Public Policy Statement
on Nicotine Addiction and Tobacco
(formerly Nicotine Dependence 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 addiction is the most common form of addiction in the United States. The National Survey on Drug Use and Health database shows that one of every three first time cigarette users becomes dependent.\(^1\)

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

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 addiction 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 addiction.

Nicotine addiction most often begins as a pediatric disease. In 2006, three million young people, aged 12-17 years, were current users of cigarettes.\(^2\) Three thousand youth become regular users each day, one-third of whom will eventually die from a tobacco-caused disease.

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\(^3\) 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.\(^4\) 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 that that of nonsmokers.

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\(^1\) Family Practice News, 3/15/05
\(^2\) 2006 National Survey on Drug Use and Health, Substance Abuse and Mental Health Administration.
\(^3\) MMWR 2005;54(25):625-8
\(^4\) Missouri Department of Health and Senior Services. *Smoking-Attributable Mortality in Missouri, 1999*
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.

Non-smokers, too, are harmed by tobacco use. Non-smokers 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). Non-smokers who are exposed to second-hand 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.\(^5\) Almost 60% of U.S. children aged 3-11 years—or almost 22 million children—are exposed to secondhand smoke.

The nicotine addiction epidemic is fueled in part by the wide availability of industry-marketed discounts and discount internet sites, which evade some federal and state excise taxes and minimum age limits for sales to youth; the ready availability of tobacco products 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.

Taxation is one means of raising the price of tobacco products, which has been shown to reduce the purchase/use of tobacco products by youth, who are particularly sensitive to changes in price. Tax increases imposed on a federal basis minimize inequities in tax structure in various states that create unbalanced markets affecting purchasers’ travels across jurisdictional lines to purchase lower-price products; federal excise taxes also can be directed to increasing federal funding support for biomedical research regarding nicotine addiction and nicotine addiction treatment. Native American nations should be encouraged to equalize their retail prices for tobacco with those in surrounding jurisdictions and not create market loopholes which promote sales of lower-tax and thus lower-priced tobacco products, especially in outlets targeted to tobacco purchasers such as tribal-operated 'smoke shops.'

Changing public policy can happen via judicial initiatives, but usually happens via legislation, which is a political process. Lobbyists for the tobacco industry are active at national, state and local levels. Ideally, wise policy changes can be implemented on a national scale, but political realities sometimes get in the way. And state governments, which rely on tobacco taxes for revenue, may feel some conflict of interest in establishing policies that would reduce tobacco sales and, thence, tobacco tax revenues. Policy change should be implemented wherever it is possible to do so: if not at the national level, at the state level; if not at the state level, at the county or municipal level. Localities should not be dissuaded from advancing policy to improve the public health even if the adoption of policy changes at the state or federal level has not yet been attained.

The general public is aware that tobacco use is harmful, but it seriously underestimates the magnitude of the harm which tobacco causes. At the same time, there is incomplete appreciation of the positive impact in several states achieved by the application of tobacco settlement funds to targeted education campaigns regarding the public health implications of tobacco.

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\(^5\) California Air Resources Board [CAR], 2005
tobacco use. For example, the Virginia Tobacco Settlement Foundation announced in 2008 that
the percentage of high school students who smoke in this tobacco-growing state declined from
29% in 2001 to 15.5% in 2007, nearly a 50% drop and below the national average. The
Foundation claims that successful prevention efforts save the state $1.25 billion each year in
smoking-related costs.6

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 addiction is best left untreated during the
course of treatment for other drug addiction lacks empiric support.

Although the addiction 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 addiction in addiction services treatment plans for all nicotine addicted 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 (SBI) 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 addictions, 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 (ASAM) recognizes that nicotine is an
addictive drug, and there is no safe level of consumption for tobacco products, in any
age group, among any special populations. Abstinence from tobacco use should be
the ultimate goal for clinical interventions regarding tobacco use and addiction.
ASAM 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:

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http://www.vtsf.org/data/youth-tobacco-survey.asp
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, mail order, and—ideally—Internet 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:

- The regulation of all nicotine-containing products intended for human consumption should be assigned 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.

- State and federal excise taxes on tobacco products should be increased substantially in order to decrease the use of tobacco and tobacco products and the incidence of nicotine addiction among youth. Revenues generated from increased taxes should be used to fund sustained, integrated, multifaceted public health programs to reduce or eliminate tobacco consumption and to treat nicotine addiction, as well as to increase funding for biomedical research regarding nicotine addiction and nicotine addiction treatment.

- When federal policy reform has not yet been attained due to political realities at a given time, state governments should not be dissuaded from adopting policy reforms regarding tobacco use, sales, advertising, production, distribution, taxation, or the like. When federal or state-wide reforms have not yet been adopted, localities should be encouraged to advance tobacco policy reforms to promote public health goals.

- Tobacco product manufacturers should be required 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.

- The sale of flavored tobacco products should be prohibited, including tobacco laced with fruit flavorings and menthol flavorings intended to attract specific subpopulations of consumers.

- Package inserts should be required 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.

- Warning labels on cigarettes and smokeless tobacco should be extended and the warning label system expanded 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.
All advertising and other promotional activities for nicotine-containing tobacco products should be eliminated, with a mandate that all packaging for tobacco products be plain packaging, in order to eliminate the allure provided by package design and brand-associated symbols.

The ban against cigarette advertising in broadcast media should be enforced 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.

Research and public health efforts funded through the various branches of government should be supported, 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.

Governmental edicts should be adopted, such as those in place in a few states and provinces, which prohibit pharmacies and stores with pharmacy departments from selling tobacco products or which ban smoking in vehicles with children.

Subsidies and all other forms of governmental assistance which encourage the production of tobacco and tobacco products should be eliminated. Tobacco should be eliminated as an export crop and tobacco products as export products from the United States. Government assistance for tobacco product exports should be replaced with the export of medical and public health knowledge about tobacco and about how to control the tobacco epidemic.

Transition programs for displaced workers should be funded 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.

Alternative designs should be required to make cigarettes fire-safe, since these products are the leading cause of death in household fires.

Tobacco should be excluded from international trade agreements (see ASAM Public Policy Statement on the Establishment of a Framework Convention on Alcohol Control and the Exclusion of Tobacco and Alcohol from Trade Agreements).

c) Because they increase overall smoking and tobacco use rates, the sale of low-cost cigarettes and other tobacco products by "smoke shops" or Internet sellers based on Native American Tribal lands is a significant public health problem. Such sellers should comply with all applicable laws relating to such sales, including Federal tax laws and the Jenkins Act, and should implement effective measures to block any sales to youth. With full respect for Tribal sovereignty and immunity rights, existing laws applicable to tobacco product sales from Tribal lands should be regularly enforced and new laws should be implemented, as needed.

d) Treatment for nicotine withdrawal and nicotine addiction should be broadly available and utilized.
• Physicians and other health care providers should engage in Screening, Brief Intervention, and Referral for Treatment (SBIRT) for tobacco use and nicotine addiction. People who screen for nicotine addiction should also screen for all other substance use and addiction.

• 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 (U. S. Public Health Service).

• All hospitals and medical schools should address nicotine addiction on a par with other chemical dependencies. Physicians and all clinicians should be trained to screen for nicotine addiction when they do medical evaluations, including 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, and appropriate medication should be offered to address nicotine withdrawal while the patient is hospitalized.

• Accreditation and regulatory agencies at the state and national level (such as the Joint Commission on Accreditation of Healthcare Organizations) should take steps to assure that hospitals include interventions for nicotine withdrawal and nicotine addiction whenever the patient’s clinical condition so indicates.

• ASAM encourages policy changes that lead to the integration of evidence-based nicotine addiction treatment into mental health and addiction services. Addiction treatment services should address nicotine addiction on a par with other chemical addictions. Counselors should be trained to assess for nicotine addiction when they do assessments for other chemical addictions. 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. Addiction treatment service providers should make their facilities and grounds smoke-free environments for patients, staff and visitors alike.

• 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 consider selecting a non-smoking AA sponsor. For their patients who accept the recommendation to make a quit attempt, counselors should advise attendance at Nicotine Anonymous meetings as an option.

• 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.

• 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 consequences of smoking and smokeless tobacco use.
2. Research, professional education, and clinical expertise in the areas of nicotine addiction should receive increased emphasis through the following measures:

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

b) Train all health professionals to regard nicotine addiction as a primary medical problem, including training in the management of nicotine addiction 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) Teach about the addiction process and about the management of nicotine addiction in CME courses and other professional education programs.

d) Teach that nicotine addiction and withdrawal needs to be diagnosed and treated along with other drug addictions.

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

f) Refuse 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) Encourage 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:

a) Establish 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 addiction.

b) Teach youth in the schools about the risks of addiction, other 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-market 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.

4. Tobacco-free policies should be implemented in all workplaces and places of public accommodation, including all hotels, motels, restaurants and taverns. (See ASAM Public Policy Statement on Clean Indoor Air.)
5. All hospitals, other health-care facilities, and medical schools should establish not only completely tobacco-free buildings but also tobacco-free grounds throughout their entire campuses. Smoke and tobacco-free grounds regulations should apply to all patients, staff, volunteers and visitors alike.

6. Elected officials should refuse to accept support from tobacco companies so that they can more easily work to control the epidemic caused by tobacco.

7. 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. In cases where a settlement agreement exists which directs tobacco firms to pay monies to governments to recoup governmental expenditures spent on treating tobacco-related illnesses, settlement funds should be directed to nicotine addiction treatment, prevention, research, or education and not diverted to other uses. ASAM supports litigation, if necessary, to ensure that tobacco settlement proceeds are not directed away from such public health uses.

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


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