Smoking cessation and addictions services
working together to support the needs of people with a history of substance misuse

30 March 2012 The Salvation Army, Gorgie Road, Edinburgh

Report of a conference and the actions arising

Action on Smoking & Health (Scotland) (ASH Scotland) is a registered Scottish charity (SC 010412) and a company limited by guarantee (Scottish company no 141711).
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The event planning group and report editors

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Executive summary

A partnership of organisations operating smoking cessation, alcohol and drug addictions services held a successful conference to explore common ground in the treatment of substance misuse. The event raised awareness of the benefits of smoking cessation for people with substance use problems and engaged managers and practitioners across sectors in a dialogue over shared concerns relating to referral and cooperation.

All the delegates who responded to the evaluation rated the event as excellent or good. 34 out of 35 respondents (from 64) said that the event provided new insight and new knowledge relating to smoking cessation and addiction services. All agreed that this event was successful in sharing knowledge and providing insights into the ways cessation and addiction services can support each other’s clients.

The plenary session speaker showed nicotine to be a highly addictive drug which acts upon neural receptors in the brain in a mode analogous to cocaine and amphetamines\(^i\). There is a strong link between smoking and alcohol dependence\(^ii\) and alcohol and nicotine interact to increase craving for nicotine, which counters the depressant effects of alcohol. An estimated 80% of alcohol-dependent people smoke\(^iii\) and more alcohol-dependent clients die of tobacco related illness than alcohol-related problems\(^iv\).

A much higher proportion of smokers than non-smokers are alcohol dependent\(^v\) and co-dependency has significant synergistic effect on health risks\(^vi\). Studies of methadone, cannabis, cocaine and ecstasy users have shown 90% or more are smokers\(^vii\). A meta-analysis of 18 studies has shown that addressing tobacco use in clients can improve their alcohol and drug outcomes by an average of 25%\(^viii\).

Suggestions for policy, practice, research, training and resourcing were put forward at the event by experts in the field of smoking cessation and substance misuse treatment, both in plenary sessions and through dialogue with experienced practitioners in parallel workshops. Notes of these discussions and responses from a post-event evaluation have been distilled with the help of the expert event planning group into recommendations for action by policy makers and service providers.

Policy and practice

The provision of smoking cessation within addictions and mental healthcare settings should be standard. In order for this to happen there needs to be a greater level of support from senior addictions staff and policy makers to acknowledge smoking as an issue for their client group and encourage their staff to consider their clients’ smoking status and provide interventions to address this. This will require a change in culture within addictions services to de-normalise smoking both for staff and clients.

Two models were presented for the inclusion of smoking cessation within substance misuse settings.

1. Smoking cessation provision can be embedded in the service with addictions staff providing support for their clients to stop smoking as part of a holistic programme of health improvement.
One advantage of this approach is a reduction in staff smoking and a move towards a service where smoking is de-normalised more effectively. In addition this approach may more effectively embrace the findings of research studies showing the efficacy of tackling smoking and other substance misuse together in order to maximise success in maintaining abstinence.

2. The other model is to work closely with smoking cessation services to refer clients to specialist smoking cessation advisors. This allows the service to concentrate on provision of alcohol and drug treatment avoiding the need to renegotiate funding agreements in the delivery of care. This approach has the advantage of fashioning good working relationships between services and reciprocal referral arrangements.

Pharmacists were identified as having a key role to play since they are often involved in the treatment of substance abuse, for example in the supervised administration of methadone and in support for smoking cessation through carbon monoxide monitoring and nicotine replacement therapy (NRT) prescription.

In some areas ‘cut down to quit’ has yet to be adopted as a tool in the smoking cessation armoury. Those with alcohol or drug issues are more likely to be heavy smokers with whom this approach may be a route to cessation and should be considered as an option in interventions.

Cannabis is the second most frequently used main drug among drug users attending addiction services but there are few services offering support to users who wish to quit. Where there is provision, there is heavy demand on the service and where there is not, smoking cessation services are often the first to be approached. There is a clear need for services to work in partnership to provide cannabis cessation support and to make the case for resources to be allocated.

Ensuring continuity of care is an issue across the sectors. Those recovering from substance abuse in prison and mental healthcare settings may have also begun smoking quit attempts and there should be support for them when they return to the community to support abstinence.

Services should develop good networks of communication and take time to evolve combined approaches that ensure sharing learning and shared objectives in the provision of care.

Poly-substance users may present themselves to stop-smoking services before approaching addictions services and vice-versa and will often have accompanying mental health problems.

Practitioners need to recognise the complexity of people’s situations when they are polysubstance users. There was an acknowledgement that one approach does not suit all clients, it should be individual care in which the patient’s own strengths are identified and used to help them succeed in their quit attempt.

Poly-substance users should be asked if they wish to stop-smoking and given appropriate support to do so. More research is needed to clarify the benefits of a dual approach to smoking cessation and other addiction therapies and to identify the most effective combinations of treatment.
Training and resources

There was a call for more regular meetings and events to enable sharing of best practice between services especially where partnership working is concerned. Workers from both stop-smoking and drug and alcohol services have mutually beneficial skills.

There should be annual continuing professional development (CPD) sessions for addictions staff on smoking cessation and annual CPD sessions for cessation staff on other substances.

Shadowing of each other’s services to aid personnel working in addiction and cessation fields to gain better insight into strengths (and gaps) in each service can bring benefits to clients.

Where services are not integrated, smoking cessation services should provide briefing sessions to local addiction services to raise awareness and inform addiction workers of cessation services available locally. The aim would be to break down any reservations addiction workers may have about what happens in a stop smoking support service.

In recognition of the growing contact with substance misusers and heavy alcohol users, cessation staff would benefit from training provided by local addictions services and through these initiatives better referral pathways can be established.

Addictions counsellors may have a greater grasp of issues relating to mental ill-health than cessation staff but this may be an area where training could be provided in partnership across the sectors.

Training in smoking cessation and support around cannabis misuse should be more widely available, or more widely publicised, for addictions services- especially activities, resources and support tailored to young people.
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tr>
<td>09.30-10.00</td>
<td>Coffee and registration</td>
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<tr>
<td>10.00-10.15</td>
<td>Introduction: Conference Chair [Dave Liddell], Director of Scottish Drugs Forum</td>
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<td>10.15-10.40</td>
<td>Who are we trying to help? Major Dean Logan, Territorial Addiction Services Officer, Salvation Army</td>
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<td>10.40-11.05</td>
<td>Why can't people quit smoking? David Balfour, Professor of Behavioural Pharmacology, University of Dundee</td>
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<td>11.05-12.20</td>
<td>The harm caused by tobacco and the benefits of quitting for users of alcohol, cannabis and other drugs Dr Amul Patel, Consultant Psychiatrist, NHS Fife</td>
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<td>11.25-12.50</td>
<td>First parallel session with time for comfort break and coffee (session 50 minutes)</td>
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<td>Improving mental health through treatment of addiction: examples from alcohol and smoking cessation services. Peter Rice, Consultant Psychiatrist with Tayside Alcohol Problems Service (TAPS) will give an overview of the interaction between substance misuse and mental health.</td>
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<td>Peter and Denise Meldrum. Smoking Cessation Nurse at Levernade Hospital in Glasgow will describe some case studies of improved mental health through addiction and smoking cessation support and invite comment and discussion.</td>
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<td>Differences and similarities between treating nicotine, opiate and alcohol withdrawal. Brian Pringle, Director of Projects and Services, ASH Scotland and Dr Saket Priyadarshi will describe pharmacological approaches to nicotine, opiate and alcohol dependency. What can cessation and addictions practitioners learn from each other?</td>
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<td>Managing cannabis cessation. Cheryl Irvine from WLNAS, Scotland's only dedicated cannabis cessation worker and Maureen Heddle, Tobacco Development and Support Worker at Aberdeen Foyer will talk through their approaches to cannabis cessation with the help of some case studies.</td>
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<td>12.25-13.00</td>
<td>Supporting our long-term opiate users to improve their respiratory health. Dr Saket Priyadarshi, Senior Medical Officer, Greater Glasgow and Clyde Addiction Services with Karen Mather, Health Improvement Senior (Tobacco), NHS Greater Glasgow and Clyde</td>
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<td>Smoking, cannabis, opiates, alcohol an integrated approach. Margot Ferguson, General Manager of West Lothian Drug and Alcohol Service</td>
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Lunch

Return for questions and debate from the panel of speakers
Chaired by Dave Liddell with Dean Logan, Dr Amul Patel, Margot Ferguson, Saket Priyadarshi and Brian Pringle.

Second parallel session with movement time and comfort break at the end
(session 45 minutes)

Group work and one to one with recovering drug and alcohol users who want to quit
Brian Saunders, Addictions Therapist, NHS Lothian will describe a small group programme on smoking cessation with those who are in recovery from addiction (alcohol and drugs). Brian Murphy, Floating Support Project Manager, Grenchock Salvation Army Addictions Service will describe one to one support to recovering substance users.

Supporting smokers and drinkers. Is there a role for buddying in smoking cessation and alcohol interventions?
Alan Curley, Health Improvement Team Senior, Renfrewshire CHP, Smoke free Services and Joe Callary a quit smoking buddy will describe a supportive service for smokers in Renfrew. Mark Gallagher, Area Manager, Phoenix Futures Glasgow will outline support for recovering substance users in Glasgow.

Providing support and advice to pregnant women on smoking and substance misuse issues
Lorraine McLeod, Specialist Midwife Substance Misuse, NHS Lanarkshire will provide a discussion opportunity for those interested in how pregnant women can be helped to improve their health and that of their baby in a supportive, non-judgmental way.

Supporting clients with multiple needs
David T. Gray, Phoenix Futures HMYOI Polmont, and Jeanne Rutherford, Area Manager, Phoenix Futures will describe the referral and assessment process including smoking cessation support within a prison setting, the client journey illustrated by use of an outcome star and the relationships built between different service providers in a prison setting.

What are the lessons for services operating in community settings?

Closer working between cessation and addictions services
Conference Chair, Dave Liddell, Director of Scottish Drugs Forum Open forum. What have we learned that can improve referral between services and embed support for all forms of substance misuse in our approach to health improvement?

Conference closing remarks
Conference aims and objectives

In 2011 ASH Scotland in partnership with Alcohol Focus Scotland staged a successful conference focusing on tobacco and alcohol health policy issues. Inspired by this example the STCA Coordinating Group conceived a one-day conference for those working and supporting smoking cessation, drug and alcohol services to share good practice and debate some of the key challenges and solutions in continuing to reduce substance use in Scotland.

The conference learning objectives:

- understand the importance of addressing respiratory ill-health resulting from tobacco, cannabis and other smoking
- recognise the differences and similarities between the support offered to recovering poly-drug users and quitting tobacco smokers
- identify opportunities to support clients from the parallel services (drug and alcohol addiction and stop-smoking services) through referral
- consider how the smoking cessation client group can best be supported, particularly in regard to cannabis and alcohol use
- make an effective contribution towards good practice in addiction services that enables clients to be better supported in regard to their smoking.

The event was intended to not only raise awareness of the benefits of smoking cessation to people with other substance use problems but to engage practitioners and management from across sectors in a dialogue over shared concerns relating to referral and cooperation.

Conference evaluation

- 64 delegates attended the event, including presenters and 35 people responded to the on-line evaluation and comment invitation.
- 100% rated the conference excellent or good (51%) overall
- 100% rated the plenary session speakers as excellent (51%) or good
- 97% strongly agreed or agreed that this event has provided new insight and new knowledge relating to smoking cessation and/or addiction services
- 100% agreed that this event was successful in sharing knowledge and providing insights into the ways cessation and addiction services can support each other’s clients
- 49% having returned to work as a service manager, educator, policy advocate, provider of support or care felt that they would change the way they worked and 37% felt that the event reinforced current knowledge and practice
- 23 out of 30 respondents offered ideas for further action.
**Conference planning**

The conference was developed through a partnership planning group drawn from representatives of smoking cessation, drug alcohol and addictions services. This approach ensured that the event would be relevant to both cessation and addictions based professionals, helped to identify a range of presenters to give good coverage of the subject and engage interest across the sectors.

The cost to delegates of staging the conference was off-set with a financial contribution from the ASH Scotland Inequalities Project and NHS Health Scotland. The Salvation Army provided a suitable venue, resonant with the purpose of the event and good value catering and channelled resources back into the community and voluntary sector.

**Conference presentations**

Most of the conference presentations are available to download from the ASH Scotland website: [Tobacco and Substances Event](#).

**Why can’t people quit smoking?**

David Balfour, Professor of Behavioural Pharmacology in the Medical School at Dundee University provided an elegant introduction to the behavioural properties of nicotine. The key learning points for those working in addictions services from Professor Balfour’s presentation was that nicotine is an addictive substance with addictive properties similar to those of other addictive substances that they are already familiar with.

Nicotine evokes a ‘pleasant’ or ‘rewarding’ effect which is sought by the smoker and withdrawal, following a period of chronic treatment elicits an abstinence syndrome characterised by symptoms such as craving, difficulty concentrating, depression and anxiety.

The mechanism for mediating the rewarding feeling comes from the increased release of dopamine in the brain (as with cocaine and amphetamines) and there are observable changes to brain structure as a result of sustained smoking. The addictiveness of nicotine alone does not account for the powerful addiction to tobacco experienced by most smokers. Secondary reinforcers present in tobacco smoke also seem to play an essential role in maintaining smoking particularly when the receptors which mediate the effects of nicotine in the brain are desensitised (made tolerant) to nicotine by sustained exposure to the drug and no longer stimulate dopamine release. The secondary reinforcers include the sensory stimuli present in tobacco smoke which irritate the mouth, throat and bronchi whilst smoking. Other chemicals found in tobacco smoke may also enhance the effects of nicotine and increase the addictiveness of the drug when delivered in tobacco smoke.

**The harm caused by tobacco and the benefits of quitting for users of alcohol, cannabis and other drugs**

Dr Amul Patel, Consultant Psychiatrist in General Adult Psychiatry, NHS Fife described the harm caused by smoking particularly among substance abusers and the efficacy of
combining treatment for substance abuse with smoking cessation. Dr Patel also addressed the prevailing attitudes and knowledge of smoking within addictions services.

In a recent survey of an addictions ward at a Scottish hospital he found that both staff and patients regarded smoking cessation as important although some staff did not envisage offering help as part of their role. This despite having a good knowledge of the harm caused by smoking; that smoking is the single most preventable cause of death and disability. Surveys such as these are useful for turning what is suspected anecdotally into a clearer indication of a need for culture-change within addiction services; staff need to be more proactive in relation to smoking cessation and one barrier is their attitude towards the importance and effectiveness of intervention.

Mental ill-health is of course strongly associated with drug and alcohol abuse but smoking is also associated with increased prevalence of all psychiatric disorders and smokers are more likely to have thoughts of self-harm.

There is a strong link between smoking and alcohol dependence, more alcohol-dependent clients die of tobacco-related illness than alcohol-related problems. A large-scale survey in the United States suggests that people who are dependent on alcohol are three times more likely than those in the general population to be smokers, and people who are dependent on tobacco are four times more likely than the general population to be dependent on alcohol. Co-dependency has significant synergistic effect on health risks. Studies of methadone, cannabis, cocaine and ecstasy users have shown 90% or more are smokers.

The key points from Dr Patel’s presentation related to the benefits of considering smoking along with drug treatment because nicotine deprivation increases alcohol craving and consumption in non-clinical hazardous drinkers, smoking increases alcohol craving and relapse post-treatment, smokers have a harder time abstaining from illegal drugs than non-smokers and drug using smokers have a harder time quitting. And yet a meta-analysis of 18 studies has shown that addressing tobacco use in clients can improve their alcohol and drug outcomes by an average of 25%.

**Supporting long-term opiate users to improve their respiratory health: a pilot project within North East Glasgow Addictions Service**

Saket Priyadarshi, Senior Medical Officer with GGC Addictions Service and Karen Mather, Health Improvement

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Smoking cessation can be integrated into alcohol and drug misuse treatment without jeopardising recovery goals. Given the improved physical and mental health improvement following from stopping smoking, why as health professionals would we not offer our clients the opportunity to quit smoking? Dr Amul Patel.

**AIM of the NE Glasgow Addictions Service Cessation Project**

To establish a service where clients are routinely asked about their smoking status, given information about the smoking cessation service and offered a referral/signpost to the on-site service.
Practitioner (Tobacco) described how their initiative to tackle smoking in opiate users came about.

Firstly there was joint recognition of the high incidence of smoking by drug users in North East Glasgow which if tackled would not only be serving the Glasgow Tobacco Strategy and the Alcohol and Drugs Partnership Strategy but would make a contribution to reducing a health inequality and contribute towards 2011 to 2014 HEAT Targets.

One of the core principles of the Glasgow Tobacco Strategy is that all smokers should have the right to receive stop smoking advice and support through the NHS. It states that we should tailor the service model to meet the needs of key priority groups. Clients attending addiction services were seen as a key group. A key part of the Alcohol and Drugs Partnership Strategy for Glasgow City is around recovery and the partnership identified health improvement through cessation as part of a person’s recovery.

An initial survey of addictions service clients showed that they were all smokers; over 40% were interested in getting advice on quitting and only half had been offered support in the past.

Before the project started the three addictions clinics in the area, linked surgeries and pharmacies were visited by cessation staff to raise awareness of the project aims and objectives, enlist support of staff, clarify referral pathways and explain how NRT may be prescribed for clients. The cessation specialist involved shadowed the addiction workers within the clinics to become more familiar with the client group and some of the challenges faced by staff.

Encouragement would be given to clients to set a quit date but arrangements were made to record other aspects of the intervention and recognise engagement and reduced smoking amongst clients.

Clients are referred by the addictions workers once their suitability for the service and willingness to quit is assessed. The intervention is offered on a 1-2-1 basis with the client for up to 12 weeks of intensive support and using a withdrawal oriented model in conjunction with motivational interviewing. CO levels are checked weekly – as a motivational tool.

NRT can be offered for use in line with the NHS GG&C Smoke-free Services protocol. These products include patches, gum and lozenges – guidance from the Public Health Pharmacist for NHSGG&C and Lead Pharmacist for Glasgow Addiction Services indicated that Varenicline would not be an option for clients within this project.

As with other services there are drop-outs and non-attenders. Several attempts are made to re-engage but in the end there will be reasons for non-attendance. The client may simply decide that they are not ready to quit or other things in their life take priority. Clients who are seen by an addictions worker at home need to be really motivated to come to a Tuesday clinic and some fall at this hurdle. The client group have many serious issues which can undermine confidence and affect motivation, in addition to health problems relating to substance abuse such as mental health issues, financial issues and housing problems. However, these problems are not exclusive to those recovering from substance abuse and are part of the challenges faced by clients and cessation staff working with a mixed client group.

The health improvement practitioner from the tobacco team played the (key role in the pilot) and although the CAT staff were involved in referral and signposting, it was the health improvement
practitioner who carried out the key interventions, and had the expertise and time to provide the support. The cessation and addictions service partnership sees this project as a component of a social model of health; treating the person as an individual and providing opportunity for the improvement of their wellbeing.

Karen Mather, Health Improvement Practitioner (Tobacco), 0141 201 9832, Karen.mather@ggc.scot.nhs.uk.

**Integrating tobacco work in an addiction service**

Margot Ferguson, General Manager, West Lothian Drug & Alcohol Service

A Local Tobacco Alliance was established in 1992 by the Chief Executive of West Lothian Healthcare Trust who saw the clear link between poverty and smoking. At the time there were no smoking cessation services and so, because tobacco is an addictive substance an initiative was started to integrate tobacco policy development & cessation work into the West Lothian Drug and Alcohol Service (WLDAS).

From the beginning of this work the links between drug, alcohol use and smoking were clear. Clients to the service were using more than one substance and that there was a need to address this.

In 1993 tripartite funding for our tobacco post (Development Worker) was found from NHS Lothian, West Lothian Council and Lothian Region. Various tobacco initiatives soon followed:

- an audit of smoking needs for people with mental health
- a pilot of a youth smoking cessation project “Cloud Nine” which is still funded today.
- a pilot education project in two local secondary schools and their cluster primaries “Pack It In”
- adult smoking cessation posts for difficult-to-reach clients
- a pilot older people and smoking project.

WLDAS has been very proactive in tobacco policy and smoking cessation in West Lothian for the past 20 years. However, much of our specific funding for smoking cessation interventions has recently ceased.

Even though we were very active in assisting smokers, we like many drug and alcohol agencies were less proactive with our drug and alcohol using clients in supporting them to cut down or stop smoking.

We are addressing this with a contract with West Lothian Tobacco, Alcohol and Drugs partnership to deliver tobacco brief interventions will all our clients and have staff trained to deliver cessation support.

Closely linked to our smoking cessation work is support for cannabis users. Cannabis is the most widely used illicit substance; the drug of first choice for many drug users. Since it is commonly
smoked with tobacco it is difficult to provide supportive treatment for those suffering from years of heavy cannabis use without also considering tobacco use.

In the past, due to the demand, drug services worked predominantly with opiate users and are not particularly geared to treating cannabis users and in our experience cannabis users avoid drug services because they do not see themselves as ‘heavy drug users’, nor do they sometimes see themselves as smokers. Some cannabis users will present to stop smoking services. 80% of young clients (ASH Scotland Young People & Smoking Pilot Projects) were found to be cannabis users. In a snapshot survey of users of cannabis in mental health services in West Lothian approx. 50% had used cannabis.

The Cannabis Interest Group set up in West Lothian in October 2003 as a sub group of the Local Tobacco Alliance established that there was a need for a service to tackle cannabis use and pioneered cannabis cessation training for Scotland. Following on from the training, West Lothian Tobacco, Alcohol and Drug Partnership commissioned a specialist cannabis cessation worker at WLDAS. The worker always has a full case load of clients being supported to quit cannabis use and reduce and quit tobacco use.

The experience accumulated by WLDAS should be invaluable in generating the policies and protocols required to enable support for cannabis and tobacco users in other parts of Scotland.

In the future it would be helpful to see the Scottish Government consolidating a single funding stream for all treatment for substance misuse so that the linked addictive behaviours associated with opiate, stimulants, alcohol, cannabis and tobacco use may be dealt with holistically in a variety of different professional settings.

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**Improving mental health through treatment of addiction**

Peter Rice, Consultant Psychiatrist with Tayside Alcohol Problems Service gave an overview of the interaction between substance abuse and mental health and Denise Meldrum, Smoking Cessation Nurse at Leverndale Hospital introduced a typical case study.

**Discussion**

Is there a role for cessation and addictions staff supporting positive mental health?

There is a good evidence base to assert that giving up the use of substances and or tobacco improves mental health and wellbeing and delegates agreed that this has positive impacts on self-esteem. Counselling staff from both services have the opportunity to contribute to improved mental health throughout the intervention. Practitioners have training in behavioural change that can be easily built upon to help motivate and improve the self-esteem of clients.

In addictions counselling it is part of the intervention to enhance self-esteem and motivate the individual to make a quit attempt possible, and success feeds back to increase self-esteem and happiness. One area where addictions staff may have more expertise than those working in cessation services is in maintaining or enhancing coping strategies, although clearly there will be much that experienced cessation practitioners could share with addictions staff specifically in relation to smoking.
One area of consensus within the group was that where patients are concerned, irrespective of their state of mental health, they ought to be provided with the information about the harm caused by their smoking, the benefits to them of quitting and the support available to help. Professionals should not make the decision to avoid providing that information from a mistaken belief that this would somehow complicate the patient’s life.

The view was expressed that mental health patients who are heavy smokers often show signs of respiratory problems such as wheeze and shortness of breath (signs of potential Chronic Obstructive Pulmonary Disease (COPD)) and will themselves deny it. Liaising with GP’s or ward staff to have these symptoms investigated (since they may not bring them to the attention of a doctor themselves) may help to highlight the damage a smoker is inflicting on their physical health and motivate them towards a quit attempt. This obviously applies to patients with other substance issues to be addressed as well.

In terms of the support that might be offered to someone who is presenting for quit support and who may need help with a mental health problem, a brief intervention that poses questions and provides motivation to make a self-referral for support from a GP should be something that cessation practitioners could be comfortable with.

Training through the mental health first aid programme or choose life (suicide prevention) might be considered as part of a counsellors professional development.

**Useful references:**

For resources Quitting in Mind Website may be helpful: [www.quittinginmind.net/resources.html](http://www.quittinginmind.net/resources.html)

*Tobacco use and people with mental health problems* (updated April 2011) (pdf 84kb)


Training on line:

[www.northlanmindset.org.uk/](http://www.northlanmindset.org.uk/)

[www.mindset.scot.nhs.uk](http://www.mindset.scot.nhs.uk)

Health Scotland VLE website / mentally healthy workplaces
The differences and similarities of treating opiate, alcohol and tobacco withdrawal

Utilising several case-studies Dr Saket Piryadarshi and Brian Pringle described approaches to managing addiction with behavioural and pharmacological support. Through discussion of these case studies a list of similarities and differences in treatment was generated.

It was noted that each area of substance misuse has a tool to measure dependence. Tobacco services initiated treatment quicker than drug or alcohol services. Drug and alcohol services provided a more comprehensive package of care than tobacco services, often involving other agencies or staff and engaging in more planning and review.

Drug and alcohol services were more holistic in their approach to client health. Tobacco services wanted to be better able to support the wider health needs of clients. Across the three areas funding restrictions and priorities shaped what could and couldn’t be provided. All areas used when applicable some form of pharmacological support combined with behavioural support. Drug and alcohol services had far more of a say when discharge from services took place than tobacco services where policy rather than client need dictated discharge.
Post-conference observations and suggestions for action

Delegates to the conference were asked to evaluate the event, to outline what action they might take as a result of attending the event and to provide suggestions for improving services for poly-substance users and any ideas they might have for future action by the STCA and others.

The table below shows responses sorted into a number of different categories and edited to improve readability and reduce duplication. The full evaluation is available from ASH Scotland on request.

<table>
<thead>
<tr>
<th>General observations</th>
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<tr>
<td>I was interested to hear and see how relapse of alcohol users has a high correlation with smokers that do not also tackle smoking cessation.</td>
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<tr>
<td>Shadowing of each other’s services to aid personnel working in addiction and cessation fields to gain better insight into strengths (and gaps) in each service can bring benefits to clients.</td>
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<tr>
<td>We need to recognise the complexity of people’s situations when they are poly-substance users. Recognition that addiction clients deserve better access to smoking cessation services even if ‘hard’ outcomes take more time to achieve.</td>
</tr>
<tr>
<td>Patients in mental health units are not allowed to take illicit drugs or alcohol so it is unclear why smoking is perceived as acceptable and a patient choice? Surely the choice to be able to take alcohol or drugs also applies? A change in culture is required led by mental health.</td>
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<tr>
<td>Acknowledge one approach does not suit all clients, it should be individual care. Identify patients’ own strength and use it to help them succeed in their quit attempt. Always involve clients in every step of planning of their attempt to quit and further decision making. Provide information on what has been helpful to others when offering support, and then suggest to patient whether group work or one-to-one is more appropriate.</td>
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<tr>
<td>More research is needed to build the case for treating smoking alongside other addictions.</td>
</tr>
<tr>
<td>Normalising smoking cessation treatments or at least offering it as standard across mental health and addiction services is a goal too.</td>
</tr>
<tr>
<td>I would have like to have seen someone from the Government speaking at the event and would like to see the Government ensuring that ADP’s take on the subject matters raised at the event.</td>
</tr>
<tr>
<td>The issue of cannabis use and tobacco has to be bottomed out as if the drug worker wants to help with cannabis cessation then they likely also have to tackle the tobacco use, it really is fundamental and yet is the elephant in the room.</td>
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<tr>
<td>Suggest an electronic forum for sharing of information/good practice.</td>
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<tr>
<td>Suggest a commitment to follow up this event by designing and delivering a</td>
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</table>
workshop at the Scottish Smoking Cessation Conference and an equivalent substances event.

A request for research to be undertaken to explore the benefits/challenges/possibilities of a partnership approach to cessation/substances

An issue which I am sure effects other services is how to maintain continuity of care. In the case of prisoners they may begin or complete treatment in prison but when they leave support does not easily follow especially for young men leaving as non-smokers and being transferred to an adult prison. Prison cessation work might be regarded as being very challenging but it is surprising how successful quitting can be within the prison setting. It has surprised a lot of people.

Cannabis is certainly an issue with my substance using client group but I do not treat cannabis users because the number of referrals would simply be too many for my case-load.

Cannabis use is actually the main first drug of choice for clients but from what I have learned, there is very little attempt to tackle cannabis dependency in services outwith my own.

<table>
<thead>
<tr>
<th>Lessons for cessation services</th>
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<tbody>
<tr>
<td>It seems clear that cessation services have to get closer to their potential clients and be more flexible about how they reach smokers - as shown by Karen Mather’s presentation.</td>
</tr>
<tr>
<td>Identify if there is a need for further support after a successful quit attempt.</td>
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<tr>
<td>Educating staff/volunteers that smoking cessation is the responsibility of all and not just an option to those more educated about their health.</td>
</tr>
<tr>
<td>That we shouldn’t be cautious about developing networks with drug and alcohol workers in our patch, although it will take time to develop any combined approaches we can do so much for each other and learn from each other.</td>
</tr>
<tr>
<td>The issue of ‘reduce to quit’ came up as an approach which should be considered for heavy smokers and yet (in England and I think also in Scotland) our protocols don’t really allow for this except as a pilot. It seems to me that the heaviest smokers are also likely to use alcohol and their alcohol abstinence is enhanced if they quit smoking, it’s our view that we should be able to use this approach more easily.</td>
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<table>
<thead>
<tr>
<th>Lessons for drug services</th>
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<tbody>
<tr>
<td>Embed smoking cessation practitioners in each substance misuse service. Have those from substance misuse services educate smoking cessation service practitioners on the difficulties that their client group can face that can make cessation difficult.</td>
</tr>
<tr>
<td>More active and regular encouragement of service users to access smoking cessation.</td>
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</tbody>
</table>
Promote empathy when dealing with smokers - listen to them to see if continuing to smoke is their choice.

Change in attitude around smoking being perceived as 'normal' behaviour is required.

In our drug and alcohol service, where the cessation service is already embedded we have found that the policy has led to fewer smokers on the staff and everyone will be aware that smoking staff members can be a barrier to tackling smoking.

It has proved helpful to be able to refer to the cessation specialists. Addictions staff would no doubt be qualified and capable of effecting an intervention in support of quitting but given the numbers involved it would reduce the number of addictions clients they could see.

We have found that 9 out of 10 of our alcohol clients smoke. The evidence base shows that relapse to alcohol is predicted by continued smoking. Sustained sobriety is improved by addressing smoking after initial support to reduce and stop drinking. Why would we not help our clients to stop smoking?

<table>
<thead>
<tr>
<th>Action by cessation practitioners</th>
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<tbody>
<tr>
<td>I will incorporate more statistical information into my work, as from experience I feel clients respond to this information.</td>
</tr>
<tr>
<td>Be more reflective and use a holistic approach when working with smokers who have mental illness and other substance misuse issues.</td>
</tr>
<tr>
<td>Encourage the development of a one stop service that makes good use of support services available to maximise the chance for smokers to address their smoking habit and have a better chance to succeed in quitting smoking.</td>
</tr>
<tr>
<td>Develop smoking cessation briefing sessions to local addiction services to raise awareness and inform addiction workers of cessation services available locally. The aim of this to breakdown any reservations addiction workers may have about what happens in a stop smoking support service. This would also enable appropriate referrals to be made as and when clients state they are ready to stop. Establish cross-referral protocol and pathways.</td>
</tr>
<tr>
<td>Annual CPD sessions for tobacco staff on other substances.</td>
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</table>

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<th>Action by drug service practitioners</th>
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<tr>
<td>I will share knowledge around benefits of cessation in mental health with mental health colleagues in an attempt to move cessation up the MH agenda.</td>
</tr>
<tr>
<td>Invite smoking cessation staff to come and speak to patients (addictions, mental health) in a group setting.</td>
</tr>
<tr>
<td>In conjunction with smoking cessation staff consider staff questionnaire to assess attitude to smoking and consider possibility of brief intervention for smoking.</td>
</tr>
</tbody>
</table>
I am going back to my service and plan to look at developing a pilot offering smoking cessation support to clients undergoing alcohol rehabilitation.

Build up better relationships with pharmacists regarding the positive benefit of those on methadone accessing NRT at the same time (some pharmacists understand the benefit of this relationship but there are others who use their judgement to tell clients that they should only deal with one addiction at a time).

Training on smoking cessation and support around cannabis misuse made more widely available (or widely publicised if they are available) for addictions services—especially activities/resources/support tailored to young person’s services.

I would like to see more joint working of staff at strategic and ground level from addictions and cessation services and a greater level of support from senior addictions staff and policy makers to acknowledge smoking as an issue for their client group and encourage their staff to consider their clients’ smoking status and provide interventions to address this.

Annual CPD sessions for addictions staff on tobacco.

**Cooperation**

Try and integrate smoking cessation service within addiction service.

Regular conferences/events to enable sharing of best practice between services: here isn’t much evidence out there so let’s create some by raising the issue of partnership working between services in these fields at as many opportunities as possible.

More proactive projects like the one in Glasgow (Karen Mather’s work) but not just with the health service - with all the voluntary sector substance abuse support agencies.

Build bridges between cessation services and substance misuse services to enable better connections and referral pathways.

Collaborative work with all healthcare professionals involved in providing care to this client group and good liaison between them to keep everyone involved informed will ensure continuity of interventions and support and re-enforcement of what is agreed by clients.

Delegates were asked:

*If you have ideas to take forward regarding what you might do to change your service, practice or policy please give an example or two.*

Twenty-three people provided a written response:

1. I am already in discussions over last few years with local addiction service for a pilot project. Unfortunately due to circumstances outwith both our hands this pilot has been delayed but
aim to start pilot in May this year. Pilot is working with EDAMH team who are delivering a recovery project and we will link in with project during behaviour change topic week.

2. More active and regular encouragement of service users to access smoking cessation.

3. Promote services that would benefit smokers wanting to quit smoking. Identify if there is a need for further support after a successful quit attempt.

4. Try and integrate smoking cessation service within our addiction service.

5. I was interested to hear and see how relapse of alcohol users has a high correlation with smokers that do not also tackle smoking cessation. I think I will in future, where appropriate, address this with clients.

6. I will incorporate more statistical information into my work, as from experience I feel clients respond to this information.

7. I'm at the start of a new project which will entail embedding smoking cessation more firmly within substance misuse services.

8. I will bring up smoking cessation more regularly and adapt how we approach young people seeking support around cannabis use.

9. Share knowledge around benefits of cessation in mental health with MH colleagues in an attempt to move cessation up the MH agenda.

10. Be more reflective and use holistic approach when working with smokers who have mental illness and other substance misuse. Encourage other professionals to use similar approach and offer patients a one stop service and make good use of services available to maximise the chance for smokers to address their smoking habit and better chance to succeed in quitting smoking.

11. Invite smoking cessation staff to come and speak to patients (addictions, mental health) in a group setting. In conjunction with smoking cessation staff, consider staff questionnaire to assess attitude to smoking and consider possibility of brief intervention for smoking.

12. I will try and take some of the learning from drug and alcohol services into my cessation coordination role.

13. Look at developing pilot offering smoking cessation support to alcohol rehab unit and share learning from conference with stop smoking advisors in team meetings.

14. Use information gained from presentations to inform advice to clients on NRT and cravings.

15. It has introduced the idea that smoking cessation should work alongside other treatments for better outcomes but it has also introduced some of the potential barriers to this. It was a very adult, mature and pragmatic discussion with a good emphasis on what works and what is empirically verifiable.

16. I have never underestimated the difficulty of quitting smoking, but now have a much better understanding of why it’s so difficult (it’s so much more complex than ‘nicotine is one of the most addictive substances’). I hope that will help me to give more realistic advice to those who want to stop smoking and I will certainly be looking to spread the practice of ‘buddy’ groups for those who have quit. I will be developing closer links with healthcare professionals who work in the field of mental health and hope to use this to improve the lung health of their patients.

17. I will definitely work on partnership relationships with the addictions services and I am keen to establish stronger working links with key partners.

18. I plan to share the info I gathered at the event with the rest of the team and will be making recommendations to my line manager on the issues discussed at the event.
19. Looking to foster better links with addiction services. Practical examples shared were helpful in considering ways forward. Will be sharing information with city-wide colleagues. I believe that this work has to be supported at a strategic level, rather than only a local level.

20. I will contact some of the people I met on the day to get their advice on how we move forward with the generic agenda.

21. Looking to provide smoking cessation services for a staff team.

22. More partnership work between local addiction and smoke-free services; develop cannabis support service.

23. Seek to actively visit the alcohol unit to make introductions, shadow and build relationships.

**Conclusion**

The high prevalence of smoking and often greater dependence on nicotine within groups of substance misusers puts them at greater risk of smoking related disease. This is further complicated by a higher incidence of mental ill-health amongst both smokers and substance misusers when compared with the non-smoking population.

Studies suggest that important mental and physical health benefits follow quitting smoking and that alcohol, cannabis and other drug users undergoing treatment for their substance misuse can be more successful in maintaining abstinence when their smoking is also tackled.

Services can learn from each other and develop robust cross-referral pathways and it is possible to integrate smoking cessation into drug and alcohol services once barriers such as misconceptions around smoking and drug treatment are addressed.

A clear commitment by service commissioners to recognise the value of reducing smoking prevalence amongst poly-drug users is required so that more progress can be made in reducing the burden of smoking on a section of society struggling to overcome serious physical and mental health issues.

The observations and the suggestions for action recorded by the conference delegates provided an insight into the commitment and dedication of smoking cessation and addictions staff in Scotland but also the challenges and constraints they face in their work. The post-event editorial group considered the event report and evaluation and put forward recommendations to service providers and service commissioners.

**Recommendations**

1. To ensure a positive attitude and proactive approach to tackling smoking and substance mis-use support in health care settings:

a. awareness of the cumulative physical and mental health burden of smoking along with other substance use needs to be raised within the healthcare community

b. the benefits to health and to successful treatment of alcohol and drug addiction when combined with smoking cessation, need to be communicated effectively.
2. Local smoking cessation and addictions services should coordinate to ease referral between services and improve provision of support for substance misusers.

3. Staff from both services should be provided with training that equips them to provide brief advice and referral to the other service.

4. More support is required within health care settings to support cannabis cessation.

5. Smoking cessation services should be supported to provide a more holistic approach to treatment that enables issues such as substance misuse and mental health to be taken into account when support is provided.

6. There needs to be support and encouragement given to the services and pilots currently in place to help them evaluate their work, identifying lessons learned on engagement, referral, changes in behaviour and well-being as well as successful quit attempts.

7. Scotland should work towards a national service delivery framework for smoking cessation and substance misuse services.

References


Become an STCA member

Join the community working towards a smoke-free society. Become an advocate for tobacco control in Scotland.

Contact the Alliance administrator: JBlack@ashscotland.org.uk or visit our Alliances page at ashscotland.org.uk

For further information about the conference or about tobacco and substance misuse please contact the Alliances Manager: DRobertson@ashscotland.org.uk

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