# NAADAC, TOBACCO USE DISORDER: THE NEGLECTED ADDICTION

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[The broadcast is now starting. All attendees are in "listen-only" mode.]

>> SAMSON TEKLEMARIAM: Hello everyone and welcome to today's webinar on Tobacco Use Disorder: The Neglected Addiction, presented by Andree Aubrey.

It's great that you can join us today.

My name is Samson Teklemariam, and I am the Director of Training and Professional Development for NAADAC – the Association for Addiction Professionals. I'll be the organizer of today's event.

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Let me tell you about today's very skilled presenter:

Andree Aubrey,

is the Director of the Area Health Education Center at FSU College of Medicine and is responsible for statewide tobacco training and cessation programs for behavioral health and peer recovery organizations. Aubrey directs and teaches at the FSU Tobacco Treatment Specialist Course which is one of only 18 accredited training programs in the U.S. She trains medical faculty, physicians, health professionals and students. She is a tobacco subject matter expert for the Florida Certification Board. She co-authored a six week group cessation curriculum, Quit Smoking Now, which is used in

all 67 counties in Florida and Operation Tobacco Free Marines, a standardized group cessation curriculum and manualized facilitator guide.

NAADAC is delighted to provide this webinar presented by this excellent presenter:

So, Andree, if you are ready…I'll hand this over to you…

>> ANDREE AUBREY: Thank you so much, Samson. And welcome to all of you. I appreciate you joining this webinar. On your screen now, you'll see the learning objectives.

Samson-- I thought we would start by reviewing the clinical criteria for a diagnosis of Tobacco Use Disorder. You'll see that this criteria are very consistent with the other substance use disorders. I wanted to calm your attention to number four, craving or strong urge to use tobacco.

A very strong craving for tobacco is highly predictive of your clinical outcomes. We know also that individuals living with a mental illness, substance use disorders and have clinical depression and anxiety experience more severe withdrawal symptoms.

Here's the continuation of the diagnostic criteria. There seems to be a delay, Samson, in advancing of the slides. So if you could bear with us for a minute here.

>> SAMSON TEKLEMARIAM: Hi, Andree no worries. Any time that happens, go ahead and use your mouse to click the screen until it advances, and you can use the arrow keys after that.

>> ANDREE AUBREY: Okay, I tried the mouse. I'll try that again. So we seem to be a little stuck, Samson.

>> SAMSON TEKLEMARIAM: okay, let me see if I can advance the slides for you. Go ahead and give it a try now.

>> ANDREE AUBREY: There we go. I want to point out the number nine. Psychological problem exacerbated by tobacco use. We see it's common with Tobacco

Use Disorder. You all may be familiar with Debbie Austin. Her advertisements were promoted as part of the CDC campaign.

Can you advance the slides for me, please, Samson?

So here are the symptoms of nicotine withdrawals. The most common symptoms are in bold that individuals experience.

And I also want to point out the slight increase in appetite or weight gain is really only four to seven pounds. And many times the fear of gaining weight is a deterrent for people. They are afraid about quitting smoking. They may gain weight. But of course, a slight increase in your weight is much lower risk than continuing to use tobacco.

I also wanted to speak about a couple of important features of tobacco use disorder that are different than other substance use disorders. And nicotine is the addictive agent in tobacco products. And nicotine is highly addictive but it's not intoxicating. So tobacco use gets completely integrated into a person's lifestyle.

So I could not have 20 beers a day and maintain my family relationships and my employment. But I could easily smoke 20 cigarettes a day without having it interfere in my lifestyle or with the psychosocial consequences that we see with other substance use disorders.

So nicotine, when it is smoked is very rapidly absorbed. And the high amount of nicotine and that high rate of absorption is responsible for creating and really sustaining the addiction to nicotine whether we're talking about smoking nicotine in cigarettes or chewing nicotine or even vaping. So within seven to 10 seconds, the nicotine controls the blood-brain barrier, and the same area of the brain,ed reward pathway lights up as it would with other drugs of abuse.

And that release of dopamine delivers to the user a feeling of calmness and pleasure. And what happens is pretty rapidly within 60 to 90 minutes, nicotine withdrawal will start. If you recall the symptoms of nicotine withdrawal we reviewed, the frustration, poor mood, angry, et cetera, users tend to experience this as stress. And so they smoke a cigarette and they feel better.

And then they conclude that smoking is helping me deal with my stress. But what's really happening is that, the smoking behavior is interrupting their nicotine withdrawal symptoms. So it's really not doing anything for a person's stress.

And I think this is one of the most important clinical interventions that we can make is to help tobacco users understand that smoking a cigarette is not helping them at all with their stress. It's simply interrupting their nicotine withdrawal symptoms, and this is going to happen many, many time throughout the day.

Because the users interpret those psycho active effects of nicotine as positive. And generally assume that the devastating physical consequences will not happen for 10 or 20 or 30 years.

So if we take a look at the tobacco use prevalence rate in the general population, you see we've made a great deal of progress with our tobacco control programs. And in fact, in Florida our prevalence rate is down to 15%.

Next slide, please. But if we look at the prevalence rate amongst individuals who are living with a mental illness, we see rates, two, three, or even four times higher than the general population. If you pay attention though those individuals with serious mental illness in the second group of columns on your screen, you'll see a prevalence rate as high as 38 or 40%.

And I wanted to give all of you just a brief idea of the prevalence rates in your state. And one of the consequences of these high prevalence rates is the preventible deaths that occur.

So there are about 480,000 deaths annually attributable to tobacco use. And this is a very conservative number. And about half of these deaths occur amongst individual who have a behavioral health condition, a mental illness or a substance use disorder.

I just wanted to put this 480,000 deaths number in perspective. And so if you look at the number of deaths that occur because of opioid use, not to say anything negative about that, there's about 88,000 deaths per year. And if you think about the

country's response to the opioid epidemic, you don't see similar kinds of alarm about the numbers of deaths that are occurring through the use of this legal product.

Alcohol use and tobacco use are highly comorbid conditions. And what we see is that amongst individuals with alcohol use disorders, they use their smoking at about four times the prevalence compared to the general population. And we see the reverse amongst individuals with tobacco use disorders. They're using alcohol about three times higher than the general population. We have to remember that more alcoholics or people with alcohol use disorder are going to die from a tobacco related illness compared to their alcohol related health consequences.

There are other health disparities populations. We see tobacco use is concentrated amongst individuals living with lower levels of income, who are unemployed or are employed in blue collar or service positions. You'll also see astronomical prevalence rates amongst individuals involved in the criminal justice system or experiencing homelessness.

And this is very deliberate because the tobacco industry has specifically marketed to what they call their down-scale markets. And here's just a graphic that represents some of those tobacco disparities populations.

And so I believe that brings us to our first polling question. So I'll turn it over to you, Samson.

>> SAMSON TEKLEMARIAM: thanks, Andree. We're going to launch this poll on your screen. You should at the it in a moment. The question s how many tobacco disparity group would pertain to the clients you serve? You see four options. This is an opportunity to interact with your presenter. If you have questions, continue to put them on the questions box. About half of you have already responded. I'll give you about ten more seconds.

Excellent. Thank you so much, everyone, 75% of you, more than that now have responded to the open poll that you see on the screen. I'm going to go ahead and close that poll and share the results. And I'll turn it back to Andree to speak to those results.

>> ANDREE AUBREY: This is interesting. This factors increase the likelihood that a person will have begun using tobacco at an earlier age and also they will be heavier smokers and experience more difficulties with quitting.

So that's very interesting to see.

So we have to remember that half of all the long-term users will die from a tobacco related illness. And when you think about most commonly people will start using tobacco at very early ages, 13, 14, 15, 16 years old. So long-term use is 20 years. We're talking about individuals that could be in their late 30s and 40s.

And smokers who have a mental illness who have a cancer incidence rate that is two and a half times higher than the general population.

Of course, it's not just preventible deaths but also needless disabilities. And tobacco use is a risk factor for every health condition that a person might have.

So now we're going to move into our second learning objective and talk a little bit about some of the common barriers for integrating treatment for Tobacco Use Disorder. And some of the strategic interventions we can use to integrate that treatment along with behavioral health services.

So why don't we consistently assess tobacco use and treat this particular addiction? Well, there really has been acceptance of myths that individuals who have a mental illness, for example, can benefit from smoking and that it helps these folks deal with their stress. And many times I've had addictions professionals explain to me that it really is a risk to sobriety and they never encourage their clients to even attempt to quit smoking until they have at least 1 months of sobriety under their belt. We want to talk about these myths a little bit more in depth.

Because there are no benefits from smoking, yes, there is that release of dopamine that delivers the feeling of calm and pleasure. It can act as both a stimulant or a depression. It does increase or reinforce the effects of other drugs and this improvement in cognition and motor function is short lived. And that improvement has been focused on by the tobacco industry as a way communicating to not only the

general population but especially to professionals that people with schizophrenia in particular will benefit from smoking.

But we have to remember that tobacco is the problem. It could never be a solution if half the individuals who use this product long-term are going to die.

So before we get started, Samson, we'd like to launch the second polling question. And I'm interested in learning from all of you, what kind of barriers you see to addressing Tobacco Use Disorder either in your private practice or in your o?

>> SAMSON TEKLEMARIAM: thanks, Andree, everyone should see the poll pop-up on the screen. I see a lot of you are answering already. We'll give you about 20 more seconds. This will be a two opportunities to interact with the presenter using the polling feature. If you have any questions for our presenter today, please go ahead and send them right into the questions box. We would love to know where you're joining us from. And we'll log your question in the order received either in the live webinar or using our Q&A document online. About three-quarters have answered the poll. I'll give you five more seconds.

Wonderful. Thanks so much, everyone. 78% have responded. We will close the poll and share the results. And turn it back over to the presenter.

>> Thank you all for sharing your experience with me because this is very important to me. And I really want to understand what some of those barriers are.

And this being considered less important than other substance use disorders, there were a lot of good reasons for that. So I'm going to return to our webinar slides.

So let's talk first about some of the clinical barriers. And I do understand this consideration of Tobacco Use Disorder as less important than other substance use disorders because tobacco use does not have the same kind of psychosocial consequences in one's life compared to struggles with alcohol and the lack of intoxication as I talked about earlier.

There's also a lack of time for staff training. We do see a bias amongst addiction professionals sometimes about the use of cessation medication. And the use of

medication assistive treatment can triple the likelihood of success with cessation. So we need to encourage this.

The other barrier is sometimes the symptoms of nicotine withdrawal can be misinterpreted as a worsening of symptoms amongst symptoms of mental illness rather.

One of the organizational barriers is that the funding reimbursement for Tobacco Use Disorder treatment is low. It's considered an ad onto other interventions. There may be a lot of ambivalence about establishing tobacco free grounds particularly among the private providers. So if one provider in a community allows individuals to bring their tobacco products with them to treatment and another does not, that second program can be concerned about having a lower census or not able to reach the population they're trying to serve.

There are standards for tobacco use disorder treatment. But there's not always good resources for training staff. And if you're interested in that, if you would send a question along and I'll include that in the responses that will get posted later.

And as I mentioned earlier, we do have a treatment culture that historically has been amenable to tobacco use. And in fact, we still see smoke breaks being used as a reward. We work closely with recovery peer specialists. And I had an individual tell me recently when she was rehospitalized not too long ago, she pretended to be a smoker because that was her opportunity to get outside. So this could be a significant challenge.

But there are so many benefits to quitting smoking. And a person doesn't have to be quit for ten or 15 years before they experience those health benefits. And in fact, within 20 minutes of stopping smoking, your heart rate and your blood pressure are going to drop.

But it's not just the benefits in one's physical health. So this was a very rigorous study and methodology, meta-analysis of 26 longitudinal studies. And there was consistent evidence that, when individuals are able to quit smoking, they experience improvements in depression, anxiety, stress, their overall psychological quality of life

and positive affect or positive mood. And the effect sizes are equal or larger than antidepressant treatment for mood and anxiety disorders.

So that is a very important benefit. And it's just not mental health but there is consistent evidence that quitting smoking may improve substance treatment outcomes. So this was another rigorous meta-analysis of 19 randomized controlled trials conducted by Judith. And the preponderance of standardize case offering treatment of Tobacco Use Disorder will not jeopardize sobriety or their substance use disorder outcomes. In fact they may experience the increased likelihood of long-term abstinence from alcohol and other elicit drugs.

We see that continued tobacco use is associated with greater odds of substance use disorder relapses and associated with risk of new onset of mood and anxiety disorders. Those individuals who are smoking the highest number of cigarettes a day, more than 20 cigarettes a day are more likely to experience those new onset mood and anxiety disorders.

So Samson, here we come to another polling question.

>> SAMSON TEKLEMARIAM: thank you, Andree. Yes, anybody who see this third poll pop-up on the screen. What is the estimated tobacco use prevalence rate among treatment staff compared to the general population? You will see four answer options here. Go ahead and answer this and um have a chance to interact with our presenter as she speaks to the results. We'll give you about ten more seconds.

Excellent. Thank you so much everyone. We're just about three-quarters of the group here had a chance to respond. If you have a questions for our presenter go send them in the questions box and will be sent to the presenter. We'll answer them here in the webinar or on the website. We're going to close the poll and share the results. I'll turn it back over to Andree.

>> Thank you for participating in the polls. What I'd like you to see is that the prevalence use rates for tobacco use among treatment staff is significantly higher than the general population.

And this is a great clinical barrier. I'm trying to advance my slides here, Samson. So we see about a 30 to 35 percent prevalence rate among the behavioral health workforce compared to. We see higher rates amongst treatment professionals. If you think about a nurse who is smoking, would you volunteer to go to work at the pediatric unit of your hospital or would you try to be employed at the cardiac unit or would you be more interested in working at the mental health unit where you can take smoking breaks with your patients?

And we have many people who are in recovery themselves who are working as part of the behavioral health workforce and that could be another influence for the higher prevalence rates. So before we can be effective in, would go with clients, we have to remember to often treatment resources for the staff.

There is a clinical practice guideline for the treatment of Tobacco Use Disorder. And you can access this resource. You'll see the URL right there at the bottom of your screen.

It has not been updated since 2008. But the guideline remains the gold standard treatment of Tobacco Use Disorder.

And now we're moving to our next or final polling question.

>> Yes, this is our final polling question, everyone. The question is asking, what percentage of individuals with mental health and/or substance use disorders are interested in quitting smoking? You see four options. You can go ahead and answer the question. I am give you about 15 more seconds. It looks like more than half of you already answered.

Perfect. Thank you so much everyone for participating in that poll. We'll share the results there so Andree can speak to the results and turn it over to our presenter.

>> ANDREE AUBREY: So I think you all might be interested in knowing about 70% of individuals living with a mental health disorder or substance use disorder are interested in quitting smoking. But most of us assume that people are not really interested in quitting smoking. And that is the same prevalence rate as the general population.

So we cannot let that assumption be a barrier. The most effective treatment for smoking cessation is a combination of practical counseling and far pharmacotherapy. Meaning the medications. All smokers should be offered medication-assisted treatment when making an attempt. And the exceptions are pregnant women, individuals who are less than 18 years of age because the medications were not tested with adolescent population. They're not approved by the FDA. Individuals who have a infarctions and individuals with angina or heart pain.

Brief interventions can be delivered by all clinicians and all clinicians are effective in delivering these interventions which will significantly increase client willingness to make a quit attempt.

We also know that it's rare for individuals to quit on their first attempt. I can disclose I'm a former smoker. I smoked more than 30 years ago. And I counted one time, it took me 18 attempts before I was really success. . And so no quit attempt is wasted effort. And every time an individual tries to quit, it moves them closer to their eventual success with being quit completely. And on average it takes people about 8 or 10 attempts to quit. At least that's the number we see in the literature.

This last bullet is really interesting. The more intensive the counseling, the higher the long-term quit rate. But the guy line defines intensive counseling as about four sessions of 10 to 15 minutes each.

So in our world as counselors, sometimes that's not the definition we use of intensive counseling.

This is the brief intervention from the clinical practice guideline. We ask about tobacco use. We advise users to quit. And then we can either deliver treatment ourselves which is a more intensive intervention or we can refer to treatment resources. You'll see the number at the bottom of the screen. That's a national number. And it will direct callers to the quit line with within their state. So in the first step we ask everyone about their tobacco use status. We want to identify those individuals who never used tobacco, individuals who are current tobacco users. And you have to remember to ask about chewing tobacco especially if you're in a rural area. The use of E cigarettes now,

vaping. And then we want to ask about former tobacco use because the relapse rate with this disorder is so high. It's important for us to continue to ask this question at every visit so that we can identify people who have relapsed early on in that process.

After we ask we also have to record either in the intake interview, documentation. Many times in behavioral health this information gets recorded in the psychosocial assessment. And we have to make sure that we then follow-up. So tobacco use should be included in the problem list or the treatment plan.

The next step of the brief intervention is to advise individuals to quit. This is not giving advise like your parent might give. This is advisement like you might receive from an academic advisor. We want to make sure our message is clear, it is strong. And it's personalized to the individual.

So we want to offer new treatments and medications that are available to help. Ask if the individual is interested. We want to help the person understand that quitting is the most important thing that they can do to improve their health. And the continuing to smoke makes your depression worst. And quitting will help dramatically or quitting tobacco will reduce relapse from alcohol and other drugs.

What we have done is tailor to the concerns of the individual, a benefit that may really interest them. As health professionals we tend to focus on health benefits but there are also social benefits in that there's more stigma now for people who are using tobacco. And there may be concerns about pets preventing cancer amongst pet, exposing family members and children to secondhand smoke.

So as we are tailoring that message, when working with a very young man, we may want to talk benefits to sexual performance rather than delivering a message of avoiding lung cancer, for example.

We want to take advantage of the teachable moments. It is important to acknowledge that it is difficult to quit. And for many people it involves multiple attempts. As I said before, you want to explore that with folks and let them know that no quit attempt is wasted effort. With every attempt people learn a lot about the challenges that

they're going to face and what kind of skills and supports they're going to need to be successful long-term.

We always want to stress the benefits of quitting. Messages that try to scare people about the health consequences are really not effective. We want to maintain our caring, empathetic and positive messages. And it doesn't matter how long a person's been smoking or how many times they've tried. All individuals are capable of quitting when they have the right kinds of supports and treatment.

And again, we want to offer counseling and medications. There are many resources for the final step, the referral. So there were lots of local programs, the state and national quit line that I mentioned earlier.

Many private insurance plan offers benefits, counseling, usual live the health plans will offer at least one or two of the medication options. And you see smoke free.gov on your screen that has very, very robust resources. And there are many others that I haven't listed here. The VA, the Department of Defense. American Cancer Society and American Heart Association and American Lung Association. And you're familiar with the resources in your communities.

So from the clinical practice guidelines, we see that, if you do want to deliver the counseling instead of just referring people, there are three critical steps. And if you look at the descriptions of step 2 and 3, I'm sure that all of the counselors and addictions professionals on this call are well versed in the skills needed for steps 2 and 3. But it's important to learn more about the unique features of tobacco use disorder. Treatment options, and the successful quit strategies which we talked about briefly. But we're going to talk more in depth now about the FDA approved medications.

So there are seven medications that are approved. The nicotine patch is a long-acting medication which delivers nicotine. And then the nicotine lozenges, short acting to deliver nicotine in a safer formula with all the other toxins and carcinogens. It will not completely relieve an individual's withdrawal symptoms. But use of these products will take the edge off of that withdrawal and allow the individual to focus on the behavioral

interventions and the psychological interventions that they'll need to be successful in their quit attempt.

Then we have two products for which tunic tin replacement products for which a prescription is required. The nasal spray and the inhaler. And then two medications bupropion and Varenicline, the brand name is Chantix.

Nicotine replacement therapy, sometimes speaking with clients, all call these nicotine replacement medications, it's really extremely safe because it's the same drug that the client is already using but it doesn't have all those known carcinogens and other chemicals that are in cigarette smoke.

We're not introducing a new drug, a new medication into the body. That nicotine is already interacting with any other medication your client might be taking. There are some caveats for some of the psychotropic meds and caffeine. It's the tar in the tobacco smoke, not the nicotine itself which accelerate the metabolism. And they're metabolized in the liver. An additional benefit is, an individual using these medications who is able to quit smoking may be able to lower the dose that they're needing of their psychotropic medication in order to have that good clinical response. So when people quit, it is important that they speak with their personal who is prescribing that medication to let them know that they've quit.

Because after four weeks or so, their blood levels will need to be checked to make sure that they're not being overmedicated. And the same holds true for caffeine. I know many of our clients drink quite a bit of coffee. They will have more the effects from the caffeine, the jitteriness and nervousness. And we want people to understand that's caffeine overdose and not from the medication.

There is a very low potential for addiction with the over-the-counter nicotine replacement products. And this is a great concern amongst treatment professionals. So on your screen, if you look at the green line, that is the blood plasma concentration of nicotine. So when people smoke, they get a very rapid dose of nicotine delivered to the brain. And if you look at the blue line, that's the nicotine concentration in snuff, or what we call chewing tobacco here in the south.

If you look at the very bottom of that chart, it's a purple line. And this is the nicotine patch. So the nicotine is released at a slower rate to the brain and you get a higher dose or more rapid concentration with the gum and the lozenge. And so the long acting patch is a steady medication. And we recommend that people also use the gum and the lozenge. That's a short-term dose of nicotine and effective in helping people deal with those cravings.

So if you know that everyone morning at 10:15, you take a smoke break with your friends from work, we would encourage that person to go ahead and use a piece of the gum or a lozenge at 10:00 o'clock so they get a little extra dose of nicotine and they're able to resist that craving or that urge to smoke.

So I really love this quote from the CDC, quitting isn't about what you give up. It's about what you get back. And that's a great framework with which to approach your clients. So it's always about the benefits of quitting and their personal benefits, how they think their life might be different if they were able to quit.

And another really important clinical intervention is, most smokers have a sense of failure. I've tried this before. I tried everything. I tried the patch. And I failed. Nothing works for me. We have to reframe that experience because they haven't failed. It's just that, they quit for a much shorter time than they had hoped.

So even an individual who goes one day without smoking, we have to reframe that and be sincere in congratulating them on their success. They did something that worked for a whole day. And they were able to quit at the most difficult time, very early on in the process when they have a very strong withdrawal from nicotine. So we have to reframe that with success. It was just shorter term. And they learned a lot about how it happened that they returned to smoking, what were the circumstances, how were they feeling? And so now they're better prepared moving forward to understand some of the skills and the strategies they're going to need to be able to cope with withdrawal and have a longer time of abstinence.

And so I want to leave you with those two positive messages. And I'm glad to see we have a little bit of time left for some questions.

>> Thank you so much, Andree, for that excellent information. Yes, we're going to go ahead and start a live Q&A here with our presenter. Andree our first questions comes from Kayla from Indiana. She asks, how do you handle the need to use recovery focused language, not labeling people by their illness, for example, alcoholic, smoker. This is a big push seen in the recovery community now. Thank you, Kayla for your question. I'll turn it over to Andree.

>> you're correct, Kayla. We need to shift our language a little bit and talk about people who are using tobacco. I apologize because I talked about smokers quite a bit in the webinar. So thank you for reminding all of us about that.

>> Okay, and-- asks, do you think that there's less urgency of addressing tobacco use because most of its effects are considered physiological?

>> An excellent question. I agree with your perspective. But we have to remember that, um, folks who are in recovery, individuals who are living with mental illness and substance use disorder spend a great deal of time with their counselor and amongst their recovery community.

And folks spend a much less amount of time with their primary care physician, for example.

And so thank you for also pointing that out to everybody.

So I think it's our responsibility as clinicians to address Tobacco Use Disorder because even though there is that attention amongst the medical community, we don't spend a lot of time with our doctors. I think the average physician visit is less than ten minutes.

And often times other physical needs will take priority over the tobacco use.

>> Thank you, and it looks like we have a lot of questions coming in about vaping. I'm going to let you answer them more specific live in the Q&A document. I'm ask you, maybe a combination of what the bulk of them are asking. Regarding vaping, is, you know, what do addiction counselors do with vaping? Is it unethical for addiction counselors to stop their client from vaping and encourage them not to? Or may be considered an evidence-based tool in that area? Or is it better for addiction counselors

to worry and be concerned about the overall health of the client and you know maybe discourage using vaping because of health concerns? I think we've gotten at least, 2 to 4 questions just coming in now and a few more. Thank you, jack Laurie asking that.

Andree the question is about vaping and what addiction counselors do about that now as a smoking cessation option?

>> ANDREE AUBREY: This is a very complicated issue. Vaping is not an evidence-based strategy for quitting tobacco. However, vaping is less harmful than using combustible tobacco, smoking sick receipts. In the UK, for example, there's nor support amongst the primary care physician workforce about assisting people vape not as an alternative.

So if an individual has been able to use vaping to wean themselves off of chewing tobacco or combustible tobacco, that's a harm reduction strategy.

We have to remember though that vaping is continuing to dose the brain with a highly addictive drug which is nicotine. So once the person is able to get off the cigarettes and are now using a vaping product, they also will need to be disciplined in weaning themselves off of vaping. It's harder to assess. It's easy for the individual to be getting even higher doses of nicotine with the vaping than they were when they were smoking.

So this harm reduction is quite a controversy in the public health community. But we can say unequivocally that vaping is never harm reduction for adolescence. What we see is the progress we've made in reducing the use of chewing tobacco and combustible tobacco amongst youth has been quite successful. But at the same time astronomical jumps in the use of these vaping products among adolescence and young adults. And adolescence who are saying, are more likely as they get older go onto use traditional cigarettes. It's a satisfy way to get large doses of nicotine.

I have a colleague that I work with-- it is really a nuance issue.

>> Thank you Andree. We may have time for one maybe two. From Donna, asked, can you speak specific little to the link between trauma and nicotine addiction.

>> ANDREE AUBREY: There's evidence that individuals who have had adverse child hood experiences, who have experienced trauma have higher prevalence rates of using tobacco. And they are heavier smokers. And of course, heavy smoking is usually defined as more than 20 cigarettes a day. So when you're smoking heavily, you're getting-- your body has much more exposure to those carcinogens and the chemicals. Can he see a link between trauma and tobacco use. And it can be challenging for those individuals to quit because of their high level of physical dependency, the strength of their withdrawal symptoms.

And what happens amongst all individuals who are using tobacco is it becomes your primary coping mechanism. So especially whether you're under stress, it's hard to learn new coping mechanisms. That can be a challenge amongst individuals who have had trauma in their backgrounds.

Thank you so much, Andree.

One last quick one. Kimberly, thank you for your question. Asks, I've read recently there's more push to make cigarette packs less attractive. Do you think that would be a deterrent?

>> Yes, I think that would be a deterrent. If you look at tobacco products from Australia for example, they have to be in this dull khaki color and the warning labels are really-- cover like three-quarters of the cigarette pack.

What we've seen in the history of this country is that the manufacturers have been able to select the message that they want to put on their product. So you might see a brand that's marketed primarily to women like Virginia Slims. Would have a warning label that says, warning, this product may cause cancer.

But if you look at a brand that's now associated amongst male smokers like Marlborough, for example, you would see a warning label that says, warning, tobacco use is associated with complications of pregnancy. So having more robust labels, I think would be quite help. .

>> Thank you.

>> And the FDA has really drugged with these regulations.

>> SAMSON TEKLEMARIAM: Thank you so much, Andree for this excellent presentation. Everyone, thank you for participating in that Q&A. Those of you whose questions did not get answers, they will be sent to our presenter. And she will have a moment to answer those and will get them up on the website within about a week. Um see a Q&A document. And speaking of our website, so you can remember where it is, the website is --. You can go to this page in the future when you need information related to this webinar like the PowerPoint slides, the CE quiz and the of course the Q&A document that will have all the questions and answers posted. You can go to that web page probably in about an hour or two and we will have our CE posts. If not it will be posted by latest this evening. To obese the CE certificate, follow these steps. This webinar is available for one continuing education hour. Watch and listen to the webinar, pass the online quiz posted at --. Um be prompted to make the payment of $15 of a processing fee. Which is pretty standard for continuing education credits. It's free to NAADAC members. If you have questions, feel free to people us as CE@NAADAC.org. Here is the schedule for our upcoming webinar. We are gifted presenters on pertinent topics. The 2019 NAADAC annual conference is only two weeks away. Join me in Orlando, Florida and earn up to 43 CEs. You can register now by visiting NAADAC.org. We will send you the hyperlink. We currently have over a thousand participants registered in Orlando, Florida which also makes this an excellent opportunity to exhibit your business, your private practice, your published work or your organization. You may be the exact referral, EF the treatment provider is looking for. Please email-- her people is on the screen. I'm read it out to this IVAYNER@NAADAC.org.

Also course three of a six part training series on addiction treatment in veteran culture continues on Saturday, October 19, 2019 from 12:00 to 1:30PM facilitated by Duane France. Join the series--

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Also included in NAADAC membership are Independent Study Courses, regional and annual conferences, and certificate programs for advanced education in specialty topics.

Thank you again for participating in this webinar, and thank you Andree for your valuable expertise. I encourage you to take some time to browse our website to learn how NAADAC helps others – Stay connected with us on Linkedin, Facebook and Twitter. I hope to meet you all in Orlando for our conference.