“Let’s take a moment”
quit smoking brief intervention
– a guide for all health professionals
foreword

Smoking is recognised as the leading preventable cause of morbidity and premature mortality in Australia, particularly from cancer, cardiovascular disease and chronic obstructive pulmonary disease (COPD). The evidence is clear that smoking cessation reduces the risk of these diseases and a broad range of other serious illnesses, resulting in major health benefits that commence within minutes of smoking the last cigarette and continue to accrue for many years.

It was recently estimated that the total social costs of smoking to NSW were $6.6 billion in 1998/99. This figure includes health care costs, absenteeism and loss of productivity in the workforce, and costs arising from the high level of premature mortality caused by smoking. The health care costs to NSW included medical, hospital, nursing home and pharmaceutical costs and totalled almost $480 million in that year.

There is evidence that advice from health professionals is effective in encouraging smoking cessation. Combining brief advice with other effective interventions such as pharmacotherapy can considerably increase quit smoking success.

This document has been developed to assist health professionals in the NSW health system to provide evidence-based brief advice to clients who smoke, as part of their routine clinical practice. The following recommendations are relevant for all health professionals and not only those based in primary care.

The evidence base for the provision of smoking cessation advice is stronger for some health professionals than others. The World Health Organization recommends that the involvement of health professionals in offering smokers help should be based on factors such as their access to smokers and level of training and skill, rather than their professional discipline.

Advising and supporting smokers in quitting is an activity for the whole health care system and should be integrated into as many settings as possible throughout the NSW health system. This includes hospital and community settings.

This document, “Let’s take a moment”, Quit smoking brief intervention – a guide for all health professionals outlines clear and practical advice in the provision of smoking cessation interventions for health professionals. It is based on evidence for best practice and I hope that it will encourage health professionals in the NSW Health workforce to address this important public health problem. I commend this document to you.

Yours sincerely,

Dr Denise Robinson
Chief Health Officer and
Deputy Director-General, Population Health
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NSW Health Quit smoking brief intervention – a guide for all health professionals
The staff of the NSW Health Tobacco and Health Branch would like to thank the following people and organisations for the advice and assistance provided in the preparation of this document:

- The officers of the Queensland Department of Health Alcohol Tobacco & Other Drugs Service, who collaborated on earlier drafts of this booklet.
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acknowledgments
There has never been a better time for all health professionals to join, or reaffirm a commitment to, the effort to address tobacco smoking in our community.

Many smokers may now be contemplating a quit attempt as a result of new smoking bans being introduced in all indoor areas of licensed venues and in some jurisdictions, all workplaces. A 2004 Victorian study found that smoking bans in pubs and clubs can reduce cigarette consumption and increase quitting among smokers who frequently patronise these places. Twenty-eight per cent of smokers reported that they were somewhat, or very likely to quit smoking altogether, if smoking is banned in pubs and clubs (Letcher, Black, Lipscombe, Wakefield & Durkin 2004).

Most current smokers would like to quit smoking. More than half of smokers plan to quit smoking in the next six months (NSW Health 2005) and more than 80 per cent have made a previous quit attempt (Carter et al 2001).

There is now a plethora of evidence for the effectiveness of quit smoking interventions and pharmacotherapy, creating momentum to reinforce our activities to help all smokers to quit.

This guide provides health professionals with effective strategies to identify smokers and assist them to make a quit attempt.

This guide and accompanying chart provides:

- a simple five-step process (the ‘5As’) for smoking cessation brief intervention
- an evidence-based approach
- practical ways to assess nicotine dependence and stage of change quickly and effectively as part of routine client consultation
- information on the health effects of smoking and the benefits of quitting
- information on pharmacotherapy
- tips for motivational interviewing
- sample questions to use when conducting brief interventions.


Components of the recommended brief interventions in this guideline are adapted from the ‘Smokescreen’ program, (Richmond et al 1991) which applied Prochaska and DiClemente’s ‘Stage of Change Model’ to smoking cessation intervention in the General Practice setting. The Smokescreen program acknowledges that the smoker’s level of motivation to quit smoking is a key issue and advice is provided based on the smoker’s readiness to quit. This approach may be of assistance to busy clinicians providing brief advice.

The evidence base that underpins this guide has been drawn from the National Tobacco Strategy publication ‘Smoking cessation interventions: review of evidence and implications for best practice in health care settings’ (Miller and Wood 2002).
role of the health professional

There is evidence that advice from health professionals is effective in encouraging smoking cessation. The World Health Organization (WHO) encourages provision of brief opportunistic interventions delivered by all health professionals in the course of their routine work. WHO proposes that involvement in offering smokers help be based on factors such as access to smokers rather than professional discipline (World Health Organization 2001).

Health professionals are well placed to make a significant difference in smoking cessation (Richmond et al 1999; Silagy et al 2003) because:

- they are seen as important sources of credible health information
- smokers expect to receive quit smoking advice from health professionals
- brief, repeated, non-judgmental assistance works.

Combining brief advice with other effective interventions such as pharmacotherapy can considerably increase quit smoking success.

Time is a limited commodity in health care provision. That’s why brief intervention, which can involve as little as three minutes of assistance, is particularly suitable. Making the most of any opportunity to raise awareness, share information and get a client to think about making changes to their tobacco smoking behaviour is worth the time and effort. In busy health services, clients may consult a different health professional each time they visit. Recording the intervention in the client record enables multiple service providers to monitor the client’s smoking status and progress with quitting.

Brief smoking cessation counselling can assist smokers to quit. Similar to other population-based strategies, when implementing brief intervention it can be difficult to see immediate results. However, although there may be a modest effect for the individual, there is the potential for substantial population health benefit. This is because brief interventions motivate large numbers of smokers to make a quit attempt. Also, for every client who becomes an ex-smoker, there is a new smoke-free role model for young people, and there are potential positive impacts on family, work colleagues, and community.

Treatments delivered by more than one type of health professional increase abstinence rates. Individual and group counselling, proactive telephone counselling, provision of problem-solving skills training, and helping smokers obtain social support outside of treatment, are all effective methods of increasing long-term quit rates. There is evidence that greater numbers of counselling sessions, with total contact time of up to 90 minutes (over multiple sessions) increase cessation rates. There is no evidence that acupuncture is an effective treatment and insufficient evidence to recommend hypnotherapy as a treatment for smoking cessation (Miller & Wood 2002).
The Quitline service is referred to throughout this guide. The Quitline is a 24-hour, seven-days, telephone service that offers free assistance to smokers and former smokers interested in changing their smoking behaviour and quitting or staying quit. Callers can access this service by ringing one telephone number (13 7848 or '13 QUIT') from anywhere in Australia. The Quitline service is available for the cost of a local call, with higher costs for mobile phones.

The Quitline counsellors can provide advice about quitting smoking, help to assess a smoker's level of nicotine dependence, provide strategies on preparing to quit, prevention of relapse and staying a non-smoker, and can provide information on products and services to assist in quitting. All callers will be offered a free Quit Kit, which the counsellor will arrange to be posted to the caller within one working day. The NSW Quitline offers a free 'callback' service to provide extra support to people during their quit attempt. Quitting smokers can enrol in this service free of charge and receive a series of calls tailored to meet their individual needs, to help them keep on track.

The national Quitline number in use since 1997 was 131 848 and many people may still have existing resources with this original Quitline number displayed on them. The new number (13 7848) has been introduced to enable use of the alphanumeric keypad facility to assist in memorising the number (13 QUIT). Both numbers can be used interchangeably until late 2006 when the original number (131 848) will be phased out. Existing resources with the original number can be used until then.

NSW Health introduced a fax referral system to the Quitline throughout all NSW health services in 2004. Smokers wanting assistance to quit can sign a fax form during a consultation with their health professional, which is then faxed to the Quitline, and a counsellor will call the person at the designated time to provide support.

All NSW health professionals can obtain fax referral pads and Quitline pamphlets for clients from the Tobacco Resources Officer at the Better Health Centre, who can be contacted by phone on 02 9879 0443 or by email at tobinfo@doh.health.nsw.gov.au. A copy of the fax referral form and the instructions for its use are included in Appendix 1 on page 27 and can also be downloaded from the NSW Health website at www.health.nsw.gov.au.
Smokers are often unaware of how the contaminants in tobacco smoke affect their health. Tobacco smoke is a mix of more than 4,000 chemicals, including carcinogens, mutagens and toxins which can reach the brain, heart and other organs within 10 seconds of inhaling the smoke, including:

- **carbon monoxide** – robs the heart of oxygen and makes the blood sticky
- **tar** – clogs the lungs and causes or stimulates cancer
- **phenols** – paralyses and eventually kills the hair-like cells lining airways
- **fine particles** – irritate the throat and lungs, cause smoker’s cough and damage lung tissue
- **cadmium, lead, formaldehyde and hydrogen cyanide** – toxins affecting all organs of the body.

Exposure to environmental tobacco smoke can cause cardiovascular disease, lung cancer, respiratory tract irritation, and an increased risk of bronchitis, pneumonia, and early onset of asthma in children. It also increases the risk of sudden infant death syndrome (SIDS) and the frequency and severity of asthma symptoms (Miller & Wood 2002).

Tobacco smoking is a proven risk factor for a range of fatal and debilitating diseases and conditions. These include cardiovascular disease, stroke and cancer. Smoking is widely recognised as causing lung cancer but it also increases the risk of cancer of the lips, tongue, mouth, nose, oesophagus, pharynx, larynx, pancreas, bladder, cervix, vulva, penis and anus. Other cancers, including those of the stomach, kidney, liver and blood, have also been linked to smoking (US Department of Health and Human Services 2004).

Smoking increases the risk of male impotence, and women who smoke can experience menstrual problems and / or reduced fertility. Smoking during pregnancy increases risks of miscarriage, premature labour, stillbirth, complications during labour and low birth weights (British Medical Association 2004).

Half of all long-term smokers will die from tobacco-related disease. Long-term smokers suffer more diseases and disability before they die at younger ages. In addition to the crippling effects of chronic obstructive lung disease and stroke, other risks of disability associated with smoking include reduced bone density in menopausal women, increased risk of hip fracture, exacerbation of diabetes, and increased vision loss due to accelerated macular degeneration (US Department of Health and Human Services 2004).
Nearly all smokers are aware that smoking is damaging their health, but many have fairly limited knowledge about the diversity of adverse effects. Many are unaware that most of the adverse health effects from smoking decline rapidly after quitting. Smoking cessation results in health benefits commencing within minutes of smoking the last cigarette and continuing to accrue for many years (US Department of Health and Human Services 2004).

### Table 1. Benefits of quitting

<table>
<thead>
<tr>
<th>Time since quitting</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 minutes</td>
<td>Heart rate reduces.</td>
</tr>
<tr>
<td>12 hours</td>
<td>Blood levels of carbon monoxide reduces dramatically.</td>
</tr>
<tr>
<td>2 weeks-3 months</td>
<td>Heart attack risk begins to reduce, lung function improves.</td>
</tr>
<tr>
<td>1-9 months</td>
<td>Coughing and shortness of breath decrease.</td>
</tr>
<tr>
<td>1 year</td>
<td>Risk of coronary heart disease is halved after one year compared to continuing smokers.</td>
</tr>
<tr>
<td>5 years</td>
<td>Stroke risk is reduced to that of a non-smokers 5-15 years after quitting.</td>
</tr>
<tr>
<td>10 years</td>
<td>Risk of lung cancer death is about half that of a continuing smoker and continues to decline.</td>
</tr>
<tr>
<td>15 years</td>
<td>Risk of coronary heart disease is the same as a non-smoker. The all-cause mortality in former smokers declines to the same level as people who have never smoked.</td>
</tr>
</tbody>
</table>

Other benefits of quitting include:
- Risk of low birth weight baby drops to normal if the mother quits before pregnancy or during the first trimester
- Senses of smell and taste improve
- Appearance of skin improves
- Fitness improves
- Money is saved – based on one $10 pack of cigarettes per day in one year the cost of smoking is $3,650 and over five years $18,250 (Zwar et al 2004).
Ask all clients
- Do you smoke tobacco?
  - Record smoking status (current smoker).

Ask all clients
- Have you ever smoked?
  - Yes
    - Affirm decision to quit and record smoking status (ex-smoker).
    - Give relapse prevention advice if quit <1 year.

Ask all clients
- No
  - Record smoking status (never smoker).

Advise
- All smokers should be advised to quit in a way that is clear but non-confrontational.
  - eg. "The best thing you can do for your health is to quit smoking."

Assess nicotine dependence
- Nicotine dependence can be assessed by asking:
  1. How many minutes after waking to first cigarette?
  2. Number of cigarettes per day?
  3. What cravings or withdrawal symptoms in previous quit attempts?

- Smoking within 30 minutes of waking, smoking more than 15 cigarettes per day and history of withdrawal symptoms in previous quit attempts are all markers of nicotine dependence.

- Pharmacotherapy for dependent smokers is proven to double the chances of successfully quitting.

Assess stage of change:
- "How do you feel about your smoking at the moment?"
- "Are you ready to stop smoking now?"
- Record stage of change.
- Assess nicotine dependence.

Assess
- Discuss relapse prevention.
- Review and reinforce benefits of quitting.
- Offer written information (eg Quit Kit) and referral to Quitline 13 7848.

Arrange follow-up
- For clients attempting to quit, arrange follow-up visit, if possible.
  - At these visits:
    - congratulate and affirm decision
    - review progress and problems
    - encourage continuance of pharmacotherapy
    - discuss relapse prevention
    - encourage use of support services.
  - OR
    - Refer to GP.
    - Refer to Quitline 13 7848.

Assist – action and maintenance
- Congratulate.
- Discuss relapse prevention.
- Review and reinforce benefits of quitting.
- Offer written information (eg Quit Kit) and referral to Quitline 13 7848.

Relapse
- Offer support and reframe as a learning experience.
- Explore reasons for relapse and lessons for future quit attempts.
- Offer on-going support.
- Ask again at future consultations.

Successful quitter
- Congratulate and affirm decision to quit.
- Discuss relapse prevention.

Assist – not ready
- Discuss the benefits of quitting and risks of continued smoking.
- Provide information about not exposing others to passive smoking.
- Advise that help is available when they're ready.

Assist – unsure
- Do motivational interviewing “What are the things you like and don’t like about your smoking?”
- Explore their doubts.
- Explore barriers to quitting.
- Offer written information (eg Quit Kit) and referral to Quitline 13 7848.

Assist – ready
- Affirm and encourage.
- Provide a Quit Kit and discuss a quit plan (see over).
- Recommend pharmacotherapy to nicotine dependent smokers (see Assess).
- Discuss relapse prevention.
- Offer referral to Quitline 13 7848.
quit smoking brief intervention

Tobacco dependence is a chronic condition that usually requires repeated intervention. Effective interventions exist that can produce long-term successful cessation at up to double the rate achieved by smokers without treatment or assistance (Miller & Wood 2002).

This guide focuses on brief intervention. The identification of smoking status and the provision of brief advice independently increase quit smoking rates when compared to no intervention. A brief intervention can take between three minutes and 20 minutes to conduct. Interventions can be repeated or followed up at appropriate intervals, either by the same provider or multiple providers.

The ‘5As’ approach is an evidence-based framework for structuring quit smoking brief intervention in health care settings and includes:
- Ask
- Advise
- Assess
- Assist
- Arrange follow-up.

(Fiore et al 2000; Zwar et al 2004)

The chart on page 6 provides summary information on the ‘5As’ approach. The next section of this guide provides information for each component of the approach.

1. Ask

If smoking status is unknown, all clients should be asked and smoking status recorded. Implementing clinic systems designed to increase the assessment and documentation of tobacco use almost doubles the rate at which clinicians intervene with their patients who smoke and results in higher rates of smoking cessation (Miller & Wood 2002).

KEY QUESTIONS TO ASK
- “Do you smoke tobacco?”
- “Have you ever smoked?”
For a current smoker, a brief smoking history can be established as follows:

- Number of cigarettes smoked per day.
- Previous quit attempts and what happened.
- Presence of smoking-related disease (Zwar et al 2004).

For an ex-smoker, reaffirm their decision to quit, and promote the benefits of staying a non-smoker. Congratulate them on having made a significant decision to improve their health. If they have been an ex-smoker for less than one year, discuss their coping strategies and relapse prevention. Refer to relapse prevention (page 18) under ‘Assist’, for more information.

For never smokers, congratulate them on their decision about not smoking.

2. Advise

Brief, repetitive, consistent, positive reminders to quit from multiple providers, or reinforcement of a recent quit attempt, can double success rates. Advice and assistance are useful whatever stage of change the client is currently in. Use messages that are clear, strong, personalised, supportive and non-judgmental (NZ National Health Committee 2002).

If the health professional links the risks associated with the presenting condition, this can assist the smoker to recognise the personal salience to themselves of the cessation message. Where possible, personalise the benefits of quitting smoking. Examples are improvement in other illnesses, importance of smoking as a risk factor for future illness, not exposing others (including children) to passive smoking, importance as a role model to children, and saving money.
3. Assess

Assess nicotine dependence
- Nicotine dependence can be assessed by asking:
  1. How many minutes after waking to first cigarette?
  2. Number of cigarettes per day?
  3. What cravings or withdrawal symptoms in previous quit attempts?
- Smoking within 30 minutes of waking, smoking more than 15 cigarettes per day and history of withdrawal symptoms in previous quit attempts are all markers of nicotine dependence.
- Pharmacotherapy for dependent smokers is proven to double the chances of successfully quitting.

Assessing stage of change

More than 80 per cent of smokers think they should quit, over half (53.6%), plan to quit in the next six months and 18 per cent plan to quit within the next month (NSW Health 2005). The ‘Stages of readiness to change model’ is a tool for assessing a person’s readiness to change a variety of behaviours. This model was originally developed and applied to smoking cessation by Prochaska and DiClemente in 1983.

The purpose of determining a person’s ‘stage of change’ is to enable a health professional to deliver the most appropriate and beneficial assistance for a quit attempt. For a busy clinician with limited time, this understanding may provide insight into the type of brief advice most likely to be useful to the person at this time.

Quitting smoking is a process occurring over time, rather than a single discrete event. Smokers cycle through the stages of being ready, quitting and relapsing on an average of four to five times before achieving long term success. Success is defined as movement through the model, not just quitting.

Stages of readiness to change model

KEY QUESTIONS TO ASK

● "How do you feel about your smoking at the moment?"
● "Have you ever thought of giving up smoking?"
● "Are you ready to quit now?"
● "How can I help to increase your confidence in quitting?"
● "What would it take for you to quit?"

Table 2. Stages of readiness to change

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>These smokers do not recognise their smoking as a problem, or are unconcerned about their smoking. Individuals in this stage are not ready to change their behaviour and will insist that their behaviour is acceptable. They generally see the positive aspects of smoking and do not like to acknowledge the disadvantages or have been discouraged by failure in past quit attempts.</td>
</tr>
<tr>
<td>Contemplation</td>
<td>These smokers are ambivalent or unsure about their smoking and are thinking about changing their behaviour. They may be apprehensive, possibly because they have tried in the past and failed. This group is particularly amenable to motivational interviewing.</td>
</tr>
<tr>
<td>Determination</td>
<td>These individuals are ready to change their behaviour and plan to do so within the next 30 days. They have usually made a quit attempt in the past year. These smokers are most likely to actually attempt to quit in the near future. There is a window of opportunity, which may only open for a short time. Those in this group are most likely to ask for help with quitting. These individuals need assistance with problem solving and social support.</td>
</tr>
<tr>
<td>Action</td>
<td>The smokers in this stage have taken action and are actively quitting (ie they have already quit smoking in the past six months). This is when the risk of relapse is highest with about 75 per cent of relapse occurring in this stage, most within the first week. The new ex-smoker is trying to lose their associations and triggers for smoking and establish himself or herself as a non-smoker. This is a period where support and strategies to prevent relapse are especially important.</td>
</tr>
<tr>
<td>Maintenance</td>
<td>These smokers have quit over six months ago. The non-smoking behaviour is established and the threat of smoking gradually diminishes. The chances of maintenance of the change increase over time – only about four per cent of those who quit for more than two years ever go back to smoking. Counselling for relapse prevention is necessary at this time.</td>
</tr>
<tr>
<td>Relapse</td>
<td>Individuals in this stage have gone back to smoking. If relapse should occur, it is important for the client to see it as part of a learning experience and not a failure. Relapse is common during the quitting process. A relapsed smoker should be encouraged and motivated to quit again.</td>
</tr>
</tbody>
</table>

When assessing, it is important to express concern and interest, and not criticism or judgment. Clarify responses by asking a client whether they are willing to make a quit attempt at this time or in the near future (e.g., the next 30 days) (Richmond et al. 1991).

Assessment also includes discussing barriers to quitting, triggers for smoking (e.g., social situations, stress, negative emotions), social support and the smoker’s experience in previous quit attempts. Assessing previous use of pharmacotherapy is helpful to determine if it was used optimally and what problems occurred (Zwar et al. 2004).

Assessing nicotine dependence helps to predict whether a smoker is likely to experience nicotine withdrawal on stopping smoking.

Nicotine is the component of tobacco smoke responsible for physical dependence and is considered to be as addictive as heroin and cocaine. Nicotine is rapidly and extensively metabolised and the smoker has a number of peaks and troughs of nicotine throughout the day. This then promotes dependence, as the smoker tends to experience early withdrawal effects such as craving and irritability when nicotine levels decrease.

The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) states that nicotine dependence and withdrawal can develop with all forms of tobacco.

Features of nicotine dependence include:

- smoking soon after waking
- smoking when ill
- difficulty refraining from smoking
- reporting the first cigarette of the day to be the most difficult to give up
- smoking more in the morning than in the afternoon.

Dependence on nicotine may be assessed using the ‘Fagerstrom Test for Nicotine Dependence’ (FTND) (Heatherton et al. 1991) on page 12.
Table 3. Fagerstrom test for nicotine dependence

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>Answers</th>
<th>Score (please circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How soon after waking up do you smoke your first cigarette?</td>
<td>Within 5 minutes</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>6-30 minutes</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>31-60 minutes</td>
<td>1</td>
</tr>
<tr>
<td>2. Do you find it difficult to abstain from smoking in places where it is forbidden?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>3. Which cigarette would you hate to give up?</td>
<td>The first one in the morning</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Any other</td>
<td>0</td>
</tr>
<tr>
<td>4. How many cigarettes a day do you smoke?</td>
<td>10 or less</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>11 - 20</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>21 - 30</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>31 or more</td>
<td>3</td>
</tr>
<tr>
<td>5. Do you smoke more frequently in the morning than in the rest of the day?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>6. Do you smoke even though you are sick in bed for most of the day?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


When time and resources are limited, nicotine dependence can be assessed using the two questions in Table 4 below.

Table 4. Nicotine dependence two-question test

<table>
<thead>
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<th>Score (please circle)</th>
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<td>6-30 minutes</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>31-60 minutes</td>
<td>1</td>
</tr>
<tr>
<td>4. How many cigarettes a day do you smoke?</td>
<td>10 or less</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>11 - 20</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>21 - 30</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>31 or more</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Score 0-2 = very low dependence 3 = high dependence 5 = very high dependence

Score 3 = low dependence 4 = moderate dependence
Smokers who are highly nicotine dependent wake up in the morning feeling very ‘nicotine deprived’ and will want to smoke very soon after waking. If time is limited, simply asking one question: “How long till the first cigarette after waking?” can provide a good indication of level of dependence. Consider those who smoke within the first 30 minutes to be moderately to highly dependent.

Clients who have had withdrawal symptoms during previous quit attempts may be expected to experience them again in subsequent attempts. The response to an additional question: ‘Did you have cravings and withdrawal symptoms in a previous quit attempt?’ can provide additional indications to the likelihood of this recurring.

Nicotine withdrawal
More than 80 per cent of smokers will experience symptoms of nicotine withdrawal on quitting smoking. Nicotine withdrawal symptoms are at their worst in the first 24 to 48 hours and typically resolve over 10 to 14 days but can last up to four weeks. Associations that cause the person to think about smoking can persist for years (Zwar et al 2004).

Nicotine withdrawal symptoms can be promoted to clients as ‘recovery symptoms’ and commonly include:

- Cravings (which can be strong, but typically come in short bursts)
- PLUS four or more of the following:
  - Depressed mood.
  - Insomnia.
  - Irritability, frustration or anger.
  - Anxiety.
  - Difficulty in concentration.
  - Restlessness.
  - Decreased heart rate.
  - Increased appetite or weight gain.

As the body is removing nicotine, it absorbs up to twice as much caffeine. It is helpful to reduce intake of tea, coffee and cola drinks by half, to avoid exacerbation of some withdrawal symptoms.

Pharmacotherapy
The rate of success in unaided quit attempts is very low. In most cases it is better to encourage clients to use pharmacotherapy in the first instance rather than to wait to see if they can succeed unaided (Fiore et al 2000; Miller and Wood 2002).

There are currently two forms of pharmacotherapy available in Australia to assist with smoking cessation, nicotine replacement therapy (NRT) and bupropion sustained release (trade name Zyban®).

Use of pharmacotherapy to quit smoking is preferable to smoking, because unlike smoking, these medications do not:

- contain non-nicotine toxic substances such as carbon monoxide, ‘tar’ or any of the other 4000+ chemicals in tobacco smoke
- produce dramatic surges in blood nicotine levels
- produce strong dependence (Fiore et al 2000).
Nicotine replacement therapy (NRT)

The aim of NRT is to replace some of the nicotine from cigarettes without the harmful constituents found in tobacco smoke, thus reducing withdrawal symptoms. This then allows the smoker trying to quit to concentrate on behavioural aspects of their smoking. Evidence indicates that the best results in terms of sustained smoking cessation are achieved when the use of NRT is combined with behavioural advice and follow-up (Zwar et al, 2004).

NRT is currently available in five forms: patch; gum; lozenge; inhaler and sublingual tablet. All are available over the counter in pharmacies, however the gum, patch and lozenge were recently descheduled by the Australian Government and may be provided by non-pharmacists.

All of the commercially available forms of NRT are effective as part of a strategy to promote smoking cessation. They increase the odds of quitting approximately 1.5 to 2 fold, regardless of setting (Silagy et al 2004).

A NSW Health pamphlet that explains the correct use of NRT products, ‘Products to help you quit smoking’ is available for clients in 15 languages (see Resources on page 23 ).

### Table 5. Nicotine replacement therapy initial dosing guidelines

<table>
<thead>
<tr>
<th>Client group</th>
<th>Dose</th>
<th>Duration</th>
<th>Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patch</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;10 cigs per day</td>
<td>21mg / 24 hr patch or 15mg / 16 hrs</td>
<td>&gt;8 weeks</td>
<td>(Unscheduled) Recent MI, CVA; unstable, Prinzmetal angina; severe arrhythmias; generalised skin disease; children (&lt;12 yrs); pregnancy, lactation.</td>
</tr>
<tr>
<td>and weight &gt;45kg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10 cigs per day</td>
<td>14mg / 24 patch or 10mg / 16hrs</td>
<td>&gt;8 weeks</td>
<td></td>
</tr>
<tr>
<td>or weight &lt;45kg or CVD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;8 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10 cigs per day</td>
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</tr>
<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;8 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gum</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;10 and &lt;20 cigs</td>
<td>2mg gum, 5-12 per day</td>
<td>&gt;8 weeks</td>
<td>(Unscheduled) Non-tobacco users; recent MI (&lt;3 mths); unstable, progressive angina pectoris; Prinzmetal variant angina; severe cardiac arrhythmias; acute phase stroke; pregnancy, lactation, children (&lt;12 yrs).</td>
</tr>
<tr>
<td>per day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;20 cigs per day</td>
<td>4mg gum, 6-10 per day</td>
<td>&gt;8 weeks</td>
<td></td>
</tr>
<tr>
<td><strong>Inhaler</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;10 cigarettes</td>
<td>6-12 cartridges per day</td>
<td>&gt;8 weeks</td>
<td></td>
</tr>
<tr>
<td>per day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lozenge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First cigarette</td>
<td>2mg lozenge, 1 lozenge every 1-3 hrs</td>
<td>&gt;8 weeks</td>
<td>(Unscheduled) Non-smokers, occasional smokers; phenylketonuria; unstable angina; Prinzmetal angina; severe arrhythmias; recent MI, stroke; pregnancy, lactation, children (&lt;12 yrs).</td>
</tr>
<tr>
<td>&gt;30 mins after waking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First cigarette</td>
<td>4 mg lozenge, 1 lozenge every 1-2 hrs</td>
<td>&gt;8 weeks</td>
<td></td>
</tr>
<tr>
<td>&lt;30 mins after waking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sublingual tablet</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low dependence</td>
<td>2mg tablet every 1-2 hrs</td>
<td>&gt;8 weeks</td>
<td></td>
</tr>
<tr>
<td>High dependence</td>
<td>2mg tablet every 1-2 hrs</td>
<td>&gt;8 weeks</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Zwar et al 2004.

Please note: Each of the NRT formulations may have potential adverse affects:

Transient local itching, burning or redness of the skin, or sleep disturbance including insomnia or vivid dreaming can occur with the NRT patch. Clients should be advised to apply the patch to dry non-hairy skin above the waist and to rotate the patch site daily. The patch can be removed at night, however absorption of nicotine continues for up to two hours after removal.
Use of NRT gum may cause gastrointestinal disturbances, dyspepsia, nausea, headaches, jaw pain or dental problems. People with dentures should not use the gum.

Possible side effects of the inhaler include coughing, headache, heartburn, nausea, hiccups, throat irritation, rhinitis and occasionally taste disturbance and sinus irritation (Zwar et al 2004).

If side effects of NRT products are of concern to the client, this can be discussed with their pharmacist or doctor.

Combination therapy
Combining nicotine patches with a self-administered form of NRT (gum, lozenge, sublingual tablet or inhaler) or combining bupropion with any form of NRT can be more efficacious than a single form of therapy. Clients should be encouraged to use combined treatments if they are unable to remain abstinent, or if they are still experiencing withdrawal symptoms using a single type of pharmacotherapy.

Bupropion
Bupropion SR is a non-nicotine medication for smoking cessation. It is available only on prescription and is included in the Pharmaceutical Benefits Scheme. The medication is commenced approximately one week prior to quitting and reduces the urge to smoke. Bupropion can be combined with NRT to help with quitting, however blood pressure should be monitored (Richmond and Zwar 2003; Zwar et al 2004).

Bupropion may not be appropriate for all smokers and is not recommended for people with seizure disorders, those on certain medications for depression, or those with a history of bi-polar disorder. At the time of publication Zyban is the only form of bupropion available in Australia.

Pregnant and lactating woman
Reproductive health is harmed by smoking tobacco in both men and women. There is conclusive evidence that smoking causes compromised fertility, and that parental smoking potentially has long-term and serious consequences for child health. Smoking while pregnant contributes to an increased risk of a broad range of obstetric complications, including ectopic pregnancy, spontaneous abortion, pregnancy and labour complications, stillbirth, low birth weight and sudden infant death syndrome (SIDS) (British Medical Association 2004).

Exposure to environmental tobacco smoke (ETS) otherwise known as ‘secondhand smoke’, is known to be a risk factor for lung cancer and cardiovascular disease in adults, and for SIDS, asthma, and lower respiratory disease in children (Ridolfo and Stevenson 2001). Exposure to ETS is a risk during pregnancy, and harms both the mother and foetus.

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Pregnancy is a time when many women are motivated to improve health behaviours, including smoking cessation, and they are in regular contact with health professionals. Although abstinence early in pregnancy will produce the greatest benefits to the mother and the foetus, smoking cessation at any point in the pregnancy will be beneficial to the mother and the foetus. Smoking cessation programs of various types are effective at achieving smoking cessation in pregnant women. Effective smoking cessation interventions should be offered to pregnant smokers at the first antenatal visit and throughout pregnancy and post-partum. Extended psychosocial interventions that exceed minimal advice to quit should be made available for pregnant women (Miller and Wood 2002).

The goal in pregnancy should be to be both tobacco and nicotine-free. Pregnant and lactating women are contraindicated for NRT. However, while it is always preferable for a pregnant woman to avoid unnecessary medication, pharmacotherapy should be considered when a pregnant women is otherwise unable to quit and when the likelihood and benefits of cessation outweigh the risks of NRT and potential continued smoking (Miller and Wood 2002). The level of nicotine obtained from NRT is lower than that obtained from smoking and there is no exposure to carbon monoxide and the other 4000+ chemicals in tobacco smoke. Short-term exposure to low-dose nicotine during the first trimester is unlikely to cause a hazard to the foetus (MIMS online 2005).

The safety of the transdermal patch during pregnancy has not been established. If the clinician or the pregnant or lactating patient decides to use NRT to quit smoking, delivery systems should be considered that yield intermittent, rather than continuous nicotine exposure (ie inhaler, gum, lozenge or sublingual tablet, rather than transdermal patch) due to potential neurotoxicity in the foetus of continuous exposure to nicotine (Fiore et al 2000, Benowitz 1991; Dempsey and Benowitz 2001).

Pregnant smokers who have been unable to quit using behavioural methods and are considering the use of pharmacotherapy to quit smoking should be advised to discuss the implications with their medical practitioner.

The decision on what assistance to provide depends on the needs and preference of the client, and the capacity of the health professional and their service. The assistance offered should match the client’s stage of change and their level of nicotine dependence.
Pre-contemplation (not ready)
For smokers who indicate they do not want to quit:
● Note in their client record that you have discussed their smoking and the benefits of quitting.
● Discuss their smoking and the benefits of quitting at next visit.
● Remind smokers of the importance of quitting smoking by displaying information and posters.
● Discuss the effects of exposure to passive smoking on children and others, and encourage smokers to smoke outside the car and home.

Contemplation (unsure)
For health professionals who have very little time available, the offer of written information (eg Quit Kit) and/or referral to Quitline 13 7848 is the most appropriate assistance for smokers who indicate they are unsure.

Motivational interviewing
For health professionals who have some time available, motivational interviewing is a proven counselling technique to help explore a client’s ambivalence about their behaviour (eg their smoking). Motivational interviewing involves open-ended questions, reflective listening and summarising, and was developed by Rollnick et al (1997).

Guiding principles for motivational interviewing include:
1 expressing empathy, acceptance and respect for your client’s position facilitates change
2 developing discrepancy between present behaviour, values and goals
3 rolling with resistance. Confrontation only creates defensiveness
4 supporting self-efficacy to strengthen the client’s belief in the potential for change.

Other suggestions are:
● personalising the intervention, ultimately the client presents the argument for change
● being non-judgmental
● being positive and demonstrate your own belief that people can change
● understanding that the client takes responsibility for decisions and consequences.

Smokers who are unsure about quitting can be motivated to change by:
● helping them to weigh up the pros and cons of smoking
● asking clients to rate their motivation and confidence in quitting
● discussing health effects of smoking and benefits of quitting.
Asking clients to rate their motivation and confidence in quitting on a scale of 1 to 10 can be a helpful addition to motivational interviewing. Distinguishing motivation and confidence can provide an insight into the barriers to quitting and can be used to initiate a discussion on how to enhance motivation or confidence (Rollnick et al 1997).

Information on the health effects of smoking and benefits of quitting are outlined on page 4 and 5.

Barriers to quitting

Concerns or barriers to quitting are important for all smokers. An informed discussion can be very helpful to assist smokers to overcome these, by providing information and correcting misconceptions. Some of the common barriers to quitting are discussed in Table 6 below.

Table 6. Barriers to quitting

<table>
<thead>
<tr>
<th>Barriers to quitting</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Withdrawal symptoms</strong></td>
<td>Most regular smokers will experience symptoms of nicotine withdrawal on quitting. Irritability and cravings for cigarettes are two of the most common symptoms. Withdrawal symptoms may be lessened or prevented by using NRT or bupropion.</td>
</tr>
<tr>
<td><strong>Stress</strong></td>
<td>Smokers often use their cigarettes to help them cope with stress. Nicotine has been shown to have a direct relaxing effect on the brain as well as having stimulant effects. However, some of the relaxing effect of smoking is the break from the stressful activity that goes with it and the relief of short-term nicotine withdrawal symptoms. There is evidence that nicotine dependence increases stress, due to the effect of short-term withdrawal symptoms, like anxiety and irritability. Smokers may benefit from exploring other ways of coping with stress and learning to relax, such as progressive muscle relaxation and breathing techniques.</td>
</tr>
<tr>
<td><strong>Fear of failure</strong></td>
<td>Relapse is a common feature of the quitting process and most smokers have tried and relapsed four to five times before finally becoming successful ex-smokers. Smokers should be encouraged to view each quit attempt as a learning experience (not a failure) that increases the chances of success next time. It is important to find out why they relapsed and explore ways of coping with that situation in future.</td>
</tr>
<tr>
<td><strong>Peer and social pressure</strong></td>
<td>High-risk times such as social situations with alcohol are often strongly associated with smoking. Avoidance of these situations early in the quit attempt can be suggested. For some clients, it can be helpful to rehearse how to say no to a cigarette offer.</td>
</tr>
<tr>
<td><strong>Weight gain</strong></td>
<td>This is a very important barrier, especially for women. Mechanisms of weight gain include the return to a normal metabolic rate after cessation of nicotine intake and increased food intake. Weight gain affects about 75 per cent of those who stop smoking. The average weight gain is 2-4kg in weight and about 10 per cent of people experience major weight gain (&gt;13kg). However, the average weight gain just brings the ex-smoker’s weight up to the average weight of non-smokers of similar age and gender. Weight gain is delayed while people are using either NRT or bupropion. Advice to reduce weight gain includes: a balanced diet with plenty of fruit and vegetables and avoidance of high-fat and high-sugar foods; drinking water or low-calorie drinks as a substitute to snacking; regular physical activity; and identifying eating triggers and learning new ways to cope with them. It is important to emphasise that the health benefits of quitting far outweigh any health risks from extra weight. Quitting smokers should ensure that they quit smoking first, then deal with the weight gain when they are a successful ex-smoker.</td>
</tr>
</tbody>
</table>

Adapted from Zwar et al 2004
Determination (ready) and Action (already quitting)

For those smokers who want to quit and/or are in the process of quitting:

- Congratulate and encourage their decision to quit.
- Review and reinforce benefits of being a non-smoker.
- Offer written information such as the Quit Kit.
- Recommend pharmacotherapy to nicotine-dependent clients.
- Discuss a quit plan.
- Discuss relapse prevention.
- Offer referral to Quitline 13 7848 (or fax referral, see Appendix 1 on page 27).

Quit plan

Smokers who plan before they quit are more successful than those who don’t, and planning can be done quickly. For example:

- Set a realistic quit date and stick to it.
- Identify why and where you smoke and what ‘triggers’ you to want to smoke.
- Develop coping strategies for ‘trigger’ situations.
- Review past quitting experiences and learn from it (what helped? what hindered?).
- Write out a list of reasons for quitting and display in prominent positions (eg fridge, car).
- Tell everyone you are quitting – you are going to need their support.
- Check your house, car, workplace etc and throw out cigarettes, lighters and ashtrays, the day before quit day.
- Plan to reduce caffeine intake by half and avoid alcohol for the first two weeks.
- Set incremental goals and reward yourself for not smoking.
- Consider use of pharmacotherapy.
- Contact the Quitline on 13 7848 (13 QUIT) to arrange receiving the free call-back service, where the Quitline will make pro-active calls at agreed times.

Maintenance

If they have recently quit, congratulate them and reinforce the benefits of being a non-smoker. Assist with relapse prevention by offering support and helping them to identify high-risk situations such as drinking alcohol, emotional stress and social situations with smokers. Help to plan coping strategies. The Quitline 13 7848 (13 QUIT) can support a person who has already quit to help prevent them going back to smoking.
Relapse prevention

Relapse can occur because people have not planned how to cope with cravings, do not recognise triggers or decide to 'just have one'. Common triggers for relapse are alcohol and negative emotional states such as interpersonal conflict, anger, frustration and anxiety. Avoiding alcohol during the first two weeks of a quit attempt may also help to reduce the risk of relapse.

Relapse prevention, which includes ‘coping strategies’, aims to assist people to avoid or cope with high-risk situations. Such strategies also aim to prevent a lapse or a full relapse to regular levels of smoking from occurring.

Suggested strategies are:
- Identify high-risk smoking situations and important smoking triggers.
- Plan coping strategies in advance.
- Consider lifestyle changes that may reduce the number of high-risk situations.
- Encourage clients to have a plan to deal with a slip, to prevent it becoming a full relapse back to smoking.

5. Arrange follow-up

**Successful quitter**
- Congratulate and affirm decision to quit.
- Discuss relapse prevention.

**Arrange follow-up**
- For clients attempting to quit, arrange follow-up visit, if possible.
- At these visits:
  - congratulate and affirm decision
  - review progress and problems
  - encourage continuance of pharmacotherapy
  - discuss relapse prevention
  - encourage use of support services.
- OR
  - Refer to GP.
  - Refer to Quitline 13 7848.

**Relapse**
- Offer support and reframe as a learning experience.
- Explore reasons for relapse and lessons for future quit attempts.
- Offer on-going support.
- Ask again at future consultations.

Follow-up visits after assistance to quit have been shown to increase the likelihood of successful long-term abstinence. If the client has been referred for assistance in their quit attempt, a note should be made to follow-up their progress upon subsequent visits (Zwar et al 2004).
Actions during follow-up contact can include the following:

If relapsed:
- empathise and reframe as a learning experience
- explore reasons for relapse
- help build motivation to reach the stage of readiness to try again
- discuss relapse prevention.

If client has not made their planned quit attempt:
- explore reasons for delay
- explore ambivalence and help build motivation to reach the stage of readiness to try
- encourage client to set a quit day.

If not smoking:
- congratulate, praise and affirm decision
- review progress and problems
- review withdrawal symptoms, address issues
- encourage completion of full course of pharmacotherapy
- discuss coping strategies and relapse prevention.

Relapse

Quitting is a dynamic and continuing process often involving repeated attempts, rather than a discrete event. It is very common for people to have slips or lapses in the course of a quit attempt. A slip or lapse is occasional smoking (no more than one or two cigarettes), often occurring at times of stress, in social situations, and can be accompanied by alcohol. A relapse is considered to be a return to regular smoking. Repeated relapse is a normal part of this process. Most successful ex-smokers have tried to quit and relapsed four to five times before finally succeeding.

Should your client relapse, help them to refocus on wanting to quit, regain abstinence and develop strategies to avoid further slips. Use open-ended questions to help the client identify what precipitated the relapse and encourage active discussion to identify strategies to overcome this.

Problems could include:
- lack of support to quit
- no quit plan
- negative mood or depression
- strong or prolonged withdrawal symptoms
- weight gain
- flagging motivation / feeling deprived
- holiday season celebrations.

(Zwar et al 2004)

TIP

The risk of relapse is highest in the first week after a quit attempt. Seventy-five per cent of relapses occur in the first six months.

If a lapse during a quit attempt occurs, support your client and reaffirm their ability to quit. Ask open-ended questions to help them identify why the lapse occurred and develop strategies to prevent another lapse, or before there is a full relapse to regular levels of smoking.

If full relapse has occurred, encourage the client to set another quit date and provide information on Quitline 13 7848.
Clients with mental health problems

Smoking prevalence is significantly higher among people with mental health problems than among the general population. Nicotine may help to alleviate some of the symptoms associated with psychiatric illnesses and may also help to alleviate the side effects associated with their medications (McNeill 2001).

Depression decreases the likelihood that attempts at abstinence will be successful, and depressed mood is a common symptom of nicotine withdrawal (Degenhardt & Hall 2001). A study of smokers with a history of major depression and who quit smoking found that their risk of a recurrence of major depression was seven times higher than people who continued to smoke. Risk of depression did not generally arise immediately after cessation but was distributed across the entire study period of six months (Glassman et al 2001).

Psychiatric comorbidity places smokers at increased risk for relapse, however these smokers can quit successfully using evidence-based cessation treatments. Stopping smoking may affect the pharmacokinetics of certain psychiatric medications (eg anti-psychotic medications). Therefore it is important to ensure that a clinician monitors closely the actions or side-effects of psychiatric medications in smokers attempting abstinence (Fiore et al 2000).

All health professionals working with smokers with mental health problems should encourage smokers to quit and refer those needing further support to their treating medical practitioner and/or a specialist smoking cessation service.
Resources for clients

- **Products to help you quit smoking pamphlet** – explains the use of pharmacotherapies, withdrawal symptoms and behavioural strategies to assist cessation. This leaflet is available in English from the NSW Health Tobacco Resources Officer (contact details below) and can be downloaded in the following 15 community languages from the NSW Health Multicultural Communication tobacco website at: www.mhcs.health.nsw.gov.au
  - Arabic
  - Bosnian
  - Chinese
  - Croatian
  - Farsi / Persian
  - Greek
  - Indonesian
  - Italian
  - Japanese
  - Korean
  - Macedonian
  - Serbian
  - Spanish
  - Turkish
  - Vietnamese

- **New Quitline pamphlet** – explains the services provided by the NSW Quitline, including the callback service. This pamphlet should be provided as part of a brief intervention. It is preferable to provide clients with this pamphlet, rather than a Quit Kit, as the kit will be offered when the client rings the Quitline.

- **Fact sheets** on the following topics are available from the NSW Tobacco and Health Branch website: www.health.nsw.gov.au
  - Health effects of smoking
  - Smoking and pregnancy (also available in 8 community languages from www.mhcs.health.nsw.gov.au)
  - Cardiovascular disease and smoking
  - Nicotine and other poisons
  - Light cigarettes
  - Benefits of quitting smoking
  - Getting ready to quit
  - Quitting smoking – the first few days
  - Nicotine dependence and withdrawal
  - Remaining a non-smoker
  - Products to help you quit smoking
  - Car and Home smoke-free zone
  - Supporting someone to quit smoking
  - So you’ve returned to smoking

- **Quit Kits** contain: the Quit Book, a pocket guide, the Products to help you quit pamphlet and a No smoking sticker. Quit Kits can be ordered from the NSW Health Tobacco Resources Officer, however clients who are ready to quit and who call the Quitline (13 7848) will be offered one, which will be posted to the caller within one working day.

- **Stickers**:
  - International no smoking symbol, available in a variety of sizes.
  - Thinking of quitting smoking? – call the Quitline.
Resources for health professionals

- 'Health Smart – Nicotine replacement therapy' video. A 13-minute video explains nicotine dependence, treatment, how to use nicotine replacement therapy products, problem solving and the quitting process. Narrated by Juanita Phillips, this video was created in 2004 by NSW Health and is available for loan from public libraries around NSW. Further copies are available from the NSW Health Tobacco Resources Officer (contact details below) for health professionals and health services for use in waiting rooms, for loan to clients, to use in presenting to groups etc. Also useful for training health professionals.

- Guide for the management of nicotine dependent inpatients – Summary of evidence. Published by NSW Health in 2002, this booklet provides evidence-based information regarding the treatment of nicotine dependence during hospitalisation of smokers.


- Quitline fax referral forms (in pads of 50). See Appendix 1 on page 28 for a copy of the form and instructions for its use. This form provides a simple method of ensuring that the client receives a follow-up to the intervention and can be used with inpatients or outpatients by any health service in NSW. Client consent is required. Once the NSW Quitline receives the fax, a counsellor will call the client at an agreed time to provide ongoing support throughout the quit attempt. The instructions for use are printed on the cover. Each client referred by this method should be provided with a New Quitline pamphlet.

- National Tobacco Campaign posters (suitable for waiting rooms etc).
  - Eye – macular degeneration (A2 size)
  - Aorta – fatty deposits (A2, A3)
  - Lung tumour (A2)
  - Tar on lung (A2)
  - Every cigarette is doing you damage (A2)
  - Thinking of quitting – let us talk (Quitline) (A2, A3)
  - Lung – Before & After (A2, A3)
  - Lung (multi-lingual) (A3)
  - Brain (A3)

- A series of culturally appropriate Aboriginal and Torres Strait Islander client pamphlets, health professional resources and training materials have been developed as part of the NSW Health SmokeCheck project. This project is expected to be launched in 2006 and further information is available from the Tobacco and Health Branch (contact details below).

All the above resources can be ordered from the NSW Health Tobacco Resources Officer, tel. (02) 9879 0443, fax. (02) 9879 0994 or email. tobinfo@doh.health.nsw.gov.au

Further information on these resources is available from the NSW Health Tobacco and Health Branch, tel. (02) 9391 9111.


DiClemente CC and Prochaska JO 1982, Self change and therapy, change of smoking behaviour: A comparison of processes of change in cessation and maintenance, Addictive Behaviour, 133-142.


references


QUITLINE REFERRAL FORMS

Procedure to refer a patient/client to the NSW Quitline

Step 1  Ask all patients/clients if they smoke tobacco.
Step 2  Ask all smokers the question: ‘Would you like some help to quit smoking?’
Step 3  To all those who agree that they would like help to quit smoking:
        explain that the NSW Quitline now has a new free confidential callback service
        and the expert counsellors can telephone on a day and time to suit your patient/client.
Step 4  Provide them with a ‘New Quitline’ pamphlet.
Step 5  Assist the patient/client to fill out the fax referral form, make sure they have read the
        privacy and consent information at the top and bottom of the form, and have signed the form.
Step 6  Fax the form directly to the NSW Quitline Fax. (02) 9361-8011.
Step 7  Attach the referral form to the patient/client record.

IMPORTANT – Complete staff contact details on the faxback form.

Please note
A NSW Quitline counsellor will call the patient/client during the selected time period to provide information,
support and advice on smoking cessation.
A counsellor will be available Monday to Friday 8.30am-9.30pm, excluding public holidays.

To order further copies of this referral pad,
the New Quitline pamphlet, or for Quit Kits contact:
Tobacco Resources Officer
Better Health Centre
Mail address – Locked Mail Bag 5003, Gladesville 2111
Tel. (02) 9870-0443
Fax. (02) 9870-0094
Email. tobinfo@doh.health.nsw.gov.au

This fax referral form is also available to print out from the:
• NSW Health Tobacco and Health Branch websites
  – NSW Health Intranet (health service access only) – intranet.health.nsw.gov.au/public-
    health/promotion/tobacco/smoking/index.html
    health/promotion/tobacco/quitting/index.html
• Cancer Institute of NSW – www.cancerinstitute.org.au

For further information about smoking cessation, the NSW
Quitline or to obtain an electronic version of this form contact
the NSW Health Tobacco and Health Branch Cessation Unit:
Mail address – LMB 061, North Sydney 2059
Tel. (02) 9391-8111
Fax. (02) 9424-5965
Email. tobacco@doh.health.nsw.gov.au
appendix 1 – fax referral form

Referral to NSW Quitline
Fax to: (02) 9361-8011

(If you receive this fax by mistake, please re-send to above number)

CONFIDENTIAL – PRIVACY WARNING. The information contained in this fax message is intended for Quitline staff only. If you are not the intended recipient, you must not copy, distribute, take any action reliant on, or disclose any details of the information in this fax to any other person or organisation.

To refer a patient or client to the NSW Quitline for help with smoking cessation, please fill in following details:

Staff contact details (please print)

Division of general practice

Practice name

Town/suburb (and postcode)

Referring health professional’s name

Telephone number

Signature

Patient/client contact details (please print)

Patient/client’s name

Age

Patient’s preferred phone no/s (h) (w) (m)

Interpreter required

Yes

No

If yes, which language

Is it okay for Quitline to leave a message?

Yes

No

Preferred date for first call (or discharge date)

Preferred day/s of week (please circle)

Monday

Tuesday

Wednesday

Thursday

Friday

Preferred time of day (please circle)

Morning

Afternoon

Evening

Are you currently using any medication?

Yes

No

Do you have any health conditions relevant to quitting smoking?

Heart disease

Respiratory/lung disease

Diabetes

Depression/anxiety

Pregnancy

Other – please specify

I consent to this information being faxed to the Quitline and for Quitline to call me at a time that I have suggested on this form. I understand that persons within the organisation with access to the fax machine, who may not be a Quitline counsellor, may view this form. I also consent for the Quitline to contact me at a later date to evaluate the usefulness of the Quitline proactive telephone service to patients and clients.

Patient’s signature

Date / /

Quitline staff use only

In response to this fax referral, specialist Quitline staff will call the patient/client as close as possible to the indicated time to provide information, support and advice on smoking cessation. For the cost of a local call from anywhere in NSW, the Quitline telephone service (131 849) can receive Quit Referral forms 24 hours a day 7 days a week. Recorded information about smoking is available 24 hours.

St Vincent’s Hospital

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