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Smoking and Recovery: Get the Facts.

Myth: *"Quitting smoking will interfere with abstinence from other substances."*

Fact: People are actually more likely to stay clean/sober when they quit, or don't start, smoking. A nationally representative, prospective longitudinal investigation published in 2017 found that continued smoking, as well as smoking initiation by nonsmokers, was associated with a greater chance of substance use disorder (SUD) relapse (Weinberger et al., 2017). In a meta-analysis of 17 studies examining people in treatment for SUD, quitting smoking was found not to interfere with their treatment in the short term, and was actually associated with 25% increased likelihood of staying abstinent in the long term (Prochaska et al., 2004).

Myth: *"People in recovery have bigger problems than smoking."*

Fact: Smoking is actually a #1 killer in individuals with mental illness and/or substance use disorder. The major causes of death in people with mental health/substance use disorder (MH/SUD) are cardiovascular disease, respiratory/lung disease, and diabetes mellitus (Parks et al., 2006; Lawrence et al., 2010), all of which are caused or exacerbated by smoking (Schroeder & Morris, 2010; Lawrence et al., 2010). In the United States, 200,000 of the 443,000 total annual premature deaths due to smoking take place in individuals with mental illness, inclusive of substance use disorder (Schroeder & Morris, 2010). Shockingly, cigarette smoking is actually one of the top three most powerful predictors of future suicidal acts (Oquendo et al., 2004).

Myth: *"People in recovery need to smoke for self-medication or symptom management."*

Fact: Quitting smoking, compared to continuing to smoke, is associated with a significant decrease in anxiety, depression, mixed anxiety and depression, and stress, regardless of mental health diagnosis, according to a recent systematic review and meta-analysis of

available research. Effect sizes of smoking cessation were found to be equal to or larger than those of antidepressant treatment for mood or anxiety disorders; quitting was also associated with improved positive mood and quality of life (Taylor et al., 2014).

Did you know? Smoking (not nicotine) increases the rate at which the body metabolises various psychotropic medications commonly prescribed to individuals with schizophrenia, bipolar disorder, anxiety disorders, etc.. Smoking may decrease blood levels of certain antipsychotics up to 40%. Quitting smoking can actually reduce the amount of medication needed for symptom management (Desai et al., 2001; Johnson et al., 2009).

Myth: *"People with mental illness or substance use disorder can't quit smoking."*

Fact: A 2000 survey showed that quit rates in smokers with mental illness, while somewhat lower than those without a mental health diagnosis, were still substantial. 42.5% of smokers without mental illness had quit, compared to 37.1% of those with a lifetime history of mental illness and 30.5% of those with mental illness in the past month. Quit rates were even higher for people who were abstinent from alcohol (41.5%) and drugs (39.0%) (Lasser et al., 2000).

Myth: *"People with MH/SUD don't want to quit smoking."*

Fact: Many smokers with mental illness do intend to quit: studies have shown that about 70% of them have a desire to quit smoking. Over 40% are in the contemplation stage, which is about the same as the general population; 24-28% are in preparation, ready to quit in the next 30 days. Even among people with substance use disorder, research shows that 44% to 80% of them are interested in quitting smoking (pp. 414-415, Hall & Prochaska, 2009).

Myth: *"It's not my job (as an addiction/behavioral health professional) to help people quit smoking."*

Fact: The behavioral health setting is ideal for smoking cessation, thanks to your specialized skill set in behavioral change strategies, as well as the frequency and long-term nature of most clients' treatment (Schroeder & Morris, 2010). Greater frequency of contact plus more points of contact (for example, with a case manager, peer support specialist, therapist, and psychiatrist) are associated with greater success rates in quitting (Fiore et al., 2008). Mental health patients tend to think of their mental health provider as their primary health care resource (Morris et al., 2009), and psychiatrists are often the only doctors consistently seen by the seriously mentally ill (Hall & Prochaska, 2009); so you may not only be the best, but perhaps the *only*, person to help your clients quit. Indeed, it has rightfully been argued that behavioral health providers have a moral obligation to help and encourage their clients to quit smoking (Prochaska, 2010).

Myth: *"I don't have the time to deal with smoking in my patients/clients."*

Fact: Helping people to quit smoking can be as easy as A, B, C… 1, 2, 3… or, more accurately, the "5 A's" or "2 A's & R." The 5 A's is an evidence-based intervention, recommended by the Centers for Disease Control and Prevention and the Department of Health and Human Services, that can be implemented quickly and easily into standard treatment. It may be performed by a single staff member or it is even more effective when delivered as part of a coordinated team care approach (Fiore et al., 2009). As an alternative, it takes only 5 minutes for a single clinician/peer to do 2 A's & R with a client (Schroeder & Morris, 2010).

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