

Tobacco Treatment Specialists: A New Profession

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Tobacco treatment specialists (TTS) are essential to developing an adequate system of treatment for smoking. Tobacco cessation treatment should be seen, not solely as a public health or prevention activity, but rather as a clinical activity. TTS should increase their professionalism by embracing evidence-based medicine. TTS should form professional organizations and credentialing bodies to insure a high quality professional identity.

The purposes of this article are (a) to argue for the need for tobacco treatment specialists (TTS), (b) to suggest cessation treatment be redefined as a clinical rather than public health activity, (c) to encourage TTS to increase their professionalism by embracing evidence-based medicine, (d) to encourage TTS to form provider organisations and credentialing bodies to insure their professionalism.

The Need for Tobacco Treatment Specialists

Currently, at least two types of behavioural therapies and seven medications reliably help smokers to stop smoking (Aveyard & West, 2007). What organisations should deliver these interventions varies widely across countries. For example, private insurers, public medical insurance, health departments, and for profit and non-profit organisations have been all used to deliver these interventions. Who should implement these interventions is also unclear. Most medical organisations add smoking cessation treatment to the duties of primary care providers. Other organisations such as quitlines, health departments or charities employ providers that have had brief trainings in tobacco treatment. Both types of organisations usually appear to assume that tobacco dependence requires only brief treatment and have no specialists for the treatment of tobacco use. Despite this, recently training programs have evolved and professional organisation formed to promote the profession of tobacco treatment specialists (TTS). Tobacco treatment specialists, like medical specialists (e.g., cardiologists) have more formal training and experience than other.

The need for TTS has been outlined in several treatment guidelines (2007; Fiore, Bailey, Cohen, Dorfman, Goldstein, et al., 2000; Fiore, Croyle, Curry, Cutler, Davis, et al., 2007; Hennrikus, Jeffery, & Lando, 1995; West, McNeill, & Raw, 2000). In addition, many training programs make a distinction between brief trainings that teach a primary care provider the basics covered in most tobacco treatment guidelines versus longer trainings for those who want to deliver more than brief interventions. At present, there is no consensus on the minimum amount of training, certification and experience one has to have to be a TTS.

The development of a profession of TTS is important for several reasons. First, many primary care providers are reluctant to diagnosis and start treatment of a problem if they have no specialist to refer to, if their treatment does not work (Zwar & Richmond, 2007). Second, most changes in medical practice occur by a trickle-down effect. Initially, researchers endorse a treatment notion, then specialists in that field, then primary care providers, and finally health care organisations. In the absence of TTS, this places the burden on disseminating new smoking cessation treatments to be from researchers to primary care providers. This is problematic because researchers typically are not very interested in dissemination and because clinical specialists are more credible to primary care providers than researchers.

Third, in many countries, changes in health care come about largely due to pressure from patient advocates or from medical specialists. Currently, there is no patient group advocating for better cessation treatments or better access to current treatments. And, it is unlikely,

primary care providers will take up the mission to reform the way health care address tobacco cessation. Also, specialists often have more credibility to healthcare organisations than primary care providers.

Fourth, the push to improve the quality of treatment typically comes from specialists. For example, decisions about screening for prostate cancer have been based much more on what urologists thought rather than on what the lay public or primary care providers thought. Fifth, specialists in a profession legitimise treatments to trainees of that profession. For example, psychologists are probably unlikely to engage in diagnosis and treatment of alcoholism if they have never seen a psychologist who specialises in alcoholism. However, if such a psychologist were to have several lectures, a rotation onto an alcohol treatment site, and so on, then the psychology trainee is more likely to diagnose alcoholism in their patients. In addition, questions on certification exams for professions have a great influence on what is taught in training programs and exam questions typically come from specialists.

Finally, some question whether intensive treatments are needed for smoking cessation (Chapman, 1985). If one believes that all smokers can quit if they are just sufficiently motivated, then it might be reasonable to dismiss TTS. On the other hand, if one believes that many smokers have a drug dependence (Fiore et al., 2000) or are unlikely to quit without assistance, then TTS makes sense. Perhaps the best argument for TTS are meta-analyses and large randomised controlled trials (RCTs) that show more intensive treatment improves quit rates. (Fiore et al., 2000; Hall, Humfleet, Reus, Munoz, & Cullen, 2004)

The profession of TTS currently has no 'home' within existing profession; that is, TTS come from a wide range of professions (Table 1). This is both bad news and good news. The bad news is that most TTS are doing something that is not main-stream in their profession and thus can feel professionally isolated. In addition, few professions have devoted a large effort to developing smoking cessation curriculum for their members. Finally, this also means conferences, organisations, certifications, and so on for TTS will have to be set up de novo. The good news is that this diversity of professions can mean a diversity of ideas and ways to do things and a damper on hierarchal relationships.

Smoking Cessation Treatment as a Clinical Versus Public Health Benefit

Most regulatory and reimbursement systems distinguish between clinical practices and prevention practices (Hopkins, Husten, Fielding, Rosenquist, & Westphal, 2001). The former refers to practices that relieve patients of suffering, disability or imminent death. The later refers to practices that reduce the population incidence of a disorder, death, disability or suffering. Typically, the

Table 1

Possible Professions of Smoking Interventions

Chemical dependency counsellors
Mental health/school counsellors
Dentists/dental hygienists
Health educators
Lay public facilitators
Nurses/nurse practitioners
Pharmacists
Physicians
Physician assistants
Psychologists
Respiratory therapists
Social workers

amount of data necessary to convince systems that clinical practices are worth supporting has been much less than that needed for prevention practices.

Smoking cessation treatments have been considered a public health, not a clinical, intervention for several reasons. First, recognition that tobacco use is a form of drug dependence was not fully recognised by the public and administrators till the 1980s. (Fiore et al., 2000) Second, at least in the developed countries, the rate of self-cures is high. (Giovino, 2002) For example, assume you are at a dinner with 10 people in the United States. On average, six of these will have never smoked, two currently smoke and two have quit. (Giovino, 2002) Now when smoking comes up in the conversation, the six who have never smoked probably cannot fathom why it is so difficult to stop. Among the two who have quit, the one who has done it on his/her own will quickly tell you how he/she did it and says all one needs is strong will and motivation. The other who quit but could only do so when they used a medication, says nothing because of the stigma attached to having to use a treatment to stop smoking (Bayer & Stuber, 2006). Thus the conversation concludes that treatment is unnecessary.

Third, if smoking cessation were accepted as a clinical activity, which profession should be responsible for it? One could argue this would be psychiatrists, or psychologists because they specialise in mental disorders and tobacco dependence is a mental disorder. However, psychiatrists and psychologists focus on decreasing psychological symptoms or socially disruptive behaviors. Although this can occur with non-nicotine dependencies, this does not occur with nicotine dependence. Thus, until recently, psychiatrists and psychologists have not taken much interest in smoking cessation. Another possibility is chemical dependency counselors since they have experience treating drug disorders. However, many of the concepts used in treating alcohol/illicit drugs (e.g., denial, recovery and spirituality) are not used in the treatment of smoking. Another possibility would be

professions that treat the medical consequences; for example, pulmonologists, oncologists and cardiologists; however, these professions focus not on changing behavior but on improving medical functioning. Most have little or no training on behavioral interventions.

Logically, one would think that provision of treatment would be an important part of any effort to decrease the prevalence of smoking; however, as documented by West (in press), this may not be the case. For example, about 20% of US smokers use a treatment when they try to quit. Over-the-counter nicotine replacement therapy (OTC NRT) is, far away, the most common treatment (Cokkinides, Ward, Jemel, & Thun, 2005; Fiore et al., 2000). Thus, assume that one was able to increase NRT use by 1.5-fold (which has never been achieved), so that treatment use increased from 20% to 30%, or by +10%. Then, assume OTC NRT increases quit rates by +5% (Hughes, Shiffman, Callas, & Zhang, 2002). Thus, a +10% increase in use will result in a decrease in active smokers by 0.5% (i.e., $10\% \times 5\%$). Finally, assume smokers are 20% of the US population (MMWR, 2007), then decrease in smoking prevalence would be 0.1% ($0.5\% \times 20\%$).

So, should we abandon support for smoking cessation treatment? Most clinicians would say no, because they know that, in fact, most medical interventions are done, not to decrease the prevalence of a disorder, but rather because someone is seeking help for a problem that the clinician has expertise in. In addition, though many clinicians, and even many TTS on the surface know that stopping smoking is the most important behavioral change a person can achieve to improve their health (US Department of Health and Human Services, 1990), they may not realise that, in fact, tobacco cessation interventions save more lives than almost all clinical interventions in medicine. For example, treating 100 persons for hypertension saves 1.4 lives over a 5-year period (Fahey & Schroeder, 2006). To calculate a similar statistic for the treatment of tobacco dependence, I have assumed that of 100 smokers who try to quit on their own, 10 will succeed (Hughes, Keely, & Naud, 2004). I have then conservatively assumed if 100 smokers entered optimal treatment with a TTS, 30 would quit (in fact, several studies show quit rates closer to 40–50%; Hall et al., 2004). Thus, if 100 persons were treated, an extra 20 would stop. To determine how many of these 20 avoided a death from smoking, I assumed that if they continued to smoke, 10 of them would have died (US Department of Health and Human Services, 1990). I then assumed these smokers did not stop until they were 50 (again a conservative estimate) that would then decrease their risk of a smoking-related death by 40% (Peto, Deo, Silcocks, Whitley, & Doll, 2000). Thus of these 10, treatment saved 4 deaths *or 3 times more than treating hypertension*. Although I have not done formal cost-effectiveness calculations, in our program, specialists

average about 1.5–2.0 hours/smoker. Clearly, treatment of hypertension over a lifetime would require more than 2 hours of a physician's time.

A reconceptualisation of smoking cessation treatment as a clinical, not public health, service has several implications for TTS. When medical specialists take on the care of a patient with a chronic medical disorder, their expectancy is that they will need to see the patient repeatedly and to change treatments until some level of success is achieved. Even then they may have to change it again as the disorder changes or comorbidities arise. Interestingly, very few RCTs of smoking cessation are based on this model. In contrast, most are based on a one-shot treatment experience. Unfortunately, these trials have led primary care clinicians and many health administrators to overly focus on the outcome of a given single attempt to stop smoking. In contrast, many TTS know that, even with the best of treatments, the large majority of smokers will fail (Hall et al., 2004). Thus, they know it is important to set up relationships with smokers such that they feel comfortable with returning post-relapse. In fact, the three RCTs with the highest quit rates are three studies that did more than one-shot provision of treatment (Anthonisen, Connett, Kiley, Altose, Bailey, Buist et al., 1994; Hall et al., 2004; Hughes, Hymowitz, Ockene, Simon, & Vogt, 1981). All three provided extended care including post-relapse interventions to prompt new quit attempts. Thus, specialists need to convince clinicians and administrators to not focus on a given attempt to quit but rather on whether over several attempts perhaps occurring over several months or years, a TTS can increase the probability of abstinence, the same way that a clinician or administrator would judge success of hypertension treatment in terms of preventing medical problems occurring over several years.

Specialists also need to redefine their role to include proactive as well as reactive treatment. Only a minority of those with treatable mental disorders seek treatment (The WHO World Mental Health Survey Consortium, 2004), thus oftentimes behavioral specialists set up 'case-finding' systems or procedures. This can range from healthcare organisations promoting the availability of cessation treatment in newsletters to hospitals sending to specialists the names of all smokers who were admitted that day. Some specialists have become creative in case finding; for example, setting up booths at automobile races or outside bars. Another method of case-finding is proactive contacts with smokers independent of their interest in quitting. For example, proactive brief tailored messages sent via mail or 'cold calls' to smokers increases quit rates (Carpenter, Hughes, Solomon, & Callas, 2004; Velicer, Prochaska, & Redding, 2006). Helping unmotivated smokers reduce their smoking does so as well (Hughes & Carpenter, 2006). Although there is less data, motivational interviewing techniques also appear to increase quitting (Rubak,

Sandbaek, Lauritzen, & Christensen, 2005). Thus, specialists should not restrict their role to simply helping those already motivated to remain abstinent but also to helping motivate unmotivated smokers via systems or individual interventions.

The traditional role of medical specialists is to receive patients either by referral from other professionals or via self-referral by patients. However, most medical specialists also have other roles including providing ‘side-walk’ consults either via phone or via written opinions or in person and didactic education to other professionals. As mentioned above, oftentimes primary care providers look to specialists for opinions about new diagnoses, treatments, and so on. Thus, optimally tobacco treatment specialists would also fill this role by proactively informing their local primary care providers and administrators of important advances in treatment. Finally, specialists often are called on to provide didactic or experiential training for students or for CME. Waiting to be called on to provide such training is often ineffective and thus many specialist are proactive in trying to gain access to students etc to inform them about the treatment of smoking cessation.

Professionalism

The smoking cessation field is fortunate in that most all providers place great value on empirically verified treatments. However, some providers mistakenly believe that only outcomes of meta-analyses and RCTs are relevant. Although these are the optimal data sources, professionals ranging from geologists to physicians have to use less-than-optimal science to make the large majority of their day-to-day decisions. For example, assume you see a 23-year-old young man who has been using 5 cigars/day since age 16, and it helps treat his attention deficit disorder and comes for help in stopping. There are no RCTs of 18- to 24-year-old young adults, of stopping cigar use, or of smokers with attention deficit. Should you say ‘Sorry there are no RCTs of your problem, so I cannot help you. Best of luck?’ Clearly, a TTS would not say this but would come up with a treatment plan based on something other than RCTs.

What non-RCT information is used in such cases defines the quality of any specialist. One possibly is to use ‘clinical experience’, however that is defined. However, a better alternative is ‘evidence-based medicine’ (EBM) information (Akobeng, 2007; Collins, 2007). Evidence based medicine refers to the use of four types of information in making decisions: scientific evidence — including non-RCT data, scientific logic, clinical expertise, and patient preference.

Scientific evidence varies widely in its ‘internal validity’ (i.e. whether results are true or not) with RCTs at the top. Non-RCT data varies in validity from prospective non-randomised controlled trials (e.g., we treated smokers in this clinic with A and those in the other

clinic with B), prospective case-control studies of self-selected groups (e.g., smokers who did A were followed over time and did better than those who did B), retrospective case-control studies (e.g., in a one-time survey smokers who said they did A when they quit did better than those who said they did B), uncontrolled studies (e.g., 50% of 200 smokers who did A quit smoking), and case reports (one smoker who could not stop did A and could stop). Studies also vary widely in their ‘external validity’ (i.e., even if true, would they apply to the person I am helping) depending on how they recruited smokers and what the inclusion criteria were. These types of validity considerations are used when guidelines rank recommendations (e.g. A, B or C).

Scientific logic refers to use of scientific principles or use of information in one area to inform decisions in another area. For example, in the above case, the TTS knows that smoking 5 cigars/day can produce nicotine levels similar to that in cigarettes and that daily tobacco use often leads to nicotine dependence; thus, the TTS can expect that, if this young man tried to stop smoking, he would likely have withdrawal and thus is likely to benefit from NRT. Furthermore, a general treatment principle is to promote coping skills to replace lost benefits of smoking; thus, the TTS could brainstorm with him alternate behavioral methods to sustain his attention. In fact, the TTS may suggest he talk with his physician about possibly increasing his attention-deficit medication. On the other hand, the TTS knows that stimulants sometimes promote smoking and thus may need to find out the smoker believes his own medication increases or decreases his smoking.

Clinical expertise refers to prior experiences of the TTS and generalisations the TTS has noticed. For example, in the above case, perhaps the TTS has treated prior cigar smokers and noted that when they stopped cigars they experimented with cigarettes (reasoning a cigarette was much less harmful than a larger cigar), found cigarettes were much less objectionable to others and became non-daily cigarette smokers. Thus, in this case the TTS would want to warn this young man to resist temptations to just have one or two cigarettes.

Patient preferences refer to acknowledging that patients should participate in decision-making. Thus, assume the above case has previously been in psychotherapy for a conduct disorder (which often occurs with ADD), disliked it and, thus, when the TTS mentions ‘counselling’ he rejects it. However, the TTS could then clarify what the smoker did not like about the prior counseling and clarify what will and will not happen in tobacco counseling.

Many TTS already use scientific logic, clinical expertise and patient preferences in delivering treatment. Many may also know the evidence from RCTs summarised guidelines; however, they may not be adept at quickly and efficiently accessing evidence to help

improve their practice. Ideally, the TTS would find some fellow experts to provide consults and would attend relevant conferences. However, because many TTS are isolated finding consultants may be difficult. One method would be to either join a professional organisation of TTS (see below) and use its listserve to ask for opinions.

Attending conferences in person has become expensive and thus, specialists should consider using internet-based webinars (programs based on slide shows via computer and conferencing via phone), websites, etc to obtain information and to ask important questions. There are also a few 'how to' textbooks on smoking cessation treatment (Abrams, Niaura, Brown, Emmons, Goldstein, & Monti, 2003; McEwen, Hajek, McRobbie, & West, 2006; Perkins, Conklin, & Levine, 2007). Another method is to identify the most important journals in an area and access them via the internet. Journals vary widely in whether they allow free reading over the internet and this varies across libraries. Many journals now will send an email of the table of contents of each issue when they come out. The only true continuing education journal in smoking is the *Journal of Smoking Cessation*. Scientific journals that have the most smoking-related clinical articles are *Addiction*, *Addictive Behaviors*, *Nicotine and Tobacco Research* and *Tobacco Control*. Some of these have lay summaries of articles.

Perhaps the most difficult hurdle for TTS is accessing published scientific evidence about a case in a quick and efficient method (Onady & Raslich, 2007). I suggest TTS spend a morning or afternoon with a learning how to use the relevant databases. The best databases are the Cochrane Library (www.cochrane.org), PubMed (<http://www.ncbi.nlm.nih.gov>) and PsychInfo (www.apa.org/psycinfo). Whether these are free to a TTS varies depending on their workplace or library. For the latter two, I have found that restricting searches to words appearing in title or abstract, using the 'review' limitation, and being sure to allow variations of terms (e.g., smok* to include smokers, smoking, smokeless, and so on) most important

Organising

As stated above, the lack of a clear home for tobacco treatment and the isolation of many TTS has, understandably, undermined the development of a strong professional identity in many locales. Also, the income and prestige accorded to most TTS is less than given physicians, and so on. However, income and prestige in our society seem to almost be inversely related to the amount of good one is doing for our society. For example, compare the income and prestige versus contribution to society of Brittany Spears versus nuns working in third world countries. The reason I bring this up is that, when professionals garner little prestige, then it becomes even more important that receive social validation from peers and others that their work is

important. For many specialists they will not receive this from their health care organisation nor from a discipline that does not value smoking cessation. Thus, belonging to a professional organisation of tobacco treatment specialists that can validate their work is very important to TTS (including this author).

Professional organisations of TTS can provide several benefits. They can provide learning experiences, consultations on cases, employment opportunities, credentialing, etc. Also, as stated above, oftentimes such organisations are almost a necessary condition to change treatment practices. Currently, in the United States alone, there are over 400 healthcare professional associations (www.pohly.com/assoc2.html). I am aware of three such organisations for TTS: the Association for the Treatment of Tobacco Use and Dependence (www.attud.org), the British Association for Stop Smoking Practitioners (<http://www.brit-thoracic.org.uk/> Smoking-BASSP) and the Australian Association of Smoking Cessation Professionals.

Credentialing is important to all professions but is perhaps especially for TTS because many clinicians and health care organisations do not distinguish between those who know enough about smoking cessation to provide a primary care intervention and true specialists. The major issue will be how high to make the bar to be labelled a specialist. Too high and the paucity of specialists will be a hindrance to growth. Too low and the credibility of specialist will be undermined.

Summary

Tobacco treatment specialists (TTS) are essential to developing an adequate system of treatment for smoking. Tobacco cessation treatment should be seen, not solely as a public health or prevention activity, but rather as a clinical activity. TTS should increase their professionalism by embracing evidence-based medicine. TTS should form professional organisations and credentialing bodies to insure a high quality professional identity.

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