

Manuals for Training in Cancer Control

# Manual for Tobacco Cessation



Directorate General of Health Services  
**Ministry of Health and Family Welfare**  
Government of India

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**Dr. S. P. AGARWAL**  
M. S. (Surg.) M. Ch. (Neuro)  
DIRECTOR GENERAL

भारत सरकार  
स्वास्थ्य सेवा महानिदेशालय  
निर्माण भवन, नई दिल्ली – 110011  
GOVERNMENT OF INDIA  
DIRECTORATE GENERAL OF HEALTH SERVICES  
NIRMAN BHAVAN, NEW DELHI - 110011  
TEL. NO. 23018438, 23019063  
FAX NO. 91-11-23017924  
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## FOREWORD

India is one of the few countries in the world to have a National Cancer Control Programme. The programme was conceived with the objectives of providing preventive and curative services through public education and enhancement of treatment facilities.

We have been able to develop 23 Regional Cancer Centres and several Oncology Wings in India, which provide comprehensive cancer care services. One of the major limitations of the programme is the late stage at presentation of common cancers thus reducing the chances of survival. There is a need to increase awareness among the community regarding prevention and early detection of cancers. The programme is developing IEC materials for the same. Once the population is armed with the necessary information, it is expected that the health system should be geared to tackle the increased demand for care. There have to be trained health care professionals to support the needs of the community. This can be addressed by proper training and sensitisation of general practitioners and health care providers.

These manuals are developed for training health professionals and specific modules have been prepared for Cytology, Palliative care and Tobacco cessation. The facilitator's manual will assist the trainers to conduct the programmes. The manuals are self-explanatory and the health professionals will be able to use them on their own.

(S. P. AGARWAL)





**K. RAAMAMOORTHY**

Joint Secretary  
Tele: 23061706  
Fax: 23061398  
E-mail: kr.moorthy@nic.in

भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011

## PREFACE

Demographic and epidemiological transitions and changes in lifestyle are leading to the emergence of cancer and other chronic diseases as public health problems in India. Cancer pattern in India reveals the predominance of tobacco related cancers, which are amenable to primary prevention. Cancer Registries in different parts of the country reveal that majority of cancer cases present in an advanced stage and makes treatment options prolonged and expensive. Therefore, the National Cancer Control Programme has placed its emphasis on prevention, early detection, enhancement of therapy facilities and provision of pain and palliative care. Comprehensive legislation on tobacco by the Government of India will help to control the tobacco related cancers. The programme has been able to augment the treatment capacity and to address the geographical gaps in cancer care services. Awareness and early detection programmes are undertaken through District Cancer Control Programmes.

Health care personnel have a major role in providing awareness, promoting early detection, prompt referral to a cancer treatment facility and in providing pain relief and palliative care. The knowledge and skills in the above areas have to be enhanced and these manuals have been developed in response to this need. This set of manuals, which consists of a facilitators' manual and separate manuals for health professionals, cytology, tobacco cessation and palliative care, is an attempt at providing the minimum required capacity. The manuals are self explanatory and will help the trainers, who will be from Regional Cancer Centres and other cancer treatment centres.

The manuals and the compact disc will be widely disseminated and same will be available on the website of the Ministry of Health and Welfare. The National Cancer Control Programme will urge that these may be used in cancer control training programmes in various settings.

  
(K. RAAMAMOORTHY)  
22.8.2005



# 1

## The Problem of Tobacco Addiction

**T**obacco may be smoked (in the form of cigarettes, beedis), chewed (as gutka, khaini, etc), and inhaled as snuff.

Cigarettes and other forms of tobacco are addictive because of the presence of nicotine. Nicotine blood levels achieved by smokeless tobacco use are similar to those from cigarette smoking.

### Nicotine – A Stimulant

Nicotine, the chemical that makes addicts out of tobacco users, is a stimulant with properties similar to those of cocaine and amphetamines. It provides the pick-me-up feeling that tobacco users feel. It increases the heart rate, blood pressure, and respiratory rate, and makes the user feel more alert. Unfortunately these effects wear off after twenty minutes or so, and the tobacco user is left craving for another pick-me-up. Chronic use affects brainstem structures (locus ceruleus); Noradrenergic cells become more excitable. When a person abstains, the firing rates become abnormally high, causing withdrawal symptoms like feeling tense and irritable, trouble in concentrating, sleep disturbance, headaches, digestive upset etc.

The role of nicotine in the compulsive use of tobacco products is now known to be equivalent to the role of cocaine, ethanol and morphine.

## Effects of Nicotine:

### Central Nervous System

- Arousal or relaxation
- Enhanced concentration, vigilance
- Appetite suppression
- EKG changes

### Hematological

- Increase in platelet adhesiveness

### Cardiovascular

- Increased heart rate, cardiac contractility
- Increased blood pressure
- Cutaneous vasoconstriction
- Systemic venoconstriction
- Increased muscle blood flow
- Catecholamine release

### Metabolic

- Lipolysis with fatty acid release
- Increased energy expenditure

### Endocrine

- Increased growth hormone
- Inhibition of prostacyclin synthesis



## Acetaldehyde & Carbon Monoxide

Acetaldehyde, a by-product of cigarette smoke has some sedative properties. The carbon monoxide in cigarettes makes people feel dull the way one would in a stuffy room without enough air. These chemicals seem to dampen some people's feelings of tension, anger, or strong emotion.

## Other Psychological Effects

Conditioning occurs over many years after exposure to things in the environment, which stimulate the user to want a cigarette or other forms of tobacco. People learn to manage their emotions with tobacco.

For many, the act of smoking or chewing itself - pausing in one's work, lighting up, exhaling a certain way - becomes a comforting ritual in itself. The act of tobacco use may go hand in hand with other activities, such as toilet rituals in the morning, drinking tea or alcohol or relaxing after a meal. These "triggers" are the reason why quitting involves more than just kicking the nicotine habit. Patterns of behaviour are very difficult to change.

## Stages of Development of addiction

The initiation and development of tobacco use among children and adolescents progresses in stages:

1. Forming Attitudes and Beliefs about Tobacco
2. Trying Tobacco
3. Experimenting with Tobacco
4. Regularly Using Tobacco
5. Becoming Addicted to Tobacco

This process generally takes about 3 years.

## Withdrawal

Attempts to stop use lead to craving, withdrawal symptoms, and high rates of relapse.

Withdrawal begins within a few hours of the last cigarette and manifests as:

- Dysphoric or depressed mood
- Insomnia
- Irritability, frustration, or anger
- Anxiety
- Difficulty in concentrating
- Restlessness
- Decreased heart rate
- Increased appetite or weight gain

The following questionnaire may be administered to tobacco users to identify whether their dependence on tobacco is more physical, psychological or behavioral.

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## Why Do You Use Tobacco?

This questionnaire will help you identify why you use tobacco and where your addiction is the highest. Addiction affects the body in three areas: physically, psychologically and behaviorally (habit). Knowing where your addiction is strongest will help you select the tools and resources to deal with your withdrawal process.

Circle the number that best describes your answer.

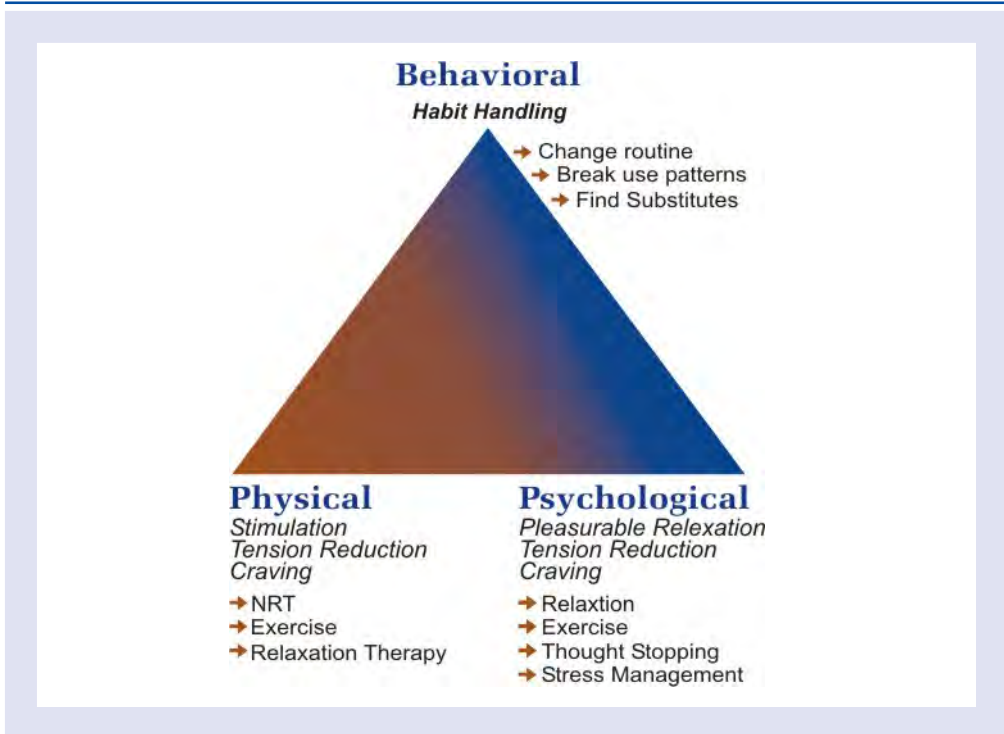
- A. I use tobacco to keep from slowing down.
- B. Handling a cigarette is part of the enjoyment of smoking.
- C. Smoking is pleasant and relaxing.
- D. I use tobacco when I'm upset about something.
- E. When I run out of tobacco, I find it unbearable.
- F. I use tobacco automatically without being aware of it.
- G. I use tobacco to perk myself up.
- H. Part of the enjoyment of smoking comes from the steps I take to light up.
- I. I find cigarettes pleasurable.
- J. When I feel uncomfortable about something, I use tobacco.
- K. I am very much aware of the times when I am not using tobacco.
- L. I light up a cigarette without realizing I still have one burning in the ashtray.
- M. I use tobacco to give myself a "lift."
- N. Part of the enjoyment of smoking is watching the smoke I exhale.
- O. I want to use tobacco when I am comfortable and relaxed.
- P. When I feel "blue" or want to take my mind off my cares, I use tobacco.
- Q. I get real cravings for tobacco when I haven't used in a while.
- R. I've found a cigarette in my mouth and couldn't remember having put it there.



Scores of over 7 in all areas indicate a need for a combination for pharmacological adjuncts, NRT and behavioural methods.

See the Addiction Pyramid

### The Addiction Triangle to assess Treatment Needs



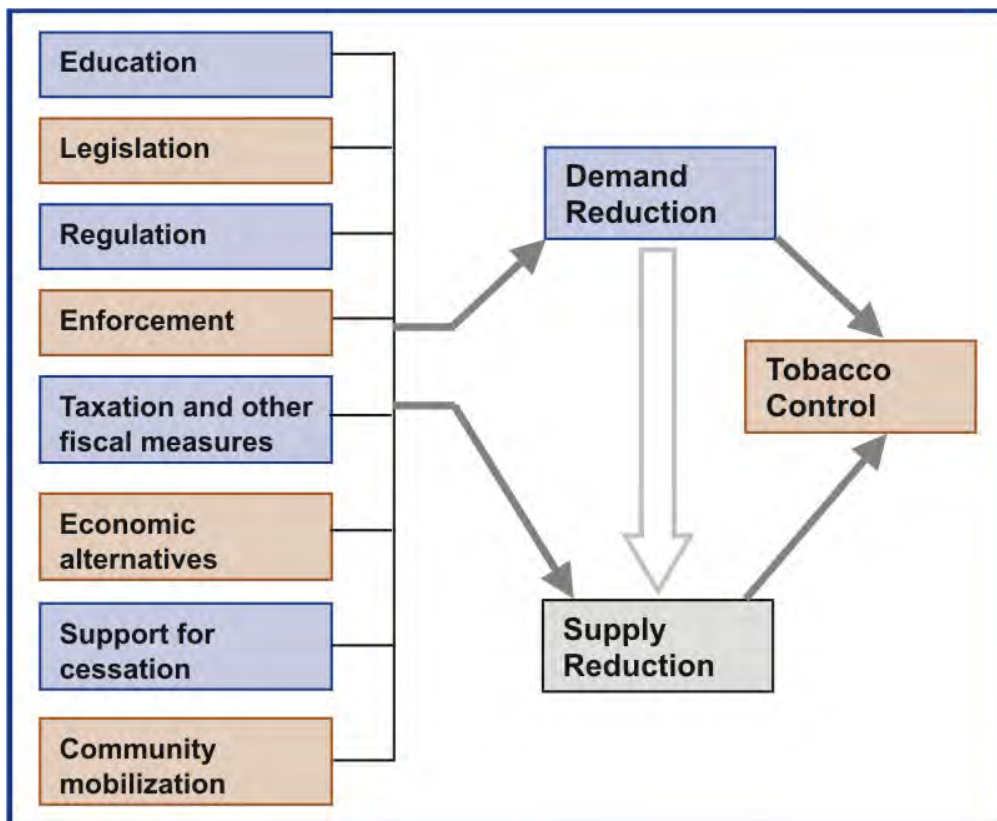
NRT\*(Nicotine replacement therapy)

Ref: Tobacco Cessation Programme Facilitator Guide. Available at <http://chppm-www.apgea.army.mil/dhpw/Population/Tobacco.aspx>

## Strategies for tobacco control and specific strategies for tobacco cessation:

The recent enactment of legislation for tobacco control and ratification of the framework convention on tobacco control (FCTC) by India should only be regarded as steps which mark the beginning of a major national effort to deal effectively with an active and increasingly menacing threat to health and development. The follow up process requires a comprehensive multicomponent strategy which is implemented through coordinated multisectoral measures. Such a strategy should combine measures for demand reduction as well as Reduction of supply.

For effective tobacco control, various factors like education, legislation, regulation, enforcement, taxation and other fiscal measures, economic alternatives, support for cessation, and community mobilization are important in regulating demand reduction and reduction of supply of tobacco in an effective manner.



Courtesy: ReddyKS, GuptaPC, Report on tobacco control in India, July 2004 'Tobacco control-what works?' 255-320;

### **Interventions at the national level:**

- A rational tax structure needs to be designed to provide a tax- and price-based disincentive for tobacco consumption in all forms, rather than merely transferring consumption from one tobacco segment to another.
- While taxes on cigarettes must be progressively increased, beedies and other tobacco products should be taxed at sufficiently high rates.
- Several countries, e.g. New Zealand, Australia and the USA, have used an earmarked 'tobacco tax' to generate financial resources for funding health promotion programmes and specifically designed tobacco control programme.
- India has used an earmarked beedi tax to provide several benefits to beedi workers. This concept needs to be extended as a dedicated tax or cess that will be utilized for resourcing tobacco control programmes.
- The regulation of tobacco products aims to progressively reduce the levels of harmful chemicals and alter their physical characteristics.
- While a potential for 'harm production' exists theoretically, it is as yet unproven in public health terms.
- A Scientific Advisory Committee on Tobacco Product Regulation (SACtob), established by the WHO in 2002, provides technical guidance on matters related to tobacco product regulation-limitations of testing methods, setting up of upper limits for toxic ingredients and their emissions.
- India needs to develop laboratory capacity for regulatory testing of tobacco products (both smoking and chewed tobacco products)
- To monitor and discipline the tobacco industry, it is essential to develop a National Regulatory Authority with a clearly defined mandate and adequate resources.
- Supply-side actions are complementary to demand-side measures to control tobacco consumption in India.
- Supply-side actions pertain mainly to crop substitution, trade restrictions, controlling smuggling and even banning of the product.
- It is feasible and viable for tobacco cultivators to switch over to alternative crops such as cotton, chillies, isabgul (plantago), cotton, maize, soyabean, sugarcane and potato.
- An in-depth market analysis is required to identify alternative crops.
- The government should provide assistance during transition, especially to poorer farmers, which include rural training, broader off-farm employment opportunities and assistance with crop diversification.
- Tobacco diversification needs to be considered within a broader developmental framework.

- The feasibility of non-farming jobs should also be considered, which might entail infrastructural investment.
- There is convincing evidence that tobacco advertising plays an important part in encouraging non-smokers to begin smoking.
- When countries ban tobacco advertising in one medium, such as television, the industry can substitute advertising in other media with little or no effect on overall marketing expenditures.
- Comprehensive bans on tobacco advertising and promotion can result in a considerable reduction of tobacco consumption at the national level.
- A complete ban on advertisements coupled with an intensive public information campaign on the ill effects of using tobacco products will lead to a reduction in tobacco consumption by 6%.
- In India, surrogate advertisements are still prevalent in the media and the existing laws need to be strengthened and enforced.
- The WHO and the World Bank recommended warning labels on tobacco products, which are an effective way to inform smokers about the hazards of tobacco consumption, encourage smokers to quit, and discourage non-smokers from starting to smoke.
- Warning are effective only if they contain multiple, strong and direct messages that are prominently displayed.
- Health warning message labeling on the product package is a critical component of a comprehensive tobacco control strategy. Health warning message labels are a cost-effective way to inform the public, especially smokers, of the hazards of tobacco use.

### **Protection of vulnerable groups: A human rights approach to tobacco control**

- The poor, the young and women are particularly vulnerable for becoming the victims of tobacco.
- Tobacco control policies must encompass a human rights approach to protect vulnerable groups from the hazards of tobacco.
- Tobacco smoking is inversely associated with educational status.
- Homeless people in India spend more on tobacco than on food, education or savings.
- Enabling conditions must be created to help individuals make informed choices.

## Community interventions:

- Based on current trends, some 30%-40% of the 2.3 billion children and teenagers in the world would become smokers in early adult life.
- The most susceptible time for initiation of tobacco use in India is during adolescence and early adulthood, i.e. in the age group of 15-24 years.
- Raising the prices of tobacco products through taxes, increasing the size of the packages and a comprehensive ban on tobacco advertising (direct and indirect) are effective means of preventing the youth from initiating use.
- Youth involved in anti-tobacco advocacy are more like to avoid tobacco use.
- Exposure to second-hand smoke is a entirely preventable cause of significant morbidity and mortality associated with tobacco use.
- Smoke-free workplaces not only protect non-smokers from the dangers of passive smoking, they also encourage smokers to quit or reduce consumption.
- For smoking bans to succeed, enthusiastic endorsement by and active participation of the community and an awareness of the health consequences of exposure to second-hand smoke are needed.
- The combined effect of people stopping smoking and reducing consumption reduces the total cigarette consumption by 29%.
- Regulations restricting smoking in public places have a considerable impact on teenage smoking behaviour.
- Increasing the knowledge and awareness about the harmful effects of tobacco use among the people is one of the ways to reduce tobacco use.
- Health education leads to a long-lasting reduction in tobacco use, when it is imparted through the mass media and combined with a school- and community-based education programme.
- Education campaigns through the mass media are among the most cost-effective methods currently available to prevent or reduce tobacco use.
- School-based tobacco prevention programmes that identify the social influences which promote tobacco use among the youth and teach skills to resist such influences can significantly reduce or delay adolescent smoking, especially if strengthened by booster session and community programmes involving parents and community organizations.
- Public education programmes should be well funded and based on rigorous research.
- The distinct cultural profiles of the targeted population groups should be kept in mind while designing programmes.



## Benefiting from models of behaviour change

- Influencing behaviours to change them in a manner that reduces risks is a necessary step to promote health.
- A number of influential models of behaviour change have been proposed and evaluated. These models provide a framework to show how behaviours can be changed to achieve better health and social practices.
- The use of communication planning systems, such as social marketing and Precede-Proceed models, increases the probability of programme success by examining health-related behaviour at multiple levels.
- The Precede-Proceed model directs initial attention to outcomes rather than inputs and hence planners view the planning process from the outcome point of view.
- The transtheoretical model of change provides the basis for stimulating and supporting individual efforts at tobacco cessation.
- Lessons learned from social marketing stress the importance of understanding the targeted audience and designing strategies based on their wants and needs rather than what good health practices direct them to do.

## Individual interventions: promoting tobacco cessation (this book addresses these techniques in detail)

- Tobacco use cessation is an essential component for reducing the mortality and morbidity related to tobacco use, as the lack of it may lead to an additional 160 million global deaths among smokers by 2050.
- Tobacco use cessation provides the most immediate benefits of tobacco control and maximizes the advantages for a tobacco user who quits the habit.
- Tobacco cessation to the wide range of products used in India.
- Capacity-building strategies for the identification and management of tobacco use and disorders related to its use must strengthen the services available through the existing health care facilities.
- Involvement of the community is an essential component of a tobacco cessation programme.

**Courtesy:** Reddy KS, Gupta PC,  
Report on tobacco control  
in India, July 2004  
Tobacco control-what works? 255-320

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# Approaches to the Problem

## At the level of the individual

It is established that a majority of smokers (as many as 70%) desire to quit, but only 30% actually try each year, and only 3%- 5% actually succeed in quitting. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence. Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments:

1. Patients willing to try quitting tobacco use should be provided with treatments identified as effective.
2. Patients unwilling to try quitting tobacco use should be provided with a brief intervention designed to increase their motivation to quit.

Brief interventions offered by physicians and other primary health care personnel are valuable in the management of individuals with tobacco-related problems. They are low in cost and have proven to be effective in tobacco cessation. The physician has the influence, as a credible expert in a position of authority, to suggest and advise patients to quit tobacco use. Simple advice alone administered by a physician, which can take as little as 30 seconds, can produce quit rates of 5-10% per year. Such interventions fill the gap between primary prevention efforts and more intensive treatment for persons with long-standing and more intractable addiction to tobacco.

Not every person is ready to change their nicotine habit, and studies have identified a consistent behavior change pattern, which may be helpful in understanding and facilitating change. The trans-theoretical model of Prochaska and Di Clemente emphasizes stages of change: pre-contemplation, contemplation, preparation, action, maintenance, and

### **Intervention Works!**

**Intervention from health professionals has been shown repeatedly, in randomized controlled trials, to increase the percentage of tobacco users who stop and remain abstinent for 6 months or more.**

**This is highly cost-effective.**

termination. The key features of this model are that an individual's readiness to change can be assessed; and that specific interventions are tailored to the person's stage of change, in order to increase the likelihood of success.

Intensive Counseling by a specialist increases quit rates additionally by 4-7% compared to normal. Relapse prevention strategies given individually suggest increased cessation rates by about 1.5 - 2%.

Numerous effective pharmacotherapies for tobacco cessation now exist. Except in the presence of contraindications, these should be used with all patients attempting to quit tobacco use.

Pharmacological interventions when used with behavioural strategies can produce quit rates of about 25 –30 %. Pharmacotherapies that reliably increase long-term smoking abstinence rates include:

- a. Agents that appear to decrease craving - Bupropion, Selegeline, Nortryptiline etc.

**Tobacco cessation centres from India, have reported overall quit rates around 16% at 6 weeks post-intervention. The addition of pharmacological adjuncts improves the quit rates. Agents like the anti-depressant Bupropion have been shown to increase the quit rates in the treatment of nicotine dependence by approximately 1.5 to 2 times, irrespective of the setting. Combined with behavioral interventions they produce quit rates up to 35% (TCC India).**

- b. Agents, which are used to substitute the nicotine, obtained from tobacco - Nicotine gum, Nicotine patch, Nicotine inhaler or Nicotine nasal spray. Nicotine replacement Therapy (NRT) is useful and associated with quit rates of about 23% as against 13% with placebo.

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## Helping People Change

Most clinicians involved in smoking cessation have felt discouraged when, despite their best efforts and genuine desire to be helpful, the person they are trying to help doesn't seem to be changing. They may wonder whether their clients are unmotivated, or think their patients are denying or rationalizing away the risks of smoking. The clinician may become frustrated when detailed information and a range of coping strategies appear insufficient to increase motivation to quit.

### Why do people not change?

There are usually four forces, which influence change:

Forces keeping a person in his/her current behavior:

- What I like about my current behavior
- What I fear about the new behavior

Forces encouraging change to a new behavior:

- What I dislike about my current behavior
- What I imagine the advantages of the new behavior would be

When people feel that what they like about their tobacco use and what they fear (anticipate) about what will happen if they stop is more compelling than what they dislike about using tobacco and what they imagine would be good about becoming a nonuser, then the chances that they will think about quitting is rather remote.

Ignorance about the consequences of their use or lack of knowledge about effective quitting strategies, denial of problems faced because of tobacco use, personal choices related to lifestyle or perceived self-image, anger and entitlement, defiance or even a fear of failure (because of earlier failed attempts at quitting) are the major factors that discourage change.

These perceptions and feelings are not rigid and stable. At various stages in their lives people tend to attach more or less emotional significance to each of these four factors.

In effect this is like a continual balancing game with people see-sawing from one decisional end to another.

The clinician's goal is to be able to help the person tip the balance so as to favor a decision to change.

Quitting does not happen in one step – people progress through five stages on the way to successful change. In each of the stages a person has to grapple with a different set of issues and tasks that relate to their tobacco using behaviour.

## 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**

## Stages of Readiness to Change

Prochaska and Di Clemente have described a series of stages through which people pass in making changes in their behaviors. At each stage a person is thinking and feeling differently about the problem behaviour and finds that different processes and interventions help them move on to the next stage.

The model can be pictured in a diagram as a circle. Before entering this cycle of change a person can be said to be in *pre-contemplation*. Pre-contemplators are not interested in change. Sometimes this is because they do not see their behaviour as a problem. Sometimes they do not know that it is causing, or putting them at risk of problems. Sometimes, even though they may be fully aware of the risks, they may value it so much for other reasons that they do not wish to change. For some others, previous failed attempts at quitting make them believe that they cannot change.

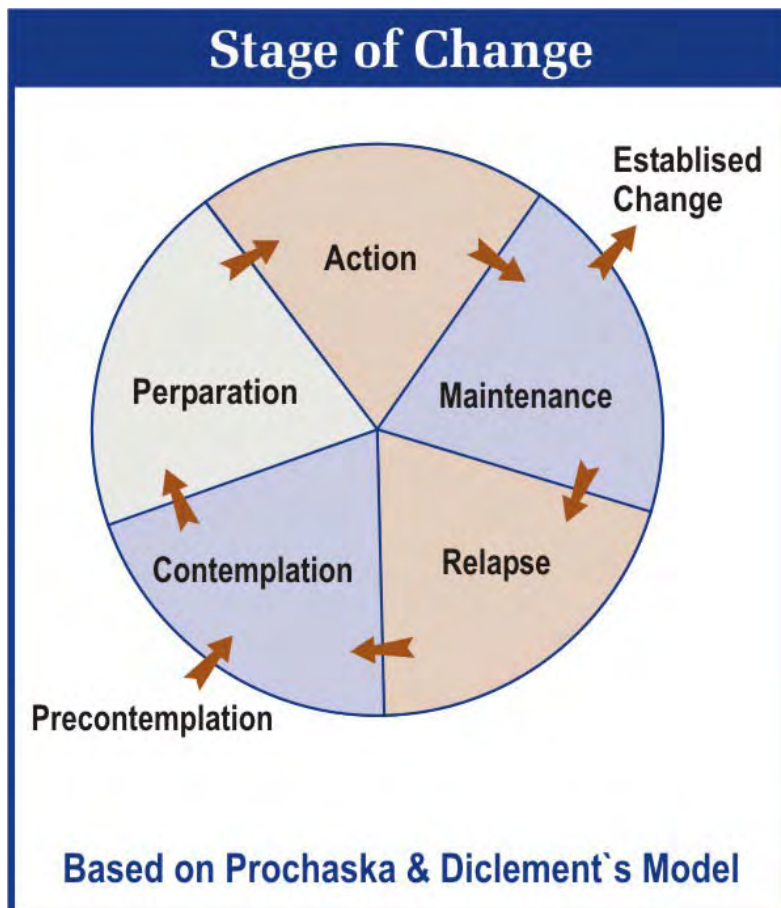
Raised awareness or concern about the risks and problems can lead to the person moving into *contemplation*. In this stage the person is torn two ways – aware that he or she ought to change but still feeling attached or drawn to the behaviour. They are not ready to change yet and may stay for years,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

Those in *preparation* are planning to take action very soon. They are beginning to make 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 effort into it. This is often the time that people seek out professional help.

This action phase is followed by *maintenance* in which change in behaviour is continued and consolidated, temporary changes become part of a more settled pattern. Unless this consolidation takes place the person may move into *relapse* and return from there to pre-contemplation 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.



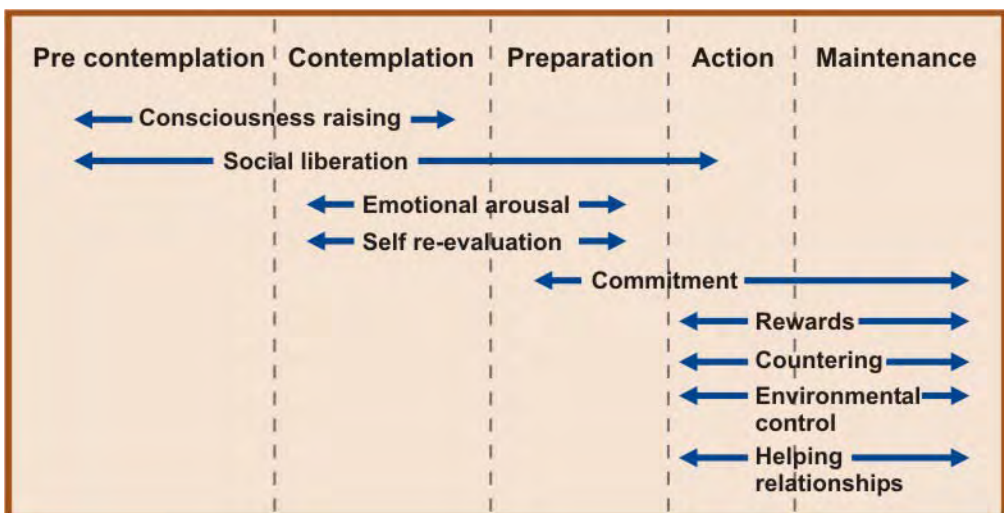
## Processes helpful in change

In order to change their behaviour people also need to change many other aspects of their lives. While the modification of the target behaviour – in this case stopping tobacco use – is the most visible change and receives the most attention, other less visible changes that they make, help to move from one stage of change to the next.

There are nine key processes that people seem to apply to their problems as they go through the stages of change.

- 1. Becoming informed (Consciousness raising):** Becoming aware of one's own behaviour patterns by keeping a smoking diary or feedback from others (physician) about the relationship of their tobacco use to their personal consequences or even reading health information material. People use consciousness-raising most in the precontemplation and contemplation stages.
- 2. Increasing alternatives (social liberation):** This is an external supportive force arising out of environmental changes. Such changes may influence people in different stages differently. If offices, restaurants or trains are made 'No Smoking', precontemplators may become more aware of how important smoking is to them and how difficult it is to pass a few hours without smoking. This in turn may raise their consciousness about their dependence on the habit. People in the maintenance stage might find it supportive in finding a risk-free environment at a high-risk point in their day.
- 3. Emotional arousal:** A major emotional experience triggered by tragedy in someone's life (People often report that ill health or death of a relative moved them from precontemplation into contemplation). Films and dramatic recreations in role-plays can also provoke emotional arousal. This process is most useful in contemplation and preparation.
- 4. Creating a new image (self re-valuation):** 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. This involves weighing the costs of the behaviour and the benefits of changing. Most often used in the contemplation and preparation stages.
- 5. Commitment:** Comes with accepting responsibility for choosing to make changes and taking appropriate action and is important in the preparation and maintenance stages. Publicly announcing the decision to stop, to family and friends creates social pressures to support the change.

- 6. Rewards:** People can reward themselves for making change by using self-praise, eliciting praise from friends or colleagues or gifting themselves and others with the money saved from not buying tobacco. In the action phase, such rewards are most important as the intrinsic benefits of the change take time to become evident. In fact immediately after stopping people feel worse not healthier until a few weeks, when the changed behaviour begins to provide its own rewards.
- 7. Using substitutes (Countering):** Substituting healthy or harmless behaviours for the one who is trying to give up is very effective in the action and maintenance stages. Mood changing activities (listening to music, physical or relaxation exercises) are a way of countering the emotional need previously provided by the nicotine high. Any activity distracting from thinking about or craving for tobacco is another.
- 8. Environmental control:** Controlling one's environment in order to reduce temptations or triggers to use are helpful in the action or maintenance stage. Not drinking alcohol which is tied to the smoking behaviour and would lower one's inhibition and vigilance, or throwing away all ashtrays, which are likely to remind one of the previous behaviour, are examples. Others may write themselves notes and reminders and put them in the pocket that held the tobacco or in strategic places at home or work.
- 9. Helping relationships:** Anyone can provide a helping relationship; health professionals, family members, colleagues and friends or members of self help groups. Such help is supportive in all the stages. People need different types of help at different stages (e.g. someone to listen and ask pertinent questions to help self-evaluation, or someone to provide rewards).





**Benefits of quitting of quitting tobacco-Giving up tobacco has some immediate and long-term benefits;**

## After

### 20 minutes

- Blood pressure and pulse drop to a normal rate
- Temperature of hands and feet increases to normal

### 8 hours

- Carbon monoxide level in the blood drops to normal
- Oxygen level in the blood goes up to normal

### 24 hours

- Chance of heart attack starts going down

### 48 hours

- Nerve endings start growing again
- Ability to taste and smell begins to improve

### 2 weeks to 3 months

- Circulation improves
- Walking gets easier
- Lung function improves up to 30%

### 1 month to 9 months

- Coughing, sinus congestion, tiredness and shortage of breath decrease
- Cilia (small hairs) grow back in lungs to better handle mucus, clean the lungs and reduce infection

### 1 year

- Risk of coronary artery disease is half that of a smoker

### 5 years

- Lung cancer death rate goes down by one half
- Risk of stroke becomes the same as non-smoker
- Risk of cancer of the mouth, throat, esophagus, bladder, kidney and pancreas goes down

In addition: if you have a chronic illness like diabetes, asthma or kidney failure, quitting can dramatically improve your health.

## Helping People Change: Self Help Tips

These tips may be taught to tobacco users to help them change.

1. Review your tobacco use. Talk to your family and friends about your tobacco use. THINK.... “ Whom do they dislike.... Me or my addiction?”
2. Accept that it is a problem.  
“Do you know that you are damaging your body?”
3. Don't be overconfident about quitting.  
DON'T THINK,... “Though tobacco is a problem, I can leave it any time”.
4. Decide to quit. THINK,... “What can I do?”
5. Accept the need for external help (Friends/Family/ Colleagues). THINK... “ Who can help me in quitting tobacco?”
6. Don't postpone. Set a target date to quit. DECIDE... “I will leave it on \_\_\_ day”.

## First Few Steps of Quitting

### To reduce quantity -

1. Change to non-preferred brand.
2. Buy less cigarette / sachet at a time rather than piling the stock.
3. Keep a record of the amount and frequency of tobacco used.
4. Decrease the number of puffs when smoking.
5. Leave large stubs.
6. Don't inhale deeply.

### To Deal with Triggers

1. If you have an extraordinary urge to take tobacco- Try alternatives (chewing gum, toffee, peppermint).
2. Increase your water intake.
3. Take small sips of water when the urge to smoke/chew is high.
4. Deep breathing can calm you and help you to cope with the urge to use tobacco.
5. Do something else when you feel the urge to smoke/ chew tobacco. This will help you keep your mind off tobacco.
6. Delay the act, count till 100 and think of pleasant situations and thoughts.

7. Substitute stimulus associated with tobacco i.e. tea can be replaced by milk or juice.
8. Remove ashtrays or lighters from your house or workplace.

## Once You Quit

1. Learn to say no to tobacco offers from others.
2. Don't take even one puff.
3. Try to remain in smoke free areas. Avoid company of smokers and chewers.
4. Make a group of people who have quit tobacco.
5. Try alternative ways to deal with stresses  
Like — Relaxation, deep breathing, listening to music, exercises, taking a walk, talking to someone over telephone etc
6. Remember there can be some withdrawal symptoms when you quit  
Like — Headache, irritability, lack of concentration etc.  
But — these are temporary and will disappear in a few days.
7. Even if you fail in your attempt-
  - \* Don't get disheartened- TRY AGAIN
  - \* Seek help of those who have quit tobacco.
  - \* Seek professional help and medical advice.

## Why Should You Quit

- \* Nearly 40% of people detected with cancer in India are due to tobacco use.
- \* Cigarette smoking is associated with over 8,00,000 deaths in India every year.
- \* Tobacco usage causes over 1.6 lakh new oral cancers, 45 lakh cardio-vascular disease cases and 39 lakh cases of chronic obstructive pulmonary disease every year in India.

## Helping People Change: Brief Intervention

Most of the effective treatments, which seek to bring about change in addictive disorders, contain a common core of ingredients that evoke change. It is believed that six critical elements are necessary and sufficient to induce change. Miller and Sanchez (1994) described six elements, which they believed to be active ingredients of the relatively brief interventions that have been shown by research to be effective. These can be summarized by the acronym FRAMES. [See box]

The responsibility and capability for change lie with the client. The therapist's task is only to create a set of conditions that will enhance the client's own motivation for and commitment to change. Offering support to the *intrinsic* motivation for change will lead the client to initiate, persist in, and comply with behavior change efforts.

The objective is to help clients consider seriously two basic issues.

- A. How much of a problem their drug use poses for them, and how it is affecting them (both positively and negatively). Tipping the balance of these pros and cons of drug use toward change is essential for movement from contemplation to determination.
- B. The client in contemplation assesses the possibility and the costs/benefits of changing the drug use. Clients consider whether they will be able to make a change, and how that change will impact their lives. In the determination stage, clients develop a firm resolve to take action. That resolve is influenced by past experiences with change attempts. Individuals who have made unsuccessful attempts to change their drug use in the past need encouragement to decide to go through the cycle again.

Understanding the cycle of change can help the therapist to empathize with the client, and can give direction to intervention strategies. Though individuals move through the cycle of change in their own ways, it is the same cycle. The speed and efficiency of movement through the cycle, however, will vary. The task is to assist the individual in moving from one stage to the next as swiftly and effectively as possible. There is reason to believe that this strategy is particularly effective with less motivated clients.

Research shows that most effective treatments contain a common core of ingredients, which promote change.

They can be summarized by the acronym **FRAMES**:

- **F**EEDBACK of personal risk or impairment
- Emphasis on personal **R**ESPONSIBILITY for change
- Clear **A**DVICE to change
- A **M**ENU of alternative change options
- Therapist **E**MPATHY
- Facilitation of client **S**ELF-EFFICACY or optimism

*Miller and Sanchez (1994)*

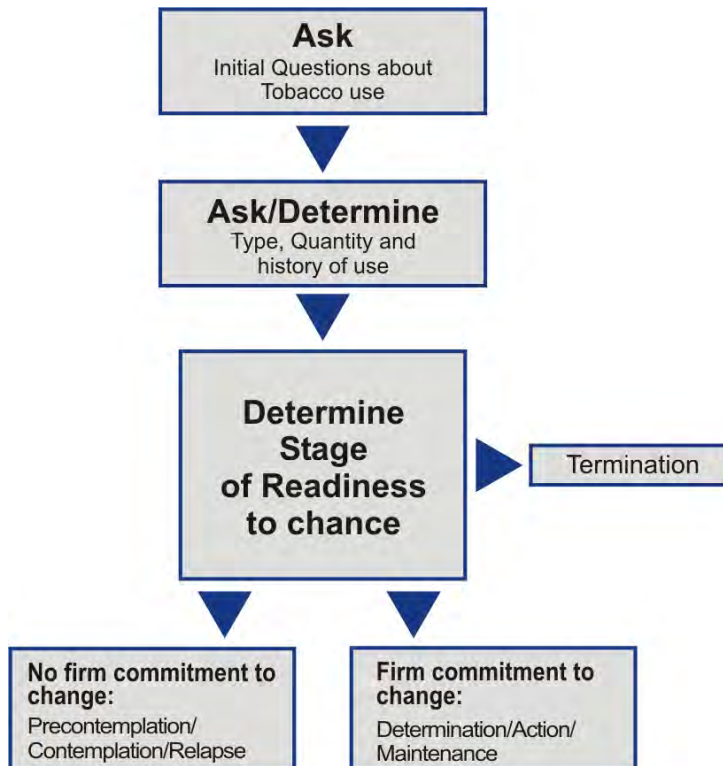
## Solutions to the problem:

### ASK- ADVISE – ASSESS – ASSIST - ARRANGE

The 5 A's is a brief intervention method (or approach in counseling), used to guide the clinician in tobacco cessation counseling. This brief intervention essentially can be used with numerous types of behavior change. It is important to include some sort of intervention for persons using tobacco. This method can be effective and only takes 5-15 minutes.

The 5 major steps in this intervention are:

1. **Ask** — about tobacco use
2. **Advise** — to quit
3. **Assess** — commitment and barriers to change
4. **Assist** — users committed to change
5. **Arrange** — follow-up to monitor progress



## ASK – ALL Persons About Tobacco Use

Tobacco use is an important aspect of a person's health status and it is therefore important to maintain up-to-date records about this. Two pieces of information are important: a) whether the person uses tobacco currently and, b) if so, whether the individual is interested at present in stopping.

### Times to ask:

1. As part of the vital signs at the beginning of a visit
2. When taking a history
3. During a physical examination

#### Ask ALL Persons

Identify every adult's tobacco use status. Identify the smoking status of a child's parents/caregivers for conditions potentially impacted by second-hand smoke

Determine if a person:

- Does not smoke / chew
- Does smoke/ chew
- Recently quit (<1 year).

Ask, ***“Do you currently smoke or use tobacco?”*** If no, ask ***“Have you quit in the past year?”***

Ask adults accompanying children, ***“Does anyone in your / this child's household smoke?”***

Ask children over the age of 10, ***“Have you ever smoked a cigarette or do you use any variety of smokeless tobacco [specify]?”***

POSITIVELY REINFORCE non-smoking, particularly with adolescents.

#### ASK about Type, Quantity and History

***“What kind of tobacco do you use now?”***

***“How often do you smoke / chew?”***

***“How many cigarettes (or how much smokeless tobacco) do you use during a typical day?”***

***“Use the Fagerstrom questionnaire to better quantify severity of tobacco use***

#### ASK about first use and first daily use:

***“How old were you when you first used tobacco? What kind of tobacco did you use?”***

***“How old were you when you first started using tobacco daily?”***

## Fagerstrom Addiction Scale for Smokers

1. How soon after you wake in the morning do you smoke or first use tobacco?

- a. Within 30 minutes **1**  
 b. More than 30 minutes **0**

2. Do you find it difficult not to use tobacco where tobacco is forbidden?

- a. Yes **1**  
 b. No **0**

3. Which of all the times you use tobacco during the day is the most satisfying?

- a. First thing in the morning **1**  
 b. Any other time **0**

4. How many cigarettes do you smoke a day?

- a. 1-15, light smoker **0**  
 b. 16-25, moderate smoker **1**  
 c. 26 or more, heavy smoker **2**

5. Do you use tobacco more in the morning than the rest of the day?

- a. Yes **1**  
 b. No **0**

6. Do you use tobacco when you are sick enough to have to stay in bed?

- a. Yes **1**  
 b. No **0**

7. What is the tar/nicotine rating of the brand you smoke?

- a. Low tar, 1-8 mgs **0**  
 b. Medium tar, 9-16 mgs **1**  
 c. High tar, 15 or more mgs **2**

8. How often do you inhale?

- a. Occasionally **0**  
 b. Often **1**  
 c. Always **2**

Your score =

The highest possible score = 11 The closer to zero your score, the less dependent you are on tobacco. The higher the score, the more strongly you are addicted.

**Add the points before each answer you circled.**

**Your total score indicates your level of dependence:**

- 0 to 2 — Very low dependence.      3 to 5 — Medium dependence.**  
**6 to 7 — High dependence          8 to 10 — Very high dependence**



## Modified Fagerstrom Questionnaire for Smokeless Tobacco Users

1. After a normal sleeping period, do you use smokeless tobacco within 30 minutes of waking?
  - a. Yes **0**
  - b. No **0**
2. Do you use smokeless tobacco when you are sick or have mouth sores?
  - a. Yes **1**
  - b. No **0**
3. How many times do you use tobacco per week?
  - a. Less than 2 times **0**
  - b. More than 2 times **1**
  - c. More than 4 times **2**
4. Do you intentionally swallow your tobacco juices rather than spit?
  - a. Never **0**
  - b. Sometimes **1**
  - c. Always **2**
5. Do you keep a dip or chew in your mouth almost all the time?
  - a. Yes **1**
  - b. No **0**
6. Do you experience strong cravings for a dip or chew when you go for more than two hours without one?
  - a. Yes **1**
  - b. No **0**
7. On average, how many minutes do you keep a fresh dip or chew in your mouth?
  - a. 10-19 minutes **1**
  - b. 20-30 minutes **2**
  - c. More than 30 minutes **3**
8. What is the length of your dipping day (total hours from first dip/chew in a.m. to last dip/chew in p.m.)?
  - a. Less than 14.5 hours **0**
  - b. More than 14.5 hours **1**
  - c. More than 15 hours **2**
9. On average, how many dips/chews do you take each day?
  - a. 1 - 9 times **1**
  - b. 10 - 15 times **2**
  - c. >15 times **3**

Your score =

The highest possible score = 16 The closer to zero your score, the less dependent you are on tobacco. The higher the score, the more strongly you are addicted.

## ADVISE – ALL Users to Quit

Health professionals are in a good position to help users to understand how the general facts about smoking and health apply to them personally and to consider their implications. **In a clear, strong, and personalized manner, every tobacco user should be urged to quit.**

### Advise those people who smoke to stop

Brief, repetitive, consistent, positive reminders to quit from multiple providers (or reinforcement of a recent quit attempt) double success rates.

Advice and assistance are useful whatever the stage of change a tobacco user is at.

Use messages that are clear, strong, personalised, supportive, and non-confrontational.

Specifically, advice should be:

Clear

***“I think it is important for you to quit smoking and I can help you.”***

Strong

***“As your doctor, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The staff here and I will help you.”***

Personalised

Tie smoking to current health/illness, significant life events, social and economic costs, motivation level, readiness to quit and/or the impact of second-hand smoke on children and others in the household.

***“I know you’re concerned about your cough and that your son gets so many colds. If you stop smoking, your cough should improve and your son might get fewer colds as well.”***

If the opportunity is right, provide motivational interventions as specified in the **5 R’s**. The purpose of these interventions is to get tobacco users themselves to identify the key issues for them personally.

- **Relevance** *Encourage the tobacco user to identify why quitting is personally relevant*
- **Risks** *Ask the smoker to identify negative consequences of continued tobacco use for them in both the short and long term*
- **Rewards** *Ask the tobacco user to identify and discuss specific benefits of quitting*
- **Roadblocks** *Assist the tobacco user to identify barriers and specific impediments to quitting*
- **Repetition** *Reinforce the motivational message at every opportunity and reassure that repeated quit attempts are not unusual* It is important to note that not all of the **5 R’s** apply to each of the stages in the cycle of change. Use history, physical exam findings and significant life events to further personalise advice. Provide reinforcement via consistent/repeated advice to stop tobacco use.

You need to make it clear to the user about the diseases he/she is at risk to develop:

If you smoke but don't have any problems from it yet, you have...	If you use smokeless tobacco, you're at high risk of...	For smokers who have developed problems, smoking is correlated with...
<p>Twice the risk of heart disease</p> <p>Six times the risk of emphysema</p> <p>Ten times the risk of lung cancer</p> <p>Increased risk of colorectal cancer</p> <p>Increased risk of at least one type of skin cancer (giant basal cell carcinoma)</p> <p>Increased risk of macular degeneration (acquired blindness)</p> <p>A lifespan 5-8 years shorter than non-smokers</p>	<p>White or white/red mouth patches (leukoplakia)</p> <p>Oral and pharyngeal cancer at 4 to 7 times the normal risk.</p> <p>Stained and abraded teeth</p> <p>Gum disease, periodontal bone loss, tooth loss</p> <p>Dental caries, bad breath</p> <p>Poor oral wound healing</p> <p>Hairy tongue</p>	<p>Angina – chest pain; Shortness of breath; Upper respiratory infections, sore throat and cough</p> <p>Ulcers, Heartburn Osteoporosis; Pain -claudication</p> <p>Gum disease</p> <p>Hearing loss</p> <p>Cancers of all types</p> <p>Macular degeneration – acquired blindness</p> <p><i>Heart disease / Stroke</i></p>

## ASSESS – To determine Stage of Readiness to Change

### Useful Lines of Enquiry

- What are the good things (benefits) for you about smoking / chewing?
- Are there any things about smoking/ chewing 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?

<p><b>1. Determine stage of change:</b> Ask open-ended questions, listen carefully and determine stage.</p>	<p><b>No firm commitment to change:</b> (Person is in a state of Precontemplation, Contemplation or Relapse)</p> <p><b>Firm commitment to change:</b> (State of Determination/Preparation, Action or Maintenance)</p>
<p><b>2. Determine self-efficacy</b> (belief in his or her ability to carry out or succeed with a specific task).</p>	<p>Ask open-ended questions about other attempts the person has made to change behavior, i.e. attempts to quit smoking or using smokeless tobacco.</p> <p>Ask what worked and what didn't.</p>
<p><b>3. Examine the pros and cons of tobacco use</b></p>	<p><b>Rewards of tobacco use:</b> Ask open-ended questions to explore the positive aspects of tobacco use</p> <p>Follow by <b>Prompts for rewards:</b> Reduces Stress - Relieves boredom Good feeling - Satisfaction of Craving Handles other feelings Like the taste Weight loss / appetite control</p>

**Sample open-ended questions:**

*“How do you feel about your tobacco use?”*

*“What do you think about your smoking?”*

*“How does smoking fit into your life?”*

**Suggested follow-up questions if needed:**

*“So, are you saying that you’re thinking of [changing] soon, or not really??”* *“I’m confused. Are you saying that you’re ready to [change], or is this a bad time?”*

*“Have you ever tried to quit or cut down use of tobacco? If so, what went well? What got in the way?”*

*Is there something you could do to prevent this from getting in your way if you tried to quit or cut down again?”*

*“What do you think would have to change for you to succeed?”*

**Questions about pros:**

*“What are the positive aspects of smoking for you? ... any others?”*

*“Does smoking help you control your feelings?”*

	<p><b>Risks of tobacco use:</b>          Ask open-ended questions to explore the relevant risks and negative consequences of tobacco use</p> <p>Follow if necessary by <b>Prompts for risks:</b>          Long-term health concerns: heart disease, cancer, COPD, lifespan          Short-term health concerns: asthma, allergies, respiratory infections, others          Finances – cost of tobacco use over 1 year          Attractiveness to others – odours, stains on fingers and teeth          Acceptance by others          Example setting for others          Secondary smoke</p> <p><b>Weigh positives and negatives:</b>          Use a decisional balance sheet to summarize the perceived positive versus negative effects.</p>
<p>4. Offer information</p>	<p><b>Strategies for delivery or information:</b></p> <ul style="list-style-type: none"> <li>● Avoid a “scare tactic” tone, which may diminish the person’s openness to the feedback or information provided.</li> <li>● Deliver information in small chunks.</li> <li>● Acknowledge and explore any emotional responses to information by making reflective statements:  <i>“I imagine this is little scary.”</i>  <i>“You seem surprised.”</i> or <i>“You don’t seem surprised.”</i></li> </ul>

**Questions on Cons:**

*“Do you feel there are any less positive aspects of smoking for you...any others?”*

*“Are you concerned about any long-term tobacco-related health problems? ...or short-term problems like asthma, allergies, or respiratory infections?”*

*“How much do you spend on tobacco in a usual week? So, that’s about \_\_\_\_ rupees in a year. Is that money you would prefer to have for other things?”*

**Examples of statements:**

*“How do you think the lists of pros and cons compare?”*

*“So, for now, there seem to be many more advantages of smoking than disadvantages.”*

*“So it looks like there are major reasons to give up tobacco use.”*

**A. Establish patient receptivity:**

Responds to user’s requests for information? Ask users if they want certain information

**B. Solicit and reflect the patient’s general reactions and understanding:**

*“Does this make sense to you?”*

*“How do you feel about this?”*

**C. Ask users about perceived relevance:?**

*“How do you think this applies to you?”*

*“Does this seem relevant to you?”*

<p><b>5. Identify relevant goals</b>          The purpose of exploring goals is to discover ways in which the problem behavior is inconsistent with or undermines important values and goals for the patient.</p>	<ul style="list-style-type: none"> <li>● Ask open-ended questions about person’s goals for the future.</li> <li>● Help users determine whether tobacco use might interfere with those goals.</li> </ul>
<p><b>6. Explore for more commitment</b></p>	<p><b>Develop discrepancy between patients’ current behavior and future goals:</b></p> <ul style="list-style-type: none"> <li>● The user’s awareness of consequences is important</li> <li>● A discrepancy between current behavior and important goals can motivate change</li> <li>● Exploring the discrepancy heightens the anxiety about indecision about quitting</li> </ul> <p><b>Reassess stage of readiness to change:</b>          After the previous discussion ask the users to reconsider their thoughts about changing.</p> <p><b>Respond:</b>          Pause and wait for a response and discuss without “pushing”. Accept the patient’s position. Be empathic.</p> <p>For users who are not yet committed to change, leave the door open for future discussions</p>



**Sample questions to clarify goals:**

*“What would be the best results you could imagine if you make a change?”*

*“How long would you like to live with a minimum of health problems?”*

*“What would you like to be able to accomplish in your life?”*

*“What are the most important things in your life?”*

*“Do you have any other goals about: -health, ?family,? work,? finances, leisure?”*

*“Does tobacco use help or interfere with you reaching these goals?”*

**Sample Statement:**

*“So on one hand, smoking helps you relax a lot. On the other hand, you want to stay healthy well into your 80’s. It sounds like a real dilemma.”*

**Sample question:**

*“So I’m wondering where all this leaves you feeling about your smoking?”*

**Sample statement:**

*“I can understand why you’re not ready to try again just yet. If you decide you want some help in the future, please make another appointment. Anyone here would be glad to help with this.”*

## A. For Users Willing to Change

### ASSIST

<p>1. Reinforce commitment to change</p>	<p><b>Strategies to Reinforce Commitment to Change:</b>          Reinforce the potential benefits of change</p> <p>Bolster self-efficacy for behavior change</p> <p>Explore realistic options if needed</p>
<p>1. Help make a plan</p> <p>[see Model treatment algorithm – p. 72]</p>	<p>1. Identify what works/doesn't work</p> <p>2. Triggers          Help identify triggers, both internal and external, for using tobacco:</p> <p><b>Help develop strategies to manage triggers:</b></p> <ul style="list-style-type: none"> <li>● <b>Substitute behaviors</b> such as exercise, playing computer games, creative pursuits, meditation, journal writing, cooking, chewing gum, eating fruits or vegetables</li> </ul> <p><b>Think of rewards.</b></p> <ul style="list-style-type: none"> <li>● <b>Changes in environment.</b></li> <li>● <b>Explore use of medications</b> such as gum, patch, Bupropion or Selegeline, etc. (See Pharmacotherapy chapter.)</li> </ul>

**Sample statement to reinforce the benefits of change:**

Provide opportunities to individuals to remind themselves of the anticipated positive results of making the change. Mention positives important to the user.

*“Let’s review some of the positive reasons for quitting or cutting down on your use of tobacco.”*

**Sample statements to support self-efficacy:**

Provide opportunities for individuals to remind themselves of why they are likely to succeed better than they have in the past.

*“Remember you told me you’ve succeeded before.”*

*“You’ve shown that you’ve had what it takes in some very tough situations.”*

*“I bet you can do this.”*

“What worked well last time you stopped using tobacco?”

“What didn’t work? What were some of the problems?”

**Biological**, such as cravings

**Psychological**, such as activities or events, memories, stresses, moods, apathy, depression, anxiety

**Social**, such as celebrations, being with others who use tobacco, being alone, talking on the phone, boredom, after eating or sex

*“Some people like to set up rewards for themselves if they make changes. Do you think this would be helpful for you? What kind of a reward would help you keep on track?”*

	<ul style="list-style-type: none"> <li>● <b>Identify social supports</b> such as: support people (family members, friends, co-workers, health care professionals). Support groups in TCCs and professional counselors and programs. Make a referral if the patient is interested.</li> </ul>
<p>3. Help foresee possible weaknesses in plan maximizing concreteness and specificity, as the person agrees</p>	
<p>4. Guidelines for developing and refining plans:</p>	<p><b>Help identify options</b> and present menus of options if asked  <b>Honor the individual's decisions.</b>  <b>Make statements of partnership.</b></p>
<p>5. Implementation</p>	<p>Suggest that the patient <b>make promises and track implementation</b> such as keeping a diary or journal, listing successes as well as barriers and triggers.  <b>Set an implementation date.</b> Make the date specific and reasonable. It could coincide with a special date such as a birthday or New Years Day.</p>
<p>6. Suggest making a contingency plan</p>	<p><b>Explore any stresses</b> or special events coming up that might make a difference. <b>Make a contingency plan.</b></p>
<p>7. Summarize the main steps of the plan and bolster self-efficacy</p>	<p>You may want to suggest that the <b>patient write down the main steps</b> of the plan and both sign it. <b>Give feedback</b>  <b>Remind the person that you are here to help.</b></p>

*“Are there certain things about your environment that might need changing to help you succeed?”—such as social contracts, neighborhood, home, work space? Ask, “What could you do to change these?” or “Would it help to throw away all your tobacco matches, and lighters?”*

Ask, “How would you ask them for help?”

*“As you think about it do you see any weaknesses in the plan?*

*“Any ideas about how to shore up this part of your plan?”*

“I’m here to help you work this out and to support you.”

“When would you like to get started? It helps to choose a day with special significance to you!”

“Would it be helpful to have a contingency plan to help when stresses increase?”

“I am really encouraged by this.” “It sounds like you’re heading in a great direction.”

## ARRANGE - FOR FOLLOW-UP

<p><b>Set a specific follow-up appointment</b> in two weeks or a month to review the progress on the plan.</p>	
<p><b>Reinforce your partnership:</b></p>	<p>“Sometimes despite the strongest intentions and the best plans, the plan doesn’t succeed. If this happens, I won’t be angry, and I won’t judge you. I would just want to help you figure out where things didn’t work and how we could improve the plan for next time. OK?”</p>
<p><b>Project optimism.</b> Take the opportunity to encourage success. Be enthusiastic</p>	<p>“I’m very encouraged about your willingness to try to change your tobacco use. You’ve done things like this before and you have a realistic plan, I believe you can do this</p>
<p>Check-in with the person by phone call if possible or post a pre-printed letter or post-card</p>	
<p><b>Users may slip back to earlier stages of change:</b></p> <p>During a visit or in between visits, users may slip back to earlier stages of change. Even after making a plan they may again become ambivalent about making a change. If so, be accepting and empathic, reassess the stage of change and return to the appropriate step in the tobacco intervention process.</p>	

## B. For the User Unwilling To Change: Promoting the Motivation To Quit

### ASSIST

Users unwilling to make a quit attempt during a visit may lack information about the harmful effects of tobacco, may have fears or concerns about quitting, or may be demoralized because of previous relapse. Such persons may respond to a motivational intervention that provides the clinician an opportunity to educate, reassure, and motivate such as the motivational intervention built around the '5 R's': *Relevance*, *Risks*, *Rewards*, *Roadblocks*, and *Repetition*.

#### Relevance

Encourage the person to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a person's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

#### Risks

Ask the individual to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. Emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco) will not eliminate these risks.

***Acute risks:*** Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, increased serum Carbon Monoxide.

***Long-term risks:*** Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability and need for extended care.

***Environmental risks:*** Increased risk of lung cancer and heart disease in spouses; higher rates of smoking by children of tobacco users; increased risk for low birth weight, SIDS, asthma, middle ear disease, and respiratory infections in children of smokers.

<p><b>Rewards</b></p> <p><i>The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the individual.</i></p>	<p>Improved health.</p> <p>Food will taste better. Improved sense of smell.</p> <p>Save money.</p> <p>Feel better about yourself.</p> <p>Home, car, clothing, breath will smell better.</p> <p>Can stop worrying about quitting.</p> <p>Set a good example for children.</p> <p>Have healthier babies and children.</p> <p>Feel better physically. Perform better in physical activities.</p> <p>Reduced wrinkling/aging of skin.</p>
<p><b>Roadblocks</b></p> <p><i>The clinician should ask the person to identify barriers or impediments to quitting and note elements of treatment (problem solving, pharmacotherapy) that could address barriers.</i></p>	<p>Typical barriers might include:</p> <p>Withdrawal symptoms.</p> <p>Fear of failure.</p> <p>Weight gain.</p> <p>Lack of support.</p> <p>Depression.</p> <p>Enjoyment of tobacco.</p>
<p><b>Repetition</b></p> <p>The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.</p>	



## C. For the User Who Has Recently Quit : Preventing Relapse

Because of the chronic relapsing nature of tobacco dependence, clinicians should provide brief effective relapse prevention treatment. When clinicians encounter a person who has quit tobacco use recently, they should reinforce the person's decision to quit, review the benefits of quitting, and assist the person in resolving any residual problems arising from quitting. Although most relapses occur early in the quitting process, some relapse occurs months or even years after the quit date. Therefore, clinicians should engage in relapse prevention interventions even with former tobacco users who no longer consider themselves actively engaged in the quitting process.

Relapse prevention interventions are especially important soon after quitting and can be delivered by means of either scheduled clinic visits, telephone calls, or any time the clinician encounters an ex-tobacco user. A systematic, institutionalized mechanism to identify recent quitters and contact them is essential to deliver relapse prevention messages effectively.

Problems	Responses
Strong or prolonged withdrawal symptoms	Consider extending the use of an approved pharmacotherapy or adding/combining pharmacological adjuncts to reduce strong withdrawal symptoms.
Negative mood or depression	Provide counseling, prescribe appropriate medications, or refer the individual to a specialist.
Lack of support for cessation	Help the person identify sources of support within his or her environment. Refer the person to an appropriate organization that offers cessation counseling or support.
Flagging motivation/ feeling deprived	Reassure the person that these feelings are common. Recommend rewarding activities. Emphasize that beginning to smoke (even a puff) will increase urges and make quitting more difficult.
Weight gain	Reassure the person that some weight gain after quitting is common and appears to be self-limiting. Emphasize the importance of a healthy diet.

## Some Skills to Help You Talk People into Changing

### Ask Open-ended questions:

Rather than asking questions, which only require a yes or no answer, try and ask open questions. For example, instead of saying “*Would you like to quit, ask, “What do you think about your smoking?” “How does smoking fit into your life?”* Instead of asking a closed question like “*Do you know that tobacco is bad for you?”* you could ask, “*How do you feel about your smoking?*”

That way, instead of closing the conversation down into a yes or no response, you open it out and encourage the other person to keep talking. This helps uncover the user’s priorities and values and avoids socially desirable responses. It also draws people out

Open questions usually start with.... how? what? could? would? Closed questions are the ones which demand answers to: is? are? do? did?

### Clarifying

We all skirt around or gloss over the most difficult things. If we can avoid saying them, we will. If the person you’re speaking with glosses over an important point, saying ‘Tell me more about...’ or ‘...sounds like a difficult area for you’ can help them clarify the points, not only for you, but for themselves.

### Short words of encouragement

It sounds obvious, but a ‘Yes’, ‘Go on’ or ‘I see’ can really give some much-needed encouragement.

### Reflecting

Repeating back a word or phrase can encourage people to go on. If someone says, ‘So it’s been really difficult recently’ you can keep the conversation going simply by repeating ‘Difficult...’. Sometimes rephrasing or Reflection of the feeling being conveyed by the person reflects YOUR understanding of THEIR experience.

Patient: *“I’ve tried so many times to quit and I can’t do it.”*

Clinician: *“You feel unable to stop smoking.”*

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## Summarizing:

This involves reflecting back to the patient the essence of what you've heard over some time. **Summarizing says to the user:**

"What you've said is important."

*"I value what you say."*

"Here are the salient points."

"Did I hear you correctly?"

*"We covered that well. Now let's talk about..."* It helps to show that you've listened to, and understood, what's been said.

## Affirm (Validate) Or Normalize

Affirming some of the user's views and experiences and telling them that it is acceptable to talk of being attached to smoking or that others in their position also face similar difficulties e.g. *"I can understand how it would be difficult to give up smoking now."* – *"You've accomplished a lot in a short time."* provides support to the user / patient, convey respect and understanding for their position. This helps to encourage more progress and helps patients reveal less positive aspects of themselves.

Statements like "Many tobacco users who come to me tell me they feel that way. It's normal to feel that way" help similarly.

## Elicit self-motivational statements

Get users to present arguments for change in 4 areas:

Problem recognition: *"Has smoking caused you any problems?"*

Concern: *"Do you worry about your smoking?"*

Intention to change: *"What might be some advantages of changing?"*

Or

*"On a scale of 0 to 10, how important is it for you to change?"*

*"Why didn't you say (1-2 points less)?"*

Optimism: *"What difficult goals have you achieved in the past?"*

Or

*"On a scale of 0 to 10, how optimistic are you that you could change if you wanted to?"*

*"Why didn't you say (1-2 points less)?"*

### Some don'ts to Remember

Don't be judgmental.

Don't use scare tactics.

Don't exaggerate.

Don't disagree.

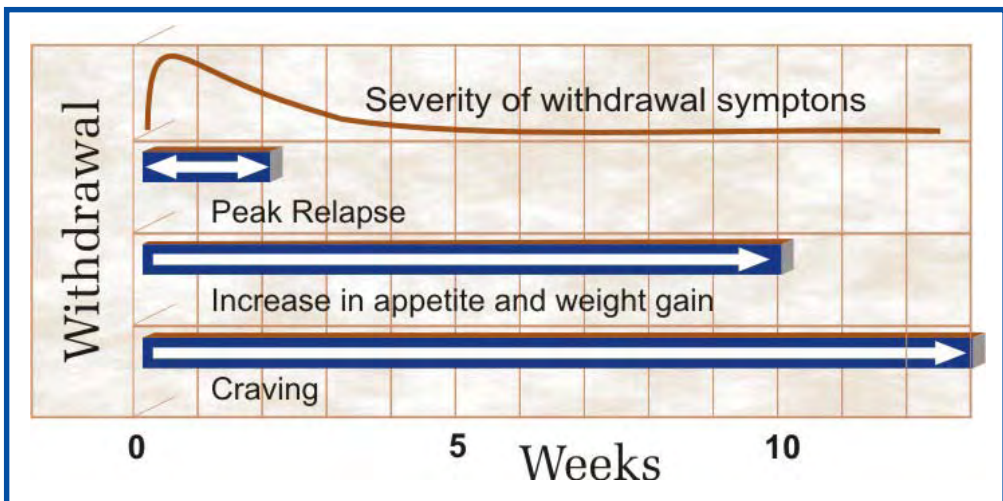
Don't push too hard.

## Behavioral Strategies: Advice for coping with withdrawal and relapse

Know the withdrawal symptoms and signs that any tobacco user may suffer from and be well versed with the ways to deal with them when encountered by a tobacco user.

### Withdrawal

Common side effects of nicotine withdrawal are: cravings, difficulty concentrating, insomnia, depression, or feelings of anger, irritability, frustration, restlessness, or anxiety. These feelings will be strong at first but they will gradually reduce as the person stays away from tobacco for longer periods.



Withdrawal effects	Techniques to be advised to users to overcome
<p><b>Cravings</b></p> <p>Cravings will be strongest in the first week. Generally they are individual “cravings” that last 30-90 seconds but sometimes people also experience “rapid fire” cravings where they follow each other in rapid succession. As the days pass, the cravings will get farther and farther apart.</p> <p><b>Most cravings begin 6-12 hours after stopping, peak for 1-3 days, and may last 3-4 weeks. Mild occasional cravings may last for 6 months.</b></p>	<p><b>1. Deep Breathing</b></p> <p>Breathing for relaxation, Three things to remember: 1. Breathe slowly, from the bottom up. Sit relaxed with hand below rib cage, above stomach. Imagine lungs divided into 3 parts. Expand the bottom, middle, and top in one continuous motion. Inhale through the nose, exhale through the mouth. Exhale with a sigh (relaxing sound) or with a “whistle,” through pursed lips (good for clearing the lungs of stale, trapped air). Repeat 10 times.</p> <p><b>2. Drinking:</b></p> <p>At least 3 glasses of water in the day and 2 glasses to counter craving</p> <p><b>3. Distraction</b></p> <p>Avoid situations/activities that are normally associated with smoking (e.g. drinking alcohol.); Change surroundings or sit down and relax; Review reasons for quitting; Talk with a friend about the urges and what you are doing about them. Take a nap or a shower and exercise.</p>
<p><b>Difficulty Concentrating</b></p> <p>Cigarettes provided relaxation breaks. Having quit, you still need to take a break. This may be quite difficult because cigarettes gave you a reason to stop working for 10-15 minutes and now you may have to manufacture a new reason. Over 50% of quitters report problems with concentration within 1 week of quitting. <i>Difficulty in concentrating usually begins within the first 24 hours, peak for the first 1-2 weeks, and disappears within a month.</i></p>	<p>Take a break: gaze into a photo, look out a window, close your eyes and relax for ten minutes. Try to come up with other things that you can do on a 10-minute break—maybe you can get some minor chores out of the way as a “break” from a repeated activity. Do different tasks instead of focusing on any one activity for too long. If you can, put off work when you feel unable to do it. Do important tasks during the times when you feel alert.</p>

<p><b>Insomnia</b>          Trouble falling asleep or disturbed sleep and daytime drowsiness. Sleep disturbances begin within the first 24 hours, remain strong for the first 1-2 weeks, and disappear within a month.</p>	<p>Avoid coffee, tea, caffeinated drinks after 6 pm. Drink fruit juices, and water. Read up on relaxation/meditation techniques and try one. Avoid changes in sleep routine: always get up at the same time every morning.          Prepare for sleep—before bed, allow for 15-30 minutes of “quiet time.”</p>
<p><b>Depression</b>          Mild feelings of depression may occur usually within the first 24 hours, continue in the first 1-2 weeks, and go away within a month. Though a prior history of depression is associated with more severe withdrawal the incidence of major depression after quitting is low.</p>	<p>Identify your specific feelings at the time that you seem “depressed.” Are you actually feeling tired, lonely, bored or hungry? Focus on and address these specific needs. Add up how much money you have saved already by not purchasing cigarettes and imagine (in detail) how you will spend your savings in six months. Call a friend and plan to have lunch, go to a movie. Make a list of things that are upsetting to you and write down solutions for them.</p>
<p><b>Irritability, Restlessness, Anger and Frustration</b>          Feeling more “edgy” and short-tempered is common. As is increased distractibility. 50-80% of quitters report increased feelings of irritability, anger, and frustration usually beginning within the first 24 hours, peak (stay high) the first 1-2 weeks, and disappear within a month.</p>	<p>Take a walk or exercise. Avoid caffeine-containing drinks like coffee or colas. Have a hot bath, use relaxation techniques. An easy method is to take one minute and, with eyes closed, pay attention to one’s breathing pattern. Breathing in deeply through the nose and breathing out through the mouth. Set aside some “quiet time” every morning and evening—a time when you can be alone in a quiet environment. Listen to your body. If you feel that you need to move around, you probably need a break...get up and stretch, go for a brief walk. Expect feelings of restlessness —take regular 10-minute mental and physical breaks from whatever work you are doing. Be active during those breaks...walk, stretch, and run. You may want to try squeezing a rubber ball or one of many “stress relief” items to help keep your hands busy.</p>
<p><b>Anxiety</b>          “Tension” and agitation – feelings of tightness in the muscles—especially around the neck and shoulders. These feelings will pass with time. Recent studies have found that 60-90% of quitters report feelings of increased anxiety within 1 week of quitting. If anxiety occurs, it will usually begin within the first 24 hours, peak in the first 1-2 weeks and disappear within a month.</p>	

**Remembering the Good Times**

Feeling the need to smoke when faced with pleasurable situations cued to previous use such as a cup of coffee, sitting with friends, quiet times, driving, etc. These feelings are strongest in the first two weeks after quitting.

Figure out which memories make you want to smoke most and learn to manage them.

Take up some new activities such as walking, reading, a hobby, playing a sport or attending community events.

Repeat the following: "If I'd known then what I know now, I never would have started smoking."

Focus on the thought that you will be able to enjoy your good memories longer, now that you've quit smoking.

**Increased Appetite and Weight Gain**

Stronger and more frequent hunger pangs are experienced, and the sense of taste also improves. Weight gain, most often due to eating more after quitting is a common but temporary phenomenon. 75% of all people who quit tobacco do not gain weight and, of those who do, gain an average of 2-3kgs!

**Increased hunger begins within the first 24 hours, peaks in the first 1-2 weeks, and may last 1-6 months.**

Do more physical activities (e.g. take the stairs instead of a lift, park further away from the door to the office/shop etc.).

Select non-food rewards— go see a new movie.

Drink more water—especially before meals.

Plan meals ahead of time and don't skip meals.

Weigh yourself every day.

Eat plenty of fresh fruit—carry it with you to work, to school, everywhere!

## Relapse Prevention

Help users identify the high-risk situations. Following are some helpful tips to be told to users to overcome such situations.

### High-Risk Situations

1. First step: identify high-risk situations where they've relapsed in the past. How would you answer this question: "If I were to start smoking again on the spur of the moment..." Be specific: where? When? With whom? How you are feeling? Thinking? Doing?
2. Next, plan and advise in advance about the responses or solutions to cope with these triggers

### Common high-risk situations and some ways to handle them

Common Smoking Signals	
●	Wake-up – toilet rituals
●	Coffee or tea
●	After meals
●	Drinking alcohol
●	On the telephone
●	Driving
●	Seeing others smoke
●	Tension/anxiety
●	Finishing task
●	Before starting task
●	To relax/ take a break
●	To concentrate
●	Studying
●	Watching T.V.



## People

### Being Around Smokers -

Expect some friends especially those who are smokers themselves, to end up trying to sabotage the individual's efforts to cut down or quit. The changes he/she intend to make may disturb friends and family members who are smokers. Friends may feel that person's efforts to control smoking will put a strain on their friendship. It will be tempting to join others for routine "smoke breaks.

" User will probably find that he/she does not always want to smoke when they see someone else doing it. It's something special about the circumstance that triggers the user.

Advice user to ask others not to smoke in his/her presence.

Provide an outside area at home where smokers may go if they wish to smoke. Encourage posting a small "No Smoking" sign by the individual's front door

If person is in a group and others light up, advice person to excuse oneself, and not to return until they have finished.

Ask them not to buy, carry, light, or hold cigarettes for others.

## Places or situations – smoking cues

### Drinking Coffee or Tea

He does not have to give up coffee or tea to quit smoking. Expect to feel a strong urge to reach for a cigarette while drinking coffee or tea. User will have to note, which coffee/tea drink gives an urge, and he/she will have to find an alternative to keep them from reaching for a cigarette. Person may be used to smoking when drinking coffee or tea during or after meals, during coffee/tea breaks, in office, or in restaurants.

If person used to smoke while drinking coffee or tea, ask him to tell people he has quit, so they won't offer him a cigarette. Between sips of coffee or tea, advice to take deep breathes to inhale the aroma. To breathe deeply and slowly, while he counts to five, breathe out slowly, counting to five again. As the users drink coffee, advice them to get a scratch pad, doodle, or make plans for the day. If the urge to smoke is very strong, advice to drink their coffee or tea faster than usual and then change activities or rooms.

## Places or situations – smoking cues

### Facing the Morning

When they wake up, ask them to begin thinking of alternatives to smoking and the changes in your routine immediately. Morning coffee will not taste the same without a cigarette.

For many smokers, lighting up is the first event of the day. Part of many people's dependence on cigarettes evolves from a routine built mostly upon their chances to smoke. The morning can set the tone for the rest of the day.



Advice to plan a different waking up routine. Put their attention off smoking right away. Be sure no cigarettes are available. Begin each day with deep breathing and one or more glasses of water. Make a list of early morning triggers, and avoid them. Ask them to begin each day with a preplanned activity that will keep them busy for an hour or more. If reducing, this will push that first cigarette to later in the day and if quitting cold turkey, it will keep user's mind and body busy so that he/she does not think about smoking for a while.

<p><b>Enjoying Meals</b></p> <p>Expect to want to smoke after meals or with others at a restaurant. Expect the urge to smoke when you smell cigarette smoke at a restaurant. Smoking urges may be stronger at different meal times, sometimes breakfast, sometimes lunch or sometimes dinner. They may be stronger with certain foods like spicy or sweet meals or snacks.</p>	<p>Ask them to know what kinds of foods increase their urge and advice them to stay away from them. Ask users to brush teeth or use mouthwash right after meals.</p> <p>Ask them to concentrate on the taste when they have coffee or tea.</p> <p>Ask to wash the dishes by hand after eating—they can't smoke with wet hands!</p> <p>Advice a brief walk after meals.</p>
<p><b>Relaxing</b></p> <p>Users may still want to reach for a cigarette whenever they start relaxing if they had been doing so for years. User may reach for a cigarette in order to ease the anxiety.</p> <p>Recent studies have found that 60-90% of quitters report feelings of increased (higher) anxiety within one week of quitting. If you feel anxious, it will usually begin within the first 24 hours after quitting, peak in the first 1-2 weeks, and disappear within a month.</p>	<p>Ask users to repeat: "I can learn to relax without having a cigarette."</p> <p>Engage him in activities that use his hands, like sewing, carving, working puzzles, playing cards, etc.</p> <p>Make an extra effort to share their leisure time with a friend, a child or even a pet.</p> <p>If the urge to smoke gets too strong, advice them to stop relaxing and start doing something physical until the urge passes.</p> <p>Deep breathing is a good way to deal with tension almost anywhere and at any time.</p>
<p><b>Having a Drink</b></p> <p>As a smoker, user may feel a strong urge to smoke when drinking alcoholic drinks. Know this up front if he/she is going to drink. Studies show that cigarette smoking is much more common among those who are regular drinkers.</p>	<p>Advice to switch to non-alcoholic drinks during the first two weeks of withdrawal, especially fruit juices. Ask user to stay away from their usual haunts for a while.</p> <p>If he/she must drink, change drinks from "their usual." Don't drink at home or alone.</p>

<p><b>Talking on the Telephone</b> Expect them to be nervous because users want something in hand while on the phone. They may want to smoke during every phone call, only during certain phone calls or only during calls made at specific times of the day. Be prepared the urges will vary.</p>	<p>Tell them to pick up a pencil and have a large memo pad for doodling.</p> <p>Hold the phone with the hand he/she used for smoking. While they are on the phone, ask them to walk around as much as possible.</p> <p>Keep some gum by the phone; ask them to chew while they talk.</p> <p>Ask them to note down which calls make them want to smoke. Do specific types of calls or calls made at a certain time affect users more? Is calling a certain person (or certain people) more difficult?</p>
<p><b>Traveling by Car</b> Expect them to want to reach for a cigarette when driving a car or traveling as a passenger. Expect to want something to do, ask them turn the radio on or put on their favorite tape or CD and sing along. On longer trips, they may be getting more sleepy than usual. Like many smokers, they may like to light up when driving to and from work as a means to: relieve stress, stay alert, relax, or just pass the time. Their desire to smoke may be stronger and more frequent on longer trips.</p>	<p>Ask them to clean their car and use deodorizers to hide the tobacco smell. Tell them to repeat "This urge will go away in a few minutes." "So, I'm not enjoying this car ride! It won't last forever!" "My car smells clean and fresh!" "I'm a better driver now that I'm not smoking while driving." Things to do: Remove the ashtray, lighter, and cigarettes from your car. Ask friends not smoke in your car. If not driving, find something to do with their hands. Take an alternate route to work. For a little while, avoid taking long car trips. If they do, ask to take plenty of rest stops. Take fresh fruit with them on long trips. Plan stops for water, fruit juice, etc.</p>
<p><b>Watching TV</b> TV programs may provide many "triggers" to smoke (i.e. movies that show smoking, re-runs of old detective shows, etc.) The time of day that they watch TV may also be a smoking "trigger." For example, they may be used to</p>	<p>Ask them to get rid of cigarettes, ashtrays, and lighters. Ask to sit in a different place.</p> <p>Explain them the Practice relaxation—take a minute and, with your eyes closed, pay attention to your breathing pattern. Breathe in deeply through your nose and breath out through your mouth. Tell them the following sentences depending on the situation;</p>

smoking when watching a morning news program or a late night talk show. When smoking in the house, they may be used to smoking while watching TV. They may also be more likely to smoke only while watching specific programs.

'If you fall asleep-enjoy it'. 'Have low fat snacks handy'. 'Channel surf away from high trigger content shows—change the channel when you see smoking! "Try watching at different times of the day."

## Feelings

### A. Situations involving negative emotional states (anger, depression, frustration, boredom)

#### Facing Boredom

They will “take a break” from working and find that they have nothing to do. They may feel very bored when waiting for something or someone. (e.g. a bus, your spouse, your kids). About 40% of smokers say they sometimes smoke to overcome boredom.

Ask them to plan more activities than the time.  
Ask them to make a list of things they like to do  
More!  
Ask not to stay in the same place too long. Ask to carry a book or magazine for waiting times.  
Ask them to carry something to keep their hands busy. Tell them to Hum a tune or favorite song—maybe even listen to a portable radio.  
Ask to go outdoors, if they can.

#### Handling Stress

Expect them to become more aware of stress during withdrawal. Nonsmokers have found many ways to break the stress cycle without lighting a cigarette. Almost 63% of smokers report smoking to handle stress. They may become more aware of stress during withdrawal. This may be largely because using cigarettes actually relieved some of this normal stress by releasing powerful chemicals in their brain.

Ask them to know the cause of stress in their life (e.g. job, children, money).  
Ask them to identify the stress signals (e.g. headaches, nervousness, insomnia or trouble sleeping).  
Ask them to create peaceful times in their everyday schedule. (e.g. Set aside an hour where they can get away from other people and usual environment.)  
Ask to try new relaxation methods and stick with the best ones.  
Ask to rehearse and visualize relaxation plan.  
Ask to put their plan into action. Encourage changing plan as needed.  
Ask them to seek and learn relaxation techniques such as progressive relaxation.

## **B. Situations involving high, positive emotional states**

### **Rewarding aspect**

Finishing a hard job or celebrating a special occasion might lead anyone wanting to treat oneself with a dose of tobacco. Find out what it is about certain situations that make the person feel that he/she has earned a dose of tobacco. Advise individual to be on his/her guard at these critical times. Feelings of wanting to treat self with a cigarette/ chewing tobacco may happen along with regular cravings for tobacco. Most of these cravings will begin 6-12 hours after a person stops, stay strong for 1-3 days, and may last up to 3-4 weeks.

### **Explain Self-Management to the user**

Suggest spending for a couple of months (e.g. ask him to buy a little gift for himself every week the person does not touch tobacco, go out to dinner once a week or see a movie).

Think of non-smoking rewards; take time to read a book, listen to a favorite tape or telephone a friend.

Advise to put the money aside as savings by not smoking, into a jar everyday. Keep a list of things that individual may want to buy with the money and buy them.

Remind the user that his/her real rewards will come later...in several extra years of health.

## **Thoughts and Urges**

### **Thought Management**

A. People say that there is not always a clear “signal” to smoke—sometimes strong urges, high risk situations do seem to come out of thin air.

1. It's natural at this stage when not smoking to be thinking about smoking.
2. Thoughts can have powerful impact on your actions. Can undermine your behavior, put you in high-risk situations.

B. There's a part of user that really wants to go back to smoking. This part will try to argue the person into going back. Its major weapon—resumption thought.

1. Resumption thoughts are thoughts about smoking, rationalizations.
2. If we can identify them, we can start to deal with them.

- C. Ask people who slipped what they were thinking about before the slip.
1. Nostalgia
  2. Testing self
  3. Crisis
  4. Unwanted changes
  5. Self-doubts
  6. Irrational “I’ll die anyway.”
- D. Strategies for Controlling Thoughts (willpower = managing thoughts in a critical situation.)
1. Advise to challenge the thoughts as they occur.
  2. Priming self. Sometimes thoughts slip by so fast, can’t confront each one. Help user Prevent himself from being overwhelmed by priming (reminding yourself on a regular basis of positive, nonsmoking thoughts).
    - a. Cues, e.g., smoking signals can be cues for nonsmoking thoughts
    - b. Index cards with positive thoughts—in pocket or posed
  3. Hand out index cards for users to write down their own personal positive thoughts and benefits. Have each person read off one from his or her cards.
- E. Strategies for Dealing With Urges
1. In addition to resumption thoughts, sometimes people experience just plain urges to smoke—usually in situations in which the person smoked in past: may sometimes seem to come out of thin air.
  2. Can deal with urges to smoke in same way you deal with resumption thoughts (challenge or priming).
  3. Other things to be told to users to remember about urges—distance from urge, don’t identify with the urge. Ways to get distance, perspective on urge.
    - a. Remind them it’s natural to have urges—learned physiological reaction. They’re just there, “Urges are not urgent.” They are not a sign that he/she “need’s” tobacco.
    - b. Remind yourself, “The urge will pass. The urge will pass whether I smoke or not.”
    - c. Picture the urge as a wave—watch the wave break upon the sand as the urge subsides.

## Common Resumption Thoughts and Strategies

Thought	Strategy
One won't hurt I can have just one.  I really enjoy smoking!	Admit the challenge I don't need to test myself—one can hurt. Do I want to go through this again? Remind self how far you've come.
It used to be so nice to smoke and be with friends/have a beer.	Remember unpleasant/embarrassing times
I'll probably die in a car crash anyway.	Confront logic. Relaxing was good/being with friends good.
It's too much work, I can't handle it.	Improvements in quality of life—think of the benefits.
Smoking will help you get through/cope.	Think: do I really want to go through this again? Time
I don't want to be fat.	May gain a few pounds—but can handle that later—just temporary.
I'm too irritable—everyone hates me!	Just temporary—warn people I'm Free! I'm proud of myself! I can do it

### Slips

- A. Warned you—one could hurt, why play with fire? Not good idea to take even one dose of tobacco. Not giving Person the permission to take tobacco. But sometimes it happens. What if, despite all planning user may slip and take tobacco. Ask group: How do you think you'd feel? If someone has experienced this before, share how it felt.
- B. People usually feel guilty, disappointed, like they've blown it, and it's all over. This is common. In fact, we have a name for this feeling—the “Abstinence Violation Effect” (AVE—explain it.)
  - Things to remember:
    - a. Feeling will pass; and
    - b. There's another way to interpret the slip.
- C. How you interpret a slip is important. Interpret it just as a mistake. Learn from it, get back in control, and remember you don't have to smoke another one. One slip is not a relapse. Slip is an indicator of where you need to do more planning.
- D. Hand out AVE cards: read with group. Emphasize importance of carrying them around and using them  
(Can use empty space to write down some positive thoughts).



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## Pharmacotherapy for Tobacco Cessation

Pharmacotherapies can be divided into nicotine replacement therapy, and non-nicotine medications that have anti-craving effects. Pharmacotherapies have an empirical record of efficacy for nicotine addiction and numerous studies have shown pharmacotherapies to significantly improve long term-quit rates. Recent consensus recommendations by multiple authorities establish them as a component of the “standard of care” for intensive treatment of nicotine addiction. Evidence is mounting for use of pharmacotherapy for smokeless tobacco users as well.

### Which tobacco users should receive pharmacotherapy?

Pharmacotherapy should be considered for every patient. There is no absolute contraindication.

Special consideration, however, is required for certain patient groups among whom one or more of the drugs may have deleterious effects:

- Pregnant/breast-feeding women: No agents are approved for these patients, but pharmacotherapy is generally considered less harmful than tobacco use itself. Quit attempts without pharmacotherapy — especially in light tobacco users — are initially preferred.
- Smokers with cardiovascular or pulmonary disease: Although all agents are generally safe, patients with these conditions should be specially cautioned not to use tobacco while using nicotine replacement. Care should be exercised with use of nicotine with patients who have had a recent myocardial infarction, experience severe or worsening angina, or have serious arrhythmias.
- Light smokers (<10 cigarettes/day), chewers (<1 sachet of SMT /week).
- Adolescents and youth – be sure that they are dependant and not just experimenting with tobacco.

### *Nicotine replacement therapy*

Nicotine Replacement Therapy (NRT) is used to relieve withdrawal symptoms in tobacco users when trying to quit. However, it must be made very clear that NRT alone is not the answer. Behavior modification is an important aspect of any behavior change, especially tobacco cessation. The use of NRT allows individuals to focus on the behavioral aspects of quitting without experiencing severe withdrawal symptoms. After the acute withdrawal period, nicotine replacement therapy is gradually reduced so that little withdrawal should occur.

### ***Nicotine gum.***

Nicotine ingested through the gastrointestinal tract is extensively metabolized on first pass through the liver. Nicotine gum (nicotine polacrilex) avoids this problem via buccal absorption. The gum, which is available in India, contains 4 mg of nicotine that can be released from a resin by chewing. Scheduled dosing (e.g., 1/2 piece of 4-mg gum/hour), and 4-mg gum for highly nicotine-dependent smokers is more effective, however using ½ piece of gum p.r.n. in response to craving has also been used. The gum manufactured in India comes in two varieties—a Guthka flavored one for pan paraag and guthka users and a Mint flavored one for smokers.

Duration of treatment is 4-6 weeks; start weaning after 2-3 months.

#### **Patient Instructions for Nicotine Gum**




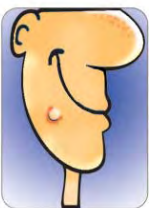





1. Do not smoke while using the gum.
2. Use one piece of gum at a time and use on a fixed schedule (1 piece/hour).
3. Chew gum slowly until a peppery taste or tingling of the gums occurs. Then, stop chewing and park the gum in between the gums and cheek until tingling stops. Start chewing gum again and repeat the parking and chewing process for about 30 minutes.
4. Parking the gum is necessary for the nicotine to absorb through the buccal mucosa. If individuals do not park the gum, more nicotine will be swallowed resulting in side effects such as nausea and vomiting.
5. Do not eat or drink anything 15 minutes prior to and during the use of the gum. Absorption of nicotine via the buccal mucosa is decreased by an acidic environment; thus, patients should not use beverages (e.g., coffee, soda, juice) immediately before, during, or after nicotine gum use.

Precautions: Pregnancy, Lactation, CVD, Peripheral Vascular Disease, Endocrine disorders, Oral or pharyngeal inflammation or esophagitis, Gastric ulcers.

Side effects: Major side effects from nicotine gum are very rare. Minor side effects are of mechanical origin (e.g., difficulty in chewing, sore jaw) or of local pharmacological origin (e.g., burning in mouth, throat irritation, nausea, vomiting, hiccups, and excess salivation). Tolerance develops to most side effects over the first week. Education about proper use of the gum (e.g., do not chew too vigorously) decreases side effects. Originally, some disorders were listed as contraindications to use of nicotine gum (e.g., cardiovascular disease,

pregnancy, hypertension), but given that nicotine blood levels are much lower with nicotine gum than with cigarettes, these contraindications have been dropped.

About 10%-20% of those who stop smoking with the help of nicotine gum continue to use nicotine gum for 9 months or more, but few use the gum longer than 2 years. There are several lines of evidence that most long-term use is not dependence. All but 1%-2% of smokers eventually stop gum use, the amount of gum use at long-term follow-up is minimal (usually 12 mg/day), the amount of gum use decreases over time, and weaning off the gum usually requires only education and reassurance even in long-term users. Harmful effects of long-term use of nicotine gum are unlikely given the absence of exposure to carcinogens or carbon monoxide and the much lower levels of nicotine from nicotine gum than from cigarettes.

<p>When there is a urge to smoke</p> 	<p>Take out a gum from its pack and start chewing it SLOWLY</p> 	<p>Continue chewing slowly until tingling or peppery taste is felt. (about 5 minutes)</p> 
<p>Place the gum between gum and inner cheek.</p> 	<p>Let it there for about 10 minutes so that the released nicotine is absorbed.</p> 	<p>Switch the gum to the other side of the mouth and start chewing slowly again for about 5 minutes.</p> 
<p>Park the gum between your gum and inner cheek again for another 10 minutes.</p> 	<p>Switch it back to the other side and repeat the whole process for third time.</p> 	<p>After that the gum may be discarded in a safe place away from children and pets.</p> 

### ***Nicotine patch.***

The transdermal formulations take advantage of ready absorption of nicotine across the skin. Three of the patches are for 24-hour use and one is for 16-hour (waking) use. Starting doses are 21-22 mg/24-hour patch and 15 mg/16-hour patch. Patches are applied each morning beginning upon cessation of smoking. Nicotine via patches is slowly absorbed so that on the first day venous nicotine levels peak 6-10 hours after administration. Thereafter, nicotine levels remain fairly steady with a decline from peak to trough of 25% to 40% with 24-hour patches. Nicotine levels obtained with the use of patches are typically half those obtained by smoking.

After 4-6 weeks patients are usually tapered to a middle dose (e.g., 14 mg/24 hours or 10 mg/16 hours) and then again in 2-4 weeks to the lowest dose (7 mg/24 hours or 5 mg/16 hours).

Most, but not all, studies indicate abrupt cessation of the use of patches often causes no significant withdrawal; thus, tapering may not be necessary. The recommended total duration of treatment is usually 6-12 weeks.

The Nicotine patch is not currently freely available in India.

#### **Patient Instruction for Nicotine Patch**

1. Do not smoke while using the patch.
2. Rotate the patch site to minimize skin irritation.
3. If insomnia occurs, remove patch before going to bed or use 16-hour patch.
4. Apply a new patch every day (remove the old patch) in a location between the neck and waist that is relatively hairless and where the skin is not broken. Apply to a different location each day.
5. Wash hands with water only after applying the patch; soap may increase nicotine absorption.
6. Do not touch face or eyes immediately following the application of the patch.
7. Discard unused patches in a protective pouch (such as a zip lock bag) and discard in a place where children and animals cannot reach it. Used patches may still contain nicotine.

## Non-nicotine agents: Anti-craving medications

### Bupropion Hydrochloride Sustained Release tablets

Bupropion (an antidepressant agent) has been used along with NRT as first-line therapy for treating tobacco dependence. Bupropion's efficacy does not appear to be due to its antidepressant effects. The exact mechanism by which bupropion works is not known, but it is presumed to reduce cravings associated with nicotine deprivation by affecting noradrenaline and dopamine, two chemicals in the brain that may be key components of the nicotine addiction pathway

**Taking the drug alone produces higher cessation rates than placebo and taking it along with nicotine replacement is even more successful.**

### Dosage

The usual adult target dose for bupropion sustained release tablets is 300 mg/day, given as 150 mg, twice daily. There should be an interval of at least 8 hours between successive doses.

Dosing with bupropion sustained release tablets should begin at 150 mg/day given as a single daily dose in the morning. If the 150 mg initial dose is adequately tolerated, an increase to the 300 mg/day target dose, given as 150 mg twice daily, may be made as early as day 4 of dosing.

Doses above 300 mg/day should not be used

Set quit date for 1-2 weeks after beginning bupropion treatment

- Continue 150 mg b.i.d. for 7-12 weeks after quit date
- For maintenance therapy, consider 150 mg b.i.d. for up to 6 months
- If insomnia is marked, the PM dose should be taken in afternoon
- Alcohol if used at all should be in moderation

Course of Treatment: 7-12 weeks, Maintenance: upto 6 months

### Bupropion for tobacco cessation

Treatment with bupropion HCl sustained release tablets should be initiated **while the patient is still using tobacco**, since approximately 1 week of treatment is required to achieve steady-state blood levels of bupropion.

Patients should set a "target quit date" within the first 2 weeks of treatment with bupropion HCl, generally in the second week.

Treatment with bupropion HCl should be continued for 7 to 12 weeks

If no significant progress toward abstinence by 7th week of therapy - unlikely that he / she will quit during that attempt, and treatment should probably be discontinued.

Dose tapering of bupropion is not required when discontinuing treatment.

**It is important that patients continue to receive counseling and support throughout treatment with bupropion, and for a period of time thereafter.**

### **Maintenance:**

Although clinical data are not available regarding the long-term use (>12 weeks) of bupropion for smoking cessation, bupropion has been used for longer periods of time in the treatment of depression. Whether to continue treatment with bupropion HCl for periods longer than 12 weeks for smoking cessation must be determined for individual patients.

### **Drug Interactions**

Antidepressants like Fluoxetine - associated with panic and Psychosis; Carbamazepine (Tegretol) increases metabolism.

### **Contraindications**

Seizure disorder; Concurrent psychiatric medications; Eating disorders like Anorexia Nervosa and Bulimia and Pregnancy

**Adverse Effects: Dopaminergic effects** may result in an activating effect with feelings of agitation or restlessness (which however decreases in 1-2 weeks after starting medication). Insomnia, Gastrointestinal upset, Appetite suppression and weight loss, Headache and Lowering of seizure threshold (Seizure Incidence is 1 in 4000, but incidence is rare with sustained release preparations below 400 mg. /day)

### **Selegeline Hydrochloride**

Changes in dopamine level are thought to play an important role in both smoking reward and withdrawal symptoms during abstinence. Medications that modulate dopamine levels may have beneficial effects on both withdrawal symptom levels and on response to smoking lapses during abstinence.

In a recent study after 8 weeks of treatment, 45 percent of participants receiving Selegeline had quit smoking tobacco compared to 15 percent of those receiving placebo. During the last 4 weeks of the study, 30 percent of participants receiving Selegeline reported that they had completely abstained from smoking compared to 5 percent of those receiving placebo. At the 6-month follow-up, smoking cessation rates were 20 percent for those that received Selegeline and 5 percent for placebo.

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## Dosage

Selegiline hydrochloride -5 mg p.o. twice daily. Higher doses should ordinarily be avoided because of the increased risk of side effects **associated with non-selective inhibition of MAO.**

Adverse effects are rare at doses of 10 mg. /day. Nevertheless, in decreasing order of frequency, discontinuation of treatment with selegiline has been reported due to: nausea, hallucinations, confusion, depression, loss of balance, insomnia, orthostatic hypotension, increased akinetic involuntary movements, agitation, arrhythmia, bradykinesia, chorea, delusions, hypertension, new or increased angina pectoris, and syncope. Events reported only once as a cause of discontinuation are ankle edema, anxiety, burning lips/mouth, constipation, drowsiness/lethargy, dystonia, excess perspiration, increased freezing, gastrointestinal bleeding, hair loss, increased tremor, nervousness, weakness, and weight loss.

*Nortriptyline:* The other antidepressant that appears to increase cessation is nortriptyline, a tricyclic antidepressant with mostly noradrenergic properties and little dopaminergic activity. Two published trials indicate that nortriptyline increases cessation rates, an effect apparently unrelated to depressive symptoms. Side effects from nortriptyline include anticholinergic effects, nausea and sedation.

*Other antidepressants:* In one study, imipramine, which has mostly noradrenergic and serotonergic effects, did not improve smoking cessation, but a small study suggested that doxepin, which has similar neurochemical effects, increased short-term cessation .

Clonidine is an  $\alpha_2$ -noradrenergic agonist that suppresses sympathetic activity:used for hypertension, to reduce alcohol and opiate withdrawal. Both as pills and as a patch in low doses (usually 0.2-0.4 mg per day), clonidine increased smoking cessation in eight of nine trials. Clonidine has more significant side effects (eg sedation, postural hypotension) and more drop-outs due to side effects than NRT. For these reasons, it is mainly used as a second-line drug for those who cannot, or do not wish to, take NRT or bupropion.

Bupropion,selegiline and clonidine are the only proven non-nicotine therapies for smoking cessation. Of these, bupropion and selegiline are preferred because of their better side effect profile. Nortriptyline, moclobemide, mecamylamine and sensory replacement have shown preliminary promise.

## A Model Sequence: Treatment Algorithm

# 1<sup>st</sup> visit

**Ask** – Advise and Assess current stage of change. Use the decisional balance form to help the patient visualize his/her state of readiness.



For persons who express willingness to try and quit, help set a Quit date approximately 1-2 weeks from the day. A day personally significant to the client makes it more relevant.

The client is encouraged to announce his/her decision to family members, friends and colleagues so as to mobilize their support as well as induce accountability to them.



**Advise use of Bupropion or Nortryptiline or Selegiline if there are no contra-indications.**

1. **Bupropion** Start with Tab Bupropion Sustained Releas [SR] 150 mg. Begin at 150 mg/day given as a single daily dose in the morning. If the 150 mg initial dose is adequately tolerated, an increase to the 300 mg/day target dose, given as 150 mg twice daily, may be made as early as day 4 of dosing. Doses above 300 mg/day should not be used.
2. **Nortryptiline** at 75 mg. / day.
3. **Selegiline** starting with a 5 mg. tablet twice daily increased gradually up to a maximum of 15mg. per day.



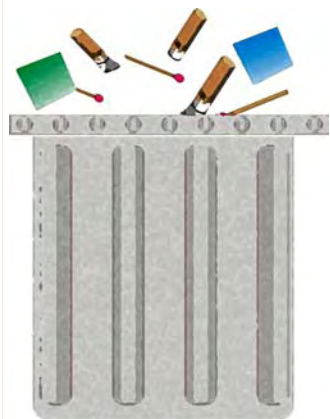
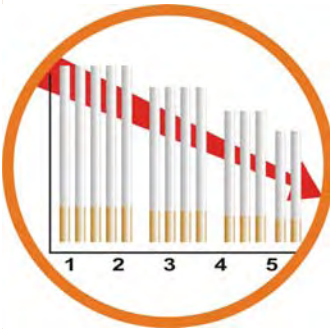


### Advise about changes in life style.

Make small changes in daily routine, especially at the critical times or situations cued to tobacco use.

Add exercise and/or yoga routine.

Stop alcohol and caffeinated drinks; drink lots of water.  
Eat plenty of fruits and vegetables.



### Advise regarding Changes in Tobacco use patterns:

*Nicotine fading* techniques so that patient is able to achieve a reduction of more than 50% of initial use by the quit date [Reduction of cigarettes or smokeless tobacco— from least needed to the most needed]. One way to try to lessen withdrawal symptoms involves gradual withdrawal from nicotine—accomplished by progressively lowering the number of cigarettes or SMT sachets daily, starting off with the least important occasions keeping the most important till the last so that nicotine intake is at the lowest possible level just before the quit date.

Also, lower intake by watching when and the way you smoke or use SMT by maintaining a tobacco use diary.

The **cold turkey** method is to give up all of a sudden on the quit date.

Remove tobacco paraphernalia.

Advise clients to throw away all tobacco and other items such as ashtrays etc. the night before the quit day dawns, preferably in a *ceremonial gesture*.

# 2<sup>nd</sup> visit

Preferably plan a second consultation just before or immediately after the quit date to 1] Review progress and problems; 2] Monitor medication – effects and side effects; 3] Inform about management of withdrawal, relapse triggers and methods of dealing with high risk situations. It is good to have the client make up a concrete [preferably written] plan from a given menu of choices and/or give out a printed self help pamphlet, with these details



## Advise about management of withdrawal with NRT

Use of Nicotine chewing gum to substitute for tobacco after the quit date

Alternatively, Nicotine patches can be started.



## Give a menu of behavioral methods to cope with withdrawal

Run through a list of withdrawal symptoms and methods of coping with them.

Craving: delay, distraction, drinking water and deep breathing

Poor concentration: Taking breaks

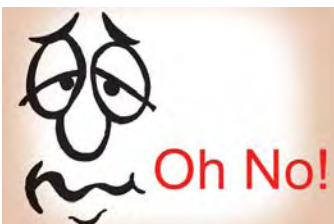
Irritability, restlessness: Physical exercise; occupying hands etc.

Insomnia/drowsiness: Relaxation exercises, avoid coffee etc.

Hunger: Drink water, eat fruits; exercise

Feeling dull and depressed: Plan alternative activities with friends

Thoughts about using: Focus on anticipated benefits etc.



Discuss relapse triggers and ways of handling them. Incorporate these strategies in the concrete plan of action

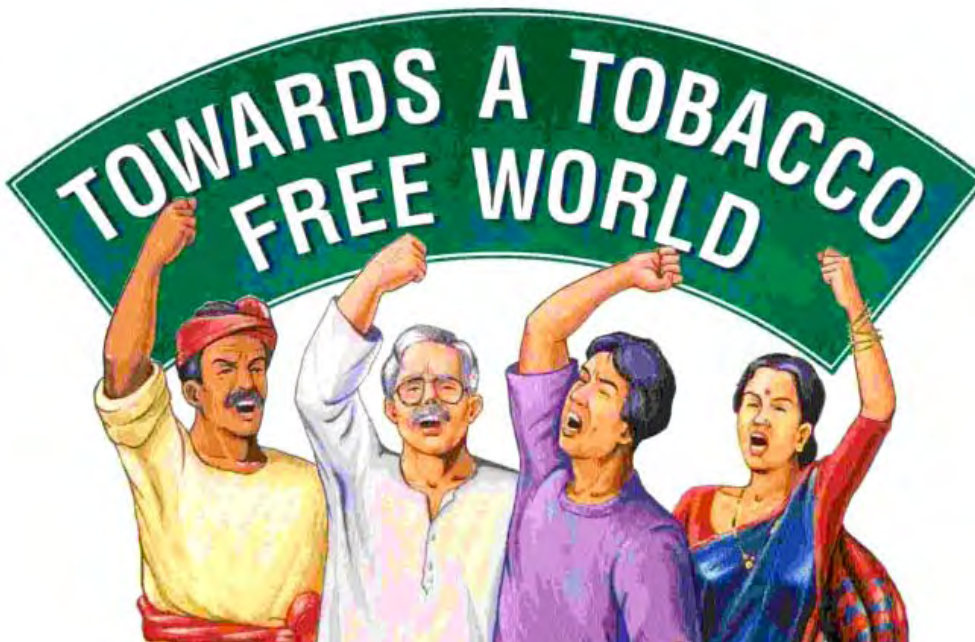
# 3<sup>rd</sup> visit



Third visit [Preferably after a week]

1. Review progress and problems
2. Monitor medication – effects and side effects; advise regarding tapering down NRT.
3. Review relapse triggers experienced and methods of dealing with high risk situations

**Subsequently, it is advised that the clinician keep in touch with the patient at least once a week in the first month and subsequently at least once a month for the first six months.**



## Appendices

### List of 18 Tobacco Cessation Clinics in India

#### 1. Tata Memorial Centre

Department of Preventive Oncology  
Dr. Ernest Borges Road, Parel, Mumbai 400012  
Dr. Surendra Shastri  
Prof. and Head and Principal Investigator, TCC Mumbai  
Tel.: 02-24154379; e-mail: shastri@vsnl.com

#### 2. Postgraduate Institute of Medical Education and Research

Chandigarh 160012  
Dr. Savita Malhotra  
Prof. and Head, Dept of Psychiatry  
Dr. Anil Malhotra  
De-Addiction Centre  
Tel.: 0172-2744503; e-mail: savita@ch1.dot.net.in

#### 3. Institute of Human Behaviour and Allied Sciences

G.T.Road, Dilshad Garden, Post Box NO. 9250, Delhi  
Dr. Nimesh Desai  
Prof and Head Department of Psychiatry  
Dr. S N Sengupta  
Dr. R A Singh  
Dr. Uday K SINHA  
Dr. Deepak K Srivastav  
Tel.: 011-22113395; e-mail: tccihbasrc@hotmail.com

#### 4. Pramukhswami Medical College and Shree Krishna Hospital

Karamsad 388325, Gujarat  
Dr. Girish Mishra  
Prof. and Head  
Department of ENT and Head and Neck Surgery  
Tel.: 02692-223010; e-mail: dakshagiri@yahoo.com

#### 5. Acharya Harihar Regional Cancer Centre

Medical Road, Manglbad, Cuttack 753007  
Dr. U R Parija  
Head of Department of Head and Neck Oncology Division  
Tel.: 0671-2302535; e-mail: urparija@csmti.com

**6. Indira Gandhi Institute of Cardiology**

Dr. Mahabir Das  
Principal Investigator  
Tel.: 0612-2532848; e-mail: mdasnotebihar@sify.com

**7. Chatrapati Shahuji Maharaj Medical University**

Lucknow 226016  
Dr. Rama Kant  
Department of Surgery  
Tel.: 0522-358230; e-mail: ramakant@globalink.org

**8. Jawaharlal Cancer Hospital and Research Centre**

P O Box No.32, Idgah Hills, Bhopal 462001, Madhya Pradesh  
Dr. B Sanyal  
Radiation Oncologist and Principal Investigator  
Tel.: 0755-2666611; e-mail: jnchwhotcc@sify.com

**9. Salgaokar Medical Research Centre**

Chicalim, Goa 403711  
Dr. Shekar Salkar  
Surgical Oncologist  
General Secretary NOTE India  
Tel.: 0832-2423366; e-mail: sssalkar@yahoo.co.in

**10. Bhagwan Mahavir Cancer Hospital**

Jawaharlal Lal Marg, Jaipur 302017  
Dr. Vivek Sharma  
Tel.: 9829049363; e-mail: cancer@datainfosys.net

**11. National Institute of Mental Health and Neuro Sciences (NIMHANS)**

Hosur Road, Bangalore-560029  
Dr. Mohan K Isaac  
Prof. of Psychiatry and Principal Investigator - TCC  
Dr. Prathima Murthy

**Additional Professor of Psychiatry and (Co-Investigator TCC)**

Dr. Vivek Benegal  
Associate Professor of Psychiatry and (Co-Investigator TCC)  
Tel.: 080-26995311; e-mail: tcbangalore@rediffmail.com

**12. Cancer Institute (WIA)**

Adyar, Chennai 600020  
Dr. Rohini Premakumari  
Professor of Radiation Oncology  
Tel.: 044-24910754; e-mail: drpremkumari@rediffmail.com

**13. Department of Respiratory Medicine**

Vallabhahai Patel Chest Institute University of Delhi, Delhi 110007

Dr. Raj Kumar

Senior Lecturer

Tel.: 011-27667102; e-mail: rajkumar\_27563@yahoo.co.in

**14. MNJ Institute of Oncology & Regional Cancer Centre,**

Red Hills, Hyderabad

Dr. B N Rao

Director

Tel.: 040-23314063; e-mail: tcchyderabad@yahoo.co.in

**15. Dr. B. Borooah Cancer Institute**

Gopinath Nagar, Guwahati-781016 Assam

Dr. A. C. Kataki

Director

Dr. Joydeep Das

Tel: 0361 2472364, 2472366; e-mail: tccguwahati@rediffmail.com

**16. Chittaranjan National Cancer Institute (CNCI)**

37, S.P. Mukherjee Road, Kolkata-700026

Prof. Indira Chakravarty

Director-in-charge

Dr. Utpal Sanyal

Principal Investigator

Tel: 033 24759313; e-mail: tcckolkata@rediffmail.com

**17. Regional Cancer Centre (RCC)**

Post Box 2417, Thiruvananthapuram-695011

Dr. B. Rajan

Director & Principal Investigator

Dr. Jaykrishnan R.

Co Investigator

Tel: 0471 2522299; e-mail: tcc@rcctvm.org

**18. Regional Cancer Centre (RCC)**

Directorate of Hospital & Medical Education

Aizwal, Mizoram-796001

Dr. Zoremthangi

Director

Dr Jane R. Ralte

Principal Investigator

Tel: 0389 2315210; e-mail: tccaizwal@yahoo.co.in

## TOBACCO CESSATION CLINIC – INTAKE FORM

Centre

Centre Code

Client No.

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Reg. Date

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1. Name: \_\_\_\_\_

2. Age: \_\_\_\_\_

3. Gender      1. Male   2. Female

4. Address: \_\_\_\_\_

Ph. No. \_\_\_\_\_

5. Area of Residence:      1. Rural   2. Urban

6. Education (Number of years of formal education) \_\_\_\_\_

7. Marital Status:   1. Unmarried   2. Married   3. Widowed   4. Separated or Divorced

5. Not Applicable

8. Occupation:      1. Professional and Semiprofessional   2. Skilled, Semi Skilled &  
Unskilled worker   3. Unemployed   4. Retired   5. Housewives   6. Students

7. Others/Not classified. \_\_\_\_\_

**Specify Occupation** \_\_\_\_\_

9. Income (per month): Rs. \_\_\_\_\_; Family income (per month) Rs. \_\_\_\_\_

10. Details of Tobacco use:

Type	Age of onset	Sachet/cigarette years (No. of cigs/bidis/sachets used per day X No. of years of regular tobacco use)	Average number of cigarettes/ sachets amount of tobacco chewed per day in the last one month
Smoking			
1.			
2.			
3.			
Smokeless			
1.			
2.			
3.			

11. Expense per month on tobacco (Average month last year) Rs. \_\_\_\_\_

12. Severity:

**Fagerstrom Addiction Scale for Smokers**

1. How soon after you wake in the morning do you smoke or first use tobacco?
  - a. Within 30 minutes **1**
  - b. More than 30 minutes **0**
2. Do you find it difficult not to use tobacco where tobacco is forbidden?
  - a. Yes **1**
  - b. No **0**
3. Which of all the times you use tobacco during the day is the most satisfying?
  - a. First thing in the morning **1**
  - b. Any other time **0**
4. How many cigarettes do you smoke a day?
  - a. 1-15, light smoker **0**
  - b. 16-25, moderate smoker **1**
  - c. 26 or more, heavy smoker **2**
5. Do you use tobacco more in the morning than the rest of the day?
  - a. Yes **1**
  - b. No **0**
6. Do you use tobacco when you are sick enough to have to stay in bed?
  - a. Yes **1**
  - b. No **0**
7. What is the tar/nicotine rating of the brand you smoke?
  - a. Low tar, 1-8 mgs **0**
  - b. Medium tar, 9-16 mgs **1**
  - c. High tar, 15 or more mgs **2**
8. How often do you inhale?
  - a. Occasionally **0**
  - b. Often **1**
  - c. Always **2**

Your score =

The highest possible score = 11 The closer to zero your score, the less dependent you are on tobacco. The higher the score, the more strongly you are addicted.



13. Previous attempt (s) at quitting tobacco: 1.Yes 2. No  
 Type of Tobacco      No. Of attempts which lasted for at least one month      Reasons for quitting\*      Reasons for relapse+      Remarks

Smoking

Smokeless

**\*Reasons for quitting:** 1. No reason 2. Social pressure 3. Presence of medical complications  
 4. Awareness of physical hazards 5. Awareness of addiction  
 6. Lack of productive work 7. Any other (specify)\_\_\_\_\_

**\*Reasons for relapse:** a. No reason b. Social pressure c. Craving d. Cues/triggers  
 e. Withdrawal symptoms f. Lack of productive work  
 g. Psychological stress h. Family tensions  
 i. Financial tensions j. Any physical location/place k. Chronic illness/pain  
 l. Any other (specify)\_\_\_\_\_

14. Alcohol use      1. Yes    2. No; Alcohol use in last one year (Pattern)\_\_\_\_\_

**\*Pattern of use in the past one year** 1. Daily Drinking 2. Regular Drinking (3 or more times/week)  
 3. Social Drinking (<3 times/week) 4. None

15.average amounts per drinking day\_\_\_\_\_

**\*Average units (30ml spirit/ 60 ml wine/ ½ mug beer = 1 Unit)**

16.Other substance use    1.Yes    2.No

Substance used	Pattern of use in the past one year*	Dependence Yes/No	Average amount/units per day+	Remarks
1. Cannabis				
2. Benzodiazepines				
3. Opioids				
4. Any other				

17. Family history in first-degree relatives:

- 1. Tobacco use      1. Yes    2. No \_\_\_\_\_
- 2. Substance use    1. Yes    2. No \_\_\_\_\_
- 3. Medical illness    1. Yes    2. No \_\_\_\_\_
- 4. Psychiatric illness 1. Yes    2. No \_\_\_\_\_

18. Physical health problems:

- History & symptoms suggestive of 1. HTN ( Yes, No) 2. Diabetes (Yes, No)  
 3. Heart attack (Yes, No) 4. Stroke (Yes, No)  
 5. Asthma/Bronchitis (Yes, No) 6. Cancer ( Yes, No)  
 7. Sexual dysfunction (Yes, No) Oral cavity:  
     a) Leukoplakia (Yes, No)                      b) Erythroplakia (Yes, No)  
     c) Sub mucous fibrosis (Yes, No)          d) Dental caries (Yes, No)  
 Any other \_\_\_\_\_

19. Physical examination:

Weight: \_\_\_\_\_ Kgs    19. Height \_\_\_\_\_ cms    20. Pulse \_\_\_\_\_

21. BP Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_ 20. \_\_\_\_\_

Motivation Stage Assessment: \_\_\_\_\_

21. Diagnosis: 1. Smoking    2. Smokeless    3. Both

22. CO Breath Analysis Test    1. Done. Breath CO level (in ppm) \_\_\_\_\_    2. Not Done

**\*Co levels    0-6N,    7-10N,    More than 10N**

23. Co morbidity    1. Yes    2. No

Co morbidity:	Diagnosis	Treatment	Remarks
1. Physical                      1.yes 2. No			
2. Psychiatric                      1.yes 2. No			
3. Substance use disorder                      1.yes 2. No			

24. Treatment:

- 1. Behavioural Counselling
- 2. Behavioural Counselling + Medication \_\_\_\_\_
- 3. Behavioural Counselling + NRT
- 4. Behavioural Counselling + NRT + Medication \_\_\_\_\_

Name of Therapist: \_\_\_\_\_

25. Follow-up details

F/U Visit No. and source of information.	Date	Use status (Not done)	Cotinine test (Done or Not done)	CO Breath (Done or Not done)	CO level	Treatment	Medication
0-2 wks							
2-4wks							
4-6wks							
6w-3months							
3-6months							
6-9months							
9-12months							

**Treatment:** 1. Behavioural Counselling                      2. Behavioural Counselling + Medication  
 3. Behavioural Counselling + NRT                      4. Behavioural Counselling + NRT + Medication

**Status:** 1.No change 2. Reduced use 3. Stopped use 4. Lost-to follow-up 5.Relapse

**Source of information:** 1. Follow-up 2. Phone call 3. Email 4. Mail.

**Remarks:**

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Compiled and edited by

**Vivek Benegal**

**Mohan K Isaac**

**Pratima Murthy**

**Dorothy P Rekha**

**Jacquleen Joseph**

**Saddichha Sahoo**

**B K Patil**

**Mathews Sebastian**

National Institute of Mental Health  
and Neurosciences Bangalore.

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### Contributors

**R. A. SINGH**

Associate Professor  
Department of Psychiatry  
Institute of Human Behaviour  
and Allied Sciences Delhi

**SURENDRA SHASTRI**

Prof. and Head  
Department of Preventive Oncology  
Tata Memorial Centre, Mumbai

**MAHABIR DAS**

Principal Investigator  
Indira Gandhi Institute  
of Cardiology, Patna

**SAVITA MALHOTRA**

Prof. and Head  
Department of Psychiatry  
Postgraduate Institute of Medical  
Education and Research  
Chandigarh

**ANIL MALHOTRA**

Additional Professor  
Drug De Addiction and Treatment Centre  
Department of Psychiatry  
Postgraduate Institute of Medical Education  
and Research, Chandigarh

**RAMA KANT**

Department of Surgery  
Chatrapati Shahuji Maharaj Medical  
University, Lucknow

**B. SANYAL**

Radiation Oncologist  
Jawaharlal Cancer Hospital and  
Research Centre, Bhopal

**GIRISH MISHRA**

Prof. and Head  
Department of ENT and Head and Neck Surgery  
Pramukhswami Medical College and Shree  
Krishna Hospital, Gujarat

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**NIMESH DESAI**

Prof and Head  
Department of Psychiatry  
Institute of Human Behaviour  
and Allied Sciences, Delhi

**U. R. PARIJA**

Head of the Department of Head  
and Neck Oncology Division  
Acharya Harihar Regional Cancer Centre  
Cuttack

**S. N. SENGUPTA**

Additional Professor  
Department of Psychiatry  
Institute of Human Behaviour  
and Allied Sciences, Delhi

**SHEKAR SALKAR**

Surgical Oncologist  
General Secretary NOTE India  
Salgaokar Medical Research Centre  
Goa

**UDAY K. SINHA**

Associate Professor  
Department of Psychiatry  
Institute of Human Behaviour  
and Allied Sciences, Delhi

**VIVEK SHARMA**

Principal Investigator, TCC  
Bhagwan Mahavir Cancer Hospital  
Jaipur

**ROHINI PREMKUMARI**

Prof. of Radiation Oncology  
Cancer Institute (WIA)  
Adayar, Chennai

**DEEPAK SRIVASTAVA**

Assistant Professor  
Department of Psychiatry  
Institute of Human Behaviour  
and Allied Sciences, Delhi

**RAJ KUMAR**

Senior Lecturer  
Department of Respiratory Medicine  
Vallabhbahai Patel Chest Institute, Delhi

**CHANDER S. J.**

Community Health Cell  
Koramangala, Bangalore

**K. S. SALUJA**

Medical Officer  
Tobacco Cessation Clinic  
Jawaharlal Cancer Hospital  
and Research Centre, Bhopal

**GURURAJ G.**

Professor and Head  
Department of Epidemiology  
National Institute of Mental Health  
& Neuro Sciences, Bangalore

**VINEET G. MUNISH**

National Professional Officer,  
TFI Office of the WHO Representative  
to India, New Delhi

**CHERIAN VARGHESE**

National Professional Officer-NMH  
Office of the WHO Representative  
to India, New Delhi

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## Suggested Reading

Mason P (2001) *Helping Smokers Change: A Resource Pack For Training Health Professionals*. World Health Organisation Regional Office for Europe. Copenhagen

There are hundreds of tobacco control websites on the Internet. Here are some of the best, all of which contain comprehensive information on many aspects of tobacco control.

1. **Tobacco Control Super site**  
[www.health.usyd.edu.au/tobacco](http://www.health.usyd.edu.au/tobacco)
2. **World Health Organization's Tobacco Free Initiative** [www.who.int](http://www.who.int)
3. **Action on Smoking and Health (London)** [www.tobaccofreekids.org](http://www.tobaccofreekids.org)
4. **International Non-governmental Coalition against Tobacco** [www.ingcat.org](http://www.ingcat.org)
5. **Tobacco BBS** [www.tobacco.org](http://www.tobacco.org)
6. **Smokescreen** [www.smokescreen.org](http://www.smokescreen.org)
7. **Tobacco Control Journal** [www.tobaccocontrol.com](http://www.tobaccocontrol.com)
8. **Essential Action (practical advice for advocates)** [www.essentialaction.org/tobacco](http://www.essentialaction.org/tobacco)

The following sites, with information on specific aspects of tobacco control, are also well worth a look:

1. **Framework Convention Alliance** [www.fctc.prg](http://www.fctc.prg)
2. **Globalisation issues and information about transitional tobacco companies. Corporate watch** [www.corpwatch.org](http://www.corpwatch.org)
3. **INFACT** [www.infact.org](http://www.infact.org)
4. **Passive Smoking** [www.tcsg.org](http://www.tcsg.org)
5. **Poverty, Hunger; Resources for Tobacco Control Advocates: PATH Canada (programme for appropriate technology in health)**  
[www.pathcanada.org](http://www.pathcanada.org)

### Books and Journals

1. International Union Against Tuberculosis and Lung Diseases. (IUATLD). 1998. **'Tobacco control and prevention: A guide for low-income countries'**  
Contact them for a copy: 68 bd. Saint-Michel, 75006.paris, France.  
E- mail: [kslama@worldnet.fr](mailto:kslama@worldnet.fr)
2. **World Bank 1999. Curbing the epidemic: Governments and the economics of tobacco control.** An extremely valuable resource on taxation, advertising bans, and other issues. Available on-line at [www.worldbank.org](http://www.worldbank.org) or from the World Bank at 1818 H Street NW, Washington DC 20433,USA;

**3. 'Tobacco Control'- an international journal published quarterly by the BMJ.**

Orders/ inquiries to: BMJ publishing group, PO Box 299, London WC1H 9TD or via booksellers. Those in low-income countries for free: when you go the website, it will automatically recognize your country of origin and give you access at [www.tobaccocontrol.com](http://www.tobaccocontrol.com)

**Tobacco industry documents**

To learn about the tobacco industry in its own words, try some of the these reports/ websites;

1. Action on smoking and health (London).  
June 1998'Tobacco explained: The truth about the tobacco industry in its own words'.  
[www.ash.org.uk](http://www.ash.org.uk)
2. Campaign for Tobacco-Free kids and ASH ( London).200 'Trust us, We're the tobacco industry'  
[www.ash.org.uk](http://www.ash.org.uk) and [www.tobaccofreekids.org](http://www.tobaccofreekids.org)
- 3.Committee of experts on tobacco industry documents. July 2000.'Tobacco company strategies to undermine tobacco control activities at the world health organization.  
[www.who.int](http://www.who.int)
4. ASH (London), Cancer research campaign, 2000,'Danger! PR in the playground: Tobacco industry initiatives on youth smoking'. [www.ash.org.uk](http://www.ash.org.uk) and [www.crc.org.uk](http://www.crc.org.uk)
5. Glantz, S et al. University of California press.1996.'The Cigarette Papers'.  
[www.library.ucsf.edu/tobacco/cigpapers](http://www.library.ucsf.edu/tobacco/cigpapers)

**More useful websites on the tobacco industry documents:**

- 1.ASH (London) and The Center for Public Integrity (USA) include material on BAT's involvement in cigarette smuggling, together with links to the relevant internal tobacco industry documents, on their websites at [www.ash.org.uk](http://www.ash.org.uk) and [www.publicintegrity.org](http://www.publicintegrity.org) respectively.
- 2.The centers for disease control and prevention (CDC) in the USA have a very comprehensive site with access to many of the thousands of internal tobacco industry documents now available on the web, at [www.cdc.gov/tobacco/industrydocs/](http://www.cdc.gov/tobacco/industrydocs/)
- 3.The tobacco documents online site, which enables you to search through a large number of documents, is at [www.tobaccodocuments.org](http://www.tobaccodocuments.org)

