Chapter 7

PROMOTING SMOKING CESSATION

CHAPTER 7: PROMOTING SMOKING CESSATION

Introduction

As Chapter 6 explained, smoking cessation is as important to the overall goal of eliminating tobacco-related disease as is the prevention of smoking uptake. Accordingly, it is a priority of the California Tobacco Control Program (TCP) to promote or encourage smokers to attempt to quit smoking, and to eventually achieve successful cessation.

Two strategies are central to this cessation promotion effort. The first strategy involves creating circumstances that increase smokers' motivation to quit. The second involves providing assistance to support those who try to quit. As for all analyses of quitting in this report, only smokers who have smoked at least 100 cigarettes are considered.

Section 1 of this chapter will discuss two of the primary motivators of quitting behavior among smokers: environmental restrictions on smoking among adults and parental norms among adolescent smokers. Section 2 of this chapter will examine a third motivator: physician's advice to quit smoking.

Section 3 of this chapter will describe and evaluate programs aimed at assisting smokers to successfully quit. It will examine the use of nicotine replacement treatment, as well as counseling and self-help programs.

Section 4 of this chapter will examine the California Smokers' Helpline, which is funded by the TCP, and designed to provide both motivation and assistance to smokers to quit smoking.

Section 5 summarizes the results presented in this chapter.

1. The Effect of Home and Work Smoking Bans on Quitting Behavior

By design, smoking restrictions in the home or workplace complicate the act of lighting up a cigarette, often requiring the smoker to defer their smoking urge or interrupt family or work activities to smoke. It therefore stands to reason that such bans not only protect nonsmokers from secondhand smoke, but also may create an environment conducive to quitting smoking simply by making smoking inconvenient for the smoker. This section explores the association between smoking restrictions and quitting behavior.

<u>Workplace Smoking Restrictions and Quitting Behavior</u>

As explained in Chapter 4 of this report, California Assembly Bill 13 (AB-13) took effect in 1995, making all indoor workplaces in the state smokefree.[1] Figure 7.1 presents the percent of current smokers with important quitting behavior indicators, comparing smokers who work in smokefree workplaces to those without workplace bans, many of whom do not work outside their home or work outdoors.

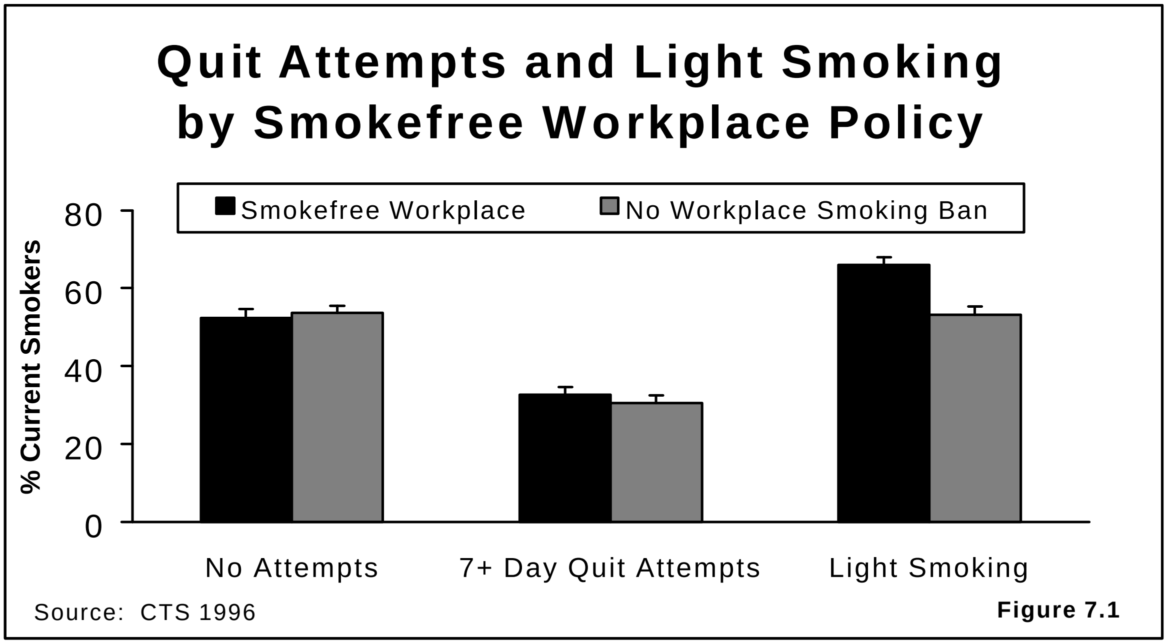


Figure 7.1

Figure 7.1 shows that despite the fact that workplace smoking bans make smoking during work hours much less convenient for smokers, working in a smokefree environment is not associated with greater rates of quitting behavior. Approximately 52% of smokers who worked in smokefree workplaces reported making no quit attempt in the year prior to the 1996 CTS. In comparison, 54% of Californians who reported that they were not subject to any workplace smoking restrictions reported making no quit attempts in the previous year. About one third of smokers in smokefree workplaces reported making quit attempts of 7 or more days. Only slightly fewer (31%) smokers without such restrictions made 7+ day quit attempts.

Smokers who work in a smokefree workplace are significantly more likely to be light smokers.

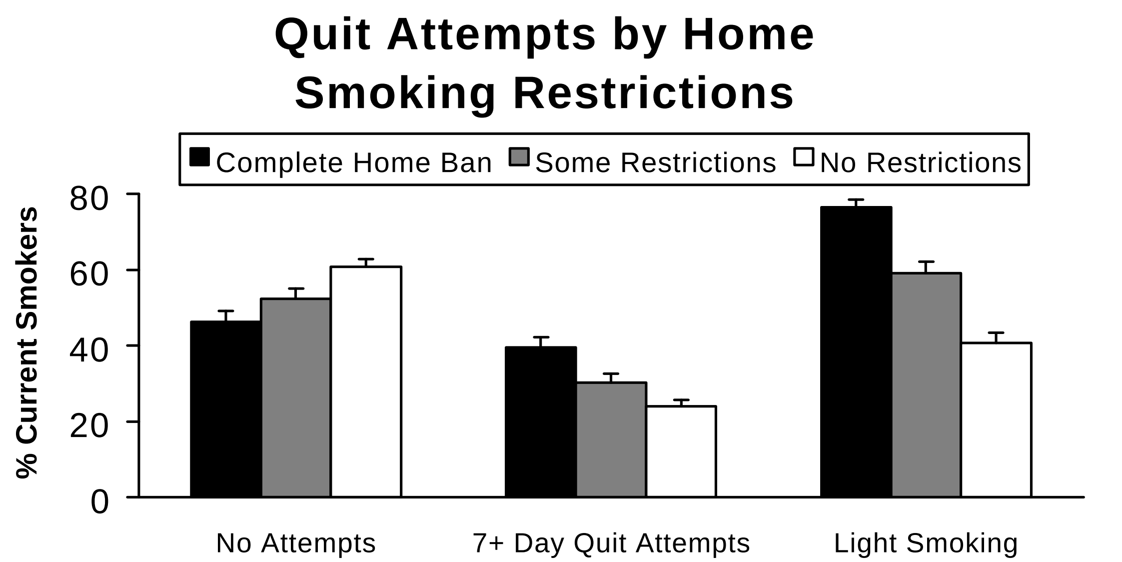
Although workplace smoking policies appear to have minimal impact on the percent of smokers who make quit attempts, complete smoking bans significantly increase the probability that a smoker will be a light smoker (<15 cigarettes per day) or occasional smoker. Figure 7.1 shows that two-thirds of smokers who work in a smokefree workplace are

[1] With the exception of bars, taverns, and game rooms (i.e., casinos), which became smokefree on January 1, 1998.

light or occasional smokers, compared to 53% of smokers who are not subject to workplace smoking bans.

Home Smoking Restrictions and Quitting Behavior

In addition to making smoking inconvenient for the smoker, home smoking restrictions may provide added impetus for smokers to engage in quitting behavior. Because they are voluntary, home smoking restrictions reflect self-imposed or family pressure to curtail or quit smoking, rather than simply compliance to state law. Figure 7.2 shows a significant dose effect for home bans; having no home smoking restrictions is associated with the least quitting activity among current smokers.



Source: CTS 1996

Figure 7.2

Among smokers with no home restrictions, 61% made no quit attempt in the 12 months prior to the California Tobacco Survey (CTS). In comparison, 52% of smokers with partial home ban made no quit attempts, and 46% of those with complete bans made no quit attempts; each of these differences was statistically significant.

Smokers with complete home bans on smoking are significantly more likely to attempt to quit smoking than those without home bans.

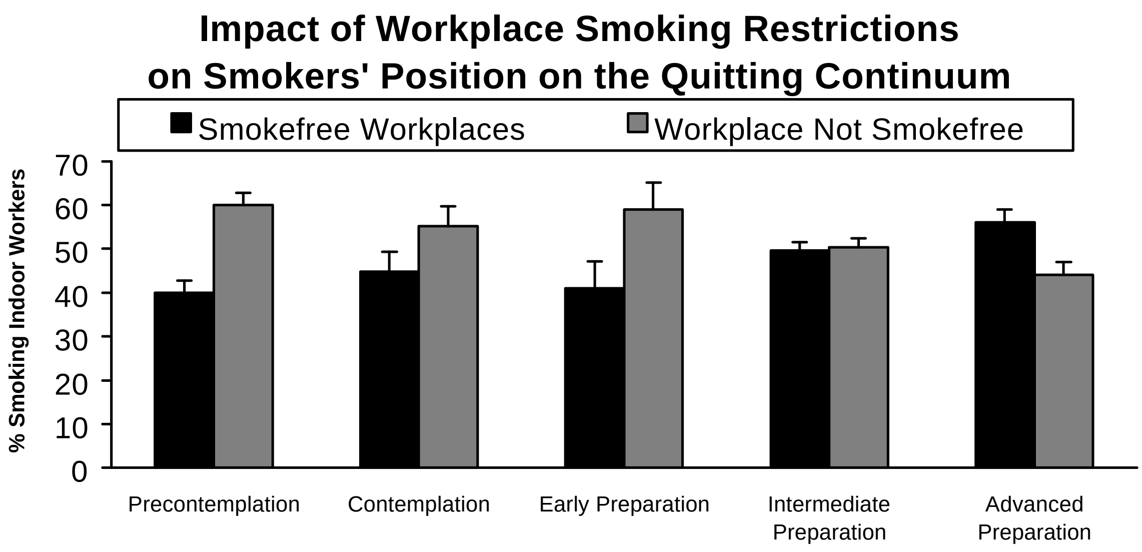
In addition, significantly more smokers with home restrictions made quit attempts of at least 7 days during the 12 months prior to the CTS. Among smokers with no home restrictions, only 24% reported making 7+ day quit attempts in the previous year. In comparison, 30% of those with partial home bans and 40% of those with smokefree homes made 7+ day quit attempts in the previous year. Again, each of these differences was statistically significant.

As with the work bans, the most obvious effect of a home ban on smoking was in the percent of smokers who could be classified as light or occasional smokers. Among smokers with no home smoking restrictions, 41% were light or occasional smokers.

Significantly more smokers (60%) with some smoking restrictions in the home were light or occasional smokers. And 77% of smokers with complete home bans were light or occasional smokers, a significantly greater percentage than those with partial restrictions.

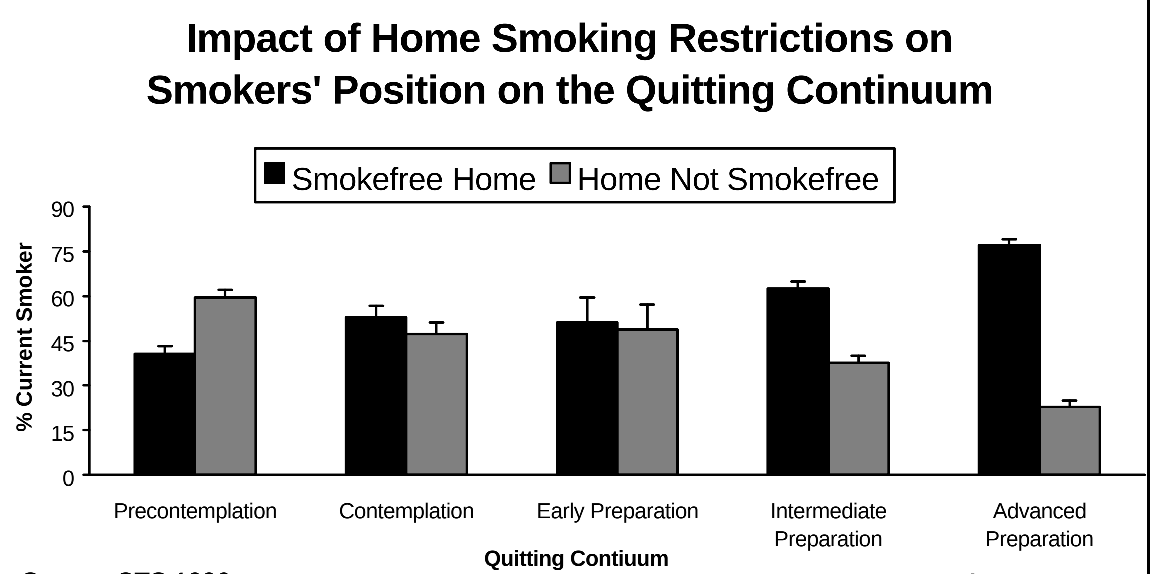
<u>Workplace and Home Smoking Restrictions and the Quitting Continuum</u>

As might be expected from the associations with key indicators of quitting behavior described above, Figure 7.3 shows a modest relationship between having a smokefree workplace and position on the Quitting Continuum. Figure 7.4 shows that the stronger effect comes from having a smokefree home.



Source: CTS 1996

Figure 7.3



Source: CTS 1996

Figure 7.4

These findings suggest that home bans on smoking are associated with greater progress toward quitting smoking than are workplace bans. These findings, however, do not suggest that workplace bans are not effective in encouraging quitting behavior. In fact, earlier research showed that workplace smoking policies were significantly associated with lower smoking prevalence (Pierce et al., 1994). Rather, these results suggest that of the two environmental stimuli that encourage quitting behavior among adult current smokers, home bans are more powerful.

Environmental Influences on Adolescent Quitting Behavior

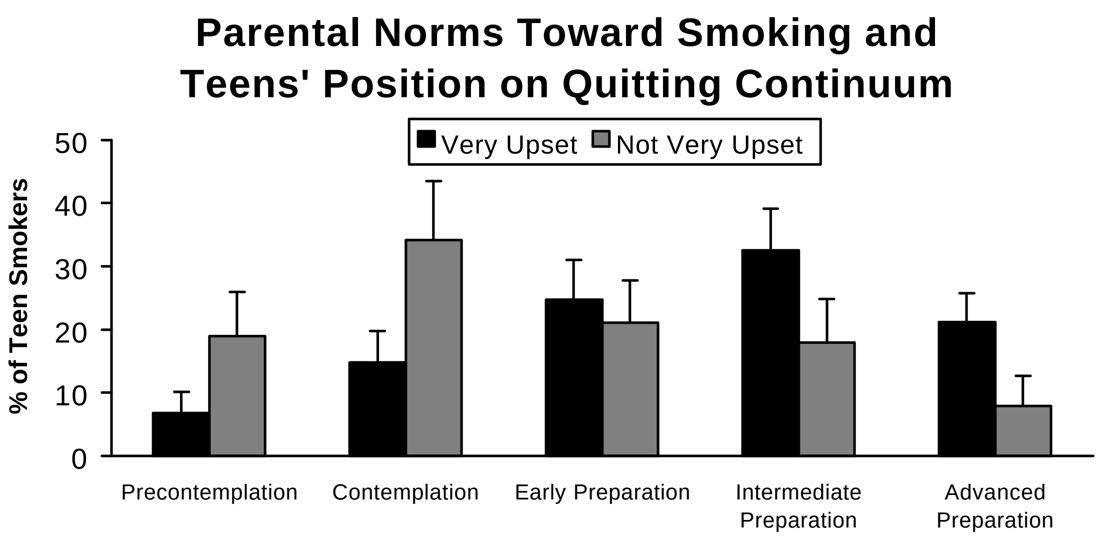
Because nearly all smoking uptake occurs among adolescents, most tobacco control efforts focus on preventing teens from starting to smoke. However, it is also critical not to write off teens who have already become smokers, but to promote quitting among these teens. One important reason to focus on motivating and assisting adolescents to successfully quit smoking is that typically teens' addiction levels are still relatively low; as a result, their habits and biological withdrawal symptoms may be less powerful barriers to success. Another reason to promote quitting among teen smokers is that, as described in Chapter 6, many already have strong quitting histories and a desire to quit. Therefore, promoting quitting could be particularly effective in this receptive population.

One of the most important environmental influences on teens is the values, or norms, about smoking that their parents express. Adolescents who are exposed to strong parental norms against smoking are significantly more likely to engage in quitting behavior than those who do not experience these norms. The 1996 Robert Wood Johnson (RWJ) Longitudinal Survey of Adolescents in California asked teens the following question to ascertain the extent of parental norms against smoking:

If you lit up a cigarette tomorrow in front of your parents, how do you think they would react?	• *Tell you to stop, and would be very upset.* • *Tell you to stop, but not be very upset.* • *Not tell you to stop, but would disapprove.* • *Have no reaction.*

Figure 7.5 shows that teens who say their parents would tell them to stop and be very upset were significantly more likely to be at advanced levels of the Quitting Continuum than teens whose parents would have more tempered reactions. Nineteen percent of teens whose parents would not be very upset were *precontemplators*, compared to 7% of teens who said their parents would be very upset if they lit up. Similarly, significantly more teens (34%) who said their parents would not be very upset were *contemplators*, compared to the 15% whose parents would be very upset who were *contemplators*. There was no significant difference between the percent of each group who were at the level of *early preparation*. Significantly more teens who reported that their parents would be very upset if they lit up could be classified at the levels of *intermediate* (32.5%)

and *advanced preparation* (21.2%), compared to those whose parents would not be very upset: 17.9% and 7.9%, respectively.



Source: CTS 1996 **Figure 7.5**

Unlike adult smokers, the imposition of a home ban on smoking does not significantly influence quitting behavior among teens. It is likely, however, that parental norms and home smoking bans are highly associated, so that the combination of these two factors is not much different than the strength of parental norms measured by itself.

2. Physician Advice and Referral

Physician advice has considerable potential both to encourage a quit attempt and to influence the use of assistance in that quit attempt (Fiori et al., 1996). Approximately 70% of smokers visit their physician in any given year (Gritz, 1988) and a survey of physicians suggests that they are interested in assisting patients to quit (Wechsler et al., 1983).

<u>Advice to Quit Smoking</u>

One-half of smokers who visited a physician in the past year reported doctor's advice to quit in 1996.

Among smokers in California, rates of visitation to a physician remained constant at approximately 70% between 1990 and 1996. In both 1992 and 1996, half of all smokers who reported visiting a doctor in the past year recalled receiving advice from their physician to quit smoking. This advice rate was significantly higher for smokers who rated their health as fair or poor (62%) compared to those who felt that they were in good or excellent health (48%).

Recall of advice to quit increased significantly with age. Less than 40% of smokers under the age of 25 years who visited a doctor in the past year recalled receiving such advice compared to approximately 60% of all smokers over the age of 45 years.

Less than one-third of those who were advised to quit smoking actually made a quit attempt.

Only 30% of smokers who were advised by their doctor to quit smoking said that they tried to quit as a result of their doctor's advice. This low percentage may be explained by the fact that, for the majority of smokers, their doctor's advice was limited to the suggestion that they quit smoking. In 1996, of the 50% who recalled receiving advice to quit, 30% reported that doctors gave them information on a smoking cessation program while only 18% reported that their doctor suggested that they set a specific quit date.

Information about Environmental Tobacco Smoke (ETS)

In the 1996 CTS, all smokers were asked whether their doctor had discussed with them the hazards of secondhand smoke to the nonsmoker. Under 30% of all smokers who visited a physician recalled having such a discussion. However, recall rates were considerably higher among minorities, smokers with less education, and women. Of those who discussed the health hazards of secondhand smoke with their doctor, 83% also reported receiving advice to quit.

3. The Use of Assistance to Quit Smoking in California

The small proportion of quit attempts that result in long-term cessation has prompted the development of a number of different treatment strategies to assist people to quit. These include a number of types of behavioral programs, many of which have been shown to significantly increase the cessation rate (Lichtenstein & Glasgow, 1992; Schwartz, 1987). In recent years, nicotine replacement treatment has become popular. This treatment, when used in conjunction with behavioral programs, can significantly increase the long-term success rate (Fiore et al., 1996).

Who Uses Assistance and What Type Do They Use?

In the 1992, 1993, and 1996 CTS, all smokers who had made a quit attempt in the past year were asked the following question concerning their most recent quit attempt:

- *Did you use counseling advice or self-help materials to adjust to life without cigarettes?*
- *For those indicating they had, further questions probed use of group counseling, one-on-one counseling, self-help materials, and use of the nicotine patch or nicotine gum.*

Approximately one in five Californians who tried to quit smoking in the last year use some type of assistance program.

In 1992, approximately 20% of Californians who tried to quit smoking in the last year reported using any form of assistance and this level was maintained through 1996. In each year, women were significantly more likely to use some form of assistance to quit than were men; in 1996, 22.8% of women used assistance compared to 17.8% of men. Also, older smokers and Non-Hispanic White smokers were more likely to seek assistance in quitting. (See Appendix B, Table 12, for detailed demographic analyses).

Of those who reported using assistance in their last quit attempt in 1996, 14% reported using some form of counseling without nicotine replacement; 22% reported using a self-help program alone; 28% reported using nicotine replacement alone; and 36% reported using both nicotine replacement with a counseling or self-help program.

Use of assistance varied considerably by the level of reported cigarette consumption. Overall, heavy smokers were more likely to seek help than light smokers. Figure 7.6 shows the distribution of type of assistance in the most recent quit attempt, according to cigarette consumption level.

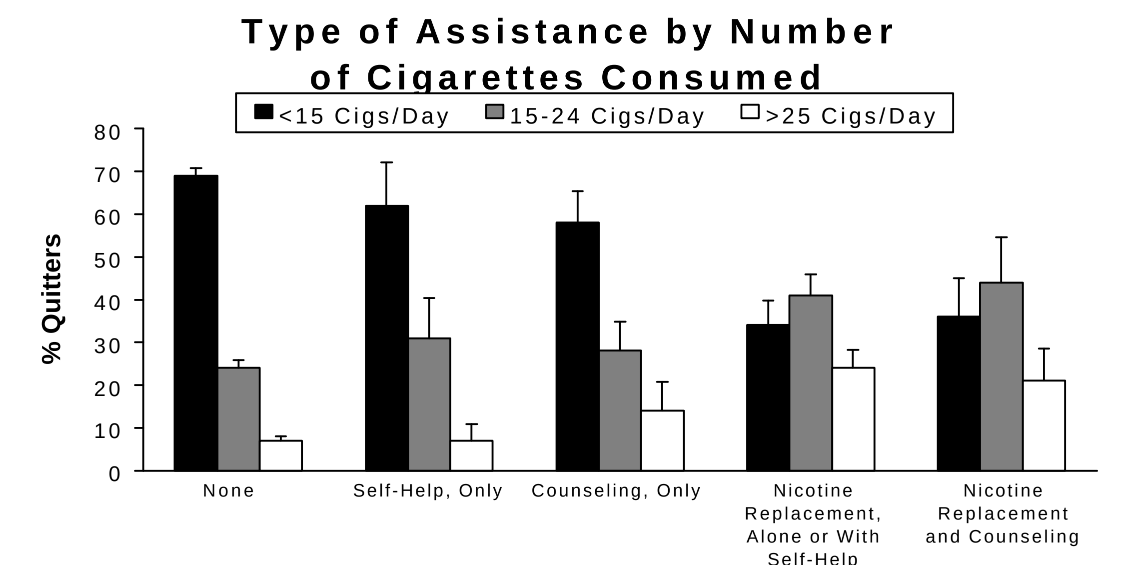


Figure 7.6

Figure 7.6 shows that the greater the consumption level of the smokers, the more likely they were to use nicotine replacement. The lighter smokers, on the other hand, were more likely to use counseling or self-help materials to quit smoking.

Nicotine Replacement Therapy

Nicotine polyacrilex gum became available for use by prescription in the mid 1980s and was made available without a physician's prescription beginning in 1996. The nicotine transdermal delivery system, the "nicotine patch," became available for use by prescription in January 1992 and "over-the counter" in July 1996. Recently, the Agency for Health Care Policy Research released guidelines for smoking cessation, recommending that cessation interventions include nicotine replacement therapies whenever appropriate (Fiori et al., 1996).

The 1996 survey shows that 13% of those who tried to quit smoking in the 12 months preceding the survey used some form of nicotine replacement. More used the nicotine patch (9%), than used nicotine gum (4%).

In 1996, there were minimal differences in the percentages of men (12%) and women (15%) who used nicotine replacement therapy. However, use of nicotine replacement therapy increased significantly with age, from 4% of quitters under the age of 25 years to 24% in those age 65 years and older. Non-Hispanic Whites (18%) were significantly more likely to use nicotine replacement than Hispanics (6%), African Americans (8%) or Asians (10%).

Consistent with earlier studies, the 1996 CTS showed that heavy smokers were significantly more likely than light smokers to use nicotine replacement to augment their quitting effort (Pierce et al., 1995). Only 7% of those who smoked fewer than 15 cigarettes used nicotine replacement, compared to 18% for those who smoked 15-24 cigarettes per day and 29% for those who smoked more than 25 cigarettes per day.

<u>Success Rates of Those Who Seek Help and Those Who Do Not</u>

A longitudinal study of California smokers identified the importance of using some assistance during a quit attempt (Pierce et al., 1994; Pierce et al., submitted). Figure 7.7 compares the time to relapse for those who reported that they sought help in quitting and those who did not on the 1996 CTS. Type of assistance was categorized as use of nicotine replacement, use of other assistance but not nicotine replacement and no use of assistance. The analysis considered only smokers and former smokers who reported that they were smoking one year before the interview and who had made a quit attempt lasting for at least one day in the past year. The percentages reaching each monthly quitting milestone were calculated using an actuarial analysis that adjusted for the fact that the final duration of the quit attempt was unknown for those who were still quit when surveyed.

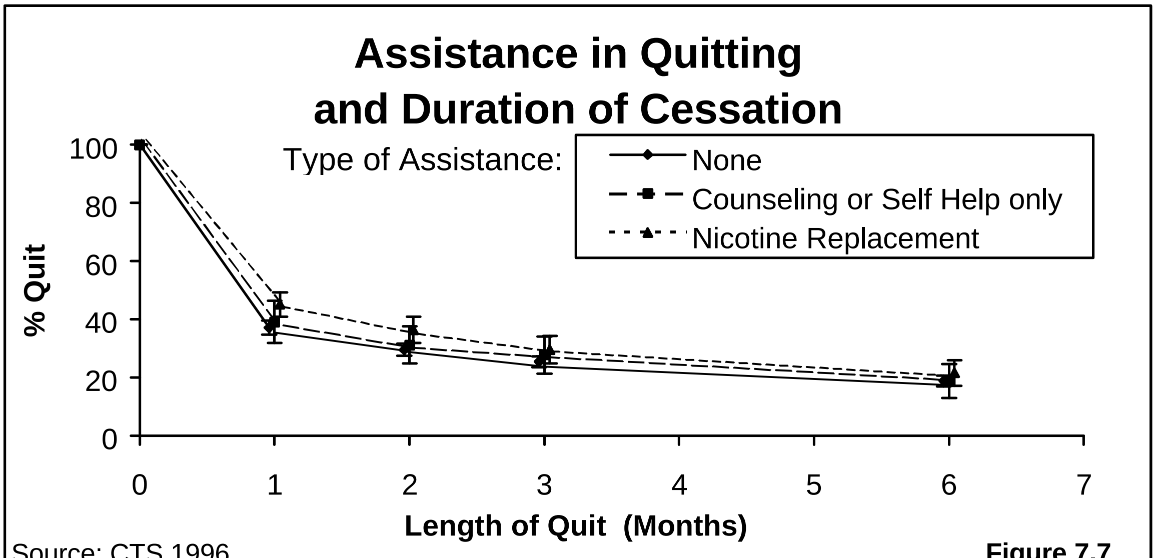


Figure 7.7

Overall, Figure 7.7 shows no demonstrable differences between those who used nicotine replacement, other forms of assistance, or no assistance at all. The lack of difference, of course, should not be construed to mean that assistance with smoking is ineffective. Rather, this finding suggests that assistance levels the playing field for highly addicted smokers, since those who seek help are typically more addicted than those who do not seek help (see Figure 7.6). Because the smokers' level of addiction is one of the strongest predictors of relapse, it is expected that without some type of assistance these heavy smokers would relapse at much higher rates than would a light smoker who did not seek help (Farkas et al., 1996; Ockene et al., 1982; USDHHS, 1989; Westman et al., 1997). Therefore, since these heavy smokers with assistance did at least as well as the lighter smokers who did not seek help, having assistance appears to compensates for the higher probability of relapse that would otherwise occur in these heavy smokers.

Perceived Assistance Available

An earlier study showed that a majority of smokers do not know whether cessation assistance is readily available for those who need help to quit smoking (Zhu et al., 1995). The 1996 CTS asked all smokers who had made a quit attempt in the last year the following question:

Can you name up to 3 programs that are helpful to people who are trying to quit smoking?

The majority of Californians trying to quit smoking is unaware of any assistance programs.

No prompts were given; the unaided responses are presented in Table 7.1. Over 60% of recent quitters were unable to name even one program for helping people to quit smoking. Strictly speaking, nicotine replacement treatment and hypnosis are not cessation programs, but types of treatment. Nicotine replacement therapy was mentioned most often (33.4%). Twelve percent of the smokers who had made quit attempts in the previous year identified specific programs such as Smokenders, Shick, and American Cancer Society programs, all of which are classified as behavioral treatment programs in Table 7.1. Approximately 9% named hypnosis. These results provide strong evidence that smokers who are trying to quit are not always aware of the programs that are available to help them with their effort.

Table 7.1
Programs that Smokers in California
Perceived as Helpful for Quitting* - 1996

Don't know of any	60.6%
Nicotine replacement therapy	33.4%
Behavioral treatment programs	12.0%
Hypnosis	9.1%
Support groups	2.6%
Others	4.5%

* Respondents could name more than one program so percentages do not total 100%.
Source: CTS 1996

4. The California Smokers' Helpline

The California Smokers' Helpline is a free, statewide telephone cessation service offered by the California Tobacco Control Program (TCP). It aims to provide convenient and accessible service for smokers across the state of California. It also serves as a supplemental source of service for other tobacco control efforts. For example, physicians can refer their patients who are smokers to the Helpline after advising them to quit smoking. The Helpline has also been used as an adjuvant behavioral program for many who are obtaining free nicotine patches covered by their insurance policies or MediCal. In addition, many local tobacco control programs refer smokers to the Helpline.

The Helpline service was first made available in 1992, following a large randomized controlled trial that demonstrated the efficacy of telephone counseling (Zhu et al., 1996). The Helpline provides service in English, Spanish, Cantonese/Mandarin, Vietnamese, and Korean, and also includes a TDD (Telecommunications Device for the Deaf) line for the hearing-impaired. It is available on a toll-free basis to all Californians.

Anti-smoking media spots on TV, radio and billboards are the primary means of promoting the Smokers' Helpline. As presented in Chapter 9 (Figure 9.3), calls to the Helpline are very responsive to mass media promotion, and increase markedly when media campaigns are being conducted.

Smokers who call the Helpline are first screened for their readiness to change. Those who are not ready to quit soon are sent motivational materials. Those who are ready to quit are asked to choose between a self-help program or telephone counseling. The advantage of this "stepped-care" approach is that it makes optimum use of available resources (Abrams, 1993).

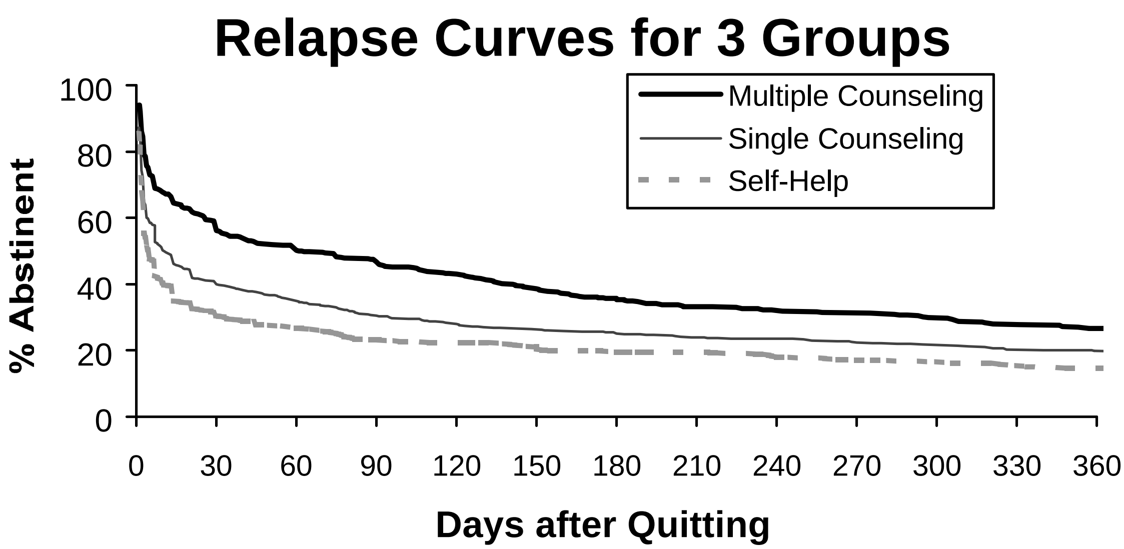
<u>Who Calls the Helpline?</u>

Since its inception in 1992, the Helpline has received calls from 58,000 smokers requesting assistance in quitting. Over half (52.8%) of the callers were female. The average age was approximately 37 years old. A total of 2,268 callers were under 18 years old. Overall, smokers of minority racial/ethnic background are well-represented among the callers. Thirty-seven percent of the callers were Hispanic, African American, Asian or Native American.

As with other forms of assistance, smokers who called the Helpline smoked more than the population average. The mean number of cigarettes smoked per day for those who called the Helpline is 20.6, while the mean number smoked daily among all smokers in the population is 13.5, and the mean number of cigarettes smoked per day among all daily smokers in the population is 17.4.

The Success Rate of Helpline Counseling

Figure 7.8 shows the results of a randomized controlled trial with over 3,000 subjects who called the Helpline, which showed that multi-session telephone counseling could nearly double the 12-month abstinence rate for those who received the counseling compared to a control group who quit with a self-help quit kit. Even a single counseling session significantly increased the success rate.



Source: Zhu SH et al., *J Consult Clin Psychol.* 1996;64, 202-211
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Figure 7.8

Helpline Counseling in Conjunction with Physician Advice and/or Nicotine Replacement Treatment

Over 7,000 smokers have been referred to the Helpline by their health-care providers. It is interesting to note that over 75% of those referred by health-care professionals identify themselves as having some health problems, compared to only 50% of those who heard of the program through the media. Callers referred by health-care providers were also more likely to choose counseling (or obtain counseling based on their medical condition) over self-help materials or information.

Recognizing the potential health-care cost savings to be realized from successful cessation, MediCal and some HMOs require that smokers participate in a behavioral treatment program, in order to obtain nicotine patches for free. Over the 3 years (1994 to 1997) that this information has been recorded, the percentage of callers who spontaneously reported that they planned to use the patch increased from 10% to over 26%. For those who received counseling from the Helpline, the percentage who used patches increased from 32% to 45%. The most significant increase in patch use was observed in those callers who were insured by MediCal. In this group, patch use increased by a factor of 129%; 659 used the patch from August 1994 through July 1995, while 1,509 used it from August 1996 through July 1997.

5. Summary

Promoting smoking cessation is central to the California Tobacco Control Program's (TCP)'s overall strategy to reduce smoking prevalence. Promoting quitting consists of increasing the motivation to quit as well as providing assistance to successfully quit smoking.

Section 1 of this chapter explained that both smokefree homes and workplaces provide motivation to quit smoking by making the act of lighting up inconvenient. While smokefree workplaces do not significantly increase the rate of quit attempts among smokers, workplace policies are significantly associated with smoking fewer cigarettes, a predictor of successful quitting in the future. Smokefree homes were significantly associated both with making quit attempts and light smoking (<15 cigarettes/day). These results suggest that, because they are voluntary, home restrictions on smoking are more powerful motivators of quitting behavior than workplace restrictions, and perhaps reflect pre-existing motivation or family pressure to quit. This section also demonstrated that one of the most important environmental influences on teens is the values or norms toward smoking expressed by their parents. Teens who believed that their parents would be very upset to see them light up a cigarette were more likely to be at advanced levels of the Quitting Continuum than teens who believed their parents would not be very upset.

Section 2 of this chapter explained that approximately one-third of current smokers received advice from their physicians to quit smoking. Smokers who reported fair or poor health status and older patients were more likely than healthier and younger patients to receive this advice. Only about one-third of patients who received a physician's advice to quit smoking actually attempted to quit smoking. This small proportion may be explained by the fact that less than one-third of patients who received this advice were provided with any information on smoking cessation or a target date for quitting. Similarly, less than one-third of smokers received any information from their physician about the dangers to nonsmokers of passive smoking, or environmental tobacco smoke.

Section 3 showed that, consistently between 1992 and 1996, approximately one in five smokers who had tried to quit used some form of assistance, whether it was self-help materials, counseling, or nicotine replacement treatments. The majority of those who received assistance used a combination of nicotine replacement and self-help or counseling. Importantly, this section showed that smokers who consumed 15 or more cigarettes per day were significantly more likely than lighter smokers to seek assistance in quitting. The assistance appeared to level the playing field for these moderate to heavy smokers, bringing their success rates up to rates comparable with lighter smokers.

Section 4 described the California Smokers' Helpline. It showed that since 1992, when it was initiated, the Helpline has received calls from over 58,000 smokers. Mass media campaigns are the primary means of promoting the Helpline, and the volume of calls is highly associated with the timing of these media campaigns. Callers who were randomized to receive the multiple counseling session treatment plan achieved significantly greater success rates than those who were randomized to the single counseling session or self-help materials. Insurance companies and MediCal sometimes provide free nicotine replacement therapy on the condition that the smoker participate in a cessation program, such as the California Smokers' Helpline.

CHAPTER 7: REFERENCES

Abrams DB. Treatment issues: towards a stepped-care model. *Tobacco Control*. **1993**; 2(suppl):S17-S29.

Farkas AJ, Pierce JP, Zhu S-H, Rosbrook B, Gilpin EA, Berry C, Kaplan RM. Addiction versus stages of change models in predicting smoking cessation. *Addiction.* **1996***;*91: 1272-1280.

Fiori MC, Bailey WC, Cohen SJ, et al. *Smoking Cessation.* Clinical Practice Guideline No. 18. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. AHCPR Publication No. 96-0692; **1996**.

Gritz ER. Cigarette smoking: the need for action by health professionals. *CA Cancer J Clin*. **1988**;38:195-211.

Lichtenstein E, Glasgow RE. Smoking cessation. What have we learned over the past decade? *J Consult Clin Psychol.* **1992**;60:518-527.

Ockene JK, Hymowitz N, Sexton M, Broste SK. Comparison of patterns of smoking behavior change among smokers in the Multiple Risk Factor Intervention Trial (MRFIT). *Prev Med*. **1982**;11:621-638.

Pierce JP, Evans N, Farkas AJ, Cavin SW, Berry C, Kramer M, Kealey S, Rosbrook B, Choi W, Kaplan RM. *Tobacco Use in California: An Evaluation of the Tobacco Control Program 1989-1993*. La Jolla, CA: University of California, San Diego; **1994**.

Pierce JP, Gilpin EA, Farkas AJ. Can strategies used by statewide tobacco control programs help smokers make progress in quitting? *Cancer Epidemiol, Biomarkers & Prev.* **1998**;7:459-464.

Pierce JP, Gilpin E, Farkas AJ. Nicotine patch use in the general population: results from the 1993 California Tobacco Survey. *J Natl Cancer Inst*. **1995**;87:87-93.

Swartz JL. *Review and Evaluation of Smoking Cessation Methods: The United States and Canada, 1978-1985*. Washington, DC: Division of Cancer Prevention and Control, National Cancer Institute. NIH Publication No. 87-2940; **1987**.

Wechsler H, Levin S, Idelson RK, Rothman M, Taylor JD. The physician's role in health promotion – a survey of primary care practitioners. *N Engl J Med*. **1983**;308:97-100.

Westman EC, Behm FM, Simel DL, Rose JE. Smoking behavior on the first day of a quit attempt predicts long-term abstinence. *Arch Int Med.* **1997**;157:335-340.

U.S. Department of Health and Human Services. *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General.* U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. DHHS Publication No. (CDC) 89-8411; **1989**.

Zhu, S-H, Anderson C, Pierce JP. *Smoking Cessation in California: The Importance of Assistance to Smokers in Quitting.* Paper presented at the American Public Health Association's 123rd Annual Conference, San Diego, CA; **1995**.

Zhu S-H, Stretch V, Balabanis M, Rosbrook B, Sadler G, Pierce JP. Telephone counseling for smoking cessation: effects of single-session and multiple-session interventions. *J Consult Clin Psychol.* **1996**;64:202-211.