

**TOBACCO DEPENDENCE TREATMENT
FREQUENTLY ASKED QUESTIONS (FAQ)**

*Prepared by: The Nicotine Dependence Service (NDS) at the
Centre for Addiction and Mental Health (CAMH)*

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TEACH PROJECT, Centre for Addiction and Mental Health (CAMH)

Peter Selby, MBBS, CCFP, FCFP, dip ABAM: Executive Director
Rosa Dragonetti, MSc: Director
Tanya Abate, BA: Community Health and Education Associate
Megan Barker, MA: Continuing Medical Education Coordinator
Leah D'Souza, MSc: Education Specialist
Myra Fahim, MSc, BEd: Project Coordinator
Parizad Hathidaru, BA: Community Health and Education Associate

STOP Program, Centre for Addiction and Mental Health (CAMH)

Laurie Zawertailo, PhD: Clinical Scientist
Erin Cameron, MPH: Research Coordinator

Nicotine Dependence Clinic, Centre for Addiction and Mental Health (CAMH)

Alexandra Andric, RN, BScN, CPMHN(C): Registered Nurse
Stephanie Cohen, MSW, RSW: Social Worker II
Sarwar Hussain, MSc: Manager
Julia Lecce, MA: Assistant Manager

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Charl Els, MBChB, FCPsych[SA], MMEDPsych [cum laude], ABAM, MROCC: Psychiatrist, University of Alberta
Sergeant Michael Harvey: Customs Policy Analyst, RCMP Cornwall detachment
Milan Khara, MBChB, CCFP, cert. ASAM: Addiction Medicine Physician, Vancouver Coastal Health

Former Nicotine Dependence Staff

Marilyn Herie, PhD, RSW: Director
Ashley Hall, MA: Project Coordinator
Lilian Riad-Allen, MSc: Research Coordinator
Andrew Thomas, MPH: Research Coordinator
Janine Fitzpatrick, MCogSc: Research Coordinator
Pamela Kaduri, MD, MMED(psych): Clinical Fellow
Justine Mascarenhas, MSc: Research Coordinator

Fellow and Summer Students

Amit Rotem, MD, Addiction Psychiatry Fellow
Rachel Stewart, BA (hons), TEACH Summer Student
Tahira Mascarenhas: TEACH Summer Student

INTRODUCTION

The TEACH (Training Enhancement in Applied Cessation Counselling and Health) Project is a Knowledge Translation initiative designed to build interprofessional capacity in evidence-based tobacco dependence treatment among healthcare practitioners. Since the beginning of the project in 2006, TEACH has trained over 6,500 participants from over 36 diverse disciplines, from more than 950 organizations and service settings.

The following document is a compendium of the most frequently asked questions from TEACH participants since 2006. These questions have emerged from trainings, webinars, as well our thriving Community of Practice of TEACH-trained healthcare practitioners. Although we respond to each question as we are asked, we have identified a need to provide further information and evidence-based research around these inquiries. This document containing the most frequently asked questions was created to bridge the gap between the responses we share with practitioners and the request to provide further information. We also wanted to provide a platform where we are able to direct similar inquiries towards a set of prepared responses to allow capacity for new questions to be addressed.

Each question asked in this document provides an evidence-based answer from subject matter experts combined with a comprehensive review of the literature. There are a total of 30 questions that are grouped into 7 content areas:

- Screening and Assessment
- Pharmacotherapy
- Specific Populations
- Smokeless Tobacco
- E-Cigarettes
- Smoke-Free Environments
- Available Services & Supports

We encourage the dissemination of this document to anyone who may be interested in expanding their knowledge and skills regarding tobacco dependence treatment. Our aim is to provide healthcare practitioners with a resource that can be used to inform daily clinical practice and can be referred to as a reference tool. Also, we aim to expand the knowledge of practitioners beyond standard treatments and encourage exploration of alternative strategies that can enhance clinical practice.

For more information regarding the TEACH Project and our activities, please email teach@camh.ca.

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E-Cigarettes

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28. Can you provide me with a list of FREE resources for cessation medications?

29. Any suggestions/supports for families of clients who: smoke and don't want to quit; are trying to quit; have quit and the family member continues to smoke?

30. What is the efficacy of “smoking cessation apps”? Some articles suggest that these apps are not following the recommended guidelines for smoking cessation.

NDS FREQUENTLY ASKED QUESTIONS

Screening and Assessment

What are your suggestions in approaching a current smoker to open a conversation regarding their smoking and seeing if they have thought about cessation/reduction?

Firstly, it is important to screen all clients for tobacco use and let them know that this is a standard of clinical practice. If they do smoke or use tobacco, ask permission if you can discuss their tobacco use further. Let them know that effective interventions exist if they are interested in quitting or cutting down. If they are not interested in quitting, ask them permission if you may revisit their tobacco use again at a future appointment. Let them know that you are concerned about their smoking and would like to discuss it with them when they are ready.

Are there finite guidelines to follow when deciding on treatment?

We recommend following the CAN-ADAPTT guidelines to help determine appropriate treatment. You can access the guidelines from the CAN-ADAPTT website by visiting www.canadaptt.net.

Helpful hint: In the guideline under Pharmacotherapy, there is an Algorithm for Tailoring Pharmacotherapy in a Primary Care Setting which can be used in treatment.

Is there a standard assessment form or preferred way to phrase questions when assessing tobacco dependence?

There are several tools available to assess for nicotine dependence and tobacco use. At CAMH, healthcare practitioners administrate two assessment forms to clients upon admission to the tobacco cessation program.

One assessment form, the “*Addiction Severity Index*,” is distributed to all clients entering any addiction program at CAMH. This assessment includes seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychological. Each section is concluded with scaling questions, which ask the client to rate on a 5-point scale how bothered they have been by any of the problems in that section and how important treatment is for that area. The scale is: 0 = not at all, 1 = slightly, 2 = moderately, 3 = considerably, and 4 = extremely. *Scaling questions can be useful to capture the degree of a patient’s subjective experience. Whether a 5-point or 10-point scale is more appropriate will often depend on the nature of the question. For example, the next assessment uses both 5- and 10-point scaling questions. Questions pertaining to how strongly a client has been feeling a particular emotion use 5-point scales while 10-point scales are often used when evaluating client readiness or the importance of quitting to the client.* Patients are warned that unanswered questions are preferred over inaccurate answers. The assessment form instructs the interviewer to make plenty of comments so that another person reading the assessment will be given a complete picture of the client’s perceptions of his/her problems.

The other assessment form, the “*Self-Assessment: Nicotine Dependence Clinic*,” is used exclusively with clients of the Nicotine Dependence Clinic. This assessment uses check-boxes, fill-in-the-blank, and scaling questions (both 5- and 10-point scales are used within the assessment form). This assessment form covers the following areas of interest: Tobacco use (type and amount of tobacco); Smoking Cessation History (quitting attempts, experience and

length of quit attempt, method used, reasons for relapse, goals for tobacco use, and stage of change); Readiness (importance of quitting, confidence to change, readiness to change, life stressors, supports, triggers, psychiatric history, substance use, caffeine use, and medical history). The assessment also includes the *Fagerstrom Test for Nicotine Dependence* and the *Minnesota Withdrawal Score*.

To access the *Fagerstrom Test for Nicotine Dependence*, the *Minnesota Withdrawal Score*, and many other tobacco cessation assessment tools, please download a copy of the “*Counsellor’s Guide to Cessation Treatment*” from the Nicotine Dependence Clinic website:

<https://www.nicotinedependenceclinic.com/English/teach/resources/SitePages/Tobacco%20Cessation%20and%20Behaviour%20Change.aspx>

How can I motivate my clients to quit “the last few” cigarettes (3-4) from their daily intake?

There are many approaches a healthcare practitioner might employ to address a client’s struggle to quit his or her final cigarettes. Some recommend using motivational interviewing techniques to address the security of these final cigarettes and the feelings of loss many clients associate with quitting. Others suggest that it may be helpful to view cigarettes as a close friend of the client’s, one that the client will lose in committing to complete abstinence from tobacco use. She further proposes trying to discover, with the client, new healthy habits that may serve to substitute smoking and mitigate these feelings of loss. In addition, she recommends using the 2mg nicotine gum to reduce cravings for these final cigarettes.

Another study (Burkett, 2006) documented the utility of the NRT inhaler in clients who have reduced their tobacco use drastically and have almost reached cessation but cannot achieve absolute cessation without assistance. The nicotine inhaler, in contrast to other smoking cessation medications, is self-titratable and allows clients the most control over their smoking cessation therapy. It also satisfies (to a degree) the behavioural aspects of nicotine addiction in addition to the pharmacological aspects, which may better address the full allurements of these final cigarettes.

According to Dr. Selby of CAMH’s Nicotine Dependence Clinic, **Assess** client motivation and explore what is leading the client to smoke these last few cigarettes. For example, the client could be receiving inadequate dosing of NRT or habitual reactions to key triggers, such as people, places or things. Once you elicit the reasons as to why the client is having issues quitting their last few cigarettes, **Assist** the client in his or her quit attempt by offering breakthrough NRT or increasing the dose or positioning of a patch.

Burkett, J.S. (2006). The use of the nicotine inhaler in smoking cessation. *Journal of the American Academy of Nurse Practitioners*, 18(3), 83-91.

Pharmacotherapy

Nicotine Replacement Therapy (NRT)

Where can I find a demonstration on how to use NRT?

The TEACH Project provides instructional videos on how to use nicotine replacement therapy (NRT). To view these videos, visit www.youtube.com/TEACHProject.

Are Nicotine Replacement Therapies addictive?

The quicker a drug reaches the brain, the sharper the dopamine spike and the greater the addiction. The addictive potential of a drug is affected by the way the drug is used to reach peak concentration. For example, crack cocaine when smoked reaches the brain at a much faster rate than cocaine that is snorted, so the addictive potential of crack cocaine is higher.

Due to the fact that therapeutic nicotine is administered in a controlled manner via the skin or the buccal mucosa of the mouth which is a slower mechanism for nicotine to reach your brain when compared with smoking, the addictive potential of NRT is very low.

Le Houezec, J. (2003). Role of nicotine pharmacokinetics in nicotine addiction and nicotine replacement therapy: A review. *International Journal of Tuberculosis and Lung Disease*, 7, 811-819.

Where can I find information or examples of an organization's algorithm for dispensing NRT and the accompanying policy, including the process for off-label administration of NRT?

The CAMH algorithm for dispensing NRT follows the “5 As” intervention approach: Ask, Advise, Assess, Assist, and Arrange. The algorithm illustrates the intervention process in a step-by-step flow chart and outlines the various treatment options available (as well as when to use them).

The CAMH policies governing the provision of NRT are outlined in the following CAMH medical directives:

- 1) CAMH Medical Directive – Delegation of Dispensing to RNs (June 2012):
http://insite.camh.net/files/Delegation_of_Dispensing_53014.pdf
- 2) CAMH Medical Directive – Initiation of NRT by RNs and Pharmacists for CAMH Inpatients (May 2011):
http://insite.camh.net/files/Medical_Directive_NRT_Inpatients_June_3_2014_53009.pdf
- 3) CAMH Medical Directive – Initiation of NRT by Outpatient Clinicians and Pharmacists for CAMH Outpatients (June 2014):
http://insite.camh.net/files/Medical_Directive_NRT_Outpatients_June_3_2014_79511.pdf

The 2008 OMA Position Paper “*Rethinking Stop-Smoking Medications: Treatment Myths and Medical Realities*” discusses the current thinking on off-label use of pharmacotherapy and dispels the myth that these medications must be used in strict accordance with manufacturer guidelines:

<https://www.oma.org/Resources/Documents/e2008RethinkingStop-SmokingMedications.pdf>

Bader, McDonald, and Selby (2009) also developed an empirically-based algorithm and guide for dispensing NRT and other tobacco cessation pharmacotherapies based on recommendations provided by the Delphi panel of international experts. The algorithm highlights the most reliable and current research available and reflects the strong empirical support at present for “off-label” upward titration of NRT or combination therapy, in special circumstances, as part of an individualized and responsibly monitored treatment plan.

<https://www.nicotinedependenceclinic.com/English/teach/resources/Visual%20Aids/Toba>

[cco%20Algorithm%20updated%20Nov%202013.pdf](#)

Bader, P., McDonald, P., Selby, P. (2009). An algorithm for tailoring pharmacotherapy for smoking cessation: results from a Delphi panel of international experts. *Tobacco Control*, 18, 34-42.

Is it safe to use the ‘rule of thumb’: ~1mg NRT for each cigarette/day smoked?

According to Williams and Jones (2012), the nicotine exposure from cigarette smoking is approximately 1 mg/cigarette. Therefore, while it is generally safe to replace ~1mg NRT for each cigarette/day smoked, client characteristics may render standard dosing inappropriate, for example, NRT dosing with pregnant or post-partum women (Coleman et al., 2011). Factors such as the NRT product used, type of smoker, health and age, and the cessation goals of the client may also impact the dose of NRT required (Seed, DeBellis, & Sullivan, 2007). Thus, it is important for healthcare practitioners to avoid resting on “one size fits all” formulas and ensure to personalize therapies according to individual client needs.

Coleman, T., Chamberlain, C., Cooper, S., & Leonardi-Bee, J. (2011). Efficacy and safety of nicotine replacement therapy for smoking cessation in pregnancy: Systematic review and meta-analysis. *Addiction*, 106, 52-61.

Seed, S.M., DeBellis, R.J., & Sullivan, K.M. (2007). State of the art reviews: Smoking cessation: A review of treatment considerations. *American Journal of Lifestyle Medicine*, 1(3), 201-213.

Williams, J.H. & Jones, T.E. (2012). Smoking cessation post-discharge following nicotine replacement therapy use during an inpatient admission. *Internal Medicine Journal*, 42(2), 154-159.

As a facility attempting to initiate a medical directive for NRT, are there any medical directives already in place at another institute that could be used as a reference?

The following link will provide you with the CAMH Medical Directives:

http://insite.camh.net/Policies_and_Forms/Medical_Directives_and_Delegations/medical_directives_delegations52074.html

For tips on how to structure, write, and revise a medical directive, please refer to the Medical Directive and Delegation Toolkit available on the CAMH website:

http://insite.camh.net/Policies_and_Forms/Medical_Directives_and_Delegations/Medical_Directive_and_Delegation_Toolkit/medical_directive_delegation_toolkit52073.html

What is the “maximum dosage” recommended in the use of nicotine patch?

At the Nicotine Dependence Clinic and CAMH, we have used as high as 84mg of nicotine replacement therapy. If your client reaches a high dose of nicotine replacements therapy, and are still smoking, they may be better suited to use varenicline or bupropion. Combination therapy (i.e. NRT + prescription medication) may also be an option with this population. Please refer to the “Algorithm for Tailoring Pharmacotherapy in Primary Care Settings” below.

<https://www.nicotinedependenceclinic.com/English/teach/resources/Visual%20Aids/Tobacco%20Algorithm%20updated%20Nov%202013.pdf>

Is it dangerous for clients to continue using the NRT gum for years?

The US Lung Health Study, the most extensive study to date on long-term NRT use, found that people who used NRT gum for an extended period of time did not experience an increased risk

of developing health problems, including cardiovascular issues (Murray et al., 1996). In addition, findings showed that even concomitant smoking and NRT use for an extended period of time (i.e. 5 years) was not associated with increases in adverse health events.

Murray, R.P., Bailey, W.C., Daniels, K., Bjornson, W.M., Kurnow, K., Connet, J.E., Nides, M.A., & Kiley, J.P. (1996). Safety of nicotine polacrilex gum used by 3,094 participants in the Lung Health Study. *Chest*, 109, 438-445.

Prescription Medications

Our psychiatrists are fearful of prescribing varenicline to their patients (even those who are in a stable psychiatric status). If accompanied with counselling, is varenicline a safe medication to use in patients with stable psychiatric status? Are there any studies that I can refer to support this?

The observation that quitting smoking can have a destabilizing effect on patients is well-documented within the literature (Fagerstrom and Aubin, 2009; Broocks et al., 2002; Zullino et al., 2002; Desai et al., 2001). Despite this, Dr. Peter Selby, Head of the Nicotine Dependence Clinic at CAMH, finds that clients with psychiatric diagnoses often report feeling much better when they quit smoking because their neuroleptics and antipsychotics work better in the absence of tobacco use. In fact, Dr. Peter Selby reports that clients sometimes require dose reductions because the medication begins to cause fatigue. All of the front-line smoking cessation medications (NRT, varenicline, and bupropion) have been found to be safe for use with the psychiatric population in both clinical practice and empirical research (Banham & Gilbody, 2010; McClure et al., 2010; P. Selby, personal communication, August 8, 2012; Purvis, Nelson, & Mambourg, 2010; Schroeder & Morris, 2010).

One issue that may arise when transitioning from cigarettes to NRT is a pharmacological issue; in which case problems may be more attributable to poorly treated withdrawal, inadequate dosing, or lack of counseling, than destabilizing medications.

- Banham, L. & Gilbody, S. (2010). Smoking cessation in severe mental illness: What works? *Addiction*, 105(7), 1176-1189.
- Broocks, A., Bandelow, B., Koch, K., et al. (2002). Smoking modulates neuroendocrine responses to ipsapirone in patients with panic disorder. *Neuropsychopharmacology*, 27, 270-278.
- Desai, H.D., Seabolt, J., & Jann M.W. (2001). Smoking in patients receiving psychotropic medications: A pharmacokinetic perspective. *CNS Drugs*, 15, 469-494.
- Fagerstorm, K. & Aubin, H.J. (2009). Management of smoking cessation in patients with psychiatric disorders. *Current Medical Research and Opinion*, 25, 511-518.
- McClure, J.B., Swan, G.E., Catz, S.L., Jack, L., Javitz, H., McAfee, T., Deprey, M., Richards, J., & Zbikowski, S.M. (2010). Smoking outcome by psychiatric history after behavioural and varenicline treatment. *Journal of Substance Abuse Treatment*, 38, 394-402.
- Purvis, T.L., Nelson, L.A., & Mambourg, S.E. (2010). Varenicline use in patients with mental illness: an update of the evidence. *Expert Opinion on Drug Safety*, 9(3), 471-482.
- Schroeder, S.A. & Morris, C.D. (2010). Confronting a neglected epidemic: Tobacco cessation for persons with mental illnesses and substance abuse problems. *Annual Review of Public Health*, 31, 297-314.
- Zullino, D.F., Delessert, D., Eap, C.B., et al. (2002). Tobacco and cannabis smoking cessation can lead to intoxication with clozapine or olanzapine. *International Clinical Psychopharmacology*, 17, 141-143.

Drug Interactions/Combinations

Is it a problem for patients to use the mouth spray in combination with the patch or gum?

Combination NRT therapy has not been associated with any known risks therefore it should not be a problem for patients to use the mouth spray in combination with other forms of NRT (Ebbert, Hays, & Hurt, 2010). As a responsible clinician, however, it is important to establish a valid rationale which justifies the use of combination therapy over monotherapy. For example,

some clients wish to use several NRT products because they assume “more is better.” In this case, the clinician may opt against prescribing combination nicotine replacement therapy and take the opportunity to educate clients that monotherapy is often sufficient enough to alleviate nicotine withdrawal and help the client to achieve abstinence.

The patch is often the first-line of defense in terms of NRT products because it is the least reinforcing and provides a constant level of nicotine to both the blood and the brain so that nicotinic and dopaminergic receptors are desensitized (Hajek, McRobbie, & Gillison, 2007; P. Selby, personal communication, August 8, 2012). This, in turn, reduces cravings and minimizes the degree to which reward pathways are activated in the event of a lapse. Fast-acting NRT products, also called breakthrough NRT (i.e. gum, spray), are reserved for high craving situations (Bader, McDonald, & Selby, 2009).

A reasonable rationale that would support the use of multiple forms of NRT would be a client who wants to tailor their treatment method according to the setting (for example, a client may prefer the discreteness of the gum while at work but prefer the inhaler in the privacy of the home). The primary guideline, according to Dr. Peter Selby (Head of the Nicotine Dependence Clinic at CAMH), is *titrate to effect* while monitoring for nicotine toxicity and the development of dependence or abuse. It is also important that clinicians engage clients in a discussion about the risks associated with each NRT product, such as the greater potential for dependence when using immediate release products, such as the mouth spray (Hajek, McRobbie, & Gillison, 2007).

Bader, P., McDonald, P., Selby, P. (2009). An algorithm for tailoring pharmacotherapy for smoking cessation: results from a Delphi panel of international experts. *Tobacco Control, 18*, 34-42.
Ebbert, J.O., Hays, Hays, J.T., & Hurt, R.D. (2010). Combination pharmacotherapy for stopping smoking: What advantages does it offer? *Drugs, 70*(6), 643.
Hajek, P., McRobbie, H., Gillison, F. (2007). Dependence potential of nicotine replacement treatments: Effects of product type, patient characteristics, and cost to use. *Preventative Medicine, 44*, 230-234.

What are the rules of combining bupropion and varenicline?

Currently, there is a lack of evidence examining the safety of combining of bupropion and varenicline. A clinic trial pilot by Ebbert et al (2009) found that combining these two medications appears to be safe. It is recommended to start one medication first, and then add the second one to monitor for side effects. If you begin both medications simultaneously it will be difficult to determine which medication is causing the side effects.

Ebbert, J.O., Croghan, I.T., Sood, A., Schroeder, D.R., Hays, J.T., & Hurt, R.D. (2009). Varenicline and bupropion sustained-release combination therapy for smoking cessation. *Nicotine & Tobacco Research, 11*(3), 234-9.

What considerations should be made when considering the combined use of multiple smoking cessation medications?

It is important to consider that monotherapy is the cheapest smoking cessation method. Most medications should produce a partial response within approximately four weeks. Although recent findings suggest varenicline may take slightly longer in certain individuals (Kaur et al., 2009), the clinician should be able to gauge whether a medication is going to work based on this partial response following four weeks of treatment.

If a partial response is not achieved, Dr. Peter Selby suggests there are several possible explanations that the clinician should explore before prescribing additional medications

(personal communication, August 8, 2012). First, the clinician may determine whether the client is taking the medication as prescribed (i.e. correct dose and correct usage). The clinician may also want to explore whether there is an emerging depression or depressive disorder that may have always been present but became more apparent upon cessation and may now be driving the client's need to smoke. The clinician may also consider whether the prescribed dose is adequate for this particular client. Finally, the client's environment and interpersonal relationship may need to be discussed to identify possible triggers and to develop strategies to manage or avoid these triggers.

If there are a number of behavioural factors that may be undermining the quit effort, combination therapy is not advised. Although no official guideline exists for combination therapy, unofficial guidelines advise clinicians to explore the possibility of combination therapy only when the client appears to be experiencing withdrawal symptoms despite following the instructions provided by the clinician (Bader, McDonald, & Selby, 2009).

There are many approaches to increase the efficacy of smoking cessation medication if the clinician and client agree more pharmacological aid is required. If the client is using the patch, the clinician may choose to increase the dosage of the nicotine patch or recommend a breakthrough NRT product, such as the nicotine gum, lozenge, or inhaler (Bader, McDonald, & Selby, 2009). The clinician may consider prescribing bupropion in addition to the nicotine patch, or vice versa, especially if there is also a complaint of depression or low mood (Ebbert, Hays, & Hurt, 2010; Hudmon, Corelli, & Prokhorov, 2010). Combination therapy involving varenicline is more controversial and more complex, according to Dr. Selby. Given that 1mg dose of varenicline occupies approximately 95% of nicotinic receptors, it is debatable whether the drive to smoke is an issue of pharmacology or learned behaviour. Clinicians can begin to discriminate the cause of relapse by asking clients to describe a situation in which they might decide to smoke as well as their experience of the smoking itself. If the client seems to smoke when triggered and reports the experience of smoking as less satisfying than usual, the issue is more likely behavioural than pharmacological. Preliminary studies combining varenicline with NRT and varenicline with bupropion have produced encouraging results (Ebbert, Burke, Hays, & Hurt, 2009; Ebbert, Hays, & Hurt, 2010). However, these combinations have yet to receive the empirical testing necessary to confirm either the safety or efficacy of this practice. Nevertheless, these findings demonstrate the potential benefit of prescribing varenicline to clients already receiving bupropion for the treatment of depression.

- Bader, P., McDonald, P., Selby, P. (2009). An algorithm for tailoring pharmacotherapy for smoking cessation: results from a Delphi panel of international experts. *Tobacco Control, 18*, 34-42.
- Ebbert, J.O., Burke, M.V., Hays, J.T., & Hurt, R.D. (2009). Combination treatment with varenicline and nicotine replacement therapy. *Nicotine and Tobacco Research, 11*(5), 572-576.
- Ebbert, J.O., Hays, Hays, J.T., & Hurt, R.D. (2010). Combination pharmacotherapy for stopping smoking: What advantages does it offer? *Drugs, 70*(6), 643.
- Hudmon, K.S., Corelli, R.L., & Prokhorov, A.V. (2010). Current approaches to pharmacotherapy for smoking cessation. *Therapeutic Advances, in Respiratory Disease, 4*(1), 35-47.
- Kaur, K., Kaushal, S., & Chopra, S.C. (2009). Varenicline for smoking cessation: A review of the literature. *Current Therapeutic Research, 70*, 35-54.

Specific Populations

Can you recommend examples of innovative and/or evidence-based programs that are designed for or target "specific populations"?

A list of programs designed to target special populations can be found below:

Aboriginal Tobacco Cessation

- National Collaborating Centre for Aboriginal Health. www.nccah-ccnsa.ca
- Aboriginal Tobacco Wise. www.tobaccowise.com
- IT'S TIME Toolkit. www.teachproject.ca
- Inuit Tobacco-free Network. www.naho.ca/inuittobaccofree
- Sacred Smoke Program, Wabano Centre for Aboriginal Health. www.wabano.com
- Sema Kenjigewin Aboriginal Tobacco Misuse Program, Anishnawbe Mushkiki Aboriginal Community Health Centre. www.mushkiki.com

Women and Pregnant Women

- PREGNETS. www.pregnets.org
- Side by Side toolkit. www.aware.on.ca/side-by-side
- SmokeFreeWomen. <http://women.smokefree.gov>
- Early Years Centre in Ontario:
<http://www.children.gov.on.ca/htdocs/English/topics/earlychildhood/oeyc/locations/index.aspx>
- Motherisk: Call 1-877-439-2744 or visit online at <http://www.motherisk.org>

LGBTTTIQQ

- BENT ON QUITTING
- The Gay American Smoke Out

Youth and Young Adult

- Leave the Pack Behind. www.leavethepackbehind.org
- Lungs for Life. www.lungsforlife.ca
- Break it Off: <http://breakitoff.ca/>
- Project Stupid. www.stupid.ca

Psychiatric and Substance Use Disorders

- Nicotine Dependence Service (NDS), CAMH. www.nicotinedependenceclinic.com
- Mental Health-Addiction Services Public Health Program (MAPP).
- Break Free Mental Health and Addiction Tobacco Treatment Program.

General

- CAN-ADAPPT. www.canadaptt.net
- CAMH's Knowledge Exchange Portal. <http://knowledgex.camh.net>
- Smoker's Helpline. www.smokershelpline.ca

Can I offer NRT to pregnant women and adolescents? If so, what resources can I refer to for further information (i.e. dosing)?

Generally speaking, when working with pregnant or adolescent clients, healthcare practitioners should always opt for *nonpharmacological smoking cessation therapies*, such as behavioural counseling, before considering the use of NRT or any other smoking cessation medication (Briggs, 2008; Coleman et al., 2011). These therapies pose the least risk during these critical stages of development and have shown to be effective in helping clients quit smoking (Coleman et al., 2011; Ginzler et al., 2007).

Although healthcare practitioners may offer NRT to pregnant and adolescent clients, the use of

NRT in these populations is *controversial* (Briggs, 2008). In terms of a health practitioner's professional obligations, at CAMH, as long as the client is over 16 years of age, they may opt to use NRT as a smoking cessation aid (CAMH: STOP, personal communication, May 2012). If the client is under 16 years of age, the healthcare practitioner is entitled to use his or her discretion in prescribing NRT.

While NRT use is proven to be both safe and effective for the general population, empirical findings have failed to demonstrate either of these criteria in the context of pregnancy or adolescence (Slotkin, 2008). The CAMH Medical Directive at CAMH cites pregnancy and lactation as a contraindication for NRT use. However, the directive also states that this contraindication is not absolute, due to recent studies which indicate that NRT use is safer than smoking, but advises healthcare practitioners to consult with a primary care clinician or physician on call before administering NRT to these groups.

To access CAMH Medical Directives, please refer to the following link:

http://insite.camh.net/Policies_and_Forms/Medical_Directives_and_Delegations/medical_directives_delegations52074.html

Risks of Nicotine Exposure

On the whole, the intake of “clean nicotine” provided by NRT products is believed to be safer than smoking, which exposes the user to over 3, 000 harmful chemicals in addition to nicotine (Briggs, 2008). However, empirical findings are showing that nicotine specifically may be the chemical responsible for the observed consequences of smoking on development; prenatally, in infancy, and in adolescence (Ginzel et al., 2007; Slotkin, 2008). Therefore, although NRT is generally safer than smoking cigarettes, its use in adolescents and pregnant women is likely to cause some of the same permanent and deleterious disruptions to development as smoking (Briggs, 2008; Slotkin, 2008).

Prenatal Exposure

It should be noted that the concentration of nicotine in the fetal brain is 15% higher than that in the maternal blood (Ginzel et al., 2007). The developmental damage caused by prenatal exposure to smoking has both immediate and delayed consequences (Briggs, 2008; Ginzel et al., 2007; Slotkin, 2008). The immediate consequences include, “spontaneous abortions, intrauterine growth retardation and perinatal deaths, and Sudden Infant Death Syndrome” while the delayed consequences include, “subsequent learning disabilities, cognitive dysfunction, behavioral problems, attention deficit hyperactivity disorder, psychiatric disorders [(such as adolescent depression)], conduct disorders, criminal behaviors, and school and career failure.” (Slotkin, 2008, p. 1).

Adolescent Exposure

Empirical studies using both humans and animals have demonstrated that adolescents are more vulnerable to developing nicotine dependence than adults (Ginzel et al., 2007; Slotkin, 2008). This is because the brain of an adolescent is still in the process of developing. It has been shown that even a single exposure to nicotine has the potential to create permanent neuronal changes in the adolescent brain, particularly in the areas involved in learning and memory, and these changes increase the risk of addiction even if followed by a long period of nonsmoking (Ginzel et al., 2007). Early exposure also prompts vulnerabilities to later stress and depression. Finally, findings indicate that nicotine has a greater impact on the developing brain the earlier the exposure occurs. The concern is that the widespread availability of NRT may attract curious youth into experimenting with nicotine, at which point they may quickly lose autonomy over their nicotine consumption which may lead to illicit drug use. However, given that

most daily smokers begin smoking before the age of 18, the nicotine patch and gum are safer than smoking even for those under 18 years old (OMA, 2008). According to CAN-ADAPTT (2011), while there is little empirical evidence to support the effectiveness of NRT in young smokers, NRT has been shown to be safe (i.e. NRT does not pose additional problems when compared to smoking and remains a far safer alternative to tobacco use).

Treatment Guidelines

As discussed, healthcare practitioners generally advise that behavioural counseling serves as the primary intervention strategy to combat nicotine addiction (CAMH, 2010). However, if counseling proves ineffective, pharmacotherapy is generally viewed as a safer alternative to smoking (CAMH, 2010; OMA, 2008). Within the literature, Bupropion has been cited as the first line of pharmacological defense during pregnancy and adolescence, followed by varenicline with the use of NRT as the final resort (Briggs, 2008).

The literature discourages NRT use in the first trimester of pregnancy, as findings indicate the fetus is most vulnerable to congenital malformations during this time (CAMH, 2010; Ginzel et al., 2007). Pregnant women are also advised to discontinue use after two or three months (Smoking: Chemist & Druggist, 2006). *In terms of dosing, the Centre for Addiction and Mental Health (2010; 2011) recommends the lowest effective dose of nicotine, which should be used in combination with continued behavioural interventions and initiated only after behavioural interventions alone have proven ineffective.* Patches should be avoided in favor of more intermittent forms of NRT (i.e. gum or lozenge) or removed at night if intermittent forms of NRT are not an option (CAN-ADAPTT, 2011; CAMH 2010; 2011; Slotkin, 2008). Although breast milk contains very little nicotine, breast-feeding women would also benefit from intermittent forms of NRT in order to allow spacing between nicotine exposure and breast-feeding (CAMH, 2010). Nicotine is metabolized more quickly during pregnancy (Coleman et al., 2011), therefore, healthcare practitioners should anticipate that standard doses may prove ineffective for their pregnant clients and may require adjustment on an individual basis under careful supervision. As discussed, the recommendation of NRT to adolescents under 16 years old falls under the discretion of the healthcare practitioner. Before recommending NRT to adolescents, the healthcare practitioner should determine: 1) the presence of a nicotine addiction and 2) the desire to quit tobacco use. These precautions are especially important when treating this population due to the risk of NRT abuse (Ginzel et al., 2007). *Adolescent use of NRT should not exceed 12 weeks, as to avoid exacerbating dependency in this especially vulnerable population (Smoking, Chemist & Druggist, 2006).*

Given the inherent vulnerabilities of these populations, pregnant and adolescent clients undergoing smoking cessation therapy should be carefully monitored.

For more information, the 2008 OMA Position Paper "*Rethinking Stop-Smoking Medications: Treatment Myths and Medical Realities*" provides an insightful discussion on smoking cessation practice with vulnerable populations with emphasis on dispelling the myths associated with pharmacotherapy use in these populations (including pregnant women and adolescents; Myths 7 and 8 respectively):

<https://www.oma.org/Resources/Documents/e2008RethinkingStop-SmokingMedications.pdf>

Briggs, G.G. (2008). Cigarette smoking cessation. *Family Practice News*, 38(23), 28-28.

CAN-ADAPPT. (January, 2011). Canadian practiced-informed smoking cessation guideline: Summary statements. Toronto, Canada: Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment, Centre for Addiction and Mental Health.

Centre for Addiction and Mental Health. (2011). Day 3: Harm Reduction Approaches. [PowerPoint slides]. A comprehensive course on smoking cessation: Essential skills and strategies; Participant manual. Toronto,

TEACH Project /CAMH.

Centre for Addiction and Mental Health. (2010). Day 2: Smoking Reduction Strategies & Pharmacological Treatment. [PowerPoint slides]. Helping pregnant women quit smoking: A women-centred approach; Participant manual. Toronto, TEACH Project/CAMH.

Coleman, T., Chamberlain, C., Cooper, S., & Leonardi-Bee, J. (2011). Efficacy and safety of nicotine replacement therapy for smoking cessation in pregnancy: Systematic review and meta-analysis. *Addiction*, 106, 52-61.

Ginzel, K., Maritz, D., Neuberger, M., Pauly, J., Polito, J., Schulte-Hermann, R., & Slotkin, T. (2007). Critical review: Nicotine for the fetus, the infant, and the adolescent? *Journal of Health Psychology*, 12(2), 215-224.

Ontario Medical Association. (2008). Rethinking stop-smoking medications: Treatment myths and medical realities. Retrieved from

<https://www.oma.org/Resources/Documents/e2008RethinkingStop-SmokingMedications.pdf>.

Slotkin, T.A. (2008). If nicotine is a developmental neurotoxicant in animal studies, dare we recommend nicotine replacement therapy in pregnant women and adolescents? *Neurotoxicology and Teratology*, 30(1), 1-19.

Smoking: How to use NRT in new patient groups. (2006). *Chemist & Druggist*, 33-33.

Regarding pregnant women and smoking, how do you maintain a woman centered approach when pregnant (rather than focusing on fetal issues)?

In order to maintain a women centered approach, tobacco cessation should be tailored specifically for women and should take into account psychosocial, biological, and physiological factors that influence an individual's preference and success. It should also build on confidence and increase motivation by outlining cessation goals, reducing stigma, and identifying social support (British Columbia's Centre of Excellence for Women's Health, 2012; Fang et al., 2004). It should also be holistic and comprehensive by acknowledging other issues that may affect tobacco use such as: mental health recovery, trauma, and substance use. For women centered tobacco intervention guides, please see British Columbia's Centre of Excellence for Women's Health or Expecting to Quit (see links below).

British Columbia Centre of Excellence for Women's Health. (n.d.). *Liberation Helping Women Quit Smoking*.

Retrieved August 23, 2014. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2012/05/2012_Liberation-HelpingWomenQuitSmoking.pdf

Fang, W. L., Goldstein, A. O., Butzen, A. Y., Hartsock, S. A., Hartmann, K. E., Helton, M., & Lohr, J. A. (2004).

Smoking cessation in pregnancy: a review of postpartum relapse prevention strategies. *The Journal of the American Board of Family Practice*, 17(4), 264-275.

Summary of Better and Promising Practices. (n.d.). *A Summary Of Best Practices For Quitting Smoking While Pregnant*. Retrieved July 25, 2014, from <http://www.expectingtoquit.ca/about/summary.htm>

What technique is most effective in helping clients with schizophrenia in quitting smoking? What barriers are seen in research with this population and possible solutions? Any studies in motivational interviewing in this population? Any tactics in dealing with no-shows?

When working with clients living with schizophrenia, you can adapt the behavioural interventions for this population. There may be a need to provide more frequent sessions and to break down complex topics so they are easier to understand. Martino et al. (2002) published a detailed strategy on how to adapt MI skills for those with severe mental illness. This is a highly recommended article. You may also want to set smaller more achievable goals to help increase confidence. You might expect the following barriers/obstacles:

- No shows
- Compliance with treatment
- Slower progress
- Environmental triggers that might hinder their ability to quit (living in group homes where many smoke)
- Having to cope with changes in their psychiatric symptoms based on any medication interactions

Martino, S., Carroll, K., Kostas, D., Perkins, J., & Rounsaville, B. (2002). Dual diagnosis motivational interviewing: a modification of motivational interviewing for substance-abusing patients with psychotic disorders. *Journal of substance abuse treatment*, 23(4), 297-308.

Smokeless Tobacco

Is it appropriate to apply our knowledge about addiction, withdrawal and cessation interventions involving cigarettes to clients who are addicted to smokeless tobacco products?

Until recently, it was expected that the management of smokeless tobacco addiction could be translated directly from the intervention strategies found to be effective in cigarette smokers (Ebbert & Fagerstrom, 2012). However, the growing body of empirical literature on smokeless tobacco users has demonstrated distinct and clinically relevant differences between smokeless tobacco users and cigarette smokers. *Quickly becoming evident is the need to recognize smokeless tobacco users as a different population of tobacco users from cigarette smokers, requiring a slightly different clinical approach.*

Behavioural Therapy

Much of the empirical literature recommends the use of the same behavioural approaches utilized for smokers to treat smokeless tobacco users (Ketterman, Scott, & Smith, 2005). The controversy within the scientific community exists around the efficacy of smoking cessation pharmacotherapy when used to treat smokeless tobacco addiction (Arabi, 2007; Ebbert & Fagerstrom, 2012; Ketterman, Scott, & Smith, 2005).

Education and counseling should be the basis of any comprehensive tobacco cessation intervention, as they serve to build clients' motivation to quit (Arabi, 2007). Education may be even more powerful when working with smokeless tobacco users due to the relative lack of awareness surrounding the health risks associated with smokeless tobacco products compared to cigarettes (Arabi, 2007; Borland et al., 2011). For example, empirical research has found that there is a widespread perception that smokeless tobacco use is a safer alternative to smoking cigarettes (Borland et al., 2011). This is especially apparent among women and people of low socioeconomic status. However, the use of smokeless tobacco, like cigarettes, often leads to nicotine dependence and causes similar withdrawal symptoms upon cessation (Ketterman, Scott, & Smith, 2005). Smokeless tobacco use is associated with serious health consequences, such as periodontal disease, leukoplakia, cancer, and possibly cardiovascular disease. Given the emerging evidence that smokeless tobacco may serve as a "gateway" drug to smoking, it is especially important not to minimize the health consequences of smokeless tobacco (Arabi, 2007). Healthcare practitioners who provide their clients with physical exams may benefit clients by discussing oral health, taking advantage of this opportunity to provide information about the oral consequences of smokeless tobacco use. The five "A"s, a counseling approach widely used to treat cigarette smokers, is also recommended as a highly effective intervention strategy for smokeless tobacco users. This strategy prompts the healthcare practitioner to **A**sk about tobacco status each visit, **A**dvice to quit, **A**ssess willingness to attempt quitting, **A**ssess method of quitting, and **A**rrange follow-up.

Pharmacotherapy

While the behavioural approaches used to treat cigarette smokers have been established as effective intervention strategies, in the context of smokeless tobacco cessation, the utility of smoking cessation pharmacotherapy with smokeless tobacco users is more controversial. Empirical findings on the efficacy of these pharmacological agents when applied to smokeless

tobacco users have been inconclusive (Arabi, 2007; Ebbert & Fagerstrom, 2012; Ketterman, Scott, & Smith, 2005). Overall, *NRT* seems to reduce withdrawal symptoms and improve short-term abstinence rates, but most clinical trials are unable to show that *NRT* use is associated with any improvement in long-term abstinence rates (Arabi, 2007; Ebbert et al., 2007; Ebbert & Fagerstrom, 2012; Ketterman, Scott, & Smith, 2005). *Bupropion*, on the other hand, seems to attenuate weight gain and reduce tobacco cravings, but also fails to impact abstinence rates in smokeless tobacco users (Arabi, 2007; Ebbert & Fagerstrom, 2012). *Varenicline* has achieved far greater success with this population and has been empirically shown to improve long-term abstinence rates in smokeless tobacco users (Ebbert & Fagerstrom, 2012).

Arabi, Z. (2007). An epidemic that deserves more attention: Epidemiology, prevention, and treatment of smokeless tobacco. *Southern Medical Journal*, 100(9), 890-894.

Borland, R., Cooper, J., McNeill, A., O'Connor, R., & Cummings, M.K. (2011). Trends in beliefs about the harmfulness and use of stop-smoking medications and smokeless tobacco products among cigarette smokers: Findings from the ITC four-country survey. *Harm Reduction Journal*, 8(1), 21-21.

Ebbert, J.O., Dale, L.C., Patten, C.A., Croghan, I.T., Schroeder, D.R., Moyer, T.P., & Hurt, R.D. (2007). Effect of high-dose nicotine patch therapy on tobacco withdrawal symptoms among smokeless tobacco users. *Nicotine & Tobacco Research*, 9(1), 43-52.

Ebbert, J.O. & Fagerstrom, K. (2012). Pharmacological interventions for the treatment of smokeless tobacco use. *CNS drugs*, 26(1), 1-10.

Ketterman, E., Scott, M.A., & Smith, K.D. (2005). What interventions can help patients stop using chewing tobacco? *Journal of Family Practice*, 54(4), 368-368.

Can I use NRT for patients using smokeless/chew tobacco? If so, where can I find information on dosing?

Dr. Herb Severson from the Oregon Research Institute, developed a Spit tobacco algorithm in 2010 which provides dosing recommendations for the *NRT* patch, gum and lozenge. If you are interested in using an *NRT* dosing algorithm with your clients who use smokeless tobacco, you can access the algorithm here:

<https://www.nicotinedependenceclinic.com/English/teach/resources/Visual%20Aids/Spit%20Tobacco%20NRT%20Dosing%20Algorithm.pdf>

E-cigarettes

We recently had a patient “vape” in a treatment unit and nurses and management were unclear on how to proceed. How would you advise we proceed in regards to policy and/or approaching similar “vaping” instances at our hospital?

Each organization will have to think about how to deal with vaping indoors given the increased use of e-cigarettes. Since we do not know the harms around high concentrations of the vapour produced by e-cigarette use, we cannot say it's completely safe. Also, vaping can be a trigger to smokers since the behavior is similar. Vaping can also normalize “smoking” again which is something we want to avoid. Therefore, you might consider banning these products similar to cigarettes.

Toronto Medical Officer of Health. (2014). Toronto Public Health Position Statement on Electronic Cigarettes. <http://www.toronto.ca/legdocs/mmis/2014/h/bgrd/backgroundfile-72510.pdf>

What about electronic (non-nicotine) electron cigarettes and their safety? Effectiveness in smoking cessation? Distribution/law issues in Canada? Chemical composition of propylene glycol?

The main difference between e-cigarettes and cigarettes is that e-cigarettes do not contain tobacco. E-cigarettes with nicotine are not currently legal within Canada. Studies are currently being done to determine efficacy and safety of e-cigarettes. Currently, we cannot say they are safe or effective cessation aids. Below are several studies that address their safety and effectiveness:

- Bullen, C., Howe, C., Laugesen, M., McRobbie, H., Parag, V., Williman, J. & Walker, N. (2013). Electronic cigarettes for smoking cessation: a randomised controlled trial. *The Lancet*, 382(9905), 1629–1637.
- Caponnetto, P., Campagna, D., Cibella, F., Morjarai, J.B., Caruso, M., Russo, C. & Polosa, R. (2013). Efficiency and safety of an eElectronic cigAreTte (ECLAT) as tobacco cigarettes substitute: A prospective 12-month randomized control design study. *PLoS One*, 8(6), e66317.
- Dawkins, L. & Corcoran, O. (2013). Acute electronic cigarette use: Nicotine delivery and subjective effects in regular users. *Psychopharmacology*, 231(2), 401-407.
- Etter, J.F. & Bullen, C. (2011). Electronic cigarette: Users profile, utilization, satisfaction and perceived efficacy. *Addiction*, 106(11), 2017–2028.
- Non-Smoker's Rights Association: <http://www.nsra-adnf.ca/cms/page2292.cfm>
- Toronto Medical Officer of Health. (2014). *Toronto Public Health Position Statement on Electronic Cigarettes*. Retrieved from: <http://www.toronto.ca/legdocs/mmis/2014/hl/bgrd/backgroundfile-72510.pdf>

Smoke-Free Environments

How can a hospital really become smoke-free?

In order for a hospital to become smoke-free it is important to implement a full ban rather than a partial ban. Although staff may have concerns about increased stress and anxiety among patients in a smoke-free hospital, there is no evidence of increased aggression or smoking-related problems (Jochelson & Majrowski, 2006). Furthermore, staff tend to develop a more positive view of the smoke-free policy after it has been implemented for a longer period of time (El-Guebaly, Cathcart, Currie, Brown, & Gloster, 2002; Lawn & Pols, 2005). Research has shown that complete smoking bans are more effective than partial smoking bans as implementing selective bans may increase conflict and verbal aggression due to the focus on negotiating smoking privileges. For this reasons, in 2005, CAMH implemented a smoke-free policy throughout its facility. It was found that there was a high level of support from staff that increased between the announcement of the policy and implementation (Voci et al., 2010). Furthermore, the high level of support was maintained for two years after implementation with no evidence of increased behaviour problems among patients. Currently, CAMH is launching a tobacco-free policy. More information about this policy can be found here:

http://www.camh.ca/en/hospital/visiting_camh/Pages/Tobacco-Free-CAMH.aspx.

- El-Guebaly, N., Cathcart, J., Currie, S., Brown, D., & Gloster, S. (2002). Public health and therapeutic aspects of smoking bans in mental health and addiction settings. *Psychiatric Services*, 53, 1617-1622.
- Jochelson, K., & Majrowski, B. (2006). Clearing the air: Debating smoke-free policies in psychiatric units. King's Fund. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/clearing-the-air-debating-smoke-free-policies-psychiatric-units-karen-jochelson-bill-majrowski-kings-fund-18-july-2006.pdf
- Lawn, S., & Pols, R. (2005). Smoking bans in psychiatric inpatient settings? A review of the research. *Australian and New Zealand Journal of Psychiatry*, 39, 866-885.
- Voci, S., Bondy, S., Zawertailo, L., Walker, L., George, T. P., & Selby, P. (2010). Impact of a smoke-free policy in a large psychiatric hospital on staff attitudes and patient behaviour. *General Hospital Psychiatry*, 32(6), 623-630.

Available Services & Supports

Where can I find a listing of active tobacco cessation service providers in my area?

The TEACH website offers listings of Tobacco Cessation Practice Leaders according to Ontario Tobacco Control Area Network (TCAN) Regions. Please click the following link to proceed to the TEACH website and find a tobacco cessation service provider near you!

<https://www.nicotinedependenceclinic.com/English/teach/Pages/KnowledgeTransfer-Exchange/Practice-Leaders.aspx>

Nunavut is struggling with access to NRT in our isolated communities where there are no pharmacies and most people require NIHB coverage, which requires a prescription. How can we make NRT more accessible in these communities?

Accessibility to smoking cessation treatment is a major problem in many isolated communities across Canada. However, there are many ways in which communities can collaborate to develop creative and innovative ideas to increase access to NRT and other smoking cessation treatment to compete with the generally wide-spread availability of cigarettes in these regions. When the STOP Study was first developed, the program attempted to reach out to Family Health Teams in order to increase the accessibility of NRT in communities that STOP could not reach itself (P. Selby, personal communication, August 8, 2012). However, Family Health Teams were still in their infancy and there were simply not enough of them to meet the large demand for NRT. *Local advocacy became, and remains today, the most effective strategy to increase access to smoking cessation treatment in isolated communities.*

In these isolated communities, local advocacy leaders argued that manufacturers should have smoking cessation products available at every retail outlet where cigarettes are sold. Although NRT products may appear more expensive than cigarettes in the short-term, they are substantially cheaper in the long-term and having these products available alongside cigarettes allows the smoker to exercise choice. As a result of local advocacy efforts, suppliers who were transporting cigarettes to these communities were forced to transport NRT as well. Since NRT products do not require a prescription, it was feasible to argue that NRT products be sold outside of a pharmacy setting in remote locations with little access to this type of venue. STOP responded to the need for smoking cessation treatment in isolated communities using a different strategy. STOP initiated a call-in centre, which provided counselling over the phone to members of these remote communities and also mailed NRT to those who requested it. Canada Post was able to deliver to almost every address in Ontario with a two percent error rate (Zawertailo et al., 2012). STOP found, in comparing different methods to address accessibility issues in these communities, that this strategy was highly cost effective and much more economical than other methods available. An important factor to consider when addressing accessibility issues in these communities may be whether residents have access to phones or other mediums of communication with outside communities.

Zawertailo, L., Dragonetti, R., Bondy, S.J., Victor, J.C., & Selby, P. (2012). Reach and effectiveness of mailed nicotine replacement therapy for smokers: 6-month outcomes in a naturalistic exploratory study. *Tob Control, in press.*

If I wanted to begin a group for smoking cessation, do you have resources (DVDs, PowerPoint) that I could access to provide information to a group of patients?

The TEACH Project provides instructional videos on how to facilitate smoking cessation groups. To view these videos, visit www.youtube.com/TEACHProject.

Counselling resources including “Running a Smoking Cessation Group Guidelines” and “Counsellors’ Guide to Cessation Treatment” are available on the TEACH website at:

<https://www.nicotinedependenceclinic.com/English/teach/resources/SitePages/Tobacco>

Can you provide me with a list of FREE resources for cessation medications?

Free cessation medications are available from the following sources:

- The STOP Program at participating family health teams, community health centres, aboriginal health access centres, nurse practitioner-led clinics, addiction agencies and public health units. Contact stop.study@camh.ca for more information.
- Leave the Pack Behind: <http://www.leavethepackbehind.org/>
- Health units may offer free NRT in a limited capacity
- Some insurance plans may cover cessation medications
- Non-insured Health Benefits for First Nation and Inuit: <http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php>
- Ontario Drug Benefit Program: <http://www.health.gov.on.ca/en/public/programs/drugs/programs/odb/odb.aspx>

Any suggestions/supports for families of clients who: smoke and don't want to quit; are trying to quit; have quit and the family member continues to smoke?

It is important to recognize that quitting smoking is a process and supporting someone through this process can be challenging. Smoker's Helpline provides a useful resource when dealing with family members who smoke. More information can be found at

<http://www.smokershelpline.ca/friends-and-family> or by calling 1-877-513-5333.

Additional resource: Health Canada (2012). Help Someone Quit. Retrieved from <http://healthycanadians.gc.ca/health-sante/tobacco-tabac/help-aide-eng.php>.

What is the efficacy of "smoking cessation apps"? Some articles suggest that these apps are not following the recommended guidelines for smoking cessation.

Given today's reliance on technology, many clients are turning to the internet and apps to aid in their quit journey. Smartphone apps such as "Break it Off" and "Crush the Crave" are recommended apps (from Health Canada / Canadian Cancer Society and Leave the Pack Behind in partnership with Propel) that may help motivate those clients who are technologically savvy and are looking for the latest tools to aid with their cessation. There are many other apps available however we suggest looking to see if they have been evaluated and what the results are. If apps do not follow a theory of behavior change, then they are just an app and may not be effective. However, if the client finds them to be helpful as an aid to quit smoking and they are seeing results, they should continue to use them.

"Break it Off" app - <http://breakitoff.ca/stay-split-up/break-it-off-mobile/>

"Crush the Crave" app - https://www.leavethepackbehind.org/quitting/#story_page_953