



New Jersey Guidelines for Tobacco Dependence Treatment

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Table of Contents

New Jersey Guidelines for Tobacco Dependence Treatment

Preface

I. Introduction

A. General understanding of the problem

1. Scope and extent of tobacco consequences
2. Factors that promote the problem
3. Factors that control or lessen the problem

B. Overview of treatment methods

1. Pharmacotherapies
2. Conventional non-pharmacological approaches
3. Unconventional (unproven) approaches
4. Characteristics of effective treatments

C. Types of help to stop smoking in New Jersey

1. Brief Intervention and Referral
 - a. NJ Quitline
 - b. NJ Quitnet
 - c. Health care provider
2. Self-instruction and self-help
 - a. NJ Quitnet Registered Users
 - b. Written materials
 - c. Nicotine Anonymous
3. Intensive
 - a. NJ Quitline Counseling
 - b. NJ Quitcenters: Specialist face-to-face counseling
4. Tertiary treatment
 - a. Outpatient
 - b. Inpatient
5. Rationale for tobacco dependence treatment services in New Jersey

II. Quitcenter Requirements

A. Facility requirements

1. Smoke-free setting
2. Recommended: Tobacco-free, all property
3. Recommended: Tobacco-dependence treatment offered to all employees
4. CO monitor in-house

B. Quitcenter Administration

1. Data-gathering and Evaluation
2. Record-keeping
3. Patient consent

4. Marketing
5. Program development
6. Access to prescription medicines for treatment of tobacco dependence
7. Communication with referring professionals

III. Provider Requirements

A. Qualifications

1. Tobacco-free, 6 months
2. Educational requirements
3. Code of Ethics

B. Addiction Theory and Pharmacology

C. Treatment

1. Assessment and Treatment Planning
 - a. Initial interview
 - b. Intake evaluation
 - c. Readiness to change and motivation to quit
 - d. Diagnosis of Tobacco Dependence and related disorders
 - e. Fagerstrom Test For Nicotine Dependence
 - f. Laboratory Testing
 - g. Motivators for and barriers to quitting
 - h. Psychosocial Factors
 - i. Overall psychiatric/general medicine evaluation
 - j. Smoking history and prior quit attempts
 - k. Patient preferences
 - l. Assessment of need for intensity of care
 - m. Community resources
 - n. Treatment planning considerations
 - o. Reimbursement issues
2. Treatment Methods
 - a. General clinical management
 - b. Initial interventions while doing assessment and creating a treatment plan
 - c. Common elements of effective counseling and behavioral therapies
 - d. Specific psychosocial treatments
 - e. Medicines/use of pharmacotherapies
 - f. Aftercare
 - g. Referral and second opinion
 - h. Record keeping

IV. Cultural Competence

V. Sources

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Preface

These guidelines have been compiled to provide a standard for the face-to-face tobacco dependence treatment services that the Department of Health and Senior Services will support in various clinical settings in New Jersey as part of its Comprehensive Tobacco Control Program (NJ CTCP). We also hope that this document will be useful beyond this specific purpose, to help define appropriate care for tobacco dependent persons in all settings. To this end, we encourage each reader of these guidelines to consider himself or herself a reviewer and to let us know if this document meets your needs and if not, how it falls short. We expect to revise these guidelines from time to time and we have worked with a panel of distinguished national experts to help us review this document and will continue to do so in any subsequent revisions.

These guidelines are grounded in the scientific evidence of treatment effectiveness that has recently been reviewed by the US Public Health Service in its clinical practice guideline, *Treating Tobacco Use and Dependence* (PHS Guideline).¹ The scientific knowledge of how to best treat tobacco use and dependence is now substantial and members of the public should expect that treatments they are offered and that are recommended in this Guideline are evidence-based. Accordingly, the approaches to treatment emphasized here have each been proven to increase the likelihood of success in ceasing tobacco use. Not every clinical situation has been (or can be) subjected to a clinical trial, but the variations on proven approaches that are reflected here are solidly grounded in both existing research and the theories upon which that research is based.

In these guidelines, we call the person who conducts the intensive treatment a clinician or, more specifically, a “tobacco dependence treatment specialist,” or TDTS. This term is similar to that used by the pioneering training program in Massachusetts and is used instead of the term “counselor.” “Counselor” has several levels of use, being both a description of a role and a job title. Since we expect people who serve in this role to come from a variety of professions, we thought it best to use a term that does not connote a specific job title. This choice is supported by the PHS Guideline, which states,

In many cases, intensive tobacco dependence interventions are provided by clinicians who specialize in the treatment of tobacco dependence. Such specialists are not defined by their professional affiliation or by the field in which they trained. Rather, specialists view tobacco dependence treatment as a primary professional role.

Hence, our choice of “tobacco dependence treatment specialist.”

We welcome comments and suggestions. This is intended to be a living document, one that fosters high quality care for tobacco use and dependence in the service of reducing the toll of illness and death that tobacco products cause.

I. Introduction

A. General understanding of the problem

1. Scope and extent of tobacco consequences

It is widely accepted that tobacco use is the primary avoidable cause of illness and death in our society, responsible for more than 430,000 deaths in the United States each year.² The cigarette is the most deadly (as well as the most addictive) tobacco product. Half of all individuals who continue to smoke will die prematurely as a result of an illness that has been caused by the cigarette; that is, the mortality rate from cigarettes is 50%. At the same time, although half of all continuing smokers will not die prematurely, they might still have non-fatal illnesses caused or made worse by smoking, including pneumonia, heart attacks, and emphysema. Cigars cause the same range of major illnesses that cigarettes cause, and the risk of those, apart from mouth and throat diseases, is a function of inhalation. In addition, snuff and chew tobacco products cause mouth and throat diseases including cancer.

The major categories of illness resulting from continued smoking are cancer, cardiovascular disease (including heart disease, stroke and peripheral vascular disease), and chronic obstructive pulmonary disease (COPD), sometimes referred to as bronchitis and emphysema.

Lung cancer was a rare disease in this country a hundred years ago. The cigarette epidemic changed that. Lung cancer rates rose in step with the rise in cigarette use with about a 20-year lag time. Lung cancer is now the most common cause of death from cancer in both men and women, and smoking is responsible for about 90% of all the cases.

Tobacco products also cause numerous other cancers. These include cancers of the mouth, throat, larynx, esophagus, pancreas, bladder, some forms of leukemia (related, it would seem, to benzene exposure), and cancer of the uterine cervix.

The cigarette contributes to atherosclerosis and therefore to all the major atherosclerotic diseases. Cigarettes are a cause of stroke, heart attack, and peripheral vascular disease. Although cigarettes are responsible for a third of cancer deaths, cigarettes kill more people from cardiovascular disease than from cancer.

Smoking causes about 90% of chronic obstructive lung disease (COPD). In COPD, the airways become progressively less efficient, breathlessness becomes common, and endurance falls. A number of problems, ranging from heart failure to a need for supplemental oxygen to frequent respiratory infections and death, can result from this disease.

There are thousands of studies in the scientific literature that document the causal

relationship between many serious diseases and tobacco. The evidence for causal links between these diseases and tobacco use has been painstakingly reviewed in reports of the Surgeon General since 1964.^{3,4}

Numerous other problems arise from tobacco use besides cancer, cardiovascular disease and COPD. While the following discussion is not exhaustive, it illustrates the breadth of problems caused by tobacco.

Reproductive ill effects: Among women, smoking leads to reduced fertility and an early menopause. For the fetus and infant, smoking contributes to spontaneous abortion, low birthweight (and intensive care admissions), and perinatal death including SIDS. Among men, smoking causes impotence and reduced fertility.

Surgical, ophthalmologic and orthopedic effects: Cigarette smoking is associated with poor wound healing and delayed recovery from surgery. Smoking increases the risk of anesthesia complications. Smoking also contributes to macular degeneration (a leading cause of blindness) and to cataract formation. Smoking is associated with an increased severity and occurrence of low back pain problems and with an increased risk of injury.

Other problems: Smoking contributes to osteoporosis in women (perhaps as a result of the endocrine changes that lead to an early menopause) and to peptic ulcer disease in both sexes.

There are numerous situations in which smoking makes other conditions worse. For example:

Diabetics who smoke have twice the risk of serious vascular disease complications from diabetes compared to diabetics who do not smoke.

Smokers with HIV infection are more likely to develop pneumonia than those who do not smoke, probably because smoking damages many of the non-specific defenses that protect against lower respiratory infections and HIV infection reduces the body's ability to limit the damage caused by cigarette smoke-induced inflammation in the lung.

Smoking worsens asthma, resulting in more frequent and more severe attacks.

Persons with sickle cell disease who smoke have further compromise of oxygen-carrying capacity on top of the reduction imposed by their anemia because of the carbon monoxide in cigarette smoke.

In some cases, smoking in combination with another problem increases the risks posed by both in a multiplicative fashion. For example,

Cancers of the throat are caused by both tobacco and by alcoholic beverages. Persons who use both are at far greater risk than those who only use one or the other.

Most of the lung cancer associated with radon exposure is actually caused by a combination of radon plus cigarette smoke exposure. Radon does not contribute much to lung cancer except among people who smoke.

Tobacco smoke is so dangerous to health that it even causes many of these same illnesses in non-smokers who are exposed to and breathe air that has been contaminated by other people's tobacco smoke (Environmental Tobacco Smoke or ETS). ETS is a human lung carcinogen that accounts for 3000 lung cancer deaths among adult non-smokers in the US annually and contributes to many more deaths from heart disease and asthma, as well as to sudden death in infants. In addition, ETS causes ear, nose and throat infections in children.

Despite all these problems, approximately 25 % of adult Americans smoke,^{3, 5} and smoking prevalence among adolescents has risen dramatically since 1990, with more than 3,000 additional children and adolescents becoming regular users of tobacco each day.³

In New Jersey around one in five adults smoke cigarettes (1.15 million)^{5,6,7} and 39% of high school students have used tobacco in the previous 30 days. 70% of smokers want to quit and in New Jersey the average adult smoker made two attempts to quit in the previous year⁶. Tobacco dependence is the major cause of premature death and disease in New Jersey.

2. Factors that promote the problem

There is now a consensus amongst the medical and scientific communities that tobacco is addicting, that nicotine is the drug causing addiction to tobacco and that the mechanisms causing tobacco addiction are similar to those causing addiction to heroin and cocaine.⁸ Current diagnostic systems typically use the term "tobacco dependence" rather than "addiction", with its main characteristic being difficulty in controlling or ceasing tobacco use despite awareness of its harmful consequences⁹. In addition, many tobacco users suffer from nicotine withdrawal syndrome when they try to abstain from tobacco. Nicotine withdrawal syndrome is characterized by a disturbance of mood, sleep and mental concentration typically lasting up to four weeks, in addition to increased appetite and a craving for tobacco⁹. Difficulties coping with nicotine withdrawal symptoms are a major barrier to quitting tobacco.

Everyone who grows up in our culture is exposed to tobacco products. Each person sees a variety of tobacco products being used, advertised, and offered for sale. Approximately 70% of kids growing up in the US experiment with cigarettes at least once. This usually happens during late childhood and early adolescence. Some of the time, the experience is aversive, never to be repeated. About half the time, though, experimentation develops into regular use. Symptoms of dependence can develop within weeks to months, even before there is daily smoking. As smoking becomes more regular, it becomes more and more a part of what a person does. In fact, most individuals who start to smoke regularly are

unable to stop, and continue to smoke for decades. In the US, of those who become regular smokers, over 80% started before the age of 18 and 50% by 16, despite the fact that it is illegal to sell tobacco to people under 18.

In addition to the pharmacological effects of nicotine, there are numerous social and cultural factors that influence the chances of a person using tobacco. While sometimes referred to loosely as “causes”, these are actually risk factors or predisposing factors, that affect the likelihood of use.

Such things as product design, price, availability, marketing, use by family or friends, and personal vulnerability factors (e.g., genetics, socioeconomic status, school performance, or the presence of a predisposing condition such as Attention Deficit Hyperactivity Disorder, depression, or schizophrenia) affect the likelihood that an individual will become dependent on tobacco. Some of these (e.g., price, marketing) can be affected by public policies. Others are important to be aware of and to deal with in the course of treatment (e.g., depression).

3. Factors which control or lessen the problem

Education has been a mainstay of reducing tobacco use since 1950. Compelling evidence of health problems caused by tobacco use is the key motivator for quitting. Without information about the harm tobacco causes, it is difficult to justify other measures such as those that follow.

Environmental tobacco smoke (ETS) control is in many ways the natural complement to education about the harms of high dose tobacco exposure through smoking. Low dose exposure, in the form of environmental tobacco smoke, is also deadly, and control of ETS reduces harm to nonsmokers while providing support for smoking less and for quitting altogether. Increasing awareness that ETS exposure causes serious illness has resulted in increasing regulation to ban smoking in public places. The only way to protect non-smokers from ETS-caused illness is to implement smoke-free regulations ensuring that no one smokes in places open to the public. Workplace smoking bans have been particularly effective in reducing exposure to ETS and have also motivated many people to try to stop smoking.

Taxation is another fundamental strategy. It is clear that price affects both adults and children, but the effects are different. For adults, price increases reduce use and lead to some quitting. For children, price increases discourage new use. Price increases have a larger effect on tobacco use by children than they have on adults.

Counter-marketing has been successful in Massachusetts, California and Florida in reducing tobacco use among adults and adolescents and in providing a context for local tobacco control efforts.

Controls on marketing have been difficult to develop for the United States for a variety of reasons, including the political power of the tobacco industry and the protections afforded commercial speech under the First Amendment to the US

Constitution. Countries that have achieved a complete ad ban have seen beneficial effects on tobacco sales.

Litigation is a potentially potent weapon for tobacco control. The recent widespread availability of internal company documents as a result of the Minnesota Attorney General lawsuit against the industry, and the successful use of these in a number of lawsuits, has infused new life into this strategy.

Disclosure of consumer product information about cigarettes, cigars, and moist snuff has in the past been mainly a tool for tobacco companies to exploit to falsely reassure customers about the supposed benefits of filtered and low tar smokes. Currently, the state of Massachusetts and the province of British Columbia are forcing more extensive disclosures, efforts that may actually help consumers better understand these deadly products. Traditional tar and nicotine testing is misleading and has been used to advance the fraud of light cigarettes. The Federal Trade Commission, the original sponsor of the testing method, has, in effect, disowned it and is looking for a substitute approach.

Product labeling and messages are common consumer protection tools for a myriad of products. In the case of tobacco products, the manufacturers have managed to avoid labeling requirements that have done them any real harm in the marketplace. The history of warning labels in the United States is a sad one. Weak warnings imposed by Congress that shield the industry from legal liability have been the rule.

Tobacco product regulation by the Food and Drug Administration is a step the industry has feared for decades. The companies concealed their knowledge of the addictive nature of nicotine in part to avoid FDA jurisdiction. Presently, the issue of whether the FDA will have jurisdiction over tobacco products has become a US Congressional issue. Tobacco products can be made less addictive and less toxic than they presently are through regulation, but the manufacturers have resisted proper regulatory oversight when a consequence might be reduced product sales. The labeling and advertising of tobacco products can also be subject to much more stringent regulations than are currently in place. It may also be possible to make markedly less dangerous nicotine delivery products more widely available.

Limits on the availability of tobacco products have been a feature of public policy for a number of years now. These approaches have taken the form of reducing tobacco product sales to minors. Some of these approaches, such as eliminating self-service displays and forbidding sales in pharmacies (as is the case in Ontario), and college campuses also benefit adults.

Treatment of tobacco use and dependence is an essential component of a comprehensive tobacco control program. Treatment complements the indirect approaches described above, by providing direct support for people who cannot stop without assistance or who would not be able to stop as easily on their own. Treatment is a humane response to the unwanted entrapment in tobacco

dependence that millions of people experience. In the past fifteen years, treatment has become more reliable and more effective. Treatment saves lives, reduces exposure of nonsmokers to ETS, and reduces the exposure of others to the modeling of tobacco use. This is important both for children who are at risk of becoming regular users and for those who have stopped or who are trying to stop. Being in the presence of someone using tobacco is a common trigger for relapse. Conversely, someone who finds him or herself to be the last smoker in his or her group of friends may be more motivated to try to quit.

B. Overview of treatment methods

In the years since the release of the landmark 1964 Report of the Surgeon General on Smoking and Health, several approaches to treating tobacco dependence have been developed. They have included, in the early years, education about the health hazards of smoking, taking pledges to quit, increased physical activity and a buddy system to stay stopped. In the 1960's, programs emphasized behavior modification strategies and conditioning techniques, while in the 1970's programs began to include cognitive as well as behavioral treatment components. In the 1980's, emphasis was placed on developing effective relapse prevention strategies and using pharmacological adjuncts. There was also a recognition that quitting was a process that frequently involves multiple quit attempts.

In June, 2000, the Public Health Service of the U.S. Department of Health and Human Services published the Clinical Practice Guideline *Treating Tobacco Use and Dependence* (PHS Guideline).¹ This Public Health Service (PHS) guideline describes tobacco dependence as a chronic disease. This model recognizes the long-term nature of the disorder with an expectation that patients may have periods of relapse and remission requiring ongoing, rather than just acute care. This Guideline also reviews the evidence on treatment effectiveness and concludes that there is a dose-response effect of treatment, such that brief interventions work but more intensive interventions are even more effective. A summary of the main conclusions with regard to the effectiveness of different treatments is provided below.

1. Pharmacotherapies

In recent years, research has shown that nicotine replacement products and bupropion are effective in treating tobacco dependence. While they are especially useful for patients who are highly addicted, for heavy smokers, and for those who have exhibited severe withdrawal symptoms with previous quit attempts, they also boost the chances of success for people who are less severely dependent on tobacco.

Overall, appropriate use of an FDA-approved medication for tobacco use and dependence approximately doubles the chances of success for a given quit attempt. The PHS Guideline recommends five first-line pharmacotherapies for individuals making a quit attempt: nicotine gum, nicotine patch, nicotine inhaler, nicotine nasal spray and bupropion. The Guideline recommends that individuals making a quit

attempt use one of these five agents except in special circumstances (e.g. medical contraindications, pregnancy or breast-feeding).

2. Conventional non-pharmacological approaches

Several established non-pharmacological methods of treating tobacco dependence have been found to be helpful. They include brief interventions by a primary care provider to motivate and support quitting, individual and group counseling and proactive telephone counseling. Treatments that maximize the social support for abstinence appear to be particularly effective. These approaches will be described in more detail in the next section of these guidelines.

3. Unconventional (unproven) approaches

Unconventional approaches for the treatment of tobacco dependence have been available for a number of years and include hypnosis, acupuncture, homeopathic remedies and nutritional supplements. None of these approaches have been shown to be effective.

Hypnosis has been promoted as an aid to increase motivation or commitment to stop smoking, and generally includes posthypnotic suggestions that stress the negative aspects of smoking and positive affirmations for living without smoking. Hypnosis by itself has not been demonstrated to be an effective treatment for tobacco dependence.

Acupuncture involves the use of needles or staple-like attachments most often administered to the ear. Most reports of acupuncture have not employed controlled evaluations and many have failed to include long-term follow-up or biochemical validation of self-reported quitters. Currently there is no scientific evidence for the efficacy of acupuncture either in relieving withdrawal symptoms or in helping individuals stop smoking. Claims of homeopathic remedies and nutritional supplements are generally related to supposed relief of withdrawal symptoms. They have not been subjected to an FDA approval process and have not been scientifically proven to work.

Unconventional methods lack the research base to support their use and are not regarded by the scientific community as effective treatments for tobacco use and dependence.

4. Characteristics of effective treatment

Around 70% of US smokers report that they would like to stop smoking and around 40% try to stop each year. Of those who make a serious quit attempt, less than 10% will remain abstinent a year later, but around half succeed over a lifetime of repeated attempts. Despite the fact that many eventually quit, many more would quit if this were easy to do or if effective treatments were readily available

The PHS Guideline defined an intervention as effective if it has been shown to increase the proportion of tobacco users who successfully quit for at least 6 months,

when compared to no intervention, placebo intervention or an alternative intervention, in randomized controlled trials.

Brief interventions (typically lasting three minutes or less), involving physicians and allied health professionals, motivate more tobacco users to make a serious quit attempt and achieve higher long-term quit rates than no intervention. More intensive treatment programs involving person-to-person contact are consistently effective and a clear dose-response relationship has been documented between intensity of treatment and the quit rate. Practical counseling involving provision of extra social support for quitting has been shown to be effective, as have a number of medications. The most effective intensive treatments are typically multi-component treatments that include behavioral interventions, social support, medication and relapse prevention techniques.

C. Types of Help To Stop Smoking Available In New Jersey

The New Jersey Department of Health and Senior Services (NJDHSS) is funding a toll-free telephone quitline (1-866-NJSTOPS), and an internet web site (www.nj.quitnet.com), each of which can offer either simple advice and referral, or more detailed and interactive ongoing support. In addition, NJDHSS is funding a network of clinics (“Quitcenters”) to provide intensive, specialist face-to-face treatment.⁷ The Department encourages other treatment options, including brief interventions in all health care settings, self-help groups, and stop-smoking interventions offered by voluntary health agencies and private organizations. All identified organized resources in New Jersey offering treatment services consistent with these guidelines that DHSS becomes aware of will be included in the resource directories used by Quitline, the Quitnet and the Quitcenters to provide information and referral. Such treatment services will need to make themselves known to the NJDHSS in order to be listed in the resource directory.

The descriptions of each form of service in this section are organized roughly along a general dimension of intensity of care, combining both those that are supported directly by DHSS and those that will be included in the resource directory.

1. Brief intervention and referral

- a. NJ Quitline is a toll free phone service (1-866-NJSTOPS) that can be the first point of contact for an individual who is thinking about quitting (as well as a source of information for people who are not yet ready to quit), and can provide basic information and/or referral to a more intensive treatment modality when appropriate. Those requiring more intensive counseling on the telephone can also obtain this on the Quitline (see next section). This resource was launched in New Jersey in the fall of 2000.
- b. NJ Quitnet is a website (www.nj.quitnet.com) that offers basic information and quitting tips to everyone who logs on. Those who want to use this modality more intensively can access additional interactive features by registering online (see next section).

c. Health care providers: Studies have shown that most smokers quit for health reasons and say that advice from their physicians would be compelling. In addition, all health professionals are in a position to provide brief advice for stopping smoking to their patients. The PHS Guideline found that brief advice offered by physicians increased quit rates compared with the absence of such advice. The primary care provider has a critical role in promoting quitting, and this role is emphasized in the current PHS Guideline. A hallmark of this guideline is that tobacco use should be treated as a vital sign and every patient who uses tobacco should be identified and should receive an intervention, however brief, at each visit.

2. Self instruction and self help

a. NJ.Quitnet.com Registered users: In addition to providing basic information and referral, the website can be a personalized, interactive planning tool for quitting tobacco use. People who register on the site have access to these features which include “chat-rooms” and “ask-the-expert” interactive features designed to increase support for quitting smoking. Individuals with computer literacy may find this tool to be engaging and helpful.

b. Written self-help materials: Pamphlets, books, and other self-instruction materials may help some individuals to structure their quit attempt. Resources are available through organizations such as the National Cancer Institute, the American Cancer Society, the American Lung Association, and national, state and local health departments, or can be found in bookstores and libraries or through catalogues from educational services.

c. Nicotine Anonymous (NicA): NicA continues to be available to smokers looking for a 12-step support group to aid in quitting their tobacco use. The program of Nic-A may be helpful for persons who have resolved other problems using a 12-step approach. Nicotine Anonymous can be reached at Nicotine Anonymous World Service Office, P.O. Box 126338, Harrisburg, PA, 17112, Phone: (415) 750-0328. Their website is <http://www.nicotine-anonymous.org>; e-mail: info@nicotine-anonymous.org.

It should be noted that none of the self help methods mentioned in this section have strong evidence supportive of their effectiveness in helping people to stop smoking. In part this is because some of these methods have yet to be properly evaluated (e.g. websites and Nic-A.) and in the case of written self-help materials they appear to add only marginally to the chances of success. Thus, although these methods have advantages in terms of ease of accessibility and low cost, their efficacy remains to be proven. Tobacco users should be encouraged to use methods with proven efficacy.

3. More Intensive Support

Intensive tobacco dependence treatment can be provided by trained clinicians who have the resources available to provide these services. There is substantial evidence that intensive interventions are appropriate for any

tobacco user willing to participate in them, and that more intensive interventions produce higher success rates.

- a. NJ Quitline: While the New Jersey Quitline (1-866-NJSTOPS) can be a source of information and referral, it also has the added advantage of one-on-one interaction with skilled personnel, and can provide an ongoing contact for individualized counseling. Telephone counseling has advantages in terms of ease of access and relatively low cost. Where there is a need for an assessment of co-morbidity, for prescription medicine, or where the caller wants face-to-face support, they can be referred to the most convenient Quitcenter offering face-to-face counseling.
- b. NJ Quitcenters: These centers offer face to face counseling. This includes both individual counseling, which has the advantage of allowing the therapist to tailor the content of the counseling session to the patient's specific needs, and group counseling, which has the advantage of identification among group members, and the ongoing support that group members can offer one another. In New Jersey, specialist face-to-face counseling is being provided by trained tobacco dependence specialists at a network of treatment centers known as Quitcenters. The Tobacco Dependence Treatment Specialists (TDTs) working at the New Jersey Quitcenters have all completed training in both tobacco dependence counseling and pharmacological treatment of tobacco dependence, provided by the Tobacco Dependence Program at UMDNJ-School of Public Health. As of September 2001, 15 such Quitcenters have been set up.

4. Tertiary treatment

- a. Outpatient treatment: In some cases, individuals with special needs will require specialized treatment for their tobacco dependence. These may include persons with acute or complex medical problems caused by tobacco, or a co-occurring condition that interferes with recovery (such as mental illness or another addiction) for which additional expertise may be required. In New Jersey, individuals whose tobacco problems are resistant to other interventions will be referred to practitioners who have been trained in these specialized areas as well as in the management of tobacco dependence. The Tobacco Dependence Program at UMDNJ-School of Public Health has a multidisciplinary team that will accept such referrals or provide consultation to other NJ providers.
- b. Inpatient treatment: While most individual counseling takes place in outpatient settings, a few inpatient programs have been established strictly for the treatment of nicotine dependence. Residential settings may be appropriate for patients who have been unable to quit on their own or with the help of individual or group counseling, or patients who are unable to stop smoking despite the fact that they are suffering from tobacco-caused illnesses. Inpatient programs generally include comprehensive evaluation, group therapy, individual therapy, educational sessions, relapse prevention counseling, and may also include psychodrama, self-help meeting participation (including

Nicotine Anonymous), behavior modification exercises and physical exercise. The advantages of inpatient treatment are that the patient is totally focused on recovery, and the tobacco-free environment supports abstinence. The potential disadvantages relate to the high cost, and the current lack of evidence of greater effectiveness than less expensive forms of treatment. There presently is no specialist tobacco dependence inpatient service offered in New Jersey. Persons in need of this service will be referred to existing programs elsewhere.

5. Rationale For Tobacco Dependence Treatment Services In New Jersey.

The US Public Health Service Guideline has identified both effective treatments and a strong dose-response relationship between intensity of tobacco dependence treatment and likelihood of quitting smoking. Baseline surveys in New Jersey have revealed a high level of motivation to stop using tobacco among existing tobacco users in the state. However, only a few percent of those who try to quit on their own are successful each year. There is, therefore, a need to provide New Jersey's tobacco users with access to effective treatment.

Tobacco dependence treatment services in New Jersey have therefore been designed to provide highly accessible and highly visible sources of evidence-based advice on quitting. In addition to the usual, proven form of brief advice and referral via primary health care professionals, the NJ Quitline and NJ Quitnet provide free, accessible sources of advice and referral.

People can also select to receive a more intensive level of support from these resources, by registering on NJ Quitnet, enrolling in telephone counseling on NJ Quitline, or obtaining medication and a follow-up appointment from their primary care provider.

Those tobacco users who are motivated to obtain specialist face-to-face tobacco dependence treatment from a specialist should be referred to the NJ Quitcenters (or can refer themselves directly). Information and access to self-help materials and other sources of help in the local community will also be made available at each of these levels of assistance.

The Tobacco Dependence Program at UMDNJ-School of Public Health is available as a tertiary referral service as well as to provide ongoing training, consultancy and advice to providers of tobacco dependence treatment in New Jersey.

II. Quitcenter Requirements

The following set of NJ Guidelines for Tobacco Dependence Treatment will outline the requirements for the Quitcenters offering face-to-face treatment, as well as the requirements for individual Tobacco Dependence Treatment Specialists (TDTS) providing services.

A. Facility requirements

1. Smoke-free setting

Following in the footsteps of many health care institutions, the programs involved in treating tobacco dependence are required to be smoke-free. As defined by the *Tobacco Dependence Program*, smoke-free means that smoking is not permitted indoors. The smoke-free building is not only a safe environment for those in the program's care but also serves as a model for work and home environment.

A written smoke-free policy should be posted in the facility and given to employees and patients. The smoke-free policy is conveyed at the initial screening and upon assessment for entry into the program. All personnel are expected to comply with the policy.

2. Recommended: Tobacco-free, all property

The smoke-free setting is by definition an environmental protection for clients and staff. It is recommended that programs go a step further by adopting a *tobacco-free* policy. Tobacco-free is defined as "tobacco use is not permitted in any form indoors or on the grounds..."

A tobacco-free policy designates all the property under control of the program, both buildings and grounds, as a safe environment for dealing with all of the issues related to tobacco dependence. A tobacco-free policy recognizes that it is inconsistent with the main mission of a healthcare or addiction treatment setting to facilitate the ongoing use of tobacco by allowing tobacco use on its premises. By not merely moving the use of tobacco products to outside a door or a waiting area, a tobacco-free policy promotes freedom from tobacco products, validates treatment of tobacco dependence as an addiction, and distinguishes between tobacco products containing nicotine and medications containing nicotine that are used to treat tobacco dependence.

The tobacco-free policy is specified at the time of hiring personnel. It is also detailed verbally and in writing at the time a client is screened and assessed for the program.

3. Recommended: Tobacco-dependence treatment offered to all employees

It is difficult and inconsistent for people who work in a treatment facility that helps others to stop using tobacco, to continue with active tobacco dependency themselves. Since every employee is important to the program, it is essential to offer treatment options to everyone on the treatment team, including support staff, those in charge of grounds and meal delivery, and administrators.

Tobacco dependence treatment programs are encouraged to use the Employee Assistance Program model: offer referral to employees when the use of tobacco

products is affecting job performance. Such is the case when an individual is not complying with the tobacco-free policy by using during work hours or when the use of tobacco by an individual charged to treat tobacco dependent patients interferes with clinical care. Affected staff may also request treatment. Treatment options should be part of the employees' health benefits package and should include both counseling and medications approved by the FDA for tobacco dependence treatment (nicotine replacement and bupropion).

4. CO monitor in-house

A carbon monoxide monitor is a useful tool for a tobacco dependence treatment program. Carbon monoxide testing can be an effective motivational intervention to help people stop smoking and can be easily incorporated into the treatment regimen.¹⁰ CO testing personalizes the risks of continued smoking and the benefits of stopping.

The carbon monoxide monitor is used to show the body's burden of one of the important poisons in tobacco smoke as well as the immediate changes brought about by reducing or stopping smoking. When someone stops smoking, the CO level falls to normal within a couple of days.

The CO monitor also provides a clear way of distinguishing between the smoking of tobacco products and the use of nicotine replacement products since the CO level is normal when such medicines are used.

B. Quitcenter Administration

1. Data-gathering and Evaluation

While many of the facilities offering tobacco dependence treatment may have a means for data gathering, each center is required to gather data for the purpose of evaluating the treatment program overall, and so the data should be gathered in a required, uniform way to facilitate combining and comparison of data across centers.

It is expected that the data collected for evaluation will include basic demographic and patient identifying information and measure the treatment outcomes based on: CO monitoring, self-reported change of use, abstinence, and the use of medications at specified intervals, such as 1 month and 6 months after the quit date.

Further, in an effort to assess the overall impact of the program, each site is expected to keep account of items such as reimbursement, recruiting efforts, sources of referral, and the ability of patients to pay for services in determining the overall impact of the program.

2. Record-keeping

The facilities that provide tobacco dependence treatment under DHSS contract must have a system for record keeping. These records must be legible,

confidential, consistent, up-to-date, and secure. Documentation should include pertinent information for following client care as well as records about the activities of the program. The completeness of these records will be a factor in the evaluation of each program funded by DHSS.

3. Patient consent

Consistent with confidentiality rules for chemical dependency, the facilities are required to obtain a patient's signature consenting to any correspondence between the organization and a referral source and other entities needing information about a patient.

In the initial encounter with the patient, written permission will be obtained for sharing individually identifiable information with the evaluation team and permission will be sought for the evaluation team to contact the patient for follow-up. These permissions will bind the evaluation team to maintain confidentiality and to insure that all reports and external communication, including communication to DHSS, is aggregate and will not identify individual patients.

4. Marketing

The tobacco treatment program has as its goal to help tobacco users in its local community to stop using tobacco. While some services may have already been available, the new program is a fresh approach to treatment and one that is based on the best scientific evidence. The treatment providers should be described as highly professional, expertly trained, and capable of providing a full range of secondary treatment services.

Professionals, including physicians, nurse practitioners, dentists, other hospital and clinic personnel, chiropractors, psychotherapists, chemical dependency, and mental health practitioners in the area should be invited by mail, e-mail, seminar, and/or professional publication to recommend the services offered by the program to their patients.

The program will develop and implement a marketing and advertising campaign using paid and public media, as appropriate to the program modality. The campaign should include print media as well as television, radio, and the Internet. Additional outreach and marketing to the general public will be accomplished locally through the CATs (Coalitions Against Tobacco) that are active in the region served by the program. All Quitcenters should ensure that their current and accurate contact/referral information is provided to DHSS and available on NJ Quitnet (www.nj.quitnet.com) and NJ Quitline.

5. Program development

The tools provided at the time of training professionals for this work are to be used to craft a program for the individual facility. Taking into consideration the population served, as well as any innovations in the area of treating tobacco dependence, it is expected that the elements of the program will become further

enriched and develop over time. Feedback to the writers of these guidelines, especially innovations and changes, should be provided on a regular basis.

The Tobacco Dependence Program at UMDNJ-School of Public Health will arrange regular meetings and seminars for Quitcenter staff and other clinicians providing tobacco dependence treatment in New Jersey. An e-mail list-serve has also been set up to facilitate communication and ongoing program development. Quitcenter staff are expected to participate in these meetings and on the list-serve in order to enhance program development.

For its part, the Tobacco Dependence Program will endeavor to stay abreast of developments in the field and to communicate these developments in a variety of ways (regular meetings, seminars, the list-serve and trainings) with the individual treatment centers.

6. Access to prescription medications for tobacco dependence

Some of the medicines approved for the treatment of tobacco use and dependence (bupropion, nicotine inhaler, nicotine nasal spray) are only available by prescription. It is expected that some patients will require prescribed medications. If the program does not have a medical, dental or nursing professional with prescription privileges on its staff, it is required that there be a convenient referral relationship with one who can write prescriptions.

7. Communication with referring professionals

The program has a responsibility to cooperate with any referring professional. With a release to do so, it is required that the referral source be given a courtesy “thank you” as well as progress up-dates and any other information which is necessary or appropriate for medical or psycho-social care.

III. Provider Requirements

A. Qualifications

1. Tobacco-free, six months

Tobacco Dependence Treatment Specialists (TDTS) must themselves be tobacco-free in order to work conscientiously and free of conflict with patients about tobacco use. This guideline is more restrictive than the usual practice in the management of alcohol problems in which problem-free alcohol use is not seen as a conflict for a counselor being able to conscientiously deal with a patient’s alcohol problem.

The difference in the case of tobacco use and dependence is that addiction is a far more common accompaniment of tobacco product use than it is of alcoholic beverage use. Most who use cigarettes are addicted to nicotine while only about one in ten who drink have alcohol dependence.

The requirement for a TDTS to be tobacco-free for six months is to provide a general measure of the stability of the person's abstinence from tobacco products. The guideline does not proscribe the use of NRT or bupropion by TDTSs. This means that clinicians who are still using NRT or bupropion would be considered eligible to work as TDTSs, so long as they had not used tobacco for at least 6 months.

As described below, if a TDTS relapses to tobacco use, that relapse should be addressed by the employer through an employee assistance program. If they continue to use tobacco, then this would be seen as incompatible with their role as a TDTS.

2. Educational requirements

Tobacco treatment specialists must be knowledgeable about and proficient in basic counseling theory and practice. The training that the Tobacco Dependence Program (UMDNJ-SPH) provides for people who will be delivering intensive treatment for tobacco use and dependence assumes that each trainee already possesses basic counseling knowledge and skills.

For this reason, TDTSs will be required to have a master's degree in a counseling-related field plus at least one year's experience as a counselor, or a bachelor's degree in a counseling-related field plus at least four years' experience practicing in that field.

These minimum requirements have been adopted to assure the highest quality care for persons coming for help to DHSS supported treatment centers. It has been the experience of the training program at the University of Massachusetts for Tobacco Treatment Specialists that persons at the masters level are best able to understand and apply the material taught in a course that is very similar to that which is offered in New Jersey by the Tobacco Dependence Program.

This educational requirement may be modified if third party payors require specific levels of education, experience and/or licensure on the part of providers in order for a program to receive payment from insurers for the provision of these services.

3. Code of Ethics (adapted from the Massachusetts program for Tobacco Treatment Specialists).

TDTSs will strive to maintain the highest level of professional competence and professional and personal conduct and will:

- Respect the privacy, dignity and culture of all individuals and ensure fair and equitable treatment of all individuals.
- Provide people with all relevant and accurate information and resources so they may make their choices freely and intelligently.
- Observe principles of informed consent and confidentiality of individuals.

- Be truthful in dealings with the public, never misrepresenting or exaggerating potential benefits or services.
- Avoid activities which may be a conflict of interest or unethical in nature and disclose activities that may be perceived to represent a conflict.
- Maintain the highest level of competence through continued study and training.
- Accurately represent capabilities, education, training and experience, and act within the boundaries of professional competence, recognizing one's limitations and seeking help or providing appropriate referrals when confronted with issues of mental illness or psychosocial problems that the tobacco treatment specialist may not be trained to manage.

B. Addiction theory and pharmacology

Tobacco products are highly engineered devices that deliver finely controlled doses of nicotine. These products induce dependence with striking consistency. The characteristics of tobacco products and the biology of addiction are essential elements for the TDTS to understand as background for helping people stop using these products.

The addictive hold that tobacco products have over individuals is augmented by numerous environmental factors that make it more difficult to stop. Conversely, there are other environmental factors that make it easier to stop. The TDTS needs to understand how these elements work and how they can be turned to the advantage of efforts at achieving abstinence from tobacco.

Medications to help people stop smoking are an increasingly important part of the treatment of tobacco use and dependence. The theory, pharmacology, and practical aspects of the use of these medicines is another essential part of the background knowledge for the TDTS to ensure that the most current treatment for tobacco use and dependence is provided.

C. Treatment

1. Assessment and treatment planning at a Tobacco Dependence Treatment Center (Quitcenter).
 - a. Initial interview

At present, there are no patient placement criteria for the treatment of tobacco use and dependence. Nearly all persons who present for treatment have tried repeatedly to stop in the past, often with professional help or the support of an FDA-approved medication. Failure to achieve stable abstinence is very common for a large number of reasons, including the power of the addiction, the presence of a large array of environmental cues to use tobacco, the presence of co-occurring conditions which make stopping more difficult, and the high

frequency with which ineffective or ineffectively applied treatment has been available in the community.

In the absence of patient placement criteria, self-selection is an appropriate way to make most initial decisions about treatment modality.

At the initial contact with a self-referred individual, the clinic will briefly describe the services available. Callers who are clear that they require face-to-face treatment or who are referred by a health professional to the clinic will be scheduled for an intake assessment at the clinic. All clients will be told about the NJ Quitline and NJ Quitnet as they participate in the clinic's program since these resources will be valuable supplements to the services of the clinic.

These interim guidelines are offered with the recognition that the more intensive the intervention the more likely it is that a stable abstinence will be achieved (PHS Guidelines, June, 2000).¹

b. Intake evaluation

The clinician must have the basic knowledge of what information is relevant to ask the patient in order to develop a treatment plan that will meet the specific needs of that individual. A brief standardized **Patient Information Questionnaire** must be completed for every new patient. This provides basic demographic and tobacco use history information in a format that can largely be self-completed by patients. Use of a longer and more comprehensive **Clinician Initial Assessment Form** will be taught at the required training conducted by the Tobacco Dependence Program for all New Jersey Tobacco Dependence Treatment Specialists. The clinician must have the skills to review the patient information questionnaire and use this to guide him/her as to which aspects of the patient's history require further attention and more in-depth assessment using the assessment form as a guide.

The clinician should be able to document the evaluation material in the clinical chart and present the material in a manner that demonstrates a sound clinical understanding of the material.

c. Readiness to change and motivation to quit

The clinician must have knowledge of the 5 Stages in the Model of Readiness for Change by Prochaska and DiClemente (Prochaska et al, 1992)¹¹ that describes how people move along a continuum from resisting change to taking action. The clinician must have the skill to evaluate the patient's current stage of readiness and how to modify the treatment plan to provide what is needed to move the client along to the next stage. They must be familiar with clinical interventions designed to enhance motivation.

d. Diagnosis of tobacco dependence and related disorders

The clinician must know the most current diagnostic criteria and possess the skills necessary to establish the diagnoses with clients using the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (presently, DSM-IV) for Nicotine Dependence, Nicotine Withdrawal, and Nicotine-Related Disorder Not Otherwise Specified.⁹

e. Fagerström Test For Nicotine Dependence

The clinician should know and have the skills to use the results of the Fagerström Test of Nicotine Dependence, a series of questions that correlates highly with a person's degree of dependence on nicotine.¹²

f. Laboratory testing

The clinician should have knowledge of the laboratory tests used to evaluate nicotine usage, including tests for nicotine, cotinine, and carbon monoxide (CO). The clinician should be able to use a CO monitoring device and be able to understand how to use the results of the CO testing. The clinician should understand the biohazard issues involved in obtaining CO breath measurements and samples for cotinine testing if the center does onsite sampling of saliva, urine, or blood for cotinine testing onsite or through a laboratory.

g. Motivators for and barriers to quitting

The clinician should have knowledge about the common barriers and motivators to quitting smoking and have the skills to evaluate what are the specific pros and cons to smoking for each patient and how to use this information in increasing motivation and in relapse prevention treatment.

h. Psychosocial factors

The clinician should have knowledge of important psychosocial factors that aid or hinder tobacco dependence treatment, including evaluating social support and smoking status of others in the household. The clinician should have knowledge and skills in family systems and involving other household members in the treatment process.

i. Overall psychiatric / general medicine evaluation

The clinician should have some knowledge of the interrelationship between smoking and psychiatric disorders, as well as the common medical diseases that are caused by tobacco use. The clinician should have the skills to screen for these medical and psychiatric problems and know how to include these in the treatment planning and treatment process. This will include referral to appropriate health care providers for these disorders. The clinician should have an understanding of how abstinence from tobacco will affect the health

of patients. The clinician should also ask as part of the evaluation of every women of childbearing age if she is or plans to become pregnant.

j. Smoking history and prior quit attempts

The clinician should be able to assess the smoker's prior quit attempts, including causes of prior relapses, how long abstinence was sustained, whether treatment had been sought before, whether prior treatment was adequate in terms of advice, dose and duration of medication, or compliance with treatment, and whether the client believes that treatment helped. Expectations about the current treatment should be explored as well.

k. Patient preferences

The clinician should take into account the client preferences for treatment, including interest in pharmacotherapy, group, individual, and self-help approaches. Client preferences should be respected within the limits of evidence-based treatments.

l. Assessment of patient's need for intensity of care

The clinician should have knowledge of the continuum of care for tobacco dependence, including the different intensities and types of treatment modalities (pharmacotherapies, brief interventions, intensive interventions, specific behavioral therapies, self-help approaches, Web based education and treatment options, telephone support, and options for specialized treatment).

m. Community resources

The clinician should have knowledge of existing community resources in their geographic area, including Nicotine Anonymous and educational group programs (American Lung Association, internet web sites, telephone counseling services, etc.) and be able to integrate these resources into the overall treatment plan.

n. Treatment planning considerations

The clinician should be able to integrate the information learned through the evaluation process to create realistic treatment goals and treatment plans, especially considering treatment matching to specific stage of readiness to change, behavioral problems, chemical dependence, pharmacological treatment components and aftercare / relapse prevention approaches.

o. Reimbursement issues:

The clinician should know how to document diagnoses in an effort to assist in the reimbursement process. The clinician should be able to obtain information on specific insurance plans and their willingness to reimburse for treatment of tobacco dependence (DSM-IV: 305.1 Tobacco Dependence, 292.0 Nicotine

Withdrawal, and 292.9 Nicotine Related Disorder Not Otherwise Specified; and the ICD-9 code, 305.1, Tobacco use and dependence).⁹ The clinician should know how to use the procedure codes for each service offered by the clinic and understand the ethics and options in billing insurance for the treatment of tobacco dependence alone or in combination with other medical and psychiatric disorders.

2. Treatment methods

a. General clinical management

The clinician must have knowledge and skills in basic counseling and clinical management. These skills and techniques are critical to the care of all patients with tobacco dependence regardless of what specific treatment techniques are used. Especially important are establishing a therapeutic alliance, and familiarity with the five As (Ask, Advise, Assess, Assist, Arrange Follow-up)¹. Clinicians must have the knowledge and skills to do ongoing monitoring and evaluation of the patient's progress and clinical documentation. The clinician must have the ability to work with other disciplines, knowing when to seek a second opinion and how to provide referrals. The clinician recognizes the importance of making the treatment setting smoke-free and working with other clinicians to increase their awareness of the impact on patients of smoking by staff members.

b. Initial interventions and creating a treatment plan

The clinician should be knowledgeable about tobacco dependence and its treatment and be able to teach the patient this information. The clinician should have the ability to assist the patient in selecting a quit date and discuss the transition from smoker to non-smoker. Important topics include the option of abrupt versus gradual quitting, dealing with weight gain concerns, advising about alcohol and caffeine use, scheduling follow-up visits, and discussing how to manage slips and relapses.

c. Common elements of effective counseling and behavioral therapies

The Clinician should have knowledge and skills in practical counseling problem solving / skills training treatment, intra-treatment supportive interventions, and extra-treatment supportive interventions:

- i. Practical Counseling (Problem Solving / Skills Training) Treatment, including identify events, internal states, or activities that increase the risk of smoking or relapse; identifying and practicing coping or problem solving skills to cope with high-risk situations, and providing basic information about smoking and successful quitting.
- ii. Intra-treatment Supportive Interventions, including encouraging the patient in the quit attempt, communicating caring and concern, and encouraging the client to talk about the quitting process

iii. Extra-treatment Supportive Interventions, including training the client in support solicitation skills, prompting support seeking, and arranging outside support.

d. Specific psychosocial treatments

The clinician should be skilled in doing motivational interviewing (motivational enhancement therapy), cognitive-behavioral therapies (including Relapse Prevention), and group treatments, and should be familiar with self-help approaches (including written materials, internet, and telephone support).

e. Medicines / Use of pharmacotherapies

The clinician must have knowledge of the specific medicines / pharmacotherapies that are available to treat nicotine withdrawal and dependence, including precautions and contraindications, adverse effects, dosage, duration of therapy, combinations and costs. The clinician needs skills in explaining this knowledge to patients, especially reviewing potential side effects and the practical aspects of how to use these medications. The clinician should know how to work with a physician in seeking an evaluation for use of medications, include discussing medication options during treatment planning, and monitoring for ongoing compliance and adverse effects. The clinician should have specific knowledge on the first line agents, including sustained-release bupropion (Zyban) and the Nicotine Replacement Treatments (nicotine gum, inhaler, nasal spray, and patch) as well as the second line agents (clonidine and nortriptyline).

f. Aftercare, follow-up and evaluation

The clinician should know the risks of relapse in the action and maintenance phases of recovery and the community resources that can support abstinence, including aftercare sessions, Nicotine Anonymous, support groups and follow-up appointments to review maintenance concerns and examine overall wellness lifestyle concerns.

In addition to normal clinical contacts, all patients should be contacted one month after their planned Quit Date to review progress for evaluation purposes. A standardized **4-Week Follow-up Questionnaire** should be used for this purpose. Patients who are not still in treatment four weeks after their Quit Date should be contacted by mail or telephone to assess their progress.

Similarly, all patients who were either abstinent or still attempting to quit (by either self-report or continued attendance at the center) at the one month follow-up should be followed up 6-months after their original Quit Date. A standardized **26-week Follow-up Questionnaire** should be used, as at four weeks.

Quitcenters should also seek feedback from their patients on the service provided as part of clinical audit. A questionnaire such as the one entitled,

“Your Views on the Tobacco Dependence Clinic” (provided at Quitcenter staff training) should be given to patients for anonymous completion and returned as part of good practice and audit.

The NJ DHSS will require regular reports from Quitcenters describing the aggregate numbers, characteristics of patients seen and their outcome at the one and 6 month follow-up points. The monthly and quarterly report forms will be described in the UMDNJ training.

g. Referral and second opinion

The clinician should be aware of the limits of his or her knowledge and skills, and actively seek appropriate assistance in the care of patients who present with problems that call for more specialized assessment and treatment or that are otherwise unusually difficult to manage. Examples might include patients with serious psychiatric, substance abuse or medical conditions, or unusual forms of tobacco/nicotine use (e.g. long term dependence on a treatment medication).

h. Record keeping

The clinician must maintain a clinical record that accurately records the assessment, treatment plan, and progress of the patient. The record should be kept in sufficient detail that another clinician can make ready use of it to manage the patient’s treatment.

IV. Cultural Competence

The clinician will be working with a wide variety of patients and should have the attitudes, skills, and knowledge to work with diverse populations including women / men, different ethnic and racial groups, a full range of age groups, alcohol and drug-involved patients, patients with co-occurring tobacco dependence and psychiatric disorders, patients with co-occurring medical illnesses caused by or worsened by tobacco use, pregnant women, and family members.

The clinician should use language and behavior that consistently reflect and perpetuate the dignity of those with co-occurring mental health and substance use disorders. The clinician should understand the full range of (social, emotional, physical, or spiritual) issues facing persons attempting to quit tobacco and their cultural context.

The clinician should appreciate the diversity among individuals dually diagnosed with psychiatric and substance abuse disorders. Dual diagnosis can affect persons in every walk of life, every economic class, geographic area, sex, sexual orientation, age, education, lifestyle, race, and ethnicity. Treatment plans should recognize and address the differences among patients with specific dual diagnosis subtypes. The treatment plan shall address the issue of tobacco dependence. Psychiatric and substance abuse disorders shall be referred to an appropriate venue.

Cultural competence values differences, and is responsive to diversity at all levels of an organization, i.e., policy, governance, administrative, workforce, provider, and

consumer/patient. Cultural competence is developmental, community focused, and family oriented. The importance of culture and diversity includes values, beliefs, and lifestyle behaviors that influence health and health behaviors, workplace policies, professionals and systems competencies.

1. The clinician should have an increased awareness of the attitudes, beliefs, biases, perceptions and stereotypes about cultural differences and how that can impact clinical care.
2. The clinician should be knowledgeable about culture and how to use this information in treating tobacco dependence and related problems.
3. The clinician should be able to ask questions relevant to the influence of familial and cultural values on developing, or maintaining tobacco dependence.
4. The clinic should try to employ clinicians with cultural and linguistic expertise appropriate to their patients. The clinician should be able to work with interpreters as needed and be aware of other culturally sensitive community resources.
5. The clinician should have an understanding and appreciation for the history and culture of the diverse groups they serve.

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Sources

1. Fiore, MC, Bailey, WC, Cohen, SJ, et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: US Department of Health and Human Services. Public Health Service. June 2000
2. CDC. Smoking-attributable mortality and years of life lost- United States, 1984. MMWR 1997; 46:444-51
3. U.S. D.H.H.S. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta, Georgia. Office on Smoking and Health. 2000.
4. U.S. D.H.H.S. The Health Benefits of Smoking Cessation: A Report of the U.S. Surgeon General. Atlanta, Georgia. Office on Smoking and Health. 1990.
5. C.D.C. State-specific prevalence of current cigarette and cigar smoking among adults – United States, 1998, MMWR 1999; 48:1034-9.
6. Evaluation of the New Jersey Comprehensive Tobacco Control Program: Baseline Measures. April, 2001. (<http://www.state.nj.us/health/as/tcpbaseline.pdf>).
7. New Jersey Comprehensive Tobacco Control Program. Annual Report. April, 2001.
8. U.S. D.H.H.S. The Health Consequences of Smoking: Nicotine Addiction. A Report of the U.S. Surgeon General. Atlanta, Georgia. 1988.
9. American Psychiatric Association. Diagnostic and Statistical Mental Disorder (4th Ed.) Washington, D.C. 1994
10. Orleans, C.T., Slade, J., Editors. *Nicotine Addiction – Principles and Management*, Chapters 8, 10 and 11. New York: Oxford University Press. 1993
11. DiClemente, CC., et al. The process of smoking cessation: an analysis of precontemplation, contemplation and preparation states of change. J. Consult Clin Psychol 1991; 59:294-304.
12. Heatherton TF et al. The Fagerstrom test for nicotine dependence: a revision of the Fagerstrom tolerance questionnaire. Br J. Addiction, 1991; 86:1119-27.