

A CAREER IN ADDICTION SERVICES

UNEXPECTED NEW MISSION

I remember the day I discovered a statistic I wasn't looking for that changed my life direction. The statistic came from some data I discovered on the prevalence and incidence of nicotine dependence in disparate or special needs populations.

The data reported that the prevalence of smoking in the alcohol and drug addiction population was 78%. I had no idea this data existed and couldn't believe it could be true. I knew smoking was common in both the treatment of addiction and the recovering community.

This 78% prevalence of smoking by alcoholics and other addicts was striking because smoking in the general population had improved from 42% to somewhere near the 22% range over 50 years.

If this data was accurate and credible it meant those I had been treating since 1975 were getting sick and dying from tobacco at more than 3 times the rate of tobacco deaths in the general population. How could this be acceptable?

Little did I know this information and the issues it generates would become the obsession and mission of what remained of my life.

I had worked as an addiction, clinician, manager and administrator since 1975. I was in long term recovery from alcohol and tobacco myself. I became tobacco and nicotine free in 1963. I became alcohol free in 1956. I was well aware of the important role and the prevalence of tobacco and smoking in treatment and recovery. I just had done nothing about it other than quit smoking myself and advise smokers and dippers to quit.

I think it was sometime in 1998 or 1999. I was getting ready to retire as my 65th birthday was coming up on April 15th, 2000. I was working as an addiction counselor in the St Clare Center in Baraboo, Wisconsin and doing some outreach business promotion assignments.

I was sharing an office with Judy Spring the St Clare Hospital Health Education Director. Judy was the coordinator of the Sauk County Tobacco Free Coalition (SCTFC) as part of her scope of activities.

Judy knew I was retiring soon and invited me to serve as a consultant on a planning grant, she was working on that could provide some education and intervention services for adolescents with drinking problems.

Judy said I might have other opportunities with SCTFC. She suggested I get some orientation from her colleagues at the UW-Center for Tobacco Research and Intervention (CTRI) and the Wisconsin Division of Public Health's Tobacco Prevention and Control Program.

Gayle Laszewski was CTRI's Southern District Outreach Specialist at the time and provided the orientation I needed to understand what the state's and national goals and objectives were. I never had any tobacco education or Inservice training in my 25 years working in addiction.

Gayle and Judy Spring educated me on the fundamentals of tobacco prevention and control policies. I learned the Wisconsin Tobacco Prevention and Control Program (TPCP) has a responsibility to provide services to disparity populations. These had been identified by the Federal Government's Office of Smoking and Health for special attention at the state level.

I studied these prevalence and incidence demographics and stumbled on the 78% prevalence in some of the material I was given to study. It wasn't in the special populations data that provided the priority focus for disparity populations objectives. I couldn't find anywhere that seemed to consider the addiction population now called Substance Use Disorders as a priority.

I couldn't find anywhere in the addictions literature that had tobacco identified as being either a treatment or policy issue of significance. I not only didn't find it in the literature I knew from 25 years of service in the addiction, treatment, intervention and recovery practices tobacco was an ignored issue. But, if the data I was discovering was accurate, this should be a major concern of providers, patients and government. I determined to find out for myself.

I knew nicotine dependence as we called it then had a DSM1V diagnosis code. It as 305.1 I knew each county had an individual report on every addiction treatment they provided and funded. I knew that because I had completed many of them myself.

I went to the Division of Mental Health and Substance Abuse and asked for a study on the incidence of Nicotine Dependence in Wisconsin. The researcher, Michael Quirk, did the survey and found none, no record of any nicotine dependence 305.1 cases was identified or reported for intervention and treatment. Mike was as surprised as I was with this discovery and became an ally. His credibility as a researcher was well established. We believed it was important to address this issue with data. His colleagues became open to support the search for a remedy that addressed this obvious gap in addiction/AODA treatment and related services.

I decided to design a study of my own and implement it at the St Clare Center and determine the prevalence of nicotine dependence in 52 of the residential and day treatment patients over several months. I used the Fagerstrom questionnaire, DSM1V criterial for nicotine dependence and a readiness to change questionnaire.

The study revealed nearly 86% of those with other substance use disorders also were nicotine dependent and 75% of them were willing to address their tobacco use and nicotine dependence at some point in their treatment.

I have spent the next 20 years trying to remedy this unacceptable gap in addiction treatment for many reasons not the least of which is to save the lives of people like me who have addiction and mental health disorders.