



Health Development Agency

Meeting Department of Health smoking cessation targets

Recommendations for service providers

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About the HDA

The Health Development Agency (HDA) is an NHS special health authority, established to support and enhance national efforts to improve health in England, with a particular focus on reducing health inequalities. In partnership with others, it gathers evidence of what works, advises on putting health into practice, and develops the skills of all those working to improve people's health.

About this publication

This publication offers information on important aspects of service provision. It is complemented by a separate publication, ***Meeting Department of Health smoking cessation targets: Recommendations for primary care trusts***, which contains recommendations on the continued development of smoking cessation services to help meet the targets set in the government's *Priorities and Planning Framework 2003-2006*.

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Contents

Acknowledgements	iv
Introduction	1
Issues	2
Type of treatment	2
Special client groups	3
Medication	4
Relapse prevention	7
Smokeless tobacco	7
Monitoring	7
Training	8
Maximising throughput	8
Additional resources	9
References	10

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Introduction

The need for these recommendations

The Department of Health's *Priorities and Planning Framework 2003–2006*, published in October 2002, includes targets for primary care trusts (PCTs) to achieve over the next three years across a range of health service provision (Department of Health, 2002a). These include key targets for smoking cessation services, in particular a target of 800,000 smokers successfully quitting at the four-week stage by 2006.

To meet the new NHS targets, the 'average' PCT will have to produce at least 900 smokers per year who have been treated by their smoking cessation service and who stopped smoking at the end of four weeks of treatment.

To set this in context:

- The target for 2001–02 was 50,000 nationally (equivalent to 167 per average PCT)
- The target for 2002–03 was 100,000 nationally (equivalent to 333 per average PCT).

Thus the new target represents a 170% increase on the current figure. This will require a considerable increase in activity among all members of the primary care team in recruiting smokers into the smoking cessation services, and expansion of those services. Individual PCTs will have different targets depending on size and demographic characteristics – those with large numbers of low-income smokers will have higher targets. Strategic health authorities will be responsible for setting the targets.

In setting these targets the Department of Health has signalled that it places a high priority on smoking cessation, and that the funding allocation to PCTs from 2003 onwards will reflect this.

Smoking cessation rates per 100,000 are also one of the seven key PCT performance indicators for health improvement. The annual rate achieved is banded (1–5), reflecting performance relative to other PCTs throughout the country.

Aim

This publication aims to provide smoking cessation service providers (coordinators, clinicians and counsellors) with information on important aspects of the provision.

Using this publication

This publication is structured in a question-and-answer format. It covers the most common issues that have been raised by coordinators and advisers during meetings, conferences and training sessions, through the smoking cessation listserve or personally with the authors, during the three years the services have been in operation. Much of the advice given derives from the clinical experience of specialists working in the smoking cessation services, or indirect evidence from published studies, and may be subject to change. **This document represents the views of the authors; no liability can be accepted for consequential loss or damage, and readers must always apply standard principles for clinical governance.**

Issues

Type of treatment

1. Under what circumstances, if any, should groups be preferred over individual counselling?

A service should, as far as possible, offer treatment that meets the needs of its community, in accessibility as well as effectiveness. At present we cannot tell from randomised controlled trials whether group treatment is generally more or less effective than individual treatment (Stead and Lancaster, 2000). But it has been found that smoking cessation services in England that have used mainly group treatment have had higher success rates with their clients than those using mainly individual treatment (L. Bauld and co-workers, unpublished data). The case studies find that group treatment yielded higher success rates than individual treatment, even though they are often dealing with clients with higher levels of dependence. Moreover, groups can be extremely cost effective, with group sizes of up to 40 being practical (L. Bauld and co-workers, unpublished data). However, groups are not generally sustainable in rural areas or where the local population is less than about 100,000 head of population, because it would take too long to accumulate enough clients, and small groups (starting with fewer than 10 or so) can be counterproductive. The advice is that smokers may benefit from the offer of group treatment where practical, but the offer of individual treatment is essential to maximise take-up of the service.

2. What features of counselling might improve success rates?

Frequency and overall duration of face-to-face contact appear to be important (Fiore *et al.*, 2000). It has been suggested that teaching problem-solving skills may be

helpful (Fiore *et al.*, 2000), but the evidence for this is not strong. Similarly, social support (eg buddying) and physical activity advice have been suggested as potentially helpful, but the evidence is weak (May and West, 2000; Ussher *et al.*, 2000). We could find no evidence for specific efficacy of 'motivational interviewing' as a technique (Dunn *et al.*, 2001). There is some evidence that a structured approach with clear goals is more effective than a more *ad hoc* approach (Maguire *et al.*, 2001). It is believed that 'not a puff' abstinence should be the very clear target, because of the strong statistical link between minor lapses and later full-blown relapse, but there have been no direct tests of this hypothesis.

3. What advice should be given to smokers who wish to continue using cannabis?

Cigarette smokers who continue to smoke cannabis, with or without tobacco, appear to be less likely to be successful in stopping cigarette smoking (Gourlay *et al.*, 1994; Ford *et al.*, 2002) – although not all studies have found this (Humfleet *et al.*, 1999). Smokers attending the service should be advised that they should stop cannabis use at least for the first few months of their quit attempt.

4. What advice should be given to smokers concerned about weight gain?

The evidence clearly shows that weight gain from stopping smoking is usually permanent, and almost certainly represents a return to the weight that the client would have had if they had never smoked (Froom *et al.*, 1998). There is some evidence that smokers who gain *less* weight when they stop are more likely to relapse (Norregaard *et al.*, 1993), but that smokers with greatest concern about weight gain at baseline are more likely to relapse (Gourlay

et al., 1994). Unless the smoker is already severely obese, the advice is not to battle against the weight gain early in the quit attempt, but rather to examine ways of dealing with it once non-smoking status has become firmly established. NRT and bupropion reduce weight gain while they are being used. Increasing physical activity levels and eating healthy snacks are generally to be recommended. Smokers who are suffering from severe obesity may need special treatment. Some research has found that intensive behavioural support, together with nicotine replacement therapy and a very low calorie diet may improve cessation rates in this group (Danielsson *et al.*, 1999). However, the diet did not reduce long-term weight gain. Another study has suggested that cognitive behavioural therapy designed to reduce concerns over weight gain may improve smoking cessation outcomes (Perkins *et al.*, 2001).

Special client groups

1. How can the service attract more low-income smokers?

Clinical trials and the experience of services indicate that low-income smokers are just as likely to be motivated to stop, and to be successful following treatment, as other smokers. The services are already attracting a substantial proportion of low-income smokers; however there is pressure to do more to meet the needs of this target group. This is an under-researched area and so it is only possible to give advice based on common-sense analysis. On this basis, flexibility and accessibility appear to be important. This may involve helping patients with transport costs, taking the services to the smokers, or involving community organisations.

2. What services should be provided for patients awaiting surgery?

One study of particular relevance suggests that highly targeted advice from the surgeon, together with behavioural support and medication, can lead to quite high quitting rates, at least prior to surgery, and reap immediate benefits in terms of post-operative complications (Moller *et al.*, 2002). Acute hospital trusts should have a system for ensuring smokers waiting for elective surgery are informed of the need to stop prior to admission and put in touch with the patient's local smoking cessation services.

3. What services should be provided for hospital inpatients?

One might imagine that hospital inpatients would be a good target group for smoking cessation interventions. Evidence from randomised trials suggests that behavioural support and medication can be effective (Munafi *et al.*, 2001). But it appears that brief counselling from routine clinical staff alone is not sufficient to have a lasting effect (Bolman *et al.*, 2002; Hajek *et al.*, 2002; West 2002). There are some practical difficulties with implementing smoking cessation interventions: length of stay is usually only a few days; patients are often inaccessible during this time because they are asleep, undergoing tests or treatment, or too unwell; and smoking status is often inaccurately recorded or not recorded at all in the notes. Hospital patients who smoke should probably be able to receive NRT during their stay, and should be put in touch with smoking cessation services on discharge.

4. What services should be provided for psychiatric patients?

There is little evidence to go on, but what there is suggests that behavioural support and medication can help with cessation in those who are motivated to use it (El-Guebaly *et al.*, 2002). It is likely that the services would have to be specially tailored to meet the needs of this group (Cataldo, 2001; D'Mello *et al.*, 2001; Evins *et al.*, 2001; McChargue *et al.*, 2002; Patten *et al.*, 2002). Special skills and training may be required, but specialist services working in conjunction with psychiatric and primary care staff could develop a programme of support for psychiatric patients wishing to stop (Watt *et al.*, 2001). The HDA has recently prepared a guidance document on tobacco control in psychiatric and long-stay units (Seymour, 2001).

5. What services should be provided for prisoners?

Prisoners' smoking rates are much higher than in the rest of the population. There is no hard evidence on which to recommend a particular approach to cessation, although no evidence exists to suggest that specialist support would not work with this group. Regarding pharmacotherapies, it is likely that NRT may be more appropriate than bupropion because of the high prevalence of mental health problems and other substance misuse among prisoners. All forms of

gum are prohibited in prisons and this would include nicotine chewing gum, so other forms of NRT should be recommended. A number of pilot schemes have been initiated by the Department of Health Tobacco Policy Team, Prison Health Policy Unit and Prison Health Task Force (a joint unit of the Home Office and Department of Health) involving groups and one-to-one interventions supported by NRT provided free of charge. An evaluation of these, carried out by the University of Strathclyde, **will soon be available on the Department of Health website**. A toolkit will be produced early in 2003 to assist with setting up such services, which will be made available through strategic health authority leads.

6. What services should be provided for teenagers?

There have been some studies looking at the needs of this group, but there is no hard evidence on which to recommend a particular approach (Donovan, 2000; Backinger and Leischow, 2001). Recent studies involving use of families (Bauman *et al.*, 2000) and a stages-of-change derived intervention (Aveyard *et al.*, 2001) have not shown any benefits. (See the following section, 'Medication', for recommendations regarding NRT and adolescents.)

7. What services should be provided for pregnant smokers?

It is clear that intensive behavioural support provided by trained specialists can increase a pregnant smoker's chance of succeeding at a quit attempt (West, 2002). The problem appears to be that only a tiny proportion of pregnant smokers attend treatment services, even when these are made very accessible (eg by having the specialist visit them in their homes). Many pregnant smokers do not disclose their smoking status to their GP or their midwife, and so no opportunity arises to engage them. Setting up independent services aimed at pregnant smokers has not been successful so far in substantially boosting recruitment. It has been argued that better engagement can be achieved by training midwives to deliver relatively brief interventions during the course of their other interactions with smokers. But the evidence to date shows no effect of such an approach, and it cannot be recommended (Wisborg *et al.*, 1998a; Hajek *et al.*, 2001). Pending further research, it seems appropriate to train one of the specialists to deal with pregnant smokers, and for this

person to link with GPs and midwifery services to provide a source of referral when a pregnant smoker wishes to stop and is willing to receive more intensive support. Direct monitoring of maternity computer records and contacting all known smokers to offer specialist support in their homes is another approach that has been tried, achieving a 13% take-up rate (HDA, 2003: 'You Two Can Quit' case study). Against this unpromising background, it is worth noting that the health gains are so important to both mother and foetus that even if the cost per quitter is much more for this group, it is still worthwhile.

Medication

1. Should NRT users be allowed to use for longer than it says on the label?

NRT is generally not harmful to the user, and if a smoker is having difficulty with coming off the medication there is a good chance that he or she will resume smoking if forced to do so. For these reasons, smokers should be allowed to continue to use their medication as required until they feel ready to stop. The NICE guidance stipulates three months for a normal course of treatment, but does not prohibit use thereafter (NICE, 2002). There is evidence that longer-term use of the nicotine patch does not confer any benefit (Tonnesen *et al.*, 1999), but the effect of longer-term use of the more acute dosing forms has not been tested (Sims and Fiore, 2002).

2. Should NRT and bupropion be combined?

Combining the two forms of medication appears to pose limited or no risk to the smoker. One study reported an increase in blood pressure in some subjects, but this was not statistically more than would be expected by chance. On the other hand, there is no clear evidence that the combination is better than either product alone. The above study found the combination to be more effective than the patch alone, but not significantly more effective than bupropion alone. In general, the advice is to use just one medication or the other until more evidence emerges (NICE, 2002).

3. Should different forms of NRT be combined?

There is some evidence that this may improve success rates, and it does not appear to be harmful (McNeill *et al.*, 2001). NICE also concluded that a combination of two

different NRTs has in general been found to be more effective than a single NRT (NICE, 2002). However, it is still specifically prohibited in the labelling. Smokers considering using more than one product at a time should be advised of the evidence so they can make an informed choice. In general, if they choose to use more than one form, it is sensible for them to purchase the additional forms themselves so the responsibility for taking it is clearly theirs (West *et al.*, 2000).

4. Should users be given a restricted range of NRT products to choose from?

Although there is no clear evidence to suggest that one form of NRT is better or worse than other forms (Hajek *et al.*, 1999), if it is practical to offer the full choice, this would be expected to maximise uptake and usage. On the other hand, where offering the full range is not practical, this should not significantly affect success rates.

5. What should be done with long-term NRT users who want to stop using?

Users should be informed that their use is not likely to be harmful, and that it generally declines spontaneously over a period of months or years (Sims and Fiore, 2002). If a user indicates a clear and definite need to stop, it would be worth considering a behavioural support programme similar to that used for smoking cessation, switching the user from their NRT form to patch for, say, eight weeks, then terminating patch use if the client is ready.

6. How many nicotine inhaler cartridges should be used per day and how much use can one get out of a single cartridge?

Under normal usage each inhaler cartridge can last for three 20-minute puffing sessions. This means only six cartridges would normally be needed per day (Hajek *et al.*, 1999). The dosing pattern indicated on the label is based on a much more intensive puffing regimen than smokers normally adopt.

7. For acute-dosing NRT products the label says use when smokers have the urge to smoke; but in training counsellors are instructed to advise clients to use regularly throughout the day – which is correct?

There is no hard evidence concerning the best dosing pattern to adopt (Silagy *et al.*, 2001). The reason for proposing that smokers use their product on a regular basis and top up usage when urges get strong is that the nicotine delivery is much slower than a cigarette, and if one only used the product when an urge started, it could well be too late by the time the product has delivered enough nicotine to make any difference. Evidence from the patches clearly shows that having a background level of nicotine in the system all the time reduces urges to smoke, and the acute-dosing forms will provide that as long as they are taken regularly throughout the day.

8. How should the services approach the problem of GPs who refuse to prescribe NRT or bupropion?

This is a matter of clinical governance, and no different in principle from a GP refusing to prescribe medication to treat high blood pressure. In the first instance it would be politic to try gentle persuasion and perhaps make sure the GP has the summary from the NICE guidance. If that fails, it may be necessary to refer the matter to the person at PCT level responsible for clinical governance.

9. In order to make prescribing more efficient, when is it appropriate to use patient group directions?

Patient group directions can greatly increase the efficiency of services because they increase access to those who are not registered with a GP, and can avoid smokers having to make a specific visit to their GP for prescriptions. Core clinic staff and community advisers are eligible to provide smoking cessation medication to clients using patient group directions, provided the appropriate arrangements are in place for their supply and financing (Department of Health, 2002b). A template patient group direction for NRT has been produced by the Pharmacy Healthcare Scheme (www.ash.org.uk/html/cessation/pgd.html). This template is currently being revised, and will also incorporate a patient group direction for bupropion, as suggested by NICE. The updated patient group direction will provide

clear guidance for prescribing NRT outside the licence, including prescribing issues concerning pregnant smokers. It will be available in January 2003.

10. Is it appropriate to prescribe NRT to pregnant smokers?

The more recently licensed NRT products such as the Niquitin CQ patch, Nicorette Microtab and Niquitin CQ Lozenge may in principle be used by pregnant smokers if it is judged that they could not stop smoking otherwise (NICE, 2002). This recognises that, while nicotine carries some risk to the foetus, the risk is substantially lower than smoking so that use of these products may be beneficial. However, in the one randomised trial that looked at the effect of NRT use in pregnancy, patch-users were no more likely to be successful in stopping smoking than users of a placebo patch (Wisborg *et al.*, 1998b), although the group allocated nicotine patches had significantly higher birth-weight babies than the women allocated to placebo patches. Therefore the view that NRT may help pregnant smokers to stop is based on generalisation from studies of other smokers.

11. Is it appropriate to prescribe NRT to adolescent smokers?

There have been no published controlled trials of sufficient size to say with confidence that NRT helps adolescents to stop smoking (Backinger and Leischow, 2001). However, generalising from studies of adult smokers suggests that it may help, and there is no reason to believe that it would be harmful if the other indications for use are present. Therefore the question of whether or not to prescribe NRT to an adolescent needs to be considered on the individual circumstances. It seems reasonable to require that the potential client provide a clear indication of a sustained determination to stop smoking, and a smoking history that reveals clear evidence of dependence (McNeill *et al.*, 2001). The GSK Niquitin patch labelling does permit use by those 12 years or over under certain circumstances.

12. What drug interactions may occur with NRT?

Smoking increases the metabolism of a variety of psychoactive drugs (Zevin and Benowitz, 1999). When a patient quits smoking, the decreased metabolism of many medications can result in significantly higher medication

blood levels. This could increase therapeutic efficacy, but could also cause increased medication side effects. Monitoring may be needed to assess whether dosage needs changing. Most of the effects of smoking on drug metabolism are caused by the hydrocarbons in cigarette smoke, not by the nicotine. Clinicians need not avoid the use of nicotine replacement medications. According to the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Nicotine Dependence, psychiatric medications likely to follow the pattern of increased blood levels after smoking cessation include: clomipramine, clozapine, desipramine, desmethyl diazepam, doxepin, fluphenazine, haloperidol, imipramine, oxazepam, nortriptyline, and propranolol. Abstinence may or may not affect the blood levels of alprazolam, chlorpromazine, and diazepam. Abstinence does not appear to increase blood levels of amitriptyline, chlordiazepoxide, ethanol or lorazepam.

13. Should smokers with diabetes use NRT, and what should be done about their insulin dose?

Smoking is associated with insulin resistance, and it is doubly imperative that smokers with diabetes stop smoking (Mikhailidis *et al.*, 1998; Haire-Joshu *et al.*, 1999). Behavioural support has been found in at least one study to help smokers to stop (Canga *et al.*, 2000). Stopping smoking may affect uptake and utilisation of insulin, so diabetic smokers should be advised to check their dosage levels during the post-cessation period (Attvall *et al.*, 1993). NRT may, if anything, mitigate the effect (Epifano *et al.*, 1992; Eliasson *et al.*, 1996), and it is unlikely that special steps would need to be taken because of use of this medication.

14. How soon after a heart attack can patients be prescribed NRT?

NRT has not been found to lead to serious adverse events in cardiac patients. However, to date studies of NRT with this group have not shown clear evidence of effectiveness. As with other special groups, such as pregnant smokers, it is a matter of weighing up the probability that NRT will have some benefit against any possible risk. Each case may be considered on its merits, but in general one month has been proposed as a reasonable threshold (McRobbie and Hajek, 2000).

Relapse prevention

1. Should the services offer relapse prevention sessions after the four-week treatment period?

On average, some 50–70% of smokers who have been abstinent for four weeks can be expected to relapse in the next 12 months (Stapleton, 1998). Various interventions and treatments have been proposed to reduce this figure. On patients using bupropion, continued treatment has been found to delay relapse but not prevent it once the medication is terminated (Hays *et al.*, 2001). The US Lung Health Study managed to achieve high 12-month abstinence rates with continued behavioural support and NRT use throughout the period (Anthonisen *et al.*, 1994). However, no other intervention so far tried has been found to be effective for smoking (Irvin *et al.*, 1999). Monthly relapse-prevention sessions that any clients who have been through treatment can attend are commonly used, but there is no clear evidence that they are effective. Each quit attempt gives a significant chance of success. That chance is substantially improved by using the specialist services and clients should be encouraged to go back to the services after an appropriate period.

Smokeless tobacco

1. What services should be run for smokeless tobacco users?

This is the topic of new HDA guidelines (West *et al.*, 2002). There is very little hard evidence on the effectiveness of treatments, but what there is suggests that behavioural support can have some effect, while NRT has not been found to help. In general, the advice is that in areas of high smokeless tobacco use there might be sufficient demand to run a smokeless tobacco cessation service. Otherwise users should be treated by the existing smoking cessation services using a behavioural support approach similar to that used for cigarette smokers, but probably not involving medication.

Monitoring

1. How should services monitor user perceptions of the service?

Several services have expressed an interest in gauging consumer reactions to their treatment. Such reactions can

be helpful in making a case for continued funding and for improving service delivery. The obvious limitation of this monitoring is that consumer responses will critically depend on whether the smoker managed to stop smoking, which in turn will be affected by many factors other than the treatment provided. In general, it is sensible to collect this information at the four-week end-of-treatment session, and to attempt to gauge the views of those who are unsuccessful as well as those who are successful. Where possible, assessments should also be made of the people who are referred or who self-refer, but who do not actually use the service. Simple anonymous written questionnaires with a mixture of closed-response and open-ended questions are likely to provide the most useful material.

2. What data should services collect in addition to that required by the Department of Health?

The Department of Health monitoring requirements are important, but not sufficient to ensure that success rates from different services or elements of the service are being compared fairly. It has become apparent that many potential observers or funders of the services remain to be convinced that four-week self-report data are sufficient. It is recommended that services record the following for each element of the service to be monitored:

- Numbers of smokers making an initial enquiry (can be difficult to record – it is worth checking with other services to see how it has been done and to maximise consistency)
- How they heard about the service
- Numbers setting a quit date
- Numbers attending the quit date
- Proportion of these coming from each possible source (eg GP referral, GP suggestion, etc.)
- Numbers reporting abstinence for the last two weeks of the four-week treatment
- Numbers confirmed abstinent for the last two weeks of the four-week treatment by expired-air CO
- Numbers reporting continuous abstinence for 12 months by self-report, and confirmed by expired-air CO
- Socio-economic group
- Ethnic group
- Gender
- Age group
- Physical health status
- Nicotine dependence (by Fagerstrom test for nicotine dependence; Heatherton *et al.*, 1991).

Training

1. What are the most important training needs of GPs?

GPs have now widely accepted that medical plus behavioural support are appropriate treatments to aid cessation and should be available on the NHS (McEwen *et al.*, 2002). The priority now is to ensure that they all feel sufficiently knowledgeable and have the skills to raise the topic of smoking appropriately and encourage smokers wanting to make a quit attempt to use the treatment services. The HDA is currently engaging in an exercise to determine appropriate content for training to achieve this, and the results are expected in 2003. Once identified, the key content areas will form the basis of a national standard for training in smoking cessation and will ultimately lead to accreditation in training courses. The BMA Tobacco Resource Control Centre is currently piloting a brief intervention training package for GPs.

2. What are the most important training needs of hospital clinicians?

Hospital clinicians need to have accurate information about the relevance of smoking to the condition they are investigating or treating. They should be trained to provide clearly targeted and appropriate advice to smokers concerning cessation and where to get assistance.

3. What are the most important training needs of community advisers – practice nurses, midwives, health visitors, pharmacists?

These groups have been in the vanguard of the smoking cessation services and have a critical role in providing brief opportunistic advice and, where appropriate, in becoming smoking cessation specialists. For the cadre as a whole it is important that they have accurate information about smoking as it relates to the patient groups they see, and can raise the topic of smoking, encourage smokers to make a quit attempt, and try to ensure they obtain help from the services. For those wishing to be trained as community advisers, the inclusion of training on the use of a treatment protocol can ensure the quality of their interventions.

4. How should the services determine which trainer to use?

The potential for misinformation in this area is considerable, and the HDA is in the process of developing a system of accreditation for smoking cessation training courses. This system is expected to be completed in 2003. In the meantime, those considering setting up training should consult the HDA.

Maximising throughput

1. What are the most effective forms of recruiting clients into the services?

Sustained recruitment relies heavily on GPs advising smokers to contact the services (not necessarily engaging in formal referral), word-of-mouth from those who have used the services, and community advisers (eg pharmacists) recruiting their own clients. Some smoking cessation coordinators have reported that paid advertisements in local newspapers and on transport systems do not appear to have been cost effective (Crosier, 2002).

Additional resources

The following resources may be helpful:

www.ash.org.uk

An excellent source of up-to-date information on all aspects of smoking, with links to important scientific and training resources and policy documents

www.doh.gov.uk/tobacco/cessation.htm

Home page of the Department of Health tobacco policy team, with links to key policy and guidance documents

www.hda-online.org.uk

Home page of the HDA, with links to authoritative reviews and educational materials on smoking cessation topics

www.quit.org.uk

Home page of the organisation QUIT, with a wealth of practical guidance and materials relating to cessation

www.srnt.org

Home page of the Society for Research in Nicotine and Tobacco – the society has an excellent listserv where members can get answers to queries from some of the world's leading tobacco experts

www.treatobacco.net

An authoritative database on treatments, managed by the World Health Organization and the Society for Research in Nicotine and Tobacco

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