SMOKING CESSATION TREATMENT INTEGRATION INTO ONTARIO ADDICTION AGENCIES' PROGRAMS

(INITIAL DATA REPORT)

August 2010

Prepared by
Natalie T. MacLeod
M.Sc. Candidate
McMaster University
Department of Clinical Epidemiology and Biostatistics
Health Research Methodology Program

Acknowledgements

This survey was supported by a seed grant from the CAN-ADAPTT (Canadian Action Network for the Advancement, Dissemination, and Adoption of Practice-informed Tobacco Treatment) Project. The CAN-Adapt Project has been made possible through a financial contribution from the Tobacco Control Programme, Health Canada.

We would also like to express appreciation for the support of the following organizations for their strategic, logistical and in-kind support for the survey: Addictions Ontario (AO), Centre for Addiction and Mental Health (CAMH), CONNEXOntario, and the Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP). A final thank you is extended to the community staff of CAMH's Provincial Services who connected with local partners to help secure involvement in completing the survey – another contribution to the impressive response rate achieved.

The design and implementation of this study was overseen by the Integrating Tobacco Cessation into Addiction Treatment (ITCAT) Planning Group:

Mike DeVillaer, CAMH (Chair)
Norma Medulun, AO
Barney Savage, CAMH
Peter Selby, CAMH
Ian Stewart, OFCMHAP

It is thought that Ontario's addiction treatment system fails to adequately and formally recognize and respond to tobacco addiction. The current collaborative research aims to address a lack of data about this inadequate recognition and insufficient response of Ontario's addiction treatment system related to tobacco. This research is a collaboration between the two provincial organizations in Ontario that represent addiction treatment programs (AO and OFCMHAP), CAMH and CONNEX*Ontario* Health Services Information (CONNEX). CONNEX is a corporation, funded by the Ontario Ministry of Health and Long-Term Care, which improves access to alcohol and drug, gambling and mental health services for the people of Ontario. As part of its services, CONNEX hosts the Drug and Alcohol Registry of Treatment (DART) that provides information and referral to drug and alcohol treatment services in Ontario. Currently, DART does not provide information for individuals who suffer from tobacco dependence.

Primary objective:

To determine a baseline count and percentage of the number of programs within addiction agencies in Ontario that currently offer smoking cessation to their clients.

Secondary objectives:

a) To determine the percentage of each program type (provincial service categories) that provides smoking cessation and, in the case that it is not provided, the reasons cited by each category.

b) To determine the overall dominating reasons for not providing smoking cessation.

c) To assess respondents' thoughts regarding smoking cessation treatment integration into their programs.

Methods

Study Design and Population

In January 2010, AO and the Federation distributed the survey through email to their respective member distribution lists. 183 addiction agencies across Ontario received the survey. The first email dissemination occurred on January 21st, 2010. The survey was emailed a second time about 10 days later on February 1st, 2010. About a week after the second email dissemination, follow-up began by contacting non-respondent organizations through telephone calls. Each non-respondent organization was called at least twice, and frequently up to three times. After these two emails and two to three phone calls, a list of non-respondents was compiled and organized according to Local Health Integration Network. This list was used to aid Provincial Services staff who then approached their local non-respondents and asked them to respond to the email survey. The survey was closed on May 17, 2010. Survey results reflect agency and program status as of that date.

Survey Instrument

The survey instrument was developed by a research team composed of key representatives from each of the collaborating organizations – AO, CAMH, and OFCMHAP. To secure a higher response rate, the team elected to use the survey

strictly to identify whether or not an agency's programs provided smoking cessation and if not, to provide the applicable reason(s). The final survey instrument (Appendix 1) asked for the organization's name, program name, location and DATIS program number for each program in the organization the provides smoking cessation. If the program did not provide smoking cessation to its clients, a list of twelve possible reasons was made available to the respondent who was asked to use the list to identify the appropriate reasons. Space was provided for the program to identify any reasons not identified on the list provided, as well as space for any additional comments.

Data Analysis

The survey results include both quantitative and qualitative data. Data points that were considered included each program's response to whether or not they provide smoking cessation to their clients, the reason cited for not providing this service and the each program type according to CONNEX's provincial service categories. This data was summarized quantitatively to address the primary objective and two of the secondary questions.

The organizations/programs were also given an opportunity to identify "Other Reasons" not cited in the survey for not providing smoking cessation treatment and generally any "Comments" they may have concerning smoking cessation treatment delivery. This data was summarized qualitatively to address the third secondary question.

Results

Response Rate

The initial survey email dissemination yielded responses from 21 addiction agencies. Following the second email dissemination, and just before phone calls began, 46 responses to the survey had been received. Telephone follow-up successfully collected responses from 68 additional addiction agencies. Provincial Services staff efforts yielded an additional 18 survey responses. The 183 addiction agencies that were surveyed hosted a total of 1,395 programs. Of the 1,395 programs, 1,130 responses were received from 132 addiction agencies. The survey methods resulted in a 72.1% addiction agency response rate and an 81.0% addiction program response rate.

Agencies/Programs Providing Smoking Cessation

To address the primary outcome of how many programs within addiction agencies provide smoking cessation, a percentage was calculated. Of the 132 addiction agencies who responded (1,130 programs), 31 agencies identified themselves as providing smoking cessation (266 programs). According to these survey results, 23.5% of addiction agencies in Ontario, and (coincidentally) 23.5% of programs within addiction agencies, provide smoking cessation to their clients.

To determine the types of programs that currently provide smoking cessation, the programs were categorized into provincial service categories, as defined by CONNEX (Appendix 2). Each provincial service category represents a broad category of specialized addiction treatment or support that constitutes part of the continuum of care. These categories were then investigated to determine (a) the program types that

provide smoking cessation (Table 1) and (b) the percentage of each program type providing smoking cessation (Table 2). Program types *Community Treatment* and *Initial Assessment/Treatment Planning* accounted for 81% of the programs that provided smoking cessation. Within each program type, the provincial service categories that had the greatest percentages of smoking cessation provision were Community Treatment, Residential Treatment and Residential Withdrawal Management Level 2 (28.4%, 27.7% and 27.3%, respectively).

Table 1: Program Types Providing Smoking Cessation

Program Type	# of programs providing SCC	% of all programs providing SCC	Cumulative percentage
Community Treatment	153	58%	58%
Initial Assessment / Treatment Planning	61	23%	81%
Residential Treatment	23	9%	90%
Community Day / Evening Treatment	9	3%	93%
Residential Supportive Treatment Level 1	6	2%	95%
Residential Withdrawal Management Level 2	6	2%	97%
Case Management	3	1%	98%
Community Withdrawal Management Level 1	2	1%	99%
Residential Supportive Treatment Level 2	2	1%	100%
Community Medical / Psychiatric Treatment	1	0%	100%
Community Withdrawal Management Level 2	0	0%	100%
Residential Medical / Psychiatric Treatment	0	0%	100%
Residential Withdrawal Management Level 1	0	0%	100%
Residential Withdrawal Management Level 3	0	0%	100%
Total	266	100%	-

Table 2: Percentage of Program Types Providing Smoking Cessation

Provincial Service Category	Total Responses	Total "Yes" Responses	% Providing Smoking Cessation
Community Medical/ Psychiatric Treatment	1	1	100%
Community Treatment	539	153	28.4%
Residential Treatment	83	23	27.7%
Residential Withdrawal Management Level 2	22	6	27.3%
Community Withdrawal Management Level 1	9	2	22.2%
Residential Supportive Treatment Level 2	10	2	20.0%
Residential Supportive Treatment Level 1	33	6	18.2%
Initial Assessment/Treatment Planning	344	61	17.7%
Case Management	17	3	17.6%
Community Day/Evening Treatment	54	9	16.7%
Community Withdrawal Management Level 2	17	0	0.0%
Residential Medical/ Psychiatric Treatment	N/A	N/A	N/A
Residential Withdrawal Management Level 1	1	0	0.0%
Residential Withdrawal Management Level 3	N/A	N/A	N/A

Reasons for Not Providing Smoking Cessation

Apart from the reasons provided as part of the survey instrument, respondents cited other reasons to explain why their program or agency does not provide smoking cessation. Table 3 presents a summary of all the reasons cited by respondents.

Table 3: Legend of Reasons for Not Providing Smoking Cessation

Abbreviation	Reason
Reasons provided as part of the survey	
R1	Smoking is not that serious of a problem, relative to other substances
R2	Clients are not motivated to quit smoking
R3	Clients need smoking to help them cope with problems in their lives
R4	Dealing with a client's smoking could jeopardize his/her other treatment goals
R5	Having staff at this agency who smoke would make this unworkable
R6	Requires too much of a change in our program's culture
R7	Demand for smoking cessation services will increase agency wait times
R8	This agency does not have such a directive or mandate from its funder
R9	This agency cannot afford the necessary increase in staffing
R10	This agency cannot afford the necessary staff training
R11	This agency cannot afford to purchase stop-smoking medication
R12	There will be too much resistance from referring agencies
Other reasons cited by respondents	
R13	Local Public Health Unit provides Smoking Cessation Treatment
R14	Internal resistance/disinterest exists
R15	Smoking cessation is too much to handle alongside existing services
R16	Not enough time to address smoking cessation alongside other services
R17	Too many other initiatives underway
R18	Smoking cessation provision has not hit this agency's radar
R19	No demand for smoking cessation services exists among the clients served

To address the secondary objective that aimed to determine the most popular reasons for smoking cessation treatment, the frequency of responses across all provincial service categories were considered. It was found that overall, the most popular reasons cited for not providing smoking cessation are:

R8 = This agency does not have such a directive or mandate from its funder

R9 = This agency cannot afford the necessary increase in staffing

R11 = This agency cannot afford to purchase stop-smoking medication

R10 = This agency cannot afford the necessary staff training

Cumulatively, these four reasons account for 81.8% of the responses. Table 4 demonstrates the scope and nature of this finding.

Table 4: Frequency and Percentage of Reasons Cited for Not Providing Smoking Cessation

Reasons for Not Providing Smoking Cessation	# of times cited	% of all reasons cited	Cumulative percentage
R8	443	28.60%	28.60%
R9	345	22.27%	50.87%
R11	288	18.59%	69.46%
R10	191	12.33%	81.79%
R2	82	5.29%	87.09%
R1	45	2.91%	89.99%
R4	43	2.78%	92.77%
R6	27	1.74%	94.51%
R7	27	1.74%	96.26%
R3	19	1.23%	97.48%
R5	11	0.71%	98.19%
R12	10	0.65%	98.84%
R13	9	0.58%	99.42%
R14	4	0.26%	99.68%
R15	1	0.06%	99.74%
R16	1	0.06%	99.81%
R17	1	0.06%	99.87%
R18	1	0.06%	99.94%
R19	1	0.06%	100.00%

To explore what each program type's dominating reasons are for not providing smoking cessation, the reasons chosen by each provincial service category were examined. The response frequencies within each provincial service category are presented in Table 5. It was found that the top reasons within each service category are as follows:

Case Management programs cited an inability to afford the necessary increase in staffing and an inability to afford purchasing of stop-smoking medication. **Community Day/Evening Treatment**, **Community Treatment**, **Initial Assessment/Treatment Planning**, and **Residential Treatment** programs each most often cited that the provision of smoking cessation was not part of the directive or mandate it receives from its funder. **Community Withdrawal Management Level 1** and **Community Withdrawal Management Level 2** cited not having such a directive or mandate from its funder, and an inability to afford the necessary increase in staffing, staff training, and stop-smoking medication. Additionally, the one Community Withdrawal Management Level 1 program that responded also cited that it believed a demand for smoking cessation services would increase agency wait times. **Residential Supportive Treatment Level 1**, **Residential Supportive Treatment Level 2** and **Residential Withdrawal Management Level 2** programs all cited their agencies' inability to afford the necessary increase in staffing. Additionally, Residential Supportive Treatment Level 2 and Residential Withdrawal Management Level 2 programs cited that their agencies could not afford to purchase stop smoking medications. Finally, the only respondent from the **Residential Withdrawal Management Level 1** category indicated that reasons they do not provide smoking cessation include clients' lack of motivation to quit smoking, and the agency's inability to afford either the necessary staff training or stop smoking medications.

Table 5: Survey Response Frequencies by Provincial Service Category

SERVICE CATEGORY	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	R12	R13	R14	R15	R16	R17	R18	R19
Case Management	0	0	0	0	0	0	1	4	6	3	6	0	2	0	0	0	0	0	0
Community Day/Evening	8	9	0	6	0	0	0	21	18	8	16	0	1	0	0	0	0	0	0
Community Medical/ Psych	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Community Treatment	6	30	8	9	3	12	14	218	162	87	120	5	6	2	1	0	1	0	1
Community Withd Mgt 1	0	0	0	0	0	0	1	1	1	0	1	0	0	0	0	0	0	0	0
Community Withd Mgt 2	0	0	0	0	0	0	0	7	5	3	7	0	0	1	0	0	0	0	0
Assess/Treat Planning	12	17	4	8	4	14	9	145	104	62	86	1	0	0	0	0	0	0	0
Residential Medical/ Psych	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Residential Supportive1	5	8	2	5	1	0	1	8	13	9	11	1	0	0	0	0	0	0	0
Residential Supportive 2	2	3	2	4	1	0	0	3	5	2	5	0	0	0	0	0	0	0	0
Residential Treatment	12	11	2	9	1	1	1	30	23	13	26	3	0	1	0	1	0	1	0
Residential Withd Mgt 1	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
Residential Withd Mgt 2	0	3	1	2	1	0	0	6	8	3	8	0	0	0	0	0	0	0	0
Residential Withd Mgt 3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTALS	**45**	**82**	**19**	**43**	**11**	**27**	**27**	**443**	**345**	**191**	**288**	**10**	**9**	**4**	**1**	**1**	**1**	**1**	**1**

Reasons Provided as Part of the Survey

R1 = Smoking is not that serious of a problem, relative to other substances
R2 = Clients are not motivated to quit smoking
R3 = Clients need smoking to help them cope with problems in their lives
R4 = Dealing with a client's smoking could jeopardize his/her other treatment goals
R5 = Having staff at this agency who smoke would make this unworkable
R6 = Requires too much of a change in our program's culture
R7 = Demand for smoking cessation services will increase agency wait times
R8 = This agency does not have such a directive or mandate from its funder
R9 = This agency cannot afford the necessary increase in staffing
R10 = This agency cannot afford the necessary staff training
R11 = This agency cannot afford to purchase stop-smoking medication
R12 = There will be too much resistance from referring agencies

Other Reasons Cited by Respondents

R13 = Local Public Health Unit provides Smoking Cessation Treatment
R14 = Internal resistance/disinterest exists
R15 = Smoking cessation is too much to handle alongside existing services
R16 = Not enough time to address smoking cessation alongside other services
R17 = Too many other initiatives underway
R18 = Smoking cessation provision has not hit this agency's radar
R19 = No demand for smoking cessation services exists among the clients served

Open-ended responses received regarding other reasons programs do not provide smoking cessation to their clients most frequently cited the area's Public Health Unit as already providing smoking cessation. These organizations indicated that they refer clients who wish to quit to their respective health unit, usually since their program is not mandated to provide the service. As well, internal resistance to the integration of smoking cessation in a program was frequently cited. Responses indicated that board members, physicians or staff served as a source of resistance that needed to be worked on. On a related note, one respondent expressed a belief that smoking cessation is too much to handle alongside efforts to quit other drugs and another respondent mentioned that there wasn't enough time to address smoking cessation alongside the existing services provided. As well, one organization indicated that it had too many other initiatives underway, while another organization said that none of the reasons provided applied to it, rather smoking cessation had not hit its "radar" and was not on its priority list. These additional comments have been coded (R13 - R19) and are included alongside the reasons provided on the survey instrument, as seen in Table 4.

General Comments by Agencies

Open-ended responses that concerned other comments about smoking cessation integration were also documented (Appendix 3). Comments included the sentiment that smoking cessation should be a part of the services that programs in addiction agencies provide and that integration is a worthwhile endeavor. Concern was expressed that to mandate commitment to smoking cessation as a prerequisite to take part in a particular addiction program would exclude a certain percentage of the

population who would benefit from the program's existing services. As well, it was mentioned that clients tend to prefer stopping the use of other drugs first and then working up to a healthier lifestyle that may, for example, include smoking cessation. The Training Enhancement in Applied Cessation Counselling and Health (TEACH) program was cited and one program mentioned that all its addiction counselors have been or will be trained by TEACH, while another cited interest in TEACH but could not afford the training. A number of organizations indicated they are non-smoking facilities and that they have an informal approach to smoking cessation that generally involves providing the client with information about resources to help them quit. One program indicated it was in the process of evaluating the feasibility of smoking cessation integration.

Conclusion

This survey of addiction agencies in Ontario collected data that provides a baseline count of the number of programs that currently offer smoking cessation. Additionally, this data will allow for a new field in CONNEX's DART database on provision of smoking cessation among service providers in Ontario's addiction treatment system. Thus, prospective clients will be able to search the database to find programs that offer both smoking cessation, as well as help for other addictions.

The next step involves determining a standardized definition of what it means to provide smoking cessation treatment in order to follow-up with the organizations who responded positively to the survey. This definition, along with the identities of the programs who indicated they provide smoking cessation, will be communicated to CONNEX. Subsequently, CONNEX will contact the identified programs to determine

the specific details about the services it provides for smoking cessation to be included in the DART database.

Appendix 1: Survey Instrument

Tobacco has not traditionally been a priority for addiction treatment. Yet tobacco is the single addiction most likely to cause the death of our clients. And clients who quit smoking achieve better overall outcomes.

That is why representatives of Addictions Ontario, CAMH, and the Ontario Federation of Community Mental Health and Addiction Programs are collaborating to improve the integration of smoking cessation into Ontario's addiction treatment programs. As part of our efforts to raise awareness of this challenge - and to improve service to Connex/DART clients - we would like to identify programs that currently provide smoking cessation to their clients. We are also interested in identifying barriers to doing so.

We need to hear from you! This survey should take less than five minutes to complete. We would be grateful if you could complete it now or forward it to the most appropriate person at your organization for prompt completion. Whoever completes the survey should forward it to: Natalie.MacLeod@utoronto.ca
Be sure not to use the 'reply' function to this email. We would be grateful for your responses no later than [date=7 days from anticipated mailing from AO & Fed.]

Thanks for your support of this initiative. If you have any questions, please contact Natalie.MacLeod@utoronto.ca

For each program in your organization that provides smoking cessation, please provide the following information:

1) Organization Name

2) Program Name

3) Location (city, town)

4) DATIS Program Number

If your organization does not provide smoking cessation, please respond to this email to let us know that. In this case, we would also be grateful if you could place an 'X' before any of the following reasons why your program does not provide smoking cessation for its clients:

Smoking is not that serious of a problem, relative to other substances

Clients are not motivated to quit smoking

Clients need smoking to help them cope with problems in their lives

Dealing with a client's smoking could jeopardize his/her other treatment goals

Having staff at this agency who smoke would make this unworkable

Requires too much of a change in our program's culture

Demand for smoking cessation services will increase agency wait times

This agency does not have such a directive or mandate from its funder

This agency cannot afford the necessary increase in staffing

This agency cannot afford the necessary staff training

This agency cannot afford to purchase stop-smoking medication

There will be too much resistance from referring agencies

Other Reasons (list as many as you like):

Any other comments ?

Thanks so much for your help,

Appendix 2: Definitions of Various Provincial Service Categories

Provincial Service Category	Definition
Initial Assessment/Treatment Planning	The initial assessment is a process involving mutual investigation or exploration that provides the clinician with more detailed information for the purpose of determining specific client needs, goals, characteristics, problems and/or stage of change. Assessments vary in length according to the clients situation, and comprehensive assessments may be reserved for clients with more complicated histories and problems. This assessment forms the basis for initial treatment planning, a process of negotiation based on feedback from the assessment results, the clients strengths, prioritized problem areas, clinician judgement, client preferences and readiness for change, and the identification of potential barriers to treatment entry. This culminates in the development of a clear plan of action, including referrals as appropriate.
Case Management	A process which includes the designation of a primary worker whose responsibilities include the ongoing assessment of the client and his/her problems, ongoing adjustment of the treatment plan, linking to and coordination of required services, monitoring and support, developing and implementing the discharge plan, and advocating for the client. Case management services are offered regardless where the individual is in the system.
Community Treatment	1-2 hour sessions in group or individual format, typically once a week or less often, while the client resides elsewhere in the community. Community counselling/treatment includes brief intervention, lifestyle and personal counselling to assist the individual to develop skills to manage substance abuse/gambling and related problems, and/or maintain and enhance treatment goals. Such activities as relapse prevention, Guided Self-change, family intervention, follow-up and aftercare are included here. Care may be provided with or without medical/psychiatric treatment. Frequency and length of sessions may vary depending on client need and program format. May be offered in a variety of settings including outreach to the clients home, school, an addiction agency or other service setting. Outreach includes activities such as early intervention but not prevention, education or public relations activities.

Community Day/Evening Treatment	A structured, scheduled program of treatment activities typically provided five days or evenings per week (e.g., 3-4 hours per day) while the client resides at home or in another setting, including residential supportive treatment services, to assist the individual to develop skills to manage substance abuse/gambling and related problems.
Community Medical/Psychiatric Treatment	A specific non-residential service to meet the needs of individuals with concurrent disorders. This service may be offered either through a structured day/evening program or community treatment. These services are usually part of broader hospital services and employ physicians, nurses and staff specializing in the treatment of concurrent disorders.
Community Withdrawal Management Level 1	Assistance with voluntary withdrawal from alcohol and/or other drugs to clients who are under the influence of these substances and/or in withdrawal or otherwise in crisis directly related to these substances. Clients may be simultaneously accessing residential support services, or they may be residing in their home, the home of a significant other or in another community setting, supervised or unsupervised. Care may be provided with or without the aid of drug therapy and/or other medical interventions. Additional support such as discharge planning and early recovery education is provided. Level 1 Client symptoms can be safely monitored by staff who are not medically trained. Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department. Client/staff ratios do not permit high intensity symptom monitoring. In consultation with a physician, if necessary, consider/assess individuals for admission who are taking the following types of medication: medications for medical problems; medications for diagnosed psychiatric problems; and pain medications only for acute injuries or recent surgery.
Community Withdrawal Management Level 2	Client symptoms can be safely monitored by staff who are not medically trained. Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department. Routine medical consultation and sufficient staff resources are available to consider management of the following medications/ situations: all medications as listed in Level I; clients on

	methadone; clients being tapered from benzodiazepines or narcotics.
Community Withdrawal Management Level 3	Client symptoms require monitoring by medically trained staff. Medical consultation and staff are available on a constant basis to monitor and manage the following medications/situations: all medications as listed in Level I; circumstances as listed in Level II; medically-assisted withdrawal.
Residential Withdrawal Management Level 1	Assistance with voluntary withdrawal from alcohol and/or other drugs to clients who are under the influence of these substances and/or in withdrawal or otherwise in crisis directly related to these substances. This care is provided in a Withdrawal Management (detox) Centre, or on an inpatient basis in a hospital. Care may be provided with or without the aid of drug therapy and/or other medical interventions. Additional support such as discharge planning and early recovery education is provided. Service is provided at three levels. Level 1 Client symptoms can be safely monitored by staff who are not medically trained. Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department. Client/staff ratios do not permit high intensity symptom monitoring. In consultation with a physician, if necessary, consider/assess individuals for admission who are taking the following types of medication: medications for medical problems; medications for diagnosed psychiatric problems; and pain medications only for acute injuries or recent surgery.
Residential Withdrawal Management Level 2	Client symptoms can be safely monitored by staff who are not medically trained. Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department. Routine medical consultation and sufficient staff resources are available to consider management of the following medications/ situations: all medications as listed in Level I; clients on methadone; and clients being tapered from benzodiazepines or narcotics.

Residential Withdrawal Management Level 3	Client symptoms require monitoring by medically trained staff. Medical consultation and staff are available on a constant basis to monitor and manage the following medications/situations: all medications as listed in Level I; circumstances as listed in Level II; medically-assisted withdrawal.
Residential Treatment	A structured, scheduled program of treatment and/or rehabilitation activities provided while the client resides in-house, to assist clients to develop and practise the skills to manage substance use and related problems. In addition to the scheduled program activities, clients have 24 hour access to support and the residential treatment milieu.
Residential Medical/Psychiatric Treatment	A structured, scheduled program of addictions treatment and/or rehabilitation activities provided For clients whose biomedical, emotional and/or behavioural problems are severe enough to require individualized medical/ psychiatric care, while the client resides in-house. The treatment and/or rehabilitation is intended to assist the individual in stabilizing and managing his/her medical/ psychiatric problems, while also addressing the addiction problem per se, or to allow for referral to appropriate substance abuse/gambling treatment. In addition to the scheduled program of addictions treatment and rehabilitation activities clients have 24 hour access to support and the residential treatment milieu.
Residential Supportive Treatment Level 1	Housing and related recovery/support services such as lifestyle counselling, coaching for activities of daily living, community reintegration, vocational counselling and mutual aid, provided to clients who require a stable, supportive environment prior to, during, or following treatment, which is accessed elsewhere.
Residential Supportive Treatment Level 2	Housing/accommodation in alcohol/drug-free setting. Addiction services are not offered on-site or as part of the housing service.

Appendix 3: General Comments from Respondents

Some residents who are wheel chair bound are (with great difficulty) coming to the clinics in order to get the NRT. These are patients with other disabilities and mental health issues so it makes it very difficult to get these residents to the smoking cessation clinics. In our groups we had "X" give education sessions in "X" College where they learn about their substance use mental health and late life issues. In these sessions usually about 50% of the participants committed to stop smoking, Letters were sent to the LTCH indicating that they had taken a training session on NRT and were aware of the risks and benefits of NRT. The letters were faxed and originals sent by mail to the LTCH. We pursued this for quite some time up to one year and finally the physicians declined to prescribe for these patients. This was very disappointing for the residents and three years later they continue to ask for education on smoking cessation and NRT in hopes that they will be able to access the programs. LTCH's have provincial mandates for residents not to smoke in their buildings so there is a high need to offer NRT to the residents. If COPA was able to easily access the NRT and we had medical support to ensure the safe use of NRT it would be a welcome addition to our programs. The LTCH staff all our Geriatric Addiction Specialist for LTCH often to request smoking cessation for their residents however, if the Staff physicians won't prescribe the NRT and there is no funding for NRT there isn't much we can do.
All Addiction Counsellors are trained or new workers are soon to be trained in TEACH. Catalyst has not reflected the program yet > one of our counsellors is involved in a "X" Community of Practice to ensure collaboration with other community partners (Hospital, Health Unit, Family Health Teams, Mental Health organizations to name a few). Keep us abreast of any new happenings.
All programs indicated have staff who have been specifically trained in smoking cessation. These staff all work in programs specific to serving a population of clients with concurrent disorders. This leaves the vast majority of our staff without the specialized training, and smoking cessation is not a part of our larger MoHLTC programs as it is not a mandated service under that funding.
We are a 100% non smoking both in the building and on the grounds. Our clients are not allowed to smoke during the four month treatment program. They are provided with Nicotine Replacement Therapy at no cost to them for the first two weeks. We implemented this non smoking policy two years ago and it went smoothly with no issues.
Because it is legal and your facility does not have to be licensed as would be a drinking establishment - clients (some) prefer to stop the other drugs first and work up to healthier lifestyles - smoking cessation, diet, exercise, weight gain/loss, etc. Our hospital still has a smoking area outside. If the cost savings are significant as have been indicated, increase in funding should be readily available.
Currently our Urban Aboriginal Healthy Living Worker has the Smoking Cessation Training. However, she works primarily with Prenatal clients. There has not been full Program Integration.
I agree that smoking cessation should be offered to the clients and they should be supported with that goal. But I have been told that the nicotine replacements are similar to methadone as just a substitute. My question is do people die as a result of the replacement therapies as they do from smoking???

I am not sure if we have this mandate from our funder however I am not sure it would be a concern to them. If funder did formalize a mandate they might be concerned that they will be asked to provide resources for NRT and staff/program support (FTE).
I can tell you that with the news of St. Joseph's WMS going smoke free I have been getting lots of negative feedback from the community. The comments run along the lines of: I am requesting help to withdraw from my crack cocaine addiction but now you are telling me that I have to stop smoking to get that help? How is this a client centered approach to addiction treatment? You are going to tell people they have to quit smoking to get help for their addiction and in a withdrawal management program they are there for 5 days and get NRT - what happens after that?
I feel it is important to describe the assistance that we provide to clients related to smoking; we provide community treatment and therefore clients are seen primarily on an individual basis; as part of each assessment all substances of concern are identified including nicotine; if tobacco is identified then clients are encouraged to consider changing their smoking behaviors; if they are ready to do so assistance re cessation is part of their treatment plan or they can be referred for other assistance which specializes in smoking cessation only for services such a NRT, group support, or telephone support services. Many clients decline to include smoking in their goals to change their substance abuse...what we are not able to offer would be...NRT, specialized smoking cessation group work, marketing of smoking cessation assistance through our agency as a specialty; ...usually in our area there have been services funded for assistance specific to tobacco in the areas of cessation and/or prevention such as Public Health; However currently the local children's mental health agency is offering cessation assistance to youth and adults;
If the province provided funding for smoking cessation then the agency would deliver the program. We cannot, however, provide these services within existing resources.
Our Board passed a resolution in 2001, that the Training and Learning Centre is a non-smoking facility.
Our next step is to develop a 'module' re: smoking to incorporate into our existing groups. Please note we did contact TEACH to come complete staff training but could not afford it was not in budget.
Our residential program is non-smoking. We are experimenting with how to support our clients through withdrawal, and would appreciate helpful advice about this. Our day treatment program allows only one smoke break per day, and is experimenting with psycho-education about smoking cessation. Both programs provide limited NRT to interested participants.
Our treatment centre is 6 months long and they pay rent to be here - it becomes their home for 6 months. I would be concerned that many women would see it being a non-smoking centre as a reason not to commit to treatment with us.
We do not currently provide a formal smoking cessation program. However, we do take a history of use of substances and behaviours, including smoking, and respond to a client's desire or consideration to reduce or quit by providing information to the client about resources in our area that do offer smoking cessation programs and by keeping the discussion alive regarding progress towards meeting that goal, among others. Even though I have placed an 'x' beside reasons that might influence why we don't offer a formal smoking cessation program, the reasons don't quite 'fit'. For example, while we don't have a directive or mandate from our

funder, it does not restrict us from supporting our clients to reduce or quite smoking. Offering such support to clients who are already engaging for help with other substances and/or harmful gambling behavior does not currently increase agency wait times for our clients, but it would if clients could come for only smoking cessation, without other substance use or gambling concerns. Supporting existing clients to reduce or quit smoking does not require an increase in staff because of providing that support, but if the agency offered smoking cessation as a stand-alone reason for seeking services at the agency, then that increased demand would certainly create wait list challenges without an increase in staff. It makes sense to incorporate smoking cessation programs within existing substance use / behavioural change services; however, such programs have historically been supported through public health departments and primary care physicians. We would wholly support a move to incorporate smoking cessation programs into existing addiction services, along with the required supports to ensure success.
Personally, I absolutely believe we should be 'not smoking'. We have a funding issue in that we depend on $300,000-$400,000 to keep our doors open from 'fee for service beds'. I have consulted our referrals and they have said 'NO referrals if we were no smoking. I believe this has to be mandated from the Ministry to be effective.
Smoking cessation programs would require additional resources, but would be a worthwhile endeavour if planned properly. Making it a mandatory part of service would definitely exclude a certain percentage of the population that could/would benefit from our existing service.
This program's staff encourages healthy life styles changes as seen as contributing to overall well-being, including smoking reduction/cessation, improving dietary practices, exercise etc.
We are a drug and alcohol treatment centre - we don't deal with sex problems or eating disorders either…alongside not providing smoking cessation program.
We are increasing our focus on tobacco cessation, but at present this is an informal approach which we are integrating into our 1-1 and group sessions. In the past, our agency has collected data on clients' smoking behaviours under the catalyst DHQ and have provided resource materials (handouts and contact #s) to assist clients who have indicated an interest in making changes. Over the past 8 months we have been taking a more proactive approach and providing additional education and opportunities for clients to work on their tobacco cessation issues.
We are intending to move the program to a non smoking site in the near future. We are currently gathering information on how best to do this and from what we understand, this needs to be well planned to ensure staff buy in and suitable cessation support to both staff and residents in the transition period and once we are smoke free. It would be great if it was just mandated.
We are offering this to our residential service...however the environment currently is not conducive to a smoke cessation program as many clients do not partake and there is a lot of activity around smoke breaks etc. On April 1st, we are implementing this service for all clients...those who do not wish to partake will be offered our non residential Withdrawal services.
We have a full medical department but not the funding and expertise to implement a program.
We have begun to address additional smoking awareness and smoking restrictions with staff and clients as the beginning of smoking cessation more visible in our agency.

We have had a completely smoke free home since 1992, long before Provincial legislation came into effect although a smoking area is available outside. If more training were made available for staff to attend, we would gladly send staff for training and integrate more into our programs to address tobacco addiction. If we made it mandatory that women quit smoking in order to attend our programs, they would not attend and it would become a barrier to treatment.
We have one counselor trained in smoking cessation and provide service to only our current clients who may wish cessation services in addition to their drug/alcohol and or gambling issues. We would like to provide service more broadly but due to Ministry restriction in mandate, we have not expanded on this although the need is certainly there.
We have two trained counsellors and are setting up to be a bit more formal.
We see the value in smoking cessation and have residents who are interested. We even did a group a few years ago - the main problem is funding for nicorette gum or the patch. In a 6 month program it is almost impossible to quit without some support. I don't feel that we can require clients to quit without any support at all.
We will offer this service to any clients that request, and regularly discuss health effects of smoking with clients who disclose their addiction. We have a certified smoking cessation counsellor on staff, but we do not promote this aspect of our service or report on it as we have not been funded to do so. In our community, the Family Health Team has now begun to offer groups for smoking cessation.
What good timing to get this survey. We just decided in December that we would try to offer an in-house smoking cessation program. Our program will begin next week and run as a trial for 6 to 8 weeks. The other comment I would like to make is that we are receiving no support from our funder, this program was staff initiated as we see a need for it in our clients. We are receiving materials from local agencies (Health Unit, Cancer Centre) and are developing our own program. As our program is abstinence based, that will also be the goal of our smoking cessation program.
We have had tobacco cessation programming for about 4-5 years and have added a pre-contemplative / contemplative 4 session program for all clients in the treatment program over the last 1.5-2 years. We began the journey of including tobacco as a drug of choice in all aspects of our programming - WMS, 5-week day and residential treatment, pre-treatment and aftercare programming, about 7 years ago. “X” will go smoke-free in late March 2010. We have had a tobacco addiction specialist on team for over 5 years and 3 are also trained, 1 additional person this March. Men's Withdrawal Management has had 3 tobacco addiction trained team members on team for 2 years with an additional person getting training this March 2010. We offer a couple of session in our WMS programming and will be starting a tobacco cessation course this spring 2010. Men's will also go smoke-free in late March 2010.
Yes our programs provide smoking cessation for our clients. We use the similar principles as those for other drugs and do this on an individual basis and infrequently on a group basis when there is sufficient interest. We have also used materials provided by the Lung Association and other resources. We RARELY have clients who want to complete a smoking cessation piece with us. If we had a higher demand for such a service we would likely refer elsewhere due to lack of human resources to provide such a service in a more in-depth manner.

We are a non smoking program. When we went to Non-Smoking we created a package to assist the youth to cut down or quit prior to coming into the Residential Program. We encourage them to use a smoking aid if they need to. We supply Nicorette gum and the Nurse Practitioner or the doctor here will prescribe the patch or oral prescription if needed. We have regular gum and suckers available as well. We have material to read and we do information sessions with them, we also get the Health Unit here to send over their specialist in this area to assist if need be. Staff are informed and talk to them about withdrawal and craving.