Treating Tobacco Dependence

AODA Professionals Manual

WiNTiP

Wisconsin Nicotine Treatment Integration Project

WisconsinWintip.com

Sponsored by: Wisconsin Division of Mental Health and Substance Abuse
Wisconsin Tobacco Prevention and Control Program
UW Center for Tobacco Research and Intervention

Trainer Manual

Addressing Nicotine Dependence in AODA Treatment

A Clinical Guide

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Resources

WINTIP Website Home Page
http://web.mac.com/creativerep/WiNTiP_Site_1/WiNTiP_Home.html
UW-Center for Tobacco Research and Intervention website home page (click on Healthcare Providers in the directory masthead to access mental health/ substance abuse http://www.ctri.wisc.edu/index.html
UW-Center for Tobacco Research and Intervention website Mental Health/ Substance Abuse http://www.ctri.wisc.edu/HC.Providers/healthcare_mental.health.htm
New York State (OASAS) free online nicotine dependence training/32 clock hours http://www.tobaccorecovery.org/

Appendix

Psychoactive Drugs – Find Pleasure/Relieve Pain
Is Nicotine Dependence an Addiction?
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<u>The Issue</u>: Extraordinary Prevalence and Incidence of Nicotine Dependence in those with Substance Use and Dependence and Mental Health Disorders

430,000 Americans are dying every year from tobacco caused and related diseases. It is estimated by leading tobacco authorities that 200,000 of these deaths are those with alcohol, drug or mental health disorders. There are 5-million tobacco deaths worldwide. This death toll is expected to more than double in the next century as tobacco companies focus more on developing countries where strong tobacco prevention and control does not exist.

In Wisconsin there are 8,000 tobacco deaths annually. Our residents with substance dependence and mental health disorders account for 3,520 of these deaths. That equates to 290 deaths a month in our state; or 10 a day. This is not a one-year death toll. Half of our family members, friends and co-workers who are addicted to nicotine and have substance abuse and mental health disorders will die from lung cancer, emphysema, heart disease and other cancers and lung disease. Sadly, those who die from tobacco this year are being replaced by new smokers; our children.

Meanwhile, Wisconsin has a statewide network of alcohol and drug treatment programs and county counselors who are trained to produce abstinence-based treatment and recovery plans for patients with substance dependence disorders.

We also have statewide mental health services active in every county of the state. Although we now have evidence-based nicotine treatment practices that are effective these services are not available to patients with substance dependence and mental health disorders.

Now that we have nicotine treatment that works and we have substance abuse and mental health treatment providers it is time to train those working in these fields with the skills and knowledge they need. Addiction treatment programs can treat nicotine dependence in their existing facilities and programs. Mental health professionals can be trained to either offer nicotine dependence or have access to other resources were their patients could get the treatment they need.

After 5 years of advocacy and preparation Wisconsin is now in a position to energize the planning process and develop implementation strategies that effectively address the high prevalence of nicotine dependence in this special needs population.

The WiNTiP Story

Saving Wisconsin lives by integrating evidence-based nicotine dependence treatment into alcohol and other drug dependence and mental health services

Why WINTIP?

- ✓ Prevalence studies document the need for integrating evidence-based nicotine dependence treatment into Wisconsin's AODA and mental health services. Patients with mental health and substance use disorders smoke and use tobacco products at rates from twice to four times those of the general population losing up to 25 years of their expected life spans.

- ✓ Treating nicotine dependence in the mental health and substance abuse treatment systems reduces the mortality, suffering and costs from this lethal addiction.

- ✓ Mental health and addiction providers are well positioned to treat nicotine dependence. When they are trained in specific tobacco/nicotine treatment practices, they can successfully offer this as part of their scopes of practice

- ✓ Barriers to offering nicotine treatment in AODA and mental health and substance abuse have been identified and are reversible

- ✓ WINTIP research has determined Wisconsin has a model integrated nicotine dependence treatment program that can be replicated (St. Joseph's Hospital, Marshfield.) Visits and interviews with nicotine integration programs in New Jersey, New York, Massachusetts and Connecticut have provided assurance Wisconsin can be a successful "integrator."

- ✓ Wisconsin has one of the nation's most respected research, training and intervention programs, UW-Center for Tobacco Research and Intervention invested in WINTIP's nicotine integration mission

Who and what is WINTIP?

- ✓ The Wisconsin Nicotine Treatment Integration Project (WINTIP) is an initiative originating from and funded by the Tobacco Prevention and Control program in the Division of Public Health. WINTIP is coordinated by the UW-Center for Tobacco Research and Intervention.

- ✓ WINTIP contracts with a Managing Consultant, David "Mac" Macmaster and Medical Director, Eric Heiligenstein, M.D. WINTIP for expertise and direct services.

- ✓ WINTIP is directed and accountable to a steering committee with members from AODA, mental health, tobacco and government. The WINTIP steering committee meets monthly and is guided by input from a 30+ member Advisory Group.

- ✓ WINTIP is the first Wisconsin partnership of stake-holders from government, tobacco, mental health and substance abuse (AODA) working together to reduce tobacco harm and death in these two high risk populations.

When and where does WINTIP operate?

- ✓ **WINTIP is a state-wide public health initiative.** WINTIP is based in Madison, Wisconsin but represents all regions of the state served by UW-CTRI Outreach services. WINTIP intends to introduce policies that lead to training of AODA and mental health managers and service providers in evidence-based nicotine dependence treatment.

- ✓ Nicotine dependence treatment training will prepare treatment professionals from AODA to effectively treat their patients with substance use disorders and co-occurring disorders within the scope of their practice. These services are expected to be available in all Wisconsin counties and at all levels of care when evidence-based nicotine dependence treatment is integrated into Wisconsin AODA and mental health services.

How will WINTIP accomplish its mission?

- ✓ Increase the number of invested stake-holders from tobacco, AODA and mental health motivated to serve in advisory and support roles for the WINTIP mission

- ✓ With its stake-holders steering committee WINTIP will provide the infrastructure, support and coordination to:

- ✓ Develop nicotine dependence treatment integration policies and guidelines for the approval of the major stake-holders, government departments, and agencies responsible for the treatment of substance use and mental health disorders

- ✓ Explore and propose funding for ongoing nicotine dependence training, technical and support assistance for Wisconsin's mental health and substance abuse providers

- ✓ Design nicotine dependence treatment education and training materials appropriate for the various professional service providers.

- ✓ Launch and sustain a systematic awareness, communication and information program that informs stake-holders and interested parties of the integration issue and progress toward its solution and implementation utilizing electronic resources.

- ✓ Manage an internet website and information bulletins that encourages input and distributes integration information and developments.

Visit the WINTIP Website
www.wisconsinwintip.com

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Clinician & Consumer Surveys 2009 and 2010

kkkk

Wisconsin Nicotine Treatment Integration Project
www.wisconsinwintip.com

WiNTiP Provider Survey

208 total questionnaires completed
73 Primarily AODA providers
18 Primarily Mental Health Providers
117 Providers of both AODA and Mental Health Services

1. Is it the clinical and ethical responsibility of mental health/AODA clinicians to address tobacco use and nicotine dependence as other care is provided?

Yes, (92%) No (8%)

2. Do you believe you have the skills to intervene or treat nicotine dependence effectively?

Can Intervene: **43% (yes) 42% (maybe) 15% (no)**

Can treat: **27% (yes) 42% (maybe) 30% (no)**

3. Would you be interested in taking an intensive 5-day training to become a Certified Tobacco Treatment Specialist?

Yes (26%) Yes, if free (54%) No (20%)

4. The prevalence of nicotine dependence among those with mental illness and/or other substance abuse disorders is as high as 85% in some populations which is four times the prevalence of nicotine dependence among the general adult American population of about 20%. **Did you know this fact before now?**

Yes, I knew this (55%) No, I didn't know this (45%)

5. 44% of all cigarettes are consumed by people that have mental illness and/or other substance abuse disorders. Smokers with substance use disorders and/or mental illness get sick and die from tobacco-related diseases at 2 to 4 times the rate in the general public and will die 10 to 25 years prematurely. **Did you know these facts before now?**

Yes, I knew this (51%) No, I didn't know this (49%)

6. Are you interested in providing information to your patients about how to quit and arranging for referrals for such treatment?

Yes, a lot (67%) Yes, a little (31%) No (1%)

7. If you were provided training in the delivery of evidence-based nicotine dependence treatment and technical assistance how willing are you to provide treatment to your clients?

Very willing (66%) Somewhat willing (30%) Not willing (3%)

8. How ready are you for smoke-free treatment and recovery facilities and programs?

Very ready (63%) Somewhat ready (30%) Already smoke-free (7%)

9. Would you support adding nicotine dependence treatment knowledge and skills to your professional credentialing requirements?

Yes, (72%) Under some conditions (14%) No (14%)

Wisconsin Mental Health Consumer Survey

Method:

Self-administered from packet that contained survey, postage-paid return envelope, pencil and $1.00
Anonymous and IRB approved as exempt
24 questions
1,000 packets prepared

Description of Respondents:

At least 30% response rate (302 returned)
51.5% male

78.1% consumers of mental health services
21.8% consumers of both mental health and AODA services
Age:
18-30: 12.3%
32-40: 18.9%
42-50: 30.5%
51-60: 28.1%
61-70: 9.9%

<u>Smoking Status:</u>

58.2%: current smokers
18.8%: never smokers
22.9%: Ex-smokers

<u>Quitting:</u>

46.7% said it was a good time to quit
83.1% have tried to quit
22.9 % have quit (are ex-smokers)
63.5% have known consumers like themselves who have quit

So, how are providers doing in the eyes of the consumers?

Has any doctor, nurse, therapist or other health provider:
Ever talked with you about your need to quit?
- **Many times: 43%**
- **Once or twice: 32.6%**
- **Never: 24.3%**

If yes, did any give you medications?
- **No: 56.7%**

If yes, did any talk to you about how to quit?
- **No: 49.7%**

If yes, did any send you to someone who helped you quit?
- **No: 84%**

Ever helped while in hospital?
- **Yes: 39.7%**

Common Characteristics of Substance Dependence

David “Mac” Macmaster, CSAC, PTTS

Introduction

Substance dependence disorders (SUD’S), commonly referred to as addiction, are now recognized and confirmed as treatable health disorders. Appropriate treatment can lead to abstinent recovery. Not treating the pathology of a substance dependence disorder usually leads to life threatening health problems, death or serious life problems.

Treating tobacco/nicotine dependence in integrated addiction treatment services is vital. The reason is those with alcohol, other drug dependence and mental illness disorders together are the largest single population of those dependent on nicotine (44%.) They are getting sick and dying at from twice to four times the rate in the general population.

There are 12 substance disorders listed in DSM-IV4. They are identified and described in the Diagnostic and Statistical Manuals we use for providing appropriate treatment and obtaining reimbursement from public and private insurance providers.

We will address five substance dependence disorders seeking common characteristics they share:

Alcohol dependence (303.90)
Opioid Dependence (304.00)
Cannabis Dependence: (304.30)
Cocaine Dependence (304.20)
Nicotine Dependence (305.1)

The history of substance dependence treatment reveals that most addiction treatment providers treat all the listed substance disorders but one. That one is nicotine dependence.

Recently research indicating successful treatment of nicotine dependence can be safely integrated into the treatment of the other substance dependence disorders has been confirmed. New York’s statewide-integrated programs and our Wisconsin integrated program

at Alcohol and Drug Recovery Service at St. Joseph's Hospital in Marshfield have proven including evidence-based nicotine dependence treatment is effective and will save lives.

This training presentation makes the case that trained AODA specialists can successfully treat nicotine dependence as other treatment is provided.

AODA counselors already possess the skills and basic knowledge to treat nicotine dependence. Specific tobacco training will prepare AODA counselors to integrate evidence-based tobacco/nicotine into their scope of practice more comfortably than previously thought to be possible.

Let us begin by identifying some of the common characteristics of addiction beginning with an explanation for the progressive nature of substance dependence disorders.

1. Most, but not all, substance dependent people begin with the social use of their drugs; to have fun with family and friends. Typically the gateway drugs are nicotine in tobacco and alcohol in beverages. Both are legal drugs and historically part of American culture. When drinkers, smokers and other drug users discover something they like that produces positive benefits they want to experience these benefits more often by increasing the frequency and amounts used.

2. Substance dependent people discover that the alcohol, nicotine and other psychoactive properties in the beverages we drink, cigarettes we smoke and the other pleasure producing drugs we use are also powerful and effective "medications. These drugs relieve anxiety, seem to improve low self esteem; stimulate motivation; produce anticipation and risk-taking behavior and other benefits. Here again when such desirable benefits are discovered people will increase the frequency and amounts.

Some, but not all, substance dependent people have apparent hereditary and genetic pre-disposition to the drugs they use that produce substance dependence.

Another factor in the development of substance dependence disorders are cultural and social issues. Many begin their smoking, drinking and drugging in the context of their social group or culture where such behavior is the norm.

One cultural example is the ceremonial use of tobacco by some Native American tribes and communities. Giving out cigarettes, as part of celebrations is not unusual suggesting smoking cigarettes is an acceptable behavior to many. This has led to a high prevalence of nicotine dependence with its health problems in the Native American community.

Another is the drinking behavior of many residents of Wisconsin. Wisconsin has some of the highest indicators in the USA.

Drug users often have using peers who use together as part of their life style.

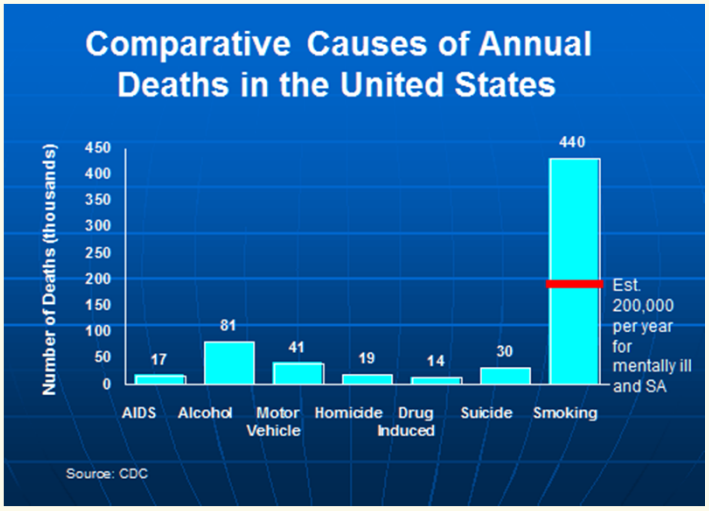
In addition to these common characteristics of substance dependence they're others. This lecture/presentation explores aspects of all substance dependence disorders that appear to be very similar. They all are diagnosed, as substance dependence disorders if the assessment indicates 3 or more of the 7 diagnostic criteria's are present.

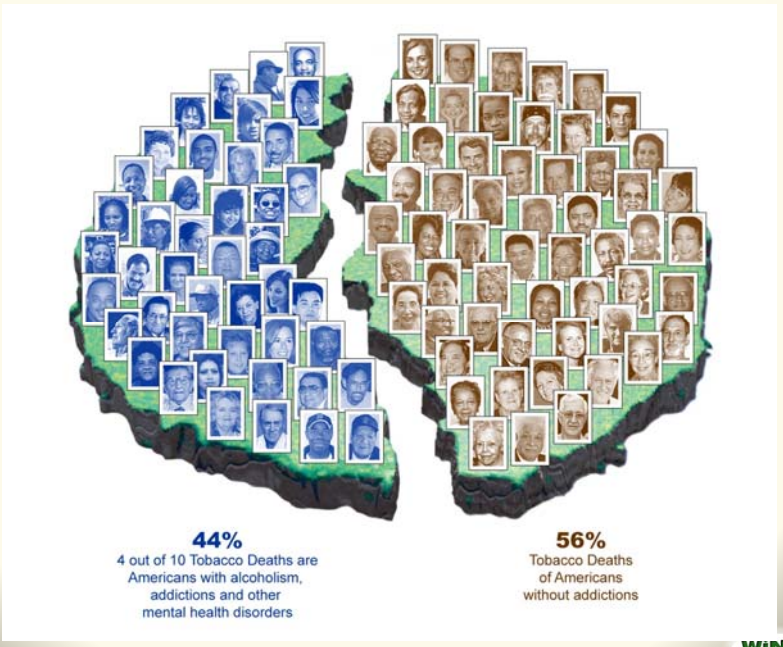
Common Characteristics of Addiction

Substance Dependence Disorders Including Nicotine Dependence

WINTIP Training 2011

David "Mac" Macmaster, CSAC, PTTS





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The WINTIP Model
For Including Nicotine Dependence in Traditional Substance Dependence Treatment

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Common Characteristics of Substance Dependence

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5 Common DSM-IV Substance Dependencies

303.90 Alcohol dependence
304.00 Opioid dependence
304.20 Cocaine dependence
304.30 Cannabis dependence
305.10 Nicotine dependence

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Substance Dependence

When an individual persists in use of alcohol or other drugs despite problems related to use of the substance, substance dependence may be diagnosed. Compulsive and repetitive use may result in tolerance to the effect of the drug and withdrawal symptoms when use is reduced or stopped. This, along with Substance Abuse are considered Substance Use Disorders

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Some Common Characteristics of Substance Dependence

Heredity
Social and Cultural Norms

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Tobacco Dependence
Alcohol and Other Drug Dependence

Similarities and Differences

Major Difference

Alcohol and other drug interventions usually require a current life crisis (hitting bottom) as motivator for entering treatment

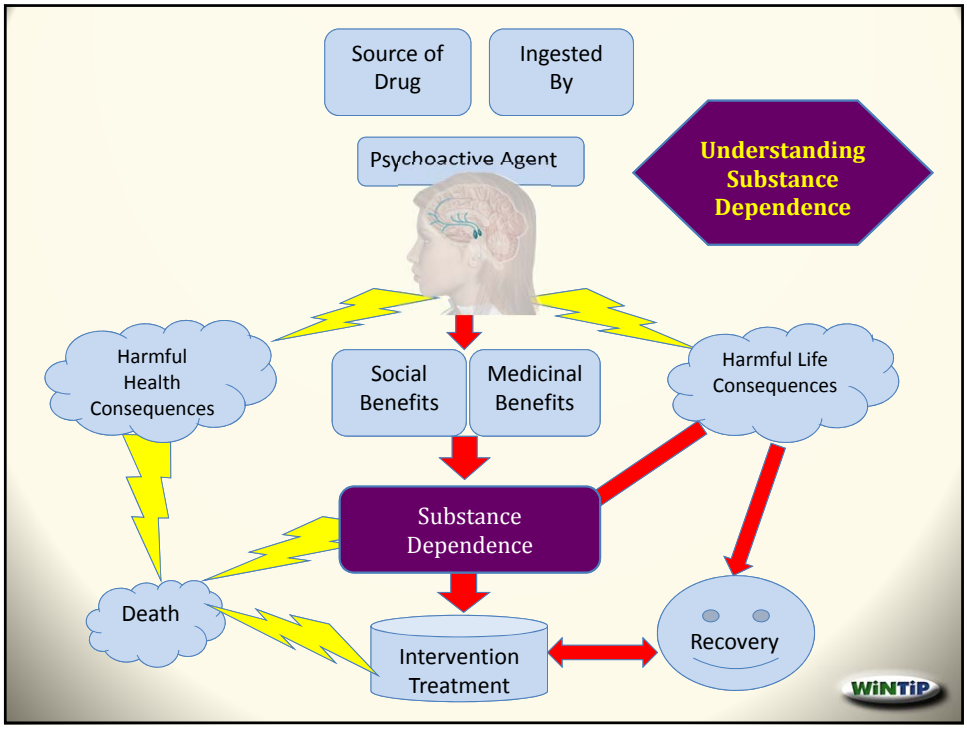
Not typically true for tobacco

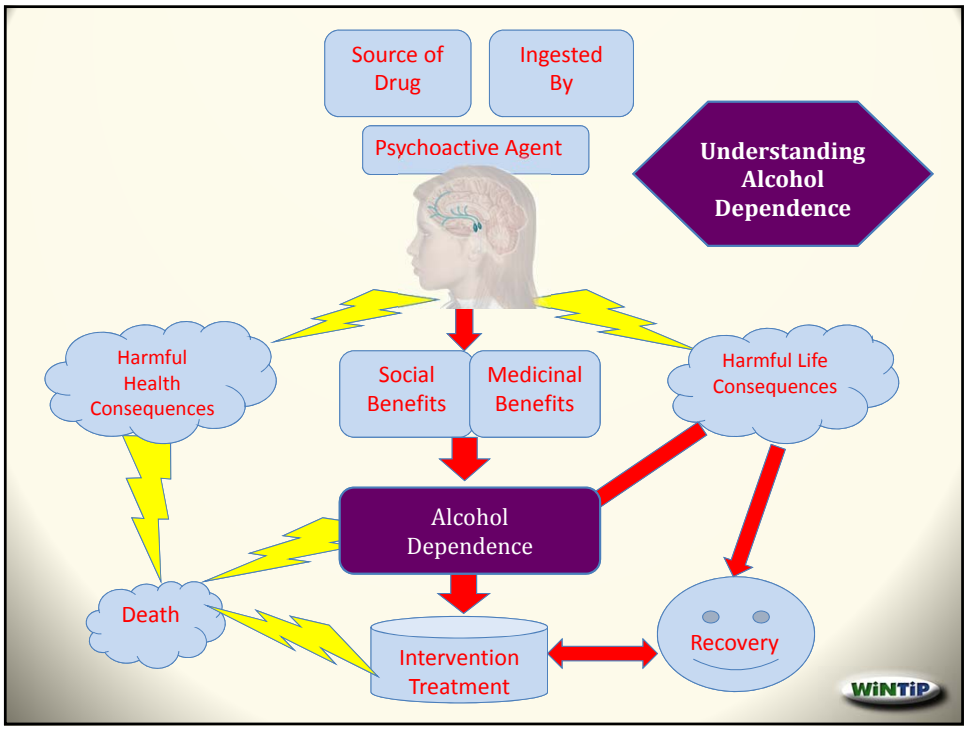
How Tobacco/Nicotine Dependence Differs from Other SUD'S

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

How Tobacco Dependence is Similar to Other SUD'S

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


Source of Drug
Ingested By
Psychoactive Agent
Understanding Substance Dependence
Harmful Health Consequences
Social Benefits
Medicinal Benefits
Harmful Life Consequences
Substance Dependence
Death
Intervention Treatment
Recovery
WiNTiP


Source of Drug
Ingested By
Psychoactive Agent
Understanding Alcohol Dependence
Harmful Health Consequences
Social Benefits
Medicinal Benefits
Harmful Life Consequences
Alcohol Dependence
Death
Intervention Treatment
Recovery
WiNTiP

Sources of Drug

Alcohol

Grains

Potatoes

Sugar Cane

Corn

Alcohol

Ingested By

Drinking Beverages

Whiskey, Beer, Vodka, Gin, Rum

Others ?

Psychoactive Agent

In Alcoholic Beverages

Alcohol

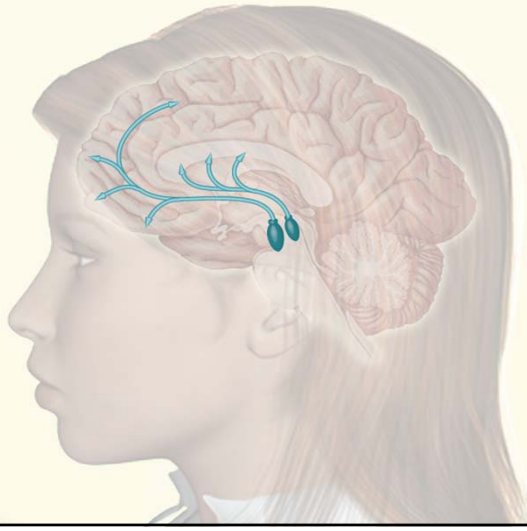
SD

IB

PA

It has now been established that all substances that trigger dependencies in human beings increase the release of a neuromediator, **dopamine,** in a specific area of the brain

Brain Chemistry/ Neurobiology



What is alcohol?

Tranquilizer

Sedative Hypnotic

Analgesic

Anesthetic

Social Benefits

Alcohol

Fun with Friends

Shared Experiences

Cultural Norm

Social Acceptance

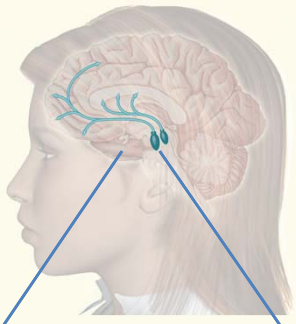
Relationship and Sex Opportunities

Others?

Medicinal Benefits

Alcohol

Relaxation	Anxiety Relief
Pain Relief	Anesthesia
Euphoria	Sedation – Sleep Aid



SB

MB

Harmful Life Consequences

Alcohol

Legal Financial Employment

Family Problems Self Esteem/Shame

Important Relationships

?

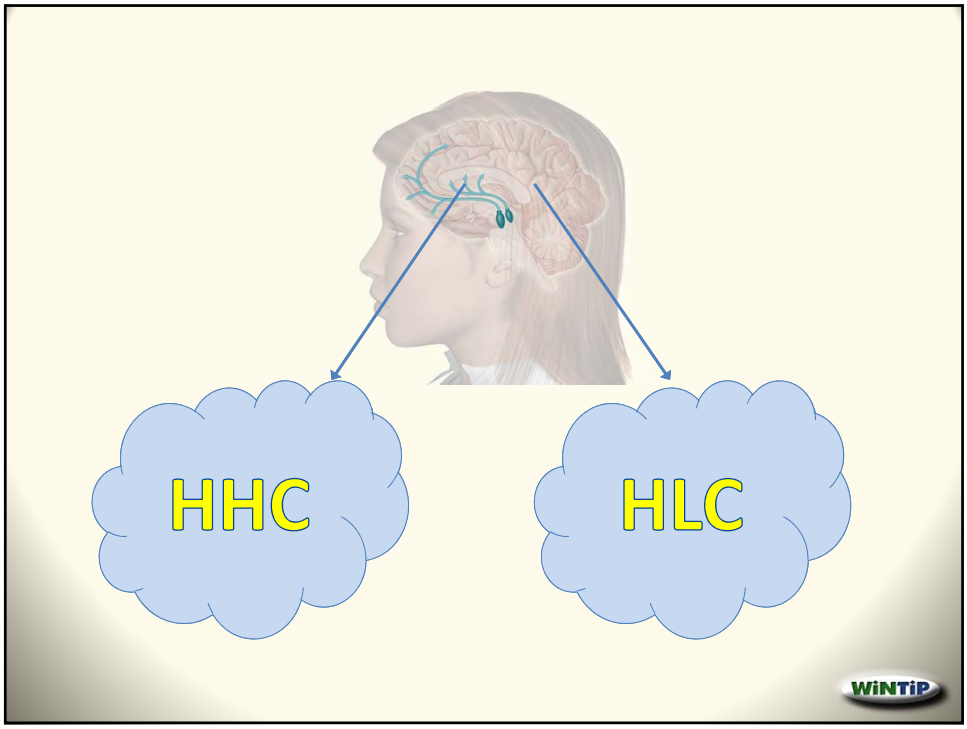
Harmful Health Consequences

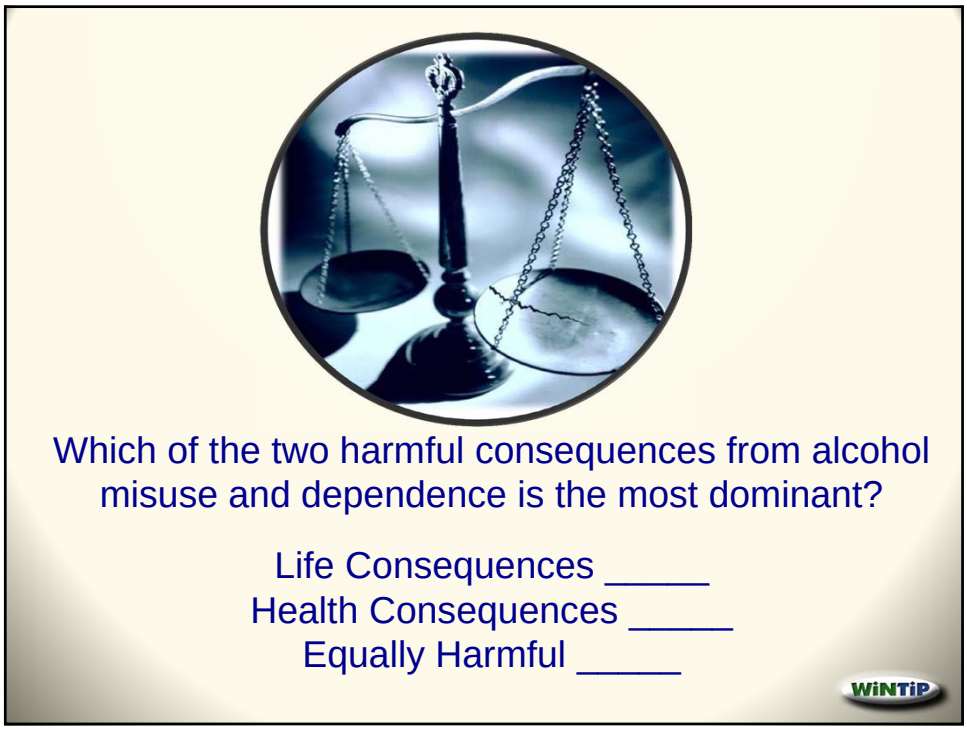
Alcohol

Liver Disease Injuries Heart Disease

Suicide Gout Brain Disease

Esophageal Vertices ?


HHC
HLC
WiNTiP


Which of the two harmful consequences from alcohol misuse and dependence is the most dominant?
Life Consequences _____
Health Consequences _____
Equally Harmful _____
WiNTiP

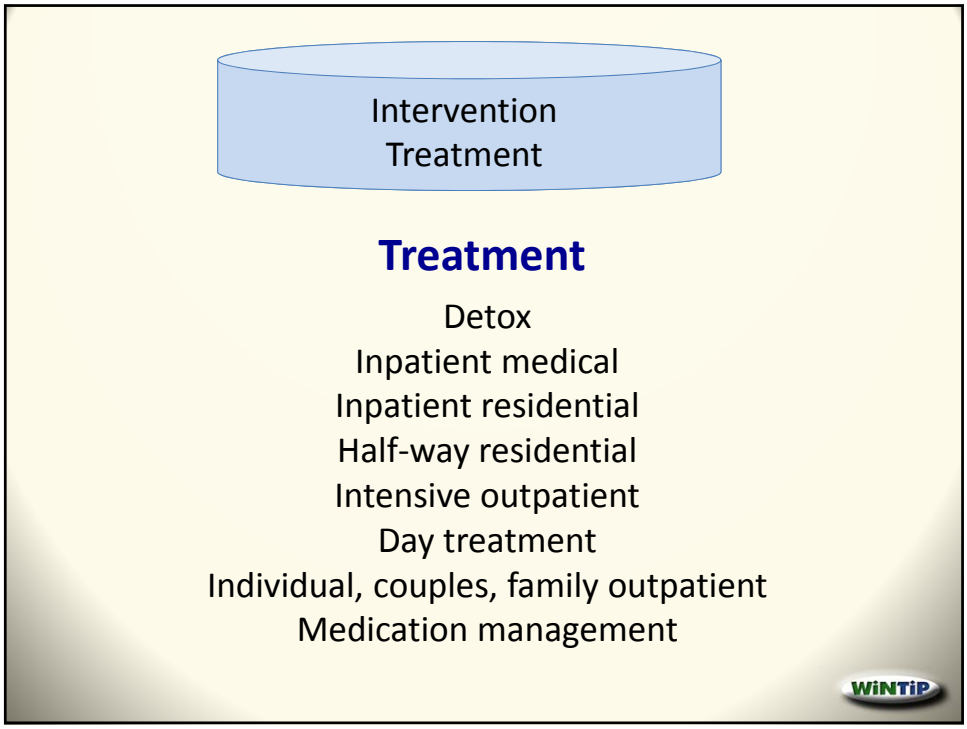
Alcohol Dependence 303.90

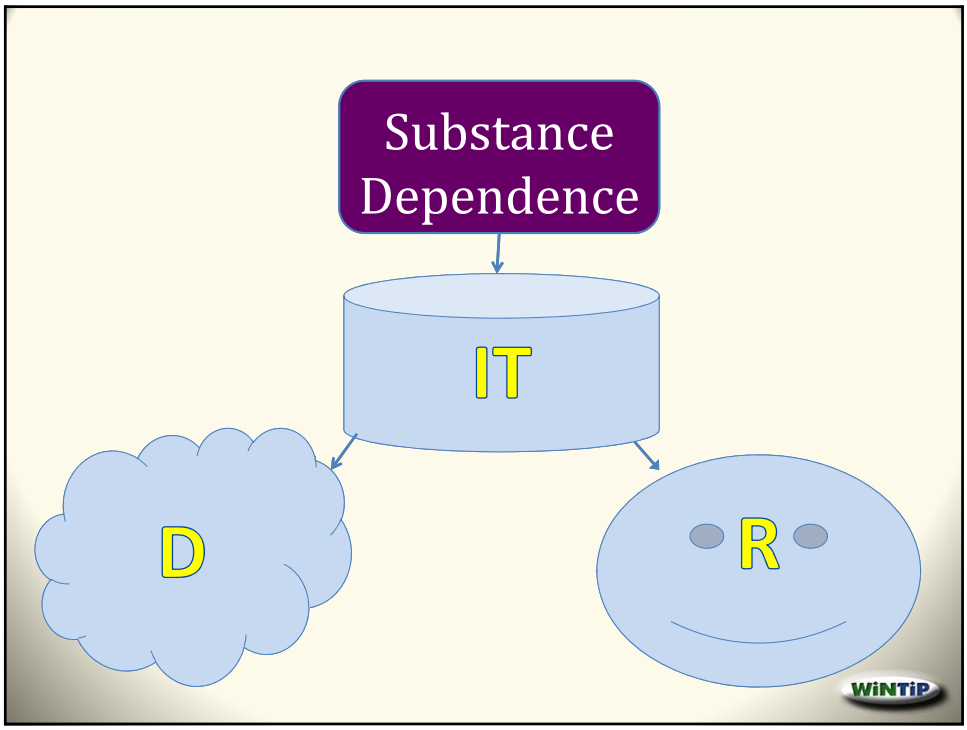
When persistent use of alcohol despite problems related to use of alcohol, alcohol dependence may be diagnosed. Compulsive and repetitive use may result in tolerance to the effect of alcohol and withdrawal symptoms when use is reduced or stopped.

Intervention Treatment

Interventions

Medical
Legal
Family
Employer
Friends
Self referred


Intervention
Treatment
Treatment
Detox
Inpatient medical
Inpatient residential
Half-way residential
Intensive outpatient
Day treatment
Individual, couples, family outpatient
Medication management
WiNTiP


Substance Dependence
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WiNTiP

What effects on family members and friends does death by alcohol of a family member or friend cause?

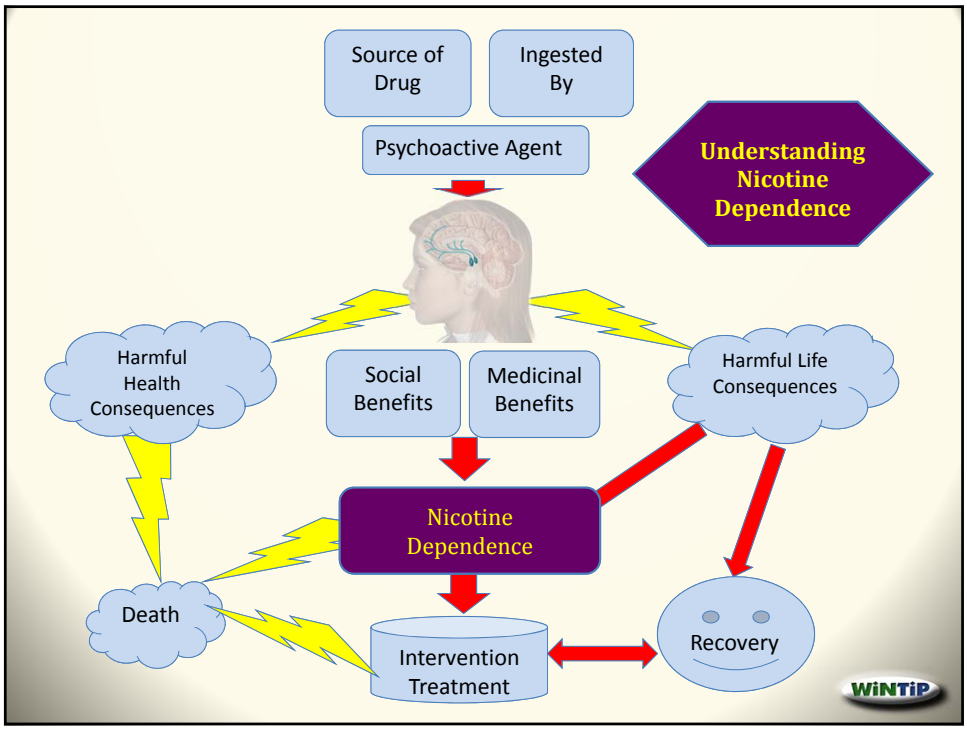
Grief

Anger

Depression

Guilt

?



What is Nicotine?

Nicotine is a stimulant and a relaxant and is found in tobacco plants (in the nightshade family of plants.) It is an alkaloid.

Sources of Drug

Nicotine

Tobacco Plants

Other Sources?

Nicotine

Ingested By

Smoking

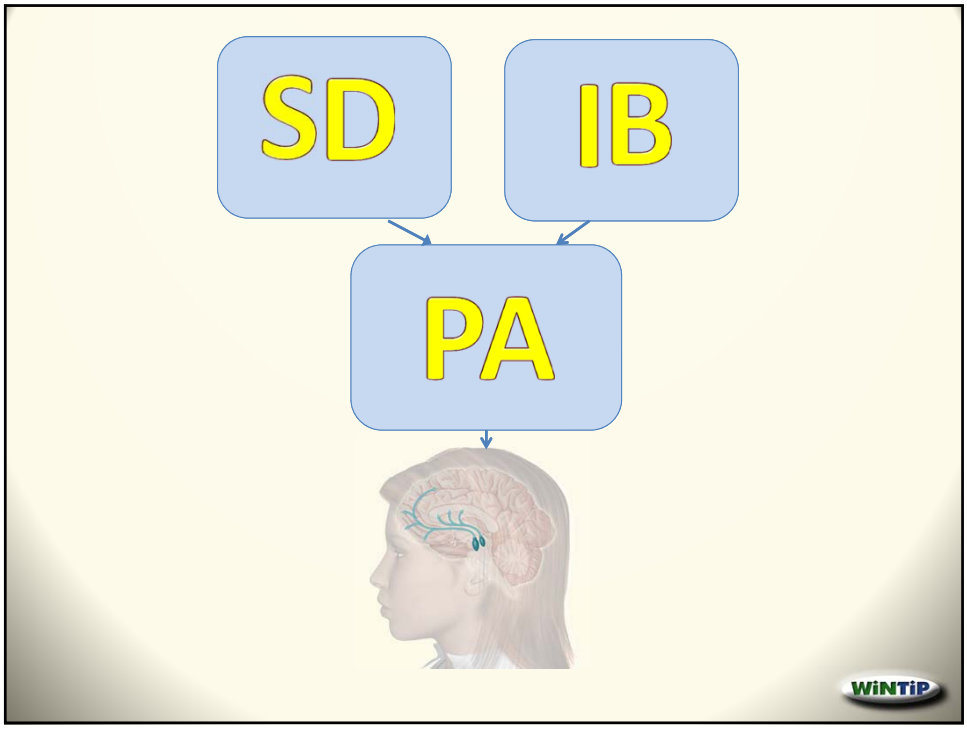
Chewing, Dipping, Lozenges, Gum

Transdermal Patches, Sprays

Psychoactive Agent

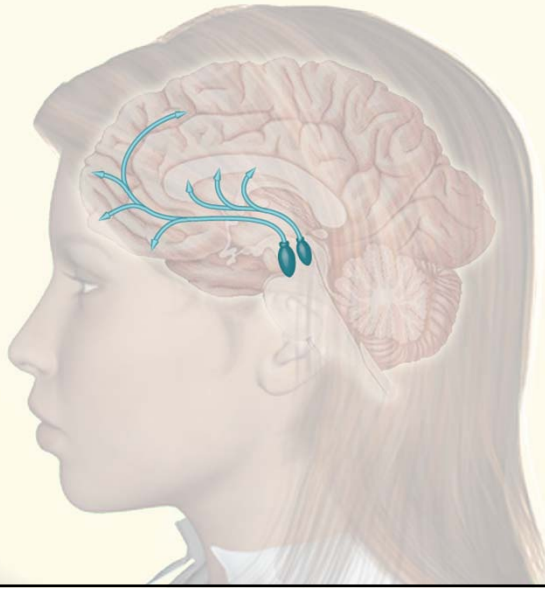
In Tobacco

Nicotine



It has now been established that all substances that trigger dependencies in human beings increase the release of a neuromediator, **dopamine**, in a specific area of the brain

Brain Chemistry/ Neurobiology



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What is Nicotine?

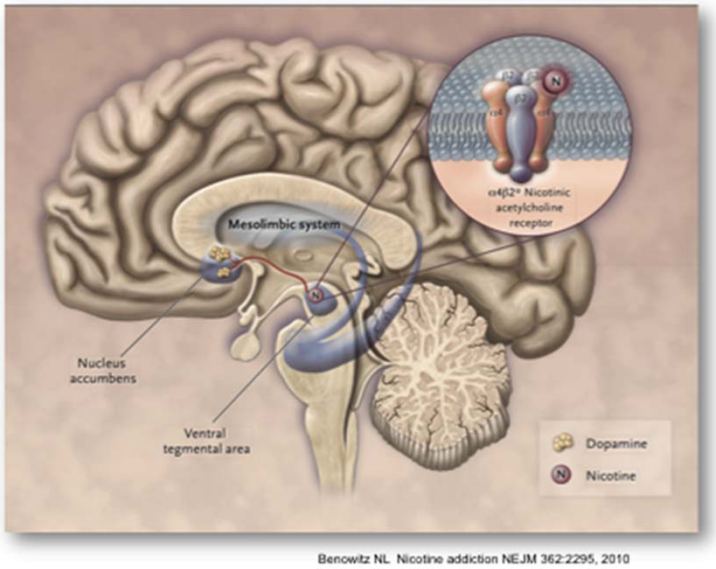
Sedative

Stimulant

Other ?

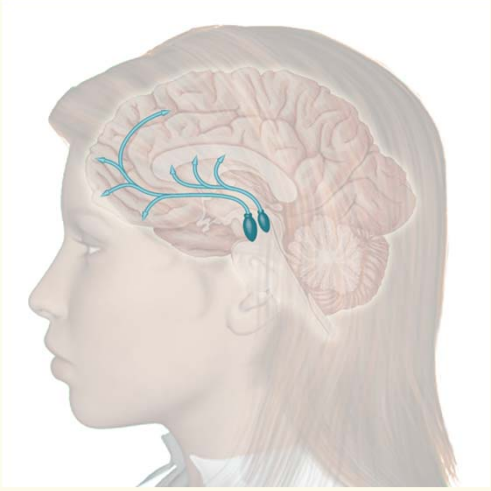
WiNTiP

Tobacco Effects on the Nervous System



Benowitz NL. Nicotine addiction NEJM 362:2295, 2010

Back to Brain Chemistry



Harmful Life Consequences

Nicotine

Financial

Employment

Family Problems

Self Esteem/Shame

Important Relationships

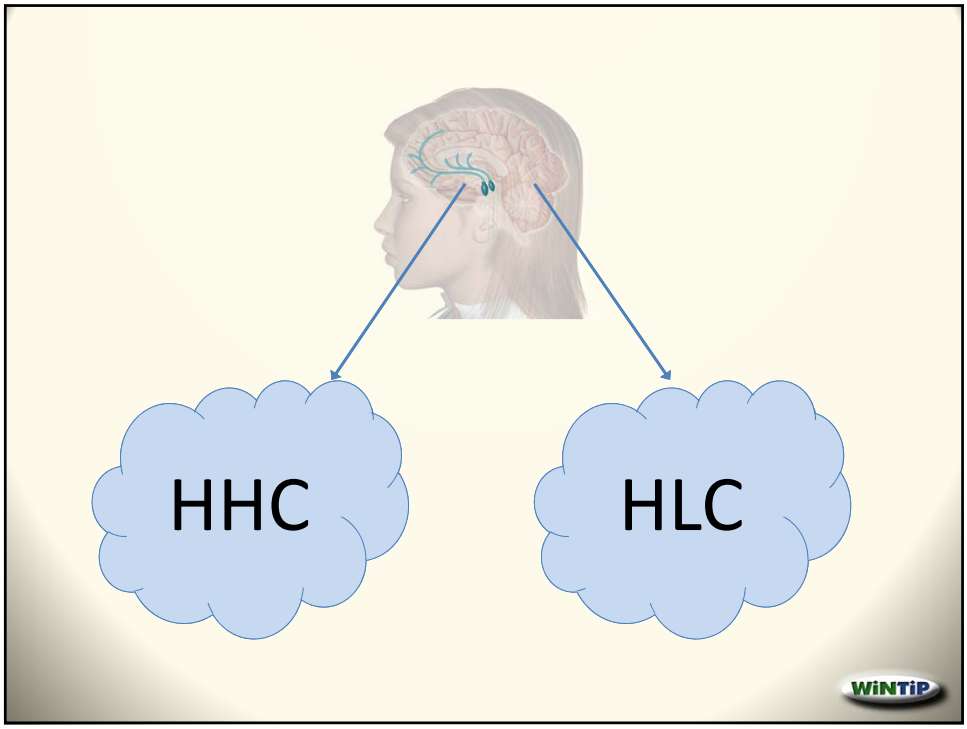
Other ?

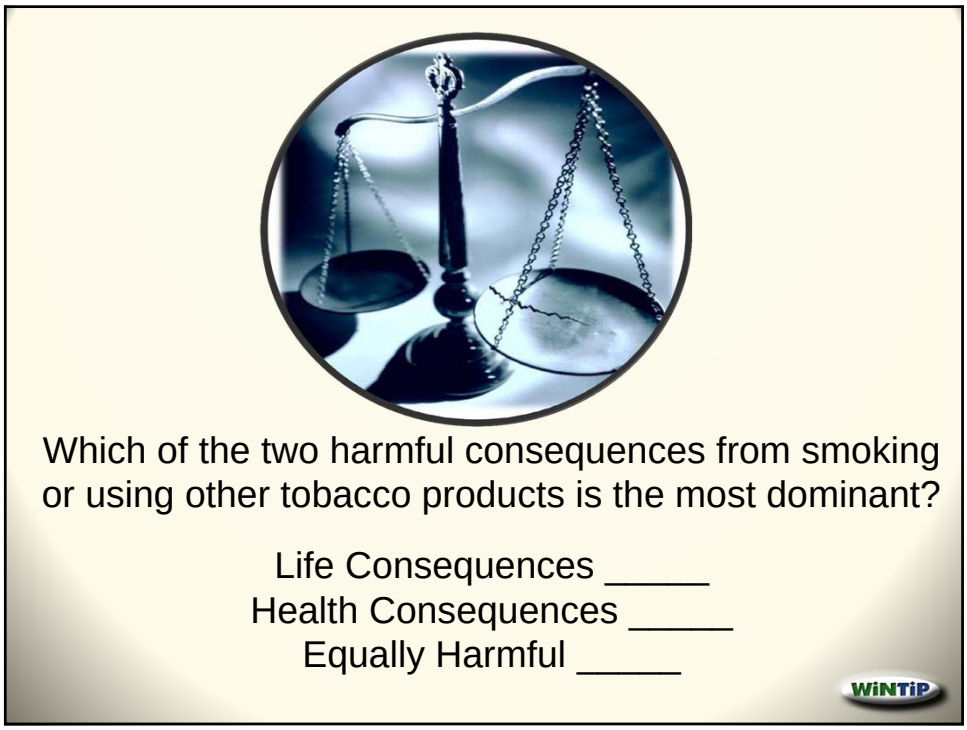
Harmful Health Consequences

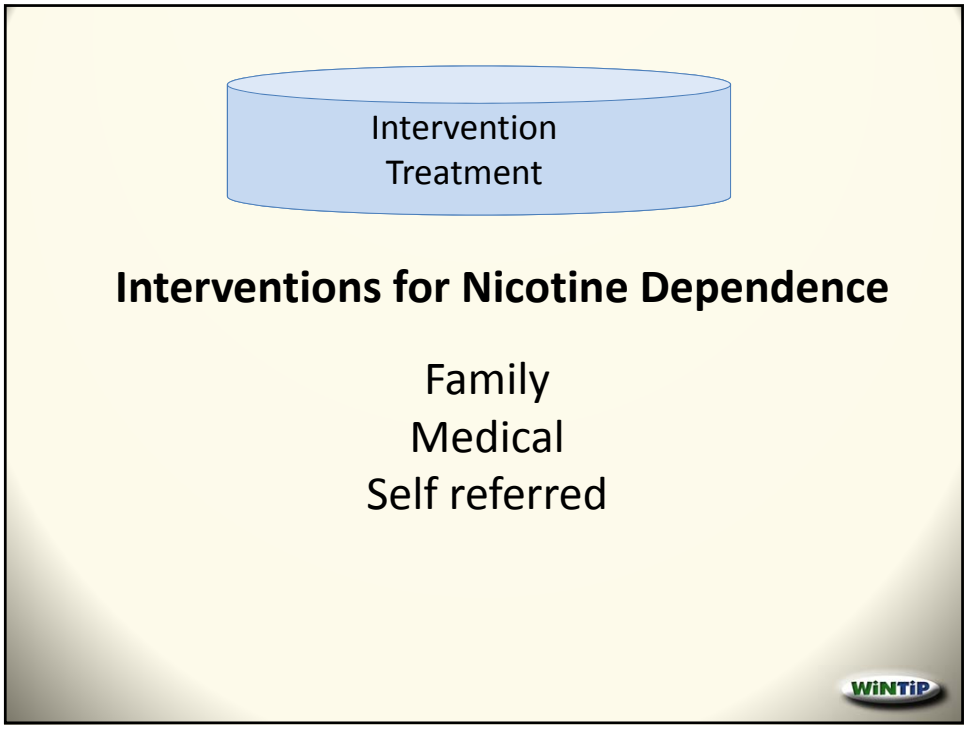
Nicotine

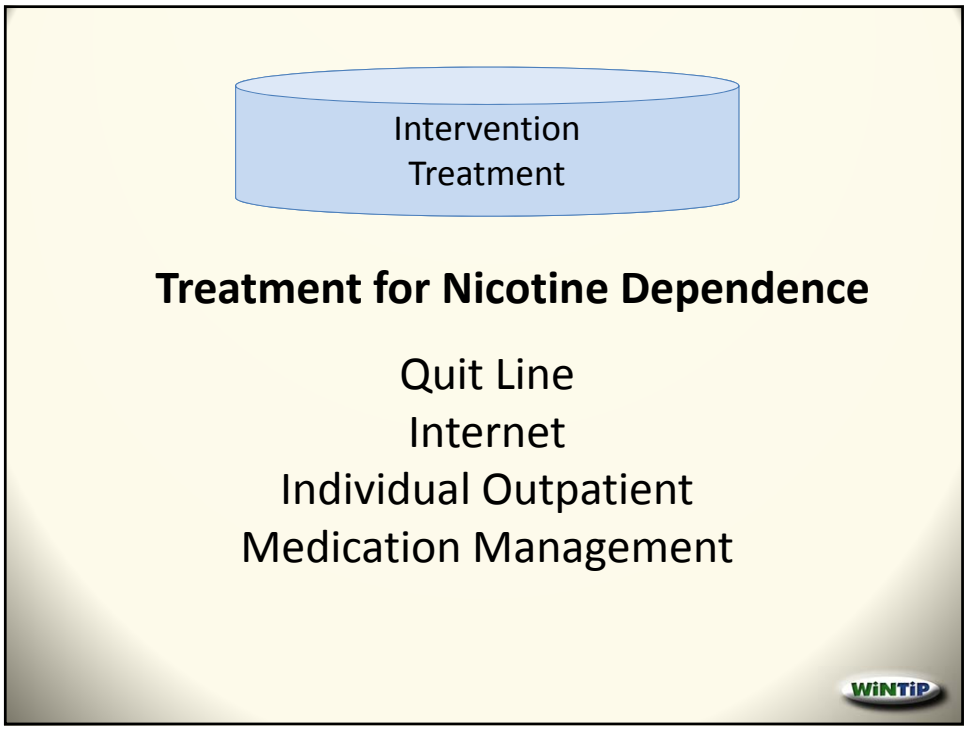
Lung Cancer	Burns	Heart Disease
Throat Cancer	Bronchitis	Emphysema
Pancreatic Cancer		Other?

Tobacco is the single greatest cause of preventable death in the United States and worldwide. Tobacco use leads most commonly to diseases affecting the heart and lungs, with smoking being a major risk factor for heart attacks, strokes, chronic obstructive pulmonary disease (COPD) (including emphysema and chronic bronchitis), and cancer (particularly lung cancer, cancers of the larynx and mouth, and pancreatic cancer). It also causes peripheral vascular disease and hypertension.


HHC
HLC
WiNTiP


Which of the two harmful consequences from smoking or using other tobacco products is the most dominant?
Life Consequences _____
Health Consequences _____
Equally Harmful _____
WiNTiP


Intervention
Treatment
Interventions for Nicotine Dependence
Family
Medical
Self referred
WiNTiP


Intervention
Treatment
Treatment for Nicotine Dependence
Quit Line
Internet
Individual Outpatient
Medication Management
WiNTiP

Indicators of Recovery from Nicotine Dependence

Abstinence
Effective relapse prevention
Improved self esteem
Improved employment, health, finances, relationships

Death By Tobacco

Lung Cancer
Throat, pancreas and other cancers
Heart disease
Emphysema
Other lung diseases

Nicotine Dependence 305.01

When persistent use of nicotine despite problems related to use of nicotine, nicotine dependence may be diagnosed. Compulsive and repetitive use may result in tolerance to the effect of nicotine and withdrawal symptoms when use is reduced or stopped.

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Summarize learning's from this presentation on understanding alcohol and nicotine dependence

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Understanding Alcohol Dependence/Common Characteristics

What are some organic sources of alcohol?	

What are some non-organic sources of alcohol?	

How is Alcohol Ingested?	

What is Alcohol?

What do we know about alcohol and brain chemistry?

Understanding Alcohol Dependence/Common Characteristics

Benefits from Alcohol

Social Benefits	

Medicinal Benefits	

Understanding Alcohol Dependence/Common Characteristics

Harmful Consequences from Alcohol

Harmful Social Consequences	

Harmful Medicinal Consequences	

Which of the two harmful consequences from alcohol abuse is most dominant?

Social Consequences ____

Health Consequences ____

Equally harmful ____

What is Substance Dependence and is it Treatable?

Identify the Types of Alcohol Interventions Available

What is Recovery from Alcohol Dependence?

What Causes Death from alcohol abuse and dependence?

What Effects on family members and Friends does death by alcohol of a family member or friend cause?

What Have We Learned about Alcohol Dependence from This Information?

Understanding Nicotine Dependence/Common Characteristics

What are some organic sources of nicotine?	

What are some non-organic sources of nicotine?	

How is nicotine Ingested?	

What is nicotine?	

What do we know about nicotine and brain chemistry?

Understanding Nicotine Dependence/Common Characteristics

Benefits from Nicotine

Social Benefits	

Medicinal Benefits	

Understanding Nicotine Dependence/Common Characteristics

Harmful Consequences from Nicotine

Harmful Social Consequences	

Harmful Medicinal Consequences	

Which of the two harmful consequences from nicotine abuse is most dominant?

Social Consequences ____

Health Consequences ____

Equally harmful ____

What is Substance Dependence and is it Treatable?

Treatable? Yes _____ No _____

Identify the Types of Nicotine Interventions And Treatment Available

What is Recovery from Nicotine Dependence?

What Causes Death from Nicotine Abuse and Dependence?

What Effects on family members and Friends does death by tobacco of a family member or friend cause?

What Have We Learned about Nicotine Dependence from this Information?

Tobacco Awareness

Tobacco Awareness

Education and Group Activities

People who are dependent on nicotine appear to be stuck in either pre-contemplation stages of change (don't or won't consider giving up tobacco) or contemplation (I want to quit but am not ready to consider quitting just now. Patients/clients entering treatment for substance dependence disorders are not there to quit smoking or using other tobacco products. They may be surprised, resistant and unmotivated to address tobacco in treatment and recovery.

So, how can we increase motivation to address tobacco while they are being treated for the substance dependence disorders they came to treatment for?

Tobacco/Nicotine Education

Part of evidence-based substance dependence treatment includes an education process that provides information relevant to the substance disorders being treated. Substance dependence clinicians are experienced and skilled at presenting this important information to patients and families.

One of the skills substance dependence clinicians typically use for education and motivation is "motivational interviewing – MI."

Motivational interviewing increases awareness producing a willingness to become better informed when it is successful. This increased awareness is more likely to occur if the information is credible and verifiable in the patient/client's personal experience. A clinician's confidence he/she can use motivational interviewing to address tobacco/nicotine increases as the MI does in fact assist patients consider dealing with tobacco in their treatment and recovery based on better information.

"I am willing to change my mind about anything when I have better information than I have right now."

In Wisconsin we have excellent tobacco/nicotine information and educational materials available from the UW-Center for Tobacco Research and Intervention (UW-CTRI.)

These materials are free and can be downloaded for education and patient handouts. This information is comparable with the education resources we use for all the other substance use disorders. As we increase patient's education they can make more informed decisions about alcohol and other drugs. With appropriate nicotine/tobacco education they will be more likely to include tobacco in their recovery and invest in treatment for their nicotine dependence.

WINTIP's website also has helpful information and resources.

But education is not enough. Those with substance dependence disorders often have good information about alcohol and other drugs including tobacco but do not abstain even with accurate information and harmful life and health consequences they have experienced.

Tobacco Awareness Groups (TAG)

Tony Klein, a New York State clinician, clinic manager and trainer is a pioneer developer of strategies for integrating nicotine dependence treatment into New York State's licensed addiction programs. Tony has assisted WINTIP as we develop our own tobacco/nicotine integration plans for integrating evidence-based nicotine dependence treatment into our Wisconsin AODA and mental health services. Tony Klein created Tobacco Awareness Group and Tobacco Recovery Groups that are now standard approaches to nicotine dependence treatment.

WINTIP will include TAG training and support in our fundamental outreach and training activities.

We expect resistance to the integration of nicotine dependence treatment practices. We believe it is imperative to motivate patients/clients to move beyond pre-contemplation resistance and contemplation ambivalence to the planning and action phases of treatment and recovery if our interventions are to be successful.

We believe The Tobacco Awareness Group has great potential for achieving these treatment and recovery goals that produce abstinence and an improved quality of life.

Simply stated a TAG is the vehicle for patients to safely explore the relationship they have with tobacco in their drinking and drug using experience.

A sample of a TAG can be observed as Tony Klein facilitates a TAG with patients in treatment. This TAG can be watched on the New York State on line tobacco integration training. The training is free; registration in uncomplicated. There are 24 clock hours of documented training offered with a completion certificate awarded when the training is completed.

To access Tony Klein's TAG training videos go to:

http://www.tobaccorecovery.org/

Go to E-learning at the bottom of the home page.
Select #5 (red) on the learning hub and view Tony's TAG group sessions.

A narrative of these videos is available elsewhere in this WINTIP training manual.

A TAG is a non-threatening, non-critical examination of the relationship those with substance dependence disorders have with tobacco. It is exploration of the real experiences and relationship those suffering from substance disorders share with each other in groups. A TAG is not a quit smoking/dipping/cessation experience.

Getting into nicotine recovery planning and action activity is another step many may not be ready for. TAG is probably the first time patients with substance dependence disorders have had a safe forum for talking about their smoking and other tobacco use without feeling threatened. It may be the decisive treatment/recovery intervention that has promise for nicotine/tobacco recovery.

Clinicians facilitating a TAG need to have a number of leading questions that stimulate group discussion. Some of these leading questions are available in the additional TAG materials in this manual (Tony Klein's narrative.) Feel free to choose some of them for your groups.

The group will respond to being asked for their experience as together they explore the roles and rituals tobacco use has been part of their addictions.

A TAG is a research activity in a way. The group is searching for links between their use of alcohol, tobacco, drugs and prescription medications. Acknowledging this research will help the treatment program learn how best to address tobacco in treatment and recovery. It is asking the group to contribute their tobacco/alcohol/drug experience for the good of themselves and others. This approach tends to be a positive for TAG's.

We are just learning how to include tobacco/nicotine in our substance dependence programs. Our patients/client's will be our best teachers as they share their stories and experiences with us. They will help us save more lives by addressing tobacco in treatment and recovery. Paradoxically, they may save their own lives in the process by accepting that:

Tobacco Recovery Makes Other Recovery Better

Finally, nicotine dependence recovery is not only based on better health by abstaining from tobacco. Nicotine recovery prevents relapse as well as providing a much-improved quality of life for those suffering from substance dependence disorders. Tobacco Awareness Groups are our best option for making this happen.

INTRODUCTION

The comprehensive integration of tobacco dependence treatment into the service continuum requires that programs offer assessment of tobacco dependence and provide evidence-based treatment interventions. This includes psychoeducation, in the form of tobacco awareness education for patients, as a way to increase patient knowledge, skills, attitudes, and motivation that contribute to a positive change in substance use behaviors. Additionally, programs need to provide recovery support for patients working toward tobacco abstinence.

The goals of psychoeducation in the context of addiction treatment and recovery are:

- Promote insight into tobacco use behavior
- Identify correlation of tobacco use to alcohol and other drug use
- Talk about the recovery/relapse process
- Identify ambivalence towards tobacco use and elicit change talk

Motivational techniques are effective in helping patients resolve their ambivalence about their tobacco use and move towards healthy change. The techniques and topic areas of the tobacco awareness group help the patient to think differently about their tobacco use. The clinician in the tobacco awareness group does not suggest solutions or teach practical skills, rather, they utilize the tools of Motivational Interviewing such as reflective listening, open-ended questions, affirmations, and summarizing to reduce resistance and elicit change talk from the patients. The more the patient talks about healthy change, the advantages of change, and the disadvantages of change, the more likely it is that change will occur.

By using motivational techniques and group facilitation strategies, the clinician works with patients in a tobacco awareness group (TAG) to resolve their ambivalence about their tobacco use by raising awareness of tobacco related issues and topics. The clinician does not advocate for change, but elicits change talk from the patients, engaging them in the group process. Listed below are several desired outcomes of the tobacco awareness group:

- Normalize and resolve ambivalence
- Raise awareness of tobacco related topics
- Increase motivation to change
- Develop discrepancy
- Help patient move to the next stage of change

It is important for clinicians to understand the difference between a tobacco awareness group and a tobacco recovery group. The clinician in the tobacco awareness group does not tell the patients they need to stop using tobacco or suggest solutions for the patients. The purpose of the tobacco awareness group is to stimulate the patient's thinking, help them to resolve their ambivalence, and move towards healthy change. The tobacco awareness group is about introducing new knowledge and new thinking, while the tobacco recovery group is about taking action and making behavioral changes.

TOBACCO DEPENDENCE INTERVENTIONS WITHIN AOD PROGRAMMING

TOBACCO RECOVERY GROUP COUNSELING GUIDELINE

TONY KLEIN, MPA, CASAC, NCACII

IMPORTANCE

(1) Verify and Bolster Autonomous Motivation (intra-treatment social support):

- Always start by asking each patient to express his/her personal reasons for tobacco abstinence: "How is your life going to be better free of tobacco?"
- Use reflective listening to process patient disclosure.
- Suggest development of a "personal slogan" to symbolize and reinforce motivation.

CONFIDENCE

(2) Define Tobacco Recovery:

A personalized plan to address the 3 aspects of tobacco dependence:

- Physical
- Behavioral
- Emotional

(3) Teach Recovery Tools (problem solving skills training):

Physical

- Reasons for and proper use of pharmacotherapy
- Diet recommendations
- Relaxation techniques
- Exercise
- Cognitive behavioral craving management interventions

Behavioral

- Structured "a day at a time" approach integrated into AOD recovery plan
- Menu of replacement activity
- Contingency planning for challenging environments
- Identify and address barriers

Emotional

- Cognitive restructuring, prayer, meditation
- Journaling
- Grief counseling
- Recovery support network, community supports including NYS Quitline, whyquit.com, Nicotine Anonymous, etc. (extra-treatment social support)

(4) Close Group Session:

- Consistent with treatment program norm, i.e. serenity prayer.

Note: Do not expect to address all of these areas in one session. A weekly Tobacco Recovery Group allows for repeated dosing of the intervention during client's length of stay.

More Tobacco Awareness Group Transcripts From Tony Klein Training Video

TONY: "Alcohol? Anyone here have a history of booze? Okay. Cigarette, cigar with the drinking? Was that connected for anybody?"

PATIENT 4: "They came together. Every time you go out, you know, you'd have a cigarette, find a person, well, actually my experience is that every time you're with a girl, and she asks for a cigarette, that's an interesting conversational piece."

TONY: "Oh, you dog, you! How many of you have started hooking up with the phrase, 'excuse me, do you have a light?' okay, so the drink, the cigarette..."

PATIENT 4: "Weed."

TONY: "Did you ever drink without a cigarette, or was it always there?"

PATIENT 4: "Absolutely not, even though I can't even drink, because I might relapse smoking a cigarette."

TONY: "So they're that strongly connected for you."

PATIENT 4: That urge."

TONY: "Okay."

PATIENT 3: "I know for a fact that if I smoke a cigarette, I'm going to be getting high again. So, I can't touch cigarettes. I just cannot. I cannot ever smoke a cigarette, because if I smoke a cigarette, I'll be sniffing dope again, I'll be smoking crack—everything that's out there, I'd be using if I start that cigarette."

TONY: "How do you know that?"

PATIENT 3: "I know it. I know it."

TONY: "I'm impressed with your view on that, because a lot of people—you know, we have a hard often realizing that one substance can trigger the use of another. A lot of times we're in an inpatient treatment program here when folks are first time treatment experience or whatever and we really don't have a lot of insight or understanding at that point. You know, maybe I hit bottom with my cocaine use. So, I'm never going to go there again. Okay? I don't want to use any cocaine, but don't tell me I can't smoke a little weed! That should be legal anyway! I'm not an alcoholic! I should still have a few drinks when I'm out at the club, right? Did you ever hear that or think of that perhaps yourself? Is that true? Can we do that?

PATIENT 3: "You can't do it because even if you stop sniffing dope the first thing you think about is, 'Oh, I can sell it and make a lot of money!' That's not true. You can't do it. You've just got to—you can't do any of it. You can't. There's no such thing as, well, I can do this, but I can't—there's no such thing. Because if you can do that, everything else is going to start. It's like a domino effect."

TONY: "Okay so there's something about how one kind of triggers the other, is what you're saying? And is it fair to say, based upon what I'm hearing from you today, that tobacco for some of us, it fits into the picture, too?

PATIENT 3: "It definitely fits into the picture for me."

TONY: "So, in essence, we're keeping alive the active addict thinking, feeling, and behavior that is now extended, if you will, to the cigarette. Does that make any sense at all? I'm saying this because I was interested in your comment, where you're saying I always thought it was something different, but then I realized that there still is a similar pattern kind of—no, we don't get arrested for smoking cigarettes, but in essence we keep alive a lot of that whole preoccupation, that mindset, of chemical coping, I need something, there's a connection there that we believe can indeed impact quality of recovery.

Folks that researched this will tell us that if we let go of the cigarettes concurrently with other substances—if indeed it was always there, and that may not be true for everybody in this room. I understand that. But if EVERY single time it was there while I was drinking or using some other substance, that is not a separate issue. That is part of my ritual of use. So, if I'm keeping that thing alive—change people, places, and things—stop living the problem, start living the answer, the problem goes away—this fits into everything that Twelve-Step programs teach us. If we let go of that cigarette, concurrently, the chances of relapsing to the cocaine are going to be diminished in a profound way—for some of us. Perhaps not everyone. Yes, sir.

PATIENT 9: "I disagree, simply because I wasn't—I'm a smoker. I smoke tobacco. I don't have the combination thing going. I don't drink alcohol. I don't sniff cocaine. And I have it in control. I don't prostitute myself. If I don't have it, I'm okay. I choose to smoke. I'm not ready to give up smoking."

TONY: "Thanks for sharing that. Can I explore that a little bit with you?"

PATIENT 3: "A lot of people will always say well, I don't have an addiction because I smoke cigarettes, but you do have an addiction, because you do have to have that cigarette—you still want that cigarette."

TONY: "So, hold up. Don't beat up on the guy. Let me ask you the question: do you think you're addicted to tobacco? Are you hooked?"

PATIENT 9: "Um, I've stopped. I went through the same symptoms as when I stopped drinking, but no, I don't. I think when I'm ready, because I'm just simply not ready to give up smoking, I'll take the steps necessary."

TONY: "Okay. So right now cigarette smoking is still important to you. You're not ready to kind of let go of that, and I'm guessing—correct me if I'm wrong—the way you're communicating this, you're not ready to go there because you don't see a connection to the booze, right?"

PATIENT 9: "Or to the drugs. Absolutely I don't."

TONY: "Okay."

TONY: Well, I'm glad that he's saying this, because we all have different patterns of use, right? There's different associations for all of us. And I'm glad you're being honest. I appreciate that—that you're being honest. You're saying that you're not connecting to this the way perhaps some of these other folks are saying, that it's always there."

TONY: "We're going to talk about craving management techniques in our tobacco recovery group, which we also run in the program. It's a little different focus. Today what we really just want to focus on is how and why, for some of us, this may be an issue in terms of our thinking, our feeling, the way that we relate to the lifestyle of active addiction. Then, for those of us that need more assistance with regard to really including this in our day-at-a-time recovery program, we have a separate group for that.

We're going to talk about how to attend an AA meeting and not have a cigarette afterwards. How do you weave this into your daily affirmation. How do you take a personal inventory at the end of the day. How do we relate the 12 steps to the powerlessness and the unmanageability around tobacco use. So, if we're really going to get invested—if, indeed, you believe that this is an issue for you, and we think for a lot of people in this room it is or we wouldn't be spending the time talking about this right now—that will be a focus that we're going to put in place in our tobacco recovery groups. You can look forward to that. We're going to be doing that in about 20 minutes here in Room B."

PATIENT 2: "I'm kind of realizing the power of tobacco right now because you know even though I'm in a tobacco-free environment right now? I mean just sitting here talking about tobacco and cigarettes? I feel like as soon as I get a pack, as soon as I pass out of here, I'm going to go look for a loosie, man. Even though I know the negative effect it's having on my body? I mean, like my mind is telling me that don't make a difference right now. I'm really looking forward to Room B, because I know I need help with this tobacco."

TONY: Well, it's so powerful that you're saying that right now. Are you going to be in our tobacco recovery group?"

PATIENT 2: "Yes, I really need that."

TONY: How would your life be better tobacco-free?

PATIENT 2: "Oh, man, because I was tobacco-free before and it felt wonderful. I was smoking before I came here into this program."

TONY: "What was better about it? What's the comparison? Here's my life where I'm actively using—whatever, including tobacco—and here's my life free of alcohol, tobacco, and other drugs. What's the difference between those two pictures?"

PATIENT 2: "I slept a whole lot better. My breathing was better. I mean, I live on the fourth floor, and I walked up the four flights of steps without a problem. Now, before I entered this treatment program, there was a problem all over again, but I just didn't care, man."

TONY: "So, you want to get back to that better quality of life."

PATIENT 2: "Yes."

TONY: "It sounds like you've got some thinking pointing you in the right direction, and it's not unusual for us to be romancing continued use. That's part of the disease. That's why this is relapsing, by definition, this thing called addiction. By just talking about that, though, you've exposed that, and that's how we get healthy. So, I'm looking forward to seeing you in our recovery program, tobacco recovery program—there's no question we can help you out with that—you know, the group will help you out with that and help pull you out. So, thanks for sharing that."

PATIENT 2: "I'm looking forward to being there."

TONY: We learn, I think, in the recovery process—it's just not the use, it's the lifestyle. What we're doing when we're changing our identity, we're moving from this active addict into someone who's embracing healthy recovery, there's a lot of different kind of thinking that takes place. The drama of the lifestyle is part of the lifestyle. The manipulation of the lifestyle is part of being an addict. Getting good at playing people is part of being an addict. It's not just that moment in time when I'm hitting the stem or shooting up or doing whatever I'm doing, there's a whole lifestyle that is part of this."

PATIENT 2: "Sitting in this group, it's making me like put the pieces together on how tobacco is a drug and it's addictive. Because, just like the drug, I'd try to sneak around after I'd quit smoking. You know how you try to sneak and use drugs, like nobody knows?"

TONY: "You mean for a cigarette?

PATIENT 2: "I did that with the tobacco. And one day I came up the steps and I was huffing and puffing and my wife says, 'You need to leave the cigarettes alone.' Like all this time I think I'm sneaking around and getting over—I see the problem with that now. I'm really looking forward to that self-help group."

PATIENT 5: "I just wanted to share that you were talking earlier about people, places, and things, and, having been in treatment before, I remember when we used to get the cigarette breaks—so every time we get a break here, those triggers seem to come up. I get the desire to want to smoke a cigarette—and that's a struggle for me. Every time there's a break, I'm praying that there isn't a break, because I struggle with it."

TONY: "You're using what, a skin patch? What did they offer you here?"

PATIENT 5: "I'm using the skin patch."

TONY: "Is that helping you out at all?"

PATIENT 5: "It is, but that doesn't mean that I still don't get the desire to smoke during the breaks. Because I've been in treatment before, and every time we had a break, we had a cigarette break. So, when we get a break here, I start thinking."

TONY: "So, you're talking about a trigger or a cue."

PATIENT 5: "So the breaks are a trigger for me."

TONY: "Exactly. Again, that's great that you're recognizing that, because the idea here is to identify alternative behaviors. So, what do people do when they just want to take some time out or reward themselves for completing a task or to fill boredom. Part of the recovery process is very much learning things that were available to us that we never knew were available to us before. And when we first stop using our substances, we don't have those answers. What does somebody do if they just want to take a break and I don't have something that I'm using? How do you explain to somebody what chocolate tastes like if they've never had a candy bar? How do you know what a life of recovery is like if I've never really experienced it?

Understanding our triggers and cues, though, gives us that opportunity to start exploring the alternatives, the replacements—what are healthy ways of coping and kind of regulating the way I feel through the day. That's very much what this whole process is about—recovery. So, again, along with your man here and our friend here—I think we're going to have a very good tobacco recovery group later today, because that's exactly what we're going to identify—and that's got to be a very personal thing, because what may work for you during the break may be something different than is going to

work for you during the break. So, we really need to talk about that in terms of what are some of those options that are going to satisfy my needs."

TONY: "And what, can I ask you, what would it do for you? I mean exactly what was the effect of it that helped you out, as you're describing this?"

TONY: "So, say more about that—how is it not just a cigarette? Why is it similar? What is the thinking?"

TONY: "Okay, so what's the feeling of that? Is this hopeful? Is anybody feeling angry about this? What's the feeling that we're relating to as we have this discussion here today?"

TONY: "Can I explore that with you a little bit?"

TONY: "What if you had a bag of cocaine and you didn't have any cigarettes. What would you do?"

TONY: "And what did that cigarette do for you that was so important?"

TONY: "It affected your high, is that what you're saying?"

TONY: "So it's mood altering, this thing tobacco, is that what we're saying here?"

TONY: "But the question here today, and really what we want to explore, is why is that so significant for some of us?"

TONY: "Does this make sense at all? Give me some feedback. What do you think about what I'm saying right now?"

TONY: "Can you relate to this? Am I explaining this okay?"

TONY: "So now it's connecting a little better for you?"

TONY: "I just want to summarize this a little bit. So, just to kind of reflect back on what we said here so far today, what are the key points? Help me out with this. What did we talk about today?"

TONY: "We go to great lengths for our drugs, don't we. And tobacco is really a big player in that. We talk about the consequences of drug use—that it's not the same with tobacco. And I'm going to suggest to you that it's EXACTLY the same. It impacts our behavior in very profound ways. We violate our values—we violate our own standards in order to get our next nicotine hit. The lengths that we go through in order to do this can be very powerful for many of us. Absolutely."

TONY: "I just wanted to summarize this just a little bit. So, just to kind of reflect back at what we said here so far today, what are the key points? Help me out with this. What did we talk about today?"

PATIENT 3: "That the nicotine goes along with the drug. It's a drug. Cigarettes ARE a drug and they're very addictive. And, if you're using, and if you get into recovery—I feel, my belief is that once you're in recovery, that you should leave the cigarettes alone. I think that if you're allowed to smoke the cigarettes in the program, that's going to lead you to relapse. As soon as you leave that program, you're going right out to the car."

TONY: "So, what we're saying is that there's such a STRONG association for some of us, with our use of other substances and in that ritual of getting high—where the cigarette is a major player in that use—that it indeed is something that we need to let go at the same time. Okay. What else?"

PATIENT 6: "The insanity of the cigarette smoke and the insane lengths that we go to to smoke. Scary."

PATIENT 4: "And cigarettes is one of those drugs that you can buy in front of a cop and not go to jail for it."

TONY: "Okay. There you go. It's on every street corner, in a pretty package, the tobacco cartel are better organized than the cocaine cartel, I guess. What did you want to say?"

PATIENT 7: "I felt like they change the cigarettes a lot. They go out now, and as they go out, they make people smoke more because the cigarette went out. We didn't really get the feeling, because now you have to smoke another one. And it keeps going out."

TONY: "I mean, this is so important to recognize, because the cigarette has been reengineered. The smoke is different. When you're hitting on that cigarette, what's happening in terms of our neurochemistry, you know, where that addiction to heroin, or addiction to cocaine, or addiction to alcohol lives—those same pathways are being lit up each and every time we're working that cigarette. So, the comments that you're making are very significant, but that's the basis of why this is. This is a brain disease. And so if we're still acting out our thinking, feeling, and behavior toward the cigarette and firing up—I call it the Christmas tree in the brain—you know, where it glows!—this is an issue that we really need to share with one another and let folks know that."

TONY: "I really appreciate all of the insight and comments that you've shared here today. How was it talking about this today? How do you feel right now? Is this hopeful? Is anybody feeling angry about this? What's the feeling that we're relating to as we have this discussion here today?"

PATIENT 3: "Right. To a point, I got a little bit agitated, because, you know, all of us have different beliefs, but some of us believe that it is NOT addictive! My stomach just started aching a little bit, because this is serious. It's definitely addictive. It just got me a little bit aggravated. I'm cool, but it brought up a lot of stuff. You know, a lot of things I thought about—the dumb crap that I did—and it all revolved around—cigarettes was a main part of it."

TONY: "When we experience that moment of truth, often it takes us to a different place, and then we're going to feel a little anger. We're going to feel a sense of loss. We're going to feel some remorse. But that's part of the process of recovery. So, again, it's so great that we can be here today and talk about this today. I want to thank you for you all being here and look forward to our next session. We'll see you then."

Tobacco Awareness Groups
TAG
Facilitator Guide for Trainees

Tony Klein, a tobacco integration specialist, developed the Tobacco Awareness Groups. Tony has used the TAG approach to introduce the relationships between tobacco, alcohol and other drugs for many years with documented successful outcomes.

Tony's presentations have been included in New York State's training program for addiction professionals and managers. They are demonstrated in training videos on line at www.tobaccoresources.org

They are part of a free 24-hour e-training on line. They are in the Tobacco Awareness Group arm of the training hub for those wishing to register.

It was believed that dealing with tobacco and nicotine in AODA treatment was not a good idea. Providers believed patients would resist the inclusion of their smoking or using smokeless tobacco in their substance dependence treatment. After all they didn't come to treatment to quit smoking.

It turns out that is not true when patients/clients are encouraged to address their tobacco use as part of their substance dependence treatment. This is true when appropriate education on tobacco and nicotine is provided. TAG'S provide the non-offensive, respectful approach patients accept. TAG'S are not challenges to patient's tobacco use and harm from tobacco. When patients/clients learn how important tobacco recovery is for preventing relapse and assuring a more complete recovery from substance dependence, they tend to respond to this information.

Introducing a TAG in a Group Setting (Inpatient/residential)

Explain the purpose of the TAG

1. "We are here to explore how tobacco fits into other drug use. We are not here to focus on your smoking or other tobacco use."

2. "This group does not challenge your tobacco use or try to diagnose nicotine dependence."

3. "We want to find out the relationship between tobacco and other drug rituals and drinking/using in a treatment/recovery group."

4. "We want to inform you of the tobacco industry's deliberate attempt to strengthen the nicotine content in cigarettes. They developed chemical processes' to deepen the addiction and assure long-term tobacco customers."

5. "We want to have you consider if tobacco is important to you and how it fits into your lifestyle."

<u>Preamble:</u> inform patients/clients this TAG session is to help staff and patients learn the relationship between the rituals established for personal alcohol or other drug use. It is also to explore the issue of tobacco use/relapse and strong recovery. This is not a lecture; it is group discussion and learning from peers.

<u>(Facilitate learning with active listening responses on what patients share.)</u>

After explaining the purpose of the TAG, begin the session with leading questions.

For example:

1. "**Let's start with alcohol and smoking. Who wants to share their experience with smoking and drinking? Do you smoke more when drinking? Ask if other group members can identify with this information."**

Offer assumptions on what this may mean relative to the rituals of smoking and drinking. Ask for group opinions about what is being shared.

2. **"Let's continue with cocaine next. Who has some experience with crack or other cocaine to share about the connection between cigarettes and using cocaine? Does smoking enhance the pleasure of using cocaine? Does it help coming down after heavy cocaine?"**

Active listening responses to what is shared. Tie in with what is being shared with the theme of how tobacco is associated with cocaine and other stimulants use.

At this point, inform patients/clients of the tobacco industry's deliberate attempt to strengthen the nicotine content in cigarettes. They developed chemical processes' to deepen the addiction and assure long-term tobacco customers, e.g. ammonia doping.

3. "Can anybody share their experience with marijuana and cigarettes or other tobacco products? Is this experience of using both tobacco and pot familiar to anybody?"

Active listening responses to what has been shared. Continue tying in the responses to the role and rituals of using/drinking and smoking.

4. "What if you are using other drugs together like alcohol and cocaine or any other combinations that includes tobacco? Do you smoke more when using or coming down after drinking or using?"

Active listening and demonstrating you understand what is being shared.

5. "Does anybody have experience with using spit tobacco with other drugs?"

Active listening and demonstrating you understand what is being shared.

"Ask what drug the group members used first. Ask which is the last drug to go."

Conclude by asking group members what they learned that was new and what was not. Ask if any group members want to explore their tobacco use further.

Trainees are encouraged to experiment with their own questions and responses as they implement TAD'S in their own programs.

Introducing Tobacco Awareness in individual therapy (Outpatient therapy)

The questions and TAG process used in inpatient/residential AODA treatment are the same. The process is to establish a dialogue between therapist and patient/client.

Trainees are encouraged to experiment with their own questions and responses as they implement TAD'S in their own programs.

Technical assistance on evidence-based nicotine dependence treatment is available from UW-CTRI specialists

Mayo Nicotine Dependence Center
PATIENT QUESTIONNAIRE

Instructions

Please complete the following questionnaire by filling in the blanks and checking the appropriate boxes. The questions evaluate various aspects related to your smoking. It takes about 15 minutes and should be completed and available when the smoking cessation counselor sees you.

---

1. General Information

1.1 Today's date: _____ - _____ - _____
mo. day year

1.2 Your Mayo Clinic registration number: __ - _ _ _ _ - _ _ _ _

1.3 Name (please print): ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other _____

_____
First Middle Last

Phone: Home (_ _ _) _ _ _ - _ _ _ _

Work (_ _ _) _ _ _ - _ _ _ _

Best time and place to contact you by phone:

Time: _____ ☐AM ☐PM ☐Home ☐Work

1.4 Gender: ☐ Male ☐ Female

1.5 Date of birth: ____ - ____ - _____
mo. day year

1.6 Height _____ ft. _____ in. Weight _____ lbs.

1.7 Marital status:
☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

1.8 Race: ☐ White ☐ Black ☐ American Indian ☐ Oriental
☐ Other _____

1.9 Mayo Medical Center Employed: ☐ No ☐ Yes

1.10 Usual occupation/profession: _____
Present occupation/profession: ☐ same as above ☐ retired
☐ Other _____

1.11 Highest level of education _____

1.12 Reason for visit with Nicotine Dependence Consultation Service

_____

_____

1.13 Referring doctor _____

2.0 Smoking History

		Age / Cigarettes/day
2.1	How old were you when you first smoked a cigarette?	_____
2.2	How old were you when you first started regular daily cigarette smoking?	_____
2.3	On average, how many cigarettes are you *currently* smoking per day?	_____
2.4	*Over the past six months*, how many cigarettes did you smoke per day?	_____
2.5	On the average *of the entire time you have smoked*, how many cigarettes did you smoke per day?	_____
2.6	*When smoking the heaviest*, how many cigarettes did you smoke per day?	_____

2.7 Do you inhale cigarette smoke? ☐ Never ☐ Sometimes ☐ Always

2.8 List brands of cigarettes smoked:

Starting brand _____

Current brand _____

2.9 Please check the appropriate boxes

	Never	Past Only	Currently
Smoke a pipe?	☐	☐	☐
Smoke cigars?	☐	☐	☐
Chew snuff?	☐	☐	☐
Chew tobacco?	☐	☐	☐
Smoke other non-tobacco products?	☐	☐	☐

2.10 When do you smoke the heaviest? — Check one answer.

☐ Mornings ☐ Afternoons ☐ Evenings

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

☐ Immediately
☐ Within 30 minutes
☐ Between 30 minutes and 1 hour
☐ Beyond 1 hour

2.12 Which cigarette would be the most difficult to give up? Check one answer.

☐ First in the morning
☐ After meals
☐ During or after stressful situations
☐ During social occasions
☐ Other — specify _____

2.13 Do you find it difficult to keep from smoking in places where it is forbidden (for example in church, at the movies)?

☐ No ☐ Yes

2.14 In what situations don't you smoke? — Check as many as apply.

- ☐ In public
- ☐ At work
- ☐ At home
- ☐ In presence of certain relatives (e.g. parents, grandparents, in-laws)
- ☐ In presence of my children
- ☐ At meetings
- ☐ Inside the home of non-smokers
- ☐ In my car when non-smokers are with me
- ☐ In other peoples' cars
- ☐ In restaurants
- ☐ In airplanes
- ☐ Other, specify _____

2.15 Please indicate whether or not you think you would smoke in the following situations:

Situation	Probably would not smoke	Unsure	Probably would smoke
1. When feeling anxious or under a lot of stress	☐	☐	☐
2. When wanting something in your mouth	☐	☐	☐
3. When relaxing	☐	☐	☐
4. When wanting to cheer up	☐	☐	☐
5. When wanting to keep busy	☐	☐	☐
6. When bored or trying to pass the time	☐	☐	☐
7. When around other smokers	☐	☐	☐
8. When drinking alcoholic beverages	☐	☐	☐
9. When drinking coffee or tea	☐	☐	☐
10. When talking on the telephone	☐	☐	☐
11. When in pain	☐	☐	☐
12. After meals	☐	☐	☐

2.16 Have you *in the past* had symptoms, a disease or illness you believe was caused or made worse by your smoking?

☐ No ☐ Yes, please describe _____

2.17 Do you now have symptoms, a disease or illness you believe is caused by or made worse by your smoking?

☐ No ☐ Yes, please describe _____

2.18 Does your desire for a cigarette ever disrupt the activities you are involved in?

☐ No ☐ Yes

2.19 Do you lose time from work or other planned activities because of smoking?

☐ No ☐ Yes, describe _____

2.20 Do you smoke when you are so ill that you are not able to carry on your normal activities?

☐ No ☐ Yes

2.21 Do you use tobacco despite a serious physical disorder which you know is made worse by tobacco use?

☐ No ☐ Yes — what is the serious disorder? _____

2.22 Do you ever find yourself smoking more than you intended?

☐ No ☐ Yes, describe _____

2.23 Has a doctor ever told you to stop smoking?

☐ No ☐ Yes, why? _____

2.24 At this visit, has a Mayo doctor told you to stop smoking?

☐ No ☐ Yes

3. History of Stopping Smoking

3.1 Have you tried to cut down or limit your smoking?

☐ No ☐ Yes

3.2 _____ How many times have you *attempted* to stop smoking?

3.3 _____ How many times have you stopped smoking for at least one day?

3.4 Have you ever experienced uncomfortable symptoms when you stopped smoking?

☐ Does not apply — I have never stopped smoking.
☐ I have stopped smoking in the past but *never experienced* uncomfortable symptoms.
☐ I have stopped smoking in the past and *have experienced* uncomfortable symptoms.

If yes ↴

3.5 What symptoms did you experience when you stopped smoking? — check all that you experienced.

☐ Craving ☐ Anxiety ☐ Restlessness
☐ Decreased heart rate ☐ Increased eating ☐ Difficulty concentrating
☐ Irritability ☐ Other _____

3.6 Since you started smoking regularly, what is the longest time you have gone without smoking anything? (Check one answer.)

☐ Never gone without smoking
☐ Less than a day
☐ At least one day but less than one week
☐ At least one week but less than one month
☐ At least one month but less than one year
☐ One year or more

3.7 Enter the number of times you have tried the following methods to stop smoking.

_____ Self-help material (for example American Lung Association material, materials from your doctor, etc.)

_____ A formal cessation program (for example, with classes, group discussions, etc.)

_____ A private consultation with your doctor or mental health professional

_____ Hypnosis

_____ Nicotine medicated gum

_____ Other, please describe _____

3.8 Have you ever used nicotine skin patches?

☐ No ☐ Yes ↴

How many times? _____
Any problems with the patch? _____

3.9 When was your last attempt to stop smoking?

☐ Never attempted

_____ hours ago _____ days _____ weeks _____ months _____ years ago

3.10 For how long did you go without smoking at that time?

☐ Never attempted

_____ hours ago _____ days _____ weeks _____ months _____ years ago

How did you stop?

Describe _____

Why did you start again? _____

3.11 If you are still smoking, what has kept you from stopping?

_____

_____

4. We Would Also Like to Know How Much Support You Have for Your Efforts to Stop Smoking.

4.1 Please indicate *those relatives* who regularly smoke. — Check all that apply.

☐ Spouse/significant other
☐ Parent(s)
☐ Child(ren)
☐ Grandparent(s)
☐ Inlaw(s)
☐ None of the above

4.2 Among your close *friends*, what percentage would you say smoke? — Check one answer.

☐ Almost none
☐ About 25%
☐ About 50%
☐ About 75%
☐ Almost 100%

4.3 Among your *co-workers*, what percentage would you say smoke? Leave blank if not applicable, otherwise check one answer.

☐ Almost none
☐ About 25%
☐ About 50%
☐ About 75%
☐ Almost 100%

4.4 How much do the people closest to you want you to stop smoking? — Check one answer.

- ☐ Not at all
- ☐ Not much
- ☐ Neutral
- ☐ Somewhat
- ☐ Very much

4.5 If you were to stop smoking, how helpful would the people closest to you be?

- ☐ Not helpful
- ☐ Not much help
- ☐ Neutral
- ☐ Somewhat helpful
- ☐ Very helpful

5. Assessing Your Desire to Stop Smoking

5.1 Are you seriously planning to stop smoking?

- ☐ Yes, have already stopped
- ☐ Yes, in the next 30 days
- ☐ Yes, in the next 6 months
- ☐ Yes, in the next year
- ☐ Undecided
- ☐ Not planning to stop

5.2 How motivated are you to stop smoking completely? (Check one answer.)

- ☐ Not at all motivated
- ☐ Not too motivated
- ☐ Neutral
- ☐ Somewhat motivated
- ☐ Very motivated

5.4 How long have you wanted to stop smoking?

- ☐ Never wanted to
- ☐ For a week or less
- ☐ A week to a year
- ☐ For over a year

5.5 If you have stopped smoking cigarettes completely, when did you stop?

_____ - _____ - _____
mo. day year

5.6 Are you ready to set a stop date?

☐ No ☐ Yes Stop date _____ - _____ - _____
mo. day year

The HONC

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

SCORING THE HONC

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

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

Individuals who score a zero on the HONC by answering NO to all ten questions enjoy full autonomy over their use of tobacco.

Because each of the ten symptoms measured by the HONC has face validity as an indicator of diminished autonomy, a smoker has lost full autonomy if any symptom is endorsed.

In schools and clinics, smokers who have scores above zero can be told that they are already hooked. Many youths become hooked before they even consider themselves to be smokers, because they don't smoke every day.

In research, a dichotomous scoring is helpful when the HONC is used to predict the trajectory of smoking.

Continuous Scoring- The HONC as a measure of severity of diminished autonomy

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

Some researchers prefer to provide multiple response options for questionnaire items, e.g., *never*, *sometimes*, *most of the time*, *always*. In certain situations, this can improve the statistical properties of a survey. When this has been done with the HONC, its performance was not improved (O'Loughlin et al., 2002).[16] Having more response options complicates the scoring because the total score does not coincide with the number of individual symptoms. Therefore we recommend the Yes/No response format.

Researchers who wish to measure frequency or severity of symptoms may do so by adding to the yes/no format additional questions about any item endorsed by a smoker. Here is an example:

Have you ever felt like you were addicted to tobacco? A smoker who checked "yes" would then respond to:

How often have you felt addicted? *Rarely*, *Occasionally*, *Often*, *Very Often*

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

Diagnosing Nicotine Dependence

Diagnostic & Statistical Manual IV-R

A maladaptive pattern of tobacco use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following occurring at any time in the same 12-month period:

1	Tolerance, as defined by either of the following: a) A need for markedly increased amounts of tobacco to achieve the desired effect b) Markedly diminished effect with continued use of tobacco	Yes _____ No _____
2	Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for tobacco b) Smoking a cigarette or using another tobacco product to relieve or avoid withdrawal symptoms	Yes ____ No _____
3	Tobacco is often taken in longer amounts or over a longer period of time than was intended	Yes ____ No _____
4	There is a persistent desire or unsuccessful efforts to cut down, control how many cigarettes or other tobacco products are smoked or used, or trying to quit smoking or using other tobacco products	Yes ____ No _____
5	A great deal of time is spent in activities obtaining tobacco, actually smoking or using other tobacco products (e.g. chain smoking) or recovering from the effects of smoking or using other tobacco products	Yes ____ No _____
6	Important social, work or recreational activities are given up or reduced because of smoking or using other tobacco products	Yes ____ No _____
7	Smoking or using other tobacco products is continued despite knowledge of having persistent physical or psychological problems that is likely caused by, or made worse from smoking or using other tobacco products (e.g. having lung or breathing problems from smoking despite medical advice or family pressure to quit)	Yes ____ No ____
	Total Number of Symptoms	

Assessing the Stages of Change for Nicotine Dependence

How Ready Am I to Change?	Check All That Apply	Comments
I have no intention of quitting tobacco now or ever. I have tried to quit and it never worked, so I am not interested any more	_____	
I want to quit but I don't want to give up the benefits of smoking or using other tobacco products. I am torn between quitting or not.	_____	
I have decided to quit sometime in the next week I have decided to quit in the next 30 days I have decided to quit in the next 60 days	_____ _____ _____	
I have started to quit and have a plan to stay off tobacco	_____	
I have quit smoking, or using other tobacco products and want to prevent relapse	_____	

Assessment of Motivation: Readiness to Quit Ladder

Instructions: Below are some thoughts that smokers have about quitting. On the ladder, circle the one number that shows what you think about quitting. Please read each sentence carefully before deciding.

10	I have quit smoking.
9	I have quit smoking, but I still worry about slipping back, so I need to keep working on living smoke free.
8	I still smoke, but I have begun to change, like cutting back on the number of cigarettes I smoke. I am ready to set a quit date.
7	I definitely plan to quit smoking in the next 30 days.
6	I definitely plan to quit smoking in the next 6 months.
5	I often think about quitting smoking, but I have no plans to quit.
4	I sometimes think about quitting smoking, but I have no plans to quit.
3	I rarely think about quitting smoking, and I have no plans to quit.
2	I never think about quitting smoking, and I have no plans to quit.
1	I have decided not to quit smoking for my lifetime. I have no interest in quitting.

Reprinted with permission from: Abrams DB, Niaura R, Brown RA, Emmons KM, Goldstein MG, Monti PM. *The Tobacco Treatment Handbook: A Guide to Best Practices*. New York: Guilford Press, 2003 (page 33). Adapted by the Center For Tobacco Independence.

WINTIP

Assurance Planning

Common Complications of Addiction

Severity of Addiction Index

(Scale: 0 least severe – 5 most severe – circle your selection)

#	Addiction Complications	Scale	Score
1	Grief and Loss Issues	0 1 2 3 4 5	
2	Guilt and Shame	0 1 2 3 4 5	
3	Sexuality/Gender	0 1 2 3 4 5	
4	Self Esteem	0 1 2 3 4 5	
5	Legal Problems	0 1 2 3 4 5	
6	Financial Distress	0 1 2 3 4 5	
7	Career/ employment Problems	0 1 2 3 4 5	
8	Family and/or Personal Relationships	0 1 2 3 4 5	
9	Medical/ Physical Problems	0 1 2 3 4 5	
10	Psychiatric/ Mental Health Problems	0 1 2 3 4 5	
11	Parenting/ Childcare Issues	0 1 2 3 4 5	
12	History of Early Life Abuse/ Neglect	0 1 2 3 4 5	
13	Post Traumatic Stress Disorder/trauma	0 1 2 3 4 5	
14	Lack of Personal and/or Community Resources to Sustain Independent Living	0 1 2 3 4 5	
15	**Relapse History:** One relapse = 3 points Two relapses = 5 points Three relapse = 8 points More than 3 relapses = 15 points More than 5 relapses = 25 points More than 10 relapses = 50 points	 …… …… …… …… …… ……	
		Total Score	

TREATMENT PLAN SAMPLES

Substance Dependence Disorders Including Nicotine Dependence

WINTIP Training 2011

David "Mac" Macmaster, CSAC, PTTS

Nicotine Dependence

305.1

Stage of Change
Pre-contemplation

"I am not interested in addressing tobacco in my treatment and recovery – "No Way!"

Assessment/Diagnostic Findings

The patient is nicotine dependent as evidenced by results from comprehensive assessment using DSM-IV4 criteria for 305.10, Nicotine Dependence Disorder, Fagerstrom Severity of nicotine dependence indicating heavy tobacco use and determined to be at **the pre-contemplation phase in the Stages of Change continuum.**

Treatment Plan Samples for Nicotine Dependent Patient In Pre-contemplation Stage of Change

Goal #1

Motivate Patient to Accept Information on Tobacco and Nicotine Dependence

Objectives

- Assign patient to Tobacco Awareness Groups as scheduled and participate in group discussions and individual sessions with counselor on tobacco and nicotine
- Assign patient to review videos/DVD's on tobacco and nicotine; literature from UW-CTRI resources that present current information on the risks of tobacco use and diagnostic criteria for nicotine dependence

Outcomes

As a result of appropriate education and participation in Tobacco Awareness Groups, the patient will increase knowledge of the risks of nicotine dependence and tobacco use and identify resources for continuing nicotine and tobacco education.

Goal #2

Motivate patient to accept tobacco-free treatment and facility policies and support peers in their recovery from nicotine dependence

Objective

Assign patient to Tobacco Awareness Groups as scheduled and participate in group discussions and individual sessions with counselor on tobacco and nicotine. Monitor progress in motivation for addressing tobacco and nicotine dependence while in treatment.

Outcomes

- By being exposed to a tobacco-free environment during treatment the patient will be willing to support peer's efforts to achieve abstinence from tobacco.

Goal #3

Motivate patient to advance to the contemplation state of change

Objectives

In group and individual sessions use the pro/con exercise to consider the benefits and liabilities from continuing smoking or using other tobacco products, encourage the patient to consider reviewing the decision not to address tobacco/nicotine while in treatment.

Outcomes

As a result of tobacco/nicotine treatment activities and self-reflection, the patient has decided to address tobacco while in treatment for other substance dependence disorders.

Stage of Change
Contemplation

"I have been thinking about quitting, but don't know if I really want to quit (or have the ability to do it.) I feel torn and ambivalent about quitting. In a way I am stuck."

Assessment/diagnostic Findings

The patient is nicotine dependent as evidenced by results from comprehensive assessment using DSM-IV4 criteria for 305.10, Nicotine Dependence Disorder, Fagerstrom Severity of nicotine dependence indicating heavy tobacco use and determined to be at the contemplation phase in the Stages of Change continuum.

Ambivalence
Should I? Can I?

Treatment Plan Samples for
Nicotine Dependent Patient
In Contemplation Stage of Change

Goal #1

Motivate patient to accept information on tobacco and nicotine dependence

Objectives

- Assign patient to Tobacco Awareness Groups as scheduled and participate in group discussions and individual sessions with counselor on tobacco and nicotine
- Assign patient to review videos/DVD's on tobacco and nicotine; literature from UW-CTRI resources that present current information on the risks of tobacco use and diagnostic criteria for nicotine dependence

Outcomes

As a result of appropriate education and participation in Tobacco Awareness Groups, the patient will increase knowledge of the risks of nicotine dependence and tobacco use and identify resources for continuing nicotine and tobacco education.

Goal #2

Motivate patient to accept tobacco-free treatment and facility policies and support peers in their recovery from nicotine dependence

Objectives

Assign patient to Tobacco Awareness Groups as scheduled and participate in group discussions and individual sessions with counselor on tobacco and nicotine. Monitor progress in motivation for addressing tobacco and nicotine dependence while in treatment.

Outcomes

By being exposed to a tobacco-free environment during treatment the patient will be willing to support peer's efforts to achieve abstinence from tobacco.

Goal #3

Motivate patient to advance to the preparation/planning state of change

Objectives

In group and individual sessions use the pro/con exercise to consider the benefits and liabilities from continuing smoking or using other tobacco products, encourage the patient to consider making some concrete plans for addressing tobacco/nicotine dependence while in treatment.

Objectives

- In group and individual sessions review model tobacco treatment and recovery plans for achieving abstinence from tobacco and eventual abstinence from nicotine in all forms.
- In group and individual sessions consider evidence-based nicotine dependence treatment options including medication management and community support for tobacco recovery.

Outcomes

As a result of tobacco/nicotine treatment activities and self-reflection, the patient has decided to address tobacco while in treatment for other substance dependence disorders; has selected plans for achieving abstinence from tobacco.

Stage of Change
Preparation/Planning

"I know in my heart and soul that I need to end my dependence on tobacco and my harmful relationship with nicotine and am no longer torn and am ready to begin my nicotine dependence treatment and recovery."

Assessment/Diagnostic Findings

The patient is nicotine dependent as evidenced by results from comprehensive assessment using DSM-IV4 criteria for 305.10, Nicotine Dependence Disorder, Fagerstrom Severity of nicotine dependence indicating heavy tobacco use and determined to be at the preparation/planning phase in the Stages of Change continuum.

Treatment Plan Samples for Nicotine Dependent Patient In the **Preparation/Planning** Stage of Change

Goal #1

Develop a personal plan for achieving abstinence from tobacco and beginning nicotine dependence recovery

Objectives

- With counselor explore the elements of evidence-based treatment and recovery from nicotine dependence
- Review history of past quit attempts; identify past relapse triggers and issues
- In group discuss past quit attempts; emphasize past successful quit attempts and benefits from being tobacco-free

Objectives

- Individually Identify and list action steps that will strengthen the recovery plan after treatment, e.g.; removing all traces of tobacco and paraphernalia from home and vehicles; discuss these action steps with peers and staff in group and individual sessions

Outcomes

As a result of appropriate education and participation in Tobacco Awareness Groups, the patient will increase knowledge of the risks of nicotine dependence and tobacco use and identify resources for continuing nicotine and tobacco education.

Goal #2

Identify community and online resources that support successful, long term recovery from nicotine dependence

Objectives

- With assistance from staff and peers, identify and contact local, regional, state, national and international resources for long term recovery support
- With assistance of staff and peers identify and practice contact with online and telephone recovery resources

Outcomes

By time of discharge from current level of care the patient will have completed both a primary and a continuing care plan that involves family and other supportive persons and programs.

Goal #3

Motivate patient to advance to the preparation/planning state of change

Objectives

In group and individual sessions use the pro/con exercise to consider the benefits and liabilities from continuing smoking or using other tobacco products, encourage the patient to consider making some concrete plans for addressing tobacco/nicotine dependence while in treatment.

Objectives

- In group and individual sessions review model tobacco treatment and recovery plans for achieving abstinence from tobacco and eventual abstinence from nicotine in all forms
- In group and individual sessions consider evidence-based nicotine dependence treatment options including medication management and community support for tobacco recovery

Outcomes

As a result of tobacco/nicotine treatment activities and self-reflection, the patient has decided to address tobacco while in treatment for other substance dependence disorders; has selected plans for achieving abstinence from tobacco.

Stage of Change
Action

"I am now invested in my treatment and recovery from tobacco and nicotine dependence. I am doing what works for me to remain tobacco free."

Stage of Change
Maintenance/Relapse Prevention

"I am no longer a smoker/tobacco user. I am dependent on nicotine but now am prepared to protect my recovery. I understand relapse is common in the struggle to remain tobacco free. I am committed to remain tobacco and nicotine free and do what is necessary to remain that way (smober)."

WiNTiP

Wisconsin Nicotine Treatment Integration Project : Mental Health, AODA and Tobacco Dependence

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WINTIP WEBINAR

We Can Do This

Expanding AODA Scope of Practice to Include Nicotine Dependence

Presented at UW-CTRI by
David "Mac" Macmaster, CSAC, TTS

WiNTiP

The Issue: Extraordinary Prevalence and Incidence of Nicotine Dependence in those with Substance Use and Dependence and Mental Health Disorders

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1 2 3 4 Play

WHO WE ARE:

The University of Wisconsin Center for Tobacco Research and Intervention is nationally recognized for its leadership in translational tobacco research and tobacco treatment... More

UW-CTRI INTRANET | UW Health | WISCONSIN UNIVERSITY OF WISCONSIN-MADISON | School of Medicine and Public Health UNIVERSITY OF WISCONSIN-MADISON

U.S. Public Health Service
Clinical Practice Guideline:
Treating Tobacco Use and Dependence - 2008 Update

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Mental Health, Substance Abuse and Nicotine Dependence

1 2 3 4 5 6 7 8 Play

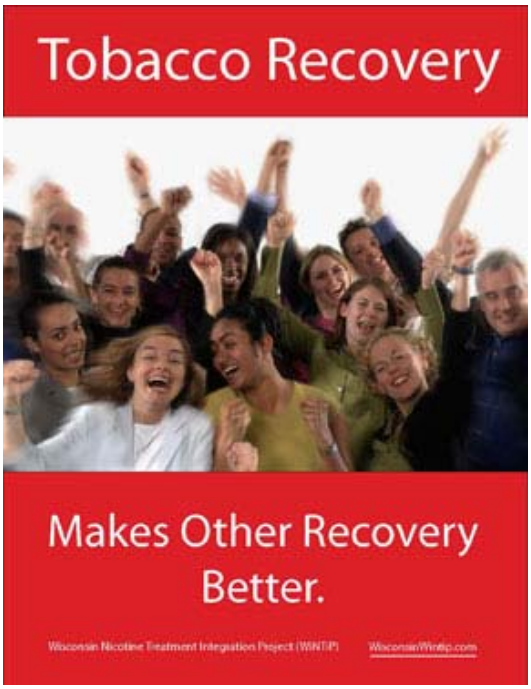
Addiction: The Scandal of Smoking and Mental Illness

ATTUD Position Paper on Nicotine Treatment Ingegration

Counselors Learn How to Help Patients Quit Smoking, Drinking, &/or Drugs All at Once During Day-Long Conference

Patients with Schizophrenia Smoke for Reasons Different Than Others

CME	WiNTiP: Treatment Integration
Webinars	WiNTiP Newsletters
Toolkits	Tobacco-Use Assessment Form
Fact Sheet	PowerPoint
Pod Cast	Research
Case Studies	Posters



INFORMATION FOR or ABOUT:

Researchers | Healthcare Providers | Smokers | Insurers | Employers | Advocates | Quit Line

New York State

Free Online Nicotine Dependence Training
24 Clock Hours

http://www.tobaccorecovery.org/

Psychoactive drugs
Find Pleasure – Relieve Pain

A **psychoactive drug**, **psycho pharmaceutical**, or **psychotropic** is a chemical substance that crosses the blood–brain barrier and acts primarily upon the central nervous system where it affects brain function, resulting in changes in perception, mood, consciousness, cognition, and behavior.[1] These substances may be used recreationally, to purposefully alter one's consciousness, as entheogens, for ritual, spiritual, and/or shamanic purposes, as a tool for studying or augmenting the mind, or therapeutically as medication.

Because psychoactive substances bring about subjective changes in consciousness and mood that the user may find pleasant (e.g. euphoria) or advantageous (e.g. increased alertness), many psychoactive substances are abused, that is, used excessively, despite the health risks or negative consequences.

With sustained use of some substances, psychological and physical dependence (*"addiction"*) may develop, making the cycle of abuse even more difficult to interrupt. Drug rehabilitation aims to break this cycle of dependency, through a combination of psychotherapy, support groups and even other psychoactive substances such as acamprosate or naltrexone in the treatment of alcoholism, or methadone or buprenorphine maintenance therapy in the case of opioid dependency.

However, the reverse is also true in some cases, that is, certain experiences on drugs may be so unfriendly and uncomforting that the user may never want to try the substance again. This is especially true of the deliriants (e.g. *datura*) and dissociatives (e.g. *salvia divinorum*).

In part because of this potential for abuse and dependency, the ethics of drug use are the subject of a continuing philosophical debate. Many governments worldwide have placed restrictions on drug production and sales in an attempt to decrease drug abuse. Ethical concerns have also been raised about over-use of these drugs clinically, and about their marketing by manufacturers.

[1]From Wikipedia, the free encyclopedia

Is Nicotine Dependence an Addiction?

Have you ever thought of the perfect response to a comment later? That happened to me a few days ago when I was talking to a group of physicians. One said, "Nicotine is not an addiction.

Addiction is when you hold up your mother for money to buy your drugs." I mumbled some answer and only later thought about what I wish I had said: When I talk about nicotine being addictive, I'm talking about how nicotine hijacks the smokers brain, just as other addictive substances also do. What this man was talking about was the behavior to obtain the addict's drug of choice.

It is the difference between an illegal, expensive and hard to obtain drug (such as heroin) and a legal, cheap drug that can be bought in every grocery store. If the roles were reversed between heroin and nicotine, I think you would see more heroin addicts because of increased availability but with a cheap cost, crime would drop.

On the other hand, if nicotine were illegal, many smokers would quit due to lack of availability but crime would increase. There would be some smokers that would rob their own mothers to get money to buy cigarettes. Addicts will do almost anything to get their drug of choice regardless of the drug. It is the disorder of the brain that causes this compulsion.

I've talked to smokers who are homeless and penniless. They will scour the street for tossed butts that they can finish off or get a pack of papers and re-roll the used tobacco. It that's not an addiction, I don't know what is.

Obtained from a Google search on addiction.

Substance Dependence Disorders
DSM-1V-R

303.90 Alcohol dependence

304.00 Opioid dependence

304.20 Cocaine dependence

304.30 Cannabis dependence

305.10 Nicotine dependence

304.10 Sedative, hypnotic, or anxiolytic dependence (including benzodiazepine dependence and barbiturate dependence)

304.40 Amphetamine dependence (or amphetamine-like)

304.50 Hallucinogen dependence

304.60 Inhalant dependence

304.80 Polysubstance dependence

304.90 Phencyclidine (or phencyclidine-like) dependence

304.90 Other (or unknown) substance