

Integration of Smoking Cessation into Addiction Treatment in Ontario

Mike DeVillaer

Provincial System Support Program

Centre for Addiction and Mental Health (CAMH)

Department of Psychiatry & Behavioural Neurosciences,
Faculty of Health Sciences, McMaster University

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About
Mike
DeVillae



Over his three and a half decades with ARF and CAMH, Mike has enjoyed a varied career as a clinician, research/evaluation collaborator, educator, systems developer, policy advocate, and strategic planner. He has played a leadership role in the evolution of the addiction treatment system in both Hamilton and more broadly in Ontario. This includes the establishment of women's withdrawal management services, interagency clinical data systems, and the integration of tobacco cessation into the addiction treatment system. Mike also maintains a part-time faculty appointment in the Department of Psychiatry and Behavioural Neurosciences at McMaster University. He was the 1996 recipient of the *John C. Sibley Award for Excellence in Health Sciences Research and Education by a Part-time Faculty Member at McMaster*. Mike's current interests include epidemiology of drug problems, drug policy, and health professional education on addictions. He is an active contributor to discussions on drug issues and social justice on EENet, Portico, and Twitter.



For just a few minutes, I'd like you to imagine that you are not looking at a presentation from an addictions/mental health conference, but at a presentation from an investment seminar, in which I am trying to convince you to invest a portion of your hard-earned savings in my company.

The first thing I tell you is that half of our customers will ultimately die from their use of our product. This level of mortality occurs on a large scale every year. So much so, that generating new customers, to replace those that have died, is Job #1. Since few people are inclined to begin using our product once they reach their mid-late 20s, it is critical for our marketing efforts to focus on young people. However, advertising our product to young people is illegal in most places, and even in the most libertarian markets, it is frowned upon. But we do it anyway – in cleverly subtle ways – even though we will never publicly admit this.

In an attempt to fetter our ambition, governments have imposed a variety of restrictions on how we can manufacture, promote, and retail our products. Our packaging must carry a prominently-displayed health warning with graphic images of the various harms associated with the use of our product. We are also not allowed to display our product at retail outlets. They must be hidden inside unmarked drawers. People are not allowed to use our product inside any public buildings, or even outside near the entrances, and increasingly, are not allowed to use them in outdoor public spaces such as sports fields, parks, and beaches.

Provincial governments in Canada have launched, or are planning to launch, class-action lawsuits against us. Out-of-court settlements have already been successful in the US where our American counterparts agreed to pay out \$ billions in damages. Such lawsuits are proliferating internationally. The families of those who have died from their use of our product have also successfully sued our industry.

Many governments are spending \$ millions advising people not to use our product, and it is working, particularly with young people where we have seen unprecedented declines in the last decade and a half. There is no reason to expect a reversal of this trend. And keep in mind that youth are our key market. To make matters worse, our product is heavily taxed, making it quite expensive to buy – particularly by young people who tend to have less disposable income. And now, lower quality versions of our product are being produced for black-market distribution. They sell for much less than our legal product and have taken a fair-sized portion of our market share.

I'm certain that all readers have figured out what product I am talking about, but if you didn't know, would you be thinking "I'm in ! Show me where to sign ! This sounds like a business with a promising future"? Of course you wouldn't. You would exit the room with the kind of haste reserved for a ringing smoke alarm at a gasoline depot, your fist tightly clenched around your cheque book. But in the atypical case of tobacco, from a purely financial perspective, your conclusion would be wrong. Amazingly, despite all these perils and liabilities, the tobacco industry remains one of the most financially successful industries in the world, and is almost certain to remain so for quite some time.

Targeting the Mentally Ill

Schizophrenic.

Other low tars are pretty one-dimensional. Dull. But the New Merit is a whole other story: big new taste with lower tar. And that's exciting. In fact, the New Merit has as much taste as cigarettes with up to 57% more tar. Big taste, lower tar, all in one. For New Merit, having two sides is just normal behavior.

LOW TAR - ENRICHED

The New Merit. We've got flavor down to a science.

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- Prochaska et. al. Schiz. Bull. 2007
- chronicles interest going back to the 1950s
- "...having two sides is just normal behavior."

Part of the reason that the tobacco industry has remained so successful, apart from the fact that they traffic in a highly addictive drug product, is that the industry is absolutely ruthless. Prochaska & colleagues have chronicled the interest of the tobacco industry in schizophrenia & draw attention to this ad for Merit cigarettes. Note the prominently placed word 'Schizophrenic' at the top of the ad and that the cigarette pack is presented as a double image. The copy reads "Having two sides is just normal behaviour." Clearly these are allusions to schizophrenia and which perpetuate the myth of what schizophrenia is not. We all know and accept that we are all targeted by ads. But the enterprise becomes more contemptible when the most vulnerable among us are strategically targeted – whether it is our children struggling with peer acceptance, the mentally ill, or maybe even your clients.

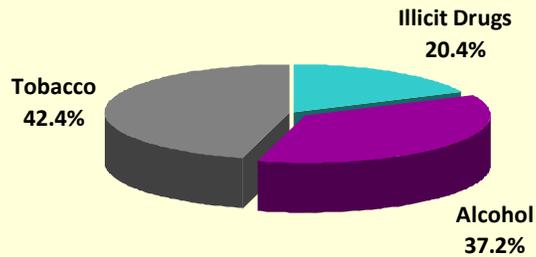
Prochaska et. al. *Tobacco Use Among Individuals With Schizophrenia: What Role Has the Tobacco Industry Played?* Schizophrenia Bulletin, 2007

Why should Ontario's addiction treatment system care about tobacco ?



I'm going to provide an overview for why the addictions field should be concerned about tobacco. Once I've laid a foundation, I will provide an update on how successful we have been so far in integrating smoking cessation services into the addiction treatment system.

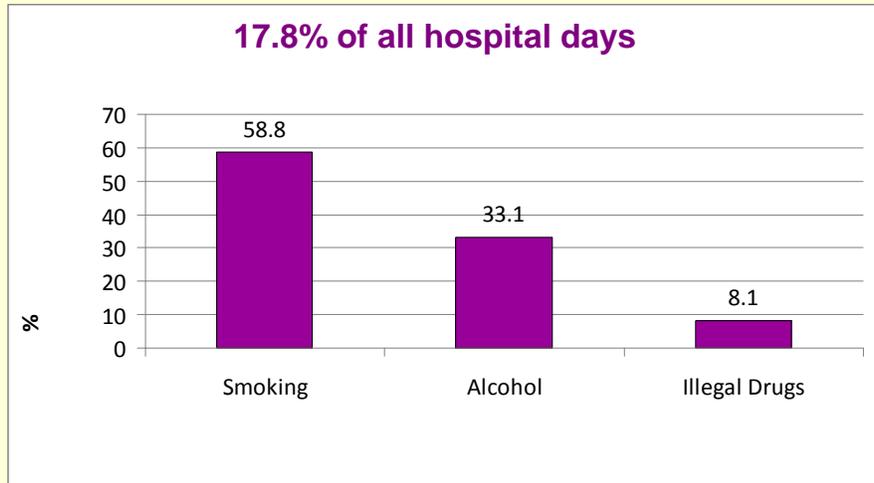
Economic Costs of Drug Problems in Ontario, 2002 = \$14,300 million



Rehm et. al. (2006) The Costs of Substance Abuse in Canada in 2002. Canadian Centre on Substance Abuse.

Each year in Ontario, drug use costs the Ontario economy over \$14 billion. This is based upon a wide variety of costs including health and social care costs, rehabilitation, policing, court and legal proceedings, incarceration, productivity losses, etc. As you can see from the pie chart, tobacco accounts for the highest proportion of the costs at 42.4%, even more than alcohol, and twice as much as all illegal drugs combined.

1.3+ Million Alcohol, Tobacco, & Illegal Drug-Related Hospital Days, Ontario 2002

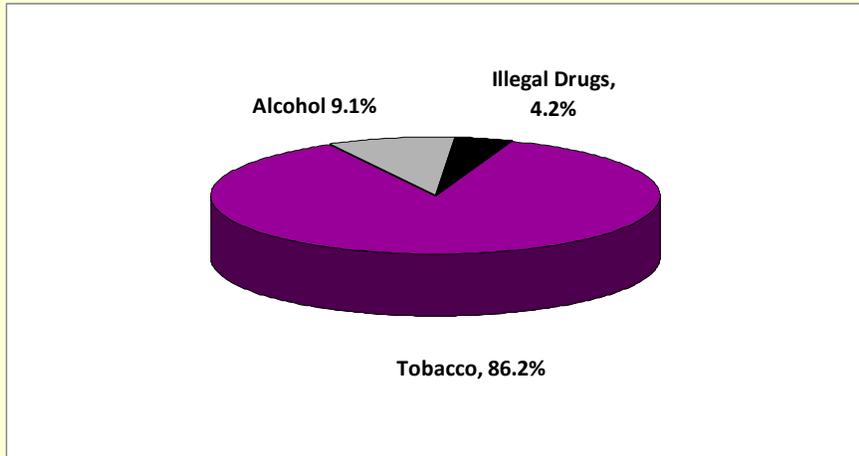


Rehm J. et.al. (2006). The Costs of Substance Abuse in Canada, 2002. Canadian Centre on Substance Abuse.

Our hospitals routinely collect information on days spent in hospital. If someone is injured in a car accident and as a result spends three days in hospital, those are counted as three hospital days. If someone is in a car accident in which alcohol is involved, those are counted as three drug-related hospital days, in this case, more specifically, as alcohol-related hospital days. This chart shows us that alcohol, tobacco & illegal drugs account for in excess of 1.3 million hospital days per year. That accounts for 17.8% of all days spent by patients in hospital. Another albeit crude way of thinking about this is that if you could walk into a typical Ontario hospital on a typical day, one of six patients in that hospital would be there for reasons related to their use of alcohol, tobacco, or illegal drugs. The chart also shows us that of the three drug types, smoking accounts for the most drug-related hospital days – at 58.8% - more than alcohol and all illegal drugs combined.

Type of Drug-related Deaths in Ontario (2002)

Drug-related deaths = 15,253



Rehm J. et.al. (2006). The Costs of Substance Abuse in Canada, 2002. Canadian Centre on Substance Abuse.

15,000 drug related deaths every year – can you imagine the public outcry if that many Ontarians died in airline crashes every year ? As a society, we would not tolerate such a thing. But we do for drug-related deaths. Important point here is that mortality is where tobacco really becomes prominent, accounting for 86% of drug-related deaths.

High Mortality in Treatment Population

- more addiction treatment clients die from tobacco-related disease than from all other causes combined (Hurt et al., 1996)
- **Is Ontario's addiction treatment system saving people from the perils of other drugs just so they can die prematurely from their untreated addiction to nicotine ?**



Tobacco use and mortality is not high only among the general population, but is particularly so among the addiction treatment population.

Hurt, R. D., Offord, K. P., Croghan, I. T., Gomez-Dahl, L., Kottke, T. E., Morse, R. M., et al. (1996). Mortality following inpatient addictions treatment. role of tobacco use in a community-based cohort. *JAMA: The Journal of the American Medical Association*, 275(14), 1097-1103

Better Client Outcomes Overall

- Non-smoking clients in addiction treatment programs have better outcomes than those who continue to smoke (McCarthy et. al., 2002)



McCarthy, W. J., Zhou, Y., Hser, Y., & Collins, C. (2002). To smoke or not to smoke: Impact on disability, quality of life, and illicit drug use in baseline polydrug users. *Journal of addictive diseases : the official journal of the ASAM, American Society of Addiction Medicine*, 21(2), 35-54.

High Level of Awareness Among Clients

- Each yr, over 20,000 clients entering addiction treatment identify tobacco as a 'problem substance' (DATIS)
- Comprise 26.0% of admissions in 2013
- We know this to be an under-estimate

The issue of tobacco as a problem substance being underestimated is addressed later in this presentation.
Drug & Alcohol Treatment Information System Database, CAMH. Data accessed over various years up to 2013.

Why should Ontario's addiction treatment system care about tobacco ?

- Regardless of how we measure it, tobacco is Ontario's **#1 drug problem**
- Clients who continue to smoke have **poorer outcomes**
- **Kills** more addiction treatment clients than all other causes combined

To return to my earlier question and summarize...

So, what's the problem ?



An Ontario Addiction Treatment System Policy on Tobacco Does Not Exist

1999: Ontario Ministry of Health's "*Setting The Course: A Framework for Integrating Addiction Treatment Services In Ontario*"

- did not include the words 'tobacco' or 'smoking'

2010: MH<C released "*Report of the Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy*"

- did not include the words 'tobacco' or 'smoking'

2011: "*Open Minds, Healthy Minds - Ontario's Comprehensive Mental Health and Addictions Strategy*"

- "*Ontarians do many things to maintain their physical health – like eating healthy foods, staying active, and **not smoking.***" [my emphasis]

1999 – also about the scope of addiction services in Ont

I raised concerns – dismissive response

2010 – also raised a fuss in a few locations – a bit more acceptance

2011 – only this feel-good platitude found in the Introduction to the report

Remember, this is Ontario's number one drug problem we are talking about, and our policy frameworks have a long legacy of ignoring it

Tobacco-tolerant Milieu

- across all studies, median prevalence of smoking in US addiction treatment programs is **76.3%** (*J. Guydish, et. al., 2011*)
- across all programs in Ontario in 2013, prevalence of smoking among admissions was **47.3%** (DATIS, 2014)
- anecdotally, many programs **not even asking** if clients smoke at admission

What we do have is a tobacco-tolerant milieu in many of our addiction treatment organizations. It should be no surprise that if tobacco is not addressed at the policy level, it will not have much of a profile at the service level either. There is no reason to believe that smoking prevalence among those in treatment would be higher in the US than here, so we should expect similar levels of smoking to be observed in Ontario. But **recorded levels** are in fact much lower.

Guydish, J. Passalacqua, E. Tajima, B. Chan, M. Chun, J. & Bostrum, A. Smoking Prevalence in Addiction Treatment: A Review. *Nicotine and Tobacco Research*, April 4 2011, 1-11.
DATIS (2014). Client Characteristics Open Admissions for 2013. CAMH.

Why is detection so low in Ontario?

- Catalyst software: has a limit of 5 substances used & 5 problem substances
- indifference to tobacco at some programs
- 2010 & 2011 surveys: < 1/4 addiction treatment programs provided “smoking cessation” treatment

Dynamics of the Milieu

- counselling **staff** will go outside to smoke with clients
- defended as an effective way to 'bond with clients'
- would they inject crystal meth ? smoke a joint ? or even go for a drink together ?; of course not
- staff smoking with clients **normalizes** the use of an addictive harmful drug product
- also creates, in a treatment environment, a major trigger for **relapse** to other drug use

Both formal and informal consultations with staff in the field have revealed interesting dynamics at play.

It is not my intention to be so harsh on our addiction treatment system. I think it has always been a very progressive system with conscientious people who care for their clients' welfare with dedication to evidence-based practice. I have a high level of respect for the system. But I also think the system has this one blind spot regarding tobacco.

So,
what
to do ?



Viewers of the television show “Mad Men” may recall an early episode about the “It’s toasted” tobacco campaign. That episode was based on an actual tobacco campaign. Here is an actual ad arising from that campaign.

Let's Talk

- formal consultation with the field
- presentations
- mobilized early-adopters
- formed a work group
- engaged leaders from the field



We engaged the addiction treatment system in as many ways as we could.

CAMH. Integrating Tobacco Interventions into Addictions Treatment:
An Ontario Addictions Sector Meeting: Thematic Summary Report. Toronto, Ontario
March 3, 2009. (contact: michael.devillaer@camh.ca)

Developed a Proposal

Partners:

CAMH, AMHO & ConnexOntario

Proposal Targets:

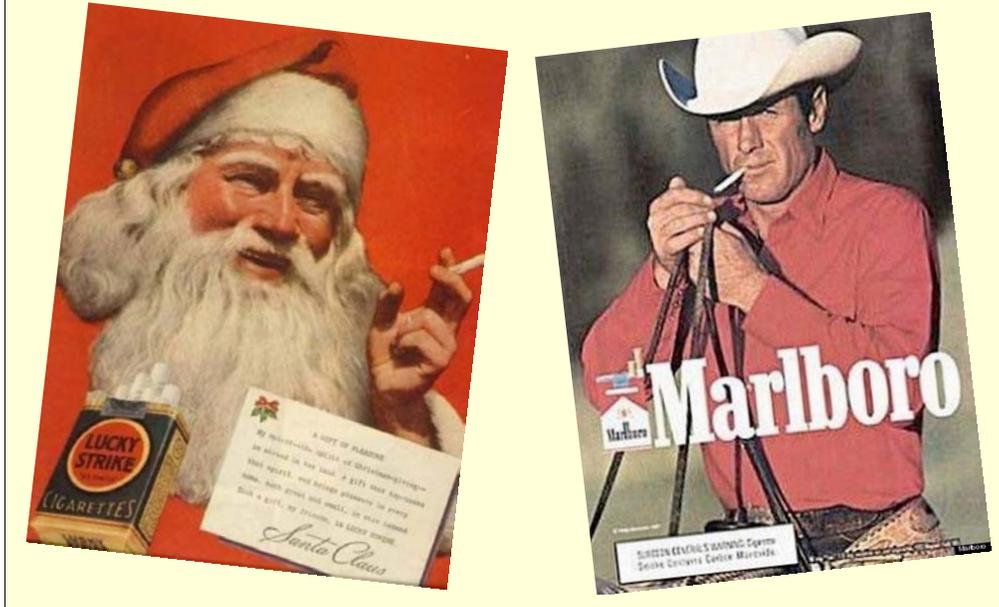
- engage 189 addiction organizations
- provide smoking cessation training to all addiction counsellors (estimated 1,900)
- 7,500 individuals receive free NRT each year x 3 yrs = 22,500 clients

At the time, AMHO (Addiction Mental Health Ontario) consisted of two precursor organizations: (The Ontario Federation of Community Mental Health & Addiction Programs & Addictions Ontario)

Funded

- MoH<C \$4.9 million
- Minister announced January 18 2012
- CAMH's Nicotine Dependence Service (under direction of Dr. Peter Selby) to implement training and NRT distribution
- CAMH's Provincial Services (Mike DeVillaer) to work with ConnexOntario & AMHO to promote participation & monitor progress

So, how are we doing ?



ConnexOntario

- maintains a database of organizations providing treatment for addiction, mental health & gambling problems
- includes characteristics of organizations, their services & availability
- just under 200 organizations reporting on addiction services
- just over 300 organizations reporting on mental health services

Primary data source is ConnexOntario

Types of Tobacco Services

Priority

- Routine Screening
- Counselling
- NRT
- Follow-up

Other

- Education/Advice
- External Referral

These are the types of tobacco services we have been monitoring. The first four are the critical ones we would like all organizations to provide. We are also monitoring provision of 'education or advice' and 'making a referral to an external organization'.

Provision of Any Kind of Tobacco-related Service

Substantial:

- All of: routine screening, counselling, free NRT, and follow-up

Minimal:

- a supply of 'quit smoking' pamphlets on display in the waiting room

or

- referring to an external community service and only if the client took the initiative to ask

% of Addiction Organizations Providing Any Kind of Tobacco-related Service

January 2012*: 72.0 %

April 2014: 91.9 %

* before Ministry announcement

The January 2012 data was accessed, and a report generated about two weeks before Ministry announcement of funding.

Most recent Connex database snapshot taken on April 2, 2014. 91.9% translates into 16 addiction organizations in Ontario that do not provide any services related to smoking cessation.

% of Addiction Organizations Providing Specific Tobacco-related Services

| Type of Tobacco Service | Jan 2012 (n=189) | Apr 2014 (n=198) | Change (A14-J12) |
|---|---------------------|---------------------|---------------------|
| Education/Advice | 23.8 | 68.2 | 44.4 |
| Routine Screening | 20.1 | 50.5 | 30.4 |
| Counselling | 39.2 | 56.5 | 17.4 |
| Follow-up | 5.3 | 19.7 | 14.4 |
| External (Formal) Referral for Treatment | 43.4 | 54.0 | 10.6 |
| Free NRT | 11.6 | 19.2 | 7.6 |

The largest increases were seen for the interventions which are not resource/cost intensive. The more resource/cost intensive interventions did not increase much. The priority services are in bold: External referrals for treatment and for follow-up must be formal – initiated by agency; not just advice to client

Agencies provide full treatment for all other drugs. Why not for tobacco ? Out-sourcing treatment for tobacco is not defensible

% of Addiction Organizations Providing Gold Standard

Must provide all 4 of:

- Routine screening
 - Counselling
 - Free NRT
 - Follow-up
-
- January 2012*: 1.1%
 - April 2014: 8.6%

January 2012 data were collected just before Minister's announcement

How Much Change Relative to Mental Health System ?

- intervention not targeted at mental health system
- MH system can serve as a comparison group for assessing progress in addiction system

But can't totally separate the two systems:

- a general increase in societal awareness
- pre-existing interest among some MH agencies
- awareness of Ministry funding announcement
- some overlap in organizational mandates

There may be a wave of increased awareness of tobacco in society, in health care, and in the addiction/mental health field that is quite independent of our efforts. Since our efforts are restricted to the addiction system, the mental health system can be used as a comparison group to see if we exert an effect above and beyond what is generally happening anyway.

However, it's not as if the mental health system could be completely isolated from the effect of our efforts on the addiction system. But this contamination would act in a way that would reduce observed differences between the two systems. So, if there are still observed differences this would suggest that our efforts produced an effect above and beyond more general currents of influence.

**Addiction & Mental Health Systems
Change in % of Organizations Providing Any
Kind of Tobacco-related Service**

| | 2012 | 2014 | Change (2014 - 2012) |
|---------------------------------|-------------|-------------|---------------------------------|
| Addiction System | 72.0 | 91.9 | 19.9 |
| Mental Health System | 63.8 | 84.2 | 20.4 |

This is for 'any kind' of change.

Speculative interpretation: Our efforts, the funding announcement, and other more generalized societal forces created an increased awareness that prompted agencies in both systems to make some gains in addressing tobacco.

Addiction & Mental Health Systems Change in Providing Specific Smoking Cessation Services (2012 & 2014)

| Type of Tobacco Service | % Increase in Addiction System | % Increase in Mental Health System |
|--|--------------------------------|------------------------------------|
| Education/Advice | 44.4 | 31.4 |
| Routine Screening | 30.4 | 15.0 |
| External (Formal) Referral for Treatment | 10.6 | 15.2 |
| Counselling | 17.4 | 9.1 |
| Follow-up | 14.4 | 7.0 |
| Free NRT | 7.8 | 4.0 |

But how do things look with the more specific indicators of change ? The middle column provides the same change data we already saw for the addiction system. The right column provides the same change data for the mental health system. Between 2012 and 2014, for Education/Advice, we saw an increase of 44.4% in the addiction system, compared to an increase of 31.4%, in the mental health system. Etc.

The increases in the mental health system for all types of services suggest that there was either a lot of cross-influence or a societal-driven increase in the level of awareness of tobacco issues at these organizations that had nothing to do with our efforts. Probably a bit of both.

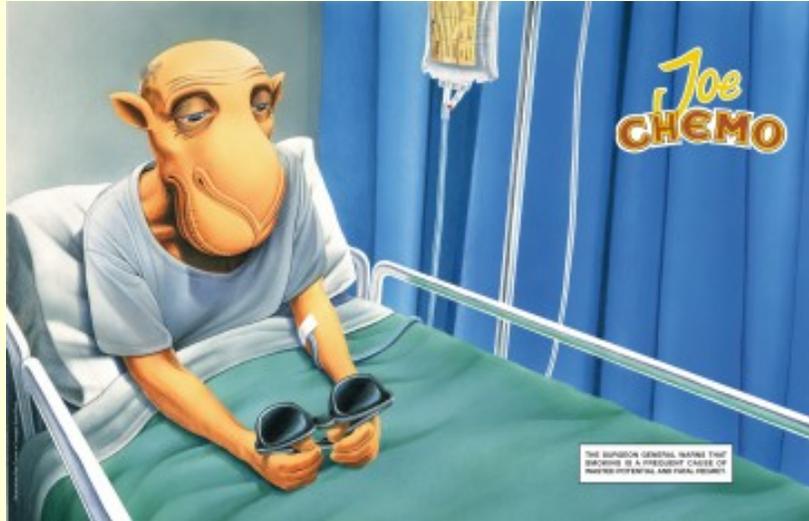
However, in all cases (except Ext. Referral), there was more change in the addiction system than in the mental health system, in most cases almost double. This would suggest that our targeted efforts have had an effect above and beyond cross-influence or general societal trends. Changes in External Referrals is difficult to interpret. Both increases and decreases could be good news. If programs that were doing nothing started to make external referrals (an improvement), that would **increase** the count of external referrals. If programs that were referring externally started to provide the service themselves (also an improvement), that would **decrease** the count of external referrals. Both of these trends would be good, and yet affect the count of external referrals in opposite directions. To really derive any meaning from changes in external referrals, we would have to conduct a more complex time-series kind of analysis that would track the path of change among programs. This is not currently feasible resource-wise.

Addiction & Mental Health Systems Change in Providing Gold Standard

| | 2012 | 2014 | Change (2014 - 2012) |
|-------------------------------------|------|------|-------------------------|
| Addiction System | 1.1 | 8.6 | 7.5 |
| Mental Health System | 2.6 | 6.6 | 4.0 |

There was change in both systems with more change in the addiction system.
But bottom line is that improvement in the gold standard is low in both systems.

What does DATIS tell us ?



Drug & Alcohol Treatment Information System (DATIS)

- database of characteristics of clients in addiction treatment in Ontario
- just short of 200 agencies
- approximately 100,000 admissions per year based upon approximately 60,000 distinct individuals

A second data source is DATIS: addictions only. The culmination of what agencies enter into the Catalyst software.

% Admissions Reporting *Use of Tobacco* and *Tobacco as a Problem Substance*

| | 2011 (n=107,512) | 2013 (n=94,833) |
|---|----------------------------|---------------------------|
| Use of Tobacco | 43.5 | 47.3 |
| Tobacco as a Problem Substance | 22.0 | 26.0 |

2011 –includes a full calendar year of data immediately previous to Minister’s announcement

2013 –a full calendar year of data two years post announcement

This data will reflect changes in the tendency of agencies to ask the questions rather than actual fluctuation in the client population.

-diligent screening should identify about 75% as smokers which is the common prevalence in treatment programs

-proportion of those who would accordingly identify tobacco as a problem is not possible to reliably project

Obviously there is very little improvement in the detection of tobacco use and problems within addiction programs. This is disappointing.

CAMH NDS's STOP Program

- Research project examining the effectiveness of providing cost-free smoking cessation treatment (pharmacotherapy + behavioural support) to Ontario smokers
- Goal: Decrease smoking prevalence in Ontario by increasing patient access to evidence-based treatments, and building local capacity to deliver treatment

A third data source is the STOP Program, which had been making NRT available to Family Health Teams & Public Health Units, and now to addiction agencies in Ontario.

STOP with Addictions: Goals

The **STOP Program** is now aiming to engage **Addictions Agencies** across Ontario to:

1. Provide Nicotine Replacement Therapy (NRT) and cessation counselling, at no cost, to individuals who access addiction programs
2. Increase the capacity of addiction program staff to provide comprehensive smoking cessation interventions

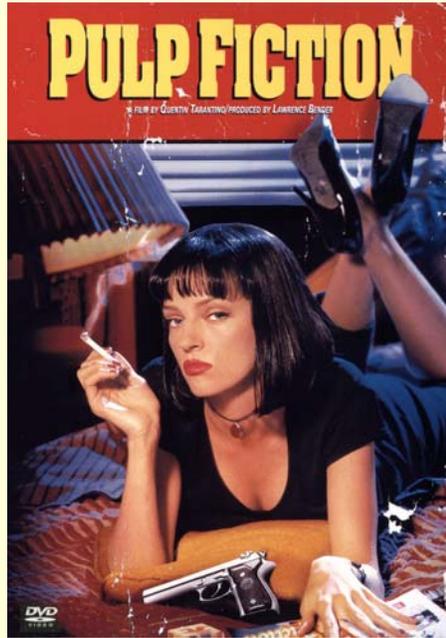


Proposal Targets & STOP Addictions Actuals

| | Counsellors Trained | Organizations Operational | Clients Receiving NRT |
|--|----------------------------|----------------------------------|------------------------------|
| Proposal 3 Yr Targets (Apr '12–Mar '15) | 1,900 | 189 | 22,500 |
| 2 yr Target (Mar '14) | 1,267 | 126 | 15,008 |
| Mar '14 Actual | 345 | 19 | 1,724 |

The first row of data represents what we had submitted to the Ministry and was approved by the Ministry as the project's end date targets (after three years) for the number of counsellors trained, the number of organizations providing nrt to clients, and the number of clients actually receiving nrt. The second row shows what these targets are prorated at the end of the second year. The third row shows what STOP Addictions had actually achieved at the end of two years. Clearly, the actuals fall far below the targets.

So
where
are we
now ?



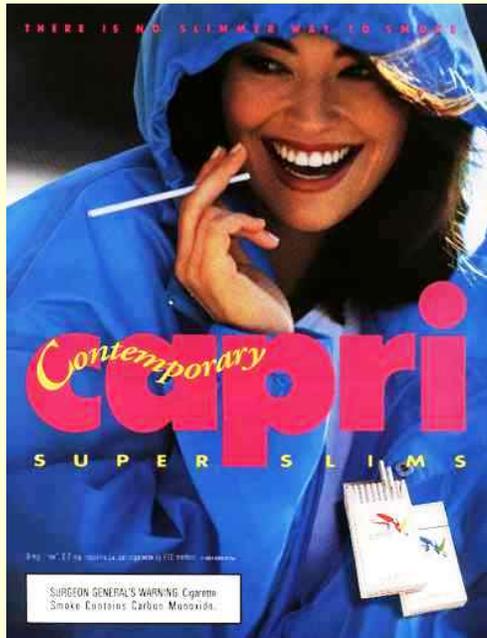
Some progress...

- addiction agencies are giving tobacco more attention
- particularly those services that are easy to implement: education & routine screening
- modest increases in counselling and follow-up

... but lots of room for improvement

- negligible increase in access to free NRT
- provision of gold standard remains low
- negligible improvement in identification of smokers at admission
- negligible improvement in identification of tobacco as a problem substance at admission

What's
Next ?



DATIS

Add a tobacco screening item to Catalyst:

Smoking Status:

- Never smoked tobacco
- Have quit smoking over 1 year ago
- Have quit smoking less than 1 year ago
- **Smoke with a desire to quit/change**
- **Smoke with no desire to quit/change**
- Smoke occasionally/socially (less than 4 cigarettes per week)

Inclusion of this item should dramatically increase the number of agencies doing **routine screening**

It is expected that this item will be added to the new version of the Catalyst software used by addiction agencies to produce the content of the DATIS database.

STOP Addictions

STOP Addictions to accelerate agency participation

Specifically,

- remove the \$5 million insurance liability requirement
- offer web-based training
- enhance communications with the field

This would increase # agencies enrolling in STOP & consequently providing **counselling** & **NRT**

CAMH & Connex

Continue to:

- work with AMHO to champion the integration of smoking cessation into addiction treatment
- monitor integration of tobacco services into addiction organizations
- report back to the field on progress at least annually

To Summarize

Pursuit of **Gold Standard**:

- **Routine Screening** – DATIS
- **Counselling** – STOP Addictions
- **Free NRT** – STOP Addictions
- **Follow-up** – Smokers' Help Line (CAMH)

To improve our success, we hope to engage partners for each of these components of the Gold Standard. If anyone is interested in working on the Follow-up piece, please let me know. Input from the addiction system will be crucial to come up with a model that would work well for clients of the addiction treatment system.

A story:
What do
“women’s detox”
and
“integration of
smoking cessation
into addiction
treatment”
have in common ?



When I started working with the Addiction Research Foundation in 1978, there was a fairly well-resourced capacity for providing withdrawal management (“detox”) for men, but none for women. Astonishingly, this was widely justified by claims that women did not need it, because their problems were “different”. Certainly there were differences but not that justified this inequity in access to care. Even though I was right out of grad school and pretty green, I wasn’t buying this, and I began to design Ontario’s first needs assessment for a ‘women’s detox’ in Hamilton. It was a tough battle facing opposition from just about everywhere. But with some great inspiration and guidance from people like Virginia Carver and Janet York, we prevailed in Hamilton, and ultimately across most of the province. These days, no one questions the need for withdrawal management services for women, and it seems astounding to think that there was a time when the need for these services was dismissed in such a cavalier fashion. I think we are seeing a comparable evolution in the field now in relation to the integration of tobacco interventions into addiction treatment. The tobacco-tolerant milieu that has prevailed in the addiction field has only very recently begun to change. We still have a long way to go, but I believe that in less than a decade, the new recruits to the addiction field will be similarly astounded to hear that there was a time when tobacco was not considered to be a serious drug dependency worthy of inclusion in a comprehensive treatment plan. I’m hoping that this presentation will inspire readers to become an active part of this exciting and important evolution.

Questions ?



Michael.DeVillaer@camh.ca

@MikeDeVillaer