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## The Range of Practice

### Overview

All quitlines in the United States provide some sort of individual cessation assistance, but they vary significantly in several important ways. They employ different combinations of service modalities and range considerably in the size and scope of their operations. The populations they serve vary with respect to readiness to quit and cultural and linguistic backgrounds. Quitlines also vary in addressing specific populations such as tobacco users from low-income households, pregnant women, adolescents, and users of smokeless tobacco products, such as chewing tobacco.

This chapter explores and contrasts the various statewide quitline services offered in the United States. The goal is to document the current range of practice and to identify important considerations for those who fund or operate quitlines and those who are preparing to do so. Included at the end of the chapter is a case study highlighting services provided by the California Smokers' Helpline—the nation's oldest statewide quitline.

### Populations Served

#### *Readiness to Quit*

Telephone counseling has been seen primarily as a means of helping tobacco users quit and only secondarily as a means of moving tobacco users along the continuum of readiness to quit. Most research trials demonstrating the efficacy of proactive telephone counseling for smoking cessation have served callers who were almost ready to quit when they made their first call. Most quitlines still spend the bulk of their resources on such callers. In fact, several quitlines reserve counseling, their most intensive and expensive service, for those who report that they are ready to make a quit attempt; many others require a commitment to quit within a certain timeframe. For example, California offers counseling services for those ready to quit

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within a week, and Arizona reserves counseling for those ready to quit within 30 days. Both states, however, send motivational materials to callers who do not yet fit these descriptions and invite them to call back for counseling when they do.

Some programs also target tobacco users who are not yet ready to quit. For example, Blue Cross Blue Shield of Minnesota established a private quitline for its members that actively recruits callers at all stages of readiness. Funders of statewide, public quitlines must also consider whether they will offer counseling to those who are not ready to quit in the near future. There is some evidence that telephone counseling can benefit even those who, at baseline, are not planning to quit (Curry et al. 1995).

### *Cultural and Linguistic Diversity*

Statewide quitlines serve English-speakers of all races and backgrounds, and most of them also provide services in Spanish. Some quitlines advertise only in English and Spanish, but retain staff members who speak other languages and use their language skills when needed. Other quitlines use third-party translation services, such as AT&T Interpretive Services, to increase the number of languages supported.



Wisconsin Tobacco Control Board 2003. "Let's Be Clear" media campaign ad targeting African American smokers.

Quitlines serving regions with ethnic minority populations must carefully consider the cultural and linguistic appropriateness of their programs. An ethnically and linguistically diverse base of callers presents a wide range of expectations for service, and all elements of the quitline, from outreach and promotion to programming and staff training, must address this range of expectations. For example, a service successfully billed as "counseling" in English-speaking

communities may fare better if billed as “help” or “information” in Asian-language communities, where use of programs perceived as mental health services is often stigmatized.

Studies to establish the efficacy of proactive telephone counseling for smoking cessation have included English- and Spanish-speaking participants of ethnically diverse backgrounds, but no significant differences in outcomes along ethnic or linguistic lines have been reported, suggesting that this type of counseling may be effective for English- and Spanish-speaking smokers from many racial and ethnic backgrounds (Stead et al. 2004). As yet, the field has not established an evidence base for Asian-language quitlines.

### *Low-Income Tobacco Users*

Quitlines may receive many calls from tobacco users with low socioeconomic status (SES) (Anderson & Zhu 2002). Quitlines should make special efforts to reach this segment of the population, which has the highest prevalence of tobacco use of any socioeconomic group (USDHHS 2000b). If resources are insufficient to provide comprehensive services to all callers who want them, states may consider prioritizing low-SES tobacco users to help address this disparity.

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### *Pregnant Smokers*

Quitline media campaigns aimed at the general population of adult smokers generate a significant number of calls from pregnant smokers. Many quitlines have responded to this demand by developing special protocols addressing the unique needs of pregnant smokers, and studies testing the effectiveness of these protocols have begun to show promising results (Cummins et al. 2002). In addition, the scientific literature for other counseling venues provides some guidance in the development of specialized protocols for pregnant smokers (Melvin et al. 2000). Because smoking while pregnant is more common among women of low SES, such protocols must address the increased social and economic instability in which many pregnant smokers live, relative to the general smoking population. These circumstances may make it more difficult for the quitline to reach pregnant women for proactive counseling. Another challenge is the

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high rate of postpartum relapse: as many as 70% of women who quit during pregnancy return to smoking within 6 months after delivery (Floyd 1993).

Despite these challenges, most quitlines actively assist pregnant callers given the potential danger of smoking to fetal health. National organizations have become involved in the effort as well. Smoke-Free Families is a multisite, multiphase, biobehavioral research program that is exploring innovative approaches to prevent smoking during pregnancy and beyond (Orleans et al. 2004). Great Start is a national media campaign that encourages women to call the Great Start quitline service, jointly sponsored by the American Legacy Foundation and the American Cancer Society. Given the recent increase in cessation efforts directed at this population, states and quitline operators should monitor the scientific literature for developments relating to telephone interventions for pregnant smokers.

### *Adolescent Smokers*

Media campaigns to promote quitlines generate calls from tobacco users of all ages, including adolescents. In response, many U.S. quitlines have developed specialized protocols for underage smokers. While the proportion of quitline callers who are younger than 18 is small (less than 2% in 2001) (Zhu 2002a), they often receive considerable attention from quitline funders and operators. Interest in this population is high because studies have shown that most long-term smokers start smoking as teenagers. Another concern is that in most areas, very few teen cessation services are available.

The main challenge encountered by states that want to provide quitlines for teens is the lack of proven models for long-term effective interventions with adolescent tobacco users. Teens have not been included as participants in most of the major trials of quitline efficacy (Zhu 2002b). Another challenge is that in addition to the relapse pressures that ex-smokers of all ages face (uncomfortable withdrawal symptoms, for example), adolescent ex-smokers may also face “reuptake” pressures (Zhu 2003). These include the influence of aggressive, age-specific marketing by the tobacco industry and social pressure from peers who may regard smoking as socially desirable. A third challenge is the requirement in many states that quitline staff obtain parental consent before providing proactive counseling to teenage callers. This requirement decreases the likelihood of teens receiving the intended service, not so much because teens are afraid their parents or guardians will discover they smoke (they usually already know), but because contacting the parents or guardians and then recontacting the teens can be logistically difficult (Zhu 2003).

Despite these challenges, most quitlines offer at least a minimal level of service to teens who call. However, until the evidence base has been more firmly established, it is not recommended that states aggressively promote services for this population (Zhu 2003). Funders and quitline operators should monitor the scientific literature for developments in this area. Recent cessation efforts with teens have met with modest success, so there is reason to be cautiously optimistic (Hollis et al. 2002, Zhu 2003, McDonald et al. 2003, Mermelstein 2003).

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### *Chewing Tobacco Users*

The use of chewing tobacco is a serious public health concern, especially in rural areas (CDC 1993b). Quitline media campaigns, even if they do not specifically target this audience, result in small but significant numbers of calls from “chewers.” In response, most quitlines have developed special protocols for working with them (Zhu 2002a).

Quitline operators may find that callers who chew are more likely than callers who smoke to be young, white, and male (Padgett et al. 2002). Because the great majority of anti-tobacco messages have focused on smoking, chewers may have less knowledge about the health risks of chewing tobacco than smokers have about the risks of smoking. Chewers also have different triggers and absorb nicotine differently than smokers do. For this reason, some quitting strategies that work well for smokers may be less effective for chewers (Hatsukami & Severson 1999).

While quitlines for smoking cessation have been more widely studied and proven effective, there is also evidence that telephone counseling can be effective for chewing tobacco cessation (Severson et al. 2000). Mass media promotion of chewing tobacco quitline services may be less cost-efficient, however, since chewers comprise a much smaller portion of the general population than smokers and are less likely to live in urban areas where most media campaigns are aired. The extent to which states dedicate resources to treating the use of chewing tobacco should be guided by statewide assessments of chewing tobacco usage and its toll on public health.

## Types of Service Provided

### *Counseling*

All quitlines provide some sort of counseling intervention, but there is considerable variety in how the counseling is provided, particularly with regard to intensity. Quitlines can design their counseling intensity

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to be consistent with their mission. They may provide a basic level of service to the greatest number of callers, or a maximally effective time-intensive service to a more limited number of callers, or a mixture of both strategies.

The quitlines of some states, such as Illinois and New York, operate on a reactive, hotline basis, providing brief, on-the-spot, one-time counseling to smokers who call during operating hours. This approach allows a quitline to provide minimal counseling services to a large number of callers.

Many other states offer more time-intensive, proactive counseling that may begin with a reactive session when a tobacco user first calls the quitline. For example, Arizona provides a comprehensive planning session that lasts a little over half an hour. The caller then has a choice of continuing with proactive counseling (for up to eight sessions), receiving a referral to a local group counseling program, or both. Some states triage callers, providing reactive support to all callers and proactive follow-up only to the uninsured or other priority populations.

Some states with relatively large quitlines augment the counseling staff with a group of intake specialists. These specialists answer the majority of incoming calls and collect basic demographic, personal, and behavioral information, explain available services, and record each caller's choice of services. Callers who want counseling may be directly transferred to an available counselor, scheduled for an appointment at a time that is convenient for them, or told that a counselor will be contacting them within the next couple of days.

Quitlines that provide proactive follow-up sessions differ in the scheduling of calls. California's quitline schedules follow-up sessions according to the probability of relapse, with the first call occurring within 24 hours of quitting and subsequent calls at 3 days, 1 week, 2 weeks, and 1 month. Thus, the sessions are "front-loaded" around the quit day and become less frequent as the probability of relapse diminishes. In most cases, all sessions are concluded within a month of the quit date. This model has the advantage of preventing relapse before it happens or addressing it soon afterward (Zhu et al. 1996). In some states, the Free & Clear program provided by the Center for Health Promotion offers a similar number of follow-up sessions, with the first session scheduled shortly after the quit date and the other sessions distributed over a 3- to 4-month period, at the rate of one session per month. This model has the advantage of identifying callers who have relapsed and creating an opportunity to encourage them to quit again (Orleans et al. 1991).

Other states offer more time-intensive, proactive counseling. Arizona provides a comprehensive planning session that lasts a little over half an hour.

### *Pharmacotherapy*

Many quitlines help eligible callers obtain pharmacotherapeutic quitting aids such as nicotine replacement therapy (NRT) or bupropion (Zyban®) (Waa et al. 2000). California provides a certificate of enrollment in quitline services, which, together with a prescription from their doctor, enables callers who are insured by Medicaid to obtain free nicotine patches, nicotine gum, or bupropion at their local pharmacy. Some other insurance plans also honor these certificates. Maine, Minnesota, Utah and Washington State provide NRT directly to eligible callers who participate in comprehensive, proactive counseling. Because the efficacy of NRT and bupropion was demonstrated in trials that usually involved counseling support (Fiore et al. 2000), it is appropriate that quitlines play a role in facilitating smokers' use of these medications (Swan et al. 2003).

Many NRT products, including the patch, gum, and lozenge, have been approved by the Food and Drug Administration for over-the-counter sales, and thus there are few medical or legal concerns about quitlines providing these products. Some private quitlines even dispense bupropion and prescription forms of NRT (e.g., the nasal spray and inhaler). They have developed mechanisms to inform the caller's provider of the recommendation prior to mailing the medication to the client, to ensure concurrence with the prescription.

### *Referral*

Most quitlines maintain updated listings of local cessation programs to which they refer callers who want face-to-face counseling or group support. In an innovative statewide cessation project called QuitWorks, Massachusetts helps callers enroll in local programs. Some quitlines transfer callers directly to their health plans if those plans provide counseling or other cessation benefits such as NRT or bupropion. Most quitlines also have procedures for identifying and referring callers with mental health issues that fall outside the scope of the quitline or that exceed the training of their counselors. Long-time quitline operators have observed the necessity of ensuring that their staff are aware of the most reliable resources for callers in crisis and know when to break confidentiality to ensure safety (for example, to report a suicide threat to the local police or to report suspected child abuse to child protective services).

### *Mailings*

Packets of self-help materials represent one of the least intensive services provided by quitlines, and are usually provided to all callers. The packets may be matched to the caller's level of readiness to quit,

California, Maine, Massachusetts, Minnesota, Utah and Washington State use various methods to help callers obtain free or reduced-cost nicotine replacement therapy.

Because the efficacy of NRT and bupropion was demonstrated in trials that also involved counseling, it is appropriate that quitlines play a role in facilitating the use of these medications.

or they may be designed for specific populations, such as chewers, teens, pregnant smokers, and non-English speakers. They may be further customized according to concerns that arise during the first interview (Borland et al. 2004). Arizona, for example, has developed fact sheets covering a wide range of topics, which are selectively included in callers' packets to supplement the basic materials. Some quitlines also enclose smoking substitutes such as a worry stone or a straw.



Examples of materials provided by quitlines.

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Self-help materials have not been demonstrated to be efficacious when used on their own (Fiore et al. 2000). However, since many quitline callers may be ineligible for counseling services (such as those with private insurance), may not be willing to quit within a specified time period (e.g., 30 days), or may choose not to receive counseling, these relatively inexpensive self-help materials allow quitlines to provide every caller with at least a basic level of support. Self-help materials are also used to supplement any counseling services provided. (See Appendix D for a list of some of the self-help materials provided by quitlines.)

### **Web Sites**

Most state quitlines have a Web site. Some states simply provide an online brochure that directs visitors to the quitline. Others also provide a modest intervention component, and a few states offer comprehensive Web-based cessation services. New Jersey offers both a quitline and Web-based services, and has experienced little overlap between users of the two programs. This state's experience suggests that incorporating Web-based services may be a promising way for



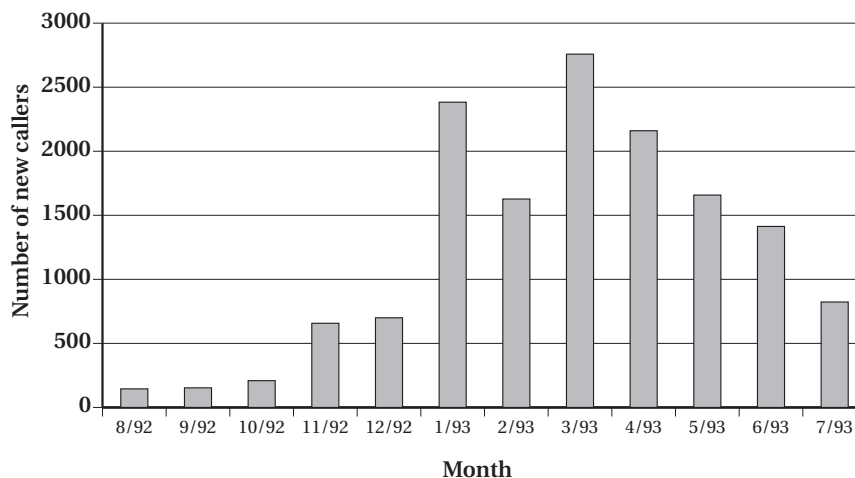
other state tobacco control programs to increase their reach. Because there is not yet an evidence base to support Internet interventions, it is not recommended that limited cessation dollars be spent on online services. However, several Web-based cessation programs are currently under evaluation, so states should monitor the scientific literature for developments in this area.

Since Web sites represent a cessation activity distinct from that of quitlines, they are not discussed at length in this document. However, a list of cessation sites currently offered by states is presented in Appendix C.

## Utilization of Quitlines

The call volume of new quitlines often undergoes alternating “feast or famine” phases in the first years of operation, until the mechanisms promoting the service are fully understood. Initially, advertising drives utilization, and fluctuations in the level of promotion lead directly to fluctuations in call volume. The first statewide quitline, established by California in 1992, registered more than 14,000 callers during its first 12 months of operation but experienced a large variation in monthly call volume, as shown in Figure 2.1. The peaks in call volume were the direct result of relatively heavy media advertising, while the valleys corresponded to lulls in the campaign. Many other quitlines have experienced similar fluctuations in utilization due to sporadic media promotion. With improvements in coordination between the states, their advertising contractors, and quitline operators, the call volume can become steadier and more predictable over time.

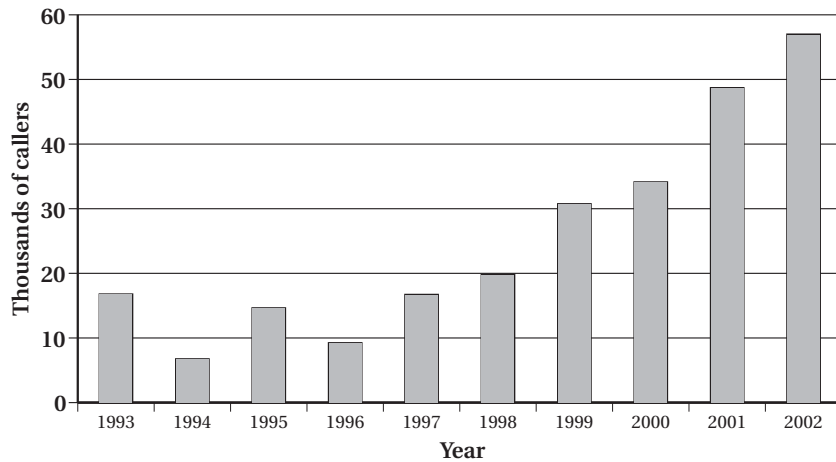
**Figure 2.1** *California Smokers' Helpline Monthly Call Volume, August 1992–July 1993*



The occasional dramatic spikes in demand following suddenly intensified campaigns suggest that the primary limiting factor in the utilization of quitlines is funding.

Gradually, as a quitline begins to fill gaps in the availability of cessation services and word-of-mouth referrals begin to supplement the media campaign, the quitline may generate greater demand among tobacco users. Figure 2.2, depicting the annual call volume of the California Smokers' Helpline during the first decade of operation, illustrates the steady growth in demand experienced by this quitline. This growth is attributed not only to increased advertising but also to the branding of the quitline and to grassroots efforts to "institutionalize" the service in the minds of people throughout the state who are in a position to refer tobacco users to the quitline. These individuals include doctors, nurses, pharmacists, educators, and others who interact with tobacco users every day.

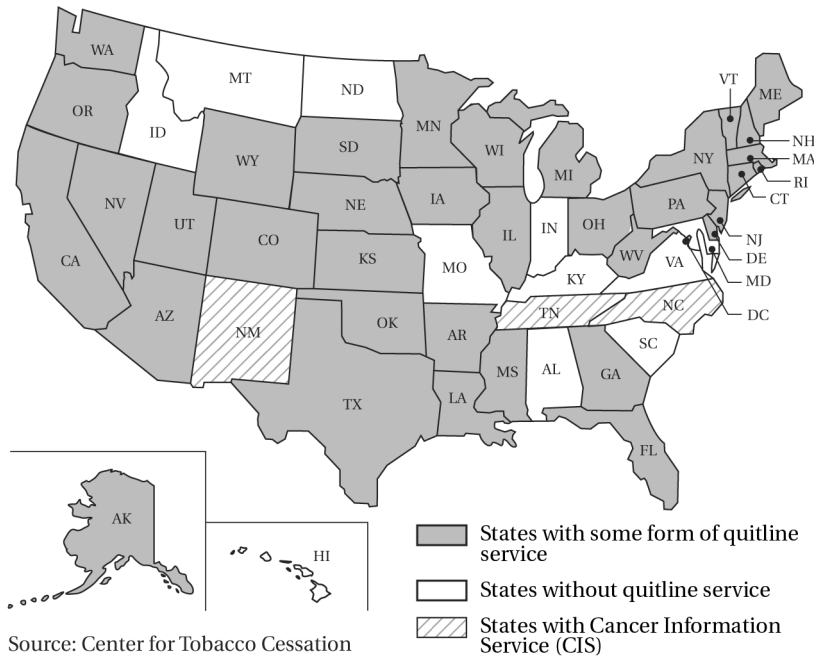
**Figure 2.2 California Smokers' Helpline Annual Call Volume, 1993–2002**



In 2001, 28 statewide quitlines were used by more than 241,000 people, which represents 1% to 5% of the tobacco users in the states that had quitlines. These utilization rates compare very favorably with other cessation programs, but there is still ample room for expansion (McAfee 2002, Zhu 2002a). The occasional dramatic spikes in demand that follow suddenly intensified media campaigns suggest that the primary limiting factor in the utilization of quitlines is funding, both for promotion and for operations.

Figure 2.3 shows the distribution of state quitlines as of January 2004; 38 states and the District of Columbia had active quitlines at that time. (Please see Appendix A for a chart with information about each state quitline.)

**Figure 2.3 State Quitlines as of January 2004**



## New Jersey Quitline Reaches Out to the Hispanic/Latino Community



Marta Mangual started smoking with her girlfriends when she was 24 years old and worked her way up to three packs a day by age 67. Although she tried to quit by using nicotine gum, Marta found she could not stay off cigarettes on her own. That changed the day her daughter brought home a brochure for the New Jersey Quitline’s Spanish-language service that she had picked up at the supermarket. “After just one call, I felt more motivated than ever,” Marta reports. “The counselors were friendly, they seemed to genuinely want to help me, and best of all, I was able to share my feelings about smoking in my native language.”

Marta has nothing but great things to say about the quitline. She has been smoke-free for more than a year, and says she thinks it will last this time. “I haven’t felt this good in years!” she declares. When asked if she would recommend the Spanish-language service to her friends, Marta quickly replies, “I already have! The New Jersey Quitline es muy bueno!”

(New Jersey Comprehensive Tobacco Control Program 2001)

## Case Study

### Nation's First Statewide Quitline Is Thriving

Since its inception in 1992, the California Smokers' Helpline has served more than 300,000 callers. In 2002 alone, nearly 57,000 callers used the Helpline, which is operated by the University of California, San Diego, and funded through tobacco taxes administered by the California Department of Health Services and the California Children and Families Commission. The Helpline's services include self-help kits, referrals to local programs, and one-on-one telephone counseling.

The state of California has a very diverse population, and the Helpline uses a variety of strategies to reach out to different segments of that population. Services are provided in English, Spanish, Mandarin, Cantonese, Vietnamese, and Korean, and each of these language groups is strongly represented among Helpline callers. Targeted advertising in urban areas and grass-roots efforts in rural areas have helped achieve geographic diversity. The state helpline also partnered with the state Medicaid program to help beneficiaries receive pharmacotherapy, which helps to ensure active participation by tobacco users of low socioeconomic status.

Tobacco users calling the Helpline for the first time are asked a brief series of questions assessing tobacco consumption and readiness to quit, as well as contact information and demographics. Callers are then offered a range of Helpline services. At a minimum, they receive a "quit kit" consisting of self-help materials appropriate to their stage of readiness and a descriptive list of cessation resources available in their area.

Callers who choose to receive counseling work with a trained cessation counselor who spends about 40 minutes helping them prepare to quit. The first session covers current tobacco use and quitting history, smoking-related health concerns, social and environmental challenges and resources, planning for difficult situations, and setting a quit date. Counselors use motivational interviewing techniques intended to uncover and enhance callers' inherent motivation for change. They also help callers develop greater confidence in their ability to succeed at quitting.

Subsequent sessions are timed to help prevent relapse, with the most extensive help being provided during the early stages of the quitting process. In the most comprehensive protocol, the counselor follows up within 24 hours of quitting, and again within 3 days, 1 week, 2 weeks, and 1 month. In the beginning, the follow-up sessions focus on immediate concerns such as dealing with withdrawal symptoms, learning from relapse, modifying quitting strategies as needed, and boosting motivation. With time, the focus of the sessions shifts to long-term maintenance issues, such as planning for highly emotional situations and adopting the self-image of a nonsmoker, rather than that of a smoker who is simply not smoking.

The Helpline's counseling service is based on protocols that were proven effective in a large, randomized, controlled trial in San Diego County before implementation of the statewide service (Zhu et al. 1996) and again later in the context of ongoing statewide operations (Zhu et al. 2002). In the original study the effect of multiple proactive counseling sessions was significantly greater than that of a single counseling session, and nearly double that of self-help materials alone (12-month continuous abstinence rates of 26.7%, 19.8%, and 14.7%, respectively).

## Recommendations

- ◆ Provide a mix of reactive and proactive services to maximize the overall impact of the quitline. As funding permits, expand the provision of proactive counseling, which has the strongest evidence of efficacy.
- ◆ Facilitate access to and use of effective pharmacotherapeutic quitting aids such as nicotine patches, nicotine gum, and bupropion.
- ◆ Carefully consider the cultural appropriateness of the quitline's services for the populations they are intended to serve. Provide in-language counseling for linguistic minority communities, as feasible.
- ◆ Target low-income tobacco users for participation in telephone cessation services, since they have a higher prevalence of tobacco use.
- ◆ Provide proactive counseling to help pregnant smokers quit. Recent evidence has shown the efficacy of counseling protocols designed for this population.
- ◆ Provide counseling to adolescent smokers, but do not devote a major portion of resources to aggressively promote services for this population until there is a firmer evidence base to support telephone counseling for teen cessation.
- ◆ Consider providing counseling for chewing tobacco cessation, as there is some evidence of efficacy for telephone counseling for this population.
- ◆ Maintain up-to-date listings of local cessation programs, as well as a listing of agencies able to help with a range of health and mental health issues, and refer callers to them as appropriate.
- ◆ Train staff on resources available to callers in crisis and on when to break confidentiality to ensure safety.
- ◆ Provide self-help materials to callers who do not receive counseling, if not to all callers.

