INTEGRATING
TOBACCO EDUCATION & TREATMENT
INTO SUBSTANCE USE TREATMENT

A Manual for Substance Use Treatment Providers
INTEGRATING TOBACCO EDUCATION & TREATMENT INTO SUBSTANCE USE TREATMENT

A Manual for Substance Use Treatment Providers

Developed by

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# Skills & Principles of Treating Nicotine Addiction

## User’s Guide

This user’s guide offers suggestions for getting the most out of the manual, and references the sections where you can find materials pertinent to the topics listed below. We hope this gives you a good starting place from which to become familiar with the manual, appendices and resources.

### Target Audiences

*### New staff orientation*

For all of these groups, start by reviewing the following chapters and/or sections of chapters:

- I, II-A 1, 4–6
- IV-A 2: Tobacco Guidelines
- IV-B

*### Boards of Directors* *

For clinicians/case managers, in addition to above:

- Chapters II-B; III, IV-D, and all Appendices.

*### Program managers*

*### Clinicians*

*### Case managers*

### Getting Started with Tobacco Education and Treatment Activities

#### Integrating tobacco issues into existing groups

Chapter II-A sections 4-6; IV-D section 6; Appendices, especially B

#### Planning an education group

Chapter IV-D 6; Appendix B; Appendix F, Tobacco Quiz

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Appendix G: Tobacco Quiz

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IV-A

IV-B

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Introduction

Background

Tobacco use was historically an accepted part of recovery culture both in substance use treatment programs and in Alcoholics Anonymous and Narcotics Anonymous meetings. Hazy blue smoke and overflowing ashtrays were ever-present. Smoking was generally seen as a bad habit but a necessary one, and clients were routinely counseled to take care of alcohol and other drugs first. It was assumed that quitting tobacco use too soon might jeopardize recovery and, over time, that people would quit naturally on their own, or not.

Since the mid-1980s, accumulating research and experience has begun to challenge these assumptions and beliefs. Research is showing that quitting smoking does not jeopardize recovery (Sees & Clark, 1993); that smokers also addicted to alcohol and opiates may be at increased risk of relapse if they continue to smoke (Stuyt, 1997); that the benefits of smoking cessation may extend to opiate addiction recovery as well (Frosch, Shoptaw, Nahom, & Jarvik, 2000); and that treatment for heroin, cocaine, or alcohol addiction might be more effective if it included concurrent treatment of tobacco addiction (Taylor, Harris, Singleton, Moolchan, & Heishman, 2000). In addition, a large morbidity and mortality study showed that “tobacco-related diseases are the leading cause of death in patients previously treated for alcoholism and/or other non-nicotine drug dependence” (Hurt et al., 1996, p. 1102).

In 1994, the Massachusetts Department of Public Health, Bureau of Substance Abuse Services (BSAS) began to address tobacco use and nicotine dependence within the substance use treatment delivery system through a new initiative. This initiative later became known as the Tobacco, Addictions, Policy and Education Project (TAPE Project) of the Institute for Health and Recovery. Basing its approach on the work of the New Jersey program, Addressing Tobacco in the Treatment and Prevention of Other Addictions (later the Tobacco Dependence Program), directed by the late Dr. John Slade, the TAPE Project targeted systems change and capacity-building through staff training and policy development and implementation.

The underlying objectives of the initiative have been to promote increased awareness of the importance of addressing nicotine dependence during substance use treatment, and to provide the technical assistance treatment programs need in order to begin incorporating smoke-free policies and interventions for nicotine dependence, including education, assessment, and treatment. In 2004, with the release of the BSAS Tobacco Guidelines, consistent policies and assessment, education, and treatment components are in place across all modalities, and the TAPE Project is assisting with implementation.
The Council to End Nicotine Addiction in Recovery (CENAR), also formed in 1994, is a provider group with representation from BSAS and the Department of Public Health's Massachusetts Tobacco Cessation and Prevention Program (MTCP). CENAR has served a vital role in advising the work of the TAPE Project and guiding BSAS tobacco policy initiatives. Members meet every other month to address nicotine addiction issues statewide as well as in their own programs.

The work of the TAPE Project has been supported by and linked with MTCP services. MTCP resources made it possible for substance use programs to refer staff and clients for help, through telephone counseling, a statewide network of treatment programs, and a website. The work of MTCP changed norms about tobacco use in Massachusetts through public education and anti-smoking media campaigns, and staff and clients in BSAS programs had their awareness and interest in quitting increased.

In 1999, a tobacco treatment specialist certification program was developed with the support of MTCP at the Center for Tobacco Prevention and Control, Division of Preventive and Behavioral Medicine, University of Massachusetts Medical School. Many BSAS treatment providers have taken the prerequisite course, “Basic Skills for Working with Smokers,” now an on-line course, and some have completed the certification process.

Among Massachusetts adults in the general population, current smoking rates are 16% (CDC, 2010). Informal surveys in Massachusetts treatment programs, across modalities, indicate that rates of smoking among clients entering treatment can be as much as four to five times higher. In Massachusetts, 77% of adult smokers want to quit completely, and 61% tried to quit smoking at least once in the past year (Massachusetts Department of Public Health, 2010). While these numbers may not be representative of clients in early recovery, they do increase as people remain clean and sober. Tobacco addiction is now viewed as a chronic and treatable condition, characterized by relapse, for which effective treatments are available, including pharmacotherapy, counseling, and social support.

**Philosophy, Description, and Use of the Manual**

This manual has been a joint endeavor among the Bureau of Substance Abuse Services, the Institute for Health and Recovery and the Center for Tobacco Prevention and Control, Division of Preventive and Behavioral Medicine, University of Massachusetts Medical School, funded through the Massachusetts Department of Public Health. The philosophy and principles of the manual encompass the following points:

- In providing holistic treatment to clients with substance use disorders, include tobacco/nicotine issues as part of treatment planning
• Addictions counseling skills already in use can be applied to helping clients achieve and maintain recovery from nicotine addiction

• Breaking the silence on tobacco dependence plants the seed for future quit attempts

• Change is possible and incremental

• Any step forward is a cause for celebration

This manual will be helpful in setting up and enhancing comprehensive services for nicotine addiction treatment and recovery. Comprehensive services encompass clinical skills for treating tobacco but also include a focus on the following areas:

• Review of the challenges to addressing tobacco use, and the rationale for doing so

• Creating and implementing program policies

• Roles of administration, boards of directors, and clinical staff

• Special health issues for substance abusing clients

• Creation of office systems and practices which institutionalize tobacco treatment

• Modality-based suggestions for integrating tobacco education, assessment, and treatment

Included in this manual are suggested discussion topics for staff meetings as well as handouts and exercises that can form the basis for a client group. Feel free to make copies of the handouts and worksheets and distribute them. Begin by ensuring staff review and discussion, because staff buy-in is key to integrating nicotine dependence treatment.

The Challenge

In 1994 one of the founding members of CENAR, the director of a men's residential program, described how the only staff turnover he had in his program was due to lung cancer. This is a sobering reality for those of us who work in the alcoholism/addictions treatment field: we have seen many of our colleagues and former clients recover from alcohol and other drug use and live dynamic lives dedicated to service, helping others, and making a difference, only to die from tobacco-caused illnesses. This substance, overlooked for so long, has had a devastating impact on our field. But it is also a chronic, treatable addiction that is complex and characterized by relapse. We know how to treat addiction. Our field has always offered hope, help, understanding and resources to those suffering with drug dependencies.
Many substance use treatment programs are now see treating nicotine dependence as part of that mission.

In sixteen years, the treatment system has changed: most sites are smoke-free; programs have integrated tobacco education, assessment, and treatment; and many staff and clients have addressed their tobacco addiction and quit smoking. People are more open to examining the role of tobacco in their lives and its impact on treatment.

This manual is designed to help all programs become familiar with the options and opportunities for treating nicotine dependence, and provide assistance for organizational movement forward on the Stages of Change. It is our hope that Skills & Principles of Treating Nicotine Addiction will contribute to more discussion and greater awareness, and that the included resources and materials will be helpful to substance use treatment providers.
I. Addressing Nicotine Addiction in Recovery

*Breaking the Silence on Tobacco, or Why Bother?*

Addressing tobacco during treatment for substance use is a concept that is not new: in the early 1900’s, private programs were opened that advertised treatment for alcohol, opium and tobacco. However, with the advent of Alcoholics Anonymous, and other 12 step recovery programs, and the establishment of alcoholism and addiction treatment in the United States in the mid-twentieth century, tobacco was rarely included as a substance to be addressed. The silence on tobacco use—cigarettes, cigars, pipes, chewing tobacco and snuff—has been pervasive.

Approximately 20% of the general population in the United States today smokes cigarettes (CDC, 2011). Among people with histories of substance use, that figure is much higher: estimates range up to 80%. A 2000 survey of Massachusetts Department of Public Health, Bureau of Substance Abuse Services (BSAS) funded programs (n=205 returned surveys) listed system-wide, program-reported averages of smokers as 63% of clients and 26% of staff, although there were wide ranges over modalities. Most acute care and residential rehabilitation staff estimate the percentage of clients who smoke to be between 74% and 86% (Institute for Health and Recovery, 2000).

The high numbers affected by nicotine dependence in the substance use treatment field—staff, clients and their families—compel us to break the silence on tobacco and the resultant costs to health and parallel addiction issues. A 1996 study by Richard Hurt and colleagues at the Mayo Clinic found that alcoholics and individuals addicted to drugs are more likely to die from tobacco-caused illnesses than alcohol or drug-related health complications (Hurt et al., 1996). Other studies have found that treating nicotine dependence had a positive impact on recovery and that continuing to smoke cigarettes may be a relapse trigger (Prochaska, Delucchi, & Hall, 2004).

In Massachusetts, and across the country, there has been a shift in cultural norms about smoking. Changes in workplace policy have called attention to the dangers of exposure to the 7,000 chemicals in environmental tobacco smoke (ETS) and moved smokers outdoors. Smokers are beginning to feel under attack and like “second class citizens” as norms change on the acceptability of smoking. More information has become available on health effects and tobacco-caused illnesses, as well as on the misinformation campaigns and cover-ups by the tobacco companies.

For substance use treatment counselors in BSAS services, some of whom are smokers themselves, addressing nicotine dependence and developing smoke-free and tobacco-free facilities may be new and threatening concepts. To some, a focus on tobacco will seem beside the point.
This manual seeks to reach out and invite staff, administrators and clients alike to increase their awareness and understanding of the issues. Tobacco use impacts all of us, and we have all known colleagues and former clients who have lived sober and drug-free, only to die from the consequences of preventable tobacco-caused illnesses. In fact, the founders of Alcoholics Anonymous, Bill W. and Dr. Bob, died prematurely from illnesses caused by their smoking.

As professionals who are committed to improving the health and recovery of our clients, we must begin to break the silence around tobacco use. As experts in treating addictions, we already have many of the skills needed to effectively address nicotine addiction. This manual will build on your existing expertise and give you the additional information you need to begin integrating nicotine dependence treatment into your program and your work with clients.

The following chart looks at the historical thinking in the addictions treatment field regarding the inclusion of nicotine addiction and contrasts it with more current thinking and knowledge.
### Table 1. Historical Thinking/New Ideas

<table>
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| Smoking should be dealt with last because it will jeopardize sobriety. | • Studies show quitting is beneficial and, in fact, continuing to smoke can be a relapse trigger especially in clients who drank alcohol and who smoked their drugs.  
• Smokers may continue characteristic drug-seeking behaviors, such as lying about and hiding tobacco use and organizing their activities around smoking.  
• Tobacco is used to cope with feelings but, in fact, masks them. |
| We can’t ask them to give up everything at once! | • There are positive gains to becoming nicotine-free: increased self-esteem, better health, sense of freedom, money saved.  
• Through education and discussion, we can help plant the seed for future quit attempts and help clients move closer to making the decision to stop.  
• We can ask clients to consider “giving up” something that adversely affects their health and the health of those around them. |
| Tobacco use doesn’t have the same social and personal consequences as other addictions. | • Nicotine addiction does have acute consequences: loss of stamina, sense of smell and taste, clean air, money, health, time.  
• Smoking is lethal. It severely limits quality of life prior to premature death, e.g., shortness of breath, increased risk of bronchitis, angina, emphysema, frequent illness, and hospitalizations.  
• Smokers are separated from society in worksites and public places: there are fewer and fewer places to smoke. |
| Clients in treatment for substance use do not want to hear about nicotine addiction. | • 70% of smokers nationally say they want to quit  
• Studies have shown that clients are willing to receive treatment for tobacco cessation while in substance use treatment programs.  
• In most studies, smoking cessation among active alcoholics/addicts is rare. However, smoking cessation among recovering alcoholics appears to happen quite often. |
| We have other life-threatening issues to prioritize. | • For pregnant and parenting women and their children, people with HIV/AIDS and Hepatitis C Virus, and men and women with chronic health problems such as heart and respiratory illnesses, tobacco use and exposure to secondhand smoke is hazardous. Quitting smoking can improve health and well-being.  
• Newly clean and sober people are often interested in making a variety of healthy life-style changes. Involvement in a supportive treatment atmosphere allows them to try. |
| No major changes in the first year of recovery. | • Clients who want to stop smoking when newly sober may need extra support and monitoring, but research shows quitting smoking improves recovery outcomes.  
• Counselors’ unresolved feelings about smoking may be discouraging clients from attempting to quit. |

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1 Information included in the “Historical Thinking/New Ideas” section is drawn from the Centers for Disease Control and Prevention.
2. Why Bother?

This list of reasons to address tobacco use was developed through the work of Dr. John Slade of the Addressing Tobacco Project in New Jersey, and through suggestions from BSAS programs:

- Treating nicotine dependence saves lives
- Many clients/consumers want to deal with it
- Tobacco smoke harms non-smokers
- Tobacco use is often a trigger for drug or alcohol use
- Avoiding nicotine addiction is inconsistent with the mission of addictions treatment programs
- A growing number of clients come into addictions treatment as non-smokers
- A substance use treatment setting may offer the only professional support and treatment which clients may receive to stop smoking
- Adolescent treatment programs and programs serving pregnant women and children have special responsibilities
- The increasing cost of cigarettes takes away from clients who have few financial resources
- The treatment process is affected: clients are less available for group and individual therapy when they are in nicotine withdrawal because they are focused on having that next cigarette

As part of staff discussions, brainstorm your own list of reasons for addressing tobacco. Your list can identify the degree of staff concern, offer guiding principles and establish staff commitment. Addressing tobacco and integrating nicotine addiction issues into treatment can be a difficult journey, and it helps to have a list which can remind staff why this is important when progress does not happen easily.
II. Tobacco 101: Overview of Health Issues

A. Public Health Concerns

Extensive research has been conducted on the treatment of nicotine dependence, and numerous models for treating nicotine dependence have been developed. Research and experience have shown that healthcare settings offer an excellent opportunity for intervention and that intervention should be conducted as often as possible (Fiore et al., 2008). This includes substance use treatment programs. Substance use clinicians can have an important role in helping their clients to think about quitting or actually quit smoking. A basic understanding of what a cigarette is and how it affects the body is an important foundation for clinicians to have.

Information about the health consequences of tobacco is not always what motivates people to stop smoking. Many smokers are aware of the harmful effects and “tune out” information about smoking and disease. However, health consequences are a concern for many. Understanding the health benefits of stopping is equally important. In fact, emphasizing the health benefits of quitting is far more likely to motivate lasting change than using health consequences to scare people into stopping. Nonetheless, it is important for smokers and those trying to help them to understand how cigarettes damage the body.

The bottom line is that the body was not designed to take in the heat, smoke, tars, chemicals and nicotine that are found in cigarettes and other tobacco products. The remainder of this section will explore in more detail the composition of cigarettes and the impact that smoking has on the human body.

1. Anatomy of Tobacco/Cigarettes

What are tars?

Tars, major components of cigarette smoke, contain sticky brown residues that stain fingers and teeth. Tars also contain benzopyrene, a deadly carcinogen.

What is nicotine?

Nicotine is the psychoactive ingredient (chemical compound) in tobacco which makes tobacco addictive. Nicotine does not cause cancer, but it increases heart rate, blood pressure, and metabolic rate. Like cocaine, it constricts blood vessels (vasoconstriction), interfering with blood moving through the body and, in pregnant women, to the fetus.
What is tobacco?

Tobacco is a plant which contains the addictive, psychoactive chemical nicotine. When dried tobacco is smoked or chewed, the nicotine causes a pleasurable change in the human brain by releasing the brain chemical dopamine.

In addition to nicotine, tobacco contains many harmful chemicals and additives that are used in the farming and processing of the tobacco plant. Tobacco is soaked in pesticides, and shriveled and desiccated in drying barns. At the factory, during processing into cigarettes, snuff, and chewing tobacco, it is pulverized, mixed with seeds, stems and scraps, saturated with secret coloring and flavoring chemicals. For example, ammonia is added because tobacco company research showed it releases more nicotine to the smoker.

What else is in a cigarette?

Smoking by-products include smoke and heat, tars, carbon monoxide, additives and nicotine.

Filters are made of cellulose, paper, plastic and glue and were added in the 1950’s to make cigarettes seem safer. Some of the first filters contained asbestos. Research has shown that filters do almost nothing to reduce danger.

When it is burned, the smoke from tobacco releases many more chemicals, 69 of which are known to cause cancer and other health problems in humans. Over 7,000 chemical compounds are found in tobacco smoke, including the following:

- Ammonia (found in floor cleaner)
- Formaldehyde (used in preservation of body tissue)
- Arsenic (used in rat poison)
- Butane (a common lighter fluid)
- Cadmium (found in batteries)
- Hydrogen cyanide (used as a gas chamber poison)
- Carbon monoxide (component of car exhaust)

2. Smokeless Tobacco

Smokeless tobacco (also known as spit tobacco, dip, snuff, chew, chewing tobacco and snus) is not a safe alternative to cigarette smoking. Smokeless or spit tobacco

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2 Information included in the “Smokeless Tobacco” section is drawn from Mayo Clinic (2009) and Campaign for Tobacco-Free Kids (n.d.). See also: National Spit Tobacco Education Program (www.nstep.org); National Cancer Institute, Dept. of Cancer Control and Population Science, Tobacco Control Research (dccps.nci.nih.gov/tcrb/less_effects.html); American Cancer Society (www.cancer.org); Centers for Disease Control and Prevention (www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/smokeless_tobacco.htm); National Institute of Dental and Craniofacial Research (www.nidcr.nih.gov); American Academy of Family Physicians (familydoctor.org).
commonly comes in two different forms: moist snuff and chewing tobacco. Snuff, a fine grain tobacco, comes in cans or pouches. Users take a pinch, dip, or quid, and place it between the lower lip or cheek and gum and suck on it. Some people prefer to sniff it. Chewing tobacco comes in pouches in the form of long strands of tobacco that, when used, are commonly called “plugs,” “wads,” or “chew.” It is also available in small pouches that you can place between the cheek and gum. This gives the user a continuous high from the nicotine. Snus (pronounced “snoose”) is a moist powder tobacco product derived from a variant of dry snuff that does not result in the need for spitting. It is consumed by placing it under the lip for extended periods of time.

The most serious health effect of smokeless tobacco is an increased risk of cancer of the mouth and pharynx (throat). These cancers occur several times more often among snuff dippers compared with non-tobacco users. Smokeless tobacco users are 50 times more likely than non-users to contract cancers of the cheek, gums and inner surface of the lips. Smokeless tobacco users risk oral cancer every time they use. Smokeless tobacco can also cause other types of cancers. Ingredients in smokeless tobacco juice can induce cancers of the esophagus, larynx, stomach, pancreas and prostate.

Other harmful health effects of chewing tobacco, snuff and snus include:

- Addiction to nicotine
- Leukoplakia (white sores in the mouth that can lead to cancer)
- Gum recession (peeling back of gums)
- Bone loss around the teeth
- Abrasion of teeth
- Staining of teeth
- Bad breath

Leukoplakia is a white sore or patch in the mouth that can become cancerous. Studies have consistently found high rates of leukoplakia at the place in the mouth where users place the “chew.” One study found that almost 75% of daily users of moist snuff and chewing tobacco had non-cancerous or pre-cancerous lesions (sores) in the mouth (Severson, 1997; Mecklenburg et al., 2000). The longer a person uses smokeless tobacco, the more likely it is that he or she will have leukoplakia. Many regular spit tobacco users have gum recession and bone loss around the teeth. The surface of the tooth root may be exposed where gums have drawn back. Tobacco can irritate or destroy the tissue.

A person who uses eight to ten dips or chews a day receives the same amount of nicotine as a heavy smoker who smokes 30 to 40 cigarettes a day. The amount of nicotine in one dip, or chew, of spit tobacco can deliver up to 5 times the amount found in one cigarette. For example, a 30-minute chew gives the same amount of nicotine as three cigarettes and a two-can per week snuff dipper delivers the same nicotine as a 1½ pack-a-day cigarette habit.

Smokeless tobacco is made from a mixture of tobacco, nicotine, sweeteners, abrasives, salts and chemicals. It contains over 3,000 chemicals including about 28 known carcinogens (cancer-causing substances). These include formaldehyde,
nickel, polonium-210 and nitrosamines. Dip, or moist snuff, has the highest levels of nitrosamines—up to 100 times the level lawfully permitted in regulated products like bacon or beer. Spit tobacco contains high concentrations of salt, which contributes to high blood pressure. Some of the harmful chemicals in spit tobacco are:

- Polonium 210 (a radioactive element)
- Tobacco-specific N-nitrosamines or TSNAs (cancer-causing agents only found in tobacco)
- Formaldehyde
- Nicotine
- Cadmium
- Cyanide
- Arsenic
- Benzene
- Lead

An individual addicted to smokeless tobacco will suffer withdrawal when he or she tries to quit using because smokeless tobacco contains nicotine. Nicotine is highly addictive, which means that smokeless tobacco users quickly find themselves physically and psychologically dependent on the drug. The user will experience stress, irritability, sleep problems, cravings, appetite increase and stomach and intestinal disorders.

Prior to quitting completely, the National Spit Tobacco Education Program recommends tapering down use. While some people are able to quit smokeless tobacco “cold turkey,” others find that cutting back in their spit tobacco use and changing some aspects of their behavior and lifestyle makes it easier. In the week or two before your quit date, consider:

- Switching to a lower nicotine content brand of smokeless tobacco
- Taking only half the amount of smokeless tobacco you normally consume with every dip
- Systematically reducing the number of dips you take per day
- Noticing where and when you dip the most
- Finding other things to do at those places and during those times
- Using oral substitutes like sunflower seeds or sugarless gums or hard candies to get you through cravings

All of the suggestions for treating tobacco dependence found in this manual apply to quitting “dip” and smokeless tobacco. While the FDA has not specifically approved nicotine replacement products or Bupropion (Zyban) for quitting smokeless tobacco, nicotine replacement therapy (NRT) may be helpful in reducing withdrawal and cravings. Nicotine gum and lozenges can provide an oral substitute for chew and snuff, and also allow the user to control the dosage to help with cravings.
Remember: smokeless tobacco is not a safe product or a safe alternative to smoking. Smokers trying to quit cigarettes or cigars should not switch to other tobacco products as part of a quitting process.

3. The Use of Tobacco Can Cause or Exacerbate the Following Serious Health Effects

Cardiovascular (heart and blood vessel) diseases

- Including heart attacks, narrowing and hardening of the arteries, abnormal blood lipid (fat) levels, and high blood pressure.
- Including coronary heart disease, peripheral vascular disease, and abdominal aortic aneurysm, a weakening and ballooning of the major artery near the stomach.

Stroke

- Tobacco use increases blood pressure and causes hardening of the arteries, including those supplying blood to the brain. Smoking increases the risk of strokes.

Cancers

- Smoking causes cancer in organs throughout the body.
- Smoking causes cancers of the lung, bladder, mouth, lip, throat, pancreas, stomach, kidney and cervix. Using both cigarettes and alcohol causes most cases of larynx (voice box) cancer.
- Smoking causes acute myeloid leukemia, which is a cancer of the blood.
- Lung cancer is the leading cause of cancer deaths, and smoking causes 90% of all lung cancer deaths in men and 80% in women.

Respiratory diseases

- Smoking damages lung tissue, making breathing increasingly difficult.
- Chronic obstructive pulmonary disease (COPD) is the fourth leading cause of death in the U.S. Smoking causes more than 90% of these deaths. COPD encompasses both chronic bronchitis and emphysema. Emphysema is an

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3 Information included in the “The Use of Tobacco Can Cause or Exacerbate the Following Serious Health Effects” section was also drawn from Napier (1995).
advanced stage of this damage, which results in the person being unable to take in enough air.

- Smoking aggravates and worsens asthma and increases risk for pneumonia (Surgeon General, 2004).

**Hepatitis C Virus (HCV)**

- HCV is more aggressive in patients who smoke. Hepatitis C is a risk factor for developing a cancer called HCC (hepatocellular carcinoma). There is evidence that smoking may increase the risk for progression to HCC in hepatitis C patients (Tzonou, Trichopoulous, Kaklamani, Zavitsanos, & Hsieh, 1991).

- People with HCV should avoid drinking alcohol and smoking cigarettes as this can cause further damage to the liver. Researchers looked at levels of ALT, a liver enzyme, to evaluate liver damage caused by alcohol consumption and cigarette smoking in nearly 7,000 people ages 35 and over in an area with high prevalence rates of HCV and hepatitis B virus (HBV). People with HCV who drank alcohol were twice as likely to have increased ALT levels, and smoking almost doubled this risk. People with HCV who smoked 20 or more cigarettes a day and frequently drank alcohol were seven times more likely to have elevated ALT levels. The same impact of drinking and smoking was not found on the ALT levels in people with HBV (Wang, Wang, Chang, Yao, & Chou, 2002).

- Heavy smokers diagnosed with HCV face a significantly greater risk of developing a form of cancer known as non-Hodgkin's lymphoma (NHL). While smoking by itself isn't necessarily thought to be a major risk factor for NHL, smokers with HCV face about four times the risk (Talamini et al., 2005).

**Other health effects**

- Smoking reduces blood flow to the gums. Smoking causes half of all cases of adult periodontitis, a serious gum infection that can cause pain and tooth loss. Smokers are more likely to lose teeth and take longer to heal after oral surgical procedures.

- For men, smoking may cause sexual problems such as erectile dysfunction (impotence).

- Smoking increases the risk of peptic ulcers (Surgeon General, 2004).
4. Electronic Cigarettes

Electronic cigarettes, also known as “e-cigarettes,” are battery-operated devices that look very much like regular cigarettes, but do not contain tobacco. Rather, each e-cigarette contains a cartridge filled with liquid nicotine, flavor and other chemicals which are converted into a vapor when the user inhales through the mouth-piece. When the cartridge is empty, it is replaced or refilled from a bottle of liquid nicotine that is sold in a variety of strengths and flavors. Electronic cigarettes are available for sale at shopping mall kiosks, tobacco retailers and over the Internet.

Because these products have not been submitted to the U.S. Food and Drug Administration (FDA) for evaluation or approval, there is no way of knowing the exact levels of nicotine or the amounts or kinds of other chemicals that the various brands of e-cigarettes deliver to the user. A small sample of cartridges tested by the FDA labs detected carcinogens, including nitrosamines and toxic chemicals (including diethylene glycol, a toxic chemical found in antifreeze) to which users could be exposed.

Information included in the “Electronic Cigarettes” section was drawn from FDA (2009a).
5. Special Issues for People with Substance Use Disorders

Tobacco is the leading cause of death

- In a 10-year retrospective study, the leading cause of death among graduates from a large inpatient substance use treatment center was tobacco-related diseases. The authors stated that nicotine dependence treatment is vital in this high-risk group. Tobacco-related illnesses caused death more frequently than alcohol-related causes: 51% vs. 34% (Hurt et al., 1996).
- Among individuals treated for narcotics, the death rate of smokers was four times that of non-smokers (Hser et al., 1994).

The combination of smoking and alcohol causes a greater risk for health problems than is caused by each one alone

- The risk for developing mouth and throat cancer is 38 times greater for those who use both tobacco and alcohol, compared to rates for non-smoking nondrinkers (Blot, 1992).
- Pancreatitis and cirrhosis are caused by severe alcohol use and are made worse by the use of tobacco. Pancreatitis is increased ten-fold among alcoholics who smoke compared to those who do not. Cirrhosis is three times more common among alcoholics who smoke (Pitchumoni, Jain, Lowenfels, & DiMagno, 1988; Klatsky & Armstrong, 1992).
- Smoking interferes with the ability of the brain to recover from chronic alcohol abuse (Meyerhoff, 2006).
- Cigarette smoking exacerbates alcohol-induced brain damage (Durazzo et al., 2004).

Smoking: a recovery issue

- Smoking cessation is indicated for substance dependent persons already in recovery and may protect against relapse to the illicit drug of choice (Sullivan & Covey, 2002).
- Alcoholics who stop smoking during early recovery are more likely to maintain long-term abstinence from drinking (Shiffman & Balabanis, 1996).
- Smokers relapsed to alcohol and illicit drugs more often, more frequently and sooner than did non-smokers (Sees & Clark, 1993).
- There is anecdotal evidence that people with histories of smoking drugs (crack, marijuana) may be continually triggered and cued to relapse to drug
use by the similarities to cigarette smoking rituals and associations (Sees & Clark, 1993).

- Non-tobacco users maintain longer periods of sobriety after inpatient treatment for alcohol/drug dependence than tobacco users (Stuyt, 1997).

- Smoking status (non-smoker, chipper, heavy smoker) proved a more powerful predictor of cocaine and opiate use than daily methadone dose. Findings lend support to existing evidence suggesting associations between tobacco, opiate and cocaine use and strongly suggest that smoking cessation should be offered to all methadone-maintained clients (Frosch et al., 2000).

- Participation in smoking cessation efforts while engaged in other substance abuse treatment has been associated with a 25% greater likelihood of long-term abstinence from alcohol and other drugs (Prochaska et al., 2004).

6. Tobacco Use and Women’s Health

Tobacco use can cause women-specific health problems, including:

- Higher risks of lung cancer for women as compared to men, after fewer cigarettes and with fewer years of smoking
- Reduced fertility; more difficulty becoming pregnant
- Lower hormone levels, particularly estrogen
- Women who smoke and use birth control pills are more likely to have a heart attack or a stroke, and birth control pills are less effective in smokers
- Early onset of menopause and increased symptoms
- Osteoporosis: loss of bone density and bone mass
- Cervical cancer

Smoking and pregnancy

- Greater risk for miscarriage, stillbirth, and premature birth
- Other complications of pregnancy including placenta previa and abruption of the placenta
- Higher rates of infant deaths

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5 Information included in the “Tobacco Use and Women’s Health” section was drawn from Campaign for Tobacco Free Kids (n.d.) and from SmokefreeWomen.gov (n.d.).
- Babies born to mothers who smoke are at greater risk for low birth weight, a leading cause of infant deaths.
- Other conditions related to prenatal tobacco exposure in children: lower IQ, attention deficit disorder and decreased head circumference.

7. Secondhand Smoke\(^6\)

What is secondhand smoke?

- Secondhand smoke is composed of side-stream smoke (the smoke released from the burning end of a cigarette) and exhaled mainstream smoke (the smoke exhaled by the smoker).
- According to the Office of the Surgeon General, although secondhand smoke has been referred to as "environmental tobacco" smoke (ETS) in the past, the term "secondhand" smoke better captures the involuntary nature of the exposure (since most non-smokers do not want to breathe tobacco smoke).
- Cigarette smoke contains more than 7,000 chemicals of which at least 250 chemicals are known to be toxic or carcinogenic.
- Secondhand smoke contains many of the same chemicals that are present in the smoke inhaled by smokers.

There is no risk-free level of exposure to secondhand smoke.

- The Surgeon General has concluded that breathing even small amounts of secondhand smoke exposure can be harmful to people’s health.
- Secondhand smoke causes lung cancer in non-smokers.
- Secondhand smoke causes heart disease in non-smokers. Breathing it for even a short time can have immediate serious effects on the cardiovascular system, interfering with the normal functioning of the heart, blood, and vascular systems in ways that increase the risk of heart attack.
- Secondhand smoke causes acute respiratory effects in non-smokers. It can quickly irritate and damage the lining of the airways and trigger coughing, wheezing, breathlessness, and phlegm production.
- Infants exposed to secondhand smoke are at greater risk for sudden infant death syndrome (SIDS).

\(^6\) Information in the "Secondhand Smoke" section was drawn from Surgeon General (2010).
Children and infants exposed to secondhand smoke are at greater risk for developing ear infections, colds, pneumonia, bronchitis, and impaired lung functioning.

Brief exposure can trigger an asthma attack in children with asthma.

B. The Benefits of Quitting

Continued smoking or tobacco use during recovery from alcohol and drug use requires that people maintain some of their "addictive behaviors." Many people reach for a substance and all the rituals involved with its use when they have strong emotions or stressful situations to deal with. They continue to believe that the answers to their problems lie outside themselves. They may need to maintain addictive behaviors such as: hiding their tobacco use, planning their tobacco use, making excuses for their tobacco use, defending their tobacco use and/or feeling guilty or ashamed about their tobacco use.

All of these may affect people’s emotions and may put them at higher risk for relapse to alcohol or other drug use.

1. Enhanced Quality of Recovery

As treatment professionals, we are concerned about our clients’ overall well-being. Stopping smoking not only improves health, but also enhances the quality of recovery. For many, smoking is used to cope with or mask difficult feelings. When we help our clients stop smoking, we are also helping them develop a wide range of coping strategies that will help them in all areas of their lives.

2. Improved Health

The health benefits of stopping nicotine use are immediate, and keep improving the longer one abstains from using nicotine. People in recovery begin to notice and take steps to improve their health, often for the first time in their lives. Often smokers, especially those who have been smoking for a number of years, feel that the damage to their health has already been done and that, therefore, there are no health benefits to quitting. While it’s true that some smoking-related damage may be permanent, once someone stops smoking, the body shows an amazing capacity for regeneration. Many of the health benefits of quitting quickly follow and the effects are felt immediately.
3. Changes and Benefits after Quitting

Wondering what changes to expect once you quit? The following is a brief timeline illustrating some of those positive changes.

Immediately after quitting:

- The carbon monoxide level in blood declines.
- Sense of taste and smell improve.
- Oral health improves.
- The effects of nicotine on pulse rate and blood pressure are eliminated within 20 minutes of the last cigarette.

20 minutes after quitting:

- The body begins a series of changes that continue for years.
- Blood pressure drops to a level close to that before the last cigarette.
- Temperature of hands and feet increases to normal.

8 hours after quitting:

- Carbon monoxide level in blood drops to normal.

24 hours after quitting:

- Chance of heart attack decreases (Surgeon General, 1988).

2 weeks to 3 months after quitting:

- Circulation improves.
- Lung function increases up to 30%.

1 to 9 months after quitting:

- Coughing, sinus congestion, fatigue, and shortness of breath decrease.
- Cilia regain normal function in lungs, increasing ability to handle mucus, clean the lungs, and reduce infection (Surgeon General, 1990).

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7 Information in the “Changes and Benefits after Quitting” section was also drawn from Arkansas Department of Health, the American Stroke Association, and the American Heart Association.
2 years after quitting:

- The risk of heart attack is cut in half (Stratton, Shetty, Wallace, & Bondurant, 2001).

5 years after quitting:

- After 5–15 years, the risk of stroke is that of a non-smoker (Stratton et al., 2001).

10 years after quitting:

- The risk of coronary heart disease is that of a non-smoker.
- Risk of cancer of the mouth, throat, esophagus, bladder, kidneys and pancreas decreases (Surgeon General, 1990).

20 years after quitting:

- The risk of lung cancer remains only slightly above non-smokers (Stratton et al., 2001).

Other benefits of quitting:

*Fitness level increases*

You will notice that you have more energy. You can climb that flight of stairs without feeling short of breath. As your fitness level increases, you will also suffer fewer colds, flus, coughs, and other respiratory infections.

*Saving money*

It is said that stopping drinking or using drugs is the biggest pay raise one can give to oneself. The second biggest is to stop using tobacco. (See Appendices, Section G, for a chart on the cost of smoking.)

*Hygiene*

Appearance and hygiene become more important to people in recovery. Increased oxygen circulating in the blood gives the non-smoker a healthy glow, and reduces the premature skin wrinkling which occurs in smokers. Clothes, hair, skin, and breath will smell better. Teeth and fingers will not have yellow and brown stains (See Appendices, Section G, for handouts on the benefits of treating nicotine addiction).
III. Overview of Nicotine Addiction & Treatment

A. Nicotine is an Addictive Substance

Nicotine is the active ingredient in tobacco. It is the component that produces the desired effects of smoking (or dipping and chewing) and is also the substance in tobacco that has been proven to be physically addictive.

In fact it appears, from research on the physiology of addiction, that nicotine affects the brain in ways that are basically the same as other substances of abuse: opiates, cocaine, alcohol, and marijuana. All of them increase the level of dopamine, a chemical in the brain that transmits signals to the parts of the brain that affect mood, sense of well-being and satisfaction. This is the same system that is targeted by antidepressant medication.

A 1988 report of the U.S. Surgeon General stated that cigarettes and other forms of tobacco are addicting, that nicotine is the drug in tobacco that causes addiction, and that the pharmacologic and behavioral processes that determine tobacco addiction are similar to those that determine addiction to other drugs, such as heroin and cocaine.

As substance use treatment professionals, we know the characteristics of addiction, but we may not think of tobacco use in the same way that we think of other mood-altering chemicals. Four of the criteria of substance dependence as described in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) include: tolerance (the need to increase the dose to get the desired effect, as well as not feeling some of the negative aspects of use because the body has become accustomed to the substance); withdrawal symptoms and the use of the substance to relieve them; unsuccessful attempts or persistent desire to cut down or stop using the substance; and continued use of the substance despite knowing that it is causing harm.

We also think about preoccupation with using the substance; denial rationalization, minimizing, defensiveness and other forms of not acknowledging to oneself the truth about one’s use; protecting one’s supply of the substance, sometimes going to great lengths to do so; and avoiding or being uncomfortable in situations where use of the substance is not possible.

All of these apply to tobacco use, although, as with other substances, the addicted person may not be conscious of them. For example, most smokers will have a cigarette just as their bodies begin to experience the first symptoms of withdrawal. But they won’t usually be aware of withdrawal unless they have not been smoking for more than an hour or two, like in a movie theater, or when they first wake up in the morning. In fact, we now realize that nicotine addiction is a chronic, relapsing condition with many similarities to other addictions.
1. Tolerance

Few smokers are aware of their tolerance to the toxic effects of tobacco smoke. These toxic effects include nausea and light-headedness, and are normally experienced by people new to tobacco use. People without a tolerance to nicotine generally would feel seriously ill if they tried a typical use level, for example, a pack of cigarettes in a day.

A person who picks up a cigarette after not smoking for a while (or who uses chewing tobacco after abstaining for a while) will often experience the toxic effects as well.

Once tolerance is established, most adult smokers do not need to increase the amount smoked to achieve the desired effect. Usually adults will maintain a consistent smoking level, for example a pack of cigarettes a day. But under conditions of increased stress, addicted smokers will tend to smoke more than their usual amount, even if it makes them feel sick.

2. The Desire and Inability to Quit

Around 70% of smokers say they would like to quit, and 41% tried to quit during the previous year (CDC, 2002). People who smoke are aware, at least on one level, of the harm caused by smoking but are caught up in the physical addiction to nicotine. In addition, smoking is so much a part of their daily lives that they cannot imagine functioning without it.

However, most adult smokers have made at least one serious attempt to give up their dependence on nicotine. Many have tried several times to quit. As with any addiction, it is possible to learn from each quit smoking attempt and try again, but people who are not successful tend to get progressively more discouraged with each try. In fact, after several attempts, many smokers will stop trying. They feel frustrated, defeated, “like a failure.” How often have we heard this when we talk to people who have tried to give up other substance use?

3. Minimizing and Denial

Because of this contradiction between knowing the facts about smoking and their actual experience as smokers, people who are addicted to nicotine engage in denial and minimization about the effect that their smoking is having on them.

It is fairly easy to be in denial about future consequences, like cancer or emphysema, but people will also ignore or minimize the symptoms that they have today, like decreased energy, shortness of breath, frequent chest colds or bronchitis and chronic cough. Some of these indications that smoking is having a negative health effect have developed so gradually that they are not noticeable to the person.
But sometimes the person just ignores the truth, like the smoker who says, “Well, my doctor did say my heart is a little enlarged, but he didn't seem to make a big deal of it.” We have known people who continued to smoke even after a major heart attack or a diagnosis of a tobacco-related illness, like emphysema, and we have heard of people who smoke through a tracheotomy (openings in their throats resulting from cancer in the larynx). This clearly shows the power of nicotine addiction.

There are other consequences of smoking that people will tend to ignore, or be defensive about (which is another strategy for protecting oneself from uncomfortable truths). They may get feedback from others about their appearance or the smell of their breath, or loved ones may express concern about their health. They may not be able to sit through a movie without going for a cigarette, or they may avoid situations where they won’t be able to smoke. They may complain about restrictions on smoking, and make light of the concerns of non-smokers about secondhand smoke.

Like other substance-dependent people, smokers protect their supply of cigarettes, always prepared with at least a “wake up” cigarette, and usually a fresh pack for the next day. And haven’t we seen smokers go out in a downpour or even a blizzard to make sure their supply of cigarettes will be available?

Because tobacco use is legal, and the mood alterations that nicotine produces are subtle, it has been easy until now to put smoking in a different category from other addictions. There are fewer obvious social and behavioral consequences than with other substances, and we have seen people who are in recovery continue to smoke while maintaining years of abstinence from alcohol and other drugs.

What is harder to see are the ways that smoking may negatively affect a person’s successful recovery. (For more on this topic, see I.A. “Breaking the Silence on Tobacco, or Why Bother?”) Until recently we have been unaware that tobacco will be responsible for the death of more individuals addicted to alcohol and other drugs than alcohol and other drugs. For these reasons, it is important to acknowledge that nicotine is an addictive substance that is “cunning, baffling and powerful,” and one to which we need to apply the tools of recovery to overcome.

4. A Bio-Psycho-Social Model of Nicotine Dependence

Nicotine addiction is a complex addiction that has at least three main components. There is an intense physiological addiction that is maintained both by the reinforcing and rewarding properties of nicotine and by withdrawal symptoms. There is a complex psychological addiction built on the routine of smoking and the triggers associated with it. A pack per day smoker takes 200 doses of nicotine per day (20 cigarettes x 10 drags per cigarette), each time pairing behavior with an activity, like drinking coffee, talking on the phone or driving. When someone stops smoking, he or she must learn how to do all of these activities without smoking, un-learning a routine behavior that is almost unconscious. In addition, many people
use cigarettes to cope with feelings of stress, anger, depression or boredom. When they quit, they need new coping strategies.

Finally, smoking is almost always begun as a social activity and remains so for most people. People who quit may have to find new ways to relate to their friends, partners, and families. In some cases, they may even have to change their social context to avoid relapsing. In order to be effective, treatment of nicotine dependency must address all three of these spheres.

See Appendices, Section E, for a handout that summarizes this model of nicotine dependence.

The next section will describe the advances that have been made in treating this complicated and powerful addiction.

B. Interventions & Treatment for Nicotine Dependence

Numerous interventions have been developed and used to treat nicotine over the past 30 years. We now know more than ever before about what works. In fact, the U.S. Department of Health and Human Services issued three clinical guidelines for treating tobacco use and dependence, in 1996, 2000, and 2008.

Some strategies have been more successful than others. As with substance use treatment, every individual is different and responds differently to certain methods.

In nicotine addiction treatment you will work with smokers in all stages of readiness for change, and it will be important to use an intervention which is appropriate for a particular individual’s stage. (See III.G. “The Stages of Change.”)

No single treatment suitable for all smokers has emerged. It is important for the therapist to develop a multi-component program and examine past quit attempts in developing an individualized plan.

1. Self-Instruction Approaches

The concept of self-instruction is somewhat unique to stopping smoking as opposed to discontinuing other drug dependencies. This may be true, in part, because other addictions manifest a variety of social problems that generally require more intense and formal interventions. Unfortunately, smoking has been seen as a “bad habit” or a behavior that it would be advisable to change, as opposed to a full-blown addiction. Many people have been able to quit smoking on their own, but many others have failed. Therefore, self-instruction is probably best suited for those who are highly motivated to quit, have a strong support system, have a broad range of psychosocial assets, and whose smoking history and current use are less severe.
Self-instruction materials include:

- Pre-quitting strategies such as monitoring smoking rates, reviewing reasons for quitting, reducing the number of cigarettes smoked or the places where one smokes, identifying triggers and cues to smoking
- Advice about setting a quit date
- Methods for coping with withdrawal symptoms
- Techniques for remaining off cigarettes, including the development of new habits
- Suggestions for avoiding weight gain and how to prevent a relapse

Self-instruction materials range from short pamphlets to formalized step-by-step programs that guide the reader through the process of quitting over an established period of time. Resources are available through organizations such as the National Cancer Institute, the American Cancer Society, the American Lung Association, and national, state and local health departments, or can be found in bookstores and libraries. Hazelden Educational Materials also has quitting guidelines and workbooks available. Other resources can be found in the Appendices.

2. Brief Advice

A very compelling case can be made for a brief advice strategy for treating addictions—in particular, nicotine dependence—when given by primary care providers and other health care professionals. Studies have shown, for example, that most smokers quit for health reasons and say that advice from their physicians would be motivating. In addition, nurses, respiratory therapists, physician assistants, pharmacists, chemical dependency counselors, dentists, and dental hygienists are all in a position to provide brief advice for stopping smoking to their patients. A review of research by the Agency for Health Care Research & Quality (AHRQ) found that quit rates increased when brief advice was given (see IV.A. “Administrative/ Program Issues” for 5A brief intervention model).

3. Individual Counseling

This method helps the smoker develop a quit plan that is suited to his or her individual needs. With a counselor, the smoker will review his or her past experiences with smoking and quitting and work on strengthening the motivation, determination and skills needed to successfully quit this time.

The counselor can help clients gain some insight into the various ways they use cigarettes, identify trigger situations and feelings, and make some concrete plans for quitting so that they can learn to resist the urge to smoke. Counselors can also help the person build on the skills and knowledge he or she may have gained in quitting
other addictions. Counseling can also help the smoker learn how to limit weight gain, how to relax and reduce stress, and how to prevent relapse.

Generally, counseling is most effective when done by someone with experience and training in treating nicotine dependence. In Massachusetts, certified Tobacco Treatment Specialists can be found throughout the state by contacting 1-800-QUIT-NOW or by visiting the website www.makesmokinghistory.org.

4. Group Counseling

Various group facilitation models have been developed to help treat nicotine addiction. The most popular feature a structured curriculum and a trained facilitator.

The most widely used are the American Cancer Society’s (ACS) Fresh Start and the American Lung Association’s (ALA) Freedom from Smoking. Both of these have been adapted for use with youth, and a program titled Tobacco Awareness Program has also been specifically developed for youth by a teacher in California.

Group counseling works very much like individual counseling. The differences are that groups tend to have a more structured format than individual counseling, there are often homework assignments which are then discussed in the next session, and there is more emphasis on interchange among group members. Personal quit smoking plans may be started in the group and then developed by the individual as part of the homework.

The peer support that occurs in groups can be instrumental in supporting positive change.

5. 12 Step Programs

The 12 Steps developed by Alcoholics Anonymous (AA) have been used successfully for treating other addictions (e.g., drugs, food, gambling and nicotine).

The 12 Steps have been used both in formal programs (Nicotine Anonymous) and informally by tobacco users recovering from alcoholism or drug addiction on their own. People in recovery who have stopped smoking often report that the principles of the 12 Steps, which had helped them to stop drinking and using drugs, are very helpful in helping them stop smoking.

Nicotine Anonymous (“Nic-A”) has adapted the 12 Steps of AA for use in recovery from nicotine addiction.

Nicotine Anonymous meetings are held regularly across the United States. A list of meetings can be found at the following website: www.nicotine-anonymous.org. On-line meetings are also available.
6. Telephone Counseling

Telephone counseling, either as part of an individual or group program or as a primary form of support, has been found to be effective. Quit-lines have become an increasingly popular form of counseling, providing services that are free, easily accessible, and convenient. Different quit-lines offer different services: information, referral, and/or counseling programs. The Massachusetts Smoker’s Helpline at 1-800-QUIT-NOW offers free telephone support and information and referral services to Massachusetts residents who want to stop smoking.

7. Internet

For tobacco users who have access to the Internet, a growing number of websites exist for help with quitting smoking and other forms of tobacco. Sites vary in focus and tone, with some primarily providing information and others more focused on chat rooms and community interaction. A good place to start is at the MTCP website, www.makesmokinghistory.org and also the American Legacy Foundation quit-smoking support and education website, www.becomeanex.org (also available in Spanish). A listing of on-line Nicotine Anonymous meetings can be found at www.nicotine-anonymous.org.

8. Medications/Pharmacotherapy

Pharmacological adjuncts to other forms of nicotine dependence treatment have been shown to double quit rates and should be included whenever they are indicated. In particular, they are useful for patients who are highly addicted, for heavy smokers, and for those who have exhibited severe withdrawal symptoms with previous quit attempts.

Nicotine replacement therapy (NRT)

A wide variety of nicotine replacement products are now on the market as an aid in treatment of nicotine addiction. They are most effective when they are used in decreasing doses to alleviate withdrawal symptoms while a patient is concurrently participating in self-help, self-instruction or formal treatment activities. The products often include their own self-instruction information and may offer the individual the opportunity to call a support hotline while using the product. Products include nicotine gum, nicotine patches, nicotine inhalers, nicotine nasal spray, and the nicotine lozenge. (See III.C. “Nicotine Replacement Therapy (NRT)” for details of NRT use.)
Zyban (bupropion)

Zyban (bupropion) is the first non-nicotine product available by prescription as an aid to quitting smoking. Initially developed and marketed as an antidepressant (Wellbutrin), bupropion was approved for use in the treatment of nicotine dependence in 1997. Although the exact way in which Zyban works remains unclear, it is presumed to affect levels of dopamine and norepinephrine in the brain, two chemicals that are associated with craving and withdrawal symptoms. It helps reduce the urge to smoke and helps make quitting bearable by reducing nicotine withdrawal symptoms. (See III.D. “Pharmacological Treatment for Nicotine Dependence: Zyban” for details of Zyban use and FDA warning.)

Chantix (varenicline)

Chantix was approved by the U.S. FDA for use in smoking cessation in May 2006. Chantix binds with the nicotinic receptors which blocks the rewarding effects of nicotine and reduces craving and withdrawal. The approved course of treatment is 12 weeks, though that may be doubled. (See III.E. “Pharmacological Treatment for Nicotine Dependence: Chantix” for details of Chantix use and FDA warning.)

9. Alternative Approaches

There are a number of approaches that have wide appeal even though there is no empirical data to confirm their effectiveness. Some individuals find these alternative approaches to be helpful. However, these alternative methods should be used in conjunction with research-based treatment interventions such as behavioral counseling and use of pharmacotherapy (e.g., NRT, Zyban).

Hypnosis

Hypnosis is a state of consciousness in which a person is highly responsive to suggestions, provided the suggestions are welcome and believable. Hypnotherapy can be provided either in a group or on an individual basis. In hypnosis the smoker is given suggestions which continue to have an effect after the session is over. Hypnosis can help strengthen motivation to quit, decrease the intensity of cravings, and teach skills for relaxation and stress management.

Acupuncture

Acupuncture involves the use of needles or staple-like attachments most often administered to the ear. Most reports of acupuncture have not employed controlled evaluations and many have failed to include long-term follow-up or biochemical
validation of self-reported quitters. The efficacy of acupuncture either in relieving withdrawal symptoms or in aiding stopping smoking has not been widely researched. However, it is generally a painless procedure and many people find that it promotes feelings of relaxation and well-being.

Homeopathic remedies

Claims of these products are generally to relieve withdrawal symptoms. They are not, however, subject to FDA approval and most often their ingredients are used in relation to general symptoms and not specific to nicotine withdrawal.

10. Key Elements in Helping Smokers Think About Which Method(s) to Use:

- Does the method help the smoker address his or her specific quitting needs, such as fear of withdrawal, weight gain, medical issues, or ability to adhere to a plan and cost?
- Is the method or program something he or she feels comfortable with?
- What methods were used in the past? What worked well? What didn’t work as well?
- Are there medical or psychiatric issues that may cause concern for the method currently being considered? If so, is there a medical professional that can be consulted?

Smokers often have unrealistic beliefs or expectations about particular methods. They may think that a given method will “make them quit.” They may also have limited belief in their own abilities, usually based on past unsuccessful attempts to quit. For these reasons it is essential that people are helped to understand that past quit attempts often contain many successes, as well as experiences to learn from and apply to the present attempt, and that no program or service can work effectively without the active participation of the smoker.

Giving up smoking or other tobacco use requires motivation, commitment, effort and a plan, no matter what method a person uses, including “quitting on your own.”

C. Nicotine Replacement Therapy (NRT)

The U.S. Public Health Service, Agency for Health Care Research & Quality (AHRQ) issued a clinical practice guideline for smoking cessation in the spring of 2000 and again in 2008. This guideline recommends the use of pharmacotherapy (NRT or bupropion) for all persons trying to quit smoking, unless medically contraindicated. Research has demonstrated that a person’s chance of successfully quitting is doubled if s/he uses NRT or bupropion (trade name Zyban or Wellbutrin).
Also, combining counseling and medication increases abstinence rates (Fiore et al., 2008). NRT manages the physiological aspect of early recovery so that the person’s focus can be on making behavioral changes.

There are 5 types of nicotine replacement products: transdermal patch, gum, inhaler, nasal spray, and lozenge. The patch, gum, and lozenge are available over the counter, while the inhaler and nasal spray require a prescription. In general, the patch is easiest to use, has the highest compliance rate and the lowest abuse potential. The gum may be effective for some smokers, especially those who may be allergic to the adhesive in the patch. The gum is also useful as a supplement to the patch, that is, to be used to boost blood nicotine levels when cravings break through or when a smoker is in a high risk situation. The spray and inhaler are generally not recommended because of their lower compliance rates and higher abuse potential.

Detailed instructions for the choice and use of various pharmacological products can be found in the handout, “Quick Guide to Nicotine Dependence Pharmacotherapy” (Appendices, Section F).

The following points are pertinent to NRT use:

- It is essential to evaluate a smoker’s stage of readiness to stop: NRT is not appropriate or useful for people in either precontemplation or contemplation.
- NRT is most effective when paired with adjunctive therapies, such as individual or group counseling and relapse prevention skills training.
- It is important to monitor people who are on the patch regarding responses such as insomnia, discomfort, and increased anxiety, in order to determine the appropriateness of dose level and whether a person might be over or under-medicated; either of these could cause people to give up on NRT and feel more hopeless about trying to remain abstinent from tobacco.
- Use of NRTs has been shown to delay weight gain.

Limits of NRT include the following:

- NRT is often perceived as a “magic pill,” lessening commitment to addressing the holistic aspects of dependency and recovery.
- There are contraindications with certain populations or conditions: NRT is not recommended for women who are lactating or pregnant, for children and adolescents, or for persons with active ulcers, active or unstable heart disease, vascular disease or poorly controlled insulin-dependent diabetes.
- In purposefully introducing this drug into their systems, clients are prolonging the dependence on nicotine, though NRT is much less harmful than continuing to smoke, dip or chew tobacco.
NRT: Strategies for Successful Treatment

- Clinically appropriate reasons exist for the client to begin, i.e., that the client is motivated and ready to quit.
- Appropriate monitoring and supervision should be present at the initiating stage, and staff should follow-up throughout nicotine addiction treatment to monitor the client’s progress and comfort with the medication.
- Programs should develop a capacity to provide or refer for adjunctive counseling if clients will be receiving NRT, as such counseling increases effectiveness and success.
- Clients should have the education necessary to make an informed choice regarding quitting method(s) they intend to use.
- Programs should develop a protocol for dealing with clients who continue to use tobacco while on NRT.

D. Pharmacological Treatment for Nicotine Dependence: Zyban

In July 2009, the Food and Drug Administration (FDA) announced it would require labeling for Zyban and bupropion to include its strongest safety message, warning that people taking this medication should be closely watched for signs of serious mental health changes. These include changes in behavior, depressed mood, hostility, and suicidal thoughts. However, an October 2009 study led by epidemiologist David Gunnell, Ph.D., and his colleagues in the United Kingdom found no clear evidence of an increased risk of self-harm, suicidal thoughts, or depression in users of Zyban or bupropion (Gunnell, Irvine, Wise, Davis, & Martin, 2009).

Zyban, the brand name for bupropion, was the first non-nicotine medication approved by the FDA shown to be effective in treating nicotine dependence. Bupropion, originally used as an anti-depressant under the brand name Wellbutrin, is available by prescription only. Because it has been demonstrated to double quit rates, bupropion has been recommended for use in treating nicotine dependence in the Clinical Practice Guidelines issued by the U.S. Public Health Service. Researchers also discovered that Zyban delays or limits the weight gain that many smokers experience when they quit (Fiore et al., 2008).

While not a lot is known about exactly how and why Zyban works, experts believe that it is effective as a stop-smoking agent because, like nicotine, it affects the level of dopamine, a neurotransmitter associated with positive feelings. Zyban also seems to help limit withdrawal symptoms. Researchers began investigating the effectiveness of anti-depressants in treating nicotine dependence when they noticed that people taking Wellbutrin for depression began to spontaneously cut down or stop smoking. In fact, there is a strong association between smoking and depression. Smokers are more likely to have a history of major depression than non-smokers,
and one common symptom of withdrawal is depression. There is some speculation that Zyban helps some smokers by treating underlying depression. However, Zyban has also been shown to be effective with smokers who are not depressed.

The use of Zyban doubles quit rates, making it as effective as nicotine replacement therapies (NRT), like the patch, gum, lozenge, inhaler and nasal spray. Unlike nicotine replacement therapies, such as the patch and gum, Zyban is started one-to-two weeks before a person’s quit date, while still smoking. Generally, a 150 mg dose is prescribed for the first three days, followed by an increase of up to 300 mg (or 2 pills a day) for 7-12 weeks. People who have not made significant progress towards remaining abstinent from cigarettes by the 7th week are unlikely to succeed during this attempt. For those experiencing cravings or other withdrawal symptoms, Zyban can be used in conjunction with the patch or gum. It is only available through prescription.

The most common side effects are insomnia and dry mouth. Current drinkers, people with a history of seizures or eating disorders and those taking other medications that contain bupropion or MAO inhibitors (medication for mood disorders) should not take Zyban. People with a history of alcoholism should be carefully evaluated by a medical doctor since they may have a lower threshold for seizures. People with past or current mental health concerns should talk with their medical doctor about whether Zyban is right for them. Health care professionals who prescribe Zyban or bupropion should monitor patients for any unusual changes in mood or behavior after starting this medication. Patients should immediately contact their health care professional if they experience such changes.

Zyban may be a good choice for those who have not succeeded with nicotine replacement therapy, who have had adverse reactions to NRT or who prefer a non-nicotine treatment. As with any pharmacological treatment, Zyban works best when used by someone motivated to quit and as part of a total treatment plan. Counseling support, Nicotine Anonymous, exercise, rest and proper nutrition all contribute to a successful quit attempt.

Disclaimer: This information is for general educational purposes only. It is not meant to substitute for professional medical advice. Please consult your health care professional if you or someone you know is considering treatment with Zyban or bupropion.

E. Pharmacological Treatment for Nicotine Dependence: Chantix

In May, 2006, a promising new medication for stopping smoking was approved by the FDA. Chantix (varenicline) was developed “to address the mechanism re-
sponsible for satisfaction from smoking and to reduce the urge to smoke.” Effectiveness was demonstrated in six clinical trials, with over 3500 smokers. Chantix is designed to partially activate the nicotinic receptors, which reduces a smoker’s craving and relieves the severity of withdrawal symptoms. Chantix is available by prescription.

Use of the medication starts seven days before a person quits smoking so the medication can build up in the body, similarly to Zyban. Chantix cuts the rewarding effects of nicotine, such that if a person resumes smoking while on the medication, the effects of nicotine are blocked. Chantix comes in a white tablet (.5 mg) and a blue tablet (1 mg). Patients begin by taking .5 mg of Chantix once a day on days 1-3, then .5 mg twice a day on days 4-7, morning and evening. From day 8 until the end of treatment, patients take one blue tablet (1 mg) twice a day.

The approved course of treatment is 12 weeks, which can be doubled in patients who successfully quit to increase the likelihood that they will stay smoke-free. Studies indicate that abstinence rates with Chantix were higher than those achieved with Zyban, and experts have indicated that the greatest value of the medication will be for smokers who have tried Zyban or nicotine replacement therapy without quitting success (Gonzalez et al., 2006; Jorenby et al., 2006).

In clinical trials, the most common adverse effects of Chantix were nausea, headache, vomiting, flatulence (gas), insomnia, change in taste perception and abnormal dreams (e.g., vivid, unusual, or strange dreams). Patients taking Chantix may also experience impairment in the ability to drive or operate heavy machinery.

People with past or current mental health concerns should talk with their medical doctor about whether Chantix is right for them. Chantix may cause worsening of a current psychiatric illness even if it is currently under control and may cause an old psychiatric illness to recur. In most cases, neuropsychiatric symptoms developed during Chantix treatment, but for others, symptoms developed after the discontinuation of Chantix treatment. While Chantix has demonstrated clear evidence of efficacy, it is important to consider these safety concerns. Health care professionals who prescribe Chantix should instruct patients, family members and caregivers to monitor for any atypical changes in mood or behavior (e.g., anxiety, nervousness, tension, depressed mood, unusual behaviors, or suicidal thoughts) after starting or discontinuing this medication. If this does occur, discontinue taking Chantix and contact the prescribing physician immediately.

In November 2007, February 2008, and May 2008, the FDA issued public health advisories to alert patients, caregivers, and healthcare professionals to important changes to Chantix prescribing information. At the request of FDA, Pfizer, the manufacturer of Chantix, updated the Chantix prescribing information to include warnings about the possibility of severe mood and behavioral changes in patients taking Chantix.
As with Zyban, the FDA announced in 2009 that it would require labeling for Chantix to include its strongest safety message, warning that people taking this medication should be closely watched for signs of serious mental health changes. The Gunnell study referenced in the previous section also found no clear evidence of an increased risk of self-harm, suicidal thoughts, or depression in users of Chantix (Gunnell et al., 2009).

For more information visit www.chantix.com.

F. Assessment of Nicotine Dependence

Assessment of nicotine dependence is conducted in order to accomplish the following goals: to determine physiological dependence, and to aid in planning for withdrawal and pharmacotherapy use; to identify strengths to aid in the recovery process; and to identify challenges and barriers to be addressed prior to quitting and as part of an ongoing treatment plan.

The Fagerström Test for Nicotine Dependence (see Appendices, Section C) is a six-question test developed by Dr. Karl Fagerström for use in planning for withdrawal and medication needs. Two questions are most indicative of nicotine dependence levels:

1. How soon after you wake up do you smoke your first cigarette?
2. How many cigarettes/day do you smoke?

Smoking within the first 5–30 minutes after waking is indicative of greater nicotine dependence, as is smoking more than 10–15 cigarettes per day. Other questions on the Fagerström Test hint at substance dependence criteria, such as question #6, “Do you smoke if you are so ill that you are in bed most of the day?” which describes use of tobacco despite consequences.

Another assessment being utilized statewide in health centers and BSAS programs, as required by the BSAS Tobacco Guidelines, is the 5A assessment (See Appendices, Section C). This brief intervention can be offered to all clients to Ask about smoking status, Advise quitting now or in the future, Assess readiness to quit, Assist with ideas and plans to quit, and Arrange follow-up for support. The U.S. Public Health Service’s Clinical Practice Guideline for Treating Tobacco Use and Dependence recommends that all persons accessing health delivery systems, including substance use treatment programs, should receive a 5A intervention at every visit. In substance use treatment programs, it is important to re-assess readiness on a regular basis, as clients may move forward on the Stages of Change while in treatment.

Use of the Fagerström Test and the 5A assessment will raise interest in quitting and educate clients about nicotine dependence. In order to prepare a nicotine de-
dependence treatment plan, more thorough assessment must be conducted which includes the following components and sample questions:

**Smoking history**
- Age at first use/age when regular use began
- Family history of smoking
- Current pattern of use: how much, what brand
- Has the pattern recently changed, and if so, why?

**Smoking triggers and patterns of use**
- What situations, moods, social situations and other triggers prompt the client to smoke?
- Negative consequences of smoking
- Does the client have health concerns related to smoking?
- Has the client been advised to stop smoking by a physician?
- Other difficulties: family, financial

**History of past quit attempts**
- Specifics of reasons for quitting each time
- Explore the longest and most recent quit attempts: What worked? What might help or hinder next time?
- What quitting methods have been tried?
- What were the causes of relapses to tobacco use?

**Role of smoking in a client’s life**
- What pleasures does the client derive from smoking?
- What role does smoking play in client’s moods or emotional well-being?

**Support systems**
- Who/what are current supports for client’s recovery from substance use? Are these people/institutions supportive of quitting tobacco use?
- Which strategies being used to stay clean and sober could help the client stay smoke-free and away from chewing tobacco or snuff?
- Other psychosocial issues which might affect ability to quit
- Does the client have support for mental health issues to help monitor for anxiety and depression?
- What medications is the client currently on?

**Level of readiness to quit**
- What is the client’s goal regarding his/her tobacco use?
- What is the client’s actual stage of change (precontemplation, contemplation, preparation, action, maintenance, relapse)?
Substance use treatment clinicians will note the similarities between taking a general substance use history and taking a tobacco use history. Assessment of nicotine dependence can be streamlined into standard treatment by including tobacco as another substance to be explored.

Existing treatment plans can be utilized by adding “tobacco use,” “tobacco addiction” or “nicotine dependence.” As part of monthly reviews of treatment plans, follow-up on tobacco use can then also happen. Clients may not be ready to think about quitting smoking upon intake to treatment. However, with assessment and education provided over time combined with clients’ renewed interests in health, clients in residential and outpatient settings may become more ready to quit. Information gathered in a thorough assessment will point directly to areas to be addressed by a treatment plan.

The next section, “The Stages of Change,” describes strategies for working with people in different stages of readiness for quitting tobacco use.

G. The Stages of Change

Changing any long-term behavior can be difficult and takes time. When people decide to change a behavior, they usually go through a process before the change is complete. They think about changing, make plans, try the new way, maybe slip backwards and then try again, until eventually the new behavior is a part of their lives.

This is what James Prochaska and Carlo DiClemente observed in their research on addiction and behavior change. They outlined specific stages to describe a person’s readiness and activity level at each point in the process of change.

Change is a process that can be broken down into separate stages. This process is characterized by ambivalence. In other words, people have reasons to stay the same. They have thoughts and feelings on both sides of the issue. People may go forward and backward through these stages, approaching and backing off from making a change, depending on a number of factors. When we are trying to help people make changes in their tobacco and other substance use, we will be most effective if we target our interventions to the specific stage they are in. Stages theory can be diagrammed as a wheel. People may go around this wheel several times before the behavior change is integrated into their lives.

Stages:

- Precontemplation: Not seriously considering change
- Contemplation: Thinking about change
- Preparation: Getting ready to make change
- Action: Making the change
• Maintenance: Sustaining behavior change until integrated into lifestyle

**Stages of Change** *(Prochaska & DiClemente)*

![Stages of Change Diagram](image)

Figure 2. Stages of Change (Prochaska & DiClemente, 1986).

The following is a brief discussion of the Stages of Change as they relate to smoking, with some ideas about what a person can best use at each point in the process.

Questions are provided which are tailored to each stage of change. Clinicians can use these questions in individual and group counseling sessions for further exploration and reflection with clients.

For more information on the Stages of Changes, see Section E, “Stage-Based Strategies” in the Appendices.

*Precontemplation*

"I don’t want to quit." + "I don’t want to hear it."

The person is not even thinking about quitting. She may be unaware of the problem, or be unwilling to do anything about it.

- She may not think it is a problem. If any doubts come to mind, they are dismissed. She often uses denial, rationalizing about the risks, or about being dependent.

- The smoker may have a “rebellious” attitude and seem hostile or put up resistance to the idea of change.

- “More” (more education, more confrontation, more intensity, etc.) is not necessarily better in terms of helping the person to consider the change. In fact, too much from the counselor will usually result in the client being more resistant.
Developing discrepancy within the smoker’s belief system, that is, bringing to light her contradictory ideas and feelings, is the most effective approach with a person in precontemplation. This means listening empathically, providing an opportunity for the smoker to explore both the good and the bad sides of smoking, listening for any expression of concern that she has about smoking, and gently questioning her about it.

**Goal:** Introduce ambivalence.

- “Is there any way you might be better off if you quit?”
- “What happens when you think about quitting?”
- “What do you imagine will happen if you continue to smoke?”

**Contemplation**

“I want to quit, but I really like smoking (need to smoke, don’t know how I’d manage without smoking, don’t think I can do it, etc.).”

or

“Maybe it’s a problem, or maybe it’s not.” / “It could be a problem, but it isn’t yet.”

“I’m willing to talk about it. Help me think this through.”

The person is willing to consider that tobacco is a problem, and that quitting is something that he wants or needs to consider.

- He will be seeking information (about smoking and about the quitting process itself) to tip the balance in favor of stopping smoking.
- Because of the ambivalence inherent in quitting, however, he may also be quick to latch onto ideas that support continuing to smoke (e.g. that withdrawal is horrible; that Uncle Bob smoked until he died in his sleep at age 94, etc.).
- His sense of self-efficacy, or confidence in his ability to successfully quit, will also play a role in his decision-making process.
- He needs to think that quitting is “do-able,” so it will help for him to remember what he has done in the past that helped (with smoking or other substance use) and have some ideas about what he could do this time.
- He is thinking about quitting at some point in the foreseeable future, but how soon that will actually happen may be viewed very differently from day to day.
- Remember that he is still ambivalent and may need to talk about what he likes about smoking or reasons why he might want to continue to smoke.
- Sometimes discussing these feelings helps the person say on his own that these reasons aren’t sufficient to prevent him from quitting.

Goal: Help the person to resolve his ambivalence in favor of quitting.

- Explore both sides of the ambivalence.
  - “What do you like about smoking?”
  - “What are the reasons you’re thinking about quitting?”
  - “What would you be losing if you quit?”
  - “What would you gain from becoming a non-smoker?”
- Explore barriers to quitting.
  - “When you think about quitting, what are your concerns/fears?”
- Reframe past experiences to include perspective of successes, lessons learned, coping skills gained.
  - “When you’ve quit in the past, how did you manage to do it?”
  - “To what do you attribute the success that you have had?”

**Preparation**

“I am ready to quit smoking.” + “Tell me more.”

The person is taking steps to stop smoking. She is planning to quit at some time in the near future (within the next month) and is beginning to imagine how she will manage different situations and triggers without cigarettes. This person needs to develop a clear reason, an understanding of the obstacles she will confront, and a plan for how to overcome them.

- The stronger her reason and the more specific her plan, the more likely it is that she will actually quit.

- She may already be doing things in anticipation of quitting: cutting down, either consciously or without even thinking about it; keeping track of the cigarettes she smokes and what the triggers are; or telling people she is planning to quit.

As giving up cigarettes becomes more of a reality, anxiety about quitting is very high. She will still need to talk about her ambivalence, with an emphasis on how she will manage the side that wants to keep smoking.

Some people will make a plan to quit and then not follow through. Appropriate timing is a genuine consideration; but some people will need help in seeing that no time is perfect, that there will always be reasons to keep smoking.

Quitting smoking does require effort. Counseling can help the person strengthen commitment and determination to quit no matter what it takes.
Goal: Help the smoker strengthen her motivation, develop strategies for quitting, and commit to a Quit Date.

- “Your reason for quitting is an excellent one. How could you say it to yourself in a way that will really get to you—when you’re tempted to smoke?”
- “What problems or challenges do you anticipate?” or “What do you think would help in that situation?”
- “What would make sense as a Quit Date for you?”

Action

“I’m not smoking (but I’m thinking about it a lot).”

+ “Let me tell you what I’m going through. Help me think about this more.”

The person is actually quitting and putting his plan into action. He will be having a variety of experiences, physiological, emotional, situational and interpersonal and is putting plans “to the test.”

This client will need an opportunity to talk about successes, “close calls,” and failures. He will need support and feedback. He may not see the successes as such, especially in the early days of quitting, so input from the counselor to help him reframe his experiences can be very valuable.

He may also need help altering, refining or elaborating his planned methods of coping. He may also need to learn new skills, such as new ways of managing stress or conflict, assertiveness when dealing with smokers, etc.

Goal: Support changes, emphasize successes, identify triggers and relapse situations, normalize the experience. Give praise for his efforts and accomplishments.

- “What are the situations that have been the most challenging that you've handled successfully?”
- “What were the triggers that you hadn’t anticipated?”
- “Where do you need to strengthen your coping strategies?”
- “What's ahead that you need to plan for?”
- “What are you going through is a normal withdrawal symptom.”
- “Many people feel a sense of loss when they give up cigarettes.”
Maintenance

“I’m a non-smoker, and I feel good about it.”

“I am able to give information to others.”

The person has stopped smoking and is well beyond the withdrawal period. The challenge at this stage is to stay quit, no matter what comes up.

- Developing a non-smoker self-image is the central component of staying “smoke-free.” This takes time. It requires a degree of conscious effort to learn to see oneself in a new way, especially after having a different identity since adolescence, when adult identity is forged.

- As time goes on, the person will continue to encounter situations or people that will trigger the urge to smoke. She will need to anticipate and prepare for such events, and also develop the capacity to generate strategies spontaneously.

- Often recently quit (and even long time quit) smokers will believe that they can have “just one cigarette.” However, experience and research has shown that most people who try even one cigarette will soon be smoking regularly. Encouraging total abstinence is important.

This client will need to have the issue of non-smoker identity addressed directly. She may need to have new non-smoker behaviors or attitudes pointed out to her as a part of this process.

Goal: Empower the “expert,” and look to the future.

- “What would you suggest to someone who is planning to quit in the next week?”
- “Why do you think that some people go back to smoking after being off cigarettes for a long time?”
- “How would you handle [the previous relapse situation] if it came up now?”
- “How would you manage a highly emotional or stressful situation?”

Relapse

“I give up.” “I’m a failure.” “It’s not worth it.” “I can’t.” “I’ll never be able to quit.”

“I feel so stupid/guilty/hopeless.”

“It’s hard to get motivated again.”
The person has resumed smoking, or has returned to a pattern of smoking (e.g., only when feeling stressed at work), or has smoked more than once in a week.

- He will be feeling shameful, defeated, “weak,” and hopeless.
- He will need help to see the experience as an opportunity to learn and move forward.

**Goal:** Help the person to reframe the experience, understand relapse, and develop optimism about trying again.

- “It’s great that you made it for four days. You were almost past the hardest part. What could you do differently the next time?”
- “You managed to handle a lot of situations without smoking. What was it about this situation that you weren’t prepared for?”
- “What did you learn?”
- “Each time you make an effort to quit you get closer to your goal. How can we work together so that the next time you can succeed for good?”

**H. Principles of Counseling/Support for Nicotine Dependence Treatment**

Understand where someone is from a Stages of Change perspective:

- You can help someone move forward, one stage at a time.
- People who are in precontemplation can probably tolerate only a very brief intervention.
- Contemplators are generally open to more help, especially information about quitting. They need to build their motivation to quit and their belief that they can do it.
- People who are in preparation and action stages need help with developing and then refining their strategies for coping with the urge to smoke.

Ambivalence:

- Smokers, even when they want to quit, usually feel attached to smoking, and afraid of giving it up.
- Because of this ambivalence, the closer someone gets to the Quit Day, the harder it may become.
- This ambivalence is a part of any change.

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9 Information in the “Principles of Counseling/Support for Nicotine Dependence Treatment” and the “What Does it Take to Quit Smoking Successfully?” sections was drawn from the Training Manual of the American Cancer Society’s Massachusetts Smokers Quitline, and the work of the California Smoker’s Helpline.
• The most important things for this person to remember are:
  • Change is a process
  • Ambivalence is normal
  • People may go back and forth about quitting before they finally give up smoking for good
  • A person may also need support around keeping in mind his reason for quitting
  • If the person sets a date and doesn’t follow through, he or she will often feel defeated, like a failure, “weak,” ashamed.
  • The ideas above apply even more strongly to this person.
  • The issue of “timing” may also be important. The circumstances will never be perfect, but sometimes are harder than others, and there is no reason for someone to set him- or herself up to fail.

Help the person get clear and definite about why he or she wants to stop smoking. For more information about this, see “Motivation” in the next section.

• A person has to have a strong reason to quit smoking.
• This reason will help him resist the urge to smoke when old thoughts and feelings about smoking come up.

Help the person plan for quitting. For more information about this, see “A Plan” in the next section.

• For a person to successfully quit, he or she will need strategies for managing situations that smoking has always been a part of.
• Different cigarettes smoked during the course of the day have different functions or meet different needs for the person.
• It’s helpful if a range of coping strategies can be developed, so the person can respond in different ways to different situations.
• There isn’t a “perfect match.” For example, getting up from the table after dinner is not the same as sitting and having a cigarette, but it can work very well as a strategy.
• The best ideas are the ones that come from the person who is quitting.
• Your job is to help the person come up with a plan that will work for him.
• If he has quit before, you can help him recall what worked before, and see if those strategies can be applied now.
• What may be most important for the person in recovery is to draw on those experiences to help her gain recovery from smoking.
• What can she recall from the early days of sobriety that could help here?
What are the tools that have been most helpful in her recovery? Can they be applied to quitting smoking?
What needs to be added, modified, or changed? For example:
Does her sponsor smoke? Would it help to have additional sponsorship around this issue? Who are the other supports in her life?
What 12-step slogans could be applied to quitting smoking?
How will she manage the issue of smoking at A. A. or N. A. meetings?

I. What Does It Take to Quit Smoking Successfully?

Motivation = A Reason

Principles:

- A person has to have a powerful reason for giving up cigarettes/tobacco use.
- He or she should be able to say it using clear and specific terms (for example, “I don’t want to die from this addiction”), rather than a more vague way (for example, “my health”).
- A strong statement, that he or she cannot deny, can help a person cope with the urge to smoke.
- No one quits smoking without mixed feelings, but the reasons for stopping must outweigh the reasons for continuing to smoke.
- People need to be able to talk about both sides.
- That way, they can be prepared when they have a craving or a wish to smoke.
- They also need to know that it’s okay to talk about their conflicts about giving up cigarettes. Later, if a person has a slip, he or she will feel safer to tell you about it.

Useful questions for smokers to ask themselves:

- Why do I want to stop smoking?
- What is the single, most important/undeniable reason why I need to stop smoking now?
- What will keep me motivated?
- What do I like about smoking? What do I dislike about it?
- In what ways am I attached to smoking?
- What do I think will happen when I first quit smoking?
- What do I imagine my life would be like without cigarettes?
- What are my fears about quitting?
- What are my hopes?
“Self-Efficacy” = The Belief that I Can Do It

Principles:
- Many people are hesitant to quit smoking because they think it is impossible for them to succeed.
- They may have tried in the past to stop, but not been able to make it last.
- They may feel like cigarettes have such a grip on them that they will never be able to manage a craving.
- They may have fears about handling situations or feelings without smoking.
- If people feel helpless and hopeless about quitting smoking, it is not likely that they will try.
- If they have some ideas about how to handle different situations and feelings without smoking, trying to quit will seem more possible.
- People can learn from past successes or even partial successes.
- If they have quit smoking in the past, even for a week or two, they have had many experiences of successfully managing the urge to smoke.
- But they may not recognize “success,” because they are focused on the “failure” of relapse.
- To believe you can accomplish something, you need to know how you are going to do it.
- An important part of self-efficacy is having a plan (see next section).
- As a counselor, you can help people see the successes within their past experiences.

Useful experiences for smokers to ask themselves:
- What have my past experiences been with quitting smoking?
- What were my successes? How did I manage to stay quit for as long as I did?
- Are there things I can learn from my past smoking relapse?
- What else have I accomplished in my life that I can apply to quitting smoking?
- What do I need to feel more confident in my ability to quit smoking and stay quit?

A Plan

Principles:
- The best strategies are the ones the smoker comes up with, rather than the ones the counselor suggests.
- It can be very useful for the person to identify situations that will be challenging and to write down strategies to handle each one.
• “Cognitive” strategies, things someone tells herself, are always available to use, no matter what state the person is in. Some examples are:
  - “I want nicotine out of my life.”
  - “I can handle this without smoking.”
  - Or simply, “No smoking!”
  - Prayer

• Behavioral strategies are things a person does when he has an urge to smoke.
  - Sometimes the simplest thing can be very effective.
  - For example, just distracting oneself—by watching TV, concentrating on a task or doing something that isn’t associated with smoking—can be enough until the craving passes.

• Pharmacological strategies, such as NRT, Zyban, or Chantix greatly increase quit rates.

Useful questions for smokers to ask themselves:
• What are the specific situations that I think will be most challenging?
• What do I use the cigarette for in those situations? What can I do instead of smoking?
• What will I tell myself when I have the urge to smoke?
• What have I learned in my recovery that can help me give up cigarettes? Which tools have helped me the most in the past? Can I apply them here?
• Does my sponsor smoke? What does my sponsor think about my quitting smoking? Who else can be a support?

Determination/Commitment

Principles:

• Quitting smoking takes effort.
• The person who is giving up cigarettes has to be prepared to do some work to make it happen.
• She has to believe that it is worth the effort and be willing to do whatever it takes to reach her goal.

• The more effort someone makes in the process of quitting, the more likely it is that he will succeed.
• It can be useful for the person to do something concrete to symbolize his or her intention to quit; marking the planned Quit Date on a calendar; giving away clothing or other items that have cigarette logos on them; putting away...
all ashtrays except one, and restricting smoking to that one place; beginning other kinds of preparation (see below).

Useful questions for smokers to ask themselves:
- What am I willing to do to quit smoking?
- What will I gain from quitting? How much effort is it worth to me to become a non-smoker?
- What are my alternatives to quitting? What will happen if I don't quit?
- What can I do to symbolize my determination to quit?

**Preparation**

Principles:

- The most successful quit efforts are usually the ones that involve some preparation.
- Having plans for coping with triggers is one component of preparation.
- Other things to consider:
  - Setting an appropriate Quit Day
    - Should it be a weekend or a workday?
    - Should it be a significant day, like a birthday? If so, what will happen if the person doesn’t quit on that day?
  - Quitting cold turkey or cutting down on a schedule until the Quit Day
  - What will the person do with any cigarettes that remain on the Quit Day?
  - What needs to be available?
    - Low calorie foods, hard candies, oral substitutes like toothpicks
    - Projects or other ways of keeping the hands busy
    - Forms of distraction, like books or magazines, videos, puzzles, plans with a friend
    - Phone numbers of people to call, and the numbers of the Tobacco-Free Helpline (1-800-TRY-TO-STOP), the Spanish language line (1-800-8-DEJALO) and Quit Tips Line (1-800-9-GET-A-TIP)
  - Preparing the environment by:
    - Getting rid of lighters and ashtrays
- Hanging up pictures (of loved ones, of the future non-smoker self, etc.), reminders, affirmations
- Cleaning and airing out rooms, the car, work area
- Buying flowers
- Social considerations:
  - Does the person want to tell people he or she is quitting?
  - Who will be a support? How can they be helpful?
  - Who may be challenging to spend time with? How will he or she manage that situation?
- What can the person do that will be positive?

Useful questions for smokers to ask themselves:
- What can I do to get ready for my Quit Date?
- What do I need to think about?
- Who will be a support? How can they help me?
- Who will be a challenge? How can I manage interactions with that person?
- What can I do that will be positive?
- What are the situations that will be most challenging? What can I do, or tell myself, when I feel the urge to smoke?

J. Relapse Management

In the addiction treatment field we are very familiar with the issue of relapse. Often we think about relapse prevention when we are working with a client, but we know that by the time we encounter someone, he or she has probably had more than one experience with relapse already. And we know that relapse experiences can offer opportunities to learn but are usually accompanied by feelings of shame, hopelessness and failure.

This is certainly true when it comes to tobacco use. So, as with any addiction, your role as a counselor includes helping the person develop a new perspective on past relapses, learn lessons that will be useful this time, and plan for the future.

How Do We Define Relapse?

We generally think of relapse as resuming regular use of a substance, usually at the previous level of consumption. Relapse can also be a return to a pattern of use,

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10 Information in the “Relapse Management” section was drawn from the Training Manual of the American Cancer Society’s Massachusetts Smoker’s Quitline, based on the work of the adapted California Smoker’s Helpline.
for example, the woman who only smokes when she sees her mother, or the man who “bums” a cigarette from a co-worker when things are really stressful at work.

This is very much like any other substance use. If a person is giving him- or herself permission to smoke under certain circumstances, there will always be a day when there are reasons to smoke more, and soon the person will be smoking regularly again.

We think of a “slip” as a single incident of smoking, which may involve one or more cigarettes. A person goes to a social event with smokers and has several cigarettes, but wants to be a non-smoker, and the next day resumes abstinence. The key factor is that he or she decides to get back on track and does not continue to smoke.

Relapse as Part of the Recovery Process

We know that most people make several attempts to stop smoking before they finally quit for good. Under the best circumstances they learn something from each attempt, so that the next time around they are better equipped to handle the challenges. Unfortunately, people who have relapsed often come to the conclusion that quitting smoking is just not possible for them. Sometimes people who are in precontemplation (not thinking about quitting) have tried to quit and relapsed and are feeling hopeless because of it.

Counselor’s Role

As a counselor, your role with regard to relapse has two aspects:

1. Relapse prevention = anticipating, planning, preparing, rehearsing
2. Coping with relapse = reflecting, reframing, learning, re-motivating

You can help the client who is planning to quit, or who has quit and then slipped or relapsed, to diagnose the “real problem” underlying the slip or relapse (see below), and to plan for the future.

Coping with Relapse

For the person who is thinking about quitting, looking at past experiences in a useful way can be the key factor that helps him or her decide that it could be possible to try to again. The person who has been actively trying to quit and relapsed will need help to look at it as a learning opportunity and get motivated to try again.

Relapses from two perspectives:

1. From a feelings perspective: the person has feelings of failure, incompetence, and inability. This results in low self-efficacy (not believing in one’s
ability to be successful), low self-esteem, and an increased sense of “external locus of control” (believing that the control is outside oneself, for example, in the cigarette itself). The person needs to see partial successes, gain confidence, and see the opportunities to act in a different way the next time.

2. From a learning and planning perspective: the person needs to learn from past experiences, anticipate difficulties, to be prepared to meet challenges.

Relapse prevention

Relapse prevention begins when the person is in the Preparation stage and continues through Action and Motivation. Based on past experience, he or she will need to think about the situations that will be the most difficult and then make concrete plans to manage those challenges.

Some people will have difficulty imagining the situations and will need help “walking through” their days. The more specific and detailed and do-able the plan, the more likely it will be effective. Cognitive strategies (things we tell ourselves) are always available and often precede doing a behavior. Be sure client does the work. The ideas that he or she comes up with will more likely be things that will work. If someone is really stuck, ask, “How could you distract yourself until the urge to smoke passes?”

After the quit date (24 hours or more smoke-free):

- Ask the person, “What situations have been difficult that you’ve overcome successfully?”
- Emphasize the strategies that have worked.
- This helps the person build self-efficacy
- In the early days of quitting, most people focus on how difficult things feel. They need to be reminded of what they are doing right!
- Were the situations anticipated in the planning stage?
- Listen for close calls or strategies that might not work well in the future.
- Help the client refine, reinforce, further develop strategies.
- After talking about what they have been dealing with so far ask, “Is there anything that’s coming up that you need to plan for?”
- People need to learn to plan ahead, so they are not caught off guard.
- Eventually, as they have more experience with handling triggers, they will be more able to “think on their feet” when they have an urge to smoke.
- If there has been a slip or relapse:
  - Deal with the feelings about it (shame, embarrassment, etc.).
  - The good news is that he or she is there to talk about it with you.
  - Help the client diagnose the “real problem” and plan for the future.
• Re-evaluate NRT and/or Zyban use and develop new plan.

Relapse issues and strategies

*Motivation to stay quit was insufficient:* in a given situation, the desire to smoke was stronger than the desire to quit.

• Always review motivation, helping the client recall his primary reason for quitting and strengthen it. This may involve restating the reason in stronger terms.

• Help the client to develop cognitive coping strategies that focus on the reason for quitting or will engage his determination and commitment to quitting.

*Expectation of withdrawal:* the person’s experience of withdrawal symptoms is more uncomfortable than she was prepared for.

• Normalize the experience, educating her about the reasons for particular symptoms, so they can be experienced in a different way.

• Inform her about the duration of the symptoms she is troubled by, so she knows they are time-limited.

• Problem-solve with her about how she will manage or tolerate the symptoms she is experiencing.

*Lack of assertiveness in social situations:* when he encountered a situation with other smokers, he was unable to ask them not to smoke in his presence, or was unable to refuse the offer of a cigarette.

• Do some basic assertiveness training, including some role plays so he can practice new behaviors.

• Work with the client to develop new coping strategies which focus on situations with other smokers.

• Encourage him to observe non-smokers in those situations, to see how they handle them.

• Help the client uncover the thoughts that resulted in his making a poor decision, so that he will make better decisions in the future.

*Ineffective coping strategies:* the client had anticipated the situation, but did not have adequate strategies. Strategies need to be useful and applicable in a variety of situations.

• Help the client determine what was lacking in her repertoire and make appropriate changes and modifications.
• Reinforce the value of cognitive strategies.
• Remind the client to use the “7 D’s and 3 R’s.”

The 7 D’s
• Delay the cigarette
• Deep breathe
• Drink water
• Do something different
• Dialogue with a friend
• Divert energies positively
• Dial the Smoker’s Helpline: 1-800-QUIT-NOW or visit the website: www.makesmokinghistory.org

The 3 R’s
• Remind yourself of the reasons you quit
• Rehearse tricky situations
• Refuse to give into negative thoughts

Coping strategies were not used: the situation had been anticipated and planned for, but when it occurred, the person smoked without attempting to use a coping strategy.
• Return to the issue of motivation.
• Examine with the client whether the planned strategy is something that he would actually be inclined to use.
• Help the client make a more usable plan, if necessary.

Unanticipated stressful event: the client was not prepared for the unexpected and needed alternative ways to cope with stress. She will often have used smoking as the primary way of dealing with stress and will usually strongly associate smoking with stress.
• Help the client develop new stress-management skills.
• Work with her on coping strategies, both cognitive and behavioral, that will be useful even if she experiences stress.

Misunderstanding weight gain: the person has noticed an increase in his weight and has chosen to smoke, seeing it as a better option.
• Provide facts about quitting smoking and weight gain, so the person is making decisions based on information rather than fear.
• Help the client examine his food intake and exercise pattern and encourage a commitment to new behaviors.
- If possible, offer ways to reframe the weight gain in a more acceptable way, so he can think in a more positive way about the future outcome of quitting.

*Problems with self-monitoring skills:* she may not be very self-aware and may act without thinking.
- Question the client: does she see a potential situation coming? Does she recognize the course she chose and the alternative options that were available?
- Suggest methods that may help her become more self-observant, such as keeping track of situations, cravings, and coping strategies.

*Repeated smoking while on NRT:* Client may not be ready to quit and may need to stop all NRT use immediately.
- Assess timing of and motivation for quit attempt. If necessary set new quit date.
- Develop new plan and examine relapse triggers and coping strategies.

**K. Reaching Clients Where They Are**

The reduction of cigarette smoking would be one of the most crucial and effective means of reducing the disparities in health status between majority and minority Americans.

Ramirez & Gallion, 1993, p. 350

The strategies and suggestions offered in this manual are based on the applications developed over the past 20 years in the smoking cessation field. It is important to acknowledge that research is limited on identifying what works best in helping people in recovery stop smoking and stay stopped. In addition, research is only beginning to recognize the different meanings smoking has across culture, class, gender, age, race, ability, and sexual orientation, and the implications of these contexts for the design on successful treatment strategies.

Fortunately, the addictions treatment field has recognized the importance of cultural sensitivity and achieving cultural competency in preventing and treating substance use disorders. Many of the conclusions drawn from this ongoing work can be applied to nicotine dependence counseling. The following section will outline some overall principles. We encourage programs to use the Appendices sections which contain handouts and a list of resources to further develop inclusive and/or specific approaches.
1. Tobacco Treatment Interventions

1. Individualized attention is particularly important since culturally sensitive written materials may not be available.
2. Do not assume that a particular community knows a lot about the damaging effects of smoking because often information does not always reach the community, and/or culturally appropriate smoking cessation services may be unavailable.
3. In order to reach people effectively, understand what matters to members of the community or cultural group. Find out what their core values are.
4. Find out the cultural meanings and values assigned to tobacco, smoking, seeking help, health, etc., and adapt your approach accordingly.
5. The negative influences of tobacco use may not be understood and may need to be presented in a way that explains their impact on priority issues such as substance use, poor health, infant mortality, stress and coping.
6. Provide written materials with specific, culturally relevant benefits of quitting. Information in all languages must include materials designed for the reading level of individuals with a low educational level.

2. Women and Tobacco

It has been found that women-only cessation programs allow better dissemination of women-specific messages. Women’s programs have adapted a comprehensive, process oriented, holistic approach in substance use treatment which can be used effectively with smoking cessation. In addressing tobacco use with women, the World Health Organization suggests attending to the following five concepts:

- Accessibility: Be sensitive to factors such as race, socioeconomic status, culture, ethnicity, and age. Use tapes, films, and materials in different languages, including American Sign Language.
- Comprehensiveness: Issues cannot be restricted to smoking behavior only but placed within the context of women’s experiences.
- Skill-building: Skills must be developed in assertiveness, identifying internal and external motivators and relapse triggers, resisting pressure, stress management and positive health behaviors.
- Support: Social support, respect, acceptance and trust are most important.
- Address all stages of the process of change: Ensure that you have materials that target people in precontemplation as well as those interested in or committed to quitting.
3. Interventions based on core values

One key element for reaching clients where they are is learning more about what matters to your clients and how smoking impacts these things. Rather than making assumptions about what people care about, ask your clients what they value and care about. The more you can explore with them how continuing to smoke interferes with the achievement of their goals or conflicts with their core values, the more successful you will be in helping them be motivated to quit and stay quit. Once you know what your clients care about, you can direct your intervention to speak directly to what is important to them.

The following chart gives examples of core values and how to tailor interventions in response.
Values/Possible Ways to Intervene

Values/Possible Ways to Intervene.

| Family | ● Emphasize parents as role models for children  
|        | ● Family support for smoker’s cessation efforts  
|        | ● Engagement in family activities is incompatible with smoking  
|        | ● Improvement in relationships with relatives  |
| Employment | ● Emphasize the inconvenience of smoking in a smoke-free workplace or decreased problems with non-smoking employees in a workplace that allows smoking  
|        | ● Improved perception by employers could improve performance reviews  |
| Religion/Spirituality | ● Use prayer/meditation among strategies to quit or stay quit  
|        | ● Involve religious leaders in community cessation efforts  
|        | ● Explore how smoking/not smoking fits with religious or spiritual values  |
| Health | ● Emphasis on preserving the health of spouse/partner, children, parents, and self  |
| Friends | ● Friends can speak to smokers about quitting, as credible and trustworthy sources of information and agents for change in community norms/social acceptability  
|        | ● Friends can also reinforce mass media anti-tobacco messages and help create an environment of community support  |
| Social Support | ● Peer cessation groups  |
| Appearance | ● Improved smell and hygiene  |
| Oppression | ● Message of freedom, emancipation, independence, non-conformity  
|        | ● “Quitters are winners”  
|        | ● Even those not ready to quit are angered and alarmed by the tobacco companies’ targeting of African American and Latino communities, women and girls, and gays and lesbians  |
| Community | ● Activities that increase self-esteem and community pride  
|        | ● Use of social activities and popular events to promote anti-tobacco norms  
|        | ● Smoke-free social events, meetings  |

4. Working with Pregnant Women

The importance of the previous concepts can be seen in the following points, which was developed based on focus groups conducted with pregnant women in Los Angeles, California, by the American Lung Association.
Why Pregnant Women Smoke (Why Can't She Just Stop?)

1. Tobacco is a highly addictive drug.
2. Some women do not believe that smoking is dangerous.
3. Many pregnant women believe smoking reduces stress.
4. Some pregnant women believe smoking prevents them from gaining weight.
5. Many pregnant women live in environments that encourage rather than discourage smoking.
6. Many pregnant women do not know how to stop smoking even if they want to stop.

Strategies which are most helpful to pregnant women are strategies which take the above health beliefs into consideration and provide education, stress management, counseling and support. Approaches which judge or lecture clients are likely to back-fire, making pregnant women feel guilty or defensive.

Just as women have special considerations when they stop smoking, so do other populations. For example, interventions should take into consideration the unique needs of youth; gay, lesbian, bisexual and transgender clients; and people with mental illness. Linguistic and literacy abilities are also important considerations in designing effective strategies to meet people where they are.

5. General Treatment Recommendations for Treating Tobacco Dependence in People with Mental Health Disorders

Be aware that your role is to assist clients to quit using tobacco. Mental health conditions that are present or occur after tapering or quitting need to be treated by or in conjunction with a mental health treatment provider. Our responsibility is to support clients who struggle with mental health issues to learn some strategies for quitting and staying quit, as outlined below.

Overall treatment considerations

- Be aware of client’s past and present mental health history. If the disorder is active, be sure it is treated first, usually with psychotherapy and medication.
- Continue to assess mental health symptoms throughout tobacco treatment.
- Watch for the interaction of smoking and mental health issues.

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12 Information included in the “General Treatment Recommendations for Treating Tobacco Dependence in People with Mental Health Disorders” section was drawn from the Center for Tobacco Prevention and Control, University of Massachusetts Medical School Tobacco Treatment Specialist Core Certification Course.
• Ask clients to identify their symptoms related to their mental health issues.
• Coordinate with physicians, psychiatrists and other counselors when a client stops using tobacco in order to ensure follow-up related to other medical and clinical issues.
• Know when and how to refer.
• Meet with your clinical supervisor weekly.
• Be aware of treatment boundaries.

Mood disorders and smoking

• Smoking and depression are highly related: 40-50% of patients with depression smoke.
• Among psychiatric illnesses, the prevalence of substance use disorders is highest for bipolar disorder and major depression.
• Smoking may improve depressed mood.
• People with mania have poor impulse control, and may have difficulty reducing or quitting smoking. Also, they often sleep very little, and may smoke to keep busy when awake.
• Recommended strategies for quitting
• Relapse to depression is likely a risk with smoking cessation; people can identify symptoms that might indicate relapse.
• Use techniques to assist with affect and stress management: problem solving, social skills training, relaxation exercises, coping strategies that have worked previously.
• People with a history of recurrent major depressive illness have higher abstinence rates with cognitive behavioral therapy (CBT) than health education (Haas, Munoz, Humfleet, Reus, & Hall, 2004).
• Medications: bupropion or nortriptyline started prior to quitting (along with nicotine replacement therapy, started once client quits smoking) may help with cravings and depressive symptoms in highly nicotine dependent clients (Wilhelm, Arnold, Niven, & Richmond, 2004; Lerman et al., 2004).
• Medications: Fluoxetine 60 mg significantly improves post-cessation positive affect and may help decrease relapse (Cook et al., 2004).

Schizophrenia and smoking

• 70–90% of people with schizophrenia are smokers.
• People with schizophrenia are more likely to smoke, and smoke differently, showing higher cotinine levels for a given number of cigarettes. Cotinine is the major metabolite (breakdown product) of nicotine.
• Smoking reduces blood levels and side effects of antipsychotic medications.
• Nicotine may improve energy, mood and ability to focus.
• Nicotine transiently improves the ability to screen out sensations and focus on a single stimulus (this ability is decreased in schizophrenia).
• Nicotine withdrawal symptoms may mimic drug-induced side effects and symptoms of schizophrenia such as irritability and insomnia.
• Quitting may temporarily worsen drug-related movement disorders.
• Check medication levels post-quitting, as quitting may decrease the dosage of antipsychotic medications required.

Recommended strategies for quitting

• People with schizophrenia show motivation and want to quit smoking.
• Motivational techniques are useful: identify personalized reasons for quitting and remind people why they want to quit in their own words.
• Behavioral therapy is important: people need help developing coping skills to deal with stress and planning for change.
• Be concrete in helping patients plan for their quit date.
• Monitor physiologically if possible, such as with readings from a carbon monoxide machine.
• Give empathic and nonjudgmental feedback. Praise successes.
• No visual imagery.
• Use caution with relaxation techniques that involve work with closed eyes.
• Medications: bupropion is associated with stable clinical symptoms and increased quit rates but high relapse rates after treatment discontinuation in this population; combination of bupropion and NRT may be superior.
• Antipsychotic meds may be affected by changes in nicotine intake. Communicate with the prescribing psychiatrist.

Anxiety disorders and smoking

• About 45–60% of people with anxiety smoke.
• Smoking may help increase feelings of relaxation acutely but increase average daily anxiety level because of frequent withdrawal anxiety.
• Smoking improves focus/attention.
• Smoking may provide a social connection; people need to establish other connections.
• Recommended strategies for quitting
• Help clients identify non-smoking strategies for managing anxiety.
• Clients may need a referral to a therapist to develop anxiety management skills before being able to quit.
• Nicotine withdrawal symptoms may be interpreted as anxiety symptoms.
• Chronic use of nicotine can increase anxiety (Williams & Zeidonis, 2004).
• Use caution with relaxation techniques for people with post-traumatic stress disorder. Give people a choice of keeping eyes open or closed.
• Medications: keep NRT doses stable over the course of the day to reduce fluctuations in nicotine which may feel like anxiety; use caution if considering bupropion.
• If needed, consult with therapist/psychiatrist regarding medication management.
IV. Integrating Education, Assessment, & Treatment of Nicotine Dependence into Substance Use Treatment Programs

A. Administrative/Program Issues

Nicotine dependence treatment interventions are most effective when they take place in a supportive environment. For clients to have the best chance of success at stopping smoking, the entire program must be involved and committed to supporting those who choose to stop smoking. Tobacco treatment works best when it is institutionalized and woven into the fabric of the treatment milieu, program systems and policies. The following section examines implementing supportive policies.

1. What Do We Mean by These Terms?

Smoke-free: When smoking is not permitted indoors, a program is smoke-free. A smoke-free program protects non-smokers from the hazardous effects of environmental tobacco smoke. Depending on the program, clients’ addiction to nicotine may be addressed with tobacco education and/or nicotine dependence treatment.

Tobacco-free: Tobacco use is not permitted in any form indoors or throughout the grounds. Staff and clients adhere to a policy that prohibits tobacco use throughout the program and spells out consequences and enforcement guidelines. Even if off-site, the expectation is that clients are not smoking or using tobacco products, and that staff members are not using tobacco during the work day. Tobacco-free programs understand that use of tobacco products is incongruent with a life-style free of addictive drugs. These programs recognize the need to assist clients, employees and volunteers at the facility in addressing tobacco and nicotine issues through ongoing education and access to treatment. Tobacco dependence is treated on par with other substance use disorders.

2. Developing and Implementing Policies on Tobacco Use

When implementing new tobacco policies it is important to remember these vital facts:

- Having a policy in place, without addressing the underlying addiction issues, can only lead to repeated undermining of the policy (“Just Say No” – without education, help, or treatment).
- The most effective way to address tobacco use is with positive messages, in a smoke-free setting.
Staff tobacco use must be addressed as part of policy development, implementation and enforcement. All staff members are expected to follow-up with tobacco policies, regardless of tobacco use status.

Staff members who smoke may feel concerned about how to talk with their clients about tobacco use, and express feeling like “hypocrites” in doing education or conducting 5A assessments. Supervisors can assist staff to examine how their own tobacco addiction interferes with their responsibility to move clients towards health and recovery. All staff, whether clinical or administrative, can break the silence on nicotine addiction. Clinicians can also be helped to deliver positive messages about the importance of quitting, acknowledging their own struggles or intentions in this area. This may also help staff’s motivations to address their own tobacco addiction.

Reviewing your program’s progress over the past ten to fifteen years is helpful: Remember when smoking in treatment groups or sessions was the norm? Remember how hard you worked to become smoke-free, and how routine that now seems?

3. Steps for Becoming a Tobacco-Free Program

The Tobacco Dependence Program was a New Jersey tobacco treatment, training and consultation project which began its work in the state’s alcohol and drug treatment system. This group developed the following steps as a process for becoming entirely tobacco-free (i.e., no use of tobacco by clients or staff at the facility):

- Acknowledge the profound challenges tobacco creates for the addictions treatment community.
- Establish a leadership group or committee and secure commitment of the organization.
- Develop a tobacco-free policy.
- Establish a policy implementation timeline with clear, measurable goals and objectives.
- Conduct staff training.
- Provide recovery assistance for nicotine dependent staff.
- Assess and diagnose nicotine dependence in patients and use this treatment planning.
- Incorporate tobacco/nicotine into patient education curriculums.
- Establish ongoing communication with AA/NA, professional colleagues and referral agents about these changes.
- Staff should not be identifiable as smokers.
- Establish tobacco-free facility and grounds.
- Implement nicotine dependence treatment throughout the program.
The Tobacco Dependence Project estimated that it takes a program 2–3 years to implement a timeline to become entirely tobacco-free, with a review of goals, progress, and successes along the way. Smaller programs may take less time. Becoming smoke-free or moving smoking to designated outdoor sites generally takes less time.

The above steps demonstrate the links between policy implementation, staff and client education, and integration of nicotine dependence assessment, treatment planning, and education into a program. These steps can be utilized in developing any tobacco-related policy, and institutionalizing nicotine education, assessments, and treatment.

4. Challenges and Benefits to Becoming a Tobacco-Free Program

In Massachusetts, several publicly and privately funded acute treatment services and residential programs have become tobacco-free since 1996. In most cases, the programs prepared for this policy shift over time, with intensive staff training, nicotine treatment for staff and clients, advance notice, and by following steps similar to those listed above. Most programs either had NRT available on-site or were affiliated with tobacco treatment programs to which clients could be referred.

Becoming tobacco-free is really phase one of a longer process. The tobacco-free programs found that new challenges presented themselves once the policy was in place, including the following:

- Staff who did not comply with the policy and did not want to quit smoking on or off premises
- Clients who didn’t want to quit
- Clients continuing to smoke outside and inside the facility
- Clients smoking on bupropion (Zyban) beyond their quit date, as well as taking the nicotine patch off and smoking
- Clients’ negative behaviors
- Staff’s inconsistency with follow-up and enforcement of the policy
- Clients who come in as smokers going into withdrawal, without access to medications or counseling
- Secrets in the treatment program between clients and between staff and clients about who is breaking the rules and smoking
- Weight gain experienced by those who quit

Many of these challenges are related to the need for ongoing management and treatment of nicotine dependence, from helping clients and staff with withdrawal to addressing addictive behaviors (secrets and/or lying). However, staff undermining of policy can have very serious consequences. Supervisors can frame staff rule infractions as job performance issues, and ongoing problems with smoking on the job can be viewed as an addiction issue: referrals to an employee assistance program
or a tobacco treatment specialist may be necessary for an employee whose addiction to nicotine makes it difficult to comply with agency regulations.

Programs have also identified benefits to going tobacco-free. These include:

- Changes in staff smoking, as many staff have quit or cut way back on their smoking
- Clients are smoking less
- Program environment smells better; reduced exposure to secondhand smoke
- A health education component and/or tobacco treatment component has been added to programs
- In some cases, acupuncture which is available for other substance use treatment is used to assist with nicotine withdrawal
- Health benefits of quitting
- People are saving money
- Clinicians find that concentration is better in groups, which are less “ruled” by cigarettes, and that clients’ feelings are more available to work with

The process of becoming tobacco-free is best entered into once a program has integrated and has gained experience in providing on-site nicotine dependence education, assessment and treatment. Staff must be well-trained and comfortable with including tobacco issues in individual and group treatment. People coming in for substance use disorder treatment are new to the idea of the importance of addressing tobacco use, and many are probably not interested in or ready for quitting. A program’s biggest challenge can be finding the balance between mandates and need for consistent policy on the one hand, and flexibility and a recognition of an individual’s stage of readiness for change on the other.

5. Elements of a Policy on Tobacco Use

The next section describes the role and recommended elements of a policy on tobacco use.

Policy Overview

A written policy on tobacco use sets the tone, guides the procedures, and affirms the program’s pro-health, public health commitment. A policy tells staff, clients, and visitors where the program stands regarding nicotine use on the premises, highlighting the importance of a written, visible, explained policy, and states a program’s philosophy regarding the drug nicotine.

In your planning process for writing the policy, include consideration of the following factors and elements:
Compliance with the BSAS Tobacco Guidelines
Policy enforcement
Nicotine recovery assistance for staff and clients
Plan for staff and client education
Staff breaks: how will these be structured?
In-house communication about the policy, including administration, board of directors, and coverage staff
Communication to clients’ families, referral sources, aftercare programs, graduates

6. Essential Elements of a Written Policy

Purpose/background/rationale section

- Health reasons for policy: secondhand smoke; vulnerable populations served, e.g., youth, pregnant women, people with HIV/AIDS, people with histories of chronic illnesses related to smoking; health issues for smokers, importance for recovery
- This section “makes it real” for staff and clients, present and future

Guidelines for program

- Statement and clear descriptions of physical changes to site: designated areas, outside and/or inside; prohibited and permitted areas for tobacco use for clients, staff, visitors

Statement of timeline for implementation

- Statement of times for phased-in changes prior to final endpoints, such as notification of clients, former clients, referral sources; notification of prospective clients

Statement of assistance that will be provided for smokers (staff and clients)

- Tobacco treatment resources, materials, referrals
- Agency’s encouragement of and support for quitting smoking/tobacco use

Monitoring and enforcement of policy

- Include a clear statement of consequences, with the options available for grading them in severity for repeated violations
- Include education plans for staff, clients, boards, managers
- Allow ample time between announcing and implementation, usually 4–6 months (6 months–2 years if becoming totally tobacco-free)
- State consequences for non-compliance
- Staff input and understanding are essential to the process
- List a contact person, for staff who may have questions


The Agency for Healthcare Research and Quality (AHRQ), an arm of the U.S. Public Health Service, is a government agency that establishes guidelines for medical practice based on scientific evidence. In 2000, the Public Health Service issued clinical practice guidelines on how to help people quit using tobacco. The guidelines were updated in 2008 and based on review of more than 6,000 research studies on treating nicotine dependence and represent the best practices in the field. The guidelines targeted three health care audiences: health care administrators, insurers and purchasers; smoking cessation specialists; and primary care clinicians, among which AHRQ included mental health and substance use treatment clinicians.

The guidelines emphasize the importance of primary care and other clinicians and counselors in the smoking cessation process. The guidelines build on the use of the 5As. Some of the following can be incorporated into your program’s overall approach to addressing tobacco.

- Ask every client at every visit if they smoke.
- Write a patient’s smoking status in the medical chart under vital signs.
- Ask patients about their desire to quit, reinforcing any intention to quit.
- Motivate patients reluctant to quit by asking them to identify and then discuss the possible negative consequences of smoking and benefits of quitting.
- Help motivated smokers set a quit date and assist them by offering nicotine replacement therapy, providing self-help materials, and providing key advice including problem-solving.
- Help patients resolve problems that result from quitting, including weight gain.
- Encourage quitters not to resume smoking and encourage relapsed smokers to try again. For pregnant and postpartum women, continually emphasize the effects of secondhand smoke on infants and children—asthma, middle ear infections, etc.—to help prevent relapse.

The Public Health Service Clinical Practice Guideline on Treating Tobacco Use and Dependence and other clinician and consumer reference guides are available at
no charge from the AHRQ Publications Clearinghouse, 800-358-9295, or online at www.surgeongeneral.gov/tobacco/

8. Systems Approach

Extensive research has been conducted on the treatment of nicotine dependence, and numerous models for treating nicotine dependence have been developed (see III. “Overview of Nicotine Addiction & Treatment”). Research and experience have shown that healthcare settings offer an excellent opportunity for intervention and that intervention should be conducted as often as possible. This includes substance use treatment programs. According to the Agency for Health Care Research and Quality (www.ahrq.gov/clinic/tobacco) and research studies, an essential component of successful intervention in a healthcare setting is an office system which facilitates interventions.

Office systems allow:

- Smokers to be identified at each visit.
- Treatment to be offered at each visit.
- Tobacco users to realize the seriousness of nicotine addiction and the resources that can help them.

How to incorporate a systems approach:

- Integrate the BSAS Tobacco Guidelines and establish a tobacco policy for your substance use treatment program.
- Routinely ask all patients their smoking status.
- Incorporate questions about smoking status and history into intake forms. (See Appendices, Section C, for sample questions and intake forms used in other substance use treatment programs.)
- Record smoking status in the patient record or chart.
- Integrate tobacco use as part of treatment plans. Revisit at regular intervals.
- Offer each patient who smokes the option of some form of treatment for his or her nicotine addiction.

9. 5A Brief Intervention Model

Originally developed for physicians to use with their patients who smoke, it is easily adapted by other health care providers for use with their patients and clients, and can be integrated into a treatment program’s intake and assessment forms.
It is based on five steps: *Ask, Advise, Assess, Assist and Arrange follow-up*, which provide certain questions to ask and steps to follow to identify a user’s stage of change and develop a plan for addressing his or her nicotine use (see Sample 5A forms in Appendices, Section C). The model is designed to be “patient-centered” and non-threatening, meaning it will prompt individuals to think of their own reasons for addressing their tobacco use. The model also stresses the importance of developing standard “office systems” that ensure that all patients who smoke receive intervention. Systems vary from setting to setting, but the model is adaptable to numerous settings. Recommended by the Public Health Service clinical practice guideline (www.ahrq.gov/path/tobacco.htm) as an effective brief smoking intervention tool, the brief 5A assessment has been included in the BSAS Tobacco Guidelines to be implemented by all BSAS-funded programs at intake.

**B. Staff Issues: Points to Consider**

Staff is key to the success of policy implementation and integration of strategies addressing tobacco use. Staff benefit from open discussions about the issues. Attitudes exploration and values clarification have helped to break the silence on tobacco, and have helped staff to see points of agreement as well as disagreement. Time in regular staff meetings can be set aside to focus on tobacco issues from personal and professional perspectives and to receive in-service education on tobacco’s impact on health, special issues for substance users who smoke, and ways to talk about tobacco use with clients. Resistance to these issues may be the result of a lack of information or reflect the staff smoker’s own process and readiness to change. (See III.G. “The Stages of Change.”)

It is optimal for those counselors who are to address nicotine issues with clients to be non-smokers. But, of course, in many programs, there will be smokers on staff.

**Issues for staff who are current smokers, and possible solutions**

- Clinicians who are smokers may be resistant to this process. If clients are aware that some staff smoke, it is important to have a plan for what staff will say to clients.
  - Staff may want to talk about the negative effects of their own smoking.
  - Staff may tell clients they want to quit smoking and intend to quit.
  - Staff may emphasize that quitting while living in a supportive smoke-free community can be easier than quitting later.

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13 Information included in the “Issues for staff who are current smokers, and possible solutions” and “Issues for all staff” sections was drawn from Ker & Markovitz (1996).
• Staff who smoke may experience an ethical dilemma and/or guilt if asked to help smoking clients quit; also, they know that clients will be alert to mixed messages.
  - Discuss the policy and ethical issues openly with staff.
  - Provide support and supervision to staff to assist them in separating their personal issues from clinical treatment issues.
• Staff may be enforcing something they may not believe in when programs change the tobacco use policies, and anticipate “police work” with new monitoring responsibilities.
  - Smoking already has not been allowed inside most treatment facilities for safety reasons. Staff can be encouraged to see taking further steps as a continuation of health, safety, and relapse prevention issues.
  - Place smoke alarms in bathrooms and other areas to monitor clients’ smoking; purchase a carbon monoxide monitor which can discern smoking.
  - Remind staff of the importance of having all staff enforcing the policy. Staff who refuse to implement the policy correctly should be dealt with in the same manner as if they refused to implement any other policy.
• Job performance issues and coverage issues need to be discussed openly: e.g., leaving to take a smoke break and the possible tension/resentment from other staff, coverage issues, possible increase in environmental tensions and stress.
  - Establish times when staff can smoke and ensure that they get those breaks.
  - Establish break policies for all staff to lay out coverage responsibilities and encourage non-smokers to take a break, too.
  - Fewer opportunities to smoke may result in staff experiencing impaired concentration and mood swings due to the impact of nicotine withdrawal. Staff can be encouraged to take non-smoking mini-breaks at their desks and do stretches, drink water, do some deep breathing.
  - If break and coverage issues become problematic, make it clear to non-smoking staff that they are not to harass staff who smoke but instead bring the issues to a general staff meeting or a supervisor.
• Staff who use tobacco and work in programs that actively address nicotine use may worry about having to defend their counseling qualifications and professional competence.
- For some, this may provide motivation to quit smoking and to examine how not addressing nicotine dependence interferes with clients’ treatment.

- Staff who smoke may experience fear of job loss and feelings of vulnerability at the work site as programs talk about changing the tobacco policies.
  - It is vital to include staff in the policy planning and implementation process.

- Staff may feel pressure to be role models and to support something in which they may not believe.
  - See “ethical dilemmas,” above.
  - Utilize open discussions to find common ground for agreement, such as concerns about secondhand smoke exposure and their commitment to clients’ health and recovery.

- Those trying to quit have been discouraged by the absence of smoking cessation materials and methods specific to people with a history of alcohol/drug problems.
  - Utilize this manual and other suggestions which can be found in the bibliography

Issues for all staff

- Many treatment providers went through treatment programs themselves where they were taught that quitting smoking too soon could jeopardize sobriety, while in fact it supports long-term sobriety. To work with tobacco dependence issues, additional education, training, and time requirements will be involved.
  - Do not focus only on the staff who smoke: all staff need education and training
  - Never-smokers may need help to develop sensitivity to nicotine addiction and the challenges of the quitting process

- Staff may resent assuming responsibility for a client’s recovery from nicotine.
  - Take a programmatic stance that “a drug is a drug,” and that this includes addressing clients’ nicotine dependence

- Programmatic issues and “unwritten rules” will get stirred up.
  - Is there support for staff to address stress management and self-care issues? Are staff members able to utilize “health” breaks instead of smoke breaks?
  - Can staff take a walk during lunch? Are staff members able to schedule a lunch break on a regular basis?
C. Boards of Directors: Issues to Consider

The importance of receiving support for agency changes has to start with administration—at the top. If not, a tug of war can develop between the Board of Directors and the on-site staff over plans to address tobacco use.

The recommendations for facilitation of attitudes exploration, education, training, and referrals to MTCP services extend to an agency’s board of directors. Board members may not be as aware of the research and information presented in this manual and may lack the knowledge necessary to make informed decisions regarding the importance of addressing tobacco. They may have concerns about the impact of these issues on client dropout rates and admissions numbers, the “bottom line.” In this case it is best to let the experience and findings of CENAR members and TAPE staff speak for itself: when programs have offered counseling, education, or referrals for nicotine dependence treatment, clients are interested and participate. Also, in informal surveys of staff and clients in Massachusetts BSAS programs, many identify that they have previously attempted to stop smoking and indicate a current desire to stop.

Boards of Directors have many legitimate concerns, and these should be identified and addressed with material from this manual. Their support of policy and concern about the health and addictions issues with tobacco use can set a positive tone and provide important leadership.

D. Integrating Nicotine Addiction Treatment into Substance Use Treatment Programs

Developing and implementing smoke-free or tobacco-free policy is an important first step in addressing and managing tobacco use within a program. However, if a program sees policy implementation as an endpoint and does not address the behaviors and consequences of nicotine addiction, compliance with the policy can be undermined and enforcement becomes more difficult.

A more comprehensive approach combines a smoke-free/tobacco-free policy with the integration of a brief nicotine dependence assessment form, ongoing client education on nicotine addiction and recovery, and help, referrals, and strategies for treating tobacco use. With an assessment form that includes questions on all drug use, including tobacco, programs can identify smokers who are thinking about change or ready for action. With ongoing education groups, programs can plant the seed about stopping nicotine and support the motivation of those interested in becoming abstinent. Individual and group counseling that focuses on quitting tobacco use and preventing relapse can actually build on the recovery strategies clients are already utilizing to recover from alcoholism and other drug addictions.

The following section provides strategies for integrating nicotine dependence assessment, education, and treatment into substance use treatment programs.
Start with the following programmatic considerations:

1. What is the program’s current policy on tobacco use?
2. What is the program’s philosophy about nicotine as a drug?
3. Develop an overall staff approach/philosophy.
4. Develop and enhance linkages to resources such as the Institute for Health and Recovery’s Tobacco, Addictions, Policy, and Education (TAPE) Project; the Council to End Nicotine Addiction in Recovery (CENAR); the Smokers’ Helpline; and Nicotine Anonymous meetings.
5. If nicotine dependence is addressed as a treatment issue (assessment, education, treatment assistance), the overall agency policy should be reviewed to make sure it is congruent. For example, if tobacco treatment is available, should staff and clients ever be allowed to smoke together? Or does this give a mixed message?

The next section offers suggestions for program components that can be integrated over time.

1. Integrating Education, Assessment, and Treatment of Nicotine Dependence

Program components:

- Self-help/educational materials are available
- Assessment/intake/screening questions/5A assessment
  - Standard questions asked of all clients/consumers
  - Fagerström Test for Nicotine Dependence
  - Chart nicotine dependence (305.10, DSM IV); include on problem list; address in treatment plan; follow-up on status as treatment plan is updated
- Tobacco education/counseling is available on a voluntary basis
- Local tobacco treatment resources or health educators come in to do group sessions
- On-site staff become trained and able to do group and 1:1 interventions and support
- “Thinking About Change” support groups for those considering stopping smoking, led by either staff or peers
- Mandatory ongoing tobacco education is included as part of psycho-educational/substance use education groups for all program participants
- Individual counseling for nicotine dependence is available
• Mandatory group counseling is offered to nicotine dependent clients to help educate and motivate them
• Nicotine dependence is included as part of Step I inventory and other treatment material, examining powerlessness and unmanageability as they relate to nicotine
• Nicotine Anonymous meetings become an option for 12 Step meeting attendance
• Aftercare planning includes setting goals addressing nicotine dependence and referrals to 1-800-QUIT-NOW
• Alumni groups receive information/education/referrals on tobacco issues and treatment resources

2. Issues Specific to Types of Programs: What Can Be Done?

Acute care settings

• Assessment of clients for tobacco use/placing a client on the Stages of Change/assessing readiness to quit
• Use of 6-question Fagerström screening tool to assess levels of nicotine dependence; higher scores will identify clients who might be at risk for smoking and violating the tobacco policy, and who would benefit from extra intervention and help from staff
• Education about health effects of smoking for people in recovery and strategies for quitting can be provided in existing groups
• Nicotine patch and gum can be offered, with monitoring, when available/appropriate; acupuncture can also be utilized to assist in patient withdrawals from nicotine
• Staff education on tobacco can be provided on a regular basis
• Treatment milieu can be expanded to foster pro-cession or harm reduction atmosphere: including posters, pamphlets, and banning tobacco paraphernalia (e.g., clothing and hats with cigarette names)
• Vital signs documentation can include smoking status
• Information can be provided about referrals for help with tobacco dependence as part of aftercare, including Nicotine Anonymous
• Unit can be tobacco-free for clients, with NRT and other pharmacological support provided to assist in withdrawal
• Staff relationship to tobacco can be changed through ongoing dialogue
• Treatment services and support information can be made available for staff who want to quit
Transitional support services, residential, and narcotic treatment programs

- Staff can receive education on tobacco issues on a regular basis
- The 5A brief intervention model can be institutionalized into the intake process and throughout the program as other treatment plan goals and objectives are reviewed
- Assessment of clients/placing a client on the Stages of Change
- Use of 6-question Fagerström assessment
- Nicotine patch can be offered, with monitoring, when appropriate; acupuncture can also be utilized to assist in withdrawal from nicotine
- Education about health effects and strategies for quitting can be provided in existing groups
- For those residents who are in contemplation or preparation stages, encouragement can be given to start a peer-led quitting smoking support group
- A voluntary treatment group can be conducted by trained staff to support clients in quitting smoking
- Attendance can be facilitated or encouraged at local Nicotine Anonymous meetings or programs can start an on-site meeting if there are none in the area
- Relapse prevention strategies can be offered to those who have stopped tobacco use
- Treatment milieu can be expanded to foster pro-cessation or harm reduct-ion atmosphere: including posters, pamphlets, and banning tobacco paraphernalia
- Program events can be planned around the American Cancer Society’s Great American Smokeout Day (third Thursday in November) or World No Tobacco Day (May 31)
- Information about referrals for help with tobacco dependence as part of aftercare
- Staff relationship to tobacco can be changed

3. Education vs. Treatment

Many alcoholic and other drug-addicted smokers are initially not motivated to quit smoking when they enter substance use treatment—either because they do not believe that their smoking constitutes an immediate health risk or because they (as well as many substance use treatment staff) believe that their success at achieving sobriety may be compromised by stopping smoking. A strong, clear message that tobacco dependence is a life threatening addiction may be needed to improve motivation.
Thinking back to the Stages of Change model, we can expect that smokers in treatment are primarily in precontemplation and contemplation. We may encounter more smokers in the preparation stage in residential rehab and outpatient settings, although only an assessment form and utilization of the 5 A’s model (see description in IV.A. “Administrative/Program Issues”) upon intake and again at various points in the treatment process will help us ascertain this. There may be clients in acute care services who are ready to detoxify from all their drugs of dependence.

Remember: the goal of addressing tobacco use in Stages of Change theory is to help smokers move one stage at a time. For example, a person may enter your program in precontemplation: “I don’t want to hear about it, I’m comfortable with my smoking, I quit before and gained weight and I will never try that again.” To assist this person to open the door even a crack, to drop that defensiveness and move into ambivalence is a major accomplishment. For this person to leave having moved into contemplation—“I like smoking, but know I need to stop; I want to stop but I’m afraid I’ll fail; I plan to stop someday but this isn’t the right time; I have resources and information on how to find support when I am ready to stop smoking”—and beginning to explore that ambivalence is a major change.

Education is key to assisting this movement. Education about tobacco and nicotine can be integrated into a variety of existing groups or can be provided in a discrete tobacco education group. People across the Stages of Change can participate in education groups where only those in the preparation, action, or possibly relapse stages would be ready for an actual tobacco treatment group.

A growing number of studies are available on the effects of tobacco treatment for people in substance use treatment. Some conclusions may be drawn from them:

- Voluntary nicotine dependence treatment may be less disruptive than mandatory treatment
- Voluntary quitting or reduction in smoking does not appear to have a detrimental effect on sobriety regardless of the timing of the treatment
- The more intensive behavioral treatments, as well as NRT, seem to produce rates of quitting comparable with those of nonalcoholic smokers

Quitting implies treatment: a readiness to stop smoking and a particular stage of change. Including an education group may be perceived as more welcoming and less threatening and does not hint at expectations. In such an open atmosphere, material can be offered in a manner which allows clients to explore their own concerns and histories and personalize their own risks.
4. Tobacco Education: A Few Suggestions for Getting Started

1. Consider the setting in which the information is presented.
   - Is it a smoke-free setting? Is secondhand smoke noticeable?
   - Who will be presenting the information?
   - What messages about tobacco use are given by the staff as a whole?

2. What is said is as important as how we say it.
   - Do not underestimate the power of planting seeds.
   - Consider your audience: Are people expecting to be lectured and nagged? Are they ready to focus on quitting smoking?

3. Emphasize the health benefits of quitting as much as the health hazards of tobacco use.
   - Scare tactics work with a few, but alienate many.
   - Education helps to personalize the benefits and risks.
   - Do not assume that people already have all the information.
   - Ask about what clients like and dislike about smoking; listen as they identify their own concerns and reflect back to them.

4. It is important to meet people where they are and to give positive support for any changes that are tried.

5. Emphasize public health issues and addiction issues instead of non-smokers’ or smokers’ rights.

6. Expect, plan for, and re-frame resistance: it is normal.

7. Stay informed and up-to-date on current information about tobacco, nicotine dependence, and stopping smoking.
   - Encourage clients to follow and discuss these current events as well.
   - We never know what will reach someone and open the door for change.
   - Build educational events around special dates.

   - Great American Smokeout: third Thursday in November
   - National Wear Red Day: first Friday in February (heart disease)
   - World No Tobacco Day: May 31 every year
   - July 4: Independence Day
   - New Year’s resolutions

5. Client Education

Client education begins with an assessment, paperwork, and then an orientation of the client to rules and regulations of the treatment program, including a smoke-free policy. Such times can be considered “teachable moments” when clients are educated about the program’s philosophy on nicotine, the program’s level of concern
about tobacco-related health issues, and the support that will be provided to address this issue. When asking clients about addictions in their lives and including tobacco, counselors give a clear message and perhaps begin to change the client’s perception of his or her relationship to the drug nicotine.

The following is an outline of topics for a weekly education group on tobacco issues. Detail on all of these topics can be found in the manual or its appendices. These sample group “menus” are based on groups that are being offered in programs throughout the state and include acute care settings as well as residential and outpatient settings.

6. Tobacco Education Groups: 10 Topics/Agendas to Include

1. Ingredients in cigarettes and cigarette smoke/secondhand smoke
   - Anatomy of a cigarette, including tars and nicotine
   - The processing story, from the farm to the consumer
   - Ingredients in cigarettes and smokeless tobacco
   - What is secondhand smoke? (SHS)
   - Review other tobacco products: chew, dip, snus, cigars

2. Nicotine: the addictive substance
   - Is nicotine a drug?
   - Similarities with other drugs
   - Smoking and feelings: What are the feelings smoking soothes?
   - The effect of nicotine on the brain
   - Effect on the heart and effects on the body

3. Reasons to smoke/reasons not to smoke
   - Finding ways to help clients internalize and personalize their reasons to quit
   - Moving from pre-contemplation into contemplation
   - Do an exercise: have clients write a list of personal barriers to stopping, including fears about stopping, and a list of personal concerns and reasons to stop smoking

4. The process of quitting tobacco use: Part 1
   - Importance of having a plan to stop
   - Rethinking quit attempts: learning from the past and that past attempts do not predict present attempts; identify what did/did not work before
• Methods of quitting: review/provide resource lists of quit smoking programs, Tobacco Helpline, and other resources; discuss applying 12 Step recovery principles to recovery from nicotine addiction
• Methods of quitting: individual and group counseling; hypnosis; acupuncture; Nicotine Anonymous; others clients have heard about or tried

5. The process of quitting tobacco use: Part 2

• Benefits of stopping smoking
• Normalize the experience of quitting smoking: what to expect
• Dealing with withdrawal, including Nicotine Replacement Therapy, Zyban, Chantix and stress management methods (see Appendices, Section G for the handout, “Symptoms of Nicotine Withdrawal”)
• Cognitive and behavioral strategies: positive self-talk as well as drinking water and other substitute behaviors
• Dealing with others in the quitting process: pros and cons of quitting with someone else; seeking support; watching out for others’ sabotage
• Practice new behaviors: limit-setting and assertiveness

6. Weight gain after quitting: myths, realities, and prevention

• Healthy eating and exercise tips
• Nicotine and body metabolism
• Early recovery from nicotine addiction is not a time to diet, as dieting and deprivation can jeopardize quit attempts
• Body image: myth and reality
• The relationship between foods and moods
• Identifying eating disorders and resources for support

7. Health information

• Short and long-term health consequences of tobacco: present information that is relevant now, such as the relationship between smoking and fatigue, loss of stamina, coughing, respiratory infections
• Less obvious tobacco-related health consequences, such as gum disease, cervical cancer; infertility in men and women; loss of vision; disc degeneration
• Gender-specific health consequences, health issues in different racial and ethnic groups, and impact of smoking on people living with HIV/AIDS and Hepatitis C Virus
• Discuss the impact of smoking on clients and their loved ones
• Discuss how both of the founders of A. A. died from smoking-related illnesses

8. Is smoking a recovery issue?

• Increase awareness
• Is smoking a substitution?
• Explore the role of smoking/using tobacco in clients’ recovery, i.e., “How has your smoking changed? Do you use smoking to deal with feelings? How else could you do that?”
• Inform about special health issues; smoking as a trigger in relapse to alcohol and other drugs; developing a quit plan for while in this program
• Stopping everything all at once: ways to cope

9. Advertising/media awareness

• Examine magazine advertisements, and ask: how does the tobacco industry convince us that there is no problem with smoking?
• Discuss placement of ads and to whom they are targeted

10. Change is a process: a stage-based model of behavior change

• Explore the following: What makes change difficult? What makes it happen? What promotes change?
• Learn about the Stages of Change model. Discuss where clients are in the stages regarding tobacco use and other behaviors they wish to change. What helped them get from the previous stage into the present one? What will help them move to the next stage?
• Change is a process; it does not happen overnight. Any positive change should be celebrated. The process of quitting smoking is not an all or nothing one.

The next table suggests ways to integrate nicotine dependence issues into groups commonly held in acute care, residential, and outpatient treatment settings with group topics and discussion questions. The three types of groups listed are alcohol/drug education; vocational groups; and health and wellness groups.
<table>
<thead>
<tr>
<th>Topic</th>
<th>A/D education</th>
<th>Vocational</th>
<th>Health &amp; wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco 101</td>
<td>Include info on tobacco/nicotine as one of the drugs your program addresses</td>
<td>Many worksites do not allow smoking now? Reasons?</td>
<td>What are you smoking? Ingredients, SHS, impact on self and others; benefits of stopping</td>
</tr>
<tr>
<td>Nicotine, the addictive</td>
<td>Describe effects of nicotine; as addictive as cocaine/heroin; what is the impact of nicotine on the brain; nicotine and suppression of feelings; smoking histories</td>
<td>Need for breaks interferes in job performance; can a work EAP help with quitting? Health plan options for quitting?</td>
<td>Examine the ways nicotine works “for” and “against” us</td>
</tr>
<tr>
<td>Quitting process</td>
<td>Examine similarities to stopping alcohol/drug use</td>
<td>Seeking support at work; utilizing EAP resources or telling supervisor</td>
<td>Ways to ease withdrawal and manage stress when quitting smoking</td>
</tr>
<tr>
<td>Advertising/ media</td>
<td>How addictions are marketed, “pushed” to consumers, especially youth</td>
<td>Cost of tobacco in comparison to amount that could be saved; budgeting and the impact of tobacco</td>
<td>What are the messages of these ads about health and body size? What are the realities of smoking?</td>
</tr>
<tr>
<td>Stages of change: change is a process</td>
<td>What are the stages of changing behavior? How can change be promoted?</td>
<td>Identify barriers and facilitators to change, and who can provide support; apply this to stopping smoking</td>
<td>Look at what helps add a positive health behavior, what takes away a negative behavior; review stages of change</td>
</tr>
<tr>
<td>Health information, benefits of stopping</td>
<td>Include health consequences of nicotine addiction, health benefits from quitting</td>
<td>Emphasize how smoking takes a daily quality of life toll: smell, breath, interpersonal consequences; stamina, fatigue</td>
<td>Identify benefits of stopping</td>
</tr>
</tbody>
</table>

83
<table>
<thead>
<tr>
<th>Topic</th>
<th>A/D education</th>
<th>Vocational</th>
<th>Health &amp; wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking as a recovery issue</td>
<td>Statistics about smoking and relapse to other drugs; dealing with feelings in recovery: what about smoking? Plant seed that there will come a time when you may want to take action and stop: use similar tools as for this recovery, etc.</td>
<td>How do you cope with triggers to use on the job? What can you do besides smoke?</td>
<td>Smoking increases stress to body; propose a broader vision of recovery, which includes health and wellness: smoking interferes with a full recovery</td>
</tr>
<tr>
<td>Weight gain after quitting smoking</td>
<td>“Healthy substitutions” in recovery: what to do instead of drink, drug, or smoke?</td>
<td>Packing a lunch for work; self-care on the job; stress management; how to unwind after work; exercise as a daily habit</td>
<td>The food pyramid; 5-a-day fruits and vegetables; caffeine, sugar, and nicotine; buying, cooking, and eating low-fat/low-carbohydrate meals and snacks; ways to begin to exercise; metabolism and weight gain; body image issues and referrals for eating disorders</td>
</tr>
<tr>
<td>Relapse prevention</td>
<td>Universal recovery tools: HALT; positive self-talk; ask for help; learn from past attempts; identify triggers and have a plan in place</td>
<td>Identify stressful situations and plan ahead</td>
<td>HALT; cognitive and behavioral skills</td>
</tr>
</tbody>
</table>

Tobacco education topics can be grouped in a variety of ways. At Stanley Street Treatment and Resource Center (SSTAR), the following 4-week education program was developed, incorporating many of the topics mentioned above:

- Week 1: Tobacco 101
- Week 2: The Road to Addiction
- Week 3: Stages of Addiction
- Week 4: How to Stop Tobacco Use

A series of groups can be designed and offered on a weekly basis or repeated over the course of several months, depending on client turnover.
V. APPENDICES

A. Policy & Program Development: Staff Discussion Questions

1. Questions to Consider in Assessing the Current Status of Tobacco Policy and Treatment

For Program Directors:

- What is the current practice at your site in terms of smoking? (Where and when do clients and staff smoke? Other rules governing smoking?)
- What messages about tobacco use is the program currently communicating to clients directly or indirectly?
- Approximately what percentage of the clients smokes or uses smokeless tobacco products?
- Approximately what percentage of the staff smokes or uses smokeless tobacco products?
- Are the program policies and practices in compliance with the BSAS Guidelines?
- Is time provided in staff meetings and supervision sessions to follow up on tobacco policy compliance and treatment issues?

For All Staff:

- Does the issue of smoking come up with your clients? If so, how and in what context?
- What concerns do you have about the agency revising its policy and becoming more proactive in integrating tobacco treatment services throughout its programs?
- What concerns do you have about addressing tobacco with your clients?
- What support do you need from the agency and your supervisors to better address the issue of tobacco use with clients?
- What specific areas of training would be most helpful to you in addressing clients’ tobacco use?

2. Creating a Supportive Atmosphere for Addressing Tobacco Use

Think of as many ways as you can to support clients in addressing tobacco use and nicotine dependence.
- What messages should the program and program staff give to clients about tobacco and nicotine dependence treatment?
• What would the role of different staff be in addressing tobacco use and nicotine dependence?
• What could you do to integrate nicotine dependence issues into current counseling, education, intake and other program activities?
• What things could be done to the program environment to promote recovery from nicotine dependence?
• What can the agency do to support you to do this work? What do you need?

3. Implementing the BSAS Guidelines: An Action Plan

• Where is your agency in terms of compliance with the BSAS Tobacco Guidelines?
• What is working in your agency in regards to addressing tobacco?
• What barriers interfere with implementing the Guidelines?
• What are some solutions to the barriers?
• How will you help to move your agency along? (For example, what can be done in the program environment? What messages should programs and program staffs give to clients about tobacco dependence treatment?)
### 4. Creating a Friendly Environment to Address Tobacco: Action Plan

<table>
<thead>
<tr>
<th>Possible activities</th>
<th>Your action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Celebrations:</td>
<td></td>
</tr>
<tr>
<td>1. For clients/staff working on quitting smoking</td>
<td></td>
</tr>
<tr>
<td><strong>Examples:</strong></td>
<td></td>
</tr>
<tr>
<td>• Ongoing verbal support and congratulations</td>
<td></td>
</tr>
<tr>
<td>• House meeting acknowledgment of client/staff smoke-free for 1 day, 1 week, etc.</td>
<td></td>
</tr>
<tr>
<td>• Party for client/staff after 1 month smoke-free</td>
<td></td>
</tr>
<tr>
<td>2. For special events connected with quitting smoking</td>
<td></td>
</tr>
<tr>
<td><strong>Examples:</strong></td>
<td></td>
</tr>
<tr>
<td>• Promote Great American Smokeout (3rd Thursday in November) &amp; World No Tobacco Day</td>
<td></td>
</tr>
<tr>
<td>(May 31) with posters/materials on hand; contests; outside speakers; parties; theme</td>
<td></td>
</tr>
<tr>
<td>arts and crafts</td>
<td></td>
</tr>
<tr>
<td><strong>Other ideas:</strong></td>
<td></td>
</tr>
<tr>
<td>Incentives: for clients/staff working on quitting tobacco use</td>
<td></td>
</tr>
<tr>
<td><strong>Examples:</strong></td>
<td></td>
</tr>
<tr>
<td>• Time off to attend support group</td>
<td></td>
</tr>
<tr>
<td>• Fun rewards from program</td>
<td></td>
</tr>
<tr>
<td>• Reduction of certain house fees</td>
<td></td>
</tr>
<tr>
<td>• Shopping with money saved from not smoking</td>
<td></td>
</tr>
<tr>
<td><strong>Other ideas:</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Possible activities

**Program-wide integration:**

**Examples:**
- Classes/workshops on stress management techniques to include things like meditation, yoga, breathing exercises, and guided imagery
- Add material on nicotine addiction and recovery to existing groups, i.e. HIV/AIDS education, wellness, relapse prevention

**Other ideas:**

### De-emphasize smoking as a social activity:

**Examples:**
- Change smoking environment by removing table/chairs where smokers gather comfortably
- Organize other activities at break time, such as group non-smoking walk, microwave popcorn break or arts and craft project

**Other ideas:**
B. Health Education Handouts

1. The Health Consequences of Smoking

Cancer

- Cancer is the second leading cause of death in the U.S. Researches have estimated that over 1,500 people a day die of cancer.
- Smoking can damage important genes that control the growth of cells and lead to cancer.
- Smokers are 20 times more likely to develop lung cancer than non-smokers. Smoking causes 90% of lung cancer deaths in men and 80% in women.

Cardiovascular Disease

- Heart disease is the leading cause of death and stroke is the third leading cause of death in the U.S.
- The risk of dying from heart disease is 4 times higher for smokers than non-smokers.

Respiratory Diseases

- Smokers have more upper and lower respiratory tract infections than non-smokers because smoking damages the body’s defenses against infections.
- COPD (chronic obstructive pulmonary disease) includes chronic bronchitis and emphysema. It is the fourth leading cause of death in the U.S. and over 90% of the 100,000 COPD deaths per year are caused by smoking.

Reproduction

- Babies whose mothers smoke before and after birth are 3 to 4 times more likely to die from sudden infant death syndrome.
- Low birth weight babies are at greater risk for childhood and adult illnesses. Low birth weight is also the leading cause of infant deaths.

Other Effects

- Smokers are less healthy overall than non-smokers.
- Smoking harms the immune system and increases the risk of infections.
- Smoking increases the risk of complications after surgery.

Figure 3. Annual Deaths and Estimates of Smoking Attributable Mortality 1997-2001 (CDC, 2005).

Figure 4. Actual Causes of Death in the US in 1990 and 2000 (Mokdad, Marks, Stroup, & Gerberding, 2004).
2. What Research Tells Us about HIV, Hepatitis C Virus and Tobacco Use

Effects of smoking on HIV

- Whether or not smoking increases the rate of HIV progressing to AIDS is not clear, though it is clear that smoking exacerbates HIV-related illnesses (Galai et al., 1997). Researchers seem to think that while smoking does not seem to have a systemic impact on the immune system; it does affect the body’s ability to fight off various infections and, in particular, damages the lungs’ defenses (Arcavi & Benowitz, 2004).

- Smokers are approximately three times more likely than non-smokers to be hospitalized with the AIDS-defining pneumonia PCP, and twice as likely to be hospitalized with community-acquired pneumonia. (Miguez-Burbano et al., 2005).

- Smoking anything damages the cilia, hair-like projections in the lungs, which sweep out microbes and other matter that can cause disease. This can have severe implications for people with weak immune systems (Mueller, 1997).

- Cigarette smoking was found to decrease the percentage and the absolute number of CD4 and CD8 cells in the bronchial fluid of HIV positive people. Researchers hypothesize that this may, in turn, impair the lungs’ ability to defend against infections (Wewers et al., 1998).

- Research has also found an association between smoking and AIDS-related dementia (Burns et al., 1996).

- HIV-positive women who smoke have a significantly higher prevalence and incidence of human papilloma virus (HPV) in the cervix than HIV-positive non-smoking women. Study investigators believe that smoking alters the natural history of HPV infection, therefore increasing the risk of cervical disease (Minkoff et al., 2004).

- Women with AIDS on highly active antiretroviral therapy (HAART) who smoked were more likely to be diagnosed with ailments associated with AIDS and to die than non-smokers. Smokers had a higher viral load and lower CD4 count, indicating poorer health, and the outcome was similar regardless of how much women smoked. In addition HAART is not as beneficial in smokers as non-smokers (Feldman et al., 2006).

- The bacterium that causes Mycobacterium avium complex (MAC) that affects up to 40% of HIV positive people is found in tobacco, cigarette papers
and filters. It survives the smoking process (Eaton, Falkinham III, & Fordham von Reyn, 1995).

- Smoking doubles the risk of Cryptococcus in HIV positive people (Hajjeh et al., 1999).

Effects of HIV on smoking-related diseases

- In the earlier years of the epidemic, smoking cessation was not emphasized because people thought the long-term health consequences of smoking were unimportant in patients whose longevity was compromised. As people are living longer, there are an increasing number of non-AIDS defining cancers being reported in HIV positive people (Wistuba et al., 1998).

- In a 1998 study that looked at lung cancer, the expected rate in people who were HIV positive was 6.5 times greater than the general population (but the study did not control for age of onset or smoking) (Wistuba et al., 1998).

- A study comparing lung cancer in people with and without HIV found that among HIV positive people:
  - There was a younger age of diagnosis (38 years median age).
  - The lung cancer displayed more aggressive clinical behavior.
  - The cancer was diagnosed in later stages of progression.
  - There were shortened survival rates. (Wistuba et al., 1998)
  - The prevalence of smoking in the 2 groups was the same but those who were HIV positive had less overall exposure (number of years smoking) (Wistuba et al., 1998).

- HIV accelerates smoking-related lung damage, such as emphysema (Diaz et al., 2000).

- In Levine et al.’s study (as cited in Carter, 2010), smoking cigarettes proved to be the sole risk factor for the development of lung cancer in women who had, or who were at risk of, HIV

Effects of pharmacotherapy for tobacco treatment on HIV medications

- Bupropion (Zyban), a medication used as an aid to quit smoking, has been shown to interact with protease inhibitors and NNRTIs, causing an increase in the amount of bupropion in the blood. It should not be taken with ritonavir, though it is unclear if this applies when a small dose is used to
boost another protease inhibitor. Use of Zyban should be first cleared with one's HIV doctor and health practitioners.

Smoking and Hepatitis C

- People with hepatitis C virus (HCV) should avoid drinking alcohol and smoking cigarettes as this can cause further damage to the liver. Researchers looked at levels of ALT, a liver enzyme, to evaluate liver damage caused by alcohol consumption and cigarette smoking in nearly 7000 people 35 and over in an area with high prevalence rates of HCV and HBV. People with HCV who drank alcohol were twice as likely to have increased ALT levels, and smoking almost doubled this risk. People with HCV who smoked 20 or more cigarettes a day and frequently drank alcohol were 7 times more likely to have elevated ALT levels. (The same impact of drinking and smoking was not found on the ALT levels in people with HBV) (Wang et al., 2002).
3. Cigarette Smoke Ingredients

There are over 7,000 chemicals that have been identified in cigarette smoke, some of which are included on the list below. Of these, at least 250 are known to be harmful and at least 69 of the toxic chemicals in secondhand tobacco smoke cause cancer. Children are especially susceptible to these poisons. For them, exposure to secondhand smoke can cause middle ear effusion, decreased lung function, lower respiratory tract infections and increase the intensity of asthma conditions. Inhalating secondhand smoke causes lung cancer and premature death in non-smoking adults.

<table>
<thead>
<tr>
<th>Acetone Nail Polish Remover</th>
<th>Nitrobenzene Gasoline Additive</th>
<th>Vinyl Chloride Makes PVC2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrogen Cyanide Gas Chamber Poison</td>
<td>Carbon Monoxide Car Exhaust</td>
<td>Hexamine Barbecue Lighter</td>
</tr>
<tr>
<td>Acetic Acid Vinegar</td>
<td>Nitrous Oxide Phenols Disinfectant</td>
<td>Butane Cigarette Lighter Fluid</td>
</tr>
<tr>
<td>Methane Swamp Gas</td>
<td>DDT/ Dieldrin Insecticides</td>
<td>Nicotine Insecticide/Addictive Drug</td>
</tr>
<tr>
<td>Ammonia Floor/Toilet Cleaner</td>
<td>Formaldehyde Preservative - Body Tissue &amp; Fabric</td>
<td>Cadmium Rechargeable Battery</td>
</tr>
<tr>
<td>Methanol Rocket Fuel</td>
<td>Naphthalene Mothballs</td>
<td>Ethanol Alcohol</td>
</tr>
<tr>
<td>Arsenic Poison</td>
<td>Toluene Industrial Solvent</td>
<td>Stearic Acid Candle Wax</td>
</tr>
</tbody>
</table>

Adapted from Massachusetts Tobacco Cessation and Prevention Program (www.makesmokinghistory.org), and the National Cancer Institute (www.cancer.gov).
<table>
<thead>
<tr>
<th>Cancer Causing Agents</th>
<th>Metals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitrosamines</td>
<td>Aluminum</td>
</tr>
<tr>
<td>Crysenes</td>
<td>Zinc</td>
</tr>
<tr>
<td>Cadmium</td>
<td>Magnesium</td>
</tr>
<tr>
<td>Benzo(a)pyrene</td>
<td>Mercury</td>
</tr>
<tr>
<td>Polonium 210</td>
<td>Gold</td>
</tr>
<tr>
<td>Nickel</td>
<td>Silicon</td>
</tr>
<tr>
<td>P.A.H.s</td>
<td>Silver</td>
</tr>
<tr>
<td>Dibenz Acidine</td>
<td>Titanium</td>
</tr>
<tr>
<td>B-Napthylamine</td>
<td>Lead</td>
</tr>
<tr>
<td>Urethane</td>
<td>Copper</td>
</tr>
<tr>
<td>N.Nitrosonornicotine</td>
<td></td>
</tr>
<tr>
<td>Toluene</td>
<td></td>
</tr>
</tbody>
</table>
C. Assessment Tools

1. Nicotine Dependency Assessment and Treatment

Fagerström Test for Nicotine Dependence

How to Assess Nicotine Dependency

A. Ask the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>0 Points</th>
<th>1 Point</th>
<th>2 Points</th>
<th>3 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How soon after you wake do you smoke your first cigarette?</td>
<td>After 60 minutes</td>
<td>31-60 minutes</td>
<td>6-30 minutes</td>
<td>within 5 minutes</td>
</tr>
<tr>
<td>2. Do you find it difficult to refrain from smoking in places where it is forbidden, such as the library, theater, or doctor’s office?</td>
<td>No</td>
<td>Yes</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3. Which would you hate most to give up?</td>
<td>All others</td>
<td>The first one in the morning</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. How many cigarettes do you smoke a day?</td>
<td>10 or less</td>
<td>11-20</td>
<td>21-30</td>
<td>31 or more</td>
</tr>
<tr>
<td>5. Do you smoke more frequently during the first hours after waking than the rest of the day?</td>
<td>No</td>
<td>Yes</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Do you smoke when you are so ill that you are in bed most of the day?</td>
<td>No</td>
<td>Yes</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Total Score: [Blank]

How to Interpret Nicotine Dependency Score

Score of 6 or higher: Indicates high nicotine dependency and represents individuals who would be particularly likely to benefit from tapering and/or the prescription of nicotine replacement therapy (gum or patch) to decrease nicotine withdrawal symptoms as an adjunct to standard counseling.

Score of 5 or less: Suggests low to moderate nicotine dependency and represents individuals who may be less likely to require tapering and/or the prescription of nicotine replacement therapy (gum or patch). Standard counseling is most appropriate. Note: Question numbers 1 and 4 are key questions for brief assessment.

(Heatherton, Kozlowski, Frecker, & Fagerström, 1991)

B. Ask about nicotine withdrawal symptoms experienced with prior quit attempts:

- Dysphoric/depressed
- Mood
- Anxiety
- Increased appetite or weight gain
- Restlessness
- Irritability, frustration, or anger
- Fatigue
Sample: 5A Assessment Form for Substance Use Treatment Settings

ASK about smoking/tobacco use

1. Smoking status: ___recovering ___current ___never

If recovering smoker: How recent? ____________________________
Is there any additional support that you need? ____________________________

If current: How much do you smoke? ____________________________
How long have you been a smoker? ____________________________
Do you use: ___cigars ___chewing tobacco ___snuff

2. Past quitting experience:
How many times have you tried to quit? ____________________________
When was your most recent try? ____________________________
What technique(s) did you use? ____________________________
Did you use NRT (patches, gum, inhaler, spray?) ___yes ___no
What withdrawal symptoms did you have related to your quitting?

What was the reason for the most recent relapse? ____________________________

3. Nicotine dependency: Use Fagerstrom questions #1-6. Score:

ADVISE: encourage smoker to quit

1. Ask client what his/her concerns are about his/her smoking:

2. Express concern: “I am concerned about your health (and your family’s health) if you continue to smoke.

3. Personalize advice to quit: “Consider quitting now or in the future, especially because there are special risks for smokers with histories of alcohol and other drug use.”
   a. More and more people are finding that quitting smoking has a positive impact on overall recovery.
   b. Research is showing that continuing to smoke in recovery increases the craving for alcohol/other drugs and could lead to relapse. In several studies, people who are non-smokers or who quit everything at once have longer periods of abstinence than people in recovery who continue to smoke.
   c. Smokers with histories of drinking and drug use are at higher risk for pancreatitis, cirrhosis of the liver, and cancers of the mouth, throat, and esophagus, and other preventable health problems. Quitting smoking in recovery can help these problems from developing or getting worse.
d. This program treats nicotine as a drug of addiction and we can help you get nicotine treatment.

4. Talk about the positive benefits of quitting.

---

**ASSESS willingness to try to quit**

How interested are you in quitting smoking? __ not at all ___ some ___ very

If some/very: What are your reasons for wanting to quit? ________________

---

**ASSIST**

For the person interested in quitting:
Review his/her reasons for wanting to quit.
Discuss quitting strategies:

___ NRT
___ tapering
___ cold turkey
___ other (please specify)

Would you like a referral to a tobacco treatment specialist? ___ yes ___ no
Would you like some literature about quitting smoking? ___ yes ___ no
Discuss person's support system: Who is supportive of your quitting?
Family/friends? Others? ________________

Provider Smoker's Helpline number: 1-800-QUIT-NOW

For the person not interested in quitting:
Explore roadblocks to and rewards for quitting.
Offer information about smoking and quitting.
Offer the name of a counselor or agency and resource phone numbers if they consider quitting at a future time.

---

**ARRANGE follow-up**

Was referral made to Tobacco Treatment Specialist? ___ yes ___ no
If yes, who (or which agency)? ________________

Was another visit/session set up with the client? ___ yes ___ no
If yes, when? ________________

Were other referrals made or suggested? ___ yes ___ no
Please specify: ________________
Smoking/Tobacco Use Assessment

Name: _________________________________ DOB: _________

Counselor: ______________________________ Date: _________

1. Smoking Status
   ___ Recovering
   ___ Current
   ___ Never

2. If recovering smoker:
   ___ Quit within last 6 months
   ___ Continuously abstinent > 6 months

3. If current: how long have you smoked? _________________________

4. Number of cigarettes per day: _____

5. How soon after you wake up do you smoke?
   ___ Within 30 minutes
   ___ More than 30 minutes

6. Do you use any other form of tobacco?
   ___ Chew
   ___ Dip/Snuff
   ___ Cigars

7. How interested are you in quitting at this time?
   ___ Not at all
   ___ Some
   ___ A lot

8. Are you planning to quit:
   ___ In the next 6 months?
   ___ In the next 30 days?

9. Would you like support from this program to work on quitting smoking?
   ___ No
   ___ Check back later

10. Would you like some literature about quitting smoking?
    ___ Information provided

Brief Intervention/Assessment Protocol

➢ **ASK – Systematically identify all tobacco users at every visit**

**SMOKING STATUS:** [check one]
NEVER SMOKED → → Encourage continued abstinence
RECOVERING SMOKER → → Do you need any further help at this time?

SMOKER □ OTHER TOBACCO USE (snuff, chew, etc...)
Average number of cigarettes smoked per day? __________
How soon after waking do you smoke your 1st cigarette? __________

➢ ADVISE – Strongly urge all tobacco users to quit

This program is an addictions treatment program that cares about all aspects of your health and addictions, including nicotine addiction, especially because there are special risks for smokers with histories of alcohol and other drug abuse. I encourage you to consider quitting either now or in the future.

➢ ASSESS – Determine willingness and readiness to make a quit attempt

MOTIVATION & CONFIDENCE IN QUITTING:

On a scale of 1-10 (1 = not at all important and 10 = extremely important) answer the following questions:

➢ How important is it for you to quit smoking? (Not at all) 1..2..3..4..5..6..7..8..9..10 (Extremely important)

➢ How interested are you in quitting? (Not at all) 1..2..3..4..5..6..7..8..9..10 (Extremely interested)

If uninterested, ask: What would make you more interested?
_______________________________________________

➢ If you decided to try and quit smoking how confident are you that you could successfully do it?
(Not at all) 1..2..3..4..5..6..7..8..9..10 (Extremely confident)

If unconfident, ask: How could the program help you become more confident?
________________________________________

➢ If you were to quit, what would be some reasons?
______________________________________________________

STAGE OF CHANGE

➢ Pre-contemplation (Not considering quitting)
➢ Contemplation (Thinking about quitting)
➢ Preparation (Ready to quit in next 30 days)
➢ Action (Off tobacco 1 day to 6 months)
➢ Maintenance (Off tobacco 6 months or more)

If in preparation, ask: What steps have you taken to prepare for your quit attempt?
________________________________________

➢ ASSIST – Aid the client in quitting or planning for the future
Evaluate past quitting experience:
1. How many times have you tried to quit smoking? _____________________
2. What kinds of pharmacotherapy have you tried? (e.g. – gum, patch, inhaler, Zyban, Chantix) ________________________________

Discuss what your program offers:
 Individual and/or group counseling and pharmacotherapy on-site
 Support for tapering
 Self-help materials
 Nicotine Anonymous information
 Referrals for additional quit-smoking services.

Give materials, encourage support and use of telephone counseling with the Smokers’ Help-line 1-800 QUIT-NOW or visit: www.makesmokinghistory.org and www.becomeanex.org to get more information and support.

➢ ARRANGE – Schedule follow-up contact

Interested in on-site tobacco treatment

Will follow-up as part of regular treatment planning
2. Hooked On Nicotine Checklist (HONC)

The HONC identifies youth for whom help and encouragement with cessation would be appropriate. In treatment, the HONC can also be used to signal the loss of autonomy, the onset of dependence, and the degree of dependence.

Nicotine Addiction’s 10 Warning Signs
HONC - Hooked On Nicotine Checklist

- Have you ever tried to quit but couldn’t?
- Do you smoke now because it is really hard to quit?
- Have you ever felt like you were addicted to tobacco?
- Do you ever have strong cravings to smoke?
- Have you ever felt like you really needed a cigarette?
- Is it hard to keep from smoking in places where you are not supposed to, like school?

In answering the last four questions, when you tried to stop smoking, or when you have not used tobacco for a while...

- Did you find it hard to concentrate?
- Did you feel more irritable?
- Did you feel a strong need or urge to smoke?
- Did you feel nervous, restless or anxious because you couldn’t smoke?

A positive response to any HONC item signals a loss of autonomy and the onset of dependence. The number of positive responses is proposed to reflect the degree of dependence.

(DiFranza et al., 2002)
D. Counseling Approaches

1. Dealing with Triggers

A trigger is an activity, thought, or feeling that sets off the craving for a cigarette.

- Examples of activities: waiting for a bus, driving, end of a meal, talking on the telephone, socializing with friends, drinking coffee, taking a break at work
- Examples of feelings: bored, angry, edgy, anxious, happy, sad, relaxed, frustrated

Think about the times and places you smoke most often: what are the feelings linked with smoking? Make a list of the situations and feelings (triggers) that will be hardest to deal with when you quit smoking. Be specific!

Think about ways you can cope with these situations without smoking. Can you avoid the situation altogether until you feel stronger? Can you change the situation or do something else?

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Things to Do Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Waiting for the bus</td>
<td>• Carry bottled water and drink that instead</td>
</tr>
<tr>
<td></td>
<td>• Do deep breathing</td>
</tr>
<tr>
<td></td>
<td>• Tell myself: I am a non-smoker, remember why!</td>
</tr>
</tbody>
</table>

(Use back of worksheet if you need more room.)

What strategies are you already practicing to help cope with stress in your recovery?

How can you apply these strategies to your tobacco dependence recovery?
2. My Plan for Quitting Smoking/Tobacco Use

<table>
<thead>
<tr>
<th>My hardest times not to smoke:</th>
<th>Things I can do instead of smoke:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

MY QUIT DATE IS: ________________________________

My reasons for quitting are: (Be as specific as possible. Use back of worksheet if you need more room.)

My plan to deal with stress instead of smoking includes:

My plan for physical activity includes:

My plan to deal with nicotine withdrawal is:

My plan for social support includes:

My plan to reward myself when I quit includes:
3. Counseling Approaches for Nicotine Dependence Treatment

Motivational Interviewing: Clinical Principles

- Express Empathy
- Develop Discrepancy
- Avoid Argumentation
- Roll with Resistance
- Support Self-efficacy

Traps to Avoid

- Assuming health consequences will motivate
- Using strategies appropriate for a different stage of change
- Thinking interest is the same as commitment to change
- Lecturing, nagging, shaming
- Underestimating the positive aspects of smoking
- Believing one final piece of information will compel change
- Accepting ambivalence (or lack of ambivalence) as the end point

Counseling Tips

- Use open-ended questions
- Provide a menu of options
- Compliment all positive changes
- Build coping skills
- Re-frame slips and relapses
- Have realistic expectations

When a Client Quits Smoking:

- Coordinate with other relevant treatment and health care providers
- Schedule more frequent check-ins, especially in the first few weeks
- Monitor all medications, as quitting smoking may necessitate a change in dosage
- If client has a history of depression or other psychiatric disorders, quitting smoking may precipitate a relapse to this disorder and the client may need to be assessed for appropriate medication
- Encourage healthy eating, drinking water, exercising and reducing caffeine intake
- Remind clients that this is a big deal and encourage them to seek support
- Help clients identify positive ways to reward themselves for this achievement

(Miller & Rollnick, 2002)
4. Decisional Balance Worksheet

This worksheet is designed to help you think about all the *good* and *not-so-good things* about making a change in your tobacco use. It can help you decide *whether* you want to make a change and *what may be difficult* in making a change. Begin with box 2; proceed to box 1, then 3, and end with box 4.

<table>
<thead>
<tr>
<th>QUITTING SMOKING (Tobacco Use) CHANGING BEHAVIOR</th>
<th>CONTINUING TO SMOKE (Use Tobacco) NOT CHANGING BEHAVIOR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits of:</strong></td>
<td><strong>Box 1</strong>: Good things about quitting smoking</td>
</tr>
<tr>
<td><strong>Costs of:</strong></td>
<td><strong>Box 2</strong>: Good things about continuing to smoke</td>
</tr>
<tr>
<td><strong>Box 3</strong>: Not-so-good things about quitting</td>
<td><strong>Box 4</strong>: Not-so-good things about continuing to smoke</td>
</tr>
<tr>
<td>smoking</td>
<td></td>
</tr>
</tbody>
</table>

(Miller & Rollnick, 1992)
Topic: ________________________

**IMPORTANCE RULER**

⇒ For a moment, forget about everyone else. How important is it to you to make a change around __________?
⇒ On a scale of 0-10, with “0” being “NOT AT ALL IMPORTANT” and “10” being “EXTREMELY IMPORTANT,” where are you on the ruler?

Not At All Important

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Extremely Important

**CONFIDENCE RULER**

⇒ If you decide that you do want to make a change around __________, how confident are you that you would be successful in achieving your goals?
⇒ On a scale of 0-10, with “0” being “NOT AT ALL CONFIDENT” and “10” being “EXTREMELY CONFIDENT,” where are you on the ruler?

Not At All Confident

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Extremely Confident
5. Clinician Guide for Using the Ruler Worksheet

“I know that you and I have been talking about the issue of ___. Would it be ok if we talked about this a little bit more, and I asked you a few questions?”

Use the “Importance and Confidence Ruler” worksheet with the client and ask client the questions on the ruler worksheet.

For Further Discussion: The Issue of Importance

“I see that the Importance Ruler scale is at ___."

- If the # is 4 or below, you might want to say: “Wow! Why is it at [#] _ and not at [#] (a number slightly lower)?”
- If the # is 5 or above, you might want to say: “Wow! It looks like this is a somewhat/very important issue for you!”
- If the # is 0, you might want to say: “It looks like this is NOT an issue that you feel needs any change at this time. Do I have this correct?” and/or: “Is there anything that would ever make the number on this scale increase?”

You can continue to explore importance by asking:

- “What are some things that determine that this issue is a little/ somewhat/extremely important to you?”
- “What would you need to help you move that importance number from a [#] to a [#] (for example, from a 4 to a 6)?” (Use small increments.)
- “What would make this issue more important for you?”

For Further Discussion: The Issue of Confidence

“I see that the Confidence Ruler scale is at ___."

- If the # is 4 or below, you might want to say: “Wow! Why is it at _ and not at [?] (a number slightly lower)?”
- If the # is 5 or above, you might want to say: “Wow! It looks like you are somewhat/very confident you can make this change!”
- If the # is 0, you might say: “What would help move that number from a 0 to a 1?”

You can continue to explore confidence by asking:

- “What are some things that make you a little/somewhat/very confident that you can make this change?”
- “What would you need to help move your confidence level from a [#] to a [#] (for example, from a 4 to a 6)?” (Remember to use small increments.)
- “What would give you more confidence to make a change?”
E. Stage-Based Strategies

1. Working with People in Precontemplation

More people in recovery die from tobacco-related causes than any other cause. The good news is that a lot of smokers want to quit and try to quit each year. Of all current smokers, 70% want to quit smoking and 46% make a quit attempt each year (CDC, 1997a).

But what about people who do not want to quit? What can we do for them? While we probably won’t get committed smokers to put down their cigarettes or set a quit date, we still have opportunities to help them move closer towards the day when they are tobacco-free.

The goal in working with “precontemplators” is not to get them to quit smoking immediately, but rather to get them to move towards the contemplation stage where their ambivalence about smoking is more pronounced and they can begin to actively weigh the pros and cons of quitting. When the benefits of smoking seem to outweigh the benefits of quitting, motivation for quitting will be low.

How do we recognize precontemplation?

People who express no desire to quit are “precontemplators” (i.e., they are not contemplating quitting). They may tell you they do not want to hear about treatment for tobacco addiction or that they have no intention of giving up cigarettes. Precontemplators are sometimes called “committed smokers.” However, just because someone is not thinking about quitting does not mean that he is not thinking about his smoking. In fact, many pre-contemplators may have tried to quit in the past or may harbor some ambivalence about continuing to smoke.

Reasons for being in precontemplation

People are in the precontemplation stage for a variety of reasons. Understanding their reasons for not changing is important. They often have very good, sometimes complicated, reasons for not changing a long-held behavior—even one that they know is harmful.

- They are enjoying positive benefits from their smoking, such as a sense of well being, relaxation, breaks, bonding with other smokers, etc., and are not experiencing any negative consequences.
- They may be unconcerned about the health impacts, think they will escape them, or shut out information about the harmful effects of tobacco use.
- They may be unaware of the dangers of smoking.
They use cigarettes to cope with stress, anxiety or depression and cannot imagine getting by without them.

They have tried quitting in the past and failed. They may have tried spontaneously, without any preparation or support. They may have used the nicotine patch or other medications incorrectly.

They may be motivated to quit, recognizing that cigarettes are damaging their health, but because they lack the confidence to believe they can succeed at quitting, they have given up on the idea.

How to approach a person in precontemplation

The primary objective in working with someone in the precontemplation stage is to introduce ambivalence about smoking and to help illuminate any discrepancies in his/her belief system. The clinician’s role is to establish rapport, explore what smoking means to the client and elicit any mixed feelings s/he may have about smoking. Common pitfalls to avoid are minimizing the importance of smoking to the client, arguing with or confronting the client, lecturing, or assuming that there is no interest at all in quitting.

Because we often feel a sense of urgency in getting someone to stop smoking, it is easy to fall into trying to persuade or argue with someone about why his or her reasons for smoking or for not quitting are invalid. Unfortunately, once we begin to attack their reasons, they will most likely feel that they have to defend and protect them.

A more productive approach is to engage smokers in conversation about their smoking, giving them room to truly explore all sides of smoking and quitting. Open-ended questions, like the following, can be a good starting place:

- What do you like about your smoking? What are the good things about it?

- What are the things that are less good? What problems do you see with continuing to smoke?

- What are the negatives of quitting? What do you imagine quitting would be like?

- What would be the advantage of a change? What would be the disadvantages?

- How would you know if you were ready to quit?

Another approach is to ask the client about short and long term goals for recovery, for example, improving health, saving money, learning to relax and cope, and becoming a better parent. Counselors can then ask what kind of impact continuing to smoke has on achieving that goal: positive, negative, or neutral.
Other approaches

- Make connections between smoking and other health issues, such as the impact of smoking on Hepatitis C Virus, HIV/AIDS, asthma, diabetes, and children’s health.
- Listen for opportunities to raise questions about a client’s own concerns about his or her smoking.
- Raise awareness through education, but do not scare or shame clients in providing information.
- Ask clients where they are with their tobacco use.
- Ask client’s permission to check-in about smoking and continue to follow up on a regular basis: “Where are you with your tobacco use at this time? Any changes since we last met?”

The most important role is to remain empathic, and express concern but also offer hope that the individual can stop smoking and can get help to stop when they are ready. In working with those in precontemplation, even a small movement should be seen as major success. Even if the person seems to be still firmly committed to smoking, counselors may have planted seeds or asked questions that will have an impact later on. Remember to keep the door open and to gently raise the issue in the future.

2. Working with People in the Contemplation Stage

Contemplation: the stage where the person is thinking about making changes, but...

There is plenty of work to be done in this stage. The task of this stage is not to quit, but to wrestle with ambivalence about quitting in order to become ready to make a decision and a commitment to prepare to quit. Availability of NRT may tip some contemplators into wanting to take immediate action, but they should be helped to first make a plan to do so.

Contemplators are interested in making a change. That is not the same as committing to quit.

How do I recognize contemplators?

- Open to receive new information; lower resistance
- Talk about wanting to change; less committed to being a smoker than in precontemplation stage
- On the fence
• “I want to quit, BUT…”
• Aware of the need to change
• Reluctant to take action, such as setting a quit date or telling others about quitting
• Reasons to quit are more external (other people’s reasons, such as the doctor, the kids, to please the addictions counselor) than internal
• Search for one more piece of information to convince them to quit. A scary video may inspire them to quit on the spot, but this does not necessarily resolve the ambivalence.
• Can identify and work with barriers to quitting

Contemplators can work on:

• Increasing their knowledge of nicotine addiction and recovery: learn how the addiction works and how others have recovered from it
• Identifying individual triggers and patterns of smoking
• Listing personal reasons to quit
• Identifying roadblocks to quitting and their solutions
• Looking at the decisional balance: list costs (pros) and benefits (cons) of smoking, costs and benefits of quitting
• Becoming familiar with the experiences of successful quitters
• Trying new ways to deal with stress besides smoking: deep breathe, talk with a support person, exercise

3. Working with People in the Preparation Stage

Preparation: the stage where the person is ready to stop smoking.

This is the stage that people often skip. In this stage, people have made the decision to quit for their own reasons, want to quit, and use the time prior to their quit date to prepare. They practice for the days when they won’t be smoking. They gather information on how their tobacco addiction functions and make self-care plans for their first days and weeks into recovery.

People in preparation are readying to quit.

How do I recognize readiness to quit?

• People show openness to receiving new information; resistance is lower
- Readiness to take action is shown by setting a quit date and telling others about plan for quitting.

- Reasons to quit can be identified, and should be made as specific as possible.

- People can identify and address their barriers to quitting.

People in preparation can work on:

- Identifying individual triggers and patterns of smoking
- Listing personal reasons to quit
- Identifying roadblocks to quitting and their solutions
- Reviewing the decisional balance, ensuring that their quit plan addresses what they previously identified as the benefits of smoking and the costs of quitting
- Becoming familiar with the experience of successful quitters
- Trying new and/or additional ways to deal with stress besides smoking: deep breathe, talk with a support person, exercise
- Developing plans for encountering challenges: avoid, change, or escape the situation (Plan A and Plan B). These ideas can be written down and/or role-played.
- Choosing a method of quitting (cutting down gradually, cold turkey, use of nicotine replacement therapy or Zyban, counseling).
- Monitoring smoking patterns: people can track their current use of cigarettes by attaching a smoking log to the pack. For each cigarette, record the time of day smoked, mood at the time, and rate how important the need for the cigarette was (on a scale of low-high).

4. Preparing to Quit Smoking

Once you’ve decided to quit smoking, there are a number of things you can do to prepare for your quit date. The more prepared you are, the better your chances for success. Take a couple of weeks before your quit date to get ready and to practice some skills that will help you when you quit.

Understand why you want to quit

- List the costs and benefits of continuing to smoke and the cost and benefits of quitting.
• Write down some of the ways your smoking affects others and how your stopping smoking would affect them.

• Make a list of the most important reasons why you want to quit smoking and write them down. Decide the single most important reason to you, write it down, carry it with you, and look at it often.

Choose a method and set a quit date

• Choose a method of quitting (cutting down gradually, “cold turkey,” use of nicotine replacement therapy or Zyban, counseling).

• Talk to your health care provider about whether using a prescription stop-smoking aid (like Zyban or nicotine inhaler) makes sense for you.

• Set a quit date and tell your friends and family about it. You may want to choose a date to quit that has personal significance for you or that you anticipate will be the least stressful.

Monitor your smoking

• Track your current use of cigarettes by attaching a smoking log to your pack. For each cigarette, record the time of day you smoked, your mood, and how important the cigarette was to you. Notice patterns of smoking.

Prepare and practice

• Try cutting back on those cigarettes that are less important to you. Each day try to smoke 2-3 fewer cigarettes. Each and every time you want to smoke, stop long enough to feel and recognize the urge. Then make a conscious choice to smoke or not smoke.

• Other methods for tapering down include switching to a brand you like less, delaying your first cigarette of the day, only smoking half of each cigarette, and scheduling when and how often you will smoke.

• Anticipate situations that you think will be difficult for you. Visualize yourself handling those situations as a non-smoker. What are you doing? What is different? How can you plan ahead for these challenging situations?

• Make a list of things that you can do instead of smoke when a craving hits.

• Practice doing one thing without smoking that you usually do while smoking: talking on the phone, drinking coffee, driving, etc. After a week, add a second activity to do without smoking.
- Try creating a new smoke-free place in your life. Choose an area where you currently smoke (car, living room, bus stop) and decide not to smoke there for the next two weeks.

- Practice ways to manage stress without smoking. Try deep breathing and muscle relaxation.

- Practice eating well. Eat low-fat foods, drink lots of water and don'tlinger at the table after a meal. Try developing new rituals (like having a cup of tea) to replace your after-meal cigarettes.

- Start exercising to help prevent and relieve the stress that many smokers experience when they quit. This will also help prevent the weight gain that many smokers fear. Each day, choose to do one active thing instead of smoking when you feel the urge.

- Take a trial run. Pick a day when you will try to go for 24 hours in a row choosing not to smoke. Know that you can return to smoking after 24 hours if you want to. Notice that you can resist the urge to smoke. Pay attention to which cigarettes or times of day were the most challenging.

- Plan some personal rewards to celebrate each milestone (1 day, 2 days, 3 days, 1 week, 1 month, etc.). Some people put the money they would have spent on cigarettes towards a reward, like an evening out or a vacation.

- Ask for support from friends, family and co-workers. Get additional support through telephone counseling at 1-800-TRY-STOP, 1-800-8-DEJALO, and/or www.makesmokinghistory.org and www.becomeanex.org.

- On your quit date, throw away all of your cigarettes and matches. Put away your ashtrays or fill them with sugar-free candy or gum.


5. Action Stage: Slips, Relapse, Craving and Coping

The action stage of change is the first six months after making a behavioral change. In recovery from tobacco dependence, this stage is characterized by an initial withdrawal from tobacco, which affects mood, thinking, and sense of physical well-being. Severity of withdrawal varies for each person, and some symptoms can last up to several months. This is a time to celebrate success, and to utilize and review the effectiveness of the quitting plans developed in the preparation stage.
1. Assessment/action stage
   - Review effectiveness of medications (NRT, Zyban, or Chantix)
   - Review withdrawal symptoms weekly
   - Identify benefits of quitting
   - Plan for high risk situations
   - Help client formulate an action plan to stay quit

2. Relapse prevention
   - Anticipate factors in a possible relapse
   - Plan specific strategies to help deal with these situations
   - Talk about slips or near slips: review what happened; discuss what the client could have done differently; learn from the slip
   - Review reasons for quitting
   - Help clients recognize successes

3. Dealing with cravings
   - Specific questions the client should ask if he/she is experiencing cravings:
     - When do the cravings occur?
     - Where am I at the time?
     - Who else is present?
     - What am I thinking when I get the craving?
     - How do I feel?
     - Am I using my coping skills?
     - Could I handle the situation differently?
     - Is this craving undermining my confidence to stay quit?

4. Other issues
   - Stress management: what new coping skills are being utilized?
   - Nutrition and exercise: what concerns does the client have? What is the client doing for exercise on a daily basis?
   - Handling recovery/sobriety: how’s it going?
Continual slips/relapse to smoking: what does the client need?

Sources: adapted from Richard Brown, M.D., of Brown University, and the Massachusetts General Hospital Tobacco Treatment Program.

6. Maintenance Stage: Stabilizing Progress and Continuing Recovery

After approximately six months of continuous recovery from tobacco dependence, people enter the maintenance stage. This stage lasts up to several years. In this stage, efforts are made to sustain gains achieved in the action stage. Clients and therapists work together to acknowledge progress, review and practice coping strategies, and examine overall wellness and lifestyle. People in maintenance are exploring personal growth issues such as “Who am I now that I don’t smoke?” and they begin to identify more and more as non-smokers.

Tobacco dependence is a chronic, relapsing condition. Vigilance is still vital, as recurrence of smoking can happen. Life transitions and losses can bring up thoughts about and urges to smoke or use tobacco products. People in the maintenance stage of recovery from nicotine dependence can continue to develop and utilize strategies for moving through trigger feelings and situations.

Clinician’s role in supporting people in the Maintenance stage

- Support lifestyle changes
- Affirm client’s resolve and self-efficacy
- Review long-term goals and identify manageable steps to achieve them
- Help client review, practice and use coping strategies to avoid a return to tobacco
- Review progress and celebrate milestones
- Identify positive rewards and pleasurable activities
- Expect and plan for occasional return of client’s ambivalence about smoking
- Help client identify self-defeating behaviors and clarify what needs to change

People in maintenance can:

- Identify relapse triggers and alternative behaviors and coping skills
• End use of pharmacotherapy for tobacco treatment: if still using NRT, re-
view needs and work on alternative coping methods; taper use; discuss quit 
plan
• Identify long-term goals in areas such as physical and mental health, well-
ness, personal growth, and relationships. Look at barriers to reaching these 
goals and ways to address them
• Continue to build social support for tobacco dependence recovery through 
Nicotine Anonymous and/or supportive friends in 12 Step programs
• Establish and integrate daily activity and exercise routines and maintain 
healthy eating and nutritional habits
• Monitor feelings of depression and seek help and support from a 
healthcare practitioner if they persist

Sources: adapted from SAMHSA (1999); and Hoffman et al. (1997).
F. Understanding and Treating Nicotine Dependence

1. DSM IV Substance Dependence Criteria

Nicotine Dependence

305.10

1. Tolerance
2. Withdrawal
3. The substance is often taken in larger amounts or over a longer period than was intended
4. Persistent desire or unsuccessful attempts to cut down or control substance
5. Time spent in activities necessary to obtain/use the substance, and recover from its effects
6. Important social, occupational, or recreational activities given up or reduced because of use of the substance
7. Use is continued despite the knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
2. Criteria for Diagnosing Nicotine Withdrawal, DSM IV, 292.0
   A. Daily use of nicotine for at least several weeks
   B. Abrupt cessation of nicotine use, or reduction in the amount of nicotine used, followed within 24 hours by four (or more) of the following signs:
      1. Dysphoria or depressed mood
      2. Insomnia
      3. Irritability, frustration or anger
      4. Anxiety
      5. Difficulty concentrating
      6. Restlessness
      7. Decreased heart rate
      8. Increased appetite or weight gain
   C. The symptoms in B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
   D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder
3. A Bio-psychosocial Model of Nicotine/Tobacco Dependence

**Facts:**
- Nicotine is comparable to other drugs, like heroin or cocaine, in its addictive potential
- Average number of quit attempts before final success: 8 (source: MA EOHHS)
- Success increases when there is a plan developed ahead of time that combines NRT and/or pharmacology, cognitive-behavioral coping strategies and counseling support

**Treatment should address ALL THREE aspects of the addiction:**

**Physiological**
- Consider nicotine replacement therapy (NRT) options such the patch, gum, lozenge and – by prescription only – the nicotine inhaler and nasal spray
- Bupropion (also known as “Zyban”) – by prescription only
- Varenicline (also known as “Chantix”) – by prescription only

**Psychological**
- Cognitive behavioral strategies: identify triggers, habits, and paired activities; develop new coping skills for those situations. Example: change ways you think about smoking: “Smoking is not an option” and change behaviors: “Coffee is a trigger. Instead, I will drink water.”

**Social**
- Develop coping strategies for social triggers
- Develop social supports for non-smoking lifestyle
- Use counseling to support learning new coping strategies and process feelings of loss
4. Quick Guide to Nicotine Dependence Pharmacotherapy

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosing</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicotine gum</td>
<td>Use 2 mg (&lt;25 cigarettes/day) and 4 mg (≥ 25 cigarettes/day) pieces on a regular schedule or as needed. Up to 24 pieces of gum may be used daily. Recommended dosing scheme is 1 piece: every 1-2 hrs weeks 1-6; every 2-4 hrs weeks 7-9; and every 4-8 hrs weeks 10-12.</td>
<td>Chew the gum slowly until mint or pepper is tasted. Then park the gum between the cheek and gum to permit absorption through the oral mucosa. Repeat when taste subsides and continue for approximately 30 minutes. Avoid eating or drinking for 15 minutes before and during use. Use for up to 12 weeks.</td>
</tr>
<tr>
<td>Nicotine lozenge</td>
<td>Use 2 mg lozenge for those who smoke their first cigarette after 30 minutes of waking; 4 mg lozenge for those who smoke their first cigarette within 30 minutes of waking. Recommended dosing scheme is 1 lozenge: every 1-2 hrs for weeks 1-6; every 2-4 hrs during weeks 7-9; and 4-8 hrs during weeks 10-12.</td>
<td>Suck on the lozenge until it dissolves. Do not bite or chew it like a hard candy, and do not swallow it. Avoid eating or drinking for 15 minutes before use. Recommended length of therapy is 12 weeks.</td>
</tr>
<tr>
<td>Nicotine patch</td>
<td>Use one patch every day. This is a 24-hour patch that comes in 3 doses for tapering. Recommended dosing scheme is 21 mg for 4 weeks; 14 mg for 2 weeks; and 7 mg for 2 weeks.</td>
<td>Every morning, place a fresh patch on a relatively hairless area of skin between the waist and neck. If sleep disruption occurs, remove the patch at bedtime. Use a hydrocortisone cream for minor skin reactions. Recommended length of treatment is 8 weeks.</td>
</tr>
<tr>
<td>Prescription medication</td>
<td>Dosing</td>
<td>Instructions</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Nicotine inhaler</strong> (Nicotrol Inhaler) [FDA Class D]</td>
<td>Puff as needed. One cartridge delivers 4 mg of nicotine in the course of 80 inhalations (about 20 minutes). 6-16 cartridges should be used per day, with tapering of use in the last 6-12 weeks therapy.</td>
<td>Avoid eating or drinking for 15 minutes before and during use. Duration of therapy is up to 6 months.</td>
</tr>
<tr>
<td><strong>Nicotine nasal spray</strong> [FDA Class D]</td>
<td>A dose is one spray in each nostril (1 mg total nicotine). Initial treatment is 1-2 doses per hour, as needed, for symptom relief. Minimum treatment is 8 doses per day; maximum is 40 doses per day (5 doses per hour). Each bottle contains 100 mg of nicotine.</td>
<td>Do not sniff, inhale, or swallow during administration as this increases irritating effects. Tilt the head back slightly during administration. Duration of therapy is 3-6 months.</td>
</tr>
<tr>
<td><strong>Bupropion sr</strong> (Zyban, Wellbutrin) [FDA Class C]</td>
<td>Take 150mg for first 3 days; 300mg after day 3. Ensure at least 8 hours between doses.</td>
<td>Begin bupropion 1-2 weeks before quit date. Limit alcohol intake. Duration of therapy is 7-12 weeks and may be extended up to 6 months.</td>
</tr>
<tr>
<td><strong>Varenicline</strong> (Chantix) [FDA Class C]</td>
<td>Take 0.5mg daily for 3 days then 0.5mg twice daily for 4 days then 1mg twice daily for up to 12 weeks.</td>
<td>Begin Varenicline 1 week before quit date. Duration of therapy is for up to 12 weeks and may be extended for up to another 12 weeks.</td>
</tr>
</tbody>
</table>

Inclusion of this adult dosage chart is strictly for the convenience of the prescribing provider.

Please consult the Physicians’ Desk Reference for complete product information and contraindications.

**Source:** adapted from 2000 USDHHS Treating Tobacco Use and Dependence Clinical Practice Guideline and product information.

Center for Tobacco Prevention and Control, University of Massachusetts Medical School, 2008
5. Nicotine Replacement Therapy (NRT)

<table>
<thead>
<tr>
<th>Product</th>
<th>Gum</th>
<th>Lozenge</th>
<th>Patch¹</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nicorette², Generic OTC</td>
<td>Commit², Generic OTC</td>
<td>Nicoderm CQ²</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 mg, 4 mg</td>
<td>2 mg, 4 mg mint</td>
<td>24-hour release</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Original, FreshMint², Fruit Chill², mint, orange²</td>
<td></td>
<td>7 mg, 14 mg, 21 mg</td>
<td></td>
</tr>
<tr>
<td>Precautions</td>
<td>Pregnancy (Cat. D)</td>
<td>Pregnancy (Category D)</td>
<td>Pregnancy (Category D)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recent (&lt;2 weeks) myocardial infarction</td>
<td>Serious underlying arrhythmias</td>
<td>Recent (&lt;2 weeks) myocardial infarction</td>
<td>Serious underlying arrhythmias</td>
</tr>
<tr>
<td></td>
<td>Serious or worsening angina pectoris</td>
<td>Serious underlying arrhythmias</td>
<td>Serious or worsening angina pectoris</td>
<td>Serious or worsening angina pectoris</td>
</tr>
<tr>
<td>How to use</td>
<td>Smoking is stopped before using gum.</td>
<td>The lozenge releases nicotine as it dissolves. Allow it to dissolve slowly.</td>
<td>Smoking is stopped before using the patch.</td>
<td>Nicotine goes into the body though the skin using a time-release system.</td>
</tr>
<tr>
<td></td>
<td>Nicotine is released as the gum is chewed.</td>
<td>Do not chew, bite, or swallow.</td>
<td>The patch is worn like bandage. Peel off the backing ½ at a time and apply firmly.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The gum is chewed slowly until a peppery or mint taste comes. Then “park” the gum (hold it still), between the check and then gums to permit absorption through the oral mucosa. Repeat when the taste subsides and continue chewing and parking for about 30 minutes.</td>
<td>Occasionally rotate to other areas of the mouth</td>
<td>Nicotine goes into the body though the skin using a time-release system.</td>
<td></td>
</tr>
<tr>
<td>Dosing</td>
<td>&gt;25 cigarettes/day: 4 mg</td>
<td>1st cigarette ≤30 minutes after waking: 4 mg</td>
<td>&gt;10 cigarettes/day: 10 cigarettes/day:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;25 cigarettes/day: 2 mg</td>
<td>1st cigarette &gt;30 minutes after waking: 2 mg</td>
<td>21 mg/day x 6 wks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Week 1 – 6:</td>
<td>Week 2 – 6:</td>
<td>14 mg/day x 2 wks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 piece q 1 – 2 hours</td>
<td>1 lozenge q 1-2 hours</td>
<td>7 mg/day x 2 wks</td>
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<td></td>
<td>Week 7 – 9:</td>
<td>Week 7 – 9:</td>
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<td></td>
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<tr>
<td></td>
<td>1 piece q 2 – 4 hours</td>
<td>1 lozenge q 2-4 hours</td>
<td>≤10 cigarettes/day:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Week 10 – 12:</td>
<td>Week 10 – 12:</td>
<td>14 mg/day x 6 wks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 piece q 4 – 8 hours</td>
<td>1 lozenge q 4-8 hours</td>
<td>7 mg/day x 2 wks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum, 24 pieces/day</td>
<td>Maximum, 20/day</td>
<td>Duration: 8-10 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Park in different areas of the mouth</td>
<td>No food or bev. 15 min before or during use</td>
<td>Duration: 8 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No food or bev. 15 min before or during use</td>
<td>Duration: up to 12 wks.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹Transdermal patch formulations previously marketed, but no longer available: Nicotrol 5 mg, 10 mg, 15 mg delivered over 16 hours (Pfizer) and generic patch (formerly Prostep) 11 mg and 22 mg delivered over 24 hours.

²Marketed by GloxoSmithKline.

<table>
<thead>
<tr>
<th>Adverse Effects</th>
<th>Gum</th>
<th>Lozenge</th>
<th>Patch</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mouth/jaw soreness</td>
<td>Nausea</td>
<td>Local skin reactions (erythema, pruritus, burning)</td>
</tr>
<tr>
<td></td>
<td>Hiccups</td>
<td>Hiccups</td>
<td>Headache</td>
</tr>
<tr>
<td></td>
<td>Dyspepsia</td>
<td>Cough</td>
<td>Sleep disturbances (insomnia) or abnormal/vivid dreams (associated with nocturnal nicotine absorption)</td>
</tr>
<tr>
<td></td>
<td>Hypersalivation</td>
<td>Heartburn</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Effects associated with incorrect chewing technique:</td>
<td>Headache</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Flatulence</td>
<td></td>
</tr>
</tbody>
</table>
Abbreviations:  
NRT=nicotine replacement therapy  
OTC= (over the counter) non-prescription product

For complete prescribing information, please refer to the manufacturers’ package inserts.

**Sources:**
- Center for Tobacco Treatment Research and Training, University of Massachusetts Medical School, Worcester, MA.  
  (www.umassmed.edu/behavmed/tobacco)
- Plan to Quit: Nicotine Replacement, Brochure from ETR Associates  
  (http://pub.etr.org/)
- The Regents of the University of California, University of Southern California, and Western University of Health Sciences.  

<table>
<thead>
<tr>
<th>Lightheadedness</th>
<th>Nausea/vomiting</th>
<th>Throat and mouth irritation</th>
<th>Insomnia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td>Gum use might satisfy oral cravings</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gum use may delay weight gain</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients can titrate therapy to manage withdrawal symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Purchased over the counter</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lozenge use might satisfy oral cravings</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients can titrate therapy to manage withdrawal symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Purchased over the counter</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provides consistent nicotine levels over 24 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Easy to use and conceal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Once-a-day dosing associated with fewer compliance problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Purchased over the counter</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>There are no reports (worldwide) of anyone getting addicted to the patch.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Disadvantages** | Gum chewing may not be socially acceptable |
|                  | Gum is difficult to use with dentures |
|                  | Patients must use proper chewing technique to minimize adverse effects. |
|                  | May cause jaw ache, especially if chewed like regular gum |
|                  | It is relatively easy to get addicted to because it is “self-dosing” just like smoking. |
|                  | Gastrointestinal side effects (nausea, hiccups, heartburn) might be bothersome |
|                  | It is relatively easy to get addicted to because it is “self-dosing” just like smoking. |
|                  | Patients cannot titrate the dose |
|                  | Allergic reactions to adhesive might occur |
|                  | Patients with dermatologic conditions should not use the patch |
|                  | The patch irritate the skin, which can be controlled with hydrocortisone cream, but sometimes develops into a major rash, making it impossible to wear. |
|                  | The patch sometimes causes sleep disturbances that are not controlled by taking it off at bedtime. The person may have to take the patch off several hours before bed to get the nicotine out of their system, thus creating a time period that could be tempting to smoke. |
|                  | Patients cannot titrate the dose |
|                  | Allergic reactions to adhesive might occur |
|                  | Patients with dermatologic conditions should not use the patch |
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|                  | The patch sometimes causes sleep disturbances that are not controlled by taking it off at bedtime. The person may have to take the patch off several hours before bed to get the nicotine out of their system, thus creating a time period that could be tempting to smoke. |

G.Exercises/Handouts for Client Education & Staff Education

1. Exercise: Beliefs/Values Clarification

Please select the response to each of the statements listed below that most closely matches how you feel. Be sure to answer each question. **Do not** put your name on your form as they will be collected, shuffled and redistributed to participants for discussion.

Check statements:

SA=Strongly Agree; A=Agree; D=Disagree; SD=Strongly Disagree

1. ______ Smoking breaks are great opportunities for staff and clients to have an informal counseling session.
2. ______ Clients have more serious problems to deal with than their smoking.
3. ______ I am comfortable with incorporating nicotine addiction issues into my work with clients.
4. ______ Clients in early recovery from other substance use will jeopardize their sobriety by trying to stop smoking.
5. ______ Asking clients about their smoking will hurt our counseling relationship.
6. ______ Substance use treatment programs should incorporate planting the seed in clients’ minds about giving up smoking.

Source: adapted from Addressing Tobacco in the Treatment and Prevention of Other Addictions, New Brunswick, NJ
2. Symptoms of Nicotine Withdrawal

Stopping smoking brings about a variety of symptoms associated with physical and psychological withdrawal. Most symptoms decrease sharply during the first few days of cessation, followed by a continued, but slower rate of decline in the second and third weeks of abstinence. For some people, coping with withdrawal symptoms is like “riding a rollercoaster:” there may be sharp turns, slow climbs and unexpected plunges. Most symptoms pass within two to four weeks after stopping.
<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>CAUSE</th>
<th>AVERAGE DURATION</th>
<th>RELIEF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritability</td>
<td>Body’s craving for nicotine</td>
<td>2 to 4 weeks</td>
<td>Walks, hot baths, relaxation techniques</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Nicotine is a stimulant</td>
<td>2 to 4 weeks</td>
<td>Take naps, rest; do not push yourself</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Nicotine affects brain wave function, influences sleep patterns; coughing and dreams about smoking are common</td>
<td>1 week</td>
<td>Avoid caffeine after 6:00 pm; practice relaxation techniques</td>
</tr>
<tr>
<td>Cough Dry Throat</td>
<td>Body is getting rid of mucus which blocked airways and restricted breathing</td>
<td>A few days</td>
<td>Drink plenty of fluids and try cough drops</td>
</tr>
<tr>
<td>Nasal Drip</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td>Body is getting extra oxygen</td>
<td>1 or 2 days</td>
<td>Take extra caution; change positions slowly</td>
</tr>
<tr>
<td>Lack of Concentration</td>
<td>Body needs time to adjust to not having constant stimulation from nicotine</td>
<td>A few weeks</td>
<td>Plan workload accordingly; avoid additional stress during first few weeks</td>
</tr>
<tr>
<td>Tightness in the Chest</td>
<td>Probably due to tension created by body’s need for nicotine; may be caused by sore muscles from coughing</td>
<td>A few days</td>
<td>Relaxation techniques (especially deep breathing)</td>
</tr>
<tr>
<td>Constipation</td>
<td>Intestinal movement decreases for a brief period</td>
<td>1 or 2 weeks</td>
<td>Drink plenty of fluids, add roughage to diet (i.e. fruits, vegetables, whole grain cereals)</td>
</tr>
<tr>
<td>Stomach Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hunger</td>
<td>Craving for cigarette can be confused with hunger pang; oral craving/desire for something in the mouth</td>
<td>Up to several weeks</td>
<td>Drink water or low-caloric liquids; be prepared with low calorie snacks.</td>
</tr>
<tr>
<td>Craving for a Cigarette</td>
<td>Withdrawal from nicotine, a strongly addictive drug</td>
<td>Most frequent first 2 or 3 days; can happen occasionally for months or years</td>
<td>Wait it out! Urges last only a few minutes. Distract yourself: exercise or go for a walk around the block</td>
</tr>
</tbody>
</table>
3. Tobacco Quiz

Work on this with a partner. Discuss each question and then choose your answer.

1. If you smoke a pack of cigarettes a day for one year, about how much will it cost? (at $8.00 per pack)
   a) $1590  b) $1825  c) $2065  d) $2920

2. Which of these chemicals are found in cigarette smoke?
   a) Arsenic (rat poison)  b) Ammonia (toilet bowl cleaner)
   c) Nicotine (kills insects)  d) Carbon monoxide (car exhaust)
   e) All of the above

3. Light or ultra-light cigarettes are safer than regular cigarettes.
   a) True  b) False

4. What are some of the risks from smoking during pregnancy and smoking around kids?
   a) Greater chance of a baby being born prematurely, before full-term
   b) Greater chance of a baby being born with low birth weight, a dangerous condition
   c) Increased risk in children for ear infections, asthma, bronchitis, sudden infant death syndrome (SIDS)
   d) All of the above

5. Smoking is a good way to help the body deal with stress.
   a) True  b) False

6. What is the average number of tries it takes before a person can quit smoking?
   a) 2  b) 8  c) 12  d) it is impossible to quit

7. The only way to stop smoking is “cold turkey.”
   a) True  b) False
Quiz Answer Sheet

1. d: $2920.00, at $8.00 a pack, multiplied times 365

2. e: Arsenic probably gets into a cigarette in the process of growing and storing the plant. Ammonia is added to cigarettes by the tobacco companies, whose research discovered that when small amounts of ammonia are burned together with tobacco, increased amounts of nicotine are made available to the smoker. Nicotine, a psychoactive drug, is a substance that occurs naturally in the tobacco plant. Carbon monoxide is an odorless poisonous gas which binds with the hemoglobin in the bloodstream, causing less oxygen to be available to the smoker’s body. Exposure to tobacco smoke has been shown to cause cancer in humans.

3. b: There is no such thing as a “safe” cigarette. Also, these cigarettes are designed in such a way that smoke is vented out through tiny holes in the filters. This means that less nicotine may be measured on Federal Trade Commission measuring machines. However, consciously or unconsciously, smokers cover these holes, and receive as much nicotine and tar as in regular cigarettes.

4. d: Quitting smoking greatly improves the health of a mother and her baby. A partner/spouse can also be supportive by not smoking around moms and babies.

5. b: A trick question. Nicotine relieves withdrawal symptoms once the drug gets to the brain and so people feel less stressed. But the body is being stressed: heart rate increases, blood pressure rises, blood vessels constrict, smoke fills the lungs and interferes with breathing!

6. b: Average is around 8 tries (MA Executive Office of Health and Human Services), but some people take fewer, some people need to try more times. Remember: keep trying, and use what worked and try to change what did not. Get support, prepare and plan, be ready.

7. b: There are many ways to quit. Quitting cold turkey, on the spot and without a plan or preparation, can be difficult to maintain in the long term. Talk with recovering smokers to find out what worked for them. Here are a few methods:
   - Nicotine replacement therapy (patch and gum) and counseling
   - Tapering down the number of cigarettes each day to practice coping strategies and lower the amount of nicotine in the body prior to quitting
   - Nicotine Anonymous meetings
   - Tobacco treatment group at a community health center
   - Acupuncture, meditation, deep breathing, exercise
   - Prayer and positive thinking; A.A. and N.A. slogans, like “Easy Does It”
   - Zyban (prescribed medication), the nicotine patch, and daily contact with friends who are supportive
4. Smoking

What does it Cost.

<table>
<thead>
<tr>
<th>Amount smoked per day</th>
<th>Average cost per day</th>
<th>Average Cost per week</th>
<th>Average cost/ month</th>
<th>Average cost/Year</th>
<th>10 year cost</th>
<th>20 year cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 pack</td>
<td>$8.00</td>
<td>$56.00</td>
<td>$243.36</td>
<td>$2,920.00</td>
<td>$29,200.00</td>
<td>$58,400.00</td>
</tr>
<tr>
<td>1.5 packs</td>
<td>$12.00</td>
<td>$84.00</td>
<td>$365.04</td>
<td>$4,380.00</td>
<td>$43,800.00</td>
<td>$87,600.00</td>
</tr>
<tr>
<td>2 packs</td>
<td>$16.00</td>
<td>$112.00</td>
<td>$486.72</td>
<td>$5,840.00</td>
<td>$58,400.00</td>
<td>$116,800.00</td>
</tr>
<tr>
<td>2.5 packs</td>
<td>$20.00</td>
<td>$140.00</td>
<td>$608.40</td>
<td>$7,300.00</td>
<td>$73,000.00</td>
<td>$146,000.00</td>
</tr>
<tr>
<td>3 packs</td>
<td>$24.00</td>
<td>$168.00</td>
<td>$730.08</td>
<td>$8,760.00</td>
<td>$87,600.00</td>
<td>$175,200.00</td>
</tr>
<tr>
<td>3.5 packs</td>
<td>$28.00</td>
<td>$196.00</td>
<td>$851.76</td>
<td>$10,220.00</td>
<td>$102,200.00</td>
<td>$204,400.00</td>
</tr>
<tr>
<td>4 packs</td>
<td>$32.00</td>
<td>$224.00</td>
<td>$973.44</td>
<td>$11,680.00</td>
<td>$116,800.00</td>
<td>$233,600.00</td>
</tr>
</tbody>
</table>

Quitting: What are the rewards?

<table>
<thead>
<tr>
<th>Amount smoked per day</th>
<th>1 month savings</th>
<th>3 months savings</th>
<th>6 months savings</th>
<th>5 years savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 pack</td>
<td>$243.36</td>
<td>$730.08</td>
<td>$1,460.16</td>
<td>$14,600.00</td>
</tr>
<tr>
<td>1.5 packs</td>
<td>$365.04</td>
<td>$1,095.12</td>
<td>$2,190.24</td>
<td>$21,900.00</td>
</tr>
<tr>
<td>2 packs</td>
<td>$486.72</td>
<td>$1,460.16</td>
<td>$2,920.32</td>
<td>$29,200.00</td>
</tr>
<tr>
<td>2.5 packs</td>
<td>$608.40</td>
<td>$1,825.20</td>
<td>$3,650.40</td>
<td>$36,500.00</td>
</tr>
<tr>
<td>3 packs</td>
<td>$730.08</td>
<td>$2,190.24</td>
<td>$4,380.48</td>
<td>$43,800.00</td>
</tr>
<tr>
<td>3.5 packs</td>
<td>$851.76</td>
<td>$2,555.28</td>
<td>$5,110.56</td>
<td>$51,100.00</td>
</tr>
<tr>
<td>4 packs</td>
<td>$973.44</td>
<td>$2,920.32</td>
<td>$5,840.64</td>
<td>$58,400.00</td>
</tr>
</tbody>
</table>

- With the money saved in just one week, a pack-a-day smoker could afford about 150 Huggies “Snug and Dry” diapers.
- With the money saved in just one month, a pack-a-day smoker could buy an Apple iPod Touch.
- With the money saved in just one month, a pack-a-day smoker could subscribe to Netflix for 1 year and still have extra money left over.
- With the money saved in one year, a pack-a-day smoker could pay for 243 hours of babysitting at $12/hour.
- With the money saved in five days, a one-and-a-half pack-a-day smoker could buy a one-month unlimited MBTA subway/bus pass.
- With the money saved in two months, a one-and-a-half pack-a-day smoker could afford a 42-46 inch flat screen LCD HDTV.
- With the money saved in four years, a two pack-a-day smoker could pay cash for a 2011 Toyota Camry or a Subaru Forester.
- With the money saved in six years, a two pack-a-day smoker could put a 10% down payment on a $350,000 house.
5. Great American Smokeout Day: Tips for Quitting

On the third Thursday in November, join millions of Americans and participate in Great American Smokeout Day. Quit smoking for 24 hours, one minute or one hour at a time, and then go for one more!

Preparing to quit smoking is essential, and can help you feel more comfortable. Here are suggestions to help you get ready.

- Cut back the number of cigarettes you smoke in a day to practice waiting out urges and to reduce the level of nicotine in your body prior to quitting.

- Make a list of your reasons for quitting. Be specific: “when I’m a non-smoker, I will breathe easier.” “I will have more energy.” Keep your list handy. Read it often.


- Put away lighters and ashtrays the night before you quit. Throw out cigarettes and matches. Clean the ashtray in your car or by your favorite chair, and fill it with sugar-free candy or cinnamon toothpicks.

- Ask for extra support from friends and family. Get phone numbers of ex-smokers whom you can call for help.

- Go to non-smoking A.A./N.A. meetings, movies, smoke-free malls, the gym, and other places where smoking is prohibited.

- Cut down on caffeine! Besides being a trigger to smoke, coffee and caffeine-containing beverages can make withdrawal symptoms worse. Once nicotine is out of your system, insomnia, irritability and mood swings can be exacerbated by coffee. Drink tea, water or unsweetened fruit juices.

Remember: health benefits begin 20 minutes after your last cigarette. Hang in there, and focus on why you want to quit.
H. Resources for Information and Materials

Literature


Consumer Helping Other Improve their Conditions by ending Smoking (CHOICES) (2005-present). CHOICES Newsletter. UMDNJ-RWJMS Division of Addiction Psychiatry, the Mental Health Association in NJ (MHANJ) and the NJ Division of Mental Health Services. Retrieved January 14, 2009, from http://www.njchoices.org/Pages/newsletter.htm


**Massachusetts Resources**

- Massachusetts Tobacco Cessation and Prevention Program (MTCP): www.mass.gov/dph/mtcp

- Help for smokers: www.makesmokinghistory.org – This MTCP sponsored website provides tobacco-related news, information, education and resources to help people quit tobacco use.

- The Smoker’s Helpline: 1-800-QUIT-NOW – Helpline staff offer health education information on tobacco. Tobacco users who want to quit can get support, self-help materials, free telephone-based counseling services and referral to local Tobacco Treatment programs.

- Tobacco, Addictions, Policy and Education (TAPE) Project of the Institute for Health and Recovery. For information email tape@healthrecovery.org; call 617-661-3991; or go to www.healthrecovery.org.

- Massachusetts Health Promotion Clearinghouse: www.maclearinghouse.com – This is a statewide resource funded by the Massachusetts Department of Public Health that develops and distributes *free health promotion materials* on a variety of health topics including tobacco cessation and prevention.
National Resources

- National Clearinghouse on Alcohol and Drug Information: http://ncadi.samhsa.gov or call 1-800-729-6686
- National Institute on Drug Abuse: www.nida.nih.gov and click on “smoking/nicotine”
- National Cancer Institute: www.cancer.gov or www.smokefree.gov or call 1-800-QUITNOW
- National LGBT Tobacco Control Network: www.lgbttobacco.org/about.php
- Centers for Disease Control and Prevention: www.cdc.gov/tobacco

Additional Resources

- American Cancer Society: www.cancer.org 1-800-ACS-2345
- American Lung Association: www.lungusa.org
- American Legacy Foundation: www.legacyforhealth.org
- Nicotine Anonymous: www.nicotine-anonymous.org
- International Network of Women Against Tobacco: www.inwat.org
- Women’s Health: www.womenshealth.gov/quit-smoking/
- The Center for Tobacco-Free Older Persons: www.tcsg.org/tobacco/info.htm
- Tobacco Free Nurses: www.tobaccofreenurses.org
- Action on Smoking and Health: www.ash.org.uk
- Hazelden Publications: www.hazelden.com
- Novartis Consumer Health, Inc.: www.habitrol.com
Addressing Tobacco Use in the Treatment and Prevention of Substance Dependence and Mental Health Disorders

- Tobacco Cessation Leadership Network: www.tcln.org
  The mission of the TCLN is to help increase the capacity in every state to establish effective, sustainable, and affordable cessation services to help people quit for life. This site features a CME link & a resource guide for professionals working with those who have mental illnesses & substance use disorders.

- Smoking Cessation Leadership Center: smokingcessationleadership.ucsf.edu
  SCLC aims to increase smoking cessation rates and increase the number of health professional who help smokers quit. Handouts, resources and peer curriculums available on website.

- Tobacco Dependence Program of New Jersey: www.tobaccoprogram.org
  Click on “research” at the top of the web page to access articles.

Teens/Youth Cessation and Resources

- Campaign for Tobacco-Free Kids: www.tobaccofreekids.org
- Foundation for a Smoke-Free America: www.tobaccofree.org
- Youth Tobacco Cessation Collaborative: www.youthtobaccocessation.org/
- Help for Teen Girls: www.womenshealth.gov/quit-smoking/teens
- Youth Tobacco Prevention and Advocacy: www.the84.org
- California Smokers Helpline: www.nobutts.ucsd.edu
- NIDA for Teens: teens.drugabuse.gov/facts/facts_nicotine1.php
- American Legacy Foundation: www.americanlegacy.org
- BADvertising: www.badvertising.org

Videos

Free from the Centers for Disease Control and Prevention (CDC)
www.cdc.gov/tobacco

- Scene Smoking: Cigarettes, Cinema & the Myth of Cool
  A documentary about smoking in film and television with interviews by Hollywood insiders who speak out about artists’ rights, social responsibility and the First Amendment. Includes a facilitator’s guide.
• Smoke Screeners: An Educational Program to Help Young People Decode Smoking in the Movies
  Includes a facilitator’s guide.

• Women and Tobacco: Seven Deadly Myths
  Geared to women, but informative for all audiences.

• Secrets through the Smoke
  Featuring Dr. Jeffrey Wigand, subject of the Academy Award-nominated film, The Insider. He achieved national prominence in 1995 when he became the tobacco industry’s highest-ranking former executive to publicly acknowledge the devastating effects of smoking on health, risking career, reputation and his family. Includes a facilitator’s guide.

• I Can’t Breathe: A Smoker’s Story (Pam Laffin, 1969–2000)
  The story of Massachusetts resident Pam Laffin, anti-tobacco activist and former smoker who died of emphysema at age 31. Includes a facilitator’s guide.

Other Recommended Videos

• Quit & Stay Quit: Understanding the Problems of Nicotine and Tobacco Dependence and The Stages of Quitting Nicotine and Tobacco
  Hazelden Publications: www.hazelden.com

• The Insider
  Touchstone Pictures, 199

• Quit to Live: Fighting Lung Cancer

• “Smoke Alarm: The Truth About Smoking and Mental Illness” (2007)
  Download the “Smoke Alarm” order form at www.clubhouseofsuffolk.org
VI. References


Institute for Health and Recovery funded by the Massachusetts Department of Public Health Bureau of Substance Abuse Services. (2000). Assessment of tobacco policies and programming in the Massachusetts substance abuse services system. Cambridge, MA.


