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module 234

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Welcome to the two hundred and thirty fourth module in the *Pharmacy Magazine* Continuing Professional Development Programme, which revisits the subject of tobacco harm reduction.

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forthismodule

GOAL:

To give an overview of tobacco harm reduction and how pharmacists can incorporate harm reduction approaches into their daily practice.

OBJECTIVES:

After studying this module you should be able to:

- Describe what is meant by harm reduction in relation to smoking
- Understand the key points in the NICE guidance on harm reduction approaches to smoking and how they might apply in practice.

First in professional development pharmacy magazine

the continuing professional development programme

CPD

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Tobacco harm reduction

Contributing author: Andrea Tarr, BPharm, MSc, MRPharmS, clinical and medical writer

Introduction

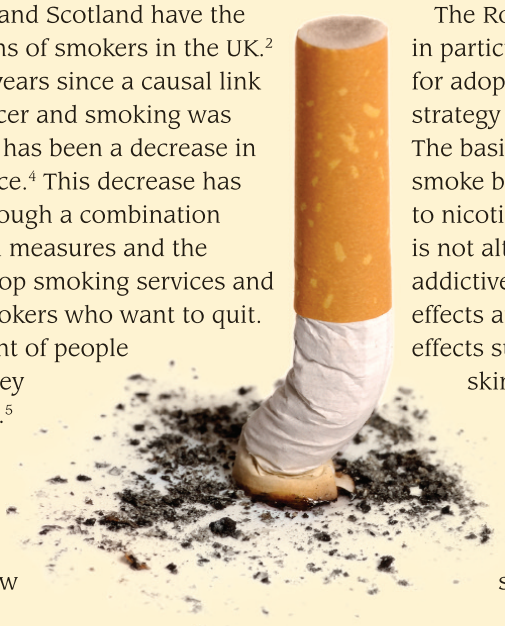
Smoking remains the biggest cause of preventable illness and early death in the UK.[1] One in five adults in the UK (about 10 million people) are smokers[2] and second-hand exposure to smoke in the home affects an estimated 5 million children under the age of 16 years.[3]

Unemployed people (i.e. those not working but seeking work) are around twice as likely to smoke as those either in employment or economically inactive (e.g. students or retired people).[2] Regions in the North of England and Scotland have the highest proportions of smokers in the UK.[2]

In the 50 or so years since a causal link between lung cancer and smoking was established, there has been a decrease in smoking prevalence.[4] This decrease has been achieved through a combination of tobacco control measures and the development of stop smoking services and treatments for smokers who want to quit.

About 67 per cent of people who smoke say they would like to stop.[5] Figures for the NHS Stop Smoking Service in England (April 2013 to 2014) show that 586,337 people had set a quit date and, of those, 51 per cent had successfully quit at a four-week follow-up.[6]

Just over 90 per cent of people who successfully quit received smoking cessation therapies. However, the number of people setting a quit date and successfully quitting has been falling since 2011. The loss of momentum in reducing smoking rates in recent years has prompted some bodies to call for radical approaches to reducing tobacco-related harm.



The Royal College of Physicians in particular has argued the case for adopting a harm reduction strategy in relation to smoking.[7] The basis for this is that people smoke because they are addicted to nicotine. While nicotine itself is not altogether harmless (it is addictive, has cardiovascular effects and can cause minor effects such as throat, nose or skin irritation depending on the method of administration[8]), it is the tobacco that causes the major harm related to smoking.

NICE guidance outlines harm reduction approaches in smoking

Harm reduction is therefore feasible in tobacco smoking by providing smokers with nicotine from a source that does not involve inhaling tobacco smoke.

What is harm reduction?

Harm reduction strategies are intended to reduce harm to self and others that arise from a behaviour that is not generally condoned. They are widely used in medicine and public health and have been used successfully in relation to illicit drug use, particularly heroin.

Community pharmacists are key providers of services that contribute to harm reduction. Such services include supervised consumption of substitute medication and needle exchange schemes. There is good evidence that needle exchange schemes reduce transmission of HIV infection and thereby reduce drug-related deaths.[9]

Reflection exercise 1

- What harm reduction services do pharmacies provide?
- How do you feel about community pharmacies offering such services?

Tobacco harm reduction

In June 2013, the National Institute for Health and Care Excellence (NICE) published guidance on harm reduction approaches to smoking.[10] It defined tobacco harm reduction as "reducing the illnesses and deaths caused by smoking tobacco among people who smoke and those around them. People who smoke can do this by stopping smoking altogether, cutting down before quitting, smoking less, or abstaining from smoking temporarily. These changes in behaviour might involve completely or partially substituting the nicotine from smoking with nicotine from less hazardous sources that do not contain tobacco."

'NICE Public Health Guidance 45: Tobacco: harm reduction approaches to smoking' recommends wider use of licensed nicotine-containing products for smokers who struggle to quit and outlines how healthcare professionals should help smokers who find it difficult to give up.

Tobacco harm reduction: the role of pharmacy

Stop smoking support has always fitted well into community pharmacy services across the UK. In England, as well as promoting healthy lifestyles as a component of the essential services tier of the contractual framework and participating in stop smoking activities as part of the requirement to support up to six local campaigns a year, pharmacies are also required to undertake prescription linked interventions in major areas of public health concern including encouraging smoking cessation.

Pharmacy-based NHS stop smoking services are commissioned locally as enhanced services in England and Wales, while smoking cessation is part of the public health element of the Scottish pharmacy contract.

The NICE tobacco harm reduction guidance has implications for how pharmacists practise, whether in asking clients about their smoking in day-to-day pharmacy interactions and providing

Key points about reducing harm from smoking[10]

- Smoking causes a range of diseases and conditions, including cancer, chronic obstructive pulmonary disease and cardiovascular disease
- Most health problems are caused by other components in tobacco smoke, not by the nicotine
- Smoking is highly addictive largely because it delivers nicotine very quickly to the brain and this makes stopping smoking difficult
- Nicotine levels in licensed nicotine-containing products are much lower than in tobacco and the way these products deliver nicotine makes them less addictive than smoking tobacco
- Licensed nicotine-containing products are an effective way of reducing the harm from tobacco for both the person smoking and those around them
- It is safer to use licensed nicotine-containing products than to smoke
- Nicotine replacement therapy products have been shown in trials to be safe to use for at least five years
- There is reason to believe that lifetime use of licensed nicotine-containing products will be considerably less harmful than smoking
- There is little direct evidence available on the effectiveness, quality and efficacy of nicotine-containing products that are not regulated by the MHRA – however they are expected to be less harmful than tobacco.

Table 1: Harm reduction approaches[10]

STOPPING SMOKING
Cease smoking but using one or more licensed nicotine-containing products as long as needed to prevent relapse.

CUTTING DOWN BEFORE STOPPING SMOKING
(cutting down to quit)
- With the help of one or more licensed nicotine-containing products (used for as long as needed to prevent relapse)
- Without using licensed nicotine-containing products.

SMOKING REDUCTION
- With the help of one or more licensed nicotine-containing products (used for as long as needed to prevent relapse)
- Without using licensed nicotine-containing products.

TEMPORARY ABSTINENCE FROM SMOKING
- With the help of one or more licensed nicotine-containing products
- Without using licensed nicotine-containing products.

brief advice or interventions to support them, or in the delivery of pharmacy-based smoking cessation services. It is clear that pharmacists should consider harm reduction approaches for people who might benefit from them.

The NICE guidance on harm reduction is intended to complement (not replace) NICE's guidance on smoking cessation. The recommendations outlined in the guidance on harm reduction are designed to help people who:

- May not be able (or do not want) to stop smoking in one step
- Want to stop smoking, without necessarily giving up nicotine
- May not be ready to stop smoking, but want to reduce the amount they smoke.

The guidance may particularly apply to people who are highly dependent on nicotine and groups where smoking prevalence is high (e.g. people with mental illness; people from lower socio-economic groups).

A range of harm reduction approaches, including the temporary or long-term use of licensed nicotine-containing products, are outlined in the guidance (see Table 1). Licensed nicotine-containing products are defined as any product with a marketing authorisation for use as a smoking cessation aid and for harm reduction.

Fourteen recommendations are made in the NICE guidance covering everything from choosing a harm reduction approach for an individual through to how commissioners should integrate harm reduction approaches into smoking cessation services (see Table 2).

Table 2: Tobacco harm reduction guidance recommendations

- Raising awareness of licensed nicotine-containing products
- Self-help materials
- Choosing a harm reduction approach
- Behavioural support
- Advising on licensed nicotine-containing products
- Supplying licensed nicotine-containing products
- Follow-up appointments
- Supporting temporary abstinence
- People in closed institutions
- Staff working in closed institutions
- Commissioning stop smoking services
- Education and training for practitioners
- POS promotion of licensed nicotine-containing products
- Manufacturer information on licensed nicotine-containing products

The recommendations are intended to support and extend the reach and impact of existing stop smoking services. The guidance does not cover pregnant women or maternity services. Nor does it cover reduced exposure cigarettes, smokeless tobacco or any other products containing tobacco that may be used as a means of harm reduction.

Make sure your team is clear about the health problems caused by smoking and the benefits of giving up

Choosing a harm reduction approach

In their daily practice pharmacists should continue to identify people who smoke, advise them to stop smoking and recommend that stopping in one step is the best approach.[11] If a person indicates that they are unable, do not want – or are not ready – to stop in one step, they can be asked if they would consider a harm reduction approach.

If they agree, pharmacists should help the person to identify why they smoke, their smoking triggers and smoking behaviour. This information can then be used to work through the harm reduction approaches in Table 1 to enable the pharmacist to suggest a suitable strategy. The pharmacist can then take the following action:

- Ensure the person knows that licensed nicotine-containing products make it easier to cut down before stopping, or reduce the amount smoked, and that using these

REMEMBER:
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The number of people setting a quit date is dropping...

Reflection exercise 2

What are your thoughts on adopting a harm reduction approach in relation to smoking? What are the potential ethical and moral questions to be considered?

products also helps to avoid compensatory smoking (inhaling more deeply or smoking more of each cigarette to compensate for smoking fewer cigarettes) and increases the chances of stopping in the longer term

- Recommend and supply, where appropriate, one or more licensed nicotine-containing products and advise the person that they can continue to use nicotine-containing products in the long-term rather than risk relapsing after stopping or reducing smoking
- Offer a referral to local NHS stop smoking services if more intensive support is needed.

Behavioural support

Offering behavioural support may help an individual to implement successfully a tobacco harm reduction approach. This might be offered during an opportunistic smoking intervention or as part of a formal stop smoking service.

Finding out about an individual's smoking behaviour and the level of nicotine dependence can help in setting goals and discussing reduction strategies. For example, information about the number of cigarettes smoked and how soon they are smoked after waking can be used to offer advice such as:

- Increasing the interval between cigarettes
- Delaying the first cigarette of the day
- Choosing periods of the day when the person will not smoke.

Those who cut down before quitting should be helped to set a quit date and to develop a schedule detailing how much they aim to cut down and when in the lead-up to the quit date.

Those who aim to reduce the amount they smoke, but not stop altogether, should be helped to set a date when they will have achieved that goal. Assistance should be given to people looking to develop a schedule for cutting down on their smoking. Specific periods of time or events when they will not smoke should be identified.

Those who are not prepared to stop smoking can be advised that the health benefits from reducing smoking are unclear but that if they reduce their smoking they are more likely to quit in the future. This is particularly true if they use licensed nicotine-containing products to help reduce the amount they smoke. Follow-up appointments can be used to review progress.

Reflection exercise 3

What smoking cessation services do you currently provide that might require the integration of a tobacco harm reduction approach?

Advising on licensed nicotine-containing products

The use of licensed nicotine-containing products is a key part of tobacco harm reduction approaches. People taking a harm reduction approach should be advised that:

- Licensed nicotine-containing products are a safe and effective way of reducing the amount they smoke
- They can be used as a complete or partial substitute for tobacco, either in the short or long-term
- It is better to use these products and reduce the amount smoked than to continue smoking at their current level
- One product or a combination of different products can be used (e.g. a fast-acting product, such as a lozenge, to deal with immediate cravings with a longer-acting product, such as a patch, to give a steadier supply of nicotine)
- If possible, each cigarette should be replaced with a licensed nicotine-containing product (e.g. a lozenge or piece of gum). Ideally this should be used before the usual time they would have smoked a cigarette, to allow for the slower nicotine release from the product

... as are hospital admissions due to smoking

- Licensed nicotine-containing products can be used for as long as they help to reduce the desire to smoke and for the long-term if necessary to prevent relapse
- Some nicotine-containing products, such as e-cigarettes, are not regulated so their effectiveness, safety and quality cannot be assured. At the same time, advise that these products are likely to be less harmful than cigarettes.

When counselling clients, explain how to use licensed nicotine-containing products correctly and ensure they know how to achieve a sufficiently high dose to control cravings, prevent compensatory smoking and achieve their goals of stopping or reducing the amount they smoke.

Follow-up appointments

It can be useful to follow up people taking a harm reduction approach to see if they have achieved their goals. Pharmacists should use their professional judgement to decide the number, timing and frequency of appointments offered.

When an individual has been successful in reducing the amount they smoke (or temporarily abstaining), assess their motivation to further reduce the amount they smoke or stop smoking completely. Questioning about daily activities (e.g. has climbing the stairs or walking to the bus stop become easier?) might be used to prompt a discussion about the benefits of reducing smoking and encourage further reduction or stopping completely.

E-cigarettes have now overtaken NRT as the quitting aid of choice, research shows

Reflection exercise 4

In order to provide the best possible advice on NRT, you need to know about the various products available and how they should be used. Where would you find more information?

Supporting temporary abstinence

People might temporarily abstain from smoking for the short-term to comply with smoke-free policies (e.g. at work); for the medium-term (e.g. because of admission to hospital) or for the long-term (e.g. during a custodial sentence). Such people should be offered advice on how to do this and provided with information on the types of licensed nicotine-containing products that can help and be shown how to use them.

E-cigarettes

Use of e-cigarettes (known as 'vaping') is becoming increasingly popular, with over 2 million estimated users in the UK.[12,13] Electronic cigarettes are also known as vapourisers or electronic nicotine delivery systems. There are three main types:

- Disposable products (non-rechargeable)
- Electronic kits, that are rechargeable with replaceable pre-filled cartridges

NRT and psychological support still the best way to quit

Nicotine replacement therapy plus psychological support is still the best way to quit smoking, according to a report commissioned by PAGB and published by UCL School of Pharmacy[14]. Evidence shows that licensed smoking cessation medicines, including nicotine replacement therapies (NRT), combined with psychological support from NHS Stop Smoking Services, still offers the best opportunity for people to quit smoking. However research shows that more and more people are turning away from NRT and professional support in favour of electronic cigarettes.

The number of people using NHS Stop Smoking Services and setting a quit date in England dropped by 25 per cent between 2011-12 and 2013-14, according to the UCL report, 'Will smoking meet its match?', with the decline predicted to reach 50 per cent by April 2015. Meanwhile data from Mintel estimates that the smoking cessation market fell by 4 per cent in 2014, while the e-cigarette market grew by the same percentage.

Some 82 per cent of e-cigarette users (or 'vapers') surveyed agree that the devices represent a good way to cut down – and 78 per cent think they can help smokers to quit. Yet without additional support from a stop smoking adviser, almost 90 per cent of vapers continue to use tobacco, the UCL report found. It speculates that the rise in e-cigarette use may have been partly fuelled by the decline in accessibility and quality of NHS Stop Smoking Services following the NHS reorganisation in England.

'Costly catastrophe'

"Stop smoking services have been a casualty of the costly catastrophe of the NHS reshuffle," says Robert West, professor of health psychology and UCL director of tobacco studies. "E-cigarettes have picked up some of the tab, but studies show that they are not as effective as stop smoking services. We should regroup and focus on quality."

The UCL report urges healthcare professionals to adopt a "smoker centred" approach and help end "ill-informed controversies" surrounding e-cigarettes. "Naturally we have concerns about the safety and efficacy of unlicensed products but they are not tobacco products and using them is far less risky than smoking," says Deborah Arnott, chief executive of Action on Smoking and Health (ASH). "Healthcare professionals should give people accurate information about e-cigarettes and not put forward messages of doubt. We need to ensure that stop smoking services adapt and evolve to give smokers what they need."

Ash Soni, president of the Royal Pharmaceutical Society, agrees that while pharmacists are advised to only supply medically licensed products, "if people are using e-cigarettes they should still be able to benefit from the psychological support [available from] pharmacy".

The report concludes that the present priority is to further reduce lung cancer, COPD and other smoking-related diseases by all effective means necessary. Nevertheless, while e-cigarettes may have a role in reducing the burden of tobacco-related disease alongside specialist support, the report cautions that a future in which "commercially driven mass nicotine addiction" remains after smoking has stopped could prove to be a "sub-optimal societal choice".

Hospital admissions due to smoking

- **In 2012/13 there were approximately 1.6 million admissions for adults aged 35 years and over with a primary diagnosis of a disease that can be caused by smoking. This is approximately 4,400 admissions per day on average. The annual number of admissions has been rising steadily since 1996/97, when the number of such admissions was approximately 1.1 million in number**
- **Around 460,900 hospital admissions were estimated to be attributable to smoking. This accounts for 4 per cent of all hospital admissions in this age group (35 years and over). It compares to 559,800 admissions in 2004/05, which is a decrease of 18 per cent**
- **The proportion of admissions attributable to smoking as a percentage of all admissions was greater amongst men than women (6 and 3 per cent respectively)[2]**

- Electronic cigarettes that are rechargeable and have a tank or reservoir that has to be filled with liquid nicotine.

In its guidance on a harm reduction approach to smoking, NICE supports the use of licensed nicotine-containing products "to help smokers cut down for temporary abstinence and as a substitute for smoking, possibly indefinitely". Although NICE does not recommend unlicensed nicotine-containing products, the guidance is clear that using electronic cigarettes is safer than smoking.

E-cigarettes are targeted at adult smokers as a cheaper and less harmful alternative to smoking. Although they are not marketed as smoking cessation aids (as this would make them medicinal by function and require marketing authorisation), people do use them to support a quit or cut-down attempt. However, to date, there is little formal evidence regarding their efficacy and long-term safety.

An analysis of the constituents of e-cigarette vapour, published in the journal *Addiction*[15], found that popular e-cigarette brands were at least 20 times safer than tobacco cigarettes in terms of long-term health risks. Furthermore, the vapour, which consists mainly of water and propylene glycol/glycerine, is considered unlikely to cause an acute adverse reaction in the user or pose a risk to bystanders.

Nevertheless, with nearly 500 products on the market, there is a wide variation in safety and quality.

Reflection exercise 5

Is your pharmacy team involved in the provision of stop smoking advice? Do they know what the NICE guidance on tobacco harm reduction recommends?

Professor Robert West from University College London's department of epidemiology and public health, who is conducting ongoing research into the benefits and risks of electronic nicotine delivery systems, concedes that "it is not clear whether long-term use of e-cigarettes carries health risks", but believes that "from what is known about the contents of the vapour, [the risks] will be much less than from smoking".

In a YouGov survey for Action on Smoking and Health (ASH)[16] over half of current and ex-smokers reported having tried electronic cigarettes, with nearly two-thirds of users made up of current smokers and one-third comprising ex-smokers.

The majority of former smokers had used e-cigarettes to help "keep off tobacco" or "stop smoking entirely", while many current smokers were turning to the devices as an aid to cutting down or quitting.

Professor West has shown that electronic nicotine delivery systems have now overtaken NRT as the quitting aid of choice in England. While the growth in e-cigarette prevalence has coincided with a small increase in the rate at which smokers are making quit attempts, other factors may be involved.

These findings were backed up by a large UCL survey of smokers published in *Addiction* in May 2014. This found that people attempting to quit smoking without professional help are approximately 60 per cent more likely to succeed if they use e-cigarettes rather than willpower alone or OTC NRT products[17].

"E-cigarettes could substantially improve public health because of their widespread appeal and the huge health gains associated with stopping smoking," concludes Professor West. "However we should also recognise that the strongest evidence remains for use of the NHS stop smoking services."

Reflection exercise 6

What are your thoughts about selling e-cigarettes through pharmacies? How would you advise a person who asked you about the use of e-cigarettes as a step towards giving up smoking?

E-cigarettes are continuing to grow in popularity despite safety and efficacy concerns

Regulation

The rapid growth of the e-cigarette market, coupled with the increasing involvement of the tobacco industry and the variation in safety and nicotine levels between products, has prompted calls for greater regulation and standardisation of products.

The Medicines and Healthcare products Regulatory Agency (MHRA) announced its plans to license e-cigarettes as smoking cessation aids in June 2013, but has been slow to implement the regulatory processes.

Meanwhile, the European Commission has amended the EU Tobacco Products Directive to include legislation to regulate e-cigarettes containing a certain level of nicotine as medicines alongside other nicotine-containing products.[18]

Once the Tobacco Products Directive comes into effect in May 2016, e-cigarettes will be regulated either as licensed medicinal products (if they are marketed as a quit aid) or as consumer products. In the latter case, they must adhere to certain quality and safety standards, have a maximum nicotine strength of 20mg/ml and will be subject to the same advertising restrictions as tobacco products.

For products containing higher levels of nicotine, manufacturers and importers will have to decide to opt in to medicines regulation and such products will require authorisation by the MHRA as over-the-counter medicines. There are several advantages associated with the products becoming medicines that might be attractive to companies (e.g. the ability to make health claims; the potential for products to be prescribed). In the meantime, the MHRA is encouraging companies to obtain marketing authorisation.

To date, just one novel nicotine delivery system has secured a medicines licence. Not strictly an electronic cigarette, Voke uses non-electronic, miniaturised breath-operated valve technology to deliver nicotine without heat or combustion. Developed by Kind Consumer, the device will be exclusively distributed by Nicoventures, a wholly owned subsidiary of British American Tobacco.

Professional policy

The Royal Pharmaceutical Society's policy is that e-cigarettes should not be sold or advertised by pharmacies, on the basis of a lack of standardisation of safety, efficacy and quality.[19] The Society advises that if a nicotine-containing product is considered the best option for a person attempting to quit or reduce their smoking, then pharmacists should encourage the use of licensed products.

When someone is unwilling to use a licensed product, pharmacists should use their professional judgement when giving advice on the use of e-cigarettes, taking into consideration current evidence on safety and efficacy; the risks and benefits of using unlicensed e-cigarette products; and the normalising of the smoking habit itself, particularly for young people and non-smokers. Despite this advice, e-cigarettes are being sold in many pharmacies.[20]

Prescribing costs of quit therapies

- The number of prescriptions dispensed in England to help people stop smoking in 2013/14 was 1.8 million, compared to 1.6 million 10 years earlier in 2003/4
- In 2013/14 the net ingredient cost (NIC) of all prescription items used to help people quit smoking was nearly £48.8 million. This is a decrease of 16 per cent on the £58.1 million spent in 2012/13 and 26 per cent less than 2010/11, when the NIC of all prescription items peaked at £65.9 million[2]

Deaths from smoking

In 2013, 17 per cent (79,700) of all deaths of adults aged 35 years and over were estimated to be caused by smoking. This proportion is unchanged from 2005.[2]

References

1. 'Healthy lives, healthy people: our strategy for public health in England'. Department of Health, 2010
2. Statistics on smoking, England 2014. Health and Social Care Information Centre
3. BMA Board of Science and Education. Breaking the cycle of children's exposure to tobacco smoke. London, BMA, 2007
4. 'Fifty years since Smoking and Health: progress, lessons and priorities for a smoke-free UK'. Royal College of Physicians and UK Centre for Tobacco Control Studies, 2012
5. Lader D. Opinions Survey Report No.40. Smoking-related behaviour and attitudes, 2008/9. Office for National Statistics, 2009
6. Statistics on NHS Stop Smoking Services in England, April 2013 to March 2014
7. 'Ending tobacco smoking in Britain. Radical strategies for prevention and harm reduction in nicotine addiction'. Royal College of Physicians, 2008
8. Nicotine and health. *DTB* 2014; 52:78-81
9. Wodak A, Cooney A. Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. Evidence for action technical papers. WHO Geneva 2004
10. Tobacco: harm reduction approaches to smoking. NICE Public Health Guidance 45. NICE 2013
11. Brief interventions and referral for smoking cessation. NICE 2006
12. Public Health England. E-cigarette uptake and marketing. 2014
13. Ash Briefing. Electronic cigarettes (also known as vapourisers). November 2014
14. Will smoking meet its match? www.ucl.ac.uk/pharmacy/pharmacy-news/smokingreport2015
15. Hajek, Etter, Benowitz, Eissenberg, McRobbie. Electronic cigarettes: review of use, content, safety, effects on smokers and potential for harm and benefit. *Addiction* 2014; 109(11):1801-1810
16. Use of electronic cigarettes in Great Britain. ASH. Oct 2014: ash.org.uk/media-room/press-releases/over-2-million-britons-now-regularly-use-electronic-cigarettes
17. Brown, Beard, Kotz, Michie, West. Real-world effectiveness of e-cigarettes when used to aid smoking cessation: a cross-sectional population study. *Addiction* 2014; 109(9):1531-1540
18. Questions and answers: new rules for tobacco products. European Commission, February 2014
19. E-cigarettes position statement. RPS, February 2014
20. *Pharmaceutical Journal*. Boots and LloydsPharmacy join the vaping fold by selling e-cigarettes, February 2014

TOBACCO HARM REDUCTION

assessment questions

1. What proportion of adults in the UK are smokers?
a. One in three
b. One in five
c. One in 10
d. One in 20

2. Approximately how many people who smoke say that they would like to quit?
a. 47 per cent
b. 57 per cent
c. 67 per cent
d. 77 per cent

3. Which statement is FALSE?
a. People are addicted to tobacco, not nicotine
b. Tobacco harm reduction may involve continued use of nicotine
c. People are addicted to nicotine, not tobacco
d. The Royal College of Physicians is a key advocate of adopting tobacco harm reduction approaches

4. Which group is NOT among those the NICE guidance on tobacco harm reduction is designed to help? People who:
a. May not be able (or do not want) to stop smoking in one step
b. Want to stop smoking in one step
c. Want to stop smoking, but not necessarily give up nicotine
d. May not be ready to stop smoking, but want to reduce the amount they smoke

5. Which is a harm reduction approach outlined in the NICE guidance?
a. Stopping smoking but using an unlicensed NCP
b. Cutting down before stopping smoking
c. Smoking reduction using one or more licensed NCPs for a limited period of time
d. Temporary abstinence from smoking with the help of an unlicensed NCP

6. Which statement is TRUE about licensed NCPs?
a. They are an ineffective way of reducing the amount smoked
b. They can be used as a complete or partial substitute for tobacco, either in the short or long-term
c. A combination of different NCPs cannot be used
d. The effectiveness, safety and quality of licensed NCPs cannot be assured

7. Which statement about e-cigarettes is TRUE?
a. Around 100,000 people in the UK use e-cigarettes
b. E-cigarettes are marketed as stop smoking aids
c. The RPS has advised pharmacists not to sell e-cigarettes
d. E-cigarettes contain tobacco

8. When is the Tobacco Products Directive due to come into effect?
a. May 2015
b. June 2015
c. May 2016
d. June 2017

Pharmacy Magazine CPD record

CPD April 2015

Use this form to record your learning and action points from this module on Tobacco Harm Reduction or record on your personal learning log at pharmacymagazine.co.uk. Any training, learning or development activities that you undertake for CPD can also be recorded as evidence as part of your RPS Faculty practice-based portfolio when preparing for Faculty membership. So start your RPS Faculty journey today by accessing the portfolio and tools at www.rpharms.com/Faculty

Activity completed. (Describe what you did to increase your learning. Be specific)
(ACT)

Date: Time taken to complete activity:

What did I learn that was new in terms of developing my skills, knowledge and behaviours? Have my learning objectives been met?*
(EVALUATE)

How have I put this into practice? (Give an example of how you applied your learning). Why did it benefit my practice? (How did your learning affect outcomes?)
(EVALUATE)

Do I need to learn anything else in this area? (List your learning action points. How do you intend to meet these action points?)
(REFLECT & PLAN)

You can also record in your personal learning log at pharmacymagazine.co.uk

*** If as a result of completing your evaluation you have identified another new learning objective, start a new cycle. This will enable you to start at Reflect and then go on to Plan, Act and Evaluate. This form can be photocopied to avoid having to cut this page out of the module. You can also complete the module at www.pharmacymagazine.co.uk and record on your personal learning log**

ENTER YOUR ANSWERS HERE Please mark your answers on the sheet below by placing a cross in the box next to the correct answer. Only mark one box for each question. Once you have completed the answer sheet in ink, return it to the address below together with your payment of £3.75. Clear photocopies are acceptable. **You may need to consult other information sources to answer the questions.**

1.	2.	3.	4.	5.	6.	7.	8.
a. ☐	a. ☐	a. ☐	a. ☐	a. ☐	a. ☐	a. ☐	a. ☐
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Name (Mr, Mrs, Ms) _____

Business/home address _____

Town _____ Postcode _____ Tel _____ GPhC/PSNI Reg no. ☐☐☐☐☐☐☐☐

I confirm the form submitted is my own work (signature) _____

Please charge my card the sum of £3.75 Name on card _____ ☐ Visa ☐ Mastercard ☐ Switch/Maestro

Card No. _____ Start date _____ Expiry date _____

Date _____ Switch/Maestro Issue Number _____

Processing of answers
Completed answer sheets should be sent to Precision Marketing Group, Precision House, Bury Road, Beyton, Bury St Edmunds IP30 9PP (tel: 01284 718912; fax: 01284 718920; email: cpd@precisionmarketing group.co.uk), together with credit/debit card/cheque details to cover administration costs. This assessment will be marked and you will be notified of your result and sent a copy of the correct answers. The assessors' decision is final and **no correspondence** will be entered into.

234