Tobacco use cessation counseling of parents

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Purpose of review

Tobacco use and secondhand tobacco smoke exposure of children are a significant problem faced by pediatricians. This article reviews the recommendations of the 2008 update of the guideline *Treating Tobacco Use and Dependence* and their application in the pediatric setting.

Recent findings

Every tobacco user seen in the clinical setting, including parents and other persons who are not patients, should be offered evidence-based treatment. At minimum, treatment consists of brief counseling and access to resources that support quit attempts. Pharmacotherapies should be offered to all tobacco users, except for pregnant women, adolescents, and other groups for which effectiveness of pharmacotherapies has not been shown. The five As (ask, advise, assess, assist, and arrange follow-up) continue to be recommended as the key points in counseling.

Summary

Tobacco use is a chronic disease that develops early in life and affects many patients and families seen in the pediatric setting. Every tobacco user should be offered treatment, including parents and other family members, and the most effective treatment is a combination of counseling and pharmacotherapies.

Keywords

child, parent, secondhand tobacco smoke, tobacco

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Introduction

Smoking by parents is the primary source of exposure to secondhand smoke (SHS) for children; these exposures are associated with significant morbidity and mortality in both the short term and long term [1–3] (Table 1). Many parents, especially of young children, see their child's healthcare provider more often than their own; these encounters may be the parent's primary interaction with the healthcare system. Treating every tobacco user seen in the clinical setting, 'including parents and other persons who are not patients', is a new recommendation in the 2008 update of the clinical practice guideline, *Treating Tobacco Use and Dependence*. The guideline recommends that 'clinicians ... ask parents about tobacco use and offer them cessation advice and assistance [4••]'. The rationale for the recommendation is that eliminating SHS exposure of the child is an important contribution to the child's health, and giving parents information on the harms of SHS may reduce the child's SHS exposure and promote tobacco use cessation by parents [4••]. This article reviews the recommendations of the guideline and best practices in tobacco use cessation counseling of parents.

Counseling parents

The healthcare setting provides opportunities for clinicians to use 'teachable moments' (health events that motivate individuals to adopt risk-reducing health behaviors [5]) to discuss important issues in children's health. Tobacco use is one of these important issues and is a key factor in a child's health and the health of the adult he or she will become.

The five As (ask, advise, assess, assist, and arrange; Table 2 [4••,6]) are the major components of cessation counseling and have been shown to increase the number of quit attempts and the success of those attempts [4••]. Pediatricians can counsel patients and parents to quit smoking and make their homes and cars smoke-free.

Screening for tobacco use and SHS exposure (ask) in the pediatric setting includes asking not only about tobacco use by adults who live in the home but also about tobacco use or SHS exposure in other settings, including childcare settings, cars, and outdoor venues. It is important to ask using clear, nonjudgmental questions such as 'does anyone who lives with your son use tobacco in any way?' or

Table 1 Major conclusions of the health consequences of involuntary exposure to tobacco smoke: a report of the surgeon general

Exposure type	Disease	Strength of evidence
Maternal exposure to SHS during pregnancy	Preterm delivery	'Suggestive' of a causal relationship
	Low birthweight	'Sufficient' to infer a causal relationship
Maternal exposure to SHS during pregnancy and postnatal SHS exposure	Childhood cancer, leukemia, lymphoma, and brain tumors	'Suggestive' of a causal relationship
Maternal smoking during pregnancy and postnatal SHS exposure	Lung function	'Sufficient' to infer a causal relationship between maternal smoking during pregnancy and persistent adverse effects on lung function across childhood
		'Sufficient' to infer a causal relationship between exposure to SHS after birth and a lower level of lung function during childhood
Postnatal SHS exposure	Sudden infant death	'Sufficient' to infer a causal relationship
	Lower respiratory illnesses	'Sufficient' to infer a causal relationship; the increased risk for lower respiratory illnesses is greatest from smoking by the mother
	Middle ear disease	'Sufficient' to infer a causal relationship between parental smoking and middle ear disease in children, including acute and recurrent otitis media and chronic middle ear effusion
		'Suggestive' of a causal relationship between parental smoking and history of middle ear effusion
	Cough, phlegm, wheeze, breathlessness, and asthma	'Sufficient' to infer a causal relationship between SHS exposure from parental smoking and the onset of wheeze illnesses in early childhood and school-age children
		'Suggestive' but not sufficient to infer a causal relationship between SHS exposure from parental smoking and the onset of childhood asthma
		Among school-age children, the evidence is 'sufficient' to infer a causal relationship between parental smoking and ever having asthma

Adapted from [1].

'does your daughter spend time in places where tobacco is used?' Leading questions, such as 'no one smokes in the home, right?' are less likely to encourage the parent to discuss his or her tobacco use. Making tobacco use and SHS exposure a 'vital sign' is recommended highly because it 'systematizes' the ASK step. Other ways to systematize the ASK step include chart stickers, electronic health record reminders, and preprinted questions on encounter forms [4••].

Advice to quit using tobacco and make homes and cars smoke-free (advise) should be delivered in a clear, strong, and personalized way. Clearly stating 'you should quit using tobacco' rather than 'you probably should quit' delivers an unequivocal message. Advice should be strong, 'quitting smoking is the most important action you can take to protect your health', and personalized 'quitting smoking and making your home and car smoke free is important for your daughter's health'. Remember that most tobacco users are physically and psychologically addicted, and that tobacco use is a chronic disease [4••]. Because of the chronic nature of tobacco dependence, repeated interventions may be needed and multiple quit attempts tried before success is achieved [4••].

The assess step is based on the transtheoretical stages of change [7], which breaks tobacco use behavior change into stages:

(1) Precontemplation, in which the tobacco user is not thinking about quitting and has no intention of quitting within the next 6 months;
(2) Contemplation, in which the tobacco user is thinking about quitting, perhaps in the next 6 months, but has not taken any steps toward quitting;

Table 2 The 'five As' and 'two As and an R'

The five As [4••]		Two As and an R [6]
Ask	Systematically identify all tobacco users at every visit	Ask – about any tobacco use by any member of the household, including preconception and prenatal use
Advise	Strongly urge all tobacco users to quit	Advise – all tobacco users to quit, using a clear, strong, personal message
Assess	Determine willingness to make a quit attempt	Refer – every tobacco user to a cessation resource, such as a quit line, cessation program, or web-based program
Assist	Aid the patient in quitting (provide counseling and medication)	
Arrange follow-up	Ensure follow-up contact	

(3) Preparation, in which the tobacco user is planning to quit within the next month;
(4) Action, in which the tobacco user has successfully quit smoking for at least 24 h; and
(5) Maintenance, in which the tobacco user has quit smoking for at least 6 months.

One of the primary goals of the assess step is to determine the tobacco user's stage, then to help the tobacco user move to the next stage [4••].

The assist step is the actual 'counseling' step. The goal is to help the parent or patient quit using tobacco and make their home and car smoke-free. If the tobacco user is ready, help him or her to set a quit date. Ideally, a quit date within 2 weeks of the visit should be set. This may not be appropriate, however, if the patient or parent will be using pharmacotherapies, because additional time to get an appointment with the prescriber may be needed. The guideline specifically recommends pharmacotherapy for all tobacco users except those for whom there is insufficient evidence of effectiveness: pregnant women, smokeless tobacco users, light smokers, and adolescents. In addition to the guideline, an excellent resource for the use of pharmacotherapy can be found at http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/pub_health/askact/prescribguidelines.Par.0001.File.tmp/PrescribGdln.pdf. In preparation for quitting, tobacco users should focus on why they smoke, develop an awareness of factors that influence their tobacco use, modify their tobacco use, and develop ways of coping with stress that are tobacco-free [4••].

Problem solving and skills training, as well as social support in and out of the clinical encounter, are important components of the assist step. Table 3 lists important elements of problem solving and skills training. Self-help materials and pharmacotherapies should be discussed and recommended when appropriate. Clinicians can help the tobacco user anticipate challenges and plan strategies for dealing with urges. Other important topics include strategies for telling other family and household members (who may or may not use tobacco) about quitting and past experiences with quit attempts and relapses. Social support, such as encouragement and belief in success, can be provided by clinical staff and outside counseling resources [4••].

Relapse-prevention strategies include anticipation of cues to smoke and development of strategies for coping with the cue or urge. The typical urge to smoke is brief (a matter of minutes), and distraction techniques, including deep breathing, going for a walk, drinking a glass of water, knitting, or similar activities, may help. Other interventions are practical counseling and stress management [4••].

Tobacco users, in the preparation or action stages, may benefit from information about the quitting process or referral to a quitline or other cessation resource. Parents in the precontemplation or contemplation stages may benefit from information about the health effects of tobacco use to their children and themselves, the costs of using tobacco, and the benefits of quitting [4••].

Support quit attempts and behavior changes through follow-up contacts (arrange follow-up). If possible, calling the parent can be very supportive, even if the call comes from a staff member, not the pediatricians. Reassess stage of change at every visit and discuss successes or challenges to success since the last contact. Discuss relapses, and be supportive of renewed attempts to quit. Other important topics include sources of SHS exposure in the home and car, establishing 'smoke-free home' rules, the need for continued vigilance around cues to smoke, and celebrating the success [4••].

Table 3 Key elements of problem solving and skills training

Key elements	Examples
Recognize danger situations: identify events, internal states, and activities that increase relapse risk	Stress, bad moods
	Being around other tobacco users
	Drinking alcohol
	Urges and cues to smoke
	The availability of tobacco products
Develop coping skills: identify and practice coping and problem-solving skills	Anticipate trigger situations
	Learn cognitive strategies that reduce bad moods
	Implement lifestyle changes that reduce stress, improve quality of life, and reduce exposure to cues
	Learn activities to cope with urges, such as distraction techniques
	Implement changes in routines associated with urges, cues or tobacco use
Learn from previous quit attempts and relapses	What worked? What didn't?
	What problems were encountered?
	What withdrawal symptoms were experienced?

Adapted from [4••].

Relapse

Some people start smoking again shortly after quitting and are said to have 'relapsed'. Relapse should not discourage either the clinician or the tobacco user from trying to quit again. Recognizing that tobacco use is a chronic disease is an important part of counseling; for many tobacco users who reach the action or maintenance stages, succeed for a while, only to relapse days, weeks, or months later. The clinician's role is to help motivate the tobacco user to make another quit attempt, incorporating the reasons or cues for relapse into the new attempt. Most users make several attempts to quit before they truly succeed [4••].

Pharmacotherapies should be considered for use with persons who have relapsed. For some smokers, extended use of nicotine replacement, meaning use past the recommended period (which is specific to the product and ranges from 6 to 14 weeks), can be effective [8]. One randomized trial showed that giving an additional 12-week course of varenicline (Chantix or Champix, a partial agonist selective for nicotinic acetylcholine receptors available by prescription for smoking cessation) to people who were abstinent at the end of the first 12-week course reduced the relapse to smoking by 30% up to 6 months after the end of all treatment compared with placebo [9].

Quitlines

Telephone counseling, both proactive and reactive, has been shown to be an effective resource to promote tobacco use cessation. Proactive telephone counseling has been shown to be a useful strategy to promote smoking cessation among parents of young children [10]. One major advantage of quitlines, apart from their effectiveness, is that they are accessible and can reach a large population of diverse tobacco users [11]. In the United States, a national network of quitlines for tobacco cessation has been established that can refer tobacco users to their own regional quitline by calling 1-800-QUIT NOW.

In Australia, an evaluation of a campaign including a telephone helpline estimated that 3.6% of adult smokers called the quitline during 1 year, and there was a 5% sustained quit rate in a cohort followed for a year [12]. In a 1994 UK 1-year follow-up of quitline callers who spoke to a counselor their quit rate was estimated to be 15.6% (95% confidence interval, 12.7–18.9%) [13]. A more recent evaluation compared the profile of quitline callers with the general population of smokers and clinic attendees. The age distribution of quitline callers was more similar to the general population than of clinic attendees, who were predominantly over 35 years of age. The quitline attracted a higher proportion of younger smokers and women than the general population [14]. In the UK, the quitline can be reached by calling 0800 00 22 00 or e-mailing stopsmoking@quit.org.uk. In Australia, the quitline can be reached by calling 131 848 or e-mailing quitnow@health.gov.au.

Adolescents

The most commonly cited reasons for quitting by youths are health concerns, although many do not grasp the long-term consequences of tobacco use [15]. Other reported reasons include social (peer or family) concerns, cost, and impairment of physical activity [16]. As with adults, it is important to assess the stage of readiness to quit and intervene appropriately. Many adolescents make prior cessation attempts [15]; discussing these attempts may reveal successful strategies and obstacles to success, especially as many teens attempt to quit without formal treatment. Interventions should be developmentally appropriate (e.g., appropriate for a 12-year-old vs. an 18-year-old) [4••].

An additional barrier to interventions with adolescents around tobacco is confidentiality. Many teens assume that their physician would tell their parents about their smoking status and view this as a barrier for discussing smoking with their healthcare provider. Adolescents also report concerns about receiving a lecture from their physician if they disclose their status as a smoker. Despite these findings, many teens report that if their doctor were to ask them confidentially about smoking, they would respond honestly. Unfortunately, many pediatricians do not ask about tobacco use [17].

Prevention

The most effective methods of preventing smoking and other forms of tobacco use are cultural, legislative, and regulatory. Interventions that have been effective in controlling and eliminating tobacco use include clean indoor air legislation, such as that enacted in Ireland, Scotland, and France, taxes on tobacco products, restricting youth access to tobacco products, mass media campaigns such as The Truth Campaign (http://www.thetruth.com/), tobacco advertising restrictions, and comprehensive community interventions that combine multiple approaches [18]. It is important to note that interventions targeting a single aspect are not sufficient to achieve tobacco control. The most effective strategies employ multiple interventions targeting different aspects of tobacco control, including school-based programs, antitobacco use advertisements, and enforcement of existing tobacco control policies [19•].

Conclusion

Tobacco use is a chronic disease that develops early in life and affects many patients and families seen in the pediatric setting. Every tobacco user should be offered

treatment, including parents and other family members, and the most effective treatment is a combination of counseling and pharmacotherapies. Providing both counseling and pharmacotherapy substantially increases the likelihood of success of the quit attempt.

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References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:

- • of special interest
- •• of outstanding interest

Additional references related to this topic can also be found in the Current World Literature section in this issue (p. 760).

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