

Addressing Nicotine Dependence in Treatment

The Elephant in the Living Room



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Tobacco Use Has Traditionally Been Trivialized



- Nicotine addiction has been ignored in the treatment community, with few exceptions
- There is probably no setting in the U.S. with higher rates of smoking than substance abuse treatment facilities and 12 step meetings, where 80-95% of people smoke *(McIlvain et al., 1998)*

“Can’t give up everything at one time”
“First things first”
“No major changes for the first year”

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A Gateway Drug

- Tobacco is a gateway drug
 - Begins the addictive process in the brain
 - Releases the same neurotransmitters
 - Many addicts smoked a cigarette before getting up the nerve up to engage in more serious levels of drug use.

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The Cigarette is a Drug-Delivery System

- Smokers typically take 10 puffs per cigarette over a 5-minute period
- A 1-1/2 pack (30 cigarettes) per day smoker gets 300 “hits” of nicotine to the brain each day
- The process of smoking drugs is similar across all drug types and failure to address all smokable drugs may predispose clients to relapse (Sees & Clark, 1993)

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Nicotine Is Mood-Altering

- Nicotine is a mild stimulant and a depressant
- Nicotine is more serious than heroin or cocaine (NIDA)
- It is psychoactive (changes information processing in the brain) and highly addictive
- Nicotine stimulates dopamine, just like heroin and cocaine, changing brain cells and damaging bodily functions.

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Tobacco Use Triggers Alcohol and Other Drug Use

- The emotional and cognitive processes associated with tobacco use are identical to those associated with the use of AOD
- Nicotine produces intensive addictive urges cravings –central issues in treatment
- Craving for nicotine increases cravings for other drugs
 - Substance abusers that smoke had cue induced cravings for opiates and cocaine when tobacco cravings were triggered (Heishman, et al, 2000)

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“Hey, same as my meth...”

- After seeing the list of ingredients in cigarettes, women from a Long Beach, CA treatment center stated that many of these ingredients were the same as the ones they used to make methamphetamine.

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Ingredients in Tobacco



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Tobacco Use Leads to Nicotine Addiction

“The pharmacologic and behavioral processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine.”

-Surgeon General Report, 1988

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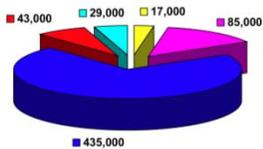
Tobacco Use Leads to Nicotine Addiction

- Nicotine stimulates the production of dopamine which increases the desire to consume drugs
- Produces rapid distribution of nicotine to the brain, with drug levels peaking within 10 seconds of inhalation
- Acute effects of nicotine dissipate in a few minutes
 - causes the smoker to continue dosing to maintain the drug's pleasurable effects and prevent withdrawal

(Benowitz NL, 1996, NIDA website)

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Actual Causes of Death U.S., 2000



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■ Illicit Drugs ■ Alcohol ■ Tobacco ■ Motor Vehicles ■ Firearms

A Unique Setting



- In general, if a person has not started smoking by age 20, it is unlikely that they will ever smoke. However, a significant number of adult substance abusers start smoking while in treatment/recovery, suggesting that the treatment climate is particularly conducive to smoking *(Friend & Pagano, 2004).*

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Heavier Users



- Substance abusers are heavier smokers (≥ 2 packs per day) (Hughes & Kalman, 2005; Marks et al, 1997),
- Heavier smokers:
 - Have higher nicotine dependence scores (Hughes & Kalman, 2005; Marks et al, 1997)
 - Have more (72% vs. 9%) AOD problems (Hughes, 1996)
- Nearly 50% of substance abusers in recovery will die from tobacco-related diseases (Hughes et al, 2000; Hurt et al., 1996).

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Most Important Facts



- More recovering drug and alcohol addicts will die of tobacco-related causes than any other cause. Both co-founders of Alcoholics Anonymous, Bill W. and Dr. Bob, died of tobacco-related causes
- Smokers have a higher relapse rate than do clients who have quit smoking while in recovery

(Clinical Psychiatry News, 1999, *Push Tobacco Cessation When Treating Drug and Alcohol Addicts*)

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Myths Among Treatment Staff



- Smoking cessation is too difficult for clients in early recovery (Chiauzzi & Liljegren, 1993).
- Smoking is less harmful than illegal drug or alcohol use (McIlvain et al, 1998)
- Treatment programs perceive that they may suffer financially if clients do not enter treatment or leave prematurely because of smoking bans or pressure to quit smoking (Hurt & Slade, 1990; Eliason & Worthington, 2005).

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Myths Among Treatment Staff



- A common belief of both administrators and staff is that smoking relieves the anxiety associated with withdrawal from alcohol and other drugs (*Eliason and Worthington, 2005*)
- Treatment staff who smoke are more prone to endorsing the myths about smoking than nonsmokers (*Gill et al., 2000; Eliason and Worthington, 2005*)

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Other Barriers to Cessation



- Many treatment counselors are in recovery and are smokers
- 12 step meetings and treatment facilities have traditionally allowed smoking, so staff and clients are comfortable in this environment
- Smoking cessation counseling is not included in counselor education
- Separate research and treatment funding sources for tobacco versus other drugs

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Harmful Opinions

- “From a treatment perspective, the findings may argue against asking [AOD] patients to tackle too many problems at once, such as quitting smoking at the same time...” (*Join Together, 2002, “Will to Stay Sober Can Be Weakened”, Bob Curley*)

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Research Confirms Cessation Improves Recovery Rates



- Kalman et al. (2001) found that people in concurrent tobacco and alcohol/drug treatment had a lower rate of relapse on alcohol/drugs than clients in a delayed tobacco treatment that occurred after they finished alcohol/drug treatment.
 - All participants who achieved nicotine abstinence also achieved abstinence from alcohol.

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Research Confirms Cessation Improves Recovery Rates



- Lemon et al. (2003) examined data from the Drug Abuse Treatment Outcomes Study for over 2300 smokers in treatment and reported that smoking cessation during treatment was associated with greater abstinence from drugs and alcohol after treatment and at 12 month follow-up (see also Joseph et al., 2003; Burling et al., 1991; Campbell et al., 1995; Hurt et al., 1994; Shoptaw et al., 1996, 2002)

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Research Confirms Cessation Improves Recovery Rates



- Friend & Pagano (2005a) examined 1300+ people from Project Match data set.
 - clients who quit on their own had more abstinent days from alcohol and a lower rate of drinking on drinking days than those who continued to smoke.
 - clients who decreased tobacco use were less likely to relapse than those who maintained or increased their tobacco use

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Research Confirms Cessation Improves Recovery Rates



- Recovering alcoholics who were encouraged to quit smoking were less likely to relapse to drinking (*MA Medical Society, MMWR 1997*)
- Alcoholics who stopped smoking during recovery are more likely to maintain long-term abstinence from alcohol than those who continued to smoke (*Bobo, et al., 1989; Sees and Clark, 1993*)
- Continued use of nicotine may be a relapse factor for resuming alcohol use (*Stuyt, 1997*)

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Research Confirms Cessation Improves Recovery Rates



- Successful tobacco quitters were 3X's as likely not to use cocaine as their peers who smoked (*Frosch, et al., 1997*)
- Researchers report that smokers who fail to quit smoking are more likely to use cocaine than those who quit (*Frosch, et al., 1997; Shoptaw et al., 1996*)
- Non-tobacco users maintain longer periods of sobriety after inpatient treatment than tobacco users (*Stuyt, 1997*)

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Research Confirms Cessation Improves Recovery Rates



- Patients use common tools/methods to deal with all addictions
- Recovering alcoholics should be encouraged to use abstinence coping skills learned in alcohol treatment to quit smoking (*Bobo, 1993*)
- Addressing nicotine addiction promotes fuller freedom from addictive urges and abstinence

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Research Confirms Cessation Improves Recovery Rates



- Clients are much better able to focus on the issues central to their recovery when not using tobacco.
- Emotional and cognitive processes with tobacco use are identical to those associated with use of alcohol and other drugs.

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What can we do?

- There are a wide variety of ways that treatment professionals can begin to change this social norm
- Treatment professionals have a responsibility to their clients to address tobacco

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Policy Examples



- Program
 - No smoking within 50 ft of doors and windows
 - No visitor smoking
 - No smoking on the grounds
 - No tobacco products allowed on the premises
 - No upper management or administrator smoking
 - Address all tobacco use with the goal of being completely tobacco free within a reasonable amount of time

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Policy Examples

- Staff
 - Offer cessation and incentives for quitting to staff
 - No smoking with clients
 - No evidence of smoking while on the clock



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Policy Examples

- Clients
 - Assess for tobacco dependence immediately
 - Mandate cessation classes or integrate tobacco addiction treatment into the general curriculum
 - No smoke breaks between/during groups
 - No smoking on the grounds



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Stages of Change

- Widely used in substance abuse treatment programs today as a theoretical model/framework.
- Smokers relate best to interventions that are drawn from the stage of change that they are currently in



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Stages of Change



- Pre-contemplative
- Contemplative
- Preparation
- Action
- Maintenance
- Relapse

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Motivational Interviewing



- MI is used in both substance abuse treatment and in smoking cessation settings
 - establishes a positive, non-confrontational, empathic relationship with clients that facilitates and guides, but does not direct the client

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Motivational Interviewing



- Encourages clients to identify their ambivalence about smoking
- Builds internal motivation for change
- Counselors
 - reflect back client's statements,
 - avoids getting into confrontations or trying to break down denial
 - Rewards/enhances statements about change and growth

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Just Like Other Drugs...

- Nicotine withdrawal symptoms include irritability, craving, cognitive and attention deficits, sleep disturbances, and increased appetite.
- Symptoms may begin within a few hours after the last cigarette, quickly driving people back to tobacco use.
- Symptoms peak within the first few days of smoking cessation and may subside within a few weeks

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(Henningfield, JE, 1995, NIDA website)

A Long Process



- Step by Step Process
- Do not expect staff and clients to quit smoking today
- Consider tobacco use an addiction issue to be addressed
- Embrace a more comprehensive approach to treatment that addresses *all* addictions

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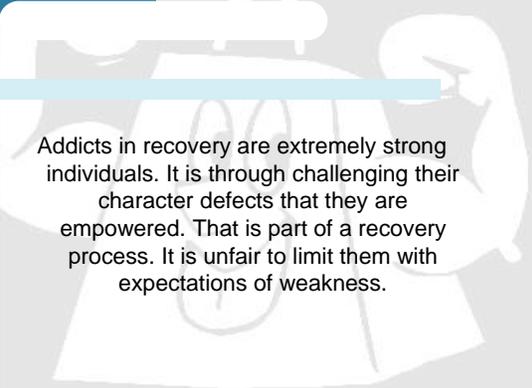
NAADAC's Position on Tobacco

- NAADAC recommends that all patients presenting for substance abuse services be screened and assessed for tobacco use
- NAADAC further recommends that tobacco dependence be included in the treatment plan for every patient to whom it applies. Furthermore, discharge plans should address all unresolved problems, including the use of tobacco, identified at admission or during treatment.

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Addicts in recovery are extremely strong individuals. It is through challenging their character defects that they are empowered. That is part of a recovery process. It is unfair to limit them with expectations of weakness.



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The Bottom Line!



Clients should be given the opportunity to embrace recovery from all forms of substance abuse in a treatment setting.

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Tobacco IS an Issue!

- Alcohol & drug programs in NJ, TX, WA, TN, ND, SD, CA, MN and others have begun to include tobacco treatment in their programs
- *NAADAC, The Association for Addiction Professionals*
 - adopted a Position Statement on Nicotine Dependence (6/21/01)
- *The American Society of Addiction Medicine (ASAM)*
 - Adopted a Policy Statement regarding Nicotine and Addiction (4/20/88)

Tobacco Dependence in Substance Abuse Treatment

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