

Visions

BC's Mental Health and Addictions Journal

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bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, Jessie's Hope Society and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. *Visions* is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

The BC Partners are grateful to BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority, for providing financial support for the production of *Visions*



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Well, out of all the issues that I have written editorials on, this one leaves me the most conflicted. While I do not smoke, many important people in my life have been and are smokers. I know the potentially tragic consequences of smoking on a person's body and on their family but like all addictions, smoking has many facets. In fact, smoking can become a convenient catch-all rationale for an overburdened medical system on which a multitude of bodily issues can be pinned.

Smoking has really come full circle. Early on, it was a visible sign of non-conformity that progressed not only into a socially acceptable but socially necessary habit. Now, smoking is again socially unacceptable and some non-smokers can be rather fanatic in their condemnations. As the CACTUS project (see article in this issue) points out, shame and guilt are two of the most potent feelings reported by smokers who felt that others were judging them. Is this how we want smokers to feel? Is this the tactic that we use with other addicted people?

The personal experiences are telling: one shows us just how conflicted smokers really are, between wanting to stop and enjoying it, others talk of the use of smoking to fit in socially. It's a particularly difficult addiction to beat because it is legal and so many people still smoke. As for the debate, my favourite smoker claims arguing against non-smoking is like arguing against global warming; there is little room for contrary thought.

But there is some caution to be used here. We sometimes grasp at smoking as a worthy and necessary target while not considering the effect that we have on individuals. As we know from other addictions, individual commitment to change is a must. But policies are also part of the picture. For example, do policies such as smoking bans in health care facilities open an avenue of communication or close them off? Let me be clear. I wish no one smoked. But, the arguments have reached a level of such social acceptability that there is no questioning of method, judgement, or consequence.

On a personal note, this is my last editorial in *Visions*. I want to say how much I have enjoyed brainstorming, reading, and debating with the many people work at producing an edition. I have learned so much from all the contributors and feel uniquely blessed. **i**

Christina Martens

Christina is Executive Director of the Canadian Mental Health Association's Mid-Island and Cowichan Valley Branches. She has an MEd in Community Rehabilitation and Disability Studies and is working towards her doctorate in Policy and Practice in the Faculty of Human and Social Development at the University of Victoria

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Why Tobacco Control is Still Important



Simon Barton

Simon is Manager of the BC Ministry of Health Tobacco Control Program, where he has been the lead on each of the core program areas of cessation, prevention, protection and enforcement. He has also worked on prevention programming for the Stopping the Violence Branch and has supported self-care projects such as the BC NurseLine

Recent headlines might have you thinking the most pressing public health concern is obesity or a lack of physical activity. If you live in the Lower Mainland, you might think it's illegal drug use. All are important issues, but the leading cause of preventable death in British Columbia is tobacco-related illness. As you'll see, the numbers really do speak for themselves.

While we can hold our heads up high because we have the lowest smoking rate (15% in 2005) in Canada (for people ages 15+), BC still has over 600,000 daily and occasional smokers. An argument could be made that we have achieved great success by reducing the overall smoking rate from around 45% to 15% in the last 40 years. However, we have only reduced the actual number of smokers by an estimated 200,000.

Even though the overall provincial smoking rate looks promising, some populations still have a long way to go. There has been a very high rate of tobacco use (45% in 1997) among Aboriginal populations in BC.¹ This includes smoking rates of 41% for those ages 12 to 18 and 61% for those ages 19 to 24.¹ For young gay men, the smoking rate is twice the rate of other men in BC.²

For people with mental illness and/or addictions, tobacco use rates can exceed 70%.³ Since socializing in treatment centres often involves tobacco, it is common for individuals to enter as non-smokers and exit as smokers. Clearly, there is more work to be done to support this population.

Tobacco use is expensive. The Canadian Centre on Substance Abuse has estimated that the cost associated with tobacco use for British Columbia was approximately \$2.3 billion in 2002. This includes \$605 million for overall health care costs.⁴

Sadly, most of us know someone whose life has been cut short by smoking. The smoking-attributable mortality (SAM) rate in British Columbia is more than 6,000 individuals each year (6,027 in 2004), or approximately 16 smokers every day⁵—twice as many as those who die from all other drugs, motor vehicle accidents, suicides, homicides and HIV/AIDS combined. These SAM figures don't even begin to cap-

ture the quality of life lost for many smokers.

Most British Columbians have protection at work as a result of the 2001 WorkSafe BC regulation that restricts smoking in the workplace. The provincial government recently announced legislation that will make school grounds tobacco free, and designated smoking rooms a thing of the past. A recent tour of some of the nightclubs in downtown Vancouver with smoking rooms reinforced that there is still much work to be done.

More than 300 non-smokers die in Canada each year from causes related to second-hand smoke.⁶ Sadly, Heather Crowe was one of them:⁶ she never smoked a day in her life, but worked in a smoky restaurant and banquet hall. In our province between 100 and 140 people will die from passive smoking this year.⁷

On a positive note, we have the lowest provincial rate of children exposed to second-hand smoke at home (5%), which is 7% lower than the national average. While some people think exposure to second-hand smoke is just an issue for infants and children and feel it is simply a nuisance for the rest of us, exposure to second-hand smoke should be an important issue for everyone.

A recent survey by BC Stats revealed strong support for smoke-free public spaces: 85% agree that non-smokers have a right to a smoke-free environment. In this same survey, over 70% agreed that smoking is dangerous to those around the smoker.⁸ While these results tell us there is still work to do educating the public on the harms caused by second-hand smoke, there is clear support for smoke-free public spaces. We know there are many patrons waiting for their opportunity to enjoy sitting out on a restaurant patio in a smoke-free environment.

If there were no new smokers, we could simply stand back and watch the smoking rates decline as a result of the health impacts of smoking and old age. Unfortunately, young people start to smoke despite best efforts from parents and health educators. Currently, about 27% of young adults ages 20 to 24 in BC are smokers.⁸ This is the highest smoking rate of any age group in the province. It doesn't help that the tobacco industry spent over \$100 million in 2005

For people with mental illness and/or addictions, tobacco use rates can exceed 70%. It's common for individuals to enter treatment centres as non-smokers and exit as smokers.

promoting their products with retailers, a dramatic increase from \$74 million in 2001.⁹ We have found that approximately half of all underage smokers get their tobacco products from their friends, family and even strangers.¹⁰ It's hard to believe that a friend or parent would consciously contribute to an addiction that can cost another person's life.

So when we are asked why we still need to invest in tobacco control, the answers are clear:

- Over 6,000 smokers and between 100 and 140 non-smokers are expected to die in the next year in British Columbia, and many more will have their health compromised.
- Tobacco use impacts the health care system
- At-risk populations have smoking rates that greatly exceed the provincial average.
- Many youth and young adults will start to smoke in the next year.
- Tobacco products are widely available throughout the province.
- If we let our guard down, smoking rates will increase. ❗

footnotes

1. Heart and Stroke Foundation of BC & Yukon. (1997). *Tobacco Use in BC 1997* (Survey). Vancouver: Author. www.healthservices.gov.bc.ca/tobacs/index.html.
2. Lampinen, T.M., Bonner, S.J., Rusch, M. et al. (2006). *High prevalence of smoking among urban-dwelling Canadian men who have sex with men*. Journal of Urban Health: Bulletin of the New York Academy of Medicine, 83(6), 1143-1150.
3. Johnson, J.L., Macdonald, S., Reist, D. et al. (2006). *Tobacco reduction in the context of mental illness and addictions: A review of the evidence* (Report). Victoria: Provincial Health Services Authority.
4. Rehm, J., Baliomas, D., Brochu, S. et al. (2006). *The costs of substance abuse in Canada 2002*. Ottawa: Canadian Centre on Substance Abuse.
5. BC Vital Statistics Agency. (n.d.). Smoking-attributable mortality in British Columbia 2004 (Table 42). In Selected vital statistics and health status indicators: Annual report 2004. Victoria: Author. www.vs.gov.bc.ca/stats/annual/2004/index.html.
6. Illing, E.M.M. & Kaiserman, M.J. (2004). *Mortality attributable to tobacco use in Canada and its regions*. Canadian Journal of Public Health, 95(1), 38-44.
7. Health Modernization Branch, *Knowledge Management and Technology* (KMT), Ministry of Health, 2006. KMT supplied this range of figures, citing their sources as the Canadian Centre for Substance Use (100) and the BC Vital Statistics Agency (140).
8. BC Stats, Ministry of Labour and Citizens' Services. (2007). *Summary of smoking rates for BC: December 2005 through November 2006*. www.bcstats.gov.bc.ca/data/ssa/reports/tobacco/smokingstats_20052006.pdf
9. Provided by Health Canada based on reports pursuant to the Tobacco Reporting Regulations.
10. Context Research. (2005). *Youth access to tobacco project: Final report*. Victoria: Ministry of Health, Tobacco Control Program.

we want your feedback!

If you have a comment about something you've read in Visions that you'd like to share, please email us at bcpartners@heretohelp.bc.ca with 'Visions Letter' in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3. Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive.

I have been a subscriber to the Mood Disorders Association of BC newsletter for the past 6-8 years and have received *Visions* along with my subscription. As a support person for individuals with mood disorders, I have found both publications very helpful for each of us. I am also a union counsellor where members can contact someone in my role about accessing services, and information, about mood disorders, addiction issues, personal problems, job stress etc. So *Visions* has been very helpful with sharing resources and getting information out. A feature publication on the impacts of job stress, family issues, mental health and addiction problems in the work sector would be useful. —Diane Moran, Burnaby

By great fortune I was forwarded information regarding the *Visions* Journal. I was so pleased to read the article in your recent publication by Ruth Bancroft, who happens to be a colleague of mine on the Board of Directors for the Coalition of Child Care Advocates of BC. Westcoast Child Care Resource Centre produces a newsletter that is distributed to Child Care Resource and Referral Centres around the province. Ruth's article articulates a very important aspect of family support and we're delighted to have been given permission to reprint the article in our newsletter. —Crystal Janes, Westcoast Child Care Resource Centre, Vancouver

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Tobacco Control in the Context of Mental Illness and Addictions

Reviewing the evidence

Joy L. Johnson, PhD, RN

Joy is the UBC Site Director for the Centre for Addictions Research of BC. She is also Professor and Associate Director of Graduate Programs and Research at the University of British Columbia School of Nursing

Tobacco use is prevalent among people with mental illness or addictions, and the effects of tobacco use are more widespread in this population than in the general population. Because of this high tobacco use rate, thousands of smokers with mental illness or addictions die each year due to smoking. They experience greater physical health consequences and deaths related to tobacco compared with the general population.

Additional costs of tobacco addiction include the financial burden associated with buying tobacco products. Because of their strong tobacco addiction, people with mental illness and other addictions sometimes choose to buy tobacco products instead of buying food and taking care of their other basic needs. In addition, smoking can affect a person's ability to secure housing and employment.

There is conflicting information about the benefits and limitations of encouraging people with addictions and mental illness to stop smoking. This conflict creates a barrier to moving forward with tobacco reduction programs and strategies for these populations. This past year, under the direction of Dr. John Millar and Lydia Drasic, the Centre for Addictions Research of BC conducted a review of the evidence related to tobacco reduction in the context of mental illness and addictions.

In this review, we considered the complex reasons why people with mental illness and addictions continue to smoke. We explored the evidence related to whether nicotine has a therapeutic benefit for people with mental illness and addictions, and we examined the approaches that could be used to address the harmful effects of their tobacco smoking.

Statements made in this article are based on our findings, which are presented in the 2006 report, *Tobacco in the Context of Mental Illness and Addictions*.¹

Biological and social reasons reinforcing use

Our review revealed that there are many factors contributing to the high rates of tobacco use among those with mental illness or addictions. Nicotine is known to trigger several biochemical events, including enhanced release of neurotransmitters such as dopamine, norepinephrine and serotonin. These neurotransmitters are implicated in many psychiatric disorders and are involved in the reward systems associated with other addictive substances. Not surprisingly, people with mental illness have used tobacco to cope with the effects of their illness. Those with addictions have used nicotine as a replacement when withdrawing from other drugs.

Self-medication is only part of the issue. While biological factors are powerful,

social factors continue to reinforce tobacco use among people with mental illness or addictions. Tobacco use has traditionally been part of the culture of mental health and addictions services. Cigarettes have been used to reinforce behaviour, and tobacco use has been seen as an acceptable substitute for other substance use.

Impacts of stopping

We considered the benefits and harms associated with smoking cessation for people with addictions and mental illness. The positive health benefits of smoking cessation are well known. Smoking cessation dramatically reduces the risk of heart disease and cancer and prevents continued impairment of lung function in those with chronic obstructive pulmonary disease.

There are a number of potential negative consequences that must be balanced with these outcomes. Nicotine withdrawal can include symptoms of depressed mood, insomnia, irritability, frustration or anger, anxiety, difficulty concentrating, restlessness, and increased appetite or weight gain. Some of these symptoms might become particularly aggravated among people with mental illness or addictions. For example, nicotine withdrawal may aggravate some psychiatric disorders, mimic or worsen medication side-effects, and, for some people taking medi-

footnote

1. Johnson, J., MacDonald, S., Reist, D. et al. (2006). *Tobacco illness in the context of mental illness and addictions*. This report was shared with the Provincial Mental Health and Addictions Steering Committee and has been used to inform policy and programming. Copies are available through the Provincial Health Services Authority, online at www.phsa.ca/HealthPro/PreventionPromoProtect

“People with mental illness and other addictions sometimes choose to buy tobacco instead of buying food and taking care of their other basic needs.”

cations for psychiatric symptoms, blood levels of these medications may rise. This can happen because the tar in cigarettes affects the way the liver metabolizes certain medications.

On the up side, the evidence suggests that, in general, smoking cessation among those with a history of other substance use problems does not increase the risk of addiction relapse.

Evidence suggests that those with mental illness or addictions have many of the same barriers for smoking cessation as other smokers—addiction and fear of withdrawal, weight gain and failure.

Evidence also suggests that people with mental illness and addiction face additional challenges. They tend to have more extensive histories with cigarettes.

They have more severe tobacco dependence, because their smoking has been positively reinforced. They express attitudes reflecting less readiness to quit—in part, because they’ve not been encouraged to quit. They can also experience a worsening of their psychiatric symptoms during their smoking cessation attempts and may lack the focus and motivation to be successful with cessation.

Because of these challenges, those with mental illness and addictions represent a subset of smokers for whom specialized smoking treatments are needed.

Recommendations

Based on the evidence we reviewed, the following approaches to tobacco control were recommended:

- Tobacco treatment for

people with mental illness or addictions should be integrated into existing mental health and addictions services

- Service providers need support and training to incorporate brief tobacco-related interventions into their practices
- Nicotine replacement therapy should be provided to all individuals with mental illness or addictions who want to quit or reduce their smoking
- Individuals who are taking antipsychotic medications and quit smoking should have their medication dosages monitored in the first months following cessation
- Smoke-free spaces support and encourage individuals with mental illness and addictions to remain smoke-free **i**



Getting to the Bottom of a Burning Issue

Tobacco's top myths and facts

In today's climate of confused debate over what's more important—personal choice, profits or public health—few topics are hotter than tobacco control. Unfortunately, however, much of the confusion stems from people not knowing a lot about basic tobacco truths. To shed some light on the subject, here are some common myths and facts about a substance that has been getting policy makers, pub owners and the public fired up for years.

Myth: Smoking helps calm the nerves.

Fact: It's true that the nicotine in cigarettes triggers the release of dopamine, a chemical in the brain that is associated with feelings of pleasure. And it's true that for a short time a smoker may relax a little. But nicotine is a stimulant drug that raises activity in the heart and nervous system. A smoker's system quickly

becomes used to this activity and demands stimulation. When a person is nicotine dependent, not having a cigarette creates anxiety and irritability. So smoking may only work to return that person's tension levels to normal.¹ In other words, tobacco use actually appears to increase stress and put smokers at greater risk of panic disorders.^{2,3} In contrast, quitting has been linked to long-term drops in stress and anxiety, and improved mood.^{1,4}

Myth: Smokers don't become hard drug users.

Fact: While there's much debate about whether tobacco is a “gateway” to other substance use, there's no denying the very strong relationship between cigarette smoking and all types of drug consumption—both legal and illegal—especially among youth. Canadian smokers aged 15 to 19 appear 14 times more likely to drink

Sara Perry and
Nicole Pankratz

Sara and Nicole are both with the Communication and Resource Unit of the University of Victoria's Centre for Addictions Research of BC. Sara is the Research Coordinator and Nicole is the Publications Officer



alcohol, 25 times more likely to use cannabis, and 12.5 times more likely to use other illegal substances, such as cocaine, heroin, amphetamine, ecstasy and hallucinogens.⁵ Smokers may also be more prone to engaging in especially risky behaviours, including drinking excessively and having unprotected sex.⁶

Myth: Some cigarettes are healthier than others.

Fact: Nearly 60% of Canadian smokers use “light” or “mild” cigarettes, yet there’s no evidence that these products are less harmful than regular cigarettes.⁷ In fact, studies show that at least six types of “light” Canadian cigarettes contain higher

levels of nicotine than other cigarettes.⁸ There’s also no link between “light” cigarettes and lower levels of health risk or cardiovascular disease.⁹ Still, Canadians continue to buy into what experts are calling a marketing scam. About 43% of Canadian adult smokers trust that “light” cigarettes are healthier.¹⁰ And partly because of such misinformation, smokers of “light” cigarettes are potentially 54% less likely to be attempting to quit the habit altogether.¹¹

Myth: Second-hand smoke isn’t a big deal, and smoke-free areas don’t benefit anyone anyway.

Fact: Second-hand smoke contains the same toxins as first-hand smoke, and puts non-smokers at risk of many of the same diseases as smokers.¹² According to Health Canada, more than 1,000 deaths per year may be linked to second-hand smoke.¹³ Some researchers say the number could be as high as 7,800.¹⁴

Reducing second-hand smoke exposure through public smoking bans not only benefits non-smokers, but also helps smokers cut down or quit smoking. In a 2005 study of worksites, smoke-free regulations were related to a drop in smoking of up to four cigarettes per day by employees.¹⁵ This same study showed that workers in non-smoking establishments were twice as likely to quit smoking as those in workplaces that allowed smoking.

Nearly 94% of British Columbians support smoke-free places, and smoke-free bars and other businesses are benefiting. In a Canadian study of 29 different reports on the costs of smoke-free legislation to businesses, there wasn’t one case in which a smoking ban caused a drop in profits. In some places, sales actually improved.¹⁶

Myth: There’s no hope for people who don’t want to quit. Even cutting back doesn’t make a difference.

Fact: Reducing the number of cigarettes a person smokes in a day won’t reduce many (if any) of their health risks, but it could help with future change. People who substantially cut down on their cigarette intake may increase their odds of eventually quitting by nearly 50%.¹⁷ Reductions in use may also be linked to fewer relapses and greater motivation to change. These effects are important, since about 80% of all smokers, and 90% of daily smokers, have no plans to quit smoking anytime soon.¹⁸ But many of them may be prepared to slow down on the number they’re smoking today, possibly leading to full cessation down the road.

Myth: It’s unfair to burden smokers with interventions like higher tobacco taxes—they don’t help anyone but the state.

Fact: Among really vulnerable groups, federal and provincial taxes on tobacco products appear to be less harmful to smokers than smoking itself. That is, the potential financial hardships associated with tax increases are probably less risky than the harms associated with smoking.¹⁹

The links between price increases on cigarettes and improved mental and physical health have been shown in study after study. Tobacco taxes seem to deter young people from starting smoking, and to prompt current smokers to give up the habit²⁰⁻²¹—especially when accompanied by tools to help smokers quit (e.g., free cessation aids). Taxation has also been linked to lower rates of smoking among pregnant women, improved birth outcomes, and decreased rates of suicide among men. In the end, this means reduced health risks among the general population, and less second-hand smoke in both private and public places. **i**

footnotes

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did you know?

- o In an eight-hour shift, a bar employee working in an environment that permits smoking may inhale enough second-hand smoke to equal a full package of cigarettes.²²
- o Workers in restaurants that allow smoking can be 50% more at risk of lung cancer than the general population.²²
- o By July 31, 2007, the three major Canadian cigarette manufacturers will have eliminated “light” and “mild” labels on their cigarette packages. This will affect more than 75 brands.²³
- o By 2008, you’ll see smoking phased out of all indoor public places in BC.²⁴

The CACTUS Project

[Cultivating the Awareness of the Context of Tobacco Use]

“I wish something could be done. All my problems in life are related to smoking.” —CACTUS participant



These are the powerful words of a person living with a mental illness and tobacco addiction. Tobacco addiction affects from 50% to 90% of people living with a mental illness.¹ It has been estimated that more tobacco is consumed by people living with a mental illness than any other population in the Western world.² The severity of this addiction is extreme, and the lives of mentally ill smokers are often consumed by procuring and maintaining their tobacco supply as well as spending much of their time smoking cigarettes.

Nicotine addiction,

cigarette reduction and tobacco cessation are all concepts that deserve attention within the mental health and addictions arena. For the past year, the CACTUS Project (Cultivating Awareness of the Context of Tobacco Use) has been examining the role that tobacco plays in the lives of people living with mental illness, in the context of their communities.

Who we talked to

We surveyed mental health consumers about their tobacco use, and, in addition to developing a statistical profile of tobacco use patterns, we uncovered com-

PELLING accounts about the impact of tobacco use.³

We surveyed 781 outpatient clients of the Vancouver community mental health teams and learned that almost half of these clients are current smokers. This is almost three times the current rate of smoking in BC overall. The clients also tended to be heavy smokers, smoking on average 20 cigarettes every day, and they considered themselves to be extremely addicted to cigarettes—62% described themselves as “chain smokers.”

What they told us about tobacco’s impacts

The implications of such a severe addiction include a long list of adverse health consequences. Many of the smokers we surveyed, most in their late forties, were already experiencing serious health repercussions of their cigarette habit. Over half revealed they had experienced symptoms of a disease or illness that was caused or worsened by their smoking (e.g., lung infections, emphysema).

A more hidden cost of tobacco use is the extreme economic hardship these individuals endure as a result of their tobacco consumption. Many indicated that they spend most of their disposable income on cigarettes, having no money left at the end of the month and giving up necessities

like food and toilet paper so they will have money for cigarettes. ‘Bumming’ cigarettes, picking up butts from the street and buying smuggled tobacco are just some of the ways in which these individuals maintain their pack-a-day habit.

In our study, 69% of the smokers reported that they smoke to cope with the symptoms of their psychiatric illness. There is scientific evidence to suggest that nicotine affects people living with mental illness in a different and possibly more profound way, making quitting smoking particularly difficult. Nicotine affects receptors (brain chemicals) on the same pathways implicated in mental illness.

The social implications of smoking were exposed by clients’ reports of shame and guilt about their tobacco use. Most clients who smoked reported that they received looks of hostility and messages of reproach about their tobacco use. Almost three-quarters of the smokers indicated that they felt people—family, friends and the general public—were judging them because of their smoking habit.

Social isolation can be an important aspect of tobacco addiction. The majority of smokers indicated that they avoid settings where they cannot smoke, and over a third found it difficult not to smoke in

Syd Malchy, BA, MSc and Joy L. Johnson, PhD, RN

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- “When I was first hospitalized, I pretended to smoke because I wanted to go outside and only smokers were allowed to go outside” —*Non-smoker*
- “Everyone in my boarding house smokes heavily; I get peer group pressure and I feel like I don’t belong if I don’t smoke” —*Non-smoker*
- “It costs more to smoke than to feed myself.” —*CACTUS participant*
- “Smoking is like a best friend, because it’s always there” —*CACTUS participant*

footnotes

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The Federal Tobacco Control Strategy

Zoe Kahn

Zoe works as a Policy Analyst for Health Canada's Tobacco Control Program

Tobacco use is the number one preventable cause of disease and death in Canada. Every year, over 37,000 Canadians die from smoking-related illnesses, including 800 non-smokers who die from illnesses due to exposure to second-hand smoke.¹ Half of current smokers will die prematurely from illnesses such as cancer, heart disease and pulmonary disease.

Despite achievements resulting in fewer smokers, health care costs attributable to smoking increased by about a third since 1991—from \$3.4 billion to \$4.4 billion in 2002. When the societal impacts of lost productivity are factored in, the total economic cost of tobacco use soars to \$17 billion annually.¹

footnotes

1. Rehm, J., Baliunas, D., Brochu, S. et al. (2006). *The costs of substance abuse in Canada 2002*. Ottawa: Canadian Centre on Substance Abuse. www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm.
2. Health Canada. (2002). *The Federal Tobacco Control Strategy (FTCS): A framework for action*. Ottawa: Author. www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/ffa-ca/index_e.html.
3. Conference of Federal-Provincial-Territorial Ministers of Health. (2002). *A National Strategy: New Directions for Tobacco Control in Canada*. Banff, AB: Author. www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2002/2002_58bk3_e.html.
4. World Health Organization. (2003). *WHO Framework Convention on Tobacco Control*. Geneva: Author. www.who.int/tobacco/framework/download/en/index.html.
5. Statistics Canada. (2006). *Canadian Tobacco Use Monitoring Survey (CTUMS)*. Ottawa: Health Canada. www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/ctums-esutc/index_e.html.

Federal Tobacco Control Strategy: 2001-2011

The Government of Canada introduced the 10-year Federal Tobacco Control Strategy (FTCS) in 2001. Its purpose is to implement a comprehensive, integrated and sustained tobacco control strategy to significantly reduce disease and death due to tobacco use. The strategy encourages and supports a range of activities that fall broadly into four interdependent areas:²

- **Protection** activities, such as assisting in the planning, implementing and evaluating of non-smoking by-laws, work to create an environment that supports non-smoking as a societal norm.
- **Prevention** activities work to discourage all Canadians (especially youth) from taking up smoking. These include programs that educate youth about the dangers of tobacco use and that share best practices with health care professionals, teachers and parents.
- **Cessation** activities focus on helping Canadians quit smoking, and include working with a range of stakeholders to provide telephone quit line counselling nationally.
- **Harm reduction** recognizes that some smokers will not quit, and works toward a better understanding of the new and novel products in the marketplace.

The FTCS is built on a foundation of partnership. Health Canada's FTCS mandate is health focused. The Canada Revenue Agency, Justice Canada, the RCMP, the Canada Border Services Agency, and Public Safety and Emergency Preparedness provide support in monitoring and providing surveillance for contraband tobacco.

Health Canada also consults and collaborates regularly with provincial and territorial partners. In 1999, a pan-Canadian approach to tobacco control was developed under the title, *New Directions for Tobacco Control in Canada: A National Strategy*.³ The four goals identified—prevention, cessation, protection and de-

normalization—continue to form a strong basis for federal, provincial and territorial cooperation.

The FTCS is further strengthened through close collaboration with the private and voluntary sectors and with the international community. As one of the first countries to ratify the first ever public health treaty, the WHO's Framework Convention on Tobacco Control (FCTC),⁴ Canada takes its leadership role in tobacco control seriously. Health Canada provides both technical and financial assistance to developing countries and countries with economies in transition.

Achievements to date

To date, the FTCS has exceeded expectations and is successfully meeting the goals outlined in 2001. The goal of reducing the number of people who smoke to 20% of the population was achieved in 2004, seven years ahead of schedule, and has since been further reduced to 19%.⁵ This reduction in prevalence translates into well over one million fewer Canadians smoking than in 2000, and means that more than half of Canadians who ever smoked have quit.

There has also been good progress in meeting the other goals. The number of cigarettes sold in Canada declined from 43.2 billion in 2000 to 33.6 billion in 2004, representing over two-thirds of the 10-year target of a 30% reduction. Retailer compliance with laws on tobacco sales to youth improved from 69.8% in 2000 to 80.8% in 2005, exceeding the original 80% target.

The FTCS has also been successful in reducing the number of people exposed to tobacco smoke in enclosed public places. The number of children under 12 exposed to second-hand smoke at home dropped from 1.1 million in 1994 to 379,000 in 2006. In same period, the number of Canadian workplaces with total smoking bans more than doubled to upwards of 70%.

New safety initiatives include Cigarette Ignition Propensity Regulations, which now require manufacturers to produce cigarettes less likely to start fires.

Looking Ahead

The Government of Canada remains committed to reducing tobacco-related death and disease. Progress to date has reinforced that the battle to reduce smoking can eventually be won. As Health Canada works with its partners to establish new objectives for the remaining years of the FTCS, the focus is on how to best meet the remaining challenges and ensure that smoking rates continue to fall. ■

for more information

www.gosmokefree.ca

Staying 'Quit' Pride on My Side



.....
CACTUS project | continued from page 9

those places. Often, clients use cigarettes as a substitute for these missing social interactions.

But it is more complex: tobacco use can enable both isolation and socialization, depending on the person. Within the context of the mental health care system, smokers' tobacco use is often validated by health care providers and other peers with serious mental illness. This normalizes tobacco use for clients who smoke. It also may alienate clients who do not smoke and may magnify the difficulty for those who wish to reduce or quit smoking, or who have already quit smoking.

The good news

While the study results may seem dismal, there is encouraging news as well. Contrary to widely held beliefs that people with mental illnesses are not interested in reducing their tobacco use, 86% of clients indicated that they

do want to quit smoking. The majority indicated that they had made several attempts to quit. Even more promising is that these clients described times when they successfully stopped smoking, sometimes for as long as one to five years before returning to cigarettes. Over half of the smokers were considering making a serious attempt to cut down on cigarettes or to quit entirely.

This new information implies a conversation is needed between those struggling with tobacco addiction and those struggling to help support them. The CACTUS Project will be hosting a forum in the spring of 2007 to promote awareness and encourage dialogue about these issues. Anyone concerned is invited to attend. For more details, please check our website at www.nahbr.nursing.ubc.ca. Both the client and provider survey results are also available on this website. |

Every time I coughed, my left lung felt as though it was tearing apart. I was 18 and it was my third bout of bronchitis in recent years.

Nevertheless, first thing in the morning on November 12, 1985, I lit up a last cigarette. I had a two-and-a-half-year habit, with each pack I bought—they cost about \$2.75 back then—lasting me one to two days.

I smoked about half the cigarette before I coughed and, feeling disgusted, threw the rest of the cigarette over the side of the balcony.

Later that day I saw my doctor about the bronchitis. I told him I would quit smoking for the duration of my bronchial illness. As he wrote out a prescription for antibiotics, he retorted: "While you're already at it, why not just quit altogether?"

As I left his office and made my way to the Work & Learn program (a special, very small school for regular-school dropouts), I thought, "Yeah, why don't I just quit? I already feel like crap whenever I inhale because of my bronchitis. So, why not quit now!" And I did.

When I got to school, I announced to my peers that I had quit smoking.

"Yeah, right," they all said, or thought.

Before I knew it, it was smoke time. There were

two smoking breaks during the school day. Everybody—or almost everybody—lit up. Even though the windows were open, the small room filled with cigarette smoke. And, unlike those smokers who claim it's harder to quit the habit when around second-hand smoke, I felt repulsed. In fact, just breathing in the smoke was more than enough to calm any 'nic-fit' I might have otherwise endured.

After about two weeks, I got over my bronchitis and was, for the most part, over my habit. The urge simply was not there. And, the fact that my proud-of-me parents didn't smoke made my transition easier.

Ah. But I hadn't entirely given up 'smoking.' On May 25, 1986, I intentionally inhaled my last blast of marijuana smoke. Soon after, I successfully targeted alcohol (though to be honest, to this day I've had bouts of alcohol consumption). I had become obsessed with my health and didn't want to abuse my body anymore.

I was clean. But I still hung out with my substance-abusing peers. Instead of being tempted, I felt proud—even smug—that I could be around these somewhat jealous friends with whom I had consumed many drugs (including tobacco) and could now completely abstain.

Frank G. Sterle Jr.

Frank lives in White Rock, BC. His website is www.mentalhealthconsumer.net/FrankGSterleJr

The dangle of cigarettes in mental health institutions

Come the new year, 1987, I was still completely clean. It was about that time, however, that I began to experience the onset of mental illness. Although I was suffering from a more mild form of obsessive-compulsive disorder (OCD) than I later would, I believe that quitting the above-mentioned substances brought to the fore a latent potential

In late spring 1988, my psychiatrist got my permission to admit me to Hillside, a (then) six-week inpatient program at Riverview Hospital.

Really, I can recall only a few patients other than myself who didn't smoke tobacco. And with the price of tailor-made, filtered cigarettes being as high as they were, such cigarettes—for those who didn't have to buy loose tobacco and roll it up

during my stay at Hillside that stunned me into realizing the potent tobacco addiction endured by the patients who smoked. One young woman in the program I was in was asking around to “borrow” a cigarette—until she had the misfortune of turning to the disgusting preconditions of one young guy. Thanks to his parents' money, he had an ample supply of tailor-made cigarettes. The next thing I knew, they had both disappeared. A short time later, she walked back into the building counting out four or five cigarettes in her hand, followed by the young guy, who had a mischievous smile on his face.

“I just got a blow job,” he bragged to me.

She had performed oral sex on him for a small handful of cigarettes!

It was then that I realized just how disgustingly

potent the cigarette market at Riverview was—and perhaps is for the entire mental health consumer population, including off the grounds of Riverview and in other hospital psychiatric wards.

Currently, the cigarette supply held by institutionalized mental health clients is regulated by institution staff. This is a positive step forward. But, as far as I can tell, such control doesn't hold much sway over (mostly) women with mental illness, who are desperate enough for a cigarette to perform oral sex—and who knows what else—on men who have the funds to purchase cigarettes. Nor does it hold sway over men, mentally ill or not, who dangle the cigarettes underneath these vulnerable women's noses.

I am so thankful to the spiritual “powers that be” for giving me the will power to quit—and stay quit. ■

“For Riverview patients, cigarettes were like legal currency”

of my brain chemistry for diagnostic mental illness—ironic, since my obsession with good health helped me quit smoking. Without getting into the details of my illness(es), let it be known that I went through more than a year of undiagnosed-mental-illness hell before I was stabilized.

themselves—were like legal currency.

A friend who, in the mid-1980s, spent a lot of time in Riverview, once traded his fairly expensive ghetto-blaster—a gift from his parents—for a relatively small number of cigarettes.

However, it was one very shameful incident

Smoking: Habit or Addiction?

Susan J. Katz

Susan is a mental health services consumer and writer. She lives in Vancouver with her husband and her Balinese cat, Mousie

I crouched, face to the floor, my eyes burning badly, straining to breathe. I was six years old and following the procedure for avoiding smoke inhalation that I had learned in elementary school—except this was not an accidental fire emergency. We were cruising home with our car windows rolled up tight because it was winter and too cold to open them, and my parents were both smoking. I hated inhaling the cigarette smoke. But, I accepted smoking as a normal part of what the adults around me did. What else could I do at six?

Other things besides cigarette smoke inhalation were a threat for me as a child. I had to accept life in an exceptionally chaotic and abusive family in order to survive. One effect of my traumatic childhood, besides recurrent depression, has been a pervasive feeling of never ‘fitting in’ with others. As a typical teenager, this included the need for peer acceptance and I became a ‘social smoker,’ having the occasional cigarette with friends and trying cigars and a pipe in my bedroom with an adventurous girlfriend.

My smoking increased in university; study breaks, social drinking and role models who smoked were added inducements.

Living in Alaska was the final boost that got me hooked to the habit. I was 19 and worked on commercial salmon boats. I loved the fresh air, romance and challenge of my adventure—and I already spoke the universal language of smokers. “I need a smoke.” “Want a cigarette?” “Which smokes do you want me to get?”

Smoking helped me gain acceptance by the rough, independent fishermen despite the fact that I was a single, young, Jewish, female university student from California working in what I've been told is the most dangerous of livelihoods—commercial fishing.

I got up to one-and-a-half packs a day. I bought them by the carton and stashed them under the pillow of my ship's bunk, thinking that I could handle anything as long as that carton lasted. I managed to handle the stress of watching helplessly as a companion's boat and crew were swept into the sea and drowned. I

had to protect myself from threatening approaches by some rough and often jealous men. One boat lost its propeller into the deep, and the engine of another one burned out from too much strain, both in isolated areas of open water. If we hit a big run of salmon, we worked non-stop hauling in fish for two or three days at a time. The peace, space and companionship I gained by taking smoke breaks helped me get through all this.

I returned to university with a hard-core tobacco habit that persisted for about three years. But over the last six months of that time, I gradually quit.

What was the secret to quitting? I had moved into a new location and had begun graduate school. I now found myself surrounded by people who did not smoke. I don't recall any of my fellow students, professors or friends as being smokers. As a young woman already insecure about fitting in socially, however, breaking into the traditionally male domain of the mammalogists (biologists who study mammals) was particularly challenging and stressful. But, without the former social inducements to smoke, turning to cigarettes was no longer attractive for me.

I developed new ways to find relief from stress: I took up jogging, which was popular with the other students; for a study break I had a coffee or other low-calorie drink; and I joined a western swing dance club and made new friends and had fun.

After about six months of new activities and associates, I had tapered down to one or two cigarettes a day. The final kicker was that I preferred spending time with my new non-smoking boyfriend than with a cigarette—I met him at the western swing dance club, and have now been married to for almost 27 years. Then, I just stopped buying cigarettes one day.

There were times I really missed the fresh sea spray mixed with the smell and taste of that first drag. But, hey, realistically, I was no longer at sea!

A few years later, in a moment of wanting relief from stress, I longingly recalled the sense of fulfillment offered by that first drag and tried a smoke. It was nauseating. I recalled the early memories of choking

on smoke on the floor of my parents' car and wondered how I could ever have smoked as much as I did.

I recently chatted with a relative over dinner about a major research project he is managing for a large pharmaceutical company. The goal of the project is to develop a



An injection won't eliminate the other incentives I had for smoking, such as attracting companionship or preventing boredom.

drug that prevents nicotine in a smoker's blood from stimulating the pleasure sensations in the brain that reinforce nicotine's addictive aspects. This sounds promising—a 'vaccine' that will stop people from smoking. It also raises concerns, such as what side-effects this vaccine may have. And it raises this question: what benefit would a vaccine that targets nicotine addiction have for me, or for others who, like me, smoke for complex behavioural reasons?

Physical addiction is a real and serious problem for many smokers. But looking for simple solutions, such as 'magic bullet' vaccines or pills that can be aimed at some physiological 'target' is not a realistic approach, either. An injection won't eliminate the other incentives I had for smoking, such as attracting companionship or preventing boredom.

Stress is a normal and inevitable part of life, and particularly so for someone with my compromised sense of self-assurance. But, by finding fulfillment with healthier stress reducers such as exercise and refreshing drinks or snacks, by having relationships with people who didn't smoke and by making productive lifestyle choices, I was able to quit. ■

Smoking My Life Away

My throat is killing me, I've got no groceries in the house and I've got three cigarettes to my name. Even though I'm sitting here telling myself that I have to quit smoking, that I just can't afford to smoke and that it's killing me, I know I'll go and buy more cigarettes today.

This is my definition of addiction: wanting to quit, hating smoking, feeling like it is killing me—and still doing it. In my opinion, addiction is craziness.

I was an addicted, full-time smoker by the time I was 13, and in my twenties, I smoked through three pregnancies. My

partner smoked as well, and our three babies were exposed to all the smoke our home was steeped in. Now, as I look back, I feel such shame about making my children inhale all those chemicals for so many years. What an unhealthy start to life!

If I could just smoke

and not worry about the consequences, I would be okay. I am so clear that smoking brings me down physically, emotionally and financially. And, unfortunately, I am keenly aware of the dangers of smoking. I come from a family with a long history of addiction to tobacco,

Catherine St. Denis

Catherine lives in Vancouver and is a member of the Mood Disorders Association of BC. She has raised three children and is now learning to raise herself...with care

alcohol and prescription medication, and with high incidence rates of cancer, heart disease, hypertension and obesity. I feel like a time bomb, with cancer just waiting to explode in my lungs or elsewhere. So I worry and create a huge amount of anxiety about smoking.

This anxiety brings with it a heavy sense of failure mixed with anger and disappointment at myself for being unable to quit. I tell myself constantly that if I were “more” or “better” or “different,” then I would have the character to quit smoking. I would never say to any of my friends who smoke that it’s their lack of character that keeps them addicted. But when it comes to my-

self, I am much harder and more unforgiving.

During my twenties I began to want to quit smoking. I had been a two-pack-a-day smoker for many years and, even though I was young, I really did feel the effects of smoking. My throat was constantly sore and inflamed. I tried to quit on several occasions, but only lasted a few days each time. Smoking two packs a day since I was so young had made smoking a normal part of who I was. I have always felt like an ‘innate’ smoker—kind of like I was born to it; like it was part of my genetic makeup. Maybe the constant example of smoking in the household made me feel smoking was just

the way to live.

What’s hard for me to believe is that I have smoked for 19 out of my 42 years. I did successfully stop smoking once for seven-and-a-half years and once for three years. Both times I quit because I couldn’t stand the damage I was doing to my body, my kids’ bodies and our bank account—many times we could barely afford decent food. I used smoking cessation gum and will power to stop. Because I receive such a limited income, the gum and the will are, in my opinion, the only avenues open to someone in poverty who wants to quit smoking.

In 2006 I tried to quit five times; I also had five smoking relapses. Cigarettes

help me manage bad feelings. They calm me—and yet, they add to my anxiety.

But I’m committed to beating smoking this year. I am no longer at an age where my body can so easily manage illness; the stakes are getting higher. It’s not just the physical concerns about smoking, but also the anxiety and self-abuse I dish out because I’m knowingly cooperating in my death from cigarettes. This gnaws at me.

I need to quit smoking to confirm that I care enough about myself to want life and health over sickness and addiction. In 2007 I want to feel proud of myself. Today, as I write this, I am on day three of not smoking. Today, I am showing myself I care. **i**

The Joys of Smoking (Yeah, right)

Ronald P. MacIntyre

Ron lives in Vancouver and helps others live smoke-free. He will soon be involved with hosting an internet music-poetry show (through Blog Radio) and doing stand-up comedy. Contact Ron at bcearthangel@hotmail.com

I started smoking at nine years of age. I still remember my sister and I getting caught smoking these non-filtered cigarettes in our back alley in Toronto. The neighbour reported us to our mother.

My mother proceeded to punish us by having us each smoke a big old White Owl cigar. She made the mistake of telling us that if we smoked a whole cigar, we would be allowed to smoke whatever we want and do it in the house. She made us inhale each puff, and my sister turned green after the first two puffs. I, however, finished mine. And, being a smart aleck young buck, I then took my sister’s and smoked hers too. “Well,” I said, “I guess I’m allowed to smoke now, eh?”

That was the beginning of my smoking. Thank you, Mom.

Back then cigarettes were only 37 cents a package and easy to get. You could just walk into a store and say you were getting them for your parents or an adult, if asked. In most cases, no one asked.

I smoked for 33 years. Four years ago I quit. In the beginning, one package lasted me one to two weeks; in the end, I was smoking three packs and a quarter ounce of pot—also thanks to Mom—every day. (Yes, she introduced me to my first joint—better to do it at

home than out in the big, bad world!) So, I was smoking a lot before I decided to quit—a decision I didn’t think I would ever make, because I was so into smoking.

You don’t realize how much smoking controls your life until your friends stop inviting you out with them because you always make up excuses to leave or for arriving late. But I had to figure out how many cigarettes or joints I needed to smoke before going, and then how long I could actually stand being there before I started to fidget if they didn’t allow smoking. Then I’d leave and, usually, not return. Or, if I did, I’d smell like a butt or like pot.

When out for dinner, I always sat in the smoking section, even if friends didn’t want to. If they didn’t sit with me, well, too bad. I’d eat dinner by myself in the smoking section.

In the last couple years that I smoked, after walking for a block or two, I would have to stop and catch my breath. It felt like my breath was being sucked out of me. I couldn’t run any more, because it felt like my chest was going to explode. That’s when I felt it was time for me to take back control.

Oh yeah, I had tried to quit before. Three times. Two of those times, I became so irritable that I had

As I say to everyone, "If you're thinking about quitting, quit thinking and just do it..."

even non-smoking friends actually throw cartons of cigarettes at me, telling me *not* to stop. Another time I tried acupuncture, without any luck.

So, I needed a plan.

I started to tell myself this was it. Even though I was still smoking, I started saying to myself: I am a non-smoker. I repeated that phrase over and over, every day, even when I was smoking. I told myself to enjoy each smoke I was having. So that, along with the repeated phrase, was the beginning of having a more positive attitude towards quitting. I was loving-a-negative-habit-free.

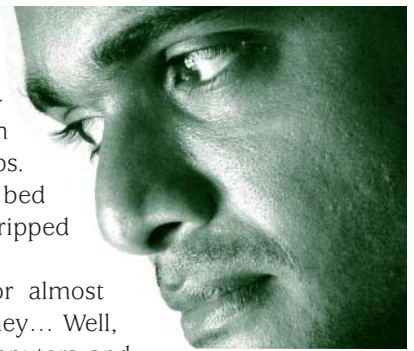
I then went to a health food store and asked for something that would prevent me from ripping people's arms off and slapping them with the soggy end when I finally decided to stop smoking. The gentleman there suggested strawberry-flavoured Nordic Naturals DHA.¹ He suggested it to ladies with PMS (premenstrual syndrome). I thought, well, if it worked for them, it had to work for me.

That night I went home and smoked the last six

cigarettes I had. I woke up the next morning, started repeating to myself, I am a non smoker, and took two of those DHA gel caps. Then I took two at lunch and two before bed and did this for two months—and never ripped anyone's arms off.

I have been free from cigarettes for almost four years now. I have saved a lot of money... Well, not 'saved,' because I've invested in computers and software and spend a lot of time online—where you can find a lot of support sites for people trying to quit smoking.

My friends know I will never be a militant non-smoker, like a lot of people are when they quit. But I am here for my friends, if they wish to quit. Quitting is a choice you have to make. As I say to everyone, "If you're thinking about quitting, quit thinking and just do it. There are so many safe products out there to assist people in quitting, and so many groups out there to support you. Just reach out and butt out and stop thinking about it." **i**



footnote

1. DHA is docosahexaenoic acid, an omega-3 fatty thought to be essential for proper brain function in adults. Fish oil is a primary source.

Smoke-free Success

At the age of nine, I first shared a pack of stolen cigarettes with three other nine-year-old friends. After that, I would steal cigarettes from my parents and smoke them in the barn. At the age of 10, I stopped kissing my parents good night in case they could smell the smoke on me. I remember actually missing the good-night routine. To me, it was the price of growing up.

By the time I was in grade six, my girlfriend and I were smoking two or three stolen cigarettes a day. By grade seven, we each needed to buy a pack a week to be able to smoke four a day. We could buy them from the store with our babysitting money, and we could smoke on the school grounds from grade six to grade twelve.

I can also remember trying to quit at least eight times

before I succeeded. During the 30 years I smoked, I spent over \$50,000 in my time using nicotine.

One belief I had that ensured my failure to quit, was that I couldn't handle extreme stress without the use of nicotine. At age 21, I experienced a psychotic break; I was hearing voices and smelling things that weren't real. I had stopped smoking just two months before, in an attempt to bring the depression I was experiencing under control. I started smoking again during my two months of hospitalization.

Many years and many hospitalizations later, I was diagnosed with bipolar disorder and my mental state improved considerably from getting on the right medications. When Zyban came out, I tried to quit smoking again. The Zyban kept me

awake, though, which aggravated my bipolar disorder—and I was back to smoking.

One thing that kept me from trying to quit was the fear that I would experience psychosis again. I got my mental health symptoms under control with medication, but believed I'd experience the symptoms of mental illness if I went through the stress of quitting. I also believed that the nicotine was keeping my moods stable, as bipolar disorder is marked by mood swings.

I began to have confidence that I could quit when I learned that others with mental health issues have quit. I learned that people living with mental health issues have a harder time quitting. Knowing that helped me find as much help and support as was available. I began to believe that quitting was not

Kathryn Lestage, RSW

Kathryn is a Coordinator with the BC Schizophrenia Society in Prince George

footnotes

1. The Butt Out Education Program was written by Judy Mitchell, BSW, during her practicum at Northern Health in 2004. It consists of 12 units, each to be presented in a two-hour period over 12 weeks. The program provides information, a myriad of quitting strategies and group support.

2. The Butt Out Education Program, funded by Northern Health, is offered through the BC Schizophrenia Society. Visit www.bcssp.org, or contact Kathryn Lestage at 1-888-561-8055.

3. Massachusetts Tobacco Control Program. (2006). *Basic Skills for Working with Smokers*. Prince George, BC: Northern Health Authority.

impossible. Indeed, it is possible: I have been a non-smoker since June 9, 2005.

This ninth and last time I set out to quit—people quit an average of eight times before they are successful, so I fit right into that statistical norm—I prepared myself to become smoke-free. I made a new year’s resolution to quit by June 2005. I attended the Butt Out program, along with other people who had smoked a long time and felt hopeless about quitting because they were living with a mental illness. The Butt Out Education Program, available in the Northern Health Authority region, is 12 weeks of group support and education about nicotine cessation.¹⁻² I became smoke-free by week eight of this program.

For additional support, I also attended one-on-one nicotine cessation counsel-

ling sessions and used nicotine replacement therapy, which included medications, patches, gum and inhalers. (Northern Health supplies one free month of nicotine replacement to participants in Butt Out.) And, I attended the Gator Club, a support group for people wanting to quit, and for those who have quit. This integrated approach really helped me.

Since April 2006 I have facilitated the Butt Out program and have trained others to facilitate it. I was trained by my health authority in skills to help others quit—through an online course in nicotine cessation offered by the Massachusetts Tobacco Control Program.³ I have also trained in a counselling technique called motivational interviewing through the Justice Institute. These skills help me encourage people

in their quit attempts.

I feel like I have never smoked, and I don’t have cravings. I won’t pretend that I haven’t gained weight; however, I have read that you would have to gain over 65 pounds to negate the heart-health gains from becoming smoke-free.

One thing that quitting smoking and finding recovery from a mental illness has helped me to realize is that when I set a goal, I can achieve it. When I was searching for a diagnosis and the proper medications, I found my peers as well. I learned that through support and education from my peers, recovery from mental illness was possible and attainable. Setting a goal and being open to the ways to achieve that goal helped me succeed in recovering from both mental illness and nicotine addiction. ■

related resources

Nicotine Intervention Counselling Centre, Northern Health Authority

For clients seeking appointments, call 250-565-7344

For more information on NICC, contact Wanda Dean at 250-649-7271

Gator Club

Contact Bob Doriaty at home, at 250-964-6536

Puffing It Up

Dawn-Marie Tytherleigh

Dawn-Marie lives in the Fraser Valley. She is a multi-talented artist, writer and athlete who attributes her zeal for life to her bipolar disorder. She says it is a gift. “I don’t walk in the slavery of labels; rather, I rejoice in my brilliance.” She plans to get on a Harley and seek the open road

started smoking tobacco when I was 13. But that wasn’t the first time I had funnelled smoke down my throat.

One cold and stormy Vancouver night, when I was 10, the power had gone out and my family was outside cooking on a bonfire with our neighbours. Out behind the garage, a group of us kids—dared by a teen neighbour to “puff it up”—were smoking rolled-up pine

needles in newspaper. A lot of coughing and hacking ensued, but that wasn’t the end of tarring my lungs.

Being an adventure-some kid, I was naturally game for anything. By the time I was 13, smoking—and drinking and skipping out of school and doing whatever the kids around me were doing—was about as cool as I could get. As time went on, smokes came to be

just a part of who I was.

Yes, smoking is a habit. But it also goes hand in hand with mental illness. I’ve lived with the challenge of bipolar disorder, which has kept me swinging in and out of psychiatric hospitals for 35 years. And today, I still have the same complaints about being ‘locked up’ in hospitals as I always had. You go into hospital, get pumped full of pills, then join the rest of the captives in a designated smoking area to spend most of the time ‘puffing it up.’

Walk into the patio areas of psych units and you will be astounded at all the

people vegetating while puffing on cigarettes. When it comes to people who are in the mental health system, smoking is such a common behaviour that it has become an accepted action, despite the health risks. Health care workers seem to passively accept this.

Smoking is not a good health choice, as we all know. But smoking is one of the ways mentally ill people—like many other people—cope. People with mental illness are lonely and isolated and have lots of time to kill. Smoking kills time; it gives them something to do. This is especial-

Tobacco Addiction

Cunning, baffling and powerful

work in an environment where tobacco is treated with respect. It is carefully tied in white, yellow, black and red pieces of cloth, each representing a different race. The tobacco is then offered to Mother Earth as a token of thanks for her many gifts, such as medicinal plants, berries and flowers. When an animal is killed, tobacco is offered to acknowledge the animal for giving its life so man can eat. It fills the bowls of the pipe in prayer ceremonies.

This reverent attitude is hard to grasp when we know tobacco kills. We are reminded of this each time we peel the wrap off of a package of cigarettes or open a can of chew. Hundreds of studies confirm the fact that smoking causes heart disease, cancer or lung disease.

It's pretty baffling why anyone would consider having an affair with nicotine. The answer lies in addiction.

I recently attended a conference on addictions facilitated by Dr. Robert Ross, an addiction specialist in Vernon. He posed the question: "If there were a prohibition on tobacco, to what extent would you go to get nicotine?" This interesting query fuelled a lively discussion. One participant shared how she had left her young children alone to go buy a couple of packs of cigarettes, only to arrive home to find her children terrified and crying, looking for mom. I myself have rummaged through the ashtray looking for smokeable butts.

These behaviours and a myriad of others are big indicators of the addiction process, which affects our >>

Marianne Linthorne, RN

Marianne is a Registered Nurse, presently working at Round Lake Treatment Centre in Armstrong, BC. She has worked in the addictions field for over 25 years and has been a non-smoker for 20 years

puffing it up | continued from previous page

ly true in hospitals, where there really isn't much else to do, and where there is a huge deficit of treatments other than drug therapy.

I would like to see psychiatric hospitals treat people with more dignity and help them learn ways to occupy themselves. Health care workers give many excuses as to why there is little attention given to such programs—most often that there isn't enough money or space. I look at it this way: if people with mental health issues were taught to discover their potential through learning new skills, there might be fewer admissions for these people, and more available beds. Doctors and support staff should be designing programs that help condition mental health consumers to celebrate their lives, by discovering what their gifts are and moving forward in that positivity.

I have quit smoking, a couple of times. I'm a firm believer in holistic medicine, and in the past have used licorice root to help quit. It's a body tonic and blood cleanser and, when sucked and chewed on, will cleanse the body of nicotine in a couple of days. The root comes in stick form, so can satisfy the oral fixation of smoking.

I always went back to smoking, though. Honestly, I like it. I like to 'puff it up' and blow smoke!

As I write this, however, I am celebrating the fact that six weeks ago I quit. And I am determined never to succumb to the looming monster again. My motivation for quitting this time has to do with cosmetics: I'm not a teen smoking behind the school gym anymore. I'm forever doing everything I can to keep young, healthy and in shape. I swim a lot

and you'd think that clearing my lungs would be the reason I quit. But no! I just decided I will not end up with ugly yellow teeth. And that was that.

I feel great since quitting. The sports I enjoy are way more fun now, because I'm not out of breath. In fact, when it comes to breath... Have you ever wondered what it is about filling one's lungs with smoke and then blowing it out that creates satisfaction? Each person has their own theory—but I think it gives a sense of power, in that we have something in our hands that we are in control of. It's not control, however, if you can be disempowered at any time by the 'six-foot drop.'

My decision to be a non-smoker was easy, because I strive to be the best I can be and to move forward in life no matter what obstacle may be in



"I just decided I will not end up with ugly, yellow teeth. And that was that."

the way. Smokes were an obstacle—so I got rid of them. To my comrades, who also suffer from the stigma and labelling of mental illness, I say: if you just 'puff' your self up and recognize your worth and capabilities, you can do whatever you set your mind on doing. ■

self-esteem and leaves us feeling powerless.

The old lament, “I have to quit smoking,” is often heard. As with any addiction, quitting tobacco can be a difficult task. The initial physical withdrawal from nicotine takes from 48 to 72 hours. However, as with all addictions, the obsession of the mind can be a lifelong battle.

There are different methods of quitting. The two most common are total abstinence and harm reduction. The premise of harm reduction is to gradually decrease the nicotine levels in the body. This is done with chewing a gum containing nicotine. The other choice is a patch that you apply to your skin once a day and that releases nicotine into the body. These products help decrease the uncomfortable physical symptoms that accompany cessation of nicotine. The option of total abstinence, or going ‘cold turkey,’ can be quite challenging physically.

Whatever choice you make, remember how cunning an addiction can be, and how easy it is to give in. Having support from others with the same struggle often decreases the chances of relapse. There are even 12-step programs to help support your decision to quit.¹

footnote

1. There are three communities in BC currently running Nicotine Anonymous groups: Qualicum Beach, Okanagan Falls and Victoria. There are also internet meetings offered for anyone. Go to www.nicotine-anonymous.org and search for Canada under the Meetings tab.



Remember, your desire to quit and become healthy can be much stronger than the foe of addiction. Each time you choose not to smoke, congratulate yourself. You are mastering one of the hardest-to-quit addictions of all. ■

Break's Over!

Lyle Richardson

Lyle is a trained volunteer operator for the BC Mental Health Information Line. He sometimes calls himself a consumer/survivor/vigilante of mental health services. Lyle is a person living with schizophrenia, but he says they're just roommates

A close friend recently said to me: “Lyle, if I know you at all, you’re smoking because you’re bored.”

She knew me before I was diagnosed with schizophrenia—in the days when life was full of unlimited prosperity and synchronicity. Those were the days when smoking was something I did periodically, on weekends or camping trips. It wasn’t anywhere near the main drag (no pun intended) of my daily life.

Sadly, until just over a month ago, smoking had, indeed, been the “main drag” for about seven years. With the devastation of schizophrenia, life does tend to be “boring.” Isolation is easy, and denial is rampant.

Smoking had become a reward system for my attempts to grasp at just a fraction of the achievement level that had come so easily before becoming disabled by mental illness. For me, smoking was chemically induced, blissful procrastination, and it provided a mental adrenaline that reinforced the illusion that my life was eventful.

Quitting smoking was one of the challenges I have to turn my life around. My life, derailed by this serious mental illness, is now on a much different track. I gain momentum the more I hold the conviction that my new life has solutions and fun built into it.

My solution to the quitting-smoking challenge was

easy. I brainstormed with myself until I came up with something monetarily attainable that I enjoy more than smoking. The \$60 dollars a week I save, I use to treat myself to live Vancouver Canucks hockey games about once a week. And I often go for a swim and steam at a downtown hotel, and enjoy a Caesar salad or cappuccino poolside.

I had always projected that I would quit smoking sometime. I didn’t want to wait until I was told by my doctor that I had throat cancer. So I said to myself, “If I’m going to quit, then why not now?” Also, I wanted to quit in an “original way”; that is, I wanted to at least say that “yeah, one Tuesday I just said ‘I quit’ and that was that.” I hoped that would show I had some control over this nasty little molecule called nicotine.

Yes, there were serious cravings, but I learned that they always pass. I didn’t

bother with the gum, Zyban or the patch—my doctor recommended determination. Walking, chocolate, deep breathing, juice detox—all played a part in my cessation.

A smoker has to find his or her own way to quit. Creative solutions are the key to any problem. It also seems as though the solution to a challenge can lead to an opportunity, because it produces change. Who knows, maybe I’ll be sitting next to my new boss at the hockey game next week, or I might meet a new girlfriend in the hot tub at the hotel.

All in all, I’ve got a life to live. Smoking was just getting in the way. My ‘fun factor’ replacement is about having faith that there will be something better on the horizon than having a smoke. I’ve been taking a break from life. What’s the opposite of life?...Exactly. Break’s over! ■

Quitting A Journey to Compassion and Song



I began smoking cigarettes at 21 years of age, when I won a few packs in a poker game. For the next 20 years I chain smoked two and a half to four packs a day.

At 41, I climbed the Grouse Grind, smoking three or four cigarettes on the way up. I reached the top after four and a half hours, having stopped every eight minutes to catch my breath. I felt elated at reaching the top, but realized smoking was having a negative effect on my fitness level and health.

I quit smoking back in 2000. For the last 10 years I smoked, I didn't enjoy it; it was just habit and something to do with my hands. But it took me three attempts over 10 years to finally quit for good. I used the patch and had a buddy to help me along.

One reason I quit was because a good friend of mine had a mild heart attack. This heart attack happened in part because of his cigarette smoking. I had shortness of breath and noisy breathing, which constantly reminded me that my health, too, was at risk if I kept smoking so heavily.

Another reason I quit was that my ex-wife Alisen had suffered from respiratory problems and the onset of emphysema related to smoking. She died on September 27, 2001. We were very close. By the time Alisen passed away, I had already quit smoking tobacco for about a year and a half. She had supported me wholeheartedly in my quest to quit.

My addiction to marijuana, however, continued until Easter 2004. I had smoked weed every day since 1984; smoking to feel 'normal.' But when I hit a low point with a high point of anger, with the help of a Dual Diagnosis Anonymous group, I decided to clean up my life. I quit marijuana, got some anger management skills, became a Christian, adopted some Buddhist beliefs, became a vegan and quit drinking coffee.

But it was Alisen's death that motivated me to eventually start the Butt Out group. I knew that I had to find a way to help others stop smoking. I'm sure that if I'd had the support of Butt Out, quitting smoking would have been easier. I started the group with help from Lori Keith, the occupational therapist for the West End mental health care team. We based it on a book called *Breathe Easy*.¹ And I had my Dual Diagnosis group experience to call on.

Our first Butt Out meeting took place February 24, 2005, at the Coast Mental Health Resource Centre, with

four or five people attending. One of the attendees was Joanne Kirk, who had smoked for 45 years and finally quit on April 1, 2005, with the help of Butt Out. Joanne says, if she can quit, anyone can. If you join Butt Out, chances are you will hear Joanne's amazing story, as she is usually the inspirational speaker at one of the first meetings.

Butt Out is for mental health consumers. The groups provide support and encouragement to find the path to better health, without smoking. 'Quitting buddies' at Butt Out provide support between meetings to keep you focused on your cessation goals. There is no judgment of any of the attendees. Vancouver Coastal Health funds the program.²

I believe in compassion and serving others. I run a support group every Saturday morning at the Coast Mental Health Resource Centre, followed by a free lunch. This is a group for people not ready for Butt Out, or people waiting for space in the Butt Out group.³ At the meetings we discuss triggers: alcohol, coffee, peer pressure and stress. Some participants are not at all aware of why they smoke as much as they do. Some people want to quit because they simply can't afford it anymore, health-wise and money-wise. My top three reasons for quitting were health, fire hazard fears and finances.

I also assist the professionals who facilitate the Butt Out groups. This helps me stay true to my commitment of maintaining sobriety from smoking marijuana and cigarettes. It has been said that smoking cigarettes is harder to kick than heroin. That said, it can be done. I never thought I could do it, but I haven't had a cigarette for seven years.

It's been tough at times, but it's worth it. I now have a much easier time exercising—and, the day after I quit smoking I noticed the tone of my voice was louder. I also discovered that I can sing. I've been singing with a group at the Coast Clubhouse and am taking singing lessons. When I smoked, I was 'doing' something. Now I'm always singing. Singing helps keeps anger away, and it makes me happy, which smoking never did.

Through Butt Out, I believe we are working to save lives. Every person that is successful in quitting, or even in cutting down, makes me so happy. I wish that Alisen was one of those. If she had quit, maybe she would still be here today. ■

Rene Rey

Rene is a member of Coast Mental Health Clubhouse and Resource Centre. He leads a weekly support group for mental health consumers who have quit smoking. He lives in Vancouver.

footnotes

1. The *Breathe Easy* book is a program workbook that was developed by Canadian Mental Health Association—Simon Fraser Branch. See the article on *Breathing Easy* (what the program is now called) on page 34.
2. For more information on Butt Out, see Tom Heah's article on page 33.
3. Contact Rene Rey at 604-716-0903 for more information about this support group.

The Role of Schools in Addressing Tobacco

Dan Reist

Dan is Director of the Communication and Resource Unit for the Centre for Addictions Research of BC at the University of Victoria



Challenges are, when you think of preventing smoking, you think of education programs in school. But, as a recent Ministry of Health document shows, prevention is much more than education.¹ Schools are also being asked to develop policies to respond to tobacco and other drug use by students, not just prevent it. This article explores briefly the complex role of schools in tobacco control.

Impact of school-based drug education programs

School-based drug education can have a modest impact in reducing or delaying alcohol and tobacco use.² Mixed results in the research, however, suggest caution in assuming that any education program will have a positive impact. Delivering such programs within health education at key stages in youth development improves effectiveness.

In-school education should seek to influence behaviour in the short term. Since early substance use predicts later problems, delaying use can have a significant positive impact.

The best programs are interactive and provide information that students can readily put into use. They focus on developing practical skills—how to negotiate social situations

or deal with stress, for example—reinforced across a period of years.¹

Challenges of drug education programs

Even though education programs can have some positive impact, schools have very few learning resources or curriculum supports from which to choose. Even fewer of these resources have been properly evaluated. BC Tobacco Facts is a learning resource developed in BC several years ago.³ It meets many of the criteria of effective programs, but lacks a full evaluation.

BC Partners for Mental Health and Addictions Information and other partners are working with the Centre for Addictions Research of BC to develop classroom resources. These will address tobacco use along with other substances and mental health issues. Some of these resources will be piloted in selected school districts this spring. Work on developing and testing these resources will need to continue over the next several years to ensure effectiveness.

Other ways schools can promote prevention

Preventing tobacco use is not only about education; schools can also contribute to prevention in other ways. Smoking bans in public places are effective in preventing tobacco use.



Some evidence suggests that school-based bans can also be effective when strongly enforced.⁴ Such policies should be part of a community-wide strategy, rather than being isolated to the school.

Schools can also play a role in other aspects of tobacco control. They can promote messages and programs that support students who want to quit smoking. This can be as simple as providing highly visible information about resources that assist students to quit.

BC schools can participate in the Tobacco-Free Sports program, which supports both prevention and cessation. Alternatively, they can offer cessation support at school through a program like Kick the Nic.⁵

Why tobacco use prevention is really a community concern

The BC Ministry of Health estimates that 12% of premature death and disability in BC is the result of tobacco use.⁶ Smoking by school-aged children is of particular concern, so it is natural to think of addressing the

issue in the schools. As noted, schools can help prevent and reduce smoking, thereby reducing death and disability, as well as health care costs. But it is both unfair and unwise to expect schools to carry the burden of tobacco use prevention.

School-based strategies have more impact when linked to effective policies and programs in the community. Taxation and retail regulations that increase the cost of tobacco are very effective. Social marketing campaigns that reinforce the messages presented at school are vital.

Attention needs to be given to factors that influence early childhood development. This should involve programs to decrease the use of tobacco during pregnancy, as well as programs for parental education and support. Early school adjustment, in particular, deserves careful attention—which brings us back to schools.

Schools, though important institutions within all communities, are not the community. And it takes a community to prevent and reduce tobacco use. ■

footnotes

1. Centre for Addictions Research of BC. (2006). *Following the evidence: Preventing harms from substance use in BC*. Victoria: Ministry of Health.
2. McBride, N. (2005). The evidence base for school drug education interventions. In T. Stockwell et al. (Eds.), *Preventing harmful substance use: The evidence base for policy and practice* (pp.101-112). Chichester, UK: John Wiley & Sons.
3. BC Ministry of Health. (n.d.). *bc.tobaccofacts: A tobacco prevention resource for teachers*. www.silink.ca.
4. Wakefield, M.J., Chaloupka, F.J., Kaufman, N.J. et al. (2000). *Effect of restrictions on smoking at home, at school, and in public places on teenage smoking: Cross sectional study*. *British Medical Journal*, 321(7257), 333-337.
5. Information about these programs is available on www.silink.ca.

Blue-Collar Taste

Researching strategies to shift the smoking norms in trades workers

Smoking rates have been declining in BC and across Canada, except in some segments of society—blue-collar workers being one of them. We are working with BCIT and Health Canada to change this for blue-collar workers. Following is a synopsis of the work we are doing.

“Blue-collar taste means taste that punches in every time you light up. Taste that comes at you straight from the shoulder. Taste that’s never meek or wishy-washy. Blue collar taste...”

Sound tasty? Well, it’s meant to. This is American ad copy for Viceroy cigarettes. It shows how, for decades, the tobacco industry has been targeting and manipulating blue-collar workers to sell its deadly products and make gigantic profits. And, the marketing strategy has been highly successful: trades workers have been among the highest smoking rates in British Columbia, ranging from about 40% to 55%¹—three times higher than the provincial rate of 16%. Furthermore, this population smokes more heavily, and they have less success in quitting.² Sadly, this means that blue-collar workers will suffer higher rates of tobacco-related diseases like lung cancer, emphysema, strokes and heart disease.

In Canada, even though there is such a compelling rationale to support this population to quit, there have been no specific tobacco cessation interventions to help them. However, in November 2004, we teamed with the British Columbia Institute of Technology (BCIT) and received funding from Health Canada to develop an ongoing smoking cessation strategy for trade school students—targeting them before they enter the workforce.

What trades students are telling us

So far, we have learned a number of things. We have determined that trade school students want to quit smoking, but are unaware of quit smoking programs. Also, we are coming to understand that this population presents a number of needs that are quite different

from those of other populations.

For example, in focus groups with the students, we learned a lot about their view of their smoking experiences. One student said, fatalistically, “We’re [iron workers] in the top ten of dangerous jobs. It’s high risk. I’ll probably die from a fall before I die from smoking.” Another said, “Once your apprenticeship starts, you smoke a lot more because there’s so much stress.” A student who was apprenticing in construction said, “No one at a construction site cares if you smoke. And it’s hard not to smoke on the job, because you’re kind of on your own.” And, from an aircraft maintenance engineering student: “If you’re working for a small company up north, everybody smokes. It gives you something to do, because most of the time you’re just so bored.” The most astounding finding was that many students thought they would be lifelong smokers and would smoke more when they actually got into the workplace.

A two-part intervention

As a result of these findings, Health Canada has extended this project. We are now developing a two-pronged strategy to shift the culture of smoking that many trades workers are exposed to.

One part of the strategy will infuse smoking prevention messages into the training curricula of trades workers/students. An important part of this curriculum will be to ensure construction workers understand the synergistic effects of smoking with other toxic chemicals encountered at the construction site. For example, a construction worker who smokes is 11 times more at risk for developing lung cancer; a construction worker who works with asbestos is five times more at risk of lung cancer; but a construction worker who both smokes and works with asbestos is 50 times more at risk for developing lung cancer.³ When the hazard of tobacco smoke is added to other workplace toxins, workers’ risk skyrockets. The body needs to deal with both the toxic chemicals at the construction site and the toxins in the tobacco smoke. Previous research shows that when trades workers understand this synergistic effect of smoking they are more likely to quit smoking.^{4,5}

Kate Dahlstrom, EdD and Tara Ney, PhD, RPsych

Kate is an experienced educator, curriculum developer, writer and presenter. She has authored Science, Tobacco and You; Quit 4 Life (revision), Smoke Screen and THINK SMART! DON’T START!, as well as numerous research and evaluation papers

Tara is a Registered Psychologist and Adjunct Professor at the University of Victoria. She is the co-editor of Smoking and Human Behaviour, and has researched and published in many areas, including addictions and clinical assessment

Tara and Kate are the developers of the widely used tobacco cessation and prevention programs for public schools, Kick the Nic and bc.tobaccofacts.



“No one at a construction site cares if you smoke. And it’s hard not to smoke on the job, because you’re kind of on your own.”

The other part of the strategy is to develop tobacco control awareness and policies for construction sites. While most municipalities in BC ban smoking in indoor workplaces, they do not address smoking at outdoor worksites or the use of other tobacco products (like chewing tobacco) at work. We are seeking opportunities to develop partnerships with BC and Yukon Territory Building and Construction Trades Council, WorkSafe BC and specific trade unions. The aim is to work together toward building awareness and adopting voluntary joint tobacco control policies at construction sites that aren't covered by municipal or provincial law.

The overall objective is to shift the culture of smoking that many blue-collar workers are exposed to and to support them to choose healthier lifestyles. We are optimistic that, as this project continues, a gradual shift will occur. **i**

footnotes

1. Health Canada. (1996). *Smoking on the job: Trends and issues - Smoking prevalence in the labour force*. In Workplace smoking: Trends, issues and Strategies (Report). www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/1996-work-travail/part1_smoking_prev_e.html.
2. Barbeau, E.M., Li, Y., Calderon, P. et al. (2006). *Results of a union-based smoking cessation intervention for apprentice iron workers (United States)*. *Cancer Causes & Control*, 17(1), 53-61.
3. US Department of Health and Human Services, Public Health Service, Office of Smoking and Health. (1985). *The health consequences of smoking - Cancer and chronic lung disease in the workplace: Report of the Surgeon General*. Rockville, MD: Author.
4. Erren, T.C., Jacobsen, M., & Piekarski, C. (1999). *Synergy between asbestos and smoking on lung cancer risks*. *Epidemiology*, 10(4), 405-411.
5. Omowunmi, Y.O., Afilaka, A.A., Doucette, J. et al. (2002). *Study of smoking behavior in asbestos workers*. *American Journal of Industrial Medicine*, 41(1), 62-69.

Learning about "TRIPs" Men, women and tobacco in intimate relationships

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Pregnancy is often a time when couples start to think about changes in tobacco use by one or both partners. Smoking cessation for pregnancy is often temporary, with many women relapsing after childbirth. Although a number of resources to support smoking cessation during pregnancy have been developed, many women still find it difficult to remain smoke-free. We are interested, therefore, in gaining a better understanding of the difficulties women experience in reducing or stopping smoking, in order to develop new approaches to supporting smoking cessation.

In our research, we set out to learn about the everyday routines and habits in couples' everyday lives that may influence smoking cessation. Twenty-eight women who quit

or reduced smoking for pregnancy and their male partners were interviewed following delivery and at three to six months postpartum. Interviews focused on: pre-pregnancy smoking practices; interactions regarding tobacco use before, during and after the woman's pregnancy; conflicts over smoking; and efforts to minimize environmental tobacco smoke.

What are TRIPs?

When individuals establish relationships as a couple—and one or both individuals smoke—habits and routines that involve tobacco use are developed over time. We examined the interaction patterns that many couples develop around tobacco use and how this influences women's efforts to reduce or stop smoking. We call these interaction patterns tobacco-related interaction

patterns (TRIPs).¹

TRIPs become embedded in a couple's daily life and are often taken for granted. They are reflected in the routines couples establish related to:

- where and when smoking usually occurs
- who smoking usually occurs with (partners, co-workers, friends, alone)
- the way women and men talk about smoking
- rituals that involve smoking (e.g., taking turns, lighting each other's cigarettes, sharing a cigarette)

We identified three types of TRIPs: accommodating, conflictual and disengaged.

Accommodating

Couples who demonstrate accommodating TRIPs share common views about smoking and are empathetic about their partner's need to smoke.

Whether they both smoke or not, the couple tend to view smoking as a "joint issue" and have non-confrontational discussions about tobacco use. Non-smoking partners have a high degree of tolerance for slips and relapse. The following scenario reflects a couple with this TRIP:

Andrew doesn't smoke, but he accepts that Liz enjoys smoking and that it helps her relax. He doesn't mind getting the kids ready when they go out. This gives Liz a chance for a quick smoke break. Smoking is her chance to unwind, relieve stress and be social. Liz's favourite cigarette is the after-dinner cigarette. She usually cooks while Andrew goes for a run. After dinner, Andrew does the dishes and Liz has a few minutes to herself and she often enjoys a smoke.

In couple relationships—when one or both individuals smoke—habits that involve tobacco use are developed over time.

Conflictual

In conflictual TRIPs, couples consistently describe tensions related to tobacco use, which sometimes include shaming, coercion, monitoring and hostility. For some couples, conflict about tobacco becomes a part of everyday life. Non-smoking partners have a low degree of tolerance for slips and relapse. Women who smoke try to minimize conflict by keeping their smoking away from non-smoking partners. The following scenario reflects a couple with this type of TRIP:

Despite Janet's gradual reduction, Nick (ex-smoker) is annoyed when he sees her enjoying cigarettes. Janet's habit of limiting her smoking to their apartment kitchen instead of their balcony bothers Nick. Negative comments, such as "Quit" or "Gross—you should go outside," are triggered when he enters the kitchen after a run and encounters smoke. When Nick openly criticizes her smoking, Janet thinks, "Be quiet. Leave me alone." To avoid an argument, she sometimes goes outside to smoke.

Disengaged

In this interaction pattern, couples consistently treat tobacco use as a personal decision and individual activity. Because couples do not question each other's smoking practices, there is little discussion of tobacco use. Tolerance by partners, whether they smoke or not,

is high for women's slips and relapse. The following scenario reflects a couple with this type of TRIP:

Lorna rarely speaks to Tyler about smoking or cigarettes. Both feel smoking is an individual choice, so there is no reason for them to talk about it. They both smoke as a break from work, with co-workers or when they are hanging out with their own friends. Lorna and Tyler each have their favourite brand and they buy their own cigarettes. They both smoke at home in the evenings, but usually not together.

How do TRIPs influence women's efforts to reduce or stop smoking?

We discovered that these interaction patterns can influence women's efforts to reduce or stop smoking in different ways.²

- **Accommodating TRIPs:** Partners accept and support women's goals and decisions about reducing or stopping smoking. Women openly discuss progress related to reducing or stopping smoking, and feel comfortable asking their partner for support. Sometimes, couples attempt to reduce or stop smoking together.
- **Conflictual TRIPs:** Women find their efforts to reduce smoking closely monitored by their partners and sometimes experience increased pressure to stop smoking. To reduce conflict about smoking, women tend to avoid talking

about any difficulties they experience (e.g., with cravings), they hide slips and rarely ask their partners for support. Reductions in tension are noticeable in couple relationships when women stop smoking.

- **Disengaged TRIPs:** When women become pregnant and begin to think about tobacco reduction, they are surprised and sometimes irritated when partners unexpectedly try to monitor and restrict their tobacco use. As women begin to reduce or stop smoking, they often do not receive the support they expect from their partners. Because partners often lack understanding of women's needs related to smoking, they do not offer either emotional or practical support. This creates tension, especially when partners continue to smoke despite requests by women to reduce or stop their smoking.

Further TRIPs initiatives

A project is underway to evaluate an information booklet describing TRIPs for use with pregnant women who smoke. In addition, we are conducting studies to develop interventions for reducing exposure to second-hand smoke in homes and for helping new fathers stop smoking. **i**



for more information

contact Joan Bottorff at joan.bottorff@ubc.ca

footnotes

1. Bottorff, J.L., Kalaw, C., Johnson, J.L. et al. (2005). *Unraveling smoking ties: How tobacco use is embedded in couple interactions*. *Research in Nursing & Health*, 28(4), 316-328.
2. Bottorff, J., Kalaw, C., Johnson J.L. et al. (2006). *Couple dynamics during women's tobacco reduction in pregnancy and postpartum*. *Nicotine and Tobacco Research*, 8(4), 499-509.

tips for women who

- Identify TRIPs that have developed over time.
- Talk about TRIPs with your partner. Explain how these influence you.
- Work with your partner to create new, healthier habits.
- Encourage your partner's efforts to quit smoking. Don't blame or nag.
- Tell your partner how you would like to be supported.
- Thank your partner for their support.
- Accept that quitting might take several quit attempts.
- Remember that each quit attempt makes it easier the next time.
- Ask your doctor, community clinic or public health nurse about tobacco reduction.
- Celebrate successes!

want to reduce or stop smoking

Faith in Tobacco Control

How spirituality can help prevent and reduce smoking

Sara Perry and Ian Kirkpatrick

Sara and Ian are both with the Communication and Resource Unit of the University of Victoria's Centre for Addictions Research of BC. Sara is the Research Coordinator, Ian is the Stakeholder Relations Officer

It's ironic that after decades of research into ways to prevent and reduce smoking, the very individuals who are most vulnerable to tobacco's negative effects are often still overlooked. Rural populations, minority groups, people on lower incomes or those with fewer years of education—these, among many others, are more likely to experience harms from smoking, yet are less likely to be exposed to services that can protect them and lower their risks.^{1,2} Exploring opportunities to close this gap is a priority in tobacco control. And working with people's spiritual faith could offer one path toward reducing tobacco's burden of harm.

Faith may protect against smoking

The connections between religion and human health have often been ignored, but a growing body of evidence points to a link between certain forms of spiritual involvement and everything from longer life expectancy to healthier eating.³ In fact, religious commitment could help to protect against drug use, including smoking. Research indicates that spiritual involvement may be related to lower rates of tobacco use, and later start-up of use.⁴ Being part of a faith community may also be linked to consuming fewer cigarettes.⁵ In addition, youth who attend religious events seem more likely to reduce or quit smoking. And young people who say that faith and prayer are important to them may be more prone to staying smoke-free.⁶

So what's behind this tie between religion and tobacco? It's possible that faith groups offer strong social networks that favour non-smoking lifestyles. Or perhaps they teach coping skills and positive self-esteem, which help to prevent smoking. Some even argue that maybe we've got it backwards: that drug use itself scares people away from religion, isolating them from one of the very systems that offers lasting support and care.³

Faith communities may be an ideal vehicle for tobacco control

Faith is important to many of us. About 65% of British Columbians report that they affiliate with a specific religion.⁷ Plus, more than 40% have said they physically attend religious services at least once a year.⁸

In addition, there are nearly 4,000 non-profit organizations in BC focused on religious activities, many working at the municipal, city, rural community, or neighbourhood level.⁹ This local focus is important, as it hints that religions have a presence in areas that have typically been left out of tobacco control. Moreover, it suggests that faith communities could be a key tool in accessing those who are most at risk of smoking harms.

In fact, research indicates that religious groups do have direct contact with vulnerable, hard-to-reach people.¹⁰⁻¹² What's more, faith communities may be able to deliver health services more quickly and at less cost than others, and may be more successful than the government in providing smoking cessation programs to tobacco users.¹³⁻¹⁴ Arguably, this is because faith communities tend to have long-term, personal relationships with their members, which may make them better able to support and monitor individual quit outcomes.

Effective cessation services in religious settings haven't seen a lot of scientific research. Nonetheless, some evidence shows that faith-based programs can help motivate people to change, including the most vulnerable smokers.¹⁵⁻¹⁶ As well, faith communities tend to possess a type of legitimacy and respect that governments may not. Faith communities are complex and diverse systems, which respond to the equally complex and diverse needs of the local population. This complexity and diversity should not be forgotten. Health officials have too often dealt with religions as if they were all the same.¹⁷ These actions have led some spiritual groups to shun involvement with researchers and health programs. It's no wonder, then, that faith-based tobacco control is still in its infancy.

Ultimately, spiritual groups link into powerful systems of social and environmental support, which are often vital to smoking prevention and cessation. To neglect these systems is to miss out on a key opportunity to impact public health. Religious communities can help to reduce the burden of harm from smoking—and this should leave us with faith that the most vulnerable individuals don't have to keep slipping through the cracks of tobacco control. **i**

footnotes

visit www.heretohelp.bc.ca/publications/visions for Sara and Ian's complete footnotes or contact us by phone, fax or email (see page 3)

did you know?

- o The Faith United Against Tobacco campaign has brought religious leaders from around the United States together in preventing and reducing tobacco use.¹⁸ This faith-based coalition has worked on everything from letter writing campaigns to smoke-free policy enactment.
- o In Canada, the Seventh Day Adventists are one faith organization that offers cessation support to the public. And in the US, major state-wide public-private sector campaigns have been initiated in Mississippi and Delaware to offer funds to a range of religious groups to facilitate smoking prevention and reduction in their communities.¹⁹

BC Government QuitNow Project

Outreach to income assistance clients wanting to butt out

The Ministry of Employment and Income Assistance announced a \$1.27-million pilot project called Quit Smoking Now! This voluntary smoking cessation program available to income assistance clients, including those on disability, began January 22, 2007.

“Giving up smoking is one of the best things our clients can do for their health and a great way to free up money for other living expenses,” said Claude Richmond Employment and Income Assistance minister. “We want to make sure our clients have the best chance possible to quit for good. Through this pilot program we hope to confirm our belief that our clients will choose to quit smoking if we provide them with support.”

Clients who decide to sign up for the program

will be provided with nicotine replacement therapy (NRT)—skin patches or gum—for three months, as well as counselling support from QuitNow, a free, 24-hour-a-day service operated by the BC Lung Association on behalf of the Ministry of Health.

Through the program, approximately 30,000 clients will be eligible to receive either nicotine patches or gum. This will follow a two-step registration process. First, the client will contact QuitNow and speak with a professional health care worker, who will provide advice on the various NRTs available. Second, the client will sign up for the project through their Employment and Income Assistance office or one of the 17 third-party administration agencies across the province, such as the John Howard Society.

Although the ministry has no statistics on the number of people on income assistance that smoke, the front-line staff have roughly estimated that 30% of their caseloads are smokers. This rate is twice as high as in the general public.

“Since the program

was announced, there has been an overwhelming response, with case workers receiving more than 10,000 calls in the first week from clients interested in signing up,” said ministry spokesperson Richard Chambers. “We are surprised and pleased with this response.” To meet the demand, QuitNow has started to ramp up its service levels by hiring and training at least 30 more people, including nurses and counsellors, to answer calls.

Furthermore, according to Chambers, “Sixty percent of our caseloads are made up of clients on disability income. What we’ve heard from the daily reports received from staff is that the vast majority of calls are from people on disability.” However, no additional focus will be given to people with disability, including people with mental health issues, despite the fact that they may have a harder time quitting.

Twelve weeks may not be long enough for people who have been smoking for a decade or more. But ministry officials believe the patches and gum will

help people overcome the initial craving, and the free counselling will help to keep their resolve and overcome further addiction issues.

Case workers will not be taking any new applications after the end of March. Three months after the last participant has received their supplies, there will be an evaluation to determine the success and the future of the project. Ministry officials will randomly interview participants, as well as staff, to find out what worked and what didn’t. Continuation of this project will depend on the outcome of this evaluation.

Providing clients with NRTs and counselling on how to quit smoking also supports ActNowBC, an integrated, cross-government, partnership-based approach that helps British Columbians make healthy lifestyle choices. A key pillar of this initiative is to reduce the incidence of tobacco use by 10% by 2010.

BC has the lowest smoking rate in all of Canada, but it still kills almost 5,600 people in this province every year. ■

Jake Adrian

Jake was a mental health counsellor for 10 years, working with children and youth living in institutions or on the street. He has recently switched careers to communications

QuitNow Services

Quitnow.ca, a web-based cessation program or QuitNow by Phone, available 24 hours a day, seven days a week, in 130 languages.

In BC call toll-free: 1-877-455-2233



Income assistance clients who decide to sign up for the program will be provided with nicotine replacement therapy as well as counselling support

Banning Smoking in Hospitals Helpful or Harmful for People with Mental Illness?

Ron Plecas

Ron is Chair of the Nanaimo Mental Health and Addictions Advisory Council, Director of the Nanaimo branch of the BC Schizophrenia Society, and President of Open Minds Open Windows Society. He has been diagnosed with a bipolar illness

While it would be irresponsible to suggest advocating the use of tobacco, it would be equally irresponsible for medical authorities to ban smoking in hospital facilities without taking into account the effects a ban would have on a number of patients/wards.

I am a member of the Nanaimo Mental Health and Addictions Advisory Council that meets once a month to deal with mental health issues facing the community. The advisory council is composed of about 25 people, including people with a mental health issue, family members and service providers from non-profit agencies and from the Nanaimo Mental Health Services of the Vancouver Island Health Authority (VIHA). We monitor the state of care, identify gaps in service, and ensure services are evaluated based on the needs of people with mental health and/or addiction issues.

In 2005, newspapers reported that VIHA Public

in the end, proved to be most insightful. Among others, we consulted with Dr. Jill Williams, a psychiatrist in New Jersey who specializes in schizophrenia and tobacco issues. We were staggered to learn that 44% of the tobacco consumed in the United States is consumed by people with a mental health issue.⁴ Furthermore, tobacco use is the leading cause of premature death among people with mental illness or addiction.⁵ And, interestingly, research has shown that nicotine may reduce symptoms in people who have schizophrenia.⁵

Through our research, a number of concerns arose. For example, if nicotine replacement was going to be offered in hospital, would VIHA institute a program for tobacco users once they were released from the hospital? Also, would people voluntarily admit themselves to hospital if they knew they couldn't smoke? Is it humane to have someone go through nicotine withdrawal while they're also experiencing a psychiatric crisis?

“Would people voluntarily admit themselves to hospital if they knew they couldn't smoke? Is it humane to have someone go through nicotine withdrawal during a psychiatric crisis?”

footnotes

1. Vancouver Island Health Authority. (n.d.). *Health Services 3-year plan: 2005/06–2007/08* (Section 4.1.1). www.viha.ca/about_viha/accountability/health_services_plan.htm.
2. Correctional Service of Canada. (2005, July 12). *CSC announces plan to further reduce exposure to second-hand smoke in all federal correctional facilities* (News release). www.csc-scc.gc.ca/text/releases/05-07-12_e.shtml
3. Capital Health. (2005, March 7). *Mental health strategic planning – Community consultation* (News story). Halifax: Author. www.cdha.nshealth.ca/newsroom/NewsItems/NewsDetail (see Archives).
4. Lasser, K., Boyd, J.W., Woolhandler, S. et al. (2000). *Smoking and mental illness: A population-based prevalence study*. JAMA: The Journal of the American Medical Association, 284(20), 2606-2610.

Health was going to impose a smoking ban¹ on all their properties and in their facilities. This ban would have included the psychiatric wards and their smoking areas. This became a major topic for the advisory council.

The council approached VIHA in advance of their decision, with a view to having input into the decision-making process. The council was concerned that the unique needs of people with mental illness were not being addressed or accommodated. One council member had learned that, when an indoor smoking ban was placed in Canadian penitentiaries, discussions took place with inmate groups prior to implementing the ban.² And, Halifax's Capital Health engaged over 500 people, including those dealing with a mental health issue, in a community consultation to discuss mental health strategy.³

It has never been the advisory council's position to oppose the ban; we simply wanted to have some input—and we were assured by VIHA that our input would be granted. VIHA's position was repeatedly released through the media—but we were not invited to the table.

Our council began doing its own research, which,

Our advisory council wanted VIHA to consider these impacts and consequences. But to get VIHA to come to the table, we had to twice write letters requesting involvement in the discussions of a smoking ban. The second letter was copied to the BC Minister of Health and our two Nanaimo MLAs, in addition to VIHA personnel and the board. We finally received a response advising that VIHA was “keen to work with key stakeholder groups such as yourselves to develop joint and pragmatic solutions to the challenging issues such as this.”

A special meeting with the VIHA chief medical officer, director of Mental Health and Addictions and regional manager of Tobacco Control took place in Nanaimo on September 9, 2005, with our council and other interested parties.

At the meeting, we presented the research by Dr. Williams recommending using a nicotine nasal spray as nicotine replacement therapy (NRT), coupled with psychosocial support.⁶

Our council also supplied information on a 12-step program developed for the state of New Jersey.⁷ The program addresses issues such as establishing leadership groups, creating a time plan, conducting staff



February 2, 2007

As you are no doubt aware, our Board approved in-principle a draft policy to restrict smoking on health authority premises.

This endorsement is based on a fundamental understanding that, as a healthcare organization, we are dedicated to improving the health status of those we serve. That being said, we are also aware of the diverse needs and special circumstances of certain patient populations.

A final policy and implementation plan are under development. VIHA's Board and senior leadership team, expect the final policy to respect the needs of all our patient populations – including palliative, residential care, and mental health and addictions patients/clients.

VIHA remains committed to designing a policy that will support addicted individuals in designated populations and at the same time, protect our visitors, patients and staff from second-hand smoke.

Sincerely,

Howard Waldner
President and Chief Executive Officer
Vancouver Island Health Authority

message: any program put in place that affect patients on VIHA property must accommodate the trials a person with a mental illness undergoes.

My voluntary involvement in the mental health field over the past five years has led me to believe that, without a doubt, there is no accommodation made for how mental illness affects a person. People with a mental illness are expected to use their brain to complete government forms, which mentally healthy individuals can have difficulty with; they are expected to behave properly, when the body organ that governs behaviour is under attack; and they are expected to make healthy, rational decisions, when their brain may not be healthy or rational. There is no accommodation made for a brain in disarray. Accommodation needs to be made for an illness that is both unique and, at times, devastating. A blanket ban on smoking

5. Williams, J.M. & Ziedonis, D. (2004). *Addressing tobacco among individuals with a mental illness or an addiction*. Addictive Behaviors, 29(6), 1067-1083. www.quitnownc.org/pdfs/williams2004.pdf.

6. Williams, J.M., Ziedonis, D.M. & Foulds, J. (2004). *A case series of nicotine nasal spray in the treatment of tobacco dependence among patients with schizophrenia*. Psychiatric Services, 55(9), 1064-1066.

7. Stuyt, E.B., Order-Conners, B. & Ziedonis, D.M. (2003). *Addressing tobacco through program and system change in mental health and addiction settings*. Psychiatric Annals, 33(7), 447-456.

training, providing recovery assistance for nicotine dependent staff, educating patients in a psychiatric ward setting, providing medication for those dependent on nicotine, and developing support groups.

We also raised a legal issue—more as a question than a fact. A Nanaimo lawyer I had interviewed prior to the meeting thought there could be a conflict between the Canadian Charter of Rights and Freedoms' security-of-person clause as it may pertain to involuntarily committal to psychiatric wards and VIHA's ability to enforce a smoking ban against patients under those circumstances. This is an issue that can only be decided by a court challenge.

VIHA, as a consequence of this meeting, decided to postpone implementing their smoking ban. Subsequent to that meeting, however, the council learned that a number of psychiatric wards on Vancouver Island were implementing smoking bans on their own. A call was made to VIHA, who immediately contacted the hospitals and cancelled their individual initiatives.

The smoking ban issue died with no communication between VIHA and our council for the next year. In December 2006, another newspaper article indicated that the issue of a smoking ban on VIHA property had again risen. My request to make a 10-minute presentation at the January 31, 2007, VIHA board meeting in Nanaimo was granted. My presentation had a simple

on VIHA property would not accommodate the issues of mental illness.

Our council still hasn't taken a position on a smoking ban. It may very well be that smoking on psychiatric wards will always be required. At the same time, who can argue the health benefits of anyone with a mental illness not smoking?

Ideally, we would like VIHA to study the issue of tobacco and mental illness in depth and to share their findings with us, since we don't have the resources to do this type of research. Then, when we are all better informed, we could hopefully work together with VIHA on an acceptable approach, leading to a well-thought-out program. **i**

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Vancouver Community College

Treating Tobacco Dependence in the Addictions Setting

The Aurora Centre's Experience

Gail Malmo, MA, MSW

Gail is the Program Director for the Aurora Centre

On May 15, 2006, the Aurora Centre, a residential and outpatient treatment centre for women with substance use problems, became tobacco-free. This means that clients are not allowed to smoke for the duration of their treatment stay, either on or off the property. It also means that clients receive tobacco dependence treatment alongside their treatment for other drugs and alcohol.

Setting the context

It's no secret that the rate of smoking tobacco among clients with other substance use problems is high, and Aurora clients have been no exception. However, like many drug and alcohol agencies, we didn't think addressing tobacco dependence was within the scope of our mission. The reasons were numerous. Long-held beliefs within the addictions field that smoking isn't the 'real' problem, and that you can't ask clients to give up everything at once, are just two. So, we have tended to leave the tobacco problem to the public health field, with their emphasis on the negative health consequences of smoking. But has this been an appropriate response?

Studies show that for smokers previously treat-

ed for alcohol and other drug problems, tobacco use is the leading cause of death.¹ And mortality rates due to smoking in this population are estimated to be twice that of other smokers. While smoking rates in the general population have decreased dramatically over recent years, smoking rates for individuals receiving treatment for other drugs and alcohol remain at approximately 70% to 95%.²

Despite the fact that Aurora clients themselves were telling us for years that smoking was a problem for them—nicotine has been routinely cited by our clients as one of their top three problem drugs—we did little to seriously address tobacco until recently.

Making the shift

It took the words of the brilliant Dr. John Slade, the late director of the Tobacco Dependence program in New Jersey, to jolt us from contemplation to action. Puzzled by the addiction field's nearly complete failure to address its clients' addiction to smoking, Dr. Slade concluded that tobacco was the profession's "big, dirty and embarrassing secret." He suggested that tobacco was our "elephant in the living room."³

Acknowledging this elephant at Aurora was a

process not without challenges, difficult conversations and some trepidation.

Once we did so, however, we began to shift both the way we characterized smoking itself, and the language we used when talking about it. For example, we began to see clients going outside to smoke for what it really is: going out to dose several hundred times a day. We went from talking about "smoking patios" and "smoking breaks," to talking about "patios" and "breaks." And we started to talk about "recovery"

from tobacco dependence, rather than talking about smoking cessation, and about "tobacco-caused" illness versus "tobacco-related" illness. We began to see our clients' tobacco use for what it really is: a deadly, treatable addiction with all the hallmarks of any other chemical addiction.

Fears

Would clients want to come to Aurora if they couldn't smoke? And furthermore, would they stay? Would referral agents support our endeavour, and even more importantly, would they

footnotes

1. Hurt, R.D., Offord, K.P., Croghan, I.T. et al. (1996).

Mortality following inpatient addictions treatment. Role of tobacco use in a community-based cohort. JAMA: The Journal of the American Medical Association, 275(14), 1097-1103.

2. Williams, J.M., Foulds, J., Dwyer, M. et al. (2005).

The integration of tobacco dependence treatment and tobacco-free standards into residential addictions treatment in New Jersey. Journal of Substance Abuse Treatment, 28(4), 331-340.



be able to offer our clients the kind of pre-treatment support they needed?

And perhaps the most uncomfortable question of all: what about the staff who smoked?

We relied on several resources to help us with these questions. Several recent studies, for example, suggested that addressing smoking would improve our clients' chances for recovery from all problem substances. They also suggest that continued tobacco use post-treatment may well increase overall relapse rates.⁴

As a guide to the process of becoming tobacco-free, we relied heavily on the excellent resource, *Drug-Free Is Nicotine-Free: A Manual for Chemical Dependency Treatment Programs*.³ On the subject of staff use of tobacco, the manual stresses that this issue must be addressed before a program becomes tobacco-free, and that staff be offered treatment for their tobacco dependence. Aurora followed this advice. In addition to developing a policy restricting staff use of tobacco during work hours, we offer our staff free nicotine replacement therapies (NRTs), such as the patch and gum.

We also had to confront fears arising from the knowledge that for the most part we were taking this journey pretty much

by ourselves. Although we had several supporters cheering us along from the sidelines, most were glad they were not the first to go down this road.

Our tobacco dependence programming

Addressing tobacco dependence in addictions settings means more than just restricting clients' use of tobacco. It also means treating tobacco use as we would any other chemical dependency. At Aurora, for example, we assess incoming clients' tobacco dependence, offer free NRTs and provide specific group and individual counselling on tobacco dependence. We have also ensured that the tobacco addiction is woven into all of our educational seminars and group discussions. This reinforces that the dynamics and patterns of the tobacco addiction are no different from those for any other addiction.

Impact on clients and their treatment

We didn't expect that implementing the tobacco-free policy would be easy. It's a new concept, and there's a lack of systemic support from drug and alcohol practitioners for clients who wish to stop smoking. We also knew that most clients had likely not thought about their tobacco addiction in the same way as their other

addictions, nor had they been encouraged to do so.

Not unexpectedly, we did experience an initial increase in the number of clients leaving treatment early. While the reasons for this were not explicitly due to the smoking ban, we suspect that it was a contributing factor in some cases. Recently, however, our retention rates have improved, and we are confident that this trend will hold as clients and staff alike become more comfortable with the idea of treating tobacco dependence in our setting.

Client support for the policy has been very high, with scores ranging from 65% to 93% of our residential clients stating they strongly support the policy. Client use of NRTs has also been high: 87% of clients who had smoked within two months of admission used the nicotine patch, gum or both during treatment. Almost all reported that these aids had been very helpful or somewhat helpful to them in alleviating withdrawal symptoms.

Client ratings of their achievement of their alcohol and drug treatment goals haven't decreased since the implementation of our tobacco-free policy. Their rating of their physical health goals has improved.

Challenges

Unlike the 30-day clean/sober admission requirement we have for other drugs and alcohol, we don't require any clean time from smoking. Working with clients in active withdrawal has been a challenge for staff. We have also struggled with how best to deal with clients who relapse to tobacco while in treatment. And finally, staff report feeling uneasy when referring clients post-treatment to facilities that still allow smoking.

System changes

We hope our colleagues in the drug and alcohol system of care will acknowledge there are compelling reasons to treat tobacco dependence concurrently within addictions treatment settings. At every level of the system, we hope to see clients assessed for tobacco dependence and provided appropriate treatment. Professional bodies such as the Association for Addiction Professionals⁵ and the American Society of Addiction Medicine⁶ call for no less.

It is no longer acceptable for drug and alcohol professionals to remain silent on the issue of tobacco addiction. At Aurora Centre, we are committed to treating all of our clients' chemical dependencies—our clients deserve no less. **i**

3. Hoffman, A.L., Kantor, B., Leech, T. et al. (1997). *Drug-free is nicotine-free: A manual for chemical dependency treatment programs*. New Brunswick, NJ: Tobacco Dependence Program.
4. Sees, K.L. & Clark, W. (1993). *When to begin smoking cessation in substance abusers*. *Journal of Substance Abuse Treatment*, 10(2), 189-195.
5. NAADAC: The Association for Addictions Professionals. (n.d.). *Position statement: Nicotine dependence*. naadac.org/documents/display.php?DocumentID=36.
6. American Society of Addiction Medicine. (2005). *Public policy statement on nicotine dependence and tobacco*. [americ20.temp.veriohosting.com/ppol/NICOTINE%20DEPENDENCE%20&%20TOBACCO%2010-96%20\(1\).htm](http://americ20.temp.veriohosting.com/ppol/NICOTINE%20DEPENDENCE%20&%20TOBACCO%2010-96%20(1).htm).

“Client ratings of their achievement of their alcohol and drug treatment goals haven't decreased since the implementation of our tobacco-free policy. Their rating of their physical health goals has improved.”

Fraser Health Launches “30 Seconds to Save a Life” Campaign

Jami Brown

Jami is a Tobacco Reduction Coordinator for the Fraser Health Authority

Take 30 seconds to save a life. That’s all it takes for health care workers to ask their clients about tobacco use, advise them to quit and refer them to QuitNow¹ services.

Fraser Health (FH) is committed to helping their clients live a healthier lifestyle. As part of an overall Fraser Health Tobacco Cessation Strategy, FH recently launch Take 30 Seconds to Save a Life, a cross-discipline campaign to motivate health care workers. The campaign highlights just how easy it is and what little time it takes to address one of the most significant ways to improve client health: quitting smoking.

The launch of this campaign took place at the Setting the Stage: Addressing Client Tobacco Use for Health Professionals workshop series, February 12 to 16, 2007.

Setting the Stage was a response to years of feedback to the FH Tobacco Reduction Program. It addressed the need for simple, easily transferable information and training that encourages health care professionals to address tobacco use in a meaningful way. If more health care workers address tobacco use with their clients, there will be a greater chance that more clients will attempt to quit.

has adapted this to: Ask everyone about tobacco use; Advise about quitting; Refer to QuitNow.

A fax-to-quit form supplied by Fraser Health is designed to be faxed by a health practitioner, with their client’s signed approval, to the provincial QuitNow by Phone service. QuitNow staff follow up by phoning the client. (QuitNow will also report back to the FH Tobacco Cessation Strategy program, so the success of the campaign and referral sources can be tracked.) This referral system provides clients with one-on-one support to establish a quit plan through QuitNow.

Fraser Health created a series of visual resources, including a fax-to-quit referral form pad, the Take 30 Seconds to Save a Life flyer and standardized self-help materials, which were distributed to all workshop participants.

Early on in the planning for the workshop series, the Tobacco Reduction Program identified key populations that are at special risk from tobacco use and whose health professionals showed interest in addressing this issue. A day was devoted to each of these special areas, though all days provided brief clinical intervention and fax-to-quit training, as well as medications information presented by Fraser Health’s Dr. Deb Thompson.

- **Day one: Mental health and addictions.** Research indicates that prevalence rates among mental health and addictions clients can be anywhere from 70% to 90%.³ In the past, mental health and addictions workers have not consistently addressed tobacco use.

Gail Malmo, program director of the Aurora Centre in Vancouver, shared their journey to become a tobacco-free centre (see article on p. 28). Dr. Charl Els, who has completed clinical fellowships in addiction medicine and schizophrenia and tobacco dependence, and is currently establishing an integrated treatment model in concurrent disorders in Alberta, also provided information on how to address tobacco use with mental health and addictions clients.

- **Day two: Hospitalized smokers/Primary care.** Primary care is the first point of entry to health care for most people. Workers in primary care can play a very important role in the overall success of quit-smoking endeavours, by providing support to their hospital clients. To improve health outcomes, hospital sites need to address the problem of tobacco use in a more systematic way.

Dr. Tim McAfee of Seattle, Washington, the executive medical director of Free & Clear, a tobacco treatment provider, shared his expertise regarding

campaign flyer



Setting the Stage

Hundreds of health professionals from Fraser Health gathered for the five-day workshop series to learn about integrating tobacco cessation strategies into their daily practices.

The main goals of the series were to advocate that health professionals address tobacco use with their clients—that is, undertake brief clinical intervention—and that they incorporate the use of a “fax to quit” referral system.

The brief clinical intervention training is modelled on the “Ask, Advise, Assess, Assist and Arrange” approach of the Smoking Cessation Leadership Center.² The FH campaign

the benefits of referring patients to quit-smoking services. Workshop participants discussed, among other things, establishing an in-hospital tobacco cessation team, withdrawal management protocols, nicotine replacement protocols, and making standardized resource materials available to patients.

- **Day three: Aboriginal people.** Aboriginal people use tobacco at very high rates (at last count nearly one in every two Aboriginal people were smokers).⁴ The tobacco issue is also more complex in Aboriginal cultures because of the ritual use of tobacco for sacred purposes. Denise Lecoy, provincial coordinator for the BC Ministry of Health Service's Aboriginal Tobacco Strategy, presented the Honour Your Health Challenge, a six-week program that challenges and supports Aboriginal people to quit or reduce tobacco misuse in the car and/or at home.

Self-help resources, cessation support protocols and referral resources were provided to assist our partners (Aboriginal support services) with augmenting existing services or developing new tobacco cessation programs. Participants shared their experiences in tobacco cessation and made commitments to work on integrating Fraser Health services with their own activities.

- **Day four: Pregnancy,** with combined tobacco cessation and fetal alcohol spectrum disorder (FASD) training. Christine Urquhart, provincial training coordinator for the ActNow BC Healthy Choice in Pregnancy Initiative, and Nancy Poole, a policy/research associate related to women's substance use—both with the BC Centre of Excellence for Women's Health—presented materials and information specifically for those working with the perinatal population.

- **Day five: Youth.** Emphasis was put on how imperative it is to get youth to quit, because the sooner youth quit, the less likely it is they will have health impacts later in life. Dr. Chris Lovato, an associate professor in health care and epidemiology at the University of British Columbia, shared her research on smoking patterns in teenagers. Discussions included better practice options and introducing a guide for making informed decisions about addressing tobacco use with youth.

Systemic approach needed

It is hoped that a systemic approach to tobacco cessation—including both FH staff and external partners such as primary care physicians, dentists and pharmacists—will result in more health care professionals encouraging their clients to quit and supporting them by referring to QuitNow services. It is hoped that this will, in turn, increase quit attempts.

A comprehensive marketing strategy for the entire region accompanied the workshop series. A full-page For Your Health community newspaper advertisement encouraged smokers across FH to reach out to smoking cessation support services. Newsletter articles about the 30 Seconds campaign were created for specific populations, such as physicians. And thousands of promotional packages incorporating all of the visual resources are currently being distributed to doctors, dentists, pharmacists and other health care professionals.

Fraser Health will evaluate this system-wide approach over the next year to determine its effectiveness. Those results, along with the process followed, will be shared with other health authorities in BC. **i**

footnotes

1. QuitNow is a smoking cessation program provided free of charge to all British Columbians. It's operated by the BC Lung Association and funded by the BC Ministry of Health. Visit QuitNow.ca or phone 1-877-455-2233.

2. US Public Health Service. (2003). *Treating Tobacco Use and Dependence*. www.surgeongeneral.gov/tobacco/clinpack.html

3. Lasser, K., Boyd, J.W., Woolhandler, S. et al. (2000). *Smoking and mental illness: A population-based prevalence study*. JAMA: The Journal of the American Medical Association, 284(20), 2606-2610.

4. Heart and Stroke Foundation of BC & Yukon. (1997). *Aboriginal Report. In Tobacco Use in BC, 1997* (p.E-6). Victoria, BC: Ministry of Health and Ministry Responsible for Seniors. www.healthservices.gov.bc.ca/tobacrs/pdfs/e-aborig.pdf.

for more information

604-587-7922 or jami.brown@fraserhealth.ca

Tobacco—NOT the 'Least of Their Worries' Interior Health's Nicotine Intervention Counselling

"I have kicked alcohol and crack (cocaine), but I can tell you from the bottom of my heart that stopping smoking is the hardest thing I have ever done!"

"Thanks for not giving up on me when I was trying to stop smoking. Stopping smoking is so hard."

These quotes are from individuals who struggle with mental

illness, as well as tobacco dependence. They highlight the importance of support on the difficult journey to become tobacco-free.

Tobacco use remains the leading preventable cause illness and death in our society. The facts show that smoking kills more people in this country than HIV/AIDS, motor vehicle collisions, murder, suicide and illicit drug use combined.¹

Tobacco smoking prevalence among people with mental illness, however, is twice that of the general population.²

People struggling with mental illness as well as tobacco dependence often find it very difficult to stop smoking on their own or with little support. Many have additional challenges. They may have lower incomes and, because of this powerful addiction,

may spend their limited resources on tobacco rather than on basics of life such as food. Many have fewer social supports and less education than members of the general population do. They may also have other physical illnesses, such as lung disease, heart disease and diabetes. The health effects of tobacco use are, needless to say, huge.

Tobacco use by people who have a mental illness

MaryAnne Waters

MaryAnne is a Senior Tobacco Reduction Coordinator with Interior Health. For the past three years, she has coordinated the successful Nicotine Intervention Counselling (NIC) pilot project across BC's interior region. She is passionate about supporting health care providers to help their clients become tobacco-free

footnotes

1. BC Ministry of Health Services. (2004). *BC's tobacco control strategy: Targeting our efforts*. www.tobaccofacts.org/pdf/bc_strategy.pdf
2. Lasser, K., Boyd, J.W., Woolhandler, S. et al. (2000). *Smoking and mental illness: A population-based prevalence study*. *JAMA: The Journal of the American Medical Association*, 284(20), 2606-2610.
3. Nicotine Dependence Centre (NDC), Mayo Clinic, Rochester, Minnesota: www.mayoclinic.org/ndc-rst.
4. Nicotine Intervention Counselling Centre (NICC), Northern Health Authority: Visit www.northernhealth.ca/Your_Health/Programs/Tobaccoreduction.asp, or for information on the program contact Wanda Dean at 250-649-7271.
5. Nicotine Intervention Counselling Centre, Northern Health Authority. (2007, January 29). *NICC participants smoking status by follow-up type: January 1, 2006, to December 31, 2006. General Smoking Status Report*. Prince George: Author.
6. Health Canada. (2006). *It's your health: Second-hand smoke (Fact sheet)*. www.hc-sc.gc.ca/iyh-vsv/life-vie/shs-fs_e.html.

for more information contact MaryAnne at 250-851-7954 or maryanne.waters@interiorhealth.ca

is sometimes viewed—by the clients, their family and friends, and even health care professionals—as “the least of their worries” or “normal.” This has meant that many mental health consumers have not been supported to stop their tobacco use. Worse still, tobacco use has sometimes been encouraged in ways such as sanctioned “smoke breaks” or tobacco offered as a “reward.”

Most health care providers have received little (if any) training in effective ways to help people stop smoking. Other than saying, “don’t smoke,” many have few other tools, so find it difficult to be helpful.

The NIC pilot

In Interior Health, we piloted the Nicotine Intervention Counselling (NIC) program from April 2003 to December 2006. This program was designed to help tobacco users who may need more intensive support to be successful in stopping their use. It addressed those unlikely to succeed with interventions such as self-help books, websites, ordinary physician appointments or talking to their pharmacist.

NIC was based on the world-renowned Nicotine Dependence Centre (NDC) program at the Mayo Clinic in the United States³ and on the Nicotine Intervention Counselling Centre (NICC) program offered in BC’s Northern Health Authority.⁴

Interior Health adapted these programs to best fit the needs of our region. This included adapting for a variety of health professionals—respiratory thera-

pists, nurses, pharmacists, care aids, social workers and doctors—who work in a variety of settings, from hospital wards to community outreach. These professionals serve communities that range from small, remote locations to larger urban centres. Fifteen communities were involved in the pilot project.

Over the three years of the pilot, 173 health care providers were trained to provide NIC services. The initial training was two days, followed by a yearly, two-hour recertification. These health care providers learned a comprehensive approach to providing support for their clients, as an integrated part of the regular care given. Client-centred care was a key focus.

Our NIC pilot had three major components:

- **Planning session**—Clients and health care providers met to develop a plan that was best for the individual client. These sessions addressed tobacco use habits such as how much they smoke, how long they’ve smoked and when they smoke. They explored whether the client has tried to quit before and, if so, what has worked for them and what hasn’t worked. Carbon monoxide levels and nicotine dependence were tested. How important quitting is to the client, their confidence in their ability to quit, their triggers and fears, what support systems they have, and other health issues were also discussed.

- **Medication support**—A seven-day supply of

66 **Helping smokers is now one of the favourite parts of my job; I am able to do this as I work with my clients** —NIC Counsellor

nicotine patches and gum was offered to the client in most cases. Clients were also encouraged to see their doctor about other possible medications that may be helpful.

- **Ongoing support**—Clients were offered brief support by health care providers in the weeks and months after the initial visit. This tended to vary, depending on health care providers’ abilities to do follow-up. Initially, phone contact was routinely offered at one, three, six and 12 months, but this changed to a three-month limit for follow-up. An office visit was encouraged at the one-week mark, where tobacco use was reassessed, including carbon monoxide testing. If clients were tobacco-free, they were offered a second ‘starter kit’ of nicotine replacement therapy.

Some communities had a one-hour, weekly support group. People were encouraged to use other support, such as QuitNow internet or phone support, or other health care providers.

The NIC pilot also had a very small but significant staff component. Support was offered to staff who wanted to stop using tobacco. Staff comprised about 5% of the quit-smoking clients.

NIC results

Over the three-year pilot, a total of 2,125 clients, including staff, were seen. “Tobacco-free” rates for NIC participants were:

- 59% at one week
- 47% at one month
- 40% at three months

These rates compare well with other effective stop smoking programs.⁵

There were some challenges in following up with clients, including clients moving or not having phones, as well as limited staffing time. Also, phone follow-up was sometimes done locally and sometimes centrally; in the latter case, the client was called by someone they didn’t know. However, even in cases where clients had started to smoke again, most of them welcomed the phone support and encouragement offered.

It is important to note that as smokers quit, the risk of exposure to second-hand smoke may also decrease. Second-hand smoke exposure is a clear health hazard.⁶ By becoming tobacco-free, clients were no longer exposing others to their tobacco smoke.

The experience with our NIC pilot has increased the skills and abilities of both clients and health care providers in dealing with tobacco dependence. Future steps for this service are being evaluated. ■

Vancouver's Butt Out Stop Smoking Program

The Butt Out Stop Smoking Program is a Vancouver Community Mental Health Services initiative funded by the Tobacco Reduction Strategy and two mental health teams of Vancouver Coastal Health. Since its beginning in February 2005, just under 80 people have attended one of the eight groups that are co-facilitated by an interdisciplinary team that includes mental health consumers, occupational therapists and a psychiatrist. The groups are offered on both the east and west sides of Vancouver. Group attendees are given the option of attending at a community agency, the Coast Foundation Resource Centre or at two community mental health teams.

Structure

The Butt Out program provides education, nicotine replacement therapy (NRT) and behavioural techniques to assist people who have serious mental illnesses to quit smoking.

- Education includes topics such as the dangers and benefits of smoking, how tobacco addiction works, lifestyle changes and strategies on quitting and staying quit.
- Nicotine replacement is provided free of charge to clients based on their Fagerstrom Nicotine Tolerance Scale scores.¹ Participants are provided an optional combination of

up to 24 weeks of nicotine gum and patch, and this regime is monitored by their psychiatrist or physician. Some clients are also provided the nicotine nasal inhaler, a relatively new NRT product. Participants require a doctor's agreement to monitor them while on NRT, as NRT may affect the levels of medication uptake by clients.

- Our NRT practices are consistent with the research on smoking cessation that highlights the importance of supplying NRT to people who have serious mental illnesses, to help them to quit smoking.^{2,3} We also follow the recommendations of the BC Doctors Stop Smoking Program⁴ and other findings, such as those of the Ontario Medical Association.⁵
- Behavioural techniques include mindfulness and relaxation techniques in each session. Clients are encouraged to attend stop smoking support groups, and to use BC's QuitNow

service, offered by the BC Lung Association.

Successes

To date, the Butt Out program has helped nearly 40% of attendees with serious mental illness to stop smoking. A significant number of other people who haven't quit smoking have greatly reduced their cigarette consumption. In one of the most recent groups, with 18 attendees, 10 people attended more than 75% of sessions, and of these, four people have quit for more than five months each. A further two people, who attended fewer than three sessions, quit for more than six months each. In addition, five other people reduced their smoking from an average of one and a half packs a day to an average of half a pack or less a day.

Beyond the quitting and reductions, clients who have successfully quit smoking also report experiencing increased self-esteem and being proud of their achievement at overcoming a vicious addiction. Other

Tom Heah, OT

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footnotes

visit www.heretohelp.bc.ca/publications/visions for Tom's complete footnotes or contact us by phone, fax or email (see page 3)





“Beyond the quitting and reductions...Other outcomes include improved health, getting a job or continuing their education, an easier time breathing, resolution of certain lung and physical health conditions, and having extra money.”

outcomes include improved health, getting a job or continuing their education, an easier time breathing, resolution of certain lung and physical health conditions, and having extra money.

Some clients, as a result of quitting smoking, have increased their participation in personal activities that they value, as well as their involvement in family life. One group member who, prior to starting smoking, was a marathon runner, has

now stopped smoking and, as a result, is considering returning to running. This same member reports that attending the Butt Out program and quitting smoking “was a life changing event.” Another group member reports meeting new friends because he now has more time.

Contingent on continued funding, this evidence-based smoking cessation program will continue to be offered in 2007. **i**

for more information

to attend the Butt Out Stop Smoking Program, contact Tom Heah at 604-253-5353

Breathing Easy Smoking Cessation A CMHA Simon Fraser Branch program for people with mental illness

Rona Wilkman, BA, CPRP
and
Rodney Baker, MA, CPRP

Rona originated the Breathing Easy program at the Canadian Mental Health Association's Simon Fraser branch. She is also the primary author of the Breathing Easy participants' workbook. Currently, Rona is a community living support worker with CMHA

Rodney is Executive Director of the Canadian Mental Health Association's Simon Fraser Branch

the risks of smoking are well documented. It is the single most preventable cause of death in the world, but statistics show that tobacco-related diseases kill one out of two tobacco users.¹ This issue is highly relevant for people with mental illness, who are about twice as likely to smoke as the general public.² Those living with schizophrenia are three to four times as likely to smoke.²

Fortunately, the same researchers who have documented these high rates have also found that this population can, with the right program, also have a quit rate similar to people without mental illness.²

Many people with mental illness, especially those taking neuroleptic (antipsychotic) medications, have an increased risk of nicotine addiction. This is due to complex chemical actions in the brain that seem to lessen some symptoms of schizophrenia and bipolar disorder. As a result, many mental health consumers appear to derive extra “benefits” from smoking, such as increased concentration, increased sense of ‘well-being’ and reduction in auditory hallucinations. These ‘benefits’ can make smoking a very hard habit to quit.

Many consumers who quit smoking report an improvement in their daily nutrition, in addition to the usual benefits to heart and lung health. Many people with mental illness also live in poverty, so, to support their tobacco addiction, they will choose to purchase cigarettes rather than food. They may also purchase foods that fill them, but have little or no nutritional value. When consumers are no longer purchasing cigarettes, they then have money to buy a wider variety of foods.

The Breathing Easy program

Breathing Easy³ is an education and support program designed to help people with a psychiatric diagnosis face the extra challenges of quitting smoking. Seed funding through Health Canada, from 2003 to 2006, allowed the Canadian Mental Health Association's Simon Fraser Branch (CMHA-SF) to develop a comprehensive smoking cessation program for people with mental illness.

The program combines nicotine replacement therapies with cognitive-behavioural and psychosocial approaches to quitting smoking. It was formulated from

existing information in the public domain, including work done by the Canadian Cancer Society⁴ and information supplied by Dr. Debbie Thompson of Surrey North Mental Health Centre on the effect of nicotine on the brain and interactions with pharmaceutical drugs, as well as research on social and healthy lifestyle alternatives to smoking.^{2,5-6}

By March 2006, eight Breathing Easy groups in seven cities within the Fraser Health region were in operation. Thanks to additional Health Canada funding from 2005 to 2006, CMHA-SF was able to educate and provide program materials to other mental health agencies. After March 2006, Fraser Health began to incorporate this program as a smoking cessation option for the mental health and addictions population in the Fraser North area.

The 12-week program is, ideally, facilitated by consumers who are reformed smokers. A course workbook serves as both a facilitator's guide and a participant resource.

Throughout the program, participants are encouraged to understand why they smoke and what triggers their smoking. They then learn to develop alternate healthy habits, behaviours, thoughts and social circles, to replace their current smoking patterns.

Group participants often form strong bonds with each other, and consequently provide mutual support and encouragement throughout the process of quitting smoking.

Breathing Easy results

From January to June 2006, 113 consumers—69 female and 44 male—participated in the Breathing Easy program. Each participant attended three or more sessions of the 12-week smoking cessation program. People who registered for this program but attended two or fewer of the sessions were assigned to a control group for comparison.

Table 1 below indicates how many participants

table 1: program results ✓

Location	# of people in group	# quit	% quit	% reduction in cigarettes smoked by program completion
New Westminster	21	6	28.6	-37.8
Burnaby	13	4	30.1	-58.2
Tri-Cities	19	5	26.3	-42.0
Maple Ridge	10	0	0	-23.9
Surrey	12	3	25.0	-46.7
Langley	11	3	27.0	-42.5
Mission	7	2	28.5	-74.4
Abbotsford	20	3	15.0	-16.9
All groups	113	29	25.7	-40.0
Control Group	22	0	0	+37.0



housing & homelessness

Our summer issue of *Visions* looks at housing for people with mental illness and addictions who have complex needs, including those who are homeless or at risk of homelessness. Do you have an innovative resource, program or approach you'd like to tell others about? A personal story to share as someone who used to be homeless or as a family member or friend?

send us your story ideas!

bcpartners@heretohelp.bc.ca or 1.800.661.2121

Visions

were active in each of the locations, the number of these participants who quit smoking in each group, the percentage of people who quit in each group, and the percentage reduction for each group at completion of the program. These results are given in percentages, with a negative number indicating that the overall cigarette consumption went down during the course of the program, and a positive number indicating that the number of cigarettes consumed increased during the course of the program.

With additional funding, we would be interested in evaluating the long-term impact of the program.

Interested in Breathing Easy?

The participant workbook⁷ is available from CMHA-SF for a fee of \$18.00 per copy. Facilitator guidance and training is also available, on a fee-for-service basis. Organizations who wish to start their own Breathing Easy smoking cessation groups can contact Rodney Baker at cmhasf@telus.net for more information. **i**

footnotes

1. World Health Organization. (2006). *Facts and figures about tobacco*. Geneva: Author. www.who.int/tobacco/fctc/tobacco%20factsheet%20for%20COP4.pdf.
2. Lasser, K., Boyd, J.W., Woolhandler, S. et al. (2000). *Smoking and mental illness: A population-based prevalence study*. JAMA: The Journal of the American Medical Association, 284(20), 2606-2610.
3. The Breathing Easy program was formerly called Breathe Easy.
4. Canadian Cancer Society. (2002). *For smokers who want to quit: One step at a time*. www.cancer.ca.
5. Addington, J., el-Guebaly, N., Campbell, W, et al. (1998). *Smoking cessation treatment for patients with schizophrenia*. American Journal of Psychiatry, 155(7), 974-976.
6. George, T.P., Ziedonis, D.M., Feingold, A. et al. (2000). *Nicotine transdermal patch and atypical antipsychotic medications for smoking cessation in schizophrenia*. American Journal of Psychiatry, 157(11), 1835-1842.
7. Wilkman, R. & Holland, W. (2005). *Breathing Easy: Participant's workbook*. New Westminster, BC: Canadian Mental Health Association—Simon Fraser Branch.

Stop Smoking Resources

- BC Quitnow Services, BC Lung Association:
 - **QuitNow by Phone: 1-877-455-2233.** A confidential, free-of-charge, helpline available 24/7 and staffed by specially trained registered nurses who are there to listen and provide support and guidance.
 - **Quitnow.ca.** An Internet-based quit smoking service, available free-of-charge to all British Columbia residents that combines effective methods for quitting smoking with a powerful, individualized program that is available anytime and anyplace.
- **Gosmokefree.ca.** The Government of Canada's resource portal for tobacco resources including self-help and research publications.
- **Substance Information Link:** www.silink.ca. By the Centre for Addictions Research of BC. Click on Tobacco for good-quality BC and Canadian resources
- **Canadian Health Network:** www.canadian-health-network.ca. Click on Tobacco under Topics.

this list is not comprehensive and does not imply endorsement of resources

don't forget all the resources listed at the end of Visions articles as well

Publications

- Piaseck, M.P. & Newhouse, P. (Eds.). (2000). **Nicotine and psychiatry: Psychopathology and emerging therapeutics.** Washington, DC: American Psychiatric Press.
- BC Partners for Mental Health and Addictions Information. (2006). **Tobacco. The Primer: Fact Sheets on Mental Health and Substance Use Issues.** heretohelp.bc.ca/publications/factsheets/tobacco.shtml
- Johnson, J.L., MacDonald, S., Reist, D. et al. (2006). **Tobacco reduction in the context of mental illness and addictions: A review of the evidence.** Vancouver, BC: Provincial Health Services Authority. www.phsa.ca/HealthPro/PreventionPromoProtect/

- Greaves, L., Jategaonkar, N., & Sanchez, S. (Eds.). (2006). **Turning a new leaf: Women, tobacco, and the future.** Vancouver, BC: British Columbia Centre of Excellence for Women's Health. www.bcccewh.bc.ca/PDFS/newleafdoc_06-28-06.pdf
- Brown, C. (2004). **Tobacco and mental health: A literature review.** Edinburgh: ASH Scotland. www.ashscotland.org.uk/ash/files/tobacco%20and%20mental%20health.pdf

Journal Articles

- Ziedonis, D., Williams, J.M. & Smelson, D. (2003). **Serious mental illness and tobacco addiction: A model program to address this common but neglected issue.** *The American Journal of the Medical Sciences*, 326(4), 223-30.
- Snyder, M. (2006). **Serious mental illness and smoking cessation.** *Issues in Mental Health Nursing*, 27(6), 635-45.
- Williams, J.M. & Ziedonis, D. (2004). **Addressing tobacco among individuals with a mental illness or an addiction.** *Addictive Behaviors*, 29(6), 1067-83. www.quitnownc.org/pdfs/williams2004.pdf
- Grant, B.F., Hasin, D.S., Chou, S.P. et al. (2004). **Nicotine dependence and psychiatric disorders in the United States: results from the national epidemiologic survey on alcohol and related conditions.** *Archives of General Psychiatry*, 61(11), 1107-15.
- Williams, J.M., Cain, B.W., Fredericks, T. et al. (2006). **A tobacco treatment model for persons with serious mental illness.** *Psychiatric Services*, 57(8), 1210.

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