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Happenings

Integrati ıg Treatment for Tobacco and Othe : Addictions at the Aurora Centre of the British Columbia Women's Hospital and Health Centre[1]

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Introduction

Experience in the women's health field indicates that women often experience addictions in concert with other social and health concerns, making intersections among substance use, mental health and illness, trauma, violence, and HIV/AIDS a key issue. However, both research and practice often overlook these intersections and resulting co-morbidities and tend to address substance use in isolation. In addition, research and practice concerned with alcohol and other drugs rarely address tobacco addiction, so that clinical practice in women's addictions often is not fully informed by an integrated approach. A multidisciplinary and interdisciplinary approach to both research and practice is necessary in order to address the complex issues involved in women and addiction.

While few treatment programs in Canada address cigarette smoking in the context of other addictions, those that do are meeting with some success. The Aurora Centre, a multi-faceted women's substance-use treatment centre based at British Columbia Women's Hospital and Health Centre in Vancouver, does address nicotine addiction in the context of treatment for other addictions. The initiatives taken by the Aurora Centre since 1998 are focused on supporting women's motivations to examine and change their smoking patterns in the context of residential treatment for other drug and alcohol use, and in the aftercare period.

Integrating Tobacco into Addictions Treatment

Although cigarette smoking poses a serious threat to the health of substance-addicted women, there has been resistance to considering tobacco a "problem drug," along with other substances, in addictions treatment

[1] A longer, more detailed version is published in *CJNR* online at www.ingentaselect.com

programs. This resistance stems from three sources. The most significant barrier is the perception that addressing cigarette smoking will interfere with and have a negative impact on treatment for other addictions (Hahn, Warnick, & Plemmons, 1999). A second barrier is resistance by staff members who may be smokers themselves to the creation of a smoke-free environment (Bobo & Davis, 1993). Finally, resistance within addictions treatment programs mirrors societal resistance in terms of accepting tobacco as a problem substance.

Over the past decade, evidence has slowly emerged indicating that treatment for tobacco addiction does not interfere with treatment for other addictions (Abrams, Monti, Niaura, Rohsenow, & Colby, 1996; Hurt et al., 1994; Martin et al., 1997). In addition, some studies have found that treating tobacco addiction in conjunction with treatment for alcohol and other drugs increases the chances of maintaining sobriety (Bobo, Schilling, Gilchrist, & Schinke, 1986; Orleans & Hutchinson, 1993; Trudeau, Isenhart, & Silversmith, 1995). Treatment centres have addressed staff resistance by offering, supporting, and paying for personnel to undergo smoking-cession treatment themselves (Campbell, Krumenacker, & Stark, 1998).

Another myth that is being discredited is that clients being treated for substance abuse are not ready to quit smoking or would be overwhelmed by undergoing nicotine withdrawal during treatment for other addictions.

Acknowledging Tobacco as a "Problem Drug"

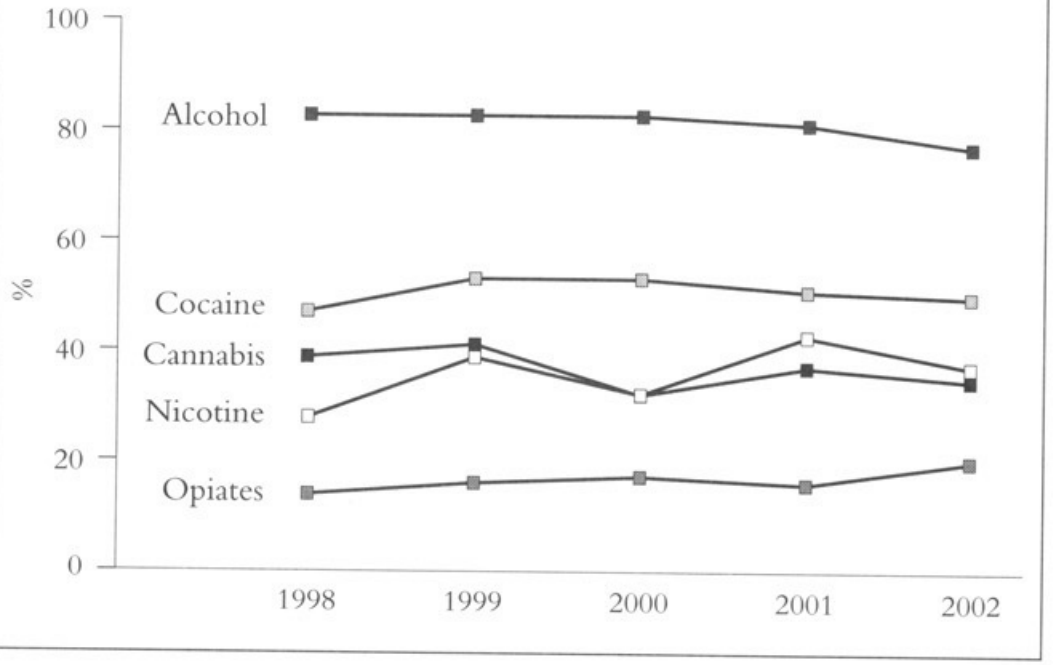
Central to the assessment of addictions problems and individualized treatment planning is the identification of problem drugs by those entering treatment. Traditionally, problem drugs were identified by the woman entering treatment in conjunction with her referring agent, yet seldom did women identify tobacco as one of their problem drugs.

In 1997 the Aurora Centre staff began to draw attention to tobacco as a problem for women by presenting it as a drug that clients might consider among their "top three problem substances" upon entering the program. Since that time, women entering treatment have consistently identified nicotine as one of their top three problem drugs (see Figure 1). In 2001, 76% of women entering treatment were smokers and 43% identified nicotine as one of their top three problem drugs. Only alcohol and cocaine were cited more frequently.

Creating a Welcoming and Supportive Setting for Cutting Down on Smoking

Removing barriers to access to intensive treatment is an ongoing challenge for the Aurora Centre and other treatment centres for women.

Figure 1 ***Drugs Identified by Aurora Centre Clients as Their "Top Three Problem Substances," 1998–2002***



Developing strategies for removing barriers as varied as transportation costs, pregnancy and mothering-related issues, lack of community-based referral agents, and use of prescribed psychotropic drugs is a constant challenge. At Aurora it has been important for program planners to create a setting that is welcoming for women at all stages in the process of changing their smoking habits. Some women are not yet ready to make a change, but some clearly want to use the treatment context to quit. Steady leadership has been required to bring about the environmental support necessary for women at both of these stages.

One strategy was to make the smoking space less visible (with the non-smokers in mind) and less convenient (as a deterrent for smokers) by moving it from a 4th-floor rooftop deck (easily accessible to the 5th-floor program) to the street level. While less convenient for the smokers and less irritating for the non-smokers, this arrangement was not supported by patients and staff of other women's health services, who had to pass by the smokers at the main entrance. Consequently, a pagoda was built further out on the hospital grounds to create more space around the smokers and move them away from the entrance.

Another way of encouraging change in smoking patterns has been to link smoking to other components of the program that support improved health. Unsupervised early-morning walks, a component

designed to support health recovery, were often being used as an opportunity to smoke and access caffeine at the local coffee bar. To shore up the motivation of those who want to quit smoking, and to encourage all clients to value the benefits of exercise over stimulants, staff members now join the walks. The yoga instructor and the nutritionist at Aurora also stress the benefits of quitting smoking and the benefits of yoga and nutritional strategies in supporting changes in smoking patterns.

Smoking-Awareness Programming Within Treatment

Catching Our Breath, developed by Deborah Holmberg-Schwartz (1998) for the Women's Health Clinic in Winnipeg, Manitoba, was chosen as the basis for the Aurora Centre's intervention on tobacco addiction. This program focuses on empowering women to make and sustain change in their lives by identifying and adopting a variety of self-care strategies that may be equally applicable to quitting smoking and maintaining abstinence from other substances.[2]

Five or six 1-hour sessions based on the Catching Our Breath model are offered over the course of each residential treatment cycle. All participants, whether they are smokers or not, attend the first session, which is oriented around self-care and making changes related to all categories of drugs. The other sessions focus specifically on tobacco and are designed to help participants increase their knowledge of the physical effects of smoking, question some of their assumptions about smoking, appreciate the influence of the tobacco companies and the media on their health, and learn specific change strategies such as "thought stopping."

Evaluation after the first year of the program showed that by the end of treatment 62% of participants were smoking less and 43% planned to quit within 6 months of completing treatment. Participants rated highly the information provided on the physical impact of smoking, on the statistics related to the risks of smoking, and on cigarette advertising. Consistent with DiClemente and Prochaska's (1998) *pre-contemplation* and *contemplation* stages of change, they clearly benefited from the consciousness-raising about the risks and impact of smoking. In the year 2000, 33% of the clients reached for a follow-up interview had in fact quit smoking within 6 months of completing treatment.

This response has been gratifying for program planners at Aurora in affirming the importance of a harm-reduction approach to smoking in treatment programming. The creation of the conditions for learning about the risks of failing to change smoking habits and strategies for

[2] An evaluation of the Catching Our Breath model implemented in several contexts at the British Columbia Women's Hospital and Health Centre was designed and first implemented in 1998 (see Horne, Barr, & Greaves, 1999).

instituting change, along with a non-judgemental approach whereby participants are free to discuss their feelings and thoughts on smoking, have proven beneficial to women in treatment. It has in fact facilitated participants' movement along the continuum of change to the *action* stage (DiClemente & Prochaska, 1998) in the aftercare period.

Smoking-Cessation Programming in the Aftercare Period

The Aurora Centre also offered a Catching Our Breath group as one of four groups piloted in 2001 to address the need for aftercare support for women completing day and residential treatment. The women who participated in these groups had become interested in quitting or reducing their smoking while at Aurora. They chose to build on the motivation and progress made over the course of treatment by participating in these aftercare sessions. Two cycles of an aftercare smoking group were offered — a 12-week session and then (based on feedback from participants) a 10-week session.

The women participating in these groups had a long history of smoking. None had smoked for less than 10 years and many had smoked for over 30 years. In the year prior to joining the group, participants had made considerable effort to address their smoking (43% had tried to quit, 43% had tried to cut down, and 64% had paid more attention to the times and places they smoked). This confirms that women who have entered treatment for other drug problems do indeed see their cigarette smoking as problematic and are ready to accept help with reduction or cessation.

Consistent with the previous evaluation of the Catching Our Breath program (Horne et al., 1999), specific health strategies employed by the participants were identified at the beginning and end of the group intervention. Over the course of the Aurora aftercare group intervention, the participants *increased* their use of health-oriented strategies for self-care, including relaxation activities, breathing exercises, and participation in leisure and physical activity. They also increased the number of times they rewarded themselves for having made positive changes. Interestingly, the participants *decreased* their use of cognitive strategies such as making self-affirmations and "stopping" negative thoughts.

While the aftercare intervention remained open to women with a range of goals (quitting completely, cutting down), more women in the aftercare program had the goal of quitting, which is consistent with DiClemente and Prochaska's (1998) *preparation* and *action* stages of change. The immediate outcomes for the participants in this group were similar to those of the women who participated in the in-treatment "awareness" program. One third of participants in the aftercare group

were able to quit smoking over the course of the group intervention and another 44% reduced their level of smoking.

Conclusion

The introduction of smoking cessation and reduction programming into treatment for women with addictions has been successful at the Aurora Centre for both residential and aftercare (day) patients. Similar results were obtained for the two groups. One third of the women in both groups had quit smoking as measured at 6-month follow-up and larger percentages of women (62% of residential and 44% of aftercare patients) had reduced their smoking. These results reinforce the importance of integrating smoking cessation into addictions treatment for women.

It must be noted that the tobacco education program at the Aurora Centre is a women-centred holistic program that focuses on encouraging positive health behaviours and meaningful self-analysis of tobacco use. Therefore, the results reported here are linked to the adoption of a women-sensitive approach that has been developed and tested in a range of settings and contexts.

Women in addictions treatment report a higher rate of smoking than women in the general population. It is essential that smoking be addressed in order to reduce the health risks that result from use of tobacco in conjunction with other substances. Women who are struggling with addictions to other substances should not be denied an adequate smoking-cessation program on the basis of assumptions about other substances or the attitudes of staff.

It is clear that introducing women-centred smoking-cessation programming into addictions treatment should be encouraged, particularly as women with addictions identify nicotine as a "problem substance" and are therefore primed for its consideration in the planning of their addictions treatment. Resistance by some patients and staff can be seen as a normal response to changing norms and approaches in treatment and a reflection of societal ambivalence regarding tobacco use and smoking cessation.

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