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>> All right.
I think folks are joining in now.
If anyone is having trouble hearing me, feel free to send in a chat box or type into your chat box and let us know if you can't hear our audio or see the screen.
All right.
I'm just letting folks join for a little bit longer.
It looks like, you know, the Zoom function basically works, so people are being led in through waiting rooms.
So as folks are doing that, I'll just kick us off.
Good afternoon, everyone.
Welcome to National Council for Behavioral Health Webinar today, a Trauma-Informed Care to Support Tobacco Cessation in Individuals Diagnosed with PTSD.
Thank you so much for joining us today.
So my name, Dana Lange.
I'm a Project Manager at the National Council for Behavioral Health.
I'll be serving as your moderator and one speaker for today's webinar.
I'd also like to introduce you to my colleagues and presenters, Karen Johnson, a consultant for Trauma-Informed Services.
And Taslim van Hattum, director of practice improvement, also at the National Council.
You can find our presenters' full bios available for download on our webpage at bhthechnage.org following the webinar.
So just some quick housekeeping notes today, this webinar is being recorded and all of you are kept in listen-only mode by default.
You can dial in through phone or through computer audio to listen to this webinar.
Questions can be submitted at any time by typing it into the Q and A Section on your webinar dashboard.
We also have a copy of PDF handouts of these slides available for download on our webinar archives page currently at bhthechange.org.
Finally, a short participant survey will be administered in the webinar follow-up email from Zoom.
So, before we dive into the content, I'd first like to provide a brief overview of the National Behavioral Health Network for Tobacco and Cancer Control that is hosting today's presentation, otherwise known as NBHN.
NBHN is one of eight CDC national networks to eliminate cancer and tobacco disparities in priority populations.
Through NBHN, we provide webinars like today's, communities of practice, and many other valuable resources and information all focused on addressing tobacco and cancer disparities, and individuals with mental illness and addictions.
Feel free to visit us at our website to join the network for free.
So here's a quick overview of the topics that we planned to cover in the hour that we have this afternoon.
We're going to cover a basic overview of PTSD and its linkages with tobacco.
We will then discuss strategies to infuse trauma-informed principles into treatment for both PTSD and tobacco use.
We'll then get to as many questions as time allows.
So with that, let's just move into a few basic definitions.

Many of you are probably familiar at least on a basic level with Post-Traumatic Stress Disorder.
But just to cover the basics, it's generally defined by the characterization that people developed it after exposure to a traumatic event.
Some examples would be a natural disaster, war and combat, assault, acts of violence, car accidents, just to name a few, though, there are many, many examples.
PTSD affects about 3.5% of US adults at any given time or roughly 11 million people.
Symptoms can be short-term, so they can last for example for a month after a single event, but can also persist for many months or years.
Additionally, the disorder could receive and reappear at a later time or not surface until months or years after exposure to trauma.
So, we know from that that the duration and severity of PTSD lies on a spectrum, but generally speaking about one in every eleven people will receive a formal diagnosis of PTSD in their lifetime.
So here are diagnostic criteria for PTSD as given currently in the DSM-5.
I won't run down the entire list in the interest of time, but this should give you a sense of the depth and breadth of the disorder and how it plays out depending on the individual.
For point B, intrusion symptoms are typically characterized by distressing memories, dreams, reactions to the trauma like flashbacks is a common example.
Additionally, many symptoms can also be distinguished in certain categories, commonly depersonalization which is when you're feeling out-of-body yourself or derealization, generally experiencing a sense of unreality.
So these are all -- can be found online, but this just a basic list.
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>> So, now that we've kind of set the groundwork for how PTSD is formed and how it presents itself, we might ask ourselves, "Where does tobacco come into this?"
So these are just a few introductory statistics on what we already know about the link between trauma and tobacco.
Multiple studies have shown that individuals with PTSD diagnosis are twice as likely to smoke.
It can also go both ways and that smokers are approximately twice as likely to also have a PTSD diagnosis, than nonsmokers.
Additionally, we have info that 45% of adults with PTSD smoke, when considering outcomes over the lifespan, about two-thirds of people with a lifetime PTSD diagnosis, so a long-term condition also reported a concurrent lifetime history of smoking.
Finally, we also have some research that indicates about 73% of people who smoke and have a PTSD diagnosis are relatively heavy smokers, excuse me, smoking at least one pack of cigarettes per day.
So from this information, I think we can say with a good deal of confidence that these statics show at least a correlation between tobacco use and he presence of PTSD.
So now I'll turn it over to Taslim to dive a bit deeper into the mechanics behind this connection.
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>> Great, so thank you so much, Dana, and again, thank you to all of you who are joining on the line today.

We're so excited for today's webinar, and as many of you know, this is the third in our tobacco and trauma webinar series.
So why three?
I think because we know that these conversations around the intersection of trauma and tobacco are complicated, and there's no easy fix in three hours' worth of webinars, but we are hoping to build a larger set of information and supports around the intersection of tobacco and trauma, knowing that many of you continue within the field to see the highest rates of tobacco use in trauma in your clients or patients.
So we know that trauma has layers, and we know addiction has layers too, and both are deeply multifaceted.
They impact each other through complex interactions, and exists at different points in time as well as simultaneously.
So I want to introduce our conversation today around this by simply saying tobacco, trauma, and PTSD, this is incredibly complicated.
Sometimes the developmental process is very linear such as exposure to trauma increases the risks of tobacco use.
Sometimes tobacco use is pre-existing when someone is exposed to trauma followed by an adult PTSD diagnosis.
And then sometimes smoking or tobacco use is initiated well before or after both.
So as with many parts of mental health and addiction, there will be a few moments within this presentation and with our work where we ask ourselves, "Which came first, the chicken or the egg?"
But I think -- I will talk about the relationship regardless. And then Karen will talk about, "So what now?"
Regardless of when something developed or was exacerbated or existed simultaneously, how do we support individuals now?
So with that in mind, as you can see on this slide, there is a relationship in it, bidirectional relationship between smoking and PTSD.
It increase -- you know, the relationship is seen that there's an increase in tobacco use which also heightens the risk of emotional disorder symptoms such as those found in PTSD.
We also know that despite immediate perceptions of tobacco users, sustained abstinence of smoking decreases the emotional symptomology around PTSD and so that we know that recovery is easier, we -- pardon me.
We know that despite this [Speaking indistinctly] it's easier said than done.
So although sustained abstinence does decrease symptomology, we know in the immediacy that is not always the case.
So smoking possesses three unique factors that may get a reinforcer for at-risk individuals as you can see in the slide.
And due to these effects, individuals with PTSD trying to quit may frequently relapse.
And we'll talk a little bit more about that within this.
So certainly that there's a pleasure of positive affect that anxiety reduction in the temporary physical and immediate sense takes place or behavioral anxiety reduction, even if we know that study show in the long run, and in the long term tobacco use actually negatively affects anxiety and anxiety symptomology.
And then of course there's distress termination and that is very much based on the -- on what nicotine activates within brain receptors.

So as you can see from this, nicotine is delivered by smoking, the nicotine travels to the brain and activates receptors which stimulate the release of dopamine.
And then through that release, it leads to present feelings of calmness and immediacy of reward which reduces the withdrawal symptoms, leading to the immediacy of reduction of stress and anxiety within that behavioral immediacy.
But I think as we talk through this a little bit more today, we'll see that the long-term relationship between anxiety and symptoms are around that are not decreased.
So next slide, please?
So, I know Karen will go much deeper into supportive mechanisms and interventions for change.
So although I want to own that we are limited in these two -- but I want to talk us through a little bit of the cycle of change around this, more specifically so folks on the line understand how withdrawal and symptomology triggers play into ultimately -- recovery or relapse.
And so thinking through the phases of nicotine dependence such as initiation progression to regular smoking.
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And then, developmental maintenance of nicotine dependence, and then sensation or relapse.
So knowing that very specifically when we're talking about PTSD, we're talking about anxiety sensitivity, negative affect or anxiety symptomology and then fearful reactivity to symptoms of anxiety and what those bring about.
So really looking into the cycle of change around tobacco cessation knowing that with every smoking or tobacco cessation, quit attempts, individuals enter into nicotine withdrawal causing hypersensitivity and hyperreactivity to those nicotine withdrawal symptoms which ultimately in the immediacy impacts motivation to smoke to reduce negative affect usually, triggering relapse and ensuring that chronic and daily use continue.
Next slide, please.
So it's clear that PTSD smoking comorbidity is common.
I think Dana really described that to us.
It's less clear as I said which disorder always emerges first.
Although I encourage you to listen to webinar one in our series where we talk about one of the greatest risk factors for early initiation of tobacco use and adult smoking is exposure to ACEs or Adverse Childhood Experiences.
And so in many cases, the trauma does come first creating a risk and reinforcement halfway around tobacco use and ultimately dependence.
People with -- or individuals with a PTSD diagnosis who smoke are more likely to experience exacerbated symptoms of PTSD including depression and anxiety.
As we talked about it before and as Dana mentioned, have a higher trauma history, negative affect, and greater comorbid psychiatric history.
And then of course endure escalating negative psychological symptoms such as emotional reactivity and startle responses.
All of which deeply impact the motivation but also the efficacy of traditional tobacco cessation efforts.
Next slide, please?

So in addition to that, we know the reduction of negative affect is most consistently identified as the smoking motive amongst individuals with PTSD.
And that tobacco use can worsen the physical symptomatology of PTSD including cardiovascular diseases and premature death.
Individuals with PTSD or diagnosed with PTSD -- excuse me can harbor expectations that smoking will reduce the severity.
So, with the perception that smoking will reduce the severity of negative affect, many individuals diagnosed with PTSD may increase their rates of tobacco use and smoking in an attempt to regulate their emotions.
So very often, talking to your clients about this, I think, is incredibly critical.
Many people do not know that in the long run, tobacco use exacerbates anxiety and other symptoms.
So discussing the difference between immediate withdrawal, discomfort, and anxiety systems -- symptoms and long-term better anxiety-reducing outcomes is critical to the larger conversation around treatment and success.
In addition, tobacco users with PTSD tend to smoke in response to stress or PTSD symptoms.
So this creates a negative reinforcing pattern that strengthens the perceptions of false association between anxiety reduction and smoking, in actual, you know, discordance with the science around what tobacco use and the associated chemicals involved in cigarettes caused within symptomatology.
So, what's often less discussed is that many patients don't realize they might have PTSD or a diagnosis of PTSD and try to relieve symptoms through self-medication with alcohol, with tobacco, and with other substances worsening all of those habits that existed both before the trauma or of course starting anew.
So next slide, please?
So I know we could spend an entire additional webinar discussing the population that are particularly impacted by PTSD that many of you are seeing in the field.
But given our time constraint today and the trauma-informed care aspect of the presentation that we still like to cover, we will only briefly touch on populations of special consideration with PTSD under smoking with the caveat that this is by no means an exhaustive list.
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But we certainly want to note that a group of individuals that the public commonly associate with PTSD diagnosis are veterans.
You can see here that about twenty percent or about one in five returning veterans present symptoms of PTSD or major depression.
And the number of veterans who use tobacco is almost double for those with PTSD about six in ten versus those without a PTSD diagnosis.
Another study shows that trauma exposure that results in fear and helplessness as well as concurrent PTSD symptoms and severity is a significant critic -- predictor of smoking during pregnancy.
So pregnant smokers also have higher rate of current and lifetime PTSD than females who quit smoking or engaged in smoking cessation during pregnancy.
So I think the take away message in here is that despite knowing we actually have a number of different special population, we do -- and not enough time to focus in on each of them in depth today, we do know that there are some really strong links between PTSD and smoking that have been

discovered in a pretty wide variety of special populations in different contexts.
And it's worth noting that you might be seeing this in all of your different contexts.
Next slide, please?
So, you know, to [Speaking indistinctly] transition into some of the operationalizing around this, what does cessation look like in people who have a diagnosis of PTSD?
So generally, quit attempts are less successful in this group over time, and PTSD symptoms do play a role in those cessation efforts.
Commonly, like I said, in the form of using smoking as an emotional tool or an emotional coping mechanism or an emotional numbing tool to try to impact the severity of symptomatology.
That taken into account, it's been bound that rates of cessation or smoking abstinence about one month out are less than half when considering folks with a PTSD diagnosis and their attempts to quit.
So we know that PTSD and the symptomatology really affect longer -- both short term and longer terms of patient efforts.
So at this point, I know we've covered a ton around some of the backgrounds and I want to allow ample time for Karen to discuss how we read trauma-informed principles into your treatment planning based on knowing that this significantly affects short and long-term tobacco abstinence.
And really talk about the multilayered relationship between PTSD smoking and how to best think about this in treatment planning.
Karen?
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>> Thank you so much Taslim and Dana.
It's a pleasure for me to be able to join you today.
I'm pleased to be able to spend some time talking about, you know, some ideas related, the solutions and considerations around serving this population.
As Tas and Dana both noted, someone -- an individual who experiences PTSD and has an addiction to tobacco, that's a -- those are complex processes that are going on.
And in theory, they could be served by numerous different systems.
So there's complex systems involved as well.
And so today I want to just spend some time when we -- when we're looking at solutions and considerations to talk about both trauma-informed approaches but also addiction and recovery and how that includes work related to tobacco cessation.
So next slide?
So we've known for over 50 years that people who smoke cigarettes are much more likely to develop and die from certain diseases than people who don't smoke.
So it was in 1964, approximately, going on 30 years now, that we received that we received the general -- Surgeon General's report on smoking and health.
This picture here is the front page of the guide to this overall report.
And I, you know, as I was reading this in preparation for this webinar, I noticed some points of history related to our smoking cessation movement and wanted to share them here briefly.
So, you know, it was in 1960 that we added warning labels on cigarettes.
And in the early 1970s, we phased out cigarette ads on TV and radio.

It was 1975 when the army and navy stopped providing cigarette rations to their troops.
1988, the Surgeon General reported that nicotine is addictive and California introduces cigarette tax for the first time.
And it was 1990 that we stopped smoking on our airlines.
I actually remember that one because I traveled in 1986 in an airplane while I was pregnant with my first child and I remember not appreciating everyone around me who was smoking when I was pregnant.
But there was -- that was the deal then.
So it was 1990 when we became smoke-free.
You know, 1999, CDC launches the National Tobacco Control Program supporting tobacco control programs in 50 states.
And that's around the time that outdoor and billboard advertising was banned.
In 2006, a federal court finds major use tobacco companies are guilty of deceiving the public on dangers of smoking and second-hand smoke.
And 2014, 50 years after the Surgeon General's report on smoking, as a result of all these efforts, we have a bit -- decrease in smoking has dropped significantly.
So in 1964 when the report came up -- came out, 42% of American smoked and in 2014 it dropped to 18%.
Next slide, Dana?
So, you know, talking about history, we certainly have a long history of how we've addressed smoking cessation and mental health services --really, how we have not addressed smoking cessation and mental health services.
I think many of you who have worked in this field for going on two decades would know that we have a long history of promoting smoking, giving out cigarettes as incentive, for meeting treatment goals or resisting -- for example, JCAHO's efforts to make hospitals tobacco-free which happened approximately 27 years ago, at that time when they did that, it was really [Speaking indistinctly] secrets around people, those who served the mentally-ill that strongly opposed this ban.
So, you know, those bans were around, you know, smoking is necessary, self-medication for those who experience mental illness.
People with mental illness are not interested in quitting.
They can't quit smoking.
It interferes with recovery from mental illness.
And that should be -- the fifth myth might be that that should be the lowest priority concern for individuals who experience mental illness.
So as people who are working in a helping profession, everyone on this webinar, we are currently experiencing an increased understanding of addiction and its connection to trauma.
But we are still working on bridging the gap between the silos, between the addiction silo, the mental health silo, and actually the trauma-informed silo as well.
We're striving to connect the dots to build bridges.
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And we have not effectively yet integrated the treatment for tobacco into each -- into either mental health or addiction treatment.
So -- and overall, we have not yet recognized or sufficiently studied how social determinants, such as educational opportunities, employment status, gender and equity, racial segregation, or access to housing and healthcare is also connected to increased rates of smoking and how this understanding

around this connection needs to be integrated into our treatment approaches and our processes.
So when you look at treating both PTSD and smoking, there is very little evidence out there to draw from about what works best.
Today, we want to share the consideration that we can embrace the components of the most current models we are using to address addiction and trauma-informed approaches, to provide effective treatment for tobacco cessation and to address PTSD.
Next slide.
So when we talk about the history -- moving to the history of treatment addiction, it -- wrong.
Addiction treatment, moving a little bit out of -- tobacco cessation hasn't necessarily been embraced within the addiction treatment movement.
And we're going to talk about that in just a minute.
But when we talk about the history of addiction treatment, we know it started as an attempt to help people with sin.
So it's -- there was a temperance movement in the 19th and early 20th centuries.
Zero tolerance that we're more recently familiar with.
In the 1980s, we had the Just Say No campaign and addiction, you know, is criminalized.
We have the war on drugs.
And basically, historically, our view of addiction and the way to treat it has been punitive assuming that there's a moral failing involved here.
So on the slide here, we have a new addiction definition from the America's -- American Society of Addiction Medicine.
Let me just read it.
Addiction is a treatable chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences.
People with addiction use substances or engage in behaviors that become a compulsive and often continue despite harmful consequences.
So it fits very well with the information that has recent -- shared just a few minutes ago.
Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.
So it's important to know here that his addiction -- this definition leaves out addiction is a moral failing and it speaks to both the fact that the brain is impacted through the addiction process and an individual's experiences or trauma also influence the development of an addiction.
So as addiction leaves the shadow of the taboo and enters more into our public discussion and consciousness, we move away from the moral failing.
Updated definitions like this are really important to help public and policymakers and scientists create and support new pathways to recovery.
So now moving to the recovery movement.
Can you go back one slide?
Some more?
Yes.
This report came out in 2016 from the Surgeon General's office.
And you can download it, it has chapters on neurobiology, brain science, prevention treatment and recovery supports, health systems, and how addiction treatments fit into this.

It really moves us away from addiction as a moral failing to a chronic brain disorder.
It moves from criminal justice approaches to public health strategies, helps us move to more person-centered language, dropping that old stigmatized language.
Helps us to develop a science base that informs policy and practice and addresses substance use, misuse, and disorders across a full continuum in the lifespan.
Interesting thing about this report, when I looked at this report and tried to figure out where tobacco and nicotine fit in here, it does mention nicotine as an addictive substance but only 11 times.
And it notes in there that it only mentions it 11 times because problems associated with tobacco use and nicotine addiction have been covered extensively in other Surgeon General's reports, similar to the one that I started talking about just a few minutes ago.
So again, we got the recovery movement focusing on addiction, but nicotine isn't necessarily embraced yet within that movement.
And again today, we are offering that we need to explore bringing treatment for tobacco cessation especially -- when connected to the chronic mental health such as PTSD, into the addiction and recovery frameworks that are also trauma-informed.
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Next slide?
So here is SAMHSA's working -- Substance Abuse and Medical Services Administration working definition of recovery.
A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
So this definition is open-ended and covers both recovery for mental health and substance use disorders.
And when we look at the pie chart and these guiding principles, we can see that there are many pathways to recovery.
The people have a choice for how they may be treated and how they want their recovery to look like, which can change at any given time.
And I think we can make the case that bringing our work related to tobacco cessation especially when connected to a comorbid disease such as PTSD is warranted to look more at that.
So let's talk about recovery oriented systems of care.
Our next slides, ma'am?
So this -- recovery oriented systems of care has been around for less than 20 years.
It's new, really.
And ROSC is the acronym we use.
Is really a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of anyone that might be connected to an individual.
looking at how we take systems that currently exist and change them in a way that supports all areas of recovery.
We ensure again that they're person-centered, strength-based, Trauma-Informed.
Close to the family, individualized and comprehensive.
Always connected to the community -- always focused on data that tells us about what works.

The evidence that tells us that and -- makes -- we also make sure that they're appropriately-funded.
So again, we can ensure that all the services of -- that we have for the people that we serve include tobacco association is part of the continuum of addictions in our work.
Next slide.
So this is just a little bit more about recovery.
When in recovery, people talk about peeling the onion that you kind of have to keep peeling at different layers and really learn everything over from scratch.
From your relationships in social networks, develop goals and aspirations, rethink and reframe those personal narratives, find a positive messages, the narrative that says I'm a survivor, I'm a thriver.
Explore child development and family of origin work, this is really where Trauma-Informed Approaches can play a role and -- well -- I would argue that our Trauma-Informed lens is relevant to everything we do in our recovery or in assistance of care.
And here, we're talking about making sure we understand when we can how it impacts -- how childhood adversity has impacted and influenced how -- where a person is today.
We developed strong identities and we identify roots of anger, guilt, shame, and fear.
Next slide.
So looking again at trauma and addiction, which we always need to do when addressing the challenges of addiction and PTSD and smoking, we look at root causes.
Reasons that people are -- use substances in the first place.
We identify barriers and ensure our systems are Trauma-Informed.
We help people to connect thoughts and emotions.
This can be really difficult to think about emotions on any level when people have very difficult -- would have -- people have had very difficult experiences and are having symptoms of PTSD, and are really afraid of those -- of addressing those emotions.
Attachment and connection, connecting with others who have had a similar experience can be incredibly important.
Healing happens when within the context of relationships.
Do you remember that?
That's a core tenant of Trauma-Informed Approaches.
We understand that contact, engagement, and trust is a key throughout the process, and we work to create stability.
In our next slide, we have -- you've seen this before, so I don't need to, I think, spend any -- spend much time here.
But Trauma-Informed Approaches is a universal approach to responding to trauma in clients.
It assumes universal precaution approach, meaning we assume everyone has been impacted in some way by adverse events in their lives, and as we behave in a Trauma-Informed way with everyone.
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>> As noted -- as I noted earlier, treatment for tobacco use has not been integrated with addiction treatment or our treatment for mental health problems.
So mental health concerns.

So we can bring this Trauma-Informed Approach for tobacco sensation into mental settings, in our homeless shelters, into our transition houses, into our drug treatment centers, and sexual assault centers, etcetera.
We can ensure that all of our services are embracing Recovery Oriented Systems of Care and Trauma-Informed Approaches.
And we are also prioritizing smoking sensation within the context of those services.
So in our next slide, briefly, you've seen this -- I'm sure in our first webinar, just to remind you of the principles of a Trauma-Informed approach.
That come out -- these come out of SAMHSA.
Safety, Trustworthiness, and Transparency, Peer Support, Collaboration and Mutuality, Empowerment, Voice, and Choice, and making sure honoring Cultural, Historical, and Gender Issues.
All of our services that we're striving to create for individuals in this case who experience both smoking and PTSD need to honor and ensure these principles are infused throughout.
So, we bring a Trauma-Informed lens to all of our work and ensure that every -- all of these principles are a part of everything that we do.
The paradigm shift in Trauma-Informed Approach is, next slides, Mara.
Again, this is mostly reminder, but it just helps us acknowledge common connections between substance abuse and trauma.
And again, substance use here including nicotine and tobacco.
Recognizes range of responses can have that there's a continuum as was noted by both Dana and Taslim.
Recognizes that trauma responses impact the ability to develop trusting relationships which impact the ability to healm, when we struggle to connect and struggle to have relationships, we -- that is going to impact our recovery process and our healing journey.
And paradigm shift also notes that we make adaptations to reduce re-traumatization and respond to awareness of trauma.
So, we're making sure that we're never -- we're doing no harm within the context of the organization's that are striving to be Trauma-Informed and Recovery-Oriented.
And this slide here, this next slide really is one more slide about Trauma-Informed approaches.
We change the question from "What's wrong with you" to "What happened to you."
We assume generous intent that everyone is doing the best they can.
A very important tenant of Trauma-Informed Approaches.
Again, we commit to do no harm.
We are very careful to not use shame-based strategies, understanding that that those strategies drive disconnection and set people back.
They do not help people move forward in healing journeys.
And as I noted, we strive to use a Trauma-Informed lens in every interaction.
So, this slide shows us a crosswalk and how closely aligned, both Recovery Oriented Systems of Care or the recovery process for addictions and Trauma-Informed Approaches, how aligned they are.
When you look at this, you can see that, you know, in recovery -- authenticity of recovery experience and voice mirrors empowerment, voice and choice and safety in our Trauma-Informed Approaches.

Recovery, visibility accountability in Recovery Oriented Systems of Care is very, very closely aligned with trustworthiness and transparency in Trauma-Informed Approaches.
Leadership in recovery, peer support in Trauma-Informed Approaches are really very much the same thing about people helping or partnering with -- people who have experience of challenges partnering with those who are on their healing journey.
Cultural diversity, inclusion goes along with cultural, historical, and gender issues.
Collaboration and mutuality and participatory processes are really very much one of the same.
Empowerment, voice, and choice mirrors strength-based perspectives.
And again, back to peer support in both Trauma-Informed Approaches and recovery are very prevalent and very important.
So, here -- this next slide is some key considerations in addressing smoking and PTSD.
So, let's talk through some of these.
So, one, build in more time for conversation.
So, as -- you know, if an individual can engage in a conversation or even to just be in a room with you, that can be very helpful.
Allow the time to be with that person.
Periods of silence are okay.
Active listening.
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>> Listening to understand versus listening respond or to create plans is very, very important.
And explain the person's current concerns and symptoms or level of readiness for change through motivational interviewing can go a long way.
Focusing on the relationship.
Again, healing happens within the context of relationship.
So, we want to always avoid power struggles or any sense of judgment and talk in a way that reflects affirmations and really focuses on the strengths the individual brings with them today.
So, kind of it's like, "Wow. You've been through a lot."
"What brought you here today?"
"I'm really impressed that you're with me -- with us today."
These reflections can still be forward moving.
"So, where do you want to go next?"
"And thank you so much for sharing with me today."
We can do intentional planning around relapse.
As Tas noted tobacco dependence, especially when connected to PTSD, it's a chronic disease that often requires repeated intervention and multiple attempts to quick -- to quit.
So, we can talk about that with the individuals we're partnering with and do some planning around that.
And help people understand that relapse is possibly going to be a normal part of the process.
We can infuse Trauma-Informed principles and sensitive practices into policies and interactions as I noted.
So, being respectful, building rapport, sharing information and control, respecting boundaries, being curious, always being curious and making sure this is -- we're learning from each other or it's bidirectional.
We understand nonlinear healing.
And we always demonstrate awareness and knowledge of trauma.

We can teach about the connection between trauma and smoking.
So, we can help and individual understand the high correlation between smoking and trauma.
Explore ways that smoking may have resulted to address very painful emotions and thoughts that resulted from trauma, and are now part of current PTSD symptoms.
We can share information that research tells us that smoking does not make the symptoms better as Tas noted, but intensifies them.
And we can also provide education that the chemicals in a cigarette, in nicotine and slow down the metabolization of cytotropic meds or make medications that are prescribed for PTSD less effective.
We can talk about the mind-body connection, explore ways and an individual can calm craving, and their anxious thoughts through strategies such as meditation, yoga, journaling, exercise, and other grounding techniques.
Techniques that can help a person return to their body when they might be experiencing fight, flight or freeze and be -- or experiencing stress that is causing an intense desire to smoke.
We can use peer to peer interventions.
So, if your program has a peer services component, you may want to consider integrating peer support into your tobacco cessation interventions.
A program of the University of Colorado in Denver trains peers to offer emotional informational support for tobacco dependence recovery through motivational and engagement strategies, peer-led support groups, community referrals, and educational activities.
We want to use interventions that help people cope with stress.
Similar to what I noted related to the mind and body connection and use motivational interviewing skills.
So, just briefly to go back to motivational interviewing skills as a review, I know you covered this on your last interview -- on your last webinar.
But, you know, this motivational interviewing piece is so Trauma-Informed.
Anyone can learn it.
Anyone can practice it.
And it is so relevant to recovery.
We -- when we're using MI, we're remembering that readiness is not necessarily related to a diagnosis.
And especially when working with someone who has PTSD.
We need to be careful not to assume or give up on people because we might think that's the last -- that's the least of their issues.
So, we -- I'm sure many of you understand that on our -- in that place just to -- just as a reminder, I note that.
You know, the spirit of M - Motivational Interviewing is helping us get people more ready for change, identify where they are with that.
It's a collaborative conversation.
It's not about making someone change.
It's about creating motivation in the other person.
The Spirit of MI is about acknowledging that the individual is the expert in their own life and we value their partnership, and their relationship in figuring out together how best to help them be healthy and address, you know, these complex experiences that they're having related to smoking and PTSD.
--> Display at 00:45:12:10
>> Next slide, please.

So, what does a research say about treatment for PTSD and smoking?
First, it's not surprising after all that we talked about that we're learning that we need to bring assistance approaching to the work.
So, simultaneous treatment is warranted.
Up to 60% of people in addiction treatment are estimated to have PTSD.
Although, they seldom acknowledge the PTSD symptoms and they are three times more likely than other patients to drop out of addiction treatments.
So, one study among smokers with military PTSD found an integrating smoking cessation treatment into mental health care compared with referral to specialized cessation treatment resulted in greater prolonged abstinence.
So, we bring the two together.
We bring smoking cessation treatment into the mental health care for PTSD.
Motivational Interviewing, Smoking Cessation and PTSD Telehealth in a 2016 study with a hundred and seventy-eight veterans, this study found that integrating MI-based smoking cessation treatment into PTSD home telehealth is an effective method to help veterans with PTSD quit smoking.
It did acknowledge that further research is needed to understand how to optimize the Motivational Interviewing integration into this process.
I think it's important to know here the telehealth piece, you know, attendance and smoking cessation programs can be low due to transportation, inconvenience in time, other barriers that may come up.
So, that's an example of sorting out how best to meet the needs of a group -- of an individual or a group.
How we find the pathways to recovery.
Also, research notes that not wanting to quit is a factor -- that not wanting to quit is a factor in low quit rate.
So, 55% of Veterans Health Administration patients who smoke reportedly do not want to quit.
So, motivational strategies and working with helping individuals explore and resolve ambivalence, a common -- a barrier to making a behavior change are critical to an effective approach for this group of individuals.
So, here is a current study which combines Chantix with a common treat -- a common trauma treatment prolonged exposure.
2017 study with a hundred and forty-two individuals indicated that using prolonged exposure therapy for PTSD to smoking cessation treatment for smokers with moderate to severe PTSD, not the low -- not low PTSD severity significantly improved smoking abstinence for up to three months following end of treatment.
And one final example, here's an example of -- next slide, Samara, of a treatment focused on PTSD for veterans.
It very much incorporates the principles and components that we talked about related to both Recovery Oriented Systems of Care and Trauma-Informed Approaches.
This program aimed at encouraging personal growth without, in this case, using medication or moving away from the use of medication to address PTSD.
The sessions are led before combat veterans, so peers are brought into the process and focused on facilitating post-traumatic growth.
Medication and traditional therapies in this program are replaced by exploring family histories and examining reasons why an individual enlisted in the army, meditation, yoga, hiking, kayaking, and archery.
So I want to move now to one case example to see if we can talk through bringing some of these, again, principles across these various systems.

Recovery from addition, Trauma-Informed Approaches, and then of -- again, incorporating tobacco and nicotine into the addictions paradigm, and see, you know, how we can advise the case example.
So here's an individual you may encounter.
And this individual comes to services and notes the following.
Smoking keeps me calmer and helps me keep away intrusive thoughts.
While I would like to quit, it is not a priority for me right now.
I'm just trying to survive and can't envision giving up smoking right now.
So if you could please write in the checkbooks how you might approach this conversation with this individual.
And Dana, thank you.
--> Display at 00:49:56:07
>> Uh-hmm.
--> Display at 00:49:56:10
>> You can help us with some of the ideas that people share.
--> Display at 00:50:03:09
>> Right.
So folks can either write, you know, what they would say in response or, like, what they would say to this person; right, or just generally how they would approach the situation given this context.
--> Display at 00:50:20:11
>> So--
--> Display at 00:50:22:23
>> So one -- we just got one.
What might motivate you to quit in the future; as a question, using a reflective statement as another example.
Explore stress management coping skills.
Again, keep some other tools for finding calmness, seeking out what the patient might want right now.
A lot of just additional questions to get more insight into, like, what is going on with them personally as it connects to their need -- their perceived need to keep smoking to remain calm.
--> Display at 00:51:08:16
>> Very good.
Very good.
Thank you.
I see more answers coming in, but, you know, really, the responses that you've shared so much are spot on and relate to the things we've talked about today.
Both -- we talked about the Recovery Oriented System of Care and Trauma-Informed Approaches that, you know, helping people understand mind-body connection advocacy on strategies for remaining calm.
Joining with the individual listening, providing insight, reflecting back using reflective statements back.
I just saw one related to building rapport, you know, focusing on the relationship, understanding that connection.
However, that -- whatever that looks like within the context of the session with this individual is going to go a long way to help them want build relationship with you.
So perhaps -- then you have the opportunity to do more MI skills and you have the opportunity to teach more about benefits of stopping smoking, how that will help decrease their PTSD symptoms, et cetera.
The relationship is key.
So really, very excellent responses.

I'll just note a couple more things, you know, using -- use--
[Beeping]
Using the--
[Beeping]
Excuse me, there's beeping in the background, so I apologize. Using the -- open the OARS from Motivational Interviewing, an open-ended inquiry, what is most to you; someone I heard said that.
Focus on their mindset.
[Beeping]
If you decided to quit, how would you do it?
Affirmation, you noted that.
[Beeping]
It -- you know, we use affirmation to counter social stigma, feeling invalidated, or incapable.
And then reflections, many -- we talked about reflections.
You know, maybe saying something like, "Quitting -- I hear right now that quitting is not a priority for you, but you have thought about it and have you noted you want to do it, would you be open to hearing some information how smoking may be helpful to -- quitting smoking may be helpful to addressing your PTSD symptoms?"
Very -- so yes.
And then I -- and I would also -- you know, bringing in this Recovery Oriented Systems of Care piece and the community, perhaps over time, maybe not in the first session, but to focus on, you know, what are your system of support.
What -- you know, what other ways can you move forward to bring wellness into your life?
Do you have peers that you can partner with?
And are you willing to integrate trauma -- treatment for trauma and smoking cessation into the same process?
So treatment for your PTSD and smoking cessation.
Okay.
And I think we're going to move to Q and A now. Thank you so much Dana and Taslim.
--> Display at 00:54:10:14
>> Thank you so much both of you.
So we'll -- we have about five minutes to take any questions that have come in.
We've gotten several so far, so we won't be able to get to all today, but thank you so much for your participation in the case example.
So we'll give you a couple of seconds to ask some questions.
But one that we have is, at my facility, I'm being asked to hold the smoking cessation class, do you have any additional curriculum that I could utilize in order to hold the most help -- healing and helpful class.
So I can answer that partially.
I definitely recommend visiting our website for this -- for NBHN at bhthechange.org.
We have several examples of resources that you can utilize for that smoking cessation group.
And we're happy to follow up with you individually, Shana, I believe, as well, if you can give us a little more information.
So the next question, this might be more Karen, I mean, maybe Taslim as well.

What are the preventative strategies you recommend with the children and youth with high ACEs scores to avoid tobacco use?
So maybe both of you could speak to this piece.
--> Display at 00:55:27:15
>> So I mean, I can -- [Sighs] so I just would note that educating or helping children and youth understand how they may want to -- they may be at high risk for using substances including tobacco to address, you know, difficult emotions, thoughts that they don't like, you know, to help them calm down, especially when they're in environments in which, you know, adults are so -- it is -- and so it's important to learn how to manage behaviors in the way adults need us to, right?
So to do some psycho-education around that with the youth to help them understand how they are -- they -- their brains work and their bodies work, and they're impacted by the events in their lives, to help them learn strategies for self-regulation that are not connected to an outside substance.
Those are some of the strategies that can be helpful to youth.
Tas, do you a few -- you'd have other pieces to add?
--> Display at 00:56:42:04
>> So Taslim, the question was basically asking, are there any -- do we have any ideas of preventative strategies to use with children that have ACEs score to avoid tobacco use now or down the line?
--> Display at 00:56:59:11
>> Yeah, so I similarly think that the way in which we approach -- addressing trauma and -- in therapeutic settings is a key and important part of this.
However, I think based on the fact that we know, as I said, that one of the strongest correlations between early tobacco initiation and adult use is Adverse Childhood Experiences.
I think as we're engaging young people in therapeutic services, one of the first things that we should be doing is really screening for tobacco use.
And I would say that a pretty wide range of both traditional tobacco product as well as E-cigarettes and vaping, JUULing, and all other tobacco product, and doing really early initiation of screening and counseling.
And then I think in addition to that, really making sure that we're using what we know are really fantastic evidence-based interventions with the young people, whether that's really utilizing experts or other additional models that we know had been adapted to some youth and the young people to best serve their specific needs around tobacco and addiction, as well as other substances.
--> Display at 00:58:23:21
>> Great.
Thank you.
So a couple of you have really helpfully chimed in with some resources that you're aware of and we can share these later as well.
But there -- you know, our tobacco treatment specialist trainees that are around the country, there are about 22 accredited programs currently.
So you can just do a simple internet search for that and get quickly accredited to become just -- a certified treatment specialist.
Additionally, there's a curriculum called Learning About Healthy Living that you can also find online.
So we're just out of time right now.
I want to make sure to be respectful of our panelists' time and all of yours.

So once again, thank you all so much for joining us today.
We'll be sending out a follow up email that comes in automated from Zoom, which will have a link to a brief post-webinar survey.
Everything from today's webinar including handouts, a transcript of our speech, and a recording will all be posted publicly available to all of you on our website at bhthechange.org.
So, no problem accessing any of that.
And if you any questions, feel free to reach out to me.
My name is Dana and my email address was shared in the registration, but it's danal@thenationalcouncil.org.
I'm happy to follow up with individual requests for training and technical assistance to the best of our ability.
Finally, one quick push.
The National Council's annual conference is open for registration.
It's April 5th to 7th 2020 in Austin, Texas.
So visit us online and start registration.
I think early bird rates are still available.
We have a public health track this year with focuses on tobacco as well.
So with that, I will conclude for today.
Thank you again, Taslim and Karen.
And thank you all for joining us.
Have a wonderful rest of your day.