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Integrating smoking cessation into substance use disorder treatment for military veterans: Measurement and treatment engagement efforts☆

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HIGHLIGHTS

- Tobacco cessation emphasis is lacking in SUD treatment despite high smoking rates.
- VA has implemented tobacco use measurement and intervention into primary care.
- Our VA program incorporated tobacco assessment items into a national addictions measure.
- Initial data indicated an increase in the use of nicotine replacement products.
- Future interventions will include peer support and an evidence-based treatment protocol.

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ABSTRACT

Military personnel and veterans smoke at higher rates than the general population, compromising physical performance readiness and health (Committee on Smoking Cessation in Military and Veteran Populations & Institute of Medicine, 2009). While efforts are being made within both the Department of Defense and the Veterans' Administration (VA) hospitals to prevent onset, change the smoking culture, and promote smoking cessation; smoking rates are increasing among combat deployed service members, and smoking rates are particularly high among veterans with mental health and other substance use disorders (McFall, 2006). Recent research supports making smoking cessation widely available and integrated with other forms of care (Gierisch et al., 2012; McFall et al., 2010). This paper describes the efforts of one VA substance use disorder (SUD) treatment program to integrate smoking cessation in routine care, including assessment of tobacco use and motivation and intention to quit via the proposed Nic-BAM assessment. Our team was 100% successful in incorporating the Nic-BAM into our regular assessment of treatment program participants. This suggests that staff members are amenable to assessing for tobacco addiction alongside other substance addictions. Although smoking did not decrease according to the Nic-BAM, an increase in the use of nicotine-replacement products suggests that participants are willing to initiate a quit attempt during SUD treatment. The availability of new evidence-based approaches for integration of tobacco cessation with mental health and SUD treatment may help to enhance programmatic efforts. Environmental changes are needed to fully incorporate tobacco recovery into SUD programming, and additional resources may include peer support specialists.

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1. Introduction

"Smoke 'em if you got 'em" is a refrain offered by many veterans in describing the way that smoking was a part of the culture of their military experience. Up until 1975, combat soldiers' food rations contained cigarettes, and tobacco products can still be obtained tax-free at military commissaries (Joseph, Muggli, Pearson, & Lando, 2005). A 1985 study by the Department of Defense (DoD) concluded that smoking adversely impacted military readiness through reduced physical performance capacity, and in 1986 an anti-smoking campaign was initiated (Taft, 1986). Smoking was banned during basic training and eventually was eliminated from indoor spaces, including submarines in 2010 (Shah & Arnold, 2011). Despite these changes, military personnel continue to have higher smoking rates than the general population (32% vs. 21%) (Bray et al., 2005; Committee on Smoking Cessation in Military and Veteran Populations & Institute of Medicine, 2009), and rates of smoking and use of smokeless tobacco products are increased among those who are deployed into combat areas (Smith et al., 2008). While the average smoking rate for veterans was recently reported to be 26–27% (Brown, 2010; Chwastiak, Rosenheck, & Kazis, 2011), rates are as much as 2–3 times higher among individuals who have mental health

☆ Portions of the Nic-BAM were presented in poster form at the 2012 annual meeting of the American Psychological Association in Orlando, FL.

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or other substance use disorders (SUDs) (Lasser et al., 2000) and have even been reported to be as high as 92% in one SUD treatment sample (Moore et al., 2007).

In response to these challenges VA has been working to implement programs and policies that promote smoking cessation (Hamlett-Berry et al., 2009). Primary care medical staff members are routinely prompted to inquire about smoking behavior and offer assistance, and smoking cessation programs have been developed within primary care settings. More recently, evidence-based smoking cessation treatment is also being incorporated into PTSD programs based on findings that integrated approaches have shown greater effectiveness (McFall et al., 2010). A recent study which used focus groups to survey Iraq and Afghanistan-era veterans indicated that veterans welcome help with smoking cessation that is widely available, inexpensive and individualized (Gierisch et al., 2012).

Research on the combined treatment of tobacco and other substance addictions has been slow to accumulate. However, there is now an evidence base, along with national guidelines, that supports the concurrent treatment of nicotine dependence and other addictions (Fiore et al., 2008; Prochaska, Delucchi, & Hall, 2004), and many substance use disorder (SUD) treatment programs have integrated tobacco cessation interventions with promising results (Baca & Yahne, 2009). It has been noted that mental health and SUD treatment providers have advanced training and skills in promoting behavior change that can be applied to addressing nicotine dependence (Carmody, 2006), and efforts are being made to shift SUD treatment culture to support tobacco cessation (Cooney, 2006).

Despite these encouraging observations, integration of smoking cessation into SUD treatment programs on a system-wide level has been limited. While the Uniform Mental Health Services plan (Department of Veterans' Affairs, 2008) includes mention of smoking cessation, recent SUD initiatives have not taken advantage of opportunities to optimize integration. For example, in 2011, funding was provided to VA SUD programs for the development of contingency management programs to augment existing SUD treatment. Unfortunately, these funds could not be used to promote smoking cessation.

VA SUD programs nationwide are currently implementing procedures for assessing substance use and related behaviors using the Brief Addiction Monitor (BAM). The BAM was developed to offer a brief, easily administered instrument based on valid clinical constructs that yields clinically relevant information and can track change over time for both clinical and program evaluation purposes (Cacciola et al., 2013). The 17 BAM items were generated based on a review of existing measures and feedback from clinicians, researchers, and veterans participating in an outpatient SUD program. An initial evaluation of the BAM has indicated good test–retest reliability and sensitivity to change over the course of SUD treatment, and exploratory factor analysis resulted in identification of three factors that can be described as "recovery protection, physical and psychological problems, and substance use and risk" (Cacciola et al., 2013, p. 261). It has been recommended that the BAM be administered at the beginning of treatment and, at minimum, 60–90 days after the initial (baseline) assessment.

While the BAM examines alcohol and drug use and associated behaviors, it unfortunately does not include any questions regarding tobacco use or factors related to tobacco cessation. The follow-up question for individuals who acknowledge drug use inquires about an extensive list of substances of abuse, even including a category for "other." Exclusion of nicotine use from nationwide SUD program initiatives may unwittingly communicate a perception that nicotine dependence is separate from other substance-use disorders and not an appropriate target for intervention within SUD programs.

Failure to optimize integration of smoking cessation into SUD treatment is concerning because substance dependent individuals smoke cigarettes at a rate of 3–4 times that of the general population (Lasser et al., 2000). They are also more likely to die from tobacco-related illnesses than from those associated with the use of alcohol (Hurt et al., 1996). SUD treatment programs have specialized expertise for treating addictive behaviors and would seem to be uniquely equipped to help those whose nicotine dependence may be the most severe and challenging to treat. Indeed, attempts have been made within VA to promote integration of tobacco cessation into ongoing mental health care and SUD treatment through the training of preceptors (Hamlett-Berry, 2006) and more recently through dissemination of an evidence-based protocol for integrated smoking cessation treatment (McFall et al., 2010). The rationale offered for integration highlights the chronic and relapsing nature of nicotine dependence, the increased prevalence among veterans with mental health and substance use disorders, and the ongoing nature of the relationship between veteran clients and their mental health treatment providers (McFall, 2006). This paper describes one VA medical center SUD treatment program's efforts to monitor smoking-related behavior and attitudes and to integrate smoking cessation efforts into intensive outpatient SUD treatment.

1.1. Chronological course of SUD program interventions

Efforts to incorporate smoking cessation into our Alcohol and Drug Abuse Treatment Program (ADATP) began in 1999 when the intensive outpatient program (IOP) added a nicotine education class for all program participants and a weekly nicotine recovery support group for those who were interested in quitting smoking. Nicotine replacement patches and gum were ordered by ADATP prescribing providers upon request from program participants. During this time period, all participants completed measures of tobacco use, self-efficacy, and motivation to quit at the beginning and the end of treatment, and follow-up data were obtained using the Addiction Severity Index (ASI) (McLellan et al., 1992). Performance improvement data indicated that participants who attended the nicotine recovery groups increased in motivation to quit and smoked fewer cigarettes over the course of their treatment (Shealy et al., 2001). At this point in time, there was some concern among program staff that attempting to quit smoking might jeopardize participants' ability to abstain from other substances. Follow-up ASI data suggested that there was no difference in substance use outcomes, and the participants who participated in nicotine recovery groups showed a trend toward decreased medical problem severity at follow-up (Shealy et al., 2001).

In 2002, ADATP started offering a weekly nicotine recovery class for all intensive treatment participants (replacing the voluntary support group). This psycho-education group was offered to raise awareness about the availability of nicotine replacement and to engage participants in consideration of the decision to continue smoking or to quit. In 2008, a program psychologist conducted individual assessment of smoking attitudes and behavior with all program participants and offered smoking cessation counseling to those who were interested in quitting or preparing for a quit attempt. Tobacco use, degree of motivation for quitting, perceived barriers, and self-efficacy were measured, as well as motivating reasons for quitting. Results were published in a peer-reviewed journal for healthcare professionals in the VA and other parts of the federal system (Winn et al., 2011). Of the 116 program participants in the study sample, 73% used tobacco products with a 5.66 average score on the Fagerstrom Test of Nicotine Dependence (FTND; Heatherton, Kozlowski, Frecker, & Fagerstrom, 1991), indicating a moderate level of dependence. Consistent with previous findings, participants' readiness to quit increased over the course of treatment and cigarette use decreased by nearly 6 cigarettes per day. Health was the greatest motivating factor, followed by a desire to save money and a concern that smoking "smells or tastes bad." "Being around others who smoke" was identified as the most significant obstacle followed by concern about "stress" (Winn et al., 2011).

Importantly, our team has also studied our own staff members' perceptions of patients' motivators, obstacles, and self-efficacy to quit tobacco (Milford-Winn et al., 2009). Our staff survey showed that staff identification of participant motivators for smoking cessation was highly