

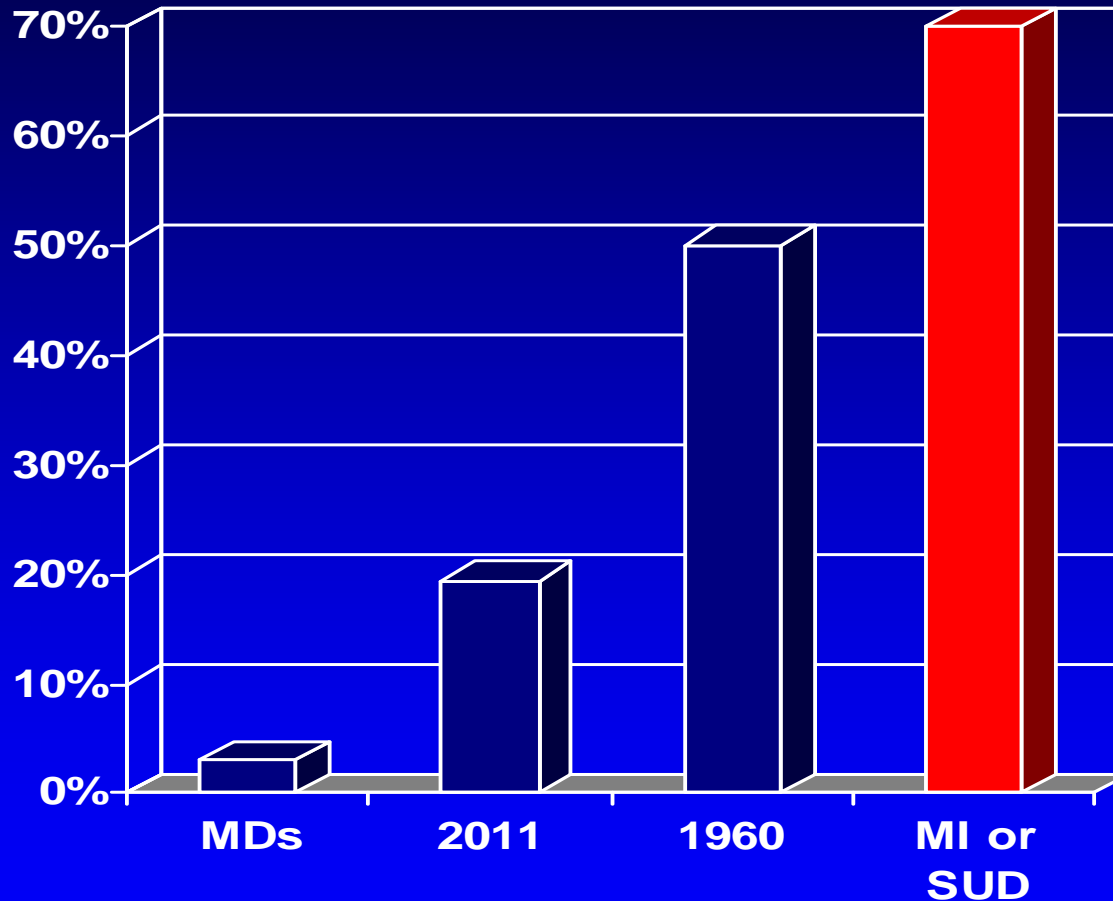
# **The Time is Now for Addressing Tobacco in Addictions Treatment Programs**

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# Smoking Prevalence Rates



■ MDs ■ 2011 ■ 1960 ■ MI or SUD

# Three Fourths of Smokers have a Past or Present Problem with



**Mental Illness**

**or Addiction**

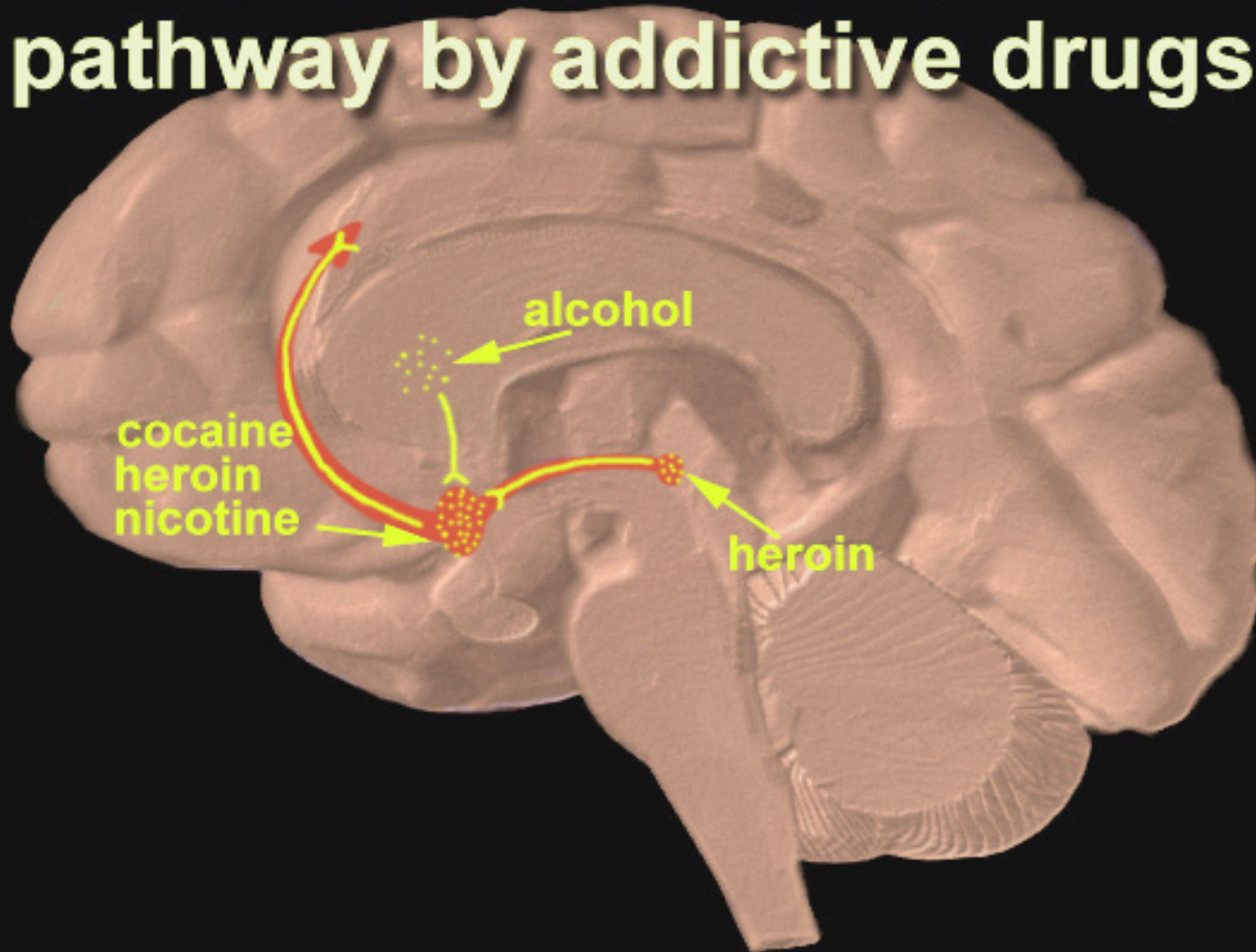


# Rationale Not to Treat Tobacco Dependence in SUD Patients

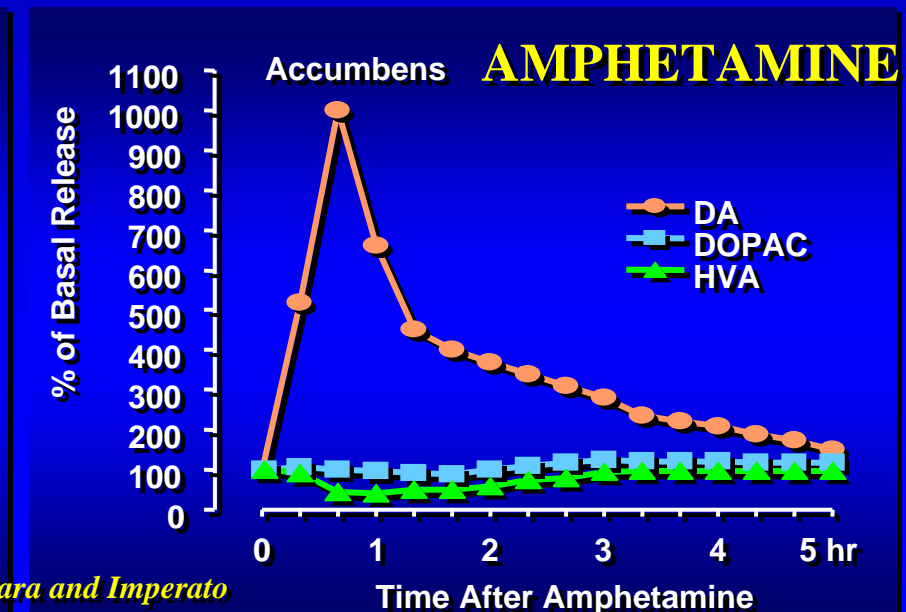
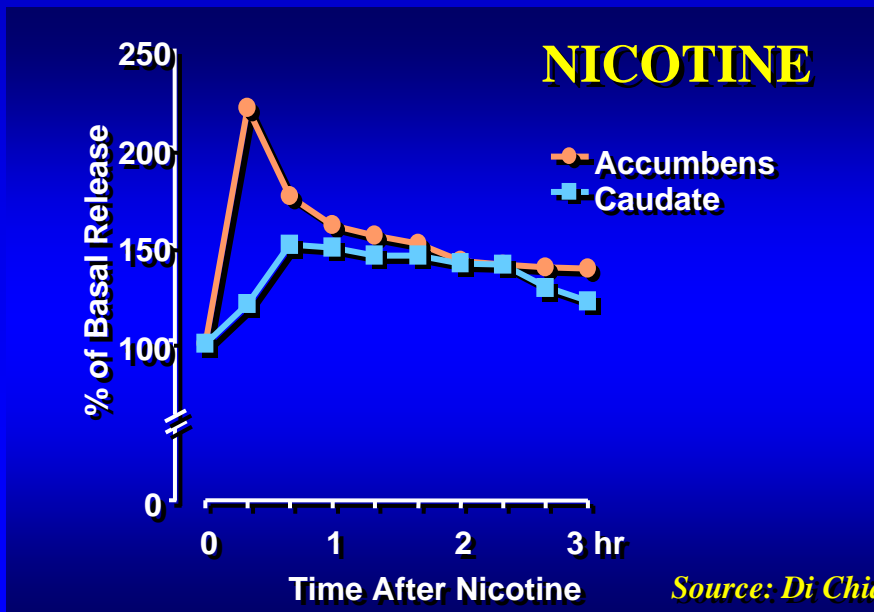
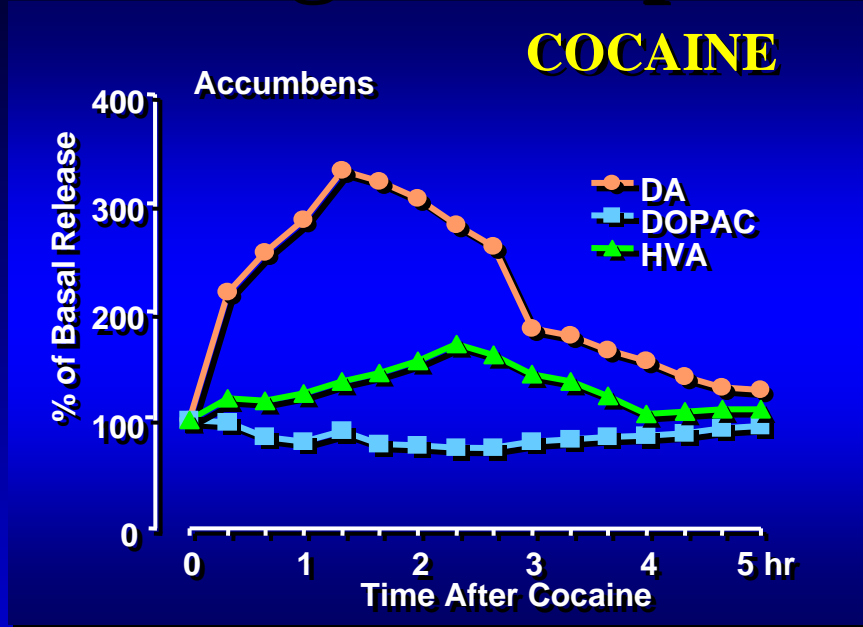
- Not a real drug
- Fewer consequences / Not as disruptive to patients' life
- Disruptive to SUD treatment
- Patients don't want tobacco treatment
- Patients can't quit smoking successfully
- Jeopardizes recovery from other substances

# Not a Real Drug

Activation of the reward pathway by addictive drugs



# Effects of Drugs on Dopamine Levels



Source: Di Chiara and Imperato

# Fewer Consequences; Not Immediate

- More alcoholics die from smoking related diseases than from alcohol related diseases
- Synergistic effects of alcohol and tobacco  
↑ risk of developing pancreatitis and oral cancers
- Smoking reduces recovery from cognitive deficits during alcohol abstinence

Hurt et al, 1996; USDHHS 1982 Durazzo et al, 2007

# Disruptive to SUD Treatment

- No increase in irregular discharges when residential SUD settings went TF(NJ)
- ↑ Clients enrolled in treatment when facility went TF (Kotz et al, 1993)
- Longer LOS when patients enrolled in smoking cessation program (Burling et al., 1991).
- No increase in early discharges (Joseph, 1993).



Did the NJ 2001 implementation of the Tobacco Provisions of the Licensure Standards result in an increase in premature client discharges?

- NO
- There was no increase in irregular discharges.
- Rates were not statistically significant from discharge rates in previous years.
- The rates of irregular discharge were also not statistically significant between smokers and non-smokers.

Williams et al, 2005

# Patients Resistant to Tobacco Treatment

- Two-thirds of smokers wanted to stop (41%) or cut down on tobacco use (24%) at time of admission to residential addictions treatment Williams et al, 2005

- Patients highly interested in treatment and believe inpt treatment is best time

Orleans & Hutchinson, 1993; Shoptaw et al., 2002; Richter et al, 2001; Nahvi, et al, 2006; Sees & Clark, 1993; Clemmey et al, 1997; Frosch et al, 1998; Clarke et al 2001; Joseph et al., 1990; Saxon et al., 1997; Joseph et al., 2002

# Patients with SUD Can't Quit Smoking

- H/o ETOH Just as likely to succeed in quitting smoking as other smokers
- Usual treatments effective
- Smokers learned skills in recovering from alcohol that helped them quit smoking

# Lifetime Quitting

- Smokers with current alcohol problems, were less likely to have quit in their lifetime than smokers with no problems
- ? Fewer quit attempts

Hughes & Kalman, 2006

# Jeopardizes Recovery from other Substances

- Several studies show no adverse effects on abstinence

Bobo et al. 1996, 1998; Hurt et al., 1994; Cornelius et al. 1997, 1999; Prochaska et al. 2004; Lemon et al, 2003; McCarthy et al, 2002; Shoptaw et al., 2002

- Quitting smoking may help with long-term abstinence from alcohol and other drugs

# Tobacco Treatment Availability

- National survey of 550 OSAT units (2004–2005)
  - 88% response rate
- 41% offer smoking cessation counseling or pharmacotherapy
- 38% offer individual/group counseling
- 17% provide quit-smoking medication
- More likely : medically oriented, more comprehensive services, recognize the health burden of smoking

# 2001 NJ Integration of Tobacco Dependence Treatment into Residential Substance Abuse Treatment

- In 1999, NJ established NJAC 8:42A
- Required residential addictions programs
  - To provide tobacco assessment and treatment
  - Prohibited tobacco products on the grounds of facilities.
- Full implementation by Nov 2001.
- The state provided free nicotine patches and gum to clients in these settings
- UMDNJ training and consultation

Did 2001 NJ Licensure Standards produce an increase in the treatment of tobacco dependence in residential addictions treatment?

YES

- **All programs** (n=30; 91% response rate) were providing some tobacco dependence treatment, including assessment, counseling and/or NRT.
- **Many programs** complied with Licensure standards, sent staff for tobacco training, utilized on-site consultation, and provided NRT to clients



How many agencies had tobacco-free grounds after November 15, 2001, when the tobacco-free grounds provisions became effective?

- 73% (22/30) had TF Grounds at some point
- Lack of central enforcement and the concern over reduced admissions were cited as the main reasons programs rescinded TF grounds

Were clients and agencies receptive to the use of nicotine replacement (NRT) during treatment?

YES

- 85% of programs used free NRT
- Patch >> gum
- More than 2326 residential clients received treatment with state-provided NRT (15 mo period)

# History Repeats Itself in NY

## TOBACCO-FREE SERVICES

TITLE 14 NYCRR PART 856Section 856.4

New York State Office of Alcoholism and Substance Abuse  
Services

- (a) Tobacco-free means prohibiting the use of all tobacco products in facilities, on grounds and in vehicles owned or operated by the service subject to this Part.
- (c) Tobacco products include but are not limited to cigarettes, cigars, pipe tobacco, chewing or dipping tobacco.
- (d) Patient means any recipient of services in a facility certified or funded by the Office.

Effective July 24, 2008.



# **Tobacco-Free State Psychiatric Hospitals**

## **NJSA 26:3D-58.1**

**2008**

**BE IT ENACTED** *by the Senate and General Assembly of the State of New Jersey:*

1. a. A publicly-operated residential facility may prohibit smoking on its grounds, if it offers a smoking cessation program for both employees, and residents and patients, as applicable.
- b. The smoking cessation program shall be developed in consultation with the Commissioners of Health and Senior Services and Personnel, and shall be initiated one year prior to prohibiting smoking on its grounds and continue to be offered as long as smoking is prohibited.

**July 8, 2009**

**Ancora and GPPH**

**October 6, 2009**

**TPH, AKFC and Hagedorn**

# Policy for Assessment and Treatment of Tobacco in NJ State Hospitals

- Training for staff
- Assessment (FTND)
- Psychiatrists primary responsibility for tobacco treatment meds
- Pre-printed orders and floor stock (NRT)
- LAHL or other groups
- Tobacco on discharge plan

# Proposed REGS 2011

## NJAC 10:161A-3.11(b)2 Transportation

(a) i. The use of tobacco products, spit tobacco, alcohol or illegal substances is prohibited by employees and clients **in facility vehicles.**

# Proposed REGS 2011

## NJAC 161A-3.129(b) Tobacco products

- (a) Facilities shall immediately comply with the New Jersey Smoke-Free Air Act, P.L. 2005, c. 383, in which the smoking of tobacco products and the use of spit tobacco is prohibited within all buildings.
- (b) The smoking of tobacco products and the use of spit tobacco is prohibited within the facility, on the grounds of the facility, within facility vehicles or when representing the facility.
  1. Compliance with the requirements in this section, governing the prohibition of tobacco products and the use of spit tobacco on the grounds of the facility and in facility vehicles shall begin on **December 12, 2012**

# Proposed REGS 2011

## NJAC 161A-3.5(b) and 161A

### 3.5(b)1, Personnel

- (b) The facility administrator shall establish written policies and procedures addressing the period of time during which staff in recovery are determined to be continuously substance-free (alcohol and/or other drug) before being employed in the facility, and which **address the consequences of employee use of alcohol, tobacco or illegal substances during working hours or when representing the treatment facility.**

The facility shall establish written policies precluding illegal substance, alcohol use and tobacco use, or **showing evidence of use** (for example, paraphernalia, cigarette packs or other tobacco products) within the facility, on the grounds of the facility or when representing the facility.



# Twelve Steps to Addressing Tobacco within Addiction Treatment Programs

1. Acknowledge the Challenge to Address the Barriers and Integrate the Solutions
2. Establish a Leadership Group and Make a Commitment to Change
3. Create a Change Plan and Realistic Implementation Timeline
4. Start with easy program and system changes, including tobacco policies
5. Conduct Staff Training
6. Assess and Document in charts nicotine use, dependence, and prior treatments
7. Incorporate Tobacco Issues into all client education curriculum
8. Provide Medications for Nicotine Dependence Treatment
9. Provide treatment and recovery assistance for interested nicotine dependent staff
10. Integrate Motivation-Based Treatments throughout the program
11. Establish ongoing communication with 12-Step Recovery Groups, Professional Colleagues, and Referral Sources about system changes
12. Consider additional Addressing Tobacco Policies, including Smoke-Free Grounds

# Plan for Services to Help Clients

- Kick off events
  - New Brunswick 11/30/11
  - Newark 12/6/11
- Onsite trainings
- Onsite consultation
- CO meters
- Free NRT (14 day supply)
- Web resources/ online ordering

# Plan for Services to Help Employees

- Personalized and confidential tobacco assessment
  - Onsite or in New Brunswick
- 4 weeks supply free NRT if have assessment
- Referral to Quitline

# **Policy Development and Strategies for Changing Health Systems to Incorporate Tobacco Treatments**

One-day training for Addictions Professionals

**FREE REGISTRATION and CREDITS**

**November 9, 2011**

**New Brunswick, NJ**

[http://ccoe.umdnj.edu/catalog/medical/12MR03\\_DL03.htm](http://ccoe.umdnj.edu/catalog/medical/12MR03_DL03.htm)

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# **RWJMS**

## **Division of Addiction Psychiatry**

We look forward to working with you!

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