

Smokescreen for the 1990s

A new approach to smoking cessation

■ Smokescreen for the 1990s is a brief program designed specifically for general practitioners to help patients to stop smoking and is based on the latest research in smoking cessation. This article looks at the major principles on which the revised program is based and outlines the key steps taken to assist smokers according to their readiness to quit.

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S *Smokescreen for the 1990s*¹ is a brief smoking cessation program specifically designed for general practitioners to use. It was developed in the School of Community Medicine at the University of New South Wales.

The program consists of a range of practical strategies. Interventions may be personalised for the needs and concerns of individual patients and can be adapted to the time available. The program incorporates both cognitive strategies and behavioural skills, as well as nicotine replacement therapy, which addresses the pharmacological addiction to nicotine.

Since 1985 over 3500 GPs from Australia and New Zealand have attended training workshops to learn the Smokescreen program. The original program had a 3 year abstinence rate of 36%.^{2,3} The results of the latest version, *Smokescreen for the 1990s*, are to be published shortly.

A kit of materials is available and consists of a manual for the doctor, booklets and pamphlets for patients, a flipover display unit of coloured photographs, a deskcard, poster, stickers for patient files and a copy of *Become a Non-Smoker* — a self-help manual for patients.

Is the patient ready to quit?

The key issue determining success in smoking cessation is the patient's motivation or readiness to quit. *Smokescreen for the 1990s* is based on the Stages of Change Model,⁴ which recognises that at any one time only 10% of smokers are ready to quit (action stage),

30% are unsure (contemplation stage) and 60% are not ready to quit (precontemplation stage).^{3,5} (Figure 1). Each of these groups is represented by a different cartoon on the program materials (see Figure 2). It is important to differentiate those smokers who want to quit (80 to 90%) from those who are ready to quit right now (only 10%).

Thus the first step in the Smokescreen program is to allocate patients to one of the three groups. Ask the key question: "How do you feel about your smoking?"⁶ This open-ended question raises the issue of smoking in a non-confrontational and non-judgemental way and will often lead to dialogue in which the doctor and patient together determine the patient's readiness to quit. If this is still unclear, then asking "Are you ready to quit now?" may provide a more definitive answer. An alternative way of allocating smokers to groups is to show the smoker the deskcard (Figure 2) and ask him or her to nominate one of the three stages of readiness to quit.

The Stages of Change Model is a dynamic process. Smokers move from one stage to another and may present to the doctor at various times in different stages of readiness to quit.

Operation of the program

Smokescreen for the 1990s consists of 3 different interventions, one for each group of smokers. Each group has different needs and requires a different approach. The steps of the program are de-

scribed in the manual for doctors and a summary of the main strategies appears on its cover (Figure 3).

Not ready smokers

Sixty per cent of smokers at any one time are not ready to quit.⁵ They should be gently encouraged to think about their habit and advised that the doctor is available to help should they wish to discuss it later. The intervention is non-confrontational and very brief as these smokers are resistant and change is unlikely at this stage. They are given a pamphlet appropriate to their stage of readiness, *Smokers: You Have a Right to Know* (Figure 4).

Unsure smokers

Thirty per cent of smokers are ambivalent or uncertain about their habit.⁵ They have concerns about their smoking (such as health effects), but are also aware that there are disadvantages to quitting (such as weight gain), so the aim is to motivate

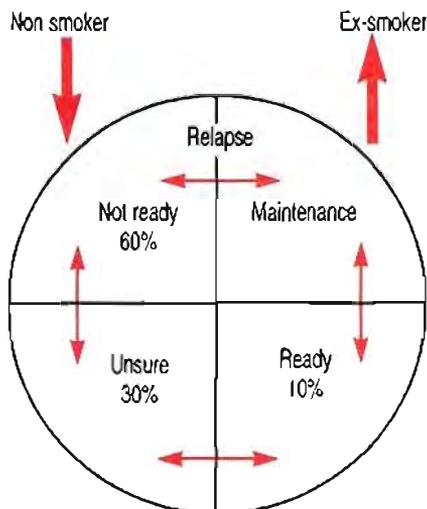


Figure 1. The Stages of Change. A model of the stages of readiness to change (adapted from Prochaska and DiClemente)⁴

these people to change. Motivational interviewing, discussing barriers to quitting and any health concerns about smoking, help achieve this.

Motivational interviewing

This is a style of counselling for patients who are ambivalent about changing a behaviour. The aim is to help the smoker weigh up the pros and cons of smoking and decide whether continuing to smoke is worth it at the moment. The four steps of motivational interviewing used in *Smoke-screen for the 1990s* are listed in Table 1. Firstly, the doctor elicits the patient's thoughts about the good and bad aspects of smoking. The doctor then summarises these and encourages the patient to look at the balance. This allows the patient to decide whether to change the behaviour.

A key principle of motivational interviewing is that the patient takes responsibility for the problem. The doctor acts as a facilitator rather than telling the patient what to do. Patients are more likely to make a decision to change a behaviour if they have reached that decision by their own reasoning and based on what they see as important.

HOW DO YOU FEEL ABOUT YOUR SMOKING AT THE MOMENT?

<p>I'm not interested in stopping I'm happy being a smoker I enjoy it</p>  <p style="background-color: #e91e63; color: white; text-align: center; padding: 5px;">NOT READY TO STOP</p> <p style="text-align: center;">I won't hassle you</p>	<p>I'm thinking about stopping I'm not sure if I am ready at the moment I'm interested in weighing it up</p>  <p style="background-color: #ff9800; color: white; text-align: center; padding: 5px;">UNSURE</p> <p style="text-align: center;">Would you like to discuss it now?</p>	<p>I want to stop NOW I may need some help The disadvantages of smoking outweigh the benefits for me</p>  <p style="background-color: #4caf50; color: white; text-align: center; padding: 5px;">READY TO STOP NOW</p> <p style="text-align: center;">Would you like me to help you quit?</p>
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Figure 2. The deskcard. Used to help allocate smokers to groups.

TABLE 1**Motivational Interviewing.
Weighing up the pros and
cons of smoking.**

1. "What do you like about smoking?"
2. "What are the things you don't like about smoking?"
3. Summarise your understanding of the patient's pros and cons.
4. "Where does this leave you now?"

Concerns about quitting

An informed discussion about these issues may remove important barriers to quitting. The most common are:

Weight gain Tell patients that 25% of smokers do not gain weight when they quit and the average weight gain is only 4.0 kg.⁸ This may be minimised by dietary advice, exercise, attention to eating habits and regular weighing. Emphasise that the health risks of smoking are far greater than the health risks of a small weight gain.

Stress It is often best to deal with the stress before attempting to quit. Would the patient benefit from some counselling or stress management? Help the patient find healthier ways of coping with stress other than smoking.

Withdrawal Explain that only two-thirds of patients will experience withdrawal symptoms. The worst of the physical symptoms will subside within 2 to 3 days and will virtually cease in 7 to 10 days in most patients, although the psychological symptoms may persist for longer. Nicotine patches are helpful in relieving withdrawal symptoms.⁹

Fear of failure Explain that most ex-smokers have tried and failed three to five times before finally being successful. Each attempt at cessation is not a failure but a 'learning experience' and increases the chance of success next time.

Tablets, Injection

PEPCIDINE[®]

(famotidine, MSD)

ABRIDGED PRODUCT INFORMATION (0291-AUS)

Full product information should be consulted before prescribing.

**INTRODUCTION**

PEPCIDINE (famotidine, MSD) is a competitive inhibitor of histamine-H₂-receptors. The primary clinically important pharmacological activity of PEPCIDINE is inhibition of gastric juice secretion. PEPCIDINE reduces the acid and pepsin content, as well as the volume of basal, nocturnal and stimulated gastric secretion.

*** INDICATIONS**

• Duodenal ulcer • Benign gastric ulcer • Zollinger-Ellison Syndrome • Prevention of relapses of duodenal ulceration • Short term (no more than 12 weeks) symptomatic relief of gastroesophageal reflux not responsive to conservative measures • Healing of oesophageal erosion or ulceration associated with gastroesophageal reflux disease • Prevention of relapses of symptoms and erosions or ulcerations associated with gastroesophageal reflux disease.

CONTRAINDICATIONS

Hypersensitivity to any component of these products.

PRECAUTIONS

Gastric Neoplasms: Gastric malignancy should be excluded prior to initiation of therapy of gastric ulcer with PEPCIDINE. Symptomatic response of gastric ulcer to therapy with PEPCIDINE does not preclude the presence of gastric malignancy.

Renal Dysfunction: Since PEPCIDINE is excreted primarily by the kidney, caution should be observed in patients with impaired renal function. A reduction in daily dosage should be considered if creatinine clearance falls below, 10mL/min (see DOSAGE & ADMINISTRATION).

Use In Pregnancy (Category B1): PEPCIDINE is not recommended for use in pregnancy and should be prescribed only if clearly needed. Before a decision is made to use PEPCIDINE during pregnancy, the physician should weigh the potential benefits from the drug against the possible risks involved. (See full product information for further details).

Nursing Mothers: Famotidine is detectable in human milk. Nursing mothers should either stop this drug or stop nursing.

Paediatric Use: Safety and effectiveness of PEPCIDINE in children have not been established.

Use in the Elderly: When PEPCIDINE was administered to elderly patients in clinical trials, no increase in the incidence or change in the type of adverse effects was observed. No dosage adjustment is required based on age alone.

Drug Interactions: No drug interactions of clinical importance have been identified. PEPCIDINE does not interact with the cytochrome P₄₅₀-linked drug metabolising enzyme system. Compounds metabolised by this system which have been tested in man in short-term studies included warfarin, propranolol, theophylline, phenytoin, diazepam, aminopyrine and anipyrine. Indocyanine green as an index of hepatic blood flow and/or hepatic drug extraction has been tested and no significant effects have been found. A study of 11 patients stabilized on phenprocoumon therapy have shown no pharmacokinetic or anticoagulant activity of phenprocoumon.

Intensive Care Units: Agents that elevate gastric pH may increase the already present risk of nosocomial pneumonia in intubated ICU patients receiving mechanical ventilation.

ADVERSE EFFECTS

PEPCIDINE has been shown to be generally well-tolerated. Headache, dizziness, constipation and diarrhoea have been reported at a frequency of greater than 1% in controlled clinical trials and may be causally related to famotidine. A similar incidence of the same effects was seen in the placebo or active comparison arms of these studies. Rarely reported events included dry mouth, nausea and/or vomiting, rash, abdominal discomfort or distension, anorexia, fatigue, pruritus, urticaria, liver enzymes, abnormalities, cholestatic jaundice, anaphylaxis, angioedema and arthralgia. The causal relationship to therapy with PEPCIDINE has not been established: reversible psychic disturbances including depression, anxiety disorders, agitation, confusion, hallucinations and decreased libido, paresthesia, somnolence, insomnia, grand mal seizure, thrombocytopenia, pancytopenia, leukopenia, agranulocytosis. Rare cases of impotence have been reported, however, in controlled clinical trials the incidence was not greater than that seen with placebo.

DOSAGE & ADMINISTRATION**DUODENAL ULCER**

Initial Therapy: The recommended dose of PEPCIDINE is one 40mg tablet daily taken at night. Treatment should be given for four to eight weeks but the duration of treatment may be shortened if endoscopy reveals that the ulcer has healed. In most cases of duodenal ulcer, healing occurs within four weeks on this regimen. In those patients whose ulcers have not healed completely after four weeks, treatment should be continued for a further four-week period.

Maintenance Therapy: For the prevention of recurrence of duodenal ulceration, it is recommended that therapy with PEPCIDINE be continued with a dose of one 20mg tablet daily taken at night. In ongoing clinical studies this regimen has been continued for twelve months.

BENIGN GASTRIC ULCER. The recommended dose of PEPCIDINE is one 40mg tablet daily, taken at night. Treatment should be given for four to eight weeks, but the duration of treatment may be shortened if endoscopy reveals that the ulcer has healed.

ZOLLINGER-ELLISON SYNDROME. Patients without prior antisecretory therapy should be started on a dose of 20mg every six hours. Dosage should be adjusted to individual patient needs and should continue for as long as indicated clinically. Doses up to 800mg daily have been used in a small number of patients for up to one year without the development of significant adverse effects or tachyphylaxis. Patients who have been receiving another H₂ antagonist may be switched directly to PEPCIDINE at a starting dose higher than that recommended for new cases, this starting dose will depend on the severity of the condition and the last dose of the H₂ antagonist previously used.

* **GASTROESOPHAGEAL REFLUX DISEASE.** The recommended dosage for the symptomatic relief of gastroesophageal reflux disease is 20mg of famotidine taken orally twice daily.

For the treatment of oesophageal erosion or ulceration associated with gastroesophageal reflux disease, the recommended dosage is 20mg of famotidine twice daily.

Maintenance Therapy: For the prevention of recurrence of symptoms and erosions or ulcerations associated with gastroesophageal reflux disease, the recommended dosage is 20mg of famotidine twice daily. Efficacy studies have not been conducted beyond six months.

DOSAGE ADJUSTMENT FOR PATIENTS WITH SEVERE RENAL INSUFFICIENCY. In patients with severe renal insufficiency, i.e., with a creatinine clearance less than 10mL/min, the elimination half-life of PEPCIDINE may exceed 20 hours, reaching approximately 24 hours in anuric patients. Although no relationship of adverse effects to high plasma levels has been established, the dose of PEPCIDINE may be reduced to 20mg at night to avoid excess accumulation of the drug, or the dosing interval may be prolonged to 36-48 hours as indicated by the patient's clinical response.

Intravenous: In conditions where it is necessary to reduce gastric acid secretion, such as upper gastrointestinal haemorrhage, when oral administration is not feasible, PEPCIDINE should be administered initially as a 20mg dose given intravenously over a period of no less than 2 minutes and subsequently by repeated injection or by infusion of 20mg over a 30 minute period every 12 hours.

Reconstitution, Intravenous: Each vial contains: famotidine 22mg L-Aspartic Acid 8.8mg mannitol 44mg. The contents should be dissolved in 5.2mL of a compatible diluent. When reconstituted each vial contains famotidine 20mg/5mL. For injection withdraw 5.0mL of the reconstituted solution. For infusion dilute 5.0mL of the reconstituted solution to 100mL with the compatible diluent. The reconstituted solution should be used immediately and any unused solution discarded. The vial contains no antimicrobial agent.

Compatible diluents are: Normal saline. Glucose Solutions (5%-20%) Fructose Solution (5%) Water for Injection Dextran 70 (6%) Dextran-glucose Low molecular weight dextran Xylitol 10%

I.V. injection therapy should be changed to oral treatment as soon as feasible.

Storage conditions - Store below 25°C. Protect from light.

OVERDOSAGE

There is no experience to date with overdosage. Doses of up to 800mg daily have been used in a small number of patients with Zollinger-Ellison Syndrome for more than a year without development of significant adverse effects. The usual measure to remove unabsorbed material from the gastrointestinal tract, clinical monitoring and supportive therapy should be employed.

AVAILABILITY

PEPCIDINE - 40mg, tan (light brownish-orange), rounded square, film-coated tablets, one side engraved with "MSD 954" and the other side plain. Supplied in blister packs of 30 tablets.

PEPCIDINE M - 20mg, beige, rounded square, film-coated tablets, one side engraved with "MSD 963" and the other side plain. Supplied in blister packs of 60 tablets.

Injection:

PEPCIDINE Intravenous injection is supplied as a white to off-white, sterile, lyophilised powder in single dose vials, each when reconstituted contains 20mg of famotidine per 5mL.

*Please note changes in Product Information.

Date Approved: January 1994.

PEP 5341A

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SMOKESCREEN FOR THE 1990s

The Stop Smoking Programme for use by General Practitioners

MANUAL

Ask: "How do you feel about your smoking?" Help patients decide which group they belong to using the deskcard or flipover. If necessary ask: "Are you ready to quit now?"



NOT READY GROUP

- Give pamphlet
Smokers: You Have a Right to Know
- Invite back when ready to discuss smoking



UNSURE GROUP

- Ask: "Would you like to discuss it now?"
Choose from these options:
- Weigh up pros and cons of smoking (flipover p2)
 - Offer lung function test
 - Offer discussion of health effects (flipover p 3-7)
 - Discuss concerns about quitting
 - Give booklet
Smoking: The Choice is Yours
 - Invite back



READY GROUP

- Ask: "Would you like me to help you quit?"
Choose from these options:
- Visit 1: Preparation**
- Highlight benefits of quitting
 - Discuss concerns about quitting
 - Praise use of the nicotine patch
 - Set Quit Day
 - Give booklet *Taking Action to Stop Smoking*
- Visit 2: Quit Day**
Within next 2 weeks
- Identify smoking triggers
 - Discuss alternatives to smoking
 - Discuss correct use of the nicotine patch
- Visit 3: Follow up 3 to 7 days later**
- Review progress and problems
 - Invite back for further follow up visits

Figure 3. The manual. The steps of the program are summarised on the cover.

Health issues

It is useful to examine any relevant health issues related to smoking, especially if these are of concern to the patient. The flipover (Figure 5) consists of a set of 8 coloured photographs to facilitate education about the health effects of smoking. It is important to take a positive approach and focus on the many benefits that result from quitting, such as the reduced risk of a heart attack. A lung function test may be offered to patients concerned with lung damage, as this is

objective evidence of organ damage and is very motivating for many patients.²

Unsure smokers are given a booklet designed specifically for this stage of ambivalence about smoking, *Smoking: The Choice is Yours* (Figure 4) and are invited back to discuss smoking or quitting when they are ready.

Ready smokers

Ten per cent of smokers at any time are motivated and ready to quit right now.⁵ These patients require practical advice

and strategies to help them quit. Support over several visits assists them to remain abstinent. The advice should be personalised for the individual patient's concerns and needs.

Preparation visit

This visit is to prepare patients for quitting, by helping them plan their quitting strategies and prepare themselves psychologically in advance for Quit Day. A discussion of the benefits of quitting may help boost motivation. It is important as in 'the unsure pa-

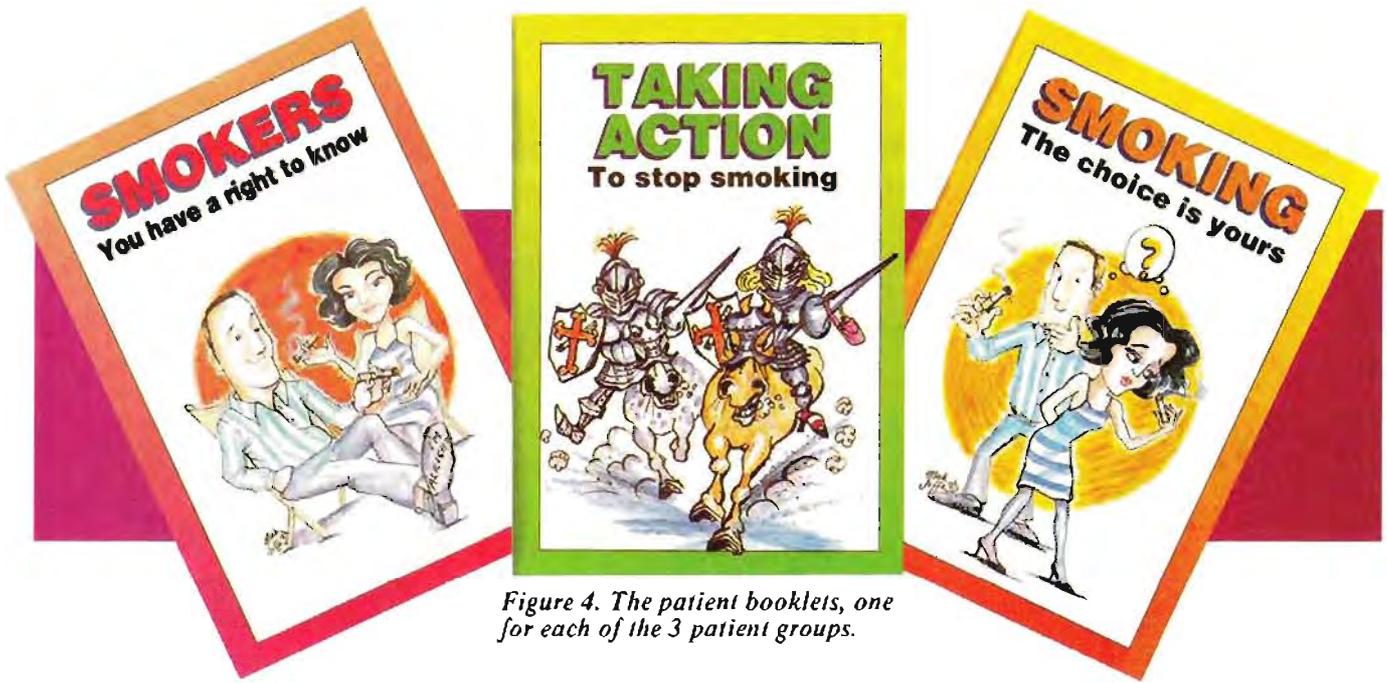


Figure 4. The patient booklets, one for each of the 3 patient groups.

tient' to examine any concerns about quitting, and offer assistance where appropriate.

Advise patients at this visit that the nicotine patch is available to alleviate any craving and withdrawal symptoms.

Importantly, a quit date should be set. Some time in the next week. Patients are encouraged to examine their smoking habit over this next week and pinpoint the important cigarettes smoked each day. They should

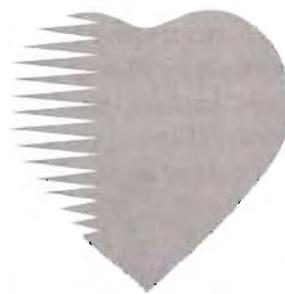
gradually reduce their cigarette intake during this time. Patients are given a booklet containing practical strategies for quitting, *Taking Action to Stop Smoking* (Figure 4) and invited back for the Quit Day visit.

Before prescribing, please review Product

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Estraderm®
(oestradiol)



Transiderm-Nitro®
(glyceryl trinitrate)



Nicotinell®
(nicotine)

Quit day visit

Abrupt cessation or 'cold turkey' occurs on Quit Day and is preferred to gradual withdrawal.

Smoking triggers

Removing the association between smoking triggers and having a cigarette is important in breaking the smoking habit. On Quit Day, help patients to identify their main cues to smoking and discuss strategies for coping with them. Strategies fall under four main headings:

- **Distraction**
Divert the patient's mind from smoking, for example with a drink of water, cleaning the teeth or mental arithmetic.
- **Avoidance**
Avoid major situations that trigger smoking, such as alcohol, coffee, the pub and friends who smoke. This strategy can be very beneficial, especially in the first 2 weeks.
- **Delay**
Postpone the cigarette for several minutes which is easier than "never having one again".

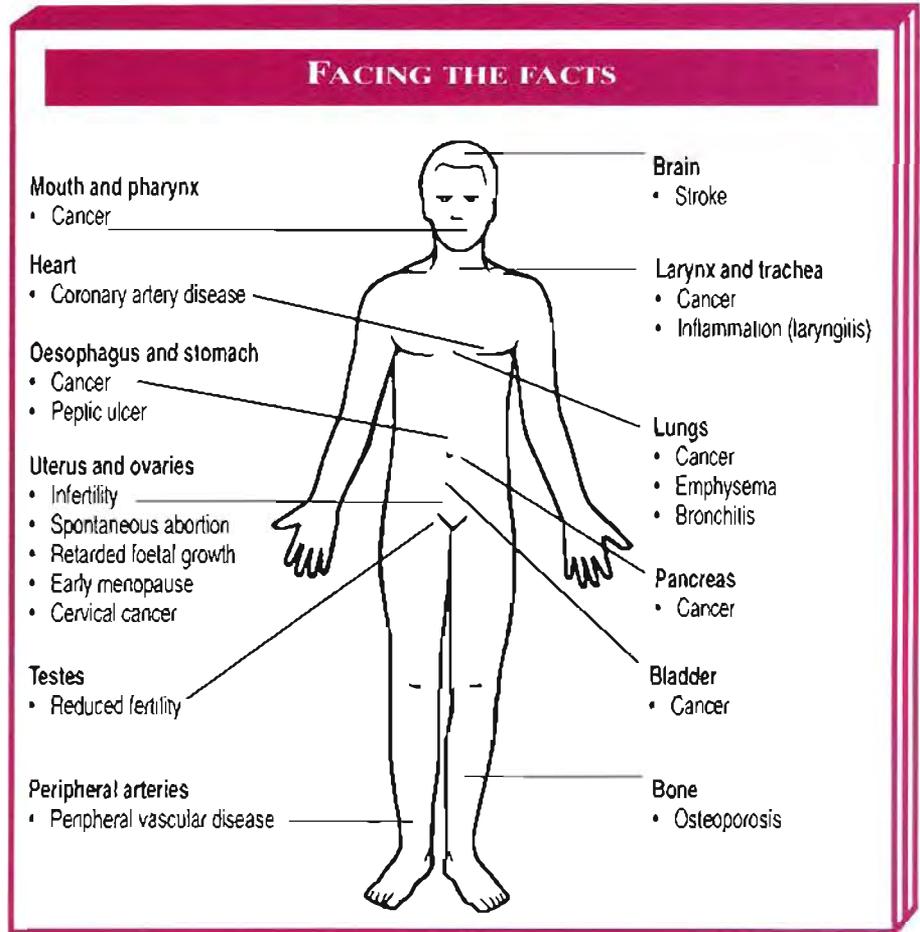
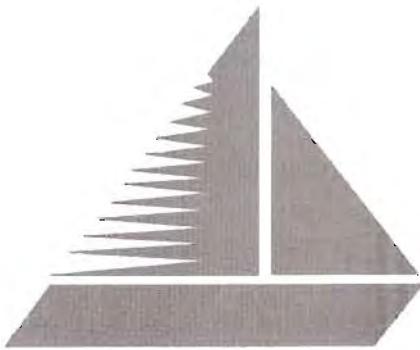


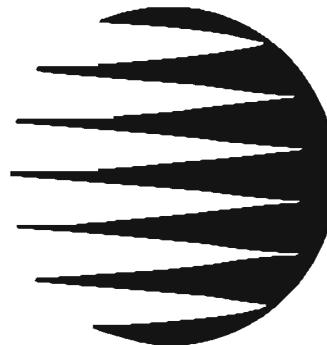
Figure 5. The flipover (page 8). Used to facilitate education about the health effects of smoking.

Information by referring to Advertisers' Index

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(hyoscine)



The symbol of quality from the world leader in transdermal therapy

ciba

• Escape

When all else fails, remove yourself from the trigger until the craving subsides, for example, leave a smoky room and go for a short walk.

The nicotine transdermal patch

The patch is an important advance in smoking cessation and is a valuable aid for many quitters.^{9,10} Its use doubles the likelihood of success compared with the use of a placebo patch. The patch reduces craving for cigarettes and withdrawal symptoms, especially negative mood states.

Correct use of the patch is safe and well tolerated with skin reactions and sleep disturbances being the most common side effects. The patch is easier to use than nicotine gum and is more effective.⁹ Instruct patients to apply the first patch on the morning of Quit Day and not to smoke while using the patch.

The nicotine patch should only be offered to patients who are dependent on nicotine. A quick assessment of dependence can be made by asking the following three questions:¹¹

1. Do you smoke more than 20 cigarettes a day?
2. Do you smoke your first cigarette within 30 minutes of waking and
3. Have you experienced strong cravings or withdrawal symptoms during a previous quit attempt?

Invite the patient back for a follow up visit, 3 to 7 days after Quit Day.

Follow up visit

At the first **Follow up Visit**, review the patient's progress and discuss any problems. Examine any slips, so more effective coping strategies can be planned. Explain slips as valuable learning experiences, not as failures. Give encouragement and praise for the patient's efforts. Positive reinforcement by the GP is an important factor in maintaining abstinence.

Review the use of the nicotine patch. In particular, is the patient having any side-effects from it? Is the dose of nicotine replacement adequate? If there are withdrawal symptoms, a larger dose of nicotine may be required.

Encourage the patient to enlist the support of family and friends. Self-rewards are a useful strategy as smokers often feel deprived when they quit.

Further follow up visits

Patients who attend further follow up visits have been found to have fewer lapses and a better chance of success.¹² Follow up at 3 and 6 months is recommended, although the timing should be negotiated with each patient. Other visits may be required for the supply of nicotine patch prescriptions.

Ask the patient to describe the improvements and changes observed since quitting as this reinforces the positive aspects of their non smoking status.

Relapse is common with any quitting method, especially in the first few days, but also over the next 3 months. Help patients to examine the cause of the relapse, plan a strategy to deal with it next time and try again when ready.

Conclusion

Helping patients to quit smoking is an important role of the general practitioner. *Smokescreen for the 1990s* provides GPs with a flexible framework with which to assist smokers. After assessing the smoker's readiness to quit, each patient can be offered a personalised intervention appropriate to their needs and concerns.

Smokescreen training workshops are being conducted throughout Australia and all general practitioners are invited to attend. Workshops are free and are endorsed by the RACGP Quality Assurance and Continuing Education Program: Category "A" CME, 2 points per hour: a total of 4 credit points. For further infor-

mation, please refer to the CME Calendar in *Australian Family Physician*, or contact the Lifestyle Unit on (02) 697 8228 or (02) 697 8123.

References

1. Richmond R L, Mendelsohn C P, Webster I, Elkins L, Rollnick S. *Smokescreen for the 1990s: the stop smoking programme for use by general practitioners*. Sydney: School of Community Medicine and National Drug and Alcohol Research Centre, University of NSW, 1991.
2. Richmond R L, Webster I W. Smoking cessation programme for use in general practice. *Med J Aust*, 1985; 142:190-194.
3. Richmond R L, Austin A, Webster I W. Three year evaluation of a programme by general practitioners to help patients to stop smoking. *Brit Med J*, 1986; 292:803-806.
4. Prochaska J O, DiClemente C O. Towards a comprehensive model of change. In: Miller W R, Heather N, editors. *Treating addictive behaviours: processing of change*. New York: Plenum, 1986:3-27.
5. Prochaska J O. From recruitment to recovery: a stage analysis of smoking cessation. Presented at the conference — Brief interventions for smokers: an international perspective, Sydney, April 1990.
6. Mendelsohn C P, Richmond R L. GPs can help their patients to stop smoking. *Med J Aust* 1992; 157:463-467.
7. Rollnick S, Bell A. Brief motivational interviewing for use by the non-specialist. In: Miller W, Rollnick S. *Motivational interviewing: preparing people for change*. New York: Guildford, 1991; 203-213.
8. Richmond R L, Kehoe L, Webster I W. Weight change after smoking cessation in general practice. *Med J Aust* 1993; 158:821-822.
9. Mendelsohn C P, Richmond R L. The nicotine patch: guidelines for practical use. *Modern Medicine* 1994; 37(3):105-112.
10. Richmond R L, Harris K, de Almeida Neto A. The transdermal nicotine patch: results of a randomised placebo-controlled trial. *Med J Aust*. In press.
11. Fiore M C, Jorenby D E, Baker T B, Kenford S L. Tobacco dependence and the nicotine patch. *JAMA* 1992; 268:2687-2694.
12. Richmond R L, Makinson R J, Kehoe L A. One year evaluation of three smoking cessation interventions administered by general practitioners. *Addictive behaviours* 1993; 18:187-199. □