

QUICK REFERENCE GUIDE FOR CLINICIANS

Treating Tobacco Use And Dependence

U.S. Department of Health and Human Services
Public Health Service

To ALL CLINICIANS

The Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, on which this Quick Reference Guide for Clinicians is based was developed by a multidisciplinary, non-Federal panel of experts, in collaboration with a consortium of tobacco cessation representatives, consultants, and staff. Panel members and guideline staff were:

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An explicit, science-based methodology was employed along with expert clinical judgment to develop recommendations on treating tobacco use and dependence. Extensive literature searches were conducted and critical reviews and syntheses were used to evaluate empirical evidence and significant outcomes. Peer review was undertaken to evaluate the validity, reliability, and utility of the guideline in clinical practice.

This Quick Reference Guide for Clinicians presents summary points from the Clinical Practice Guideline. The guideline provides a description of the development process, thorough analysis and discussion of the available research, critical evaluation of the assumptions and knowledge of the field, more complete information for health care decisionmaking, and references. Decisions to adopt particular recommendations from either publication must be made by practitioners in light of available resources and circumstances presented by the individual patient.

As clinicians, you are in a frontline position to help your patients by asking two key questions: “Do you smoke?” and “Do you want to quit?” followed by use of the recommendations in this Quick Reference Guide for Clinicians.

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ABSTRACT

This Quick Reference Guide for Clinicians contains strategies and recommendations from the Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence*. The guideline was designed to assist clinicians; smoking cessation specialists; and health care administrators, insurers, and purchasers in identifying and assessing tobacco users and in delivering effective tobacco dependence interventions. It was based on an exhaustive systematic review and analysis of the extant scientific literature from 1975-1999, and uses the results of more than 50 meta-analyses.

This Quick Reference Guide summarizes the guideline strategies for providing appropriate treatments for every patient. Effective treatments for tobacco dependence now exist, and every patient should receive at least minimal treatment every time he or she visits a clinician. The first step in this process—identification and assessment of tobacco use status—separates patients into three treatment categories: (1) patients who use tobacco and are willing to quit should be treated using the “5 A’s” (*Ask, Advise, Assess, Assist, and Arrange*); (2) patients who use tobacco but are unwilling to quit at this time should be treated with the “5 R’s” motivational intervention (*Relevance, Risks, Rewards, Roadblocks, and Repetition*); and (3) patients who have recently quit using tobacco should be provided relapse prevention treatment.

SUGGESTED CITATION

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PURPOSE

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. Clinicians have a vital role to play in helping smokers quit.

The analyses contained within the Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, demonstrate that efficacious treatments for tobacco users exist and should become a part of standard caregiving. Research also shows that delivering such treatments is cost-effective. In summary, the treatment of tobacco use and dependence presents the best opportunity for clinicians to improve the lives of millions of Americans nationwide in a cost-effective manner.

KEY FINDINGS

The guideline identified a number of key findings that clinicians should utilize:

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 with treatments that are identified as effective in the guideline.
 - ▶ 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 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 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:
 - ▶ Provision of practical counseling (problemsolving/skills training);
 - ▶ Provision of social support as part of treatment (intra-treatment social support); and
 - ▶ 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.
 - ▶ Five *first-line* pharmacotherapies were identified that reliably increase long-term smoking abstinence rates:
 - Bupropion SR
 - Nicotine gum
 - Nicotine inhaler
 - Nicotine nasal spray
 - Nicotine patch



- ▶ Two *second-line* pharmacotherapies were identified as 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.
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 that are identified as effective in this guideline; and
 - ▶ Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.

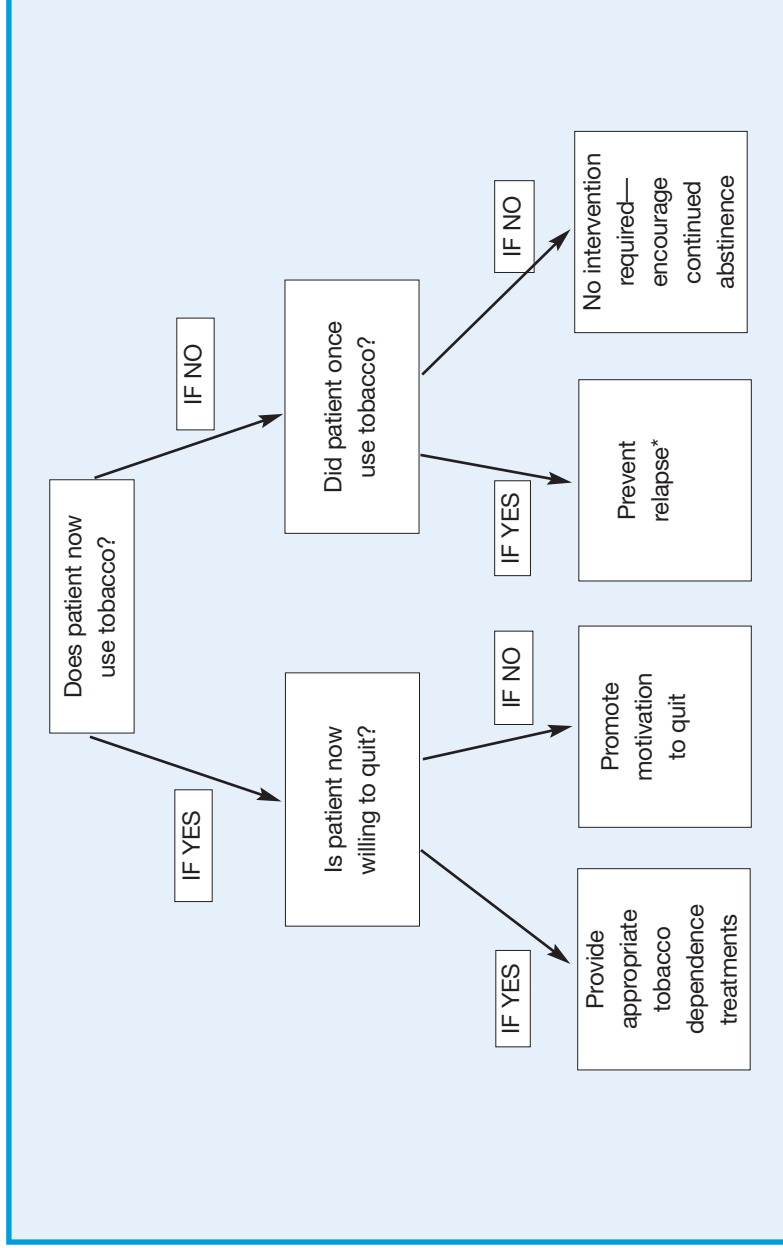
IDENTIFICATION AND ASSESSMENT OF TOBACCO USE

The single most important step in addressing tobacco use and dependence is screening for tobacco use. After the clinician has asked about tobacco use and has assessed the willingness to quit, he or she can then provide the appropriate intervention, either by assisting the patient in quitting (the “5A’s”) or by providing a motivational intervention, the (“5 R’s”). Figure 1 can be used as a guide to identify both current and former tobacco users and to provide the appropriate treatment of all patients. The following three sections address the main three groups of patients: (1) smokers who are willing to make a quit attempt, (2) smokers who are unwilling to make a quit attempt at this time, and (3) former smokers.





Figure 1. Screen for tobacco use status



*Relapse prevention interventions are not necessary in the case of the adult who has not used tobacco for many years.

Table 3. Assess—determine willingness to make a quit attempt

<p>Ask every tobacco user if he or she is willing to make a quit attempt at this time (e.g., within the next 30 days).</p>	<p>Assess patient's willingness to quit:</p> <ul style="list-style-type: none">■ If the patient is willing to make a quit attempt at this time, provide assistance.■ If the patient will participate in an intensive treatment, deliver such a treatment or refer to an intensive intervention.■ If the patient clearly states he or she is unwilling to make a quit attempt at this time, provide a motivational intervention.■ If the patient is a member of a special population (e.g., adolescent, pregnant smoker, racial/ethnic minority), consider providing additional information.
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Table 4. Assist—aid the patient in quitting

<p>Help the patient with a quit plan.</p>	<p>A patient's preparations for quitting:</p> <ul style="list-style-type: none">■ <i>Set a quit date</i>—ideally, the quit date should be within 2 weeks.■ <i>Tell</i> family, friends, and coworkers about quitting and request understanding and support.■ <i>Anticipate</i> challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms.■ <i>Remove</i> tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, car).
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Table 4. Assist—aid the patient in quitting (continued)

<p>Provide practical counseling (problemsolving/training).</p>	<ul style="list-style-type: none"> ■ <i>Abstinence</i>—Total abstinence is essential. “Not even a single puff after the quit date.” ■ <i>Past quit experience</i>—Review past quit attempts including identification of what helped during the quit attempt and what factors contributed to relapse. ■ <i>Anticipate triggers or challenges in upcoming attempt</i>—Discuss challenges/triggers and how patient will successfully overcome them. ■ <i>Alcohol</i>—Because alcohol can cause relapse, the patient should consider limiting/abstaining from alcohol while quitting. ■ <i>Other smokers in the household</i>—Quitting is more difficult when there is another smoker in the household. Patients should encourage housemates to quit with them or not smoke in their presence.
<p>Provide intra-treatment social support.</p>	<ul style="list-style-type: none"> ■ Provide a supportive clinical environment while encouraging the patient in his or her quit attempt. “My office staff and I are available to assist you.”
<p>Help patient obtain extra-treatment social support.</p>	<ul style="list-style-type: none"> ■ Help patient develop social support for his or her quit attempt in his or her environments outside of treatment. “Ask your spouse/partner, friends, and coworkers to support you in your quit attempt.”

Table 4. Assist—aid the patient in quitting (continued)

<p>Recommend the use of approved pharmacotherapy, except in special circumstances.</p>	<ul style="list-style-type: none"> ■ Recommend the use of pharmacotherapies found to be effective. Explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy medications include: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch.
<p>Provide supplementary materials.</p>	<ul style="list-style-type: none"> ■ <i>Sources</i>—Federal agencies, nonprofit agencies, or local/state health departments. <i>Type</i>—Culturally/racially/educationally/age appropriate for the patient. <i>Location</i>—Readily available at every clinician’s workstation.

Assist Component—Three Types of Counseling

Assisting patients in quitting smoking can be done as part of a brief treatment or as part of an intensive treatment program. Evidence from the guideline demonstrates that the more intense and longer lasting the intervention, the more likely the patient is to stay smoke-free; even an intervention lasting fewer than 3 minutes is effective. The following three tables provide further detail and examples of the three forms of counseling that were found to be effective in treating tobacco use and dependence: (1) practical counseling (problemsolving/skills training), (2) intra-treatment social support, and (3) extra-treatment social support.



Table 5. Common elements of practical counseling

<p><i>Recognize danger situations—</i> Identify events, internal states, or activities that increase the risk of smoking or relapse.</p>	<ul style="list-style-type: none"> ■ Negative affect. ■ Being around other smokers. ■ Drinking alcohol. ■ Experiencing urges. ■ Being under time pressure.
<p><i>Develop coping skills—</i> Identify and practice coping or problemsolving skills. Typically, these skills are intended to cope with danger situations.</p>	<ul style="list-style-type: none"> ■ Learning to anticipate and avoid temptation. ■ Learning cognitive strategies that will reduce negative moods ■ Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure. ■ Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention).
<p><i>Provide basic information—</i> Provide basic information about smoking and successful quitting.</p>	<ul style="list-style-type: none"> ■ Any smoking (even a single puff) increases the likelihood of full relapse. ■ Withdrawal typically peaks within 1-3 weeks after quitting. ■ Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating. ■ The addictive nature of smoking.

Table 6. Common elements of intra-treatment supportive

Encourage the patient in the quit attempt.	<ul style="list-style-type: none"> ■ Note that effective tobacco dependence treatments are now available. ■ Note that one-half of all people who have ever smoked have now quit. ■ Communicate belief in patient's ability to quit.
Communicate caring and concern.	<ul style="list-style-type: none"> ■ Ask how patient feels about quitting. ■ Directly express concern and willingness to help. ■ Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings.
Encourage the patient to talk about the quitting process.	<p>Ask about:</p> <ul style="list-style-type: none"> ■ Reasons the patient wants to quit. ■ Concerns or worries about quitting. ■ Success the patient has achieved. ■ Difficulties encountered while quitting.

Table 7. Common elements of extra-treatment supportive

Train patient in support solicitation skills.	<ul style="list-style-type: none"> ■ Show videotapes that model support skills. ■ Practice requesting social support from family, friends, and coworkers. ■ Aid patient in establishing a smoke-free home.
Prompt support seeking.	<ul style="list-style-type: none"> ■ Help patient identify supportive others. ■ Call the patient to remind him or her to seek support. ■ Inform patients of community resources such as hotlines and helplines.
Clinician arranges outside support.	<ul style="list-style-type: none"> ■ Mail letters to supportive others. ■ Call supportive others. ■ Invite others to cessation sessions. ■ Assign patients to be "buddies" for one another.



Assist Component—Pharmacotherapy

The use of pharmacotherapy is a key part of a multicomponent approach to assisting patients with their tobacco dependence. The following tables address the clinical use of pharmacotherapies for tobacco dependence and some of the more common questions and concerns regarding pharmacotherapy.

Table 8. Clinical guidelines for prescribing pharmacotherapy for smoking cessation

Who should receive pharmacotherapy for smoking cessation?	All smokers trying to quit, except in the presence of special circumstances. Special consideration should be given before using pharmacotherapy with selected populations: those with medical contraindications, those smoking fewer than 10 cigarettes/day, pregnant/breastfeeding women, and adolescent smokers.
What are the first-line pharmacotherapies recommended?	All five of the FDA-approved pharmacotherapies for smoking cessation are recommended, including bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and the nicotine patch.
What factors should a clinician consider when choosing among the five first-line pharmacotherapies?	Because of the lack of sufficient data to rank-order these five medications, choice of a specific first-line pharmacotherapy must be guided by factors such as clinician familiarity with the medications, contraindications for selected patients, patient preference, previous patient experience with a specific pharmacotherapy (positive or negative), and patient characteristics (e.g., history of depression, concerns about weight gain).
Are pharmacotherapeutic treatments appropriate for lighter smokers (e.g., 10-15 cigarettes/day)?	If pharmacotherapy is used with lighter smokers, clinicians should consider reducing the dose of first-line NRT* pharmacotherapies. No adjustments are necessary when using bupropion SR.

*NRT=Nicotine replacement therapy

Table 8. Clinical guidelines for prescribing pharmacotherapy for smoking cessation (continued)

What second-line pharmacotherapies are recommended?	Clonidine and nortriptyline.
When should second-line agents be used for treating tobacco dependence?	Consider prescribing second-line agents for patients unable to use first-line medications because of contraindications or for patients for whom first-line medications are not helpful. Monitor patients for the known side effects of second-line agents.
Which pharmacotherapies should be considered with patients particularly concerned about weight gain?	Bupropion SR and nicotine replacement therapies, in particular nicotine gum, have been shown to delay, but not prevent, weight gain.
Are there pharmacotherapies that should be especially considered in patients with a history of depression?	Bupropion SR and nortriptyline appear to be effective with this population.
Should nicotine replacement therapies be avoided in patients with a history of cardiovascular disease?	No. The nicotine patch in particular is safe and has been shown not to cause adverse cardiovascular effects.
May tobacco dependence pharmacotherapies be used long-term (e.g., 6 months or more)?	Yes. This approach may be helpful with smokers who report persistent withdrawal symptoms during the course of pharmacotherapy or who desire long-term therapy. A minority of individuals who successfully quit smoking use <i>ad libitum</i> NRT medications (gum, nasal spray, inhaler) long term. The use of these medications long term does not present a known health risk. Additionally, the FDA has approved the use of bupropion SR for a long-term maintenance indication.
May pharmacotherapies ever be combined?	Yes. There is evidence that combining the nicotine patch with either nicotine gum or nicotine nasal spray increases long-term abstinence rates over those produced by a single form of NRT.



Table 9. Suggestions for the clinical use of pharmacotherapies for smoking cessation^a

First-line Pharmacotherapies		(Approved for use for smoking cessation by the FDA)				
Bupropion SR	History of seizure History of eating disorder	Insomnia Dry mouth	150 mg every morning for 3 days, then 150 mg twice daily (Begin treatment 1-2 weeks pre-quit)	7-12 weeks maintenance up to 6 months	Zyban (prescription only)	\$3.33
Nicotine Gum		Mouth soreness Dyspepsia	1-24 cigs/day- 2 mg gum (up to 24 pcs/day) 25+ cigs/day- 4 mg gum (up to 24 pcs/day)	Up to 12 weeks	Nicorette, Nicorette Mint (OTC only)	\$6.25 for 10, 2-mg pieces \$6.87 for 10, 4-mg pieces
Nicotine Inhaler		Local irritation of mouth and throat	6-16 cartridges/day	Up to 6 months	Nicotrol Inhaler (prescription only)	\$10.94 for 10 cartridges
Nicotine Nasal Spray		Nasal irritation	8-40 doses/day	3-6 months	Nicotrol NS (prescription only)	\$5.40 for 12 doses





Table 9. Suggestions for the clinical use of pharmacotherapies for smoking cessation^a (continued)

Nicotine Patch		Local skin reaction Insomnia	21 mg/24 hours 14 mg/24 hours 7 mg/24 hours	4 weeks then 2 weeks then 2 weeks	Nicoderm CQ, (OTC only), Generic patches (prescription and OTC)	Brand name patches \$4.00- \$4.50 ^c
			15 mg/16 hours	8 weeks	Nicotrol (OTC only)	
Second-line Pharmacotherapies (Not approved for use for smoking cessation by the FDA)						
Clonidine	Rebound hypertension	Dry mouth Drowsiness Dizziness Sedation	0.15-0.75 mg/day	3-10 weeks	Oral Clonidine- generic, Catapres (prescription only) Transdermal Catapres (prescription only)	Clonidine- \$0.24 for 0.2 mg Catapres (transdermal) \$3.50
Nortriptyline	Risk of arrhythmias	Sedation Dry mouth	75-100 mg/day	12 weeks	Nortriptyline HCl-generic (prescription only)	\$0.74 for 75 mg

^aThe information contained within this table is not comprehensive. Please see package insert for additional information.

^bPrices based on retail prices of medication purchased at a national chain pharmacy, located in Madison, WI, April 2000.

^cGeneric brands of the patch recently became available and may be less expensive.

Assist Component—Intensive Interventions

Intensive interventions are appropriate for any tobacco user who is willing to use them. Evidence shows that intensive interventions are more effective than brief interventions and should be used whenever possible (e.g., available resources, patient is willing). The following table presents the results of guideline analyses that examined different components of intensive treatment programs.

Table 10. Components of an intensive intervention

Assessment	Assessments should ensure that tobacco users are willing to make a quit attempt using an intensive treatment program. Other assessments can provide information useful in counseling (e.g., stress level, presence of comorbidity).
Program clinicians	Multiple types of clinicians are effective and should be used. One counseling strategy would be to have a medical/health care clinician deliver messages about health risks and benefits and deliver pharmacotherapy, and nonmedical clinicians deliver additional psychosocial or behavioral interventions.
Program intensity	Because of evidence of a strong dose-response relationship, the intensity of the program should be: <i>Session length</i> —longer than 10 minutes. <i>Number of sessions</i> —4 or more sessions. <i>Total contact time</i> —longer than 30 minutes.
Program format	Either individual or group counseling may be used. Proactive telephone counseling also is effective. Use of adjuvant self-help material is optional. Followup assessment intervention procedures should be used.
Type of counseling and behavioral therapies	Counseling and behavioral therapies should involve practical counseling (problemsolving/skills training) (see Table 5) and intra-treatment (see Table 6) and extra-treatment social support (see Table 7).

Table 10. Components of an intensive intervention (continued)

Pharmacotherapy	Every smoker should be encouraged to use pharmacotherapies endorsed in the guideline, except in the presence of special circumstances. Special consideration should be given before using pharmacotherapy with selected populations (e.g., pregnancy, adolescents). The clinician should explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy agents include: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and the nicotine patch. (see Tables 8 and 9).
Population	Intensive intervention programs may be used with all tobacco users willing to participate in such efforts.

Assist Component—Special Populations

Interventions should be culturally, language, and educationally appropriate. In general, the treatments that were found to be effective in the guideline can be used with members of special populations, including hospitalized smokers, members of racial and ethnic minorities, older smokers, and others.

Table 11. Arrange—schedule followup contact

Schedule followup contact, either in person or via telephone.	<p><i>Timing</i>—Followup contact should occur soon after the quit date, preferably during the first week. A second followup contact is recommended within the first month. Schedule further followup contacts as indicated.</p> <p><i>Actions during followup contact</i>—Congratulate success. If tobacco use has occurred, review circumstances and elicit recommitment to total abstinence. Remind patient that a lapse can be used as a learning experience. Identify problems already encountered and anticipate challenges in the immediate future. Assess pharmacotherapy use and problems. Consider use or referral to more intensive treatment.</p>
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TOBACCO USERS UNWILLING TO QUIT

The “5 R’s,” *Relevance*, *Risk*, *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. 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. Examples of risks are:

- ▶ Acute risks: Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, and increased serum carbon monoxide.
- ▶ Long-term risks: Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability, and need for extended care.
- ▶ Environmental risks: Increased risk of lung cancer and heart disease in spouses; higher rates of smoking in children of tobacco users; increased risk for low birth weight, SIDS, asthma, middle ear disease, and respiratory infections in children of smokers.

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. Examples of rewards follow:

- ▶ Improved health.
- ▶ Food will taste better.
- ▶ Improved sense of smell.
- ▶ Save money.
- ▶ Feel better about yourself.
- ▶ Home, car, clothing, breath will smell better.
- ▶ Can stop worrying about quitting.
- ▶ Set a good example for children.
- ▶ Have healthier babies and children.
- ▶ Not worry about exposing others to smoke.
- ▶ Feel better physically.
- ▶ Perform better in physical activities.
- ▶ Reduced wrinkling/aging of skin.

Roadblocks

The clinician should ask the patient to identify barriers or impediments to quitting and note elements of treatment (problemsolving, pharmacotherapy) that could address barriers. Typical barriers might include:

- ▶ Withdrawal symptoms.
- ▶ Fear of failure.
- ▶ Weight gain.
- ▶ Lack of support.
- ▶ Depression.
- ▶ Enjoyment of tobacco.

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 problemsolving (e.g., How has stopping tobacco use helped you?). The clinician should encourage the patient's *active* discussion of the topics below:

- ▶ The benefits, including potential health benefits, that the patient may derive from cessation.
- ▶ Any success the patient has had in quitting (duration of abstinence, reduction in withdrawal, etc.).
- ▶ The problems encountered or anticipated threats to maintaining abstinence (e.g., depression, weight gain, alcohol, other tobacco users in the household)

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 and potential responses follow:

Lack of support for cessation

- ▶ Schedule followup visits or telephone calls with the patient.
- ▶ Help the patient identify sources of support within his or her environment. (Table 7.)
- ▶ Refer the patient to an appropriate organization that offers cessation counseling or support.

Negative mood or depression

- ▶ If significant, provide counseling, prescribe appropriate medications, or refer the patient to a specialist.

Strong or prolonged withdrawal symptoms

- ▶ If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved pharmacotherapy or adding/combining pharmacologic medication to reduce strong withdrawal symptoms.

Weight gain

- ▶ Recommend starting or increasing physical activity; discourage strict dieting.
- ▶ Reassure the patient that some weight gain after quitting is common and appears to be self-limiting.
- ▶ Emphasize the importance of a healthy diet.
- ▶ Maintain the patient on pharmacotherapy known to delay weight gain (e.g., bupropion SR, nicotine-replacement pharmacotherapies, particularly nicotine gum).
- ▶ Refer the patient to a specialist or program.

Flagging motivation/feeling deprived

- ▶ Reassure the patient that these feelings are common.
- ▶ Recommend rewarding activities.
- ▶ Probe to ensure that the patient is not engaged in periodic tobacco use.
- ▶ Emphasize that beginning to smoke (even a puff) will increase urges and make quitting more difficult.

CONCLUSION

Tobacco dependence is a chronic disease that deserves treatment. Effective treatments have now been identified and should be used with every current and former smoker. This Quick Reference Guide for Clinicians provides clinicians with the tools necessary to effectively identify and assess tobacco use, treat tobacco users *willing* to quit, treat tobacco users who are *unwilling* to quit at this time, and treat former tobacco users. There is no clinical intervention available today that can reduce illness, prevent death, and increase quality of life more than effective tobacco treatment interventions.



GUIDELINE AVAILABILITY

This guideline is available in several formats suitable for health care practitioners, the scientific community, educators, and consumers.

The *Clinical Practice Guideline* presents recommendations for health care providers with brief supporting information, tables and figures, and pertinent references.

The *Quick Reference Guide* is a distilled version of the clinical practice guideline, with summary points for ready reference on a day-to-day basis.

The *Consumer Version* is an information booklet for the general public to increase consumer knowledge and involvement in health care decisionmaking.

The full text of the guideline documents and the meta-analyses references for online retrieval are available by visiting the Surgeon General's Web site: **www.surgeongeneral.gov/tobacco/default.htm**

Single copies of these guideline products and further information on the availability of other derivative products can be obtained by calling any of the following Public Health Service clearinghouses' toll-free numbers:

Agency for Healthcare Research and Quality (AHRQ)
800-358-9295

Centers for Disease Control and Prevention (CDC)
800-CDC-1311

National Cancer Institute (NCI)
800-4-CANCER

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