

Tobacco Treatment for Persons with Substance Use Disorders

A Toolkit for Substance Abuse Treatment Providers



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Additional copies of the toolkit may be ordered through STEPP at www.steppitems.com.

Why address tobacco use among persons with substance abuse disorders?



They need to quit.

Treating tobacco use saves lives and is a key part of holistic, individualized treatment planning.

They want to quit.

People being treated for other substance use disorders want to stop using tobacco and want help in quitting.¹ In Colorado, over 34 percent of clients at treatment centers surveyed said that they were currently trying to quit or wanted to quit in the next six months.²

They can quit.

People with substance use disorders can successfully quit using tobacco.³

They can quit tobacco, while successfully addressing their use of alcohol and other drugs.

Stopping tobacco use does not appear to negatively affect treatment of alcohol and other drugs,⁴ and may even help clients with their alcohol and other drug use.⁵

Note: Throughout this toolkit, the term “tobacco use” is used to refer to all forms of tobacco use, including spit tobacco, snuff, cigars, and pipes. The toolkit is intended to be generally applicable to users of all types of tobacco.

1] Richter and Arnsten, 2006

2] Colorado Social Research Associates, 2006

3] Hughes et al., 2003; Richter et al., 2002

4] Lemon et al., 2003; McCarthy, Collins and Hser, 2002

5] Prochaska et al., 2004

Alarming statistics

Tobacco kills over 430,000 Americans every year.¹

Just under half of all cigarettes smoked in America are smoked by people with a substance use disorder or a mental illness.²

Nationally, 77 to 93 percent of clients in substance abuse treatment settings use tobacco, a range more than triple the national average.³

While only 17 percent of adult Coloradoans smoke, 80 percent of adult clients receiving treatment for substance abuse use tobacco.⁴

Among clients in substance abuse treatment, 51 percent died of tobacco-related causes, a rate double that of the general population.⁵

Heavy smoking may contribute to increased use of cocaine and heroin.⁶

Use of tobacco may increase the pleasure clients experience when drinking alcohol.⁷

About this toolkit

Who is this toolkit for?

This toolkit is intended for professionals involved in the delivery of substance abuse treatment – counselors, clinical supervisors, managers, administrators and behavioral health organizations.

How do I use this toolkit?

The toolkit contains a variety of information and step-by-step instructions about the following:

- Low burden means of assessing readiness to quit
- Possible treatments
- Referral to Colorado community resources
- Recommended agency policies for tobacco treatment and control

“Tobacco is a big blind spot for many in our field. We are used to working with clients with what sound like more severe problems...but sometimes we forget that tobacco kills more of our clients than all those other ‘serious’ drugs put together.”

– Erik Stone, MS, CACIII, Director of Compliance and Quality Improvement, Signal Behavior Health Network

1] CDC Fact Sheet, 2006

2] Lasser et al., 2000

3] Richter et al., 2001

4] Baumann and Levinson, 2007; Colorado Social Research Associates, 2006

5] Hurt et al., 1996

6] U.S. DHHS NIDA Notes, 2000

7] U.S. DHHS NIAAA Alcohol Alert, 2007

Tobacco Use and Substance Abuse: What Counselors Should Know



Overview

Nicotine is strongly addictive. Approximately one-third of people who use tobacco develop nicotine dependence, while only 23 percent of heroin users, 17 percent of cocaine users, and 15 percent of alcohol users develop dependence on those substances.¹ The 1990 U.S. Surgeon General's report on nicotine addiction² concluded the following:

- All forms of tobacco are addictive. Patterns of tobacco use are regular and compulsive; tolerance and withdrawal syndromes are often associated with tobacco use.
- Nicotine is the addictive chemical in tobacco. Nicotine is psychoactive, provides pleasurable effects, and serves as a reinforcer to motivate tobacco-seeking and tobacco-using behavior.
- Addiction to tobacco appears to follow the same biochemical and behavioral processes as those that determine addiction to other drugs such as heroin and cocaine.

Clients in treatment for substance use disorders use tobacco more than the general population, suffer greatly from their tobacco use, and are in need of treatment to eliminate or reduce their tobacco use.

The Disparities Connection: Clients in treatment for substance use disorders have extraordinarily higher rates of tobacco-related health problems than the general population.

- People with DSM-IV (The Diagnostic and Statistical Manual of Mental Disorders 4th edition) diagnoses of substance use and mental health disorders consume 44 percent of all tobacco sold in America.³

1] Anthony et al., 1994

2] U.S. DHHS, 1990

3] Lasser et al., 2000

- The relative risks of developing cancers of the mouth and throat are 7 times greater for tobacco users, 6 times greater for those who use alcohol, and 38 times greater for those who use both alcohol and tobacco.¹
- Among polydrug users, use of tobacco was associated with higher rates of disability and decreases in general health and vitality.²
- Among clients in treatment for substance use disorders who smoked, 51 percent died of tobacco-related causes – a rate double that of the general population.³
- Nicotine positively affects mood, feelings of pleasure, and enjoyment.
- Tobacco use may temporarily relieve feelings of tension and anxiety, and is often used to cope with stress.
- Tobacco appears to affect the same neural pathway – the mesolimbic dopamine system – as alcohol, opioids, cocaine, and marijuana.⁷
- Smoking hinders the metabolism of some medications, such as highly active antiretroviral therapy for persons with HIV/AIDS, interfering with their effectiveness.⁸

The Substance Abuse Connection: Tobacco use is strongly correlated with development of other substance use disorders and with more severe substance use disorders such as the following:

- Early onset of smoking and heavy smoking are highly correlated with the subsequent development of other substance use and psychiatric disorders.⁴
- Heavy smokers have more severe substance use disorders than do non-smokers and more moderate smokers.⁵
- Tobacco use impedes recovery of brain function among clients whose brains have been damaged by chronic alcohol use.⁶

The Chemical Connection: Nicotine affects the actions of neurotransmitters such as dopamine. Psychological effects and considerations include the following:

- Nicotine enhances concentration, information processing, and learning.

The Social Connection: Smoking is often associated with social activities or with “smoke breaks” while at work or in treatment. Examples include the following:

- People may smoke to feel “part of a group” and may be afraid that quitting tobacco will damage their social relationships.
- In substance abuse treatment settings, “giving” smoke breaks to clients rather than healthy alternatives, such as walks or quiet times, can reinforce the social connection to tobacco.
- Persons who do not participate in many activities may become bored and smoke more to keep themselves busy.
- Workplace smoking restrictions lead to less smoking among employees.⁹
- Smoking bans and restrictions in workplaces lead to reductions in daily consumption of cigarettes and increases in tobacco use cessation among workers.¹⁰

1] U.S. DHHS NIAAA Alcohol Alert, 1998

2] McCarthy, 2002

3] Hurt et al., 1996

4] Degenhardt, Hall, and Lynskey; 2001

5] Marks et al., 1997; Krejci, Steinberg, and Ziedonis; 2003

6] Durazzo et al., 2007; Durazzo et al., 2006

7] Pierce and Kumaresan, 2006

8] Tobacco Cessation Leadership Network, 2008

9] U.S. DHHS, 2006

10] Task Force on Community Preventive Services, 2005

The Treatment Connection: Between 70-80 percent of clients receiving treatment for alcohol and other drug problems want to stop using tobacco.¹ Integrating tobacco treatment into the treatment of alcohol and other drug problems helps clients and improves treatment outcomes, such as the following:

- Clients who receive treatment for tobacco use are more likely to reduce their use of alcohol and other drugs and have better treatment outcomes overall.²
- People with alcohol problems are as successful at quitting tobacco as people without alcohol problems.³ Illicit drug-user rates are lower, but still promising.⁴
- A meta-analysis of 18 studies found that treating the tobacco use of clients improved their alcohol and other drug outcomes by an average of 25 percent.⁵

“We provided closure exercises, referrals, and patches. We planted seeds of knowledge so that when a client was really ready to make a change in their life and quit their addictions, including tobacco, they had the support systems in place to help.”

– Angela Bornemann, Arapahoe House

The Benefits of Tobacco Cessation

Quitting tobacco use produces immediate and long-term benefits. Education about these benefits is a useful motivational tool.

Positive health changes occur almost immediately. When clients stop smoking, the body begins to heal almost immediately.⁶

20 minutes after quitting	Blood pressure and pulse rate return to normal.
8 hours	Nicotine and carbon monoxide levels in blood reduce by half; oxygen levels return to normal.
24 hours	Carbon monoxide is eliminated from the body. Lungs start to clear out mucus and other smoking debris.
48 hours	There is no nicotine left in the body. Ability to taste and smell is greatly improved.
72 hours	Breathing becomes easier. Bronchial tubes begin to relax and energy levels increase.

1] Richter, 2006

2] McCarthy et al., 2003; Shoptaw et al., 2002

3] Hughes, et al., 2003

4] Richter et al.; 2002

5] Prochaska et al, 2006

6] U.S. DHHS, 1990; Action on Smoking and Health, 2007

Long term health and quality of life improve.

Quitting smoking immediately reduces risks for cardiovascular disease and cancer including cancers of the esophagus, larynx, kidney, pancreas, and cervix.¹

2-12 weeks after quitting	Circulation improves.
3-9 months	Coughing, wheezing, and breathing problems improve as lung function increases by up to 10 percent.
1 year	Risk of a heart attack falls to about half that of a smoker.
10 years	Risk of lung cancer falls to half that of a smoker.
15 years	Risk of heart attack falls to the same level as someone who has never smoked.

• Clients who quit have more money to spend elsewhere:

- In 2007, a pack of cigarettes in Colorado cost an average of \$4.13/pack. Clients who smoke a pack of cigarettes a day will *save an average of over \$1500 a year* when they quit.²
- A 40-year-old, pack-a-day smoker who quits and puts the savings into a 401(k) earning 9 percent a year will have \$250,000 by age 70.³
- Smokers pay more for insurance and lose money on car and home resales.⁴

Notes

1] U.S. NIH, 2007
 2] Tobacco Free Kids, 2007
 3] Tobacco Free Kids, 2007
 4] MSN, 2007

Tobacco Treatment with Clients Receiving Treatment for Other Substance Abuse Disorders



Overview

Clients receiving treatment for alcohol and other drug abuse problems are disparately affected by tobacco use. These clients use tobacco at much higher rates than the general population; thousands and thousands of clients die from their tobacco use every year. Yet, counselors and agencies providing substance abuse treatment have traditionally ignored their clients' tobacco use, even though studies consistently show that many clients want to quit and want help in quitting.

A growing body of evidence is now demonstrating that counselors and agencies can successfully help their clients stop using tobacco, which improves client health and saves lives. Furthermore, recent studies indicate that treating tobacco use actually helps clients to address their alcohol and other drug problems. Integrating tobacco treatment into the mainstream of substance abuse treatment is rapidly becoming a nationwide best practice.

Few tobacco treatment programs have been specifically adapted for clients in substance abuse treatments. The most commonly used models for tobacco treatment generally combine cognitive behavioral therapy with cessation medications such as nicotine replacement therapies (NRT). Motivational enhancement approaches also show promise. These clinical approaches are widely used in the substance abuse treatment field, which should allow comparatively easy integration of tobacco treatment into existing clinical protocols.

Treatment content often focuses on

- education about tobacco use and its effects, as many clients have only a superficial knowledge of the negative effects of tobacco and may be unaware of the short and long-term benefits of quitting;
- practical counseling that helps focus on developing coping and problem solving skills such as controlling cravings, recognizing triggers, and reducing stress;
- supportive counseling that addresses client feelings about quitting and enhances motivation for change; and
- changing the client's environment to support recovery from tobacco use.

An excellent resource for additional information on tobacco treatment is the *Bringing Everyone Along Resource Guide*. Published in January 2008 by the Tobacco Cessation Leadership Network, the Guide is intended for all health care professionals working with people with mental illness and substance use disorders. The Guide is available at www.tcln.org/bea/index.html.

General Components of Successful Tobacco Treatment Programs

Counselors and agencies seeking to incorporate tobacco treatment into their daily practice with clients receiving treatment for other substance use disorders should do the following:

Integrate Assessment of Tobacco Use into Standard Practice

- Assessment of tobacco use should be included in the client's initial assessment and should follow the same structure and format used with other addictive substances; assessment of client tobacco use should be regularly updated.
- Assessment should include examination of how tobacco use interacts with the client's use of other addictive substances. This is particularly important when the client is using alcohol.
- Assessment should directly include asking whether tobacco users are willing to make a quit attempt.

- Assessments should be structured to help generate information about the benefits and consequences of the client's tobacco use, as well as information relevant to the client's treatment plan, such as past quit attempts, current stress level, and presence of psychiatric symptoms.
- Assessments should include review of client's exposure to secondhand smoke.

Train Counselors in Delivery of Tobacco Treatment

- Substance abuse counselors have considerable knowledge and skills about how to help clients deal with their use of addictive substances. These are directly applicable to treatment of tobacco. However, counselors should be educated about the addictive properties of nicotine and receive training specifically on tobacco treatment.
- Current evidence suggests that multiple types of clinicians are effective in delivery of tobacco treatment, indicating that tobacco treatment does not need to be limited to any particular type of counselor.¹
- There is some evidence that treatment outcomes improve when multiple types of clinicians are involved.² For example, one counseling strategy is to have a medical/healthcare clinician deliver messages about health risks and benefits as well as deliver pharmacotherapy, while behavioral health clinicians deliver additional interventions such as cognitive behavioral therapy. This approach provides a consistent, inescapable environment that supports cessation.

Provide Clients with Tobacco Cessation Medications

- Prescription and non-prescription medications have been developed for the treatment of tobacco dependence.
- Use of cessation medications in conjunction with behavioral interventions significantly improves quitting rates. (See Guideline provided in this kit.)

1] US DHHS, Public Service, 2008

2] US DHHS, Public Service, 2008

Determine the Best Treatment Format for Your Agency

- Individual and group counseling appear equally effective in treating tobacco use.¹ Counselors and agencies should use the type of counseling that best fits their clients and agency.
- More intensive interventions are, in general, more effective than less intensive interventions. Counselors should try to have a minimum of at least four face-to-face sessions with clients addressing their tobacco use.²
- Quitlines that use proactive telephone counseling appear effective for adult tobacco users, although there is little research on use of quitlines with clients in treatment for substance abuse disorders.
- Self-help interventions, such as giving clients pamphlets, videotapes, referrals to 12-step groups, or lists of community resources by themselves appear to have limited impact on clients. However, tailored materials that address specific issues and concerns related to tobacco cessation are useful additions to behavioral interventions or pharmacotherapy.

Behavioral Interventions

Individual and group counseling have been shown to be effective treatments for tobacco dependence.³ Cognitive behavioral and motivational enhancement therapy strategies have been endorsed by the American Psychiatric Association (2006). Persons with substance abuse problems often are severely addicted to tobacco and have few social supports and coping skills. Therefore, intensive behavioral interventions should be considered for clients in treatment for alcohol or other drug disorders, even if there is no history of failed tobacco quit attempts.

Behavioral Interventions for Tobacco Cessation Typically Include Three Major Components:

- Practical oriented counseling that provides education on nicotine and its effects and focuses on problem solving and skills training relevant to stopping tobacco use
- Supportive counseling to maintain and enhance motivation for quitting
- Improving the client's recovery environment by increasing family and social support for tobacco cessation

These interventions are very similar to the ways in which substance abuse treatment counselors address alcohol and other drugs and can be readily incorporated into existing clinical protocols. However, some programs may choose to use a specialized tobacco curriculum. There are a variety of such curricula available, which tend to use cognitive behavioral approaches. One popular curriculum is "Fresh Start," a 4-session intervention created by the American Cancer Society.

No specialized curriculum for treatment of tobacco use among clients receiving treatment for other substance use disorders has yet been created.

"Tobacco is a deadly addiction – and at IDEA, we treat addictions. That's our philosophy."

– Marcella Paiz, IDEA

1] US DHHS, Public Health Service, 2008

2] US DHHS, Public Health Service, 2008

3] Lancaster & Stead, 2005; Stead & Lancaster, 2005

Below are common elements of practical counseling, supportive counseling, and methods for increasing family and social support.

Common elements of practical counseling

Practical counseling treatment component	Examples
<p><i>Provide basic information:</i> Talk about smoking and successful quitting.</p>	<p>Nicotine is an addictive substance; most people need multiple attempts before successfully quitting. Any tobacco use, even a single puff from a cigarette, increases the likelihood of a full relapse. Withdrawal typically peaks within 1-3 weeks after quitting. Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating.</p>
<p><i>Recognize trigger situations:</i> Identify events, stressors, internal states or activities that increase the risk of smoking or relapse.</p>	<p>Negative mood Psychiatric symptoms Being around other smokers Drinking alcohol or using drugs Experiencing urges and cravings Being under time pressure</p>
<p><i>Develop coping skills:</i> Identify and practice coping or problem solving skills.</p>	<p>Learning to anticipate and avoid temptation Learning cognitive strategies that will reduce negative moods Accomplishing lifestyle changes that reduce stress and improve quality of life or produce pleasure Learning cognitive and behavioral activities to cope with smoking urges (e.g. distracting attention)</p>

Common elements of recovery environment improvement

Recovery environment treatment component	Examples
<p>Train clients in how to get support.</p>	<p>Show videotapes that model skills. Practice requesting social support from family, friends, and coworkers. Aid client in establishing a smoke-free home.</p>
<p>Prompt support seeking.</p>	<p>Help client identify the support of others. Call the client to remind him or her to seek support. Inform clients of community resources such as the Colorado QuitLine and Nicotine Anonymous. For clients attending 12-step meetings, help clients identify smoke-free meetings.</p>
<p>Arrange outside support.</p>	<p>Mail letters to those who can provide support. Call to enlist the support of others. Invite others to cessation sessions. Assign clients to be “buddies” for one another.</p>

Pharmacological Interventions

A variety of medications have been identified as effective in helping people to stop using tobacco. The medications that have been found to be safe and effective for tobacco dependence treatment and that have been approved by the Food and Drug Administration (FDA) are the following:

- Nicotine replacement therapies (NRT), which include gum, lozenges, inhalers, nasal spray, and the patch
- Bupropion SR (Wellbutrin, Zyban), which was the first non-nicotine medication shown to be effective for smoking cessation and was approved by the FDA for that use in 1997
- Varenicline (Chantix), which is a medication that blocks nicotine receptors and was approved by the FDA for the treatment of tobacco dependence in 2006

For more information on the research on these medications, recent literature reviews can be found on nicotine replacement therapy,¹ bupropion SR² and varenicline.³ Please note that there is currently insufficient evidence of effectiveness for these medications with pregnant women, smokeless tobacco users, light smokers, and adolescents. Additionally, the FDA has reported a possible association between Chantix and serious neuropsychiatric symptoms and recommends that clients taking Chantix be closely watched for any changes in mood or behavior.

The Colorado QuitLine offers free patches and telephone-based coaching. The QuitLine can be contacted at 1.800.QUIT.NOW or www.coquitline.org.

Clonidine and nortriptyline have demonstrated some success in treating tobacco dependence. However, they have not been approved by the FDA to treat tobacco dependence, and there are more concerns about potential side effects than exist with the first-line medications. Clonidine and nortriptyline should be prescribed by a physician on a case-by-case basis and only after first-line medications have been used without success or are contraindicated.⁴

The use of medications significantly increases the likelihood that the client will be able to quit using tobacco. NRT and bupropion have been shown to double the chances of sustained tobacco abstinence; varenicline has been shown to triple the chances of sustained tobacco abstinence.⁵

Every tobacco user should be informed about the available medications; use of medications should be recommended and provided unless contraindicated. NRT is particularly important with clients likely to have significant withdrawal symptoms.

The optimal duration of NRT is not known. Some individuals appear to require long-term use of NRT (e.g., ≥ 6 months), but almost all individuals eventually stop using NRT and the development of dependence on NRT is rare. Thus, client preference should be the major factor for the duration of NRT.⁶ Clinicians should closely monitor actions or side effects of any prescription medications in smokers making quit attempts, particularly when utilizing NRT.

1] Silagy et al., 2004

2] Hughes et al., 2007

3] Cahill et al., 2007

4] US DHHS, Public Health Service, 2008

5] Tobacco Dependence Resource Center, 2008

6] APA Practice Guidelines, 2006

Tobacco Cessation and Substance Use Disorders: Conflicting Data to Consider

Not surprisingly, concurrent use of alcohol and/or other drugs is a negative predictor of smoking cessation outcomes during smoking cessation treatment.¹ Long-term quit rates of smokers in early recovery from substance use disorders are low, at approximately 12 percent.² However, persons with a past history of alcoholism do not differ significantly from control subjects in tobacco treatment outcomes.³

The combined effects of co-occurring substance abuse and smoking behaviors appear to significantly influence the high rates of smoking cessation treatment failure.⁴ While there are few studies of pharmacotherapeutic interventions for smoking in substance abusers, some evidence exists suggesting that nicotine replacement and behavioral approaches are effective.⁵ A review of tobacco cessation studies found that quit rates ranged from 7 percent to 60 percent directly after treatment and from 13 percent to 27 percent at 12 months.⁶ These success rates are comparable to those in non-treatment populations. To date, there are no published controlled studies using bupropion SR in smokers with co-occurring substance use disorders, although these studies are in progress.

The best time to introduce tobacco treatment for substance abuse users remains unclear. Some studies found that concurrent treatment for smoking and other drugs is not associated with increased use of alcohol or other drugs.⁷ However, one study found that while patients in alcohol treatment are interested in smoking cessation, participate in treatment, and demonstrate success, they did not

show any benefit from concurrent tobacco cessation treatment.⁸ In fact, Joseph et al. found that drinking outcomes were worse with concurrent tobacco treatment. A recent review concluded that even though the research is not yet conclusive, tobacco treatment should be provided to clients at the same time as their alcohol treatment whenever clients request tobacco treatment.⁹

Assessment and Intervention Planning Readiness to quit and the treatment process

Nicotine is an addictive substance; the changes in the brain associated with tobacco dependence are similar to those associated with other addictive substances such as cocaine and amphetamines.

Tobacco dependence is a chronic, relapsing disorder, and it is helpful to think of tobacco treatment as a process rather than a single event. Most tobacco users need multiple quit attempts before they finally quit for good. Many clients do not realize that it usually takes several attempts to stop using tobacco, and they will need a high level of motivation to try to quit if they have been unsuccessful in the past.

Once a client being treated for other substance use disorders has been identified as a tobacco user, his or her readiness to quit can be determined with the same Stages of Change model that is widely used in the substance abuse treatment field. This is important because tobacco users need interventions appropriate for their readiness to quit. For example, a useful intervention for clients who are not currently thinking of quitting (Precontemplators), is to ask the client to consider the personal consequences of their tobacco use and how they might personally

1] Hughes, 1996

2] Sussman, 2002

3] Hayford, 1999

4] Weinberger, 2006

5] Burling, 1996; Shoptaw, 1996

6] El-Guebaly, 2002

7] Burling, 2001; Kalman, 2004; Kalman, 2001

8] Joseph et al., 2004

9] Kodl et al., 2006

benefit if they quit. Providing personalized information on benefits and consequences can help the client to move into the next stage of change (Contemplators).

With all clients, regardless of their readiness to quit, treatment providers should actively encourage quitting, offer support and treatment, and consistently convey the message that persons with substance use disorders can successfully quit using tobacco. Further, clients who have already stopped using tobacco should be assessed for relapse potential and provided support to remain abstinent.

Stages of change

- Precontemplation: No change is intended in the foreseeable future. The individual is not considering quitting.
- Contemplation: The individual is not prepared to quit at present, but intends to do so in the next six months.
- Preparation: The individual is actively considering quitting in the immediate future or within the next month.
- Action: The individual is making attempts to quit. However, quitting has not been in effect for longer than six months.
- Maintenance: The individual has quit for longer than six months and is continuing to work on staying abstinent from tobacco.

The 5 As:

Ask, Advise, Assess, Assist and Arrange

The U.S. Public Health Service's Guideline on treating tobacco use and dependence¹ provides healthcare clinicians a strategy for tobacco treatment that is built around the "5 As" (Ask, Advise, Assess, Assist and Arrange). Knowing that providers have many competing demands, the 5 As were created as a simple, concise guide.

On the following pages, you will find a summary of these easily implemented steps.

The Guideline recommends that all people entering a healthcare setting should be **asked** about their tobacco use status and that this status should be documented. Providers should **advise** all tobacco users to quit and then **assess** their willingness to make a quit attempt. Persons who are ready to make a quit attempt should be **assisted** in the effort. Follow-up should then be **arranged** to determine the success of quit attempts. In substance abuse treatment settings, it is also important to assess the relapse potential of clients who have already stopped using tobacco and provide support or assistance in staying abstinent from tobacco.

The full 5 As model is most appropriate for agencies and organizations that have tobacco cessation behavioral and/or medications services available for clients. For agencies and organizations that do not have tobacco treatment services readily available, we recommend the use of the first two As (**ask** and **advise**) and then **refer** to available community services.

1] U.S. DHHS: Public Health Service, 2008

Actions and Strategies for Substance Abuse Providers to Help Clients Quit Smoking

ASK	
Action	Strategies for Implementation
<p>Ask every client at every admission, including detox and residential admissions, if they use tobacco.</p>	<p>Within your agency, systematically identify all tobacco users at every admission.</p> <p>Establish a procedure to identify tobacco use status periodically throughout the client's treatment; one option is to ask about tobacco during every treatment plan review.</p> <p>Determine what form of tobacco is used.</p> <p>Determine frequency of use.</p> <p>Determine tobacco use status.</p> <p>Ask clients about exposure to secondhand smoke.</p>
ADVISE	
Action	Strategies for Implementation
<p>In a clear, strong and personalized manner, advise every tobacco user to quit.</p> <p>Be mindful to advise in a non-judgmental manner.</p>	<p>Clear: "As your counselor, I want to provide you with some education about tobacco use and encourage you to consider quitting today."</p> <p>Strong: "As your counselor, I need you to know that quitting smoking is one of the most important things you can do to protect your health now and in the future. The clinic staff and I will help you."</p> <p>Personalized: Tie tobacco use to current health/illness, its social and economic costs, motivation level/readiness to quit, and/or the impact of tobacco use and secondhand smoke on children and others in the household. Using a carbon monoxide (CO) monitor to show clients the increase in CO following smoking is a good way to personalize the effects of smoking.</p>

ASSESS

Action	Strategies for Implementation
<p>Assess willingness to make a quit attempt within the next 30 days.</p> <p>Determine with the client the costs and benefits of smoking for him or her.</p> <p>Determine where the client is in terms of the Stages of Change model.</p>	<p>Assess readiness for change.</p> <p>If the client is ready to quit, proceed to Assist (below) and/or arrange for more intensive services to help with the quitting process.</p> <p>If the client will participate in an intensive treatment, deliver such a treatment or refer to an intensive intervention (Arrange).</p> <p>If the client isn't ready to quit, do not give up. Providers can give effective motivational interventions that keep clients thinking about quitting. Conduct a motivational intervention that helps clients identify quitting as personally relevant and repeat motivational interventions at every visit.</p> <p>For addressing tobacco cessation with tobacco users unwilling to quit, recommend smoking outside and proceed to the 5 Rs on the following pages.</p>
<p>Assess past quit attempts and any issues or concerns about quitting now.</p>	<p>For the client who is willing to quit:</p> <p>Obtain history of tobacco use and assess experience with previous quit attempts, including the following:</p> <ul style="list-style-type: none"> • Changes in functioning when he or she tried to stop • Length of abstinence from tobacco • Causes of relapse, particularly if due to withdrawal symptoms or increased alcohol or other drug use • Prior treatment in terms of type, adequacy (dose, duration), compliance and client's perception of effectiveness • Expectations about future attempts and treatments • Recovery support system <p>Determine if there are any concerns about whether this is the best time to stop using tobacco:</p> <ul style="list-style-type: none"> • Is the client presently in crisis, or is there a problem that is so pressing that tobacco treatment should be delayed? • What is the likelihood that cessation would worsen the client's other substance use problems? And, can that possibility be diminished with frequent monitoring, use of nicotine replacement therapy or other therapies? • What is the client's ability to mobilize coping skills to deal with cessation? Would the client benefit from individual or group therapy? • Is the client highly nicotine dependent or does the client have a history of relapse due to withdrawal symptoms? If so, which medication might be of help? • Is the client taking medications? Will they be affected by stopping tobacco use? <p>Increasing readiness/motivation: If a client with substance use disorders is not ready to make a quit attempt, enhance motivation and deal with anticipated barriers to cessation:</p> <ul style="list-style-type: none"> • Use problem solving strategies. • Increase monitoring of tobacco use. • Employ behavioral therapy and/or nicotine replacement therapy. • Address fears of withdrawal symptoms or increased alcohol or other drug use.

ASSIST	
Action	Strategies for Implementation
Help the client with a quit plan.	<p>Set a quit date, ideally within two weeks.</p> <p>Tell family, friends and coworkers about quitting and request understanding and support.</p> <p>Anticipate triggers or challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. Discuss how the client will successfully overcome these triggers or challenges.</p> <p>Remove tobacco products from the environment. Make home and auto smoke-free. Prior to quitting, client should avoid smoking in places where they spend a lot of time (e.g. work, home, car).</p> <p>For clients with cognitive difficulties (e.g. memory or attention deficits), have them write down their quit plan, so they can refer to it later.</p>
Recommend use of approved nicotine replacement therapy (NRT) and/or counseling.	<p>Recommend the use of NRT medications to increase cessation success.</p> <p>Discuss options for addressing behavioral changes, such as addressing tobacco on their treatment plans, providing individual or group counseling or referring to the QuitLine.</p> <p>Encourage clients who are ready to quit that their decision is a positive step.</p>

ARRANGE	
Action	Strategies for Implementation
Schedule follow-up contact.	<p>Timing. Follow-up contact should occur soon after the quit date, preferably within the first week. A second follow-up contact is recommended within the first month. Schedule further follow-up contacts as needed.</p> <p>Actions during follow-up contact:</p> <p>Congratulate success!</p> <p>If the client has relapsed, review the circumstances and get a new commitment to total abstinence.</p> <ul style="list-style-type: none"> • Remind client that a lapse can be used as a learning experience. • Identify problems already encountered and anticipate challenges in the immediate future. • Assess NRT use and any associated problems, if any. • Consider increasing the intensity of treatment. • Give positive feedback about the client's attempts to quit. Individuals often cut down substantially on their tobacco use before quitting, and this reduction needs to be recognized and congratulated. <p>If the client has been abstinent from tobacco, help maintain abstinence by developing an integrated relapse prevention plan that addresses tobacco, alcohol, and other drugs. The plan should recognize the stresses associated with early recovery.</p> <p>Monitor psychiatric status, particularly for symptoms of depression; monitor medication as quitting may produce rapid, significant increases in medication blood levels.</p>

For agencies that do not have the capacity to implement the 5 As – Ask, Advise, and Refer.

ASK

Action	Strategies for Implementation
<p>Ask every client at every admission, including detox and residential admissions, if they use tobacco.</p>	<p>Within your agency, systematically identify all tobacco users at every admission.</p> <p>Establish a procedure to identify tobacco use status periodically throughout the client's treatment. One option is to ask about tobacco during every treatment plan review.</p> <p>Determine what form of tobacco is used.</p> <p>Determine frequency of use.</p> <p>Determine tobacco use status.</p> <p>Make note of clients' exposure to secondhand smoke.</p>

ADVISE

Action	Strategies for Implementation
<p>In a clear, strong and personalized manner, advise every tobacco user to quit.</p> <p>Be mindful to advise in a non-judgmental manner.</p>	<p>Clear: "As your counselor, I want to provide you with some education about tobacco use and encourage you to consider quitting today."</p> <p>Strong: "As your counselor, I need you to know that quitting smoking is one of the most important things you can do to protect your health now and in the future. The clinic staff and I will help you."</p> <p>Personalized: Tie tobacco use to current health/illness, its social and economic costs, motivation level/readiness to quit, and/or the impact of tobacco use and secondhand smoke on children and others in the household. Using a carbon monoxide (CO) monitor to show clients the increase in CO following smoking is a good way to personalize the effects of smoking.</p>

REFER

Action	Strategies for Implementation
<p>For clients interested in quitting</p>	<p>Refer to the Colorado QuitLine at 1.800.QUIT.NOW or www.coquitline.org. The QuitLine offers a free program tailored to the client with free nicotine replacement therapy and telephone coaching and other resources, such as an online support network.</p> <p>Fax a referral form to the Colorado QuitLine:</p> <p>After getting written client permission, health care providers can fax the client's contact information to the QuitLine. QuitLine staff will contact the client to help start his or her program.</p> <p>See Colorado QuitLine fax referral form at end of this section.</p> <p>Document the referral on the client's treatment plan.</p>

The 5 Rs: Addressing Tobacco Cessation for the Tobacco User Unwilling to Quit

The “5 Rs” – **Relevance, Risks, Rewards, Roadblocks** and **Repetition** – are designed to motivate smokers who are unwilling to quit at this time.

Tobacco users may be unwilling to quit due to misinformation, concern about the effects of quitting, or demoralization because of previous unsuccessful quit attempts. Therefore, after asking about tobacco use, advising the smoker to quit and assessing the willingness of the smoker to quit, it is important to provide the “5 Rs” motivational intervention.

Relevance

Encourage the client to talk about why quitting is personally relevant, as specifically as possible. Motivational information has the greatest impact if it is relevant to a client’s medical status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

Risks

Ask the client to identify potential negative consequences of tobacco use. Suggest and highlight those that seem most relevant to them. Emphasize that smoking low-tar/ low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars and pipes) will not eliminate these risks. Don’t forget to discuss the risks of secondhand smoke.

Examples of risks follow:

- **Acute risks:** Shortness of breath, worsening of asthma, harm to pregnancy, impotence, infertility, and increased serum carbon monoxide
- **Long term risks:** Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long term disability, and need for extended care
- **Health Effects of Secondhand Smoke Exposure include the following:**
 - increased risk of lung cancer, heart disease
 - immediate risk for heart attack
- **Children exposed to Secondhand Smoke Exposure are at increased risk for the following health conditions:**
 - sudden infant death syndrome (SIDS)
 - acute respiratory infections
 - ear problems
 - more frequent and severe asthma
 - slowed lung growth

“Tobacco is just another addictive substance. Everything we do to help people get off alcohol and drugs works with tobacco, too. At the end of the day, we’re helping clients live healthier, longer lives.”

– Erik Stone, MS, CACIII, Director of Compliance and Quality Improvement, Signal Behavior Health Network

Rewards

Ask the client to identify potential benefits of stopping tobacco use. Suggest and highlight those that seem most relevant to the client.

Examples of rewards:

- Improved health
- Good example for children
- Improved sense of taste
- Improved sense of smell
- Money saved
- Better self image
- Home, car, clothing, and breath smell better
- No more worrying about quitting
- Healthier babies and children
- No more worrying about exposing others to smoke
- Feel better physically
- Perform better in physical activities
- Reduce wrinkling/aging of skin
- New skills helpful in quitting alcohol or other drugs

Roadblocks

Ask the client to identify impediments to quitting and note elements of treatment (problem solving, medications) that could address barriers.

Typical barriers might include the following:

- Withdrawal symptoms
- Fear of failure
- Weight gain
- Lack of support
- Depression
- Enjoyment of tobacco
- Association between alcohol and tobacco use

Repetition

Repeat motivational interventions every time an unmotivated client visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

Working with Groups Disparately Affected by Tobacco



Overview

Tobacco negatively affects everyone who uses tobacco. However, the impact of tobacco is not evenly spread throughout our society. There are certain groups that bear a greater tobacco burden than other groups. For example, when compared with Caucasian smokers, African-American smokers are found to have a higher incidence and death rate for cancers of the oral cavity and pharynx, esophagus, cervix, larynx, stomach, and pancreas.¹ These differences are called tobacco disparities or tobacco inequalities.

In Colorado, 10 groups are currently identified as populations experiencing tobacco disparities:

- African-Americans
- Native Americans
- Asian Americans and Pacific Islanders
- Lesbian, Gay, Bisexual, Transgender, and Questioning community
- Latinos and Hispanics
- People with low socio-economic status
- People with disabilities
- People receiving treatment for mental illnesses
- People receiving treatment for substance abuse
- Spit tobacco users

1] Mazas and Wetter, 2003

Recommendations for Substance Abuse Counselors

When working with persons from populations disparately affected by tobacco, the substance abuse counselor should do the following:

- Ask, Advise, and/or Refer all clients for treatment of their tobacco use. There is a critical need to deliver effective tobacco education and treatment to all persons negatively impacted by tobacco in ways that are appropriate for their communities.
- Use cessation interventions that have been shown to be effective. For example, for persons being treated for mental illness, nicotine replacement therapy (NRT) or bupropion in combination with individual or group counseling that employs motivational interviewing or cognitive-behavioral strategies has proved helpful. A variety of smoking cessation interventions including screening, clinician advice, self-help materials and the nicotine patch have demonstrated to be effective for tobacco cessation in disparately-affected populations.
- Programs and counselors that subtly encourage smoking by sanctioning smoke breaks, by openly modeling smoking behaviors, or by failing to conduct relapse prevention planning for non-smokers entering treatment, have the potential to do harm. Clinicians are advised to provide healthy alternative activities to smoking and help non-smokers plan for relapse. Clinicians who are smokers should avoid smoking within the sight of clients.
- Be respectful of your clients' culture and tailor your treatment approaches to fit appropriate cultural values. This will increase clients' acceptance of treatment and reduce barriers to change.
- Provide education, counseling, and self-help materials in a language understood by the client.

Special Populations: Adolescents

Many youth who enter substance abuse treatment have experimented with tobacco use, currently use tobacco, or are likely to initiate use in the future.

Although tobacco use is already prohibited in many adolescent facilities, intervening in tobacco use with adolescents is an essential element of substance abuse treatment.

Common Barriers to Treatment:

- Adolescents may perceive tobacco use as a normal and socially acceptable behavior.
- Adolescents may perceive use of tobacco as less problematic than other substances.
- Adolescents have a propensity to experiment with new behaviors, such as use of tobacco and other substances.

Clinical Considerations:

- Utilize an integrated screening and assessment process for both current and risk of future use of substances including tobacco.
- Provide education on tobacco with a strong message about the importance of tobacco abstinence.
- Use individualized motivational strategies to improve treatment compliance and response. Overly confrontational or authoritarian approaches may increase resistance to stopping tobacco use.
- Counseling and behavioral interventions should be developmentally appropriate, involve positive reinforcement, and utilize peer support.
- Adolescents may benefit from ongoing community- and school-based intervention activities to help improve their success in remaining tobacco-free.¹

Women

As with alcohol and drug use, the motivations and barriers to addressing tobacco use often differ for men and women.

Common Barriers to Treatment:

- Women have a higher prevalence of depression than men.
- Women typically have significant concerns regarding the weight gain associated with stopping tobacco use.

1] U.S. DHHS: AHRQ, Children and Adolescents

- Hormonal changes during menopause may worsen negative moods, hinder weight control, and increase negative body image, making cessation more difficult.
- Support from family and social relationships is essential to ongoing recovery for women. If tobacco use is closely associated with personal relationships, women may find it harder to quit or to sustain recovery.

Clinical Considerations:

- Identification of social supports for tobacco cessation in their family and peer network is essential for women attempting to quit tobacco use.
- Eliminate the social support for tobacco use while in treatment by providing activities such as “walk breaks” or “chat breaks” as opposed to “smoke breaks.”
- There is some evidence that nicotine replacement therapies (NRT) may be less effective with women than men.¹ Clinicians should take this into consideration in recommending type, dosage, and duration of any use of NRT.

Women and Pregnancy

Pregnancy presents unique opportunities to intervene in women’s tobacco use and further reduce the intergenerational consequences of tobacco use.

Reduced Barriers: Although the barriers to treatment noted above remain relevant, women who are pregnant or considering becoming pregnant may be especially receptive to tobacco cessation treatment.

Clinical Considerations:

- Utilize clients’ interest in a healthy pregnancy to educate clients about the relationship between tobacco use/cessation and pregnancy outcomes.
- Women who smoke are less likely to become pregnant than nonsmokers.
- Nicotine use increases risks to the fetus and is associated with negative birth outcomes including miscarriage, still-birth, premature birth, and low birth weights.

- Quitting tobacco use increases the amount of oxygen the fetus receives and lowers the risk of the baby being born too early or being still-born, which can lead to serious health problems as newborns, lasting disabilities, and even death.²
- Quitting tobacco use prior to conception or early in pregnancy is most beneficial. However, health benefits result from abstinence at any time during pregnancy.
- Pregnancy can be a particularly stressful time for women, especially those receiving treatment for alcohol and drug problems. Treating tobacco use will likely require psychosocial interventions beyond brief advice to quit.
 - Interventions aimed at tobacco cessation should be integrated into treatment for alcohol and drug problems.
 - Messages that present tobacco use as less harmful than other drug use may undermine quit attempts and have lasting negative health effects for women and their children.
 - Encourage pregnant women to identify coping and stress-reduction skills aimed at reducing the stress associated with tobacco cessation.
- The risks and benefits of using NRT during pregnancy are not fully understood. However, some physicians may approve the use of NRT during pregnancy.
 - Whenever possible, pregnant women should be encouraged to quit tobacco without the use of NRT.
 - To reduce the risk of treatment drop-out, pregnant women with histories of drug or alcohol problems who have been unable to quit tobacco use should be evaluated by a physician for appropriateness for NRT.
 - Pregnant women should be advised of the increased risk of lower birth rates associated with smoking in conjunction with NRT.
 - Pregnant substance users should receive encouragement and assistance throughout the prenatal and postnatal period. Approximately 33 percent of women relapse after childbirth.³

1] U.S. DHHS, Public Health Service, 2008

2] March of Dimes, 2005

3] U.S. DHHS: AHRQ, Pregnant Women

Families/Parents

Parental tobacco use is the most significant predictor of youth smoking.¹ Providing education and treatment to clients with children can help prevent tobacco use by future generations.

Clinical Considerations:

- Parents in substance abuse treatment should be educated and urged to stop smoking, especially in the presence of their children, to prevent serious health implications for their children.
- Clinicians should provide information on the risks to children from secondhand smoke.
 - Secondhand smoke contains over 60 cancer-causing substances increasing chances for cancers of the lung, nasal sinus, cervix, breast, and bladder.
 - Children exposed to secondhand smoke have increased risk for asthma, bronchitis, pneumonia, eye and nose irritation, and middle ear infections.²
- Clinicians should educate parents on role modeling that places children at higher risk to become tobacco users.

Clients with Co-Occurring Disorders

Interventions aimed at reducing and eliminating tobacco use should be offered to clients with mental health and trauma-related disorders and concurrent substance use disorders. Despite some complications with administering tobacco cessation treatment to persons within this population, effectiveness has been demonstrated. Most evidence suggests that abstinence from tobacco presents little adverse impact on substance abuse treatment.

Common Barriers to Treatment:

- Some clients may experience an increase in mental health or trauma symptoms upon quitting tobacco.
- Withdrawal from tobacco may affect the pharmacokinetics of certain psychiatric medications.
- Co-occurring mental health and trauma issues can place smokers at increased risk for tobacco relapse.

Clinical Considerations:

- Behavioral interventions including anger and stress management skills, as well as moderately increased physical activity, can lessen any increased anxiety and depression associated with tobacco cessation.
- Alternative strategies to manage symptoms of mental health disorders, withdrawal from alcohol and drugs, and withdrawal from tobacco should be provided.
- Clients should receive appropriate consequences when they violate agency tobacco policies. Consistent and fair enforcement of tobacco policies will help clients stay tobacco-free.
- Client treatment plans may need to directly address adherence to agency tobacco policies.
- Having a history of depression is associated with more severe withdrawal symptoms and an increased risk of a new major depressive episode after quitting. Among clients with no history of depression, major depression after quitting is rare.³ Clinicians should monitor symptoms of depression, particularly among clients with a history of major depression.
- Pharmacology:
 - The dual effectiveness of bupropion SR and nortriptyline in the treatment of tobacco dependence and depression suggests that they may be particularly desirable treatments.
 - The tars in tobacco smoke can lower a client's metabolism of many medications, including psychiatric medications such as valium, cymbalta, elavil, and haldol. When clients stop smoking, blood levels of such medications can rise, increasing the risk of unanticipated side effects.⁴
 - Clinicians must monitor the actions and side effects of psychiatric medications, as well as other prescription medications, in tobacco users making a quit attempt and collaborate closely with prescribing providers.⁵

1] U.S. DHHS: AHRQ, Children and Adolescents

2] U.S. DHHS:NCI, 2007

3] U.S. DHHS, National Cancer Institute, 2004

4] Tobacco Cessation Leadership Network, 2008

5] Tobacco Cessation Leadership Network, 2008

Relapse Prevention



Overview

Most relapses occur soon after a person quits smoking, yet some people relapse months or even years after the quit date. Relapse prevention programs can take the form of either minimal (brief) or prescriptive (more intensive) programs.

Components of Minimal Practice Relapse Prevention

The following interventions should be part of every encounter with a client who has quit recently.

Positive reinforcement:

- Congratulate all clients quitting tobacco on any success.
- Strongly encourage them to remain abstinent.

Use open-ended questions designed to initiate client problem solving such as, “How has stopping tobacco use helped you?” or “What has helped you the most to stay tobacco-free?”

Encourage the client’s active discussion of the topics below:

- Stress associated with recovery from alcohol and drug abuse and ways the client can minimize the risk of relapse
- Problems encountered or threats anticipated to maintaining quit (e.g., depression, weight gain, alcohol and other tobacco users in the household)
- Benefits, including potential health benefits that the client may derive from cessation
- Any success the client has had in quitting (duration of quit attempt, reduction of cigarettes smoked, etc.)

Ask about the client’s support from family and friends for quitting; encourage the client to continue to seek out such support.

Agency Policies on Tobacco Treatment and Tobacco Control



Agency policies are a significant factor in changing the culture of substance abuse treatment agencies, and assisting counselors to consistently and effectively address their clients' tobacco use.

Agency staff may also be tobacco users themselves. Policies emphasize the importance of tobacco treatment, provide clear guidelines for addressing client tobacco use, and provide support for agency staff who are trying to quit as well.

Basic Policies

- Agencies should have a written policy or policies which address tobacco use by all employees and clients. Agency policy should clearly address use of all tobacco products and paraphernalia, such as spit tobacco use.
- Agency policy ideally will clearly state that all agency facilities and grounds are to be completely tobacco-free. Agencies not able to have completely tobacco-free facilities must, at a minimum, comply with the Colorado Clean Indoor Act of 2006, which prohibits smoking in all public areas, including inside substance abuse treatment facilities. The Act further prohibits smoking within 15 feet of the main entrance unless designated differently by local law.
- Agency tobacco policy should be reviewed as part of orientation procedures for all new employees and periodically reviewed with all current employees.
- Agency tobacco policy should be clearly communicated to all individuals seeking services, to referral sources, and to the public.
- All agency facilities should have prominent signage indicating that no tobacco use is permitted in agency facilities. Free signs can be obtained at www.steppitems.com, provided by Colorado Department of Public Health and Environment/State Tobacco Education & Prevention Partnership (STEPP).

“We offered workshops and recognition programs. We explained the rationale behind creating a healthy work environment. The staff always kept their eyes on the overall strategy and understood the importance of this change.”

– Angela Bornemann, Arapahoe House

Clinical Policies

- Agencies should have clinical protocols for treatment of tobacco. Key elements of such a protocol include the following:
 - Assessing all clients for tobacco use
 - Advising all clients currently using any form of tobacco to stop use
 - Providing clients with educational materials on tobacco and secondhand smoke and ways to quit using tobacco
 - Offering assistance in stopping tobacco use via referral, or provision of a specialized tobacco treatment curricula, or full integration of tobacco treatment into existing substance abuse treatment
 - Assisting clients in obtaining nicotine replacement products such as nicotine gum or patches or prescription medications for tobacco treatment
 - Providing healthy alternatives to smoke breaks
- Agency clinicians should routinely include tobacco related problems and goals on client treatment plans and agencies should routinely track the outcomes of client tobacco treatment as they do treatment of any other substance.

Staff Policies

- Agency policy should clearly prohibit staff use of all tobacco products on agency premises or while engaged in job-related activities. This should include a clear statement that staff cannot use tobacco in areas where they can be seen by clients. Agency policy should clearly state that tobacco use on the job can be grounds for discipline up to, and including, termination.

- Agencies should incorporate training on tobacco treatment into staff training procedures. This should include providing information on cessation resources such as the Colorado QuitLine.
- Agencies should encourage all staff using tobacco to quit and should provide education and information about quitting options.
- Agencies should make treatment available to staff using tobacco.

Additional information on policy recommendation can be found in the 2007 TURN report “Key Elements of Model Tobacco Policies for Substance Abuse Treatment Providers” available at www.signalbhn.org. Another excellent resource on tobacco policies in substance abuse treatment agencies can be found at the New York State Tobacco Dependence Resource Center www.tobaccodependence.org. The Center provides copies of sample tobacco policies on its website.

TURN provides technical assistance to Colorado providers wishing to improve their tobacco-related policies. For more information, contact Erik Stone at estone@signalbhn.org or 303-639-9320 x1015.

Local and National Tobacco Treatment Resources



American Cancer Society

www.cancer.org

1-800-ACS-2345: Facts and statistics about effects of tobacco use and quitting, advocacy, and support

American Lung Association of Colorado

www.alacolo.org

1-800-LUNG-USA: Facts and statistics about effects of tobacco use and quitting

Centers for Disease Control and Prevention, Office on Smoking and Health

www.cdc.gov/tobacco

Free tobacco use prevention and cessation resources for clients and professionals including posters, DVDs, and pamphlets – with many items available in Spanish

Colorado Clinical Guidelines Collaborative

www.coloradoguidelines.org

A resource for evidence-based practices and guidelines on tobacco cessation

State Tobacco Education & Prevention Partnership (STEPP)

www.steppcolorado.com

Provides information, resources, and links for all aspects of tobacco education and control

Colorado STEPP Healthcare Provider Web Site

www.cohealthproviders.com

Aimed at healthcare professionals in Colorado and includes tobacco education best practices, evidence-based guidelines, and educational tools

Colorado QuitLine

The Colorado QuitLine is a FREE telephone coaching service that connects people who want to quit smoking or using other tobacco products to an experienced Quit Coach. The Quit Coach sets up a personal quit plan and provides tips and support that will increase the chances of quitting tobacco for good. These expert coaches can talk to callers about overcoming common barriers, such as dealing with stress, fighting cravings, coping with irritability and controlling weight gain. Along with individualized coaching, the telephone service offers a free supply of nicotine patches. Colorado QuitLine also offers a Web-based service that provides online quit tools and tips based on the latest research. Colorado residents can use either service or a combination of both.

The free telephone coaching service — 1.800.QUIT.NOW (1-800-784-8669) is available in both English and Spanish. The Web-based service is available at www.coquitline.org.

Colorado Tobacco Education and Prevention Alliance

www.ctepa.org

The umbrella organization for the tobacco prevention movement in Colorado

Denver Area Central Committee of Alcoholics Anonymous

www.daccaa.org

Useful in identifying smoke-free AA meetings

National Partnership for Smoke-Free Families

www.helppregnant smokersquit.org

Provides resources on tobacco treatment with pregnant women

New York State Tobacco Dependence Resource Center

www.tobaccodependence.org

Provides substance abuse providers with resources and support on integrating tobacco treatment into substance abuse practice and policy information

Nicotine Anonymous

www.nicotine-anonymous.org

A non-profit 12-step fellowship of men and women helping each other live nicotine-free lives

Society for Research on Nicotine and Tobacco

www.srnt.org

The leading organization in research on nicotine and tobacco

Surgeon General

www.surgeongeneral.gov/tobacco/

Tobacco cessation resource page with links for clients and clinicians, including supportive materials, pocket cards, fact sheets, and a variety of clinical guidelines for treating tobacco dependence, including special populations and *Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians*. Provides materials in Spanish.

Tobacco Cessation Leadership Network

www.tcln.org

Provides resources, links, and regular roundtable discussions on tobacco treatment with considerable material directly related to the relationship between substance abuse and tobacco treatment including *Bringing Everyone Along Resource Guide*

Tobacco Dependence Program

www.tobaccoprogram.org

Associated with the University of Medicine and Dentistry of New Jersey which provides research and policy information and materials aimed specifically at clients with substance use disorders and mental illnesses

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