

Regular article

Survey of smoking cessation services in Canadian addiction programs

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Abstract

Many alcohol and drug treatment programs now offer smoking cessation (SC) services to their clients. Little is known about the prevalence of such services in Canadian addiction programs. A telephone survey was conducted of all Canadian adult substance abuse programs with outpatient, day program, and residential treatment to determine: (a) whether the program offered help in quitting smoking; (b) the type of SC services; (c) the overall priority placed on quitting smoking; and (d) for residential programs, what type of smoking ban (indoors, outdoors, or both), if any, is imposed. Over half (54%) of the 223 programs that responded to the survey reported providing help in quitting smoking. Twenty-three programs had formal SC services, most often in the form of group treatment. The majority of programs surveyed stated their program placed ‘very little’ emphasis on smoking. Smoking was relatively unrestricted in residential programs. The implications of these findings for substance abuse treatment are discussed. © 2003 Elsevier Science Inc. All rights reserved.

Keywords: Smoking cessation; Telephone survey; Outpatient services; Residential programs; Smoking ban

1. Introduction

Many addiction treatment programs are choosing to take a more active role in promoting smoking cessation (SC) for clients with alcohol, drug, and gambling disorders. The experiences of some of these programs have been documented and published in recent years (Campbell, Krume-nacker, & Stark, 1998; Capretto, 1993; Goldsmith & Knapp, 1993; Karan, 1993; Kotz, 1993; Trudeau, Isenhardt, & Silversmith, 1995). However, detailed information on the extent of tobacco reduction initiatives in North American substance abuse clinics is extremely limited. The rationale for addressing nicotine dependence in clients with addictive disorders is well grounded. Persons with drug and alcohol abuse problems are three times as likely to be smokers compared to non-abusers (Bobo, 1989; Hughes, 1993; Marks, Hill, Pomerleau, Mudd, & Blow, 1997). Most substance abusers tend to be heavy smokers: they smoke more cigarettes per day, choose higher nicotine brands, and

are more nicotine dependent (Currie, Hodgins, el-Guebaly, & Campbell, 2002; Keenan, Hatsukami, Pickens, Gust, & Strelow, 1990; Kozlowski, Jelinek, & Pope, 1986). The health consequences of smoking are also well known (Wetter et al., 1998). Substance abusers are more likely to die from tobacco-related illnesses (e.g., coronary artery disease and lung cancer) than alcohol-related illnesses (Hurt et al., 1996). In Canada, smoking accounts for about 80% of all deaths attributed to substance abuse, compared to alcohol which accounts for only 16% of deaths from substance abuse (Single, Robson, Rehm, & Xie, 1999).

Greater awareness of this issue has prompted new initiatives in substance abuse programs to specifically address the problem of smoking. For example, some facilities are choosing to impose smoking bans (el-Guebaly, Cathcart, Currie, Brown, & Gloster, in press; Goldsmith, Hurt & Knapp, 1992; Hurt, Croghan, Offord, Eberman, & Morse, 1995; Joseph, Nichol, Willenbring, Korn, & Lysaght, 1990). Others have tried to tailor and integrate interventions for quitting smoking into conventional drug and alcohol treatment. A special issue of the *Journal of Substance Abuse Treatment* in 1993 was devoted to highlighting the efforts of select programs in the U.S. that combined nicotine treatment with existing drug abuse treat-

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ments (Capretto, 1993; Goldsmith & Knapp, 1993; Karan, 1993; Kotz, 1993). Subsequent reports of similar endeavors have emerged in the literature (Bernstein & Stoduto, 1999; Campbell et al., 1998; Rustin, 1998; Trudeau et al., 1995). The success of these initiatives has varied but some general conclusions can be made. With a few notable exceptions (Joseph, 1993; Pletcher, 1993; Rustin, 1998), the imposition of mandatory smoking cessation in treatment programs has not been tremendously successful. Typical problems that emerge with forced cessation include staff resistance to the policy, increases in rate of premature discharges, and considerable “underground” smoking (Capretto, 1993; Karan, 1993; Kotz, 1993). Providing SC treatment on a voluntary basis seems to be a more appealing approach for both clients and staff in substance abuse treatment programs (Bernstein & Stoduto, 1999; Burling, Burling, & Latini, 2001; Campbell et al., 1998). The impact of concurrent SC on posttreatment substance use has been documented in several outcome studies. In general, quitting smoking does not appear to negatively affect abstinence from other substances (Burling et al., 2001; Rustin, 1998) and can even enhance recovery (Bobo, Walker, Lando, & McIlvain, 1995; Pletcher, 1993). On the other hand, the concurrent treatment of smoking and substance abuse does not appear to significantly improve smoking outcomes compared to treating one after the other (i.e., sequential interventions), although either approach is superior to no SC treatment (Bobo et al., 1995; Burling et al., 2001; Burling, Marshall, & Seidner, 1991; Campbell, Wander, Stark, & Holbert, 1995).

Other research has examined the efficacy of SC for substance abusers that are further advanced in their recovery. The largest study to date has been project SCRAP (Smoking Cessation for Recovering Alcoholics Program; Martin et al., 1997). Clients in this project were abstinent from alcohol for an average of 4 years. The 12-month quit rates for project SCRAP and other related studies (see also Patten, Martin, Myers, Calfas, & Williams, 1998; Patten et al., 1999) are comparable to those observed in community-based SC programs involving nonabusers. Depending on the treatment condition, between 12% and 46% of substance abusers in these studies maintained a smoke-free status at 12 months. The 12-month quit rates for community-based programs are between 15% and 20% (Wetter et al., 1998). These findings suggest that recovering alcoholics are as motivated to quit smoking as non-substance abusers. In summary, research to date suggests that there is merit to addressing smoking while clients are in substance abuse treatment. Importantly, the fear that quitting smoking will endanger abstinence is largely unfounded.

The present survey was conducted to better understand how smoking was being dealt with in addiction programs across Canada. The goals for the study were to determine: (a) how many substance abuse programs in Canada provide help in quitting smoking; (b) the type and format of nicotine treatment being offered; (c) the priority placed on quitting smoking compared to quitting other substances; and (d) for

residential programs, the extent of restrictions, if any, on smoking in the program. A secondary aim of the survey was to explore trends in nicotine treatment across programs in relation to the population served (male, female, or mixed gender) and type of program (outpatient vs. residential).

2. Materials and methods

2.1. Identification of substance abuse programs

Preliminary criteria for the selection of addiction programs included the stipulation that they be Canadian, that their population served is adult, and that they provide either outpatient/day treatment, residential, or a combination of these services. A list of programs that met these criteria was obtained from the Canadian Centre on Substance Abuse website (www.ccsa.ca). The list was sorted into women-specific, men-specific and mixed-gender programs. In some cases, the male and female programs were housed in the same physical structure while maintaining distinct administrative bodies and clinical staff. Similarly, a few programs had very distinct residential and outpatient programs. These programs were surveyed separately.

A total of 223 programs took part in the survey. Twelve programs declined to participate, making the overall participation rate 95%. Reasons varied from failure to contact the appropriate person to the center's refusal to participate. The programs not surveyed included eight from Quebec, two from British Columbia, one from Newfoundland, and one from Manitoba.

2.2. Survey instrument

The instrument consisted of eighteen questions administered over the phone, with the exception of three French-only facilities in Quebec that completed the survey by fax. The Quebec programs were all initially contacted by phone and if an appropriate English-speaking individual to conduct the survey with could not be found, a French language version of the survey was faxed to them. The main survey questions were:

Do you offer clients help quitting smoking? “Help” was defined as incorporating SC therapy into one-on-one counseling if the client requested it, giving clients self-help booklets for quitting smoking, offering formal SC programs, or a combination of these services. Because respondents' definition of help varied widely, additional questions were usually asked to ascertain whether their answer fell within the desired definition.

Do you have formal SC services? “Formal” was defined as a specific group or individual therapy dedicated to SC. Therapy was the key element in this definition; groups or sessions dedicated only to awareness or education were not recorded as formal services. However, programs that offered group or individual therapy for quitting smoking but on an

“as needed” basis were considered to have formal services. Those with a formal group were asked about the number of sessions and the major approach used for SC: Canadian Cancer Society, Motivation Enhancement Therapy, 12-Step, or other. Information on the timing of the interventions (concurrent or sequential with other substance abuse interventions) was also recorded.

Do you plan to offer formal SC services? This was asked of those programs that did not currently have formal SC services. Those that had formal services were asked if there were any plans to offer additional services. If the answer was “yes”, exactly what was planned was recorded.

Compared to quitting drugs/alcohol, how much emphasis does your facility place on SC? The answer options of ‘very little,’ ‘some,’ ‘moderate,’ ‘considerable,’ or ‘extreme’ were given after this question was asked. A minority of respondents did not wish to answer this question, did not believe they could provide an accurate answer, or felt that the emphasis varied from counselor to counselor. These responses were recorded and collapsed into a sixth category, ‘cannot say.’

Do you treat smokers who don't have alcohol/drug/gambling problems? This question was directed towards those with formal SC programs to determine if their services were extended to clients who were just smokers. For those who said “yes”, the approximate percentage of clients who were smokers in the absence of other addictions was recorded.

Are clients in your residential program permitted to smoke? This question was confined to facilities that provided residential services. The answer options given were ‘indoors-anywhere,’ ‘indoors-special room,’ ‘outdoors-anywhere,’ ‘outdoors-special place,’ and ‘have to quit’ (i.e., total ban on smoking).

The remaining questions inquired about the availability of other services or support for quitting smoking including dedicated telephone support for clients quitting smoking, administration of nicotine replacement therapy or bupropion (Zyban) on-site, educational material on smoking (e.g., published materials outlining the risks of smoking and general methods for quitting), specific self-help booklets for quitting smoking, or other interventions. Beliefs concerning the feasibility and appropriateness of SC within an addiction population often emerged at this point in the survey and were also recorded.

2.3. Procedure

A pilot survey was conducted over the phone with representatives from five addiction programs, after which the survey instrument was adjusted into its present form. The full survey was then conducted between May and June 2001. Hence, programs that instituted SC services after this period would not be reflected in the current data. On initial contact a brief description of the survey and its purpose was presented and inquiries were made as to whom at the facility

would be the most appropriate person to speak with regarding program planning and development. This was the executive director, manager, or supervisor of clinical services for the majority of programs. Specific instructions were provided for the surveyed individual to speak for the program as a whole rather than provide his or her personal opinion. If the identified person was unavailable, several attempts were made to contact him or her on subsequent days. Most programs were interested in the survey and participated willingly. Facility name, phone number, and the name of the person with whom the survey was conducted were all recorded. In some cases, the program was contacted a second time to clarify responses to the survey.

3. Results

3.1. Overview of addiction treatment programs

Although some programs could not be surveyed, the following is a good representation of addiction treatment programs for adults in Canada operating in 2001. There were 90 women-specific (40%), 56 men-specific (25%), and 77 mixed gender (35%) programs. Ninety-eight programs (44%) that offered primarily outpatient services (individual, group, and day programs), 48 (21%) that were exclusively residential, and 77 (35%) that offered a combination of day program and residential services. In total, 125 programs (56%) had residential services. Every program surveyed indicated their treatment mandate covered alcohol and drugs. Some programs also treated gambling. British Columbia and Ontario had the largest number of addiction programs (65% of all those surveyed), owing to their larger populations.

3.2. Availability of SC services

Table 1 shows the availability of help for quitting smoking in Canadian addiction treatment programs. Over half (54%) of the programs reported that they offered their clients some help in quitting smoking. Outpatient programs were more likely than residential programs to report offering help for clients to quit smoking (65% vs. 44%, respectively, $\chi^2 = 10.63, p < .005, df = 2$). The most common form of help reported was counseling for SC that was incorporated into the individual sessions of clients and their primary counselors (44% of all programs reported such practice). Such counseling was conducted on an “as needed” basis, typically when requested by the client. For most programs, counseling for quitting smoking was conducted on an irregular and largely informal basis. Consequently, the prevalence of formal SC services in addiction programs was low. In total, 23 individual programs (10% of all programs surveyed) reported having a formal SC treatment. (The complete list of programs is available from the first author.) Most of these programs served women and mixed-

Table 1
Availability of smoking cessation (SC) services by population served

Question (% Yes)	Women-specific (<i>n</i> = 90)		Men-specific (<i>n</i> = 56)		Mixed (<i>n</i> = 77)		Total (<i>N</i> = 223)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
1. Offer clients help quitting smoking	46	51.1	24	42.9	51	66.2	121	54.3
2. Formal SC treatment services	9	10.0	2	3.6	9	11.7	23	10.3
3. Plan to offer formal SC services	13	14.4	2	3.6	9	11.7	24	10.8
4. Provide clients educational material on smoking	66	74.2	26	46.4	59	76.6	151	68.0
5. Provide clients self-help booklets for SC	30	33.3	16	28.6	25	32.5	71	32.0

gender clients. Of the remaining 199 programs without formal services, 24 representatives (12%) stated that they planned to offer a formal treatment program in the future.

3.3. Emphasis on quitting smoking

Representatives from ten programs (4%) declined to answer this question because they did not want to speak for the entire facility (it appeared that opinions varied considerably in some facilities regarding the emphasis that currently was, and should be, placed on SC). The majority of those surveyed (*n* = 120; 54%) reported that their facility placed very little emphasis on SC. On the other hand, about 55 program representatives (25% of all those surveyed) reported that they placed between moderate and extreme emphasis on SC. For statistical purposes, responses were collapsed across the moderate to extreme range and chi-square analyses were conducted to explore trends in emphasis on quitting. The results indicated that degree of emphasis varied significantly according to population served with men-specific program reporting the least emphasis (74% endorsed 'very little') followed by women-specific (55%) and then mixed-gender programs (45%), $\chi^2 = 11.37$, $p < .05$, $df = 4$. Residential programs also placed the least emphasis on SC compared to outpatient programs (72% vs. 42% endorsing 'very little,' respectively), $\chi^2 = 12.20$, $p < .005$, $df = 4$.

3.4. Type of interventions

The majority of programs with formal services offered SC groups (mean number of sessions = 9.1, $SD = 6.0$; range 4 to 24), with some also offering individual counseling. Four programs offered treatment exclusively in an individual format. For these programs it appeared that a specific counselor at the facility with training and a special interest in SC provided the individual sessions to interested clients. For all programs with formal services, treatment for quitting smoking was optional for clients (i.e., alcohol and drug abuse clients were not forced to attend a quitting smoking program). In some programs, groups were run "as needed" when enough clients expressed an interest. There was also variability in the timing of SC treatment. Programs with formal services let their clients choose when to start nicotine treatment. In most cases, this occurred after clients com-

pleted their drug and alcohol treatment (i.e., sequential treatment), although some clients opted for concurrent treatment of smoking and substance abuse.

Smoking cessation approaches also varied among the programs. The most common approach (used by 6 facilities) was the Canadian Cancer Society program (a structured behavioral approach similar to the American Lung Association quitting program), but many programs combined approaches into an eclectic format. Of the 23 programs with formal SC services, 19 (83%) representatives stated that the program also treated smokers without other addictions. The percentage of clients who were smokers only in these programs was less than 5% for 15 out of 19 facilities; the remaining programs reported to attract 5% to 20% of smoking clients without other addictions.

Representatives were asked about other types of interventions or supports provided to smokers wanting to quit. One program had a telephone support line specifically for smokers. Seven programs administered nicotine replacement therapy (patch or gum) on site, and four programs provided clients prescriptions for bupropion (Zyban) when requested. Programs that provided prescriptions were those with physician support (on-site or regular consultant).

All facilities, with and without formal SC services, were asked if they provided educational material, self-help booklets on quitting, or other smoking-related services to clients. Sixty-eight percent of programs provided clients with educational material on smoking and 32% provided self-help booklets. Other services included: providing videos on smoking (*n* = 9; 4%), referrals to physicians (*n* = 22; 10%), educational sessions on smoking (*n* = 13; 6%), and acupuncture (*n* = 5; 2%). Programs with acupuncture stated it was available for treating all addictions, including smoking.

3.5. Residential smoking bans

The 125 programs that provided residential treatment were asked about restrictions, if any, on client smoking. Fifty-nine programs (47%) allowed smoking indoors: 12 (20%) allowed smoking anywhere indoors, and 47 (80%) allowed smoking only in a designated smoking room. The remaining 66 programs banned indoor smoking, but allowed outdoor smoking either with no restrictions (*n* = 37) or in a designated place (*n* = 26). Three programs required clients to quit smoking while staying in residential care.

4. Discussion

These survey results provide a brief but telling snapshot of how addiction treatment programs in Canada are addressing the issue of smoking among clients with a primary alcohol, drug, or gambling disorder. The time sensitive nature of these data should be emphasized. Progress in this area appears to be rapid, and many programs are evolving toward broadening the definition of chemical dependency to include nicotine. As evidence of this progress, many of the representatives we surveyed stated that their program planned to offer formal SC services to clients in the future.

Over half of the programs reported that they currently offered their clients help in quitting smoking. The nature of help was largely informal for most programs. Most often, discussion of smoking was integrated into one-on-one counseling sessions. We do not know how much time is devoted in individual sessions to discussing nicotine as a substance of abuse. In fact, most of the representatives surveyed estimated that their program as a whole placed very little emphasis on quitting smoking in relation to quitting other substances. This finding is consistent with the common belief in many addiction centers that clients should not try to give up all substances at once. Nicotine is still viewed by many as an acceptable chemical for clients to use in place of their drug of choice. Notwithstanding, the evidence suggests that substance abusers can successfully quit smoking along with, or shortly after, quitting other chemicals of abuse (Hurt et al., 1994; Martin et al., 1997). Furthermore, concurrent treatment of nicotine and other dependencies can contribute to fewer relapses with alcohol and drugs (Bobo et al., 1995; Bobo, McIlvain, Lando, Walker, & Leed-Kelly, 1998).

Less than 10% of programs surveyed were identified as providing formal services for quitting smoking. We are nonetheless encouraged by the fact that some programs have taken the ambitious step of offering structured treatment for smoking in combination with other addictions. Hoffman and Slade (1993) referred to these programs as pioneers in the field of substance dependence treatment and applauded their efforts for challenging the tradition of ignoring smoking as a health issue in persons with addictions. There appear to be a range of treatment options available in Canadian programs with formal cessation services. Groups were the most common format, but some programs offered both group and individual counseling to clients. Treatment for smoking was voluntary in all the programs surveyed. A sequential treatment approach was also the most common. Clients would attend a SC group (or individual sessions) after completing their primary treatment for alcohol or drug problems.

Relatively few programs directly administered cessation aids like nicotine patches or bupropion on-site. Some programs indicated they would like to provide such aids but simply could not afford it. The use of bupropion would also require physician monitoring, and the majority of

programs surveyed were community based with little direct medical support. Both nicotine replacement therapy and bupropion are useful adjuncts to behavioral treatment that can increase the chances of successful quitting. There is little difference in their efficacy as smoking cessation aids (Niaura & Abrams, 2002). Nicotine replacement products have the advantage of being available without a prescription and being less expensive overall.

Nearly all of the programs with formal SC services treated individuals without other addictions, although the proportion of clients who were just smokers was low overall. One could view substance abuse programs as another resource for providing SC treatment to the general public. The process of quitting smoking is not dissimilar to quitting other substances (Goldsmith & Knapp, 1993; Sobell, Sobell, & Kozlowski, 1995), and drug abuse counselors have considerable training and expertise that could be easily adapted to SC treatment. It may be necessary to persuade staff to accept nicotine as a drug of dependence like other substances. This could be achieved by providing education and training in the specifics of nicotine dependence treatment (Hurt et al., 1994; Rustin, 1998).

Population served and type of addiction program had a moderating effect on some findings. Proportionately, mixed-gender and women-specific programs were more likely to have formal SC services and place greater emphasis on quitting smoking compared to men-specific programs. The reasons for this finding are unknown. There were more women-specific and mixed-gender programs overall, so the differences may simply reflect the smaller number of male-only treatment centers. Many of the men's programs are grounded in the 12-step/AA treatment model where the culture of smoking during recovery could be more ingrained.

Outpatient programs were more likely to address smoking, both formally and informally, compared to residential programs. In fact, smoking was relatively unrestricted in residential settings. Over one third of the residential programs allowed smoking indoors. The remaining programs allowed smoking outdoors, with the exception of three that imposed a total smoking ban. The paucity of restrictions on smoking in residential programs may reflect administrative policies that are intended to recruit and retain clients rather than purposefully encouraging smoking. Smoke-free residential programs may attract fewer clients, and mandatory smoking cessation has been shown to lead to premature discharges in inpatient settings (Karan, 1993; Kotz, 1993). On the other hand, a residential program would provide the optimal setting for concurrent treatment of smoking with other substances of abuse. In addition to benefits such as 24-h support for withdrawal symptoms, it makes practical, cost-effective sense for clients to address all addictions in one program. Because mandatory smoking cessation may be met with considerable resistance and may affect recruitment, residential programs would need to offer two streams of treatment with separate units, one that is smoke-free and

another that places no expectations of quitting smoking. Hurt et al. (1994) noted several problems associated with providing a SC intervention to clients staying on a chemical dependency unit that was not completely smoke-free.

In some geographic areas there is no reimbursement scheme for offering smoking cessation services. This can pose a significant barrier to clinicians wanting to provide treatment. The situation in Canada is somewhat less restrictive because the national health care system is designed to be universally accessible. Hospital-based programs such as the Addiction Centre in Calgary are essentially free to patients. Professionals, including physicians, are paid to treat any addiction including smoking. Access to hospital programs is mainly limited by long waiting lists. The majority of programs we surveyed are in fact non-profit, community-based programs that obtain their funding from multiple sources (e.g., government grants, private donations, and charities). Clients pay for services on a sliding scale, and the fees are generally not prohibitive. These programs have total flexibility in determining the scope of their addiction treatment (i.e., which substances they will and will not treat). In short, reimbursement for smoking cessation should not be a significant barrier to offering treatment in most Canadian programs, except in the sense that treating another addiction puts additional strain on available resources. It is worth noting that smoking cessation treatment is considered one of the most cost-effective health interventions available (Niaura & Abrams, 2002).

A few limitations of the present study need to be acknowledged. To encourage full participation from the program representatives, the survey instrument was kept brief. Other information would have been interesting to collect, such as the rate of smoking among staff, the methods employed to recruit clients into cessation groups, and the actual success of the treatment in terms of quit rates. The question pertaining to emphasis on quitting smoking is very subjective and responses could differ depending on the staff member interviewed. This individual subjectivity was compensated for by interviewing the person most responsible for program planning, and giving specific instructions to speak for the program as a whole rather than provide his or her personal opinion. Lastly, only Canadian programs were surveyed and information was obtained from only a small number (about 16%) of the Quebec programs.

Without the benefit of previous survey data, we have no means to determine if the present findings represent progress in the Canadian addictions field. We also have no comparable data from other nationalities. Therefore, the status of programs in Canada relative to other countries is unknown. Judging from the attention this issue is receiving in the literature, it is fair to say that there has been general progress toward programs broadening the definition of recovery from substance abuse to include smoking. Nonetheless, standard practice in most programs is still to allow clients to continue smoking with few impediments. Ironically, the philosophy of addiction treatment is to encourage

clients to reduce or abstain from substances that are harmful to their well being (Hoffman & Slade, 1993; Sobell et al., 1995). Failing to address nicotine as a harmful substance seems a basic contradiction to the principles on which addiction programs were founded.

Although our findings are tentative, we feel that some recommendations are justified. Foremost, it appears that offering SC services as an adjunct to standard substance abuse treatment is a viable option for addiction programs. Among those with formal services were fairly large and well-established programs in Canada (e.g., Centre for Addiction and Mental Health in Toronto, The Aurora Centre in Vancouver). One of our goals in publishing these data is to make programs aware of the trends occurring in substance abuse treatment and to encourage active dialogue between treatment centers on this issue. We feel that all programs could do more to address the issue of nicotine dependence. Research suggests that substance abusers with only one month of abstinence are interested in quitting smoking (Irving, Seidner, Burling, Thomas, & Brenner, 1994). Ideally, a range of interventions should be available so clients can be matched according to their stage of change and motivation for cessation (Karan, 1993; McIlvain, Bobo, Leed-Kelly, & Sitorius, 1998). The client's presence in substance abuse treatment is a unique opportunity to address his or her dependence on nicotine, build motivation to change, and present treatment options. Several clients in our own program have indicated that they would return for help in quitting smoking if a formal intervention was offered and was specifically tailored for persons in recovery. Substance abuse programs may ultimately be able to engage more substance abusers in SC by offering the treatment within their own center instead of referring to outside services.

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