

**TOBACCO RECOVERY
RESOURCE EXCHANGE**



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The Foundation:

**Integrating Tobacco Use Interventions into
Chemical Dependence Services**

**Participant Manual
Module 1**



PROFESSIONAL DEVELOPMENT PROGRAM
ROCKEFELLER COLLEGE UNIVERSITY AT ALBANY State University of New York

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About This Training

PDP Background

Since its founding in 1976, the Professional Development Program (PDP) has been committed to making extended learning and public engagement a reality for the public service and not-for-profit workforces through its ongoing education and training programs. The mission of the Professional Development Program is to make a difference in a changing world by linking the learning, applied research, and evaluation resources of the university with the continuing professional education needs of the public service.

Over the past 30 years, PDP has had a wide variety of partners and has secured funding in excess of \$350 million to help organizations meet their workforce development needs. Programs and services offered by PDP include:

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About This Training, Continued

About the New York Tobacco Control Program

The New York Tobacco Control Program, located at the New York State Department of Health, envisions all New Yorkers living in a tobacco free society and works aggressively to reduce the morbidity and mortality, and alleviate the social and economic burden, caused by tobacco use in New York State.

About the Tobacco Interventions Project

In August 2007, the New York Tobacco Control Program, in collaboration with the New York State Office of Alcoholism and Substance Abuse Services (OASAS), released a Request for Applications entitled *Integrating Tobacco Use Interventions into New York State Chemical Dependency Services*.

In January 2008, this contract was awarded to PDP to serve as the Development, Management, and Oversight Agency (DMOA). PDP oversaw the six Regional Technical Assistance and Training Centers (RTATC) across the state, and developed all classroom-based training curricula, web-based learning, technical assistance tools, and the Tobacco Recovery Resource Exchange website. Classroom training and technical assistance was completed in December 2009, and online training was continued.

The Tobacco Interventions Project provided training and technical assistance to all NYS Office of Alcoholism and Substance Abuse Services (OASAS) funded and/or certified chemical dependence service providers to implement integrated tobacco use interventions (tobacco-free environment policies, tobacco education, and tobacco dependence treatment) into existing treatment protocols.

Visit the project web site www.tobaccorecovery.org for online learning and other resources

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About This Training, Continued

**Tobacco Use:
A Serious
Public Health
Problem**

Tobacco use is a serious public health problem. Tobacco use is the most preventable cause of death in the United States. Over 440,000 Americans die each year from tobacco-related disease. Cigarette use alone results in 25,500 deaths in New York State.

People who breathe in second-hand smoke from cigarettes also suffer adverse health consequences. In June 2006, the US Surgeon General issued a comprehensive scientific report, which concluded that there is no safe level of exposure to secondhand smoke (US Surgeon General, 2006). In 1993 and 2006, the US Environmental Protection Agency (EPA) concluded that environmental tobacco smoke (ETS) is responsible for approximately 3,000 lung cancer deaths annually among adult U.S. nonsmokers, and contributes to the risk of heart disease. Furthermore, in infants and young children, ETS exposure causes:

- An increased risk of lower respiratory tract infections such as bronchitis and pneumonia. EPA estimates that 150,000 to 300,000 cases annually in infants and young children up to 18 months are attributable to ETS.
- An increased prevalence of fluid in the middle ear, symptoms of upper respiratory tract irritation, and small reductions in lung function.
- Additional episodes and increased severity of symptoms in children with asthma. EPA estimates that up to 1 million asthmatic children have their condition worsened by exposure to ETS.

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About This Training, Continued

The Cost of Tobacco Use

Tobacco use is also a costly problem. Research has clearly shown that the annual health care costs in New York directly caused by smoking total \$8.17 billion, with \$5.41 billion covered by New York Medicaid funding (CDC, 2008). The state and federal tax burden to New York State amounts to \$842 per household annually for government expenditures that are related to tobacco use (Campaign for Tobacco-Free Kids, 2008).

Tobacco Use and Chemical Dependence

Nationally, approximately 19.8% of all adults use tobacco (CDC, 2009). This is a decline over the past 5 years from a tobacco use rate of over 21%. People with substance use and co-occurring mental disorders, more than other populations, are likely to be addicted to tobacco. Historically, chemical dependence treatment agencies have not treated tobacco dependence concurrently with other chemical dependencies.

Among people with drug or alcohol problems, the rate of tobacco use ranges from 75% to 100% (Campbell et al., 1998).

People with substance use disorders who smoke are much more likely to die from their tobacco use than from their drug or alcohol addiction (Hurt et al., 1996; Hser, 2001).

Until recently, many chemical dependence treatment agencies have not addressed patient tobacco use. Some agencies have expressed concern that patients who are denied access to tobacco may choose to leave treatment. Other agencies have been unsure how to institute a tobacco use policy, or how staff would react.

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About This Training, Continued

Addressing the Issue

Current research shows that many staff and patients are in favor of tobacco abstinence. Tobacco abstinence is also associated with improved treatment completion rates and improved post-treatment abstinence from alcohol and other drugs (Prochaska et al., 2004). Tobacco relapse is shown to trigger relapse to alcohol and other drug use and vice-versa (Stuyt, 1997; Sobell et al., 1995), a concern that was also noted by early pioneers of the treatment for alcohol and narcotic dependence (White, 1998).

Tobacco dependence is chemical dependence and addiction service providers already possess much of the essential knowledge and many of the skills necessary to incorporate tobacco use interventions into chemical dependence services.

This training and technical assistance initiative was designed to help agencies use a multidisciplinary approach to integrate tobacco interventions into chemical dependence agencies. PDP supported OASAS certified and/or funded agencies as they addressed tobacco dependence treatment and recovery.

Original Project Goals

- Create and maintain a tobacco-free environment in buildings, vehicles, and on the grounds of chemical dependence service programs
 - Integrate tobacco use interventions into chemical dependence services
-

Overview of the Training Modules

Module 1 - The Foundation

Attitudes and Beliefs
History and Rationale
Tobacco Dependence
OASAS Regulation Part 856

Module 2 - Assessment, Diagnosis, and Pharmacotherapy

Assessment, Screening, and Diagnosis
Stages of Change and Readiness to Change
Pharmacotherapy
Case-based Applications

Module 3 - Behavioral Interventions

Counseling Techniques
Facilitating a Tobacco Awareness Group

Module 4 - Treatment Planning

Treatment Plan Components
Writing a Treatment Plan and Case Study

Module 5 - Co-occurring Disorders

Attitudes and Beliefs, Challenges and Barriers
Prevalence and Co-morbidity Factors
Treatment Strategy Review and Case Studies

E-Learning – Seven Modules

Module 1 Agenda and Objectives

- Module 1
Agenda**
- Attitudes and Beliefs Activity
 - A Brief History
 - Rationale
 - Tobacco Dependence
 - NYS OASAS Regulation Part 856
-

- Module 1
Objectives**
- Identify personal attitudes and beliefs about integrating tobacco use interventions into chemical dependence services
 - Identify three milestones in the history of the integration of tobacco use interventions into chemical dependence services
 - Describe at least three reasons for integrating tobacco use interventions into chemical dependence services
 - Explain at least three similarities and three differences between tobacco dependence and other chemical dependencies
 - List at least three characteristics of cigarettes that contribute to their dependence potential
 - Identify elements of tobacco-free policies required by OASAS Regulation Part 856 Tobacco-Free Services
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Unit 1

Setting the Stage

Purpose To provide participants with an opportunity to examine their personal attitudes and beliefs regarding tobacco use and dependence, an overview of the history of tobacco dependence treatment within the recovery movement and in chemical dependence services, and the rationale that supports this practice improvement initiative.

- Objectives**
- Identify personal attitudes and beliefs about integrating tobacco use interventions into chemical dependence services
 - Identify three milestones in the history of integrating tobacco use interventions into chemical dependence services
 - Describe at least three reasons for integrating tobacco use interventions into chemical dependence services
-

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Attitudes and Beliefs Activity

Directions

Please indicate the extent to which you agree or disagree with each of the following statements by placing a mark in the appropriate box.

Then take five sticky notes from your table and place one note on your selection on each of the corresponding pages of newsprint posted around the room.

<u>Statement</u>	<u>Strongly Agree</u>	<u>Agree</u>	<u>Ambivalent</u>	<u>Disagree</u>	<u>Strongly Disagree</u>
Continued tobacco use makes relapse more likely.					
Stopping tobacco use increases cravings for alcohol and other drugs.					
Nicotine Replacement Therapy (NRT) does not belong in abstinence-based treatment programs.					
Tobacco dependence should be treated in chemical dependence programs.					
Tobacco-free policies infringe on individual rights.					

A Brief History

Brief Historical Review

- 1798: Benjamin Rush, a physician and signer of the Declaration of Independence, who argued that alcoholism and mental disorders were medical diseases, expressed concern against the habitual use of tobacco as it "led to a desire for strong drink." (Rush, 1798, Coleman, 1976).
- 1870s - 1920s: Most inebriety and alcoholism treatment specialists – including TD Crothers (Walnut Lodge Hospital), Leslie Keeley (Keeley Institute), John Harvey Kellogg (Battle Creek Sanitarium), Charles B. Towns (founder of Towns Hospital), and Alexander Lambert – argued that tobacco was a harmful, addictive substance, and that smoking was a contributing factor in alcoholic relapse and narcotic relapse (White, 1998).
- 1920 - 1930s: The Oxford Group (OG), an English religious fellowship that provided the foundations for Alcoholics Anonymous (AA), migrates to the United States. The OG did not ban alcohol or tobacco use, but strongly frowned on tobacco use. Only OG alcohol and tobacco abstinent members were considered “maximum” with the fellowship (Hazelden 1997, Hartigan, 2000).
- 1935: Founding of Alcoholic Anonymous, which draws many ideas from the Oxford Group. AA founding members, Bill W. and Dr. Bob continued to smoke during their recovery, and both died from smoking-related disease. Most AA members used tobacco and continued to use during their recovery. Tobacco use becomes woven into the informal allowances and practices of 12 Step work and recovery.
- 1935s - 1960s: Alcoholism counseling as a profession gradually evolves from AA members. Most also continue to use tobacco in their recovery.
- 1964: Surgeon General’s Report “Smoking and Health” reported on the health risks associated with tobacco use, including lung and laryngeal cancer in men, a probable cause of lung cancer in women, and the most important cause of chronic bronchitis.
- 1965: Federal Cigarette Labeling and Advertising Act enacted
- 1969: Public Health Cigarette Smoking Act enacted and required a health warning on cigarette packages and banned cigarette advertising in the broadcast media.
- 1970s: Drug counseling profession begins to evolve, mostly from staff who are former drug users; most also continue to use tobacco.

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A Brief History, Continued

Brief Historical Review, cont'd

- 1970s - 1980s: Alcoholism and drug counseling profession continues to evolve. Tobacco is not considered a “drug problem” nor is use seen as relevant to recovery. The emphasis is on alcohol, narcotics, cocaine, amphetamines, inhalants, and psychedelics.
- 1982: Nicotine Anonymous (originally called Smokers Anonymous) is begun by several AA members in California (White, 1998).
- 1985: Little Hill-Alina Lodge founder Geraldine Delaney (a contemporary of Bill Wilson), makes her facility the first tobacco-free residential chemical dependence treatment program in the U.S. (Delaney, 1988).
- Late 1980s: After overwhelming evidence of negative effects of tobacco, some chemical dependence treatment programs across the U.S. began to examine and confront their approach to tobacco smoking for the majority of workforce and patients (White, 1990).
- 1991: Harris County Psychiatric Center in Houston, TX became tobacco-free (Rustin, 1998).
- 1992: Addressing Tobacco in the Treatment of Other Addictions Project receives funding from Robert Wood Johnson Foundation to develop educational materials and training to promote integration of tobacco use interventions into New Jersey addictions treatment programs; develops Drug-Free and Nicotine-Free manual and Twelve Steps to Tobacco-Free model (Hoffman and Slade, 1993).
- 1996: All federally-funded alcohol and drug prevention services are required by the Substance Abuse and Mental Health Services Administration (SAMSHA) to actively address and report on youth tobacco use, enforcement, and distribution activities per the Synar Amendment.
- 1996: Van Dyke and Norris Addiction Treatment Centers (ATC) became the first inpatient chemical dependence treatment programs in New York State to be tobacco-free; Stutzman ATC follows in 1997 (Sharp et al., 2003).
- 1999: New Jersey becomes first state to require tobacco-free addiction programming in residential treatment facilities (Foulds et al., 2006).

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A Brief History, Continued

Brief Historical Review, cont'd

- 2000: New York State Department of Health begins the New York Tobacco Control Program.
- 2000: US Public Health Service releases Clinical Practice Guideline: Treating Tobacco Use and Dependence, an evidence-based guide based on a meta-analysis of over 5,000 studies (Fiore et al., 2000).
- 2003: NYS Office of Alcoholism and Substance Abuse Services (OASAS) forms an internal tobacco taskforce to examine regulatory and resource options to promote tobacco-free chemical dependence programs.
- July 2003: Enactment of the NYS Clean Indoor Air Act, which exempts substance abuse and mental health treatment programs.
- Fall 2003: The American Cancer Society and the New York Association of Alcoholism and Substance Abuse Providers (ASAP), formulated a mission statement to promote tobacco-free chemical dependence programming.
- Winter 2003-2004: American Cancer Society convenes NYS Partnership for the Treatment and Prevention of Tobacco Dependence, with representatives from ASAP, OASAS, New York Tobacco Control Program, and chemical dependence treatment providers. The Partnership develops a four-year plan for raising awareness and support for tobacco-free chemical dependence services.
- 2004: OASAS holds forums throughout NYS, and the OASAS Commissioner issues an advisory about responsibility of chemical dependence providers to address all addictions, indicating the provider community is uniquely positioned to advocate for community-wide acceptance of tobacco dependence prevention, treatment, and recovery.
- 2004: More than a dozen addiction service providers in Albany, NY form the Tobacco Recovery Coalition of the Capital District. The group works together for four years to develop strategies and to support each other's efforts to establish tobacco-free facilities and grounds, and to address abstinence from tobacco in their organizations and by the people they serve.
- 2004: The NYS Partnership for the Treatment and Prevention of Tobacco Dependence, with representatives from ASAP, OASAS, and NYSDOH, begins raising awareness and support for tobacco-free chemical dependence services.

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Setting the Stage, Continued

**Brief
Historical
Review,
cont'd**

- 2005: All thirteen OASAS-operated Addiction Treatment Centers (ATCs) in transition to become tobacco free programs.
 - 2005: OASAS Medical Director issues a letter to NYS chemical dependence service providers that significant changes are underway for Chemical Dependence regulations; highlights the proposed tobacco-free policy changes. ASAP convenes the First Annual Tobacco Dependence Institute at their Annual Conference.
 - 2006: ASAP convenes the Second Annual Tobacco Dependence Institute. NYS DOH awards ASAP a contract to operate the NYS Tobacco Dependence Resource Center and website; project starts in May and website launches in December, 2006.
 - December 2006: OASAS Local Services Bulletin re-states intention to amend regulations to require tobacco-free environments, tobacco education, and tobacco dependence treatment within programs, and provides a two-year recommended timeline for planning and implementation for system changes.
 - 2007: OASAS proposes Part 856 Tobacco-Free Services regulation, effective date of July 24, 2008. NYS DOH provides funding for free nicotine replacement therapy (NRT) for uninsured staff and patients of OASAS-certified programs, and releases RFP for a two-year training and technical assistance initiative; NRT begins shipping.
 - 2008: US Public Health Service releases Clinical Practice Guideline, 2008 Update: Treating Tobacco Use and Dependence, an evidence-based guide based on a meta-analysis of over 8,700 research articles.
 - 2008: NYS DOH awards statewide training and technical assistance contract to assist NYS OASAS programs to integrate tobacco interventions into chemical dependence services.
 - 2008 – 2009: Statewide classroom training on tobacco interventions begins in NYS and is completed. Website is developed and online learning is created and implemented for all curricula.
 - 2009: Family Smoking Prevention and Tobacco Control Act is enacted, granting the FDA authority to regulate tobacco and nicotine levels. Flavored cigarettes are adulterated and regulated as of September 2009, with the exception of menthol.
-

Rationale

Mission and Purpose of Chemical Dependence Services

Tobacco dependence is a chronic addictive disease. Treating tobacco dependence is consistent with the mission of an addiction treatment program. The following are actual mission statements from chemical dependence treatment programs:

“We provide quality, cost-effective care to those suffering from alcoholism and chemical dependency and to the many whose lives are affected by the diseases of addiction.”

“Our mission is to provide a quality continuum of comprehensive treatment and related services, in a caring atmosphere and at a reasonable price, for all people experiencing problems with alcohol or other drug use.”

Skills and Knowledge of Addiction Professionals

It makes sense to treat tobacco dependence in addiction treatment programs. Addiction professionals, by virtue of their education, training and experience to treat alcohol and other drug dependencies, already possess much of the knowledge and many of the skills necessary to treat tobacco dependence.

Clinicians can enhance their abilities by learning about specific tobacco treatment medications, how to assess tobacco use, how to engage patients either individually or in groups to discuss tobacco use, and by learning about patients with co-occurring disorders.

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Rationale, Continued

- Prevalence of Tobacco Use**
- General Population 19.8% (a drop from 20.8% in 2006)
 - Addiction Treatment 60 - 95%
 - Serious Mental Illness 75 - 80%
 - HIV and AIDS 50 - 70%

(These data are drawn from multiple sources, and reflect the range for each population).

In 2008, the tobacco use among the general population in NYS was below 18%.

<u>Level of Care</u>	<u>% Using</u>	<u>% Males</u>	<u>% Females</u>
Intensive Residential	76%	74%	82%
Community Residential	73%	71%	80%
Supportive Living	81%	79%	84%
Inpatient Rehabilitation	80%	79%	82%
Outpatient Clinic	63%	63%	65%
Outpatient Rehabilitation	77%	76%	79%
Methadone Clinic	83%	82%	84%
Data: 2006, OASAS Certified Treatment Programs			

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Rationale, Continued

Tobacco's Relationship to Alcohol and Other Drugs

The prevalence of tobacco use among people receiving addiction treatment or who are in recovery is dramatically higher than the general US adult population. This high prevalence of use is also common for people with co-occurring substance use and mental health disorders.

Several studies indicate that the prevalence of tobacco use among people receiving treatment or in recovery is dramatically higher than the general U.S. adult population rate of 20.9% (CDC, 2006).

- 90% among alcoholic inpatients in the U.S. (Bien and Burge, 1990)
 - 83% among urban methadone maintenance patients in the Northeastern U.S. (Richter et al., 2001)
 - 77% among methadone maintenance patients in the Midwestern U.S (Nahvi et al., 2006)
 - 71 - 93% among alcoholic outpatients (Istvan and Matarazzo, 1984)
 - 85 - 90% among substance abuse inpatients (Burling and Ziff, 1988)
-

Tobacco's Relationship to Alcohol and Other Drugs: NSDUH Findings

The 2005 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2007) found:

- Among persons aged 12 or older, 20.2% of past-month cigarette smokers reported current use of an illicit drug compared with 4.1% of persons who were not current cigarette smokers
 - Past month alcohol use was reported by 67.6% of current cigarette smokers compared with 46.6% of those who did not use cigarettes in the past month
 - An association also was found with binge drinking (43.8% of current cigarette users vs. 15.7% of current nonusers) and heavy drinking (16.1 vs. 3.5%, respectively)
 - People with a DSM-IV-TR diagnosis (not including nicotine dependence) consume 44% of all tobacco sold in the U.S. (Lasser et al., 2000)
 - People with a co-occurring mental health and substance use disorder consume 70% of tobacco products (Grant et al., 2004)
-

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Rationale, Continued

The Tobacco Industry Over the decades, the tobacco industry has become expert at selling tobacco and tobacco smoke, especially targeting specific groups of people including children, adolescents, young adults, people of color, women, and people of lower socio-economic status.

- Tobacco Industry Practices**
- Knowingly sell a product that kills and maims people
 - Targets youth
 - Lots of money and no morals
 - Aggressively lobbies against regulation and control
 - Massive advertising campaigns
 - Insidious and deceptive marketing
-

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Rationale, Continued

Toll of Tobacco Use

In the general population, the consequences of tobacco dependence have been well documented (Campaign for Tobacco Free Kids, 2006)

- Tobacco causes over \$194.3 billion in annual health care and productivity costs, approximately \$10.28 per pack of cigarettes sold (CDC, 2006)
 - Smoking kills over 438,000 Americans a year, more than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined (CDC, 2004)
-

Tobacco Toll on People in Chemical Dependence Treatment and Recovery

People who receive treatment for chemical dependence more often die from their tobacco use, than as a consequence of other chemical dependencies.

- Among deaths of alcoholics during a 20-year period after receiving inpatient treatment, 51% were tobacco-related, while 34% were alcohol-related; the actual mortality was 48.1% vs. an expected 18.5% for the group (Hurt et al., 1996)
 - Among treated heroin addicts, the death rate of smokers was four times that of nonsmokers (Hser et al., 1993)
 - Among a cohort of 581 male heroin addicts followed over a 33-year period, tobacco use was responsible for 23.4% of deaths as compared to 21.6% for accidental overdose, 19.5% for suicide/homicide/accidents, and 15.2% for chronic liver disease (Hser et al., 2001)
-

Tobacco Toll on People in Recovery Movement

Tobacco dependence has led to the deaths of thousands of people who were in recovery including:

- Bill Wilson (co-founder of Alcoholics Anonymous)
 - Dr. Bob Smith (co-founder of Alcoholics Anonymous)
 - Marty Mann (“first lady” of AA and pioneer public health reformer)
-

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Rationale, Continued

Health Consequences For every person who dies from his/her tobacco use, there are twenty people living with serious health problems from their tobacco use (CDC 2008).

Smoking Related Health Problems It is well-known that tobacco smoke negatively affects the whole body - not just the lungs. There is no organ system that is not affected by smoking.

Some tobacco-related cancers and other illnesses include:

- Bladder, cervical, esophageal, kidney, laryngeal, lung, oral, pancreatic, stomach cancer, and leukemia
- Abdominal aortic aneurysm
- Atherosclerosis and cerebrovascular disease
- Coronary heart disease
- COPD and pneumonia
- Cataracts
- Hip fractures and low bone density
- Peptic ulcer disease

(Nhu Tran, MD. Director, Smoking Cessation Program, NYC DOHMH)

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Rationale, Continued

Tobacco and Reproductive Health

Tobacco use primarily through smoking during pregnancy has adverse effects on pregnancy and fetal development. This may also be true for secondhand smoke. Some possible consequences include:

- Reduced lung function among infants
- Respiratory disease in childhood and adolescence
- Fetal death and stillbirth
- Reduced fertility (men and women)
- Low birth weight
- Pregnancy complications

(Nhu Tran, MD, Director, Smoking Cessation Program, NYC DOHMH)

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Rationale, Continued

Efficacy of Integrated Tobacco Dependence Treatment

Several studies and a meta-analytic review have concluded that patients who receive tobacco dependence treatment during addiction treatment have better overall substance abuse treatment outcomes compared with those who do not (Ziedonis et al. 2006).

Efficacy of Integrated Tobacco Dependence Treatment, cont'd

Despite frequently voiced concerns that treating tobacco dependence at the same time as other chemical dependencies jeopardizes sobriety, research fails to bear that out:

- Campbell et al. (1995) found no evidence that their participants (66 inpatient, outpatient and methadone patients) who were either successful or unsuccessful at smoking cessation relapsed to other substances in any significant numbers
 - Martin et al. (1997) study of 205 recovering alcohol and drug abusers with three months of continuous abstinence found that the stress of quitting smoking does not appear to prompt relapses to alcohol and drug use
 - Concurrent intervention for nicotine dependence did not significantly harm treatment outcomes of patients using alcohol or marijuana as their drug of choice (Joseph et al., 1993; 314 substance abuse inpatients with 8-21 months follow-up)
 - Treatment for nicotine dependence, when provided as part of other addictive disorder treatment, enhanced the chance of smoking cessation and did not have a substantial adverse effect on abstinence from the non-nicotine drug of dependence (Hurt et al., 1996; inpatient substance abusers with one year outcome)
-

Continued on next page

Rationale, Continued

Improved Outcomes in Tobacco-Free Programs

Research also suggests that integrating tobacco dependence interventions into chemical dependence programs, and promoting recovery from tobacco dependence, improves treatment outcomes:

- Alcoholics who stopped cigarette use during recovery were more likely to maintain long-term abstinence (Bobo et al., 1987; Bobo, 1989, Sees and Clark, 1993)
- Cigarette smokers relapsed to their primary drugs of choice more frequently and sooner than did nonsmokers (Sees and Clark, 1993)
- A 12 month recovery rates compared after substance abuse inpatient treatment found that non-tobacco users maintain longer periods of sobriety after inpatient treatment for alcohol/drug dependence than tobacco users (Gulliver et al., 2006)
- Smoking status (nonsmoker, “chipper”/“social smoker”, or heavy smoker) proved a more powerful predictor of cocaine and opiate use than receiving a daily methadone dose. Findings lend support to existing evidence suggesting associations between tobacco and opiate and cocaine use, and strongly suggested that smoking cessation should be offered to all methadone-maintained patients (Frosch et al., 2000, Taylor et al., 2000)
- Smoking cessation is indicated for substance dependent persons already in recovery, and may protect against relapse to the illicit drug of choice (Sullivan and Covey, 2002)
- Controlling for multiple factors, smoking cessation was associated with greater abstinence from drug use after completion of drug abuse treatment. Despite drug abuse programs’ hesitance to encourage smokers to quit, smoking cessation does not negatively affect drug use outcomes (Lemon et al., 2003)

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Rationale, Continued

Summary

There is a compelling rationale for integrating tobacco use interventions into chemical dependence treatment services.

- Tobacco use was recognized by the early addiction treatment pioneers in the late 1800s as an impediment to chemical dependence recovery
 - Treating tobacco dependence is consistent with the mission of chemical dependence services
 - Addiction professionals possess many of the skills and much of the knowledge necessary to treat tobacco dependence
 - Patients who stop using tobacco are less likely to relapse with alcohol or other drugs, but also have better quality of life and better overall recovery
 - Health and well-being of patients (and staff) who stop using tobacco is improved
-

Unit 2

Tobacco Dependence

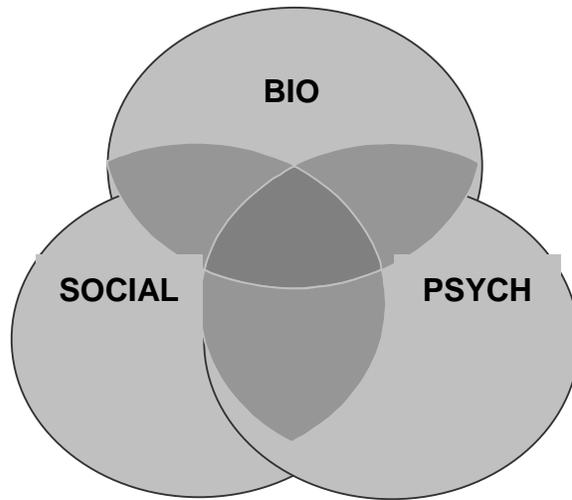
Purpose The purpose of this lesson is to examine tobacco dependence from several perspectives including diagnosis, addiction pathways, characteristics of nicotine, comparison with other AOD dependence, tobacco treatment medications, and the challenges of treatment.

- Objectives**
- Explain at least three similarities and three differences between tobacco dependence and other addictions
 - List at least three characteristics of cigarettes that contribute to their dependence potential
-

A Biopsychosocial Disease

Addiction:

A Bio-Pscho-Social Disease



Notes:

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A Biopsychosocial Disease, Continued

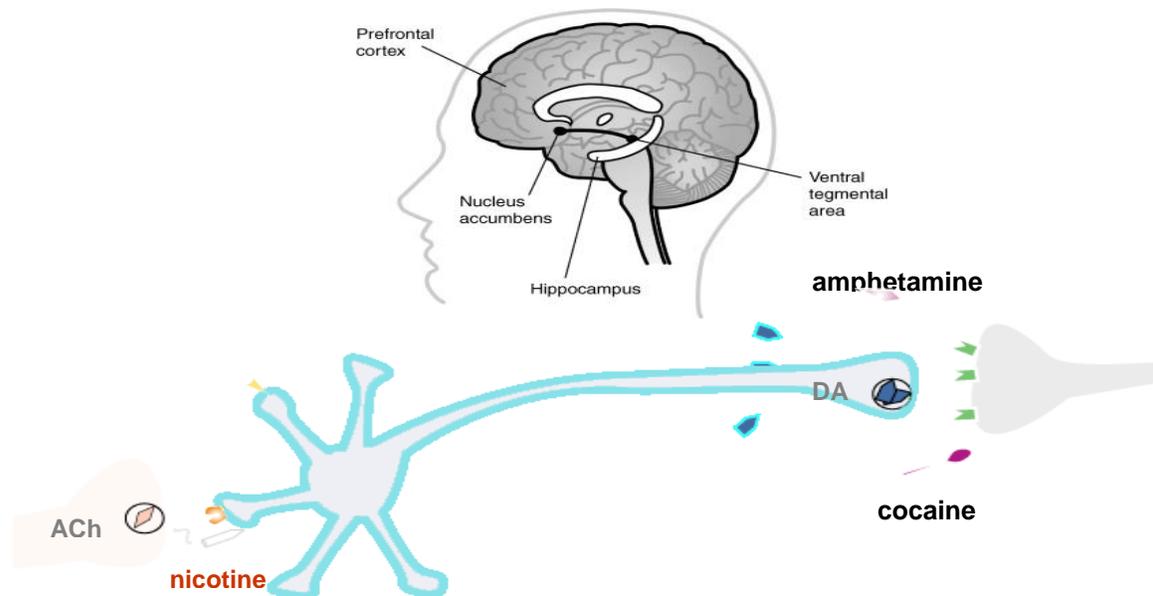
Development of Tobacco Dependence

Tobacco dependence develops in the same way as cocaine and amphetamine dependence. Tobacco smoke is absorbed in the lungs, sending nicotine to the brain within seven to ten seconds.

Nicotine attaches to neurons that stimulate dopamine release in the ventral tegmental area of the mesolimbic system, an area of the brain involved in appetite, learning, memory, and feelings of pleasure.

Normally, neurons reabsorb (re-uptake) neurotransmitters after they have triggered other brain cells. Nicotine and tobacco smoke prevent re-absorption and cause dopamine to stay in the synapses. The effects of nicotine diminish rapidly leading to the need to re-dose frequently.

Nicotine and possibly other chemicals in tobacco smoke alters the effects of other neurotransmitters including beta-endorphin, norepinephrine, serotonin, acetylcholine, GABA, and glutamate, resulting in modest levels of decreased hunger, cognitive arousal, mood modulation, and memory enhancement.



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A Biopsychosocial Disease, Continued

Theories for Tobacco Use Prevalence

There is a high prevalence of concurrent tobacco use (co-occurring tobacco dependence) among people with other chemical dependencies.

There are several theories to explain this:

- **Shared Characteristics:** Alcohol, tobacco, and other drugs appeal to persons with similar personality characteristics (sensation seeking and impulsivity) and co-occurring depression (Little, 2000).
 - **Reinforcing Effects:** Tobacco may enhance the effects of alcohol (Little, 2000) and cocaine (Wiseman and McMillan, 1998).
 - **Shared Brain Pathways:** Tobacco affects the same neural pathway - the dopamine system - as alcohol, opiates, cocaine, and marijuana (Pierce and Kumaresan, 2006).
 - **Modulating Effects:** Tobacco may reduce cocaine-induced paranoia (Wiseman and McMillan, 1998).
 - **Scientists speculate that there are common genetic risk factors for people prone to developing addiction to alcohol, other psychoactive drugs, and tobacco.**
-

DSM-IV-TR Criteria

**DSM-IV-TR
Criteria for
Nicotine
Dependence
(a.k.a.
Tobacco
Dependence)**

1. The DSM-IV-TR does not define additional criteria for the diagnosis of nicotine dependence 305.1 (defined here as tobacco dependence). It requires the clinician to use the criteria listed under Substance Dependence.
2. Three or more of the following criteria are required:
3. Tolerance
4. Withdrawal
5. Substance used in larger amount or longer than intended
6. Persistent desire, unsuccessful efforts to cut down or control substance use
7. Great deal of time spent in substance-related activities
8. Important social, occupational, or recreational activities given up or reduced
9. Substance use continues despite knowledge of negative physical or psychological consequences

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DSM-IV-TR Criteria, Continued

**DSM-IV-TR
Criteria for
Nicotine
Withdrawal,
292.0**

The presence of a characteristic syndrome that develops after abrupt cessation of, or reduction in, the use of nicotine-containing products following a prolonged period (at least several weeks) of daily use.

- A. Daily use of nicotine for at least several weeks.
- B. Abrupt cessation of nicotine use, or reduction in the amount of nicotine used, followed within 24 hours by four (or more) of the following signs:
 - 1. dysphoric or depressed mood
 - 2. insomnia
 - 3. irritability, frustration, anger
 - 4. anxiety
 - 5. difficulty concentrating
 - 6. restlessness
 - 7. decreased heart rate
 - 8. increased appetite or weight gain
- C. Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

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DSM-IV-TR Criteria, Continued

Challenges in Managing Nicotine Withdrawal

- Typically more intense among people who smoke cigarettes
 - Cigarette use leads to a more intensive use pattern that is difficult to give up because of the frequency and rapidity of reinforcement and the greater physical dependence
 - Duration is typically three weeks or longer
 - Chronic, low-range discomfort can last for weeks or even months, and is often the cause of frequent relapse
-

Tobacco Treatment Medication Overview

Nicotine Withdrawal and Tobacco Treatment Medications

The management of nicotine withdrawal is crucial to help the patient avoid withdrawal symptoms and engage successfully in treatment.

Clinicians should advise all patients attempting to stop using tobacco to use effective medications for tobacco dependence treatment (pharmacotherapy), except where contraindicated, or in specific populations for which there is insufficient evidence of effectiveness (Fiore et al., 2008).

Effectiveness of Medication for Many Populations

- HIV-Positive
 - Hospitalized
 - Lesbian/Gay/Bisexual/Transgender (LGBT)
 - Low Socio-Economic Status (SES)
 - Limited Formal Education
 - Medical Co-morbid Conditions
 - Older Individuals
 - People with Mental Health and Substance Use Disorders
 - Racial and Ethnic Minority Populations
 - Women and Men
- (Fiore et al., 2008)
-

Insufficient Evidence of Effectiveness

- Pregnant Women
- Smokeless Tobacco Users
- Light Smokers
- Adolescents

Prescribing professionals may still consider using NRTs on an individual basis for pregnant women, smokeless tobacco users, light smokers, and adolescents.

Continued on next page

Tobacco Treatment Medication Overview, Continued

First-Line Medications

- Safe for tobacco dependence treatment
 - FDA approved for this use
 - Established empirical record of effectiveness
-

First-Line Nicotine Medications: Nicotine Replacement Therapy (NRT)

Five Nicotine Medications

Over the Counter (OTC):

- Nicotine patch
- Nicotine gum
- Nicotine lozenge

Prescription:

- Nicotine nasal spray
 - Nicotine inhaler
-

First-Line Non-Nicotine Medications

Two Non-Nicotine Medications (prescription)

- Bupropion SR (Zyban® or Wellbutrin®)
 - Varenicline (Chantix®)
-

Continued on next page

Tobacco Treatment Medication Overview, Continued

- Combination Pharmacotherapy**
- Long-term (>14 weeks) nicotine patch plus other NRT (gum, nasal spray)
 - Nicotine patch plus nicotine inhaler
 - Nicotine patch plus bupropion SR
-

Tobacco Abstinence and Medication Blood Levels

When an individual stops smoking tobacco, metabolic changes take place that may require adjustments in other medications he/she may be taking. This effect is not due to nicotine, but is the result of the tar in tobacco smoke, which can enhance the ability of specific liver enzymes (CYP1A2) to metabolize some medications.

For example: tobacco smoke increases the metabolism of many drugs and patients taking certain psychiatric medications, and who then cease smoking tobacco, may require a 20 - 30% reduction in their medication dosage.

- Medical Contra-indications for NRT**
- Myocardial infarction (within the last 2 weeks)
 - Serious arrhythmias
 - Serious or worsening angina pectoris (chest pain)
 - Uncontrolled hypertension
-

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Tobacco Treatment Medication Overview, Continued

Medication with Supportive Counseling

Treatment outcomes are enhanced when tobacco treatment medications are combined with supportive counseling.

Motivational Interviewing techniques, Cognitive Behavioral Therapy, Relapse Prevention Therapy, and psychoeducation (Tobacco Awareness Groups and Tobacco Recovery Groups), are all useful to help patients learn about tobacco dependence. Supportive counseling also helps to motivate patients to stop using tobacco, teaches problem-solving and coping skills, and builds the patient's support system.

These approaches may be accomplished in multiple settings including individual, group, and psychoeducational sessions, and also informal interactions.

NRT Summary Points

- Wide margin of safety – with little potential for abuse
 - Dose should be equivalent to tobacco use
 - Combining NRT is effective
 - Patients with other chemical dependencies may require higher dosage
 - Under-dosing may not manage withdrawal or cravings, and often results in relapse
-

The Cigarette- A Perfect Drug Delivery Device

Comparison of nicotine delivery from cigarette smoke vs. various NRTs

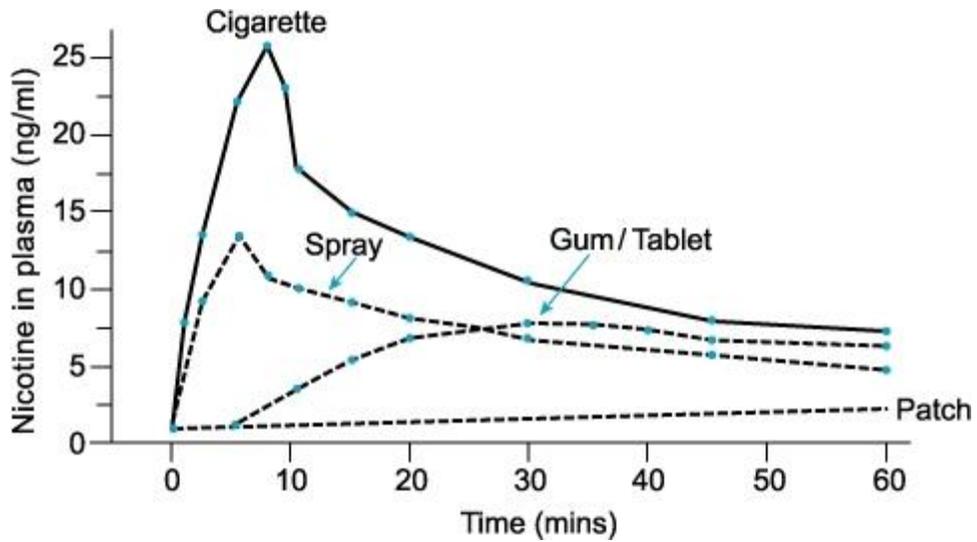


Diagram shows rise in blood nicotine levels after using a cigarette as compared to different nicotine replacement therapy products (adapted from Royal College of Physicians, 2000).

Continued on next page

The Cigarette- A Perfect Drug Delivery Device, Continued

The Cigarette: A Perfect Drug Delivery Device

- The cigarette is a highly engineered device designed to rapidly deliver nicotine to the brain - approximately 30ng/ml (nanograms per milliliter) within seven to ten seconds.
 - Using one cigarette produces a nicotine level that is five to seven times higher than wearing a 21 mg nicotine patch.
 - The typical smoker inhales 10 times on a cigarette over 5 - 7 minutes. A one and half pack per day user gets 300 doses (“hits”) of nicotine.
 - Three factors that contribute to titration: frequency of use, intensity of use, and ability of user to fine tune delivery of the nicotine.
 - The cigarette user adjusts nicotine dosing by the number of puffs, depth of puffs, duration of puffs, and blocking of cigarette filter holes.
 - Some low SES tobacco users extinguish (“clip”) and re-light a single cigarette several times in an attempt to getting as many hits as possible out of each cigarette. This allows a person using ten cigarettes per day to engage in as much smoking as a pack a day user.
 - Menthol cigarettes, popular among African American tobacco users, anesthetize airways, allowing for deeper inhalation of tobacco smoke, and yielding higher levels of nicotine per cigarette. Menthol cigarettes allow low SES tobacco users to maintain dependence for less money.
-

Tobacco Dependence vs. Alcohol/Other Drug Dependence (AOD)

**How Tobacco
Dependence
Differs from
AOD
Dependence**

- Tobacco use does not cause intoxication
 - Tobacco use generally does not cause adverse behavioral outcomes
 - Tobacco use does not produce significant euphoria
 - Tobacco use causes minor improvements in cognitive and affective functioning.
-

**How Tobacco
Dependence is
Similar to
AOD
Dependence**

- Affects release of dopamine in the brain
 - Compulsive use
 - Continued use despite harmful effects
 - Withdrawal syndrome
 - Rapid rates of relapse after an attempt to stop
 - Induces self-administration in animal studies
 - Causes range of illnesses and leads to death
-

Language of Treatment and Recovery

Reframing Language

Work with a partner to develop alternative terms to the public health language used and which are more appropriate to the language of addiction treatment and recovery.

<u>Public Health Terminology</u>	<u>Recovery Terminology</u>
smoking	
smoker	
quit date	
cessation	

Treatment Challenges

Challenges in Treating Tobacco Dependence

Nicotine can have some beneficial effects:

- Reduced aggression
- Improved focus on cognitive tasks
- Increased vigilance
- Decrease in weight gain
- Improved mood

Smoking tobacco optimizes the reward effects:

- Rapidity - nicotine reaches the brain in 7 - 10 seconds
- Frequency - one pack per day = approximately 200 “hits” per day
- Reliability - receive the same dose each time
- Ease of Attainment - legal for adults, underage purchase easier than illicit drugs or alcohol

Nicotine is not intoxicating

- Does not cause intoxication nor does it usually cause extreme behaviors
- Large amounts of the drug can be ingested over time increasing the probability of physical dependence

Nicotine withdrawal

- Long duration (average three weeks or longer)
 - Chronic, low range discomfort; the cause of frequent relapse (Hughes, 2001)
-

Summary

Summary

Nicotine is among the most highly addictive drugs. Tobacco dependence is a biopsychosocial disease, like any other chemical dependence. Chemical dependence treatment professionals should address tobacco dependence in the same manner as any other chemical dependency. Tobacco use correlates with an increase in alcohol and drug use, and tobacco smoke increases the metabolism of other drugs. Continued tobacco use during recovery is a factor in relapse, and tobacco abstinence can increase recovery success. A high percentage of patients in chemical dependence treatment and recovery use tobacco, and tobacco dependence needs to be addressed during treatment. All tobacco using patient should be offered tobacco treatment medications and counseling. NRT is effective, has a wide-margin of safety, and can be used in combination with other tobacco treatment medications.

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Unit 3

OASAS Regulation Part 856

Purpose OASAS-Certified and funded programs were required to be in full compliance with this regulation by July 24, 2008. Program administrators and directors must understand the regulation and develop policy and procedures to implement the regulation. Clinical and administrative staff should understand the general requirements and intent of the regulation.

Objective Identify elements of tobacco-free policies required by OASAS Regulation Part 856 Tobacco-Free Services.

Background and Intent of the Regulation

Concerns and Misconceptions

- Some addiction professionals incorrectly believe that their CASAC, CPP, or CPS credentials will be in jeopardy if they continue to use tobacco or if they return to using tobacco.
- There is an incorrect belief that patients must be administratively discharged if they violate any aspects of the tobacco-use policy.
- There is an incorrect belief that OASAS will be punitive when reviewing programs, putting operating certificates in jeopardy.
- There is an incorrect belief that a program must discharge patients for using tobacco on the grounds, in vehicles, or in program buildings.

856.1 - Background and Intent

Background and Intent

- (a) To reduce addiction, illness and death caused by tobacco products.
 - (b) To provide a healthy environment for staff, patients, volunteers and visitors to entities organized and operating pursuant to the provisions of this Title and certified and/or funded by the Office of Alcoholism and Substance Abuse Services (“the Office”) as a provider of prevention, treatment or recovery services for alcoholism, substance abuse, chemical dependence and/or gambling.
 - (c) To establish tobacco-free services in a tobacco-free environment. To reduce addiction, illness and death caused by tobacco products.
-

Legal Basis of the Regulation

856.2 - Legal Base

Legal Base

(a) Section 19.07(e) of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services (“the Commissioner”) to adopt standards including necessary rules and regulations pertaining to chemical dependence services.

(b) Section 19.09(b) of the Mental Hygiene Law authorizes the Commissioner to adopt regulations necessary and proper to implement any matter under his or her jurisdiction.

(c) Section 19.21(b) of the Mental Hygiene Law requires the Commissioner to establish and enforce certification, inspection, licensing, and treatment standards for alcoholism, substance abuse, and chemical dependence facilities.

(d) Section 19.21(d) of the Mental Hygiene Law requires the Commissioner to promulgate regulations, which establish criteria to assess alcoholism, substance abuse, and chemical dependence treatment effectiveness and to establish a procedure for reviewing and evaluating the performance of providers of services in a consistent and objective manner.

(e) Section 32.01 of the Mental Hygiene Law authorizes the Commissioner to adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by Article 32 of the Mental Hygiene Law.

(f) Section 32.07(a) of the Mental Hygiene Law authorizes the Commissioner to adopt regulations to effectuate the provisions and purposes of Article 32 of the Mental Hygiene Law. Mental Hygiene Law.

Applicability of the Regulation and Definitions

856.3 - Applicability

- Any entity certified and/or funded by OASAS as a provider of prevention, treatment, or recovery services for chemical dependence and/or gambling.

Note: OASAS has exempted vocational rehabilitation services and permanent supportive housing from this regulation.

856.4 - Definitions

- Tobacco-free means prohibiting the use of all tobacco products in facilities, grounds, and vehicles owned or operated by the service.
 - Facility means any part of the service that is used by patients, staff, visitors, or volunteers. This includes service buildings and grounds.
 - Tobacco products include but are not limited to cigarettes, cigars, pipe tobacco, chewing or dipping tobacco.
 - Patient means any recipient of services in a facility certified or funded by OASAS.
-

Requirements of the Agency’s Tobacco Use Policy

856.5 - Policy and Procedures

The service shall determine and establish written policies, procedures, and methods which should at a minimum include the following:

- Defines the facility, grounds, and vehicles which are tobacco-free
- Prohibits patients, family members and other visitors from bringing tobacco products and paraphernalia to the service
- Requires all patients, staff, visitors, and volunteers to be informed of the tobacco-free policy including posted notices and provision of copies of the policy
- Prohibits staff from using tobacco products while at work, during work hours
- Establishes a tobacco-free policy for staff while they are on the site of the service
- Establishes treatment modalities for patients who use tobacco
- Describes training on tobacco use and nicotine dependence available to staff including clinical, non-clinical, administrative, and volunteers
- Describes tobacco and nicotine prevention and education programs made available by the service to patients, staff, volunteers, and others
- Establishes policies and procedures to address patients who relapse on tobacco. Additionally, each facility shall address staff relapse consistent with the employment procedure of that facility

856.6 - Severability

If any provision of this Part is held invalid, it will not affect any other provision of this Part which can be given effect without the invalid provision, and to this end the provisions of this Part are declared to be severable.

Continued on next page

Requirements of the Agency's Tobacco Use Policy, Continued

**The Bottom
Line**

By July 24, 2008, each OASAS certified and funded programs must have a written policy. As a result, program administrators must:

- Write a tobacco-free environment policy.
 - Post notices and provide copies of the policy to all patients, staff, volunteers, and visitors.
 - Identify tobacco and nicotine prevention and education programs available to all patients, staff, volunteers, and visitors.
 - Establish treatment modalities for patients who use tobacco.
 - Identify tobacco use and nicotine dependence training available for all staff and volunteers.
 - Establish procedures for patient and staff policy violations.
 - Manage their organization's change process as they develop, implement, and evaluate their policy.
-

True or False Activity

**OASAS
Regulation
Part 856 -
Quick Review**

True or False Questions - Regulation Part 856

1. Patients, family members, or other visitors may not bring tobacco or tobacco paraphernalia to the program or service.
 2. OASAS-funded Permanent Supportive Housing and Vocational Rehabilitation programs are exempt from the regulation.
 3. Staff may use tobacco during work hours, while on break, and off the program's premises.
 4. In residential treatment programs, patients who relapse on tobacco must be administratively discharged.
 5. In outpatient treatment programs, all patients must stop using tobacco for the duration of their treatment.
-

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Resources

**Resource
Directory**

Tobacco Recovery Resource Exchange (<http://www.tobaccorecovery.org>) can be used to access e-learning opportunities, resources, web tools, and more.

**New York State Office of Alcoholism and Substance Abuse Services
Tobacco Independence** <http://www.oasas.state.ny.us/tobacco/index.cfm>

New York State Tobacco Dependence Resource Center
<http://www.tobaccodependence.org>. A wealth of resources including sample policies, research articles, and more.

**Treating Tobacco Use and Dependence: Clinical Practice Guideline 2008
Update:** call to order a copy at 1-800-358-9295 or go to
<http://www.surgeongeneral.gov/tobacco/default.htm>.

Continued on next page

Resources, Continued

**Resource
Directory,
cont'd**

NYS Medicaid Policy Smoking Cessation Policy

- Smoking cessation therapy consists of prescription and non-prescription agents. Covered agents include nasal sprays, inhalers, Zyban® (bupropion), Chantix® (varenicline), over-the-counter nicotine patches and gum.
- Two courses of smoking cessation therapy per recipient, per year are allowed. A course of therapy is defined as no more than a 90-day supply (an original order and two refills, even if less than a 30 day supply is dispensed in any fill).
- If a course of smoking cessation therapy is interrupted, it will be considered one complete course of therapy. Any subsequent prescriptions would then be considered the second course of therapy.
- Some smoking cessation therapies may be used together. Professional judgment should be exercised when dispensing multiple smoking cessation products.
- Duplicative use of any one agent is not allowed (i.e., same drug and same dosage form and same strength).
- For all smoking cessation products, the recipient must have an order. A prescription is the terminology for an order of a prescription product. A fiscal order refers to an order, which looks just like a prescription - written on a prescription blank, for an over-the-counter product.
- NYS Medicaid reimburses for over-the counter nicotine patches. Prescription nicotine patches are not reimbursed.
- Name brand Zyban® requires a prior authorization, but generic bupropion does not.

NYS Smokers Quitline (866) NY-QUITS (866-697-8487)

American Cancer Society 1-800-227-2345

American Lung Association 1-800-586-4872

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Glossary

Agonist: A medication that stimulates an action on a given receptor

Ambivalence: Uncertainty or inability to make choices caused by having thoughts or feelings that oppose or contradict each other

Antagonist: A medication that acts against or blocks an action on a given receptor

AOD: Alcohol and Other Drugs

Articulate: Clearly explain, describe, or talk about

ASAP: Alcoholism and Substance Abuse Providers of New York State (www.asapnys.org)

ATC: New York State Office of Alcoholism and Substance Abuse Services (OASAS) Addiction Treatment Centers (<http://www.oasas.state.ny.us/atc/index.cfm>)

ATOD: Alcohol, Tobacco, and Other Drugs

Autonomy: Personal capacity to consider alternatives, make choices, and act without undue influence or interference from others.

Blended Learning: The combination of multiple approaches to learning, for example, a combination of technology-based materials and classroom sessions to deliver instruction

Bupropion (Zyban® or Wellbutrin ®): A first-line non-nicotine medication used in the treatment of tobacco dependence

CASAC: New York State Credentialed Alcoholism and Substance Abuse Counselor (<http://www.oasas.state.ny.us/sqa/credentialing/CASACCover.cfm>)

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Glossary, Continued

CBT: Cognitive-Behavioral Therapy. CBT is a form of counseling that emphasizes the important role of thinking in how we feel and what we do

CDC: Centers for Disease Control, U.S. Department of Health and Human Services

Cessation Centers: NYS Department of Health -funded contractors that provide technical assistance, training, and follow-up to health care institutions in their catchment areas in implementing the Clinical Practice Guideline, 2008 Update (CPG). The main task is to help screen patients for tobacco use and prompt health care providers to offer brief interventions for stopping tobacco use
(http://www.health.state.ny.us/prevention/tobacco_control/community_partners/tobacco_cessation_centers.htm)

Change Talk: Patient statements (e.g., desire, ability, reasons, and need to change) that indicate a patient's beginning to commit to change.

CIAA: NYS Clean Indoor Air Act, in effect July 24, 2003
(http://www.health.state.ny.us/nysdoh/clean_indoor_air_act/general.htm)

Cognitive: The use of mental activities such as perception, thinking, remembering, reasoning, mental images, and taking information to create new ideas.

CO Monitor: A breath carbon monoxide (CO) monitor is a non-invasive device that estimates the amount of carbon monoxide in a person's blood, providing evidence of one of the harmful consequences of smoking.

Co-morbid Condition: Two or more disorders or illnesses occurring in the same person, simultaneously or sequentially (example: opiate dependence and HIV).

Co-morbidity: Describes the negative interaction between the two or more illnesses, which affects the progression and prognosis of each disorder.

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Glossary, Continued

Competency: The required knowledge, skills, and attitudes of addiction professional practice. (See Technical Assistance Publication (TAP) Series 21, which is available online at <http://www.kap.samhsa.gov/products/manuals/pdfs/TAP21.pdf>)

Co-occurring Disorders: Co-occurring substance use (abuse or dependence) and mental health disorders (example: alcoholism and depression)

CPD: Cigarettes Per Day

CPG: Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, U.S. Department of Health and Human Services, Public Health Service, 2008 Update (http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf)

CPP: New York State Credentialed Prevention Professional

CPS: New York State Credentialed Prevention Specialist

Craving: An urgent, seemingly overpowering desire to use a substance, which often is associated with tension, anxiety, or other dysphoric, depressive, or negative affective states.

DARN-C: An acronym for how to increase change talk. Used to encourage patients to make statements that tell about their **D**esire, **A**bility, **R**easons, and **N**eed to change, which leads to stronger language for making a **C**ommitment to change.

Discrepancy: A variance or difference between present behavior and a desired goal, or the difference between what is happening now and how one wants things to be. The larger the discrepancy, the greater the importance of change.

DMOA: Development, Management, and Oversight Agency

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Glossary, Continued

DOH: NYS Department of Health (www.health.state.ny.us)

Dopamine: An important neurotransmitter (messenger) in the brain that can trigger feelings of pleasure

DSM-IV-TR: Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, Text Revision

Effectiveness: The outcome achieved from a treatment that is provided in a “real-world setting” (in a clinic or community).

Efficacy: The power to produce a desired effect. Efficacy is the outcome achieved from a treatment provided under near-ideal circumstances of control (for example treatment provided during a controlled research study).

E-Learning: Self-paced instruction or professional development activities provided over the Internet

Empathy: Nonjudgmental understanding, compassion, and acceptance of the patient's experience. Empathy requires understanding another person’s experience and effectively communicating that understanding.

ETS: Environmental Tobacco Smoke, also known as second hand smoke

Evidence-Based Practice: Interventions that have been repeatedly documented in the scientific literature as effective in treating tobacco dependence

Expectancy: A learned anticipation of an effect from a cause

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Glossary, Continued

FDA: U.S. Food and Drug Administration (www.fda.gov)

First-Line Medications: Medications approved by the FDA for a specific use and which have an established empirical record of effectiveness

Functional Analysis: A behavior analysis (or assessment) problem-solving process that identifies why a person behaves in a certain manner. It identifies triggers for the behavior, patterns of the behavior, and the consequences or benefits from the behavior.

Individualized Intervention: Tailoring an intervention to fit the needs of a particular patient. For example, relapse prevention can be individualized based on information obtained about problems the patient has encountered in maintaining abstinence.

Intervention: An action or program that aims to bring about identifiable outcomes. In tobacco dependence treatment, the intervention generally is clinical in nature and may consist of counseling and the use of medications. Also referred to as "treatment."

LCSW: Licensed Clinical Social Worker

LGBT: Lesbian/Gay/Bisexual/Transgender

Medication Assisted Treatment: The use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders

Metabolism: The chemical processes occurring within a living cell or organism that are necessary for the maintenance of life

MI: Motivational Interviewing. Motivational interviewing is an effective evidence-based approach to overcoming the ambivalence that keeps people from making desired changes in their lives (<http://motivationalinterview.org>)

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Glossary, Continued

Modality: A treatment modality is any specific treatment method or procedure used to relieve symptoms or motivate behaviors that lead to recovery.

Modulate: To alter the function or status of something in response to a drug effect

Module: A self-contained component of an instructional system. PDP instruction is broken into modules to make the instruction easy to access and deliver
Negative Reinforcement: A behavior is reinforced when a negative condition is stopped or avoided as a consequence of the behavior (example: use of tobacco to avoid withdrawal symptoms). Negative reinforcement should not be confused with punishment, which weakens a behavior when a negative condition is introduced

Neuron: A cell specialized to conduct and generate electrical impulses and to carry information from one part of the brain to another

Neurotransmitter: A natural chemical in the body released by one neuron to influence or communicate with another. Examples include dopamine, serotonin, norepinephrine, and acetylcholine, GABA, glutamate, beta-endorphin, and others

New York State Clean Indoor Air Act: Effective July 24, 2003, the New York State Clean Indoor Air Act (Public Health Law, Article 13-E) prohibits smoking in virtually all workplaces, including restaurants and bars

Nicotine: The psychoactive and highly addictive substance found in tobacco products

NIDA: The National Institute on Drug Abuse (NIDA), part of the National Institutes of Health (NIH) organized within the U.S. Department of Health and Human Services

NRT: Nicotine Replacement Therapy, including the nicotine patch, gum, lozenge, inhaler, and nasal spray

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Glossary, Continued

NYS Smoker’s Quitline: A free statewide helpline through which tobacco users can obtain information, services, and nicotine medication to support an attempt at tobacco abstinence (www.nysmokefree.com)

OARS: An acronym from Motivational Interviewing that refers to the counseling micro-skills of Open Questions, Affirmations, Reflective Listening, and Summarizing

OASAS: NYS Office of Alcoholism and Substance Abuse Services (www.oasas.state.ny.us)

OASAS Regulation Part 856: Requires all New York State OASAS funded and/or certified providers of prevention, treatment, or recovery services for chemical dependence and/or gambling to implement tobacco-free policies as of July 24, 2008 (<http://www.oasas.state.ny.us/tobacco/providers/reg856.cfm>)

OTC: Over the Counter, a medication for which a prescription is not needed

Partial Agonist: Bind and activate a given receptor, but have only partial efficacy at the receptor relative to a full agonist

PDP: Professional Development Program, Rockefeller College, University at Albany (www.pdp.albany.edu)

Pharmacotherapy: The treatment of disease using medications

Positive Reinforcement: A behavior is reinforced as a consequence of experiencing a positive response from the behavior (example: use of tobacco provides a pleasurable effect, increasing the likelihood that the behavior will be repeated)

PPD: Packs Per Day (of cigarettes)

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Glossary, Continued

Promising Interventions Partners: Funded community partners who worked to demonstrate the effectiveness of promising, but not yet established, tobacco control interventions

Rapport: The degree to which trust and openness are present in the relationship between counselor and patient; an essential element of the therapeutic relationship

Readiness: A person's stage of awareness of the need and willingness to change. Can be influenced by external pressure (family, legal system, employer) or internal pressure (physical health concerns)

Receptor: A structure on the surface of a neuron (or inside a neuron) that selectively receives and binds a specific substance

Recovery: Achieving and sustaining a state of health or actively working to regain a state of health (i.e., stopping tobacco use and non-medical psychoactive drug use), and establishing a lifestyle that embraces healthy behaviors.

Relapse Prevention Therapy (RPT): A clinical approach that helps patients to anticipate obstacles and high-risk situations when working to maintain a change, and when such obstacles or situations occur, to use effective coping strategies

Route of Administration: The path by which a substance is taken into the body (i.e., by mouth, injection, inhalation, rectum, or by topical application)

RPT: An acronym for Relapse Prevention Therapy, which is a clinical approach that helps patients to anticipate obstacles and high-risk situations when working to maintain a change, and when such obstacles or situations occur, to use effective coping strategies

RTATC: An acronym for Regional Technical Assistance and Training Center

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Glossary, Continued

SAMHSA: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (<http://www.samhsa.gov>)

Screening: Gathering and sorting of information to determine if a person may have a problem with substance use (i.e., Fagerstrom Test for Nicotine Dependence) and, if so, whether a more detailed clinical assessment is appropriate

Second-Line Medications: Medications that have not been approved by the FDA for a specific purpose but which health practitioners prescribe as “off- label” drugs to treat a disease or condition (i.e., nortriptyline, an antidepressant, is sometimes used for helping some people stop tobacco use, but is not FDA approved for this purpose).

Self-efficacy: One’s beliefs about his or her capability to successfully act to achieve specific goals or influence events that affect one’s life.

SES: Socioeconomic Status

SOC: an acronym for Stages of Change (i.e., precontemplation, contemplation, preparation, action, and maintenance)

Stages of Change: The Transtheoretical Model of Change or Stages of Change (SOC) is a theory developed by James Prochaska and Carlo DiClemente, which suggests that most people progress through five different stages on their way to successful change. The stages are precontemplation, contemplation, preparation, action, and maintenance

TAG: Tobacco Awareness Group

Tailored Interventions: Treatments based on a dimension or a subset of dimensions of the patient (e.g., weight concerns, dependency). See also Individualized Interventions

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Glossary, Continued

TC: Therapeutic Community, a drug-free residential setting where the community (treatment staff and patients in recovery) interact in structured and unstructured ways to influence attitudes, perceptions, and behaviors associated with drug use. This approach is often referred to as “community as method.”

TCP: Tobacco Control Program, within the NYS Department of Health
(http://www.health.state.ny.us/prevention/tobacco_control)

Technical Assistance: Help, resources, practical advice, problem-solving, and guidance to establish, strengthen, or enhance a program’s capacity to implement tobacco use interventions provided by Regional Technical Assistance and Training Centers (RTATCs)

Titration: The process of gradually adjusting the dose of a medication until the desired effect is achieved

Tobacco Awareness Group: A treatment modality primarily helpful for patients in the precontemplation and contemplation stages of change. The goal of the group is to help patients resolve their ambivalence about their tobacco use and move on to the next stage of change. The tobacco awareness group develops interest, elevates importance, and enhances motivation

Tobacco dependence: A chronic biopsychosocial disease characterized by persistent use, inability to limit or control use, withdrawal symptoms when use is stopped abruptly, frequent relapse after attempts at abstinence, and continued use despite knowledge of serious physical and psychological consequences

Tobacco Interventions Project: NYS Department of Health Tobacco Control Program, state-wide, Technical Assistance and Training grant awarded to the Professional Development Program (PDP) to support NYS addiction service providers to integrate tobacco interventions into chemical dependence and gambling programs

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Glossary, Continued

Tobacco Recovery Group: A treatment modality primarily helpful for patients in the preparation, action, and maintenance stages of change. The goal of the group is to define tobacco recovery and teach recovery tools in the physical, behavioral, and emotional arenas. The tobacco recovery group helps patients develop skills, elevate confidence, and embrace lifestyle change

Tolerance: There are different forms of tolerance, and in this manual the term refers to metabolic tolerance, a need for increased amounts of a substance to achieve the desired effect

Treatment: An action or program that aims to bring about identifiable outcomes. For tobacco dependence, the treatment generally is clinical in nature and may consist of counseling and the use of medications. Also may be referred to as "intervention"

UMDNJ: University of Medicine and Dentistry of New Jersey (<http://www.umdnj.edu/>)

Varenicline (Chantix®): A first-line non-nicotine medication used in the treatment of tobacco dependence

Withdrawal: Symptoms of discomfort and distress when use of a substance is abruptly stopped, and may include intense craving for the substance
