- Quitting may be a struggle for consumers and they will likely need more time to work towards their goals. The issue may not be *motivation* to quit but *confidence* that it can be done. Any reduction in cigarettes smoked in a day needs to be recognized as progress. For these reasons, quit dates need to be flexible and goals need to be frequently reevaluated.
- Group sessions can work very well. Consumers support one another in their quit attempts in the group and socially outside the group.
- Support for quitting is improved when the agency has smoke-free policies. Overall support by staff is invaluable to consumers, as is creating a social environment where nonsmoking consumers do not feel marginalized.
- To be successful, the staff in mental health facilities need to be educated, involved, and also helped to quit.

SUBSTANCE USE TREATMENT PROGRAMS

INTRODUCTION: THE SUBSTANCE USE TREATMENT CULTURE

Tobacco dependence is classified as an addiction and is the most common substance use disorder.[77] Even so, tobacco dependence is commonly ignored in substance use treatment programs.[78] Explanations for why this is the case are related to the ways in which the culture of recovery programs has developed and to the attitudes, skills, and knowledge of the staff.[78] The culture of substance use treatment programs typically supports tobacco use and can undermine tobacco dependence treatment. About 30 to 40% of staff in community-based treatment programs are tobacco dependent.[79] Many treatment program staff strongly believe that tobacco is not a "real" drug, that it is not as harmful as other drugs of abuse, and that quitting smoking is too stressful and would jeopardize recovery from other substances.[78]

Increasingly the data are showing otherwise. In a 10-year prospective study of graduates from an inpatient substance use treatment center, tobacco related illnesses caused significantly more deaths than alcohol related causes.[80] The death rate among narcotic addicts who received treatment was fourfold higher among smokers compared to non-smokers.[81] There is also evidence that smoking cessation may help clients already in recovery programs and may protect against relapse to the illicit drug of choice.[82] Alcoholics who quit smoking are more likely to succeed in treatment.[83] Smokers relapse back to alcohol and illicit drugs more often, more frequently and sooner than nonsmokers.[84]

Although the culture of treatment programs and treatment staff are slow to change, they are changing. Addiction treatment specialists are recognizing the importance of addressing mental illness and tobacco use during substance use recovery programs. And, treatment programs are recognizing the importance of assisting their staff members who use tobacco to quit. More training and ongoing supervision of staff is also helping to reinforce the importance of quitting, to address problems, and to build capacity and skills within treatment programs.

The substance use treatment programs that were included in our survey had undergone the cultural change from programs that supported tobacco use to programs that treat tobacco dependence. They all emphasized the importance of directly addressing the cultural and staff issues in order to better integrate effective tobacco dependence treatment into substance use treatment.

INTAKE ASSESSMENT

Tobacco use questions need to be incorporated into the standard substance use intake assessment and follow-up care, whether it is done in person or over the phone. Intake questions for tobacco use follow the same format as questions about other substances: frequency of use, his-

tory of use, current use, time of use, quit attempts, and symptoms of withdrawal. Programs can also use the Fagerström test[68] and take a carbon monoxide reading[1] (with client permission) in their assessment to establish level of dependence.

Readiness to quit needs to be assessed since many clients may not have tried to quit before and may not be prepared to quit now. The categories used to gauge readiness to quit are: 1) not thinking about quitting, 2) not prepared to quit now but thinking about quitting sometime in the next 6 months, 3) thinking about quitting in the next month. From there, the counselor helps the client develop a treatment plan tailored to the client's specific needs and stage of readiness to quit. Some clients may have tried to quit before and will have more experience. These clients may be more ready and prepared to quit when they enter treatment. Many clients will not have tried to quit before and will need more education and preparation before they are ready to quit. See Section 4 for example intake questions and assessments. Clients with substance use disorders and mental illness may need even more time to prepare before attempting to quit.

TREATMENT PLANNING

Clients who use tobacco should be offered tobacco treatment services if they are interested and ready to quit. In smoke-free residential programs, the decision to be abstinent has already been made and tobacco dependence treatment is part of the overall treatment protocol. Including tobacco dependence treatment in the overall treatment plan and providing NRT or other pharmacotherapy to these clients when they first enter treatment is essential.

In outpatient settings, clients make their own decision. If they are interested, tobacco dependence treatment can be integrated into their ongoing treatment plan. Tobacco users can be offered assistance (information, resources, medication, quitline information) depending on their readiness to quit, and encouraged to take advantage of the resources available to them in the community. Treatment providers need to have good knowledge of the free and low-cost resources available in the community and any benefits available through their clients' health plan coverage. Clients who are in recovery, especially those with less functional impairment, will benefit from services offered through tobacco quitlines.

Initial treatment planning needs to cover:

- Education and explanation about tobacco use and dependence.
- Education on specific health and psychosocial implications for smokers with current/past history of substance use disorders (risks of continued smoking, benefits of quitting) to support motivation to quit and increase awareness in committed smokers.
- Withdrawal symptoms that can be anticipated.
- Treatment options (NRT's, prescription medications, cost, availability, and any benefit coverage).
- General health and wellness.
- Identification of support systems (physicians, therapists, friends, family, peers).

If clients are ready to quit tobacco permanently, tobacco treatment is provided concurrent with other treatments. If they are not ready to quit, motivational interviewing can be used to help move clients along the continuum from smoker to ex-smoker.

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[1] The level of toxic carbon monoxide (CO) inhaled from tobacco smoke can be read using a CO monitor. As part of a tobacco cessation program, measurements of carbon monoxide (CO) in expired air may be useful in showing smokers both their exposure to CO and their rapid return to normal CO levels when they stop smoking.[85]

TREATMENT APPROACHES AND FOLLOW-UP

A treatment approach using cognitive behavioral therapy with cessation medications is recommended. Treatment content typically includes:

- Education on tobacco use and dependence (many clients will not be familiar with the harm associated with tobacco use, the benefits of quitting, and nicotine addiction).
- Use of pharmacotherapies to quit.
- Individual counseling to help develop coping skills (other than using substances) for controlling cravings, recognizing triggers, and developing motivation and confidence.
- Group sessions for establishing a network of social support.

For clients with functional impairment, treatment may need to be more flexible with the content provided in smaller steps that can be more easily accomplished. For clients new to quitting and who may have fewer skills, the treatment may need to focus less on setting a specific quit date and more on how to overcome obstacles to quitting. Peer support in groups, important to substance use recovery, can also help clients address common problems in recovery from tobacco dependence and be reassured that they are not alone in their efforts.

Follow-up during recovery helps maintain abstinence. Clients in recovery may continue to attend support groups for longer periods of time than those from a more general population.

CESSATION PHARMACOTHERAPY

Use of pharmacotherapy is strongly recommended for these clients. Medication may be used alone (varenicline or bupropion) and is often used in combination (especially NRT) to suppress withdrawal symptoms. Many of the substance use professionals interviewed recommended higher doses of NRT and regularly used combination medications.

There are a few recommendations for cessation medications for clients recovering from substance use. Bupropion is contraindicated with a history of alcohol abuse. Agitation is a potential side effect of bupropion that substance use treatment providers report can remind clients of the effects of their drug of choice. Some clients may want to avoid use of bupropion to eliminate this potential side effect. For similar reasons some substance use treatment programs avoid recommending nicotine nasal spray for clients recovering from cocaine addiction.

THE ROLE OF SMOKE FREE POLICIES

Smoke-free policies are a significant catalyst for changing the culture of substance use treatment programs and for integrating tobacco dependence treatment. Treatment staff members often are in recovery themselves, and many are still smokers. Smoke-free policies provide support for clients and staff trying to quit and emphasize the important benefits of quitting.

EDUCATIONAL MATERIALS

Educational materials are used in recovery programs more often than in treatment for mental illness. Tobacco users in recovery, often unfamiliar with tobacco use and dependence and how to quit, benefit from learning more about quitting. Because these clients may have previously learned about the mechanism and effects of alcohol and other substances in their recovery program, this background can be readily applied to tobacco.

Many standard tobacco treatment materials are used, depending on the reading level and functional status of the client. Free materials can be obtained from the Centers for Disease Control and Prevention, Office on Smoking and Health. (See Section 4.)

SUMMARY OF PROFESSIONAL ADVICE

- Education is an important first step in motivating clients to consider quitting. Motivational interviewing helps move them through the stages of readiness.
- Many of these clients need more intensive treatment than a quitline can provide.
- It is important that substance use providers believe that their clients can quit smoking and that it is worth the time and resources to take clients from one step to the next.
- A focus on learning coping skills and developing confidence to quit is needed. These clients may lack experience and self-confidence to undertake cessation.
- Aggressive use of medications is often necessary and may be used over a longer period of time. Medications need to be provided at low or no cost, especially for clients without health care benefits.
- Adoption of smoke-free policy at treatment centers helps support cessation together with participation in smoke-free recovery support groups.
- Clients with experience in recovery settings do well in groups.

PRIMARY CARE PROVIDERS

INTRODUCTION

Primary care providers, because they see many patients and care for them over longer periods of time, are on the "front line" of tobacco dependence treatment. Brief treatment (3 minutes or less), outlined in the PHS Clinical Practice Guideline, is designed especially for primary care providers who have limited time. Because it is relatively easy and can reach many tobacco users, the Guideline recommends that all tobacco users receive at least brief treatment from their primary healthcare professionals.[86]

The introduction of tobacco quitlines in all 50 states has helped streamline the delivery of brief treatment into three steps:

- Ask: screen for tobacco use as part of vital signs at each clinic visit.
- Advise: all tobacco users to quit and prescribe/recommend stop smoking medications for those who are ready to set a quit date.
- Refer: tobacco users to a tobacco quitline for follow-up.

Clinical Monitoring Recommendations for Patients with MI/SUD[1,2]

1. Patients should be seen 1-3 days after initiating smoking cessation.

2. Patients should be monitored weekly for the first four weeks for signs of psychotic relapse, onset of depression or depressive symptoms, and the need to change medication levels.

3. After the first month, patients should be reviewed monthly for six months.

4. The primary care provider and the mental health provider should communicate at the beginning of tobacco dependence treatment and then during the cessation period if any psychiatric complications occur.

1 Strasser, K., Moeller-Saxone, K., Hocking, B., Stanton, J., & Kee, P (2002). Smoking cessation in schizophrenia. General practice guidelines. Australian Family Physician, 31, 21-24.

2 Provincial Health Services.(2006). Tobacco reduction in the context of mental illness and addictions: A review of the evidence. Centre for Addiction Research of British Columbia.

PATIENTS WITH MI/SUD

Compared to other tobacco users, tobacco dependence treatment for patients with MI/SUD is more complex. These patients:

- Need more intensive behavioral therapy. More person-to-person contact yields better outcomes.