Smokers' Clinic Guideline

Effective: 15 September 2021

1. Guiding Principles

Smoking rates in people with mental illness in Australia remain alarmingly high whilst they have been declining in the general population over the last decade (1-3). People with mental illness have higher levels of nicotine dependence, lower rates of cessation, and higher rates of morbidity associated with smoking than the general population. They are also more likely to die as a consequence of smoking, including from cardiovascular disease, respiratory disease and cancer, than from their psychiatric condition (4).

Research indicates that individuals with mental illnesses respond to the same evidence-based approaches as the general population (5-7) and stopping smoking is associated with improvements in mental health, quality of life and assisting in reducing other substance related disorders (8). Currently, people with mental illness are less likely to be offered assistance with their nicotine dependence, making an inpatient admission the opportune time to give people a chance to address their smoking status (See Smoking Care Guideline - Albany Hospital Acute Psychiatric Unit). But it is not best practice to solely address smoking status as an inpatient. There is a recognised need to have tailored nicotine dependence treatment which is both integrated directly into mental health care plans and continued in an outpatient community setting. Furthermore, it is integral for this treatment to be augmented by a multidisciplinary team, with inclusion of primary care providers, psychiatrists and allied health staff.

The purpose of this document is to provide guidance for staff caring for patients accessing the Smokers' Clinic from their initial assessment to discharge, in order to effectively continue to address nicotine dependence in a supportive and evidence-based manner.

2. Guideline

What is the "Smokers' Clinic"?

The Smokers' Clinic offers a 1-hour initial assessment followed by weekly 30-minute follow up (in person and telephone) for 6-8 weeks by a Resident Medical Officer.

Appointments will be scheduled with consideration to both clinician and patient preference, with availability from Monday – Friday 10:00- 15:00.

The Smokers' Clinic can provide additional support and treatment to the smoker's care as outlined in Smoking Care Guideline - Albany Hospital Acute Psychiatric Unit.

The training and support for Resident Medical Officers at the commencement of the 10 week psychiatry rotation includes an initial one-hour session of education, provided by their supervisor in addition to ongoing weekly supervision by a consultant psychiatrist regarding tobacco smoking, nicotine dependence and treatment options.

Smokers' Clinic Referral

All nicotine dependent patients and staff in the Great Southern Mental Health Service (GSMHS), both inpatient and community based, can be referred to the Smokers' Clinic for targeted assessment and management. Referrals can be made by faxing a referral (See *Appendix 1*) through to GSMHS Triage (08 9892 2605) or by emailing the Assessment and Treatment Team.

Assessment

Assessment sessions utilise the Brain Mind Research Institute (The University of Sydney) (9) assessment protocols for nicotine dependence and tobacco cessation. All patients and staff referred will undergo a comprehensive initial assessment (See *Appendix 2*). On the last page of the initial assessment, the Fagerstrom Test for Nicotine Dependence (FTND) (See *Appendix 3*) is completed, which provides a universally accepted detailed measure of nicotine dependence (low, low-moderate, moderate, high) used to guide interventions.

In addition, a Carboxymeter reading is taken to measure initial expired Carbon Monoxide (eCO) levels. This can confirm smoking status and be used as a comparison to readings between follow up sessions or after a period of abstinence.

The FTND in conjunction with the eCO level is continued in the 30min follow up sessions over 6-8 week sessions in an effort to determine effectiveness of treatment or where changes can be made.

Pharmacotherapies including NRT, varenicline, bupropion and others, are offered in addition to behavioural interventions. Interventions are consistent with best practice standards, derived from the latest iteration of the RACGP Clinical Guidelines for Tobacco Cessation (10).

Management of Nicotine Dependent Outpatients

a) Nicotine withdrawal

Nicotine withdrawal can be recognised by two or more of the following within 1-24 hours of a nicotine reduction or smoking cessation, and can last up to 2-4 weeks.

- Anxiety
- Irritability or restlessness
- Reduced concentration
- Tobacco craving
- Malaise
- Increased cough
- Dysphoria
- Mouth ulceration
- Insomnia
- Increased appetite

b) Behavioural Supports

Behavioural support interventions are non-pharmacological interventions designed to assist people in making changes to their level of tobacco use. They make take the form of advice, encouragement, discussion or distraction activities. Evidence based non-pharmacological interventions that can be offered include:

- Encouragement that making these changes is possible and they are supported in this.
- Education around the nature of cravings and 'urge surfing' cravings.
- Using strong mints or other sweets to manage cravings.
- Engaging in brief periods of exercise.
- Using progressive muscle relaxation or other relaxation techniques.
- Asking about the benefits to that individual in addressing their tobacco use.
- Acknowledging that it can be difficult to make changes around tobacco use.
- Providing encouragement to continue and validating changes already made.
- Breakdown the financial cost of smoking and what else the money could be spent on.
- Identification of cues that trigger cravings for an individual.

c) Medical Management

Nicotine Replacement Therapy

Nicotine Replacement Therapy (NRT) aims to replace the nicotine from smoking cigarettes with safe alternatives in order to reduce the symptoms of nicotine withdrawal. NRT is also a treatment for tobacco smoking cessation. Use of NRT over months can down regulate nicotine receptors in the brain, making it easier for patients to then cease the use of NRT over time.

Using the FTND and eCO readings, the Nicotine therapy options guideline (See *Appendix 4*) can be used to determine appropriate recommendations.

Varenicline

Varenicline (Champix) is a prescription medication designed to help people to stop smoking by binding to the nicotine receptors and blocking the rewarding effect of smoking cigarettes and reducing nicotine withdrawal through partial agonist activity. Varenicline has been shown to be an effective treatment for smoking cessation in people who tolerate this medication. Genetics determine the shape of our nicotine receptors and for some patients Varenicline will cause abrupt nicotine withdrawal when clients smoke. This will become apparent within the first 4 days of use and for these people Varenicline is not an appropriate treatment, should be ceased by medical staff and not trialled again. While Varenicline is just as safe to use in patients with mental illness as the general population, the ongoing use of Varenicline in patients for which it induces nicotine withdrawal is inappropriate and can increase psychiatric symptoms.

As the effectiveness of Varenicline is determined by continuing to smoke for the first days of treatment it may not be as useful in a smoke free environment. However, the choice to use Varenicline should be based on patient preference, previous patient experience with Varenicline, individual medication safety and ability to follow up the patient. If Varenicline is preferred by a patient, they may still require immediate NRT to manage withdrawal symptoms in a smoke free environment and in addition to Varenicline for highly dependent patients. Doctors should refer to the medication safety sheet before prescribing any medications. Patients interested in trialling this treatment as an inpatient should also be referred to the GSMHS Smokers' Clinic for ongoing follow up.

Buproprion

Buproprion (Zyban) is a prescription medication that targets dopamine and nor-adrenaline systems in the brain. While less effective than combination NRT and Varenicline, Buproprion can have some useful anti-depressant effects. There are some contraindications to prescription which doctors should consider before prescription. Patients interested in trialling this medication as an inpatient should also be referred to the GSMHS Smokers' Clinic for ongoing follow up.

d) Drug interactions

Products in tobacco smoke affect CYP450 enzymes (specifically 1A2) and affect drug clearance. Patients reducing or ceasing their tobacco use may need medication adjustments, generally dose reduction. NRT, Varenicline and Buproprion do not affect hepatic clearance in this way, but may have other drug interactions. Common medication interactions with smoking cessation are listed in Appendix 5.

Clozapine is particularly sensitive to changes in levels of tobacco smoking and this interaction should be discussed with patients at every review, with ongoing blood levels in addition to regular, frequent Psychiatrist reviews.

e) Concessions

For certain circumstances at the discretion of the treating RMO, the initial cost of NRT and pharmacotherapy may be subsidised by the GSMHS. Refer to WACHS Great Southern Mental Health Service Supply of Pharmaceuticals and Medical Supplies Procedure.

f) Multidisciplinary supports

In order to uphold best practice, coordinated care is essential, with nicotine assessment letters (See *Appendix 6*) communicated to General Practitioners for continuation of care and options. Psychiatrists, case managers and other clinical community mental health staff have access to this letter and the written consultation notes in the individual medical record.

3. Definitions

Nicotine Replacement Therapy (NRT)	Pharmacotherapies designed to alleviate nicotine withdrawal. Include nicotine patches, mist spray, lozenge, gum and inhaler

4. Roles and Responsibilities

As described throughout the guideline

Psychiatry Resident Medical Officer (RMO): Coordinate booking of patients to smoker's clinic, preform assessments for nicotine dependence and initiate and follow up pharmacotherapies and behavioural intervention strategies.

Consultant Psychiatrist Supervisor: Provide training and support for the RMO, including an initial one-hour session of education in addition to ongoing weekly supervision regarding tobacco smoking, nicotine dependence and treatment options.

All Staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place.

5. Compliance

Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

All WACHS clinical records must be managed in accordance with Health Record Management Policy.

7. Evaluation

Monitoring of compliance with this document is to be carried out by GSMHS every five years.

8. Standards

National Safety and Quality Health Service Standards – 4.3, 4.13, 5.3, 5.6, 5.7, 5.11
National Standards for Mental Health Services- 5.2

9. Legislation

Tobacco Products Control Act 2006 (WA)

10. References

1. Australian Bureau of Statistics. National Health Survey, First Results, 2015.
2. Cooper J, Manusco SG, Borland R, Slade T, Galletly C, Castle D. Tobacco smoking among people living with a psychotic illness: the second Australian Survey of Psychosis. Australian & New Zealand Journal of Psychiatry 2012; 46:851-63.
3. Morgan VA, Waterreus A, Jablensky A et al. People living with psychotic illness in 2010: the second Australian national survey of psychosis. Australian & New Zealand Journal of Psychiatry 2012; 46: 735-52.
4. Williams JM, Steinberg ML, Griffiths KG, Cooperman N. Smokers with behavioural health comorbidity should be designated a tobacco use disparity group. American Journal of Public Health 2013; 103:1549-55.
5. Drake RE, Essock SM, Shaner A et al. Implementing dual diagnosis services for clients with severe mental illness. Psychiatric Services 2001;52:469-76.
6. Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.
7. Roberts E, Eden Evins A, McNeill A, Robson D. Efficacy and tolerability of pharmacotherapy for smoking cessation in adults with serious mental illness: a systematic review and network meta-analysis. Addiction 2016; 111:599-612.
8. Ragg M, Gordon R, Ahmed T, Allan J. The impact of smoking cessation on schizophrenia and major depression. Australasian Psychiatry 2013; 21:238-45.
9. Bittoun R. Nicotine Addiction and Smoking Cessation 3-day Training Course. NSW, Australia: Smoking Research Unit, The University of Sydney, 2014.
11. Supporting smoking cessation: a guide for health professionals. Melbourne: The Royal Australian College of General Practitioners, 2011

11. Related Forms

Nicotine Dependence Screening Tool (GS MR 201D)
Nicotine Withdrawal Management Plan (GS MR202F)

12. Related Policy Documents

Smoking Care Guideline - Albany Hospital Acute Psychiatric Unit

13. Related WA Health System Policies

MP 0158/21 Smoke Free Policy
WA Health Guidelines for Supporting Involuntary Mental Health Inpatients

14. Policy Framework

Mental Health Policy Framework

This document can be made available in alternative formats on request for a person with a disability

Contact:	Manager Mental Health		
Directorate:	Mental Health	**EDRMS Record #**	ED-CO-19-29872
Version:	2.00	**Date Published:**	15 September 2021

Appendix 1: Referral Form Smokers' Clinic

Government of Western Australia
WA Country Health Service

REFERRAL FORM
SMOKERS' CLINIC

Smokers' Clinic
Lower Great Southern Mental Health Service
Hardie Road / PO Box 252
Albany WA 6330

< Insert Sticker >

Phone 9892 2440 / Fax 9842 1028

Note – priority is given to patients with significant smoking related diseases

Y ☐

Chronic Obstructive Pulmonary Disease Y ☐ N ☐
Spirometry _____
ABGs _____
Admissions Y ☐ N ☐ _____ (date)

Ischaemic Heart Disease Y ☐ N ☐
Symptoms _____
Procedures _____
Admissions Y ☐ N ☐ _____ (date)

Peripheral Vascular Disease Y ☐ N ☐
Claudication Y ☐ N ☐
Procedures _____
Malignancy Y ☐ N ☐
Gastro Intestinal Disease Y ☐ N ☐

Cerbrovascular Disease Y ☐ N ☐
Diabetes Y ☐ N ☐
Hypertension Y ☐ N ☐
Osteoporosis Y ☐ N ☐

Psychiatric Disease Y ☐ N ☐
Substance Use Disorder Y ☐ N ☐
Anxiety Disorder Y ☐ N ☐
Pending Surgery Y ☐ N ☐

Affective Disorder Y ☐ N ☐
Psychosis Y ☐ N ☐
Surgical Procedure Y ☐ N ☐

Medications : _____
_____
_____

Referring Health Professional : _____ Location : _____
Phone : _____ Date : _____

Appendix 2: Brain Mind Research Institute (BMRI) MRI Initial Assessment of Smoking

Bittoun, Harrison, Mohamed (Smoking Cessation Unit, Brain Mind Research Institute, University of Sydney)

Tobacco Dependence Intensive Treatment Assessment Form – Clinician Version

* STRICTLY CONFIDENTIAL*

Demographical Details

Surname: _____ **First Name:** _____

Gender: Male/Female **Date of Birth:** _____

Age: _____ **Phone: (W)** _____ **(Mob)** _____

Have you been referred by a health professional to the tobacco treatment program?

Yes/No

Referring Health Professional Details:

Name: _____ **Phone:** _____

Type of Health Professional: _____

Address/Location: _____ _____

Other Medical/Health Consultants:

1. _____ Location:_____ Phone:_____

2. _____ Location:_____ Phone:_____

3. _____ Location:_____ Phone:_____

(Tobacco dependence is a mental health disorder which crosses other specialities eg. respiratory, cardiology. Smoking cessation may impact on aspects of the patient's medical management within these specialties. [1-4])

How old were you when you started smoking? _____ Yrs

(Younger starting age is related to higher long-term dependence, late initiation age associated with higher quitting success. [5-8])

What is the longest period of time you have ever gone without smoking?

___ Hours____ Days____ Weeks____ Months____ Years

(Dependence is related to unsuccessful efforts to cut down on substance use. [9] The shorter the length of previous abstinences the more frequent the follow-up and the more intensive therapy should be for this attempt. [10])

How long ago was this? _____

(More recent quit attempt(s) associated with higher success. [10])

What is the longest period of time you have gone without smoking in the last 5 years?

____ Hours____ Days____ Weeks____ Months____ Years

(The shorter the abstinence period in the last 5 years the more intensive the treatment and management of the patient is likely to be. [10])

How many times have you attempted to quit smoking?

Never ___ 1-3 _____4-6_____ 7-10_____ More _____

(More quit attempts associated with higher success, on average 4-6 times. [11])

(Smokers with nicotine dependence require numerous attempts at quitting before achieving long term abstinence. [12])

What is the least number of cigs you smoke in a day? _____

What is the maximum number of cigs you smoke in a day? _____

(Smokers smoke cigarettes differently, changing the topography of their smoking to obtain the desired amount of nicotine that is required by the brain. Cigarette number variability is reflected in changes in expired carbon monoxide levels. [13])

Do you wake up at night to smoke cigs? Yes / No

(Waking up to smoke during the night signifies higher nicotine dependence and the need for more intensive treatment. α4 β2 nicotine acetyl cholinergic receptors become responsive during periods of abstinence, such as during sleep. [14])*

What is the full brand name of the tobacco you usually smoke?

_____

Are some brands too strong? yes / no

Are some brands too weak? yes / no

(Every smoker has a blood and brain level of nicotine which needs to be maintained. On switching tobacco brands, smokers will titrate (change the number of cigarettes they smoke and drag and puff depth and rate to achieve the same amount of nicotine. [15] Mentholated cigs associated with higher dependence due to increased nicotine metabolism by menthol. [16])

If you smoke hand rolled cigarettes, how many grams of tobacco per week do you smoke?

_____grams (1 pouch of tobacco = 50 grams)

How much of the following do you smoke each week?

Pipe _____grams cigars _____

(Cigar and pipe smokers are likely to have a lower expired CO level and high levels of nicotine dependence as this type of tobacco is highly concentrated in nicotine. [12])

Do you smoke Chop Chop or buy it in bulk? Yes / No

(CO and nicotine blood level can be higher as with any "roll you own" cigarette and risk of fungal and other infection due to contamination. [17, 18])

Do you live with a smoker? yes / no

Is your partner a smoker? yes / no

Do you some inside your house? Yes/No

Do you smoke inside your car? Yes/No

Are you exposed to other people's cigarette smoke at home most of the time? Yes/no

Are you exposed to other people's cigarette smoke at work most of the time?

Are most of your friends smokers? yes / no

(Close proximal smoking by others is a risk factor for relapse. Environmental cue conditioning is strong and triggers urges. More exposure is associated with higher difficulty to quit and maintain abstinence (increases relapse), plus dangers of secondhand smoke. Everyone needs to smoke outside the house and car. [19-21])

Who else in your family is/was a smoker like you? (This means also having/had trouble quitting)

- ☐ MOTHER
- ☐ FATHER
- ☐ SISTER/S
- ☐ BROTHER/S
- ☐ GRANDPARENT/S
- ☐ SON
- ☐ DAUGHTER

(Stronger genetic predisposition and inheritance associated with higher dependence [22, 23]. Discuss with patient the strong genetic predisposition and inheritance associated with higher dependence, and like alcohol dependence, is a life-long trait.)

Do you smoke marijuana? [This information is confidential] Yes / No
Frequency: _____ (daily / weekly / monthly)
Manner : _____ (joint / in a bong / tobacco added)

(CO levels are higher due to deep inhalations, higher relapse to tobacco smoking when attempting to quit, risk of pulmonary infection. [16] Need to eliminate tobacco and use alternative methods for marijuana. [10])

Do you drink alcohol? Yes / No

If yes, how frequently?
Very rarely?

- Less than 10 drinks/week ☐
- 1-5 drinks/day ☐
- 6-10 drinks/day ☐
- More than 10 drinks/day ☐

Have you ever been dependent on alcohol? Yes / No

When drinking alcohol, do you smoke:

- ☐ The same
- ☐ Twice as much
- ☐ Three times as much
- ☐ More

(Tobacco smoking reduces potency of alcohol by increasing its metabolism thus more alcohol is required, more smoking [two-fold] associated with alcohol dependence. [24] Alcohol use and abuse increases risk of relapse [10])

Do you drink coffee or caffeine/energy drinks e.g. Coca-Cola, Red Bull, Mother, etc?
Yes / No

If yes, do you consume caffeinated drinks:

- ☐ Very rarely
- ☐ 1-3 times per day?
- ☐ 4–6 times per day?
- ☐ 7 or more times per day? _____

(Smoking reduces potency of caffeine by increasing its metabolism, more caffeine drinking associated with tobacco dependence. Need to halve caffeine intake during quit attempt but do not abstain caffeine altogether to avoid caffeine withdrawals. [25, 26]

Have you used any other drugs regularly in the past which are dependence producing?
Yes / No

If yes, which drug(s) did you use?

_____

Do you feel you were dependent on any of these? Yes / No

(Drug dependence increases risk of smoking relapse. Certain drugs interact with tobacco smoke - dosing adjustment needed to avoid toxicity during quitting. [16])

1. Do you gamble regularly? Yes/ No
   Frequency: _____ (daily / weekly / monthly)

(Addicted gambler often smokes more, increases relapse to tobacco smoking. [27])

Which of the following methods have you used to try and quit smoking?

Approved pharmacotherapy for smoking cessation			
Type	Strength	No. per day	Duration
Nicotine patch	21mg, 14mg or 7mg/24hr		
	15mg, 10mg or 5mg/16hr		
Nicotine gum	2 mg or 4 mg		
Nicotine lozenge	2 mg or 4 mg		
Nicotine inhaler			
Nicotine Sublingual Tablet (Microtab)			
Buproprion (Zyban)			
Varenicline (Champix)			
Nortriptyline (Allegron)			
Others (non evidence-based therapies)			
Hypnosis			
Acupuncture			
Cutting down to "lighter" cigs			
Cutting down cig numbers			
Cold turkey			
Other(s)			

What has been the best method of quitting for you so far?

(Identify correct use of evidence-based treatment, discuss the level of evidence for others. [28])

2. Were you still smoking while you were on any of the treatment for quitting smoking?
Yes / No

Treatment:
- ☐ Nicotine patch
- ☐ Nicotine gum
- ☐ Nicotine lozenge
- ☐ Nicotine inhaler
- ☐ Nicotine Sublingual Tablet (Microtab)
- ☐ Buproprion (Zyban)
- ☐ Varenicline (Champix)
- ☐ Nortriptyline (Allegron)

(If yes, indicates the need for higher dose and/or combination of agents [29, 30])

When you attempted to quit smoking previously, did you experience any of the following:

☐ cravings ☐ anxiety ☐ nervousness ☐ tension ☐ irritability

☐ aggression ☐ depression ☐ lack of concentration ☐ indecisiveness

☐ lack of mental coordination ☐ insomnia ☐ hypersomnia

☐ hyperactivity ☐ headaches ☐ cramps ☐ lightheadedness

☐ constipation ☐ increase in appetite ☐ weight gain ☐ mouth ulcers

☐ Dreaming about smoking ☐ rationalising smoking

☐ missing the handling of the cig. ☐ focusing more on cigs.

Other:_____

(Identify symptoms of withdrawals at last quit attempt and the need to modify treatment to reduce/eliminate them for this attempt [31-33])

Medical History

☐ female:

☐ Pregnant

☐ Breast Feeding

☐ Oral Contraceptive

☐ HRT

(Discuss differences between women and men, premenstrual effects on exacerbation of symptoms of withdrawal [34]. Risks of oestrogen and smoking. [35])

☐ allergies _____

☐ Cardiovascular Disease

☐ Ischaemic heart disease

☐ Stroke

☐ Peripheral vascular disease

☐ Hypertension

(Discuss safety of NRT in cardiovascular disease [36, 37])

☐ Diabetes Mellitus

☐ Respiratory Disease

☐ Asthma ☐ COPD ☐ Pneumonia

☐ Malignancy

☐ Lung cancer ☐ Head and neck cancer ☐ Other cancer

☐ Epilepsy ☐ Osteoporosis

☐ Neurological Disease _____

☐ Psychiatric Disease

☐ Depression ☐ Anxiety ☐ Bipolar Disorder

☐ Schizophrenia ☐ OCD ☐ PTSD

☐ ADD ☐ Tourretic Disorder

Other:

_____

_____ ☐

Current medications

_____

_____

_____

Previously taken medications

☐ antidepressants _____

☐ tranquilizers _____

☐ sleeping tablets _____

Revised Fagerstrom Test For Nicotine Dependence

How soon after you wake do you smoke your first cigarette?

- Within the first 5 minutes
- Within 30 minutes
- 31-60 minutes
- After 60 minutes

(Time to first cigarette (TTFC) is the single best indicator of level tobacco dependence. [14, 38])

Treatment Prescribed :

_____

_____

_____

_____

Clinical Notes:

_____

_____

_____

_____

FREQUENTLY ASKED QUESTIONS

Can you get addicted to NRT?
Addiction to NRT products is almost non-existent and they have been used safely by millions of smokers.

Are some of the NRTs too strong?
It is very rare for anyone to be started on a weaker dose.
Many times one strong NRT, e.g., patch is not enough and another (1 or 2) or other NRT needs to be added.

What happens if you smoke while on NRT?
Usually nothing, at worst some nausea. There are no reported cases of deaths in people wearing patches and smoking.

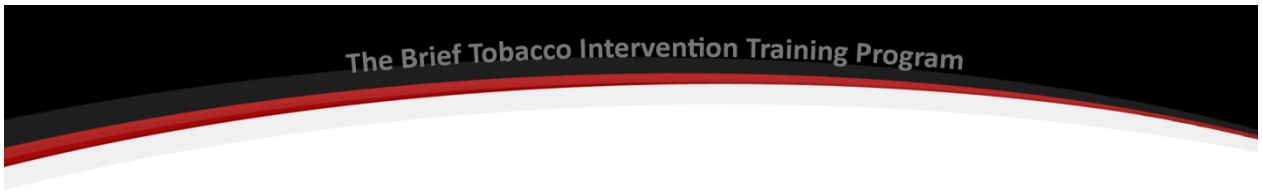
Does it help to remove the patch when smoking?
There is no point as the nicotine is absorbed subdermally and is still in the skin when the patch is removed. It may take hours for the subdermal nicotine to dissipate so there is no point in removing the patch first.

Is wearing the patch only delaying the inevitable withdrawals from nicotine?
The principal of the patch is low dose, slow release nicotine to satiate (or bathe) the brain cells and "desensitize" them to nicotine. This takes weeks but will prevent the fall from nicotine that happens abruptly when quitting cold-turkey.

Can you cut the treatment short if you are not smoking and don't feel any urges?
It is strongly advised that the smoker does not cut the treatment short as they will risk relapsing to smoking. A minimum of 8-12 weeks, every day is essential. There is evidence that even longer is better and prevents relapse in the long term.

What are the causes of the vivid dreams?
Nicotine is a stimulant and though people do not smoke while asleep, the low dose of nicotine from the patch will stimulate the brain and cause dreams. This is not serious and people should not stop wearing the patch at night unless they are awakened by the dreams. Most people quickly adapt and these effects wear off.

Appendix 3: Fagerstrom Test for Nicotine Dependence



	PLEASE TICK (√) ONE BOX FOR EACH QUESTION	
How soon after waking do you smoke your first cigarette?	Within 5 minutes 5-30 minutes 31-60 minutes	☐ 3 ☐ 2 ☐ 1
Do you find it difficult to refrain from smoking in places where it is forbidden? e.g. Church, Library, etc.	Yes No	☐ 1 ☐ 0
Which cigarette would you hate to give up?	The first in the morning Any other	☐ 1 ☐ 0
How many cigarettes a day do you smoke?	10 or less 11 - 20 21 - 30 31 or more	☐ 0 ☐ 1 ☐ 2 ☐ 3
Do you smoke more frequently in the morning?	Yes No	☐ 1 ☐ 0
Do you smoke even if you are sick in bed most of the day?	Yes No	☐ 1 ☐ 0
	Total Score	
SCORE	1- 2 = low dependence 3-4 = low to mod dependence	5 - 7= moderate dependence 8 + = high dependence

Add up the scores from the questionnaire

Information about scoring the Test is on the next page.

Appendix 4: Nicotine Replacement Therapy Options

NRT	Time to Peak Effect	Recommended Dose	How to Use
Patches	2-6 hours	21mg/ 24 hours OR 25mg/ 16 hours	Place a patch on clean, dry, hair free skin. Do not apply straight after a hot shower. Commence patch at night to cover morning cravings for nicotine. Rotate the patch site daily to prevent build-up of adhesive.
Gum	15-20 minutes	4mg Every 1-2 hours	Chew the gum until a bitter taste or tingling emerges, then tuck the gum into your cheek pocket. When the flavour disappears, repeat. Chewing more frequently does not increase the amount of nicotine released.
Mist spray	<5 minutes	1-2 sprays Maximum of 4 sprays/ hour	Spray two pumps of the mist spray under your tongue. The nicotine is absorbed through the lining of your mouth.
Lozenge	20 minutes	4mg Every 1-2 hours	As the lozenge dissolves nicotine is released into your saliva. Try not to swallow your saliva. Sucking or chewing on the lozenge does not speed up the nicotine release. The lozenge stops being active if swallowed. Do not eat 15 minutes before use and do not eat or drink with the lozenge in your mouth. It takes about 20 minutes to dissolve.
Inhalator	20-30 minutes	10mg cartridge Every 2 hours	Breathe in and out through the inhalator in short puffs whenever you feel like a cigarette. The nicotine in the cartridge will evaporate over 2 hours once removed from packaging.

Appendix 5: Common medication interactions with smoking cessation

Most commonly it is tobacco smoke, and not nicotine, that causes medication interactions through induction of the CYP450 hepatic enzymes. Generally medication levels increase with smoking cessation and a lower dose may be required.

Medication	Interaction with smoking	Action required
Antipsychotics		
Clozapine	Smoking increases clearance	Dose reduction required on smoking reduction/ cessation to avoid toxicity
Olanzapine	Smoking increases clearance	Dose reduction required on smoking reduction/ cessation to
Haloperidol	Smoking increases clearance	May require dose reduction
Antidepressants		
Fluvoxamine	Smoking increases clearance	Monitor, may require dose reduction
TCAs	Smoking increases clearance	Monitor
Drugs for Dementia		
Rivastigmine	Smoking increases clearance	Decreased dose may be needed
Tacrine	Smoking increases clearance	Decreased dose may be needed
Benzodiazepines		
All	Smoking increases clearance	Monitor for increased sedation
Cardiovascular drugs		
Propranolol	Smoking increases clearance	Closely monitor and consider dose reduction
Verapamil	Smoking increases clearance	Closely monitor and consider dose reduction
Warfarin	Smoking increases clearance	Closely monitor INR and reduce dose
Diabetes drugs		
Insulin	Reduced subcutaneous absorption	Monitor BSLs, may need dose adjustment
Oral hypoglycaemics	Nicotine can increase plasma glucose	Monitor BSLs, may need dose adjustment
Respiratory drugs		
Theophylline	Smoking decreases clearance	Monitor levels and adjust dose
Other		
Caffeine	Smoking increases clearance	Recommend reducing intake

Appendix 6: GP letter template example

Department of **Health**
Mental Health

Private and Confidential
Not to be released without
permission of the Author

Great Southern Mental Health Service
Hardie Road, Albany
PO BOX 252, Albany WA 6331
Phone: 9892 2440 - Fax: 9892 2605

Wednesday, 22 August 2018

Dr Barry Smith
GP Practice
1 GP Practice Road
Albany, WA 6330

Dear Dr Smith,

Re: Miss Patient, UMRN G1100110
DOB 01/01/1990
Address: 1 Waterfall Drive, Albany, WA, 6330

Today I had the pleasure of reviewing Patient, a 28 year old female with moderate nicotine dependence. Please find below a summary of the consultation.

Diagnosis/ Issues List:

1. **Moderate nicotine dependence:**

Date	FTND /10	Initial Expired Carbon Monoxide (ppm)	Time to First Cigarette	No. of Cigarettes in 1st Hour of Waking	Number of Cigarettes Per Day
10/8/18	4	8	<5	2	4-6
22/08/18	7	28	<5	2	11-20

Management suggestions & plan:

1. Patient has been prescribed a nicotine patch 21mg/24 hours daily.
2. Use of pulsatile nicotine inhaler has been discussed and encouraged in conjunction with the nicotine patch and information has been provided.
3. Behavioural strategies of increasing regular short bursts of exercise and use of hard boiled sweets have been encouraged.
4. Follow up has been arranged in 1 week's time with Clinical Nurse Specialist (Nurse Y) 04/09/2018 at 09:00.

Kind regards,

Dr Mary Jane
RMO for Consultant Psychiatrist Dr Joe Bloggs

CC: Nurse Y (Clinical Nurse Specialist)