

Smoking Intervention Within Alcohol and Other Drug Treatment Services: A Selective Review with Suggestions for Practical Management

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Abstract:

This selective review was undertaken in order to highlight the need for alcohol and other drug treatment services to provide intervention for tobacco smoking to their clients. The reasons for the failure of treatment services to date to deal with nicotine addiction within their programs are discussed and positive suggestions for change are proffered. In addition to the transformation of institutional culture which will be required, managers and staff of alcohol and other drug agencies need to know how best to implement smoking intervention within the treatment setting. The paper concludes with some practical suggestions for the management of intervention for tobacco smoking within treatment settings. These suggestions include: making decisions and formulating policies and procedures with regard to how tobacco smoking will be addressed; considering the particular physical, psychological and social/environmental factors that apply to substance abuse clients; building intervention around a simple structure such as 'the 5 A's'; encouraging and facilitating the use of nicotine replacement therapies; and allowing flexibility to tailor intervention to the individual. A great deal of further research is required to inform us as to how to most effectively intervene for tobacco smoking among this population group.

Tobacco smoking and substance abuse: Why is it an issue?

The great majority of people with substance abuse problems also smoke tobacco, with figures as high as 80-90% often reported (1-3). A strong link has been demonstrated to exist between alcohol and nicotine use: individuals who are more severely dependent on alcohol for instance, smoke more cigarettes per day and smoke sooner on awakening than those who are less severely dependent drinkers (4). Heavier drinkers also smoke each cigarette using more puffs and drawing in larger volumes of smoke (5). Also, individuals with a history of alcohol problems are less likely to quit smoking than those without such a history (6,7). While many theories have been advanced to explain why these addictions are linked, very few studies have tested any theory and no single theory has achieved prominence (4,8). Recent physiological experimentation with rats has suggested that nicotine reduces blood alcohol levels: if the same were true in humans, it would imply that alcohol abusers who smoke will end up drinking more alcohol to get an expected level of intoxication (9). A link has similarly been established to exist between other substances and nicotine use (10,11), although less intensively studied than the alcohol and tobacco relationship.

Those members of the community who have substance abuse problems and who smoke tobacco are also at particularly high risk of experiencing harm as a consequence of tobacco smoking due to the synergistic effects of these substances. It has been estimated that the combined health risks of smoking and alcohol use are 50% higher than the sum of their individual risks (12,13).

Research with adolescents indicates that substance-abusing youth are very heavy cigarette smokers for whom smoking-related health problems are often already evident (14). Their smoking behaviour persists into early adulthood following substance abuse treatment regardless of drug and alcohol use outcome (14). A retrospective cohort analysis of patients admitted to an inpatient addiction program in the U.S for the treatment of alcoholism and other non-nicotine drugs of dependence provided stark demonstration of the impact of tobacco on overall mortality among this population group (2). On admission, 75% were current cigarette smokers (and 8% former), 3% were current cigar or pipe smokers, and 2% were current users of smokeless tobacco. Of the high total cumulative mortality after 20 years (48.1% observed vs. 18.5% expected), 50.9% had a tobacco-related and 34.1% an alcohol-related underlying cause. Nicotine-dependence treatment is an imperative among such high risk patients: The appropriate question is not whether to treat nicotine addiction in patients with another addiction, but when and how to do so.

Why hasn't tobacco smoking been addressed within substance abuse treatment programs?

Reason for change!

Smoking intervention is not routinely implemented when the opportunity exists to do so for clients undergoing treatment. Often, not even the first basic steps of detecting smoking status or

raising the issue of smoking occur (15). Factors such as the following have contributed to most treatment programs still ignoring their clients' smoking behaviour, and it is time for change.

1. A strongly-held system of beliefs or dogma has held sway among those providing treatment to substance abusing populations, including beliefs that (15-17):

- substance abusers are intractable hard core smokers, not interested in smoking cessation;
- even should they be interested, substance abusers are not able to make changes to their smoking and other substance abuse behaviours concurrently;
- attempting smoking cessation may negatively impact the likelihood of successful intervention for the other substances of abuse; and
- that it's an 'unfair' ask of someone that they reduce or cease multiple substances concurrently or within a short time period.

Such beliefs sometimes result in smoking cessation being actively discouraged among patients in substance abuse treatment (17), with the obvious potential for significant detrimental effects on patient health. The dogma within the substance abuse treatment community that it is too hard to give up all addictions at once seems however to have been applied in a curiously inconsistent manner. The reality is that nicotine is often the only addiction not addressed, with some treatment facilities for instance having only decaffeinated coffee and carbonated beverages, and limiting patients' intake of simple sugars, while allowing their patients to continue to smoke.

These non-evidence-based beliefs are myths and need to be dispelled...

Many people with substance abuse problems are interested in and would like to cease smoking: proportions ranging from 46% to over 70% of clients in substance abuse treatment express interest in quitting smoking (15,18). It is possible for some substance abuse clients to cease their smoking while (or in close temporal proximity to) changing their other substance use behaviours (18). While the extent of research in the area remains unfortunately limited, sustained smoking cessation is clearly not easily achieved with substance abusers (19-22), and there is a need for further research to tailor interventions to this population group. There is no evidence that attempting smoking cessation has a negative impact on successful intervention for other substances of abuse (8,15,22). In fact, the evidence suggests a positive impact: continuing nicotine use may be a risk factor for alcohol relapse (23,24). Hurt et al (1994) concluded that nicotine dependence treatment provided as part of substance abuse treatment 'enhanced smoking cessation and did not have a substantial adverse effect on abstinence from the non-nicotine drug of dependence' (20).

2. The smoking behaviour and related attitudes of drug and alcohol staff impact on the occurrence and effectiveness of smoking intervention

Hurt and colleagues (1995) suggest that the attitudes and behaviours of staff within drug and alcohol treatment services are important in setting the tone of treatment milieu and that failure to understand the impact of staff acceptance of nicotine as a drug of dependence can lead to changes in the treatment environment being undermined (25). Whether staff are smokers themselves has an influence on the implementation of smoke free policies and the integration of nicotine treatment in the drug and alcohol setting (10,26,27). Smoking staff have been shown to be less likely to raise the issue of smoking or to encourage smoking cessation among clients, and they may not be as effective when the issue is addressed (26,28). Bobo & Davis (1993) for instance found that nonsmokers among staff were six times more likely to report that they routinely urged clients to quit smoking (27). Reporting on the results of observations made during the conduct of a demonstration project conducted to examine factors that facilitate implementation of nicotine dependence treatment in a substance abuse treatment setting, Campbell et al (1998) noted: less participation by smoking staff in discussion of smoking cessation treatment for clients; occurrence of staff smoking with clients outside buildings on facility grounds; fewer staff to train as smoking cessation group leaders due to the criterion of smoke free status for facilitators; and non-verbal signs of discomfort by smoking staff in the presence of the smoking cessation specialist (18).

Change in the smoking behaviour and related attitudes of staff can be encouraged through supportive training and policy implementation

Change may be slow, but it is possible if encouraged and appropriately resourced by the highest levels of management. Staff smoking cessation for instance should become a priority. Changes in the smoking norms within substance abuse treatment settings not only have the potential to positively influence the attitudes of clients about smoking and cessation, but may also impact more directly on smoking treatment, for instance, reducing smoking cues (eg fewer smoking models) may lessen withdrawal symptoms (10).

Encouragingly, there is some evidence that proactive efforts to impact staff attitudes and behaviours can be successful in creating environments that support smoking cessation efforts among substance abusers in early recovery (10,29,30). Hurt et al (1995) surveyed treatment staff before and after a prospective intervention study: significantly more staff post-study thought nicotine dependence treatment should be provided to all smokers, and overall staff attitudes changed towards greater acceptance (25).

3. The relative social and clinical acceptability of smoking and tobacco abuse, as compared to other forms of substance abuse

Neither substance abusers nor treatment staff, nor indeed the general community, perceive tobacco smoking to have a high relative priority when compared to changing other substance use

behaviours and their consequences: there is a lack of appreciation of the important and powerfully addictive nature of nicotine vis a vis other drugs of dependence and for the scale of harm it causes. For instance, in random community surveys undertaken by the National Drug Strategy, tobacco has been consistently 'underrated' in comparison to other drugs: in the 1998 survey, when asked to name the drug they thought of when people talked about a drug 'problem', 4.2% of the sample nominated tobacco, in comparison to 37.4% heroin, 21.0% marijuana/cannabis and 14.1% alcohol (31). Respondents in the same survey considered tobacco and alcohol the most acceptable drugs for regular use by adults, with two out of five and three out of five Australians respectively regarding their use as acceptable (31). It has been noted that tobacco use is often viewed by treatment staff as less disruptive and more socially acceptable than other drug use (32), and that the family similarly provide support for continued smoking by prioritising smoking cessation lower than substance abuse treatment (10,33).

Whilst in treatment, the level of smoking engaged in by clients has actually been shown to increase, possibly an indication of 'drug substitution' behaviour (11). It also seems likely however that the treatment environment itself may actually foster and encourage increased smoking: almost all clients are smokers, and it is a perceived 'de-stressing' and 'boredom-relieving' activity which can be shared throughout the treatment program, during breaks, with both other clients and often with staff members as well. In their demonstration project, Campbell et al (1998) concluded that the environmental factor of smoking by fellow clients as well as staff

on the treatment grounds must be considered a risk, noting that residential clients appeared to have greater difficulty with this factor (having greater exposure to both client and staff smoking) (18). Anecdotal reports made to us certainly suggest that some staff view smoking to have a positive 'therapeutic role' in substance abuse treatment, in terms of: helping establish a positive therapeutic relationship between client and staff member, when sharing a 'smoke' together; its 'socialising value' with regard to interacting with other clients; and as 'the addiction which is allowed'. Even if smoking is not overtly 'encouraged' or 'allowed', it has been suggested that not addressing nicotine in the context of substance abuse treatment may inadvertently serve to reinforce tobacco use - as evidenced by heavy post-treatment tobacco use among treated adolescent substance abusers (14). Adolescents may perceive the omission as tacit approval of tobacco use: addressing tobacco along with alcohol and other drugs during treatment will provide a more consistent message re addiction.

The process of establishing greater social and clinical credibility and priority for smoking cessation may entail considerable time and some effort, nevertheless, there is reason only for optimism.

Policies and procedures need to be modified to ensure that smoking detection and (appropriate) intervention is a standard part of service delivery for every client who smokes. Reducing levels of smoking among clients needs to be established as a priority for services generally and for all

staff - reflected for instance through measuring and reporting client cessation achievements as service and individual performance indicators. Policies and procedures alone however are not sufficient. Previous research has indicated that many treatment providers who would say that they support cessation do not engage in behaviours consistent with this, and that substance abuse treatment programs evidence similar inconsistencies between their stated beliefs about the need for nicotine dependency treatment and their smoking treatment policies (10,34,35). Education and skills-based training for staff is required to: change knowledge and attitudes re the importance of intervening for smoking, particularly the roles and responsibilities of staff themselves, and to facilitate the implementation of new policies and protocols; encourage and assist staff in quitting smoking themselves; and to provide staff with the skills necessary to appropriately and effectively implement intervention for smoking.

Whether treatment settings should or need to be completely 'smoke free' is an issue which many may still debate (30,33-37). Nevertheless, it is true to say that many drug and alcohol services have instituted bans on smoking indoors (38). Furthermore, a number of programs for drug abusing teens have successfully instituted 'smoke free' policies after persistent effort (39). There is an onus on all drug and alcohol services to provide an environment which at least does not encourage smoking or discourage cessation, and also to consider the issue of risk from passive smoking for staff and non-smoking clients. The risks associated with environmental tobacco smoke give rise to increasing legal implications and the possibility of being sued for

disregarding a 'duty of care'. The introduction of 'smoke free' services would also certainly require services to rapidly develop and implement strategies to assist staff and clients in achieving and maintaining cessation. Further, the move would be in line with the growing proportions of workplaces and homes that have adopted smoke free policies and practices – with concomitant reductions in smoking prevalence among the general community (31,40,41).

4. A substantive lack of descriptive and intervention research

Abrams et al (1996) concluded that resistance to quitting smoking or to the implementation of smoking cessation activities exists in part because of a paucity of research. Specifically, that little research has either contradicted patient and staff beliefs that quitting might derail sobriety (although also noting that no research directly supports the idea) or determined how best to change smoking behaviours among substance abusers (42). This is unfortunately still the case: basic research that could inform the development of specifically targeted interventions has not been undertaken.

Little is known about the smoking (and cessation) behaviours of substance dependent populations with regards, for instance, to levels of smoking and dependency, relationships between smoking and other substance use, desire to quit, quit attempts, and methods tried/desired in quitting. Descriptive studies that have been conducted indicate for example that:

substance abusers do self-report relationships between their use of tobacco and other substances (although it is largely unknown whether or not these have a basis in fact); that many substance abusers are interested in ceasing their tobacco smoking; and that there may be a predictive relationship between an expressed interest in ceasing smoking concurrently with other substance use and the likelihood of success in doing so (15,42,43). It nevertheless continues to be the case that we have no good experimental data to inform us as to the relative advantages and disadvantages of commencing smoking treatment concurrently with or sequentially to the treatment of other substances of abuse: There have been no randomised trials evaluating the temporal ordering of dual cessation (15). It has been suggested that health care practitioners should routinely assess the relationship between clients' smoking and other substance use as well as interest in resolving both cessation problems, and that dual cessation should be explored as part of the formal treatment plan if a client is interested and willing (23,44).

Very few smoking interventions have been developed or trialed with substance abusing populations in treatment (or even following shortly after treatment). Those that have been undertaken generally have substantive methodological limitations – small sample sizes, biased samples and non-randomised, non-controlled designs (19,45,46). Results of research to date suggest the need to develop and test intensive interventions, tailored to factors that characterise substance abusing populations (10). There is also a need to ensure that research is undertaken

within a range of substance abusing populations, rather than predominantly with people whose main substance of abuse is alcohol, as has been the case to date.

Regardless of a lack of information and intervention tools specific to substance abuse populations, there is an ethical and clinical imperative to make use of existing opportunities and knowledge 'now' to reduce the prevalence and consequences of smoking among these populations. In addition to the transformation of institutional culture which will be required, managers and staff of alcohol and other drug agencies need to know how to best implement smoking intervention within the treatment setting.

What is required to implement effective smoking intervention within substance abuse treatment programs?

We would suggest that consideration of the following issues might be useful to underpin the development and implementation of smoking intervention with substance abusing populations in treatment:

- 1. Capitalise on existing advantages of the setting**

Whether operating as inpatient or outpatient services, all alcohol and other drug treatment settings/programs offer several features likely to enhance the feasibility, efficacy and cost-efficiency of smoking cessation treatment, including:

- . the opportunity for regular contact, often over an extended timeframe, so that there is a cumulative impact of intervention (47);
- . the environment being one which is already designed to promote and support behavioural change;
- . the use of behaviour change techniques, such as relapse prevention strategies and self management skills, likely to also apply to smoking cessation;
- . clients who are likely to be at a stage of readiness to make significant lifestyle change;
- . the possibility that treatment and behaviour change with regard to one addictive substance will generalise to others, given the substantial overlap in skills and behaviours needed for abstinence from different substances; and
- . the minimal likelihood that there will be any concern to attempt to conceal smoking status.

2. Formulate and ensure implementation of policies and procedures with regard to how tobacco smoking will be addressed

Decision-making is required at the service level with regard to how smoking intervention can best be accommodated within or around existing service provision. For instance, whether smoking

intervention is most appropriately integrated within the broader treatment approach and model of service delivery, or whether it should be implemented alone as a separate program, or whether some combination is possible/preferable. Campbell et al (1998) summarise the advantages and disadvantages of these approaches and make some suggestions. They conclude that smoking should be addressed as an integrated component of treatment, in addition to providing cost-effective interventions specific to treating nicotine dependence, including: educational/motivational pre-quit groups; use of nicotine replacement therapy; provision of special snacks and therapeutic activities during traditional 'smoking breaks' for newly abstinent smokers, and the provision of smoking cessation treatment groups if client numbers are adequate (18).

Decision-making should also involve consideration of issues such as going 'smoke free' and whether it is appropriate for staff to be smokers, given the need to provide an environment conducive - or at least not destructive - to the behaviour change being asked of clients. The decisions made will require the development of appropriate policies and procedures, and the will to enforce them.

3. Consider the particular physical, psychological and social/environmental factors that apply to substance abuse clients

These factors are well summarised by Burling et al (1997) (10). The physical factors to consider include: the likelihood that clients may be more dependent on nicotine than non-abusers, indicating a particular role for nicotine replacement therapies; the possibility that clients may experience greater physiological withdrawal and craving than non-users following smoking cessation, and the need to consider possible iatrogenic effects of substance abuse treatment on nicotine withdrawal; the greater number of general health problems likely to be experienced as a consequence of drug and alcohol use, and the need for medical screening; neuropsychological deficits which are often the sequelae of substance abuse, and the limits they may place on the complexity and sophistication of smoking intervention design.

The psychological factors to consider include: the different learning histories with respect to both nicotine and other abused substances that clients may have as compared to non-abusers, some of which may increase the strength of the smoking habit; the prevalence of comorbid depression, anxiety and personality disorders; and differences in some smoking-related attitudes. It has been found for instance that a greater proportion of substance abusers are in earlier stages of 'readiness to change' than non-abusers: approximately 65 to 70% of abusers appear to be in the 'pre-contemplative stage' (ie are not considering quitting in the next six months) (43,48) versus approximately 40% of non-abusers (49), possibly related to lower levels of smoking cessation-related self-efficacy (43,50,51).

The social/environmental factors to consider include: the influence of peers and family, where smoking rates will likely be high and support for smoking cessation lacking; and the influence of treatment providers and the program, and the importance of providing as supportive an environment as possible with important implications for staff training, selection and 'smoke free' policies.

4. Build intervention around a simple structure such as 'the 5 A's'

Given the limited information as yet available with regard to what works best for substance abusing populations, what we do 'now' should be based on current best-evidence for smoking cessation generally whilst incorporating where possible factors which pertain specifically to substance using populations and/or treatment contexts. Consideration should be given to building intervention around a simple structure such as 'the 5 A's': ask, advise, assess, assist and arrange follow-up (a modified form of 'the 4 A's' recommended within the Agency for Health Care Policy and Research Smoking Cessation Clinical Practice Guidelines) (52).

This five-step process is outlined in Figure 1. Ask about smoking status, and the history and patterns of tobacco use and previous quit attempts. Explore the use of tobacco within the context of the client's other drug use, and the impact (if any) of previous quit attempts on other drug use. Advise the individual of the risks of smoking and benefits of quitting, personalising information

as far as possible, and countering the reasons clients may give for exempting themselves from the need to stop smoking or the possibility of doing so. In particular, advise of the additive synergistic risks of smoking and other substance abuse, and suggest that quitting smoking may actually help with changing other drug using behaviours. Some of the 'self exemptions' raised may be peculiar to the situation of the substance abusing client, with others reflecting the concerns of smokers generally. Table 1 suggests examples of the type of self-exemptions clients may raise and possible responses to counter them. Assess the client's desire to quit (readiness to change) - 'not at all'; 'not yet'; or 'now' – and tailor the nature of intervention accordingly. In particular, ascertain how the client feels about the pros and cons of quitting whilst also addressing their other drug issues. Assist the individual who is ready to quit 'now' by providing helpful tips and behavioural strategies for dealing with nicotine withdrawal symptoms and urges to smoke, complementary written material, and possibly nicotine replacement therapy (NRT). For clients not yet ready to quit, encourage consideration of quitting and express support for their ability to do so. Arrange follow-up and provide opportunities for counselling, reinforcement, problem-solving and support. Plans for future contact however will need to take into account the relative lack of stability and high mobility among substance abusing populations, and perhaps a greater propensity for forgetting and/or non-attending follow-up appointments.

FIGURE 1 ABOUT HERE

TABLE 1 ABOUT HERE

5. Encourage and facilitate the use of nicotine replacement therapies, subsequent to appropriate medical screening

Nicotine replacement therapy (NRT), in all of its commercially available forms, has demonstrated considerable effect towards achieving smoking cessation among general community and primary care populations: increasing quit rates approximately 1.5 to 2 fold regardless of setting (53). A recent Cochrane review further indicated that NRT use should be preferentially directed to smokers who are motivated to quit and have high levels of nicotine dependency. The one trial conducted comparing the effectiveness of NRT to the anti-depressant bupropion ('Zyban') found bupropion to be more effective, although Silagy et al caution re the need to take into account potential adverse effects as well as benefits in deciding which pharmacotherapy to use (53).

While there has as yet been little work done with regard to examining the effect of NRT among substance abusing populations, that which has occurred supports the value of including it as a treatment option. Hurt et al (54) undertook a post hoc analysis of prior nicotine patch studies in order to investigate the levels of nicotine dependency and effect of NRT among recovering

alcoholics and non-alcoholics. They concluded that alcoholic smokers were more likely to be nicotine dependent than non-alcoholic smokers but could achieve comparable short term cessation rates with nicotine patch therapy. Saxon et al (1997) reported the results of an 'open trial' of NRT among alcohol and drug dependent in-patients: despite methodological limitations, the authors concluded that a substantial proportion of the patients entering treatment were willing to attempt simultaneous tobacco cessation and that transdermal NRT held promise as a treatment modality among this group (55). Patten et al (2000) examined the effect of three behavioural smoking treatments on nicotine withdrawal symptoms in abstinent alcoholic smokers: one of the treatments being behavioural counselling plus nicotine gum (56). Neither type of behavioural smoking treatment nor amount of smoking reduction modulated increases in withdrawal, and all three groups showed similar overall reductions in smoking rate. The authors concluded with a statement of the clear need for further research.

In including NRT in smoking cessation treatment offered to clients of drug and alcohol programs however, consideration may need to be given to the generally poorer health status of this population group and to treatment being preceded by a thorough medical screening. Particular caution may also be required with regard to the use of bupropion, as there may be more contraindications for its use among this group. Further, given this group's characteristically low socioeconomic status, it may be desirable /necessary for a program to consider providing some

assistance with the financial costs of NRT for clients, in order that this not become a factor limiting the success of treatment.

6. Allow flexibility to tailor intervention to the individual

Whatever the approach adopted to smoking intervention within a drug and alcohol treatment setting, there is a need to ensure a capacity to tailor the program to the needs of individual clients. For instance, while the opportunity of structured assistance to quit smoking should be offered to all clients concurrent to treatment for other substances, and some attempt made to address a 'reluctance' to do so if it appears to arise from misinformation or a lack of confidence, the issue should not be forced. Reasons the client may give for not concurrently attempting to cease smoking should be attended to and afforded due regard. However, as long as intervention is appropriately tailored to an individual's 'readiness to quit' according to a staged approach such as Prochaska and DiClemente's transtheoretical model (57), some level of intervention could and should be implemented with every individual. 'Motivational' intervention may not have the immediate objective of cessation per se but perhaps at least 'contemplation' of the same and/or building confidence for a future cessation attempt (36,42,58). Bobo et al (1996) suggest that where treatment resources are scarce, it may be appropriate to target counselling efforts to those more likely to make a serious quit attempt within 6 months of discharge (lower Fagerstrom dependence scores, and in the 'contemplation' or 'preparation' stage) (59).

Conclusions

There is a need to address the issue of smoking now for clients of drug and alcohol treatment services. While there is a great deal of research still required to be undertaken in order to further inform us as to how we can most effectively intervene for smoking among this population group, we cannot afford or justify to wait any longer. Services providing care for drug and alcohol clients need to make some hard decisions and implement policies, procedures and staff training accordingly. We have as great a responsibility and obligation to assist clients in recognising and overcoming nicotine dependence as we do for any other substance of abuse.

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Table 1 Countering self-exemptions among drug and alcohol clients

Self-exemption	Counter Argument
Smoking is a (relatively) minor health concern	<p>Synergism Overall contribution to mortality</p> <p>Drug of dependence – addiction</p>
Damage by other drugs is already done	There <u>will</u> be immediate benefits from the day of quitting
I've got enough to cope with already (in terms of changing other drug use)	Quitting smoking may actually help you cope better
I need to smoke to relieve stress	Nicotine is actually a stimulant and there are better means to relieve stress
No one has bothered about my smoking before	We know more now about the risks to you of smoking, and the benefits of quitting – and how to help you quit.
Smoking is my one remaining vice/luxury	<p>So why let smoking get the better of you?</p> <p>There must be better things to spend the money on.</p> <p>Smoking often occurs together with alcohol or other drug use – why not make a clean break?</p>
Need smoking to stay off other drug I've tried to quit and I failed	<p>May increase chance of relapse for some clients Most smokers make several quit attempts before they are successful. Don't be discouraged.</p> <p>We will provide whatever help we can to support you in quitting smoking.</p> <p>It's well worth it to try again.</p>