Treating Tobacco Dependence in the Addictions Setting

The Aurora Centre's Experience

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On May 15, 2006, the Aurora Centre, a residential and outpatient treatment centre for women with substance use problems, became tobacco-free. This means that clients are not allowed to smoke for the duration of their treatment stay, either on or off the property. It also means that clients receive tobacco dependence treatment alongside their treatment for other drugs and alcohol.

Setting the context

It's no secret that the rate of smoking tobacco among clients with other substance use problems is high, and Aurora clients have been no exception. However, like many drug and alcohol agencies, we didn't think addressing tobacco dependence was within the scope of our mission. The reasons were numerous. Long-held beliefs within the addictions field that smoking isn't the 'real' problem, and that you can't ask clients to give up everything at once, are just two. So, we have tended to leave the tobacco problem to the public health field, with their emphasis on the negative health consequences of smoking. But has this been an appropriate response?

Studies show that for smokers previously treated for alcohol and other drug problems, tobacco use is the leading cause of death.[1] And mortality rates due to smoking in this population are estimated to be twice that of other smokers. While smoking rates in the general population have decreased dramatically over recent years, smoking rates for individuals receiving treatment for other drugs and alcohol remain at approximately 70% to 95%.[2]

Despite the fact that Aurora clients themselves were telling us for years that smoking was a problem for them—nicotine has been routinely cited by our clients as one of their top three problem drugs—we did little to seriously address tobacco until recently.

Making the shift

It took the words of the brilliant Dr. John Slade, the late director of the Tobacco Dependence program in New Jersey, to jolt us from contemplation to action. Puzzled by the addiction field's nearly complete failure to address its clients' addiction to smoking, Dr. Slade concluded that tobacco was the profession's "big, dirty and embarrassing secret." He suggested that tobacco was our "elephant in the living room."[3] Acknowledging this elephant at Aurora was a process not without challenges, difficult conversations and some trepidation.

Once we did so, however, we began to shift both the way we characterized smoking itself, and the language we used when talking about it. For example, we began to see clients going outside to smoke for what it really is: going out to dose several hundred times a day. We went from talking about "smoking patios" and "smoking breaks," to talking about "patios" and "breaks." And we started to talk about "recovery" from tobacco dependence, rather than talking about smoking cessation, and about "tobacco-caused" illness versus "tobacco-related" illness. We began to see our clients' tobacco use for what it really is: a deadly, treatable addiction with all the hallmarks of any other chemical addiction.

Fears

Would clients want to come to Aurora if they couldn't smoke? And furthermore, would they stay? Would referral agents support our endeavour, and even more importantly, would they be able to offer our clients the kind of pre-treatment support they needed?

And perhaps the most uncomfortable question of all: what about the staff who smoked?

We relied on several resources to help us with these questions. Several recent studies, for example, suggested that addressing smoking would improve our clients' chances for recovery from all problem substances. They also suggest that continued tobacco use post-treatment may well increase overall relapse rates.[4]

As a guide to the process of becoming tobacco-free, we relied heavily on the excellent resource, Drug-Free Is Nicotine-Free: A Manual for Chemical Dependency Treatment Programs.[3] On the subject of staff use of tobacco, the manual stresses that this issue must be addressed before a program becomes tobacco-free, and that staff be offered treatment for their tobacco dependence. Aurora followed this

advice. In addition to developing a policy restricting staff use of tobacco during work hours, we offer our staff free nicotine replacement therapies (NRTs), such as the patch and gum.
We also had to confront fears arising from the knowledge that for the most part we were taking this journey pretty much by ourselves. Although we had several supporters cheering us along from the sidelines, most were glad they were not the first to go down this road.

Our tobacco dependence programming

Addressing tobacco dependence in addictions settings means more than just restricting clients' use of tobacco. It also means treating tobacco use as we would any other chemical dependency. At Aurora, for example, we assess incoming clients' tobacco dependence, offer free NRTs and provide specific group and individual counselling on tobacco dependence. We have also ensured that the tobacco addiction is woven into all of our educational seminars and group discussions. This reinforces that the dynamics and patterns of the tobacco addiction are no different from those for any other addiction.

Impact on clients and their treatment

We didn't expect that implementing the tobacco-free policy would be easy. It's a new concept, and there's a lack of systemic support from drug and alcohol practitioners for clients who wish to stop smoking. We also knew that most clients had likely not thought about their tobacco addiction in the same way as their other addictions, nor had they been encouraged to do so.
Not unexpectedly, we did experience an initial increase in the number of clients leaving treatment early. While the reasons for this were not explicitly due to the smoking ban, we suspect that it was a contributing factor in some cases. Recently, however, our retention rates have improved, and we are confident that this trend will hold as clients and staff alike become more comfortable with the idea of treating tobacco dependence in our setting.
Client support for the policy has been very high, with scores ranging from 65% to 93% of our residential clients stating they strongly support the policy. Client use of NRTs has also been high: 87% of clients who had smoked within two months of admission used the nicotine patch, gum or both during treatment. Almost all reported that these aids had been very helpful or somewhat helpful to them in alleviating withdrawal symptoms.
Client ratings of their achievement of their alcohol and drug treatment goals haven't decreased since the implementation of our tobacco-free policy. Their rating of their physical health goals has improved.

Challenges

Unlike the 30-day clean/sober admission requirement we have for other drugs and alcohol, we don't require any clean time from smoking. Working with clients in active withdrawal has been a challenge for staff. We have also struggled with how best to deal with clients who relapse to tobacco while in treatment. And finally, staff report feeling uneasy when referring clients post-treatment to facilities that still allow smoking.

System changes

We hope our colleagues in the drug and alcohol system of care will acknowledge there are compelling reasons to treat tobacco dependence concurrently within addictions treatment settings. At every level of the system, we hope to see clients assessed for tobacco dependence and provided appropriate treatment. Professional bodies such as the Association for Addiction Professionals5 and the American Society of Addiction Medicine6 call for no less.
It is no longer acceptable for drug and alcohol professionals to remain silent on the issue of tobacco addiction. At Aurora Centre, we are committed to treating all of our clients' chemical dependencies—our clients deserve no less.

About the author

Gail is the Program Director for the Aurora Centre

Footnotes:

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3. Hoffman, A.L., Kantor, B., Leech, T. et al. (1997). *Drug-free is nicotine-free: A manual for chemical dependency treatment programs.* New Brunswick, NJ: Tobacco Dependence Program.

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