Behavioral Health & Wellness Program

Co-Treatment of Tobacco and Cannabis Use Disorders

Chad Morris, PhD
Jim Pavlik, MA, TTS
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School of Medicine
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ANSCHUTZ MEDICAL CAMPUS

Presenters

Dr. Chad Morris, PhD,
Director Behavioral Health & Wellness Program
Department of Psychiatry, University of Colorado

Jim Pavlik MA, CTTS
Sr. Program & Policy Analyst, BHWP
Department of Psychiatry, University of Colorado

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Conflicts of Interest Disclosure

There are no conflicts of interest, financial or otherwise, to disclose concerning the contents of the following presentation

Objectives

Demonstrate	Why tobacco and cannabis treatment is a key to population health and individual recovery goals
Describe	The compelling factors for co-treatment of nicotine and cannabis use
Discuss	Practical applications of screening, brief intervention, and referral to treatment for nicotine and cannabis use
Delineate	Opportunities to optimize policies for nicotine and cannabis-free treatment environments

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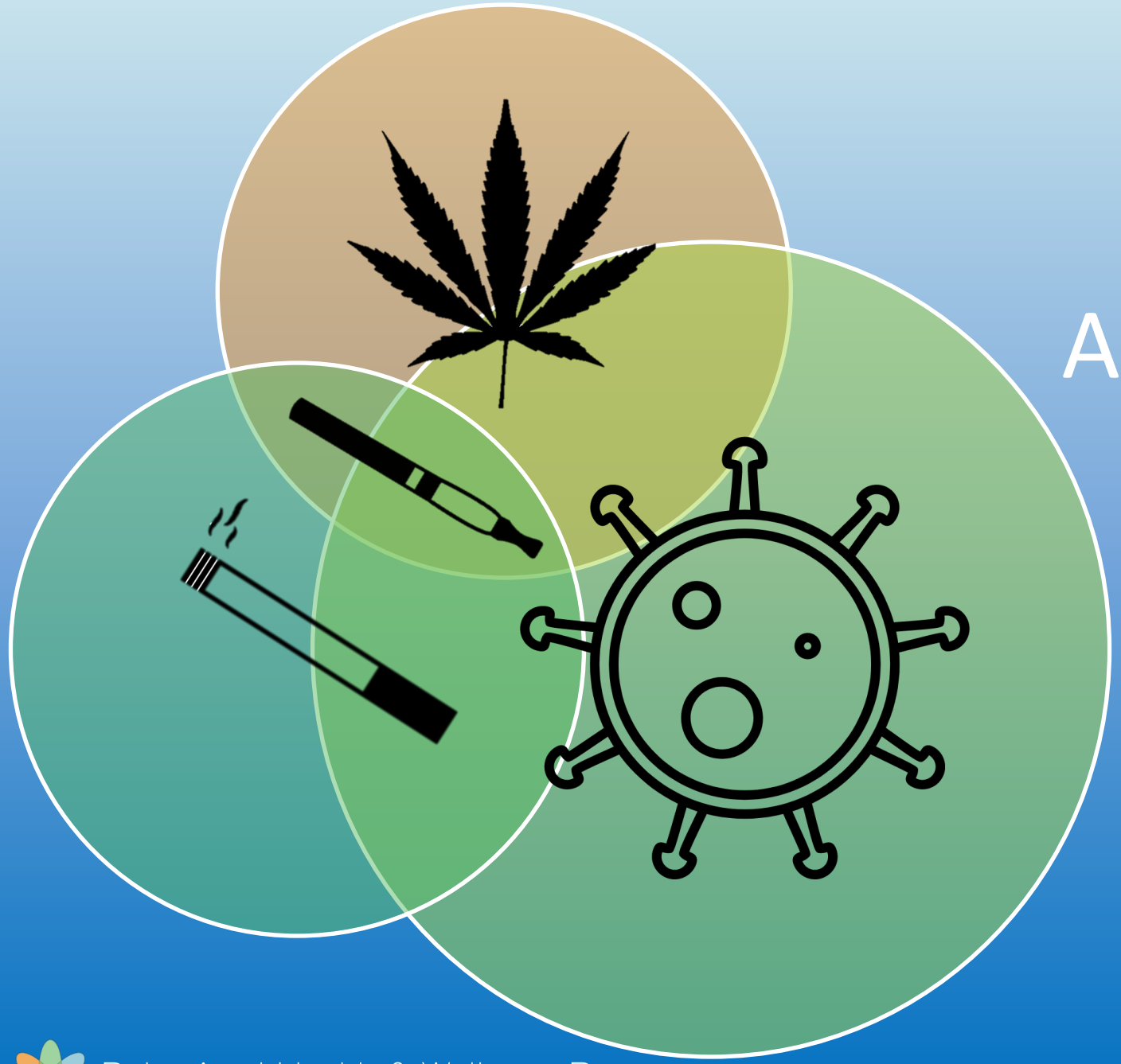

An epidemic…

In an epidemic…

In a pandemic

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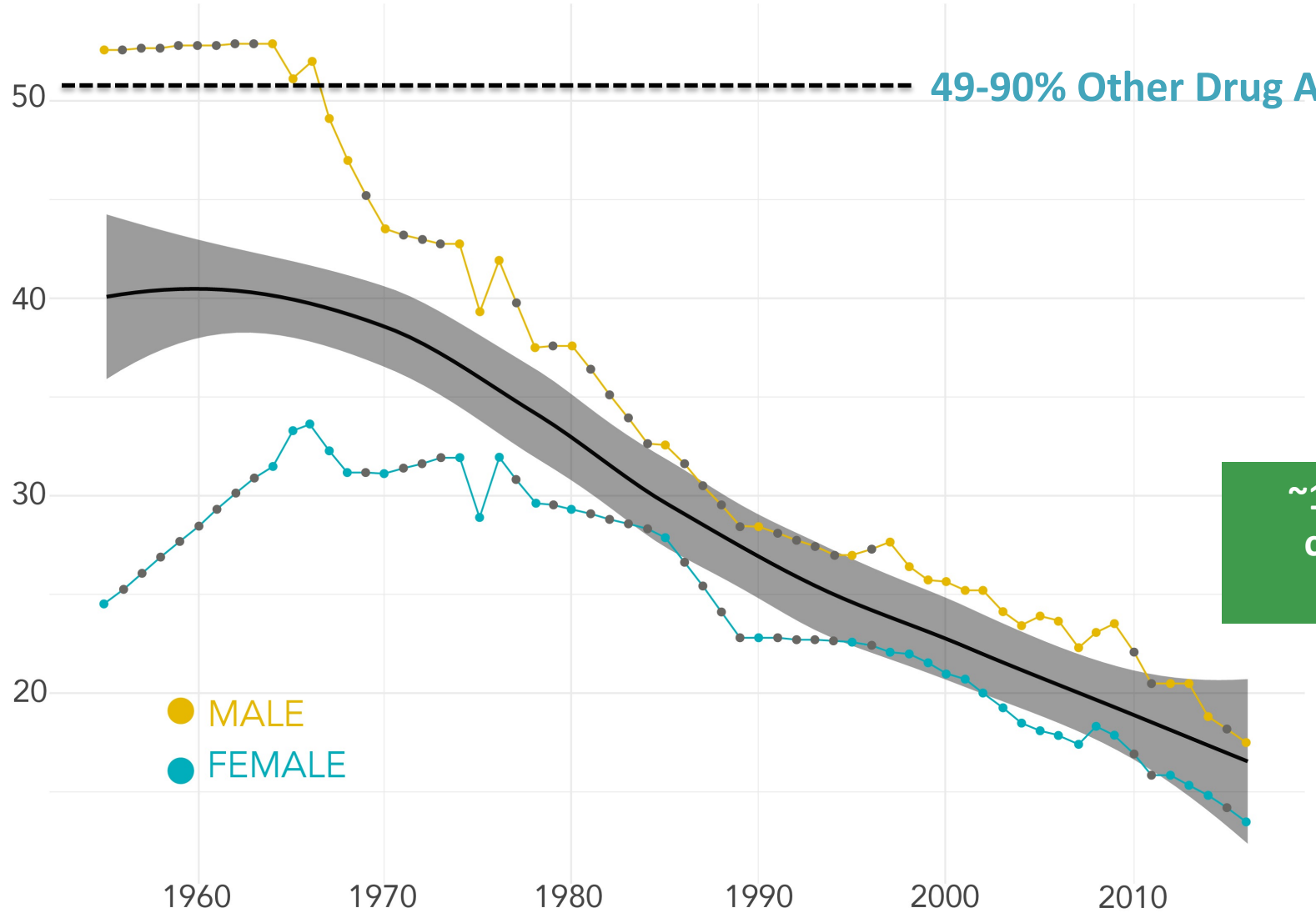
Trends in U.S. Adult Smoking



~14% of adults are current cigarette smokers

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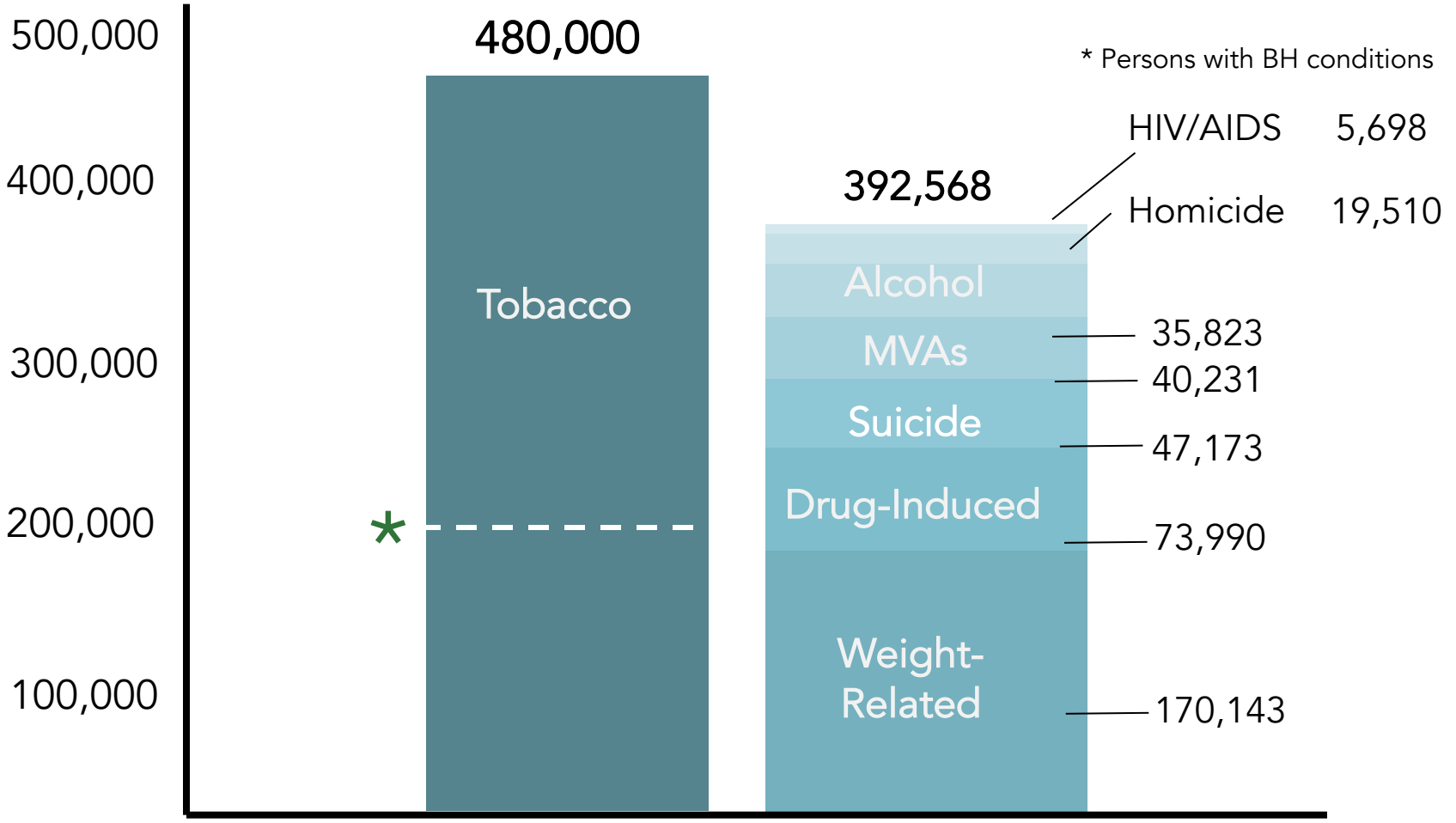
Behavioral Causes of Death in US, 2017



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Smoking in Addiction Treatment Programs

A review of smoking prevalence in U.S. addiction treatment programs, from 1987 to 2009, found a median annual smoking prevalence of 76%.

(Guydish et al., 2011, 2017)

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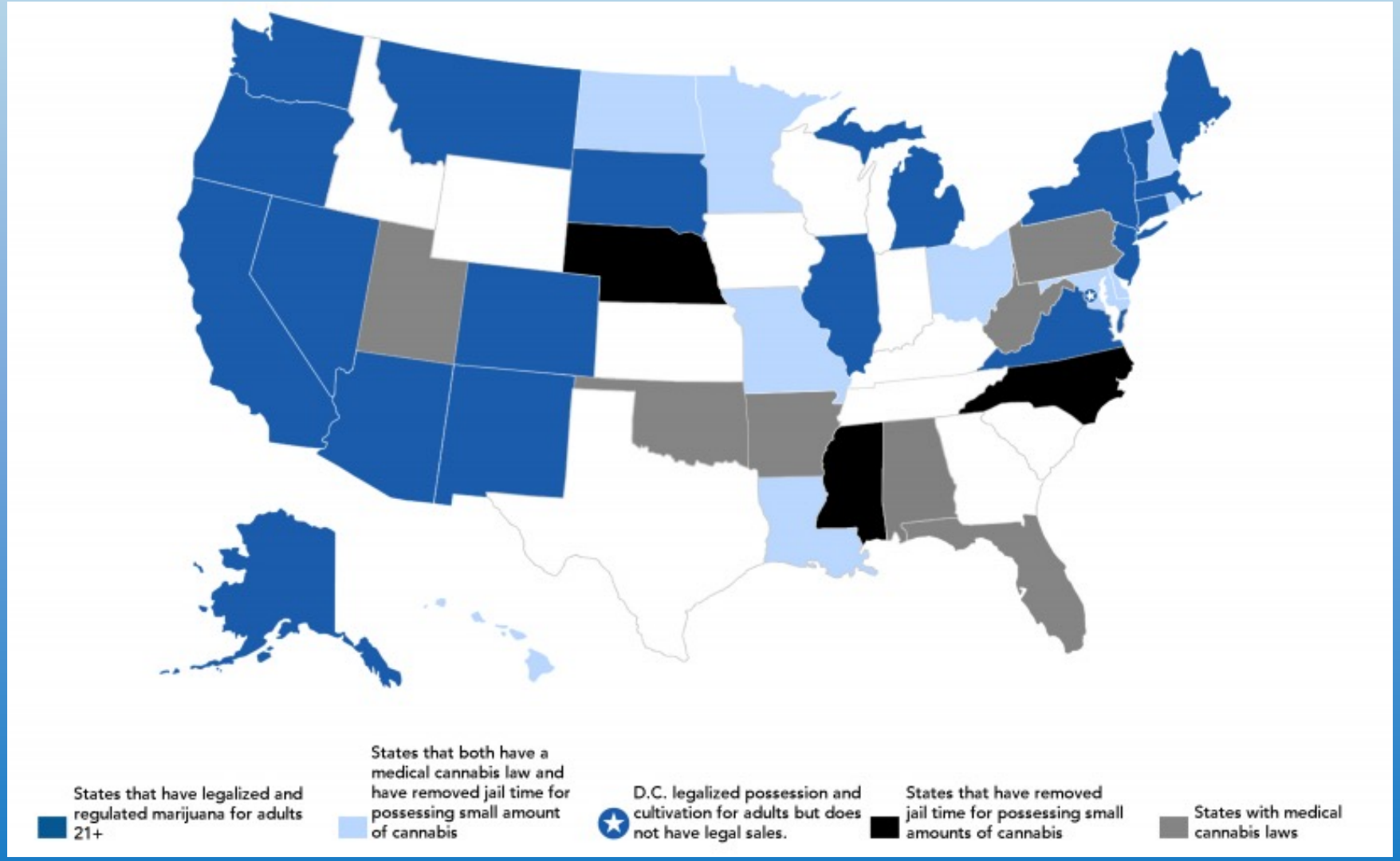
State Marijuana Laws in 2021



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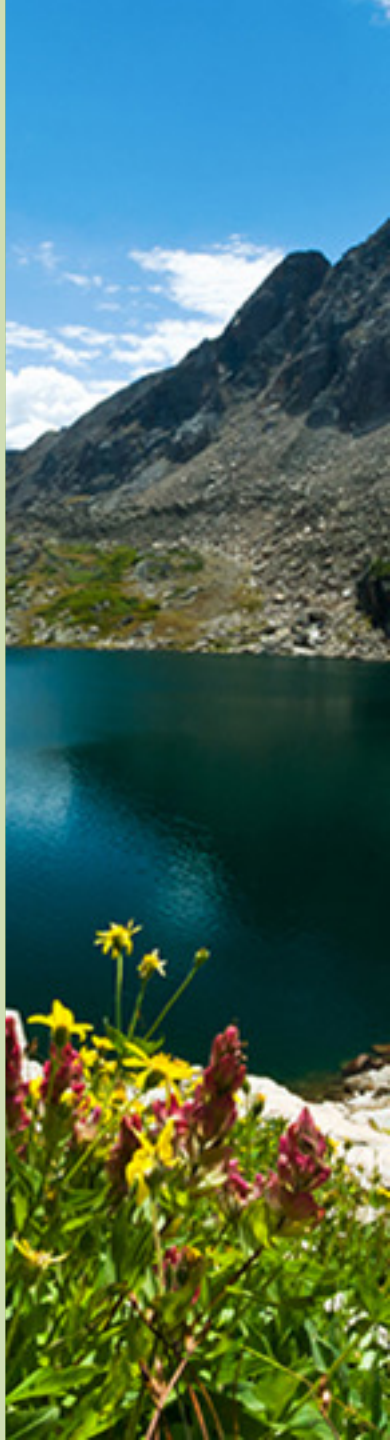
Prevalence of Cannabis Use

- 3.9% of ages 15-64 globally
  - For North America- 14.6% use past year
    - 4.7% daily users or near daily users
    - 1 in 5 risk developing Cannabis Use Disorder
    - Big jump in those 18-25 years to 30-35%
- During pandemic- possibly a 35% increase
  - 91% say they are using medicinally
- Among young adult e-cigarette users, 80% are also current cigarette smokers and 53% are current marijuana users



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Co-Use of Cannabis and Nicotine

- 18%-39% of adults who used tobacco in the past month in the U.S. also used marijuana
- 69% to 78% of marijuana users used tobacco in the past month
- There is a 3.6-fold increase in nicotine dependence among daily marijuana users

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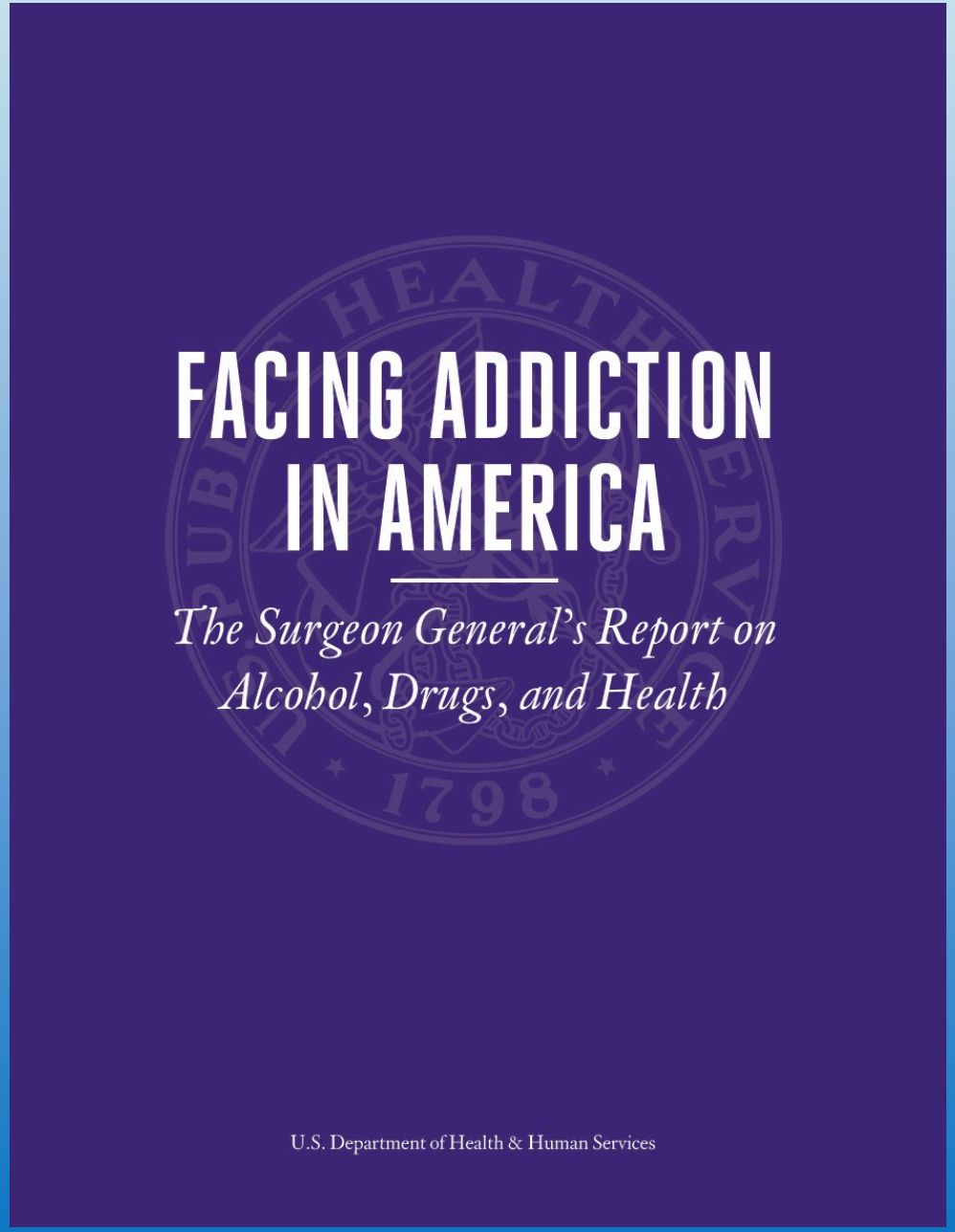
Co-treatment is the only adequate solution



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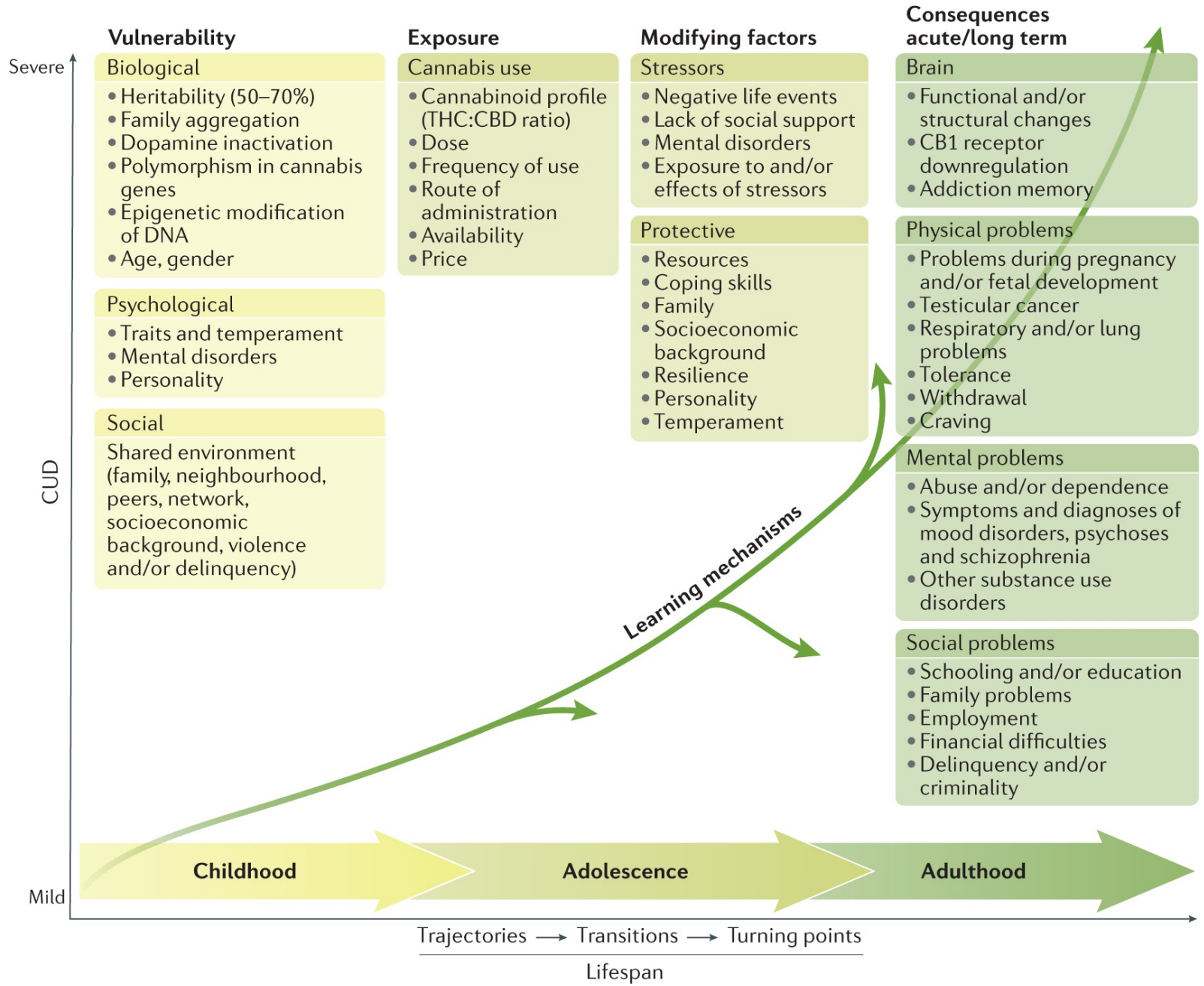

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https://rdcu.be/ckRl6

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Key Factors Driving Substance Use Disorder

- Increased COVID-related stress
  - Virus-related fears
  - Job uncertainty
- Boredom
- Isolation
- Lack of meaning
- Irregular or altered daily routines
- Financial pressures

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Consequences of Co-Use

- Tobacco increases the addiction potential of marijuana an vice versa
- Co-use of tobacco and marijuana makes it difficult to quit either
- There are high rates of substitution when trying to quit one or the other
- Stress, anxiety, and depression increase over time

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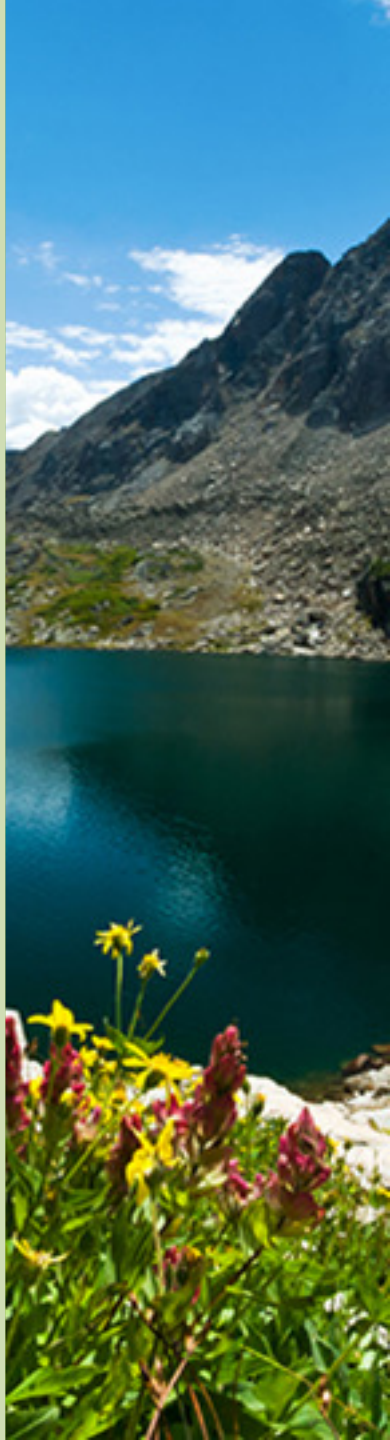
Marijuana Smoke

- Marijuana smoke contains several of the same carcinogens as the tar from tobacco
- Secondhand marijuana smoke contains 50 harmful chemicals (70% more than tobacco smoke)
- Marijuana smoke contains significant amounts of mercury, lead, ammonia, and hydrogen cyanide, among others
- Respiratory symptoms caused by marijuana smoke include:
  - Chronic bronchitis
  - Frequent phlegm
  - Shortness of breath
  - Frequent wheezing
  - Chest sounds without a cold



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Tobacco and Cannabis Withdrawal Effects

- Irritability, aggression, anger
- Anxiety
- Difficulty concentrating*
- Restlessness, impatience
- Depressed mood
- Sleep difficulty
- Increased* or decreased appetite
- At least one of the following physical symptoms that causes discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache

Most symptoms:

- Appear within first 1–2 days
- Peak within the first week
- Decrease within 2–4 weeks

*Applies only to tobacco withdrawal

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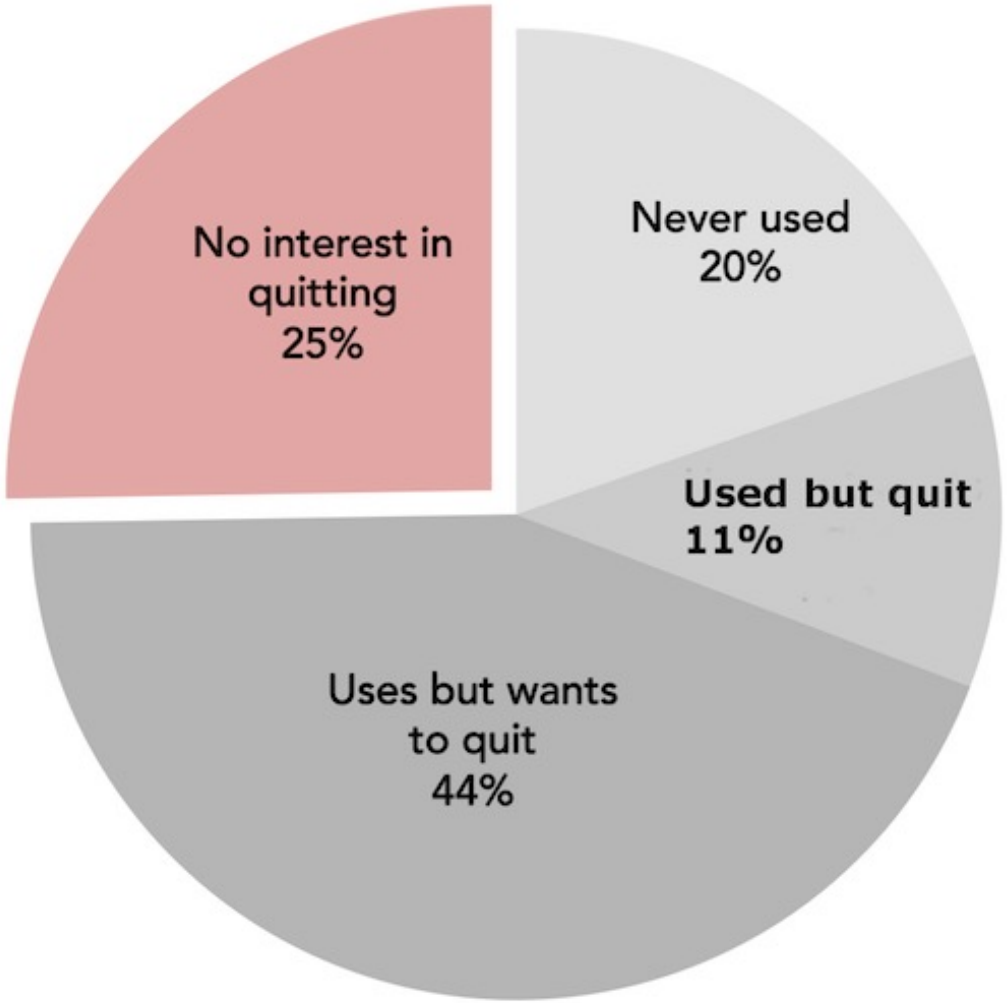
Is This a Social Justice Issue?
Recent Community of Practice Findings



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Tobacco Use Affects Treatment & Recovery from Addiction

Addressing tobacco dependence during treatment for other substances is associated with a 25% increase in long-term abstinence rates from alcohol and other substances

(Prochaska et al., 2004)

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US Preventative Service Task Force Recommendations

Category	Adolescent	Adult
Unhealthy Drug Use: Screening	I	B
Illicit Drug Use	I	I
Tobacco Use: Interventions	B (unless use has started, then I)	A
Ecigs as cessation	I	I
Unhealthy Alcohol Use	I	B
Depression Screening	B	B
Suicide Screening	In progress	I

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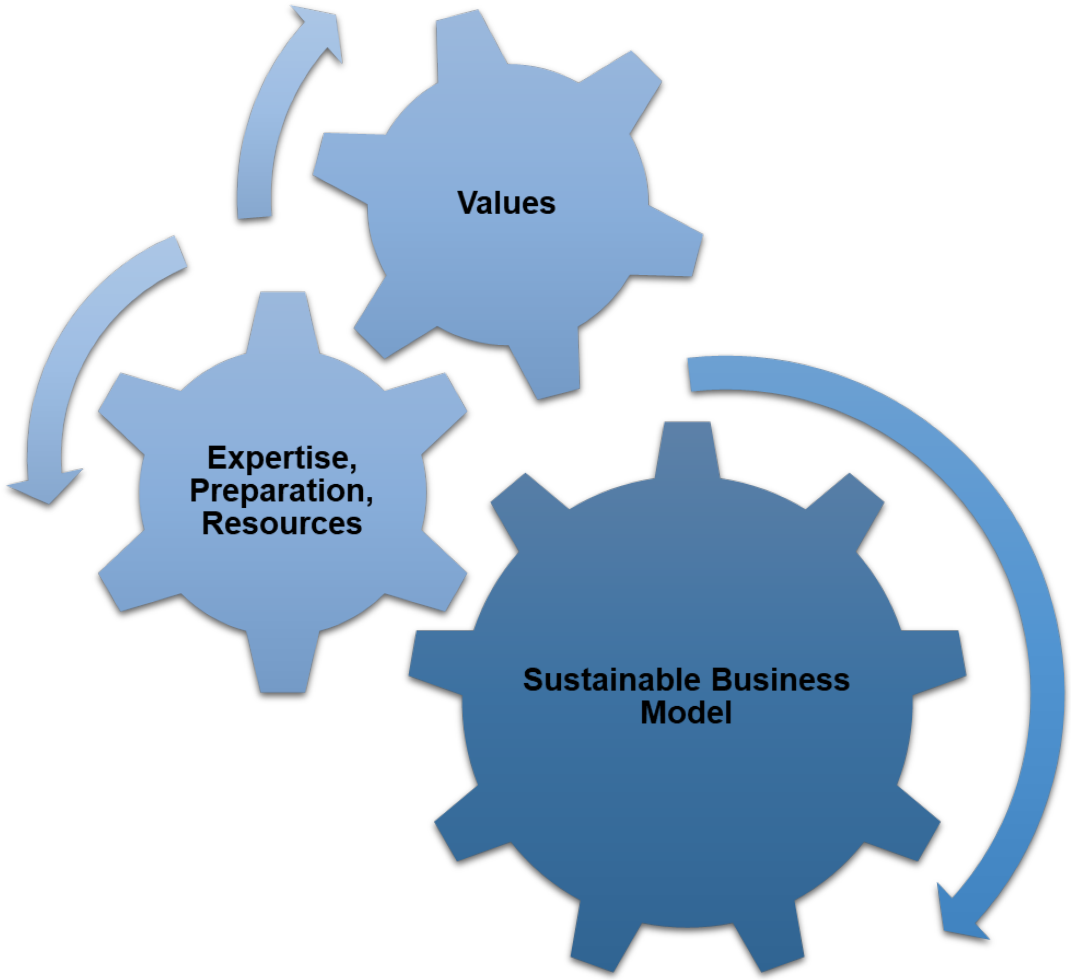
A Standard of Care



The medical standard of care refers to the idea that a provider possessing the same knowledge and skills as any other provider owes patients the best possible treatment and care they can provide.

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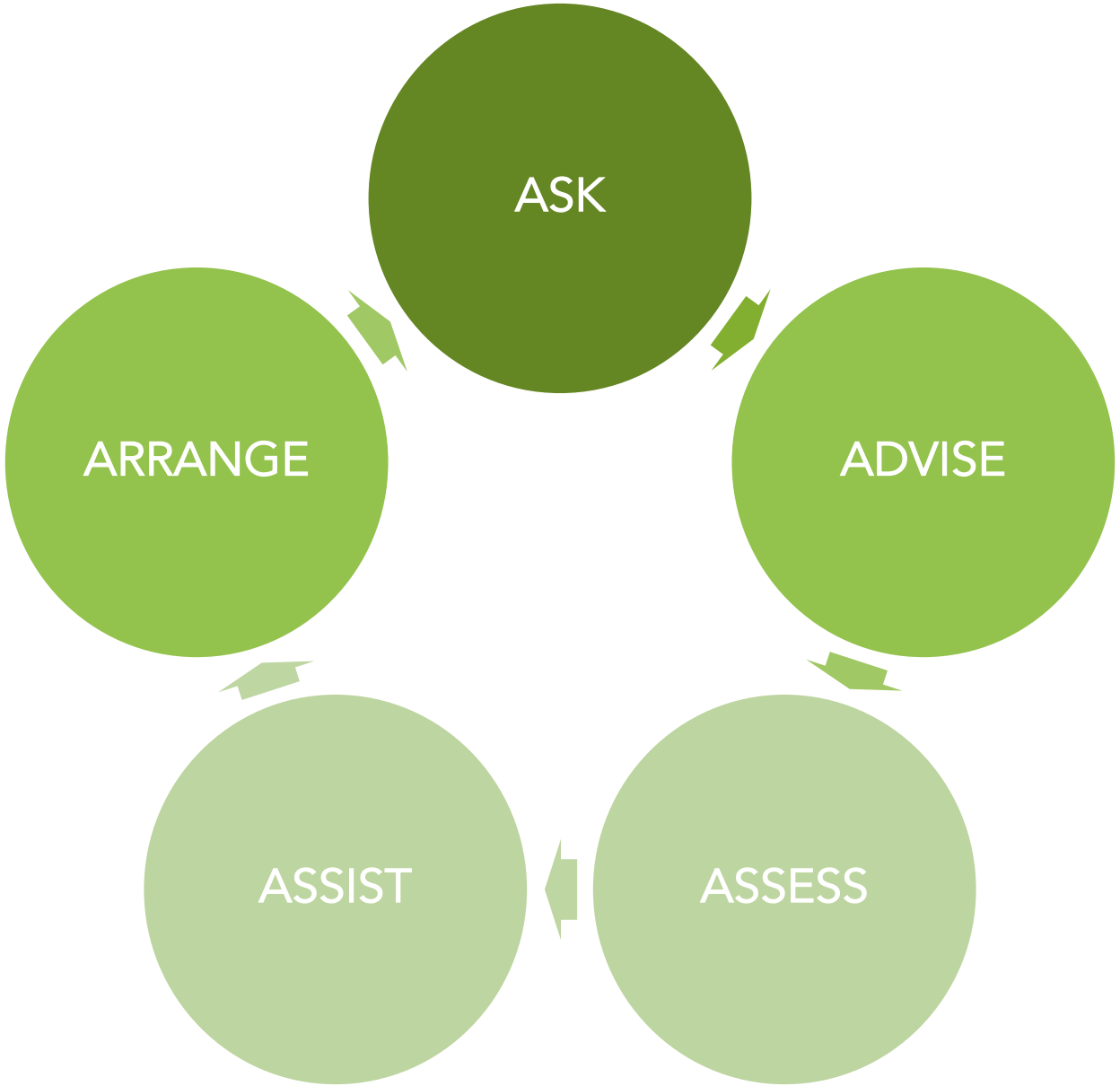

The 5A's

- Evidence-based best practice
- Applicable across chronic disease prevention efforts
  - Nutrition improvement
  - Physical activity
  - Diabetes management
  - High blood pressure management
- Not a silver bullet

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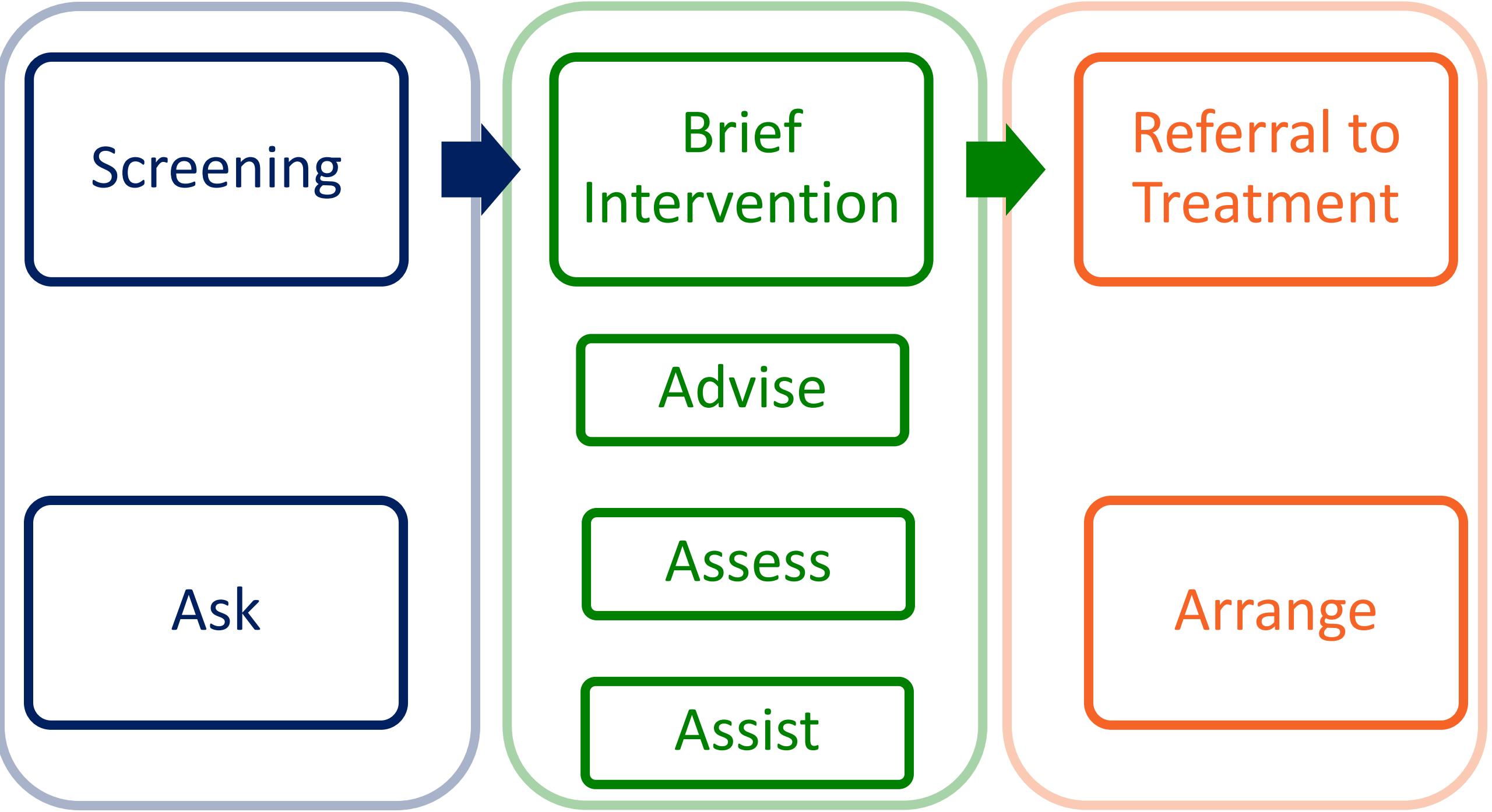
Screening
Ask
Brief Intervention
Advise
Assess
Assist
Referral to Treatment
Arrange

5As Functions

A	Function	Purpose
Ask	Screening	Ensure services are delivered to all who are at risk and not to those who are not
Advise	Motivation	Advise, especially from a physician, has the power to motivate a quit attempt
Assess	Evaluation	Helps determine the intensity of the intervention
Assist	Exploration	Helps tailor cessation supports to meet the user's unique needs
Arrange	Follow-up	Knowledge of future meetings is itself a motivation to succeed. Also provides an opportunity to fine-tune the treatment plan

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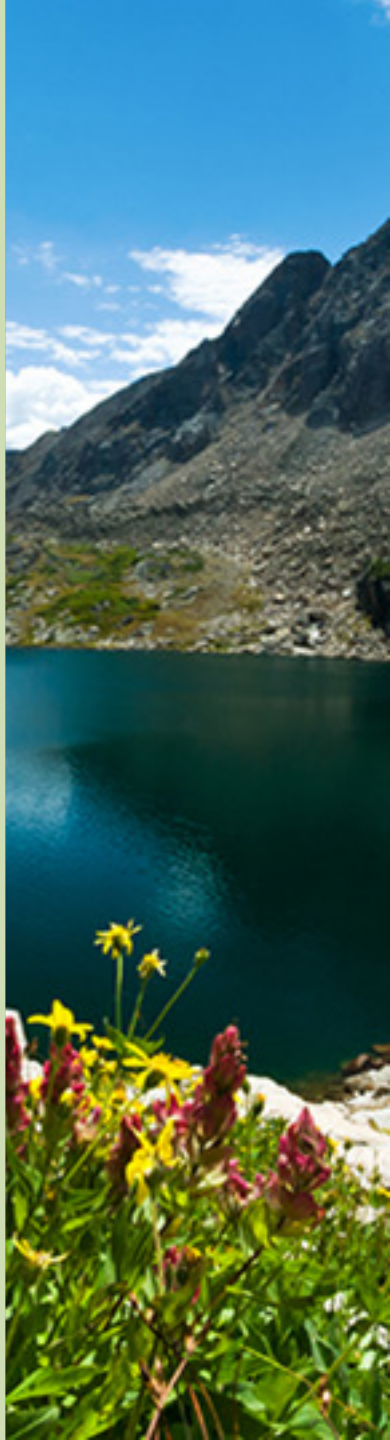
Cross-Cutting Interventions

Motivational Enhancement

Cognitive Behavioral Therapy and Variants

Contingency Management



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Behavioral Strategies

① Self-Monitoring

(Time, activities, triggers, feelings, people, environments)

② Role Play

(Practice new behaviors)

③ Skills Building

(knowledge, new coping skills, boundary setting, physical activity, identifying high risk situations)

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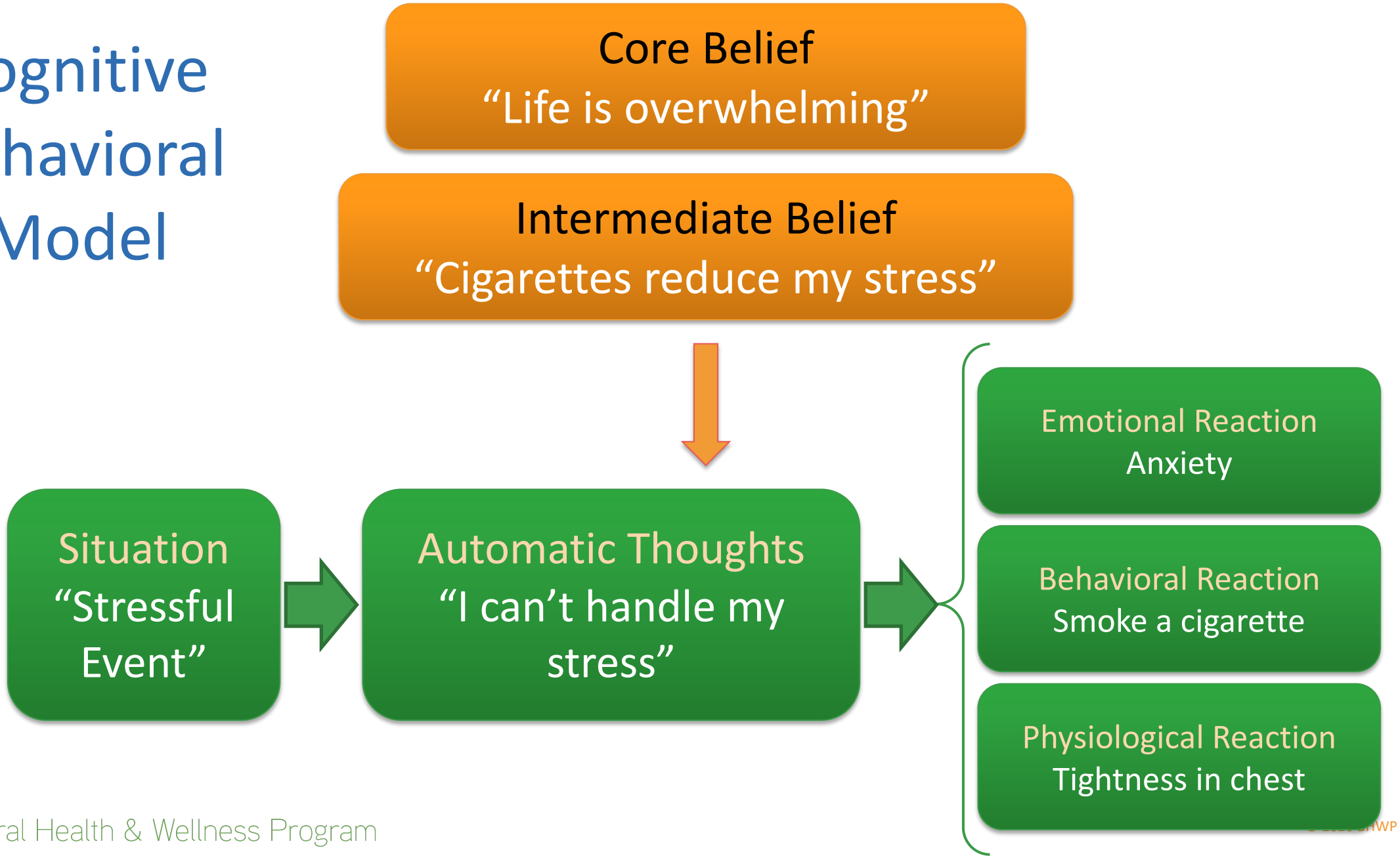
Cognitive Behavioral Model



Adolescent Drug Use is Different

- Typical day is ordered differently than typical adult day
- Different social dynamics
- Higher value on social esteem
- Different relationship with “leisure cash”
- Bodies still developing
- Reduced experience of physical harm

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Motivational Intervention

- Planning
- Evoking
- Focusing
- Engaging

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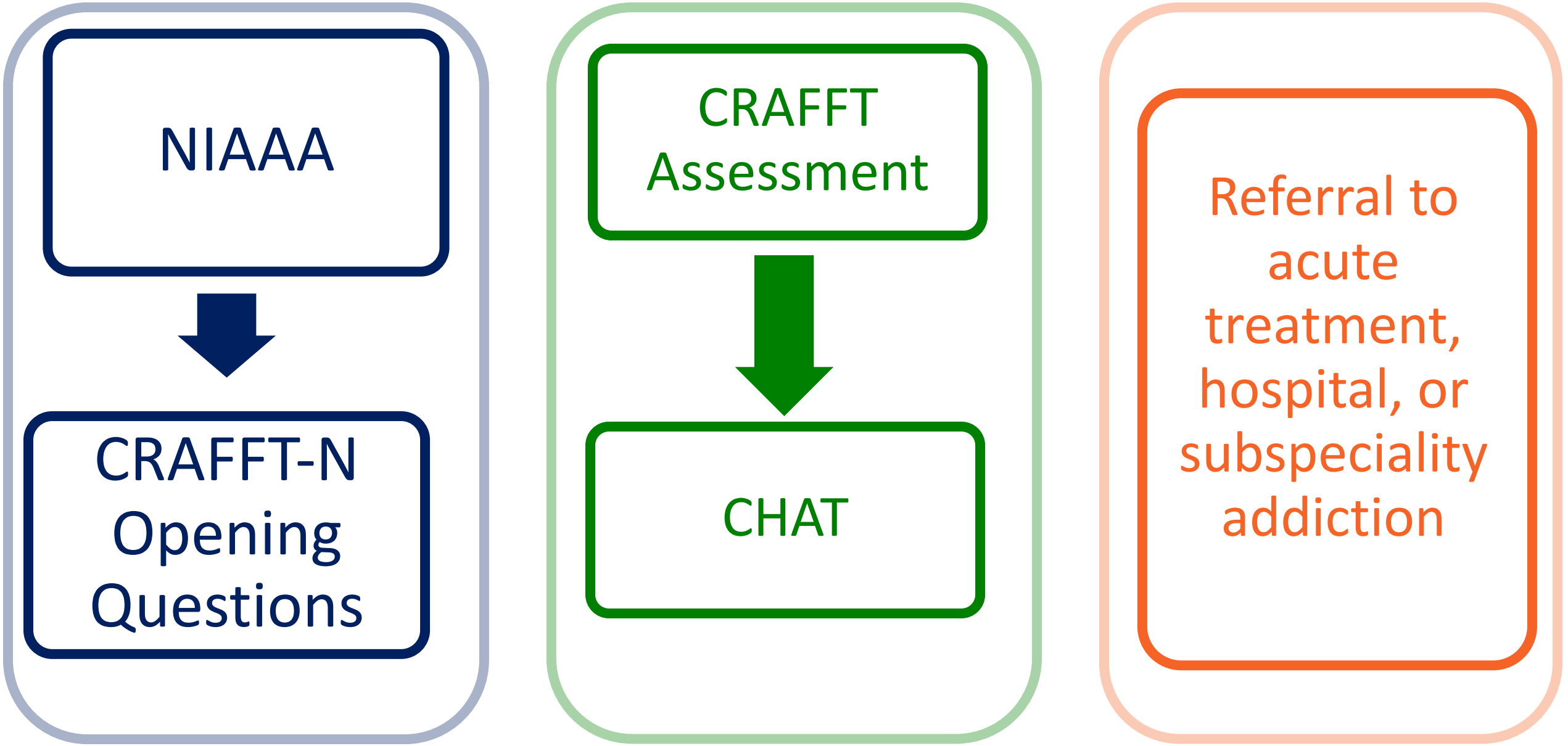
Example Adolescent Workflow



Example Adult Workflow

ASSIST

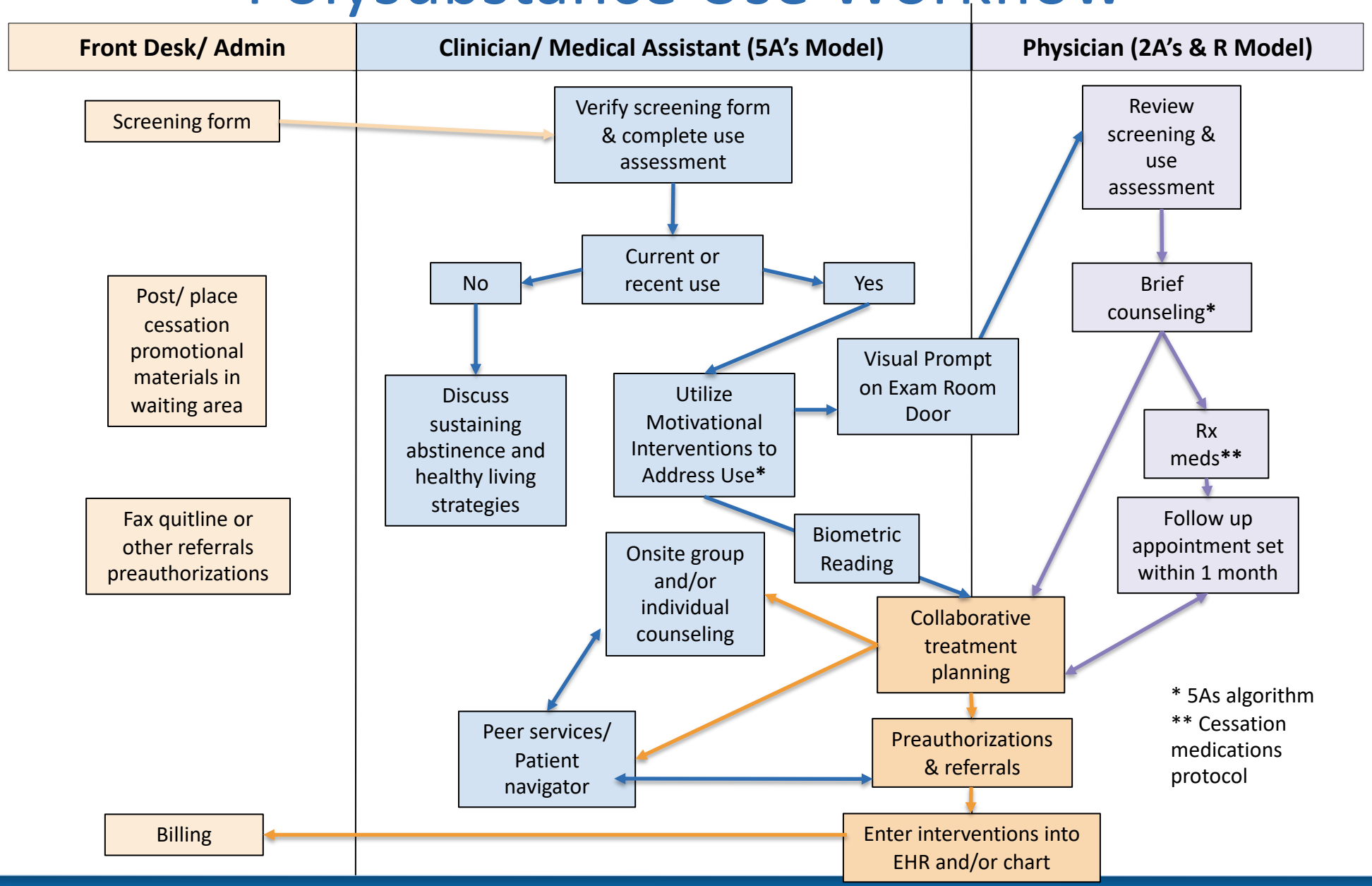
Advise

Motivational Interviewing

Low Risk: Co-develop treatment plan and provide self-help materials

High Risk: Refer to specialty care

Polysubstance Use Workflow



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Practice Considerations

Embedded within global psychosocial assessment

Confidential

Start early (education around 9)

Every well visit (and relevant acute care visits)

Paper or computerized screeners

Follow-up is necessary

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Leverage Technology

https://www.bhthechange.org/wp-content/uploads/2020/05/Telehealth-and-Tobacco-Cessation-resources-v1-0501420.pdf

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Medication Assisted Treatment

- Combination of behavioral interventions and medications
- Highly effective treatment option for alcohol, opioid, or tobacco dependence
- Reduces illicit drug use and overdose deaths

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Tobacco Cessation Medications

The only medications approved by the Food and Drug Administration (FDA) for tobacco cessation are:

- Nicotine patch
- Nicotine gum
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine inhaler
- Bupropion SR tablets
- Varenicline tablets

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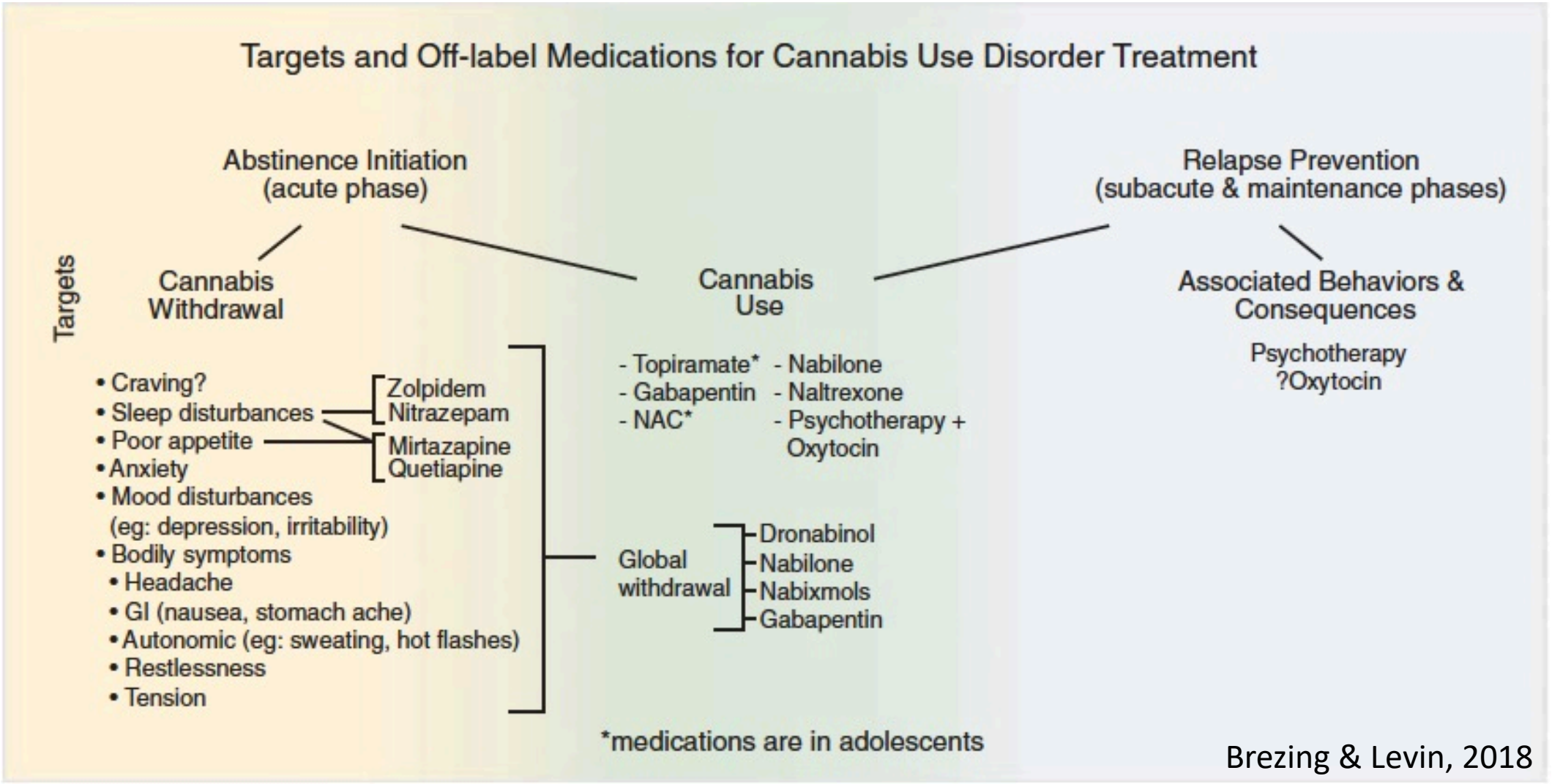
Cannabis Off-Label Use and Targeted Research



Brezing & Levin, 2018

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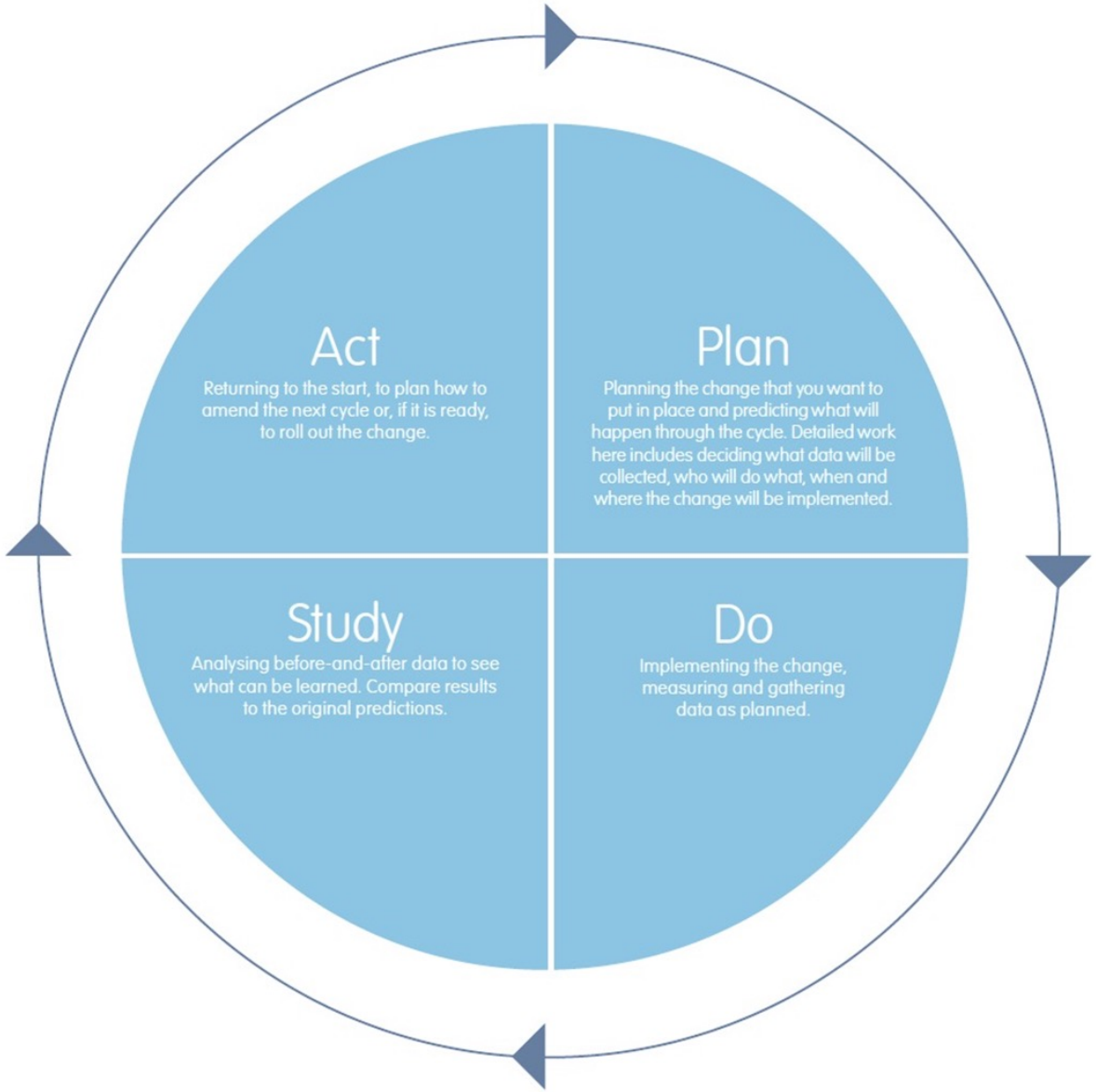
Resources



Workflow Improvement and the Use of PDSA Cycles: An Exploration Using Screening, Brief Intervention, and Referral to Treatment (SBIRT) Integration

Tami Moser, PhD, DBH; Jorie Edwards, PhD; Frannie Pryor, MSW, LCSW, LADC; Lesley Manson, PsyD; Caroline O'Hare

Background and Objectives: The purpose of the study was to use a best practice quality improvement process to identify and eliminate barriers to Screening, Brief Intervention, and Referral to Treatment (SBIRT) integration in a Federally Qualified Health Center. SBIRT provides an initial method for addressing mental health and substance abuse concerns of patients. The method is very useful in integration of behavioral health screening in primary care. **Methods:** A Process Improvement Team used 4 Plan-Do-Study-Act cycles during a 10-week time frame to (1) reduce the reported frequency of barriers to the SBIRT process, (2) reduce non–value-added activities in the SBIRT workflow, (3) reduce bottlenecks, and (4) increase patient receipt of SBIRT. A modified Referral Barriers Questionnaire, a swim lane diagram, non–value-added versus value-added analysis, and a Shewhart control chart (P-chart) were used to evaluate process and outcome measures. **Results:** Nurses reported a 23.82% reduction in referral barrier frequency and a 21.12% increase in the helpfulness of SBIRT. Providers reported a 7.60% reduction in referral barrier frequency and a decrease in the helpfulness of SBIRT. The P-chart indicated that the process changes resulted in a positive shift in behaviors and an increase in patient receipt of SBIRT. **Conclusion:** The use of a best practice quality improvement process resulted in improvements in workflow related to SBIRT, greater communication about SBIRT, and identification of barriers that blocked successful receipt of SBIRT.

Key words: behavioral health integration, integrated primary care, Plan-Do-Study-Act (PDSA) cycle, process improvement, SBIRT, screening, substance use

While primary care often lacks appropriate screening, evaluation, and treatment to meet holistic patient needs, it is often the first, and sometimes only, way for patients to access behavioral health care.[1,2] It is imperative that workflow adapts to integrate mental health to address patient needs while maintaining efficiency.[3] Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a framework that provides structure in primary care for behavioral health assessment, brief intervention(s), brief treatment(s), and/or referrals to higher levels of care and provides a way to integrate evidence-based behavioral health services into the typical scope of practice.[4] Furthermore, using a systematic evidence-based quality improvement (QI) process improves the clinic team's ability to evaluate and eliminate its clinic's unique barriers and therefore increase the patient's receipt of appropriate services.[5] In addition, initiatives that engage the relevant personnel in the change efforts, while also smoothing out workflow that is shared, are imperative to improving the overall workflow.[6]

Barriers to the adoption of SBIRT in primary care settings include reimbursement challenges,[1,7] costs of adding services,[8] timing of the screening/intervention/treatment in a sick visit,[9] shortage of SBIRT training for all practitioners,[10] lack of clarity of roles/responsibilities,[11] communication silos, lack of time, physical space and/or personnel, and failure to adapt the workflow appropriately.[1,4,7,9-18] The type and degree to which a barrier exists are often specific to a clinic setting and culture, patient demographics, and personnel skills and buy-in.[16,19] Therefore, there is not a consistent pattern of barriers related to the type or severity that can be used to create one best workflow model for SBIRT useful to all practice types. The variance of contextual barriers within different settings requires a QI process to determine what barriers exist and how best to improve the system.[5] Implementation research, using value-added (VA) analysis and Plan-Do-Study-Act (PDSA) cycles within specific settings, can be a method for appropriately testing workflow to improve outcomes.

A VA analysis is a tool to study a process, clearly identify activity that improves or enhances the patient experience, identify problems, and identify non–value-added

Author Affiliations: *Department of Pharmaceutical Sciences, College of Pharmacy (Dr Moser and Ms O'Hare), and Department of Psychology, College of Professional and Graduate Studies (Dr Edwards), Southwestern Oklahoma State University, Weatherford; Frannie Pryor Consulting, LLC, Oklahoma City, Oklahoma (Ms Pryor); and Department of Integrated Behavioral Health, Arizona State University, Phoenix (Dr Manson).*

Correspondence: *Tami Moser, PhD, DBH, Department of Pharmaceutical Sciences, College of Pharmacy, Southwestern Oklahoma State University, 100 Campus Dr, WSB 109-D, Weatherford, OK 73096 (tami.moser@swosu.edu).*

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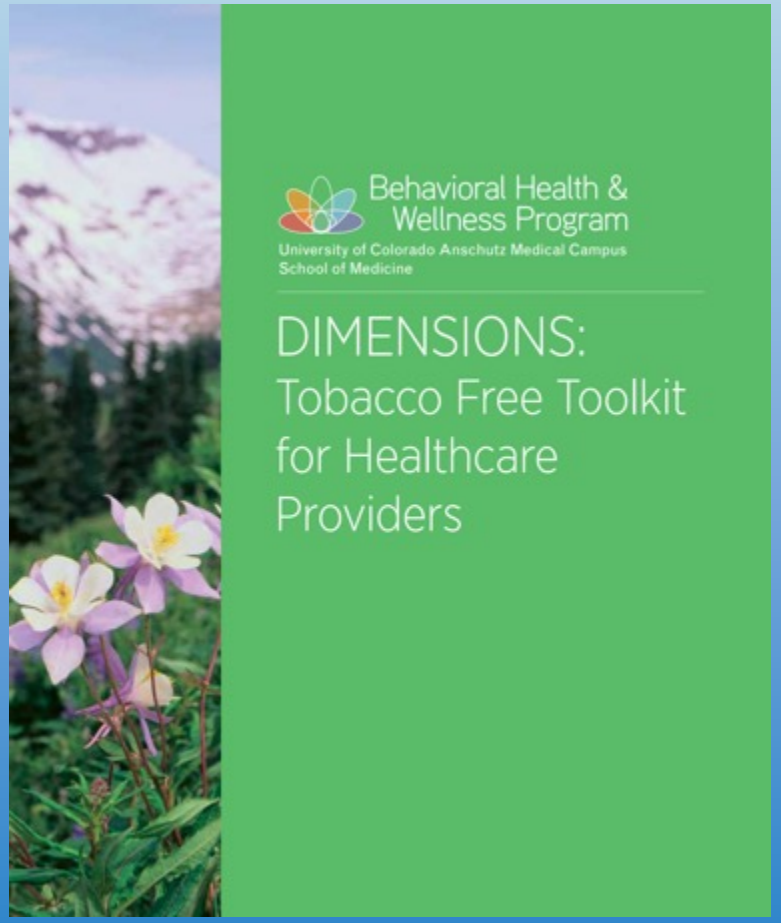
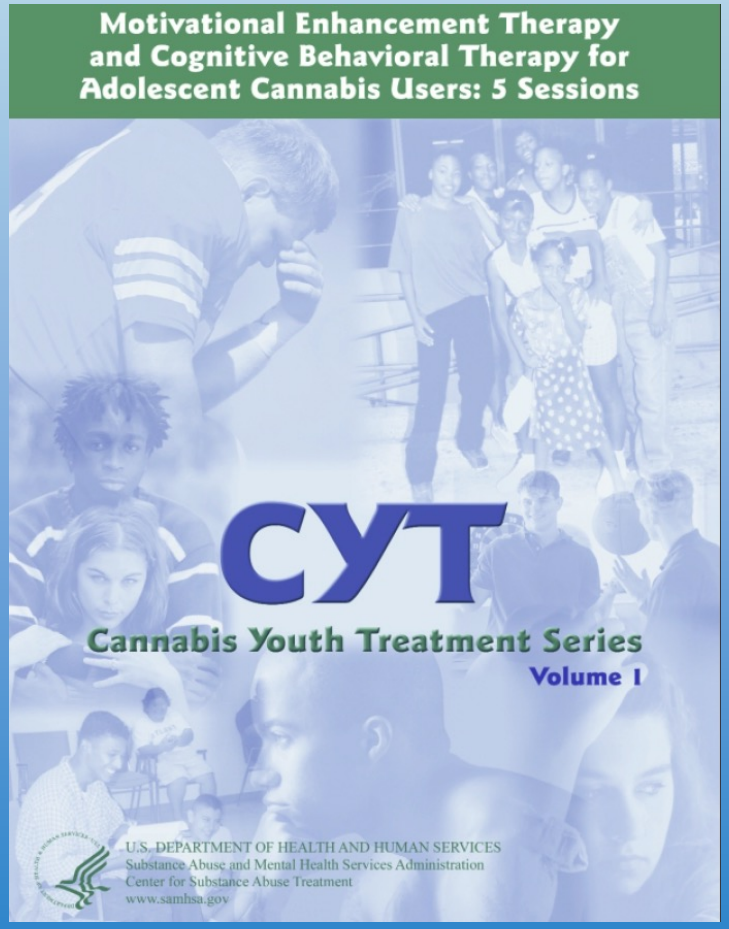
Evidence-Based Guidance



http://www.bhwellness.org/resources/toolkits/



http://www.bridgeinc.org/pages/?pageID=40

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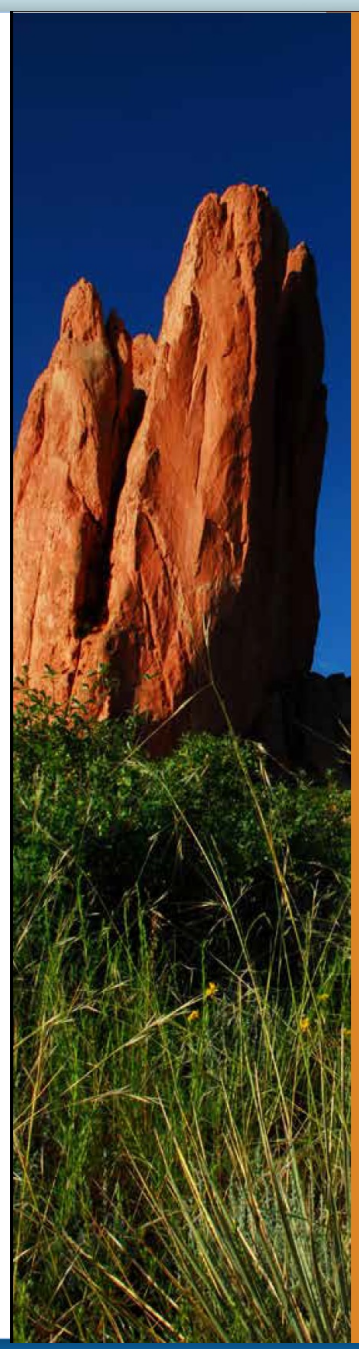
Peer Support

A peer provider is a person who uses his or her lived experience, plus skills learned in formal training, to deliver services in health and public health settings to promote mind-body recovery and resiliency.

http://www.bhwellness.org/resources/toolkits/



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DIMENSIONS:
Peer Support
Program Toolkit

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https://www.lung.org/getmedia/5d1979a7-21cb-4e85-86d3-c53ce1a31195/billing-guide-addendum-for.pdf.pdf

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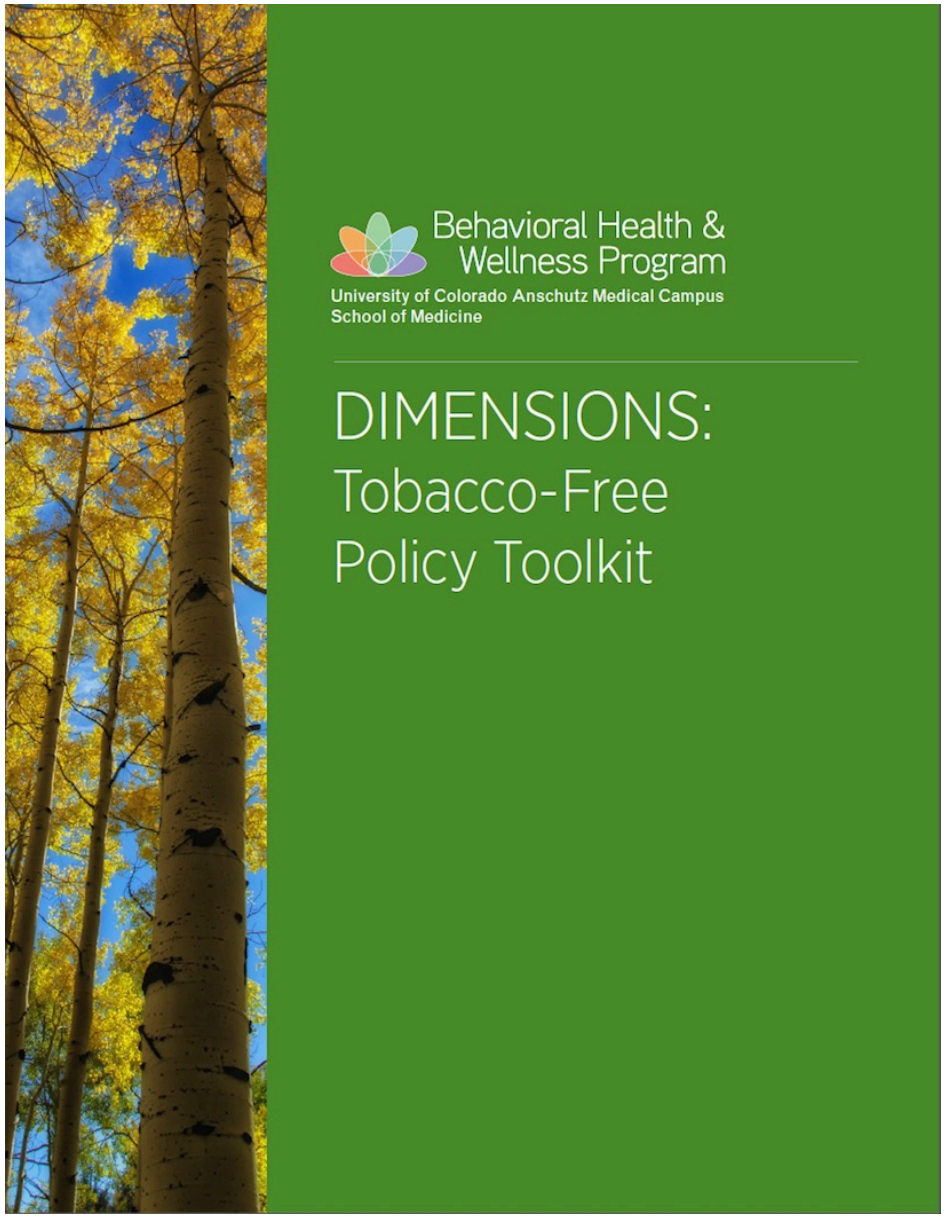

- Convene Your Wellness Committee
- Provide Education
- Create Your Change Plan
- Offer Tobacco Cessation Services
- Draft Your Policy
- Launch Your Policy
- Communicate Your Plan
- Enforce Your Policy
- Build Community Support
- Evaluate Your Program

https://www.bhwellness.org/resources/toolkits/Tobacco-Free%20Policy%20Toolkit-web%20v.2.pdf

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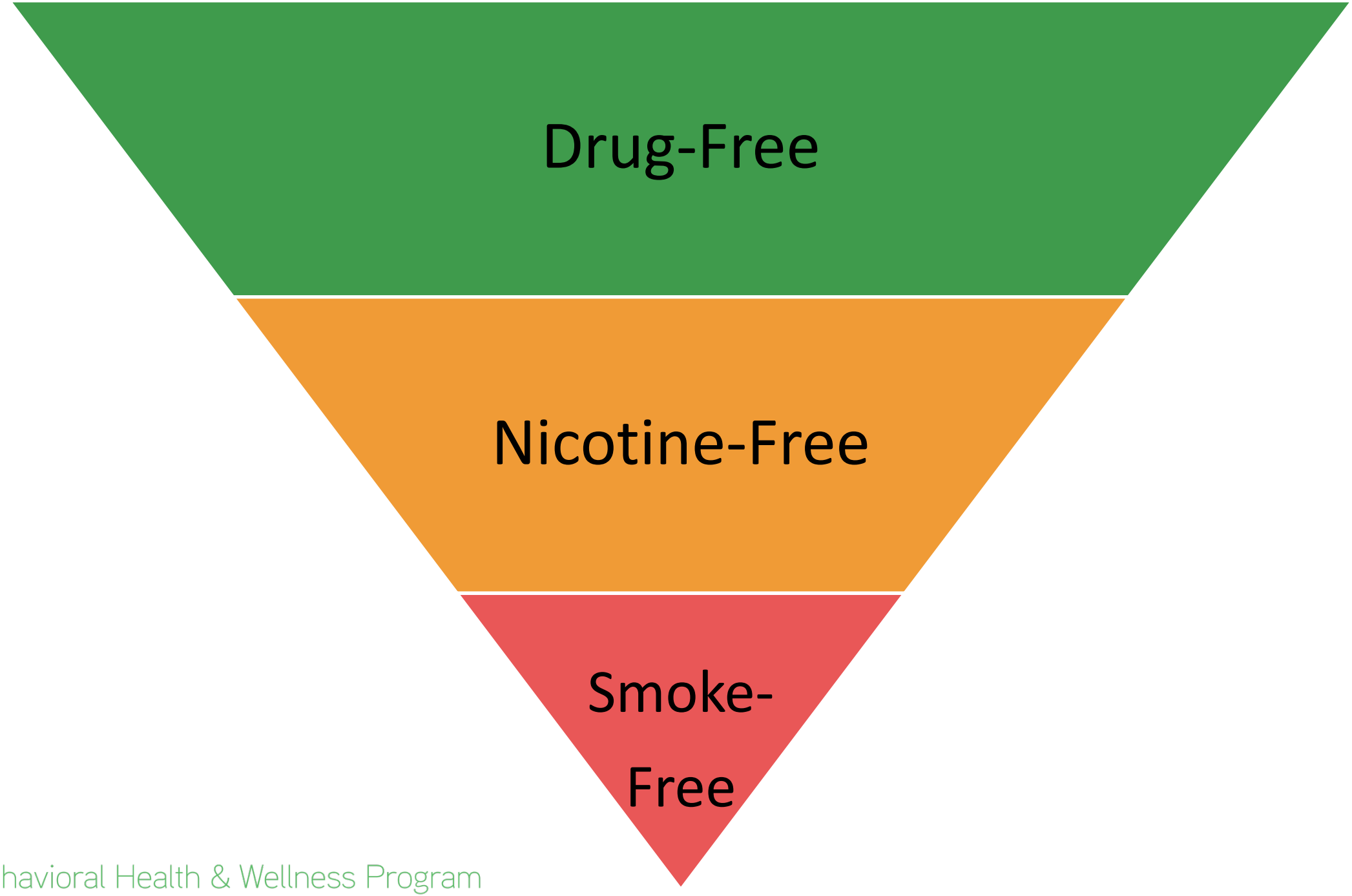

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National Behavioral Health Network
For Tobacco & Cancer Control

- Jointly funded by CDC's *Office on Smoking & Health* & *Division of Cancer Prevention & Control*
- Provides resources and tools to help organizations reduce tobacco use and cancer among people with mental illness and addictions
- 1 of 8 CDC National Networks to eliminate cancer and tobacco disparities in priority populations

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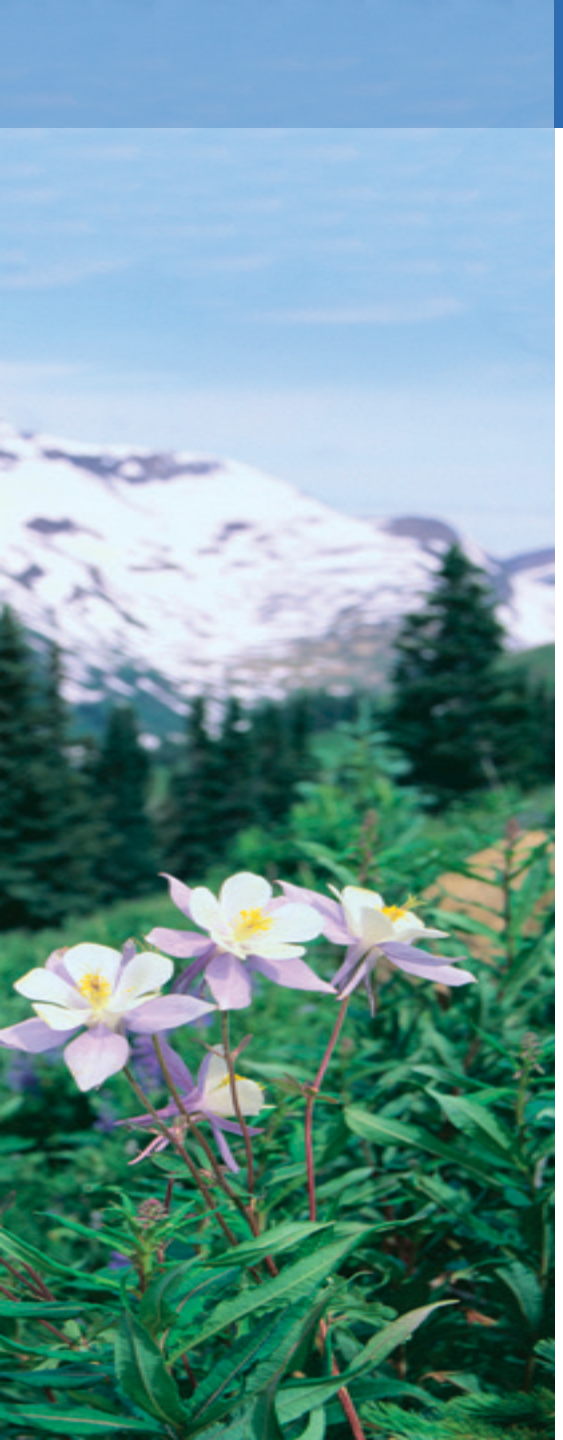

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bh.wellness@ucdenver.edu

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