

# Realignment of the Nation's Tobacco Agenda: The Need to Treat Tobacco Dependence<sup>1</sup>

Ad Hoc Working Group on Treatment of Tobacco Dependence<sup>2,3</sup>

**Background.** Tobacco use remains the leading cause of preventable death in the United States. Although comprehensive tobacco control has a number of essential components, support for cessation services can yield the largest short-term public health benefit. While effective treatments for tobacco dependence do exist, they are not currently available to many of the tobacco users who want and need them. Finding cost-effective, science-based strategies for reducing tobacco dependence in the United States should be a national priority.

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**Methods.** Late in 1997 a group of experts in the science of tobacco control was convened by the Center for the Advancement of Health to develop recommendations regarding the use of federal funds for treating tobacco dependence. These recommendations were prepared based on the priority of the actions and the estimated cost and effort required to implement them. Following the Master Settlement Agreement in 1998, the recommendations were adapted to address the needs of state policy makers.

**Results.** Effective treatments for tobacco dependence do exist; however, our nation currently lacks the *capacity* to deliver these services to the many millions who require them. There is a compelling need for funding from a variety of sources to create this capacity.

**Conclusions.** The priority must be to develop the systems, competencies, and resources needed to deliver, and to monitor the delivery of, evidence-based treatments to tobacco users. Treatment must be delivered in an integrated manner, consistent with the needs of tobacco users. Additionally, financial barriers to treatment must be reduced, and consistent, high-quality treatment services must be ensured for *all* tobacco users who seek them. © 2001 American Health Foundation and Academic Press

**Key Words:** tobacco dependence; tobacco use cessation; research priorities; resource allocation; public policy.

## INTRODUCTION

Tobacco use is the leading preventable cause of death and disability in the United States [1]. Up to half of all long-term smokers will prematurely develop debilitating disease [2]. Although strategies to prevent young people from taking up smoking are essential, such efforts will only begin to impact death rates after 30 years of successful smoking prevention [3]. In the meantime, an estimated 3,000 young people become smokers each day, and more than 48 million adults in the United States continue to use tobacco products. The medical need for Americans to discontinue their tobacco use is

not being met: nearly 440,000 Americans will die of tobacco-related diseases this year [4].

According to the U.S. Centers for Disease Control and Prevention, smoking cessation services can provide the “quicker and probably larger short-term public health benefit than any other component of a comprehensive tobacco control program” [5]. Most adult smokers in the United States want to stop smoking [6], and proven, effective behavioral and pharmacological treatments do exist for tobacco dependence. These methods were recommended in the clinical practice guideline first released by the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) in 1996 [7], and were reaffirmed in the updated clinical practice guideline released by the Public Health Service in 2000 [8]. Evidence-based tobacco dependence treatments are more cost-effective than a number of interventions that are now routinely paid for by insurance, including mammograms and treatment for hypertension and hypercholesterolemia [9]. Indeed, treatment of tobacco dependence has been called the most cost-effective of all clinical preventive services [10].

Despite this compelling evidence for the use of tobacco use cessation services, proven treatments are not widely available or used at this time. Although some progress has been made through expanded access to the nicotine patch and gum as nonprescription medications, as well as through the availability of new prescription medications [11–13], these products are not inexpensive, and the immediate cost of cessation services to tobacco users remains high: Medicaid programs in just 23 states and the District of Columbia cover any type of tobacco treatment services, and fewer still cover pharmacotherapy [14,15]. Furthermore, when treatment for tobacco dependence is offered as a reimbursable benefit from health care providers, a wide range of barriers may be in place which limit utilization of the benefit [16].

Our state and national tobacco control policies must address the need to make effective treatments available to the widest possible group of tobacco users. Treatment of tobacco dependence not only reduces morbidity and mortality, but also is cost effective. Given the price increases tobacco companies have already put in place to cover their settlement costs, and the tobacco taxes that many states have implemented, tobacco users deserve to see some of the benefits of those revenues.

This paper lays out clear, concise guidelines for state and national policy makers, as well as health insurance decision makers, regarding the effective use of funds to make high-quality cessation services, from basic to intensive, available to all tobacco users who want and/or need them.

## METHODS

Late in 1997, a group of experts in tobacco control was convened by the Center for the Advancement of Health through a grant from SmithKline Beecham Consumer Healthcare. Members of this group represented leading researchers and administrators with expertise in addiction, tobacco-related diseases, health behavior and outcomes, health care economics, and health care policy. Many members had served on advisory panels and committees to public and private organizations concerned with tobacco control.

The group engaged in a process of systematically reviewing the available information on the individual and public health costs and outcomes of tobacco use and cessation. Evidence was collected on the range of services available to treat tobacco dependence and assist in tobacco use cessation. Current data were also collected on tobacco use and addiction, the public health costs of continued usage, the estimated cost of providing cessation services, and the availability of such services to tobacco users. The group compiled these data and examined them to assess gaps between tobacco users' desires for cessation services and access to them and the most effective ways to address those gaps.

## RESULTS AND RECOMMENDATIONS

State and federal legislation and/or executive action are needed to appropriate and allocate funds from a variety of sources (particularly tobacco settlement funds and tobacco tax revenues) to build and maintain the capacity of health care systems to deliver, as a part of routine care, effective tobacco-use treatment interventions to all who use tobacco products. Funds allocated for tobacco-use cessation should be divided among the following: *basic* treatment services, delivered within traditional health care settings; *intensive* treatment services, delivered by health professionals trained specifically in addiction treatment; *quality assurance* for the services that are delivered; and *research and policy* to develop more effective cessation services and increase the range of incentives for abstinence from tobacco use.

### A. Basic Tobacco Dependence Treatment Interventions

It is recommended that approximately 60% of funds designated for tobacco use cessation be allocated to support *basic* treatment interventions that:

- promote *evidence-based*<sup>4</sup> interventions as the standard of care for all clinicians;

<sup>4</sup> The Center for the Advancement of Health has recently published a review of the evidence for smoking cessation. Copies of these evidence tables and study abstracts may be obtained from the Center.

- implement tobacco-user identification and monitoring systems in every office and clinic and ensure that clinicians and patients have needed treatment resources (e.g., staff trained to integrate tobacco use interventions into clinical services, reminder systems, and efficacious, evidence-based patient aids and pharmacotherapies);

- provide for treatment that can be accessed outside of the standard health care system, including telephone helplines and FDA-approved nonprescription medications.

Funding should be provided to establish and maintain this basic level of treatment for all tobacco users in all health care settings, including nontraditional settings such as school and workplace-based clinics and community health centers and public systems such as the Indian Health Service, military and Veterans' Affairs, Medicare, and Medicaid. The basic recommendation, then, is that *all* health care clinicians (including physicians, nurses, dentists, hygienists, pharmacists, respiratory therapists, health counselors, etc.) take the following steps with all patients:

*Ask*—systematically identify tobacco use at every visit;

*Advise*—strongly urge all tobacco users to quit;

*Assist*—with brief (3–5 minutes) behavioral counseling, the provision of treatment materials, and the recommendation/prescription of appropriate pharmacotherapy;

*Arrange*—follow-up support/referral to more intensive treatments if needed;

*Anticipate*—assess and intervene to reduce the risk for tobacco use in children.

*Rationale.* Seventy percent of smokers see a clinician each year [17]. If clinicians provided brief interventions to all smokers, the national annual quit rate could be more than doubled [18]. The addition of brief behavioral counseling and pharmacotherapy could more than triple the annual quit rate [19,20]. Because basic interventions can have such a powerful effect at the population level, they are already promoted as the standard of care by health organizations including the National Committee for Quality Assurance, the American Medical Association, the American Academy of Family Physicians, the National Cancer Institute, and the American Cancer Society. In addition, basic services are both inexpensive and cost-effective: the Centers for Disease Control and Prevention estimates the cost of identification and brief counseling to be \$3 per smoker [21].

Investing in developing the capacity for delivering a basic level of treatment intervention, in addition to paying individual clinicians for each encounter, is important for three reasons. First, the current health care system lacks, at many levels, the capacity to treat smokers effectively. Second, funds from tobacco settlements

or taxes are not likely to be available in perpetuity, so systemic changes are needed to ensure that service delivery continues when the funds are depleted. Finally, insurers and health plans will be more likely to provide incentives to providers if they can be assured that good quality, effective interventions will be delivered by trained clinicians.

Funding should support the systems, competencies, and resources needed to incorporate this standard of care into basic medical care. For instance, funds allocated to publicly and privately funded health care systems, clinics, provider organizations, and health plans should ensure that:

- clinicians understand recommendations for, and are trained to deliver, basic treatment services;

- clinicians and patients have access to a range of treatment resources, from the Public Health Service guideline for smoking cessation, to resources provided by state and local health departments and organizations;

- every office and clinic maintains tobacco-user identification and monitoring systems to evaluate the degree to which health care systems are meeting the basic standard of care.

### *B. Intensive Tobacco Dependence Treatment Interventions*

It is recommended that an additional 20–25 percent of treatment funds be used to develop the capacity to deliver *intensive* treatment services to certain smokers and to ensure access to treatment services for underserved populations. This would include:

- referral protocols for smokers needing more intensive treatment;

- training for providers to deliver more intensive treatments;

- training and/or certification to encourage and enable the provision of targeted interventions to individuals with varying backgrounds and treatment needs;

- reimbursement for delivery of intensive treatment to low-income, uninsured, and publicly insured populations.

Building the capacity to provide intensive treatment will require training practitioners to address ways in which to meet individual patient needs. Model programs should be funded as well and should include programs tailored to serve specific cultural groups and patients with various physical and psychological health risks and conditions.

*Rationale.* While basic, low-cost interventions in medical and consumer settings are likely to reach the majority of tobacco users, yielding by far the largest

number of quitters, many tobacco users will require more intensive treatment services. Those in need of intensive treatment are often tobacco users with increased health risks, (e.g., pregnancy, alcohol and other dependency problems, psychiatric comorbidities, life- or limb-threatening tobacco-related diseases), making intensive intervention particularly cost-effective [22]. In these cases, treatment should be readily accessible through providers with demonstrated proficiency in treating tobacco dependence.

Providing intensive treatment requires knowledge of the patient's tobacco dependence and previous quit attempts, the patient's physical and psychological health status, pharmacologic treatment options, counseling and other behavioral support techniques, and criteria for determining the type and scope of treatment required. In general, intensive treatments involve a combination of components, including multiple treatment encounters, application of both behavioral and pharmacological interventions, individual or group counseling and follow-up, and treatment of coexisting physical or psychological conditions.

Funds also should be made available to reduce financial barriers to accessing treatment by reimbursing the delivery of intensive treatments through Medicare and Medicaid, the Indian Health Service, and HRSA-supported clinics and health departments, as well as for people who lack health insurance coverage. In addition, studies should be funded to determine whether health plans and third-party payers would be encouraged to establish or expand and maintain coverage for treatment services if incentive programs—such as state or federal regulations, inclusion in health plan accreditation or reporting indices, or appropriation of tobacco settlement monies—were established.

### C. Enhancing Quality of Treatment Services

It is recommended that another 10–15% of treatment funds be allocated to assure the *quality* of both basic and intensive treatment services by establishing procedures for:

- ensuring that treatment is guided by the best available effectiveness and cost-effectiveness data;
- developing curricula for training and/or certifying health professionals in the skills and knowledge needed to deliver basic and intensive treatment services;
- monitoring program impact.

The proportions of allocations recommended here apply to the current need for capacity-building; these proportions should be altered over time to respond to changing circumstances.

*Rationale.* Systems should be put into place to ensure that both basic and intensive treatments are of

the highest quality and represent state-of-the-art modalities. The current best evidence regarding efficacious treatment methods is summarized in the 2000 Public Health Service clinical practice guideline. However, it is not clear that these interventions are being widely implemented. At the same time, treatments with little or no evidence to support their efficacy (e.g., lobeline sulfate and its varieties) are being marketed [23]. Mechanisms must be developed to ensure that funds are not diverted to unproven or ineffective treatments. Also, a mechanism should be established to update and promulgate new treatment guidelines as more effective treatments become available.

Quality assurance also entails ensuring access to providers who are knowledgeable and proficient in delivering state-of-the-art treatments. Health professions educational curricula generally do not include formal programs or clinical training in the treatment of tobacco dependence, nor are there standardized criteria for continuing medical education or training. Treatment of tobacco dependence should be a standard component of the training of physicians and nurses, dentists and hygienists, pharmacists, health counselors, and allied health professionals.

There is currently no way for consumers, third-party payers, and health systems to determine whether individual practitioners possess the requisite knowledge and skills to provide high-quality treatment services. Given the need to provide quality care, it is essential that proficiency standards be established at the national level. The Secretary of Health and Human Services should be directed to develop such standards and to provide states with models for adaptation and adoption of such standards; this should include standards for training and certification or licensing of health professionals and others engaged in the delivery of treatment services.

Activities are also needed to promote the use of quality control measures for both voluntary and mandatory treatment programs. These should be integrated with existing quality control measures (e.g., HEDIS indicators) for other clinical interventions. Monitoring will allow feedback to providers, health systems administrators, purchasers, regulatory agencies, and accrediting organizations to assess the quality of treatment services being provided. Therefore, funding for programs should be contingent upon the incorporation of reasonable monitoring methods into service delivery.

### D. Related Needs

Finally, it is recommended that 5–10% of funds allocated to the treatment of tobacco dependence be used to support other research and policy efforts. Substantial portions of all funds allocated for biomedical and behavioral research should be dedicated to developing increasingly effective tobacco treatment interventions,

particularly for underserved and high-risk populations. In addition, broader tobacco prevention and control activities, such as media campaigns and policy changes, should incorporate tobacco dependence treatment strategies.

*Rationale.* Research into the processes of tobacco dependence and its treatment has greatly advanced our ability to help smokers quit [24], and research on nicotine and tobacco can significantly benefit public health [25]. However, the level of funding currently devoted to tobacco-use research is insufficient relative to the public health costs of continued tobacco use [26]. Many national and international organizations concerned with public health—including the National Cancer Institute, the World Health Organization, Health Canada, and others—have set priorities for tobacco use research, based on extensive literature reviews and consultative processes, which include improving options for and delivery of treatment services. For example, research has been sparse on the treatment needs of specific populations of tobacco users, and existing treatment methods may be ineffective or unacceptable for some tobacco users. Funds should therefore be leveraged from a variety of sources to support continued research in the following areas:

- assessing and treating tobacco-dependent youth [27], with attention to the different forms of tobacco used, (e.g., smokeless tobacco, cigarettes, cigars, and bidis<sup>5</sup>) [28];
- enhancing treatment effectiveness among other high-risk or poorly studied populations, including racial and ethnic minorities [29], the elderly, and women [30,31] (particularly during pregnancy [32]);
- increasing the understanding of tobacco dependence and treatment among users of smokeless tobacco, cigars, and pipes [33];
- evaluating new and innovative approaches including more intensive behavioral therapies, new pharmacotherapies, and combination therapies [34];
- expanding the acceptability, reach, and utilization of, as well as adherence to, treatment programs [35];
- increasing the understanding around the reasons why treatment programs and quit attempts may fail [36,37];
- improving the integration of relevant treatment services into general health care settings;
- providing incentives to practitioners to deliver effective treatments.

*It is critical that new funds for treatment research*

<sup>5</sup> *Bidis* are small, brown cigarettes made in countries in southeast Asia in which tobacco is rolled in tendu or temburni leaves instead of paper; they often come in appealing flavors, such as chocolate and mango, and they are popular among youth. Typically, bidis deliver more carbon monoxide, tar, and nicotine than other cigarettes.

*expand the research funding pool and not be diverted from or used to replace existing funds.*

In order to increase tobacco users' interest in quitting and to better support their current desires and efforts to do so, clinical interventions need to be coordinated with broader tobacco-use prevention and control activities. Activities which would be likely to increase interest in quitting among tobacco users include, as examples:

- media messages, which should not only advocate against initiation of the use of tobacco products, but also promote available behavioral and pharmacological treatments for tobacco dependence; local media messages should provide information on how to access support services such as treatment clinics and hotlines;
- policy changes, which should include clean indoor air laws and an increase in the price of cigarettes;
- worksite smoking bans, which could be accompanied by incentives such as reduced health care premiums for nonsmokers.

Finally, smokers' access to proven interventions, particularly for those smokers who do not regularly use the health care system, could be improved by increasing funding for public health interventions such as telephone hotlines, counseling services, and referral services to existing providers.

## CONCLUSION

We can make a dramatic impact on the overall rate of tobacco use and tobacco-related diseases in this country by delivering low-cost, low-intensity interventions to large numbers of smokers using existing health care channels. Attention to tobacco use should be as routine as attention to blood pressure during all medical encounters.

Many smokers will require more intensive treatment from trained providers—particularly those smokers with more severe addictions, with psychiatric comorbidities, or facing illnesses or other factors complicating their care. It is especially critical that effective interventions be available to smokers with conditions such as cardiac disease, vascular disease, or diabetes, where immediate reduction in smoking is necessary in the management of the condition.

Unfortunately, our nation currently lacks the capacity to deliver effective basic and intensive treatments to all those who need them. State and federal policy makers thus have an important obligation to allocate funds to improve the delivery of tobacco dependence treatment services, and in allocating these funds, the highest priority must be assigned to developing the systems, competencies, and resources needed to deliver and monitor integrated, evidence-based treatments to tobacco users.

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### REFERENCES

1. McGinnis JM, Foege WH. Actual cause of death in the United States. *JAMA* 1993;270 (18):2207–12.
2. Thun MJ, Day-Lally CA, Calle EE, Flanders WD, Heath CW. Excess mortality among cigarettes smokers: changes in a 20 year interval. *AJPH* 1995;85(9):1223–30.
3. Peto R, Lopez A, Boreham J, Thun M, Heath C. Jr. Health effects of tobacco use. In: Slama K, editor. *Tobacco and health*. New York: Plenum Press, 1995;109–120.
4. Centers for Disease Control and Prevention. Smoking-attributable mortality and years of potential life lost—United States, 1984 (Reprint of landmark article with update.) *MMWR* 1997;46(20):444–51.
5. Centers for Disease Control and Prevention. Best practices for comprehensive tobacco control programs. U.S. Department of Health and Human Services, 2000.
6. Centers for Disease Control and Prevention, 1997.
7. U.S. Department of Health and Human Services. Smoking cessation: clinical practice guideline. Rockville, MD: United States Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research and Centers for Disease Control and Prevention, 1996. AHCPH Publication No. 96-0692.
8. 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. AHCPH Publication No. 96-0692.
9. Cromwell J, Bartosch WJ, Fiore MC, Hasselblad V, Baker T: Cost-effectiveness of the clinical practice recommendations in the AHCPH guideline for smoking cessation. *JAMA* 278(21): 1759–66, 1997.
10. Eddy DM. David Eddy and the tests. *Harvard Health Lett.* 1992; July 10–11.
11. Fiore MC, Novotny TE, Pierce JP, et al. Methods used to quit smoking in the U.S.: do cessation programs help? *JAMA* 263(20):2760–65, 1990.
12. Centers for Disease Control and Prevention. Cigarette smoking among adults—United States, 1995. *MMWR* 46(51):1217–20, 1997.
13. Shiffman S, Gitchell J, Pinney J, et al. Public health benefit of over-the-counter nicotine medications. *Tobacco Control* 6(4): 306–10, 1997.
14. Zembrak, A. Smoking cessation [in Medicaid]. Health Policy Tracking Service, Oct 10, 1998.
15. Orleans CT, Schauffler HH, Barker DC, et al. 1997 Survey of state policy on nicotine addiction treatment. Paper presented at the 1998 Annual Meeting of the Society for Research on Nicotine and Tobacco, New Orleans, March 27–29, 1998.
16. Henningfield JE. Tobacco dependence treatment: scientific challenges; public health opportunities. *Tobacco Control* 9(1 suppl): i3–10; 2000.
17. Tomar CL, Husten CG, Manley MW. Do dentists and physicians advise tobacco users to quit? *JADA* 127:259–66, 1996.
18. U.S.D.H.H.S., 1996.
19. Ockene JK, Kristellar J, Goldberg R, Amick TI, Petow PS, Hosmer D, Quirk M, Kalan K. Increasing the efficacy of physician-delivered smoking interventions: a randomized clinical trial. *J Gen Intern Med* 6:1–8, 1991.
20. U.S.D.H.H.S., 1996.
21. Centers for Disease Control and Prevention, 2000.
22. Cromwell et. al., 1997.
23. Henningfield JE, Fant RV, Gopalan L. Non-nicotine medications for smoking cessation. *J Respir Dis* 1998;19(8 suppl): S33–S42.
24. Agency for Health Care Policy and Research. The Agency for Health Care Policy and Research Smoking Cessation Clinical Guideline. *JAMA* 275(16): 1270–80, 1996.
25. Hughes JR. Tobacco Control Research. Health Sciences Analysis Project No. 2. Washington, DC: Advocacy Institute, Apr 1998.
26. IBID.
27. Youth Tobacco Cessation Collaborative. National blueprint for action: youth and young adult tobacco-use cessation. Washington, DC: Center for the Advancement of Health, 2000.
28. Jordan M. Behind a hot smoke, hard labor: women toil to supply bidi cigarette. *The Wall Street Journal*, 1999 Aug 17.
29. U.S. Department of Health and Human Services. Tobacco use among U.S. racial/ethnic minority groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: a report of the Surgeon General. Atlanta (GA): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1998.
30. World Health Organization. Making a difference in tobacco and health: avoiding the tobacco epidemic in women and youth.” Proceedings of the WHO International Conference on Tobacco and Health. Kobe, Japan. November, 1999.
31. Tobacco Research Implementation Group. Tobacco research implementation plan: priorities for tobacco research beyond the year 2000. U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. Bethesda (MD): Nov, 1998.
32. Windsor RA, Boyd NR, Orleans, CT. A meta-evaluation of smoking cessation intervention research among pregnant women: improving the science and art. *Health Edu Res: Theory Prac* 13:3: 419–38. 1998.
33. Tobacco Research Implementation Group. 1998.
34. IBID.
35. Henningfield, 2000.
36. Fiore et. al., 2000.
37. Cohen S, et al. Debunking myths about self-quitting: evidence from 10 prospective studies of persons who attempt to quit smoking by themselves. *Am Psychol* 1989; Nov 1355–65.