Smoking cessation programs in substance abuse treatment facilities: A closer look

Jessica Legge Muilenburg, PhD
The University of Georgia
College of Public Health

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The success of sobriety increases when considering the impact that smoking may have on a person recovering from drug or alcohol abuse (Baca & Yahne, 2008; Prochaska et al., 2004).

However, many smokers, particularly low-income ones, have limited access to EBTs (Evidence-Based Treatments) for smoking (Fagan et al., 2004).
As a consequence, the overall risk of a wide range of co-morbid conditions may be significantly increased, particularly among low-income individuals.
In the AA model individuals are taught that their first and primary responsibility is sobriety.

They are advised to avoid tackling other challenges, such as smoking until they are confident that they can remain sober.

Until recently
Why a Smoking Culture

- This smoking culture is reinforced and maintained by
  - the high rate of smoking among clinicians
    - around 40%
  - the misguided belief that clients are not interested in smoking cessation
  - the belief that smoking is a lesser evil compared to other addictions
  - the unsubstantiated idea that smoking cessation compromises the successful treatment of other addictions

- In fact, treatment planning often includes smoke breaks and designates specific outdoor smoking areas.
57% agreed/strongly agreed with the statement that they “actively provide assistance and support” to staff who desire to quit smoking.

However, in only 40% of these programs do counselors receive health insurance benefits that include coverage for smoking cessation medications and counseling.
Evidence Based Treatments

- According to the recent authoritative Clinical Practice Update (Fiore et al., 2008), commissioned by the U.S. Surgeon General, there is strong evidentiary support for several types of treatment.
- FDA-approved first-line
  - nicotine replacement therapy (patch, gum, lozenge, inhaler, spray),
  - Bupropion, and Varenicline
- Two other pharmacological treatments
  - Nortriptyline and Clonidine
- Second, two types of counseling have a strong empirical basis (Abrams et al., 2004; Fiore et al., 2008)
  - Coping skills
  - Supportive counseling
- Furthermore, the combination of counseling and a pharmacological treatment has been consistently supported in controlled studies.
- Group counseling has also been demonstrated to be efficacious.
- Motivational interviewing
- Additional resources via
  - telephone hotlines, self-help materials, and other community resources, and brief clinician interventions that use the “Five A’s” (Ask, Advise, Assess, Assist, Arrange), are effective.
No single pharmacological approach has been definitively determined to be superior to the others.

- *It is preferable for a treatment facility to provide access to as many types of these treatments as possible* (Brigham et al., 2007; Fiore et al., 2008).
Methods (Program Administrators)

- As part of a larger NIDA-funded research project, longitudinal data were collected from in-depth telephone interviews administered to 1005 program administrators. The substance abuse treatment facilities were randomly selected using the SAMHSA database. Counselors employed in public and private treatment centers located throughout the United States.

- These facilities were selected using the Substance Abuse and Mental Health Services Administration (SAMHSA) database which represents a diverse cross-section of addiction treatment programs.

- Data reported are from Year 1 and Year 2 of data collection.
  - Average age 45.15
  - 69% are female
  - 6.5% identified as Hispanic
  - The respondents are overwhelmingly Caucasian (76.7%)
    - African American (15.2%)
    - Asian, American Indian or Alaskan Native, Native Hawaiian or Other Pacific Islander and Multi-racial composing 7.1% of respondents
Methods (Counselors)

- 997 counselors employed in public and private treatment centers located throughout the United States. These facilities were selected using the Substance Abuse and Mental Health Services Administration (SAMHSA) database which represents a diverse cross-section of addiction treatment programs.

- Data reported are from Year 1 and Year 2 of data collection.
  - Average age 45.12
  - 69.4% are female
  - 7.2% identified as Hispanic
  - The respondents are overwhelmingly Caucasian (78.4%)
    - African American (13.3%)
    - Asian, American Indian or Alaskan Native, Native Hawaiian or Other Pacific Islander and Multi-racial composing 8.3% of respondents
Counselors who assist patients in quitting smoking

Yes 47%

No 53%
## What is available (Program Administrators)

### Behavioral Methods

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide self-help materials</td>
<td>76.9%</td>
</tr>
<tr>
<td>Have additional community resource referrals</td>
<td>72.7%</td>
</tr>
<tr>
<td>Provide individual counseling that focuses on problem solving/skills training</td>
<td>38.3%</td>
</tr>
<tr>
<td>Offer individual counseling that focuses on social support</td>
<td>37.5%</td>
</tr>
<tr>
<td>Use specific motivational interviewing techniques to enhance motivation for smoking cessation</td>
<td>37.4%</td>
</tr>
<tr>
<td>Has four or more individual counseling sessions available.</td>
<td>32.1%</td>
</tr>
<tr>
<td>At admissions implement brief counselor interventions. “The Five A’s”</td>
<td>30.5%</td>
</tr>
<tr>
<td>Offer group counseling</td>
<td>29.4%</td>
</tr>
<tr>
<td>Provide combined counseling and medication treatment</td>
<td>22.5%</td>
</tr>
<tr>
<td>Provide telephone counseling/quitline support</td>
<td>16.2%</td>
</tr>
<tr>
<td>Use contingent reinforcement (specific rewards for not smoking)</td>
<td>14.8%</td>
</tr>
</tbody>
</table>
What is available (Program Administers)

<table>
<thead>
<tr>
<th>Pharmacological Methods/ Nicotine Replacement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicotine Patch</td>
<td>24.2%</td>
</tr>
<tr>
<td>Nicotine Gum</td>
<td>17.5%</td>
</tr>
<tr>
<td>Bupropion</td>
<td>16.3%</td>
</tr>
<tr>
<td>Varenicline</td>
<td>12.5%</td>
</tr>
<tr>
<td>Nicotine Lozenge</td>
<td>10.4%</td>
</tr>
<tr>
<td>Clonidine</td>
<td>6.7%</td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>5.0%</td>
</tr>
<tr>
<td>Nicotine Inhaler</td>
<td>3.7%</td>
</tr>
<tr>
<td>Nicotine Nasal Spray</td>
<td>2.9%</td>
</tr>
</tbody>
</table>
Treatment Facilities Offering Evidence Based Treatments (EBTs)

Yes: 38%
No: 62%
How often are methods being used?

- Nicotine Patch: 41.0
- Nicotine Gum: 25.7
- Nicotine Lozenge: 15.8
- Nicotine Inhaler: 5.7
- Nicotine Nasal Spray: 3.9
How often are methods being used?

- Bupropion: 31.7%
- Varenicline: 21.1%
- Clonidine: 13.9%
- Nortriptyline: 7.5%
How often are methods being used?

- Ask if patients currently smoke: 85.5%
- Assess patient willingness to quit: 62.5%
- Advise patients to quit smoking: 45.6%
- Assist in quitting by developing a quit plan or arranging for counseling for smoking cessation: 44.8%
How often are methods being used?

- Provide individual counseling that focuses on problem solving/skills training: 71.8
- Have additional community resource referrals specifically for smoking cessation: 69.4
- Provide self-help materials specifically for smoking cessation: 64.4
- Offer individual counseling that focuses on social support specifically for smoking cessation: 63.5
Treatment facilities that permit smoking

- Yes: 61.3%
- No: 38.7%
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Do Not Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all Smokers Identified at Intake?</td>
<td>79.9%</td>
<td>19.5%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Do you Provide Counselor Training on Smoking Cessation Treatments?</td>
<td>30.9%</td>
<td>68.7%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Do you Provide Counselor Resources for Smoking Cessation Treatments?</td>
<td>51.2%</td>
<td>48.5%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Is Clinical Supervision Provided on Smoking Cessation Treatments?</td>
<td>26.0%</td>
<td>74.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Do you Assess Smoking Cessation Treatment in Staff Performance Evaluations?</td>
<td>8.3%</td>
<td>91.0%</td>
<td>0.7%</td>
</tr>
</tbody>
</table>
Extent that Financial Resources for Smoking Cessation Exist in Substance Abuse Treatment Programs

- Not at all: 63.3%
- To a very limited extent: 20.1%
- To some extent: 12.1%
- To a great extent: 4.6%
Financial barriers

- PAs who report no or little existence of financial resources for smoking cessation in their programs are more likely to AGREE that:
  - **staff does not have the skills** to provide smoking cessation treatments to patients \((p<0.001)\).
  - **staff does not have interest** in providing smoking cessation to patients \((p=0.001)\).
  - **smoking and tobacco use are not important issues in the successful treatment of other substance abuse problems** \((p<0.001)\).
Conclusions

- Over 83% of program administrators reported that no or very limited financial resources exist within their treatment programs to support smoking cessation.
- It is important to continue investigating this topic because allocation of resources to smoking cessation programs may increase treatment of this addiction in patients being treated for other substance addictions.
Conclusions

- Smoking effects disproportionately impacts
  - Lower SES
  - People of color
  - Users of drugs and alcohol

- Access to services?
- Access to patients in need?
- Increase in sobriety?
Wrap up

- EBTs for smoking in substance abuse hindered by
  - lack of clinician knowledge and training on how to effectively treat smoking (Guydish et al., 2007; Kurita & Guydish, 2007)
  - the belief that treating smoking behavior reduces the likelihood of sobriety (Guydish et al., 2007).

- And limits on receiving reimbursement for the treatment of smoking (Fuller et al., 2007; Knapp et al., 1993; Kurita & Guydish, 2007 McCool et al., 2005; Ziedonis et al., 2006).
Patients seeking drug treatment are interested in quitting smoking (Bobo et al., 1996; Richter et al., 2005; Clarke et al., 2001).

Smoking cessation into substance abuse treatment does not negatively affect treatment for the primary substance of abuse and it might actually increase treatment success (Baca & Yahne, 2008; Prochaska et al., 2004).
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