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Quitting Smoking in Early Recovery: Why Chapter 150 Will Have Little Effect on Tobacco Use Reduction

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Code Sections Affected
Health and Safety Code § 11756.5 (new)
AB 541 (Berman); 2021 STAT. CH. 150

"Giving up smoking is the easiest thing in the world. I know because I've done it thousands of times."[1]

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1. *NVRH To Offer New Tobacco Cessation Course*, VT. BUS. MAG. (Jan. 26, 2021), https://vermontbiz.com/news/2021/january/26/nvrh-offer-new-tobacco-cessation-course (on file with the *University of the Pacific Law Review*) (attributing the quote to Mark Twain).

I. INTRODUCTION

In 1935, Bill Wilson started a support group for alcoholics in Akron, Ohio, which served as the foundation for Alcoholics Anonymous.[2] Unbeknownst to Bill, that group would evolve into an international recovery system with additional programs for individuals struggling with narcotics, overeating, gambling, and other addictions.[3] Bill's twelve-step program kept him alcohol-free for thirty-seven years, and it has since freed millions of others from the chains of addiction.[4] Despite his long-term sobriety from alcohol, Bill died from a different dependency.[5] He gave up the bottle but continued smoking cigarettes—a habit that took his life after a years-long battle with emphysema.[6] This unfortunate ending to the incredible achievement of long-term sobriety is not uncommon.[7]

2. Dan Wagener, *Alcoholics Anonymous: The 12 Steps of AA & Success Rates*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/rehab-guide/12-step/whats-the-success-rate-of-aa (last updated Mar. 3, 2022) (on file with the *University of the Pacific Law Review*).

3. *See* Tim Stoddart, *List of 12 Step Programs*, SOBER NATION (Sept. 23, 2011), https://sobernation.com/list-of-12-step-programs/ (on file with the *University of the Pacific Law Review*) (listing dozens of twelve-step programs including Overeaters Anonymous, Anorexics and Bulimics Anonymous, Cocaine Anonymous, Bloggers Anonymous, Sex and Love Addicts Anonymous, and more).

4. Editorial Staff, *Bill Wilson*, AM. ADDICTION CTRS., https://alcoholrehab.com/alcoholism/bill-wilson/ (last updated May 18, 2022) (on file with the *University of the Pacific Law Review*); Mandy Erickson, *Alcoholics Anonymous Most Effective Path to Alcohol Abstinence*, STANFORD MED. (Mar. 11, 2020), https://med.stanford.edu/news/allnews/2020/03/alcoholics-anonymous-most-effective-path-to-alcohol-abstinence.html (on file with the *University of the Pacific Law Review*) ("AA now boasts over two million members in 180 nations and more than 118,000 groups.").

5. *Bill Wilson*, *supra* note 4.

6. *Id.* (explaining that Bill Wilson continued to smoke heavily throughout his sobriety).

7. *See Hearing on AB 541 Before the Assemb. Comm. on Health*, 2022 Leg., 2021–2022 Sess. 2 (Cal. 2021) (hereinafter *Hearing on AB 541*) (on file with the *University of the Pacific Law Review*) (noting the disproportionate prevalence of tobacco-related death among people who struggle with addiction of other substances).

Substance use disorder (SUD) is deadly.[8] In 2020, over 100,000 people died from drug overdoses, and another 95,000 people died from alcoholism.[9] That same year, however, an estimated 500,000 people died from tobacco-related illnesses.[10] Surprisingly, people recovering from SUD are more susceptible to death from tobacco-related illness than from the addiction they are treating.[11] While smoking in the United States has decreased in recent decades, it remains prevalent among individuals struggling with or in recovery from SUD, which includes alcoholism.[12] Some individuals even increase tobacco use during early SUD recovery.[13] Accordingly, the California Legislature recently enacted Chapter 150 to address the disproportionate rates of tobacco use disorder (TUD) among those seeking treatment for SUD.[14]

Chapter 150 requires licensed recovery centers to assess for, explain, and recommend treatment for TUD when a patient comes in for help with another addiction.[15] While Chapter 150 will help more SUD patients learn about the benefits of concurrent TUD treatment, the new law is unlikely to achieve more than mere education.[16] Nicotine is an extremely addictive chemical.[17] Informing patients that quitting tobacco is a healthy choice is not enough to motivate them to quit, especially in a facility where other patients and employees smoke regularly.[18]

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8. Press Release, Ctrs. for Disease Control & Prevention, U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020—But Are Still Up 15% (May 11, 2022), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm (on file with the *University of the Pacific Law Review*); *Alcohol Facts and Statistics*, NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM, https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohol-facts-and-statistics (last updated Mar. 2022) (on file with the *University of the Pacific Law Review*).

9. Ctrs. for Disease Control & Prevention, *supra* note 8; *Alcohol Facts and Statistics*, *supra* note 8.

10. Joshua M. Pierce, *Tobacco Killed 500,000 Americans in 2020—Is It Time to Control Cigarette-Makers?*, CONVERSATION (Mar. 2, 2021), https://theconversation.com/tobacco-killed-500-000-americans-in-2020-is-it-time-to-control-cigarette-makers-153611 (on file with the *University of the Pacific Law Review*).

11. Press Release, Cal. State Assemb. Democratic Caucus, Governor Newsom Signs Bill to Integrate Tobacco Treatment in Substance Use Disorder Programs (Sept. 1, 2021), https://a24.asmdc.org/press-releases/20210901-governor-newsom-signs-bill-integrate-tobacco-treatment-substance-use (on file with the *University of the Pacific Law Review*).

12. *See Hearing on AB 541*, *supra* note 7 ("Nearly 25% of adults in the US have a mental health condition or SUD and these adults consume almost 40% of all cigarettes smoked by adults in the US.").

13. *Id.*

14. CAL. HEALTH & SAFETY CODE § 11756.5 (enacted by Chapter 150).

15. *Id.*

16. *Id.*; *see also* Kristy Marynak et al., *Tobacco Cessation Interventions and Smoke-Free Policies in Mental Health and Substance Abuse Treatment Facilities*, 67 MORBIDITY & MORTALITY WKLY. REP. 519, 519 (2018) (theorizing that tobacco use reduction among those with SUD would require "full integration" of tobacco cessation programs in addition to tobacco-free campuses).

17. *Why It's So Hard to Quit Smoking*, AM. HEART ASS'N (Oct. 17, 2018), https://www.heart.org/en/news/2018/10/17/why-its-so-hard-to-quit-smoking (on file with the *University of the Pacific Law Review*).

18. *See* David Krauth & Dorie E. Apollonio, *Overview of State Policies Requiring Smoking Cessation Therapy in Psychiatric Hospitals and Drug Abuse Treatment Centers*, 13 TOBACCO INDUCED DISEASES 1, 1–2 (2015) (stating that many staff members of substance abuse treatment centers are also in recovery from SUD and use tobacco products themselves).

One way treatment facilities could motivate patients to quit tobacco is by providing nicotine replacement therapy (NRT).[19] NRT is a TUD treatment method which delivers nicotine to the body in forms other than tobacco.[20] NRT can drastically relieve withdrawal symptoms and help prevent relapse.[21] Aside from physical dependence, the social aspect of smoking often deters people in treatment from facing their tobacco habit.[22] Furthermore, many individuals in the SUD recovery community view TUD as a low-priority issue in comparison to the more immediate dangers of other substances.[23] Despite this myth, the reality is that quitting tobacco in early recovery can decrease the risk of relapse and results in instant physical health benefits.[24] Chapter 150 attempts to break down the seemingly impenetrable culture of smoking in recovery with a generic conversation about the benefits of quitting.[25] To reduce TUD more effectively, future legislation should additionally require SUD treatment facilities to be tobacco-free and offer individualized treatment plans utilizing NRT.[26]

II. LEGAL BACKGROUND

The decades-long fight between legislators and tobacco is complex.[27] Federal and state entities have created countless statutes, regulations, and policies over the last 100 years in an effort to reduce tobacco-related harm.[28] Section A outlines the policies that helped reduce tobacco use among the general United States population.[29] Section B explains the role Congress has played in efforts to reduce tobacco use among young people.[30] Section C analyzes state approaches to the

19 *See Nicotine Replacement Therapy to Help You Quit Tobacco*, AM. CANCER SOC'Y (Aug. 2, 2021), https://www.cancer.org/healthy/stay-away-from-tobacco/guide-quitting-smoking/nicotine-replacement-therapy.html (on file with the *University of the Pacific Law Review*) ("Many studies have shown using NRT can nearly double the chances of quitting smoking.").

20. *See id.* (listing gum, lozenges, and patches as examples of NRT delivery systems).

21. *See id.* (noting that NRT is capable of almost doubling the success rate of quitting tobacco).

22. Krauth & Apollonio, *supra* note 18, at 1–2.

23. *Id.* at 1.

24. SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 4 (June 22, 2021).

25. CAL. HEALTH & SAFETY CODE § 11756.5 (enacted by Chapter 150) (requiring treatment centers to provide information about quitting tobacco and recommend a concurrent treatment plan to patients with TUD).

26. *See generally* Jonathan Foulds et al., *Integrating Tobacco Dependence Treatment and Tobacco-Free Standards into Addiction Treatment: New Jersey's Experience*, 29 ALCOHOL RSCH. & HEALTH 236 (2006) (describing the challenges of quitting tobacco in recovery and recommending NRT provision as a solution).

27. *Tobacco Control Milestones*, AM. LUNG ASS'N, https://www.lung.org/research/sotc/tobacco-timeline (last updated Jan. 26, 2022) (on file with the *University of the Pacific Law Review*).

28. *Id.*

29. *Infra* Section II.A.

30. *Infra* Section II.B.

specific problem of TUD among people who struggle with addiction to another substance.[31] Section D examines California's history of tobacco use reduction legislation.[32]

A. Nationwide Tobacco Use Reduction Success

In 1965, 42.4% of adults in the United States smoked cigarettes.[33] By 2020, that statistic had dropped to 12.5%.[34] Over the past few decades, younger generations became increasingly less likely to try cigarettes.[35] Experts have attributed the decline of tobacco experimentation to advertisements highlighting the adverse health effects of smoking and an increase in cigarette prices via taxation.[36] Research shows that antismoking advertisements with personalized stories that trigger emotional reactions are the most effective in discouraging people from starting or encouraging people to quit.[37] However, not every smoker who would like to quit is genuinely willing or able.[38]

Another effective tactic legislators use to discourage smoking is raising cigarette taxes.[39] On the federal level, the tax increase on cigarettes in 2009 led to a 30% increase in calls to the national hotline for help with quitting smoking.[40] In California, the current tax rate on cigarettes is $2.87 per pack, which is the thirteenth-highest rate among jurisdictions across the nation.[41] The District of Columbia boasts the highest tax rate at $5.01 per pack, while Missouri has the lowest tax rate at just $0.17 per pack.[42] Despite long-standing evidence that increased cigarette prices decrease sales to youth and low-income communities,

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31. *Infra* Section II.C.

32. *Infra* Section II.D.

33. Angelica LaVito, *CDC Says Smoking Rates Fall to Record Low in the US*, CNBC (Nov. 8, 2018), https://www.cnbc.com/2018/11/08/cdc-says-smoking-rates-fall-to-record-low-in-us.html (on file with the *University of the Pacific Law Review*).

34. *See* Monica E. Cornelius et al., *Tobacco Product Use Among Adults—United States, 2020*, 71 MORBIDITY & MORTALITY WKLY. REP. 397, 397 (2022) (noting that total tobacco use accounting for all products including cigarettes, e-cigarettes, cigars, smokeless tobacco, and pipes amounted to nineteen percent of U.S. adults in 2020).

35. LaVito, *supra* note 33.

36. *Id.*

37. *See* Sarah J. Durkin et al., *Effects of Different Types of Antismoking Ads on Reducing Disparities in Smoking Cessation Among Socioeconomic Subgroups*, 99 AM. J. PUB. HEALTH 2217, 2217 (2009) (providing that emotional advertisements can deter the general population from tobacco but providing no data about advertising toward the population of smokers in recovery for SUD).

38. *See Why It's So Hard to Quit Smoking*, *supra* note 17 ("From a scientific standpoint, nicotine is just as hard, or harder, to quit than heroin . . . .").

39. LaVito, *supra* note 33.

40. Ann Boonn, *Raising Cigarette Taxes Reduces Smoking, Especially Among Kids*, CAMPAIGN FOR TOBACCO-FREE KIDS (Dec. 28, 2020), https://ndlegis.gov/prod/assembly/67-2021/testimony/HFINTAX-1422-20210209-6015-F-AUSTIN_HEATHER.pdf (on file with the *University of the Pacific Law Review*).

41. *Tobacco & Cigarette Tax by State for 2022*, IGEN, https://igentax.com/cigarette-tax-state/ (last visited on June 14, 2022) (on file with the *University of the Pacific Law Review*).

42. *Id.*

California did not increase its tax on cigarette packs to $2.87 until 2017.[43] While taxation is a valuable tactic, it constitutes just one sliver of a given state's comprehensive tobacco control strategy.[44]

B. Federal Strides Against Tobacco Use Among Young People

Before 2009, the U.S. Food and Drug Administration (FDA) did not possess regulatory authority over tobacco products.[45] However, President Barack Obama granted the FDA such authority when he signed the Family Smoking Prevention and Tobacco Control Act (FSPTCA) into law on June 22, 2009.[46] The FSPTCA allows the FDA to ban flavored cigarettes, regulate nicotine levels, inspect tobacco product manufacturing facilities, and charge tobacco manufacturers a regulation fee based on market share.[47] While the FSPTCA aims to reduce tobacco-related harm among the general population through the above methods, it also restricts tobacco marketing and sales to minors and youth.[48]

More recently, the federal government took another step to reduce tobacco use among young people.[49] In 2019, President Donald Trump raised the national age of tobacco purchase eligibility from eighteen to twenty-one when he signed legislation known as Tobacco 21 into law.[50] Tobacco 21 aims to reduce the likelihood that people under twenty-one try tobacco products, and thereby reduce the rate of TUD development into adulthood.[51] Increasing the required age to twenty-one is most likely to reduce smoking rates among teenagers aged fifteen to

43. Jeff Daniels, *Feds Give Big Tobacco New Headache as California Taxes Proving Hazardous to Cigarette Sales*, CNBC (July 28, 2017), https://finance.yahoo.com/news/feds-big-tobacco-headache-california-164852210.html (on file with the *University of the Pacific Law Review*).

44. Boonn, *supra* note 40.

45. *Family Smoking Prevention and Tobacco Control Act - An Overview*, U.S. FOOD & DRUG ADMIN., https://www.fda.gov/tobacco-products/rules-regulations-and-guidance/family-smoking-prevention-and-tobacco-control-act-overview (last updated June 3, 2020) (on file with the *University of the Pacific Law Review*).

46. *Id.*

47. *See id.* (mentioning that the Act does not grant the FDA authority to require prescriptions for tobacco products or ban entire classes of products).

48. *See Family Smoking Prevention and Tobacco Control Act - An Overview*, *supra* note 45 (stating that the FSPTCA specifically bans vending machine sales, free samples or other promotional items, sales to minors, and tobacco brand-sponsored social events in an effort to protect young people).

49. *Tobacco 21*, U.S. FOOD & DRUG ADMIN. (Sept. 1, 2021), https://www.fda.gov/tobacco-products/retail-sales-tobacco-products/tobacco-21 (on file with the *University of the Pacific Law Review*).

50. *Id.*

51. *Id.*; *see* Paulien A.W. Nuyts et al., *An Increase in the Tobacco Age-of-Sale to 21: For Debate in Europe*, 22 NICOTINE & TOBACCO RSCH. 1247, 1247 (2020) (explaining that the tobacco purchase age of eighteen is "proving to be inadequate as adolescents continue to access cigarettes . . . via proxy purchases; adolescents ask acquaintances or strangers over the age of [eighteen]—often young people under [twenty-one]—to buy cigarettes for them").

seventeen.[52] Teenagers in this vulnerable age range, who are likely to have eighteen-year-old friends, are far less likely to have friends over twenty-one who are willing to buy tobacco for them.[53]

C. State-Level TUD Reduction Efforts for People with SUD

Currently, nine states require all state-licensed SUD treatment facilities—including both state-operated and private facilities—to enforce tobacco-free grounds policies.[54] Of those nine states, some have also implemented incentives for treatment centers to follow the tobacco-free law because enforcement can be challenging.[55] For example, Maine's Gold Star Standards of Excellence program recognizes and awards treatment facilities that maintain tobacco-free policies every year.[56] In Indiana, facilities must be tobacco-free in order to receive funding from the Indiana Department of Mental Health and Addiction.[57]

Four other states require some treatment facilities to operate on tobacco-free grounds but allow lenient exceptions to the rule.[58] In North Carolina, for example, only the small number of state-operated treatment centers must be tobacco-free.[59] This narrow law requires just fourteen of the dozens of treatment centers in the state to prohibit tobacco.[60] Oklahoma previously passed an administrative regulation to require tobacco-free facilities statewide, but the state revoked that requirement in 2021.[61] Now, Oklahoma law states "restrictions on tobacco smoking . . . shall not apply to . . . treatment centers, if smoking is integral to the research or treatment."[62]

Perhaps the strictest laws in the country regarding tobacco use and SUD treatment facilities exist in New York.[63] New York law requires all treatment facilities to be tobacco-free, and the exceptions are limited.[64] For example, patients

52. Nuyts et al., *supra* note 52.

53. *Id.*

54. *See* PUB. HEALTH L. CTR., U.S. STATE LAWS REQUIRING TOBACCO-FREE GROUNDS FOR MENTAL HEALTH AND SUBSTANCE USE FACILITIES 2 (2020) (listing Alaska, Hawaii, Illinois, Indiana, Maine, New Mexico, New York, North Dakota, and Oregon as tobacco-free SUD treatment facility states).

55. *Id.* at 21.

56. *Id.*

57. *Id.* at 17.

58. *See id.* at 2 (listing Idaho, North Carolina, Oklahoma, and Vermont as partial tobacco-free SUD treatment facility states).

59. *Id.* at 32.

60. PUB. HEALTH L. CTR., *supra* note 54, at 32; *State Operated Healthcare Facilities*, N.C. DEP'T OF HEALTH & HUMAN SERVS., https://www.ncdhhs.gov/divisions/state-operated-healthcare-facilities (last visited Jan. 12, 2023) (on file with the *University of the Pacific Law Review*).

61. PUB. HEALTH L. CTR., *supra* note 54, at 35–36.

62. OKLA. STAT. tit. 21, § 1247(G) (2021).

63. PUB. HEALTH L. CTR., *supra* note 54, at 30.

64. *Id.*

and guests may smoke in outside designated areas, but not within thirty feet of any building on campus.[65] While no state requires SUD patients to accept TUD treatment, tobacco-free campuses provide a strong incentive to do[66]

D. California's History and Potential Future of Tobacco Use Reduction Legislation

Historically, California has been a trailblazer in tobacco restriction laws.[67] In 1990, San Luis Obispo, California, became the first city in the United States to ban smoking in restaurants, bars, and all other public buildings.[68] Eight years later, the California Legislature passed a law to ban smoking in bars across the state.[69] Consequently, California became the first state in the nation with a statewide smoke-free air law.[70] California is now one of the twenty-eight states with a statewide ban on smoking indoors including restaurants, bars, and places of employment.[71] However, California law specifies "place of employment" within the smoke-free law does not include "treatment sites, if smoking is integral to the . . . treatment being conducted."[72]

Despite its early history of spearheading tobacco legislation, California is not the first state to enact a law like Chapter 150.[73] In 2001, New Jersey implemented a similar policy, which made tobacco cessation treatment a requirement in order for SUD treatment centers to get a license.[74] Unlike California, however, New Jersey also phased in a tobacco-free grounds requirement to supplement the principal policy.[75] Subsequent studies of New Jersey's approach determined that tobacco cessation in SUD treatment centers can be successful—under certain conditions.[76] These conditions include "policy regulation, training, and the provision of nicotine replacement therapy."[77]

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65. *Id.*

66. *See* Marynak et al., *supra* note 16, at 522 ("Tobacco-free campus policies that prohibit all forms of tobacco product use . . . can support tobacco cessation, reinforce tobacco-free norms, and eliminate exposure to secondhand tobacco product emissions.").

67. *Tobacco Control Milestones*, *supra* note 27.

68. *Id.*

69. *Id.*

70. *Id.*

71. *Smoke-Free Laws*, CAMPAIGN FOR TOBACCO-FREE KIDS (Apr. 1, 2022), https://www.tobaccofreekids.org/what-we-do/us/smoke-free-laws (on file with the *University of the Pacific Law Review*).

72. CAL. LAB. CODE § 6404.5(5).

73. Krauth & Apollonio, *supra* note 18, at 1–2.

74. *Id.*

75. *Id.* at 3.

76. Foulds et al., *supra* note 26.

77. *Id.*

III. CHAPTER 150

Chapter 150 aims to decrease the disproportionately high rates of TUD among those receiving treatment for SUD.[78] People who abuse alcohol or other substances are more likely to smoke—and more likely to smoke heavily—than the general population.[79] The state of California ranks forty-first in the country on inquiring about tobacco use in SUD treatment.[80] To improve this ranking, Chapter 150 now requires licensed substance abuse treatment facilities to assess all patients for TUD during their initial intake process.[81]

Assembly Member Marc Berman authored Assembly Bill (AB) 541, which took effect as Chapter 150 on January 1, 2022.[82] Assembly Member Berman was "surprised to learn that people with [SUD] are more likely to die from tobacco-related illness than from the addiction that brings them to treatment."[83] If a patient qualifies for TUD, facilities must now inform them about the benefits of treating TUD in concurrence with treatment for SUD.[84] The most important benefit of quitting tobacco is liberating the body from all chemical dependency, which creates a higher chance of long-term abstinence from drugs and alcohol.[85] Lastly, Chapter 150 states facilities must also recommend TUD treatment in concurrence with SUD treatment or refer the patient to an outside TUD treatment plan.[86]

Chapter 150 does not itself describe which tobacco products facilities should consider for TUD assessment.[87] Instead, Chapter 150 refers to the statutory definition of "tobacco products," which includes cigarettes, snuff, cigars, and e-cigarettes.[88] Chapter 150 also fails to specify any requirements for what TUD treatment should entail for individuals who choose to accept the recommendation.[89]

78. SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 3 (June 22, 2021).

79. *Hearing on AB 541*, *supra* note 7, at 2, 3.

80. SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 6 (June 22, 2021).

81. CAL. HEALTH & SAFETY CODE § 11756.5 (enacted by Chapter 150).

82. Cal. State Assemb. Democratic Caucus, *supra* note 11; *Complete Bill History of AB 541*, CAL. LEGIS. INFO., https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202120220AB541 (last visited Jan. 12, 2023) (on file with the *University of the Pacific Law Review*).

83. Cal. State Assemb. Democratic Caucus, *supra* note 11.

84. HEALTH & SAFETY § 11756.5.

85. Cal. State Assemb. Democratic Caucus, *supra* note 11; SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 4 (June 22, 2021).

86. HEALTH & SAFETY § 11756.5.

87. *Id.*

88. CAL. BUS. & PROF. CODE § 22950.5(d)(1)(B).

89. HEALTH & SAFETY § 11756.5.

IV. ANALYSIS

Many decades have passed since U.S. authorities began to publicize the dangers of smoking.[90] It is long overdue for legislators to address tobacco abuse in SUD recovery centers across California.[91] Chapter 150 is a small step in the right direction because more SUD patients will become aware of the benefits of quitting tobacco.[92] However, Chapter 150 fails to recognize the unlikelihood of SUD patients electing to quit in a place where peers and employees still smoke.[93] Furthermore, Chapter 150 does not suggest nor require treatment facilities to help patients quit by providing NRT.[94] Section A describes the disproportionate rates of tobacco abuse among people with SUD.[95] Section B dispels the myth that quitting smoking at the same time as alcohol or drugs will jeopardize rehabilitation success.[96] Section C explains how tobacco-free treatment facilities can help break down the culture of smoking in recovery.[97] Section D outlines the benefits and effectiveness of NRT.[98]

A. The Prevalence of Smoking in the SUD Recovery Community

In the United States, people in recovery for SUD or mental health disorders are twice as likely as the general population to die from tobacco-related illness.[99] It is no coincidence that smoking is so prevalent among people struggling with alcohol or drug addictions.[100] Unfortunately, some people even increase tobacco

90. *See Tobacco Control Milestones*, *supra* note 27 (noting that the Advisory Committee to the Surgeon General published its first official smoking report which recognized the "proven link between smoking and lung cancer" in 1964).

91. *See* Joseph Guydish et al., *Smoking Prevalence in Addiction Treatment: A Review*, 13 NICOTINE & TOBACCO RSCH. 401, 401–02 (2011) (finding the smoking prevalence range to be even higher—75% to 90%—among SUD patients in recovery than those in active SUD—56% to 68%).

92. *See* HEALTH & SAFETY § 11756.5 (requiring recovery centers to "[p]rovide information to the patient or client on how continued use of tobacco products could affect their long-term success in recovery from substance use disorder").

93. *Id.*; Krauth & Apollonio, *supra* note 18, at 1–2; *see also Adults Suffer Peer Pressure Too*, VILLA TREATMENT CTR. (Dec. 4, 2016), https://thevillatreatmentcenter.com/adults-suffer-peer-pressure-too/ (on file with the *University of the Pacific Law Review*) (recognizing that peer pressure—feeling influenced to do something based on others' behavior—is powerful in adulthood, especially between the ages of eighteen and thirty).

94. HEALTH & SAFETY § 11756.5.

95. *Infra* Section IV.A.

96. *Infra* Section IV.B.

97. *Infra* Section IV.C.

98. *Infra* Section IV.D.

99. *See* SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 3 (June 22, 2021) (defining "behavioral health disorders" as a term which encompasses mental health disorders, substance use disorders, and the combination thereof).

100. *See Hearing on AB 541*, *supra* note 7, at 4 (stating that people with behavioral health issues, who make up twenty-five percent of the population, consume forty percent of the cigarettes in the United States).

use while in SUD recovery.[101] However, society does not view TUD treatment with the same urgency it views treatment for drug addiction or alcoholism.[102] For example, there are over 1,000 weekly Alcoholics Anonymous meetings in Los Angeles alone and just nine weekly Nicotine Anonymous meetings in the entire state.[103] Chapter 150 aims to close the gap that exists between treating SUD and treating TUD by requiring TUD assessment at SUD treatment facilities.[104]

One reason for the lack of urgency to quit smoking compared with the urgency to quit other addictions is the slow nature of tobacco's consequences.[105] A drug overdose or alcohol poisoning can end someone's life suddenly, but even the heaviest smokers will likely never experience nicotine poisoning.[106] Plus, destructive behaviors that accompany intoxication by alcohol or hard drugs—many times due to loss of decision-making ability—do not typically occur after using tobacco alone.[107] Instead, cigarettes destroy essential body functions slowly and silently.[108] Unlike alcohol and other drugs, tobacco use alone does not typically cost someone their job or cause problems in their personal lives.[109] This juxtaposition of the short-term consequences of using tobacco versus using other substances creates the illusion that quitting cigarettes can wait.[110] However, the legislators behind Chapter 150 have taken a small step toward dispelling that illusion by aiming to educate SUD patients that additionally quitting tobacco is vitally important.[111]

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101. ASSEMBLY FLOOR, FLOOR ANALYSIS OF AB 541, at 1 (June 22, 2021).

102. *See Quitting Cigarettes in Early Recovery: Good or Bad Idea?*, WELLNESS RETREAT RECOVERY CTR., https://wellnessretreatrecovery.com/quitting-cigarettes-early-recovery-good-bad-idea/ (last visited July 17, 2022) (on file with the *University of the Pacific Law Review*) ("Some say that quitting cigarettes in the first year of recovery is a recipe for disaster because it can cause someone to be overwhelmed by the pressure . . . of making so many drastic life changes at once.").

103. *Search for AA Meetings*, L.A. CENT. OFF. ALCOHOLICS ANONYMOUS, https://lacoaa.org/meetings.php (last visited May 18, 2022) (on file with the *University of the Pacific Law Review*); *Face-to-Face Meetings*, NICOTINE ANONYMOUS, https://www.nicotine-anonymous.org/face-to-face-meetings (last visited May 18, 2022) (on file with the *University of the Pacific Law Review*).

104. *Hearing on AB 541*, *supra* note 7, at 1.

105. *See Limited Time: Life Expectancy Data for the Worst Addictions*, NORTHPOINT RECOVERY (Nov. 19, 2017), https://www.northpointrecovery.com/blog/limited-time-life-expectancy-data-worst-addictions/ (on file with the *University of the Pacific Law Review*) (noting tobacco use shortens life by an average of ten years while other drugs can shorten life by thirty years or more).

106. *See* Sabrina Felson, *Nicotine Poisoning: Can You Overdose?*, WEBMD (June 12, 2020), https://www.webmd.com/smoking-cessation/nicotine-poisoning-can-you-overdose (on file with the *University of the Pacific Law Review*) (emphasizing the unlikelihood of overdosing on nicotine from cigarettes because the body only absorbs about one milligram of nicotine per cigarette).

107. *See Alcohol Facts and Statistics*, *supra* note 8 (asserting alcohol alone contributes to about eighteen percent of emergency department visits).

108. *See How Smoking Might Slowly Kill You*, KRIMS HOSPS. (May 31, 2022), http://www.krimshospitals.com/how-smoking-might-slowly-kill-you/ (on file with the *University of the Pacific Law Review*) (explaining that smoking tobacco slowly breaks down lung and heart functions in ways which can be reversible, but many times are not).

109. SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 6 (June 22, 2021).

110. *Quitting Cigarettes in Early Recovery: Good or Bad Idea?*, *supra* note 102.

111. *See* SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 4 (June 22, 2021)

B. Debunking the Myth That Concurrently Quitting Smoking Will Jeopardize Sobriety

There is a longstanding impression that quitting smoking while getting sober from other substances may do more harm than good.[112] First, some people believe quitting tobacco can make it harder for an individual with SUD to stay sober from other substances.[113] Another argument is that because nicotine can reduce stress, smoking may be a helpful coping mechanism in the early stages of rehabilitation in a treatment center.[114] These reasons are grounded in the belief that SUD patients are vulnerable individuals who should wait until they are more stable in sobriety to address their tobacco use.[115]

Fortunately, the California Legislature denied the notion that quitting tobacco during SUD treatment is risky by enacting Chapter 150.[116] However, the lingering prevalence of this opinion may explain why California legislators did not enact harsher tobacco use reduction policies through Chapter 150.[117] Chapter 150 merely requires TUD assessment and treatment recommendation, perhaps to avoid resistance from treatment facilities that view smoking as a low-priority issue.[118] Nevertheless, overcoming such potential resistance would be well worth the benefits of stronger tobacco use reduction policies.[119]

Despite the myth that quitting smoking could jeopardize sobriety from other substances, scientific research shows quitting tobacco in early SUD recovery improves chances of long-term success.[120] One Columbia University study found alcoholics who continued smoking after they stopped drinking were twice as likely

("Research shows that quitting tobacco use supports behavioral health treatment, could improve mental health, could make relapse less likely, and has immediate physical health benefits.").

112. *See Quitting Cigarettes in Early Recovery: Good or Bad Idea?*, *supra* note 102 (outlining the arguments that exist in favor of and against quitting smoking in early recovery).

113. *See* SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 4 (June 22, 2021) ("[T]reatment settings have permitted tobacco use among clients in part because of misperceptions that smoking . . . cessation could interfere with treatment.").

114. *Quitting Cigarettes in Early Recovery: Good or Bad Idea?*, *supra* note 102.

115. *See id.* ("A lot of people agree that putting too much on your plate in early sobriety can end in disaster, so many people also agree that quitting cigarettes can wait until a recovering individual is more stable.").

116. *See* SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 4 (June 22, 2021) (acknowledging the "misperception[] that smoking could alleviate symptoms of mental health conditions and that cessation could interfere with treatment"); CAL. HEALTH & SAFETY CODE § 11756.5 (enacted by Chapter 150).

117. *See Quitting Cigarettes in Early Recovery: Good or Bad Idea?*, *supra* note 102 (suggesting that a number of people in the SUD recovery community would not support a policy requiring tobacco-free treatment centers); HEALTH & SAFETY § 11756.5.

118. HEALTH & SAFETY § 11756.5; *see also* Krauth & Apollonio, *supra* note 18, at 1 ("Many healthcare providers . . . believe that the health risks from smoking are less important than the perceived benefits of smoking, which are thought to calm psychiatric patients and reduce the risk of relapse.").

119. *See* Marynak et al., *supra* note 16, at 522 (advocating for strong policies—such as tobacco-free treatment facilities—which can quickly dissolve the smoking culture of a treatment center and motivate more people to quit).

120. SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 4 (June 22, 2021).

to relapse as those who quit both drinking and smoking.[121] According to addiction experts, the human brain links the chemical rewards of nicotine to those of other substances.[122] Therefore, people often associate using tobacco with drinking or other drugs without even realizing it.[123] This subconscious association can increase the risk of relapse when a person in recovery from SUD continues smoking cigarettes.[124] Other research shows people who smoke in active addiction will have a better chance of avoiding drugs and alcohol after leaving treatment if they break all related habits.[125] Thus, quitting smoking upon entry into a treatment facility will likely give SUD patients a higher chance of long-term success.[126] While the legislators behind Chapter 150 grounded the law in research supporting tobacco cessation in treatment, they approached the issue cautiously by merely requiring TUD assessment and general recommendations.[127]

C. The Benefits of Tobacco-Free Recovery Facilities

In addition to the reasons above, the social aspect of smoking often discourages people in treatment from facing their tobacco habit.[128] The tobacco culture is especially strong where recovery center employees are people with past SUD who still use tobacco themselves.[129] By failing to acknowledge the culture shift necessary to decrease tobacco use in recovery centers, Chapter 150 lacks a crucial component for achieving real change—tobacco-free grounds.[130] Subsection 1 discusses how surrounding peer behavior can dissuade someone from quitting a habit such as smoking.[131] Subsection 2 explores the results of New York requiring tobacco-free treatment facilities across the state.[132]

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121. *See* Andrea H. Weinberger et al., *Cigarette Smoking and Risk of Alcohol Use Relapse Among Adults in Recovery from Alcohol Use Disorders***,** 39 ALCOHOLISM: CLINICAL & EXPERIMENTAL RSCH. 1989, 1996 (2015) ("Concurrent treatment of cigarette smoking when treating [alcohol use disorder] may help improve long-term alcohol outcomes."); *Quitting Cigarettes in Early Recovery: Good or Bad Idea?*, *supra* note 102.

122. *Quitting Cigarettes in Early Recovery: Good or Bad Idea?*, *supra* note 102.

123. *Id.*

124. *Id.*

125. *Id.*

126. *See* Weinberger et al., *supra* note 121 (concluding that quitting smoking while treating alcohol use disorder could improve sobriety success).

127. *See* SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 4 (June 22, 2021) (supporting the bill with research that shows the positive outcomes of treating TUD and SUD concurrently); CAL. HEALTH & SAFETY CODE § 11756.5 (enacted by Chapter 150).

128. *See* Krauth & Apollonio, *supra* note 18, at 1–2 (explaining that because many individuals who staff drug treatment centers are smokers themselves, tobacco is a common part of treatment center culture).

129. *Id.*

130. *See* Lillian Turner de Tormes Eby et al., *A Qualitative Examination of the Positive and Negative Consequences Associated with Going Tobacco-Free in Substance Abuse Treatment: The NY State Experience*, 14 NICOTINE & TOBACCO RSCH. 1407, 1411 (2012) (listing positive outcomes of New York's tobacco-free treatment facility policy, including more clients and staff "acknowledging their need to quit smoking"); HEALTH & SAFETY § 11756.5.

131. *Infra* Subsection IV.C.1.

132. *Infra* Subsection IV.C.2.

1. The Power of Peer Pressure—For Better or For Worse

Although educators and parents typically warn children and teenagers about peer pressure, it can be powerfully influential among adults.[133] Most people find comfort in feeling as if they belong and strive to fit in with the people around them.[134] This is no different among people in SUD recovery centers.[135] Part of the reason treatment centers and support groups are effective is due to the utilization of positive peer pressure.[136] Positive peer pressure is the idea that individuals in a group are more likely to reach their goals due to the accountability of wanting to succeed together.[137] Being surrounded by people who possess the same goal of sobriety is extraordinarily helpful for an addict.[138]

Similarly, being surrounded by people who are smoking will likely discourage someone from quitting, which is already a difficult process.[139] Many studies have found that the percentage of patients in recovery for SUD who use tobacco ranges from seventy-five to ninety percent.[140] Plus, many treatment providers believe smoking cessation upon entry into treatment could jeopardize recovery.[141] With Chapter 150, treatment centers will recommend quitting tobacco; however, patients will not likely accept such recommendation if those around them continue to smoke.[142] Trying to quit smoking around tobacco users is like trying to quit drinking at a bar—while possible, there is a better way: enforcing tobacco-free campuses.[143]

133. *Adults Suffer Peer Pressure Too*, *supra* note 93.

134. *See id.* (suggesting that peer pressure causes people to "forget to listen to [their] own inner self").

135. *Id.*

136. *Positive Peer Pressure in Addiction Recovery*, DISCOVERY HOUSE (Oct. 10, 2021), https://www.thediscoveryhouse.com/positive-peer-pressure-in-addiction-recovery/ (on file with the *University of the Pacific Law Review*).

137. *Id.*

138. *See id.* (listing the following benefits of positive peer pressure: feeling like a valuable part of a group, working toward similar goals within a community, and learning how to cope through building relationships).

139. *See Adults Suffer Peer Pressure Too*, *supra* note 93 ("Negative peer pressure can hold a person back from realizing one's true potential.").

140. *See* Guydish et al., *supra* note 91, at 402 (considering a variety of papers to calculate this figure and recognizing that "there is at present no systematic review of papers reporting smoking prevalence among those in addiction treatment").

141. Marynak et al., *supra* note 16, at 521.

142. CAL. HEALTH & SAFETY CODE § 11756.5 (enacted by Chapter 150); *see also Adults Suffer Peer Pressure Too*, *supra* note 93 (recognizing the tendency of adults to mirror their peers' behavior); Krauth & Apollonio, *supra* note 18, at 1–2.

143. *See* Marynak et al., *supra* note 16, at 522 (finding various positive outcomes of tobacco-free treatment facilities, such as increased support for quitting and decreased secondhand smoke exposure).

2. Results of New York's Tobacco-Free Grounds Policy

In 2008, New York became the first state to implement a tobacco-free grounds requirement for state-funded SUD treatment centers.[144] About one year after the requirement took effect, treatment counselors and supervisors reported various positive outcomes.[145] First, the social norm of smoking in recovery dissipated in treatment facilities throughout the state.[146] As a result of creating environments which banned tobacco instead of embracing it, counselors found it easier to help clients quit during treatment.[147] Second, employees reported an increase in patients asking for help to quit smoking.[148]

It can be difficult for states to enforce tobacco-free requirements due to lingering beliefs that smoking in recovery is acceptable.[149] Nonetheless, New York is proof that more facilities and patients become willing to comply as the culture shifts from smoking to non-smoking.[150] The authors of Chapter 150 should have followed in New York's footsteps by enacting a law which requires tobacco-free grounds at recovery centers.[151] The California Legislature even acknowledged tobacco-free campus policies as an effective strategy, yet made no efforts to incorporate it into the bill.[152] Instead, Chapter 150 tolerates smoking in SUD recovery by continuing to permit tobacco use in California treatment facilities.[153]

144. *New York Implements Tobacco-Free Campus Policies*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/tobacco/stateandcommunity/tobacco-control/promising-policies-and-practices/new-york-implements-tobacco-free-campus-policies.html (last reviewed Feb. 18, 2022) (on file with the *University of the Pacific Law Review*).

145. *But see* Turner de Tormes Eby et al., *supra* note 130, at 1410 (reporting perceived negative consequences as well, including patients dealing cigarettes in private and smoking in the bathrooms).

146. *New York Implements Tobacco-Free Campus Policies*, *supra* note 144.

147. *See* Turner de Tormes Eby et al., *supra* note 130, at 1410 (identifying "less smoking by patients and staff" and "improvement in the physical work environment" as positive reported outcomes of tobacco-free grounds policies).

148. *See id.* (including "patients more proactively seeking smoking cessation in treatment" as another positive reported outcome of tobacco-free grounds policies).

149. *See New York Implements Tobacco-Free Campus Policies*, *supra* note 144 (noting treatment providers reported difficulty enforcing the policy during the first year).

150. *Id.*

151. *See id.* ("[Reporting] research findings showing that New York is the state with the highest proportion of substance use disorder treatment facilities that have smoke-free campuses, screen for tobacco use, offer cessation counseling, and offer [NRT].").

152. *See* SENATE HEALTH COMMITTEE, COMMITTEE FLOOR ANALYSIS OF AB 541, at 4 (June 22, 2021) (noting the Centers for Disease Control and Prevention recommends tobacco-free campuses because they "can support tobacco cessation, reinforce tobacco-free norms, and eliminate exposure to secondhand tobacco product emissions"); CAL. HEALTH & SAFETY CODE § 11756.5 (enacted by Chapter 150).

153. *See* HEALTH & SAFETY § 11756.5 (lacking any explicit prohibition of tobacco products in treatment facilities).

Fostering tobacco-free environments where smoking is discouraged will help de-normalize smoking in recovery.[154] However, SUD patients will also need guaranteed access to tobacco use reduction aids such as NRT.[155]

D. NRT Should Be Readily Available in Treatment Facilities

Many people who smoke are unable to quit on their own.[156] Most smokers are already aware of tobacco's health risks, but they struggle to quit because they are physically dependent.[157] Nicotine replacement therapy—which utilizes patches, gum, lozenges, and other delivery systems—can drastically relieve withdrawal symptoms and help prevent relapse.[158] Instead of providing specific guidance for recovery centers on effective ways to quit smoking—such as NRT—Chapter 150 simply requires them to recommend treatment for TUD.[159] Subsection 1 examines the challenges of quitting tobacco without utilizing NRT.[160] Subsection 2 explains why NRT is an effective way to manage nicotine withdrawal symptoms.[161]

1. The Reality of Quitting Without NRT

Nicotine improves focus, increases energy, suppresses appetite, and triggers the release of feel-good adrenaline.[162] However, these perceived benefits come with a cost.[163] Nicotine also harms the body immediately: the adrenaline release increases blood pressure, breathing, and heart rate.[164] Plus, the numerous dangerous chemicals found in tobacco products are proven to cause cancer and other diseases.[165]

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154. Joseph Guydish et al., *Tobacco Use and Tobacco Services in California Substance Use Treatment Programs*, 214 DRUG ALCOHOL DEPENDENCE 1, 5 (Sept. 1, 2020).

155. *Id.* at 9.

156. *See Why It's So Hard to Quit Smoking*, *supra* note 17 (asserting nicotine is just "as addictive as cocaine or heroin").

157. *Id.*

158. *See Nicotine Replacement Therapy to Help You Quit Tobacco*, *supra* note 19 (noting that NRT is capable of almost doubling the success rate of quitting smoking).

159. CAL. HEALTH & SAFETY CODE § 11756.5; *Nicotine Replacement Therapy to Help You Quit Tobacco*, *supra* note 19.

160. *Infra* Subsection IV.D.1.

161. *Infra* Subsection IV.D.2.

162. *See* Hui Chen et al., *Cigarette Smoking and Brain Regulation of Energy Homeostasis*, 3 FRONTIERS PHARMACOLOGY 1, 1–2 (July 25, 2012) ("Weight gain and increased craving for high caloric junk food on cessation of smoking without nicotine supplementation is one of the reasons given by people that prevents them from ceasing smoking.").

163. *How Smoking Might Slowly Kill You*, *supra* note 108.

164. *How Smoking Might Slowly Kill You*, *supra* note 108; *Hearing on AB 541*, *supra* note 7, at 2.

165. *See How Smoking Might Slowly Kill You*, *supra* note 108 (explaining that a single cigarette releases more than 6,000 chemicals when lit—about seventy of which are known carcinogens).

While quitting without NRT is physically possible and rarely dangerous, the withdrawal symptoms drive most first-time quitters straight back to their tobacco product of choice.[166] Within just a few hours of quitting nicotine, intense cravings, hunger, headache, and fatigue start to take over the body.[167] Plus, mental withdrawal symptoms include anxiety, depression, irritability, and mental fog.[168] Withdrawal symptoms can last weeks, and cravings can last months.[169] These unfortunate side effects of quitting explain why so many tobacco users do not drop the habit, even if they want to.[170] Although recovery centers may choose to incorporate NRT into TUD treatment plans under Chapter 150, requiring NRT availability would ensure alleviated withdrawal symptoms for anyone wanting to quit.[171]

2. NRT Effectiveness

Chapter 150 provides little guidance for treatment facilities once they determine a patient has TUD.[172] The law states "a licensed facility . . . shall . . . [r]ecommend treatment for [TUD] in the treatment plan."[173] Because it is so difficult to quit, this lack of direction could increase the risk of unsuccessful TUD treatment plans.[174] Requiring NRT provides a solution by significantly relieving withdrawal symptoms while still allowing a person to break the habit of smoking or using a different tobacco product.[175]

NRT reduces the urge to smoke or use tobacco by delivering nicotine through means which do not contain the harmful chemicals of tobacco products.[176] When used correctly, the person quitting intakes less and less nicotine over time until it feels bearable to quit altogether.[177] NRT administration comes in a variety of

166. *Why It's So Hard to Quit Smoking*, *supra* note 17.

167. Aaron Kandola, *Nicotine Withdrawal Symptoms and How to Cope*, MED. NEWS TODAY (Jan. 11, 2020), https://www.medicalnewstoday.com/articles/323012 (on file with the *University of the Pacific Law Review*).

168. *Why It's So Hard to Quit Smoking*, *supra* note 17.

169. *See* Kandola, *supra* note 167 (explaining how withdrawal symptoms peak after a few days of quitting, then slowly alleviate over the following three to four weeks).

170. *Why It's So Hard to Quit Smoking*, *supra* note 17.

171. CAL. HEALTH & SAFETY CODE § 11756.5 (enacted by Chapter 150); *Nicotine Replacement Therapy to Help You Quit Tobacco*, *supra* note 19.

172. *See* HEALTH & SAFETY CODE § 11756.5 (enacted by Chapter 150) (requiring treatment facilities to recommend TUD treatment to patients and provide information about how using tobacco may influence their SUD recovery, but providing no further, specified guidance).

173. *Id.*

174. *See Why It's So Hard to Quit Smoking*, *supra* note 17 (referring to the time period when first trying to quit smoking as a "real rollercoaster").

175. Kandola, *supra* note 167.

176. *See Nicotine Replacement Therapy to Help You Quit Tobacco*, *supra* note 19 (stating NRT allows people who are trying to quit using tobacco to tackle the psychological challenges of quitting without having to withstand intense physical withdrawals).

177. *See id.* ("NRT can help relieve some of the physical withdrawal symptoms so that you can focus on

options: gum, lozenges, patches, nasal spray, sublingual tablets, and more.[178] These methods are easy to use and have limited side effects when used properly.[179] Side effects are normally related to the type of product, such as occasional rashes from patches or mouth irritation from gum.[180]

Research shows NRT can increase the success rate of quitting tobacco by a range of fifty to sixty percent.[181] NRT works with or without additional treatment methods, such as group therapy or individual counseling.[182] According to recent studies, NRT does not increase the risk of heart attack when used correctly.[183] Since most NRT products do not require a doctor's prescription, California law should guarantee that those products are available at SUD treatment centers.[184] This will increase success rates of quitting tobacco and ensure that people who quit are as comfortable as possible throughout the withdrawal process.[185]

V. CONCLUSION

Despite known health risks and vast general legislation against tobacco-related dangers, smoking remains prevalent among people with active SUD and those in recovery.[186] Chapter 150 requires treatment centers to assess patients for TUD upon entry, discuss the benefits of concurrent SUD/TUD treatment, and recommend TUD treatment accordingly.[187] To break down the longstanding, widely-accepted culture of smoking in recovery from addiction to alcohol or other drugs, California treatment centers should be tobacco-free.[188] In addition, NRT should be available to anyone in treatment who tries to quit cigarettes or other tobacco products.[189] Chapter 150 alone will not provide the motivation or means necessary for SUD patients to move forward with TUD treatment recommendations.[190]

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the psychological (emotional) aspects of quitting.").

178. *Id.*

179. Kandola, *supra* note 167.

180. *See Nicotine Replacement Therapy to Help You Quit Tobacco*, *supra* note 19 (including the following side effects related to nicotine, which may occur with all NRT products: racing heart, nervousness, and headache).

181. Kandola, *supra* note 167.

182. Lindsey F. Stead et al., *Nicotine Replacement Therapy for Smoking Cessation*, COCHRANE DATABASE SYSTEMATIC REVS. 1, 2 (2012).

183. *Id.*

184. *Id.*

185. *Id.*

186. *Hearing on AB 541*, *supra* note 7; *supra* Section II.A.

187. CAL. HEALTH & SAFETY CODE § 11756.5 (enacted by Chapter 150).

188. Foulds et al., *supra* note 26, at 239.

189. *Nicotine Replacement Therapy to Help You Quit Tobacco*, *supra* note 19.

190. HEALTH & SAFETY § 11756.5.

Chapter 150 would have been more effective had it required tobacco-free SUD treatment facilities with individualized treatment plans utilizing NRT.[191] California legislators should continue addressing the disproportionate rates of TUD among people addicted to alcohol or other drugs.[192] Science has proven that quitting tobacco in early recovery will help success rates, not hurt them.[193] Now is the time for California to foster holistically beneficial recovery environments to give everyone the opportunity to become the healthiest version of themselves.[194]

191. Foulds et al., *supra* note 26.

192. *Hearing on AB 541*, *supra* note 7, at 2.

193. Weinberger et al., *supra* note 121.

194. *See* Marynak et al., *supra* note 16, at 522 ("Proven interventions, including . . . comprehensive smoke-free laws . . . and providing barrier-free access to proven cessation treatments, are critical to reduce smoking-related disease and death in the United States.").

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