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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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)[4,5] (*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 these people to change. Motivational interviewing, discussing barriers to quitting and any health concerns about smoking, help achieve this.

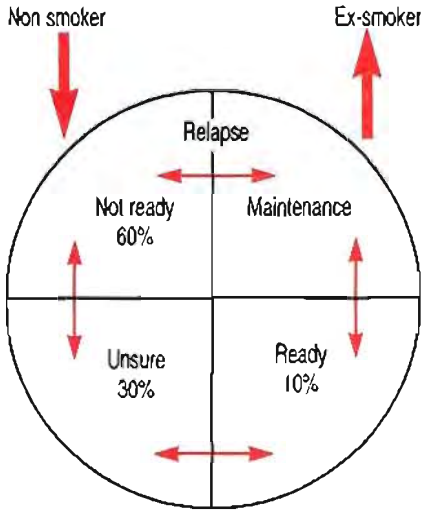

Figure 1. The Stages of Change. A model of the stages of readiness to change (adapted from Prochaska and DiClemente)[4]

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 *Smokescreen 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.

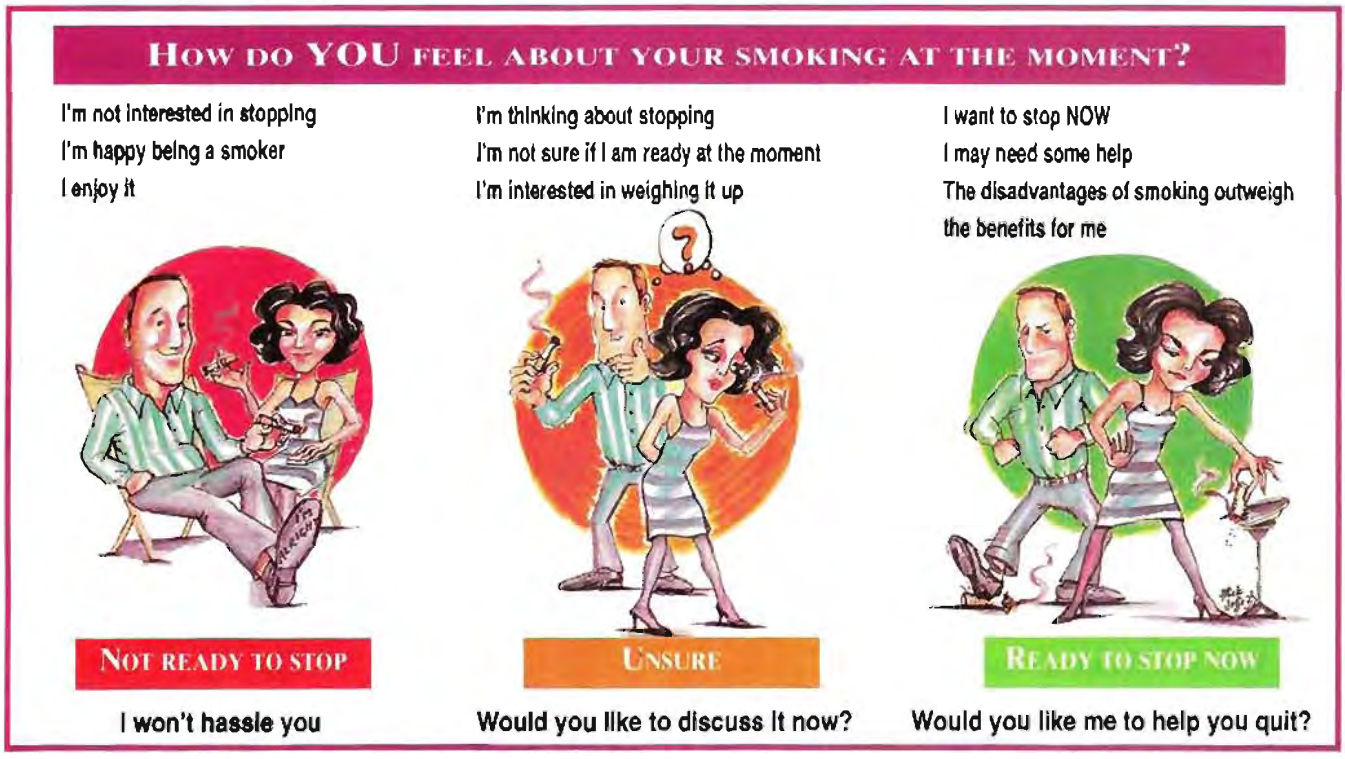

Figure 2. The deskcard. Used to help allocate smokers to groups.

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 If 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.

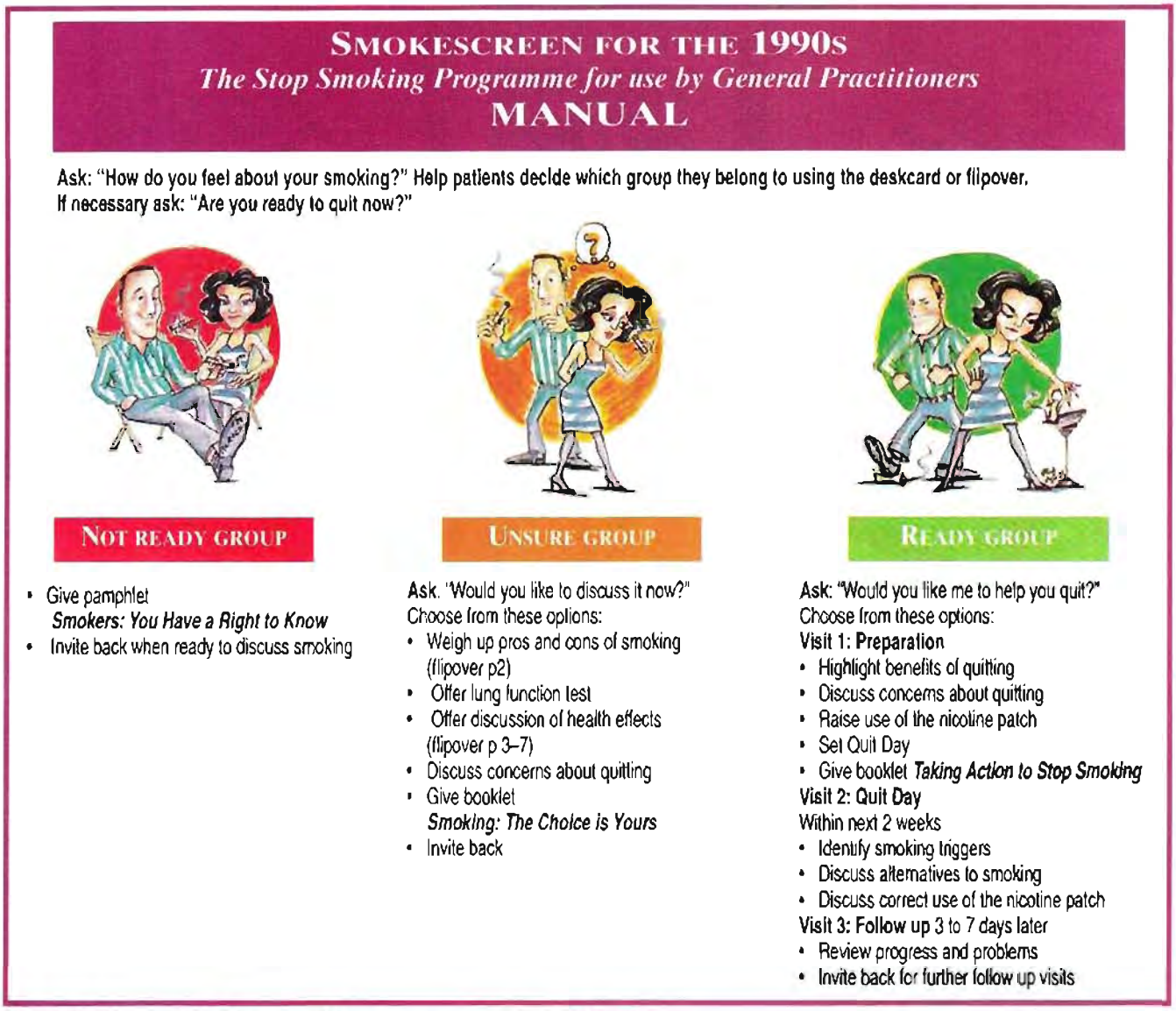

Figure 3. The manual. *The steps of the program are summarised on the cover.*

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-

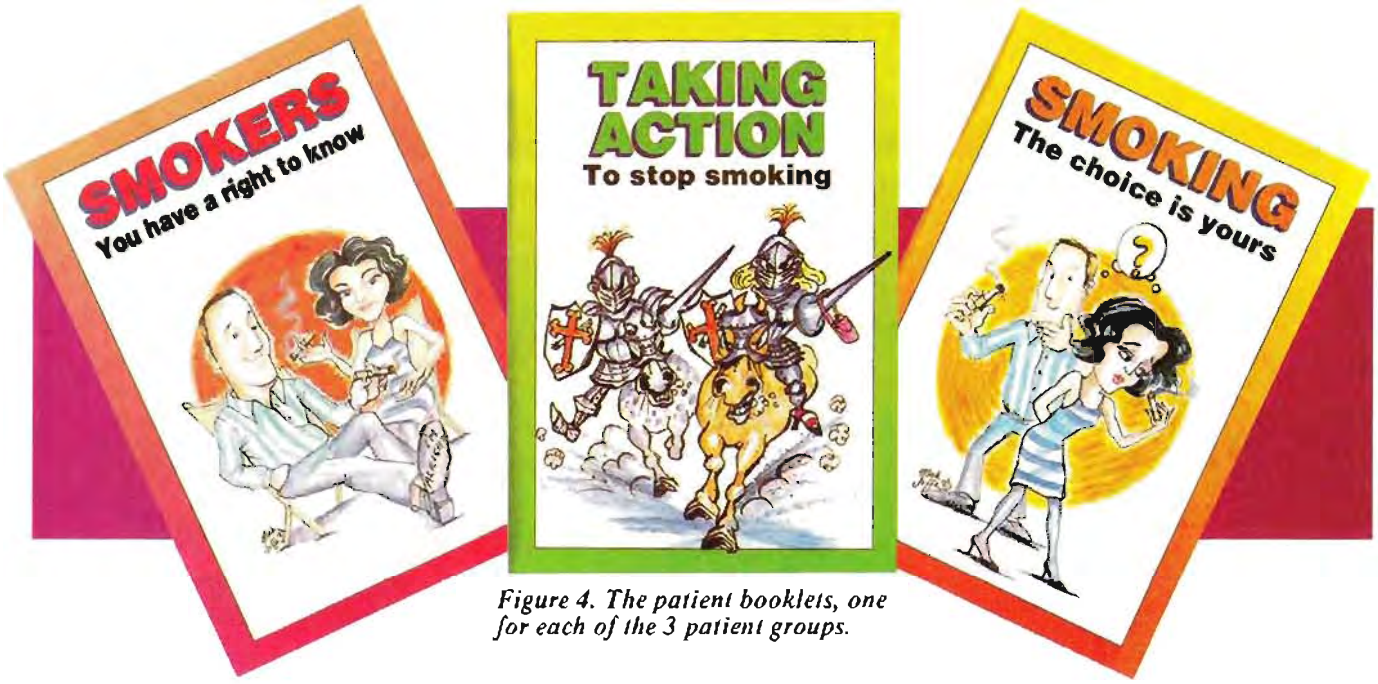

Figure 4. The patient booklets, one for each of the 3 patient groups.

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.

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".

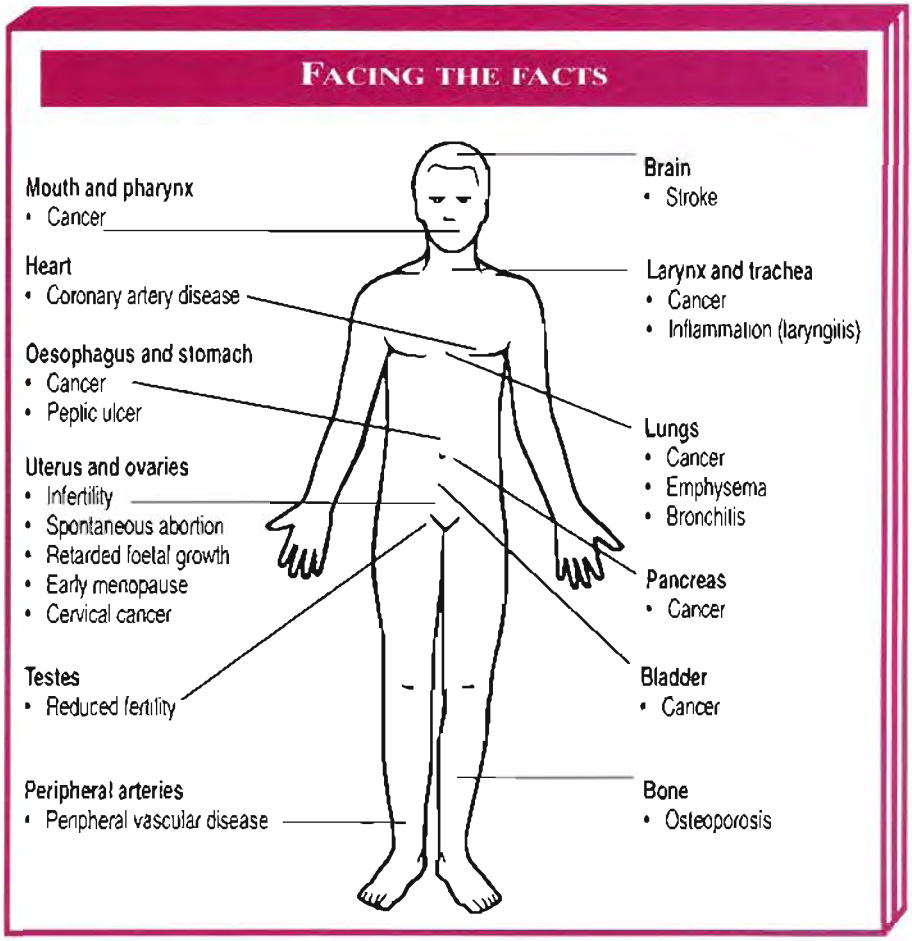

Figure 5. The flipover (page 8). Used to facilitate education about the health effects of smoking.

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

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