



SETTING THE STAGE: CONDUCTING TOBACCO TREATMENT WITH CLIENTS WITH SUBSTANCE USE DISORDERS

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June 27, 2007
TCLN Meeting
Portland, Oregon

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Tobacco, Addictions , Policy and Education (TAPE) Project

- Funding: MA DPH, Bureau of Substance Abuse Services (BSAS), 1994; MTCP; Am. Legacy Fdn. grant, 2004
- Statewide Targeted Capacity Building Grant
- Serves all BSAS prevention and treatment programs by providing:
 - Consultation/TA/On-site staff training; support to implement BSAS Tobacco Guidelines
 - “For Smokers Only: Thinking About Change?” staff workshops
 - Resources, referrals, info
 - Conferences, statewide training
 - Consumer education and treatment: focus groups, “Circle of Friends,” Consumer Advisory Board, conferences



ATTUD

Association for the Treatment of
Tobacco Use and Dependence

www.attud.org

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Membership

Any individual who is currently active or has been historically active in the treatment of tobacco use and dependence, including:

- Health Care Providers (e.g. counsellors, tobacco treatment specialists).
- Researchers
- Educators/Trainers
- Policy makers
- Students

For more information: www.attud.org

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Scope of the Problem: Prevalence

- Smokers are over represented in psychiatric populations.
- Psychiatric patients are 2-3 times more likely to smoke:
 - 40-50% of pts. with depression and anxiety disorders smoke.
 - 70-90% of pts. with schizophrenia smoke.
- 75-100% of substance abusers smoke.
- 44% of all cigarettes smoked in US are by individuals with psychiatric or substance abuse disorders

Campbell et al, 1998; Ziedonis & George, 1997; Lassser et al, 2000



Scope of the Problem: Mortality

- Smoking kills more Americans than all other drugs combined, including alcohol.¹
- Among treated narcotic addicts, smokers' death rates were 4X that of nonsmokers.¹
- Among treated alcoholics who died, 51% of mortality attributed to smoking-related illness.²
- In the same study, mortality was 48% for smokers vs. 19% expected mortality.²

1) Hser et al, 1994; Lynch & Bonnie, 1994 ; 2) Hurt et al, 1996



Systems Issues

- Barriers exist in all health care systems—may be more prominent in SA/MH systems.

Examples:

- Belief that smoking cessation will adversely affect SA/MH treatment
- Use of cigarettes as reward/distraction/coping
- Attitude that smoking is the lesser evil
- Staff smoking
- Lack of knowledge about risks of tobacco use and how to quit



Systems Issues

- Staff may be current smokers, in various stages of readiness to quit.
- Staff may lack information about the impact of tobacco and smoking as a recovery issue.
- TTS must be clear on role: Listen, share resources, work collaboratively.
- Emphasize and respect confidentiality.



Substance Abuse and Smoking: Considerations

- Meaning of cigarettes/tobacco
- Buffer for feelings
- Smoking as “the last vice,” last to go
- Lesser of two evils



Tobacco Use in Recovery—Barriers

- Tobacco use is pervasive.
- Historical role of tobacco in the “culture of recovery.”
- Higher levels of nicotine dependence among substance abusers.
- Tobacco use seen as a lower priority than the immediate consequences of other substance abuse



Rationale for Tobacco Treatment (1)

- Demonstrated interest in quitting across treatment modalities and populations.
- Research demonstrates quitting smoking does NOT jeopardize recovery: alcoholics who quit smoking are more likely to succeed in alcoholism treatment
- Continued smoking identified as a factor in relapse back to active substance abuse.
- The majority of research indicates that smoking cessation is unlikely to compromise alcohol use outcomes.



Rationale for Tobacco Treatment (2)

- Participation in smoking cessation efforts while engaged in other substance abuse treatment has been associated with a 25% greater likelihood of long-term abstinence from alcohol and other drugs.
(Prochaska, J.L. et al 2004)
- Treatment for heroin, cocaine, or alcohol addiction might be more effective if it included concurrent treatment of tobacco addiction. (Taylor et al, 2000)
- There are compelling reasons for implementing smoking cessation programs for patients in methadone treatment, as the benefits of smoking cessation may extend to opiate addiction as well.
(Frosch et al, 2000)



Rationale for Tobacco Treatment (3)

- Similar relapse prevention techniques: stress management and wellness issues.
- Tobacco use negatively impacts other psychosocial issues that challenge clients in recovery:
 - Finances
 - Health, HIV status
 - Pregnancy, children's health
 - Treatment compliance
 - Medications
 - Dealing with feelings
- Increased risk for other health problems through multiple substance abuse.



Smoking and Alcohol Use

Among alcoholics who smoke:

- 10x greater risk of pancreatitis than in those who do not smoke
- 3x greater risk of cirrhosis
- 38x greater risk of developing mouth and throat cancer than nonsmoking nondrinkers
- “Chronic cigarette smoking increases the severity of brain damage associated with alcohol dependence”

Durazzo, 2004 (Alc: Clin and Exp Research)



Co-morbidity

- Negative impact on co-occurring diseases: HIV/AIDS, HCV
- Impact on pregnancy, children's health
- Negative impact on metabolism and efficacy of medications, including antidepressants, anti-psychotics, asthma meds, ritonavir, insulin
- Adds to health effects from illicit drug use



Concerns with HIV/AIDS

- HPV infection more common in HIV+ women who smoke
- Oral thrush and PCP more common in smokers
- Increased risks for heart disease and stroke (HIV disease, anti-HIV meds.)
- Increased risk of lung cancer and emphysema in HIV+ smokers



Concerns with HCV

- Smoking makes HCV damage worse, similar to alcohol ; frequent alcohol use plus smoking 20+ cigarettes a day = 7x more likely to have elevated ALT enzyme
- Smokers with HCV have a 4x greater risk of developing non-Hodgkin's lymphoma than smokers without HCV, who face 2x the risk of NHL compared to never-smokers



Working With A Client Actively Using A Substance

- Screen and assess as part of overall client history.
- Identify the problem or concerns.
- Make connections with active use as a barrier to quitting tobacco use.
- Discuss resources for support.
- Assist with referrals.



Assessments

- **CAGE: Cut down; Angry; Guilt; Eye-opener** (Mayfield 1974; Ewing 1984; Rouse 1970)
- **CRAFFT: Car, Relax, Alone, Friends, Family, Trouble** (Knight, Sherritt, Shrier, Harris and Chang 2002)
- **MAST-G: Michigan Alcoholism Screening Test Geriatric** (Blow et al 1992)
- **5 P's: Peers; Parents; Partner; Past; Pregnancy/Present** (Ewing 1990)



Working with the Client in Recovery

- Identify through assessment that the client is in recovery.
- Ask questions to allow discussion of other major lifestyle changes that the client has made, including recovery.
- “Many roads, one journey” (Charlotte Kasl): TTS should develop familiarity with supports
 - Alcoholics Anonymous/ other 12-step programs
 - SMART Recovery, Women for Sobriety, SOS, Religious support, family support, psychotherapy



Challenges for Tobacco Treatment

- Compared to smokers without substance use disorders, smokers with co-occurring disorders: more nicotine-addicted; smoke higher-nicotine cigarettes; smoke more per day; score higher on CO assessments / nicotine dependence measures
- Smoking is used to cope with urges to drink/use drugs
- Alcoholics who smoke (and the systems and counselors who work with them) may have stronger views about the benefits of continued use than other smokers (Gulliver et al, 2006)



Treating Tobacco Dependence in Recovering Alcoholics (Dale, 2005)

- Recommend proven therapies
 - NRT; bupropion
 - CBT
 - Social support
- Monitor, follow-up
- Let patient decide the timing
 - Possible role for delayed treatment
 - Postponing means potentially never



What Works?

- Stages of Change framework
- Acknowledge and work with ambivalence
- Tie in with addictions treatment: integration; language: ATOD; similarity of approaches
- Build buy-in of leadership and line staff
- Take the long view: change is a process; changing norms and culture
- Promote systems-based approach
- Make research meaningful, relevant; end scare tactics; educate, involve