EXECUTIVE SUMMARY

Introduction

Smoking is a leading cause of death and disability in Ontario today. It causes about 25 life-threatening diseases, including heart disease, stroke, lung cancer and respiratory disease. However, smokers who quit can significantly reduce their risk of developing these diseases. Many of these benefits happen immediately, while others take longer. Helping smokers quit also has significant fiscal and social benefits. This report presents current trends related to quitting in Ontario, up-to-date evidence on quitting interventions, and a listing of smoking cessation programs and resources available in Ontario. Our recommendations call on government, communities, health professionals, workplaces and families to effectively deal with smoking at a population level.

Smokers in Ontario *can*, and *do* quit smoking…but more should be thinking about it and doing it

Although quitting smoking can be difficult, the good news is that half of Ontarians who have ever smoked and are still alive have already quit smoking (Fig. 1). Regrettably, nearly half of all remaining smokers aren't even thinking of quitting (Fig. 2). Only one third of current smokers in Ontario make a serious attempt to quit each year.

Help is available to smokers in Ontario who want to quit…but help is hard to find without a systematic referral system

A significant number of government and non-government agencies offer programs to assist smokers to quit smoking (see Chapter 4 for a comprehensive list of resources and services with contact information). However, there are gaps in knowledge related to access, uptake, effectiveness, and cost-efficiency of these programs that make it difficult for smokers to get the help they need. There is no systematic referral system available in the province.

We need to let smokers know what works and how to get it

Businesses are well aware of the importance of marketing their services and products to the appropriate audience. However, the health community does not do the same for smoking cessation resources. Studies indicate that marketing campaigns can dramatically improve the utilization of cessation interventions, particularly if messages are worded and communicated differently for specific populations. Ontario should have a systematic and segmented marketing campaign to better inform smokers of the benefits of quitting and how to get assistance.

We should not ignore the positive impact of strong tobacco control policies on smoking cessation

Four in ten former smokers cite the cost of tobacco as one reason why they quit (Fig. 3). Six in ten current smokers cite others' smoking as one reason why they started smoking again after quitting (Fig. 4). Smoking prevalence is higher in environments where smokers are regularly exposed to others' smoking (Fig. 5). Public policies, such as smoking bans in public places and workplaces, as well as increases in tobacco taxes, may contribute significantly to smokers' chances of remaining smoke-free.

We can address each of the reasons given by smokers for their relapse

The most common reasons for relapse reported by current smokers are strong urges to smoke, others smoking around them, and stress (Fig. 4). Other reasons are drinking alcohol, lack of social support, irritability (a symptom of withdrawal), and weight gain. We are able to address each of these reasons. Properly designed behavioural interventions can help smokers to cope with urges to smoke, stress, and weight gain. Pharmacotherapies known to be effective, such as nicotine replacement therapy and bupropion, can help smokers control their withdrawal symptoms. Public policies and greater public awareness, together with local mutual aid groups can provide the environmental and social support that smokers need and deserve.

Determining the best way to assist smokers to quit is not an easy task

Recommending ways to quit involves more than just implementing the effective strategies in Chapter 3. There are some important caveats. The cost-efficiency of each intervention should be considered. Smokers do not have an equal probability of success: some are more likely to succeed in some programs than others. Further, the body of knowledge on smoking cessation is sparse for some populations. For example, we are unaware of *any* single smoking cessation intervention that has been rigorously proven effective with young smokers. Lastly, we should broaden our definitions of success. Currently, measures of success are limited to dichotomous outcomes (success vs. failure) that do not capture other changes, such as an increase in learning or self-efficacy, that may eventually lead to behaviour change. Success could also be defined as a substantial reduction in smoking. A reduction in the number of cigarettes smoked in the population as a whole would lead to a net reduction in excess risk of smoking-related morbidity or mortality attributable to a given treatment. Program providers, policy analysts, consumers, health care professionals and others need to exercise caution when attempting to select the "best practices."

Recommendations

Helping smokers improve their chances of quitting and staying quit will require commitment, careful planning, co-ordination, and considerable effort on the part of government, communities, health care providers, workplaces, and families.

We offer the following recommendations to effectively deal with smoking at a population level:

1. Begin immediately to develop a comprehensive population-based smoking cessation strategy for the province of Ontario and incorporate it as part of the Ontario Tobacco Strategy.

2. Fund and implement services, policies, media campaigns and other interventions through the strategy that maximally reduce the expected smoking-related burden on health among current smokers.

3. Develop and implement the cessation strategy in co-operation with major stakeholders concerned with tobacco cessation, including the Ontario Ministry of Health and Long Term Care, voluntary agencies, independent health practitioners, business, and researchers.

4. To ensure continuity and coordination, the Ministry of Health and Long Term

Care should play an active role in formulating policy and providing services though the Health Promotion Branch, the Public Health Branch, local health departments, etc.

5. Base the strategy on the latest scientific, clinical, and economic evidence and subject it to continuous evaluation. Interventions should include, at a minimum:

    - Training for physicians, nurse practitioners, pharmacists, dentists and other health professionals to provide brief interventions for smoking cessation in accordance with the latest practice guidelines;
    - A province wide toll-free telephone helpline that smokers, health professionals and others can call to receive information on available cessation services, request suitable self-help materials, and receive advice and support to quit from trained counsellors;
    - A request that the federal government require tobacco manufacturers to print the toll-free cessation helpline number on every tobacco package distributed in Ontario;
    - An extensive media campaign to inform smokers of the benefits of quitting as well as how and why to seek assistance to quit;
    - Mutual aid support groups in every major community in Ontario;
    - A network of clinics where smokers who meet certain criteria can receive free one-on-one or group counselling from a qualified professional counsellor;
    - Specialized cessation interventions in every hospital and cancer treatment centre in the province;
    - Financial support to assist individuals with low incomes to purchase a limited supply of approved pharmacological smoking cessation aids;
    - Training and materials for workplaces willing to sponsor a cessation program;

    Three key regulatory interventions could also substantially impact cessation and relapse:

    - A substantial increase in tobacco taxes to ensure prices are at least as high as those of surrounding provinces and states;
    - A province-wide ban on smoking in all indoor workplaces and public places;
    - A request that the Federal Government strictly regulate the amount of nicotine in tobacco products.

6. Use existing resource centres to identify and disseminate best practices in tobacco cessation.

7. Provide financial support for program developers and researchers to rigorously evaluate new or promising evidence-based interventions.

8. Provide financial support to researchers to develop innovative methods to improve the population impact of smoking cessation.

9. Continuously monitor/evaluate each component of the strategy, as well as its overall impact.

10. Based on the work of the United States Centers for Disease Control and Prevention, as well as the experience of

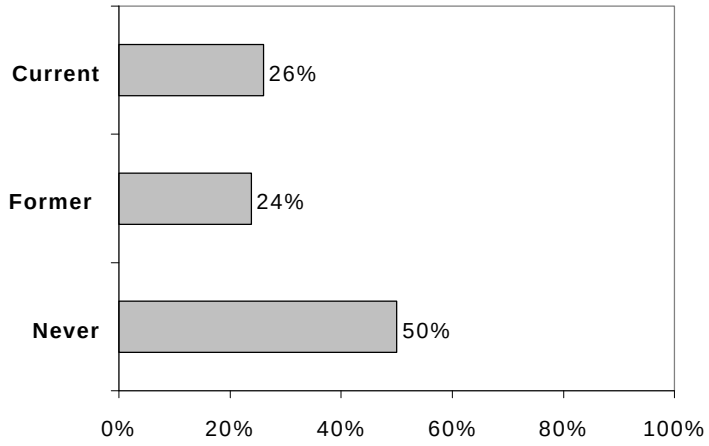
other jurisdictions, provide annual funding through the Ontario Ministry of Health (exclusive of physician billings to OHIP) to implement the cessation strategy in the amount of:

- $4 per smoker to advise smokers about the benefits of quitting, promote the availability of smoking cessation services, establish a telephone helpline, and provide written and internet-based self-help materials;
- $2 per smoker to train health care professionals, provide them with resources and encourage them to provide brief counselling as appropriate;
- $6 per smoker to establish a comprehensive network of support groups, support worksites, and cessation clinics across the province;
- $2 per smoker to supplement the cost of pharmacological treatments for low income smokers and the provision of pharmacological treatments through clinics.
- $0.50 per smoker to support policy development and administration of the cessation strategy;
- $ 1.50 per smoker to support the identification of best practices for tobacco cessation, monitor progress towards the cessation strategy's objectives, and stimulate basic and applied research to improve the effectiveness, efficiency, accessibility and acceptability of smoking cessation interventions.

It is noteworthy that the total cost of financing these recommendations is $32 million per year. This is less than 7 per cent of the annual revenue generated by provincial tobacco taxes.

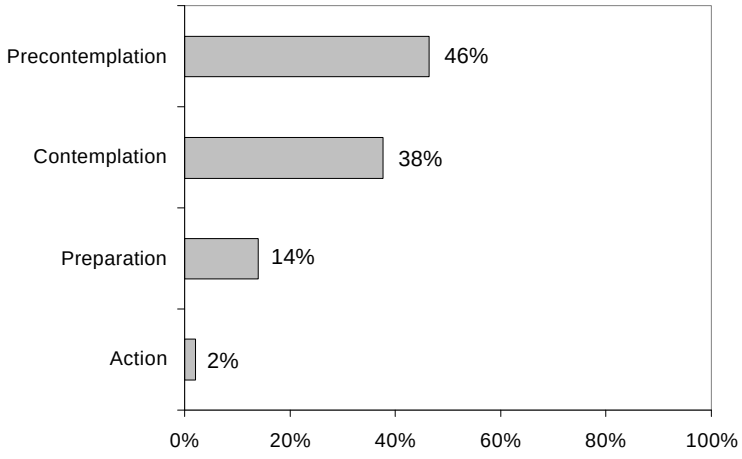
The good news is that people want to quit and many already have. Effective interventions do exist. We simply need a comprehensive and co-ordinated approach to deal with this complex and urgent problem.

Fig. 1: Smoking Status (% Former Smokers)
Age 18+, Ontario 1998



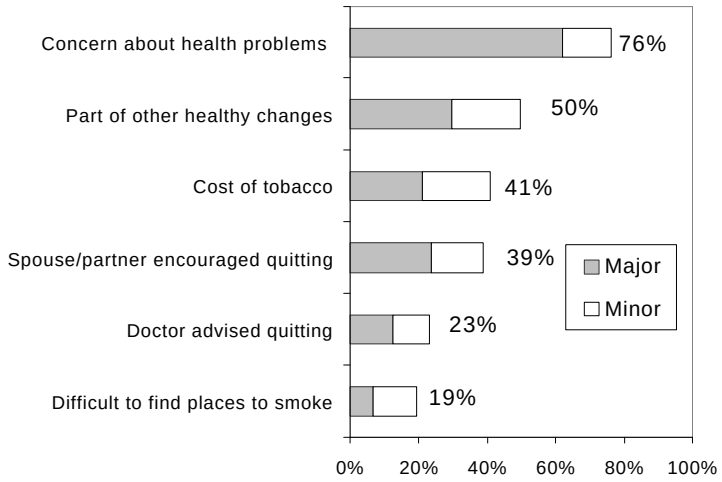
Source: Ontario Drug Monitor 1998, CAMH

Fig. 2: Current Smokers by Stage of Change,
Age 18+, Ontario 1998



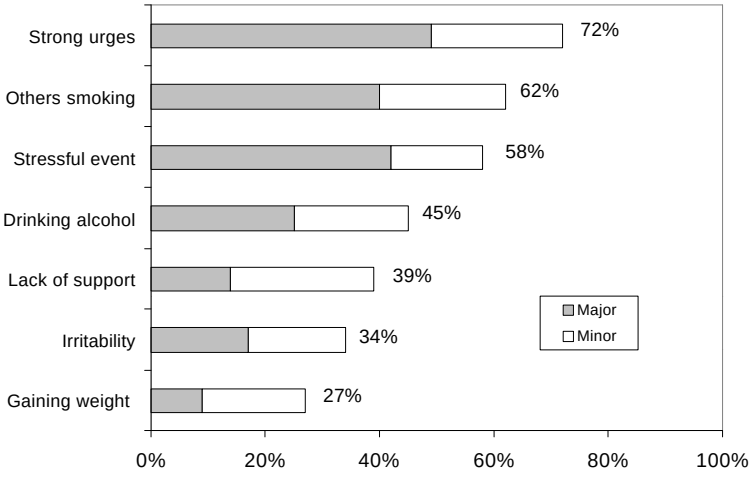
Source: Ontario Drug Monitor 1998, CAMH

Fig. 3: Former Smokers' Reasons for Quitting, Age 18+, Ontario 1996



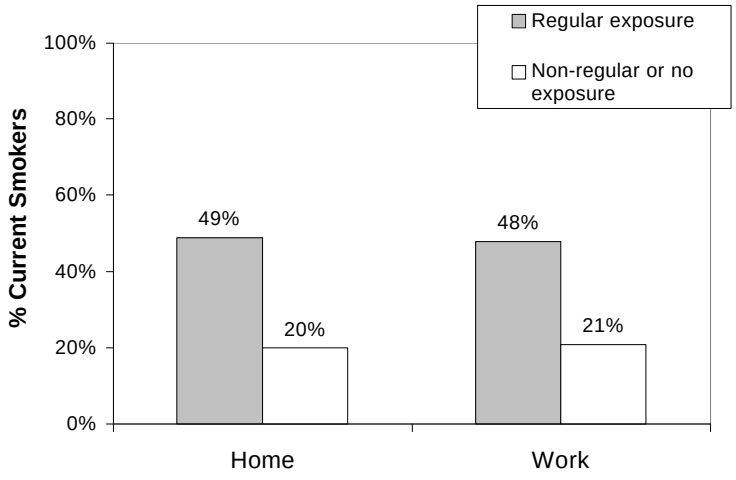
Source: Qualitative and Quantitative Study 1996, Ontario Tobacco Research Unit

Fig. 4: Current Smokers' Reasons for Relapse, Age 18+, Ontario 1996



Source: Qualitative and Quantitative Study 1996, Ontario Tobacco Research Unit

Fig. 5: Current Smoking by Regular Exposure to Others' Smoking, by Site, Age 18+, Ontario 1998



Source: Ontario Drug Monitor 1998, CAMH