



Nicotine Dependence

Tobacco use disorder is the most common substance use disorder in the United States. Approximately 60% to 80% of current smokers fulfill classic criteria for drug dependence; e.g., they have difficulty stopping, have withdrawal when they stop, are tolerant and continue despite knowledge of personal harm. Nicotine is the primary addictive substance in tobacco; however other chemicals likely increase the addiction risk. Tobacco use appears to have an addictive / dependence potential at least equal to that of other drugs. For example, among persons who experiment with alcohol, 10% to 15% will meet criteria for alcohol use disorder at some point in their life. Among persons who experiment with cigarettes, 20% to 30% will meet criteria for tobacco use disorder in their lifetime.

Among smokers, tobacco use disorders and tobacco-related disorders should be viewed as primary problems and health-related diseases as consequences of tobacco use and tobacco use disorders. Psychiatrists, other mental health professionals, and physicians of other specialties are aware that tobacco use and use disorders are harmful, but they often underestimate the magnitude of the risks that it poses to patients. Tobacco use is the largest and most preventable cause of mortality in the United States. Smoking causes more than 443,000 premature deaths annually among U.S. smokers alone. In addition, over 49,000 deaths per year¹ among U.S. nonsmokers are associated with environmental tobacco smoke exposure.

Tobacco use disorders are especially prevalent in persons with alcohol and other drug use disorders (e.g., over 80% of alcoholics are current smokers). The notion that tobacco use disorders are best left untreated during the treatment of alcohol/drug use disorders lacks empirical support and there is extensive support now from the literature that treating tobacco does not worsen other addiction treatment outcomes. Over half of the persons with alcohol/drug use disorders want help to stop smoking but do not receive such help. There is substantial scientific evidence that smoking cessation helps recovery. Research has shown that tobacco cessation does not disrupt alcohol abstinence and can increase longer-term recovery from alcohol and other drugs.² Unfortunately, many addiction psychiatrists have been unaware of the influence of tobacco use on the diagnosis and treatment of alcohol and other substance use disorders. For example, symptoms of tobacco / nicotine withdrawal (e.g., restlessness and insomnia) can be confused with or exacerbate alcohol withdrawal and caffeine intoxication; i.e., both produce irritability, restlessness, difficulty concentrating, anxiety, depression, and insomnia. Caffeine metabolism is affected by tobacco smoking. Finally, since persons with alcohol/drug use disorders are especially heavy smokers, they are especially likely to die of smoking-related diseases.

Tobacco Use Disorder is highly treatable using FDA-approved and regulated pharmacological, behavioral, and/or psychosocial treatments and such treatment can substantially reduce the widespread complications of tobacco use disorders. Many of the basic skills and knowledge that addiction psychiatrists possess are readily applicable to helping smokers stop.

In view of the above, the AAAP advocates and supports the development of policies and programs which promote prevention, treatment, and research activities in the area of tobacco use disorders. These include, but are not limited to, the following:

1. Addiction psychiatrists should take an active role in treatment, research, prevention, and advocacy activities. Since prevention is crucial to reducing the prevalence of smoking and since patients with alcohol/drug problems are especially vulnerable to developing tobacco use disorders, addiction psychiatrists should be actively involved in prevention activities. Addiction psychiatrists must be aware of the new tobacco and nicotine products such as electronic cigarettes, etc.
2. The prevention and treatment of tobacco use disorders should receive attention comparable to other drug dependencies in the training of psychiatrists. There should be greater teaching about the nature of tobacco use disorders and their assessment and treatment in medical schools, psychiatry residency training programs, and continuing professional education programs. This teaching should occur in units on alcohol/drug abuse.
3. Addiction psychiatrists should integrate assessing and treating tobacco use disorders in their work and support the development of tobacco-free policies in all health-care facilities including alcohol/drug abuse units. They should be comfortable and trained to use all 7 FDA medications approved for the treatment of nicotine dependence. These medications should be available on formularies and made available when patients are in these forced abstinence environments to help prevent nicotine withdrawal. Staff should not have the appearance of being a tobacco user when working in these environments. Psychosocial treatment options should also be made integrated into treatment and available in addiction treatment programs, including nicotine anonymous meetings. Relapse prevention and psychosocial treatment groups should include tobacco since most in attendance are users. Also consider specific tobacco use treatment groups for both the lower and higher motivated patients. Addiction Psychiatrists should consider additional CME training in this area, such as the AAAP MOC PIP on this topic.
4. Psychiatrists and the AAAP should work to change governmental policies regarding tobacco in the following ways:
 - a. Control the availability of tobacco products to young persons through the establishment of a national minimum age of 21 years for purchase of all tobacco products and enhance enforcement of existing laws regulating the sale of tobacco products.
 - b. Eliminate subsidies and all other forms of governmental assistance which encourages the production or exportation of tobacco and tobacco products and, concomitant with this, encourage funding of transition programs for those with tobacco-related jobs.
 - c. Substantially increase state and federal taxes on tobacco products with the proceeds of such taxes invested in the prevention, treatment, and research of tobacco use disorders.

- d. Change the warning labels of tobacco products to include the high likelihood of developing dependence on nicotine as well as the proven health problems caused by use.

5. Several aspects of public education should be promoted:

Early teaching in schools should inform young people about the high risk of developing nicotine dependence after experimentation with tobacco and the health hazards consequent to tobacco use disorders.

Counter-marketing measures, including public service announcements and anti-tobacco marketing programs, should be designed to counter the seduction of tobacco advertising imagery and to educate the public about the hazards of smoking, to discourage experimentation with smoking, and to promote smoking cessation.

6. Addiction psychiatrists should work to help convince third party payors, including government-supported health insurance programs (Medicaid, Medicare, Champs), to reimburse qualified health professionals using clinically recognized methods for the treatment of tobacco use disorders. Reimbursement for tobacco use disorders should be included in alcohol/drug abuse benefits

7. Although smoking is clearly recognized as the most preventable cause of early death and disability, only about one percent of the federal research budget concerns smoking and of that amount, only a small proportion is slated for research on behavioral and psychiatric aspects of tobacco use disorders. Increased research efforts by government, universities, and other institutions into the causes, prevention, and treatment of tobacco use disorders, is long overdue. Among the many areas of research needed, the following are especially relevant to addiction psychiatry:

- a) The co-morbidity of tobacco use disorders with other alcohol/drug use disorders and psychiatric disorders.
- b) The positive effect of smoke-free inpatient units on the diagnosis and treatment of alcohol/drug use problems.
- c) The advisability and time of treatment of smoking cessation in those with alcohol/drug use disorders.
- d) Recognition of nicotine withdrawal as affecting human laboratory experiments with psychological, self report, and behavioral endpoints.

In summary, tobacco use disorders take an enormous toll on the health of our nation. The AAAP urges all of its members to work toward the goals outlined in this policy statement.

Footnote: Sections of the above policy statement were adopted from and are consistent with the policy statements on tobacco use disorders of the American Psychiatric Association, the American Society of Addiction Medicine, and the American Medical Association.

References:

¹<http://www.cdc.gov/chronicdisease/resources/publications/aag/osh.htm>

²<http://pubs.niaaa.nih.gov/publications/arh293/208-212.htm>

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