Is nicotine replacement therapy (NRT) an addiction-appropriate treatment? Is tobacco a drug?

The following is some of the evidence that suggests nicotine replacement therapy, NRT, used to stop smoking is not effective . . . nicotine patches, gum, lozenges and more are not based on reliable addiction science or the common knowledge gained from specialized clinical experience.

If you think tobacco is a drug, an untruth repeatedly told to you that kills, you also believe NRT products probably work . . . at least if combined with counseling. For the sake of the many lives you can save, it is necessary to give you this evidence of unenlightenment for you to accept it and no longer think or say that tobacco is a drug.

You are making an honest mistake if you even suspect I am exposing evidence that nicotine replacement therapy is not effective in order to sneakily defend or promote tobacco and smoking. Some folks do.

Devious supporters of dubious "smokers' rights" challenge the efficacy of NRT products, but they also tell the popular untruth that says even chronic heavier smoking is a "choice" rather than resulting from nicotine addiction. They attempt to give weight to that lie by pointing out that statistically most people stop without external help: Smokers simply quit; they "bite the bullet" and "go cold turkey."

Underhanded nicotine pushers allege in so many words, "When they choose to, most of those smokers can and do stop smoking for good on their own and without significant complications." Wrong! The reality is far closer to they don't stop; they REPLACE. That's called "addiction transfer." Smokers more often switch to so-called "comfort" foods, overeating or abusing alcohol. They unwittingly self-medicate and swap one major health threat and drain on their and our financial resources for another.

- Longtime specialized clinical experience enables a different perspective. Because of more than three decades of specialized clinical experience that began before the widespread introduction of NRT products, I've known to question the value of nicotine replacement therapy: now the dominant and dominating cigarette smoking cessation intervention. In 1989, Counselor: The Magazine for Addiction Professionals published an opinion article I wrote entitled "Why Treat Nicotine Addiction with Nicotine?" The more I learn the less I'm sure of what I know. One exception is that nicotine replacement therapy is not a nicotine addiction-knowledgeable approach.

  Behavioral health clinicians who are certified or licensed to treat addiction to alcohol and other drugs are dependence-knowledgeable. They could help more than professionals with training similar to my own. Understandably they don't realize that NRT is not effective. Those specialists have had very little if any experience treating nicotine addiction. Their sources of authoritative treatment information taught them politically correct untruths: that nicotine replacement products are effective with or without counseling when they aren't and tobacco is a drug when it isn't.

  Those sources of authoritative treatment information are thought to be allied with the pharmaceutical industry. They say and believe otherwise, but still they subtly and powerfully suggest to addiction specialists that their involvement to help treat nicotine dependence is NOT needed. Those information sources focus way too much on the plant (tobacco) and too little on the essential problem (nicotine). They say that tobacco is the psychoactive drug when they mislabel with the description "alcohol, tobacco, and other drugs" or ATOD. Besides avoiding profit-threatening competition from clinical specialists, the drug industry that makes nicotine-filled cigarette replacement products may find it easier to sell those expensive additional ways to deliver the highly addictive insecticide, nicotine, when the stop-smoking products it promotes are not clearly identified as containing the real threat.

  Addiction specialists accept the implied killer untruth conveyed by those authorities: Nicotine replacement therapy works and already has the cigarette smoking problem significantly covered. When you and I raise awareness among specialists of the considerable need for their enlightened expert help, the health of a great many children and billions of their health care dollars will be saved. (Why is none of this to be taken as criticism of sources of treatment information or drug companies? Read this page.)
- Probably the most intense form of clinical addiction help for smokers is an inpatient treatment program. Highly regarded Hazelden Foundation and its residential stop-smoking program avoid nicotine replacement products. The director of Nicotine Dependence Treatment Services at Hazelden describes this important feature of that "Your Next Step" service: "Our thinking is that we have seven days to get people off nicotine and develop strategies to remain tobacco-free for the rest of their life," he says. "If they use nicotine replacement, then they're going to walk out of here still addicted to the drug."
- Tapering off the highly addictive insecticide, nicotine, is an essential and prominently-promoted supposed advantage of the nicotine replacement therapy approach. What highly addicting drug other than nicotine might we think it's okay for people away from residential treatment to taper off? The answer is "none."
- Like other substance-dependent people who aren't yet in recovery, smokers are in denial when thinking they can stop for good by gradually cutting back on (tapering off) nicotine. Nicotine replacement therapy (NRT) promotes that unhealthy view. Those NRT products subtly but powerfully promote health risk denial.
- Isn't it probable that urging a smoker to use nicotine, even as part of a broader treatment such as professional counseling, suggests that nicotine isn't the problem and negates whatever else might be done to help? NRT suggests "NOT" . . . as in "NOT truly addicted."
- No reputably published research suggests adding counseling to NRT was effective to stop smoking where all testing of efficacy was done post nicotine ingestion (research subjects no longer used the drug). See "measurements of the efficacy" below.

- Twelve-step programs talk in terms of "one is always too many and never enough." Isn't it likely to be true that one hit of nicotine, no matter the delivery device or method, makes someone not yet in the recovery required to survive? I am convinced that's a fact.
- The nicotine-drenched stop smoking patch is another means to deliver the drug. Indians in South America have "smoked" that way. They mixed nicotine with cooked animal fat and rubbed it on their arms.
- The drug companies that produce and sell replacements are fond of having others suggest that delivering the drug with their products and reduced quantities of the substance make them nonaddicting. Possibly that's true if using replacements with folks who aren't already dependent.
- Those pharmaceutical company allies also suggest that NRT products help by removing the activities (lighting-up, etc.) associated with smoking. But smokers aren't addicted to the associated activities any more than heroin users are addicted to shoving needles into their bodies.
- The fact that hardly any behavioral health addiction specialists primarily focus on nicotine dependence (addiction) means they don't pay attention and question the largely industry financed, or otherwise influenced, research that alleges replacement therapy is effective.

  When advertising asserts that using a replacement doubles a smoker's chance to stop, that more likely means going from little chance to still little chance – maybe doubled and practically no one stays stopped.

  A 2006 NIDA research report (www.drugabuse.gov/researchreports/nicotine/nicotine2.html) says that nearly 35 million U.S. smokers want to stop each year and a number of them make the effort. Only about 6 percent stay free of smoking longer than one month. Author's note: At any given time, approximately 15 percent of trying-to-quit smokers are relying for help on the nicotine gum, lozenge, patch or another such cigarette replacement product.

  No published research that obviously was done independent of the influence of the makers of NRT and other psychoactive drugs (example, Wellbutrin or Zyban) has shown that they performed better than simply stopping.

  A survey of 73 double-blind, placebo-controlled nicotine replacement trials identified just 17 studies that made some effort to assess the integrity of their double-blind procedures. Twelve (12) of the 17 studies found that subjects accurately judged treatment assignment at a rate significantly above chance. These few studies provide insufficient evidence for definitive conclusions about the overall integrity of blindness in the NRT literature . . . Addictive Behaviors 29 (2004) 673–684

  Measurements of the efficacy of nicotine replacement therapy to stop smoking are done while subjects continue to ingest the drug. Is that fair? Would anyone give the same gigantic advantage when, for example, testing the effectiveness of a heroin injection cessation program? No way!
- If nicotine replacement is science-based and effective shouldn't we reasonably expect that smoking would be declining? In fact, for most of the 20 years replacement products have been available the incidence of smoking has been stagnant and now is projected to increase.
- Nicotine is a deadly poison (insecticide). It isn't somehow "good science" or "best practice" to encourage using or do nothing as human beings unknowingly poison themselves with nicotine replacement therapy products.
- Nicotine is the exceedingly toxic substance used to kill animals. Even if there aren't other reasons, and there are, that's a legitimate one to avoid the patches, gum, lozenges, cigarettes, and other ways to deliver nicotine. Any poison, no matter the source, is too much.

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Thank you.