CAN ADAPTT
Canadian Smoking Cessation Guideline

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Counselling and Psychosocial Approaches

CAN-ADAPTT's Clinical Practice Guideline Development Group;
Section Lead: Gerry Brosky, MD, CCFP

Overview of Evidence

The following recommendations, and supporting evidence, have been extracted from existing clinical practice guidelines to inform the development of the CAN-ADAPTT Summary Statements.

CAN-ADAPTT worked with the Guidelines Advisory Committee (GAC) to conduct a literature search (years: 2002-2009) to identify existing clinical practice guidelines (CPGs). Five existing clinical practice guidelines were identified as meeting the high quality criteria set out in the AGREE Instrument. The recommendations contained in these high-quality CPGs have been used as the evidence base for the CAN-ADAPTT guideline development process. Visit www.can-adaptt.net to view CAN-ADAPTT's guideline development methodology.

U.S. Department of Health and Human Services Public Health Service (2008)[1]

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)***

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)*** 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)***

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)*** 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)*** 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)***

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

[1] U.S. Department of Health and Human Services Public Health Service. (2008, May). Clinical practice guideline: Treating tobacco use and dependence: 2008 update.

Proactive telephone counselling, group counselling, and individual counselling formats are effective and should be used in smoking cessation interventions. ***(Strength of Evidence = A)*** Smoking cessation interventions that are delivered in multiple formats increase abstinence rates and should be encouraged. ***(Strength of Evidence = A)*** 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)***

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)***

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

The combination of counselling and medication is more effective for smoking cessation than either medication or counselling alone. Therefore, whenever feasible and appropriate, both counselling and medication should be provided to patients trying to quit smoking. ***(Strength of Evidence = A)*** There is a strong relation between the number of sessions of counselling, when it is combined with medication, and the likelihood of successful smoking cessation. Therefore, to the extent possible, clinicians should provide multiple counselling sessions, in addition to medication, to their patients who are trying to quit smoking. ***(Strength of Evidence = A)***

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)***

New Zealand Ministry of Health (2007)[2]

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)***

All doctors should provide brief advice to quit smoking at least once a year to *all* patients who smoke. ***(Grade = A)*** 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)*** Record the provision of brief advice in patient records. ***(Grade = C)*** Aim to see people for at least four cessation support sessions. ***(Grade = A)***

Health care workers providing evidence-based cessation support (that is, more than just brief advice) should seek appropriate training. ***(Grade = C)*** Health care workers trained as smoking cessation providers require dedicated time to provide cessation support. ***(Grade = C)***

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

[2] Ministry of Health. (2007, August). New Zealand smoking cessation guidelines. Wellington: Ministry of Health.

Institute for Clinical Systems Improvement (ICSI) (2004)[3]

Adults who have not used tobacco for at least 12 months and who have an easily visible mark on their chart to that effect should be asked about their tobacco use status yearly until abstinent for five years. Everyone without a tobacco use mark on the chart or those with a mark indicating use within the past six months should be asked at nearly every visit. ***(Class = A, C, D, M, R)***

Ask a tobacco user who is ready to quit to set his/her own quit date. ***(Class = C, R)***

All discussions with tobacco users should be documented. ***(No Grade)***

Consideration may also be given to making a referral to a tobacco cessation consultant or a center with programs in tobacco cessation. Other resources include local tobacco cessation classes, community support systems, and self-help brochures and materials from drug companies. ***(Class=A)***

Compliment and reinforce non-use in former tobacco users. ***(Class = R)***

The first 12 months after quitting (especially the first two weeks) is when one is at the highest risk for relapse. Follow-up options include a face-to-face, telephone, or mailed (postal or electronic) expression of support and willingness to help. ***(Class = M)***

A pre-contemplator (a user not ready to consider quitting within the next six months) benefits from non-confrontational messages about the importance of quitting and the awareness that provider help is available when ready. ***(No Class).***

A contemplator (who will consider quitting within the next 1-6 months) is accepting of supportive urging to quit and encouragement of a plan. ***(Class = C, R)***

---

[3] Institute for Clinical Systems Improvement (ICSI). (2004, June). Health care guideline: Tobacco use prevention and cessation for adults and mature adolescents. Retrieved October 24, 2007 from: http://www.icsi.org/tobacco_use_prevention_and_cessation_for_adults/tobacco_use_prevention_and_cessation_for_adults_and_mature_adolescents_2510.html

Registered Nurses Association of Ontario (RNAO) (2007)[4]

Nurses implement minimal tobacco use intervention using the "Ask, Advise, Assist, Arrange" protocol with all clients. ***(Strength of Evidence =A)***

Nurses introduce intensive smoking cessation intervention (more than 10 minutes duration) when their knowledge and time enables them to engage in more intensive counselling. ***(Strength of Evidence =A)***

Nurses recognize that tobacco users may relapse several times before achieving abstinence and need to re-engage clients in the smoking cessation process. ***(Strength of Evidence = B)***

Nurses should be knowledgeable about community smoking cessation resources, for referral and follow-up. ***(Strength of Evidence = C)***

Nurses encourage persons who smoke, as well as those who do not, to make their homes smoke-free, to protect children, families and themselves from exposure to second-hand smoke. ***(Strength of evidence = A)***

CAN-ADAPTT Summary Statements *Comment on the discussion board*

CAN-ADAPTT's development process reflects a dynamic opportunity to ensure that its guideline is practice informed and addresses issues of applicability in the Canadian context. It has built from the evidence and recommendations contained in existing guidelines. It did not review the primary literature to inform the development of its Summary Statements unless emerging evidence was identified by the Guideline Development Group. The CAN-ADAPTT Guideline Development Group has provided the below Summary Statements for Counselling and Psychosocial Approaches.

[4] Registered Nurses Association of Ontario (RNAO). (2007, March). Integrating smoking cessation into daily nursing practice. Retrieved October 26, 2007 from: http://www.rnao.org/bestpractices/PDF/BPG_smoking_cessation.pdf

Summary Statement #1 –

ASK: Tobacco use status should be updated, for all patients/clients, by all health care providers on a regular basis.
GRADE*: 1A

Summary Statement #2 –

ADVISE: Health care providers should clearly advise patients/clients to quit.
GRADE*: 1C

Summary Statement #3 –

ASSESS: Health care providers should assess the willingness of patients/clients to begin treatment to achieve abstinence (quitting).
GRADE*: 1C

Summary Statement #4 –

ASSIST: Every tobacco user who expresses the willingness to begin treatment to quit should be offered assistance.
GRADE*: 1A

a) Minimal interventions, of 1-3 minutes, are effective and should be offered to every tobacco user. However, there is a strong dose-response relationship between the session length and successful treatment, and so intensive interventions should be used whenever possible.
GRADE*: 1A

b) Counselling by a variety or combination of delivery formats (self-help, individual, group, helpline, web-based) is effective and should be used to assist patients/clients who express a willingness to quit.
GRADE*: 1A

c) Because multiple counselling sessions increase the chances of prolonged abstinence, health care providers should provide *four or more counselling sessions* **where possible.**

GRADE*: 1A

d) Combining counselling and smoking cessation medication is more effective than either alone, therefore both should be provided to patients/clients trying to stop smoking where feasible.
GRADE*: 1A

e) Motivational interviewing is encouraged to support patients/clients willingness to engage in treatment now and in the future.
GRADE*: 1B

f) Two types of counselling and behavioural therapies yield significantly higher abstinence rates and should be included in smoking cessation treatment: 1) providing practical counselling on problem solving skills or skill training and 2) providing support as a part of treatment.
GRADE*: 1B

Summary Statement #4 –

ARRANGE: Health care providers:

a) **should conduct regular follow-up to assess response, provide support and modify treatment as necessary.**
GRADE*: 1C

b) **are encouraged to refer patients/clients to relevant resources as part of the provision of treatment, where appropriate.**
GRADE*: 1A

*GRADE: See below or click here for Grade of Recommendation and Level of Evidence Summary Table.

Clinical Considerations

Comment on the discussion board

- Health care providers should be encouraged to ask about all forms of tobacco use including tobacco that is smoked (cigarettes, cigarillos, cigars, blunts, pipe, shisha, hookah, electronic cigarette) and smokeless (chewing tobacco, dipping tobacco, dissolvable tobacco, snus, snuff). This can be best asked by "Have you used **any form of tobacco** in the past six months?"
- A systematic approach to asking about tobacco use is best. Documenting tobacco status can involve medical questionnaires, stickers on client charts, electronic health records, chart reminders or through computer reminder systems.
- Encourage smoke-free homes, including skills to modify habits in order to minimize, avoid and/or counter triggers.
- Health care providers functioning within a team should be encouraged to discuss their smoking cessation strategy for their practice to ensure consistent application and to increase effectiveness.
- Evidence demonstrates that tobacco dependence treatment can be effective and should be considered even where specialized assessments are not used or available.
- Where appropriate, counselling can be delegated by arranging for referral, when barriers to the provision of counselling exist (i.e. limited time, resources, staff etc.) There are effective programs available to support health care providers and their patients/clients (see tools/resources section).
- All health care providers should be encouraged to obtain training in cessation counselling.
- Education of health care providers and patients should have consistent messaging, align tools and services to serve both targets. This includes addressing collaboration across the continuum of care (i.e. clinical or community setting) and across disciplines.

Tools/Resources — *Contribute a Tool/Resource*

Resource	Details
5 A's Tools	• PREGNETS: The 5A's Tool • Ontario Medical Asscociation: Clinical Tobacco Intervention: Smoking Cessation Guideline Flow Sheet • TRac (Tobacco Reduction and Cessation) Safety Sensitive Algorithm
AlbertaQuits.ca	• Comprehensive online quit smoking service with access to counselling, self-assessments, medication guide, international community, and forums
Centre for Addiction and Mental Health (CAMH) Nicotine Dependence Clinic	• This clinic offers service to smokers and tobacco users who want to quit or reduce their tobacco use. It also provides specialized treatment services for smokers who are pregnant and for people with other substance use issues, chronic mental illness and serious health concerns.
Cost of smoking calculator (Canadian Cancer Society)	• Online tool to calculate the cost of smoking.
Decisional Balance Sheet	• A tool designed to facilitate a discussion between care providers and patients/clients about the pros and cons of substance use.
Fagerström Test for Nicotine Dependence	• A validated tool for assessing initial dosing of NRT patches.
Motivational Interviewing Website	• These pages provide background information on the practice of Motivational Interviewing.
On the Road to Quitting: Guide to becoming a non-smoker	• This guide will help individuals prepare and take action to successfully stop smoking.
One Step at a time Series (Canadian Cancer Society)	• For smokers who want to quit (English/French) • For smokers who don't want to quit (English/French) • If you want to help a smoker quit (English/French)
Ontario Tobacco Research Unit Online Course – Cessation Module	• Free online course • Cessation module deals with the complexities of quitting smoking, the roles that nicotine addiction and motivation play in the quitting process, and best practices for smoking cessation.
Partnership to Assist with Cessation of Tobacco	• Smoking cessation workshops provided free of charge to groups, facilities and health regions with funding from Saskatchewan Health.

(PACT)	
Program Training and Consultation Centre (PTCC)	• Online information and training on brief tobacco interventions for health professionals Variety of minimal contact tobacco trainings available. Free of charge.
Q.U.I.T.: Quit Using and Inhaling Tobacco	• Canadian Pharmacists Association resource. • QU.I.T. is a continuing education program, available in both live and online formats, that trains pharmacists to expand their role in patient care and offer smoking cessation services in their pharmacy.

Smokers' Helpline Online	• Alberta
	  • 1-866-332-2322 (English)
	  • Fax Referral form
	• British Columbia
	  ○ 1-877-455-2233 (English, French + 121 other languages)
	  ○ QuitNow.ca
	  ▪ Fax Referral form
	  ▪ Helping Women Quit Guide
	• Manitoba
	  • 1-877-513-5333 (English, French)
	  • Fax Referral form
	• Newfoundland and Labrador
	  • 1-800-363-5864 (English)
	  • CARE program (Community Action and Referral Effort) and fax referral form
	• New Brunswick
	  • 1-877-513-5333 (English, French)
	  • Fax Referral program and form
	  • Personalized Quit Plan: Tear Off Pads
	• Northwest Territories
	  • 1-866-286-5099
	• Nova Scotia
	  • 1-877-513-5333 (English, French)
	  • Fax Referral form
	• Nunavut
	  • 1-866-368-7848
	• Ontario
	  • 1-877-513-5333 (English, French, Interpreter service)
	  • Fax Referral form
	• PEI
	  • 1-877-513-5333 (English, French)
	  • Fax Referral form
	• Quebec
	  • 1-866-527-7383 (French, English)
	• Saskatchewan
	  • 1-877-513-5333 (English, French)
	  • Fax Referral form
	• Yukon
	  • 1-877-513-5333

Smoking Diary	• A tool for tracking ongoing smoking when patients/clients are attempting to reduce or quit smoking. The tool is intended to enhance patients' awareness of their smoking behaviour.
Stages of Change diagram	• Diagram illustrating Prochaska and DiClemente's Stages of Change Model
TEACH (Training Enhancement in Applied Cessation Counselling and Health) Program	• TEACH is geared toward training health care professionals providing counselling services to tobacco users. The program is designed to enhance knowledge and skills in the delivery of intensive tobacco cessation interventions, including detection and treatment of people with concurrent tobacco dependence and mental health and/or addictive disorders and motivational interviewing. • Training program for health care professionals on tobacco cessation interventions
TRaC (Tobacco Reduction & Cessation) training	• Training to help build capacity of health professionals in providing smoking cessation treatment

Research Gaps

Contribute a Research Gap

- When should the topic of smoking be raised if a patient/client is dealing with multiple stressors? When is the optimal time to advise someone to quit and how does a professional recognize this "optimal time"?
- Social network research and how this can be used in practice
- Research on the social impact of smoking withdrawal (what has been successful in assisting people to maintain their social network?)
- Effectiveness/efficacy of interventions and referrals to programs
- Effectiveness of alternative treatments (i.e. hypnosis, laser therapy)
- The frequency and timing of health professional interventions when it comes to the effectiveness of brief provider interventions, by more than one type of health care provider.

Overview of CAN-ADAPTT's Practice-Informed Guideline

The full text guideline is available online at www.can-adaptt.net. The Guideline includes the following sections:

- Counselling and Psychosocial Approaches
- Pharmacotherapy *(in development)*
- Aboriginal Peoples
- Hospital-Based Populations
- Mental Health and/or Other Addictions
- Pregnancy and Breastfeeding Women
- Youth (Children and Adolescents)

We invite you to comment on the applicability and usability of this section, suggest additional tools and resources, and help to identify any gaps in knowledge.

Table 1. Grade of Recommendation & Level of Evidence Summary Table**

GR/LOE*	Clarity of risk/benefit	Quality of supporting evidence	Implications
1A. Strong recommendation. High quality evidence.	Benefits clearly outweigh risk and burdens, or vice versa	Consistent evidence from well performed randomized, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk.	Strong recommendations, can apply to most patients in most circumstances without reservation. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
1B. Strong recommendation. Moderate quality evidence.	Benefits clearly outweigh risk and burdens, or vice versa	Evidence from randomized, controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on our confidence in the estimate of benefit and risk and may change the estimate.	Strong recommendation and applies to most patients. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
1C. Strong recommendation. Low quality evidence.	Benefits appear to outweigh risk and burdens, or vice versa	Evidence from observational studies, unsystematic clinical experience, or from randomized, controlled trials with serious flaws. Any estimate of effect is uncertain.	Strong recommendation, and applies to most patients. Some of the evidence base supporting the recommendation is, however, of low quality.
2A. Weak recommendation. High quality evidence.	Benefits closely balanced with risks and burdens	Consistent evidence from well performed randomized, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk.	Weak recommendation, best action may differ depending on circumstances or patients or societal values
2B. Weak recommendation. Moderate quality evidence.	Benefits closely balanced with risks and burdens, some uncertainly in the estimates of benefits, risks and burdens	Evidence from randomized, controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on our confidence in the estimate of benefit and risk and may change the estimate.	Weak recommendation, alternative approaches likely to be better for some patients under some circumstances
2C. Weak recommendation. Low quality evidence.	Uncertainty in the estimates of benefits, risks, and burdens; benefits may be closely balanced with risks and burdens	Evidence from observational studies, unsystematic clinical experience, or from randomized, controlled trials with serious flaws. Any estimate of effect is uncertain.	Very weak recommendation; other alternatives may be equally reasonable.

*GR- Grade of Recommendation, LOE – Level of Evidence

**Adapted from: UpToDate. Grading guide. No date. Available from: http://www.uptodate.com/home/about/policies/grade.html; and Guyatt G, Gutterman D, Baumann MH, Addrizzo-Harris D, Hylek EM, Phillips B, Raskob G, Lewis SZ, Schünemann H. Grading strength of recommendations and quality of evidence in clinical guidelines: Report from an American College of Chest Physicians task force. Chest. 2006 Jan;129(1):174-81, originally adapted from the GRADE Working Group.