Brief Intervention for Smoking Cessation in Substance Use Treatment

By Carol Daws

Tobacco Related Harm -Why Intervene

- Britton & Edwards (2008)

  - Tobacco responsible for the deaths of more than 100 million people

  - Currently, worldwide there are around 1.1 billion smokers

  - Expected to reach 1.6 billion by 2025

- Australian Institute of Health and Welfare (2008)

  - In the past 16 years smoking rates in Australia declined by 30%

Tobacco Related Harm

- Ridolfo & Stevenson (2001)

  - Despite this, tobacco use remains the leading cause of ill health and preventable death in Australia

  - Contributes to more drug related hospitalisations than the combined consequences of alcohol and illicit drugs

- Doll (1998), US Depart Health (2004)

  - Positively linked to more than 40 diseases

  - Risks include non-smoking bystanders

Benefits of Quitting

Time since Quitting	Benefits
20 minutes	Heart rate reduces
12 hours	Blood levels of carbon monoxide reduced dramatically
2 weeks to 3 months	Heart attack risk is reduced, lung function improved
1–9 months	Coughing and shortness of breath decrease
1 year	Risk of heart disease reduces compared to smokers
5 years	Stroke risk is reduced to that of non smoker, risk cancer decreases
10 years	Risk lung cancer half that of continuing smoker and reducing, risk other cancers decreases
15 years	Risk of heart disease is same as non smoker. All cause mortality declines to same as non smokers
	Source: US Depart of Health and Human Services (2004)

Smoking Interventions

- Lancester, Stead, Silagy & Sowden (2009)

  - Some form of smoking cessation treatment acts as aid to support further attempts

  - Primary care physicians have important role given 75% visit doctor

- Savrin (2008)

  - Even brief advice increases quit rate

- Rice & Stead (2000)

  - Nurses are effective with treatment through structured smoking cessation interventions

Smoking Interventions

- Hughes (1993)

  - NRT in combination with psychotherapy effective

- Hall et al. (2002)

  - Antidepressant medication such as buropion is effective

- Health Department (2008)

  - combination therapy, such as fast acting gum, lozenges, inhalers and NRT effective for highly dependent individuals

Brief Intervention

- National Institute for Health & Clinical Excellence (2006)

  - An intervention that involves advice, discussion, negotiation, awareness raising or encouragement for individuals with problematic drug use

  - Provides a framework where counseling skills can be used to enhance motivation to change

Relevance to AOD Dependency

- Kalman (1998)

  - Tobacco smoking high among AOD dependent individuals

  - In treatment populations 74% - 88%

  - Heavy smokers, early onset, more dependent

  - more likely to have history of comorbid presentations

  - strong culture of smoking in mental health and AOD treatment settings

  - ingrained belief that they are not willing or able to quit

Relevance to AOD Treatment

- American Psychiatric Association (1994)

  - Recognised nicotine dependence as a psychoactive substance use disorder

  - Focus on treating illicit drug and alcohol use with no emphasis on tobacco in treatment settings

  - Health risk from tobacco smoking greater than risk drugs and alcohol combined

  - Given high prevalence of nicotine dependence in people presenting with substance use disorders, it is imperative to offer smoking cessation interventions

Barriers to Nicotine Dependence Interventions

- Guydish, Passalacqua, Tajima & Manser (2007)

  - Most frequently reported barrier for smoking cessation interventions was lack of staff training and knowledge

  - Nicotine dependence training was associated with more positive attitudes towards smoking interventions by staff and a greater likelihood of addressing smoking with their clients

Barriers to Nicotine Dependence Interventions

- Staff smoking was also noted as a barrier to the provision of smoking cessation interventions
  - Commonly held belief attributed to AOD workers included the view that substance users were not interested in quitting, particularly not in treatment
  - Further, that smoking cessation interventions could impede progress on treatment of other drug and alcohol use

Why Cyrenian House ?

- Restricts where people can and cannot smoke
- As of January 2008 Smoke Free WA Health System Policy (SFQAHS) became effective
- The policy applies to all staff, patients, visitors and contractors (buildings, grounds and vehicles)
- Aim to protect people from exposure to second hand smoke

Why Cyrenian House?

- As such, clients presenting to AOD treatment from detox would have been offered smoking cessation interventions
- These strategies would assist people to make both short and long term decisions about their smoking
- Smoking cessation in AOD treatment is essential,and staff should be trained appropriately as part of their routine work to deliver interventions

Policy on Smoke Free Environment

- Williams et al. (2005)

  - Having a policy that supports a smoke free environment in residential settings including: smoking in the grounds, financial implications, and developing workforce capacity (need to be considered)

  - A workforce trained in brief interventions for tobacco smoking

  - Staff who believe it is their role to intervene lends support to smoking cessation interventions within these facilities

Nicotine Treatment

- Fiore (2000)

  - All residents who smoke should be offered nicotine treatment

  - Those not prepared to stop smoking should be offered a brief intervention to increase motivation to address their smoking

  - Brief intervention can generally be offered by staff for little or no further cost than brief interventions for AOD use

  - Most TC's have access to medical support for NRT and prescription medications

Developing Workforce Capacity

- Workforce development is more than just education and training therefore in isolation is unlikely to bring about work place change
- There are a number of factors that may impact on an individuals capacity to transfer newly acquired knowledge, skills and abilities to work practices
- Training needs to be conceptualised in the context of a systemic approach to learning and development ie. improving individual, team and organisational effectiveness

Training Transfer

- Three main factors that are integral to the uptake of effective responses to AOD issues:
  - - Role competence: I have the skills and knowledge to respond
  - - Role confidence: I can do it
  - - Role legitimacy: It is a legitimate part of my role

    Needs to include opportunities for practice, supervision support, beliefs and values, as well as other organisational factors

What did we do?

- We spoke with the staff in the TC and raised the possibility of looking at a smoke free TC
- Developed a policy supporting an incremental approach to a smoke free environment in the TC
- Sought staff involvement to play an active role in both developing the policy and its implementation
- Staff selected two separate smoking areas for staff and residents
- Trained staff in brief intervention for smoking cessation

Brief Intervention Training for Tobacco Smoking

- Training was designed and delivered by Steve Allsop (Professor and Director of NDRI)
- Training was three and half hours duration and offered to Cyrenian House staff only
- Consisted of a series of lectures, small groups and skill rehearsal exercises
- Covered the effects of tobacco use and dependence, implications for interventions, a review of the steps in brief motivational

Brief Intervention Training for Tobacco Smoking (cont)

- interviewing, and the use of the ‘5 A’s’ (a summarised version of brief intervention for tobacco cessation) approach to tobacco interventions
- Pre and post training participants were asked to complete a questionnaire. A follow-up questionnaire was completed six weeks post training
- Participants in the control group were offered the training when the study was complete
- NDRI website for online version of training is:
- http://ndri.curtin.edu.au/

Outcomes

- The findings from this study support the provision of brief intervention training for tobacco smoking for staff in TC's and AOD treatment settings as one component of an incremental approach to a smoke free environment
- Staff who received the training were more confident in responding to smoking related issues and believed they had a legitimate role to respond
- Participants in the training group also had a greater knowledge of tobacco interventions at post and followup levels of knowledge
- It should be noted that it is the package of organisational support, policy development for smoking cessation, staff training and education is required to ensure success of smoking cessation interventions in AOD settings

Where to next?

- It is envisaged that this study will provide a role model for other TC's and AOD treatment centres to emulate by doing the following:

  1) Implement a smoking cessation policy

  2) Provide training and education to their staff to provide brief intervention for their residents and clients for smoking cessation

  3) Develop and implement a smoke free environment for all persons attending and working in a TC or AOD treatment setting

What to do

- Get staff on side – Take the time to talk it through, share the research, explain the advantages, support staff in quitting etc
- Staff actively involved in the development and implementation of a policy on smoking in the TC using a developmental approach
- Designate two separate areas for smoking for staff and residents – role modeling
- Provide the Brief Intervention for Smoking Cessation Training to all staff
- Ensure all residents are screened for smoking and interventions provided