

# Clear and Concise Interventions for Smoking Cessation

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## INTRODUCTION

### The Challenge

A pack-a-day smoker cradles a lighter and a cigarette in his hands 20 times a day, taking roughly 10 puffs from each cigarette. That's almost 6,000 puffs a month, more than 70,000 a year. A cigarette is a finely tuned drug delivery system. With each puff, a smoker can titrate his blood nicotine levels to help him become more alert or to soothe his nerves. He may enjoy the company of friends, or find a moment of solitude. The act of smoking is wedded to life's routines. Considering the physiologic complexity and repetition of this behavioral ritual, it is remarkable that brief medical intervention is effective in helping smokers extinguish the habit. But it undoubtedly is—smoking cessation intervention is the most important preventive care tool physicians can deploy for their patients who smoke.

### What Works?

The proven components of successful smoking cessation intervention in medical practice are well-defined. The recently published United States Public Health Services' *Clinical Practice Guideline for Treating Tobacco Use and Dependence*<sup>1</sup> as well as recommendations of the Agency for Health Care Policy and Research,<sup>2</sup> the American Medical Association,<sup>3</sup> the National Cancer Institute,<sup>4</sup> and the United States Preventive Services Task Force<sup>5</sup> endorse the following key components, often termed the 5 A's:

- **Ask** about and document the tobacco use status of all patients
- **Advise** all tobacco users to discontinue use at each medical encounter
- **Assess** willingness to quit
- **Assist** with a cessation plan by means such as:

Setting a quit date

Providing self-help materials

Recommending over-the-counter nicotine replacement

Prescribing cessation aids, such as bupropion or nicotine replacement

Counseling about techniques to achieve and maintain cessation

Referring for more intensive services

- **Arrange** follow-up to monitor progress and provide support

### Will I Get Results?

A physician who simply advises all the smokers in his or her practice to quit can anticipate average sustained cessation rates of 3% to 9% among "nonvolunteers"—that is, patients who do not specifically request assistance with quitting.<sup>5</sup> This rate can exceed 50% among the smokers at highest risk, such as those who have had a recent myocardial infarction or who have smoking-related morbidity.<sup>5</sup> Providing self-help materials increases the probability of cessation beyond providing advice alone, as does referral to support groups for interested patients.<sup>6</sup> Appropriate recommendation of nicotine replacement products increases sustained cessation by an additional 5% to 16% above advice and educational materials alone.<sup>5,7</sup> Bupropion, approved in 1997 as a cessation aid to reduce cravings, gains an additional 10% to 15%.<sup>8,9</sup> This pattern—that more resources are more effective—has been documented in meta-analyses of clinical trials.<sup>10</sup> In general, the number of resources used in intervention is directly related to cessation rates.<sup>2</sup> Comprehensive intervention, including use of pharmacologic support, has been shown to be cost-effective in preventing future smoking-related health care costs and in reducing years of life lost.<sup>11,12</sup>

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### **But Who Has Time?**

The 5 A's are deceptively simple; practitioners quickly recognize the major pitfall—time. The keys to accomplishing intervention are to integrate the processes into existing routines and to have the appropriate materials on hand. The first A, screening for tobacco use, needs to occur automatically, as part of intake questionnaires or admission documentation. Charts should be flagged, and a flow sheet for tracking the progress of counseling should be incorporated into the record to facilitate the remaining A's. Self-help materials should be on hand; it is helpful to have 1-page instruction sheets describing the use (and restrictions) of prescription and over-the-counter pharmacologic supports. Having these tools—a method for identifying smokers, prompts in the chart, and self-help materials—available triples the likelihood that a provider who is trained to counsel about cessation will get all 5 A's accomplished. It frees the physician to concentrate on actually advising the patient to quit and helping the patient to make a plan.

### **Getting to the Point**

Physicians often report that in advising cessation, they open the door to a maze of patient concerns and rationalizations that lead to counseling dead ends and consume time without apparent results. At University of North Carolina Hospitals, we have found that a scripted approach to intervention, originally designed to standardize the content of counseling for research, is a valuable tool for negotiating the intervention maze. Scripts provide a general map for brief and effective counseling that gets to the point (**Table 1**). These scripts are not intended as a literal transcript but rather as a guide to be learned and adapted to the practitioner's personal style as he or she develops confidence and skill.

Models for smoking cessation intervention are often based on assessing readiness to change smoking behavior and tailoring the discussion to stage of change. However, we have observed 3 difficulties in using these models in brief interventions: (1) it is difficult to quickly and reproducibly assign stage of change; (2) counseling designed to move patients from their initial stage to one more favorable to cessation can be viewed by patients as an opportunity to aim for a destination short of cessation; and (3) such an approach undermines the consistency of the message—the point is to quit.

Nationwide, 90% of smokers report that they would like to quit, and more than 60% have made serious attempts to quit.<sup>13,14</sup> Two out of 3 adult smokers fear personal health consequences; knowledge and attitude

studies consistently reveal that tobacco users are aware of the major health risks. Thus, the majority of smokers do not need to be convinced that smoking is dangerous; rather, they need a focus on negotiating specific behavioral changes. A philosophy of consistently aiming for cessation informs the approach described herein.

### **THE SCRIPT**

#### **Clearly Advise Cessation**

More than half of smokers report that they have not been advised by their physician to quit, yet most physicians report they discuss smoking with their patients.<sup>15,16</sup> If we are advising our patients to quit, they are not hearing the message. Brief asides, such as “you know it's time for you to give up cigarettes” or “are you ready to quit yet?” are not received as invitations to action. It is crucial to unequivocally advise cessation—patients perceive their physician as uniquely qualified to deliver this message. Using information from an intake questionnaire or familiarity with the patient, tailor your opening: “Mrs. Ashton, you've smoked a pack a day for more than 30 years now. That's too long; my best advice is that you need to quit.” In a breath you have summarized her personal risk, delivered a health message, and given advice in response to her circumstances. Remember, physician advice alone can double the spontaneous quit rate.

#### **Recognize the Challenge of Quitting**

Most smokers doubt that you have any insight into what you are asking them to do. They are confident that you do not understand the complexity of their relationship to cigarettes, and that you are unable to imagine the mood changes, poor concentration, disturbed sleep, and anxiety that result from the absence of cigarettes. Acknowledgment of the magnitude of the task you are proposing needs to happen early in the discussion. A promise of benefit should quickly follow.

This is a good opportunity to escape the script if time allows; however, this is not a requirement for successful intervention. Look for and use examples of things your patient considers to be motivations to quit. Intake questionnaires can be profitably expanded to include a checklist of potentially motivating factors—eg, saving money, worrying less about their health, feeling more in control, or pleasing family or friends. Including individual responses allows another opportunity for you to personalize the exchange: “I know I'm asking you to do something that requires a lot of effort, but I'm confident that your health will benefit if you quit. I also see that you'd like to quit because your granddaughter has asthma; that's a great reason.”

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### **Provide Self-Help Materials and Negotiate a Plan**

Smoking cessation materials are plentiful and are available through professional societies, public health agencies, foundations, and government clearinghouses. If your clinic or hospital does not have cessation support resources for patients, make this a priority—they are proven to contribute to the likelihood that a patient will quit and stay quit. Guidebooks with practical suggestions to help patients prepare to quit and maintain cessation are the most helpful. A good place to start is the National Cancer Institute (NCI) manual *How to Help Your Patients Stop Smoking*.<sup>17</sup> This publication discusses the 5 A's and lists free publications for patients. The manual is available from the NCI Cancer Information Service at (800) 4-CANCER. If you are involved in selecting materials for your institution or practice, consider using a focus group of patients to gather input on which materials they find most appropriate, useful, and attractive. This is particularly valuable if you serve adolescents, pregnant women, or minority ethnic groups, because print materials tailored toward these populations are available.

To incorporate self-help materials into your counseling efforts, make sure the item literally gets into your patient's hands. As you talk, extend the booklet to the patient as you describe it and request that she review it, so that she takes it from you. This technique increases the probability that the patient will accept and actually look over the materials. You'll find fewer left behind on your desk or in examination rooms.

### **Set a Quit Date**

The script takes a direct path to setting a quit date. It moves uninterrupted from obtaining an agreement to quit, to looking at self-help materials, to describing how to quit: "You need to choose a specific date so that you can be prepared. Would it be easier to quit on a weekday or a weekend?" Patients who intend to continue smoking will most likely say so at this time. Their stage of change has been explicitly tested. Those who would like to quit or who are undecided can then be guided one step further, to agreeing on a quit date.

During training sessions to teach this approach, physicians often raise the concern that this approach is too aggressive and may antagonize patients. I encourage you to try it before reaching this conclusion. The exchange is not awkward and has been successfully used in a randomized trial and a statewide demonstration project by hundreds of doctors with thousands of patients.<sup>18,19</sup> In confidential exit interviews, patients who set a quit date as well as those who did not reported that they appreciated their physician's concern and

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**Table 1.** Brief Intervention Script for Adult Smokers

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#### **Clearly advise cessation**

"You've smoked \_\_\_\_\_ pack(s) a day for \_\_\_\_\_ years."

"That's too long."

"That's not good for someone with \_\_\_\_\_ (specific condition)."

"My advice is that you stop smoking."

#### **Recognize the challenge of quitting**

"I know I'm asking you to do something that takes a lot of effort."

"But I'm confident that your health will benefit."

"I see you also have reasons you'd like to quit."

(List examples.)

#### **Provide self-help materials**

"This is a workbook designed to help smokers stop after 7 days of getting ready."

"Will you look it over?"

#### **Set a quit date or negotiate other action**

"I'd like to tell you a good way to quit."

"You need to choose a specific date so you can be prepared."

"Would it be easier to quit on a weekday or weekend?"

"The workbook is designed to help you quit in 7 days; that would be \_\_\_\_\_ (day, date)."

"Is that okay?"

"Many people benefit from medications to prevent withdrawal symptoms when they're quitting. Have you ever thought about using medications like bupropion or nicotine patches to quit?"

#### **Congratulate and encourage the patient**

"Deciding to quit is half the battle. I know you can do it."

"Congratulations, you're doing a great thing."

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did not feel pressured. Participants in the intervention group also rated their physicians as better physicians than did those in the usual-care control group.

When a patient sets a quit date, it should be documented as a "prescription to quit." Write the quit date on a standard prescription slip, and also write a reinforcing message on the slip (eg, "I know you can do it!"). It is important to formalize the transaction. A personal letter congratulating the patient on setting a quit date, offering encouragement, and explaining the short duration of withdrawal symptoms, is also valuable. Sample prescriptions and letters are included in the NCI manual.<sup>17</sup>

### **Pharmacologic Aids for Improving Success**

Sustained-release bupropion and nicotine replacement systems, individually or combined, improve the probability of maintaining cessation. Bupropion can be used by current smokers who fear the anxiety, cravings, loss of concentration, and other symptoms associated with cessation. The drug is contraindicated for patients with a history of seizures or conditions that may predispose to seizures, and for patients with hepatic or renal impairment. Bupropion should be initiated before the intended quit date; unlike nicotine replacement therapy, use of bupropion is not associated with increased danger to the patient if he or she relapses while taking the drug.

Two important trials of bupropion have been published. The first trial evaluated dosing; both 150 mg/day and 300 mg/day dosing regimens were more effective than placebo. The absolute benefit from the higher dose was 11% higher cessation rates at 12 months, for a total of 23% of subjects receiving 300 mg/day still quit at one year.<sup>9</sup> The second trial compared bupropion to placebo, with and without nicotine patches. Outcomes were evaluated at 12 months and were significantly better for those receiving bupropion (30% cessation) and bupropion with nicotine replacement (35%) than placebo (16%); however, it is not definitive that nicotine replacement added to the benefit of bupropion.<sup>8</sup> These subjects smoked at least 15 cigarettes daily at enrollment; however, nicotine replacement alone (16% cessation) did not achieve results comparable to bupropion alone. A slow-release formulation of bupropion is initiated at 150 mg/day for 3 days and then increased to twice daily (for a total of 300 mg/day). The minimal effective duration of treatment is unknown, but a 7- to 12-week course is considered appropriate.

Nicotine replacement is an important cessation aid for nicotine-dependent smokers.<sup>7</sup> Heavy smokers who fear withdrawal symptoms and those who strongly believe they need to wean themselves from nicotine over time are the most likely to benefit from this intervention. The modified Fagerstrom Nicotine Tolerance Test can be used to identify high nicotine dependence (**Table 2**).<sup>20</sup>

Judicious use of nicotine replacement is warranted. It perpetuates exposure to the addicting component of tobacco and requires smoking cessation before it can be used. Use of nicotine patches or nasal spray while smoking is associated with an increased risk of cardiac ischemic events; therefore, nicotine replacement should be restricted to patients without contraindications and who clearly intend to quit. Unless available on the patient's prescription plan, patches are quite expensive. A 4-week supply of nicotine patches costs about \$100. Most patients are motivated to use a short course.

Average duration of use is 10 weeks: a 21 mg/day patch for 4 weeks, a 14 mg/day patch for 4 weeks, and a 7 mg/day patch for the last 2 weeks. For very heavy smokers, 21 mg/day is recommended for the first 6 weeks, followed by 2 weeks at each of the lower doses. Light smokers (ie, < 10 cigarettes per day) do not need nicotine replacement, although bupropion may be helpful.

### **Alternatives—Steps on the Way to Cessation**

Alternative plans should be made only if a patient declares himself unable or unwilling to quit. Just as you would not advise a Greenfield filter in a patient who was eligible for and had not yet received anticoagulation, the focus on cessation assures that you have advised the action most consistent with good medical practice. In brief intervention, partial successes are useful only if they act as steps on the way to cessation. For example, the patient may begin steps toward cessation by logging smoking habits, by giving up specific cigarettes each day, or by completing worksheets that help reflect on reasons for smoking and potential motivations to quit.

At any point that a patient clearly communicates that he or she does not want to quit, the discussion can be concluded easily: "That's fine, would you at least consider telling someone close to you that I've advised you to quit?" With others, attempt to negotiate a specific action: "That's fine, but before your next visit will you keep a smoking diary so that we can review it?" If time and tensions allow, these interactions may provide an opportunity to explore the patient's thoughts about quitting. Requesting a specific action, even if just informing a loved one of your advice, leaves the door open to follow-up.

### **Follow-Up Keeps Things on Track**

Patients who set quit dates, especially those who plan to use pharmacologic support, should be scheduled for follow-up to track their progress. For otherwise healthy patients, a follow-up appointment 1 month after the quit date is appropriate. Those who are asked to take alternative actions, even if it is just to inform a loved one of your advice, should also be scheduled to return. If an office visit is impractical, telephone follow-up from you or your staff is worthwhile. In our clinic we use a breath carbon monoxide measurement—obtained instantly using a small handheld device (Vitalograph USA, Lenexa, KS)—as a reinforcement tool. The breath levels clearly convey to patients the reality of their exposure to toxic substances. Those who have quit smoking or reduced their smoking become very interested in knowing what their breath carbon monoxide "number" is at visits. Checking these levels can be used as part of

**Table 2.** Fagerstrom Nicotine Tolerance Test

Question	Answer (Points assigned to response)		
	1. How soon after you wake up do you smoke your first cigarette?	Within 30 min (1)	After 30 min (0)
2. Do you find it hard to refrain from smoking in places where it is forbidden (eg, church, the library, airplanes)?	Yes (1)	No (0)	
3. Which cigarette would you hate most to give up?	The first one in the morning (1)	Any other (0)	
4. How many cigarettes a day do you smoke?	15 or less (0)	16–25 (1)	26 or more (2)
5. Do you smoke more frequently during the first hours after awakening than the rest of the day?	Yes (1)	No (0)	
6. Do you smoke if you are so ill that you are in bed most of the day?	Yes (1)	No (0)	
7. What is the tar content of your brand?	Low (0)	Medium (1)	High (2)
8. Do you inhale?	Never (0)	Sometimes (1)	Always (2)

Total point score of 1 to 6 indicates low to moderate nicotine dependence; score of 7 to 11 indicates high dependence.

Adapted with permission from Heatherton TF, Kazlowksi LT, Frecker RC, Fagerstrom KO: The Fagerstrom Test for Nicotine Dependence: a revision of the Fagerstrom Tolerance Questionnaire. *Br J Addict* 1991;86:1125.

routine intake vitals to help identify smokers or as a teaching tool, depending on the setting.

Keep track of the progress of each intervention contact in a consistent place in the patient's record. Tracking progress facilitates resuming counseling at subsequent visits, even if smoking-specific follow-up appointments are not kept. Tracking progress also improves continuity of care if more than one physician is involved in the patient's care.

For follow-up counseling, remember that the average number of quit attempts for an individual smoker is 3.5 before long-term success. Each genuine quit attempt is valuable for the patient's understanding of vulnerabilities to relapse. If reassured, smokers can use this information to make a better plan for dealing with withdrawal symptoms, stresses, and temptations in subsequent quit attempts.

## BRIEF INTERVENTIONS FOR ADOLESCENTS

### Making the Point in a Different Way

Until proven otherwise, adolescents are an exception to this counseling approach. There are no ran-

domized trials of brief intervention for general clinical use among young patients. Developmental wisdom suggests that less directive and more insight-oriented approaches are warranted. Nonetheless, a script is a useful framework for counseling and should prioritize cessation. A sample script is provided in **Table 3**. This script is based on principles of motivational interviewing using the FRAMES (Feedback, Responsibility, Advice, Menu of options, Empathy, Self-efficacy)<sup>21</sup> structure for behavioral counseling.

The key elements of the adolescent script are similar to the adult intervention script, but lend themselves to further discussion. For example, when negotiating a trial of cessation: "Do you think that you can go without cigarettes as an experiment for a week?" This kind of question may create an opportunity to explore other related issues: "I know turning down cigarettes from your friends will be hard—how are you going to handle that?" You may also have an opportunity to endorse personal perceptions and offer reassurance: "I agree, I think you'll feel more in control, and I'm sure you can do it." Follow-up should also be incorporated when

**Table 3.** Brief Intervention Script for Adolescent Smokers Using the FRAMES Model

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**Feedback**

“I see you smoke cigarettes \_\_\_\_\_.” (frequency)

“I’m worried about that.”

**Responsibility**

“Ultimately, it’s your choice.”

**Advice**

“My best advice is that you need to quit completely.”

**Menu of options**

“What do you see as your options?”

“Let’s agree on some things you can do before we talk about this again.”

- Set a quit date
- Make a temporary cessation contract
- Promise not to increase
- Turn down a cigarette
- Interview an adult smoker whom you trust for advice
- Tell someone important to you that we talked

**Empathy**

“I understand it’s difficult.”

**Self-efficacy**

“...but I’m sure you can do it; I’d like to hear how it goes.”

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FRAMES = feedback, responsibility, advice, menu of options, empathy, self-efficacy.

intervening with adolescents while simultaneously protecting the adolescent’s privacy: “Why don’t we make a phone appointment for you to call me in a few weeks and let me know how it turned out?” Strong relationships with patients count; it is equally important with adolescents as it is with adults to be clear and to return to the issue of smoking at each visit in order not to undercut your advice. The American Academy of Pediatrics *Adolescent Health Update* from July 1997<sup>22</sup> provides a complete and practical review of approaches to integrating tobacco prevention and cessation tools into adolescent health care opportunities.

**CONCLUSION**

**Brief Intervention Works**

Intervention is mandated for all smokers in all medical care settings and has become a measure of quality of care. Health care systems, hospitals, and residency training programs should be highly motivated to help

their physicians provide effective intervention. The tools required for intervention are simple, inexpensive, and easily adapted to the full range of clinical settings. The best news is that the evidence is clear: brief but comprehensive interventions will achieve results. The scripts reviewed in this article have been used in challenging clinical circumstances with no additional staff. For adults, the average time to complete intervention is 3 to 4 minutes for the initial contact, and 2 minutes at subsequent visits. The basic framework for motivational counseling can be accomplished with adolescents in roughly 5 minutes. Coupled with appropriate pharmacologic support, you will increase cessation rates among the patients you reach by 3- to 5-fold over expected spontaneous quit rates. The time commitment is small, and yet the return will be measured in thousands of years of life saved for each physician who invests in conducting cessation intervention with all of his or her patients who smoke.

Advising others about their behavior is not a natural skill in our culture. A scripted approach keeps the patient and provider from getting lost in the smoking maze and assures that the discussion will get to the point—advising cessation. With experience, the route becomes clear and you can put the script away, knowing that your message will be clear and consistent. **HP**

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