Executive Summary

Consultation with users of the 2002 NHC Guidelines for Smoking Cessation was conducted in order to identify and quantify its usefulness. This survey was commissioned to inform the scheduled 2005 revision of the Guideline.

This report contains the results of this survey. In-depth interviews were conducted with key informants and a postal and web-based survey was administered to health workers working in the area of smoking cessation.

One hundred and forty-nine questionnaires were completed (42% response rate). In addition, ten interviews were conducted with key informants. The recommendations are based on the results of both the interviews and the questionnaires. Detailed results form the main body of this report.

In summary, the Guideline is used and is deemed to be useful by a large number of those surveyed. However, comments from both the interviewees and the questionnaire respondents indicated that the Guideline needs to be updated. The demographics of clients seen by those surveyed were varied (see Table 10) and included those from the general population, Maori, European/Pakeha, pregnant women and youth. The organisations working with these clients included Primary Health Organisations, Maori and Iwi providers, and educational institutes (see Table 1).

The majority of respondents (65%) wanted to retain the hard-copy booklet and 34% wanted a shorter reminder card. Twenty-two percent preferred a web-based Guideline.

The Guideline was most commonly accessed at training workshops and most respondents used it for reference only (74%) or when talking with clients (60%). Fifty-four percent of respondents used the Guideline only ‘when unsure of something’.

Respondents’ perceptions of the usefulness of sections of the Guideline are described in Table 6 and were mainly positive, with recommendations for future improvements. There were few sections of the Guideline that respondents felt were not useful. However, further comments strongly recommended updating the information and having clearer recommendations for the use of Nicotine Replacement Therapy (NRT) and combination therapies.

There was also overwhelming support for the inclusion of a section on the effectiveness of alternative therapies (see Table 7).
Recommendations

The New Zealand Guidelines Group (NZGG) recommends that an update of the smoking cessation Guidelines be commissioned and that it includes the following:

1. A literature review of the evidence relating to the efficacy of alternative therapies.
2. An understanding of how to assist those who are under 18 years of age.
3. Review of the policy of not prescribing NRT to under-18-year-olds or those who smoke less than ten cigarettes a day.
4. Clear guidelines on Nicotine Replacement Therapy (NRT) during pregnancy and while breastfeeding.
5. A literature review of new evidence on the role of antidepressants in smoking cessation.
7. That the entire document is reviewed for accuracy, eg, Quit for our Kids is no longer a national initiative.

There is no doubt that the 2002 Guidelines for Smoking Cessation has been used extensively in New Zealand. This study gives a clear mandate for providing the resources for revision.
Preface

This document is the final report of a study commissioned by the NHC through the NZGG.

Prior to revision of the current *Guidelines for Smoking Cessation*, the NHC wished to seek input from the people who use the Guideline in their smoking cessation practice. This included practice nurses, Maori health workers, iwi health workers, Pacific Island health workers, general practitioners, primary health organisations and occupational health nurses.

Primary data was collected from key stakeholders in in-depth interviews. These interviews informed the recommendations and the development of a questionnaire. The questionnaire was posted to a sample of health workers who were known to have used the *Guidelines for Smoking Cessation*. 


Acknowledgements

The New Zealand Guidelines Group subcontracted Isobel Martin PhD from Omega Research, to undertake this survey. Information in this report has been gleaned from many sources and Isobel would like to record her grateful thanks to all those who gave so generously of their time and resources.

In particular, special thanks to those participants who took the time to answer the questions and/or return the questionnaire. Their input has been invaluable.

Grateful thanks also to Rowena Cave and Catherine Marshall of NZGG, Michele Grigg of The Quit Group, Barbara Langford of the National Health Committee, Tahu Potiki Stirling of Te Hotu Manawa Maori, Stephen Cook of Quit Cards Programme and Dr Marewa Glover of the University of Auckland for their helpful comments and input. A special thanks to Phillipa Scott for her superb and very patient editorial input.
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Background

The background to this survey is as described in the ‘Request for Proposals’ issued by the NHC in 2005.

In 1999, the NHC published the first version of *Guidelines for Smoking Cessation*. This Guideline was developed for use by health practitioners, based on good evidence that even brief advice from health professionals has a significant effect on smoking cessation rates. The advice given in the Guideline was based on systematic reviews of evidence of the effectiveness of interventions and current practice. The Guideline was reviewed again in 2002, with a further and fuller revision planned for 2004. In both versions of the Guideline there was significant stakeholder involvement. However, the NHC decided that before a review of the Guideline is undertaken, a survey of users should be carried out to establish their needs.

The aim of the Guideline is to increase the quit rate among smokers seen by health workers. It is designed to:

- reinforce the importance of smoking as a preventable risk factor for disease that is amenable to health practitioner intervention
- promote the integration of smoking cessation interventions into routine clinical care throughout the health system
- improve the information and support given to people who want to stop smoking
- ensure health workers feel confident in the advice they give and the resources available to support smoking cessation.

The overall objective of the survey is to inform any subsequent review of the Guideline. The specific aims of the survey are:

1. to identify how useful the Guideline has been
2. to establish the form in which the Guideline would be most useful to users ie, hard copy, web-based, summary sheets etc
3. to identify what parts of the Guideline worked and what did not
4. to identify what would need to change in any further version.
Methods

This was a two-stage mixed methodology exploratory study.

Stage One

Key informants were identified by the steering committee of the project. A total of ten semi-structured in-depth interviews were undertaken. An additional four health professionals discussed the Guideline in brief. Notes were taken, transcribed and analysed for themes and issues relating to the research objectives.

Stage Two

A postal and web-based questionnaire was developed from issues identified in the interviews with the key informants, discussions with health professionals, Quit Group staff, NZGG staff, evidence in the literature and discussions with NHC experts. The questionnaire was piloted prior to distribution.

A total of 360 health workers who were users of the Guideline were targeted. These were identified by Quit Group staff. Six questionnaires were returned as unknown. A total of 149 questionnaires out of the remaining 354 were completed giving a 42% response rate.

Analysis of questionnaire data

Quantitative data was entered in SPSS 11.0 and descriptive statistics calculated. Comments written on the questionnaires were collated within each question item and summarised within those question domains.

Some questions allowed for multiple responses. The percentage for each response was calculated according to the number of responses divided by the overall number of questionnaires. Therefore, each percentage is discrete.
Results

The topics within this results section are structured in the general order of the questionnaire (with the exception of Question 18). Results from the interviews are included, when applicable, under the questionnaire headings. The question number is alongside each heading to help navigation for those referring back to the questionnaire (see Appendix 2). The topics in the interviews that differed from the questionnaire can be found at the end of the questionnaire topics.

The main issues identified in the interviews and questionnaires are outlined in the results with a representative sample of comments. They include comments on advice to pregnant women, working with adolescents, medication issues (including Nicotine Replacement Therapy [NRT], antidepressants and combination therapy), alternative treatments and the importance of individualising treatment.

Predictably there was a diversity of opinion among the questionnaire respondents and interviewees. A selection of direct quotes (highlighted text) is used to illustrate points. The comments from the questionnaires are listed in Appendix 3 and the theme list for the interviews is in Appendix 1.

Represented Providers
(Question 18)

Some of the respondents work for more than one provider. The majority of the 149 respondents were from PHOs (53%) or hospital settings (17%) as illustrated in Table 1. Ten percent worked for Maori providers and a further 6% for iwi providers with 2% working for Pacific Island providers. The ‘other’ category included: occupational health workers (5%), drug and alcohol related centre (<1%), public health (2%), Corrections Department (<1%), community workers (<2%), Asthma Society (<1%), Independent GP contracted to DHB (<1%), Cancer Society (<1%).

Table 1 Distribution of providers represented in respondents

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>PHO</th>
<th>Maori</th>
<th>Iwi</th>
<th>Pacific Island</th>
<th>Hospital</th>
<th>Mental Health</th>
<th>Educational Institute</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (%)</td>
<td>78 (53%)</td>
<td>15 (10%)</td>
<td>9 (6%)</td>
<td>3 (2%)</td>
<td>26 (17%)</td>
<td>3 (2%)</td>
<td>11 (8%)</td>
<td>17 (12%)</td>
</tr>
</tbody>
</table>

Note: Each percentage is discrete and calculated out of 149 (the total number of respondents)
Availability and Access to the Guideline
(Question 1)

The majority of people received their copy of the Guideline at a training workshop (64%). A further 19% had it posted to them personally and 15% used a workplace copy. Some had received it through more than one means (see Table 2).

Six (4%) respondents did not have a copy of the Guideline available to them.

Table 2

<table>
<thead>
<tr>
<th>Where did you get the Guideline from?</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posted to me personally</td>
<td>28 (19%)</td>
</tr>
<tr>
<td>A colleague gave it to me</td>
<td>7 (5%)</td>
</tr>
<tr>
<td>I use a Practice/workplace copy</td>
<td>22 (15%)</td>
</tr>
<tr>
<td>Downloaded from the Web</td>
<td>6 (4%)</td>
</tr>
<tr>
<td>Got it at a Training Workshop</td>
<td>94 (64%)</td>
</tr>
<tr>
<td>Other</td>
<td>7 (5%)</td>
</tr>
</tbody>
</table>

Note: Each percentage is discrete and calculated out of 149 (the total number of respondents)

Use in the Past Two Years
(Question 2)

In the past two years, 140 respondents (94%) have used the Guideline.

Some of the reasons that the remaining 6% did not use it was that they were ‘too busy’, ‘The NZ Heart Foundation training is more extensive and… refer to that’, ‘too many words when I’m in a hurry’, and ‘haven’t had time…’, ‘funding lost’ and that they ‘remember the training’.

The Guideline was mainly used for reference (74%) and when talking with clients (60%). It was used less often for teaching smoking cessation to other health care workers (26%). Other uses (10%) included for a ‘postgraduate study assignment’ and ‘for developing the Nicotine Dependant Guideline’. See Table 3 for a summary of these uses.

Table 3

<table>
<thead>
<tr>
<th>How the Guideline has been used in the past two years</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In teaching smoking cessation to other health care workers</td>
<td>38 (26%)</td>
</tr>
<tr>
<td>For reference</td>
<td>110 (74%)</td>
</tr>
<tr>
<td>When talking with clients</td>
<td>90 (60%)</td>
</tr>
<tr>
<td>Other</td>
<td>14 (10%)</td>
</tr>
</tbody>
</table>

Note: Each percentage is discrete and calculated out of 149 (the total number of respondents)
How often is the Guideline Referred to? (Question 3)

The majority of respondents used the Guideline when they were unsure of something (54%). A smaller number (28%) used the Guideline every time they conducted an interview. Other reasons for referring to it varied from looking at specific issues like NRT in pregnancy to training or working with clinical staff, and as a refresher.

... when discussing the need for NRT in pregnancy
... revision and planning before talking with clients
... recommending approaches to others – especially clinical staff.
... to review my knowledge…
... use out Tukana as a back up

Six percent of the total respondents did not refer to it at all and a further 7% did not respond to this question.

Table 4

<table>
<thead>
<tr>
<th>How often is the Guideline referred to?</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every time I conduct a smoking cessation interview</td>
<td>39 (28%)</td>
</tr>
<tr>
<td>Just when unsure of something</td>
<td>81 (54%)</td>
</tr>
<tr>
<td>Other</td>
<td>9 (6%)</td>
</tr>
<tr>
<td>Never</td>
<td>9 (6%)</td>
</tr>
<tr>
<td>No response</td>
<td>11 (7%)</td>
</tr>
</tbody>
</table>

Note: Each percentage is discrete and calculated out of 149 (the total number of respondents)

Helpfulness of the Guideline (Question 4)

The majority (72%) of respondents rated the Guideline as ‘very’ to ‘extremely’ helpful, with 20% finding it ‘not at all helpful’ to ‘somewhat helpful’.

Table 5

<table>
<thead>
<tr>
<th>How helpful have you found the Guideline?</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely</td>
<td>39 (26%)</td>
</tr>
<tr>
<td>Very</td>
<td>68 (46%)</td>
</tr>
<tr>
<td>Somewhat</td>
<td>21 (14%)</td>
</tr>
<tr>
<td>Only a little</td>
<td>9 (6%)</td>
</tr>
<tr>
<td>Not at all</td>
<td>1 (&lt;1%)</td>
</tr>
<tr>
<td>No response</td>
<td>11 (8%)</td>
</tr>
</tbody>
</table>
How useful are the Sections
(Questions 5, 6 and 7)

Overall, the response rates to these questions varied. There were a number of responses for how useful various sections of the Guidelines are (818 in total for all questions) and a lot less for the question about the sections that were not useful (94) and the ones that needed to change (75) (see Table 6).

The sections that were most useful were those on Nicotine Replacement Therapy (76%) and the 5As (69%). The antidepressants section had the lowest response rate for usefulness at 43%.

The responses to the question about which sections were not useful ranged from 2 to 6% for all sections, with both the Evidence summary and the Nicotine Replacement Therapy sections scoring 6%. Twenty-three percent of respondents checked that there were no sections they found ‘not useful’.

Nicotine Replacement Therapy was also the section that the highest percentage of respondents (13%) indicated needed changing. The percentages for the remaining sections ranged from 1 to 6%.

In general, most of the comments related to updating the sections. Below is a commentary of both the interviews and the questionnaires on how useful each section of the Guideline is and what needs to be changed.

Table 6 Usefulness of the Guideline, including areas that need to be changed

<table>
<thead>
<tr>
<th>Sections</th>
<th>Useful</th>
<th>Not Useful</th>
<th>Need to change</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 5As</td>
<td>103 (69%)</td>
<td>5 (3%)</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>Recommendations for primary care providers</td>
<td>80 (54%)</td>
<td>5 (3%)</td>
<td>7 (5%)</td>
</tr>
<tr>
<td>Evidence summary</td>
<td>76 (51%)</td>
<td>9 (6%)</td>
<td>6 (4%)</td>
</tr>
<tr>
<td>Nicotine Replacement Therapy</td>
<td>113 (76%)</td>
<td>8 (6%)</td>
<td>19 (13%)</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>64 (43%)</td>
<td>7 (5%)</td>
<td>9 (6%)</td>
</tr>
<tr>
<td>Combination therapy</td>
<td>79 (53%)</td>
<td>6 (4%)</td>
<td>8 (5%)</td>
</tr>
<tr>
<td>Medicines’ interactions with smoking</td>
<td>79 (53%)</td>
<td>7 (5%)</td>
<td>6 (4%)</td>
</tr>
<tr>
<td>Considerations for special high-risk populations</td>
<td>70 (47%)</td>
<td>5 (4%)</td>
<td>7 (5%)</td>
</tr>
<tr>
<td>Information for patients</td>
<td>81 (54%)</td>
<td>5 (4%)</td>
<td>8 (6%)</td>
</tr>
<tr>
<td>The Guideline Summary</td>
<td>72 (48%)</td>
<td>3 (2%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>None of the above</td>
<td>1 (&lt; 1%)</td>
<td>34 (23%)</td>
<td>Not appl.</td>
</tr>
</tbody>
</table>

Note: Each question was discrete. The figures given are for those who responded ‘yes’.
5As
Responses from the interviews indicated that there is ambivalence about the usefulness of the 5As. However, more information was requested. These are indicated by the following comments:

- ... ambivalent as to their usefulness
- ... advice to be tailored to person – followed up with 5As. Need more information to make them effective in their advice
- ... doesn’t use 5As but does them anyway in her own way
- ... the 5A approach and the Cycle of Change model are central to the process and should be maintained
- ... don’t use 5As – as written, it looks as though one person does all – just needs one person to do one point and they’ve done it well

The 69% of questionnaire respondents that find the 5As useful contrasts with the ambivalence of those that were interviewed. Twenty eight of the 29 comments were positive. Respondents felt that they were a good formula ‘to ensure nothing is left out’ and that it ‘helps to keep the interview focused’.

For those that wanted to see a change to the 5As section it was suggested that the word ‘smokefree’ be used and that it would be helpful if this section was ‘bullet pointed’ as the information gets lost in so many words, and a change to a ‘less busy’ format.

Recommendations
The majority of respondents from the questionnaires thought that the recommendations section was useful. However, many suggested including a referral to an appropriate service. This topic was not addressed with the interviewees.

Fifty-four percent of respondents found the recommendations section useful, with only 3% indicated they were not useful and a further 5% that they needed changing (see Table 6). Two suggestions for change were to have a guideline for patients on how ‘often they can apply for subsidized NRT’ and ‘to have a focus for Maori providers methods…’

Evidence summary
While the evidence summary was thought to be useful by 51% of respondents, one respondent thought it should be updated and another did not use it at all. One respondent identified that it would be helpful if more of the evidence used was New Zealand based. Another identified the need for more information and evidence on the safety of NRT in acute disease.

Nicotine Replacement Therapy
The NRT section was considered to be the most useful part of the Guideline (76%). It was also the one that had the highest number of respondents wanting to change (19%). Some of the ways that respondents indicated they would like to see the section updated was in regard to the evidence, as well as the cost and subsidies available for each type of
medication, including the different brands (e.g., Habitrol, Nicotrol). Another respondent identified that the NRT section needed updating because the government regulations have changed.

It was also suggested that there needs to be more information regarding how often they can apply for subsidised NRT when they have been unsuccessful.

**Antidepressants**
The interviewees thought that stronger evidence is needed to justify the recommendation of using antidepressants in conjunction with NRT, as the opinion about effectiveness in this area is divided, as can be seen from the following comments:

... Zyban is superior to Nortriptyline

... Nortriptyline – sceptical – what is the level of evidence

... Nortriptyline – a lot of GPs advocate Nortriptyline – didn’t think they needed it – one or the other If had no mental health issues ?need it? Need more evidence, Guideline for practices

... Zyban – evidence [is] needed [for the use of this]

... [There is] no point using an antidepressant [and] NRT. [It] seems inconsistent

Forty-three percent of the respondents to the questionnaire indicated that the antidepressant section was useful, with 6% indicating it needed to be changed (see Table 6).

For 5 out of 16 of the respondents who wrote a comment, this section was not used, as they either do not prescribe antidepressants or have not needed to at this point in time.

**Combination therapy**
While 53% of respondents felt the section on combination therapy was very helpful, there were others (5%) who would like it to be changed. Comments included that more information or evidence regarding this is required.

Interviewees thought that more information was needed about the effectiveness and recommended prescribing of combination therapy.

... [this section] needs to be updated [to include] NRT [and] gum [and] patches

... [the guideline is] fairly generic in [its] use of NRT. Some may require NRT patch [and] gum. Guideline is basic and generic

... In NZ need more use of the inhaler, lozenge, under tongue. Lower, intermittent doses underutilized

... Co-therapy – hasn’t got dosing and weaning down – come off gum first, then patches next

Another comment was, that there needed to be a greater emphasis on for those that are highly addicted – with patches and rapidly acting co-therapy
Medicines’ interactions with smoking
A small majority of respondents found this section on the interactions of smoking with particular medicines useful, a smaller proportion found that it was not useful (4%) and felt that it needed changing (4%)

Comments on this section included that it needed to be ‘jargon free’ and that it would be helpful if this section had a wider, specific medications list.

High-risk populations
Forty-seven percent of respondents felt that the considerations for high-risk populations were useful, with 5% wanting to see a change in the section.

There were several suggestions for high-risk populations. These included that it ‘takes longer for Maori women to quit – recommend using NRT for longer’, and that there needed to be a ‘referral for pregnant women to go to Smokechange’. Respondents also wanted to include information on Education for Change Ltd ‘Smokechange’ program that provides specialist support for pregnant women and their families.

There also needs to be clear recommendations for assisting clients with immediate post-myocardial infarction. There was also a query about adding specific needs for migrants.

Patient information
Fifty-four percent of the respondents found the section with information for patients useful. Six percent felt that it needed changing. Generally, the comments relating to the patient information were all positive, although it was suggested that the information be summarised into ‘easy wording’. They felt that it needed to be simplified and that it could be provided as a handout sheet or pamphlet. It was suggested that a flip card could be developed that can be used when talking with clients.

Summary
Forty-eight percent of respondents found the Guideline summary useful, with a very small number finding that it wasn’t useful (2%) and that it needed to be changed (1%). Comments were that the algorithm was particularly useful, although it needs updating.

Alternative Treatments
(Question 8)
Of the 149 respondents, 82% (122) thought that it would be helpful to have a section on the effectiveness of alternative therapies. All the listed modalities were selected as being of interest to the majority of respondents (ranging from 57 to 70%). Acupuncture was the most popular (70%), with hypnotherapy and herbal remedies (both 66%) eliciting strong interest. Rongoa is also of interest to just over 50% of respondents.

Only a small number made comments and a lot of comments under the different modalities appear general. Many respondents indicated that their clients ask about alternatives to NRT and they would like more information. Three of the general comments suggested that
an overview of each modality be given. Further comments made under individual modalities indicated that they would like evidence on their effectiveness or usefulness. Other less frequent comments were how to identify whether the practitioner providing alternative therapies is qualified.

Opinion was divided amongst interviewees on the usefulness (or validity) of including alternative therapies in the Guideline.

… [I] would like evidence on hypnosis and acupuncture
… when [I] last looked [I] found little evidence to support hypnotherapy or acupuncture – unless you can find new evidence which supports these, they should not be endorsed, despite anecdotal stories of effectiveness

<table>
<thead>
<tr>
<th>Do you think it would be helpful to have a section on the effectiveness of alternative therapies?</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>104 (70%)</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>99 (66%)</td>
</tr>
<tr>
<td>Herbal remedies</td>
<td>99 (66%)</td>
</tr>
<tr>
<td>Rongoa</td>
<td>85 (57%)</td>
</tr>
<tr>
<td>Other</td>
<td>21 (15%)</td>
</tr>
</tbody>
</table>

Note: Each question was discrete. The figures given are for those who responded ‘yes’.

**Adequacy of Groups Covered**
(Question 9)

Less than 50% of respondents thought that under 18 year olds, pregnant women, lapsed smokers and light smokers were adequately covered by the Guideline (see Table 8) and therefore the majority thought these groups were not adequately covered. Below is an outline of the comments that were made for each group.

<table>
<thead>
<tr>
<th>Do the Guideline adequately cover the following groups?</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18 years old</td>
<td>45 (30%)</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>72 (48%)</td>
</tr>
<tr>
<td>Lapsed smokers</td>
<td>64 (43%)</td>
</tr>
<tr>
<td>Light smokers</td>
<td>57 (40%)</td>
</tr>
</tbody>
</table>

Note: Each question was discrete. The figures given are for those who responded ‘yes’.
**Under 18-years-old**

Strong themes came through from the 30 respondents that commented on whether the information for under 18-year-olds was adequate. For those who work with clients in this area, there is a need to have more information (9 of 30) with youth specific resources (11 of 30). Four respondents identified that more information is required about NRT for this age group.

The following comments were made:

… there is a need for information/evidence on treatment of those under 18 years old and the development of ‘youth friendly’ resources

… Guidelines are currently directed towards adults – dealing with and options for under 10 year olds is not really addressed.

… this is a high risk target group yet there is inadequate information and support programs for them. Would like to see more focus on how to support rangatahi.

The questionnaire respondents reflected the views of a substantial number of interviewees, who did not think that the Guideline adequately covered under 18 year olds. They also felt there was no evidence to support interventions for youth.

**Pregnancy**

There were less comments for this section compared with those for those under 18 years old, even though only 48% of respondents found that the information was adequate. Two comments mentioned addressing the issue in a way that does not enhance the ‘guilt’ associated with smoking during pregnancy. There were five comments regarding NRT and pregnancy or breastfeeding. Generally, the comments called for more information regarding smoking during pregnancy.

… more information on ‘foetal tobacco syndrome’.

… more information on best practice that empowers rather than leaves them feeling guilty and averse to seeking further help.

The interviewees also thought that the recommendations for pregnant women could be improved. They indicated it would be helpful to have information about evidence regarding the safety of NRT in pregnancy. Representative comments include the following:

… should advise to quit as soon as possible

… would like clearer section on smoking in pregnancy – advice

… NRT in pregnancy and breastfeeding women. Seems contradictory – is it dangerous or OK[?]?

… it would be helpful to have a section on ‘foetal alcohol syndrome’
**Lapsed smokers**

The majority (57%) of questionnaire respondents indicated that the information for lapsed smokers was inadequate. From the twelve comments received it is clear that this is something that happens frequently and that other strategies would be welcome.

… Most of [my] clients experience that the medication is not strong enough as they lapsed 3–4 times. The guidelines should have other strategies for it.

… maybe need more information specific to lapsed smokers.

… they have to wait a year if tried patches…

The interviewees agreed with the views of the questionnaire respondents.

… more information is needed for treatment of lapsed smokers and how to deal with ‘I’ve tried it all’

**Light smokers (less than 10 cigarettes per day)**

Sixty percent of respondents thought that the Guideline did not adequately cover light smokers. The comments received include:

… I would like more information on people who cannot get off the last 2 smokes.

… this is a difficult group because they probably don’t need NRT but have it fixed in their mind that they do.

A view of one of the interviewees was:

… there is more information needed on treating light smokers – ‘how do you help people who cannot get over the last 2 smokes’. There also needs to be a reassessment of the recommendation that only those who smoke > 10 a day qualify for subsidized NRT. A person may be classified as a ‘light smoker’ but may inhale deeply

**Format of the Guideline**

(Question 10)

It was suggested that the main issues, recommendations, information be put at the beginning of the Guideline and that the methodology ranking evidence etc should be an Appendix at the back. Comments from the questionnaire respondents include:

… markers that stick out for quick reference.

… keep it simple, user friendly for a busy practice. Flow charts [are] a good idea.

… keep it concise so that it still easy to use.
The opinion of interviewees was largely in favour of the current format of the Guideline, although there were some requests for changes. There was a strong call to keep it friendly and simple.

… print too small
… guideline is a good, small booklet + 1 pager
… useful for setting best practice
… tend to look them up on specifics
… very useful as a tool in terms of encouraging HPs to undertake brief interventions
… useful as a resource, reference – medical professionals checking own practices
… slightly more level of detail
… include evidence for hypnotherapy

**Preferred Access of the Guideline**
*(Question 11)*

Sixty-five percent of respondents preferred having a hard copy of the booklet, with 34% wanting a shorter reminder card. Less than quarter would prefer a web-based guideline.

<table>
<thead>
<tr>
<th>How would you prefer to access the Guideline…</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web-based Guideline</td>
<td>33 (22%)</td>
</tr>
<tr>
<td>A hard copy booklet</td>
<td>97 (65%)</td>
</tr>
<tr>
<td>Shorter reminder card</td>
<td>51 (34%)</td>
</tr>
</tbody>
</table>

Note: Each question was discrete. The figures given are for those who responded ‘yes’.

**Evidence behind the Recommendations**
*(Questions 12, 13 and 14)*

Sixty-three percent (*n=94*) of respondents felt that the Guideline provided sufficient information about the evidence behind the recommendations.

Fifty-three percent (*n=79*) of respondents felt it would be helpful for detailed evidence table to be available on the Web.

Fifty-eight percent (*n=86*) of respondents felt it would be helpful to have a ‘Companion Guide’ for the consumer.
Demographics of Clients and Appropriateness of the Guideline
(Questions 15 and 16)

Generally, respondents had a range of clients with the majority from the general population (71%). These included a mix of European/Pakeha (64%), Maori (60%) and Pacific Island peoples (40%). Youth (33%), pregnant women (30%) and mental health consumers (26%) were also represented (see Table 10).

Table 10

<table>
<thead>
<tr>
<th>Demographics of clients</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td>89 (60%)</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>60 (40%)</td>
</tr>
<tr>
<td>European/Pakeha</td>
<td>96 (64%)</td>
</tr>
<tr>
<td>General population</td>
<td>106 (71%)</td>
</tr>
<tr>
<td>Youth</td>
<td>49 (33%)</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>44 (30%)</td>
</tr>
<tr>
<td>Mental health consumers</td>
<td>38 (26%)</td>
</tr>
</tbody>
</table>

Note: Each question was discrete. The figures given are for those who responded 'yes'.

The majority (78%) of respondents felt that the Guideline was appropriate for the populations they were working with. Ten percent indicated that the Guideline did not meet their requirements. The remaining respondents either did not have a Guideline or did not respond to this question.

Questions Frequently Asked
(Question 17)

The questions asked by clients largely related to medication, what to do when an attempt at quitting fails, and appropriate alternative therapies. Long-term smokers also want to know what the benefits of quitting will be after smoking for so long.

‘Teenagers with a blank look [curtains down over the eyes] [say...] “How can I stop smoking and still be with my smoking friends and drinking alcohol as before? Can I only smoke the greenstuff [cannabis]?”’
Complexity

Several respondents requested an acknowledgement of the complexity of changing smoking behaviours. Smoking is not an isolated issue and other issues may need to be addressed in conjunction with smoking cessation advice.

… If smoke <10 a day don’t give NRT but they may be heavy inhalers (several respondents mentioned this).

… Got to a more complex stage in NZ. Need more guidance for relapsed smokers. Suggest a flowchart: Ask → Advise → No, I’ve tried → Then what does the Dr do if they don’t want to try again.

… The one pager undermines the complexity of working with Aukati. Quitline is a short-term intervention, Aukati long term, face to face. Weekly visits for 4 months etc. Not just dealing with smoking – lots of other things. A little bit of an underestimation of the complexity.

Tailoring Treatment

Tailoring treatment was discussed in the interviews, and many interviewees indicated they wanted more emphasis on individualising treatment especially for those who had tried to quit previously and had not succeeded.

… Doesn’t educate need to tailor product and dosage

… Guideline needs to be clearer for people who have tried patches or med[ication]s. People who are quitters, are they not interested or not capable? Did Quitline not call them back? How do we reduce harm for those [people]?

… May need to develop a cut down programme with harm minimisation

… Biological monitoring could be used as a tool.
4.0 Discussion

This study shows that the Guideline is a very useful tool for those working with clients who wish to stop smoking. While it is likely that there is a response bias, with those who are interested and familiar with the Guideline being more inclined to return the questionnaires, the data from the questionnaires, in general, supports the comments of the key informants.

While the results are presented with minimal interpretation there were several very clear messages.

1. Treating smoking cessation is a complex issue and cannot be treated in isolation
2. The sections on medication need to be updated
3. More information and evidence is required for alternative therapies
4. The sections on youth and pregnancy are not adequate

The data came from the health workers who actually use the Guideline with their clients. The task now is to consider each of the suggestions and, after testing the appropriateness of each suggestion, incorporate them in the 2005 Smoking Cessation Guideline.

This study provides a clear mandate for investment in the revision of the 2002 Guideline to ensure that it is updated and effective.

Recommendations

The New Zealand Guidelines Group (NZGG) recommends that the National Health Committee (NHC) commission an update of the smoking cessation Guideline that includes the following:

1. A literature review of the evidence relating to the efficacy of alternative therapies.
2. An understanding of how to assist those who are under 18 years of age.
3. Review of the policy of not prescribing NRT to under-18-year-olds or those who smoke less than ten cigarettes a day.
4. Clear guidelines on Nicotine Replacement Therapy (NRT) during pregnancy and while breastfeeding.
5. A literature review of new evidence on the role of antidepressants in smoking cessation.
7. That the entire document is reviewed for accuracy, eg, Quit Kids is no longer a national initiative.
There is no doubt that the Smoking Cessation Guideline has been used extensively in New Zealand. This study gives a clear mandate for providing the resources for revision of the 2002 Guideline.
Appendix 1

Theme List for Smoking Cessation Interviews

The question will initially be very broad in order to illicit spontaneous comment. However, if prompting is required (in order for all issues to be covered) prompts will be used.

Initial question after introduction and ascertaining the interviewee is aware of the Guideline:

Can you tell me about your experience of using the Smoking Cessation Guideline?

Prompts

Where actually are they normally located?

How do you use them?

How helpful have you found them?

How often do you refer to them?

When do you refer to them? (e.g. just for specifics?)

Are there any parts of the Guideline you have found particularly useful?

Are there parts of the Guideline that you have found irrelevant or not useful?

Are there parts of the Guideline you think can be improved? If yes, how could these be improved?

(Depending on how the interview is flowing it may be helpful to take the interviewee through each section of the Guideline).
Appendix 2

Smoking Cessation Guidelines Survey
Commissioned by the National Health Committee

Please tick appropriate boxes. Your help is very much appreciated.

1. Do you have a copy of the Smoking Cessation Guidelines available to you?
   - [ ] Yes
   - [ ] No

   If yes, how did you get it (where did you get it from)?
   - [ ] Posted to me personally
   - [ ] A colleague gave it to me
   - [ ] I use a Practice/workplace copy
   - [ ] Downloaded from the Web
   - [ ] Got it at training workshop
   - [ ] Other……………………………………………………

2. Have you used the Guidelines at any time in the past two years?
   - [ ] Yes
   - [ ] No

   If yes, how?
   - [ ] In teaching smoking cessation to other health care workers
   - [ ] For reference
   - [ ] When talking with clients
   - [ ] Other……………………………………………………

   If no, why not?
   …………………………………………………………………………..
   …………………………………………………………………………..
3. How often do you refer to the Guidelines?

☐ Every time I conduct a smoking cessation interview
☐ Just when unsure of something
☐ Never
☐ Other

………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………

4. How helpful have you found the Guidelines?

☐ extremely  ☐ very  ☐ somewhat  ☐ only a little  ☐ not at all

5. Are there any parts (or subsections) of the Guidelines that you have found particularly useful?
(Tick as many as apply and we would appreciate your comments)

☐ The Five As (pages 5-10)

………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………

☐ Recommendations for primary care providers (p.11)

………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………

☐ Evidence summary (pages 12-14)

………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………

☐ Nicotine Replacement Therapy (pages15-17)

………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………

Survey of Smoking Cessation Guidelines
6. Are there any parts (or subsections) of the Guidelines that you have found not useful?
(Tick as many as apply and we would appreciate your comments)

☐ The Guidelines Summary (Insert)

☐ None of the above

☐ The Five As (pages 5-10)

☐ Recommendations for primary care providers (p.11)

☐ Evidence summary (pages 12-14)

☐ Nicotine Replacement Therapy (pages 15-17)

☐ Antidepressants (pages 18-19)
7. Are there any parts (or subsections) of the Guidelines which you would like to see changed? (Tick as many as apply and what changes would you suggest?)

☐ None of the above

☐ The 5As (pages 5-10)

☐ Recommendations for primary care providers (p.11)

☐ Evidence summary (pages 12-14)

☐ Nicotine Replacement Therapy (pages 15-17)
8. Do you think it would be helpful to have a section on the effectiveness of alternative treatments?
☐ Yes ☐ No
If yes, which ones (we would appreciate your comments)

Acupuncture
☐ Yes ☐ No

Hypnotherapy
☐ Yes ☐ No

Herbal smoking cessation aids (such as Nicobrevin)
☐ Yes ☐ No

Rongoa (Maori Medicinal Practice)
☐ Yes ☐ No
9. In your experience, do you think the Guidelines adequately cover the following groups? (We would appreciate your comments.)

Under 18 year olds

☐ Yes  ☐ No

Pregnant women

☐ Yes  ☐ No

Lapsed smokers (people who had quit but have started again)
10. Do you have suggestions for changing the format of the Guidelines?

☐ Yes  ☐ No

If yes, please explain.

........................................................................................................
........................................................................................................
........................................................................................................

11. Would you prefer:

☐ Web based Guidelines
☐ A hard copy booklet (in the current format)
☐ Shorter reminder card

12. Do you think the Guidelines give sufficient information about the evidence behind the recommendations?

☐ Yes  ☐ No
13. Would you find it useful to have a detailed evidence table on the Web for referral?

☐ Yes  ☐ No

14. Do you think a ‘companion guide’ for the consumer (based on the Guidelines) would be helpful?

☐ Yes  ☐ No

If yes ……. What would you like to see included?

................................................................................................................................................................

................................................................................................................................................................

................................................................................................................................................................

15. Do you work with: (Tick as many as apply but please also circle which would be the majority of your clients)

☐ Maori

☐ Pacific Island

☐ Pakeha

☐ General population

☐ Youth

☐ Pregnant women

☐ Mental Health consumers

16. Are the Guidelines appropriate for the population/s you are working with?

☐ Yes  ☐ No

If no, what would be your suggestions for change?

................................................................................................................................................................

................................................................................................................................................................

17. Are there any questions you are commonly asked by consumers that the Guidelines do not currently address?

☐ Yes  ☐ No

If yes, what are they?

................................................................................................................................................................
18. Please indicate the category of provider you work for

- Primary Health Organisation
- Maori Provider
- Iwi Provider
- Pacific Island Provider
- Hospital
- Mental Health
- Educational Institute

Thank you very much for taking the time to complete this survey.
Your input is invaluable.
Appendix 3

Comments on Questionnaires

Note: Comments are, for the most, exactly as written by the respondent. Any changes for clarification are captured within square brackets ([ ]). A question mark (?) denotes an illegible word.

Question 1
Also utilize other information/educational data obtained from S.C. Training Programme.
New Ethicals catalogue summary copy I have used. Discontinued in the MIMS unfortunately – I wonder why.
Originally had copy from Public Health.
Accessed prior to workshop.
From our PMN? Resource Centre
We use them as a resource with work and supply them to participants on our study days.
Te Aotu Manowa Maori – Aukati Kaipaipa

Question 2
Other – for study
Other – in learning about smoking cessation.
Sometimes.
We have not completed any of the questions other than 18 as it is not appropriate to us.
We act as a conduit? For supply of cards to member practices and as such are not actively involved in service delivery.
Remember the training.
Have alerted PG students to its availability and where to get it. Funding of our smoking cessation program was withdrawn.
Other – during smoking cessation training that I was receiving.
Other – students at high school.
Only recently received it, have yet to fully read.
Flow chart better in a busy practice.
Other – when doing an assignment for a post grad paper.
Used but limited too many words when I’m in a hurry.
Other – pre legislation change 10.12.04 to establish employers obligations etc.
Have not had it to implement. Other training initiatives used.
New Ethicals catalogue summary copy I have used discontinued in the MIMS unfortunately – why I wonder. We do use most Guidelines extensively in our practice.
I have only just started and have only given out 5 cards to date. The NZ Heart Foundation training info is more extensive and therefore I tend to refer to that. I don’t think you need to re-invent the wheel – the info is mostly out there already – it’s just knowing where to get it
When conferring with colleagues.
For developing the Nicotine Dependant Patient Guidelines.
Teaching smoking cessation in group setting with mental health clients.
Haven’t seen it and it has never been promoted to me.
Don’t have a copy.
Haven’t had time to refer to them. Forgot they existed.
I also use my training ? from the Cancer Society a lot.
Use Quit Group guidelines only.
Use occasionally.

Question 3
Other – when I need a specific resource for smoke cessation consultation
When discussing the need for NRT in pregnancy.
For help in doing a case study – reviewing good practice.
Checked it out when I received it to ensure I was ‘up to date’.
When others seek advice from me.
Revision and planning before talking with clients.
Rarely – most info is in my pack when I did training.
At present not at all as I am only at work for short periods in between travelling.
Not keen to look because of so many words.
To double check own info.
Like the Algorithm for quick logical check that steps have been taken.
Giving exerts of info to other staff.
When I feel I need to look up relevant information.
Check for new evidence regularly.
Recommending approaches to others – especially clinical staff.
To update myself and to review my knowledge of what was taught to me.
Preparation for non-smoking education class.
And occasional other times for review/refresh info.
Not often, usually as a reference.
When talking with some clients, health professionals arid in study days.
Use out Tukana as a back up.

Question 4
Wonderful!
The resource is great.

Question 5
The following are the ones I focused on when reading through.
None of the page numbers correspond with the book I have.
Very helpful for my assignment.
All
All good, very helpful
All of these.
Five As
These are useful but many of my clients have already done the first 3As.
Standard advice – concise and practical – especially useful for new nurses? In practice as guideline.
Especially explanation of stages of change etc in Assess. Assist part great too.
The MOH smoking database addresses all of the 5As.
I don’t actually use these but excellent for patients presenting for other issues.
Keeps it focused and helps you not to miss anything.
Very useful. Ask/Assess/Advice/Assist – no problems. Arrange – clients often difficult to contact or ignore contact – cost is a problem.
As a point of reference only.
An easy to remember list of that I have used regularly.
Aukati Kai Paipa program deals with people actually choosing to quit.
Help given clear structure
Because this section provides the foundation for smoking cessation, it is valuable for reference, reminders etc.
Good memory tool which packages all key into one block.
I found them an excellent guideline.
All very good. New ‘Relapse’ booklet (Code 1605) could be referred to.
We put this into pamphlet form to issue to the wards for staff to refer to when approaching patients.
A simple formula to ensure nothing is left out.
Process of cessation providing support
This helps with planned strategy for each patient.
Page 4 summary. The remainder is best accessed from NHF training manual as guidelines sections are difficult to read (for me).
Good if I haven’t done it for a while to jog memory.
Clear. Good teaching tool for others.
Good as a reminder
We have a smoking cessation program based on these points.
A good refresher.
Includes some great tips/suggestions. A good guide to look at.
I personally don’t use this – but very useful for the GP teams delivering our program.
More so in learning stage of training for referral to.
Useful information to refresh memory on advice, assistance when with staff, client or patient.

Recommendations
The advice on the handout is very useful and I often use parts of it.
SLH – currently undertaking a review on smoker/non smoker classification for pts [patients].
Great to see identification of smoking status recommended. It would be good to see referral to appropriate service [with permission]. Recommended.
Including smoking data status on routine data OK. The rest of page 11 should be referral to trained quit coaches.
Very useful. Government’s monopoly of the industry is well supported. However, a mention of private providers re contact ask for a list of smoking options would be helpful to clients and providers.
Use as a referral guideline during prequit sessions.
This is applicable in a range of settings.
Sets out clearly guidelines to follow.
Vital in terms of PHOs giving us relevant info on patients smoking status, or assistance in hospital, back to PROs in community for follow up.
In our Accident Medical Clinic, we routinely enquire re smoking status of every patient.
If a smoker, give the ‘Having a smoke, having a think’ brochure – explain we do run a free clinic if patient is interested.
The 5As are very helpful.
Good to have positive plan to help with risks.
Useful but currently my work is in secondary care.
Incorporated most of these into our program.
Very helpful advice to give patients.
Page 1, 5–10. Smoke, Assessment Quit Checklist Handouts, Nicotine patches.
Not applicable to our service – but we do utilize from bullet point 3 →.
Also used mainly in early days following training but occasionally refer back to these.
Good information to review.

**Evidence summary**
I often use these facts when I am talking to classes at schools re cessation.
Informative.
Good for being sure what has/hasn’t worked – evidence based.
Very useful.
Tend to use ‘benefits of smoking cessation’.
This needs updating.
Assist GPs when concerned with NRT.
Useful statistics which are important to include in guideline publications.
Good references with research backed notes – helpful.
Key points to quote to clients.
A variety of stats that providers, cessation coaches, doctors, nurses and GPs can refer to when talking to patients about smoking.
Would help if page 12 & 13 to consumer satisfaction were in pamphlet or tear off pad for information to handout.
Helps with reinforcing reasons for cessation when people are still considering.
Most people like these facts – good reference section.
Useful summary – used in teaching sessions for nurses.
Great to reinforce the benefits of not smoking to self and clients and colleagues.
Very useful for reference.
Interesting to know numbers and statistics.
Useful to find where to locate further information when clients ask for it.
Not used usually.
Good for using as statistics and evidence with consultation. Well formed steps to follow.

**NRT**

Often clients ask how the product works and if there is anything that will harm them!!
Able to give advice.
Especially for knowledge of other forms of NRT that we don’t provide quit cards for info on other brands other than quit card brands.
Over simplified. NRT is overrated. Statistics and research support quit rates are contested by scientific community. Point prevalence hides the truth about long term quit rates ie, 1 year, 3 years, 7 years. Client remains primed to smoke and relapses.
Use as a reference during quit-date session.
Needs updating.
Just the rationale.
Suggested doses table is useful.
I found the ‘steps for providing NRT’ a useful tool.
Basically covers all forms available and symptoms/contraindications. A comprehensive guideline.
Only prescribed for >10 cigarettes daily unless patient has tried quitting without NRT, when Hobitrol or 2 mg gum prescribed.
Can only use patches in a prison situation.
Most people want this.
But as NRT changes will it need to be updated.
Used in teaching sessions.
Good guide through consultation if unsure.
We subsidise what the government does not pay for so it is free to our patients.
Refer to this the most, write correct dosage and numbers according to how much they smoke.
Contains very useful information – a great starting point.
Always check before writing card – however have to refer to updates.
Used as part of treatment.
Unfortunately, patches change frequently but information is good and often use as a guideline in consultation – side effects info very helpful.
May need updating with new product names.

**Antidepressants**

Not enough information
I often use Nortriptyline in my clinic and have found this to be a huge benefit to some patients.
Good for people who are thinking about using it – so I know a little (am not in the dark/ignorant).
Over simplified. NRT is overrated. Statistics and research support quit rates are contested by scientific community. Point prevalence hides the truth about long term quit rates ie, 1 year, 3 years, 7 years. Client remains primed to smoke and relapses. Use as a reference during quit-date session.
Needs updating.
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Good for people who are thinking about using it – so I know a little (am not in the dark/ignorant).

Good summary.

To date no clients have been referred.

Reference only.

Not prescribed by me so don’t usually refer to it unless patients want to discuss this option.

Aware of this section or use of antidepressants in smoking cessation but, to date, have not needed to advise on this area.

Useful info.

More for the clinical people. But arms us with info when referring to GPs to maybe allow clients to use as another means of quitting smoking.

So far, I have not had to refer patients to a doctor for antidepressants.

Haven’t needed to use this yet.

As useful information.

Haven’t used.

Useful information by Nortriptyline not safe for acute cardiac patients. I cannot find evidence of safety in low doses with cardiac [acute] patients.

I have just found I must have a different resource as nothing on antidepressants and no page 21–23, The book I received was guidelines for smoking cessation July 2001.

**Combination therapy**

I have never use a combination of NRT.

Would like some guidelines for this.

Good summary.
Not referring clients.
Reference only.
Need more info here. Eg, combining patches with gum.
I have not had any problems with this.
Very useful.
Reference only.
I work in the area of mental health.
As a reference.
Would like to see more info re this therapy as I find using NRT in combination (ie, gum & patches) useful for heavy smokers particularly.
In terms of 3–4 quitters, this is a handy recommendation.
Good recommended guidelines for dosage.
Used this for reference.
Useful but not used in acute care but information appropriate when talking to chronic rather than acute cardiac disease.
Not needed.
Have quite a few questions regarding this.
Even though I haven’t needed this I feel it is important to have info on how.
Used now.

Medicines interactions
Please remember that your reading audience may not have medical/health training and keep it jargon free!!
Important advice when dealing with patients whole medical situation.
Important info re interactions.
Working in hospital has huge relevance, many staff members are grateful for information.
Particularly useful.
I ask the doctor when he is on site if not sure re issuing patches.
Haven’t used.
Useful to consider when patients on multiple drugs.
Good for consumers to be reminded.
Reference.

High-risk populations
I have worked on targeting 2nd smoke with adults re their families etc. I have worked with mental health but have found that to be very difficult and have not had a great success rate.
All good to know. Pregnancy – great stuff here but referral to Smokechange should be recommended (and not to give the woman/their partner or family the number → referral comes from the health professional).
Takes longer for Maori women to quit. Recommend using NRT longer.
Very useful.
Good to refer to.
Refer to during pre quit and quit session.
Good – what about a section on migrants/ethnic needs?
Many patients fall in high risk CVD.
Useful as background advice and information.
Table format is easy to me.
Covers all people we work with. Good basic information to refer to.
I work with Maori.
Good to see recommendation for cardiac patients.
Reference
Use the ‘pregnant women’ section.
Pregnant women and under 18s especially.

Patient information
I have a sheet that I give to my patients on how to use their NRT.
Have this as a handout sheet for people who receive a NRT card [modified].
Very useful to copy for clients.
These are very helpful and photocopied to give to clients.
Excellent.
Extremely useful – is in my pack but if I go out it is smaller to take with me.
I photocopy these pages and give to patients.
Use 24–27 regularly.
Needs updating.
Patients needs this material for reference when at home.
Use a handout to patient along similar lines.
Great handouts – motivational.
Good but obviously needs updating.
I found this important and useful to refer to.
Day by day?
Going through the quit book with the patient and giving it to be taken home gives most of the information necessary. While going through the book the opportunity is there to enlarge with the information in the guidelines.
I issue the quit book when they apply to quit smoking program so they are making an informed decision.
Feel like they are taking positive information away but not always used when home.
Very useful.
I think it needs to summarise the information to an easy wording and short to read by the patients.
Good for patients to take home.
Used as a guideline for teaching others and for information for patients etc.
Very useful for patient discussions.
Very useful and used the most along with P9, 15–17. Costs also got to go by.
Good for photocopying and handing out.
I use the quit book.
Summary

I often use the Algorithm when identifying at what stage the client is when I first see them.
Excellent.

Never looked at it – it’s good – I should.

Nice to have.

Useful quick reference.

Very useful.

Kept with information we give clients as a quick reference.

Particularly the Algorithm for smoking cessation.

Especially Algorithm.

Quick checklist too.

Haven’t used the info much except for Algorithm which I use a lot (Use info from other pages).

Useful when tutoring staff on cessation and/or our cessation program.

Especially helpful when speaking to GPs about the use of NRT in pregnancy.

Now out of date.

Use all references and find them all very useful.

Haven’t used.

Excellent section – especially good for promoting the provision of smoking cessation advice and intervention with the Sas.? 

It will be good to be in a size that is small enough to place for view.

Excellent – used the most for one to one teaching sessions with nurses.

Quick reference.

Keep it in my bag for quick reference.

I don’t have this insert.

Clear concise guide.

Excellent

Used most often.

None of the above

Everything has its place.

Also quit cards quit smoking help. Not sure if they should both be incorporated into one text. The summary insert is good but was more useful in New Ethicals where all GPs and nurses could quickly refer to at consultations. Why has it been removed from MIMS when others are continued.

Question 6

No.

No – it depends on the client’s needs case by case basis.

All no.

No all good for reference.

In general language is very academic – more simple language would help busy people extract the info they need more efficiently.

Important to have theory-based research.

Using 1999 book and many of these not included.
Five As
People I deal with have already made the decision to stop so I don’t use but are good for others.
All helpful.
Good info but limit words short and concise is good for me.
New Relapse booklet could be referred to (Code 1605)
Helpful.
No. All areas are very useful.

Recommendations
Maybe some way of identifying who were quit exchange cards/GP surgeries etc are located regionally.
In prison there are different barriers to quitting eg, no work, boredom, peer pressure, lack of money.

Evidence summary
Bit short.
Clients aren’t interested.
Antidepressants. Should be more info on use of Nortriptyline as is subsidised whereas Bupropian is not. I use Medsafe handouts for patient info but gives more confidence if patient sees good info in guideline.
Helpful.
Don’t recall using this at all.

NRT
Now out of date.
Refer to my comments in useful section.
I find the quit cards quit smoking help better detailed for use in answering questions or reference for special situation.
Very helpful to staff at quit time.
Habitrol update.

Antidepressants
As in previous answer. Need patient info on Nortriptyline endorsement.
Needs updating,
No recommended.
We concentrate on NRT firstly.
Needs 2 formats. 1. general overview for information purposes. 2. clinical focus for clinicians. These two uses are currently together and confusing for me as an everyday person but at times needs to respond to questions (basic) on those medications.

Combination therapy
Perhaps need more updated information in this field especially important for dealing with those having a heavy addiction.
Bit more info would be more helpful.
Not possible.
Interactions with medicines
Expand the list.
Helpful.
Can’t remember this part.

High-risk populations
Not interested in these – clients. We as nurses find them interesting.
Some parts.

Patient information
Good information.
Update this info. Better print layout/type would be useful for patients use. Make these stronger
Algorithm, 5As, NRT info expanded.
Good
Quickly outdates. Local summaries found to be more satisfactory.

Summary
None of the above
All this info is in my training pack, was covered at training. Tend not to use this book as I use my
training manual when I see clients.
Out of date info re dosing etc. Leave out the evidence, benefits et. Make it a providers prescribing
sheet etc.
Every bit of information has its place in smoking cessation and promoting good health.

Question 7
No.
All no.
All need updating.
Consumer friendlier, smaller and card like.
A suggestion. A flip card for provider to use with staff, client or patient. One side facing patient with
one or two words on an appropriate picture the side facing the provider with points to jog the
memory and verbally use. Also small magnetic cards for fridges or put with important messages. Eg,
the four As or the four Ds.

Five As
Include the word ‘smokefree’ ie “Are you smokefree?” “Being smokefree is the best thing you can do
for your health.”
Limit words – or bullet point this – good info but gets lost in so many pages.
In terms of assisting with my work I have no reason to see any changes with all this.
Change of format – colours difficult – very busy pages.

Recommendations
Would be good to see referral to appropriate service (with permission) recommended.
Information. If there are any updates then please keep us informed.
Guidelines for giving patients information re how often they can apply for subsidised
NRT when they have failed after using 2 months NRT. What criteria apply to giving a third month eg?
I use the Fagerstrom’s Smoking Tolerance Assessment as assessment form.
It will be good to list providers who also provide the services as well. Most clients prefer to talk in person/face to face about the status of their smoking habit
To have a focus for Maori providers methods for Maori clients.

Evidence summary
Available in written form as information to be handed out.
Could be extended eg the Auit? Group Tobacco Facts cover more topics and are overall simple yet comprehensive.
It will be good if the evidence summary are New Zealand because it was underestimated how we are dealing issue of smoking.
Would be useful to have evidence of safety of NRT in acute disease.

NRT
New products on the market?
Yes.
Clearer info on actual dosing. I know its clear in but even a simpler presentation of all the info more appealing
More information re Habitrol.
Update the NRT and specify the dosage.
Suggest removing name of NRT to suit changes to funding.
Due to change in NRT now subsidized – changed to Habitrol so dosage different to Nicotrol (formally used).
This needs updating because govt regulations change.

Antidepressants
Improve Nortriptyline info page (as is subsidized for patient).
Are there any other evidence based medications as the antidepressant idea puts people off.
Safety of low dose of Nortryptiline in acute conditions.
As nurses we do not prescribe so this section not quite so relevant.

Combination therapy
Would like some guidelines for this.
See comments on page 3 & 5.
We would like to have more information about combination therapy.
More info on using patches and gum – doses etc.

Medicines’ interactions
Create wider, specific medications list.
Is the bottom line that NRT quitting is going to be more beneficial than possible drug reactions.
(Obviously has to be discussed with doctor)
High-risk populations
The Education for Change Ltd smokechange program provides specialist support for pregnant women and their families. Include information on their service and training courses.

Pregnancy – need to have recommendation for referral to Smokechange by the Health professional (referral does not come from the woman herself). Smokechange will also work with partners/families of pregnant women.

Extending time for Maori to be on NRT. Have found that Maori unable to be successful unless NRT is begun earlier during RRP.

For me, big problem is the immediate post MI patient who has been ‘shocked’ into needing to quit but leaves hospital with no immediate availability of NRT or other help. Need definitive guideline about how/when to initiate any NRT or preferred meds. Usually anxious, desperately trying not to smoke and can’t start NRT or Nortriptyline etc.

Patient information
Have as a handout sheet.

More simplistic, bullet points, important info does tend to get lost in all the words.

Provide these in bigger print. Update to current Habitrol etc.

Resources/services perhaps needs to be an easily replaceable insert and needs to make sense at local levels.

Available in pamphlet form when educating patients.

Need to be more appropriate for people with low reading ages.

Remember many learnt by visual pictures.

Summary
See comments in the ‘not useful’ section.

Question 8
Alternative treatments

Not so much the effectiveness, just an overview of alternatives.

Many people request info on this alternative.

What is meant by ‘alternative’? Many more than these. These are the main ways people quit. What about the more standard methods? Cold turkey, stopping without help, getting help from GP & family, cutting down and support groups.

However, I fear the bias towards NRT and the bias against alternative would be a reflection of the current system which does not examine clients’ long term experiences. Perhaps the answer is not to concentrate on effectiveness but rather state what is offered.

For every person quitting there are many stories of reported failures. While brief intervention has its place its importance is over-rated as nicotine addiction is too complex to be addressed just by brief intervention.

All other alternatives that our smokers use to try to quit.

Only if subsidized meds/++ ?

Many patients do try ‘alternative’ therapies so it’s good to be able to recommend the ones that work.

Would prefer to see these alternatives listed as options and perhaps a brief description of them as to date their level of actual effectiveness as such remains unproven – scientifically and clinically.

NRT is proven as an aid to cessation. What evidence is there for the other treatments – info needs to be evidence based.
**Acupuncture**

It would be good to offer people choices other than NRT.
Same as above. Usually those who don’t like drug therapy or who haven’t actually tried anything.
Providing evidence based.
I have had several (2–5) enquiries about this.
Some info for this section can be great to ensure patients are making informed decisions about treatments they have heard of or might like to try.
Evidence based.
Give clients another option if not keen on patches.
Have been asked about this with other therapies.
Yes but has yet to be proven.
Patients often ask re alternative treatments. Be good to have info sheet for all these.
Many of our clients have asked for alternative treatments. I say ‘Whatever it takes’ to help our clients quit.
Work marginally? in small % of smokers (only ? points)
It would be helpful to compare evidence of treatment.
Often asked about alternative treatments availability/effectiveness
Patient often ask about alternative treatments.
Any evidence for/against?
Interesting to see success rates of this.
I haven’t had anyone who has tried this for a long time.
Info on all these treatments should show both sides and not just any positive or negative info.

**Hypnotherapy**

As above
But give recommendations re ‘legitimate’ hypnotherapist identification.
Evidence based.
Yet to be proven.
Then please have this information available.
Works well in small amount of patients, depends on the skill of the hypnotherapist and no drug involve at all the good point.. ?
This would appeal to some smokers.
Does this help – evidence.
Numbers and outcomes.
I haven’t had anyone who has tried this for a long time.

**Herbal**

As above
Evidence based.
My co-worker is interested and practices herbal medicine.
It may help the believers.
Evidence of effectiveness,
Evidence of usefulness.
I am frequently asked about various aids.
I would like to know more.

**Rongoa**
As above
Evidence based.
Out of interest?
No experience of this area.
Unless they are qualified to ? nicotine ?
Sometimes these types of treatment work well.
This may be useful to know although I have never been asked
Evidence – what is used.
Definitely!!
I would like to know more.

**Other**
Nortriptylline tablets/Nasal spray.
“Cold turkey”.
I think that when you are providing evidence for alternative treatments that it is vital that you also provide formation on suitable qualifications/assessment of the providers to avoid poor quality providers.
The Smokefree system – taking back control and other self-help and supportive programs.
Not sure – whatever possibilities.
Reflexology or something not tried because the smoking is only a part of the equation.
Reading the book, don’t know title, smoke all the way through and then stop. Some people really like. I cannot discuss + - because I don’t know. ???
Meditation and relaxation techniques.
Other cultures may have their own unique styles that may help our clients.
I think having the option of alternative therapies would be great for our participants – would be important to note safety during pregnancy too.
We need to combine physical mental and medication on smoking but particularly the way smokers think. I think this will successfully work for the long run.
Books resources Alan Carr?
Any others that people may ask about – these are the most common.
All of them.
It would be good to include the main alternative treatments. Some people prefer/want to know about alternative treatments.
A brief summary of all.
But let’s make it robust! eg evidence based/sound trials.
Reading material the easy way to stop smoking. Anything that is of help.
Individuals should be able to make their own choice from all options.
Allan Carr’s book
Question 9

**Under 18-year-olds**

I would like to have more information as I target secondary schools and need all the help I can get.

Limited info on this group. Not many in this group ask for assistance — often the parent is keen — but not the actual patient.

Age limit for NRT — had 13-year-old in smoking cessation class.

A little more. Consent issue — say something about it to cover community workers and the non-medical group.

I know that we still don’t have enough data on cessation in this group but it is the one I get the most enquiries about!

Could do with more input from age group.

For 77% of smokers this is where the trouble begins.

You just use different language etc but the info is still the same.

I have just started doing smoking cessation so I cannot comment appropriately regarding these questions. I find I use my training resource manual for more than the guidelines.

Would like more info on using replacement therapy for younger children ie those that start smoking 10–12 years when can they use replacement therapy?

Youth friendly version needed. Too much technical jargon for young people to understand. Separate guideline summary.

15-year-old teenagers have just used my book for research for school and thought there should be more youth focused items. I do not work with under 18s so cannot comment personally.

This is the only group I have worked with. They don’t take it very seriously though. An excuse to get out of class.

Not applicable in my practice.

A bit light on stats

Have not had to deal with this age group as yet.

More info relating to NRT and ‘other’ drugs & interaction cannabis, party drugs etc.

To me, it depends on the style of delivery by the quit coach as to how effective this information is in helping our rangatahi. This info is relevant to all smokers and whanau.

Schools programs? How can smoking association practitioners assist in running these programs. This age group needs a lot more input and resources — should be a whole separate resource with age appropriate material and ideas.

But this is a difficult group to reach and educate.

Too much peer pressure for practically any method to work, unless the teenagers ‘idol’ has time (lots of time) to influence and change his or her outlook in life.

We are unable to give NRT. What other strategy works best with this age group.

In general? The guideline is applicable to all subgroups. However, some approach status specific to teenagers would be helpful.

Have very few clients of this age.

Guidelines are currently directed towards adults — dealing with and options for under 18 year olds is not really addressed.

Haven’t used for this.

We should have a part of the guidelines cover the age of under 18 years old. We have several clients in this category so help them with supporting until they get the age of 18 years.
They are a difficult group as in my experience don’t really see the benefits of quitting. Maybe need a more focused section for under 18s.
Actually no, now that you ask.
Need to consider younger age group.
Haven’t worked with this group.
This is a high risk target group yet there is inadequate information and support programs for them. Would like to see more focus on how to support rangatahi.
Under 18 are a growing smoking population – especially Maori. This needs to be addressed with smoking cessation guidelines
I only work with over 20 year olds.
It doesn’t cover them specifically but the same principles apply.
Can be adapted but have rarely had contact with this age group wanting to quite, rather the opposite.
More specific info re patches and changes to doses – although nothing proven to work in this group. Their needs, reasons for quitting and issues around stopping often different to adults, self esteem, peer pressure.
The page have seems adequate. It is brief but to the point. Information received in the quit group NRT health providers exchange card program folder.

**Pregnant**
I usually refer to a specialist smoking cessation counsellor.
See previous suggestions
Include information on ‘foetal tobacco syndrome’.
A lot of midwives have reservations about the use of NRT on pregnant women.
I still don’t feel 100% sure about using during pregnancy.
More info on best practice that empowers rather than leave them feeling guilty and averse to seeking further help.
Perhaps not as motivation levels will be difficult especially with importance of peer interaction. Need special strategies for this age group.
Could be more for working with adolescents. I work with a group on smoking cessation in our high school and it would be great to have more resources.
Could have more details including research findings for all these groups.
Is it possible to have a ? of ante natal class contact in each area?
Include info for breast-feeding mums re OK to use NRT.
Different focus required – they already feel so guilty.
We refer to GP for consideration of NRT.
More up to date info now that there is more research.
For what we use it for it is Ok, However, would be good to have more information supplied to others regarding the use of NRT.
Page in the quit group NRT health providers exchange card program folder is adequate and to the point.
Lapsed
This is our biggest group of people and they often say they have tried it all.
Pretty good.
5As still relevant and other info in book.
‘Lapsed’ relapse booklet has good ideas.
More into, include studies etc.
This happens fairly frequently.
Now some good resources/info on relapse that could be easily integrated into guidelines.
Most of client experience that the medication is not strong enough as they lapsed 3–4 times. The
guidelines should have other strategies for it.
Maybe need more information specific to lapsed smokers.
They have to wait a year if tried patches etc.
Relapse prevention is common place with cessation work.
Needs to have more coverage on relapsed.

Light
I would like more information on people who cannot get off the last 2 smokes.
Why not low strength patches for 8 weeks.
Difficult to assess their needs/amount of replacement therapy.
As above.
Increasing numbers of these. Low addiction and motivation to quit.
Especially those who are social smokers (ie in weekends) and who don’t regard themselves as being
addicted.
Need specific strategies for this group as some still struggle to stay without any assistance.
Some people only smoke 8–10. However would still like to give up – reduction therapy. Unsure if
this belongs in guidelines so much as in training manuals as guidelines state not to provide NRT to
this group.
We should look at whether they smoke less or more the attraction level is still the same. Several
clients at less than 10 cigarettes a day was use high dosage and really work for them.
This is a difficult group because they probably don’t need NRT but have it fixed in their mind that
they do.
This is a difficult group to deal with and in general are the majority of my clients.
Low dose patches but often not recommended.

Question 10
To quote out GPs “Put the guts in the beginning” – the methodology ranking evidence etc should be
an appendix at the back. In the interests of time, the crucial points for, recognizing your summary
should cover this but preferable that people start to ‘get into’ the full version easily.
Keep it simple, user friendly for a busy practice. Flow charts a good idea.
Youth section. Pregnancy section.
Shorter factual document. Bullet points, frequently easier to assess points but takes more time
working out amounts, contraindications, etc. Easy for me to assess the points, state of mind. ‘Keep it
simple’.
Print pages larger type so more easily read by patients
The colour is so dark if it was in a normal plain typing and table will be fine with font to be 12pt that really readable.
Any additions suggested would be helpful but keep it concise so that it is still easy to use.
Enjoy the layout.
More compact – not so wordy.
Hard copy full book suits use as reference and other specific resources are used in daily education.
Markers that stick out for quick reference.
Just more info on the above especially relapse prevention, info for patients on wily they relapse after 2–6 months eg reasons why.

**Question 11**
A web based guideline would be useful. How about a printed tear off sheet with info on each treatment pgs? 24
A web based guideline plus.
A hard copy booklet is a good reference to have.
A hard copy booklet great for full info. Shorter rc [reminder card] better for consults.
Hard copy and reminder card as in ‘summary’ suggestions.
Web based so it can be updated daily.

**Question 12**
Would be good to have more references.
But lot of other information missing.
NRT is not the golden calf. It, like other programs, should not be highlighted, but rather, appear similar to acupuncture etc. NRT is for most people just something else to try.
But there is a page of references.
Generally but note previous comment – more stats.
But detailed info on web would be great.

**Question 13**
Evidence behind the recommendation would be great to have on a site to visit for further understanding of certain recommendations.
Maybe but time limitations to utilize.

**Question 14**
Too much info often confusing for people
Enough info already available.
Easy to read, friendly information on the use of NRT patches/gum. Information on the effects smoking on the unborn child.
Different options and effectiveness.
Short bullet type information.
Basic info ? for stopping ?.
They have access to the full guide anyway – and there are many ‘patient information’ booklets already so ? cost effectiveness.

5As evidence summary

Tips for ‘diversion’ when craving? dietary advice/alternate input to nicotine.

List the additives. 2. List of additives govt allows. 3. Potency of nicotine in NZ cigs. 4. Political – who is lobbying for what. A referral list for services and products smokers and people quitting may require in psychologists for stress counselling, dieticians etc. Evidence based statistics, self help sectional interactive medicines, information for patients.

Area to record their input in the motivational interviewing section. How to put on patches.

Do not know.

Section question 10.

Doses of patches given? General information that can be retrieved quickly.

The positive reasons for quitting support support support support.

Brief overview, facts on prescribing and amount. Not so much on leading into assessing. Evidence summary, NRT, info on patches, gum, resources/services – précis of these sections.

General guidelines for NRT use, possible side effects, reinforcing advice given by NRT provider. Comparison of different methods and their action.

I leave that to you.

Post quit smoking [utilizing NRT] surveys ie survey NRT clients 12 months after commencement of their program.

Possibly. Especially if it/they were focused on separate groups – eg youth/pregnant women etc

Simplify versions for teenagers and the different groups.

Do you send out updated guidelines for practitioners issuing NR.

A booklet stating smoking cessation – what are the best options – a guide for the consumer.

A summary of guidelines and advice given during session.

Uncertain.

Helpful quick reference information to refer to or access for client.

There are already some excellent useful information leaflets and booklets available for the consumer – why duplicate?

Bullet points with brief facts and suggestions.

Ways to assist smokers to quit.

Perhaps this could be web based with pamphlets specifically for NRT products.

Side effects – the info in the quit book.


Don’t think it is needed.

Unsure.

Pamphlet size, compact, precise, 4 d’s, NRT advice, method of use.

As much as reasonably possible.

Everyday coping.

More cost to the taxpayer.

Easy to carry small flip folder.
Question 15
Staff members of a hospital.
Aukati Kai Paipa
Workforce.
Health Board employees.
Workplace

Question 16
Great to see change seen as a process.
Harder for Maori to quit. Staying longer on NRT.
A little more on the biological factor – ours? has been the economic factor etc.
But starting to recognize difference issues to address with the Asian/Chinese population youth.
More information on Mental Health consumers and cessation would be useful
Written in Maori option. More youth orientated.
Once again, a shorter format more appealing. No one has time to read so much info.
A lot of Pacific Islanders are not aware of NRT and its availability a there is an extra step in the above process.
More tailored to general health worker rather than quit coach specifically but that is understandable to suit everyone.
Would like to see some simple ? colourful info series leaflets to give as multicultural handouts.
But more information for pregnant women would be good.
Updated info please.
More specific information re acute cardiac [safety Nortryptiline, NRT].
Perhaps a specific section aimed at under 18.
Could be improved.
Condense it down to booklet.
Could have more Maori specific info.
Mostly but info on rongoa would be beneficial and recognition more under 18s are smoking. Also that most smoking under 10 per day are still ‘addicted’ and find NRT necessary.
I use other material as well.
It is only used by professional in the field.

Question 17
Recognised alternative providers i.e. hypnotherapist.
Why can’t the heavy long term smokers who have tried/failed before (many times) get a three month patch supply – surely cheaper in the long term to have it work successfully. (I know trials haven’t shown this to be necessary…) Quitting by yourself, cutting down, group support.
Questions re cessation in younger people mental health consumers.
I support the Guidelines contact the info about nicotine addiction and increase info on support. Most common comments – ‘I’ve tried everything. Nothing works.’ ‘Quitting didn’t help’. ‘In the end I will have to do it on my own’. 
More info needed for combination therapy and evidence for effectivity? It would be definitely helpful to have produces our packaging on display in Medical Clinic?
Other than previously mentioned.
Smokers know more than quit card provider. I can only present simple, helpful guides, alternatives to current practice.
What are the benefits of quitting after smoking for so long? What/how does their health repair itself? Why are the inhalers not subsidized.
Info relating to new Habitrol was poorly introduced, no handout info supplied and even had difficulty getting Medsafe info from company or chemist.
Alternatives to NRT
‘If I fail to quit with this session(s) of NRT, how soon can I apply for a subsidized course in the future?’
Teenagers with a blank look (curtains down over the eyes). How can I stop smoking and still with my smoking friends and drinking alcohol as before. Can I only smoke the greenstuff (cannabis) Alternative therapies and effectiveness.
What to do with teenagers. How to manage the ‘multiple quitter’ best re?
What action to take if smoking < 10 per day.
How much nicotine is in a cigarette.
Don’t deal directly with consumers.
How long will it be before I am free of smoking?
Where are the support people or places in our community.

Question 18

Private organization
We work with community and hospital groups.
Community groups.
Nurse educator – NGO working in the community.
GP practice.
Public Health Unit
Youth Service.
Other occupation health contracting.
Private company manufacturing site.
Workforce
GP surgery. Have run quit smoking clinic for about 3 years. Nurse led: through quit group/Steve Cook Shall look forward to working with the new guidelines.
Private industry (H & SM’ger)
Corrections Department.
Public Health Nurse.
District Health Board
Occupational Health Consultancy
Not for profit organizations.
I am a project manager for Pegasus – smoking cessation program provided by GPs in Christchurch. Updated guidelines would be great. I use them a lot.
Occupational Health nurse.
RGON AND Nurse at factory with 300+ staff.
Self employed GP contracted to PHU