Freeing Veterans from Tobacco:

A Toolkit for Assessing and Implementing Tobacco Treatment Services

PROJECT UNIFORM
UNDOING NICOTINE INFLUENCE FROM OUR RESPECTED MILITARY

info@projectuniform.org
(916) 339-3424
projectuniform.org

CYAN is a statewide organization dedicated to changing the tobacco use culture of young people in California. The organization provides training and technical assistance to community organizations, public health agencies, college and universities, medical facilities, and military installations working to prevent tobacco use as well as support tobacco users in quitting.

Project UNIFORM, CYAN's Military Program, creates military-civilian partnerships to address tobacco use in military communities by providing culturally appropriate tobacco control information and trainings; collaborating with military support networks to promote cessation services; and educating tobacco control and health professionals on the culture and existing services within the Armed Forces of the United States.

Suggested Citation:

California Youth Advocacy Network. (2017). *Freeing Veterans from Tobacco: A Toolkit for Assessing and Implementing Tobacco Treatment Services*. Sacramento, CA.

 This material was made possible with funds received from the California Department of Public Health, under contract #14-10013.

Table of Contents

Introduction

Despite the knowledge that tobacco products harm nearly every organ in the body, causing many illnesses and reducing life spans, tobacco use continues to be the leading cause of illness, disability, and premature death in the United States. Tobacco use rates are disproportionally higher for military personnel and veterans. With all tobacco users, there are a variety of biological, social, and psychological factors that play into the addiction and continued use of tobacco.

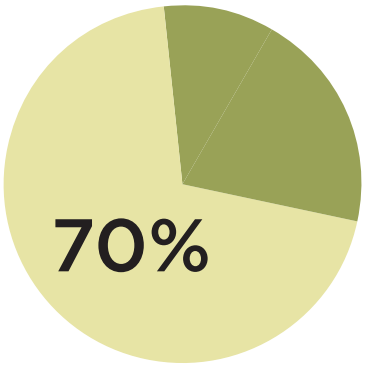
Within the military, there has been a long history of tobacco use embedded into the culture. This culture has contributed to higher rates of the use of cigarettes and other tobacco products by service members compared to civilians.[1] In addition to causing significant health problems for service members and Veterans, tobacco use is costly for the Department of Defense (DoD) and Veterans Administration (VA). In recent years, DoD and the VA have expanded efforts to address the high rates of tobacco in the military. Specifically, the VA has been engaged in efforts to promote tobacco cessation and have contributed to advances in treatments. However, Veterans continue to have higher rates of tobacco use compared to the general population.

Tobacco use rates are disproportionately higher for military personnel and veterans.

With continued high rates of tobacco use in the military, it is likely many new Veterans accessing health care will also be tobacco users, especially those who have been deployed to Iraq and Afghanistan. Moreover, in 2014, President Barack Obama signed into law The Veterans Access, Choice, and Accountability Act that expands the availability of medical services for eligible Veterans with community providers. Evidence-based systems level interventions that are effective include tobacco use identifications systems for all patients, provider education, and dedicated staff. Tobacco cessation treatment modalities can be delivered in many settings and formats. However, treatment effectiveness is irrelevant if tobacco users are not aware of treatment options, cannot access them, or do not use them when they are available. Physicians and other providers can play a significant role in helping Veterans quit through increased attention and delivery of tobacco cessation treatments.[2, 3]

Why Focus on Veterans

- With 1.8 million Veterans, California is the state with the highest number of Veterans and it has one of the highest concentrations of post-9/11 Veterans [Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), Operation New Dawn (OND)].[4, 5]
- Rates of tobacco use by service members and Veterans are significantly higher than their civilian counterparts. Understanding the disparities that exist and how to address them may accelerate quit attempts among military community members.
- Veterans have a strong desire to quit using tobacco; 70% of Veterans who smoke want to quit.[6]



U.S. VETERANS WANT TO QUIT SMOKING

- A significant amount of VA health care costs are attributable to tobacco-related diseases. In 2008, the VA spent over $5 billion dollars to treat chronic obstructive pulmonary disease (COPD). More than 80% of COPD is attributed to smoking.[2]

Overview of Toolkit

Quitting tobacco is one of the best things a person can do for his or her health. The goal of this Toolkit is to:

- Increase awareness of tobacco products and health implications
- Educate on the problem of tobacco use in the active duty military and Veteran populations
- Educate on tobacco dependence treatment best practices
- Support providers in developing new tobacco dependence treatment protocols and/or programs for supporting Veterans in quitting tobacco

Section 1
Overview of Tobacco Products

Tobacco and Additives

Tobacco products contain various harmful chemicals in every stage of development: from growing the plants, to manufacturing, and using the products. Tobacco plants are vulnerable to a variety of pests and diseases, thus, they require the application of large quantities of pesticides, growth inhibitors, and ripening agents during different stages of growth.[7] Once the tobacco plants have been harvested, the leaves are dried and cured. During the curing process, carcinogens called Tobacco-Specific Nitrosamines (TSNA's) form. In addition to naturally occurring chemicals in the plant and processing, manufacturers add hundreds of chemicals to tobacco products to control moisture, enhance flavor, and mask harshness. Consequently, these additives can increase nicotine absorption, thus increasing the addiction, and making it even more difficult for a tobacco user to quit.[8]

Nicotine

Tobacco contains the addictive drug nicotine, which is just as, if not more, addictive than heroin and cocaine. Nicotine is absorbed in the bloodstream when a tobacco product is used and, within eight seconds of inhalation, reaches the brain. The drug increases levels of the neurotransmitter dopamine, which affects the pathways in the brain that control reward and pleasure. As a result, many tobacco users experience long-term brain changes that contribute to addiction.[9]

NOTE: One method of treating tobacco is the use of Nicotine Replacement Therapy or NRT. It is important to understand the difference between tobacco products (like cigarettes and cigars) and NRT. Types of NRT include nicotine patches, gum, lozenges, inhalers and nasal spray. These are U.S. Food and Drug Administration (FDA)-approved tobacco cessation medications. They provide a person with nicotine, but without all the other harmful chemicals found in tobacco products. NRT helps lessen the urge to use tobacco and, as a person quits, they can decrease NRT nicotine doses.

Tobacco Products: Combustible, Smokeless, and Electronic

There are many different types of tobacco products aside from cigarettes. Some are burned and produce smoke, others are smokeless, and the newest forms of tobacco and nicotine produce an aerosol.

COMBUSTIBLE TOBACCO PRODUCTS

CIGARETTES

Cigarettes are the most commonly consumed tobacco products worldwide. They consist of chopped tobacco leaves, stems, reprocessed pieces, and scraps wrapped in paper. There are approximately 600 ingredients in cigarettes that, when burned, release over 7,000 chemicals.[10, 11] Not only are additives found in the tobacco, but manufacturers also add chemicals to the paper to control how fast the cigarette burns. All cigarettes, even those advertised as natural, organic, or additive-free, contain chemicals and toxins harmful to health.[12]

Tobacco smoke contains at least 70 chemicals known to cause cancer. Smoking is most known for causing lung cancer, but it can also cause cancer throughout the entire body including in the esophaus, larynx, stomach, bladder, pancreas, and kidney (to name a few). Additionally, smoking is linked to a number of diseases such as leukemia, heart disease, autoimmune disease, and an increased risk for osteoprorsis.[11]

MENTHOL CIGARETTES

Menthol is a chemical compound extracted from the peppermint or corn mint plant. It may also be created synthetically.[13] It was first added to cigarettes in the 1920's.[14] The natural anesthetic properties of menthol reduce the pain and irritation caused by harsh tobacco smoke. Hence, it makes it an appealing option to first time smokers. In 2014, menthol products comprised 30% of the tobacco market.[15] While they are advertised and perceived to be a safer alternative to traditional cigarettes, the FDA has found that menthol products are associated with an increased smoking initiation by youth and young adults, prolonged use, greater signs of nicotine dependence, and users are less likely to successfully quit smoking.[16]

CIGARS, CIGARILLOS, AND LITTLE CIGARS

Cigars are rolls of air-cured and fermented tobacco, wrapped in a tobacco leaf (or wrapped in a substance that contains tobacco). Cigars come in a variety of shapes and sizes. **Large cigars** are usually about seven or more inches long.[17] **Cigarillos** are larger than cigarettes and smaller than cigars. **Little cigars** are the smallest, usually about the size of a cigarette. Both cigarillos and little cigars are sold in sweet and fruity flavors.

Cigars can cause cancer of the oral cavity, larynx, esophagus and lungs. Even if the smoke is not inhaled deeply, a user's lips, mouth, tongue, throat and larynx are still exposed to the toxins in the product by way of the smoke or direct contact with the tobacco leaf wrapper. Cigar smokers also have an increased risk for developing heart disease and other types of lung disease.[17]

HOOKAH

Hookah is a form of water pipe that is widely used around the world. A flavored blend of tobacco, commonly known as shisha, is smoked in a hookah using ignited coal as a heat source. The primary components of hookah include: shisha, coal, water, hose and mouthpiece. Shisha is a sticky blend of tobacco and other ingredients such as spices, dried fruit, molasses, honey, and artificial flavors that is smoked using a hookah pipe. The coal heats the shisha to create smoke, while water in the hookah cools the smoke, making it more comfortable to inhale. A single waterpipe session lasts for 45-60 minutes. During this time, users are likely to take up to 200 puffs and inhale 100-200 times the volume of smoke inhaled by a single cigarette.[18, 19, 20]

There are many misconceptions about hookah being healthier and non-addictive compared to other tobacco products. Compared to smoking one cigarette, a single session of smoking a waterpipe is associated with:

- 1.7 times the nicotine
- 8.4 times the carbon monoxide
- 36 times the tar[18]

In addition to health consequences of smoking tobacco and exposure to secondhand smoke, the practice of sharing a mouthpiece while smoking hookah exposes users to communicable diseases such as colds, herpes, oral bacterial infections, and tuberculosis.[21]

SMOKELESS TOBACCO PRODUCTS

The words chew, spit, snuff, and dip are all common terms referring to smokeless tobacco products. The two basic forms of smokeless tobacco are chewing tobacco and snuff.

- **Chewing tobacco** consists of loose tobacco leaves that are placed between the cheek and gum, which allows nicotine to absorb through the lining of the mouth.
- **Snuff** is finely ground tobacco. Moist snuff is placed between the lower lip or cheek and gum.
- **Snus** is a type of moist snuff that is usually flavored and comes in small pouches. It is typically placed between the upper gum and lip. It is designed so that users do not have to spit.
- **Dry snuff** is in a powdered form and is sniffed or inhaled into the nose.

Smokeless tobacco contains higher levels of nicotine than cigarettes and the absorption of nicotine per dose is greater with the use of smokeless tobacco than cigarette smoking.[22] Similar to smoked tobacco products, smokeless tobacco contains harmful chemicals that can cause cancer, such as cancer of the mouth, esophagus and pancreas. Use of these products can also lead to many oral health conditions like tooth loss and decay, and gum disease. Smokeless tobacco use may also increase a person's risk for heart disease and stroke.[23]

ELECTRONIC SMOKING DEVICES

Electronic Smoking Devices, also referred to as e-cigarettes, are designed to mimic the use of a conventional cigarette. A battery powers a heater, or atomizer, that vaporizes a solution usually containing nicotine and flavor additives suspended in propylene glycol or glycerin. Many e-cigarettes are rechargeable and users purchase replacement cartridges or refill vials. Some resemble pens or other everyday items. Larger devices such as tank systems or "mods" bear little or no resemblance to cigarettes and allow the user to produce larger amounts of aerosol.

The aerosol produced by electronic smoking devices contain small particulate matter, cancer-causing toxins, and may contain nicotine.[24, 25] While e-cigarettes are commonly believed to help tobacco users quit their addiction, e-cigarettes have not been approved by the FDA as a device that can help people quit smoking or using other tobacco products.[26]

Section 2
Tobacco and the Military

History of Tobacco and the Military

Tobacco has a long history in the military. Much of this can be attributed to tobacco industry practices that have directly resulted in higher rates of tobacco use among service members and Veterans. The relationship between tobacco companies and the military dates back to World War I when cigarette smoking was promoted as a way for service members to escape the stresses of war.[27] Wartime promotion grew substantially as the industry targeted troops with free tobacco products, direct advertising, branded items, ways to communicate with family, and welcome home events.[28]

While DoD has increased efforts to decrease tobacco use by service members, prevalence rates continue to be high. The following information details factors that contribute to tobacco use in the military and with Veterans.

TOBACCO USE AND MILITARY CULTURE[29]

Despite the various restrictions on every day behaviors and activities that the military imposes on personal choices, such as hairstyle, weight standards, and uniform protocols, tobacco use is often regarded as an earned right for military personnel. This belief is widespread throughout the ranks and with policy leaders. There is the assertion that tobacco is a legal product, thus legality is equated with permissibility, despite existing military policies restricting otherwise legal activities and practices. Tobacco use is embedded in daily military life, as it is one of few reasons for sanctioned breaks. Military members have reported that smoke breaks facilitate camaraderie, and provide relief from stress and boredom, especially in deployed environments. Given the risks faced by military personnel, tobacco use is relatively an insignificant concern to military commanders, despite being fundamentally at odds with the health impact and readiness of service members.

LIMITED TOBACCO-FREE POLICIES AND INDUSTRY INTERFERENCE[30]

The military has implemented a number of tobacco control policies that address tobacco use and prevention, secondhand smoke, and tobacco sales. However, these policies are not effectively enforced and they are typically not a priority for military commanders.

Since 1985, DoD has had emerging evidence of the negative impacts of smoking on the health and readiness of military personnel as well as the economic burden of health care costs on the Department. In response to the alarming rates of tobacco use with military personnel, DoD implemented Directive 1010.10, which provided a baseline for tobacco control policies for all military branches.
As branches and installations began to implement the Directive and initiate stronger tobacco control measures, tobacco companies and their lobbyists applied pressure on pro-tobacco Congress members within the House and Senate Armed Services Committee and the Defense Appropriations Subcommittees. In their correspondence with decision makers, the tobacco industry invoked rhetoric about infringements on personal freedom and individuals' right to smoke. The industry's interference in DoD activities resulted in weakened military tobacco control efforts.

Attempts by military branches to deglamorize tobacco use and prohibit use on installations continue to be thwarted. Furthermore, implementation of the directive is devolved to individual base or unit commanders within each service. The lack of priority and understanding among senior leadership about the impact of tobacco use on readiness increases the barriers to effective tobacco-free policies.

ACCESS TO DISCOUNTED TOBACCO PRODUCTS[31, 32]

One of the most effective strategies for reducing tobacco use is price. There is a significant amount of scientific literature that has demonstrated tobacco use is impacted by cost; when tobacco excise taxes are increased, smokers quit at a higher rate and previous smokers are significantly less likely to restart. According to the DoD's Instruction 1330.09, which was approved in December 2005, "Prices of tobacco products sold in military resale outlets... shall be no higher than the most

> "Prices of tobacco products sold in military resale outlets... shall be no higher than the most competitive commercial price in the local community and no lower than 5 percent below the most competitive commercial price..."
>
> - DoD's Instruction 1330.09

competitive commercial price in the local community and no lower than 5 percent below the most competitive commercial price…"

Unfortunately, military retail outlets continue to sell tobacco products at heavily discounted prices. A longitudinal analysis of cigarette prices in military retail outlets found only 4.6% of exchanges had cigarette prices within 5% of Wal-Mart prices.

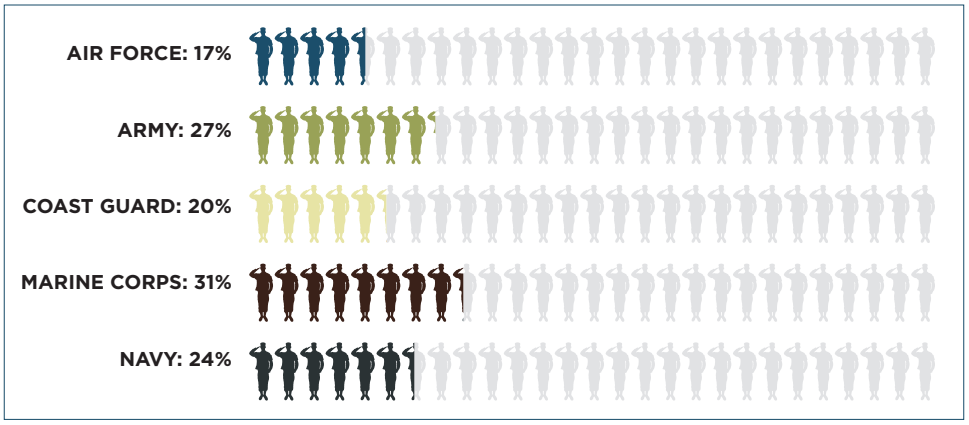
Active Duty Tobacco Use

In 2011, the DoD published a survey that reported nearly half of active duty service members (49.2%) used a nicotine product in the past 12 months. Current **cigarette smoking** among active duty military personnel was reported at 24% compared to 19% of civilians at that time. The same study found approximately one-fifth of all personnel smoked **cigars** (22.6%) or used **smokeless tobacco** (19.5%) in the past year.[33]

Active duty service members used a nicotine product in the past 12 months

MILITARY TOBACCO USE RATES BY BRANCH

Each branch of the military has different rates of tobacco use. The Marine Corps has the highest rate of smoking, followed by the Army, Navy and the Air Force with the lowest.[33]



WHY MILITARY PERSONNEL USE TOBACCO[33]

- Fosters social connections and sense of camaraderie
- Justification for taking breaks
- Cope with stress and boredom, particularly during deployment
- Helps them stay awake/alert
- Misconceptions of perceived harm from smokeless tobacco and e-cigarettes

Veteran Tobacco Use

Many Veterans started to use tobacco in the military or found it to be a place that made it easy for them to keep using tobacco.[34] As a result, similar to active duty military personnel, Veterans have a higher rate of tobacco use than the civilian population.

> **Current smokers reported higher prevalence of clinical depression, heavy alcohol use, respiratory disorders, and having a poor perception of overall health.**

According to a 2015 survey of VA enrollees, 1.4 million Veterans or 16.8% of the entire enrollee population reported current **cigarette smoking**.[35] A study of Veterans OEF/OIF Veterans found 32.5% of respondents reported current smoking, 24.8% were former smokers, and 42.7% were never smokers. Current smokers reported higher prevalence of clinical depression, heavy alcohol use, respiratory disorders, and having a poor perception of overall health. Veterans who were active duty had the highest rates of cigarette use (58.3%) compared to those who served in the reserves (20.1%) or National Guard (21.6%).[36]

CURRENT SMOKERS
32.5%

FORMER SMOKERS
24.8%

NON-SMOKERS
42.7%

Similar to cigarette smoking, **smokeless tobacco** prevalence among Veterans is higher than the civilian rate. Among OEF/OIF Veterans, lifetime and current use of smokeless tobacco use is highest among those living in rural communities.[37]

WHY VETERANS CONTINUE TOBACCO USE[6]

- Cope from stress during reintegration into civilian life
- Unaccustomed to unstructured daily lives after structured military life and, therefore, smoke to fill the time
- Environmental triggers, such as driving, eating, and drinking alcohol
- Being around friends and family who use tobacco
- Cope with anger and mental health issues
- Addiction

Section 3
Tobacco Treatment Basics

Quitting tobacco can be a challenging process, taking a person multiple attempts before they quit for good. There are evidence-based treatments to help a person quit. Tobacco dependence is considered a chronic disease and, like any other chronic conditions such as asthma, diabetes, or cardiovascular disease, demands the same long-term chronic care management approach.

In 2008, a set of guidelines were published by the U.S. Department of Health and Human Services called, *Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guideline*.[38] This Guideline will be referenced throughout this section as it provides the gold standard for tobacco cessation and education for healthcare providers and institutions. Since then, the DoD and the Veterans Health Administration (VHA) have adopted the evidence-based tobacco treatments into their clinical practices. Although treatment facilities have made progress in tobacco treatment and education, consistent implementation and engagement for cessation services for Veteran tobacco users are not optimal. The Guideline urges all healthcare providers and institutions to make tobacco cessation a priority, but unfortunately this is not the case for the military and Veteran communities. It is imperative that Veterans who are tobacco users are identified, advised to quit, and offered evidence-based treatments.

Each recommendation is labeled as easy, moderate, or advanced. The recommendations labeled as *easy* can be implemented with little to no cost and do not require a robust tobacco treatment program. Recommendations labeled as *moderate* and *advanced* may take more time and resources to implement; however, once put in place will strengthen an organization or clinic's tobacco treatment efforts.

10 Key Guideline Recommendations

1. *Have a system in place to ensure every patient is asked whether or not they use tobacco and their answer is documented. [Easy]*

2. *Medical providers should, at a minimum, use brief tobacco treatment interventions. [Easy]*

3. *Tell tobacco users about the California Smokers' Helpline (or other telephone support lines) to help them quit. [Easy]*

4. *Make sure patients and clinicians both have access to resources (brochures, pamphlets, a list of community services, medication information sheets, etc.) that will help Veterans quit tobacco. [Easy]*

5. *Medical providers should encourage tobacco users to quit by using both counseling AND medication (as medically appropriate). [Moderate]*

6. *Medical providers/healthcare professionals should use "motivational interviewing" to increase tobacco users' motivation to quit. [Moderate]*

7. *Provide trainings (e.g. lectures, workshops, in-services) that teach clinic staff about tobacco treatment and each person's responsibility to help Veterans quit.[Moderate]*

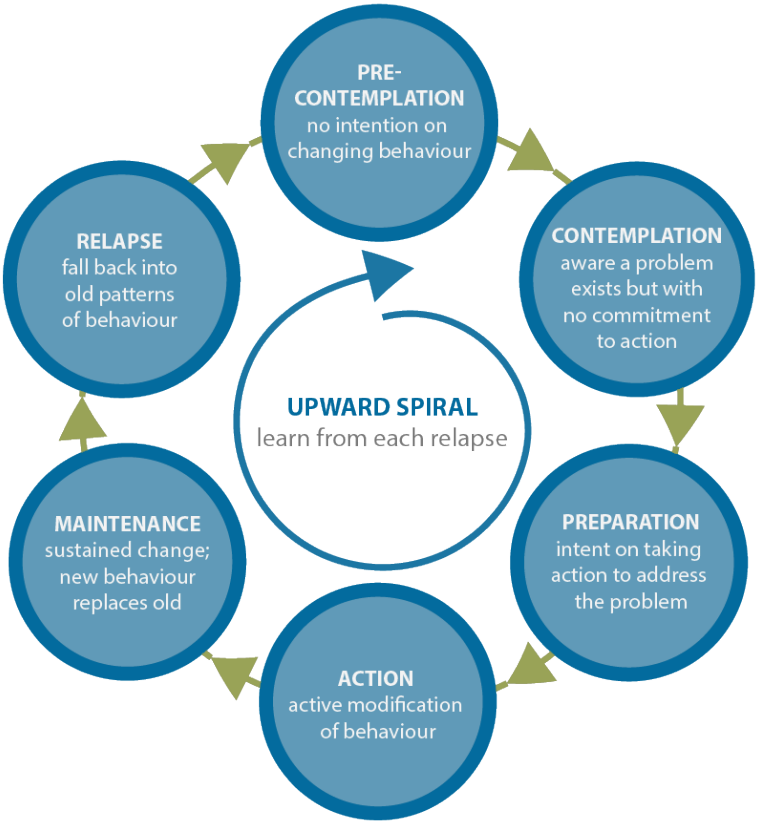
8. *Provide intensive counseling (multiple visits for longer periods of time) to Veterans, including individual (one-on-one), group and/or phone counseling. [Advanced]*

9. *Dedicate a staff member at your clinic to work on tobacco treatment. [Advanced]*

10. *Evaluate your tobacco treatment efforts and provide performance feedback to clinicians. [Advanced]*

Assessing Readiness to Quit

Once a Veteran has been identified as a tobacco user, it is important to know where they are in terms of readiness to change so that the approach and interventions will have to be adjusted accordingly. The Stages of Change Model is a known and researched model of the process of change. When the intervention matches the person's readiness to change, it is more likely to increase the Veteran's willingness to make a quit plan.



THE STAGES APPLIED TO TOBACCO CESSATION:

STAGE	DEFINITION	INTERVENTION
Pre-Contemplation	The individual is not considering quitting.	Educate/Inform
Contemplation	The individual has considered quitting and intends to do so within the next six months.	Encourage/Motivate
Preparation	The individual is actively considering quitting in the immediate future.	Assist with goal setting
Action	The individual had made or is making attempts to quit (< 6 months).	Provide support, assist as needed to overcome barriers
Maintenance	The individual has been tobacco free for longer than six months.	Continued support, set new goals when ready

The most important factor in tobacco treatment is engaging patients. Providing patients with information about the impact of tobacco use, assessing their level of motivation to quit, and helping them develop a quit plan are critical components of brief interventions (3-10 minutes).

Cultural Considerations

As previously noted, service members and Veterans have disproportionate rates of tobacco use compared to civilians. In addition to their service, active duty military and Veterans face other risk factors that compacts tobacco use, such as mental health issues and substance abuse. Having further knowledge about these unique risk factors will assist in providing effective and culturally appropriate tobacco treatment to Veterans.

TOBACCO USE AND MENTAL HEALTH CONDITIONS AFFECTING MILITARY COMMUNITIES[39, 41]

Tobacco use often co-occurs with mental health conditions. Individuals with a mental health disorder are at increased risk for cancer, lung disease, cardiovascular disease, and they die 25 years sooner than the general population. This critical health disparity compacts the already alarming rates within the Veteran community. Unfortunately, there continues to be a misconception that people with mental health conditions lack the desire or ability to quit their tobacco use. In addition, many providers only address the mental health symptoms, believing that quitting tobacco will exacerbate psychiatric symptoms. Any benefits from tobacco use for symptoms of mental illness (i.e. stress relief, concentration, alertness) are short-lived and are far outweighed by the harmful effects of tobacco. However, people with mental health disorders, including Veterans, want to quit and can successfully quit tobacco use.

> The rates of smoking in Veterans with PTSD are approximately double those of VA enrollees in general

Post-traumatic stress disorder (PTSD) is one of the most prevalent mental health conditions among Veterans. The rates of smoking in Veterans with PTSD are approximately double those of VA enrollees in general (53-66% vs. 30%, respectively). Veterans with combat-related PTSD tend to smoke more heavily compared with Veterans who smoke but do not have PTSD. In addition, tobacco users with PTSD have one of the lowest quit rates for 13 mental disorders. Tobacco users with PTSD report that smoking relieves anxiety and tension and can experience nicotine withdrawal symptoms in response to encounters with trauma-related stimuli.

TOBACCO USE AND PSYCHOTROPIC MEDICATIONS[42]

Because of the toxic nature of smoking, it can affect the amount of medication a person needs to manage symptoms. There are several psychotropic medications, including various antidepressant and antipsychotic medications that can have decreased effectiveness due to tobacco use. Since the liver recognizes tobacco smoke as a toxin, it increases metabolism to clear out the toxins, which subsequently induces drug-metabolizing enzymes. This creates a need for higher doses of medication to get the same therapeutic plasma concentration

levels; quitting smoking can result in an increase in blood levels of psychotropic medications, which can be fatal. Thus, it is important for the healthcare provider to be knowledgeable about all medications the Veteran is currently taking and to monitor them when quitting tobacco.

SUBSTANCE USE DISORDERS[43]

Few studies have been done on the prevalence of illicit drug use among OEF and OIF Veterans. However, one study of VA enrollees reported more than 11% of OEF and OIF Veterans had been diagnosed with a substance use disorder, inclusive of an alcohol use disorder, a drug use disorder, or both. Increased combat exposure among OIF Veterans has been linked to more frequent and greater levels of alcohol consumption compared to veterans with less combat exposure. Tobacco use is highly correlated with substance use disorders in which both interplay with cravings and behavioral and social indicators for use.

WHAT TOBACCO TREATMENT METHODS VETERANS PREFER[6]

In 2006, a study was done to look at tobacco use among Iraq- and Afghanistan-Era Veterans. Three focus groups were held among participants in North Carolina to explore issues on tobacco use and smoking cessation for Veterans who continued to smoke after their deployment. Focus group participants had several recommendations for improving programs to help them quit.

These included:

- A personalized approach. One size does not fit all and each person's individual needs must be considered.
- Free or reduced-cost nicotine replacement therapy and other smoking cessation medications were important. Veterans even suggested incentives to quit smoking, like gas, grocery coupons, or cash.
- Access to programs. Classes can be challenging when they are only offered during work hours or there is a long waiting list to enroll.
- Participants were interested in telephone quitlines but found them to be impersonal. An idea was suggested to also offer in-person counseling sessions.
- Some Veterans were interested in peer-to-peer support where they could talk with Veterans who have successfully quit tobacco.
- Veterans had interest in providing their family or members of their household with access to treatment.

Section 4
Putting Tobacco Treatment Recommendations into Practice

This section provides an in-depth overview of the 10 key tobacco treatment recommendations. While, this section will not cover everything you need to know, it should provide a good foundation and better understanding of each recommendation. Also included are implementation tips and tools (templates, scripts, charts) to assist with the creation, implementation, or strengthening of tobacco treatment programs for Veterans.

1

Have a system in place to ensure every patient is asked whether or not they use tobacco and their answer is documented. [Easy]

Before you can help a Veteran quit tobacco, you need to know if they use it. Not every Veteran will immediately provide this information. Often, they will have to be asked this question directly. It is very important to write down or log a person's answer. That way, anyone else that sees the patient will also have this information.

Many clinic staff members can ask this question, including doctors, nurses, medical assistants, or anyone who takes vital signs or helps patients with intake forms. Staff should understand the importance of asking this question and documenting the answer.

RECOMMENDATIONS:

- You will miss a lot of people if you just ask, "Do you smoke?" Remember, not all tobacco users are smokers. Instead, consider asking, "Do you smoke or use tobacco products?" "Do you use electronic cigarettes?"
- It is important to be specific. Veterans might not understand that tobacco means "smoking," "chew," or "e-cigarettes." List a few examples of tobacco products to make this clear.
- Add tobacco use as a vital sign.

2

Medical providers should, at a minimum, use brief tobacco treatment interventions. [Easy]

Brief interventions are ways to help a person quit using tobacco that usually take less than 10 minutes. They are rather simple to learn, don't take up too much time, and are a great starting point if you are new to tobacco treatment. The most commonly used brief interventions are the 5 A's and the AAR method (see Helpful Tools). Medical providers can make a difference even when they spend **less than three minutes** talking with a patient about quitting tobacco.

Veterans can be motivated to quit when a medical provider advises them to stop using tobacco. Even if they are not willing to make a quit attempt, medical providers can help to increase motivation and the chances they will quit in the future. There is growing evidence that smokers who receive advice and help with quitting from their medical provider will have greater satisfaction with their health care than those who do not.

All medical providers (e.g. medical assistants, nurses, clinicians, etc.) should, at a minimum, use brief interventions. Non-medical staff could also use brief interventions. Staff using brief interventions should receive proper training.

HELPFUL TOOLS

THE "5 A'S" MODEL FOR TREATING TOBACCO USE AND DEPENDENCE[38]

ASK ABOUT TOBACCO USE.

- Identify and document tobacco use status for every patient at every visit.
    - *"Do you use tobacco?"*
- Ask about more than just cigarettes.
    - *"Do you use hookah, snus, e-cigarettes, or other tobacco products?"*
    - *"Do you currently, or have you ever used tobacco on a daily or occasional basis?"*

Advise to quit

- In a clear, strong, and personalized manner, urge every tobacco user to quit.
    - *"As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you."*
    - *"Continuing to smoke makes your asthma worse, and quitting will help improve your health."*

Assess willingness to make a quit attempt

- Is the tobacco user willing to make a quit attempt at this time?
    - *"Sounds like you have tried to quit before. Can we talk about what worked and what didn't work and use that for another quit attempt?"*

Assist in quit attempt

For the patient willing to make a quit attempt, offer medication (as medically appropriate) and provide or refer for counseling or additional treatment to help the patient quit. This includes providing educational materials and quitline information.

- Help the patient make a quit plan. A patient's preparations for quitting includes the STAR method:
    - **S**et a quit date. Ideally, the quit date should be within 2 weeks.
    - **T**ell family, friends, and coworkers about quitting, and request understanding and support.
    - **A**nticipate challenges to the upcoming quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms.
    - **R**emove tobacco products from your environment. Prior to quitting, avoid using tobacco in places where you spend a lot of time (e.g., work, home, car). Make your home tobacco-free.
- *"Let's talk about some options for quitting. I would like to help you with this, if that's okay."*
- This is also a good time to use practical counseling (problem solving/skills training) and social support.
- For patients unwilling to quit at the time, provide interventions designed to increase future quit attempts, such as motivational interviewing.

Arrange a follow up

- For the patient willing to make a quit attempt, arrange for follow-up contacts, beginning within the first week after the quit date. A second follow-up contact is recommended within the first month. Schedule further follow-up contacts as indicated.
    - *"I would like to see how you're feeling after you quit, can we schedule an appointment for next week?"*
- Actions during follow-up contact:
    - For all patients, identify problems already encountered and anticipate challenges in the immediate future.
    - Assess medication use and problems.
    - Remind patients of quitline support (1-800-NO-BUTTS).
    - Address tobacco use at next clinical visit (treat tobacco use as a chronic disease).
    - For patients who are abstinent, congratulate them on their success.
    - If tobacco use has occurred, review circumstances and elicit recommitment to total abstinence. Consider use of or referral to more intensive treatment.
- For patients unwilling to make a quit attempt at the time, address tobacco dependence and willingness to quit at next clinic visit.

THE AAR MODEL (ASK, ADVISE, REFER)[38]

A sample script is below:

Ask about tobacco at every visit.

"Do you use tobacco?"

Advise those who use tobacco to quit.

"*The best thing you can do for your health is to quit."*

Refer tobacco users to the California Smokers' Helpline (1-800-NO-BUTTS)

"The Helpline can help you with a plan to quit smoking/using tobacco. It's free and can double your chances of quitting."

3

Tell tobacco users about the California Smokers' Helpline (or other telephone support lines) to help them quit. [Easy]

Quitlines provide telephone counseling to help tobacco users quit. They can double a person's chance of quitting compared to not getting any support at all.[44] A person greatly increases their chances of quitting when they use a quitline AND use tobacco cessation medication. Quitlines are very helpful for rural Veterans or Veterans who are not able to easily get to in-person services.

The California Smokers' Helpline (1-800-NO-BUTTS) is available to anyone living in California. They help people quit any form of tobacco, not just cigarettes. Some callers may be eligible for free nicotine patches. In addition to the California Smokers' Helpline, there is also a national quitline available just for Veterans, 1-855-QUIT-VET (1-855-784-8838).[44]

RECOMMENDATIONS

- Visit the Helpline's online catalog to learn more or to order free materials: www.nobutts-catalog.org.
- Place Helpline materials around your clinic to inform Veterans of this resource.
- Make sure all staff know about the Helpline and feel confident telling Veterans about it and handing them materials.
- Referrals. The Helpline has several ways providers can refer patients to the Helpline. Read more here: http://www.nobutts.org/helpline-referral-options.

HELPFUL TOOLS

SAMPLE SCRIPT

You might see someone smoking outside your clinic; holding a can of chew; or talking about his or her need for a cigarette. These are great opportunities to let them know about the Helpline. Consider using the following script to start your conversation:

> *"I noticed you use tobacco. Quitting is the best thing you can do for your health. Have you heard about the California Smokers' Helpline?"*
>
> *"The California Smokers' Helpline is a free quitline where you can talk to a counselor on the phone about quitting tobacco. They can help you make a quit plan and provide support along the way. Their number is 1-800-NO-BUTTS. Would you like me to get you a brochure?"*

4

Make sure patients and clinicians both have access to resources (brochures, pamphlets, a list of community services, medication information sheets, etc.) that will help Veterans quit tobacco. [Easy]

There are different ways to help Veterans quit using tobacco and it is a good idea to advertise evidence-based approaches through your proram or in your clinic. Having resources available can be a constant reminder of quitting tobacco, for both patients and staff.

Anyone in a clinic can tell tobacco users about available resources. Materials should be easy for patients to find. While placing materials for Veterans to take on their own is helpful, there can be an even greater impact when a medical provider hands these materials to Veterans.

Materials should also be available specifically for medical providers so they can learn more about evidence-based tobacco treatment recommendations and how to help Veterans quit.

Place materials all around your office or clinic—in the waiting room, clinician's workstations, exam room, on bulletin boards, etc. Exam rooms are a great place to have materials since it will increase the chance a medical provider will hand a material to a patient. Medication information sheets are especially helpful to have in exam rooms.

Consider placing materials specific for clinic staff in break rooms or disseminating this information via email.

RECOMMENDATIONS

- Make sure all clinic staff are familiar with different tobacco treatment resources (local, state and national). At a minimum, staff should know where to find a list of resources they can give to Veterans.
    - Many local health departments have their own list of community tobacco cessation resources. Find your County's list here to print out: http://www.nobutts.org/county-listing. Your local health department may also be able to provide free brochures, pamphlets and quit kits (small bags/boxes of items to help people quit).
- Encourage medical providers to use these materials when talking to Veterans about quitting tobacco.
- Make sure materials are culturally/racially/educationally/age-appropriate for the patient.

HELPFUL TOOLS

SAMPLE RESOURCE SHEET

Create a list of resources tailored to your clinic, using the template below. Consider printing this out or emailing it to all staff. It can serve as an easy way to remember tobacco treatment resources.

Tobacco Treatment Resources

QUITTING TOBACCO IS THE BEST THING A PERSON CAN DO FOR THEIR HEALTH!

Clinic Tobacco Treatment Coordinator: _____

Phone: _____

Email: _____

QUITLINES:

- California Smokers' Helpline: 1-800-NO-BUTTS
- California Tobacco Chewers' Helpline: 1-800-844-CHEW
- Quit VET: 1-855-QUIT-VET

ONLINE RESOURCES:

Quit Tobacco—Make Everyone Proud: www.ucanquit2.org

National Cancer Institute: www.smokefree.gov/veterans/

California Smokers' Helpline: www.nobutts.org

LOCAL RESOURCES:

_____

_____

_____

_____

5

Medical providers should encourage tobacco users to quit by using both counseling AND medication (as medically appropriate). [Moderate]

Tobacco cessation medications help reduce a person's feelings of withdrawal and their cravings for tobacco. But, they do not completely take away the urge to smoke. This is important as many people think they are a quick fix or solution to quit smoking.

When counseling and medication are used together, they are more helpful than either used alone. For this reason, medical providers should encourage all Veterans making a quit attempt to use both counseling and medication (as medically appropriate).

Only someone with the proper training and qualifications should talk to a patient about medications. This is best done by a medical provider, a pharmacist or a tobacco treatment counselor who is trained on how to educate patients about medications. A patient should always talk with their doctor and pharmacist before starting a new medication.

RECOMMENDATIONS

- Medical staff who do not feel confident prescribing smoking cessation medications should seek additional training or continuing education. This would be a good example of a training to arrange for medical staff.
- Keep medication information sheets available in exam rooms for providers and patients to discuss.
- Medications should always be discussed with a clinician and pharmacist and used as directed.
- Clinicians should encourage the use of smoking cessation medications by all patients attempting to quit smoking, except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness such as with pregnant women, smokeless tobacco users, light smokers and adolescents.
- Clinicians should also consider the use of certain combinations of medications identified as effective in the Guideline.

Clinical Use Guidelines for all Pharmacotherapies Approved by the FDA for Tobacco Cessation

	Availability	Precautions/ Contraindications	Common Side Effects*	Dosage	Duration	Absorption Rate
Nicotine Gum	**Over the counter as:** Nicorette Nicorelief Thrive Generic		Mouth soreness Dyspepsia Hiccups	**4mg** - use if they smoke 1st cigarette within 30 mins of waking **2mg** - use if they smoke 1st cigarette after 30 mins of waking – Use for up to 30 mins	Up to 12 weeks Weeks 1-6 - 1 every 1-2 hrs Weeks 7-9 - 1 every 2-4 hrs Weeks 10-12 - 1 every 4-8 hrs	Highest levels at 30-60 mins
Nicotine Inhaler	**Prescription only as:** Nicotrol inhaler		Local irritation of mouth/throat	**10 mg cartridges** (4 mg delivered) Use 6-16 cartridges/day or 1 every 1-2 hrs – Puff cartridge for up to 20 mins	Up to 12 weeks	Highest levels at 30 mins
Nicotine Lozenge	**Over the counter as:** Commit lozenge Equate Nicorette Generic		Mouth/throat soreness Dyspepsia	**4mg** - use if they smoke 1st cigarette within 30 mins of waking **2mg** - use if they smoke 1st cigarette after 30 mins of waking	Up to 12 weeks Weeks 1-6 - 1 every 1-2 hrs Weeks 7-9 - 1 every 2-4 hrs Weeks 10-12 - 1 every 4-8 hrs	Highest levels at 30-60 mins
Nicotine Nasal Spray	**Prescription only as:** Nicotrol NS	Asthma Chronic nasal disorders Severe reactive airway disease	Nasal irritation Throat irritation Rhinitis Change in taste/smell	1 dose = 1 spray in each nostril (1mg) 1-2 doses/hr *Not to exceed 5 doses/hr or 40 doses/day	12 weeks *Not to exceed 6 months	Highest levels at 10-15 mins
Nicotine Patch	**Over the counter as:** Equate Habitrol NicoDerm CQ Generic		Local skin irritation Insomnia Vivid dreams	21 mg 14 mg 7 mg – Change every 24 hours	8-10 weeks **If 10+ cigarettes/day:** Weeks 1-6 - 21 mg Weeks 7-8 - 14 mg Weeks 9-10 - 7 mg **If <10 cigarettes/day:** Weeks 1-6 - 14 mg Weeks 7-8 - 7 mg	Highest levels at 3-12 hours
Bupropion SR**	**Prescription only as:** Zyban Generic Wellbutrin (depression)	History of seizure History of eating disorder Bipolar disorder MAOI within 2 weeks	Insomnia Dry mouth Agitation Nausea Dizziness Headache	150 mg every morning for 3 days, then 150 mg twice daily for 6-12 weeks – Begin treatment 1-2 weeks pre-quit	7-12 weeks *Maintenance up to 6 months possible	N/A
Varenicline**	**Prescription only as:** Chantix	Psychiatric illness Kidney disease Cardiac problems Individuals who drive/ operate machinery Some medications*	Nausea Headache Insomnia Abnormal dreams Constipation Flatulence	0.5 mg a day for 3 days, then 0.5 mg twice daily for 4 days, then 1 mg twice daily for 11 weeks – Begin treatment 1 week pre-quit	12 weeks *Additional 12 week course possible	N/A

*Consult full prescribing information. **Patients should stop taking varenicline or bupropion SR and contact a health care provider immediately if they experience agitation, depressed mood, and any changes in behavior that are not typical of nicotine withdrawal, or they experience suicidal thoughts or behavior.

Behavioral Health & Wellness Program, University of Colorado Anschutz Medical Campus, School of Medicine. (2017). Clinical Use Guidelines for all Pharmacotherapies Approved by the FDA for Tobacco Cessation. Retrieved from www.bhwellness.org/resources/fact-sheets-reports.

6

Medical providers/healthcare professionals should use "motivational interviewing" to increase tobacco users' motivation to quit. [Moderate]

Motivational interviewing (MI) is a counseling method that can help increase a person's motivation to quit tobacco. It is especially helpful to use with Veterans who are unwilling or unsure about quitting. Research shows that MI is helpful in increasing future quit attempts.

MI explores a tobacco user's feelings, beliefs, ideas and values about their tobacco use. The goal is to empower Veterans to make the argument for change themselves. Research shows that it is more powerful for patients to use their own words about quitting than for someone else to tell them.

RECOMENDATIONS

- Read more about MI: http://www.motivationalinterviewing.org
- Identify staff interested in learning MI skills
- Plan a training for staff on MI skills
    - Find an MI training at www.motivationalinterviewing.org/motivational-interviewing-training
- Learn about MI strategies and the 5 R's (see below).
- Find ways to practice MI skills

HELPFUL TOOLS

MOTIVATIONAL INTERVIEWING STRATEGIES[38]

Express empathy, Develop discrepancy, Roll with resistance, Support self-efficacy

EXPRESS EMPATHY

- Use open-ended questions to explore the importance of addressing smoking or other tobacco use.
    - *"How important do you think it is for you to quit smoking?"*
- Use open-ended questions to identify concerns and benefits of quitting.
    - *"What might happen if you quit?"*

- Use reflective listening to seek shared understanding. Reflect words or meaning.
    - *"So you think smoking helps you to maintain your weight."*
- Summarize.
    - *"What I have heard so far is that smoking is something you enjoy. On the other hand, your boyfriend hates your smoking, and you are worried you might develop a serious disease."*
- Normalize feelings and concerns.
    - *"Many people worry about managing without cigarettes."*
- Support the patient's autonomy and right to choose or reject change.
    - *"I hear you saying you are not ready to quit smoking right now. I'm here to help you when you are ready."*

DEVELOP DISCREPANCY

- Highlight the discrepancy between the patient's present behavior and expressed priorities, values, and goals.
    - *"It sounds like you are very devoted to your family. How do you think your smoking is affecting your children?"*
- Reinforce and support "change talk" and "commitment" language.
    - *"So, you realize how smoking is affecting your breathing and making it hard to keep up with your kids."*
    - *"It's great that you are going to quit when you get through this busy time at work."*
- Build and deepen commitment to change.
    - *"There are effective treatments that will ease the pain of quitting, including counseling and many medication options."*
    - *"We would like to help you avoid a stroke like the one your father had."*

ROLL WITH RESISTANCE

- Back off and use reflection when the patient expresses resistance.
    - *"Sounds like you are feeling pressured about your smoking."*
- Express empathy.
    - *"You are worried about how you would manage withdrawal symptoms."*
- Ask permission to provide information.
    - *"Would you like to hear about some strategies that can help you address that concern when you quit?"*

SUPPORT SELF-EFFICACY

- Help the patient to identify and build on past successes:
    - *"So you were fairly successful the last time you tried to quit."*
- Offer options for achievable small steps toward change:
    - Call the Quitline (1-800-NO-BUTTS) for advice and information.
    - Read about quitting benefits and strategies.
    - Change smoking patterns (e.g., no smoking in the home).
    - Ask the patient to share his or her ideas about quitting strategies.

ENHANCING MOTIVATION TO QUIT TOBACCO—THE "5 R'S"[38]

Relevance, Risks, Rewards, Roadblocks and Repetition

Relevance

Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

Risks

The clinician should ask the patient to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks. Examples of risks are:

- Acute risks: Shortness of breath, exacerbation of asthma, increased risk of respiratory infections, harm to pregnancy, impotence, and infertility.
- Long-term risks: Heart attacks and strokes, lung and other cancers (e.g., larynx, oral cavity, pharynx, esophagus, pancreas, stomach, kidney, bladder, cervix, and acute myelocytic leukemia), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), osteoporosis, long-term disability, and need for extended care.
- Environmental risks: Increased risk of lung cancer and heart disease in spouses; increased risk for low birth-weight, sudden infant death syndrome (SIDS), asthma, middle ear disease, and respiratory infections in children of smokers.

Rewards

The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient.

Examples of rewards:

- Improved health
- Food will taste better
- Improved sense of smell
- Saving money
- Feeling better about oneself
- Home, car, clothing, breath will smell better
- Setting a good example for children and decreasing the likelihood that they will smoke
- Having healthier babies and children
- Feeling better physically
- Performing better in physical activities
- Improved appearance, including reduced wrinkling/aging of skin and whiter teeth

Roadblocks

The clinician should ask the patient to identify barriers or impediments to quitting and provide treatment (problem solving counseling, medication) that could address barriers.

Typical barriers might include:

- Withdrawal symptoms
- Fear of failure
- Weight gain
- Lack of support
- Depression
- Enjoyment of tobacco
- Being around other tobacco users
- Limited knowledge of effective treatment options

Repetition

The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

7

Provide trainings (e.g. lectures, workshops, in-services) that teach clinic staff about tobacco treatment and each person's responsibility to help Veterans quit.[Moderate]

Training medical providers on tobacco treatment increases the chance they will assist Veterans in quitting tobacco. Training medical providers AND making changes throughout your clinic (e.g. adding tobacco use as a vital signs question) is especially helpful in reminding medical providers to treat tobacco.

Trainings are useful for any clinic staff member, both medical providers and non-medical providers. Someone skilled and qualified in the training topic should provide the trainings.

Trainings should be held on a regular basis to ensure all staff remain up-to-date on tobacco cessation. It is important to pick a time of day that works best for your staff.

RECOMENDATIONS

- Provide training at your facility. Trainings held at your office or clinic can work well since staff will not need to travel.
- Identify and share online trainings. Live and recorded webinar on tobacco treatment are often available at no cost.
- Look into local trainings provided by organizations like the American Cancer Society, your Local Health Department or the American Lung Association.
- CYAN's Project UNIFORM can provide free trainings, both in-person and online to health professionals in California.

HELPFUL RESOURCES

CYAN PROJECT UNIFORM

Project UNIFORM offers a variety of trainings including subject-matter topics such as an overview of tobacco products, the impact tobacco use has on military community members, and nicotine addiction as well as skill-based trainings such developing tobacco treatment programs, training individuals to do brief interventions.

www.projectuniform.org

THE CENTER FOR TOBACCO CESSATION (CTC)

CTC helps organizations throughout California to increase their capacity in tobacco cessation. CTC offers free trainings and webinars on topics ranging from the basics of tobacco cessation, to pharmacotherapy, to treatment considerations for special populations, and more. They can also customize trainings.

http://www.nobutts.org/free-training

SMOKING CESSATION LEADERSHIP CENTER (SCLC)

SCLC's webinar series is integral to the technical assistance provided by the SCLC. Nationally recognized tobacco cessation experts offer the latest information related to tobacco treatment (including effective interventions) for the general and the behavioral health populations. Some webinars are available for CME/CE credit.

http://smokingcessationleadership.ucsf.edu/webinars

8

Provide intensive counseling (multiple visits for longer periods of time) to Veterans, including individual (one-on-one), group and/or phone counseling. [Advanced]

Unlike brief counseling sessions that are often less than 10 minutes and may only happen once, intensive counseling is longer and happens over many visits. Research shows that intensive counseling is more likely to help someone quit than brief counseling.

Someone with special training and expertise in tobacco cessation should provide intensive counseling. This might be a clinician with continuing education coursework; a health educator who completed the American Lung Association's Freedom From Smoking Training; or a nurse who became a Certified Tobacco Treatment Specialist.

Whoever it is, this person should have the skills, knowledge and training to help Veterans quit tobacco using evidence-based practices. It is important to think about using different types of medical providers, as this can increase a Veteran's chance of quitting. For example, one medical provider might talk to a patient about medications and a different provider might follow up to help the patient create a quit plan.

Individual, group, and telephone counseling are all types of intensive counseling.

Individual Counseling

- In one-on-one counseling, a person trained in tobacco cessation provides in-person counseling sessions to help a tobacco user quit. Counseling sessions are tailored to the individual to help them work on specific issues.

Group Counseling

- In group counseling, a person trained in tobacco cessation leads group sessions on quitting tobacco. In this setting, Veterans can share their experiences with others and gain peer support and guidance.
- There are different types of group programs. It is important to choose an evidence-based curriculum that will work for your clinic. An example of a Veteran's group session is found on page 67 of the VA's "Primary Care & Tobacco Cessation Handbook: A Resource for Providers" available here: http://www.publichealth.va.gov/smoking/professionals/tools-publications.asp
- Some training programs will teach you to use their curriculum. Keep this in mind to make sure the curriculum is evidence-based and appropriate for Veterans.

Phone Counseling

- Counseling provided over the phone may also be something to consider, especially if your clinic already conducts follow-up calls with patients or provides health education services over the phone. While, this is certainly an option, don't forget about pre-existing services already available such as the California Smokers' Helpline (1-800-NO-BUTTS).

RECOMMENDATIONS

- Identify clinic staff who are interested in learning more about tobacco treatment. This could be a medical provider, like a doctor or nurse, or a non-medical provider, like a Health Educator or Community Health Worker.
- Advance knowledge and skills. Anyone interested in getting more involved with tobacco cessation should want to learn more and improve their skills. Find a training program to become a Certified Tobacco Treatment Specialist: http://ctttp.org
- Understand relapse and how to address factors contributing to relapse.
    - Smokers who have recently quit face a high risk of relapse.
    - Although most relapse occurs early in the quitting process, some relapse occurs months or even years after the quit date.
    - Don't treat relapse as a failure. It was an attempt to quit and puts a person one step closer to quitting for good. Veterans should be encouraged to make another plan to quit using lessons learned from their relapse.

HELPFUL TOOLS

The following are approaches that can be used when providing counseling to individuals quitting tobacco.

PRACTICAL COUNSELING (PROBLEM SOLVING/SKILLS TRAINING)[38]

Recognize danger situations – Identify events, internal states, or activities that increase the risk of tobacco use or relapse.

- Negative affect and stress
- Being around other tobacco users
- Drinking alcohol
- Experiencing urges
- Smoking cues and availability of cigarettes and other tobacco products

Develop coping skills – Identify and practice coping or problem solving skills. Typically, these skills are intended to cope with trigger situations.

- Learning to anticipate and avoid temptation and trigger situations
- Learning cognitive strategies that will reduce negative moods
- Accomplishing lifestyle changes that reduce stress, improve quality of life, and reduce exposure to smoking cues
- Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention; changing routines)

Provide basic information – Provide basic information about tobacco and successful quitting.

- The fact that any smoking (even a single puff) or tobacco use increases the likelihood of a full relapse
- Withdrawal symptoms typically peak within 2 weeks after quitting but may persist for months. These symptoms include negative mood, urges to smoke, and difficulty concentrating.
- The addictive nature of tobacco and nicotine

Encourage the patient in the quit attempt.

- Note that effective tobacco dependence treatments are now available.
- Note that one-half of all people who have ever smoked have now quit.
- Communicate belief in patient's ability to quit.

Communicate caring and concern.

- Ask how patient feels about quitting.
- Directly express concern and willingness to help as often as needed.
- Ask about the patient's fears and ambivalence regarding quitting.

Encourage the patient to talk about the quitting process. Ask about:

- Reasons the patient wants to quit.
- Concerns or worries about quitting.
- Success the patient has achieved.
- Difficulties encountered while quitting.

Intervening with the patient who has recently quit

The former tobacco user should receive congratulations on any success and strong encouragement to remain abstinent.

When encountering a recent quitter, use open-ended questions relevant to the topics below to discover if the patient wishes to discuss issues related to quitting:

- The benefits, including potential health benefits, the patient may derive from cessation
- Any success the patient has had in quitting (duration of abstinence, reduction in withdrawal, etc.)
- The problems encountered or anticipated threats to maintaining abstinence (e.g., depression, weight gain, alcohol, other tobacco users in the household, significant stressors)
- A medication check-in, including effectiveness and side effects if the patient is still taking medication

ADDRESSING PROBLEMS ENCOUNTERED BY FORMER SMOKERS[38]

A patient who previously smoked might identify a problem that negatively affects health or quality of life. Specific problems likely to be reported by former smokers and potential responses follow:

Lack of support for cessation

- Schedule follow-up visits or telephone calls with the patient.
- Urge the patient to call the California Smokers' Helpline (1-800-NO- BUTTS).
- Help the patient identify sources of support within his or her environment.
- Refer the patient to an appropriate organization that offers counseling or support.

Negative mood or depression

- If significant, provide counseling, prescribe appropriate medication, or refer the patient to a specialist.

Strong or prolonged withdrawal symptoms

- If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved medication or adding/combining medications to reduce strong withdrawal symptoms.

Weight gain

- Recommend starting or increasing physical activity.
- Reassure the patient that some weight gain after quitting is common and usually is self-limiting.
- Emphasize the health benefits of quitting relative to the health risks of modest weight gain.
- Emphasize the importance of a healthy diet and active lifestyle.
- Suggest low-calorie substitutes such as sugarless chewing gum, vegetables, or mints.
- Maintain the patient on medication known to delay weight gain (e.g., bupropion SR, NRTs—particularly 4-mg nicotine gum— and lozenge.)
- Refer the patient to a nutritional counselor or program.

Smoking lapses

- Suggest continued use of medications, which can reduce the likelihood that a lapse will lead to a full relapse.
- Encourage another quit attempt or a recommitment to total abstinence.
- Reassure that quitting may take multiple attempts, and use the lapse as a learning experience.
- Provide or refer for intensive counseling.

9

Dedicate a staff member at your clinic to work on tobacco treatment. [Advanced]

Identify a person within your organization or clinic who can serve as the lead tobacco treatment expert. This individual needs to be familiar with (or wants to learn) evidence-based ways to help Veterans quit tobacco and have the skills, knowledge and training to provide tobacco cessation. If a current staff member does not have the capacity to take on tobacco treatment, consider potential new hires and if tobacco cessation could be included in job descriptions.

The lead tobacco treatment person may be responsible for all tobacco prevention, education, and cessation at your clinic or agency. They can also be a liaison between your clinic and community organizations that provide cessation services. The more connected this person is with local resources, the more options they can provide to Veterans interested in quitting tobacco. If it is too difficult to find just one person, consider splitting up the tasks. For example, a medical provider might play more of a role in providing treatment, while a non-medical provider may be more involved in planning and organizing trainings.

Questions to ask yourself before recruiting someone:

- Can you afford to hire someone new?
- Should you look for an unpaid volunteer or intern?
- Can this task be added to someone's current job / role in the clinic?
- Do you need a team or task force of individuals to focus on tobacco treatment? (If taking a team approach, assigning a leader or chairperson is highly recommended).

Questions to ask yourself when looking for the right person(s):

- Do they have the right skills, knowledge and qualifications?
- Do they have enough time to devote to this?
- Are they committed to making tobacco cessation a priority?
- Are they willing to learn more and attend trainings?

Determine what this person(s)' role will be. Below are some examples of what this person could do:

- Plan trainings for clinic staff
- Make sure clinic staff feel comfortable and confident in helping Veterans quit tobacco

- Provide tobacco cessation counseling to Veterans (individual and group)
- Implement a clinic-wide system to identify every Veteran who uses tobacco
- Make sure all patients and staff have access to evidence-based tobacco treatments
- Schedule follow-up visits with tobacco users
- Let each clinic staff member know his or her responsibilities when it comes to helping Veterans quit tobacco
- Monitor the program and conduct performance evaluations with clinic staff

Determine what type of additional training this person needs.

- Do you have the budget for this person to become a Certified Tobacco Treatment Specialist? Are there gaps in knowledge or skills this person needs to work on?
- This person should always look for ways to keep learning and improving their skills.

Evaluate your tobacco treatment efforts and provide performance feedback to clinicians. [Advanced]

It is incredibly important to provide performance feedback to individuals and seek ways to continually improve your tobacco treatment program. This can be achieved by evaluating your tobacco cessation efforts. This can help you answer questions such as:

- Are we implementing activities as planned?
- Do staff adhere to tobacco treatment responsibilities?
- To what degree do providers identify, document and treat Veterans who use tobacco?
- What effect has our tobacco cessation program had on tobacco use rates in our clinic?

This information can be used to improve your program and to provide performance feedback to clinicians and other providers to are interacting with Veterans. This task is best suited for someone with knowledge and experience in program evaluation and /or performance feedback. This might be your site's tobacco treatment coordinator, a health educator, administrator or perhaps an external, outside party. This person should also have the authority to provide performance evaluations and to access necessary clinic records and systems.

The frequency of evaluation is ultimately up to each clinic. Depending on what you are measuring, you may decide to collect data yearly, quarterly, monthly, weekly, and/or daily to assess your program.

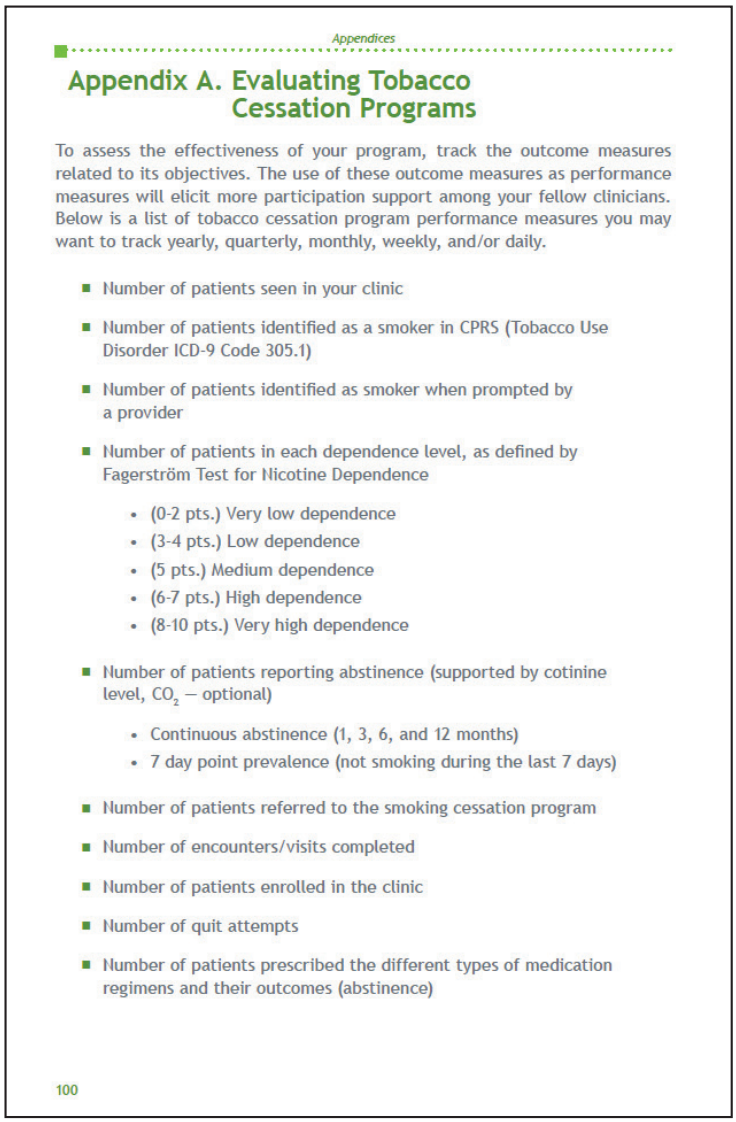
RECOMMENDATIONS

- You can use data from chart audits, electronic medical records, and computerized patient databases to evaluate the degree to which clinicians are identifying, documenting, and treating Veterans who use tobacco.
- Identify someone who will take lead on program evaluation and performance evaluations.
- Determine in advance what you plan to learn from this process, including key questions you hope to answer.
- Learn more about evaluation methods, protocols and best practices. Seek training as needed.

HELPFUL TOOLS

TOBACCO CESSATION PROGRAM PERFORMANCE MEASURES

The VA's Primary Care and Tobacco Cessation Handbook includes a suggested performance measures resource to evaluate tobacco treatment programs. The evaluation tool can be found on page 100 of the Handbook which is available at: www.publichealth.va.gov/smoking/professionals/tools-publications.asp



Appendices

Appendix A. Evaluating Tobacco Cessation Programs

To assess the effectiveness of your program, track the outcome measures related to its objectives. The use of these outcome measures as performance measures will elicit more participation support among your fellow clinicians. Below is a list of tobacco cessation program performance measures you may want to track yearly, quarterly, monthly, weekly, and/or daily.

- Number of patients seen in your clinic
- Number of patients identified as a smoker in CPRS (Tobacco Use Disorder ICD-9 Code 305.1)
- Number of patients identified as smoker when prompted by a provider
- Number of patients in each dependence level, as defined by Fagerström Test for Nicotine Dependence
  - (0-2 pts.) Very low dependence
  - (3-4 pts.) Low dependence
  - (5 pts.) Medium dependence
  - (6-7 pts.) High dependence
  - (8-10 pts.) Very high dependence
- Number of patients reporting abstinence (supported by cotinine level, CO_2 – optional)
  - Continuous abstinence (1, 3, 6, and 12 months)
  - 7 day point prevalence (not smoking during the last 7 days)
- Number of patients referred to the smoking cessation program
- Number of encounters/visits completed
- Number of patients enrolled in the clinic
- Number of quit attempts
- Number of patients prescribed the different types of medication regimens and their outcomes (abstinence)

100

Section 5

Creating and Strengthening Tobacco Treatment Programs for Veterans

This section consists of an assessment and discussion that will assist your program or clinic in understanding its capacity to address and treat the problem of tobacco. The information in this section provides an opportunity to consider what your facility does well, what it can improve on, and opportunities for creating or strengthening a tobacco treatment program for Veterans.

Assessment[38]

How does your facility currently address tobacco use with patients?

	Check One		
	YES	NO	UNSURE
Does your clinic have a system in place for asking every patient whether or not they use tobacco and documenting their answer?			
Do medical providers use brief tobacco cessation interventions (e.g. 5 A's; Ask, Advise, Refer)?			
Does your clinic tell tobacco users about the California Smokers' Helpline (1-800-NO-BUTTS) or other telephone quitlines as a way to quit?			
Does your clinic provide resources for both patients and clinicians (brochures, pamphlets, a list of quitting resources, medication information sheets, etc.) to help Veterans quit tobacco?			
Do medical providers encourage all tobacco users to use both counseling AND medication (as medically appropriate) to help them quit?			
Do medical providers/healthcare professionals use "motivational interviewing" to increase tobacco users' motivation to quit?			
Does your clinic have trainings (e.g., lectures, workshops, in-services) that teach staff about tobacco cessation and each person's responsibility to help Veterans quit?			
Does your clinic offer individual (one-on-one), group, and/or phone counseling to help Veterans quit using tobacco? (Multiple sessions, lasting more than 10 minutes)			
Do you have someone at the clinic that takes the lead on tobacco cessation?			
Do you evaluate your tobacco cessation efforts and provide performance feedback to clinicians?			

The questions with YES responses are the areas that support your facility's implementation of tobacco cessation treatments.

The questions with NO responses are areas that may need further assessment and consideration.

The questions with UNSURE responses are areas that may require further research and inquiry as you consider the implementation of tobacco cessation treatments.

Utilizing Existing Resources to Support Tobacco Treatment Services

Consider your facility's resources, such as supplies, materials, people, money and space. Knowing the available resources will help you determine which tobacco treatment recommendations your clinic is most prepared to implement. Several resources are provided to get you started.

RESOURCE	*WHY IS THIS IMPORTANT?*
Support from Management/ Administration	Some recommendations require support or even approval from management or clinic administration. This support is extremely helpful and often necessary to start tobacco cessation activities. Adding a vital sign question, starting a group cessation program, and hiring a new staff person are all examples of activities that may require special permissions. Think about each recommendation and what level of approval is needed at your clinic.
Electronic Medical Records System	Electronic medical records systems can be used to remind medical providers to ask patients if they use tobacco; record whether a patient uses tobacco; and even make direct referrals to the California Smokers' Helpline.
Staff interested in tobacco cessation	It is important to have staff that want to make tobacco cessation a priority. These staff can become champions for your clinic and move you toward your tobacco cessation goals. Not every staff person will understand why he or she should get involved. Sometimes you have to find a way to make tobacco relevant.
Educational Materials (Brochures, flyers, fact sheets)	See if your clinic already uses materials to educate patients and clinicians about tobacco. Are these materials up-to-date? Can patients easily find them around the clinic? Are you missing materials on certain topics, like secondhand smoke, chewing tobacco or medications?
Staff Reminder Systems	Do you already have a system in place for staff reminders? You might have a pop-up reminder on your electronic medical records system or use chart stickers or checklists. With these systems already in place, it would be much easier to add tobacco cessation reminders.

Funding/ Money	Not every recommendation requires money. But, having funds available to focus on the problem of tobacco can be very helpful. You could use these funds to buy educational materials, purchase food and refreshments for meetings, pay for staff trainings and certifications, and/or hire a tobacco cessation coordinator.
Bulletin boards/ brochure holders and displays	Bulletin boards and brochure holders are helpful to display your materials. Try to place materials in high-traffic areas where many people will see them.
Conference room or private space for group meetings	Room space is important for holding group cessation meetings or staff trainings. Choose a room that is quiet and creates a private space for Veterans to share among one another.
Staff person trained in tobacco cessation and education	It is very helpful to have a trained person at your clinic who is dedicated to making tobacco cessation a priority. This person can help you meet your tobacco cessation goals and encourage other staff to get involved.
Time/ Well-Staffed	Think about the staff time you have available to work on each recommendation. Some do not require much time, while others take more planning and staff involvement. Can your clinic spend the right amount of time on each cessation activity?
Pharmacy	If your clinic has a pharmacy, don't forget to include it in your cessation plans. Veterans can talk to their pharmacist about tobacco cessation medications. It also makes it easier for patients to meet with their doctor AND get a prescription filled during the same visit. Even if your clinic does not have a pharmacy, medical providers should still talk to their patients about cessation medications (as medically appropriate).
Clinic Training Program	Does your clinic already offer trainings for staff? Do you have a staff person who plans these trainings? This could be a great opportunity to suggest tobacco cessation as a future training.
Volunteers/ Interns	Does your clinic have volunteers and/or interns who could help work on tobacco cessation? Would it be easy to recruit volunteers and interns to assist with administrative tasks related to each recommendation?

Overcoming Barriers and Challenges to Providing Tobacco Treatment

It is common for clinics and health programs to experience barriers and challenges, which may prevent them from creating or strengthen tobacco cessation programs. A number of common challenges are identified below as well as potential solutions for addressing the barrier.

CHALLENGE/ BARRIER	***POSSIBLE SOLUTIONS TO CHALLENGES/BARRIERS***
Lack of staff/ time	• Not having enough staff or time to work on tobacco treatment can be a challenge, but it is possible. Here are some ideas: • Start with the easy recommendations first. Do something simple like putting brochures in your waiting room. Once you have met this goal, move onto another one. Take it step-by-step! • Think about ways your clinic could save time. Are there faster or more efficient ways of doing certain activities. • Make a list of priorities to see where tobacco cessation fits. Remember, quitting tobacco is the best thing Veterans can do for their health. • Recruit volunteers and/or interns who can help with the extra work. Many student interns are looking for public health experience. This can be a win-win situation.
Lack of money	• Not every recommendation requires money. But, having funds available to focus on the problem of tobacco can be very helpful. You can use these funds to buy educational materials, advertise group cessation meetings, purchase food and refreshments for meetings, pay for staff trainings and certifications, and/or hire a tobacco cessation coordinator. • At first, work on recommendations that do not require money. You might be surprised by how much you can actually do. It does not cost any money to advise a person to quit tobacco. Many trainings and educational materials are also free. • If you want to try more advanced recommendations, consider seeking funds for tobacco treatment or searching for community grants. • Talk with Clinic Administration and Finance/Budget Staff to see if there is any flexibility in the budget for tobacco cessation.

Lack of resources	• Not having sufficient resources can be a challenge. Consider trying the following: • Start with a recommendation that requires the fewest new resources. • Make a list of resources you need and identify free/low-cost ways to obtain them. For example, County Health Departments often have free educational materials available for community clinics and organizations. At a minimum, the California Smokers' Helpline has free resources available: www.nobutts-catalog.org • Get creative. If you do not have space available at your clinic for group meetings, think about community spaces you could use like public libraries or County facilities.
Lack of knowledge	• There is a lot of information to learn and it can sometimes feel overwhelming! • Take it step-by-step. You do not need to know everything at once. • Ask staff what they know about tobacco and what they want to learn. Look for trainings to fill these knowledge gaps. • Contact CYAN's Military Program, Project UNIFORM for free training and assistance to help you meet your tobacco education and treatment goals.
Lack of support/ interest	• It can be tough to work on tobacco cessation without the support and interest of other clinic and medical staff. • Sometimes you have to find a way to make tobacco more relevant to their work. • It is important to find clinic champions who want to make tobacco treatment a priority. Search for other staff members who are also interested in tobacco cessation. Start building your team one person at a time.

Section 6
Tobacco Treatment Resources

PROJECT UNIFORM

Project UNIFORM creates military-civilian partnerships to address tobacco use in military communities by providing culturally appropriate tobacco control information and trainings to existing military cessation programs on installations; collaborating with military support networks to promote cessation services; and educating tobacco control professionals to the culture and existing services within the Armed Forces of the United States.

www.projectuniform.org

TELEPHONE QUITLINES

CALIFORNIA SMOKERS' HELPLINE TELEPHONE COUNSELING: 1-800-NO-BUTTS

Helpline counseling is easy, convenient, and has been proven to double smokers' changes of quitting for good. Counselors are available weekdays from 7:00am to 9:00pm and Saturdays from 9:00am to 5:00pm. Services are available in multiple languages. Helpline counselors have received training on providing tobacco cessation support to service members and Veterans.

www.nobutts.org

1-800-QUIT-NOW

Operated by the National Cancer Institute (NCI), the number serves as a national portal to link callers to their state quitline based on their area code. A memorable number to call for telephone cessation assistance from anywhere in the US and U.S Territories and Pacific Islands.

QUIT VET

Any Veteran receiving health care through VA is eligible to use the Quit VET quitline. Call 1-855-QUIT-VET (1-855-784-8838) to speak with a tobacco cessation counselor Monday-Friday. The quitline is closed on Federal holidays. Counseling is available in English and Spanish.

http://www.publichealth.va.gov/smoking/quitline.asp

MOBILE

SMOKEFREEVET

SmokefreeVET is a mobile text messaging service for military Veterans who receive their health care through VA. The program was created to provide 24/7 encouragement, advice, and tips to help smokers quit and stay quit.

http://smokefree.gov/VET

VA STAY QUIT COACH (APP)

Designed to help Veterans with Post-Traumatic Stress Disorder (PTSD) quit smoking. The app guides users in creating a tailored plan that takes into account their personal reasons for quitting. It provides information about smoking and quitting, interactive tools to help users cope with urges to smoke, and motivational messages and support contacts to help users stay smoke-free. This treatment is based on evidence-based clinical practices, and has been shown to double quit rates for Veterans with PTSD. Available in the iTunes store.

VA MOBILE SITE

Includes resources, trivia, mobile apps and other helpful resources on quitting tobacco.
http://www.mirecc.va.gov/visn6/quit/index.html

NATIONAL TOBACCO CESSATION RESOURCES

QUIT TOBACCO—MAKE EVERYONE PROUD

This campaign, sponsored by the U.S. Department of Defense, aims to help U.S. service members quit tobacco. Veterans can also use the website to access online tools, quit plans and chat online with an expert about quitting tobacco. The online chat service is available 24 hours a day, 7 days a week! https://ucanquit2.org

U.S. DEPARTMENT OF VETERANS AFFAIRS— TOBACCO AND HEALTH

This site provides community resources and facts for Veterans and health professionals. It also includes special topics such as “HIV and Tobacco,” “Mental Health and Tobacco,” and “Women and Tobacco.” http://www.publichealth.va.gov/smoking

BETOBACCOFREE.GOV

This site, provided by the U.S. Department of Health and Human Services, has many free resources, including quitline numbers, mobile apps and topic-specific online factsheets.
http://betobaccofree.hhs.gov

SMOKEFREE.GOV'S SMOKEFREE VET

Information and resources on tobacco cessation tailored just for Veterans. http://smokefree.gov/veterans

NATIONAL CANCER INSTITUTE LIVEHELP SERVICE

Information Specialists can answer your questions about cancer, clinical trials, and quitting smoking. LiveHelp is available Monday-Friday, 8:00 AM - 11:00 PM Eastern Time. At this time, LiveHelp is available in English only. https://livehelp.cancer.gov/app/chat/chat_launch

SMOKEFREETXT

SmokefreeTXT is a mobile text messaging service designed for adults and young adults across the United States who are trying to quit smoking. The program was created to provide 24/7 encouragement, advice, and tips to help smokers quit smoking and stay quit. http://smokefree.gov/smokefreetxt

References

1. Nelson, J.P. & Pederson, L.L. (2008). Military tobacco use: A synthesis of the literature on prevalence, factors related to use, and cessation interventions. *Nicotine and Tobacco Research*, 10(5), 775-790.

2. Institute of Medicine. (2009). C*ombatting tobacco use in the military and veteran populations.* Washington, DC: National Academies Press.

3. US Department of Veterans Affairs. (2017). *About the Choice Program*. Retrieved from www.va.gov/opa/choiceact/index.asp

4. National Center for Veterans Analysis and Statistics. *Profile of Veterans: 2015*. Retrieved from www.va.gov/vetdata/docs/SpecialReports/Profile_of_Veterans_2015.pdf

5. National Center for Veterans Analysis and Statistics. (2016). *Profile of Post-9/11 Veterans: 2014*. Retrieved from www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2014.pdf

6. Gierisch, J.M., Straits-Tröster, K., Calhoun, P.S., Acheson, S., Hamlett-Berry, K., & Beckham, J.C. (2012). Tobacco use among Iraq- and Afghanistan – era veterans: A qualitative study of barriers, facilitators, and treatment preferences. *Preventing Chronic Disease*, 9, E58.

7. Lecours, N., Almeida, G.E., Abdallah, J.M., & Novotny, T.E. (2012). Environmental health impacts of tobacco farming: A review of literature. *Tobacco Control*, 21(2), 191-196.

8. U.S. Food and Drug Administration. (2017). *Chemicals in Every Cigarette*. Retrieved from www.fda.gov/tobaccoproducts/labeling/productsingredientscomponents/ucm535267.htm

9. National Institute on Drug Abuse. (2017). *Cigarettes and Other Tobacco Products*. Retrieved from www.drugabuse.gov/publications/drugfacts/cigarettes-other-tobacco-products

10. American Lung Association. (n.d.). *What's in a cigarette?* Retrieved from http://www.lung.org/stop-smoking/about-smoking/facts-figures/whats-in-a-cigarette.html

11. U.S. Department of Health and Human Services. (n.d.). *Smoked tobacco products.* Retrieved from http://betobaccofree.hhs.gov/about-tobacco/Smoked-Tobacco-Products/#cigarette

12. American Cancer Society. (2015, November 13). *Is any type of smoking safe?* Retrieved from www.cancer.org/cancer/cancercauses/tobaccocancer/is-any-type-of-smoking-safe

13. Tobacco Products Scientific Advisory Committee. (2011). *Menthol Cigarettes and Public Health: Review of the Scientific Evidence and Recommendations*. Rockville, MD: Center for Tobacco Products, Food and Drug Administration.

14. Anderson, S.J. (2011). Marketing of menthol cigarettes and consumer perceptions: A review of tobacco industry documents. *Tobacco Control*, 20, ii20-ii28.

15. Federal Trade Commission. (2016). *Federal Trade Commission Cigarette Report for 2014*. Washington, DC.

16. U.S. Food and Drug Administration. (n.d.). *Preliminary scientific evaluation of the possible public health effects of menthol versus nonmenthol cigarettes.* Retrieved from https://www.fda.gov/downloads/UCM361598.pdf

17. National Cancer Institute. (2010, October 27). *Cigar smoking and cancer.* Retrieved from www.cancer.gov/cancertopics/causes-prevention/risk/tobacco/cigars-fact-sheet

18. Cobb, C., Ward, K.D., Maziak, W., Shihadeh, A.L., & Eissenberg, T. (2010). Waterpipe tobacco smoking: an emerging health crisis in the United States. *American Journal of Health Behavior*, 34(3), 275-285.

19. Schubert, J., Heinke, V., Bewersdorff, J., Luch, A. & Schulz, T.G. (2012). Waterpipe smoking: the role of humectants in the release of toxic carbonyls. *Archives of Toxicology*, 86(8), 1309-1316.

20. Shihadeh, A., Azar, S., Antonios, C., & Haddad, A. (2004). Towards a topographical model of narghile water-pipe café: a pilot study in a high socioeconomic status neighborhood of Beirut, Lebanon. *Pharmacology, Biochemistry, and Behavior*, 79(1), 75-82.

21. Asotra, K. (2005). *Hooked on Hookah? What you don't know can kill you; Burning issues: Tobacco's hottest topics*. Tobacco-Related Disease Research Program Newsletter, 7(3), 1-10.

22. National Institute of Health. (2012). *Smokeless tobacco: A guide to quitting*. Retrieved from www.nidcr.nih.gov/oralhealth/topics/smokelesstobacco/smokelesstobaccoaguideforquitting.htm

23. World Health Organization. (2007). *Smokeless Tobacco and Some Tobacco-Specific N-Nitrosamines*. International Agency for Research on Cancer Monographs on the Evaluation of Carcinogenic Risks to Humans, 89. Lyon, France.

24. Goniewicz, M.L., Knysak, J., Gawron, M., Kosmider, L., Sobczak, A., Kurek, J., Prokopowicz, A., Jablonska-Czpapla, M., Rosik-Dulewska, C., Havel, C., Jacob III, P., & Benowitz, N.(2014). Levels of selected carcinogens and toxicants in vapour from electronic cigarettes. *Tobacco Control*, 23(2), 133-139.

25. Williams, M., Villarreal, A., Bozhilov, K., Lin, S., & Talbot, P. (2013). Metal and silicate particles including nanoparticles are present in electronic cigarette cartomizer fluid and aerosol. *PLOS ONE*, 8(3), e57987.

26. U.S. Food and Drug Administration. (2014). *Public Health Focus: Electronic Cigarette*s.

Retrieved from www.fda.gov/NewsEvents/PublicHealthFocus/ucm172906

27. Brandt, A.M. (2007). *The cigarette century: The rise, fall, and deadly persistence of the product that defined America.* New York, NY: Basic Books.

28. Smith, E.A. & Malone, R.E. (2009). Everywhere the solider will be: Wartime tobacco promotion in the US military. *American Journal of Public Health*, 99(9), 1595-1602.

29. Poston,W.S.C, Haddock, C.K., Jahnke, S.A., Jitnarin, N., Malone, R.E., & Smith, E.A. (2016). Perspectives of US military commanders on tobacco use and tobacco control policy. *Tobacco Control*, 1-6.

30. Arvey, S.R. & Malone, R.E. (2008). Advance and retreat: Tobacco control policy in the U.S. military. *Military Medicine*, 173(10), 985-991.

31. Haddock, C.K., Jahnke, S.A., Walker, S.C.P., & Williams, L.N. (2013). Cigarette prices in military retail: A review and proposal for advancing military health policy. *Military Medicine*, 178(5), 563-569.

32. Haddock, C.K., Hyder, M.L., Walker, S.C.P., Jahnke, S.A., Williams, L., & Lando, H. (2014). A longitudinal analysis of cigarette prices in military retail outlets. *American Journal of Public Health*, 104(4), 82-87.

33. Department of Defense. (2013). *2011 Department of defense health related behaviors survey of active duty military personnel*. Fairfax, VA: ICF International. Retrieved from https://www.murray.senate.gov/public/_cache/files/889efd07-2475-40ee-b3b0-508947957a0f/final-2011-hrb-active-duty-survey-report.pdf

34. U.S. Department of Veterans Affairs. (2016, January 12). *Tobacco use in VA*. Retrieved from www.publichealth.va.gov/smoking/professionals/tobacco-use.asp

35. Gasper, J., Liu, H., Kim, S., & May, L. (2015 December). 2*015 Survey of veteran enrollees' health and use of health care.* Rockville, MD: Westat. Retrieved from https://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf

36. Cypel, Y.S., Hamlett-Berry, K., Barth, S.K., Christofferson, D.E., Davey, V.J., Eber, S., Schneiderman, A.I., & Bossarte, R.M. (2016). Cigarette smoking and sociodemographic, military, and health characteristics of operating enduring freedom and operation Iraqi freedom veterans: 2009-2011 National health study for a new generation of US veterans. *Public Health Reports*, 131(5), 714-727.

37. Weg, M.V. & Cunningham, C. (2011). *Tobacco use among rural veterans*. Iowa City, IA:VHA Office of Rural Health.

38. Fiore MC, Jaén CR, Baker TB, et al. (2008) *Treating Tobacco Use and Dependence: 2008*

Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service.

39. Mcfall, M., Saxon, A.J., Thompson, C.E., Yoshimoto, D., Malte, C., Straits-Tröster, K., Kanter, E., Xiao-Hua, A.Z., Dougherty, C.M., & Steele, B. (2005). Improving the rates of quitting smoking for veterans with posttraumatic stress disorder. *American Journal of Psychiatry*, 162, 1311-1319.

40. Tsai, J., Edens, E.L., & Rosenheck, R.A. (2011). Nicotine dependence and its risk factors among users of veterans health services, 2008-2009. *Preventing Chronic Disease*, 8(6), A127.

41. Prochaska, J.J. (2011). Smoking and mental illness-breaking the link. *The New England Journal of Medicine*, 365(3), 196-198.

42. Desai, H.D., Seabolt, J., & Jann, M.W. (2001). Smoking in patients receiving psychotropic medications. *CNS Drugs*, 15(6), 469-494.

43. Substance Abuse and Mental Health Services Administration (2012). *Behavioral health issues among Afghanistan and Iraq US war veterans*. In Brief, 7(1), 1-8 (HHS Publication No. (SMA) 12-4670).

44. U.S. Department of Veterans Affairs. (2015, February 12). *Smoking quitline*. Retrieved from www.publichealth.va.gov/smoking/quitline.asp