Smoking Care Guideline – Albany Hospital Acute Psychiatric Unit

1. Guiding Principles

Cigarette smoking is the leading preventable cause of death in Australia. People with mental illness have rates of smoking 2-3 times higher than that of the general population and are more likely to experience ill health and death as a result of smoking related illnesses. While people with mental illness who smoke have higher levels of nicotine dependence, they are just as likely to want to address their smoking behaviours and just as likely to alter their tobacco use with appropriate support as the general population. 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. Cigarette smoking, and nicotine withdrawal can impact on symptoms of mental illness and effectiveness of mental health and medical treatment. Time spent on smoking related activities reduces the amount of time available for therapeutic engagement and activities.

Behavioural and pharmacological interventions are effective in helping patients admitted to Acute Psychiatric Units (APUs) abstain from smoking and to maintain changes in their smoking behaviour in the long term. Not engaging in smoking cessation activities acts as a lost opportunity for significantly improving mental and physical health outcomes.

The purpose of this document is to provide guidance for staff caring for patients on the Albany Acute Psychiatric Unit from their initial assessment to discharge and beyond, in order to effectively address nicotine dependence in a supportive and evidence-based manner. All staff have a responsibility for their own health and the health of others on the ward by working in accordance with this guideline.

The Smoke Free Policy requires that all WA health system entities are smoke free and sets the requirements to achieve a smoke-free environment and uphold their responsibility to prevent exposure to second-hand smoke. This is supported by the WACHS Smoke Free WA Health Policy Implementation Procedure.

2. Guideline

Assessment

The WACHS Nicotine Dependence Screening Tool (Appendix 1) must be completed on admission to enable strategies to manage nicotine dependence to commence at the earliest possible opportunity. This screening tool assesses smoking status and time to first cigarette (TTFC) which is a measure of nicotine dependence and a useful guide for how much nicotine replacement a patient might need.

With the patients consent, a Carboxymeter reading is taken to monitor initial expired Carbon Monoxide (eCO) levels. This can confirm smoking status and be used as a comparison to readings after a period of abstinence later in the admission.

All staff admitting patients who smoke cigarettes to the ward must enquire about past attempts to change their smoking status to determine what was effective or where changes could be made.

All patients are informed that the ward is a smoke free environment and that this Smoking Care Guideline is in place to ensure nicotine dependence will be well managed during their time on the ward. Reassurance and early intervention, e.g. combination Nicotine Replacement Therapy (NRT), will be offered to all patients to manage this transition. Patients who smoke should also be informed of the Great Southern Mental Health Service's Smokers Clinic and referrals for interested patients made as early as possible.

Patients who use E-Cigarettes (vaporisers) require assessment of their nicotine dependence. E-Cigarettes are not permitted on the Albany APU.

As with other patient property, packets of cigarettes or tobacco are to be noted on admission and stored for patients until discharge. Patients are encouraged to store these inpatient lockers or give them to friends or family rather than keep them on their person. Lighters and matches are not permitted on the APU.

Nicotine Withdrawal

Recognising and managing nicotine withdrawal improves a patient's wellbeing and compliance with this Smoking Care Guideline and enhances their ability to engage in other therapeutic activities.

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

Smokers Clinic Referral

All nicotine dependent patients in GSMHS (inpatient and community based) can be referred to the Smokers Clinic for targeted management and follow up for up to 8 sessions with a medical officer. The Smokers Clinic can provide additional support and treatment to smokers. Refer to Smokers Clinic Guideline.

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. 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.

Key Points

Elimination half-life of nicotine is 40-120 minutes, meaning patients will seek to smoke unless their need for nicotine can be provided in this time. Short acting nicotine may need to be provided during the admission process.

Nursing and medical staff share the responsibility for making sure a patient's NRT needs are adequately covered. Nursing staff may initiate NRT via the Nurse Initiated Medication protocol in the WACHS Medication Prescribing and Administration Policy while medical staff are responsible for charting adequate NRT on review, throughout the admission and before discharge.

Clinical staff should advise patients of the correct use of different NRT products and reminders of this should be placed on the ward. Written information and instructions should be provided to all patients using NRT

All patients should be charted for regular long acting NRT through patches and additional short acting NRT in alternative forms if they smoke cigarettes, regardless of their intent to smoke when discharged from the ward.

Many patients will be high level nicotine dependent, meaning that a single patch and use of one form of short acting nicotine will be inadequate to cover their replacement needs. If patients are reporting ongoing cravings or withdrawal, or these are observed by staff, then additional nicotine should be offered. (See Flow Chart Appendix 3)

Monitoring cravings for smoking cigarettes provides an assessment of the effectiveness of combination NRT. Nursing and medical staff should titrate NRT dosing upwards if patients continue to experience cravings.

Patients going on leave should be offered NRT to take with them to reduce the chance of smoking on leave. Carboxymeter eCO readings should be undertaken, with patient consent, on return from leave to demonstrate the effects of smoking, or not, whilst on leave. eCO readings provide immediate biofeedback for smokers to observe the effect of NRT and other treatments vs smoking, acting as an individualised motivator to engage/continue with nicotine dependence treatments.

Some patients may be concerned about becoming dependent on forms of NRT. Education should be provided that the nicotine in NRT is to replace that from cigarettes and is a harm minimisation strategy that is safe to continue for as long as needed. NRT is also an effective treatment strategy to achieve smoking cessation and nicotine dependence over time. Nicotine receptors in the brain down regulate, making it easier for people to cease NRT than it is to stop smoking 'cold turkey'.

Other smoking cessation medications (see below) are available in addition to NRT. Patients who are interested in trialling these medications should be referred to the smokers' clinic.

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. 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. Prescribers should refer to the medication safety sheet before prescribing any medications. Patients interested in trialling this treatment should also be referred to the GSMHS Smokers Clinic.

Bupropion

Bupropion (Zyban) is a prescription medication that targets dopamine and nor-adrenaline systems in the brain. While less effective than combination NRT and Varenicline, Bupropion can have some useful anti-depressant effects. There are some contraindications to prescription which must be considered before prescription. Patients interested in trialling this medication should also be referred to the GSMHS Smokers Clinic.

Drug Interactions in Smoking Cessation

Products in tobacco smoke (Polycyclic aromatic hydrocarbons (PAH's)) 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 Bupropion do not affect hepatic clearance in this way but may have other drug interactions. Common medication interactions with smoking cessation are listed in Appendix 4.

Clozapine is particularly sensitive to changes in levels of tobacco smoking and this interaction should be discussed with patients both when commencing clozapine and before discharge. Smoking status should be part of every clozapine initial workup and review. Blood levels should be taken if the level of tobacco use changes.

Behavioural Support Interventions

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 on the ward 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.
- 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.

Approaching People Non-adherent with the Smoking Care Plan

Given previous allowances for exemptions under the WA Health Smoke Free Policy, there will be times when patients, visitors, contractors or staff may smoke in areas where this is no longer allowed. The key steps to addressing this are:

- Assume the individual is unaware of the policy.
- Politely inform them that the ward is smoke free.
- Let the individual know that there is plenty of assistance for them if they are craving a cigarette or are in nicotine withdrawal and then offer either NRT, behavioural intervention or both.
- Indicate that all of the Albany Health Campus is Smoke Free and therefore smoking is only to occur off the campus.
- As in any situation, staff safety is paramount and if there is any concern about aggression the individual should be approached in a pair and any aggression should be managed ideally with verbal de-escalation before further action is taken in line with the WACHS Disturbed Behaviour Management Clinical Practice Standard.

Smoking on Ward Leave

Patients may have leave from the ward for appointments, time with family, for recovery related activities or community re-integration. During this time off hospital ground the choice to smoke is an individual one. That being said, patients should be given the best chance to continue to address their changes in smoking behaviour.

- Offer encouragement to continue abstinence off the ward
- Discourage taking cigarettes whilst on leave
- Offer short acting NRT to take on leave
- Advise that nicotine withdrawal can be exacerbated if smoking intermittently

- If a patient has smoked whilst off the ward, offer to measure CO levels by use of the Carboxymeter to demonstrate the immediate effects of smoking and to re-engage in smoking care strategies

Leave off the ward specifically to smoke is against the spirit of the WA Health Smoke Free Policy as it negates the physical and mental health benefits of going smoke free and increases the symptoms of nicotine withdrawal with intermittent smoking. Thus, specific 'smokers leave' has no place in a smoke-free health campus.

On organised outing from the ward there should be no smoking and patients should be encouraged to bring a short acting form of nicotine with them on these trips.

Staff Facilitating Smoking

Staff may be approached by patients to facilitate obtaining cigarettes. This function is not appropriate under the WA Health Smoke Free Policy.

Discharge Planning

An admission to Albany APU with a smoking care approach is an opportunity for patients to address their smoking behaviour. To maintain the benefits there must be planning for continuation of care for the patient upon discharge. This includes;

- Discussion with the patient regarding the benefits of continuing to reduce or cease tobacco use
- Repeat readings with the Carboxymeter to show the physical benefits of addressing tobacco use
- Recognition of cues to smoke and ways to manage cues and cravings.
- Referral to the Smokers Clinic, ideally done early in the admission so an appointment can be made before discharge
- Offering short and long acting NRT and/or pharmacology to continue at home
- Including the smoking cessation actions taken, including amount of NRT required, in the discharge summary
- Referral to additional resources, such as Quitline 13 78 48
- Adding smoking related diagnoses to the discharge summary including advice to General Practitioners for continuation of care and options
- Include smoking plan in the care transfer summary

Nicotine Dependent Staff

A portion of staff working on a smoke free ward will themselves be dependent on nicotine. Smoking cessation interventions including NRT and referral to the Smoker's Clinic are available free of charge to staff of GSMHS staff and they should be encouraged to take this opportunity.

For staff who continue to smoke the following should be considered:

- Staff must leave hospital grounds to smoke
- Regularly scheduled breaks may be used for smoking, but 'smoke breaks' are not permitted in addition to these

- Staff should be mindful of the effect that residual toxins and the smell of cigarettes may have on a smoke free ward

3. Definitions

Nicotine Replacement Therapy (NRT)	Pharmacotherapies designed to alleviate nicotine withdrawal. Include nicotine patches, mist spray, lozenge, gum and inhaler.
Polycyclic Aromatic Hydrocarbons (PAH's)	Organic compounds produced by smoking tobacco which interfere with medication metabolism by inducing certain liver enzymes.
Smoker's Clinic	An outpatient program provided by GSMHS for patients seeking to increase their awareness of the health risks of smoking and/or quit smoking. The program is provided by the Resident Medical Officer under the supervision of a Consultant Psychiatrist

4. Roles and Responsibilities

As described throughout the guideline

Clinical Nurse Manager of APU and smoking clinic staff: Are responsible for ensuring all staff are orientated to the process for managing smoking on the unit and ensuring there are processes in place to communicate this information to patients.

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 policy document 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 the GSMHS Management Committee, in consultation with key internal stakeholders using audit tools developed by the in consultation with key internal stakeholders. Monitoring of compliance with this document is to be reviewed every five (5) years.

8. Standards

National Safety and Quality Health Service Standards - 1.29, 2.10, 4.13, 5.10, 5.12, 5.13
National Standards for Mental Health Services - 2.6, 10.5.1

9. Legislation

Mental Health Act 2014
Occupational Safety and Health Act 1984 (WA)
Occupational Safety and Health Regulations 1996
Tobacco Products Control Act 2006

10. References

A.Davies, H.Ngo, M. Coleman. Australasian Psychiatry. An Evaluation of a pilot specialist smoking cessation clinic in a mental health setting. 2018
Campion J. Review of smoking cessation treatments for people with mental illness. Adv. Psychiatr. Treat. 2008
King DP. Smoking cessation pharmacogenetics. Analysis of varenicline and bupropion. Neuropsychopharm. 2012
Australian National Survey of Mental Health and Wellbeing. ABS 2008

11. Related Forms

GS TMR 201D Nicotine Dependence Screening Tool

12. Related Policy Documents

WACHS Smoke Free WA Health Policy Implementation Procedure
Smokers Clinic Guideline - Great Southern Mental Health Service
Medication Prescribing and Administration Policy
WACHS Disturbed Behaviour Management Clinical Practice Standard

13. Related WA Health System Policies

MP 0158/21 Smoke Free Policy
Guidelines for Supporting Involuntary Mental Health Inpatients
Guidelines for the Implementation of the Smoke Free Policy

14. Policy Framework

Public Health Policy Framework

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

Contact:	Regional Mental Health Manager		
Directorate:	Mental Health	**EDRMS Record #**	ED-CO-19-29879
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Appendix 1

PLEASE USE ID LABEL OR BLOCK PRINT

Hospital _____	Surname	MRN	
Nicotine Dependence Screening Tool	Given Name	DOB	Sex
Taken by: _____ Date: _____	Address		Post Code

ASK, ACT, ADVICE (RECORD and COMMUNICATE)
All clients are to be informed of the Smoke Free WA Health System Policy.

Ask and Act: Every person who accesses a health service should be asked about smoking at admission and offered support to quit, during hospital stay or as outpatient

Do you currently smoke? (Do not re-ask if screening prompted by MR111. Tick yes and follow flow -chart) → ☐ **No:** No further intervention

↓ ☐ **Yes**: Time to First Cigarette (TTFC)?

↓ ☐ Smokes within 30 minutes of waking. Will need support to manage nicotine dependence.

→ ☐ Smokes after 30 minutes of waking. May need support for nicotine dependence.

☐ **Make offer of combination NRT immediately to manage withdrawal.**
Fast acting NRT and a patch. If offer declined but withdrawal symptoms arise re-offer and encourage NRT. (Turn page for details)

☐ **Make offer of NRT if client reports withdrawal symptoms or asks for help to manage withdrawal.**
Fast acting NRT. May require patch or other NRT products if cravings persist. (Turn page for details)

Outpatients and Primary Health Care Settings:

- Depending on referral pathway client may have recently been screened as inpatient. If they are attempting to quit, acknowledge progress and encourage them to continue. If not quitting, ask if they would like help to start today.
- Provide education about and encourage the use of NRT (Turn page for details).
- Consider prescribing NRT and or other pharmacotherapies if this is an option.
- Check and affirm progress or provide encouragement to make another attempt in any subsequent appointments.

Advice: All clients offered support for smoking cessation

- Advice patient that quitting smoking is best for their health.
- Provide quit resource to client and encourage them to complete self-help resources.
- Provide education about recognising cues and triggers to smoke and suggest ways to effectively manage cravings. (Turn page for details)
- Refer client to GP, or local specialist cessation support or treatment program. Refer and encourage contact with Quitline 13 7848 and provide link to online resources http://www.quitnow.gov.au.

Record: Document nicotine dependence and brief intervention in the patient medical record, and in inpatient setting chart NRT use.

GS TMR 201D NICOTINE DEPENDENCE SCREENING TOOL

Communication at discharge: Every person who smokes can access ongoing support to quit

- Acknowledge smoke free efforts during admission. Affirm any decision to cease smoking post discharge.
- Document nicotine dependence and or smoking related diagnoses in referrals and discharge summary. Include a summary of any actions taken during admission or outpatient appointment, including use/dose of NRT, behavioural advice and outcomes of these actions.

Nicotine Replacement Therapy

- NRT aims to replace the nicotine from smoking cigarettes with safe alternatives to reduce symptoms of nicotine withdrawal and is also a treatment for smoking cessation.
- Fast acting NRT should always be offered. Ensure NRT products are being used correctly.
- Combination NRT (patch and fast acting) is more effective at supporting temporary abstinence and/or changing smoking behaviour than monotherapy.
- People who report NRT to be ineffective are not being adequately replaced and should be offered higher dosages or more frequent fast and long acting NRT. Smoking in addition NRT or continued cravings to smoke indicate under-dosing of NRT.
- There are few contraindications associated with NRT use. It is very safe with minimal addictive potential and no serious side effects.
- NRT should be used cautiously in people with recent coronary events, pregnant women, weigh less then 45kgs, people with phenylkenonuria, or hypersensitivity to nicotine. Specialist advice may be required in these cases. Refer to the WACHS Alcohol Tobacco and Other Drugs Clinical Practice Standards for further information.

Product Guide

NRT	Product Information
FAST Mist spray	**1-2 sprays, maximum of 4 sprays/ hour. Time to Peak Effect (TTPE) - <5 minutes** Spray two pumps of the mist spray under your tongue. The nicotine is absorbed through the lining of your mouth. Product is very effective and should be offered to all clients.
FAST Gum	**4mg every 1-2 hours. TTPE – 15-20 minutes** Chew the gum until a bitter taste or tingling emerges, then tuck the gum into your cheek pocket. When the flavour disappears, repeat. Nicotine is absorbed through lining of the mouth. Chewing more frequently does not increase the amount of nicotine released.
FAST Lozenge	**4mg every 1-2 hours. TTPE - 20 minutes** As the lozenge dissolves nicotine is released into your saliva. Try not to swallow your saliva as nicotine is absorbed by lining of the month. 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.
FAST Inhalator	**10mg cartridge every 2 hours. TTPE - 20-30 minutes** Breathe in and out through the inhalator in short puffs, holding the product in your mouth where it is absorbed whenever you feel like a cigarette. The nicotine in the cartridge will evaporate over 2 hours once removed from packaging.
LONG Patches	**21mg/ 24 hours OR 25mg/ 16 hours. TTPE – 2-6 hrs** 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. Patches are most effective when combined with fast acting product.

Behavioural supports for smoking cessation

- There are no benefits in providing smoking cessation advice based on an assessment of motivation to quit. Health professionals should provide advice, in a non-judgemental way, that the client should quit and then support any decision to quit with immediate access to NRT, referral to treatment, education and resources.
- Assist client to identify and manage behavioural cues and triggers to smoke. Provide education around that nature of cravings and how to use behavioural techniques to manage triggers and 'urge surf' cravings.
- Behavioural interventions for quitting include relaxation techniques, brief periods of exercise, eating breakfast, using small sugary sweets for cravings, distraction and/or Quit buddy App. Encourage client to try the 4 Ds of Quitting. Delay, Deep breathe, Drink water, Do something else.
- Acknowledge that smoking cessation is difficult, whilst providing encouragement, positive feedback and validation regarding progress. Highlight economic benefits of quitting smoking and encourage client to prompt spouse or family members to also quit smoking.

Appendix 2:

Who requires nicotine replacement?

Anyone who smokes within 30 minutes of waking and/or experiences nicotine withdrawal on reduction or cessation of smoking. For those whose TTFC is >30 minutes but experience cravings, short acting NRT should be offered.

Combination of long acting NRT (patches) and short acting NRT is more effective at changing smoking behaviour than monotherapy.

People will titrate their nicotine usage to what they require. Smokers with mental illness often require more nicotine, which may differ from patient information leaflets.

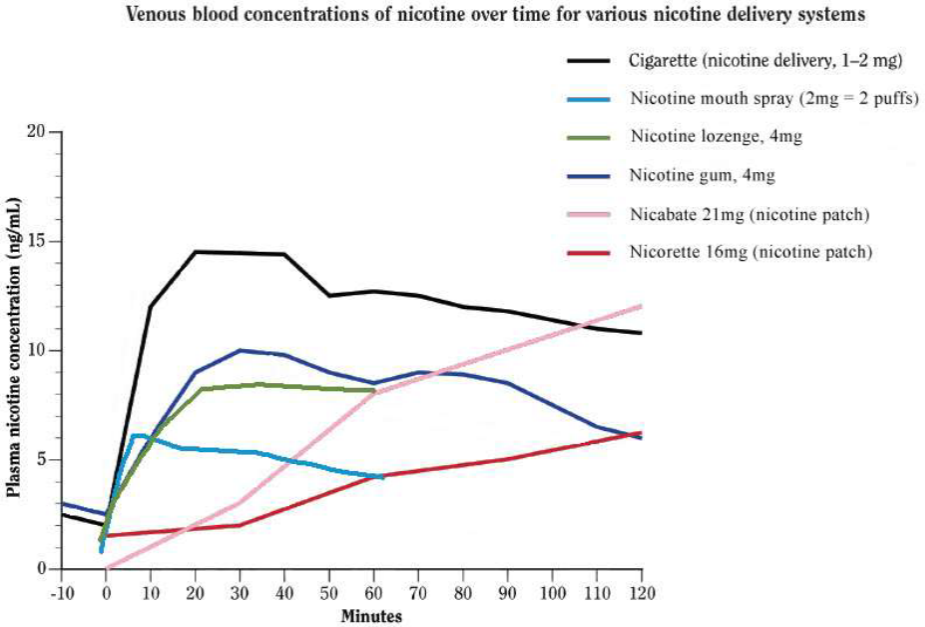
People who report NRT to be ineffective are not being adequately replaced and should be offered higher dosages or more frequent short and long acting NRT.

Contraindications

NRT should be used cautiously in people with recent coronary events, pregnant women, people with phenylkenonuria or hypersensitivity to nicotine. Nicotine gum should be avoided in patients with dentures. Patients with chronic throat conditions or unstable asthma should use inhalationals with caution. In most cases NRT is still much safer than smoking cigarettes. Any persons with contraindications should be immediately referred to the Smoker's Clinic and their treating team should be notified.

People under the age of 18 can use NRT safely but should be assessed by a medical officer prior to initiation. NRT is contraindicated in people under the age of 12.

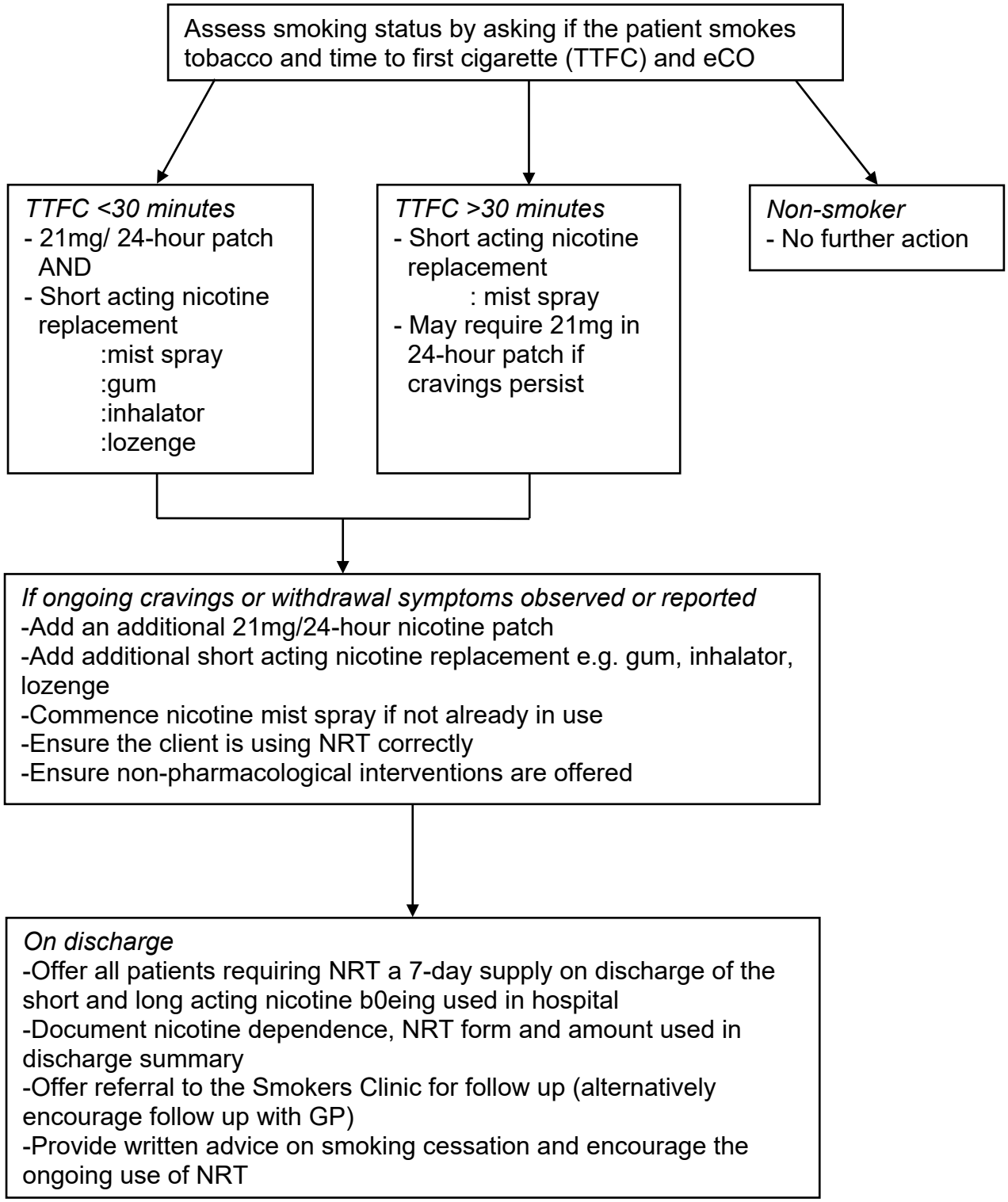
NRT dose for people weighing <45kg may need to be adjusted.



Source: Adapted from Fant et al. 1999 with permission from Elsevier, ©1999.
Note: **mg** = milligrams; **ng/mL** = nanograms per milliliter.

The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General, 2014

Appendix 3: Nicotine Replacement Flow Chart



Appendix 4: Drug 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