

# Why, When, & How to Help Substance Abusers Stop Smoking

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# “Addressing Tobacco Through Organizational Change”

- ◆ NIDA R01 DA020705-03
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Brigham, G. S., Schroeder, G., & Schindler, E. (2007).  
Addressing smoking in community drug abuse treatment  
programs: Practical and policy considerations. *Journal of  
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# Why Should Community Treatment Programs Consider Smoking Policy?

- ◆ Smoking is a major public health concern and represents the number one preventable cause of death (Stewart & Kleihues, 2003)
- ◆ Individuals with substance use disorders smoke at rates double to triple that of the general public, presenting a heightened risk for negative health outcomes (Batel, Pessione, Maitre, & Rueff, 1995)
- ◆ Many individuals who are successfully treated for drug dependencies will have a substantially reduced quality of life and longevity due to continued smoking (Ziedonis & Williams, 2003; Hurt et al., 1996; Hser, McCarthy & Anglin, 1994)
- ◆ Although adult smoking has declined in recent years, no significant reduction in smoking has occurred in persons with substance use disorders (Kalman, 1998; Mendez, Warner, & Courant, 1998).

# Full Range of Organizational Considerations

- ◆ Employer: Workforce
- ◆ Business: Financial & public relations
- ◆ Healthcare providers
- ◆ Specialty addiction providers:
  - Patients smoke at higher rates
  - Population not responding like general public
  - Unique opportunity to access persons with SUDs; access & opportunity



# Four Areas for Policy Consideration



1. Buildings & grounds
2. Workforce
3. Patient smoking
4. Financial considerations

# Smoking in Buildings and on Program Grounds

- ◆ Ban on Indoor Smoking
- ◆ Regulated Outdoor Smoking
- ◆ Ban Smoking on Grounds
- ◆ Regulating Smoking in Residential Treatment Environments.

# Outdoor Smoking

- ◆ Ban on indoor smoking now required – same as bars
- ◆ Default Position is regulated outdoor smoking
- ◆ Staff may smoke with patients which can normalize the behavior (Ziedonis et al., 2006)
- ◆ Some staff think smoking with patients can be helpful (Walsh et al., 2005)
- ◆ Complicated in residential settings where “smoke breaks” can result in monitored smoking.
- ◆ Further complications include: triggering those trying to quit, relapses to join in camaraderie of breaks.

# Ban Smoking on Grounds

- ◆ Many large organizations have successfully taken this approach (O'Donnel, 2006)
- ◆ Programs worry about financial impact through reduced utilization.
- ◆ With careful planning only temporary dips in census (Rustin, 1998).
- ◆ Residential programs may find it necessary to provide treatment to assist patients with compliance.
- ◆ Providers must make decisions regarding enforcement and consequences for violations (Stuyt et al., 2003).
- ◆ Most report reduction in number of difficulties (Williams et al., 2005).

# Smoking-Related Workforce Issues

- ◆ Why worry about the workforce?
- ◆ Workforce Attitudes
- ◆ Personnel Policy Restrictions on Employee Smoking
- ◆ Impact of Smoking Restrictions on Employee Recruitment

# Why worry about the workforce?

- ◆ Smokers Have 40% higher healthcare costs (Burendregt et al., 1997).
- ◆ Smokers spend 18 days a year on smoke breaks,
- ◆ Smokers are absent from work 26 to 37% more (Smoke Free Oregon, 2003; Halpern et al., 2001).

# Workforce Attitudes

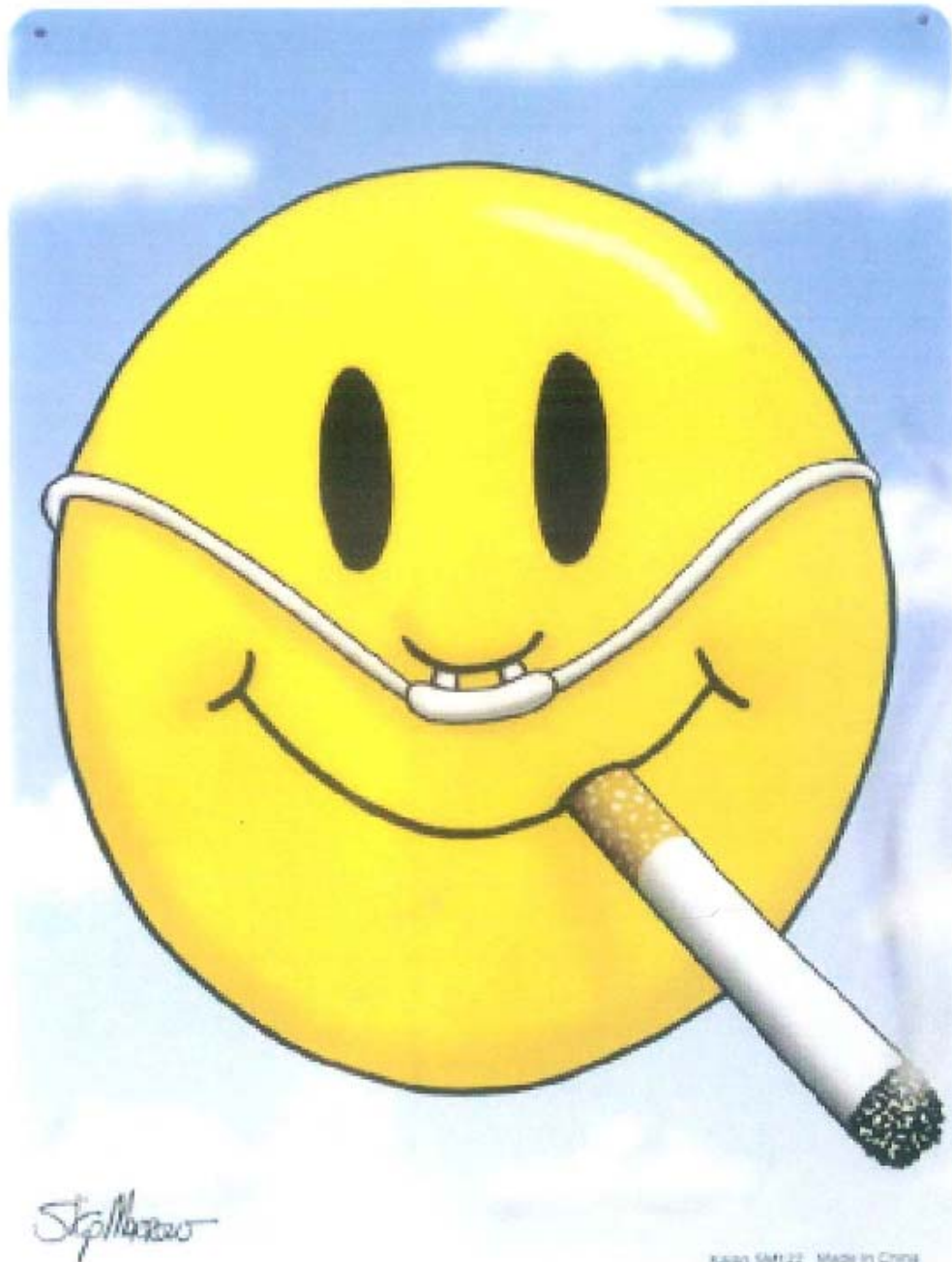
- ◆ Rates of smoking among CTP staff are reported: range of 30 to 40 percent (Bernstein & Stoduto, 1999).
- ◆ Surveys of CTP staff show: smokers are the least supportive of addressing smoking, followed by past smokers and finally non-smokers (Gill, et al., 2000).
- ◆ Professionals who smoke prefer to never address cigarette smoking in their patients (Bobo & Davis, 1993).
- ◆ Good news! Staff attitudes are highly responsive to education.
- ◆ Gill, et al., 2000 found 100% of staff receiving 20 hours or more of annual training were supportive in addressing smoking during SUD treatment.

# Personnel Policy Restrictions on Employee Smoking

- ◆ Employers can and do place restrictions on employee's smoking.
- ◆ A growing amount of legal evidence indicates that smokers do not possess a legal right to smoke (Graff, 2005).
- ◆ It is not difficult from a policy perspective to forbid smoking on company property (O'Donnell, 2006).
- ◆ Employees may be required to not be identifiable as smokers on workplace grounds.
- ◆ Some employees will have great difficulty with smoking cessation and some may ultimately be unable or unwilling.

# Impact of Smoking Restrictions on Employee Recruitment

- ◆ In 2001 76% of workplaces were reported to be smoke-free (Bauer, Hyland, Steger, & Cummings, 2005).
- ◆ An estimated 6000 employers do not hire smokers (Ozols, 2006).
- ◆ Some employers have begun to fire employees for smoking (Brat, 2005).



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# Addressing Patient Smoking

- ◆ **Provider Responsibility for Patient's Health**
- ◆ **The Primary Mission is Substance Abuse Treatment**
- ◆ **Mandatory versus Voluntary Smoking Cessation**
- ◆ **The Role of Patient Choice**

# Provider Responsibility for Patient's Health

- ◆ Most accreditation bodies now require a minimum of assessment and smoke free environments (CARF, JCAHO).
- ◆ Smoking rates general public = 20.5% (CDC, 2006) : Substance abuse populations = 74% to 88% (Sussman, 2002; Richter et al., 2001; Kalman, 1998; Clemmey et al., 1997).
- ◆ Clinical Practice Guidelines for Treating Tobacco Use and Dependence (Fiore, 2000) recommend treatment or motivation to quit.
- ◆ Without direct intervention only about 3% of substance abuse patients will attempt to quit (Prochaska et al., 2004).

# The Primary Mission is Substance Abuse Treatment

- ◆ Some providers worry that treatment of smoking will negatively effect SUD outcomes (Ziedonis et al., 2006).
- ◆ Meta-analysis of 19 RCTs of smoking intervention in substance abuse populations found an increase in likelihood of long term abstinence for alcohol and illicit drugs in groups that receive smoking cessation intervention (Prochaska et al., 2004).

# Mandatory vs. voluntary smoking cessation

- ◆ Requiring all patients to be “smoke free” is controversial.
- ◆ A drug is a drug is a drug!
- ◆ Relapse to tobacco may be considered the same as relapse to other drugs.
- ◆ Goal is abstinence from all drugs.
- ◆ In extreme instances individuals who still smoke may not be considered to be in recovery!

# Opponents of Mandatory Treatment

- ◆ Question providers right to impose health related behaviors on patients, akin to requiring patients to: practice safe sex, reduced dietary fat, eliminate obesity, and wear seat belts – where do you draw the line?
- ◆ No evidence that requiring smoking cessation is effective for smoking.
- ◆ There is some evidence smokers who are not ready to quit have poor outcomes when smoking is prohibited (Haller, 2004).
- ◆ Evidence suggest that staged approaches are more effective (Prochaska et al., 2004).

# Supporters of Mandatory Treatment

- ◆ Nicotine is a drug dependence and it makes no sense to treat one drug and not the other.
- ◆ Nicotine dependence is more likely to cause death than the “drug of choice.”
- ◆ Evidence suggest that it can be implemented without reductions in numbers of smokers entering treatment (Williams et al., 2005)

# What do Patient's Think?

- ◆ Surveys substance abuse patients indicate an overall interest in addressing smoking (Richter et al., 2001; Zullino et al., 2000; Clemmey et al., 1997; Sees & Clark, 1993).
- ◆ Views are not uniform and many worry that it may lead them to relapse (Asher et al., 2003; Stein & Anderson, 2003; Irving et al, 1994).

# Progressive Costs of Treatment

- ◆ No Cost Nicotine Interventions
  - Assessment & referral
- ◆ Low Cost Nicotine Interventions
  - Behavioral treatments
  - Changes in the culture related tobacco
- ◆ Cost of Pharmacological Interventions
  - NRTs are comparable to the cost of cigarettes

# Effective Smoking Cessation Intervention in Substance Abuse Treatment

- ◆ Sequential or staged approaches appear more effective (Prochaska et al, 2004).
- ◆ Prepare smoker for quit attempt.
  - “Smoke Free and Living It” Mayo Clinic
  - Wellness Groups
  - Quitters Groups
  - Quit for Good: <http://www.quitforgoodnow.com>
- ◆ Combination of pharmacological and behavioral interventions.

# Conclusions

- ◆ Smoking represents a major health concern in the SUD population and too little has been done to address smoking in the substance abuse treatment.
- ◆ The call action can easily exceed the evidence available to make good decisions.
- ◆ As best practices continue to emerge they are likely to support a range of treatment options.
- ◆ Progress can be made with existing resources.
- ◆ The biggest barriers to advancing smoking policy are the awareness and attitudes of substance abuse professionals.