CAN ADAPTT

CANADIAN
SMOKING CESSATION
CLINICAL PRACTICE GUIDELINE

OVERVIEW OF
SUMMARY STATEMENTS

For the complete guideline please visit: www.can-adaptt.net

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

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CAN-ADAPTT: Practice-Informed and Evidence-based Smoking Cessation Guideline

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

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

The full text guideline is available online at www.can-adaptt.net. Each section includes the following headings:

- Overview of Evidence
- Background
- Summary Statements
- Clinical Considerations
- Tools and Resources
- Research Gaps

We invite you, through our website and discussion board, to comment on the applicability and usability of this guideline, suggest additional tools and resources, and help to identify any gaps in knowledge.

For more information, or to view the complete guideline, visit www.can-adaptt.net.

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COUNSELLING AND PSYCHOSOCIAL APPROACHES

SUMMARY STATEMENT #1

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

GRADE*: 1A

SUMMARY STATEMENT #2

ADVISE: Health care providers should clearly advise patients/clients to quit.

GRADE*: 1C

SUMMARY STATEMENT #3

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

GRADE*: 1C

SUMMARY STATEMENT #4

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

GRADE*: 1A

SUMMARY STATEMENT #4 (cont'd)

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

GRADE*: 1A

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

GRADE*: 1A

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

GRADE*: 1A

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

GRADE*: 1A

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

GRADE*: 1B

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

GRADE*: 1B

** GRADE: See Table 1 for Grade of Recommendation and Level of Evidence Summary Table*

SUMMARY STATEMENT #5

ARRANGE: Health care providers:

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

GRADE*: 1C

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

GRADE*: 1A

■ ABORIGINAL PEOPLES†

SUMMARY STATEMENT #1

Tobacco misuse[Δ] status should be updated for all Aboriginal peoples by all health care providers on a regular basis.

GRADE*: 1A

SUMMARY STATEMENT #2

All health care providers should offer assistance to Aboriginal peoples who misuse tobacco with specific emphasis on culturally appropriate methods.

GRADE*: 1C

SUMMARY STATEMENT #3

All health care providers should be familiar with available cessation support services for Aboriginal peoples.

GRADE*: 1C

SUMMARY STATEMENT #4

All individuals working with Aboriginal peoples should seek appropriate training in providing evidence-based smoking cessation support.

GRADE*: 1C

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† *Aboriginal peoples is used as an inclusive term which includes First Nations (both on and off reserve), Inuit, and Métis. This is not meant to take away from the diversity that exists among Aboriginal peoples*

Δ *Tobacco misuse does not refer to tobacco use for traditional/ceremonial purposes.*

* *GRADE: See Table 1 for Grade of Recommendation and Level of Evidence Summary Table*

HOSPITAL-BASED POPULATIONS

SUMMARY STATEMENT #1

All patients should be made aware of hospital smoke-free policies.

GRADE*: 1C

SUMMARY STATEMENT #2

All elective patients who smoke should be directed to resources to assist them to quit smoking prior to hospital admission or surgery, where possible.

GRADE*: 1B

SUMMARY STATEMENT #3

All hospitals should have systems in place to:

a) identify all smokers;

GRADE*: 1A

b) manage nicotine withdrawal during hospitalization;

GRADE*: 1C

c) promote attempts toward long-term cessation and;

GRADE*: 1A

d) provide patients with follow-up support post-hospitalization.

GRADE*: 1A

SUMMARY STATEMENT #4

Pharmacotherapy should be considered:

a) to assist patients to manage nicotine withdrawal in hospital;

GRADE*: 1C

b) for use in-hospital and post-hospitalization to promote long term cessation.

GRADE*: 1B

MENTAL HEALTH AND/ OR OTHER ADDICTION(S)

SUMMARY STATEMENT #1

Health care providers should screen persons with mental illness and/or addictions for tobacco use.

GRADE*: 1A

SUMMARY STATEMENT #2

Health care providers should offer counselling and pharmacotherapy treatment to persons who smoke and have a mental illness and/or addiction to other substances.

GRADE*: 1A

SUMMARY STATEMENT #3

While reducing smoking or abstaining (quitting), health care providers should monitor the patients'/clients' psychiatric condition(s) (mental health status and/or other addiction(s)). Medication dosage should be monitored and adjusted as necessary.

GRADE*: 1A

** GRADE: See Table 1 for Grade of Recommendation and Level of Evidence Summary Table*

PREGNANT & BREASTFEEDING WOMEN

SUMMARY STATEMENT #1

Smoking cessation should be encouraged for all pregnant, breastfeeding and postpartum women.

GRADE*: 1A

SUMMARY STATEMENT #2

During pregnancy and breastfeeding, counselling is recommended as first line treatment for smoking cessation.

GRADE*: 1A

SUMMARY STATEMENT #3

If counselling is found ineffective, intermittent dosing nicotine replacement therapies (such as lozenges, gum) are preferred over continuous dosing of the patch after a risk-benefit analysis.

GRADE*: 1C

SUMMARY STATEMENT #4

Partners, friends and family members should also be offered smoking cessation interventions.

GRADE*: 2B

SUMMARY STATEMENT #5

A smoke-free home environment should be encouraged for pregnant and breastfeeding women to avoid exposure to second-hand smoke.

GRADE*: 1B

YOUTH (Children and Adolescents)

SUMMARY STATEMENT #1

Health care providers, who work with youth (children and adolescents) should obtain information about tobacco use (cigarettes, cigarillos, waterpipe, etc.) on a regular basis.

GRADE*: 1A

SUMMARY STATEMENT #2

Health care providers are encouraged to provide counselling that supports abstinence from tobacco and/or cessation to youth (children and adolescents) that use tobacco.

GRADE*: 2C

SUMMARY STATEMENT #3

Health care providers in pediatric health care settings should counsel parents/guardians about the potential harmful effects of second-hand smoke on the health of their children.

GRADE*: 2C[1]

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* *GRADE: See Table 1 for Grade of Recommendation and Level of Evidence Summary Table*

[1] *Priest N, Roseby R, Waters E, Polnay A, Campbell R, Spencer N, Webster P, Ferguson-Thorne G. Family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD001746. DOI:10.1002/14651858.CD001746.pub2*

Table 1 – Grade of Recommendation (GR) & Level of Evidence (LOE) Summary Table**

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

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

INTERESTED IN HELPING SMOKERS QUIT?

By joining the CAN-ADAPTT online network (membership is free), you can:

- *Access the complete evidence-based guideline*
- *Comment on the applicability and usability of the guideline*
- *Connect and collaborate with other health care providers, researchers, policy makers and more across Canada*
- *Share and access tools & resources*
- *Help to identify any gaps in knowledge*
- *Interact via the discussion board*

GUIDELINE DEVELOPMENT GROUP:

Peter Selby, MBBS, CCFP, MHSc, FASAM; Gerry Brosky, MD, MSc, CCFP; Charl Els, MBChB, FCPsych, MMed Psych(cum laude), Cert. ASAM, MRO; Rosa Dragonetti, MSc; Sheila Cote-Meek, BScN, MBA, PhD; Jennifer O'Loughlin, PhD; Paul McDonald, PhD, FRSPH; Alice Ordean, MD, CCFP, MHSc; Robert Reid, PhD, MBA

WITH SUPPORT FROM THE CAN-ADAPTT TEAM:

Stephanie Elliott, Administrative Secretary; Katie Hunter, MSc, Atlantic Canada Coordinator; Denise Koubanioudakis, MA, Québec Coordinator; Tamar Meyer, MA, Ontario Coordinator; Janet Ngo, MA, Western Canada Coordinator; Jess Rogers, BA, Manager and Director, Centre for Effective Practice; Louise Walker, BA, BSc(Hons), Former Manager

CAN-ADAPTT is the Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment and is based at the Centre for Addiction and Mental Health (CAMH).

For more information or to join the network, please visit: www.can-adaptt.net

Or write to us: can_adaptt@camh.net