OPINION

Counselors in Glass Houses

By Janis Dauer, MS, CSAC

An item in the January 21, 2014 edition of NAADAC's *Addiction & Recovery eNews* titled "Most U.S. Doctors Fail to Discuss Alcohol with Patients" linked to a news story about a study showing that doctors aren't asking patients about their alcohol use like they should be (NAADAC, 2014). Numerous valid points were made and no doubt many addiction counselors agreed with them, but this old adage came to mind as I read it: "People in glass houses shouldn't throw stones." Before addiction treatment professionals point their fingers at a perceived gap in primary care providers' services, perhaps we should look at ourselves and assess the situation with regards to the Axis I substance use disorder most often left untreated in our programs: nicotine dependence.

"[S]urely clinicians and programs that specialize in addiction treatment should be addressing tobacco use disorder just like alcohol and other drug use disorders…No other substance use disorder is identified (diagnosed) and then ignored by our field"

If we feel physicians should screen patients for alcohol use because 38 million American adults drink excessively, about 88,000 people in the United States die each year because of drinking too much, and yet only one in six adults discuss drinking with their doctor (Beasley, 2014)—surely addiction counselors ought to be screening every client for tobacco use and dependence. In the United States, over 440,000 tobacco-caused deaths occur annually and a hugely disproportionate percent of those are people with substance abuse and mental health disorders (Schroeder & Morris, 2010). National data on how many SA/MH treatment providers assess tobacco use disorder and address it as an Axis I primary substance use disorder, which is the appropriate service for these behavioral healthcare settings, is not even available. There simply is no data collection tool that asks about this service.

If we feel primary care practices need to change and make alcohol use screening part of routine care in the same way they screen for high blood pressure and high cholesterol, surely clinicians and programs that specialize in addiction treatment should be addressing tobacco use disorder just like alcohol and other drug use disorders. Not as a risk factor for health problems, not just in our prevention programs but throughout the treatment continuum. No other substance use disorder is identified (diagnosed) and then ignored by our field.

Doctors often say they are too busy to screen patients for alcohol abuse and may view treatment options as ineffective. They frequently do not feel they have the training needed to effectively discuss alcohol or drug abuse and believe most patients are not interested in counseling (Beasley, 2014). Sadly, addiction counselors often make the same statements about tobacco use among their client population, in spite of the fact that treatment of substance use disorders is actually their specialty. Who is better trained and qualified to assess dependence to a drug, to effectively work with people not ready to totally abstain from use yet, to approach addiction as a chronic disease in which relapse is common and recovery takes time, and to provide individualized assistance?

If addiction treatment providers screen, assess motivation, and provide an appropriate counseling intervention (e.g., Motivational Interviewing or Cognitive-Behavioral Therapy) or at a minimum do an Screening, Brief Intervention, and Referral to Treatment (SBIRT) intervention and refer to a local Tobacco Treatment Specialist or trained Quitline Coach, this could result in a substantial reduction in tobacco use and increase in tobacco recovery among their client population. Instead, skills addiction providers possess are not applied and while clients are helped to recover from their other addictions, they are left to get sick and die prematurely from the drug use that kills more of them than all the others combined.

I hope this opinion piece will generate interest in discussion about the professional responsibilities of addiction counselors to provide comprehensive treatment services that address all drug use disorders with clients admitted to their programs for any substance use disorder or co-occurring disorder, including tobacco. The concept of parity should apply here, too. While it may not be possible to admit people into treatment who only have a tobacco use disorder, there is no valid reason for the addiction treatment field to be ignoring the DSM diagnostic code 305.1 when fully aware of which clients have this substance use disorder.

Is the program staff at your facility screening for nicotine dependence? Ask staff or check some charts—what percentage of clients are being counseled about tobacco use and nicotine dependence? I hope NAADAC will provide continuing leadership in advocating for full integration of treatment for tobacco use disorder into SUD/MH services provided by its members and the field in general. But change can begin with you.

For an excellent source of training tailored to addiction counselors, go to the Tobacco Recovery Resource Exchange at www.tobaccorecovery.org. You may be surprised to find out how capable you already are and realize you only need to begin using your skills.

REFERENCES

Beasley, D. (2014, January 7). Most US doctors fail to discuss alcohol with patients: study. *Reuters US*. Retrieved from: http://www.reuters.com/article/2014/01/07/us-usa-health-alcohol-idUSBREA0612320140107.

NAADAC, the Association for Addiction Professionals. (2014, January 21). Most U.S. Doctors Fail to Discuss Alcohol with Patients. *Addiction & Recovery eNews*. Retrieved from: http://naadac.informz.net/InformzDataService/OnlineVersion/Public?mailingInstanceId=2962258.

Schroeder, S. A. & Morris, C. D. (2010) Confronting a Neglected Epidemic: Tobacco Cessation for Persons with Mental Illnesses and Substance Abuse Problems. *Annu. Rev. Public Health, 31*, 297–314.

Janis Dauer, MS, CSAC, is the Executive Director of the Alliance for the Prevention and Treatment of Nicotine Addiction, where she provides consultation, training, and program management services in the areas of nicotine addiction treatment, tobacco use policy development and implementation, smoking cessation clinical services, and medical practice guidelines. Previously, she was a Field Coordinator and Trainer for the VDH Tobacco Use Control Project, and has 10 years of experience as a substance abuse Program Coordinator, Clinical Supervisor, and Counselor. Ms. Dauer presented on nicotine addiction treatment, tobacco-free policy, smoking cessation, and healthcare provider training throughout the United States. Ms. Dauer has a B.S. in Psychology and an MSEd in Counseling from Old Dominion University. She is a member of the Association for the Treatment of Tobacco Use and Dependence, the Society for Research on Nicotine and Tobacco and the North American Quitline Consortium.