

Addressing Tobacco Dependency in Women's Substance Use Treatment

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It is surely paradoxical that as substance use treatment professionals, whose discipline requires us to treat denial in others, we are ourselves in denial about our professional obligation to treat tobacco dependency. Our profession has continued to avoid treating clients for tobacco dependency despite widespread awareness that the consequences of addiction to nicotine, while not necessarily acute, can be deadly. John Slade, in his foreword to *Drug-Free Is Nicotine-Free: A Manual for Chemical Dependency Treatment Programs*, wrote that when he first began working as a physician in the substance use treatment field, he was puzzled as to why tobacco was largely ignored by substance use service providers. Eventually, he came to regard tobacco as “the big dirty, embarrassing secret of addictions treatment. It was the elephant in the living room” (Hoffman et al., 1997, p. i).

In this chapter, we will first look at some of the reasons why tobacco dependence must be treated along with alcohol and other drug dependencies. We will then explore the journey that we at the Aurora Centre, a 29-bed residential treatment centre for women located in Vancouver, have taken toward incorporating tobacco dependency¹ into our programming.

1. A word about language: While there is not necessarily consensus on the use of the various terms to describe the addictive process as it relates to smoking, the Aurora Centre has chosen to use the term “tobacco dependency” over “nicotine dependency.” This is in part because we believe that the harms associated with smoking come primarily as a result of the delivery system—i.e., smoking tobacco products—rather than of the nicotine itself. Others however, might well argue that it is the nicotine that is the addictive substance, and hence, the dependency is better characterized as “nicotine dependency.”

Programs can be considered either tobacco-free or nicotine-free. Programs that provide nicotine replacement therapies are defined as “tobacco-free.” Programs that do not allow the use of either tobacco products or nicotine replacement therapies are categorized as “nicotine-free.”

Tobacco Dependency Treatment: Why We Cannot Ignore It

Looking at smoking prevalence rates among people in treatment for alcohol and other drug problems is both alarming and instructive. Studies show that anywhere from 80 per cent to 90 per cent of the members of this population are smokers (Bobo, 1989, as cited in Goldsmith & Knapp, 1993). This rate is approximately two to three times greater than that of the general population (Joseph et al., 1990, as cited in Hahn et al., 1999). The Aurora Centre's own statistics mirror those found in the literature: in 2003, for example, 79 per cent of the residential participants and 71 per cent of the day-program participants were smokers. These figures have held constant since 1997 when the centre first began collecting smoking status data. Not only do most of our program participants smoke, they smoke more (Perine & Schare, 1999), they start earlier and they have more difficulty quitting than other smokers (Asher et al., 2003).

It is estimated that the mortality rate for people with substance use problems who smoke is twice that of other smokers. Cigarettes kill 20 times more people than all illegal drugs combined (Wen et al., 1990, as cited in Ker et al., 1996) and, in fact, are the leading cause of death among those previously treated for alcohol and other drug problems (Hurt et al., 1996, as cited in Hahn et al., 1999). Even more disturbing is the fact that researchers believe the rates of tobacco-caused morbidity and mortality in Canadian women have not yet peaked (Kirkland et al., 2003). For the first time ever, the rate at which girls begin smoking has overtaken that for boys, so we may well see the numbers of women smokers in treatment rise, not fall (Kirkland et al., 2003).

In 1998, the National Institute on Drug Abuse (NIDA) stated that "... like addiction to heroin and cocaine, addiction to nicotine is a chronic, relapsing disorder" (1998). The American Society of Addiction Medicine, among other U.S. national bodies, advocates that treatment for nicotine dependency be on a par with treatment for alcohol and other drug dependencies (Hahn et al., 1999). As treatment providers, we need only to consider how many of the dynamics of tobacco dependency are the same as those of other drug and alcohol dependencies to ask ourselves: Why do we not apply all of our expertise in substance use treatment to nicotine, one of the most addictive and harmful substances our clients use?

The failure to address tobacco use in programs for other substance use tacitly sends the message that addiction to nicotine is not only less important than other addictions, but that it is, in fact, acceptable. Additionally, such programs indirectly ensure that the women using them find themselves within a treatment community where their smoking patterns are reinforced rather than challenged (Sussman, 2002). The evidence suggests that those who continue to smoke post-treatment are not only exposing themselves to the health effects of continued tobacco use, but are also at higher risk for returning to alcohol and other drug use than those who stop smoking (Sees & Clark, 1993). The presence of treatment staff who smoke only compounds the confusing and clinically inconsistent message about nicotine dependency received by people recovering from other addictions. In short, treatment centres for other substance use that do not address the use of tobacco are providing care that is at best hypocritical, and at worst unethical.

The argument for addressing tobacco dependency as a part of substance use treatment is further strengthened by the fact that many clients actually want to quit smoking (Ellingstad et al., 1999). At the Aurora Centre, for example, 64 per cent of residential program participants who smoked reported that they planned to quit smoking. Of these, 62 per cent reported that they planned to quit after treatment, while 33 per cent said they would like to quit during treatment. Similarly, Kozlowski et al. (1989) found that when asked, 46 per cent of the participants in a substance use treatment centre said they would like to quit smoking at the same time as receiving treatment for alcohol and other drugs. While there are arguments back and forth in the literature about the ideal time to begin nicotine-dependency treatment, there is evidence to support the notion that many people would like to participate in concurrent treatment, and that it may increase their chances of successfully reducing or quitting smoking as well as supporting their abstinence from alcohol and other drugs (Joseph et al., 1993).

Tobacco Dependency Treatment: What Is Stopping Us?

Several American surveys show that most substance use counsellors believe both that nicotine is an addictive substance and that substance use programs should treat tobacco dependency (Hahn et al., 1999). Translating these beliefs into action, however, appears to be another matter altogether. In 2000, for example, only 20 per cent of American substance use treatment centres addressed tobacco dependency in any fashion (McDonald, 2000, as cited in Fogg & Borody, 2001).

Administrators have also been found to be supportive, in theory, of the notion of treating tobacco dependency. Following a statewide tobacco dependency educational campaign in Minnesota, for example, 71 per cent of administrators surveyed agreed that tobacco dependency should be treated on a par with treatment for all other drugs and alcohol (Knapp et al., 1993). At the same time, however, the proportion of treatment facilities that were actually tobacco-free after the campaign was still only 27 per cent—up from the pre-campaign figure of 11 per cent, but still low (Knapp et al., 1993). Other studies have found similar discrepancies between staff attitudes toward tobacco dependency treatment and the presence of actual programming that delivered such treatment (Hahn et al., 1999).

STAFF PERCEPTIONS OF RISK AND STAFF SMOKING

There are many reasons why practitioners and administrators alike fail to effectively address the question of tobacco dependency. Cultural acceptance of tobacco use within society, combined with a belief that tobacco dependency is not as serious as other drug dependencies, is one common reason. The smoking status of substance use treatment staff also constitutes a significant barrier, especially since alcohol and other drug counsellors are more likely to be smokers than other health care professionals (Bobo et al.,

1997). While it is imperative that treatment centres wishing to introduce tobacco dependency treatment first and foremost address staff smoking, this can be a difficult process, often giving rise to resistance, dissension, fear of job loss and even concerns about human rights challenges. Approaches that can help overcome these issues include providing cessation supports for staff who smoke, implementing changes slowly and respectfully, including smokers in all phases of the planning and providing thorough training and education (Hoffman et al., 1997).

PARTICIPANTS' FEAR OF QUITTING

Administrators and counsellors are often reluctant to treat tobacco addiction because they have concerns relating to participants' fears about addressing tobacco dependency. However, such fears can and should be dealt with in the same way as fears about letting go of other addictions. For example, in one study, program participants expressed the fear that they might not have the necessary willpower to stop smoking while in treatment (Asher et al., 2003). Substance use treatment professionals can respond to this concern by bringing to bear their knowledge that, as with successful recovery from other substance use problems, willpower alone is not sufficient to cease tobacco dependency, but there are many other coping strategies that can help (Asher et al., 2003).

INSUFFICIENT EVALUATION RESEARCH

Because so few substance use professionals have even begun to consider the question of integrating tobacco treatment into their work, examples of successful tobacco initiatives are still relatively scarce. Especially scarce are studies of women-only treatment facilities that have successfully introduced concurrent tobacco treatment. Consequently, unanswered questions about the specifics of what makes such treatment effective abound. For example:

- What is the optimal timing of treatment?
- How best do we tailor treatment to varying motivation levels?
- What is the long-term impact of treatment on both smoking status and outcomes for substance use treatment?

These are just a few questions requiring more research. In the absence of definitive answers, however, there remains a desperate need to do more than we have done in treating smoking within the context of substance use treatment (Covey et al., 2003). At the Aurora Centre, we have decided it is time for us to do more. While our efforts to date have been modest, we offer our story in the hope that it will inspire other women's treatment programs to address this important issue.

Aurora's Story

For 20 years, both program participants and staff at Aurora House smoked indoors, with few restrictions. A year or so after I arrived at Aurora in 1991, having assumed the role of executive director, our cook approached me and expressed concern that the smoke billowing around her throughout the day was affecting her health and her training as a triathlon competitor. She also sagely pointed out the contradictions between, on the one hand, the healthy food she was preparing for the program participants, our insistence that we were a holistic program and our philosophy that “a drug is a drug,” and, on the other hand, participants' heavy use of this addictive and harmful substance.

FROM RESISTANCE TO ACCEPTANCE

Shortly thereafter I proposed that Aurora restrict smoking to the outdoors. Initially cautiously supportive, some staff withdrew their support for this restriction once the policy went into effect. Uncomfortable seeing program participants standing outdoors smoking, and even worse, working on writing assignments while huddled on the back steps, staff characterized the policy's effect as demeaning and shaming. However, after the initial turbulence (which included some threats of staff resignations) and the construction of an outdoor smoking shelter, staff and participants alike soon came to accept the indoor smoking restriction. Indeed, over time new clients to Aurora arrived *expecting* to find such a policy in place.

A WOMEN-CENTRED AWARENESS PROGRAM

Approximately five years after this initial change, Aurora introduced a five-session smoking awareness program. Loosely based on the women-centred Catching Our Breath smoking reduction/cessation program developed by Deborah Schwartz for the Winnipeg Women's Health Clinic, these sessions were designed to raise awareness about smoking and its effect on women's lives, and to introduce harm reduction and coping strategies (Holmberg-Schwartz, 1997).

Recent literature suggests that women smoke for different reasons than men do, and that their treatment therefore also needs to be different (Poole et al., 2003). For example, at Aurora we have long observed how smoking is used by women as a way to socialize and bond with other women. Indeed, Lorraine Greaves, in her book *Smoke Screen: Women's Smoking and Social Control* (1996), reports such a finding based on in-depth interviews with 35 women about what smoking meant to them. Her research also suggests that some women use smoking as a way to control or suppress negative emotions and as a means of coping with unpredictability and a lack of control in their lives. Greaves concludes, “. . . women's smoking is often a response to women's lot” (p. 9).

Catching Our Breath is a good example of a reduction/cessation program created specifically for women that takes into account women's relationship with smoking and the myriad meanings it has for them. The model used in the program is empowering and respectful, as opposed to prescriptive and judgmental. It would be an excellent beginning for any women's treatment facility wishing to address smoking.

In keeping with the centre's women-centred approach to treatment, these sessions were a non-judgmental place where program participants could freely explore their feelings about their tobacco use. Indeed, one of the first participants reported: "... the sessions didn't make me feel bad about smoking." Not everyone responded so positively, however, and some were, and in fact continue to be, resistant to the program. These women have reported feeling judged and guilty about their smoking:

[The program] was okay; I didn't feel like I was learning anything though. I already know the dangers of smoking, what they portray in the media, and what types of resources are available for you to quit. I appreciate having handouts for future reference, but it made me feel guilty about smoking because I'm not ready or willing to quit. I quit smoking crack—that's good enough for me right now. One thing at a time.

Overall, however, feedback about this program has been encouraging. In 2003, for example, 81 per cent of participants rated the smoking awareness sessions as either "very helpful" or "somewhat helpful," while only 5.8 per cent rated them as "unhelpful." Of those program participants contacted three months after treatment, 28 per cent reported they had reduced their smoking levels and nine per cent reported having quit smoking (Poole, 2003).

AFTER-CARE PROGRAMMING

The Aurora Centre also conducted a pilot project in which it ran Catching Our Breath groups for clients who had completed treatment for alcohol or drug use. The results of this after-care program's evaluation were also encouraging. Participants reported, for example, an increase in the use of alternative self-care strategies promoted by the program to help them stop smoking completely (Poole et al., 2003). While establishing a quit date was not a requirement of the program, a higher number of women who participated in the Catching Our Breath sessions identified quitting as a goal than those participating in the smoking awareness groups that were provided during treatment. One-third of the Catching Our Breath participants did quit smoking while enrolled in the program, and another 44 per cent reduced their smoking levels (Poole et al., 2003).

A NEW PERSPECTIVE

Addressing tobacco dependency effectively within the context of substance use treatment is not simply a matter of adding new programming. It means applying the lens of this dependency to every aspect of our work as treatment providers, and seeing things in a new perspective. The Aurora Centre has gradually made subtle but nevertheless critical changes to its language, its referral and assessment forms, its seminars, and its policies and procedures to ensure that all aspects of its program address tobacco dependency. For example, the centre:

- stopped talking about the “smoking patio” and started talking about the “patio”
- revised referral and assessment forms to include identification of nicotine as a drug of choice
- rewrote seminars to ensure that tobacco dependency was routinely addressed alongside dependency on other drugs and alcohol
- developed guidelines to address staff use of tobacco—for example, restricting display of tobacco products and limiting outdoor smoking to areas unobserved by clients
- shifted perceptions about smoking—for example, from thinking about “a smoking habit” to thinking about “tobacco dependency.”

Treatment facilities wishing to introduce concurrent nicotine dependency treatment are faced with a great deal of uncertainty and myriad questions. For example:

- Should we become completely nicotine-free, or just tobacco-free?
- Can we require our staff to stop smoking?
- Can staff addicted to tobacco effectively provide treatment on tobacco dependency?

These questions are practical, difficult and value-laden—and they must all be explored thoroughly. For help in addressing them and many others, we at the Aurora Centre have turned to an excellent resource, the manual *Drug-Free Is Nicotine-Free* (Hoffman et al., 1997), as our guide. Developed to help substance use treatment facilities to become nicotine-free, this invaluable manual has served both as an inspiration for us and as a template for how to go about such a major and, at times, controversial undertaking.

Conclusion

While some American treatment facilities have been aided in their tobacco work efforts by state licensing standards that require substance use centres to treat tobacco dependency on a par with other drug and alcohol dependencies (Addressing Tobacco Project, 2000), there are no such licensing standards in Canada. In fact, in the Health Canada document *Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems* (2001), treating tobacco dependency does not even appear as a “best practice,” and indeed, the issue of tobacco dependency treatment is not mentioned at all.

Clearly, efforts to incorporate tobacco dependency treatment within substance use programming in Canada would be easier if better research existed and if some of the

policy directives existing in some U.S. states were more widely adopted. But in the absence of these conditions, treatment professionals must foster the leadership, knowledge and courage within their organizations to tackle this difficult and complex issue.

To place tobacco in a different category from all other substances is contrary to everything we as treatment professionals know about substance use problems and addictions. To fail to treat women's tobacco dependency is to fail the women who seek our services.

Postscript: The Aurora Centre became completely tobacco-free—inside and out—on May 22, 2006.

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