Objectives

- Know that brief interventions are effective.
- Describe the components of a brief intervention for smoking cessation.
- Describe how brief interventions are different from motivational interviewing.

Background

Tobacco is the single greatest cause of disease and premature death in America today, and is responsible for more than 430,000 deaths each year. Nearly 25 percent of adult Americans currently smoke, and 3,000 children and adolescents become regular users of tobacco every day. The societal costs of tobacco-related death and disease approach $100 billion each year. However, more than 70 percent of all current smokers have expressed a desire to stop smoking; if they successfully quit, the result will be both immediate and long-term health improvements.

As a physician in training, you should realized that:

1. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.

2. Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments:
   A. Patients willing to try to quit tobacco use should be provided with treatments that are identified as effective in the US Public Health Service guideline.
   B. Patients unwilling to try to quit tobacco use should be provided with a brief intervention that is designed to increase their motivation to quit.

3. It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user who is seen in a health care setting.

4. Brief interventions for tobacco dependence treatment are effective, and every patient who uses tobacco should be offered at least brief treatment.

5. There is a strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact).

6. Three types of counseling and behavioral therapies were found to be especially effective and should be used with all patients who are attempting tobacco cessation:
   A. Provision of practical counseling (problem-solving/skills training).
   B. Provision of social support as part of treatment (intra-treatment social support).
   C. Help in securing social support outside of treatment (extra-treatment social support).

7. Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients who are attempting to quit smoking.
   Six first-line pharmacotherapies reliably increase long-term smoking abstinence rates:
Bupropion SR.
Nicotine gum.
Nicotine inhaler.
Nicotine nasal spray.
Nicotine patch.
Nicotine lozenges

Two second-line pharmacotherapies are efficacious and may be considered by clinicians if first-line pharmacotherapies are not effective:
Clonidine.
Nortriptyline.

Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.

Smokers with greater degrees of dependence are more likely to require pharmacotherapy to successfully quit. The following indicate increased degree of dependence:

- Smoke more cigarettes
- Smoke first thing upon arising
- Smoke more during first hour or two of day than later in day
- Have trouble not smoking in places where it is not allowed (eg, theatres, airplanes)
- Smoke when they are sick enough to stay in bed

8. Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, insurers and purchasers should ensure that:
   A. All insurance plans include as a reimbursed benefit the counseling and pharmacotherapeutic treatments that are identified as effective in this guideline.
   B. Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.

Identification and Assessment of Tobacco Use

The single most important step in addressing tobacco use and dependence is screening for tobacco use. After you have asked about tobacco use and have assessed the willingness to quit, he or she can then provide the appropriate intervention, either by assisting the patient in quitting (the "5 A's") or by providing a motivational intervention, the ("5 R's").

Tobacco Users Willing To Quit

The "5 A's," Ask, Advise, Assess, Assist, and Arrange, are designed to be used with the smoker who is willing to quit.

Ask—Systematically identify all tobacco users at every visit

Advise—Strongly urge all tobacco users to quit

Assess—Determine willingness to make a quit attempt

Assist—Aid the patient in quitting

Help the patient with a quit plan.

Provide practical counseling (problem solving/training).
Provide intra-treatment social support.
Help patient obtain extra-treatment social support.
Recommend the use of approved pharmacotherapy, except in special
Tobacco Users Unwilling to Quit

The "5 R's," Relevance, Risks, Rewards, Roadblocks, and Repetition, are designed to motivate smokers who are unwilling to quit at this time. Smokers may be unwilling to quit due to misinformation, concern about the effects of quitting, or demoralization because of previous unsuccessful quit attempts. Therefore, after asking about tobacco use, advising the smoker to quit, and assessing the willingness of the smoker to quit, it is important to provide the "5 R's" motivational intervention.

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. (and acknowledge benefits patient derives from smoking) 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.

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.

Roadblocks

The clinician should ask the patient to identify barriers or impediments to quitting and note elements of treatment (problem-solving, pharmacotherapy) that could address barriers.

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.

Former Smokers—Preventing Relapse

Most relapses occur soon after a person quits smoking, yet some people relapse months or even years after the quit date. All clinicians should work to prevent relapse. Relapse prevention programs can take the form of either minimal (brief) or prescription (more intensive) programs.

Components of Minimal Practice Relapse Prevention

These interventions should be part of every encounter with a patient who has quit recently. Every ex-tobacco user undergoing relapse prevention should receive congratulations on any success and strong encouragement to remain abstinent. When encountering a recent quitter, use open-ended questions designed to initiate patient problem solving (e.g., How has stopping tobacco use helped you?). The
clinician should encourage the patient’s active discussion benefits derived from quitting, success patient has had in quitting, problems or potential threats to abstinence.

**Components of Prescriptive Relapse Prevention**

During prescriptive relapse prevention, a patient might identify a problem that threatens his or her abstinence. Specific problems likely to be reported by patients are:

Lack of support for cessation

Negative mood or depression

Strong or prolonged withdrawal symptoms

Weight gain

Flagging motivation/feeling deprived

**References:**


Other references:


Silagy, C, Stead, LF. Physician advice for smoking cessation. Cochrane Tobacco Addiction Group, Cochrane Database of Systematic Reviews. 1; 2002.

