Original Article

Smoking among users of a psychosocial care center for alcohol and drugs: a pilot study*

Tabagismo em usuários de um centro de atenção psicossocial alcool e drogas: um estudo piloto

Tabaquismo en usuarios de un centro de atención psicosocial alcohol y drogas: un estudio piloto

Sandra Cristina Pillon[1], Natália Priolli Jora[2], Gisela Pereira Amorim[3], Josélia Benedita Carneiro Domingos[4], Ronildo Alves dos Santos[5]

ABSTRACT

Objective: To evaluate the pattern of tobacco consumption in clients of a service specializing in the treatment of psychoactive substance dependence. **Methods:** This was a descriptive quantitative approach, undertaken in 2009, in an Alcohol and Drugs Psychosocial Care Center, located within the State of São Paulo. We used a questionnaire containing sociodemographic information and the Fargeström test in 48 attendees in a single day at this service. **Results:** The sample was characterized as predominantly adult males, unmarried, with low educational levels, and who were currently employed. In relation to smoking, we identified a high frequency of current smokers, with moderate level of tobacco dependence, motivated to change their smoking habits. **Conclusion:** Knowing the smoking behavior among users of a specialized service can help professionals rethink preventive and educational actions in the area of health.

Keywords: Tobacco; Smoking; Ambulatory Care Facilities

RESUMO

Objetivo: Avaliar o padrão de consumo do tabaco em clientes de um serviço especializado no tratamento da dependência de substâncias psicoativas. **Métodos**: Trata-se de um estudo descritivo de abordagem quantitativa realizado, em 2009, em um Centro de Atenção Psicossocial Álcool e Drogas, situado no interior do Estado de São Paulo-SP. Aplicou-se um questionário contendo informações sociodemográficas e o teste de Fargeström em 48 usuários atendidos, em um único dia, nesse serviço. **Resultados**: A amostra foi caracterizada como sendo predominantemente adulta, com indivíduos do sexo masculino, solteiros, com baixo nível de escolaridade e com vínculo empregatício. Em relação ao consumo de tabaco, identificou-se uma frequência alta de fumantes atuais, com nível moderado de dependência do tabaco, motivados a mudarem o hábito de fumar. **Conclusão**: Conhecer o comportamento de fumar entre usuários de um serviço especializado auxiliará a repensar as ações preventivas e educacionais na área da saúde.

Descritores: Tabaco; Tabagismo; Instituições de Assistência Ambulatorial

RESUMEN

Objetivo: Evaluar el patrón de consumo del tabaco en clientes de un servicio especializado en el tratamiento de la dependencia de sustancias psicoactivas. **Métodos**: Se trata de un estudio descriptivo de abordaje cuantitativo realizado, en el 2009, en un Centro de Atención Psicosocial Alcohol y Drogas, situado en el interior del Estado de Sao Paulo-SP. Se aplicó un cuestionario que contenía informaciones sociodemográficas y el test de Fargeström en 48 usuarios atendidos, en un único dia, en ese servicio. **Resultados**: La muestra fue caracterizada como predominantemente adulta, con individuos del sexo masculino, solteros, con bajo nivel de escolaridad y con vínculo laboral. En relación al consumo de tabaco, se identificó una frecuencia alta de fumantes actuales, con nivel moderado de dependencia del tabaco, motivados a cambiar el hábito de fumar. **Conclusión**: El conocimiento del comportamiento de fumar entre usuarios de un servicio especializado ayudará a repensar sobre las acciones preventivas y educativas en el área de la salud.

Descriptores: Tabaco; Tabaquismo; Instituciones de Atención Ambulatória

---

** This study was developed in the Psychosocial Care Center for Alcohol and Drugs (CAPS-ad) of a municipality of the interior of the State of Sao Paulo, Brazil*

[1] Associate Professor at the Department of Psychiatric Nursing and Human Sciences at the College of Nursing at Ribeirão Preto. University of São Paulo - Ribeirão Preto (SP), Brazil

[2] Posgraduate student (PhD) at the Program in Psychiatric Nursing at the College of Nursing at Ribeirão Preto. University of São Paulo – USP – Ribeirão Preto (SP), Brazil.

[3] MD. Occupational Therapist at the Psychosocial Care Center for Alcohol and Drugs, Ribeirão Preto (SP), Brazil.

[4] Posgraduate student (PhD) at the Program in Psychiatric Nursing at ht. College of Nursing at Ribeirão Preto. University of São Paulo – USP – Ribeirão Preto (SP), Brazil

[5] Doctor Professor at the Department of Psychiatric Nursing and Human Sciences at the College of Nursing at Ribeirão Preto. University of São Paulo – USP. Ribeirão Preto (SP), Brazil.

Correspoding Author: **Sandra Cristina Pillon**
Av. Bandeirantes, 3.900 - Monte Alegre - Ribeirão Preto - SP - Brazil
CEP. 14040-902 E-mail: pillon@eerp.usp.br

Received article **30/04/2010** and accepted **13/11/2011**

INTRODUCTION

Globally, tobacco use constitutes one of the dependencies of higher prevalence, considered the leading cause of preventable death, killing more than five million people per year worldwide[1]. In this century, if there are no public policies aimed at preventing tobacco use, there will be millions of deaths which could be prevented, and a considerable portion of these deaths would occur in low-income countries. If current trends continue, tobacco will be responsible for about 80% of the cases of premature deaths in such countries. It is also estimated that by the end of this century, tobacco could kill one billion people or more, if urgent measures are not taken. Over the next 20 years, nicotine will become, worldwide, the single greatest cause of premature death or the number of years lost to premature death caused by smoking (measured in *disability-adjusted life years*, DALYs, a comparative index of the morbidity and mortality burden).

According to the World Health Organization (WHO)[2], various studies indicate that it will not be possible to reduce the number of deaths related to the consequences of smoking in the next 30 to 50 years, unless smokers are encouraged to stop smoking. Thus, the WHO highlights the importance given to the *Framework Convention on Tobacco Control*, which established worldwide standards for legislative and policy measures that contribute to reducing smoking rates[2].

Nicotine is the principal active substance of tobacco and, due to the power it has to cause addiction, many smokers need support to stop smoking[3]. There is evidence that approximately one third of smokers try to stop smoking each year. However, only a small percentage of these (3% - 5%) achieve abstinence (at least 12 months without smoking), using only "willpower" without the help or assistance of a health professional[3-4]. This fact indicates the great potential that the routine approach of smokers by health professionals can provide to make them aware of the need to stop smoking and, consequently, to reduce the number of smokers[5].

In recent years there has been a growing interest concerning the implementation of effective and evidence-based healthcare practices, by the health service professionals, as well as the integration of services that provide treatment for smoking cessation with the policies to control smoking, causing an increasing number of smokers to want to modify their behavior in relation to smoking[3].

Furthermore, there was a progressive increase in the demand for support actions in the cessation of this habit, which highlights the role of the health institutions and of their professionals in the actions of approach to smokers[6].

Changes in the control policies were needed considering the smoking rates in Brazil, which demonstrate that one in ten Brazilians aged between 12 and 65, is dependent on nicotine[7]. Faced with this worrying index there was a growing anti-tobacco movement, which occurred not only in Brazil.

For a long time, the Ministry of Health assumed, together with the National Cancer Institute, the role of organizing the National Program for Tobacco Control, which has the aim of reducing smoking prevalence and consequently morbidity and mortality from diseases caused by the consumption of tobacco. It uses prevention of smoking initiation strategies, protection of the population faced with environmental exposure to tobacco smoke, promotion and support for smoking cessation and regulation of the tobacco products by means of educational actions and mobilization of policies and legislative and economic initiatives[8]. Predicting the articulation between the training of health professionals and the financing of actions aimed at the approach and treatment of smokers in the network of the Brazilian National Health System (SUS) through Regulation GM/MS 1.035/04, regulated by SAS/MS 442/04, which extends the approach and treatment of smoking to the primary and intermediate complexity healthcare, and establishes the support materials and medication for smoking cessation treatment, provided by the Ministry of Health to municipalities with health units trained and accredited for this purpose[8]. This regulation was supplemented by Regulation GM/MS 1.575/02, which created the Centers of Reference in the Approach and Treatment of Smokers and included, in the Outpatient Information System of the Brazilian National Health System (SIA/SUS)[8], the approach and treatment of the smoker, which should be offered by the Psychosocial Care Centers for Alcohol and Drugs (CAPS-ad). This policy was highlighted by the WHO[2] as one of the pillars of the process of reducing the number of smokers in Brazil.

In addition, strong evidence of the relationship between smoking and mental illness (anxiety and depression), the object of numerous publications in the last two decades, has implications for the organization of the health service, specifically those performed by the CAPS-ad, since patients with psychiatric disorders are more likely to abuse or to be dependent on psychoactive substances[9-13]. In the specific case of nicotine, dependence severity has been shown to be more intense and there are many difficulties for tobacco cessation, resulting in constant relapses[14]. As an example, patients with schizophrenia presented higher rates of smoking (90%), not responding effectively to treatment (medical or not); the few cases of patients who stop smoking, relapse quickly. This situation is no different for those dependent on alcohol, since 70% of these are

smokers[14] and present difficulties in changing behavior in relation to smoking cessation.

Thus, in view of the importance of the subject, the changes in the national policy to control smoking, the evidence of the relationship between smoking and mental illness and the relative scarcity of studies regarding tobacco consumption among CAPS-ad users, the present study aimed to evaluate the pattern of tobacco consumption among clients of a CAPS-ad.

METHODS

This was an exploratory, descriptive, quantitative study performed in the Psychosocial Care Center for Alcohol and Drugs (CAPS-ad) of a municipality of the interior of the State of Sao Paulo. This study is part of a larger research project concerning the evolution of the patients attended in this service.

The sample consisted of 48 clients in treatment for problems related to the use of psychoactive substances that were present for the therapeutic activities in the service, of which 36 (75%) were current smokers.

Data collection occurred in September 2008 on a single day, due to the number of active patients in the therapeutic program offered by the CAPS-ad, who remain constantly in treatment. Interviews were conducted person to person by the authors of the study by prior appointment. For the data collection a questionnaire was constructed composed of sociodemographic questions and the Fagerström Test, which evaluates the tolerance and the degree of dependency on nicotine[8]. Its internal consistency is satisfactory and relates to indicators of smoking behavior. It consists of six questions regarding current smoking behavior. For its reading, the scores of the responses are totaled, giving a range from zero to 11 points, which provides the following classification of the levels of nicotine dependence severity: mild (0-4 points), moderate (5-7 points) and severe (8-11 points)[9].

For the analysis a database was prepared in the program *Statistical Package Social Science for Windows*. Os resultados foram apresentados em números absolutos e porcentagens.

The results were presented in absolute numbers and percentages. The research project was approved by the local Research Ethics Committee, Process nº.0705/2006, according to the regulations of Resolution nº. 196/96, following the ethical aspects, with the voluntary participation of the clients who signed the Terms of Free Prior Informed Consent.

RESULTS

Of the clients attended in the service, 48 subjects composed the study sample (96%), giving a loss rate of 4%. The sample was predominantly composed of 41 male subjects (85.4%), with a mean age 43 of years (SD±12.62 years), ranging between 18 and 64 years (data not presented in the table). Regarding marital status, 24 were single (50%), 27 had low levels of schooling, with complete or incomplete elementary education (56.3%), and 20 were working (41.7%), as shown in Table 1.

Table 1 - Clients of the Psychosocial Care Center for Alcohol and Drugs according to sociodemographic characteristics – Sept/2008

(n=48)

	n	%
Gender		
Male	41	85.4
Female	7	14.6
Marital status		
Single	24	50.0
married	12	25.0
Separated / divorced	12	25.0
Schooling		
Elementary education complete / incomplete	27	56.3
High school complete / incomplete	14	29.2
Further education complete / incomplete.	4	8.4
Illiterate	3	6.3
Professional Situation		
Employed	20	41.7
Unemployed	17	35.4
Retired	10	20.8
Work at home	1	2.1

Table 2 - Evaluation of nicotine dependence (Fagerström Test) in clients of the Psychosocial Care Center for Alcohol and Drugs – Set/2008

(n=36)

Questões /Respostas	n	%
1. How many cigarettes do you smoke per day?		
1 to 15 cigarettes	13	36.1
16 to 25 cigarettes	18	50.0
More than 26 cigarettes	5	13.9
2. Do you smoke when you are sick or bedridden?		
Less	18	50.0
The same	16	44.4
More	2	5.6
3. Is it difficult not to smoke in prohibited places such as the church and other places?		
Yes	14	38.9
No	22	61.1
4. Do you smoke more frequently in the morning?		
Yes	26	72.2
No	10	27.8
5. How soon after waking up do you light your first cigarette?		
After 30 minutes	12	33.3
No more than 30 minutes	24	66.7
6. Which cigarette do you find most difficult "not to smoke"?		
Any one of the day	26	72.2
The first one in nothing	10	27.8

Regarding the age of initiation of cigarette use, the mean age was 14.95 years (SD±4.25 years), ranging from 7 to 25 years of age.

In relation to the cigarette consumption pattern of the respondents, 36 were current smokers (75%), including 18 that smoked 16 to 25 cigarettes per day (50%) and fewer when ill, 22 considered it difficult not to smoke in places where it is forbidden (61.1%), 24 smoked soon after waking (66.7%) and, finally, 26 considered it more difficult to go without smoking at least one cigarette a day (72.2%), as indicated in Table 2.

According to Fagerström test results, the following levels of nicotine dependence were identified: 14 mild cases (38.9%), 17 moderate (47.2%) and 5 severe (13.9%).

In relation to the motivation for changes in smoking behavior, 18 clients (50%) said they would like to quit smoking and 29 said they needed help to make these changes (80.6%), as presented in Table 3.

Table 3 - Motivations for changes in smoking behavior in relation to smoking according to clients of the Psychosocial Care Center for Alcohol and Drugs – Set/ 2008

		(n=48)
Motivações	**n**	**%**
Which best describes you now.		
I would like to stop smoking.	18	50.0
I would like to cut down smoking	13	36.1
I do not want to stop smoking	5	13.8
Do you need help to stop smoking		
Yes	29	80.6
Do not want	3	8.3
Do not know	3	8.3
Do not need	1	2.8

DISCUSSION

The results of this study corroborate those presented in the literature[11-12]. Regarding gender, the highest prevalence of smoking worldwide are found predominantly in men, although the difference between the sexes has decreased mainly in developed countries (37% men and 21% in women)[2]. Furthermore, it should also be considered that there is a lower number of women seeking assistance in specialized services, compared to men, especially for the treatment of psychoactive substance use[13].

In terms of age, the literature[14] mentions that the age group considered here offers a great opportunity for performance, first due to the cost effectiveness of the intervention, and secondly due to the fact that quitting smoking promotes a significant reduction in mortality before 35 years of age and to a lesser extent in the range above 65 years of age.

In this study, the low level of education was identified among participants, considering 75% of the interviewees were smokers. This result supports the literature that mentions higher smoking prevalence among people with less than eight years of study, when compared to others[15]. Being a sample that has low levels of education, an issue that can be raised concerns the understanding that users have about nicotine and its consequences for health.

Regarding the age of initiation of cigarette use, it was found that the average age was approximately 15 years and that the habit of smoking started in childhood and adolescence highlighting the need for preventive measures for smoking among adolescents. Nevertheless, the literature[5] describes that, although it starts at a very early age, sickness and death caused by smoking are manifested in adulthood. Which leads us to reflect that the damage from smoking is caused in a cumulative way, and to consider, therefore, that the earlier a person starts smoking, the greater the risks and the sooner one stops smoking, the greater the health benefits.

Studies show that the act of smoking usually begins in adolescence, not because of the psychoactive effects of nicotine, which are unpleasant, but due to a series of sociocultural factors, such as peer pressure, curiosity about the effects of smoking, the pursuit of independence, rebellion and a cultural image associated with pleasure and well-being, the presence of smokers in the family and the experience of stress, among other factors, which are accentuated with various reinforcements[5,15].

Furthermore, it should also be considered that adolescence is characterized by a great interest in experimenting with new behavior, which makes young people more susceptible to stimuli from older colleagues and the massive appeal of advertising. As cigarette consumption intensifies, it becomes a daily consumption, allowing the presence of symptoms of nicotine withdrawal, such as irritability and decreased attention, which, imperceptible at first, usually appear after a period from one to two hours without smoking[16]. From a certain moment, the social factors that contributed to the initiation of nicotine use now count for less and smoking becomes motivated by the use of tobacco more to control withdrawal symptoms than for pleasure. This can be evaluated in the consumption pattern of smokers studied here, where 72% considered it very difficult to refrain from smoking at any time of day. This fact leads us to the past, in which social norms were much more permissive, constructing the act of smoking as glamorous, elegant and charming behavior, which eventually progressively transformed into undesirable behavior and the cause of serious health problems. However, preventive actions are contributing to a significant paradigm shift in this scenario.

Although a pilot study, the data obtained confirmed

high rates of smokers (75%) among clients attended in a service specializing in the treatment of psychoactive substances. According to the literature, the prevalence of smokers is much greater in individuals with psychiatric disorders (70% to 80%)[10-11], who present high levels of smoking severity and a higher risk of relapse after cessation, which does not exclude special attention from programs to help these smokers in the cessation of tobacco use[6,10]. The literature also indicates that smoking rates among individuals seeking treatment for drug addiction are high, being four times higher than those identified in the general population[10].

The limitations of the present study regarding the dual diagnosis were not investigated. However, it is worth noting the existence of the association between tobacco dependence and comorbidities, given that rates are high in the population considered here. In this context, there is evidence that these patients usually present lower socioeconomic status, are single and consume alcoholic beverages at problematic levels, and that these characteristics are associated with smoking[10]. Furthermore, nicotine dependence presents a strong association with the consumption of alcohol and other substances, showing that smokers are more likely to consume alcohol, however, the reverse also occurs[11]. Although not the objective of the study, in the service studied most clients had a main diagnosis of alcohol dependence syndrome[12].

Concerning the characteristics of the pattern of tobacco consumption, half of the participants smoked 16 to 25 cigarettes per day and less when sick, most considered it difficult to refrain from smoking in places where it is forbidden, they smoked soon after waking and finally, they considered that it is hard not to smoke (Table 2). In this respect, studies show that patients who smoke 20 or more cigarettes per day and/or light the first cigarette within half an hour of waking, possibly find it more difficult to abandon tobacco because they present a more intense dependence, requiring specialized assistance coupled with pharmacological treatment[3].

Regarding the results presented by the Fagerström test, it can be observed that nearly half the sample demonstrated a moderate degree of nicotine dependence (5 to 7 points), which confirms the findings presented in literature[17]. However, the representativeness of the sample should also be considered, in that the results cannot be generalized and further studies are needed.

The motivations for behavior change in relation to smoking and the need for help to do so, expressed by the participants, were very positive (Table 3), agreeing with other studies on the subject[3-6]. These data provide indicators for the implementation of actions to support smoking cessation, and highlight the role of the health institutions and their professionals, particularly the nurse, in working with these motivations. Once the motivation to stop smoking is manifested, less than 10% of smokers manage this alone and will probably require some type of support[3-6].

Today motivation is understood as a psychological process that can be accelerated or not by the intervention of health professionals. Such intervention can be evaluated by phases, or stages, of motivation[14], for which health professionals must be trained. This then moves away from the idea of motivation as an immutable trait, on the basis that someone is either motivated to change their behavior, and can be helped, or they are not motivated, and therefore nothing can be done. These motivational stages can be characterized as: pre-contemplation, contemplation, action and maintenance, in which the motivations for behavior change in relation to tobacco use are perceived. Nurses and other professionals should identify these various stages and help the patient to move forward in this process, supported by the therapeutic relationship[14].

In this study, the percentages of smokers who were motivated (to decrease or stop) were added and it was identified that the majority expressed this desire (86.1%). This is a positive fact, also presented in the literature[15], since the best results are usually achieved when the nicotine addict is highly motivated to abandon the use of tobacco. Furthermore, the abrupt cessation of smoking or its gradual reduction present the same probability of success[18-19].

These results present implications in the organization of the service and training of the health team. However, in the CAPS-ad, although it is a specialized service, there were difficulties in the insertion of the smoking cessation program and in the implementation of a tobacco-free environment, compromising the offer of a specific program for smoking cessation, conforming to the proposals of the Ministry of Health.

Thus, the importance of training health professionals who work in the CAPS-ad was identified, mainly concerning the nurses, who are the professionals that are closest to the care. However, quality care to these smokers may be compromised since it appears that this issue is still little explored in the curricular and extracurricular activities of the undergraduate courses in the area of health[14,20].

In particular, the service where this study was developed had structural limitations in the care for smokers because, due to changes in legislation, the demand for professional training was identified, as well as the need to promote a "cigarettes free environment" in a place where seven out of ten clients are smokers. These limitations prevented the CAPS-ad from obtaining its certification as a reference center for the treatment of smoking.

In contrast, after the development of this study, there was a commitment by the professional staff for the adoption of actions aimed at the promotion of a

"tobacco free environment", in order to comply with Law No. 13.541/2009, as well as for an investment in permanent work to raise awareness among service users.

As management measures, notices were placed in all sectors of the service regarding the smoking ban and all ashtrays were removed, for the effectuation of the legislation. Regular awareness workshops were developed, coordinated by the occupational therapist and the nurse, regarding the damage that the consumption of tobacco and its derivatives can cause.

It is noteworthy that the users of the service that are smokers have not been forbidden to smoke, because, for them, there are restricted areas and times for smoking. After the enactment of Law No. 13.541/2009 that restricts smoking, it was noticed empirically that there was a reduction of this behavior, with a significant decrease in the number of cigarettes smoked in this service.

CONCLUSION

Despite the focus of smoking cessation not traditionally being included in treatment programs for drugs, this approach becomes imperative today. Cigarette smoking is now seen not as a problem requiring the approach of the specialist, but as a public health issue, the responsibility for all health professionals. For the field of Nursing, specifically that related to Mental Health, this leads to rethinking the organization of the service in terms of care, and the professional formation, both at the technical level and higher. As evidenced in the literature and in this study, the users of mental health services also have high rates of nicotine dependence.

This data can be added to the existence of motivations for smoking cessation in this same type of user. From the point of view that motivation is not an immutable factor, but can be accelerated by a policy intervention, the offer of effective and continuous programs with a view to stopping smoking, from motivational approaches, may contribute to the establishment of healthy life habits, thus contributing to reducing morbidity and mortality and for the understanding and implementation of existing legislation concerning the subject.

REFERENCES

1. World Health Organization. WHO framework convention on tobacco control. Geneva: World Health Organization; 2003 (updated reprint 2004, 2005). http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf , accessed 23 September 2009
2. World Health Organization; Costa e Silva V, editor. Tools for advancing tobacco control in the XXIst century: policy recommendations for smoking cessation and treatment of tobacco dependence. Tools for public health. Geneva: World Health Organization; 2003. Disponível em: http://www.who.int/tobacco/resources/publications/en/intro_chapter3.pdf
3. Laranjeira R, Gigliotti A. Tratamento da dependência de nicotina. Psiquiatr Prat Med. 2000;33(2):9-18.
4. Fiore MC, Bailey WC, Cohen SJ, Dorfman SF, Goldstein MG, Gritz ER, et al. Treating tobacco use and dependence: Clinical Practice Guideline. Rockville: U.S. Department of Health and Human Services, Public Health Service
5. Cinciripini PM, Hecht SS, Henningfield JE, Manley MW, Kramer BS. Tobacco addiction: implications for treatment and cancer prevention. J Natl Cancer Inst. 1997;89(24):1852-67.
6. Azevedo RCS, Higa CMH, Assumpção ISMA, Frazatto CRG, Fernandes RF, Goulart W, et al. Grupo terapêutico para tabagistas: resultados após seguimento de dois anos. Rev Assoc Med Bras (1992). 2009;55(5):593-6.
7. Carlini EA, Galduróz JCF. II Levantamento domiciliar sobre o uso de drogas psicotrópicas no Brasil: estudo envolvendo as 108 maiores cidades do país: 2005. São Paulo: CEBRID - Centro Brasileiro de Informação sobre Drogas Psicotrópicas: UNIFESP - Universidade Federal de São Paulo; 2006.
8. Brasil. Ministério da Saúde. Instituto Nacional de Câncer. Plano de Implantação da Abordagem e Tratamento do Tabagismo na Rede SUS. Portaria GM/MS 1.035/04. Portaria SAS/MS 442/04. Fluxos de Informação e Instrumentos de Avaliação. Manual de Operação [Internet] 2004. [citado 2010 Abr 01] Disponível em: http://www.inca.gov.br/tabagismo/publicacoes/plano_abordagem_sus.pdf
9. Heatherton TF, Koslowski LT, Frecker RC, Fagerström KO. The Fagerström Test for Nicotine Dependence: a revision of the Fagerström Tolerance Questionnaire. Br J Addict. 1991;86(9):1119-27.
10. Williams JM, Ziedonis D. Addressing tobacco among individuals with a mental illness or an addiction. Addict Behav. 2004;29(6):1067-83. Review.
11. Malbergier A, Oliveira Júnior HP. Dependência de tabaco e comorbidade psiquiátrica. Rev Psiquiatr Clín (São Paulo). 2005;32(5):276-82.
12. Pereira GAM. Evolução dos pacientes com síndrome de dependência de álcool no CAPS-AD II [dissertação]. Ribeirão Preto: Escola de Enfermagem de Ribeirão Preto da Universidade de São Paulo; 2008.
13. Marchini GO, Dellari NO, Taveira MC, Finencio LV, Pillon SC. Uso de álcool e drogas entre mulheres de um CAPS-AD. In: Anais do 9º Congresso Nacional e I Internacional Amor Exigente, 2009, Aracruz ES.
14. Rosemberg J, Rosemberg AMA, Moraes MA. Nicotina: droga universal. São Paulo: Secretaria de Estado da Saúde. Centro de Vigilância Epidemiológica; 2003.
15. Brasil. Ministério da Saúde. Instituto Nacional de Câncer - INCA. Coordenação de Prevenção e Vigilância (CONPREV). Abordagem e tratamento do fumante – Consenso 2001. Rio de Janeiro: INCA; 2001. 38p.
16. Ferreira PM. Tabagismo. In: Andrade AG, Nicastri S, Tongue E. Drogas: atualização em prevenção e tratamento. São Paulo: Lemos; 1993.
17. Halty LS, Hüttner MD, Oliveira Neto IC, Santos VA, Martins G. Análise da utilização do Questionário de Tolerância de Fagerström (QTF) como instrumento de medida da dependência nicotínica. J Pneumol. 2002;28(4):180-6.
18. Jain A. Treating nicotine addiction. BMJ. 2003;327(7428):1394-5.
19. Balbani APS, Montovani JC. Métodos para abandono do

tabagismo e tratamento da dependência da nicotina. Rev Bras Otorrinolaringol. 2005;71(6):820-7.

20. Ramos LH, Pillon SC, Cavalcante MBG, Vilar Luíz M, Padredi FM, Laranjeira RR. O ensino sobre dependência química em cursos de graduação em Enfermagem no Brasil - 1998. Acta Paul Enferm. 2001;14(3):35-43.