Key Findings of the
TREATING TOBACCO USE AND DEPENDENCE
Clinical Practice Guideline

(Published jointly by the Agency for Healthcare Research and Quality, The US Public Health Service and the National Cancer Institute, this guideline was based on an exhaustive systematic review and analysis of the extant scientific literature from 1975 to 1999, using the results of more than 50 meta-analyses)

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:
   - Patients *willing* to try to quit tobacco use should be provided treatments identified as effective in this guideline.
   - Patients *unwilling* to try to quit should be provided a brief intervention designed to increase their motivation to quit.

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

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

5. There is a strong dose-response relation 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:
   - Provision of practical counseling (problem-solving/skills training)
   - Provision of social support as part of treatment (intra-treatment social support)
   - Help in securing social support outside of treatment (extra-treatment social support).

7. Numerous effective pharmacotherapies for smoking cessation now exist. Except in presence of contraindications, these should be used with all patients who are attempting to quit smoking:
   - Five *first-line* pharmacotherapies were identified that reliably increase long-term smoking abstinence rates:
     1) Bupropion SR 2) Nicotine gum
     3) Nicotine inhaler 4) Nicotine nasal spray 5) Nicotine patch
   - Two *second-line* pharmacotherapies were identified as efficacious (clinicians may consider these if the first-lines are not effective):
     1) Clonidine 2) Nortriptyline
   - Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.

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:
   - All insurance plans include as a reimbursed benefit the counseling and pharmacotherapeutic treatments identified as effective in this guideline
   - Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.

Treating Tobacco Use and Dependence:
Patients Willing to Quit
The 5 As

ASK - Systematically identify all tobacco users every visit (i.e., smoking status is the 5th vital sign).

ADVISE - Strongly urge all tobacco users to quit (in a *Clear, strong* and *personalized* manner).

ASSESS - Determine willingness to make a quit attempt (within 30 days).
YES: provide assistance (see next "A") or refer out
NO: provide motivational intervention (see 5Rs)
Special Populations: provide additional information

ASSIST - Aid the patient in quitting.
Help them develop a plan
Provide practical counseling (problem solving/skills training)*
Provide intra-treatment support**
Help patient obtain extra-treatment support***
Recommend approved pharmacotherapy****
Provide supplementary materials

*Practical counseling to help recognize danger situations, develop coping skills and provide basic information on smoking/quitting.

**Intra-treatment support to encourage quit attempt, communicate caring/concern, encourage talking about quitting.

***Extra-treatment support – to help patient learn how to solicit support, prompt them to seek support, arrange outside support.

****Pharmacotherapy – 5 recommended first-line medications (nicotine gum, patch, nasal spray or inhaler and bupropion). Should be used if not contraindicated, special considerations may be needed for some patients (see guideline for details).

ARRANGE – Schedule follow-up contact
Either in-person or via telephone
Soon after quit date, preferably during the first week
Second follow-up within the first month

Treating Tobacco Use and Dependence
Patients Unwilling to Quit
The 5 Rs

Relevance
Elicit specific, personal reasons why quitting is relevant to patient
Help make connection to disease status/risk, family or social situation, health concerns, age, gender, etc.

Risks
Ask patient to identify potential negative consequences (highlight those that are relevant). Look at acute, long-term and environmental risks

Rewards
Ask patient to identify potential benefits of quitting (highlight those that are relevant). E.g., improve health, save money, set good example for children, feel better about self, etc.

Roadblocks
Ask patient to identify barriers to quitting and note elements of treatment (problem solving, pharmacotherapy) that could address them. E.g., withdrawal, fear of failure, weight gain, lack of support, depression, loss of enjoyment

Repetition
Repeat motivational intervention each clinic visit

Former Smokers: Preventing Relapse

Minimal Practice Relapse Prevention =
Use open-ended questions and encourage active discussion of benefits of cessation, successes, problems encountered or anticipated.

Prescriptive Relapse Prevention =
Help patient identify coping mechanisms to address potential threats to abstinence (e.g., lack of support, negative mood/depression, strong or prolonged withdrawal symptoms, weight gain, flagging motivation/feeling deprived).

Source: Fiore MC, Bailey WC, Cohen SJ, et. al. *Treating Tobacco Use and Dependence.* Quick Reference Guide for Clinicians. Rockville, MD: USDHHS Public Health Service. October 2000.

Barriers to Change Identified by VHQC Collaboratives:

1. Current training/practice patterns are difficult to change
2. Staff feel they are doing an adequate job now, they don't see any reason to change
3. Staff are not aware of an impact due to positive outcomes
4. Staff do not sense the seriousness of avoidable adverse events
5. There is resistance to having to do more paperwork and/or documentation
6. There is too little time and/or too many patients
7. Nursing staff does not have the time or knowledge to educate patients about smoking cessation
8. It is difficult to organize a team and set meeting dates (due to issues such as staff illness and weather interfering)
9. Placement of reminder sheets on patients' records and including all patients is difficult to accomplish.
10. It is difficult to get approval from various committees for new/revised forms that will become a permanent part of the patient's record.
11. Chart documentation of discharge instructions is an issue being grappled with
12. "New forms" (reminder systems) are leading to defensiveness from physicians.
13. Pathways are not being used as staff feels they "already know what to do."
14. Screening does not always lead to counseling (in reference to smoking cessation).
15. Physician buy-in has been difficult to obtain.
16. Other items are considered more urgent.
17. Getting staff members to use newly created materials and/or distributing new materials.

Integrating Health Behavior Counseling into Medical Practice

Successful methods of helping clinicians implement effective counseling strategies will be built on what clinicians feel capable of doing well, on appropriate tools and system supports they need and on the expectation that they can't do it all.

How best to implement counseling services means exploring and evaluating clinicians' willingness to counsel patients, the perceived barriers to clinicians' involvement in providing this type of care and the things that would encourage clinicians' participation.

Barriers to identifying and using effective new interventions include:

- Information overload (no time to read a lot, especially in disciplines other than their own)
- No incentives to change they way they practice (which might involve more time, additional training, etc.)
- Difficulty applying academic research done with special resources and controlled populations to real life situations with patients who have multiple problems.
- Questions about what role various clinicians should play in doing health behavior counseling as part of routine care
- Systems-based barriers include: lack of time with patients, lack of reimbursement for these services, fragmented approach to care, and skepticism that health behavior change interventions can make a difference in specific health outcomes.

Facilitators to overcoming barriers (criteria used to evaluate interventions) include:

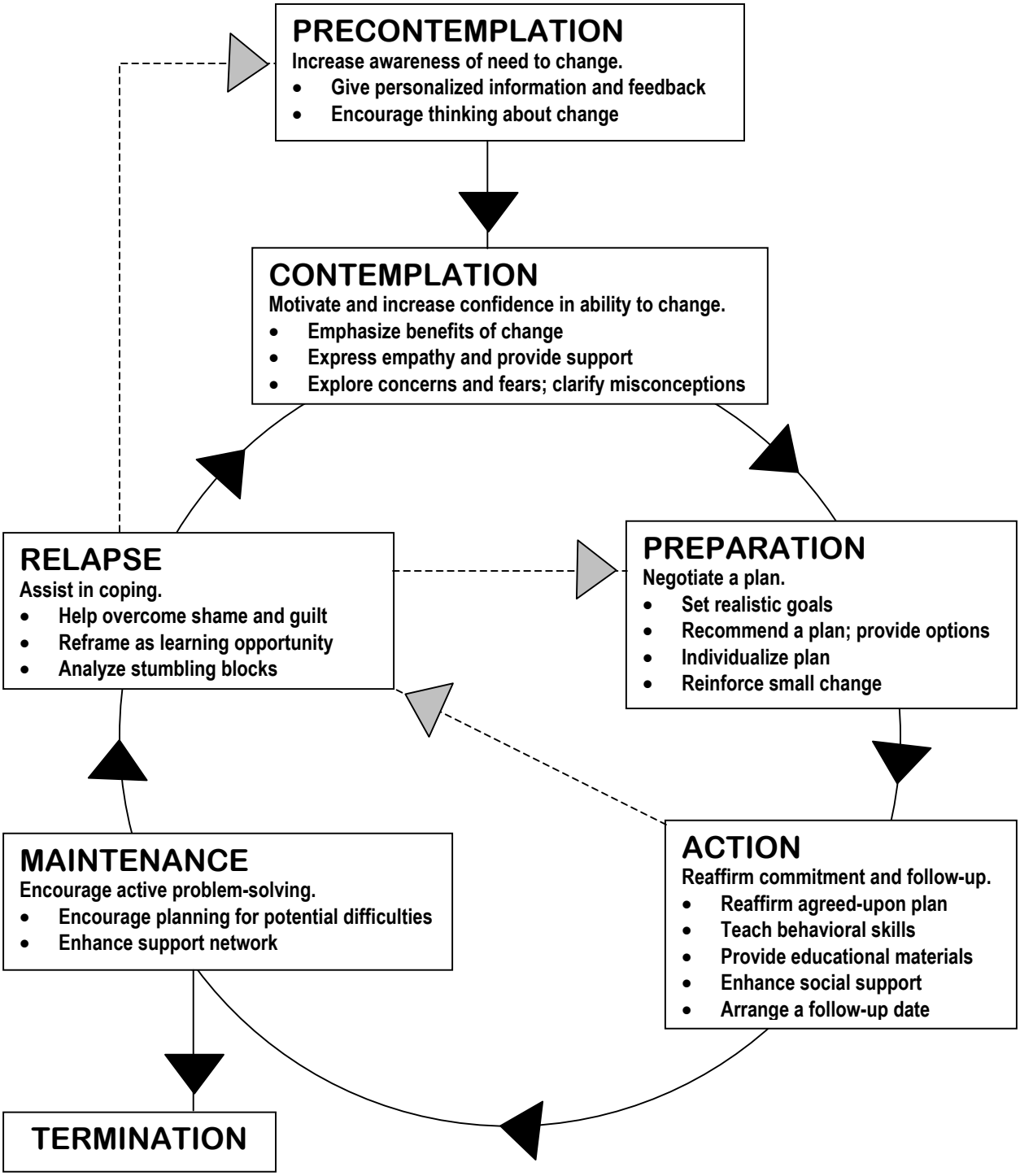
- Perception of effectiveness of the intervention
- Relevance of the research to their practice in terms of population served and health problem/risk factor addressed
- Resources they need to be able to offer the intervention
- Capability they felt of actually carrying out the intervention.

Common Elements of Successful Programs:

- Incorporated health behavior change research findings when designing program (frequently mentioned were Stages of Change model and NCI 4As)
- Overwhelmingly used formal clinical guideline/protocols to deliver services
- More than half developed procedures to encourage guideline use and many provided feedback to clinicians on how well they were adhering to them.

From: *Integration of Health Behavior Counseling in Routine Medical Care*, Center for the Advancement of Health (funding by The Robert Wood Johnson Foundation), April 2001.

Matching Interventions to Stages of Change



STAGES OF CHANGE

Precontemplation:

Smoking, not ready to change, no intention to quit, neither considering stopping nor actively processing smoking and health information.

Ambivalence:
Not ambivalent, wants to keep smoking (the pros greatly out weigh the cons).

Behavior: rejects new information.

Resistance:
Denial, defiance, rationalization, ignorance.

Counseling Approach:
✱ Encourage them to listen to the experience of others, to talk to an ex-smoker;
✱ Raise consciousness/awareness;
✱ Introduce ambivalence: "Is there any way at all in which you'd be better off if you quit? What would it take for you to quit?...";
✱ Correct misunderstandings, provide education about negative consequences of use in all life areas *and* benefits of quitting;
✱ Have them keep a log of tobacco use and identify reasons for use (what role tobacco use plays in their life and it's importance);
✱ Discuss past quit attempts; reinforce reasons for becoming tobacco-free.

Facilitator Behaviors:
✱ Be patient; gain trust, develop rapport, remain non-judgmental;
✱ Acknowledge their thoughts, feelings and concerns (especially if they have attempted to quit in the past);
✱ Explore advantages of quitting for that patient *personally*.

Primary Objective:
INTRODUCE AMBIVALENCE
(plant a "seed")

Contemplation: 60-80% are in this stage

Smoking, thinking about stopping but no "quit date" in mind, not ready for action yet (substituting thinking for acting).

Ambivalence:
Mixed feelings (pros and cons fluctuate), know they "should" quit or "cut down". Aware of need for change but reluctant to take action; Pregnancy may move a woman into this stage.

Behavior:
Willing to receive new information (effects and ways to stop). Most stay in this stage for a year or more (some get "stuck" here).

Resistance: Fear of failure, rationalization.

Counseling Approach:
✱ Evoke recognition of reasons to change and risks of not changing;
✱ Review coping skills, list all "triggers", identify resources and support system;
✱ Educate re: withdrawal and use of adjuncts;
✱ Clarify values and role of smoking, personalize benefits of quitting;
✱ Explore potential barriers, expectations, fears;
✱ Explore both sides of the ambivalence (reasons for/against stopping): "What do you like about smoking?... How would you be better off if you quit?... What will you miss most?... In past, which withdrawal symptoms gave you trouble?"

Facilitator Behaviors:
✱ Acceptance, patience, be supportive (and positive about previous attempts);
✱ Validate feelings of helplessness/defeat and offer hope by expressing willingness and ability to help - be optimistic about chances of success;

Primary Objective:
RESOLVE AMBIVALENCE
(tip the balance)

Preparation/Planning:

Smoking, motivated to stop within one month, wants to develop strategies for quitting, committed to acting but needs to prepare.

Ambivalence:
Not ambivalent, wants to stop smoking (cons outweigh the pros).

Behavior:
Requests advice/information, may have already taken steps to quit (cut down/delayed first smoke of the day).

Resistance:
Fear of failure/success, ignorance.

Counseling Approach:
✱ Directness, clarity, specific suggestions & behavioral strategies such as: eliminate stash, clean house/car/clothing, develop diet/nutrition & exercise plan, positive self-talk, oral/handling substitutes, develop "rewards", list positive effects of not smoking/reasons for quitting;
✱ Select a quit date within a few weeks & schedule a follow-up session, use a contract;
✱ Identify an acceptable approach, structure a plan of action with patient - describe options available for quitting and help patient negotiate a selection;
✱ Identify the function tobacco served, the triggers & high risk situations and how to develop alternative behaviors and sources of support;
✱ Provide resource materials, teach skills (stress management, relaxation & distraction techniques);
✱ Prepare for withdrawal; refer for OTC &/or prescription medication(s) if appropriate;
✱ Assess for depression and eating disorders.

Facilitator Behaviors:
✱ Allow the individual to make the decisions;
✱ Use approval, praise, encouragement.

Primary Objective:
PROVIDE STRATEGIES
(give them tools).

Action:

Not smoking (quit date to 6 months), has successfully stopped, is at risk for relapse.

✱ Continue assessing efficacy of current plan, along with appropriate restructuring;
✱ Identify relapse issues as they arise and review/expand coping skills;
✱ Distinguish between lapse and relapse(lapse does not *have* to lead to relapse);
✱ Educate re: all tobacco-free time (even one day or one hour) is proof of successful quitting/coping strategies;
✱ Develop strategies to deal with withdrawal symptoms and weight gain;
✱ Refer for depression/eating disorders, etc;
✱ Encourage use of support system (e.g., NicA);
✱ Support even minimal progress & acknowledge all progress.

Maintenance:

✱ Continue relapse prevention strategies (identifying relapse triggers and specific countermeasures or alternative behaviors);
✱ Identify self-defeating behaviors & clarify what needs to change;
✱ Explore personal growth issues & monitor health regularly.

Relapse:

✱ Reduce patient's feelings of shame;
✱ Identify barriers to success;
✱ Thoroughly explore relapse triggers & events around the relapse;
✱ Move as quickly as possible into Preparation or Action stage.

Sources: Dr. Terry Rustin and the UMDNJ Tobacco Dependence Program.

(Excerpts)

Techniques for Smoking Cessation: What Really Works?

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Abstract

Cigarettes (and tobacco) represent the most significant lifestyle risk for cancer, accounting for more than 400,000 deaths in the US each year. The cancer risk in smokers is proportional to the number of cigarettes smoked in the patient's lifetime; therefore, smoking cessation is always in the best interest of a smoker's health.

Physicians can play a crucial role in the success of their patients' smoking cessation programs. Experimental studies, observational studies, and the experience of seasoned physicians have identified a number of effective strategies which any physician can use. This article presents several brief counseling approaches and a summary of pharmacologic treatments which can be incorporated into office and hospital practice.

Cancer of the lung, larynx, mouth, esophagus, stomach, head and neck, urinary bladder, breast and colon are associated with smoking—as well as heart disease, chronic obstructive lung disease, and stroke. Tobacco smoking kills more than 400,000 Americans every year. The incidence of these illnesses is proportional to the total number of cigarettes smoked during the individual's lifetime; quitting smoking reduces the risk[1].

Smokers look to their physicians for help in quitting smoking, and physicians can assist patients in quitting smoking through advice, brief counseling, support, and the prescribing of medications[2]. However, busy physicians often hesitate to broach the subject of smoking cessation with patients because they believe they lack both the time and the expertise. The following strategies, including several brief interventions and the prescribing of medication, demonstrate that successful smoking cessation interventions can be done by any physician, in less than three minutes, in the context of an office or hospital visit.

Brief intervention counseling approaches for physicians

Establishing the patient's readiness to quit smoking[3]

Ask your staff to add "smoking status: former smoker/current smoker/never smoked" to the vital signs they measure and record on the chart when the patient arrives in your office. This establishes the patient's behavior but does not clarify their cognitions. During your interview, ask the patient, "What are your thoughts and feelings about quitting smoking?" Patients who reply with an answer reflecting no ambivalence about continuing to smoke, such as, "I don't want to quit smoking," are in the Precontemplation stage (about 10 percent of smokers). Patients who give an ambivalent response, such as "I'd like to quit smoking, but I don't think I can," or "I know I need to quit smoking, but I don't want to give it up" are in the Contemplation stage (about 80 percent of smokers). Preparation patients (just 10 percent) will give an answer showing that they have resolved their ambivalence and are ready to quit, such as, "What kind of treatment can you give me to help me quit?"

Focusing your intervention on the patient's stage of readiness

Brief interventions succeed when the physician correctly identifies the patient's stage of readiness to change, and focuses the intervention on moving the patient one stage at a time toward quitting.

Precontemplation. Precontemplation patients intend to continue to smoke and are not ambivalent; therefore, the goal is to introduce ambivalence—not to get them to quit smoking. Here are two proven strategies:

Strategy 1: During the examination, the physician examines the patient's heart, lungs, etc, and detects a physical finding associated with smoking. The

physician pauses and states, “You know, that wheezing in your chest (or those cyanotic fingertips, those premature wrinkles, that flaccid penis, or that rapid pulse) will get a lot better after you quit smoking.” Not “might get better,” but “will get better.” Not “if you quit,” but “after you quit.” The keys to success are making the observations personal and specific, and making the predictions positive and affirming.

Strategy 2: Use projection to identify a patient’s unspoken thoughts and feelings, in this way: “Many of my patients have quit smoking; in fact, the research shows that 50 million Americans have quit smoking. Why do you imagine all those people have quit smoking?” No matter what the patient says, agree, and then ask for details. For example, the patient might state: “For their health.” The physician should then inquire about the specific health risk the patient has in mind. Psychologically, the patient is revealing his or her inner worries (projection), since the patient has no idea why all those people really quit smoking.

Contemplation. Contemplation patients are ambivalent. The physician can assist these patients in resolving their indecision by exploring both sides of their ambivalence, but emphasizing the value of change. Start by asking, “What do you like about smoking,” and acknowledge every statement the patient makes. Then ask, “How will your life be better, after you have quit smoking?” spending more time and asking for details about the new, smokefree lifestyle. Physicians will have more success with these patients by discussing their future than by lecturing them on the dangers of smoking.

Preparation. Preparation patients have resolved their ambivalence and are ready for a plan. Move them into action by giving them self-help material, helping them set a Quit Date, and advising them on medication. The best Quit Date is one that has intrinsic value to the patient (a birthday, anniversary, holiday), and that has been set at least a few weeks into the future to give the patient time to prepare. The website www.quitandstayquit.com includes self-help materials, self-assessment tools, patient information, and links to other helpful sites, as well as assessment tools for professionals.

Summary

Brief counseling interventions can help move patients who smoke from Precontemplation (when they are angry and unwilling), through Contemplation (when they are troubled and uncertain) to Preparation (when they are committed and decisive). Once they have set a Quit Date, they are good candidates for medication to treat nicotine withdrawal and craving. Using a judicious combination of brief interventions and medications, physicians can help their patients make the most important lifestyle change of their lives—quitting smoking.

References

1. U.S. Department of Health and Human Services. The Health Consequences of Smoking: Nicotine Addiction. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office on Smoking and Health, DHHS Publication 88-8406, 1988.
2. The Agency for Health Care Policy and Research. Smoking Cessation Clinical Practice Guidelines. (1996). JAMA 275:1270-1280.
3. DiClemente CC, Prochaska JO, Fairhurst SK, Velicer WF, Velasquez MM, Rossi JS. (1991). The process of smoking cessation: An analysis of precontemplation, contemplation, and preparation stages of change. J Consult Clin Psychology 59:295-304.

(Excerpts)

Assessment of Nicotine Dependence in Family Practice Patients

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Abstract

Family physicians can make an assessment of their patients' smoking in one or two minutes, using carefully chosen questions. The CAGE for Smoking test (modified from the familiar CAGE test for alcoholism), The Four Cs (based on the DSM-IV), and the Fagerström Test for Nicotine Dependence help make the diagnosis of nicotine dependence based on standard criteria. Additional questions assess the patient's readiness to change and the nature of the reinforcement the patient receives from smoking. An even more extensive assessment form is available on the World Wide Web for free downloading.

Accurate assessment precedes treatment in any medical condition. Using one or more of the tools described in this paper will assist family physicians in guiding patients toward quitting smoking—which is the single most important thing smokers can do to improve their health.

READINESS TO CHANGE

After using one or more of the above assessment tools, the family physician will have sufficient information to know what a patient needs to do to quit smoking. However, the physician will not yet know how ready the patient is to make a serious attempt to quit smoking. If clinicians only ask, "Do you currently smoke?" and the patient answers "yes," the clinician has information about the patient's behavior, but not about the cognition behind the behavior. Knowing the patient's cognitive set is crucial to success, because advice and treatment must match the patient's cognitive stage in order to be effective.

Prochaska and DiClemente identified discreet stages along the continuum of change and formulated the Transtheoretical Model of Change based on cigarette smoking behavior. They now identify those stages as Precontemplation, Contemplation, Preparation, Action, Maintenance, and Relapse [13,14,15]. Several instruments have been designed to measure the patient's readiness to change, the best known being the URICA (University of Rhode Island Change Assessment).

However, most clinicians will do just as well with a two-question assessment for determining the stage of change of smokers:

> "Do you currently smoke?"
> If yes: "What are your thoughts and feelings about quitting smoking?"

Patients in Precontemplation will respond with a non-ambiguous answer, indicating that they have no intention of changing. Some actual responses by Precontemplation smokers have been:

- Anger: "Just get off my back, all right?"
- Entitlement: "Who the hell are you to tell me what to do?"
- Ignorance: "I already smoke a low-tar cigarette, so there's no need to quit."
- Denial: "Some people get lung cancer from smoking, but it won't happen to me."
- Defiance: "I'll smoke if I want to."

The goal of counseling with Precontemplation patients is to introduce ambivalence, so they will begin to consider quitting; prescribing cessation medication and providing cessation strategies does not help these patients quit smoking.

Patients in Contemplation usually respond with two answers, one about wanting to quit, and the other about wanting to continue smoking. Some actual responses by Contemplation smokers have been:

"I want to quit smoking, but I don't think I'll be able to."
"I like smoking, but I'm concerned about this cough."

The goal of counseling with Contemplation patients is to explore both sides of their ambivalence (with the emphasis on how their lives will improve after quitting), which helps them resolve their ambivalence in favor of quitting.

Patients in Preparation will respond with a non-ambiguous answer, indicated that they have resolved their ambivalence. Even though they are still smoking, they have made a decision to quit. They respond with statements like these:

"You finally convinced me to quit smoking, Doc."
"I've heard there's some new medication out to help me quit."

The goal of counseling with Preparation patients is to assess previous quit attempts, identifying what worked before (in order to build on prior successes) and what the barriers to success have been in the past.

Precontemplation and Contemplation patients have not yet decided to quit smoking—only Preparation patients have reached that stage. In this model, the clinician's responsibility is to guide patients one stage at a time toward Action, when they actually cease smoking. [see Table 1] Although this transition often takes many years, some patients move from Contemplation through Preparation and into Action within a single clinical encounter.

SUMMARY

Assessment precedes treatment in the management of all medical conditions, including nicotine dependence. This paper has presented a variety of formats family physicians can use to query patients about their smoking, yielding information to diagnose nicotine dependence, to assess their physical dependence on nicotine, to identify some of the factors perpetuating their smoking behavior, and to assess their readiness to quit.

TABLE 1. Summary of physician counseling based on the Stages of Change

Stage of Readiness	**"What are your thoughts and feelings about quitting smoking?"**	**Goal of the intervention**	**Typical physician intervention**
Precontemplation	"I like to smoke."	Introduce ambivalence	"Your emphysema will improve after you've quit smoking."
Contemplation	"I like to smoke, but I know I need to quit."	Resolve ambivalence	"How will your life be better after you've quit smoking?"
Preparation	"I'm ready to quit."	Identify successful strategies	"Choose a Quit Day and let's make plans for it."
Action	"I'm not smoking, but I still think about smoking from time to time."	Provide solutions to specific relapse triggers	"How can you deal with your desire to smoke in those situations?"
Maintenance	"I used to smoke."	Solidify patient's commitment to a smoke-free life	"This would be a good time to share your experience with other people."

REFERENCES

13. DiClemente CC, Prochaska JO, Fairhurst SK, Velicer WF, Velasquez MM, Rossi JS. The process of smoking cessation: An analysis of precontemplation, contemplation, and preparation stages of change. J Consult Clin Psychology 1991;59:295-304.
14. Prochaska JO, DiClemente CC. Toward a comprehensive model of change. In: Miller WR, Hester NK, eds. Treating addictive behaviors: Processes of change. New York: Plenum Press, 1986:3-27.
15. Rustin TA, Tate JC. Measuring the stages of change in cigarette smokers. J Substance Abuse Treatment, 1993;10:209-220.

THE HARRIS POLL #10, February 14, 2001 (excerpts)

THE POWER OF TOBACCO ADDICTION

by Humphrey Taylor

- 80% of smokers have tried to stop (on average eight times)
- 88% of smokers believe that their smoking increases their risk of getting lung cancer
- 84% of smokers believe that their smoking increases their risk of getting heart disease
- 80% of smokers believe that their smoking will probably shorten their lives
- 80% of smokers say they have tried to stop, and have done so more than a few times
- On average, people who are still smoking say they have tried to stop, and failed, as many as eight times

Of course, smoking has been declining, but many people have been surprised that it has not declined faster when it is generally accepted, even by most smokers, to be a major cause of death and disease and is no longer acceptable in most offices, restaurants or homes. Indeed it is now decidedly unfashionable. The reason is clearly the difficulty of breaking a very strong addiction. One other theory – which is disproved by this Harris Poll – is that smokers do not believe that they themselves are at risk from smoking. Most smokers know it puts them at risk. Unfortunately smokers' understanding of the health risks of tobacco is not enough to stop them lighting up. These survey data leave little room to doubt that the power of nicotine addiction is the main reason why smoking has not declined any faster, even though most smokers would like to, and try to, give it up.

Seven Aspects of Nicotine Dependence

1. Addiction to the drug nicotine
2. Satisfaction derived from smoking/tobacco use behavior
3. Attachment to the image of being a smoker/tobacco user
4. Ritualized behaviors associated with tobacco use
5. Conditioned responses
6. Use of nicotine/tobacco/smoking to control feelings
7. Denial of the consequences of tobacco use

CHARACTERISTICS OF ADDICTION

- Distortion - inhibits self-awareness & distorts perception of reality

- Compulsive
  - addict no longer has a choice
  - nothing can compete with use
- Predictable
  - seeks same drug effect
  - provides escape
- Restrictive
  - consumes time & energy
  - limits involvement in life
- Destructive
  - lowers self-esteem
  - negative consequences

Addiction is negative adaptive behavior in that it seeks short-term rewards (produced by drug effect) and ignores long-term consequences.

Changing addictive behavior requires conscious and continuing effort until new behavior patterns are established.

Hospital Stay Represents "Teachable Moment" for Smokers

By Ann Quigley, Contributing Writer, Health Behavior News Service, 4/22/03
Source: http://www.hbns.org/news/teach04-22-03.cfm

Smokers who are hospitalized for any condition are in a perfect place to receive help in quitting, suggest the results of a recent study that offered smoking-cessation help to patients and followed their success for a year.

"The findings strongly suggested that hospitalization presents an excellent teachable moment for virtually all smokers," says lead study author Harry Lando, Ph.D., of the Division of Epidemiology at the University of Minnesota in Minneapolis.

After interviewing 1,477 inpatient smokers, Lando and colleagues offered one of three treatments. Some patients received manuals and resources for smoking cessation, others received manuals plus brief smoking cessation advice from nurses and physicians, and still others received manuals, advice, bedside counseling and several telephone calls from a smoking-cessation counselor after discharge.

The researchers contacted the participants to ask them about their smoking status within a few weeks after discharge and again about a year after discharge. Participants who reported having quit at the 12-month interview were asked to prove it by submitting a saliva sample that was tested for cotinine, a tobacco byproduct.

The researchers then examined whether certain groups of participants (e.g., older vs. younger, men vs. women) were more likely to quit. While certain categories of participants demonstrated higher quit rates than others, the researchers found the hospitalization experience generally benefited most categories of smokers.

"The experience of hospitalization itself led to substantial long-term quitting for virtually all categories of hospitalized smokers," Lando says. The study results are published in the current issue of the journal *Nicotine & Tobacco Research*.

Those who were the least likely to quit were younger, had not contemplated quitting at the start of the study period and tended to start smoking just after awakening. In contrast, older participants, those who had already started to quit at the beginning of the study, those diagnosed with a smoking-related illnesses, and those who were not likely to smoke first thing in the morning were the most likely to quit.

In the short-term, but not at the 12-month study checkpoint, males had higher quit rates than females, married individuals had higher quit rates than the unmarried, and black participants had lower quit rates than other ethnic groups.

"The lower initial rates of quitting for African-Americans suggest the need for more aggressive promotion of cessation in this population," Lando says, while noting that "the 12-month abstinence rates for African-Americans of 10.4 percent were at least moderately encouraging."

The researchers suggest that different smoking cessation approaches may be appropriate for different categories of patients. For example, patients not currently planning to quit, who had the lowest quit rates in the study, may need some extra attention to nudge them to the next stage of quitting readiness. For these pre-contemplators, "motivational interviewing techniques may be particularly appropriate," Lando says.

The researchers say they plan to report the success of the individual treatments in a future study; in this study they focused on the success of the treatments as a whole.

This research was supported by a grant from the National Institutes of Health. Health Behavior News Service: (202) 387-2829 or <www.hbns.org >. Contact Harry Lando at lando@epi.umn.edu or (612) 624-1877.

Predictors of quitting in hospitalized smokers

Harry Lando, Deborah Hennrikus, Maribet McCarty, John Vessey
Nicotine & Tobacco Research, Volume 5, Number 2 / April 2003, pp. 215-222

Abstract:
Hospitalization represents a teachable moment for quitting. The current study examined predictors of quitting among hospitalized smokers. Patients reported smoking history and demographic characteristics during in-hospital baseline interviews. Discharge diagnosis also was collected. Smoking status was ascertained in interviews at 7 days and at 12 months after discharge. A total of 2,350 patients in four Minneapolis and St. Paul (Twin Cities), Minnesota, area hospitals participated in the study; 1,477 patients who provided data at both follow-ups and whose 12-month self-report of quitting was corroborated by cotinine analysis of saliva samples were included in the current analyses. Predictors of both short- and long-term abstinence in the multivariate analysis included smoking-related illness, age (those who were older were more likely to be abstinent), stage of change (precontemplators were least likely to quit, and those initially in action were most likely to quit), and time to first cigarette (those who reported smoking within 5 min of awakening were least likely to quit). The predictors presented few surprises; the most important finding may have been that the experience of hospitalization itself led to substantial long-term quitting for virtually all categories of hospitalized smokers.

RESEARCH DATA – STAGES OF CHANGE:

Characteristics of participants in each stage of change (averages from three staging questionnaires)

STAGE OF CHANGE	AGE	CIGARETTES PER DAY	24 HR QUIT ATTEMPT MADE IN PAST 12 MO. (%)	INTENTION TO QUIT (0-10 score)	QUIT AMOKING AT 32 DAY FOLLOW-UP (%)
PRECONTEMPLATION	39	21	35	2.1	5
CONTEMPLATION	40	18	53	6.6	8
PREPARATION	38	15	100	8.6	23
ACTION	39	-	-	-	78
MAINTENANCE	50	-	-	-	97

From: Assessing 'stage of change' in current and former smokers. Etter JF, Sutton S. *Addiction* (2002) 97, 1171-1182.

Predictors of cessation at 7-day and 12-month post-hospital discharge

VARIABLE		% QUIT AT 7 DAYS	% QUIT AT 12 MONTHS
Time to first cigarette	Within 5 minutes	26.4	14.0
	6-30 minutes	36.1	18.1
	31-60 minutes	34.7	18.5
	After 60 minutes	34.2	22.1
Stage of change	Precontemplation	9.4	6.1
	Contemplation	30.2	18.5
	Preparation	34.0	16.6
	Action	77.1	34.8
Cigarettes per day	9 or fewer	31.3	20.7
	10-19	32.1	17.6
	20-19	29.5	13.7
	30 or more	36.7	20.1
Patient perception: smoking related to hospitalization	Not at all related	24.4	13.7
	Somewhat related	34.6	16.2
	Very much related	49.1	29.2
	Don't know	41.6	15.6
Smoking-related diagnosis	Yes	48.6	27.0
	No	24.7	13.0
24-hr quit attempt from discharge to 7-day interview	Yes	48.9	23.0
	No	.0[a]	6.3
Quit at 7-day interview	Yes		38.1
	No		7.4

[a]By definition, a subject could not be abstinent at 7-day follow-up without having made at least a 24-hr quit attempt.

From: Predictors of quitting in hospitalized smokers. Lando H, Hennrikus D, McCarty M, Vessey J. *Nicotine & Tobacco Research* (2003) 5, 215-222.

NATIONAL PNEUMONIA
Medicare Quality Improvement Project

Interventions Sampler: Inpatient

Took Kit for Tobacco Dependency and Smoking Cessation	Click below to view samples One Hospital Story... (20k) Key findings (21k) Strategies (18k) Chart sticker (11k) Counseling sticker (17k) Stop smoking poster (13k) TDTP order form (175k)	RTF format: Letter from Hospital to PCP (30k) Sample hospital policy (30k) Sample physician order (31k) Sample patient education discharge contract (31k) Supplemental order info (32k)
Developed by:	Missouri Patient Care Review Foundation	
Brief Overview:	Took kit for tobacco dependency and smoking cessation was developed in response to requests from providers. It is designed to capitalize on capturing the opportunity of a patient's need for medical intervention as a time to impact smoking cessation. It was tested with five hospitals prior to mass production and includes a CD-ROM to allow providers to personalize materials for their facility. The kit includes sample letters, physician orders, and discharge contract in both paper and electronic formats. Stickers and a poster are also included.	
Setting:	Inpatient/Outpatient	
Target audience:	• Beneficiaries • Hospital Staff • Providers	
Collaborators and Partners in Intervention Development	The toolkit includes materials from the American Cancer Society, US Department of Health and Human Services, AHRQ	
Barriers:	One of the pilot hospitals expressed concern over the "Smoker" sticker that was to be placed on the patient's chart. The concept of the sticker was to identify the patient as being on the tobacco dependency program so that each caregiver could provide support during their care of the patient. The QIO suggested that the sticker be placed in a more confidential location within the chart. An additional barrier identified by several of the facilities is regarding smoking professionals and the irony of having a smoking caregiver providing smoking cessation advice.	
Lessons Learned:	• As a response to the needs of the pilot hospitals, the QIO made the tools easy to individualize to the facility. • The tool is called "Tobacco Dependence Treatment Program," rather than "Smoking Cessation Program" because of the psychological connotations. Quitting smoking is hard and the patients need to know that the caregivers recognize the difficultyof this life change.	
Helpful Hints:	• The occasion of hospitalization creates a "teachable moment." Literature shows that the patients are, during this time at the peak of motivation and are at a point of readiness to assess their illness and health status. • Literature also shows that there is a definite negative effect to not providing smoking cessation counseling – the patient may think that "smoking is okay" because no one said anything negative about it. • Please read the section "One Hospital's Story..." to find how this project can improve patient satisfaction and decrease the demand on human resources for the hospital.	
Relevant Links:	Missouri Patient Care Review Foundation, www.mpcrf.org	

Source: http://www.nationalpneumonia.org/interventions/sampler/sampler-inpt/sampin7/sampin7.html