Addressing Tobacco Treatment in Mental and Behavioral Health Settings

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MANAGED BY UK HEALTHCARE

Goals of this presentation

- Describe factors associated with tobacco use dependence among persons living with mental and behavioral health challenges
- Describe evidence-based treatment approaches when providing tobacco dependence services to persons living with mental and behavioral health challenges
- Discuss resources to enhance tobacco treatment for those living with mental and behavioral health challenges

Mental Disorders are Prevalent

- 18.1% have any mental disorder
- 4.1% suffer from a serious mental illness (SMI)

2015 National Survey on Drug Use and Health: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf

Substance use Disorder

Problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- The substance is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Craving, or a strong desire or urge to use the substance.
- Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
- Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
- Recurrent use of the substance in situations in which it is physically hazardous.
- Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
  - A markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for that substance (as specified in the DSM- 5 for each substance).
  - The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

American Psychiatric Association. (2013). *DSM 5*. American Psychiatric Association.

Classes of substances of abuse

Opioids/Narcotics

- Fentanyl
- Heroin
- Hydromorphone
- Methadone
- Morphine
- Opium
- Oxycodone

Hallucinogens

- Ecstasy/MDMA
- K2/Spice
- Ketamine
- LSD
- Peyote & Mescaline
- Psilocybin
- Marijuana/Cannabis
- Steroids
- Inhalants

Stimulants

- Amphetamines
- Cocaine
- Khat
- Methamphetamine
- Alcohol (low dose)
- Nicotine (high dose)

Depressants

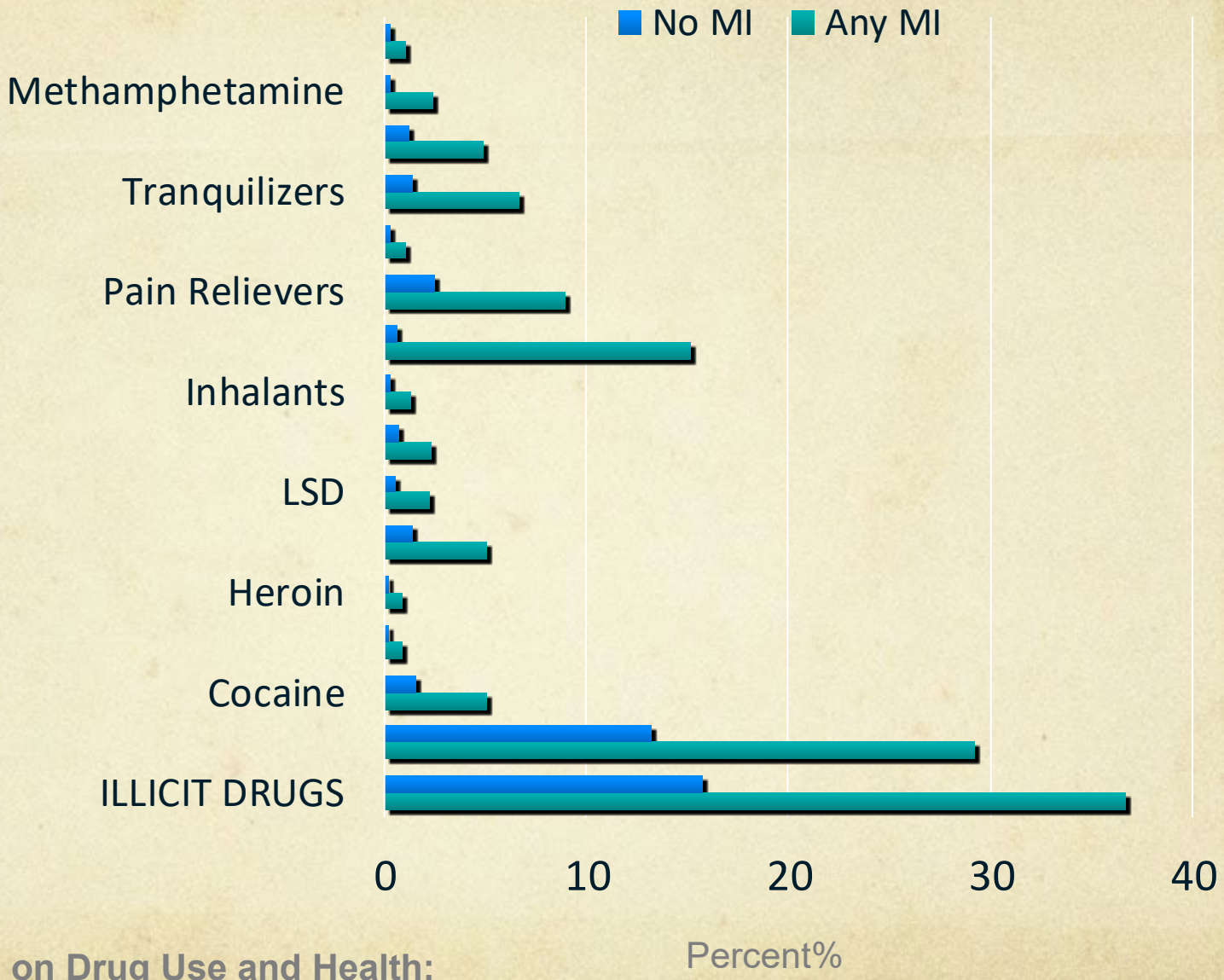
- Barbiturates
- Benzodiazepines
- GHB
- Rohypnol®
- Alcohol (high dose)
- Nicotine (low dose)

Drugs of Concern

- Bath Salts or Designer Cathinones
- DXM
- Kratom
- Salvia Divinorum

Drug Enforcement Administration. (2011). Drugs of Abuse: 2011 Edition. A DEA Resource Guide. *US Dept of Justice. www. justice. gov/ dea/ drugs_ of_ abuse_.*

Past year use of illicit drugs by MI status (adults ≥ 18 yrs)

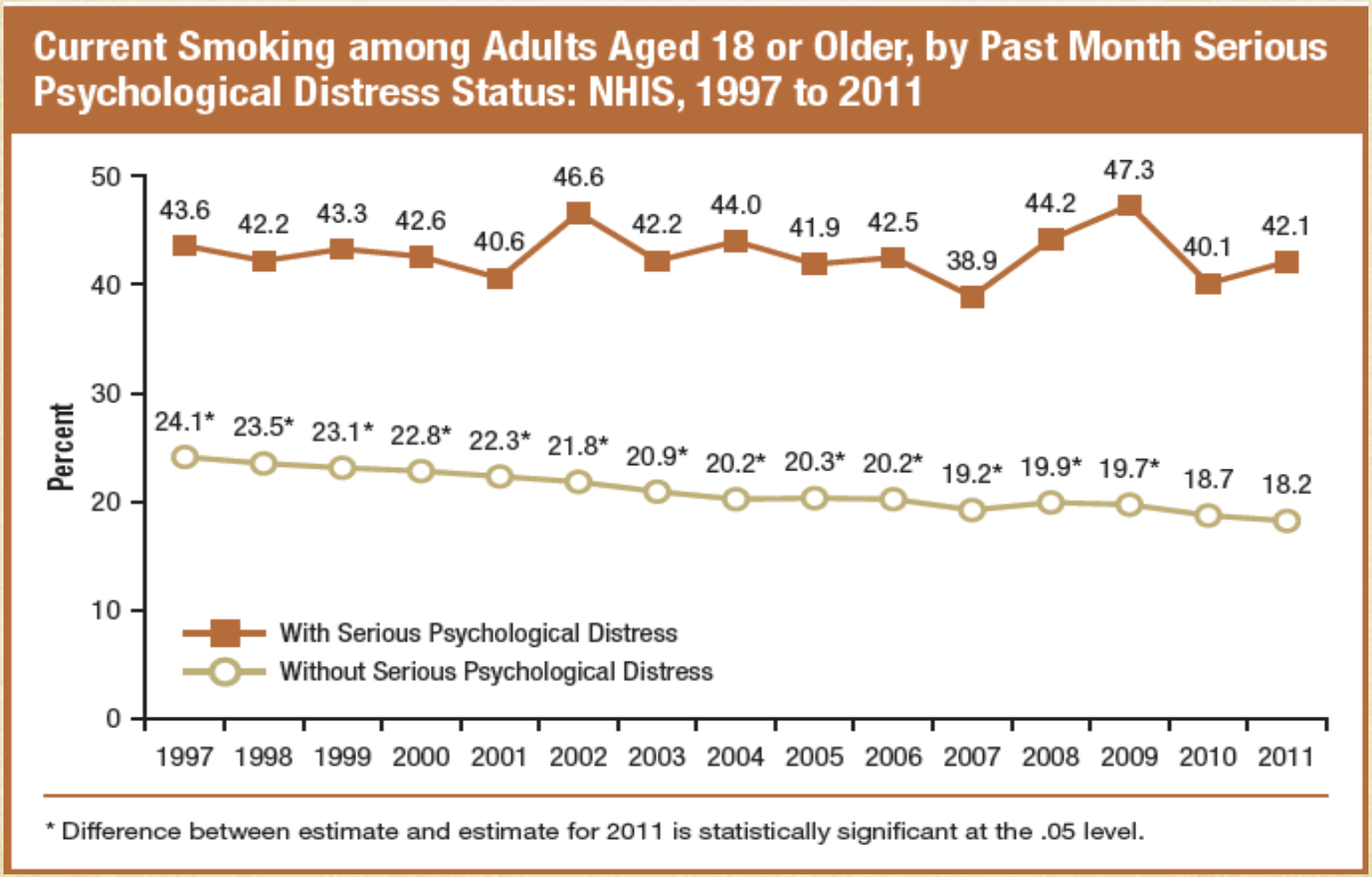


2018 National Survey on Drug Use and Health:
https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetTabsSect8pe2018.htm

Why Engage Persons with mental and behavioral health challenges in Tobacco Treatment?

https://pixabay.com/

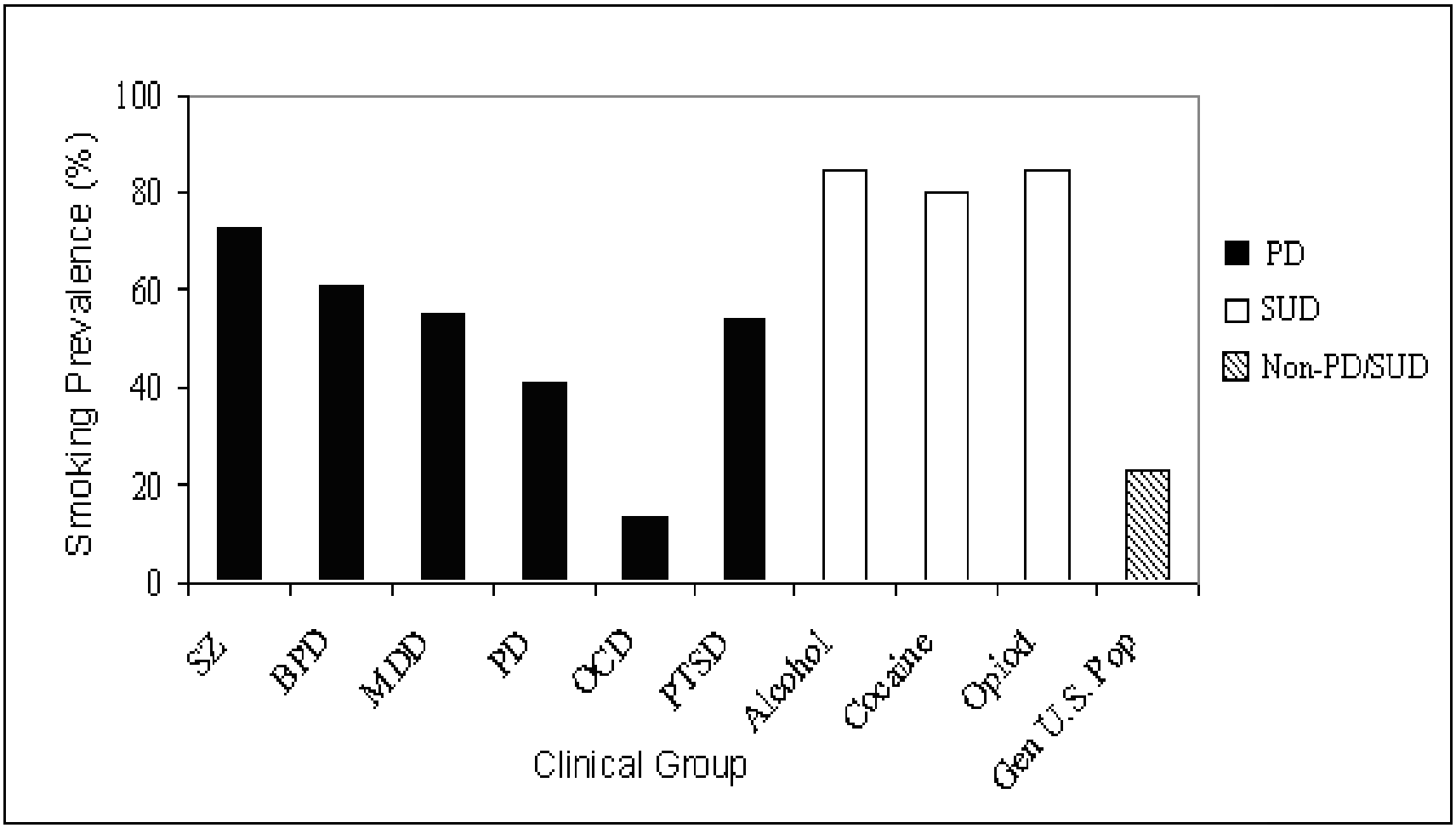
Little decline in smoking prevalence among those with mental illnesses



US Department of Health and Human Services. (2014). The health consequences of smoking—50 years of progress: a report of the Surgeon General. *Atlanta, GA*

Data from the National Health Interview Survey. Current smoking is defined as those who had smoked 100 cigarettes in their lifetime and smoked daily or some days at time of the interview. This illustration was obtained with permission from the SAMHSA CBHSQ Report, July 18 2013:http://www.samhsa.gov/data/sites/default/files/spot120-smokingspd_/spot120-smokingSPD.pdf

Prevalence of smoking by MI/SUD disorder



Kalman, Morissette, & George. "Co-Morbidity of Smoking in Patients with Psychiatric and Substance Use Disorders." *The American journal on addictions / American Academy of Psychiatrists in Alcoholism and Addictions* 14.2 (2005): 106–123. *PMC*. Web. 7 Mar. 2016

Effects of smoking among persons with MI/SUD

Smokers with MI/SUD:

- Die 10-25 years earlier
- Have more depression and anxiety
- Have more substance use problems
- Have more cardiovascular and cardiopulmonary problems
- Are more likely to commit suicide
- Have sexual problems

Nonsmokers with MI/SUD:

- Have better health
- Live longer
- Need less medication
- Have less depression
- Save more money

Parks, Svendsen, Singer, Foti (2006). Morbidity and Mortality in People with Serious Mental Illness.
National Association of State Mental Health Program Directors (NASMHPD). Medical Directors Council www.masmhpd.org

Smoking is the leading cause of death in individuals with mental illness and substance use disorders!

Smoking tobacco causes more deaths among clients in substance abuse treatment than the alcohol or drug use that brings them to treatment. A seminal 11-year retrospective cohort study of 845 people who had been in addictions treatment found that 51 percent of deaths were the result of tobacco-related causes.[1] This rate is twice that found in the general population and nearly 1.5 times the rate of death by other addiction-related causes. Despite these statistics, most substance abuse treatment programs do not address smoking cessation.

Hurt, R. D., Offord, K. P., Croghan, I. T., Gomez-Dahl, L., Kottke, T. E., Morse, R. M., & Melton, L. J. (1996). Mortality following inpatient addictions treatment: Role of tobacco use in a community-based cohort. *Jama*, *275*(14), 1097-1103.

Why do people with MI/SUD use tobacco?

Reasons for smoking among persons with MI

Genetic	• Smoking and **major depression** [1,2] • Nicotine dependence and **PTSD** [3] • Smoking behaviors and **schizophrenia** [4]
Bio-behavioral	• Nicotine reduces **sensorimotor gating** in schizophrenia [5] • Smoking reduces brain **levels of MAO-A** (an enzyme linked to depression) [6] • Nicotine may be an **anxiolytic** [7]
Psychosocial	• Smoking used as a **'token economy'** in mental health facilities [8] • Smoking encouraged as a means of **enhancing 'socialization'** among patients[9]

1. Kendler, et al. Smoking and Major Depression: A Causal Analysis. Archives of General Psychiatry 1993; 50:36-43
2. Lyons, et al. A twin study of smoking, nicotine dependence, and major depression in men. Nicotine & Tobacco Research 2008; 10:97 – 108
3. Koenen, et al. A Twin Registry Study of the Relationship Between Posttraumatic Stress Disorder and Nicotine Dependence in Men. Arch Gen Psych 2005; 62:1258-1265
4. Faraone, et al. (2004). A novel permutation testing method implicates sixteen nicotinic acetylcholine receptor genes as risk factors for smoking in Schizophrenia families
5. Postma, et al. (2006). Psychopharmacology, 184: 589–599
6. Fowler, et al. (1996). Proceedings of the National Academy of Sciences of the United States of America, 93:14065-14069
7. McCabe, et al. (2004). Journal of Anxiety Disorders, 18:7-18
8. Lawn S. Cigarette smoking in psychiatric settings: occupational health, safety, welfare and legal concerns. Australian and New Zealand J Psych 2005; 39:886-891
9. Kawachi I, Berkman L. Social ties and mental health. Journal of Urban Health 2001; 78:458-467

Reasons to treat tobacco use in persons with MI

They **WANT** to quit!	Siru et al., 2009	Review study (9 studies)	• 50% contemplating cessation
	Stockings et al., 2013	Australia (97 inpatients)	• 47% made quit attempt in previous year
	Du Plooy, et al., 2016	South Africa (116 male inpatients)	• 59.4% attempted to quit in the previous year
They **ARE ABLE** to quit!	Anthenelli et al., 2016	RCT (8144 with & without MI)	• Pharmacotherapy (VAR, BUP, NRT) superior to placebo in both groups
	Prochaska et al., 2013	RCT (224 inpatient smokers)	• Motivational counseling + NRT initiated in hospital increased quitting success
Cessation **IMPROVES** Psychiatric symptoms	Taylor et al., 2014	Meta-analysis (26 studies)	• Cessation associated with improvements in depression, anxiety, stress, mood and quality of life

1. Siru, R.; Hulse, G.K.; Tait, R.J. Assessing motivation to quit smoking in people with mental illness: A review. *Addiction* **2009**, *104*, 719-733
2. Stockings, *et al.* Readiness to quit smoking and quit attempts among australian mental health inpatients. *Nicotine & Tobacco Research* **2013**, *15*, 942-949.
3. Du Plooy, et al. (2016). Cigarette smoking, nicotine dependence, and motivation to quit smoking in South African male psychiatric inpatients. *BMC psychiatry*, *16*(1), 403.
4. Anthenelli, et al. (2016). Neuropsychiatric safety and efficacy of varenicline, bupropion, and nicotine patch in smokers with and without psychiatric disorders (EAGLES): a double-blind, randomised, placebo-controlled clinical trial. *The Lancet, 387*(10037), 2507-2520. doi:10.1016/S0140-6736(16)30272-0
5. Prochaska, et al. Efficacy of initiating tobacco dependence treatment in inpatient psychiatry: A randomized controlled trial. *Am J Public Health* **2013**, *104*, 1557-1565
6. Taylor, et al. (2014). Change in mental health after smoking cessation: systematic review and meta-analysis. Bmj, 348, g1151

Our responsibility

"All smokers with psychiatric disorders, including substance use disorders, should be offered tobacco dependence treatment, and clinicians must overcome their reluctance to treat this population….

Treating tobacco dependence in individuals with psychiatric disorder is made more complex by the potential for multiple psychiatric disorders and multiple psychiatric medications."

(*Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline)*

Fiore M, Jaén C, Baker T, et al. *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline.* Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. ;2008

CDC Recommendations for behavioral health settings

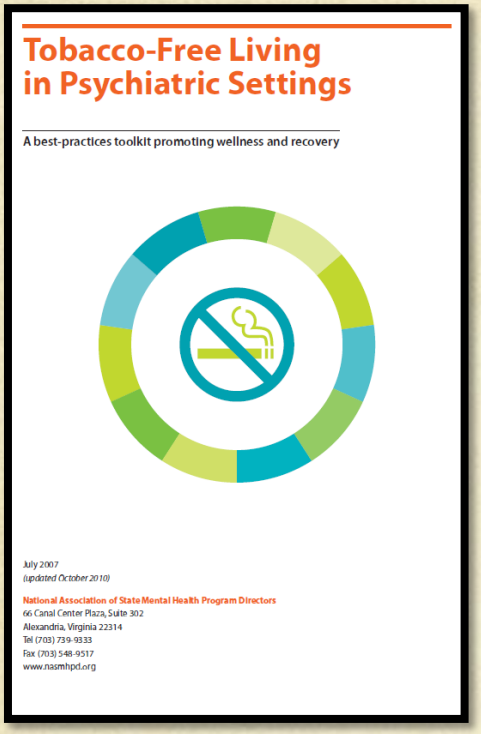
- Stopping practices that encourage tobacco use (such as not providing cigarettes to patients and not allowing staff to smoke with patients)

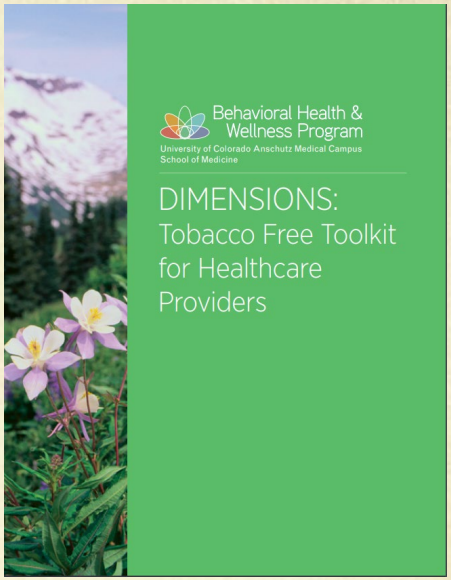
- Making entire campus 100% tobacco-free

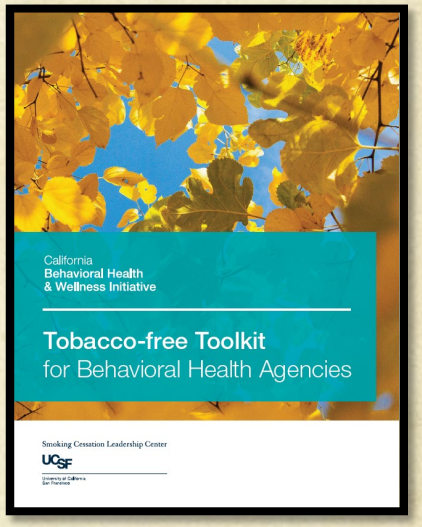
- Including tobacco treatment as part of mental health treatment and wellness

http://www.cdc.gov/vitalsigns/pdf/2013-02-vitalsigns.pdf

Tool-kits tailored to Behavioral Health Settings







https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/tobacco-free-psychiatric-settings.pdf
https://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Downloads/Toolkits/nasmhpd_toolkit_updated_april_2011.pdf
https://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Downloads/Toolkits/TF-Toolkit-Supp-Behavioral-Health.pdf
https://www.publichealthlawcenter.org/sites/default/files/resources/Kansas-Tobacco-Guideline-Behavioral-Health-Care-Toolkit-Dec2018.pdf

Going Tobacco Free: Key Considerations

Policy Development

- TF work group
- Baseline survey
- TF policy review
- Educate community partners
- Draft Policy
  - Language
  - Clear definitions
  - Enforcement
  - Realistic timeline

Organization Preparation

- Disseminate reason for policy
- Tobacco Treatment process for Clients & Staff
- Staff buy-in procedures
- Educate clients and staff
- Solicit feedback
- Create signage
- Promotional material
- Remove cigarette receptacles/ashtrays

Policy Implementation

- Post signage in facility/grounds
- Ensure compliance with policy
- Celebrate implementation day

Monitoring and Assessment

- Conduct follow-up surveys
- Compare pre-post policy health costs
- Determine changes in tobacco use

https://www.publichealthlawcenter.org/sites/default/files/resources/Kansas-Tobacco-Guideline-Behavioral-Health-Care-Toolkit-Dec2018.pdf

Take Away

- Tobacco use is a leading cause of morbidity and mortality for those with MI & SUD
- Tobacco users with MI & SUD **WANT** to and **CAN** stop using tobacco—they need evidence-based assistance
- It is a matter of **professional practice** and a **moral imperative** to address tobacco use among those living with MI & SUD
- **Best practices approaches** should be applied in mental and behavioral health settings to enhance tobacco treatment provision and engagement.

Research Addressing Tobacco Treatment among people with MI

Cooper-Clayton Stop Smoking Program ©

Participation Station, Lexington, KY

1. Okoli, C. T., Mason, D. A., Brumley-Shelton, A., & Robertson, H. (2017). Providing Tobacco Treatment in a Community Mental Health Setting: A Pilot Study. *Journal of addictions nursing*, *28*(1), 34-41.

Intervention-Cooper Clayton Program ©

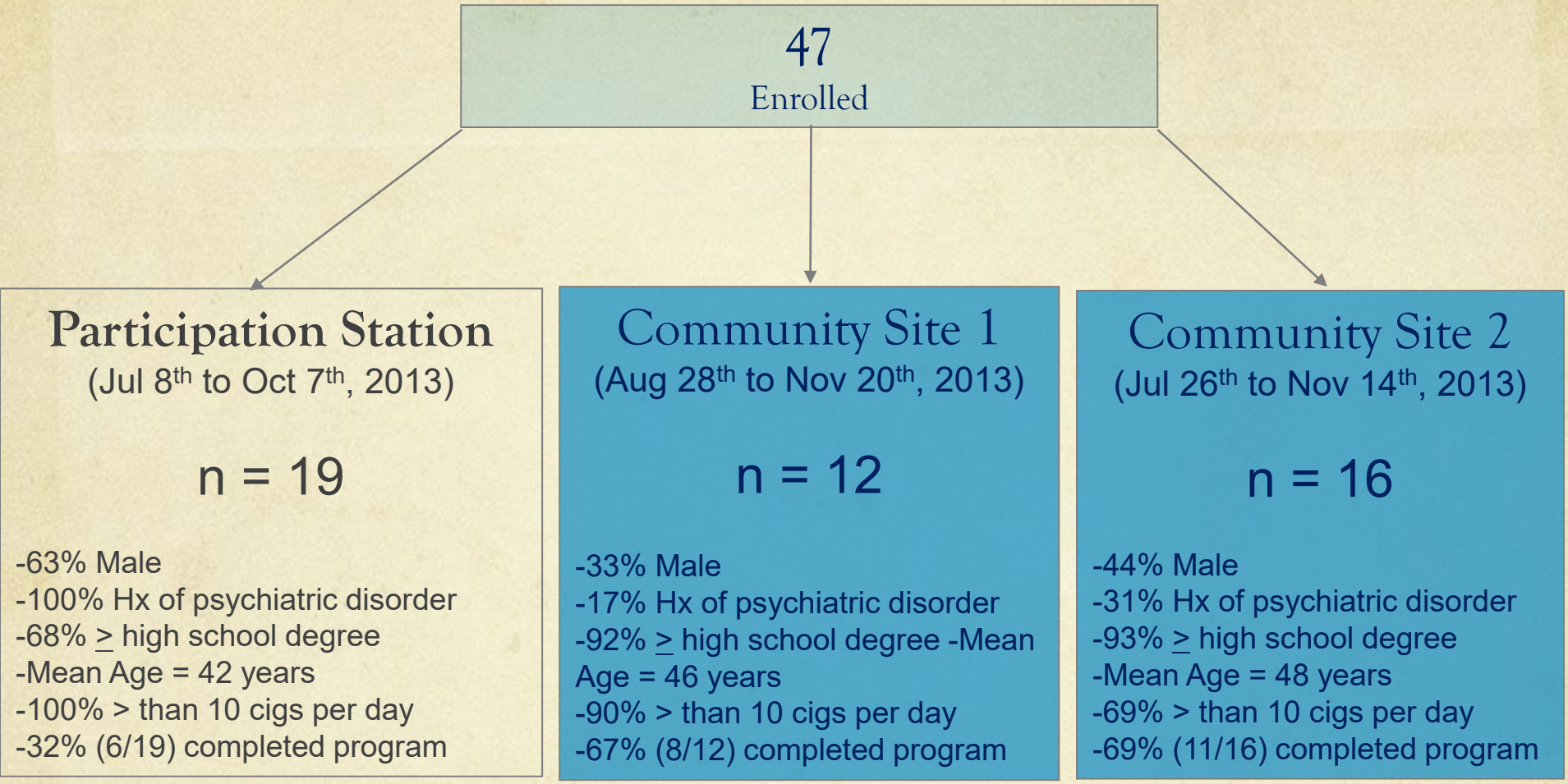
Behavioral Counseling (13 Wks)

- **Psychoeducation:** On smoking and reaction of body and brain to nicotine replacement therapy
- **Counseling:** On relapse prevention techniques
- **Setting a Quit date****: Must set quit date by week 5 of program

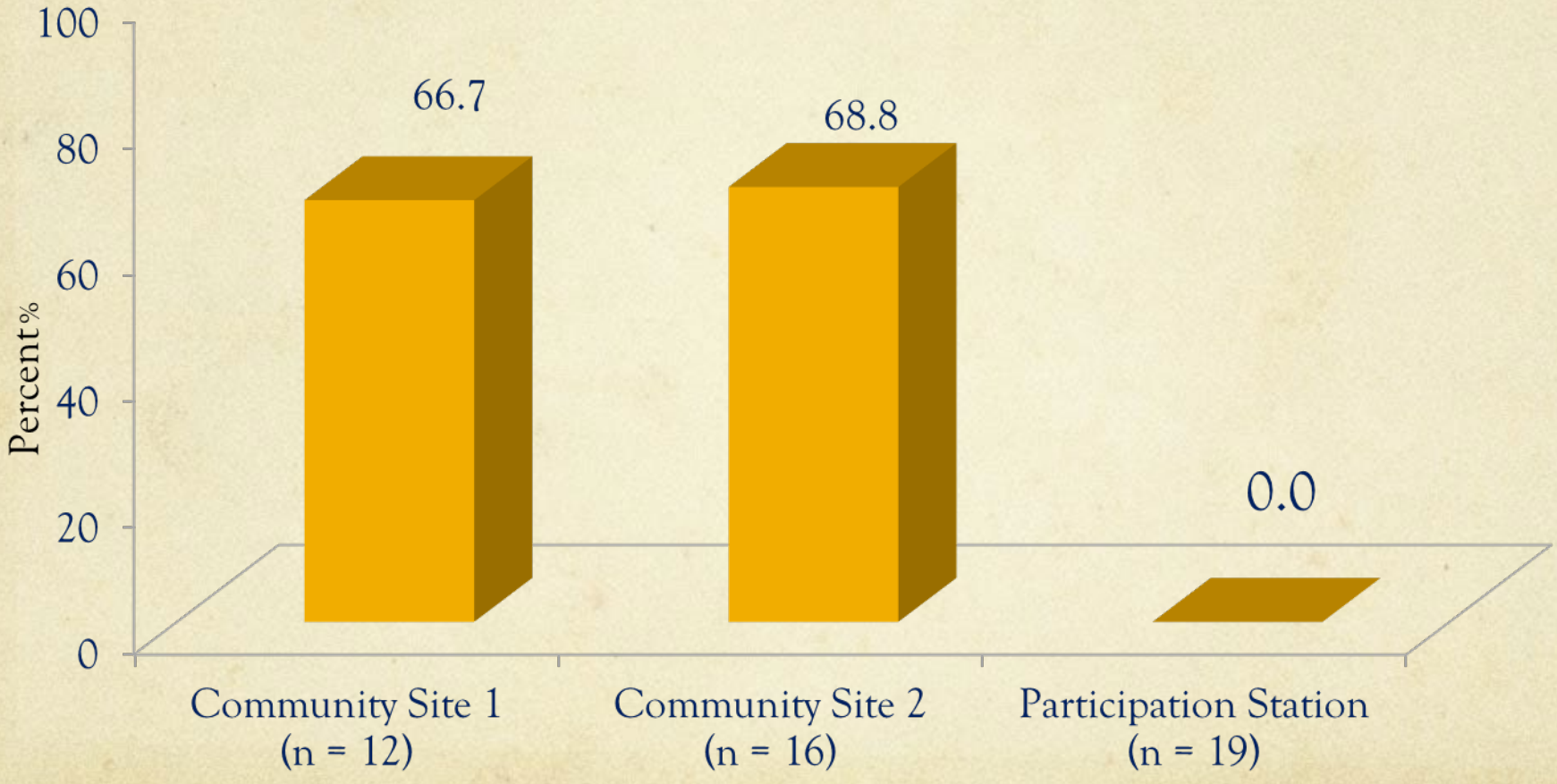
Nicotine Replacement Therapy

Cooper TM, Clayton RR. Stop-smoking program using nicotine reduction therapy and behavior modification for heavy smokers. *J Am Dent Assoc.* 1989;118(1):47-51.
Cooper TM, Clayton RR, Inventors. Method for stopping smoking. US patent 5,055,478.1991

Sample


47
Enrolled
Participation Station
(Jul 8th to Oct 7th, 2013)
n = 19
-63% Male
-100% Hx of psychiatric disorder
-68% ≥ high school degree
-Mean Age = 42 years
-100% > than 10 cigs per day
-32% (6/19) completed program
Community Site 1
(Aug 28th to Nov 20th, 2013)
n = 12
-33% Male
-17% Hx of psychiatric disorder
-92% ≥ high school degree -Mean Age = 46 years
-90% > than 10 cigs per day
-67% (8/12) completed program
Community Site 2
(Jul 26th to Nov 14th, 2013)
n = 16
-44% Male
-31% Hx of psychiatric disorder
-93% ≥ high school degree
-Mean Age = 48 years
-69% > than 10 cigs per day
-69% (11/16) completed program

Smoking cessation outcomes by treatment site (intent-to-treat)



Take Away

- Providing 'non-tailored' behavioral counseling + pharmacotherapy in community mental health settings may be less effective
  - ❑ Existing tobacco treatment programs for the general population may need to be modified for those with chronic mental illnesses
  - ❑ More studies are needed to understand components of effective programming for those with chronic mental illnesses

Eastern State Hospital Tobacco Treatment Services

1. Okoli, C.T., Shelton, C., Khara, M. (in preparation). Predictors of tobacco use among inpatients in a psychiatric hospital
2. Okoli, C.T., Al-Myrazat, Y., Stead, B. (under review). The effect of implementing a tobacco treatment service on adherence to evidence-based practice in an inpatient state-owned psychiatric hospital. *The American Journal on Addictions*
3. Okoli, C. T., Otachi, J. K., Kaewbua, S., Woods, M., & Robertson, H. (2017). Factors Associated With Staff Engagement in Patients' Tobacco Treatment in a State Psychiatric Facility. *Journal of the American Psychiatric Nurses Association*, 1078390317704045.
4. Okoli, C. T., Otachi, J. K., Manuel, A., & Woods, M. (2017). A cross-sectional analysis of factors associated with the intention to engage in tobacco treatment among inpatients in a state psychiatric hospital. *Journal of psychiatric and mental health nursing*.

ESH Tobacco Treatment Services Approach

Patient identified as a tobacco user at admission

↓

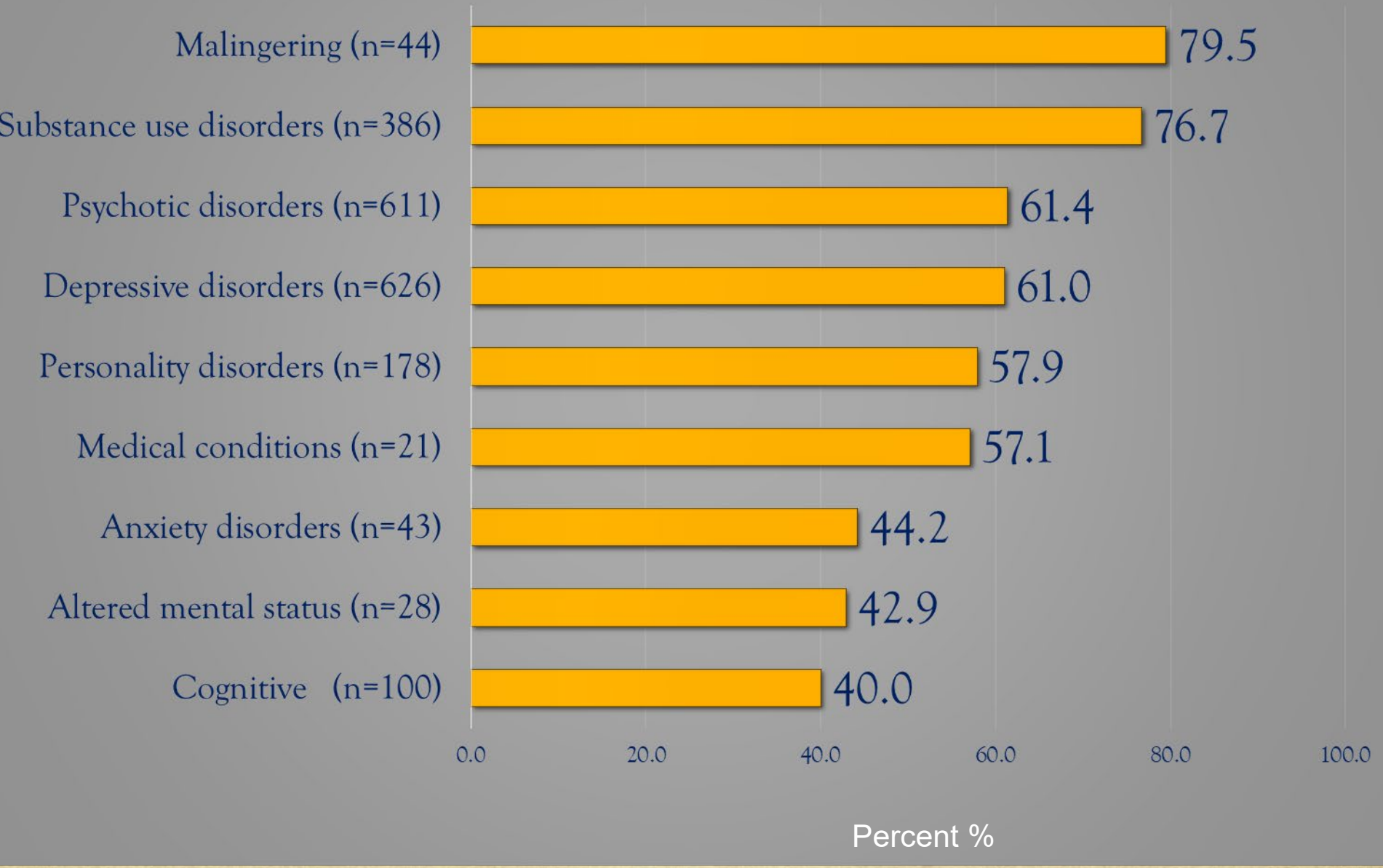
Admitting Physician/APP offers appropriate NRT

↓

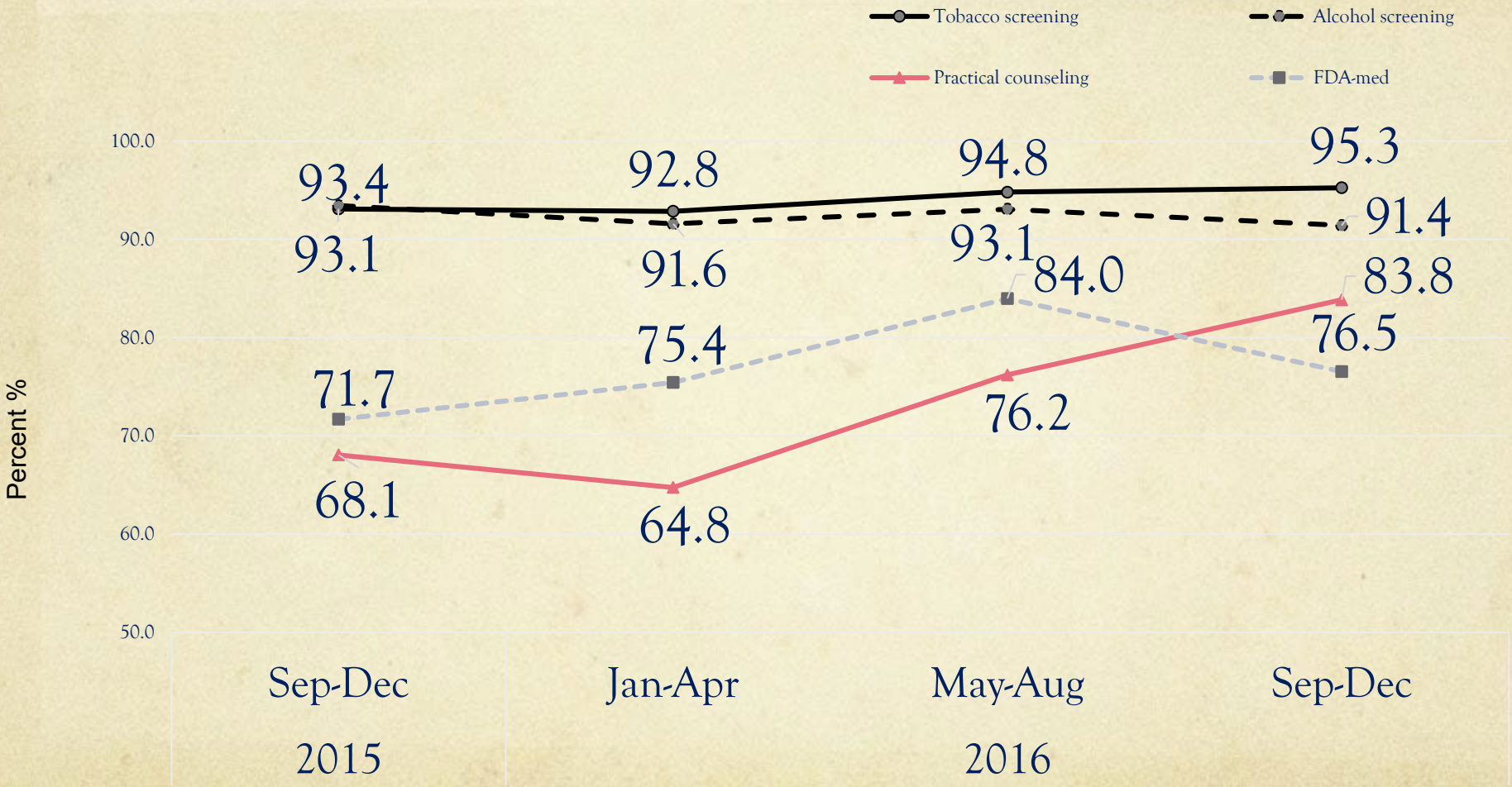
Tobacco Treatment Nurse provides follow-up assessment on unit

1. Assesses nicotine withdrawal, motivation to quit, and stage of change
2. Make recommendations to care team for tobacco treatment plan
   a) Adjustment of tobacco cessation medication
   b) Attend tobacco dependence education or cessation group (based on SOC)

Tobacco use by diagnosis among non-repeat admissions in 2016 (n = 2037)



Changes in screening for tobacco use and provision of nicotine replacement and practical counseling by 4-month intervals (Sept 2015-Dec 2016)

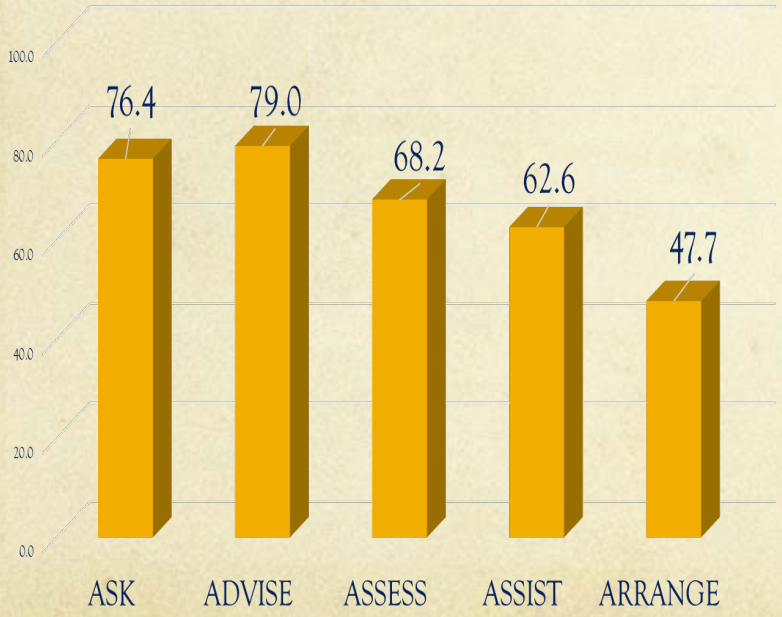


Data obtained from the NRI Analytics. Analytics improving behavioral health. 2017; http://www.nri-inc.org/.

ESH Needs Assessment Results (Survey Patients and Providers, 2016-2017)

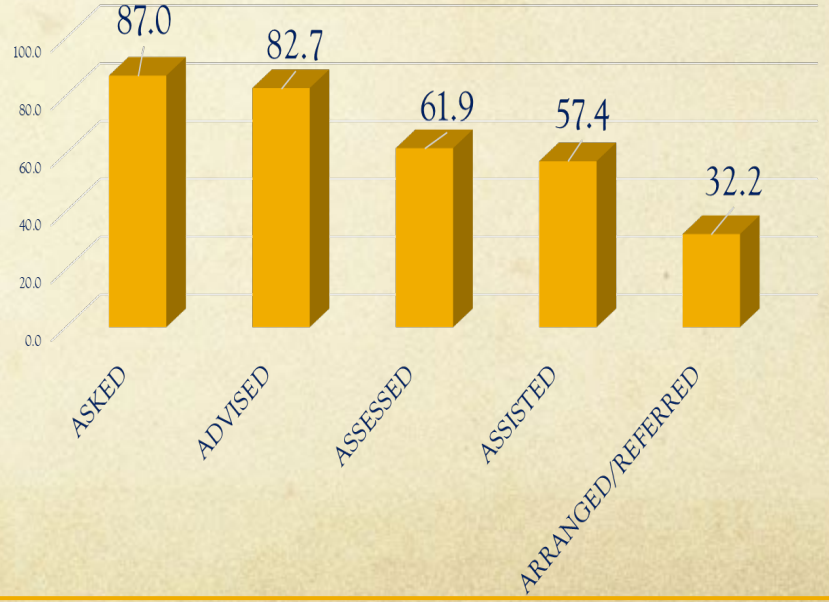
Providers (n=195):

- Intention to treat was related to 'subjective norms'
- Likely to ask, not likely to arrange



Patients (n=115):

- Intention to engage in treatment related to 'subjective norms'
- Often asked, not often 'assisted'



Okoli, C. T., Otachi, J. K., Manuel, A., & Woods, M. (2018). A cross-sectional analysis of factors associated with the intention to engage in tobacco treatment among inpatients in a state psychiatric hospital. *Journal of psychiatric and mental health nursing*, *25*(1), 14-25.

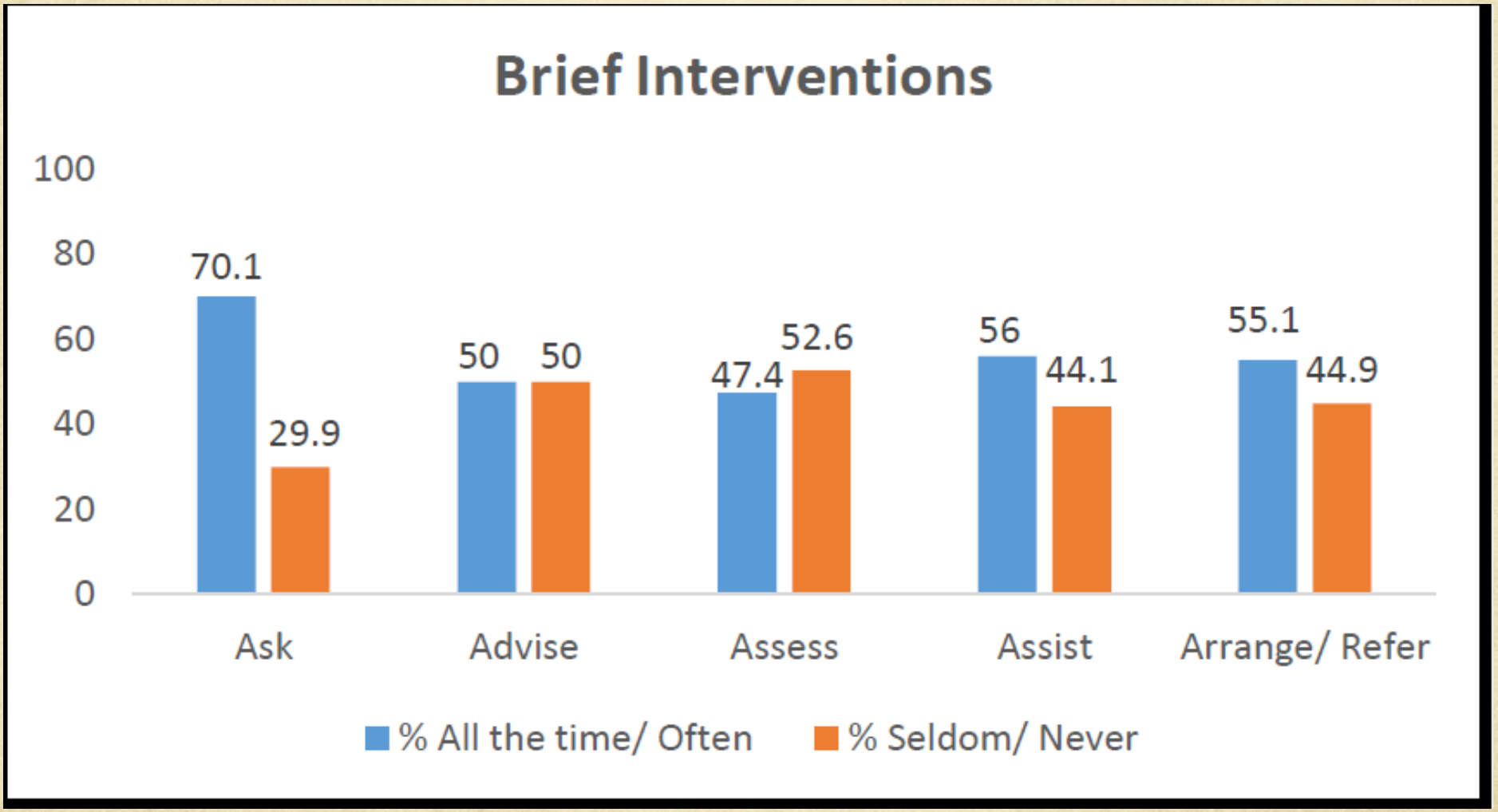
Okoli, C. T., Otachi, J. K., Kaewbua, S., Woods, M., & Robertson, H. (2017). Factors Associated With Staff Engagement in Patients' Tobacco Treatment in a State Psychiatric Facility. *Journal of the American Psychiatric Nurses Association*, *23*(4), 268-278.

Community Mental Health Center Tobacco Policy and Treatment Survey 2019-2020

Table 1. Key findings from the CMHC's provider policy survey (N = 159)		
	n	%
Provider Role		
Manager/ Supervisor	82	51.6
Staff Member	49	30.8
Healthcare Provider	28	17.6
Facility has "No Smoking" signs displayed	92	57.9
Facility has a written policy restricting tobacco product use	131	82.4
• **Policy highlights impact of tobacco use on physical health**	29	18.2
• **Policy highlights impact of tobacco use on mental health**	14	8.8
Facility provides tobacco treatment services	45	28.3
Facility interested in training on tobacco free policy	81	50.9
Facility interested in tobacco treatment specialist training	88	55.3
Facility interested in community tobacco treatment referral resources	106	66.7

Funded by KY State Department of Medicaid Services

Community Mental Health Center Tobacco Policy and Treatment Survey 2019-2020



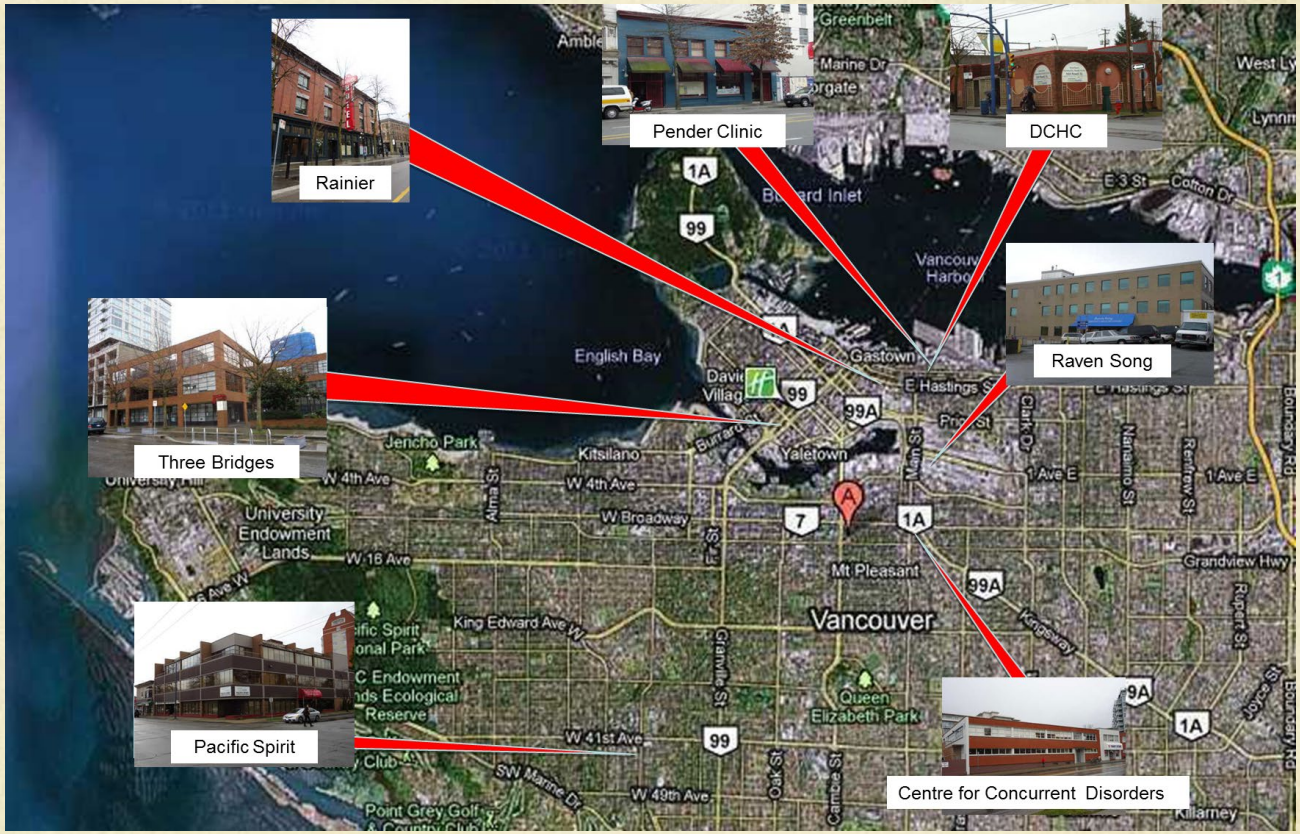
Funded by KY State Department of Medicaid Services

Take Away

- Efforts should be made to promote tobacco treatment **as a normative behavior** within inpatient psychiatric settings.
- Direct care staff should be **trained** in evidence-based tobacco treatment, particularly assessing, assisting, and following-up (or referring) tobacco using patients
- Providing **a systematic approach** to addressing tobacco treatment within mental and behavioral settings can enhance uptake

Tobacco Dependence Clinics,

Vancouver Coastal Health Authority, British Columbia, Canada



1. Khara, M., & Okoli, C. T. (2011). The Tobacco-Dependence Clinic: Intensive Tobacco-Dependence Treatment in an Addiction Services Outpatient Setting. *The American journal on addictions*, *20*(1), 45-55.
2. Okoli, C. T., Anand, V., & Khara, M. (2017). A Retrospective Analysis of the Outcomes of Smoking Cessation Pharmacotherapy Among Persons With Mental Health and Substance Use Disorders. *Journal of Dual Diagnosis*, *13*(1), 21-28.

Phases of Treatment

MANUALIZED 'CLOSED GROUP'

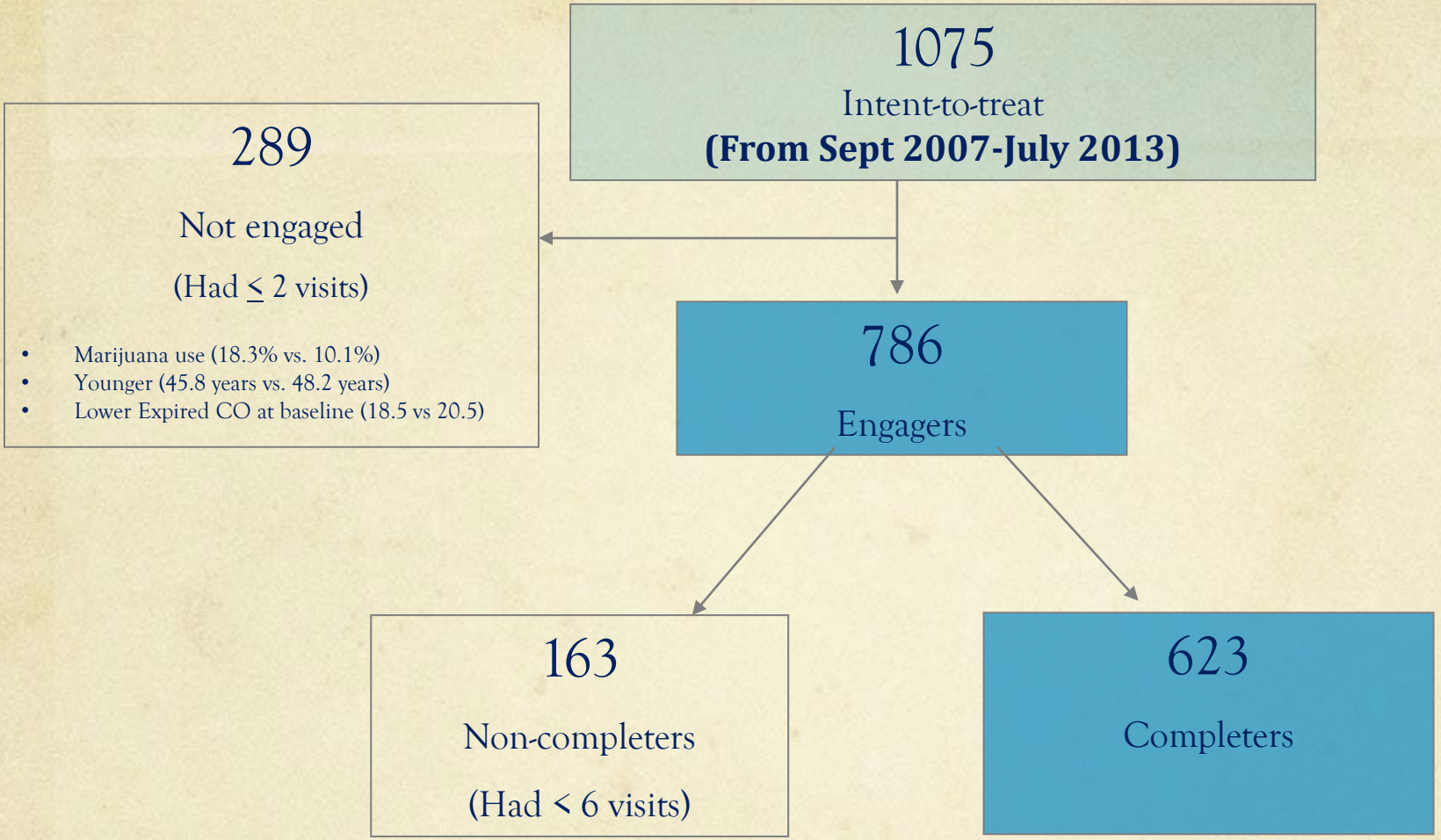
Phase 1: Process engagement – weeks 1-2

Phase 2: planning for change – weeks 3-4

Phase 3: sustaining change – weeks 5-8

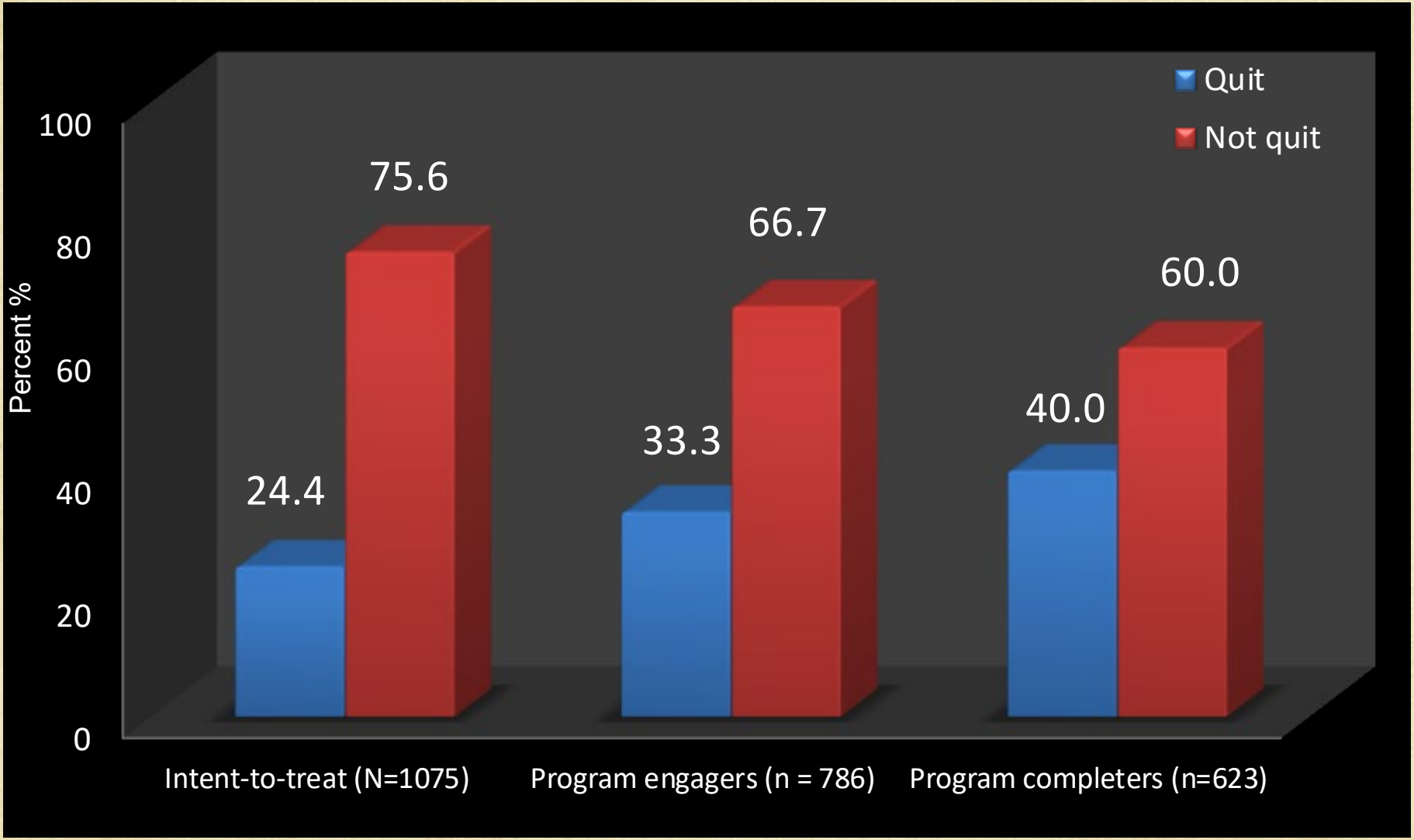
NON MANUALIZED 'OPEN GROUP'

Sample



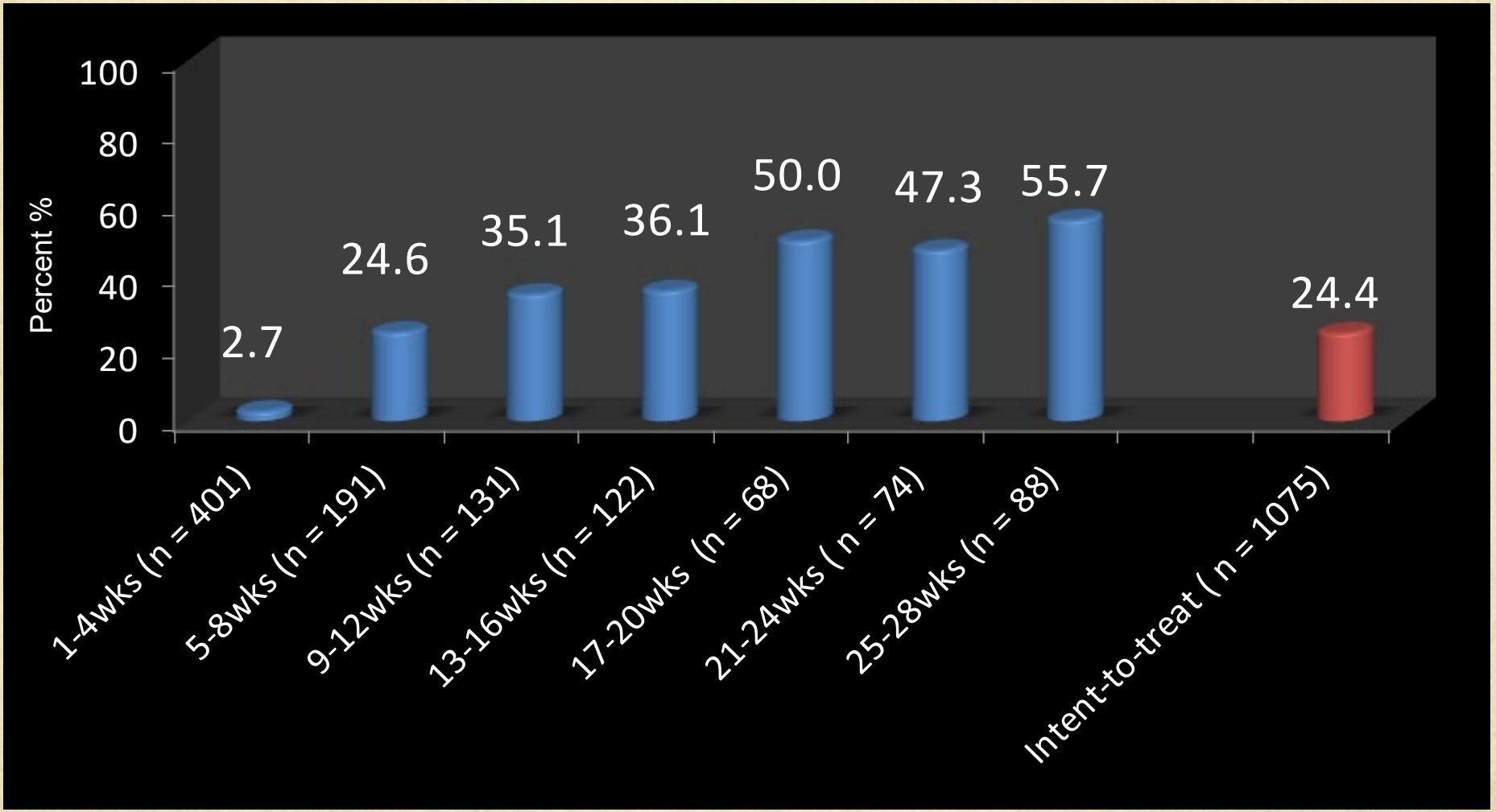
Analysis is based on a retrospective chart review of participants in the Tobacco Dependence Clinic program (between Sept 2007 and Mar, 2012) from 8 clinics, in Vancouver, Canada

Smoking cessation* outcomes at end-of-treatment



*Smoking cessation at end-of-treatment (i.e., anytime between 8 weeks to 26 weeks) based on 7-day point-prevalence of abstinence verified by expired CO levels

Smoking Cessation by length of stay in the program (n = 1075) Sept 2007-July 2013

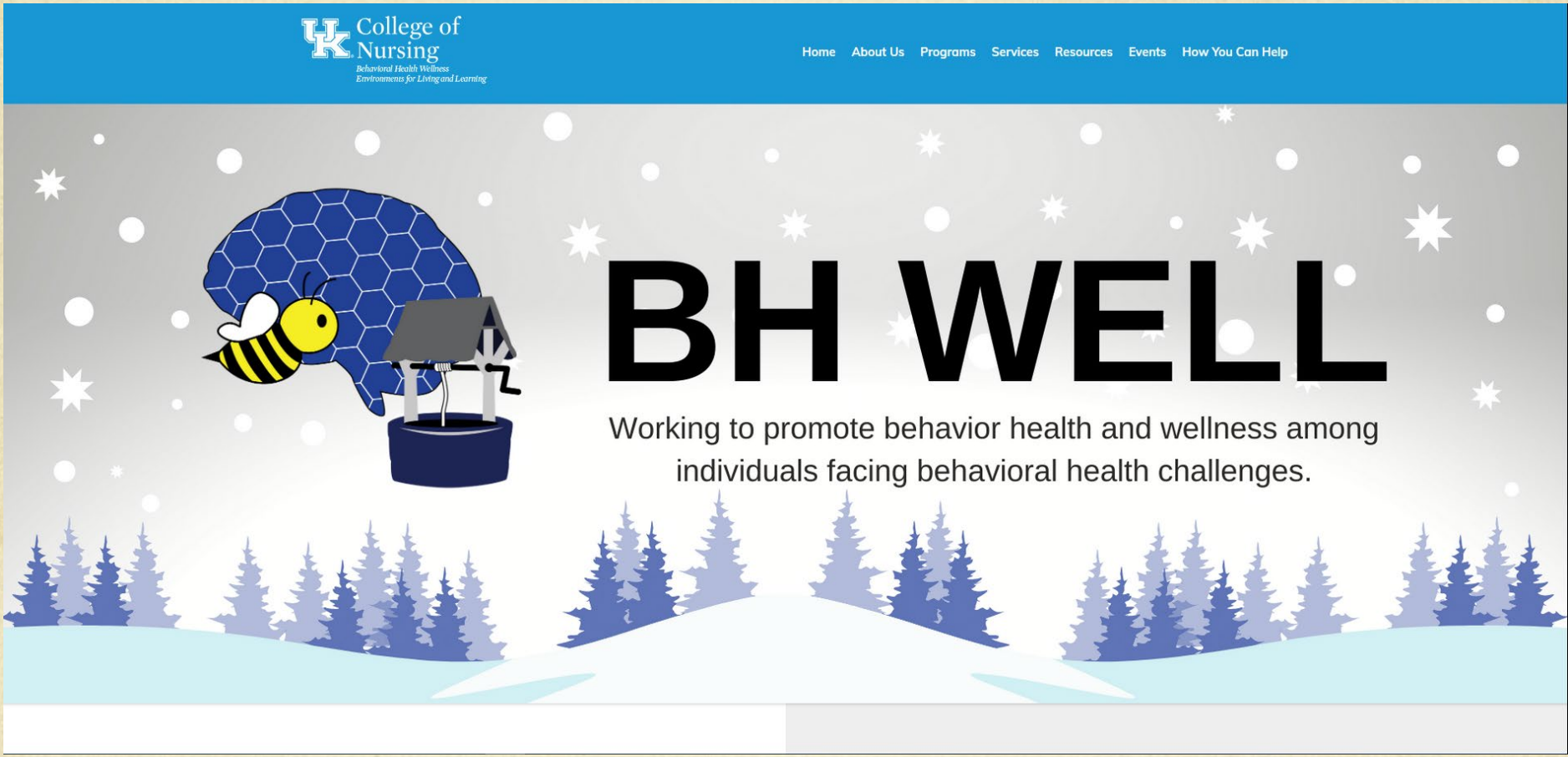


Statistically significant linear-by-linear associations $\chi 2=195.7$ (df = 1), p <.0001

Take Away

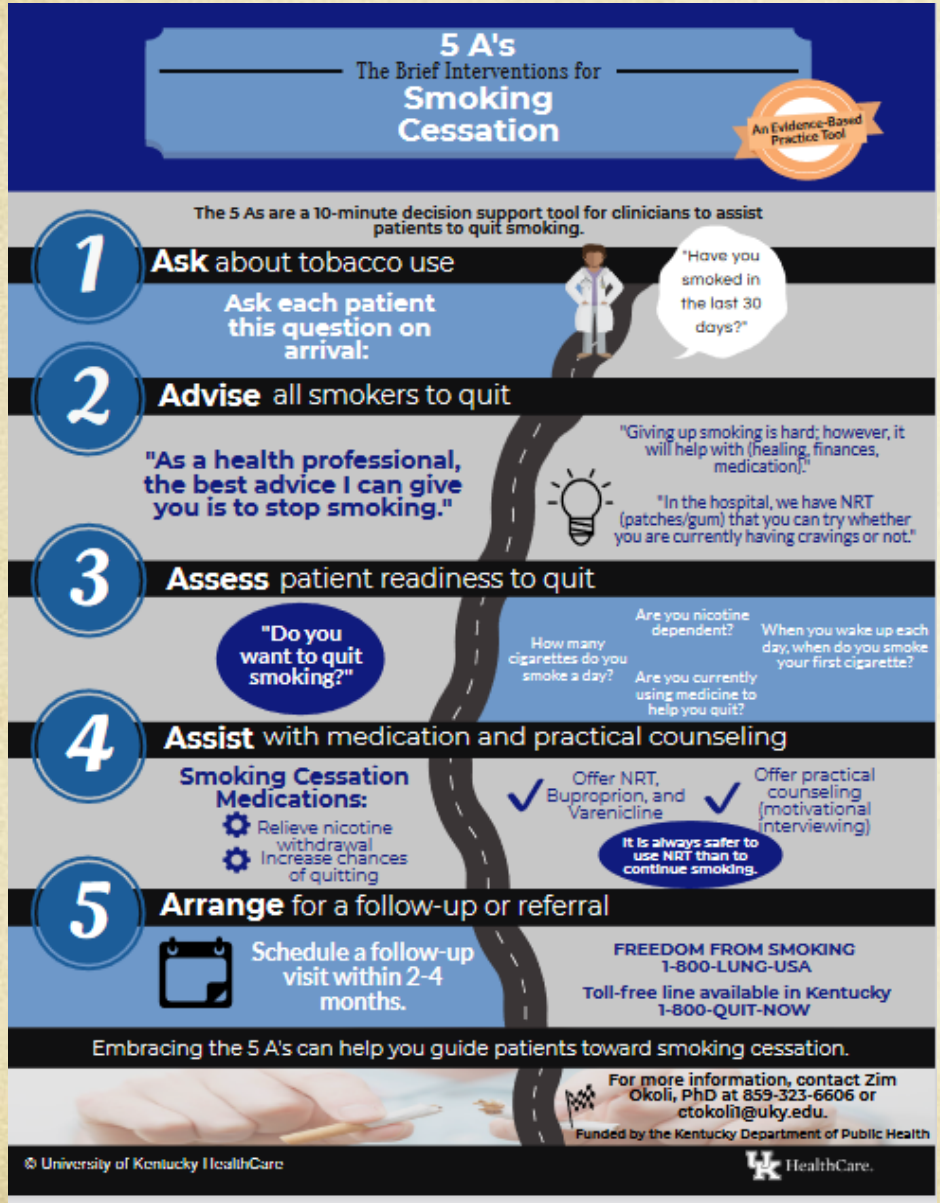
- Providing tobacco treatment behavioral Counseling + tailored Pharmacotherapy in community mental health and addictions settings works
  - ❑ Greater intensity of treatment (longer duration) increases success
  - ❑ High doses of smoking cessation medications (and in combinations) to achieve success

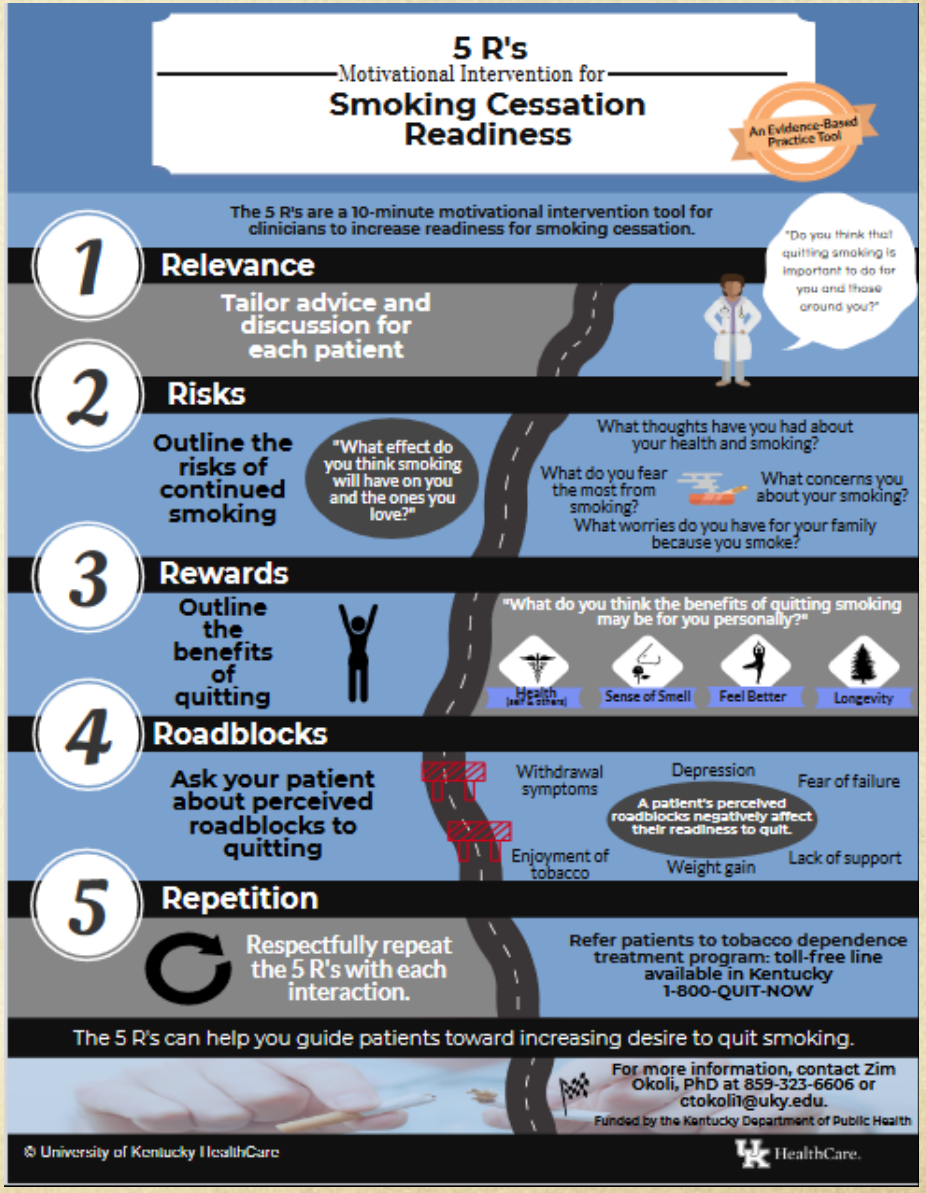
Resources



www.uky.edu/bhwell

Tobacco Treatment-Clinicians





Tailored Tobacco Treatment Options

Quick Reference for Tailored Tobacco Treatment

A practice tool to help clinicians decide on tobacco treatment options

Tobacco Treatment Pharmacotherapy Options*

Monotherapy

Long Acting Options

- Varenicline
- Bupropion
- Patch (21mg, 14 mg, 7mg)

Short Acting Options

- Inhaler
- Lozenge (2mg, 4mg)
- Gum (2mg, 4mg)

Combination Therapy**

(Long and Short Acting)

- Bupropion + Patch (21mg, 14mg, 7mg)
- Patch (21mg, 14mg, 7mg) + Lozenge (2mg, 4mg)
- Bupropion + Lozenge (2mg, 4mg)
- Patch (21mg, 14mg, 7mg) + gum (2mg, 4mg)
- Bupropion + Inhaler
- Patch (21mg, 14mg, 7mg) + Inhaler

*The selection of patch dose is generally based on the number of cigarettes/day, with 1 mg of patch per cigarette smoked. For example, a 10 cigarette per day smoker could use a 14 mg patch; a pack a day smoker, a 21 mg patch. Gum and lozenge strength (2 mg vs. 4 mg) are determined by the time to first cigarette after waking. If the first cigarette is smoked within 30 minutes, the 4 mg is used. If later, the 2 mg. The gum/lozenge dose selection applies to use of lozenge or gum either as a single agent, or in combination with the patch or bupropion.

Baker, R., McDonald, R., & Selby, P. (2009). *An algorithm for tailoring pharmacotherapy for smoking cessation: results from a Delphi panel of international experts. Tobacco control, 18*(1), 36-42.

Lindson, N., Chepkin, S. C., Ye, W., Fanshawe, T. R., Bullen, C., & Hartmann-Boyce, J. (2019). *Different doses, durations and modes of delivery of nicotine replacement therapy for smoking cessation. Cochrane Database of Systematic Reviews*, (4).

Cahill, K., Stevens, S., Perera, R., & Lancaster, T. (2013). *Pharmacological interventions for smoking cessation: an overview and network meta-analysis. Cochrane database of systematic reviews*, (5).

**The first line treatment for snuff/smokeless tobacco users is counseling in combination with an oral exam by a dental professional, with medications added afterward or at the time of the oral exam. Among medications, varenicline and lozenge have be found to be the most efficacious for snuff/smokeless tobacco users.

The American Dental Association: https://www.ada.org/en/member-center/oral-health-topics/smoking-and-tobacco-cessation Ebbert, J. O., Elrashidi, M. Y., & Stead, L. F. (2015). Interventions for smokeless tobacco use cessation. Cochrane Database of Systematic Reviews, (12).

Appropriate pharmacotherapy with proper counseling should be offered to all tobacco users willing to reduce or stop their tobacco use

Evidence Based Clinician Approach

ASK
about tobacco use
"Have you used tobacco in the last 30 days?"

ADVISE
to quit
"As a health professional, the best advice I can give you is to stop smoking."

ASSESS
readiness to quit
"On a scale of 1-10, how confident and ready are you to quit using tobacco?"

ASSIST
to quit
Use practical counseling and offer pharmacotherapy

REFER
to program
1-800-LUNG-USA (Freedom from smoking)
1-800-QUIT-NOW (QUIT NOW Kentucky)

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For more information, contact Zim Okoli, PhD
Phone: 859-323-6606; Email: ctokoli@uky.edu.

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Pharmacotherapy Choices

Quick Reference for Pharmacotherapy to Manage Nicotine Withdrawal

A practice tool to help clinicians decide on nicotine withdrawal management pharmacotherapy

Nicotine Replacement Equivalencies*

Cigarettes

- 2 packs/day → two 21mg patches
- 1.5 packs/day → 21mg + 14mg patches
- 1 pack/day → one 21mg patch
- 0.5 pack/day → one 14mg patch
- 5 or less cigarettes/day → 4mg gum OR 4mg lozenge PRN

Snuff

- 3 cans/week → two 21mg patches + 4mg gum
- 2 cans/week → two 21mg patches
- 1 can/week → one 21mg patch

Cigars

- 1-2 cigars/day → one 7mg patch

*These nicotine replacement equivalencies are based on research studies and clinical experience to provide adequate replacement of nicotine during tobacco free hospitalizations. As such these equivalencies may be off-label prescribing/use.

Agaku, I. T., & Alpert, H. R. (2016). *Trends in annual sales and current use of cigarettes, cigars, roll-your-own tobacco, pipes, and smokeless tobacco among US adults, 2003–2012. Tobacco Control*, *25*(6), 621–627.

Anantharaman, D., Chabrier, A., Gaborieau, V., et al. (2014). *Genetic variants in nicotine addiction and alcohol metabolism genes, oral Cancer risk and the propensity to smoke and drink alcohol: A replication study in India. PLoS One*, *9*(2), e89262.

Using adequate pharmacotherapy can help manage withdrawal and optimize success while stopping tobacco use

Evidence Based Clinician Approach

ASK
amount of tobacco use
"What kind of tobacco products do you use? How often do you use them?"

ASSESS
nicotine withdrawal
"Have you experienced any of the following symptoms in the past 24 hours: (cravings, depressive symptoms, insomnia, anger, anxiety, poor concentration, restlessness, and decreased appetite)?"

PROVIDE
nicotine replacement
Offer nicotine replacement based on withdrawal score and tobacco product use.

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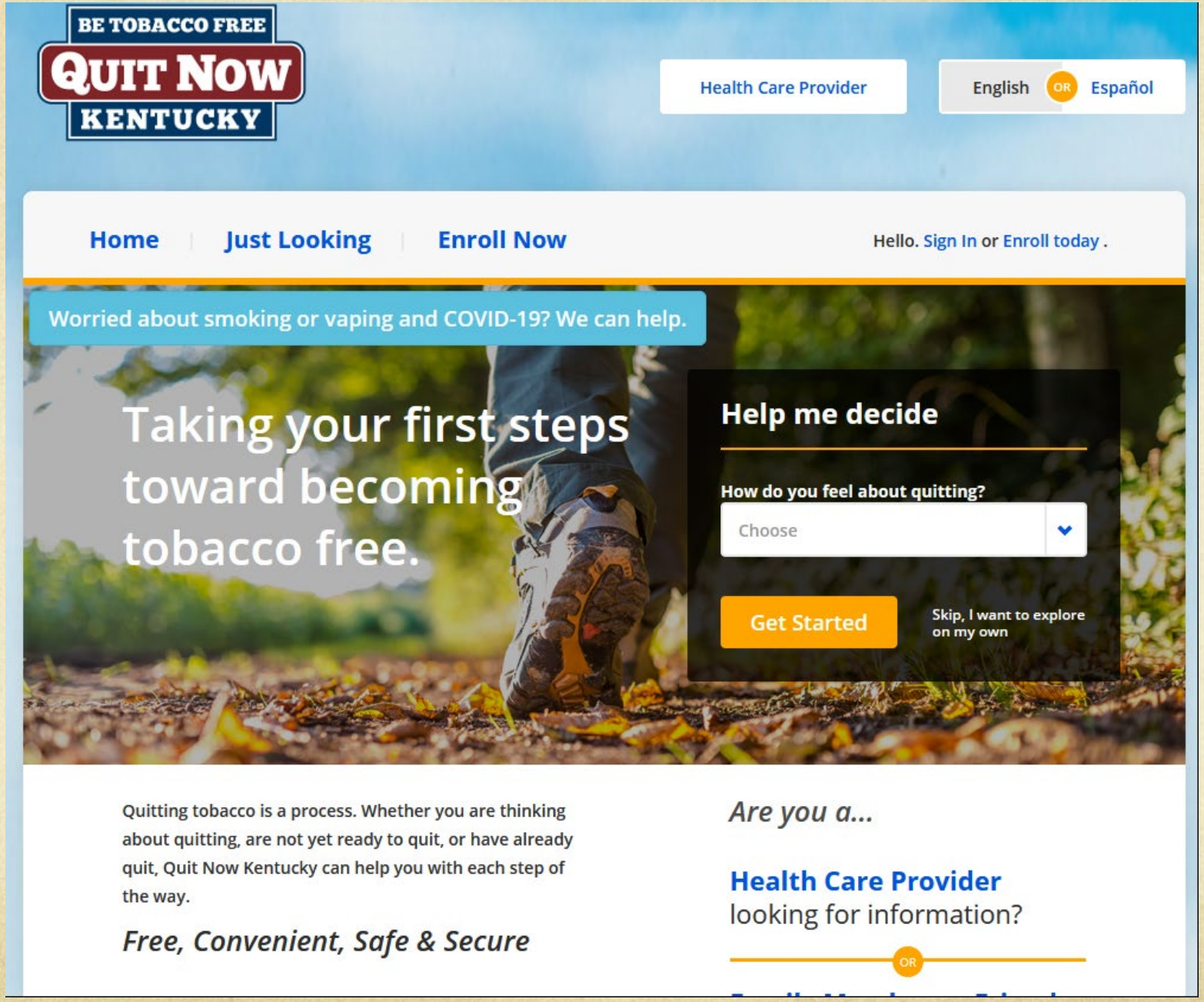
BE TOBACCO FREE
QUIT NOW
KENTUCKY
Health Care Provider
English OR Español
Home
Just Looking
Enroll Now
Hello. Sign In or Enroll today .
Worried about smoking or vaping and COVID-19? We can help.
Taking your first steps toward becoming tobacco free.
Help me decide
How do you feel about quitting?
Choose
Get Started
Skip, I want to explore on my own
Quitting tobacco is a process. Whether you are thinking about quitting, are not yet ready to quit, or have already quit, Quit Now Kentucky can help you with each step of the way.
Free, Convenient, Safe & Secure
Are you a...
Health Care Provider
looking for information?
OR


THE DIMENSIONS
When Nicotine Attacks:
FIGHT THE CRAVE
STORE ON THE CORNER
TOBACCO
WINE+SPIRITS
ATM