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The facts are clear

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Commentary on Shu & Cook (2015): The facts are clear

The strong association between substance use disorders (SUDs) and cigarette smoking is well documented, as are the ravages smoking wreaks upon this population [1–5]. Whether and when to incorporate smoking cessation into the treatment of people with substance use disorders, however, has been more controversial. Barriers include the often more pressing issues of the underlying substance use disorder; clinician unfamiliarity or discomfort with smoking cessation treatments, concerns that clients are unwilling or uninterested in quitting smoking, the fear that stopping tobacco use might exacerbate underlying SUDs and a sense that tobacco is a relatively unimportant problem [6]. However, as evidence mounts that cessation is not only possible and beneficial for overall health, but that those who stop smoking also have a better chance of reaching sobriety [7,8], conventional wisdom is beginning to shift towards more support for integrating smoking cessation into SUD treatment [9]. Evidence of this shift is the move towards smoke-free treatment facilities and increasing interest in tobacco use evidence-based treatments to quit [10–12].

In this issue of Addiction, Shu & Cook, using data from the US 2009–12 National Survey on Drug Use and Health, explore tobacco use and cessation among people in SUD treatment. Not surprisingly, those with histories of SUDs had much higher smoking rates than those who did not. Their main finding is that those engaged in SUD treatment are less likely to have quit smoking compared with smokers who also have SUD but were not enrolled in treatment during the past year. Three reasons are postulated for this: people in SUD treatment may have used tobacco to cope with withdrawal from other substances during drug treatment; clinicians may discourage patients from quitting smoking during SUD treatment; and smokers in treatment facilities may differ from smokers not in treatment in other unmeasured ways, such as level of nicotine dependence [13].

Evidence pointing to the third explanation—that those in treatment constitute a different population that is less motivated or less able to quit smoking—can be found in the large discrepancy between those with and without criminal records (78% of those ever in drug abuse treatment versus 41% never in such treatment). Thus, those in SUD treatment are probably over-represented by those incarcerated because of drug and/or alcohol problems. In all likelihood, this incarcerated population of SUD is more disadvantaged than those not incarcerated. In other words, those same demographic variables—education, social class and coexisting mental health disorders—that influence smoking rates in the general population may also predict smoking prevalence within the more specialized class of those with SUDs.

One thing the authors could not observe, because their data included only people who are smokers, is that the rate of smoking is much higher to start with among people in drug abuse treatment than those who meet SUD criteria but are not engaged in treatment. This would amplify their findings, as not only are those in SUD treatment less likely to quit, they are also more likely to smoke in the first place. The 16% quit rate shown in Table 1 for people with any life-time SUD treatment refers to a population with an estimated smoking prevalence of 70% [2]. The 29% quit rate for people with SUD who have never entered treatment refers to a population whose smoking rates are closer to 50% for people with drug use disorders and 35% for alcohol use disorders [14].

The authors attribute why those who were in SUD treatment have lower rates of smoking cessation to insufficient cessation activities. An alternate explanation, offered above, is that those under treatment constitute a different population with less interest in quitting and less ability to do so. It is possible that both explanations are correct.

The facts are clear. Those entering the health-care system for addiction treatment smoke at higher rates, quit at lower rates, are less likely to receive tobacco intervention and more likely to die of tobacco-related illness. There are emerging examples of efforts to address tobacco use in addiction treatment settings, including the Substance Abuse and Mental Health Services Administration (SAMHSA) Pioneers program [15], the US VA health-care system [16] and New York State’s programs [11].

However, these are not sufficient. Effectively addressing tobacco use in addiction programs requires that tobacco control agencies and addiction treatment systems partner to prioritize smoking cessation [17]. State addiction systems must adopt tobacco policies that follow New York’s lead—mandating tobacco-free grounds and supporting smoking cessation services in all treatment programs [11]. The federal Center for Substance Abuse Treatment, an arm of SAMHSA, should undertake large-scale smoking cessation initiatives to expand capacity, and the National Institute on Drug Abuse should fund the development and testing of new smoking cessation interventions for this population. Finally, the entire drug treatment community must agree that every smoker deserves the opportunity to use evidence-based treatments to quit [18]. Few situations offer comparable opportunities to improve the health of the public.
Declaration of interests

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