Section 3
One-On-One Smoking Cessation Intervention

Introduction

This chapter is relevant to a broad range of people who work with women. As a nurse, teacher, women's centre volunteer, physician, midwife or other service provider, you can make a difference with brief, immediate smoking cessation interventions that are based on techniques that work.

Most women smokers, including those living on low incomes, want to quit. Health care providers and others working with these women play an important role in enabling them to stop smoking. Repeated, one-on-one interventions that combine emotional support, counselling, skills training, and educational and self-help materials have been shown to be effective. At the same time, it is important to accept that brief interventions are unlikely to achieve immediate success. Smoking cessation is a process; it can take numerous serious attempts (an average of five - seven) before a woman quits permanently. Each time, she learns new skills that will assist her in her next attempt.

Although this section focuses on a one-on-one intervention, most of the concepts from the group program are applicable and adaptable to a one-on-one intervention.

After you have reviewed the information in this chapter, you will need to adapt it to your clients' needs and your situation. Working with different types of women may require gathering additional information or emphasizing different aspects of the cessation process. If, for example, you work with aboriginal women, you and your client may need to talk about smoking within the cultural context of her community. When discussing cessation and second-hand-smoke with a recent immigrant to Canada, you may want to learn more about her concept of family roles before suggesting an intervention.

Chapter 1
The Intervention Process

Types and Benefits of One-On-One Interventions

One-on-one interventions are usually distinguished by the length of time involved in the intervention.

A minimal smoking cessation intervention lasts one to three minutes and is provided during the natural flow of activities in a clinical or community setting. There is good evidence that even brief advice from health professionals has a significant effect on smoking cessation rates, decreasing the proportion of people who smoke by about two percent per year. Minimal interventions are cost-effective. They may encourage a committed smoker to think about the disadvantages as well as the benefits. Therefore, they should be provided to all tobacco users at EVERY appropriate occasion. For example, healthcare personnel should treat smoking as a standard assessment question at every visit, recording current use, history and amount.

An intensive smoking cessation intervention lasts more than 10 minutes and should be carried out by health professionals and other trained people when their knowledge and time enables them to do so. Increasing the intensity (time spent and duration of follow-up) improves the effectiveness of the intervention, decreasing the proportion of smokers by approximately three to five percent. Intensive interventions are sometimes carried out as part of a routine clinical or community activity (for example, as part of the interaction between a nurse and client in hospital). In other cases, smokers are referred to a trained counsellor for specific sessions on smoking cessation. Trials have shown that about one in 13 smokers who are motivated enough to attend individual counselling with a smoking cessation counsellor are likely to quit as a result. While more costly than minimal interventions, intensive interventions are appropriate for all smokers who are willing to participate. They are especially recommended for pregnant women and clients with other chemical dependencies, psychiatric disorders and health problems such as cardiovascular disease.

Telephone quit-lines provide a low-cost way to provide counselling or advice to motivated smokers, although they are less effective than face-to-face encounters. Proactive follow-up telephone calls may be especially useful at helping smokers quit. A 2003 Cochrane review found that a call from a counsellor is likely to increase the chances of quitting relatively around fifty percent or absolutely by two to four percentage points, compared with providing standard self-help materials.

There is evidence that self-help materials (print, videos and CDs) alone are of some benefit. The Cochrane review (a review of evidence-based literature) did not find evidence that self-help materials produce incremental benefits over advice from a healthcare professional or nicotine replacement therapy. However, materials that are tailored for individual smokers have a positive effect. While acupuncture and hypnotherapy are popular, there is little evidence to support their effectiveness. However, if an individual has faith in one of these therapies, they may benefit from the counselling that these approaches offer.

The most effective method to help smokers quit is to combine pharmacotherapy with advice and behavioural support. Pharmacological options approximately double the long-term abstinence rates over those produced by

* All references can be found in Section 1, Appendix B.

placebo interventions. As part of tobacco-dependence treatment, NRT and bupropion should be considered first as they have been proven to significantly improve cessation rates.

In addition to helping her overcome a powerful addiction, the skills your client learns when she quits smoking can assist her in other aspects of her life. For example, some women who quit smoking report having a greater sense of control in their lives, higher self-esteem, and being less afraid to be assertive. Moreover, they possess better planning and behaviour modification skills, and have increased knowledge about all aspects of their health.

The Intervention Process—An Overview

The one-on-one intervention process described here consists of three components.

1. An effective approach to counselling. Effective counselling involves asking open-ended questions, listening empathetically and using other motivational techniques that are described in this chapter.

2. An assessment and intervention framework based on the Stages of Change Model. The basic premise of this model is that people who quit smoking go through a series of five successive stages. Smokers at each stage have unique needs for support. By understanding where a woman is in the change process, you can create interventions that will be more relevant and effective for her.

3. An intervention process based on the 4A's. Your intervention consists of four steps: ask, advise, assist and arrange. The ASK step discusses when and how to ask about your client's smoking, and how to assess her readiness to quit. The ADVISE step discusses how to offer her support for quitting, depending on her level of readiness. The ASSIST step discusses how to intervene effectively with your client, how to develop a personal cessation plan, obtain partner and family support, and prevent relapses. The ARRANGE section discusses possible follow-up or referral options.

1. An Effective Approach to Counselling

There is an enormous body of literature on counselling and people who wish to engage in intensive counselling need to study a variety of sources. At the same time, there are a number of underlying principles for effective counselling that can be applied in one-on-one interventions for smoking cessation. Some of these are based on the concepts of adult education and a woman-centred approach. Others are based on what we have learned about motivational interviewing techniques that have been successfully used to effect behaviour change in one-on-one interventions, most notably in the areas of drug and alcohol use.

Motivational interviewing (MI) is a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence. The assumption in MI is that ambivalence or lack of resolve is the principal obstacle to be overcome in triggering change. Once that has been accomplished, there may or may not be a need for further interventions, such as skill training.

The spirit of the method can be characterized in a few key points:

- ✧ Motivation to change comes from the client, and is not imposed from outside.
- ✧ It is the client's task to articulate and resolve her ambivalence. The counsellor's task is to facilitate expression and guide the client toward a resolution that triggers change.

- ✧ Direct persuasion is not an effective method for resolving ambivalence. Persuasion tactics generally increase client resistance.
- ✧ The counselling style is generally quiet and probing.
- ✧ The counsellor is directive in helping the client to examine and resolve ambivalence.
- ✧ Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction. Client resistance is often a signal that the counsellor is assuming greater readiness to change than is the case.
- ✧ The therapeutic relationship is more like a partnership or companionship than expert/recipient roles.

The research related to motivational interviewing suggests the use of several general principles in effective counselling:

Listen well and express empathy
When clients feel that they are understood, they are more able to open up to their own experiences and share them with others. Listening empathetically will create a safe, warm and trusting atmosphere for your conversations. This will help your client feel comfortable exploring key issues in her life and hopefully, understanding smoking as a symptom of those issues. Reflective listening focuses on change talk and pays less attention to non-change talk. For example, "You are not quite sure you are ready to make a change, but you are aware that smoking has caused some of your health problems." A good rule of practice is a ratio of three reflections for every question asked.

Summarize. Summaries are a specialized form of reflective listening where you reflect back to the client what she has been telling you. A summary begins with an announcement that you are about to summarize and is then followed by a listing of selected elements, an invitation to correct anything missed and then an open-ended question. For example, "I am hearing you say that smoking gives you a chance to get away from the noise and confusion of the kids and have some space of your own. Am I interpreting it right? How would you feel about taking that space without a cigarette?" If ambivalence was evident in the interaction that preceded the summary, this should be included in the summary.

Support self-efficacy. Help your client believe that she can successfully make a change. For example, you might inquire about other healthy changes she has made in her life, and highlight skills she already has. Use affirmations or statements that recognize a client's strengths. For example, "So you quit smoking for a week after your last visit. How were you able to do that?" Resistance can also be used as a source for affirmations. For example, "You didn't want to come today, but you did it anyway. It seems like that if you decide something is important enough, you are willing to put up with a lot to do it."

Roll with resistance. Do not fight resistance; instead, use the client's "momentum" to further explore her views. Ask open-ended questions that avoid pat "yes or no" answers and require your client to reflect upon your questions, think about the implications of her answers, and discover new understandings about the role of smoking in her life. For example, "It sounds like you've given up trying to convince your mother not to smoke in your house. How do you feel about that?"

Develop Discrepancy. Help your clients examine the discrepancies between their current behaviours and future goals. When people perceive that their current behaviours are not leading toward some important future goals,

they become more motivated to make further changes. For example, "I am hearing a bit of a disconnect between your goal to not smoke in the car and your habit of lighting up in the car when you feel tense. How do you explain that?"

Reframe. Reframing is a strategy in which you invite clients to examine their perceptions in a new light. For example, if a client reports a spouse or loved one as saying, "You really need to get in treatment and deal with your smoking," the client may view this as "he's such a nag" or "he is always telling me what to do." The counsellor can reframe this as "this person must care a lot about you to tell you something he feels is important to you, knowing that you will likely get angry with him."

2. Overview of the Stages of Change

The Stages of Change Model was developed by Prochaska and DiClemente to explain how people change their behaviour naturally (see Section 1 for additional information on the model). Many people who work in tobacco reduction use the model to identify where people are in the quitting process. Most people go through five stages in the quitting process:

1. **Pre-contemplation** – At this stage they are not thinking about quitting smoking in the near future.
2. **Contemplation** – They are beginning to seriously think about quitting smoking in the near future (next six months).
3. **Preparation** – At this stage most people have tried to quit smoking at least once in the past year, and they are thinking about quitting again within the next month.
4. **Action** – Real steps are being actively taken to quit smoking. This is the stage where a slip is most likely to occur.
5. **Maintenance** – During this final stage people are better able to avoid returning to smoking and they also know that a slip at this point is not a failure, but a mistake they will learn from and get past.

People can move from one stage to another in order, but they can also move back and forth between the various stages before they quit for good. Again, a slip is not a failure, but an important part of the learning and quitting process. Most smokers try to quit several times before they succeed and the chance of success increases every time they try to quit.

Assessing the Client's Stage of Change

When you ask a client, "Have you quit smoking cigarettes?" here are some answers that can help you to determine where she is in the stages of change process:

If she answers:

- ✧ Never smoked, or quit for at least five years. >Skip the following
- ✧ Yes, I have for more than six months. > Defines maintenance
- ✧ Yes, I have, but for less than six months. >Defines action
- ✧ No, but I plan to in the next 30 days and have tried in the past year. >Defines preparation
- ✧ No, but I plan to in the next six months. > Defines contemplation
- ✧ No, and I do not plan to in the next six months. >Defines pre-contemplation.

3. The 4A's
Ask, Advise, Assist, Arrange

Overview of the Protocol

Both minimal and intensive interventions involve the use of the 4 A's.

Minimal Smoking Cessation Intervention (1 to 3 minutes)

- ✧ ASK: about tobacco use with all clients (e.g., non-smoker, smoker, ex-smoker) and assess readiness to quit.
- ✧ ADVISE: every tobacco user of the importance of quitting.
- ✧ ASSIST: provide referral to community resource, self-help material, referral to other healthcare provider and/or smokers' telephone quit-line.
- ✧ ARRANGE: follow-up or referral.

Intensive Smoking Cessation Intervention (More than 10 minutes)

- ✧ ASK: about tobacco use with all clients (e.g., non-smoker, smoker, ex-smoker) and assess readiness to quit.
- ✧ ADVISE: every tobacco user of the importance of quitting.
- ✧ ASSIST: determine and discuss the stage of change, reasons for smoking, nicotine dependence, pharmacotherapy options. Review quitting history and set a quit date. Review potential challenges and triggers, and encourage support of family and friends.
- ✧ ARRANGE: follow-up or referral.

Combining the 4 A's with the Stages of Changes Model

Here are some intervention guidelines to use after you have determined the stage of change your client is in.

Pre-contemplation

The client is unaware or unwilling to change, and not thinking of quitting in the next 6 months. Your goal is to help her begin to think seriously about quitting

What to do

- ✧ ASK about her feelings about smoking and discuss the impact and role of smoking in her life.
- ✧ ASK about the pros and possible cons of smoking.
- ✧ ADVISE by linking health problems and smoking.
- ✧ ASSIST by providing relevant information and offering further assistance.
- ✧ ARRANGE to discuss further at next meeting.

Contemplation

The client is ambivalent, but thinking about quitting within six months. Your goals are to help her move towards a decision to stop smoking and to feel more confident.

What to do

- ✧ ASK about the pros and cons of continuing to smoke and quitting. Acknowledge her ambivalent feelings.
- ✧ ASK about her concerns about quitting and discuss ways of dealing with them.
- ✧ ASSIST by asking her to fill out a decision balance sheet listing the pros and cons of smoking.
- ✧ ASSIST by reinforcing her reasons for change, and exploring new ones.
- ✧ ADVISE by suggesting she cut back, or stop for a day, or keep her house or car smoke free.
- ✧ ASSIST by providing relevant information
- ✧ ARRANGE to discuss further at next meeting or refer her to a community program or counsellor.

Preparation

The client is getting ready to stop within the next 30 days. She has set a stop smoking date and likely has quit before for at least 24 hours. Your goal is to help her prepare for her quit date and anticipate success.

What to do

- ✧ ASK about concerns, preparations and lessons learned from previous attempts.
- ✧ ASK about other smokers and levels of social support. Encourage her to seek help from family and friends.
- ✧ ADVISE by helping her identify barriers to stopping and discussing solutions.
- ✧ ADVISE by assessing nicotine dependence and recommending pharmacological options.
- ✧ ASSIST her in selecting the best approach to quitting.
- ✧ ASSIST by helping her develop an action plan and set a quit date.
- ✧ ADVISE that slips are normal and do not mean a relapse.
- ✧ ASSIST by providing relevant information.
- ✧ ARRANGE to discuss further at next meeting or refer her to an intensive counsellor.

Action

The client has quit smoking within the past 6 months and is actively applying cessation skills. Your goal is to help her stay off tobacco products and recover from relapses.

What to do

- ✧ Congratulate her!
- ✧ ASK how she is doing: relapses, temptations, successes, use of medications, etc.
- ✧ ADVISE re: relapse prevention, weight gain, triggers.
- ✧ ASSIST by focusing on successes, encouraging self rewards and increasing support from others.
- ✧ ASSIST by providing reassurance and relevant information.
- ✧ ARRANGE to discuss further at next meeting or refer her to an intensive counsellor.

Maintenance

The client has quit for more than 6 months and integrated smoke-free living into her routine. Your goal is to help her remain smoke-free for a lifetime.

What to do

- ✧ ASK how the client is doing: risk situations, relapses, etc.
- ✧ ASK her to reflect on situations that might still trigger relapse and how she can prevent this.
- ✧ ASSIST by offering suggestions for difficult times; provide support and encouragement.
- ✧ ASSIST by providing relevant information.
- ✧ Congratulate her!

Some Common Counselling Mistakes

Asking dead-ended questions: Asking open-ended questions is a lot harder than it sounds, especially at first. Most professionals are trained to ask for facts. Our questions often require little more than a yes or no response. Your goal in a smoking cessation intervention is to enable the client to listen carefully to her own thinking about smoking and the role it plays in her life. In order to achieve this, we must ASK questions that encourage reflection and details, not simply yes and no answers. Words and phrases such as "I'd like to hear more about...", "Tell me how...", "What do you think about...", or "How is smoking helping you with..." will encourage your client to examine smoking as an issue in her life that she can explore, rather than something that she simply does and over which she has no control.

Interrupting: Avoid interruptions of any kind – even a nod or an interjection such as "hmm hmm.." might distract her, make her uncomfortable, or lead her to believe that she has said enough. To really hear her, we must LISTEN empathetically and from the woman's perspective.

Setting goals for your client: Because we want the client to quit smoking, there is always a temptation to jump ahead to the action stage before she is ready. She must set her own achievable goals, which are often interim steps such as developing a pros and cons list of the benefits of smoking or cutting down on the number of cigarettes she smokes in a day.

Falling in the blaming trap*:* Clients may wish to blame others for their problems. Counsellors may feel compelled to show the client how he or she is at fault for the difficulties encountered. Neither of these urges are useful; blame is irrelevant. Counsellors need to establish a "no-fault" policy, for example by saying: "I'm not interested in looking for who's responsible, but rather what's troubling you, and what you might be able to do about it."

Feeling like a failure when a client fails to quit or relapses: Counselling smoking cessation can be discouraging if you base your criteria for success only on successful quit rates. Small movements such as engaging a client in meaningful reflection or helping her move from one stage to another are important successes that deserve to be recognized.

A Sample 2.5 Minute Smoking Cessation Intervention

***Counsellor*:** Congratulations! I see from your chart that you quit smoking two months ago. How is it going?

***Client*:** Pretty good but I'm gaining weight.

***Counsellor*:** How do you feel about that?

***Client*:** It bothers me. I don't look good or feel comfortable in my clothes. Wouldn't it be funny it if I end up getting sick because I'm fat rather than because I smoke?

***Counsellor*:** I understand how you feel. I gained weight when I quit smoking too. But let me assure you that a few extra pounds is not nearly as hard on your health as smoking. How are you feeling otherwise?

Client: Good really. I notice a big difference climbing stairs. I don't huff and cough as much. It's just that I'm hungry all the time. And I don't want to gain any more weight.

Counsellor: Okay, let's talk about what you can do to keep your weight down and still stay off cigarettes. How do you feel about exercising? You said you're not huffing and puffing as much.

***Client*:** I'd like to start a walking program. A friend of mine got a pedometer and she says it really helps.

***Counsellor*:** That's right. There are some good studies from Japan that show that people who walk 10,000 steps a day and eat a varied healthy diet effectively lose weight. A good pedometer costs about $20.00.

***Client*:** I've got way more than $20 saved from not smoking. Maybe I'll try it.

***Counsellor*:** Great. Here's some information on weight control that might help. It suggests that it helps to have a buddy. Maybe you could partner up with your friend to reinforce each other. But remember the most important thing is staying smoke free. You're really doing well with that.

Let me know how it works out. And bring in the pedometer. I'd like to see how they work.

***Client*:** Okay, see you next time.

Chapter 2
Other Interventions

Helping with Relapse

Relapse is perfectly normal and does not mean that a smoker has failed. Even after recovery (withdrawal) symptoms pass, the risk of relapse continues to be high, largely due to exposure to temptations, social situations and other smoking triggers. Your interventions need to help her re-enter the cycle of change without becoming demoralized.

Some of the most common factors related to relapse include alcohol use, negative mood or depression, negative self-talk, other smokers in the household, prolonged recovery (withdrawal) symptoms, exposure to high-risk situations (such as social situations, arguments and other sources of stress), dietary restrictions, lack of cessation support, problems with pharmacotherapy (such as side effects, compliance or premature discontinuation) and recreational drug abuse.

Most relapse occurs within the first three months after quitting and strategies to prevent relapse should be included in the initial preparation for a quit attempt. Among pregnant women in Canada, it is estimated that 30 to 35 percent relapse before childbirth. Postpartum is a high–risk period for relapse. Estimates of relapse rates range between 26 to 56 percent during the period from thirty days to six weeks postpartum, and 50 to 90 percent at six months postpartum. After six weeks postpartum, the risk of relapse gradually decreases.

It is important to encourage clients to report difficulties (e.g., lapses, depression, side effects) promptly while continuing their efforts to quit. A greater emphasis on the importance of follow-up care and offering additional training in relapse prevention may also improve long-term quit rates.

Researchers have found that the more past attempts to stop smoking a person has made, the more likely they will be to successfully stop. All experiences learned in previous attempts are useful and can be built on for a future successful attempt. Praise all attempts to quit; never condemn the smoker for lapsing. Encourage her to take time to plan for her next stop smoke attempt and to use the information learned from the last one.

A slip does not have to mean relapse. Some clients will slip and have one cigarette or take a few puffs of a cigarette, then go back to non-smoking after the slip. This is a critical time for you and your client. Reinforce the fact that many women slip and still quit successfully. Ask her to think about what other situations may evoke a similar slip and how she will deal with her urges to smoke.

Strategies to Avoid Relapse

Encourage client to identify tempting situations and develop a specific plan to handle them (e.g., write down three strategies and carry this list at all times).

Reframe a lapse (slip) as a learning opportunity, not a failure.

Recommend that the client learn stress management and relaxation techniques, and how to balance her lifestyle so that pressures and triggers are not so overwhelming.

Help her explore common triggers for relapse (e.g., alcohol use, other smokers in the household, arguments) and specific ways that she can handle them.

Assisting With Second-Hand Smoke

Clients often say that when other people light up a cigarette, they want to light up as well. It is difficult to avoid this situation if someone in your household or frequent guests smoke.

One solution is to develop a policy regarding smoking in the home. Here are some guidelines:

- ✧ Discuss the adverse health effects of secondhand smoke on others in the home (especially important for pregnant women and children).
- ✧ Help your client develop a complete (or partial) non-smoking policy for her home.
- ✧ Include the partner in decisions.
- ✧ Decide who should be informed about the policy.
- ✧ Discuss different options for how she will tell people about the policy and enforce it.

Although a complete non-smoking policy is preferable (no smoking anywhere inside the home), a partial non-smoking policy might still be helpful for your client (e.g., smoking allowed in one room only).

If the partner is present, discuss how he or she can assist. If the partner lives with the client and smokes, they should try to work out a situation that is mutually agreeable. It is important that the partner is consulted and feels included in the process.

It is often difficult for a woman to stand up to a spouse or family member who is accustomed to smoking in their home. Some women approach this problem by simply laying down the ground rules and sticking to them. Others tell their spouse or family members that their doctor had told them that there should be no smoking in the home. This approach relies on the authority of the doctor and takes some pressure off her. A woman may choose this approach if she expects the person will not respect her choice, but she should be careful not to use it with people who do not react well to authority.

Creating Supportive Environments for Smoking Cessation

Individuals and organizations need to create supportive environments for smoking cessation for both their clients and the people who are providing the interventions.

For clients

- ✧ Screen for tobacco use and offer a minimal intervention (less than 3 minutes) to all smokers at every opportunity.
- ✧ Prominently display “quit smoking” posters and materials in waiting rooms, reception rooms and lounges.
- ✧ Become familiar with community resources and programs and refer clients to them.
- ✧ Organize or refer clients to a self-help support group of like-minded women.
- ✧ Develop a buddy system to pair up ex-smokers with those who want to quit, or partner two smokers who want to quit at the same time.
- ✧ Be sure the environment you work in with women is smoke-free.
- ✧ Continue to express your confidence and pride in a client for trying to quit and for making progress. Suggest that other staff congratulate her when she quits and encourage her to stay smoke-free.

- ✧ Give successful quitters a small reward such as buttons, certificates or t-shirts that recognize her accomplishment.

For counsellors

- ✧ Provide ongoing training and educational opportunities in smoking cessation counselling to all who work with women living in disadvantaged circumstances.
- ✧ In a group situation, assign a dedicated person to provide support and leadership to other counsellors and to ensure that materials are available.
- ✧ Provide administrative and management support for smoking cessation interventions. The RNAO Toolkit: Implementation of Clinical Practice Guidelines can help. (See www.rnao.org/bestpractices)
- ✧ Make use of cueing systems to help healthcare providers consistently integrate smoking cessation into their practice. For example, The BC Doctors' Stop-Smoking Program provides stickers for clients' charts that indicate the stage of change.
- ✧ Be sure your work environment is smoke-free.

This section summarizes a large body of information about one-on-one interventions in smoking cessation. The following resources served as the basis for the information in this chapter and provide guidelines, detailed information and numerous tools on smoking cessation interventions.

- ✧ *Integrating Smoking Cessation into Daily Nursing Practice, Nursing Best Practice Guidelines*. Registered Nurses Association of Ontario, 2004. www.rnao.org/bestpractices

- ✧ *How to Treat your Patient's Tobacco Addiction. Smoking Cessation Guidelines*. Department of Family and Community Medicine, University of Toronto, 2000. Toronto, Ontario: A Pegasus Healthcare International Publication.

- ✧ *BC Doctors' Stop-Smoking Program*. Society for Clinical Preventive Health Care, 2002. www.bcdssp.com

- ✧ *Clinical Practice Guideline: Treating Tobacco Use and Dependence*. U.S. Department of Health and Human Services Public Health Service (2000). Office of the Surgeon General. www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf