

- Pharmacotherapy is essential: work with client's prescriber to monitor medications and health status.
- Provide specific education to clients (and staff) about nicotine addiction and tobacco cessation medications. For example, some people have concluded that because they know smoking is harmful, it is nicotine that causes cancer.
- For group programs, clients who have been treated for addictions or been part of recovery support programs can be an asset in any group treatment setting. They can help solidify a group and make it more effective for those members who have little experience in therapeutic or support group settings. Clients with serious mental illness may do better in a group together. They may be more likely to find greater acceptance and understanding of their disorders as they attempt to quit smoking. However, programs need to provide enough flexibility so that clients could opt to be in general population groups, if they chose to.
- Supplementing group experiences with individual counseling time for additional support and skill development may improve client satisfaction and reduce anxiety.
- Level and type of training for professionals providing cessation services to this population is important to outcomes. A background in addiction, behavioral health (including group dynamics) in addition to tobacco dependence training can help professionals feel more competent and comfortable when working with these clients.
- The availability of a physician, medical director, or other health care provider embedded in the treatment team is an advantage. Most clients will have co-morbid medical conditions and a medical provider can help provide direct input into the cessation treatment plan.

TOBACCO QUITLINES

INTRODUCTION

Quitlines are mostly state funded, telephone-based services that provide counseling and support by trained professionals for tobacco users who want to quit. Quitlines represent the public health model of tobacco dependence treatment – low-cost effective interventions to a potentially large population of tobacco users. The general approach to quitline services is to first complete an initial screening for all callers to determine client needs and appropriate educational materials that can be mailed. Callers interested in quitting are then connected to a trained counselor. The trained counselor develops a quit plan, and then (depending on the resources of the quitline) may offer medications (e.g. nicotine patches) and provide several, proactive follow-up calls scheduled at specific times. Quitline services vary by state. Each state contracts with a quitline vendor and negotiates the protocol.

Some quitline counselors are professionally trained mental health or substance use specialists, although most are not. Some have had continuing education in this area and others have received training as part of their quitline training. The quitlines who responded to our survey all receive a significant number of calls from clients affected by a range of MI/SUD.

Some quitlines have modified their basic format to accommodate callers with MI/SUD. All quitlines agreed that they better serve clients who have less functional impairment than those with serious MI or callers in treatment for SUD. Three variations in services were identified from our survey: 1) Adding mental health and substance use questions to the initial assessment. Clients are then referred for adjunct treatment in the community if necessary; 2) Developing a proactive/ interactive network with mental health and substance use providers to link clients seen in either setting and sharing information about clients' tobacco dependence treatment; and

3) Staffing the quitline with certified state-credentialed addictions counselors, a full-time counselor with a dual license in mental health and addictions and a medical director for case management. This type of treatment team can focus on a more comprehensive strategy through an integrated constellation of providers and services within the quitline itself.

The following sections summarize the combined advice from these different approaches.

INTAKE ASSESSMENTS

Quitline intake assessments are similar to assessments used in community tobacco treatment programs (see Section 4). Most quitlines have also adopted the Minimum Data Set, a standardized set of assessment questions. The core questions, developed through the North American Quitline Consortium, currently do not have questions on mental health or substance use.⁶⁶

Quitlines, like other treatment programs, vary in how they ask MI/SUD questions. Some use a direct questioning approach and others a more indirect, conversational approach.

DIRECT APPROACH

Quitlines using a direct approach include MI/SUD questions as part of the standard intake process for all clients. Examples are: “Do you have any physical and/or emotional disabilities?” and “Do you have any mental health or emotional issues that might impact quitting?” These broad questions are intended to cover both clients with known histories of mental health or substance use disorders as well as those who might have an undiagnosed disorder.

While these questions do not directly address substance use/abuse, they provide the counselor with a vehicle to follow-up on these issues during the initial counseling sessions. Follow-up questions can include asking about current problems with alcohol, substance abuse, depression or anxiety, current medications (including psychiatric medications), and any care received from a psychiatrist, social worker, counselor or other mental health professional.

In one program, the American Society of Addiction Medicine (ASAM) assessment⁶⁷ is completed during the intake assessment. The counselor assigns a low, medium or high rating to each dimension of the assessment and recommends a level of care in a three-step care model. Level 1 is basic triage by a client service specialist. Level 2 is handled by a counselor and addresses co-occurring conditions including alcohol or substance abuse, depression, and anxiety. The Level 2 counselor provides treatment information on medications, relapse prevention, withdrawal symptoms and managing triggers and cues. Level 2 is usually one time with follow up at 7 and 13 months. Level 3 care is comprehensive, intense and individualized treatment with multiple preparation calls and a schedule of follow-up calls timed to help prevent relapse.

INDIRECT APPROACH

The quitline using an indirect approach did not ask mental health or substance use questions during the intake assessment. Rather, the potential presence of these conditions was indirectly assessed during the counseling phase of treatment. The counselor discussed medications, alcohol use, and asked the client about any history of professional support or recovery programs. Counselors were also trained to listen for cues such as cognitive disorganization, slower processing, or accelerated speech which might indicate the presence of serious MI/SUD. Based on the history information, the self-reported information and observed cues, individual treatment plans were developed on a case-by-case basis. The counselors from this quitline were trained to generally adapt their tobacco treatment protocol to individual quitters, but did not necessarily have a background in mental health or substance abuse treatment.

QUITLINE ISSUES

A concern raised by some quitlines regarding assessing for mental health and substance use disorders was the potential legal and ethical obligation to refer to the primary prescriber to assess the client's condition before continuing to treat for tobacco dependence. Quitlines not in a position to collaborate in treatment with a client's primary prescriber (due to resources or program format) are in a more difficult position than quitlines who can. These quitlines may opt not to assess MI/SUD. A counter concern was that by not assessing MI/SUD before initiating tobacco dependence treatment, clients could become unstable resulting in greater liability. A suggested solution was to recommend that the client check in with their primary prescriber before the next scheduled quitline appointment to continue treatment.

Another concern was that since quitlines are based on a public health delivery model rather than a clinical treatment model, there is a strong need to clearly establish with all clients the scope of services that can be provided. Specifically, quitlines need to establish that the cessation counselor is **not** functioning as a mental health provider, even if their counselors have those credentials. Clients without access to a mental health or a primary care provider, but in need of such services, would need to be referred. For example, the California Smokers Helpline uses a set of crisis line numbers with referral information of all kinds and community mental health access numbers, all organized by county of the caller.

WORKING AS A TEAM

If the client does have a primary care or mental health provider, these quitlines advised encouraging clients to inform their providers about their plans to quit. One program does this proactively, asking for a signed release so counselors can directly contact a client's mental health provider. This approach, whenever possible, is strongly encouraged by our expert advisors.

Some quitlines receive referrals for cessation services through partnerships with mental health counseling centers in the community. In these cases, the mental health assessment is done by the referring program prior to contact with the quitline. Under this system, release of personal health information has been obtained from the client to be shared with the quitline so that the respective providers can communicate about a client's care.

Ongoing training, supervision, and case review with trained professionals is strongly recommended to help increase skills and confidence in handling callers with a broad range of mental illness and substance use disorders.

TREATMENT PLANNING

Quitline treatment plans followed standard protocols with modifications for clients who reported MI/SUD. Again, an important modification was that clients were encouraged to contact their primary care or mental health provider and inform them of their decision to quit smoking before continuing. Adding this extra step was intended to help ensure that the client is being followed for their mental health or substance use disorder, and that their level of functioning is adequate and stable before proceeding.

TREATMENT APPROACHES AND FOLLOW-UP

Treatment approaches for callers with MI/SUD who were stable and without functional impairment were the same as for other callers. The best advice for lower functioning callers was to make the treatment approach supportive and flexible, keeping the content more concrete and

Using 211 to find resources.

2-1-1 is an easy to remember telephone number that, where available, connects people with important community services and volunteer opportunities. The implementation of 2-1-1 is being spearheaded by United Way and comprehensive and specialized information and referral agencies in states and local communities. For more information, visit www.211.org.

focused, as opposed to facilitative and insight-oriented. Increased time for cognitive processing is needed, necessitating assignment of smaller tasks and less reading. Likewise, calls could be split into several, shorter calls rather than fewer, longer calls.

Characteristics of the therapeutic relationship, important for any client, are especially important for clients with MI/SUD. These include trust, message consistency, compassion, being non-judgmental, expressing confidence in the ability to quit, and help increasing support.

Clients were encouraged to use pharmacotherapy and referred to their primary prescriber for prescriptions. The possible need for dose adjustments of any psychiatric medications was also discussed. Some quitlines provide medications, primarily nicotine replacement therapy, and some advise clients to purchase cessation medications on their own.

SUMMARY OF PROFESSIONAL ADVICE

- Assess current participation in MI/SUD treatment and treatment compliance.
- Assess current level of functioning.
- Determine level of functioning for previous quit attempts.
- Encourage contact with current prescriber prior to and during the quitting process.
- Keep the approach brief, focused and concrete, especially for lower functioning clients with MI/SUD. More repetition may be necessary.
- Pay close attention to a client's cognitive processing. Calls may need to be shorter and not move too quickly.
- For lower functioning clients, limit the use of abstract or open-ended questions.
- Limit the use of written materials. Lower functioning clients may have difficulty processing much written information.
- Provide clients with mental health referrals in their local area, if needed.
- Provide ongoing training and supervision for quitline staff.

MENTAL HEALTH TREATMENT PROGRAMS

INTRODUCTION

The culture of mental health treatment facilities and services plays an important part in the success of tobacco dependence treatment for consumers. Because staff members help establish and support the social norms of the facility, when they smoke themselves and/or believe that smoking is an important part of treatment for consumers, tobacco dependence treatment programs can be undermined. Education outreach to staff members is needed to increase awareness about the harms of smoking and benefits of quitting, help reduce barriers to quitting, for promoting quitting among staff, and for ensuring more routine screening and treatment for tobacco use.

INTAKE ASSESSMENT

The initial mental health assessment conducted by a counselor, social worker, nurse, psychologist, or other psychotherapist, should include a standard set of questions to screen for tobacco use. The tobacco screening questions identify and assess a tobacco use status by asking about current use (what product, how much, how often, when), history of use, previous quit attempts, level of dependence (using Fagerström Test for Nicotine Dependence scale⁶⁹) and interest in trying to quit (see Section 4 for examples). Mental health providers need to then act on the assessment information and offer treatment tailored to the consumer's needs. Consumers will need to continue to be screened and their tobacco use monitored throughout their treatment. Since