

# Integrating Tobacco Into Addiction Treatment Facilities: A Student's Experience

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Embarking upon my second semester internship at the Tobacco Dependence Program led me to a project involving consultation work with an addiction treatment agency in Trenton, NJ. The agency serves approximately 600 clients in an outpatient setting. The project immediately piqued my interest. Substance users in treatment have a higher rate of tobacco use when compared to any other group. This is problematic because they are more likely to be killed by their tobacco smoking than by their other substance use. Cigarette smokers with a history of drug addiction are also more likely to experience disability and premature mortality. More alarming evidence indicates that 85 to 98 percent of patients in methadone maintenance programs smoke (Richter, Choi, McCool, Harris & Ahluwalia, 2004, p. 1258). Cigarette use perpetuates the addiction cycle and exacerbates ill health.

Few addiction treatment services provide assessment and treatment of their clients' tobacco use. Inevitably, this contributes to the intractability of nicotine addiction. This knowledge incited an increased drive to tackle this project avidly. The project focused on assisting a methadone maintenance treatment program with the establishment of its first psychosocial tobacco cessation group. Most clients want to quit, so agency support is necessary.

Addictions treatment agencies have a demand for smoking treatment and, yet, few do so routinely (McCool, Richter, & Choi, p. 358). Health professionals have contributed to the stigmatization of addicts. Staff beliefs and attitudes precipitate this negative characterization. Some feel smoking cessation will compromise patients' recovery from illicit drug and/or alcohol use, that patients are unwilling or unable to quit, or that quitting is of miniscule concern (McCool, Richter, & Choi, p. 358). The personal biases of health professionals have resulted in nicotine addiction remaining on the periphery of addiction treatment.

Only 18% of U.S. methadone maintenance facilities provide smoking cessation counseling and only 12% provide nicotine replacement therapy (Nahvi, Richter, Li, Modali, & Arnsten, 2006). The agency I worked with is a rarity due to its expressed interest in a quit group and request for assistance. Priority for their clients' nicotine addiction and their other drug addictions is deemed equal.

Prior to my work with the agency, a tobacco-free policy that prohibited smoking in or on facility grounds was implemented. This created an environment conducive for a quit group. It also allowed clients to become more receptive to smoking cessation. Thus, staff trainings occurred. I met regularly with them at their site location. In order to facilitate the planning phase of the project, we developed client assessment forms for tobacco use as well as quit group protocols. We also secured nicotine

patches, a carbon-monoxide monitor and tubes along with clinic space for group sessions.

Clients at the facility initially expressed interest in smoking cessation with their individual counselors. A flyer advertising an upcoming quit group, was created and posted around the facility. Eighty-eight clients responded to the flyer. Subsequently, 41 completed the self-administered tobacco assessment form and an initial cohort of 21 received a structured assessment. Clients were eligible for the quit group upon completion of the structured assessment and on a first-come, first-served basis. The quit group offers free nicotine replacement therapy via transdermal nicotine patches and psychosocial support via open group sessions. The group meets once per week. The goal is to encourage a target quit date so that group participants could strive towards smoking cessation and maintain a longevous quit state. Psychosocial interventions have been adapted successfully for smokers with schizophrenia and depression (Steinberg, Hall, & Rustin, 2003, p. 470). Similarly, special populations, composed of substance abuse clients, can maintain their quit status with a comprehensive approach and minimal barriers (client-perceived or otherwise real).

The first quit group session presented much success. Clients responded well to the intervention. Out of the eleven clients who participated in the first session, eight set their target quit date (TQD) for the next day. Thus, seven patches, equivalent to one week's supply, were distributed to each of those clients. In addition, two of the remaining clients set their TQD for the following week and the other client's TQD was scheduled for the week after that one.

Two-week follow-up (equivalent to three group sessions) was measured via statistical analysis of group descriptive data and an evaluation form requesting a staff member's prognosis of group members. (Please note: Although evaluation provided essential feedback, responses did not accurately capture whether or not the intervention would be effective in the long run, due to its formative stage.) In the evaluation, the staff member reported feeling that the clients are benefiting from the quit group and reported very good progress of group clients with regard to their quit status. The staff member also felt that it is very likely for clients who have not expressed a target quit date to do so because of their participation in group sessions.

The group was comprised of 7 women and 4 men. Group members were between the ages of 30 and 53 years old. The average age of smoking initiation was 12 years old – 28 years



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spent smoking was the average. They smoke an average of 129 cigarettes per week (CPW) and, on average, have tried to quit smoking twice. Their average methadone dose in the week prior to the first group session was 104mg. One out of the eight group members who received the patches after the first group session self-terminated due to transportation issues. Thus, of the seven who received patches at the first group session and participated in group during the second session, 6 out of the 7 (86%) reduced their Carbon Monoxide (CO) level by the second group session. Their exhaled CO level reduced from an average baseline measurement of 20 parts per million (PPM) to an average of 11ppm. Moreover, they decreased their self-reported cigarettes per week (CPW) from an average of 156 to 47 by the second week.

One female client self-reported that no cigarettes were consumed from the first to the second group session, a time span of a week. This was biochemically verified via her baseline CO level. It reduced from 19ppm in the first group session to 2ppm by the second group session. During the third group session, 3 out of the initial 11 first group session members did not return. The 8 out of 11, who did return to the third group session, attended all three consecutive sessions. On average, they self-reported a reduction of 115 weekly cigarettes over the time frame of three smoking cessation group sessions. Their average CPW at the first group session was 156 and by the third group session it had decreased to 41 CPW.

Conducting this project revealed that setting up a smoking quit group at a Methadone Maintenance Treatment Program is feasible. Clients expressed interest in quitting smoking. Furthermore, they participated in smoking cessation treatment and showed positive signs of behavior change. It remains to be seen whether these changes can be sustained and how many can quit smoking in the longer term. Addictions treatment agencies should determine whether their focus will be on smoking reduction or cessation. Nicotine addiction is worth incorporation into drug treatment services. This perspective is a paradigm shift from the pervasive mainstream notion of condoning tobacco use among substance abuse users. Healthcare providers in drug treatment settings must take responsibility for holistically treating their clients. This project definitely offered a start for the agency in Trenton, NJ and I am grateful for contributing to their progress.

#### References

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- Nahvi, S., Richter, K., Li, X., Modali, L., & Arnsten, J. (2006, February 10). Cigarette smoking and interest in quitting in methadone maintenance patients. *Addictive Behaviors*.
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- Steinberg, M. L., Hall, S. M., Rustin, T. (2003). Psychosocial therapies for tobacco dependence in mental health and other substance use populations. *Psychiatric Annals*, 33(7), 469-478.

## IMPORTANT DATES



### 5-Day Tobacco Dependence Treatment Specialist Training

September 25-29, 2006

January 22-26, 2007

April 2-6, 2007

June 11-15, 2007

September 24-28, 2007

### 2-Day Youth Quit2Win Training

October 4 & 5, 2006

January 22-26, 2007

March 5 & 6, 2007