



Rx for CHANGE

Ask-Advise-Assess-Refer

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"CIGARETTE SMOKING...

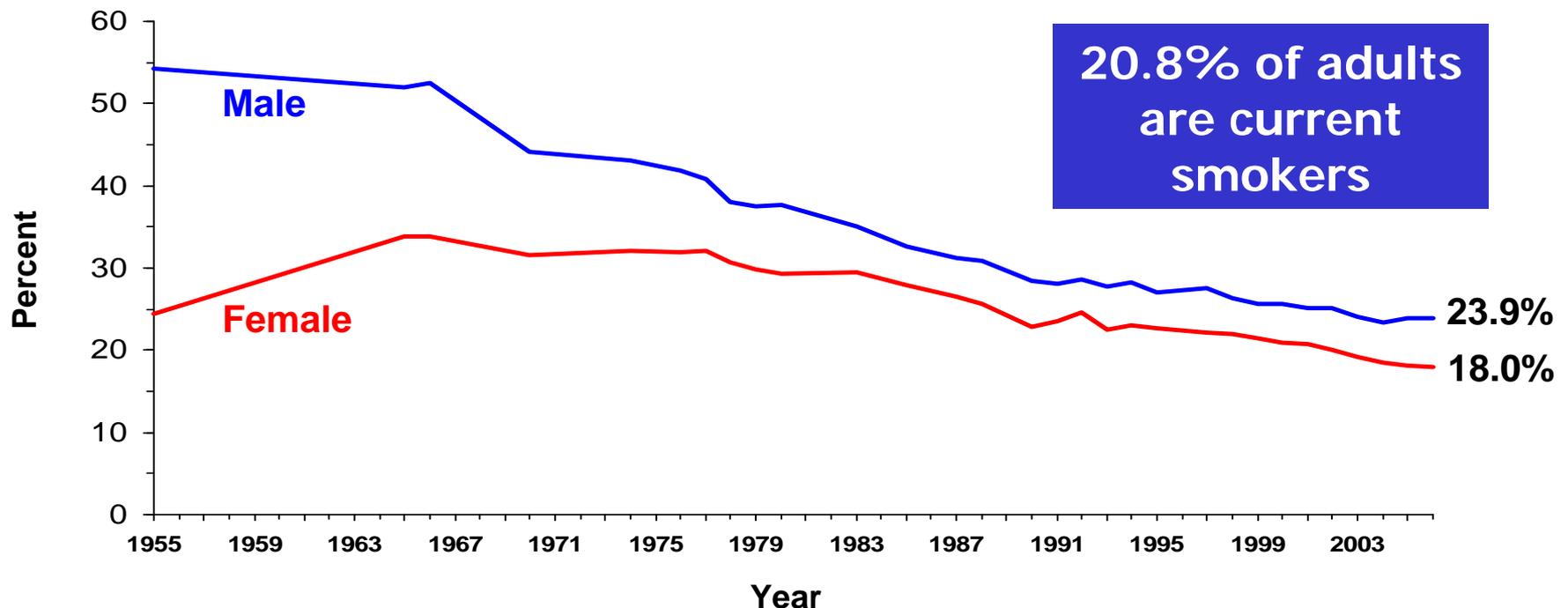
is the chief, single,
avoidable cause of death
in our society and the most
important public health
issue of our time."

C. Everett Koop, M.D., former U.S. Surgeon General



TRENDS in ADULT SMOKING, by SEX — U.S., 1955–2006

Trends in cigarette current smoking among persons aged 18 or older



70% want to quit

Graph provided by the Centers for Disease Control and Prevention. 1955 Current Population Survey; 1965–2005 NHIS. Estimates since 1992 include some-day smoking.





ANNUAL U.S. DEATHS ATTRIBUTABLE to SMOKING, 1997–2001

Percentage of all smoking-
attributable deaths*

Cardiovascular diseases	137,979	32%
Lung cancer	123,836	28%
Respiratory diseases	101,454	23%
Second-hand smoke*	38,112	9%
Cancers other than lung	34,693	8%
Other	1,828	<1%

TOTAL: 437,902 deaths annually

* In 2005, it was estimated that nearly 50,000 persons died due to second-hand smoke exposure.



COMPOUNDS in TOBACCO SMOKE

An estimated 4,800 compounds in tobacco smoke, including 11 proven human carcinogens

Gases

- Carbon monoxide
- Hydrogen cyanide
- Ammonia
- Benzene
- Formaldehyde



Particles

- Nicotine
- Nitrosamines
- Lead
- Cadmium
- Polonium-210

Nicotine does NOT cause the ill health effects of tobacco use.



2004 REPORT of the SURGEON GENERAL: HEALTH CONSEQUENCES OF SMOKING

FOUR MAJOR CONCLUSIONS:

- Smoking harms nearly every organ of the body, causing many diseases and reducing the health of smokers in general.
- Quitting smoking has immediate as well as long-term benefits, reducing risks for diseases caused by smoking and improving health in general.
- Smoking cigarettes with lower machine-measured yields of tar and nicotine provides no clear benefit to health.
- The list of diseases caused by smoking has been expanded.



HEALTH CONSEQUENCES of SMOKING

- Cancers
 - Acute myeloid leukemia
 - Bladder and kidney
 - Cervical
 - Esophageal
 - Gastric
 - Laryngeal
 - Lung
 - Oral cavity and pharyngeal
 - Pancreatic
- Pulmonary diseases
 - Acute (e.g., pneumonia)
 - Chronic (e.g., COPD)
- Cardiovascular diseases
 - Abdominal aortic aneurysm
 - Coronary heart disease
 - Cerebrovascular disease
 - Peripheral arterial disease
- Reproductive effects
 - Reduced fertility in women
 - Poor pregnancy outcomes (e.g., low birth weight, preterm delivery)
 - Infant mortality
- Other effects: cataract, osteoporosis, periodontitis, poor surgical outcomes



HEALTH CONSEQUENCES of SMOKELESS TOBACCO USE

Periodontal effects

- Gingival recession
- Bone attachment loss
- Dental caries

Oral leukoplakia

Cancer

- Oral cancer
- Pharyngeal cancer

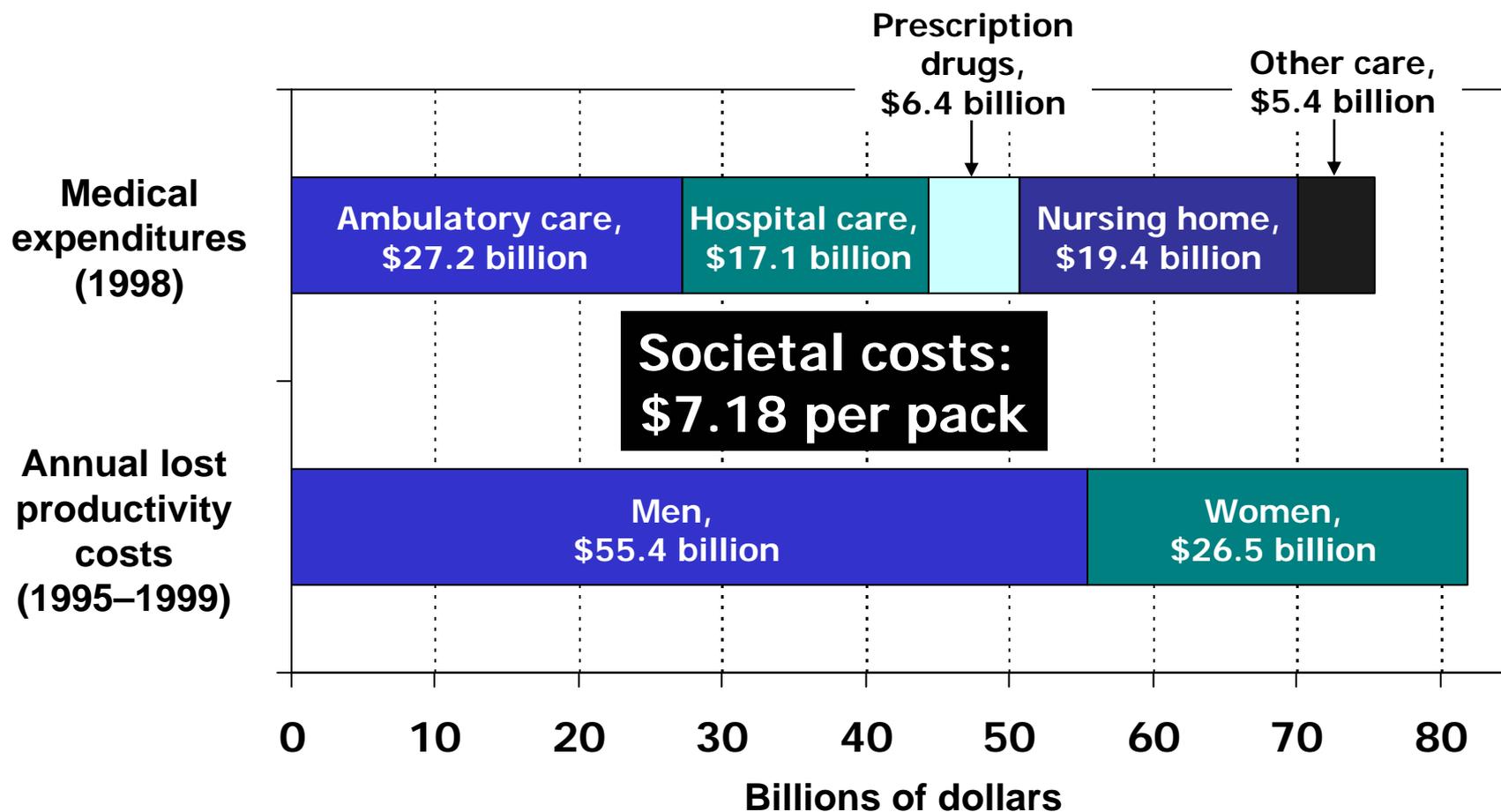


Oral Leukoplakia

*Image courtesy of Dr. Sol Silverman -
University of California San Francisco*



ANNUAL SMOKING-ATTRIBUTABLE ECONOMIC COSTS—U.S., 1995–1999





2006 REPORT of the SURGEON GENERAL: INVOLUNTARY EXPOSURE to TOBACCO SMOKE

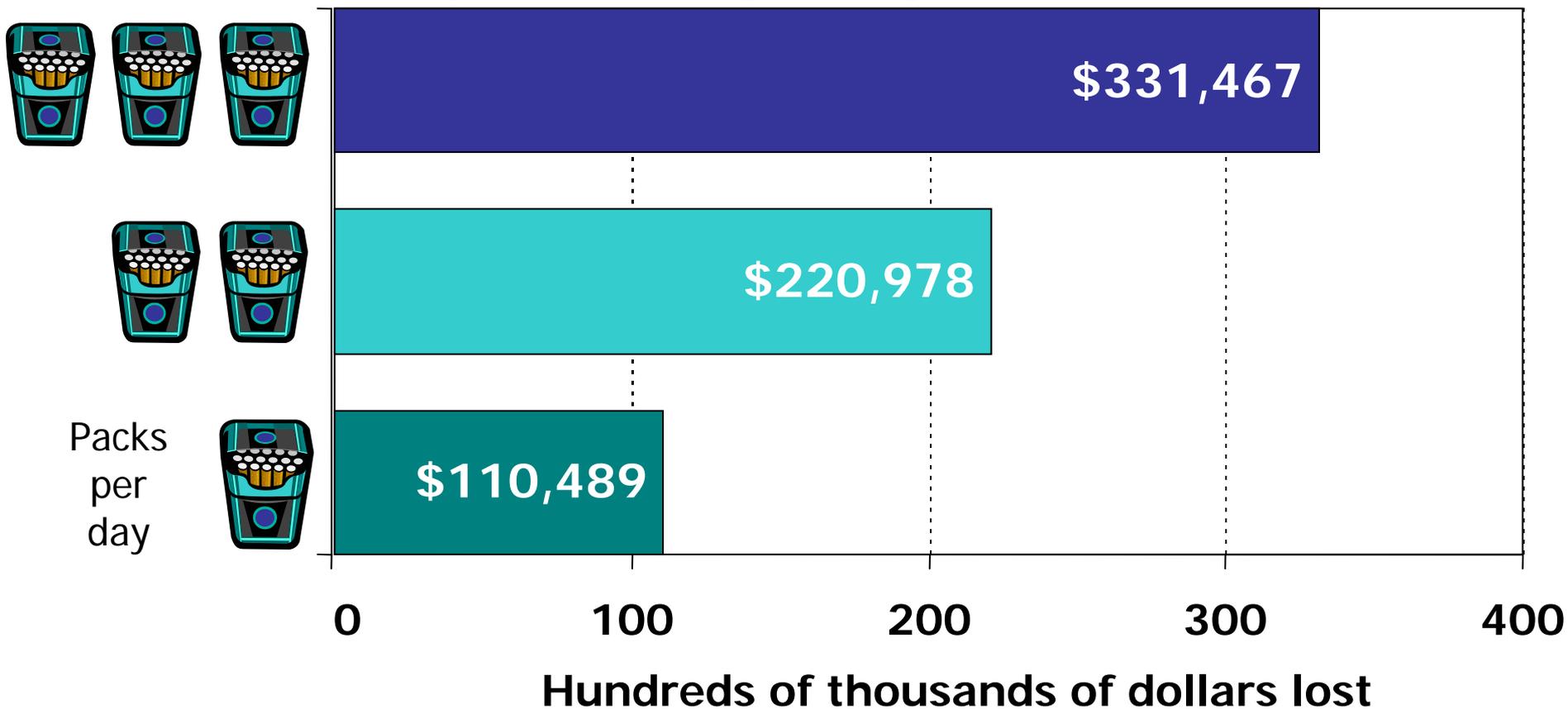
- Second-hand smoke causes premature death and disease in nonsmokers (children and adults)
- Children:
 - Increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma
 - Respiratory symptoms and slowed lung growth if parents smoke
- Adults:
 - Immediate adverse effects on cardiovascular system
 - Increased risk for coronary heart disease and lung cancer
- Millions of Americans are exposed to smoke in their homes/workplaces
- Indoor spaces: eliminating smoking fully protects nonsmokers
 - Separating smoking areas, cleaning the air, and ventilation are **not** effective

**There is no
safe level of
second-hand
smoke.**



FINANCIAL IMPACT of SMOKING: COSTS to the INDIVIDUAL

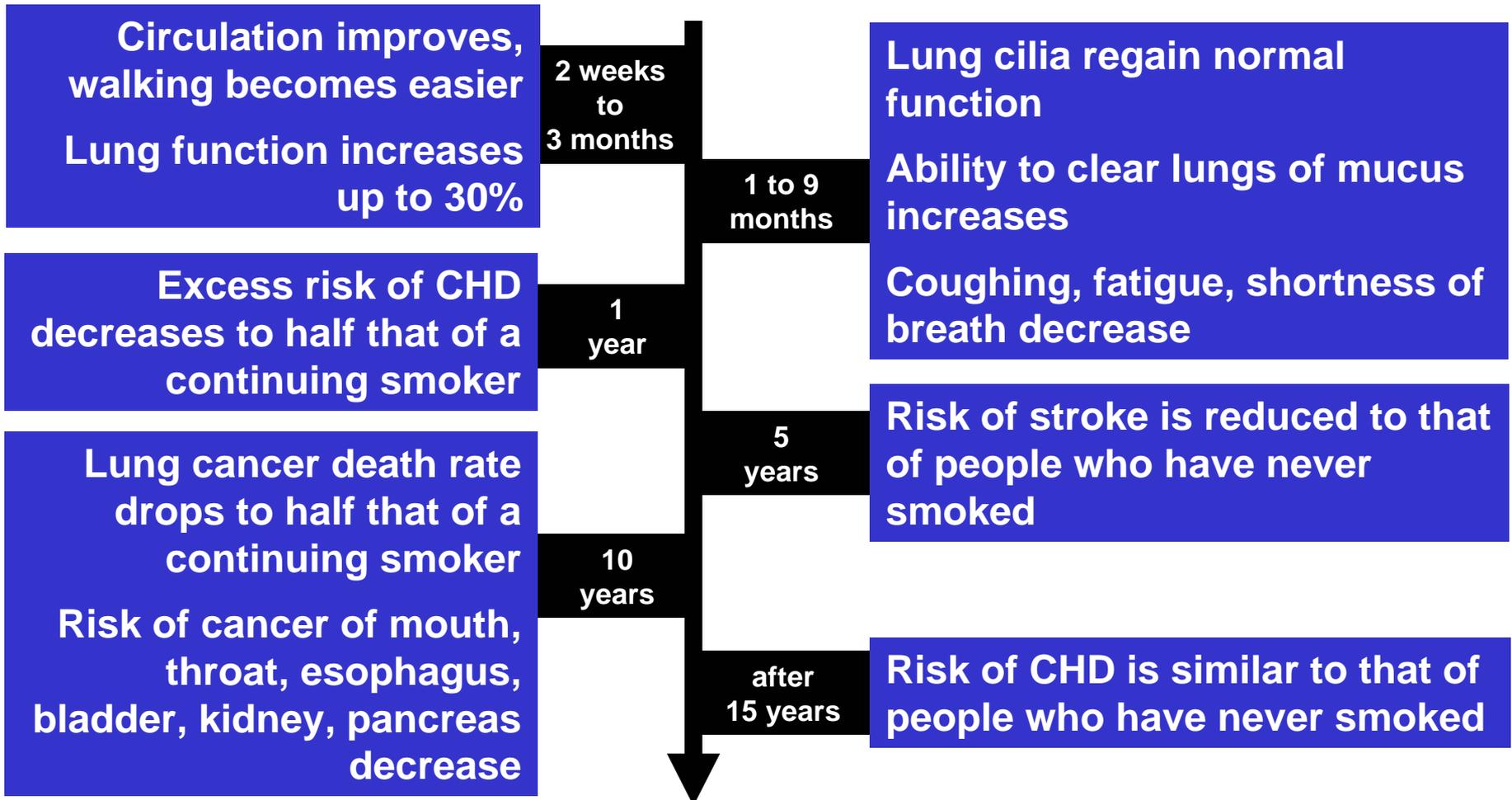
Buying cigarettes every day for 50 years @ \$4.12 per pack
Money banked monthly, earning 1.5% interest





QUITTING: HEALTH BENEFITS

Time Since Quit Date





ADDRESSING TOBACCO USE In a Community Pharmacy Setting



WHY COMMUNITY PHARMACISTS?

- Long-term, established relationships with many patients
- High degree of trust
- Frequent and easy access
- Point-of-sale contact:
 - Patients filling prescriptions for tobacco-related illnesses
 - Patients purchasing cessation medications



WHY PHARMACISTS DON'T COUNSEL

- "I don't have the time."
- "It's not relevant."
- "I don't get reimbursed to counsel."
- "Patients are unlikely to quit."
- "I want to respect my patients' privacy."
- "I don't know what to do."



"I don't have the time."

- Simply advising someone to quit can have an impact
 - In surveys, 70% indicate that a health-care professional has never told them to quit
 - You may be the person this patient will listen to!
- Interventions can take as little as 30 seconds
 - More powerful, motivational counseling can be provided in fewer than 5 minutes



“It’s not relevant.”

- Smoking adversely affects every smoker. It can:
 - Cause the illness you are treating
 - Exacerbate the symptoms
 - Impair immune response/delay healing
- Drug interactions:
 - More than 20 categories of drugs



DRUG INTERACTIONS with SMOKING

Clinicians should be aware of their patients' smoking status:

- Clinically significant interactions result not from nicotine but from the combustion products of tobacco smoke.
- Constituents in tobacco smoke (e.g., polycyclic aromatic hydrocarbons; PAHs) may enhance the metabolism of other drugs, resulting in a reduced pharmacologic response.
- Smoking might adversely affect the clinical response to the treatment of a wide variety of conditions.



PHARMACOKINETIC DRUG INTERACTIONS with SMOKING

Drugs that may have a *decreased effect* due to induction of CYP1A2:

- Bendamustine
- Caffeine
- Clozapine
- Erlotinib
- Fluvoxamine
- Irinotecan (clearance increased due to increased glucuronidation)
- Olanzapine
- Ropinirole
- Tacrine
- Theophylline

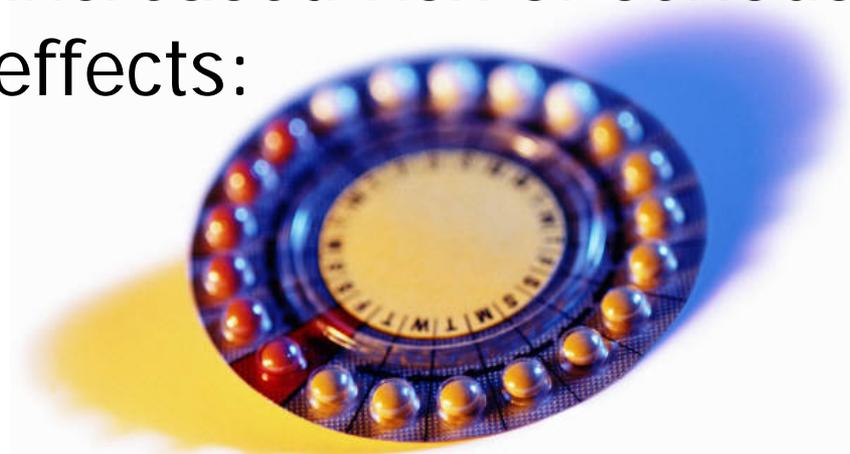
Smoking cessation will reverse these effects.



PHARMACODYNAMIC DRUG INTERACTIONS with SMOKING

Smokers who use combined hormonal contraceptives have an increased risk of serious cardiovascular adverse effects:

- Stroke
- Myocardial infarction
- Thromboembolism



This interaction **does not** decrease the efficacy of hormonal contraceptives.

Women who are 35 years of age or older AND smoke at least 15 cigarettes per day are at significantly elevated risk.



"I don't get reimbursed to counsel."

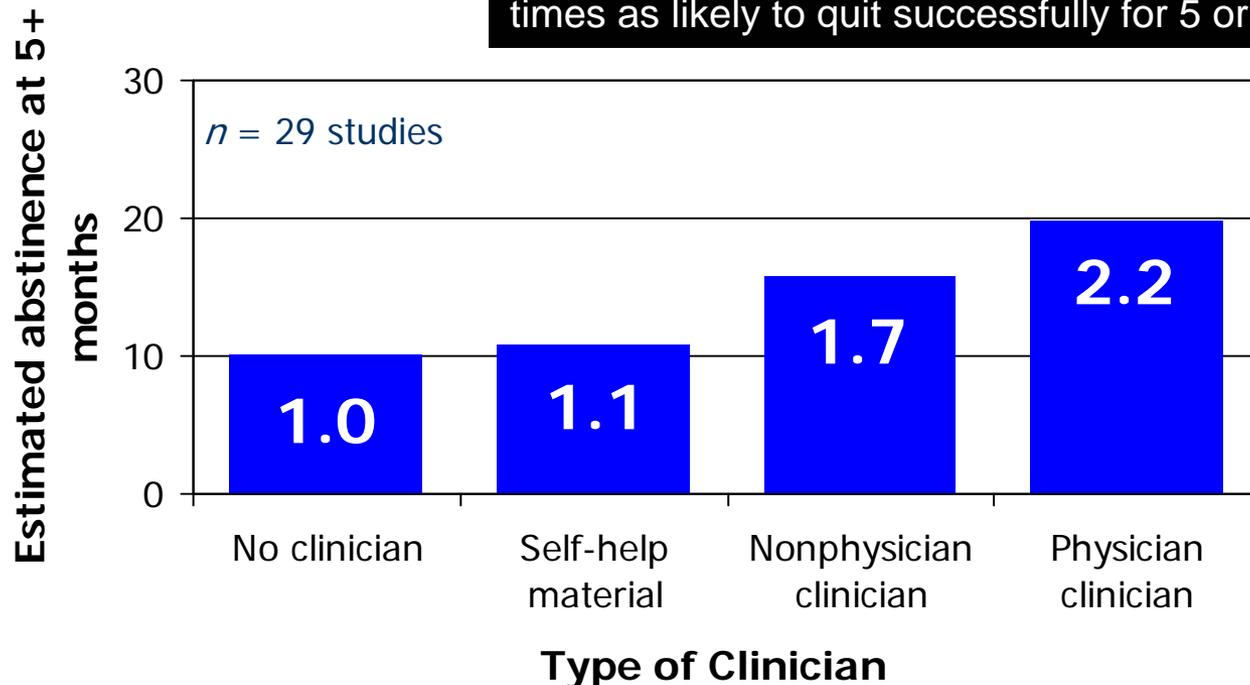
- Addressing tobacco use should be part of routine pharmacy practice
- Counseling might be reimbursable in some situations
 - Many states now reimburse pharmacists through medical assistance
 - Many practitioners charge fee-for-service
 - Can charge in conjunction with disease state management services



“Patients are unlikely to quit.”

With help from a clinician, the odds of quitting approximately doubles.

Compared to smokers who receive no assistance from a clinician, smokers who receive such assistance are 1.7–2.2 times as likely to quit successfully for 5 or more months.





“I want to respect my patients’ privacy.”

- Tobacco users expect to be encouraged to quit by health professionals
 - Studies suggest that patients, even those who plan to continue using tobacco, prefer that health professionals advise them to quit
- Most tobacco users want to quit and want support and encouragement to do so, especially from those they respect and trust

Failure to address tobacco tacitly implies that “quitting is not important”



"I don't know what to do."

- Virtually no expertise is needed to refer patients to telephone quitlines, websites or other resources in the community
- Basic facts are straightforward– counseling plus pharmacotherapy can significantly help patients quit for good
- Tobacco cessation providers in the community, or quitline or website staff can provide patients with the information needed for a quit attempt



The PHARMACIST'S ROLE

- **ASK** about tobacco use
- **ADVISE** patients to quit
 - Link current illness and tobacco use
 - Counsel on proper use of cessation medications
 - Review the benefits of behavioral counseling
- **ASSESS** readiness to quit
- **REFER** to the Michigan Tobacco Quitline
- The pharmacist does not need to create or conduct the entire quitting program...**just start it!**



The PHARMACIST'S ROLE (cont'd)

- Create a supportive atmosphere
- Encourage:
 - Emphasize "Quitting is possible."
- Address ambivalence:
 - "Ambivalence about quitting is normal. Getting stuck there is not!"



ADDRESS COMMON MISCONCEPTIONS

- Regarding medications for quitting:
 - “The products don’t work!”
 - “I’m trading one addiction for another.”
 - “I can quit on my own.”
 - “NRT is harmful.”



"The products don't work!"

"Numerous effective medications are available for tobacco dependence, and clinicians should encourage their use by all patients attempting to quit smoking—except when medically contraindicated or with specific populations* for which there is insufficient evidence of effectiveness."

MEDICATIONS SIGNIFICANTLY IMPROVE SUCCESS RATES.

* Includes pregnant women, smokeless tobacco users, light smokers, and adolescents.

Fiore et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline.* Rockville, MD: USDHHS, PHS, May 2008.



"The products don't work!"

- Let's review how you used "[medication]" the last time you quit.
 - Most individuals who make this statement have used the product incorrectly in the past.
 - Wrong strength of medication
 - Too few doses taken per day
 - Stopped too soon
 - Review concurrent smoking and product use
 - Explain proper usage



“I’m trading one addiction for another!”

- Cessation medications provide nicotine much more slowly than cigarettes and therefore are less likely to result in physical addiction.
 - When nicotine from cigarettes is absorbed through the lungs, it reaches the brain in fewer than 11 seconds. This is what makes smoking so addicting.
 - Compared to cigarettes, it’s less difficult to wean off of the products.



“I can quit on my own.”

- Medications approximately double patients' chances of quitting
- Medications make it more comfortable while quitting
 - “What will not using a product accomplish?”
 - “If you broke your leg, would it heal better if you turned down pain medication? What makes you think the quit will go better without a medication? ”
 - “Think of quitting as learning a new behavior. And remember that most people who quit without a product go through withdrawal, including irritability and anxiety. Could you learn anything if you felt this way all day?”



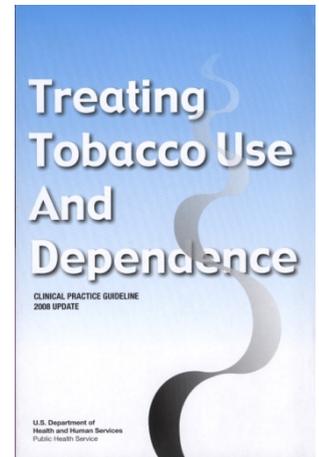
"NRT is harmful."

- Nicotine is not the harmful component of tobacco. Harm results from the thousands of toxic chemicals found in cigarette.
 - "NRT is a safe, 'clean' form of nicotine that eliminates exposure to the toxins found in tobacco."
 - "People don't die from using the nicotine medications, but thousands of people die every day from smoking."



QUITTING: WHAT WORKS?

- Combining a cessation medication with a behavior modification program
 - Evidence-based practice
 - Many tools available to clinicians
- Pharmacists are in an excellent position
 - To promote effective strategies
 - To **begin** this process!





TOBACCO DEPENDENCE: A 2-PART PROBLEM

Tobacco Dependence

Physiological

The addiction to nicotine



Treatment

Medications for cessation



Behavioral

The habit of using tobacco



Treatment

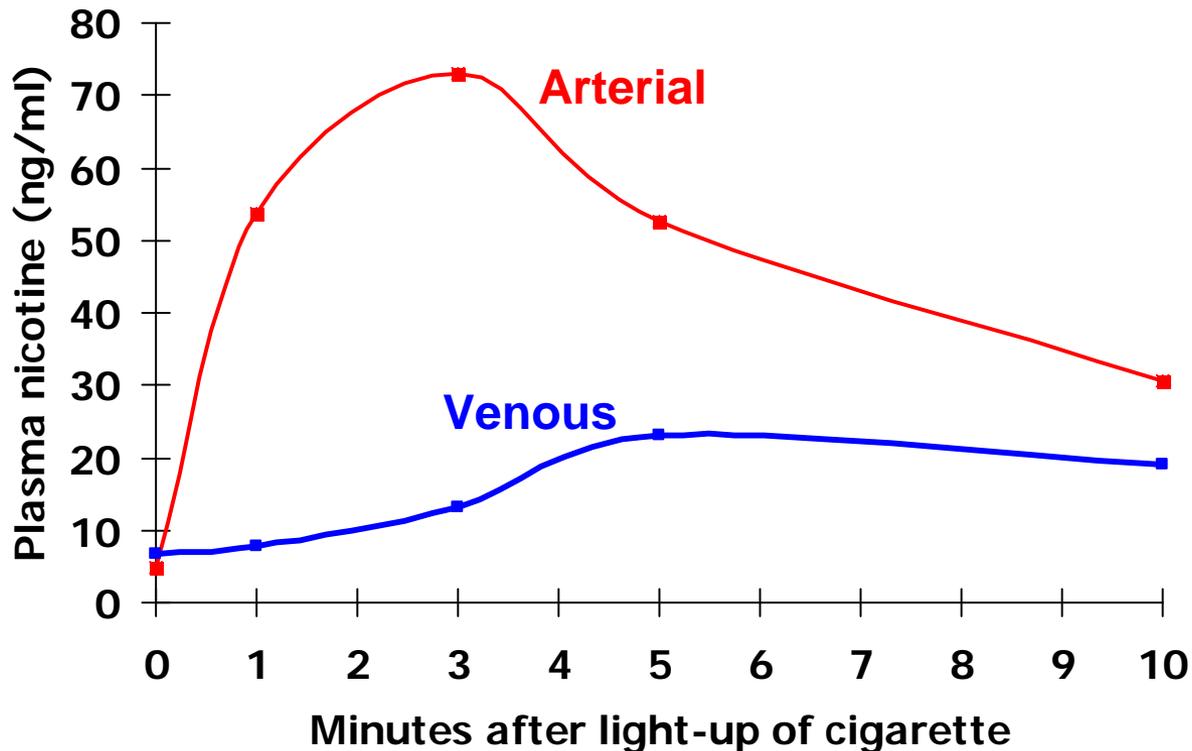
Behavior change program

Treatment should address the physiological
and the behavioral aspects of dependence.



NICOTINE DISTRIBUTION

Nicotine reaches the brain within 11 seconds.





NICOTINE WITHDRAWAL EFFECTS

- Depression
- Insomnia
- Irritability/frustration/anger
- Anxiety
- Difficulty concentrating
- Restlessness
- Increased appetite/weight gain
- Decreased heart rate
- Cravings*

Most symptoms peak 24–48 hr after quitting and subside within 2–4 weeks.

* Not considered a withdrawal symptom by *DSM-IV* criteria.



FDA-APPROVED MEDICATIONS for CESSATION

Nicotine polacrilex gum

- Nicorette (OTC)
- Generic nicotine gum (OTC)

Nicotine lozenge

- Commit (OTC)
- Generic nicotine lozenge (OTC)

Nicotine transdermal patch

- Nicoderm CQ (OTC)
- Nicotrol (OTC)
- Generic nicotine patches (OTC, Rx)

Nicotine nasal spray

- Nicotrol NS (Rx)

Nicotine inhaler

- Nicotrol (Rx)

Bupropion SR (Zyban)

Varenicline (Chantix)

**These are the only medications that are
FDA-approved for smoking cessation.**



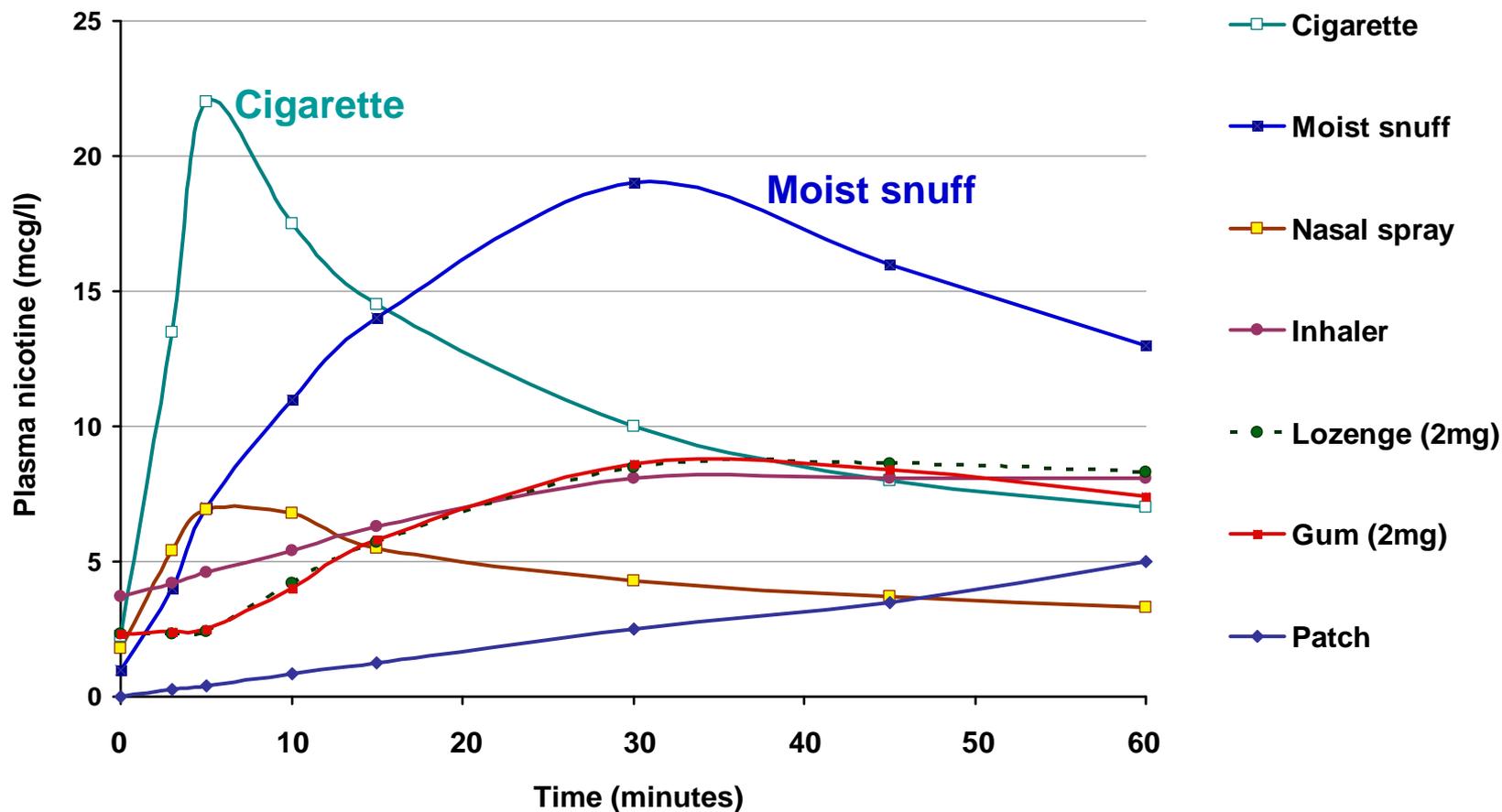
NICOTINE REPLACEMENT THERAPY: Rationale for use

- Reduces physical withdrawal from nicotine
- Eliminates the immediate, reinforcing effects of nicotine that is rapidly absorbed via tobacco smoke
- Allows patient to focus on behavioral and psychological aspects of tobacco cessation



PLASMA NICOTINE CONCENTRATIONS for NICOTINE-CONTAINING PRODUCTS

Nicotine levels for various nicotine-containing products





NICOTINE GUM

Nicorette (GlaxoSmithKline); generics

- Resin complex
 - Nicotine
 - Polacrillin
- Sugar-free chewing gum base
- Contains buffering agents to enhance buccal absorption of nicotine
- Available: 2 mg, 4 mg; regular, FreshMint, Fruit Chill, mint, & orange flavor





NICOTINE LOZENGE

Commit (GlaxoSmithKline); generics

- Nicotine polacrilex formulation
 - Delivers ~25% more nicotine than equivalent gum dose
- Sugar-free, mint or cherry flavor (boxed or POP-PAC)
- Contains buffering agents to enhance buccal absorption of nicotine
- Available: 2 mg, 4 mg

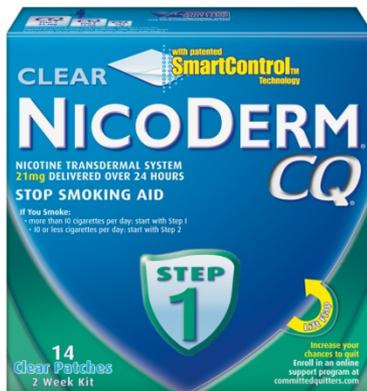




TRANSDERMAL NICOTINE PATCH

Nicoderm CQ (GlaxoSmithKline); generic

- Nicotine is well absorbed across the skin
- Delivery to systemic circulation avoids hepatic first-pass metabolism
- Plasma nicotine levels are lower and fluctuate less than with smoking





NICOTINE NASAL SPRAY

Nicotrol NS (Pfizer)

- Aqueous solution of nicotine in a 10-ml spray bottle
- Each metered dose actuation delivers
 - 50 μ l spray
 - 0.5 mg nicotine
- ~100 doses/bottle
- Rapid absorption across nasal mucosa

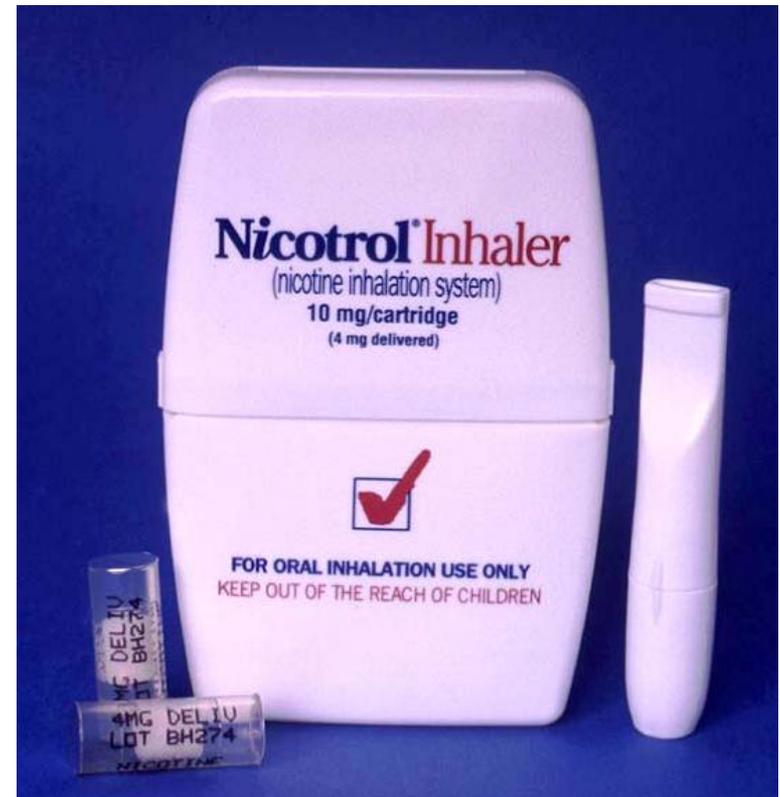




NICOTINE INHALER

Nicotrol Inhaler (Pfizer)

- Nicotine inhalation system consists of
 - Mouthpiece
 - Cartridge with porous plug containing 10 mg nicotine
- Delivers 4 mg nicotine vapor, absorbed across buccal mucosa
- May satisfy hand-to-mouth ritual of smoking

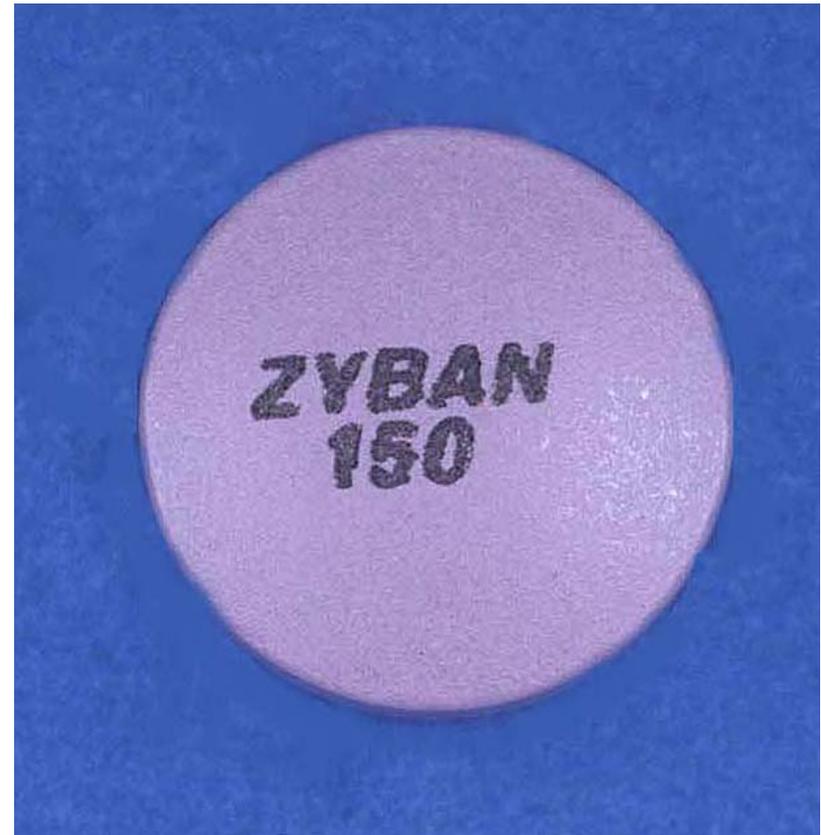




BUPROPION SR

Zyban (GlaxoSmithKline); generic

- Nonnicotine cessation aid
- Sustained-release antidepressant
- Oral formulation





VARENICLINE

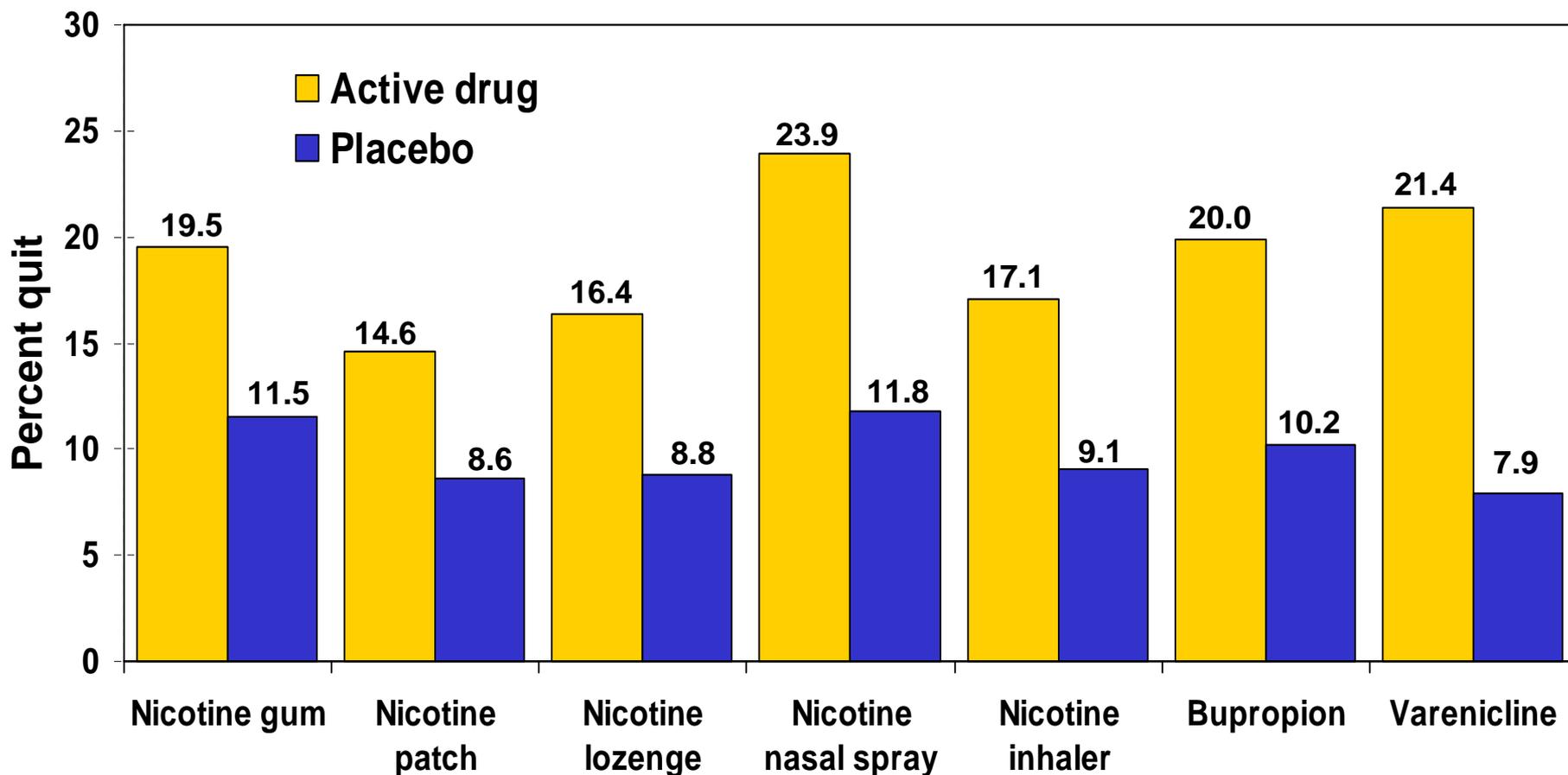
Chantix (Pfizer)

- Nonnicotine cessation aid
- Partial nicotinic receptor agonist
- Oral formulation





LONG-TERM (≥ 6 month) QUIT RATES for AVAILABLE CESSATION MEDICATIONS



Data adapted from Silagy et al. (2004). *Cochrane Database Syst Rev*; Hughes et al., (2004). *Cochrane Database Syst Rev.*; Cahill et al. (2007). *Cochrane Database Syst Rev*



COMBINATION PHARMACOTHERAPY

- **Combinations proven to be effective**
 - Long-term nicotine patch (>14 weeks) + other NRT (gum and spray)
 - Nicotine patch + nicotine inhaler
 - Nicotine patch + bupropion SR
- **Other combinations** might be effective, but have not been sufficiently tested.
 - The safety and efficacy of combination of varenicline with NRT or bupropion has not been established.
- Only the patch + bupropion SR has been approved by the FDA
 - All other combinations are off-label use

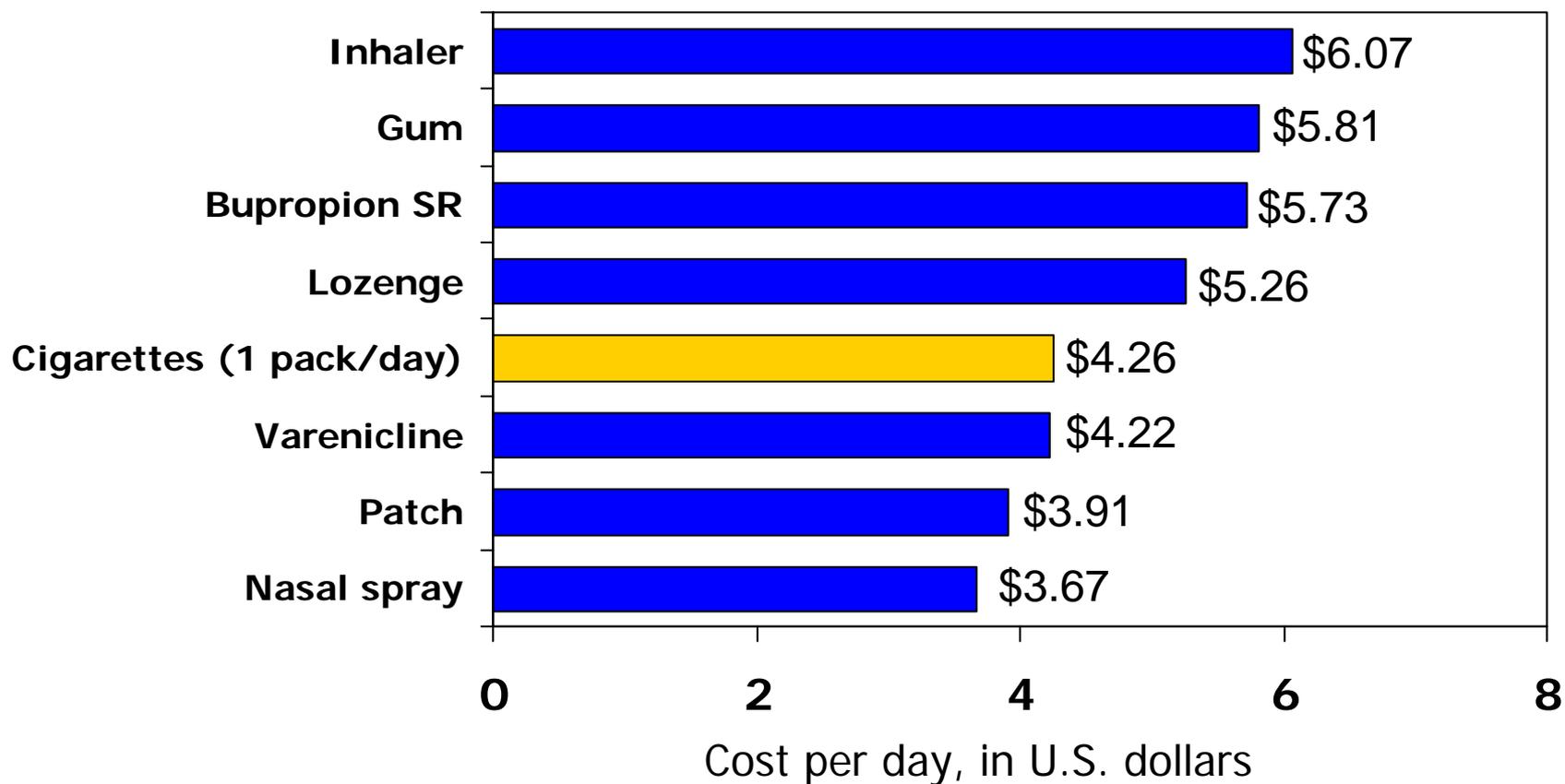


PROMOTING CORRECT MEDICATION USE

- Most patients under dose the products.
- You can have an important impact on patients' success in quitting if you:
 - Instruct patients to read **all** directions.
 - Advise patients to use the products according to the recommended dosing schedule.
 - Use on a steady, consistent basis throughout the day
 - Do **not** use "as needed."



COMPARATIVE DAILY COSTS of PHARMACOTHERAPY





Medications are effective, but they are just one component of comprehensive treatment for tobacco cessation.

Behavior change is equally important.

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TOBACCO DEPENDENCE: A 2-PART PROBLEM

Tobacco Dependence

Physiological

The addiction to nicotine



Treatment

Medications for cessation



Behavioral

The habit of using tobacco



Treatment

Behavior change program

Treatment should address the physiological **and** the behavioral aspects of dependence.



TOBACCO CESSATION REQUIRES BEHAVIOR CHANGE

- Fewer than 5% of people who quit without assistance are successful in quitting for more than a year.
- Few patients adequately PREPARE and PLAN for their quit attempt.
- Many patients do not understand the need to change behavior.
- Often, patients think they can just “make themselves quit.”

Behavioral counseling is a key component of treatment for tobacco use and dependence.



HOW CAN PHARMACISTS HELP PATIENTS CHANGE THEIR BEHAVIOR?

ASK: about tobacco use

ADVISE: tobacco users to quit

ASSESS: readiness to quit

REFER: tobacco users to the tobacco quitline



STEP 1: ASK

- **ASK** about tobacco use
 - “Do you ever smoke or use any type of tobacco?”
 - “I take time to ask all of my patients about tobacco use—because it’s important.”
 - “Medication X often is used for conditions linked with or caused by smoking. Do you, or does someone in your household smoke?”
 - “Condition X often is caused or worsened by smoking. Do you, or does someone in your household smoke?”



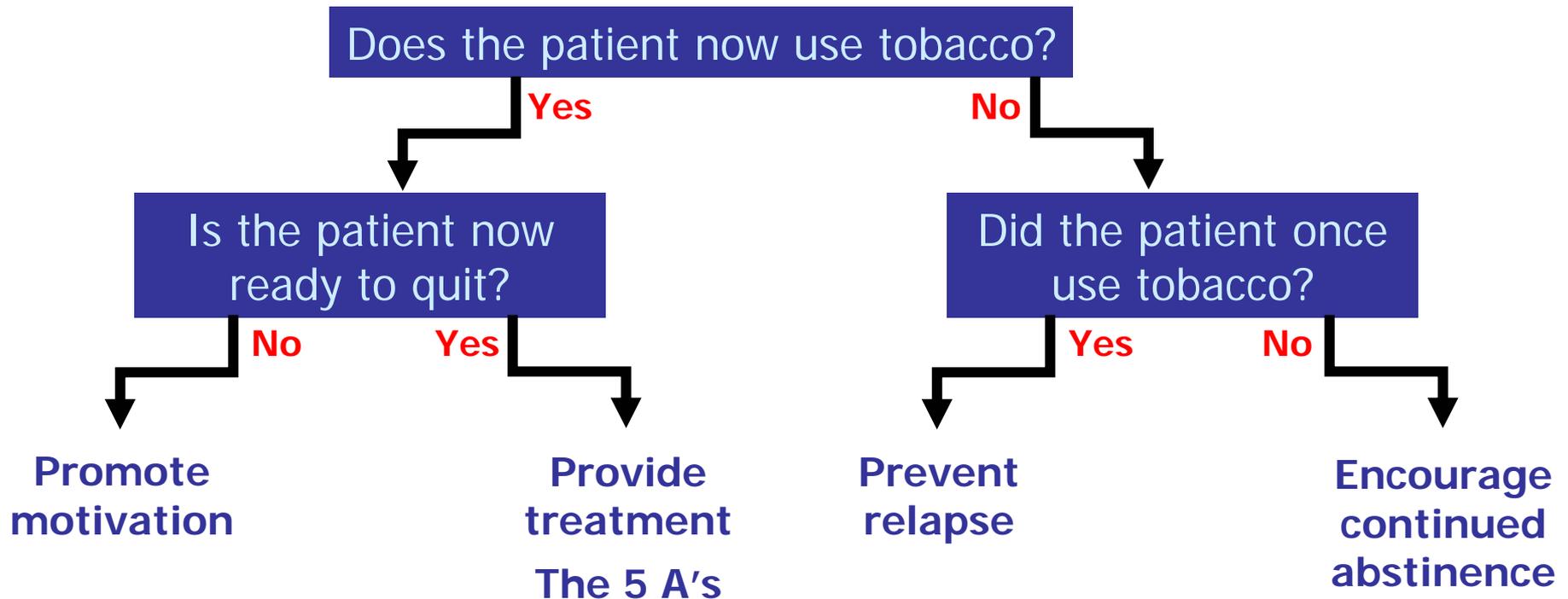
STEP 2: ADVISE

- **ADVISE** tobacco users to quit (clear, strong, personalized, sensitive)
 - “It’s important that you quit, and I can help you.”
 - “I realize that quitting is difficult. It is the most important thing you can do to protect your health now and in the future.”
 - “Patients who get help are more likely to be able to quit for good.”



STEP 3: ASSESS

- **ASSESS** readiness to make a quit attempt





STEP 4: REFER

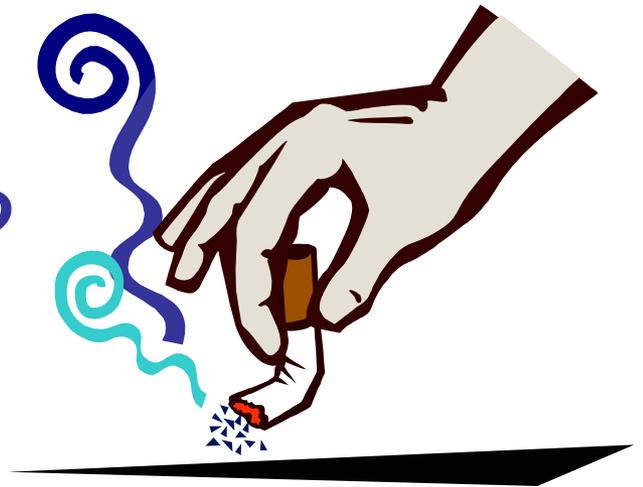
- **REFER** tobacco users to other resources:
 - Local group programs
 - Web-based programs
 - e.g., Quitnet.com
 - The toll-free Michigan Quitline
 - 1-800-480-QUIT
 - 1-800-480-7848
 - Hand patient:
 - Quit Kit, Quitline Card, Quit Tobacco Resources Sheet



The (DIFFICULT) DECISION to QUIT

- Faced with change, most people are not ready to act.
- Change is a process, not a single step.
- Typically, it takes multiple attempts.

HOW CAN I LIVE
WITHOUT TOBACCO?





HELPING SMOKERS QUIT IS a CLINICIAN'S RESPONSIBILITY

**TOBACCO USERS DON'T PLAN TO FAIL.
MOST FAIL TO PLAN.**

Clinicians have a professional obligation to address tobacco use and can have an important role in helping patients plan for their quit attempts.

**THE DECISION TO QUIT LIES IN THE
HANDS OF EACH PATIENT.**



ASSESSING READINESS to QUIT

Patients differ in their readiness to quit.

STAGE 1: Not ready to quit in the next month

STAGE 2: Ready to quit in the next month

STAGE 3: Recent quitter, quit within past 6 months

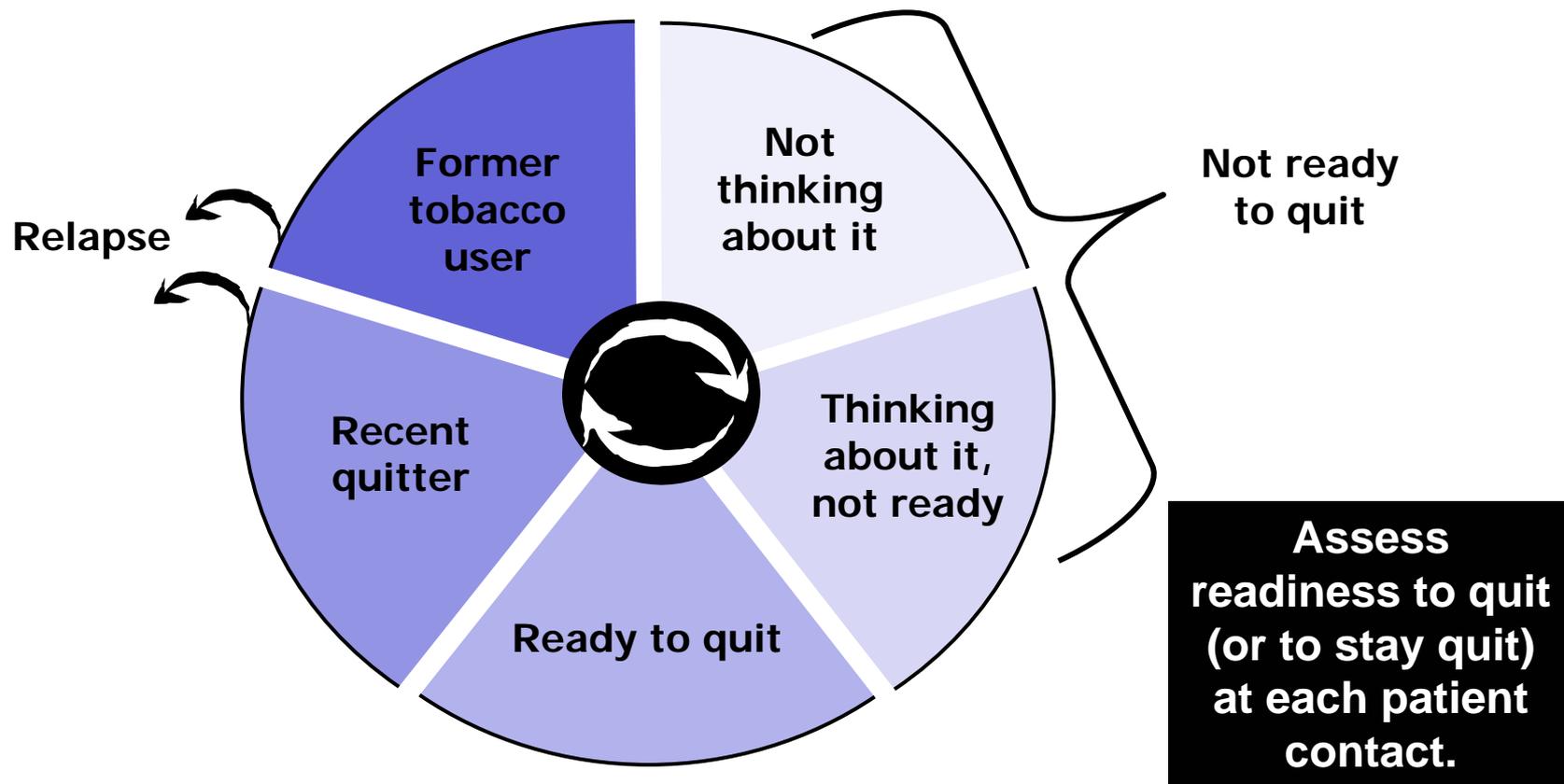
STAGE 4: Former tobacco user, quit > 6 months ago

Assessing a patient's readiness to quit enables clinicians to deliver relevant, appropriate counseling messages.



ASSESSING READINESS to QUIT (cont'd)

For most patients, quitting is a cyclical process, and their readiness to quit (or stay quit) will change over time.





ASSESSING READINESS to QUIT (cont'd)

STAGE 1: Not ready to quit

Not thinking about quitting in the next month

- Some patients are aware of the need to quit.
- Patients struggle with ambivalence about change.
- Patients are not ready to change, yet.
- Pros of continued tobacco use outweigh the cons.

GOAL: Start thinking about quitting.



STAGE 1: NOT READY to QUIT Counseling Strategies

DOs

- Strongly advise to quit
- Provide information
- Ask noninvasive questions; identify reasons for tobacco use
 - "Envelope"
- Raise awareness of health consequences/concerns
- Demonstrate empathy, foster communication
- Leave decision up to patient

DON'Ts

- Persuade
- "Cheerlead"
- Tell patient how bad tobacco is, in a judgmental manner
- Provide a treatment plan



STAGE 1: NOT READY to QUIT Counseling Strategies (cont'd)

The 5 R's—Methods for increasing motivation:

- Relevance
- Risks
- Rewards
- Roadblocks
- Repetition

**Tailored,
motivational
messages**



STAGE 1: NOT READY to QUIT PHARMACIST COUNSELING

CASE SCENARIO: **MS. STEWART**

You are a clinician providing care to Ms. Stewart, a 55-year-old patient with emphysema.

She uses two different inhalers to treat her emphysema.



STAGE 1: NOT READY to QUIT

Case Scenario Synopsis

- Ask about tobacco use
 - Link inquiry to knowledge of disease
- Assess readiness to quit
 - Aware of need to quit; not ready yet
- Advise to quit
 - Discuss implications for disease progression
- “I will help you, when you are ready”



STAGE 1: NOT READY to QUIT

Case Scenario Synopsis (cont'd)

The clinician has

- ✓ Established a relationship
- ✓ Established herself as a resource
- ✓ Planted a seed to move patient forward
- ✓ Opened a door to facilitate further counseling



ASSESSING READINESS to QUIT (cont'd)

STAGE 2: Ready to quit in the next month

ASK

about tobacco USE

ADVISE

tobacco users to QUIT

ASSESS

readiness to make a QUIT attempt

For patients interested in quitting

REFER to QUITLINE*

GOAL: Remain tobacco-free for life.

*Quitline operation to be discussed in detail later, by Karen Brown.



BRIEF INTERVENTIONS: REFERRAL to a QUITLINE

- Referring patients to a toll-free quitline is simple and easily integrated into routine patient care.
 - Quitline callers receive one-on-one coaching from trained counselors
 - Follow-up counseling is provided
 - Quitlines are effective and are provided at no cost to the caller

1-800-480-QUIT



STAGE 1: NOT READY TO QUIT REFERRAL to TOBACCO QUITLINE



A patient approaches the pharmacy counter with a new prescription.



STAGE 1: NOT READY to QUIT

Case Scenario Synopsis

What happened in this scenario?



STAGE 2: READY to QUIT

Assess Tobacco Use History

STAGE 2: Ready to quit in the next month

- Praise the patient's readiness
- Assess tobacco use history
 - Current use: type(s) of tobacco, brand, amount
 - Past use: duration, recent changes
 - Past quit attempts:
 - Number, date, length
 - Methods used, compliance, duration
 - Reasons for relapse



STAGE 2: READY to QUIT

Discuss Key Issues

- Reasons/motivation to quit (or avoid relapse)
- Confidence in ability to quit (or avoid relapse)
- Triggers for tobacco use
 - What situations lead to temptations to use tobacco?
 - What led to relapse in the past?
- Routines/situations associated with tobacco use
 - When drinking coffee
 - While driving in the car
 - When bored or stressed
 - While watching television
 - While at a bar with friends
 - After meals
 - During breaks at work
 - While on the telephone
 - While with specific friends or family members who use tobacco



STAGE 2: READY to QUIT

Discuss Key Issues (cont'd)

Stress-Related Tobacco Use

THE MYTHS

- "Smoking gets rid of all my stress."
- "I can't relax without a cigarette."

THE FACTS

- There will always be stress in one's life.
- There are many ways to relax without a cigarette.

Smokers confuse the relief of withdrawal with the feeling of relaxation.

STRESS MANAGEMENT SUGGESTIONS:

Deep breathing, shifting focus, taking a break.



STAGE 2: READY to QUIT

Discuss Key Issues (cont'd)

Concerns about Withdrawal Symptoms

- Most pass within 2–4 weeks after quitting
- Cravings can last longer, up to several months or years
 - Often can be ameliorated with cognitive or behavioral coping strategies
- Refer to Withdrawal Symptoms Information Sheet
 - Symptom, cause, duration, relief

Most symptoms manifest 24–48 hours after quitting and subside within 2–4 weeks.



STAGE 2: READY to QUIT

Facilitate Quitting Process

Cognitive Coping Strategies: Examples

- Thinking about cigarettes doesn't mean you have to smoke one:
 - "Just because you think about something doesn't mean you have to do it!"
 - Tell yourself, "It's just a thought," or "I am in control."
 - Say the word "STOP!" out loud, or visualize a stop sign.
- When you have a craving, remind yourself:
 - "The urge for tobacco will only go away if I don't use it."
- As soon as you get up in the morning, look in the mirror and say to yourself:
 - "I am proud that I made it through another day without tobacco."



STAGE 2: READY to QUIT

Facilitate Quitting Process (cont'd)

Behavioral Coping Strategies

- Control your environment
 - Tobacco-free home and workplace
 - Remove cues to tobacco use; actively avoid trigger situations
 - Modify behaviors that you associate with tobacco: when, what, where, how, with whom
- Substitutes for smoking
 - Water, sugar-free chewing gum or hard candies (oral substitutes)
- Take a walk, diaphragmatic breathing, self-massage
- Actively work to reduce stress, obtain social support, and alleviate withdrawal symptoms



ASSESSING READINESS to QUIT (cont'd)

STAGE 3: Recent quitter

Actively trying to quit for good

- Patients have quit using tobacco sometime in the past 6 months and are taking steps to increase their success.
- Withdrawal symptoms occur.
- Patients are at risk for relapse.

GOAL: Remain tobacco-free for at least 6 months.

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STAGE 3: RECENT QUITTERS

Evaluate the Quit Attempt

- Status of attempt
 - Ask about social support
 - Identify ongoing temptations and triggers for relapse (negative affect, smokers, eating, alcohol, cravings, stress)
 - Encourage healthy behaviors to replace tobacco use
- Slips and relapse
 - Has the patient used tobacco at all—even a puff?
- Medication compliance, plans for termination
 - Is the regimen being followed?
 - Are withdrawal symptoms being alleviated?
 - How and when should pharmacotherapy be terminated?



STAGE 3: RECENT QUITTERS

Facilitate Quitting Process

Relapse Prevention

- Congratulate success!
- Encourage continued abstinence
 - Discuss benefits of quitting, problems encountered, successes achieved, and potential barriers to continued abstinence
 - Ask about strong or prolonged withdrawal symptoms (change dose, combine or extend use of medications)
 - Promote smoke-free environments
- Social support
 - Discuss ongoing sources of support; continued use of quitline



ASSESSING READINESS to QUIT (cont'd)

STAGE 4: Former tobacco user

Tobacco-free for 6 months

- Patients remain vulnerable to relapse.
- Ongoing relapse prevention is needed.



GOAL: Remain tobacco-free for life.



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“I knew you hadn’t quit smoking!”

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STAGE 4: FORMER TOBACCO USERS

- Assess status of quit attempt
- Slips and relapse
- Medication compliance, plans for termination
 - Has pharmacotherapy been terminated?
- Continue to offer tips for relapse prevention
- Encourage healthy behaviors, continued use of quitline
- Congratulate continued success

Continue to assist throughout the quit attempt.



FINAL THOUGHTS

- Many pharmacists have hesitated to provide cessation advice due to the mistaken belief that they would have to conduct the complete quitting program.
- Rather, pharmacists can play a vital role by initiating the quitting process and then referring the patient to other resources.



ENCOURAGE PHARMACISTS to MAKE A COMMITMENT...

At a minimum,

make a commitment to incorporate brief tobacco interventions as part of routine patient care.

Ask, Advise, Assess, and Refer.

It takes less than a minute to save a life.



DR. GRO HARLEM BRUNTLAND, FORMER DIRECTOR-GENERAL of the WHO:

“If we do not act decisively, a hundred years from now our grandchildren and their children will look back and seriously question how people claiming to be committed to public health and social justice allowed the tobacco epidemic to unfold unchecked.”