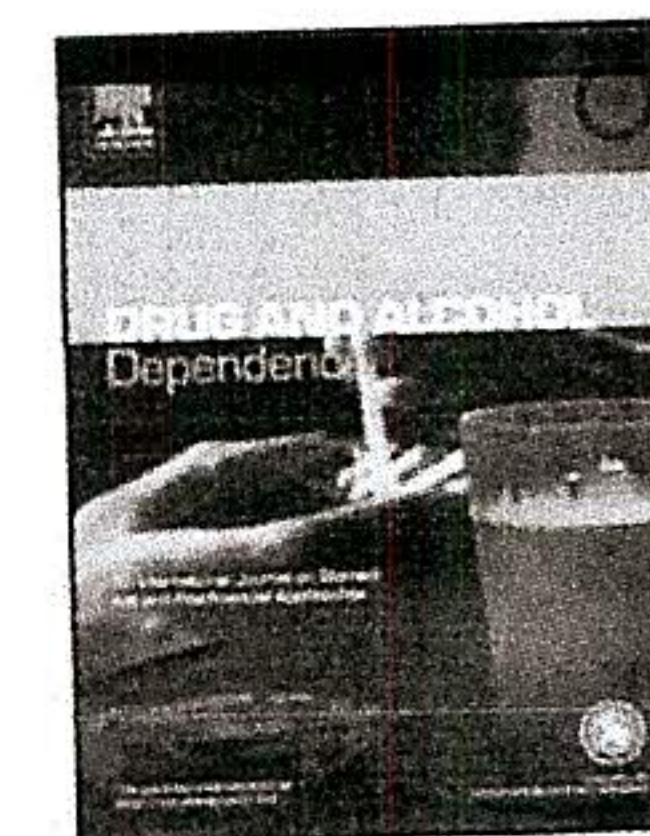




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## Commentary

Failure to treat tobacco use in mental health and addiction treatment settings:  
A form of harm reduction?

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## ABSTRACT

In mental health and addiction treatment settings, failure to treat tobacco dependence has been rationalized by some as a clinical approach to harm reduction. That is, tobacco use is viewed as a less harmful alternative to alcohol or illicit drug use and/or other self-harm behaviors. This paper examines the impact of providers' failure to treat tobacco use on patients' alcohol and illicit drug use and associated high-risk behaviors. The weight of the evidence in the literature indicates: (1) tobacco use is a leading cause of death in patients with psychiatric illness or addictive disorders; (2) tobacco use is associated with worsened substance abuse treatment outcomes, whereas treatment of tobacco dependence supports long-term sobriety; (3) tobacco use is associated with increased (not decreased) depressive symptoms and suicidal risk behavior; (4) tobacco use adversely impacts psychiatric treatment; (5) tobacco use is a lethal and ineffective long-term coping strategy for managing stress, and (6) treatment of tobacco use does not harm mental health recovery. Failure to treat tobacco dependence in mental health and addiction treatment settings is not consistent with a harm reduction model. In contrast, emerging evidence indicates treatment of tobacco dependence may even improve addiction treatment and mental health outcomes. Providers in mental health and addiction treatment settings have an ethical duty to intervene on patients' tobacco use and provide available evidence-based treatments.

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## 1. Introduction

Tobacco dependence is the most prevalent drug abuse disorder among adults with psychiatric diagnosis or illness, a group estimated to account for nearly 1 in 2 cigarettes sold in the United States (Grant et al., 2004; Lasser et al., 2000). Neurobiological and psychosocial factors are thought to contribute to the high rates of tobacco use in this group, including the reinforcing mood-altering effects of nicotine, shared environment or genetic factors, and reduced coping for cessation efforts (Dursun and Kutcher, 1999; Kendler et al., 1993; Ziedonis et al., 1994). Nicotine's reinforcing actions on the mesolimbic dopamine reinforcement pathway in the brain are similar to those of cocaine and amphetamine, contributing to elevation of mood, cognitive enhancement, and decreased appetite (Stahl, 2000). Nicotine delivered by a transdermal patch has produced improvement in attention among smokers and non-smokers, in persons with and without attentional deficits (Connors et al., 1996; Levin et al., 1998), and in patients with schizophrenia and nonpsychiatric controls (Barr et al., 2008).

Though a number of factors are believed to contribute to the high smoking rate among individuals with psychiatric disorders,

systemic factors and failure to treat tobacco dependence in mental health and addiction treatment settings have been largely ignored. Historically, the tobacco industry marketed their product to persons with mental illness, provided tax-free cigarettes to psychiatric facilities, and funded research promoting a self-medication hypothesis for nicotine (Prochaska et al., 2008a). In inpatient psychiatry, cigarettes were provided to patients, considered among the most effective forms of reinforcement, with some patients first starting to smoke while hospitalized (Hayworth, 1996; Holtzman, 1975; Robertson, 2000). Still to this day, most mental health training programs lack adequate instruction in treating tobacco dependence (American Psychiatric Nurses Association, 2008; Prochaska et al., 2006), and, likely related, psychiatric patients' tobacco dependence is rarely addressed in clinical practice (Himelhoch et al., 2004; Montoya et al., 2005; Phillips and Brandon, 2004; Prochaska et al., 2005). In a recent national survey, psychiatrists were the least likely to address tobacco use with their patients relative to other medical specialties (Association of American Medical Colleges, 2007).

In mental health and addiction treatment settings, failure to treat tobacco dependence has been rationalized by some as a clinical approach to harm reduction. That is, tobacco use is viewed as a lesser evil, a lower treatment priority, or less harmful alternative to alcohol or illicit drug use and/or other self-harm behaviors (Fuller et al., 2007; Prochaska et al., 2006; Richter et al., 2002). The assertion by treatment providers is that if patients were to quit

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