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The Foundation:

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

Trainer's 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:

- Child Welfare Training
- Computer Training Services
- HIV/AIDS Training Center
- Instructional Technologies
- Temporary Assistance Training
- Tobacco Interventions Project
- Media Production

For further information on the programs and services offered by the Professional Development Program, contact us at:

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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 website: 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, among 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
-

Background Information for the Trainer

Trainer Note

The trainer is an integral part of making this workshop format successful. This manual was designed to be a guide for creating and facilitating the training entitled *The Foundation: Integrating Tobacco Use Interventions into NYS Chemical Dependence Services*. The suggested scripts and activities in each Unit will guide you through the entire training process. It is important that you become familiar with both the Trainer and Participant Manuals so that you can easily direct participants to particular pages as they are being discussed.

This training is designed to be presented in a three and one-half hour session, which will include a short break. The training includes both large and small group activities, which will require preparation prior to the training. It is divided into three Units and is prefaced by an Introduction.

Unit 1 provides participants with an opportunity to examine personal and addiction treatment and recovery culture attitudes, values and beliefs regarding tobacco use and dependence, a brief overview of the history of the integration of tobacco dependence treatment into chemical dependence services, and the rationale that supports this practice improvement initiative.

Unit 2 provides participants with an overview of tobacco use and dependence, nicotine withdrawal, and medications that are appropriate for the treatment of tobacco dependence.

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Background Information for the Trainer, Continued

**Trainer Note,
cont'd**

Unit 3 identifies elements of tobacco-free policies required by OASAS Regulation Part 856 Tobacco-Free Services.

The content in italics in this manual is intended to provide the trainer with a context and basis for developing his or her presentation. It is not intended to be read aloud, word-for-word. Adaptations such as professional experiences and personal observations, and using the trainer's style of expression, are expected. The acronym **PM** refers to the Participant Manual and indicates the page number and **Slide** refers to the Slide Number in the PowerPoint presentation.

The purpose of this training module is to build awareness and provide participants with the knowledge they need to begin to successfully integrate tobacco use interventions into the addiction services continuum. This training module is not designed to build specific clinical skills necessary to diagnose or treat tobacco dependence.

Trainer Tips and Responsibilities

Trainer Tip

Adult Learning Principles:

There are specific learning principles that are based on the needs of adult learners:

- Emphasize how the learning can be applied to practice
- Relate the learning to the goals of the learner
- Relate the materials to the past experiences of the learner
- Allow debate and challenge of ideas
- Listen to and respect the opinions of learners
- Encourage learners to be resources to the trainer and to one another
- Treat learners as adults

Trainer Tip

As learners, adults:

- Decide for themselves what is important to be learned
- Need to verify the information based on their beliefs and experiences
- Expect what they are learning to be immediately useful
- Have much past experience upon which to draw - may have fixed viewpoints
- Have significant ability to serve as a knowledgeable resource to the trainer and fellow learners

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Trainer Tips and Responsibilities, Continued

Trainer Responsibility

In a trainer-led, learner-centered training, you should:

- Provide learners with resources and models to help them develop their own correct approaches and solutions
- Help them develop better ways of relating to stakeholders
- Limit lecture and maximize use of active learning methods and participation
- Demonstrate belief and confidence in the learners' ability to learn and change
- Respect learners by starting and ending on time and using the learners' names
- Encourage the learners to interact with each other during the learning process. As the facilitator, you can encourage this by mixing learners into different groups for small group activities, as appropriate.
- Expand learners' questions/issues to include the larger group
- Ask learners to examine their attitudes and beliefs
- Lead by example; be enthusiastic, positive and considerate
- Value and allow differing viewpoints, even if you do not agree with those viewpoints
- Exercise self-discipline and avoid topping off comments by adding your own opinion

Continued on next page

Trainer Tips and Responsibilities, Continued

Timeframes These timeframes are approximate.

<u>Units</u>	<u>Time</u>
Welcome and Introduction	20 minutes
Unit 1 – Setting the Stage	1 hour, 10 minutes
Break (Trainer Discretion)	15 Minutes
Unit 2 – Tobacco Dependence	1 hour
Unit 3 – OASAS Regulation Part 856	30 minutes
Total Time	3 hours, 45 minutes

Continued on next page

Trainer Tips and Responsibilities, Continued

Materials and Supplies Needed

- Laptop
- LCD Projector
- PowerPoint Slides
- Trainer Manual
- Participant Manuals
- Flipcharts
- Easels
- Sticky notes
- Masking tape
- Markers
- Pre-prepared newsprint for activities
- Workshop Evaluation Forms (WEF)
- Certificates of Attendance
- Rosters/Sign-in Sheets

Optional

- Name tags or table tents
- Pre-tests, Post-tests and Answer Sheets (can be used to evaluate participant learning and to evaluate the impact of training)

Option of Pre-Test and Post-Tests

Pre-tests and post-tests were originally designed for this training as a measure of the training effectiveness, and not as an evaluation of the participants.

If using Pre-Tests and Post-Tests, provide participants with the Test Questions and Answer Sheet and then ask them to complete the pre-test before the class begins. Ask participants to write responses on the answer sheet and make their best guess if they are not sure of the correct answer.

Collect the pre-test questions and ask participants to hold on to their double-sided answer sheet to complete the post-test at the end of class

Welcome and Introductions

Trainer Note Prior to the training, prepare a large sheet of newsprint paper turned in landscape format (horizontally) and labeled “Confidence Scale.” Then place a continuum of numbers from 1 – 10, with number 1 listed as “Low Confidence” and the number 10 listed as “High Confidence”

Trainer Note After welcoming the participants to the training, explain the following information:

The Tobacco Recovery Resource Exchange, at the Professional Development Program, University at Albany also developed online versions for all the classroom-based training modules. The online modules allow you to learn at your own pace and earn additional professional education hours. To access this, go to www.tobaccorecovery.org.

Slides 1 - 3

- Introduce the trainer(s).
- Explain that the training was part of a project sponsored by the NYS Department of Health, Tobacco Control Program.
- An introduction about the original project can be crafted based on the information found on page 4 of this Trainer Manual.

Continued on next page

Welcome and Introductions, Continued

Trainer Note Review Housekeeping Issues

Slide 4

- Training Schedule
 - Breaks
 - Restrooms - location and access
 - Tobacco use policy for the training location
 - Cell phones - off or silent mode
 - Active participation encouraged
 - Complete pre-test/post-test (If this evaluation method is being used)
 - Complete training evaluation
-

Trainer Note Introductions

Slide 5

Ask participants to state their name, their job role, the type of treatment program or service where they work, and using the scale of 1 - 10, with 1 being low and 10 being high, to rate their level of confidence to successfully integrate tobacco-use interventions into their program.

As participants report their confidence level, place a mark on the continuum (either a check mark or a small post-it) so that at the end the group will have a visual representation of the range of confidence among participants.

After introductions are completed, acknowledge the range of responses and advise participants that this chart will be revisited at the end of the training.

Overview of the Training Modules

Trainer Note	Review the training topics for each module and refer participants to the topics listed under each module within their PM.
Slide 6	
PM 8	Emphasize the e-learning versions of each module, which they can access at www.tobaccorecovery.org .

Modules and Topics

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 Basic Neurobiology
Treatment Strategy Review and Case Studies

E-Learning – All Modules www.tobaccorecovery.org

Module 1 Agenda and Objectives

Trainer Note Slides 7 - 8 PM 9	Introduce Module 1 and Review the agenda and module objectives. Refer participants to the PM to review the agenda and objectives
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Module Agenda	<ul style="list-style-type: none">• Attitudes and Beliefs Activity• A Brief History• Rationale• Tobacco Dependence• NYS OASAS Regulation Part 856
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Module 1 Objectives	<ul style="list-style-type: none">• 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

Trainer Note
Slide 9
PM 11

Unit 1 will help participants explore their personal attitudes and beliefs about tobacco use in the context of addiction treatment and recovery. The unit will then provide a brief historical review about how tobacco dependence has historically been addressed within treatment, fellowship programs, and chemical dependence services, and will be followed by the rationale that supports this initiative.

Refer participants to the purpose and list of unit objectives in their PM. Answer any questions before moving forward with the content.

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
-

Attitudes and Beliefs Activity

Trainer Note Prior to the start of the module, place five small sticky notes at each participant's place. Then post five (5) sheets of newsprint around the room with one statement from the survey on TM 21 written at the top of each piece of paper. Each newsprint page should have the statement at the top with five (5) columns as illustrated in the example below:

Continued Tobacco Use Makes Relapse More Likely				
Strongly Agree	Agree	Ambivalent	Disagree	Strongly Disagree

Trainer Note **Transition to the Attitudes and Beliefs Activity by asking participants:**
Ask: Do you believe that our patient's are aware of our attitudes and beliefs? Do you think that our attitudes and beliefs can affect how patients react and behave?

Slide 10

Many participants will probably agree that clinician attitudes and beliefs are detected by patients and affect their reactions. Explain that during this discussion the purpose is not to judge anyone's personal beliefs or attitudes. Rather, it is to ask participants to look honestly at themselves as professionals, and consider some serious questions about their view of tobacco and recovery from chemical dependence.

Explain: *Staff attitudes and beliefs can play a significant role in patient responses to a practice or process improvement initiative. This activity provides you the opportunity to examine your attitudes and beliefs about the integration of tobacco use interventions into chemical dependence services, and explore how attitudes and beliefs can affect patient perceptions and response. Throughout the training, you will be encouraged to examine your attitudes and beliefs regarding tobacco's relationship to alcohol and other drug dependencies, and to challenge perceptions about integrating tobacco use interventions into your services.*

Continued on next page

Attitudes and Beliefs Activity, Continued

Trainer Note **Refer to PM and Ask** participants to complete the Attitudes/Beliefs Survey. Once participants have completed their Attitudes and Beliefs Survey, ask them to take five (5) sticky notes from their table and place one note on the appropriate column of each newsprint sheet. Each sticky note should match the response they made to the respective question on the Attitudes and Beliefs Survey.

Slide 10
PM 12

When all participants have finished placing their post-it notes, debrief the activity using the suggested process questions on TM 22 and 23.

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.					

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Attitudes and Beliefs Activity, Continued

Trainer Note **Debriefing Activity**

The debriefing for this activity should be guided by participant responses; different audiences will take trainers in different directions. This activity sets the stage for an ongoing examination of personal attitudes and beliefs related to tobacco use interventions and their integration into the addiction service delivery system.

The debriefing questions listed below and on the following page are provided as a way to “jump start” a more in-depth discussion, the purpose of which is to enable participants to clarify their attitudes and beliefs regarding integrating tobacco use interventions into chemical dependence services. This activity is intended to uncover and explore some myths and misperceptions related to addressing tobacco dependence in addiction treatment and recovery services.

Trainer Note Slide 11 PM 12

Ask the large group the following questions one at a time, and process and summarize the responses before moving to the next question:

- *As you look around at the flipcharts, what jumps out at you regarding the placement of the sticky notes?* (Varying responses/attitudes will be revealed toward different questions. Encourage a number of responses before moving on to next question.)
- *What shapes our attitudes, values, beliefs, perceptions, etc., about tobacco use and dependence?* (Examples include level of understanding of the relationship between tobacco dependence and alcohol and other drugs; social attitudes; perception of patient receptivity to treating tobacco dependence; tobacco company marketing tactics, etc.)
- *What are some beliefs about concurrently treating tobacco dependence and other chemical dependencies that may affect patient and/or provider attitudes regarding tobacco recovery?* (Examples may include that stopping tobacco use is too stressful during early recovery, that tobacco use is not as serious as alcohol or other drug (AOD) issues, that tobacco does not cause the same problems as AOD, that people have a right to use tobacco, that patients will not attend treatment if they must stop using tobacco, etc.)

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Attitudes and Beliefs Activity, Continued

**Trainer Note,
cont'd**

- *How might addiction professionals' and 12 Step member attitudes and beliefs affect efforts to address tobacco dependence?*
- *How might staff attitudes and beliefs affect patient responses regarding the integration of tobacco use interventions into chemical dependence services?*

(Examples: Patients may pick up and adopt clinician's negative points of view, thereby becoming less receptive to interventions for creating tobacco-free services; patients may have strong negative attitudes themselves that must be considered when introducing new interventions.)

**Trainer Note
Slide 12**

Summarize/Connect responses to the confidence level scale that each participant was asked to provide during the introductions. Help facilitate learners' ability to draw a connection between the confidence level that they described about their agency's ability to successfully integrate tobacco interventions into their program and their attitudes and beliefs.

Transition to Discussion of the A Brief History.

A Brief History

Trainer Note

Explain the following points as a lead-in to the historical review:

Slide 12

- *Efforts to address tobacco use during chemical dependence treatment is not new and these efforts now span three different centuries*
- *It was common practice among many early chemical dependence treatment pioneers to routinely treat tobacco dependence concurrently with other chemical dependence*
- *Addressing tobacco dependence as a serious addiction was lost with the emergence of Alcoholics Anonymous in the mid-1930s. It was rediscovered in the late 1980s as treatment providers were confronted by the devastating toll tobacco exacts on people in recovery.*
- *Science, laws, culture, and policy have all influenced the movement to address tobacco dependence in chemical dependence treatment and recovery*

Trainer Note

Slides 13 - 30

PM 13 - 16

The timeline contained in this section is presented using the PowerPoint slides. It is meant as an overview to provide a context for how tobacco use, dependence, and treatment has been viewed for 150 years, with recognition of the effect of tobacco use on excess alcohol use being recognized more than 200 years ago.

Refer participants to the PM to follow along while you briefly review the historical facts that highlight and illustrate the key points detailed in their PM. This section of slides is designed to move quickly and should not require more than about 20 minutes. The trainer may wish to highlight certain slides especially those relating to the early AOD treatment concerns about tobacco, the merging awareness in the mid -1980s, and recent changes, such as the Family Smoking Prevention and Tobacco Control Act (FSPTCA).

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A Brief History, Continued

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. 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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A Brief History, 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.

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A Brief History, Continued

**Trainer Note
Summary**

The following is suggested to summarize this historical overview and to transition to the Rationale.

This brief history gives you a sense of the process of change regarding tobacco use and tobacco use interventions from a cultural, scientific, statutory, and policy perspective.

This process led to the issuance of OASAS Regulation Part 856 - Tobacco-Free Services in 2007. This regulation took effect on July 24, 2008. New York is the first state to require all funded and/or certified chemical dependence services to integrate tobacco use interventions into their programs. At least two large states are planning to follow the approach of New York State beginning in 2010.

As of 2009, the FDA now has the authority to regulate tobacco and additives, but cannot eliminate nicotine or menthol from tobacco.

Now that we have looked at the historical context of this initiative, we will next examine some of the rationale that supports this change in policy and practice.

Rationale

Trainer Note
Slide 31

In this section of Unit 1, you will provide participants with the opportunity to discuss a variety of issues that contribute to the rationale that supports the integration of tobacco use interventions into chemical dependence services.

Trainer Note
Slides 32 - 34
PM 17

The questions below are suggested to generate a discussion about the mission of chemical dependence programs to address tobacco.

Looking back at our Attitudes and Beliefs Activity, what was the range of responses to the statement “tobacco dependence should be treated in chemical dependence programs?”

What does your agency’s mission statement say (or not say) about treating all chemical dependencies?

Do you think your mission statements should be amended to read “alcohol, tobacco, and other drugs”?

Explain that treating tobacco dependence is consistent with the mission of addiction treatment. Two slides provide actual examples of chemical dependence agency mission statements.

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.”

Continued on next page

Rationale, Continued

Trainer Note
Slide 35
PM 17

Facilitate a large group discussion regarding the skills and knowledge that addiction professionals possess by using this series of questions:

As addictions professionals, what knowledge base and skill sets do you already possess, that positions you to treat tobacco dependence?

(Examples: motivational interviewing, cognitive-behavioral therapy, and pharmacotherapy are integral elements of evidence-based treatment for tobacco dependence and other chemical dependencies.)

What additional knowledge and skills will you need to treat tobacco dependence?

Explain: addiction professionals already have many of the necessary skills to treat tobacco dependence.

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.

Continued on next page

Rationale, Continued

Trainer Note

Slide 36

PM 18

Refer to the prevalence on the slides and as listed in the PM.

Facilitate a discussion using the following questions:

For the past 40 years, the prevalence of smoking rates in the general population has been dramatically reduced. Why do you think this has occurred?

What is the percentage of tobacco use in the general population in the United States?

What are the unique populations (groups of people) that have a high prevalence of tobacco use?

Why do you think the tobacco use prevalence in these populations is so high?

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

Continued on next page

Rationale, Continued

Trainer Note	Refer participants to the chart in their PM.
Slide 37	Explain that the chart displays data that OASAS collected in 2006 from their certified treatment programs.
PM 18	<p>Refer back to the national statistics just presented and explain using the following suggested language:</p> <p><i>You will note that the statistics for NYS are seemingly lower than the national statistics. As explained by the Office of the Medical Director at OASAS, it is not because these patients fall outside the norm; rather it is a result of how OASAS asked the survey questions.</i></p>

<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			

Continued on next page

Rationale, Continued

Trainer Note PM 19

State: *Jonathan Foulds, Director of the Tobacco Dependence Program at the University of Medicine and Dentistry of New Jersey, School of Public Health, describes those who suffer from mental health and/or substance use disorders as the “forgotten smokers.” The “forgotten smokers,” is a large segment of the population in the US who consume tobacco at two to three times the rate of the general population. This is a health disparity issue.*

Ask: *This seems like tacit acceptance of tobacco use and the adverse consequences of that use with respect to these populations. Why do you think this has occurred?*

(Possible Participant Responses: Patients don't really want to stop. None of them can stop. Their other problems will get worse if they stop using tobacco. Staff tell patients not to stop smoking because they fear recovery will be at risk.)

Refer participants to the PM and the studies listed below and continued on the next page.

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.

Several studies indicate that the prevalence of tobacco use among people receiving treatment or in recovery is dramatically higher than the general US adult population rate of 19.8% (CDC, 2009)

- 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 US (Nahvi et al., 2006)
- 71 - 93% among alcoholic outpatients (Istvan and Matarazzo, 1984)
- 85 - 90% among substance abuse inpatients (Burling and Ziff, 1988)

Continued on next page

Rationale, Continued

**Trainer Note,
cont'd
PM 19**

Refer participants to the PM and the studies listed below.

Ask: How are you feeling and reacting to hearing this information and how does it affect their view of treatment?

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

The 2005 National Survey on Drug Use and Health (NSDUH, 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

Trainer Note
Slides 38 - 40
PM 20

Refer participants to PM. Before moving to the tobacco advertising slides, the following content is suggested to help facilitate a brief discussion about the tobacco industry.

Like any business, tobacco companies need consumers to buy their products to make money. Advertising is what draws attention to their products and provides an opportunity to convince consumers that they want, and even "need," to buy those products. Moreover, the tobacco industry's aggressive advertising campaigns are incredibly successful. Over the decades, these companies have become experts at selling smoke, especially targeting specific groups of people, including young adults, people of color, women, and people of lower socio-economic status (SES).

- As you view these advertisements, think about how the tobacco industry is trying to sell their products and to what types of people.
- How do these various marketing strategies combine information, images, emotion, and psychology to influence viewers?
- What types of consumer do you think each ad is targeting?

Then allow participants to view each slide and make comments.

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 (SES).

Continued on next page

Rationale, Continued

Trainer Note	Refer participants to the slide and to the PM about tobacco industry practices.
Slide 41	<i>Ask: How do you think/feel about this list of statements about tobacco companies?</i>
PM 20	

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
-

Trainer Note	Ask:
Slide 42	<ul style="list-style-type: none"> • Is it possible to relate tobacco company tactics back to your responses in the Attitudes and Beliefs activity? • Why are tobacco companies targeting youth (and insist they do not)? • Why did Phillip Morris, the largest of the big tobacco companies, support the bill that provided for FDA regulation of tobacco products? (It will likely drive smaller tobacco companies out of business, thereby increasing their market share.)
PM 20	<p>Transition Summary: Media literacy education is an essential part of a comprehensive tobacco prevention and intervention program. It helps children, adolescents, and adults learn how to interpret and evaluate tobacco advertising, promotion, and marketing campaigns, and strengthens the protective factors that deter tobacco use.</p>

Continued on next page

Rationale, Continued

Trainer Note **Refer participants to the content in their PM and explain that**
Slides 42 -43 *Tobacco use is a pervasive and significant problem for chemical dependence*
PM 21 *patients. Treating tobacco dependence will save lives.*

There is a significant body of research that demonstrates high morbidity due to tobacco use for people who suffer from alcohol or other drug dependence, serious mental health disorders, and co-occurring disorders.

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 die more often from their tobacco use than from the consequences 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)

Continued on next page

Rationale, Continued

Trainer Note **Refer participants to the content in their PM and explain that:**

Slide 44
PM 21 *Tobacco use became normalized and embedded into the fellowship programs, into the recovery movement, and in treatment programs as part of practice folklore (the traditional beliefs about what is believed to work) despite the lack of research to support this practice.*

Reference the deaths of AA founders Bill Wilson and Dr Bob, and the "first lady" of AA, Marty Mann as due to tobacco-related illness.

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)

Continued on next page

Rationale, Continued

Trainer Note
Slides 45 - 46
PM 22 - 23

Refer to the PM

Explain: The ratio of those who die from tobacco use compared to those living with serious tobacco related illness (1:20).

State: *There are less well known but serious consequences of tobacco use, for example, cataracts, hip fractures, low bone density, reproductive health issues, and adverse effects on fetal development and pregnancy.*

Suggested follow-up questions:

- *When you are doing assessments with patients, are you making the connection between their presenting health problems and tobacco use?*
- *Is it ever too late to stop using tobacco?*

Health
Consequences

For every person who dies from his/her tobacco use, there are twenty people living with serious health problems caused by 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. All organ systems are 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)

Continued on next page

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)

Continued on next page

Rationale, Continued

Trainer Note

Slide 47

PM 24

Explain that for more than a decade, addiction treatment professionals have recognized that co-occurring mental illness and addiction need to be addressed concurrently in the context of addiction treatment. Likewise, members of this field are beginning to recognize that there also is a need to integrate tobacco dependence treatment across the continuum of substance abuse treatment and prevention services. Improved health services interventions for tobacco dependence are needed at the clinical, program, and system levels (Stuyt et al. 2003).

**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).

Continued on next page

Rationale, Continued

Trainer Note
Slide 47
PM 24 - 25

Refer to PM and Explain that concerns expressed by treatment professionals that treating tobacco dependence simultaneously with other chemical dependencies (or a mental health disorder) will jeopardize recovery or stability, has not been supported by a number of research studies. In fact, the research indicates that treatment is efficacious, most patients do not get worse, and many patients actually show improved recovery outcomes.

**Efficacy of
 Integrated
 Tobacco
 Dependence
 Treatment**

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)
 - 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)
-

Summary

Trainer Note
PM 26

Summarize: There is compelling rationale for addressing tobacco dependence within chemical dependence treatment. Tobacco use was recognized by early treatment pioneers in the late 1800s and early 1900s as an impediment to recovery. It is consistent with agency mission. It is the number one cause of death for people with chemical dependence. It causes serious and often fatal health consequences. Treatment outcomes are improved. Treating tobacco is also efficacious.

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
-

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Unit 2

Tobacco Dependence

Trainer Note
Slide 48
PM 27

Unit 2 will help participants examine tobacco dependence from several perspectives. It will help the participant to understand tobacco dependence within a biopsychosocial perspective, how nicotine dependence develops in a way similar to cocaine and amphetamine dependence, and why there is a high prevalence of tobacco use among chemical dependence patients. It will also review the criteria used for nicotine dependence and nicotine withdrawal in the Diagnostic and Statistical Manual for Mental Disorders, Text Revision (DSM-IV-TR). There is a discussion of how tobacco dependence compares with other AOD dependence, and a brief review of tobacco treatment medications and the challenges of tobacco dependence treatment.

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

Trainer Note

Slide 49

If time permits, divide participants into three groups. (It is advantageous to mix participants randomly so that groups are diverse.) Alternately, you may choose to lead this discussion with the large group, asking for biological, social, and psychological reasons for using tobacco.

After the three groups are created, give each group a sheet of flipchart paper and a marker. Tell each group that they will need a recorder and a reporter. Allow a few minutes for groups to identify those members of the group who will assume those roles.

State: *A core concept that underlies addiction professionals' understanding of chemical dependence has evolved with scientific advances and practice wisdom over more than two decades; chemical dependence is a biopsychosocial disease. That is, the manifestation, maintenance, and course of addiction are influenced by biological vulnerabilities, psychological predispositions, and pervasive social factors (Erickson, 2007). People begin using and continue their use of alcohol, tobacco and other drugs for many reasons.*

Trainer Note

PM 28

Refer to the PM and to the biopsychosocial chart on the next page.

Assign Group 1- Biological reasons why people use tobacco

Assign Group 2 - Psychological reasons why people use tobacco

Assign Group 3 - Social reasons why people use tobacco

Allow groups to work independently for a few minutes and circulate around the room. When it appears the groups have generated the lists, ask the reporter in Group 1 to post their list so that it is visible to all participants, and ask the reporter to briefly review the list. Repeat with the other two groups and facilitate a discussion as appropriate.

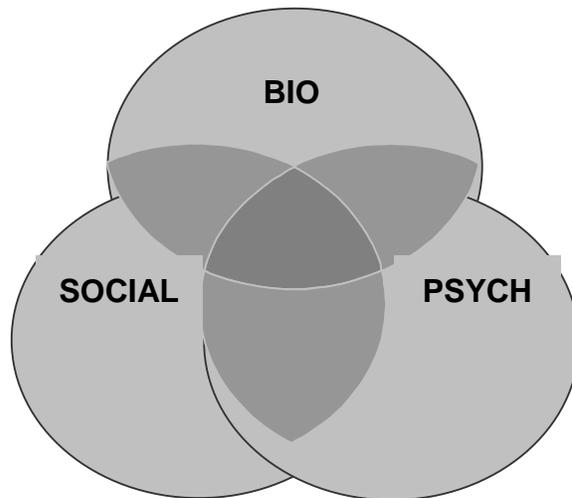
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A Biopsychosocial Disease, Continued

Trainer Note If they choose, participants may use the following biopsychosocial model to record some of the responses of the large group.
PM 28

Addiction:

A Bio-Pscho-Social Disease



Notes:

Continued on next page

A Biopsychosocial Disease, Continued

**Trainer Note,
cont'd**

Slide 50

State: *Tobacco dependence is a biopsychosocial disease like any other chemical dependence. Using the insight that you have gained doing the biopsychosocial exercise, let's discuss why we use the term "tobacco dependence" instead of the DSM-IV-TR terminology of "nicotine dependence."*

Ask the group to brainstorm why they might think this training uses the term "tobacco dependence" rather than "nicotine dependence."

Orally summarize responses. The following are key reasons to identify:

- Patients are far more likely to develop symptoms of chemical dependence from using tobacco than from using nicotine replacement therapy (NRT)
- Patients using alcohol and other drugs are far more likely to co-administer tobacco than NRT
- The thoughts, feelings, and behaviors underlying tobacco use (e.g., protecting the supply, looking forward to using, drug use rituals) are associated with alcohol and other drug use. The same is not true of NRT.
- The most common – and most severe – consequences patients experience come from the use of commercial tobacco products, not NRT

Explain that the term "tobacco dependence" describes the overall effects of tobacco use and is similar to using the term "cannabis dependence" used to describe the overall effects of smoking marijuana or hashish. If not identified by the groups, explain that while nicotine causes dependency; it is the tobacco smoke, not nicotine, which causes cancers, COPD, cardiovascular disease, emphysema, and other diseases.

Explain that while the tobacco industry failed to prevent the inclusion of "tobacco dependence," in DSM-III in 1980, "tobacco dependence" became "nicotine dependence" with the publication of DSM -III R in 1984 (Neuman et al., 2005).

Continued on next page

A Biopsychosocial Disease, Continued

Trainer Note	Refer to PM and Nicotine Dependence diagram on the next page. State:
Slide 51	<i>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.</i>
PM 29	<i>Nicotine locks into acetylcholine receptors in different parts of the brain, and raises heart rate and respiration rate. It also causes glucose (blood sugar) and cortisol to be released. This may explain why tobacco users report feeling more alert after using.</i>
	<i>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.</i>
	<i>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.</i>
	<i>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.</i>

Continued on next page

A Biopsychosocial Disease, Continued

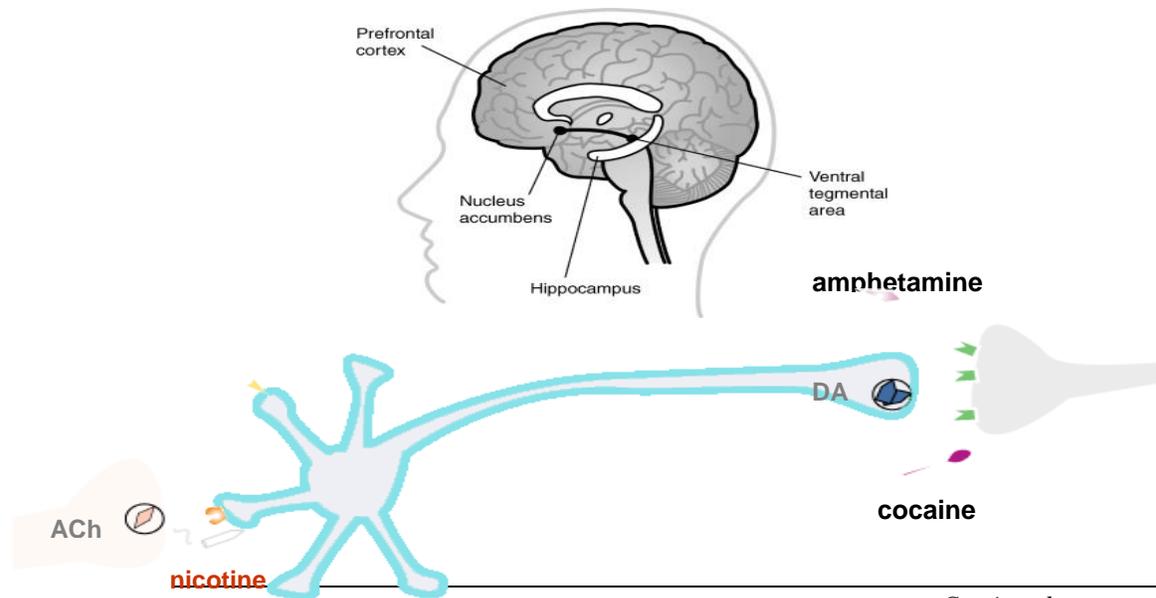
Development of Tobacco Dependence

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.



Continued on next page

A Biopsychosocial Disease, Continued

Trainer Note

Slide 52

PM 30

Explain: Refer to the PM and summarize that as discussed in Unit 1, 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.**

Theories for Tobacco Use Prevalence

- **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

Trainer Note
Slide 53
PM 31

Familiarize participants with DSM-IV-TR terminology and coding for nicotine dependence and nicotine withdrawal.

Explain: *The DSM-IV-TR code for nicotine dependence is 305.1. Further explain that the DSM-IV-TR does not have additional criteria for the diagnosis of nicotine dependence (a.k.a. tobacco dependence), and it simply applies the criteria listed under Substance Dependence (see list below). This issue will be addressed in more depth in Module 2*

**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

Continued on next page

DSM-IV-TR Criteria, Continued

Trainer Note
Slide 54
PM 32

State: *There is general agreement across the health care and addiction treatment professions that nicotine use can result in a well-defined withdrawal syndrome.*

Ask participants to review the two pages in their PM about nicotine withdrawal, and then lead a discussion using the questions on the next page.

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.

Continued on next page

DSM-IV-TR Criteria, Continued

Trainer Note **State:** *There is no DSM-IV-TR diagnosis code for nicotine abuse or nicotine intoxication. The reason is that the DSM-IV-TR cites a lack of clinically relevant data. Further, there is difficulty applying substance abuse criteria to nicotine, dependence potential for nicotine is very high, and nicotine causes pleasure but not significant euphoria or intoxication.*

Trainer Note **Use a large group discussion and ask:**
PM 33 *How is nicotine withdrawal similar to AOD withdrawal? (Physical and psychological symptoms, significant distress, impairment in functioning)*
What are the challenges in managing nicotine withdrawal? (Withdrawal is often intense, use pattern hard to break, long duration, drug availability)

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 is the cause of frequent relapse

Tobacco Medication Overview

Trainer Note This section provides a brief overview of tobacco treatment medications, the effectiveness of medications in specific populations. First-line nicotine and non-nicotine medications, combination medications, and contraindications are discussed. This content is covered in greater depth in Module 2.

Explain: *Assessment, diagnosis, and pharmacotherapy are covered in more detail in Module 2. The United States Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence, 2008 Update (Fiore et al., 2008), abbreviated CPG, directs health care providers to advise their patient to use effective medications as a component of their tobacco dependence treatment, except in populations where there is insufficient evidence of effectiveness or where medication is contraindicated.*

The key point is that the effective management of nicotine withdrawal results in a more comfortable patient and a greater chance of successful engagement in treatment.

Continued on next page

Tobacco Medication Overview, Continued

- Trainer Note** **Begin this section by referring to the Attitudes and Beliefs Activity. The following questions are suggested for this discussion:**
- *What are the advantages of using medications when treating tobacco dependence?*
 - *What is your current comfort level in advising patients about medication?*
-

- Trainer Note** **Refer** to the importance of effectively managing nicotine withdrawal.
- Slide 55** **Explain** that according to the CPG, 2008 Update, all patients should be advised to stop using tobacco and to use medications (pharmacotherapy), except where contraindicated or where there is insufficient evidence of effectiveness.
- Bullets 1 - 2**
- PM 34**
-

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).

Continued on next page

Tobacco Medication Overview, Continued

Trainer Note, cont'd

**Slide 55
Bullets 3 - 4
PM 34**

Explain the effectiveness of tobacco treatment medications and their applicability to a wide range of populations. Also indicate there is currently insufficient evidence that these medications are effective for pregnant women, adolescents, light smokers (less than 10 cigarettes per day), and smokeless tobacco users. However, these medications may still be effective on a case-by-case basis, as determined by a physician or other health care provider.

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 Medication Overview, Continued

Trainer Note As you discuss each of the following blocks of information, bring up the corresponding bullet on the slide.

Slide 56

Bullets 1 - 2

PM 35 Review the first line medications, both nicotine and non-nicotine, approved by the FDA for treating tobacco dependence, emphasizing that these medications have been shown to be both safe and effective. State that combinations are often more effective than single medications.

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 Medication Overview, Continued

-
- | | |
|--|---|
| Combination
Pharmaco-
therapy | <ul style="list-style-type: none"> • Long-term (>14 weeks) nicotine patch plus other NRT (gum, nasal spray) • Nicotine patch plus nicotine inhaler • Nicotine patch plus bupropion SR |
|--|---|
-

**Trainer Note,
cont'd**

The following blocks of information have a corresponding bullet on the slide.

**Slide 56
Bullet 3
PM 36**

Explain tobacco smoke can increase the metabolism of many drugs. Stopping smoking may sometimes require a reduction in dosage.

**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.

Continued on next page

Tobacco Medication Overview, Continued

**Trainer Note,
cont'd**

**Slide 56,
bullet 4
PM 36**

Explain that there are few medical contraindications for using nicotine replacement medications. There are some contraindications for bupropion (acute alcohol withdrawal, seizure disorders, eating disorders), and varenicline (renal disease), which are discussed in more detail in Module 2. Some patients may develop psychiatric symptoms from taking bupropion or varenicline, but these symptoms may also be due to tobacco withdrawal or other factors.

**Medical
Contra-
indications for
NRT**

- Myocardial infarction (within the last 2 weeks)
 - Serious arrhythmias
 - Serious or worsening angina pectoris (chest pain)
 - Uncontrolled hypertension
-

**Trainer Note
Slide 57
PM 37**

Mention that supportive counseling includes Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), Relapse Prevention Therapy, and Tobacco Awareness Groups, and Tobacco Recovery Groups, which are covered in-depth in Module 3 and in Online Modules 3-5.

**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.

Continued on next page

Tobacco Medication Overview, Continued

Trainer Note Slide 58	Explain that nicotine replacement medications have a wide margin of safety, have been used for many years, and are much safer than using tobacco.
PM 37	Explain that many patients do not use enough medication to control their withdrawal or they use the medication incorrectly. Tobacco treatment medications are covered in-depth in Module 2.

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

Trainer Note Refer to the comparison chart in PM regarding nicotine levels.

Slide 59

PM 38

Explain: Note that the peak levels of nicotine delivery from cigarette smoke and the rapid decline in effect, require repeated use. The peak nicotine level from tobacco smoke is nearly twice as high as for nasal spray, and is three to four times higher than gum, lozenges, or inhalers. The nicotine patch provides the most gradual and prolonged effect.

Discuss nicotine absorption using various NRTs vs. cigarettes, by describing the peak nicotine levels from each method, using the graph below.

Comparison of nicotine delivery from cigarette smoke vs. various NRTs

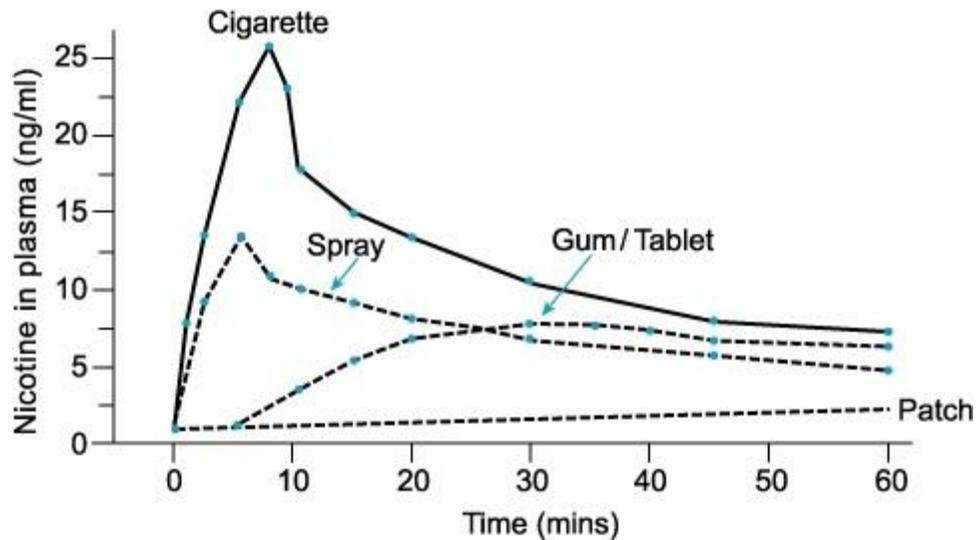


Diagram shows rise in blood nicotine levels after using a cigarette as compared to different nicotine replacement therapy products (adapted from Royal College of Physicians, 2000).

Continued on next page

The Cigarette - A Perfect Drug Delivery Device, Continued

Trainer Note
Slides 60 - 61
PM 39

Explain: *Although it is the nicotine in cigarettes, that causes chemical dependence, it is the smoke, and other ingredients volatilized during smoking that are the causes of a myriad of diseases and serious health conditions.*

Ask participants to read the material, and explain that mentholated cigarettes were invented to stimulate dependence for low socio-economic class consumers. Menthol's anesthetic effect allows the user to inhale more deeply, leading to greater absorption of nicotine. This makes it possible to maintain dependence with fewer cigarettes. Menthol cigarette users are more likely than non-mentholated cigarette users to develop deadlier, more invasive forms of lung cancer.

**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)

Trainer Note	Refer to PM
Slides 62 - 63 PM 40	Discuss the differences and similarities of tobacco dependence to alcohol and other drug dependence (AOD) as listed below.

How Tobacco Dependence Differs from AOD Dependence	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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

Trainer Note

Introduce this activity by stating:

Using language that is consistent with the language of addiction treatment and recovery is helpful for the integration of tobacco interventions into addiction services and to help the shift old beliefs. Research on tobacco use and dependence is extensive and is written in public health terminology; little comes from the chemical dependence treatment field. The public health messages are appropriate when delivered by public health service providers to the general population. For addiction professionals to treat tobacco dependence just like alcohol or other drug dependence, it is helpful that the language they use be familiar terms that patients will recognize or are familiar with using.

**Reframing
Language
Slide 64
PM 41**

Refer participants to their PM. **Ask** them to work in dyads to develop alternative terms to the public health language that are more appropriate to the language of addiction treatment and recovery. Allow a few minutes for the activity, then process with the large group.

<u>Public Health Terminology</u>	<u>Recovery Terminology</u>
smoking	tobacco use, dose
smoker	tobacco user
quit date	recovery start date
cessation	treatment / recovery

Continued on next page

Language of Treatment and Recovery, Continued

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

Trainer Note *Ask: What are the challenges of treating tobacco dependence? Cull out responses and summarize.*
Slide 65
PM 42 **Refer** to the PM about the key points listed.

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

Trainer Note

Summarize:

PM 43

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.

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.

Unit 3

OASAS Regulation Part 856

Trainer Note The purpose of this unit is to familiarize participants with key aspects of OASAS Regulation Part 856 and to address any misconceptions about what the regulation requires and what is not required of chemical dependence programs. The entire regulation is reprinted in the PM.

Slide 66

PM 45

Refer participants to appropriate pages as necessary during the discussion and address specific questions about the regulation.

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.

Continued on next page

OASAS Regulation Part 856, Continued

Trainer Note

Slide 67

As a trainer, it is a challenge to make this discussion of the regulation engaging, stimulating, and non-threatening. There are several strategies that can help keep participants engaged:

- As you discuss the regulation, encourage participants to ask questions and/or contribute their experiences of how they are implementing the regulation in their own agencies/facilities
- Begin by using a large group activity to elicit participant concerns and assumptions about the regulation

The following is suggested language for how to frame a discussion about the regulation:

We have examined some of the reasons behind the movement to integrate tobacco-use interventions into chemical dependence services.

As we begin to discuss the actual regulation and the policies that will need to be implemented, it is important to focus on what the regulation actually requires as policy elements, and the many elements that are subject to determination by the programs. You may be surprised that while there are required aspects of the regulation, programs have significant latitude in how to implement the regulation and how to write their agency policy.

Background and Intent of the Regulation

Trainer Note
Slide 67
PM 46

Explain: *There have been concerns expressed from some of professionals in the field regarding the implications of the regulation. Some of these concerns are based on wrong assumptions and/or incorrect information. Here are a few examples:*

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.
-

Trainer Note

Emphasize that these concerns are unfounded and are not in the regulation. *OASAS recognized the challenges and obstacles that agencies face in implementing the regulation and has made allowances. While programs were required to have established their tobacco free services policy July 24, 2008, providers did not “lose points” on their reviews before July 24, 2009. OASAS communicated that they saw the regulation as a starting point for programs to begin making a treatment culture shift, as well as the workforce making personal transitions necessary to sustain a change in clinical practice.*

Continued on next page

Background and Intent of the Regulation, Continued

Trainer Note
Slide 68
PM 46

An important part of Regulation Part 856 is the section that outlines required policy elements. The emphasis of this discussion should be centered on the required elements and participants should come away from the training knowing what their policies must contain.

State: *It is important to stress that outside of required elements, agencies have considerable latitude about how to write their policies. For example:*

*A minimum policy requirement is that programs establish treatment modalities for patients who use tobacco. There are **no** requirements as to what those modalities should be. Agencies are expected to implement modalities using evidence-based practices and based upon the needs of patients.*

**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

Trainer Note **Refer to PM and Review** the legal basis and OASAS authority for establishing this regulation. It may be useful to refer to the history of discussion between ASAP, OASAS, the NYS Tobacco Control Program, and American Cancer Society and that the regulation did not emerge without significant discussion and planning over several years.

Slide 68

PM 47

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 Regulation and Definitions

Trainer Note
Slide 69
PM 48

Explain which programs the regulation applies to, noting that OASAS has exempted the following types of funded programs from the regulation:

- Vocational rehabilitation services
- Permanent supportive housing

Help participants understand that the definition of “tobacco-free” refers to grounds, vehicles, and buildings solely under the control of the program and not those areas shared with other agencies that do not follow this regulation. Vehicles owned by staff that are used to transport patients are also covered.

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

Trainer Note
Slides 70 -72
PM 49

Explain that the following are minimum requirements and that programs can make their policies more rigorous, if they so desire.

The regulation does allow staff to possess tobacco and tobacco paraphernalia while at work, but patients, visitors, and patients may not. Tobacco may not be used on the premises by anyone, however, staff may use off grounds and while away from the facility, if not transporting patients. The program needs to develop a policy addressing the key points and inform all parties of the policy in writing. The policy must define how patients' tobacco use violations are addressed and that staff policy violations be consistent with normal facility employment procedures for any job-related violation.

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

Continued on next page

Requirements of the Agency's Tobacco Use Policy, Continued

Trainer Note **Explain** that even though any part of the regulation is later ruled invalid or is disallowed, the rest of the regulation is still valid and in force.
Slides 73 - 75
PM 50 **Review** the main required components and address questions as they arise.

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.

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

True or False

Review the True or False Questions - Regulation Part 856

**Slides 76 - 80
PM 51**

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

**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.
-

Module Closure

Trainer Note
Slides 81 - 82
PM 53 - 54

Refer participants back to the Confidence Scale Activity that was completed during the Introduction.

State *because of this session, how many of you would adjust the confidence rating you identified at the beginning of training?* (Ideally, the level of confidence has increased.) If time allows, ask participants if they can quickly identify a need that was unmet in this training that would help boost their confidence level. Use flipchart to capture any participant needs identified.

Be sure that participants know how to access e-learning and web resources at www.tobaccorecovery.org

If using the Post-tests, distribute the post-test questions and training evaluation form. Thank participants for their participation, and remind them that the post-test is a measure of the training and that their thoughtful completion of the evaluation is appreciated.

When participants hand-in completed evaluation (and if required a post-test) provide participants with a Certificate of Completion.

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

Continued on next page

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

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Appendix

Pre-Test/Post-Test and Answer Sheet

Sample Pre-test and Post-Test Questions

Sample Pre-Post Test Answer Sheet

Workshop Evaluation

Sample Workshop Evaluation Form

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Module 1 Pre-Post-Test Questions

This instrument is used to evaluate the effectiveness of the training. It is not used to rate individual participants. Please complete the test anonymously. Record your answers on the answer sheet provided.

1. Which of the following statements is false?
 - a. Continued tobacco use negatively impacts recovery rates from other substances.
 - b. People with substance use disorders who smoke are much more likely to die from their tobacco use than from their alcohol or other drug addiction.
 - c. Addiction service providers possess much of the knowledge and many of the skills necessary to treat tobacco dependence.
 - d. Most tobacco users do not want to stop.

2. The idea that tobacco is a harmful addictive substance and that tobacco use was a contributing factor in alcohol and other drug relapse was first introduced in:
 - a. 1920s
 - b. 1960s
 - c. 1870s
 - d. 1940s

3. Which of the following nicotine replacement therapy (NRT) products requires a prescription?
 - a. Nicotine gum
 - b. Nicotine nasal spray
 - c. Nicotine patch
 - d. Nicotine lozenge

4. In what way does tobacco dependence differ from alcohol and other drug dependence?
 - a. Tobacco use affects release of dopamine in the brain.
 - b. Tobacco use causes a range of illnesses and leads to death.
 - c. Tobacco use generally does not cause adverse behavioral outcomes.
 - d. People continue to use tobacco despite harmful effects.

5. Which of the following policy elements is required by OASAS Regulation Part 856 Tobacco-Free Services?
 - a. The policy must state that patients in outpatient treatment programs must agree to stop using tobacco while they are enrolled in the program.
 - b. The policy must establish treatment modalities for patients who use tobacco.
 - c. The policy must state that staff who repeatedly violate the policy will be terminated.
 - d. The policy must state that nicotine replacement therapy (NRT) is not a recommended treatment method in abstinence-based programs.

6. What substance causes the greatest number of deaths for individuals who have received chemical dependence treatment?
 - a. Alcohol
 - b. Tobacco
 - c. Opioids
 - d. Cocaine

7. The prevalence of tobacco use among people in treatment for alcohol or other drug dependency in the U.S. is approximately:
 - a. 47 - 54%
 - b. 35 - 45%
 - c. 60 - 95%
 - d. 10 - 25%

8. In what way is tobacco dependence similar to alcohol and other drug dependence?
 - a. Tobacco use generally does not cause intoxication and/or extreme behaviors.
 - b. Tobacco use can cause improvements in cognitive and affective functioning.
 - c. Tobacco use has a well-defined withdrawal syndrome.
 - d. Tobacco use does not produce intense euphoria.

9. Which of the following is not a theory that attempts to explain the high level of concurrent tobacco use among people with other chemical dependence?
 - a. People who use alcohol, tobacco and other drugs are less intelligent than the rest of the population.
 - b. Alcohol, tobacco, and other drugs appeal to people with similar personality characteristics.
 - c. Tobacco may enhance the effect of alcohol.
 - d. Tobacco affects the same neural pathway as alcohol, cocaine, opioids, and amphetamines.

10. Which of the following statements is true?
 - a. OASAS will revoke the credentials of CASACs who do not stop smoking pursuant to Regulation Part 856.
 - b. Agencies have considerable latitude in crafting their tobacco-free policy.
 - c. If it causes too much hardship for staff and patients, agencies can choose not to implement Regulation Part 856 right away.
 - d. All agencies must submit their tobacco-free policies to OASAS for review and approval.

Module 1 Pre-Post-Test Questions (Correct answers in bold italic)

This instrument is used to evaluate the effectiveness of the training. It is not used to rate individual participants. Please complete the test anonymously. Record your answers on the answer sheet provided.

1. Which of the following statements is false?
 - a. Continued tobacco use negatively impacts recovery rates from other substances.
 - b. People with substance use disorders who smoke are much more likely to die from their tobacco use than from their alcohol or other drug addiction.
 - c. Addiction service providers possess much of the knowledge and many of the skills necessary to treat tobacco dependence.
 - d. ***Most tobacco users do not want to stop.***

2. The idea that tobacco is a harmful addictive substance and that tobacco use was a contributing factor in alcohol and other drug relapse was first introduced in:
 - a. 1920s
 - b. 1960s
 - c. ***1870s***
 - d. 1940s

3. Which of the following nicotine replacement therapy (NRT) products requires a prescription?
 - a. Nicotine gum
 - b. ***Nicotine nasal spray***
 - c. Nicotine patch
 - d. Nicotine lozenge

4. In what way does tobacco dependence differ from alcohol and other drug dependence?
 - a. Tobacco use affects release of dopamine in the brain.
 - b. Tobacco use causes a range of illnesses and leads to death.
 - c. ***Tobacco use generally does not cause adverse behavioral outcomes.***
 - d. People continue to use tobacco despite harmful effects.

5. Which of the following policy elements is required by OASAS Regulation Part 856 Tobacco-Free Services?
 - a. The policy must state that patients in outpatient treatment programs must agree to stop using tobacco while they are enrolled in the program.
 - b. ***The policy must establish treatment modalities for patients who use tobacco.***
 - c. The policy must state that staff who repeatedly violate the policy will be terminated.
 - d. The policy must state that nicotine replacement therapy (NRT) is not a recommended treatment method in abstinence-based programs.

6. What substance causes the greatest number of deaths for individuals who have received chemical dependence treatment?
 - a. Alcohol
 - b. Tobacco**
 - c. Opioids
 - d. Cocaine

7. The prevalence of tobacco use among people in treatment for alcohol or other drug dependency in the U.S. is approximately:
 - a. 47 - 54%
 - b. 35 - 45%
 - c. 60 - 95%**
 - d. 10 - 25%

8. In what way is tobacco dependence similar to alcohol and other drug dependence?
 - e. Tobacco use generally does not cause intoxication and/or extreme behaviors.
 - f. Tobacco use can cause improvements in cognitive and affective functioning.
 - g. Tobacco use has a well-defined withdrawal syndrome.**
 - h. Tobacco use does not produce intense euphoria.

9. Which of the following is not a theory that attempts to explain the high level of concurrent tobacco use among people with other chemical dependence?
 - a. People who use alcohol, tobacco and other drugs are less intelligent than the rest of the population.**
 - e. Alcohol, tobacco, and other drugs appeal to people with similar personality characteristics.
 - f. Tobacco may enhance the effect of alcohol.
 - g. Tobacco affects the same neural pathway as alcohol, cocaine, opioids, and amphetamines.

10. Which of the following statements is true?
 - i. OASAS will revoke the credentials of CASACs who do not stop smoking pursuant to Regulation Part 856.
 - j. Agencies have considerable latitude in crafting their tobacco-free policy.**
 - k. If it causes too much hardship for staff and patients, agencies can choose not to implement Regulation Part 856 right away.
 - l. All agencies must submit their tobacco-free policies to OASAS for review and approval.

Module 1 Pre-Test Answer Sheet

Workshop Title _____ Date _____

RTATC Region _____

Please circle the most appropriate response to each question using this page.

1. a b c d

2. a b c d

3. a b c d

4. a b c d

5. a b c d

6. a b c d

7. a b c d

8. a b c d

9. a b c d

10. a b c d

Module 1 Post-Test Answer Sheet

Please circle the most appropriate response to each question using this page.

1. a b c d

2. a b c d

3. a b c d

4. a b c d

5. a b c d

6. a b c d

7. a b c d

8. a b c d

9. a b c d

10. a b c d



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

Workshop Evaluation Form

Workshop Title _____ Date _____

Workshop Location _____

Instructor(s) Name(s) _____

Please use this form to evaluate the training you have just received. It is important for us to know whether the instruction is meeting the needs of the participants. Your comments will make a valuable contribution to course improvement. All responses are confidential. Thank you.

- Section One -

Instructions: Please use the following scale to indicate your level of agreement with each of the following statements.

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
1. The course objectives were very clear	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
2. The course content supported the objectives	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
3. The knowledge and skills gained from this course will help me perform my job more effectively	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
4. The instructor(s) was well prepared and well organized	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
5. The instructor(s) was very knowledgeable about the content	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
6. The instructor(s) demonstrated excellent communication skills	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
7. The instructor(s) allowed for and responded appropriately to questions	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
8. The materials and handouts were very helpful	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
9. The course was of overall high quality	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁

Over — Please complete items on back — Over

- Section Two -

Instructions: Please be as specific as possible when responding to the following two items.

10. Which content areas or training methods do you feel were most helpful?

11. Do you feel any of the content areas or training methods should be changed?

12. What additional training would help you perform your job better?