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## Introduction

A major achievement occurred when the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence* was published in June 2000. The Guideline provided recommendations for treating tobacco dependence based on findings of over 6000 research studies and offered healthcare providers a roadmap for smoking cessation treatment that is built around the “5A’s” (*Ask, Advise, Assess, Assist and Arrange*).

The Guideline recommends that all patients entering a health care setting be *asked* about their tobacco use status and that this status be documented. Clinicians should *advise* all tobacco users to quit and then *assess* their willingness to make a quit attempt. Patients who are ready to make a quit attempt should be *assisted* in the effort by receiving at least brief counseling in which the clinician helps the patient to set a quit date, encourages the patient to enlist the assistance of friends, family and coworkers, anticipates challenges to quitting and encourages the patient to remove tobacco products from their environment. The findings of the Guideline indicate that “There is a strong dose-response relation between the session length of person-to-person contact and successful treatment outcomes. Intensive interventions are more effective than less intensive interventions and should be used whenever possible.”

In addition, as a part of the clinicians assistance, all patients willing to make a quit attempt should be offered one of the pharmacotherapies found effective in the Guideline. *By using the pharmacotherapies found to be effective in the PHS Guideline, you can double or triple your patients’ chances of abstinence.*

For patients not ready to make a quit attempt, clinicians should counsel them briefly to promote the motivation to quit. Patients unwilling to make a quit attempt may lack information about the harmful effects of tobacco, may lack the required financial resources, may have fears or concerns about quitting, or may be demoralized because of previous relapse. Such patients may respond to a motivational intervention that provides the clinician an opportunity to educate, reassure, and motivate such as the motivational intervention built around the “5R’s” (*Relevance, Risks, Rewards, Roadblocks, and Repetition*). Motivational interventions are most likely to be successful when the clinician is empathic, promotes patient autonomy, avoids arguments, and supports the patient’s sense of self-efficacy.

### The Purpose of the Video:

This video and training manual is a tool for training clinicians to integrate the evidence based finding of the PHS Guideline into their practices. The video was developed to give information on how to conduct a brief counseling session. Ideally, the video should be viewed in a small group and discussion should take place after each counseling session. This recommended format is designed to be used in a training session of between 10 and 30 participants, broken into small groups of 5-10.

The manual also includes a variety of interactive activities that are designed to give participants the opportunity to apply the learning from the video to their own practice.

This training manual is one of a variety of training materials based upon the PHS Guideline produced by the University of Wisconsin Center for Tobacco Research and Intervention and the Agency for Healthcare Research and Quality. Please see the “Resources” section of this packet for other available training materials.

### Intended Audience:

The key audience for this training video is health care providers from a variety of disciplines (e.g., physicians, nurses, physician assistants, nurse practitioners, dentists, dental hygienists, psychologists, pharmacists, and health educators).

### Educational Objectives:

After viewing the video presentation, participants will be able to:

- Deliver brief, effective interventions to patients willing to quit tobacco use the “**5A’s**”. Skills include: **Asking** patients if they use tobacco, **Advising** all patients who use tobacco to quit in a strong, clear and *personalized* manner, **Assessing** patients’ willingness to make a quit attempt by providing brief counseling, **Assisting** patients in their quit attempt by providing brief counseling and pharmacotherapy, and **Arranging** follow-up for patients who have made a quit attempt. The primary purpose of the video training program is to improve key counseling skills although pharmacotherapies for smoking cessation are also discussed.
- Deliver brief, motivational interventions to patients unwilling to quit tobacco use at that time, the “**5R’s**”. Clinicians will learn to help patients identify the **Relevance** of quitting, the **Risks** of continued tobacco use, the **Rewards** gained from stopping tobacco use, the **Roadblocks** to quitting, and will learn to **Repeat** motivational interventions at each visit.

## Lesson Plan

**1 hour, 45 minutes**

This video is designed to provide, using interactive strategies, key counseling training for treating tobacco dependence. The program can be completed in one hour to one hour, 45 minutes. The video training program works best when a facilitator leads participants through the program. The following guidelines will help the facilitator and participants with the process and includes session specific activities designed to help participants develop counseling skills.

**1. Introductions and framework . . . . .5 minutes**

- Introduction to video
- Impact of tobacco dependence
- Educational objectives

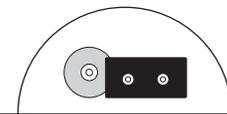
**2. Guideline . . . . .5 minutes**

- Introduction to guideline
- Key guideline recommendations
- Treating tobacco users willing to quit; the 5 A's
- Treating tobacco users unwilling to quit; 5 R's

**3. Video . . . . .35 minutes**

- Begin video
- Stop video after session 1 for discussion questions (~10 minutes)
- Watch session 2
- Stop video for discussion questions (~10 minutes)
- Watch session 3
- Stop video for discussion questions (~10 minutes)
- Finish video
- Final thoughts and discussion (~5 minutes)

**4. Interactive activities . . . . .15-60 minutes**



<b>Description of Video</b>	
<b>Introduction</b>	<b>03:12</b>
<b>Session 1</b>	<b>02:40</b>
Explanation of Session 1	<b>00:34</b>
<b>Session 2</b>	<b>04:35</b>
Explanation of Session 2	<b>01:12</b>
<b>Session 3</b>	<b>04:59</b>
Explanation of Session 3	<b>00:29</b>
<b>Final Statement</b>	<b>00:41</b>
<b>Credits</b>	<b>00:36</b>
<b>Total</b>	<b>18:58</b>

**Summary of Suggestions for Use of Video During Training Programs:**

- Show counseling sessions, stop tape, and facilitate small-group discussion of each session.
- After viewing counseling sessions, facilitate small-group discussion using questions or interactive activities in this training manual.

## Discussion Questions and Interactive Activities

The following discussion questions and interactive activities are designed to assist participants in applying evidence based tobacco dependence treatment interventions to their own practices. They may be used in any combination and the number of activities will be determined by the time available. Enacting a mock counseling session is an ideal method of applying the information from the video. When using the mock counseling technique, facilitators may wish to do the activity more than once with different case studies.

### Discussion Questions for the Three Sessions

#### QUESTIONS TO FOLLOW SESSION 1

1. Who gave up on the intervention first, the doctor or the patient? Why?
2. What were some of the patient's concerns that the doctor failed to address?
3. What could have been said regarding medication?
4. Which strategies were effective and which were ineffective?

#### ADDITIONAL QUESTIONS

1. What are some positive aspects of this intervention?
2. What are some negative aspects of this intervention?
3. What about the clinician's manner was off-putting to the patient?
4. How could this intervention be improved?
5. What strategies would you use to counsel this patient to quit?
6. Which of the 5 A's were used?
7. Which were lacking?
8. Did the doctor use any of the 5 R's?



### QUESTIONS TO FOLLOW SESSION 2

**Be sure to note:** In a complete clinic visit, a clinician would discuss medication more thoroughly, including checking for history of seizures or other contraindications before prescribing medication.

1. How did the doctor increase the patient's self-confidence?
2. What improvements would you suggest for this intervention?
3. How were the patient's weight gain concerns addressed?
4. How did the doctor utilize the patient's past quit attempts in the intervention?
5. Did you think this intervention was too long?  
How could it be made shorter?

### ADDITIONAL QUESTIONS

1. What are some positive aspects of this intervention?
2. Negative aspects?
3. How could this intervention be improved?
4. Which of the 5 A's were used?
5. Were the 5 R's used?
6. Why did the clinician choose to prescribe bupropion for this patient, instead of a nicotine replacement product?
7. What are the side effects and contraindications for bupropion?
8. What strengths and resources does this patient have to help her in her quit attempt?
9. What are the barriers to quitting in this case?



## QUESTIONS TO FOLLOW SESSION 3

1. How did the doctor motivate the patient?
2. What aspects of the intervention could be improved upon for the next visit with this patient?
3. What resources could the doctor have provided?
4. What are some of the strengths of this intervention?
5. What are some commitments that the doctor got the patient to make in order to facilitate a quit attempt? What are some additional commitments that could be addressed?



## ADDITIONAL QUESTIONS

1. Was this intervention effective?
2. Did the clinician push this patient too far in the motivational intervention?
3. What could be improved?
4. How did the clinician utilize the 5 R's?
5. How did the clinician utilize the 5 A's?
6. What strengths and resources does this patient have to help him in his quit attempt?
7. What are the barriers to quitting in this case?
8. What are some barriers in your system that would keep you from intervening in this case?
9. What are some strategies that you could use to overcome these barriers?

## ADDITIONAL QUESTIONS AT END OF VIDEO VIEWING

1. Questions or comments?
2. What are your concerns about implementing tobacco cessation interventions into your practice?
3. What concerns about motivational interviewing do you have?
4. What strategies will be useful for you when carrying out motivational interviewing?
5. What will you do if you encounter resistance during your intervention attempt?
6. What should you avoid when carrying out motivational interviewing?
7. What are some barriers in your system that could keep you from intervening?

## Interactive Activities

After viewing the video and discussing each session, participants should have the opportunity to integrate the learning by practicing the counseling activities modeled in the video.

These interactive activities are designed to give a participant the opportunity to apply the learning from the video to their own practice. These activities are presented in a continuum from low interactivity/low risk to high interactivity/high risk. For example, Interactive Activity #1 requires that participants answer questions presented by the facilitator; Interactive Activity #4 requires that participants enact counseling sessions in front of other participants. Facilitators should use low interactivity/low risk activities with participants new to interactive training and counseling. Participants experienced in interactive training and experienced in counseling may benefit from the more interactive activities.

### INTERACTIVE ACTIVITY #1 (ONE GROUP ACTIVITY)

<b>Audience:</b>	Small to medium sized group
<b>Facilitator:</b>	1 facilitator
<b>Environment:</b>	Small to medium room, classroom seating
<b>Length of Time:</b>	15-30 minutes



**Step 1:** Facilitator introduces activity. The group will view case studies and discuss how to counsel the patient based upon the information in the video.

**Step 2:** Facilitator will present case study by passing out case study information.

**Step 3:** Facilitator will read the case study.

**Step 4:** Facilitator will ask the following questions:

- What barriers does this patient have to quitting?
- What strengths could assist this patient in quitting?
- How would you encourage this patient to quit?
- What strategies would you suggest to assist this patient in a quit attempt?

### INTERACTIVE ACTIVITY #2 (ONE GROUP ACTIVITY)

<b>Audience:</b>	Small to medium sized group
<b>Facilitator:</b>	1 Facilitator
<b>Environment:</b>	Medium sized room, classroom seating
<b>Length of Time:</b>	30 minutes



**Step 1:** Instruct participants that they will be asked to discuss the following questions:

- Reflect on your interactions with patients who have other health problems such as diabetes or obesity. How is brief counseling for tobacco cessation similar to these interactions?
- How are interactions for tobacco cessation different than these interactions?
- What is your experience with tobacco cessation? What have you learned? How can this video help you to improve your interactions?

**Step 2:** Facilitator will record results of each question on a flip chart.

### INTERACTIVE ACTIVITY #3 (SMALL GROUPS ACTIVITY)

<b>Audience:</b>	Any size of group
<b>Facilitator:</b>	1 Facilitator per 20 participants
<b>Environment:</b>	One room, round tables
<b>Length of Time:</b>	1 hr.



**Step 1:** Participants should form groups of no more than 10, even numbers.

**Step 2:** Instruct participants to choose a partner and to choose one member of the group as the recorder. The role of the recorder is to write and present the answers to the questions at the conclusion of the patient, counselor interactions.

**Step 3:** Instruct participants that one partner will play the part of the patient and one the part of the counselor.

**Step 4:** Pass out to the “patient” the case study information. (Each group may use the same case study or different case studies). Instruct the “patient” to read the information and to think about how he she wishes to enact the interaction (5 minutes).

**Step 5:** Instruct the “counselors” that they have 10 minutes to discuss the patients tobacco use.

**Step 6:** Allow 10 minutes for the counseling interaction.

**Step 7:** After telling the groups to stop, instruct each table to discuss the following questions:

- What was easy about the interaction?
- What was difficult about the interaction?
- How could the interaction be improved?
- How did the “counselor” empower the “patient” to make decisions?

- e) List barriers discussed and explain how the “counselor” assisted in overcoming barriers.
- g) List quit strategy solutions presented, explain how “counselor” encouraged “patient” in quit strategies.
- h) How did the “counselor” arrange and encourage follow-up?

**Step 8:** The recorder should record the answer to the above questions. Each small group should report to the large group.

### INTERACTIVE ACTIVITY #4 (ONE GROUP ACTIVITY)

<b>Audience:</b>	Small to medium size group
<b>Facilitator:</b>	1 facilitator per 20 participants
<b>Environment:</b>	Medium sized room, classroom seating
<b>Length of time:</b>	1 hr



**Step 1:** Facilitator introduces activity. Volunteers will enact case studies for the group, with discussion.

**Step 2:** Facilitator will ask for two volunteers.

**Step 3:** Volunteers will choose to play either patient or counselor.

**Step 4:** “Patient” will be given case study information. Facilitator will ask “patient” to read the case study information and to think about how he/she wishes to enact the interaction (5 minutes).

**Step 5:** The “counselor” will also read the case study information.

**Step 6:** “Counselor” and “Patient” enact a tobacco intervention (10 minutes).

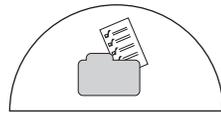
**Step 7:** Facilitator asks the group to answer the following questions:

- a) What was easy about the interaction?
- b) What was difficult about the interaction?
- c) How could the interaction be improved?
- d) How did the “clinician” empower the “patient” to make decisions?
- e) List barriers discussed and explain how the “clinician” assisted in overcoming barriers.
- g) List quit strategy solutions presented, explain how “clinician” encouraged “patient” in quit strategies.
- h) How did the “clinician” arrange and encourage follow-up?

**Step 8:** Facilitator writes answers on flip chart.



### Case Study #1



**Reason for clinic visit:** Robert is a 24 year old male. He presents in the clinic with a severe productive cough, shortness of breath and increased temperature x3 days. He had two previous diagnoses of acute bronchitis.

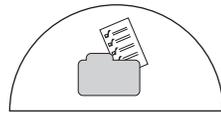
**History:** Family history includes his mother with a recent diagnosis of emphysema and his father who died of lung cancer. Both of Robert's siblings smoke. He is presently dating a smoker.

**Physical exam:** On physical exam his BP is 138/76, pulse 90, respirations 22 and temperature 101.1 F. His lungs have diffuse rhonchi and he has a cough that is productive of purulent sputum. His smoking history indicates that he has smoked 2 packs of cigarettes per day for 8 years.

**Smoking history:** He has his first cigarette immediately after waking. He tried to quit last year using the patch but was only able to remain abstinent for 2 days. His girlfriend smokes but may be willing to quit smoking with him.



### Case study #2



**Reason for clinic visit:** Leigh is a 27 year old female who presents in the clinic for a family planning consultation.

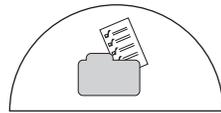
**History:** She has no significant past medical history and has recently discontinued oral contraceptives. She has been married for 3 years to a non-smoker. She and her husband want to start a family. She works as a computer programmer.

**Physical exam:** On physical exam she has a BP of 114/70, pulse 70.

**Smoking history:** Smoking history indicates that she smokes 20-25 cigarettes per day, has smoked for 5 years, and she smokes her first cigarette within 30 minutes after waking. She only smokes outside the home and has never tried to quit. Her husband is encouraging her to quit.



### Case study #3



**Reason for clinic visit:** George is a 58 year old male. He is visiting the clinic with a c/o depression.

**History:** Family history includes a father who smokes cigars. Both parents are alive and in apparent good health. He has two children who live in other states. He is married and works as a mechanical engineer. He has been having marital problems and is presently in counseling. The onset of his depression coincides with the beginning of his marital problems. He states that he has been sleeping poorly and has difficulty concentrating. He feels “stressed out all the time”.

**Physical exam:** His physical exam is unremarkable.

**Smoking History:** Smoking history includes cigars and cigarettes x 40 years. After several attempts over the past ten years, he quit “cold turkey” seven months ago and developed depression soon thereafter. He states that he is tempted to start smoking again as “smoking will help me to feel better”.

## Key Guideline Evidence Supporting the Video

### Fact Sheet

1. Recent surveys show that about 23 percent of all American adults smoke.
2. More than 430,000 deaths in the United States each year are attributable to tobacco use, making tobacco the No. 1 cause of death and disease in this country.
3. Smoking prevalence among adolescents rose dramatically starting in 1990 and peaked in the late 1990's. Currently an estimated 2,000-3,000 children and adolescents become regular tobacco users each day.
4. Nationwide, medical care costs attributable to smoking (or smoking-related disease) have been estimated by the Centers for Disease Control and Prevention to be more than \$50 billion annually. In addition, they estimate the value of lost earnings and loss of productivity to be at least another \$47 billion a year.
5. It would cost an estimated \$6.3 billion annually to provide 75 percent of smokers 18 years and older with the evidence based intervention — counseling, nicotine patches, nicotine gum, bupropion or a combination — of their choice. This would result in 1.7 million new quitters at an average cost of \$3,779 per quitter — a move that would be highly cost-effective relative to other medical interventions such as mammography or blood pressure screening.
6. Epidemiologic data suggest that more than 70 percent of the 50 million smokers in the United States today have made at least one prior quit attempt, and approximately 46 percent try to quit each year. Most smokers make several quit attempts before they successfully quit.
7. Only 21 percent of practicing physicians say that they have received adequate training to help their patients stop smoking, according to a recent survey of U.S. medical school deans published in the Journal of the American Medical Association. The majority of medical schools do not require clinical training in smoking cessation techniques. It is hoped that this guideline will serve as a call to action.

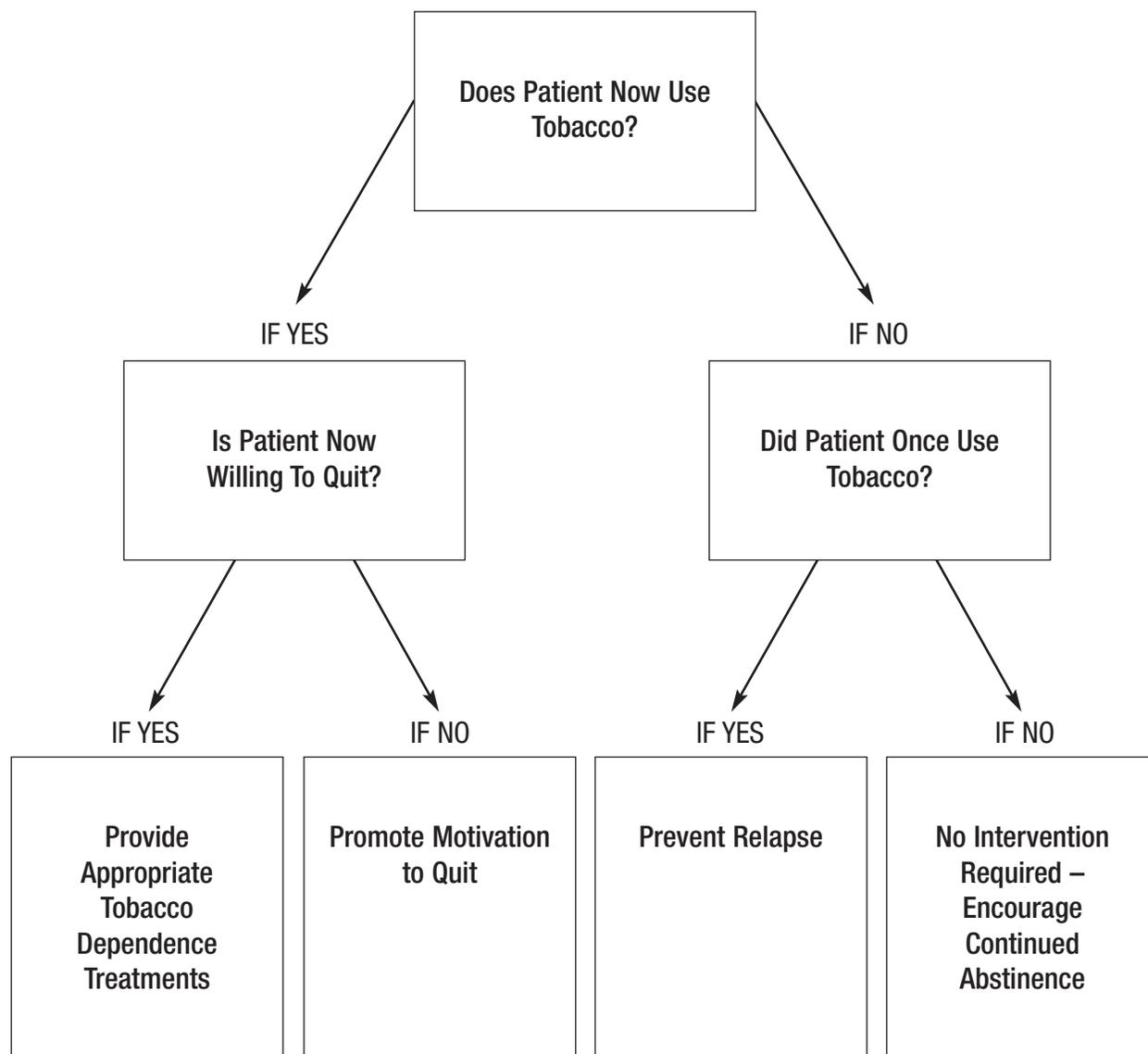
## What is the Guideline?

### “The 5A’s”

The training video “Treating Tobacco Use and Dependence: Practical Strategies to Help Your Patient Quit” is based upon the finding of the Public Health Service Clinical Practice Guideline Treating Tobacco Use and Dependence (Fiore, Bailey, Cohen, Dorfman, Goldstein, Gritz, Heyman, Jaen, Kottke, Lando, Mecklenburg, Mullen, Nett, Robinson, Stitzer, Tommasello, Villejo, & Wewers, June, 2000). This Guideline outlines five major steps (**the “5A’s”**) for clinicians to intervene with patients who smoke. It is important for the clinician to **Ask** the patient if he or she uses tobacco, **Advise** him or her to quit, **Assess** willingness to make a quit attempt, **Assist** him or her in making a quit attempt, and **Arrange** for follow-up contacts to prevent relapse. The strategies are designed to be brief, requiring 3 minutes or less of direct clinician time.

As you view the video you will see examples of how these five steps are integrated into brief interventions with smokers. In the following pages you will find information from the PHS Guideline on each of the “5A’s”, including information on integrating asking as a vital sign, pharmacotherapy for smoking cessation and counseling smokers to quit. In addition you will find information on the “5R’s” for smokers not interested in making a quit attempt, and tips on motivational interviewing.

## Algorithm for treating tobacco use



- Relapse prevention interventions are not necessary in the case of the adult who has not used tobacco for many years.

## Ask — Systematically identify all tobacco users at every visit

In the video you will note that the clinician documents the smoking status on the patients chart. Integrating smoking status as the “5th vital sign” on the chart encourages clinicians to routinely ask about tobacco status.

Action	Strategies for Implementation
Implement an officewide system that ensures that, for every patient at every clinic visit, tobacco-use status is queried and documented.	Expand the vital signs to include tobacco use or use an alternative universal identification system.

Vital Signs
Blood Pressure: _____
Pulse: _____ Weight: _____
Temperature: _____
Respiratory Rate: _____
Tobacco Use: (circle one)    Current    Former    Never

## Advise — Strongly urge all tobacco users to quit

You will note in the video sessions that the successful interventions included strong messages by the clinician to quit smoking. The messages should be clear, strong and personalized.

<b>Action</b>	<b>Strategies for Implementation</b>
<p>In a clear, strong, and personalized manner, urge every tobacco user to quit.</p>	<p>Advice should be:</p> <ul style="list-style-type: none"><li>• Clear — "I think it is important for you to quit smoking now and I can help you." "Cutting down while you are ill is not enough."</li><li>• Strong — "As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you."</li><li>• Personalized — Tie tobacco use to current health/ illness, and/or its social and economic costs, motivation level/readiness to quit, and/or the impact of tobacco use on children and others in the household.</li></ul>

## Assess — Determine willingness to make a quit attempt

The sessions in the video demonstrate the importance of assessing a patient's willingness to make a quit attempt.

<b>Action</b>	<b>Strategies for Implementation</b>
<p>Ask every tobacco user if he or she is willing to make a quit attempt at this time (e.g., within the next 30 days).</p>	<p>Assess patient's willingness to quit:</p> <ul style="list-style-type: none"><li>• If the patient is willing to make a quit attempt at this time, provide assistance. (See page 20)</li><li>• If the patient will participate in an intensive treatment, deliver such a treatment or refer to an intensive intervention. (See page 28)</li><li>• If the patient clearly states he or she is unwilling to make a quit attempt at this time, provide a motivational intervention. (See page 34)</li><li>• If the patient is a member of a special population (e.g., adolescent, pregnant smoker, racial/ethnic minority), consider providing additional information.</li></ul>

### Assist—Aid the patient in quitting

The video sessions demonstrate brief counseling interventions. In addition to counseling, all smokers making a quit attempt should receive pharmacotherapy, except in the presence of special circumstances.

Action	Strategies for Implementation
<p>Help the patient with a quit plan.</p>	<p>A patient's preparations for quitting:</p> <ul style="list-style-type: none"> <li>• Set a quit date — ideally, the quit date should be within 2 weeks.</li> <li>• Tell family, friends, and coworkers about quitting and request understanding and support.</li> <li>• Anticipate challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms.</li> <li>• Remove tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, car).</li> </ul>
<p>Provide practical counseling (problemsolving/training).</p>	<ul style="list-style-type: none"> <li>• Abstinence — Total abstinence is essential. "Not even a single puff after the quit date."</li> <li>• Past quit experience — Review past quit attempts including identification of what helped during the quit attempt and what factors contributed to relapse.</li> <li>• Anticipate triggers or challenges in upcoming attempt — Discuss challenges/triggers and how patient will successfully overcome them.</li> <li>• Alcohol — Because alcohol can cause relapse, the patient should consider limiting/abstaining from alcohol while quitting.</li> <li>• Other smokers in the household — Quitting is more difficult when there is another smoker in the household. Patients should encourage housemates to quit with them or not smoke in their presence. (See page 21)</li> </ul>
<p>Provide intra-treatment social support.</p>	<ul style="list-style-type: none"> <li>• Provide a supportive clinical environment while encouraging the patient in his or her quit attempt. "My office staff and I are available to assist you." (See page 22 for more details on providing intra-treatment social support)</li> </ul>

Action	Strategies for Implementation
Help patient obtain extra-treatment social support.	<ul style="list-style-type: none"> <li>• Help patient develop social support for his or her quit attempt in his or her environments outside of treatment. "Ask your spouse/partner, friends, and coworkers to support you in your quit attempt."</li> </ul> (See page 23)
Recommend the use of approved pharmacotherapy, except in special circumstances.	<ul style="list-style-type: none"> <li>• Recommend the use of pharmacotherapies found to be effective. Explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy medications include: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch.</li> </ul> (See pages 26)
Provide supplementary materials.	<ul style="list-style-type: none"> <li>• Sources — Federal agencies, nonprofit agencies, or local/state health departments.</li> <li>• Type — Culturally/racially/educationally/age appropriate for the patient.</li> <li>• Location — Readily available at every clinician's workstation.</li> </ul>

### Assist Component — Three Types of Counseling

Assisting patients in quitting smoking can be done as part of a brief treatment or as part of an intensive treatment program. Evidence from the guideline demonstrates that the more intense and longer lasting the intervention, the more likely the patient is to stay smoke-free; even an intervention lasting fewer than three minutes is effective.

The following three tables provide further detail and examples of the three forms of counseling that were found to be effective in treating tobacco use and dependence:

1. Practical counseling (problem solving/skills training). (See page 21)
2. Intra-treatment social support. (See page 22)
3. Extra-treatment social support. (See page 23)

### Common elements of practical counseling—ADVICE to quit

In the video sessions you will see examples of how the clinician uses the principles of practical counseling. Practical counseling refers to a tobacco use treatment in which tobacco users are trained to identify and cope with events or problems that increase the likelihood of their tobacco use. For example, quitters might be trained to anticipate stressful events and to use coping skills such as distraction or deep breathing to cope with an urge to smoke. Related and similar interventions are coping skill training, relapse prevention, and stress management.

Practical counseling (problem solving/ skills training) treatment component	Examples
Recognize danger situations— Identify events, internal states, or activities that increase the risk of smoking or relapse.	<ul style="list-style-type: none"> <li>• Negative affect.</li> <li>• Being around other smokers.</li> <li>• Drinking alcohol.</li> <li>• Experiencing urges.</li> <li>• Being under time pressure.</li> </ul>
Develop coping skills— Identify and practice coping or problem solving skills. Typically, these skills are intended to cope with danger situations.	<ul style="list-style-type: none"> <li>• Learning to anticipate and avoid temptation.</li> <li>• Learning cognitive strategies that will reduce negative moods.</li> <li>• Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure.</li> <li>• Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention).</li> </ul>
Provide basic information— Provide basic information about smoking and successful quitting.	<ul style="list-style-type: none"> <li>• Any smoking (even a single puff) increases the likelihood of full relapse.</li> <li>• Withdrawal typically peaks within 1-3 weeks after quitting</li> <li>• Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating.</li> <li>• The addictive nature of smoking.</li> </ul>

## Common elements of intra-treatment supportive interventions

Intra-treatment social support refers to an intervention component that is intended to provide encouragement, a sense of concern, and interested empathetic listening as part of the treatment. As you view the videos, you may note these components of the clinician-patient interaction.

Supportive treatment component	Examples
Encourage the patient in the quit attempt.	<ul style="list-style-type: none"><li>• Note that effective tobacco dependence treatments are now available.</li><li>• Note that one-half of all people who have ever smoked have now quit.</li><li>• Communicate belief in patient's ability to quit.</li></ul>
Communicate caring and concern.	<ul style="list-style-type: none"><li>• Ask how patient feels about quitting.</li><li>• Directly express concern and willingness to help.</li><li>• Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings.</li></ul>
Encourage the patient to talk about the quitting process.	<p>Ask about:</p> <ul style="list-style-type: none"><li>• Reasons the patient wants to quit.</li><li>• Concerns or worries about quitting.</li><li>• Success the patient has achieved.</li><li>• Difficulties encountered while quitting.</li></ul>

## Common elements of extra-treatment supportive interventions

Extra-treatment social support component refers to interventions or elements of an intervention wherein patients are provided with tools or assistance in obtaining social support outside of treatment. This category is distinct from intra-treatment social support, in which social support is delivered directly by treatment staff. As you view the video sessions, note how the clinician involves family members and other individuals that can assist the patient in his or her quit attempt.

Supportive treatment component	Examples
Train patient in support solicitation skills.	<ul style="list-style-type: none"><li>• Show videotapes that model skills.</li><li>• Practice requesting social support from family, friends, and coworkers.</li><li>• Aid patient in establishing a smoke-free home.</li></ul>
Prompt support seeking.	<ul style="list-style-type: none"><li>• Help patient identify supportive others.</li><li>• Call the patient to remind him or her to seek support.</li><li>• Inform patients of community resources such as hotlines and helplines.</li></ul>
Clinician arranges outside support.	<ul style="list-style-type: none"><li>• Mail letters to supportive others.</li><li>• Call supportive others.</li><li>• Invite others to cessation sessions.</li><li>• Assign patients to be "buddies" for one another.</li></ul>

## Assist Component — Pharmacotherapy

The use of pharmacotherapy is a key part of a multicomponent approach to assisting patients with their tobacco dependence. The following tables address the clinical use of pharmacotherapies for tobacco dependence and some of the more common questions and concerns regarding pharmacotherapy.

### Clinical guidelines for prescribing pharmacotherapy for smoking cessation

<p>Who should receive pharmacotherapy for smoking cessation?</p>	<p>All smokers trying to quit, except in the presence of special circumstances. Special consideration should be given before using pharmacotherapy with selected populations: those with medical contraindications, those smoking fewer than 10 cigarettes/day, pregnant/breastfeeding women, and adolescent smokers.</p>
<p>What are the first-line pharmacotherapies recommended?</p>	<p>All six of the FDA-approved pharmacotherapies for smoking cessation are recommended, including bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and the nicotine patch.</p>
<p>What factors should a clinician consider when choosing among the six first-line pharmacotherapies?</p>	<p>Because of the lack of sufficient data to rank-order these five medications, choice of a specific first-line pharmacotherapy must be guided by factors such as clinician familiarity with the medications, contraindications for selected patients, patient preference, previous patient experience with a specific pharmacotherapy (positive or negative), and patient characteristics (e.g., history of depression, concerns about weight gain).</p>
<p>Are pharmacotherapeutic treatments appropriate for lighter smokers (e.g., 10-15 cigarettes/day)?</p>	<p>If pharmacotherapy is used with lighter smokers, clinicians should consider reducing the dose of first-line nicotine replacement therapy (NRT) pharmacotherapies. No adjustments are necessary when using bupropion SR.</p>
<p>What second-line pharmacotherapies are recommended?</p>	<p>Clonidine and nortriptyline.</p>

<p>When should second-line agents be used for treating tobacco dependence?</p>	<p>Consider prescribing second-line agents for patients unable to use first-line medications because of contraindications or for patients for whom first-line medications are not helpful. Monitor patients for the known side effects of second-line agents.</p>
<p>Which pharmacotherapies should be considered with patients particularly concerned about weight gain?</p>	<p>Bupropion SR and nicotine replacement therapies, in particular nicotine gum, have been shown to delay, but not prevent, weight gain.</p>
<p>Are there pharmacotherapies that should be especially considered in patients with a history of depression?</p>	<p>Bupropion SR and nortriptyline appear to be effective with this population.</p>
<p>Should nicotine replacement therapies be avoided in patients with a history of cardiovascular disease?</p>	<p>No. The nicotine patch in particular is safe and has been shown not to cause adverse cardiovascular effects.</p>
<p>May pharmacotherapies ever be combined?</p>	<p>Yes. There is evidence that combining the nicotine patch with either nicotine gum or nicotine nasal spray increases long-term abstinence rates over those produced by a single form of NRT.</p>

### Suggestions for the clinical use of pharmacotherapies for smoking cessation

#### First-line Pharmacotherapies (Approved for use for smoking cessation by the FDA)

Pharmacotherapy	Precautions/Contraindication	Side Effects	Dosage	Duration	Availability	Cost/day
Bupropion SR	<ul style="list-style-type: none"> <li>History of seizure</li> <li>History of eating disorder</li> </ul>	<ul style="list-style-type: none"> <li>Insomnia</li> <li>Dry mouth</li> </ul>	<ul style="list-style-type: none"> <li>150 mg every morning for 3 days, then 150 mg twice daily (Begin treatment 1-2 weeks pre-quit)</li> </ul>	<ul style="list-style-type: none"> <li>7-12 weeks maintenance up to 6 months</li> </ul>	<ul style="list-style-type: none"> <li>Zyban (prescription only)</li> </ul>	<ul style="list-style-type: none"> <li>\$4.60</li> </ul>
Nicotine Gum		<ul style="list-style-type: none"> <li>Mouth soreness</li> <li>Dyspepsia</li> </ul>	<ul style="list-style-type: none"> <li>1-24 cigs/day-2 mg gum (up to 24 pcs/day)</li> <li>25+ cigs/day-4 mg gum (up to 24 pcs/day)</li> </ul>	<ul style="list-style-type: none"> <li>Up to 12 weeks</li> </ul>	<ul style="list-style-type: none"> <li>Nicorette</li> <li>Nicorette Mint (OTC only)</li> <li>Nicorette Orange (OTC Only)</li> </ul>	<ul style="list-style-type: none"> <li>\$6.25 for 10, 2-mg pieces</li> <li>\$6.70 for 10, 4-mg pieces</li> </ul>
Nicotine Inhaler		<ul style="list-style-type: none"> <li>Local irritation of mouth and throat</li> </ul>	<ul style="list-style-type: none"> <li>6-16 cartridges/day</li> </ul>	<ul style="list-style-type: none"> <li>Up to 6 months</li> </ul>	<ul style="list-style-type: none"> <li>Nicotrol Inhaler (prescription only)</li> </ul>	<ul style="list-style-type: none"> <li>\$11.20 for 10 cartridges</li> </ul>
Nicotine Lozenge		<ul style="list-style-type: none"> <li>Nausea</li> <li>Insomnia</li> </ul>	<ul style="list-style-type: none"> <li>Smoke more than 30 min. after waking=2mg</li> <li>Smoke less than 30 min. after waking=4mg</li> </ul>	<ul style="list-style-type: none"> <li>Up to 12 weeks</li> </ul>	<ul style="list-style-type: none"> <li>Commit Lozenge (OTC)</li> </ul>	<ul style="list-style-type: none"> <li>\$5.97 for 10 lozenges</li> </ul>
Nicotine Nasal Spray		<ul style="list-style-type: none"> <li>Nasal irritation</li> </ul>	<ul style="list-style-type: none"> <li>8-40 doses/day</li> </ul>	<ul style="list-style-type: none"> <li>3-6 months</li> </ul>	<ul style="list-style-type: none"> <li>Nicotrol NS (prescription only)</li> </ul>	<ul style="list-style-type: none"> <li>\$28.80 for 12 doses</li> </ul>
Nicotine Patch		<ul style="list-style-type: none"> <li>Local skin reaction</li> <li>Insomnia</li> </ul>	<ul style="list-style-type: none"> <li>21 mg/24 hours</li> <li>14 mg/24 hours</li> <li>7 mg/24 hours</li> <li>15 mg/16 hours</li> </ul>	<ul style="list-style-type: none"> <li>4 weeks then 2 weeks then 2 weeks (8 weeks)</li> </ul>	<ul style="list-style-type: none"> <li>Nicoderm CQ (OTC)</li> <li>Generic patches (prescription and OTC)</li> <li>Nicotrol (OTC)</li> </ul>	<ul style="list-style-type: none"> <li>Brand name patches \$3.60</li> </ul>

#### Second-line Pharmacotherapies (Not approved for use for smoking cessation by the FDA)

Pharmacotherapy	Precautions/Contraindication	Side Effects	Dosage	Duration	Availability	Cost/day
Clonidine	<ul style="list-style-type: none"> <li>Rebound hypertension</li> </ul>	<ul style="list-style-type: none"> <li>Dry mouth</li> <li>Drowsiness</li> <li>Dizziness</li> <li>Sedation</li> </ul>	<ul style="list-style-type: none"> <li>0.15-0.75 mg/day</li> </ul>	<ul style="list-style-type: none"> <li>3-10 weeks</li> </ul>	<ul style="list-style-type: none"> <li>Oral Clonidine-generic, Catapres (prescription only)</li> <li>Transdermal Catapres (prescription only)</li> </ul>	<ul style="list-style-type: none"> <li>Clonidine: \$0.24 for 0.2 mg</li> <li>Catapres (transdermal): \$3.50</li> </ul>
Nortriptyline	<ul style="list-style-type: none"> <li>Risk of arrhythmias</li> </ul>	<ul style="list-style-type: none"> <li>Sedation</li> <li>Dry mouth</li> </ul>	<ul style="list-style-type: none"> <li>75-100 mg/day</li> </ul>	<ul style="list-style-type: none"> <li>12 weeks</li> </ul>	<ul style="list-style-type: none"> <li>Nortriptyline HCl-generic (prescription only)</li> </ul>	<ul style="list-style-type: none"> <li>\$0.74 for 75 mg</li> </ul>

a. The information contained within this table is not comprehensive. Please see package insert for additional information. b. Prices based on retail prices of medication purchased at a national chain pharmacy, located in Madison, WI, Fall 2003. c. Generic brands of the patch are available and may be less expensive. **NOTE:** OTC=Over the Counter.

## Components of an intensive intervention

In the sessions that appear in the video, each intervention is brief, lasting no more than four minutes. There is, however, a strong dose-response relation between the session length of person-to-person contact and successful treatment outcomes. Intensive interventions are more effective than less intensive interventions and should be used whenever possible. The more time that the clinician can spend in counseling and assisting the patient in the quit attempt, the more successful the attempt.

### Assessment:

Assessments should ensure that tobacco users are willing to make a quit attempt using an intensive treatment program. Other assessments can provide information useful in counseling (e.g., stress level, presence of comorbidity).

### Program clinicians:

Multiple types of clinicians are effective and should be used. One counseling strategy would be to have a medical/health care clinician deliver messages about health risks and benefits and deliver pharmacotherapy, and nonmedical clinicians deliver additional psychosocial or behavioral interventions.

### Program intensity:

Because of evidence of a strong dose-response relationship, the intensity of the program should be:

- Session length—longer than 10 minutes.
- Number of sessions—4 or more sessions.
- Total contact time—longer than 30 minutes.

### Program format:

Either individual or group counseling may be used. Proactive telephone counseling also is effective. Use of adjuvant self-help material is optional. Follow-up assessment intervention procedures should be used.

### **Type of counseling and behavioral therapies:**

Counseling and behavioral therapies should involve practical counseling (problem solving/skills training) and intra-treatment and extra-treatment social support.

### **Pharmacotherapy**

Every smoker should be encouraged to use pharmacotherapies endorsed in the guideline, except in the presence of special circumstances. Special consideration should be given before using pharmacotherapy with selected populations (e.g., pregnancy, adolescents). The clinician should explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy agents include: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and the nicotine patch.

### **Population**

Intensive intervention programs may be used with all tobacco users willing to participate in such efforts.

### **Assist Component—Special Populations**

Interventions should be culturally, language, and educationally appropriate. In general, the treatments that were found to be effective in the guideline can be used with members of special populations, including hospitalized smokers, members of racial and ethnic minorities, older smokers, and others.

## Arrange — Schedule follow-up contact

The last of the “5A’s” — arrange, involves arranging follow-up after the counseling intervention. You may note in the video that the clinician offered information on a quit line. Quit lines have been used effectively in many states to follow-up and offer continuing support for patients making a quit attempt.

### Action Strategies for implementation

Schedule follow-up contact, either in person or via telephone.

- Timing — Follow-up contact should occur soon after the quit date, preferably during the first week. A second follow-up contact is recommended within the first month. Schedule further follow-up contacts as indicated.
- Actions during follow-up contact — Congratulate success. If tobacco use has occurred, review circumstances and elicit recommitment to total abstinence. Remind patient that a lapse can be used as a learning experience. Identify problems already encountered and anticipate challenges in the immediate future. Assess pharmacotherapy use and problems. Consider use or referral to more intensive treatment.

## How to Use the Cessation Tear Sheet

In the video, you will see the “cessation tear sheet” used in a counseling intervention. Once tobacco use has been documented a plan of cessation strategies should be outlined. The tear sheet provides a framework of clinicians to personalize a short 3-5 minute interaction tailored to the clinicians’ own style. This personalized plan can then be given to the patient as a take-away.

The front of the Cessation Tear Sheet offers motivational messages and specific advice on how to quit successfully. The back of the Cessation Tear Sheet offers five key steps that embody the key recommendations from the Guideline. Using these steps, the clinician can easily design a personalized quit plan for the patient.

The Cessation Tear Sheet provides space for a clinician and patient to interactively discuss quitting and to establish a plan. It can be used to discuss pharmacotherapy, and identify stratifies for avoiding and dealing with cessation barriers as well as learning new skills and behaviors. It works best when the clinician fills in the 5 steps on the back of the sheet, personalized for the patient.

The Cessation Tear Sheet also includes space for a follow-up plan which any include a follow-up visit and/or referral information as well as additional resources.

Cessation Tear Sheets can be ordered from the Agency for Healthcare Research and Quality (AHRQ) by calling 800-358-9295. They can also be downloaded from the University of Wisconsin Medical School Center for Tobacco Research and Intervention at [www.ctri.wisc.edu](http://www.ctri.wisc.edu).

## Tobacco Users Unwilling to Quit at This Time

The "5 R's," **Relevance, Risks, Rewards, Roadblocks, and Repetition**, are designed to motivate smokers who are unwilling to quit at this time. The final of the three sessions in the video demonstrates a patient unwilling to make a quit attempt at that time. Smokers may be unwilling to quit due to misinformation, concern about the effects of quitting, or demoralization because of previous unsuccessful quit attempts. Therefore, after asking about tobacco use, advising the smoker to quit, and assessing the willingness of the smoker to quit, it is important to provide the "5 R's" motivational intervention.

### Relevance

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

### Risks

The clinician should ask the patient to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks.

### Examples of risks are:

- Acute risks: Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, and increased serum carbon monoxide.
- Long-term risks: Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability, and need for extended care.
- Environmental risks: Increased risk of lung cancer and heart disease in spouses; higher rates of smoking in children of tobacco users; increased risk for low birth weight, Sudden Infant Death Syndrome, asthma, middle ear disease, and respiratory infections in children of smokers.

### Rewards

The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient.

### Examples of rewards follow:

- Improved health.
- Food will taste better.
- Improved sense of smell.
- Save money.
- Feel better about yourself.
- Home, car, clothing, breath will smell better.
- Can stop worrying about quitting.
- Set a good example for children.
- Have healthier babies and children.
- Not worry about exposing others to smoke.
- Feel better physically.
- Perform better in physical activities.
- Reduced wrinkling/aging of skin.

### Roadblocks

The clinician should ask the patient to identify barriers or impediments to quitting and note elements of treatment (problem solving, pharmacotherapy) that could address barriers.

### Typical barriers might include:

- Withdrawal symptoms.
- Fear of failure.
- Weight gain.
- Lack of support.
- Depression.
- Enjoyment of tobacco.

### Repetition

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

## Motivational Interviewing

When initiating the “5R’s” it is helpful to use the principles of motivational interviewing. In the video, you will see the clinicians use these principles in all sessions, with this technique emphasized in the third session. Motivational interviewing is a type of intervention designed to bolster patients’ resolve to quit through manipulations such as setting a quit date, use of a contract with a specified quit date, reinforcing correspondence (letters mailed from clinical/study staff congratulating the patient on his or her decision to quit or on early success), or providing information about the health risks of smoking and so on. Motivational interventions are most likely to be successful when the clinician is empathetic, promotes patient autonomy, avoids arguments, and supports the patient’s self-efficacy.

### Motivational Interviewing Principles:

#### 1. Express empathy

- Acceptance facilitates change.
- Skillful reflective listening is fundamental.
- Ambivalence is normal.

#### 2. Develop discrepancy

- The patient rather than the clinician should present the arguments for change.
- Change is motivated by a perceived discrepancy between present behavior and important personal goals or values.

#### 3. Roll with resistance

- Avoid arguing for change.
- Resistance is not directly opposed.
- New perspectives are invited but not imposed.
- The patient is a primary resource in finding answers and solutions.
- Resistance is a signal to respond differently.

#### 4. Support self-efficacy

- The person’s belief in the possibility of change is an important motivator.
- The patient, not the clinician, is responsible for choosing and carrying out change.
- The clinician’s own belief in the person’s ability to change becomes a self-fulfilling prophecy.

## Former Smokers — Preventing Relapse

Although the video does not demonstrate a relapse prevention intervention, it is important that clinicians understand the importance of revisiting the quit status of patients at each visit. Although most relapses occur soon after a person quits smoking, some people relapse months or even years after the quit date. All clinicians should work to prevent relapse. Relapse prevention programs can take the form of either minimal (brief) or prescriptive (more intensive) programs.

### Components of Minimal Practice Relapse Prevention

These interventions should be part of every encounter with a patient who has quit recently. Every ex-tobacco user undergoing relapse prevention should receive congratulations on any success and strong encouragement to remain abstinent. When encountering a recent quitter, use open-ended questions designed to initiate patient problem solving (e.g., How has stopping tobacco use helped you?). The clinician should encourage the patient's active discussion of the topics below:

- The benefits, including potential health benefits, that the patient may derive from cessation.
- Any success the patient has had in quitting (duration of abstinence, reduction in withdrawal, etc.).
- The problems encountered or anticipated threats to maintaining abstinence (e.g., depression, weight gain, alcohol, other tobacco users in the household).

### Components of Prescriptive Relapse Prevention

During prescriptive relapse prevention, a patient might identify a problem that threatens his or her abstinence. Specific problems likely to be reported by patients and potential responses follow:

#### Lack of support for cessation

- Schedule follow-up visits or telephone calls with the patient.
- Help the patient identify sources of support within his or her environment.
- Refer the patient to an appropriate organization that offers cessation counseling or support.

#### Negative mood or depression

- If significant, provide counseling, prescribe appropriate medications, or refer the patient to a specialist.

#### Strong or prolonged withdrawal symptoms

- If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved pharmacotherapy or adding/combining pharmacologic medication to reduce strong withdrawal symptoms.

### **Weight gain**

- Recommend starting or increasing physical activity; discourage strict dieting.
- Reassure the patient that some weight gain after quitting is common and appears to be self-limiting.
- Emphasize the importance of a healthy diet.
- Maintain the patient on pharmacotherapy known to delay weight gain (e.g., bupropion SR, nicotine-replacement pharmacotherapies, particularly nicotine gum).
- Refer the patient to a specialist or program.

### **Flagging motivation/feeling deprived**

- Reassure the patient that these feelings are common.
- Recommend rewarding activities.
- Probe to ensure that the patient is not engaged in periodic tobacco use.
- Emphasize that beginning to smoke (even a puff) will increase urges and make quitting more difficult.

## Guideline Availability

This guideline is available in several formats suitable for health care practitioners, the scientific community, educators, and consumers.

The Clinical Practice Guideline presents recommendations for health care providers with brief supporting information, tables and figures, and pertinent references.

The Quick Reference Guide is a distilled version of the clinical practice guideline, with summary points for ready reference on a day-to-day basis.

The Consumer Version is an information booklet for the general public to increase consumer knowledge and involvement in health care decisionmaking.

The full text of the guideline documents and the meta-analyses references for online retrieval are available on the Surgeon General's Web site (<http://www.surgeongeneral.gov/tobacco/default.htm>).

Single copies of these guideline products and further information on the availability of other derivative products can be obtained by calling any of the following Public Health Service clearinghouse's toll-free numbers:

**Agency for Healthcare Research and Quality (AHRQ): 800-358-9295**

**Centers for Disease Control and Prevention (CDC): 800-CDC-1311**

**National Cancer Institute (NCI): 800-4-CANCER**

**U.S. Department of Health and Human Services**

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1. Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.
2. Miller WR, Rollnick S. (2002). *Motivational interviewing: Preparing people for change*. 2nd Edition. New York: The Guilford Press.
3. *Treating Tobacco Use and Dependence*. Quick Reference Guide for Clinicians, October 2000. U.S. Public Health Service. <http://www.surgeongeneral.gov/tobacco/tobaqrg.htm>

## Helpful Website Addresses\*

The inclusion of websites in this appendix is intended to assist readers in finding additional information regarding the treatment of tobacco dependence and does not constitute endorsement of the contents of any particular site.

Addressing Tobacco in Managed Care	<a href="http://www.aahp.org/atmc.htm">http://www.aahp.org/atmc.htm</a>
Agency for Health Care Research and Quality	<a href="http://www.ahrq.gov/">http://www.ahrq.gov/</a>
American Academy of Family Physicians	<a href="http://www.aafp.org">http://www.aafp.org</a>
American Cancer Society	<a href="http://www.cancer.org/">http://www.cancer.org/</a>
American Legacy Foundation	<a href="http://www.americanlegacy.org/">http://www.americanlegacy.org/</a>
American Psychological Association	<a href="http://www.apa.org">http://www.apa.org</a>
Center for Tobacco Cessation	<a href="http://www.ctcinfo.org/">http://www.ctcinfo.org/</a>
National Cancer Institute	<a href="http://www.nci.nih.gov">http://www.nci.nih.gov</a>
National Center for Tobacco Free Kids	<a href="http://www.tobaccofreekids.org/">http://www.tobaccofreekids.org/</a>
National Heart, Lung, and Blood Institute	<a href="http://www.nhlbi.nih.gov/index.htm">http://www.nhlbi.nih.gov/index.htm</a>
National Institute on Drug Abuse	<a href="http://www.nida.nih.gov/NIDAHome1.html">http://www.nida.nih.gov/NIDAHome1.html</a>
Office on Smoking and Health Centers for Disease Control and Prevention	<a href="http://www.cdc.gov/tobacco/">http://www.cdc.gov/tobacco/</a>
Office on Smoking and Health Centers for Disease Control and Prevention – State highlights including lists of state tobacco control contacts	<a href="http://www.cdc.gov/tobacco/statehi/statehi.htm">http://www.cdc.gov/tobacco/statehi/statehi.htm</a>
Society for Research on Nicotine and Tobacco	<a href="http://www.srnt.org">http://www.srnt.org</a>
World Health Organization	<a href="http://www.who.int">http://www.who.int</a>

\*Adapted from Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.1