Cut Down to Stop:
A briefing for stop smoking services



NCSCT

Department of Health & Social Care

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Evidence statement

Individuals who feel unable to commit to stop smoking abruptly **can be supported to cut down the amount that they smoke prior to a planned quit date.** Support for Cut Down to Stop (CDTS) or Cut Down to Quit (CDTQ) should include use of a first-choice stop smoking aid (nicotine replacement therapy [NRT], nicotine vape or varenicline) and structured multi-session behavioural support from a trained stop smoking practitioner.

Key points:

- CDTS should be viewed as an effective stop smoking intervention, to be implemented when quitting in one go is not possible.
- CDTS is particularly useful for engaging people with severe mental illness, people experiencing homelessness and people with substance misuse problems.
- CDTS is distinct from smoking reduction in that it involves structured reduction with a plan to stop completely over several weeks (four to six weeks is recommended), but longer periods may be required for some.
- CDTS can appeal to people who lack confidence in their ability to stop abruptly, are more tobacco dependent and have greater barriers to stopping.
- CDTS interventions are significantly more effective when a first-choice stop smoking aid is used. There is evidence that the use of NRT and varenicline significantly increases the likelihood of stopping successfully.
- There is emerging evidence that nicotine vapes are effective as part of CDTS.
- At present, there is no reported research to evaluate the use of cytisine as part of CDTS.
- Structured support that includes multi-session behavioural support from a trained practitioner, the setting of progressive smoking reduction goals and an individualised coping plan is recommended.
- When evidence-based approaches are used, CDTS will often have a greater average cost per quit relative to abrupt stopping. However, CDTS remains a cost-effective approach to stopping because the relatively small incremental cost is offset by the significant benefits to clients who are successful. This is particularly true for people who might not otherwise engage in, or be successful with, abrupt approaches to stopping. This additional cost should be viewed as part of equity-based approaches to the delivery of stop smoking support.
- Abrupt quitting is the preferred approach to stopping smoking due to the immediate health gains when compared to CTDS and should be recommended to people who can stop in one go.

What is CDTS?

Structured CDTS programmes involve setting progressive smoking reduction goals, with a plan to stop completely within a specified period. **CDTS support should include both a first-choice stop smoking aid and structured multi-session behavioural support from a trained practitioner.** CDTS allows people who smoke to experience the value of stop smoking aids, make progressive steps towards quitting over several weeks and achieve initial success with smoking reduction that serves to increase confidence in their ability to stop completely.

Individuals who feel unable to commit to stopping smoking abruptly **can be supported to cut down the amount they smoke with the help of combination NRT, a nicotine vape or varenicline** as part of a structured CDTS programme. This strategy is supported by NICE guidance (NG209) and the 2024 Local Stop Smoking Services and support: commissioning, delivery and monitoring guidance.[1,2]

How is CDTS different to simply reducing tobacco consumption?

CDTS is different from the harm reduction strategy of supporting reduced tobacco consumption because, with CDTS, **the intention is to work towards stopping smoking completely, typically over several weeks.**

Available evidence suggests that **people who prefer CDTS are those who find it more difficult to quit abruptly and are less successful in stopping.**[3–5] They may be more tobacco dependent, have tried and failed to stop smoking in the past, have greater barriers to stopping and lower confidence in quitting.[3–6]

> *"It should always be made clear that the ultimate goal is to stop smoking tobacco completely, but that clients will be able to do so over a few weeks."*
>
> Professor Simon Gilbody, University of York

What is the supporting evidence for CDTS?

A 2019 Cochrane review evaluated evidence for smoking reduction interventions versus abrupt stopping and found no significant difference in long-term effects between the two approaches (RR 1. 01, 95% CI 0.87 to 1.17; I^2 = 29%; 22 studies, 9219 participants).[4]

Importantly, the review identified that smoking reduction interventions that included the use of a stop smoking aid resulted in significantly higher rates of stopping when compared to not using an aid (RR 1.68, 95% CI 1.09 to 2.58; 11 studies, 8636 participants).

The evidence was strongest for the use of varenicline or a faster-acting NRT product as part of the CDTS intervention.[4] A large, high-quality study investigating the use of varenicline reported large increases in rates of stopping (RR 3.99, 95% CI 2.93 to 5.44; I2 = n/a; 1 study, 1510 participants),[7] whilst a number of studies found that use of a faster-acting NRT product resulted in significantly higher rates of stopping (RR 2.56, 95% CI 1.93 to 3.39; 7 studies, 5323 participants).[4]

The review also found some evidence that, whilst the inclusion of behavioural support for smoking reduction resulted in higher quit rates than self-help alone, the ability to assess the value of behavioural support was limited due to confounding factors. As a result, more research is needed.[4]

Since the 2019 Cochrane review, there have been several studies looking at CDTS in specific populations.[9,10] One large study (n=916) found that, when combined with NRT, scheduled smoking (systematically reducing cigarette consumption according to a predetermined schedule that increases the time between cigarette consumption) resulted in significantly higher quit rates than abrupt quitting with NRT.[10]

A number of studies have **examined the use of nicotine vapes as part of CDTS or smoking reduction interventions.**[11–14] A systematic review reported that the effect of nicotine vapes was similar to NRT for CDTS, but concluded that there was insufficient evidence due to the small size of the studies.[9] A recent randomised controlled trial conducted in an English stop smoking service (n=135) compared eight weeks of NRT treatment versus a vaping starter kit, accompanied by limited behavioral support, among people who were unable to stop using conventional methods.[11] The study found that **nicotine vapes were significantly more effective than NRT in supporting smoking reduction (26.5% versus 19.1%) and abstinence (6% versus 3%) at six months.**

Systematic reviews have also found evidence that the use of stop smoking aids, particularly varenicline and nicotine vapes, may increase rates of stopping among those who are not initially interested in stopping.[14–17]

What quit rates can be expected from CDTS?

The success rate for CDTS may be lower than that documented for abrupt quitting, but some studies have shown both approaches to be comparable. **Table 1** provides quit rates from three evaluations of CDTS. The Rapid Reduction Trial reported a four-week smoking abstinence rate of 39.2% for CDTS with NRT and 49.0% for abrupt stopping (however, individuals quitting abruptly also received pre-treatment with NRT).[3] Another recent study which provided participants with nicotine vapes found that 12-week quit rates were 29% in both the CDTS and abrupt quitting groups.[13] The one study that assessed varenicline for CDTS reported that 32.9% of participants remained smokefree at 24 weeks.[7]

It is important to acknowledge that quit rates for both CDTS and abrupt quitting may be lower within priority groups compared to the general population of people who smoke.

Table 1: Quit rates for abrupt quitting versus CDTS

Intervention	CDTS	Abrupt
CDTS with NRT[3]	4 weeks: 39.2%	4 weeks: 49.0%
CDTS with nicotine vape[13]	12 weeks: 29.6%	12 weeks: 29.2%
CDTS with varenicline[7]	24 weeks: 32.9%	–

What's in the pipeline?

Dashes Study: Researchers at the University of Edinburgh are examining a CDTS intervention for people in drug and alcohol recovery.[22]

Trident Study: Researchers at the University of Oxford are examining the use of nicotine vapes for CDTS among individuals with mental illness.

CDTS in pregnancy: Researchers at the University of Nottingham are planning the design of a study that will evaluate the role of CDTS for pregnant women who are unable to stop abruptly.

Are there any concerns about CDTS?

There is some concern that the availability of CDTS may mean that more clients choose this approach over the abrupt quit model, and that this could result in prolonged treatment and reduced success with stopping.

There has been some conflicting evidence on the efficacy of CDTS versus abrupt quitting and, as such, CDTS has not been introduced as a standard offer in Local Stop Smoking Services (LSSS). While the Cochrane review found no difference between CDTS and abrupt stopping, the Rapid Reduction Trial found abrupt stopping to be superior.[6] The authors of the study have considered reasons for this finding, with a possible explanation being that participants in the abrupt treatment arm received two weeks of pre-treatment with NRT before setting a quit date, which is not in line with standard treatment.[6]

Analyses of population surveys looking at methods of stopping smoking in the UK and internationally have reported abrupt stopping to be superior to CDTS.[18–20] It has been acknowledged that **population surveys assessing smoking reduction may be at risk of bias, as people who choose CDTS may be more tobacco dependent, less motivated to quit and may more frequently include people who find stopping more challenging**, such as people with mental illness.[6]

The role of CDTS in supporting people from priority groups

National experts across the UK are engaged in developing CDTS approaches to help facilitate stopping smoking among people in priority groups. Investigators from the University of York (the SCIMITAR study), University College London and the University of Edinburgh have successfully used CDTS to support stopping in people with severe mental illness (SMI), people with co-addictions who are being supported by drug and alcohol services, and people experiencing homelessness.[21–23] In addition, **experts report on the value to priority groups of CDTS interventions that make use of nicotine vapes, either alone or in combination with the NRT patch.**

> *"Many clients find abrupt stopping intimidating. CDTS offers a longer lead-in time prior to stopping smoking. Consequently, CDTS engages more people who might not otherwise try to stop smoking."*
>
> Mary Yates, Mental Health and Smoking Expert, NCSCT

Recommendations for CDTS in Local Stop Smoking Services (LSSS)

NICE, the Department of Health and Social Care and the NCSCT's guidance for stop smoking services advocate for the introduction of CDTS for individuals unable to stop abruptly.[1–2]

To optimise outcomes, it is recommended that CDTS should:

- be introduced as an effective, evidence-based treatment option, for people unable or not willing to stop abruptly, in particular those in priority groups
- involve the use of a first-choice stop smoking aid (NRT, varenicline or nicotine vape)
- involve structured reduction goals over several weeks (typically within six weeks, with individual tailoring)
- include multi-session support from a trained stop smoking practitioner

Should CDTS be available to all people who smoke or only certain sub-groups?

CDTS has been shown to be particularly useful for engaging people with SMI, people experiencing homelessness, and people with substance misuse problems in stop smoking support.[21–24]

CDTS is not recommended for women who are pregnant due to the significant risk of tobacco exposure to the foetus. However, there is interest in examining how CDTS can be used with pregnant women who are unable to stop smoking abruptly.

Which stop smoking aids can be used as part of a CDTS attempt?

There is strong evidence that, when used as part of CDTS, **both faster-acting NRT and varenicline significantly increase rates of smoking abstinence**, as well as reduce daily smoking.[4]

There is some evidence indicating that the use of **nicotine vapes** as part of smoking reduction interventions could be effective and it is reasonable to expect they would have similar or greater efficacy to fast acting NRT products.

There is no reported research on the use of cytisine as part of CDTS interventions. However, it is **reasonable to expect that cytisine would have similar efficacy to varenicline**, given that they are both nicotine analogue medications.

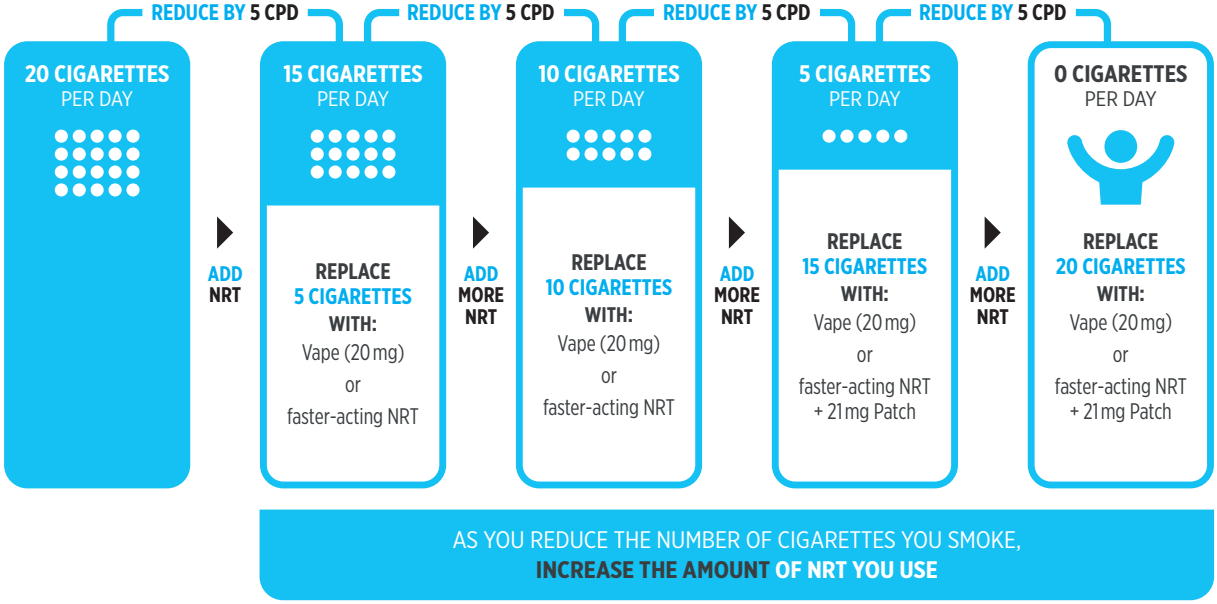
As clients reduce the number of cigarettes they smoke, they will need to increase the amount of replacement nicotine they receive from NRT and/or a nicotine vape. **It is recommended that clients using NRT and/or nicotine vapes receive an amount of nicotine that at least matches the amount of nicotine they would have received from the cigarettes they are attempting to cut out.** It can be beneficial to provide higher doses of nicotine to make achieving reduction goals easier.

Typically, for people in the general population we replace each cigarette with 1mg of NRT, while for people with mental illness the recommendation is to replace every cigarette with 2mg of NRT. Regular review, to monitor for withdrawal symptoms and side effects, and to inform adjustment (up or down) according to the client's feedback, is essential. See **Figure 1** for a visual representation.

A faster-acting product should always be recommended, and the NRT patch plus a faster-acting product is recommended when reducing by 10 or more cigarettes, or when clients are struggling with meeting reduction targets.

It is recommended that clients be smokefree for a minimum of four weeks before a reduction in nicotine is considered.

Figure 1: Example of a reduction plan for a person who smokes 20 cigarettes per day



Are stop smoking aids licensed for use for CDTS?

NRT has been granted a license indication called 'cut down to stop', 'nicotine assisted reduction to stop (NARS)' or 'cut down to quit (CDTQ)'. The summary of product characteristics (SPC) for varenicline also indicates its use for 12 weeks for people who are reducing smoking, with an additional 12 weeks recommended to prevent relapse.

What is the recommended reduction timeframe?

CDTS support should include the initial reduction phase followed by support following quitting. **NICE guidance recommends up to six weeks of reduction before the quit date.** However, individual tailoring of this duration, as appropriate, is recommended to meet the needs of clients and optimise success.

The client's comfort level and success with achieving reduction goals should be used to assess what is realistic. Too short a time might prove unrealistic for some clients, such as those with very high daily tobacco consumption, whereas too long a reduction period may result in lost momentum. **A flexible approach to the duration and reduction targets tailored to the client's needs is therefore recommended.** Be prepared to pause the reduction if life gets tougher for them. Support should attempt to help clients not to lose sight of the ultimate goal of stopping, while celebrating milestones along their journey.

It is important that, following the cutting down phase, use of smoking aids and provision of behavioural support continue in order to prevent relapse. **It is recommended that support be continued for at least four weeks following stopping completely** and ideally longer (12 or more weeks) for clients who are more at risk of relapse.

How is behavioural support adapted for CDTS?

Behaviour change techniques (BCTs) described in the NCSCT Standard Treatment Programme can be used with some small modifications for clients being supported with CDTS (see **Box 1**).

Most clients will benefit from weekly contact to provide structure to the reduction programme. Weekly appointments are initially valuable to encourage client engagement and development of the coping and reduction plan. However, some clients may be seen less frequently, particularly those whose reduction goals are over a longer period or those for whom there may be barriers to contact. Short contacts may be sufficient for some clients who are receiving support in settings such as homelessness services and treatment centres.

The CDTS Treatment Plan provides guidance on how to structure support and adapt BCTs for CDTS interventions (see Resources and training section below).

These sessions will include:

- setting weekly reduction goals
- coping strategies for addressing withdrawal symptoms and urges to smoke
- discussing smoking routines and triggers and planning for the week ahead
- supporting effective use of stop smoking aids
- building client confidence and commitment to the reduction plan

Box 1: Recommended components of CDTS interventions

Intervention components used at initial contact:

- Assess current readiness and ability to quit
- Inform client about the CDTS treatment programme
- Assess past attempts to quit or cut down
- Explain tobacco dependence and what to expect in terms of withdrawal and urges to smoke
- Assess current smoking
- Explain and conduct CO monitoring
- Agree to reduction plan and weekly targets
- Discuss the use of stop smoking aids
- Identify smoking routines and triggers and support problem solving
- Elicit commitment to reduction targets
- Summarise the CDTS plan

Intervention components used at follow-up contacts:

- Assess progress
- Assess urges to smoke and withdrawal symptoms, and use of stop smoking aids
- Conduct CO monitoring
- Identify challenges experienced in the last week and plan for dealing with these
- Agree on weekly reduction goal
- Advise on use of stop smoking aids
- Review plan for achieving reduction goal
- Elicit commitment to reduction targets
- Summarise the CDTS plan

This support from a trained stop smoking practitioner is important for reducing the risk of relapse. As we do when someone quits smoking abruptly, we want to continue to provide behavioural support and advice on stop smoking aids to address urges to smoke and high-risk situations.

Evidence suggests that people do not view CDTS and abrupt quitting as mutually exclusive, and may switch between the two approaches after deciding to change their smoking behaviour.

What are the methods for reducing the amount of tobacco smoked?

While several methods have been used to develop tailored plans for reducing smoking, **there is very little research examining the effectiveness of different methods to recommend one over another.**[25] The following methods have been proposed:[2]

- Delaying the first cigarette of the day
- Eliminating a specified number of cigarettes per day, often beginning with the ones that would be easiest to give up
- Increasing the time interval between cigarettes
- Choosing periods during the day, or specific occasions, when they will not smoke (e.g. at home, in the car, with children)
- Choosing places such as the car, house, or other places where they spend time where they will not smoke

How should we communicate to clients about the availability of CDTS?

In services where CDTS is on offer, **Very Brief Advice on Smoking (VBA+) conversations should include the availability of support to gradually reduce smoking prior to stopping.** This is particularly relevant for frontline staff working with priority groups, such as people with SMI and people experiencing homelessness. Staff involved in scheduling appointments and delivering VBA+ should be trained in how to advise clients on the CDTS option so that it accurately reflects the offer while supporting client-centred engagement.

> *"The CDTS offer should be communicated to clients via both Very Brief Advice on Smoking (VBA+) and service communications and marketing. We want to have the CDTS offer visible as an alternate way to stop smoking to attract people who might not otherwise have come into the service to stop."*
>
> Sarah Hepworth, Sheffield Tobacco Control Partnership

What training and resources are recommended for staff who will be delivering CDTS?

Staff who are working with priority groups should be trained in supporting clients with a structured CDTS programme. This training should focus on introducing CDTS to clients, adapting BCTs for CDTS and the appropriate use of stop smoking aids as part of a CDTS treatment programme.

The NCSCT has developed competences, training and a treatment plan for supporting clients with CDTS. See the Resources and training section below.

What are the cost considerations?

The average cost per quit for CDTS can be expected to be greater than for abrupt stopping, as both stop smoking aids and behavioural support are typically provided for approximately six weeks longer. **CDTS, however, remains a cost-effective approach to stopping as the relatively small incremental cost is offset by the significant benefits to clients who are successful.** This is particularly the case for priority groups who might not otherwise engage in, or be successful with, abrupt approaches to stopping.[24–28] **This additional cost should be viewed as part of equity-based approaches to the delivery of LSSS support.**

Quality standards and performance measurement

To support the introduction of evidence-based CDTS interventions, a set of quality standards and performance indicators have been developed.

CDTS service-level quality standards

1. The service offers CDTS to clients and collect data on who attempts to quit with this method
2. The behaviour support programme is adapted to CDTS
3. Stop smoking aids are available (prescribed and/or recommended) for CDTS
4. There is review process at six weeks to assess the client's progress
5. Staff are trained and/or supported to deliver CDTS

Performance measurement

The best way of measuring the success of CDTS has yet to be agreed. CDTS service-level quality indicators and client outcome measures are needed to allow services to evaluate and compare CDTS interventions within and between services. The NCSCT is leading a consultation on this with the Department of Health and Social Care, involving leading researchers and practitioners.

In the meantime, below is a set of interim service-level quality indicators and outcome measures for CDTS that you may wish to use.

Service-level indicators:

- Number of clients who are engaging with the CDTS programme overall and the number from priority groups (broken down by priority group)
- Number of sessions of behavioural support completed
- Use of first-choice stop smoking aids (ideally broken down by aid and duration of use)
- Compliance with first-choice stop smoking aids (measured at end of four-week reduction period and four weeks after target quit date)
- Number of quit dates set for CDTS clients

Reduction indicators:

- Mean change in daily cigarette consumption reported four weeks following reduction date (i.e. date they started to cut down)
- 50% or greater smoking reduction four weeks from reduction date (i.e. date they started to cut down)

Smoking status (outcome) indicators:

- Self-reported smoking status four weeks and 12 weeks after target quit date
- Carbon monoxide (CO) validation of self-reported smoking status remains best practice

Clients reduce smoking for four to six weeks before their target quit date. Smoking status is then assessed four weeks and 12 weeks after their target quit date, approximately 10 and 18 weeks from the start of the CDTS programme.

Resources and training

Resources

Cut Down to Stop Treatment Plan
The CDTS treatment plan provides guidance on how to support smoking cessation for people who are not ready to stop abruptly, but who are willing to engage with support to gradually reduce and then stop smoking.
www.ncsct.co.uk/publications/cut-down-to-stop

My Cut Down to Stop Smoking Plan
This client resource is designed to support CDTS interventions. The plan is designed to be used to develop a personalised CDTS plan during sessions with clients and to monitor progress over the course of the programme.
www.ncsct.co.uk/publications/cut-down-to-stop

Competency Framework for Stop Smoking Practitioners
Published in August 2025, this framework details the competences required for delivering a CDTS support programme.
www.ncsct.co.uk/publications/competency-framework

Training

Tobacco Dependence Treatment Advanced Training Course
This new two-day advanced course includes training in the delivery of CDTS interventions.
www.ncsct.co.uk/publications/advanced-training-course

Community Mental Health Tobacco Treatment Training
This two-day course includes training in the delivery of CDTS.
www.ncsct.co.uk/publications/category/NHSE-training-materials-SMI

The CDTS-specific module (module 13) can be accessed via the link below
www.ncsct.co.uk/publications/modules_for_trainers

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