Helping Smokers Change

Pip Mason

Acknowledgements

MAKING UP THE TRAINERS MANUAL

It is very important that when you create this manual the pages are made up back to back. This is because the manual, especially the training sections, has been designed as two page spreads and will therefore function best in this format. This may be achieved simply by photocopying the entire pack in duplex (back-to-back) mode. Thus all even-numbered pages will be on the left side of a two-page spread, and all odd-numbered pages on the right side.

Trainers may also find it useful to insert dividers between the main sections to simplify cross-referencing between these.

We ask countries who translate and use this pack to let WHO have a copy of the translation (please contact Patsy Harrington at PHA@who.dk or Ivana Skovgaard at ISL@who.dk). Copies of the handouts in Word format are available on request.

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Helping Smokers Change

The Author

Pip Mason is a nurse, trained in cognitive-behavioural approaches to counselling people with addictions problems. Before working as a freelance consultant she was Assistant Director and Head of Education for Aquarius, an alcohol and drugs agency in England. She is an honorary lecturer, teaching addictions counselling at the School of Psychology, University of Birmingham. She is co-author of the training manual *Helping People Change* (London: Health Education Authority, 1994) and of *Health Behavior Change, A Guide for Health Professionals* (Edinburgh: Churchill Livingstone, 1999).

The WHO Europe Partnership Project

A reduction in tobacco use is one of the single most important public policy actions that a country can undertake to improve the health of its citizens and reduce the economic burden of tobacco use. Tobacco products are responsible for 1.2 million deaths (14% of all deaths) each year in WHO's European Region. Unless more effective measures are implemented to help the current 200 million European adult smokers stop or at least reduce their tobacco consumption, tobacco products will be responsible for 2 million deaths (20% of all deaths) each year by 2020.

However, it is clear that this is not going to be achieved unless policies and programmes are implemented to help current smokers reduce their dependence on tobacco products. There is overwhelming evidence for the effectiveness and cost effectiveness of tobacco dependence treatments. WHO has the mandate and the opportunity to influence treatment policy processes and programmes, but cannot do so without the support of the private sector and other partners.

The WHO European Partnership Project on Tobacco Dependence, launched in 1999, was set up to create the opportunity for well-funded and targeted implementation of projects that aim to change the policy environment and enable current smokers to reduce or stop their tobacco consumption. The main objective of the Partnership Project is to reduce tobacco related death and disease among tobacco dependent smokers.

This trainers' pack has been produced as part of the Partnership Project's activity four, the goal of which is to promote the uptake of evidence-based treatment for smokers. The pack will be made as widely available as possible to trainers who wish to train health professionals to help smokers stop.

Further details of the project can be obtained from:
Patsy Harrington, Project Manager, WHO. Tel: + 45 3917 1302 (e-mail PHA@who.dk) or Ivana Skovgaard, Project Assistant, WHO. Tel: + 45 3917 1530 (e-mail ISL@who.dk) at WHO Regional Office for Europe, 8 Scherfigsvej, 2100 Copenhagen, Denmark.

Foreword

There is overwhelming evidence for the effectiveness and cost effectiveness of tobacco dependence treatments. Nowadays consensus on what treatments work is so strong that the emphasis has shifted slightly from researching new treatments (although that of course remains important) to disseminating what we already know. A crucial part of this process is engaging health professionals in advising and supporting smokers who wish to stop. To do that successfully, health professionals need good knowledge and skills. WHO, which has set the fight against tobacco dependance as one of its main priorities, is very pleased to be able to contribute to smoking cessation initiatives through this training package. The trainers' pack can be locally adapted and translated and provides trainers with a flexible tool to aid their work. It is based on current scientific evidence and will be periodically updated to keep abreast of new developments. WHO encourages its adaptation to any country and culture and hopes that it will make a positive and lasting contribution to the building of the skills needed to help smokers conquer their dependence.

Dr *Roberto Bertollini*, Director,
WHO EURO Division of Technical Support

Contents

Introductory Pages

Introduction to Smoking Cessation

A reduction in tobacco use is one of the single most important public policy actions that countries can undertake for health gain. Although preventing people starting smoking is very important if we want to lower prevalence, this only produces health gain over 40-50 years. Smoking cessation in adults brings much quicker health gains. Unless more effective measures are implemented to help smokers to stop smoking or at least reduce their tobacco consumption, in Europe alone tobacco products will be responsible for 2 million deaths each year by 2020 (20% of all deaths). There is overwhelming evidence for the effectiveness and cost effectiveness of behavioural and pharmacological treatments for tobacco dependence, a disorder recognised by WHO's ICD-10. Such treatments are guaranteed to bring population health gains for relatively modest costs and in the long run they will reduce smoking related health care costs, releasing resources for other needs.

Many smokers can be motivated to change through brief advice given by a primary care health professional. Others need the extra support that specialist smoking cessation clinics can offer. This pack comprises resource materials for training health professionals to provide evidence-based treatment for the smokers in their care. It has been produced as part of the WHO European Partnership Project to Reduce Tobacco Dependence.

The Resource Pack

The materials in this pack are intended to assist tutors in putting together training courses to meet the needs of health professionals engaged in smoking cessation. The pack includes:

- Fifteen plans for sessions of between 30 and 70 minutes duration. Each session plan gives speakers' notes, exercises and suggested timings.

- Background notes for each session, designed to help the tutor prepare and run the session. The background notes often include suggestions for additional reading and ideas on how links can be made with other related sessions.

- Handouts, to be photocopied and given to students at the points indicated in the session plans.

- Visual aids, to be reproduced as slides, overhead transparencies or on black/ whiteboard to support didactic inputs as indicated in the session plans.

The session plans can be mixed and matched to meet the needs of a particular student group. Suggested programmes are given below.

The students

The training may be delivered to a range of health and social care professionals. In writing the materials the author was thinking particularly of those physicians, nurses, pharmacists and dentists who are working in primary care or undergoing training to do so. Although the word 'student' is used throughout, those being trained might well be experienced practitioners attending as postgraduates to update their knowledge and skills. In selecting which materials to use the tutor will, of course, need to take account of existing skills and knowledge.

The tutors

This pack assumes that the tutors are experienced trainers, who already know how to

set up and run a training course. Ideally courses will be taught by people who also possess expertise in smoking cessation treatment. The main areas of expertise required are:

- knowledge of smoking and the damage it does,
- an understanding of addiction and the ways it can be treated,
- an understanding of the psychology of behaviour change,
- skills in using a client-centred approach and counselling.

It is often useful to have a tutor team of two or three people who between them can provide all the expertise required. The sessions are designed in such a way that they can be shared between tutors as appropriate. The methods used are participatory rather than didactic, and will best suit people accustomed to work in this way.

Training methods and terminology

In order to maximise skills development and retention of information, participative methods of adult learning are used in all sessions. The following techniques and methods are included.

Brainstorm
This is a quick exercise intended to gain students' attention and focus their minds on the issue. A board or sheet of paper is headed with a question or title and students are asked to call out as many suggestions as they can think of. The tutor lists all suggestions without comment or discussion and aims to elicit as many creative answers as possible in no more than 5 minutes. A brainstorm is normally followed by further discussion or input when issues raised can be followed up.

Buzz group
This is another way of keeping students alert and involved. Students are usually divided into pairs or trios and invited to consider a particular question for a few minutes before returning to a plenary to follow up the issue further.

Plenary
This word is used in the session plan to describe any situation where students have been working in small groups and are brought back together to consolidate the learning. Either discussion or didactic presentations may take place in a plenary.

Experiential exercises
In these exercises students are asked, usually in pairs, to talk about their own experiences of, for example, attempting to make behaviour changes. They may be asked to be themselves, talking about issues in their own lives but take a client role while a colleague tries out a particular skill or approach. The purpose of these exercises is to heighten the training experience and gain a better understanding of how smokers feel about their smoking and about being advised to stop. They differ from role plays where students are asked to pretend to be someone else.

Role plays
The purpose of these is usually skills rehearsal. A brief is given for the 'client' which is designed to give the person playing the health professional an opportunity to practise particular skills or techniques. Students often report that they dislike doing role plays but then find them extremely useful! Tutors may wish to customise the role play briefs to reflect local cultural issues or the client group with whom the students are working.

Input
This word is used whenever there is a need for the tutor to ensure the students are in possession of particular facts or ideas. The style of an input will vary between tutors. It may be a didactic presentation or a tutor-led discussion or a mixture of the two. Generally, as is explained in the background notes, a handout is provided, which can double as notes for the tutor and as reference for the students.

Further Resources

Tutors will want to ensure that their training is as up-to-date as possible and will want to give students additional, locally produced material.

A useful internet site for anyone involved in smoking cessation is www.treatobacco.net launched in 2001, bringing together evidence-based data, guidelines and toolkits on the treatment of tobacco dependence. As new information and tools become available they will be reviewed and, if approved, included in the appropriate section.
The sections are efficacy, safety, health economics, policy, demographics and health effects. Key developments will be added regularly to *treatobacco.net.*

In 2000 a number of important publications (in English) appeared:

FIORE MC, BAILEY WC, COHEN SJ et al (2000) *Treating Tobacco Use and Dependence. Clinical Practice Guideline.* (Rockville: US DHHS)

ROYAL COLLEGE OF PHYSICIANS (2000) *Nicotine addiction in Britain. A report of the Tobacco Advisory Group of the Royal College of Physicians* (London: Royal College of Physicians)

SURGEON GENERAL (2000) *Reducing Tobacco Use. A Report Of The Surgeon General* (Washington: US DHHS)

A copy of the following document is included in the 'Resources' section of this pack:

WORLD HEALTH ORGANIZATION EUROPEAN PARTNERSHIP PROJECT (2000) *First European recommendations on the treatment of tobacco dependence.* (Copenhagen: WHO.)

Designing a Course

These materials have been designed to be used in a flexible way by tutors. The list of training sessions indicates the aims, objectives and duration of each and thus serves as a good starting point. The sessions have been divided into three sections:

Section 1: Climate building. A session to set the scene for participative learning.

Section 2: Increasing knowledge. Sessions that primarily deal with factual and theoretical matters.

Section 3: Developing skills. Sessions that enhance students' abilities to apply their knowledge to helping smokers overcome their tobacco dependence.

A typical training course will include sessions from each section.

Some students will be learning how to give brief advice only; others may be learning how to give more intensive support or preparing to be smoking cessation specialists. Some may have a strong background in counselling and behaviour change and be seeking to apply these skills to smoking cessation; others may be knowledgeable about tobacco and health but keen to learn intervention skills. For this reason suggestions are made for programmes but tutors will need to make their own decisions.

It is suggested that tutors begin by using the list of training sessions to draft a programme; then check the session plans and background notes to see what sessions are cross-referenced and ensure the draft leads to a coherent whole. The combined objectives of each session will comprise the objectives for the course as a whole.

List of Training Sessions

Section 1: Climate Building

1.1 Introductions   *30 mins*
Aim

To introduce students to each other and to the course, and to promote student participation.

Objectives

By the end of the session students will be able to:
* give the name of at least one other person on the course,
* state the objectives of the course as a whole.

Section 2: Increasing Knowledge

2.1 Promoting Health – Key Action Areas   *45 mins*
Aim

To give students an overview of the range of health promotion activities and an understanding of their own role as part of a wider programme.

Objectives

By the end of the session, students will be able to:
* describe the five key action areas contained in the Ottawa charter,
* give examples of smoking cessation work in each of these action areas.

2.2 Tobacco and Health   *30 mins*
Aim

To inform about health harm related to smoking.

Objectives

By the end of the session students will be able to:
* describe the main ways in which smoking damages health,
* explain why it is important for health care professionals to provide at least brief advice to smokers.

2.3 Brief Interventions   *30 mins*
Aim

To teach a framework for a brief intervention encouraging smoking cessation.

Objectives

By the end of the session students will be able to:
* describe the elements of a brief intervention,
* describe situations in their own work setting when they could use such a framework.

2.4   Stages and Processes of Change   *70 mins*
Aim

To teach the stages of change model and the processes of change which can be engaged when conducting consultations about smoking cessation.

Objectives

By the end of the session students will be able to:
* describe Prochaska and DiClemente's stages of change model,
* list and describe the processes that people use in progressing through the stages of change,
* give examples of each.

2.5 Understanding Resistance *60 mins*
Aim

To enable students to see that resistance to advice and reluctance to change is a normal part of the process of considering change.

Objectives

By the end of the session students will be able to:
* describe typical ways clients show their resistance to smoking cessation advice,
* describe reasons why people are sometimes attached to unhealthy behaviours,
* describe ways in which health professionals' different *styles* of intervention can provoke or reduce resistance.

2.6 Enlisting Support   *45 mins*
Aim

To enable students to consider the range of helping relationships that may be available to people making lifestyle changes.

Objectives

By the end of the session students will be able to:
- describe actions families and friends can take to support the change process,
- describe key community agencies who can provide support.

2.7 Helping Smokers Stop   *60 mins*
Aim

To teach students about the sort of help smokers need in order to stop and to ensure they have the information they need to help.

Objectives

By the end of the session students will be able to:
- describe the reasons why some smokers experience withdrawal symptoms,
- describe specialist treatments available and their value in helping smokers stop,
- answer accurately some frequently asked questions about smoking cessation.

Section 3: Developing Skills

3.1 Information Exchange   *30 mins*
Aim

To teach the skills of information exchange and promote a client-centred approach to brief interventions.

Objective

By the end of the session students will be able to:
- conduct a two-way exchange of information in the context of a brief intervention to promote smoking cessation.

3.2 Developing a Helping Relationship   *70 mins*
Aim

To explore the elements of a helping relationship and revise active listening skills.

Objectives

By the end of the session students will be able to:
- discuss ways to handle situations in which their own attitudes to smokers may be a barrier to forming a helping relationship,
- describe why it is important to use active listening skills,
- describe the behaviours which are helpful in actively listening to clients,
- describe the behaviours which are unhelpful in actively listening to clients.

3.3 Skills for Enabling Change *60 mins*
Aim

To teach some specific strategies that are helpful in consultations about smoking cessation.

Objectives

By the end of the session students will be able to:
- respond to a client's resistance in a way that does not provoke further argument,
- elicit from a client self-motivational statements.

3.4 The Decisional Balance   *60 mins*
Aim

To provide a tool for working with clients who are still considering whether or not to change.

Objectives

By the end of the session students will be able to:
- use the decisional balance framework to understand a client's motivation,
- help clients to use the decisional balance to assess the importance of change for them.

3.5 Developing Confidence   *45 mins*

Aim

To enable students to understand the factors that undermine clients' confidence in their ability to change and the factors that can help develop confidence.

Objectives

By the end of the session students will be able to:

- describe the factors that undermine confidence,
- describe the processes that are useful in developing confidence.

3.6   Relapse Prevention and Recycling
**   *60 mins***

Aim

To teach students that relapse is normal and that practical coping strategies can be used to prevent and to manage it.

Objectives

By the end of the session students will be able to:

- list typical situations that precipitate relapse,
- help a client learn from a relapse and recycle,
- describe ways to manage their own feelings when a client relapses.

3.7   Smoking Cessation Groups
**   *70 mins***

Aim

To give smoking cessation specialists a framework for planning and running groups.

Objectives

By the end of the session students will be able to:

- describe the rationale for running groups,
- list key issues to consider when setting up a group,
- write a programme for a group,
- discuss how to handle difficult situations that may arise with group members.

Example Programmes

Tutors will select material to meet their own participants' needs. Here are two examples of courses designed in this way.

Example One
Half-day course for primary care physicians learning to give brief advice to smokers – *2½ hours*

1.1.   Introductions
2.3   Brief Interventions
3.1   Information Exchange
2.7   Helping Smokers Stop

Example Two
Two-day course for health professionals learning to become smoking cessation specialists –
12 hours 15 minutes

1.1   Introductions
2.1   Promoting Health – Key Action Areas
2.2   Tobacco and Health
2.4   Stages and Processes of Change
2.5   Understanding Resistance
3.2   Developing a Helping Relationship
3.1   Information Exchange
3.3   Skills for Enabling Change
3.4   The Decisional Balance
2.7   Helping Smokers Stop
2.6   Enlisting Support
3.5   Developing Confidence
3.6   Relapse Prevention and Recycling
3.7   Smoking Cessation Groups

Contents

Training Sessions

1.1 Introductions   Background Notes

Materials Needed
Equipment: Flip-chart and pen or blackboard and chalk.
Other: Copies of course programme, name badges and list of students if appropriate.

This style of training works best in an informal environment. A circle of chairs (without desks or tables) encourages more participation than rows of desks and chairs.

1. Introductions to participants

Tutors may need to adapt this to the needs of the group. If students are already in a group and know each other it will be unnecessary. If students are all complete strangers and there are reasons to think they will be particularly shy with each other it may be worthwhile extending the time spent getting to know each other in order to create a good, participative learning environment.

Where there is an odd number, form a trio instead of a pair.

Encourage use of first names for both students and tutors as the informality will help facilitate discussion and sharing of difficulties later on in the course.

With a group who do not know each other, name badges can be helpful. Again, use of first names on badges rather than titles and family names is preferable in order to create the right atmosphere.

2. Brainstorm

The purpose of this brainstorm is partly to heighten awareness of the range of health and social care professionals who may be involved in smoking cessation. It is also to begin the process of engaging the students in the learning process.

Encourage the generation of lots of short answers. Do not discuss them; just record them at this point, and use as a link back to the objectives of the course to be discussed next.

3. Introductions to the course

The tutor should write objectives for the course as a whole, which can be presented on a visual aid or handout. These can be devised by combining the objectives from all of the chosen sessions.

It is important to explain that the course will be participatory, drawing on and adding to students' existing knowledge. The 'ground rules' will be those that help people to learn from each other and share their ideas and expertise.

A typical list of ground rules
We agree to: • *keep confidentiality – do not talk about each other's personal matters outside the course,*   • *respect everyone's viewpoint, even if we do not agree with it,*   • *be punctual in attending, and in returning from breaks,*   • *in group discussions, speak one at a time and listen to each person's contribution,*   • *respect difference and not discriminate against people who are of different cultural backgrounds, beliefs, abilities, etc.,*   • *ask questions if anything is unclear,*   • *attend all sessions.*

30 mins   1.1 Introductions

Aim
To introduce students to each other and to the course, and to promote student participation.

Objectives
By the end of the session students will be able to:
- give the name of at least one other person on the course,
- state the objectives of the course as a whole.

Time	Methods	Notes
5 mins	**1. Introductions to participants** As students arrive, pair them up with people they do not already know (if possible) and ask them to find out each other's name, occupation and what they hope to gain from attending this course.	
10 mins	Ask each person in turn to introduce their partner – name, occupation and, if appropriate, how he or she would prefer to be addressed (e.g. short version of name). Tutors introduce themselves.	
5 mins	**2. Brainstorm** *'Who has the opportunity to work with individuals or groups to promote smoking cessation?'* Generate as many ideas as possible under this heading, writing each suggestion up on flip-chart or blackboard.	
5 mins	**3. Introductions to the course** Show the course aims and objectives and describe briefly the programme and the style in which it will be presented.	
5 mins	Agree ground rules with the students.	

2.1 Promoting Health – Key Action Areas   Background Notes

Materials Needed
Equipment: Overhead projector. Flip-chart and pen or blackboard and chalk.   **Visual aids**: 1. Health promotion   2. Charter for a tobacco-free life   **Handouts**: 1. Key action areas for health promotion   **Other**: Five large pieces of paper and 5 felt-tipped pens. Mark each sheet of paper with one of the Ottawa charter key action areas.

1. Input on the five key action areas of the Ottawa charter

In presenting this introduction it is best to keep it brief. It can be based on the handout. It may be tempting to give a large number of examples to illustrate points but this will pre-empt the following exercise. If students need more examples, in order to understand the key action areas, consider using examples from other topics, such as nutrition, physical activity, alcohol, sexual health, immunisation or food hygiene.

2. Small group exercise

Each large piece of paper should be headed with one of the key action areas.
- Creating supportive environments
- Strengthening community action
- Building healthy public policy
- Developing personal skills
- Re-orienting health services

Students list examples relevant to their given action area. It is helpful to circulate around the groups as they work to ensure they understand the task. It may be necessary to give one or more specific suggestions to move a group on if they are having difficulty. As the sheets of paper are moved on from group to group less time may be required, as most of the interventions that fit under that heading will already have been listed by previous groups.

3. Review

Check that students have a chance to ask about any items on the charts that are unclear.

4. Conclusions

It is important in this session to acknowledge that effective health promotion involves action at all levels in a community or society. However, it is also important that the students, as health professionals, do not feel disempowered or intimidated by the scope of the range of interventions. They will, inevitably, only be able to make a limited contribution and will need to rely on other colleagues in other departments and organisations to work on other action areas. This particular course focuses on interventions to develop smokers' personal skills in the context of reorienting and developing health services.

45 mins   2.1 Promoting Health – Key Action Areas

Aim
To give students an overview of the range of health promotion activities and an understanding of their own role as part of a wider programme.

Objectives
By the end of the session students will be able to:
• describe the five key action areas contained in the Ottawa charter,
• give examples of smoking cessation work in each of these action areas.

Time	Methods	Notes
10 mins	**1. Input by a tutor – The five key action areas of the Ottawa charter** • Explain the origin of the charter. • Describe each key action area, giving an example of each (using visual aid 1).	
20 mins	**2. Small group exercise** Divide participants into 5 groups. Give each group one key action area to consider. Distribute the large sheets of paper (each headed with one key action area) and the pens. Under the heading on their sheet, instruct students to list suggestions of relevant interventions to prevent smoking or to promote smoking cessation. After a few minutes pass the sheets of paper on between the groups so that each group can review the suggestions already made under another key action area (by the previous group) and add to that list. After a few more minutes pass the sheets round again for more contributions and continue in this way until everyone has had an opportunity to contribute to each.	
5 mins	**3. Review** Pin the sheets of paper up around the room and invite students to read them all.	
10 mins	**4. Conclusions** Encourage students to consider their own roles as health professionals and how they relate to the tasks, using visual aid 2. Describe how the rest of the course relates to the Ottawa charter key action areas. Distribute handout 1.	

2.2 Tobacco and Health   Background Notes

Materials Needed
Equipment: Overhead projector. **Visual aids**: 3. Examples of smoking and health harm 4. Is it worth stopping? 5. Passive smoking 6. Smoking in pregnancy 7. Intervention works **Handouts**: 2. Tobacco and health quiz 3. Tobacco and health quiz – Answers

1. Quiz

This session is in a quiz format to enable students to think about what they already know and to engage actively in increasing their knowledge.

The quiz itself can be adapted to meet local need, and questions could be added about local prevalence trends, and morbidity and mortality rates. (If questions are added to the quiz, remember to allow longer for the session.)

While the teams complete the quiz, circulate to ensure they keep to time. If a team gets stuck on one particular question, suggest they leave it for now and move on, to return later if time permits.

2. Plenary

Teams should be encouraged to contribute and discuss the answers. This provides an opportunity to correct any inaccurate information students have and to answer any additional queries on the topic. It may be useful to have available any local leaflets or reference sources for students to look at afterwards.

3. Summary

It is hoped that this session will confirm students' commitment to smoking cessation work and the summary can be oriented towards this. In closing the session refer to any sessions to follow on skills training etc.

Further reading

DOLL, R, & CROFTON, J.(1996) Tobacco and health, *British Medical Bulletin* 52 (1).

PETO, R, ET AL (1994) M*ortality From Smoking in Developed Countries, 1950 – 2000.* (Oxford: Oxford University Press)

ROYAL COLLEGE OF PHYSICIANS (2000) *Nicotine addiction in Britain. A report of the Tobacco Advisory Group of the Royal College of Physicians* (London: Royal College of Physicians)

30 mins   2.2 Tobacco and Health

Aim
To inform about health harm related to smoking.

Objectives
By the end of the session students will be able to:
• describe the main ways in which smoking damages health,
• explain why it is important for health care professionals to provide at least brief advice to smokers.

Time	Methods	Notes
10 mins	**1. Quiz** Introduce the session and put students into small 'teams' of 3-4 people. Distribute handout 2 and ask them to discuss and record their answers.	
15 mins	**2. Plenary** Taking one question at a time, elicit the answers from each team. Correct any misunderstandings and fill in any gaps in knowledge, using visual aids 3, 4, 5, 6 and 7 to support your input. Take this opportunity to add any information about smoking and health that students ask for and to add local statistics if available. Distribute handout 3.	
5 mins	**3. Summary** Summarise, making key points about the value of promoting smoking cessation and relating it to the students' own professional role.	

2.3 Brief Interventions   Background Notes

Materials Needed
Equipment: Overhead projector. **Visual aids**: 7. Intervention works 8. Brief interventions **Handouts**:   4. Brief interventions

1. Input

In presenting this the tutor can take account of the students' professional backgrounds and add any extra information about the evidence base relevant to their specific situation. It might also be appropriate to make any references to local examples of innovation or good practice in this area.

2. Buzz groups

Buzz groups give all participants a chance to respond to what they have just heard, and to reflect on it before embarking on a more formal plenary discussion. It also gives an opportunity for students to formulate any questions or issues they may wish to raise in the last part of the session.

3. Plenary

Encourage constructive discussion on how this approach can be used.

Further reading

Tutors need to be familiar with the evidence for effective intervention outlined in the further reading and in particular the WHO European recommendations. These are referenced below and appear in the 'Resources' section at the end of this pack. The cost effectiveness figures on visual aid 7 come from Parrott *et al.*

FIORE MC, BAILEY WC, COHEN SJ et al (2000) *Treating Tobacco Use and Dependence. Clinical Practice Guideline.* (Rockville: US DHHS)

PARROTT, S, GODFREY, C, RAW, M, WEST, R & MCNEILL, A (1998) Guidance for commissioners on the cost effectiveness of smoking cessation interventions. *Thorax,* 53, supplement 5, part 2.

RAW,M, MCNEILL, A & WEST, R (1998) Smoking cessation guidelines for health professionals. A guide to effective smoking intervention for the health care system. *Thorax,* 53, supplement 5, part 1.

WEST, R, MCNEILL, A & RAW, M (2000) Smoking cessation guidelines for health professionals: an update. *Thorax,* 55, 987-999.

WORLD HEALTH ORGANIZATION EUROPEAN PARTNERSHIP PROJECT (2000) *First European recommendations on the treatment of tobacco dependence.* (Copenhagen: WHO.)

30 mins		2.3 Brief Interventions

Aim
To teach a framework for a brief intervention encouraging smoking cessation.

Objectives
By the end of the session students will be able to:
• describe the elements of a brief intervention,
• describe situations in their own work setting when they could use such a framework.

Time	Methods	Notes
15 mins	**1. Input** Input by a tutor, using visual aids 7 and 8, on the evidence supporting brief interventions, and the 'Ask, advise, assess, assist, arrange' framework.	
5 mins	**2. Buzz groups** Distribute handout 4 and divide group into pairs or trios to share ideas on the situations in their own work when they could use this approach.	
10 mins	**3. Plenary** Elicit students' views on how they could build brief interventions into their work with clients and encourage group discussion of how to resolve any difficulties that they foresee.	

2.4 Stages and Processes of Change   Background Notes

Materials Needed

Equipment: Overhead projector.
            Flip-chart and pen or
            blackboard and chalk.
Visual aids: 9. Stages of change
            10. Processes of change
Handouts: 5. Stages of change
            6. Processes of change
            7. Stages of change group
            exercise – Questions
            8. Stages of change group
            exercise – Answers

1. Introduction to the model – Input

This initial input can be kept simple. The later input on the processes illustrates the complexities within the model.

2. Consolidation – Pairs exercise

The purpose of this is to enable students to check if they understand the model, by trying to apply it to a real situation. Students always find they can do this but sometimes enquire about their experiences of appearing to miss stages or go backwards. Reference to the handout should help clarify this. The detail of students' behaviour change can be confidential within the pairs and the discussion focus on theoretical points or queries.

3. Processes of change – Input

This is based on the handout with reference back to the stages of change as introduced previously.

4. Group exercise

Again, this exercise is to help students to clarify and consolidate their understanding of what has been said by applying it to real life situations. Use the discussion time to check students' understanding of what each process is and how it relates to the stages of change.

70 mins   2.4 Stages and Processes of Change

Aim
To teach the stages of change model and the processes of change which can be engaged when conducting consultations about smoking cessation.

Objectives
By the end of the session students will be able to:
• describe Prochaska and DiClemente's stages of change model,
• list and describe the processes that people use in progressing through the stages of change,
• give examples of each.

Time	Methods	Notes
	1. Introduction to the stages of change model – Input	
10 mins	Describe the stages of change, basing input on handout 5 and using visual aid 9. Distribute handout 5.	
	2. Consolidation – Pairs exercise	
10 mins	Split students into pairs and invite them to describe to each other a behaviour change that they have personally made or tried to make, and to see whether they can apply the stages of change model to it.	
10 mins	Invite and discuss any questions relating to the model.	
	3. Processes of change – Input	
15 mins	Describe and explain the processes of change, basing input on visual aid 10 and handout 6. Distribute handout 6.	
	4. Group exercise	
15 mins	Divide students into groups of 4-6. Distribute handout 7 and invite group to try to reach a consensus in the exercise.	
	Circulate to check understanding and keep groups to task. Distribute handout 8 for group to check answers.	
10 mins	Reconvene in plenary and discuss any issues or difficulties arising from the exercise. Sum up, explaining that the skills taught in the course relate to helping clients to use the processes to move through the stages.	

2.5 Understanding Resistance   Background Notes

Materials Needed
Equipment: Overhead projector. Flip-chart and pen or blackboard and chalk.   **Visual aids**: 9. Stages of change   11. Why smokers sometimes resist changing   **Handouts**: 9. Reluctance to change

1. Introduction

It is important, if we are to facilitate change in others, to understand the processes that are at work in each of the stages of change. This session explores the factors that contribute to unwillingness to change in the precontemplation and contemplation stages. Show the students the stages of change model in the introduction to this session, as a reminder. (If the stages of change model has not been taught previously, introduce it here before moving on to the pairs exercise.)

2. Pairs exercise 1

This exercise is *not* a role play. Students should be themselves, talking about issues that are real for them. They should choose something which they are willing to discuss with a fellow student. The personal detail about these discussions will not be shared with the whole group.

It may be necessary to give very clear instructions about giving *strong advice*. Even if students are not accustomed to this style of interaction with clients or patients, they should carry out this exercise according to your instructions. It can help to explain it to them as an 'experiment' in different ways of working. It is useful to check, as the exercise proceeds, if everyone is doing what was asked and, if not, gently interrupt that pair and remind them.

3. Feedback from pairs

Elicit from each pair any experiences of resistance. Not all will have felt resistance. If any students found the strong advice very helpful and were comfortable receiving it, ask them which stage of change they are in regarding that behaviour. People who are already preparing for action or making changes often find strong advice reinforces the decision they have made. Those feeling most resistant to advice will be those in the earlier stages.

It may be helpful to list, on flip-chart or blackboard, resistance behaviours noticed in the pairs.

60 mins   2.5 Understanding Resistance

Aim

To enable students to see that resistance to advice and reluctance to change is a normal part of the process of considering change.

Objectives

By the end of the session students will be able to:
- describe typical ways clients show their resistance to smoking cessation advice,
- describe reasons why people are sometimes attached to unhealthy behaviours,
- describe ways in which health professionals' different *styles* of intervention can provoke or reduce resistance.

Time	Methods	Notes
5 mins	**1. Introduction by a tutor** Refer to the stages of change (visual aid 9) and explain that this session will relate to understanding precontemplation and contemplation.	
10 mins	**2. Pairs exercise 1** Split the students into pairs. In turn, *A* thinks of a 'bad habit' he or she has and *B* gives strong advice to change. After 3 minutes reverse roles: *A* now give *B* strong advice to change a bad habit for 3 minutes. Pairs discuss for 2 minutes their responses to and feelings about being given strong advice to change.	
10 mins	**3. Feedback from pairs** Elicit how many people found themselves resisting the advice (either verbally or internally). How did this resistance show? • arguing • non-verbal responses • use of humour to divert the conversation • pretending a willingness to change that was not genuine. *Continues overleaf*	

2.5 Understanding Resistance – *continued*   Background Notes

4. Input and discussion

This can be based on the handout. The focus is on helping students to see, from their experiences in the pairs exercise and from their work with clients, that a confrontational or directive style tends to produce resistance in precontemplators or contemplators. This is unhelpful and can result in an argument between the health professional and the client. A more helpful approach employs empathy, and aims to get the health professional and client working alongside each other, jointly confronting the problem behaviour.

5. Pairs exercise 2

Again it is important that students do what is asked, this time avoiding advice-giving and expressing empathy instead.

6. Input and discussion

First, briefly elicit from the pairs their reflections on the process of this second exercise. Was there any difference in the resistance behaviours shown? It is probable that some students will report feeling more 'understood' and consequently more willing to talk about their ambivalence about the behaviour. These observations can be followed up in subsequent sessions on skills development.

Then encourage discussion of the sorts of reasons why people are reluctant to change their smoking.

Summing up of the discussion can be based on the handout.

60 mins	**2.5 Understanding Resistance –** *continued*

Time	Methods	Notes
10 mins	**4. Input and discussion led by a tutor** Resistance is a frequently encountered response to confrontation and coercion. It may be overt or covert. It obstructs the process of enabling people to think clearly about whether they have their own reasons for wanting to change. Discuss and explain empathy.	
10 mins	**5. Pairs exercise 2** In the same pairs student take it in turns to discuss, once again, their 'bad habits'. This time *A*, instead of giving advice, asks *B* about, and listens empathically to: • any benefits or enjoyment the person gets from the bad habit, • any reasons why they feel it would be difficult *or* undesirable to change. After three minutes reverse roles, as before. Allow two minutes discussion in pairs about their responses to this approach.	
15 mins	**6. Input and discussion** Encourage students to develop an appreciation of the reasons why people are sometimes attached to unhealthy behaviours such as smoking (using visual aid 11). This may be because: • it does not seem important to them to change, • they do not feel confident in their ability to change. Distribute handout 9.	

2.6 Enlisting Support   Background Notes

Materials Needed

Equipment: Flip-chart paper and pens,
                 blackboard and chalk.
Handouts: 10. Enlisting support

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1. Introduction

In the introduction it is helpful to refer back to the session on stages and processes of change.

2. Group work

It can be helpful to give each group a card with their question and instructions written on, for use as a prompt in case the discussion wanders off course.

3. Feedback

This will be a dialogue between the groups. Each group does not have to read out their points in the order they wrote them down but can choose the order that complements the issues raised by the other. As time here is limited it is best to try to keep this as a series of brief, concise points rather than a flowing discussion .

4. Plenary discussion

The handout provides possible content for this, but ideally elicit guidance for helpers from the students rather than providing input. If the group produce a particularly good list of dos and don'ts it may be worth getting it typed and copied for students' reference.

This is an opportunity to inform students about sources of specialist or intensive treatment or groups. It may be helpful to add a handout describing local resources and how to access them.

In summarising, it can be useful to remind students of the importance of developing networks and healthy alliances to provide the most supportive environment possible for people seeking to change their lifestyle.

45 mins	2.6 Enlisting Support

Aim

To enable students to consider the range of helping relationships that may be available to people making lifestyle changes.

Objectives

By the end of the session students will be able to:
- describe actions families and friends can take to support the change process,
- describe key community agencies who can provide support.

Time	Methods	Notes
3 mins	**1. Introduction**	
12 mins	**2. Group work** Split students into two groups. One group considers: • *'How do families, close friends and colleagues help people quit?'* The other group considers: • *'How do families, close friends and colleagues hinder people's efforts to quit?'* Each group should consider their question, make a note of key points and appoint a spokesperson.	
10 mins	**3. Feedback** Take one point from each group alternately, i.e. one way change is helped, followed by one way change is hindered, until each group comes to the end of its ideas.	
20 mins	**4. Plenary discussion** Using the points made by the groups, discuss and record on flip-chart or blackboard a list of 'do's and don'ts' for 'helpers' of those going through the stages of change. Remind group of any community sources of support for smokers, and give referral information as appropriate. Distribute handout 10. Summarise session.	

2.7 Helping Smokers Stop   Background Notes

Materials Needed
Equipment: Flip-chart and pen or blackboard and chalk.
Handouts: 11. Smoking – habit or addiction? 12. Questions clients ask about smoking cessation. 13. Answers to clients' questions about smoking cessation. 14. Specialist treatments available to help smokers stop.

1. Input on addiction

It is important that students realise that the symptoms of withdrawal from nicotine can be real and distressing and coping with them is an important part of an action plan to stop. Helping smokers stop needs to include both interventions to help break the habit and interventions to help manage withdrawal symptoms.

2. Quiz in small groups

If any group is very slow in completing the task it may be that they cannot agree on one question. If so it may help to invite them to skip that question and move on.

3. Plenary

This is an opportunity to provide technical information on the topic. Use the quiz as a basis, but there is no need to restrict discussion to these questions if others are asked too.

4. Brainstorm

This is mainly a device to get students actively participating in between two pieces of tutor input. If it is omitted, their attention may waver due to being lectured for too long at once!

5. Input on treatments

While being based on the handout, this can include any details of local interest and be adapted to take account of local availability. Tutors may also wish to refer to visual aid 7 and the references cited below. Details of research findings relevant to the students' own work area may be provided. The handout provides references to key research papers and reports.

If there is time, it may be worth including some discussion around placebo effects. If a smoker is interested in and believes in treatment for which there is scant evidence of effectiveness, should the health professional support or even encourage its use? What is the health professional's duty here?

Tutors need to be familiar with the evidence for effective intervention outlined in the further reading and in particular the WHO European recommendations. These are referenced below and appear in the 'Resources' section at the end of this pack.

Further reading

FIORE MC, BAILEY WC, COHEN SJ et al (2000) *Treating Tobacco Use and Dependence. Clinical Practice Guideline.* (Rockville: US DHHS)

RAW M MCNEILL, A & WEST, R (1998) Smoking cessation guidelines for health professionals. A guide to effective smoking intervention for the health care system. *Thorax,* 53, suppl. 5, part 1.

ROYAL COLLEGE OF PHYSICIANS (2000) *Nicotine addiction in Britain. A report of the Tobacco Advisory Group of the Royal College of Physicians* (London: Royal College of Physicians)

WEST R MCNEILL A & RAW M (2000) Smoking cessation guidelines for health professionals: an update. *Thorax,* 55, 987-999.

WORLD HEALTH ORGANIZATION EUROPEAN PARTNERSHIP PROJECT (2000) *First European recommendations on the treatment of tobacco dependence.* (Copenhagen: WHO.)

60 mins   **2.7 Helping Smokers Stop**

Aim
To teach students about the sort of help smokers need in order to stop, and to ensure they have the information they need to help.

Objectives
By the end of the session students will be able to:
* describe the reasons why smokers experience withdrawal symptoms,
* describe specialist treatments available and their value in helping smokers stop,
* answer accurately some frequently asked questions about smoking cessation.

Time	Methods	Notes
10 mins	**1. Input on addiction** Introduce the session and explain the difference between habit and addiction, based on handout 11. Distribute handout 11.	
15 mins	**2. Quiz in small groups** Split students into small groups (threes or fours at most). Distribute handout 12 and ask them to consider how they would respond to a smoker asking these questions.	
15 mins	**3. Plenary** Taking one question at a time, elicit the answers from each small group. Correct any misunderstandings and fill in any gaps in knowledge. Take this opportunity to add any technical information about smoking cessation, NRT or bupropion that students ask for. Distribute handout 13.	
5 mins	**4. Brainstorm:** *'Specialist treatments to help smokers quit.'* Elicit from students the treatments about which they have heard.	
15 mins	**5. Input on treatments** Drawing on students' knowledge where appropriate, give information on specialist treatments and their effectiveness, based on handout 14. Distribute handout 14.	

3.1 Information Exchange   Background Notes

Materials Needed
Equipment: Overhead projector. **Visual aids**: 12. Information exchange **Handouts**:   15. Information exchange

1. Input

This session should follow either the session on brief interventions or other sessions on skills. Examples can thus be drawn from previous discussions to illustrate the type of information that needs to be exchanged and the health professional's purposes in doing so.

2. Demonstration

A demonstration is the best way to explain the principles of this approach. If at all possible it works well to have prepared a demonstration on video-tape and to show this. This leaves the tutor free to assess the students' reactions while watching it and takes away the stress of wondering whether a live demonstration will 'work.'

3. Plenary

Encourage the group to reflect on the approach demonstrated. In effect, demonstrate the skills of information exchange while conducting this group discussion!

Further reading

ROLLNICK, S, MASON, P AND BUTLER, C, (1999) *Health behavior change,* (Edinburgh: Churchill Livingstone)

30 mins   3.1 Information Exchange

Aim
To teach the skills of information exchange and promote a client-centred approach to brief interventions.

Objective
By the end of the session students will be able to:
• conduct a two-way exchange of information in the context of a brief intervention to promote smoking cessation.

Time	Methods	Notes
10 mins	**1. Input** Input by a tutor, using visual aid 12, on the skills of information exchange. Distribute handout 15.	
10 mins	**2. Demonstration** A tutor demonstrates, either with another tutor or a student role playing the smoker, how to use the elicit-provide-elicit sequence when giving brief advice to a smoker.	
10 mins	**3. Plenary** Elicit from students the skills demonstrated and the way that the smoker was treated as an equal partner in the interaction. Encourage discussion on the benefits of a client-centred approach.	

3.2 Developing a Helping Relationship   Background Notes

Materials Needed
Equipment: Flip-chart and pen or blackboard and chalk.
Handouts: 16. Helping relationships and smokers
17. Building a helping relationship

1. Introduction

It is useful here to refer back to the processes of change. The helping relationship has been shown to be a key factor in people moving from *precontemplation* to *contemplation* and in *maintaining* a change. The helping relationship is a well established concept and this session will cover material that is familiar to most students but will be revised here as it is crucial to learning more specialised interventions. Depending on the skill base of students this session can be extended or reduced. Do not be too hasty in deciding to omit this session. Even experienced practitioners are sometimes poor at active listening.

2. Brainstorm

'What would you look for in a helper?'
These are examples of responses from students:
• The helper cares
• The helper is empathic
• The helper understands
• The helper shows s/he understands
• The helper listens and is interested in me

3. Group work

The purpose of this exercise is to raise students' awareness of their own attitudes and prejudices, which may need to be put on one side if they are to develop effective helping relationships with smokers. The work done in groups can be confidential to the group and students can be told this. The learning from this exercise is very personal and public feedback of personal views is not necessary, although students may wish to discuss general issues for a few minutes.

4. Pairs exercise

Active listening uses a specific set of skills which enables the health professional to build a good helping relationship.

In the listening exercise, people generally find it difficult to keep to the task – a tutor may need to circulate to remind people what they should be doing. The 'not listening' is particularly uncomfortable for both parties. The exercise should be timed precisely and the students told this. One of the interesting things that often emerges from feedback on this exercise is that when a person is not being listened to, the three minutes feels like six, or even more.

5. Plenary

In summing up, stress again the importance of listening and building a good 'helping relationship'. If time permits, do an input on the obstacles to listening as described in the handout.

70 mins	3.2 Developing a Helping Relationship

Aim
To explore the elements of a helping relationship and revise active listening skills.

Objectives
By the end of the session students will be able to:
- discuss ways to handle situations in which their own attitudes to smokers may be a barrier to forming a helping relationship,
- describe why it is important to use active listening skills,
- describe the behaviours which are helpful in actively listening to clients,
- describe the behaviours which are unhelpful in actively listening to clients.

Time	Methods	Notes
3 mins	**1. Introduction** Introduction by a tutor.	
7 mins	**2. Brainstorm** *'What would you look for in a helper?'*	
25 mins	**3. Group work** Split students into groups of four. Distribute handout 16 and invite groups to discuss it *(20 minutes)*. Reconvene for 5 minutes to discuss any points arising.	

25 mins	**4. Pairs exercise**
	Introduce listening as a key component of building a helping relationship and split the students into pairs. In pairs, students take it in turns to practise different degrees of listening:
	    A -talks about something in which s/he is interested
	    B -does not listen (3 minutes)
	           -half listens (3 minutes)
	           -fully listens (3 minutes).
	    Then *A* and *B* change roles and repeat exercise.	

10 mins	**5. Plenary** - *How did it feel not to be heard or to be half-heard?* - *What were the features of bad or half-listening?* - *What were the features of good listening?* List on flip-chart or blackboard. Discuss the importance of using listening skills when developing a 'helping relationship' with a smoker. Distribution of handout 17. Sum up.	

3.3 Skills for Enabling Change   Background Notes

Materials Needed

Handouts: 18. Skills for enabling change
            19. Skills for enabling change –
            Case studies

1. Introduction

This session should be preceded by the session on 'Understanding resistance'. It addresses some of the skills used in 'motivational interviewing' (*Miller & Rollnick 1991*). This approach uses client-centred reflective listening skills within a structure that fosters the client's motivation to change. In order to use the approaches taught in this session students will need to be able to listen reflectively. If they do not already have these skills as part of their professional repertoire, or if they need refreshing, precede this session with 'Developing a helping relationship.'

2. Input

This can be based on the handout using examples appropriate to the student group and their areas of interest.

3. Role play

If necessary adapt the client scenarios to suit the group, ensuring that each brief includes some motivation for change and some reasons for wanting to continue with the risky lifestyle. Each client scenario is written so it can be a man or a woman, and the health professional can be anyone in a relevant role.

Keep an eye on the time keeping. Although the observer is briefed to keep time, groups may get so involved in discussion that they do not move on to the next scenario. Try and ensure everyone gets a turn to practise.

4. Plenary

At the end of the exercise ensure everyone has stepped out of the roles they were playing, before you answer any questions and sum up.

Further reading

Tutors unfamiliar with the motivational interviewing approach will find it helpful to read:

MILLER, W R AND ROLLNICK, S (1991) *Motivational interviewing*, (New York: Guilford Press)

ROLLNICK, S, MASON, P, & BUTLER, C (1999) *Health behavior change,* (Edinburgh: Churchill Livingstone)

60 mins	3.3 Skills for Enabling Change

Aim
To teach some specific strategies that are helpful in consultations about smoking cessation.

Objectives
By the end of the session students will be able to:
- respond to a client's resistance in a way that does not provoke further argument,
- elicit from a client self-motivational statements.

Time	Methods	Notes
3 mins	**1. Introduction** Explain the objectives of this session.	
15 mins	**2. Input** Remind students of the pairs exercise in the session on 'Understanding resistance', which compared a directive advice-giving approach to an empathic approach. Reluctant clients become resistant with a too directive approach. Explain how to elicit self-motivational statements and roll with resistance based on handout 18. Distribute handout 18.	
35 mins	**3. Role play** Split students into trios and distribute handout 19. Use the case studies in handout 19 for skills rehearsal following the instructions. Circulate to check understanding and to help trios keep to task.	
7 mins	**4. Plenary** Ensure role players have de-roled. Discuss any difficulties encountered in the role play. Sum up.	

3.4 The Decisional Balance   Background Notes

Materials Needed

Equipment: Overhead projector.
Flip-chart and pens or
blackboard and chalk.
Visual aids: 9. Stages of change
10. Processes of change
13. The decisional balance
14. Useful lines of enquiry
Handouts: 20. The decisional balance and
self re-evaluation
21. The decisional balance –
Pairs exercise

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1. Introduction

In introducing the session, links can be made to the stages of change and to the skills for enabling change. This session provides a framework to integrate the theory and skills already taught. Ideally it should be preceded by the sessions on 'Understanding resistance', 'Developing a helping relationship' and 'Skills for enabling change.'

2. Input

Students usually find the decisional balance concept easy to grasp. Prepare an example in advance taking account of local smoking patterns. It is important to make very clear the point that the decisional balance is subjective. Its value is that it reflects the prejudices, attitudes and values of the client. It is not possible to complete a meaningful balance sheet on behalf of someone else, so active listening and a client-centred approach are crucial.

3. Pairs exercise

It is important to encourage students NOT to role play but to be themselves, using their own

issues for this. They should choose a lifestyle change that they are considering and that they are willing to discuss with a partner in the group. Confidentiality will stay in the pair. Students should be advised NOT to pick an issue that will generate too many strong emotions as there will only be 10-15 minutes to discuss it.

4. Plenary

Elicit feedback from pairs on the *process* not the content of the exercise and clarify any points that arise.

Encourage creative discussion around ways to use this framework in students' own work situation.

Further reading

More background information on the decisional balance can be gained by reading:

PROCHASKA, JO, NORCROSS, JC, DICLEMENTE, CC (1994) *Changing for good. The revolutionary program that explains the six stages of change and teaches you how to free yourself from bad habits,* (New York: William Morrow and Company)

ROLLNICK, S, HEATHER, N AND BELL, A (1992) Negotiating behaviour change in medical settings; the development of brief motivational interviewing, *Journal of Mental Health*, 1, 25-37

ROLLNICK, S, MASON, P AND BUTLER, C, (1999) *Health behavior change,* (Edinburgh: Churchill Livingstone)

60 mins	3.4 The Decisional Balance

Aim

To provide a tool for working with clients who are still considering whether or not to change.

Objectives

By the end of the session students will be able to:

• use the decisional balance framework to understand a client's motivation,

• help clients to use the decisional balance to assess the importance of change for them.

Time	Methods	Notes
3 mins	**1. Introduction** Explain the purpose of the session, relating it to the contemplation and preparation stages of change (visual aid 9) and the process of creating a new image (visual aid 10).	
12 mins	**2. Input** Explain the decisional balance, basing input on the handout and using visual aids 13 and 14. Show an example on flip-chart, OHP or blackboard. Remind students about rolling with resistance and eliciting self-motivational statements. Distribute handout 20.	
30 mins	**3. Pairs exercise** Divide students into pairs, ideally each with someone they do not know particularly well. Distribute handout 21. Check that students understand the instructions. Remind them of the time after 15 minutes, and encourage them to swap roles in they have not already done so at this point.	
15 mins	**4. Plenary** Elicit feedback from pairs. Conduct a discussion on the opportunities for using the decisional balance framework in students' own situations.	

3.5 Developing Confidence   Background Notes

Materials Needed

Equipment: Overhead projector.
      Flip-chart and pen or
      blackboard and chalk
Visual aids: 10. Processes of change
      15. Factors affecting confidence
      16. Developing confidence in
      ability to stop smoking
Handouts: 22. Developing confidence
      23. Developing confidence –
      Role play

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1. Introduction

This session complements the 'Decisional balance' session. The first paragraph on Handout 22 covers what needs to be said in introducing it.

2. Brainstorm

The ideas generated should approximately fit with the categories in visual aid 15. If they do not then prompt participants to think about any areas that they may not have considered. As usual with brainstorms, the intention is to generate as many ideas as possible without discussion or comment at this stage.

3. Input

The first part of this is intended to give students a framework for thinking about confidence and for assessing when practical strategies can be used to help. As far as possible show how the responses to the brainstorm fit the framework. The handout provides more detail than the visual aid.

The next visual aid and the handout provide content for a brief input on the principles of developing confidence which can be extended to discussion by eliciting examples from the group.

4. Role play

Brief descriptions of the roles are given. Students can invent any additional information about the role as required.

5. Plenary

Students have had a chance to listen to the theory and apply it to practice. The last 5 minutes of the session are just to pick up any queries and summarise.

45 mins	3.5 Developing Confidence

Aim
To enable students to understand the factors that undermine clients' confidence in their ability to change and those that can help develop confidence.

Objectives
By the end of the session students will be able to:
*   describe the factors that undermine confidence,
*   describe the processes that are useful in developing confidence.

Time	Methods	Notes
3 mins	**1. Introduction** Explain the purpose of this session, as in the opening paragraph of handout 22, referring to the processes of change (visual aid 10) and the decisional balance.	
7 mins	**2. Brainstorm** *'What stops people feeling confident about change?'* Elicit and record, but do not discuss responses yet.	
15 mins	**3. Input** Show visual aid 15, and use examples from the brainstorm to illustrate the points. Using visual aid 16, describe the principles of developing confidence and elicit examples from the group. Distribute handout 22.	
15 mins	**4. Role play** Pair students up and give them handout 23 (instructions). Circulate to check understanding of the task. After 10 minutes stop the role play, ask them to de-role, and discuss the experience in their pairs.	
5 mins	**5. Plenary** Discuss and clarify any points arising. Summarise the session.	

3.6 Relapse Prevention and Recycling   Background Notes

Materials Needed

Equipment: Overhead projector.
Flipchart and pen or blackboard and chalk
Visual aids: 9. Stages of change
17. What precipitates relapse?
18. Helping people to recycle
Handouts: 24. Relapse prevention and recycling
25. Recycling – Practice exercise

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1. Input – Relapse prevention

Most elements of relapse prevention have already been considered in the course, so the focus of this input is to draw these threads together and see how the key processes can be used in the maintenance stage to prevent relapse.

2. Pairs exercise

This is not a role play. Students are to be themselves and to recall real situations. If any student has never experienced relapse (or is not willing to admit to this!) invite him or her to think of a real situation when s/he was helping someone change, and they relapsed, and to talk about his or her feelings *as a helper*. This can be drawn out in discussion later as an extra dimension.

3. Feedback

Typical thoughts and feelings about relapse are:
• Guilt: *"I've let everyone down"*
• Sadness: *"I've failed again"*
• Anger: *"If only x hadn't happened I would have been alright"*
• Despair: *"I'll never manage it"*

The strength of these feelings may relate to the importance of the behaviour change and the amount of effort that went into making it. Such feelings may also increase or decrease with subsequent relapses.

4. Input – Helping people to recycle

Relapse can be a positive learning experience and a health professional can help a client work through the negative feelings and move on to practical problem solving.

5. Practice in pairs

There is not time to do the exercise both ways so only one student will be able to be the client and one the health professional. If more time is available they can be invited to exchange roles and use another case study.

Only brief information is given about each client – students can invent any extra information needed as the role play progresses.

6. Discussion in plenary

Encourage students to acknowledge any thoughts that:
• the client has let them down
• they have let the client down
and the feelings of anger, resentment, guilt or sadness that may accompany these. Acceptance of clients' personal responsibility to make changes in their own lives (or not to) and a genuine appreciation of the difficulties entailed can be helpful.

Re-emphasise that relapse is normal. Preparing for the possibility of relapse is an important part of a health promotion intervention.

| **60 mins** | **3.6 Relapse Prevention and Recycling** |

Aim

To teach students that relapse is normal and that practical coping strategies can be used to prevent and to manage it.

Objectives

By the end of the session students will be able to:
- list typical situations that precipitate relapse,
- help a client learn from a relapse and recycle,
- describe ways to manage their own feelings when a client relapses.

Time	Methods	Notes
10 mins	**1. Input – Relapse prevention** Input based on first part of handout 24, and using visual aids 9 and 17, relating back to the stages of change.	
10 mins	**2. Pairs exercise** Invite students to think of a situation in their own lives when they tried to change a behaviour and relapsed. How did they feel? Pair students up to discuss it (5 minutes each way, one student listens and reflects while their partner describes their experience.)	
5 mins	**3. Feedback** Elicit from pairs typical thoughts and feelings. List on board.	
10 mins	**4. Input – Helping people to recycle** Input based on second part of handout 24, using visual aid 18. Distribute handout 24.	
20 mins	**5. Practice in pairs** Split group into pairs. Distribute handout 25 and invite students to choose any one of the case studies to practise. Keep pairs to time. Reconvene for a few minutes, ensure everyone de-roles and check any queries.	
5 mins	**6. Discussion in plenary** After brief discussion on the exercise, encourage students to consider how they feel when clients relapse and how they can handle these feelings. Clarify any difficulties. Summarise session.	

3.7 Smoking Cessation Groups   Background Notes

Materials Needed
Equipment: Overhead projector. Flipchart and pen or blackboard and chalk **Visual aids**: 9. Stages of change 10. Processes of change 19. Running a group **Handouts**: 26. Why run groups? 27. Checklist for setting up a group 28. Running a stop smoking group 29. Group members – Case studies

1. Why run groups? – Brainstorm and input

As usual with a brainstorm, elicit ideas and record them without discussion. This will raise the energy level of the group and engage their interest. This is particularly important as the first part of this session is largely didactic.

The input on the rationale for running groups can be based on the handout. Most points may already have been mentioned in which case this can be very brief and run immediately into the next section.

2. Discussion and input

This should be as interactive as possible. Even students with no experience of running groups should be able to imagine what the key considerations might be.

3. Input

The programme described in the handout is one that has been used successfully in the UK for many years. If you have other programmes that have run successfully in your locality these could be described here too. It is ideal if the tutor presenting this session has some experience of their own in running groups.

4. Groupwork and plenary

Some groups will consider all the case studies given in the 15 minutes allowed for the task. Others will involve themselves in long discussions or controversies about one or two only. By instructing each group to begin by discussing a different case you ensure that in the plenary at least one group has looked at each case.

There are no absolute right answers to how to handle these situations. In plenary, encourage discussion of the underlying principles of enabling change, referring back to previous sessions as appropriate.

5. Summary

It is important that students make the links between the psychology of change and the ways groups work, and recognise that a person-centred approach is applicable to groups as well as to individual consultations.

| 70 mins | 3.7 Smoking Cessation Groups |

Aim
To give smoking cessation specialists a framework for planning and running groups.

Objectives
By the end of the session students will be able to:
• describe the rationale for running groups,
• list key issues to consider when setting up a group,
• write a programme for a group,
• discuss how to handle difficult situations that may arise with group members.

Time	Methods	Notes
5 mins	**1. Why run groups? – Brainstorm and input** Ask for and list ideas on why a smoking cessation clinic might choose to run groups to help those trying to stop rather than, or in addition to, seeing people in individual consultations.	
5 mins	Summarise key points arising from the brainstorm and add any points not yet mentioned on the rationale for running groups, using handout 26. Distribute handout 26.	
10 mins	**2. Discussion and input** Elicit from the group ideas on the issues to consider when setting up a group. Distribute handout 27.	
15 mins	**3. Input** Using visual aid 19, present the programme for a group described in handout 28. Distribute handout 28.	
15 mins	**4. Groupwork and plenary** Divide students into groups of 4-5. Distribute handout 29. Instruct each group to begin with discussing a different case study and to move on to one of the others when they have come to a consensus.	
15 mins	In plenary, taking one case study at a time, elicit suggestions on how to handle each situation.	
5 mins	**5. Summary** Summarise the session and refer back to the stages and processes of change using visual aids 9 and 10, reminding students that the aim of any intervention is to engage these processes and facilitate smokers' movement through the stages.	

Contents

Visual Aids

Visual Aids

Health Promotion

Five Key Action Areas

- Building healthy public policy

- Creating supportive environments

- Strengthening community action

- Assisting the development of personal skills

- Re-orienting existing health services

WORLD HEALTH ORGANIZATION, HEALTH AND WELFARE, CANADA AND CANADIAN PUBLIC HEALTH ASSOCIATION (1986) *Health Promotion. Proceedings of the First International Conference on Health Promotion.* (Ottawa: WHO, HWC & CPHA)

Charter for a Tobacco-Free Life

This charter includes:

- "Every smoker has the right to receive encouragement and help to overcome the habit"

- "Each citizen has the right to be informed of the unparalleled health risks of tobacco use"

First European Conference on Tobacco Policy, Madrid 1988

Examples of Smoking and Disease

- Up to 90% of lung cancer deaths and 75% of deaths from chronic obstructive pulmonary diseases are smoking related

- Cigarette smokers are twice as likely to die of coronary heart disease than non-smokers

- Women taking higher dose contraceptive pills are 2-3 times more likely to die of heart attack or stroke if they smoke

- Smoking is related to cancers of the: lung, kidney, buccal cavity, oesophagus, larynx, bladder, pancreas and cervix

- One in two smokers will die earlier than they otherwise would have, as a result of smoking

- Smokers have a poorer quality of life in their older age

Visual Aid 3

Is it Worth Stopping?

- Health risks decline immediately

- After 15-20 years the risks of lung disease are almost as low as for non-smokers

- After 15-20 years the risk of coronary heart disease is no greater than if the smoker had never smoked

- Stopping improves the symptoms of bronchitis, asthma, emphysema and coronary heart disease

- Stopping before middle age reduces the health risks to the level of a non-smoker

Passive Smoking

Being exposed to others' smoke increases non-smokers' risk of:

- lung cancer

- heart disease

- childhood respiratory disease

- chronic middle ear effusions in children

- asthma

- eye, nose and throat irritation

- cot death

Smoking in Pregnancy

Babies of women who smoke in pregnancy:

- Are more likely to be of low birthweight

- Are generally slower to develop

- Have a higher risk of disease in infancy

Intervention Works

- Intervention from health professionals has been shown repeatedly, in randomized controlled trials, to increase the percentage of smokers who stop and remain abstinent for 6 months or more.
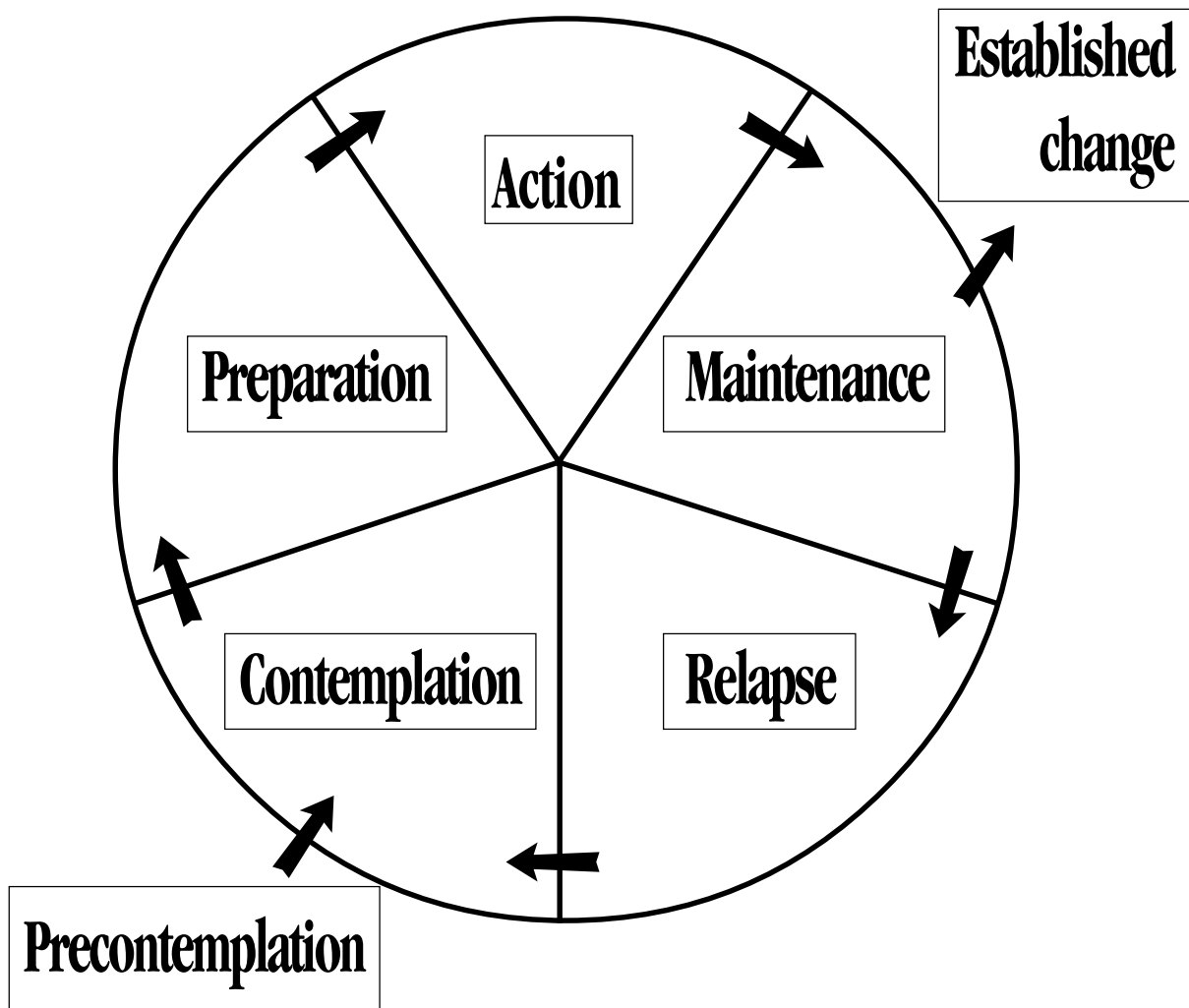
  This is highly cost-effective.

- Smoking cessation costs around US$1,500 per life year saved, compared with around US$26,000 for medical interventions.

Brief Interventions

- ASK

- ADVISE

- ASSESS

- ASSIST

- ARRANGE

Stages of Change

Action

Established change

Preparation

Maintenance

Contemplation

Relapse

Precontemplation

Based on Prochaska & DiClemente's model

Processes of Change

In moving around the stages of change, people use 9 main processes to help them:

- Becoming informed

- Increasing alternatives

- Emotional awareness

- Creating a new image

- Making a commitment

- Rewarding self

- Using substitutes

- Taking control over the environment

- Using support

Why Smokers Sometimes Resist Changing

- They feel they get some benefits from smoking, so for them it is

  IMPORTANT TO CONTINUE.

- They are not really convinced that smoking is bad for them personally, so it is

  NOT IMPORTANT TO CHANGE.

- It seems almost impossible to stop smoking, so they have

  INSUFFICIENT CONFIDENCE IN THEIR ABILITY TO CHANGE.

Information Exchange

Elicit

⬇

Provide

⬇

Elicit

The Decisional Balance

	Advantages	Disadvantages
Current behaviour		
Change		

Consider:

- Consequences to self
- Consequences to others
- How I feel about myself
- How others feel about me

Useful Lines of Enquiry

- What are the good things for you about smoking?

- Are there any things about smoking that are not so good for you?

- If you were to consider changing, what things might be difficult for you?

- Do you see any advantages that there would be for you in changing?

- So, from what you say, it looks like this… (*summarise*).

  Is there anything else to take into account?

- Where does that leave you?

Factors Affecting Confidence

- Generally low level of self-confidence arising from other life experiences

- Previous unsuccessful experiences of trying to stop

- Perceived disadvantages of change

- Lack of a concrete plan

Developing Confidence in Ability to Stop Smoking

- Countering

- Environmental control

- Rewards

- Learning from previous efforts to change

- Having a specific plan

What Precipitates Relapse?

- Emotional distress

- Feeling good and wanting to feel even better

- Temptation or urges

- Social pressure

Helping People to Recycle

- Acknowledge the feelings

- Check: slip or relapse?

- Identify high risk situations

- Identify better coping strategies such as countering or environment control

- Check need to develop stronger helping relationships

- Check readiness to change

Running a Group

Introductory Session

- To help smokers consider a NEW IMAGE, and enable them to decide whether to join the group and make a COMMITMENT to trying to stop.

Subsequent Sessions

- To SUPPORT them in:

    - Their commitment

    - Using substitutes

    - Rewarding themselves

    - Controlling their environment.

Visual Aids

Contents

Handouts

Handouts

Key Action Areas for Health Promotion

Health promotion is the activity of enabling people to increase control over and improve their health. There are several avenues of health promotion, all of which are important.

In 1986 the First International Conference on Health Promotion took place in Ottawa, Canada. It issued a charter for action to achieve Health for All by the year 2000 which was signed by the World Health Organization member states. The 'Ottawa charter', as it has become known, identified key action areas for health promotion:
• building healthy public policy,
• creating supportive environments,
• strengthening community action,
• assisting the development of personal skills,
• re-orienting existing health services.

A healthy public policy underpins and facilitates the other areas. Examples of such policies might be high taxation on substances that harm health such as alcohol and tobacco, investment in cycle paths and walkways, or provision of subsidised milk and meals to schoolchildren.

Supportive environments may be created on a national, local or even family basis. It is easier for people to maintain a healthy lifestyle if their surroundings encourage such action. Prohibition of smoking in public places (restaurants, trains, colleges) or workplaces is an example. Restrictions on advertisements for alcohol or tobacco, media coverage of healthy lifestyle issues and sports facilities open for use before or after work are further examples.

Strengthening community action may involve advocacy or mediation to support those setting up healthy initiatives or seeking to prevent unhealthy developments. Health promoters may wish to support, for example, food co-operatives to increase access to healthy food, availability of school sports facilities to adults outside of school hours, or they may wish to oppose plans to build on land currently rented out for private gardening (allotments).

The development of personal skills includes ensuring people have sound and appropriate knowledge, skills in decision making and the skills required to take action in a particular health area. Examples of skills development include teaching assertive skills to those who find it difficult to maintain their personal decisions in the face of pressure from others, giving nutrition information to enable healthy food choices, or teaching drinkers how to monitor the amount of alcohol they are consuming.

Re-orienting existing health services is made easier or harder by the way a country's health facilities are funded, so it needs to be a national policy priority. If both resources and attitudes towards health care can be shifted in the direction of primary care and prevention then services will become health services rather than sickness services. Such a shift involves individual health professionals in adjusting their own attitudes and learning new skills to make such services effective.

All these action areas are important. Individual health professionals may have a key role in one or more and rely on their colleagues in other sectors to complete the entire pattern of health promotion initiatives to ensure 'health for all'.

Reference

WORLD HEALTH ORGANISATION, HEALTH AND WELFARE, CANADA AND CANADIAN PUBLIC HEALTH ASSOCIATION (1986) *Health Promotion. Proceedings of the First International Conference on Health Promotion.* (Ottawa: WHO, HWC & CPHA)

Handouts

Tobacco and Health Quiz

1. What proportion of deaths in the World Health Organization's European region is caused by tobacco?

   - 5%
   - 9%
   - 14%

2 In the European region as a whole how many people aged between 35 and 69 years die each year as a result of smoking?

   - 200,000
   - 450,000
   - 750,000

   Is this figure:

   - increasing?
   - decreasing?
   - stabilising?

3. What proportion of lung cancer deaths are smoking related?

   - About half
   - At least three quarters
   - All

4. Once lung cancer has been diagnosed someone has:

   - a very poor chance of living another 5 years
   - a good chance of survival with prompt, appropriate treatment
   - a 50/50 chance of recovery

5. What proportion of lifelong smokers, who started in their teens, will die as a direct result of their smoking?

6. A smoker who has smoked for more than 25 years has probably incurred so much damage that there is little point in stopping.

   Is this true or false?

7. Smokers are only harming themselves.

   Is this true or false?

8. Women smokers who stop before pregnancy have babies of the same birthweight as women who have never smoked.

   Is this true or false?

9. Professor Sir Richard Peto has estimated that in the 20th century about 100 million smokers worldwide died as a result of their smoking. If current trends continue, how many will die in the 21st century?

10. Smokers do not take any notice of health professionals telling them to stop.

   Is this true or false?

Handouts

Tobacco and Health Quiz – Answers

1. *What proportion of deaths in the World Health Organization's European region is caused by tobacco?*

   14%. Unless more effective measures are taken to help the current 200 million European adult smokers to stop or at least reduce their tobacco consumption, tobacco products will be responsible for 20% of all deaths by 2020.

2. *In the European region as a whole how many people aged between 35 and 69 years die each year as a result of smoking? Is this figure increasing, decreasing or stabilising?*

   About three quarters of a million die each year in this age group. In 1990 the figure was 740,456. After a steady increase over the last 30 years the increase appears to be slowing. However the picture is complex. Deaths for women continue to rise overall. In many countries women have taken up smoking more recently than men and so the full health consequences of their smoking have not yet become evident. There are considerable differences between countries. In the European Union member states deaths in men are decreasing whereas in the former socialist economies they continue to rise.

   Source: PETO, R, ET AL (1994) *Mortality From Smoking in Developed Countries, 1950 – 2000.* (Oxford: Oxford University Press)

3. *What proportion of lung cancer deaths are smoking-related?*

   At least three quarters. This is due to the tar in cigarettes being carcinogenic and the fact that very few other things cause lung cancer. The risk of dying from lung cancer rises both with increasing consumption and with duration of the smoking habit.

   Source: HEALTH EDUCATION AUTHORITY (1996) *Health Update – Smoking,* (London: HEA)

4. *Once lung cancer has been diagnosed what are the chances of survival or recovery?*

   Unfortunately the prognosis for lung cancer once diagnosed is very poor. Less than 20% may live for 5 years. The five year survival rate in Britain is about 8% and the average survival time is less than one year. Thus prevention is crucial.

   Source: OFFICE OF POPULATION CENSUSES AND SURVEYS (1990) *Longitudinal Study: socio-demographic differences in cancer survival. 1971 – 83* (London: HMSO)

5. *What proportion of lifelong smokers, who started in their teens, will die as a direct result of their smoking?*

   Peto's estimate from the British doctors long-term follow up is that one in two smokers will die from their smoking, meaning, earlier than they would have died if they had not smoked.

6. *A smoker who has smoked for more than 25 years has probably incurred so much damage that there is little point in stopping: True or false?*

   False. For anyone stopping, at any age, the health risks begin to decline immediately. After 15-20 years the risks of lung disease are almost as low as for non-smokers and the risk of coronary heart disease is no greater than if the smoker had never smoked. Even those already suffering from bronchitis, emphysema or coronary heart disease can improve their health by stopping smoking.

It is true that beginning to smoke early in life is particularly risky. Those who started smoking by the age of 15 are three times more likely to get lung cancer than those who started in or after their mid 20s *(Zaridze & Peto, 1986)*. Stopping smoking before the age of 35 years can reduce the risk of dying from a smoking-related disease to the same level as someone who has never smoked. *(Doll et al, 1994).*

A smoker can considerably increase his or her chances of a healthy old age by giving up now, despite a long history as a smoker.

Sources: DOLL, R ET AL (1994) Mortality in relation to smoking: 40 years observations on male British doctors, *British Medical Journal*, 309, pp 901-911

ZARIDZE, D AND PETO, R (eds) (1986) *Tobacco: a major health hazard* (Lyons: IARC scientific publication 74)

7. *Smokers are only harming themselves: True or false?*

False. Being exposed to other people's cigarette smoking increases non-smokers' risk of:
- Lung cancer.
- Heart disease.
- Acute respiratory disease in early childhood.
- Chronic cough and wheeze in children.
- Chronic middle ear effusions in children.
- Reduced levels and growth of lung function in children.
- Suffering from asthma and having increased symptoms.
- Irritation of eye, nose and throat.

Non-smokers exposed for a lifetime to tobacco smoke (e.g. by living with a smoker) have a 10-30% higher risk of lung cancer and asthmatic adults may experience a significant and substantial decline in lung function when exposed to sidestream smoke for an hour.

Source: HEALTH EDUCATION AUTHORITY (1996) *Health Update – Smoking,* (London: HEA)

8. *Women smokers who stop before pregnancy have babies of the same birthweight as women who have never smoked: True or false?*

True. Those who stop before conception have babies of the same birth weight as women who have never smoked. Babies of smoking mothers are, on average, 200g lighter than those whose mothers did not smoke during pregnancy. These babies have a higher risk of death and disease in their infancy and early childhood. This is because they are lighter because their development has been slowed. Stopping in the first 3 months of pregnancy is the best way to avoid this for women smokers who become pregnant.

Some other effects are currently being investigated. Smoking can reduce fertility *(Howe et al 1985)* and fertility improves again on stopping. There are links with Sudden Infant Death Syndrome and may be links with ectopic pregnancy and miscarriage.

Overall, stopping smoking before, or soon after conception, is clearly a good way to increase the chances of a healthy baby.

Reference: HOWE, G ET AL (1985) Effects of cigarette smoking and other factors on fertility: findings in a large prospective study, *British Medical Journal*, 290, pp1697-1700

9. *Professor Sir Richard Peto has estimated that in the 20th century about 100 million smokers worldwide died as a result of their smoking. If current trends continue, how many will die in the 21st century?*

Peto estimates that there will be 900 million smoking related deaths in the 21st century if we cannot stop the increase in smoking in less developed countries.

Reference: Peto, R, Lopez, AD (2000) Future worldwide health effects of current smoking patterns, in Koop, CE, Schwarz, MR (eds) *Critical issues in global health,* (San Francisco: Jossey-Bass.)

10. *Smokers do not take any notice of health professionals telling them to stop: True or false?*

False. It is well established, for example, that – compared with normal care – opportunistic brief advice from a primary health care physician helps about 2% more smokers to stop. Because of the large 'reach' of brief interventions of this sort, and because smoking cessation results in

considerable health gain, this is very cost-effective and therefore very worthwhile. More intensive interventions and follow up increase success rates further.

For the most up-to-date information into the evidence base for the treatment of tobacco dependence see www.treatobacco.net (which is available in a number of languages).

Reference: West, R, McNeill, A & Raw, M (2000) Smoking cessation guidelines for health professionals: an update. *Thorax,* vol 55, pp 987-999.

Handouts

Brief Interventions

Many health professionals see a large number of smokers in the course of their routine clinical work but have very limited time in which to discuss smoking with them. However, it has been shown to be worthwhile to spend a few minutes doing so. Very brief advice increases the number of smokers who achieve abstinence for 6 months or longer by 2% (compared with control groups given normal care). If this is increased to a 10 minute intervention a further 3% will quit. Use of nicotine replacement therapy (NRT) or bupropion approximately doubles these success rates.

Because smoking is so dangerous and results in such huge costs to health care and to society, even these relatively low success rates are incredibly cost-effective. One way of looking at the success rates of brief advice is that if a primary care doctor gives 100 people 3 minutes very brief advice to quit, two of them will succeed in doing so who would not otherwise have stopped. Of these two ex-smokers we can expect that one of them would have been killed by his or her smoking if he or she had continued. Thus, a total of two and a half hours work has saved a life. This makes it a very successful and cost-effective intervention. Smoking cessation improves health more cheaply than many other medical interventions.

The essential features of a brief intervention are:
• Ask
• Advise
• Assess
• Assist
• Arrange

Ask
Smoking is an important aspect of a client's health status and it is therefore important to maintain up-to-date records about this. Two pieces of information are important: whether the person smokes currently and, if so, whether they are interested at present in stopping.

Advise
The health professional should ensure that if the client does smoke he or she is aware of the value of stopping and the health risks associated with continuing to smoke. Health professionals are in a good position to be able to help smokers to understand how the general facts about smoking and health harm apply to them personally and to consider their implications.

Assess
Assess the smoker's motivation to stop. A useful question to start with is: *"Have you ever thought of trying to stop smoking?"*

Assist
If the smoker does want to stop, a few key points can be covered in a few minutes.
• Set a stop day and stop completely on that day
• Review past experience and learn from it (what helped? what hindered?)
• Make a personalised action plan
• Identify likely problems and plan how to cope with them
• Ask family and friends for support

Information relating to how to stop can be reinforced with leaflets, booklets or other self-help materials. All smokers can be given information about pharmaceutical treatments (NRT and bupropion) and all those who smoke 10 or more a day should be encouraged to try them.

Arrange
Follow up is important, in maintaining motivation and in providing continuing support. For some smokers referral to a specialist smoking cessation clinic will be appropriate. Health professionals therefore need to keep themselves well informed about sources of more intensive help and about NRT and bupropion. It is important to remember that most smokers make several attempts to quit before succeeding. Follow up provides an opportunity for support with relapse.

Handouts

Stages of Change

Prochaska and DiClemente have described a series of stages through which people pass in making a behaviour change. At each stage a person is thinking and feeling differently about the problem behaviour and will find that different processes and interventions help them move on. This model is most often pictured diagrammatically as a circle. Before entering this cycle of change a person can be said to be in *precontemplation*. Precontemplators are not interested in change. Sometimes this is because they do not see the behaviour as a problem. Sometimes they do not know that it is causing, or putting them at risk of problems. Sometimes they are fully aware of the risks the behaviour poses, but value it so much for other reasons that they do not wish to change.

Raised awareness or concern about the risks and problems associated with the behaviour can lead to the person moving into *contemplation*. In this stage the person is torn two ways – aware that he or she ought to change but still feeling attached or drawn to the behaviour. They are not ready to change yet and may stay in contemplation for years, continually thinking about change.

Those in *preparation* are planning to take action soon. They are beginning to make some small changes and trying out different ways of behaving. They may tell others about their intention to change and make clear plans on how they are going to do it.

In *action* people visibly make changes and put considerable energy into it. This is often the time that people engage with professional helpers or self help groups.

This active period is followed by *maintenance* in which the change in behaviour is continued and consolidated, temporary changes become part
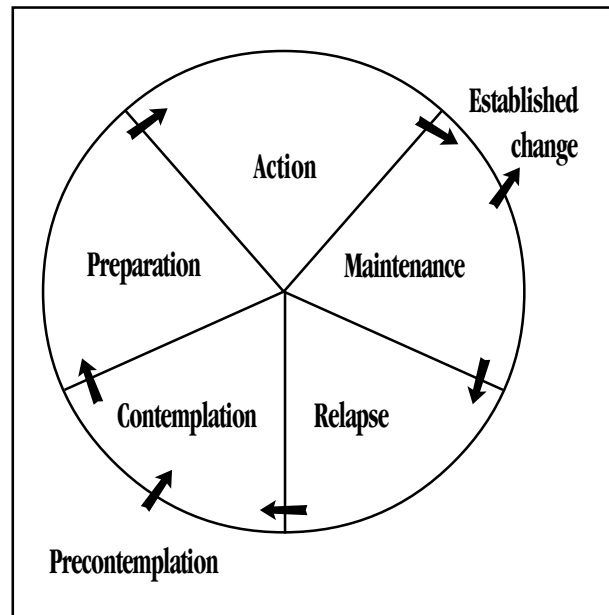
of a more settled pattern. Unless this consolidation takes place the person will move into *relapse* and return from there to *precontemplation* or *contemplation*.

Successful changers move systematically through all the stages until *maintenance*, where they consolidate the change sufficiently to exit the cycle. The change becomes an established new way of life.

Some people move very fast through the stages, or skip stages. If *contemplation* or *preparation* are rushed, there is a greater risk of relapse as the decision to change, and the plan to support change are not robust enough.

The model is transtheoretical. That is, it describes stages people move through regardless of how they explain their problem to themselves, whether they use professional help or not and, if they do, what theory and techniques that therapist uses.

Reference

PROCHASKA, J O AND DICLEMENTE, C C (1986) Towards a comprehensive model of change, in: MILLER, W R AND HEATHER N (Eds) *Treating addictive behaviors: processes of change* (New York: Plenum)

Handouts

Processes of Change

In order to change behaviour people also change many other aspects of their lives, including their:
- awareness of themselves,
- awareness of the effect the behaviour has on them,
- feelings about the behaviour,
- self-image,
- thinking.

Modification of the *behaviour* is the most visible change and often receives the most attention. However, by helping people to make other, less visible changes we can help them to move from one stage of change to the next.

There are nine key processes people apply to their problems as they go through the stages of change. They apply different processes at different stages. These nine processes are:
- Consciousness-raising
- Social liberation
- Emotional arousal
- Self re-evaluation
- Commitment
- Rewards
- Countering
- Environmental control
- Helping relationships.

Consciousness-raising
(becoming informed)
This arises from increased knowledge of oneself or the nature of one's problem. Reading health information material or becoming aware of one's own behaviour patterns through diary keeping or feedback from others are some examples of how consciousness-raising can take place. People use consciousness-raising most in the *precontemplation* and *contemplation* stages.

Social liberation
(increasing alternatives)
Social liberation is an external force arising out of environmental changes. Such changes are

perceived differently by people at different stages. For example, if a public transport system (buses, trains) is made 'no smoking', *precontemplators* may become more aware of how important smoking is to them and how difficult it is to travel home from work, tired and tense, without a cigarette. This may in turn raise their consciousness about their dependence on this habit. However, those on the bus or train in the *maintenance* stage may find it supportive in providing a smoke-free environment at a high-risk point in their day.

Emotional arousal
This is much like the concept of 'catharsis' – a major emotional experience triggered by an event relevant to the problem. It can occur as a result of tragedy in someone's life (people often report that the ill-health or death of a relative led to their move from *precontemplation* into *contemplation*). Films and drama techniques can also provoke emotional arousal. This process is most often found useful in *contemplation* and *preparation*.

Self re-evaluation
(creating a new image)
This arises from thinking through how one perceives oneself, what one's important values and goals are and how the 'problem' behaviour fits in with, or conflicts with these. Using this process often involves weighing up the costs and benefits of the behaviour and the costs and benefits of changing it. People most often use this process in the *contemplation* and *preparation* stages.

Commitment
Commitment is important in the *preparation*, *action* and *maintenance* stages. It comes with accepting responsibility for choosing to make changes and taking the appropriate action. If a private commitment to oneself is then made public it creates social pressures to support the change. Self-help groups often encourage public statements of commitment for this reason.

Rewards

There are different ways in which people reward themselves for making changes when they are in the *action* phase. One can use self-praise or elicit praise from friends, colleagues or family. Some people buy themselves gifts with the money saved from giving up smoking or drinking. In the *action* stage, rewards are most important because the intrinsic benefits of the change take time to become evident. People sometimes feel worse, not healthier when they first give up smoking or drinking or take up exercise, for example. It is only after a few weeks or months that the change in behaviour begins to provide its own rewards.

Countering
### *(using substitutes)*

This is the substitution of healthy or harmless behaviours for the one that is changed. It is particularly relevant to behaviours that one is trying to *give up* (e.g. smoking, drinking, over-eating). Mood changing activities (listening to music, physical activity, relaxation therapies) are one way of countering by meeting the emotional need in another way. Any activity that distracts one from thinking about or craving the problem behaviour is another. People in the *action* and *maintenance* stages use countering.

Environmental control

It is also helpful, in the *action* and *maintenance* stages, to control the environment so that temptations are reduced in order for healthy behaviours to become easier than unhealthy ones. For example, someone seeking to change their eating or drinking behaviour might limit the types of food and drink that are kept at home. Other people write themselves reminders and put them in strategic places at home or work.

Helping relationships

Anyone can provide a helping relationship: the health professional, a member of a self-help group, family member, friend, clergy, colleague. The helping relationship is an important process. People seeking to change are most likely to seek such support when they are in the *action* and *maintenance* stages. Health professionals are likely to want to provide a helping relationship to *precontemplators*, *contemplators* and those *preparing to change* too. People need different types of help at different stages, relating to the other processes they are using (e.g. someone to listen and ask pertinent questions in the process of self-evaluation, or someone to provide rewards).
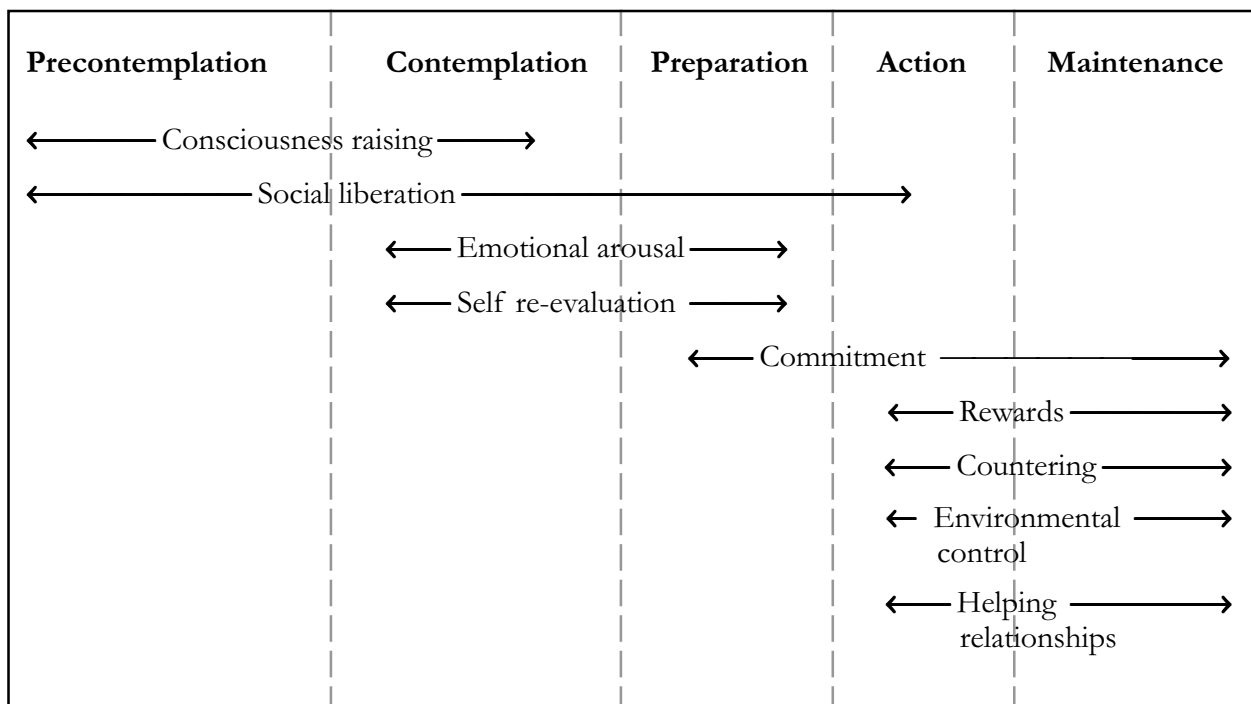
Summary

The change processes are most useful in particular stages of change. Most frequently, people who make changes use the processes as shown in the table.

Source

PROCHASKA, JO, NORCROSS, JC, DICLEMENTE, CC (1994) *Changing for good. The revolutionary program that explains the six stages of change and teaches you how to free yourself from bad habits.* (New York: William Morrow and Company)

Handouts

Stages of Change Group Exercise – Questions

Consider the 10 actions listed below. Each might trigger one or more of the processes of change. Beneath each, write down the processes that might be engaged by this action and circle one or more of the answers, to indicate at which stage or stages (circle as many as you wish) someone would find this action helpful. Try to reach a consensus in your group. If you disagree discuss your reasons fully.

1. Keeping a diary recording your smoking pattern for a day.
Processes:

Stages (circle one or more)
- precontemplation
- contemplation
- preparation
- action
- maintenance

2. Joining a smoking cessation group.
Processes:

Stages (circle one or more)
- precontemplation
- contemplation
- preparation
- action
- maintenance

3. Telling friends and family that you have decided to stop smoking.
Processes:

Stages (circle one or more)
- precontemplation
- contemplation
- preparation
- action
- maintenance

4. Receiving medical test results that show that your smoking is beginning to cause real damage to your health.
Processes:

Stages (circle one or more)
- precontemplation
- contemplation
- preparation
- action
- maintenance

5. Weighing up the costs and benefits of smoking for you.
Processes:

Stages (circle one or more)
- precontemplation
- contemplation
- preparation
- action
- maintenance

6. Watching a TV film about someone with a very unhealthy lifestyle dying from heart disease.
Processes:

Stages (circle one or more)
- precontemplation
- contemplation
- preparation
- action
- maintenance

7. Downloading from the internet some pages about different ways to stop smoking.
Processes:

Stages (circle one or more)
- precontemplation
- contemplation
- preparation
- action
- maintenance

8. Declaring your office, your bedroom or your car, a smoke-free area and putting up a no smoking sign.
Processes:

Stages (circle one or more)
- precontemplation
- contemplation
- preparation
- action
- maintenance

9. Buying yourself a small present as a reward for stopping smoking for a month.
Processes:

Stages (circle one or more)
- precontemplation
- contemplation
- preparation
- action
- maintenance

10. Learning relaxation skills.
Processes:

Stages (circle one or more)
- precontemplation
- contemplation
- preparation
- action
- maintenance

Stages of Change Group Exercise – Answers

Each of the activities considered in this exercise might trigger one or more of the processes of change and thus be more useful in some stages than others. Below are some examples of how individuals might respond to these activities.

1. Keeping a diary recording your smoking patterns for a day.

This will inform the smoker about his or her behaviour and might **raise consciousness** of the pattern of the behaviour, its implications and consequences. Used in this way it is most helpful in *precontemplation* and *contemplation*. Someone in *preparation* might use a diary to identify triggers to the behaviour and thus construct a good action plan, using substitutes as **countering** strategies.

Some people keep a diary to record their efforts at change. If the efforts are at least partially successful the diary may serve as **a reward** in the *action* or *maintenance* stage.

2. Joining a smoking cessation group.

This may fulfil a number of functions. Commonly it is a part of the process of **commitment** to a new way of life, provides **rewards** and supportive, **helping relationships**. Therefore it is most likely to be of value in *preparation*, *action* and *maintenance*.

3. Telling friends and family that you have decided to stop smoking.

Again this is an expression of **commitment** and may be a precursor to **enlisting support** and help with **rewards** or **environment control**. It is useful in *preparation, action* and *maintenance*.

4. Receiving medical test results that show that your smoking is beginning to cause real damage to your health.

This information may well lead to **raised consciousness** and **emotional awareness** so will have most impact in *precontemplation, contemplation* and *preparation*.

5. Weighing up the costs and benefits of smoking for you.

This will lead to **self re-evaluation** and considering a **new self-image** so be most useful in *contemplation* and *preparation*.

6. Watching a television film about someone with a very unhealthy lifestyle dying from heart disease.

This may lead to **emotional arousal** or to **consciousness-raising** so be useful in *precontemplation* or *preparation*.

7. Downloading from the internet some pages about different ways to stop smoking.

This may lead to **consciousness-raising** and thus be useful in *precontemplation* and *contemplation*. The information downloaded may be used for **countering**, i.e. for devising substitutes for smoking. Used in this way it would be helpful in *action* and *maintenance*.

8. Declaring your office, your bedroom or your car a smoke-free area and putting up a no smoking sign.

This may reinforce **commitment** and be a way of **controlling the environment**. Thus it is most likely to be used by people in *preparation, action* and *maintenance* stages.

9. Buying yourself a small present as a reward for giving up smoking for a month.

As a **reward** this will be useful in the *action* and *maintenance* stages.

10. Learning relaxation skills.

Using relaxation skills is **countering**, using a **substitute** way of relaxing. Someone might learn them as *preparation* and use them in *action* and *maintenance*.

So, tailoring an intervention or an activity to the stage of change a person is at will be likely to set in motion the right processes. It can also be seen that, encouraged to choose activities for themselves, people are likely to do things that are relevant to their readiness to change. A precontemplator is unlikely to choose to join a self-help group or put up a no smoking sign in the office. Someone in maintenance is unlikely to spend time reading basic health information about smoking.

Reluctance to Change

A major frustration for health professionals promoting smoking cessation is that smokers frequently resist change. In order to address this reluctance it is important to try to understand why people are sometimes attached to behaviours and the processes that need to take place for someone to move into preparation and action.

Behaviours that are unhealthy often seem beneficial in other ways.

Human beings are generally purposeful, seeking their own survival and comfort. Smoking may be seen to have a positive function in someone's life, relieving stress, bringing pleasure, facilitating social or business intercourse. In order to decide to change, the smoker has to offset the risks or harm associated with smoking with the benefits it confers. Many of the benefits are immediate and the risks or harms longer term. In the short term it can seem more important to continue smoking than to change and this balance will have to tip before the person will be ready to act.

People are not easily convinced that smoking is a problem for them personally.

There is a difference between knowing that a behaviour increases health risk and believing that it will cause oneself, personally, real harm. Until a health problem arises in a person's own life or for someone close to them, the theoretical risk may not be seen as a personal threat.

It sometimes seems almost impossible to change.

Where smoking confers – or is seen to confer – short term benefits or where it is a regular part of the person's daily life, it can seem that it would be almost impossible to change. To stop smoking would mean changing a lot of other things. It may mean learning new skills. For example, someone who relaxes by sitting down with a cigarette might find it difficult, initially, to find other ways to relax if he or she decided to stop smoking. So when someone has repeatedly tried to change and failed he or she can lose confidence in their own ability to change and feel hopeless about it. Sometimes there seems to be little support in the environment for the change (e.g. many people smoking in public places and widespread advertisements of tobacco products).

So, in order to move into preparation and action a person needs to believe it is *important* enough to do so and to feel *confident* in his or her ability to succeed.

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Enlisting Support

The helping relationship is of critical importance. It need not be provided by a professional helper. Informal and family networks probably have the greatest potential for providing support and help. People usually spend more time at home or at work than they do with their doctor or therapist! Family and friends are often aware of problems before we are and sometimes a family will approach a health professional before the person themselves does – seeking advice on how to help.

On the other hand, an unsupportive partner or colleague can make it very difficult for someone to change. One person changing has an impact on those close to him or her and this impact is not always wanted or supported.

Prochaska and colleagues give the following advice to those seeking to help people change:

- Don't push someone into action too soon. Allow them time to go through the earlier stages.

- Don't give up – show that you continue to be concerned although you are not pushing for premature action.
- Don't enable, i.e. don't make it easier for them to continue the behaviour by avoiding discussing it, minimising negative consequences or making excuses for them.
- Show empathy and unconditional warmth while the person is contemplating change.
- When the person begins to make changes, help them to control the environment to avoid temptations.
- Tell them when they are doing well, as well as when they are slipping.
- Keep up the support during the maintenance stage.

Some people find joining groups particularly helpful in that they provide opportunities both to gain extra support and to give help to others, which can strengthen commitment.

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Handouts

Smoking – Habit or Addiction?

Smoking has been legal and socially acceptable in many countries for centuries. Because of this it tends to be seen as a habit and as different from other forms of drug dependence or addiction. As the death and disease caused by smoking have become clearer and better understood there has been increasing pressure on smokers to stop.

Some people, once they have made the decision to stop, find it relatively easy. For others, however, it is very difficult and they discover they are physically dependent on tobacco in similar ways that other people are dependent on narcotics or tranquillisers. Furthermore, the spontaneous remission rate in a population of smokers is very low. In a long established smoking culture like the UK, of those smokers who want to stop, only about 3% manage to do so within one year just through their own efforts.

What is in tobacco smoke?

There are many ingredients in tobacco smoke which are harmful in different ways.

Tar and carbon monoxide are responsible for most of the damage. Tar is responsible for the lung and throat cancers associated with smoking and can aggravate other lung disease. Carbon monoxide reduces the oxygen carrying capacity of the blood, impairs oxygen supply to the tissues and plays a significant role in development of smoking-related heart disease.

Nicotine causes blood vessels to constrict, raises blood pressure, increases heart rate and increases the heart's demand for oxygen. It stimulates the nervous system. It is this ingredient that leads to people becoming 'addicted' to smoking. However, compared to the other components of tobacco smoke nicotine is not thought by experts to be so harmful.

Other chemicals and additives such as ammonia, arsenic (a poison used in insecticides and weedkillers), benzene, hydrogen cyanide, lead and mercury are found in tobacco smoke too. In fact, tobacco smoke actually contains a collection of between 4,000 and 8,000 chemicals, including flavouring agents, naturally occurring poisons, and additives added by the tobacco industry.

Withdrawal

With many drugs used regularly, the nervous system adapts to the continuing presence of the chemical. This is known as neuroadaptation. If administration of the drug is stopped abruptly, physiological withdrawal symptoms can be experienced as the body adapts again to a drug free state. Nicotine causes neuroadaptation and many people who stop experience some degree of withdrawal symptoms, including the following:
- craving to smoke,
- light-headedness,
- headaches,
- sore tongue,
- mouth ulcers,
- upset stomach,
- constipation,
- tension,
- irritability,
- restlessness,
- depression,
- sleeplessness,
- poor concentration.

The intensity of these symptoms usually diminishes rapidly over the first couple of weeks.

Tolerance

'Tolerance' is one of the processes that comprise neuroadaptation. When someone becomes tolerant to a drug they become decreasingly responsive to it, thus needing larger doses to produce the same effects. With smoking this can lead to smoking more cigarettes, or inhaling more nicotine per cigarette.

New smokers quickly learn to inhale, and experienced smokers regulate their blood nicotine levels by their inhalation pattern (depth/ frequency). Smokers crave most strongly when their blood nicotine levels go down. Some of the difficulties associated with giving up are the result of the way smokers' nervous systems quickly adjust to nicotine. Those most heavily addicted in this way are those who want a cigarette as soon as they wake in the morning or even wake in the night craving one.

Habits

However, the social habits involved in smoking are also hard to break. Many smokers have several key times in the day that they associate with smoking e.g.
- waking up (when they have a low blood nicotine level)
- arriving at work
- coffee breaks
- after meals
- after sex.

Sharing cigarettes is a ritual in many social situations. Smoking can be a part of someone's identity or self-image. Thus, the processes of countering and environment control can be very important in breaking such established behaviour patterns.

Nicotine replacement therapy (NRT)

It has been shown in almost 100 clinical trials that NRT helps smokers stop smoking. It helps partly by breaking down the process of stopping into two parts: changing the behaviour, then removing the nicotine. Once someone has established him or herself socially as a non-smoker and has stopped reaching out automatically for a cigarette at key times it is easier to cope with withdrawal from the nicotine. If wished, the nicotine withdrawal can then be done gradually by using successively lower dose products.

Bupropion (Zyban)

Bupropion is an anti-depressant medication that is now licensed in the US and very widely throughout Europe for the treatment of tobacco dependence. It comes in sustained release capsules. Bupropion is an effective aid to smoking cessation. To date only two controlled trials have been fully published but from these it is estimated that about 1 in 11 smokers (9%) who take it manage sustained abstinence for 12 months as a direct result. It also reduces the severity of urges of smoke and other withdrawal symptoms.

Bupropion has only been shown to be effective when used with substantial support so it needs to be seen as an *aid* to treatment not a stand-alone intervention at the moment.

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Questions Clients Ask About Smoking Cessation

In your small groups consider the following questions. How would you respond to a smoker who asked you this? Make some notes on key points.

1. *"Would it help to switch to cigars, or a pipe?"*

2. *"What about switching to lower tar cigarettes?"*

3. *"Do I have to stop smoking altogether, or is it alright to have an occasional cigarette?"*

4. *"Will I get withdrawal symptoms?"*

5. *"What does nicotine replacement therapy do? Should I use it?"*

6. *"What about the new drug bupropion?"*

7. *"Doesn't smoking help me cope with stress?"*

8. *"I've heard people gain weight when they stop smoking. Surely that's just as bad for me as smoking?"*

9. *"I like the idea of living longer if I stop smoking but what about in the short term? Are there any immediate benefits?*

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Answers to Clients' Questions About Smoking Cessation

Here are the facts relating to the questions asked by smokers considering stopping.

1. *"Would it help to switch to cigars, or a pipe?"*

No. A recent British survey found that pipe or cigar smokers who had never regularly smoked cigarettes had mortality rates from smoking-related lung diseases that were less than cigarette smokers although higher than non-smokers. *(Doll et al, 1994).* This is probably because they did not inhale. However, cigarette smokers who switch to cigars or pipes often do inhale deeply, as they did with cigarettes, so switching does not help them. Pipe and cigar smokers also have similar lip and mouth cancer rates as cigarette smokers.

2. *"What about switching to lower tar cigarettes?"*

There is no clear evidence that this would help. In practice, smokers who switch brands tend to compensate for the reduction in nicotine either by smoking more cigarettes or by inhaling more deeply or both. They often do not realise they are doing this but unfortunately it offsets the benefits of switching brands *(Russell, 1980).*

3. *"Do I have to stop smoking altogether, or is it alright to have an occasional cigarette?"*

If your purpose in reducing your smoking is to be healthier, then the less smoke you inhale the less health risk you run. Risk is proportional to consumption. It may be better to smoke two a day than 40 a day, but even healthier not to smoke. As mentioned above, people who cut down often inhale more and take more puffs of the cigarettes they smoke. Unfortunately, nicotine is a very addictive drug and very few people are successful in cutting down. Those who try occasional smoking tend to find it becomes more and more frequent until they revert to the original pattern. Therefore it is agreed that stopping altogether is the best advice.

4. *"Will I get withdrawal symptoms?"*

Many smokers experience withdrawal symptoms when they stop. Usually the worst is over in a month or so. These can include:
*   craving to smoke,
*   irritability,
*   light-headedness or dizziness,
*   headaches,
*   sleeplessness and inability to concentrate,
*   tiredness/fatigue,
*   sore tongue, mouth ulcers,
*   upset stomach.

The nervous system of a smoker has adapted to the frequent intake of nicotine, a powerful stimulant. It has to re-adapt to cope without nicotine. Although withdrawal symptoms are common and can be unpleasant, in a survey of smokers who had tried to give up smoking, only 9% said withdrawal symptoms were the factor that led to relapse. *(HEA/MORI, 1992).*

Increased coughing can occur as the body clears itself of mucus that has accumulated in the lungs. This is a sign of the respiratory system returning to health.

5. *"What does nicotine replacement therapy do? Should I use it?"*

Nicotine replacement therapy (NRT) replaces the nicotine smokers were getting from smoking tobacco, but in a much 'cleaner' and safer form (with no tar, carbon monoxide, or smoke). It reduces withdrawal symptoms, enabling the user to concentrate first on breaking the habit of smoking. A gradual reduction in the replacement nicotine then enables the nervous system to re-adapt gradually with less discomfort.

Nicotine replacement therapy is available as chewing gum, sub-lingual tablets, lozenges, skin patches, nasal spray and inhalators, although not all forms are available in all countries. The most widely used products are the chewing gum and skin patch. The chewing gum and the patch are the most evaluated because they have been around for much longer. It is important that these products are used according to instructions to ensure the dependence on nicotine is reduced effectively and gradually. Skin patches give a steady, gradual intake of nicotine whereas other forms such as gum, inhalators and nasal spray produce higher nicotine levels and permit better control of the nicotine dose. There is no strong evidence of a difference in effectiveness between the different forms of NRT. Users can choose on the basis of availability and personal preference.

Below is some advice given to users of nicotine replacement therapy (*Health Education Authority, 1999*).

- It is not a magic cure and will not, by itself, stop someone smoking.
- It reduces withdrawal symptoms like irritability and craving.
- It provides nicotine but not as quickly or as much as a cigarette. It will not be as satisfying as a cigarette and will not remove the need for willpower.
- NRT should be used instead of a cigarette, not as well as.
- NRT is safer and less addictive than cigarettes.
- Very few people become addicted to NRT.
- NRT should be used in sufficient quantities, and for long enough. You should follow the instructions in the package and seek advice from a pharmacist if you need more information.

6. *"What about the new drug bupropion?"*

Bupropion, marketed as Zyban, is now widely licensed as a prescription-only medicine for smoking cessation. It is an anti-depressant whose impact on smoking rates was noticed incidentally, and which has been shown in four trials (two of them published in peer review journals) to be effective. Its mechanism of action is not known but appears not to be connected with its anti-depressant effect. Initial trial results are very encouraging but until more trials have been published we cannot be certain exactly how effective it will prove. It is at least as effective as NRT however, achieving broadly similar cessation rates. However it is used differently: a smoker starts treatment and then sets a stopping date within the second week. The recommended initial dose of 150mg per day also should not be increased as there is a small (1 in 1,000 - about the same as for other anti-depressants) dose related risk of seizure. Bupropion is also contra-indicated for pregnant and breast feeding smokers, under 18s, and a range of other conditions. There are also interactions with other drugs, which is why it is a prescription-only medicine.

7. *"Doesn't smoking help me cope with stress?"*

Not really. If a smoker feels edgy due to falling nicotine levels, then a cigarette will reduce this perceived 'stress' which is actually the beginning of withdrawal from smoking. Nicotine is a stimulant. In fact smokers as a whole tend to have slightly higher anxiety levels than non-smokers or ex-smokers.

8. *"I've heard people gain weight when they stop smoking. Surely that's just as bad for me as smoking?"*

It is common for people to put on a few kilograms when they first stop smoking. This can be made worse by snacking on sweet and fatty foods as a substitute for smoking. However, this does not happen to everyone and being slightly overweight is less of a health risk than being a smoker.

9. *"I like the idea of living longer if I stop smoking but what about in the short term? Are there any immediate benefits?"*

Giving up smoking begins to have benefits straight away. The following are typical benefits.

After 20 minutes Blood pressure and pulse rate return to normal. Circulation improves in hands and feet.

After 8 hours Oxygen levels in the blood return to normal. Chances of a heart attack start to fall.

After 24 hours Carbon monoxide is eliminated from the body. Lungs start to clear out mucus and other debris.

After 48 hours Senses of taste and smell are greatly improved. The stale smoke odours on breath and body disappear.

After 3 months The lung function increases making it easier to breathe. The nagging cough disappears. The risk of further gum disease reduces significantly. Tooth staining begins to reduce.

After 9 months The risk of experiencing complications during pregnancy or foetal death has returned to that of a non-smoker.

After 5 years The probability of contracting mouth, throat and oesophageal cancer has been reduced by 50%. The risk of a heart attack falls to about half that of a smoker.

Source
Much of the information in this handout is drawn from WAITERS, R, WHENT, H ET AL (1996) *Health update, smoking* (London: Health Education Authority). Useful additional information can be found in the references below.

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Specialist Treatments Available to Help Smokers Stop

Many interventions to help smokers stop have been investigated in randomised controlled trials (RCTs), which have been systematically reviewed. The research evidence, summarised in the US and English clinical guidelines, broadly supports three main types of intervention for health care systems: brief opportunistic interventions delivered by health professionals in the course of their routine work; more intensive support delivered by treatment specialists, often in what have been called 'smokers clinics'; and pharmacological aids, which approximately double cessation in minimal or more intensive settings. The principal aids in the last category are nicotine replacement therapy (NRT) and bupropion, both of which are widely available in Europe. NRT can be found on prescription, over-the-counter and on general sale (but not all of these in all countries, nor all six NRT products in all countries). Bupropion is a prescription only medicine. Core recommendations for European health care systems are set out in more details in the first European treatment recommendations (see 'further resources').

Brief opportunistic interventions

As part of their normal clinical work, health professionals should: ask about and record patients' smoking status; make sure that the records are kept up to date; advise them to stop; assess motivation to stop; offer assistance if possible; offer follow-up if possible; and refer to specialist cessation service if necessary. They should recommend NRT or bupropion if and when needed, and be able to provide accurate information and advice on both. Smoking and smoking cessation should be part of the core curriculum of the basic training of all health professionals.

The essential features of brief interventions are:

- **Ask** about and record smoking status, keep record up to date;
- **Advise** smokers of the benefit of stopping in a personalised and appropriate manner;
- **Assess** motivation to stop;
- **Assist** smokers in their quit attempt if possible (this might include the offer of support, recommendation to use NRT or bupropion and information about them, referral to specialist help with stopping);
- **Arrange** follow up if possible.

If help can be offered a few key points can be covered in a few minutes:
- set a stop day and stop completely on that day
- review past experience and learn from it (what helped? what hindered?)
- make a personalised action plan
- identify likely problems and plan how to cope with them
- ask family and friends for support.

Such opportunistic interventions motivate smokers to try to stop, and increase cessation rates compared with controls by around 3%. Although this may seem low, it is such a cheap intervention to deliver that it is enormously cost effective in producing health gain.

Smoking cessation clinics

Specialist smoking cessation clinics that offer behavioural support sessions (about five or so 1 to 1½ hour sessions over a period of about 5 weeks) plus NRT have been found to be effective. Support can be one-to-one or in groups but obviously, other things being equal, groups will be more cost effective. Intensive support includes peer support, help to develop behavioural and cognitive coping skills, and information on effective use of NRT or bupropion. Where the group is run in such a way as to facilitate group and peer support and increase participants' commitment to change, it might be expected to have extra benefits.

Intensive support combined with NRT or bupropion increases cessation rates by 13-19% over and above control (usually non-intervention) rates. The European recommendations suggest that health care systems should offer intensive support/ treatment as back up to brief opportunistic interventions for those smokers who need it. Although it is more expensive than brief interventions it remains extremely cost effective.

Pharmaceutical treatment aids

Nicotine replacement therapy (NRT) alleviates the discomfort of withdrawal and has been the subject of extensive, rigorous research. It is available (but not in all European countries) as:
- chewing gum (available in 2mg and 4mg doses)
- transdermal patches (available in various doses, some lasting 16 hours and others 24 hours)
- nasal spray
- inhalator
- sublingual tablets
- lozenges.

There is little strong evidence yet that any one product is more effective than any other, so the choice between them can be made on the basis of acceptability to the individual, availability and cost. Some products (for example the patch) result in a slower absorption of nicotine whilst others, such as the nasal spray, deliver a rapidly absorbed peak of nicotine very quickly. All products need to be used according to the instructions given, and it is always wise if possible to refer the smoker to a pharmacist to get advice on which product is most suitable and to get instructions on use. Most smokers, because of a concern about nicotine, tend to use too little NRT rather than too much. It is important to advise them to take a high enough dose, and for long enough, to alleviate withdrawal effectively. The difference between the nicotine, and the toxic smoke components like tar, should be clearly explained to them. They should be advised that compared with

smoking, NRT is safe. At present in most countries, NRT is not recommended for pregnant women, young people, or those with coronary heart disease. NRT approximately doubles cessation rates compared with controls, in whatever setting it is used. For example the cessation rate in moderate to heavy smokers who seek and receive intensive support is about 7% (over and above controls). With NRT this rises to about 15%.

Bupropion was originally developed as an antidepressant in the US but is now licensed for the treatment of tobacco dependence, and its smoking cessation efficacy appears to be independent of its anti-depressant effect. It is given one week prior to cessation and treatment continues for 7-12 weeks. It is available in a slow release preparation. Like NRT it approximately doubles cessation rates Although in two clinical trials bupropion achieved encouragingly high cessation rates these trials need replicating before we can be sure exactly how effective it is. Furthermore bupropion has only been shown so far to work in the context of medium to heavy smokers receiving behavioural support. Its effectiveness is similar to NRT. The cessation rate in moderate to heavy smokers who seek and receive intensive support is about 7% (over and above controls), rising to about 16% with bupropion.

Many other smoking cessation methods have been tried, some in randomised clinical trials but many not. The research evidence is not yet good enough to conclude that they have a therapeutic value better than a placebo. There is currently insufficient evidence to recommend: aversive smoking, hypnosis, anxiolytics and anti-depressants, lobeline, silver acetate. Acupuncture has only been shown to work as a placebo, clonidine does work but has side effects and so is not recommended as a first line treatment. All of these treatments have been subjected to systematic reviews by the Cochrane Collaboration in Oxford. There are currently no grounds for promoting or offering these treatments from publicly funded health care

systems. Indeed, in countries with scarce resources, there is a strong argument to concentrate resources only on methods proven to work in rigorous clinical trials. However, if a smoker wants to engage in one of these treatments, believes it will help them in their efforts to change, and can afford it, the health professional may wish to go along with such a plan, especially if it appears to support one of the change processes, e.g. confirming commitment or adding to a network of helping relationships. The smoker should be told, however, what he or she is buying and understand that it is not a magic cure (such treatments, including hypnosis and acupuncture, are often promoted with exaggerated claims for effectiveness).

As this is a very active area, clinicians will want to keep up-to-date with new findings. They will be able to do this with increasing ease through the internet (see references).

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See also: www.treatobacco.net – a web-based database developed by the Society for Research on Nicotine and Tobacco, with the support of the WHO Partnership Project. It is free and will contain up-to-date summaries of the evidence for effective treatments for smokers.

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Information Exchange

During the course of giving brief advice to smokers health professionals will be continually exchanging information with them. For the health professional the purposes of this process are:

- to open up discussion about smoking cessation,
- to ensure the client is in possession of all the facts relevant to the personal decision whether to continue smoking or not,
- to help build motivation for change,
- to provide any assistance where appropriate.

The information exchanged might be related to any of the following:

- the health risks of smoking,
- the effect smoking is currently having on the smoker or his or her family,
- ideas about how the smoker might go about changing,
- referral options for specialist support.

In effect this is what is meant by the term 'advice': an exchange sensitive to the smoker's needs, not directive advice imposed on the smoker.

A client-centred approach

The smoker is going to have to stop smoking for themselves. The important thing is not what information has left the health professional's lips, but what sense the client has made of it and what they think the implications are.

If only a few precious minutes are available for the intervention, it is vital to provide the most relevant information and ensure the smoker has an opportunity to understand and integrate it. A useful sequence to follow is:

Elicit ⇨ Provide ⇨ Elicit

1. Elicit readiness and interest

How much does the smoker already know?

Would he or she like to know more about…? Would he or she be interested to know more about how…? There is no point in providing irrelevant information or that which the smoker does not want to receive.

2. Provide information neutrally

If information is provided as if it were a weapon the recipient is likely to put up a defence against it, especially if it is frightening information! People often respond to being told *x will happen to you if you don't stop smoking* by producing explanations of why it will not happen to them, or why they have some special immunity to such an outcome.

Information is more likely to be heard accurately if given in a neutral way avoiding the word *you*. For example you can explain that: W*hat happens to some people is that… Other people find that…* Use language that the smoker will understand and **pause regularly to check their comprehension**.

3. Elicit the client's interpretation of the facts provided

Follow their reaction giving them an opportunity to integrate their new understanding into their view of the situation.

Ask: *What do you make of all this?*
       How have you been affected by hearing this?

Leaflets and material to take home

These principles can also be applied to self help materials and information leaflets. Ask people what they would like and would find useful and give only what is relevant to their own situation and stage of thinking about change. Next time you see them, elicit their response to reading the material.

Further reading
ROLLNICK, S, MASON, P, & BUTLER, C, (1999) *Health behavior change,* (Edinburgh: Churchill Livingstone)

Handouts

Helping Relationships and Smokers

Consider the following clients. Each has attended your clinic or surgery for health care. Each smokes.

In your group discuss:

• How do you feel about this person's smoking?

• Does their continued smoking affect your attitude or feelings towards them?

• Might any of your attitudes towards them, or their smoking be a barrier to you developing a helping relationship with them? If so, what can you do about this?

When you have discussed each client, consider the following, each from your own personal perspective. You may be a non-smoker, an ex-smoker or a current smoker.

• How does your own smoking status, and your feelings about it, affect your work with smoking clients?

• How does it help or hinder your attempts to understand and empathise with them in contemplation and support them in action and maintenance?

Client 1
A teenage girl, intelligent, from a comfortable loving home. She is good at sports, despite being asthmatic, and has begun college to train to be a physical education teacher. She smokes 5-10 cigarettes a day since going away to college.

Client 2
A 60 year old man has an elderly wife who he cares for. She is housebound with chronic bronchitis and emphysema. She used to be a smoker but gave up a few years ago. He smokes 20 cigarettes a day.

Client 3
A young mother has 2 children under 4 years old and is expecting a third. The last child was low birthweight and is often ill with infections. The mother smokes 20 cigarettes a day.

Client 4
A 50 year old man had a heart attack 2 years ago from which he was lucky to recover. He continues to smoke 30 cigarettes a day.

Handouts

Building a Helping Relationship

One of the key factors in people changing their behaviour is having a 'helping relationship' with someone who they feel really cares, understands and is committed to helping them. This is particularly valuable in moving from precontemplation to contemplation and in the maintenance stage. The helping relationship may be with a professional carer, a friend, spouse or family member.

For professional carers, who spend a limited amount of time with clients, and in a clearly defined role, one important way of building a helping relationship is to listen carefully and actively to what people have to say about themselves and their problems. This has two functions – firstly it enables one to gain an accurate understanding of the person and the problem, which leads to genuine caring and commitment and, secondly, it demonstrates this understanding, caring and commitment to the client. For the talker, being listened to is in itself therapeutic, as well as being a way of informing the listener.

At the bottom of the page is a checklist of behaviours which are either helpful or unhelpful in active listening and relationship building.

Some obstacles to active listening

Active listening is difficult to maintain. Some of the obstacles to listening are described below.

'On-off' listening
Most of us think about 4 times as fast as the average person speaks. Thus, the listener has three-quarters of a minute of spare thinking time for each listening minute. Sometimes we use this extra time to think of something else instead of listening.

'Open ears – closed mind' listening
Sometimes we decide rather quickly that either the subject or the speaker is boring and what is said makes no sense or is untrue. Often we

Helpful Listening Behaviours	Unhelpful Listening Behaviours
Good eye contact	Fidgeting
Appropriate head nodding, smiles, facial expressions, gestures (hands etc)	Looking away from client
Relaxed body posture	Fiddling with clothes, pen etc
Leaning forward	Physical barriers (e.g. desk)
Allowing silence	Clock watching
Reflecting client's movement	Looking bored, impatient, hostile
Noticing client's body language	'On-off' listening
Clear voice	Patronising
Verbal prompts *'mm', 'go on'*	Condescending
Repeating key words	Devaluing
Open-ended questions	Jumping to conclusions
Checking/clarifying	Judging
Reflecting back	Talking too much
Summing up	Filling in silence too quickly
Focusing	Interrupting
Structuring	Too many questions
No physical barriers	'Telling'
	Giving advice

jump to conclusions that we can predict what will come next thus, we conclude, there is no reason to listen because we will hear nothing new if we do.

'Glassy-eyed' listening

Sometimes we look at a person intently and we almost seem to be listening although our minds may be on other things or on far distant places. We drop back into the comfort of our own thoughts. We get glassy-eyed and often a dreamy expression appears on our faces.

'Too-deep-for-me' listening

When we are listening to ideas that are too complex and complicated there is a danger we will 'shut-off'.

'Matter-over-mind' listening

We do not like to have our pet ideas, prejudices, and points of view overturned. We do not like to have our opinions and judgements challenged. Consequently, when a speaker says something that clashes with what we think,

believe, and hold firm to, then we may unconsciously stop listening or even become defensive and plan a counter-attack.

Being 'subject-centred' instead of 'speaker-centred'

Sometimes we concentrate on the problem and not the person. Detail and fact about an incident become more important than what people are saying about themselves.

'Fact' listening

Often as we listen to people we try to remember the facts and repeat them over and over again to drive them home. As we do this, frequently the speaker has gone on to new facts and we lose them in the process.

'Pencil' listening

Trying to put down on paper everything the speaker says, usually means we are bound to lose some of it because the speaker's words come out faster than we can write them down. Eye contact also becomes more difficult.

Skills for Enabling Change

When considering change, people weigh up the advantages and disadvantages. They are motivated by any perceived disadvantages of smoking and by the benefits and advantages they expect to accrue from stopping.

Often they are torn, however, between wanting to continue smoking, but also wanting to stop. This 'ambivalence' is a source of conflict within them. When talking about change with someone else (health professional, family member, friend) this conflict becomes apparent. Often the helper is tempted to take on one side of the conflict, i.e. to put forward the disadvantages of smoking and/or the advantages of stopping. This can result in the client adopting the opposite stance and the conflict moves from being within the client to being external between the client and the helper.

Unfortunately, the consequence of such a dialogue is that the client finds himself or herself explaining to the helper all the reasons why change would be a bad idea, and why the smoking is not really a big problem. This can increase his or her attachment to smoking. If the dialogue then becomes heated or confrontational the client will become more resistant to change.

'Motivational interviewing' (*Miller & Rollnick, 1991*) is an approach designed to raise the client's awareness of this conflict or ambivalence and enable them to view it as clearly as possible and decide how best to resolve it. Described below are some of the principles of motivational interviewing that can be useful in conducting brief interventions with clients who are reluctant to change.

Rolling with resistance

If clients in precontemplation and contemplation are prone to being resistant, and if confrontational approaches tend to increase resistance, other strategies are needed. Miller and Rollnick, in describing such strategies, use an analogy from martial arts where, instead of blocking or countering an attack, the martial artist 'rolls' with it, thus rendering it harmless.

This translates to a consultation as follows. If the health professional raises the topic of change and the client puts up resistance, instead of putting up a counter argument, the health professional accepts and acknowledges the resistance, using reflective listening skills. Once the resistance has been accepted the client no longer has to keep making that particular point and is free to consider other aspects of the issue.

It can even be helpful to encourage the client to explore the resistance a little so that both client and health professional come to understand it better. This may seem paradoxical when the health professional wishes to promote change. It can, however, enable the client to see the resistance and the obstacles to change as objectively as possible without becoming attached to them by having to defend them in an argument with a health professional who appears not to value their importance.

Resistance can also be 'side-stepped', to use another combat analogy. If the client puts up resistance to a particular line of questioning the health professional can move the discussion to another topic, or approach the topic from another angle. The aim is to continue a constructive, collaborative discussion for as long as possible without getting into an unproductive argument about it. While the client continues talking about it he or she continues to explore his or her feelings and thoughts on the topic and this aids the contemplation process.

Eliciting self-motivating statements

Hearing ourselves express a view, out loud, tends to reinforce our attachment to that view. Therefore if we want to encourage and enable change, it is helpful to conduct the consultation so that the client is encouraged to put forward the reasons he or she can see for changing.

Examples of such self-motivating statements might be:
- *"I am concerned that, by smoking, I am setting a bad example to my children."*
- *"My father died of a heart attack. I don't want that to happen to me. I know that by stopping smoking I could reduce that risk."*
- *"I spend a lot of money on smoking."*

Self-motivating statements may be elicited by questions such as:
- *"You have told me some of the things you enjoy about smoking. Do you have any concerns about it at all?"*
- *"Have you ever considered stopping smoking?"*
- *"From your point of view, would there be any advantages in stopping smoking?"*

References

MILLER, W R & ROLLNICK S (1991) *Motivational interviewing*, (New York: Guilford Press)

ROLLNICK, S, MASON, P, & BUTLER, C (1999) *Health behavior change,* (Edinburgh: Churchill Livingstone)

Skills for Enabling Change – Case Studies

Instructions

The aim of this exercise is to practise the skills of rolling with resistance and eliciting self-motivating statements. It is a role play. Two students will take the roles of client and health professional and a third will take the role of observer.

Play the roles for 8 minutes and then the observer should give feedback for 2-3 minutes. Then de-role and move on to the next scenario, exchanging roles so everyone gets a turn at each.

Scenario 1

Client

You are a young, single parent who smokes. You would like to stop smoking so as to be fitter and to give a better example to your children, both of whom are prone to chest infections and asthma. However, your life is very stressful. You cannot see how you could cope without the cigarettes which help you to relax. You are also concerned that the withdrawal symptoms would make you even more stressed and miserable.

Health professional

This client is a smoker and a parent. You are concerned about the effect on the children, one of whom you have just treated for a recurrent chest infection. Take this opportunity to raise your concerns. Acknowledge that he or she is a caring and loving parent. Try to discuss the smoking in a way that encourages the client to tell you any of his or her own concerns about it, or reasons for wanting to change. Handle any resistance in a way that acknowledges the issues and avoids argumentation.

Observer

Watch carefully for anything the health professional does which contributes to:
- eliciting self-motivating statements from the client,
- avoiding confrontation and argument,
- acknowledging and rolling with any resistance from the client.

Keep time and after 8 minutes stop the role play and tell the health professional your observations. Help them to see the things they did well.

Scenario 2

Client

You are a middle-aged, heavy smoker. You know that smoking is bad for health but you enjoy it and you believe it would be very difficult indeed for you to give up. You like to believe that because you eat well and only drink moderately you will not come to any harm from your smoking – everyone is entitled to one bad habit in your opinion!

Health professional

You are concerned about your client's smoking. From time to time, in the past, you have warned him or her about the damage smoking does to health. Talk to your client again about it and try to do so in such a way that you elicit self-motivating statements and roll with any resistance.

Observer

Watch carefully for anything the health professional does which contributes to:
*   eliciting self-motivating statements from the client,
*   avoiding confrontation and argument,
*   acknowledging and rolling with any resistance from the client.

Keep time and after 8 minutes stop the role play and tell the health professional your observations. Help them to see the things they did well.

Scenario 3

Client

You are an elderly person living alone. You have smoked for 40 years and consider it to be one of your few pleasures in life these days. You have a lot of problems with bronchitis and emphysema, which you acknowledge are probably connected to the smoking. You sometimes worry that if your chest gets worse you will be unable to cope with living in your second floor flat.

Health professional

You have been treating this elderly person for bronchitis and emphysema for several years. Recent tests show lung function is becoming very poor. On a couple of occasions you have given the client a lecture about smoking but to no avail. Take this opportunity to raise the issue again but in a less confrontative way that acknowledges how difficult it would be to break a lifetime's habit. Try to elicit self-motivating statements and roll with resistance.

Observer

Watch carefully for anything the health professional does which contributes to:
*   eliciting self-motivating statements from the client,
*   avoiding confrontation and argument,
*   acknowledging and rolling with any resistance from the client.

Keep time and after 8 minutes stop the role play and tell the health professional your observations. Help them to see the things they did well.

The Decisional Balance and Self Re-evaluation

Self re-evaluation (creating a new image) is a helpful process in the stages of contemplation and preparation. People can be helped to re-evaluate their current situation, which includes the implications of the problem or risk behaviour and also how the future might be for them, with or without the behaviour.

The decisional balance is a framework for such a re-evaluation. It was first discussed at length by Janis and Mann (*1977*) and is a major focus of much motivational interviewing *(Miller and Rollnick, 1991)*. In brief interventions it can be used either during the consultation or as a piece of self-help 'homework' for the client.

With a focus on smoking the client can first consider the advantages and disadvantages of their current situation as a smoker. They may then think ahead to an imagined scenario when they no longer smoke, and consider the advantages and disadvantages of change.

It can be helpful to invite a smoker to fill in the matrix below.

There will obviously be some similarities between the advantages of smoking and the disadvantages of quitting and there will also be an overlap between the disadvantages of smoking and the advantages of quitting.

There are four categories of responses that the client might be encouraged to consider:
1. Consequences to self (e.g. *if I continue smoking I will be less healthy*).
2. Consequences to others (e.g. *if I stop smoking my family will not have to endure 'passive smoking'*).
3. How I feel about myself (e.g. *if I continue smoking I will feel guilty about setting a bad example to my children*).
4. How others feel about me (e.g. *my partner will be proud of me if I stop smoking*).

In a one-to-one consultation it is helpful, in order to build a good helping relationship, to begin by showing a willingness to understand the attraction, or the positive aspects of smoking. Good active listening skills can be used to demonstrate empathy. Even if the client talks about advantages of smoking or disadvantages of change with which you disagree, or which you consider trivial, remember that you need to understand how it seems to them in order to proceed. Ask for clarification rather than arguing. Arguing will be likely to elicit resistance.

	Advantages	Disadvantages
Smoking		
Not Smoking		

A consultation based on the decisional balance framework might pursue the following lines of enquiry:

- *"What are the good things for you about smoking?"*
- *"Are there any things about smoking that are not so good for you?"*
- *"If you were to consider quitting what might be difficult for you?"*
- *"Do you see that there would be any advantages for you in stopping smoking?"*
- *"So, from what you say, it looks like this…* (summarise).
- *"Where does that leave you?"*

With a client who is only just beginning to consider change, it is sometimes best just to look at the advantages and disadvantages of smoking. Someone already preparing to change may wish to focus primarily on the advantages and disadvantages of change.

This process is subjective. It is crucial that the client is helped to consider how it seems to him or her and how the behaviour fits in with other important goals and values in his or her life. Health professionals should be wary of putting their own values and assumptions onto the balance sheet. What is important to one person is not necessarily important to others.

The decisional balance can be changed in several ways. For example:

- environmental changes such as no longer being able to smoke at work,
- new information such as personal evidence of physical harm resulting from smoking,
- the client's priorities changing, for example through becoming a parent,
- acquisition of new skills such as learning a new way to relax after work.

The health professional's most important role therefore consists of being someone to listen and reflect back the client's self re-evaluation without judging, or hurrying the process to a premature conclusion. This may also include:

- helping the client take a clear view of how the decisional balance looks at the moment,
- ensuring the client has, or has access to, any information relevant to the decisional balance, and understand its implications, particularly if it increases the advantages of change,
- helping identify any barriers to change that the client would like to try to remove (e.g. skills deficits) thus decreasing the disadvantages of change,
- advocating for relevant environmental changes.

The skills of rolling with resistance and eliciting self-motivating statements are central to the use of this framework.

As an alternative to using it in counselling, clients can be asked to complete this as a pencil and paper exercise as 'homework' between consultations. This gives them time to think through what the behaviour – and the prospect of changing it – means to them.

References

JANIS, I AND MANN, L (1977) *Decision making*, (New York: Free Press)

MILLER, W R AND ROLLNICK, S (1991) *Motivational interviewing*, (New York: Guilford Press)

The Decisional Balance – Pairs Exercise

This is an experiential exercise. You do not need to role play. Just be yourself – a student on the course with your real life and real concerns.

Each of you should choose an issue of your own to talk about to your partner. It should be a lifestyle issue that you are considering changing (i.e. contemplating or preparing to change). Do not pick something that is very traumatic, or too painful to discuss in a setting like this. Lifestyle issues such as eating, physical activity, smoking, drinking, working long hours, moving house or taking up a course of study are usually suitable.

Take it in turns to talk about your issue. While the first person talks, the other should help them to complete a decisional balance with regard to the chosen lifestyle issue. You will probably find it helpful to fill in the boxes as you talk. Then, after about 15 minutes, sum up and swap over so that the other person has a chance to discuss their issue.

	Advantages	**Disadvantages**
No Change		
Change		

Handouts

Developing Confidence

In order to move successfully into action, people need to develop confidence in their ability to do so. In completing a decisional balance it may be clear that it is very important to a client to change. They can see lots of advantages of change. They want to do it. However they are not confident that they can do it and this holds them back.

Lack of confidence about stopping smoking may arise from several factors:

• Some people may have had few good experiences of changing other aspects of their lives and have a low level of confidence in themselves in general. Recent trauma, or having been brought up in an environment that did not encourage self-confidence, can underlie such general low self-esteem.

• Some people have had repeated failures at trying to stop smoking. Indeed many only seek help from a health professional when they have tried and failed more than once to do it alone.

• On considering their decisional balance, some people can see that although there will be lots of advantages in changing there will also be disadvantages. If they are not sure how to cope with these, their confidence in their ability to change will be undermined.

• Without a clear cut plan to focus on, it is difficult to imagine exactly how the change will happen and therefore there is nothing concrete to feel confidence in.

Usually, confidence is best developed through having practical strategies for dealing with the perceived or feared obstacles. Some of the processes of change directly address this.

Countering

Finding alternative ways to *behave* in high risk situations is a way of countering the urge to smoke in the short term. Examples might be having a bath/shower and listening to music on returning from work instead of having a cigarette; nibbling fruit, raw carrots, celery etc; engaging in activities which preclude smoking such as swimming. Some people develop ways of distracting themselves in moments of craving.

Countering may also involve finding different ways to *think* in high risk situations. Some people have habits of self-defeating thoughts such as:

> *"I'm no good at this sort of thing"*
> *"I'll mess it up again"*
> *"Just one won't hurt."*

When people catch themselves thinking their 'favourite' self-defeating thoughts they can replace them with positive ones such as:

> *"I've done it before, I can do it again"*
> *"This craving will pass if I wait 5 minutes"*
> *"I'll do without it this time"*

or with visual images of the healthy self they are aiming to become.

This takes practice, but in time the new thoughts can become habitual.

Environmental control

Lack of confidence can arise from a fear that the immediate environment will be hostile to the change. Unsupportive friends and colleagues, easy availability of cigarettes and poor access to healthy alternatives such as exercise facilities and healthy foods can make the task of change seem impossible.

It can be helpful to take these concerns seriously. Do not expect willpower to be sufficient; practical plans are needed. Helpful questions to ask someone trying to develop confidence are:

• Are there some situations that, for now, you had best avoid completely? What are they? How can you avoid them? What excuses will you make and what alternatives can you find?

- What are the cues that trigger the behaviour? Are there particular feelings or thoughts that put you at risk? How can you prepare for or even practise dealing with these cues?

- In order to make the change feasible, are there any other aspects of your life you need to change, to create an environment that will support you (e.g. have lunch somewhere different, change working hours to fit with leisure or sports opportunities)?

- Would it be helpful to make your home, car or office a non-smoking zone or to throw away lighters, ashtrays etc?

Rewards

The intrinsic benefits of quitting smoking may not be immediately obvious. Some people build short term rewards into the action plan, such as buying something they would not otherwise be able to afford with the money saved, or eliciting and giving themselves praise for achieving quit milestones such as one day, one week, one year.

Taking care of themselves physically by eating well, getting moderate (enjoyable) exercise and getting enough sleep and relaxation can be a reward too.

Learning from previous efforts to change

In helping the client to use the processes of change, try to use their previous experience constructively. Useful questions are:

- When you have tried to change this behaviour in the past, are there any things that have been helpful? If so can they be built into your plan this time?

- Is there anything you can learn from the problems you experienced the last time you tried to change?

Having a specific plan

Many people succeed by setting a date for stopping smoking in the near future (*commitment*) and then working towards it. Once the date is set, confidence can be increased by making a concrete plan for how to achieve it. *"I will try hard"* is a laudable sentiment and intention but does not give any practical indication of how the good intentions can be made to work.

A good plan will include, *countering*, *rewards* and *environment control*. It also take into account the value of having a *helping relationship* with a supporter.

Recording such a plan ensures both client and professional can check whether it has been followed and if so whether it resulted in achievement of the goals.

Developing Confidence – Role Play

In pairs decide who will be the client and who the health professional by using this method: the one whose birthday falls earlier in the year plays the client.

Take the following roles. You are in a one-to-one health consultation. If you wish, instead of the client described below, use an example from your own practice where **low confidence** is the major obstacle to change.

After 10 minutes you will be asked to step out of role and say who you really are, to each other. Then discuss briefly how you got on:
• Did you agree the nature of the central confidence problem(s)?
• Were you able to think, between you, of any practical solutions?

Client	Health professional
You are a 40 year old professional person. You have smoked since you were at college and would like to give up, for health reasons. You are well-informed about the damage smoking does to your health and it is important to you to stop. However, you have tried twice before. The first time lasted 3 weeks and then you decided to just have one cigarette and ended up smoking heavily again. The second time lasted one year. You had support from a colleague who gave up the same time as you. Then you changed jobs and the stress of the upheaval led to you beginning again, 6 months ago. You always seem to want a cigarette when life is stressful. Usually you are a confident, competent person and you find it frustrating to feel 'out of control' of your smoking.	You have discussed the client's smoking with him or her. You both agree that s/he should stop smoking, for health reasons. You sense that the client has little confidence about being able to stop. Find out what factors lead to this lack of confidence. Try to help the client to find practical strategies to develop confidence.

Handouts

Relapse Prevention and Recycling

Maintenance is a busy, active period of change. New coping strategies are learned in order to avoid relapse and to establish a new healthier lifestyle. Only about 20 percent of people permanently change long-standing problems at the first attempt *(Prochaska et al, 1994)*. Most people revert, at least for a while, to the problem behaviour, before trying again.

The most detailed work on relapse has been that by Alan Marlatt, related to people changing their drinking behaviour. This work has been reviewed and developed by others (*Addiction, 1996*) and provides a useful framework for clinical work with smokers.

What precipitates relapse?

Relapse is usually a way of:

* Coping with emotional distress (i.e. to feel better when they feel bad). For example: someone has a bad day at work; has a minor accident in the car on the way home; arrives home to find the baby is teething and the washing machine has broken down. He or she has a cigarette 'to cope'.

* Enhancing positive emotional states (i.e. to feel even better when they feel good). For example: someone is on the first night of a well-earned holiday; begins to unwind and has a cigarette to mark the beginning of a few days of relaxation.

* Giving in to temptations or urges.

* Responding to social pressure.

Avoiding relapse

People need the skills to cope with these situations and to feel confident that they can do it. Each time someone successfully avoids a

potential relapse their confidence will be increased, making it more likely they will use the strategy successfully next time. People can prepare themselves against such high risk situations when they are in the maintenance stage.

Looking ahead over future weeks they can list situations in which they can foresee wanting to return to the problem behaviour. They can then be helped to develop appropriate coping strategies: using substitutes, controlling the environment and using their supportive, helping relationships. Typical examples are:
* assertiveness skills to cope with social pressure,
* anxiety management or anger management to cope with those negative emotional states,
* support networks to cope with other emotional distresses,
* mood changing strategies to help distract themselves from urges or cravings,
* changes in routine to avoid situations where temptation is great.

'Slips' and relapses

Often people set themselves on a path of strict adherence to a non-smoking lifestyle and then slip from this path on occasion. Many people give up as soon as they slip, believing that they have failed and a complete relapse is inevitable. They then feel guilty and blame themselves. They lose confidence in their coping strategies and it becomes harder for them to get back on the path to a healthy lifestyle. Every relapse begins with a slip but not every slip needs to become a relapse. People can learn to manage their slips and to get straight back on course as quickly as possible. It *is* possible to smoke one cigarette without becoming a smoker again.

Helping people to 'recycle'

Slips and relapses can teach us a lot about our habits and attempts to change. However, we need first to acknowledge that our first response may be disappointment, anger or frustration.

Having acknowledged these feelings, identifying what triggered a slip or a complete relapse can help to clarify what situations are 'high risk' and what sort of coping strategies need to be developed.

It can be helpful to explore:

• Did the person have enough good substitutes to use? Do more need to be developed?

• Does their use of pharmaceutical therapy need reviewing?

• Was there enough support available? Can the existing helping relationships be strengthened or more support engaged?

• Were they giving themselves enough rewards?

• Was the person truly ready and committed to change or was the attempt premature? Is it a good idea to try again yet or is more contemplation and preparation needed?

Similarly, people can learn from successful attempts to avoid slips in high risk situation. These can show which coping strategies work and how skills are developing. This in turn builds confidence.

References

Addiction (1996) Vol 91, Supplement December 1996

PROCHASKA, JO, NORCROSS, JC, DICLEMENTE, CC (1994) *Changing for good. The revolutionary program that explains the six stages of change and teaches you how to free yourself from bad habits.* (New York: William Morrow and Company)

Recycling – Practice Exercise

In pairs, choose one of these case studies to role play. You have about 10 minutes to discuss the relapse and help the client to recycle, then 3-4 minutes to discuss the process.

Client 1	**Client 2**
A young mother visits for ante-natal care. She already has 2 children. The second was low birthweight and is a sickly child. When she found she was pregnant again she gave up smoking for 2 weeks. However she is under stress looking after the 2 infants as well as being pregnant and began smoking again on one particularly difficult day when the baby was ill and the older child was being naughty. She is disappointed as she had wanted to give the expected third baby the best possible start.	A teenage college girl attends for routine care of her asthma which has been generally well controlled for several years. An isolated attack of breathlessness in the gym a month ago frightened her and she gave up her recently acquired smoking habit immediately. However, 3 weeks later, at a party she began smoking again.

Client 3	**Client 4**
A 50 year old man attends a clinic for blood pressure or check and other routine checks following his heart attack 2 years ago. Following medical advice he has cut down his drinking and lost 15 kg in weight. Three months ago he tried to give up smoking too, feeling that, having achieved the other targets, he was ready to try quitting. So far 2 attempts have failed.	You visit an elderly couple, to provide health care for the housebound woman who has emphysema and bronchitis. The husband was smoking 30 a day until recently when he realised that 'passive smoking' was harmful to his wife. He then stopped smoking in the house and reduced his smoking to 5 a day, which he enjoyed when he went out shopping or on other errands. However, gradually this crept back up and instead of waiting until he goes out, now he stands at the door or window to smoke and is back to 30 a day.

Handouts

Why Run Groups?

Smokers who are trying to give up sometimes need more support than can be given in a session of brief advice and one or two follow up sessions. One way of doing this is to run a group for smokers so that they can gain support from each other and receive ongoing information, advice and support over a period of some weeks. The evidence on the effectiveness of intensive smoking cessation support does not strongly favour either individual treatment or groupwork. Some smokers will have a strong preference for one or the other. In some localities groupwork might not be an option for practical reasons. However, if it can be done groupwork is likely to be more *cost-effective* because more smokers can be helped at one time with limited resources.

Groupwork is a well established methodology in a range of health and social care areas and it is useful to consider the basic principles underlying it.

Basic assumptions about groupwork

1. Group experience is universal and an essential part of human existence.

2. Groups can be used to effect changes in the attitudes and behaviour of individuals.

3. Groups provide experiences which can be monitored or selected in some way for beneficial ends.

4. Groups offer experience shared with others so that all can come to have something in common with the sense of belonging and of growing together.

5. Groups produce change which is more permanent than can be achieved by other methods and change which is achieved more quickly also.

6. Groups assist in the removal or diminution of difficulties created by previous exposure to the process of learning.

7. Groups as instruments of helping others may be economical in the use of scarce resources, e.g. skilled workers, time etc.

8. A group can examine its own behaviour and in so doing learn about the general patterns of group behaviour. *(Douglas, 1976)*

Reference
DOUGLAS, T. (1976) *Groupwork Practice,* (London: Routledge)

Handouts

Checklist for Setting Up a Group

When planning a group, complete this checklist to ensure you have considered all the important issues.

1. What is the purpose and what are the objectives of the group?

2. What methods can you use (talk, discussion, buzz groups, role play, pencil and paper exercises etc.)?

3. Is the venue suitable?

4. How frequently will the group meet?

5. How long will each session last?

6. At what time will it meet?

7. How will members be recruited and selected? Who is eligible? What are your exclusion criteria?

8. Is it a closed group or can people join at any time?

9. What will be the contract with the group?

10. What resources do you need to get (including leaflets, equipment etc.)?

11. How many group leaders do you need? If more than one what are their roles? When do they meet to plan and debrief?

12. What style of leadership is required for this group?

13. Will the sessions be recorded? If so, how?

14. Will individual sessions be available for group members as well?

15. How will effectiveness be monitored?

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Running a Stop Smoking Group

The approach to running a group described below evolved from several decades of work, which started in Michael Russell's Maudsley Smokers' Clinic in South London in the 1970s, and continued in this and other clinics to this day. Different people worked with Professor Russell and then moved on and adapted their methods a little, but the basic approach remains similar and has become known in Britain as the 'Maudsley approach'. There has been little research separating the distinct components of what goes on in a group, partly for the very good reason that to do a series of randomised trials on each component, one at a time, would be prohibitively expensive. So although we do not know exactly which are the effective components of this approach we do know that groups, including training in coping skills, mutual support, with or without pharmacological treatment, led by cessation specialists, work. A 'Maudsley' style programme for groups is described below.

Advertising and recruitment

The groups are advertised as widely as possible (in GP surgeries, hospital waiting rooms, clinics, dental practices, local shops, community centres, etc.). There is no reason why clients need to be referred via doctors although that can be one useful route to the service.

Course format and style

Weekly walk-in groups are not run because smoking cessation groups are easier to run if everyone shares the same goal: to stop smoking. Thus a waiting list is built up and a course run when there are enough people to make up a group of smokers all committed to stopping and ready to change. Following this approach about 40 people can be admitted to an introductory session, at which they will learn about the course and how it can help them, and be encouraged to decide if they are ready to try to stop. (Some clinics assess smokers individually and then feed them into groups if they are motivated to stop.) Typically around half will decide they are not ready, leaving about 20 – 25 smokers who return the following week to start the cessation part of the course. A typical course comprises this introductory session, then 4 sessions at weekly intervals. There can be a longer (but not too long) gap between the introductory session and the beginning of the stopping sessions. Follow up 2, 3 and 6 months after starting the course is ideal if resources permit.

Small groups (5-10) can present problems. With groups this small, if after a couple of weeks several drop out, the group can dwindle to just a few people, none of whom may have succeeded in stopping. This can be demoralising for smokers and the leader. Large groups of 20-25 smokers are hard work initially, but can be very rewarding and effective once established. They cannot be run didactically with the leader controlling the conversation and telling the participants what to do. The leader's role is to facilitate, help build self-help skills and networks within the group, make general points and give information. The first task is to build group cohesiveness so that group members feel comfortable with each other. When this works well the group naturally breaks up into sub-groups, the room becomes very noisy and, because the leader is not trying to 'control' the proceedings and have all conversation channelled through him or her like a 'chairperson' he or she is free to circulate and give each sub-group or individual more attention. Groups this large are also guaranteed to produce some early successes, and these will motivate other group members.

Initial introductory session

Between 90 and 120 minutes are allowed for the introductory session. After the welcome each member of the group is invited to introduce his or herself and say a few words about their smoking and wish to stop.

A booklet on how to stop is distributed as well as a leaflet explaining the nature of the course and the principles on which it runs. Group leaders explain that the course is based on the ideas that smoking is a habit and an addiction, and smoking is a process and a choice. They refer to the cycle of change and to the evidence that most smokers try several times to stop before finally succeeding. The idea and use of the word 'failure' is discouraged and the importance of the process of 'commitment' emphasised.

A handout on the decisional balance is given out and smokers are invited to fill in the columns headed: *Reasons for stopping* and *Reasons for continuing*. Group leaders initiate discussion on where each smoker is in the cycle of change. If some are not ready they are given an opportunity to explore their beliefs about the health risks and given a handout or booklet. A video may be shown and group leaders discuss the nature of the risks as required. Smokers are given the space to make their own decisions.

Smokers who want to try to stop are helped to resolve their questions and concerns, for example: 'Will I gain weight?' or 'What about coping with stress?' Since most of the time smokers are not with a cessation advisor, the course is built around booklets and leaflets that can be made available to smokers and to which they can refer at all times.

Carbon monoxide (CO) monitoring can be extremely valuable in giving smokers feedback on their actual smoke intake. In the group setting if there are 2 leaders one can measure CO levels while the other runs the group. Alternatively they can be measured at the end as the group breaks up. People can also be taught to measure their own levels.

Second and subsequent sessions

The second and subsequent sessions run for around 90 minutes and are for those who are ready to try and stop smoking. Those people who have committed themselves to continuing in the group are welcomed, and there is a brief round of names and comments on how the last week or so has gone. Although the first session was actually to help people decide if they were ready to join a stop smoking group, some will have been ready and will have stopped in the intervening period. Their experience is a valuable resource and motivating for other members.

Discussion focuses on the basic elements of their action plans, reviewing the experience of the last week or so, drawing out the experiences of those who have already stopped and seeking experiences and views on NRT and buropion. After describing how to build an action plan the leader splits the group into small sub-groups to help each other develop personalised action plans. Those who have already stopped may be placed one in each group. CO monitoring takes place and the leaders circulate giving individual help as needed.

The sub-groups are brought back into plenary about 15 minutes before the end to review progress and discuss general questions that have arisen such as:
- Is it worth stopping?
- Will I put on weight?
- Does smoking help me cope with stress?
- What if I haven't got any willpower?
- What are withdrawal symptoms and how long will they last?

Discussion also focuses on practical issues such as:
- Action plans
- Planning ahead and anticipating problems
- Avoiding problem situations and finding alternatives
- Cutting down gradually or stopping suddenly
- Setting a date and time
- Keeping cigarettes or getting rid of them
- Telling other people or keeping quiet
- Choosing the right day
- Getting support
- Planning rewards
- NRT, buropion and other treatment aids.

Group Members – Case Studies

Consider the following situations that arise amongst members of a smoking cessation group and discuss what you would do if you were running the group. Begin with the scenario allocated to your group by the tutor and then discuss the others as time allows.

Smoker 1
In the group is a woman in her thirties who seems lacking in confidence and low in self-esteem. She has said she is living alone with her mother who she describes as 'difficult'. She seems mildly depressed with life in general. She comes up after the first group to ask you what you think; she says she would really like to stop but doesn't think she could manage it at the moment. What do you ask her? What do you advise her?

Smoker 2
A young woman has joined the group saying she does not want to stop but wants to cut down. In the second session she tells the group that she has not cut down yet but will do so when she is ready. She says she will be able to stop easily once she decides to do so. Another group member begins to question why she has joined the group and other people seem irritated by her statement. How do you handle it?

Smoker 3
At the end of the introductory session a man of about 50 comes to talk to you. He is a senior civil servant on a waiting list for heart bypass surgery. The surgeon has told him, not only that he must stop smoking but that if he does not stop he will not get the operation. Although he wants to stop he seriously doubts his ability to do so. He looks as if he badly needs the operation: his skin is pallid and grey and he seems permanently tired. He asks if you will tell the surgeon if he fails to stop. What do you say?

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WHO Evidence Based Recommendations on the Treatment of Tobacco Dependence for Health Care Systems in Europe

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World Health Organization European Partnership Project to Reduce Tobacco Dependence

About these recommendations

These recommendations on treatment of tobacco dependence have been written by Martin Raw as an initiative of the WHO European Partnership Project to Reduce Tobacco Dependence. The recommendations were commissioned by the World Health Organization and have drawn on the experience of a number of European countries, including the four original target countries of the WHO European Partnership Project to Reduce Tobacco Dependence, France, Germany, Poland and the United Kingdom.

The recommendations were discussed in two European WHO meetings on evidence-based treatment in London in November 1999 and in Barcelona in October 2000. They were revised in light of feedback at and following those meetings, as well as feedback from a wide variety of individuals and organizations, including the professional associations that have endorsed them.

As these are evidence-based recommendations and this is a rapidly developing field, the recommendations will need periodic updating. Comments are thus welcome, as are organisations that would like to add their name to the list of endorsers.

It is recognised that individual countries will translate and adapt these recommendations to suit their own terminologies and healthcare systems, but it is hoped that throughout this process countries will stay as close as possible to the evidence base.

Professional endorsement

At the time of going to press the following organizations have endorsed these recommendations: European Medical Association on Smoking or Health, European Nurses and Midwives Against Tobacco, Europharm Forum, The European Review Group on Prevention and Health Promotion in Family Medicine and General Practice (EUROPREV); ASH England, ASH Scotland, British Medical Association, Comité Nacional de Prevención del Tabaquismo (Spain), Czech Medical Association, Danish Medical Association, Dentistry against Tobacco (Sweden), Georgian Medical Association, Norwegian Medical Association, Swedish Medical Association, Quit (UK), Slovenian Medical Association, World Self-Medication Industry.

Acknowledgements

Introduction

Terminology

Tobacco dependence treatment includes (singly or in combination) behavioural and pharmacological interventions such as brief advice and counselling, intensive support, and administration of pharmaceuticals, that contribute to reducing or overcoming tobacco dependence in

individuals and in the population as a whole. A smoking cessation specialist is someone trained and paid to deliver skilled support to smokers who need help in stopping, over and above brief opportunistic advice. They need not be medically trained but should not be offering this support unpaid and squeezed into their normal work, as the evidence suggests this is not effective.

Why these recommendations are timely

Tobacco dependence is recognized as a condition in the WHO's International Classification of Diseases (ICD-10) (1) and the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV) (2). In Europe millions of smokers want to stop smoking and many have tried to do so but have difficulty succeeding because tobacco use is such a powerful addiction (3). Although the majority of cessation attempts are unaided, the success rate of these unaided attempts is low. Smoking is a chronically relapsing condition, and even in the general population of smokers trying to stop, the relapse rate is high. The natural population cessation rate, measured over a long period in one country where the tobacco control movement is long established, is only about 2% each year (3).

Tobacco use is recognized as a major cause of lung cancer, cardio-vascular disease, and chronic obstructive lung disease (including bronchitis and emphysema) and causes 1,200,000 deaths each year in WHO's European region (14% of all deaths). Unless more is done to help the 200 million European adult smokers stop, the result will be 2,000,000 European deaths a year by 2020 (4).

Support and treatment to help smokers stop is one of a range of approaches to tobacco control. It is an issue not just for individual health professionals in their work with smokers, but for the entire healthcare system. It complements other approaches (like policies to tax tobacco products, restrictions on their use and advertising, regulation of their contents and labelling, public information and education) but

addresses a specific group: those who want to stop and need help (5). However it is acknowledged that education remains crucially important in informing smokers about the dangers of smoking and motivating them to stop, and in many countries health education campaigns are conducted by the health care system. Furthermore, preventive approaches with young people, if effective, prevent disease 30-50 years in the future, whereas smoking cessation in current adult smokers brings population health gain more quickly, over 20 to 30 years. (6)

However, support and treatment to help smokers stop is not yet widely available. It is generally not integrated into European healthcare systems, although some countries are now making a start. Paradoxically, in contrast to the restricted availability of help for smokers in stopping (including pharmaceutical products designed to alleviate tobacco withdrawal), the tobacco products whose use causes the enormous burden of death and disease described above are extremely widely available.

Purpose of these recommendations

These recommendations propose the core interventions that should be integrated into heathcare systems, interventions that have been shown to work by a large and consistent international body of evidence. They are deliberately brief and general, rather than comprehensive, and detail should be sought from the reviews and guidelines they draw on (see below). This is because there is such a diversity of social and healthcare systems throughout Europe, including different regulatory and pharmaceutical treatment product licensing regimes. We hope each country will use these core evidence based recommendations as a skeleton on which they will add their own country specific detail. Because the recommendations are brief, they need to be read bearing in mind the context set out in this introduction. They also cover the roles of individual health professionals working to help and treat smokers as well as the roles of the wider healthcare system. This is important as public health impact will be a result not only of individual clinical effectiveness but also

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of coverage – hence the importance of engaging the entire system locally, nationally and internationally.

Scientific basis and review process

These recommendations reflect a global movement towards evidence-based medicine, and reflect the fact that an increasing number of countries are adopting evidence-based guidelines for the treatment of tobacco dependence. A number of authoritative reviews and guidelines have been used as the basis for these recommendations: US DHHS Public Health Service Clinical Practice Guideline Treating tobacco use and dependence, 2000 (7); Conclusions: Smoking Cessation Methods, National Institute of Public Health and Swedish Council on Technology Assessment in Health Care, Sweden (1998) (8); Conclusions and Recommendations of the Consensus Conference, France (1999) (9); Smoking cessation guidelines for health professionals: an update, England, 2000 (10); the Cochrane Library Systematic Reviews (11). These reviews and guidelines draw on hundreds of well controlled trials, and emphasize not only that treatment for tobacco dependence is effective, but also that it is extremely cost effective: Guidance for Commissioners on the Cost Effectiveness of Smoking Cessation Interventions, England, 1998 (12); Curbing the Epidemic. Governments and the Economics of Tobacco Control, 1999 (13).

These WHO recommendations are complemented by a WHO report on the regulation of tobacco dependence treatment products, which emerged from a meeting held in Helsinki in October 1999. The Helsinki report notes the contrast between the easy availability of tobacco products and tobacco dependence treatment products, which are much harder to obtain, and urges the development of regulatory approaches which will redress this imbalance. (5)

The evidence supports the development of three main types of intervention for health care systems: brief opportunistic interventions delivered by health professionals in the course of their routine work; more intensive support delivered by treatment specialists, often in what have been called 'smokers clinics'; pharmacological aids, which approximately double cessation in minimal or more intensive settings. The principal aids in the last category are nicotine replacement therapy (NRT) and bupropion, which is now widely available in Europe. NRT can in Europe be found on prescription, over-the-counter and on general sale. Bupropion is a prescription only medicine.

Although the evidence base is stronger for some health professionals than others, 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 professional discipline. Thus the recommendations for health professionals are relevant for all health professionals and not only those based in primary care. The essential features of individual smoking cessation advice have been described as the four As: ask (about smoking at every opportunity); advise (all smokers to stop); assist (the smoker to stop); arrange (follow-up). (14). The updated US guideline has introduced a new A in between advise and assist: assess willingness to stop. (7)

It is hoped that periodically, as new evidence becomes available, as well as experience gained from the implementation of these recommendations, they will be revised and updated.

Recommendations

1) Recommendations for brief interventions

As part of their normal clinical work, health professionals should provide brief interventions including the following essential features:

Ask about and record smoking status, keep record up to date;
Advise smokers of the benefit of stopping in a personalised and appropriate manner (this may include linking the advice to their clinical condition);

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Assess motivation to stop;
Assist smokers in their stop attempt if possible; this might include the offer of support, recommendation to use NRT or bupropion and accurate information and advice about them, referral to a specialist cessation service if necessary;
Arrange follow up if possible.

If help can be offered a few key points can be covered in a few minutes:

set a stop day and stop completely on that day
review past experience and learn from it (what helped? what hindered?)
make a personalised action plan
identify likely problems and plan how to cope with them
ask family and friends for support

Smoking and smoking cessation should be part of the core curriculum of the basic training of all health professionals.

2) Recommendations for smoking cessation specialists

The health care system should offer treatment as back up to brief opportunistic interventions for those smokers who need more intensive support. This support can be offered individually or in groups, and should include coping skills training and social support. A well-tested group format includes around five sessions of about one hour over about one month with follow-up. Intensive support should include the offer of or encouragement to use NRT or bupropion (as appropriate) and clear advice and instruction on how to use them.

3) Pharmacotherapies

At the moment the principal aids in this category are nicotine replacement therapy (NRT) and bupropion. There are currently six NRT products: patch, gum, nasal spray, inhalator, tablet, lozenge. Smokers of 10 or more cigarettes a day who are ready to stop should be encouraged to use NRT or bupropion as a cessation aid. Health professionals who deliver

smoking cessation interventions should give smokers accurate information and advice on these products. In Europe NRT can be found on prescription, over-the-counter and on general sale. Bupropion is a prescription only medicine and on current evidence should remain so. Evidence on the effectiveness of bupropion is currently limited to medium to heavy smokers receiving behavioural support.

4) Recommendations for specific groups

Treatment research has tended to focus on health professionals such as doctors (especially in primary care), nurses, midwives, pharmacists, and smoking cessation specialists. However advising and supporting smokers in stopping is an activity for the whole health care system and should, eventually, be integrated into as many settings as possible throughout the system. This includes hospital and community settings. However in many countries there is still high smoking prevalence among health professionals, so in addition to the education and training recommended below, health professionals should where appropriate be targeted for help in stopping smoking.

Hospital staff should ask about patients' smoking status prior to or on admission, offer brief advice and assistance to those interested in stopping. Patients should be advised of the hospital's smoke free status before admission. Hospital patients who need it should also be offered NRT or bupropion.

Healthcare premises and their immediate surroundings should be smoke free.

Pregnant smokers should receive clear and accurate information on the risks of smoking to the fetus, and be advised to stop smoking. They should be offered specialist support to stop.

Cessation interventions shown to be effective with adults should be considered for use with young people, with the content modified as necessary.

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5) Recommendations for health care purchasers and systems

Purchasing treatment for tobacco dependence represents an extremely cost effective way of reducing ill health and prolonging life. Health care purchasers should purchase tobacco dependence treatments, choosing a blend of interventions relevant to local circumstances but emphasising those interventions which have the strongest evidence base.

Because tobacco dependence treatment is so cost effective, it should be provided by public and private health care systems. Access to both behavioural and pharmaceutical treatments should be as wide as possible with due regard to local regulatory frameworks and other circumstances. Mechanisms should be found to increase the availability of treatment to low-income smokers, including at a reduced cost or free of charge.

Health professionals should be trained to advise and help smokers stop smoking, and health care purchasers should ensure the provision of adequate training budgets and training programmes. Education and training for the different types of interventions should be provided not only at the post-graduate and clinical level, but should start at under-graduate and basic level, in medical and nursing schools and other relevant training institutions.

Telephone help lines can be effective and are very popular with smokers. Although more research is needed on their effectiveness, they seem likely to provide a valuable service to smokers and should be made available where possible.

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