Smoking Cessation During Substance Abuse Treatment

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An overview of the critical issues involved in overcoming personal and organizational barriers to help substance abusers quit smoking.

Cigarette smoking is pervasive among persons who are being treated for substance use disorders. The prevalence is 3- to 4-fold higher than in the general population. Whereas approximately 20% of adults in the United States currently smoke, between 75% and 95% of persons in treatment programs for addictions are cigarette smokers. The consequences of dual addictions to cigarettes and other substances of abuse are dire. In a frequently cited study conducted over a decade ago, approximately 50% of patients who were followed after inpatient substance abuse treatment died of tobacco-related causes—a rate that exceeded deaths from alcohol-related causes (34%). These high tobacco-related mortality rates reflect not only the greater prevalence of smoking in this population but also the tendency for persons with substance abuse disorders to start smoking at a younger age, to be more dependent on nicotine, and to be particularly susceptible to certain types of cancer secondary to combined use of tobacco and alcohol (eg, cancers of the head and neck).

Smoking cessation interventions are critical for improving the health and quality of life for persons in treatment for or in recovery from alcohol and other substance use disorders. Unfortunately, such interventions have been underutilized because of a number of individual, organizational, and cultural barriers. There has been much progress over the past several decades in recognizing the importance of treating tobacco addiction in persons with other substance use disorders, yet many of the historical barriers remain entrenched in the attitudes of individuals and in organizational culture. In this article, we provide an overview of the critical issues involved in overcoming personal and organizational barriers to help substance abusers quit smoking. To highlight both the opportunities and the challenges of this work, we include illustrative statements from patients who decided to tackle both addictions at once as part of the Clean Break smoking cessation group at the Cincinnati VA Medical Center. This group is made up of veterans in the residential substance dependence
treatment program who receive combined behavioral and pharmacological treatment. (See Heffner JL et al,7 for a more detailed description of the program and its short-term outcomes.)

The effect of smoking cessation on sobriety

“I heard at AA that you shouldn’t quit everything at the same time. It’s too much of a shock to the system and might make you want to go back to drinking. Also, I really wanted to do some cocaine when I was out on my weekend pass so I thought it was better to do the less dangerous drug. It was either cocaine or smoke.”

Unfortunately, it is not uncommon to hear individuals in substance abuse treatment programs express the belief that smoking cessation would be harmful to sobriety, or conversely, that cigarette smoking facilitates sobriety by reducing urges to use other substances. Although it is tempting to characterize such statements as individual rationalizations to smoke, these attitudes are frequently espoused by treatment providers, mutual support group (eg, Alcoholics Anonymous or Narcotics Anonymous) sponsors, and family members. However, there is little evidence to suggest that smoking cessation has a negative impact on treatment for or recovery from substance use disorders. In fact, an overwhelming majority of studies suggest that smoking cessation interventions either have a positive effect on sobriety or are unrelated to abstinence from alcohol and other substances of abuse.8-10 One well-designed study did detect worse 30-day and 6-month drinking outcomes for individuals who received a smoking cessation intervention during residential substance abuse treatment (ie, concurrent treatment) than for those who received the intervention 6 months later (ie, delayed treatment).11 Nevertheless, the differences in alcohol outcomes observed for delayed treatment compared with concurrent treatment were not consistently significant on all measures of alcohol consumption at all follow-up points.11

In working with patients to address the belief that smoking cessation increases the risk of alcohol and drug relapse, we have found that sharing anecdotal evidence rather than citing research findings tends to be a more powerful motivator to reexamine such beliefs. Thus, learning more about the experiences of fellow smokers in treatment or recovery who have successfully quit smoking can be very helpful.

Group treatment settings that include both current and former smokers provide an invaluable opportunity for interactions that challenge the belief that smoking cessation is harmful to sobriety. In individual treatment settings, smokers might be directly encouraged to seek information from former smokers to “test” the hypothesis that smoking cessation increases the risk of relapse to alcohol and other drug use. This type of strategy, referred to as “collaborative empiricism” in cognitive therapy terms,12 is preferable to confrontation or challenge as a means of promoting attitudinal change in that it tends to strengthen rather than strain the therapeutic alliance, which is critical to the effectiveness of any intervention.

Recognizing and building motivation to quit
"I got to thinking . . . what good is it if I stop drinking and still smoke? Nicotine is a drug, too, right? I figure that while I am in here I might as well try to stop smoking too. If I just do all the things that I do to not pick up a drink, the same things should work for cigarettes."

Another common myth that has impeded the widespread provision of smoking cessation interventions for individuals in substance abuse treatment is the characterization of substance abusers as intractable cigarette smokers who are largely uninterested in quitting. Much like the hypothesis that smoking cessation is harmful to sobriety, this theory has not held up to scientific scrutiny. Numerous studies have found that a significant proportion of substance abusers in treatment are interested in quitting and will take advantage of the opportunity to stop using all drugs of abuse simultaneously.2,13 In fact, we have often heard patients make spontaneous comparisons between tobacco and abuse of other drugs in terms of causes, consequences, and the process of quitting, which is consistent with the goals of integrative treatment for nicotine and other substance dependence.

Nonetheless, there are undoubtedly smokers who are not interested in quitting or who are not ready to quit while they are in a substance abuse treatment program. Brief motivational interventions should be provided for all unmotivated smokers. The Clinical Practice Guideline14 provides a useful mnemonic to guide brief motivational interventions: the “5 R’s.” These are the exploring of Risks of continued smoking; discussing the Relevance (personal reasons that quitting might be important) and Rewards of quitting; identifying and addressing Roadblocks to success; and Repetition of the motivation-enhancing intervention.

As indicated by the last of the 5 Rs, persistent attention to smoking cessation by treatment providers conveys the message that this is an important issue. Repetition also takes into account the dynamic nature of motivation to quit and the possibility that smokers may change their mind about quitting in a few days, weeks, or months.

**Smoking cessation is challenging but achievable**

“Quitting drugs is hard, but quitting smoking is harder. I am really proud of myself for doing this. If I can quit smoking, what else can I do?”

There are a number of reasons smoking cessation may be particularly difficult during early abstinence from alcohol and other substance use. For example, symptoms of nicotine withdrawal may be less tolerable in the context of concurrent withdrawal from other substances. There may also be some reluctance to give up what is sometimes described by patients as the last remaining mechanism for coping with the heightened physical and psychosocial stress that often accompanies early abstinence from alcohol and illicit drugs.

The results of a recent meta-analysis suggest that the quit rates of substance abusers in active treatment who received a smoking cessation intervention were lower than the quit rates in individuals with longer-term sobriety (ie, 12% in active treatment vs 38% in recovery quit with assistance at end of treatment).15 This finding is consistent with the notion of greater difficulty of smoking cessation during early abstinence from alcohol and other drugs.

An important finding from this meta-analysis is that the efficacy of smoking cessation treatment is not different for patients in active treatment than for those in recovery. That is, although the absolute quit rates were higher for individuals in recovery, the effect sizes of the interventions were not significantly different. The relative risk was 1.77 for those in recovery (ie, treatment increased the probability of quitting by 77%) and 2.03 for those in substance abuse treatment (ie, those who received treatment were twice as likely to quit as those who received the control intervention).15 This finding suggests that smoking cessation interventions almost double the likelihood of successful quitting compared with no treatment or placebo treatment, regardless of length of abstinence from alcohol and other drugs.

Lack of effectiveness of traditional smoking cessation approaches is not an acceptable reason to postpone smoking cessation treatment for individuals who are newly abstinent from alcohol and other drugs. In fact, many of these individuals are well-positioned to attempt quitting because they are in a controlled environment where smoking is either restricted or banned. They are also likely to have regularly scheduled contact with providers who can support their efforts to quit. Research also shows that rates of participation in a smoking cessation program are higher when treatment is offered concurrent with addiction treatment as opposed to being delayed until a period of sobriety is attained.11

Although some of the benefits of and barriers to quitting smoking may be different for substance abusers than for smokers without other addictions, the process of quitting remains the same. Interventions found to be effective for the general population of smokers should therefore be offered to smokers with substance use disorders. All smokers should be given at least a brief intervention consistent with the “5 A’s” approach described in the Clinical Practice Guideline (ie, **Ask, Advise, A**
ssess, Assist, and Arrange). For individuals who are ready to quit, combined pharmacological and behavioral interventions are considered to be the gold standard of treatment. An FDA-approved medication to aid cessation (i.e., nicotine replacement therapy, bupropion SR, and varenicline) should be used in combination with individual or group behavioral treatment that offers skill training and support for quitting. The Updated Clinical Practice Guideline suggests that combination nicotine replacement therapy (i.e., a nicotine patch for 14 weeks plus a nicotine spray or gum) is more effective than a patch alone (odds ratio, 1.9; 95% confidence interval, 1.3 - 2.7).

For individuals who are not ready to quit smoking, a brief motivational intervention should be provided. Providers should consistently convey optimism that smoking cessation is both achievable and essential to the drug-free, healthy lifestyle that they are working toward as part of their treatment for substance abuse.

The role of organizational practices

“I went outside with the smokers because I needed some fresh air, and the smell of smoke got to me. I just figured, I might as well smoke and enjoy myself. I don’t know what I’m going to do. I try to stay away from the smokers as much as possible, but it’s hard when everyone here smokes.”

Challenges to successful smoking cessation in substance abuse treatment occur at multiple levels, including individual treatment providers as well as organizations. For example, the treatment environment may reinforce rather than discourage smoking. Group “smoke breaks” and mutual support group meetings where smoking is normative present a powerful environmental trigger to smoke and contribute to relapse. Staff smoking is also problematic in that it has been shown to decrease the probability of encouraging patients to quit smoking almost 6-fold.

Creating an organizational culture that supports smoking cessation is an important task worthy of the time and effort to develop and implement a plan for change. Such a plan might include free smoking cessation medications and counseling for staff; offering staff training in the assessment and treatment of tobacco use disorders as well as alcohol and other substance use disorders; providing information about and access to support meetings that are smoke-free; and restructuring break times so that they do not reinforce social rewards of smoking or the use of nicotine to “self-medicate” negative affect (e.g., encouraging smoke breaks to calm down after a difficult session). Ziedonis and colleagues provide additional suggestions on programmatic changes that can be made to facilitate smoking cessation.

Conclusions

Many individuals in substance abuse treatment are quite willing and able to quit smoking with the assistance of pharmacological and behavioral support. Although absolute quit rates tend to be lower for smokers who are in treatment than for those in recovery from alcohol and other substance use disorders, smoking cessation interventions are effective for both groups and do not appear to increase the risk of relapse to alcohol and other drug use.

Some individual and organizational barriers need to be overcome to improve smoking cessation outcomes among those in substance abuse treatment. However, the available research as well as our own experience suggest that quitting smoking during substance abuse treatment is indeed achievable—in other words, a mission possible.

References:

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