Smoking Cessation and Addiction Treatment: How Current Research Trends Inform Practice

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Learning objectives

- Explore a summary of current peer-reviewed literature on the appropriateness of smoking cessation in addictions treatment, including problem gambling.
- Describe the connection between smoking and disordered gambling based on the current scholarly literature.
- Present current suggested methods on how to approach smoking cessation in substance abuse disorder/gambling disorder populations based on current research.
Overview

- Facts and figures on tobacco use and mortality in the U.S.
- Tobacco Use Disorder (TUD), Substance Use Disorders (SUD), Gambling Disorder, and The New ASAM Treatment Criteria
- Counselor challenges to addressing TUD
- CSAT and Technical Assistance Publication Series 21 (TAP 21)
- Motivational Interviewing, and Brief Interventions
- Case Studies
Polling question #1

Individuals in early recovery from addiction are best advised to continue smoking, because tackling more than one problem at a time can overwhelm them, and smoking is probably the least of their problems anyway.

True or False?
Polling question #2

I consider addressing tobacco use disorder in addiction treatment to be (by raise of hands):

3 – Essential, high priority

2 – Important, but not an immediate priority

1 – It can wait
What percentage of methadone and outpatient treatment facilities in the U.S. provide smoking cessation services?
As many as 41%, as few as 18%

(estimates from two studies cited in Mee-Lee et al., 2013)
Tobacco use and mortality in the U.S.
Period studied by CDC (2008) was from 2000-2004 in the total U.S. population.
Smoking is the single leading preventable cause of death in the United States each year.
In the U.S. between 2000-2004, smoking resulted in an estimated annual average of 443,000 deaths among males and females (CDC, 2008).
During this same period of time 128,922 deaths were attributed to lung cancer, 126,005 to ischemic heart disease, and 92,915 to COPD. 776 infant deaths were recorded due to smoking during pregnancy. Included in this number were 49,400 second-hand smoke related deaths due to lung cancer and heart disease.
Estimated number of years of potential life lost (YPLL) was 3.1 million years for men, and 2 million among women (CDC, 2008).
Smokers lose approximately one decade of life expectancy compared to individuals who do not smoke (Jha, Landsman, & Anderson, 2013).
Smoking and mortality among addicts

- More clients who come in for substance abuse treatment die from smoking tobacco than from the alcohol/drug use that brings them in (CSAT, 2010).

- 51% of deaths among 845 addiction treatment recipients were the result of tobacco-related causes in a retrospective cohort study. This rate is 1.5 times that of the general population (CSAT, 2010).

- Despite some of these clear indications from the literature, many programs still do not address tobacco use disorder among addictions clients (Fiore et al., 2008). Fiore et al. (2008) note that over the past 40 years clinicians have classically been disinclined to intervene consistently.

- Mee-Lee et al. (2013; a.k.a. New ASAM) emphasize this need as patients with tobacco use disorder are seen in a variety of settings, but recognition, assessment, and treatment is often cursory if not lacking.
Polling Question #3

Do you, or does your current place of work screen for, treat (include in problem list/treatment plan), or make referrals in regard to tobacco use disorder in the populations you work with?
Tobacco Use Disorder and Addiction
Tobacco Use Disorder in DSM-5

Listed in Section II under Substance Related and Addictive Disorders:

A. A problematic pattern of tobacco use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Tobacco is often taken in larger amounts or over a longer period than was intended.

2. There is a persistent desire or unsuccessful efforts to cut down or control tobacco use.

3. A great deal of time is spent in activities necessary to obtain or use tobacco (e.g. chain smoking).

4. Craving, or a strong desire or urge to use tobacco.

5. Recurrent tobacco use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated “smoke breaks” at work each day).

APA, 2013
Tobacco Use Disorder in DSM-5

6. Continued tobacco use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of tobacco (e.g., arguments with others about tobacco use).

7. Important social, occupational, or recreational activities are given up or reduced because of tobacco use (if I can’t smoke I’m not going, quit exercising due to cough).

8. Recurrent tobacco use in situations in which it is physically hazardous (e.g., smoking in bed).

9. Tobacco use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by tobacco.

10. Tolerance, as defined by either of the following:
   
   1. A need for markedly increased amounts of tobacco to achieve the desired effect
   
   2. A markedly diminished effect with continued use of the same amount of tobacco.

APA, 2013
Tobacco Use Disorder in DSM-5

11. Withdrawal, as manifested by either of the following:
   a. Daily use of tobacco for at least several weeks
   b. Abrupt cessation of tobacco use, or reduction in the amount of tobacco used, followed within 24 hours by four (or more) of the following signs of symptoms:
      i. Irritability, frustration, or anger.
      ii. Anxiety.
      iii. Difficulty concentrating.
      iv. Increased appetite.
      v. Restlessness.
      vi. Depressed mood.
      vii. Insomnia

APA, 2013
TUD = addictive behavior?

- Nicotine withdrawal symptoms are similar to those of other substances and to the symptoms of some behavioral health disorders (SAMHSA, 2010):
  - An intense craving for nicotine.
  - Tension, irritability, frustration.
  - Mild depression, reduced ability to experience pleasure (anhedonia), dysphoria.
  - Anxiety
  - Anger
  - Restlessness, difficulty concentrating.
  - Increased appetite
  - Not often discussed in this light because nicotine abuse is normalized in American culture much like alcohol.
TUD and Substance Abuse

- According to SAMHSA (2010), the National Survey of Drug Use and Health (NSDUH) in 2008 revealed that

- 75% of past year SA treatment patients at a specialty facility in the past year had smoked in the past month as compared to only 24% of the general population (ages 12+).

- Fifty-four percent (54%) of those ages 12 and older who abuse alcohol or report dependence reported smoking cigarettes in the past year.

- 63 percent of people ages 12 and older with any SUD (illicit drug and/or alcohol abuse or dependence) also reported tobacco use in the past month, compared with 28 percent of the general population.
Gamblers have high rates of tobacco use and there is a linear relationship between gambling severity and both smoking frequency and nicotine dependency. (Rodda et al. 2004)

New Zealand study showed 58% of problem gamblers were daily smokers versus 22% of non-problem gamblers. (Ministry of Health, 2006)

Gamblers who smoked daily gambled more days and spent more money than non-daily smokers. They craved gambling more and had lower perceived control over gambling. (Petry & Oricken, 2002)

41.6% of heavy gamblers are smokers versus 30.1% of recreation smokers and 21.3% of non-smokers. (Smith & Ferris, 1996)

62% of treatment seeking gamblers in Connecticut and 69% in Minnesota smoked as compared to 25% of general population. (Reuter et al., 1990)

Smoking is powerful reinforcement for the trance-inducing ritual associated with gambling. (Harper, 2003)

Compiled by National Council on Problem Gambling, February 2008,

**Some not in reference list**
Problem gamblers (PGs) that smoke show elevated severity of PG, use of alcohol/drugs while gambling, increased amount of money spent, nearly 2x more likely use of slots, and reasons for gambling that focus on reward and relief (McGrath, Barrett, Stewart, McGrath, 2012).

In one study, 45% of subjects with PG reported current daily tobacco smoking (gen. pop. = 24%). Gamblers with daily tobacco smoking had higher scores on SOGS, more severe PG-YBOCS behavior scores, endorsed more DSM-IV PG criteria, lost more money gambling, and were more likely to engage in non-strategic gambling (i.e. slot machines; Grant, Kim, Odlaug, & Potenza, 2008).

Gamblers with daily tobacco smoking and a current substance use disorder reported a greater percentage of income lost to gambling during the past year (Grant, Kim, Odlaug, & Potenza, 2008).
In another sample of PGs, daily tobacco use was reported in 63% of the sample. Tobacco users presented with more severe gambling and mental health problems at intake (Odlaug, Stinchfield, Golberstein, & Grant, 2013).

Odlaug et al. (2013) found that despite the more pronounced severity of gambling problems and mental health problems at intake, *tobacco users had similar rates of treatment completion and treatment outcomes as non-smokers.*

This underlines the importance of addressing TUD in addictions treatment as part of a greater focus on outcomes-driven treatment.
Recommendations for interventions
Polling Question #4

Are you and/or others in your agency trained in evidence based treatments or counseling techniques to address tobacco use disorder?
The New ASAM: Tobacco Use Disorder

- Mee-Lee et al. (2013) maintain that there is no level of “safe” consumption of tobacco products.
- Addiction professionals have not assumed leadership in the treatment of TUD – is often not entered in the problem list of treatment plan.
- Challenges the notion of a allowing time for a “smoke-break” for treatment groups, even on tobacco free campuses (Mee-Lee et al., 2013).
- Challenges the notion of counselors continuing to smoke while counseling addictions clients who also smoke, especially if the counselor smells of tobacco (Mee-Lee et al., 2013).
The New ASAM: Tobacco Use Disorder

- Expressly recommends against counselors smoking with clients during “smoke breaks” to “bond” with clients (Mee-Lee et al., 2013).

- Strongly recommends that treatment programs first provide tobacco-related interventions with staff before even attempting to treat clients for TUD. This is because staff that smoke who discuss smoking cessation with clients may not take it as seriously, and may also encounter more ambivalence toward change in clients due to the double message (Mee-Lee et al., 2013).

- Echoes the Tsoh et al. (2011) and Grant et al. (2008) findings that abstinence from tobacco is one of the greatest predictors of long-term recovery for substance abusers and problem gamblers. Tobacco use is one of the greatest predictors of relapse.
Polling question #5

Are you aware of evidence based nicotine replacement therapies, and research-informed counseling practices to intervene with tobacco users in addictions treatment?
Counselor challenges to addressing TUD

- Highest likely barrier: Acculturation in Americans to accept the use of tobacco products as “normal,” or innocuous.
- Treatment staff may smoke, which may give them mixed feelings about talking to clients who smoke about quitting.
- The counselor might buy into the myth that clients can try to address multiple substances in recovery, except for nicotine (“too stressful”).
- A program’s structure can hinder clients from quitting even when resources are available. For example, the program allows clients “smoke breaks” during group, or allows for staff to smoke during work hours in places that clients could see them.
- Few individuals have been trained on how to address TUD, and so may feel unequipped to provide assistance.
Treating TUD: Recommendations from U.S. DHHS


1. TUD is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments significantly increase likelihood of long-term abstinence.

2. It is essential that clinicians and health care delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a health care setting.

3. Brief TUD treatment is effective. Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective in this Guideline.

4. Individual, group, and telephone counseling are effective, and their effectiveness increases with treatment intensity.
Treat TUD: Recommendations from U.S. DHHS

5. Numerous effective medications are available for TUD, and clinicians should encourage their use by all patients attempting to quit smoking. Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates:

- Bupropion SR
- Nicotine gum
- Nicotine inhaler
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine patch
- Varenicline
6. Counseling and medication are effective when used by themselves for treating TUD. The combination of counseling and medication, however, is more effective than either alone.

7. Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, clinicians and health care delivery systems should both ensure patient access to quitlines and promote quitline use.
Quitlines and websites for all states

Supplement treatment with the ample resources that Quitlines can provide you (free phone coaching, NRT medications, and much more:

Iowa – [www.quitnow.net/iowa](http://www.quitnow.net/iowa)

Nebraska – [www.quitnow.net/nebraska](http://www.quitnow.net/nebraska)

Kansas - [www.quitnow.net/kansas](http://www.quitnow.net/kansas)

Missouri - [www.quitnow.net/missouri](http://www.quitnow.net/missouri)

Oklahoma - [www.quitnow.net/oklahoma](http://www.quitnow.net/oklahoma)
Treating TUD: Brief Interventions

- In Treating Tobacco Use and Dependence: 2008 Update (Fiore et al., 2008) make a strong recommendation for at least brief interventions with smokers that come in for treatment based on a large base of scholarly literature.

- Clinicians should provide a brief intervention each time a person comes in for a session based on a broad base of literature showing their effectiveness (Fiore et al, 2008). This is based on findings that tobacco users are not likely seek more intensive interventions.

- Fiore et al. (2008) recommend utilizing the 5 A’s for a brief intervention, which is presented in the following slides in a publication from the Public Health Service, U.S. DHHS.

- SAMHSA CSAT’s Technical Assistance Publication series 21 (TAP 21) also has counseling competencies that mirror the 5 A’s. This shows the similarities between treating substance abuse and tobacco use disorder.
SAMHSA CSAT’s TAP 21: Tobacco Use Disorder

- TAP 21 on substance abuse counseling competencies:
  - Competency 25 (Ask): Collect data from client such as biopsychosocial assessment, substance use, gambling, mental health, tobacco use screening tools.
  - Competency 24 (Advise): Establish rapport, resolve immediate crisis, determine need for additional professional assistance (Freedom from Smoking class, Quitline, etc.).
  - Competency 28 (Assess): Determine readiness to change (Assess)
  - Competency 27 (Assist): Assist client in identifying negative effects of tobacco use on current life problems (i.e. substance abuse, gambling, mental health), effects of continued use.
  - Competencies 31 and 32 (Arrange): Construct intervention plan with client based on their needs/goals, and based on this plan take specific steps necessary to initiate admission/referral and ensure followthrough.
Helping Smokers Quit
A Guide for Clinicians

National Quitline
1-800-QUIT NOW

U.S. Department of Health and Human Services
Public Health Service
Released May 2006

Even brief tobacco dependence treatment is effective and should be offered to every patient who uses tobacco.

PAVS Clinical Practice Guideline
Treating Tobacco Use and Dependence: 2008 Update

open for medication chart
Ask about tobacco use at every visit.

Implement a system in your clinic that ensures that tobacco-use status is obtained and recorded at every patient visit.
Advise all tobacco users to quit.

Use clear, strong, and personalized language. For example,

“Quitting tobacco is the most important thing you can do to protect your health.”
Assess readiness to quit.

Ask every tobacco user if he/she is willing to quit at this time.

- If willing to quit, provide resources and assistance (see Assist section).
- If unwilling to quit at this time, help motivate the patient:
  - Identify reasons to quit in a supportive manner.
  - Build patient’s confidence about quitting.
Assist tobacco users with a quit plan.

Assist the smoker to:
- Set a quit date, ideally within 2 weeks.
- Remove tobacco products from their environment.
- Get support from family, friends, and coworkers.
- Review past quit attempts—what helped, what led to relapse.
- Anticipate challenges, particularly during the critical first few weeks, including nicotine withdrawal.
- Identify reasons for quitting and benefits of quitting.

(more)
Give advice on successful quitting:
- Total abstinence is essential—not even a single puff.
- Drinking alcohol is strongly associated with relapse.
- Allowing others to smoke in the household hinders successful quitting.

Encourage use of medication:
- Recommend use of over-the-counter nicotine patch, gum, or lozenge; or give prescription for varenicline, bupropion SR, nicotine inhaler, or nasal spray, unless contraindicated.

Provide resources:
- Recommend toll free 1-800-QUIT NOW (784-8669), the national access number to State-based quitline services.

- Refer to Web sites for free materials:
  - Agency for Healthcare Research and Quality: www.ahrq.gov/path/tobacco.htm
  - U.S. Department of Health and Human Services: www.smokefree.gov
Schedule followup visits to review progress toward quitting.
If a relapse occurs, encourage repeat quit attempt.
¬ Review circumstances that caused relapse. Use relapse as a learning experience.
¬ Review medication use and problems.
¬ Refer to 1-800-QUIT NOW (784-8669).

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<thead>
<tr>
<th>Medication</th>
<th>Precautions/Contraindications</th>
<th>Side Effects</th>
<th>Dosage</th>
<th>Duration</th>
<th>Availability</th>
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<tbody>
<tr>
<td>Nicotine Patch</td>
<td></td>
<td>Local skin reaction</td>
<td>21 mg/24 hours</td>
<td>4 weeks then 2 weeks</td>
<td>Prescription and OTC</td>
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<td></td>
<td></td>
<td>Insomnia</td>
<td>14 mg/24 hours</td>
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<td>7 mg/24 hours</td>
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<td>Nicotine Gum</td>
<td></td>
<td>Mouth soreness</td>
<td>1-24 cigs/day-2mg gum (up to 24 pcs/day)</td>
<td>Up to 12 weeks</td>
<td>OTC ONLY</td>
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<tr>
<td></td>
<td></td>
<td>Dyspepsia</td>
<td>25+ cigs/day-4 mg gum (up to 24 pcs/day)</td>
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<tr>
<td>Nicotine Nasal Spray</td>
<td></td>
<td>Nasal irritation</td>
<td>8-40 doses/day</td>
<td>3-6 months</td>
<td>Prescription only</td>
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<tr>
<td>Nicotine Inhaler</td>
<td></td>
<td>Local irritation of mouth and throat</td>
<td>6-16 cartridges/day</td>
<td>Up to 6 months</td>
<td>Prescription only</td>
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<tr>
<td>Nicotine Lozenge</td>
<td></td>
<td>Local irritation of throat</td>
<td>First am cigarette after 30 minutes from waking: 2 mg (up to 20 pcs/day)</td>
<td>12 weeks</td>
<td>OTC ONLY</td>
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<td></td>
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<td>Hiccups</td>
<td>First am cigarette before 30 minutes from waking: 4 mg (up to 20 pcs/day)</td>
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<td>Heartburn/Indigestion</td>
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<td>Nausea</td>
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<td>Dry mouth</td>
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<tr>
<td>Bupropion SR</td>
<td>History of seizure</td>
<td>Insomnia</td>
<td>150 mg every morning for 3 days then 150 mg twice daily (Begin treatment 1-2 weeks pre-quit)</td>
<td>7-12 weeks</td>
<td>Prescription only</td>
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<td></td>
<td>History of eating disorder</td>
<td>Dry mouth</td>
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<td>Use of MAO inhibitors in past 14 days</td>
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<td></td>
<td>Monitor for changes in mood, behavior, psychiatric symptoms, and suicidal ideation</td>
<td>Nausea</td>
<td>0.5 mg once daily for days 5-7 before quit date</td>
<td>3 months,</td>
<td>Prescription only</td>
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<tr>
<td>Varenicline</td>
<td></td>
<td>Trouble sleeping</td>
<td>0.5 mg twice daily for days 1-4 before quit date</td>
<td>maintenance up to 6 months</td>
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<td></td>
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<td>1 mg twice daily starting on quit date</td>
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\*The information contained within this table is not comprehensive.\n
\*OTC refers to over the counter. Please see medication package inserts for additional information.
Treating TUD: Motivational Interviewing

- Most specific content, and highest level of support among motivational interventions.
- Several studies have shown that MI techniques appear to be effective in motivating smokers to make quit attempts.
- A randomized controlled trial of an MI-based intervention among 137 smokers with cancer found that MI significantly increased quit attempts compared to an advice condition (Wakefield, Olver, & Whitford, et al., 2004).
- One other study showed that two 45-minute individual counseling sessions based on MI principles yielded higher levels of intention to quit smoking among adolescents than did a brief advice condition (Brown et al., 2003).
Treating TUD: Motivational Interviewing

- Express empathy
  - Use Open Ended questions to explore
  - Use Reflective Listening to seek understanding
  - Normalize feelings/concerns (Many people are concerned about living life without smoking).

- Develop Discrepancy
  - Highlight the mismatch between current behavior and client’s values, goals, and priorities.
  - Reinforce/support change talk and commitment language
  - Build and deepen commitment to change

- Roll with Resistance
  - With something as culturally normalized as tobacco use in the U.S., it is going to be common for clients to feel ambivalent about quitting, and may reel back at interventions.

- Support self-efficacy
CK is a 63-year old woman with alcohol use disorder who has been in recovery for 8 years but continues to smoke three-fourths of a pack per day (15/day). She cannot stop tobacco use despite the recent diagnosis of adenocarcinoma of the esophagus. She uses the nicotine replacement therapy prescribed for her, but she continues to smoke on top of this. CK is upset by her diagnosis and stress with the possibility of facing her own mortality. CK tried SmokEnders several years ago but only quit smoking for 3 weeks. CK was depressed when her husband left her 10 years ago. However, she went to 12-Step meetings, became sober, and went back to work after outpatient counseling. CK never participated in formal addiction treatment, but she continues to attend 12-Step meetings 3x per week. She has no other significant past medical history.

1) What are your own internal reactions to this event (possible countertransference?)

2) Share any suggestions you have with the group on how to intervene.

(quoted verbatim from The New ASAM, Mee-Lee et al., 2013)
George and Matilda come to your office because they are upset that their 17-year-old son, TJ, is smoking cigarettes and hanging around with the “wrong” group of friends. Recently, TJ’s driving license was taken away for a Minor in Possession infraction. The police came to a party where there was underage drinking and “busted” him. TJ has been cutting some classes, but he will have no problem graduating high school this year. TJ has been experimenting with alcohol and marijuana, but his only clear regular usage is cigarettes. He is otherwise healthy and without concern. TJ doesn’t want to stop smoking, and he feels that his parents are overreacting. TJ states his underage drinking was an isolated event and that it was his friends who got rowdy.

1) What are your own internal reactions to this event (possible countertransference?)

2) Share any suggestions you have with the group on how to intervene.

(quoted verbatim from The New ASAM, Mee-Lee et al., 2013)
TH is a 50-year-old addiction counselor who works at a residential addiction treatment center. The center has decided that they are going to begin treating tobacco addiction along with all other addiction. The staff is not going to be able to smoke at all at work, and will not be allowed to come to work smelling of tobacco smoke. TH is in recovery from addiction to alcohol and pain medications. He has been sober for 23 years and always felt that tobacco was not part of his disease. He feels that he has extra rapport with patients since he goes out smoking with them on breaks. TH has often advised patients who wanted to stop smoking that they should wait at least a year before they even consider stopping, because “it is too hard to quit more than one thing at a time.” TH has been told by his doctor that his frequent bouts of bronchitis are directly related to his smoking, and that he needs to stop before he does permanent damage to his lungs. TH is about 40 lbs. overweight and fears that if he stops smoking, he will gain even more weight. He has never tried to quit, and is angry about his workplace forcing him to stop.

1) What are your own internal reactions to this event (possible countertransference?)

2) Share any suggestions you have with the group on how to intervene.

(quoted verbatim from The New ASAM, Mee-Lee et al., 2013)
Summary

- TUD presents a challenge to the addictions field as a significant health issue, but also a difficult problem to address. More of our clients die from tobacco related causes than from the addictions that bring them in for help.

- Addiction professionals are thereby admonished to take leadership roles in their communities to address TUD. TUD is the leading preventable cause of death in the U.S.

- TUD is more likely to co-occur with SUD and GD, which makes it this much more important to decrease the death-toll and years of potential life lost in addictions treatment populations.


- Motivational interviewing is an efficacious treatment modality that can assist counselors in facilitating change efforts for tobacco users.

- Overall, Quit Now hotlines and websites are available in all states and have invaluable resources for tobacco-cessation attempts in treatment populations.

- Treatment is effective, even at brief intervention levels (e.g. 5 A’s; see Fiore et al., 2008). Fiore et al. (2008) put power tools in the hand of the counselor to effect change in treatment populations.
Questions?
Thanks so much for your time!

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References and Readings


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