

WHITE PAPER

**Exploring Components of Effective Smoking
Cessation System(s) Across Canada**

For Discussion Purposes Only

CAN-ADAPTT

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Preface

This document was prepared to:

- Provide a draft framework that outlines the potential goals, principles, strategies, and tactics for integrated smoking cessation systems in Canada.
- Provide a starting point (only) for participants at the CAN-ADAPTT Annual General Meeting (AGM), including key stakeholders, to discuss and come to an understanding of important components of cessation systems and to better understand some of the existing challenges and barriers, successes and gains made, emerging opportunities and needs for smoking cessation system development that should be addressed in the next version of the CAN-ADAPTT guideline

The feedback that is received on this White Paper, including additional insights about Canada-wide, provincial, territorial, and local preferences and directions through the AGM, stakeholder meetings and network input will be used to write a CAN-ADAPTT “System Guideline for Population-Based Tobacco Use Cessation”.

The “System Guideline”, as part of the CAN-ADAPTT Guideline, would be available for consideration by policy analysts, administrators, decision makers and researchers and inform shared understanding of the various key aspects of comprehensive and effective tobacco use cessation systems across Canada.

It is understood that this represents another step in the continuing process of quality improvement for tobacco use cessation systems in Canada and seeks to advance shared learning (i.e. it seeks to advance our collective efforts in pursuit of increasingly effective cessation systems through a shared approach, to generate and synthesize practice-based empirical evidence).

It is also hoped that the final “System Guideline” will serve as a resource for health providers by facilitating understanding of the tobacco use cessation systems within which they work.

A. INTRODUCTION

When referring to a tobacco use cessation system, what are we talking about? Often, for health care professionals, cessation means a clinical intervention that leads to clients quitting tobacco use. In this document, we are referring to an organized and well integrated system of public health practice that includes an articulation of goals, principles of operation, as well as the execution of various strategies, tactics and action plans. It is not simply an individual outcome or program. Moreover, rather than seeing tobacco use cessation as either the act of stopping tobacco use by clients or an intervention/program delivered by providers, this paper takes a public health perspective.

Furthermore, this paper identifies cessation as an important purpose of comprehensive tobacco control. Nonetheless, there are other important reasons for tobacco use cessation systems.

In the sections that follow, the various goals, principles, strategies, and tactics are identified. Goals represent statements of purpose or aspiration (and here they are not time referenced). Principles represent key concepts that inform the organization and management of the system. Strategies represent the general areas of action required to pursue the goals. Tactics represent areas where investments and other resources are allocated and mobilize for action or implementation. Of course, beyond the identification of which direction to go, how, and by which specific means there is a need for action plans specifying what is to be done (action/outputs), by whom (actors/providers/etc.), in which contexts (settings/locations/venues), for whom (populations/groups/clients), by when (timeframe), etc. The specification of action plans is beyond the scope of this discussion paper.

- ***Tobacco Use Cessation is an important goal within comprehensive tobacco control. Cessation is not simply a program or intervention per se.***
- ***Tobacco Use Cessation Systems (components of comprehensive tobacco control) have important purposes beyond cessation per se – i.e. the ultimate purpose being the reduction of harm caused by the use of tobacco products.***
- ***Tobacco control policies affect motivations and abilities of tobacco users to quit and remain free from tobacco use and therefore are important aspects of tobacco use cessation systems.***

B. SCOPE

Tobacco control is often thought to have three main purposes: preventing tobacco use, encouraging and motivating quitting tobacco use, and protecting the public from exposure to tobacco smoke. Comprehensive tobacco control strategies often exert their influence on each of these three purposes. For example, raising the price of tobacco products through taxation, eliminating smoking in public places, and restricting availability of tobacco may motivate quit attempts by tobacco users and supports their efforts to remain non-users. Furthermore, among scientists and public health professionals, it is now widely understood that policy interventions may have synergistic interactions with programs and mass media communications to reduce tobacco use at a population level.

Systems approaches to tobacco control integrate policy, program and media interventions which when implemented as a coherent approach can be expected to affect the rates of tobacco use by the population or priority populations within it. It is important therefore, as part of our discussion about population level approaches to cessation, to consider how tobacco control efforts affect the context within which tobacco use cessation systems exist.

This document acknowledges the broad scope necessary to adequately identify the context within which health care providers, decision makers, researchers, patients/clients and the public engage in tobacco use cessation systems. It aims to draw from the experience of the collaborative network of stakeholders, the available accepted research evidence, and existing policies and practices (as appropriate, from protection to prevention to treatment¹). This document attempts to identify key goals, principles for, and strategies that may be included in a tobacco use cessation system. The following content has focused on areas where there is some degree of evidence around impact, effectiveness and/or trends in practice. It is offered as a starting point for discussion and dialogue over the coming fall.

¹ Tobacco use cessation among young people: Tobacco use starts early for the vast majority of adult tobacco users. It has been argued that an important purpose of tobacco control is to aid young adults to stop tobacco use as early as possible in their tobacco use careers and to leave young adulthood as non-users. Early interventions for prevention and cessation with young people – adolescents and adults – has therefore been identified as a priority by various reports. Due to the focus of this paper on cessation, this guideline does not address prevention among young people per se. Further, as there is a dearth of evidence attesting to the efficacy and effectiveness of cessation interventions with this group, this issue is not addressed fully here other than to suggest that it be a priority for future research.

C. CURRENT CAPACITY IN CANADA

DISCUSSION POINT(S):

What is the current status of tobacco use cessation systems in Canada?

- What's working well?
- What are the emerging opportunities for system development?
- What are some of the major challenges for cessation system development?
- Is the current system in Canada fragmented or well aligned?

D. KEY GOALS FOR TOBACCO USE CESSATION SYSTEMS IN CANADA

There are different views about the goals for tobacco use cessation systems. As noted above, it might be argued that cessation is appropriately considered a goal. In addition, the reasons for encouraging cessation are ultimate to avoid premature disease, disability, and death caused by tobacco products. For sake of discussion, the following are suggested to be possible goals for tobacco use cessation systems:

- Reduce the health consequences (i.e. harm) of the use of tobacco products
- Motivate attempts to quit tobacco use
- Support tobacco users in their efforts to quit tobacco use

To reduce the health consequences of tobacco use, it could also be argued that the tobacco use cessation system should:

- Facilitate tobacco users stopping use at an earliest age possible
- Address the needs of high priority populations to eliminate or reduce inequities in burden of diseases caused by tobacco products (e.g. Aboriginal populations, certain occupations, those with less formal education etc), including those who may be at elevated risk due to other health conditions (e.g. mentally ill, poly-drug users)

Furthermore, it might be argued that for those who are dependent on nicotine, possibly being addicted, long term abstinence may be difficult to achieve and a therefore an unattainable ideal. Such individuals within the population may struggle in a life-long pattern of chronic dependence which includes repeated attempts to be tobacco-free, or failure to re-engage in cessation due to past failures to succeed in becoming tobacco-free. Pharmacotherapy may be indicated for such tobacco users. If reducing the burden of disease among nicotine dependent tobacco users is a goal, it could be argued that tobacco use cessation systems should:

- encourage repeated sustained quitting and reduction of long term use in order to reduce health burden among those who have difficulty quitting.

DISCUSSION POINT(S):

- Do the above stated goals resonate with you?
- What changes/comments would you make?
- Do they address the appropriate scope?

E. GUIDING PRINCIPLES FOR TOBACCO USE CESSATION SYSTEMS IN CANADA

The intention of this section is to capture the fundamental principles for a Tobacco Use Cessation System. The principles should capture the values of the key stakeholders grounded in evidence and experience. In other words, where we need to be committed to ensure consistency across organizations/settings/individuals towards a comprehensive approach that will help to inform broader population level approaches to tobacco use cessation.

A comprehensive tobacco use cessation system for Canada should be:

- Continuous (i.e. provide a range of interventions and are integrated to serve the needs of the public)
- Goal and Objective Directed
 - Goals are often considered time-lines statements of aspiration.
 - Goals may be used as a starting point to articulate objectives: i.e. specific, measurable, actionable, realistic and timely, include specific outcomes and should help to define success (see above for substantive aspects)
- Evidence Based
 - Building on available research, best practices and established approaches to inform decisions and prioritization of strategies
- Comprehensive
 - Integration of key components into a more effective system².

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- 2 In "An Integrated, Comprehensive Smoking Cessation System for Ontario Adults" the following elements were identified:
- 1) What: an easy-to-access/use smoking cessation treatment system to increase successful quit attempts
 - 2) Entry to System: Screening all over the age of 18 yrs:
 - a. Self-screening : through public awareness campaigns
 - b. Health professional screening : via primary care, especially rostered practices and hospitals. Key objective: find those who wish to quit within 30 days
 - c. Other settings: in which the possibility of screening/offers of assistance/referral via other than self-initiated or health professional intervention exists
 - 3) Interventions:
 - a. Population level: e.g. STOP, phone, web, Public Health Units.
 - b. Clinical settings: primary care, institutions and hospitals
 - i. Behavioural: counselling via phone, web, health care providers
 - ii. Medication: MD/NP/dentist with pharmacist support: tailored according to co-morbidity and presence of

- Ensuring alignment across disciplines, interventions/strategies, decision makers (organizations, individuals etc.) at the macro/meso/micro levels

It will include (or build from):

- Strong relationships with smokers/tobacco users (patient/client centeredness)
- Acknowledgement of social determinants of health and impact/implications for equitable access to provision of care
 - Acknowledges role of SDOH: disproportionate economic and health burden of tobacco on vulnerable populations. Extent to which the cessation system discourages (or inadvertently encourages) greater disparities between populations using tobacco
 - Consideration of diverse needs of the population and tailoring strategies
- Continuous learning cycle where the strategies employed are informed by what is known to be effective and where best practices emerge the learning cycle integrates this new knowledge to ensure translation across broader applications.
- Commitment to invest in research: Continue to investigate innovative and effective strategies for smoking cessation within diverse/for diverse practice settings and patient populations so, in future we can better tailor investments and interventions for higher impact.
- All health care providers should have a role in the tobacco use cessation system: Range of providers engaged/involved

tobacco related illnesses.

4) Enablers:

- Appropriate payment mechanisms for providers
 - Allow delegation/use of funds to other HCPs in rostered models.
 - Compensation models in community pharmacies for counseling and adherence monitoring.
- Appropriate coverage of STOP smoking medications on ODB: clinically determined dose and duration in a monitored program. Special focus on marginalized, mentally ill, other addictions, First Nations, medical co-morbidities (eg HIV, COPD, cancer, heart disease)
- Employers mandated to provide coverage as part of benefits package.
- A centralized coordinating system to enroll smokers in a program of escalating treatment options using a chronic disease management paradigm, given the current evidence on the causes and natural history of tobacco dependence. (i.e. must be treated like a chronic relapsing condition).
- Public education campaigns
- Practitioner training[Peter Selby] : TEACH and STOP, CTI, RNAO, PTCC

The above system's components are evidence-based best cessation practices as defined by numerous sources including the Ontario Medical Advisory Secretariat (2010), the Cochrane Review (2009), the 2007 Ontario Tobacco Strategy cessation system report, the forthcoming Ontario Tobacco Strategy Advisory Group report (fall 2010) and the CADTH assessment (2010), and dozens of journal articles from Canada, the US, and England published within the past 5 years

F. PROPOSED STRATEGIES AND TACTICS IN TOBACCO USE CESSATION SYSTEMS (FOR DISCUSSION)

STRATEGIES

Approaches to achieving the goal(s)
or those broad approaches that
should be used to achieve the goal(s)

TACTICS

How would you go about executing the
strategy? What activities are required?
Where would resources be spent?

SPECIFIED ACTION PLANS*

Pragmatic, action-oriented and
implementable tactics necessary
to move toward goals and objectives

**Not included in this draft of the White Paper*

Table 1 – Strategies and Tactics

	STRATEGY	TACTICS
ALL	10. Alignment and Coordination	<ul style="list-style-type: none"> • System coordination to align key messages, clinical evidence and interventions across stakeholder organizations, settings, and providers
	1. Planning and priority setting	<ul style="list-style-type: none"> • Capacity/Resources • Level and type of engagement
MACRO	2. Policy Interventions to motivate quit attempts:	
	a) Protection from Secondhand Smoke/ Environmental Tobacco Smoke	<ul style="list-style-type: none"> • Statutes, regulations • Voluntary and administrative policies
	b) Taxation of Tobacco Products	<ul style="list-style-type: none"> • Federal, provincial and local tobacco taxes • Countermeasures for contraband
	3. Health Communication and Media Interventions	<ul style="list-style-type: none"> • Targeting high prevalence and marginalized specific populations • Reach, Frequency and Duration • Mediums of health communication • Media advocacy • Self-help materials
MESO - MACRO	7. Investment	
	a) Programmatic Investment	<ul style="list-style-type: none"> • Integrate and coordinate programs across levels • Review of scientific and practice-based evidence for potential program interventions • Identify mechanisms of change likely to work under the relevant contexts • Funding to facilitate regional/provincial/territorial/federal programs supporting provision of cessation treatment • Consider prevalence of tobacco use and tailored/targetted approaches for populations experiencing disproportionate health and/or economic burden from tobacco use (misuse in Aboriginal populations) • Chronic Disease Programs
	b) Treatment Investment:	<ul style="list-style-type: none"> • Adequate funding allocated at all levels of the healthcare system • Appropriate infrastructure in place to allow for the provision of effective treatments (including training, human resources etc) • Eliminating cost to the patient/client and any other barriers to ensure equal access to treatments across the Canadian population (CDC)

	STRATEGY	TACTICS
	c) Research Investment	<ul style="list-style-type: none"> Promoting awareness of the value of research investment Commitment of decision makers at all levels Collaboration of policy makers, scientists and healthcare providers Capacity to identify gaps which translate into research being conducted (systems in place) Knowledge translation for new evidence to be promptly translated into practice and to policy (Ref: "An integrated...") Ensure new knowledge produced is of the greatest benefit to target end users by a practice-informed, or bottom-up process of identifying existing gaps for future research (SFO-SAC)
	8. Evaluation	<ul style="list-style-type: none"> Incorporated in all programs/strategies at all levels Funding should be allocated appropriately to ensure capacity Inclusion of short and long term outcomes
	9. Monitoring	<ul style="list-style-type: none"> Youth age restrictions/advertising Implementing tobacco industry surveillance Relative impact of size, pictures and absence of trademarks on cigarette packages Increase regulation of tobacco products at point of manufacturing and distribution Prohibition of tobacco sales in specific locations Accuracy of health warning messages from medical and scientific perspectives Retail display of tobacco products
MESO	4. Healthcare Setting/ Organization and Community Interventions	<ul style="list-style-type: none"> Role of healthcare professionals, decision makers, and administrators in establishing systems and policies for best practices (per CAN-ADAPTT) Community supports and programming Population level opportunities for HCPs
	5. Population-level Cessation Interventions	<ul style="list-style-type: none"> Specialized clinics or programs Programs directed to targeted groups Telephone counselling/quitlines improve long term cessation success while functioning at low cost and with high accessibility to smokers. Online support groups, Web Assisted Tobacco Interventions (WATIs), email support, and instant messenger services and other formats
	6. Training or Building Capacity among HCP's in the provision of smoking cessation interventions	<ul style="list-style-type: none"> Integration of evidence-based tobacco use cessation training at different levels of Training should be a core part of a tobacco use cessation program in all health authorities Standards and Accreditation Scope of Practice: Explore potential roles of all team members in the provision of a smoking cessation system Increase capacity within a setting to offer smoking cessation interventions within a team setting (external referral/community referrals or capacity important component).

	STRATEGY	TACTICS
MICRO	CAN-ADAPTT Version 2.0 Guideline	<p>Clinical Summary Statements for health care professionals working with patients/clients</p> <ul style="list-style-type: none"> • Counselling • Medication • Specific Populations <ul style="list-style-type: none"> – Aboriginal Peoples – Hospital Based Population – Mental Health and Other Addictions – Youth (Children and Adolescents) – Pregnant and Breastfeeding Women

DRAFT

STRATEGY #1 – Planning and Priority Setting (Macro, Meso and Micro Levels)

Planning involves the engagement of stakeholders to determine the overall direction, goals, principles, strategies and tactics, as well as specific action plans that specify roles, responsibilities, and sequencing of activities. Plans may be strategic, management level, or operational.

Priority setting includes the integration of tobacco use cessation as a programmatic and policy priority for organizations/healthcare setting/jurisdictions, at all levels, resulting in benefits at both the individual and population level.

Integration of tobacco use cessation as a programmatic and policy priority requires involvement of a range of different stakeholders including decision makers, policy makers, administration and management. Ideally all stakeholders involved in planning and priority setting are familiar with and understand the evidence about what has been shown to be effective. Priority setting needs to occur across various levels within health care settings, organizations and jurisdictions in order to have significant impact.

TACTICS:

- **Capacity/Resources** – The resources and capacity particular to specific organizations/ settings/jurisdictions should be taken into consideration during priority setting. Treatment approaches and smoking cessation policies can be varied according to scenarios of low/high levels of resources and low/high levels of political will so that organizations or jurisdictions can implement policies regardless of resources (*Policy recommendations for smoking cessation and treatment of tobacco dependence*, WHO 2003)
- **Level and type of engagement** – A range of levels and types of engagement may be possible, based on priorities and resources available. For example the following may be considered: development of smoke-free policy; establishing support groups for tobacco use cessation; requirement of all services, departments, etc. to introduce systems to maintain tobacco use status of all patients/clients.

STRATEGY #2 – Policy Interventions (Macro)

Tobacco control policy interventions are reviewed in this section in order to identify the need to link to contextual factors and policies to tobacco use cessation systems. Policy interventions occurring at municipal, provincial and federal jurisdictions directly impact and guide the prioritization, development and continuance of systems and interventions for population-based tobacco cessation and have been included within this document to highlight this important intersection.

Policy interventions for tobacco use cessation cover legislations designed to protect the public health through restrictions on the sale, distribution and use of tobacco products, the promotion and display of tobacco products, prohibition of smoking in workplaces and public area, etc. Policy interventions related to population-level tobacco cessation affect and impact a broad array of

individuals in addition to persons who use tobacco including employers, proprietors, retailers, and health care professionals.

TACTICS:

- **Tobacco-related disparities:** Because some populations experience a disproportionate health and economic burden from tobacco, all policy interventions need to give specific consideration to marginalized populations to ensure such tobacco-related disparities are minimized. Disproportionately affected groups include low SES, youth/young adults, pregnant, mentally ill, aboriginal, people living with HIV/AIDS, incarcerated populations, LGBTTO, geographically remote communities.

Strategy #2a. Protection from Second-hand Smoke/Environmental Tobacco Smoke – Smoking bans and restrictions include policies, legislations and laws limiting smoking entirely or to designated areas in public spaces and workplaces. All Canadian provinces have incorporated population-level tobacco use interventions through legislation that prohibits smoking in workplaces and public areas. For example, the Smoke-Free Ontario Act (SFOA) which came into effect May 2006, aimed to reduce exposure to second-hand smoke in enclosed workplaces and indoor public places like bars and restaurants. Canadian provinces and territories, as well as the federal government, have a range of statutes, regulations, and other policies to restrict or eliminate second hand smoke.

Strategy #2b. Taxation of Tobacco Products– Taxation is an effective public policy tool used to increase the retail price of tobacco products in order to decrease tobacco consumption through economic burden. There is substantial evidence illustrating that increases in the price of tobacco products through taxation results in a decrease of tobacco consumption and increase in cessation rates across a range of jurisdictions (CTI monograph 12, OTRU 2010; Ontario Cessation Task Group 2006). Internationally, tobacco taxation has been identified as a key strategy for tobacco control (CDC; WHO Framework Convention on Tobacco Control. Geneva, Switzerland, 2005; Institute of Medicine. Ending the Tobacco Problem: A Blueprint for the Nation. National Academy Press, Washington DC, 2007; Royal College of Physicians of London. Ending Tobacco Smoking in Britain: Radical Strategies for Prevention and Harm Reduction in Nicotine Addiction. London, UK, 2008. Royal College of Physicians; WHO, 1998). Young people are particularly sensitive to the cost of tobacco products (CTI, Monograph 12). Contraband tobacco has increasingly become a barrier to effective tobacco control, undermining the price mechanism to suppress demand, in addition to reducing government revenues resulting from legitimate forms of tobacco. Of particular concern is the economic accessibility contraband tobacco affords to young people and low socioeconomic status populations, challenging population level cessation efforts.

STRATEGY #3 – Health Communication and Media Interventions for Population Level Tobacco Cessation (Macro)

This includes increasing public awareness of cessation issues, to guide tobacco users to quit and seek out appropriate treatment/resources, to influence social norms regarding tobacco use (e.g.: smoke free homes), to stimulate public support for tobacco control interventions, and to denormalize the tobacco industry.

Mass media and health communication interventions are an important way to reach tobacco users at a population-level, particularly when combined with other interventions (CDC). There is significant evidence that health communication campaigns are effective in positively impacting tobacco cessation attempts amongst smokers (Macdonald 2003, CTI #12). Campaigns should also be directed to motivate tobacco users to quit even without formal help (Macdonald, 2003). Mass health communication campaigns are cost effective and efficient in delivering knowledge and information, lead to shifts in behaviour and social norms, and can be used to denormalize tobacco industry practices, all influencing the ability and willingness of smokers to quit using tobacco (Macdonald 2003, CTI #12). Tactics of effective social marketing strategies/health communication interventions have identified delivering strategic, appropriately targeted, and high-impact messages in sustained and adequately funded campaigns integrated into the overall population-based tobacco cessation system (CDC, ref?).

TACTICS:

- a) **Target high prevalence and marginalized specific populations:** Focused targeting of populations with high tobacco use prevalence rates/marginalized specific populations through appropriate channels. (CDC). The Florida “Truth” Campaign or Ontario’s “Stupid.ca” are examples of media campaigns aiming to address the high prevalence of smoking amongst youth.
- b) **Vary Reach, Frequency and Duration:** Media campaigns relating to tobacco cessation need to take into consideration the length of time a campaign should run, the number of people exposed to a particular campaign and the average number of times an individual is exposed to a campaign during a given period of time (CDC). All these tactics are crucial to consideration in the development of an effective tobacco cessation campaign.
- c) **Employ Various Media for health communication:** Health communications should cover a broad array of media including traditional media television, radio, billboard and print mediums and non-traditional (e.g.: viral and interactive media channels and the internet), at national, provincial and local levels.
- d) **Advocacy:** Health communications can also include media advocacy (e.g. press releases, local and community events; CDC).
- e) **Self-help materials:** Self-help materials can be seen as a form of health communication interventions for tobacco use cessation that do not require the intervention of a healthcare professional. The availability of self-help materials self-help including pamphlets, manuals or programs (including computer-based and audio-visual) can be used by individuals to

assist in quit attempts made without the formal help of a healthcare professional or can also be delivered as part of a treatment plan (CTI, #12).

STRATEGY #4 – Healthcare Setting/Organization and Community Interventions (Meso Level)

The healthcare settings and organizations where HCPs interact with and treat patients/clients, as well as the wider community, provide opportunities to support and offer tobacco use cessation interventions. Coordinated practices and supportive policies across settings can influence more effective tobacco use cessation interventions.

TACTICS

- a) Role of healthcare professionals, decision makers, and administrators in establishing systems and policies for best practices
 - Healthcare professionals have a unique opportunity to ensure treatment is offered to each patient/client.
 - All members of the healthcare team or practice should be aware of the tobacco use intervention process (screening, advising, referral, etc.) and recognize their role in the interventions.
 - Organizations should institutionalize systems for consistent identification, documentation and treatment of patients/clients (SFO-SAC). CAN-ADAPTT’s clinical practice guideline can be consulted for practices and systems for delivering interventions.
 - Organizational policy should ensure adequate training, resources, and staffing for tobacco use cessation treatment and support to those trying to quit (eg. smoke-free policies; policies on NRT availability) (UK Guideline).
 - Cessation intervention is to be delivered across all interactions within the system (NCI monograph 12). Administrators, healthcare professionals, and decision-makers should ensure practice-level or institutional changes promoting treatment are implemented universally and systematically (US Clinical Practice Guideline, p69-70)
 - CQI measures to ensure sustained outcomes should be instituted and practices adapted where necessary to achieve outcomes.
 - EMR systems to encourage screening and intervention with all smokers.

- b) Community supports and programming
 - Effective community programs involve and influence people in their homes, work sites, schools, places of worship, places of entertainment, health care settings, civic organizations, and other public places (as referenced, in CDC p.23)
 - Encourage relationship/coalition-building between local agencies (CDC)

- Develop “...community level programs and policies to influence societal organizations, systems, and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms”. (CDC, p22)
 - Ensure that local grantees measure and evaluate social norm change outcomes (e.g., policy adoption, increased compliance) (CDC p23-24).
 - Collect community-specific data on smoking (CDC p23)
- c) Population level opportunities for HCPs
Advocating for organizational-level policies, system-wide changes that facilitate compliance with policies e.g. advocating for in-service or CE training for evidence based smoking cessation)
- HCPs should advocate for smoking cessation services, smoke-free spaces/workplaces where they work, and prohibition of the sale or promotion of tobacco products (RNAO, p37- 40)
 - Accreditation of hospitals and institutions based on interventions with tobacco use in their patients and clients

STRATEGY #5 – Population-level Cessation Interventions

Tobacco use interventions directed toward populations of smokers have been proven effective. These interventions target specific groups or are meant to be accessible to the mass of tobacco users.

TACTICS:

- a) Specialized clinics or programs (insert Paul MacDonald’s reference)
 - Examples: CAMH’s Nicotine Dependence Clinic, RNAO program, OHI, ThunderBay Cancer Program
- b) Programs directed to targeted groups
 - Examples: Leave the Pack Behind, Youth Advocacy Training Institute (YATI), STOP
- c) Telephone counselling/quitlines improve long term cessation success while functioning at low cost and with high accessibility to smokers.
 - Optimal utility is dependent on the resources provided in terms of the number of smokers that can be reached, links to other community organizations for referrals and to media- and community-based promotions for self-referral of smokers (NCI monograph 12).
 - The centralized service of a quitline should be promoted in a coordinated public health campaign or fused with a comprehensive anti-smoking media campaign (NCI monograph 12).

- Increase diversity and basket of services provided by telephone helplines and online support (Cessation Task Group, 2007).
- d) Online support groups, Web Assisted Tobacco Interventions (WATIs), email support, and instant messenger services and other formats (Cessation Task Group, 2007)

STRATEGY #6 – Training or Building Capacity Among HCP's in the Provision of Smoking Cessation Interventions

Considerations of tobacco use cessation education, standards of practice, and scopes of practice enable HCPs of all disciplines to competently and consistently provide up-to-date and effective treatment in their practices and within their teams or health system (referrals, community resources etc.). This strategy also considers all team members as having potential roles in tobacco use cessation interventions.

TACTICS:

- a) Integration of evidence-based tobacco use cessation training at different levels of education
 - Tobacco use cessation treatment should be included in core curricula of all clinical disciplines and at different levels of education (undergraduate, university/college, residencies, continuing medical education and professional development, online training modules, mini-med school programs) (US, UK guidelines)
- b) Training should be a core part of a tobacco use cessation program in all health authorities (UK guidelines)
 - HCPs providing care to vulnerable populations with high prevalence of tobacco mis-use should be targeted for training and support to provide brief interventions (Cessation Task Group, 2007)
- c) Standards and Accreditation
 - Integrate tobacco use cessation treatment into HCPs' standards of care through accreditation bodies
 - Evaluate treatment knowledge and skills in licensing/certification exams (US Guidelines)
 - Specialty societies should adopt training as a uniform standard of competence for all members (US Guidelines)
- d) Scope of Practice: Explore potential roles of all team members in the provision of a smoking cessation system
 - Maximize the reach of tobacco users affected by increasing the number of health professionals delivering brief interventions (Cessation Task Group, 2007)

- Support staff can take roles in identifying and documenting smokers (NCI monograph 12)
 - Clear performance objectives should exist at individual, team, and organizational levels. (NCI monograph 12)
- e) Increase capacity within a setting to offer smoking cessation interventions within a team setting (external referral/community referrals or capacity important component).
- Leverage existing expertise within teams (CDC, p48)
 - Provide resources to appropriate training, technical assistance, organization development exercises, and relationship development (Cessation Task Group, 2007).

STRATEGY #7 – Investment

7a. Programmatic Investment

The programmatic investment that supports or increases the capacity for tobacco use cessation at a jurisdictional or provincial level.

- Integrate and coordinate programs across levels
 - Review of scientific and practice-based evidence for potential program interventions (SFO-SAC).
 - Identify mechanisms of change likely to work under the relevant contexts
- Funding to facilitate regional/provincial/territorial/federal programs supporting provision of cessation treatment
- Consider prevalence of tobacco use and tailored/targeted approaches for populations experiencing disproportionate health and/or economic burden from tobacco use (misuse in Aboriginal populations)
- Chronic Disease Programs

7b. Treatment Investment:

Adequate provision of funds to ensure capacity and access to known effective treatments, including pharmacotherapy and counselling. Adequate funding is essential for known effective tobacco use cessation, to ensure equal access for all patient/clients across Canada.

Tobacco use cessation pharmacotherapy including Nicotine Replacement Therapy (NRT), Varenicline and Bupropion as well as a variety of formats of counselling have all been shown to be effective to increase the chances of a successful quit. Furthermore, the provision of pharmacotherapy at no cost to the patient/client has been shown to increase abstinence rates (Reda, AA).

Currently, for example, Yukon and PEI reimburse patients/clients for at least one product while Quebec provides public funding for all pharmacotherapy (Penz, ED). Programs such as the STOP study provide NRT at no cost to study participants in Ontario.

Similarly, counselling is an important and effective strategy, and is arguably more effective at the population level than pharmacotherapy as the prevalence of addiction/nicotine dependence is ostensibly lower in the general population than the clinical population (McDonald, P). However, the STOP study has shown that small doses of NRT can increase the reach of phone based interventions at a less cost with equivalent or better effectiveness.

TACTICS:

- Adequate funding allocated at all levels of the healthcare system
- Appropriate infrastructure in place to allow for the provision of effective treatments (including training, human resources etc)
- Eliminating cost to the patient/client and any other barriers to ensure equal access to treatments across the Canadian population (CDC)

7c. Research:

A continued commitment is needed, at all levels, to identify and fund research related to tobacco use cessation best practices in Canada. Research gaps identified should directly reflect the needs of the target end users of new knowledge produced.

Many important research questions for tobacco use cessation best practices in Canada remain unanswered. Further research is needed in order to close existing knowledge gaps and allow further exploration of the determinants of quitting, needs of priority populations and key aspects affecting the Canadian system. A comprehensive research strategy includes addressing existing gaps in knowledge while ensuring prompt knowledge translation of new evidence. As part of the CAN-ADAPTT program, a practice informed research agenda has been developed that identifies key gaps and areas for research as identified by the CAN-ADAPTT network and key stakeholders. (<http://www.can-adaptt.net/about/research.aspx>).

TACTICS:

- Advocacy for research investment
- Commitment of decision makers at all levels
- Collaboration of policy makers, scientists and healthcare providers
- Capacity to identify gaps which translate into research being conducted (systems in place)
- Knowledge translation for new evidence to be promptly translated into practice and to policy
- Ensure new knowledge produced is of the greatest benefit to target end users by a practice-informed, or bottom-up process of identifying existing gaps for future research (SFO-SAC)

- Mechanisms to consistently identify and capture current research gaps to better drive decision-making.

STRATEGY #8 – Evaluation: Incorporating an element of evaluation/surveillance in all tobacco use cessation programs/strategies/systems

A key component of any comprehensive learning system is evaluation/surveillance. Evaluation and surveillance can provide accountability, monitor impact/outcomes, guide improvement, and ensure the most effective use of funding. Surveillance of outcomes can be at the macro, meso and micro levels of tobacco use cessation systems in Canada.

Numerous programs/organizations exist across Canada to support evaluation and surveillance activities. Examples include the Tobacco Information Monitoring System (TIMS), which has been developed by the Ontario Tobacco Research Unit (OTRU) and provides surveillance data on selected tobacco control indicators. Additionally, OTRU provides research, evaluation and monitoring support for programs and activities within Ontario. Nationally, the Canadian Tobacco Use Monitoring Survey provides continual data on tobacco use and key associated factors.

Evaluation should measure outcomes at all levels within Canada, including:

- a. Population health level: Behaviours, knowledge, attitudes and use/trends
- b. Practice level/organization: Organization and practice goals, patient/client outcomes
- c. Program investments: Program goals/outcomes and accountability to the investments

TACTICS:

- Incorporated in all programs/strategies at all levels
- Funding should be allocated appropriately to ensure capacity
- Inclusion of short and long term outcomes

STRATEGY #9 – Surveillance and Monitoring

Surveillance of tobacco use, the tobacco companies, various aspects of the tobacco market and tracking or monitoring progress toward goals and the attainment of public health objectives is an important part of public health practice. Epidemiological and social science methodologies (quantitative, qualitative and mixed methods) may be applied for this purpose. Surveillance and monitoring a key aspect of continuous quality improvement in the macro practice of public health interventions, including comprehensive tobacco use cessation systems.

TACTICS:

Examples of tactics include:

- Tobacco use prevalence by age, sex, social group etc. over time and geographic areas

- Youth age restrictions/advertising monitoring
- Implementing tobacco industry surveillance
- Relative impact of size, pictures and absence of trademarks on cigarette packages
- Tracking of policies related to prohibition of tobacco sales in specific locations
- Accuracy of health warning messages from medical and scientific perspectives
- Retail display of tobacco products

Strategy #10 – Alignment and Coordination

The provision of a comprehensive tobacco use cessation system needs to build on effective implementation strategies. The system needs to be appropriately coordinated to align key messages, clinical evidence and interventions across stakeholder organizations, settings, and providers to ensure consistency for all target audiences involved in the health system including:

- primary care providers (interprofessional);
- specialists;
- decision makers (e.g. government, regional, provider organizations, etc.);
- existing programs
- patients and general public;
- partners and collaborators including, where appropriate, clinical focus advocacy groups; and
- researchers.

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