From the Nicotine Dependence Relief and Recovery (NDRR) Workshop Abstract: Resulting in many thousands of needless deaths annually, hardly any behavioral health clinicians, including specialists, offer a program or service specifically designed to serve nicotine-addicted people.

Why isn't the problem-specific help available that's needed to save many thousands of lives?

- The smoking cessation program, Nicotine Dependence Relief and Recovery, reports and respectfully that U.S. adult non smokers have the same truly not-their-fault mistaken attitudes (nicotine notions) as nicotine-dependent smokers, dippers and chewers. Even when doubted, we clinicians honestly but mistakenly think and deeply that smoking is a habit or bad habit; smokers probably already know enough to successfully quit; people smoke because they choose to or like to; and more. That is the reason this program's author asked you to read and listen to the handout materials you give to NDRR participants.

The following explanations for why there is hardly any appropriate help available are simply expressions of the nine nicotine notions that block problem-specific help:

- Clinicians share with the public the false perception that significant numbers of smokers are successful quitting. If we can believe the 2006 study of research reported by the National Institute on Drug Abuse (NIDA), only 6-percent of trying-to-quit smokers still are not smoking at the end of just one month.

  NOTE: That suggests that when more than 6-percent of the adult smokers you teach NDRR are still not using nicotine after one month they are doing better than usual.

- Our and other communities have a strong tradition of not attempting to stop or doing much of anything else to discourage smoking.

- Non smokers honestly but inaccurately assume that the initial causes of cigarette smoking (peer pressure, acting out, media and other modeling, etc.) are the same for ongoing and binge smoking.

- Cigarette smoking is said to be among if not the most difficult of dependency behaviors to treat. Relapse is rampant. The high prospect for perceived failure isn't a good incentive for clinicians.

- The published research that says nicotine replacement therapy (nicotine gum, patches, etc.) or NRT is effective is taken to mean that it is also effective in non-study situations.

- Non smokers – in other words, practically everyone who reimburses for or could offer assistance – more likely view smokers as negative or weak people who care too little about the health of children rather than as substance-dependent friends or neighbors. It is understandably difficult to muster the enthusiasm needed to help such folks.

- The most advertised and promoted treatments (patches and other replacements) contain nicotine. That incorrectly suggests that dependence on nicotine isn't the essential problem . . . root cause of cigarette smoking.

- Insurance and other health service reimbursers almost never pay for stop-smoking interventions other than what are encouraged by drug companies and their allies. Reimbursers would ignore clinical nicotine addiction services.

- Sources of training for clinicians rarely offer training to help with smoking or nicotine use cessation. A review of the training currently available to NC licensed clinical addiction specialists (LCAS) identified one workshop.

- The harm done to self and others by nicotine addiction isn't so clearly or immediately obvious. The harm done by those addicted to alcohol and illicit drugs is more immediate and clear . . . for instance, drunk driving accidents.

- The effects or symptoms of nicotine intoxication that are commonly experienced (heightened alertness, increased pulse rate and blood pressure, mild nausea, headaches, jitteriness) aren't usually recognized and are not nearly so dramatic as, for example, alcohol intoxication.

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