

# *Dynamic Guidelines for Tobacco Control in Canada Version 1.0*

**CAN-ADAPTT: Canadian Action Network for the Advancement,  
Dissemination and Adoption of Practice-informed Tobacco Treatment**  
*A practice-based research network*

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**Section I: Clinical Approaches**  
**Section II: Population-level Better Practices**  
**Section III: Prevention & Population-level Interventions**

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## **Introduction:**

The Dynamic Guidelines for Tobacco Control in Canada are a review of existing clinical practice guidelines and smoking cessation literature. The aim of this publication is to translate research findings into a dynamic set of evidence-based guidelines on smoking cessation that are relevant to the unique needs of practitioners and smokers in Canada. We invite you to help us to identify gaps in current better practice guidelines for smoking cessation. The guidelines are termed “dynamic” in order to reflect a continuously evolving evidence base, practice environment, client needs and treatment opportunities.

You can search the full text of this document by selecting “Find” from the “Edit” menu and typing a keyword.

## Strength of Evidence/Grade of Recommendations

### Strength of Evidence Classifications (US Guidelines)

- A:** Multiple well-designed randomized clinical trials, directly relevant to the recommendation, yielded a consistent pattern of findings.
- B:** Some evidence from randomized clinical trials supported the recommendation, but the scientific support was not optimal. For instance, few randomized trials existed, the trials that did exist were somewhat inconsistent, or the trials were not directly relevant to the recommendation.
- C:** Reserved for important clinical situations in which the Panel achieved consensus on the recommendation in the absence of relevant randomized controlled trials.

### Key to Grade of Recommendations (NZ Guidelines)

- A:** The recommendation is supported by GOOD (strong) evidence.
- B:** The recommendation is supported by FAIR (reasonable) evidence, but there may be minimal inconsistency or uncertainty.
- C:** The recommendation is supported by EXPERT opinion (published) only.
- √:** GOOD PRACTICE POINT (in the opinion of the guideline development group)

### Key to Strength of Recommendations (FR Guidelines)

- A:** High-level, strong scientific evidence (comparative, high-powered, randomized studies; meta-analysis of comparative, randomized studies; decision analysis based on well-conducted studies)
- B:** Intermediate-level scientific evidence (comparative, but low powered, randomized studies; comparative, no-randomized but conscientious studies; cohort studies)
- C:** Low-level, evidence of limited credibility (case-control studies; comparative studies involving major bias; retrospective studies; series of cases; descriptive, epidemiological studies (transverse, longitudinal))

**Professional Consensus:** In absence of scientific evidence in the literature, the recommendations were based on a professional consensus among the experts of the multidisciplinary working group.

**Strength of Evidence/Grade of Recommendations**

**Strength of Evidence Classification (UK Guidelines)**

- A:** Many well designed randomized controlled trials directly relevant to the recommendation, yielding a consistent pattern of findings.
- B:** Some evidence from randomized controlled trials, but not optimal. More interpretation of the evidence was needed. For example, there were not many randomized controlled trials, their results were not consistent, they were not directly relevant to the recommendation. They may not have been directly relevant because, for example, the study population was different.
- C:** No randomized controlled trials but the issue is important enough to merit a recommendation which is based on published evidence and expert opinion of the authors and reviewers.

**OMA Recommendations**

Recommendations are based on the most recent expert opinions, medical experience and scientific evidence.

**Best Practices for Comprehensive Tobacco Control Programs–2007 (Centers for Disease Control and Prevention)**

Best practices were determined by evidence-based analyses of scientific literature and outcomes of comprehensive state tobacco control programs and interventions.

**The guide to community preventive services: what works to promote health? /Task Force on Community Preventive Services**

Relationship Between Strength of Evidence of Effectiveness and Recommendations

<u>Strength of Evidence of Effectiveness</u>	<u>Recommendation</u>
Strong	The intervention is recommended on the basis of strong evidence of effectiveness
Sufficient	The intervention is recommended on the basis of sufficient evidence of effectiveness
Insufficient information	Available studies do not provide sufficient evidence to determine the effectiveness of the intervention
Sufficient or strong evidence of ineffectiveness or harm	Use of the intervention is discouraged based on sufficient or strong evidence
Insufficient empirical information, supplemented by expert opinion	The intervention is recommended on the basis of expert opinion

## **Section I: Clinical Approaches to Tobacco Control**

### **Recommendations from US/NZ/FR/UK/OMA Clinical Practice Guidelines**

#### *Topics*

#### **Section I: Reference Guidelines**

##### **Section IA: Counseling and Psychosocial Recommendations**

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3. Treatment Elements

##### **Section IB: Medication Recommendations**

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7. Cost-Effectiveness of Tobacco Dependence Interventions
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10. Clinical Governance and National Service Frameworks
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##### **Section ID: Specific Populations and Other Recommendations**

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4. Non-cigarette Tobacco Users
5. Pregnant and Breastfeeding Smokers
6. People who are concerned with weight gain after stopping smoking
7. Racial or Ethnic Minorities
8. Hospitalized and Preoperative Patients
9. Patients with Cardiovascular Disease
10. People who use Mental Health Services/Patients with Psychiatric disorders
11. People who use addiction treatment services/Drug Dependence
12. People who make Repeat Attempts to Stop Smoking
13. Aging
14. Low income smokers

## Section I

### Reference Guidelines

**US = United States Guidelines**

U.S. Department of Health and Human Services. Clinical practice guidelines for treating tobacco use and dependence: 2008 update. Accessed at <http://www.surgeongeneral.gov/tobacco/> on July 25, 2008 at 12:55pm.

**NZ = New Zealand Guidelines**

Ministry of Health. New Zealand Smoking Cessation Guidelines. Wellington: Ministry of Health, 2007.

**FR = France Guidelines**

Le Foll, Melihan-Cheinin, Rostoker, for the working group of AFSSAPS. Smoking cessation guidelines: Evidence-based recommendations of the French Health Products Safety Agency. *European Psychiatry* 2005; 20:431-441.

**UK = United Kingdom Guidelines**

Raw M, McNeill A, West R. Smoking cessation guidelines for health professionals. A guide to effective smoking cessation interventions for the health care system. *Thorax* 1998;53:suppl 5(1):S1-19.

**OMA=Ontario Medical Association Guidelines**

Ontario Medical Association. Re-thinking stop smoking medications: treatment myths and medical realities. [update 2008]. *Ont Med Rev* 2008 Jan; 75(1):22-34

## Section IA: Counseling and Psychosocial Recommendations

### 1. Screening and Assessment

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

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

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

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

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

#### *ii. Specialized assessment*

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

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

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

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

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

### 2. Treatment Structure and Intensity

#### *i. General*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**iv. *Type of clinician***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**3. Treatment Elements**

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

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

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

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

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

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

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

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

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

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

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

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

## Section 1B: Medication Recommendations

### 1. General

SUMMARY: Use of pharmacological agents with regular follow up should be encouraged for patients attempting to quit or who have relapsed.

US: Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A)

FR: Prolonged follow up of patients using pharmacotherapy is necessary; patient should be seen repeatedly over a 6 month period, but more prolonged follow ups are encouraged. (Grade A)

FR: It may be useful to reintroduce a pharmacological treatment after relapse, even after prolonged periods of smoking cessation. (Professional consensus)

OMA: Highly dependent smokers who are unable or unwilling to quit completely should use NRT to help them substantially reduce their cigarette consumption. Over time, these smokers should, ideally, replace more and more of the tobacco they use with NRT. (No Grade)

### 2. First-Line Medications

#### *i. Bupropion SR (Sustained Release)*

SUMMARY: Bupropion is an effective smoking cessation treatment that patients should be encouraged to use.

US: Bupropion SR is an effective smoking cessation treatment that patients should be encouraged to use. (Strength of Evidence = A)

NZ: Bupropion can be offered as an effective medication for people who want to stop smoking. (Grade = A)

NZ: Bupropion can be used by those with stable cardiovascular and respiratory diseases. (Grade = A)

NZ: The decision to use bupropion should be guided by the person's preference and contraindications and precautions for use. (Grade = √)

FR: The recommended duration of treatment with bupropion LP is 7-9 weeks. (Grade A)

*ii. Nicotine Replacement Therapies (NRTs)*

SUMMARY: NRT should be recommended for a minimum of 6 weeks for as long as is required for a successful quit. Patients should choose which type they would like and dosages tailored to their needs (using multiple therapies or patches as required for heavy smokers) and tapered down over the course of treatment.

NZ: Offer NRT routinely as an effective medication for people who want to quit smoking tobacco. (Grade = A)

NZ: The choice of NRT product can be guided by individual preference. (Grade = B)

NZ: Use NRT for at least 8 weeks. (Grade = A)

NZ: Combining two NRT products (for example, patch and gum is a popular combination) increases abstinence rates. (Grade = A)

NZ: NRT can be used to encourage reduction prior to quitting. (Grade = B)

NZ: People who need NRT for longer than 8 weeks (for example, people who are highly dependent) can continue to use NRT. (Grade = C)

NZ: NRT can be provided to people with cardiovascular disease. However, where people have suffered a serious cardiovascular event (for example, people who have had a myocardial infarction or stroke) in the past 2 weeks or have a poorly controlled disease, treatment should be discussed with a physician. Oral NRT products are recommended (rather than longer-acting patches) for such patients. (Grade = B)

NZ: NRT can be used by pregnant women after they have been informed of and have weighed up the risks and benefits. Intermittent NRT (for example, gum, inhaler, microtab and lozenge) should be used in preference to patches. (Grade = C)

NZ: NRT can be used by young people (12-18 year of age) who are dependent on nicotine (that is, it is not recommended in occasional smokers such as those who smoke on weekends only) if it is believed that the NRT may help stopping smoking. (Grade = C)

FR: NRT is recommended as an effective smoking cessation aid for dependant patients. (Grade = A)

FR: Dose of the NRT should be adjusted when there are clinical signs of overdose (diarrhea, nausea, insomnia, palpitations) or insufficient dosage (persistence of severe withdrawal signs: irritability, restlessness, anxiety, increased appetite, depressed mood). (Professional consensus)

FR: Highly dependent patients may benefit from the use of several patches applied simultaneously on the skin or the use of higher dosage 4 mg gum, instead of 2 mg gum. This strategy may be recommended for highly dependent patients or for patients who show high withdrawal symptoms with only one form of NRT (Grade = B)

FR: Usually, the dosage of NRT is decreased progressively over 8-12 weeks. (Professional consensus)

FR: The recommended duration of treatment with NRT is at least 6 weeks to up to 6 months. (Grade = A)

UK: (For primary care teams) Recommend smokers who want to stop to use NRT and provide accurate information and advice on NRT. (Strength of Evidence = A)

UK: Smokers should be encouraged to use NRT as a cessation aid. It is effective and safe if used correctly. (Strength of Evidence = A)

UK: Health professionals who deliver smoking cessation interventions should give smokers accurate information and advice on NRT. (No Grade)

OMA: As with other drugs, NRT dosage should be modified to suit the smoker's needs. Use of the appropriate combination of products is also necessary. (No Grade)

OMA: Smokers should be encouraged to individualize their NRT dosage to meet their nicotine needs. (No Grade)

OMA: Smokers should be encouraged to use NRT for as long as needed to maintain or prolong tobacco abstinence. Periodic assessments to evaluate the continued use of nicotine should be offered to the patient. (No Grade)

OMA: Highly dependent smokers who are unable or unwilling to quit completely should use NRT to help them substantially reduce their cigarette consumption. Over time, these smokers should, ideally, replace more and more of the tobacco they use with NRT. (No Grade)

### *Nicotine Gum*

US: Nicotine gum is an effective smoking cessation treatment that patients should be encouraged to use. (Strength of Evidence = A)

US: Clinicians should offer 4 mg rather than 2 mg nicotine to highly dependent smokers (Strength of Evidence = B)

OMA: The recent approval by Health Canada of nicotine gum for the purpose of reducing consumption in those who continue to smoke should be extended to all forms of NRT. (No Grade)

*Nicotine Inhaler*

US: The nicotine inhaler is an effective smoking cessation treatment that patients should be encouraged to use. (Strength of Evidence = A)

*Nicotine Lozenge*

US: The nicotine lozenge is an effective smoking cessation treatment that patients should be encouraged to use. (Strength of Evidence = B)

*Nicotine Nasal Spray*

US: Nicotine nasal spray is an effective smoking cessation treatment that patients should be encouraged to use. (Strength of Evidence = A)

*Nicotine Patch*

US: The nicotine patch is an effective smoking cessation treatment that patients should be encouraged to use. (Strength of Evidence = A)

**iii. *Varenicline***

SUMMARY: Varenicline is an effective smoking cessation treatment that patients should be encouraged to use.

US: Varenicline is an effective smoking cessation treatment that patients should be encouraged to use. (Strength of Evidence = A)

NZ: Varenicline can be routinely offered as an effective medication for those who want to stop smoking. (Grade = A)

NZ: The decision to use varenicline should be guided by the person's preference and after discussing the contraindications and precautions for use with a clinician. (Grade = √)

OMA: Physicians should consider prolonging varenicline therapy for patients for at least 24 weeks if they are not smoking 12 weeks after they have started the medication. (No Grade)

**iv. *Interaction of first-line tobacco use medications with other drugs***

US: No formal recommendations made.

### 3. Second-Line Medications

#### *a. Clonidine*

US: Clonidine is an effective smoking cessation treatment. It may be used under a physician's supervision as a second-line agent to treat tobacco dependence. (Strength of Evidence = A)

#### *b. Nortriptyline*

SUMMARY: Nortriptyline is an effective smoking cessation treatment that can be offered to patients to use.

US: Nortriptyline is an effective smoking cessation treatment. It may be used under a physician's supervision as a second-line agent to treat tobacco dependence. (Strength of Evidence = A)

NZ: Nortriptyline can be offered as an effective medication for people who want to stop smoking. (Grade = A)

NZ: The decision to use nortriptyline should be guided by the person's preference in conjunction with discussing the risks associated with a clinician. (Grade = √)

### 4. Combination Medications

SUMMARY: Smokers should be encouraged to use NRT products in combination, combining bupropion as needed.

US: Certain combinations of first-line medications have been shown to be effective smoking cessation treatments. Therefore, clinicians should consider using these combinations of medications with their patients who are willing to quit. Effective combination medications are:

- i. long-term (>14 weeks) nicotine patch + other NRT (gum and spray)
- ii. the nicotine patch + the nicotine inhaler
- iii. the nicotine patch + bupropion ST (Strength of Evidence = A)

OMA: Smokers should be encouraged to consider use of the various NRT products concurrently, and/or in combination with bupropion as needed, to control their withdrawal symptoms. (No Grade)

### 5. Use of Over-the-Counter Medications

US: Over-the-counter nicotine patch therapy is more effective than placebo, and its use should be encouraged. (Strength of Evidence = B)

## Section IC: System Recommendations

### 1. Clinician Training and Reminder Systems

**SUMMARY:** All health professionals should have training in effective smoking cessation strategies.

**US:** All clinicians and clinicians-in-training should be trained in effective strategies to assist tobacco users willing to make a quit attempt and to motivate those unwilling to quit. Training appears to be more effective when coupled with systems changes. (Strength of Evidence = B)

**NZ:** Health care workers should seek appropriate training to enable them to provide brief advice. This training should include providing the health care workers with information on available evidence-based smoking cessation treatments. (Grade = B)

**UK:** Smoking and smoking cessation should be part of the core curriculum of the basic training of all health professionals. (No Grade)

**UK:** Training should be a core part of a smoking cessation programme in all health authorities. Protected time and funding should be built into this programme. (Strength of Evidence = B)

### 2. Cost-Effectiveness of Tobacco Dependence Interventions

**US:** The tobacco dependence treatments shown to be effective in this Guideline (both counseling and medication) are highly cost-effective relative to other reimbursed treatments and should be provided to all smokers. (Strength of Evidence = A)

**US:** Sufficient resources should be allocated for systems support to ensure the delivery of efficacious tobacco use treatments. (Strength of Evidence = C)

### 3. Tobacco Dependence Treatment as a Part of Assessing Health Care Quality

**US:** Provision of Guideline-based interventions to treat tobacco use and dependence should remain in standard ratings and measures of overall health care quality (e.g., NCQA HEDIS). These standard measures should also include measures of outcomes (e.g., use of cessation treatment, short- and long-term abstinence rates) that result from providing tobacco dependence interventions. (Strength of Evidence = C)

### 4. Providing Treatment For Tobacco Use and Dependence as a Covered Benefit

**SUMMARY:** Cessation medications should be covered by health insurance plans to lessen the financial burden especially on dependent smokers who require long-term treatment to successfully quit.

US: Providing tobacco dependence treatments (both medication and counseling) as a paid or covered benefit by health insurance plans has been shown to increase the proportion of smokers who use cessation treatment, attempt to quit, and successfully quit. Therefore, treatments shown to be effective in the Guideline should be included as covered services in public and private health benefit plans. (Strength of Evidence = A)

OMA: Cessation medications should be covered under both public and private health insurance plans without penalizing the most dependent smokers who might need long-term treatment to quit successfully. (No Grade)

## 5. Clinical Governance and National Service Frameworks

SUMMARY: Funding should be provided for cessation training in the health care system, encouraging the integration of cessation services and smoke-free policies at healthcare facilities. NRT should be provided in these facilities for patients and smoking status recorded in their charts.

UK: To produce cost effective significant health gain in the population, smoking cessation interventions should be commissioned. (Strength of Evidence = A)

UK: Review current practice, identify needs, and provide core funding to integrate smoking cessation into health services; plan a cessation strategy with public health specialists; seek advice from smoking cessation specialists. (Strength of Evidence = A)

UK: These plans should include a specialist cessation service. (Strength of Evidence = A)

UK: Core funding smoking cessation training, or make sure that smoking cessation is prioritised within existing training budgets. (Strength of Evidence = B)

UK: Make provision to ensure the NRT is available to hospital patients who need it, in conjunction with professional advice and cessation support. (Strength of Evidence = A)

UK: Require all services, departments, and clinics, to introduce systems to maintain an up to date record of the smoking status of all patients in their (paper or electronic) notes. It should be regarded as a vital sign. (Strength of Evidence = A)

UK: Ensure that all health care premises and their immediate surrounding are smoke free (Strength of Evidence = C)

UK: Work with clinicians to put systems in place to audit smoking cessation interventions throughout the health care system. (No Grade)

## 6. NRT Availability/Accessibility

SUMMARY: NRT should be as easily accessible and priced to be as inexpensive as or less expensive than tobacco products.

OMA: The manufactures of NRT products should make these products available at every retail outlet where tobacco products are sold and retailers should display them prominently. (No Grade)

OMA: The federal government should remove the GST on NRT products. (No Grade)

OMA: The pharmaceutical industry should work to closely match the package quantity of NRT to tobacco products and ensure that the cost of NRT not exceed the cost of tobacco products. (No Grade)

OMA: Free NRT programs should be offered annually to help large number of smokers making a quit attempt to be successful. (No Grade)

## Section ID: Specific Populations and Other Recommendations

1. Special populations [including HIV-positive smokers; hospitalized smokers; lesbian/gay/bisexual/transgender smokers; those with low socioeconomic status (SES)/limited formal education; smoking with medical comorbidities; older smokers; smokers with psychiatric disorders (including substance use disorders); racial and ethnic minorities; and women smokers].

US: The interventions found to be effective in this Guideline have been shown to be effective in a variety of populations. In addition, many of the studies supporting these interventions comprised diverse samples of tobacco users. Therefore, interventions identified as effective in this Guideline are recommended for all individuals who use tobacco, except when medication use is contraindicated or with specific populations in which medication has not been shown to be effective (pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = B)

### 2. Children and Adolescents

**SUMMARY:** Cessation counseling should be encouraged for adolescent smokers, supporting abstinence from tobacco and using NRT for those who are nicotine dependent. Counseling in pediatric settings can be useful to make parents aware about the harmfulness of secondhand smoke.

US: Clinicians should ask pediatric and adolescent patients about tobacco use and provide a strong message regarding the importance of totally abstaining from tobacco use. (Strength of Evidence = C)

US: Counseling has been shown to be effective in treatment of adolescent smokers. Therefore, adolescent smokers should be provided with counseling interventions to aid them in quitting smoking. (Strength of Evidence = B)

US: Secondhand smoke is harmful to children. Cessation counseling delivered in pediatric settings has been shown to be effective in increasing abstinence among parents who smoke. Therefore, to protect children from secondhand smoke, clinicians should ask parents about tobacco use and offer them cessation advice and assistance. (Strength of Evidence = B)

NZ: Offer smoking cessation interventions that incorporate known effective components (such as those identified in the previous sections) to young people who smoke. (Grade = √)

NZ: NRT can be used by young people (12-18 year olds) who are dependent on nicotine (that is, NRT is not recommended for use by occasional smokers) if it is believed that NRT may aid the quit attempt. (Grade = C)

UK: Cessation interventions shown to be effective with adults should be considered for use with young people, with the content modified as necessary. (Strength of Evidence = C)

OMA: Cessation medications should be made available for smokers under 18 who want to quit. (No Grade)

### 3. Light Smokers

US: Light smokers should be identified, strongly urged to quit, and provided counseling cessation interventions. (Strength of Evidence = B)

### 4. Non-cigarette Tobacco Users

SUMMARY: Cessation counseling interventions should be offered to all smokeless tobacco, cigar, pipe and other non-cigarette users by health professionals, including dental health professionals.

US: Smokeless tobacco users should be identified, strongly urged to quit, and provided counseling cessation interventions. (Strength of Evidence = A)

US: Clinicians delivering dental health services should provide brief counseling interventions to all smokeless tobacco users. (Strength of Evidence = A)

US: Users of cigars, pipes, and other noncigarette forms of smoking tobacco should be identified, strongly urged to quit, and offered the same counseling interventions recommended for cigarette smokers. (Strength of Evidence = C)

### 5. Pregnant and Breastfeeding Smokers

SUMMARY: Smoking cessation should be encouraged for all pregnant and breastfeeding women from initial visit and throughout pregnancy. Utilizing behavioural and cognitive therapies is a recommended first step, but if found ineffective, oral NRT is recommended over the patch after a risk-benefit analysis.

US: Because of the serious risks of smoking to the pregnant smoker and the fetus, whenever possible pregnant smokers should be offered person-to-person psychosocial interventions that exceed minimal advice to quit. (Strength of Evidence = A)

US: Although abstinence early in pregnancy will produce the greatest benefits to the fetus and expectant mother, quitting at any point in pregnancy can yield benefits. Therefore, clinicians should offer effective tobacco dependence interventions to pregnant smokers at

the first prenatal visit as well as throughout the course of pregnancy. (Strength of Evidence = B)

NZ: Offer all pregnant and breastfeeding women who smoke multi-session behavioural smoking cessation interventions from a specialist/dedicated cessation service. (Grade = A)

NZ: All health care workers should briefly advise pregnant and breastfeeding women who smoke to stop smoking. (Grade = A)

NZ: NRT can be used in pregnancy and during breastfeeding following a risk-benefit assessment. If NRT is used, oral NRT products (for example, gum, inhalers, microtabs and lozenges) are preferable to nicotine patches. (Grade=C)

FR: Since the safety and efficacy of NRT for smoking cessation during pregnancy have not been well studied, behavioural and cognitive therapy and support should first be proposed during pregnancy (Professional consensus)

FR: If behavioural and cognitive therapy and support are ineffective to promote smoking cessation, NRT should be provided; however, nicotine patches should be removed during the night in pregnant women. (Professional consensus)

FR: Behavioural and cognitive therapy and support should first be proposed during breast-feeding. (Professional consensus)

FR: If behavioural and cognitive therapy and support are ineffective to promote smoking cessation, NRT should be provided; however, nicotine gums taken immediately after feeding should be preferred over nicotine patches. (Professional consensus)

UK: Pregnant smokers should be given firm and clear advice to stop smoking throughout pregnancy, and given assistance when it is requested. (Strength of Evidence = A)

OMA: NRT should be made available to pregnant women who are unable to quit using non-pharmacologic methods. As with other drugs, NRT dosage should be matched to suit the smoker's needs. (No Grade)

OMA: Partners who smoke should not smoke around pregnant women; they should be encouraged to quit, and should also consider using stop-smoking medications. (No Grade)

## 6. People who are Concerned with Weight Gain After Stopping Smoking

US: For smokers who are greatly concerned about weight gain, it may be most appropriate to prescribe or recommend bupropion SR or NRT (in particular, nicotine gum and nicotine lozenge), which have been shown to delay weight gain after quitting. (Strength of Evidence = B)

## 7. Racial or Ethnic Minorities

**SUMMARY:** Culturally sensitive methods should be used to deliver cessation services to racial or ethnic minorities.

NZ: Offer all [racial and ethnic] people who smoke smoking cessation interventions that incorporate known effective components (such as those identified in the previous sections). (Grade = √)

NZ: Offer culturally appropriate services where available. (Grade = C)

NZ: Health care workers providing cessation support to [racial and ethnic] people should seek training in how to deliver support to [racial or ethnic] people. (Grade = √)

## 8. Hospitalized and Preoperative Patients

**SUMMARY:** All patients should be made aware of the hospital's smoke free policies and advised to quit smoking prior to hospital admission or surgery. Patients should be provided with NRT during their hospital stay to reduce tobacco use.

NZ: Provide brief advice to stop smoking to all hospitalized people who smoke. (Grade = A)

NZ: Arrange multi-session intensive support, medication and follow up for at least 1 month for all hospitalized patients who smoke. (Grade = A)

NZ: Briefly advise people awaiting surgery who smoke to stop smoking and arrange support (such as NRT) prior to surgery. (Grade = A)

NZ: All hospitals should have systems set up for helping patients to stop smoking. This includes routinely providing advice to stop smoking and either providing a dedicated smoking cessation service within the hospital or arranging for smoking cessation treatment to be provided by an external service. (Grade = B)

NZ: Advise parents and family members of hospitalized children to stop smoking and offer support to help them. (Grade = √)

FR: Quitting smoking before a surgical procedure allows reduction in complications of surgery, therefore, smoking cessation should be proposed for at least 6 weeks before surgery. (Grade B)

FR: The use of NRT as partial substitution therapy to reduce tobacco use should be proposed to patients unwilling to stop. (Grade B)

UK: Hospital staff should assess the smoking status of patients on admission, advise smokers to stop, and assist those interested in doing so. Patients should be advised of the hospital's smoke free status before admission. (Strength of Evidence = C)

UK: Hospital patients who smoke should be offered help in stopping smoking, including the provision of NRT. (Strength of Evidence = A)

OMA: Hospitals should include cessation medications in their drug formularies, and should offer a cessation program based on the Ottawa model to all smokers admitted to their facility. Standard orders should be available to relieve withdrawal and enhance the likelihood of cessation. (No Grade)

OMA: The attending physician should routinely offer cessation medications to hospitalized patients who smoke, including patient in psychiatric wards. (No Grade)

OMA: When smokers know of their hospitalization in advance, these patients should be offered assistance in gaining skills to abstain from tobacco, including the offer of cessation medications. Ideally this should be done six weeks prior to their admission. (No Grade)

## 9. Patients with Cardiovascular Disease

SUMMARY: Patients with CVD are highly recommended to quit smoking and should be provided with NRT or other stop-smoking medications to facilitate the quit as advised by a physician.

NZ: NRT can be provided to people with cardiovascular disease. However, where people have suffered a serious cardiovascular event (for example, people who have had a myocardial infarction or stroke) in the past 2 weeks or have a poorly controlled disease, treatment should be discussed with a physician. In these cases, oral NRT products rather than patches are recommended as the preferred option. (Grade = B)

FR: Smoking cessation is highly recommended for patients suffering from cardiovascular disease. (Grade = A)

FR: NRT is well tolerated and does not increase severity of cardiovascular diseases, therefore NRT is recommended for smokers suffering from cardiovascular diseases. (Grade = B)

FR: The prescription may start immediately after intensive care unit treatment for myocardial infarction. (Grade = C)

FR: The prescription should take into account loss of tolerance to nicotine with smoking cessation. (Professional consensus)

OMA: Stop-smoking medications should be made available to patients with cardiovascular disease who have not been able to quit using non-pharmacologic methods (No Grade)

## 10. People who use Mental Health Services/Patients with Psychiatric disorders

SUMMARY: Smoking cessation counseling and NRT should be offered to smokers who use mental health services. While using NRT, the patients' psychiatric conditions and medication dosages should be monitored and adjusted as necessary.

NZ: Provide brief advice to stop smoking to all users of mental health services who smoke. (Grade = A)

NZ: Offer smoking cessation interventions that incorporate known effective components (such as those identified in the previous sections) to people with mental health disorders who smoke. (Grade = √)

NZ: People with mental health disorders who stop smoking while taking medications for their illness should be monitored to determine if dosage reductions in their medication are necessary. (Grade = A)

FR: In patients suffering from psychiatric disorders, smoking cessation should start once the psychiatric disorder is stabilized. (Professional consensus)

OMA: The attending physician should routinely offer cessation medications to hospitalized patients who smoke, including patient in psychiatric wards. (No Grade)

## 11. People who use addiction treatment services/Drug Dependence

SUMMARY: Smokers in addiction services should be screened and provided with brief counselling on smoking cessation.

NZ: Provide brief advice to stop smoking to all users of addiction services who smoke. (Grade = A)

NZ: Offer smoking cessation interventions that incorporate known effective components (such as those identified in the previous sections) to people who smoke tobacco and who use addiction services. (Grade = √)

FR: Specific questionnaires such as CAGE are useful in screening for a pathological use of alcohol in the general population. (Professional consensus)

## 12. People who make Repeat Attempts to Stop Smoking

SUMMARY: Smokers who relapse should be provided with smoking cessation support when they request it, using NRT as a way to increase motivation to complete the quit.

NZ: Provide brief advice to stop smoking to all people who have relapsed. (Grade = A)

NZ: Offer smoking cessation interventions that incorporate known effective components (such as those identified in the previous sections) to people making another quit attempt. (Grade = A)

NZ: Services should be able to offer support to people who have relapsed as soon as they request support. (Grade = √)

FR: NRT used as a partial substitute should be not employed extensively and should be used as a way to increase the motivation to complete smoking cessation in subjects. (Professional consensus)

### 13. Aging

FR: Minimal counselling, behavioural and cognitive therapy and NRT have shown their efficacy in subjects more than 65 years old. (Grade = A)

### 14. Low income smokers

UK: Considerations should be given to ways of increasing the availability of NRT to low income smokers, including at a reduced cost or free of charge. (Strength of Evidence = C)

## **Section II: Population-level Better Practices**

### **Recommendations from CDC Best Practices for Comprehensive Tobacco Control Programs, 2007**

#### *Topics*

#### **Section IIA: Provincial and Community Programs**

1. Program Activities
2. Surveillance and Evaluation
3. Administration and Management

#### **Section IIB: Health Communications and Counter-Marketing Interventions**

#### **Section IIC: Tobacco-Related Disparities**

## Section IIA: Provincial and Community Programs

### 1. Program Activities

- A comprehensive approach to tobacco prevention and control requires coordination and collaboration at the federal, provincial, and local community levels.
- Individual-level educational and clinical approaches should be combined with population-based efforts at the state/province and community levels.
- Statewide/Provincial efforts should include:
  - Supporting and/or facilitating tobacco prevention and control coalition development as well as links to other related coalitions (e.g., cancer control)
  - Establishing a strategic plan for comprehensive tobacco control with appropriate partners at the state/provincial and local levels
  - Implementing evidence-based policy interventions to decrease tobacco use initiation, increase cessation, and protect people from exposure to secondhand smoke
  - Collecting community-specific data and developing and implementing culturally appropriate interventions with appropriate multicultural involvement
  - Sponsoring local, regional, and statewide/provincial training, conferences, and technical assistance on best practices for effective tobacco use prevention and cessation programs
  - Monitoring pro-tobacco influences to facilitate public discussion and debate among partners, decision makers, and other stakeholders at the community level
  - Supporting innovative demonstration and research projects to prevent youth tobacco use, promote cessation, promote tobacco-free communities, and reach diverse populations
- Individual-level educational and clinical approaches should be combined with population-based efforts at the state/province and community levels.
- Statewide/provincial programs can provide the skills, resources, and information needed for implementation of effective community programs.
- Statewide/Provincial program involvement in community-level interventions should include:
  - Providing funding to community-based organizations in order to strengthen the capacity of these groups to positively influence social norms regarding tobacco use and to build relationships between health departments and grassroots, voluntary efforts
  - Empowering local agencies to build community coalitions that facilitate collaboration among programs in local governments, voluntary and civic organizations, and diverse community based organizations

- Collaborating with partners and other programs to implement evidence-based interventions and build and sustain capacity through technical assistance and training
- Supporting local strategies or efforts to educate the public and media not only about the health effects of tobacco use and exposure to secondhand smoke, but also about available cessation services
- Promoting public discussion among partners, decision makers, and other stakeholders about tobacco-related health issues and pro-tobacco influences
- Establishing a local strategic plan of action that is consistent with the state/province's strategic plan
- Ensuring that funding formulas for the local public health infrastructure provide grantees (e.g., local and county health departments, tribal organizations, nonprofit organizations) operating expenses commensurate with tobacco control program and evaluation efforts
- Ensuring that local grantees measure and evaluate social norm change outcomes (e.g., policy adoption, increased compliance) resulting from their interventions

## 2. Surveillance and Evaluation

- A comprehensive tobacco control program must have a system of surveillance and evaluation that can monitor and document short-term, intermediate, and long-term intervention outcomes in the population to inform program and policy direction, as well as to ensure accountability to those with fiscal oversight.
- Process and outcome evaluation activities should be ongoing and should be used to assess individual program activities and to guide program improvement. Program evaluation efforts should build on and complement data collection by linking statewide/provincial and local program efforts to monitor progress toward program objectives.
- Evaluation planning should be integrated with program planning. Collection of baseline data related to each objective and outcome indicator is critical to ensuring that program-related effects can be clearly measured. For this reason, surveillance and evaluation systems must have first priority in the planning process.
- Evaluation efforts should also include counter-marketing surveillance to track new products and examine the impact of pro-tobacco influences, including the actual cost of cigarettes, free samples, advertising, promotions, media coverage, and events that glamorize tobacco use.
- State/provincial surveillance efforts should be coordinated with federal tobacco surveillance programs.

## 3. Administration and Management

- An effective tobacco control program requires a strong management structure to facilitate coordination of program components, involvement of multiple state/provincial agencies (e.g., health, education, and law enforcement) and levels of local government, and partnership with statewide voluntary health organizations and community groups. In addition, administration and management systems are required to prepare and implement contracts and provide fiscal and program monitoring.
- Administration and management activities include the following:
  - Engaging in strategic planning to guide program efforts and resources to accomplish their goals
  - Recruiting and developing qualified and diverse technical, program, and administrative staff
  - Awarding and monitoring program contracts and grants, coordinating implementation across program areas, and assessing grantee program performance
  - Developing and maintaining a real-time fiscal management system that tracks allocations and expenditure of funds
  - Increasing capacity at the local level by providing ongoing training and technical assistance
  - Creating an effective communication system internally and with local coalitions and partners
  - Educating the public and decision makers on the health effects of tobacco and evidence-based effective program and policy interventions

## Section IIB: Health Communication and Counter-Marketing Interventions

- Health communication and counter-marketing interventions can be powerful tools for preventing smoking initiation, promoting and facilitating cessation, and shaping social norms related to tobacco uses. Effective media and health communication intervention efforts should include:
  - Sufficient reach, frequency, and duration.
    - *Reach and frequency:* *Reach* refers to the number of unduplicated homes/people exposed at least once to a particular ad. *Frequency* is the average number of times a home or individual is exposed to an ad during a given period of time. It is estimated that ads should reach 75% to 85% of the target audience each quarter of the year during a media campaign, with an average of 1,200 targeted rating points (TRPs; see full document for definition and calculation of TRPs) per quarter during the introduction of a campaign and 800 TRPs per quarter thereafter.
    - *Duration:* A campaign should be expected to run at least 6 months to affect awareness of the issue, 12 to 18 months to have an impact on attitudes, and 18 to 24 months to influence behavior.
  - Audience research to define the thematic characteristics and execution of messages and to develop campaigns that are influential, have high impact, and engage specific audiences
  - Market research to not only identify the knowledge, attitudes, and behaviors of target audiences but also the behavioral theory that best motivates specific audiences to change
  - Counter-marketing surveillance to understand pro-tobacco messaging, media analysis, and marketing tactics
  - Grassroots promotions, local media advocacy, event sponsorships, and other community tie-ins to support and reinforce the statewide campaign and to counter pro-tobacco influences
  - Technologies such as viral marketing, social networks, personal web pages, and blogs to generate messages that are then disseminated by the target audience
  - Process and outcome evaluation of a comprehensive communication effort as well
  - as specific evaluations of new and innovative approaches
  - Promotion of available services, including the state/province's telephone cessation quitline number or the national portal number

## Section IIC: Tobacco-Related Disparities

- Because some populations experience a disproportionate health and economic burden from tobacco use, a focus on eliminating such tobacco-related disparities is necessary. To identify and eliminate tobacco-related disparities, state/provincial programs should:
  - Conduct a population assessment to identify the populations with tobacco-related disparities within a state/province or community and to guide efforts.
  - Seek consultation from specific population groups, tribes, and community-based organizations
  - Ensure that disparity issues are an integral part of state/province and local tobacco control strategic plan
  - Provide funding to organizations that can effectively reach, involve, and mobilize identified specific populations
  - Provide culturally competent technical assistance and training to grantees and partners
  - Provide health communications to address tobacco-related disparities in appropriate languages that support community-level interventions
  - Ensure that quitline services are culturally competent and have adequate reach and intensity to meet the required needs of population subgroups
  
- State/provincial action on tobacco use treatment should include eliminating cost and other barriers to treatment for populations disproportionately affected by tobacco use

## **Section III: Prevention & Population-level Interventions**

### **Recommendations from US/NZ Guidelines**

#### *Topics*

#### **Reference Guidelines**

**Section IIIA: Reducing Tobacco Use Initiation**

**Section IIIB: Increasing Tobacco Use Cessation**

**Section IIIC: Reducing Environmental Tobacco smoke**

#### **Reference Guidelines**

##### **US Community Prevention Guidelines**

The guide to community preventive services : what works to promote health? / Task Force on Community Preventive Services ; edited by Stephanie Zaza, Peter A. Briss, Kate W. Harris. p. cm. <http://www.thecommunityguide.org/tobacco/#initiation>. Accessed: July 29, 2008, 3:45 pm

##### **New Zealand Community Prevention Guidelines**

Wilson N. 2007. Review of the Evidence for Major Population-Level Tobacco Control Intervention. Wellington: Ministry of Health

## **Section IIIA: Reducing Tobacco Use Initiation**

### **SUMMARY:**

1. Increasing the unit price for tobacco (Recommended – Strong Evidence)
  - i. The unit price for tobacco products can be increased by raising the product excise tax, through legislation at the state or national level.
  - ii. In several states, excise tax increases have provided revenue for comprehensive tobacco use prevention and control programs.
  
2. Mass media education campaigns when combined with other interventions (Recommended – Strong Evidence)
  - i. Messages are developed through formative research, and use broadcast messages on television and radio, although other formats, such as billboards, print media, and movies, have been used.
  - ii. Campaigns are conducted over long periods of time and employ brief, recurring messages to inform and motivate individuals to quit or remain tobacco-free
  
3. Restricting minors' access to tobacco products:
  - i. Community mobilization when combined with additional interventions (stronger local laws directed at retailers, active enforcement of retailer sales laws, retailer education with reinforcement) (Recommended – Strong Evidence)
  - ii. Restricting minors' access to tobacco products: sales laws directed at tobacco retailers to reduce illegal sales to minors, when implemented alone (Recommended – Insufficient Evidence)
  - iii. Laws directed at minors' purchase, possession, or use of tobacco products, when implemented alone (Recommended – Insufficient Evidence)
  - iv. Active enforcement of sales laws directed at retailers, when implemented alone (Recommended – Insufficient Evidence)
  - v. Retailer education with reinforcement and information on health consequences, when implemented alone (Recommended – Insufficient Evidence)
  - vi. Retailer education without reinforcement, when implemented alone (Recommended – Insufficient Evidence)
  - vii. Community education about minors' access to tobacco products, when implemented alone (Recommended – Insufficient Evidence)

NZ: School-based education **relating to smoking** (Effective)

## **Section IIIB: Increasing Tobacco Use Cessation**

### **SUMMARY:**

1. Increasing the unit price for tobacco products (Recommended – Strong Evidence)
  - i. The unit price for tobacco products can be increased by raising the product excise tax, through legislation at the state or national level.
  - ii. In several states, excise tax increases have provided revenue for comprehensive tobacco use prevention and control programs.
2. Reducing client out-of-pocket costs for effective cessation therapies (Recommended – Sufficient Evidence)
  - i. These programs include efforts to reduce the financial barriers that may stop patients from using cessation therapies.
  - ii. Techniques include providing the services within the healthcare system, or providing coverage for or reimbursement of patients for expenditures on (1) cessation groups or (2) nicotine replacement or other pharmacologic therapies.
3. Multicomponent interventions that include client telephone support (Recommended – Strong Evidence)
  - i. These programs are organized efforts to help tobacco users quit and not start using tobacco again. They provide one or more sessions of counseling or assistance, usually delivered by trained counselors, healthcare providers.
  - ii. Help is delivered in one of two ways: either the tobacco user places a call requesting help, or the professional guiding the effort to quit calls the user to offer help or returns a call from a user who requested help.
  - iii. These telephone sessions, which usually follow a standardized approach to providing advice and counseling, are often combined with other efforts, such as distribution of materials about quitting, formal individual or group counseling, or nicotine replacement therapies (including patches or gum).
4. Mass media education campaigns combined with other interventions (Recommended – Strong Evidence)
  - i. Messages are developed through formative research, and use broadcast messages on television and radio, although other formats, such as billboards, print media, and movies, have been used.
  - ii. Campaigns are conducted over long periods of time and employ brief, recurring messages to inform and motivate individuals to quit or remain tobacco-free
5. Mass media education–cessation series (Recommended – Insufficient Evidence)
6. Mass media education–cessation contests (Recommended – Insufficient Evidence)
7. Healthcare provider reminder systems (Recommended – Sufficient Evidence)
  - i. Provider reminders involve efforts to identify patients who use tobacco products and to prompt healthcare providers to discuss with these patients the importance of quitting.

- ii. Providers receive these reminders through stickers on patients' charts, vital sign stamps, medical record flow sheets, checklists, and by computer. Provider reminders are often combined with other approaches.
- 8. Healthcare provider reminder systems with provider education, with or without client education (Recommended – Strong Evidence)
  - i. Efforts to increase the number of people who stop using tobacco include prompting healthcare providers to identify and to discuss with tobacco-using patients the importance of quitting (“provider reminder”), an education program for providers, so that they can help their patients quit tobacco use (“provider education”), and self-help materials for patients interested in quitting (“patient education”).
- 9. Provider education systems alone (Recommended – Insufficient Evidence)
- 10. Healthcare provider feedback and assessment (Recommended – Insufficient Evidence)

### **Section IIIC: Reducing Environmental Tobacco Smoke**

#### **SUMMARY:**

1. Smoking bans and restrictions (Recommended – Strong Evidence)
  - i. Smoking bans and restrictions are policies, regulations, and laws that limit smoking in workplaces and other public areas.
  - ii. Smoking bans prohibit smoking entirely; smoking restrictions limit smoking to designated area
  
2. Community education to reduce exposure to environmental tobacco smoke in the home (Recommended – Insufficient Evidence)