A Study Of A Lack Of Diffusion: The Case Of Nicotine Anonymous

NHCHC Conference 2012

Presented by

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Abstract

Whether various forms of treatment and recovery are diffused is an intriguing question. Here we explore the paradox of the lack of diffusion of Nicotine Anonymous, the free 12 step program of recovery for smokers. Although there has been a significant decline in cigarette use in the US, smoking rates and nicotine dependence levels remain high among people homeless populations.

Abstract (continued)

- The accessibility of smoking cessation programs, in contrast to treatments for recovery from alcohol or drugs, is often minimal, not offered consistently, and not free. We are presenting our preliminary research and working hypotheses regarding the lack of diffusion of Nicotine Anonymous. We are proposing ways to test its efficacy and the feasibility of utilizing consumers of Health Care for the Homeless centers to start Nicotine Anonymous groups after a period of training. Our presentation will provoke discussion about reaching homeless populations with culturally compatible smoking cessation approaches.

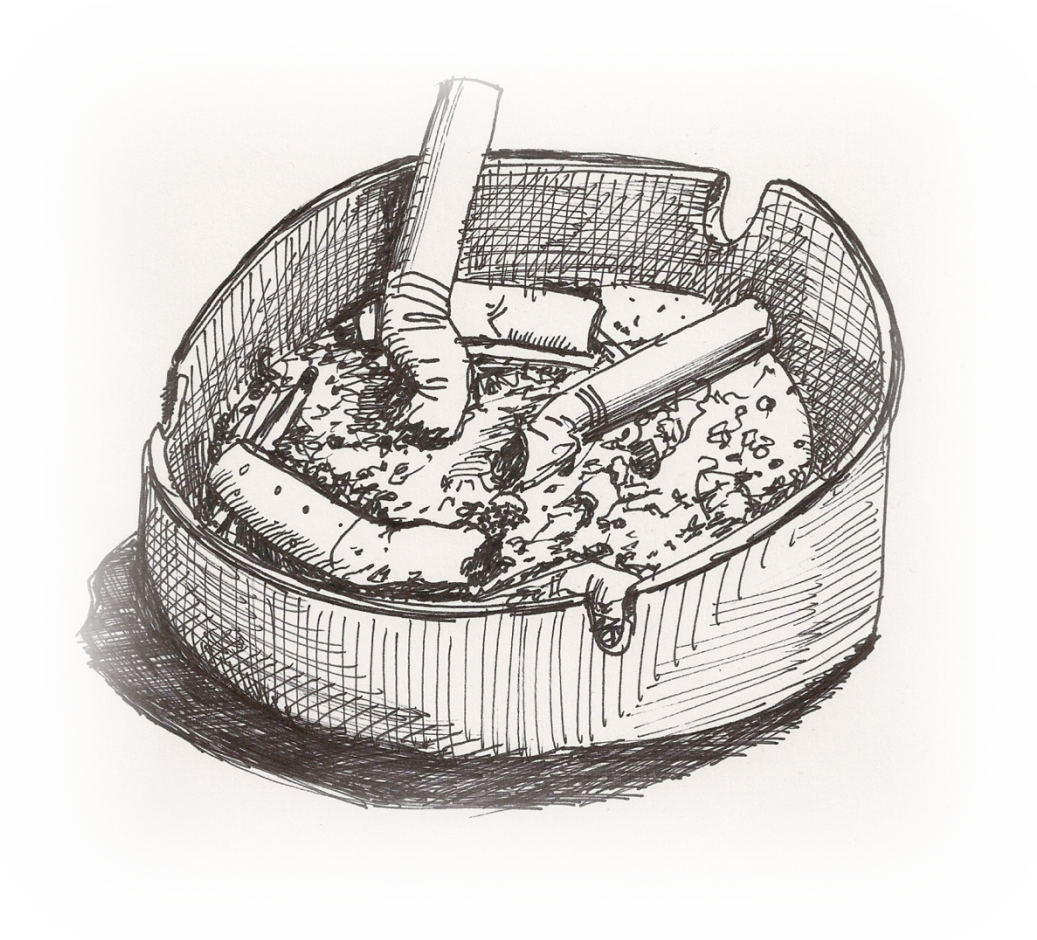
Tobacco Use in the United States

- Tobacco use is the leading **preventable** cause of death in the United States. Cigarette smoking is responsible for one in every five deaths in the United States, and it causes more deaths each year than the deaths caused by HIV, illegal drug use, alcohol use, motor vehicle injures, suicides, and murders *combined*. Furthermore, smoking is responsible for 90 percent of all lung cancer deaths in men, 80 percent of all lung cancer deaths in women, and 90 percent of deaths from chronic obstructive lung disease. Compared with nonsmokers, smokers are at increased risk of coronary heart disease, stroke, lung cancer, and chronic obstructive lung disease (CDC Smoking and Tobacco Use Fact Sheet, 2011).

Tobacco Use in Homeless Populations

- In 2009 an expert panel gathered in Washington, DC, to confront the issue of tobacco use in homeless populations (Break Free Alliance, 2009). It is estimated that between 70 percent and 80 percent of the homeless population uses tobacco, in contrast to approximately 21 percent of the U.S. adult population. Tobacco use in the homeless population takes a heavy toll in the high prevalence of cardiovascular disease, obstructive lung disease, and communicable diseases as homeless individuals share cigarettes and salvage discarded cigarette butts found on the streets.

Smoking is Pervasive in Homeless Populations



Lack of access to smoking cessation in homeless populations

- There have been several pioneering studies of smoking cessation in homeless populations. Okuyemi et al. (2006) and Shelley et al. (2010) tested the feasibility of offering smoking cessation (counseling and pharmacotherapy) in shelters and found that homeless smokers could be enrolled in programs with promising results.
- In a systematic review of interventions that would improve the health of the homeless, Hwang et al. (2005) found one study before 2004 of smoking treatment for newly recovering drug and alcohol-dependent smokers in a Veteran's Administration residential rehabilitation (Burling, Burling and Latini 2001).

- Despite the studies cited here, there is still no widespread accessibility of smoking cessation for homeless populations.

History of Nicotine Anonymous

- Nicotine Anonymous (NicA) was begun in California in 1985 by Alcoholics Anonymous (AA) members who wanted to work on their nicotine addiction using the 12 step mutual help approach. The four essential characteristics of mutual help organizations, including NicA, are that the members all share a problem or condition; there are no fees; they are voluntary associations; and the goals involve personal change. The groups are characterized by reciprocal relationships of giving and receiving help (Humphreys 2004).
- Some research indicates that heavy smokers are interested in approaches to cessation that include a spiritual dimension (Gonzales, Redtomahawk, and Pizacani et al. 2007) which exists in the 12 step approach.
- In 1999 there were 450 NicA groups in the US (Lichtenstein 1999), and in 2010 there were approximately 328 in the US (www.nicotine-anonymous.org).

The Nicotine Anonymous Program

Nicotine Anonymous grew out of AA and adapted the AA 12 Steps to addiction to nicotine.

- *We admitted we were powerless over nicotine – that our lives had become unmanageable.*
- *Came to believe that a Power greater than ourselves could restore us to sanity.*
- *Made a decision to turn our will and our lives over to the care of God as we understood Him.*
- *Made a searching and fearless moral inventory of ourselves.*
- *Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.*
- *Were entirely ready to have God remove all these defects of character.*

The Nicotine Anonymous Program (continued)

- *Humbly asked Him to remove our shortcomings.*
- *Made a list of all persons we had harmed, and became willing to make amends to them all.*
- *Made direct amends to such people wherever possible, except when to do so would injure them or others.*
- *Continued to take personal inventory and when we were wrong promptly admitted it.*
- *Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.*
- *Having had a spiritual awakening as the result of these steps, we tried to carry this message to nicotine users and to practice these principles in all our affairs.*

Nicotine Anonymous Research

There have been a limited amount of research regarding Nicotine Anonymous. We will briefly review several studies below:

Martin JE, Calfas KJ, Patten CA, Polarek M, Hofstetter R, Noto J, and Beach D (1997) "Prospective evaluation of three smoking interventions in 205 recovering alcoholics: One-year results of project SCRAP-Tobacco"

- To date this is the only research that has measured behavioral outcomes of Nicotine Anonymous.
- Nicotine Anonymous was the follow up condition to the American Lung Association 20 day quit program. The research contrasted this standard care with behavioral counseling plus exercise and behavioral counseling with post quit nicotine replacement.
- At one week post treatment the verified quit rate was 31% standard treatment, 60% counseling plus exercise, and 52% counseling plus nicotine replacement
- At 12 months the respective quit rates were 26%, 27% and 27%.

Nicotine Anonymous Research (continued)

Lichenstein, E. (1999) "Nicotine Anonymous: Community Resource and Research Implications"

- This is an excellent review article about the state of knowledge about Nicotine Anonymous in 1999. Dr. Lichenstein attended meetings, analyzed some of the printed literature, and interviewed the Nicotine Anonymous leadership at the time.
- Dr. Lichenstein noted the remarkable lack of attention to Nicotine Anonymous and noted that despite the plethora of smoking cessation interventions at the time, they were offered sporadically and for a time limited basis.
- The research study hypothesized that Nicotine Anonymous could be especially useful for the heavy smoker, or for the cross addicted smoker (alcohol and/or drugs), or for those who have tried everything else. For the later group, Nicotine Anonymous may be the "last house on the block" (said by a NicA member).

Nicotine Anonymous Research (continued)

- Mäkelä, K. et al. (1996) *Alcoholics Anonymous as a Mutual-Help Movement* discusses Nicotine Anonymous as one of the more recent adaptations of AA. He notes that despite the health risks involved with smoking, it is not the "existential" crisis for an individual as is the case with alcohol or drug addiction.
- Humphreys, K. (2004) *Circles of Recovery: self-help organizations for addictions* notes the slow diffusion of Nicotine Anonymous and its lack of ethnographic or outcome research to date.
- Glasser, I. (2010) "Nicotine Anonymous May Benefit Nicotine-Dependent Individuals" *American Journal of Public Health* suggests that Nicotine Anonymous may be beneficial for heavily dependent smokers, or those who have little access to other quit programs, or those who want to include a spiritual dimension to their quitting.
- Glasser, I. (2012) *Anthropology of Addictions and Recovery* reviews the history and lack of diffusion of Nicotine Anonymous.

Diffusion Research

- In the classic work on the diffusion of innovation Rogers (2003) suggests that there are many good ideas that never become practice. Generally, innovations that become adopted have a relative advantage over alternatives and are compatible with the existing culture. A classic example of the lack of diffusion is the failure of a two-year campaign to promote water boiling in a Peruvian village in order to prevent the spread of water borne infectious diseases (Wellin 1955). On the other hand, Pelto (1973) found an almost universal adoption of snow mobiles as a means of transportation and reindeer herding among the Skolt Lapps of Northern Finland in the 1960s, as the community saw the advantage of the snowmobiles though not the unintended consequences.

Hypotheses of Reasons for the lack of Diffusion of Nicotine Anonymous

- Alcoholics Anonymous (AA) began in 1935, well before the era of evidence based medicine. In contrast to NicA, AA received wide spread positive publicity based on AA member testimonials, which helped it diffuse throughout the world.
- NicA is a mutual help organization, outside the health professional establishment. This may help explain why it receives little research attention from the medical, psychological, or public health communities.
- Tobacco users who are helped by NicA may not feel the need to continue their attendance at NicA meetings in order to stay tobacco free, in contrast to AA members, some of whom stay in AA a lifetime. Not staying in NicA would result in fewer people starting new NicA meetings or being sponsors to new members.
- With so few NicA groups meeting, referrals (including self referrals) become difficult.

Areas of Future Research

- Does Nicotine Anonymous assist smokers and users of other tobacco products to quit and stay quit?
- What elements of NicA relate to quitting and staying quit (i.e., meetings, literature, phone calls between meetings)?
- Is it feasible for individuals who are not NicA members to begin groups in areas with no meetings? In the history of AA, non AA members initiated new groups.
- How is NicA qualitatively different from AA? Despite NicA's use of the twelve step literature, nicotine dependence is indeed different than alcohol abuse and dependence.
- Since tobacco use has been identified as the number one *preventable* cause of premature death in the US, why has NicA not been fully explored?

Questions for Discussion

- What has been your experience with helping homeless people quit smoking?
- What has been your experience with Nicotine Anonymous?
- What do you think of the potential effectiveness of Nicotine Anonymous for homeless smokers?
- What do you think of the feasibility of starting Nicotine Anonymous meetings?
- What do you think of Nicotine Anonymous as an adjunct to other smoking cessation programs, as a follow up program, or as a stand alone program?

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- Drawing by Jason Glasser (www.jasonglasser.com)