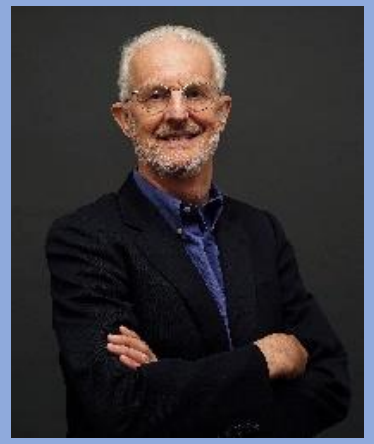
ADDRESSING CESSATION IN PRIORITY POPULATIONS

ASH ACTION ON SMOKING & HEALTH

Global action for everyone's health.

September 10, 2020

SPEAKERS



Martin Raw, Director of the International Centre for Tobacco Cessation (ICTC) and Visiting Professor, New York University (NYU) School of Global Public Health

Rachel Smolowitz, PhD, smoking cessation coordinator at Sheppard Pratt

Michael Stavros, smoking cessation counselor at Sheppard Pratt

Carolyn Dresler, MD, MPA, ASH Volunteer

MODERATOR

Laurent Huber
ASH Executive Director

ASH ACTION ON SMOKING & HEALTH — *Global action for everyone's health.*

Best practice in tobacco cessation: the global context

Martin Raw

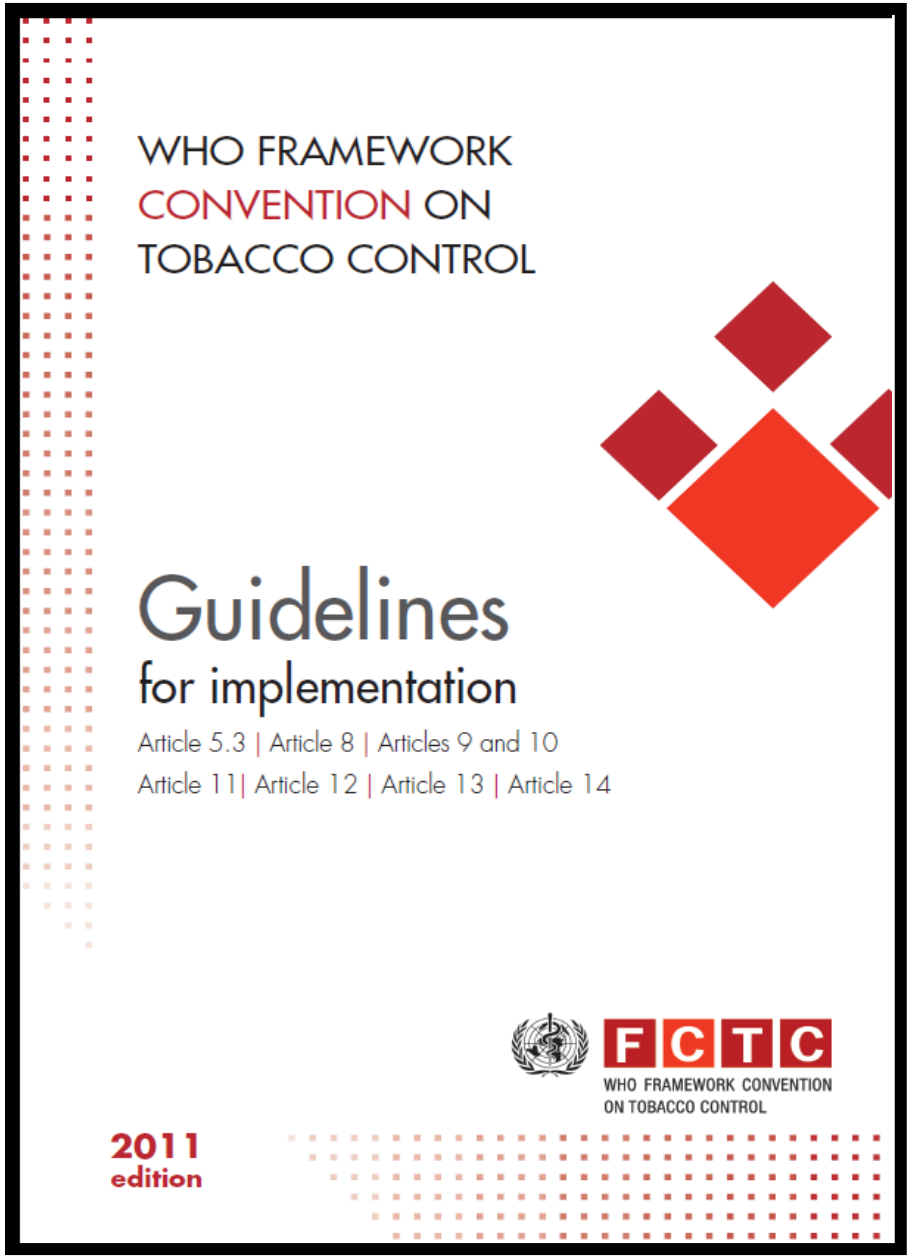
Director, International Centre for Tobacco Cessation
and
School of Global Public Health
New York University

10 September 2020

FCTC Article 14

Article 14 asks each country to develop comprehensive guidelines, based on scientific evidence and best practice, and to promote cessation of tobacco use and tobacco dependence treatment

https://www.who.int/fctc/Guidelines.pdf?ua=1#:~:text=1.-,Article%2014%20of%20the%20WHO%20Framework%20Convention%20on%20Tobacco%20Control,priorities%2C%20and%20shall%20take%20effective



https://apps.who.int/iris/bitstream/handle/10665/80510/9789241505185_eng.pdf;jsessionid=07E304A4E66D3F58E11C234C524B3934?sequence=1

The Article 14 Guidelines encourage countries to create sustainable infrastructure which

motivates attempts to quit

integrates cessation treatment into national healthcare systems

and ensures wide access to support

And they offer guidance in three main sections

How to develop an infrastructure to support cessation

The key components of a treatment system

Introduce support in a stepwise way

The stepwise approach is important – it recognises that countries have very different levels of resources available

Thus it encourages countries to use existing infrastructure as much as possible

(eg. primary healthcare system, TB clinics)

and strengthening of national coordination

(including identifying funding)

and to develop an official national cessation strategy, and guidelines

The guidelines also urge countries to address tobacco cessation in healthcare workers

including

Incorporating cessation in medical, dental, nursing and pharmacy training

Training healthcare workers to give brief advice

And helping healthcare workers quit – why so important?

Reducing tobacco use in health professionals

Table 3.1: Selected studies of GP smoking prevalence

Country	Method and sample details	Published	% who smoke
Bulgaria[3]	National survey (n=1194) in 8 of 28 regions	2005	**44.2**
Denmark[6]	Postal questionnaire with 313 GPs	1993	**33**
Greece[10]	National questionnaire of 1,284 physicians including 370 GPs	2007	**38.6**
Italy[11]	Regional phone interview	2003	**28.3**
Netherlands[12]	Postal survey with GPs and other physicians.	1990/93	**38**
Romania[14]	Survey, details not given, n=1136, p=0.05	2000	**43.2**
Slovakia[4]	European postal survey of GPs	2005	**48.5**
Sweden[4]	European postal survey of GPs	2005	**3.7**

Stead M, Angus K, Holme I, Tait G (2007) Review of the literature on factors that facilitate and hinder use of smoking cessation interventions by GPs, and of interventions to change GP behaviour. CRUK Centre for Tobacco Control Research

PLOS ONE

RESEARCH ARTICLE

Prevalence of tobacco use in healthcare workers: A systematic review and meta-analysis

Kapka Nilan[1☯*], Tricia M. McKeever[1☯], Ann McNeill[2☯], Martin Raw[3,4☯], Rachael L. Murray[1☯*]

1 UK Centre for Tobacco and Alcohol Studies, School of Medicine, Clinical Sciences Building, Nottingham City Hospital, University of Nottingham, Nottingham, United Kingdom, **2** UK Centre for Tobacco and Alcohol Studies, Institute of Psychiatry, Psychology & Neuroscience (IoPPN), King's College London, London, United Kingdom, **3** NYU College of Global Public Health, New York University, New York, New York, United States of America, **4** NYU Medical School, New York University, New York, New York, United States of America

☯ These authors contributed equally to this work.
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Citation: Nilan K, McKeever TM, McNeill A, Raw M, Murray RL (2019) Prevalence of tobacco use in healthcare workers: A systematic review and meta-analysis. PLoS ONE 14(7): e0220168. https://doi.org/10.1371/journal.pone.0220168

Editor: Stanton A. Glantz, University of California San Francisco, UNITED STATES

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Abstract

Objectives

To estimate tobacco use prevalence in healthcare workers (HCW) by country income level, occupation and sex, and compare the estimates with the prevalence in the general population.

Methods

We systematically searched five databases; Medline, EMBASE, CINHAL Plus, CAB Abstracts, and LILACS for original studies published between 2000 and March 2016 without language restriction. All primary studies that reported tobacco use in any category of HCW were included. Study extraction and quality assessment were conducted independently by three reviewers, using a standardised data extraction and quality appraisal form. We performed random effect meta-analyses to obtain prevalence estimates by World Bank (WB) country income level, sex, and occupation. Data on prevalence of tobacco use in the general population were obtained from the World Health Organisation (WHO) Global Health Observatory website. The review protocol registration number on PROSPERO is CRD42016041231.

Results

229 studies met our inclusion criteria, representing 457,415 HCW and 63 countries: 29 high-income countries (HIC), 21 upper-middle-income countries (UMIC), and 13 lower-middle-and-low-income countries (LMLIC). The overall pooled prevalence of tobacco use in HCW was 21%, 31% in males and 17% in females. Highest estimates were in male doctors in UMIC and LMLIC, 35% and 45%, and female nurses in HIC and UMIC, 21% and 25%. Heterogeneity was high ($I^2 > 90\%$). Country level comparison suggest that in HIC male HCW tend to have lower prevalence compared with males in the general population while in

Our systematic review

229 studies from 2000 to 2016 representing 457,000 healthcare workers in 63 countries

(but still few up-to-date studies – a seriously neglected area)

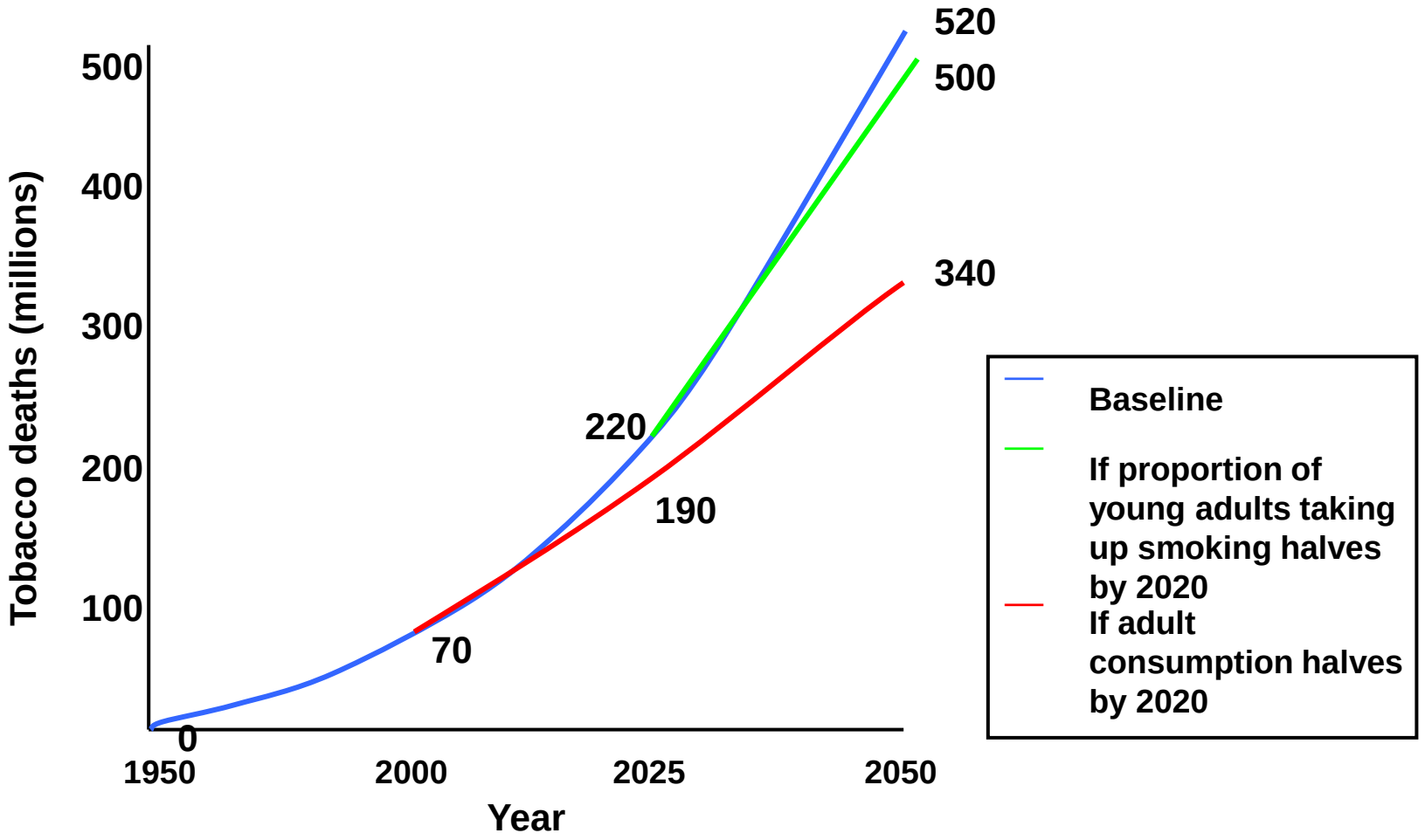
Overall average – 21% used tobacco

Highest – 35% and 45%

(male doctors in upper and lower middle income countries)

Estimated cumulative tobacco deaths 1950-2050 with different intervention strategies

Unless current smokers quit, deaths will rise dramatically in the next 50 years



World Bank. Curbing the epidemic: Governments and the economics of tobacco control. Washington, World Bank, 1999.

About 1 billion people in world smoke cigarettes

Most want to quit

Every day a smoker over 35 continues smoking they lose 3–6 hours of life

For the 500 million current adult smokers

this is 62 million days of life lost every day

Over 60% of current smokers who do not stop will die of a tobacco-related disease

This is URGENT

Our international survey of cessation provision

Field work: 2015

Research team from University of Nottingham & Kings College London, UK

Survey sample: Tobacco control contacts in 172 countries; we received replies from 142 (83%)

Basic infrastructure

Does your country	% Yes
Have an officially identified person responsible for treatment?	**54**
Have an official national treatment strategy?	**32**
Have national treatment guidelines?	**40**
Have a clearly identified budget for treatment?	**25**
Offer to help healthcare workers to stop using tobacco?	**44**
Mandatory recording of tobacco use in medical notes	**30**

Components of national treatment system

Does your country	% Yes
Integrate brief advice in existing services?	**44**
Have nationwide specialised treatment facilities?	**26**
Have a national telephone quitline?	**23**
Have cessation support via text messaging?	**17**

Availability of medications by income level

	% Yes				
	All	**High**	**UM**	**LM**	**Low**
NRT gum	**72**	96	60	61	53
Bupropion	**60**	90	58	39	18
Varenicline	**54**	88	48	36	6
Cytisine	**14**	10	13	19	12

High=High income countries; UM=Upper middle income countries; LM=Lower middle income countries; Low=Low income countries

Affordability of medications by income level

	% Yes				
	All	**High**	**UM**	**LM**	**Low**
NRT gum	**66**	88	58	45	33
Bupropion	**57**	73	43	36	33
Varenicline	**54**	77	32	15	0
Cytisine	**68**	80	80	57	50

High=High income countries; UM=Upper middle income countries; LM=Lower middle income countries; Low=Low income countries

Specialised treatment provision by income level

	% Yes			
	High	**UM**	**LM**	**Low**
Nationwide services	55	20	6	0

Note: Overall figure (all income levels) was 26%
High=High income countries; UM=Upper middle income countries; LM=Lower middle income countries; Low=Low income countries

So where are we now?

Cessation support is way behind other measures

It is not a priority for many countries

Nor, it seems, for many in the tobacco control field

Why?

Cost? Perceived cost? Lifestyle choice?

Is it ethical to introduce restrictive measures like banning smoking in public places but not offer help to those that need it?

We are failing many of the 500 million adult smokers

Seven million of them are dying every year

They do not deserve to be abandoned

We should be ashamed of ourselves

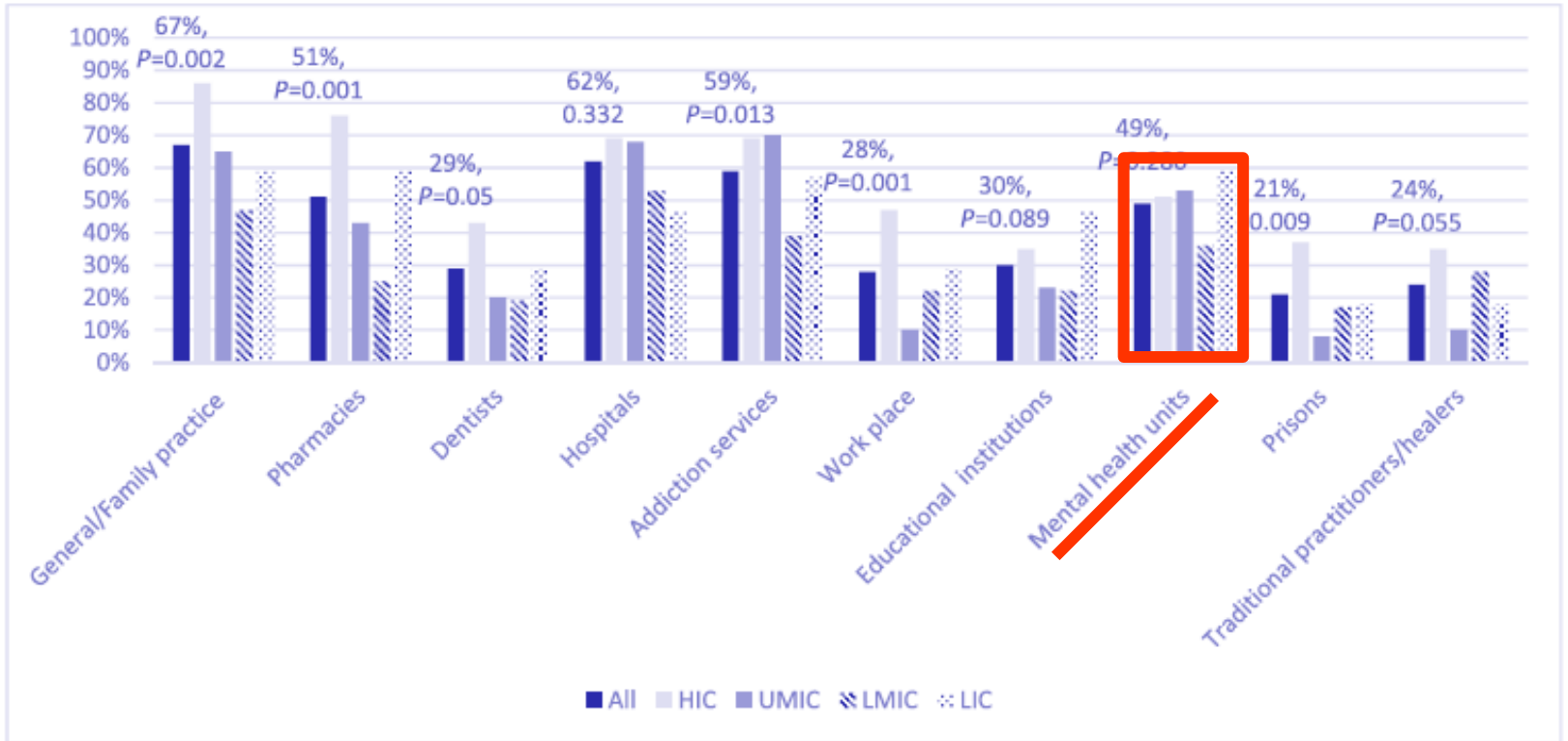


Figure 1 Access to cessation support in different settings. 'Can tobacco users get help to stop smoking in the following settings?'. The bars show 'Yes' responses overall (black) then by income-level in the order high-income countries (HIC); upper middle-income countries (UMIC); lower middle-income countries (LMIC); low-income countries (LIC). *P*-values are for difference across income level

Thank you very much

Martin Raw *PhD*

International Centre for Tobacco Cessation

Very happy to respond to questions by email as well as in the Q&A:

martin@martinraw.com

ADDITIONAL RESOURCES

- WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL (WHO FCTC) Guidelines

https://apps.who.int/iris/bitstream/handle/10665/80510/9789241505185_eng.pdf;jsessionid=07E304A4E66D3F58E11C234C524B3934?sequence=1

- WHO FCTC Article 14 Guidelines

https://www.who.int/fctc/Guidelines.pdf?ua=1#:~:text=1.-,Article%2014%20of%20the%20WHO%20Framework%20Convention%20on%20Tobacco%20Control,priorities%2C%20and%20shall%20take%20effective

The following referenced documents are available here:
https://www.dropbox.com/sh/wlvu1c7cc9qm3vr/AABQ4RspBMLo3km8ON3Zs2HKa?dl=0

- Nilan K, McKeever TM, McNeill A, Raw M, Murray RL. Prevalence of tobacco use in health care workers: A systematic review and meta-analysis. PLOS One, July 2019 (https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0220168#sec026)
- Nilan K, Raw M, McKeever T, Murray R, McNeill A. A survey of tobacco dependence treatment in 142 countries. Addiction 2017;112:2023-2031. (http://onlinelibrary.wiley.com/doi/10.1111/add.13903/full)
- National Situation Analysis (NSA), review of effectiveness and affordability calculator, and cytisine article on www.treatobacco.net.

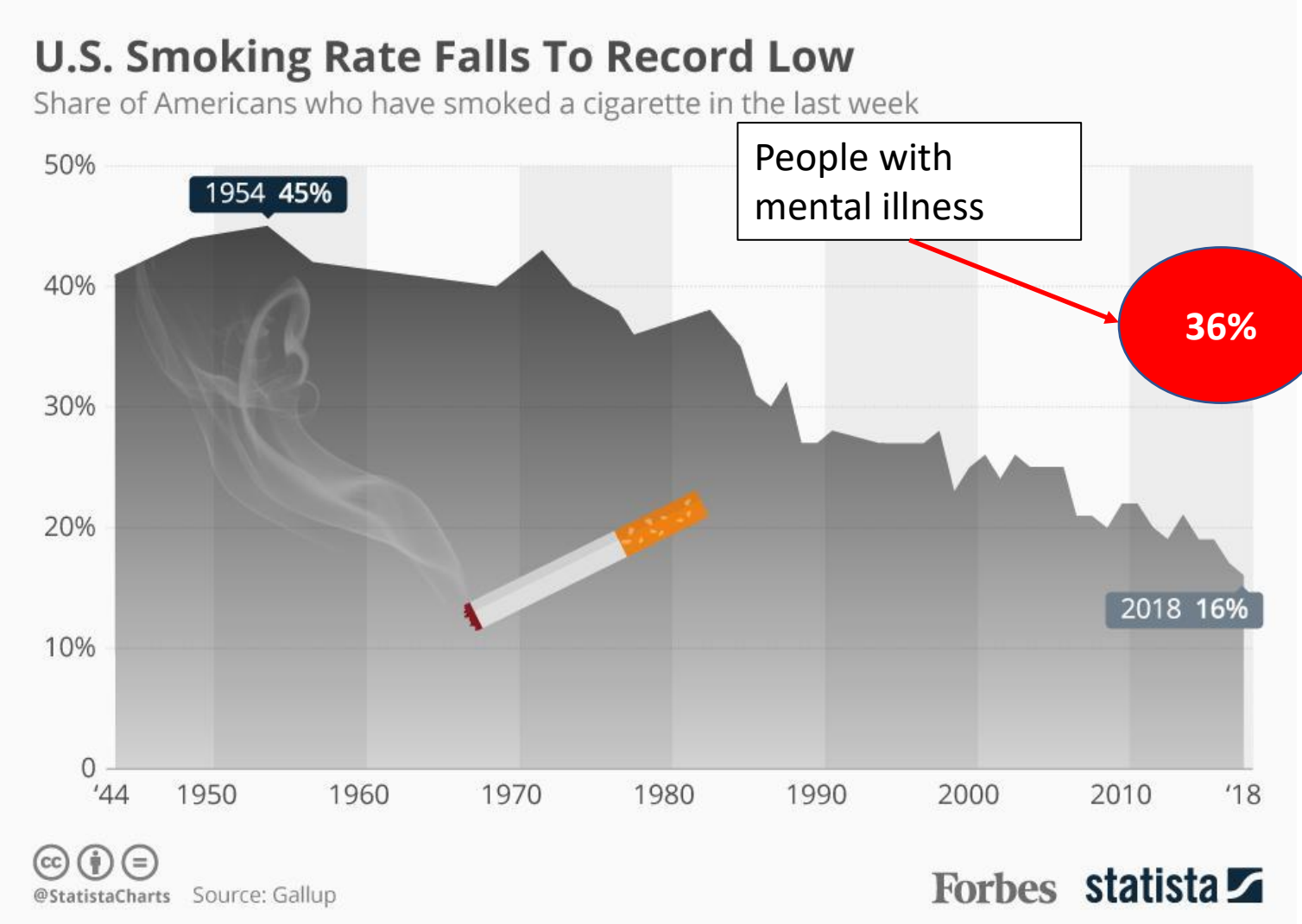
Sheppard Pratt

Reducing Health Disparities for People with Behavioral Health Disorders

Rachel Smolowitz, Ph.D.
Michael Stavros, LGPC

September 10, 2020

Most people in the general population have quit



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Smoking Cessation and Mental Illness: A home-grown health disparity

- A few decades ago, it was common to provide people with mental illnesses cigarettes as a reward for good behavior.
- Even now, most mental health programs in the US do not provide comprehensive smoking cessation services.

	Screening	Counseling	NRT	Smoke free campus
United States	48.9%	37.6%	25.2%	48.6%
Maryland	45.0%	34.4%	19.2%	45.4%

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Challenging Myths

Myth:
People with mental illnesses need cigarettes to cope

Fact: Quitting smoking leads to fewer symptoms

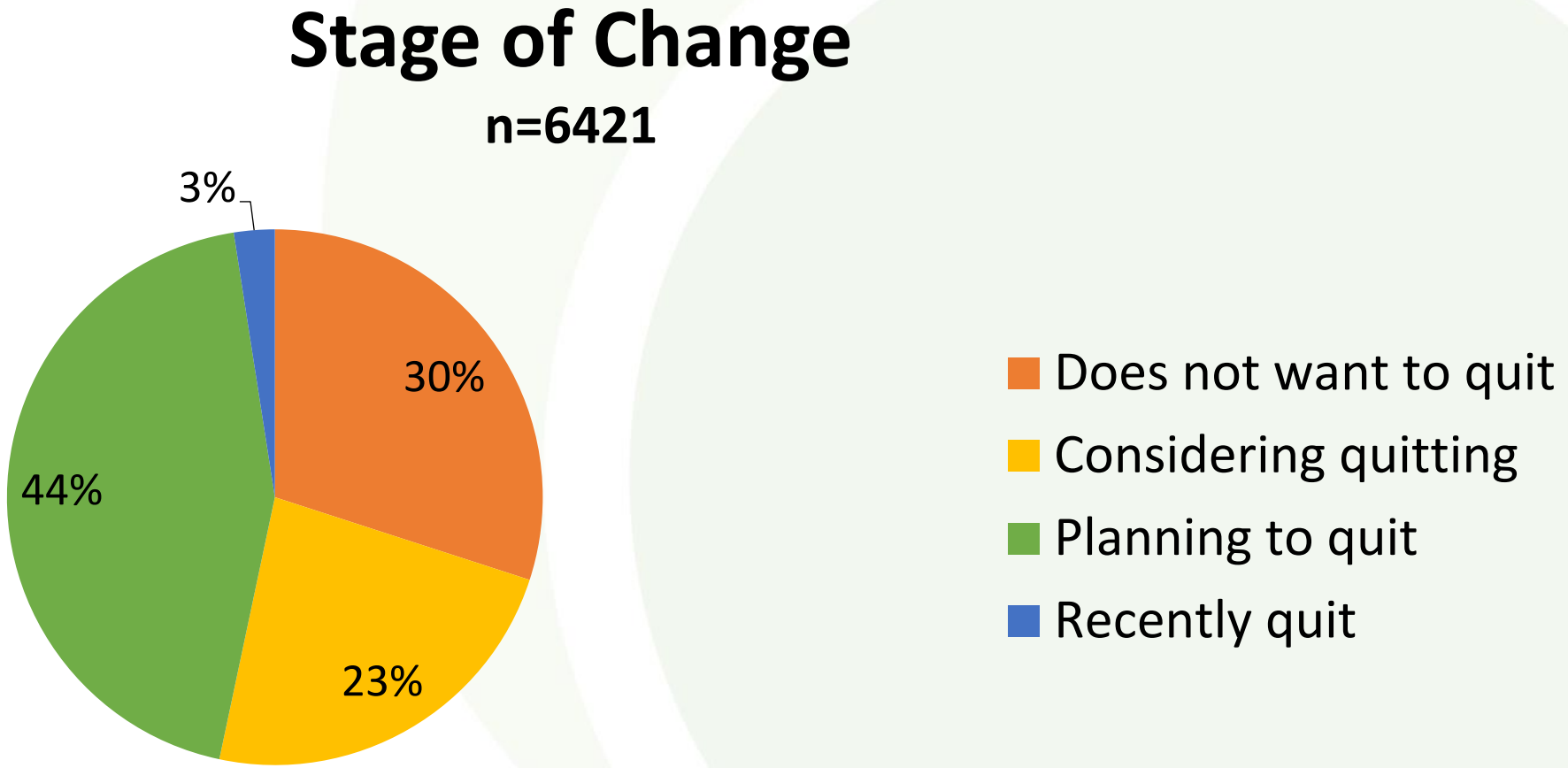
- Meta-analysis (Taylor, et al, 2014) examined benefits after smoking cessation:
  - Less depression
  - Less anxiety and less stress
  - Better quality of life

- People with substance use disorders are 25% more likely to stay abstinent when also quitting smoking (Prochaska, 2004)

- Tobacco smoking interferes with medication effectiveness (Smoking Cessation Leadership Center, 2015). This includes:
  - Some antipsychotic medications
  - Benzodiazepines
  - Even caffeine!

Myth:
People with mental illnesses do not want to quit

Fact: People are interested in quitting …even in the psychiatric hospital



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Sheppard Pratt Smoking Cessation Program

Smoking Cessation at Sheppard Pratt

- Sheppard Pratt is the largest private, nonprofit mental health system in the United States.
- Like most mental health services, smoking was allowed and even encouraged, only a few decades ago.

Smoking Cessation at Sheppard Pratt

- In 2005, with the expansion of the main hospital campus, this building and other services became smoke-free.

Smoking Cessation at Sheppard Pratt

- In 2015, a comprehensive smoking cessation program began.
- This focused on helping patients consider staying quit when they leave the hospital, recognizing we have a teachable moment during treatment.

Building a smoking cessation program

Screening

Brief intervention

- Counseling
- Nicotine replacement

Referral for treatment

- QuitLine
- NRT prescription

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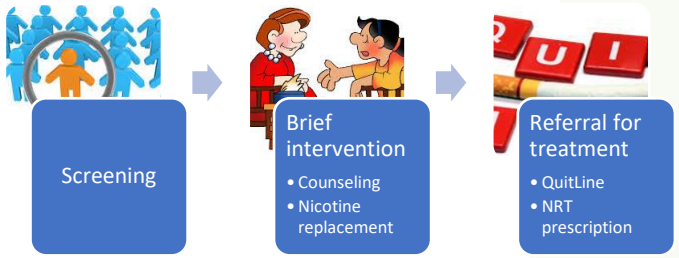
Expanding a smoking cessation program



Training employees

Peer Mentor

Electronic Medical Record changes

Continuous Quality Improvement

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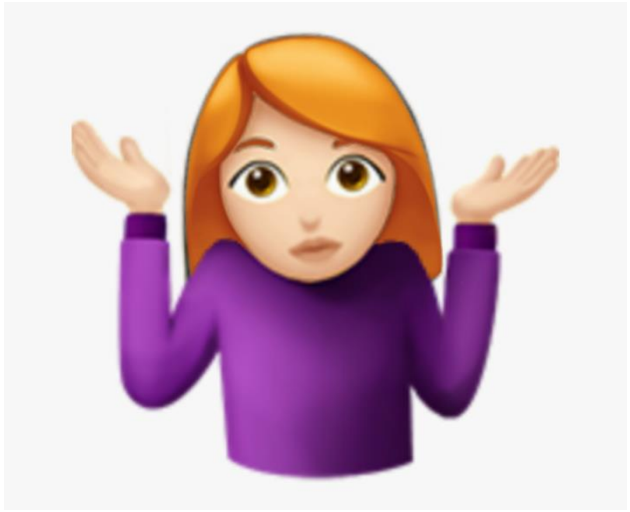
The Practical Side

Approaching Counseling: Sensitive to mental illness

- People who are in crisis with a psychiatric illness present some unique issues:
- “People tell me to smoke when I’m stressed.”
- “I want to quit but I don’t think I can.”
- “Why would I quit when I enjoy it so much?”
- “What’s the point? I’m going to die anyway.”
- “It’s better to smoke a cigarette than to use heroin.”



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Approaching Counseling: Sensitive to mental illness

- "People tell me to smoke when I'm stressed."

1) Offer some information: When people quit, they have less anxiety.
2) Engage in a discussion of healthier alternatives. If they don't have any ideas, offer some.

- When the body runs out of nicotine, the person feels badly. When they smoke, they feel relief. This can feel like being calmer.
- It may not be the cigarette that calms, but other things: Taking a break, getting away, taking deep breaths.

Approaching Counseling: Sensitive to mental illness

- "I want to quit but I don't think I can."

1) Learn about past experiences with quitting. Affirm any success – past quit attempts, thinking about reasons for quitting.

2) Encourage using help – it's not necessary to try to quit alone:

- Use a Quitline when available
- Nicotine replacement or medications

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Approaching Counseling: Sensitive to mental illness

- "Why would I quit when I enjoy it so much?"

1) Don't argue: roll with resistance

2) Engage in discussion about any change talk:

- Have you ever calculated how much you spend on cigarettes in a month?
- Why do you think your family doesn't want you to smoke?

Approaching Counseling: Sensitive to mental illness

- "What's the point? I'm going to die anyway."

1) Express empathy – offer reflective listening to allow patient to be heard before inviting new perspectives.

2) Address safety: Make sure that any suicidal ideation is being addressed in their treatment.

Approaching Counseling: Sensitive to mental illness

- "It's better to smoke a cigarette than to use heroin."

1) Build awareness: people who quit cigarettes are 25% more likely to stay clean from other substances.

2) Cigarettes and drugs are not the only two options:

- What helps you feel better **and** is good for you?

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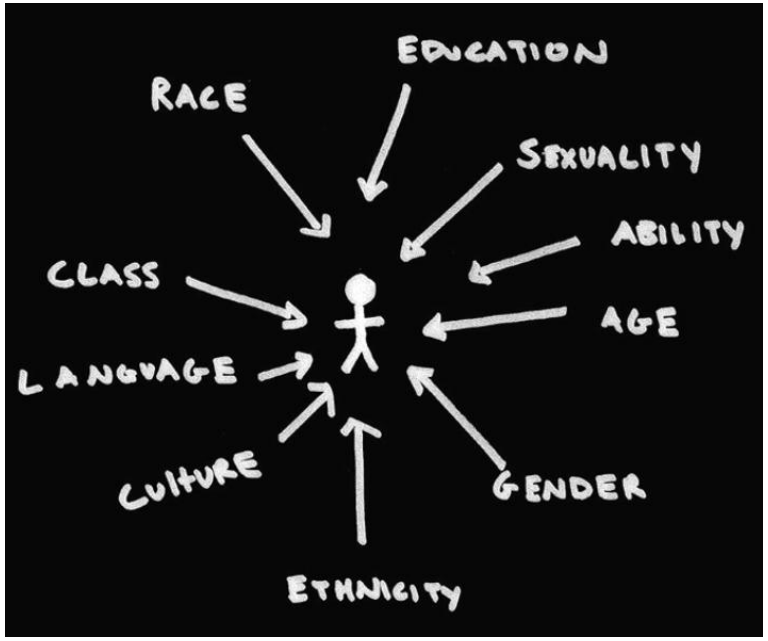
Approaching Counseling: Cultural Competence

- Recognize that many other elements may be impacting a person's risk for smoking and their willingness to work on quitting:



- Race/ethnicity
- Gender
- LGBTQ status
- Physical health/disability
- Socio-economic status
- Life history/family background

To contact Rachel Smolowitz

rsmolowitz@sheppardpratt.org

410-938-5234

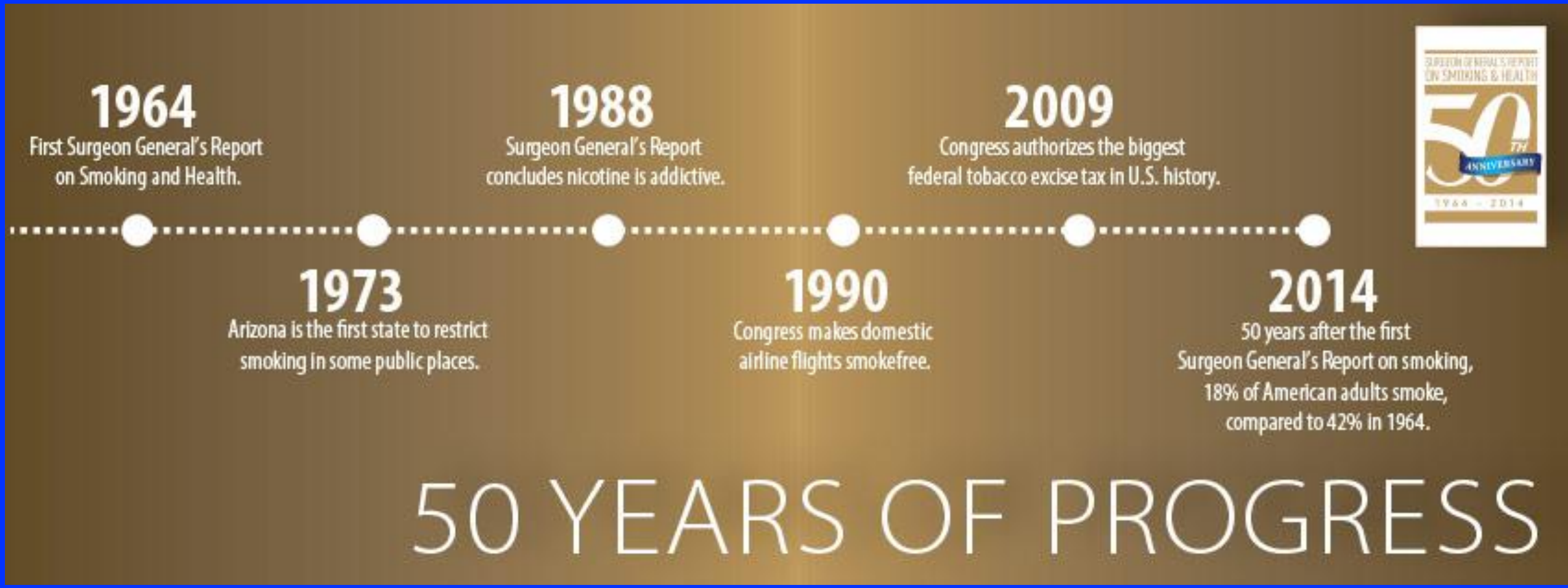
Michael Stavros

mstavros@sheppardpratt.org

410-938-3881

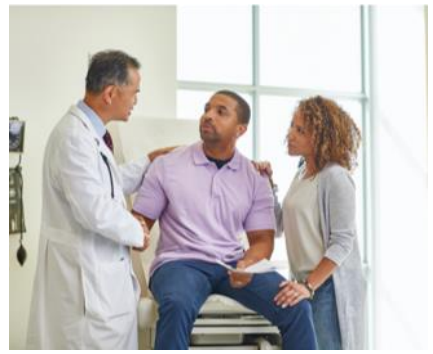
It is NEVER too late to quit

Carolyn Dresler, MD, MPA


1964
First Surgeon General's Report on Smoking and Health.
1973
Arizona is the first state to restrict smoking in some public places.
1988
Surgeon General's Report concludes nicotine is addictive.
1990
Congress makes domestic airline flights smokefree.
2009
Congress authorizes the biggest federal tobacco excise tax in U.S. history.
2014
50 years after the first Surgeon General's Report on smoking, 18% of American adults smoke, compared to 42% in 1964.
50TH ANNIVERSARY
1964 – 2014
50 YEARS OF PROGRESS

SMOKING CESSATION

A REPORT OF THE SURGEON GENERAL



Resources Available

To read the full report and access related materials, visit:
www.SurgeonGeneral.gov

To learn more about tobacco control and prevention and quitting smoking, visit:
www.CDC.gov/tobacco
www.CDC.gov/quit
www.smokefree.gov

Contact Info:

SGReports@cdc.gov

2014 USA Surgeon General's Report

- Conclusions:
  - In cancer patients and survivors, the evidence is sufficient to infer a ***causal relationship*** between cigarette smoking and ***adverse health outcomes***. Quitting smoking improves the prognosis of cancer patients.
  - In cancer patients and survivors, the evidence is sufficient to infer a ***causal relationship*** between cigarette smoking and ***increased all-cause mortality and cancer-specific mortality***.

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

2014 USA Surgeon General's Report

- **Conclusions:**

In cancer patients and survivors, the evidence is sufficient to infer a ***causal relationship*** between cigarette smoking and ***increased risk for second primary cancers*** known to be caused by cigarette smoking, such as lung cancer.

In cancer patients and survivors, the evidence is *suggestive* but not sufficient to infer a causal relationship between cigarette smoking and the risk of recurrence, poorer response to treatment, and increased treatment-related toxicity.

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

Implementing Smoking Cessation in Canadian Cancer Centres

- 2013, Cancer Care Ontario implemented a smoking cessation program in 14 regional cancer centres:
  - All new ambulatory cancer patients to be screened for smoking status
  - Current/recent quitters advised of the health benefits of cessation
  - Referred to smoking cessation services using “opt out” approach
- 2015, Canadian Partnership Against Cancer convened meeting of Canadian provinces/territories; funding made available to plan, implement or evaluate smoking cessation services; 7 provinces, 3 territories applied
- 2019, CPAC allocated funding to scale-up and spread tobacco cessation in cancer systems

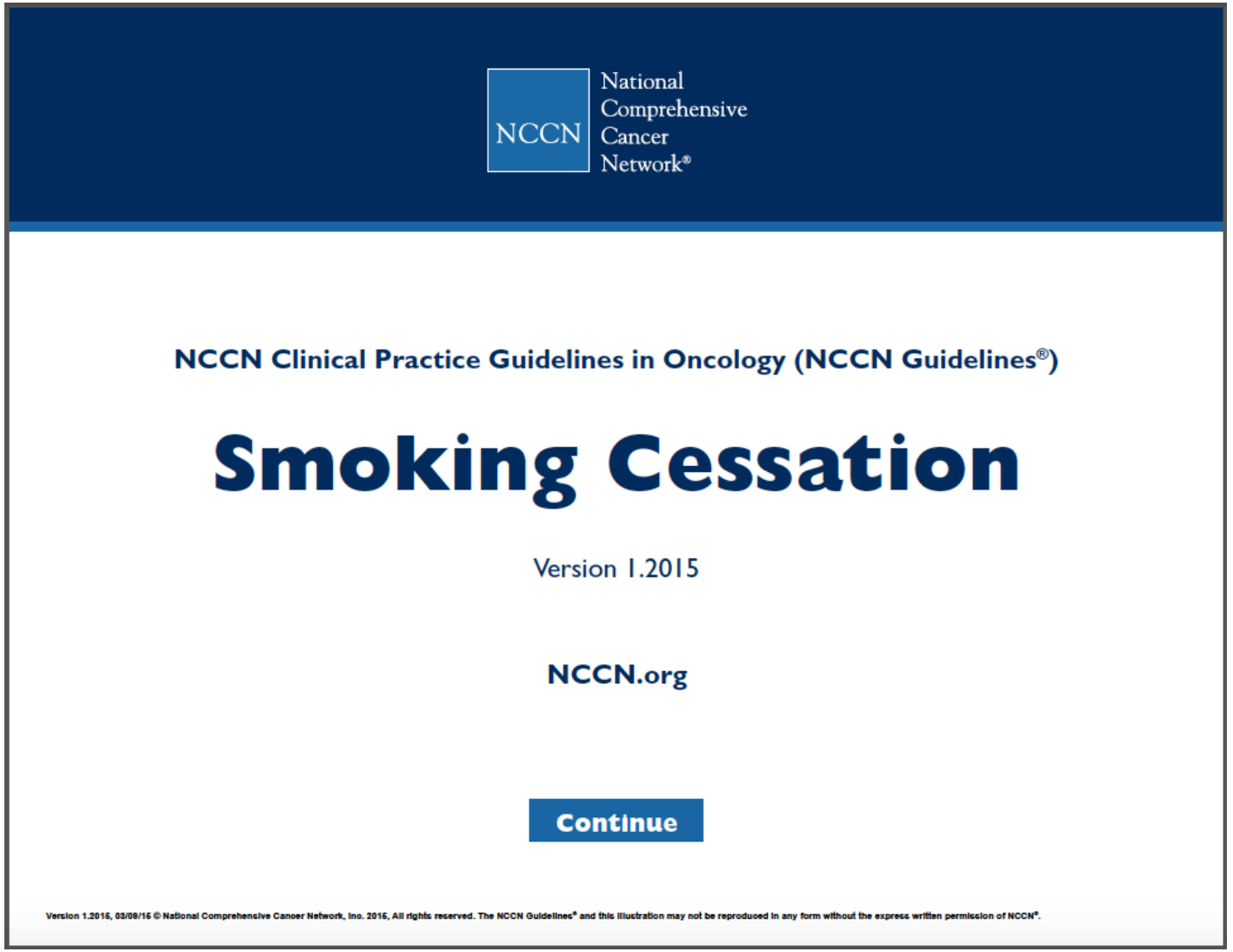
US National Cancer Center Cessation Initiative

In 2017, NCI launched the Cancer Center Cessation Initiative, as part of the NCI Cancer Moonshot program.

The long-term goal of this Initiative is to help cancer centers build and implement sustainable tobacco cessation treatment programs to routinely address tobacco cessation with cancer patients.

https://cancercontrol.cancer.gov/brp/tcrb/cessation-initiative.html

NCCN Guidelines



www.nccn.org (v1, 2015)

Tobacco Cessation in Clinical Practice

- ASK every patient about former and current tobacco use.
- ADVISE all patients to quit with a personalized message and discuss benefits of cessation
- ASSESS dependence on tobacco and willingness to quit
- ASSIST with behavioral counseling, pharmacotherapy
- ARRANGE follow up plan (in person, or if not possible- by telephone)

Tobacco Assessment by Oncologists

(Always/Most of the time)

Parameter	IASLC (n=1507)	ASCO (n=1197)
Ask if use tobacco	90.2%	89.5%
Ask if will quit	78.9%	80.2%
Advise to quit	80.6%	82.4%
Discuss medications	40.2%	44.3%
Actively treat	38.8%	38.6%

Warren GW et al. *J Thorac Oncol* 2013 8:543-548
Warren GW et al. *J Oncol Pract* 2013 9(5): 258-262

Summary

- Most lung cancer and many other cancers are linked to tobacco use.
- Most patients DO want to quit, (and often have tried multiple times).
- Physicians should be aware of and support tobacco control policies which save lives
- Cessation impacts outcomes, even after diagnosis.
- Cessation can and should be integrated into clinical practice

Declaration from IASLC: Tobacco Cessation After Cancer Diagnosis

Wednesday, September 04, 2019

Tobacco use is a well-established cause of cancer, contributing to about 1 in 3 cancer deaths annually. Whereas detrimental effects of smoking are well recognized, the harms of continued smoking after the diagnosis of cancer are underappreciated. Smoking continuation by cancer patients and survivors causes adverse treatment outcomes, including increased overall mortality, cancer related mortality and risk for second primary cancer, and considerably increases cancer treatment toxicity.

IASLC Declaration recommendations for implementation:

All cancer patients should be screened for tobacco use and advised on the benefits of tobacco cessation.

In patients who continue smoking after diagnosis of cancer, evidence-based tobacco cessation assistance should be routinely and integrally incorporated into multidisciplinary cancer care for the patients and their family members.

Educational programs regarding cancer management should include tobacco cessation training, empathetic communication around history of tobacco use and cessation and utilization of existing evidence- based tobacco cessation resources.

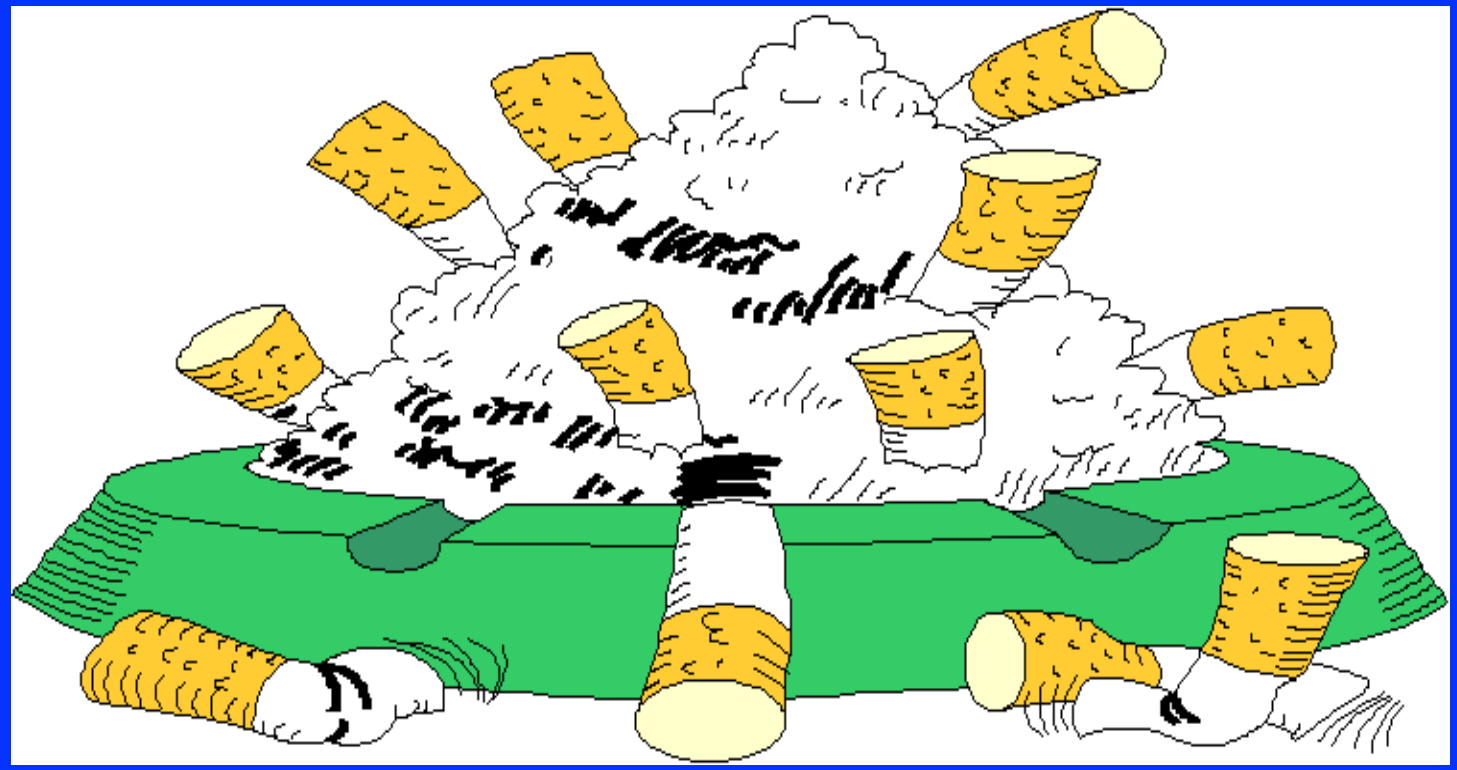
Smoking cessation counseling and treatment should be a reimbursable service.

Smoking status, both initially and during the study, should be a required data element for all prospective clinical studies.

Clinical trials of patients with cancer should consider designs that could also determine the most effective tobacco cessation interventions.

It matters what you do – so DO IT!

- Help your cancer patients to stop smoking
- Make it easier for the clinician – establish expertise or referral for cessation interventions
- ASK, ADVISE, REFER
- Work with your local coalitions to improve tobacco control policies, including CESSATION in your cancer centers



The End!

Q&A

Stay Involved

Twitter
@ASHorg
@LaurentHuber

Facebook
@ASHglobalAction

Instagram
@ASHorg

Info@ash.org

For additional Article 14 resources please visit:
www.treatobacco.net
or contact:
Martin Raw
International Centre for Tobacco Cessation
martin@martinraw.com

ASH ACTION ON SMOKING & HEALTH
Global action for everyone's health.

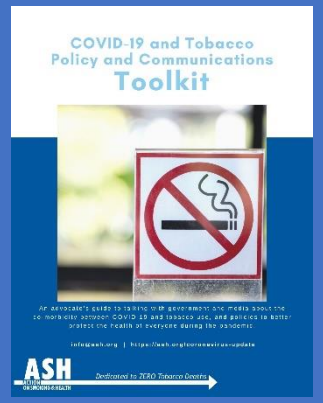
NEXT WEBINAR: Tuesday, Sept. 22nd at 3:00pm ET

Using Cessation and an International Treaty to Strengthen the Health of DC Residents

Speakers: **Dr. Carla Williams** (Interim Director of the Howard University Cancer Center and Chair of the DC Tobacco-Free Coalition), **Kelsey Romeo-Stuppy** (Managing Attorney at ASH).

Registration Link in Thank You Email

Recordings from previous webinars and Live Chats on social media: https://ash.org/webinars



Toolkit for Advocates

Talking with government and media about the COVID-19 and tobacco use co-morbidity and policies to protect the health of everyone during the pandemic.

ash.org/covid19