
***Integrating Tobacco Interventions
into Addictions Treatment:
An Ontario Addictions Sector
Meeting***

Thematic Summary Report

*Centre for Addiction and
Mental Health*

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Acknowledgements

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Introduction

Addictions sector professionals from across Ontario met at the Centre for Addiction and Mental Health (CAMH) in Toronto on March 3, 2009 to discuss the integration of treatment for tobacco addiction into Ontario's addiction treatment system.

The meeting began with three presentations and question-and-answer sessions in the morning. In the afternoon participants divided into four groups for breakout discussions and then reconvened for reports back to the larger group and for plenary discussions to identify next steps.

Mike DeVillaer, manager of Provincial Services at CAMH and chair of CAMH's Tobacco Policy Group, served as meeting facilitator. He noted that tobacco companies have long suppressed research as well as public and professional education on tobacco addiction. Yet evidence shows that tobacco addiction is one of the most difficult dependencies to shed, and one of the most harmful to health. A cultural change is needed to adopt a new understanding that tobacco addiction is a health issue rather than a lifestyle choice.

Dr. Charl Els, Alberta Regional Director for Physicians for a Smoke-Free Canada and a University of Alberta researcher, outlined evidence to support the understanding that tobacco addiction is not a weakness, a moral issue, or a lifestyle choice, but a chronic and lethal disease of the brain. Tobacco addiction and smoking behaviour are considered to be up to 60% genetically determined. The disease is relapsing but treatable. It is also important to recognize that embedded behavioural and social aspects are part of the disease.

This understanding is crucial to ensure that policy and funding are put in place for smoking cessation programming as a huge part of health promotion, Dr. Els said. This is particularly true since the majority of people who have other addictions began with an addiction to tobacco. Tobacco is often the last drug stopped and viewed as the most difficult to quit. Moreover, a significant proportion of total hospital admissions in Canada are due to tobacco addiction.

Dr. Els explained the mechanism through which tobacco acts on the brain. He also described the similarities between tobacco and other addictions and the difference in the metabolism by a healthy brain versus an addicted brain.

Individuals who have more than one addiction are at risk for a wider range of illnesses, said Dr. Els. Meanwhile, smoking is far more prevalent in people who have psychiatric and substance abuse disorders. People with problem gambling also have higher smoking rates, added **Dr. Peter Selby**, clinical director of Addiction Programs at CAMH.

Dr. Els noted that abundant research has now altered the earlier philosophy that it is dangerous to quit more than one drug at a time. Evidence now shows that tobacco interventions will not jeopardize outcomes of other addiction treatment, but suggests that people do better when they quit all drugs at the

same time. Moreover, retaining one addiction may compromise a person's ability to recover from another addiction.

As well, tobacco addiction's chronic and relapsing nature means that it does not generally respond to one single intervention but requires multiple interventions. One type of intervention is nicotine replacement therapy (NRT). Patients with higher levels of addiction may require higher doses to control withdrawal symptoms.

Dr. Els also said it might be a good approach to address tobacco addiction prior to residential treatment for other addictions. Skills learned during the smoking cessation process can be transferable to other addictions recovery.

Norma Medulun, Regional Director, Niagara Health System (NHS), described the switch to a non-smoking policy in her facility's addiction residential program. She recommended Training Enhancement in Applied Cessation Counselling and Health (TEACH) as an important staff training tool.

Chondrena Vieira-Martin, Concurrent Disorder team leader with Halton Alcohol, Drug and Gambling Assessment Prevention & Treatment Services (ADAPT), gave a presentation on tobacco interventions in concurrent disorders. She said there is debate about how best to treat concurrent disorder populations.

Advantages, Hurdles, and Solutions Related to Integration

Participants divided into four breakout groups to discuss the following questions:

- What are the advantages of integrating smoking cessation into addictions treatment for clients, counsellors, and the agency?
- What are the hurdles for clients, counsellors, and the agency?
- What is needed to overcome these hurdles?

Residential Programs

Clients

Advantages of integration

An integrated treatment program gives clients a broader range of cessation support tools and wider pool of knowledgeable staff. It gives clients the opportunity to work on all their addictions in a safe non-smoking environment where they are kept away from others using tobacco.

When on-site smoking and even cigarette breaks are eliminated, the treatment for other addictions becomes more effective because clients become more engaged in their treatment programs and are not focused on the next time they will be having a cigarette. Drug dealers also are prevented from utilizing smoke breaks to reach residents when they go out to smoke.

A smoke-free environment is also important because the hand-to-mouth motion of smoking can be a trigger for abuse of other substances, such as cannabis or crack cocaine. Research shows that inhaling nicotine provides an immediate brain response that both causes and reinforces addiction. A no-smoking program encourages counsellors to also give up smoking so that they will not smell like smoke, which can trigger their clients' addiction.

Clients who have already quit smoking have a lower risk of starting again in integrated treatment programs. Their supportive environments help build resistance, and also provide opportunities for clients to hear others' success stories which will motivate smokers who want to fit in to quit.

Hurdles for integration

Many clients use smoking to cope with and to curb emotions such as inappropriate anger. They may view their cigarettes as their "best friends." Smoke breaks also tend to be very social occasions for bonding. Smoking is socially accepted compared to other drugs, and clients may smoke once they return home. As well, cigarettes are often used as a delivery system for other drugs.

Nicotine addiction may be very strong for many clients, who may reject an integrated program since alternative programs are available. For example, there is a 12-step model of quitting that works on quitting only one substance at a time.

Solutions to Hurdles

A key solution is education. Counsellors should emphasize to clients that they are being treated for their tobacco addiction rather than being stopped from smoking. Programs should move toward a 100% smoke-free environment, including having only non-smoking staff. Clients can maintain opportunities for social bonding by going for walks with others to replace cigarette breaks.

An integrated strategy is particularly important for residential youth programs of all kinds, not only addiction treatment programs, because it helps prevent youth from starting to smoke to fit in with peers. The majority of people who have addictions began with an addiction to tobacco.

Medulun said NRT can begin five days prior to client arrival. A nurse practitioner must supervise the NRT once the client is on site and monitor dosages so that clients do not re-medicate themselves by smoking.

Starting at a higher level of NRT before entering a residential program is particularly helpful for clients dealing with withdrawal symptoms. It is also recommended to start Champix before entering residential treatment, and to ensure that clients have their prescription with them on arrival.

Clients will benefit from discharge plans that are linked with ongoing support and continuity of care. Counsellors should have strong connections to community tobacco cessation support programs. Easy access to a smokers' helpline would provide another effective support.

Counsellors

Advantages of integration

A residential setting is the best place to enable counsellors to treat people holistically. Counsellors can take advantage of common skill sets to treat different addictions. While the majority of clients tend to be smokers, it is easier to medicate smoke-free clients.

Integration allows counsellors to become leaders in their field and to help clients quit using a toxic, life-threatening substance. It gives counsellors and staff who smoke an opportunity to quit as well. They develop greater knowledge and ability to help clients and decrease their own exposure to second-hand smoke. Smoke triggers clients' addiction, and when counsellors also give up smoking, they will not smell like smoke.

Hurdles for integration

Overworked staff may be unwilling to take on the additional load of running smoking cessation programs. Some staff members see smoking cessation as punitive and do not want to be seen as the "smoking police." And it may be challenging to find reward mechanisms other than cigarettes to motivate clients. Counsellors may need to send clients who are intoxicated or high off the property for a smoke.

Some counsellors permit client smoking breaks because they need a break, or because they too smoke. Counsellors may be reluctant to quit smoking, as well.

Another challenge is obtaining professional access to NRTs and medication. Because a doctor or nurse practitioner must provide a prescription, counsellors have difficulties accessing NRTs when they are not ward stock.

Solutions to hurdles

A key solution is to educate counsellors as well as the community on the benefits of integrated smoking cessation programs. The TEACH program is beneficial for counsellors.

Counsellors need more resources and support to quit smoking. They also should be aware that the scent of tobacco on their clothing is a trigger to clients. No healthcare centre would let staff come in with alcohol on their breath, for example.

Counsellors who are ex-smokers can maintain opportunities for social bonding and informal professional discussions by going for walks with others to replace cigarette breaks.

Programs

Advantages of integration

Eliminating smoke breaks for both clients and staff leads to better use of agency time and money. Banning smoking from agency property ends cigarette butt litter, exposure to second-hand smoke, and the incongruous sight of people smoking outside.

Some clients refuse smoke-free agencies, but having more residential programs with integrated smoking cessation programs will eventually normalize non-smoking and establish an equitable new order where all programs will be smoke free.

Integrated treatment allows agencies to communicate a consistent and credible professional health message, set best practices in the field, increase their credibility, and decrease risk-management concerns by no longer allowing clients to go off-site for smoke breaks.

Integration facilitates holistic treatment for clients with concurrent disorders. For example, smoking is prevalent in people who have psychiatric and substance abuse disorders.

Hurdles for integration

It is not uncommon for counsellors to be resistant and even aggressive when asked to quit smoking. Counsellors may sabotage efforts to switch to a smoke-free treatment environment. It takes time to change the culture.

Agencies with a no-smoking policy or an integrated smoking cessation program have experienced a decline in enrolment. They are concerned because Local Health Integration Networks (LHINs) base their funding on client numbers.

Solutions to hurdles

Education, such as the TEACH program, is essential to help inform agencies of the holistic health benefits of integrated smoking cessation programs within smoke-free facilities. Medulun recommended training staff in more than one approach. She advocated offering alternative therapy on demand, including acupuncture, meditation, relaxation, counselling, and support groups.

To effectively combat smoking in any institution, Medulun said there must be absolute buy-in from senior leadership. During the process of becoming entirely smoke-free, controversy and non-compliance are to be expected. Medulun recommended having a champion and designated point person and ensuring sufficient lead time to operationalize the initiative. Advanced planning and research are essential prior to integration.

Agencies need to consider hiring only non-smokers as new staff while investing in staff smoking cessation programming. Diplomacy, creativity, and consistency are necessary.

Medulun recommended setting clear and enforceable consequences for clients' non-compliance, including identifying the precursor and trigger if a client relapses during treatment, and discharging

clients for non-compliance. Clients can be transferred to withdrawal management and then returned to the inpatient program if the clinical assessment supports this.

Agencies should alert their LHINs that client number targets might not be met in the short term, but emphasize that integrated treatment is an opportunity to adopt a best-practice approach.

Non-Residential Programs

Clients

Advantages of integration

Integration provides one-stop shopping for all addiction treatment needs, which particularly benefits clients with childcare issues and those with limited time and money.

A holistic approach to addictions treatment gives clients a clear message about substance dependence and tells clients that tobacco is an addiction. Clients have better support to achieve overall quality-of-life improvements in relationships, family life, and employment. Smoking cessation also changes one's physiology and increases lung capacity and physical stamina.

It is more effective to treat all addictions at the same time, since some addictions can act as triggers for others. Clients may find it easier to cut back on their drinking after cutting back on smoking, and vice versa. With one less trigger for abuse, it helps increase the success in dealing with other addictions. Going through withdrawal for several substances at once also lessens the impact of the symptoms.

Hurdles for integration

Clients may perceive the cost of cessation medication as a huge obstacle, especially when contraband cigarettes are so inexpensive. Clients may also hang onto smoking as a coping mechanism to deal with stress or with other addictions. Fear of failure and lack of confidence are common. Social inclusion and past unsuccessful attempts are other major factors.

Tobacco companies have been very successful in marketing smoking as a lifestyle choice. Meanwhile, clients are more motivated to deal with issues that would prevent them from being sent to jail or would help them get their children back. Without such incentives, client motivation is lower. Counsellors who themselves smoke also sabotage their clients' efforts to quit.

Solutions to hurdles

Exercise is a good way of helping control addictions. Another important approach is to consider one's finances in relation to the cost of smoking. This is especially important for clients who might be using food banks so they have money for cigarettes, or those who are smoking instead of paying rent.

Counsellors

Advantages of integration

Counsellors can apply addiction treatment philosophies for other addictions to smoking. Counsellors can also build on their relationships established from other treatment programs, strengthening the level of engagement with clients and building on previous successes and experiences.

In addition, counsellors may be more motivated to quit in an integrated program. Counsellors who are making effort to quit smoking can better sympathize with their clients.

Hurdles for integration

Counsellors cannot rely on clients to self-identify themselves as being addicted to nicotine. They must take the initiative to approach clients about their smoking.

Counsellors who smoke may not support integration. Meanwhile, some counsellors may see smoking cessation as detracting from their other work. They may see integration as a strain on already-stretched time.

Solutions to Hurdles

Counsellors can open the door for discussion with their clients about smoking cessation by approaching the topic from the point of view of finances.

An integrated program can provide counsellors with more access to people who have quit smoking. They can encourage these people to help others apply the skills they themselves learned while in the process of quitting.

Holistic addictions treatment lets counsellors make more efficient use of time by tackling more than one addiction at a time.

Programs

Advantages of integration

When counsellors can use the same skill set to deal with all addictions, agencies become more efficient. Meanwhile, client numbers will increase as more people understand the importance of quitting smoking. At the same time, relapses for other addictions can be expected to decline with treatment integration, which works to shorten wait lists for programs.

Integration adds to the wider community's perception that an organization is cutting edge in providing new treatments and services and living up to its commitment to health promotion.

Hurdles for integration

The cost of integration, including the cost of training staff in smoking cessation and the lack of funding for NRTs, is the first hurdle, and a major one. The existing belief may be that tobacco cessation is not part

of an agency's core business. To make it the agency's core business may require obtaining separate funding for that program.

The perception that people can quit on their own can lead to the notion that there are other groups needing addiction treatment more than smokers. Moreover, tobacco has a reverse stigma, in that people often refuse to classify it as an addiction. Lack of cooperation from other community agencies, such as hospitals that allow smoking on their property, also contributes to inconsistency in messaging.

Resistance may come from counsellors and other staff who smoke. It may also come from tobacco farmers, who also contribute to the local economy. Some agencies may feel they are working against their neighbours in advocating cessation programs.

Slick advertising targeting young people makes it particularly hard to reach youth. As well, negative health effects do not start soon enough to deter youth from smoking.

If agencies start accepting only people with nicotine addiction, wait lists could skyrocket. It may also be challenging to target services that rely on clients to self-identify as nicotine addicts or on staff to incorporate questions about tobacco into intake questionnaires.

Solutions to hurdles

Education is key. TEACH training is free and includes compensation for travel expenses. The program requests only a \$100 donation to the University of Toronto. Even if counsellors are smokers, TEACH programs do not disqualify them from working on cessation with their clients.

To overcome lack of funding for or access to NRT, one idea was to use budget surplus to stockpile NRT. Agencies should also be creative in finding non-medical interventions and alternatives to NRT. For example, a cigarette exchange program can be put in place that allows people to trade cigarettes for pure sources of nicotine such as NRT.

Programs should take into account factors such as triggers, cues, and the environment. They should consider the connections between clients' emotions and their tobacco use. Clients may be using nicotine to help cope with difficult emotions or life situations. Agencies should include tobacco on admissions questionnaires just as they include questions about alcohol and other drugs.

Agencies need to make effort to obtain more funding to support their mandate expansion to integrate tobacco interventions. They should highlight that long-term healthcare system costs will drop dramatically with successful cessation programs. They need to bring to federal attention that insurance companies are now covering NRT, which supports the long-term economic argument for funding cessation programs.

Participants suggested that agencies advocate to make tobacco cessation programs a national healthcare priority, and search for a high-profile champion or spokesperson to advance a national cessation strategy. It is important to dispel the widely held notion that it is best not to quit more than one substance at a time, and that other addictions should be addressed before smoking cessation. Public campaigns need to emphasize that smoking is an anti-social behaviour and an addiction.

Agencies should ensure healthcare teaching institutions are on board. They should also learn about programs offered by other agencies in the community and establish partnerships with other agencies.

Next Steps

The main objectives of the meeting were to increase the quality of life for clients and to help deliver a report to the government, said participants at the end of the day. They then discussed the key players to carry out next steps and outlined the end result they would like to see across Ontario.

Ontario's addictions system must change its view of nicotine addiction to be "part of what we do, not tangential to what we do," participants said. This takes time and money, but it also necessitates diverse and creative approaches that may not necessarily depend on funding.

LHINs should become involved with tobacco cessation training. In particular, all service providers should be trained in TEACH, and every residential addiction facility should have at least one person trained in TEACH. Dr. Selby noted that TEACH has received a Health Canada grant to examine every healthcare discipline.

Medical school curricula should reflect the seriousness of smoking. Medical conferences are an important target. Doctors should address smoking habits on intake questionnaires and ask questions that encourage smoking cessation. Veterinarians can also encourage pet owners to stop smoking for the sake of their pets' health.

It is also necessary to get corporations involved, especially those that have health and wellness programs focusing on drug and alcohol programs. Unions also have a role to play.

The Ontario premier has made commitment to a smoke-free province. The addictions sector needs to hold the federal and municipal governments accountable as well. The City of Toronto is studying the environmental impact of cigarette butts and cleanup costs, for example.

Participants suggested making an effort to have the Ontario Drug Benefit Program (ODBP) and disability plan cover tobacco addiction and NRTs. Another funding source may be the discretionary funds provided by Ontario Works.

To support a cultural shift and to become or remain smoke free, organizations should provide specialized approaches to facilitate behavioural and environmental changes, such as cognitive behavioural therapy, acupuncture, and other non-medical interventions. They should also change their language use, for example by refraining from using the term "cigarette break." Another suggestion was to provide resource materials in different languages in waiting areas.

To better help clients, program staff should focus on the possibility of quitting rather than the hazards of smoking, and give positive reinforcement and affirmation to encourage smoking cessation.

Counsellors need to support harm reduction, such as by helping clients move toward smoking fewer cigarettes, avoiding non-regulated cigarettes, not smoking butts found on the ground, and smoking outdoors only.

In addition, the sector must address challenges posed by the tobacco industry, which is marketing products as “cleaner and safer.” It should also tap into the potential of Web 2.0 technologies, such as websites and online tools, which can help reach larger populations and provide faster response than a counsellor can.