Myths and Facts: Addressing Smoking in Clients with Mental Illness and Substance Abuse Disorders

MYTH	FACT
"Quitting smoking is a low priority problem; patients and medical providers have more important things to worry about".	Smoking is a leading cause of death and disability in behavioral health populations. Rates of smoking can be as high as 90% for behavioral health populations compared to 23% in the general population.[1] Individuals with mental illness (MI) and substance use disorders (SUD) can have a 25 year shorter life expectancy; a big reason for this is smoking.[2] Tobacco use and its effects limit employment, housing and economic opportunities for clients.[3]
"Smoking is the "lesser of two evils." At least my client isn't using."	**Tobacco use kills three times as many people as drug overdoses and eight times as many people as gun homicides in Philadelphia**.[4] In fact, people with substance use disorders are at particularly high-risk of tobacco-related harm due to high smoking rates, heavier smoking, and earlier smoking initiation.[5] Research shows that people who are dependent on drugs or alcohol are more likely to die from smoking-related illness than they are from their other drugs.[6,7]
"Smoking helps clients to manage their mental illness or substance use disorder as a coping mechanism."	The Tobacco industry has spread this myth. This industry has a long history of targeting vulnerable populations, including those with MI/SUD. Nicotine triggers the same neural pathways as alcohol, opiates, cocaine, and marijuana that drive and reinforce addiction.[89]
"Our clients can't quit smoking."	**Persons with mental illness and substance use disorders can successfully quit using tobacco at rates similar to the general population**.[10] Individuals living with mental illness or substance use disorders are willing and able to quit smoking, even if they may need longer, more intense treatment than those in the general population. **Tobacco use treatment, including the use of pharmacotherapy and counseling, is effecting for treating tobacco users who are receiving treatment for chemical dependency**.[11,12]
"Persons with mental illness and substance use disorders do not want to quit."	**44 -80% of individuals with SUD want to recover from their tobacco use and want information on recovery options and supports**.[13] Tobacco users are more than twice as likely to quit for good when they quit with the help of stop smoking medications and extra coaching and support.[14]
"Clients will just start smoking again once they are discharged".	Recovery from tobacco use disorder, like many substance use disorders, may take several attempts before successful. We don't refuse treatment for other addictions, even when we believe the client is less motivated to remain abstinent. **We give everyone the opportunity to detoxify while in treatment with the hope that they will choose a substance-free life. Recovery for tobacco use is hard, especially in environments where tobacco use is acceptable.** By incorporating tobacco treatment into your recovery philosophy, we can help clients learn refusal skills, identify triggers, and regain control if they relapse to open new doors to wellness and recovery.

"Smoke breaks are one of the few opportunities that clients have to relate to other clients and staff".	Tobacco use disorder is the most common substance use disorder in the United States and adversely impacts the major domains of recovery (health, home, purpose, and community). **By treating tobacco use disorder and implementing tobacco-free policies, drug and alcohol treatment faculties are supporting wellness, recovery, and resiliency among their clients and staff.** The time, resources, and staff dedicated to managing smoke breaks can be redirected for tobacco treatment and health and wellness-oriented activities.
"Smoking cessation will jeopardize recovery for substance use disorders".	**Tobacco treatment can enhance long-term recovery for persons with other substance use disorders**. For example, if someone recovers from tobacco use disorder at the same time they are recovering from alcohol use disorder, they can have a 25% greater chance of staying clean and sober.[15]
"Drug and alcohol treatment staff do not have the training or the time to help our clients quit smoking."	**Addiction treatment professionals possess unique skills and trainings to from the treatment of other SUD's that can be applied to tobacco treatment. Effective tobacco treatment can be delivered in as little as 30 seconds to 3 minutes.** [16]
"Smoking cessation is the responsibility of the client's primary care provider."	All tobacco users with SUD's should be offered tobacco treatment. Clinicians must overcome their reluctance to treat this population. Numerous studies support that a multi-disciplinary approach of providers are most effective to help individuals recover from tobacco use.[17]
"Quit smoking medications just substitute one addiction for another."	Nicotine Replacement Therapies (NRT) deliver nicotine in lower, slower, and more evenly than tobacco products and have a much lower abuse liability compared to tobacco use. These medications do not contain the 7,000 toxic chemicals found in tobacco smoke. FDA-approved prescription medications and NRT to treat tobacco use disorder are proven effective with individuals with SUD. In cases of alcohol dependence, NRT has improved rates of recovery from alcohol as well as tobacco.[18,19]
"Even if tobacco use is a problem, we don't know what to do for our population?"	Drug and alcohol treatment facilities can create a culture change that addresses tobacco use on an organizational level by ensuring: • **Every client can be screened, assessed, treated, and discharged with pharmacotherapies and behavioral treatment for tobacco use disorder** • **All staff can be trained in evidence-based tobacco treatment and offered recovery support for tobacco use** • **Facilities can implement indoor and outdoor tobacco-free policies**

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