Smoking Cessation for People Living with HIV

February 5, 2010

PARTICIPANT MANUAL
Smoking Cessation for People Living with HIV

February 5th, 2010
TEACH Learning Centre

Learning Objectives:

At the end of this course, participants will be able to:

- Relate research evidence to clinical practice implications for patients with HIV who use tobacco
- Set practice targets and develop an implementation plan for tobacco cessation interventions
- List the steps necessary to manage co-morbid health and psychiatric conditions
- Understand the behaviour change model to motivate patients who are ambivalent or resistant to change
Smoking Cessation for People Living with HIV

February 5th, 2010
TEACH Learning Centre

Agenda

12:00pm-1:00pm  Networking Lunch

1:00pm– 2:00pm  Welcome and Introductions
Dr. Peter Selby
• Identifying learning goals
• Overview of evidence-based clinical practice guidelines
• Client presentation and large group discussion, Q & A

2:00pm– 2:15pm  BREAK

2:15pm- 3:45pm  Practice Applications
Dr. Peter Selby
Jim Cullen
Marilyn Herie
• Setting targets for clinical practice
• Developing an implementation plan
• Small group practice and discussion

3:45pm- 4:30pm  Next Steps & Supports
• Large group de-briefing
• What other supports are needed?
• Course Evaluation
Disclosures

Jim Cullen,
No disclosures

Marilyn Herie,
Honourarium from Pfizer (2007)

Dr. Peter Selby,
Schering Canada to provide buprenorphine training (2000)
Received honoraria for consultant work, grant funding, advisory board and/or lectureships from:
Johnson & Johnson Consumer Health Care Canada, Pfizer Inc, Canada, Sanofi-Synthelabo, Canada, GSK, Canada. Genpharm and Prempharm, Canada, CTI, Health Canada, SFO, CIHR
Paid Consultant to V-CC Systems Inc. and eHealth Behaviour Change Software Company
NO TOBACCO INDUSTRY FUNDS

The recipient of the funding is in compliance with the CMA and the CPA Guidelines / recommendations for interaction with the pharmaceutical industry.

These materials (and any other materials provided in connection with this presentation) as well as the verbal presentation and any discussions, set out only general principles and approaches to assessment and treatment pertaining to tobacco cessation interventions, but do not constitute clinical or other advice as to any particular situations and do not replace the need for individualized clinical assessment and treatment plans by health care professionals with knowledge of the specific circumstances.
Disclaimer: TEACH Curriculum Development

The TEACH Curriculum and slides were developed and compiled with funding from the Government of Ontario, Ministry of Health Promotion. Content of slides are primarily based on evidence based guidelines including:


Canadian Practice Guidelines are currently being developed through the CAN-ADAPTT Project (Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment. Please visit www.can-adaptt.net for more information.

The development or delivery of the TEACH curriculum was not influenced or funded in any part by tobacco industry. TEACH has not received funding from the tobacco industry. The development of the TEACH curriculum has not been influenced by pharmaceutical industry. TEACH project did receive a $10 000 unrestricted grant from Pfizer, to develop video vignettes that are used in our training. Information presented on pharmacotherapy refers to generic products only, and recommendations are based on existing research, including the US guidelines. An algorithm is provided to help practitioners determine if and which pharmacotherapy is appropriate for a smoker.
Faculty Biographies

Jim Cullen, Ph.D, RSW
Jim_cullen@camh.net
(416) 535-8501 ext. 6781

Jim is the Clinic Head and Manager for Rainbow Service and the IGT Concurrent Disorder Service at the Centre for Addiction and Mental Health. He holds the rank of Assistant Professor at the Factor-Inwentash Faculty of Social Work, University of Toronto. Jim has worked in various mental health and addiction organizations in both clinical and management capacities working particularly with vulnerable populations such as the GBTTIQ community, concurrent disorders and youth. His research and publications have focused on population specific health concerns. Jim is also a past Interior Regional Director with the Centre for Addiction Research of British Columbia at the University of Victoria.

David Fletcher, MD, FRCPC
david.fletcher@mapleleafmedical.com
(416) 595- 7075

Dr. David Fletcher is the Program Director of the HIV/Hepatitis C Preceptorship Program and has a clinical practice at Maple Leaf Medical Clinic. He is a General Internal Medicine Specialist who has been treating patients with HIV and/or Hepatitis for the past 18 years. He provides HIV/Hepatitis C and Cardiovascular Risk Reduction-related education for physicians, medical students, pharmacists, AIDS Service Organizations and people living with HIV/AIDS and/or Hepatitis C.
Marilyn A. Herie, PhD, RSW  
Marilyn_herie@camh.net  
(416) 535-8501 ext. 7434

Marilyn Herie, PhD, RSW has worked in a variety of clinical and leadership roles at the Centre for Addiction and Mental Health (CAMH) since 1992, and is Director of the TEACH Project (Training Enhancement in Applied Cessation Counselling and Health, www.teachproject.ca) and an Advanced Practice Clinician in the Concurrent Disorders Service at CAMH. She is also an Adjunct Professor at the Factor-Inwentash Faculty of Social Work, University of Toronto and Social Work Coordinator of the Collaborative Program in Addiction Studies at the University of Toronto. Marilyn has facilitated professional training workshops throughout Canada and internationally and has authored numerous publications including the book Substance Abuse in Canada (2010, Oxford University Press).

Dr. Peter Selby, MBBS, CCFP, MHSc FASAM  
Peter_selby@camh.net  
(416) 535-8501 ext. 6859

Dr. Peter Selby is the Clinical Director of Addictions Programs and Head of the Nicotine Dependence Clinic at the Centre for Addiction and Mental Health as well as Associate Professor in the Departments of Family and Community Medicine- Dalla Lana School of Public Health-and Psychiatry at the University of Toronto. He is a Principal Investigator at the Ontario Tobacco Research Unit. Some of his areas of research include smoking cessation especially in smokers with co-morbid conditions, and web-based interventions. Dr. Selby is also Principal Investigator of the STOP study, which is investigating the effectiveness of NRT in different types of intervention settings. He is involved in the development of knowledge translation programs in smoking cessation especially in pregnancy and those with concurrent addiction and mental health problems. Dr. Selby is the Executive Director of the TEACH project - a continuing education certificate program in smoking cessation counselling.
Smoking Cessation for People Living With HIV

The Smoking Environment in Canada

- 18% of Canadians (4.8 million) 15 years or older are current smokers (15 cigarettes/day)
- 55.1% of daily smokers have their 1st cigarette within 30 minutes of waking up. 73% within the first hour!
- In contrast, smoking prevalence in persons living with HIV range from 46-64%.

2. Benard et al., 2007; Collins et al., 2001; Crothers et al., 2009; Crothers et al., 2005; Fuster et al., 2009; Mamary, Bahrs, & Martinez, 2002; Webb, Vanable, Carey, & Blair, 2007). *

Mortality Due to Tobacco

- 37,000 Canadians die from smoking per year
  - 100 infants/year
- 1 in 5 deaths are due to smoking
  - Five times those due to car accidents, suicides, other drug abuse, murder and HIV combined!
- 1 in 2 smokers die from smoking related diseases.
  - 20% of smokers develop lung cancer
- 50% in the 44 to 50 years age group.
Effects of Smoking on HIV/AIDS

- Increased respiratory symptoms, noninfectious pulmonary disease, COPD, asthma and bacterial pneumonia
- Rate of lung, neck and head cancers significantly higher in HIV population
- Smoking is often seen as a secondary concern, however HIV-positive smokers do report high levels of desire to quit


Some Smokers May Need More Help to Quit……

- Higher level of dependence
  - Cigarettes per day
  - Time to first cigarette upon awakening
- Living with a current smoker
- Fewer educational qualifications
- Lower socioeconomic class
  - Routine occupation vs. professional
  - Lower income
- Co morbid psychiatric disorders

Barriers to Quitting for HIV Patients

- Coping strategy for overall stress, discomfort and symptoms of HIV
- Depression
- Co-morbid substance abuse
- Encouraging Smoking cessation is often a low priority amongst primary care physicians

Prevalence: Depression Smoking & Suicide:

Smoking as an Addiction
Conceptualizing Substance Use Problems and their Solutions

Nicotine delivery devices

• Safety concerns related to nicotine include
  – Cardiovascular disease (CVD),
  – Cancer
  – reproductive toxicity,
  – impaired wound healing,
  – peptic ulcer disease,
  – gastro-esophageal reflux and
  – addiction.

Results of Functional Neuroimaging in Smokers
Genetic Factors

• Cochrane style reviews plus expert panel
• EBM
• Ten Key Guideline Recommendations

Recommendation #1:

_Tobacco Dependence is a Chronic Disease:_
  – Multiple attempts
  – Repeated interventions
  – Treatment is effective
  – Long term remission is possible

Recommendation #2
• Identify (screen every smoker)
  – Individual clinician
  – Health care setting.
Recommendation #3
• Clinicians should encourage smokers to use effective interventions.

Recommendation #4
• Clinicians should offer at least Brief Interventions

Recommendation #5
• Individual, group, and telephone counseling are effective
• Effectiveness increases with treatment intensity.
• Two components of counseling are especially effective,
  • Practical counseling (problem solving/skills training)
  • Social support delivered as part of treatment

Recommendation #6
Medications are Effective
• Encourage in all smokers except if there is a contraindication or poor evidence
  – Pregnant
  – Oral tobacco users
  – Adolescents
  – Low level smokers ( <10cpd)
• NRT
• Buproprion SR
• Varenicline

Recommendation #7
• Monotherapy is effective (i.e. counselling or medication alone)
• Combined medication and counselling works better than either alone
• Offer both to all smokers

Recommendation #8
• Telephone quit lines work- Broad reach
• Ensure access
• Make referral

Recommendation #9
• Unmotivated smokers:
  • Use Motivational techniques to increase quit attempts
Recommendation #10

- Treatment is cost effective
- Should be made available for free for all smokers

Clinical Practice Guidelines

- We have no formal Canadian cessation guidelines
- No clinical guidelines to direct the delivery of cessation treatment for smokers living with HIV
- There are existing CPG's in:
  - France, New Zealand, UK, USA, Spain
- Often, guidelines are out-of-date due to the rapidly evolving field or smoking population

CAN-ADAPTT: www.can-adaptt.net

Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-Informed Tobacco Treatment

- To create an environment that will facilitate practice-based research informed by a dynamic set of smoking cessation guidelines
- To promote and educate health care practitioners/providers in the use of these guidelines.

The guidelines are termed “dynamic” in order to reflect a continuously evolving evidence base, practice environment, client needs and treatment opportunities.
The Five Rs & Key Steps to Eliciting Change and Developing a Change Plan in 30 Minutes:

Key Tasks in Consultations About Behaviour Change

Selby’s modification of the 5 R's:

Eliciting Change Talk:

1. Assessing Readiness:
   - **IMPORTANCE**
     “Given everything going on in your life right now, on a scale of 0 to 10, how important would you say it is for you to stop smoking?”
   
   - **CONFIDENCE**
     “On a similar scale of 0 to 10, how confident do you feel about being able to stop smoking?”

2. Readiness to Change
   - **HIGH READINESS**
     - Both importance and confidence are high
     - Move to a change plan
     - EBM
   
   - **LOW READINESS**
     (Either importance or confidence is low)
3, 4: Rewards and Risks:

• Help me understand what is good about smoking for you?
  - Reflect

• Help me understand what is not so good about smoking for you?
  – Reflect

5. Roadblocks: Brainstorm Solutions

• If you were to quit smoking how do you think you might go about it?
• What challenges will you face when quitting smoking?
• What has worked for you in the past?
• What might you do this time?
Case Study #1:

Eddy is a 35 year old Philipino male who presents at your clinic as an HIV positive smoker. He immigrated to Canada when he was 25 years old, out of a desire for both professional advancement and (sexual orientation/to be able to live as a gay man...). Eddy works in the film industry and sends a good amount of his salary home to the Philippines, where his extended family still resides. None of them are aware of his illness, or of his sexual orientation. The person closest to him is his common law partner of 10 years, -Dave- who is currently residing at Casey House, and who is also a smoker.

Eddy smokes a pack of cigarettes per day, but this can easily increase to two packs per day when he’s working on set or going through emotional upset-which is common these days. He often feels overburdened with everything going on his life. When asked about his smoking frames it as "I am dying anyway- just let me have this". His medication has also all by left HIV undetectable, which presents further challenges.

- What are some of the barriers towards Eddy’s treatment?

- Is there any other information you need with respect to this man’s HIV infection?

- What other information would you like to have about Eddy’s smoking status?

- Name some of Eddy’s main triggers and list some immediate strategies that may be of help to your client.

Client Presentation & Large Group Discussion:

1. What are some goals of HIV Primary Care Providers for their patients?

2. What are the goals of Public Health models of care?

3. How many of the potential patients receive proper interventions or supports?
What is Motivation?

• A person’s expressed degree of readiness to change behaviour
  – (Miller and Rollnick, 1991)
• Motivation is the sum of factors that influence an individual to behave in a certain way
  - (Saunders, 1994)

Evolving Definition of Motivational Interviewing: Miller and Rollnick

• 2002:
  – “client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.”
• 2009:
  – “person-centred, goal oriented method of communication for eliciting and strengthening intrinsic motivation for positive change.”
  – “collaborative person centred form of guiding to elicit and strengthen motivation for change.”

Application and Indications

• Any health behaviour change
  – smoking
  – alcohol and other drugs
  – medication self-management
  – diet
  – exercise
  – chronic disease management
Motivational Interviewing: Rationale

- People are ambivalent about changing any behaviour
- Ambivalence is normal
- Overt persuasion increases resistance
- Self motivation leads to behaviour change

4 Principles of MI

Traditional MH and Addiction Settings

- Express Empathy
- Develop Discrepancy
- Roll with Resistance
- Support Self Efficacy

In Primary care and other settings (RULE)

- Resist the Righting Reflex
- Understand patients motivations
- Listen to your patient
- Empower your patient

8 Tasks in Learning MI:

1. Spirit of MI
2. Use Client Centred Skills (OARS)
3. Recognize Change Talk
4. Elicit and Reinforce Change Talk
5. Rolling with Resistance
6. Developing a Change plan
7. Consolidating Commitment
8. Integration with Other Methods
What Do You Need to Learn in MI?

**MI Spirit:**
- Collaboration,
- Evocation,
- Autonomy
  - Come Along Side with the Client

• “Miller and Mount, 2001 have suggested that learning MI involves at least two processes, one of adding preferred behaviors, and another of suppression of non-preferred behaviors.”
  (Baer, 2004)

• “There is some evidence that eliminating those responses such as confrontations, advice without permission, directing, threatening, and raising concern without permission is more important than just adding MI-consistent responses.”
  » (Moyers and Ernst, 2001)

Unexpected Process Finding

(Moyers, Miller & Hendrickson, JCCP, in press)
• Counselor use of MI-consistent spirit and practices is positively associated with behavior change
• Within MI, modest counselor use of confront responses is also positively associated with behavior change
• but if and only if the counselor also manifests the spirit of MI (empathy, etc.)

Clinical/Training Implications

• First and foremost, manifest the overall spirit of MI
• Helping the client to develop and verbalize arguments for change increases the likelihood of change
• Helping the client *when ready* to develop a specific change plan also increases the likelihood of change
Evidence Base

- AKA “Marmite”

72 studies included so far:

- Alcohol (31)
- Drug Abuse (14)
- Smoking (6)
- HIV Risk (5)
- Treatment Compliance (5)
- Water purification (4)
- Diet and exercise (4)
- One study each:
  - Gambling
  - Eating Disorders
  - Relationships

Where was MI tested?

- Outpatient clinics (15)
- Inpatient facilities (11)
- Educational settings (6)
- Community organizations (5)
- G.P. offices (5)
- Prenatal clinics (3)
- Emergency rooms (2)
- Halfway house (2)
- EAP
- Telephone (3)
- In home (1)
- Jail (1)
- Mixed (7)
- Unspecified (8)

Findings:

2. The effects of motivational interviewing emerge relatively quickly

  - This may not be true for certain problem areas or dependent measures where “sleeper” effects occur (e.g., effects of diet and exercise)
3. The between-group effects of motivational interviewing tend to diminish over 12 months

- This is also true of other treatments
- Between-group differences diminish in part because control/comparison groups “catch up” over time
- This may not be true of MI’s additive effects with other treatment

4. The effects of MI are highly variable across sites and providers

- This is also true of other treatments, but may be more true with MI
- Provider baseline characteristics do not predict effectiveness with MI
- Treatment process variables do
- Manuals may not be a good idea

Summary

- Motivational interviewing is a way to be with patients
- Evidence is modest but has good face validity
- Helps develop a therapeutic relationship
- Another tool to help addicted patients.

Smoking Cessation and Motivation

~Across studies, high % of HIV patients are able to quit, & have high motivation to be quit~

- 50% of people living with HIV are smokers, and find support within the HIV positive community
- 66.5% of HIV positive patients who were approached agree to participate in cessation study¹
- After 12-months of follow-up, smokers with HIV had significantly higher motivation to quit than those that did not quit ²
- 67% of former smokers quit after being diagnosed with HIV ³
MI & People Living with HIV

- Limited research with MI & HIV positive patients regarding health behaviour change
- MI is successful in terms of harm reduction & HIV
- Study on Antiretroviral Therapy (ART) and MI created positive results, i.e: trusting relationships with primary care providers, strengthening of social supports, & adherence to ART through scheduling doses
- MI allows the client to lead- this is helpful for clients who are already a highly stigmatized group.

Case # 2:

Susan is an African Canadian woman who is 62 years old. She currently lives alone, and is suffering from emerging HIV dementia. Susan presents as woman with a history of substance use and is also Hep C positive. She is a smoker who wants to quit, but struggles to implement strategies due to her cognitive impairment. Susan smokes 20 cigarettes a day, and often more often when socializing.

Susan has been referred to your clinic via a social worker, while her family is trying to move her into a nursing home. A recent fire in her bedroom has caused family members to become even more concerned for Susan’s safety and overall health.

- What are some of the barriers surrounding Susan’s treatment?
- Is there any other information you need with respect to this woman’s HIV infection?
- What other information would you like to have about Susan’s smoking status?
- Name some of Susan’s main triggers. List some immediate strategies that may be of help to your client.
Skills Required to Quit: S.T.O.P.

Strategize
Take Action
Options to not smoking
Prevent Relapse

Strategize

- Decisional Balance
  - Pros and cons of quitting and of smoking
- Explore fears,
  - Barriers to quitting
- Environment:
  - Physical, financial, social aspects
- Behaviour
  - Delays, Distractions
- Biology
  - Medication

Strategize

- Plan quit Day
- What kind of support do they have for their quit day?
- Goal-setting
- Discuss medication plan (Monotherapy/combination therapy?)
- Counseling options
  - Individual
  - Group
  - On-going
- Support System
- Identify Barriers
  - Emotional, physiological, beliefs (Belief that there is a physiological component in cigarettes that relieves stress)
- Monitor – Daily tracking sheets can help raise awareness
- Develop coping strategies
Smoke-Free Environment

• Remove smoking paraphernalia
• Inform others that home and car will be smoke-free
• Implement before quit date
• Make a list of smoke-free places

Take Action

• QUIT DAY!
  • Review accomplishments and provide positive reinforcement – even for the small steps
  • Quitting is a process not an event – define clearly what process means

Options For Not Smoking

• List of other things to do besides smoking
• People, places, things, mood, habit, withdrawal
• Smokers have a personal relationship with tobacco
• Grief process (sad, mad, bargaining, acceptance…)

Preventing Relapse

• Review coping/quit strategy
  • Identify positives, challenges
  • Review accomplishments, benefits
  • Is coping plan adequate? Withdrawal managed well?
• Reward
  • Encourage clients to reward themselves
  • Quit certificates
• Re-assess their motivation, confidence
  – Decrease can be common
• Support – adequate or do they need additional?
• Mood changes
• Cravings
• Weight changes
  – Some normal weight gain
  – Strategies to minimize
• Slips
  • Normal, expected
  • Get back on track right away
  • Re-evaluate plan – what did we miss?
• Relapse
  • Extra support
  • Strategize
• Some common risky behaviour:
  – Overconfidence – I’ll never smoke again!
  – Self-testing – keeping cigarettes in the home
  – Self-blame
• Avoiding relapse
  – Monitoring
  – Self-test mentally – think of how you would handle potential situations
  – Practice coping with unavoidable high risk situations
  – Get feedback

Approved Smoking Cessation Medications

1st Line
• Nicotine patch
• Nicotine gum
• Nicotine inhaler
• Nicotine lozenge
• Bupropion
• Varenicline

Medications for Quitting Smoking: Nicotine Replacement Therapy (NRT)

Who Should Use NRT?
• Not everyone needs NRT
• Not everyone can afford NRT
• Studies show that NRT is not effective for those that smoke 10 cigarettes or less or are non-daily smokers
• Need to assess case by case
  – Discuss with client
  – Use tools to assess dependence
4 Screening Questions For Monotherapy

Cut Down Then Stop (RTQ: Reduce to Quit) is based on a 4 Step Programme:

Step 1: (0-6 weeks)
- Smoker starts to cut down
  - Smoker sets a target for no. of cigarettes per day to cut down and a date to achieve it by (at least 50% recommended)
  - Smoker uses gum to manage cravings
- Smoker should cut down within 6 weeks

Step 2: (6 weeks up to 6 months)
- Smoker continues cutting down
  - Smoker continues to cut down cigarettes using gum
  - Goal should be complete stop by 6 months
- Smoker should seek advice from HCP if smoking has not stopped within 9 months

Step 3: (within 9 months)
- Stop smoking
  - Smoker stops all cigarettes and continues to use gum to relieve cravings

Step 4: (within 12 months)
- Stop Gum
  - Smoker cuts down the amount of gum used, then stops gum use completely (within 3 months of stopping smoking)
Assessing Readiness to Come Off NRT

• Have you been in a situation in which you would normally smoke but have been able to refrain from smoking with ease?

• Have you ever forgotten to put on your patch or use your inhaler / gum / lozenge?

Demonstration & Small Group Task Demonstration

• Using skills learned so far, Facilitators will model a client interaction- one person as the primary care physician, person B as the client and person C as the Coach (observer)
• All three partners will then have a chance to participate in each of the roles.
• “Coaches” will record & report feedback to partners A &B.

Assessing Readiness for Change

Interactive Exercise:

Partner A:
• Select a behaviour you have been thinking about changing
• Something you are comfortable discussing with a partner (e.g., exercising more, eating healthier, being more environmentally conscious, work/life balance, clearing the clutter, etc.)

Partner B:
• Respond in a way that fits her/his readiness to change
• Notice: reflective responses versus # of questions asked

Partner C:
• Observe the interaction between partners A & B and make comments on the sheet provided. Be ready to provide feedback at the end.
Implementing Tobacco Reduction Interventions in a Clinical Setting

- Force field analysis
- Stakeholder buy in
- Who does what by when?
  - Screening
  - Intervention
    - Behavioural
    - Pharmacological
  - Follow up

Case Study #3:

Lewis is a 42 year old Caucasian male, HIV-positive smoker. He typically smokes one pack per day, however, when he's spending time with his partner Neil, the number of cigarettes increases. Lewis is in Recovery from his addiction to Crystal Meth. This is a major accomplishment, as he's been sober for one year. The biggest issue for Lewis is the association that occurs between smoking and his past crystal meth use, and the temptation is always there. He also relies heavily on a tight group of friends for support- but many of them are smokers themselves. Lewis is trying to find other healthier alternatives to smoking- such as a weekly game of pick-up hockey.

- What are some of the barriers surrounding Lewis' treatment?
- Do you need any other information with respect to his HIV infection?
- What other information do you need about Lewis' smoking status?
- Name some of Lewis' main triggers. List some immediate strategies that may be of help to him.
Evaluation and Wrap Up

Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment (CAN-ADAPTT)
Is a Practice-Based Research Network (PBRN) committed to facilitating research and knowledge exchange among those who are in positions to help smokers make changes to their behaviour.

Members will receive:
- Updates on CAN-ADAPTT’s research and funding opportunities
- Access to CAN-ADAPTT’s Tobacco Control Guidelines
- Access to CAN-ADAPTT’s discussion board
- Notices of General Meetings

• To become a member, simply visit www.can-adaptt.net and click "register" to fill out the short registration form found on the home page.

Course Evaluation:
Please complete the following evaluation tools before you leave:
Learning Assessment # 1
Learning Assessment # 2
Evaluation
Case Studies

Eddy:
Eddy is a 35 year old Filipino male who presents at your clinic as an HIV positive smoker. He immigrated to Canada when he was 25 years old, out of a desire for both professional advancement and (sexual orientation/to be able to live as a gay man...). Eddy works in the film industry and sends a good amount of his salary home to the Philippines, where his extended family still resides. None of them are aware of his illness, or of his sexual orientation. The person closest to him is his common law partner of 10 years, -Dave- who is currently residing at Casey House, and who is also a smoker.

Eddy smokes a pack of cigarettes per day, but this can easily increase to two packs per day when he’s working on set or going through emotional upset-which is common these days. He often feels overburdened with everything going on his life. When asked about his smoking frames it as “I am dying anyway- just let me have this”. His medication has also all by left HIV undetectable, which presents further challenges.

- What are some of the barriers towards Eddy’s treatment?
- Is there any other information you need with respect to this man’s HIV infection?
- What other information would you like to have about Eddy’s smoking status?
- Name some of Eddy’s main triggers and list some immediate strategies that may be of help to your client.
Case # 2: Susan

Susan is an African Canadian woman who is 62 years old. She currently lives alone, and is suffering from emerging HIV dementia. Susan presents as woman with a history of substance use and is also Hep C positive. She is a smoker who wants to quit, but struggles to implement strategies due to her cognitive impairment. Susan smokes 20 cigarettes a day, and often more often when socializing.

Susan has been referred to your clinic via a social worker, while her family is trying to move her into a nursing home. A recent fire in her bedroom has caused family members to become even more concerned for Susan’s safety and overall health.

- What are some of the barriers surrounding Susan’s treatment?
- Is there any other information you need with respect to this woman’s HIV infection?
- What other information would you like to have about Susan’s smoking status?
- Name some of Susan’s main triggers. List some immediate strategies that may be of help to your client.
Case # 3?

Lewis is a 42 year old Caucasian male, HIV-positive smoker. He typically smokes one pack per day, however, when he’s spending time with his partner Neil, the number of cigarettes increases. Lewis is in Recovery from his addiction to Crystal Meth. This is a major accomplishment, as he’s been sober for one year. The biggest issue for Lewis is the association that occurs between smoking and his past crystal meth use, and the temptation is always there. He also relies heavily on a tight group of friends for support- but many of them are smokers themselves. Lewis is trying to find other healthier alternatives to smoking- such as a weekly game of pick-up hockey.

- What are some of the barriers surrounding Lewis’ treatment?
- Do you need any other information with respect to his HIV infection?
- What other information do you need about Lewis’ smoking status?
- Name some of Lewis’ main triggers. List some immediate strategies that may be of help to him.
Selected Readings


