

## Section IA: Counseling and Psychosocial Recommendations

### 1. Screening and Assessment

#### *i. Screen for tobacco use*

SUMMARY: All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis.

US: All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increases rates of clinician intervention. (Strength of Evidence = A)

NZ: Ask about and document smoking status for *all* patients. For people who smoke or have recently stopped smoking, the smoking status should be checked and updated on a regular basis. Systems should be in place in *all* health care settings (medical centres, clinics, hospitals, etc.) to ensure that smoking status is accurately documented on a regular basis. (Grade = A)

UK: (For primary care teams and all health professionals) Assess the smoking status of patients at every opportunity; advise all smokers to stop; assist those interested in doing so; offer follow up; refer to specialist cessation service if necessary. (Strength of Evidence = B)

#### *ii. Specialized assessment*

SUMMARY: Clinicians should assess patient's willingness to quit and level of tobacco dependence.

US: Once a tobacco user is identified and advised to quit, the clinician should assess the patient's willingness to quit at this time. (Strength of Evidence = C)

US: Tobacco dependence treatment is effective and should be delivered even if specialized assessments are not used or available. (Strength of Evidence = A)

FR: The Fagerstrom test for nicotine dependence should be used systematically to evaluate the intensity of pharmacological dependence on nicotine. (Grade = A)

FR: It is possible to use the simplified version of the Fagerstrom test for nicotine dependence (only items 1 and 4) for practical reasons. (Professional consensus)

### 2. Treatment Structure and Intensity

#### *i. General*

UK: (For smoking cessation specialists) Intensive smoking cessation support should where possible be conducted in groups, include coping skills training and social support, and should offer around five sessions of about one hour over about one month, and follow up. (Strength of Evidence = A)

UK: (For smoking cessation specialists) Intensive smoking cessation support should include the offer of or encouragement to use NRT, and clear advice and instructions on how to use it. (Strength of Evidence = A)

**ii. *Advice to quit smoking***

SUMMARY: All physicians and other health care workers should strongly advise all patients who smoke to quit and provide brief advice.

US: All *physicians* should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A)

NZ: All doctors should provide brief advice to quit smoking at least once a year to *all* patients who smoke. (Grade = A)

NZ: All other health care workers should also provide brief advice to quit smoking at least once a year to *all* patients who smoke. (Grade = B)

NZ: Record the provision of brief advice in patient records. (Grade = C)

**iii. *Intensity of clinical interventions***

SUMMARY: Every tobacco user should be offered at least a minimal intervention; however more intensive interventions of four or more sessions are more effective.

US: Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A)

US: There is a strong dose-response relation between the session length of person-to-person contact and successful treatment outcomes. Intensive interventions are more effective than less intensive interventions and should be used whenever possible (Strength of Evidence = A)

US: Person-to-person treatment delivered for four or more sessions appears especially effective in increasing abstinence rates. Therefore, if feasible, clinicians should strive to meet four or more times with individuals quitting tobacco use. (Strength of Evidence = A)

NZ: Aim to see people for at least four cessation support sessions. (Grade = A)

**iv. *Type of clinician***

SUMMARY: Treatment should be delivered by a variety of clinician types and by multiple clinicians who are trained in evidence-based smoking cessation practices.

US: Treatment delivered by a variety of clinician types increases abstinence rates. Therefore, all clinicians should provide smoking cessation interventions. (Strength of Evidence = A)

US: Treatments delivered by multiple types of clinicians are more effective than interventions delivered by a single type of clinician. Therefore, the delivery of interventions by more than one type of clinician is encouraged (Strength of Evidence = C)

NZ: Health care workers providing evidence-based cessation support (that is, more than just brief advice) should seek appropriate training. (Grade = C)

NZ: Health care workers trained as smoking cessation providers require dedicated time to provide cessation support. (Grade = C)

**v. *Format of psychosocial treatments***

SUMMARY: Telephone counseling, face-to-face counseling (both group and individual) and tailored self-help materials are all effective formats of psychosocial treatments and should be used in smoking cessation interventions.

US: Proactive telephone counseling, group counseling, and individual counseling formats are effective and should be used in smoking cessation interventions. (Strength of Evidence = A)

US: Smoking cessation interventions that are delivered in multiple formats increase abstinence rates and should be encouraged. (Strength of Evidence = A)

US: Tailored materials, both print and Web-based, appear to be effective in helping people quit. Therefore, clinicians may choose to provide tailored self-help materials to their patients who want to quit. (Strength of Evidence = B)

NZ: Offer telephone counseling as an effective method of stopping smoking. People who smoke can be directed to Quitline (tollfree: 0800 778 778). (Grade = A)

NZ: Providing face-to-face smoking cessation support either to individual patients or to groups of smokers is an effective method of stopping smoking. (Grade = A)

NZ: Make self-help materials available, particularly those that are tailored to individuals, but such materials should not be the main focus of efforts to help people stop smoking. (Grade = √)

**vi. *Follow up assessment and procedures***

SUMMARY: Follow ups should be conducted regularly to assess abstinence at the completion of treatment and during subsequent contacts to assess adherence to treatment.

US: All patients who receive a tobacco dependence intervention should be assessed for abstinence at the completion of treatment and during subsequent contacts. (1) Abstinent patients should have their quitting success acknowledged, and the clinician should offer to assist the patient with problems associated with quitting. (2) Patients who have relapsed should be assessed to determine whether they are willing to make another quit attempt. (Strength of Evidence = C)

FR: Carbon monoxide measures are useful for reinforcing the motivation of the patient to stop, since it drops to normal levels after 1 day of withdrawal. (Professional consensus)

### 3. Treatment Elements

**i. *Types of counseling and behavioural therapies***

SUMMARY: Behavioural and cognitive therapy is validated and recommended for smoking cessation interventions.

US: Two types of counseling and behavioural therapies result in higher abstinence rates: (1) providing smokers with practical counseling (problem-solving skills/skills training), and (2) providing support and encouragement as part of treatment. These types of counseling elements should be included in smoking cessation interventions (Strength of Evidence = B)

FR: Behavioural and cognitive therapy is validated and recommended for smoking cessation should emphasize the control of environmental cues that may trigger relapse and factors such as stress or tempting situations. (Grade A)

**ii. *Combining counseling and medication***

SUMMARY: Multiple sessions of counseling combined with medication increase the chances of a successful quit.

US: The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible

and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A)

US: There is a strong relation between the number of sessions of counseling, when it is combined with medication, and the likelihood of successful smoking cessation. Therefore, to the extent possible, clinicians should provide multiple counseling sessions, in addition to medication, to their patients who are trying to quit smoking. (Strength of Evidence = A)

*iii. For smokers not willing to make a quit attempt at this time*

US: Motivational intervention techniques appear to be effective in increasing a patient's likelihood of making a future quit attempt. Therefore, clinicians should use motivational techniques to encourage smokers who are not currently willing to quit to consider making a quit attempt in the future. (Strength of Evidence = B)

OMA: Smokers who cannot imagine being without their cigarette should try using NRT to take a "cigarette holiday." Over time, these smokers should attempt to gradually extend the duration of these cigarette-free periods. (No Grade)