

**TOBACCO RECOVERY
RESOURCE EXCHANGE**



THE EXCHANGE
WWW.TOBACCORECOVERY.ORG



Treatment Planning:

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

Participant's Manual Module 4



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
Overview of the Training Modules	8
Module 4 Agenda and Objectives	9

Lessons

Unit 1 Knowledge and Skills Review	11
Unit 2 Treatment Planning Basics	15
Unit 3 Treatment Plan Case Studies	33

Resources	57
References	59
Glossary	61
Appendix	73

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. Current programs and services offered by PDP include:

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

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

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

Visit the project website: www.tobaccorecovery.org for online learning and other resources.

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

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

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 (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 improved post-treatment abstinence from alcohol and other drugs (Prochaska et al., 2004). Tobacco relapse is shown to trigger relapse to alcohol and other drug use and vice-versa (Stuyt, 1997; Sobell et al., 1995), a concern that was also noted by early pioneers of the treatment for alcohol and narcotic dependence (White, 1998).

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

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

Original Project Goals

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

Overview of the Training Modules

**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 4 Agenda and Objectives

Module 4 Treatment Planning Agenda

- Skills and Knowledge-Jeopardy
 - Treatment Planning
 - Case Study Activity
-

Module 4 Objectives

Identify the knowledge and skills necessary to write a comprehensive treatment plan that includes tobacco dependence interventions.

Explain the biopsychosocial nature of substance dependence, including tobacco dependence

Identify the elements of a comprehensive assessment for substance dependence

Identify tobacco dependence interventions in the participants' agencies or programs

Identify the components of a comprehensive treatment plan that integrates tobacco use interventions

Using a sample case study, identify a patient's stage of change, diagnosis, problem statements, goals, objectives, and a plan for therapies and activities

Using a case study, demonstrate the ability to write the key components of a treatment plan, which integrates tobacco use interventions

This page is intentionally blank

Unit 1

Knowledge and Skills Review

Purpose Participants will learn and identify the knowledge and skills necessary in order to write a comprehensive treatment plan that integrates tobacco dependence interventions.

Objective Identify the knowledge and skills necessary to write a comprehensive treatment plan that includes tobacco dependence interventions

Jeopardy Style Exercise

Jeopardy Style Exercise

You may be familiar with the TV show Jeopardy. The Jeopardy show provides contestants with the answers to questions, and asks them to respond by stating the correct question. All responses must be in the form of a question.

The training will use a similar approach as a review activity, and the class will work in teams, rather than as individuals.

To begin, one team will select an answer from the screen. The team will then have 10 seconds to state the correct question. If they are incorrect, the next team will get a chance to respond. Opportunities for each team will be rotated for each answer, so each team gets an equal number of chances.

Here are two examples:

Answer: A chronic, progressive, and often fatal disease that is characterized by compulsive use of psychoactive substances, serious life problems, and a high risk of relapse.

Question: What is addiction? Alternatively, What is chemical dependence?

Answer: A commonly used drug that is naturally found in coffee, tea, and cola beverages and which produces mental alertness and a short boost in energy.

Question: What is caffeine?

Once the groups are selected, one team will go first and will select a topic and value, such as “Because I Said So for 100”. The teams will be rotated so that each team has roughly an equal number of chances. If a team’s response is incorrect, the next team will have a chance to respond. The selections will continue until the game is completed.

The Final Jeopardy Question will be shown after the last question is completed.

Knowledge and Confidence Self Rating

**Knowledge
and
Confidence
for
Completing
Treatment
Plans**

After completing the review exercise, identify the specific knowledge and skills you already possess about tobacco dependence or which can be adapted for treating tobacco dependence.

Then consider the discussion about knowledge and skills you already have and what you need to complete a comprehensive treatment plan. Now please answer the following questions:

Using a 10-point scale with 1 being low and 10 being high, how knowledgeable are you about writing treatment plans? Explain?

Low 1 2 3 4 5 6 7 8 9 10 High

Using a 10-point scale with 1 being low and 10 being high, how confident are you about your ability to write a comprehensive treatment plan, that integrates tobacco interventions? Explain?

Low 1 2 3 4 5 6 7 8 9 10 High

This page is intentionally blank

Unit 2

Treatment Planning Basics

Purpose Unit 2 will review the components needed for writing a treatment plan and discusses how to integrate tobacco use interventions.

Objectives

- Explain the biopsychosocial nature of substance dependence, including tobacco dependence
- Identify the elements of a comprehensive assessment for substance dependence
- Identify tobacco dependence interventions in the participants' agencies or programs
- Identify the components of a comprehensive treatment plan that integrates tobacco use interventions

Elements for Writing Treatment Plans

Three Key Elements to Treatment Plans

There are three elements necessary to write a treatment plan in order to integrate tobacco dependence interventions.

- An understanding of the biopsychosocial nature of substance dependence (including tobacco),
- The completion of a comprehensive assessment, (also known as a comprehensive evaluation),
- A supportive program structure, known as the Integrated Program of Therapies and Activities (IPTA).

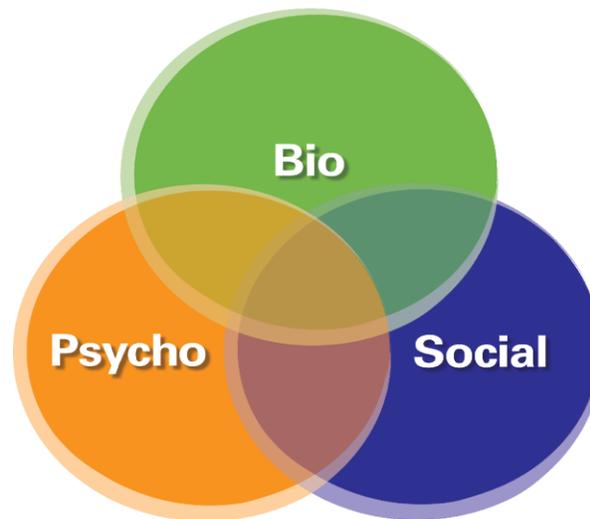
Most treatment plans include problem statements, goal statements, and objectives, and therapy or activities, along with diagnoses and may include the stage of change for each problem.

Each program will have a unique treatment planning process and the exact integration of tobacco interventions may look different in each modality of care.

Biopsychosocial Approach to Chemical Dependence

Tobacco Dependence

As with other forms of substance 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 serious consequences.



Continued on next page

Biopsychosocial Approach to Chemical Dependence, Continued

Biological Reasons	Psychological Reasons	Social Reasons
psychoactive substance	medicate depression and/or anxiety	belong to a group
stimulates release of many neurotransmitters	improve concentration	feel grown-up
avoid withdrawal	relaxation	look cool
reduce stress	coping mechanism	identify with other users
relaxation	behavior pattern	ritual
dependence	control anger	media/marketing
genetic predisposition	moderating effects from mental illness	
craving	rebellion	

All three areas should be assessed, and wherever problems are identified, they need to be taken into consideration in the individualized treatment plan

Continued on next page

Biopsychosocial Approach to Chemical Dependence, Continued

Questions to Consider

If you consider the reasons why people use tobacco, and you then replaced it with the names of other drugs (such as alcohol, cocaine, heroin, etc.), would the reasons for using change or be different?

Why is it important to treat tobacco dependence in chemical dependence programs?

When working with patients, why use the term “tobacco dependence” rather than nicotine dependence?

Continued on next page

Biopsychosocial Approach to Chemical Dependence, Continued

Key Reminders

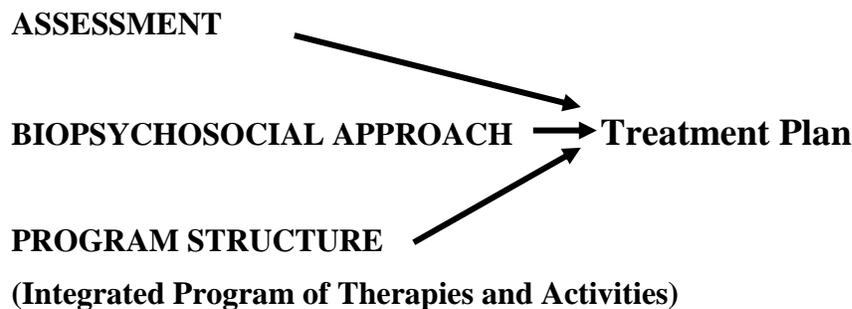
- The reasons why people use tobacco versus other drugs, such as alcohol, cocaine, heroin, etc., do not really differ.
 - Tobacco dependence is key factor in relapse to other drug use and negatively affects recovery from other chemical dependence
 - Treatment outcomes and long-term recovery can be improved if tobacco dependence is treated concurrently while treating other substance dependence
 - Tobacco use causes more illness and death than the other forms of substance use, and is important for treating the whole person
 - Most clinicians already possess much of the knowledge and many of the skills necessary to treat tobacco dependence
 - Using the term tobacco dependence rather than nicotine dependence has value for several reasons
 - Smoking of tobacco involves more than just obtaining the effects of nicotine; it also includes the many psychological, emotional, social, and behavioral aspects of using tobacco
 - The thinking, emotions, behavior, and rituals of psychoactive drug use are also associated with smoking tobacco
 - While nicotine causes the withdrawal symptoms, it is tobacco smoke that causes the many diseases
 - Tobacco smoke includes at least 4,000 chemicals and compounds, some of which affect emotions and thinking
 - While DSM-IV uses nicotine dependence and this term is used in the documentation of treatment records, the many physical, psychological, behavioral, and social problems of tobacco use need to be addressed
-

Comprehensive Assessment and Integrated Program of Therapies and Activities

What Drives the Treatment Plan?

Understanding that tobacco dependence is a chronic biopsychosocial disease (and is inter-related with other chemical dependencies, problem gambling, and mental health disorders) is the first step in developing a comprehensive treatment plan.

There are two additional factors that are needed to develop treatment plans: the assessment (also called an evaluation) and the program structure (sometimes referred to as an Integrated Program of Therapies and Activities or IPTA).



Assessment

Comprehensive assessment of substance use disorders, mental health disorders, and problem gambling is essential for diagnosis, treatment planning, and referral to supportive services during or after completion of treatment. Further, the comprehensive assessment, should be revisited and updated during a patient's involvement in treatment.

Regardless of the assessment tools or methods that your program uses, all chemical dependence patients should be screened and assessed for their tobacco use/dependence, and treatment for tobacco use/dependence should be made available.

Assessment Domains

Typical Assessment Domains

- Chemical use, abuse, and dependence history
 - Previous treatment experiences
 - Previous abstinence attempts
 - Impact of chemical use on significant others
 - Education
 - Employment
 - Legal involvements
 - Medical problems and medications
 - Mental health
 - Gambling
 - Lethality assessment
 - Readiness to change
 - Willingness and ability to change
-

Tobacco Use Assessment Areas

Tobacco Use Assessment Areas

- Level of tobacco dependence
 - Medical consequences from tobacco
 - Psychiatric and psychological consequences
 - Tobacco use by family/significant others
 - Financial implications of use
 - Stage of change/motivation
 - Abstinence attempts history
 - Most recent attempt to maintain abstinence
 - Prior attempts
 - Method(s) used for each abstinence attempt (for example: “cold turkey,” psychoeducation, counseling, medication, combination of counseling and medication)
 - Abstinence duration for each attempt
 - Withdrawal symptoms
 - Relapse factors and reasons
-

Strengths, Barriers, Successes, and Stage of Change

More about Assessment

Your assessment will also yield clinically significant information about the patient:

- Strengths
 - Previous successes
 - Barriers to treatment and recovery
 - Stage of change
 - Other considerations
-

Integrated Program of Therapies and Activities (IPTA)

The Integrated Program of Therapies and Activities (IPTA) also known as treatment interventions or treatment methods, describe what the treatment team does to help the patient successfully complete their objectives and reach their goals. The following activity will help clarify what your agencies IPTA is for treating tobacco dependence. This activity is called Modality, Assessment, and Treatment Plan (MAT).

Modality, Assessment, and Treatment Plan

The MAT Activity- Modality, Assessment, and Treatment Plan

Integrated Program of Therapies and Activities (IPTA)

In this activity, you will use the chart on next page to identify tobacco treatment interventions that have been integrated into your respective treatment programs.

- First, circle the Modality where you work, located at the top of the grid.
- Under the “Assessment” section, circle those elements where tobacco use interventions have been integrated into your patient assessment (for example, circle Psychosocial Evaluation or Intake if tobacco use assessment questions have been added).
 - Under “Assessment,” in the blank boxes you can write-in additional items that are not listed but used by your program (example: Fagerstrom Test, etc.).
- Under the “Treatment Plan” section, circle those items where interventions for addressing tobacco use have been added or integrated into your program (example, circle “Tobacco Awareness Group”, if it was added to your program, circle “Individual Counseling” if it is being provided for addressing tobacco use, etc.).
 - Under “Treatment Plan,” in the blank boxes you can also write-in any additional items not listed but used in your program.

Continued on next page

MAT Activity Grid

Modality (Select one)						
Outpatient	Medication-Assisted	Crisis	Half-Way House	Inpatient	Community Residential	Intensive-Residential
Tobacco Interventions Integrated into Assessment (Select all that apply)						
Releases of Information	Intake	Medical Exam	Urine/Breath Tests	CO Monitor	Psychosocial Evaluation	Mental Status Exam
Tobacco Interventions Integrated into Treatment Plan (Select all that apply)						
Special Issues Group includes tobacco use	Therapeutic Recreation	Physical Fitness	Co-occurring Recovery Group includes tobacco use	Referral to Specialists including tobacco use	Other Evidence-Based Treatment for tobacco	Tobacco Medication (NRT and Non-NRT)
Family Sessions includes tobacco use	CO Monitoring	Tobacco Self-Help Groups	Addiction Treatment Medication	Individual Counseling includes tobacco	Nutritional Counseling includes tobacco use	Community Meetings includes tobacco use
Group Therapy includes tobacco use	Psycho-education includes tobacco use	Tobacco Recovery Group	Psychiatric Medication	Tobacco Awareness Group	Other Interventions in program	Urine, Blood, Hair for Cotinine

Modality, Assessment, and Treatment Plan

Questions to Consider

Respond to the following questions using a scale of 1 to 10 (1 being low and 10 being high)

- How successful has your agency been with integrating tobacco use interventions into your assessment and treatment process?
Low 1 2 3 4 5 6 7 8 9 10 High
- What tobacco treatment interventions are working well at your agency?
- What barriers has your program encountered while working to integrate tobacco treatment interventions?

Continued on next page

Modality, Assessment, and Treatment Plan, Continued

**Evidenced-
Based
Tobacco
Dependence
Treatment
Interventions**

Successfully treating tobacco dependence in chemical dependence programs and problem gambling programs is made possible by the integration of evidence-based practices as outlined in the Clinical Practice Guideline, 2008 Update (Fiore, Jaen, Baker, et al., 2008).

The combination of tobacco treatment medications (nicotine replacement therapy and non-nicotine medications), supportive counseling (motivational interviewing, cognitive behavioral therapy, practical problem-solving, and coping skills training) increases the likelihood of achieving and maintaining long-term abstinence from tobacco.

Treatment Plan Principles

Treatment Plan Principles

- An individualized treatment plan is a vital agreement between the patient and the treatment agency.
 - It clarifies the patient's reasons for seeking treatment, the needs or problems that will be addressed, the type of care that will be provided, the specific activities in which the patient will participate, and the expected outcomes.
- Comprehensive assessments should examine biological, psychological, and social areas of the patient's life, and treatment plans should draw upon data from all three areas.
 - Patient problems are as diverse as the population of patients that are served. Substance use disorders have biological, psychological, and social components, and each these areas will vary in severity depending upon each patient.
- In the past, treatment for was often presented using a "one size fits all" approach ("program-driven" approach). Most patients participated in the same activities and clinicians used limited tools, often without the patient's involvement in developing the treatment plan. The unique patient's needs or wants were often not reflected and the patient was expected to fit into the program's schedule.
- In recent years, a philosophical shift has moved treatment and treatment planning from being "program driven" to "individualized" and "patient-driven" treatment plans.
 - Patients vary in the amount of care and level of care needed. With a growth of evidenced-based behavioral and pharmacological interventions, treatment providers are now able to target a patient's needs more effectively.
 - Individualized treatment plans should be designed or "sized" to match a patient's problems and needs. Individualized treatment improves patient retention and outcomes.
- Collaboration between the patient and the clinician is vital and helps to improve the patient's willingness to follow-through and complete the treatment plan objectives.

Adapted from the Northwest Frontier Addiction Technology Transfer Center, May 2006.

Continued on next page

Treatment Plan Principles, Continued

Treatment Plan Principles, cont'd

- “Treatment plans are living, continuously evolving documents intended to guide treatment interventions and track the patient’s progress” (Joint Commission on Accreditation of Health Care Organizations, *Patient Records in Addiction Treatment-Documenting the Quality of Care*, 1992).
- A patient must be assessed periodically and the treatment plan modified as necessary to ensure that the plan meets the patient's changing needs and circumstances.
- A patient may require varying combinations of services and treatment components (Integrated Program of Therapies and Activities, IPTA), during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medications, other medical services, family therapy, parenting instruction, vocational rehabilitation, social, and/or legal services.
- It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

Adapted from National Institute on Drug Abuse, 2000.

Common Treatment Plan Components

Common Treatment Plan Components

Treatment plans typically have several components. In addition to being written in compliance with agency guidelines and policies, regulatory requirements, and payer expectations, treatment plans will include:

- Diagnoses
- Problem statements
- Goal statements
- Objectives
- Treatment interventions (IPTA)

Indicating a patient's stage of change for each problem is helpful towards guiding the type of interventions that should be used.

OASAS Regulations and Treatment Plans

OASAS Regulations

OASAS operating regulations require that all treatment plans minimally address the following functional areas:

- Addiction
- Social
- Emotional
- Family
- Educational
- Vocational
- Employment
- Legal
- Mental Health
- Physical Health

While there are many common elements in treatment plans in different modalities, OASAS providers should familiarize themselves with the OASAS operating regulations specific to their service type.

Unit 3

Treatment Plan Case Studies

Purpose Unit 3 allows participants to review the components of a treatment plan. This will be accomplished by reviewing a sample case study and treatment plan, followed by the practice of writing each of the required components using a case study activity.

Objectives Using a sample case study, identify a patient's stage of change, diagnosis, problem statements, goals, objectives, and plan for therapies and activities

Using a case study, demonstrate the ability to write the key components of a treatment plan, that integrates tobacco use interventions

Treatment Plan Case Study for Mary Ann

**Case Study 1
MaryAnn** Refer to Case Study 1 for MaryAnn and the completed Case Study Activity Worksheet for MaryAnn in the Appendix of your manual.

- The treatment plan activity will only focus on MaryAnn's tobacco problems.
 - Please read about Mary Ann and read the completed Case Study Activity Worksheet (which is a treatment plan).
 - As you read this example, make note of the components of a treatment plan, including stage of change, diagnoses, problem statements, goal statements, objectives, and IPTA.
 - You can use this example about MaryAnn as a model when your small group practices writing a case study treatment plan later in this unit.
-

Case Study Application Activity

Case Study Practice Activity

For this activity, your small group will be assigned a case study (Case Study 2, 3, 4, or 5) found in the Appendix and will use the Case Study Activity Worksheet.

You and your small group will be working through this activity in steps. This will include a review of each step and practicing how to write each section by drawing from an assigned case study. The steps are:

- Step One-Assessing stage of change
- Step Two-Diagnosing substance use disorders
- Step Three-Writing problem statements
- Step Four-Writing goal statements
- Step Five-Writing objectives
- Step Six-Integrated Program of Therapies and Activities (IPTA)

For each step, there will be discussion, practice, and process.

Step One-Assessing Stage of Change

Review-Stages of Change

The important point for this review is that treatment interventions should be matched to the patient's stage of change.

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

As explained in other modules, motivational interviewing approaches work best in the earlier stages of change (precontemplation and contemplation) however, motivational approaches can be useful during any stage to address ambivalence or to help build a sense of collaboration. In general, cognitive-behavioral approaches are more effective in the later stages of preparation, action, and maintenance.

Continued on next page

Step One-Assessing Stage of Change, Continued

Step One- Assessing Stage of change

Practice

As a small group, please read your assigned case study, then identify the stage of change regarding tobacco use for the patient.

Now complete Section I. "Stage of Change" on the blank Case Study Activity Worksheet.

Step One- Assessing Stage of change, cont'd

- How easy (or difficult) was it to assess stage of change for your case study patient?
 - What was the evidence from the case that you used to support the stage selected?
-

Step Two-Diagnosing Tobacco Use Disorders

Diagnosing Tobacco Use Disorders

It is important to understand the Diagnostic and Statistical Manual of Mental Disorders IV, Text Revision (DSM-IV-TR) criteria, terminology, and coding for nicotine dependence, nicotine withdrawal, and for other substance use disorders.

The DSM-IV-TR diagnosis code for nicotine dependence is 305.1 and the DSM-IV- TR diagnosis code for nicotine withdrawal is 292.0.

As explained earlier, nicotine is the primary psychoactive drug in tobacco, but for many reasons previously noted, the term “tobacco dependence” is used.

This term is especially helpful when discussing tobacco use with patients and are similar to DSM-IV-TR referring to cannabis dependence, rather than tetrahydrocannabinol (the main psychoactive chemical in marijuana) dependence. It is also helpful to use the term “tobacco dependence”, when discussing nicotine replacement therapy, so that patients are not as prone to argue, “why should I take nicotine in order to stop using nicotine?”

However, for chart documentation and treatment planning purposes, the DSM-IV-TR terms “nicotine dependence” and “nicotine withdrawal”, along with their assigned codes must be used.

Continued on next page

Step Two-Diagnosing Tobacco Use Disorders, Continued

Reminder Due to a lack of empirical evidence, the Diagnostic and Statistical Manual for Mental Disorders, IV, Text Revised (DSM-IV-TR) does not have criteria or codes for nicotine abuse or nicotine intoxication.

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

- A. Daily use for several weeks.
- B. Abrupt cessation in use or reduction in use is followed by four (4) or more of the following specific symptoms within 24 hours after cessation or reduced use of the nicotine: dysphoric mood, insomnia, irritability, anxiety, difficulty concentrating, restlessness, decreased heart rate, increased appetite, or weight gain.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. Symptoms are not due to a general medical condition and are not accounted for by another mental disorder.

(American Psychiatric Association, 2000)

Continued on next page

Step Two-Diagnosing Tobacco Use Disorders, Continued

DSM-IV-TR Criteria for Nicotine Dependence

It is important to remember there are no additional criteria for nicotine dependence (305.1). Diagnosing tobacco dependence requires applying the DSM-IV-TR criteria for substance dependence which are:

- A maladaptive pattern of substance use, leading to clinical significant impairment or distress, with 3 or more of the following in any 12 month period
- Three or more of the following has occurred in the previous 12 months:
 1. Tolerance—either an increased amount use to obtain desired effect or diminished effect from continued use of same amount.
 2. Withdrawal—symptoms occur after cessation of substance and the symptoms cause clinically significant impairment in social, occupational, or other important area of functioning.
 3. Larger amounts used or used for longer periods than intended.
 4. Persistent desire or unsuccessful effort to cut down or control use.
 5. Great deal of time spent in substance-related activities, to obtain substance or to recover from effects of using substance.
 6. Important social, occupational, or recreational activities given up or reduced due to use substance.
 7. Substance use continues despite knowledge of persistent physical or psychological problems caused or exacerbated by substance use.

Note: a substance dependence diagnosis is specified with or without physiological dependence, however in most cases, people with nicotine dependence (tobacco dependence) will have withdrawal if they abruptly stop using tobacco or try to “cut down” their use.

(American Psychiatric Association, 2000)

Continued on next page

Step Two-Diagnosing Tobacco Use Disorders, Continued

Step Two- Diagnosing Substance Use Disorders

Practice

After reviewing the DSM-IV-TR criteria and codes, return to your case study and decide if there should be a diagnosis of nicotine dependence or nicotine withdrawal (tobacco dependence or withdrawal).

Please complete Section II. “Diagnoses” on the blank Case Study Activity Worksheet. There is also a summary of DSM-IV-TR criteria on nicotine dependence and withdrawal on page 80.

Step Three-Writing Problem Statements

Problem Statements

It is important to list all of the problems identified in the assessment, but is often not possible to address all of the problems during the course of treatment. Some problems will need to be priorities and others will be deferred.

Prioritizing of problems occurs through the collaborative process between the clinician and patient. In addition, the patient's readiness, ability, and willingness to address problems will vary. For example, a patient may be able and willing to address alcohol use but not tobacco use. The result is that tobacco use is not a high priority for the patient nor is he/she ready to address this problem. However, by listing all problems, the process of addressing the patient's ambivalence has begun and you may begin to build discrepancy through appropriate treatment interventions.

Problem statements should be:

- Specific
- Observable
- Measureable
- Non-judgmental
- Avoiding the use of jargon

Continued on next page

Step Three-Writing Problem Statements, Continued

**Problem
Statement
Examples**

Compare the two problem statements below:

Patient is in denial that tobacco use is a problem for him.

and

Patient continues to use tobacco despite being advised by his physician that tobacco use is making his asthma and hypertension worse.

What are the differences between statement 1 and statement 2?

**Problem
Statement
Exercise**

Please look at this problem statement and explain what is wrong with this example:

Patient is resistant to engaging in a dialogue about her tobacco use.

Re-write the above problem statement:

Is there anything wrong with this problem statement?

Patient states that addressing her other alcohol and cocaine dependence is more important at this time than addressing her tobacco use.

Continued on next page

Step Three-Writing Problem Statements, Continued

Step Three- Writing Problem Statements

Practice

Please return to your case study and write three problem statements that are related to the patient's tobacco use. Complete Section III "Problem Statements" on the Case Study Activity Worksheet.

Your problem statements should be:

- Specific
 - Observable
 - Measureable
 - Non-judgmental
 - Avoiding the use of jargon
-

Step Four-Writing Goal Statements

Goal Statements

Collaboration with the patient is important to establishing treatment goals.

After reviewing the problem statements with the patient to assure its completeness and accuracy, the clinician and the patient need to prioritize the list and agree which problems will initially be addressed in the treatment plan.

It is important that the clinician and the patient agree on the goals and that the patient “buys in” to the goal. By using the following guidelines, consensus and buy-in will be enhanced.

- Goal is clear and easy to understand
- Goal is free of clinical jargon
- Goal is attainable while the patient is in the program
- Goal should reflect the patient’s stage of change
- Clinician and patient understand and agree on the goal

OASAS operating regulations require that the treatment plan address at a minimum the following functional areas: addiction, social, emotional, family, educational, vocational, employment, legal, mental, and physical health. Therefore, goals should be formulated for each of these areas, and be clearly reflected on the treatment plan.

Continued on next page

Step Four-Writing Goal Statements, Continued

A Strategy for Writing Goal Statements One strategy for writing goal statements is to take the tobacco-specific problem statements and reframe them into goal statements. Look at the example listed below:

Problem Statement:

Patient states that addressing her alcohol and cocaine dependence is more important to her at this time than addressing her tobacco dependence.

Reframed into a Goal Statement:

Patient will increase her awareness about how continued tobacco use has a negative effect on her recovery from alcohol and cocaine dependence.

Reframing Problem Statements

Look at the first example and then how it is reframed.

Problem Statement:

Patient continues to use tobacco despite being advised by his physician that the tobacco use is making his asthma and hypertension worse.

Reframed as a Goal Statement:

Patient will identify the negative effects of his tobacco use on his health problems, such as asthma and hypertension.

Continued on next page

Step Four-Writing Goal Statements, Continued

**Reframing
Exercise**

Now reframe these two tobacco-specific problems statements into goal statements:

Patient has received two verbal warnings and one written warning at work due to excess smoking breaks and his job is in jeopardy.

Child Protective Services completed two investigations and decided that the patient was leaving her children alone to go outside to smoke and leaving the house to purchase cigarettes.

Continued on next page

Step Four-Writing Goal Statements, Continued

Step Four- Writing Goal Statements

Practice

After reviewing the section on goal statements, return to your Case Study Activity Worksheet and reframe the three problem statements that you wrote into goal statements.

Complete Section IV. “Goal Statements” on the Case Study Activity Worksheet”

Step Five- Writing Objectives

SMART Objectives

After developing the problem statements and goal statements, the next step in the treatment planning process is the development of objectives. Objectives are statements of action about what the patient will do to work towards achieving the goals that have been collaboratively established. They are concrete, measureable representations of a clinical goal.

The SMART model for developing objectives is a useful tool to guide the clinician in this process. Characteristics of effective objectives are:

- **S**pecific
 - **M**easureable
 - **A**ttainable
 - **R**ealistic
 - **T**ime-limited
-

The Value of SMART Objectives

Using the SMART method of developing objectives has several advantages:

- Makes it easier to document progress
 - Identifies objectives that can be completed within the level of care provided and move closer to reaching the goals
 - Increases the patient's self-efficacy
 - Are easily understood by the patient and clinician
 - Identifies the need for referral to outside agencies
-

Continued on next page

Step Five- Writing Objectives, Continued

SMART Objectives Exercise

Please look at the following two objectives: Do they pass the SMART test? Why or why not?

Patient will attend group therapy per program schedule to increase his knowledge about how tobacco use affects his other chemical dependence.

Upon completion of the Tobacco Awareness Group, patient will be able to verbalize the importance of addressing her tobacco use, in order to achieve a healthy change.

- Specific
 - Measureable
 - Attainable
 - Realistic
 - Time limited
-

Step Five- Writing Objectives

Practice

After reviewing the section on objectives, return to your Case Study Activity Worksheet and write three objectives that pass the SMART test.

Step Six-Integrated Program of Therapies and Activities

Integrated Program of Therapies and Activities (IPTA)

The Integrated Program of Therapies and Activities (IPTA) defines the clinician's role, the services, and the resources available at your treatment agency to help the patient meet their goals.

In the MAT activity completed earlier in Unit 2, you identified the specific tobacco treatment interventions at your agency.

In this next step, you will use the IPTA identified to address the tobacco use and tobacco dependence issues of your case study patient.

In the event that you are not from a treatment agency, you may use a theoretical IPTA.

More About an Integrated Program of Therapies and Activities (IPTA)

These are some examples of IPTAs:

- Tobacco Awareness Group, 90 minutes, once per week for 5 weeks.
 - Individual counseling sessions (25-30 minutes) once per week for 5 weeks.
 - Nicotine patch: 21 mg/24 hours for 4 weeks; then 14 mg/24 hours for 2 weeks; then 7 mg/24 hours for 2 weeks.
 - Nicotine gum, 2mg, ad libitum (as needed).
-

Continued on next page

Step Six-Integrated Program of Therapies and Activities, Continued

**Step Six-
Integrated
Program of
Therapies and
Activities
(IPTA)**

Practice

After reviewing the section on IPTA, return to your Case Study Activity Worksheet and write three specific tobacco treatment interventions (IPTA) for your case study patient.

Please complete Section VI. "IPTA" on the Case Study Activity Worksheet.

**Step Six-
Integrated
Program of
Therapies and
Activities
(IPTA), cont'd**

Why did you choose these specific tobacco treatment interventions?

Treatment Plan Review

Treatment Plan Review

A patient's completion of an IPTA does not by itself signify that the goals and objectives have been achieved. If the goal as stated in a specific functional area of the treatment plan has not been achieved, then objectives and integrated therapies and activities need to be revised or added. This process takes place during a treatment plan review. A treatment plan revision is done in collaboration with the patient and should describe how the goals and objectives will be achieved.

Illustrating the Treatment Plan Process

**Summarizing
the Treatment
Planning
Process**

Treatment Plan Development Process

Problem Statements (identified from the comprehensive assessment)



Goal Statements (broad outcomes, which can be created by reframing the problem statements into a goal)



Objectives (what specific and measureable actions or steps the patient will take to reach each goal)



IPTA (what the clinician/agency will do to help the patient complete his/her objectives and achieve the goals)

Module Summary

Module Summary

Successfully integrating tobacco use interventions into chemical dependence programs requires knowledge of the biopsychosocial nature of tobacco dependence, the ability to perform an accurate comprehensive assessment, and the availability of effective treatment interventions (Integrated Program of Therapies and Activities, IPTA).

Diagnoses for substance use disorders need to be made based upon DSM-IV-TR criteria and treatment interventions should then be matched to the stage of change for each patient.

The components of a comprehensive treatment plan, i.e., problem statements, goal statements, objectives, and interventions, will often be consistent across many agencies and modalities. The degree of integration of tobacco treatment interventions will likely vary among treatment programs.

The Clinical Practice Guideline, 2008 Update (Fiore, Jaen, Baker, et al., 2008), states that the combination of medication and supportive counseling is the most effective way to treat tobacco dependence.

In Modules 1, 2, and 3 of this training series, key material was presented including the assessment and diagnosis of tobacco dependence, the use of tobacco treatment medications (nicotine replacement therapy and non-nicotine medications), and the use of effective behavioral treatment interventions. As a clinician, you will need this knowledge and skill set in order to write a comprehensive treatment plan that includes tobacco treatment interventions.

Reassessing Knowledge/Skills and Confidence to Write Treatment Plans

Re-assessing Knowledge and Skills for Completing Treatment Plans

Please revisit the two scaling questions that you answered in Unit 1.

Using a 10-point scale with 1 being low and 10 being high, how knowledgeable are you now about writing treatment plans?

Low 1 2 3 4 5 6 7 8 9 10 High

Using a 10-point scale with 1 being low and 10 being high, how confident are you now about your ability to write a comprehensive treatment plan, which integrates tobacco interventions?

Low 1 2 3 4 5 6 7 8 9 10 High

How much did your scores change and what helped your scores to change?

Resources

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

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

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

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

Continued on next page

Resources, Continued

**Resource
Directory,
cont'd**

NYS Medicaid Policy Smoking Cessation Policy

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

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

American Cancer Society 1-800-227-2345

American Lung Association 1-800-586-4872

References

- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington, DC, American Psychiatric Association, 2000.
- Campaign for Tobacco-Free Kids (2006). The toll of tobacco in New York. Available online. Retrieved April 17, 2008 from <http://www.tobaccofreekids.org/reports/settlements/toll.php?StateID=NY>.
- 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*.
- Centers for Disease Control and Prevention (CDC). (2009). State-Specific Prevalence and Trends in Adult Cigarette Smoking - United States, 1998 - 2007. *MMWR* 2009; 58(09);221-226. Retrieved September 1, 2009 <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5809a1.htm>
- Centers for Disease Control and Prevention (CDC). (2008). National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). *Targeting tobacco use: the nation's leading cause of preventable death, at a glance 2008*. Retrieved July 25, 2008 from www.cdc.gov/NCCDPHP/publications/aag/osh.htm.
- Centers for Disease Control and Prevention (CDC) (2007). *Cigarette smoking among adults -- United States (2006)*. *MMWR* 2007; 56(44); 1157-1161. Retrieved April 17, 2008 from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5644a2.htm>.
- Fiore M.C., Jaen, 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.
- Hurt et al.,(1996) .Hurt, R.D., Offord, K.P., Croghan, I.T., Gomez-Dahl, L., Kottke, T.E., and 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*.
- Hser, et al., (2001). Hser,Y-I, Hoffman, V., Grella, C.E., and Anglin, M.D. (2001). "A 33-year follow-up of narcotics addicts." *Archives of General Psychiatry, 58: 503-508*.
- Joint Commission on Accreditation of Health Care Organizations, *Patient Records in Addiction Treatment-Documenting the Quality of Care*, 1992. Chicago, Illinois.
- National Institute on Drug Abuse. (2000). *Principles of Drug Addiction Treatment: A Research Based Guide*. National Institute of Health. NIH Publication No. 00-4180. Accessed December 15, 2008 from <http://www.nida.nih.gov/podat/PODATIndex.html>

Continued on next page

References, Continued

- Northwest Frontier Addiction Technology Transfer Center. (2006). *Addiction Messenger*, Volume 9, Issue 5, May 2006. Accessed December 15, 2008
<http://www.attcnetwork.org/userfiles/file/NorthwestFrontier/Vol.%209%20Issue%205.pdf>
- Prochaska et al., (2004). Prochaska, J. J., Rossi, J.S., Redding C.A., Rosen A.B., Tsoh, J.Y., Humfleet G.L., Eisendrath S.J., Meisner, M.R. and Hall S.M. (2004). Depressed smokers and stage of change: implications for treatment interventions. *Drug and Alcohol Dependence*, 76: 143-151.
- Prochaska et al. (2008). Prochaska, J.J., Hall, S.M., Tsoh, J.Y., Eisendrath, S., Rossi, J.S., Redding, C.A., Rosen, A.B., Meisner, M., Humfleet, G.L., Gorecki, J.A., (2008). Treating tobacco dependence in clinically depressed smokers: effect of smoking cessation on mental health functioning. *American Journal of Public Health*, 98(3), 446-448.
- Sobell, M.B., Sobell, L.C., and Kozlowski, L.T. (1995). Dual recoveries from alcohol and smoking problems. In: Fertig, J.B., and 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.
- 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. *The health consequences of involuntary exposure to tobacco smoke: A report of the Surgeon General*. Washington, DC 2006. Retrieved April 17, 2008 from www.surgeongeneral.gov/library/secondhandsmoke/report.
- 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.
- White, W.L., (1998). *Slaying the Dragon The History of Addiction Treatment and Recovery in America*. Bloomington, Ill. Chestnut Health Systems.
-

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

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

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

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 intentionally blank

Appendix

Case Study 1 (MaryAnn)

Completed Case Study Activity Worksheet for MaryAnn

Case Studies 2-5 (Alvin, Jorge, Barbara, and Bill)

Case Study Activity Worksheet (Two Blank Copies)-Participant Version

DSM-IV-TR Criteria for Substance Withdrawal and Substance Dependence

Case Study 1 (MaryAnn)-Medication Assisted Treatment Program Example

MaryAnn P. is a 30-year-old separated white female who is referred to your methadone clinic by her social worker. MaryAnn lives with her two children, ages four and three, in an apartment in an urban area. She is currently in a relationship with a man but doesn't talk much about him.

- MaryAnn was prescribed “painkillers” after the birth of her second child and tells you that until a few months ago, she was “doing the doctor thing” and seeing multiple physicians to obtain narcotic medications.
- Anita, MaryAnn’s mother, is concerned about MaryAnn’s chain smoking in the apartment and how this may aggravate the oldest child’s asthma. Mary Ann smokes from 1 to 1½ packs (20-30 cpd) per day.
- Sometimes when Anita visits there is no food in the apartment, so she goes out and stocks up MaryAnn with groceries and necessities, including a supply of cigarettes.
- MaryAnn gets frantic, when she runs out of cigarettes and cannot concentrate until she has obtained more cigarettes. She has even left the children alone at times to go to the store to obtain more.
- Anita has expressed concerns to the social worker that MaryAnn is often depressed, irritable, and restless when she runs out of cigarettes.
- She shares with you that she has been injecting heroin for several months. This has increased from a few times per week to daily use.
- She states that she smokes more tobacco when she is using heroin. MaryAnn also shared that she is about two months pregnant, and is worrying about the effects of her smoking and heroin use on her pregnancy.
- 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 using tobacco so many times she can’t remember how often. She has been without cigarettes for 16 hours and is feeling frustrated and angry.

Case Study Activity Worksheet-for MaryAnn

Patient: MaryAnn P.

I. Stage of Change for Tobacco Use: *Precontemplation or Contemplation*

Reminder: It is important to assess the stage of change in order to match the Integrated Program of Therapies and Activities (IPTA) to the patient's readiness to change.

II. Diagnoses

DSM-IV tobacco diagnosis: *Nicotine (Tobacco) Dependence, 305.1*

As evidenced by:

- *Tolerance*
- *Withdrawal*
- *Great deal of time spent using tobacco*
- *Persistent desire/unsuccessful efforts to cut down or control tobacco use*
- *Continued tobacco use despite knowledge of consequences*

DSM-IV tobacco diagnosis: *Nicotine (Tobacco) Withdrawal, 292.0*

As evidenced by:

- *Depressed or dysphoric mood*
- *Irritability*
- *Anxiety*
- *Restlessness*
- *Difficulty concentrating*

III. Problem Statements

This list includes tobacco-related problems only.

1. *MaryAnn chain smokes cigarettes in her apartment when her children are present, thereby exposing them to the harmful effects of second-hand smoke.*
2. *MaryAnn experiences nicotine withdrawal symptoms when she discontinues the use of tobacco.*

III. Problem Statements, continued

3. *MaryAnn is pregnant and continues to smoke tobacco, exposing her unborn child to possible harmful effects.*

IV. Goal Statements

The following goal statements are reframes of the problem statements listed above. These statements assume the patient is willing and agreeable to these goals.

1. *MaryAnn will assure that her apartment is a “smoke-free” space.*
2. *MaryAnn will successfully manage withdrawal from tobacco.*
3. *MaryAnn will achieve abstinence from tobacco to minimize the dangers to herself and her unborn child.*

V. Objectives (Specific, Measurable, Attainable, Realistic, and Time-limited)

This section shows an example of at least one objective for each goal that is listed in Section IV. These assume the patient is willing and agreeable to these objectives.

1. *MaryAnn will sign an agreement with her primary counselor to maintain a “smoke-free” apartment while in the treatment program. Weekly check-ins will be made by her caseworker to ensure compliance.*
2. *MaryAnn will comply with taking her tobacco treatment medication as recommended by the agency physician.*
3. *MaryAnn will attend group and individual counseling sessions per her individualized treatment plan.*
4. *After five (5) weeks in the program, MaryAnn will list at least three (3) reasons why her tobacco use may cause problems for her unborn child.*

VI. Integrated Program of Therapies and Activities (IPTA)

This example only shows therapies and activities for tobacco. Additional therapies and activities would be included for other problems identified.

1. *Individual counseling, for 30 minutes, 1x every other week for 12 weeks*
2. *Group counseling focused on all substance use, 90 minutes, 1x per week for 12 weeks*
3. *Tobacco awareness group, 90 minutes, 1x/week for 5 weeks*
4. *Bupropion, 150 mg daily for 3 days, then 150 mg 2 times per day for 12 weeks.*
5. *Carbon monoxide monitoring, 1x/week for 12 weeks*

Case Study 2 (Alvin C.)-Inpatient Example

Alvin C. is a 44-year-old African-American male who presents at your inpatient treatment center. Alvin was referred by his physician due to being a heavy marijuana user, plus daily use of alcohol that has increased significantly.

- Alvin said that he is not ambitious and doesn't see "what all the fuss is about". He enjoys his job, works hard, and has no desire to "move up the management ladder".
- He stated that his supervisor likes him, he shows up every day, and is always on time, although he has been spoken to about taking too many smoke breaks. Alvin admits that he gets jumpy and irritable when he "goes too long" between cigarettes.
- Alvin began using marijuana at 19 years of age and has been a daily user for several years. Alvin has also been using tobacco since age 13, and smokes "a few joints" of marijuana plus two packs of cigarettes a day.
- He admits despite efforts to control his drinking, over the years his alcohol use increased from an occasional beer to "five or six a night".
- Alvin's daily routine revolves around tobacco and marijuana use, beginning with smoking 1 or 2 cigarettes within five minutes of waking and smokes several more before he goes to work at 9:00 a.m.
- Alvin smokes cigarettes on work breaks as often as he can and on non-work days, smokes cigarettes throughout the day. When he gets home from work at about 6:00 p.m., he smokes many cigarettes before and after dinner, and then sits in front of the TV smoking marijuana and drinking beer before going to bed.
- Alvin states that his wife and physician are making too big a deal about his marijuana and tobacco use, and states he uses both substances to help him relax.
- He knows that tobacco isn't good for his health, and it is getting expensive, but he enjoys smoking and is not sure he could quit anyway.
- He is wondering if his "drinking is getting out of control" and if he should stop.

Case Study 3 (Jorge R.)-Crisis Clinic

Jorge R. is a 27-year-old Hispanic/Latino male who is referred to your crisis clinic. He was brought to the emergency room in the early morning by his girlfriend, who discovered him passed out. It is believed he took some hydrocodone pills and smells of alcohol.

- Jorge's BAC at the emergency room is .26% when he becomes conscious, but as his alcohol level decreases to .15% he becomes agitated, his pulse rate increases, he has mild sweating and mild hand tremors.
- Jorge indicates that he has been thinking about "getting some help for my drinking" and this idea has been on his mind for a while.
- He values his relationship with his girlfriend and didn't want to ruin it with too much drinking.
- Jorge has a strong tobacco smell, and a pack of cigarettes in his shirt pocket.
- He states he is a daily drinker but the amount he uses varies, and sometimes he loses track of how much he drinks. He has passed out before and thinks this is what happened during another incident were he woke up in the ER.
- It appears he has been drinking more over the last several months, and has been sneaking beers in the morning.
- He received the hydrocodone after an impacted tooth was pulled but doesn't remember taking any before he passed out.
- Jorge is surprised when asked about his tobacco use, stating he really wants to address his drinking and that tobacco helps him to relax.
- When he doesn't smoke, he is very anxious and "jittery" and when he was in the ER for several hours, he was "jonesing" for a cigarette.
- He describes himself as a chain smoker using more than two packs per day (greater than 40 cpd) and more when he is drinking heavily.
- He acknowledges that tobacco use is harmful and has developed a chronic cough, but can't imagine stopping tobacco use, much less quitting tobacco and alcohol at the same time.
- His girlfriend with whom he lives, is not concerned about his tobacco use, and she also smokes. She states that smoking together is the only time the two of them can be at ease with each other.
- Jorge's job may be in jeopardy as he has missed two important work deadlines, and has a pattern of missing work on Mondays.

Case Study 4 (Barbara G.)-Therapeutic Community

Barbara G. is 29-year-old single white female and was referred by her probation officer to a therapeutic community (TC). She was arrested after trying to buy cocaine. She currently lives with her parents and was fired a week ago after she was caught on the surveillance camera stealing money from the cash register.

- Barbara was on probation for cocaine possession and was again arrested after a traffic stop resulting in the discovery that she possessed cocaine. She agreed to enter a TC instead of taking a jail sentence.
- She asks if it's OK to smoke and is told "no", so asks to go outside to smoke because she gets "really shaky and nervous" if she can't smoke, and "had a really hard time without cigarettes" when she was in jail for 3 days after her arrest.
- After smoking off grounds, she returns and is much calmer when she comes back in.
- She lives with her parents and can't afford her own place as she spent most of her money on cocaine. She has traded sex for drugs and even cigarettes.
- She uses cocaine often, usually a few times per week. The only reason she didn't use every day was lack of money and owing money to a dealer. She sold her used car for cocaine and cigarettes.
- Barbara has tried to stop using cocaine twice without success, but has never tried to stop smoking. She states that would be too stressful, even though she knows how smoking is harmful.
- She gets very anxious and nervous if she runs out of cigarettes, or cannot "pawn off someone". She has driven to the store late at night to get more. She uses at least a pack a day, sometimes twice that when stressed or without cocaine.
- The only time she has been completely drug and tobacco-free has been in rehab as an adolescent and as an adult, and while in jail.
- She has never had a stable relationship, as she always attaches herself to other drug users all who smoke tobacco. She lacks friends and her social life revolves around use of cocaine and tobacco.
- She is extremely fearful that she cannot smoke while in the program and fears she will not be able to stay and avoid jail.

Case Study 5 (Bill J.)-Outpatient Example

Bill J. is a 36-year-old white male coming with his wife Amy to the outpatient clinic. Bill is employed full-time and is annoyed about being mandated to attend the session. Amy's son John, who is nine years old, also lives with them.

- Amy states Bill drinks too much and stinks of cigarettes, and she has to “nag” him to stop. Bill claims if he weren't so depressed, that he would not drink so much.
- Bill drinks at least a six-pack of beer and often a few mixed drinks every day, and has been increasing the amount over the last several months, it never used to be daily.
- His tobacco use has increased over the years from about ½ a pack (10 cigarettes per day) (10 cpd) to a pack and a half per day (30 cpd). He has a chronic cough, which he attributes to allergies. However, his physician says it is smoking-related.
- Bill has a cigarette immediately when waking up and it's the last thing he does before going to bed. Because John has mild asthma, Bill smokes outside, however Amy complains that secondhand smoke comes in the house and Bill's clothes smell of smoke.
- Bill sees no reason to stop drinking or smoking, stating these are the only things that relax him and make him feel better.
- He used to work out at a local gym and play golf, but he has given those activities up in the past eight months, as he would rather have a few cold ones at the house. According to him, “smoking and drinking always go together.”
- They rarely go out socially and Bill refuses to go anywhere where he can't smoke.
- Bill argues he is not hurting anybody but himself, and states he has tried to stop smoking “a bunch of times but finally gave up”.
- As he is often drinking and driving, when Amy asks what would happen if he killed somebody driving drunk, he states maybe “everybody would be better off if I wasn't around”.

Case Study Activity Worksheet-Participant Version

Patient _____

I. Stage of Change for Tobacco Use _____

II. Diagnoses

DSM-IV nicotine (tobacco) diagnosis(diagnoses _____

III. Problem Statements

1. _____

2. _____

3. _____

IV. Goal Statements

1. _____

2. _____

3. _____

V. Objectives (Specific, Measurable, Attainable, Realistic, and Time-limited)

1. _____

2. _____

3. _____

VI. Integrated Program of Therapies and Activities

1. _____

2. _____

3. _____

Case Study Activity Worksheet-Participant Version

Patient _____

I. Stage of Change for Tobacco Use _____

II. Diagnoses

DSM-IV nicotine (tobacco) diagnosis (diagnoses) _____

III. Problem Statements

1. _____

2. _____

3. _____

IV. Goal Statements

1. _____

2. _____

3. _____

V. Objectives (Specific, Measurable, Attainable, Realistic, and Time-limited)

1. _____

2. _____

3. _____

VI. Integrated Program of Therapies and Activities

1. _____

2. _____

3. _____

DSM-IV-TR Criteria for Substance Withdrawal

1. Daily use for several weeks
2. Abrupt cessation in use or reduction in use followed by four (4) or more of the following specific symptoms within 24 hours after cessation or reduced use of the nicotine: dysphoric mood, insomnia, irritability, anxiety, difficulty concentrating, restlessness, decreased heart rate, increased appetite, or weight gain
3. The symptoms causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
4. Symptoms are not due to a general medical condition and are not accounted for by another mental disorder

DSM-IV-TR Criteria for Substance Dependence

It is important to know that there are no additional criteria for nicotine dependence (305.1); it requires applying the DSM-IV-TR criteria for substance dependence as follows:

A maladaptive pattern of substance use, leading to clinical significant impairment or distress, with 3 or more of the following in any 12 month period

1. Tolerance-either an increased amount use to obtain desired effect or diminished effect from continued use of same amount
2. Withdrawal-symptoms occur after cessation of substance and the symptoms cause clinically significant impairment in social, occupational, or other important area of functioning
3. Larger amounts used or used for longer periods than intended
4. Persistent desire or unsuccessful effort to cut down or control use
5. Great deal of time spent in substance-related activities, to obtain substance or to recover from effects of using substance
6. Important social, occupational, or recreational activities given up or reduced due to use substance
7. Substance use continues despite knowledge of persistent physical or psychological problems caused or exacerbated by substance use

Note: a substance dependence diagnosis is specified with or without physiological dependence, however in most cases, people with nicotine dependence (tobacco dependence) will have withdrawal if they abruptly stop using tobacco, indicating physiological dependence.