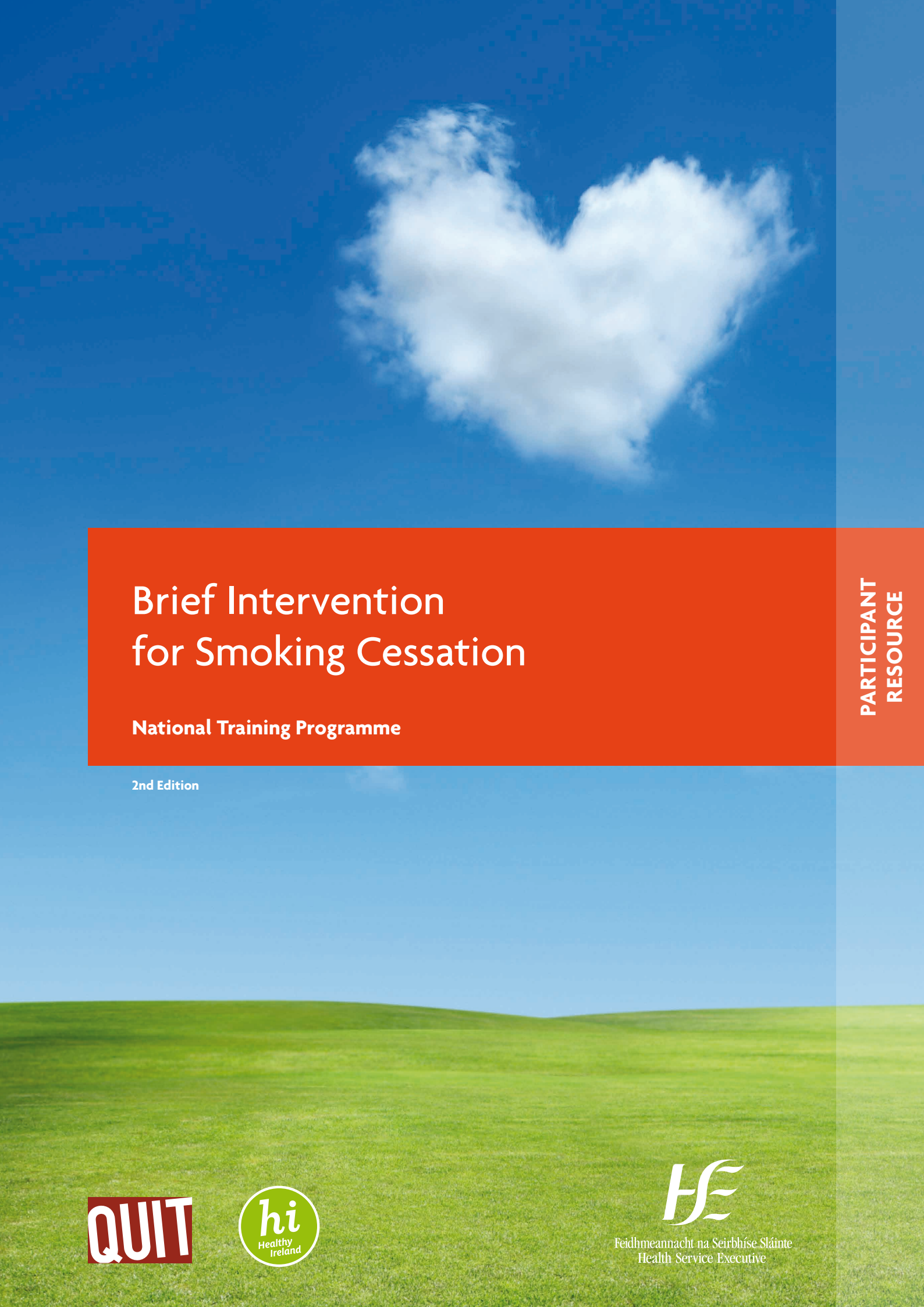


Brief Intervention for Smoking Cessation

National Training Programme

2nd Edition

PARTICIPANT RESOURCE

QUIT

hi Healthy Ireland

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

The development of an accredited National Training Programme is one of the key priorities of the HSE cross service group responsible for implementation of the HSE's Tobacco Control Framework. The course is recognised for CPD by The Irish College of General Practitioners (5.5 CPD credits and 2 GMS study leave sessions for registered doctors) and has been awarded Category 1 Approval from An Bord Altranais (6 CEUs for registered nurses and midwives). This resource was delivered in collaboration between Health Promotion, the Irish Health Promoting Health Services' Network and National Tobacco Control.

Available online at www.hse.ie/bitobacco.

First publication – September 2012
Revised edition – February 2014

Table of Contents

1. Introduction

This resource has been developed as part of the *HSE Brief Intervention for Smoking Cessation National Training Programme*. It is a practical guide to support professionals who have undertaken the training programme and will assist in integrating brief interventions into daily practice.

The resource (www.hse.ie/bitobacco) includes information and reference materials on the key topics presented during the course including:

- latest tobacco statistics for Ireland
- smoking behaviour and addiction
- 5As Framework for Brief Intervention for Smoking Cessation
- Prochaska & DiClemente's stages of change model
- motivational approach when raising the issue of smoking
- OARS: communications for effective interventions
- tools and supports to help smokers quit.

Overview of Brief Intervention in Smoking Cessation Training

Brief Intervention Definition

Brief Interventions involve opportunistic advice, discussion, negotiation or encouragement...
For smoking cessation, brief interventions typically take between 5 and 10 minutes

(NICE Guidelines, Brief Interventions and Referral for Smoking Cessation in Primary Care and Other Settings, 2006)

- Unassisted quit rate = 2-3%
- Brief advice intervention increases quit rate by 1 to 3 percentage points

(Cochrane Review, Physician Advice for Smoking Cessation, 2008)

Brief Intervention – The Evidence

- Intervention from health professionals has been shown repeatedly, in randomised controlled trials, to increase the percentage of smokers who stop and remain abstinent for 6 months or more
- It is a highly cost effective intervention

(West et al, Smoking Cessation Guidelines for Health Professionals: An Update, 2000)

Missed Opportunities

- Only 38% of current smokers who attended a GP or other health professional in the last year reported that the health professional had discussed quitting smoking with them during their consultation.

(Brugha et al, SLÁN 2007 Survey of Lifestyle, Attitudes and Nutrition in Ireland: Implications for Policy and Services, 2009)

Aim of the Brief Intervention in Smoking Cessation Course

The course aims to equip you with an evidence based Brief Intervention (BI) model that you can incorporate into your routine practice to encourage and support patients/clients to quit smoking.

The Objectives of the Course

The course is designed to address the knowledge, skills and attitudes that will help you to promote smoking cessation among your patients/clients.

You will be:

1. introduced to the idea of using BI techniques, which have been shown to be effective in promoting smoking cessation, in your work environment
2. Taught some core motivational interviewing principles & skills and a behaviour change model that will help you understand the basic theory that underpins BI and help you to use it effectively
3. Provided with a current knowledge base on the health risks of tobacco use, benefits of quitting, the resources to support a quit attempt and the referral pathways to support services

What is a Brief Intervention and when Should it be Carried Out?

Brief Interventions are a range of effective behaviour change interventions that are client-centred, short in duration and used in a variety of settings by health and other professionals. They use an empathic approach, emphasising self efficacy, personal responsibility for change, information giving and details of resources available to support change.

For smoking cessation, brief interventions involve opportunistic advice, discussion, negotiation and encouragement that typically take between 5 and 10 minutes. The intervention may involve referral to a more intensive treatment if appropriate. Interventions should be recorded and followed up as appropriate.

Brief Interventions for smoking cessation are more successful when used with clients who:

- are unlikely to need/seek or attend specialist treatment
- are unsure/ambivalent about quitting
- may require access to other appropriate services.

The components of a brief intervention are often demonstrated using the brief intervention framework. The five components of the brief intervention framework (5A's) are: ask, advise, assess, assist, arrange and are outlined in more detail on page 16. The brief intervention generally involves assessing and recording the clients current smoking status. The way to proceed then depends on which of the six 'stages' on Prochaska and DiClemente's Stages of Change model the patient is in. The aim is then to encourage smokers to move on to the next stage towards giving up.

2. Understanding Tobacco Use

Cost to Health

Smoking places an enormous burden of illness and mortality on our society. It affects the almost 1 million people who smoke in Ireland, and their families, while creating an enormous cost for our health service each year.

1 in every 2 smokers will die from a tobacco related disease, and most smokers lose between 10 to 15 quality life years. Tobacco use is the single biggest cause of cancer and chronic respiratory diseases and is a significant cause of cardiovascular disease. This major cause of death, illness, chronic disability and inequality is preventable, yet accounts for some 5,200 deaths in Ireland each year.

Department of Health estimates that tobacco use costs the exchequer somewhere in the region of €1-2bn per annum. A study of hospital discharges shows that smoking related diseases accounted for 3.7% of total discharges, but accounted for 9.4% of total costs, totalling €280m in 2008.

Reducing the number of smokers in our society is the single most significant step that can be taken to improve population health and reduce pressure on the health system – this requires a sustained multi-faceted approach.

In 2010, the HSE adopted the Tobacco Control Framework to inform HSE policy and provide a coherent response to tobacco use in Ireland. A number of actions from the Framework are prioritised in the HSE's National Service Plans, including training all healthcare workers to have the necessary skills to address smoking as a care issue. Healthcare professionals are ideally placed to raise the issue of smoking with service users – and with the right mix of knowledge, skills and attitude can really "make every contact count" by encouraging and supporting smokers to quit. It is essential that every health professional asks about smoking status and documents same at each visit.

What's in a Cigarette?

A cigarette is a very efficient and highly engineered drug-delivery system. The primary ingredient in cigarettes is tobacco (including reconstituted tobacco and genetically modified tobacco) to which hundreds of chemical additives are introduced during the manufacturing process. 600 different additives are currently approved for use in the manufacture of cigarettes and these include humectants (moisturisers) to prolong shelf life, sugars to make the smoke seem milder and easier to inhale; and flavourings such as chocolate, cinnamon and vanilla. While some additives may appear quite harmless, others are toxic or addictive in their own right, or in combination. When additives are burned, new products are formed and these too may be toxic or pharmacologically active.

What's in Cigarette Smoke?

Tobacco smoke is made up of *sidestream smoke* from the burning tip of the cigarette and *mainstream smoke* that is inhaled by the smoker. Many toxins are present in higher concentrations in sidestream smoke than in mainstream smoke due to the lower temperature at which the cigarette burns when not being smoked.

Cigarette smoke contains more than 7,000 chemicals and compounds which are released into the air as particles and gases. Hundreds are toxic and at least 69 cause cancer. Tobacco smoke is a known human carcinogen. The chemicals in tobacco smoke reach the lungs very quickly when a smoker inhales, and then go quickly from the lungs into the blood which carries these chemicals to tissues all around the body.

The particulate phase includes nicotine, tar, benzene and benzo(a)pyrene. The gas phase includes carbon monoxide, ammonia, dimethylnitrosamine, formaldehyde and hydrogen cyanide.

Nicotine

- A deadly poison
- Tobacco smoke contains very tiny amounts of nicotine and in the doses obtained from smoked tobacco is not a significant contributor to disease
- Highly addictive – according to the WHO it is more addictive than heroin and cocaine.
- A stimulant which affects many body systems, including the brain, the heart and the nervous system.
- Absorbed by the body very quickly, reaching the brain within 10-20 seconds. It activates the reward pathways in the brain and increases levels of dopamine in the reward circuits, creating feelings of pleasure for the smoker. The acute effects of nicotine and the feelings of reward do not last more than a few minutes. As nicotine levels fall in the body, smokers feel an urgent desire to smoke (at intervals of 20-45 minutes depending on consumption rates) in order to restore these pleasurable feelings and avoid withdrawal.
- Chronic exposure to nicotine causes structural changes in the brain by desensitising nicotine receptors and increasing the number of nicotinic receptors thus increasing the urge for the next cigarette resulting in addiction.
- Nicotine increases the heart rate and blood pressure, leading to the heart needing more oxygen.

Tar

- A mixture of lots of chemicals, many of which cause cancer.
- Can stain smokers' fingers and teeth as it gathers in the lungs as a sticky brown substance increasing a smoker's risk of lung cancer, emphysema, and bronchial disorders.

Carbon Monoxide

- A colourless gas with no smell which is released from burning tobacco and sticks to red blood cells in place of oxygen.
- Lowers the blood's ability to carry oxygen around the body to vital tissues and organs such as the heart and brain.
- It also kills cilia (hairs lining the lungs) and reduces the lungs' ability to clear toxins making it easier for other chemicals to attack them.
- Up to 15% of a smoker's blood can be carrying carbon monoxide instead of oxygen.

Other chemicals include:

Cancer-Causing Chemicals

- Formaldehyde: Used to embalm dead bodies
- Benzene: Found in gasoline
- Polonium 210: Radioactive and very toxic
- Vinyl chloride: Used to make pipes

Toxic Metals

- Chromium: Used to make steel
- Arsenic: Used in pesticides
- Lead: Once used in paint
- Cadmium: Used to make batteries

Poison Gases

- Hydrogen cyanide: Used in chemical weapons
- Ammonia: Used in household cleaners
- Butane: Used in lighter fluid
- Toluene: Found in paint thinners

US Department of Health and Human Services, CDC, Office on Smoking and Health, 2010. A Report of the Surgeon General: How Tobacco Smoke Causes Disease: What it Means to Us.

Why Do People Smoke?

Tobacco use is a complex behaviour influenced by a range of physiological, behavioural and cognitive factors which is why people continue to smoke, despite widely publicised evidence of the health, social and financial burden it causes.

Physical Addiction

The WHO defines addiction as *'repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means'*.

The term dependence as applied to alcohol and other drugs, is defined by the WHO as *'a need for repeated doses of the drug to feel good or to avoid feeling bad'*. In DSM-IIIR (Diagnostic and Statistical Manual of Mental Disorders), dependence is defined as *'a cluster of cognitive, behavioural and physiologic symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences'*.

Classification of Dependence

- Strong desire to take a substance, taking more than intended for longer
- Difficulty quitting or controlling use
- Considerable time spent obtaining, using and/or recovering from use
- Higher priority given to the drug than other social activities
- Continued use despite knowledge of harm
- Tolerance develops
- Withdrawal syndrome

Tobacco dependence exhibits classic characteristics of drug dependence. Nicotine is psychoactive, tolerance producing, and causes physical and psychological dependence characterised by withdrawal symptoms and cravings.

Automatic Habit

Smoking is often associated with and reinforced by routine activities, people and situations – at the end of a meal, driving the car, chatting on the phone, socialising with certain friends, drinking tea/coffee/alcohol. For some people, the feel, smell and sight of a cigarette and the ritual of handling, lighting and smoking the cigarette are all part of the enjoyment and pleasure of smoking. Within a short time, smoking becomes anchored in daily life, and often becomes an unconscious habit where a pack of 20 can be smoked without the person remembering many of the individual cigarettes.

Psychological Dependence

Emotional dependence is a feature of tobacco use and can manifest itself in many ways.

Smoking is often used as an aid to reduce and/or control negative feelings of anxiety, frustration or anger. Cigarettes are often used to cope with stress and the level of consumption may increase when a person feels under pressure. However, because nicotine is a stimulant it doesn't actually help a person relax – a smoker will "feel better" because having a cigarette will restore nicotine levels in the body preventing withdrawal.

Many smokers use cigarettes to give structure to their daily routine by providing breaks – for some this may be when they meet up with fellow smokers, for others it may be time to be alone. This behaviour can be triggered by boredom, loneliness or excitement.

Smoking is sometimes used to convey confidence and create an impression that a person is in control; it can be an ice-breaker in social situations for many individuals.

Tobacco Dependence Shows Many Features of a Chronic Disease

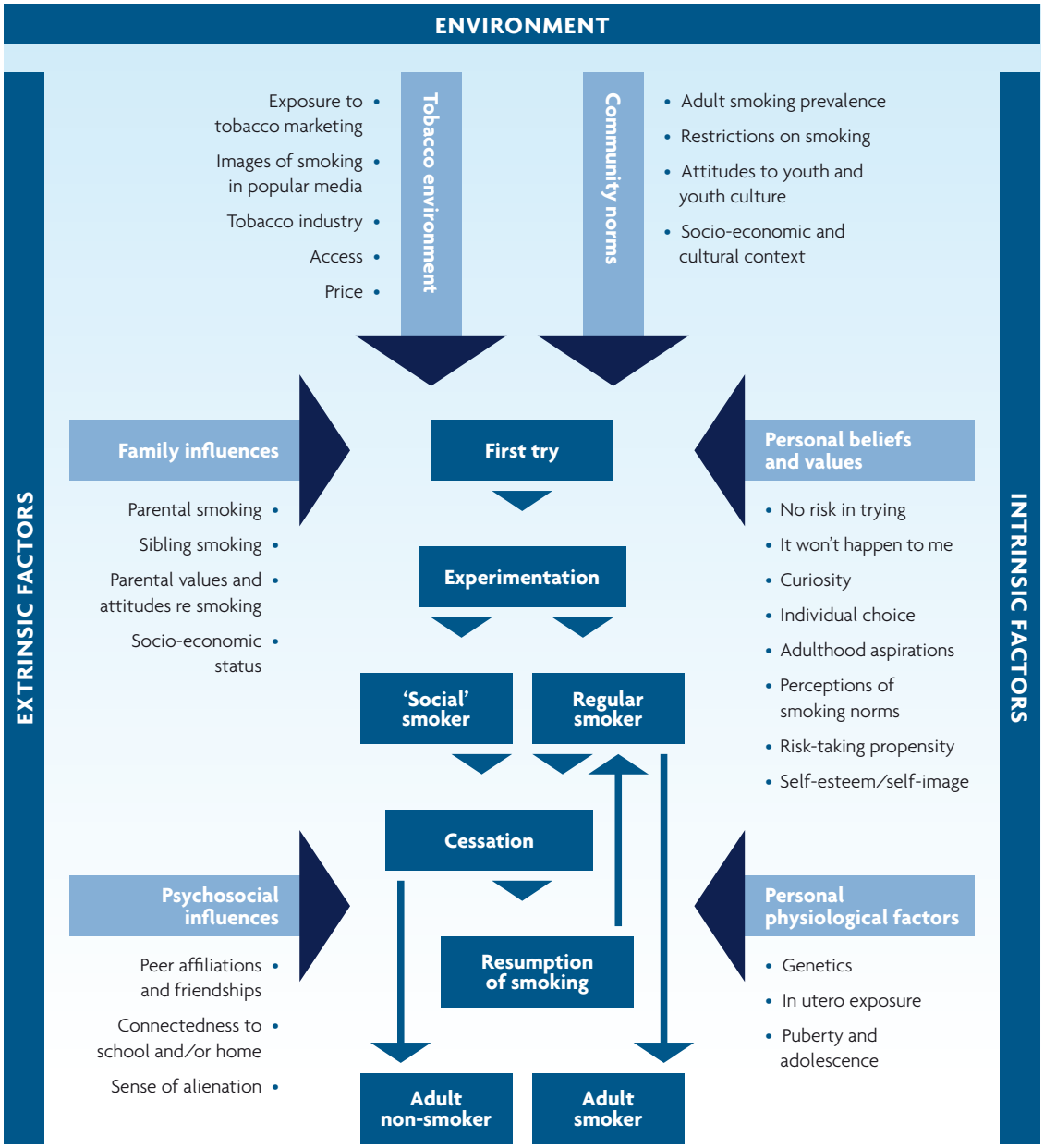
Seven out of ten smokers want to quit and four out of ten smokers make a quit attempt every year. However, only a small minority of smokers will quit successfully in an initial quit attempt. The majority of users continue to smoke for many years and typically cycle through multiple periods of relapse and remission.

Tobacco dependence is a disease that deserves treatment in the same way as other chronic diseases. Effective treatments have been identified and should be used with every smoker.

What Support Does a Person Need to Increase Their Chances of Making a Successful Quit Attempt?

- Supportive environment
- Support from health professionals
- Easy access to smoking cessation support
- Personal coping strategies
- Family support
- Support of pharmacological aids in some cases

The Story of Smoking



Scollo MM, Winstanley MH Tobacco in Australia: Facts and Issues. Third edition. Influences on Uptake of Smoking 2008.

Withdrawal Symptoms

Quitting smoking brings about a variety of physical and psychological withdrawal symptoms. For some people, coping with withdrawal symptoms is like riding a roller coaster – there may be sharp turns, slow climbs, and unexpected plunges. Most physical symptoms manifest within the first one to two days, peak within the first week, and subside within two to four weeks. Any new symptoms should be notified to a health professional, especially if severe. Recent medication changes and caffeine intake can have an impact on symptoms. It may take longer to break the psychological dependence caused by constant triggers and social cues associated with smoking.

SYMPTOM	CAUSE	DURATION	RELIEF
Craving for a cigarette	Nicotine is a strongly addictive drug, and withdrawal causes cravings	A craving for a cigarette can last for between 3-5 minutes frequently for 2-3 days; can happen for months or years	Wait out the urge, which lasts only a few minutes Distract yourself Exercise (take walks) Drink a glass of water or fruit juice Breathe slowly and deeply Use of a nicotine medication may help
Irritability	The body's craving for nicotine can produce irritability	2-4 weeks	Take walks Try hot baths Use relaxation techniques
Dizziness	The body is getting extra oxygen	1-2 days	Use extra caution Change positions slowly
Chest tightness	Tightness is likely due to tension created by the body's need for nicotine or may be caused by sore muscles from coughing	A few days	Use relaxation techniques Try deep breathing Use of NRT may help
Constipation, stomach pain, gas	Intestinal movement decreases for a brief period	1-2 weeks	Drink plenty of fluids Add fruit, vegetables, and whole-grain cereals to diet
Cough, dry throat, nasal drip	The body is getting rid of mucus, which has blocked airways and restricted breathing	A few days	Drink plenty of fluids Avoid additional stress during first few weeks

SYMPTOM	CAUSE	DURATION	RELIEF
Depressed mood	It is normal to feel sad for a period of time after you first quit smoking. Many people have a strong urge to smoke when they feel depressed	1-2 weeks	Increase pleasurable activities Talk with your clinician about changes in your mood when quitting Get extra support from friends and family
Difficulty concentrating	The body needs time to adjust to not having constant stimulation from nicotine	A few weeks	Plan workload accordingly Avoid additional stress during first few weeks
Fatigue	Nicotine is a stimulant	2-4 weeks	Take naps Do not push yourself Use of a nicotine medication may help
Hunger	Cravings for a cigarette can be confused with hunger pangs; sensation may result from oral cravings or the desire for something in the mouth	Up to several weeks	Drink water or low-calorie liquids Be prepared with low-calorie snacks
Insomnia	Nicotine affects brain wave function and influences sleep patterns; coughing and dreams about smoking are common	2-4 weeks	Limit caffeine intake because its effects will increase with quitting smoking Use relaxation techniques

Adapted from Materials from the National Cancer Institute, U.S. National Institutes of Health.

Benefits of Quitting

Within 20 minutes	Blood pressure drops, pulse rates drops to normal, body temperature of hands and feet return to normal
Within 8-12 hours	Carbon monoxide levels in the blood start returning to normal and within a few days are the same as non smokers
Within 24-48 hours	Risk of heart attack begins to decrease
Within 48 hours	Ability to smell and taste improves
Within 72 hours	Breathing gets easier as bronchial tubes relax, lung capacity increases
Within 3 weeks	Mucus in the lungs loosen, lung function and circulation improves
Within 2-3 months	Blood flows more easily to arms and legs, lung function begins to increase
After 1 year	Risk of sudden death from heart attack is almost cut in half
After 5 years	The risk of smoking related cancers and stroke is greatly reduced.
Within 10-15 years	Risk of heart attack falls to the same as someone who has never smoked. Risk of lung cancer falls to half that of a non smoker and the risk of cancer of the mouth, throat, esophagus, bladder, cervix and pancreas decreases.

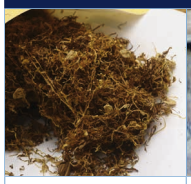
Adapted from Burnside, G. Spiers, A., Winckles, W. Help Smokers Quit Kit. Ulster Cancer Foundation, Northern Ireland; WHO Fact Sheet About Health Benefits of Smoking Cessation; NHS SmokeFree 'Why Quit Timeline'; American Cancer Society When Smokers Quit – What Are The Benefits Over Time?

What is Smoking Costing You?

NUMBER OF CIGARETTES SMOKED EACH DAY	NUMBER OF CIGARETTES SMOKED IN A YEAR	WASTED HOURS	COST PER DAY €	COST PER WEEK €	COST PER MONTH €	COST PER YEAR €
						
5	1,825	122	2.38	16.66	71.40	868.70
10	3,650	243	4.75	33.25	142.50	1733.75
15	5,475	365	7.13	49.91	213.90	2602.45
20	**7,300**	**487**	**9.50**	**66.50**	**285.00**	**3467.50**
23	8,395	560	10.45	73.15	313.50	3,814.25
40	14,600	973	19.00	133.00	570.00	6935.00
60	21,900	1,460	28.50	199.50	855.00	10,402.50

Average cost of a pack of 20 cigarettes is €9.50 as of February 2014. Average cost of a pack of 23 cigarettes is €10.45. Average days in month – 30 days.

Roll Your Own (Based on 50 grams a week)

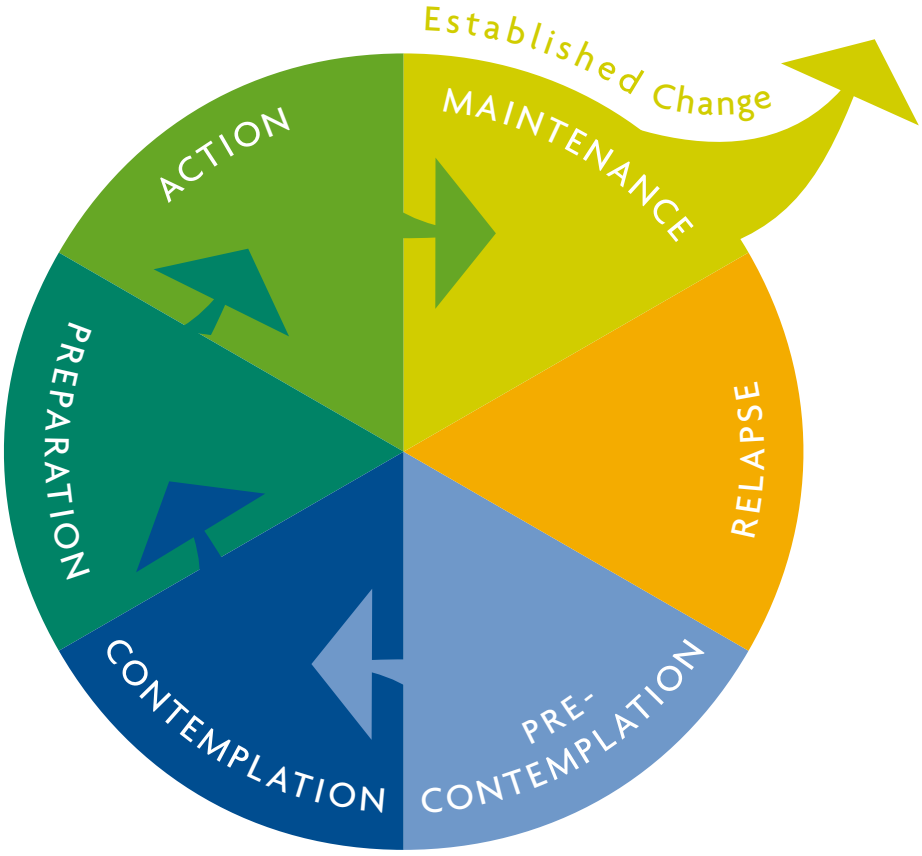
NUMBER OF CIGARETTES SMOKED EACH DAY	NUMBER OF CIGARETTES SMOKED IN A YEAR	WASTED HOURS	COST PER DAY €	COST PER WEEK €	COST PER MONTH €	COST PER YEAR €
						
Variable	Variable	Variable	2.96	20.75	88.80	1,080.40

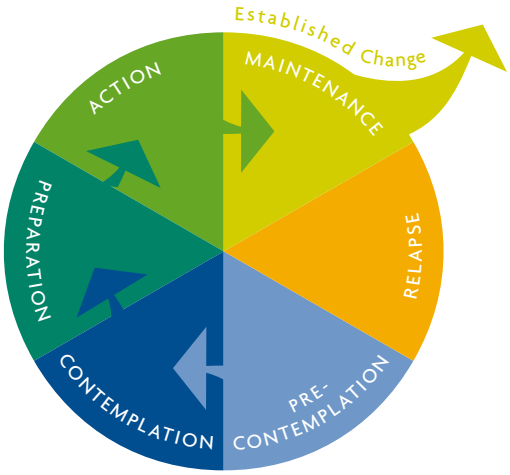
Average cost of a 25 gram pack of roll your own tobacco is €10.38.

3. Stages of Change

Prochaska and DiClemente (1983) described a series of stages through which people pass when making behaviour change. At each stage a person is thinking and feeling differently about the problem behaviour and will find different processes and interventions helpful in moving on. This model is most often pictured diagrammatically as a circle.

The Wheel of Change (Trans-Theoretical Model of Behaviour Change)





Pre-Contemplation Stage

- No interest at all in changing behaviour
- Sees many personal advantages in it
- Has mostly positive thoughts about the behaviour

Contemplation Stage

- Aware of some personal disadvantages
- Has thought about changing some aspects of the behaviour
- Still has many reasons for continuing

Preparation Stage

- Intending to make a change
- Knows why they want to change
- Planning when and how to do it

Action

- Believing that change is possible
- Actually making a quit attempt

Maintenance

- The behaviour change is ongoing
- Able to cope without relapsing
- Support and encouragement needed

Relapse

- This attempt unsuccessful
- Returns to one of the above stages

It is common to go around the model 3-4 times before reaching the maintenance stage, hence its name – the cycle of change/wheel of change. Passing through this cycle will take time, which can be months or years depending on individual circumstances.

4. Brief Intervention for Smoking Cessation

Framework for Brief Intervention for Smoking Cessation

The 5 As

ASK ▶ **systematically identify all smokers at every visit. Record smoking status, no. of cigarettes smoked per day/week and year started smoking.**

ADVISE ▶ **urge all smokers to quit. Advice should be clear and personalised.**

ASSESS ▶ **determine willingness and confidence to make a quit attempt; note the stage of change.**

ASSIST ▶ **aid the smoker in quitting. Provide behavioural support. Recommend/prescribe pharmacological aids. If not ready to quit promote motivation for future attempt.**

ARRANGE ▶ **follow-up appointment within 1 week or if appropriate refer to specialist cessation service for intensive support. Document the intervention.**

Adapted from Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. April 2009.

5. Effecting Change

Client Centred Approach

The client-centred approach considers the client holistically. It is a non-directive behaviour change approach which enhances rapport building. This approach allows the client to accept responsibility for their own health and therefore to set their own goals. The health professional's role is more focussed on listening with emphasis on **how** to say things rather than **what** to say.

Core conditions of client-centred approach

- Acceptance
- Empathy
- Genuineness

While using the client-centred approach, the client:

- Is the expert about themselves and their situation
- Is the decision maker
- Has the right not to change
- Has the capacity to find their own answers, with possible assistance from the health professional

Motivational Interviewing

Motivational Interviewing (MI) is an evidence based clinical method for helping people to make change, first proposed in 1983 by William Miller and further developed in the 1990s by Miller and Rollnick. It is a client-centred, directive, behaviour change approach which resolves ambivalence and resistance. Ambivalence is acknowledged as a significant factor in the change process. Readiness to change is also a central concept as readiness can vary constantly throughout the cycle of change. Recognising where the client is at is the starting point in any consultation and is key to an effective outcome.

The underlying spirit of MI is that change comes from within the individual, not from some outside force. It is the client's place (not the health professional's) to state and resolve their ambivalence. The health professional's role is to draw on and enhance the client's internal motivation to make changes, based on their own decisions and choice. The client is allowed to do their own self persuading and problem solving and is encouraged to state their uncertainty in a clear and complete way. Self motivational statements (change talk) are elicited; this is where the client begins to talk about their need for change, advantages of changing, their ability and intention to change. 'Change talk' leads to commitment and an increased probability of behaviour change.

Five General Principles of Motivational Interviewing (DEARS):

1. **Develop Discrepancy** – facilitate client to identify the discrepancy between current behaviour and future goals.
2. **Express Empathy** – see the world through client's eyes. Be non-judgemental; leave aside one's own views and values.
3. **Avoid Argumentation** – it's counterproductive. Look for inconsistencies and consequences that conflict with important goals.
4. **Roll with Resistance** – defuse the resistance. Be empathetic and non-judgemental and encourage client to develop their own solutions and examine new perspectives.
5. **Support Self-Efficacy** – client is responsible for choosing and carrying out personal change. Belief in the possibility of change is a good motivator and previous efforts and successes can be elicited to build self-confidence.

OARS

Effective motivational interviewing encompasses the following communication techniques commonly referenced by the acronym **OARS**:

- **O**pen ended questions – allows the client to express their perspective and provides insights for the consultation. These types of questions gather broad descriptive information, facilitate dialogue and require more of a response than a simple yes or no. Questions usually go from general to specific and often start with words like 'how' or 'what', 'tell me about' or 'describe'.
- **A**ffirmations – shows appreciation and support for the client's statements. They can be verbal or non-verbal.
- **R**eflective listening – begins with a way of thinking and includes an interest in what the person has to say and a desire to truly understand how the person sees things. It is essentially hypothesis testing; i.e. what you think a person means may not be what they mean. It can done in its simplest form by repeating what the person has just said, rephrasing it by substituting synonyms, paraphrasing and in its deepest form, reflecting back the perceived feelings of the client. Reflective listening adds direction to the consultation and helps focus on change statements.
- **S**ummarising – reinforces what has been said and shows that you have been listening carefully. It draws a number of strands together and clarifies and reflects the clients own thoughts back to them. It prepares the client to move on.

Asking permission has also been shown to be a powerful tool. It communicates respect for the client and results in increased likelihood of discussing change.

In motivational interviewing the focus shifts from giving information and advice, to helping clients explore concerns, uncertainties, reasons for change, and ideas and strategies to make change happen.

Examples of How to Raise the Issue of Smoking Using Non-Threatening Language

What Questions Could You Ask Someone Who Would Like to Quit?

- Tell me a little bit about your smoking?
- You've told me you are a smoker. What do you most enjoy about smoking?
- What's not so good about your smoking?
- What do you remember about your previous quit attempts?
- Why do you want to stop smoking now?
- Have you thought about it before? Yes – how long have you been thinking about quitting?
- What is your understanding of the benefits of quitting?
- What supports do you have in helping you quit?
- How important is this to you (on a scale of 1-10)?
- How confident do you feel that you can quit? (on a scale of 1-10)?
- If you were to set a quit date, when would be a good time to quit?
- How do you think you can be supported?
- What would you like to do with the money you save?

What Questions Can You Ask Someone Who Tried to Quit Before but Didn't Succeed?

- What is it that makes you think you couldn't manage this time?
- Why do you want to stop again?
- What did you use to help you last time?
- How long did you stop for?
- What did you find difficult?
- What do you mean by tried?
- What support did you have?
- What do you think you would or could do differently this time?
- How important is it for you to try and stop again (on a scale of 1-10)?
- What strategies do you think you could use to be more prepared this time?
- How confident do you feel this time (on a scale of 1-10)?

What Questions Can You Ask Someone Who Says "I've Cut Down"?

- What prompted you to cut down?
- What differences have you noticed since cutting down?
- How many have you cut down from – to?
- How are you coping with the reduction?
- Are your family supportive? – In what way?
- What further changes do you feel you could make?
- How have you changed your lifestyle/social circle?

- What is the next step for you? Where do you want to go from here?
- What rewards would help to keep you motivated while you are quitting?
- Let's talk about how tobacco dependence treatments could help you to quit completely.

What Questions Can You Ask Someone Who Says They Have Stopped?

- Well done. How did you do it?
- What is the next step for you?
- How are you coping with it?
- What strategies do you use?
- What support do you have?
- Do you feel better now? In what way?
- How have you managed around other smokers?

Responses for Challenging Statements

Statement 1

"My granny smoked 40 a day and she lived well into her eighties."

Response:
How does that make you feel about your tobacco use?
What was her health like for the latter part of her life?
Did she ever try to stop? Why do you think that was?

Statement 2

"Well, I have cut down and changed to a 'lighter' brand."

Response:
What made you decide to do that?
How do you feel now that you have done that?
Where do you want to go from here?
Why do you feel that smoking 'light' cigarettes will protect you?

Statement 3

"I've tried to stop so many times in the past and it just doesn't work".

Response:
Why do you think it hasn't worked before?
What do you think you could do differently this time?

Statement 4

"I have almost managed to stop, but my partner smokes and I keep having the odd one with him."

Response:
How does that make you feel?
What would you like to do?
How does your partner feel about you smoking?
What support would you need to make that final effort to quit?

Statement 5

"What's the point – the damage is done already."

Response:
What do you think will happen now if you continue to smoke?
How do you think you would feel if you did stop?
Did you ever stop before? How did you feel then?

Statement 6

"It's not like I'm hurting anyone else by smoking."

Response:
Have you ever heard about risks/harm from second hand smoke?
Tell me why you believe your smoking doesn't affect anyone else.
In what way do you think your smoking might be affecting yourself?

Statement 7

"Sure I'm only smoking, it could be worse, I could be doing drugs or something else."

Response:
It sounds like you think smoking is safer than doing drugs?
You seem to believe that 'only smoking' is okay for your health – is that right?

Statement 8

"I don't smoke tobacco anymore, instead I use the Electronic cigarettes."

Response:
Why did you decide to do that.
How does that make you feel.
What do you understand is in the electronic cigarettes.
What is your plan from here.

6. Top 10 Tips for Successful Quitting

1. Prepare to Quit Smoking

Write down your reasons for stopping and keep them close at hand. Weigh up the pros and cons.

2. Make a Date to Quit

Some smokers cut down gradually with a plan for a quit date. However, most people who successfully quit smoking do so by stopping altogether and not by gradually cutting down. Pick your day to quit and stick to it.

3. Support

Seek the support of family or friends.

4. Change Your Routine and Plan Ahead

Smoking is often linked to certain times and situations such as the first smoke in the morning, drinking coffee or alcohol. These are called your triggers. Replace triggers with new activities that you don't associate with smoking. For example, if you always had a cigarette with a cup of coffee, switch to tea for a while; or for two weeks before your quit date have your coffee but practice delaying by five minutes one day, six minutes the next day and so on until you break the association between coffee and smoking.

5. Exercise Regularly

Regular exercise contributes to good health; helps to manage your weight and can also improve the body's ability to meet the demands and stresses of daily living.

6. Think Positive

You may find you experience withdrawal symptoms once you stop smoking. These are very positive signs that your body is recovering from the effects of tobacco. Coughing, irritability and sleep disturbance are some common symptoms. Don't worry, they are all perfectly normal and should disappear within a few weeks.

7. Learn to Deal with Cravings

Cravings can occur frequently during the first few days after stopping. A craving increases in intensity over a period of 3-5 minutes and then begins to subside.

Tips for dealing with cravings – The 4 Ds:

- **Delay** at least 3 minutes and the urge will pass.
- **Drink** a glass of water or fruit juice.
- **Distract** yourself. Move away from the situation.
- **Deep** breaths. Breathe slowly and deeply.

8. Save Money

Start saving the money you would normally spend on tobacco. Work out how much you spend on cigarettes per week, month and year. Then watch your savings grow.

9. Watch What You Eat

If you are worried about gaining weight, be extra careful with your diet. Avoid snacking on chocolate bars and biscuits, try some fruit or chew sugar free gum instead.

10. Take One Day at a Time

Remember, every day without a cigarette is good news for your health, your family and your pocket.

7. Medications for the Treatment of Tobacco Dependence

Long Acting Medications

PRODUCT	USE	ADVANTAGES
Nicotine Patch*	Apply each day to clean, dry hairless skin If using 24hr patch, start with 21mg patch daily if smokes more than 10 cigs/day; can taper to 14mg at week 6 to 8; then 7mg for week 9, 10 *if no cravings* If using the 16hr patch, start with 25mg patch daily if smokes more than 15-20 cigs/day until week 8 completed, taper to 15mg for week 9, 10 and then 10mg for week 11, 12 *if no cravings*	Place and forget Over the counter, can decrease morning cravings if worn at night (24hr patch only)
Champix/ Varenicline*	0.5mg once daily days 1-3 0.5mg twice daily days 4-7 Then 1mg twice daily. Use up to 12 weeks. Extra 12 weeks if required	Reduces withdrawal and may prevent relapse
Zyban* **Wellbutrin SR** **Wellbutrin XL** **Bupropion**	150mg each morning for 3-7 days, then 300mg/day Start prior to quit date Doses must be at least 8 hours apart; take second pill in early evening to reduce insomnia	Less weight gain while using Safe to smoke while taking

DISADVANTAGES	PRECAUTIONS	SIDE EFFECTS	EST COST (FEB 2014)
Passive – no action to take when craving occurs	Not recommended to use while smoking. Use only with doctor's prescription within 4 weeks of heart attack, in patients with serious underlying arrhythmias and worsening angina Not recommended in pregnancy and breastfeeding – use short acting medication with GP prescription	Skin reaction – 50% of patients, usually mild. **Rotate sites* Can experience vivid dreams or sleep disturbance at night with 24hr patch	**Nic CQ** €27 for 1/52 of 21mg, 14mg, and 7mg. €47 for 2/52 of 21mg. **Nicotinell** €25 for 1/52 of 21mg, €25 for 1/52 of 14mg, €24 for 1/52 of 7mg. €61 for 3/52 of 21mg. **Nicorette** €23 for 1/52 of 25mg, 15mg and 10mg.
Passive – no action to take with cravings. Prescription required	Do not use if you have severe kidney disease Not licensed in pregnancy or breast feeding Acute Depressive Disease Black boxed warning for neuropsychiatric symptoms	Nausea (30%) usually mild – can reduce to 0.5mg level. Take with food. Insomnia	4/52 starter pack €131 4/52 1mg bd pack €136 (available on the Drug Payment Scheme and on the GMS scheme)
Side effects common Passive – no action to take with cravings. Prescription required	Do Not Use with: Seizure disorders; current use of Wellbutrin or MAO inhibitors; electrolyte abnormalities; eating disorders Monitor blood pressure Not licensed in pregnancy or breast feeding	Insomnia (40%) Dry mouth Headache Anxiety Rash Flexible dosing (keeping at 150mg/day) helpful with side effects	€110 on DPS per 1 month supply (available on the Drug Payment Scheme and on the GMS scheme)

Short Acting Medications

PRODUCT	USE	ADVANTAGES
Nicotine Gum* 2mg and 4mg	2mg and 4mg (4mg if smokes more than 20 cigs/day) Take every 1-2 hrs as needed. Chew and park	Use as needed Can self dose Available over the counter
Nicotine Inhaler* 15mg	Puff as needed. Use up to 6 cartridges/day, less needed if using combination therapy. Oral absorbed – no need to inhale deeply. Each cartridge lasts for 20-40 minutes of inhaling	Use as needed Mimics hand to mouth action of smoking Advise to use non smoking hand to hold
Nicotine Lozenge* 2mg and 4mg	2 and 4mg (4mg if smokes within 30 mins of waking) Take 1 lozenge every 1-2 hours. Park between cheek and gum – dissolves in mouth. Do not chew or swallow. Use approx 9 per day for first 6 weeks then taper.	Ease of use Over the counter Flexible dosing
Nicotine Quickmist* Mouthspray 1mg per spray	Point the spray nossle towards the open mouth and hold as close as possible. Press the top of the dispenser to release one spray into the mouth, avoiding the lips. For best results avoid swallowing for a few seconds after spraying. Use one spray first and if cravings do not disappear within a few minutes use the second spray. Use when you would normally smoke a cigarettes or have cravings to smoke. No more than 4 sprays per hour or 64 sprays per day.	Use as needed Over the counter Flexible dosing Discrete Fast acting
Nicotine Mini Lozenge 1.5mg, 2mg and 4mg	1.5 and 4mg (4mg if smokes within 30 mins of waking) Take 1 lozenge every 1-2 hours. Park between cheek and gum – dissolves in mouth. Do not chew or swallow	Use as needed Over the counter Flexible dosing Discrete

** Available on GMS. Duo pack quickmist mouthspray available on the GMS.*

Adapted with permission from Dr Michael Steinberg MD, MPH – Tobacco Dependence Program, UMDNJ.

Disclaimer – The above list is meant as a guide only and the manufacturers' instructions should always be adhered to.

Please note the Irish medicines Board have now licensed the use of combination Nicotine replacement therapies – 15mg patch with 2mg gum.

	DISADVANTAGES	PRECAUTIONS	SIDE EFFECTS	EST COST (FEB 2014)
	Difficult to chew	Avoid food and acidic drinks 15 minutes before and while using *(decreased absorption – reduced effect)	Jaw pain Nausea/heartburn if swallowing saliva	2mg €9/30; €25/105; €44/210 4mg €11/30; €35/105; €55/210
	Visible in hand	Avoid food and acidic drinks before and while using. Caution use in asthmatic clients	Cough; throat irritation (usually mild)	€6 for 4 cartridges €28 for 20 cartridges
		Avoid food and acidic drinks before and while using	Hiccups Nausea/heartburn if swallowing saliva	2mg €7.50/20 €25/80 4mg €25/80
		Avoid food and acidic drinks before and while using	Tingling lips if spray comes in contact with lips Mild hiccups Distinctive strong taste due to the strong taste of nicotine	1mg/€29 2 x 1mg (double pack)/€41
		Avoid food and acidic drinks before and while using	Hiccups Nausea/heartburn if swallowing saliva	1.5mg €7.50/20, €21/60 4mg €7.50/20, €21/60

Comparison of Nicotine Delivery Devices

TOBACCO PRODUCTS

NICOTINE DELIVERY DEVICE	NICOTINE IN PRODUCT	APPROX AMOUNT OF NICOTINE DELIVERED	COMMENTS
Marlboro Gold	13mg	1-3mg	Also delivers a wide range of carcinogens and other toxins
Marlboro Red	13mg	1-3mg	
Cigars	10-40mg	Highly variable	
Moist Snuff	3-12mg	Varies depending on ph and other characteristics	

NICOTINE REPLACEMENT PRODUCTS

NICOTINE DELIVERY DEVICE	NICOTINE IN PRODUCT	APPROX AMOUNT OF NICOTINE DELIVERED	COMMENTS
Nicotine Gum	2mg piece	Up to 0.8mg	Only delivers nicotine to user
Nicotine Gum	4mg piece	Up to 1.5mg	
Nicotine Patch **Step 1** **Step 2** **Step 3**		 10mg/16 hours 15mg/16 hours 25mg/16 hours	
Nicotine Patch **Step 1** **Step 2** **Step 3**		 7mg/24 hours 14mg/24 hours 21mg/24 hours	
Nicotine Inhaler	15mg/cartridge	Up to 3mg/cartridge	
Quickmist Mouthspray	1mg per spray	Approx 1mg	
Nicotine Lozenge	2mg	Approx 1mg	
Nicotine Lozenge	4mg	Approx 2mg	
Nicotine Mini Lozenge	1.5mg	Up to 0.8mg	
Nicotine Mini Lozenge	4mg	Approx 2mg	

Adapted with permission from Dr Michael Steinberg MD, MPH – Tobacco Dependence Program, UMDNJ.

Drug Interactions with Smoking

Many interactions between tobacco smoke and medications have been identified. Tobacco smoke may interact with medications through pharmacokinetic or pharmacodynamic mechanisms. Pharmacokinetic interactions affect the absorption, distribution, metabolism, or elimination of other drugs, potentially causing an altered pharmacologic response. The majority of pharmacokinetic interactions are the result of induction of hepatic cytochrome P450 enzymes (primarily CYP1A2). Pharmacodynamic interactions alter the expected response or actions of other drugs. The most clinically significant interactions are depicted in the shaded areas of the table.

DRUG/CLASS	MECHANISM OF INTERACTION AND EFFECTS
Benzodiazepines (diazepam, chlordiazepoxide	• Pharmacodynamic interaction: decreased sedation and drowsiness. • May be caused by central nervous system stimulation by nicotine.
Beta-blockers	• Pharmacodynamic interaction: less effective antihypertensive and rate control effects. • May be caused by nicotine-mediated sympathetic activation.
Caffeine	• Increased metabolism (induction of CYP1A2); clearance increased by 56%. • Caffeine levels may increase after cessation.
Chlorpromazine (Thorazine)	• Decreased area under the curve (AUC) (36%) and serum concentrations (24%). • Smokers may experience less sedation and hypotension and require higher dosages than nonsmokers.
Clozapine (Clozaril)	• Increased metabolism (induction of CYP1A2); plasma concentrations decreased by 28%.
Flecainide (Tambocor)	• Clearance increased by 61%; trough serum concentrations decreased by 25%. • Smokers may require higher dosages.
Fluvoxamine (Luvox)	• Increased metabolism (induction of CYP1A2); clearance increased by 25%; decreased plasma concentrations (47%). • Dosage modifications not routinely recommended but smokers may require higher dosages.
Haloperidol (Haldol)	• Clearance increased by 44%; serum concentrations decreased by 70%.
Heparin	• Mechanism unknown but increased clearance and decreased half-life are observed. • Smokers may require higher dosages.
Insulin	• Insulin absorption may be decreased secondary to peripheral vasoconstriction; smoking may cause release of endogenous substances that antagonise the effects of insulin. • Smokers may require higher dosages.
Mexiletine (Mexitil)	• Clearance (via oxidation and glucuronidation) increased by 25%; half-life decreased by 36%.

DRUG/CLASS	MECHANISM OF INTERACTION AND EFFECTS
Olanzapine (Zyprexa)	• Increased metabolism (induction of CYP1A2); clearance increased by 40-98%. • Dosage modifications not routinely recommended but smokers may require higher dosages.
Opioids (propoxyphene, pentazocine)	• Pharmacodynamic interaction: decreased analgesic effect; higher dosages necessary in smokers. • Mechanism unknown.
Propranolol (Inderal)	• Clearance (via side chain oxidation and glucuronidation) increased by 77%.
Oral contraceptives	• Pharmacodynamic interaction: increased risk of cardiovascular adverse effects (e.g., stroke, myocardial infarction, thromboembolism) in women who smoke and use oral contraceptives. • Risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over age 35 years.
Tacrine (Cognex)	• Increased metabolism (induction of CYP1A2); half-life decreased by 50%; serum concentrations threefold lower. • Smokers may require higher dosages.
Theophylline (Theo Dur, etc)	• Increased metabolism (induction of CYP1A2); clearance increased by 58-100%; half-life decreased by 63%. • Theophylline levels should be monitored if smoking is initiated, discontinued, or changed. • Maintenance doses are considerably higher in smokers.

Rxforchange UCSF, adapted from Zevin S, Benowitz NL. Drug interactions with tobacco smoking. Clin Pharmacokinet 1999; 36: 425-438.

Appendices

1. Tobacco Quiz

1. How many chemicals in tobacco smoke?
   a) 2,000+ b) 4,000+ **c) 7,000+**

2. How many of these chemicals are known to be cancer causing?
   a) None b) 35 **c) 69**

3. On average, by how many minutes does every cigarette shorten a smoker's life?
   a) 30 minutes **b) 11 minutes** c) Not at all

4. What percentage of men in Ireland smoke?
   a) 16% **b) 22.6%** c) 31%

5. What percentage of women in Ireland smoke?
   a) 14% **b) 20.9%** c) 27%

6. How many people die in Ireland, on average each year, from tobacco related diseases?
   a) 3,000 **b) 5,200** c) 7,000

7. How many people are diagnosed with lung cancer in Ireland each year?
   a) 700 b) 900 **c) 1,910**

8. Which type of cancer has the highest death rates among women in Ireland?
   a) Breast **b) Lung** c) Cervical

9. Women who smoke in pregnancy increase the risk of? (choose one or more)
   a) Ectopic pregnancy
   b) Low birth weight babies
   c) Babies which are slower to develop

10. Smoking has no effect on fertility?
    a) True **b) False**

11. Children are more likely to smoke if their parents and/or friends smoke?

a) True b) False

12. Young people who smoke can experience the same level of withdrawal as adult smokers?

a) True b) False

13. It is illegal for under 18s to buy tobacco products?

a) True **b) False**

*Note – It is not illegal for minors to **buy** tobacco products but it is illegal for retailers to **sell** products to minors.*

14. Second-hand smoke can cause increased risk of? (choose one or more)

a) Heart disease **b) Cancer** **c) Asthma and Bronchitis**

15. Smokers inhale 85% of tobacco smoke?

a) True **b) False**

16. Children exposed to second-hand smoke have an increased risk of (choose one or more)

a) Asthma and bronchitis **b) Lower respiratory infections** **c) Middle ear disease**

d) Bacterial meningitis **e) Sudden Infant Death Syndrome**

17. What does nicotine do? (choose one or more)

a) Causes addiction b) Nothing **c) Causes increase in heart rate**

18. How quickly does nicotine reach the brain?

a) 10-20 seconds b) 30 seconds c) 60 seconds

19. What does carbon monoxide do? (choose one or more)

a) Displaces oxygen when you inhale

b) Nothing

c) Aids hardening of the arteries (Atherosclerosis)

20. Quitting smoking raises the level of HDL (the good cholesterol) in the body?

a) True b) False

21. What does tar do? (choose one or more)

a) Nothing **b) Causes cancer** **c) Causes smoker's cough**

22. Light/Low tar cigarettes are less harmful than regular cigarettes?

a) True **b) False**

23. Which of the following chemicals are in tobacco smoke?

Nicotine	**Formaldehyde**	**Ammonia**	**Nickel**
Arsenic	**Butane**	**DDT**	**Hydrogen Cyanide**
Lead methanol	**Polonium 210**	**Radon**	**Acetone**

24. In 2008, what was the average cost of a hospital admission for tobacco related illness?

a) €3,700 b) €5,700 **c) €7,700**

25. What percentage of deaths in Ireland is caused by tobacco use?

a) 5% **b) 19%** c) 38%

26. One in every two smokers will die from a tobacco related disease?

a) True b) False

27. People with mental health issues are more likely to use tobacco?

a) True b) False

28. Cardiovascular disease is the most common cause of death in patients with schizophrenia?

a) True b) False

29. How many Irish children does the Tobacco Industry need to recruit each day, to maintain profits?

a) 25 **b) 50** c) 75

2. Five Key Tools for Successful Interventions

1. Framework for Brief Intervention for Smoking Cessation

The 5 As

ASK ▶ **systematically identify all smokers at every visit. Record smoking status, no. of cigarettes smoked per day/week and year started smoking.**

ADVISE ▶ **urge all smokers to quit. Advice should be clear and personalised.**

ASSESS ▶ **determine willingness and confidence to make a quit attempt; note the stage of change.**

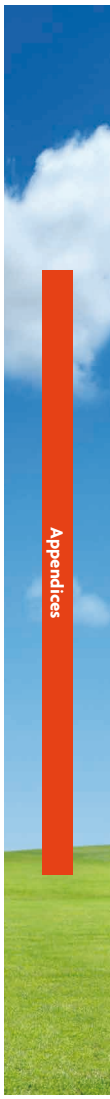
ASSIST ▶ **aid the smoker in quitting. Provide behavioural support. Recommend/prescribe pharmacological aids. If not ready to quit promote motivation for future attempt.**

ARRANGE ▶ **follow-up appointment within 1 week or if appropriate refer to specialist cessation service for intensive support. Document the intervention.**

Adapted from Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. April 2009.

2. Decisional Balance Tool

REASONS TO STAY THE SAME	REASONS TO CHANGE
Benefits: What do you like about smoking? • • • • • •	**Concerns:** What concerns you about smoking? • • • • • •
Concerns: What concerns would you have if you were to quit? • • • • • •	**Benefits:** What are the benefits of quitting? • • • • • •



On a scale of 1-10, how ready are you to quit smoking?

(1 = not ready; 10 = ready)

◄ 1 2 3 4 5 6 7 8 9 10 ►

On a scale of 1-10, how confident are you that, if you tried, you could quit for good?

(1 = not at all confident; 10 = very confident)

◄ 1 2 3 4 5 6 7 8 9 10 ►

On a scale of 1-10, how important is quitting smoking to you?

(1 = not at all important; 10 = very important)

◄ 1 2 3 4 5 6 7 8 9 10 ►

3. Fagerstrom Test for Nicotine Dependence

Score 8+ = high dependence

Score 5-7 = moderate dependence

Score 3-4 = low to moderate dependence

Score 0-2 = low dependence

QUESTION		RESPONSE	SCORE
1.	How soon after you wake up do you smoke your first cigarette?	After 60 minutes 31-60 minutes 6-30 minutes Within 5 minutes	0 1 2 3
2.	Do you find it difficult to refrain from smoking in places where it is forbidden?	No Yes	0 1
3.	Which cigarette would you hate most to give up?	The first in the morning Any other	1 0
4.	How many cigarettes do you smoke per day?	10 or less 11-20 21-30 31 or more	0 1 2 3
5.	Do you smoke more frequently during the first hours after waking, than during the rest of the day?	No Yes	0 1
6.	Do you smoke even if you are so ill that you are in bed most of the day?	No Yes	0 1

Adapted from Heatherton TF, Kozlowski LT, Frecker RC, Fagerstrom KO. The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire. British Journal of Addictions 1991; 86:1119-27.

The most distinctive indicators of nicotine dependence are:

- Time to first cigarette after waking
- The number of cigarettes smoked per day

4. Smoking Diary

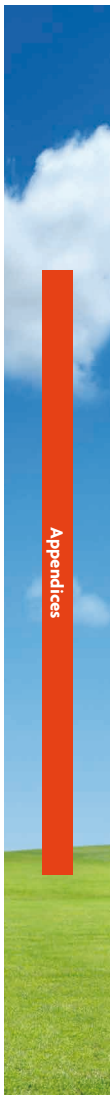
1. Number of Cigarettes Smoked

DAY	MORNING	AFTERNOON	EVENING	TOTAL
1				
2				
3				
4				
5				
6				
7				

2. Other Things to Consider

Why I needed to smoke?	
Where did I smoke most?	
Who with?	
Desire to smoke*	
How much did I enjoy it?**	
How did I feel after?	

** 10 is a very strong desire to smoke, 1 is no desire at all.*
*** 10 is really enjoyed cigarette, 1 is didn't enjoy at all.*



5. Referral Pathways to National & Local Smoking Cessation Support Services

There is a wide range of supports available to help smokers to quit. These include:

1. **QUIT.ie** is a HSE health education website aimed at encouraging smokers to quit. It has information on the health impacts of smoking, benefits of quitting, useful tips on how to measure level of addiction and a cost calculator. There is also an option to sign up to a QUITplan and receive ongoing email support during the first six weeks.
2. **'You can QUIT'** facebook page **www.facebook.com/HSEquit** is an online community supporting quitters through their quit journey.
3. HSE's **National Smokers' QUITline 1800 201 203*** offers a confidential counselling service to anyone seeking support or information about quitting smoking. The service is open Monday to Thursday 09.00-19.00 and Friday 09.00-17.00.
4. HSE **Smoking Cessation Services** provide specialist support to clients either in community or health service settings (see list). Services vary between areas and can include one-to-one, group or telephone support. Services are available free of charge.

HSE DUBLIN MID-LEINSTER	
Dublin South East	01 274 4297
Dublin South Central	01 463 2800
Dublin South West	01 463 2800
Dublin West	01 463 2800
Kildare	01 463 2800
Longford	1800 242 505
Laois	1800 242 505
Offaly	1800 242 505
Westmeath	1800 242 505
Wicklow East	01 274 4297
Wicklow West	01 463 2800

HSE DUBLIN NORTH EAST	
Cavan	041 68 50671
Dublin North City	01 8976184
Dublin North County	01 8976184
Louth	041 68 50671
Meath	041 68 50671
Monaghan	041 68 50671

HSE SOUTH	
Carlow	056 773 4863
Cork City	021 492 1641
Cork North	022 58634
Cork West	021 492 1641
Kerry	066 719 5617
Kilkenny	056 773 4863
Tipperary South	1800 201 203
Waterford	051 846712
Wexford	1800 201 203

HSE WEST	
Clare	065 686 5841
Donegal	1850 200 687
Letterkenny General Hospital	074 912 3678
Galway University Hospital	1800 201 203
Leitrim	1850 200 687
Limerick	061 301111
Mayo	1800 201 203
Roscommon	1800 201 203
Sligo	1850 200 687
Sligo General Hospital	071 917 4548
Tipperary North	1800 201 203

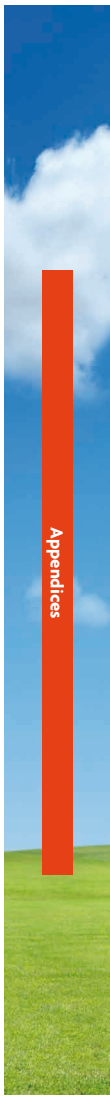
** Please note the national QUITline number has changed from a low call number to a free phone number 1800 201 203.*

3. WHO Code of Practice on Tobacco Control for Health Professional Organisations

Preamble: In order to contribute actively to the reduction of tobacco consumption and include tobacco control in the public health agenda at national, regional and global levels, it is hereby agreed that health professional organisations will:

1. Encourage and support their members to be role models by not using tobacco and by promoting a tobacco-free culture.
2. Assess and address the tobacco consumption patterns and tobacco-control attitudes of their members through surveys and the introduction of appropriate policies.
3. Make their own organisations' premises and events tobacco free and encourage their members to do the same.
4. Include tobacco control in the agenda of all relevant health-related congresses and conferences.
5. Advise their members to routinely ask patients and clients about tobacco consumption and exposure to tobacco smoke – using evidence-based approaches and best practices – give advice on how to quit smoking and ensure appropriate follow-up of their cessation goals.
6. Influence health institutions and educational centres to include tobacco control in their health professionals' curricula, through continued education and other training programmes.
7. Actively participate in World No Tobacco Day every 31 May.
8. Refrain from accepting any kind of tobacco industry support – financial or otherwise – and from investing in the tobacco industry, and encourage their members to do the same.
9. Ensure that their organisation has a stated policy on any commercial or other kind of relationship with partners who interact with or have interests in the tobacco industry through a declaration of interest.
10. Prohibit the sale or promotion of tobacco products on their premises, and encourage their members to do the same.
11. Actively support governments in the process leading to signature, ratification and implementation of the WHO Framework Convention on Tobacco Control.
12. Dedicate financial and/or other resources to tobacco control – including dedicating resources to the implementation of this code of practice.
13. Participate in the tobacco-control activities of health professional networks.
14. Support campaigns for tobacco free public places.

Adopted and signed by the participants of the WHO Informal Meeting on Health Professionals and Tobacco Control; 28-30 January 2004; Geneva, Switzerland.



4. TFU Charter

HPH & ENSH Collaborative Taskforce on Tobacco
Tobacco Free United – (TFU)

As Health Personnel (Doctor, Nurse or Other):

1. **I am conscious of the harmful effects of tobacco**
   - to each smoker/tobacco user
   - to each person who lives with a smoker
   - to society
2. **I know that exposure to environmental tobacco smoke also called "second hand smoke" and "passive smoking" is a widespread source of morbidity and mortality that imposes a significant cost on society.**
3. **I am conscious that tobacco is a drug that causes psychological and pharmacological dependence**
4. **I am ready to motivate tobacco user to quit**
5. **I am willing to discourage tobacco use of any kind:**
   - by presenting myself as a good role model by not smoking or using tobacco
   - by promoting the designation and maintenance of healthcare service as tobacco free
   - by developing skills to clarify tobacco addiction and motivate tobacco users and relatives to quit
   - by promoting tobacco cessation in my social life
6. **I realise that I have a great responsibility, not only towards patients but also to colleagues and to the general public and, in particular, towards the young generations**
   - I incite managers to approve and take appropriate preventive measures

We – as Health Personnel (Doctors, Nurses and other) – join our efforts and strength to reduce tobacco consumption in the knowledge that it is the single most important voluntary risk factor and the cause of many early deaths in our communities.

Name & Surname

Profession

Hospital/Service

City Country

Date / /

Signature

I give permission to publish my name in the Charter Register on paper & web (please tick): ☐

This Charter is based on the TFU Pact on Tobacco for Hospitals and Health Services and can be found online http://www.ensh.eu/tfu-form.php

5. WHO Statement on E Cigarettes

Issued 9th July 2013

Questions and Answers on Electronic Cigarettes or Electronic Nicotine Delivery Systems (ENDS)

What are Electronic Cigarettes?

Electronic cigarettes or ENDS (electronic nicotine delivery systems) are devices whose function is to vaporise and deliver to the lungs of the user a chemical mixture typically composed of nicotine, propylene glycol and other chemicals, although some products claim to contain no nicotine. A number of ENDS are offered in flavours that can be particularly attractive to adolescents. Electronic cigarettes (e-cigs) are the most common prototype of ENDS.

Each device contains an electronic vaporisation system, rechargeable batteries, electronic controls and cartridges of the liquid that is vaporised. The manufacturers report that the cartridges typically contain between 6 and 24mg of nicotine, but sometimes can contain more than 100mg. In the form of tobacco products, nicotine is an addictive chemical that in excessive amounts can be lethal (0.5-1.0mg per kg of weight of the person).

Most ENDS are shaped to look like their conventional (tobacco) counterparts (e.g. cigarettes, cigars, cigarillos, pipes, hookahs or shishas). They are also sometimes made to look like everyday items such as pens and USB memory sticks, for people who wish to use the product without other people noticing.

Are Electronic Cigarettes (ENDS) Safe?

The safety of ENDS has not been scientifically demonstrated.

The potential risks they pose for the health of users remain undetermined. Furthermore, scientific testing indicates that the products vary widely in the amount of nicotine and other chemicals they deliver and there is no way for consumers to find out what is actually delivered by the product they have purchased.

Most ENDS contain large concentrations of propylene glycol, which is a known irritant when inhaled. The testing of some of these products also suggests the presence of other toxic chemicals, aside from nicotine. In addition, use of these products – when they contain nicotine – can pose a risk for nicotine poisoning (i.e. if a child of 30 Kilos of weight swallows the contents of a nicotine cartridge of 24mg this could cause acute nicotine poisoning that most likely would cause its death) and a risk for addiction to nonsmokers of tobacco products. Nicotine, either inhaled, ingested or in direct contact with the skin, can be particularly hazardous to the health and safety of certain segments of the population, such as children, young people, pregnant women, nursing mothers, people with heart conditions and the elderly. ENDS and their nicotine cartridges and refill accessories must be kept out of the reach of young children at all times in view of the risk of choking or nicotine poisoning.

As ENDS do not generate the smoke that is associated with the combustion of tobacco, their use is commonly believed by consumers to be safer than smoking tobacco. This illusive 'safety' of ENDS can be enticing to consumers; however, the chemicals used in electronic cigarettes have not been fully disclosed, and there are no adequate data on their emissions.

Is Use of Electronic Cigarettes (ENDS) an Effective Method for Quitting Tobacco Smoking?

The efficacy of ENDS for helping people to quit smoking has not been scientifically demonstrated.

ENDS are often touted as tobacco replacements, smoking alternatives or smoking cessation aids. But we know that for smoking cessation products to be most effectively and safely used, they need to be used according to instructions developed for each product through scientific testing. There are no scientifically proven instructions for using ENDS as replacements or to quit smoking. The implied health benefits associated with these claims are unsubstantiated or may be based on inaccurate or misleading information. When ENDS are used as cessations aids, they are intended to deliver nicotine directly to the lungs. None of the approved, regulated cessation aids, such as nicotine patches and chewing-gum, delivers nicotine to the lungs. Therefore, the biological mechanism by which smoking cessation might be achieved by delivery of nicotine to the lungs and its effects are unknown. Delivery to the lung might be dangerous. Therefore, independently of the effects of nicotine, it is of global importance to study lung delivery scientifically.

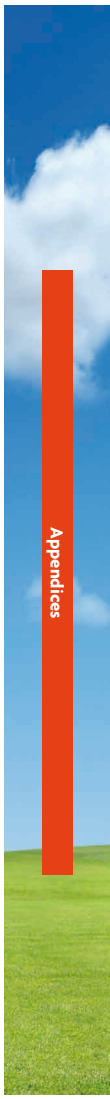
The dose of delivered nicotine is also unknown. It is suspected that the delivered dose varies notably by product, which contain nicotine in various quantities and concentrations.

Conclusion

Until such time as a given ENDS is deemed safe and effective and of acceptable quality by a competent national regulatory body, consumers should be strongly advised not to use any of these products, including electronic cigarettes.

6. Useful Resources

HSE Quit Smoking Website	www.quit.ie
HSE Tobacco Free Campus Policy	www.hse.ie/tobaccofreecampus
HSE National Tobacco Control Office	www.ntco.ie
Cochrane Reviews	http://www.thecochranelibrary.com/view/0/index.html
Treat Tobacco	www.treatobacco.net
World Health Organisation	www.who.int/tobacco/mpower
US Surgeon General	http://www.surgeongeneral.gov/initiatives/tobacco/index.html
National Institute for Clinical Excellence	www.nice.org.uk
Society for Research on Nicotine and Tobacco	www.srnt.org
Society for the Study of Addiction	www.addiction-ssa.org
Agency for Healthcare Quality Research	www.ahrq.gov
National Centre for Smoking Cessation Training UK	http://www.ncsct.co.uk/
Tobacco Free Research Institute of Ireland	http://www.tri.ie/home.aspx



Motivational Interviewing: Preparing People to Change Addictive Behaviour

William R Miller & Stephen Rollnick (1991)

Guilford Press: New York

Motivational Interviewing: Preparing People for Change

William R Miller & Stephen Rollnick (2002)

Guilford Press: New York

Health Behaviour Change: A Guide for Practitioners

Stephen Rollnick, Pip Mason & Chris Butler (1991)

Churchill Livingstone: Edinburgh

Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual

Mary Marden Velasquez, Gaylyn Gaddy Maurer, Cathy Crouch, Carlo C. DiClemente

Guilford Press: New York

7. Bibliography

A Report of the Surgeon General: How Tobacco Smoke Causes Disease: What it Means to You (2010). Available at http://www.cdc.gov/tobacco/data_statistics/sgr/2010/consumer_booklet/pdfs/consumer.pdf

A Report of the Surgeon General: How Tobacco Smoke Causes Disease 2010 – The Biology and Behavioral Basis for Smoking-Attributable Disease Fact Sheet. Available at http://www.surgeongeneral.gov/library/reports/tobaccosmoke/factsheet.html

Babor TF, Higgins-Biddle JC (2001) Brief Intervention for Hazardous and Harmful Drinking, A Manual for Use in Primary Care. Geneva: World Health Organisation.

Brugha R, Tully N, Dicker P, Shelley E, Ward M, McGee H (2009) SLÁN 2007 Survey of Lifestyle, Attitudes and Nutrition in Ireland. Smoking Patterns in Ireland: Implications for Policy and Services. Department of Health and Children. Dublin: The Stationery Office.

Button TMM, Thapar A, McGuffin P (2005) *Relationship between Antisocial Behaviour, Attention-Deficit Hyperactivity Disorder and Maternal Prenatal Smoking*. British Journal of Psychiatry. Vol. 187: 155-60.

Campaign for Tobacco-Free Kids (2012). Available at http://www.tobaccofreekids.org/research/factsheets/pdf/0001.pdf

Cancer in Ireland 2011: Annual Report of the National Cancer Registry (2011). Available at http://www.ncri.ie/pubs/pubfiles/AnnualReport2011.pdf

Department of Health and Children (2013) Healthy Ireland – A framework for improved health and wellbeing 2013-2025). Available at: http://www.dohc.ie/publications/pdf/HealthyIrelandBrochureWA2.pdf?direct=1

Department of Health (2013) Tobacco Free Ireland. Available at: http://www.dohc.ie/publications/TobaccoFreeIreland.html

Fiore MC, Jaén CR, Baker TB, et al. (April 2009) Treating Tobacco Use and Dependence: 2008 Update. Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service.

Grant BF, Hasin DS, Chou SP, Stinson FS, Dawson DA (2004) *Nicotine Dependence and Psychiatric Disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions.* Archives of General Psychiatry. Vol. 61(11): 1107-15. Available at http://archpsyc.jamanetwork.com/article.aspx?articleid=482090

Health Service Executive (2010) Tobacco Control Framework. Available at http://www.hse.ie/eng/services/Publications/topics/tobaccocontrol/tobaccoctrl.pdf

Health Service Executive (2012) Cigarette Smoking Trends in Ireland. Available at: http://www.hse.ie/eng/about/Who/TobaccoControl/Research/

Health Service Executive QUIT Campaign (2014). Available at http://www.quit.ie/en/1_in_every_2_smokers

Howe G, Westhoff C, Vessey M, and Yeates D (1985) *Effects of Age, Cigarette Smoking and Other Factors on Fertility: Findings in a Large Prospective Study*. British Medical Journal (Clin Res Ed). Vol. 290: 1697-700.

Howell F (2011) *Smoking Related Discharges, Bed Days and Costs in the Acute Hospital Sector*. Available at http://www.hse.ie/tobacco/inpatienttobaccouse

International Agency for Research on Cancer (2004) IARC Monographs on the Evaluation of Carcinogenic Risks to Humans: Tobacco Smoke and Involuntary Smoking. Vol. 83. Lyon (France): International Agency for Research on Cancer.

Irish Thoracic Society (2008) INHALE Report, 2nd Ed. Dublin: Irish Thoracic Society.

Le Houezec J (2003) *Role of Nicotine Pharmacokinetics in Nicotine Addiction and Nicotine Replacement Therapy: A Review*. The International Journal of Tuberculosis and Lung Disease Vol. 7(9): 811–9. Available at http://www.ncbi.nlm.nih.gov/pubmed/12971663

Miller BJ, Paschall CB 3rd, Svendsen DP (2006) *Mortality and Medical Co-Morbidity among Patients with Serious Mental Illness*. Psychiatris Services Vol. 57 (10): 1482-7. Available at http://www.ncbi.nlm.nih.gov/pubmed/17035569

Miller WR, Rollnick S (1991) Motivational Interviewing: Preparing People to Change Addictive Behaviour. New York: Guilford Press.

Miller WR, Rollnick S (2002) Motivational Interviewing, Preparing People for Change (2nd ed). New York: The Guilford Press.

National Institute for Health and Clinical Excellence (2006) Brief Interventions for Smoking Cessation in Primary Care and Other Settings, Public Health Intervention Guidance 1: Quick Reference Guide. London: National Institute for Health and Clinical Excellence.

Nilsen P, Kaner E, Barbor TF (2008) *Brief Intervention Three Decades On: An Overview of Research Findings and Strategies for More Widespread Implementation*. Nordic Studies on Alcohol and Drugs Vol. 25: 453-67.

Office of Tobacco Control (2004) Second Hand Smoke – the Facts. Available at http://www.ntco.ie/uploads/final.pdf

Passive Smoking and Children (2010). Available at http://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf

Prochaska JO, and DiClemente CC (1983) *Stages and Processes of Self Change of Smoking: Toward an Integrative Model of Change*. Journal of Consulting and Clinical Psychology. Vol. 51(3): 390-5.

Public Health (Tobacco) Act, 2002. Available at http://www.irishstatutebook.ie/2002/en/act/pub/0006/sec0045.html

Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine. Smoking and Tobacco Control Monograph 13 (2001). Available at http://cancercontrol.cancer.gov/tcrb/monographs/13/m13_complete.pdf

Rogers CR (1951) Client-Centered Therapy: Its Current Practice, Implications and Theory. Oxford, England: Houghton Mifflin.

Rollnick S, Mason P, Butler C (1991) Health Behaviour Change: A Guide for Practitioners. Edinburgh: Churchill Livingstone.

Scollo MM, Winstanley MH (2008) Tobacco in Australia: Facts and Issues. Third Edition. Influences on Uptake of Smoking. Available at http://www.tobaccoinaustralia.org.au/downloads/chapters/Introduction.pdf

Seltzer V (2003) *Smoking as a Risk Factor in the Health of Women.* International Journal of Gynecology & Obstetrics. Vol. 82: 393-7. Available at http://www.ijgo.org/article/S0020-7292(03)00227-3/fulltext

Shaw M, Mitchell R, Dorling D (2000) *Time for a Smoke? One Cigarette Reduces your Life by 11 minutes.* BMJ. Vol. 320: 53. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117323/

Smoking's Immediate Effects on the Body (2009). Available at http://www.tobaccofreekids.org/research/factsheets/pdf/0264.pdf

Stead LF, Bergson G, Lancaster, T (2008) Physician Advice for Smoking Cessation (Review). The Cochrane Collaboration: John Wiley & Sons Ltd.

The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General – Children are Hurt by Secondhand Smoke (2007). Available at http://www.surgeongeneral.gov/library/reports/secondhandsmoke/factsheet2.html

Tsuang MT, Stone WS, Lyons MJ (2007) Recognition and Prevention of Major Mental and Substance Use Disorders. Washington, DC: American Psychiatric Publishing.

Warner KE (2007) *In Search of the Elusive 'Replacement Smoker': Why the Tobacco Industry Hasn't Given Up on Ireland's Kids...and Why You Shouldn't Either.* Available at http://www.ntco.ie/article.asp?article=373

West R, McNeill M, Raw M (2000) *Smoking Cessation Guidelines for Health Professionals; An Update.* Thorax. Vol. 55: 987-99.

What's in a Cigarette Fact Sheet, (2009). Available at http://www.ash.org.uk/files/documents/ASH_117.pdf

World Health Organisation (1993) The ICD-10 Classification of Mental and Behavioural Disorders – Diagnostic Criteria for Research. Geneva: World Health Organisation.

Zwar N. A., Mendelsohn C. P., Richmond R. L. (2014) Supporting Smoking Cessation. British Medical Journal – Clinical Review. Vol 348, pp. f7535. Available at: http://www.bmj.com/content/348/bmj.f7535

Notes

Notes

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Health Service Executive
Health Promotion and Improvement
Health and Wellbeing Division

HPM00865