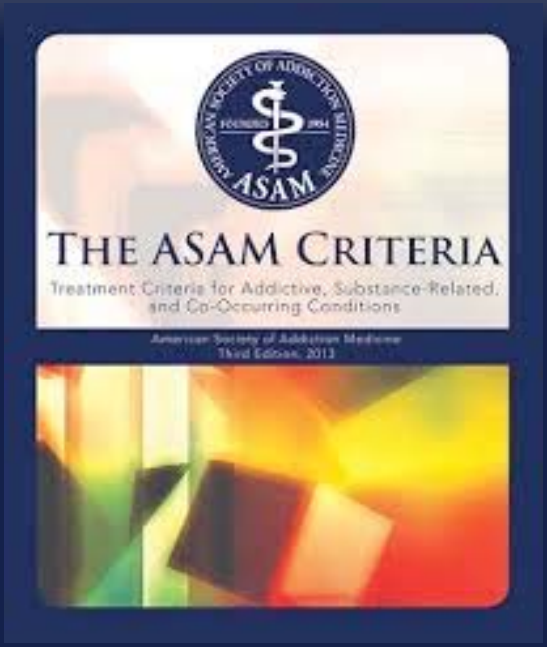
Tobacco Use Disorders



Susan Blank, MD, FAPA

Lori D. Karan, MD, FASAM, FACP

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ASAM Disclosure of Relevant Financial Relationships
Content of Activity: The New ASAM Criteria and ASAM Criteria Software – What's New and How to Use the Criteria

Name	Commercial Interests	Relevant Financial Relationships: What Was Received	Relevant Financial Relationships: For What Role	No Relevant Financial Relationships with Any Commercial Interests
Susan Blank, MD				X
Lori D. Karan, MD	Gilead Sofosbuvir (HCV Rx)	$1,500	Honorarium to attend San Francisco meeting	
Lori D. Karan, MD	Titan Pharm. Probuphine (implantable buprenorphine rod)	$10,000	Consultation to Woodside Capital Partners (Jeff Karan, brother)	

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Case #1 SW

- 64 y/o Retired Railroad Worker
- Hospitalized for pneumonia complicating COPD pO2=65% when admitted to hospital 6mo ago
- Now, pO2 on room air is normal (98%), even as he continues to smoke
- SW lives independently
- He walks slowly due to back and knee ailments

Case #1 SW (cont 2)

- Family members and physicians repeatedly urge SW to quit smoking
- SW gets anxious and responds by changing the subject and avoiding the issue
- SW chain smokes; onset 16y/o, max 4ppd, now 1.5 ppd
- SW smokes within seconds of awakening
- SW gets up and leaves conversations to smoke, even when doing so is not socially appropriate

Case #1 SW (cont 3)

- SW did not smoke for a few days when he was ill.
- SW has tried smoking cessation books, classes, & groups, as well as nicotine gum and the patch

Case #1 SW

How do you assess the severity
of SW's nicotine withdrawal and nicotine addiction?

What is the most appropriate level of care to treat SW?

DSM 5 Tobacco Use Disorder
≥ 2 Criteria within 12 mo

1. Taken in larger amts or over a longer period of time than intended
2. Persistent desire or unsuccessful efforts to cut down or control use
3. A great deal of time is spent in activities necessary to obtain or use
4. Craving, or a strong desire or urge to use tobacco
5. Recurrent use ➔ failure to fulfill major role obligations (work, school, home)
6. Continued use despite social or interpersonal problems
7. Important social, occupational, or recreational activities reduced
8. Recurrent use when physically hazardous (i.e., smoking in bed)
9. Tobacco use is continued despite knowledge of physical or psychological problem exacerbated by tobacco

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DSM 5 Tobacco Use Disorder
≥ 2 Criteria within 12 mo

10. Tolerance, as defined by either:
    a. A need for markedly ⇧ tobacco to achieve the desired effect
    b. A markedly ⇩ effect with continued use of the same amt

11. Withdrawal, as defined by either:
    a. Characteristic withdrawal syndrome
    b. Tobacco (or nicotine) is taken to relieve withdrawal sx

Problems: Tobacco vs Nicotine

Tobacco is not a drug

It is a set of toxic chemicals that serves as a flavorant and drug delivery system

Nicotine is psychoactive

Nicotine, not tobacco, causes :

- dose escalation
- tolerance
- intoxication
- withdrawal

Assessing Severity: DSM 5 Problems

General DSM issues:

- Measures are context-specific
- No threshold to determine if a specific criteria is met

Nicotine vs other drugs:

1. Nicotine does not cause gross intoxication
   - not socially acceptable ≠ behavioral disruption caused by intoxication
     - Judgment is not worsened by nicotine use
     - Less interference with role obligations & interpersonal relations
2. Dose escalation and tolerance are less important

Why is nicotine so addicting?

Craving

What is the wildest thing that you ever did to get a cigarette?

Relapse

Cigarettes are more difficult to quit than other substances

Why is nicotine so addicting?

- Early onset – often 1st drug used (incl. as a fetus)
- Rapid onset of action
- Fine-tunes behavior (both stimulates + relaxes)
- Rapid onset of action (cigarette enables 'freebase')
- Can self-adjust dose
- Numerous doses each day (1 pack = 200 puffs)
- Use linked with environmental and internal cues

Fagerstrom Test For Nicotine Dependence

How soon after you wake up do you smoke your first cigarette? <5 min ☐ 3 6-30 min ☐ 2 31-60 min ☐ 1 >60 min ☐ 0	0-3
Do you find it difficult to refrain from smoking in places where it is forbidden i.e., in church, at the library, in cinemas, etc? Yes ☐ 1 No ☐ 0	0-1
Which cigarette would you hate most to give up? 1st one of the morning ☐ 1 any other ☐ 0	0-1
How many cigarettes do you smoke? >31 ☐ 3 21-30 ☐ 2 11-20 ☐ 1 <10 ☐ 0	0-3
Do you smoke more frequently during the first hours after awakening for the day? Yes ☐ 1 No ☐ 0	0-1
Do you smoke when you are so ill that you are in bed most of the day? (I you never get sick, give the most likely response) Yes ☐ 1 No ☐ 0	0-1
TOTAL (10 points possible = most severe)	

Classification of Severity

CLASSIFY TOBACCO-DEPENDENCE SEVERITY
Clinical Features Before Treatment*

	Cigarette Use	Time to 1st Cigarette	Nicotine W/D	Fagerstrom	Serum Cotinine
Very Severe	>40 cigs/day Daily use	0-5 min	Constant	8-10	> 400 ng/mL
Severe	20-40 cigs/day Daily use	6-30 min	Constant	6-7	251 - 400 ng/mL
Moderate	6-19 cigs/day Daily use	31-60 min	Frequent	4-5	151 - 250 ng/mL
Mild	1-5 cigs/day •Intermittent Use	> 60 min	Intermittent	2-3	51-150 ng/mL
Non-Daily Social	Non-daily cigarette use Social setting, only	> > 60 min	None	0-1	<50 ng/mL

http://tobaccodependence.chestnet.org

ACCP Tobacco-Dependence Treatment Tool Kit, 3rd Ed.

Case #1 SW

How do you assess the severity
of SW's nicotine withdrawal and nicotine addiction?

What is the most appropriate level of care to treat SW?

Case #1 SW

- Severe Nicotine Addiction
  - Death imminent if smoking continues
  - Physically Dependent, Prior Tries & Unable to Quit
- Education & Intervention
- Refer to Residential Treatment
  - Intensive Pharmacotherapeutic Intervention
  - Intensive Behavioral & Addictions Rx

	Level of Care	Tobacco Use Disorder Treatments
0.5	Early Intervention	Print & Online Self-Help Education
		Over-the-Counter Nicotine Replacement
1.0	Outpatient	Online Social Support & Problem Solving
		Brief Interventions: Physicians Who Ask (Screen), Advise, Assess, Assist, and Arrange Tobacco Cessation
		Telephone Quit-Line Counseling
		Interactive Online Counseling
		Group Face-to-Face Outpatient Treatment Programs (SmokEnders, American Cancer Assoc, American Lung Assoc Programs)
		Tobacco Treatment Specialty Consultation and Follow-Up (Stand Alone or in Ambulatory Health Care Settings)

	Level of Care	Tobacco Use Disorder Treatments
2.1	Intensive Outpatient	(NONE)
2.5	Partial Hospitalization	(NONE)
3.1	Clinically Managed Low-Intensity Residential	(NONE)
3.3	Clinically Managed Population-Specific, High-Intensity Residential	(NONE)
3.5	Clinically Managed High Intensity Residential	(NONE)
3.7	Medially Monitored Intensive Inpatient	Medically Monitored Inpatient Treatment
4.0	Medically Managed Intensive Inpatient	

Treatment matching research is needed

Making Patient Placement Decisions &
Writing Clinical Justifications
Using Uniform Patient Placement Criteria e.g., ASAM.

- *Improve Patient Placement Decisions*
- *Improve Clinical Justifications*
- *Improve Treatment Plans*
- *Improve Performance*
- *Improve Outcomes*

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Case #2: MP

- 28-y/o single mother
- 16 weeks pregnant
- Cigs: 1 ½ ppd x 10 yrs
- Onset: 14 y/o
- Daily Use: 16 y/o
- Longest w/o cigs: < 36 hrs

Case #2: MP (cont-2)

Unable to quit during 1st pregnancy

1st Child

- 3 wks premature
- 5.5 lbs
- asthma & allergies

Case #2: MP (cont-3)

- Believes herself "healthy and active"

  Denies alcohol & other drugs
- Denies hx depression
- MD has advised cigarette cessation for the health of her 4 y/o & unborn child

- Prior Rx:

  nicotine patch

  nicotine gum

Case #2: MP (cont-4)

- Frequent urges to smoke
- Trigger:

  home environment, where she & her cousins smoke most of the time
- Lacks transport & childcare for local Freedom from Smoking Class

Tobacco and Pregnancy

To enable tobacco cessation and protect the unborn fetus, this woman would be best treated:

* Level 2.1-2.5 Intensive Outpt-Partial Hospitalization with child care and transportation

* Level 3.1-3.5 Residential Perinatal Rx program

* Level 3.7-4 OB-Gyn Ward with smoking cessation consultation, Rx, & skill building

Sound Expensive?

A low birth wt baby with cognitive impairment is more costly!

Case #3: BR

- 63 y/o homeless Vietnam Veteran
- Dishonorably discharged ; no VA benefits
- Praised by MD - Heroin Recovery

Case #3: BR (cont 2)

- 2 ppd x 50 yrs
- Dx COPD
- Rarely attends the free clinic
- MD advised smoking cessation & offered nicotine replacement

Case #3: BR (cont 3)

- PTSD and Paranoia after 2nd tour
- Poorly adherent with his medication and therapy
- BR's anxiety and mistrust of the system makes it difficult for him to engage

Case #3: BR (cont 4)

- Smoking has gotten to be increasingly expensive, so BR "wouldn't mind stopping"
- He has a difficult time organizing himself enough to follow through with the recommendations

Silos of Neglect

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Co-morbidity & Nicotine Addiction

Case #3: BR

- Level 2.5 Partial Hospitalization with Day Treatment
  Integrate tobacco cessation Rx with Mental Health Rx
  Provide 1^{ary} Care in Pt Centered Medical Home
    - Monitor Lung Fx
    - Screen-Lung Ca
    - TB test, influenza vaccine, & pneumovax

Benefits of Integrated Care

10 VA Centers PTSD & Tobacco N = 943 (2004-09)	6 mo tobacco abstinence (7 day point prevalence)	18 mo tobacco abstinence (7 day point prevalence)	Prolonged tobacco abstinence
Integrated care	16.5%	18.2%	8.9%
MH & Referred to Smoking Cessation	7.2%	10.8%	4.5%

McFall M, Saxon AJ, Malte CA, et al. Integrating tobacco cessation into mental health care for posttraumatic stress disorder: a randomized controlled trial. JAMA. 2010;304(22):2485-2493.

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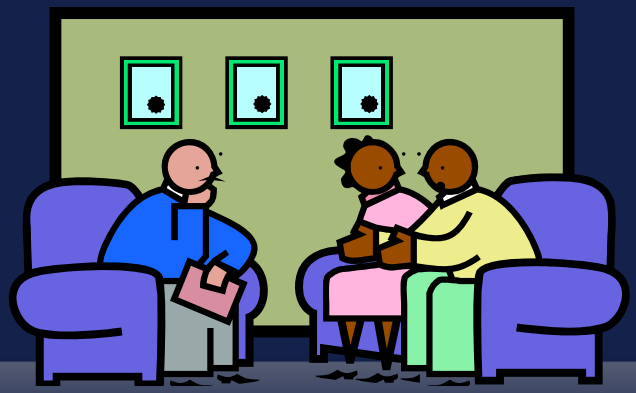
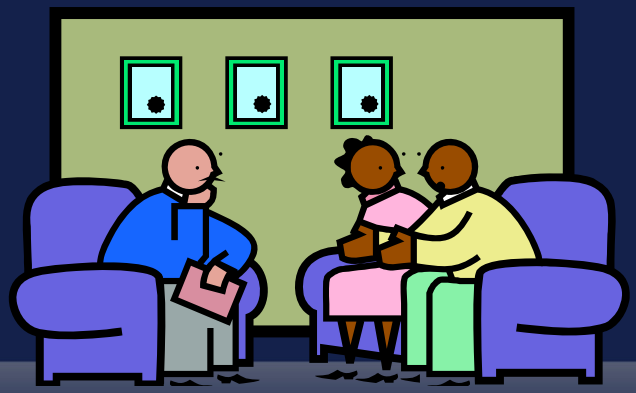
Case #4: TH



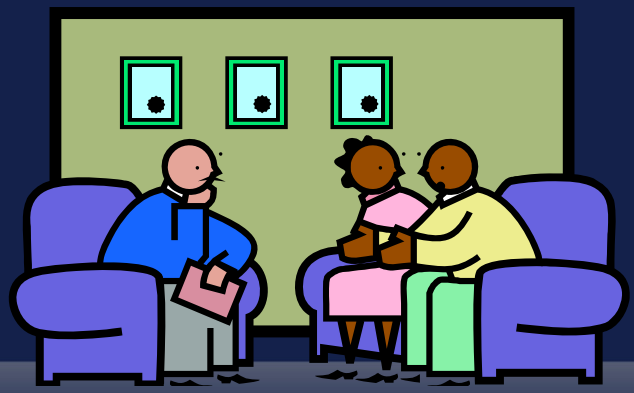
- *50* y/o Addiction Counselor - Residential Rx Center
- Rx Center to begin treating tobacco addiction along with all other addictions
- Staff cannot smell of smoke, nor smoke at work

Case #4: TH (cont 2)



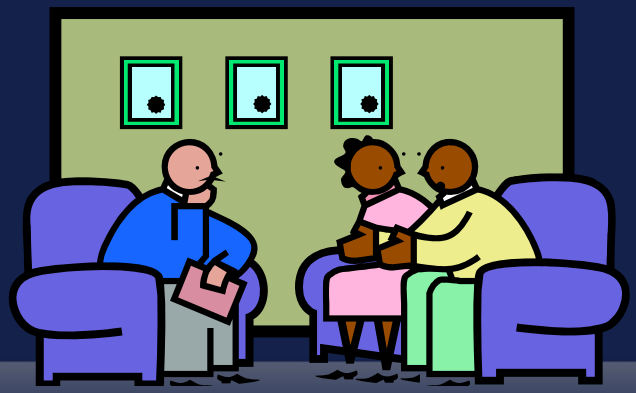
- "Recovery" alcohol & pain meds x 23 yrs
- Always knew tobacco was not part of his disease
- Feels extra rapport when takes smoking breaks with pts
- Advised pts, who wanted to stop smoking, to wait > 1 yr "it is too hard to quit more than one thing at a time."

Case #4: TH (cont 3)



- Frequent bronchitis
- MD told to stop before permanent lung damage
- 40 lbs overweight, fears wt gain if quits cigs
- Angry that workplace is forcing him to quit smoking

Case #4: TH



- Motivate for treatment & cessation
  - Improve bronchitis & lung function
- Begin with Level 0.5-1 Education & Outpatient Rx
- Devise Rx plan to address weight concerns
- Utilize knowledge of addiction &
  - 12 step Skills - Nicotine Anonymous

Addiction Professionals: Issues

- **Staff may have belief system - Nicotine Addiction**
  - **"you can only deal with one addiction at a time"**
  - **"you should wait a year before you attempt to stop.."**
  - **"tobacco use disorders are less harmful than the immediate consequences of alcohol, illicit drug use…."**

Addiction Professionals: Issues

- **Staff who are still smoking themselves:**
  - **May be reticent to diagnose and treat tobacco addiction**
  - **May be tempted to use smoking time as "milieu management"**
  - **May "feel sorry" for the patients and sabotage the patients treatment**

Addiction Professionals: Issues

- Leadership must recognize

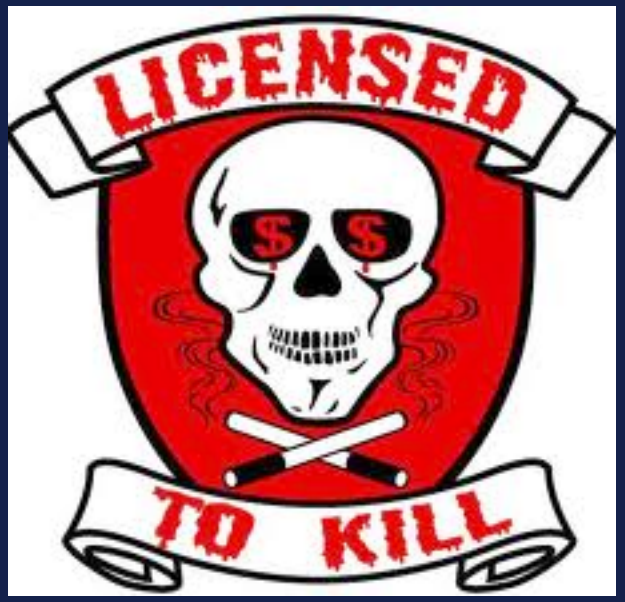
  TUD can no longer be ignored during prevention, Dx & Rx of other addictions & mental illness

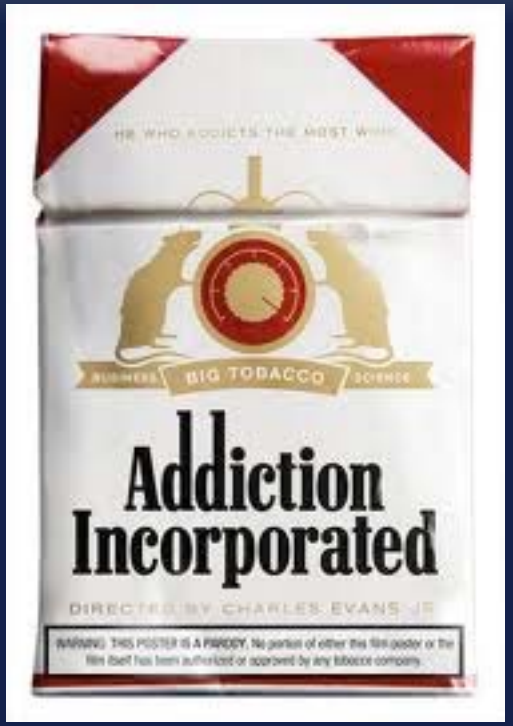
- Staff need to be trained in Dx & Rx of TUD

- All facility staff, including clinical and non-clinical support staff should not smell of tobacco

- All staff who want to quit should have access to Rx & support for cessation

Discussion






THE END