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Response: Getting Tough with Smoking

Lirio S. Covey, Ph.D., Anne M. Joseph, M.D., M.P.H., and Steven Shoptaw, Ph.D.

Steven Shoptaw: We don't know why, but the use of nicotine is associated with the use of other substances, whether you look retrospectively in a clinical trial situation or prospectively in carefully defined groups. The association is always there and always very clear. My data show that among methadone-maintained patients who were trying to quit smoking, they were more likely to use illicit drugs on any day they smoked.

Anne Joseph: There is no doubt that quitting smoking has health benefits with respect to lung disease and many other conditions. Whether it has good, bad, or no effects on chemical dependency outcomes is still up in the air, unfortunately. For a long time there were worries, not founded on any data, that there would be adverse effects. There have been about a dozen studies that did not seem to demonstrate such effects, and a few suggested smoking cessation might even have a beneficial effect on treatment outcomes.

Lirio Covey: Most of the evidence has been on recovered groups, and it shows that if people quit smoking after being abstinent from alcohol for a while, quitting smoking does not jeopardize that abstinence. Dr. Sharp and colleagues, however, are talking about people in early recovery. We know very little about how smoking cessation will affect that group.

I have some concerns. I see a parallel to the state of our knowledge with regard to smoking and psychiatric conditions such as major depression. We know a lot about people with past major depression. But we don't know what will happen if people stop smoking when they are still depressed or just recently got over their depression.

Joseph: We just completed a randomized trial of treatment for nicotine dependence given concurrently with alcohol treatment, comparing it to nicotine treatment delayed by 6 months. The smoking cessation outcomes were identical in the two groups, in the neighborhood of 15 or 16 percent at 12 months. However, there is sometimes a trend and sometimes a statistically significant difference in alcohol treatment outcomes that favors delayed treatment. This is not the result we were expecting.

Covey: Anne, can you speculate on the explanation for your finding?

Joseph: One possibility has to do with pharmacological interactions between nicotine craving and alcohol craving. For example, abstinence from cigarettes may cause nicotine craving, and that might trigger intense craving for alcohol. Depression is another possible explanation for these findings. Many alcohol-dependent patients are depressed. If their depression is exacerbated by nicotine abstinence or relative nicotine deprivation, perhaps patients will use alcohol to self-treat their depression.

Shoptaw: When you work with people who have multiple substances of dependence, removing one doesn't necessarily affect the others. Or it may. We don't know.

Joseph: Our study results have yet to be duplicated. In addition, in contrast to the ATC scenario described in this article, the nicotine treatment in our study was not compulsory. All in all, the question of how con-

currently treating nicotine dependency will affect other dependency outcomes is still up in the air.

Covey: I think the authors are to be commended for taking this approach, even though a lot of their actions and policies are based on very slim evidence. I can see it as a potential test.

Joseph: My guess is that when it all settles out, there will probably be some situations where it's not right to treat nicotine dependency, but in the majority of situations, it's probably right. Right now we undertreat nicotine dependency in the majority of drug and alcohol treatment populations. It is important to experiment with new approaches, such as those Sharp describes.

Nicotine-free and discharge policies

Shoptaw: The idea of maintaining a smoke-free facility and targeting nicotine abstinence is really groundbreaking in terms of tobacco control and conceptualizing tobacco in relation to other substances of dependence. Once you get the systems aligned for treating all substances of abuse, it makes sense to expel someone for smoking or having tobacco paraphernalia.

Covey: 'Groundbreaking' is a very apt term. I was quite struck when I read this paper. But Sharp and his colleagues' approach makes a lot of sense if you look at nicotine as part of an integrated treatment approach, with cessation of tobacco use just one among the other outcomes. The policies and the practices that are applied to nicotine should then parallel or duplicate those that have been applied to alcohol or any other substance.

Joseph: I will play devil's advocate: There is a real sense among chemical dependency clinicians that it would be absolutely wrong to discharge a patient, possibly compromising his or her chemical dependency treatment, by forcing the tobacco issue. As harmful as tobacco is to health, there are differences in how acutely tobacco and illicit drugs compromise patients' social and psychological and legal lives. Tobacco will not kill the patient in the next week, as the other substances may do if the patient is in crisis.

On the other hand, there is a desperate need to do more to address nicotine dependence in this population. So it is hard to know the right place to draw the line.

Covey: The authors' approach has theoretical appeal, but in practical and humanitarian terms, do we really want to go there at this time, with the limited information we have about the impact of smoking cessation on people in early treatment?

Shoptaw: A question—and one I ask about my own work, too—is this: The authors get a 12-percent quit rate at 3 months. If you end up with, say, a 5-percent quit rate at 1 year, is that worth putting everybody through so much pain? It's a low rate.

When you work with people who have multiple substances of dependence, removing one doesn't necessarily affect the others.

Joseph: You raise a controversial issue: Are alcohol-dependent patients' smoking cessation outcomes really worse than other individuals'? We have always presumed they are, but outcomes in the general population are proportional to the intensity of treatment. For a behavioral intervention in a general practice clinic, 15 percent long-term cessation is pretty good. We don't question it. We know that over time, as people age, more and more quit. They require repeated attempts. So I am not discouraged by the numbers in this article.

Shoptaw: We have had methadone-maintained patients use our behavioral therapy and nicotine replacement to get smoke-free and feel very proud of having done so. Then they go home, where they've spent 20 years with their spouse sitting together, watching TV and smoking. I think that sort of scenario helps to explain the relatively poor smoke-free outcomes Sharp and colleagues get at 3 months. A treatment goal that would be consistent with their approach would be to begin providing smoking cessation for the family, so you send your people home to situations that reflect what you practiced in the treatment environment.

My hat is off to the ATCs because they took the risk to go down this road and they are documenting their outcomes. The results may turn out to be disappointing, but I think it's great that they've taken this path.

Joseph: There is a distinction between an institutional no-smoking policy and the intervention practice policy with respect to smoking. They are two very different things. I think it is quite feasible to introduce a smoke-free policy into chemical dependency programs. Many people would agree that setting such a

policy is an initial step that can and should be taken because it sets the stage for providing intervention.

Interventions, costs, and generalizability

Shoptaw: Sharp's approach to nicotine replacement therapy is a commonsense one.

Joseph: The approach of using higher dose nicotine replacement therapy based on the baseline amount of smoking is not strongly grounded in evidence, though many clinicians follow that practice. The guideline from AHRQ [the Federal Agency for Healthcare Research and Quality] does not support adjusting patch dose on the basis of smoking levels, but it recommends that if patients feel cravings they can have additional doses of nicotine or supplements with gum. That sort of symptomatic treatment makes sense.

A treatment goal that would be consistent would be to begin providing smoking cessation for the family.

Covey: I liked the way the authors created a conducive environment for their smoking intervention. They laid the groundwork for over a year or more and really prepared the staff and treatment community. They also did marketing and advertising, information and education.

Shoptaw: I appreciate the way the authors monitor the bottom line. Initially their referrals dipped and their cash stream fell. But then the referrals came back, and that strikes me as very interesting. I'm not sure what to make of it, or whether it would generalize to other places.

Joseph: There has been an argument raised for requiring that inpatient chemical dependency facilities be smoke-free to receive accreditation. That would eliminate some of the business disadvantage that smoke-free facilities now may face. Still, it is hard to imagine we are anywhere near mandating nicotine treatment to the extent that these authors describe.

Shoptaw: The cost of their nicotine treatment was $55 per patient. That's pennies, not a major issue, not an issue at all. For the value of what you get back, it's great. Yet it is still hard to get major payers to cover NRT and other smoking cessation treatments. That's because the gains for implementing a smoke-free policy are further down the line and aren't going to be recovered by the person who is paying for the treatment episode.

Covey: With respect to the authors' recommendation for research to determine the long-term impact of tobacco treatment and recovery, multiple outcomes will have to be looked at. Not just tobacco cessation, but also abstinence from other dependencies and other mental health parameters. Do the patients become depressed? Do they start developing panic disorders, hallucinations?

Shoptaw: I wonder how generalizable these authors' experiences might be. It's one thing to do what they've done as a publicly funded health care provider, but it's not clear whether it will translate into managed care or HMO situations where executives make the decisions. Also, the article describes how Sharp's group got their staffs to buy in to treating tobacco dependence like every other addictive disease. They laid the argument out very nicely. But what do you do with staff members who are highly trained and good at what they do, yet continue to smoke? I think this group just told people, 'If you don't want to quit smoking, you can go work someplace else.' In some other agencies that might not be an acceptable response.

Joseph: The issue of generalizability is very important. Can a smoke-free policy and mandatory intervention be accomplished in the absence of a strong antismoking advocate such as you're likely to see in a research project? Can mandatory treatment work for chemical dependency patients who have more service options than the patients in Sharp's public clinics do?

I wonder if this would be a suitable question for NIDA's Clinical Trials Network, where you actually could randomize programs to varying degrees of obligatory nicotine dependence treatment, then look at enrollment, treatment completion rates, drug treatment outcomes, and so forth. Ultimately, the way to really test these questions is to randomize programs. That is probably the most difficult kind of research to do well—but that really is how this question is going to be figured out. &