



ALCOHOL & DRUG POLICY INSTITUTE



Smoking in Treatment Settings

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ADPI's mission is to work toward the advancement of the alcohol and other drug (AOD) field in California through the creation and dissemination of knowledge regarding AOD problems and culturally-competent approaches to their prevention and amelioration.

SMOKING IN TREATMENT SETTINGS

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Overview

Smoking is among the most pernicious disease-related behaviors. Currently, about 46 million people smoke in the US (DHHS, 2001). Annually, 430,000 die of smoking related disease (Leshner, 1998). The health consequences of smoking, now well established, include lung cancer and other cancers (larynx, esophagus, bladder, kidney, pancreas, stomach), heart disease, stroke, bronchitis, emphysema, and increased respiratory infections. Among perinatal women smoking is associated with increased risk of stillborn, premature, and low birth weight infants, and children of women who smoke perinatally are more likely to have conduct disorders (NIDA, 1998).

In addition to the personal, familial, and social impacts associated with these illnesses, the impacts of smoking have been translated into economic terms. The economic costs of smoking, estimated at \$138 billion dollars in 1995 (Rice, 1995; Robert Wood Johnson Foundation, 2001), are greater than those associated with illicit drug use, and only somewhat lower than those associated with alcohol abuse (Harwood, Fountain & Livermore, 1998).

The negative impacts of smoking are avoidable, such that smoking represents the single most preventable cause of death in the US (DHHS, 1989). Smokers who quit by age 35 increase life expectancy by 6-8 years, and smoking cessation at any later age carries some (smaller) life expectancy benefit (Taylor et al., 2002). Numerous public health interventions, regulatory practices, and litigation efforts have transformed smoking in America, by supporting innovation in research, prevention, and policy as countervailing forces to the tobacco industry.

The effects are plain. From the time of the first Surgeon General's Report on Smoking and Health in 1964 (US DHEW, 1964) and up to 1987, the prevalence of smoking among adults decreased from 40% to 29% (DHHS, 1989). Adult smoking prevalence continued to decrease from 25% in 1993 to 23% in 2001, and there are now 44 million ex-smokers in the US (Trosclair et al., 2002). In recent years, and from 1999 - 2000 in particular, decreases in smoking prevalence were non-significant.

Investigating smoking and mental illness (including alcohol and drug dependence), Lasser and colleagues (2000) reported that persons with a mental disorder were about twice as likely to smoke as those with no mental disorder and, most striking, estimated that this population smoked nearly half of all cigarettes smoked in the US.

The slowing pace of reductions in smoking prevalence, demographic disparities in rates of smoking and quitting, and smoking prevalence rates above 40% in some subpopulations give rise to the observation that those who can quit have done so, and that those who continue to smoke represent a "hard core" of smokers either unaffected by smoking cessation campaigns and strategies. For this core of continuing smokers, which includes persons with substance abuse and dependence disorders, innovative interventions are needed.

Smoking and Drug Abuse

National Household Survey data suggest that over 10 million persons were dependent on either alcohol or drugs in 1999 (DHHS, 2000). The Treatment Episode Data Set (TEDS), designed to collect admissions data from specialty drug abuse treatment programs nationwide, registers approximately 1.6 million treatment admissions annually (DASIS, 2002). Admissions overestimate number of persons treated, as some individuals cycle through treatment repeatedly. Even allowing that one-third of all admissions may reflect repeat episodes for the same persons in the same year, these data suggest that 10 million people may benefit from (or need) drug abuse treatment, and that approximately 1 million may actually enter treatment programs annually.

The prevalence of smoking among persons entering drug abuse treatment is high, with estimates that 80% are nicotine dependent (Dreher and Fraser 1967; Haberman 1969; Walton 1972; Maletzky and Klotter 1974; Moody 1976; Burling and Ziff 1988; DiFranza and Guerrera 1990; Budney *et al.* 1993; Stark and Campbell 1993; Clemey *et al.* 1997). The increased rate of morbidity and mortality of substance abusers was documented in the US Surgeon General's report on *The Health Consequences of Smoking: Nicotine Addiction* (1988). Subsequently Hurt and colleagues (1996) demonstrated that not only were active users at higher risk, but recovering substance abusers were dying from tobacco-caused illnesses at a higher rate than the general population. Hurt *et al.* (1996) concluded that persons previously treated for substance abuse had "increased cumulative mortality that was due more to tobacco-related than to alcohol-related causes. Nicotine dependence treatment is imperative in such high-risk patients."

These data suggest that persons entering substance abuse treatment smoke at a rate nearly four times that of the general population, and nearly twice that of the Troscclair *et al.* (2002) population-based sample of the currently mentally ill. They incur elevated risk for smoking-related morbidity and mortality, and they account for disproportionate amounts of cigarette consumption and related health and economic costs.

The Tobacco, Addictions, Policy and Education (TAPE, 2003) Project of the Institute for Health and Recovery compiled a summary of research findings on issues related to addressing tobacco use in substance abuse treatment settings. Numerous studies document that treating nicotine dependency in substance abuse treatment settings has a positive impact on post-treatment abstinence from the illicit drug of choice (Sullivan and Covey, 2002; Lemon *et al.*, 2003). Treatment providers may be wary of addressing nicotine dependence, under the assumption that the stress of quitting smoking or potential experiences of failure in smoking cessation may prompt relapses to alcohol and drug use. At the very least, studies demonstrate that the effects of stress, success, and failure to quit smoking have no significant effect on relapse (Campbell *et al.*, 1995; Martin *et al.*, 1997; Joseph *et al.*, 1993; Hurt *et al.*, 1994; Lemon *et al.*, 2003). On the other hand, cigarette smokers were found to be at a higher risk of relapsed to their primary drug of choice, including alcohol, than nonsmokers (Sees and Clark, 1993; Sobell and Sobell, 1996).

Treating Nicotine Dependence in Drug Abuse Treatment Settings

Admission to drug abuse treatment leaves smoking behavior and its consequences, in general, uninterrupted. There are compelling reasons to make the case that nicotine dependence treatment should be more available in drug abuse treatment: the elevated smoking prevalence, the corresponding elevations of health, social and

economic costs, and the relative failure of public health strategies to impact smoking among substance abusing persons (or at least those who enter drug abuse treatment). In fact, the absence of nicotine dependence treatment in these settings generates a matrix of paradox for several reasons:

- These systems attend diligently to numerous addictive substances, both legal and illegal, yet ignore or avoid nicotine.
- Drug abuse treatment systems are increasingly integrated into general healthcare through managed care and behavioral health models, yielding a healthcare sector wherein the single most preventable cause of morbidity and mortality goes untreated.
- Persons entering treatment often have reached a teachable moment when they are motivated to change addictive behaviors through reduced use or abstinence, yet may be discouraged from smoking cessation.

There are also understandable reasons why drug abuse treatment systems may turn a blind eye to nicotine addiction. Nicotine is legal (for adults), and does not conduct the burden of crime as does the use of illegal drugs. Its use does not carry short-term negative effects of intoxication such as accident, injury or absenteeism. The negative effects of smoking, if no less dangerous, are delayed in time.

In a qualitative investigation of barriers to nicotine dependence treatment in drug abuse treatment programs Dr. Joseph Gurdish (University of California, San Francisco) collaborated with Dr. Theresa Montini (NIAAA R21 AA12621, PI Montini). Open-ended, in-depth interviews were conducted with a national sample of clinical directors of substance abuse treatment programs. Participants were asked about their knowledge, attitudes, and beliefs regarding the role of nicotine dependence treatment within their programs. While many respondents reported that their program had an indoor smoking ban, few offered nicotine dependence treatment. Respondents commented on philosophical barriers, such as the traditional wisdom that those in treatment should avoid major life changes (including stopping smoking) during their first year of recovery, as well as practical barriers, such as the absence of funding for smoking cessation services. When asked about barriers to incorporating nicotine dependence treatment, clinical directors explained that high rates of smoking among staff, staff beliefs about smoking, and training issues all acted as barriers.

A number of projects address smoking cessation in drug abuse treatment. (For example, the Robert Wood Johnson Foundation sponsored a planning process directed toward smoking in mental health and substance abuse populations). Each of these projects, with the exception of the Robert Wood Johnson initiative, takes the individual substance user as its unit of intervention. And while they will make critical contributions to our understanding, they will not directly address the philosophical and attitudinal barriers to smoking cessation at the program level.

Conclusion

Given the increased risk for smoking-related mortality, the related economic costs, and the potentially positive impact on abstinence from the illicit drug of choice, treating nicotine dependence in the substance abuse treatment setting should be a serious consideration for treatment providers. Reshaping drug abuse treatment systems to incorporate smoking cessation will require an array of interventions operating at individual, agency, system, policy and regulatory levels.

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