

TACKLING ONE OF THE TOUGHEST ADDICTIONS: NICOTINE

What can we do to help clients quit?

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Over the past two decades, attention has been focused on clients who have two or more behavioral health problems. Programs routinely provide services to meet the treatment needs of clients who have both substance use and mental health disorders. Less attention has been paid to clients who along with other behavioral health problems are also addicted to nicotine.

Smoking Kills — Especially People with Other Behavioral Health Problems

Despite declines in the prevalence of cigarette smoking among adults, prevalence remains high among certain subpopulations, particularly persons with behavioral health disorders.¹ People with substance use and/or mental health disorders have a substantially greater likelihood of also having tobacco use disorder. They have rates two- to four-fold higher than the general population.² Half of the people with a behavioral health disorder also have a tobacco use disorder. They are twice as likely to smoke as the general population, and those who smoke tend to smoke more heavily. Adults with behavioral health disorders represent 25 percent of adults but consume 40 percent or more of all cigarettes smoked by adults.³ Smoking-related illnesses cause half of all deaths among people with behavioral health disorders.

Challenges to Quitting Nicotine

As is true of all people with nicotine addiction, clients who also have behavioral health disorders experience challenges and barriers to quit. Many fear cravings and withdrawal symptoms, such as poor concentration, restlessness, depressed mood, tension, irritability, and insomnia. Others, especially women, view increased appetite and possible weight gain as barriers. Many clients who want to quit view the lack of enjoyment of smoking as a barrier. But probably the biggest challenge is that smoking cigarettes is a form of self-medication: clients feel that it reduces stress and anxiety, and makes them feel better.

Debunking Myths

Research demonstrates that nicotine is a strongly reinforcing drug that temporarily improves concentration and attention. However, nicotine has been shown to be ineffective as a treatment for mental disorders or symptoms.⁴ People with behavioral health problems have quit

rates and rates of interest in quitting that are similar to persons without behavioral health problems and they want information about quitting.^{5,6,7} Studies show that approximately 70 percent of mentally ill smokers want to quit.⁸ Among this group, quit rates and readiness to quit are unrelated to the diagnosis, severity, or coexistence of substance use.⁹ While challenging, research demonstrates that smoking cessation among this group is effective—often better than the general population, especially when treatment is tailored.^{10,11,12}

Tobacco Cessation Does Not Interfere with Recovery

Evidence demonstrates that tobacco cessation does not interfere with recovery from mental illness or lead to increased substance use.¹³ Indeed, smoking cessation during substance abuse treatment appears to protect against relapse and enhance rather than compromise long-term sobriety.^{14,15,16} In other words, clients can successfully quit smoking at the same time they are quitting other drugs and/or alcohol.

Relationship Between Smoking and Behavioral Health Problems

Evidence is emerging that genetic, familial, and psychological factors have a role in higher smoking rates among people with behavioral health problems. Research is suggesting and exploring: (1) shared genetic factors that promote vulnerability to tobacco use disorders and behavioral health disorders, (2) self-medication of clinical symptoms, medication side effects, and cognitive deficits associated with behavioral health disorders, and (3) common environmental factors such as stress that can promote smoking behavior and mental health symptoms.^{17,18}

Treatment Approaches

Research demonstrates that there are effective treatments for tobacco use disorder. There are three broad categories of treatment approaches for tobacco use disorder. These are counseling, nicotine replacement, and medications. The approaches below have been approved as being safe and effective in treating tobacco use disorders.

Counseling and Therapy.

Counseling and therapy have an integral role in smoking cessation treatment, typically in conjunction with medication. These teach clients to recognize high-risk situations, develop coping strategies, manage stress, improve problem solving skills, and increase social support.

■ *Individual and Group Therapy.* Cognitive-behavioral counseling and therapy, as well as mo-



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tivational interviewing with multiple sessions of individual or group counseling can promote smoking cessation. Three types of counseling and therapy approaches have been shown to promote higher abstinence rates. These include (1) providing smokers with problem-solving and skills training, such as avoiding high-risk situations and identifying personal triggers, (2) providing social support as a component of the treatment program, and (3) assisting smokers to obtain social support outside of the treatment program.

- **Telephone Quitlines and Counseling.** Research suggests that proactive telephone counseling helps smokers who seek help from quitlines. Telephone quitlines are an important way for smokers to obtain support, and call-back counseling improves their usefulness. Three or more phone calls increases the chances of quitting compared to a minimal intervention such as self-help materials, brief advice, or pharmacotherapy alone. Each state has a quit line, and some have more than one. Call 800-QUIT-NOW (800-784-8669) to identify options in your state.

Nicotine Replacement Therapy.

Nicotine Replacement Therapy (NRT) can take the form of a nicotine replacement patch, gum, lozenge, nasal spray, and inhaler. NRTs relieve withdrawal symptoms and cravings. NRTs can be used short term or long term and some require a medical prescription. They produce less severe physiological alterations than tobacco-based systems and generally provide users with lower overall nicotine levels than they receive with tobacco. Behavioral treatments have been shown to enhance the effectiveness of NRTs and improve long-term outcomes.

- **Nicotine Patch.** Nicotine patches, such as NicoDerm and Habitrol, delivers nicotine through skin and into the bloodstream. A new patch is worn each day. For clients who are not able to stop smoking after 2 to 3 weeks or so of nicotine patch treatment, work with their physician for help to adjust the dose of the patch or adding another medication.
- **Nicotine Gum.** Nicotine gum, such as Nicorette, delivers nicotine to the blood system through the lining of the mouth. It is available in a 2mg dose for regular smokers and a 4mg dose for heavy smokers. Nicotine gum provides many smokers with the desired control over dosage and the ability to diminish cravings. However, some people cannot tolerate the taste and the “chewing and parking” approach to allow nicotine to be gradually absorbed into the bloodstream.
- **Nicotine Lozenge.** The nicotine lozenge, such as Commit or Nicorette mini-lozenge, dissolves in the mouth and delivers nicotine through the lining of the mouth. The lozenges are available in a 2mg dose for regular smokers and a 4mg dose for heavy smokers. Teach clients to place the lozenge between the gumline and check or under the tongue and let it dissolve. Users generally begin with one lozenge every 1 to 2 hours and gradually increase the time between lozenges. Nicotine lozenges require a prescription.
- **Nicotine Nasal Spray.** Nicotine nasal sprays, such as Nicotrol NS, are sprayed into each nostril, and is absorbed through the nasal membranes into the blood vessels. The nasal spray delivers nicotine more rapidly than lozenges, gum, or the patch, but not as rapidly as smoking a cigarette. Some users experience nasal irritation.
- **Nicotine Inhalers.** The nicotine inhaler, such as Nicotrol, is shaped somewhat like a cigarette holder. Users puff on the inhaler and it delivers nicotine vapors into their mouth. The nicotine is absorbed through the lining of the mouth and then enters the bloodstream. Some users experience mouth or throat irritation.
- **E-cigarettes as Potential Quit Tools.** E-cigarettes deliver nicotine and mitigate nicotine withdrawal. As a result, e-cigarettes are used by many smokers to help their quit attempts. Also, smokers with no intent to quit tend to smoke less after switching to e-cigarettes. It is possible that e-cigarettes may emerge as a clinical tool to help certain people in certain situations cut back or quit. At this point in time, there is emerging but insufficient evidence regarding the effectiveness of e-cigarettes for quit attempts and reducing smoking, and regarding the safety of e-cigarettes.¹⁹

Medications.

A few non-nicotine medications have been approved by the FDA for tobacco use disorder, which are described below.

- **Bupropion.** Marketed as Zyban and other names, bupropion is an antidepressant medication that increases levels of dopamine and norepinephrine, two neurotransmitters that are also increased by nicotine. It reduces nicotine cravings and withdrawal symptoms. A

Questions to consider while reading this article

What are the 5As that the Surgeon General recommends counselors use with every person who uses tobacco and has shown a willingness to quit?

Studies show that approximately what percentage of mentally ill smokers want to quit?

What are some Nicotine Replacement Therapies (NRTs)?

What are the broad categories of treatment approaches for tobacco use disorder?

Like other addictions, tobacco use disorder is what kind of illness?

Do people with substance use and/or mental health disorders have a greater likelihood of also having tobacco use disorder?

Smoking-related illnesses cause what number of all deaths among people with behavioral health disorders?

Which non-nicotine medications mentioned in the article that have been approved by the FDA for tobacco use disorder?

How does Varenicline, marketed as Chantix, work?

Recognizing the importance for counselors to enhance their knowledge of tobacco addiction and develop skills and strategies for tobacco addiction counseling, NAADAC developed a certification for what?

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typical treatment course lasts for seven to 12 weeks, with clients stopping smoking within approximately 10 days. Bupropion may be prescribed along with a nicotine patch.

- **Varenicline.** Marketed as Chantix, varenicline tartrate is a nicotinic receptor partial agonist. It stimulates nicotine receptors but more weakly than nicotine. As a partial agonist, it both reduces cravings for and decreases the pleasurable effects of tobacco products. The FDA has approved the use of varenicline for up to 12 weeks. If smoking cessation is achieved,

it may be continued for another 12 weeks. Clients are normally advised to begin varenicline 1 week before stopping smoking.

- **Nortriptyline.** This tricyclic antidepressant, marketed as Pamelor, has been shown to reduce withdrawal symptoms and smokers stop. It increases the levels of the brain neurotransmitter norepinephrine, one of the neurochemicals increased by nicotine. It is considered a second-line approach and usually recommended if other medications are not effective.

Medication Combinations.

Research suggests that cessation rates are higher when two medications are used compared to one medication at a time.^{20,21,22} For this reason, the Department of Health and Human Services suggests such combinations as nicotine patch with the nicotine gum, lozenge, nasal spray or inhaler; or the nicotine patch plus bupropion.²³

Medication Plus Counseling.

Research demonstrates that nicotine-cessation medication, including NRT, bupropion, and varenicline can help people quit smoking. Research has also examined how much additional benefit is obtained by providing medication plus behavioral approaches, such as counseling and telephone quitlines. Research demonstrates that combining counseling and medication is more effective for smoking cessation than either medication or counseling alone.²⁴

Mutual Support Self-Help Groups.

Nicotine Anonymous and Smokers Anonymous are examples of mutual support, self-help groups that are based on the 12-Step Program developed by Alcoholics Anonymous to help people stop smoking. They provide caring support and practical experience for people who wish to live without nicotine. They can and should be part of the recovery plan for clients who wish to stop smoking or using tobacco.

Does Health Care Reform Impact Smoking Cessation Programs?

The recent Patient Protection and Affordable Care Act of 2010 addresses disease prevention, including tobacco cessation programs. The health care reform requires private group and individual health plans created since March 2010 to cover all recommended preventive services, including smoking cessation, without cost-sharing. Tobacco cessation services are covered, although the government has not defined which treatment medications and therapies are included. Currently, insurance plans have significant flexibility to meet this requirement.

The Mental Health Parity and Addiction Equity Act requires plans to determine which substance use disorders are covered under the plan as long as it complies with state and federal laws and consistent with standards of medical practice. Tobacco use disorder is listed as a mental health diagnosis in the DSM-5. Thus, if a group health plan provides tobacco cessation benefits, they are subject to the parity requirements and must be substantially equivalent to medical and surgical benefits.

Does Medicaid Cover Tobacco Cessation?

Health care reform includes new coverage under Medicaid to help beneficiaries quit smoking. All state Medicaid programs must provide a comprehensive cessation benefit for pregnant women with no patient cost-sharing. Also, State Medicaid programs that voluntarily cover all recommended prevention services, including smoking cessation, will receive increased federal reimbursements. Beginning January 1, 2014, state Medicaid programs will no longer be able to exclude smok-

ing cessation medications from their prescription drug coverage. For a list of CPT, & ICD-9 Codes related to tobacco cessation counseling, click on the Ask and Act practice toolkit at www.askandact.org.

What Can Programs Do?

Treatment programs can implement a group-based cognitive behavioral psycho-education smoking cessation program. We recommend a group format consisting of approximately eight to 10 clients lasting seven to 12 weeks. Sessions would address prevalence of tobacco use, the properties of nicotine, the health effects of tobacco use, and the addictive properties of nicotine. Sessions would help clients explore the reasons why people and they smoke. Importantly, sessions must teach clients how to quit smoking, medications used for cessation, and how to develop a quit plan. Relapse prevention sessions should teach about internal, external, and sensory triggers; how to defuse triggers; and how to avoid triggers.

Pack Up & Quit. For the Center for Substance Abuse Treatment, Danya developed *Pack Up & Quit*, a smoking cessation program for clients in recovery from opioid dependence. The program provides the staff of opioid treatment programs with a rich training experience and set of client curriculum so that they can introduce a tobacco-free program to smokers in their clinics. *Pack Up & Quit* is based on the Stages of Change Model, adult learning principles, and the recognition of the smoker's central role in his or her success. Danya developed a Trainer's Guide, a treatment program curriculum, and a toolkit. Danya will soon complete the pilot training and education and will implement the tobacco cessation around the country.

Review and Modify Intake Assessments. Review your intake assessments. Ensure that they include standard questions to screen for tobacco use. These questions should assess tobacco use status by asking about current use. Ask about the type of tobacco product, how much used, how often used, and when. Ask about clients' history of use, prior quit attempts, and level of dependence using the Fagerström Test for Nicotine Dependence scale.²⁵ Ask about clients' interest in quitting. Act on this information and offer treatment services that are tailored to clients' needs. Repeat tobacco-related assessments throughout the course of treatment.

Tailor Treatment Services Based on Assessments. Tailor behavioral and pharmacological services to the specific needs of clients and their functional level. Use assessments to determine current functional status and stability. Specifically, smoking cessation is most likely when clients are functioning adequately, able to participate in treatment, ready to quit and motivated, and are medically stable regarding their overall medications. Such clients require less tailored services. Less functionally stable clients need greater tailoring and coordinated treatment management.

Use the 5As as an Initial Intervention. The Surgeon General recommends counselors use the 5As with every person who uses tobacco and who shows a willingness to quit. These have been shown to increase quit rates in primary care settings and are appropriate for behavioral health treatment settings.

- **Ask**—clients about their nicotine use and document this information in their chart—Tell me about your tobacco use over the past week.
- **Advise**—clients to quit in a strong, direct, personal, and yet empathic message—As a young mom, quitting now will really help your baby.

- **Assess**—clients willingness to make a quit attempt and consider using motivational interventions for those with low motivation and assist clients who seem ready to quit—On a scale of 10, how willing are you to quit?
- **Assist**—quit attempts through counseling, setting quit dates, reviewing challenges, recommending pharmacotherapies, and reviewing psychological treatments—Let me help you make a quit plan. Can we start now?
- **Arrange Follow-up**—to enhance clients' motivation, support successes, manage relapses, and assess the use and need for medications and psychological treatments—Let's make a follow-up appointment within a week of your quit date. Good job — keep it up!

Use an Integrated, Holistic Approach. Like other addictions, tobacco use disorder is a bio-psycho-social-spiritual disorder. Thus, both treatment and recovery should address the biological, psychological, social and familial, and spiritual needs of clients, use an approach that is multicomponent, integrated, and holistic, such as *Living In Balance: Moving from a Life of Addiction to a Life of Recovery*.²⁶ Begin with solid and comprehensive screening and assessments. With this information, develop a tailored treatment plan with behavioral and pharmacological services to meet the specific needs of your clients and their functional level. Promote a holistic recovery by encouraging the use of exercise, meditation, visualization exercises, yoga, and spiritual exercises and activities.²⁷

Become or Work with a Nicotine Dependence Specialist. NAADAC recognizes the importance for counselors to enhance their knowledge of tobacco addiction and develop skills and strategies for tobacco addiction counseling. For this reason, NAADAC developed certification for a Nicotine Dependence Specialist. Doing so, NAADAC is promoting competency in nicotine dependence treatment by promoting the recognition of nicotine dependence specialist, providing a national standard for nicotine dependence treatment, and establishing and monitoring the knowledge required for certification in this area. More information can be found at www.naadac.org regarding eligibility and application requirements, cost, examination details and schedule, and test preparation materials.

Stay Informed. Become and remained informed about issues and approaches related to clients with behavioral health and tobacco use disorders. Review the Toolkit Resources box below. Attend trainings and conferences to remain engaged on relevant issues. For instance, the Central East Addiction Technology Transfer Center (www.ceattc.org) managed by the Danya Institute, will host a Behavioral Health Conference on Tobacco Cessation May 19–20, 2014 in North Bethesda, Md. It will address such issues as the effect of health reform on tobacco cessation, electronic cigarettes and cessation, and smoking cessation and behavioral health disorders. You can promote recovery and well-being by incorporating nicotine cessation into behavioral health programs — and ultimately — save more lives.



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Toolkit Resources

Dimensions: Tobacco Free Toolkit for Healthcare Providers

http://smokingcessationleadership.ucsf.edu/Downloads/dimensions_tobacco_free_toolkit_hcp.pdf

Tobacco Treatment for Persons with Substance Use Disorders: A toolkit for Substance Abuse Treatment Providers

http://smokingcessationleadership.ucsf.edu/MH_Resources.htm

Smoking Cessation for Persons with Mental Illness: A Toolkit for Mental Health Providers

http://smokingcessationleadership.ucsf.edu/MH_Resources.htm

Tobacco-Free Living in Psychiatric Settings

http://smokingcessationleadership.ucsf.edu/nasmhpd_toolkit_2010.pdf

Tobacco Free Toolkit: For Community Health Facilities

http://smokingcessationleadership.ucsf.edu/tf_policy_toolkit.pdf

2008 U.S. Public Health Service Guideline—Treating Tobacco Use and Dependence

<http://www.surgeongeneral.gov/tobacco>

Bringing Everyone Along: Resource Guide

<http://www.tcln.org/bea>



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SAMHSA (Center for Substance Abuse Treatment/Substance Abuse and Mental Health Services Administration) Discretionary Grantee News over the past several years.

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