Now we're smokin'.....

Smoking, Injuries, and Kicking the Habit

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The third Tuesday in November is the annual Great American Smokeout. If you are still smoking, we hope you will set this day as your goal to kick the habit. If you’re reading this and November is a long way off, we suggest that you pick a date and make a commitment to stop without waiting for November. Please refer to the American Cancer Society website http://www.cancer.org/Healthy/StayAwayfromTobacco/GreatAmericanSmokeout/index for more information about this event, materials and information to help you meet your goal.

Smoking is extremely addictive, for physical, psychological, and social reasons. If you need one more reason to commit to a smoke-free life, smoking has been identified as a risk factor for both Repetitive Strain Injuries (RSI) and other musculoskeletal disorders (MSD), especially lower back pain.

How is smoking related to MSD?
Smoking increases the risk of RSI and MSD because nicotine restricts blood circulation. If blood doesn't flow well, then waste products settle into soft tissue instead of being carried away in the blood stream. In addition, good circulation brings nutrients and oxygen to the muscles, tendons and ligaments to keep them healthy and nourished. Smoking also replaces oxygen with carbon monoxide. Oxygen is essential for healthy tissues. If your soft tissues don't receive nutrients and oxygen, they tire easily. Smoking increases the chances musculoskeletal injury, even in young, healthy, active people.

What is the evidence?
Research has indicated that there are connections between smoking and general injury rates as well as disorders of the neck, shoulders, and back. Smokers report more pain in all body parts and more musculoskeletal symptoms than non-smokers. Even people who have smoked, but have stopped smoking for a number of years, report more symptoms than people who have never smoked. One study researching neck and shoulder pain found it to be related to smoking only in female subjects, though other studies have found males to be just as prone to problems.

Data from 25,455 patients was analyzed to determine if there was a relationship between smoking and back pain symptoms. Smokers were younger than non-smokers (44.2 vs. 48.7 years) and were more likely to report severe back symptoms (37% vs. 50%). Nonsmoking surgical patients reported improved health status more quickly than smokers. While both smokers and non-smokers had spinal problems for a similar period of time, smokers reported more severe symptoms. In addition, smokers had lower scores on both physical and mental health status than nonsmokers.

Another article that reviewed 38 published studies regarding the association of smoking and back disorders concluded that smoking is associated with the incidence and prevalence of nonspecific back pain. There are too few studies to make conclusions about other back conditions such as herniated discs.

In another large study, the effect of smoking on people with and without scoliosis was investigated. Statistically significant associations between back pain and current cigarette smoking were found in women with and without scoliosis, and in men with scoliosis, but not among men without scoliosis. Among current smokers, the prevalence of back pain increased with cigarette consumption. In the three groups with significant associations,
intensity, frequency, and duration of episodes of back pain were found to increase with smoking. From this it might be concluded that smoking has a greater impact on people with damaged spines.  

Another study investigated the effects of smoking on exercise-related injuries during Army basic training. The study controlled for factors such as demographic, physical fitness, and health variables. Recruits who reported smoking at least one cigarette during the month prior to basic training had significantly higher injury rates during training than those who did not smoke prior to training. The relationship with smoking history was most strongly related to overuse injuries. Injury rates were approximately 1.5 times higher for the smokers than for the non-smokers. It was concluded that the detrimental effects of smoking persist at least several weeks after cessation of smoking, since smoking was not allowed during basic training. In addition, smokers had more previous injuries and illness, were less physically active, and were less physically fit than nonsmokers. 

Some studies report that smoking can impair healing of wounds from trauma, surgery, and disease. It appears that smoking interferes with the body's ability to repair muscle, bone, and other tissue, leaving smokers more susceptible to injury and less able to heal quickly.

Health Research Conclusions.
Studies have found that smokers (as opposed to non-smokers):
- report more pain in all body parts.
- report more severe back problems, increasing as tobacco use increases.
- are more prone to overuse injury during exercise.
- are less physically active and physically fit.
- heal more slowly from injury, surgery and disease.

Research on Kicking the Habit.
According to one well-researched model, smokers tend to go through several mental phases in the process of dealing with smoking cessation. The four phases are defined as precontemplation, contemplation, action, and maintenance. This model measures people on 32 items that help to determine what phase a person is in and it has been used in a variety of settings with a wide range of issues including smoking, alcoholism, weight control, psychotherapy, and recovery from head injuries. With addictions like smoking, people tend to cycle and recycle through the stages during recovery. In fact, some research indicates that the contemplation phase is actually composed of two phases: contemplation and preparation. These are the phases leading up to making a serious attempt at quitting. Smokers in different phases do not represent different types of smokers by history (age of initiation, total years of smoking, years before first quit attempt, percent who had a spouse that smokes, or either/both parents who smoke). Their status in a particular phase indicated their current change activity in this study.

Precontemplation is a phase where people are not seriously considering quitting. They have made significantly fewer attempts to quit smoking than either the Contemplation or the Preparation phase smokers. Smokers in this phase had significantly less confidence that they could quit and that they would be easily tempted to smoke in comparison to the other two phases. Smokers in this category found that the pros and positive aspects of smoking outweigh the negative aspects of smoking significantly more than the other two phases.

Contemplation is a phase where people are seriously considering quitting in the next 6 months, but not within the next 30 days. They have made significantly fewer quit attempts than the Preparation phase smokers, but significantly more quit attempts than the Precontemplation phase smokers. Smokers in this category had significantly more confidence that they would be able to quit smoking than the Precontemplators, but significantly less confidence than the Preparation phase smokers. They also admitted a significantly higher tendency to be tempted to smoke than the Preparation phase smokers, but significantly less temptation than the Precontemplators. Smokers in this phase appeared to find the pros and cons of smoking to be about equal, significantly differentiating this phase from the other 2 phases.

Preparation is a phase where people are seriously considering quitting within the next 30 days. Smokers in this group have made significantly more quit attempts than either of the other two phases. They have significantly more confidence that they will be able to quit and will not be tempted to smoke than the previous two phases. Smokers in
this phase showed a definite belief that the cons of smoking outweigh the pros, and this was measured to be a significant difference from the other two phases.

This study did a 1 month and a 6 month followup of the participants. Educational materials in the form of self-help manuals were given to all of them. At one month, each of the phases differed significantly from the other in the expect direction with the Preparation phase smokers referring to the manuals the most and the Precontemplation smokers referring to them the least, though at the six-month followup there were not significant differences between the phases. At both the 1 and 6 month followups, there were significant differences between the phases in the number of quit attempts, with more of the Preparation phase participants making quit attempts and fewer of the Precontemplation phase making an attempt to quit. At the point of 1-month and 6-month followups, significantly more of the Preparation phase smokers were not currently smoking and/or had not smoked at all for the previous week.

Interestingly, at 6 months, nearly 80% of the Preparation phase smokers had made a quit attempt, only 48% of the Contemplators had made a quit attempt, and 12% of the Precontemplators had made a quit attempt. Even though the Contemplators had indicated at the beginning of the study that they planned to quit in the next 6 months, less than half actually made an attempt indicating that people can get stuck in the Contemplation phase. What is most interesting is that all groups actually made progress in both attempts at quitting and actual smoking abstinence over the 6 month period, even the Precontemplation phase participants. Overall, at 6 months, the abstinence rate was 13.2% across the groups (11.2% if the drop-outs were considered to be smoking).

It's generally agreed that without help, your chances of kicking the habit alone are only about 5%. Unfortunately, there is no magic that seems to work for everyone. In the previously described study of phases of action, even with simple self-help manuals, success rate was raised to 11.2%. In other research, 6-month quit rate was shown to be 17% for self-help and 24% for group therapy. The researchers felt that materials and approaches would likely have to be tailored differently to the different phases. In another review of research it was found that about half of the people who were continuously abstinent at 6 months achieved permanent smoking cessation. Only about 20% of the quitters relapse between 6 months and 12 months. Approximately 60% of those still abstinent at 12 months remain abstinent for at least 8 years. And, after 12 months, there is no difference in relapse rates between treated and untreated abstainers. Unfortunately, research has not be done on the different phases to determine which types of intervention are most effective in each phase.

Types of Treatment
The majority of smokers attempting quit appear to “go it alone” and seek no treatment. Somewhere between 64% to 78% try to quit without any type of treatment. Simple behavioral counseling, telephone support, or social support are not common methods of treatment sought out by smokers. Even fewer sought out alternative methods such as acupuncture, hypnosis, etc. (3%). Only slightly more sought out help in the form of books, videos, or the internet. The majority of smokers attempt to quit with either no cessation treatment (64%) or with pharmacologic treatment consisting of over the counter (OTC) lozenges, gum, etc., or prescription drugs (25%). The use of pharmacologic treatment increased steeply with increasing nicotine dependence.

There is evidence that smokers are both relatively unaware of the various treatments available as well as feeling little perceived effectiveness of treatment methods. About 1/3 do not think that nicotine replacement therapy or bupropion will help them stop smoking. About 2/3 do not think that professional counseling will help, and about half do not think that group counseling will help. As noted above, 78% of smokers indicated that they would be just as likely to try quitting alone with no treatment. However, the respondents of one study who indicated that they thought some type of treatment would help them were significantly more likely to intend to quit, to actually make a quit attempt within the 3-month study, and to get cessation assistance when trying to quit.

There is a confounding factor in some research regarding the success rates of various treatment methods because smokers self-select for treatment. In other words, seeking treatment in and of itself is an indication that these people may start out thinking they may fail. Smokers may seek treatment when they feel incapable of quitting by themselves. Treatment is generally sought increasingly as the number of cigarettes per day increases, but treatment is also used more when advised by a doctor to quit smoking. Having private insurance or military insurance that covers treatment, significantly increases the number of people seeking treatment, whereas those on Medicare, Medicaide, or no insurance used treatment significantly less.
For example, in one major study, smokers who used any type of treatment were less likely to be successful than those who used no treatment. Smokers who sought out counseling were 26% less likely to abstain and those using self-help materials were 35% less likely to abstain than those who used no treatment. Using multiple treatments resulted in even lower rates of abstinence, with the lowest rates among those who used both pharmacological and behavioral treatments. Receiving social support had no relationship to abstinence at all.

What Works?
The specific theoretical approach taken in various types of intervention shows little difference in effectiveness. It may be that rather than one type of therapy or another being key, it may be that it is the actually accountability to a program, therapist, or group that is critical in avoiding the procrastination that arises when the urge to smoke hits and the smoker decides to quit “tomorrow” rather than now. More research is needed to determine what components of behavioral support are most beneficial such as providing feedback on performance or prompt specific goal setting.

There is some research that indicates that behavioral support and medication are independent and actually provide much greater benefit when provided together.

A review of the success of the National Health Service (NHS) intensive treatment programs offered through a national initiative in England to smokers motivated to quit, looked at the success of various types of intervention and measured the success rate both through self-report and validation by monitoring carbon monoxide (CO). A total of 20 studies were used to draw conclusions about various behavioral approaches to quitting after culling all available research for quality. Another paper reviewed research looking at various types of behavioral intervention and their effectiveness. Results of these reports are summarized below.

- **Group vs. one-on-one intervention** – Although the vast majority of smokers received one-on-one support, research showed that group counseling substantially improved success rates (30%) over one-on-one support (19%) at 4 weeks, with CO validation. There is a 12-step program based on the principles of Alcoholics Anonymous called Nicotine Anonymous that provides fellowship meetings of people who are either all trying to quit or who have been successful and are now helping others. Their website has information about the program, a search engine to find a meeting near you, or to help you start a meeting if none exists: Nicotine anonymous.

- **Buddy interventions** – Smokers who are paired up with a buddy who is also trying to quit smoking were 2.6 times more successful in maintaining abstinence when also receiving one-on-one intervention, but the buddy system did not increase effectiveness of smokers also receiving group intervention (CO validated). Apparently no group used the buddy system without any supplemental intervention to determine it’s effectiveness alone.

- **NRT Inpatient interventions** – One study looked at the effectiveness of nicotine replacement therapy in hospital settings. This study included patients that were hospitalized for smoking-related diseases, randomized to receive NRT plus advice and support or simply advice and support without NRT. The success rate was about 14% for both groups at 1 year which is about the same rate as the NHS stop smoking services. Any of these interventions is presumably similar in effect.

- **Intensive intervention** – Quit rates appear to be improved significantly when there are more individual sessions in the course of treatment in comparison with less intensive pharmacy-delivered intervention or lower quality intervention either inexperienced counselors, primary care providers checking to make sure medication was used effectively, or support that is delivered in a non-systematic way. More research is needed to understand the complexities involved in determining what type of intensive intervention is effective, but it appears that longer-term, more individual approaches work best.

- **Flexibility of intervention** – Access to support or intervention appears to be helpful and important. By having several avenues available at any time, quitters can seek help when, where, and how they choose, fitting around work schedules, family, and other commitments.
  - **Telephone and texting support** – The telephone can provide substantial support. It can be used as an emergency contact for the smoker. There is good evidence that regular phone calls set up as appointments are quite effective, similar to face-to-face meetings, but phone calls are generally more convenient. There is also recent strong evidence that texting is a very effective means of obtaining support when the temptation to smoke hits.
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Subpopulation effects

- Younger smokers were found to be less likely to achieve success through the National Health Service (NHS) program than older smokers at both 4 week and 1 year intervals.26 Although 2/3 of the participants in the NHS program are women, only 40.5% of the women were abstinent at the 4 week measure of CO, while 53.2% of the men were abstinent indicating that men were more successful even though they were a lot less likely to seek help from the program.26 White vs. non-white data was quite limited, but there was no difference between these groups.26 Pregnant women measured for CO at the 4 week period were measured to be 40.5% successful, however pregnant disadvantaged women were measured to be 20.3% successful at 4 weeks and only 12.7% abstinent at 52 weeks.26 Among deprived populations of routine or manual laborers, smoking is considered the norm, making quitting harder.26 Cost, timing, lack of child care, lack of appropriate information, and perceived ineffectiveness and negative publicity about the program are all barriers to the ability of the NHS to reaching the deprived

Internet support – Websites can offer a great deal of information and they try to be engaging, but many lack the relationship-forming element that may be critical. Adherence to online programs appears to be lower than other types of intervention, but there is evidence that they are effective.16 Dr. Edward Feil of the Oregon Research Institute found that one of the most valuable ways to find support is online.27 The internet is there for you 24 hours a day. You can get a “helping hand” any time you feel you can’t stand another moment without a cigarette, just by logging on to a website. Give yourself one more chance by logging on (or calling up) and see if there is some tip that will help you make it through this time...and the next. The type of website appears to make a difference. Static informative websites have not been found to be effective, while tailored, interactive websites have been shown in some studies to increase abstinence rates by 17% at a 6-month follow-up, doubling smoking cessation rates compared to minimal intervention methods.

The treatment effect appears to be relatively stable over time.18 Users preferred online discussion groups, chatrooms, and “ask the expert” types of websites, while websites that provided informational materials were the least favorite.18 Unfortunately, no studies have been conducted to compare internet intervention with telephone counseling or brief advice. Online interactive support appears to be equally effective as face-to-face counseling, but it is not additive if both types of intervention are used.18 Interactive internet support provides one more avenue of intervention that is easy to access 24/7 for people who are comfortable using the computer.18 One study determined which websites were the most helpful to quitters.19 The study was conducted in 2005 and it is our guess that many of these websites have changed significantly in the years since. Interestingly, even though some of the tobacco-sponsored websites were visited most frequently, they were deemed by quitters as not being helpful.19 We have ranked the following websites not just by the results of the study, but by the level of interaction and the richness of resources available currently on the sites. The foundation for a Smoke-free America actually ranked right after Smokefree, but it currently seems to have fallen behind in terms of interactivity and online engagement possibilities.

- Smoking.About.com Online information, forums, email courses, e-newsletter: http://quitsmoking.about.com/
- Committed quitters. By Nicorette and NicoDermCQ. Programs designed depending on which of their products you are using. http://www.committedquitters.com/
- Quitnet. Online, forums, chat, clubs, buddies, and lots more: http://quitnet.com
- Freedom From Smoking (American Lung Association) http://www.ffsonline.org/
- The Foundation for a Smoke-free America. http://anti-smoking.org/ (static informational with links)

Smoking reduction prior to quitting – There is evidence that, for many smokers who cannot stop “cold turkey” or for those who do not desire to quit, but either desire or need to cut back due to factors such as social or work environment, reduction using methods normally used for total smoking cessation can be effective.16 Use of medications or NRT and behavioral instructions on how to quit actually seem to help with smoking reduction and subsequently with smoking cessation.16 Many programs do not want to offer the option of smoking reduction, since it implies that even some smoking is OK and that the program is condoning smoking on some level. In fact, reduction may be an effective way for people to ease into cessation when they find quitting completely to be impossible.16

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population, however there appears to be evidence that it is making some contribution to smoking cessation with a
success rate of 8.8% at 4 weeks vs. only 7.8% for more affluent areas.26

With regard to pregnant women, intervention by midwives appears to be successful with flexible home visits and
multi-session treatment by a small number of dedicated staff.26 There appears to be some emerging evidence that
incorporating drop-in group sessions may be helpful so that quitters can attend a group any time during their quit
attempt and this may be especially helpful in deprived areas.

Alternative Therapies
Acupuncture, acupressure, and electrical stimulation have not been proven to be very effective in helping with
smoking cessation.28, 29 These may be types of intervention that help during certain phases of the cessation process
and this has not been adequately studied. Both are safe and may be helpful in conjunction with other treatments so it
may be useful for some people to just these types of intervention if they find them an appealing option.
Unfortunately, there are some hypnosis seminars, often given by laypersons, which have given hypnosis a bad name.
A one-time seminar is not going to help! If you would like to explore hypnosis, there is a CD set by the respected
Steve Gurgevich, Ph.D.30

Medications
The decision to use medications or nicotine replacement therapy should not be taken lightly, however in most cases
they are less damaging to health than continuing to smoke. We encourage you to try to quit using the safer
behavioral or alternative therapy approaches first. But, if you cannot succeed, medications may give you the added
support you need.

Nicotine gum, patches, and candy are alternative forms of nicotine and termed Nicotine Replacement Therapy
(NRT). The theory is that you can wean yourself off of nicotine, though these substitutes can actually supply you
with loads of nicotine and potentially intensify your addiction.24,25 In fact, the candy looks just like breath mints, so
it’s easy for children to get hold of them and become addicted to nicotine at an early age without the knowledge of
parents or teachers.24 Cigarettes provide a very strong dose of nicotine directly into the blood supply in the lungs
which gets transmitted quickly to the brain.16 The cigarette itself is learned to be associated with the release of
nicotine and usually smoking is associated with certain places or situations, so when a person is in a situation
without a cigarette, even with NRT, the urge to smoke is usually present.16 Belief that smoking is a stress reliever
may actually stem from the relief experienced when symptoms of withdrawal are relieved by a cigarette.16 At any
rate, using one NRT such as a patch that supplies a lower, long-term dose of nicotine along with an NRT nose spray
which supplies short-acting dose when the craving becomes unbearable may be more effective, but it is supplying
your body with the substance that you are addicted to.16 In order to break the addiction, a person will need to
abandon these crutches at some point.

Electronic cigarettes are touted to be safe to smoke in no-smoking areas because they allegedly emit no smoke,
smell, carcinogens, tar, or carbon monoxide.25 Testing by the University of California Riverside have found
inadequate warnings on packages as well as leaking cigarette cartridges which expose people and pets to the effects
of nicotine. They are certainly not a method to stop smoking and they are provide the same strong dose of nicotine
directly into the blood supply that cigarettes do.25

Pharmaceutical drugs all have side effects, some of them quite dangerous and severe. Currently, the drug
varenicline (Chantix) has been the subject of many lawsuits and is connected with symptoms of serious depression,
suicide, and heart attacks, though it doubles the chance of quitting.20,21,22 Varenicline has been shown to be more
effective than either bupropion or use of a single-form NRT.16 More than 1 in 10 people taking Chantix experience
nausea, insomnia, experience strange dreams, or get headaches. Zyban (bupropion SR) also is associated with the
risk of serious psychological side effects including changes in behavior, hostility, agitation, depression, suicidal
thoughts, and attempted suicide.21 The FDA has required both varenicline (Chantix) and bupropion (Zyban) to
carry a “black box” warning that is the most serious warning available, and both drug appear to have similar rates of
adverse effects.20

Use of antidepressants to relieve symptoms of withdrawal have not been shown to be effective in smoking
cessation.16
Several herbal remedies have been promoted as promising aids in kicking the addiction to nicotine. Derived from the herb lobelia, the constituent lobeline, has been misconstrued to resemble nicotine. In fact, it is not biochemically similar though research does suggest that lobeline may have interesting effects on the nervous system and may be helpful in treating addictions. A lot more research is needed before conclusions can be drawn about its effectiveness in nicotine addiction. Other herbs often included in non-smoking remedies include wild oats, alfalfa, eucalyptus, gotu kola, hops, licorice, passionflower, and skullcap have either not been scientifically evaluated or have not been shown to be effective. Weak evidence has been found for melatonin and a toxic substance, cysticine, derived from the seeds of Laburnum anagyroides and related plants in helping with smoking cessation.

Reaching for success.
As with any addiction, looking at the rest of your life without another cigarette will seem hopeless when the craving sets in, but simply not smoking "this time" is possible. Over time, the physical need will decrease. Healthy substitutes for the psychological and social needs will make quitting easier.

Be aware that there are differences between men and women regarding addiction. Nicotine dependence is generally lower for women but behavioral dependence is higher (e.g., women value taste over strength and they enjoy the rituals of lighting up). And women smokers have almost twice the risk of heart disease and lung cancer compared to male smokers. It is recommended that women time their smoking cessation with the first half of their menstrual cycle, since it has been clearly shown that tobacco withdrawal symptoms and low moods are noticeably milder during that time.

Many people continue smoking because they fear weight gain. Since nicotine suppresses appetite and increases metabolism, weight gain is common when smoking is stopped. People who don't try to diet while they are quitting smoking have been found to put on less weight and are more likely to quit. However, if you've been inactive, it's helpful to add moderate exercise to your life. Improving your diet by increasing fruits and vegetables, whole grains, and low-fat sources of protein should help you combat weight gain. Most people actually gain less than 10 pounds when they stop smoking. This is definitely an insignificant risk when compared with the risk of getting emphysema, lung cancer or MSD or the many other health problems associated with smoking.

Relapse prevention.
With optimal treatment involving medication and behavioral counseling, about ½ of all smokers can end treatment abstinent. Even though successful quitters are adamant that they will not start smoking again, most will resume smoking again in the future. Long after the physical withdrawal from nicotine, which takes a few weeks, and also after weeks of breaking the habit of smoking, it appears that the rise and fall of adverse moods may have something to do with weakening will-power.

A review of randomized controlled trials has found that teaching prior smokers to recognize high-risk situations and to create plans to prevent themselves from smoking to prevent relapse is not effective at all. Other behavioral interventions have not been found to be effective either. There is some suggestive evidence that use of medication beyond the usual treatment period with varenicline or NRT may help people resist the urge to relapse, though long-term use of these medications is not suggested. Use of medications just during episodes of weakness may prove to be helpful, but research is needed to determine if this is effective.

Conclusions
In real terms, it appears that people tend to go through mental phases in preparing to quit smoking. Probably as they get closer to actually trying to quit, heavy smokers may be especially more likely to seek help from medications, nicotine replacement, behavioral or group therapy, or a combination of these, especially if their insurance will pay
for it. Lighter smokers may be able to quit without help more successfully and heavier smokers, while not succeeding at quitting in most cases, are actually able to quit in some cases.

- Without help, you have about a 5% chance of successfully quitting.
- If you remain abstinent for 6 months, the odds are that you will continue to be abstinent.
- After 12 months, 60% remain abstinent for at least 8 years and there is no difference whether you were treated or not. If you make it this far, by whatever means, the majority of people can remain abstinent.
- The vast majority of people attempt to quit without any help at all. About ¼ of the people attempting to quit use over-th-counter aids such as gum, patches, lozenges, or prescription drugs.
- Almost any type of intervention or treatment increases success rates, but most research shows that longer-term, individually tailored approaches work better than general, informative, or short-term methods such as brochures, static websites, or reminders.
- The element of caring and/or accountability and support by others and at critical times, appears quite important.
- Access to treatment at the needed times is important as is access to treatment that is flexible around work, family, and social commitments.

REFERENCES:


