ATTUD BHC NEWSLETTER COMMENTARY

TREATING TOBACCCO USE DISORDERS IN BEHAVIORAL HEALTH

By David "Mac" Macmaster, CSAC, PTTS

Who is responsible for treating tobacco use disorders (TUD?)

Typically the programs created to treat substance use disorders, and TUD is by definition a substance use disorder—do not accept people with a sole or primary diagnosis of TUD for treatment. For example, in Wisconsin TUD exclusion is confirmed in DHS75-86, the rule that governs substance use disorders in our state. As far as I know the only state that has completely integrated TUD treatment in their statewide addiction services is New York State since 2008 under their rule 856. Other states like Wisconsin are seeking tobacco integration into behavioral health treatment services.

FACT: The American Society of Addiction Medicine (ASAM) includes Tobacco Use Disorder as a legitimate substance use disorder and provides intervention and treatment practices in their ASAM CRITERIA manual

FACT: The Diagnostic and Statistical Manuals that identifies psychiatric related disorders includes "Nicotine Dependence and Abuse" as a substance dependence and abuse disorder in (DSM1V.) In 2015 (DSM1V) was updated to (DSM5) that includes "Tobacco Use Disorder" as a substance use disorder.

IMPRESSION: The CDC and the Substance Abuse and Mental Health Administration (SAMHSA) supports tobacco integration in behavioral health services

FACT: Substance Use Disorder treatment providers do not identify tobacco use disorders as being within their scope of practice and do not accept those with TUD for SUD treatment

CONCLUSIONS:

Disease and death from tobacco in behavioral health populations can be reduced when:

1. **Substance Use Disorder providers expand their scopes of practice to include treatment of tobacco use disorder with the best practices they provide for treating other SUDs**

2. **Mental health providers diagnose and either treat TUD with smoking cessation with evidence-based practices or refer those with TUD to SUD providers as an option when a TUD is confirmed through tobacco use assessments**

The public health model of smoking cessation that has successfully reduced smoking in America from 42% to the current 15% was established by the Centers for Disease Control and Prevention (CDC.) The CDC created the Office of Smoking and Health (OSH) in 1965 and established single state Tobacco Prevention and Control (TPCP) agencies in every state.

One of the OSH mission objectives was, and is, address disparity populations that smoke more; develop more tobacco caused and related diseases, and die prematurely from tobacco than in the general population. The Wisconsin Tobacco Prevention and Control Program has included behavioral health populations (substance use and mental health disorders) as disparity populations and included behavior and tobacco issues as a priority in Wisconsin's TPCP's strategic plan.

Smoking cessation has always been a priority for the CDC/OTH and TPCP services. The internationally accepted Clinical Practice Guideline for Treating Tobacco Use and Dependence provides evidence-based practices for treating TUD and establishes that these clinical practice guidelines are effective for smoking and tobacco cessation.

A review of evidence-based effective treatment practices for substance abuse disorders and a review of evidence-based TUD disorders reveals these practices are essentially identical. In other words, what works to achieve successful abstinence and harm reduction treatment outcomes for alcohol, opiates, cocaine and other substance use disorder also work for those with tobacco use disorders.

My observation is that the tobacco programs do not diagnose tobacco use disorders (TUD) using DSM5 and do not make referrals to addiction/SUD treatment providers. This has been typical practice since the Tobacco Prevention and Control Programs were established.

SUMMARY

The opening question for this opinion article was:

Who is responsible for treating tobacco use disorders (TUD?)

Should the addiction/substance use disorder treatment providers treat TUD? Of course they should, but they aren't. They can but they don't. Yet, these SUD providers have successfully integrated alcohol and other drugs and treat them at the same time and not gone out of business doing it. They can treat TUD. There is no evidence to the contrary.

Should the Tobacco Prevention and Control Programs treat tobacco use disorders? They already are. They call it cessation. They use a public health model that research reports is effective for many with tobacco use disorders.

However tobacco use disorders are on a continuum of severity. Public health smoking cessation is effective, but is not always enough for those with a severe TUD. They might be more successfully treated in substance use disorder treatment programs when access to addiction/SUD treatment becomes available.

There are reasons for this dilemma that prevents those with TUD from having the options that will save lives, but that is for another article.

I am motivated by this vision.

When we successfully integrate tobacco use disorder treatment and tobacco free recovery we will open the door to addiction treatment that has been closed too long. In Wisconsin we have more than 3,500 alcohol and other drug counselors who have the skills to treat all the substance use disorders including TUD. We have social workers, therapists, doctors and many more that

can improve treatment opportunities for those with TUD. This would be true in every state when access to tobacco use disorder treatment and tobacco free recovery support expands dramatically. We would double, triple and provide even more opportunities for smoking cessation and tobacco free recovery.

The addiction treatment providers will discover they can readily treat patients with TUD harmoniously with other SUD's. New York State and one of our Wisconsin programs have done it successfully for more than a decade.

ATTUD has been a strong advocate for tobacco treatment and recovery research, TTS training, certification and policy development. Our strong advocacy and leadership for tobacco integration in behavioral health will make it easier for decision makers to assure this gap in tobacco treatment is closed for the good of those suffering from tobacco use disorders and their families.

It's time to lead.

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