TOBACCO

CESSATION & RECOVERY

MORE THAN JUST SMOKING CIGS

- Cigarettes
- Chewing tobacco
- Smokeless tobacco
- Snuff
- Cigars
- Pipes
- Clove cigarettes
- Etc…

NICOTINE

- Nicotine is the psychoactive drug in tobacco products that produces dependence
- Most smokers are dependent on nicotine
- Nicotine dependence is the most common form of chemical dependence in the United States
- Research suggests that nicotine is as addictive as heroin, cocaine, or alcohol

(Centers for Disease Control)

NICOTINE DEPENDENCE

DSM-IV

Demonstrates at least three of the following criteria occurring at the same time during a 12-month period:

- Tolerance
- Withdrawal
- Uses in larger amounts or over a longer period than intended
- Persistent desire or unsuccessful attempts to cut down or quit
- A lot of time spent obtaining, using, recovering from use
- Important social, occupational, or recreational activities are reduced because of tobacco use
- Use continues despite physical or psychological problems caused or exacerbated by use

THE TROUBLE WITH TOBACCO

- Tobacco related deaths number more than five million worldwide each year (WHO, 2009)
- In the United States, "tobacco use is the leading preventable cause of disease, disability and death" (NIDA, 2009)
- In 2007, 19.8% of adults in the United States were current smokers (CDC, 2008)
- Nicotine is a highly addictive substance with a capture rate greater than that of heroin, cocaine, or alcohol. 31.9% of people who try tobacco will become dependent on it (NTA, 2006)

TOBACCO & DISEASE

- Heart disease
- Chronic obstructive pulmonary disease (COPD)
- High blood pressure
- Stroke
- Emphysema
- Chronic bronchitis
- Impotence
- Cancer
  - lung, larynx, oral cavity, esophagus, kidney, stomach, ovary, pancreas, etc…

4,000 CHEMICALS (Cleveland Clinic)

- Arsenic (poison)
- Ammonia (poisonous, in many household cleaners)
- Acetone (nail polish remover)
- Ammonium bromide (toilet cleaner)
- Benzene (industrial solvent)
- Carbon monoxide (exhaust pipe fumes)
- Cadmium (used in rechargeable batteries)
- Cyanide (poison used in gas chambers)
- DDT (insecticide)
- Formaldehyde (preservative, embalming fluid)
- Lead (a poison removed from nearly all paints)
- Mercury (highly poisonous and easily absorbed through respiration)
- Nickel (poisonous, a known cancer-causing agent)
- Hydrogen cyanide (deadly poison used in gas chambers)
- Hydrogen sulfide (sewer gas)
- Polonium-210 (radioactive substance)
- 50+ cancer causing agents (carcinogens)

TRENDS – THE GOOD NEWS!

- "Monitoring the Future" data from 2008 shows that since peaks in the mid 1990's, smoking rates in teenagers have been declining. Between 1997 and 2004, smoking decreased by 56% in 8th graders, 47% in 10th graders, and 32% in 12th graders (Johnston, 2009)
- In 2007, 21% of adults and 18% of high school students in Michigan reported being current smokers (CDC, 2008)

WHO IS STILL SMOKING?

- Smoking rates among certain populations in the United States are disproportionately high
  - 36.4 % of American Indians/Alaska Natives
  - 44% of people with GED's
  - 28.8% of people living below the federal poverty level
- Prevalence of smoking in individuals who suffer from substance use disorders is even higher than rates in these populations

(CDC, 2008)

PEOPLE IN & OUT OF RECOVERY

- Alcoholics make up as many as 25% of all smokers (Hurt, 1996)
- Drug users start smoking at a younger age, smoke more heavily, have a harder time quitting and have more emotional, psychological and physical problems than non drug using smokers (Sussman, 2002)

COMORBIDITY

- People aged 12+
  - 22.6% who have used tobacco in the past month reported current use of other drugs
    (compared with 4.9%)
- Youth aged 12-17
  - 52.9% of youth who have used tobacco in the past month also used other drugs
    (compared with 6.2% of youth)

(CDC, 2010)

MYTH: "Smoking is less of a problem today"

- 80-90% of those involved with clinical treatment for substance use disorders are nicotine dependent (Northeast ATTC, 2006)
- 90% of all Dawn Farm admission use tobacco
- Addicts and alcoholics smoke more heavily

TRUTH:

Tobacco use is decreasing in the general population, but is still a huge problem among addicted and recovering people

MYTH: "Smoking isn't going to kill me"

- 80% of all drug related deaths are due to tobacco (Unwin, 1999)
- 50% of substance abusers in recovery died of tobacco related illness
- Over 20 years, tobacco was the number one cause of death among substance abusers following treatment. 51% of deaths were tobacco-related, while 34% were alcohol-related (Hurt, 1996)

TRUTH:

You are more likely to die from tobacco related illness than any other cause (including relapse)

"Bill W. was lifted to the podium in his wheelchair, oxygen tank at his side. He was dying of lung disease. A brave, relentless visionary gave his last professional address about alcohol dependency, only to die from lung disease related to cigarette smoking. He died from nicotine addiction."

(Maheu, 1998)

Dr. Bob was a cigar smoker. He died of throat cancer.

WAIT A YEAR?

- 845 clients admitted to an inpatient addiction treatment center at the Mayo Clinic between 1972 and 1983
- 75% of the clients admitted to treatment were smokers, 3% cigar or pipe smokers and 2% used smokeless tobacco
- At follow up in 1994, 222 of these clients were deceased
  - 73 (34.1%) were attributable to alcohol
  - 19 (8.6%) were attributable to both alcohol and tobacco
  - 109 (50.9%) were attributable to tobacco
- Tobacco was "the leading cause of death" for people who had recently been treated for alcoholism
- Tobacco related deaths were "significantly more frequent than alcohol related causes of death" (Hurt, 1996)

MYTH: "They're really separate issues"

- Heavy smokers have worse relapses (Abrams, 1992)
- Smoking increased urges to use (Rohsenow, 2005)
- Severity of tobacco use predicts poor treatment outcomes (Patkar, 2003)
- Significantly better recovery rates were discovered for non-tobacco users (Stuyt, 1997)
- Tobacco use can harm recovery and trigger other substance use (Williams, 2005; APA 2006)

TRUTH:

People who smoke are less likely to recover

"After one month of sobriety, recovering alcoholics who smoked showed significantly less improvement than those who did not smoke in both brain function and neurochemical markers of brain cell health."

(University of California, 2006)

MYTH: "One thing at a time"

- Quitting smoking does not jeopardize sobriety or treatment outcomes (Bobo, 1987; Bobo, 1998; Burling, 1991; Cooney, 2003; Hurt, 2003; Joseph, 1993; Metz, 2005)
- Clients who quit smoking were significantly more likely to report abstinence at follow-up – 93% vs. 62% (Joseph, 2005)
- Smoking cessation interventions were associated with 25% increased likelihood of long-term abstinence (Prochaska, 2004)

MYTH: "One thing at a time" (continued)

- Treatment of tobacco dependence enhanced abstinence from drinking (Hurt, 2003)
- 48% of non-tobacco users maintained sobriety for 12 months compared to 14% of tobacco users (Stuyt, 1997)

TRUTH:

Addressing tobacco use now can improve overall chances of recovery

MYTH: "I'll quit later, on my own"

- Nicotine dependence is more severe in those with a history of alcohol dependence (Marks, 1997)
- 0-12% of clients quit on their own (Campbell, 1995; Joseph, 2005)
- Only 7% of alcoholic smokers were successful in quitting, compared to 49% of non-alcoholic smokers (DiFranza, 1990)

TRUTH:

Drug addicts and alcoholics have a harder time quitting than other smokers

MYTH: "I'm only hurting myself"

- Of non-smokers who entered treatment, 15% had started smoking by 12 month follow-up (Friend, 2004)
- Abstinence rates were lowest for those who started smoking in treatment (Kohn, 2003)

TRUTH:

Smoking areas become the center of social life in treatment centers that allow smoking. This creates new smokers, who have less success in recovery

MYTH: "I'll be more likely to leave"

- A smoke-free policy had no adverse effect on treatment outcomes (Joseph, 1993)
- Clients complained, but did not leave at higher rates (Kempf, 1996)
- There was no increase in irregular discharges, or reductions in smokers entering treatment (Williams, 2005)

TRUTH:

Quitting smoking is not associated with people getting discharged or leaving treatment early

MYTH: "People don't want to quit"

- 93% believe treatment centers should help people quit smoking (McDonald, 2000)
- Nearly half had a "strong desire" to quit smoking (Orleans, 1993)
- 46% were "very" or "moderately" interested in nicotine treatment (Kozlowski, 1989)
- <10% had no past quit attempts (Borland, 2012)

TRUTH:

Most people that use tobacco want to quit

MYTH: "I won't be able to quit"

- Six weekly post discharge, 58% were nicotine-free or had greatly reduced use (Pletcher, 1993)
- Most can quit, but staying quit is difficult (Borland, 2012)
- Reduced tobacco use is associated with improved treatment outcomes and increased motivation to quit

TRUTH:

You can quit smoking! Quitting is hard, and it may take several attempts. Every attempt is a step towards quitting for good

CHALLENGES OF QUITTING

- Habit
  - Routines
  - Familiarity
- Coping Skill
  - Stress
  - Celebration
- Physical Dependence
  - Nicotine

COSTS OF QUITTING

- Social impact in the recovering community
- Hard work!
  - Developing alternative coping skills
  - Seeking out people who do not use tobacco
  - Being mindful of situations and potential triggers
- Letting go of Culture of Addiction
  - Did tobacco use almost always accompany your primary drug use?
  - Tobacco as a "safe" addiction
- Loss of identify as a tobacco user

NICOTINE WITHDRAWAL

DSM-IV

After using nicotine daily for at least several weeks, exhibits at least four of the following symptoms within 24 hours after reduction or cessation of nicotine use:

- Dysphoric or depressed mood
- Insomnia
- Irritability, frustration, or anger
- Anxiety
- Difficulty concentrating
- Restlessness
- Decreased heart rate

TOP 10 REASONS TO QUIT

1. Reduce chance of heart attack or stroke
2. Reduce chance of lung diseases
3. Better smelling clothes, hair, breath, home, car
4. Better ability to walk and climb stairs
5. Fewer wrinkles
6. Freedom from morning cough
7. Reduce coughs, colds, earaches
8. More energy to pursue physical activities
9. Money saved from not buying tobacco
10. Tobacco will not control my life

(Adapted from the National Heart, Lung and Blood Institute)

PERSONALIZE

- Developing a personalized list of benefits is more beneficial than reciting a pre-written list

(Muller, 2009)

HEALTH BENEFITS OF QUITTING

- **20 Minutes After Quitting**
  Your heart rate drops. (CDC)
- **12 Hours After Quitting**
  Carbon monoxide level in your blood drops to normal. (CDC)
- **A Few Days After Quitting**
  Your sense of smell and taste may improve. You will breathe easier. (National Cancer Institute)

HEALTH BENEFITS OF QUITTING

- **2 Weeks to 3 Months After Quitting**
  Your heart attack risk begins to drop.
  Your lung function begins to improve. (CDC)
- **1 to 9 Months After Quitting**
  Your coughing and shortness of breath decrease. (CDC)
- **1 Year After Quitting**
  Your added risk of coronary heart disease is half that of a smoker's. (CDC)

HEALTH BENEFITS OF QUITTING

- **5 Years After Quitting**
  Your stroke risk is reduced to that of a nonsmoker's 5-15 years after quitting. (CDC)
- **10 Years After Quitting**
  Your lung cancer death rate is about half that of a smoker's. Your risk of cancers of the mouth, throat, esophagus, bladder, kidney, and pancreas decreases. (CDC)
- **15 Years After Quitting**
  Your risk of coronary heart disease is back to that of a nonsmoker's. (CDC)

	Men		Women	
	Life expectancy	Extra years compared to smokers	Life expectancy	Extra years compared to smokers
Smoked until death	69.3		73.8	
Never smoked	78.2	8.9	81.2	7.4
Quit at age 35	76.2	6.9	79.9	6.1
Quit at age 45	74.9	5.6	79.4	5.6
Quit at age 55	72.7	3.4	78.0	4.2
Quit at age 65	70.7	1.4	76.5	2.7

(Taylor, 2002)

MORE BENEFITS OF QUITTING

- Culture of Recovery
  - Utilizing healthy coping skills
- Identity as a healthy person, tobacco-free
- Accomplishing something difficult
- Money

  If you use one $7 pack of cigarettes per day….
  - You save $210 after one month
  - You save $2520 after one year
  - You save $12,600 after five years

ARE YOU READY?

Step 1 – Thinking about quitting
Step 2 – Preparing to quit
Step 3 – Quitting
Step 4 – Staying quit

smokefree.gov

STEP 1 – THINKING ABOUT QUITTING

- Learn about tobacco use and recovery
- Ask people who have stopped using tobacco about their experiences
- Think about your own level of nicotine addiction
- Weigh the pros and cons
  - Pros & Cons of Quitting
  - Pros & Cons of Continuing to Use

STEP 2 – PREPARING TO QUIT

Create a Tobacco Recovery Plan detailing your plans for quitting. Your plan may include:

- Wash your clothes
- Clean your house and car
- Visit a dentist for a teeth cleaning
- Discard tobacco products and paraphernalia
- Prepare for withdrawal symptoms
- Decide whether or not to use medication or NRT
- Make a list of reasons for quitting and keep it in your wallet

STEP 2 – PREPARING TO QUIT

Ask for support!

- Tell your sponsor and supports
- Tell your family members
- Tell your coworkers
- Tell your therapist or counselor
- Attend a support group

Recognize the situations that will be hardest for you, and develop strategies for coping with them (after meals, during stress, out with friends, etc.)

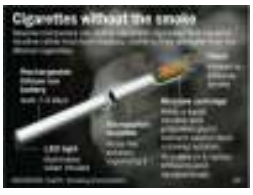
NICOTINE REPLACEMENT (NRT)

- Nicotine patch, gum, lozenge
  - Available over the counter
- Nictotine inhaler, spray
  - Require prescriptions

- Follow the instructions provided with the NRT
- 1mg = 1mg

E-CIGARETTES?

- 2009 FDA Report
  - Detectable levels of known carcinogens
  - Inconsistent/nonexistent quality control
  - Nicotine present in "non-nicotine" cartridges
  - Significant variance in nicotine levels



MEDICATIONS

Bupropion (Wellbutrin, Zyban)

- Anti-depressant
- May decrease the urge to smoke

Varenicline (Chantix)

- May decrease withdrawal symptoms by blocking the effects of nicotine if you resume tobacco use

- These medications require prescriptions
- These medications have side effects
- Ask your doctor whether these medications may be right for you
- Always use medication as prescribed

12 STEP RECOVERY

Steps 1-3

- Admitting powerlessness over tobacco use
- Believing that a higher power can help
- Deciding to ask for help from that power

Social Support

- Talk with tobacco-free members of the recovering community about what worked for them
- Build a tobacco-free support network
- Help others who are trying to become tobacco-free

STEP 3 – QUITTING

- Follow your Tobacco Recovery Plan
- Stay busy
- Drink a lot of water
- Avoid "smoky" places
- Utilize your supports
- Socialize with people who are tobacco-free
- Take it one day at a time

- More quit attempts increase likelihood of success

(Benowitz, 2011)

MANAGING CRAVINGS

When your experience a craving….

- Brush your teeth
- Count backwards from 20 to 1
- Take 10 slow, deep breathes
- Wash your hands
- Talk to a support
- Exercise for 5 minutes
- Eat carrots or celery
- Chew gum
- Remind yourself of the benefits of quitting
- Remember that the craving will pass

STEP 4 – STAYING QUIT

- Celebrate tobacco-free anniversaries
- Recognize that your body is recovering from tobacco use
- Calculate the amount of money that you are saving by not purchasing tobacco
- Continue to build a tobacco-free support network
- Help others who are trying to quit
- Feel good about it!

STAFF ROLES

- Support tobacco recovery
- Care about client health and wellness
- Believe that tobacco cessation impacts recovery
- Avoid ambivalence
- Influence culture
- Role model
- Provide accurate and consistent information and education
- Staff attitude is very important!

STAFF BARRIERS

- Greatest resistance to tobacco-free policy was from staff
- Treatment centers overstated tobacco intervention
- Staff believed that using tobacco with clients helped build relationships

(Richter, 2012)

INTERVENTION

- Chronic Disease Management (Benowitz, 2011)
  - Long term intervention/treatment
- Interventions to Increase Abstinence
  - Physician advise to quit
  - Intervention >10 minutes
  - Multiple sessions
  - Self-help only slightly higher than no intervention
  - Individual counseling
  - 2-3 or more types of intervention best

(US Department of HHS, 2009)

ORGANIZATIONAL STEPS

1. Acknowledge the challenge & barriers
2. Establish a leadership group
3. Create a change plan
4. Start with easy changes
5. Conduct staff training
6. Assess and document client tobacco use
7) Incorporate tobacco recovery in treatment
8) Provide medication/NRT
9) Provide assistance for staff
10) Use motivation-based treatments
11) Establish ongoing communication
12) Consider tobacco-free grounds

(Order-Conners, 1996)

RESOURCES

- Michigan Smoker's Quit Kit
  - Step 1 – Are you ready to quit?
  - Step 2 – Planning to quit
  - Step 3 – After you've quit
- Tobacco Recovery Resource Exchange
  - www.tobaccorecovery.org
  - Implementation Toolkits
    - For the Administrator
    - For the Clinician

RESOURCES

- US Department of Health & Human Services
  - Treating Tobacco Use and Dependence: 2008 Update
  - Clinical Practice Guidelines
- Smokefree.gov

Recovery is everywhere….

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