or communities may not have such teachings
• The preceding analysis may not apply in all settings
The Medicine Wheel (Lavallee)

• Bottom line …
  – A few thoughts from my own history
  – Tobacco is one of the most sacred medicines in many Aboriginal cultures
  – The commercial form of is quite powerful too, affecting:
    → Mind, body, spirit, emotion
    → Nation, community, family individual
QUESTIONS?
MEDIICATION
How familiar are you with the different tobacco cessation pharmacotherapies available?

a. I have very little knowledge
b. I have a good foundation, but I still have a lot to learn
c. I am well-versed
d. My team is reading the most recent pharmacotherapy journal for next month's book club
Please take a moment to complete the short quiz in your manual.

Thank you
Testing Your Knowledge
Exercise: Question 1

NRT is a safer, clean delivery system of nicotine

a. TRUE

b. FALSE

- * Vote: Show Pre-test results with current votes *.

Clean
-Typically not inhaled
-Delivers ONLY nicotine to tobacco users
-2 doses: Manage withdrawal, slightly higher dose helps with cravings
-Similar idea to methadone

TRUE
Testing Your Knowledge
Exercise: Question 2

21mg of nicotine is the strongest level of patch that a smoker can wear

a. TRUE

b. FALSE

FALSE

Heavily dependent smokers may need higher levels of NRT. Physical dependence does not solely account for difficulties that smokers have when trying to quit. Behavioural patterns and emotional triggers also play a large role. In addition, the particular inhalation technique of different smokers can result if different amounts of nicotine drawn from the same brand of cigarettes.

Combining different forms of NRT may be more effective than using one form alone (i.e. augmenting the patch with NRT gum - if necessary).

The recommended maximum dose of 21 mg is ONLY what the pharmaceutical company recommends based upon their clinical trials. Keep in mind the ‘off label’ prescriptions and match the NRT dose to the needs of the smoker trying to quit. There likely would not have been enough of a business case for the pharmaceutical companies to undertake clinical trials to assess efficacy of increased dosage that might be appropriate for a smoker who, for example, typically smokes 3 packs a day.

As with all drugs, when changing the method of administering the drug it is important to take into consideration how it is absorbed into the bloodstream – much like when changing from IV medications to tablets or pills.
What do you think?
Are Nicotine Replacement Therapies addictive?

a. Yes
b. No
c. I’m not sure
d. It depends on how you define “addiction”
Testing Your Knowledge Exercise: Question 3

Smoking while on the patch increases the risk of a heart attack.

a. TRUE

b. FALSE

This is one of the biggest myths about NRT!

This was an initial concern when the patch first came on the market in the early 1990's, however we know now that that was an unnecessary precaution. In fact, SMOKING – whether on or off the patch – increases the risk of a heart attack!

FALSE
NRT can be used as long as needed, even if this means using NRT for years.

a. TRUE

b. FALSE

Even though the pharmaceutical manufacturers list 3 months as the stated time to use NRT on the packages, there is no set time that the client must stop. Three months happens also to be the most cost-effective way of demonstrating success that the product works.

Every client should be regularly re-evaluated as to the risks and benefits of using NRT as they stop smoking.

The major issue is that most smokers wish not to use the full 10 weeks of NRT.

TRUE
Testing Your Knowledge
Exercise: Question 5

Smokers who are pregnant or under the age of 18 should not consider wearing the patch.

a. TRUE

b. FALSE

And of course, they are not supposed to use any tobacco products either. This is what the pharmaceutical companies advise because they tested their NRT products on adults.

Such circumstances should be assessed on a case-by-case basis. Clean nicotine via the patch or gum may be preferable to on-going use of tobacco products.

FALSE
NRT should not be used at the same time or in combination with Bupropion.

a. TRUE

b. FALSE

Clients who are taking bupropion can also use NRT if needed to provide relief from withdrawal symptoms.
FALSE
Testing Your Knowledge
Exercise: Question 7

There is no difference in quit rates achieved using Bupropion or Varenicline

a. TRUE

b. FALSE

Varenicline (Champix) is the most efficacious drug for smoking cessation we have today.

FALSE
Break Time 15 minutes
Pharmacological Approaches to Smoking Cessation Treatment
• Nicotine may take dependent, daily smokers more time to get a “hit” as their lungs may act as a filter therefore delaying the time it takes nicotine to get to the brain.

• The rate at which the “drug” enters your body plays a large role in its addictive properties. For example, smoking a drug gets into your system much more quickly than chewing. Therefore smoking would have the potential to be much more addictive

• NRT enters your body fairly slowly therefore having little to no addictive potential. Therefore, pay close attention to the word ‘addiction’ and how it’s used.

Biological Aspects of Addiction

– A biological need for a drug that arises because of physiological adaptation to the presence of a drug in the body
– Body becomes dependent on the drug to be able to function normally
– Stopping the drug leads to a withdrawal syndrome which is unpleasant and motivates person to continue using
– Not the complete picture
Quitting Smoking Unaided: Analysis of 4 Studies

- Long-term smoking abstinence in those who try to quit unaided = 3%–5%
- Most relapse within the first 8 days

Hughes JR et al. (2004)

**Key Point**
- Generally, willpower alone is not sufficient to achieve abstinence, thus relapse rates are very high in smokers who try to quit unaided.

**Background**
- A meta-analysis by Hughes and colleagues reviewed the literature reporting on the rates of relapse in smokers who tried to quit without treatment. Although few such studies exist, the studies that were found indicate that only 3%–5% of smokers who try to quit without treatment achieve prolonged abstinence for 6–12 months after a given quit attempt, with most relapsing within the first eight days of attempting to quit.

**Reference:**
Key Points

- Ideally, the treatment plan should be collaborative. Moreover, there is not an effective “one size fits all” model available.
- Not all smokers will want medication as part of their quit process and not all smokers will want counselling. When we look at the evidence it suggests that a combination of medication and counselling seems to be the most effective approach to offer. However, client autonomy should be respected and ideally the client will be able to chose and their treatment preference.
Guidelines for Treating Tobacco Addiction

Clinicians should encourage the use of medication by all patients attempting to quit smoking except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).

Six (in Canada) first-line medications that reliably increase quit rates:

- Bupropion SR
- Nicotine gum
- Nicotine inhaler
- Nicotine lozenge
- Nicotine patch
- Varenicline

Consider the use of certain combinations of medications.

USDHHS, 2008; Fiore MC & Jaén CR.,2008

► Key Points

• The first five medications can be used in combination- according to client preference. Bupropion contains no nicotine and therefore one or more forms of NRT can be used in conjunction with this medication- particularly if withdrawal is a problematic for the individual.
• However, varenicline is a medication that should be used without other smoking cessation medications (NRT and bupropion). Though it is a good medication to use if the individual is taking other types of prescribed medications because varenicline is processed through the kidneys and not the liver.
Costs of Smoking vs. Pharmacotherapy

<table>
<thead>
<tr>
<th>One Week Supply:</th>
<th>Approx. Cost/Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name-brand patch</td>
<td>$34.00</td>
</tr>
<tr>
<td>No-name patch</td>
<td>$22.00</td>
</tr>
<tr>
<td>Nicorette gum (10 pieces/day)</td>
<td>$99.00 (3 boxes at $33.00)</td>
</tr>
<tr>
<td>Nicorette inhaler (5 cartridges/day)</td>
<td>$150 (3.5 boxes at $42.00)</td>
</tr>
<tr>
<td>Cheap brand of cigarettes (7 packs)</td>
<td>$40.00</td>
</tr>
<tr>
<td>(e.g., Native, DK’s, etc.)</td>
<td></td>
</tr>
<tr>
<td>Name-brand cigarettes (7 packs)</td>
<td>$66.00</td>
</tr>
<tr>
<td>(e.g., DuMaurier, Players, etc.)</td>
<td></td>
</tr>
<tr>
<td>Contraband Cigarettes</td>
<td>$7.00 - $15.00</td>
</tr>
<tr>
<td>Champix</td>
<td>$60 starter kit; $70 for continuation pack</td>
</tr>
<tr>
<td>Generic Buproprion</td>
<td>$40.00</td>
</tr>
</tbody>
</table>

► Key Point

• As you can see, all these treatments cost less to use than smoking. Nonetheless, some of the reasons that people balk at the price of therapies to help them quit is that they are used to buying a pack of cigarettes at a time, which is a lower initial expenditure than purchasing a full course of NRT.

♫ Facilitator Tip

• Use these questions to engage participants in a discussion. Suggestions to probe for more comments follow each question:

• Do you think that there might be other ways to sell these NRT products, so that they would be more affordable to our clients? (smaller packages, if they were sold where ever cigarettes are sold etc.)

• What are some challenges that exist in making them more readily available? (lack of opportunity to counsel clients in correct usage etc.)

• What can we as health care providers do? (advocate for change)
**Key Points**

- In summary, NRT is a safe delivery system that gives the body a "clean" form of nicotine. Nicotine from cigarettes is considered "dirty" as it is delivered with 4,000 other chemicals when burned, which also creates carbon monoxide as a by-product of incomplete combustion.
- When taken correctly, NRT can double one’s chances of success.
- Clients should be reminded that NRT is not a “magic bullet”, and that they still need to work on behavioural strategies to help them quit smoking.
- Generally, people take more than twelve weeks to change a behaviour. You’re learning a new behaviour when you quit, therefore it is recommended to take the full course of NRT.
- Studies have shown that success increases when a person starts NRT a couple of weeks before their quit date.
- The elimination of inhaled cigarettes would essentially wipe out COPD in the western world.
Who Should Not Use NRT?

- Not everyone needs NRT
- Not everyone can afford NRT
- Studies show that NRT is not effective for those that smoke 10 cigarettes or less or are non-daily smokers
- Need to assess case by case
  - Discuss with client
  - Use tools to assess dependence

► Key Points
- If clients are only smoking less than ten cigarettes a day, NRT might not be a viable option as a quit aid. They may want to consider behavioural intervention as opposed to NRT. NRT is intended for heavy smokers (characterized as ten or more cigarettes a day), but that does not necessarily mean that someone who smokes less than ten may not benefit from NRT.
- Also, those who smoke less than ten cigarettes a day might not benefit from NRT because they are often those who experience the horrendous side effects (vomiting, nightmares, feel strange, etc.)
- In some cases, a clinician could suggest NRT to manage a patient’s withdrawal in hospital, etc.
- Your client is the expert: ask and they may indicate whether NRT is appropriate for them.
Determining Type of NRT

- Less than 10 cpd
  - No NRT
  - Behavioural Interventions

- 10 – 15 cpd
  - 14 mg patch or Inhaler, gum, lozenge

- 15 or more cpd
  - 21 mg patch
  - FTND score of 7 or higher

► Key Points

- This chart compiles the factors used to determine the type and dosage of NRT. One suggestion that has been made is to call it: “Nicotine Exchange Therapy” instead of NRT.
- When the client is adjusting to NRT ask that they keep track of the number of chewing pieces (or ‘gum’), they use, and if they need to augment their daily dose with any additional pieces during the day (‘breakthrough’ gum). Monitor them closely and move them to a lower dosage based upon their tolerance levels. Keep track of the gum usage during follow up visits, and constantly check in with the patient to make sure it’s titrated correctly.
- Recall that NRT roughly doubles success rate – so recommend clients use it as needed.
i-Clicker Check-in

a. I am completely lost
b. This is a lot of new information, but I am following along
c. This information is corresponding well with the knowledge I already have
d. I could teach this material myself
Nicotine Patch

• 24 hour continuous dose of nicotine
• 21, 14 and, 7mg patches (applied every 24h)
• Off-label use – higher than 21mg dose for highly dependent smokers
• Potential side effects
  – May cause sleep disturbance or nightmares
    → Remove before bed
  – Skin irritation

Key Points

The patch is a long acting medication. Nicoderm gets into skin faster than Habitrol. The company that manufactures Habitrol is the same as all other no-name brands.

• Clients might be hesitant about using NRT. Clinicians can use this as an opportunity to educate the clients about the myths and facts by providing them with a handout (in CD-ROM) from the Ontario Medical Association which outlines many of the concerns that clients have about NRT.

• 60-70 % of people believe the nicotine in NRT causes cancer. Remind the client that it is the many other chemicals in a cigarette that are known to contribute to cancers and other health issues.

• At best, the patch only ever replaces about 50% of nicotine taken in from smoking cigarettes – therefore may need to increase beyond 21mg with heavy smokers.

• There have been 105 clinical trials for NRT. We know NRT is effective and safe. Now we need to have health care providers and clients become more comfortable with the idea of using NRT. Client will want to rotate site daily as the adhesive can cause skin irritation if placed in same spot daily, using lotion or moisturizing soap may affect the adhesion of patch. The use of surgical tape to help patches stick can be helpful if the client sweats a lot and above the waist is recommended because there is generally less body hair there.

• Clients should be advised against cutting the patch, the same way they would be advised against taking half the amount of prescribed blood pressure pills.

• Discarding old patches is very important, as 2-3 times the nicotine level can be left in the membrane after use.

Possible Side effects:

• Sleep disturbances: Clients may experience vivid or colourful dreams which might not bother the patient. If NRT is affecting the client’s sleep, or if they are experiencing nightmares it is recommended the client takes the patch off 1-2 hours.
Nicotine Gum

• Provides body with nicotine for 20-30 minutes
• 2 & 4 mg doses
• Responds to the immediate urge to smoke
• Oral gratification
• Must be able to chew gum (i.e. no dentures, TMJ)
• Potential side effects
  – Upset stomach, hiccups
    →Chewing too fast: review proper use of gum

Key Points
• The gum could be thought of by the client as a patch for your mouth. Nicotine gum is a short-acting medication.
• The gum must be chewed in a specific manner or the client The gum can be used in conjunction with other NRTs, especially if a client is having “breakthrough” cravings.
• Absorbed via buccal mucosa (the inner lining of the cheeks and lips, nicotine is absorbed in an alkaline base). Buccal mucosa is 90-95% of the nicotine that’s swallowed and digested through the liver is destroyed (vs. inhaling). To bypass this, the nicotine should be absorbed through the mucosa in the mouth.
How to use the gum:
• 2mg can be used in combination with patch as a breakthrough medication.
• 4mg can be used in combination with patch or alone, if Fagerstrom Score was less than three.
• Chew one piece at a time, no more than one per hour. Use every hour, if not in combination with patch.
• Up to twenty pieces per day as needed.
• Chew and park in between teeth and cheeks. If it is not chewed this way, the client may experience side effects like sore throat or stomach irritation.
• Repeat chew every minute or so.
• Each piece lasts approximately thirty minutes.
• Do not chew within thirty minutes of caffeine/acidic products.
• Chewing within 30 minutes of caffeine or acidic products will reduce the effectiveness of the gum because it reduces absorption of the nicotine.

Interesting Fact
When the gum first came out it tasted like what some would describe as a dirty ashtray. The manufacturers have since created much better flavours like “Ice Mint” and whitening formulas.
### “Reduce to Quit”-Approaches

<table>
<thead>
<tr>
<th>Who?</th>
<th>Smokers not ready or unable to quit abruptly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal?</td>
<td>50% reduction in daily cigarette consumption between 6 weeks and 4 months of treatment</td>
</tr>
<tr>
<td>How?</td>
<td>Self-titrate to the level of nicotine to reduce withdrawal symptoms. A reduction of cigarette consumption should be continued until complete cessation can be attempted</td>
</tr>
<tr>
<td>When?</td>
<td>Craving to smoke in order to prolong smoke-free intervals for as long as possible</td>
</tr>
</tbody>
</table>

#### Key Points

- **Reduce to Quit**: This new method that starts with using NRT gum while cutting down on the number of cigarettes smoked each day can be very helpful to those needing more support to quit. If the goal of 50% reduction of their daily cigarette consumption between 6 weeks and 4 months has not been reached, increase the psycho-social behavioural counselling.

  - **How Long?**
    - If such a reduction has not been achieved by four months, the patient should be further counselled and/or re-evaluated.
    - A quit attempt should be made as soon as the patient feels ready – but not later than 6 months after the start of treatment.
    - Regular use of the gum beyond twelve months in the Quitting Gradually program is generally not recommended.

- **How Much?** Max twenty pieces per day.

#### Reference:

Are some cigarettes more harmful than others?

a. No- all have the same level of danger to health, no matter where the cigarettes are manufactured
b. Yes- unregulated cigarettes are more harmful
c. Maybe- I need some more information to make a decision
Nicotine Inhaler

• Small, cigarette-shaped inhaler
• Satisfies sensory and ritualistic aspect of smoking
• One cartridge contains 10mg of nicotine and 1mg menthol
• Absorbed in oral cavity, throat and upper respiratory tract by “puffing”
• Potential side effects
  – throat & mouth irritation, headache, nausea, indigestion(<20%)

Key Points
• The inhaler has been in Canada for a couple of years but has been available in other countries for much longer.
• Approximately 4mg of nicotine is absorbed from one cartridge.
• Poorly named product as clients should not actually “inhale” but “puff”.
• Some clients do not like the menthol taste associated with this product.
• Helps with the “fiddle factor” that some smokers may experience with the gum.
• Good for people with poor dentition.
• Makes a statement vs. using discreet gum.
• Be careful in forensic settings – it seems inhalers can be used as a weapon.

How to use the nicotine inhaler:
• Single cartridge lasts for approximately 80-400 inhalations or twenty minutes of continuous inhalation
• Puff the inhaler like a cigar, not deeply into the lungs.
• The client may notice a burning, warm or cool sensation when inhaling, which is ok unless it becomes bothersome to the client.
• Clean inhaler on a regular basis with soap and water.
• Can use up to six cartridges per day, use as needed.
• Once a cartridge is open it is good for at maximum 24 hours. After 24 hours, cartridge materials will evaporate.
• Some clients may not like the inhaler as it may reinforce the hand-to-mouth behaviour of a cigarette, while others find this very helpful.
• Amount of puffs/inhalations depends on how someone uses it.
• Anecdotal comment: “I can get by with just a few puffs.. vs. gum is in and out and back into the mouth.”
Nicotine Lozenge

• 1 mg and 2 mg dosages
• Max of 15 mg / day should be used
• Slowly suck until strong taste is noticed
• Rest lozenge between cheek and gum
• Wait 1 minute or until taste fades
• Repeat sucking
• Each lozenge takes about 30 minutes to consume
• Use only 1 at a time

► Key Point
• This format is also a discreet form of NRT as it is similar to a candy or mint, yet helps to relieve withdrawal symptoms.
Addictive Liability of Nicotine Delivery Devices

• Inhaled nicotine (from a cigarette) reaches the brain within:
  – 7-10 seconds for non-daily and less dependent
  – 30 seconds for daily, dependent smokers
• Patch: levels peak in 2-6 hours after application
• Gum and inhaler: levels peaks in 20-30 minutes
• Addictive potential tends to correlate with time to peak concentration
  – Because the nicotine is delivered differently, more slowly and at lower doses in NRT, it is significantly less addictive then smoking

► Key Points

• The quicker a drug gets to the brain, the sharper the dopamine spike and the greater the addiction. For example, crack cocaine smoked gets into the brain faster than cocaine that is snorted, so the addictive potential of crack cocaine is higher. Addictive potential is affected by the way a drug is used to reach peak concentration.

• Because therapeutic nicotine is administered in a controlled manner via the skin or the buccal mucosa of the mouth – both much slower mechanisms to get nicotine to your brain than by smoking, there is a much less likely chance to become addicted via these alternate nicotine delivery devices.
Effectiveness and Safety of NRT

- Recent study of 2767 predominantly middle-aged smokers not ready to quit: half were given NRT (gum, inhaler or choice of therapy) and half were given placebo for up to 18 months
- Primary Outcome was six months of sustained abstinence from smoking
- Results overwhelmingly positive
- NRT was well tolerated
- Those using the NRT achieved six months of sustained abstinence & most lasted beyond 12-26 months

Moore et al 2009;

Key Points

- Some clients may be reluctant to try NRT, stating they don’t want to “put any chemicals” into their bodies. Pointing out the incongruence of this statement might be helpful. NRT delivers nicotine alone, but cigarettes come with about 4,000 other chemicals – and more than fifty of them are known to cause cancer.
- Also, clients may feel that they “should” be able to quit with will power alone. We know that quitting smoking is not based upon an individual’s amount of will power. If there are aids available that can double their chances of success, and they may be worth considering.

Reference:
Cardiac Disease and NRT

- NRT is safer than smoking
- Cigarette smoke causes:
  - Increase in heart rate
  - Blood pressure
  - Increased clotting time
  - Polycythemia
- NRT has not been associated with any increase in cardiac events (heart attack, stroke)

Hubbard, R, et al. 2005

► Key Points
- NRT and smoking affect cardiac disease differently.
- A number of factors relating to smoking and heart disease are listed above. In particular, after smoking for several weeks the number of red cells begins to increase as the body responds to chronic oxygen deprivation resulting from the carbon monoxide exposure. This condition, characterized by an abnormally high level of red blood cells, is known as smoker’s polycythemia. In addition, smoking makes the blood clot more easily. Both of these factors may increase the risk of heart attack or stroke.
- However, because NRT delivers nicotine to the body without any carbon monoxide, there have been no studies associating it with such cardiac events.

Research still needs to be done in this area and there are hospitals that do use NRT for patients with prior cardiac issues. This just serves to emphasize the need for a complete and thorough assessment on a case by case basis.

Reference:
Long-Term Use of NRT

- Most of the time people who use NRT to stop smoking gradually reduce or stop NRT medicine without difficulty
- May use NRT long-term if needed
  - Appropriate way of reducing the harm caused by smoking
  - Using NRT is always preferable to using tobacco products
- Long-term use of NRT products can help in reducing morbidity and mortality
- Preliminary evidence suggests that long-term use of oral NRT may be associated with certain kinds of cancer (Gemenetzidis et al., 2009)

► Key Points

- About 20% of people continue to use NRT long term. This can be viewed as a harm reduction approach as the nicotine is delivered to the body through a clean delivery system via the patch, gum or lozenge rather than by smoking.
- Some preliminary evidence suggesting that long-term use of oral NRT may be associated with certain kinds of cancer

Reference:
doi:10.1371/journal.pone.0004849.
Available online:
http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0004849
Assessing Readiness to Discontinue NRT

- Have you been in a situation in which you would normally smoke but have been able to refrain from smoking with ease?

- Have you ever forgotten to put on your patch or use your inhaler/gum/lozenge?

▶ Key Points
Two simple questions to ask your clients when you think they may be ready to try stopping NRT.

- First: Personalize it to the patient. E.g. they didn’t ‘white knuckle it’ that time… so what helped them get through the situation?

- If they answer yes to the second question, use this as an opportunity to boost their confidence with the evidence that they can survive without NRT for a period of time. This helps to build self-efficacy and supports the client to OWN their treatment/recovery. If they answer no, then reassure them that eventually this likely will happen, and when it does occur it is a sign that their bodies are adapting to less nicotine – a natural part of this process.
Pregnancy and Youth - NRT

NRT should be considered in pregnancy and for youth if the likelihood of smoking cessation justifies the potential risk of using it by the pregnant patient or youth who might continue to smoke.

Benowitz et al, 2000

► Key Points

• Sometimes health care professionals are reluctant to talk about this issue, however if a pregnant women or youth has tried all other avenues to quit but not had success, NRT should be considered.
• Please review the www.pregnets.org website for current information regarding tobacco use and pregnancy.
• Youth (usually under 18) often have erratic smoking patterns. If they are smoking as an adult, treat them as an adult (and titrate the proper NRT if necessary).

☼ Background

For more information, review Treating Tobacco Use and Dependence: 2008 Update, Chapter 7 Specific Populations and Other Topics


Reference:
Bupropion

- Originally designed to treat depression
- Shown to double one’s chances of quitting
- Shown to minimize weight gain associated with quitting smoking
- Contraindications
  - Seizure history
  - Active eating disorder
  - MAOI Medications
  - Using Bupropion, sensitivity to Bupropion

Key Points

- Bupropion is an anti-depressant. It’s use as a smoking cessation medication began after Linda Ferry noticed that many of her patients who were using bupropion as an antidepressant were suddenly reducing or quitting smoking.
- It helps to decrease both the desire for a cigarette and the resulting pleasure from smoking. bupropion can be used in conjunction with NRT.

Some contraindications to review:

- Bupropion users have a 1 in 1,000 chance of seizure. If client has a pre-existing seizure condition, it should not be prescribed.
- If the client has an eating disorder or history of one they are at greater risk of seizures due to electrolyte imbalance and therefore are not good candidates for bupropion.
- Allergic reaction and hives may occur.
- Unfortunately, most extended drug plans will not pay for the Zyban but will pay for Wellbutrin if being prescribed for depression. There may be an increase in prescribing of Wellbutrin to get around this restriction.
- Bupropion is sometimes thought of as a stimulant, because in animals, it can mirror the effects of cocaine. However, in people it doesn’t have the same affect.

Background

- For a full discussion of the medication indications, contraindications, and side effect profiles of bupropion, please refer to a Doctor.
- Please note that a helpful algorithm is included in the Additional Resources tab in your CD-Rom that can be helpful in consideration of bupropion as part of a client’s tobacco intervention.
Varenicline

• Oral medication to quit smoking
• Reduces withdrawal and craving
• Prevents pleasurable effects of smoking
• $\alpha_4\beta_2$ nicotinic acetylcholine receptor partial agonist – partially mimics effect of nicotine

► Key Points
Varenicline side effects (can be mitigated by reducing the dose), include Nausea:
• 1mg bid 30%, Placebo 10%
  • Often mild to moderate, transient, early in treatment and minimized by taking the dose with food or water
  • 2-3% discontinue due to nausea
  • Small, petite women tend to suffer most from nausea side effects
• Insomnia, abnormal dreams
• Constipation, flatulence, vomiting
• Depression: not a side effect in clinical trials but has been cited as a concern by some clinicians.
• Many patients with mental health issues may use (consciously, or unconsciously) nicotine or smoke as an anti-depressant. Clinicians should monitor their clients for signs of depression.

Varenicline Dosing:
• 0.5mg daily days 1 to 3
• 0.5mg bid days 4 to 7
• 1.0mg bid thereafter
• Quit date should be day seven, but, smokers may quit up to 4 weeks after medication is started.
• Starter Pack: 11 tablets of 0.5mg, 14 tablets of 1.0mg
• Continuation Pack: 2-week blister pack 28 tablets of 1.0mg
• Loose packaging 0.5 mg tablets: 56 per bottle
• Four weeks recommended because it usually doesn’t work right away.
• Ideal if nothing else has worked and the client isn’t worried about weight gain issues.
• Can quit abruptly, do not need to taper off this medication.

Background
Varenicline (trade name Chantix in the USA and Champix in Europe and Canada, manufactured by Pfizer, usually in the form of varenicline tartrate) is a prescription medication used to treat smoking addiction. In May 2006, it was approved for sale in the US, and in 2007 in Canada. This medication is the first approved nicotinic receptor partial agonist, where its main effect involves reducing cravings for and decreasing the pleasurable effects of cigarettes and other tobacco products. Through these mechanisms, using varenicline may assist some patients in smoking cessation. Varenicline is sold as 0.5 mg and 1 mg tablets. Titrating the dose from 0.5 mg every day for 3 days to 0.5 mg twice daily for 4 days to 1 mg twice daily is recommended. The standard maintenance dose is 1 mg twice daily, with variations as permitted by the FDA. The FDA has approved its use for twelve weeks. If smoking cessation has been achieved it may be continued for another twelve weeks.

Reference:
Varenicline: Drug Interactions / Precautions

- Concomitant use of nicotine replacement therapy
  - not expected to increase cessation
  - will increase adverse drug reactions
- Does not affect and is not affected by CYP450 enzyme system
- Reduce dose in severe renal impairment

► Key Point
- Use of both NRT and varenicline may increase incidence of nausea, vomiting, headache, dizziness, dyspepsia and fatigue.
2nd Line Medications

- Use at physician’s discretion (first-line medications unsuccessful)
- Not approved as smoking cessation aids
- Clonidine
  - Anti-hypertensive
  - Helps to reduce withdrawal
- Nortriptyline
  - Antidepressant
  - Two studies demonstrated increased abstinence rates

► Key Points
- These are not approved as smoking cessation medications because there have been few clinical trials done for these drugs for cessation purposes.
- Clonidine is a blood pressure medication that has been shown to be somewhat effective in cessation. It can cause low blood pressure and weakness.
- Nortriptyline is an anti-depressant which may also have some positive effects for cessation. It can also have cardiac side effects. Its effectiveness is on par with bupropion, but it isn’t being pushed by drug companies because it’s generic.
- These are considered “best kept secrets”.
- Prescribed, but no evidence-based indication that they work
- Knowledge by doctors about these meds is not as high, but they can work very effectively.
- Economically disadvantaged clients may benefit from these drugs because they are less expensive.
Cessation Objectives

1. Increase the number of quit attempts
2. Increase long-term success of quit attempts

► Key Point

- Annually, between 30% and 50% of smokers try to quit. Some smokers succeed after making several attempts.

♫ Facilitator Tip

This is a good place to encourage participants to tell their clients to “don’t quit quitting!” and describe how with each quit attempt made the smoker who is willing to quit becomes one step closer to eventually quitting.
Sometimes the doorway has to be opened wider and held open longer…

► Key Point

• The end goal in this stage is to engage the client in a collaborative relationship that he or she experiences as helpful, and to encourage ambivalence and exploration using the MI techniques.
Integrating Tobacco and with the Treatment of Other Substances

Practice Barriers and Practice Enablers
From your experience, how has the new smoke-free grounds policy at CAMH been received?

a. Staff and clients have embraced the ban with much success
b. Both staff and clients are undecided about it
c. The smoke-free policy is very limiting and further accommodations for clients need to be developed
d. Some clients will always smoke, and should not be forced to change.
Have participants discuss in small groups (at their tables) their experiences with the new Smoke-Free Policy. This discussion can include any difficulties encountered, positive findings, observed effect on clients, etc.
Would you like to offer cessation treatment groups?

a. Yes  
b. No  
c. I’m not sure  
d. Running groups is not an option in my setting
What type of group might be realistic to offer in your program/setting?

a. Structured cessation treatment group
b. An information or education group
c. A continuing care group
d. Not sure
e. It would not be realistic to offer a group in my setting
Small Group Discussion
(20 minutes)

- In small groups, appoint a recorder
- Discuss the following questions:
  - What are the barriers to integrating tobacco treatment in your program?
  - What would facilitate integrating tobacco treatment with other addictions?
  - What changes could be made to minimize smoking triggers for clients in our programs?
Large Group Debriefing

• What strategies did you come up with to overcome barriers to integrating tobacco treatment?
• What suggestions did your group have to minimize smoking triggers for clients?
What is the next step?

- What else is needed to continue to move towards a smoke-free environment for clients, and one that is supportive of addressing tobacco dependence?
- What are your next steps, individually and as a team?
Learning Assessment 2

• Please complete Learning Assessment 2
• This is a self-reflection tool designed to gauge whether your responses to the earlier assessment have changed, and can be used for you to track these changes
• It is also an opportunity for you to set practice objectives
• This will not be collected
Course Evaluation

- Please complete the course evaluation which will help us improve future trainings
- We *will* be collecting this!
How would you rate this course?

a. Excellent
b. Very good
c. Good
d. Fair
e. Poor
CAN-ADAPTT

Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment

CAN-ADAPTT is a practice-based research network designed to facilitate knowledge exchange in the area of smoking cessation between practitioners, healthcare providers and researchers. It includes:

- Online Discussion Board
- Seed Grant Opportunities
- Access to a dynamic set of Tobacco Control Guidelines

For further information or to register for free, please visit www.can-adaptt.net
Please remember to leave your iclicker on your table, Thanks.
THANK YOU

www.teachproject.ca
www.can-adaptt.net