

**TOBACCO RECOVERY
RESOURCE EXCHANGE**



THE EXCHANGE
WWW.TOBACCORECOVERY.ORG



**Assessment, Diagnosis, and
Pharmacotherapy:**

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

**Trainer's Manual
Module 2**



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

This page is intentionally blank.

Nelson A. Rockefeller College of Public Affairs and Policy

Jeffrey Straussman, Ph.D.

Dean

Professional Development Program

Eugene J. Monaco

Public Service Professor and Executive Director

Diane Tesiny

Director

Tobacco Interventions Project Training Team

Edward J. Perka, Jr., Manager, Interim

Lisa M. Howard, Senior Education Specialist

William J. Panepinto, Senior Education Specialist

Peter J. Pociluyko, Senior Education Specialist

Peggy Dayer, Administrative Assistant

October 2009

The Tobacco Interventions Project was funded under a contract with the New York State Department of Health, Division of Chronic Disease Prevention and Adult Health, Tobacco Control Program. All materials appearing in this curriculum, except those taken directly from copyrighted sources are in the public domain and may be reproduced or copied without permission from the Professional Development Program. A citation of the source would be appreciated.

Recommended citation: Professional Development Program, Rockefeller College, University at Albany, State University of New York. *Integrating Tobacco Use Interventions into Chemical Dependence Services*, 2009.

This page is intentionally blank.

Table of Contents

Preface

About this Training	3
Background Information for Trainer.....	8
Trainer Tips and Responsibilities	10
Welcome and Introductions	14
Overview of the Training Modules.....	15
Module 2 Agenda and Objectives.....	16

Lessons

Unit 1 Assessment and Diagnosis.....	17
Unit 2 Tobacco Treatment Medications	49
Unit 3 Case Studies.....	69

Resources	91
References.....	93
Glossary	97
Appendix A.....	109
Appendix B.....	119

This page is intentionally blank.

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 Department

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

University at Albany
University Administration Building, 3rd floor
1400 Washington Avenue
Albany, New York 12222

www.pdp.albany.edu

Continued on next page

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 OASAS-funded and/or certified chemical dependence service providers to help integrate tobacco use interventions (tobacco-free environment policies, tobacco education, and tobacco dependence treatment) into existing treatment protocols.

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

Continued on next page

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

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

Continued on next page

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 (Centers for Disease Control and Prevention [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.

Continued on next page

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 post-treatment alcohol and other drug abstinence (Prochaska et al., 2004). Tobacco relapse is shown to trigger relapse into alcohol and other drug use and vice versa (Stuyt, 1997; Sobell et al., 1995), an issue 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.

Background Information for 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 *Assessment, Diagnosis, and Pharmacotherapy: Integrating Tobacco Use Interventions into Chemical Dependence Services*. The suggested scripts and activities in each unit will guide you through the entire training process. It is important to become familiar with the Trainer and Participant Manuals in order to easily direct participants to particular pages as these are being discussed.

This training is designed to be presented in a three and three-quarter hour session, which will include two short breaks. The training is divided into three units, prefaced by an introduction. The training includes large and small group activities, and case studies which will require preparation by the trainer prior to the training.

Unit 1 provides participants with an overview of several screening tools for assessing tobacco dependence, specific assessment domains, and DSM-IV-TR criteria for nicotine dependence and nicotine withdrawal, followed by a brief review of the Transtheoretical Model (TTM) for Stages of Change.

Unit 2 provides participants with an overview of first-line nicotine replacement therapy (NRT) medicines, first-line non-nicotine medications, and second-line medications, populations for which tobacco medications have been proven to be effective, and medical contraindications for use.

Continued on next page

Background Information for Trainer, Continued

Trainer Note, cont'd

Unit 3 provides participants with an opportunity to apply newly acquired knowledge to several case studies.

The content in *italics* in this manual is intended to provide the trainer with suggested language and a context for developing his or her presentation. Italicized passages are not intended to be read aloud. Adaptations from professional experience, personal observations, and 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 provide participants with the knowledge they need to begin to successfully integrate tobacco use interventions into the addiction services continuum. This training module will provide specific clinical skill-building tools that the addiction professional will need in order to diagnose and 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 participant
 - Relate the materials to the past experiences of the participant
 - Allow debate and challenge of ideas
 - Listen to and respect the opinions of participants
 - Encourage participants to be resources to the trainer and to one another
 - Treat participants like 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 participants
-

Continued on next page

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 learners 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. Mix learners into different groups for small group activities, as appropriate.
- Expand learners' questions/issues by asking the larger group to share
- 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	15 minutes
Unit 1 - Assessment, Diagnosis, and Stages of Change	1 hour, 15 minutes
Break (Trainer Discretion)	15 minutes
Unit 2 – Tobacco Treatment Medications	1 hour, 15 minutes
Unit 3 - Case Studies	45 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
- Easel
- Large Easel News Print Pads
- 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 **Introduce** the trainer(s) and Explain that the training was part of a project sponsored, 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.

Slides 1 - 3 **Explain:** *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 earn additional professional education hours. To access this, go to www.tobaccorecovery.org.*

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 **Ask** participants to introduce themselves *by stating their name, role, agency, and modality.*

Slide 5

After each person has completed their own introduction, ask the large group to identify important points they learned from Module 1, either the classroom or online version.

Summarize all key points recalled and explain that Module 2 will expand upon that existing knowledge.

Continued on next page

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 6	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 2 Agenda and Objectives

Trainer Note **Refer** participants to the PM to review the agenda and objectives.
Slides 7 - 8 **Review** the agenda and module objectives.
PM 7

- Module 2
Agenda**
- Screening and Assessment
 - Stage of Change and Readiness to Change
 - Diagnosing Tobacco Dependence and Nicotine Withdrawal
 - Tobacco Treatment Medications
 - Case Studies
-

- Module 2
Objectives**
- Identify two tobacco dependence screening tools
 - Identify three domains where tobacco-use assessment questions should be an integral part of the assessment process
 - Identify four Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) criteria that apply to the diagnosis of tobacco dependence and tobacco withdrawal
 - Identify the stages of the Transtheoretical Model (Stages of Change)
 - Explain how to measure patient carbon monoxide (CO) levels using a CO monitor
 - Identify three first-line nicotine replacement therapy (NRT) medications
 - Identify two first-line non-nicotine medications
 - Identify five populations for whom the use of tobacco treatment medications are effective
 - Identify two medical contraindications against using NRT
 - Identify tobacco dependence and nicotine withdrawal using a case study
 - Identify a patient's stage of change for stopping tobacco use by using a case study
 - Make tobacco treatment medication recommendations using a case study
-

Unit 1

Assessment and Diagnosis

Trainer Note
Slide 9
PM 11

Unit 1 discusses and reviews tobacco dependence screening tools, the domains for assessment of tobacco use, the DSM-IV-TR criteria for tobacco-related diagnoses, the stages of change model, and the use of a CO monitor.

Refer participants to the PM regarding the purpose and objectives of the unit, along with the importance of screening and assessment of tobacco use and dependence with all patients.

Purpose

Provides participants with an opportunity to examine several tobacco use screening and assessment tools that can easily be integrated into existing protocols for diagnosing tobacco dependence and identifying the stage of change readiness.

Objectives

- Identify two tobacco dependence screening tools
 - Identify three domains where tobacco-use assessment questions should be an integral part of the assessment process
 - Identify four Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) criteria that apply to the diagnosis of tobacco dependence and tobacco withdrawal
 - Identify the stages of the Transtheoretical Model (Stages of Change)
 - Explain how to measure patient carbon monoxide (CO) levels using a CO monitor
-

Unit 1 Assessment and Diagnosis

Trainer Note **Explain** that this is a brief overview regarding rationale for addressing tobacco use in chemical dependence services.

The US Department of Health and Human Services "Treating Tobacco Use and Dependence Clinical Practice Guideline: 2008 Update," establishes that it is important to determine the tobacco use status of every patient at every visit to a healthcare service provider. Addiction professionals are well positioned to address their patient's tobacco use and dependence. Effective identification of tobacco use status guides clinicians to identify appropriate stage-based interventions.

Integrated treatment, in which behavioral health practitioners provide tobacco treatment in their usual practice, can be an efficient and effective way to address tobacco dependence. Behavioral health practitioners are adept in other addiction assessment and treatment interventions, including pharmacotherapy, motivational interventions and relapse prevention. Training addiction professionals in tobacco dependence treatment (e.g., in the use of specific pharmacotherapies and core psychosocial treatments) can be accomplished quickly given their greater understanding of chemical dependence. Therefore, models for treating alcohol and other drug use disorders can be extended to include tobacco.

Adapted from Williams and Ziedonis (2006)

The Basics of Tobacco Use Screening and Assessment

Trainer Note
Slide 10
PM 12

Refer to PM

Emphasize the following points, which are also discussed in Module 1:

- Tobacco dependence is chemical dependence and is a chronic biopsychosocial disease
- The management of tobacco dependence is the same as the management of any other chronic disease process
- OASAS Regulation Part 856 requires that all patients be screened and assessed for tobacco use status, and that treatment must be available to them

Tobacco Dependence

Tobacco dependence is 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.

Importance of Tobacco Screening and Assessment

Efficient, organized, and comprehensive assessment of all substance use disorders is essential for clinical diagnosis, treatment planning, and referral to supportive services. The initial assessment is completed as part of the intake process and revisited many times during the patient's involvement in treatment.

Regardless of the assessment tools that your program uses, OASAS Regulation Part 856 requires that all patients be screened and assessed for tobacco use and dependence in order for treatment to be made available to patients who use tobacco.

Assessment is not static; throughout your work with patients it is important to capture all tobacco-related information, and to tailor treatment interventions to specific problems and the patient's stage of change.

Continued on next page

The Basics of Tobacco Use Screening and Assessment, Continued

Trainer Note
Slide 11
PM 13

Explain *There is substantial research that supports the benefits of screening and brief intervention in public health and primary care settings for alcohol use disorders and tobacco use and dependence. Because many of the patients in addiction treatment or recovery may have had the experience of working with a primary care or public health practitioner, your patients may be familiar with the brief intervention public health model known as The 5 A's.*

Explain that the 5 A's tool is commonly used and can be adapted as an assessment tool by replacing it with language that addiction professionals use in daily clinical practice.

The 5 A's

Public health and primary care professionals use a brief intervention approach that uses the following strategy:

- Ask
 - Advise
 - Assess
 - Assist
 - Arrange
-

Trainer Note
PM 13

Highlight the dose-response effect from repeated interventions and from using multiple methods to help patients become tobacco-free.

Dose-Response to Interventions

Regardless of the intervention method that is used, there is a “dose-response” effect for patients receiving repeated interventions. The more clinicians ask about tobacco use and advise people to become abstinent, the more likely a patient will move towards making a change. Also, the more evidence-based treatment methods a clinician uses to help a patient become abstinent from tobacco, the more likely it is that the patient will succeed.

Continued on next page

The Basics of Tobacco Use Screening and Assessment, Continued

Trainer Note Explain that the 5 A's tool tends to use language from a public health and primary care perspective that is different than that used by addiction treatment providers. Refer participants to the examples of reframed language that are more common in chemical dependence treatment and recovery services.

Slide 12

PM 13

Reframing Language

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

Continued on next page

The Basics of Tobacco Use Screening and Assessment, Continued

Trainer Note	Note: You may wish to record participant responses on newsprint.
Slide 13	Ask: <i>How do you currently assess or evaluate patients?</i> (Responses many include: taking a thorough history, self-report forms, assessment tools, interview collaterals, etc.)
Slide 14	Ask: <i>What are some issues/domains that you assess with your patients through the intake assessment process?</i> (Participant responses may include use of alcohol and other drugs; severity of addiction; partner, family, and social relationships; legal status; patient motivation; self-efficacy; psychiatric status; employment status; medical history; previous treatment/recovery experience, etc.)
Slide 15	
PM 14	Refer to the PM after discussing the above questions and bring up the slide.

Assessment Domains

- Presenting Problem
 - Family/Living Environment/Social Functioning
 - Educational
 - Employment
 - Medical/Medications
 - Mental Health
 - Alcohol and Other Drug Use
 - Tobacco Use
 - Stage of Change
-

Tobacco Screening Tools

Trainer Note *Ask: When you assess your patient's use of alcohol and other drugs, does the assessment tool that you use specifically address tobacco use? (Note: the ASI [Addiction Severity Index] does not assess tobacco use.)*

Ask: When assessing your patient's past and current medical histories, how are you helping the patient connect their tobacco dependence with any tobacco related illnesses (e.g., heart disease, cancer, COPD, emphysema, etc.?)

Slide 16
PM 15

Mention that there are several brief, validated tools that specifically address a patient's tobacco use that can easily be incorporated into an assessment and evaluation.

Direct participants to the PM and ask if they are familiar with any of the tools listed below.

Ask participants to share their experience using these tools and facilitate the discussion.

Examples of Tobacco Use Screening Tools

The following are examples of reliable and valid tobacco dependence screening tools.

- Fagerström Test for Nicotine Dependence
- HONC (Hooked On Nicotine Checklist)
- Heaviness of Smoking Index (HSI - Question 1 and 4 of the Fagerström)

A screening tool is useful to quickly identify a potential problem, but cannot confirm or make a diagnosis when used alone. A diagnosis requires a formal assessment of the patient by the clinician, which can include the results of screening tools.

Continued on next page

Tobacco Screening Tools, Continued

Trainer Note
Slide 17

Activity Directions:

This activity is intended to familiarize participants with some examples of tobacco use screening tools. Divide participants into small work groups by asking them to count off by three. Participants will remain in these groups for the remainder of this section.

Provide a five to ten-minute opportunity for the small groups to review the three tools.

Fagerström
PM16 – 17

Assign the Fagerström to one group, the Heaviness of Smoking Index to a second group, and the Hooked on Nicotine Checklist to a third group.

HSI
PM 18

- **Ask** them to generate a list of pros and cons about that instrument. The Fagerström is on PM 16 - 17, the Heaviness of Smoking Index is on PM 18, and the Hooked on Nicotine Checklist is on PM 19 - 20. Advise participants that a full copy of each instrument can also be found in the Appendix of the PM.

HONC
PM 19-20

Allow five to ten minutes for the small groups to generate a list of pros/cons. When groups have completed their lists, process the activity with the large group.

Trainer Note,
cont'd

Ask each group to briefly explain how the tool is used, and to identify the pros and cons of the tool.

After each group has reported out their comments, ask the large group:

- *These tools are not adequate to diagnose tobacco dependence and only screen for potential problems. Therefore, what else would you need to do and want to know in order to make a diagnosis?*

(Full tobacco use history, full details of tobacco use and symptoms, complaints by family/friends about tobacco use, medical and non-medical consequences of tobacco use, etc.)

- *How might you use any one of these tools in your clinical practice?*

Continued on next page

Tobacco Screening Tools, Continued

Fagerström Test for Nicotine Dependence

These questions can be asked directly by the clinician or given on paper for patient to answer.

1. How soon after you wake up do you smoke your first cigarette?

- After 60 minutes (0)
- 31 - 60 minutes (1)
- 6 - 30 minutes (2)
- Within 5 minutes (3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden?

- No (0) Yes (1)

3. Which cigarette would you hate most to give up?

- The first in the morning (1) Any other (0)

4. How many cigarettes per day do you smoke?

- 10 or less (0)
- 11 - 20 (1)
- 21 - 30 (2)
- 31 or more (3)

5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?

- No (0) Yes (1)

6. Do you smoke even if you are so ill that you are in bed most of the day?

- No (0) Yes (1)

Continued on next page

Tobacco Screening Tools, Continued

Scoring the Fagerström Test for Nicotine Dependence

To Score

Add together the points for each answer. Use the scale below to determine the level of dependence on nicotine:

Your level of dependence on nicotine is:

- 0-2: Very low dependence
- 3-4: Low dependence
- 5: Medium dependence
- 6-7: High dependence
- 8-10: Very high dependence

Scores under 5: “Your level of nicotine dependence is still low. You should act now before your level of dependence increases.”

Score of 5: “Your level of nicotine dependence is moderate. If you don’t quit soon, your level of dependence on nicotine will increase and you may become seriously addicted. Act now to end your dependence on nicotine.”

Score over 7: “Your level of dependence is high. You aren’t in control of your smoking - it is in control of you! When you make the decision to quit, you may want to talk with your doctor about nicotine replacement therapy or other medications to help you break your addiction.”

Continued on next page

Tobacco Screening Tools, Continued

Heaviness of Smoking Index (HSI) and Scoring Instructions

Two measures from the Fagerström test, the time to first cigarette and the number of cigarettes smoked per day, are sometimes combined into a measure of nicotine dependence called the Heaviness of Smoking Index (HSI). The HSI, like the Fagerström, is a screening tool only, and should not be the ultimate measure of nicotine dependence. Nicotine dependence is diagnosed using the DSM-IV-TR criteria for substance dependence.

The following are Fagerström questions 1 and 4.

1. How soon after you wake up do you smoke your first cigarette?

___ Within five minutes (3)

___ 5-30 minutes (2)

___ 31-60 minutes (1)

___ After 60 minutes (0)

2. How many cigarettes a day do you smoke?

___ 10 or less (0)

___ 11 - 20 (1)

___ 21 - 30 (2)

___ 31 or more (3)

Add the scores from the two questions together. The level of nicotine dependence is determined as follows:

0-1: Low dependence

2-4: Moderate dependence

5-6: High dependence

If the patient reports both a high level of cigarettes per day usage (1 pack or more) and that he/she does not smoke a cigarette within the first hour of waking, ask the follow-up question:

Do you sometimes wake up during the night and smoke? If the patient states "yes", follow-up with the question, "How many times a week?"

If the patient answers "no" they do not wake up in the night to smoke, you may want to ask the patient to describe their morning routine. Oftentimes there is something or someone that prohibits the person from smoking in the first hour of the day (i.e., getting children ready for school and won't smoke in front of children. Or a spouse/partner won't allow them to smoke in the house and the first cigarette is not smoked until the person leaves the house.)

Continued on next page

Tobacco Screening Tools, Continued

The Hooked on Nicotine Checklist

	NO	YES
1. Have you ever tried to quit, but couldn't?		
2. Do you smoke <u>now</u> because it is really hard to quit?		
3. Have you ever felt like you were addicted to tobacco?		
4. Do you ever have strong cravings to smoke?		
5. Have you ever felt like you really needed a cigarette?		
6. Is it hard to keep from smoking in places where you are not supposed to?		
When you haven't used tobacco for a while ... OR When you tried to stop smoking...		
7. Did you find it hard to concentrate because you couldn't smoke?		
8. Did you feel more irritable because you couldn't smoke?		
9. Did you feel a strong need or urge to smoke?		
10. Did you feel nervous, restless or anxious because you couldn't smoke?		

Continued on next page

Tobacco Screening Tools, Continued

Hooked on Nicotine Checklist Scoring

The HONC is scored by counting the number of YES responses.

Dichotomous Scoring - The HONC is an indicator of diminished autonomy.

- Individuals who score a zero (0) on the HONC by answering “No” to all ten questions enjoy full autonomy over their use of tobacco.
- Because each of the ten symptoms measured by the HONC has face validity as an indicator of diminished autonomy, a smoker has lost full autonomy if any symptom is endorsed (checked).
- In schools and clinics, smokers who have scores above zero can be told that they are already hooked.

Continuous Scoring- The HONC is a measure of severity of diminished autonomy.

- The number of symptoms a person endorses serves as a measure of the extent to which autonomy has been lost.
-

Using a Carbon Monoxide (CO) Monitor

Trainer Note
Slide 18

Explain that another important assessment tool is a carbon monoxide (CO) monitor. Explain the basic science of carbon monoxide.

PM 21

Emphasize that CO monitors should be used as a motivational tool to provide patients with information about their tobacco use and to increase motivation to change. It is not effective when used as a “punitive method” or to “catch” people who may have been smoking.

**Carbon
Dioxide and
Carbon
Monoxide**

Normally we breathe in air, which includes oxygen, and the oxygen attaches to the hemoglobin in our blood. The blood in our lungs also releases carbon dioxide (CO₂), which we exhale.

Carbon monoxide (CO) is an odorless, colorless, tasteless, and toxic gas. Carbon monoxide enters the blood through the lungs and readily attaches to hemoglobin, blocking the blood's ability to carry oxygen to body cells. Smoking tobacco (or cannabis) increases the CO content of your blood.

When the level of CO in your blood increases, the ability of your blood to carry oxygen is decreased. CO is harmful to your body and in large doses, it will cause death. Long-term exposure at lower levels leads to heart disease.

Continued on next page

Using a Carbon Monoxide (CO) Monitor, Continued

**Trainer Note,
cont'd**
Slide 18
PM 21

Explain that the normal CO level for a non-user is between 0 and 6 parts per million. The CO level for a tobacco smoker is usually much higher. A tobacco smoker's CO level varies according to the time of day, the number of tobacco products smoked, and how the smoke is inhaled. For example, a pack of cigarettes per day may result in a CO level of 20 parts per million, while two-packs per day may result in 40 parts per million or more.

Explain that a CO monitor measures the CO level in a person's bloodstream. The test is simple. It only requires a person to breathe into the monitor, and quickly yields a personalized reading. It is a valuable practice for a clinician to use a CO monitor to demonstrate an immediate and non-invasive measurement to the patient about the consequences of smoking.

Explain that CO has a half-life of five to six hours (a half-life is the time it takes for a drug or chemical to be reduced by 50%). After discontinuing smoking, the CO level will return to normal within three to seven days.

Mention that CO levels can be elevated for people regularly exposed to exhaust smoke, second-hand smoke for prolonged periods in enclosed areas, people who smoke cannabis, or for people with COPD, emphysema, or other medical conditions affecting oxygen exchange, even if they do not smoke.

CO Monitor

A CO monitor measures the level of CO in the person's blood. When you measure a patient's CO level, you are giving them what is known as bio-marker feedback; similar to a blood pressure test or a cholesterol test.

Important Points:

- There are environmental sources that can also raise CO levels, such as prolonged exposure to incinerator smoke, car or gas furnaces exhaust, or prolonged exposure in an enclosed area to secondhand smoke.
- CO levels will also be elevated for patients who use cannabis. They may have high elevations, even if they smoke only once a day or every other day, due to holding the smoke in their lungs for long periods.
- CO levels tend to be elevated for people with COPD, emphysema, and medical conditions affecting oxygen levels, even if they do not smoke.

Continued on next page

Using a Carbon Monoxide (CO) Monitor, Continued

Trainer Note
Slide 18
PM 22

Demonstrate how to use the CO monitor. Ask for a volunteer from the group. Be certain that participants understand that the test only measures the presence of carbon monoxide (CO) in the blood, and not nicotine levels.

After the demonstration, ask: *What are the benefits of CO monitoring when working with a patient on tobacco dependence recovery?*

Refer participants to the PM for a review of CO monitor benefits.

Benefits of CO Monitoring

- CO monitoring provides immediate and direct feedback. Seeing positive results of behavior change is reinforcing. Just like a visual report of a lower blood pressure reading or a lower cholesterol reading is positive reinforcement for person who has taken steps to reduce cholesterol or blood pressure, a lower CO level reinforces reductions in tobacco use.
 - CO monitoring provides an immediate measure of success. Other than saving money, there are not immediate benefits that the patient can see. Improved health and wellness will definitely appear over time, but giving the patient immediate, concrete feedback that they are experiencing the benefits of tobacco recovery is rewarding and reinforcing.
 - Research indicates that many people underreport the level of their tobacco use. If a person reports that they use a pack a day and they really use two packs a day, the CO monitor will indicate a higher level of CO.
 - CO levels can be interpreted as follows: 0-6 ppm, not smoking; 7-10 ppm light smoking; 11-20 ppm, medium smoking; 21+ ppm, heavy smoking. Patients can expect CO levels to drop up to 50 percent after each day of continuous abstinence.
-

Trainer Note

Emphasize that the CO test result is just a part of the clinical picture. The CO monitor gives the clinician an additional tool to both assess the patient's level of tobacco dependence and provide patients with feedback about their disease. It is not recommended that it be used to ensure compliance with a tobacco-free policy or as a punitive measure.

Continued on next page

Using a Carbon Monoxide (CO) Monitor, Continued

**Trainer Note
PM 23**

Refer to PM and review the following ways used to try to “beat the monitor.” This content is from Bedfont USA, one of the CO monitor manufacturers. It is possible to “beat the CO monitor.”

**Attempting to
“Beat” the CO
Monitor**

- CO leaves the body rapidly (6-hour half-life), and the monitor will only detect CO exposure from the last 24 to 48 hours. While it is possible to “beat the monitor” by smoking and offer some explanation for an elevated CO level or claim ignorance and lie about having smoked, most tobacco users cannot consistently beat the monitor.
 - Claiming an elevated CO level is from some other source could be true. The best way to address this is by asking lots of questions about the alleged exposure. For example, if secondhand smoke is the alleged cause, this type of exposure must be prolonged and intense to elevate CO levels. Standing next to a person who is smoking, even for many minutes is not likely to elevate CO levels. However, exposure in an enclosed environment, like a car or room, might elevate CO levels, if all the windows were closed.
 - A patient who purposefully fails to perform the test correctly (e.g., providing a poor breath sample, not providing a good seal on the mouthpiece, or blowing across and not through the mouth piece) can show low CO scores. Most CO monitor administrators can tell when a patient is not cooperating and can re-test. Clinicians can also usually tell when someone is not being truthful or not cooperating with the test.
 - Remember you are testing CO and not nicotine. This means that NRTs will not affect the test result. Cannabis smoke will provide an elevated CO level. Cannabis use often results in high CO levels because of the way it is smoked (inhaled deeply and held in the lungs).
(Bedfont USA Inc, www.bedfontusa.com)
-

Stages of Change

Trainer Note
PM 24

Ask participants if they are familiar with the Transtheoretical Model (TTM) or Stages of Change (SOC), and if they have used this model for assessing readiness to change in their clinical practice.

Ask them to briefly describe the model and their experience using SOC. Integrate these participant descriptions into your presentation.

Refer to PM and ask participants to review the two summaries below.

Stages of Change

The Transtheoretical Model of Change (TTM) or Stages of Change (SOC) suggests that people change their behavior gradually, from a stage of being uninterested, unaware, or unwilling to change (precontemplation), to considering or deciding on making a change (contemplation), to preparing to make a change (preparation), to making an effort to change (action), to maintaining the new behavior (maintenance). Relapses are common and are part of the process of working toward life-long change.

Benefits of Stage of Change Model

The Transtheoretical Model (TTM) or Stages of Change was developed in the early 1980's by Prochaska and DiClemente (1983, 1984) when they were studying how people who smoked were able to stop smoking. While it is not the only behavioral change model, the TTM:

- Incorporates useful aspects from other behavior change models including the Health Belief Model and the Locus of Control Model (see Appendix for additional details)
 - Is easily understood and applied
 - Incorporates many engagement recommendations for each stage
 - Enables clinicians to “start where the patient is”
 - Rests on the understanding that change is a gradual process that may require incremental efforts over time
 - Is used widely in the fields of HIV/AIDS, chemical dependence counseling, psychology, and social work
-

Continued on next page

Stages of Change, Continued

Trainer Note
Slide 19
PM 25

Refer to PM and **explain** the 1996 statistics cited by the American Psychiatric Association regarding patients' tobacco use and their stage of change.

**Stages of
Change and
Smoking**

In 1996, the American Psychiatric Association released the following statistics:

- Approximately 40% of people who smoke are in the precontemplation stage of change
 - Another 40% of people who smoke are in the contemplation stage of change
 - About 20% of people who smoke are in either the preparation or the early action stages of change
-

Continued on next page

Stages of Change, Continued

**Trainer Note,
cont'd
Slide 19
PM 25**

Ask:

What does a patient “look and sound like” when he or she is in a stage of precontemplation about their tobacco use?

What about a patient who is in contemplation?

As a clinician, what strategies do you use for helping a patient to shift from precontemplation to contemplation?

This provides an opportunity to briefly mention Motivational Interviewing strategies, is addressed in greater detail in Module 3:

- *Acknowledge the patients thoughts, fears, concerns and prior effort to stop using tobacco (Empathy)*
- *Explore what the patient identifies as being positive about using tobacco, what’s negative about using, and how does using tobacco support their plan for healthy recovery (Develop Discrepancy)*
- *Avoid arguing for change. Resistance is a signal to respond differently (Roll with Resistance)*
- *The patient, not the counselor, is responsible for choosing and carrying out change (Self-efficacy)*
- *Begin to help patient explore benefits of stopping use; the goal is to help the patient to move from being not interested to becoming interested and concerned (Resolving Ambivalence)*

Continued on next page

Stages of Change, Continued

Trainer Note
PM 25 As a follow-up to the discussion about how patients sound and appear in the precontemplation or contemplation stage, refer participants to the descriptions of the two stages. Address any questions and then summarize the remaining three stages of preparation, action, and maintenance.

Pre-contemplation During this stage, the patient is not thinking about changing, sees no need to change, and/or is not interested in any kind of help. People in this stage tend to defend their current behavior and do not feel it is a problem. They may be defensive in the face of other people's efforts to pressure them to quit.

Contemplation In this stage, people weigh the pros and cons of stopping or modifying their problem behavior. They think about the negative aspects of their behavior and the positives associated with change (stopping use, reducing use, etc.). They may doubt that the long-term benefits associated with quitting will outweigh the short-term costs.

This stage is typically characterized by ambivalence (feeling equal about changing and not changing). It is the clinician's task to develop discrepancy; guiding the patient to explore their conflict, and moving the patient toward resolution of the ambivalence. Using motivational interviewing skills, the clinician can help the patient focus on the positive aspects of stopping tobacco use or any other substance of abuse or dependence.

Continued on next page

Stages of Change, Continued

Trainer Note Slide 20 PM 26	Refer to the PM and mention the Preparation, Action, and Maintenance Stages. These stages are also discussed in more detail in Modules 3 and 4. Mention that relapse is common, seven relapses before finally stopping tobacco is the norm, and relapse can cause a temporary set-back or may propel the patient to move forward to a higher stage of recovery.
--	--

Preparation The patient demonstrates intention to change and is identifying and evaluating appropriate change strategies. They are gathering information about what they will need to do to change their behavior. At this stage, the patient has the opportunity to identify possible obstacles, and with the help of the clinician, consider alternative strategies, if needed.

The positive momentum that characterizes the preparation stage will increase the patient's commitment to change. Developing a solid plan for change enhances the patient's self-efficacy.

Action The patient is actively working to make the change and consciously changing behavior patterns associated with tobacco use. The patient may still identify with tobacco use, but can draw upon the information and education he/she has learned as supportive tools.

The role of the addiction professional is to be supportive, continually seeking commitment to specific behavior changes, to help the patient identify triggers, and to make a plan for dealing with each one identified. It is appropriate for the clinician to make referrals for additional support if necessary.

Maintenance This stage is characterized by successful behavior change over time, and incorporating the change into a sense of self. At this stage, the patient is able to be comfortably abstinent from tobacco use. The role of the addiction professional is to continually help the patient identify, anticipate, and develop coping strategies to deal with relapse triggers.

Assessing Readiness, Willingness, and Ability to Change

Trainer Note
Slide 21
PM 27

Refer to PM and explain that there are often differences between the patient's stage of change for each specific problem. The majority of patients who come into addiction treatment do so because of social or legal problems that they are experiencing due to alcohol or other drug use. Due to external pressures and negative consequences, their stage of change for other substances of abuse may be at a different level as compared to their stage of change for their tobacco use.

**Stages Vary
from Problem
to Problem**

A patient's stage of change for their alcohol and other drug use may often be at a different level than their stage of change for their tobacco use.

When you assess tobacco use status, you will obtain information to determine your patient's willingness and readiness to engage in:

- Abstinence
- Reduced use
- Managing withdrawal
- Taking steps to prevent relapse and changing their lifestyle (people, places, and things)

This information helps provide a more complete picture of the patient's readiness to make a change regarding tobacco use.

Continued on next page

Assessing Readiness, Willingness, and Ability to Change, Continued

Trainer Note
Slide 22
PM 28

Refer to PM and explain that it is important to understand the patient's willingness, readiness, and ability to change. Willingness has to do with wanting to change or problem recognition, readiness is about importance or priority, and ability is knowing what to do and how to do it.

Explain that this understanding is important in order to help patients to through the stages of change.

Willingness, Readiness, and Ability to Change

While assessing the stage of change, it is important to recognize that willingness, readiness, and ability are not the same thing.

- Willingness indicates a desire to change or the recognition of a problem
- Readiness indicates that making a change is important and it is a priority
- Ability indicates confidence, and that the person knows what to do and how to make it happen (self-efficacy)

Each component may vary in intensity. Patients can be willing to make a change, but not ready and/or not able to make a change.

Assessing Tobacco Use and Readiness to Change

Assessing a patient's tobacco use status provides a more complete history of their drug use behavior. Assessing for current or past tobacco use will generally result in six possible responses, and will help the clinician to determine the appropriate treatment methods and interventions to be used.

1. The patient uses tobacco and is not willing to stop using at this time
 2. Uses tobacco and is willing to stop, but is not ready to stop (not a priority) using tobacco at this time
 3. The patient is willing and/or ready, but is not able (lacks confidence, does not know what to do or how to do it, fears failure, etc.)
 4. The patient uses tobacco, and is willing, ready, and able to stop using tobacco at this time
 5. The patient once used tobacco but does not use currently
 6. The patient never used or never regularly used tobacco
-

Continued on next page

Assessing Readiness, Willingness, and Ability to Change, Continued

Trainer Note
PM 28

Summarize: *The Clinical Practice Guideline states that assessing and understanding a patient's stage of change for their tobacco use helps match and guide the type of intervention.*

Matching
Tobacco Use
with Stage of
Change

The 2008 Clinical Practice Guideline (Fiore et al., 2008) provides the clinician with simple but effective interventions for all patient groups. Using the stages of change model to its fullest involves matching intervention approaches to a person's current stage readiness (Prochaska, DiClemente, and Norcross, 1992).

Trainer Note
Transition

Explain that it is likely that the majority of patients presenting for chemical dependence services will be in the precontemplation or contemplation stage of change. There will probably be some patients who are in the preparation stage. Clinicians should tailor their interventions to match the patient's stage of change readiness.

DSM-IV-TR Criteria Applied to Tobacco Dependence

Trainer Note
Slide 23
PM 29

This activity is intended to stimulate the participants' thinking about the DSM-IV-TR diagnostic criteria for substance dependence and how this criteria applies to tobacco dependence. Note: The DSM-IV-TR uses the term nicotine dependence (305.1).

Small Group Activity

- Participants can remain in small groups from the previous activity.
- Participants will use the PM for this activity.
- Instruct participants to review the seven DSM-IV-TR symptoms for substance dependence.

DSM-IV-TR
Criteria for
Substance
Dependence

1. Presents with at least three (3) of the following seven (7) criteria:
 1. Tolerance
 2. Withdrawal
 3. Substance used in larger amount or longer than intended
 4. Persistent desire or unsuccessful efforts to cut down or control substance use
 5. Great deal of time spent in substance related activities
 6. Important social, educational, occupational, or recreational activities given up or reduced due to substance use
 7. Substance use continues despite knowledge of physical and psychological consequences related to the use
 8. (American Psychiatric Association, 2000)

Continued on next page

DSM-IV-TR Criteria Applied to Tobacco Dependence, Continued

**Trainer Note,
cont'd**
Slide 23
PM 29

While participants are in their small groups, ask them to use their current knowledge of tobacco dependence to decide which of the seven (7) DSM-IV-TR Substance Dependence criteria definitely applies, might apply, or definitely does not apply to tobacco dependence. Allow them five minutes to complete this.

- Using a flipchart, make three columns with each titled: 1) Definitely Apply, 2) Might Apply, 3) Definitely Does Not Apply
- Ask individuals or a reporter from each small group to report out their results, record on the flipchart

Debriefing Questions:

In examining the results on the chart, what observations or comments do you have about applying the diagnostic criteria to tobacco dependence?

Knowing the criteria for substance dependence, how confident are you that you can assess and diagnose tobacco dependence?

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

The seven DSM-IV-TR symptoms for substance dependence are used to diagnose dependence to all substances, including tobacco. There are no additional or special criteria for diagnosing tobacco dependence.

While the DSM-IV-TR uses the term nicotine dependence, tobacco dependence is a better descriptor due to the intense behavioral and psychological patterns that characterize tobacco use. In addition, while nicotine is the addictive substance in tobacco, tobacco smoke is the main cause of tobacco-related diseases.

DSM-IV-TR Criteria Applied to Nicotine Withdrawal

Trainer Note
Slide 23

Refer to the PM and review the DSM-IV-TR criteria for Nicotine Withdrawal 292.0.

PM 30

Ask: *How well does this criteria “fit with your experience” about nicotine withdrawal?*

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.

(American Psychiatric Association, 2000)

Continued on next page

DSM-IV-TR Criteria Applied to Nicotine Withdrawal, Continued

**Trainer Note
PM 31**

Explain that while “craving” is not identified as a withdrawal symptom in the DSM-IV-TR, many tobacco using patients describe moderate to intense craving.

Ask: *How do your patients describe craving for tobacco? How do you manage craving with your patients?*

Explain that withdrawal management, including cravings, is crucial to engage and retain patients in treatment, and to prevent relapse. This will be discussed further in Unit 2.

**Withdrawal
and Cravings**

While “craving” is not identified as a withdrawal symptom in the DSM-IV-TR, many patients describe various aspects of craving when they stop using tobacco or are forced to be abstinent.

Withdrawal management, including cravings, is crucial to engage and retain patients in treatment, and to prevent relapse.

A useful tool for diagnosing nicotine withdrawal is the Minnesota Nicotine Withdrawal Scale (See Appendix). This tool includes a patient’s self-report rating their symptoms using a five-point scale, and an observer’s daily report. The tool allows one to measure observable withdrawal severity over time.

Continued on next page

DSM-IV-TR Criteria Applied to Nicotine Withdrawal, Continued

Trainer Note
PM 31

Refer to the PM and explain:

There is no diagnosis for nicotine abuse because:

- DSM-IV-TR cites a lack of clinically relevant data
- It is difficult to apply the substance abuse criteria to nicotine
- Nicotine has a high dependence potential

Explain: there is also no diagnosis for nicotine intoxication, because nicotine causes pleasure, but not significant euphoria or intoxication. This is also a frequent cause for rationalization by tobacco users when defending their desire to continue using tobacco, while stopping alcohol and other drugs.

**Why No
Diagnosis for
Nicotine
Abuse or
Nicotine
Intoxication?**

It is important for clinicians to know that there is no DSM-IV-TR code for nicotine abuse. The reasons for this are:

- DSM-IV-TR cites a lack of clinically relevant data
- It is difficult to apply the substance abuse diagnostic criteria to nicotine
- Nicotine has a high dependence potential

There also is no diagnosis for nicotine intoxication. The reason is that nicotine causes pleasure but not significant euphoria or intoxication. This is also a rationalization often used by tobacco users when defending their desire to continue using tobacco, while stopping use of alcohol and other drugs.

Unit Summary

Trainer Note

PM 32

Summarize the following or ask participants to recall these key points:

It is important to screen and assess all patients for tobacco use. Screening tools can only identify a potential problem, but cannot be used alone to make a diagnosis. The most commonly used tobacco screening tools are the Fagerström, HONC, and HSI. Understanding the stages of change helps to determine how to intervene, as 40% of tobacco users entering chemical dependence treatment are in precontemplation and about 40% are in contemplation about tobacco use. Many patients are in a different stage of change for their other substance use disorders as compared to their tobacco use. Willingness, readiness, and ability to change are not the same thing and the intensity of each component may vary. The DSM-IV-TR criteria for substance dependence can generally be applied to nicotine dependence (or tobacco dependence), and the criteria for nicotine withdrawal (tobacco withdrawal) readily applies, except it does not mention cravings. There is no diagnosis for nicotine abuse or nicotine intoxication.

Summary

It is important to screen and assess all patients for tobacco use. Screening tools only identify a potential problem, but cannot make a diagnosis. The most commonly used tobacco screening tools are the Fagerström, HONC, and HSI. Understanding the stages of change helps to determine how to intervene, as 40% of tobacco users entering chemical dependence treatment are in precontemplation and about 40% are in contemplation. Many patients are in a different stage of change for their other substance use disorders as compared to their tobacco use. Willingness, readiness, and ability to change are not the same thing and the intensity of each component may vary. The DSM-IV-TR criteria for substance dependence can generally be applied to nicotine dependence (tobacco dependence) and the criteria for nicotine withdrawal readily applies but it does not mention cravings. There is no diagnosis for nicotine abuse or nicotine intoxication.

This page is intentionally blank

Unit 2

Tobacco Treatment Medications

Trainer Note
Slide 24
PM 35

This unit will familiarize participants with evidence-based treatment recommendations from *Treating Tobacco Use and Dependence, 2008 Update* (Fiore et al., 2008) and which is referred to as the Clinical Practice Guideline (CPG). This unit will specifically cover tobacco treatment medications, including first-line nicotine medication, first-line non-nicotine medication, and second-line medication. Common side effects, dosages, and contraindications for medications are discussed.

Purpose

Familiarize participants with the recommendations for evidence-based tobacco treatment medications and interventions as contained in *Treating Tobacco Use and Dependence, 2008 Update* (Fiore et al., 2008) referred to here as the Clinical Practice Guideline, 2008 Update (CPG).

A copy of this source can be viewed online or is available for free at <http://www.surgeongeneral.gov/tobacco>.

- Objectives**
- Identify five first-line nicotine replacement therapy (NRT) medications
 - Identify two first-line non-nicotine medications for the treatment of tobacco dependence
 - Identify five specific populations with whom the use of tobacco treatment medications is effective
 - Identify two medical contraindications to NRT medications
-

Continued on next page

Tobacco Treatment Medications, Continued

Trainer Note

When beginning this section on tobacco treatment medications, engage the group with the following questions:

- *Do you know the percentage of tobacco users who try to stop using each year?*

(Approximately 46%)

- *What method do most people use to try to stop using?*

(Cold Turkey)

- *Do you know the percentage of tobacco users who succeed in stopping?*

(About 3-5%)

- *In light of these rather dismal statistics, what can you say about the efficacy of people trying to stop using tobacco cold turkey?*

(It doesn't work very well, yet many people keep trying this method. One reason is stopping tobacco use is often seen as an issue of willpower)

- *What type of treatment is most effective for tobacco dependence?*

(A combination of medication and supportive counseling)

Evidence-Based Treatment Practices

Trainer Note You may wish to have the large group read over each topic and then discuss, or alternately you can present each section and field questions as part of a large group discussion. Use your discretion.

Key Points to Emphasize:

- Tobacco dependence treatment uses evidence-based treatment methods
- Patients should be educated about tobacco treatment medications and offered counseling and support to become abstinent
- Medication should be recommended for all patients who use tobacco, with the noted exceptions and considerations
- Addiction professionals require current knowledge of tobacco treatment medications
- Patients and tobacco-using staff need access to tobacco medications

Continued on next page

Evidence-Based Treatment Practices, Continued

Trainer Note **Refer** to the Clinical Practice Guideline (CPG) recommendations, and state
Slide 25 this is the source for all information referenced below about tobacco
PM 34 medications and interventions. Suggest participants obtain a copy at
<http://www.surgeongeneral.gov/tobacco> or by calling 1-800-358-9295.

Tobacco • Nicotine replacement therapy (NRT)
Dependence • Non-nicotine medications
Treatment: • Supportive counseling, specifically, Motivational Interviewing, Cognitive
Evidence- Behavioral Therapy, and Relapse Prevention Therapy have been shown to
based Practice be effective

The CPG 2008 Update explains that either medicine or counseling is effective, and the combination of counseling and medicine is more effective than either used alone (Fiore et al., 2008).

Importance of According to the CPG 2008 Update, clinicians should advise all patients
Medication to attempting to stop tobacco to use medications that have been shown to be
Treat Tobacco effective for tobacco dependence treatment, and use combinations of
Dependence medication where possible. The exceptions are when medication is
 contraindicated, or if there is insufficient evidence of medicine effectiveness
 for a given population (Fiore et al., 2008).

First-Line Nicotine Replacement Therapy (NRT)

Trainer Note
Slide 25
PM 35

Explain the following nicotine replacement medications are FDA approved, have been in use for a number of years, have a wide margin of safety, and clinical research has consistently shown these medications are much more effective than placebo or “going cold turkey.”

Identify three over-the-counter (OTC) nicotine replacement medications, and two prescription nicotine replacement medications.

First-line Medications

- FDA approved for this use
 - High margin of safety for tobacco dependence treatment
 - Established empirical record of effectiveness as compared to placebo and “going cold turkey”
-

Five Nicotine Medications

Over the Counter (OTC)

- Nicotine patch
- Nicotine gum
- Nicotine lozenge

Prescription

- Nicotine nasal spray
 - Nicotine inhaler
-

Continued on next page

First-Line Nicotine Replacement Therapy (NRT), Continued

Trainer Note Slides 26 - 27	Review the medication dosages, considerations, and precautions for the nicotine patch.
PM 36	Refer participants to handout “FDA Pregnancy Categories” in the Appendix of PM (page 95) for additional details on these categories.

Nicotine Patch	Considerations	Primary side effects: local skin reaction, insomnia, vivid dreams
	Precautions	Pregnancy Category D (See Appendix)
	Suggested Dosage & Duration	21 mg/24 hours for 4 weeks; then 14 mg/24 hours for 2 weeks; then 7 mg/24 hours for 2 weeks
	High Dose Therapy	Can be used in higher dosages (such as 42 mg using two 21 mg patches) and tapered off over a longer period for patients with severe dependence or severe withdrawal Severely dependent patients often have Fagerström scores of 7 points or more, use 25 or more cigarettes per day (cpd), have CO level of 20 or higher, smoked for 20 or more years, and have at least 4-5 quit attempts
	Availability	OTC
		<ul style="list-style-type: none"> • If patch produces insomnia or unpleasant dreams, it can be removed just before sleep, and replaced in morning • Skin irritations can be addressed by placing a new patch on a different location each day • Can be combined with gum, lozenge, spray, or inhaler to control “break-through” symptoms/ cravings. Can also be combined with bupropion

Continued on next page

First-Line Nicotine Replacement Therapy (NRT), Continued

Trainer Note Slides 28 - 29 PM 37	Review the medication dosages, considerations, and precautions for nicotine gum. Refer participants to handout “FDA Pregnancy Categories” in the Appendix of PM (page 95) for additional details on these categories.
--	--

Nicotine Gum

Considerations	Primary side effects: mouth soreness, dyspepsia. Patients often do not use enough to control breakthrough cravings and withdrawal symptoms
Precautions	Pregnancy Category D (See Appendix)
Suggested Dosage & Duration	2 mg and 4 mg, up to 24 pieces/day Up to 12 weeks Can be used for longer periods based on the patient’s dependence and withdrawal severity
Availability	OTC
<ul style="list-style-type: none"> • Tailor dosage and duration to fit needs of patient • Not chewed like regular gum • Bite/chew till feel tingling or peppery taste, then “park in cheek”, on a fixed schedule or as needed (prn) • Avoid eating or drinking anything except water for 15 minutes before and after chewing, avoid acidic foods which impede absorption of nicotine 	

Continued on next page

First-Line Nicotine Replacement Therapy (NRT), Continued

Trainer Note Slides 30 - 31 PM 38	Review the medication dosages, considerations, and precautions for the nicotine lozenge. Refer participants to handout “FDA Pregnancy Categories” in the Appendix of PM (page 95) for additional details on these categories.
--	--

Nicotine Lozenge

Considerations	Primary side effects: nausea, mouth soreness, dyspepsia. Patients often do not use enough to control breakthrough cravings and withdrawal symptoms
Precautions	Pregnancy Category D (See Appendix)
Suggested Dosage & Duration	2 mg and 4 mg, up to 20 per day Up to 12 weeks Can be used for longer periods based on the patient’s dependence and withdrawal severity
Availability	OTC
<ul style="list-style-type: none"> • Provides about 25% more nicotine than gum, and is easier and more discrete to use than gum • Tailor dosage and duration to fit the needs of the patient • Not chewed, but dissolved slowly in cheek pouch or under tongue • Use on a fixed schedule and as needed (prn) • Avoid eating or drinking anything except water for 15 minutes before and after using the lozenge, avoid acidic foods which impede absorption of nicotine 	

Continued on next page

First-Line Nicotine Replacement Therapy (NRT), Continued

Trainer Note Slides 32 - 33 PM 39	Review the medication dosages, considerations, and precautions for nicotine-nasal spray. Refer participants to handout “FDA Pregnancy Categories” in the Appendix of PM (page 95) for additional details on these categories.
--	--

Nicotine Nasal Spray

Considerations	Primary side effects: nasal irritation.
Precautions	Pregnancy Category D (See Appendix)
Recommended Dosage & Duration	8 - 40 doses/day 3 - 6 months Poses some risk of dependence
Availability	Prescription only
<ul style="list-style-type: none"> • Most effective for highly dependent smokers (see characteristics of severely dependent users in the nicotine patch table) • Provides most rapid absorption and fastest symptom relief as compared to other nicotine medications • Use in conjunction with patch, gum, lozenge, and can be used with bupropion • Use as a “rescue medication” for strong cravings and withdrawal relief • Some patients with schizophrenia report a preference for use, due to rapid onset of effect and symptom relief • May need to limit use to reduce risk of developing dependence 	

Continued on next page

First-Line Nicotine Replacement Therapy (NRT), Continued

Trainer Note
Slides 34 - 35
PM 40

Review the medication dosages, considerations, and precautions for nicotine inhaler.

Explain that the term “inhaler” is a misnomer, as the patient does not inhale, but puffs on the device to release nicotine into the mouth and allows it to be absorbed through the oral mucosa.

Refer participants to handout “FDA Pregnancy Categories” in the Appendix of PM (page 95) for additional details on these categories.

Nicotine Inhaler (Misnomer, actually an Oral Puffer)

Considerations	Primary side effects: irritation of mouth and throat; coughing, and rhinitis (nasal irritation)
Precautions	Pregnancy Category D (See Appendix)
Recommended Dosage & Duration	6 - 16 cartridges/day Up to 6 months; taper dosage in final 3 months
Availability	Prescription only
<ul style="list-style-type: none"> • Nicotine is not inhaled into the lungs, rather it is puffed into the mouth and absorbed through the mucosal tissue • Use in conjunction with patch, gum, lozenge, and can be used with bupropion • Use as a “rescue medication” for strong cravings and withdrawal relief • Best effects are achieved with frequent puffing 	

First-Line Non-Nicotine Medications

Trainer Note Review the actions, dosages, considerations, and precautions for bupropion.
Slides 36 - 38
PM 41 **Explain** bupropion may be a factor in unusual mood or behavior changes in some patients, but nicotine withdrawal also precipitates feelings of anxiety, restlessness, insomnia, and sometimes depression and suicidal ideation.

Bupropion

Considerations	Primary side effects: insomnia, dry mouth, and weight loss.
Precautions	Contraindicated for history of seizure, eating disorder, and recent alcohol or benzodiazepine cessation/withdrawal; may increase anxiety. Pregnancy Category C (See Appendix)
Recommended Dosage & Duration	Begin 1 - 2 weeks <u>before stopping</u> tobacco use 150 mg every morning x 3 days; then 150 mg 2 x days for 7 - 12 weeks, up to 6 months
Availability	Prescription only
<ul style="list-style-type: none"> • Approved by FDA for the treatment of tobacco dependence under trade names Zyban® and Wellbutrin SR® (sustained release). • Monocyclic antidepressant that selectively acts as a dopamine and norepinephrine reuptake inhibitor, yet doesn't induce reinforcement or dependency in humans • Doubles abstinence rates vs. placebo, and can be used along with nicotine medications or Chantix® • Reduces nicotine withdrawal and cravings; the effect on smoking abstinence is independent of relieving depression • Short-term treatment often leads to weight loss • Often effective when nicotine medication alone does not work and for people who experience depression when stopping tobacco use • With all antidepressants, the FDA requires a Black Box warning that advises stopping use if there are unusual or adverse changes in mood, behavior, or onset of suicidal ideation 	

Continued on next page

First-Line Non-Nicotine Medications, Continued

Trainer Note **Review** the actions, dosages, considerations, and precautions for varenicline.
Slides 39 - 41 **Explain** that varenicline is considered the most effective medication.
PM 42 Varenicline may be a factor in unusual mood or behavior changes in some patients; nicotine withdrawal also precipitates feelings of anxiety, restlessness, insomnia, and even lead to the emergence of depression and suicidal ideation.

Varenicline

Considerations	History of psychiatric illness. Side effects: nausea, insomnia, vivid dreams
Precautions	History of kidney disease, Pregnancy Category C (See Appendix)
Dosage & Duration	0.5 mg 1 x/day for 3 days 0.5 mg 2 x/day for 4 days 1.0 mg 2 x/day for 3 months Stop tobacco use on day 8 Continue use for up to 6 months
Availability	Prescription only
	<ul style="list-style-type: none"> • Non-nicotine medication approved by FDA in July 2006 for the treatment of tobacco dependence under the trade name Chantix® • Mechanism of action: partial agonist/antagonist of specific nicotinic acetylcholine receptors - results in lower amount of dopamine release, and also blocks nicotine activation of receptors • Reduces craving and withdrawal • Has no drug-to-drug interaction; 93% of the drug is excreted in the urine; use with caution if patient has kidney disease • Can be used with bupropion and other psychiatric medications • The FDA requires a Black Box warning that advises stopping use if there are unusual or adverse changes in mood, behavior, or onset of suicidal ideation

Second-Line Non-Nicotine Medications

Trainer Note **Identity and explain** that there are two second-line, non-nicotine prescription medications that may be useful for some patients.
Slide 42
PM 43

- Second-Line Medications**
- Are not FDA approved for the treatment of tobacco dependence
 - Have shown some evidence of effectiveness in tobacco dependence treatment in small studies
 - Greater risks and concerns with side effects
-

Nortriptyline and Clonidine

Nortriptyline

- Tricyclic antidepressant
- Potential cardiac effects
- 4% - 9% drop out rate in trials
- Dry mouth, drowsy, lightheaded, constipation, weight gain are common side effects
- Some recent small studies indicate it is as effective as bupropion

Clonidine

- Antihypertensive
 - Sedation, low blood pressure, light-headedness are common side effects
-

Tobacco Treatment Considerations

Trainer Note **Emphasize** the value of using combinations of medication, which have been shown to be more effective than using single medications.
Slide 43
PM 44

Combination Medications

According to the CPG 2008 Update clinicians should consider using combinations of medications. Some examples:

- Long-term (more than 14 weeks) nicotine patch plus other NRT (gum, lozenge, and/or nasal spray)
- Nicotine patch plus nicotine inhaler
- Nicotine patch plus nasal spray
- Nicotine patch plus bupropion SR (Fiore et al., 2008)

According to a recent study at the Mayo Clinic, bupropion and varenicline can be used in combination.

- Bupropion may be effective and helpful for patients using varenicline, if they became depressed when stopping tobacco use (Ebbert et al., 2009).
- Varenicline is excreted 93% unchanged in the urine and has no drug-to-drug interactions.

Continued on next page

Tobacco Treatment Considerations, Continued

Trainer Note
Slide 45
PM 45

Explain that the tar in tobacco smoke (not nicotine) stimulates an increase of a specific liver enzyme (Cytochrome 450, 1A2 or CYP1A2) that increases the metabolism of many drugs, including caffeine. Stopping tobacco use may require a lower dose of certain medications.

Refer to the PM and to the Smoking and Drug Interaction website below.

**Tobacco
Abstinence
and Other
Medication
Blood Levels**

The tar (not the nicotine) in tobacco smoke increases the metabolism of many drugs and medications, including caffeine, theophylline, acetaminophen, some antidepressants, and some antipsychotic medications.

When an individual stops using tobacco, metabolic changes in the liver can sometimes require lower dosages of other medications that he/she may be taking. Some patients who stop smoking tobacco may need a 20% to 30% reduction in dose to avoid having more side effects or drug-induced toxicity.

For more information on Smoking and Drug Interactions you can go to:
www.oshp.net/pdf_forms/druginteractionswithsmokingtable.pdf

**Some
Examples of
Drugs
Affected by
Smoking**

Smoking increases the metabolism of these drugs and lowers the blood levels of these drugs:

- OCD Medications: Anafranil (Clomipramine) and Luvox (Fluvoxamine)
 - Caffeine found in coffee, cola, soft drinks, some OTC medications, tea
 - Antidepressants: Elavil (Amitriptyline), Pamelor/Aventyl (Nortriptyline), Tofranil (Imipramine)
 - Asthma, bronchial, and emphysema medication: Theo-24, Theo-Dur, Theobid, Theovent (Theophylline). Theophylline is also found in tea.
 - Antipsychotics: Clozaril (Clozapine), Haldol (Haloperidol), Prolixin (Fluphenazine), Thorazine (Chlorpromazine), Zyprexa (Olanzapine)
-

Continued on next page

Tobacco Treatment Considerations, Continued

Trainer Note
Slide 45
PM 46

The CPG 2008 Update recommendations have shown that tobacco treatment medications are effective in a variety of populations. These medications are recommended for all individuals who use tobacco except where contraindicated or with specific populations for which there is insufficient evidence of effectiveness.

Effectiveness of Medication for Specific Populations

According to the CPG 2008 Update, tobacco treatment medications have proven to be effective in the following populations:

- HIV positive
- Hospitalized
- Lesbian/gay/bisexual/transgender (LGBT)
- Low socio-economic status (SES)
- Limited formal education
- Medical co-morbid conditions
- Older individuals
- Psychiatric disorders and substance use disorders
- Racial and ethnic minority populations
- Women and men

(Fiore et al., 2008)

Continued on next page

Tobacco Treatment Considerations, Continued

Trainer Note
Slide 45
PM 47

Explain that the CPG 2008 Update states that there is insufficient evidence of effectiveness of NRT medications for the populations listed below. However, this does not mean these medications cannot be used. Prescribing health care providers need to decide the risks and benefits of using tobacco treatment medications on a case-by-case basis and discuss this with their patients.

**Insufficient
Evidence of
Effectiveness**

According to the CPG 2008 Update (Fiore et al., 2008), there is insufficient evidence for the effectiveness of NRT medications for these populations:

- Pregnant women
- Smokeless tobacco users
- Light smokers
- Adolescents

While there is insufficient evidence for effectiveness, this does not mean these medications cannot or should never be used. Prescribing health care providers for these groups should weigh the risks and benefits of using tobacco treatment medications on a case-by-case basis, and discuss this with their patients.

**Medical
Contra-
indications of
NRT**

- Myocardial infarction or stroke (within 2 weeks)
- Serious arrhythmias
- Serious or worsening angina pectoris
- Uncontrolled hypertension

(Also see the package inserts for complete list of contraindications.)

Accessing Tobacco Treatment Medications

Trainer Note
PM 48-49

Refer to the several sources for accessing or distribution of tobacco dependence treatment medications.

- External/consulting medical providers
- Program medical staff
- NYS Smoker's Quitline
- Retail OTC NRT
- Program non-medical staff (OTC NRT only)

Access to
Medications

To obtain No-Cost Nicotine Replacement Therapy (NRT) contact:

NYS Smoker's Quit Line

Free starter kits of nicotine patches, gum, or lozenges

1-866-NYS-QUITS

1-866-697-8487

Partners in Corporate Health BeBetter Networks

<http://www.nrtdistribution.com/Welcome.aspx>

Through a contract with the NYSDOH, Partners in Corporate Health is able to provide nicotine replacement therapy (NRT) to OASAS-certified facilities at no cost. To order NRT, you must first become a registered user. Once you've done so, you'll be able to order nicotine patches, gum, and lozenges for your program. To obtain more information about obtaining NRT go to:

<http://www.oasas.state.ny.us/tobacco/index.cfm>

Private Health Insurance

Continued on next page

Accessing Tobacco Treatment Medications, Continued

- NYS Medicaid Coverage**
- Nicotine patch, nicotine gum, nicotine nasal spray, or nicotine inhaler are covered
 - Bupropion and varenicline are covered
 - Requires a prescription from a health care provider (or an order for OTC NRT)
 - Two courses of treatment per year - each course is continuous treatment for three months. Total is six months of treatment per year
 - Combinations allowed as long as not with same agent (dosage form and strength)
-

- Medicare Coverage**
- One initial evaluation and up to eight counseling sessions in a 12-month period:
- Services must be provided by a qualified physician who is a Medicare - certified provider
 - Covers those who take prescription medications that interact with tobacco, OR who have a tobacco-related disease or health condition
 - Covers counseling and medications
-

Unit Summary

Trainer Note
PM 50

Summarize the evidence supporting use of medications, the wide margin of safety for nicotine medications, and relative safety for non-nicotine medications, as well as the few groups where medication has not been shown to be effective, but may still be used on a case-by-case basis. There are a range of opinions and perspectives on the use of medications in the treatment of tobacco dependence. Some program staff state they do not provide nicotine replacement therapy (NRT) out of a philosophy that treating a drug dependency with another form of the same drug is wrong, and from concern that patients may abuse the medication. These concerns are not supported in research and practice. Some staff may claim that the recovery culture frowns upon the use of medication in treatment, evidence shows that tobacco treatment medications do not impede recovery, do improve treatment outcomes, and do increase the likelihood of long-term recovery.

Summary

The overwhelming clinical evidence is that use of tobacco treatment medications is much more effective than trying to stop “cold turkey.” The risk of abusing nicotine medications is very small. Nicotine medications have a wide margin of safety, and non-nicotine medications are relatively safe when used under medical supervision. Patients should be given access to these medications, receive accurate knowledge about these drugs, and be told that medications are not “magic bullets.” The combination of tobacco treatment medications works better than single medications. Use of medications plus supportive counseling provides the best outcomes. Tobacco treatment medications have been shown to be effective with a wide range of populations, with only a few exceptions. There are a small number of contraindications for medication use.

Unit 3

Case Studies

Trainer Note
Slide 46
PM 51

In this Unit, participants will review a case study, assess the patient's symptoms, apply the DSM-IV-TR diagnostic criteria for tobacco dependence and/or withdrawal, identify the stage of change for tobacco use and other chemical use, and make recommendations for appropriate medications. In addition, participants will be able to identify domains where there are issues that need to be addressed (i.e., mental health, medical, vocational, etc.).

Purpose

Provide an opportunity for participants to use newly learned knowledge, tools, and skills in a practical application.

Objectives

- Using a case study, determine if tobacco dependence and tobacco withdrawal are present
- Assess stage of change for the patient in the case study
- Using the case study, make appropriate recommendations for tobacco treatment medications

Continued on next page

Case Studies, Continued

Trainer Note Divide participants into three to five groups, depending on how many case studies are to be reviewed. Limit group size to five participants.

Slide 47

PM 52 A different case study will be distributed to each group, however all groups will address the same questions for their case. Groups should identify a person who will report-out to the large group.

Allow each group between 15 - 20 minutes to work on the case study and address the questions. Each group will then be asked to report out regarding their case in a large group discussion that follows.

Case Studies Case Study Number 1 - Bill J.
Case Study Number 2 - Barbara G.
Case Study Number 3 - Jorge G.
Case Study Number 4 - Alvin C.
Case Study Number 5 - Maryann P.

Continued on next page

Case Studies, Continued

Trainer Note	Assign case studies and explain the task for each group is as follows:
PM 52	1. Read the case study and address the five questions listed after the case study.
Bill - PM 53-54	2. Using the Fagerström screening tool, decide if there is enough information to suggest tobacco dependence for this patient
Barbara - PM 55 -56	3. Using the DSM-IV-TR diagnostic criteria, determine whether the patient has a tobacco dependency and if the patient is currently showing signs of tobacco withdrawal
Jorge PM 57-58	4. What is the patient's stage of change regarding his/her tobacco use? Is this different from the stage for other substance use problems?
Alvin PM 59-60	5. Identify any key issues about his/her tobacco use that may need immediate attention
MaryAnn PM 61-62	6. Identify what tobacco treatment medications you would recommend for this patient and why

Case Study	1. Read the case study and address the following questions:
Directions	1. Use the Fagerström screening tool and decide if there is enough information to suggest tobacco dependence for this patient
	2. Using the DSM-IV-TR diagnostic criteria, determine whether the patient has a tobacco dependency and if the patient is currently showing signs of tobacco withdrawal
	3. What is the patient's stage of change regarding his/her tobacco use? Is this different from the stage for other substance use problems?
	4. Identify any key issues about his/her tobacco use that may need immediate attention
	5. Identify what tobacco treatment medications you would recommend for this patient and why

Case Study Debriefing

Trainer Note

The trainer has two options:

Option 1 If each group uses a different case, the trainer can provide a brief summary of the case for the large group by using the case summary.

Then ask each small group to share their answers to the questions and the rationale for each answer.

Ask the large group to share any additional insights they have from hearing the case.

Option 2 If each small group uses the same case, the trainer should provide a brief summary of the case for the large group.

Then ask each small group to share their answers to the questions and the rationale for each answer.

Use the trainer notes to identify key points that were not identified by the small groups or mentioned in the large group discussion.

Case Study 1 - Bill J.

Bill J. is a 36-year-old white male who is presenting for the first time at your outpatient clinic. He is accompanied to the intake appointment by his wife Amy. Bill states in a rather annoyed fashion that the only reason he is there is because Amy made him come. You can detect a great deal of tension between Bill and Amy. Bill is employed full-time as a medical technician at a local hospital, and Amy works full-time as a medical office manager. At this point, there are no job-related problems. Bill and Amy were married a year ago and have recently bought a small house. Amy's son by her first marriage, John, who is nine years old, lives with them. This is Bill's first marriage.

When you ask the couple what brings them to your office, Bill states that he doesn't have a clue, and if his wife wasn't such a nag, everything would be fine. Amy counters by saying that if Bill didn't "drink so much and stink of cigarettes", she wouldn't "nag" him. Bill replies that if Amy lost some weight, maybe he wouldn't be so depressed all the time and drink so much.

Amy shares that she is worried because Bill drinks at least a six-pack of beer and two mixed drinks every day. She has noticed that he has been increasing the amount he has been drinking over the last few weeks, and it never used to be a daily thing. Bill stated that he needs to do this to get a good buzz. Bill has also increased his tobacco use from about 10 cigarettes per day to almost a pack and a half per day, and has developed a chronic cough. Bill attributes the cough to seasonal allergies. Amy reports that Bill has to have a cigarette immediately when he wakes up in the morning, and it's the last thing he does before going to bed. Although he smokes outside on the porch, smoke drifts into the house and Amy is concerned about the health effects on John, who has mild asthma.

Bill sees no reason to stop drinking or smoking. He states that it's the only thing that relaxes him and makes him feel better. He used to work out at a local gym and play golf, but he has given those activities up as he'd rather have a few cold ones at the house. Amy is upset because they never go out socially anymore, and Bill never does anything with John. Bill refuses to go anywhere where he can't smoke.

When you speak to Bill about the health effects of his drinking and smoking, he replies that everybody should just leave him alone because he's not hurting anybody but himself. He also states that he has tried to stop smoking a bunch of times but just gave up finally, so stop bugging him. Amy asked Bill to think about what would happen if he killed somebody driving drunk. Bill replied that maybe "everybody would be better off" if he wasn't around anymore.

Continued on next page

Case Study 1 - Bill J., Continued

Case Study Analysis Form

1. Using the Fagerström screening tool, decide if there is enough information to suggest tobacco dependence for this patient.
 - 1.
 - 2.
 - 3.
 2. Using the DSM-IV-TR diagnostic criteria, determine whether the patient has a tobacco dependency and if the patient is currently in tobacco withdrawal.
 - 1.
 - 2.
 - 3.
 3. What is the patient's stage of change regarding his/her tobacco use? Is this different from the stage for other substance use problems?
 - 1.
 4. Identify any key patient issues about his/her tobacco use that need immediate attention.
 - 1.
 - 2.
 - 3.
 5. Identify what tobacco treatment medications you would recommend for this patient and why.
 - 1.
 - 2.
- 3.

Continued on next page

Case Study 1 - Bill J., Continued

Summary of Bill J.

Slide 49

PM 53-54

Patient Demographics:

36 yr. old married white male, married 1 year, 9 yr. old stepson with asthma

Medical Issues / Mental Health / Medications:

Chronic cough, symptoms suggesting depression with hints of suicidal ideation, anger, and not currently on any medications

Alcohol / Other Drug Use Symptoms (not including tobacco):

Heavy alcohol use (6 beers plus 2 mixed drinks per day), increasing frequency and amount of use, continued use despite psychological and physical consequences, social/recreational activities given up or reduced due to alcohol use

Tobacco Use Symptoms:

Tolerance -30cpd, increased frequency and amount from 10cpd, continued use despite consequences, social and recreational activities given up/reduced, persistent desire or unsuccessful efforts to cut down or control tobacco use

Case Study Conclusions

1. Using the Fagerström screening tool, determine whether a tobacco dependence may be present in this patient. **Not enough information yet.**
2. Using the DSM-IV-TR diagnostic criteria, assess whether the patient has a tobacco dependency and is currently in tobacco withdrawal. **Tobacco dependence, does not appear to be in withdrawal**
3. What stage of change for tobacco? Is this different from the stage for other substance use problems? **Precontemplation, same for alcohol use**
4. Identify any key patient issues about tobacco use that need attention. **Tobacco use related illness, mental health status, and risk to stepson.**
5. If patient is willing to stop tobacco use or at least stop while in treatment, what tobacco treatment medications you would recommend for this patient and why? **Patch, patch plus lozenge or gum, Bupropion or combination with nicotine meds, but needs monitoring; also consideration for seizure risk if he stops heavy alcohol use**

Case Study Number 2 - Barbara G.

Barbara G. is 29-year-old single white female who is referred by her probation officer to your therapeutic community (TC) for women. Barbara was arrested when she tried to buy three grams of cocaine from an undercover police officer. Barbara currently lives with her parents. Her father is an engineer and her mother is a nurse. Barbara had been working part-time in a clothing store. She was fired a week ago after she was caught on the surveillance camera stealing money from the cash register.

Barbara has been on probation for a prior drug-related crime. She was caught with a gram of cocaine after police observed her driving erratically. Her probation officer is trying to get her into a TC in lieu of a jail sentence.

At the start of your intake assessment, Barbara asks you if it's OK to smoke in the office. When you tell her no, she asks if she can go outside for just a minute to get a few drags. She stated that she gets really shaky and nervous if she can't smoke, and really had a problem when she had to spend a few days in jail after she was arrested. She denies any suicidal ideation. You agree to let her go outside, and she is much calmer when she comes back in.

When you inquire about her current living arrangements, Barbara states that she lives with her parents because she can't afford to keep her apartment since she spends most of her money on cocaine. She also admits that she trades sex for drugs and not always with protection. Barbara states that she uses cocaine four to five times per week, about one gram per day, or as much as she can get her hands on. She states that the only reason she doesn't use every day is lack of money. She's also in trouble with her dealer, who she owes several hundred dollars. She traded the used car her parents bought her for cocaine.

Barbara states that she has tried to stop using cocaine several times without success. She has never tried to stop smoking as that would be too stressful for her, even though she knows that smoking is harmful. She gets very anxious and nervous if she runs low on cigarettes, and even hitchhiked once at 3:00 AM to get more. The only time she has been completely drug free has been in rehab (twice, once as an adolescent), and jail. She states that she has never had a stable relationship, as she always attaches herself to losers and dealers.

Barbara states that her life is a mess. She has no friends, no social life, no job, and no prospects. She is willing to come into the program, but is extremely scared that she may not be able to smoke while there.

Continued on next page

Case Study Number 2 - Barbara G., Continued

Case Study Analysis Form

1. Using the Fagerström screening tool, decide if there is enough information to suggest tobacco dependence for this patient.
 - 1.
 - 2.
 - 3.
2. Using the DSM-IV-TR diagnostic criteria, determine whether the patient has a tobacco dependency and if the patient is currently in tobacco withdrawal.
 - 1.
 - 2.
 - 3.
3. What is the patient's stage of change regarding his/her tobacco use? Is this different from the stage for other substance use problems?
 - 1.
4. Identify any key patient issues about his/her tobacco use that need immediate attention.
 - 1.
 - 2.
 - 3.
5. Identify what tobacco treatment medications you would recommend for this patient and why.
 - 1.
 - 2.
 - 3.

Continued on next page

Case Study Number 2 - Barbara G., Continued

Summary of Barbara G.

Slide 50

PM 55-56

Patient Demographics:

29 yr. old single white female, lives with parents, no known partner or children

Medical Issues / Mental Health / Medications:

Some symptoms of depression, risk of STDs

Alcohol / Other Drug Use Symptoms (not including tobacco):

Tolerance to cocaine, has made persistent attempts to stop using cocaine, continued use despite knowledge of harmful consequences, great deal of time spent in substance related activity, lost job due to theft possibly related to buy cocaine

Tobacco Symptoms:

Great deal of time spent in substance related activity, presence of withdrawal symptoms, continued use despite knowledge of consequences

Case Study Conclusions

1. Using the Fagerström screening tool, determine whether a tobacco dependence may be present in this patient. **Not enough information (what questions need to be asked?)**
2. Using the DSM-IV-TR diagnostic criteria, assess whether the patient has a tobacco dependency. **Tobacco dependence and withdrawal – as evidenced by symptoms of depression, difficulty concentrating, anxiety, restlessness, insomnia, impairment in functioning**
3. Can you assess stage of change readiness? **Precontemplation for tobacco, preparation for cocaine**
4. Identify issues or concerns in other assessment domains that need to be addressed or followed-up. **Medical (STDs), mental health status, , legal issues**
5. Identify what tobacco treatment medications you would recommend for this patient and why. **Patch, patch plus combination NRT, bupropion, bupropion combination, varenicline**

Case Study Number 3 - Jorge R.

Jorge R. is a 27-year-old Hispanic/Latino male who is referred to your outpatient clinic from the emergency room of the local hospital. According to the referent, Jorge was brought by ambulance to the emergency room at about 1:00 AM after his girlfriend Carmen, who had just returned to their apartment after her shift as a waitress, discovered him passed out on the bathroom floor. She reported that there was an empty liquor bottle and a prescription bottle containing hydrocodone pills on the floor, although it appeared that most of the pills were still in the bottle. Jorge's BAC at the emergency room was .16%, and he seemed disoriented and confused. Jorge was stabilized and sent home.

Carmen accompanied Jorge to the appointment. Jorge presented as very open to talking about his "problem" and indicated that he was at the point that he was thinking about getting some help. He stated that this had been on his mind for a while now. He stated that he valued his relationship with Carmen and didn't want to ruin it with his drinking. Jorge and Carmen have a strong tobacco odor, and Jorge has a pack of cigarettes in his shirt.

Jorge talks openly about his alcohol use, indicating that he is a daily drinker. He stated that the amount of use varied, but sometimes he loses track of how much he is drinking and ends up passing out. He thinks this is what happened during this last incident, although he states he really can't remember anything except waking up in the ER. Carmen stated that she has been worried because Jorge seems to be drinking more over the last few months, and lately he has been sneaking a couple of beers in the morning. Jorge stated that he didn't think she knew about that. When you ask Jorge about the hydrocodone pills, he stated that he got them when he had a tooth pulled but really didn't use them. Carmen confirmed this. He doesn't remember taking any the night he passed out.

Jorge is surprised when you ask him about his tobacco use. He stated that he really wants to address his drinking and that his tobacco use really helps him to relax. He states that when he doesn't smoke, he is very anxious and "jittery." He reported that when he was in the ER for several hours, he was really "jonesing" for a cigarette. He reports being a daily smoker, using two packs per day and sometimes more when he drinks. He acknowledges that tobacco use is harmful but can't imagine stopping alcohol and tobacco use at once.

Carmen does not seem concerned about Jorge's tobacco use. She stated that she smokes herself, and that it's the only time the two of them can be at ease with each other. Her real concern is that Jorge stop his alcohol use. She is worried that Jorge's job as a computer technician may be in jeopardy as he has missed several Monday's after drinking heavily on the weekends, and has already received a verbal warning.

Continued on next page

Case Study Number 3 - Jorge R., Continued

Case Study Analysis Form

1. Using the Fagerström screening tool, decide if there is enough information to suggest tobacco dependence for this patient.
 - 1.
 - 2.
 - 3.
 2. Using the DSM-IV-TR diagnostic criteria, determine whether the patient has a tobacco dependency and if the patient is currently in tobacco withdrawal.
 - 1.
 - 2.
 - 3.
 3. What is the patient's stage of change regarding his/her tobacco use? Is this different from the stage for other substance use problems?
 - 1.
 4. Identify any key patient issues about his/her tobacco use that need immediate attention.
 - 1.
 - 2.
 - 3.
 5. Identify what tobacco treatment medications you would recommend for this patient and why.
 - 1.
 - 2.
- 3.

Continued on next page

Case Study Number 3 - Jorge R., Continued

Summary of Jorge R.

Slide 51

PM 57-58

Patient Demographics:

27 yr. old, Hispanic male, lives with his girlfriend, employed as computer technician

Medical Issues / Mental Health / Medications:

Recent tooth extraction and use of hydrocodone, brought to ER after being found unconscious at home and had BAC of .16. No other known medical problems at this time, stabilized and sent home

Alcohol / Other Drug Use Symptoms (not including tobacco):

Tolerance, concerns by girlfriend about increased alcohol consumption over past months, sneaking beers in morning, has missed work several days after heavy weekend drinking and received verbal warning, denies using hydrocodone.

Tobacco Use Symptoms:

High tolerance, uses 2 packs a day, describes craving for cigarettes when in ER, smokes more when drinking, continued use despite knowledge of physical and psychological consequences, states tobacco helps him relax and feels jittery and anxious when he does not smoke

Case Study Conclusions

1. Using the Fagerström screening tool, determine whether a tobacco dependence may be present in this patient. **Not definitive**
2. Using the DSM-IV-TR diagnostic criteria, assess whether the patient has a tobacco dependency and is currently in withdrawal. **Tobacco dependence, appears to have had tobacco withdrawal symptoms in ER, but no current evidence of withdrawal**
3. Can you assess stage of change readiness? **Precontemplation for tobacco, contemplation for alcohol**
4. Identify issues or concerns that need immediate attention. **Possible risk of drug interaction overdose? Employment at risk**
5. Identify what tobacco treatment medications you would recommend for this patient and why. **Patch, patch plus gum/lozenge, bupropion and/or in combination with varenicline**

Case Study Number 4 - Alvin C.

Alvin C. is a 44-year-old African-American male who presents at your outpatient clinic along with his wife Adrienne. Alvin was referred by his primary care physician due to Alvin's admitting that he was a daily marijuana user. His doctor was concerned about Alvin's declining physical health, weight gain, low energy level, and lack of good personal hygiene. Alvin seems friendly and engaging, even though he admits that his wife was the driving force in getting him to come to the appointment.

Adrienne stated that she has been very frustrated with Alvin. She stated that its like "pulling teeth" to get him to do anything, like taking almost a year before he finally went to see his doctor. She thinks it's a miracle he actually came to this appointment. Adrienne stated that she is concerned that Alvin's current lifestyle is very unhealthy and she's worried that his "habits" are going to kill him.

Alvin admits that he is not an ambitious person and doesn't see what all the fuss is about. He enjoys his job at the local home improvement center and has no aspirations to "move up the ladder" to a management position. He stated that his supervisor likes him and he's always on time for work, although he has been spoken to about taking too many smoke breaks. Alvin stated that he has never smoked marijuana at work.

Alvin stated that he has been a marijuana user since he was about 15 years old. He and Adrienne have been married for 18 years and have no children. They used to use together, but Adrienne stopped about 10 years ago. Alvin has also been using tobacco since age 13, and uses tobacco and marijuana daily. He denies any other drug use, except an occasional beer, which Adrienne confirmed.

Adrienne described Alvin's routine as revolving around his tobacco and marijuana use. She stated that he smokes a cigarette the first thing in the morning, then several more before he goes to work at 9:00 AM. Alvin doesn't admit to it but Adrienne suspects he smokes marijuana on the way to work, since she has found drug paraphernalia in his car. When he gets home from work at about 6:00 PM, he sits in front of the TV smoking marijuana for several hours, and then smokes a cigarette before bed. She stated that they have no friends and haven't been on a vacation or done anything "fun" in years. Adrienne states they are rarely intimate anymore because the smell of him really disgusts her. Although he has never had any legal problems, she is worried that sooner or later he will get "busted" buying marijuana or get pulled over for driving under the influence.

Alvin states that Adrienne is making too big a deal out of everything. He knows that his marijuana and tobacco use isn't really good for him but is one of his only pleasures lately, and he's not hurting anyone else. He just wants to be left alone.

Continued on next page

Case Study Number 4 - Alvin C., Continued

Case Study Analysis Form

1. Using the Fagerström screening tool, decide if there is enough information to suggest tobacco dependence for this patient.
 - 1.
 - 2.
 - 3.
2. Using the DSM-IV-TR diagnostic criteria, determine whether the patient has a tobacco dependency and if the patient is currently in tobacco withdrawal.
 - 1.
 - 2.
 - 3.
3. What is the patient's stage of change regarding his/her tobacco use? Is this different from the stage for other substance use problems?
 - 1.
4. Identify any key patient issues about his/her tobacco use that need immediate attention.
 - 1.
 - 2.
 - 3.
5. Identify what tobacco treatment medications you would recommend for this patient and why.
 - 1.
 - 2.
 - 3.

Continued on next page

Case Study Number 4 - Alvin C., Continued

Summary of Alvin C.

Slide 52

PM 59-60

Patient Demographics:

44 yr. old married African American male, employed at local home improvement center, stable employment

Medical Issues / Mental Health / Medications:

Weight gain, low energy level, lack of good personal hygiene, lack of motivation

Alcohol / Other Drug Use Symptoms (not including tobacco):

Tolerance, great deal of time spent using marijuana, social and recreational activities given up to use, continued use despite knowledge of consequences

Tobacco Use Symptoms:

Tolerance, great deal of time spent using tobacco, social and recreational activities given up due to use, continued use despite knowledge of negative consequences

Case Study Conclusions

6. Using the Fagerström screening tool, determine whether a tobacco dependence may be present in this patient. **Not definitive**
7. Using the DSM-IV-TR diagnostic criteria, assess whether the patient has a tobacco dependency. **Tobacco dependence, not enough information to diagnose nicotine withdrawal at this time, prompts the clinician to ask additional questions**
8. Can you assess stage of change readiness? **Precontemplation for tobacco and cannabis**
9. Identify issues or concerns in other assessment domains that need to be addressed or followed-up. **Medical, social (relationship stress), employment, legal**
10. Identify what tobacco treatment medications you would recommend for this patient and why. **Patch, patch plus gum/lozenge, bupropion or in combination with varenicline**

Case Study Number 5 - Maryann P.

Maryann P. is a 30-year-old white female who is referred to your hospital-based outpatient clinic by her private therapist, a social worker she has been seeing for about two years. Maryann lives with her two children ages four and three, in a subsidized apartment in an urban area. She is separated from her husband, Len, the children's father; however he does have regular contact with the children. She has a boyfriend, but doesn't talk much about him, and he's somewhat of a shady character. Nobody even knows his name.

Maryann first went to see the social worker at the urging of her mother, Anita, who was concerned about the effects of Maryann's use of prescription painkillers on her two small children. Maryann was prescribed the painkillers after the birth of her last child for back pain, and shared with her therapist that she was doing the "doctor thing," seeing multiple physicians to obtain prescriptions for the medication. Anita is also concerned about Maryann's chain smoking in the apartment and how that may harm the children.

Maryann does not work and is on public assistance. Len pays a small amount of child support, as much as he can afford. Anita has been visiting the apartment three or four times per week to check up on them, and has become increasingly concerned about Maryann's physical appearance and the seeming lack of effective parenting. Sometimes there is no food in the apartment when Anita visits so she goes out and stocks up Maryann with groceries and necessities, including a supply of cigarettes. Len has called Anita to express his concern also, and has even mentioned possibly calling child protective services. Anita discouraged this and suggested they both express their concerns to the social worker, who called Maryann and asked if she could come see her, resulting in a referral to your clinic.

Maryann tells you she is feeling out of control and is scared that the children will be taken away from her. She has not told her therapist, but she shares with you that she has been injecting heroin for several months, apparently supplied from her boyfriend. This has increased from a few times per week to practically daily use. She states that if she doesn't have her drugs and tobacco, she just can't function. Maryann also shared that she is about two months pregnant by the boyfriend, and is worrying about the effects on the baby, but she can't stop using.

Maryann states she is feeling powerless and hopeless. She tells you she has thought about "ending it all," but is worried what will happen to the children. She states she has tried to stop tobacco use so many times she can't remember how many, and is frustrated and discouraged.

Continued on next page

Case Study Number 5 - Maryann P., Continued

Case Study Analysis Form

1. Using the Fagerström screening tool, decide if there is enough information to suggest tobacco dependence for this patient.
 - 1.
 - 2.
 - 3.
2. Using the DSM-IV-TR diagnostic criteria, determine whether the patient has a tobacco dependency and if the patient is currently in tobacco withdrawal.
 - 1.
 - 2.
 - 3.
3. What is the patient's stage of change regarding his/her tobacco use? Is this different from the stage for other substance use problems?
 - 1.
4. Identify any key patient issues about his/her tobacco use that need immediate attention.
 - 1.
 - 2.
 - 3.
5. Identify what tobacco treatment medications you would recommend for this patient and why.
 - 1.
 - 2.
 - 3.

Continued on next page

Case Study Number 5 - Maryann P., Continued

Summary of MaryAnn P.

Slide 53

PM 61-62

Patient Demographics:

30 yr. old separated white female, two children ages 4 and 3 with her, boyfriend, not much known about him

Medical Issues / Mental Health / Medications:

Declining physical condition, poor nutrition, use of prescription painkillers, symptoms of depression/suicidal ideation, drug and tobacco use during pregnancy

Alcohol / Other Drug Use Symptoms (not including tobacco):

Opioid tolerance, possible withdrawal, great deal of time spent using opioids, social, occupational, and recreational activities given up/reduced due to opioid use, continued opioid use despite knowledge of consequences

Tobacco Use Symptoms:

Tolerance, possible withdrawal, great deal of time spent using tobacco, persistent desire/unsuccessful efforts to cut down/control use, social, occupational, and recreational activities given up/reduced, continued use despite knowledge of consequences

Case Study Conclusions

1. Using the Fagerström screening tool, determine whether a tobacco dependence may be present in this patient. **Not enough information (what questions need to be asked?)**
2. Using the DSM-IV-TR diagnostic criteria, assess whether the patient has a tobacco dependency. **Tobacco dependence and tobacco withdrawal as evidenced by depression, difficulty concentrating, anxiety, impairment in functioning when not smoking**
3. Can you assess stage of change readiness? **Precontemplation to contemplation for tobacco**
4. Identify issues or concerns in other assessment domains that need to be addressed or followed-up. **Medical, family, social, parenting, legal**
5. Identify what tobacco treatment medications you would recommend for this patient and why. **Under medical supervision, patch, patch plus combination NRT, bupropion, bupropion combination, varenicline**

Module Summary

Trainer Note
PM 63

Summarize: When clinicians are applying their knowledge and skills to working with a patient who is using tobacco, it is best practice to have a complete assessment. The use of screening tools and CO monitors can be very helpful to provide key information about the patient and to educate the patient. A useful assessment includes tobacco dependence history, other substance use history, prior attempts to abstain from tobacco, withdrawal symptoms and severity, prior use of tobacco treatment medications, medical issues, psychiatric issues, stage of change for tobacco use (including willingness, readiness, and ability to change), a reasonable understanding of tobacco-treatment medications, and considerations and contraindications.

Summary

When clinicians are applying their knowledge and skills to working with a patient who is using tobacco, it is best practice to have a complete assessment. The use of screening tools and CO monitors can be helpful to provide key information about the patient and can be used to educate the patient. A useful assessment includes tobacco dependence history, other substance use history, prior attempts to abstain from tobacco, withdrawal symptoms and severity, prior use of tobacco treatment medications, medical issues, psychiatric issues, stage of change for tobacco use (including willingness, readiness, and ability), a reasonable understanding of tobacco-treatment medications, and considerations and contraindications.

Module Closure

Trainer Note
PM 64

Review the following questions:

What did you discover (or re-discover) about tobacco dependence?

What did you become aware of (or re-learn) about the tobacco dependence and nicotine withdrawal criteria?

What did you discover (or re-discover) about tobacco treatment medications?

What did you discover about your own professional skills and knowledge?

Recap of Learning

What did you discover (or re-discover) about tobacco dependence?

What did you become aware of (or re-learn) about the tobacco dependence and nicotine withdrawal criteria?

What did you discover (or re-discover) about tobacco treatment medications?

What did you discover about your own professional skills and knowledge?

Trainer Note
Slides 54 - 55
PM 65 - 66

Acknowledge that addiction professionals have an array of resources, strategies, and skills to address the challenges that tobacco-using patients may present.

Remind participants, about online learning (e-learning) opportunities and 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 the completed evaluation (and if required a post-test) provide participants with a Certificate of Completion.

This page is intentionally blank

Resources

**Resource
Directory**

Tobacco Recovery Resource Exchange

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

**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 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

References

- American Psychiatric Association. (1996) American Journal of Psychiatry, Practice Guideline for the Treatment of Nicotine Dependence, 153.10,6 (10/96 Supplement).
- American Psychiatric Association, (2000). Diagnostic and Statistical Manual for Mental Disorders - IV, Text Revision, American Psychiatric Association Press.
- Bedfont USA Inc. www.bedfontusa.com. Williamsburg, VA.
- Campbell, B.K., Krumenacker, J., and Stark, M.J. (1998). Smoking Cessation for Clients in Chemical Dependence Treatment. Journal of Substance Abuse Treatment, 15:4: 313-318.
- Campaign for Tobacco-Free Kids. (2006). The Toll of Tobacco in New York. Available online <http://www.tobaccofreekids.org/reports/settlements/toll.php?StateID=NY>. Retrieved April 17, 2008.
- Centers for Disease Control and Prevention. (2007). Cigarette Smoking Among Adults --- United States, 2006. MMWR 2007; 56(44);1157-1161. Available online at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5644a2.htm>. Retrieved April 17, 2008.
- Center for Disease Control and Prevention. (2008) “Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses-United States 2000-2004,” MMWR 57(45): 1226-1228. Available on line at <http://www.cdc.gov/mmwr/PDF/wk/mm5745.pdf>. Retrieved October 1, 2009.
- Centers for Disease Control and Prevention. (2009). State-Specific Prevalence and Trends in Adult Cigarette Smoking - United States, 1998 - 2007. MMWR 2009; 58(09);221-226. Available online at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5809a1.htm> Retrieved September 1, 2009.
- Chaiton, M.O., Cohen, J. E., McDonald, P. W., and Bondy, S.J. (2007). The Heaviness of Smoking Index as a predictor of smoking cessation in Canada. Addictive Behaviors, 32(5):1031-42.
- Ebbert, J.O., Croghan, I.T., Sood, A., Schroeder, D.R., Hays, J.T., and Hurt, R.D. (2009). Varenicline and bupropion sustained-release combination therapy for smoking cessation. Nicotine Tobacco Research. February, 2009.

Continued on next page

References, Continued

- Fiore M.C., Jaén C.R., Baker T.B., et al. (2008). Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.
- Hser, Y-I, Hoffman, V., Grella, C.E., Anglin, M.D. (2001). "A 33-year follow-up of narcotics addicts." *Archives of General Psychiatry*, 58: 503-508.
- Hurt, R.D., Offord, K.P., Croghan, I.T., Gomez-Dahl, L., Kottke, T.E., Morse, R.M., Melton, J. (1996). "Mortality following inpatient addictions treatment: Role of tobacco use in a community-based cohort." *Journal of the American Medical Association* 10, 275 (14):1097-1103.
- Janis I. L. and Mann L: (1977). *Decision Making: A Psychological Analysis of Conflict, Choice, and Commitment*. New York, Free Press.
- Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51, 390-395.
- Prochaska, J. O., & DiClemente, C. C. (1984). Self-change processes, self-efficacy and decisional balance across five stages of smoking cessation. In *Advances in cancer control - 1983*. New York: Alan R. Liss, Inc.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. (1992). In search of how people change. *American Psychologist*, 47, 1102-1114.
- Prochaska, J. J., Rossi, J.S., Redding C.A., Rosen A.B., Tsoh J.Y., Humfleet G.L., Eisendrath S.J., Meisner, M.R. & Hall S.M. (2004). Depressed smokers and stage of change: Implications for treatment interventions. *Drug and Alcohol Dependence*, 76:143-151.
- Sobell, M.B., Sobell, L.C., Kozlowski, L.T. (1995). "Dual recoveries from alcohol and smoking problems." In: Fertig, J.B., & Allen, J.P. eds. *Alcohol and Tobacco: From Basic Science to Clinical Practice*. National Institute on Alcohol Abuse and Alcoholism Research Monograph 30. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 207-224.
- Stuyt, E.B. (1997). "Recovery rates after treatment for alcohol/drug dependence: Tobacco users vs. non-tobacco users." *American Journal on Addictions* 6 (2):159-167.

Continued on next page

References, Continued

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006. "The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General." Atlanta, GA http://www.cdc.gov/tobacco/data_statistics/sgr/sgr_2004/index.htm. Retrieved April 17, 2008.

U.S. Environmental Protection Agency. Environmental Tobacco Smoke, Children's Environmental Health Research Centers. Washington, D.C.: Office of Health and Environmental Assessment. 2006.

U.S. Environmental Protection Agency. EPA Designates Passive Smoking a 'Class A' or Known Human Carcinogen Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders. Washington, D.C.: Office of Health and Environmental Assessment. 1-7-1993.

Williams, J. M. and Ziedonis, D. M. (2006). Snuffing out tobacco dependence: Ten reasons behavioral health providers need to be involved, *Behavioral Healthcare*. 26(5), 27-31.

White, W.L. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, Ill.: Chestnut Health Systems.

This page is intentionally blank

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>)

Continued on next page

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 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

Continued on next page

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

Continued on next page

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

Continued on next page

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>)

Continued on next page

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

Continued on next page

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)

Continued on next page

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

Continued on next page

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., Fagerström 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

Continued on next page

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

This page is intentionally blank

Appendix A

Answers for Module 2 Pre/Post Test Questions - For Trainer Only

Sample Pre-Test and Post-Test Questions

Sample Pre-Test and Post-Test Answer Sheet

Workshop Evaluation - For Trainer Only

Sample Workshop Evaluation Form

This page is intentionally blank

Answers for Module 2 Pre/Post Test Questions - For Trainer Only

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

1. Which of the following is not a screening tool useful in the assessment of tobacco dependence?
 - a. Fagerström
 - b. HONC
 - c. HSI
 - d. **Addiction Severity Index**

2. It is important to determine the effects of tobacco dependence in which of the following assessment domains?
 - a. Medical history
 - b. Medication history
 - c. Mental health history
 - d. **All of the above**

3. Which of the following statements is true?
 - a. **Tobacco dependence is a chronic biopsychosocial disease characterized by frequent relapse**
 - b. Tobacco dependence symptoms are different from other substance dependence symptoms
 - c. There is a DSM-IV diagnosis for tobacco abuse
 - d. Clinicians should not discuss tobacco use with their patients unless the patient indicates a strong desire to quit

4. Which of the following is a characteristic of the Stages of Change (SOC) model?
 - a. SOC model is not useful in treating tobacco dependence
 - b. **SOC model enables clinicians to “start where the patient is”**
 - c. SOC model is not widely used in the chemical dependence field
 - d. SOC model is complicated and hard to understand

5. People who present for chemical dependence services will most likely be in which Stages of Change?
 - a. Preparation or Action
 - b. Contemplation or Preparation
 - c. **Precontemplation or Contemplation**
 - d. Action or Maintenance

Module 2- Pre/Post Test Questions - page 2

6. Of the seven symptoms of substance dependence are listed in the DSM-IV-TR, how many are required to make a diagnosis?
- 5
 - 3**
 - 4
 - 7
7. Which of the following is not a DSM-IV-TR symptom of substance dependence?
- Blackouts**
 - Tolerance
 - Withdrawal symptoms
 - Continued use despite knowledge of physical or psychological consequences
8. Which of the following provides the most reliable, evidence-based information on the effectiveness of tobacco use interventions?
- Your patient's family doctor
 - The U.S. Public Health Service Clinical Practice Guideline**
 - DSM-IV-TR
 - Smokers Quit Lines
9. Which of the following is not an FDA approved first-line medication for the treatment of tobacco dependence?
- Nicotine inhaler
 - Bupropion (Zyban or Wellbutrin)
 - Nortriptyline (Pamelor)**
 - Varenicline (Chantix)
10. Which of the following statements is true?
- Nicotine Replacement Therapy (NRT) is not recommended for the HIV-positive population
 - When an individual stops using tobacco, adjustments in the dose of other medications may be required**
 - Research has shown that the most effective way to treat tobacco dependence is to use supportive counseling only
 - NRT should never be used with pregnant women or adolescents

Module 2 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. Please do not write on the test. Record your answers on the answer sheet provided.

1. Which of the following is not a screening tool useful in the assessment of tobacco dependence?
 - a. Fagerström
 - b. HONC
 - c. HSI
 - d. Addiction Severity Index

2. It is important to determine the effects of tobacco dependence in which of the following assessment domains?
 - a. Medical history
 - b. Medication history
 - c. Mental health history
 - d. All of the above

3. Which of the following statements is true?
 - a. Tobacco dependence is a chronic biopsychosocial disease characterized by frequent relapse
 - b. Tobacco dependence symptoms are different from other substance dependence symptoms
 - c. There is a DSM-IV diagnosis for tobacco abuse
 - d. Clinicians should not discuss tobacco use with their patients unless the patient indicates a strong desire to quit

4. Which of the following is a characteristic of the Stages of Change (SOC) model?
 - a. SOC model is not useful in treating tobacco dependence
 - b. SOC model enables clinicians to “start where the patient is”
 - c. SOC model is not widely used in the chemical dependence field
 - d. SOC model is complicated and hard to understand

5. People who present for chemical dependence services will most likely be in which Stages of Change?
 - a. Preparation or Action
 - b. Contemplation or Preparation
 - c. Precontemplation or Contemplation
 - d. Action or Maintenance

6. Of the seven symptoms of substance dependence are listed in the DSM-IV-TR, how many are required to make a diagnosis?
 - a. 5
 - b. 3
 - c. 4
 - d. 7

7. Which of the following is not a DSM-IV-TR symptom of substance dependence?
 - a. Blackouts
 - b. Tolerance
 - c. Withdrawal symptoms
 - d. Continued use despite knowledge of physical or psychological consequences

8. Which of the following provides the most reliable, evidence-based information on the effectiveness of tobacco use interventions?
 - a. Your patient's family doctor
 - b. The U.S. Public Health Service Clinical Practice Guideline
 - c. DSM-IV-TR
 - d. Smokers Quit Lines

9. Which of the following is not an FDA approved first-line medication for the treatment of tobacco dependence?
 - a. Nicotine inhaler
 - b. Bupropion (Zyban or Wellbutrin)
 - c. Nortriptyline (Pamelor)
 - d. Varenicline (Chantix)

10. Which of the following statements is true?
 - a. Nicotine Replacement Therapy (NRT) is not recommended for the HIV-positive population
 - b. When an individual stops using tobacco, adjustments in the dose of other medications may be required
 - c. Research has shown that the most effective way to treat tobacco dependence is to use supportive counseling only
 - d. NRT should never be used with pregnant women or adolescents

Module 2 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 2 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

- Section Two -

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

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

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

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

Appendix B

(Labeled as “Appendix” in Participant’s Manual)

Sample Screening Tools

Fagerström Test for Nicotine Dependence

Heaviness of Smoking Index (HSI) and HSI Scoring Instructions

Hooked on Nicotine Checklist (HONC) and HONC Scoring Instructions

Sample Nicotine Withdrawal Assessment Tool

Minnesota Withdrawal Scale - Behavior Rating Scale -Self Report

Minnesota Withdrawal Scale - Behavior Rating Scale -Observer Rating

Minnesota Withdrawal Scale - Instructions

Supplemental Handouts

FDA Pregnancy Categories

Health Belief Model (HBM)

Locus of Control

This page is intentionally blank

Fagerström Test for Nicotine Dependence *

* Heatherton TF, Kozlowski LT, Frecker RC, Fagerström KO. The Fagerström Test for Nicotine Dependence: A revision of the Fagerström Tolerance Questionnaire. *British Journal of Addictions* 1991;86:1119-27

Take this test and find out your level of dependence on nicotine.

1. How soon after you wake up do you smoke your first cigarette?

- After 60 minutes (0)
- 31 - 60 minutes (1)
- 6 - 30 minutes (2)
- Within 5 minutes (3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden?

- No (0) Yes (1)

3. Which cigarette would you hate most to give up?

- The first in the morning (1) Any other (0)

4. How many cigarettes per day do you smoke?

- 10 or less (0)
- 11 - 20 (1)
- 21 - 30 (2)
- 31 or more (3)

5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?

- No (0) Yes (1)

6. Do you smoke even if you are so ill that you are in bed most of the day?

- No (0) Yes (1)

Page 2

Fagerström Test Scoring

To Score Add together the points for each answer above. Use the scale below to determine your level of dependence on nicotine:

Your level of dependence on nicotine is:

0-2: Very low dependence

3-4: Low dependence

5: Medium dependence

6-7: High dependence

8-10: Very high dependence

Scores under 5: “Your level of nicotine dependence is still low. You should act now before your level of dependence increases. “

Score of 5: “Your level of nicotine dependence is moderate. If you don’t quit soon, your level of dependence on nicotine will increase until you may be seriously addicted. Act now to end your dependence on nicotine.”

Score over 7: “Your level of dependence is high. You aren’t in control of your smoking - it is in control of you! When you make the decision to quit, you may want to talk with your doctor about nicotine replacement therapy or other medications to help you break your addiction.”

Heaviness of Smoking Index (HSI) and Scoring Instructions

Two measures from the Fagerström test, the time to first cigarette and the number of cigarettes smoked per day, are sometimes combined into a measure of nicotine dependence called the Heaviness of Smoking Index (HSI). The HSI, like the Fagerström, is a screening tool only, and should not be the ultimate measure of nicotine dependence. Nicotine dependence is diagnosed using the DSM-IV-TR criteria for substance dependence.

The following are Fagerström questions 1 and 4.

1. How soon after you wake up do you smoke your first cigarette?

___ Within five minutes (3)

___ 5-30 minutes (2)

___ 31-60 minutes (1)

___ After 60 minutes (0)

2. How many cigarettes a day do you smoke?

___ 10 or less (0)

___ 11 - 20 (1)

___ 21 - 30 (2)

___ 31 or more (3)

Add the scores from the two questions together. The level of nicotine dependence is determined as follows:

0-1: Low dependence

2-4: Moderate dependence

5-6: High dependence

If the patient reports both a high level of cigarettes per day usage (1 pack or more) and that he/she does not smoke a cigarette within the first hour of waking, ask the follow-up question:

Do you sometimes wake up during the night and smoke? If the patient states "yes", follow-up with the question, "How many times a week?"

If the patient answers "no" they do not wake up in the night to smoke, you may want to ask the patient to describe their morning routine. Oftentimes there is something or someone that prohibits the person from smoking in the first hour of the day (i.e., getting children ready for school and won't smoke in front of children. Or a spouse/partner won't allow them to smoke in the house and the first cigarette is not smoked until the person leaves the house.)

This page is intentionally blank

The Hooked on Nicotine Checklist (HONC)

This handout is from: <http://fmchapps.umassmed.edu/honc/TOC.htm>

	NO	YES
1. Have you ever tried to quit, but couldn't?		
2. Do you smoke <u>now</u> because it is really hard to quit?		
3. Have you ever felt like you were addicted to tobacco?		
4. Do you ever have strong cravings to smoke?		
5. Have you ever felt like you really needed a cigarette?		
6. Is it hard to keep from smoking in places where you are not supposed to?		
When you haven't used tobacco for a while ... OR When you tried to stop smoking...		
7. Did you find it hard to concentrate because you couldn't smoke?		
8. Did you feel more irritable because you couldn't smoke?		
9. Did you feel a strong need or urge to smoke?		
10. Did you feel nervous, restless or anxious because you couldn't smoke?		

HONC Scoring Instructions

The HONC is scored by counting the number of YES responses.

Dichotomous Scoring - The HONC is an indicator of diminished autonomy.

- Individuals who score a zero on the HONC by answering NO to all ten questions enjoy full autonomy over their use of tobacco.
- Because each of the ten symptoms measured by the HONC has face validity as an indicator of diminished autonomy, a smoker has lost full autonomy if any symptom is endorsed.
- In schools and clinics, smokers who have scores above zero can be told that they are already hooked.

Continuous Scoring- The HONC is a measure of severity of diminished autonomy.

- The number of symptoms a person endorses serves as a measure of the extent to which autonomy has been lost.

Some researchers prefer to provide multiple response options for questionnaire items, e.g., *never, sometimes, most of the time, always*. In certain situations, this can improve the statistical properties of a survey. ***When this has been done with the HONC, its performance was not improved*** (O’Loughlin et al., 2002). Having more response options complicates the scoring because the total score does not coincide with the number of individual symptoms. Therefore, we recommend the Yes/No response format.

Researchers who wish to measure frequency or severity of symptoms may do so by adding to the yes/no format additional questions about any item endorsed by a smoker. Here is an example: *Have you ever felt like you were addicted to tobacco?* A smoker who checked “yes” would then respond to:

- How often have you felt addicted?

Rarely, Occasionally, Often, Very Often

- On a scale from 1 (*hardly at all*) to 10 (*extremely*), how addicted have you felt?

Minnesota Nicotine Withdrawal Scale

Behavior Rating Scale

Self-Report
09/05

Please rate yourself for the period for the last _____

0 = none, 1 = slight, 2 = mild, 3 = moderate, 4 = severe

1. Angry, irritable, frustrated	0	1	2	3	4
2. Anxious, nervous	0	1	2	3	4
3. Depressed mood, sad	0	1	2	3	4
4. Desire or craving to smoke	0	1	2	3	4
5. Difficulty concentrating	0	1	2	3	4
6. Increased appetite, hungry, weight gain	0	1	2	3	4
7. Insomnia, sleep problems, awakening at night	0	1	2	3	4
8. Restless	0	1	2	3	4
9. Impatient	0	1	2	3	4
10. Constipation	0	1	2	3	4
11. Dizziness	0	1	2	3	4
12. Coughing	0	1	2	3	4
13. Dreaming/nightmares	0	1	2	3	4
14. Nausea	0	1	2	3	4
15. Sore throat	0	1	2	3	4

Heart rate _____ bpm

Weight _____ kg

Minnesota Nicotine Withdrawal Scale
Behavioral Rating Scale
Observer Rating
09/05

Rate the subject on the following symptoms according to whether you observed the symptom in the subject in the last _____. It does not matter whether the subject complained of the symptom. We want to know whether you noticed the symptom.

0 = not at all, 1 = slight, 2 = mild, 3 = moderate, 4 = severe

a. Angry/irritable/frustrated	0	1	2	3	4
b. Anxious/tense	0	1	2	3	4
c. Depressed	0	1	2	3	4
d. Restless/Impatient	0	1	2	3	4

1. How confident are you that this rating is accurate?

0 = not at all

1 = somewhat confident

2 = moderately confident

3 = very confident

Instructions For Use of the Minnesota Withdrawal Scale - Revised

1. There are two scales: a self-report and an observer scale. Several items do not appear in the observer scale as observers cannot reliably rate them.
2. On the self-report scale, the first nine items are the well-validated items and are the ones to be used if calculating a total withdrawal discomfort score. The other six are promising candidate items.
3. See the attached table to further compare the content of the scales with the criteria for DSM-IV and ICD-10 nicotine/tobacco withdrawal and the contents of other withdrawal scales.
4. We have participants complete the scale before as well as after quitting.
5. We have participants rate over the last 24 hours and observers rate over the last week. We usually require observers to see the participant on average 2 hr/day.
6. We use the 0-4 response option so that we can have verbal anchors for each response. Larger response options (e.g., 0-100) are likely more sensitive but may be more difficult to interpret.
7. The scale is not labeled a withdrawal scale because subjects 1) are confused by filling out a “withdrawal” scale prior to cessation, and 2) will sometimes not report a symptom during abstinence if they do not believe it is due to withdrawal.
8. We encourage readers to read recent reviews of methodological issues in measuring tobacco withdrawal.

For Further Information Call, Write, Fax

John R. Hughes, M.D. University of
Vermont, Dept. of Psychiatry
38 Fletcher Place
Burlington, Vermont 05401-1419
(802) 656-9610 TELEPHONE
(802) 656-9628 FAX

Dorothy Hatsukami, Ph.D. Department of Psychiatry
University of Minnesota
2701 University Avenue SE, Suite 201
Minneapolis, MN 55414
(612) 627-1808 TELEPHONE
(612) 627-4899 FAX

This page is intentionally blank

FDA Pregnancy Category

Supplemental Handout

In 1979, the United States Food and Drug Administration (FDA) introduced a classification of fetal risks due to pharmaceuticals. This was based on a similar system that was introduced in Sweden just one year earlier.

The United States FDA has the following definitions for the pregnancy categories:

United States FDA Pharmaceutical Pregnancy Categories	
Pregnancy Category A	Adequate and well-controlled studies have failed to demonstrate a risk to the fetus in the first trimester of pregnancy (and there is no evidence of risk in later trimesters).
Pregnancy Category B	Animal reproduction studies have failed to demonstrate a risk to the fetus and there are no adequate and well-controlled studies in pregnant women OR Animal studies which have shown an adverse effect, but adequate and well-controlled studies in pregnant women have failed to demonstrate a risk to the fetus in any trimester.
Pregnancy Category C	Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.
Pregnancy Category D	There is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience or studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.
Pregnancy Category X	Studies in animals or humans have demonstrated fetal abnormalities and/or there is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience, and the risks involved in use of the drug in pregnant women clearly outweigh potential benefits.

One characteristic of the FDA definitions of the pregnancy categories is that the FDA requires a relatively large amount of high-quality data on a pharmaceutical for it to be defined as Pregnancy Category A. As a result of this, many drugs that would be considered Pregnancy Category A in other countries are allocated to Category C by the FDA

Health Belief Model Supplemental Handout

Source:

[http://www.cw.utwente.nl/theorieenoverzicht/Theory%20clusters/Health%20Communication/Health Belief Model.doc/](http://www.cw.utwente.nl/theorieenoverzicht/Theory%20clusters/Health%20Communication/Health%20Belief%20Model.doc/)

History and Orientation

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock, and Kegels working in the U.S. Public Health Services. The model was developed in response to the failure of a free tuberculosis (TB) health screening program. Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS.

Core Assumptions and Statements

The HBM is based on the understanding that a person will take a health-related action (i.e., use condoms) if that person:

1. Feels that a negative health condition (i.e., HIV) can be avoided
2. Has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (i.e., using condoms will be effective at preventing HIV)
3. Believes that he/she can successfully take a recommended health action (i.e., he/she can use condoms comfortably and with confidence)

The HBM was spelled out in terms of four constructs representing the perceived threat and net benefits: perceived *susceptibility*, perceived *severity*, perceived *benefits*, and perceived *barriers*. These concepts were proposed as accounting for people's "readiness to act." An added concept, *cues to action*, would activate that readiness and stimulate overt behavior. A recent addition to the HBM is the concept of *self-efficacy*, or one's confidence in the ability to successfully perform an action. This concept was added by Rosenstock and others in 1988 to help the HBM better fit the challenges of changing habitual unhealthy behaviors, such as being sedentary, smoking, or overeating.

What is Locus of Control?

Supplemental Handout

Source: <http://wilderdom.com/psychology/loc/LocusOfControlWhatIs.html>

Within psychology, Locus of Control is considered to be an important aspect of personality. The concept was developed originally by Julian Rotter in the 1950s (Rotter, 1966).

Locus of Control refers to an individual's perception about the underlying main causes of events in his/her life. Or, more simply: Do you believe that your destiny is controlled by *yourself* or by *external forces* (such as fate, god, or powerful others)?

The full name Rotter gave the construct was Locus of Control of Reinforcement. In giving it this name, Rotter was bridging behavioral and cognitive psychology. Rotter's view was that behavior was largely guided by "reinforcements" (rewards and punishments) and that through contingencies such as rewards and punishments, individuals come to hold beliefs about what causes their actions. These beliefs, in turn, guide what kinds of attitudes and behaviors people adopt. This understanding of Locus of Control is consistent, for example, with Philip Zimbardo's (a famous social psychologist) theory:

"A locus of control orientation is a belief about whether the outcomes of our actions are contingent on what we do (internal control orientation) or on events outside our personal control (external control orientation)." (Zimbardo, 1985, p. 275)

Thus, locus of control is conceptualized as referring to a one-dimensional continuum, ranging from *external* to *internal*:

External Locus of Control	Internal Locus of Control
Individual believes that his/her behavior is guided by fate, luck, or other external circumstances	Individual believes that his/her behavior is guided by his/her personal decisions and efforts.



Citation: Zimbardo, P.G. (1985). Psychology and Life. Glenview, IL: Scott Foreman and Company.

