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COMMENTS ON THE PREVENTION, IDENTIFICATION AND TREATMENT OF CO-OCCURRING DISORDERS FOR SAMSHA

By

Society for Research on Nicotine and Tobacco

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This report is in response to the Federal Registrar 67:10223 request for public comment to the Substance Abuse and Mental Health Services Administration for their required report to Congress about Co-Occurring disorders. The Society for Research on Nicotine and Tobacco (SRNT; www.srnt.org) is composed of over 600 of the leading scientists researching nicotine and tobacco issues in the US and 33 other countries. Many of our members have served on WHO, US FDA and other governmental/public organizational committees. One of SRNT's major missions is to provide scientific information and advise to policy makers.

As requested we will organize our specific topics by area, but before doing so, several comments are necessary. Nicotine dependence is a mental disorder recognized in both the American Psychiatric Association's DSM-IV-TR¹ and the World Health Organization's ICD-10² nomenclature. Nicotine dependence is the most prevalent (20% lifetime prevalence)³ and most deadly (50% die from complications)⁴ of the disorders listed in the DSM-IV-TR and ICD-10. For example, over 70% of those with alcohol/drug dependence, schizophrenia or mania smoke.⁵ Also, in all likelihood, more SAMSHA clients die from tobacco-related illnesses than from alcohol or drug-related illnesses. Nicotine dependence is also one of the most treatable of the substance use disorders with over nine scientifically-validated treatments endorsed in the USPHS Clinical Guidelines. Despite this, SAMSHA has done almost no outreach to promote identification and treatment of nicotine dependence among its clients. SAMSHA has included nicotine dependence in many of its prevention programs; thus, our comments will focus on CSAT and CMHS. We believe this document could serve as a beginning for SAMSHA to correct its prior negligence in addressing the biggest threat to the mortality of its clients.

A.

1. We are aware that nicotine dependence has been discussed at CSAT and CMHS Advisory Council and other meetings; however, we are unaware of any sustained commitment by CSAT and CMHS to address nicotine dependence.
2. SAMSHA currently participates in the Interagency Committee on Smoking or Health; however, we believe it has not take a lead role in using the information gained from this committee to address nicotine dependence among its clients.

3. To our knowledge, the strategic plan for comorbidity does not specifically address nicotine dependence
4. Our informal survey of CSAT and CMHS personnel is that each has very few persons on staff with expertise in nicotine dependence
5. We know of no efforts to coordinate funding with the Robert Wood Johnson Foundation, the American Legacy Foundation, or other institutions involved in nicotine dependence treatment, prevention or policy.

B.

1. The large majority of psychiatric and alcohol/drug abuse programs, including those funded by CSAT and CMHS, have admission criteria that do not address smoking. The few that do, do not assess interest in treatment⁶
2. Substance abuse programs rarely have any staff trained in the treatment of nicotine dependence, screen for nicotine dependence
3. Almost none of the programs screen for nicotine dependence and interest in treatment⁶
4. The few studies available indicate that in programs similar to those funded by CSAT and CMHS⁶ in programs nicotine dependence is very rarely included in the problem list
5. Methods to diagnose nicotine dependence and how nicotine dependence influence psychiatric or drug abuse disorders and visa versa are available and are scientifically based⁷
6. There are guidelines by the American Psychiatric Association⁸ and the USPHS⁹ for identifying and intervening with clients with both nicotine and other psychiatric disorders.
7. The large majority of psychiatric or alcohol/drug abuse agencies do not offer treatment for nicotine dependence at their facility and do not know what treatment options are available.⁶
8. Very few psychiatric or alcohol/drug abuse agencies attempt to address nicotine dependence even during rehabilitation, when the primary problem is in remission.

C.

1. We know of no data being collected by CSAT or CMHS that examines the prevalence of nicotine dependence in their programs
 2. We know of no data being collected by CSAT or CMHS on the availability of treatment for nicotine dependence in their programs
 3. We know of no data being collected on how many of CSAT or CMHS clients suffer from physical complications due to nicotine dependence.
- This report is being submitted to meet the March 27th deadline. A version containing scientific references for our points will be sent next week.

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