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Sent via email: donna.southern@racgp.org.au

Dear Dr Southern

Re: RACGP Consultation – Supporting smoking cessation: A guide for health professionals

Stroke Foundation is a national charity that partners with the community to prevent stroke, save lives and enhance recovery. We do this through raising awareness, facilitating research and supporting stroke survivors. Stroke Foundation is dedicated to empowering health professionals to deliver high quality best-practice care to stroke patients. We advocate for better systems, processes and resources to help health professionals deliver world class stroke care.

As the voice of stroke in Australia, Stroke Foundation welcomes the update of 'Supporting smoking cessation: A guide for health professionals', which is a valuable resource for a wide variety of health professionals working in a range of settings.

This year there will be more than 56,000 strokes in Australia, and there are more than 475,000 stroke survivors living in our community[1] - many with an ongoing disability. Unless action is taken, it is estimated by 2050 the number of strokes experienced by Australians will more than double to almost 133,000 strokes annually, and there will be one million stroke survivors living in the community.[1]

Research indicates that 80 percent of strokes can be prevented.[2] People who smoke are twice as likely to have a stroke compared with those who have never smoked.[3-6] The more an individual smokes the greater their risk of stroke.[4] Importantly, an individual's risk of stroke decreases after they quit smoking and stopping smoking has been shown to have both immediate and long-term health benefits. Two to five years after quitting, there is a large drop in an individual's risk of stroke[7], and after 15 years their risk of stroke is similar to that of a person who has never smoked.[7] Therefore, Stroke Foundation is strongly supportive of measures to reduce the prevalence of smoking in the Australian community.

The Stroke Foundation is engaged in a variety of preventive health programs and initiatives which address smoking as a risk factor for stroke, and promote smoking cessation as a strategy for reducing stroke risk.

In 2018, Stroke Foundation partnered with Quit Victoria to deliver a powerful campaign highlighting the link between smoking and stroke risk. It included feasible actions governments and the public could take to reduce the risk of stroke posed by tobacco. The successful *'Smokes can lead to strokes' campaign* was launched on World No Tobacco Day, and involved a hard-hitting television commercial, as well as messaging through outdoor, radio, and digital channels. *Quitline saw a 24 percent uplift in calls* over the campaign period.

The Stroke Foundation is part of the Healthier Queensland Alliance, which delivers *My Health for Life*, a Queensland Government-funded evidence-based behaviour modification program for patients at high-risk of developing a chronic disease. The program is designed to support positive lifestyle changes, such as quitting smoking, which will reduce an individual's risk of developing conditions such stroke. It delivers a health check supported by six sessions over six months, with ongoing maintenance after the program has finished. Phone coaching and face-to-face group programs are available, delivered by qualified health professionals trained as *My Health for Life* facilitators. The program is provided at no cost to the target community. A recent evaluation showed after completion of the program, *the proportion of participants who were current smokers decreased from seven percent to six percent.*

'Supporting smoking cessation: A guide for health professionals' addresses one of the key actions in the National Strategic Action Plan for Heart and Stroke.[8] The Heart Foundation and Stroke Foundation were commissioned to develop the Action Plan by the Australian Government in 2018. This action is focused on strengthening existing work to reduce smoking in the community. The Action Plan outlines a number of approaches that should be employed to achieve this action, including the development and funding of a dedicated National Cessation Strategy within the National Tobacco Strategy. As part of this approach, it is recommended that national clinical guidelines and program support should be developed and disseminated to embed the treatment of tobacco dependency in the health and social care systems.

The Stroke Foundation's comments on the updated guide are outlined below.

General comments

1. This draft of the guide is an update of a document first published in 2011, which has been updated on two occasions in 2012 and 2014. It would be useful for the reader if a section was included at the beginning of the document, summarising the key differences with the previous version, making it clear what changes have been made.

2. The table of contents in the document looks quite busy, making it difficult to navigate, and voiding its purpose. Ordinarily a table of contents with two levels of headings would be manageable; however, the large numbers of level two headings in the document have made it unnecessarily complex. You may want to consider reworking the hierarchy of headings within the document.

3. In the 'Summary of recommendations' section of the report (pages 8 – 11), the new clinical questions that were examined in this update used GRADE criteria for recommendations (recommendations 7, 8, 10, 11, 12 and 16), while the questions evaluated in the previous edition of the report have kept the NHMRC criteria (recommendations 1, 2, 3, 4, 5, 6, 9, 13, 14, 15, 17). It would be clearer if one set of criteria was used for all questions.

Specific comments

1. In the section on 'Nicotine replacement therapy (NRT), it is unclear whether NRT monotherapy or combination NRT is the recommended first line NRT. It appears from Figure 6, that combination NRT should be the first line NRT in all scenarios except when an individual's time to first cigarette is (TTFC) is more than 30 minutes after waking, and the number of cigarettes smoked per day (CPD) is 10 or less; however, this is not clear based on recommendations 6 and 7.

   In the section on Varenicline, there is similar ambiguity regarding which options are recommended as first line therapy.

   In order to maximise the benefits to health professionals, it is important that the guide is explicit about whether monotherapy (either NRT or varenicline, based on preference) should be used as a first line therapy. It also must be clear if this fails whether combination therapy is used, or whether combination therapy should be used from the outset.

2. On page 24 of the document, the authors' state that TTFC has been widely accepted as a more reliable marker of dependence than CPD in most people who smoke; however, CPD is then used later in the document in Figures 4 and 6. The authors should address this inconsistency.

3. With regard to the issue of preventing relapse, the authors state on page 29 'There is as yet no intervention, including behavioural support or skills training, that is proven to prevent relapse.' Later in the document however, in the section on varenicline, it is stated that 'longer-term use (a second 12 week course) reduces relapse for up to one year in people who have successfully quit at the end of week 12.' The authors should address this inconsistency.

4. The electronic cigarette (e-cigarette) debate has been a contentious and polarising one. Given some of the authors' views on this topic are well known, the inclusion of a conflict of interest disclosure for all authors in Appendix 1 was a good addition to the update. The recommendation was clear and reflective of the current evidence-base; however, it is likely to generate discussion and debate. Stroke Foundation understands a pragmatic decision was made to enable health professionals, when faced with patients who have failed first line cessation methods and are seeking advice on e-cigarettes, to recommend this method, albeit with a number of caveats.

   The Stroke Foundation does not currently support the use of e-cigarettes, nor does it condone their use in public spaces.[9] Stroke Foundation endorses the position of the NHMRC; namely other methods of smoking cessation have better evidence of safety and efficacy, and health authorities and policy makers should regulate e-cigarettes in such a way that potential harm to users and bystanders is minimised, and vulnerable groups (in particular young non-smokers) are protected.

   The recommendation on e-cigarettes in the guide has been given more prominence than the other recommendations and needs to be reduced in length.

5. In the section on smoking cessation for high prevalence groups, in addition to Aboriginal and Torres Strait Islander people and culturally and linguistically diverse

groups, the authors could also include lesbian, gay, bisexual, and transgender (LGBT) people.

In Australia, tobacco use among LGB people is 30 percent, more than double the general population.[10-12] There is a lack of Australian data regarding smoking rates amongst transgender people; however, a 2006 study reported smoking rates of 44 percent in transgender men and 35 percent in transgender women.[13] LGBT people may begin to smoke or continue to smoke for a variety of reasons, including stress due to the effects of discrimination, harassment and violence, as well as a lack of social support.

Thank you for the opportunity to provide comment on the updated guide.

Yours sincerely,

Bruce C.V. Campbell

Professor Bruce Campbell
Chair, Clinical Council
Stroke Foundation

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