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Co-occurring Disorders:

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

**Trainer's Manual
Module 5**



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

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About This Training

PDP Background

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

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

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About This Training, Continued

About the New York Tobacco Control Program

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

About the Tobacco Interventions Project

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

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

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

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

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About This Training, Continued

Tobacco Use: A Serious Public Health Problem

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

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

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

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About This Training, Continued

The Cost of Tobacco Use

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

Tobacco Use and Chemical Dependence

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

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

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

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

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About This Training, Continued

Tobacco Use and Co-occurring Disorders

Tobacco users, especially people who smoke tobacco, are over-represented among people who have substance use and/or mental health disorders. People with psychiatric disorders are two to three times more likely to smoke tobacco than the general population. Between 70-90% of people with schizophrenia smoke. Among people with depression and anxiety disorders, between 40-50% smoke. In fact, individuals with a mental health or substance use disorder consume 44% of all cigarettes sold in the U.S. (Campbell et al., 1998, Ziedonis and George, 1997, Lasser et al., 2000).

On average, people with serious mental illness die from 8 to 25 years earlier than the general population, primarily due to smoking-related illness (National Association of Mental Health Directors, 2006, Miller et al., 2006). Approximately 200,000 people with mental illness and/or addiction die each year from tobacco-related illnesses (Williams and Ziedonis, 2004, Brown et al., 2000, Hurt et al., 1996).

Addiction professionals often express concerns about addressing patients' tobacco use, fearing the stress of stopping tobacco will impede or jeopardize recovery. There are similar concerns expressed by mental health professionals for mental health patients: "what else are people going to do if they cannot smoke?", "pushing people with mental illness to stop smoking tobacco will jeopardize their stability and raise the risk of hospitalization," or, "why take away this last pleasure/coping strategy?"

Many people who have mental health and/or substance use disorders are interested in stopping their tobacco use. Tobacco treatment medications, counseling, and monitoring psychiatric medications make stopping tobacco use achievable. Moreover, helping patients stop their tobacco use has a strong positive effect on their quality of life, improves their recovery, reduces morbidity, and increases their life span (Ziedonis et al., 2000, Lasser et al., 2000; Fiore et al., 2008).

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About This Training, Continued

Addressing Tobacco use and Co-occurring Disorders

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

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

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

Original Project Goals

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

Background Information for the Trainer

Trainer Note The trainer is an integral part of making this workshop format successful. This manual was designed to be a guide for creating and facilitating the training entitled *Co-occurring Disorders: 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 that you become familiar with both the Trainer and Participant manuals so that you can easily direct participants to particular pages as they are being discussed.

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

Unit 1 provides a brief review of material that was presented in earlier modules of this training, defines co-occurring disorders and co-morbidity, and helps participants examine their attitudes and beliefs about tobacco use among people with mental health and substance use disorders.

Unit 2 covers the prevalence of tobacco use among people with mental health and substance use disorders, the adverse effects tobacco use has on this population, and basic neurobiology of tobacco dependence and interactions with co-occurring disorders.

Unit 3 reviews evidence-based treatment for tobacco use and dependence covered in earlier modules and provides an opportunity to use case studies to apply new learning.

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Background Information for the Trainer, Continued

**Trainer Note,
Cont'd**

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

The purpose of this training is to build awareness and provide participants with the knowledge and skills they need to successfully integrate tobacco use interventions into the addiction services continuum, which will include working with tobacco using patients who have co-occurring mental health and substance use disorders.

Trainer Tips and Responsibilities

Trainer Tip

Adult Learning Principles:

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

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

Trainer Tip

As learners, adults:

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

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

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Trainer Tips and Responsibilities, Continued

Timeframes These timeframes are approximate.

<u>Units</u>	<u>Time</u>
Welcome and Introduction	15 minutes
Unit 1 – Attitudes and Beliefs, Challenges and Barriers	1 hour, 15 minutes
Unit 2 – Prevalence and Co-morbidity Factors	1 hour and 15 minutes
Break (Trainer Discretion)	15 minutes
Unit 3 – Treatment Strategy Review and Case Studies	45 minutes
Total Time	3 hours, 45 minutes

Continued on next page

Trainer Tips and Responsibilities, Continued

Materials and Supplies Needed

- Laptop and External Speakers for Audio-Video
- LCD Projector
- PowerPoint Slides and Video Files
- Trainer Manual
- Participant Manuals
- Flipcharts
- Easels
- Masking tape
- Markers
- Pre-prepared newsprint for activities
- Workshop Evaluation Forms (WEFs)
- 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 After welcoming the participants to the training, explain the following information:

Slide 1-3

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

- Introduce the trainer(s).
- Explain that the training was part of a project sponsored by the NYS Department of Health, Tobacco Control Program.

An introduction about the original project can be crafted based on the information found on page 4 of this Trainer Manual.

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
-

Welcome and Introductions, Continued

Welcome and Introductions, Continued

Trainer Note Refer participants to their PM and ask them to introduce themselves by stating their name, role, agency, and modality.
Slide 5

Trainer Note After introductions are completed, ask participants:

- By a show of hands, how many of you have previously taken the classroom training of Modules 1, 2, 3, or 4?
- How many of you have taken any of the modules online at www.tobaccorecovery.org?

Summarize by stating, *Module 5 will build upon the information and skills learned in the previous four modules.*

Overview of 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 9	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 5 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 10	

- Module 5
Agenda**
- Review and recap of prior modules
 - Explore personal attitudes and beliefs about addressing tobacco use among people with co-occurring mental health and substance use disorders
 - Prevalence and co-morbidity of co-occurring disorders
 - Basic neurobiology of tobacco dependence and interactions with co-occurring disorders
 - Review of treatment for tobacco dependence
 - Case Studies
-

- Module 5
Objectives**
- Define co-occurring disorders and co-morbidity
 - Identify attitudes and beliefs about treating tobacco use and dependence among people with co-occurring disorders
 - Identify the challenges of and barriers for addressing tobacco use and dependence among people with co-occurring disorders
 - Identify the prevalence of co-occurring disorders and the co-morbidity issues of tobacco use, other substance use disorders, and mental health disorders
 - Identify the effects of smoking tobacco on medication levels among people with co-occurring disorders
 - Identify the basic neurobiological and psychosocial factors that are common to tobacco dependence, mental health disorders, and other substance use disorders
 - Use a case study to determine the best practices and recommendations to address tobacco use by a patient with co-occurring disorders
-

Unit 1

Attitudes and Beliefs, Challenges and Barriers

Trainer Note	Unit 1 will review the key points of content covered in Modules 1 – 4, define co-occurring disorders and co-morbidity, and explore attitudes and beliefs about treating tobacco dependence among people who have co-occurring disorders.
Slide 9	
PM 11	This unit includes five short video vignettes that accompany a discussion about the challenges of and barriers to addressing tobacco use by people with mental health and substance use disorders (Clubhouse of Suffolk, 2006). To display the embedded vignettes, the five WMV video files must be in the same folder as the PowerPoint slides you are presenting.
	Refer participants to the purpose and objectives of Unit 1 found in the PM.

Purpose	This unit will provide a short review of prior modules by drawing from participants recollections of other training on tobacco. This will be followed by defining co-occurring disorders and co-morbidity, helping participants explore their personal attitudes and beliefs about addressing tobacco use and dependence among people with co-occurring disorders, and discussing the challenges of and barriers to addressing tobacco use by this population.
----------------	--

Objectives	<ul style="list-style-type: none">• Define co-occurring disorders and co-morbidity• Identify attitudes and beliefs about treating tobacco use among people with co-occurring disorders• Identify the challenges of and barriers to addressing tobacco use among people with co-occurring disorders
-------------------	--

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Attitudes and Beliefs, Challenges and Barriers, Continued

Trainer Note **Review** the major learning points from Modules 1 -4 and e-Learning. The trainer has the option to ask participants to reflect and recall key learning points from prior modules and record participant responses on newsprint during this review. Alternately, the trainer may choose to recount the main points using the items listed below:

Slide 10

PM 12

The history of tobacco dependence treatment, rationale for addressing tobacco use, Regulation Part 856, diagnosing tobacco dependence and withdrawal, tobacco treatment medications, stages of change, motivational interviewing, cognitive behavioral therapy, facilitating tobacco awareness groups, and writing a treatment plan that integrates tobacco use interventions.

Ask participants to provide other key learning points that they recall. Also, ask how they have incorporated tobacco interventions into their practice as a result of taking any of the previous modules.

Review of Prior Modules This space is provided for you to make notes of key learning points presented in Modules 1 - 4.

Defining Co-occurring Disorders and Co-morbidity

Trainer Note *Ask: How do you define co-occurring disorders? Alternately - What does it mean when someone uses the term “co-occurring disorders”?*

Slide 11

PM 13

Elicit as many answers as possible before revealing the second slide bullet with the definition and the assigned page in the PM.

Refer to PM and explain: *For purposes of this training, the term “co-occurring disorder” is defined as a person having a substance use disorder and a mental health disorder at the same time.*

Ask: *What are some examples of co-occurring mental health disorders that you commonly see among your patients?*

Common conditions are tobacco, alcohol, opioid, sedative, stimulant, and marijuana dependence plus major depression, dysthymic disorder, anxiety disorders, post-traumatic stress disorder, and severe personality disorders such as borderline personality or antisocial personality disorder. Addiction professionals may also see patients who have bipolar disorder or schizophrenia.

Definition of Co-Occurring Disorder

- Co-occurring disorders refers to co-occurring substance use disorders (abuse or dependence) and mental health disorders. A patient may have one or more substance use disorders and one or more mental health disorders at the same time.
- Common substance use disorders include tobacco dependence, and abuse or dependence for alcohol, opioids, sedatives, stimulants, and marijuana.

Common Examples

- The most common mental health disorders are major depression, dysthymic disorder, panic disorders, generalized anxiety disorder, post-traumatic stress disorder (PTSD), and severe personality disorders such as borderline and antisocial personality disorders.
- Addiction professionals may also see patients who have schizophrenia or bipolar disorders along with tobacco dependence and other substance use disorders.

Continued on next page

Defining Co-occurring Disorders and Co-morbidity, Continued

Trainer Note *Ask: What is co-morbidity? Does this mean the same thing as co-occurring disorders?*

Slide 12

PM 13

Refer to PM and explain: *The terms “co-morbidity” and “co-occurring disorders” are often used interchangeably; however, the definition of co-morbidity has recently expanded to include when two or more disorders exist at the same time, and the disorders interact or affect each other. For the purposes of this training initiative, co-morbidity is defined as when two or more disorders are present at the same time and the disorders interact in ways that affect the course and/or prognosis of each disorder.*

Co-morbidity includes conditions where one disorder has caused or negatively affected the development of another disorder. For example, a person with depression may drink alcohol or use opioids to improve their mood, and in time develops an alcohol or opioid dependence. Another example is how tobacco use can negatively affect or influence the development or progression of other substance use disorders and/or mental health disorders.

Definition of Co-morbidity

The terms “co-morbidity” and “co-occurring disorders” are often used interchangeably. More recently, the definition of co-morbidity has been more specifically defined.

- Co-morbidity is when two or more disorders exist at the same time, and the disorders interact in ways that affects the course and/or prognosis of each disorder (National Institute of Drug Abuse, 2009)
- Co-morbidity includes situations where one disorder may have caused or negatively affected the development of another disorder, and vice versa
 - For example, a person with major depression drinks alcohol or uses opioids to try to control their depressed mood, and in time develops an alcohol or opioid dependence
 - Another example is tobacco use that negatively affects or influences the progression of another substance use disorder and/or mental health disorder

Setting the Context

Trainer Note

Refer to PM and explain: It is important to understand that there is little research about people who have co-occurring disorders and who are tobacco dependent.

Slide 13

PM 14

Most of the research has been about people who have a mental health disorder (depression, anxiety disorder, etc.) and a non-tobacco substance use disorder (alcohol, opioids, stimulants, etc.), or a mental health disorder plus tobacco dependence. There are few studies concerning people who have co-occurring disorders and who are tobacco dependent.

- Treatment strategies for tobacco dependence have been shown to be effective for many different groups, including people with mental health and substance use disorders (Fiore et al., 2008)
- This training draws from the existing literature and knowledge about tobacco dependence among people with mental health or substance use disorders, and will suggest that what is known about tobacco use for each group may be applicable and effective for those with co-occurring disorders

Setting the Context

It is important to understand that there is little research about people who have co-occurring disorders and who are tobacco dependent.

- Most of the research has been about people with mental health disorders and non-tobacco substance use disorders, or about people with mental health disorders who are tobacco dependent
 - Currently, there are only a few studies concerning people who have co-occurring disorders and who are tobacco dependent
 - Treatment strategies for tobacco dependence have been shown to be effective for many different groups, including people with mental health and substance use disorders (Fiore et al., 2008)
 - This training draws from the existing literature and knowledge about tobacco dependence among people with mental health or substance use disorders, and will suggest that what is known about tobacco use for each group, may be applicable and effective for those with co-occurring disorders
-

Attitudes and Beliefs Activity

Trainer Note

Prior to the start of the training, create and post five (5) sheets of newsprint around the room with one of the five statements written at the top. Place a set of post-it notes at each participant’s table.

The first sheet of newsprint will be a confidence statement using a continuum from 1 -10, with 1 being “Low Confidence” and 10 being “High Confidence.”

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

- The confidence statement is “Circle the number that represents your level of confidence to treat tobacco dependence among patients with a co-occurring substance use and mental health disorder.”

Each of the other four (4) newsprint sheets will have one statement at the top with five (5) columns. See the example below and see next page for a list of the four statements.

Statement #1

Strongly Agree	Agree	Ambivalent	Disagree	Strongly Disagree

Continued on next page

Attitudes and Beliefs Activity, Continued

Trainer Note **Explain** that this next activity is intended to raise awareness of and to explore attitudes and beliefs related to addressing tobacco use and dependence in patients with co-occurring disorders (COD).

Slide 14

PM 15

Ask participants to complete the Confidence Scale and the Attitudes and Beliefs Activity in their PM.

Once participants have completed the confidence scale and four statements, ask everyone to take the post-it notes, go to the newsprint posted around the room, and place one post-it note on each posted statement. The post-it notes should match the responses made to the five statements in their PM.

Confidence Scale and Attitudes and Beliefs Activity

Directions:

Circle the number that represents your level of confidence to treat tobacco dependence among patients with a co-occurring substance use and mental health disorder.

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

Next, indicate the extent that you personally agree or disagree with each of the following statements by placing a mark in the appropriate box.

Note: The term co-occurring disorders is represented by COD and nicotine replacement therapy is represented by NRT.

<u>Statement</u>	<u>Strongly Agree</u>	<u>Agree</u>	<u>Ambivalent</u>	<u>Disagree</u>	<u>Strongly Disagree</u>
Most patients with COD don't want to stop their tobacco use.					
NRT is not appropriate for people with COD.					
Tobacco dependence should be a priority when treating people with COD.					
Patients with COD should not stop their tobacco use.					

Continued on next page

Attitudes and Beliefs Activity, Continued

Trainer Note**Slide 15**

The debriefing questions listed below are provided to stimulate more in-depth discussion and to enable participants to begin to identify their attitudes and beliefs regarding integrating tobacco use interventions into the treatment of co-occurring disorders.

For the confidence question ask: *What are the reasons for your current level of confidence? If you have taken other modules, has your confidence to address tobacco use and dependence changed?*

Is anyone's confidence about addressing tobacco dependence for patients who only have substance use disorders, higher than for addressing tobacco use by patients with a substance use and a mental health disorder?

For the other four statements ask the following questions to process participant responses:

- *As you look around at the newsprint, what stands out for you regarding the placement of the post-its?*
- *Are there some participants who agree or strongly agree with a statement and who are willing to share one reason for your response to the specific statement?*
- *How about from willing participants who disagree or strongly disagree with a specific statement?*
- *How about for those who placed post-its in the ambivalent section?*
- *What are some frequently held staff beliefs about concurrently treating tobacco dependence and co-occurring disorders?*
- *How might staff attitudes and beliefs about tobacco use, affect the willingness of patients with co-occurring disorders to examine and address their tobacco use?*

Continued on next page

Attitudes and Beliefs Activity, Continued

Trainer Note If time permits, the trainer has the option to ask additional questions, to continue this discussion.

As a transition to the next section, the following language is suggested:

People will often have a wide range of responses to these attitudinal and belief statements, and during the course of this workshop, information will be provided to address each of these areas.

Some of you may be surprised by what the research has shown regarding the impact of tobacco use on people who have mental health and/or substance use disorders.

We will revisit these five statements at the end of the training.

Patients' Perspectives of Tobacco Use and Co-occurring Disorders

Trainer Note **Trainers will need external speakers for the computer or an audio system connected to the computer to provide video sound. In order to work, the video vignettes must also be contained in the same file as the slides.**

Slide 16

PM 16

The following is suggested language to introduce the video.

We have discussed your confidence and explored attitudes and beliefs about tobacco use for people with COD. Let's look at the challenges and barriers from the patient's perspective using a video entitled Smoke Alarm. This video was produced by Clubhouse of Suffolk (a mental health provider) as part of a NYS Tobacco Control Program funded initiative. This project was funded to identify promising tobacco use intervention practices for mental health patients in this program. Clubhouse of Suffolk refers to patients as "members" or "consumers."

While this project was implemented within a mental health rehabilitation program, a large percentage of the patients in this agency are also tobacco dependent. According to the Clinical Director of Clubhouse of Suffolk, about 60% of their patients have co-occurring substance use disorders and a majority of their patients use or have used tobacco.

The video is 17 minutes long, and this version was edited into several short vignettes and used with the permission of Clubhouse of Suffolk.

While watching this video, please look for patient fears about stopping their tobacco use, how tobacco use affected their mental health, and the challenges and barriers they identified while attempting to become abstinent from tobacco. You may wish to record these in your participant manual.

Continued on next page

Patients' Perspectives of Tobacco Use and Co-occurring Disorders, Continued

Smoke Alarm Video

Consider the following questions while watching the video:

Club House of Suffolk

- What is the relationship of tobacco to people's mental health disorder?
- What were the main fears expressed by patients about stopping their tobacco use?
- What did people describe about how tobacco use related to their mental health and/or other substance use disorder?
- What were the challenges and barriers these individuals expressed about stopping and maintaining abstinence from tobacco? (Consider individual, family, social, and the larger system challenges and barriers.)
- How might treatment need to be modified or enhanced to help people with COD to stop their tobacco use?

This video was produced by Clubhouse of Suffolk and is used for this curriculum with their permission. If you are interested in the video, please contact Clubhouse of Suffolk in Ronkonkoma, NY at (631) 471-7242 or go to their website at www.clubhouseofsuffolk.org to purchase a copy.

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Patients' Perspectives of Tobacco Use and Co-occurring Disorders, Continued

Trainer Note	<p>Ask participants to consider the following questions as they watch the first three vignettes:</p>
Slide 17	<ul style="list-style-type: none"> • <i>How did tobacco use relate to the patients' substance use and/or mental health disorder?</i>
PM 16	<ul style="list-style-type: none"> • <i>What were the main fears expressed about stopping their tobacco use?</i> <p>Show the first three vignettes. There is a brief introduction about Clubhouse of Suffolk and their tobacco intervention project, followed by vignettes in the following order:</p> <p>Vignette 1 - Introduction and Why did you start smoking?</p> <p>Vignette 2 - How does smoking relate to your mental health?</p> <p>Vignette 3 - What are your fears about stopping smoking?</p> <p>Stop and Discuss using the suggested questions listed above. The trainer can record the participants' responses on newsprint during the discussion. These questions will be revisited in Unit 2 (See Trainer's Manual 64, Factors Supporting Tobacco Use).</p>
Slides 18 - 20	
Slide 21	<p>Ask participants to consider the following questions as they watch the fourth and fifth vignettes:</p> <ul style="list-style-type: none"> • <i>What are the challenges and barriers mentioned about stopping smoking and maintaining abstinence from tobacco?</i> • <i>How might treatment need to be modified or enhanced to help people with COD to stop their tobacco use?</i> <p>Then show the next three vignettes and follow with discussion.</p>
Slides 22 - 23	<p>Vignette 4 - Reaction to mental health providers who say you cannot quit?</p> <p>Vignette 5 - How did the mental health system support your smoking?</p> <p>As a concluding point, mention that if anyone is interested in the video they can contact Clubhouse of Suffolk in Ronkonkoma, NY at (631) 471-7242 to purchase a copy for a modest sum.</p>

Unit Summary

Trainer Note

Slide 24

PM 17

We have reviewed: 1) the key learning points from Modules 1 - 4; 2) the definition of co-occurring disorders and co-morbidity; 3) attitudes and beliefs about tobacco use among people with co-occurring disorders; and 4) some of the challenges and barriers for addressing tobacco use among people with co-occurring disorders.

This next unit will explore 1) the prevalence and co-morbidity of tobacco use; 2) basic neurobiology of tobacco use among people with substance use and mental health disorders; 3) the biopsychosocial aspects of tobacco dependence; and 4) how mental health disorders, substance use disorders, and tobacco dependence interact.

Before beginning Unit 2, this may be an appropriate time to take a break.

Summary

- The key learning points from Modules 1 - 4 were reviewed and discussed
 - Co-occurring disorders was defined in this training, as being when a mental health and substance use disorder exist at the same time
 - Co-morbidity is often used interchangeably with the term co-occurring disorders, but has recently been used to define when two or more disorders interact in ways that affect the progression or course of each disorder
 - Attitudes and beliefs about tobacco use among people with co-occurring mental health and substance use disorders was examined, along with some of the challenges and barriers that exist for addressing tobacco use among people with co-occurring mental health and substance use disorders
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Unit 2

Prevalence and Co-morbidity Factors

Trainer Note Unit 2 covers the prevalence of co-occurring disorders and the co-morbidity of tobacco use with substance use disorders and mental health disorders. This information is presented using an interactive small group activity titled *What is Your Tobacco and Co-occurring Disorders Knowledge?*, followed by a large group discussion. The effects of smoking tobacco on substance use disorders, mental health disorders, and psychiatric medication levels are covered in the activity. This is followed by a discussion about the biopsychosocial view of tobacco dependence, substance use disorders, and mental health disorders. The basic neurobiological and psychosocial factors that influence tobacco use and the interaction between tobacco and co-occurring disorders are discussed using the biopsychosocial view.

Slide 25

PM 19

Refer to PM regarding the unit purpose and objectives.

Purpose Unit 2 will use a small group learning exercise and large group debriefing to help participants understand the co-morbidity of tobacco use with mental health and substance use disorders. The effects of smoking tobacco on substance use disorders, mental health disorders, and psychiatric medication levels will be covered. There will then be discussion about the biopsychosocial view of tobacco dependence, substance use, and mental health disorders. The basic neurobiological and psychosocial factors that influence tobacco use are discussed using the biopsychosocial view.

Objectives Identify the prevalence of co-occurring disorders and the co-morbidity of tobacco use with other substance use disorders and mental health disorders

Identify the effects of smoking tobacco on psychiatric medications among people with co-occurring disorders

Identify the basic neurobiological and psychosocial factors that are common to tobacco dependence, mental health disorders, and other substance use disorders

Prevalence of Tobacco Use and Co-occurring Disorders

Trainer Note**Ask****Slide 26**

By a show of hands, who works in a substance abuse program? What percentage of your patients have mental health disorders?

By a show of hands, who works in a mental health program? What percentage of your patients have substance use disorders?

What percentage of your patients also use tobacco?

Slide 27**PM 20****Explain:**

- Nationally from 50 - 75% of patients in chemical dependence treatment programs are reported to have a co-occurring mental health disorder and 20 - 50% of patients in mental health programs are reported to have a co-occurring substance use disorder (Center for Substance Abuse Treatment, 2005)
- In New York State OASAS certified chemical dependence programs, the percentage of patients identified as having a co-occurring mental health disorder breaks down as follows: 26% of outpatients, 30% of residential program patients, 42% of inpatients, and 23% of medication-assisted treatment (methadone) patients (New York State Office of Alcoholism and Substance Abuse Services, 2008)
- About 70% of patients who have substance use disorders and/or mental health disorders are also tobacco dependent (Lasser et al., 2000)

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Prevalence of Tobacco Use and Co-occurring Disorders, Continued

**National and
NYS
Prevalence
Data**

- Nationally from 50 - 75% of patients in chemical dependence treatment programs are reported to have a co-occurring mental health disorder and 20 - 50% of patients in mental health programs are reported to have a co-occurring substance use disorder (Center for Substance Abuse Treatment, 2005)
 - In New York State OASAS certified chemical dependence programs, the percentage of patients identified as having a co-occurring mental health disorder breaks down as follows: 26% of outpatients, 30% of residential program patients, 42% of inpatients, and 23 % of medication-assisted treatment (methadone) patients (New York State Office of Alcoholism and Substance Abuse Services, 2008)
 - A large percentage of patients who have substance use disorders and/or mental health disorders are also tobacco dependent (Lasser et al., 2000)
-

The Impact of Tobacco on Co-occurring Disorders

Trainer Note For the Tobacco and Co-occurring Disorders Knowledge Activity, the answers and explanations for each statement are provided in the Trainer Notes. The trainer needs to read and understand the literature research that supports each answer and be able to explain it clearly during the debriefing.

Slide 28

PM 21 - 23

The use of small groups to complete this exercise is the preferred group learning method, followed by a large group debriefing and discussion. The recommended small group size is four to six people, but can be varied as needed.

Assign participants to small groups and ask them to read the four multiple-choice questions and the eleven Agree/Disagree statements and select the best answer for each. Details for each answer will appear later in the PM and the trainer should explain that the details and citations will be provided after the debriefing is completed.

Refer to PM titled, *What is Your Tobacco and Co-occurring Disorders Knowledge?* Explain that the task for each group is to read the 15 items and work together to select the most appropriate answers. Allow the groups about 10 minutes to complete this exercise, before conducting the debriefing.

For the debriefing, trainers may wish to give each group a set of flash cards with A, B, C, or D for the four multiple-choice statements, and a card with Agree on one side and Disagree on the opposite side for the 11 Agree/Disagree statements. If using this method, ask all groups to hold up the card that represents their group response to the statement, before revealing the answer on the slide.

Continued on next page

The Impact of Tobacco on Co-occurring Disorders, Continued

What is Your Tobacco and Co-occurring Disorders Knowledge?

In this exercise, your group's task is to review and discuss the following questions and statements, and select the answer that you believe is the most accurate. There are four multiple-choice questions followed by eleven statements for which you will select "Agree" or "Disagree." The answers will be reviewed and an explanation and citations for each will be provided during a large group discussion.

1. What is the average tobacco smoking prevalence rate for people who have a substance use disorder and/or a mental health disorder?
 - a. 30 - 40%
 - b. 70%
 - c. 20 - 25%
 - d. Less than 10%
2. In the US, what is the percentage of cigarettes that are consumed by people with mental health and/or substance use disorders?
 - a. 20 - 25%
 - b. 10 - 15%
 - c. Less than 5%
 - d. 44 - 46%
3. A 2006 study by the National Association of State Mental Health Program Directors indicated that patients with serious mental illness have a reduced life expectancy as compared to people in the general population. What is the average reduced life expectancy for these individuals?
 - a. 25 yrs
 - b. 5 yrs
 - c. 12 yrs
 - d. 10 yrs
4. Studies have shown that tobacco smokers with serious mental health disorders spend what percent of their monthly budget on tobacco?
 - a. About 15%
 - b. Less than 5%
 - c. 25 - 30%
 - d. 5 - 8%

Continued on next page

The Impact of Tobacco on Co-occurring Disorders, Continued

What is Your Tobacco and Co-occurring Disorders Knowledge? cont'd

5. Daily tobacco smoking can be a predictor of suicidal thinking and attempts.

Agree or Disagree

6. Heavy tobacco smoking (20 or more cigarettes per day) can be a predictor of suicide risk and suicide completion.

Agree or Disagree

7. Nicotine causes cancer and is a major cause of cardiovascular disease.

Agree or Disagree

8. Nicotine can affect the metabolism (breakdown) of some psychiatric medications.

Agree or Disagree

9. When a patient stops smoking, they usually require an increase in the dosage of their psychiatric medications.

Agree or Disagree

10. The chronic use of tobacco can increase feelings of anxiety.

Agree or Disagree

11. Stopping tobacco-smoking leads to panic attacks, while maintaining smoking reduces the risk of panic attacks and panic disorder.

Agree or Disagree

Continued on next page

The Impact of Tobacco on Co-occurring Disorders, Continued

What is Your Tobacco and Co-occurring Disorders Knowledge? cont'd

12. The majority of people with mental health and/or substance use disorders are not interested in stopping their tobacco use.

Agree or Disagree

13. Most people with mental health and/or substance use disorders cannot stop using tobacco.

Agree or Disagree

14. Varenicline (Chantix) reduces the effects of some psychiatric medications.

Agree or Disagree

15. Smoking tobacco increases the risk for developing a substance use disorder and/or a mental health disorder.

Agree or Disagree

Continued on next page

The Impact of Tobacco on Co-occurring Disorders, Continued

Trainer Note During the debriefing, as you show each slide, refer participants to their PM for the respective page that explains the supporting research behind each answer. For each question and statement, ask each group to indicate which answer they chose. The trainer may wish to record or tally each group's answer choices on newsprint during the debriefing.

For each statement, reveal the slide and explain the answer using the content and literature sources in the manual. The trainer will need to have a sound grasp of the key facts from the literature to explain the correct answers.

What is Your Tobacco and Co-occurring Disorders Knowledge

Slide 29, PM 24

1. What is the average tobacco smoking prevalence rate for people who have a substance use disorder and/or a mental health disorder?
 - a. 30 - 40%
 - b. **70%**
 - c. 20 - 25%
 - d. Less than 10%

Studies vary as to each disorder, with some showing tobacco smoking rates of 80 - 90%. This range includes all people who have a current or prior history of mental health and/or substance use disorder (Lasser et al., 2000).

Slide 30, PM 24

2. In the US, what is the percentage of cigarettes that are consumed by people with mental health and/or substance use disorders?
 - a. 20 - 25%
 - b. 10 - 15%
 - c. Less than 5%
 - d. **44 - 46%**

In the US, people with mental health and/or substance use disorders consume close to one-half of all cigarettes (Lasser, et al, 2000, Grant, et al, 2004). Of the 435,000 smoking-related deaths, at least 200,000 are by people with mental health and/or substance use disorders (Maurer, 2006, Schroeder, 2009, Williams and Ziedonis, 2004).

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The Impact of Tobacco on Co-occurring Disorders, Continued

What is Your Tobacco and Co-occurring Disorders Knowledge? cont'd

Slide 31, PM 24

3. A 2006 study by the National Association of State Mental Health Program Directors indicated that patients with serious mental illness have a reduced life expectancy compared to people in the general population. What is the average reduced life expectancy for these individuals?
 - a. **25 yrs**
 - b. 5 yrs
 - c. 12 yrs
 - d. 10 yrs

(National Association of State Mental Health Program Directors, 2006; Miller et al., 2006). While obesity and diet are contributors, the primary cause of death is cardiovascular disease (CVD) and diabetes. Tobacco is a key factor in diabetes onset and the main cause of CVD. Studies show that individuals with a mental health disorder who smoke die 8 - 25 years prematurely when compared to the general population (Colton and Manderscheid, 2006). They also have significant elevated risk for respiratory and cardiovascular diseases and cancer, as compared to age-matched controls (Brown, et al., 2000; Dalton et al., 2002; Himelhoch et al., 2004; Lichtermann et al., 2001; Sokal, 2004).

Slide 32, PM 25

4. Studies have shown that smokers with serious mental health disorders spend about what percent of their monthly budget on tobacco?
 - a. 15%
 - b. Less than 5%
 - c. **25 - 30%**
 - d. 5 - 8 %

About 85% of this population receive public assistance benefits, with the average amount per month spent on tobacco at \$142, using 2000 and 2002 costs (Mechanic, Bilder, McAlpine, 2002; Kouzis and Eaton, 2000). Individuals with schizophrenia may spend as much as 27% of their monthly disability income on tobacco (Steinberg et al., 2004)

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The Impact of Tobacco on Co-occurring Disorders, Continued

What is Your Tobacco and Co-occurring Disorders Knowledge? cont'd

Slide 33, PM 25

5. Daily tobacco smoking can be a predictor of suicidal thinking and attempts.

Daily tobacco smoking is a strong predictor of suicidal thinking and attempts, even when taking into account people who have a history of depression, substance use disorder, and prior suicide attempts (Breslau et al., 1995). Daily tobacco smoking also increases the risk of suicide for people with bipolar illness and schizophrenia (Oquendo et al., 2004; Potkin et al., 2003).

Slide 34, PM 26

6. Heavy smoking (20 or more cigarettes per day) can be a predictor of suicide risk and suicide completion.

Heavy tobacco smoking is highly associated with greater suicide attempts among adolescents, especially females. Heavy tobacco smoking is also highly associated with increased suicide completion (Moriya et al., 2006; Cho et al., 2007; Oquendo et al., 2007).

Slide 35, PM 26

7. Nicotine causes cancer and is a major cause of cardiovascular disease

Nicotine is not a carcinogen and it is not a major risk factor for cardiovascular disease. Non-nicotine components of tobacco smoke, especially the tar, benzene, and other chemicals are the major carcinogens, and can cause cardiovascular artery disease (Benowitz and Gourlay, 1997).

Trainer Note to address if the following issue is raised: *With human tissue contained within a petri dish, nicotine does appear to increase blood flow to certain tumors. One recent study has suggested nicotine promotes oral cancer, nicotine is not viewed as a carcinogen.*

Continued on next page

The Impact of Tobacco on Co-occurring Disorders, Continued

What is Your Tobacco and Co-occurring Disorders Knowledge? cont'd

Slide 36, PM 26

8. Nicotine can affect the metabolism (breakdown) of some psychiatric medications

Nicotine does not affect the metabolism of other drugs (Williams and Hughes, 2003; Zevin and Benowitz, 1999). Tobacco smoke, especially the tar in smoke, increases the metabolism of some antipsychotics and some antidepressants, as well as caffeine, theophylline (similar to caffeine and found in tea), coumadin, acetaminophen, beta-blockers, and anti-arrhythmic drugs. These medications are metabolized by a specific liver cytochrome enzyme (1A2) and are affected by smoking. Smoking tobacco can significantly reduce the blood levels of some antipsychotics, and some antidepressants (Kroon, 2007; Williams and Ziedonis, 2004; Zevin and Benowitz, 1999; Desai et al., 2001).

Slide 37, PM 27

9. When a patient stops smoking, they usually require an increase in the dosage of psychiatric medications.

Many patients will be able to stop smoking without any effect on their medication doses. However, smokers taking medications metabolized by the liver C1A2 enzyme (see #8 above) can be impacted by stopping smoking. These patients need close monitoring. Stopping tobacco smoking could cause blood levels of these medications to rise and lead to medication toxicity (Desai et al., 2001; Williams and Ziedonis, 2004; Zevin and Benowitz, 1999). Patients taking antipsychotic medications like clozapine or olanzapine may need a dose reduction when they stop smoking to prevent serious side effects (Zullino et al., 2002). After stopping tobacco smoking, the blood levels of some antidepressants, theophylline medications, and caffeine may also increase. Side effects from antidepressants may increase and excess levels of caffeine and theophylline may cause anxiety, restlessness, irritability, and insomnia.

Refer to the smoking and medication interaction chart on next page, and also in the PM.

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The Impact of Tobacco on Co-occurring Disorders, Continued

What is Your Tobacco and Co-occurring Disorders Knowledge? cont'd

Slide 37 cont'd, PM 27

Some Common Drugs Affected By Tobacco Smoke

Trade names	Generic Name	Purpose
Anafranil	Clomipramine	OCD
Clozaril	Clozapine	Antipsychotic
Coffee, Cola, OTC meds Soft drinks, Tea	Caffeine	Cognitive Stimulant
Elavil	Amitriptyline	Antidepressant
Haldol	Haloperidol	Antipsychotic
Luvox	Fluvoxamine	OCD, Anxiety
Pamelor/Aventyl	Nortriptyline	Antidepressant, Anxiety
Prolixin	Fluphenazine	Antipsychotic
Theo-24, Theo-Dur, Theobid, Theovent	Theophylline (natural compound in Tea)	Asthma, Bronchitis, Emphysema
Thorazine	Chlorpromazine	Antipsychotic
Tofranil	Imipramine	Antidepressant
Zyprexa	Olanzapine	Antipsychotic

Continued on next page

The Impact of Tobacco on Co-occurring Disorders, Continued

What is Your Tobacco and Co-occurring Disorders Knowledge? cont'd

Slide 38, PM 28

10. The chronic use of tobacco can increase feelings of anxiety

The chronic use of tobacco increases feelings of anxiety (Breslau and Klein, 1999; Isensee, et al., 2003; Zvolensky et al., 2005, 2005b). Many users feel anxiety, restlessness, and tension from nicotine withdrawal, and often mistakenly assume that since these symptoms are relieved when they smoke, and that tobacco is providing them with general anxiety control and relief. Smoking tobacco only stops the anxiety related to nicotine withdrawal. Tobacco use actually increases general feelings of anxiety.

Slide 39, PM 28

11. Stopping tobacco-smoking leads to panic attacks, while maintaining smoking reduces the risk of panic attacks and panic disorder.

Tobacco use, especially in the form of daily tobacco smoking, is a significant risk factor for panic disorder, agoraphobia, and generalized anxiety disorder (Breslau, 2004b; Amering et al., 1999). When patients with co-occurring disorders stop smoking tobacco, they often confuse the symptoms of tobacco withdrawal with general anxiety, panic attacks, or other symptoms of their mental health disorder. Many also consume excess levels of caffeine, which can mimic feelings of anxiety or even trigger panic attacks in some people.

Slide 40, PM 28

12. The majority of people with mental health and/or substance use disorders are not interested in stopping their tobacco use

People with mental health disorders express an interest in stopping their tobacco use about as often as the general population. About 70% have expressed an interest in stopping tobacco use, and about 35 - 40% have tried to stop in the prior year (Lasser et al., 2000). Many patients with mental health and substance use disorders report that no addiction or mental health professional has ever asked them if they would like to stop using tobacco or advised that they should stop using tobacco.

Continued on next page

The Impact of Tobacco on Co-occurring Disorders, Continued

What is Your Tobacco and Co-occurring Disorders Knowledge? cont'd

Slide 41, PM 29

13. Most people with mental health and/or substance use disorders cannot stop using tobacco.

People with mental health and/or substance use disorders can successfully stop and remain abstinent from tobacco. In general, they need more continual engagement efforts about their tobacco use, more frequent/repeat treatment episodes, and more intensive treatment as compared to the general population (Williams and Ziedonis, 2004; Prochaska, et al., 2008; Williams and Foulds, 2007).

A meta-analysis of 15 studies showed no effect of having a history of major depression on smoking abstinence rates (Hitsman et al., 2003). In addition, a history of alcohol dependence is not associated with a reduced ability to quit smoking (Covey et al., 1994; Hughes and Kalman 2005).

Slide 42, PM 29

14. Varenicline (Chantix) reduces the effects of some psychiatric medications.

Varenicline is excreted 92% unchanged in the urine and has no clinically meaningful drug-drug interactions (Tonstad, 2006). Varenicline is not recommended for patients under 18 years of age, and should be used with caution in patients with renal impairment. Patients and clinicians should be alert to changes in mood or behavior during treatment with varenicline; these should be immediately reported to a healthcare provider.

Slides 43 - 44, PM 30

15. Smoking tobacco increases the risk for developing a substance use disorder and/or a mental health disorder.

Tobacco use in adolescence is a main “gateway drug” that leads to alcohol and other illegal substance use (Giovino et al. 1994; Everett et al., 1998; Rohde et al., 2001; Kandel et al., 1992; Wagner and Anthony 2002). Tobacco use during adolescence is also predictive of increased risk for mental illness, doubles the risk for major depression, and it is a strong predictor of other risk behaviors (Breslau, et al., 2004; Durant, 1999; Hanna and Grant, 1999).

Smoking in adolescence is associated with increased risk for psychiatric disorders in adulthood, including panic disorder, general anxiety disorder, agoraphobia, depression, suicidal behavior, substance use disorders, and schizophrenia (Weiser, et al., 2004; Goodman, 2000; Johnson, et al., 2000). Active psychiatric disorders are also associated with daily smoking and progression to tobacco dependence (Breslau, et al., 2004). For women, smoking increases the risk of major depression by 93% (Pasco, et al, 2008).

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The Impact of Tobacco on Co-occurring Disorders, Continued

Tobacco and Co-occurring Disorders Knowledge

Question 1: Average rate of tobacco use by people with mental health and/or substance use disorders.

- About 70% of people who have a mental health and/or substance use disorder use tobacco (Lasser et al., 2000).

Question 2: Amount of cigarettes consumed by people with mental health and/or substance use disorders.

- Of all cigarettes consumed in the US, 44 - 46% are consumed by people with mental health and/or substance use disorders (Lasser et al., 2000; Grant et al., 2004).
- Of the 435,000 annual smoking-related deaths, at least 200,000 are by people with mental health and/or substance use disorders (Maurer, 2006; Schroeder, 2009; Williams and Ziedonis, 2004).

Question 3: Average reduced life span for people with serious mental health disorders.

- Patients with chronic mental health disorders live on average 25 fewer years than the general population (National Association of State Mental Health Program Directors, 2006; Miller 2006; Colton and Manderscheid, 2006).
- While obesity and diet are contributors, the primary cause of death is cardiovascular disease (CVD) and diabetes. Tobacco is a key factor in diabetes onset and the main cause of CVD.
- This population has significantly elevated risk for respiratory and cardiovascular diseases and cancer, compared to age-matched controls (Brown et al., 2000; Dalton et al., 2002; Himelhoch et al., 2004; Lichtermann et al., 2001; Sokal, 2004).

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The Impact of Tobacco on Co-occurring Disorders, Continued

Tobacco and Co-occurring Disorders Knowledge, Cont'd

Question 4: Percentage of monthly income spent on tobacco.

- 85% of people with mental health disorders are on public assistance and spend one fourth of their monthly income on tobacco or \$142 using 2000 - 2002 costs (Mechanic, Bilder, et al., 2002; Kouzis and Eaton, 2000). People with schizophrenia may spend as much as 27% of their monthly disability income on tobacco (Steinberg et al., 2004).

Statement 5: Daily tobacco smoking can be a predictor of suicidal thinking and attempts.

- Daily tobacco smoking is a strong predictor of suicidal thinking and attempts, even when taking into account those who have a history of depression, substance use disorder, and prior suicide attempts (Breslau et al., 1995).
- Daily tobacco smoking increases the risk of suicide for people with bipolar illness and schizophrenia (Oquendo et al., 2004; Potkin et al., 2003).

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The Impact of Tobacco on Co-occurring Disorders, Continued

Tobacco and Co-occurring Disorders Knowledge, Cont'd

Statement 6: Heavy tobacco smoking (20 or more cpd) can be a predictor of suicide risk and completion.

- Heavy tobacco smoking is highly associated with greater suicide attempts among adolescents, especially females. Heavy tobacco smoking is also highly associated with increased suicide completion (Moriya et al., 2006; Cho et al., 2007; Oquendo et al., 2007).

Statement 7: Nicotine causes cancer and cardiovascular disease.

- Non-nicotine components of smoke, especially the tar, benzene, and other chemicals in smoke are the major carcinogens. Nicotine is not a carcinogen and it is not a major risk factor for cardiovascular disease (Benowitz and Gourley, 1997).

Statement 8: Nicotine can affect the metabolism (breakdown) of some psychiatric medications.

- Nicotine does not affect the metabolism of psychiatric medications (Williams and Hughes, 2003, Zevin and Benowitz, 1999).
- Tobacco smoke, especially the tar, induces the liver 1A2 enzyme and that can increase the metabolism of some antipsychotics, some antidepressants, caffeine, theophylline (similar to caffeine) and other medications. This can reduce the blood levels of some antipsychotics and antidepressants (Kroon, 2007; Williams and Ziedonis, 2004; Zevin and Benowitz, 1999; Desai et al., 2001).

Continued on next page

The Impact of Tobacco on Co-occurring Disorders, Continued

Tobacco and Co-occurring Disorders Knowledge, Cont'd

Statement 9: When a patient stops smoking, they usually require an increase in psychiatric medications.

- Many patients will be able to stop smoking without any effect on their medication dosages. However, smokers taking medications metabolized by the liver 1A2 enzyme (see Table 1), can be affected when they stop smoking and need close monitoring. Stopping tobacco smoking could cause some medication blood levels to rise, resulting in medication toxicity (Desai et al., 2001; Williams and Ziedonis, 2004; Zevin and Benowitz, 1999).
- Patients taking antipsychotics such as clozapine or olanzapine may need a dose reduction when not smoking to prevent serious medication side effects (Zullino et al., 2002). After stopping smoking, the blood levels of some antidepressants, theophylline (similar to caffeine) medications, and caffeine may increase. Side effects of antidepressants may occur and excess caffeine and theophylline may cause anxiety, restlessness, irritability, and insomnia.

Table 1: Some Common Drugs Affected by Smoking Tobacco

Anafranil	Clomipramine	OCD
Clozaril	Clozapine	Antipsychotic
Coffee, Colas, many OTC meds, Soft drinks and Tea	Caffeine	Cognitive Stimulant
Elavil	Amitriptyline	Antidepressant
Haldol	Haloperidol	Antipsychotic
Luvox	Fluvoxamine	OCD, Anxiety
Pamelor/Aventyl	Nortriptyline	Antidepressant, Anxiety
Prolixin	Fluphenazine	Antipsychotic
Theo-24, Theo-Dur, Theobid, Theovent	Theophylline	Asthma, Bronchitis, Emphysema
Thorazine	Chlorpromazine	Antipsychotic
Tofranil	Imipramine	Antidepressant
Zyprexa	Olanzapine	Antipsychotic

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The Impact of Tobacco on Co-occurring Disorders, Continued

Tobacco and Co-occurring Disorders Knowledge, Cont'd

Statement 10: The chronic use of tobacco can increase feelings of anxiety.

Regular or chronic use of tobacco increases feelings of anxiety (Breslau and Klein, 1999; Isensee, et al., 2003; Zvolensky et al., 2005, 2005b). Users feel anxiety, restlessness, and tension from nicotine withdrawal, and often mistakenly assume that since these symptoms are relieved when they smoke, that tobacco and nicotine are providing general anxiety control and relief. Smoking tobacco stops the anxiety related to nicotine withdrawal symptoms. Tobacco use actually increases general feelings of anxiety.

Statement 11: Stopping tobacco-smoking leads to panic attacks, while maintaining tobacco use reduces the risk of panic attacks and panic disorder.

- Tobacco use, especially in the form of daily tobacco smoking, is a significant risk factor for panic disorder, agoraphobia, and generalized anxiety disorder (Breslau, 2004b; Amering et al., 1999). When stopping tobacco use, patients often confuse the symptoms of nicotine withdrawal with the general anxiety, panic attacks, or other symptoms of their mental health disorder(s). Many consume excess levels of caffeine, which can mimic feelings of anxiety or even trigger panic attacks in some people.

Statement 12: People with mental health and/or substance use disorders are not interested in stopping tobacco use.

- People with mental health and/or substance use disorders express an interest in stopping tobacco use about as often as the general population. About 70% state an interest in stopping, and about 40% have tried to stop in the prior year (Lasser et al., 2000).
- Many mental health and substance use patients report that no addiction or mental health professional has ever asked if they would like to stop using tobacco nor advised them to stop.

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The Impact of Tobacco on Co-occurring Disorders, Continued

Tobacco and Co-occurring Disorders Knowledge, Cont'd

Statement 13: People with mental health and/or substance use disorders cannot stop using tobacco.

- People with mental health and/or substance use disorders can successfully stop and remain abstinent from tobacco. They often require more engagement efforts about their tobacco use, more frequent/repeat treatment episodes, and more intensive treatment, as compared to the general population (Williams and Ziedonis, 2004; Prochaska et al., 2008; Williams and Foulds, 2007).
- A meta-analysis of 15 studies showed no effect of having a history of major depression on smoking abstinence rates (Hitsman et al., 2003). Moreover, a history of alcohol dependence is not associated with reduced ability to quit smoking (Covey et al., 1994; Hughes and Kalman 2005).

Statement 14: Varenicline reduces the effects of some psychiatric medications.

- Varenicline is excreted 92% unchanged in the urine and has no clinically meaningful drug-drug interactions (Tonstad, 2006). Varenicline is not recommended for patients under 18 years of age, and should be used with caution in patients with renal impairment. Patients and clinicians should be alert to changes in mood or behavior during treatment with varenicline; these should be immediately reported to a healthcare provider.

Continued on next page

The Impact of Tobacco on Co-occurring Disorders, Continued

Tobacco and Co-occurring Disorders Knowledge, Cont'd

Statement 15: Smoking tobacco increases the risk for developing a substance use disorder and/or mental health disorder.

- Tobacco use in adolescence is the main “gateway drug” to alcohol and other illegal substance use (Giovino et al., 1994; Everett et al., 1998; Rohde et al., 2001; Kandel et al., 1992; Wagner and Anthony 2002).
 - Tobacco use during adolescence is predictive of increased risk for mental illness. Tobacco use during adolescence doubles the risk for major depression, and it is a strong predictor of other risk behaviors (Breslau, et al., 2004; Durant, 1999; Hanna and Grant, 1999).
 - Smoking in adolescence is associated with increased risk for psychiatric disorders in adulthood, including panic disorder, general anxiety disorder, agoraphobia, depression, suicidal behavior, substance use disorders, and schizophrenia (Breslau, et al., 2004; Weiser, et al., 2004; Goodman, 2000; Johnson, et al., 2000).
 - Active psychiatric disorders are associated with daily smoking and progression to tobacco dependence (Breslau, et al., 2004).
 - For women, smoking increases the risk of major depression by 93% (Pasco, et al, 2008).
-

Trainer Note Slide 45

As a conclusion, ask participants how much content they already knew regarding the effects of tobacco on substance use and mental health disorders. Compliment participants for having some knowledge of these issues. Also, ask what information was new or surprising to people during the debriefing of this activity.

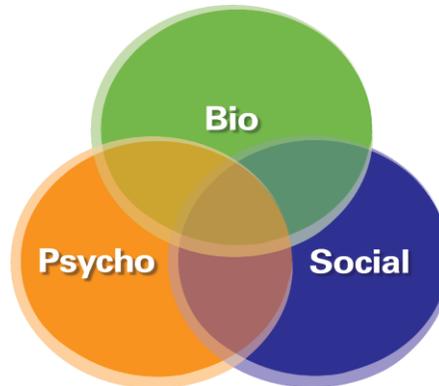
After completing a summary of this activity, transition by reminding participants about the biopsychosocial view of substance dependence, something that most, if not all of them, are already familiar with.

Explain that for most people, this discussion will be a review and reinforcement of the biopsychosocial view.

Biopsychosocial Factors for Tobacco Use and Dependence

Trainer Note	Remind participants about the biopsychosocial view of substance dependence and that tobacco dependence is substance dependence and it is a biopsychosocial disease.
Slide 46	
PM 31	Restate that it is not just nicotine that produces dependence, but also the use of tobacco, tobacco smoke, and the associated behaviors/rituals that are also highly reinforcing.

Biopsychosocial View of Chemical Dependence



This is a review of content presented in Modules 1 and 2:

- Chemical dependence is a biopsychosocial disease
- The manifestation, maintenance, and course of addiction are influenced by biological vulnerabilities, psychological predispositions, and pervasive social factors (Erickson, 2007)
- Nicotine is the main psychoactive drug in tobacco that is highly reinforcing and causes physical dependence
- Tobacco use and tobacco smoke are highly reinforcing and this leads to compulsive (addictive) use, which is supported by biological, psychological, behavioral, and social factors
- Tobacco dependence is chemical dependence and it is a biopsychosocial disease

Continued on next page

Biopsychosocial Factors for Tobacco Use and Dependence, Continued

Trainer Note *Ask: Does everyone who uses a psychoactive drug, such as alcohol, nicotine, opioids, etc, become chemically dependent on that drug?*

Slide 47

PM 32

Elicit answers as to why or why not?

Explain: *Science has found that the genetic predisposition for developing substance dependence is a strong contributor, and genetic risk is a major factor for nicotine and tobacco dependence. While a large percentage of people who use tobacco become dependent, not everyone who tries tobacco becomes addicted. The genetic reasons for this risk are complex. The main ideas are provided here in a simplified form.*

Scientists suspect that people have different genetic predispositions. Some people are more prone to using tobacco, some to becoming nicotine dependent, some are more prone to having a more severe withdrawal, and some have more difficulty with stopping.

Neuro-biological Factors for Tobacco Dependence

- Neurobiological factors for tobacco use and dependence are complex, and predisposition probably involves various genes
- It is believed that different genes have different effects on the use of nicotine, use of tobacco, and dependence (Lerman and Berrettini, 2003; Lerman, et al., 2003)
 - Tobacco initiation and reasons for first use
 - Nicotine dependence and withdrawal severity
 - Tobacco dependence and withdrawal severity
 - Ability or inability to stop using tobacco
- People with serious mental health and/or substance use disorders have lower long-term tobacco abstinence rates and higher tobacco relapse rates, as compared to tobacco users without these disorders (Hagman et al., 2008)
 - This effect is believed to be related to genetic predisposition, and could suggest common factors for mental health and substance use disorders

Continued on next page

Biopsychosocial Factors for Tobacco Use and Dependence, Continued

Trainer Note	Mention that nicotine (and possibly other chemicals in tobacco smoke) affects many brain neurotransmitters in ways that provide a number of perceived benefits for people with mental health and substance use disorders.
Slide 47	
PM 33	This may help explain why these populations readily begin to use tobacco and why they have such difficulty stopping.

Neuro-chemical Effects of Nicotine

Nicotine, and possibly other chemicals in tobacco smoke, alters the levels of certain neurotransmitters in the brain, resulting in increased attention, increased speed of simple mental processes, and mood modulation. Scientists speculate that changes in the following brain chemical systems are linked to the feelings associated with using nicotine:

- Increases dopamine - increases pleasure, reward
- Increases norepinephrine - increases arousal and less appetite
- Increases acetylcholine - increases arousal and cognition
- Increases glutamate - helps learning and memory enhancement
- Increases vasopressin - controls memory, blood pressure
- Increases beta-endorphin - reduces anxiety and tension
- Increases GABA - reduces anxiety and tension
- Increases serotonin - mood modulation and appetite suppression

(Benowitz, 1992)

Problems or deficiencies in these brain chemical pathways are believed to cut across people who have tobacco dependence, mental health disorders, and substance use disorders.

Given the perceived benefits from using tobacco, the high rates of use, and high relapse rates for people with substance use and/or mental health disorders, it is no surprise why so many are tobacco dependent and have such difficulty stopping, despite a desire to become abstinent.

Continued on next page

Biopsychosocial Factors for Tobacco Use and Dependence, Continued

Trainer Note

Slide 48

PM 34 - 35

Ask participants to recall the barriers and challenges they identified earlier from viewing the Smoke Alarm videos in Unit 1. Then have participants read the psychological, behavioral, social, treatment/recovery, and systemic factors listed in their PM, which support the continued use of tobacco.

Ask participants to identify challenges/barriers (from video discussion) or challenges/barriers from their patients that are similar to the examples listed below. Summarize these examples.

If time permits, the trainer can use a small group exercise to allow participants to work together.

Psychological Factors

- Positive reinforcement includes the pleasurable effects, plus modest increase in cognitive focus and attention span
 - Negative reinforcement is use of tobacco to stop withdrawal symptoms and alleviate withdrawal anxiety, and use helps lift depressed mood
 - Belief in tobacco's ability to ward off mental health symptoms
 - Tobacco use as a self-reward
-

Behavioral Factors

- Tobacco use is part of daily routine and a way to structure the day
 - Tobacco use is "something to do" when talking, eating, using alcohol or other drugs, working
 - Tobacco use as something to do to dispel excess energy when anxious, stressed, bored or lonely
-

Continued on next page

Biopsychosocial Factors for Tobacco Use and Dependence, Continued

-
- | | |
|--|---|
| Social Factors | <ul style="list-style-type: none"> • Tobacco use is a key facilitator of social interactions • Tobacco use is ingrained in psychiatric and addiction treatment “culture” • Tobacco use may be part of person’s family practices and culture • Tobacco use is viewed as a patient’s “only pleasure” • Tobacco is given as a reward or withheld as punishment • Tobacco use is encouraged by patients, family members, and staff • Tobacco use adds to social stigma, as patients end up associating primarily with other tobacco users |
| <hr/> | |
| Treatment and Recovery System Factors | <ul style="list-style-type: none"> • Tobacco use is not seen as a problem by staff, especially by those who smoke • Tobacco abstinence is believed to be disruptive to treatment or it is assumed that abstinence causes symptoms to increase |
| <hr/> | |
| Larger Systemic Factors | <ul style="list-style-type: none"> • The tobacco industry has a documented history of targeting people with mental health disorders (Apollonio and Malone, 2005) • Tobacco industry funding research to support the notion that tobacco use “helps” mental health patients and that stopping use will aggravate their psychiatric symptoms (Apollonio and Malone, 2005; Prochaska, et al. 2008b) • Tobacco industry lobbying against bans on smoking tobacco in mental health facilities (Apollonio and Malone, 2005) • Health care regulators succumbing to pressure to allow “smoking areas” for psychiatric and addiction patients • Lack of policy to recognize and treat tobacco dependence |
-

Interaction of Tobacco Dependence and Other Substance Use Disorder

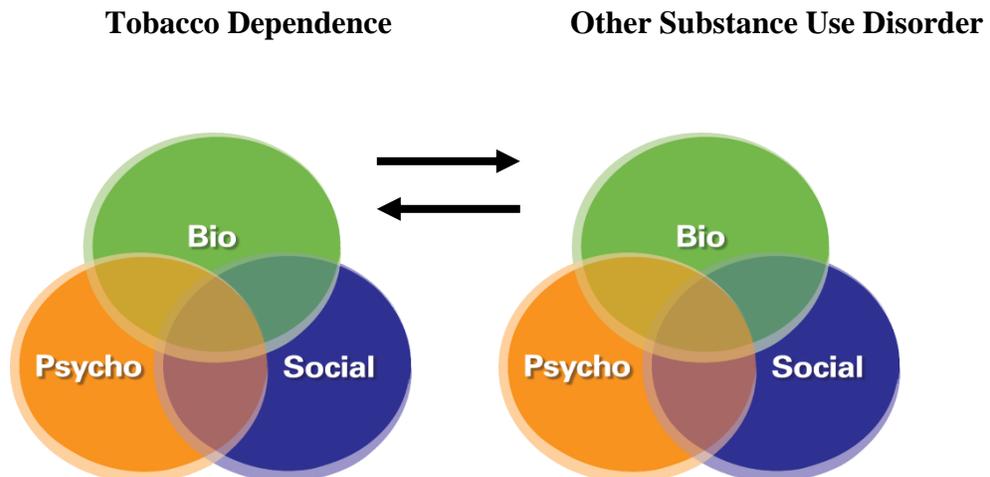
Trainer Note Remind participants from earlier modules about how tobacco use reinforces, increases, and negatively interacts with other forms of substance use disorders. Tobacco use leads to greater levels of substance use, more severe substance use disorders, co-morbid health conditions, and that a large portion of substance use disorder patients die from the consequences of tobacco use.

Slide 49

PM 36

After bringing up this slide, click once more to activate animation of interaction between both disorders.

Interaction of Tobacco and Other Substance Use Disorder



- Tobacco dependence and other types of substance dependence negatively interact. These co-morbid conditions
 - Tobacco is the common “gateway” for alcohol and other drug use
 - Using tobacco prompts or “cues” people to use other psychoactive substances
 - Tobacco use is part of the ritual for alcohol and other drug use and becomes a part of daily activities
 - People tend to use more tobacco when drinking or when using other psychoactive drugs; when people use tobacco, they tend to drink more and use greater amounts of other drugs
-

Interaction of Substance Use Disorder and Mental Health Disorder

Trainer Note

Slide 50

PM 37

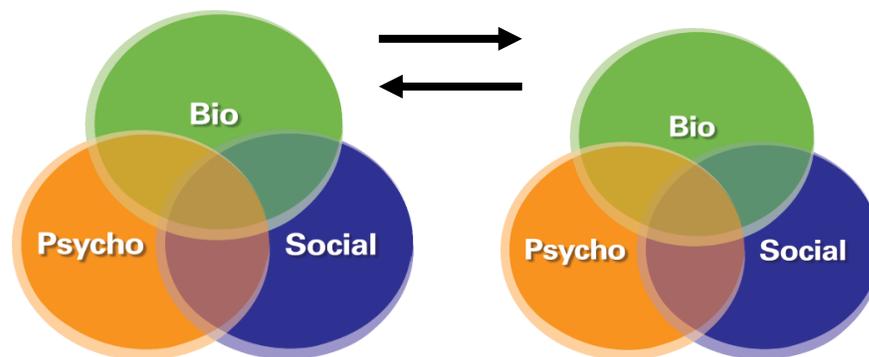
Explain that most participants will likely understand that substance use disorders and mental health disorders negatively interact. The effects of substance use and withdrawal makes mental health disorder symptoms worse, and symptoms of a mental health disorder tends to make a substance use disorder more severe.

After bringing up the slide, click once more to activate animation of interaction between both disorders.

Interaction of Other Substance Use Disorder and Mental Health Disorder

Substance Use Disorder (SUD)

Mental Health Disorder



- Substance use disorders and mental health disorders negatively interact. They are co-occurring and co-morbid conditions
- The effects of psychoactive substances and the addiction process will often magnify the symptoms of a mental health disorder
- The symptoms of a mental health disorder can help support substance use and worsen symptoms of a substance use disorder
- Some common effects of both disorders are anxiety, depression, lack of concentration, occupational and social problems, and increased risk of suicidal ideation and suicidal behavior

Both substance use disorders and mental health disorders often present with problems of judgment and cognitive functioning

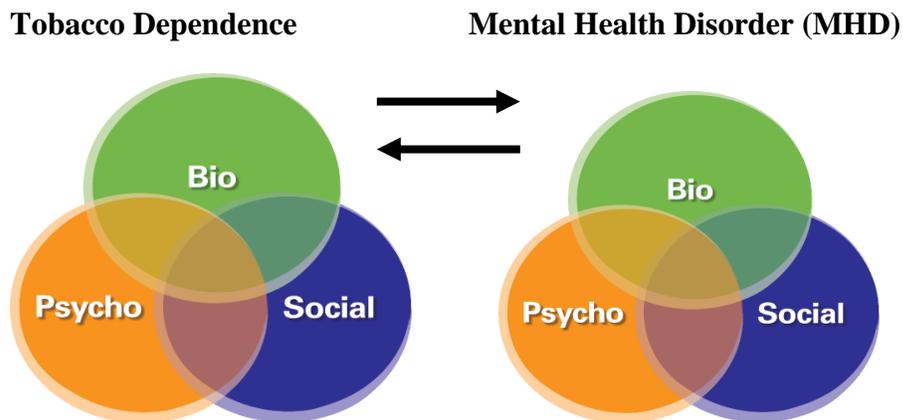
Interaction of Tobacco Dependence and Mental Health Disorder

Trainer Note Remind participants about information covered in the Tobacco and Co-occurring Disorders Knowledge activity about how tobacco use supports the onset of and negatively affects substance use and dependence. Emphasize that this effect also occurs between tobacco and mental health disorders. The results are increased risk of anxiety disorders, suicidal ideation/suicide risk, depression, increased mental health symptoms, and premature death. After bringing up the slide, click once more to activate animation of interaction between both disorders.

Slide 51

PM 38

Interaction of Tobacco Dependence and Mental Health Disorder



- A negative interaction occurs even if a person with a mental health disorder only uses tobacco. Tobacco dependence and mental health disorders are co-occurring and co-morbid conditions
- Tobacco dependence influences the development and progression of mental health disorders
- Tobacco use makes anxiety and panic disorders worse, increases the risk of suicidal ideation and suicidal behavior, and aggravates existing mental health disorders

Tobacco smoke impedes many areas of cognitive functioning and tobacco smoke interferes with some psychiatric medications.

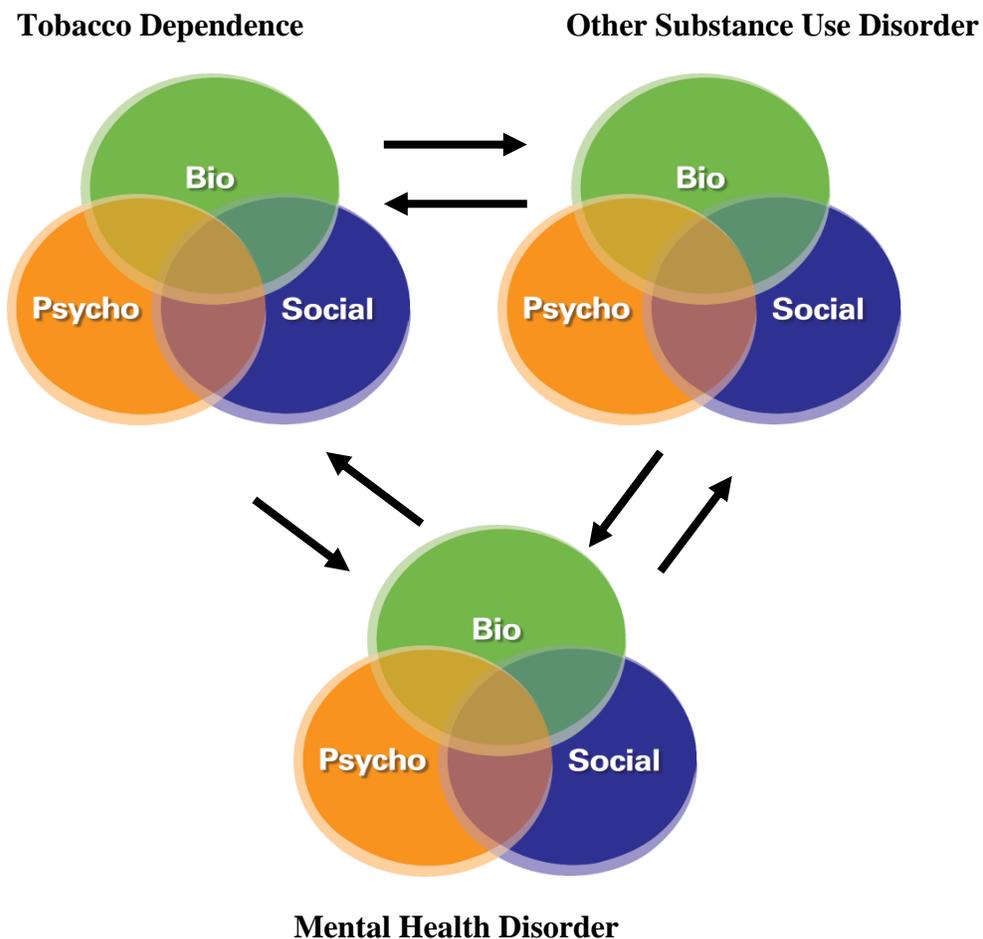
Interaction of Tobacco Dependence, Other Substance Use Disorder, and Mental Health Disorder

Trainer Note *Ask: So what do you think happens when all three conditions exist simultaneously? (Most participants should be able to recognize that all three conditions negatively interact and magnify each other.)*

Slide 52

PM 39 After bringing up this slide, click once more to activate animation of interaction between all three disorders.

Interaction of Tobacco, SUD, and MHD



When all three disorders are present, they interact and exacerbate each other

Common Factors Between MHD, SUD, and Tobacco Dependence

Trainer Note

The trainer has the option to conduct this activity by dividing the class into small groups (4 - 6 people each), using a brainstorm activity with the whole group, or, if time is limited, directly explaining the common connecting factors between tobacco dependence, mental health disorders, and substance use disorders.

Slide 53

PM 40

Think about your patients who have co-occurring mental health and substance use disorders, and are tobacco dependent. Identify a few examples that are most distinctive for you.

Now read over the list of factors on the next page of the PM.

What common connections between mental health disorders, substance use disorders, and tobacco dependence, seem to apply to those patients that you identified?

During the debriefing, record responses from the large or small groups on newsprint.

**Common
Factors
Activity**

Think about your own patients who have co-occurring mental health and substance use disorders, and who are tobacco dependent.

Now read the list of factors on the next page of your manual.

What common connections between mental health disorders, substance use disorders, and tobacco dependence do you recognize when thinking about your patients?

Continued on next page

Common Factors Between MHD, SUD, and Tobacco Dependence, Continued

Trainer Note During the debriefing, help participants to recognize or identify how all of the following factors connect for patients who have co-occurring mental health and substance use disorders, and have tobacco dependence. Include any additional factors identified during the discussion.

Slide 53

PM 41

Factors Affecting MHD, SUD, and Tobacco Dependence

- Chronic disease affecting the brain and neurobiology
 - Genetic predisposition is believed to be a factor
 - Involve common chemical pathways
 - Disorders that affect cognition, emotions, and behavior
 - Often require periods of intensive treatment
 - Recovery is possible and relapse is common
 - Require life-long management to keep the disease under control
 - Treatment requires addressing the whole person
 - Affected by psychological, behavioral, and social issues
 - Cognitive Behavioral Therapy, Motivational Interviewing, and Relapse Prevention Therapy are effective
 - Require life style changes for recovery to occur
 - Often require medication, sometimes for long periods or for life
 - Requires compliance with medication, therapy, and other activities
 - Social and peer support systems are important to recovery
-

Unit Summary

Trainer Note Summarize or ask participants to summarize the key learning points of this unit. The key points are that 1) tobacco use does not help control or reduce symptoms of mental health or substance use disorders; 2) these disorders are co-morbid biopsychosocial diseases and exacerbate each other; 3) tobacco smoke (not nicotine) affects psychiatric medications; and 4) tobacco use adversely affects treatment and recovery as well as overall health and lifespan.

Slide 54

PM 42

- Summary**
- Mental health disorders, substance use disorders, and tobacco dependence involve common brain chemical pathways involving dopamine, acetylcholine, serotonin, and many others
 - The use of tobacco does not help improve the symptoms of mental health disorders or substance use disorders
 - Tobacco use magnifies the symptoms of mental health disorders and substance use disorders, and it has significant negative effects on a patient's stability and recovery
 - Tobacco dependence, mental health disorders, and other substance use disorders are all chronic, biopsychosocial diseases
 - Tobacco dependence, other substance use disorders, and mental health disorders each have their own course and progression
 - Each disorder adds to and complicates the symptoms and course of another disorder, resulting in co-morbidity
 - When a person has all three disorders, the co-morbid effects can be multiplied
 - Treatment and recovery for a person with a substance use disorder, mental health disorder, and tobacco dependence, requires recognizing the interactions between the disorders
 - Effective treatment and recovery needs to address the biological, psychological, and social areas of all three disorders
-

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Unit 3

Treatment Strategy Review and Case Studies

Trainer Note This unit will include a brief review of treatment strategies for tobacco dependence, including nicotine and non-nicotine medications and evidenced-based counseling strategies.

Slide 55

PM 43

This review will be helpful when participants apply this information to three case studies, which involve co-occurring substance use and mental health disorders.

Purpose This unit will include a brief review of treatment strategies for tobacco dependence, including nicotine and non-nicotine medications and evidenced-based counseling strategies.

Participants will then apply this information to three case studies, which involve co-occurring substance use and mental health disorders and tobacco use.

Objective Use a case study to determine the best practices and recommendations to address tobacco use by a patient with co-occurring disorders

Tobacco Treatment Review

Trainer Note	Remind participants that during Module 2 there was significant discussion about first and second-line medications used to treat tobacco dependence, along with dosage and considerations for use. If necessary, conduct a brief review of the following key points as listed below or move directly to the case studies. This content is in the PM.
Slide 56	
PM 44	

Tobacco Medication Review

First-line medications (FDA approved, wide safety margin, and effective):

Three over-the-counter (OTC) nicotine replacement medications:

- Nicotine gum (2 and 4 mg)
- Lozenge (2 and 4 mg)
- Patch (7, 14, and 21 mg)

Two prescription nicotine replacement medications:

- Nicotine nasal spray
- Nicotine inhaler

Two non-nicotine prescription medications:

- Varenicline (trade name, Chantix)
- Bupropion (trade names, Wellbutrin and Zyban)

Second line medications (Not FDA approved for treating tobacco dependence, are effective and have more side effects) are:

- Nortriptyline (an antidepressant) is less commonly used due to it causing weight gain and have a number of side effects
- Clonidine (an anti-hypertensive)
- Some small recent studies suggest nortriptyline is as effective as bupropion for people who struggle with depressed mood after stopping tobacco smoking (Hughes, 2007)

Continued on next page

Tobacco Treatment Review, Continued

Trainer Note

Remind participants that this content on NRT and counseling strategies is provided in earlier modules and can be taken online at www.tobaccorecovery.org

Slide 57

PM 45 - 47

The trainer has the option to review the following reminders about tobacco medications on next three (3) pages or refer participants to these pages as content that they can read as reminders.

The slides for these three pages highlight the content. Time will not allow an indepth review; this content is provided only as a refresher of material covered in prior modules.

Tobacco Treatment Medication Review, cont'd

- Nicotine is well tested as a medication and has a high margin of safety (Benowitz, 1998; Joseph et al., 1996; McRobbie and Hajek, 2001)
 - Over-the-counter nicotine medications and the nicotine inhaler have very low risk for causing dependence
 - Compared to smoking, using nicotine medications lowers the risk of cardiac events (Murray, 1996; Mahmarian, 1997; Working Group for Study of Transdermal Nicotine, 1994)
 - Many patients do not use enough NRT and/or use it incorrectly, and experience withdrawal symptoms
 - As a result, many patients do not think these medications work
 - Patient education about how to use medications is important and should be repeated to ensure correct use
 - The nicotine patch, varenicline, and bupropion are “controller medications” providing steady relief from nicotine withdrawal
 - Nicotine gum, lozenge, inhalers, and nasal spray are “rescue medications” to control “break-through withdrawal and cravings”
-

Continued on next page

Tobacco Treatment Review, Continued

Tobacco Treatment Medication Review, cont'd

- New information suggests NRT dosages need to be individualized given the severity of tobacco dependence (Bars, et al., 2006; Kozlowski, et al., 2007; Sachs, 2006; Fiore, et al., 2008)
- For some patients, especially heavy smokers, dosages of NRT need to be higher than what is recommended (Fiore et al., 2008; Bars, et al., 2006; Kozlowski, et al., 2007; Sachs, 2006)
- Tobacco dependence is a chronic illness, and severely dependent patients may need to use NRT for six to 12 months, or even longer (Fiore et al., 2008; Bars, et al, 2006; Kozlowski, et al., 2007; Murray, 1996; Mahmarian, 1997)
- Combinations of two or more medications are recommended (Fiore et al., 2008)
 - A person using the patch and/or bupropion to provide steady relief, can also use the gum, lozenge, and/or inhaler
- Combining supportive counseling such as motivational interviewing or cognitive behavioral therapy along with medications enhances success (Fiore et al., 2008)
- Some smokers report a preference for the inhaler, because it simulates using a cigarette
- Some people with schizophrenia may do better with the nicotine nasal spray, which provides a higher nicotine dose and the fastest craving relief (Williams and Foulds 2007; Williams et al., 2008)
 - The nasal spray does have some potential for producing physiological dependence if used long-term
- Patients who smoke tobacco and take atypical antipsychotics such as Clozaril or Zyprexa, often report a reduction in their tobacco smoking (George et al., 1995, 2000; McEvoy et al., 1995, 1999)
 - The tobacco abstinence rate for this group was about equal to non-psychiatric smokers, when the nicotine patch was used

Continued on next page

Tobacco Treatment Review, Continued

Tobacco Treatment Medication Review, cont'd

- Nicotine medications are classified by the Food and Drug Administration (FDA) as Category D drugs, which indicates risk of adverse effects on fetal development in human
 - The benefits of NRT generally outweigh the many negative effects of smoking on fetal development (Fiore et al., 2008)
- Bupropion can provide a dual benefit for people who develop depressed mood after stopping tobacco. It is contraindicated for people with a history or risk of seizures, eating disorders, or those recently taking MAOI antidepressants
 - There is insufficient evidence to show bupropion is effective for pregnant women who smoke (Fiore et al., 2008)
 - The FDA lists bupropion as a Category C drug, meaning animal studies have shown adverse effects on fetal development, but this effect has not been adequately determined for humans
- Varenicline (Chantix) can be used successfully by many people and preliminary studies indicate it may be more effective than other tobacco treatment medications
 - It should be used with caution in people with renal impairment
 - Varenicline has not been shown to be effective for pregnant women who smoke (Fiore et al., 2008)
 - The FDA lists varenicline as a Category C drug, meaning animal studies have shown adverse effects on fetal development, but this effect has not been adequately determined for humans

Continued on next page

Tobacco Treatment Review, Continued

Trainer Note Slide 58 PM 48	Remind participants that the stages of change and counseling strategies are covered in previous modules, especially Module 3. Also, explain that while not an evidence-based approach, peer-based tobacco counseling has been widely used in mental health programs to help patients become abstinent from tobacco. Many patients report this method was very helpful to their success.
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Psychosocial Tobacco Treatment Review

- Knowing a patient's stage of change regarding their tobacco use is important to choosing the best counseling intervention
- Motivational Interviewing is effective for people in the precontemplation or contemplation stage of change with respect to their tobacco use. Psychoeducation groups focused on healthy behavior are also effective (Fiore et al., 2008)
- Cognitive Behavioral Therapy (CBT), stress management skills, and problem solving skills training work better for patients in the preparation, action, or maintenance stages of change with respect to their tobacco use (Fiore et al., 2008)
- Relapse Prevention Therapy is effective to help patients in recovery from tobacco use and helps them learn to manage day-to-day stresses and prevent a return to use (Fiore et al., 2008)
- Individual and group peer-based tobacco counseling appears to be useful for some people with mental health disorders
 - Peer counseling has been used successfully by mental health programs in New Jersey, New York, and other states to address tobacco use
 - Some patients with mental health disorders report they feel more willing to discuss their tobacco use and how to stop their use with a peer who understands tobacco dependence

Continued on next page

Tobacco Treatment Review, Continued

Trainer Note

Slide 59

PM 49

Emphasize that tobacco dependence is a chronic disease and the average smoker has significant difficulty becoming abstinent. Patients with mental health and substance use disorders have even greater difficulties. Nonetheless, most can succeed with support, medication, and counseling. Many can quit for short periods, however obtaining long-term abstinence may take multiple attempts.

Finally, emphasize that by not assessing and treating tobacco use by patients with mental health and substance use disorders, this overtly tells patients they are not capable of stopping, that they are not willing to stop, that tobacco use helps them, and that “it is good for them.”

Then make a transition by indicating the next activity is to apply this new knowledge in a case study activity.

Important Reminders

- Tobacco dependence is a chronic disease
 - Successful tobacco abstinence often takes multiple attempts and multiple treatment efforts
 - If a patient shows a reduction in the amount of tobacco used, when they use, where they use, or how often they use, that shows some success and should be affirmed
 - Due to prior failures to stop, many patients need lots of encouragement
 - Not assessing and treating tobacco use gives an unhealthy and incorrect message to patients
 - It incorrectly implies that patients are not capable of stopping
 - It incorrectly implies that they are not willing to stop
 - It incorrectly suggests that tobacco “helps them with their illnesses”
-

Case Studies

Trainer Note	Ask participants to turn to the three case studies in their PM. All of these case studies include at least one mental health disorder, at least one non-tobacco substance use disorder, and tobacco dependence.
Slide 60	
PM 50	This is a small group exercise. The trainer can assign the small groups different cases. If using this method, during the debriefing, allow the other groups to read the specific case example, before the assigned group reports their recommendations.
Slide 61	
Case 1: Kathy PM 51 - 52	Alternately, the trainer has the option to assign one case to be read and then discussed by the entire class, then can have the class read and discuss the second case, and if time permits, the third case.
Case 2: John PM 53 - 54	
Case 3: Alvin PM 55 - 56	Ask the small groups to read their assigned case and answer the questions on the next page. Allow them about 10 minutes for each. A review chart of medications that interact with tobacco smoke is after the third case study for an easy reference.
Drugs and Tobacco Smoke Interactions PM 57	When each group is ready, review their responses to each assigned case study with the large group. Ask each group to report out their case study, and then ask the large group for any additional recommendations.

Trainer Note	During the large group discussion and review of the case studies, participants should be able to identify most if not all of the key responses. Confirm correct responses and provide participants with any unstated specific answers to each case, as included in the Trainer Notes.
Slide 62	

Case Study 1 - Kathy

Kathy is a 40-year-old single woman in an outpatient program for alcohol dependence, and receives regular sessions and medication from a mental health provider for depression and anxiety. She has mild anxiety in social situations after experiencing a panic attack in a public setting. She asks if she should try to stop using tobacco.

- She has no suicidal ideation, no history of seizures, and has been abstinent from alcohol for over five months.
- She was not ready to stop tobacco 2 months ago, but the high cost of cigarettes and strong recommendation of her OB/GYN physician caused her to now consider stopping. She also must leave the building and grounds to smoke during work hours, which is becoming very inconvenient.
- Members of her fellowship group told her not to stop smoking for at least a few years, as it will jeopardize her sobriety. Her psychiatrist is concerned if she stops smoking, thinking that it may re-trigger symptoms of depression and anxiety.
- She started using tobacco at age 15, because it “kind of lifted my spirits”. Within a year, she was using a pack a day and now smokes 25 to 30 cpd. She states, “I smoke to help keep calm.” She is a regular coffee drinker, often having six or more cups a day.
- She began drinking alcohol at 18 and progressed until she began recovery five months ago. As her drinking increased, she noticed that she smoked more.
- About 3 months ago, she began taking Pamelor (nortriptyline) to control her depression and anxiety, and she sees a psychiatrist twice a month.
- Her only tobacco abstinence was during her pregnancy 20 years ago, but she started smoking soon after giving birth. She has cut down to about 15 cpd several times, but could not stop altogether and returned to her 25 - 30 cpd.
- She lives in the family-owned home with her brother, who smokes heavily.

Continued on next page

Case Study 1 - Kathy, Continued

Questions for Kathy

What challenges and barriers does Kathy have to overcome to stop her tobacco use?

What strengths/resources does she have to help her stop tobacco use?

What nicotine replacement medications might be helpful?

Would you recommend that she talks to her psychiatrist about using Chantix (varenicline) or Zyban/Wellbutrin (bupropion)? Why or why not?

If she stops using tobacco, are there any other medications she is taking that might be affected? (See Medication and Drug Chart after Case Study Questions.)

Kathy is in the contemplation stage of change with respect to her tobacco use. What counseling strategies might be helpful to use at this point?

If Kathy prepares to stop or stops using tobacco, what strategies might you use to help manage her symptoms of depression and anxiety?

Continued on next page

Case Study 1 - Kathy, Continued

Trainer Notes Questions for Kathy

What challenges and barriers does Kathy have to overcome to stop tobacco use?

Kathy lives at home with a brother who smokes, fellowship members told her not to stop, her psychiatrist thinks stopping might trigger mental illness symptoms, and she believes tobacco keeps her calm.

What strengths/resources does she have to help her stop tobacco use?

Kathy has the support of her OB/GYN physician. She has five months of stable recovery and can draw upon this success to help stop tobacco use. She can't smoke on the premises at work and the cost of tobacco is prompting her to consider stopping.

What nicotine replacement medications might be helpful?

Helpful medications might include the patch such as 21 mg, plus 7-14 mg at night, plus 2 or 4 mg gum or lozenge as needed.

Would you recommend that she talks to her psychiatrist about using Chantix (varenicline) or Zyban/Wellbutrin (bupropion)? Why or why not?

Kathy might be a candidate for either medication. If the psychiatrist prescribes Chantix, then Kathy's psychiatric symptoms should be closely monitored. There is probably no need to add Wellbutrin, as nortriptyline (Pamelor) has similar effectiveness and is an alternative for people who are depressed and who are trying to stop smoking.

If she stops using tobacco, are there any other medications she is taking that might be affected? (See Medication and Drug Chart after Case Study Questions.)

Yes. Nortriptyline is metabolized by 1A2 -the same enzyme affected by tobacco smoke. Thus, her dose may need adjustment (lowered) if medication side effects occur after she stops smoking. Nortriptyline is one medication that can be monitored by checking blood levels of the medication. Weight gain is a nortriptyline side-effect that contributes to it being used less often for tobacco treatment. Kathy should also reduce her caffeine consumption and be aware that even low dose caffeine can cause symptoms of anxiety.

Kathy is in the contemplation stage of change with respect to her tobacco use. What counseling strategies might be helpful to use at this point?

Motivational Interviewing can be used to explore Kathy's ambivalence about stopping her tobacco use. The decisional balance exercise can explore the pros and cons of all aspects of stopping or continuing to use tobacco.

Continued on next page

Case Study 1 - Kathy, Continued

Trainer Notes Questions for Kathy, continued

If Kathy begins to prepare to stop and/or stops using tobacco, what strategies might you use to help manage her symptoms of depression and anxiety?

The Tobacco Recovery Group, plus the use of Cognitive Behavioral Therapy (CBT), can help Kathy to control negative thinking that increases her feelings of depression. Stress management or relaxation techniques to control anxiety may be useful in conjunction with CBT and nortriptyline (Pamelor). Finding a fellowship sponsor and/or fellowship group that supports tobacco abstinence would also be helpful.

Case Study 2 - John

John is a former patient who called for an appointment to discuss how he could stop using tobacco. He is a 42-year old man with bipolar disorder and a history of alcohol dependence, which is in remission. He has been employed for several years.

- He has bronchitis and was diagnosed with bipolar disorder at age 29. He has experienced four past episodes of depression, resulting in three hospitalizations. He has no history of seizures and is not suicidal.
- He is taking Neurontin (gabapentin, an anticonvulsant for bipolar disorder) and Celexa (citalopram - a SSRI for depression). His symptoms are under control. He is also taking Theo-Dur for his bronchitis.
- He began smoking at age 14 “to be cool.” Smoking helps him stay focused and he feels it stops his anxiety. His tobacco use increased after he started drinking at 19.
- He entered an inpatient treatment center for alcohol dependence, then attended outpatient group therapy for three months, and now has six months of continuous abstinence.
- He attends AA regularly and a dual-recovery fellowship meeting once a week, where most members smoke before and after the meeting. Many of his friends smoke.
- He tried to quit smoking “cold turkey” several times and got down to 12 cigarettes a day, before returning to his usual two packs a day. He also drinks several large cups of coffee and some cola beverages throughout the day.
- He once used a 21 mg patch, 2 mg nicotine gum, and tobacco cessation class. The gum was uncomfortable, but he cut down to only a few cigarettes a day and stopped altogether for a few weeks. However, after a 12 week recommended program on the patch, he stopped using it and relapsed.
- When he tries to stop using tobacco, he becomes preoccupied with cigarettes. His mood fluctuates and he becomes anxious and distracted. While using the patch, his anxiety and distractibility were not as hard to manage.
- He dislikes the costs of smoking and the feeling of being controlled by tobacco. While an inpatient he wanted to quit, but his counselor told him not to quit until he had a year of recovery. He wants to quit now, which his internal medicine physician supports.
- His psychiatrist is willing to support his decision to stop tobacco, but has concerns that this might destabilize his mood.

Continued on next page

Case Study 2 - John, Continued

Questions for John

Given that, John is in active recovery from a mental health disorder and a substance use disorder, how would you respond to his wanting to stop his tobacco use?

What are John's major challenges and barriers for stopping tobacco use?

How would you work with his psychiatrist, who appears hesitant to support his becoming tobacco abstinent?

If he stops using tobacco, are there any other medications he is taking that might be affected? (See Medication and Drug Chart after Case Study Questions.)

What nicotine replacement medications might be helpful?

Would you recommend that he talks to his primary care physician or psychiatrist about using Chantix (varenicline) or Zyban/Wellbutrin (bupropion)? Why or why not?

What counseling strategies might be helpful in combination with tobacco medication?

Continued on next page

Case Study 2 - John, Continued

Trainer Notes Questions for John

Given that, John is in active recovery from a mental health disorder and a substance use disorder, how would you respond to his wanting to stop his tobacco use?

Affirm John's decision and agree that there is no need to wait for a year of recovery. Bronchitis can be caused and made worse by smoking. Stopping tobacco will help improve his physical health, mental stability, and long-term recovery. Studies have shown that smokers in early alcohol recovery can be successful in quitting smoking.

What are John's major challenges and barriers for stopping tobacco use?

Fellowship meetings where smoking occurs before and after may be a relapse trigger. Many friends also smoke. John feels anxious and distracted, and his mood fluctuates when he tries to stop tobacco use. His psychiatrist is expressing some concern about his stopping tobacco.

How would you work with his psychiatrist, who appears hesitant to support his becoming tobacco abstinent?

Advise that tobacco can make psychiatric symptoms of depression and anxiety worse and that individuals with mental illness are vulnerable to life threatening tobacco diseases just like other smokers. Explain that patients often misinterpret nicotine withdrawal symptoms as being due to mental illness, and they think that continuing to smoke is helping their mental illness. Stopping smoking will not worsen his mental health or substance dependence recovery, and his overall recovery may improve. The risk to benefit ratio is greatly in support of using nicotine replacement therapy over continued tobacco use.

If he stops using tobacco, are there any other medications he is taking that might be affected? (See Medication and Drug Chart after Case Study Questions.)

There are no issues with Neurontin and Celexa. Caffeine can be an issue as it tends to increase agitation and anxiety. John may need to cut his caffeine intake as levels may increase after he stops smoking. He may also need to have his Theo-Dur (contains theophylline) dose lowered to avoid side effects.

What nicotine replacement medications might be helpful?

Since he has succeeded in the past with nicotine replacement medications, it is reasonable to try them again. John may benefit from longer use of patch (6 months or longer) which is not associated with any long-term side effects. The risk of developing addiction to the nicotine patch is virtually non-existent. Due to his use of 40 cpd, he might use a 21 mg patch and 14 or 21 mg patch at night. He can add lozenges or gum or get a prescription for the nicotine inhaler or nasal spray to relieve break-through cravings or withdrawal.

Continued on next page

Case Study 2 - John, Continued

Trainer Notes Questions for John, cont'd

Would you recommend that he talks to his primary care physician or psychiatrist about using Chantix (varenicline) or Zyban/Wellbutrin (bupropion)? Why or why not?

John might be a candidate for either medication. If the psychiatrist or PCP prescribes Chantix, then John's psychiatric symptoms should be closely monitored. There is no contraindication for Wellbutrin, although it is probably not needed as he is already on an antidepressant and his mood disorder is stable using Neurontin.

What counseling strategies might be helpful in combination with tobacco medication?

John is in the preparation stage of change. Use cognitive-behavioral therapy (CBT) and other behavioral methods, along with a Tobacco Recovery Group to help him set an abstinence date. Relapse prevention therapy would also be helpful.

Case Study 3 - Alvin

Alvin is a 44-year-old male who is being treated at your inpatient treatment facility. He was admitted for marijuana and alcohol dependence.

- Alvin began using alcohol and marijuana at age 19 and has been a daily user for the past 17 years. His wife does not currently smoke tobacco or marijuana. She used to smoke marijuana with him but stopped many years ago. Alvin reports that she criticizes him about his marijuana use and asks him to stop.
- Despite his efforts to control his drinking, over the years his alcohol use increased from an occasional beer to “five or six a night, sometimes more.”
- His daily routine includes smoking cigarettes first thing in the morning and several before going to work. He also smokes marijuana before going to work and smokes cigarettes on work breaks as often as he can. He then smokes cigarettes before and after dinner, smokes a joint or two, and drinks several beers before going to bed.
- He began using tobacco at age 15 and now smokes almost two packs a day. He has been counseled at work about taking too many smoke breaks.
- At admission, he stated he was a National Guard veteran and honorably discharged in 1995. At 3 weeks into treatment, he stated, “pot and drinking were clearly causing me lots of problems” and then revealed that he was on active duty in the Gulf War in 1992. He saw active combat, with “lots of death and destruction.”
- He tries hard not to think about war memories and rarely discusses it. Smoking cigarettes helped to “occupy my mind and keep my spirits up.” After returning to the US, his marijuana and alcohol use steadily increased.
- He knows tobacco is not good, but does not like feeling “down in the dumps and jittery” when he tries to stop or cut down. He is on a 21 mg patch and gum while an inpatient, but he reports feeling “down in the dumps,” “generally worried, why I do not know,” and is thinking about “a lot of memories I’d like to forget.”
- After returning home from Iraq, he was prescribed Tofranil (imipramine) by the military doctor, which he took for several months. It helped some, but he stopped this medication after discharge and wonders if he could take it again.

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Case Study 3 - Alvin, Continued

Questions for Alvin

What are some of Alvin's challenges and barriers to stop his tobacco use?

If he starts using Tofranil or a similar medication, and then later stops smoking, will his medication dosage need to be adjusted? (See Medication and Drug Chart after Case Study Questions.)

What strengths and resources can he use to help stop using tobacco?

Given that Alvin is in the precontemplation stage of change about his tobacco use, what counseling strategies would be helpful?

If Alvin decides to stop using tobacco, what nicotine replacement medications might be helpful?

Would you recommend that he talks to the facility physician or psychiatrist about using Chantix (varenicline) or Zyban/Wellbutrin (bupropion)? Why or why not?

If Alvin decides to stop using tobacco, even if using NRT, do you expect an increase in any of the symptoms he is reporting? What other services would you recommend?

Continued on next page

Case Study 3 - Alvin, Continued

Trainer Notes Questions for Alvin

What are some of Alvin’s challenges and barriers to stop tobacco use?

Alvin feels tobacco keeps his mood elevated and distracts him from troublesome memories. He is allowed to smoke during breaks at work, and smokes at home indoors or outside. His use of marijuana is a problem because as another smoking behavior it likely triggers cigarette smoking and vice versa.

If he starts using Tofranil (imipramine) or a similar medication, and then later stops smoking, will his medication dosage need to be adjusted? (See Medication and Drug Chart after Case Study Questions.)

Possibly. He also should be monitored for medication side effects if he stops smoking.

What strengths and resources can he use to help?

He recognizes the effects of his alcohol and marijuana dependence, and is beginning to openly acknowledge his combat experiences and the connection to his substance dependence and tobacco dependence. He is aware tobacco is not good for his health. His wife will support him in quitting substances.

Given that Alvin is in the precontemplation stage about his tobacco use, what counseling strategies could be helpful?

Use the Tobacco Awareness Group to examine how his tobacco use supports his alcohol and marijuana dependence. Use Motivational Interviewing to explore the benefits of using tobacco vs. benefits of stopping, and to help explore his ambivalence about stopping his tobacco use.

If Alvin decides to stop using tobacco, what nicotine replacement medications might be helpful?

He could use the patch 21 mg along with 2 - 4 mg gum or 2 - 4 mg lozenge. If he needs more immediate relief, he could also use the inhaler or nasal spray, available by prescription.

Would you recommend that he talks to the facility physician or psychiatrist about using Chantix (varenicline) or Zyban/Wellbutrin (bupropion)? Why or why not?

Alvin might be a candidate for either medication. If the physician prescribes Chantix, then Alvin’s psychiatric symptoms should be closely monitored. Wellbutrin may be helpful given his report of a depressed mood after stopping smoking, however it should be used with caution in individuals with heavy alcohol use, given Wellbutrin can elevate the risk for causing seizures. In individuals using multiple substances or who may be less reliable, it is sometimes prudent to choose the treatment that has the least potential for harm. Nicotine replacement medication has advantages in that it contains only nicotine.

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Case Study 3 - Alvin, Continued

Trainer Notes Questions for Alvin, cont'd

If Alvin decides to stop using tobacco, even with NRT, do you expect an increase in any of the symptoms he is reporting? What other services would you recommend?

Even though on a 21 mg patch and nicotine gum, he is reporting a general sense of anxiety, intrusive memories and depression suggesting PTSD. He will likely experience a continued and possibly increased variety of symptoms. Longer term NRT and additional psychiatric medications may be needed. Psychiatric evaluation and follow-up is recommended along with supportive therapy for combat veterans. He may be at higher risk for developing depression or other mood changes when he is abstinent from tobacco and frequent mood monitoring of symptom changes would be an important part of his treatment plan.

Medications and Drugs Affected by Tobacco Smoke

Trade Names	Generic Name	Purpose
Anafranil	Clomipramine	OCD
Clozaril	Clozapine	Antipsychotic
Coffee, Cola, Soft drinks, some OTC medications, Tea	Caffeine	Cognitive Stimulant
Elavil	Amitriptyline	Antidepressant
Haldol	Haloperidol	Antipsychotic
Luvox	Fluvoxamine	OCD, Anxiety
Pamelor/Aventyl	Nortriptyline	Antidepressant, Anxiety
Prolixin	Fluphenazine	Antipsychotic
Theo-24, Theo-Dur, Theobid, Theovent	Theophylline	Asthma, Bronchitis, Emphysema
Thorazine	Chlorpromazine	Antipsychotic
Tofranil	Imipramine	Antidepressant
Zyprexa	Olanzapine	Antipsychotic

Unit Summary

Trainer Note
Slide 63
PM 58

Summarize that the treatment of people with co-occurring disorders does not generally differ from methods used to treat other tobacco users, including people with or without substance use or mental health disorders. The intensity of treatment may be higher, and require more frequent treatment efforts and engagement of patients in order to address their tobacco use. Nicotine medications have a wide margin of safety and non-nicotine medications, including bupropion and varenicline are also effective. Many medications can be used together, and neither nicotine or varenicline cause drug-to-drug interactions. Evidenced-based counseling strategies, such as motivational interviewing, cognitive behavioral therapy, and relapse prevention therapy are effective, and medication plus counseling is more effective than either method alone. Psychoeducation groups about tobacco are effective. Peer counseling may also be of benefit. Treatment also requires anticipating how stopping tobacco use may affect other medications.

- Summary**
- The treatment for people with co-occurring disorders does not generally differ from those methods used to treat people with or without substance use or mental health disorders
 - The main differences are often higher intensity of treatment, more frequent treatment efforts, and more effort to engage patients to address their tobacco use
 - Treatment includes nicotine medications, which have a wide margin of safety and non-nicotine medications, including bupropion and varenicline
 - Many medications can be used in combination and neither nicotine nor varenicline cause drug-to-drug interactions
 - The use of evidenced-based counseling strategies, such as motivational interviewing, cognitive behavioral therapy, and relapse prevention therapy are also effective
 - Psychoeducation groups about tobacco are effective
 - The use of medication plus counseling is more effective than either method alone; peer counseling may also be of benefit
 - Treatment also requires anticipating how stopping tobacco use may affect other medication levels and monitoring where indicated
-

Module Closure

Slide 64
PM 59

The trainer has the option to have participants use a different color post-it note, and ask them to “re-post” their response as a result of training. Alternately, the trainer can ask the large group if their individual scores changed and, if so, how and why their original choices changed.

If using different colored post-it notes, ask participants to revisit the newsprint pages of the five statements and place their new selections. Then discuss the results, making note of how many changed from their original selected choices and changes in ratings on the confidence scale.

Attitudes and Beliefs

Revisit the newsprint pages of the five statements and place their new selections.

Did your ratings on the confidence scale change?

In reviewing your earlier response to the attitudes and beliefs activity, did your answers change?

What changed and why?

Trainer Note
Slides 65-66
PM 61 - 62

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

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

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

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Resources

**Resource
Directory**

Tobacco Recovery Resource Exchange (<http://www.tobaccorecovery.org>) can be used to access e-learning opportunities, technical assistance, 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>.

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Resources, Continued

**Resource
Directory,
cont'd****NYS Medicaid Policy Smoking Cessation Policy**

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

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

American Cancer Society 1-800-227-2345

American Lung Association 1-800-586-4872

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Glossary

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

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

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

AOD: Alcohol and Other Drugs

Articulate: Clearly explain, describe, or talk about

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

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

ATOD: Alcohol, Tobacco, and Other Drugs

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

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

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

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

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Glossary, Continued

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

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

Cessation Centers: Funded community partners 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

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Glossary, Continued

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

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

CPD: Cigarettes Per Day

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

CPP: New York State Credentialed Prevention Professional

CPS: New York State Credentialed Prevention Specialist

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

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

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

DMOA: Development, Management, and Oversight Agency

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Glossary, Continued

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

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

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

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

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

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

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

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

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

Expectancy: A learned anticipation of an effect from a cause

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Glossary, Continued

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

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

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

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

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

LCSW: Licensed Clinical Social Worker

LGBT: Lesbian/Gay/Bisexual/Transgender

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

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

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

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Glossary, Continued

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

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

Module: A self-contained component of an instructional system. PDP instruction is broken into modules to make the instruction easy to access and deliver

Negative Reinforcement: A behavior is reinforced when a negative condition is stopped or avoided as a consequence of the behavior (example: use of tobacco to avoid withdrawal symptoms). Negative reinforcement should not be confused with punishment, which weakens a behavior when a negative condition is introduced

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

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

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

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

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

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

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Glossary, Continued

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

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

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

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

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

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

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

Pharmacotherapy: The treatment of disease using medications

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

PPD: Packs Per Day (of cigarettes)

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Glossary, Continued

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

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

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

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

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

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

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

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

RTATC: An acronym for Regional Technical Assistance and Training Center

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Glossary, Continued

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

Screening: Gathering and sorting of information to determine if a person may have a problem with substance use (i.e., 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

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Appendix

Pre-Test and Post-Test Questions

Pre-Test and Post-Test Answer Key

Pre-Test and Post-Test Answer Sheet

Workshop Evaluation Form

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Module 5 Co-occurring Disorders Pre-Test and 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 and do not write on the test. Record your answers on the answer sheet that is provided.

1. What is the best definition of co-morbidity?
 - a. two disorders or health conditions that positively affect each other
 - b. two simultaneous disorders that have no affect on each other
 - c. using psychiatric medications for a substance use disorder
 - d. two simultaneous disorders that negatively affect each other
 - e. all of the above

2. Bupropion can be especially helpful for treating tobacco dependence when:
 - a. the patient has panic disorder or schizophrenia
 - b. the patient has a seizure disorder
 - c. the patient has not been able to use Chantix
 - d. the patient has a depressed mood when stopping tobacco use
 - e. all of the above

3. Tobacco smoking has which effect(s) on certain psychiatric medications and caffeine:
 - a. increases the levels of many medications within the body
 - b. has little or no effect on treatment medications
 - c. increases the breakdown of certain psychiatric medications
 - d. only affects bupropion and varenicline
 - e. all of the above

4. Which are common factors of tobacco dependence, mental health disorders and other substance use disorders?
 - a. they are all influenced by genetic factors
 - b. all are biopsychosocial diseases
 - c. they are all chronic diseases and often involve relapse
 - d. each disorder involves common brain chemical pathways
 - e. all of the above

5. When patients stop smoking tobacco, what are the most frequent reason(s) for increased feelings of anxiety and restlessness?
 - a. withdrawal due to inadequate levels of tobacco treatment medication
 - b. excess caffeine use
 - c. the level of patient resistance to change
 - d. poor diet and lack of exercise
 - e. a and b

Page 2 -Module 5 Pre-Test and Post-Test Questions

6. The use of varenicline (Chantix) by people with mental health and/or substance use disorders:
 - a. is usually contraindicated due to risk of increased psychiatric symptoms
 - b. has been shown to be very effective
 - c. requires caution with people who have kidney disease
 - d. negatively interacts with psychiatric and treatment medications
 - e. b and c

7. When people with mental health and/or substance use disorders stop smoking tobacco, which of the following often occur(s)?
 - a. the risk of panic disorder and suicidal thinking decreases
 - b. their overall recovery tends to improve
 - c. they have more discretionary money
 - d. their overall health improves
 - e. all of the above

8. Chronic and regular use of tobacco often has which effect:
 - a. it reduces anxiety and reduces the risk of panic attacks
 - b. it is helpful for patients who have panic disorder
 - c. it increases anxiety and contributes to the risk of panic attacks
 - d. it can reduce fears and social phobias
 - e. none of the above

9. For people with mental health and/or substance use disorders, some challenges and barriers to stopping tobacco use include:
 - a. tobacco use is part of their daily ritual and structure for the day
 - b. tobacco use is supported or even encouraged by clinicians and family
 - c. they believe tobacco helps ward off their mental health symptoms
 - d. the tobacco industry has supported efforts to keep patients smoking
 - e. all of the above

10. When addressing tobacco use by people with mental health and/or substance use disorders it is helpful to:
 - a. use periodic confrontation about the dangers of smoking
 - b. have more frequent engagement efforts and treatment attempts
 - c. wait until patients have one year of recovery and are symptom free
 - d. wait until the patient asks about stopping his/her tobacco use
 - e. all of the above

Module 5 Co-occurring Disorders: Pre-Test and Post-Test Answer Key

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Page 2 -Module 5 Co-occurring Disorders: Pre-Test and Post-Test Answer Key

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Module 5 Co-occurring Disorders: Pre-Test Answer Sheet

Date:

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

1. a b c d e

2. a b c d e

3. a b c d e

4. a b c d e

5. a b c d e

6. a b c d e

7. a b c d e

8. a b c d e

9. a b c d e

10. a b c d e

Module 5 Co-occurring Disorders: Post-Test Answer Sheet

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

1. a b c d e

2. a b c d e

3. a b c d e

4. a b c d e

5. a b c d e

6. a b c d e

7. a b c d e

8. a b c d e

9. a b c d e

10. a b c d e



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 methods do you feel were most helpful?

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

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