British Columbia Centre of Excellence for Women's Health

Research Summary

INTEGRATING TOBACCO CESSATION INTERVENTIONS INTO MENTAL HEALTH, SUBSTANCE USE AND ANTI-VIOLENCE SERVICES

what we did

BETWEEN APRIL 2010 AND MARCH 2011, researchers at the British Columbia Centre of Excellence for Women's Health, in collaboration with community partners, conducted a study on the feasibility of integrating tobacco treatment and support within mental health, addictions and sexual violence services, in a gender informed way.

The study included focus groups with service providers and with smokers, and a review of the literature on tobacco cessation in the mental health, substance use, and trauma treatment fields. The focus groups were held in the following four settings:

- a tobacco dependency clinic serving the general population, including smokers with mental health and substance use problems;
- a women's substance use treatment centre where treatment for tobacco dependency was integrated into overall treatment;
- a mixed-gender tobacco cessation group for mental health clients; and,
- a woman's sexual assault centre with no specialised tobacco support.

what we found

OUR FINDINGS ECHOED OTHER STUDIES which have found that smokers who use mental health, substance use, and sexual violence services are generally knowledgeable about the harms of smoking, and the majority are interested in quitting.

Service providers were supportive of most efforts to expand and integrate tobacco cessation into existing services. However, this requires policy and program approaches which support service providers in recognizing misconceptions about the relative harm of smoking, addressing concerns about the timing and priority of tobacco cessation in overall service provision, and ensuring that service provider's own relationships to smoking are considered. Service providers noted a number of system-level barriers to integrated tobacco treatment, including the high cost of nicotine replacement therapy for many clients, lack of clinical support for tobacco cessation, lack of resources and integration in other health and social services.

what service providers can do

INTEGRATING TOBACCO CESSATION into mental health, addictions and sexual violence services requires system, program, and clinical change. However, individual service providers can be a catalyst for this change through small changes in their clinical practice. We include suggestions from service providers on our research team and from the service providers we interviewed on how to integrate tobacco cessation into your current work and some resources to help you get started.

Despite a decrease in the smoking prevalence of the Canadian population from 50% in the 1960s to about 19% today, many cigarette smokers remain unable to quit. Among those who continue to smoke and find it difficult to quit are people with mental health, other substance use and trauma-related concerns.

Smoking, Addictions, Mental Health, and Violence: What are the connections?

SMOKING IS PREVALENT AMONG WOMEN WITH OTHER SUBSTANCE USE, VIOLENCE AND MENTAL HEALTH CONCERNS. Women and girls with substance use problems, mental illness or experience of violence and trauma are much more likely to be smokers than the general population.

Women with **substance use problems** in particular have exceptionally high smoking rates. One study of women with alcohol use disorders in treatment reported a smoking prevalence of 82% (Bobo 2002). It is of note that gender differences in smoking among people with substance use concerns have been found: one study identified that women with alcohol use disorders are 2.3 times more likely to be nicotine dependent than their male counterparts (Daeppen et al. 2000).

Smoking is high among women with **psychiatric concerns** as well. Smoking prevalence among women veterans in mental health outpatient treatment was found to be 49.4% for panic disorder, 39.9% for major depression and for PTSD, and 30.3% for women with eating disorders, while 31.1% had alcohol use disorder (Davis et al. 2003). In a survey of pregnant women in a US maternal and child nutrition program (WIC) 35% of the women who continued smoking had a psychiatric disorder (Flick et al. 2006). In a study of women with binge eating disorder, those with a co-occurring mood disorders had a lifetime smoking prevalence of 53.8%, those with co-occurring anxiety disorders 76.9%, and those with co-occurring substance use disorder had rates of 94.2% (White and Grilo 2006).

Much higher smoking rates and heavier cigarette use are also associated with women's experience of various forms of **gender-based violence**. De Von Figueroa-Mosley and colleagues (2004) found women survivors of childhood sexual abuse are 3.8 times more likely to be current smokers. The smoking rates for women with posttraumatic stress disorder range from 39.2% (Helstrom, Bell, and Pineles 2009) and 40% - 45% (Fu et al. 2007), to 53.6% for women with trauma related to sexual assault (Amstadter et al. 2009), and 58% for severely battered women (Weaver and Etzel 2003).

Not only are women with violence-related/traumatic experiences likely to be smokers, but they are frequently heavy smokers. Women with a history of intimate partner violence were almost four times more likely than women smokers without trauma to consume a pack or more of cigarettes a day (Loxton et al. 2006; see also Lemon et al. 2002, and Weaver & Etzel, 2003), and 29% of women smokers in treatment for trauma self-reported heavy smoking of a pack or more daily (Helstrom, Bell, and Pineles 2009).

These high smoking rates for women with co-existing mental health, addictions and violence related concerns are disquieting. They provide a strong rationale for integrating education on the links and risks, as well as integrated support for smoking cessation in treatment programming for women on these related issues.

What We Learned

Integrated treatment works. So does stand-alone treatment.

Smokers reported broad interest in quitting smoking and difficulties in learning about available community supports. They appreciated having both integrated and stand-alone tobacco cessation support options; as well, many women emphasized the importance of women-only programs.

Service providers also supported the idea of a "menu of options" for their clients, although they could see the system and resource constraints that this might entail. Both service providers and smokers commented on the need for options, such as the use of therapies like acupuncture and self-help groups, free nicotine replacement therapy, and holistic/wellness programs that integrate stress management, physical activity, nutrition, and tobacco cessation.

Timing and prioritizing tobacco cessation within existing services was commented on by both groups. Service providers had a noted reluctance to address tobacco cessation in certain contexts (e.g., when a client began treatment for other substances), even when the research evidence supported an integrated approach. Broader trends in tobacco policies and legislation were seen as supportive of a move towards integrated tobacco cessation interventions.

"It's like some ingrained idea that people that work with mental health clients - I've heard so many times over the years, 'That's all they have left, like why would you take that from them?'"

"We think the clients don't want to quit; but the research shows, yeah, they do want to quit but we don't think they do."

"I probably wouldn't have quit without the [name of mental health smoking cessation] group. Just ...the way it works; specifically geared towards mental health issues."

"For me, smoking is separate than my addiction; I'm being honest, it's separate."

"Because you have mental health issues doesn't mean that you're not entitled to the same health as other people."

Gender matters.

Integrating tobacco cessation interventions into existing mental health, addictions, and sexual violence services requires attention to gender. Gender differences interact with other health concerns to affect smoking behaviours (e.g., women smokers with post-traumatic stress disorder (PTSD) smoke in response to different symptoms than men with PTSD) and gender impacts cessation (e.g., men and women vary in their smoking motivation, symptoms of tobacco dependence, and cessation attempts). Gender plays out in different ways. Some women smokers commented on the value of women-only groups while other service providers commented on how men often did not fare as well in group settings as women.

Issues such as having children are more often a factor to consider in treatment for women, but in different ways: lack of childcare was often a barrier to accessing services, children were a motivator to quit smoking, or stresses related to raising children were a reason to continue smoking.

"My smoking time is mummy time, because I don't smoke in the house, I go outside to smoke and it's 'Kids, you stay inside, mummy's going out back to have a cigarette, it's mummy's time' and you know, that's my five minutes of peace and quiet, you know."

tips for service providers

MAKING INTEGRATION OF TOBACCO CESSATION SUPPORT WORK FOR YOU

The service providers we spoke to expressed their interest in more clinical support on tobacco issues, discussed how smoke-free environments benefited them and their clients, and emphasized the importance of support for service providers as more and more organizations implement tobacco-free policies. We also heard from service providers who were considering and experimenting with strategies to integrate tobacco cessation into their current work. Here are some suggestions from other service providers.

1 **Start with the clients you already have a good relationship with.** Many service providers we spoke with discussed their fear of losing clients if they raised the issue of tobacco cessation with them or if programs mandated that tobacco cessation occur in the context of other treatment. Remember that most clients have some interest in quitting smoking. For clients that you have an established relationship with, make assessing motivation and interest a regular part of your treatment plan.

2 **Remember, you already have some of the skills to address tobacco cessation.** Different disciplines and service orientations use different clinical tools and frameworks. Many of these perspectives and skills can be applied to tobacco cessation. For example, Motivational Interviewing, the 5As model (Ask, Advise, Assess, Assist, and Arrange), physical exercise and nutrition support are all approaches that have been successfully used to support tobacco cessation.

3 **Talk to your clients about the immediate health benefits of quitting smoking.** Quitting smoking has immediate health benefits. Tell your clients what to expect and the timing of these improvements. If your client manages to quit smoking for one day, you can tell them: *20 minutes after your last cigarette, your blood pressure drops and the temperature of your hands and feet return to normal. After 8 hours, carbon monoxide levels drop to normal. After 1 day, your chance of heart attack goes down.*

4 **Know who to refer to.** You don't have to do everything yourself. If you get the ball rolling, you can enlist the support of other service providers and organizations. Find out what's available in your community and keep a list of potential resources handy. You can refer your clients to other services or use other service providers as a practical support so that you can continue to assist your clients throughout the process of cessation.

5 **Teach a new coping skill for managing stress and/or helping to regulate emotions.** This can be done with pretty much any treatment plan and can create the space to discuss issues such as: misperceptions about the relative harm of tobacco on health and the benefits of quitting tobacco and other substances simultaneously; how common smoking is for individuals facing multiple issues such as other addictions and mental health concerns; the benefits and drawbacks of tobacco use.

On talking about how smoking is used to manage feelings, during intake and assessment:

"It's one of the questions we ask when they're doing their intake. It's talking about addictions generally and substance use. We frame it as something like people use various things to help manage strong feelings or, and then we have to give the example of substances or alcohol or tobacco, so a lot of people will talk about it in the beginning, before they even see counsellors, like just when they're doing their intake."

Learn more

GET UP TO SPEED

Baca, C.T. and Yahne, C.E. (2009). Smoking cessation during substance abuse treatment: what you need to know. J*ournal of Substance Abuse Treatment*, 36(2):205-19. PMID: 18715746.

A brief review of research on tobacco cessation literature and successful methods of intervention and a discussion of how to incorporate smoking cessation into clinical practice.

Coalescing on Women and Substance Use, BC Centre of Excellence for Women's Health. Visit http://www.coalescing-vc.org

The Violence, Trauma and Substance Use section of this web site examines the connections between substance use, mental health and addictions for women and explores principles of trauma-informed care. Recently updated in Spring 2011.

Morris, C., Waxmonsky, J., Giese, A., Graves, M., Turnbull, J. (2009). *Smoking cessation for persons with mental illness: a toolkit for mental health providers.* University of Colorado at Denver and Health Sciences Center, Department of Psychiatry. Visit http://www.tcln.org/bea/docs/Quit_MHToolkit.pdf

Stead LF, Perera R, Bullen C, Mant D, Lancaster T. (2008). Nicotine replacement therapy for smoking cessation. *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD000146. DOI: 10.1002/14651858.CD000146.pub3.

On-line Clinical Tools

THERE'S AN APP FOR THAT

If you already use cell phones with your clients to support them in scheduling, goal-setting, monitoring symptoms and other therapy-related activities, then you might want to look at the possibilities for using technology in the area of smoking cessation. You could start with Quit Now which offers Internet-based and telephone-based quit smoking service, free-of-charge for all British Columbians. The service includes 24/7 web support and a free confidential helpline as well as a 14-week text messaging-based program. See www.quitnow.ca

COSTS OF SMOKING CALCULATOR

Poverty is a real concern for many clients struggling with mental health issues, substance use issues and trauma-related concerns. The Canadian Cancer Society has an on-line Cost of Smoking calculator that may help to explore money, smoking, and other motivations for thinking about quitting smoking and staying quit. Visit http://www.cancer.ca

COPING SKILLS

For many clients, smoking is one way of coping with emotional distress. This can be an opportunity to make the connection between coping and smoking and to assess motivation to quit smoking. You may want check out Lisa Najavits book *Seeking Safety: A Treatment Manual for PTSD and Substance Use*. It includes a list of over 80 "safe coping skills" that have been used in individual and group programming for women, men, and in mixed-gender settings. Visit http://www.seekingsafety.org

WITHIN 20 MINUTES OF SMOKING....

Focusing on the immediate benefits of smoking can increase motivation to quit smoking and support clients who may relapse. There are a number of versions of this information sheet available on-line. You can start with this version from the US Centers for Disease Control or do a quick on-line search to find a format that is appropriate for your client group. http://www.cdc.gov/tobacco/data_statistics/sgr/2004/posters/20mins/index.htm

THE FINDINGS OF THIS RESEARCH PROJECT complement and support recent and ongoing research in the area of gender and tobacco at the BC Centre of Excellence for Women's Health. Visit our web site at www.bccewh.bc.ca to learn more about the projects listed below.

- *Expecting to Quit: A Best Practices Review of Smoking Cessation Interventions for Pregnant and Postpartum Girls and Women*
- *Girl-centred Approaches to Prevention, Harm Reduction and Treatment*
- *Social and Built Environments and Gendered Effects of Secondhand Smoke Policies*
- *Women-centred Tobacco Dependence Treatment and Relapse Prevention*
- *Exploring Trauma-informed Practice in Mental Health and Substance Use Services in BC*

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