

# crosscurrents

AUTUMN 2008  
VOL 12 NO 1

The Journal of Addiction and Mental Health



## Clearing the smoke

### Tobacco, mental health and addiction

#### **ONE ADDICTION AT A TIME**

Is targetting tobacco too much for addiction services?

#### **"ENJOY YOUR CIGARETTES, IT'S ALL YOU HAVE"**

Stamping out the smoking and schizophrenia connection

#### **NO IFS, ANDS OR BUTTS**

Smoking bans pit client rights against client health

#### **SMOKE AND MIRRORS**

Smokeless tobacco and the harm reduction debate

#### **My suicide attempt**

Survivors share their stories of choosing to live

#### **Double whammy**

Are services improving for people with dual diagnosis?



**camh**

Centre for Addiction and Mental Health  
Centre de toxicomanie et de santé mentale

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Centre de toxicomanie et de santé mentale

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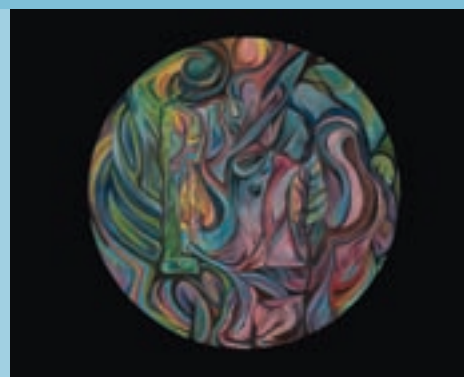
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Q&A

Smoke and mirrors? Smokeless tobacco and the harm reduction debate

*Untitled*, Christopher Hogue, acrylic on canvas, 36" in diameter

Christopher graduated from the fine arts program at Cawthra Park Secondary School in Mississauga, Ontario. His artwork has appeared nationwide, including multiple exhibits at the Ontario Lieutenant Governor's Suite.





Enjoy this stimulating issue of *CrossCurrents*. As always, send us your comments and ideas to keep the dialogue going.

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It's an indisputable fact that tobacco use causes death and disease, but what isn't common knowledge is the extent to which it affects the lives of people with mental illness and substance use issues – a population with a higher than average rate of tobacco use. In fact it is tobacco – a legal substance – that is the primary cause of death among people with mental illness or addiction to other substances, many of them illegal. This issue of *CrossCurrents* explores clinical, ethical and policy issues around tobacco use.

We begin the issue with a story that challenges the long-held assumption that substance use issues are best dealt with one at a time. The story presents a compelling argument for better integrating smoking cessation into addiction services. Anne Ptasznik's story on smoking and schizophrenia examines other long-standing assumptions about the smoking-schizophrenia connec-

tion and challenges clinicians to work with clients with severe mental illness to reduce the number one killer in this population. In a related story, Avril Roberts delves into the smoking ban debate, which pits client rights against client health. We also examine women-centred approaches to smoking cessation among pregnant women and new mothers, extending the scope of interventions to women's partners. The Q&A examines the harm reduction debate around smokeless tobacco products. Ylva Van Buuren discusses traditional tobacco use among First Nations communities and its implications for clinicians. Finally, in the Last Word column, Dr. Michael Perley of the Ontario Medical Association challenges us to consider why the provincial and federal governments continue to allow the illegal and dangerous contraband tobacco business in First Nations communities.

## a view from CAMH

Among the people I see with severe and persistent mental illnesses such as schizophrenia or bipolar disorder, I always ask about cigarettes; in contrast to the rest of Canadians, the majority of these individuals smoke. We then calculate together the cost per month of their tobacco dependence. It is not unusual for one-third or more of their income, if they are on public assistance, to go "up in smoke." Quite apart from the obvious short-term and long-term physical health consequences of smoking, the economic burden on the individual, and the difficult choices that result, are staggering.

And yet I am old enough to recall days not so many years ago when "good behaviour" on inpatient psychiatric units was "rewarded" with cigarettes. Until recently, our inpatient units had smoking rooms where people would both congregate socially and puff constantly. Staff would sometimes justify smoking for these individuals as "their only pleasure." So institutional culture both rationalized and

encouraged smoking among people with mental illnesses and/or addiction to other substances without concern for their broader health needs and their personal fulfillment needs.

In addition, smoking may meet a need beyond its own addictive properties, whether it is quelling anxiety or counteracting the side-effect of a medication. Some individuals may be genetically either more vulnerable to addiction to cigarettes or more resistant to smoking cessation interventions.

Meanwhile, public health and society at large leapfrogged ahead of the addictions and mental health communities, legislating against and shaming smokers. Smoking sections on airplanes and in restaurants and hotels have effectively disappeared, and the Canadian climate tests the hardiness of the committed smoker standing outside a building in February.

Several years ago, CAMH took the plunge and closed its inpatient smoking rooms, eliminating

smoking in the hospital (and freeing up the real estate for other purposes). But rather than simply implement a ban, CAMH trained its staff in smoking cessation techniques and made it feasible for nurses to implement nicotine replacement. Interesting discussions occurred at the level of ethics and safety before we took this step. Some predictions of the outcome were dire. But we asked ourselves how, as the Centre for *addiction* and mental health, we could turn a blind eye to the addiction that kills more Canadians than any other?

Smoking poses many questions regarding health, culture, economics, free will, free choice and institutional/governmental intervention. This issue of *CrossCurrents* touches on a number of them.

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# After my suicide attempt: Survivors share their stories of choosing to live

LESLEY YOUNG

Not a single day goes by that Brent Seal doesn't feel lucky to be alive. But it wasn't always like that. Seal attempted suicide in May 2007, after experiencing a relapse of schizophrenia. He's recovering very well, and slowly but surely reclaiming his life. "I feel very hopeful," says the 24-year-old. "I have the goals I had before, plus more."

Since the near tragedy, Seal is pursuing a business degree at Simon Fraser University in Burnaby, British Columbia, does volunteer work and is about to launch a club that offers microfinancing to people with mental illness. When asked what he would tell someone who is considering suicide, he says, "Just knowing there is hope might help. All the despair you feel is temporary. You can get past that phase and be hopeful again. I had no hope but it got back into me. I am full of it now. I have so much to live for."

Just how people who have attempted suicide get to that dark place – and emerge with new hope – is a mystery Dr. Jennifer Brasch is hoping to crack. Brasch, medical director of psychiatric emergency service at St. Joseph's Health Centre in Hamilton, Ontario, and her colleagues at McMaster University, launched the Reasons to Go On Living project this summer so mental health professionals would be better equipped to help people who are suicidal get to a positive place.

Getting to that place is important, given that more than 3,700 Canadians die by suicide every year, according to Statistics Canada, and countless others make an attempt or contemplate suicide.

It is this latter group that Brasch is focusing on. "It is surprising how much research is devoted to looking at risk factors for suicide and how little looks at how people make the transition," says Brasch, who is also an associate professor in psychiatry and behavioural neurosciences at McMaster University. "We know hopelessness is associated with high risk of completed and attempted suicide. I presume that a state of hopefulness is associated with choosing to go on living," she says. "If we have ideas about how people move to a state of hopefulness or how they transition to wanting to go one living before they make the suicide attempt, that would be powerful and effective."

Brasch is hoping to elicit some of those ideas through a narrative approach. She has asked people who have attempted suicide to recount their own stories anonymously on the project's web site ([www.thereasons.ca](http://www.thereasons.ca)). She will publish her findings after analyzing the stories for demographic information and common themes and structures. When enough stories have been collected, Brasch will post select ones on the web site to inspire and educate others. She thinks that for some people, telling their stories will be a valuable, reflective exercise to share how they have learned and grown from their experience.

The anonymity of the Internet may encourage people who might otherwise have remained silent to share these stories. Yvonne Bergmans, a suicide intervention consultant at St. Michael's Hospital in Toronto, says this is the first time people's stories are being elicited via a public medium that is completely anonymous and transparent. "People are given the freedom to talk about their story without being judged," she says. "I hope this project will give us a different approach for interventions – strategies that have meaning for clients. Right now a lot of what we have is based on risk factors and deficit models."

According to Karen Letofsky, executive director of the Distress Centres of Toronto, "Research increases the odds in what can sometimes feel like a crap shoot, because at the end of the day, suicide is highly individualistic," she says. At the very least, Letofsky is hoping that Brasch's findings will make clinicians better listeners. "Suicide risk assessment is an art rather than a science," she explains, adding that while there is a scientific component in terms of the types of questions to ask and signs to look for, the sensitivity with which those questions are asked and how we understand the answers is very nuanced. "The more stories we hear, the more we start to make sense of subtext, nuances and context, the better we fine tune our listening and train our inner ear." ■

For more information about the project and how to get clients involved, visit [www.thereasons.ca](http://www.thereasons.ca).

## TIPS FOR HELPING CLIENTS AFTER A SUICIDE ATTEMPT

Yvonne Bergmans, a suicide intervention consultant at St. Michael's Hospital in Toronto, and Karen Letofsky, executive director of the Distress Centres of Toronto, offer these tips for working with clients who are suicidal or have attempted suicide:

Hear the person's story, listen and believe. Do not tell them how they should feel.

Be genuine in terms of who you are. "It's about making a connection and having a rapport with the individual so that when they are speaking, they feel you believe

them and that they are not being judged," says Bergmans.

If there is a behavioural component to the person's expression, take the behaviour as a communicator. "Don't assume the person is able to or knows how to identify or articulate

what is going on for them at the time," says Bergmans. Avoid the tendency to diagnose the problem as opposed to what the emotional experience of that problem is to an individual. For example, what is the extent of the pain experienced when the problem is divorce?

Don't move into problem-solving mode until there is emotional de-escalation. A client running on emotion does not have the ability to reason, and it may make the situation worse.

The best way to emotionally de-escalate a situation is to be present in the moment and validate the client's feelings.

## Canada's first youth mental health court launches

ELIZABETH SCOTT

As our understanding of mental health and mental illness grows and evolves, our social institutions, including the justice system, are also slowly changing. In 2005, I became acutely aware of the need for the justice system to reflect progress in our understanding of mental illness when my 20-year-old son who has schizophrenia was referred by a criminal court to Toronto's adult mental health court. As a result of that positive experience, his recovery continues, without the permanent black mark of a criminal record.

This is the hope for other youth. Involvement with the legal system is often the first interface between youth – and others – with mental health issues and mental health professionals. Over the past 10 years, specialized “problem-solving” courts aimed at treating rather than incarcerating people in the hopes of decriminalizing behaviour linked to mental health issues and reducing recidivism have emerged. Canada's first drug treatment court opened in 1998; the country's first adult mental health court opened in 2001; and earlier this year, Canada's first youth mental health court launched in Ottawa. Today, approximately 20 cases are under the auspices of the court, which sits once a month.

“Everyone was noticing that there was a need,” says Tania Breton, a mental health court worker and one of the court's founders. “Many people played a role in starting the court – judges, defence lawyers and crown attorneys, among others. Since we all had a common interest in youth, we worked together to develop the court.” Surprisingly, the new regional provincial youth crown initiative did not require additional government funding in order to establish itself.

Support for the development of the court came from as far away as New Brunswick, where Dr. Bernard Richard, the province's ombudsman and child and youth advocate, released a report this year called *Connecting the Dots: A Report on the Condition of Youth-at-Risk and Youth with Very Complex Needs in New Brunswick*, that decries the lack of services for youth with mental health issues.

But why exactly did the youth court's founders think there was a need for such a court? Those who work with youth knew that traditional youth court was ill suited to deal with youth who have mental health issues. But they also knew that although more than 50 per cent of youth cases involve substance use issues, creating a youth drug treatment court would not have helped because these courts focus solely on treating the substance use issue. “Drug treatment courts are not able to deal with concurrent disorders, even though an overwhelming number of people have mental health as well as addiction problems,” says Heather Perkins-McVey, a lawyer and one of the youth mental health court's founders.

Extra time is also required to compile a comprehensive historical picture of each young person's past and, in the case of youth, includes accessing everyone who has had any relationship or interaction with the young person, from parents and extended family, to children's aid and community agencies, schools and mental health professionals. Breton says the new youth mental health court is very collaborative and aims to provide supports to the youth's family members, as well, “so they don't get burned out.” All of this takes valuable time. According to Mary Jerrold, youth lead and assistant crown attorney at the Youth Justice Court in Scarborough, “There isn't time in a busy courtroom to delve deeply into the young person's issues, but if judges were aware of mental health issues, outcomes may be different,” she says, adding that “time spent helping young people at the front end may make a difference.”

In addition to issues of time, young offenders with mental health issues also face very different concerns that are inextricably intertwined with the process of growing up and maturing. Youth are at the forefront of their lives, a time when serious mental illness or first episode occurs. Is a young person's behaviour the result of normal teenage angst, youth conduct disorder or symptoms of an emerging psychosis or mental

disorder? asks Perkins-McVey. The challenge is deciphering and reading the clues. Inevitably, whichever is the case, youth workers agree that an offence sensitively handled and a psychological need addressed in the courts early on could “nip” a youth's potential life of crime “in the bud.”

Young people are also sensitive to the effects of stigma, says Perkins-McVey. “Youth are particularly affected by what's said in public in court and how their peers react,” she says. “I had a client with a difficult family history and an extensive mental health history,” she recalls. “He couldn't

*An offence sensitively handled and a psychological need addressed in the courts early on could “nip” a youth's potential life of crime “in the bud”*

stand up in court with all of his peers laughing and jabbing at each other. What's needed is sensitivity, not ostracizing or stigmatizing.”

Given these unique issues faced by youth with mental health issues who become entangled in the law, it would appear that the formation of Canada's first youth mental health court is a positive step forward in treating and addressing youth mental health issues.

Dr. Lindley Bassarath, a psychiatrist in the Child, Youth and Family Program at the Centre for Addiction and Mental Health in Toronto, conducts court-ordered youth assessments for Toronto-based judges. He says that extenuating family issues and vulnerabilities like a learning disability or trauma can also affect a young person's behavioural choices, but that, “there are differing opinions about the need for a youth mental health court in Toronto. “The vast majority of cases sent here generally don't have a serious and persistent mental illness, but most have a diagnosable condition such as substance abuse or conduct disorder,” he says. However, he adds that research into the prevalence and effect of youth mental health issues in Toronto's youth court may be warranted to determine whether there is indeed the need for a youth-focused mental health court in Toronto. ■

## Are mental health services improving for people with dual diagnosis?

KIM GOGGINS

As Wendy Richardson's 21-year-old son, Nathan, was led to an ambulance in handcuffs, he asked her for a kiss, not knowing if he would ever see her again. The incident marked the end of several weeks of Nathan spiralling into a state of "unreality," explains Wendy, where he took on the personalities of characters in a game. When he became irrational and then violent towards his brother, she had no choice but to call 911.

As someone with autism, Nathan appears and speaks well but is very anxious about change and has trouble relating to others. When he is fearful he can be more aggressive, but his family had never seen this behaviour before. He had seen a psychiatrist regularly since he was 13 but had never been hospitalized.

Nathan was taken to the emergency department by police and then transferred to a local hospital's psychiatric ward. But Wendy felt that the attending psychiatrist didn't believe Nathan was in crisis. "We got the impression that the psychiatrist thought we just dumped Nathan at the hospital," says Wendy. The psychiatrist did ask about events leading up to the crisis, but we knew he wasn't really listening. He had a preconceived idea of the situation."

The Richardsons' ordeal is not unique. It is estimated that between one and three per cent of Canadians have a developmental disability, and that 30 to 40 per cent of those have co-occurring mental health issues known as a dual diagnosis. In fact, developmental disability is the most common disability in psychiatric hospitals; yet the needs of people with a dual diagnosis are largely unmet, with gaps in services and a need for more trained professionals.

However, the situation is slowly changing, prompted in Ontario by a study that looked at how to better match psychiatric services to the needs of individuals with dual diagnosis. In 2003, Dr. Yona Lunskey, research section head of the Dual Diagnosis Program at the Centre for Addiction and Mental Health (CAMH) in Toronto, spearheaded a three-year study that examined the needs of approximately 1,700 individuals with a dual diagnosis out of almost 13,000 inpatients

and outpatients using Ontario's psychiatric hospitals. The study brought together staff from the nine psychiatric hospitals involved, as well as families, policy makers and community mental health and developmental services. "In some regions, the focus group led to more advocacy and co-ordinated efforts between the mental health and developmental services sectors," says Lunskey.

It was at one of those focus groups in Thunder Bay that Janet Sillman, vice president of Mental Health and Addiction Services at St. Joseph's Care Group, sat down for the first time with people from the developmental services and mental health sectors to discuss how they could work together. "That was the start – not only recognizing the target population but also recognizing the value of working across sectors," says Sillman.

Representatives from both sectors came together in 2005 as the Northwestern Ontario Dual Diagnosis Working Group and continued to meet quarterly for two years. Part of their focus was to follow up on the study's recommendation for specialized level 4-type services, which involve community-based residential treatment with a strong rehabilitation component. The group also led to the establishment of a high-support home where people with developmental disabilities who were long-term inpatients of Lakehead Psychiatric Hospital could be supported in the community.

This home, Evergreen, opened its doors in January 2008, becoming home to five people with dual diagnosis who had lived at the hospital and did not meet the criteria for other high-support residences. "They are living like they would in a family environment," said Sillman. "They're going to community centres for craft clubs; they're integrated into that community. And these are people who were living in a hospital for up to 10 years."

Five months after the the first phase of the study was completed, the Ministry of Health and Long-Term Care announced funding for community-based services, including crisis response, early intervention in psychoses and assertive community treatment teams. "This funding is allowing

community agencies to hire staff with expertise in dual diagnosis," says Alex Conant, manager of the Dual Diagnosis Consultation Outreach Team in Kingston, part of Providence Care Centre Mental Health Services. One such position provides triage through the system and determines whether clients need the services of the outreach team.

Intended for short-term treatment and in its fifth year, Conant's team did not exist when the study began but has since expanded to include five clinicians – a psychologist, occupational therapist, two nurses and a social worker – as well as two part-time psychiatrists.

Conant also applauds the four Community Networks of Specialized Care that were established across the province in 2006/2007 as part of the transformation of developmental services. Funded by the Ministry of Community and Social Services, its purpose is to enhance service to adults with developmental disabilities who need specialized care for co-existing mental health and/or behavioural issues.

"These networks are very important because they're developing a continuum of services," says Lunskey. "They're linking the health and social services sectors and trying to integrate service co-ordination. The networks are also integrating research and education and training, a need we highlighted in the initial report."

Lunskey notes that the study helped to draw attention to the plight of people with dual diagnosis, which became an advocacy issue for the Ontario Ombudsman's office and other groups.

The study's findings reflect the situation across the country, where other provinces also struggle with inter-ministerial funding and a shortage of expertise and services, as reflected in a 2005 national survey about dual diagnosis that involved specialists in mental health and developmental disability, advocates and family members and policy makers. The survey, led by Lunskey, showed that specialized crisis services, inpatient services and emergency room expertise were limited across the

country. The major challenges identified by survey respondents were lack of services, shortage of expertise and limited funding.

However, innovative programs throughout Canada are addressing such gaps in service and expertise. In 2003, the Arnika Centre opened in Calgary, Alberta, providing outpatient psychiatric services to people with developmental disabilities with a referral from a family physician. In a team environment that includes a psychiatrist, nurse co-ordinator and social worker, as well as access to a psychologist and a neurologist, the program aims to stabilize clients in the community, reducing the need for hospitalization. Of the 440 clients the centre sees in 1,200 clinic visits annually, approximately 105 are new assessments and there is a three-to-six-month waiting list.

Funding is always a challenge, says Dr. Susan Carpenter, Arnika's medical director and founding psychiatrist. "This population is a very low priority, except when someone gets stuck in an inpatient bed," she says. "Suddenly it's high priority to get them out." Carpenter says that a spectrum of services is needed in Alberta, from the most intensive stabilization in hospital to community-based services and rehabilitation models.

While Alberta and Ontario are still in the process of closing their remaining institutions for people with developmental disabilities, British Columbia has long since closed its institutions and has been serving people with dual diagnosis for 12 years in the community. "We have very well-organized community mental health teams, which are funded through each of the five health authorities in the province," says Dr. Robin Friedlander, a clinical associate professor of psychiatry at the University of British Columbia.

However, Friedlander, who is also chair of the Developmental Disability Section of the Canadian Psychiatric Association, points to the lack of specialized beds (only eight beds for adolescents and adults) as a problem. "We need specialized mental health beds for this population because when people in crisis are sent to the local hospital for several weeks but don't get

better and there is a long waiting list to get into one of the specialized beds, patients fill beds without getting proper treatment," says Friedlander, adding that the Fraser Health Authority would like to put together its own resource for this population but does not have the necessary commitment from other agencies to co-manage the resource.

This lack of resources within communities and hospitals to provide a continuum of service is the one challenge highlighted in Lunsky's Ontario report that is the most difficult to implement throughout Canada. "People are trying to take on that general recommendation of the full spectrum of services, but there are also the challenges of having trained people and being able to fund the services," she cautions. ■

## DUAL DIAGNOSIS RESOURCES

**Canadian Association for Research and Education in Intellectual Disabilities** (CARE-ID). [www.care-id.com](http://www.care-id.com)

The **Centre for Addiction and Mental Health** Dual Diagnosis Program has a web page for professionals that provides links to information about developmental disabilities and mental health needs. Visit [www.camh.net](http://www.camh.net). Search for Dual Diagnosis: Resources for Professionals. See the report Dual Diagnosis in Ontario's Specialty Hospitals: Phase II – Final Report and refer to the appendix for a list of services in Ontario for people with dual diagnosis.

**Community Networks of Specialized Care**. [www.community-networks.ca](http://www.community-networks.ca)  
The US-based National Association for the Dually Diagnosed has branches across North America. Visit [www.thenadd.org](http://www.thenadd.org) for branches and resources.

The **Developmental Disabilities Division** of the University of Western Ontario in London provides links to dual diagnosis resources. Visit [www.psychiatry.med.uwo.ca/ddp/resources/dualdiagnosis.htm](http://www.psychiatry.med.uwo.ca/ddp/resources/dualdiagnosis.htm).

## TRAINING FOR DUAL DIAGNOSIS

The need for more trained psychiatrists and general practitioners to more effectively treat people with a dual diagnosis is an issue throughout Canada. Training is happening at the University of Toronto and Queen's University in Kingston, Ontario. Dr. Susan Carpenter and Dr. Robin Friedlander also provide training to psychiatry residents at their respective universities – the University of Calgary and the University of British Columbia – but admit more is needed.

"There will never be a huge number of people trained in this specific area, but if general psychiatry training covers how to approach a situation and gather information and do what needs to be done immediately, that's the most important thing," says Carpenter.

National health care guidelines have been developed for Canadian primary health care providers to help them treat people with developmental disabilities. These consensus guidelines were created with the input of international and Canadian experts and were published in *Canadian Family Physician* in 2006. "GPs need more training, not only around how to manage crises in individuals with developmental disabilities but also about the role they can play in preventing crises, how to treat a problem in the long term and how to access appropriate services," says Dr. Yona Lunsky, who was involved in developing the guidelines. Training has been developed for primary health care professionals in Ontario on using the guidelines and related tools are currently under development.



**Substance abuse treatment makes healthy pregnancy more likely**

Expectant mothers who have substance use problems can significantly improve their chances of having a healthy pregnancy if they receive substance abuse treatment during pregnancy, according to new research from the Permanente Group in Vallejo, California. Researchers compared 2,073 pregnant women who received treatment from the Early Start prenatal substance abuse program (SAT) with 1,203 women who screened positive for substance abuse and were assessed but did not receive treatment (SA), 156 women who screened positive but were not assessed (S) and 46,553 controls who screened negative for substance abuse. The researchers found that participants in the SAT group had significantly better outcomes than those in the S group with respect to stillbirth, pre-term delivery, placental abruption (separation of the placental lining from the mother's uterus), neonatal-assisted ventilation and low birth weight. SA group participants had outcomes that were intermediate between those for SAT and S group participants. The SAT group's favourable results are of particular note, given that this group had the highest rates of substance abuse. One factor that may have contributed to the SAT group's success could be that women who are initially at greater risk may be more aware of the risks of substance abuse and may thus be more motivated to seek treatment. These results show that substance abuse treatment for pregnant women improves the health of the mother and increases the likelihood of delivering a healthy child.

*Journal of Perinatology*, June 26, 2008, doi: 10.1038/jp.2008.70. N.C. Goler et al., Department of Obstetrics and Gynecology, The Permanente Medical Group, Northern California Region, Vallejo, California.



**Caring and inclusive schools curb student smoking**

Schools that promote caring and inclusiveness can significantly reduce the incidence of smoking among students, according to research from the Medical Research Council Social and Public Health Sciences Unit in Glasgow, Scotland. The study looked at 5,092 students, aged 13–16 who attended 24 Scottish schools. Researchers correlated smoking behaviour with indicators of school culture and student satisfaction, such as school size, school affluence, quality of teacher-student relationships, dropout rates and attendance. Overall, smoking was reported by 39 per cent of females and 25 per cent of males, but these rates varied considerably from school to school. Individual socioeconomic and sociocultural factors accounted for only a portion of this variation. To fully account for the variation, the researchers had to look at measures of school culture. It turned out that students were less likely to smoke where schools emphasized caring and inclusiveness rather than purely academics. In addition, rates of smoking were higher when students gave poor ratings to teacher-student relationships and when they had a negative attitude toward the school. Surprisingly, smoking rates for boys were higher in affluent schools with poor teacher-student relationships. These results suggest that shifting a school's culture towards a greater emphasis on caring and inclusiveness and improved teacher-student relationships could have a positive effect on smoking rates.

*BMC Public Health*, June 20, 2008, v. 8, doi: 10.1186/1471-2458-8-218. Marion Henderson et al., MRC Social and Public Health Sciences Unit, Glasgow, United Kingdom.

**Link between abortion and anxiety called into question**

Women who have had abortions are not as vulnerable to anxiety as previous research suggests, according to a new study from Arizona State University in Tempe. The study involved two surveys of women who had a first pregnancy ending in abortion or live birth: the United States National Survey of Family Growth (NSFG), with a sample of 6,714 women, and the National Comorbidity Survey (NCS), with a sample of 1,823 women. The NSFG survey found that, although women who reported abortions experienced higher levels of anxiety than those who did not report an abortion, this difference could be accounted for by other factors, notably anxiety levels prior to pregnancy and a woman's past experience of rape and other forms of violence. A review of the NCS data showed that women who ended their first pregnancies with an abortion did not have significantly higher rates of generalized anxiety disorder, social anxiety or post-traumatic stress disorder (PTSD). Furthermore, although multiple abortions were associated with higher rates of social anxiety and PTSD compared with women who had either one abortion or none, this was best explained by the presence of mental health disorders prior to pregnancy and past exposure to violence.

*Social Science and Medicine*, July 2008, v. 67: 238–252. Julia Renee Steinberg and Nancy F. Russo, Department of Psychology, Arizona State University, Tempe, Arizona.

**An active social life may protect against dementia**

People with active social lives later in life are less likely to develop dementia, according to research from Kaiser Permanente Southern California in Pasadena. Researchers recruited 2,249 women age 78 or older and followed them for four years. At recruitment all participants were free of dementia. Data on cognitive status and social networks were collected through annual telephone interviews and medical record reviews. During the study 268 participants developed dementia. Participants with larger social networks were 26 per cent less likely than those with smaller social networks to develop dementia. Participants who had daily contact with their social network were 43 per cent less likely to develop dementia. The researchers suggest several possible explanations: Social networks may help to prevent brain pathology by facilitating access to health care and encouraging healthy behaviours. Another possibility is that social engagement may reduce stress and depression. Future research will be needed to determine whether it is possible to improve the prospects of relatively isolated individuals through the creation of synthetic social networks. Further study is also required to determine precisely which aspects of social networks help to reduce dementia risk.

*American Journal of Public Health*, July 2008, v. 98: 1221–1227. Valerie C. Crooks et al., Department of Research and Education, Kaiser Permanente Southern California, Pasadena, California.



**Bipolar disorder increases risk of substance abuse in teens**

Bipolar disorder significantly increases the risk of substance abuse among adolescents, according to research from Massachusetts General Hospital in Boston. Researchers interviewed 203 adolescents with an average age of just under 14. Of these, 105 had a diagnosis of bipolar disorder, while 98 controls were free of the disorder. After adjusting for age, it was found that 34 per cent of participants with bipolar disorder had a substance use disorder (SUD), compared with only four per cent of controls. Study participants with bipolar disorder were almost nine times more likely than controls to have any SUD, almost eight times as likely to report alcohol abuse, 19 times as likely to report other drug abuse, 12 times as likely to report drug dependence and 12 times as likely to smoke cigarettes. None of the controls had both alcohol and other drug use problems compared with 14 per cent of participants with bipolar disorder. The increased risk of cigarette smoking and SUD among those with bipolar disorder was found to be independent of the presence of conduct disorder, attention deficit/hyperactive disorder or anxiety disorders. The authors speculate that the poor judgment, limited self-control and lack of inhibition typical of bipolar disorder make adolescents with the disorder particularly vulnerable to the development of a SUD. Adolescents with bipolar disorder may use alcohol and other drugs to medicate their irritable mood, aggressive tendencies and “affective storms.” The authors recommend that adolescents with bipolar disorder be carefully screened for cigarette smoking and substance use.

*Drug and Alcohol Dependence*, June 1, 2008, v. 95: 188–198. Timothy E. Wilens et al., Pediatric Psychopharmacology Unit, Massachusetts General Hospital, Boston, Massachusetts.

**Nurses can deliver cost-effective depression treatment for cancer patients**

Research from the University of Edinburgh Cancer Research Centre demonstrates that nurses who have no previous experience in psychiatry can provide a cost-effective intervention as a supplement to usual care for cancer patients with major depression. The study involved 200 cancer outpatients with a prognosis of more than six months and a diagnosis of major depressive disorder. Of these patients, 99 were assigned to usual care and 101 to usual care with a supplemental intervention. The intervention involved up to 10 one-on-one sessions over three months with nurses who educated patients about depression, treatment and coping strategies. It also included guidance from the patients’ oncologists and primary care physicians regarding management of major depressive disorder. At three months, the adjusted difference in mean score on the Symptom Checklist-20 depression scale between those who received the intervention and those who received usual care was 0.34. This advantage was maintained at six- and 12-month follow-ups. The intervention also lessened patients’ anxiety and fatigue to a greater extent than usual care alone, but there was no comparable improvement with respect to pain or physical functioning. The cost of the intervention was \$668 per patient over six months and was considered cost-effective, given the resulting improvements in quality of life. Future research will determine whether the intervention is cost-effective when implemented on a large scale and whether it can be benefit cancer patients whose prognosis is poor.

*Lancet*, July 5, 2008, v. 372: 40–48. Vanessa Strong et al., University of Edinburgh Cancer Research Centre, Edinburgh, United Kingdom.

**Early detection limits long-term impact of schizophrenia**

People with schizophrenia often experience negative symptoms such as social isolation, apathy and decreased attention to personal hygiene. A new study from Ulleval University in Oslo, Norway, has found that early detection of psychosis can help to prevent the onset of negative symptoms and improve functioning in people who develop schizophrenia. The study followed 231 individuals for two years after a first episode of psychosis, 118 of whom lived in an area that had an early detection (ED) system and 113 of whom lived in an area without an ED system. The ED system included public information campaigns about psychotic symptoms and treatment, as well as special teams to detect low-threshold psychosis. Participants in both groups received comparable treatment over the two years of the study. At the beginning of the study, researchers found that participants who were treated in the ED area had a lower average duration of untreated psychosis (5 weeks, compared with 16 weeks for those in the non-ED area), better clinical status and milder negative symptoms. At the one- and two-year follow-ups, the ED group maintained its advantage in terms of negative symptoms and continued to display better functional and social outcomes. Given that the ED group had no advantage in terms of treatment, the researchers conclude that this difference may be due to the fact that early detection reduces the duration of untreated psychosis and therefore helps to prevent symptoms from significantly worsening. These findings are particularly significant given the limited effectiveness of current treatments for schizophrenia with respect to negative symptoms.

*Archives of General Psychiatry*, June 2008, v. 65: 634–640. Ingrid Melle et al., Division of Psychiatry, Ulleval University Hospital, Oslo, Norway.

# One addiction at a time

## Does integrating tobacco cessation into addiction programs make sense?

BY KIM GOGGINS

WHEN JILL\* ENTERED THE AURORA CENTRE IN VANCOUVER, B.C., she knew it was the help she needed to recover from her crystal meth and alcohol addiction and ultimately regain custody of her children. She knew it was a tobacco-free facility, but remained ambivalent about dealing with her tobacco dependency, not thinking her pack-a-day addiction was a real concern.

But it became a serious concern when she was caught smoking during her six-week residency and placed on a tobacco contract with the centre. Although she was able to abstain from crystal meth and alcohol, one more mistake like this and she would be released from the program.

“This changed her attitude,” recalls Gail Malmo, program director of the centre, which serves women and is part of the BC Women’s Hospital and Health Centre. “She wrote in her journal that she shared with the group that she realized the lengths to which she would go to have her smokes: she would lie, break rules and even jeopardize her treatment – and that’s her chance of having her children returned to her sooner. If smoking wasn’t such a big deal, she asked herself, why would she risk all of this for it? That was when Jill became committed to change.”

Jill’s success story illustrates what can happen when substance use treatment programs integrate smoking cessation into their services. This focus makes sense, given the startling statistics: While number of smokers in the general population is decreasing, studies show that 80 to 95 per cent of people with alcohol and other substance issues use tobacco. It is the leading cause of death in people treated for alcohol and other substance use problems. Yet most Canadian substance use treatment programs are not doing much in the way of formalized treatment for tobacco dependency.

“In our society of smoking and nicotine, tobacco dependency has been viewed very differently than dependency on other substances or alcohol,” says Malmo, whose centre is one of the few – perhaps the only – addiction treatment programs in Canada that are completely tobacco-free. “Smoking has been characterized for too long as just a bad habit,” she says. “It wasn’t treated with the same seriousness as addiction because it didn’t seem to have the same daily impact as other drugs.”

The Aurora Centre is distinct in its approach to addiction treatment not only because it restricts smoking on the grounds but because the abstinence-based program also bans smoking for the duration of the treatment experience, including when clients are not on site. Tobacco dependency is also a topic in the daily lectures, dis-

ussion groups and educational group therapy.

Several issues stop many addiction professionals from treating tobacco dependency as any other addiction, says Malmo. In addition to the firmly entrenched belief that smoking is just a bad habit is the long-held assumption within the addictions movement that it is too much to address more than one substance at a time. “The only thing that’s ever exempted – ever – in an abstinence-based treatment centre is tobacco,” says Malmo. “We ask them to stop everything else except smoking, but why does tobacco have special status? When you start presenting people with evidence, the evidence speaks for itself; education is important in this field and it’s starting to spread.”

Resistance to integrating tobacco cessation into addiction treatment programs may also reflect the fact that addiction treatment professionals themselves are two to three times more likely to smoke than the general population, according to a recent study by Dr. Doug Ziedonis,

*“Addiction professionals further the misconception that their clients don’t want to give up smoking or can’t give up everything at the same time.*

*That’s the shared delusion; it’s the co-dependency of the whole field”*

chair of the Department of Psychiatry at the University of Massachusetts Medical School and University of Massachusetts Memorial Medical Centre. He says this is part of the problem because addiction professionals further the misconception that their clients don’t want to give up smoking or can’t give up everything at the same time.

“It’s one of those preposterous things that if you take a step back, you think, ‘Wow, how did we get into this delusional thinking?’” says Ziedonis. “It’s just amazing for addiction specialists because we know the power of denial, minimization and rationalization. Tobacco addiction should be the poster child for that. That’s the shared delusion; it’s the co-dependency of the whole field.”

Resistance by staff who smoke was indeed a barrier when the Aurora Centre initially went smoke-free in May 2006, but their misgivings weren’t the only challenge, notes Malmo, who points to the reluctance of referral agencies and the resultant unwillingness of some clients to quit smoking as other barriers.

“We all want our clients to succeed, but when you’re trying something new, and there isn’t yet a lot of evidence available, people are fearful that it will contribute to treatment failure,” says Malmo. “It was a challenge to encourage our referral agents to trust us and continue sending us clients.”

Every year, the Aurora Centre treats approximately 200 women

in its six-week residential program and 100 through the five-week day program. Evaluations after the first year of being smoke-free show that 62 per cent of clients at three months post-treatment had stayed quit or cut down.

When Dr. Milan Khara studied for the American Society of Addiction Medicine Certification exam in 2006, he said looking at relative models of people who have died from different substances opened his eyes to the true problem of tobacco. “Eighty per cent of all substance-related mortalities are from tobacco use, yet we were ignoring tobacco in addiction services, which made no sense,” he says. “We’re spending all our energy treating people for their opiate problems or their alcohol problems when in fact they’re going to die from tobacco use. That was the motive for realizing we had to do something.”

Khara refutes the widely held myth that smoking cessation during the treatment of other addictions may hurt recovery, and says it may actually improve outcomes.

One year ago, Khara opened the first Tobacco Dependence Clinic in Vancouver, taking referrals of existing clients with a diagnosis of substance use disorders and/or mental illness. The intensive treatment program consists of formal assessment and treatment planning, comprising 26 weeks of free pharmacotherapy and weekly group counselling. The successful program will soon open its third clinic within Vancouver Coastal Health.

“We see people who never believed they could quit doing just that and challenging many of our assumptions,” says Khara, who is the clinical director of the clinic, which is modelled after the Nicotine Dependence Clinic at the Centre for Addiction and Mental Health in Toronto. “There is increasing research evidence that these populations do want to quit and can do so successfully with suitably intensive intervention,” says Khara. “Our work will contribute to this body of evidence.”

Debbra Behrens, a tobacco addiction specialist at Womankind Addiction Services in Hamilton, Ontario, shares this view. Within the five-week residential treatment program that includes tobacco addiction programming and limits smoking on the property to specific areas, she sees her clients open up more in therapy once the tobacco is gone. “Tobacco changes the way we feel and the way we deal with things – that’s why we use it,” she says. “If clients remove tobacco along with the other substances, the issues and feelings they have to deal with come to the forefront. And clients can’t go for a smoke break and bury those issues under tobacco.”

At the two Tobacco Dependence Clinic sites in Vancouver, “off-label” pharmacotherapy – levels that are higher than conventional doses of NRT and/or the use of more than one product simultaneously – is used to tailor treatment to an individual’s degree of nicotine dependence. The high cost of NRT is often an obstacle to this population, but here, it is offered for free. “Pharmacotherapy at least doubles the likelihood of successfully quitting and should be offered to everyone,” says Khara, noting that his biggest challenge is to find ongoing funding for pharmacotherapy.

Still, many clients, like Jill, are not always ready to give up their “first addiction,” but Khara and Malmo are optimistic. “I think as the initiative spreads, we’ll start to see a change,” says Malmo. “As the culture and attitudes shift so that tobacco use becomes more integrated into the mandate of most addiction service providers, then we’ll see readiness on the part of clients.” ■

\*not her real name

## YOUTH ADDICTION PROGRAMS AND TOBACCO

Like addiction programs for adults, those targetting youth struggle with the issue of integrating tobacco cessation into treatment. A 2006 Centre for Addiction and Mental Health national survey of smoking cessation services in adolescent residential substance abuse treatment programs found that 85 per cent of these youth smoked cigarettes. Of the 50 centres surveyed, 80 per cent allowed youth to smoke, with a variety of restrictions during treatment, and only about 50 per cent offered individual or group counselling to help youth quit smoking.

“All of the facilities saw smoking as a key dependency issue,” says Russ Callaghan, lead researcher on the project. “A lot would say that smoking may be the dependency that causes the greatest harm in the long run, but there are other addictions they see as more immediate and problematic, like cocaine dependence or intravenous drug use.”

Similar to adult treatment centres, the belief among staff that youth will drop out of the program is often a key barrier to smoking bans, but Callaghan says the evidence does not support this fear. “I did some other research on smoking bans because it was thought that smoking bans affected recruitment and retention of adolescents, but in fact, admissions and drop-out rates for inpatient treatment showed that smoking bans didn’t effect recruitment or retention.”

Callaghan also notes that lack of staff training is a major barrier to integrating smoking cessation services and smoking bans into treatment programs for alcohol and other drugs. “Right now there exist protocols but we don’t have a standardized protocol for integrating both tobacco and other drugs into the program,” says Callaghan. “There are treatment centres that have done it, but I don’t think the protocols are widely available.”



# Sacred smoke

## Remembering traditional tobacco in smoking cessation and prevention

BY YLVA VAN BUUREN

“IF YOU AND I WERE TRADING HORSES AND BLANKETS 200 YEARS ago,” says Kathi Camilleri, a Cree/Métis woman who lives in the Kwakwakawak community of Campbell River, B.C., “we would summon a pipe carrier, fill a pipe with tobacco and light it. We would each take a bit of smoke into our mouths – but not into the lungs because our ancestors knew that would damage us. Then, to seal the trade, we would blow smoke, representing our commitment and word to the Creator.”

Camilleri’s story illustrates one of the traditional roles tobacco has played in First Nations communities in Canada. Unfortunately, much of its significance has been lost, along with so much else, over the last century. Today, community leaders and health advocates recommend re-instilling the importance of sacred tobacco to help First Nations people not only heal from their historical trauma, but also to help them quit smoking commercial tobacco.

Tobacco use among First Nations communities is alarmingly high – around 60 per cent. According to Caroline Lidstone-Jones, director of the Aboriginal Tobacco Strategy at Cancer Care Ontario in Toronto, among First Nations youth aged 15 to 17, 61 per cent of girls and 47 per cent of boys smoke, compared to 15 per cent and 13 per cent, respectively, in the general population.

But although smoking tobacco may be widespread in First Nations communities, studies have shown that many First Nations people who smoke don’t know the difference between the cultural and non-cultural use of tobacco, says Daniel McKennitt, a medical student at the University of Alberta and founder of the Aboriginal Health Group in Edmonton, Alberta. “Some start smoking because they think it’s part of their culture,” says McKennitt, who was born in the Sandy Bay Ojibway First Nation in Manitoba.

But it’s not. As told in creation stories, traditional tobacco was one of four burning-based medicines provided by the Creator. Burning tobacco was a way to feel connected to the Creator, says Camilleri, who is a mental health liaison worker in her community. “Tobacco was put on a sacred fire with a prayer and everyone would watch the prayer be taken in the smoke to the Creator.” Sacred tobacco was put on water in a prayer before a canoe journey. It was offered to the spirit of an animal who had been killed for food. It was carried in medicine bundles or given as a special gift.

This sacred component in First Nations cultures was never meant to be used in the form it is being used now, says Lidstone-Jones. “As a result, when we work with Aboriginal people, we try to de-normalize the use of commercial tobacco.”

Experts have determined that helping First Nations people address tobacco addiction should be culture-based and educational. Culture-based messages help support self-esteem, so clients become proud of who they are. Educating about the effects of smoking will help them make better choices, and this includes understanding advertising, says Peter Dinsdale, executive director of the National Association of Friendship Centres in Ottawa, with 114 centres in urban areas across Canada. From there, people can develop a plan for quitting. ■

### TRADITIONAL TOBACCO RESOURCES

- The Aboriginal Tobacco Resource List. [www.tobaccofacts.org/order/aboriginal.html](http://www.tobaccofacts.org/order/aboriginal.html)
- Aboriginal Tobacco Strategy, Cancer Care Ontario, [www.tobaccowise.com](http://www.tobaccowise.com)
- Aboriginal Youth Network, Online Tobacco Healing Circle. [www.ayn.ca/quit/en/c6\\_1\\_healing\\_circle.asp](http://www.ayn.ca/quit/en/c6_1_healing_circle.asp)
- *An Outreach Guide to Developing a Culturally Appropriate Tobacco Use Program for Aboriginal Youth*. Visit the Aboriginal Health Group at [www.ualberta.ca/~abhealth](http://www.ualberta.ca/~abhealth) and follow the “Publications” link.
- *Everyone Loves a Quitter: Tobacco Cessation Toolkit*. National Association of Friendship Centres, [www.nafc-aboriginal.com](http://www.nafc-aboriginal.com)

### TIPS FOR WORKING WITH FIRST NATIONS COMMUNITIES

**Use tradition to help empower individuals.** Camilleri explains that Sacred Medicine, Sacred You workshops, which were developed to help prevent smoking, look back in history and “confirm the respectful way First Nations people treated one another and the way we treated ourselves. These are values we continue to have and hope to revive.”

**Reintroduce ceremony.** Traditionally, ceremony helped First Nations people connect, but it’s missing today, says Camilleri. Using the traditional concept of a healing circle, which provides group support, can be helpful.

**Use cessation tools.** Quitting ultimately is an individual’s choice, says Dinsdale. A plan for quitting should be determined with discussion about cessation tools such as the nicotine patch.

**Be sensitive to the values of the community or person.** Remember that just because someone is of First Nations descent doesn’t mean they’re interested in sacredness, says Lidstone-Jones. They may just need to quit smoking. Provide education and cessation support.

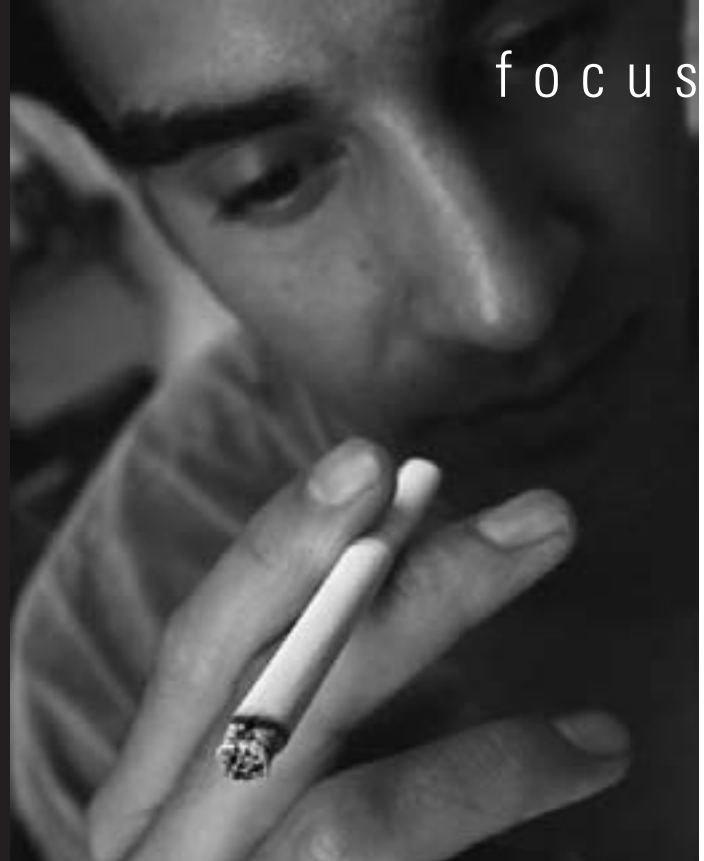
**Create a long-term relationship.** In one community, Lidstone-Jones’ program started by asking a radio station to air a public service announcement. High school students were then involved in a survey and an art contest invited younger students to submit artwork expressing what they thought of tobacco. Winning pieces were featured in a calendar sent to teachers and parents, and other entries were posted online.

**Be patient.** “Don’t give up fast or get frustrated,” says Lidstone-Jones. “When a community is dealing with suicide, high unemployment and water quality issues, it’s difficult to make smoking number one on the agenda. Commit for the long haul and take the relationship as it comes.”

# “Enjoy your cigarettes; it’s all you have”

## Stamping out the smoking and schizophrenia connection

BY ANNE PTASZNIK



**E**VEN THOUGH MICHAEL ELSON’S PREVIOUS ATTEMPTS TO QUIT smoking failed, he’s “definitely going to try again.” Elson, 34, loves the ritual of his morning cigarette, but says smoking is affecting his health and his wife wants him to quit. The challenge for Elson, who has schizophrenia and works as a peer support worker with an ACT team in Belleville, Ontario, has been finding smoking cessation supports that don’t significantly alter his mood and increase his stress level.

Elson’s addiction and his struggle to overcome it are common among people with mental health problems. A literature review by the Centre for Addictions Research of British Columbia (CARBC) found that prevalence rates of tobacco use among people with mental health issues range from 50 to 90 per cent, compared to about 20 per cent for the general population. In fact, people with mental illness consume more tobacco than any other population in the Western world. According to Dr. Joy Johnson, a nursing professor at the University of British Columbia in Vancouver and lead author of the report, “People with schizophrenia are more likely to die from the effects of their tobacco use than they are from their mental illness.” Yet despite this startling fact, most mental health professionals do not address tobacco use with their clients.

Complex clinical and institutional issues underlie this culture of acceptance of smoking. But some leading smoking cessation researchers and clinicians have taken on the challenge and are working towards changing attitudes, improving institutional responses and developing innovative treatment approaches targeting this deadly killer.

Johnson heads the CACTUS project (Cultivating the Awareness of the Context of Tobacco Use), which surveyed 789 smoking and non-smoking clients of community mental health teams and 282 mental health providers in the Vancouver area. “What surprised me most was the number of clients we surveyed who smoked and who had actually indicated some desire to either cut down or quit smoking,” says

Johnson. “Many of us assume that people with mental illness enjoy their cigarettes so much that they wouldn’t contemplate quitting, but that wasn’t the case.”

The survey found high concern about the health and economic costs of smoking. Cigarettes leave people with mental illness with little spending money for food and bus fare; some are forced to “bum” cigarettes from friends or strangers or even pick cigarette butts off the ground. Some surveyed clients had lung infections, emphysema and pneumonia, which are commonly associated with heavy tobacco use. Most felt judged by others for smoking.

For people with mental illness, smoking may have a particularly strong hold due to biological mechanisms that may provide a “beneficial” effect of nicotine, according to the CARBC review. Nicotine triggers the “reward system” neurotransmitters dopamine, norepinephrine and serotonin, which elevate mood. Nicotine also helps people to relax and deal with stress and has been found to moderate some of the symptoms of schizophrenia including lack of motivation and energy and affective blunting. Nicotine has also been found to enhance concentration, information processing and learning, which may be impaired due to the illness. Nicotine withdrawal can lead to increased cravings and agitation, staved off only by more nicotine.

Smoking may also alleviate medication side effects, but tobacco can affect the metabolism of medications, resulting in the need for more medication at additional cost. Long-term cigarette smoking may also work to “correct” the biological abnormalities among people who have major depression.

The confusion between nicotine’s purported benefits and the hazards of tobacco use may precipitate acceptance of smoking among this population. Almost all of the mental health professionals in the CACTUS survey believed that smoking helps their clients cope with stress and manage symptoms, that clients had more pressing issues than quitting smoking and that smoking was one of their clients’ few enjoyments in life. They also indicated that staff sometimes use



### TOBACCO AND MENTAL HEALTH QUICK FACTS

- 40% to 60% of people with major depression smoke. Smokers with depressive symptoms have a much harder time quitting and require more attempts to quit.
- 61% of people with bipolar disorder smoke, according to one population-based study.
- 19% to 56% of people with panic disorders smoke. Daily smoking predicts the onset of panic attacks.
- 53 to 66% of combat veterans with post-traumatic stress disorder (PTSD) smoke.
- 44% of women who have PTSD related to physical and sexual assault smoke.
- 41% of smokers increased smoking after 9/11.
- People with ADHD smoke more and start earlier.
- Adolescents with poor body image who engage in disordered weight control behaviour are 4 times likelier to initiate smoking.

Source: "Co-Morbidity of Smoking in Patients with Psychiatric and Substance Use Disorders," *American Journal on Addictions*, 2005.

### SMOKING IN THE DOCTOR'S OFFICE

SANE Australia offers these eight tips that primary care providers can use to help people with schizophrenia quit smoking:

1. Identify smokers.
2. Assess readiness to quit.
3. Assess risks of smoking reduction and cessation.
  - precipitation of psychotic symptoms
  - development of clinical depression
  - change in medication effects
4. Write an individual plan.
5. Use nicotine replacement therapy.
6. Recommend group support.
7. Monitor frequently.
8. Congratulate on progress.

Further information and guidelines are available from SANE Australia at [www.health.vic.gov.au/mentalhealth/smoke](http://www.health.vic.gov.au/mentalhealth/smoke)

cigarettes to help build a "therapeutic alliance" with clients. In a 2000 study in *Psychiatric Services*, a client reported that family members, program counsellors and others advised, "Enjoy your cigarettes; it's the only thing you have ... You don't really have that much in life – you've got a mental illness."

Dr. Charl Els, an addiction psychiatrist at the University of Alberta Hospital and the Alberta director of Physicians for a Smoke-Free Canada, says that while nicotine may have benefits for this population, "the cons of smoking still far outweigh any potential pros." Els acted as the external consultant when the Alberta Capital Health region authority directed all hospital and community health care facilities to become smoke-free within a three-month time frame. He says that the most resistance came not from clients, but from staff, who said that going smoke-free was inhumane and expressed concerns about increased aggressive behaviour. But Els says the evidence suggests that when given pharmaceutical nicotine replacements, clients are generally comfortable; they don't leave against medical advice and there's no increased level of violence. (See p. 14 for a story about the smoking ban debate.)

Els also contends that tobacco policies in health care institutions are not about forcing clients to quit; they reflect an occupational health issue "to get staff to breathe clean air" and assist clients comfortably through a smoke-free hospital admission. Research conducted by Dr. Judith Prochaska, an assistant psychiatry professor at the University of California, San Francisco, published in *Psychiatric Services* in 2004 showed that smokers on an inpatient psychiatric unit who were not given nicotine replacement therapy (NRT) were twice as likely as non-smokers and smokers given NRT to leave the hospital without medical advice.

Smoking cessation programming, however, must start with more training for mental health professionals. A study of graduate psychiatric nursing education programs published in 2008 in the *Journal of the American Psychiatric Nurses Association* found that most graduate psychiatric nurses were inadequately trained in tobacco intervention. In the CACTUS study, Johnson says that while all mental health professionals thought smoking was an important issue, "nobody thought it was their job to do it, and nobody felt they had the skills to do it." In the Alberta region, Els says 200 health care staff received training in tobacco dependence treatments.

But what happens when clients leave the hospital? A study conducted at the Cape Cod Hospital in Hannis, Massachusetts, published in 1991 in *Hospital and Community Psychiatry* found that involuntary smoking cessation, client education and nicotine gum were insufficient to help clients stop smoking over the long term after they re-entered the community. Years later, these findings seem to hold: In a 2006 study in the *American Journal of Addictions* Prochaska found that all clients in a smoke-free psychiatry unit returned to smoking within five weeks of hospital discharge; in fact, many were smoking within five minutes of leaving the unit. In a more recent clinical study, Els found that not only do people with mental illness need NRT or medication to help them quit smoking, but the duration of treatment and access to NRT also need to be open ended.

Dr. Tony George, chair of Addiction Psychiatry at the University of Toronto and clinical director of the Schizophrenia Program at the Centre for Addiction and Mental Health in Toronto, says that behavioural treatment, along with NRT, is essential. In a study published in 2008 in *Biological Psychiatry*, George and colleagues examined pharmacological and behavioural treatments for smoking cessation

among people with schizophrenia and schizoaffective disorder. All participants received pharmacological treatment and weekly group behavioural therapy to teach them the skills needed to quit smoking. Ten per cent of participants who used only the nicotine patch quit smoking, and 35 per cent of those who used the patch and bupropion (Zyban) were able to quit. George says the usual quit rate for this population is between 5 and 10 per cent, compared with 35 per cent in the general population. As the study participants were outpatients, most of whom lived in rooming houses with other smokers, George says this quit rate would not have been possible if participants had not learned the skills to refuse cigarettes.

Prochaska says that longer-term cessation requires motivational interventions and pharmacological and behavioural treatments that are extended over time after clients leave the hospital. In a randomized clinical trial with smokers who were receiving outpatient treatment for depression, participants, who did not have to be interested in quitting, received computerized motivational feedback based on the stages of change and six sessions of psychological counselling along with NRT. Abstinence was higher among this group at 12 and 18 months compared to a control group that only received a self-help guide and referral list of local smoking treatment providers. Prochaska and her colleagues are part-way through a clinical trial, funded by the National Institute on Drug Abuse (NIDA), using a similar approach on the inpatient unit. Although it is premature to disclose the quit rates, Prochaska says they look promising.

Prochaska says that what she found most disturbing when she analyzed formerly secret tobacco industry documents was industry funding of researchers to try and promote the idea that people with mental illness *need* to smoke – the self-medication hypothesis. She says if this area of study shows some potential, then it's good to explore it, but she is more concerned that clients aren't getting effective NRT.

The area of cognitive deficits, which are common among people with schizophrenia, is indeed being studied as a possible basis for developing targeted treatments. In a study published in a 2005 issue of the *Archives of General Psychiatry*, George and his Yale University associates found that cigarette smoking had some beneficial enhancement on visual spatial working memory and attentional deficits in smokers with schizophrenia. Dr. Jeff Daskalakis, a psychiatrist with CAMH's Schizophrenia Program and an expert in repetitive transcranial magnetic stimulation (rTMS), has found that stimulating particular regions of the brain with a magnetic pulse reverses the same cognitive deficits that smoking does in people with schizophrenia. George and Daskalakis have obtained Canadian Institutes of Health Research funding to determine whether using rTMS to correct the cognitive deficits, addressing the underlying reason why some people with schizophrenia smoke, along with behavioural treatments and the nicotine patch, will lead to a potential tailored smoking cessation strategy for people with schizophrenia. George has recently completed a similar pilot study using atomoxetine (Strattera), a non-stimulant drug approved for the treatment of attention-deficit/hyperactivity disorder, which seems to have the same effect as rTMS in correcting these cognitive deficits.

People with depression may also benefit from this approach. "The conventional wisdom was that people with depression smoke so much because nicotine has an antidepressant effect," says George. He was lead author of a study published in the June 2008 issue of the *Journal of Clinical Psychopharmacology* that found that when people

with depression who don't respond to SSRI antidepressants are given mecamylamine hydrochloride, a nicotine-like drug, their depression disappears and the antidepressants start to work. Similar to the rTMS study, if the underlying reason why some people with depression smoke is treated, this could work as a targeted smoking cessation strategy along with other forms of treatment. George is currently building a concurrent disorders lab at CAMH, which will study the mechanisms underlying why people with mental illness have high rates of addiction, including smoking, and vice versa, in a controlled setting.

George says that the most vulnerable people in society have been dying from something that is "very treatable." Based on the work of these leading smoking cessation experts, this culture of inaction may become a thing of the past. ■

### BREATHING EASIER WITH MUTUAL SUPPORT

The Simon Fraser Branch of the Canadian Mental Health Association in British Columbia, with funding from Health Canada, developed the Breathing Easy program – a 12-week mutual support program combining nicotine replacement therapy with cognitive behavioural and psychosocial approaches to quitting smoking. In 2006, 26% of 113 program participants quit smoking and there was a 40% reduction in cigarettes smoked by program completion. For information on how to start your own group see [www.simonfraser.cmha.bc.ca/](http://www.simonfraser.cmha.bc.ca/).

### SMOKING BY THE NUMBERS

The CACTUS project (Cultivating the Awareness of the Context of Tobacco Use), surveyed 789 smoking and non-smoking clients of community mental health teams and 282 mental health providers in the Vancouver area. Here are some quick facts from the project.

#### Community mental health team clients:

- 20% were ex-smokers with 73% going "cold turkey"
- \$41 spent per week on cigarettes
- 43% smoked first cigarette within 5 minutes of waking
- 47 – average age of clients surveyed
- 48% current smokers – 3x average rate in B.C.
- 86% wanted to quit smoking
- 87% had tried to quit smoking

#### Mental health care providers:

- 22% are current smokers
- 26% said personal smoking is a barrier to addressing tobacco
- 27% former smokers felt tempted to smoke while at work
- 30% had not given it much thought
- 39% lacked adequate smoking cessation knowledge
- 40% lacked incentives and time to deal with it
- 44% said clients smoke when they visit them at home
- 69% reported smoking is one thing clients can enjoy
- 70% believed nicotine helped clients manage symptoms
- 74% reported co-workers smoke with clients
- 81% bothered by second hand smoke
- 82% believed clients have more pressing issues
- 86% said clients smoke in their presence in public spaces
- 88% thought clients can decide for themselves about quitting

# No ifs, ands or butts

The smoking ban debate rages on

BY ASTRID VAN DEN BROEK



*“Some people say they stole our dignity by stepping in and going smoke-free, but how dignified is it to be on an oxygen machine?”*

*“I have zero tolerance for zero tolerance.”*

THESE STATEMENTS BY TWO CLIENTS OF THE MENTAL HEALTH system in Ontario reflect two perspectives on the smoke-free psychiatric facility debate that rages across the country, pitting respect for client rights, personal freedom and choice against considerations of client health and workplace safety.

Increasingly, over the past six years, individual hospitals and integrated health authorities from Newfoundland to British Columbia have declared their sites 100 per cent smoke-free. However, in some locations, exceptions continue to be made for inpatients of psychiatric facilities. For example, the 2006 Smoke-Free Ontario Act, which bans smoking in enclosed spaces, includes an exemption allowing controlled smoking areas in residential care settings.

“Part of the reason that exemption was put in the Act is that we have patients who have been in hospital for years, so in many ways it is their home and residence,” says David Simpson, program manager for Ontario’s Psychiatric Patient Advocate Office. “However, the government set the standards so high in terms of the equipment that needs to be used, that it’s not affordable for hospitals to retrofit rooms with the proper ventilation for people to smoke indoors.” Also, since municipal bylaws vary on what constitutes an outdoor smoking shelter, some facilities provide outdoor shelters and others extend the smoking ban to hospital grounds. Simpson notes that at one Ontario hospital where there is a total ban, a patient who went offsite in search of cigarettes was struck by a bus and died. “Aren’t there ethical issues entwined in that?” asks Simpson.

At the Mental Health Centre in Penetanguishene, Ontario, which banned smoking anywhere on its 225 acres in 2003, a patient at the

centre’s maximum-security Oak Ridge facility launched a court challenge. “One of the arguments was that for longer-term patients, the facility was considered to be a residence and patients should have residential smoking privileges,” says Dan Parle, the centre’s former director of planning and public information. “Although the judge had some sympathy for the argument, he was clear that the hospital was not a home and that the rights of the entire community were superior to those of the claims for individual, residential smoking privileges.”

Home or not, however, some consider it inhumane to force people to go through nicotine withdrawal while they’re in the throes of a mental health crisis. According to Dr. Richard O’Reilly, a psychiatry professor at the University of Western Ontario in London, smoking bans contradict involuntary admission principles and inflict unnecessary suffering on inpatients. “It is a widely held principle that when we certify people into psychiatric hospitals we do it in the least intrusive way,” says O’Reilly, who is also a clinician. “However, when we stop patients from smoking, we aren’t using the least restrictive alternative. In fact, we precipitate them into nicotine withdrawal, which is an extremely distressing condition.”

Beamer Smith, first vice chair of the Ontario Association of Patient Councils, agrees: “While there are accommodations that can be made, some psychiatric facilities have chosen a path that, regardless of intent, feels like punishment; yet hospitals of this type should deal in compassion.”

Simpson links smoking restrictions to disruptive behaviour and punitive measures. “We hear from patients that a lot of behavioural issues start because they’ve been denied a smoke. Some have smoked for decades and suddenly, because they need mental health treatment, that’s the end of it. They engage in acting-out behaviour and may end up in seclusion or restraints, which creates health and safety risks for patients and staff.”

O’Reilly agrees that many of his patients do not want to use nicotine replacement therapy, become more agitated as they withdraw from nicotine and some smoke illegally on the wards, creating a fire hazard. Consequently “clinicians are forced into situations where they prematurely allow patients to have off-ward privileges.”

Parle, however, draws parallels between tobacco, alcohol and other substances. “Psychiatric hospitals have never had drinking rooms on the wards. Instead, for alcohol and drug addiction, hospitals provide good cessation support. Why should tobacco be any different?”

Ron E.\*, an inpatient at Penetanguishene who smoked two packs a day for over 30 years, agrees: “Every once in a while, people with addictions get a chance to quit and move on. If you don’t take advantage of it, the chance goes away and it may never come back again.” In fact, says Ron, “When the hospital implemented this decision to go smoke free, it saved my life.”

For Parle, “the ethical choice is not to look the other way and say, ‘Yes, smoking is a dangerous addiction that might ruin patients’ finances and health and will most likely cause an early death, but we’re going to have nurses escort patients outdoors to pursue this addiction.’ That should never have happened at hospitals in the first place.” Instead, Parle cites three reasons why psychiatric hospitals should implement smoking bans: as an ethical use of scarce health care resources; as an expression of the physician’s credo – First, do no harm; and as an aggressive corrective to the high rates of smoking among psychiatric patients.

Simpson, on the other hand, believes that patients deserve the opportunity to exercise choice. “They’re adults,” he says. “Nursing staff should tell them the health risks of smoking and give them all the information they need to make an informed decision about whether they’re going to smoke or not.” Smith agrees: “When someone comes to be treated for a ‘thing,’ they should only be treated for that ‘thing,’ unless they voluntarily accept another treatment. Any smoking cessation should be truly voluntary and exclusive of any other treatment.”

Simpson considers it unfair to “put nurses into the role of being enforcers for non-smoking,” or have hospitals bring in municipal bylaw enforcement officers to threaten patients, many of them on low incomes, with fines of \$110 for illegal smoking, which he says has happened in some locations.

O’Reilly suggests it’s neither helpful nor humane to insist that patients stop smoking immediately. “Many severely ill patients live impoverished lives and say they get pleasure from coffee and cigarettes. While we should try to improve their lives more globally, that’s something to do when they’re out of hospital; but when they’re in hospital, to take away, in some cases, both things that they like, I think that’s mean.”

Smith agrees: “Often the only comfort a person gets, particularly in their time of most need, is their habits.” In fact, says Smith, “Often the only outside air a client gets is on a smoke break. Smoke breaks can be a time of networking and reflection, both of which are beneficial to wellness.”

Simpson expresses concern that some patients will avoid seeking mental health care and treatment because of non-smoking policies. However, Parle counters that, whatever your addiction, you may want to avoid hospitals, but sooner or later, if you’re in a mental health crisis, you will come. He notes that the Mental Health Centre Penetanguishene experienced no change in occupancy rate or referral pattern after its 2003 total smoking ban.

O’Reilly, who as a clinician deals primarily with involuntary admissions, says that although people may be restricted from smoking in inpatient units, the majority resume smoking when they leave hospital, and for those who go from a fairly restrictive situation

to being discharged, the resumption of smoking can interfere with the effectiveness of their antipsychotic medication dose. Critics and proponents alike agree that government funding of nicotine replacement therapy and other smoking cessation aids, including counselling, should be extended to outpatients. ■

\*not his real name

## GOING SMOKE-FREE

Dan Parle, former director of planning and public information at the Mental Health Centre in Penetanguishene, Ontario, and Eva Ingber, an advanced practice clinician in the Schizophrenia Program at CAMH, offer these tips for mental health facilities considering the move to becoming smoke-free to help them deal compassionately, not punitively, with clients who smoke:

- Be inclusive.
- Involve clients, families, patient advocates and staff.
- Get staff on side and give them the tools to help their clients.
- Identify problem areas and provide clear strategies for managing them.
- Offer nicotine replacement therapies.
- Provide smoking cessation programs tailored to your population.
- Assess the smoking status of new patients and offer health education.
- Provide social and recreational activities to replace smoke breaks.
- Make all the environmental changes first, so that by the time you announce a date for implementation of the ban, there is already an atmosphere of wellness and health.

## RESOURCES FOR GOING SMOKE-FREE

*Integrating Smoking Cessation into Daily Nursing Practice: Nursing Best Practice Guideline.* Registered Nurses Association of Ontario. [www.rnao.org/bestpractices/PDF/BPG\\_smoking\\_cessation.pdf](http://www.rnao.org/bestpractices/PDF/BPG_smoking_cessation.pdf)

*Smoking Cessation in Psychiatry: Is There Sufficient Evidence to Recommend Smoking Cessation Activities? A Review of the Literature.* Network of Health Promoting Hospitals in Denmark. [www.fares.be/tabac/hst/DK-Mental\\_health\\_workshop\\_report.pdf](http://www.fares.be/tabac/hst/DK-Mental_health_workshop_report.pdf)

*Where Do We Go from Here? Tobacco Control Policies within Psychiatric and Long-Stay Units.* National Institute for Health and Clinical Excellence, London, United Kingdom. [www.nice.org.uk/niceMedia/documents/wheredowego.pdf](http://www.nice.org.uk/niceMedia/documents/wheredowego.pdf)

*Going 100% Smoke-Free in a Secure Setting: A National Trend Emerges.* Mental Health Centre Penetanguishene. [www.mhcva.on.ca/documents/SmokeFreeArticles/Trend%20Article.pdf](http://www.mhcva.on.ca/documents/SmokeFreeArticles/Trend%20Article.pdf)

“How to Implement a Smoke-Free Policy.” *Advances in Psychiatric Treatment*, 2008. vol. 14, pp. 198–207. This subscriber-accessed article focuses on mental health settings. <http://apt.rcpsych.org/cgi/content/abstract/14/3/198>

# Healthier women, healthier children

## Addressing pregnancy and smoking requires women-centred approach

BY AVRIL ROBERTS



**M**ATERNAL SMOKING DURING PREGNANCY REMAINS A SERIOUS public health problem, wreaking havoc on the health of women, fetuses and newborns. Yet smoking cessation interventions for pregnant and postpartum women are not only scarce but often ineffective.

Many women quit smoking or reduce tobacco use, usually in the first few weeks of pregnancy. However, approximately 25 per cent will relapse before delivery, 50 per cent within four months postpartum, and by the time the baby is one year old, between 70 and 90 per cent are smoking again, according to *Expecting to Quit*, a 2003 review of smoking cessation interventions for pregnant and postpartum girls and women published by the British Columbia Centre of Excellence for Women's Health (BCCEWH) in Vancouver. "Some women go through a temporary abstinence on their own or with some intervention from their physician or others, but from a woman's health point of view, they're no further ahead at the end of their postpartum year," says Lorraine Greaves, executive director of the BCCEWH and lead on the review.

Greaves finds fault with traditional fetus-centric approaches to smoking cessation. "Once the baby is born, that external motivation to quit is removed," she says. "Success during pregnancy or postpartum means focusing on women's health as the motivation for smoking cessation or reduction," says Greaves. "This doesn't mean ignoring the importance of fetal health, but without healthy women there are no healthy children. We need to send the message that quitting smoking is good for women's health and is therefore something they should do for the long term."

At the core of this woman-centred approach is an understanding of the psychosocial context of women's smoking. Women who smoke while pregnant are primarily young – often under 25, many of them lone mothers, living in poverty or on fixed incomes. "They're a different group from those the original smoking campaigns targeted 20 years ago," says Greaves. "Those were for people with options or the money or opportunity to do other things." Pregnant women who quit spontaneously tend to be older, better educated and less likely to have partners who smoke.

Research has also found that women from disadvantaged backgrounds are more likely to take their cues about the health risks of smoking from people in their social circles and families. Louise Guyon, a researcher with the Institut national de santé publique du Québec in Ste-Foy, found that, for these women, their mothers' opinions on tobacco use during pregnancy carried the most weight, whether they were encouraging their daughters to quit or minimizing the dangers. And even though the women knew that tobacco use during pregnancy is harmful, the majority didn't understand why.

But even among women who understand the risks, smoking may reflect other issues in the woman's life. According to Rosa Dragonetti, manager of the Nicotine Dependence Clinic at the Centre for Addiction and Mental Health (CAMH) in Toronto, pregnancy and new motherhood can bring past trauma to the surface. Partner abuse may continue, escalate or actually begin during pregnancy. Poor mental health, particularly depression, may be a stressor. "These things lead some women to smoke in the first place," says Dragonetti, "so smoking is one of their coping skills. If you take that away, how are they going to cope?"

Adding another layer of complexity is the smoking environment in which the woman lives. Partners' reactions and smoking status influence women's ability to quit. One key risk factor for postpartum smoking relapse is having a partner who smokes. Dr. Joan Bottorff, chair of health promotion and cancer prevention at the University of British Columbia in Vancouver, found that women's tobacco use during pregnancy was a source of tension for some couples. Yet most of the male partners who smoked did not consider changing their own habits. Indeed, some taunted their partners – I can smoke and you can't – smoked in their presence and left cigarettes in plain view without thinking of the temptation. "When people pressured these women, including their partners, they didn't appreciate it," says Bottorff. "They wanted to make their own decisions about stopping smoking and do it on their own terms."

Given the multiple challenges in quitting and staying quit, Greaves says interventions for pregnant women and new mothers must be comprehensive, holistic and sympathetic. "We can't just say, 'Here are 10 handy tips for quitting – go for it.' We need to start pre-pregnancy with woman-positive messages that send help, support and value to women as individuals around quitting smoking. We need to discuss these issues not just with women but with doctors and nurses. We also need to segment our approach to reach low-income women, girls and other high-risk groups. And relapse prevention has to be on the agenda."

Comprehensive intervention strategies for smoking cessation/reduction in pregnant women and new mothers may involve four levels of intervention. The first level involves raising public awareness of the health risks of women's smoking and framing the messages in sensitive, non-judgmental ways that focus on women's health. The second level involves discussing smoking and related risks with all women and girls of childbearing age and with key members of their health and social networks, especially partners and mothers.

Level three encompasses specialized, accessible services for pregnant women who smoke and tailoring them to women’s social, psychological and economic circumstances. Fourth-level interventions provide postpartum support to new mothers to help them maintain or initiate changes in tobacco use, improve their health and social support and enhance the health of their children.

Here are three Canadian programs taking a unique approach to providing women-centred interventions.

**PREGNETS: Prevention of Gestational and Neonatal Exposure to Tobacco Smoke**

The PREGNETS network of tobacco control and prenatal care providers has trained health professionals to deliver brief interventions that consist primarily of asking pregnant women if they smoke, advising smokers to think about changing some of their behaviours and referring women to resources such as the Canadian Cancer Society’s Smokers’ Helpline and Motherisk, whose staff have been trained by PREGNETS. The program has also shown Canada prenatal nutrition program projects in Ontario how to integrate smoking cessation messages without alienating pregnant smoking women. The web site, which was created as a resource for health providers, now includes a moderated discussion/support group for pregnant and postpartum women. “Pregnant women don’t typically attend smoking cessation groups because of stigma,” says project co-ordinator Dragonetti at CAMH. “This online group provides a confidential way to participate and get support.”

**STARSS: Start Thinking About Reducing Second-hand Smoke**

This Health Canada-funded harm reduction support strategy helps low-income mothers identify small, measurable steps they can take to protect their children from second-hand smoke, for example, delaying smoking, reducing one cigarette a day, smoking outdoors once a day. By building skills, the program helps women gain the confidence to take larger steps. “STARSS is not for women who are ready to quit; it is for women who smoke and don’t have the self-efficacy to consider quitting,” says Wendy Reynolds, executive director of AWARE (Action on Women’s Addictions-Research and Education), which developed STARSS. AWARE also offers Breath of Fresh Air, which provides low-income single mothers who want to quit with free smoking cessation aids. AWARE is also developing a training guide for smoking interventions with women with fetal alcohol spectrum disorder.

**TRIPs: Tobacco-Related Interaction Patterns**

*Couples and Smoking: What You Need to Know When You Are Pregnant* is an information booklet designed to educate pregnant women about how their smoking is influenced by their partners and everyday routines. Developed as part of ActNow BC: Healthy Choices in Pregnancy, the booklet is being launched this fall. A related smoking cessation intervention is being developed to support tobacco reduction in new fathers (see FACET in Resources sidebar). The first of its kind, the program will build on research findings on new fathers’ smoking patterns – the changes or modifications they make after the baby is born, their reduction or quit attempts and successful quit strategies. “If we could get men to reduce or stop smoking, that would support postpartum women in maintaining their quit and ensuring their children are protected from second-hand smoke,” says Bottorff. ■

**ASSUMPTIONS ABOUT PREGNANT WOMEN WHO SMOKE**

1. Pregnancy is a good thing and is therefore an opportunity for positive change.
2. Expectant mothers know that tobacco is harmful to the fetus.
3. The health of the fetus should be a strong enough motivation for the woman to quit.
4. The pregnant woman’s partner will want her to quit smoking also.
5. Helping pregnant women to quit smoking is no different from helping any smoker.
6. The woman has told her doctor and other health care providers that she smokes.

For information about each assumption, visit the Health Canada web site at [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca) and do a keyword search on *Quit Smoking Telephone Counselling Protocol for Pregnant and Postpartum Women*.



**RESOURCES FOR A FRESH START**

**Couples and Smoking: What You Need to Know When You Are Pregnant.** Visit the ActNow BC: Healthy Choices in Pregnancy web site to access this newly released publication. [www.hcip-bc.org](http://www.hcip-bc.org). The “Readings on Pregnancy and Substance Use” link leads to readings and resources that reflect a woman-centred perspective.

**Expecting to Quit: A Best Practices Review of Smoking Cessation Interventions for Pregnant and Postpartum Girls and Women.** Visit the Health Canada web site at [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca) and do a keyword search. This resources contains a list of smoking cessation programs for pregnant and postpartum girls and women.

**Families Controlling and Eliminating Tobacco (FACET).** This multi-part project, which includes TRIPs, examines patterns of family interaction influencing tobacco reduction during pregnancy and postpartum. Visit [www.nexus.ubc.ca](http://www.nexus.ubc.ca) and do a keyword search on FACET or TRIPs.

**PREGNETS.** [www.pregnets.org](http://www.pregnets.org).

## Smoke and mirrors? Smokeless tobacco and the harm reduction debate

BY NATE HENDLEY

**H**arm reduction approaches to tobacco are relatively recent. They are also highly controversial. While proponents argue that harm reduction strategies are a more realistic approach to tackling the health risks of this highly addictive product, critics argue that harm reduction strategies distract from the only safe option – quitting tobacco entirely. Entering the scene are smokeless tobacco products (STPs) such as snuff and chewing tobacco, which are promoted as products to use when you can't smoke.

Dr. Roberta Ferrence, executive director of the Ontario Tobacco Research Unit at the Centre for Addiction and Mental Health in Toronto, and Michael Chaiton, a graduate student in the University of Toronto epidemiology program, weigh in on the STP debate.

### What issues are at the core of the smokeless tobacco products debate?

**Ferrence:** The current debate centres on whether users of smoked products should be encouraged to switch to STPs, which are supposedly less risky, and whether promoting STPs discourages quitting and encourages non-smokers to start using STPs, because they are touted as being safe. Proponents argue that because STPs produce no carbon monoxide and fewer carcinogens than smoked products, they can reduce health risks for those who can't or don't want to quit tobacco use. Critics argue that determining the harm reduction value of STPs is difficult to determine because STPs are developed by tobacco companies, whose main goal it is to keep their brand alive and some of the research on these is done by people funded by the tobacco industry.

### Proponents of smokeless tobacco products argue that they are safer than smoked products. What do the critics say?

**Ferrence:** Switching to STPs eliminates the risks of inhaling smoke, but there remain other concerns about the effect on individual smokers. Perhaps more important, there is evidence that the availability of less harmful substitutes may keep many people using tobacco products who might otherwise have quit.

**Chaiton:** Traditionally, in North America, people who use snuff or chewing tobacco are also more likely to smoke cigarettes or to be heavier smokers. Smokeless tobacco certainly could be a harm reduction product under some circumstances. It's not as harmful as smoking. But if tobacco companies are marketing STPs as a means of maintaining addiction during times when you can't smoke, that isn't harm reduction. I've noticed washroom ads for STPs in restaurants and bars, which are smoke-free places. This seems to be an attempt to build a market for smokeless products in smoke-free places.

**Ferrence:** The tobacco industry is beleaguered to some extent. What would you do if smoking rates were falling? You would try to bring in new products that appear to be less harmful and allow you to keep your brand name in the public eye. There is a whole strategy by tobacco companies to develop starter products with low nicotine that target youth, such as STPs, and then building up to stronger products.

This has been documented in the literature. Indeed, tobacco companies are targeting youth with flavoured products that appeal to them.

### But if STPs are less dangerous than cigarettes, shouldn't their use be encouraged to get smokers to quit?

**Ferrence:** If the government were willing to ban cigarettes and just allow STPs, there would be a huge reduction in tobacco-related disease. But that's not going to happen soon. If you want to encourage people to use STPs you would have to have the government recommending them. The problem is that STPs still increase the risk of developing certain diseases. It's just that tobacco is so out of the ballpark – the level of risk of lung cancer, for example, is 20 times that of non-smokers. The government can't recommend something that causes cancer.

### Where does pharmaceutical nicotine fit into the harm reduction continuum?

**Ferrence:** The present debate focuses on pharmaceutical nicotine – nicotine replacement therapy (NRT) in the form of nicotine gum, the patch and other such products – versus STPs. The patch and gum release nicotine very slowly, which means the potential for addiction is lower. The big difference is that nicotine replacement products are pure nicotine and are made under controlled conditions by pharmaceutical companies, whereas smokeless products contain tobacco and tobacco carcinogens, can have very high levels of nicotine and are made by tobacco companies, which are not subject to the same regulations for manufacture.

### Do you see any role for smokeless tobacco as part of a harm reduction strategy?

**Ferrence:** We know that certain strategies reduce harm such as increasing taxes, smoking bans in public and private places. I feel it would not be inappropriate for a doctor, on an individual basis, to say, "If you can't quit right now, try pharmaceutical nicotine, such as nicotine gum, and if that doesn't help, try a smokeless tobacco product," but we do not promote that. We aren't opposed to people using STPs to quit or to reduce their risk. What we are calling for is some skepticism – the tobacco industry can't be allowed to run the show, because their interests are not health related. There may be a small role for STPs for some people, but I don't think it's the answer. There is the potential for increased risk of harm if it's not handled properly.

**Chaiton:** Nothing about STPs is intrinsically about harm reduction, unless it can substitute for cigarette smoking. It can be a harm-reducing product, but STPs are still a dangerous product, so when we talk about harm reduction, we're really talking about strategies around promotion of use of STPs, or taxation policies, or restructuring the tobacco markets. Those are the more promising harm reduction strategies. ■

# In the realm of hungry ghosts: Close encounters with addiction

How often does a book that intends to offer an evidence-informed, comprehensive analysis of addictions end up on the bestseller list? Such has become the fate of Gabor Maté's *In the Realm of Hungry Ghosts: Close Encounters with Addiction*.

The title does catch one's attention. The reference, explains Maté, comes from Buddhism, where the mandala, the circle of life, includes the realm of the hungry ghosts, whose inhabitants are aching empty and unfulfilled, constantly thirsting for things outside themselves, without being fully there for others. This, Maté argues, is the domain of addiction.

This may be a fitting depiction given Maté's work as a doctor with the Portland Hotel in Vancouver's Downtown Eastside, where he works with street people whose lives have been ravaged by intravenous drug use, homelessness, mental illness and violence. If it were only "them" – marginalized people we perceive, depending on our values, knowledge and experience, as either threats to or victims of the social order – the book wouldn't offer much new. But Maté argues that addiction is a continuum, not a discrete category for a few people from which the rest of us are exempt. He points to our cultural preoccupation with consumption and possession as manifestations of an addicted society. He defines addiction as "any repeated behaviour, substance-related or not, in which a person feels compelled to

persist, regardless of its negative impact on his life and the lives of others."

Although Maté shows how powerful neurobiological processes are in the addictive process, he opposes current moves in science to reduce addiction to the brain, arguing that "addiction has biological, chemical, neurological, psychological, medical, emotional, social, political, economic and spiritual underpinnings – and perhaps others I haven't thought about."

For Maté, addiction is a single process with many diverse manifestations. And all too often it is accompanied by mental and physical illness, interpersonal conflict, legal troubles, social disadvantage and developmental histories of neglect, abuse and trauma. It is the developmental experiences of childhood and adolescence that Maté sees as a particularly significant incubus for the emergence of addiction problems. Using clinical vignettes, his own story and the literature on addiction, he examines the biological, psychological, social and spiritual dimensions of addiction, weaving these threads into a fabric of increasing complexity.

But how do we get out of the realm of addiction and into a more hopeful space? In the end, Maté turns his attention to recovery and the healthier regions of the mandala, but has surprisingly little to say about how to make the journey. He cautions that the brain on drugs doesn't have much chance to be either fully conscious or self-compassion-

ate enough to break out of addiction. He speaks out in favour of harm reduction and the need for a spirit of compassionate curiosity towards people with addictions and related problems. The Buddhist response to the hungry ghost, by the way, is similar – to offer nourishment; the bodhisattva emerges as a harm reduction worker.

In the end, Maté turns to spirituality and offers a eulogy to the 12 steps. Along the way, he humanizes the reality of addiction, revealing its close connection with other health and social problems. He puts the stereotypes of addiction into a new context by making himself an object of self-analysis. He proposes that our stigmatization of people with severe addictions stems from our unwillingness to acknowledge the addictive nature of our own lives and the role of appetite, consumption and possession in society. If the book succeeds, it is not by offering tidy proposals to solve a sprawling problem, but by reaching a wide audience, provoking more open, active (and not always polite) dialogue about what we think addiction is, and what needs to be done about it.

*In the Realm of Hungry Ghosts: Close Encounters with Addiction*. Gabor Maté. Knopf Canada, Toronto, 2008, 480 pp., \$34.95.

**Wayne Skinner** is deputy clinical director of the Addictions Program at the Centre for Addiction and Mental Health in Toronto.

d o w n l o a d e d

SHEILA LACROIX

## Tobacco control: A global perspective

### The Canadian Centre for Tobacco Control

[www.cctc.ca](http://www.cctc.ca)

Select "Frameworks and Strategies" from the main menu, then "International." This directs you two key resources – the World Health Organization Framework and the World Bank report, *Economics of Tobacco Control*. Refer to chapters 4 and 5 of the latter. Chapter 4 covers demand reduction strategies such as tax increases and non-price measures, including smoking restrictions and advertising bans. Chapter 5 covers supply reduction, offering strategies such as trade restrictions and smuggling deterrents.

### WHO Framework Convention on Tobacco Control

[www.who.int/fctc](http://www.who.int/fctc)

Spearheaded by the WHO, this treaty is based on the premise that we all have a right to the highest standard of health in the current climate of the global tobacco epidemic. The aim is to protect health through demand and supply reduction provisions, recognizing the complexity

and challenges of cross border effects. The treaty has been signed by 168 countries including Canada, which in signing, agree to show political commitment to embracing the provisions. The document can be downloaded from the main page of the site – see the Report icon. There is also a link to the WHO Tobacco Free Initiative, which organizes World No Tobacco Day each May.

### United States

[www.ash.org](http://www.ash.org)

For a state-by-state summary of smoke-free legislation, check out the Action on Smoking and Health web site. This is a challenging site to navigate, so it is best to go directly to the page at <http://ash.org/smokingbans.html>, you can link to a list of all U.S. cities that have smoke-free laws for workplaces, restaurants and freestanding bars. ASH is also a good resource to find "News You Should Know" (see the ASH main page). There is also an ASH international site, <http://nosmoking.ws>.

## Contraband: The quicksand beneath smoke-free Ontario

DR. MICHAEL PERLEY

The recent implementation of Ontario's ban of retail tobacco displays and an amendment to ban smoking in vehicles transporting children are continuing proof of the strength of the province's Smoke-Free Ontario Act and its accompanying strategy. Unfortunately, a growing body of evidence indicates that the protection offered by this strategy is at serious risk due to the proliferation of contraband tobacco products.

Contraband refers to cigarettes on which federal and/or provincial taxes have not been paid. It can include cigarettes manufactured by main brand tobacco companies and destined for sale to Status Indians free of provincial taxes. It can also include products manufactured under license by Grand River Enterprises on the Six Nations Reserve or unlicensed products manufactured on reserve in Ontario or New York State. The latter is often sold in plastic bags of 200 cigarettes for as little as \$6 per bag.

Surveys conducted by the retail sector, the tobacco industry itself and the Ontario Tobacco Research Unit at the Centre for Addiction and Mental Health in Toronto point to a dramatic increase in contraband tobacco products in Ontario over the past several years. A precise estimate of the prevalence of contraband is difficult, but evidence suggests that up to one in three cigarettes smoked in Ontario originate in the contraband market.

There are at least four consequences of this level of contraband:

First, and most alarmingly, evidence indicates that ongoing declines in smoking rates among the general population and younger Ontarians have stalled: The recent release of Statistics Canada's 2007 data for the Canadian Community Health Survey shows that daily and occasional smoking for Ontarians 12 years and older remained static from 2005 (20.7%) to 2007 (20.6%).

Second, cheap contraband tobacco products are easily available. This makes it more difficult for smokers to quit and promotes smoking initiation among youth, since price has long been demonstrated as the most significant deterrent to tobacco use.

Third, contraband results in lost

revenue to the provincial treasury. Provincial government budget projections show a decline in annual tobacco tax revenues for the current year to below \$1 billion for the first time since 2001/2, despite tax increases during the government's first mandate of \$7.50 per carton.

The fourth consequence of contraband is the suspension in federal and provincial tax increases. In its 2003 election platform, the provincial government committed to a \$10 per carton tax increase during its first mandate. While \$7.50 per carton of this increase has been implemented, no further progress has been made, primarily due to the presence of contraband.

Contraband tobacco is not caused by high taxes, but by an available source of supply. Ontario and Quebec have the lowest provincial tobacco tax rates in Canada; yet they have the highest levels of contraband. An effective attack on contraband requires action by both federal and provincial governments and must involve many departments – finance and revenue, aboriginal affairs, public safety and security and health.

Some key remedies are available:

- Unlicensed manufacturers must be a prime focus of remedial efforts. The supply of raw materials and packaging to unlicensed manufacturers should be illegal. Seizures of these raw materials are legal in Quebec, but not in Ontario.
- Under Ontario's so-called quota system, tax-exempt cigarettes are supplied to each reserve using a formula based on population. However, the quota now greatly exceeds the number of cigarettes that could be reasonably consumed in a year by reserve residences, and this quota must be respected.
- Ontario tobacco manufacturing licenses should be revoked if a manufacturer is operating illegally. If the Ontario license is revoked, this should be grounds for a federal license to be revoked. Without licenses, raw materials cannot be acquired and exports cannot be made.

- Performance bonds for each tobacco manufacturer license of at least \$5 million per license should be established by federal and provincial governments. If a manufacturer is found to be involved in the contraband market, the bond can be revoked.

- In the longer term, First Nations bands must be able to tax tobacco products on reserve and benefit from the revenue.

U.S. jurisdictions must also be involved. The RCMP estimates that up to 90 per cent of contraband product in Ontario originates on the St. Regis territory on the U.S. side of the Akwesasne Reserve (the reserve straddles the Ontario/Quebec/New York border).

Due to a recent significant tobacco tax increase in New York State, authorities there are likely to soon have more incentive to directly attack the problem: St. Regis manufacturers should experience increased demand, as New York smokers try to avoid to the state's tax increase.

With smoking rates two to three times those of non-First Nations communities, on-reserve populations face particular threats from the use of tobacco products, especially from the availability of cheap products. The 2006 cancellation of the federal First Nations and Inuit Tobacco Control Strategy removed needed funds from on-reserve tobacco control. It also sent precisely the wrong signal to First Nations communities about the real concern of the federal government with the health of on-reserve populations. An effective First Nations strategy must be restored, and similar efforts must be launched provincially.

Finally, we must avoid the temptation to blame First Nations communities for this problem. A small minority of both natives and non-natives are responsible for the large majority of this trade. Bridges must be built between these communities if we are to have any real expectation of controlling what is perhaps the number one tobacco control challenge in Ontario today.

**Dr. Michael Perley** is director of the Ontario Campaign for Action on Tobacco.

## CANADA

**Public Health Summit: Making Healthy Communities Count**

September 17–20, Toronto, Ontario  
 Contact: International Conference Services Ltd., 1177 West Hastings St., Ste. 2101, Vancouver, BC V6E 2K3  
 tel 604 681 2153  
 fax 604 681 1049  
 e-mail inpapnn2008@meet-ics.com  
 www.meet-ics.com/inpapnn2008/

**Canadian Conference on Suicide Prevention: Suicide and Addiction**

October 26–29, Quebec City, Quebec  
 Contact: Hélène Pigeon, Agora Event Planners, 50, St-Charles, P.O. Box 26740, Beaconsfield, QC H9W 6G7  
 tel 514 695-1624  
 tel 514 695-1624  
 e-mail congresaqps2008@aqps.info  
 www.congresaqps2008.info

**20th Annual Conference of the Canadian Society of Addiction Medicine**

October 30–November 1, Vancouver, British Columbia  
 Contact: CSAM, 375 West 5th Ave., Ste. 201, Vancouver, BC V5Y 1J6  
 tel 604 484-3244  
 fax 604 874-4378  
 e-mail admin@csam.org  
 www.csam.org/annual.htm

**Ontario Tobacco Research Unit Conference: "Tobacco Control for the 21st Century"**

November 10–12, Toronto, Ontario  
 Contact: MaryLouise Lambert, CAMH, OTRU, 33 Russell St., Toronto, ON M5S 2S1  
 e-mail MaryLouise\_Lambert@camh.net  
 www.otru.org/conference/

**Building Equitable Partnerships Symposium 2008**

November 5–7, Toronto, Ontario  
 Contact: Mary Austin, CAMH, 33 Russell St., Toronto, ON M5S 2S1  
 e-mail Mary\_Austin@camh.net  
 www.camh.net/News\_events/CAMH\_Events/bep\_symposium\_2008.html

**National Association for the Dually Diagnosed 25th Annual Conference: "A Quarter Century of Awareness – Assessment, Treatment and Policy Advances"**

November 12–14, Niagara Falls, Ontario  
 Contact: NADD, 132 Fair St., Kingston, NY 12401 USA  
 tel 845 331-4336  
 fax 845 331-4569  
 e-mail info@thenadd.org  
 www.thenadd.org/pages/conferences/25th/index.shtml

**Chronic Disease Prevention Alliance of Canada 3rd National Conference**

November 24–26, Ottawa, Ontario  
 Contact: CDPAC, 116 Albert St., Ste. 1010, Ottawa, ON K1P 5G3  
 tel 613 565-2522, ext 306  
 fax 613 565-2278  
 e-mail info@cdpac.ca  
 www.cdpac.ca/content.php?doc=98

**Growing Home: 2nd National Conference on Housing and Homelessness in Canada**

February 18–20, Calgary, Alberta  
 Contact: University of Calgary, Faculty of Social Work, Professional Facilities Building, 2500 University Dr. N.W., Calgary, AB T2N 1N4  
 tel 403 220-2459  
 fax 403 282-7269  
 e-mail nhc2009@ucalgary.ca  
 www.nhc2009.ca

**3rd International Conference on Fetal Alcohol Spectrum Disorder: Integrating Research, Policy and Promising Practice around the World – A Catalyst for Change**

March 11–14, Victoria, British Columbia  
 Contact: University of British Columbia, Interprofessional Continuing Education, 2194 Health Sciences Mall, Rm. 105, Vancouver, BC V6T 1Z3  
 toll free 1 877 328-7744  
 fax 604 822-4835  
 e-mail ipcdereg@interchange.ubc.ca  
 www.interprofessional.ubc.ca/FASD09.htm

## UNITED STATES

**National Council on Alcoholism and Drug Dependence National Conference**

October 22–25, Kansas City, Missouri  
 Contact: NCADD, 244 East 58th St., 4th fl., New York, NY 10022  
 tel 212 269-7797  
 fax 212 269-7510  
 e-mail national@ncadd.org  
 www.ncadd.org/affiliates/conferencematerials/2008-Save\_Date.pdf

**American Public Health Association 136th Annual Meeting**

October 25–29, San Diego, California  
 Contact: APHA, 800 I St., N.W., Washington, DC 20001  
 tel 202 777-2478  
 e-mail annualmeeting@apha.org  
 www.apha.org/meetings

**8th International Conference on Pain and Chemical Dependency**

October 28–November 1, Philadelphia, Pennsylvania  
 Contact: International Association for Pain and Chemical Dependency, 101 Washington St., Morrisville, PA 19067  
 tel 215 337-6104  
 fax 215 337-0959  
 e-mail info@iapcd.org  
 www.iapcd.org

**American Academy of Child and Adolescent Psychiatry 55th Annual Meeting**

October 28–November 2, Chicago, Illinois  
 Contact: AACAP, 3615 Wisconsin Ave., N.W., Washington, D.C. 20016-3007  
 tel 202 966.7300  
 fax 202 966.2891  
 e-mail meetings@aacap.org  
 www.aacap.org

**32nd Annual Association for Medical Education and Research in Substance Abuse National Conference**

November 6–8, Washington, DC  
 Contact: AMERSA, 125 Whipple St., Ste. 300, Providence, RI 02908  
 tel 401 243-8460  
 e-mail admin@amersa.org  
 www.amersa.org/conf.asp

**International Society for Traumatic Stress Studies 24th Annual Meeting: "Terror and Its Aftermath"**

November 13–15, Chicago, Illinois  
 Contact: ISTSS, 111 Deer Lake Rd., Ste. 100, Deerfield, IL 60015  
 tel 847 480-9028  
 fax 847 480-9282  
 e-mail istss@istss.org  
 www.istss.org/meetings

**Association for Behavioral and Cognitive Therapies 42nd Annual Convention**

November 13–16, Orlando, Florida  
 Contact: ABCT, 305 7th Avenue, 16th fl., New York, NY 10001  
 tel 212 647-1890  
 fax 212 647-1865  
 e-mail tchilders@abct.org  
 www.aabt.org/conv2008/

**International Society for the Study of Trauma and Dissociation [ISSTD]**

November 15–17, Chicago, Illinois  
 Contact: ISSTD, 8201 Greensboro Dr., Ste. 300, McLean, VA 22102  
 tel 847 480-0899  
 fax 847 480-9282  
 e-mail info@isst-d.org  
 www.isst-d.org

**49th Psychonomic Society Annual Meeting**

November 20–24, Chicago, Illinois  
 Contact: Psychonomic Society, 1710 Fortview Rd., Austin, TX 78704  
 tel 512 462-2442  
 e-mail mellgren@uta.edu  
 www.psychonomic.org/meet.htm

**American College of Neuropsychopharmacology Conference**

December 7–11, Scottsdale, Arizona  
 Contact: ACNC, 545 Mainstream Dr., Ste. 110, Nashville, TN 37228  
 tel 615 324-2360  
 e-mail acnp@acnp.org  
 www.acnp.org/annualmeeting/default.aspx

**American Group Psychotherapy Association Annual Meeting: "Strong Group Foundations: Building Lasting Communities"**

February 16–21, Chicago, Illinois  
 Contact: AGPA, 25 East 21st St., 6th fl., New York, NY 10010  
 tel 212 477-2677  
 fax 212 979-6627  
 e-mail info@agpa.org  
 www.agpa.org/mtgs/index.html

**American Association for Geriatric Psychiatry 2009 Annual Meeting**

March 5–8, 2009, Honolulu, Hawaii  
 Contact: AAGP, 7910 Woodmont Ave., Ste. 1050, Bethesda, MD 20814  
 tel 301 654-7850, ext.111  
 e-mail meetinginfo@AAGPonline.org  
 www.aagpmeeting.org

**Society for Research in Child Development Biennial Meeting**

April 2–4, Denver, Colorado  
 Contact: Society for Research in Child Development, 2950 S/ State St., Ste. 401, Ann Arbor, MI 48104  
 tel 734 926-0600  
 fax 734 926-0601  
 e-mail info@srcd.org  
 www.srcd.org

## ABROAD

**Society for Research on Nicotine and Tobacco 1st Asian Regional Conference**

October 28–31, Bangkok, Thailand  
 Contact: 19/2 Ekamai 10, Sukumvit 63, Wattana, Bangkok, 10110 Thailand  
 tel 66 2714 2590, ext. 1  
 e-mail srnt2008@gmail.com  
 www.srnt2008.wildblueorganizer.com

**51st International Conference on Dependencies**

November 2–7, Limassol, Cyprus  
 Contact: Rupert Schildböck, ICAA Limassol 2008, P.O. Box 189, CH 1001 Lausanne, Switzerland  
 tel 41 21 320 9865  
 e-mail icaa2008@icaa.ch  
 www.icaa2008.org

**International Society of Addiction Medicine Annual Conference**

November 17–20, Cape Town, South Africa  
 Contact: Dr. Nady el-Guebaly, Addiction Centre, Foothills Hospital, 1403 – 29 St. N.W., Calgary, Alberta, Canada T2N 2T9  
 tel 403 944-2025  
 fax 403 944-2056  
 e-mail office@isamweb.org  
 www.isamweb.org/

**17th European Congress of Psychiatry Annual Meeting**

January 24–28, 2009, Lisbon, Portugal  
 Contact: Kenes International, 17th European Congress of Psychiatry, 1–3, Rue de Chantepoulet, P.O. Box 1726, 1211 Geneva 1, Switzerland  
 tel 41 22 908 0488  
 e-mail epa2009@kenes.com  
 www.kenes.com/aep/

**14th World Conference on Tobacco OR Health**

March 8–12, Mumbai, India  
 Contact: Salaam Bombay Foundation, 46, Maker Chambers III, Nariman Point, Mumbai tel 022 645 23 837  
 e-mail secretariat@14wctoh.org  
 www.14wctoh.org/contact.asp

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