ABC of smoking cessation

Use of simple advice and behavioural support

Tim Coleman

The most effective methods of helping smokers to quit smoking combine pharmacotherapy (such as nicotine or bupropion) with advice and behavioural support. These two components contribute about equally to the success of the intervention. Doctors and other health professionals should therefore be familiar with what these strategies offer, encourage smokers to use them, and be able at least to provide simple advice and behavioural support to smokers. They also need to be familiar with other sources of support, such as written materials, telephone helplines, and strategies for preventing relapses. This article focuses on non-pharmacological interventions.

Brief advice

The Cochrane Tobacco Addiction Group defines brief advice against smoking as “verbal instructions to stop smoking with or without added information about the harmful effects of smoking.” All the published guidelines on managing smoking cessation recommend that all health professionals should give simple brief advice routinely to all smokers whom they encounter. The success rate of brief advice is modest, achieving cessation in about 1 in 40 smokers, but brief advice is one of the most cost effective interventions in medicine. The previous article in this series gave tips on how to take account of smokers’ motivation to stop, but the key point is that only one or two minutes are needed for effective brief advice to be delivered in routine consultations.

Advice along these lines is probably most effective in smokers with established smoking related disease. It is also more effective if more time is spent discussing smoking and cessation and if a follow up visit is arranged to review progress. More intensive advice (taking more than 20 minutes at the initial consultation), inclusion of additional methods of reinforcing advice (such as self help manuals, videos, or CD Roms and showing smokers’ their exhaled carbon monoxide levels), and follow up can increase success rates by a factor of 1.4. Again, the cost effectiveness of these more intensive interventions is extremely high—higher than many of the interventions provided routinely in primary or secondary care. The case is therefore strong to integrate simple advice into all health consultations with smokers and to offer more intensive advice and follow up to smokers who are motivated to quit.

Behavioural support

Intensive behavioural support provided outside routine clinical care by appropriately trained smoking cessation counsellors is the most effective non-pharmacological intervention for smokers who are strongly motivated to quit. Meta-analyses of trials have shown that about 1 in 13 smokers who are motivated enough to attend individual counselling from a smoking cessation counsellor are likely to quit as a result of this. Different approaches to counselling based on various psychological models have been studied, but no one type of intensive behavioural support is clearly more effective than any other. Behavioural support usually involves a review of patients’ smoking histories and their motivation to quit, with smokers being helped to identify situations where they might have a

Suggested phrasing for giving brief advice to smokers

- “The best thing you can do for your health is to stop smoking, and I would advise you to stop as soon as possible.”
- “Tobacco is very addictive, so it can be very difficult to give up, and many people have to try several times before they succeed. Your chances of succeeding are much greater if you make use of counselling support, which I can arrange for you, and either nicotine replacement therapy or the antismoking drug Zyban [bupropion], which I can prescribe for you if you wish.”
- “If you are ready to try to give up smoking now, then the best thing is to see a counsellor as soon as possible, and I can arrange that for you. If not, then I’d like you to take home this leaflet and read it, or ring the NHS smokers’ helpline, to get further information.”
- “The best thing is to get counselling from experts, but if this isn’t possible, you should make sure that you have good information on the health effects of smoking and some tips on ways of stopping smoking and that you know where to turn for further help and support.”
- “How do you feel about your smoking?”
- “How do you feel about tackling your smoking now?”

Cost effectiveness of brief advice versus common medical interventions

Measuring the level of carbon monoxide in smokers’ exhaled air can motivate them to quit or be a useful tool in monitoring their progress with cessation

high risk of relapsing during a quit attempt; counsellors also encourage smokers to develop problem based strategies for dealing with these situations.

Intensive behavioural support is equally effective whether for an individual or on a group basis, but the latter is more cost effective (although not all smokers are willing to take part in a group). Moreover, in a group, smokers gain mutual support from other smokers who are trying to quit. Sessions are generally smoker oriented, and group facilitators, who manage 20 to 25 smokers simultaneously, ensure that smokers' key concerns about quitting are tackled.

Who should deliver these interventions?

All doctors and other health professionals should provide brief advice as a low intensity but routine intervention to all smokers who use their services. For smokers who do not wish to take up intensive behavioural support, doctors or other professionals should, where possible, also provide advice and follow up in primary and secondary care services; this should be provided either directly by the primary or secondary care clinician or by arrangement with another healthcare professional. Intensive support services need to be available to all smokers by referral. How to organise and deliver these services is discussed later in this series.

In the United Kingdom, smoking cessation services have now been established as part of a national initiative, and all health professionals should be able to refer smokers for behavioural support from a person who has specifically trained for this role. Any interested, trained health professional can be an effective smoking cessation counsellor, and those working for smoking cessation services in England come from varied clinical and non-clinical backgrounds.

Written self help materials and helplines

Self help materials that aim to promote smoking cessation are defined by the Cochrane Collaboration as "structured programming for smokers trying to quit without intensive contact from a therapist." This definition includes written leaflets, videos, and CD Roms. Giving smokers self help materials is more effective than doing nothing but is not as effective as simple advice. The effectiveness of self help materials may be improved by tailoring them to individual smokers' needs. Telephone helplines are widely available and provide a simple alternative means of providing low cost counselling or advice to motivated smokers, although they are also less effective than face to face advice from a health professional.

Complementary therapies

Complementary therapies have been advocated by some as effective cessation interventions, but little evidence exists to support their use. Acupuncture and related therapies such as acupressure have been found to be no more effective than placebo therapies. Similarly, although hypnotherapy is also provided in the belief that it can weaken the desire to smoke or can strengthen the will to stop, no convincing evidence exists that it works. Designing placebo care for randomised, controlled trials of complementary therapies is challenging, but without such trials no conclusions can be reached about the utility of complementary therapies in smoking cessation.

Strategies used in intensive behavioural support

- Review smoking history—number smoked per day, time of first cigarette in the day. Ask smoker to keep diary of activities that coincide with smoking
- Review smoking behaviour—past quit attempts, what helped, and reasons for failure
- Emphasise need for total abstinence
- Emphasise need to combat psychological and physical nicotine addiction, where appropriate
- Identify triggers to smoking and encourage smoker to develop strategies for countering these (for example, avoid places or activities associated with smoking)
- If relevant, encourage smoker to develop strategies for avoiding relapse when drinking alcohol
- Encourage appropriate action: set quit date, inform or enlist support of peer group or family, and prescribe nicotine addiction treatment
- Follow up to review progress and prescribe or issue nicotine addiction treatment

Adequate training in smoking cessation counselling is much more important than the discipline of the health professional providing that support

Written leaflets can also help people to stop smoking

Websites giving quitline information

- <http://cancercontrol.cancer.gov/tcrb/quitlines.html> (United States)
- www.ash.org.uk/html/quit/givingup.html (for guide to UK quitlines)
- www.asianquitline.org (UK, for Asians)
- www.quitnow.info.au/quitlineinfo.html (Australia)
- www.quit.org.nz (New Zealand)

The challenge for those who advocate complementary therapies in smoking cessation is to provide evidence for their effectiveness

Prevention of relapse

Most smokers who are trying to stop make several quit attempts before they succeed. Consequently, smokers have frequently been provided with treatments that health professionals believe will help smokers to sustain quit attempts and will help to prevent relapse. Recent American guidelines on smoking cessation recommended that when clinicians encounter a patient who has recently quit smoking they should reinforce the patient's decision to quit and help the patient to resolve any residual problems.

Combination with pharmacotherapy

All the evidence on the combination of non-pharmacological and pharmacological interventions indicates that the effects multiply rather than add together. Therefore the effectiveness of all non-pharmacological therapy is increased substantially by pharmacotherapy, and the more intensive the non-pharmacological support, the greater the extent of that increase. It is therefore important that non-pharmacological interventions are recognised as equal contributors to the overall success of smoking cessation interventions, which can achieve up to 20% success with any quit attempt, and that they are not discarded as inferior or irrelevant alternatives to drug treatment. The provision of non-pharmacological interventions, ranging from simple advice to intensive behavioural support, needs to become a routine component of healthcare delivery to smokers.

Further reading

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- Stead LF, Lancaster T, Perera R. Telephone counselling for smoking cessation. *Cochrane Database Syst Rev* 2003;(2):CD002850.

Competing interests: TC has been paid for speaking at a conference by GlaxoSmithKline, a drug company that manufactures treatments for nicotine addiction; he has also done consultancy work on one occasion for Pharmacia. See first article in this series (24 January 2004) for the series editor's competing interests.

Comparison of effective smoking cessation interventions: percentage of smokers who quit as a result of the intervention. Adapted from Raw et al. *Thorax*. 1998;53(suppl 5, part 1):S1-19

Key points

- Simple advice to give up smoking is one of the most cost effective interventions in medicine
- Doctors and other health professionals should routinely give brief, non-judgmental advice to stop smoking to all smokers they see
- Self help materials such as leaflets, videos, or helplines provide additional support
- Intensive behavioural support from a trained counsellor is the most effective non-drug treatment for smokers
- Behavioural support is equally effective for groups and individuals
- The most effective interventions combine behavioural support with drug treatment
- Therapy that combines drug treatment with the level of behavioural support most acceptable to the smoker should be routinely available to all smokers

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Chronic fatigue syndrome

Chronic fatigue syndrome, which can affect children and adults, puts a heavy burden on patients, carers, and families. It is characterised by overwhelming mental and physical fatigue accompanied by a wide range of other symptoms. Treatment is supportive, encouraging the patient to manage activity, rehabilitation, and symptom control.

Chronic fatigue syndrome can affect people of either sex, at any age, and of any racial, ethnic, and social group. But its cause remains unknown. Specific infections may act as a trigger in some people. Examples of such infections include Epstein-Barr virus (up to 10% of patients with infectious mononucleosis may develop chronic fatigue syndrome), enteroviruses, viral meningitis, and viral hepatitis.

Estimates of the prevalence of chronic fatigue syndrome in Britain range from 0.4% to 2.6%, so general practitioners are likely to have patients with this condition on their list. To find out more, try our new learning module "Chronic fatigue syndrome" on *bmjlearning.com*. The module outlines the basics of the diagnosis and management and gives useful tips. For example, delayed exacerbation of symptoms after exercise (occurring up to 72 hours later) is a typical feature of the syndrome.

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