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Evaluation of Smoking Cessation Clinic in Brant 2011-2012

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Executive Summary

The Quit Clinic is a smoking cessation program offered at the Brant County Health Unit (BCHU) whereby a specially trained Public Health Nurse offers clients one-to-one counseling and administers nicotine replacement therapy to aid clients in their journey to becoming smoke-free. The service is offered free of charge and is open to all adult residents of Brant (including Brantford and the County of Brant) aged 18 and older. Although the program is offered to all adult residents of Brant, the clinic’s target audience is marginalized adults living in Brant as statistics show they have a higher incidence of smoking and likely less access to smoking cessation pharmaceuticals.

This report presents the findings of a process and outcome evaluation of the Quit Clinic conducted between June 2011 and January 2013 during which 128 clients entered the program and consented to be part of the evaluation. Client demographic, current smoking behaviours and smoking history were collected at intake. Clients smoking status was then assessed at end of treatment and 1, 3- and 6-months post treatment to determine smoking outcomes. To inform program improvements clients were also asked to complete a Client Feedback Form during their last clinical session which included questions about satisfaction with program components and any barriers they experienced to access the services. This form was also used to assess changes in clients’ feelings about tobacco use (importance, confidence and motivation to quit) and knowledge of various tobacco topics (health effects, quit methods, withdrawal, etc.).

Client demographic information indicates that the clinic is serving a marginalized group of the population as many of the clients were from lower income neighbourhoods in the community. Also the majority of clients had a high school education or less, and were on some form of income support. In regards to client smoking outcomes, at the last session 43.4% of clients were not smoking at all, 15.1% were smoking but not daily and 41.5% were smoking daily. Among people who were not smoking at all during the last session (n=46), 24 individuals (52.2%) had follow-up data. Out of these, 9 (37.5%) were not smoking at 6 months follow-up, 7 (29.2%) had definitely made it to 1 or 3 months without smoking, and the remaining 8 (33.3%) had started smoking again somewhere in between. Overall, 45 clients were still smoking daily during their last session and 35 of these clients had data on their smoking behaviour at that time. The number of cigarettes smoked per day among these 35 clients was relatively low (mean 12.0, SD 9.4, range 39, median 10, min-max = 1-40). Compared to the number of cigarettes per day at intake, daily cigarette consumption among these 35 clients had decreased significantly by an average of 9.8 per day at their last session. Findings from the Client Feedback Form indicated that overall clients were very satisfied with clinic services and very few barriers were identified that impeded clients from attending the clinic.

At follow-up, post treatment, 33.3% of those with data who had stopped smoking by their last session were smoking again; 78% of those with data who were smoking less frequently were smoking daily again; and all of those with data who were smoking daily, but cut down, were back smoking a pack a day again. The number needed to treat statistic at six months follow-up was estimated to be 30, based on a 7.3% unaided quit rate, suggesting that 8,130 people would likely need to be seen in order to reduce the population smoking rate by 1% among those aged 18+, from 25.7% to 24.7% in Brant. These numbers
suggest that the Quit Clinic does not have the resources available to reach the number of adult smokers required to have a population-level impact. The resource-intensive activities related to the quit clinic to reach a small targeted group (n = 128 over one year period) need to be balanced against activities that will reach more adult smokers (estimated 27,000 in Brant), reduce the prevalence of smoking in Brant and as a result reduce morbidity and mortality caused by tobacco use over time. The quit clinic does reach a marginalized population and success rates at end of treatment were in line with other clinic-based smoking cessation programs. In the small number of smokers followed-up, outcomes suggest relapse rates are high among quit clinic participants and will need to be addressed if the ultimate goal of the quit clinic is smoking cessation.

1.0 Program Overview

The BCHU Quit Clinic is a component of current Tobacco Cessation programming that also includes staff training on minimal intervention techniques (e.g. 5As), telephone consultation and outreach/marketing activities (The BCHU Tobacco Cessation Logic Model can be found in Appendix A). The Quit Clinic component which involves individual counseling and pharmacotherapy began offering services in September 2008 as a pilot project and has since expanded into an ongoing program. The goal of the program is to assist Brant residents to change their smoking behaviour by quitting or reducing the number of cigarettes smoked as well as to increase their confidence and commitment to staying smoke-free thereby reducing premature mortality and morbidity from preventable chronic diseases. Smokers from low socio-economic status (SES) are targeted for the quit clinic as local and provincial research indicates that this population is disproportionally affected by the health impacts of smoking (OTRU, 2008 & OTRU, 2009). However, the program is open to all adults in Brant.

The design and development of the BCHU Quit Clinic was based on best practice evidence for tobacco cessation programming. Recommendations for Treating Tobacco Use and Dependence (U.S. Department of Health and Human Services, 2008) applicable to BCHU programming are as follows:

- Individual, group and telephone counseling are effective and their effectiveness increases with treatment intensity (length and number of counseling sessions). Research shows that there is a strong dose-response relationship between counseling intensity and quitting success (U.S Department of Health and Human Services, 2008). In general, the more intense the treatment intervention the greater the rate of abstinence. Treatments may be made more intense by increasing (a) the length of individual treatment sessions and (b) the number of treatment sessions. Current best practice guidelines suggest that session length should be longer than 10 minutes and the number of sessions should be 4 or more (U.S Department of Health and Human Services, 2008). This information was used to set the 6, 15-30 minute sessions currently offered.

- Two components of counseling are especially effective and clinicians should use these when counseling patients making a quit attempt: practical counseling (problem-solving/skills training) and social support delivered as part of treatment. This information was used to set the content of the counseling sessions.

- There are numerous effective medications for tobacco dependence and clinicians should encourage their use by all patients attempting to quit smoking, except when medically
contraindicated or with specific populations for which there is insufficient evidence of effectiveness. Offering free NRT enhances the effectiveness of the program as research suggests that all forms of NRT increase quit rates at 12 months, approximately 1.5 to 2 fold compared with placebo, regardless of the setting (Stead, L.F., Perera, R., Bullen, C. Mant, D. & Lancaster, T., 2008). As a result, participants of the BCHU quit clinic are offered free NRT, unless medically contraindicated.

- Counseling and medication are effective when used by themselves for treating tobacco dependence; however, the combination of counseling and medication is more effective than either alone and thus individuals who are making a quit attempt should be encouraged to use both counseling and medication.

The individual-based, free, confidential one-to-one counseling is offered to Brant County adults (18 years of age and over) by a specially trained Public Health Nurse (UMASS Tobacco Treatment Specialist and/or TEACH training). In addition, eligible clients can receive Nicotine Replacement Therapy (NRT) in patch or gum form. The six counselling sessions (Figure 1), each 15-30 minutes in length offer clients the chance to develop individualized quit plans, learn coping skills, learn how to use smoking cessation medications and participate in ongoing support and follow-up (carbon monoxide is also available but is not a frequent request).

It is recognized that smoking cessation is not a single event and often involves several unsuccessful attempts. While 63% of smokers want to quit (Health Canada, b.), only one-third of smokers actually attempt to quit each year (Rigotti, 2002). Although most smokers who attempt to quit do so without assistance of cessation aids such as NRT or pharmacological therapies, research shows that 76% of all attempts fail within the first month, with the remaining unsuccessful attempts occurring primarily within the first six months. Of those who relapsed, 20% will attempt to quit again within the same year (Ockene, J.K., et al. 2000). In total, 79% of all smokers have made a quit attempt (The Lung Association).

In recognition of this notion, the BCHU Quit Clinic expects to increase awareness regarding strategies for successful quitting, community resources and supports. It also expects that clients will have an increased confidence to quit smoking and will increase the number of successful quit attempts or implementation of harm reduction strategies after program completion.
Client Registration
- Client calls the health unit to register for the Quit Clinic
- Client is given an appointment for an intake session or put on a waiting list

Session 1 (Group) – Intake Assessment and Program Overview
- Clients become familiar with the program and why they smoke
- Clinic staff will assess clients reason(s) to quit, nicotine dependence level and smoking history
- Clinic staff will identify any contraindications that require

Session 2 (1:1) – Personalized Treatment Plan (PTP)
- Clinic staff will assist client in developing a PTP which includes setting a quit date; identifying triggers; reviewing strategies for coping with triggers and withdrawal; reviews NRT options and dispenses one week supply of NRT; reviews signs and symptoms of nicotine overdose and adverse reactions

Session 3 (1:1) – Relapse Prevention (1-week after starting NRT)
- Clinic staff reviews smoking status and any progress made on quit attempt
- Clinic staff reviews signs and symptoms of nicotine overdose, withdrawal and adverse reactions to NRT

Sessions 4-6 (1:1) – Follow-up Support
- Clinic staff provides client with follow-up support and encouragement for progress made to date
- NRT therapy for 2 weeks each session
- Work with client to identify ways of coping with triggers and slips
- Review maintenance strategies at last appointment

End of Treatment Follow-Up
5-Week Follow-Up
6-Month Follow-up

Figure 1 – Overview of the BCHU Quit Clinic
1.1 The Public Health Issue Being Addressed

Tobacco smoke negatively affects nearly every organ of the body and is responsible for more than two dozen diseases and conditions; including a range of cancers, cardiovascular and respiratory diseases. In Canada, lung cancer is the leading cause of death due to cancer, with the majority (85%) of these cases attributable to tobacco smoking (Health Canada, a.). On average, the standardized rates of lung cancer between 1986 and 2004 were higher in Brant than Ontario, which could be attributed to higher smoking rates in Brant compared to the province.

Among Brant residents 18+ years of age, 25.7% identified as being either a daily or occasional smoker in the 2011/12 Canadian Community Health Survey (CCHS), significantly higher than the provincial rate of 20.1%. There are priority populations in Brant who are at an increased health risk due to smoking behaviours. Smoking rates are higher among Brant residents who live in low income households, who are ‘not working’ and who did not graduate from high school (BCHU, 2009). Also, smoking rates vary among neighbourhoods in Brant. Neighbourhoods with the lower proportion of non-smokers (< 66% aged 12+) include West Brant, Eagle Place, Core, Terrace Hill, Banbury, E.S. Dumfries and West Brant County.

1.2 Program Fit within the Public Health Mandate

The Ontario Public Health Standards (OPHS) outline the requirements for programs and services offered by public health units across the province to ensure community needs are being met and that improvements are being made to population health (OPHS, 2008). Under the Chronic Disease Prevention Standard each board of health is required to implement comprehensive tobacco control. As an outcome it is expected that priority populations adopt tobacco-free living and it is expected that health units offer programs and services to prevent the initiation of tobacco use among young people; promote quitting among young people and adults eliminating non-smoker’s exposure to ETS; and identifying and eliminating disparities related to tobacco use and its societal outcomes among different population groups. Another requirement is to ensure provision of tobacco use cessation programs and services for priority populations.

1.3 Purpose of Evaluation

The Quit Clinic evaluation had process and outcome components. Specifically, the evaluation was developed to assess program effectiveness, client satisfaction, program reach and cost-effectiveness. Evaluation objectives included:

- To assess the extent to which the program achieves its desired outcomes (program impact or outcome)
- To determine client experiences with the program (process objective)
- To learn more about who the program is reaching and assess the extent to which participants are progressing towards desired outcomes (process objective)
- To identify unique smoking cessation opportunities by setting, social grouping or other factors (formative)
To determine if the program is cost-effective (cost-effectiveness analysis). Please note this objective was not met as part of the evaluation, despite being planned.

2.0 Evaluation Methodology

2.1 Sampling

All Quit Clinic clients who entered the program between June 2011 and June 2012 were asked if they would consent to participate in the Quit Clinic evaluation. All clients were daily smokers at intake. It was explained to clients that participation was voluntary and any information collected would be kept confidential. Consenting to be part of the evaluation involved completing a client feedback form at the end of treatment as well as participating in a follow-up survey at 1-, 3-, 6- and 12-month(s) after the end of treatment.

2.2 Data Collection Methods and Tools

The evaluation utilized client surveys that were administered at different points throughout the program and post-program to follow-up. The following survey instruments were used for the evaluation (see Appendix B):

a) **Quit Clinic Intake Form** - Completed by program staff and/or client at first appointment. This form collected client demographic information (gender, age, education level, income, social assistance, etc.), medical history, current and past mental illness, concurrent addictions, smoking/quit smoking history, previous use of quit clinic services, nicotine dependence score, readiness to change, knowledge of smoking and quitting, access to NRT and other smoking behaviours.

b) **Quit Clinic Assessment and Counselling** – Additional questions and information collected during counseling sessions, including questions on smoking status and readiness to change

c) **Client Feedback Form** – Completed by client at the end of treatment. This form assessed client satisfaction with clinic services (i.e. number and length of sessions, usefulness of resources, etc.)

d) **Follow-up Form** – A mixed-mode survey (telephone and web-based) completed by the client at 1-month, 3-months, and 6-months after end of treatment. This determined the clients smoking status since their last appointment and current smoking status (quit or reduction in number of cigarettes smoked) as well as assessed their confidence to quit/stay quit.

2.3 Data Analysis

The analysis included three components: a descriptive analysis of clients at intake, a comparative analysis of clients between their last session and intake, and a final component assessing sustainability at follow-up. Data was entered into EpiData v3.1 software and exported for analysis in SPSS v21.0.

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1 A decision was made to drop the 12-month follow-up due to low completion rates of the earlier follow-up points.

2 Many of these questions were asked during subsequent treatment sessions, the last of which provided data for comparisons (post treatment) to intake (pre-treatment).
Additional analyses and data manipulations were performed in MS Excel 2010 and the map was created with ArcMap v10.0. Data cleaning and retrieval included reviewing some of the original data collection sheets in order to include the maximum number of responses to each question.

The descriptive analysis at intake included demographics such as age, sex, education, income and income supports, employment status, and geographical distribution of clients within Brant by neighbourhoods based on conversion of postal codes to census dissemination areas.

Smoking behavior was compared between intake and the clients’ last sessions along with comparisons of readiness to change and knowledge of smoking and quitting. These analyses excluded any client who only attended one session. As well, the type and duration of NRT was described, including adverse reactions, and client satisfaction questions were analyzed. In an attempt to test hypotheses that would explain differences in smoking status at the last treatment session, bivariate analytical analyses looked at correlations with a number of continuous and categorical variables, including the number of sessions attended and other sociodemographic and descriptive variables. Given the small number of clients who were smoking during their last session, but no longer smoking daily, the smoking status variable was dichotomized in order to see patterns more clearly. Some other categorical variables were dichotomized where possible to ease interpretation.

Ultimately, the main goal was to determine how well the program helped people quit smoking permanently, which was meant to be measured up to six months post the last treatment intervention session. Unfortunately, the number of clients dropped off dramatically in follow-up. Therefore, a univariate approach was taken to assess sustainability, and this approach differed depending on smoking status of the clients at their last session. Among those clients who had quit smoking completely, an assessment of the duration of their cessation was performed. Similarly, among those clients who were no longer smoking daily, an assessment of their smoking status at follow-up was performed. Among those clients who continued to smoke daily, the number of cigarettes smoked at various points throughout the program from intake through their last session and up to their first point of follow-up contact was compared. Lastly, the number needed to treat (NNT) statistic was calculated to estimate the number needed for one person to remain smoke free up to six months who came to the cessation clinic, above and beyond the unaided smoking cessation rate as reported by Baillie et al. (1995).

### 3.0 Evaluation Findings

#### 3.1 Client Overview

In total, 128 people entered the program during the evaluation period between June 21, 2011 and June 29, 2012. The flow chart in Figure 2 shows the number of clients at each stage of the program and follow-up. Of the 128 clients entering the program, 109 (85.1%) were seen for more than one session.
and agreed to participate in the evaluation. Of those, 50 (45.9%) had at least one follow-up point. Overall, 25 had one follow-up point, whether at 1, 3 or 6 months, 20 had two follow-up points and 5 people had all three follow-up points. In total, there were 80 follow-up measurements among these 50 people (28 at 1 month, 28 at 3 months and 24 at 6 months).

![Figure 2: Flow Diagram of Study Participants](image)

### 3.2 Client Demographics

Overall, 56% of clients were female and 43% were male with an average age of 46.1 years (range 18-73 years). Figure 3 provides a map of clients’ neighbourhood residence at intake determined by postal code. While the Quit Clinic serves all residents of Brant (including the City of Brantford and the County of Brant) the majority of clients came from downtown Brantford (Homedale-William and Core neighbourhoods) and five surrounding neighbourhoods (Brier Park, Terrace-Hill, West Brant, Eagle Place and East Ward). Many of these neighbourhoods have an average family income below the Brant average ($78, 600).
Tables 1, 2 and 3 describe client’s education level, employment status and income level. Approximately 60% of clients had a high school diploma or less. Thirty-six percent of clients indicated that they were currently employed (full-time, part-time, two or more jobs or self-employed). Of the 60% who were not employed, half of them were on disability and 13.4% were retired. Sixty percent of clients indicated a combined family income of less than $30,000. Additionally, over three quarters (77.3%) of clients indicated that they were currently receiving some form of income support including: ODSP (34.3%), CPP (26.6%), OW (11.7%), EI (3.1%), and other (2.3%). Few of the clients were First Nations or Metis/Inuit (< 4%) while many clients described themselves as white/Caucasian (91.4%). The majority (85.9%) of clients indicated that they have a primary health care provider.

Table 1: Highest Level of Education Completed

<table>
<thead>
<tr>
<th>Level of Education</th>
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<tr>
<td>Less than high school</td>
<td>15.0</td>
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<tr>
<td>Some high school credits</td>
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<tr>
<td>High school diploma</td>
<td>18.9</td>
</tr>
<tr>
<td>Some college/university credits</td>
<td>19.7</td>
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<tr>
<td>College/university diploma/degree</td>
<td>20.5</td>
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<tr>
<td>Post graduate studies</td>
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Table 2: Current Employment Status

<table>
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<tr>
<th>Employment Status</th>
<th>%</th>
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<tr>
<td>Employed (Full-Time)</td>
<td>24.4</td>
</tr>
<tr>
<td>Employed (Part-Time)</td>
<td>7.1</td>
</tr>
<tr>
<td>Employed (Two or more jobs)</td>
<td>2.4</td>
</tr>
<tr>
<td>Unemployed</td>
<td>11.8</td>
</tr>
<tr>
<td>Retired</td>
<td>13.4</td>
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<tr>
<td>Homemaker</td>
<td>1.6</td>
</tr>
<tr>
<td>Student</td>
<td>4.7</td>
</tr>
<tr>
<td>Self-employed</td>
<td>2.4</td>
</tr>
<tr>
<td>Disability</td>
<td>29.1</td>
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<tr>
<td>Other</td>
<td>3.1</td>
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Table 3: Household Income

<table>
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<th>Income</th>
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<td>&lt; $30,000</td>
<td>60.4</td>
</tr>
<tr>
<td>$30,000-$69,000</td>
<td>28.7</td>
</tr>
<tr>
<td>$70,000-$99,999</td>
<td>7.9</td>
</tr>
<tr>
<td>&gt; $100,000</td>
<td>3.0</td>
</tr>
</tbody>
</table>

More than two thirds of the clients found out about clinic services through ‘word of mouth’ either from a family member/friend (44.5%) or a health care provider (24.2%). The remaining third indicated that they learned about the Quit Clinic on the BCHU website (4.7%), BCHU Health Information Telephone Line (3.9%), through their place of employment (2.3%) or other (newspaper, flu shot clinic, etc.). Approximately thirteen percent of clients that entered the Quit Clinic during the evaluation period had used BCHU Quit Clinic services before, the majority of which (94.1%) had used individual counseling and NRT.

3.3 Concurrent Disorders and Addictions

About one third (32%) of the clients indicated that they currently have a mental illness and slightly more (39.8%) indicated having a mental illness in the past. Mentioned most often were anxiety, depression and bipolar disorder. Figure 4 provides a list of other addictions clients had, the top responses were cannabis (14.8%), alcohol (13.3%) and prescription medications (7%). A total of 28.3% of clients had at least one addiction other than cigarettes.
3.4 Smoking Behaviour

Severity of nicotine dependence has been described to be an important predictor of successful smoking cessation and is generally assessed by means of the Fagerström Test for Nicotine Dependence (FTND) (Caponnetto & Polosa, 2008). As part of the Quit Clinic Intake Assessment clients were asked the 6 questions included on the FTND. Results are expressed as a score ranging from 0 to 10. Severe nicotine dependence is characterized by a score ≥ 7. The average FTND score for clients entering the Quit Clinic was 5.81 which falls between moderate and high nicotine dependence levels. Clients smoked on average 21.7 (min 4 – max 60) cigarettes per day and had been smoking on average for 27.4 years (min 0 – max 67). The most common types of cigarettes were reserve (47.7%) and premium (31.3%). Less than 1 in 5 (18.8%) people reported using other tobacco products. Of those that were using other tobacco products cigars (7.8%) and cigarellos (3.9%) were reported most often.

Clients were asked to provide their top three reasons for why they smoke and top three reasons for why they want to quit. The results were based on qualitative analysis of open-ended questions whereby responses were grouped based on themes and then counted. The most common reasons that clients gave for smoking included: stress (~70%), habit (~40%), addiction/craving (~35%), social (~30%) and boredom (~30%). Conversely, clients indicated that they wanted to quit for the following reasons: health (~100%), family/friends (~40%), financial (~35%) and smell/taste (~30%).

Many clients (83.6%) indicated that they had tried to quit smoking in the past and reported trying various methods to help in their quit attempts (refer to Figure 5 for timing of last quit attempt among all clients). The most popular quit method was cold turkey (without any help) which 61.7% of clients had tried in the past and 21.9% of them felt this was the most successful method they had tried. The second most common method that clients had tried was the nicotine patch (44.5%) and 30.5% of clients indicated this to be the most successful past method they had tried. Nicotine gum was tried by 30.5% of
clients, while only 12.5% indicated it was their most successful method, which was less than for the previous two methods listed above. Other common methods that clients had tried to aid in past quit attempts included: Zyban (18.8%), Champix (15.6%), hypnosis (8.6%), nicotine inhaler (7.0%), nicotine lozenge (5.5%), group counseling (6.3%) and self-help pamphlets (5.5%).

![Bar chart showing clients last quit attempt](chart)

**Figure 5: Clients last quit attempt**

Over half (53.2%) of clients indicated that either they or others smoke inside their home and 72.3% indicated that they smoke inside their vehicle (excluding those who indicated that they did not have a vehicle [n=32] or who were missing responses [n=2]). On average, clients indicated that there were 2 adults living in their home ([SD 1.2, range 9] [min 0- max 9], n = 125) and 0.9 children ([SD 1.0, range 3] [min 0- max 3], n = 65).

### 3.5 Access to Smoking Cessation Medications and Services

Based on the data presented in Figure 6, the services provided by the BCHU Quit Clinic are reaching individuals in the community who would not otherwise have had access to smoking cessation supports. The majority of clients agreed that it would be difficult for them to use smoking cessation medications because of the cost, that they would not be able to afford them if they were not offered free through the Quit Clinic and that there is no other place for them to receive these services.
3.6 Smoking Outcomes (Changes to smoking behaviours and knowledge)

On average, clients attended 4 sessions ([SD 1.6, range 7], median 4 [min 2- max 9], n = 109) and received 5.4 weeks of NRT ([SD 2.5, range 11], median 5 [min 1- max 12], n = 109) (excludes clients who dropped out after intake). Most clients received NRT in the form of the nicotine patch, either 21mg (73.4%) or 14 mg (17.2%) (Figure 7).

Client’s smoking status was assessed during each counseling session. Data was available at a final session for 106 clients. Among these clients 43.4% were not smoking at all, 15.1% were smoking but not daily and 41.5% were smoking daily (Figure 8). It was found that the mean number of sessions attended did differ significantly by smoking status at the end of the clinical sessions such that those who were not smoking at all attended approximately one more session (4.46 sessions) than those who were smoking daily or occasionally (3.61 sessions; mean difference = 0.85, t=2.82, p = 0.006 2-tailed).
Only the number of sessions differed significantly between smokers and non-smokers among the continuous variables. No significant differences in smoking status were found with other continuous variables that were measured: age, cigarettes per day at intake, years smoked, severity of nicotine dependence score, ratings from 1-10 for importance, confidence, and motivation to quit, or ratings from 1-10 on knowledge questions.

Making a previous quit attempt in the past year was not found to be significantly related with smoking status ($X^2 = 3.008$, Fisher’s Exact Test, 2-sided, $p=0.114$). However, there was a significant relationship with having any other addiction and smoking status, such that 72.7% of those with any addiction were still smoking at the last session versus 50.0% of those who did not have another addiction ($X^2=4.8$, $p=0.028$). When addictions were looked at individually, the only significant difference was between cannabis use and smoking cigarettes such that 83.3% of cannabis users were still smoking at last session versus 51.7% who were not cannabis users (Fisher’s Exact Test, 2-sided, $p=0.018$).

Overall, 45 clients were still smoking daily during their last session and thirty-five of these clients had data on their smoking behaviour at that time. The number of cigarettes smoked per day among these 35 clients was relatively low (mean 12.0, SD 9.4, range 39, median 10, min-max = 1-40). Compared to the number of cigarettes per day at intake, daily cigarette consumption among these 35 clients had decreased significantly by an average of 9.8 per day at their last session (paired $t$-test = 6.5, $p<0.005$).

Clients’ feelings about changing tobacco use (importance, confidence and motivation to quit) were measured on a scale of 1-10 with 1 being not at all important, confident or motivated and 10 being very important, confident or motivated. At intake clients ranked these feelings high with averages for importance, confidence and motivation 9.4, 7.8 and 9.1 respectively. Average confidence increased to 8.6 at the last session, with a mean difference of 1.0, which was statistically significant (paired $t=3.2$, $p<0.005$). There was no significant difference in importance or motivation between the first and last session.
At the end of treatment 31.1% of clients indicated they were still smoking in the home (down from 53.2%) at intake, while 23.6% were smoking inside their vehicle (down from 72.3% at intake).

At time of intake clients were well aware of the health effects of smoking and second-hand smoke as well as the benefits of quitting; no significant change in awareness was seen at the end of treatment for these knowledge categories. However, people’s awareness of personal smoking behaviours (including triggers, reasons for smoking, etc.); awareness of community resources; and knowledge of strategies for coping, quitting and harm reduction increased significantly. Knowledge on these latter issues ranged from 6.0 to 7.9 on a 10-point scale at intake and equaled or exceeded 9.2 at the final session. Although they did not predict quitting in the current study, they may contribute to successful quitting in the future.

3.7 Post-Treatment Follow-up

Some additional analysis was done to explore long-term smoking outcomes among clients based on smoking status at their last session. Among clients who were not smoking at all during the last session (n=46), 24 (52.2%) had follow-up data. Out of these, 9 (37.5%) were not smoking at 6 months follow-up, 7 (29.2%) had definitely made it to 1 or 3 months without smoking, and the remaining 8 (33.3%) had started smoking again somewhere in between.

In addition, there were 16 clients who were smoking at their last session, but not smoking daily. Nine (56.2%) of these clients had follow-up data. The follow-up data showed that 7 (77.8%) were smoking daily again (6 at their first follow-up contact, of which 4 was at 1 month).

Among those clients who were still smoking daily at their last session, 15 (33.3%) provided information on the number of cigarettes smoked at one or more follow-up times (11 at 1 point, 3 at 2 points, and 1 at all three points). However, 3 of these did not have a measure at their last clinic session, including the person with all three follow-up points, resulting in just 12 people with a measure at their last session and at least one follow-up time. The number of cigarettes smoked per day among these 12 people was as follows: 22.3 at intake, 14.8 at their last session, and 20.5 at their first follow-up point (whether at 1, 3 or 6 months).

Table 4 shows the overall average number of cigarettes smoked per day at each time point, among the 45 clients who were still smoking daily at their last session, where the data was available.

Table 4: Average number of cigarettes smoked per day at last session among clients still smoking

<table>
<thead>
<tr>
<th>Time Point</th>
<th>Number of Clients with Data</th>
<th>Mean number of Cigarettes per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake</td>
<td>44</td>
<td>22.4</td>
</tr>
<tr>
<td>Final Session</td>
<td>35</td>
<td>12.0</td>
</tr>
<tr>
<td>Follow-up 1 Month</td>
<td>6</td>
<td>20.2</td>
</tr>
<tr>
<td>Follow-up 3 Months</td>
<td>8</td>
<td>19.9</td>
</tr>
<tr>
<td>Follow-up 6 Months</td>
<td>6</td>
<td>21.0</td>
</tr>
</tbody>
</table>
3.8 Number Needed to Treat

The number needed to treat (NNT) statistic is used to determine the number of clients needed to be treated in order for one person to remain smoke free, above and beyond the unaided quit rate. In this case, smoke free is measured up to six months post clinic cessation sessions. Essentially, the NNT is based on both the effectiveness of the treatment and the unaided quit rate. It can be thought of as the inverse of the absolute risk reduction. That is, it is equal to 1 / (difference in the rates between the experimental group and a control group). The control group in this case would be the unaided quit rate and the experimental group would be the quit rate among clients of the clinic. Ideally, we want an NNT equal to one, which means that everyone treated is cured. Thus, if the treatment effectiveness decreases, then the NNT increases; and conversely, if the unaided quit rate increases the NNT also increases; neither of which help to justify the need for the intervention.

Baillie et al. (1995) reported an unaided quit rate of 7.3% at 10 months post treatment in a meta-analysis in which controls within experimental research designs on this topic were systematically combined and studied. The six-month quit rate in the clinic can be best estimated at 10.7% (9 clients were known to have remained smoke-free at six months out of the 84 clients for whom we had data). Note that we lost data on 22 clients who had quit smoking according to their last clinic contact, but for whom we did not have follow-up data and it was assumed that anyone who had not quit by the end of their clinic sessions would still be smoking at follow-up, even if they were not reached. Also, if our end point was at one month follow-up there would have been 21 clients out of 84 that had quit. Yet, by six months that number was reduced to nine. Applying this quit rate to our work, along with the unaided quit rate reported by Baillie et al. (1995), results in an NNT of \[1/(0.107-0.073)\] = 30. That is, 30 people must be seen in the clinic for one person to remain smoke-free at six months, above and beyond those who quit unaided.

In Brant, 25.7% of the population aged 18+ identified themselves as smokers in 2011/12 according to the CCHS, which is equivalent to about 27,098 people. A 1% reduction in the smoking rate, reducing it to a population level of 24.7%, would mean that 271 people would have to quit smoking. For the clinic to have this amount of an impact on the population smoking rate in Brant, the number of people needed to be seen would be \((30*271) = 8,130\).

3.9 Client Satisfaction

Clients were asked to complete a short questionnaire at the end of treatment to assess their overall satisfaction with the quit clinic services. Quit clinic staff were to have clients complete the survey during their last appointment, unfortunately because many clients stopped unexpectedly approximately 70% of clients did not complete the questionnaire. However, of those who did complete the client satisfaction questionnaire their overall feedback was positive (Figures 9 & 10).
Very few barriers were identified by clients that made it hard for them to attend the Quit Clinic. The most common barriers that were identified were parking and transportation related.

4.0 Discussion
Smoking prevalence remains discouragingly high in certain populations, such as in those with low socioeconomic status (SES) (e.g. low educational attainment, low income, etc.), individuals with psychiatric disorders, and substance use disorders (U.S. Department of Health and Human Services, 2008). According to the Ontario Public Health Standards (OPHS), one of the Board of Health requirements is to ensure the provision of tobacco use cessation programs and services for priority populations. The Quit Clinic is reaching a priority population in the community as many of the clients are from lower SES neighbourhoods, unemployed, have a current or past history of mental illness and other addiction(s) and indicated that the cost to purchase NRT on their own would be a barrier for them.

At the end of treatment, 43.4% of clients surveyed were not smoking at all (n=46). The dose-response relationship between counseling intensity and quitting success was demonstrated through the evaluation results such that those who were not smoking at all attended approximately one more session (4.46 sessions) than those who were smoking daily or occasionally at the end of treatment (3.61 sessions). Unfortunately, follow up data is not available for about half (52.2%) of these clients so their long term abstinence cannot be determined. Of those that could be contacted, 37.5% remained smoke-free at 6-months (n=9).

As a comparison, the STOP on the Road program reports having a 35% quit rate at the end of treatment and a 24% quit rate 6-months post-treatment among survey respondents (Justine Mascarenhas, personal communication, June 13, 2013). The STOP on the Road program also offers free nicotine replacement therapy (nicotine patch); however, clients do not receive one-to-one counseling at regular intervals. Instead they participate in a group information session at the beginning of the program before the 5-weeks of NRT is dispensed all at once. Although most tobacco users in Ontario want to quit, have tried to quit or will try in the next year only a small proportion succeed without repeated attempts (Smoke Free Ontario Scientific Advisory Committee, 2010). Evidence from clinical trials demonstrates that formal cessation supports significantly increase the odds of a successful quit attempt (Smoke Free Ontario Scientific Advisory Committee, 2010). However, clinical trials performed in research settings typically restrict participants. Smoking cessation trials usually include heavier smokers, smokers who are motivated to quit and those without any co-morbidities such as psychiatric or substance-use disorders which excludes an estimated 6 out of 10 current smokers in the general population (Le Strat, Rehm & Le Foll, 2011).

The Quit Clinic was successful in assisting some clients in reaching harm reduction during the program as those clients that were still smoking at the end of treatment had decreased the amount of cigarettes smoked per day on average. Unfortunately, this outcome was not sustained as clients that were reached at the 6 month follow-up had lapsed back to smoking nearly the same number of cigarettes as they smoked originally at intake when surveyed at follow-up. Additional efforts beyond the initial 6 weeks of counseling sessions should be considered to prevent relapse in quit clinic clients and to maintain (at minimum) reductions in the number of cigarettes being smoked and continue to encourage clients to attain complete cessation. Although confidence to quit increased and participants are told of strategies and community resources to assist them in staying smoke-free, the follow-up data suggests
this is insufficient and additional efforts will be required to prevent relapse and/or recapture participants who do relapse after completing the program.

An objective of the evaluation was to explore the relationships between certain client characteristics and their smoking outcome as research suggests several factors exist that can predict whether a smoker will be more or less likely to quit (Caponetto & Polosa, 2008). The evaluation tools were specifically developed to explore some of these predictors of smoking cessation including: personal/socio-demographics factors (e.g. sex, age, previous quit attempts, etc.), psychological/physiological factors (e.g. depression, anxiety, nicotine dependence, alcoholism, etc.) and cognitive (e.g. motivation). The results of this study found that having any addiction listed, and specifically having an addiction to cannabis, was associated with the success of the smoking cessation treatment. That is, a larger proportion of clients with such addictions were still smoking at the end of the treatment session than those without such addictions. Surprisingly, the other predictors of smoking cessation were not found to be related.

Clients’ feelings about changing tobacco use (importance, confidence and motivation to quit) were all relatively high at intake suggesting that the clinic is recruiting clients at a time most appropriate to initiate a quit attempt as motivation has been suggested as an important predictor of successful smoking cessation (Caponetto & Polosa, 2008). As importance and motivation were very high at intake there was little room for improvement and therefore little variation was observed. Confidence however, did increase significantly. It is positive that clients maintained or increased their motivation and confidence to quit smoking throughout the program and demonstrates clients’ commitment to remain smoke-free or becoming smoke-free in the future.

Regarding the NNT, recognize that we only took measurements up to six months post treatment. One might expect the unaided cessation rate to be even higher in our study than found by Baillie et al. (1995) who assessed follow-up at 10 months because the maintenance is 4 months longer, although that difference is unknown. Yet, if the unaided quit rate at six months actually exceeded the 7.3% estimated from Baillie et al. (1995), then the NNT here is a conservative estimate and it would be even higher than 30, resulting in the need to see even more people in the community to reduce the smoking rate in Brant. Costs and other resources would be enormous.

Nevertheless, keep in mind that the NNT decreases as the effectiveness of the intervention increases. In this study, a highly marginalized population was being treated. It is possible that the effectiveness of the program might be less with this population than with other less marginalized people in Brant. If that assumption is correct then the overall effectiveness of the clinic could increase and at a population level lower the NNT, resulting in fewer people needed to be seen and lower costs overall to achieve a reduction in the Brant smoking rate. Yet, given even twice the effectiveness or more, it is unlikely that nothing less than a few thousand residents would need to come through the clinic per year to make any noticeable difference on the smoking rate in Brant, which would require an intense amount of resources at the Brant County Health Unit. Given the low reach of this program and high need in the community (25.7% prevalence is equivalent to 27,000 smokers in Brant), the resource-intensive activities of the quit
clinic need to be appropriately balanced activities that could reach more smokers and have a population-level impact in Brant.

5.0 Conclusion

The Quit Clinic attained smoking cessation success rates that were in line with similar programs and reduced the number of cigarettes smoked by clients not successful in quitting by the end of the treatment period. Longer term success in terms of clients maintaining smoke free status and continuing to smoker fewer cigarettes was not established due to a high lost-to-follow-up rate. Although cost-effectiveness was not assessed, it is clear that the Quit Clinic requires high resource input from the health unit when considering both staff time for providing one-to-one services (specially trained PHN for 1.5-3 hours per person) and costs for providing 6 weeks of NRT are considered. Although the Quit Clinic is one of the components of the current BCHU tobacco cessation program, it absorbs most of the available budget and staff hours. There are opportunity costs of running this program in terms of the inability to address the other components of the current tobacco cessation program as well as other comprehensive tobacco control strategies and requirements outlined in the OPHS. The Quit Clinic alone does not have the reach required to impact population-level rates of smoking in Brant, although it is addressing a high needs population.

6.0 Recommendations

- Revisit the current program logic model and shift the focus from mainly individual-level interventions to also address population-level interventions, expand the reach of programming and address the high prevalence rate of smoking in Brant (25.7% among those 18 years or older). The Quit Clinic alone does not have the reach or resources to address the population-level smoking rate and the other activities currently listed in the logic model are designed to create referrals back to the Quit Clinic.
- Decrease the resources assigned to the Quit Clinic so there is capacity to plan and implement population-level programming. Maximize the number of clients that can be seen in the reduced capacity Quit Clinic by setting an expected number of clients seen per day and monitoring any deviations. Identify areas for cost-savings to attempt to reduce the cost per client. Enhance the current program to address relapse and maintenance of smoke-free status for clients to maximize the benefit of the services.
- Consider how the Health Unit can support individual-level cessation clinics available in the community (e.g. engaging primary care physicians and services (they can bill for an initial counseling session, 2 follow-up sessions and 3 maintenance visits per year), supporting community healthcare centres who offer behavioural counseling and ensure they are participating in STOP, potentially assist either or both of these groups by providing free NRT for their low income patients.
- Capitalize on provincially-funded supports and identify any barriers for Brant residents to take advantage of existing services. At the provincial level, the Smoke-Free Ontario (SFO) strategy
funds several behavioural and pharmaceutical interventions including the Smokers’ Helpline, Smokers’ Helpline Online, the Stop Smoking for Ontario Patients (STOP) study, Leave the Pack Behind and the Ottawa Model for Smoking Cessation (Schwartz, 2010); however, these services are estimated to reach only 5% of smokers (Schwartz, 2010).

- Complete a needs assessment as recommended in the OPHS Comprehensive Tobacco Control Guidance document to determine service gaps in Brant and identify opportunities for expanding partnerships with smoking cessation providers.
- Augment current programming with a focus on policy interventions. Current healthy policies in Brant schools, workplaces, food premises and outdoor spaces in relation to tobacco control should be reviewed, any gaps identified and resources applied to addressing them. Policy interventions can complement individual treatments efforts by altering interpersonal and environmental factors (e.g. social networks/norms, product availability, etc.) (Smoke Free Ontario Scientific Advisory Committee, 2010).
- Continue to collect local data using RRFSS to determine public support for expanded tobacco-free policy and assess current social norms. With evidence of public support, the health unit may be able to encourage the adoption of a variety of tobacco policies locally including limiting the number of tobacco retail outlets.

### 7.0 Evaluation Challenges and Limitations

A big limitation of this work was the number of clients that were followed-up. It is one thing to see that people are able to quit and stay quit, or even reduce the amount smoked while still involved in the cessation clinic sessions. Yet, the proof of the effectiveness must be seen at follow-up, where maintenance and the ability to sustain the reduction in smoking really counts, and can change their life. Lapses and relapses are common among smokers trying to quit. So the question to answer is whether or not the Brant County Health Unit’s cessation clinic can reduce the likelihood of lapses and relapses. In order to test that hypothesis adequately, clients need to be followed long enough beyond the clinic sessions. In this study, more than half of the clients (59 of 109) could not be contacted for follow-up after their last session, provided they returned after their initial intake, of which another 19 did not. Among the clients followed, more than half again were not seen at six months post clinic (26 of 50).

This limitation is compounded by the fact that those in follow-up needed to be measured on different criteria, based on their smoking status at their last session. That is, 46 people were not smoking at their last session, but follow-up measurements were only available on 24 of these non-smokers, and an exact measure on sustaining was only available for 16 of these people. Only an approximate measure could be obtained for the other eight, depending on whether or not they were missing measurements at certain follow-up times. Likewise, among the 45 clients still smoking daily at the last session, of which 35 had data on the amount smoked, which showed a reduction by about 10 cigarettes per day, only 12 could be followed up to see if they sustained the reduced number of cigarettes they were smoking.
8.0 REFERENCES


Schwartz, R., O’Connor, S., Minian, N. et al (2010). Evidence to inform smoking cessation policy-making in Ontario: a report by the Ontario Tobacco Research Unit (Toronto (ON), Ontario Tobacco Research Unit)


Appendix A – Program Logic Model

Logic Model: BCHU Tobacco Cessation Program (v 2.1)

Component

Staff Training
- Train BCHU staff on conducting 5A’s assessment
- Provide ongoing support to staff regarding 5A’s assessments

Minimal Intervention
- Conduct 5A’s assessment with all BCHU clients:
  - Ask about tobacco use
  - Advise users to quit
  - Assess readiness
  - Assist by providing referrals to community supports and self-help resources
  - Arrange follow-up for consultation or counseling

Telephone Consultation
- Provide more focused support:
  - Responding to questions
  - Advising on specific concerns
  - Referring to additional resources and community supports

Quit Clinic
- Individual Counseling
  - Provide individual counseling including skill building, motivational interviewing and assistance in developing a personal treatment plan
  - Provide ongoing support and monitor client progress
  - Provide appropriate self-help resources
- Pharmacotherapy
  - Provide nicotine replacement therapy (NRT) – garner patch
  - Teach clients safe and appropriate use of NRT
  - Monitor client progress

Outreach/Marketing
- Identify neighbourhoods in Brant with high smoking rates
- Identify points of service locations throughout County
- Promote tobacco cessation services in the community
- Grant residents

Target Groups
- BCHU Staff
- Smokers and non-smokers
- Smokers in Brant
- Smokers (<6 years) who want to quit
- Eligible smokers (without contraindications)

Short-term Outcomes
- Staff awareness of 5A’s
- Staff knowledge of how to use 5A’s
- Staff use of 5A’s

Intermediate Outcomes
- Staff confidence and proficiency in conducting 5A’s
- Referrals to program

Long-term Outcomes
- Impact of second-hand smoke
- Smoking rates
- # of program participants
- Program reach

Goal
- Reduce tobacco-related morbidity and mortality in Brant County

Rev. Aug 2011
Appendix B: Data Collection Forms

Quit Clinic
Intake Form A

Name: ________________________________________
Date & Time: ___________________________________

Completed by:  ☐ Client  ☐ Public Health Nurse __________________

A. Contact and Medical Information

<table>
<thead>
<tr>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Male</td>
<td>☐ Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home:</td>
<td></td>
</tr>
<tr>
<td>Work:</td>
<td></td>
</tr>
<tr>
<td>Cell:</td>
<td></td>
</tr>
</tbody>
</table>

Postal Code:_______________________

Is it ok to leave a message?  ☐ Yes  ☐ No

Email address: ________________________________

Do you prefer that we contact you by  ☐ phone or  ☐ email?

1. Do you have a Primary Health Care Provider?  ☐ Yes  ☐ No

If yes, please provide their contact information

Name:__________________________ Phone:_______________ Fax:_______________

2. Do any of the following conditions apply to you? (Please check YES or NO for each line)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td></td>
</tr>
<tr>
<td>Recent stroke/ Transient Ischemic Attack (within last 4 weeks)</td>
<td></td>
</tr>
<tr>
<td>Recent heart attack within the last 4 weeks</td>
<td></td>
</tr>
<tr>
<td>Pregnant or a chance you might be pregnant</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td></td>
</tr>
<tr>
<td>Unstable or worsening angina (chest pain)</td>
<td></td>
</tr>
<tr>
<td>Severely irregular heart beat (arrhythmia)</td>
<td></td>
</tr>
<tr>
<td>Under 18 years of age</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td></td>
</tr>
<tr>
<td>Angina (chest pain)</td>
<td></td>
</tr>
<tr>
<td>Hypertension (high blood pressure)</td>
<td></td>
</tr>
<tr>
<td>Heart failure</td>
<td></td>
</tr>
<tr>
<td>Hyperthyroid</td>
<td></td>
</tr>
<tr>
<td>Stomach ulcers</td>
<td></td>
</tr>
<tr>
<td>Kidney or liver disease</td>
<td></td>
</tr>
<tr>
<td>Diabetes requiring insulin</td>
<td></td>
</tr>
<tr>
<td>Treatment for poor circulation (peripheral vascular disease)</td>
<td></td>
</tr>
<tr>
<td>Previous stroke/brain bleed</td>
<td></td>
</tr>
<tr>
<td>History of allergic reaction to nicotine replacement therapy</td>
<td></td>
</tr>
</tbody>
</table>
3. Please list the medications that you are currently taking:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Reason for Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

4. Do you plan to quit smoking in the next 30 days?  □ Yes  □ No

5. Which Quit Clinic services are you interested in:
   □ Individual Counselling  □ Individual Counselling and Nicotine Replacement Therapy (patch or gum)
   □ Other, please specify: ______________________________________________________________________

6. How many times have you quit smoking for at least 24 hours in the past? _______

7. What was the longest amount of time you have gone without tobacco? _______ years/months/weeks/days

8. Why did you choose to quit smoking at that time? ___________________________________________________

9. What is the main reason you started smoking again?
   □ To fit in  □ Boredom  □ Weight control  □ My family/friends smoke
   □ Social situations (e.g. parties, alcohol, etc) □ Stress  □ Craving to smoke became too strong
   □ Other (please specify): ______________________________________________________________________

B. Your Smoking Patterns

10. How soon after you wake up do you smoke your first cigarette?

   □ Within 5 minutes  3
   □ 5-30 minutes  2
   □ 31-60 minutes  1
   □ After 60 minutes  0

11. Do you find it hard not to smoke in places that you shouldn’t smoke, such as in church, in school, in a movie, on the bus, in court, or in a hospital?

   □ Yes  1
   □ No  0

12. Which cigarette would you hate to give up the most?

   □ The first one in the morning  1
   □ Any other one  0
13. How many cigarettes do you smoke each day?
   □ 10 or fewer 0
   □ 11-20 1
   □ 21-30 2
   □ 31 or more 3

14. Do you smoke more in the first few hours after waking up than you do during the rest of the day?
   □ Yes 1
   □ No 0

15. Do you still smoke, even if you are so sick that you are in bed most of the day or if you have the flu or a severe cough?
   □ Yes 1
   □ No 0

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1 ____ + 2 ____ + 3 ____ + 4 ____ + 5 ____ + 6 ____ = __________

C. Questions about You

16. What are the top three reasons for why you smoke?
   1) ____________________________
   2) ____________________________
   3) ____________________________

17. What are your top three reasons for quitting smoking?
   1) ____________________________
   2) ____________________________
   3) ____________________________

18. What is the highest level of education that you have completed? (Please check one only)
   □ Less than high school
   □ Some high school credits
   □ High school diploma
   □ Some college or university credits
   □ College/University diploma/degree
   □ Post graduate studies Degree (e.g. Master’s/Doctorate)
19. What is your current employment status?

☐ Full-time job
☐ Part-time job
☐ Two or more jobs
☐ Unemployed
☐ Retired
☐ Homemaker
☐ Student
☐ Self-employed
☐ Disability
☐ Other, please specify: __________________________

20. Which category best describes your combined household income (before tax)?

☐ Less than $30,000
☐ $30,000 – $69,999
☐ $70,000 – $99,999
☐ $100,000
☐ I don’t know
☐ I prefer not to answer this question

21. Are you currently receiving any of the following income supports? (Please check all that apply)

☐ Ontario Works (OW)
☐ Ontario Disability Support Program (ODSP)
☐ Canadian Pension Plan (CPP)
☐ Employment Insurance (EI)
☐ Other, please specify: __________________________

22. Please describe yourself. (Please check all that apply)

☐ White/Caucasian
☐ First Nations
☐ Metis and Inuit
☐ Black
☐ South Asian
☐ Chinese
☐ Filipino
☐ Southeast Asian

☐ Latin American
☐ Korean
☐ Arab
☐ Japanese
☐ West Asian
☐ None of the above
☐ Other, please specify: __________________________

23. How did you hear about the Quit Clinic? (Please check all that apply)

☐ Health care provider
☐ BCHU website
☐ BCHU Health Information Line
☐ Friend/Family
☐ Place of employment
☐ Other, please specify:

24. a. Do you currently have a mental illness including depression or anxiety?  ☐ Yes  ☐ No

If yes, describe: _________________________________________________________________________

b. Have you in the past had a mental illness including depression or anxiety?  ☐ Yes  ☐ No

If yes, describe: _________________________________________________________________________
25. Have any of the following addictions ever been an issue for you? (Please check YES or NO for each line)

<table>
<thead>
<tr>
<th>Addiction</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gambling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine/Crack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis (marijuana, hash, pot)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin/Opium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (If yes, please specify:)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D. Your Smoking History

26. How many cigarettes do you smoke on an average day? __________

27. What brand of cigarettes do you smoke? ______________________________________________________

28. How many years have you been smoking for? (exclude the years that you didn’t use tobacco) ___________

29. Do you currently use tobacco in any form other than cigarettes? (Please check YES or NO for each line)

<table>
<thead>
<tr>
<th>Addiction</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cigarellos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pipe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chewing Tobacco</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snuff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hookah</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (If yes, please specify:)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E. Quitting Smoking History

30. a. Have you tried to quit smoking before? ☐ Yes ☐ No

b. If yes, which methods have you **tried** and which were you **most successful** with? (Please check all that apply)

<table>
<thead>
<tr>
<th>Method tried</th>
<th>Most successful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cold turkey (without any help)</td>
<td>Cold turkey (without any help)</td>
</tr>
<tr>
<td>Self-help pamphlets</td>
<td>Self-help pamphlets</td>
</tr>
<tr>
<td>Individual counselling</td>
<td>Individual counselling</td>
</tr>
<tr>
<td>Group counselling/support group</td>
<td>Group counselling/support group</td>
</tr>
<tr>
<td>Internet Quit Smoking Program</td>
<td>Internet Quit Smoking Program</td>
</tr>
<tr>
<td>Nicotine gum</td>
<td>Nicotine gum</td>
</tr>
<tr>
<td>Nicotine patch</td>
<td>Nicotine patch</td>
</tr>
<tr>
<td>Nicotine inhaler</td>
<td>Nicotine inhaler</td>
</tr>
<tr>
<td>Nicotine Lozenge</td>
<td>Nicotine Lozenge</td>
</tr>
<tr>
<td>Laser therapy</td>
<td>Laser therapy</td>
</tr>
<tr>
<td>Hypnosis</td>
<td>Hypnosis</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Acupuncture</td>
</tr>
</tbody>
</table>
31. a. Have you used any of the Quit Clinic services before?
   □ Yes
   □ No

   b. If yes, please indicate what services you have received.
   □ Individual Counselling
   □ Individual Counselling and Nicotine Replacement Therapy (patch or gum)
   □ Other, please specify:___________________________________________________________

32. Have you ever used any other services to help you quit or reduce your tobacco use?
   □ Yes    If yes, name the service used:______________________________________________
   □ No

33. When was your last quit attempt?
   □ Never tried to quit
   □ Within the last month
   □ Within the last year
   □ Over 1 year ago
   □ Over 5 years ago

F. Smoking in Your Environment

34. How many people (including yourself) live in your home?    # of adults:_______    # of children:________

35. Do you or others smoke inside your home?
   □ Yes
   □ No

36. Do you or others smoke inside your vehicle?
   □ Yes
   □ No
   □ I don’t have a vehicle

G. Feelings about Changing Your Tobacco Use

37. On a scale of 1 to 10, please answer the following questions (Please indicate your answer by circling a number for each line).

   a. How **important** is it for you to change your tobacco use (quit or reduce)?
      
      | Not at all Important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
      |---------------------|---|---|---|---|---|---|---|---|---|----|
   
   b. How **confident** are you that you could change your tobacco use (quit or reduce)?
      
      | Not at all Confident | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
      |---------------------|---|---|---|---|---|---|---|---|---|----|
c. How motivated are you to change your tobacco use (quit or reduce)

<table>
<thead>
<tr>
<th>Not at all Motivated</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Very Motivated</th>
</tr>
</thead>
</table>

H. Your Knowledge of Smoking and Quitting

38. Currently, how would you rate your knowledge on the following topics (Please indicate your knowledge by circling a number for each line).

<table>
<thead>
<tr>
<th>Topic</th>
<th>I know nothing about this topic</th>
<th>I know a lot about this topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Health effects of smoking</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>b. Health effects of second hand smoke</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>c. Physical addiction to tobacco</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>d. Reasons why you smoke</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>e. Methods to reduce short and long-term effects from tobacco use</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>f. Benefits of quitting</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>g. Methods to help you quit</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>h. How to prepare to quit or reduce</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>i. What makes it hard to quit</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>j. Dealing with withdrawal (i.e. coping strategies)</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>k. Getting support when quitting</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>

I. Access to Smoking Cessation Medications and Services

39. Please indicate with a check mark (✓) the level in which you agree or disagree with the following statements about stop smoking medications (such as the nicotine patch, gum, Champix, etc.).

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. It is difficult to use smoking cessation medications because of the cost.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. I would not be able to purchase smoking cessation medications if the Quit Clinic didn’t provide them to me for free.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. There is no other place for me to receive these services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Quit Clinic
Assessment & Counselling

Date of Visit: ____________________________  Time of Visit: __________________
Client Name: ____________________________________________

Client Information

Client smoking status:
☐ Not smoking at all
☐ Not smoking regularly (daily), Describe: _______________________
☐ Smoking daily  # cigarettes/day _________________________

Since Last Appointment, have you been tobacco free to 24 hours or longer
☐ YES → Number of times: ____________________ Longest period of time: ____________________
☐ NO

Readiness to Change: (1=not to 10=very)
Importance: 1 2 3 4 5 6 7 8 9 10  Smoking in Home □ YES  □ NO
Confidence: 1 2 3 4 5 6 7 8 9 10  Smoking in Car □ YES  □ NO  □ NO CAR
Motivated : 1 2 3 4 5 6 7 8 9 10

Nursing Assessment

<table>
<thead>
<tr>
<th>Quit Date</th>
<th>Cpd at Present</th>
<th>BP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signs and Symptoms of Nicotine Overdose/Intoxication

☐ ☐ Upset Stomach  ☐ ☐ Diaphoresis  ☐ ☐ Dizziness/Vertigo
☐ ☐ Light-headedness  ☐ ☐ Severe Headache  ☐ ☐ Sleep disturbances
☐ ☐ Weakness  ☐ ☐ Racing Heart Rate*  ☐ ☐ Palpitations*
☐ ☐ Diarrhea  ☐ ☐ Cold Sweat  ☐ ☐ Mental Confusion
☐ ☐ Drooling  ☐ ☐ Fainting  ☐ ☐ Nausea/Vomiting
☐ ☐ Difficulty Hearing  ☐ ☐ Blurred Vision  ☐ ☐ Tremors
☐ ☐ Difficulty Breathing*  ☐ ☐ Abdominal Pain

If yes to any of the above → Consider lowering dose of NRT and/or discontinue use

Signs and Symptoms of Nicotine Withdrawal

☐ ☐ Cravings/Urges  ☐ ☐ Insomnia  ☐ ☐ Tired/Drowsiness  ☐ ☐ Heads
☐ ☐ Restlessness  ☐ ☐ Anxiety/Irritability  ☐ ☐ Difficulty Concentrating  ☐ ☐ Stomach Pain
☐ ☐ Nausea  ☐ ☐ Constipation  ☐ ☐ Increased Appetite  ☐ ☐ Dizziness
☐ ☐ Fatigue  ☐ ☐ Diarrhea  ☐ ☐ Shakiness  ☐ ☐ Sleep disturbances

If yes to any of the above → Consider non-medical interventions, raising the dose of NRT and/or referring to primary healthcare provider or pharmacist.

Side Effects of Stop Smoking Medications  □ NA
☐ NRT Patch
☐ NRT Gum

☐ ☐ Systemic Reaction*  ☐ ☐ Irregular Heart Beat*  ☐ ☐ Jaw Soreness
☐ ☐ Localized Skin Reaction  ☐ ☐ Chest Pain*  ☐ ☐ Mouth/Throat Soreness
☐ ☐ Sleep Disturbances  ☐ ☐ Palpitations*  ☐ ☐ Hiccups
☐ ☐ Headache  ☐ ☐ Leg Pain*  ☐ ☐ Headache
☐ ☐ Dizziness  ☐ ☐ Severe Persistent Stomach Upset (indigestion, heartburn)*  ☐ ☐ Lightheadedness
☐ ☐ Anxiety  ☐ ☐ Upset Stomach  ☐ ☐ Upset Stomach
☐ ☐ Irritability
☐ ☐ Fatigue
☐ ☐ Stomach Upset

☐ ☐ Upset Stomach
☐ ☐ Irregular Heart Beat*
☐ ☐ Chest Pain*
Health Teaching re: development of client centered treatment plan (Check all that apply)

- Review quit plan
- Review reasons for continued tobacco use
- Review triggers
- Strategies to deal with cravings and withdrawal
- Provide information regarding slips and relapse
- Provide information on healthy eating and physical activity
- Discuss follow-up appointment

Health Teaching Completed on NRT Use

- NRT Patch
- NRT Gum
- Other

- Client advised of proper use
- Client advised of safe storage and discard
- Client advised of side effects
- Client advised of when to seek care
- Client advised of possible medication changes

NRT Provided to Client:

<table>
<thead>
<tr>
<th>Product</th>
<th>Dosage</th>
<th>Amount Given</th>
<th>Lot #/Expiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRT Patch</td>
<td>21 mg</td>
<td>1 Week or ___ Weeks or ___ # of patches</td>
<td></td>
</tr>
<tr>
<td>NRT Patch</td>
<td>14 mg</td>
<td>1 Week or ___ Weeks or ___ # of patches</td>
<td></td>
</tr>
<tr>
<td>NRT Patch</td>
<td>7 mg</td>
<td>1 Week or ___ Weeks or ___ # of patches</td>
<td></td>
</tr>
<tr>
<td>NRT Gum</td>
<td>4 mg</td>
<td>___ # of pieces</td>
<td></td>
</tr>
<tr>
<td>NRT Gum</td>
<td>2 mg</td>
<td>___ # of pieces</td>
<td></td>
</tr>
</tbody>
</table>

RN Signature/Designate:

Nursing Intervention Notes:

Nursing Plan and Client Goals Notes:

Follow-up Appointment Booked:  

- Yes  
- No  

If yes, date:

__________________________  

Signature of Public Health Nurse  Date
Client Feedback Form

1. How useful did you find the Quit Clinic services? (Please indicate your response with a check mark)

<table>
<thead>
<tr>
<th></th>
<th>Not at all useful</th>
<th>Somewhat Useful</th>
<th>Quite Useful</th>
<th>Very Useful</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual counseling sessions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicotine Replacement Therapy (the patch or gum)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quit Kits (bag with stress ball, activities, tip sheets, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Did any of the following things make it hard for you to attend the Quit Clinic?
   - ☐ Transportation
   - ☐ Parking
   - ☐ Appointment date
   - ☐ Appointment time
   - ☐ The wait list
   - ☐ Other: ____________________________

3. Please indicate the level in which you agree or disagree with the following statements about the Quit Clinic services you received. (Please indicate your response with a check mark). If you disagree or strongly disagree with the statements please tell us why in the box provided.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Please explain your answer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The number of counselling sessions I attended was just right</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. The length of time of each session I attended was just right</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Were you provided with all the resources and support you needed to quit smoking?
   - ☐ Yes  ☐ No → Please explain: ____________________________________________________________

5. What would you change about the quit clinic to make it better? ____________________________________________

6. Would you recommend the Quit Clinic to other smokers?
   - ☐ Yes  ☐ No  ☐ Not Sure

7. Do you plan on attending the Quit Smoking Clinic again?
   - ☐ I quit, so don’t need to attend  ☐ I will attend if I need the service  ☐ Not sure
8. On a scale of 1 to 10, please answer the following questions:

a. How **important** is it for you to quit, stay quit or reduce the number of cigarettes you smoke at this time? (Please indicate your response by circling a number for each line)

<table>
<thead>
<tr>
<th>Not at all Important</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Very Important</th>
</tr>
</thead>
</table>

b. How **confident** are you that you could quit, stay quit or reduce the number of cigarettes you smoke at this time? (Please indicate your response by circling a number for each line)

<table>
<thead>
<tr>
<th>Not at all Confident</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Very Confident</th>
</tr>
</thead>
</table>

c. How **motivated** are you to quit, stay quit or reduce the number of cigarettes you smoke at this time? (Please indicate your response by circling a number for each line)

<table>
<thead>
<tr>
<th>Not at all Motivated</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Very Motivated</th>
</tr>
</thead>
</table>

9. Currently, how would you rate your knowledge on the following topics (Please indicate your knowledge by circling a number for each line).

<table>
<thead>
<tr>
<th>I know nothing about this topic</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>I know a lot about this topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Health effects of smoking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>b. Health effects of second hand smoke</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>c. Physical addiction to tobacco</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>d. Reasons why you smoke</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>e. Methods to reduce health effects from tobacco use</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>f. Benefits of quitting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>g. Methods to help you quit</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>h. How to prepare to quit or reduce</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>i. What makes it hard to quit</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>j. Dealing with withdrawal (i.e. coping strategies)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>k. Getting support when quitting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

10. Any additional comments or suggestions? ____________________________

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**Additional questions for quit clinic eval_20120622**

ID: ____________________________

How many sessions did the client complete: ________

Did the client receive NRT?

- **YES**
  - If yes, please indicate type and dose
    - GUM 2mg
    - GUM 4mg
    - PATCH Regimen A (21mg)
    - PATCH Regimen B (14mg)

- **NO**
  - If NO, please indicate the reason:
    - used champix
    - level 1 contraindication
    - pregnant
    - breastfeeding
    - under the age of 18
    - other, please describe__________________________

Adverse reaction to NRT:

- **YES**
  - If YES, please indicate what happened
    - Reduced dose of NRT received or
    - Discontinued product
    - other, please describe:

- **NO**