Within North America, quitlines exist in all U.S. states, the District of Columbia and the five U.S. territories; in each Canadian province; and, most recently, in Mexico. Quitlines provide a centralized resource for easy access to evidence-based information and effective counseling to assist tobacco users in discontinuing their use of tobacco products. Both individual studies and meta-analyses have confirmed that quitlines, particularly those that provide proactive counseling sessions, are effective. Quitlines also help states and provinces reach a large, diverse population more easily and more inexpensively than individual classes or counseling programs. Because of their potential reach, access and economies of scale, quitlines are an important component of a comprehensive tobacco control program and have been recommended by the Centers for Disease Control and Prevention, Health Canada and the Institute of Medicine. The 2007 IOM report, Ending the Tobacco Problem: A Blueprint for the Nation, re-emphasized the need for a national quitline network advocated for in the 2003 National Action Plan for Tobacco Cessation.

The North American Quitline Consortium (NAQC), established in 2004, provides leadership and forums for health departments, quitline service providers, researchers and others to maximize the access, use and effectiveness of quitlines. In 2004, NAQC fielded its first survey among quitline service providers to collect data on the organization, delivery and financing of quitline services. In this fact sheet, data from the 2005 NAQC Annual Survey of Quitlines in North America is described. Sixty-two North American quitlines (50 U.S. states, the District of Columbia, Puerto Rico and 10 Canadian provinces) responded to some or all of the 32 survey questions.

Who calls quitlines?

Although the great majority of callers are people interested in quitting smoking, quitlines also provide services to family members, friends and health care providers who seek information and help with referrals. In 2005, quitlines reached about 1% of all smokers (about 440,000 smokers) in the U.S.. Twenty-nine U.S. quitlines in 2005 reported calls for assistance from families or friends of tobacco users (n=10,810 calls) and health care or other professionals inquiring about services for their clients (n=9,456 calls). Twenty-seven U.S. quitlines also reported 15,401 fax referrals from professionals requesting that the quitline call a smoker. Fax referrals are a growing source of calls for many quitlines.

In the NAQC 2005 Annual Survey of Quitlines in North America, only one Canadian province reported utilization numbers, and, thus, we were not able to report any utilization statistics for Canada.
North American quitlines offer a variety of services to meet the diverse needs of callers. All quitlines provide telephone counseling services, and many provide other services such as mailing self-help materials, referring callers to community resources and providing help and information through Internet-based services. In the U.S., many quitlines also distribute smoking cessation medications or vouchers. (See chart below.)

### Telephone Counseling Services

In addition to the number of hours available to reach a “live” staff person, telephone counseling services vary across states and provinces in the type of services and the frequency and length of calls. Often, states and provinces determine their service structure based on how best to serve their population within budget constraints.

In 2005, all North American quitlines offered multi-session counseling to tobacco users, and many (66.1%, n=41 quitlines) offered single counseling sessions lasting more than 10 minutes. About half (53.2%) also provided minimal, brief interventions lasting 10 minutes or less without extensive counseling. In the U.S., 50% of quitlines reserved the more expensive single and multi-session counseling (not minimal interventions) for tobacco users ready to quit.

Some U.S. quitlines applied other eligibility criteria. Almost half (44%) of U.S. quitlines restricted services by age (e.g., to those older than 18) and some (13.4%) limited services based on insurance status. Other criteria for eligibility included parental consent for those under age 18, in-state residency and consent to follow-up calls. Canadian provinces did not have eligibility criteria for receipt of services.

Multi-session counseling can be either proactive (the smoking cessation specialist proactively calls the smoker back for subsequent follow-ups once a caller has made an initial contact) or reactive (the caller has to initiate all calls, including any follow-ups). Multi-session, proactive telephone counseling has been shown to increase quit rates¹⁻²⁻³⁻⁸⁻⁹ and is recommended by both the U.S. Public Health Clinical Practice Guideline⁹ and the Guide to Community Preventive Services.¹⁰ With the exception of one quitline in Canada, all North American quitlines scheduled multi-session, proactive counseling services in 2005. Less than two-fifths (37.1%) offer multi-session, reactive counseling services.

Most quitlines schedule follow-up calls around the quit date. In general, a typical smoker calling a U.S. quitline received five sessions, ranging from 12 to 60 minutes for the first session, followed by subsequent sessions lasting from five to 60 minutes. In the NAQC 2005 Annual Survey of Quitlines in North America, only three Canadian provinces reported this information, and, thus, we were not able to report these statistics for Canada.

Most North American quitlines (79%) also offered proactive fax referrals, where a smoking cessation counselor initiates a call to a smoker referred by other professionals in the community. Nine out of ten Canadian quitlines handled proactive fax referrals, while 40 of the 52 U.S. quitlines did in 2005. Almost all (87.1%) North American quitlines have also implemented a voice mail system to allow callers to receive a call-back from the quitline.
Counselors received, on average, over 60 hours of initial training in fiscal year 2004-2005, and most (96.6%) of North American quitlines required counselors to participate in continuing education programs. In addition, supervisors maintained quality control by reviewing taped calls, monitoring live calls, organizing peer reviews and conducting other individual and group meetings. Some (62.8%) North American quitlines also conducted follow-up evaluations with clients to assess counseling sessions.  

Sixty-one North American quitlines had access to counselors fluent in English in 2005 and most (n=48 in the U.S.; n=9 in Canada) supported counselors fluent in at least one additional language, with Spanish being the most common in the United States and French being the most common in Canada. Puerto Rico offered counseling services only in Spanish. A considerable number of U.S. quitlines (n=41) also conducted counseling through a third-party translation service, when needed. Three of the ten Canadian quitlines contracted with third-party translation services.  

North American quitlines also provided specialized counseling protocols for special populations, including pregnant women (88.5%); ethnic populations (42.6%); youth aged 12-17 years (39.3%); young adults aged 18-24 years (13.1%); lesbian, gay, bi-sexual or transgendered (LGBT) tobacco users (9.8%); persons with chronic mental illnesses (9.8%); and older adults (8.2%). Some quitlines also offered specialized services for smokeless tobacco users (60.7%) and for persons with multiple addictions (16.4%). Five North American quitlines (n=4 in U.S.; n=1 in Canada) did not offer some type of specialized counseling protocol tailored to one or more special populations. (See charts below.)

Access to Medications  

At the time of the 2005 survey, FDA had approved six medications for smoking cessation (nicotine patches, nicotine gums, nicotine inhaler, nicotine lozenges, nicotine nasal sprays and Zyban®). Quitlines distributing cessation medications have the potential to increase their impact in two ways. First, use of the medications increases the likelihood of a successful quit. Second, offering medications increases the call volume for quitlines, thereby encouraging more callers to attempt a quit, and potentially, increase abstinence rates. 

continued on page 5
**How Can Reach Be Increased?**

Quitlines have the potential to reach more tobacco users, as evidenced by documented spikes in calls following intensified media campaigns and the 4-6% reported reach in the U.K. In 2002, McAfee estimated that North American quitlines could reach 7-10% of all smokers, with sufficient ongoing support (e.g., promotion, outreach, health system integration).

The NAQC Promotion Task Force has identified five strategies for promotion: mass media, coordination, partnering and referral with other health professionals, integration of quitline services into other tobacco cessation services, distribution of medications and placement of the quitline number on cigarette packages. In 2004, the three most commonly reported promotional materials used by U.S. quitlines as reported in the 2004 NAQC Annual Survey of Quitlines in North America were brochures/fact sheets (97.4%), posters or flyers (94.7%) and radio advertising (94.6%). Most (86.8%) also had used television.

Funding for operations and promotions may be the limiting factor in reaching more tobacco users. Cummins and colleagues report a strong positive correlation between the funding level of quitlines and smokers’ utilization of these quitlines ($r=0.74, p<.001$). In fiscal year 2004-2005, North American quitlines typically budgeted $621,696 in the U.S., and $204,893 in Canada for service operations (e.g., counseling, materials, medications). This equated to about $1.77 per smoker in the U.S.

The NAQC Promotion Task Force’s Knowledge Synthesis on Quitline Promotion suggests a need to balance promotion and service delivery. Quitlines must carefully increase demand, constantly monitoring call volumes to avoid exceeding their capacity to serve callers and to ensure adequate funding for the entire contract period. A primary objective of NAQC is to facilitate a unified approach among members and national partners to manage quitline promotion.

### Funding for Quitline Services and Promotion

<table>
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<th>U.S. (in U.S. dollars)</th>
<th>Canada (in Canadian dollars)</th>
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<tr>
<td><strong>Services</strong></td>
<td>n=44</td>
<td>n=6</td>
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<tr>
<td>Median</td>
<td>$621,696</td>
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<td>($12,000 to $944,866)</td>
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Service data is from Cummins, et al, 2007 while promotional dollars were analyzed by the authors of this Fact Sheet.

**When are quitlines open?**

In 2005, all North American quitlines were open Monday through Friday for about 13 hours per day (range: 7.5-24 hours). Most quitlines provided weekend services; however, about one-quarter (25.8%) of quitlines were not open for at least some time period during the weekend (n=14 in U.S.; n=2 in Canada).
Counselors received, on average, over 60 hours of initial training in fiscal year 2004-2005, and most (96.6%) of North American quitlines required counselors to participate in continuing education programs. In addition, supervisors maintained quality control by reviewing taped calls, monitoring live calls, organizing peer reviews and conducting other individual and group meetings. Some (62.8%) North American quitlines also conducted follow-up evaluations with clients to assess counseling sessions.

Sixty-one North American quitlines had access to counselors fluent in English in 2005 and most (n=48 in the U.S.; n=9 in Canada) supported counselors fluent in at least one additional language, with Spanish being the most common in the United States and French being the most common in Canada. Puerto Rico offered counseling services only in Spanish. A considerable number of U.S. quitlines (n=41) also conducted counseling through a third-party translation service, when needed. Three of the ten Canadian quitlines contracted with third-party translation services.

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In 2005, about two-thirds (62.9%) of North American quitlines (32 U.S. quitlines and seven Canadian quitlines) used the Internet to provide supplementary services, such as general information about tobacco cessation (53.2%), self-directed Web-based interventions (33.9%), interactive counseling and/or email messaging (29.0%), automated email messaging (21.0%) and chat rooms (17.7%).

In 2005, 96.8% of North American quitlines provided self-help resources to callers, 75.8% sent specialized materials to family/friends of tobacco users who wanted to help others quit and 61.3% mailed specialized materials to health professionals.

In fiscal year 2004-2005, North American quitlines typically budgeted $621,696 in the U.S., and $204,893 in Canada for service operations (e.g., counseling, materials, medications). This equated to about $1.77 per smoker in the U.S.

Funding for operations and promotions may be the limiting factor in reaching more tobacco users. Cummins and colleagues report a strong positive correlation between the funding level of quitlines and smokers’ utilization of these quitlines (r=0.74, p<.001).

Over half (55.8%) of U.S. quitlines provided free and/or discounted medications or vouchers in fiscal year 2004-2005. Canada did not distribute quitting medications but provided information to callers about how to get these medications. Among those 18 U.S. states (34.6%) providing free NRT in 2005, 17 state quitlines offered nicotine patches, 11 states offered nicotine gum and two states offered nicotine lozenges. No state quitline offered free Zyban®, a prescription medication. Twelve U.S. quitlines (23.1%) distributed vouchers for NRT and/or Zyban®, and five quitlines (9.6%) offered discounted quitting medications.
Moving Quitlines Forward

The February 2007 draft letter with recommendations for updating the *Best Practices in Comprehensive Tobacco Control Programs* recommends sufficient funding for quitlines so that all quitlines may attain 5-10% of their potential reach and provide NRT for a minimum of two weeks. It will take significant budget increases in many states and provinces to reach goals such as these. Quitline advocates can educate policy-makers about the need for more quitline funding to expand services to meet these recommended best practices, including new dollars to help promote quitlines. In 2008, 48 U.S. states, the District of Columbia, and the U.S. Territories will receive additional state funding from the tobacco industry through the Master Settlement Agreement. It is critical that these funds support comprehensive tobacco control programs, including quitline services.

Resources of Interest


**www.naquitline.org**: Official site of the North American Quitline Consortium, which seeks to unite health departments, quitline service providers, researchers and national organizations in the U.S., Canada and Mexico to enable these quitline professionals to learn from each other and to improve quitline services. Data profiles of each state and provincial quitline from the 2005 NAQC *Annual Survey of Quitlines in North America* are available on this Web site. The following fact sheets are also available on NAQC’s Web site along with other publications and documents relevant to quitlines:

- **Quitlines Basics**: Telephone-based Cessation Services that Help Tobacco Users Quit
- **Assisted Tobacco Interventions (WATI)**: The Future of Tobacco Cessation?
- **Promoting Telephone-Based Tobacco Cessation Services**: A Collaborative Approach to Moving the Promotion Dialog Forward
- **Offering Nicotine Replacement Therapies and Other Proven Cessation Medications/Pharmacotherapy Via the Quitline**

**www.ncbi.nlm.nih.gov/sites/entrez?db=pubmed**: Free access to the NIH Pub Med database, with abstracts available for references listed in this fact sheet. Of particular interest is the Cochrane Database review article by Stead, et al. [2006], Telephone counselling for smoking cessation.
Learn More

Resources used for this publication:


Considerations for Research and Practice

Quitline services in the U.S. and Canada fill a critical role in meeting each country’s health objectives to reduce tobacco use. State and provincially-sponsored quitline services vary by entity and time as funding changes and new research becomes available. The NAQC *Annual Survey of Quitlines in North America* provides key information on the evolution of these services over time to monitor changes, to highlight differences in services and to help guide decision-making among quitline service providers and funders. Trend data describing changes from 2004-2006 will be available in the near future.

As in all surveys, the data above are limited by the availability of information at hand. For example, call volume and budget data were not available for all quitlines for fiscal year 2004-2005, limiting estimates on reach and cost. Some questions were constructed to allow the respondent to select how best to address the issue, thus limiting interpretation (e.g., budget promotion data). Some respondents also chose to skip specific subsections, making it difficult to estimate responses to the main questions. Data have been cleaned and results have been confirmed across three different analyst groups to the greatest extent possible.
Learn More (cont’d from page 7)


21 Sutton, S & Gilbert, H (2007). Effectiveness of individually tailored smoking cessation advice letters as an adjunct to telephone counselling and generic self-help materials: randomized controlled trial. Addiction, 102, 994-1000


About the North American Quitline Consortium (NAQC)
NAQC is a nonprofit organization that strives to promote evidence based quitline services across diverse communities in North American. By bringing quitline partners together, including state and provincial quitline administrators, quitline service providers, researchers and national organizations in the United States, Canada and Mexico, NAQC helps facilitate shared learning and encourages a better understanding of quitline operations, promotions and effectiveness to improve quitline services.

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