UCSF Smoking Cessation Leadership Center | National Center of Excellence for Tobacco-Free Recovery

**SCLC presents:**
**“Recovery-Oriented Tobacco Interventions in Addiction Services”**
on Friday, April 30, 2021, at 1:00 pm EDT (60 minutes)

**Speaker: Tony Klein, MPA, NCACII, Consultant and Clinical Trainer, Tobacco Recovery and Wellness Initiative**

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Q: I know an adult SUD treatment center that claims an 80% quit rate because they provide vaping supplies to smokers. Since it is an evidence-based tool for cessation, why aren't we using this more? Why does Public Health England promote vaping to adult smokers, even handing them out to medically indigent patients?

A: In the US few SUD treatment centers have integrated the HHS PHS tobacco dependence practice guidelines into their care model. From my experience, when using the published guidelines tailored to a SUD population, they are highly effective.
On the other hand, there is no long-term data to support the safety or efficacy of vaping. I seriously question these claims of 80% quit rates. Introducing another drug delivery device in SUD treatment centers does not promote culture change. Philip Morris International funds an organization based in the UK called Knowledge, Action, Change that aggressively promotes vaping as a harm reduction approach. So, draw your own conclusions.

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Q: Since the menthol cigarettes would be banned in NY do you see people substituting it with something else?

A: That’s an interesting question. I too am curious to see the impact of banning menthol in a SUD population.
My clients tell me that Newport cigarettes soaked in formaldehyde and often laced with cocaine or heroin are sold on the street. There are different names for them depending on the location. They’re called “love boats” in Jersey City, “wets” in Philadelphia. Reportedly, they’re very popular and smoked to boost a high after using other substances.
My guess is that menthol will continue to be infused in these bootlegged products. The demand is too great.

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Q: Can you speak to the common refrain we hear from clients in recovery that they have "given everything else up" and smoking is all they have left? What are your thoughts on how to work with that perception?
Ideas on how to get clients to sign up for or participate in a Tabacco Recovery group?

A: Yes – strategically highlight the benefits of learning tobacco-free coping skills relevant to long-term drug and alcohol recovery. Integrate a reference to tobacco use behavior in all client education topics. It can easily be included in discussions on neurochemistry, craving management, relapse prevention, developing healthy coping skills, self-esteem, etc.

The key is to mention it, don't dwell on it. A brief repeated reference will elevate an awareness of the association of tobacco use to other substances and clients on their own timeline will recognize the importance to address tobacco in their personal program of recovery.
Traditionally, we've pretty much ignored talking about tobacco. Once we get comfortable naturally including it in our counseling narrative, clients will increase their willingness to address it.

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Q: If we knew someone was addicted to any other drug, we would consider them impaired professionals and unfit for duty until they received treatment. Why don't we take this approach with tobacco? It seems to set tobacco use disorder aside as a "different" addiction.

A: I agree that we think about tobacco use among our colleagues in a different way. Most likely because nicotine doesn't cause mood-altering intoxication as other substances.
Nonetheless, as we strive to denormalize smoking and develop tobacco-free policy in behavioral health settings, we recommend that all staff demonstrate "no evidence of" tobacco use during hours of employment. Tobacco treatment services need to be made available for all staff to support successful implementation of the policies.

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Q: How do you respond to folks who say that TF policy implementation is targeting people who smoke and 'pushing them out' and 'forcing them to quit'? Additionally, how do you address clients/patients being triggered by tobacco conversations in TF treatment/group spaces?

A: I believe that instilling a sense of hope for positive behavioral change and recovery is fundamental to quality addiction services. Treating tobacco use disorder concurrently with other addictions is associated to an increased likelihood of long-term abstinence from alcohol and other drugs. Integrating tobacco interventions into existing programming is a care improvement initiative demonstrating respect to our clients.
Being triggered while discussing any drug use, including tobacco, is not uncommon. The key is to use the experience as an opportunity to learn how to effectively manage craving – refocusing, grounding, relaxation breathing, etc.
Nonetheless, it's been my experience that when employing a motivational interviewing style of counseling we see much less triggering than when providing a didactic lecturing approach.

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