



AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.

Public Policy Statement

on

Nicotine Addiction and Tobacco

Background

Nicotine is the psychoactive drug in tobacco. Regular use of tobacco products leads to addiction in a high proportion of users.

Nicotine dependence is the most common form of chemical dependence in the United States. The National Survey on Drug Use and Health database shows that one of every three first time cigarette users become dependent (Family Practice News 03/15/05).

This addiction is especially prevalent among those who suffer from alcoholism and from other drug dependencies.

Nicotine dependence most often begins as a pediatric disease. In 1994, four million young people, aged 12-17 years, were current users of cigarettes. Three thousand youth become regular users each day, one-third of whom will eventually die from a tobacco-caused disease.

The nicotine addiction epidemic is fueled in part by the low price of tobacco products, their ready availability to those underage (despite laws to the contrary), and the enormous marketing campaigns for these products (campaigns that are often very seductive and attractive to the young). In 2003, the cigarette industry spent more than \$15 billion on marketing. Even with restrictions placed on tobacco marketing since the early 1990s, the tobacco industry gets its message to potential new users quite effectively, including through unregulated Internet-based advertising.

Cigarettes cause an enormous burden of illness, disability and death. On average each year from 1997 to 2001, the cigarette caused more than 438,000 premature deaths in the United States (MMWR

2005;54(25):625-8) and more than 3 million worldwide. Globally 1 person dies every 7 seconds from smoking-related diseases, and a smoker loses an average of 13.8 years of life (Missouri Department of Health and Senior Services. *Smoking-Attributable Mortality in Missouri, 1999*). The 2004 Surgeon General's Report on The Health Consequences of Smoking found that children and adolescents who smoke are less physically fit and have more respiratory illnesses than their nonsmoking peers. In general, smokers' lung function declines faster than that of nonsmokers.

Smokeless tobacco use is epidemic among the young. Smokeless tobacco products, along with cigars and pipe tobacco, are causes of nicotine addiction and cancer, among other serious problems. Cigar smoke has been shown to cause lung cancer, emphysema and heart disease among the many users who inhale the smoke.

The general public is aware that tobacco use is harmful, but it seriously underestimates the magnitude of the harm which tobacco causes.

Nonsmokers, too, are harmed by tobacco use. Nonsmokers may themselves become ill with lung cancer, heart disease, lower respiratory ailments, worsening of asthma and other problems through exposure to environmental tobacco smoke (second hand smoke). Nonsmokers who are exposed to secondhand smoke at home or work increase their heart disease risk by 25–30% and their lung cancer risk by 20–30%. They suffer through the illnesses and premature deaths of family members, friends and associates. They also share unwittingly in the economic costs of tobacco use because of higher insurance and medical care costs. At least 50,000 deaths are due to secondhand smoke each year in the USA (California Air Resources Board [CAR], 2005). Almost 60% of U.S. children aged 3–11 years—or almost 22 million children—are exposed to secondhand smoke.

Becoming abstinent from tobacco has been shown to have substantial beneficial effects on health and longevity. The treatment of nicotine addiction reduces the complications of this addiction. Many who successfully recover from another addiction die from a complication of nicotine addiction. The widespread notion that nicotine dependence is best left untreated during the course of treatment for other drug dependencies lacks empiric support.

Although the medical profession has traditionally viewed tobacco use as a risk factor for other diseases, instead of a primary problem in itself, this approach has impeded, rather than promoted, the development of optimal treatment methods for patients addicted to nicotine. Nicotine dependence is a primary medical problem deserving of thoughtful, ongoing attention from every responsible clinician. Diseases either caused by or made worse by tobacco use should be regarded as complications of nicotine dependence.

Although the chemical dependency field has traditionally viewed tobacco smoking as almost normative and not central to the alcohol and other drug recovery process, attitudes and behaviors are shifting. Rather than viewing attention to a patient's smoking as 'defocusing' from their 'real' addictions, counselors are now addressing tobacco addiction in treatment plans. The New York State Office on Alcohol and Substance Abuse Services introduced Part 856 of its regulations governing certification of addiction treatment services, which requires programs to incorporate nicotine dependence in addiction services treatment plans for all nicotine dependent persons receiving alcohol or other drug addiction care; these landmark requirements became effective in mid-2008. All states should move in similar directions.

While the processes of Screening and Brief Intervention by primary care physicians were developed by professionals to reduce smoking and its adverse health effects, momentum regarding SBI in the early 21st century has focused on using SBI to address drinking and the adverse health effects of alcohol use and addiction. SBI has even been proposed to address all emerging chemical dependencies, including addiction to or misuse of prescription drugs. The emphasis on tobacco and the psychoactive drug it contains, nicotine, should not be diminished given the reality that more persons—including persons with alcohol addiction—die from nicotine addiction than from any other addiction. The U.S. Public Health Service 2008 publication, Clinical Practice Guideline Update: *Treating Tobacco Use and Dependence*, encourages all physicians to use the 5 A's of SBI (Ask, Advise, Assess Motivational Level, Assist, Arrange Follow-up) to intervene for tobacco use and addiction, employing techniques of SBIRT (Screening, Brief Intervention, and Referral to Treatment) to address nicotine addiction in patients they see in their regular workday. The 2008 Practice Guideline also encourages the use of pharmacotherapies to assist patients who desire to stop smoking.

Policy Recommendations

1. The American Society of Addiction Medicine advocates and supports the development of policies and programs which promote the prevention and treatment of nicotine addiction. These include, but are not limited to, the following:

a: The availability of tobacco products to the young should be controlled through the establishment of an enforced, national minimum age of 21 years for purchase of all tobacco products and the requirement that all sales of tobacco products be face to face encounters, eliminating vending machines, self-service and mail order sales. Efforts to reduce tobacco sales to minors should reserve punitive approaches to manufacturers, distributors and merchants, and should not include measures that penalize underage possession or use of tobacco products. Punishment of the user perpetuates a counterproductive judicial approach. Underage persons who use tobacco products should instead be referred for educational or clinical services, as indicated.

b. Governmental policies regarding tobacco should be changed in several ways. These include:

(1) Assigning the regulation of all nicotine-containing products intended for human consumption to the Food and Drug Administration. In particular, ASAM vigorously supports the proposal made by the FDA in the Federal Register of August 11, 1995 to regulate cigarettes and smokeless tobacco products as nicotine delivery devices.

(2) Requiring tobacco product manufacturers to publish and publicize the ingredients used in each brand they offer to the public and to publish and publicize the levels of toxic substances, including nicotine, that customers who consume each such product may reasonably expect to have delivered to their bodies via tobacco use.

(3) Requiring the inclusion of package inserts in each tobacco product sold to a consumer. Such inserts would contain useful information about the harm of tobacco use, the benefits of stopping, and advice on how to stop.

(4) Strengthening the warning labels on cigarettes and smokeless tobacco and extending the warning

label system to all other tobacco products so that the warnings are much more visible, easier to understand, and explicitly describe the risks of addiction, disease and death from use of these products.

(5) Increasing substantially state and federal taxes on tobacco products and assigning a portion of the revenue generated from increased taxes to fund sustained, integrated, multifaceted public health programs to reduce tobacco consumption.

(6) Eliminating all advertising and other promotional activities for nicotine-containing tobacco products, including mandating that all packaging for tobacco products be plain packaging, in order to eliminate the allure provided by package design and brand-associated symbols.

(7) Enforcing the ban against cigarette advertising in broadcast media by directing the Justice Department to take action against cigarette brand and smokeless tobacco brand promotions and sponsorships in all professional sports including motor sports.

(8) Supporting research and public health efforts funded through the various branches of government, including the Department of Defense, the NIH, CDC, SAMHSA, and state initiatives that contribute to (1) an understanding of nicotine addiction, its treatment and its prevention, and (2) controlling the epidemic, including research and programmatic assistance in understanding and dealing with the profound clinical interrelationships among nicotine, alcohol and other addictive drugs.

(9) Adopting measures such as those in place in Ontario which prohibit pharmacies and stores with pharmacy departments from selling tobacco products.

(10) Adopting measures such as those in place in Nova Scotia which ban smoking in vehicles with children under the age of 18.

(11) Eliminating subsidies and all other forms of governmental assistance which encourage the production of tobacco and tobacco products, and eliminating tobacco as an export crop and eliminating tobacco products as export products from the United States, then replacing government assistance for tobacco product exports with the export of medical and public health knowledge about tobacco and about how to control the tobacco epidemic.

(12) Funding transition programs for displaced workers from excise taxes on tobacco products when jobs now in the tobacco industry are eventually shifted to other parts of the economy as a result of the above and other measures.

(13) Requiring alternative designs to make cigarettes fire-safe, since these products are the leading

cause of death in household fires.

c. Treatment for nicotine withdrawal and nicotine addiction should be broadly available and utilized.

(1) Physicians and other health care providers should engage in Screening, Brief Intervention, and Referral for Treatment for tobacco use and nicotine addiction.

(2) Physicians and other health care professionals should utilize evidence-based pharmacotherapies and psychosocial and behavioral interventions for tobacco use and nicotine addiction, as outlined in the 2008 Clinical Practice Guideline Update: *Treating Tobacco Use and Dependence* of the U. S. Public Health Service.

(3) Addiction treatment services should address nicotine addiction on a par with other chemical dependencies. Counselors should be trained to assess for nicotine addiction when they do assessments for other chemical dependencies. When nicotine addiction is present for a patient, the treatment plan should address the patient's nicotine addiction as it would address any other addiction. Accreditation and regulatory agencies at the state and national level should take steps to assure that addiction treatment services include interventions for nicotine withdrawal and nicotine addiction whenever the patient's clinical condition so indicates. Addiction treatment service providers should make their facilities and grounds smoke-free environments for patients, staff and visitors alike and not allow any tobacco use on their premises.

(4) All addiction treatment professionals who recommend Alcoholics Anonymous or other self-help participation by their patients should recommend to their patients that they seek out smoke-free 12-step meetings and a non-smoking AA sponsor. For their patients who accept the recommendation to attempt a cessation of smoking, counselors should advise attendance at Nicotine Anonymous meetings as an option for their patient to consider.

(5) All private and government health insurance plans should cover the costs of treatment for nicotine withdrawal and addiction on a par with treatment for other medical-surgical conditions. There should not be discriminations against payment for treatment for nicotine-related health conditions, including addiction; nicotine replacement therapies and other pharmacotherapy for nicotine withdrawal and addiction should be covered by health insurance plans.

(6) Health care delivery systems should build systems for identifying and treating cases of nicotine addiction as well as patient education regarding nicotine addiction and other health consequence of smoking and smokeless tobacco use.

2. . Research, professional education, and clinical expertise in the areas of nicotine dependence should receive increased emphasis through the following measures:

a) Promoting research in universities and other institutions into the causes, prevention, and treatment of nicotine dependence, including organizational and cultural change efforts.

b) Training all health professionals to regard nicotine dependence as a primary medical problem including training in the management of nicotine dependence on the part of physician specialists in

addiction medicine, primary care physicians, clinical psychologists, and all alcohol and other drug counselors. This training should also include information on the ways the tobacco industry perpetuates the epidemic and undermines efforts aimed at reducing the problem and on ways health care professionals can help counter these influences.

c) Teaching about the dependency process and about the management of nicotine dependence in CME courses and other professional education programs.

d) Teaching that nicotine dependence and withdrawal needs to be diagnosed and treated along with other drug dependencies.

e) Exploring mechanisms for third party reimbursement for the treatment of nicotine dependence by qualified health professionals who use clinically recognized methods.

f) Refusal of any funding from the tobacco industry and its subsidiaries by medical schools, other research institutions and individual researchers to avoid giving tobacco companies an appearance of credibility.

g) Encouraging all institutions involved in health care to divest from the tobacco industry since investments in this industry are profitable only to the extent that measures to control the epidemic fail

3. Public education about tobacco should be enhanced by additional measures, including:

a) Establishing primary and secondary schools as tobacco-free zones with clinical support made available as a benefit of enrollment or employment for those students and staff who want assistance in dealing with nicotine dependence.

b) Teaching of youth in the schools about the risks of addiction, disease and death from tobacco use and about the cynical efforts of the tobacco industry to recruit new customers from among their peers.

c) Counter-marketing tobacco products, including advertisements and other efforts, to offset the seduction of tobacco advertising imagery and to educate the public about the hazards of tobacco and about methods of quitting or of not starting tobacco use.

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4. Tobacco-free policies should be implemented in all workplaces and places of public accommodation, including all health-care facilities, hotels, motels, restaurants and taverns (see ASAM Public Policy Statement on Clean Indoor Air).

5. Elected officials should be encouraged to refuse to accept support from tobacco companies so that

they can more easily work to control the epidemic caused by tobacco.

6.. Legal action against the tobacco industry should be supported, including law suits by states, private insurers and others seeking to recover money spent on medical care of tobacco-caused disease, consumer protection actions seeking to better inform the public about tobacco or to stop industry practices which harm the public health, and product liability suits brought by individuals who have been harmed by tobacco products.

7. ASAM should actively participate in a liaison network with other groups on issues of mutual interest related to tobacco.

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