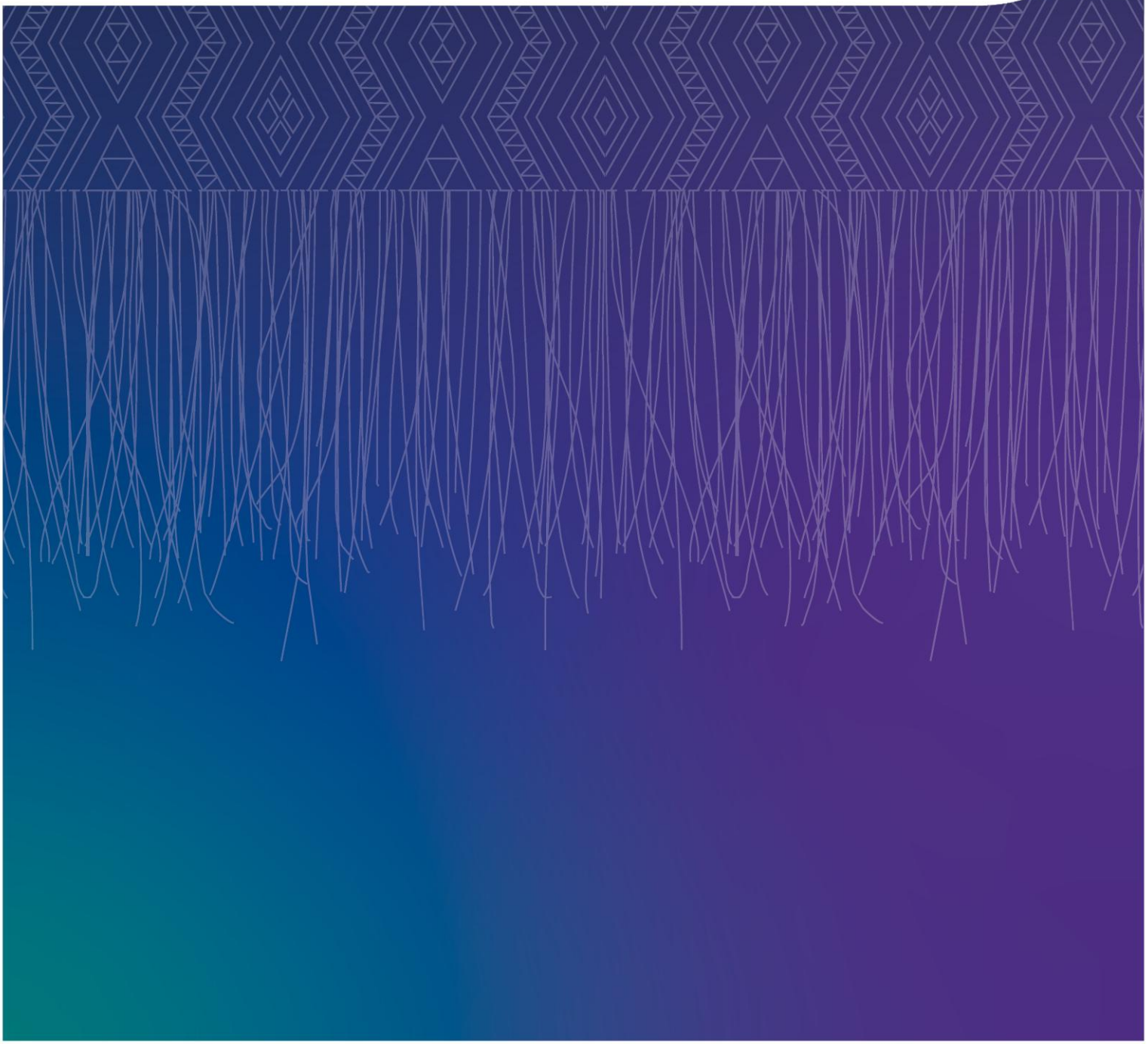
Health New Zealand
Te Whatu Ora

The New Zealand Guidelines for Helping People to Stop Smoking

2026 Update



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Introduction

Smoking remains a major cause of preventable morbidity, mortality, and health inequity in New Zealand. Although smoking prevalence has declined substantially over recent decades, smoking-related harm and inequity continue to be disproportionately experienced by Māori, Pacific peoples, people living with serious mental illness, people experiencing socioeconomic disadvantage, and others whose health outcomes are shaped by structural and social inequities.

The evidence reviewed in developing this Guideline supports a shift from opportunistic, clinician-dependent smoking cessation models toward proactive, system-enabled, equitable, and multicomponent approaches to cessation support. Smoking cessation interventions are most effective when behavioural support is combined with pharmacotherapy. Nicotine replacement therapy (NRT), varenicline, bupropion and vape-to-quit approaches all improve smoking cessation outcomes compared with behavioural support alone. Behavioural interventions, including motivational interviewing, cognitive behavioural approaches, structured counselling, group-based programmes, and digital interventions further improve quit rates, particularly when delivered intensively and over multiple contacts.

Brief advice remains an important population-level intervention. Effective brief advice does not require lengthy counselling and can often be delivered in less than 30 seconds. The evidence suggests that the key active component is the offer of practical support rather than advice alone. Communication style is critically important. Supportive, culturally safe, culturally responsive, non-judgemental, and patient-centred approaches improve engagement and reduce resistance. Motivational interviewing principles, including empathy, collaboration, and support for autonomy, provide a useful framework for smoking cessation conversations.

Digital interventions, particularly SMS/text-based programmes, are supported by strong evidence and provide scalable, low-cost opportunities to increase access to cessation support. Text messaging interventions improve smoking cessation outcomes across a range of populations and are effective for Māori as well as non-Māori. Emerging digital approaches, including apps, chatbots, artificial intelligence-supported interventions, and gamification show promise but currently have limited or inconsistent evidence.

A major theme across the evidence is the importance of system design. Reliance on opportunistic clinician behaviour alone is insufficient to achieve equitable cessation outcomes. Proactive outreach, electronic referral systems, opt-out referral pathways, automated prompts, integrated recall systems, and rapid initiation of treatment improve engagement and cessation outcomes. Delays between identification of smoking status and initiation of cessation support are associated with reduced quit success.

Tailored approaches are important for populations with additional cessation needs. People with serious mental illness experience substantially higher smoking prevalence and nicotine dependence than the general population and may benefit from more intensive, longer-duration, and multidisciplinary interventions. Evidence also supports tailored approaches for people with disabilities, chronic pain, substance use disorders, and tobacco–cannabis co-use. For people with chronic pain, smoking may function as a form of short-term symptom self-management, although smoking cessation is associated with improved long-term pain outcomes and reduced opioid use.

The evidence strongly supports culturally grounded approaches for Māori. Effective smoking cessation support for Māori includes culturally safe care, whakawhanaungatanga, whānau-centred approaches, proactive outreach, and community-based delivery. Evaluations of Māori-led programmes emphasise the importance of trusted relationships, flexible delivery, whānau engagement, and holistic support embedded within Māori values and contexts. Smoking cessation interventions effective in the general population appear to be at least as effective for Māori as for non-Māori when delivered in culturally safe and culturally responsive ways.

The review also highlights increasing complexity surrounding nicotine use in the context of vaping. The rise in vaping in New Zealand has coincided with continued declines in smoking prevalence however the relative contribution of vaping to these declines has not been established. Vaping to quit smoking is an evidence-based cessation tool for adults who smoke and may provide a harm reduction pathway for some people. However, concerns remain regarding ongoing nicotine dependence in people using this approach, increasing nicotine exposure among young people, and emerging evidence of adverse respiratory, cardiovascular, and addiction-related effects associated with longer-term vaping. While vaping is likely substantially less harmful than smoking, the long-term health effects of sustained vaping remain uncertain and continue to be studied. The literature

increasingly distinguishes between becoming smokefree or tobacco-free and achieving complete nicotine abstinence.

Financial incentives, proactive outreach, and group-based behavioural interventions also demonstrate evidence of benefit in improving engagement and cessation outcomes. Flexible, community-based, digitally enabled, and culturally responsive service models appear most promising for improving reach and equity.

Overall, the evidence supports smoking cessation systems that are:

- proactive rather than reactive
- system-enabled rather than solely clinician-dependent
- multicomponent and adaptable
- culturally safe and equity-focused
- integrated across healthcare settings
- tailored to differing levels of nicotine dependence and social complexity
- focused on rapid engagement and ongoing support rather than one-off interventions

A note on cultural safety, cultural responsiveness and equity

Cultural safety requires clinicians and organisations to reflect critically on their own culture, power, privilege, assumptions and potential biases, and to address these in ways that improve equity. It is determined by the person and whānau receiving care and applies throughout this Guideline. Cultural safety is the baseline standard of care throughout this Guideline, whether or not it is repeated in each recommendation.

Culturally responsive care involves adapting services, communication and interventions to the language, values, beliefs, preferences and context of the people and communities being served. Terms such as culturally adapted, culturally tailored, and culturally grounded describe forms of culturally responsive care.

Cultural safety and cultural responsiveness are complementary and apply to all populations. Equity focused practice recognises that achieving equitable outcomes may require different levels or types of support, and that addressing structural, institutional and

service level barriers - including system responsiveness, racism, discrimination, bias, and culturally unsafe care- is a responsibility of the health system.

The evidence behind this guideline is reported in the companion document *Background Document for the 2026 Update of the New Zealand Guidelines for Helping People to Stop Smoking* (Health New Zealand | Te Whatu Ora, 2026).

Summary of the main changes since the 2021 Guidelines

The 2026 Guidelines retain the ABC framework (Ask, Brief Advice and Cessation Support) while updating the evidence across behavioural support, pharmacotherapy, relapse prevention, pregnancy, secondary care, digital interventions, vaping and stop smoking services. New and expanded content includes smoking cessation support for Māori, Pacific Peoples, migrant and refugee populations, people with disabilities, including people with intellectual disability, LGBTQIA+ populations, people experiencing chronic pain, tobacco and cannabis co-use and lung cancer screening. Evidence relating to children and young people and other population groups has also been updated.

The updated evidence reinforces the importance of combining behavioural support with pharmacotherapy and places greater emphasis on proactive, system-enabled approaches, including digital engagement, warm handovers, opt-out referrals, multidisciplinary care, and reducing delays to treatment. Evidence on vaping has strengthened since 2021, with vaping now recognised as an evidence-based cessation option for adults who smoke, alongside consideration of ongoing nicotine dependence, uncertain longer-term harms, and eventual nicotine abstinence where appropriate.

The Guidelines also strengthen the focus on equity, culturally safe care, and tailored support, recognising the need to address barriers to accessing and engaging with cessation support and to provide more flexible, intensive, or sustained support for populations experiencing greater smoking-related harm.

The Guidelines have also been restructured to improve usability and transparency. Each section identifies its key audience and is organised into evidence-based recommendations, good practice statements, and evidence summaries, providing a clearer link between the evidence and the recommendations.

Part 1: The ABC Pathway

Part 1: The ABC Pathway

A: ASK

Audience

- All health workers
- General practice teams
- PHOs
- Hospital and secondary care services

Evidence-Based Recommendations

Clinicians

1. Ask routinely about smoking status during clinical encounters and update smoking status regularly, particularly for people who currently smoke or who have recently quit.
2. Ask about recent smoking behaviour because this improves the accuracy of smoking status classification.
3. Use supportive, culturally safe, patient- and whānau-centred communication approaches when discussing smoking.
4. Offer smoking cessation support as part of asking about smoking status.

Practices and Services

5. Use reminder systems and electronic prompts to improve recording and updating of smoking status.
6. Use questionnaire-based, digital, and patient-reported approaches to improve opportunities to identify people who may benefit from smoking cessation support.
7. Use text messaging and other proactive outreach approaches to support engagement with smoking cessation support.
8. Integrate smoking status assessment into structured clinical programmes such as cardiovascular risk assessment, enrolment processes, and recall systems.

PHOs

9. Support system-enabled approaches to smoking cessation engagement rather than relying solely on opportunistic clinician activity.
10. Support proactive outreach and recall approaches to improve equitable access to smoking cessation support, particularly for populations disproportionately affected by smoking-related harm.

Good Practice Statements

Clinicians

- Use non-judgemental, mana-enhancing, and culturally safe communication approaches.
- Avoid blame-based or stigmatising language.
- Use motivational interviewing approaches where appropriate.
- Where appropriate, ask about smoking history and offer support rather than focusing solely on smoking-related risk or current illness.
- Recognise nicotine dependence as a chronic, relapsing condition.

Practices and Services

- Record smoking status using SNOMED CT terminology when available.
- Use multiple complementary approaches to smoking status ascertainment and engagement rather than relying on a single method.
- Monitor for alert fatigue associated with electronic prompts and reminder systems.
- Combine opportunistic enquiry with proactive outreach approaches to improve equitable engagement with cessation support.

PHOs

- Prioritise equitable and culturally responsive approaches for Māori, Pacific peoples, people experiencing socioeconomic disadvantage, and other populations disproportionately affected by smoking-related harm.
- Support flexible, accessible, and whānau-centred approaches to smoking cessation engagement.

- Recognise that reduced delivery of smoking cessation interventions often reflects system pressures and barriers rather than lack of clinician commitment or patient motivation.

Evidence Summary

- Most people who smoke regret starting and want to quit.
- Brief smoking cessation interventions increase quit attempts and smoking cessation rates.
- Questions about recent smoking behaviour improve smoking status accuracy.
- Reminder systems improve smoking status recording but may contribute to alert fatigue over time.
- Questionnaire-based and text-message approaches improve smoking status ascertainment and engagement.
- Integration into cardiovascular risk assessment systems improves smoking status recording rates.
- Reliance on opportunistic approaches alone may perpetuate inequities because populations least likely to attend services often have higher smoking prevalence.
- Proactive outreach, recall systems, and opt-out approaches may improve equitable engagement with smoking cessation support.

B: BRIEF ADVICE

Audience

- All health workers
- General practice teams
- Hospital and secondary care clinicians
- Stop smoking practitioners

A note on terminology

Brief advice is the overarching term used throughout these Guidelines for the routine, opportunistic advice and offer of support provided during clinical encounters. It should include a clear recommendation to stop smoking and an offer of practical cessation support. Very Brief Advice (VBA), is a shorter form of Brief Advice.

Evidence-Based Recommendations

Clinicians

1. Offer brief advice and smoking cessation support to all people who smoke, regardless of readiness to quit.
2. Offer practical cessation assistance because offering support is more effective than advice alone in promoting quit attempts and smoking cessation.
3. Use brief advice approaches where appropriate because they improve smoking cessation outcomes and can be delivered within routine clinical encounters. Use supportive, culturally safe, relationship-based, and patient- and whānau-centred communication approaches when discussing smoking cessation.
4. Use motivational interviewing principles, including empathy, collaboration, support for autonomy, and management of ambivalence, to support engagement with smoking cessation support.
5. Use gain-framed communication approaches that emphasise the benefits of quitting because these improve motivation more effectively than loss-framed approaches.

Practices and Services

7. Ensure brief advice pathways include direct access to behavioural support, pharmacotherapy, and referral options.

8. Support routine delivery of brief advice within clinical workflows and across multiple healthcare settings.
9. Support pathways that enable rapid connection with structured smoking cessation programmes for people requiring more intensive support.

PHOs

10. Support implementation of system-wide brief advice pathways integrated across primary care, hospital, pharmacy, community, and stop smoking services.
11. Support workforce training and culturally safe delivery of brief advice.
12. Support equitable access to smoking cessation support following brief advice interventions.

Good Practice Statements

Clinicians

- Use supportive, respectful, non-judgemental, and mana-enhancing communication approaches.
- Avoid blame-based, fear-based, or stigmatising language.
- Frame smoking as a behaviour rather than an identity.
- Focus on offering help and positive health outcomes rather than emphasising guilt, failure, or current illness.
- Use whakawhanaungatanga, support for autonomy, and whānau-centred approaches where appropriate.
- Recognise that the effectiveness of brief advice is influenced more by communication style and tone than by the depth of questioning.
- Do not require extended motivational exploration during routine brief advice encounters.

Practices and Services

- Support staff training in brief advice delivery, motivational interviewing principles, and culturally safe communication.
- Incorporate brief advice into routine workflows using system-enabled approaches.

- Ensure patients can access behavioural and pharmacological support without unnecessary delays.

PHOs

- Support consistent ABC delivery across primary and secondary care settings.
- Support culturally responsive and equity-focused approaches to smoking cessation communication and engagement.
- Recognise that repeated delivery of brief advice across many encounters contributes to substantial population-level impact.

Evidence Summary

- Brief advice increases smoking cessation rates.
- Offering practical cessation assistance is more effective than providing advice alone.
- Very brief advice interventions improves smoking abstinence and can often be delivered in less than 30 seconds.
- More intensive interventions, including counselling, pharmacotherapy, and follow-up, further improve smoking cessation outcomes.
- Communication style strongly influences patient receptivity, engagement, and perceptions of stigma.
- Supportive, culturally safe, relationship-based, and non-judgemental communication improves engagement with smoking cessation support.
- Gain-framed messaging improves motivation more effectively than loss-framed approaches.
- Extended motivational exploration does not improve smoking cessation outcomes compared with brief offers of support.
- Motivational interviewing principles align well with culturally safe, whānau-centred, and autonomy-supportive approaches used in New Zealand.

C: CESSATION SUPPORT

Audience

- Prescribers
- Stop smoking practitioners
- General practice teams
- PHOs
- Secondary care services

Evidence-Based Recommendations

Clinicians

1. Combine behavioural support with pharmacotherapy because combined treatment improves smoking cessation outcomes more than either approach alone.
2. Offer evidence-based cessation support, including pharmacotherapy such as NRT, varenicline and bupropion, and vape to quit approaches where appropriate Tailor smoking cessation treatment to individual preferences, nicotine dependence, relapse risk, health conditions, social context, and previous quit experiences.
3. Use extended pharmacotherapy approaches where relapse risk is high because these improve sustained abstinence and reduce relapse.
4. Incorporate relapse prevention approaches into smoking cessation care because relapse is common following quit attempts.
5. Offer re-entry into smoking cessation programmes following relapse.
6. Offer practical support and direct connection with smoking cessation services rather than relying solely on advice or self-referral.

Practices and Services

8. Use proactive referral pathways because these improve engagement with smoking cessation support.
9. Use facilitated (“warm handover”) referral approaches because these improve enrolment and engagement with cessation services.

10. Use opt-out referral systems because these improve smoking cessation engagement and outcomes.
11. Use referral approaches that minimise the need for patient-initiated action because these improve engagement with smoking cessation support.
12. Provide structured primary care smoking cessation programmes where feasible.
13. Use behavioural interventions, including counselling and telephone support, because these improve smoking cessation outcomes, particularly when combined with pharmacotherapy.
14. Use SMS/text-based and other digital interventions because these improve smoking cessation outcomes and support ongoing engagement.
15. Consider financial incentives as part of smoking cessation support programmes where appropriate because these improve smoking cessation outcomes and engagement.
16. Provide flexible, culturally safe, and responsive smoking cessation support that recognises the broader contexts in which people live.
17. Consider more intensive, proactive, or sustained support for populations experiencing disproportionate smoking-related harm or barriers to accessing care.

PHOs

18. Support proactive outreach and opt-out referral systems to improve equitable access to smoking cessation support.
19. Support integrated multidisciplinary smoking cessation programmes across primary care, community, hospital, and specialist services.
20. Support culturally safe, equity-focused, relationship-based, and whānau-centred smoking cessation pathways.
21. Support digital smoking cessation interventions, including SMS-based systems, to improve reach and engagement.
22. Support flexible and community-based smoking cessation delivery models that improve access and equity.

23. Support workforce development and training in evidence-based and culturally safe smoking cessation care.
24. Support Māori-led, Pacific-led, and community-based smoking cessation services.
25. Reduce structural barriers to accessing smoking cessation support, including cost, transport, digital exclusion, fragmented service pathways.

Hospital / Secondary Care Services

26. Use inpatient smoking cessation interventions linked with post-discharge follow-up because these improve smoking abstinence outcomes.
27. Use temporary abstinence treatment approaches, including inpatient NRT, to support withdrawal management and ongoing cessation attempts.
28. Integrate smoking cessation support into routine inpatient, outpatient, and perioperative care pathways.
29. Embed smoking cessation pathways into discharge planning and transitions of care.

Lung Cancer Screening Services

30. Smoking cessation support should be offered as a routine component of lung cancer screening pathways. Services should provide direct access or referral to evidence-based behavioural support and pharmacotherapy.

Good Practice Statements

Clinicians

- Use supportive, culturally safe, non-judgemental, and relationship-based communication approaches.
- Recognise nicotine dependence as a chronic, relapsing condition that may require repeated and sustained support.
- Recognise relapse provides an opportunity for a repeat cessation cycle.
- Continue offering support following relapse and repeated quit attempts.
- Support autonomy and shared decision-making when discussing smoking cessation treatment options.

- Where appropriate, involve whānau and broader support networks in smoking cessation planning and support.
- Recognise that smoking may be influenced by stress, trauma, social context, mental health, financial hardship, and broader inequities.

Practices and Services

- Minimise delays between smoking identification, enrolment, treatment initiation, and quit support.
- Incorporate relapse prevention into routine smoking cessation care including rapid recycling into a new cessation attempt.
- Provide continuity of support across multiple contacts before and after quit attempts.
- Ensure smoking cessation support is accessible, flexible, and responsive to differing levels of health and social complexity.
- Use multidisciplinary smoking cessation approaches involving nurses, pharmacists, Health Improvement Practitioners, Health Coaches, Health Care Assistants, Kaiāwhina, and Community Health Workers where appropriate.
- Incorporate smoking cessation support into chronic disease management, mental health care, and preventive care pathways.
- Use practice systems and structures that support consistent delivery of smoking cessation programmes.

PHOs

- Recognise that equitable smoking cessation outcomes may require different levels of support and intensity for different populations.
- Recognise that smoking is increasingly concentrated among populations experiencing socioeconomic and health disadvantage.
- Support equitable access to smoking cessation support across primary care, secondary care, and community settings.
- Support service models that improve continuity of care and reduce barriers to engagement.

Hospitals

- Ensure smoking cessation medications are readily available within inpatient settings.
- Support multidisciplinary inpatient smoking cessation care and follow-up.

Evidence Summary

- Offering practical cessation assistance is more effective than providing advice alone.
- Very brief advice interventions improve smoking abstinence and can be delivered in less than 30 seconds.
- More intensive interventions, including counselling, pharmacotherapy, and follow-up, further improve smoking cessation outcomes.
- Supportive, culturally safe, relationship-based, and non-judgemental communication improves engagement with smoking cessation support.
- Gain-framed messaging improves motivation more effectively than loss-framed approaches.
- Extended motivational exploration is not required as part of brief advice and should not delay offers of support.
- Motivational interviewing principles align well with culturally safe, whānau-centred, and autonomy-supportive approaches used in New Zealand.

Relapse Prevention

Audience

- Prescribers
- Stop smoking practitioners
- General practice teams
- PHOs
- Secondary care services

Evidence-Based Recommendations

Clinicians

1. Recognise relapse prevention as a core component of smoking cessation care because relapse following quit attempts is common.
2. Incorporate relapse prevention approaches early and revisit them regularly throughout the quit journey.
3. Recognise nicotine dependence as a chronic, relapsing condition that often requires repeated quit attempts, ongoing engagement, and sustained support over time. Re-engage and support further quit attempts as needed.
4. Consider extended-duration pharmacotherapy because this improves sustained abstinence and reduces relapse risk. Extended-duration treatment refers to continuing pharmacotherapy beyond the standard course, typically beyond 12 weeks for varenicline and beyond 12 weeks for NRT, where relapse risk remains high.
5. Consider extended use of combination nicotine replacement therapy (NRT), including nicotine patches combined with fast-acting NRT, because this may reduce relapse risk.
6. Consider extended-duration varenicline because this improves long-term abstinence and reduces relapse, noting that extended-duration treatment beyond the funded course may incur cost for the patient.
7. Consider extended-duration bupropion where appropriate because this may improve sustained abstinence, although evidence is less consistent.

8. Continue offering support following lapses and relapse because repeated quit attempts are common and contribute to eventual long-term abstinence.
9. Recognise that behavioural relapse prevention interventions used alone have limited effectiveness once abstinence has already been achieved.

Practices and Services

10. Incorporate relapse prevention into routine smoking cessation care pathways.
11. Provide continuity of support across multiple contacts before and after quit attempts.
12. Use proactive follow-up approaches because relapse risk is highest in the first weeks following quitting.
13. Support sustained engagement with smoking cessation treatment beyond standard treatment durations where clinically appropriate.
14. Use digital interventions, particularly SMS/text-based approaches, because these may support ongoing abstinence and reduce barriers to access.
15. Use combined approaches that transition from intensive early support to lighter ongoing contact because these may improve long-term abstinence.
16. Consider relapse prevention following temporary abstinence associated with smokefree environments, including hospital admissions and perioperative care, because these are important opportunities for intervention.

PHOs

17. Support chronic care approaches to smoking cessation that include relapse prevention, ongoing engagement, and repeated offers of support.
18. Support equitable access to extended-duration pharmacotherapy and ongoing smoking cessation support.
19. Reduce barriers to sustained smoking cessation support, including cost, service fragmentation, transport, digital exclusion, and interruptions in continuity of care.
20. Support culturally safe, relationship-based, and whānau-centred relapse prevention approaches.

21. Support digital smoking cessation interventions, particularly SMS/text-based systems, because these improve access and engagement at population scale.

Hospital / Secondary Care Services

22. Incorporate relapse prevention into discharge planning and transitions of care following temporary smokefree periods.

23. Provide ongoing smoking cessation support following hospital discharge because post-discharge relapse risk is high.

Good Practice Statements

Clinicians

- Use supportive, culturally safe, non-judgemental, and mana-enhancing communication approaches following lapses or relapse.
- Avoid framing relapse as failure.
- Support autonomy, self-efficacy, and ongoing engagement following relapse.
- Where appropriate, involve whānau and broader support networks in sustaining smokefree behaviour over time.
- Recognise that stress, trauma, social context, financial hardship, and mental health may contribute to relapse risk.

Practices and Services

- Use continuity of care and relationship-based approaches to support sustained smokefree journeys over time.
- Provide repeated offers of support following relapse and disengagement.
- Tailor relapse prevention approaches to differing levels of nicotine dependence, social complexity, and barriers to care.
- Integrate relapse prevention within broader chronic disease, mental health, and preventive care pathways.

PHOs / Health Systems

- Recognise that inequities in long-term quit outcomes may reflect differences in access to sustained treatment and continuity of care.
- Support flexible and community-based relapse prevention approaches.

- Support Māori-led, Pacific-led, and community-based approaches that strengthen continuity, whakawhanaungatanga, and whānau support.

Hospitals

- Use hospital admissions and temporary smokefree periods as opportunities to support long-term smoking cessation and relapse prevention.

Evidence Summary

- Relapse following quit attempts is common and reflects the chronic and relapsing nature of nicotine dependence.
- Approximately 50–65% of people who achieve abstinence at the end of smoking cessation treatment relapse within one year.
- Relapse risk is highest during the first weeks after quitting.
- Behavioural relapse prevention interventions used alone have limited effectiveness once abstinence has already been achieved.
- Extended-duration pharmacotherapy, particularly varenicline, improves sustained abstinence and reduces relapse risk.
- Extended-duration nicotine replacement therapy probably improves long-term abstinence and relapse prevention, although certainty of evidence is lower.
- No increase in serious adverse events has been identified with extended-duration pharmacotherapy.
- Evidence for e-cigarettes (vaping) in relapse prevention remains uncertain, although some studies suggest potential benefit.
- Digital interventions, particularly SMS/text-based approaches, improve smoking cessation outcomes and may support ongoing abstinence and relapse prevention.
- More interactive and personalised digital interventions improve engagement and short-term quit rates, while simpler sustained approaches such as SMS may be more effective for maintaining longer-term abstinence.
- Digital interventions may improve equitable access by reducing barriers related to cost, geography, timing, transport, and service accessibility.

- Combined approaches that transition from intensive early support to lighter ongoing contact may provide the greatest long-term benefit.
- Respectful communication, whakawhanaungatanga, continuity of support, cultural safety, equitable access, and repeated offers of support remain central to effective relapse prevention and sustained smokefree journeys over time.

Part 2: Equity, Population Groups and Tailored Approaches

Part 2: Equity, Population Groups and Tailored Approaches

Supporting Smoking Cessation for Māori

Audience

- All health workers
- General practice teams
- Māori health providers
- PHOs
- Stop smoking services
- Community and whānau services

Evidence-Based Recommendations

Clinicians

1. Deliver smoking cessation support using culturally safe, whānau-centred, and relationship-based approaches.
2. Use whakawhanaungatanga, active listening, and non-judgemental communication to support engagement and trust.
3. Offer behavioural support and evidence-based pharmacotherapy because these are effective for Māori.
4. Discuss nicotine dependence as a chronic, relapsing condition that often requires repeated quit attempts and ongoing support.
5. Incorporate whānau support and wider social context into smoking cessation discussions where appropriate.
6. Routinely ask about exposure to second-hand smoke and support smokefree whānau environments.

Practices and Services

7. Use proactive outreach and follow-up approaches because these improve engagement with cessation support.

8. Provide flexible, accessible, and community-connected models of care.
9. Use text messaging and other digital approaches because they improve smoking cessation outcomes and may reduce barriers to engagement.
10. Integrate smoking cessation support into broader whānau-centred care and wellbeing approaches.
11. Support continuity of care and relationship-based follow-up wherever possible.

PHOs

12. Embed equity within system design, service delivery, monitoring, and accountability processes.
13. Address structural barriers including cost, access, transport, appointment availability, and system responsiveness.
14. Support Kaupapa Māori and Māori-led smoking cessation services because these improve engagement, cultural safety, and acceptability of care.
15. Support Māori workforce development and culturally grounded models of care across smoking cessation services.

Good Practice Statements

Clinicians

- Use culturally grounded, mana-enhancing, and non-stigmatising communication.
- Support autonomy, self-determination, and whānau engagement throughout quit journeys.
- Recognise that smoking cessation may occur within the context of broader health, social, and whānau priorities.

Practices and Services

- Incorporate smoking cessation into wider whānau-centred health and wellbeing discussions.
- Use flexible engagement approaches including kanohi ki te kanohi, outreach, digital contact, and community-based support where appropriate.
- Ensure services are welcoming, accessible, and culturally safe for Māori.

PHOs

- Use equity-focused quality improvement, outreach, and monitoring approaches.
- Support service co-design and ongoing engagement with Māori communities and providers.
- Recognise the importance of trusted relationships, continuity, and culturally safe systems in improving engagement and outcomes.

Evidence Summary

- Māori continue to experience inequities in access to healthcare and smoking-related harm despite high levels of healthcare need and clinical contact.
- Evidence and national policy support system-level approaches that improve accessibility, cultural safety, continuity of care, and equity within health service delivery.
- Evaluations of Aukati Kai Paipa smoking cessation identified trusted relationships, whānau-centred approaches, flexible delivery, proactive outreach, and holistic support as key components of effective smoking cessation support for Māori.
- Behavioural support and pharmacotherapy are effective for Māori populations.
- Text messaging interventions improve smoking cessation outcomes and may reduce barriers to engagement for Māori.
- Hui involving hapū māmā and whānau highlighted the importance of culturally safe discussions about nicotine dependence, withdrawal, and treatment options.
- Vaping prevalence has increased among rangatahi Māori alongside declining smoking prevalence, indicating reduced smoking may not necessarily correspond to reduced nicotine exposure or dependence.
- Exposure to second-hand smoke remains higher among Māori, reinforcing the importance of smokefree whānau environments and routine assessment of smoke exposure.

Supporting Smoking Cessation for Pacific Peoples

Audience

- All health workers
- General practice teams
- Pacific health providers
- PHOs
- Stop smoking services
- Community and whānau services

Evidence-Based Recommendations

Clinicians

1. Deliver smoking cessation support using culturally safe, culturally responsive, relationship-based, and culturally anchored approaches that are meaningful to Pacific peoples and their families.
2. Offer behavioural support and evidence-based pharmacotherapy because these are effective smoking cessation interventions and appear effective for Pacific peoples.
3. Recognise the importance of family, collective values, and social context when supporting smoking cessation.
4. Use communication approaches that support trust, engagement, and continuity of care.

Practices and Services

5. Use culturally adapted text messaging and digital interventions because these improve engagement, acceptability, and smoking cessation outcomes.
6. Provide flexible opportunities for smoking cessation support beyond standard clinician consultations where possible.
7. Incorporate family and community support approaches where appropriate.
8. Adapt smoking cessation interventions to local Pacific cultural contexts and community needs where feasible.

PHOs

9. Support culturally tailored and Pacific-led smoking cessation approaches and services.

10. Support workforce development and culturally safe models of care for Pacific communities.
11. Support flexible models of engagement that improve access and continuity of care.
12. Embed equity-focused approaches within service design, delivery, and monitoring processes.

Good Practice Statements

Clinicians

- Use culturally safe, culturally responsive, non-judgemental, and relationship-based communication approaches including critical reflection of one's own cultural assumptions and potential biases.
- Recognise the importance of family, community, spirituality, and collective wellbeing within smoking cessation support.
- Where appropriate, involve family or support people in cessation discussions and planning.

Practices and Services

- Adapt smoking cessation interventions to Pacific cultural contexts and preferred ways of engaging.
- Use proactive and flexible approaches to improve access and follow-up.
- Consider the role of wider care teams when consultation time is limited.

PHOs

- Support Pacific-led service development, community partnerships, and workforce development.
- Support culturally relevant digital and community-based smoking cessation approaches.
- Use equity-focused monitoring and quality improvement approaches.

Evidence Summary

- Pacific peoples continue to experience significant inequities in health outcomes.
- The Pacific Health Strategy identifies the importance of culturally appropriate primary care and recognises that short consultation times may limit effective management of chronic conditions, including smoking cessation support.

- Evidence supports the importance of culturally safe, culturally anchored, relationship-based, and family-oriented behavioural support approaches for Pacific peoples.
- Text messaging interventions are effective for smoking cessation and have demonstrated benefit and acceptability in Samoan and Cook Islands populations.
- Pacific research highlights the importance of culturally adapted interventions that align with social context, collective values, and cultural relevance.
- Evidence from Pacific settings suggests culturally adapted programmes can achieve high engagement and acceptability, although the evidence base remains limited.

Supporting Smoking Cessation for Ethnic Minority, Migrant and Refugee Populations

Audience

- All health workers
- General practice teams
- PHOs
- Refugee and migrant health services
- Stop smoking services
- Community and settlement services

Evidence-Based Recommendations

Clinicians

1. Deliver smoking cessation support using culturally safe, culturally responsive, and person-centred approaches.
2. Use tailored communication approaches that take account of language, cultural context, health literacy, beliefs, and lived experience.
3. Offer behavioural support and evidence-based pharmacotherapy using approaches that are accessible and acceptable to the individual.
4. Recognise that smoking behaviours and responses to cessation support may be influenced by migration experiences, trauma, displacement, family and social context, and socioeconomic factors.
5. Use interpreters and culturally appropriate communication approaches where required.

Practices and Services

6. Provide smoking cessation information in preferred languages and accessible formats where possible.
7. Adapt smoking cessation approaches to cultural, social, and family contexts to improve engagement and acceptability.
8. Ensure services are accessible to people experiencing barriers to accessing traditional healthcare services, including cost, transport, unfamiliarity with health systems, and appointment access barriers.

9. Use flexible and proactive approaches to improve engagement and continuity of care.

PHOs

10. Develop system-enabled approaches responsive to language, cultural, and access barriers.
11. Support equitable access to smoking cessation support for migrant, refugee, and ethnic minority populations.
12. Support culturally responsive service design rather than relying solely on individual clinician adaptation.
13. Support workforce capability in culturally responsive communication and use of interpreters.

Good Practice Statements

Clinicians

- Use culturally safe, culturally responsive, non-judgemental, and person-centred communication approaches including reflection on one's own cultural assumptions and potential biases.
- Avoid assumptions about smoking behaviours, beliefs, or motivations based on ethnicity, culture, or migration status.
- Recognise the potential impacts of trauma, displacement, social disruption, and settlement stress on health behaviours and engagement with care.

Practices and Services

- Ensure smoking cessation services are accessible, acceptable, and responsive to diverse populations.
- Incorporate interpreters, translated materials, and culturally appropriate resources into routine service delivery where possible.
- Consider the role of family, social networks, and community influences when supporting smoking cessation.

PHOs

- Support equity-focused service planning, outreach, and monitoring approaches.
- Partner with refugee, migrant, ethnic community, and settlement organisations where appropriate.

- Support service models that improve navigation, access, continuity, and engagement with care.

Evidence Summary

- Ethnic minority, migrant, and refugee populations may experience barriers to healthcare including language barriers, differences in health literacy, unfamiliarity with health systems, cost, and structural disadvantage.
- Refugee populations may experience additional impacts related to trauma, displacement, and social disruption which can influence health behaviours and engagement with services.
- International guidance supports people-centred, culturally responsive care that takes account of language, culture, beliefs, preferences, and lived experience.
- International guidance recommends accessible and tailored interventions including interpreters, culturally appropriate communication, and adaptation to cultural norms and health beliefs.
- Systematic review evidence suggests culturally tailored smoking cessation interventions may improve quit outcomes compared with non-tailored approaches.
- Smoking behaviours and responses to cessation support are influenced by cultural norms, migration experiences, family and social context, and socioeconomic factors.
- Evidence supports system-enabled and tailored approaches to care that improve accessibility, acceptability, engagement, and equity for populations experiencing barriers to accessing traditional healthcare services.

Supporting Smoking Cessation for People with Disabilities

Audience

- All health workers
- General practice teams
- Disability services
- Mental health and addiction services
- PHOs
- Stop smoking services

Evidence-Based Recommendations

Clinicians

1. Recognise that people with disabilities experience higher smoking prevalence and smoking-related harm.
2. Routinely offer smoking cessation support to people with disabilities because many are motivated to quit but may experience barriers to accessing support.
3. Offer tailored, accessible, and person-centred behavioural support and pharmacotherapy where appropriate.
4. Adapt communication and engagement approaches to cognitive, sensory, communication, and physical access needs.
5. Involve family, whānau, carers, or support people in smoking cessation support where appropriate and with consent.

Practices and Services

6. Address barriers to smoking cessation support including accessibility, communication, transport, appointment systems, and support needs.
7. Use flexible and enhanced support pathways for people with disabilities who smoke where appropriate.
8. Ensure smoking cessation services and resources are accessible and inclusive.
9. Integrate smoking cessation support into broader disability, mental health, and complex-care pathways where appropriate.

PHOs

10. Support development of inclusive, accessible, and disability-responsive smoking cessation services.
11. Support equitable access to evidence-based smoking cessation support for people with disabilities.
12. Support workforce capability in disability-inclusive communication and care.
13. Support research and development of tailored smoking cessation interventions for people with disabilities because the current evidence base remains limited.

Good Practice Statements

Clinicians

- Use culturally safe, respectful, non-judgemental, and person-centred communication approaches, recognising that people with disabilities hold multiple and intersecting cultural identities.
- Avoid assumptions about motivation to quit or ability to engage with smoking cessation support.
- Recognise the impact of social, environmental, and support contexts on smoking behaviour and cessation.

Practices and Services

- Ensure services are accessible, inclusive, and responsive to a range of disability-related needs.
- Adapt information and communication approaches to accessible formats where possible.
- Support continuity of care and trusted relationships.

PHOs / Health Systems

- Use disability-inclusive and equity-focused people with disabilities and disability communities.
- Recognise the significant evidence gaps regarding smoking cessation interventions for people with disabilities.

Evidence Summary

- Smoking prevalence is higher among people with disabilities than non-disabled populations.
- NZ Health Survey disability smoking estimates likely underestimate the true smoking burden because they are based on a narrower high-needs disability population.
- People with disabilities who smoke demonstrate high motivation and quit intentions but may have lower engagement with evidence-based smoking cessation support.
- Barriers to accessing smoking cessation support include accessibility, communication, cost, transport, support needs, and broader health system inequities.
- Evidence for disability-tailored smoking cessation interventions remains very limited.
- Existing interventions have generally not adequately addressed accessibility, communication, and support barriers.
- Overall evidence supports the need for more accessible, inclusive, tailored, and proactive smoking cessation approaches for people with disabilities.

Supporting Smoking Cessation for People with Intellectual Disability

Audience

- Disability services
- General practice teams
- Caregivers, whānau, and support services
- PHOs
- Stop smoking services

Evidence-Based Recommendations

Clinicians

1. Recognise that people with intellectual and developmental disabilities may experience disproportionate health, social, and financial harms related to tobacco use.
2. Recognise that people with intellectual disability may experience barriers to accessing smoking cessation support and evidence-based treatment.
3. Use enhanced and tailored smoking cessation support approaches to address barriers to cessation support.
4. Adapt communication, behavioural support, and educational approaches to individual cognitive, communication, and support needs.
5. Involve caregivers, whānau, family, or support people where appropriate and with consent.

Practices and Services

6. Address barriers related to support environments, communication, health literacy, knowledge of cessation options, confidence, and social influences.
7. Recognise that smoking may be embedded within routines, relationships, social environments, and personal identity.
8. Use flexible and person-centred approaches that support engagement and continuity of care.
9. Use complex-care and multidisciplinary service approaches where appropriate.

10. Ensure smoking cessation information and support are accessible and inclusive.
11. Support tailored and disability-responsive smoking cessation approaches for people with intellectual and developmental disabilities.
12. Support inclusive service design and equitable access to smoking cessation support for people with complex needs.
13. Integrate smoking cessation support within broader disability, complex-care, and long-term condition management frameworks.
14. Support workforce capability in accessible communication and disability-inclusive care.

Good Practice Statements

Clinicians

- Use culturally safe, respectful, non-judgemental, and person-centred communication approaches.
- Recognise that smoking behaviour may be strongly influenced by social relationships, routines, support environments, and daily structure.
- Recognise that motivation to quit may be ambivalent and may fluctuate over time.

Practices and Services

- Adapt communication and behavioural approaches to individual needs and preferred ways of engaging.
- Provide smoking cessation information in accessible formats where possible.
- Recognise the important role of caregivers, support workers, family, and whānau in supporting smoking cessation where appropriate.

PHOs

- Support integrated smoking cessation support within broader disability and complex-care frameworks.
- Use inclusive and equity-focused service planning approaches.
- Recognise the limited evidence base and need for further tailored intervention development and research.

Evidence Summary

- People with intellectual and developmental disabilities may experience disproportionate health, social, and financial harms related to tobacco use.
- Tobacco control interventions have rarely specifically targeted people with intellectual disability.
- Smoking behaviour may be strongly influenced by routines, support environments, social relationships, and personal identity.
- Barriers to smoking cessation include limited knowledge of cessation options, low confidence, communication barriers, and social influences.
- Evidence supports the need for enhanced and tailored smoking cessation approaches that address barriers to care and accessibility.
- International guidance supports use of enhanced smoking cessation approaches for people with complex health and support needs.

Smoking Cessation and Mental Health

Audience

- Mental health and addiction services
- General practice teams
- Prescribers
- PHOs
- Stop smoking services
- Community mental health services

Evidence-Based Recommendations

Clinicians

1. Offer smoking cessation support to all people with serious mental illness regardless of readiness to quit.
2. Use person-centred behavioural smoking cessation interventions because these improve cessation outcomes in people with serious mental illness.
3. Use evidence-based pharmacotherapy including varenicline, bupropion, and nicotine replacement therapy because these improve quit rates.
4. Recognise that smoking cessation is associated with improved mental health outcomes and does not generally worsen long-term psychiatric symptoms.
5. Use extended-duration (12-24 months) and more intensive interventions because these improve abstinence outcomes in people with serious mental illness.
6. Incorporate relapse prevention, physical activity, and weight management approaches where appropriate.
7. Treat nicotine dependence as a chronic, relapsing condition that may require ongoing support and repeated treatment attempts.
8. Before a person stops smoking, review their other medicines for interactions with tobacco smoke. Doses of clozapine, olanzapine, chlorpromazine, haloperidol, theophylline, and other affected medicines may need to be lowered. Additional monitoring of medication levels and symptoms of toxicity may be needed. This effect is caused by tobacco smoke rather than nicotine, and therefore applies whether or not the person is using NRT, varenicline, or a vaping product.

Practices and Services

8. Integrate smoking cessation support into routine mental health and addiction care.
9. Use tailored, person-centred, and culturally responsive behavioural interventions.
10. Use multidisciplinary and extended-duration treatment approaches where feasible.
11. Ensure appropriate pharmacotherapy dosing and follow-up support for people with mental health conditions.
12. Use proactive engagement approaches and ongoing follow-up to support long-term abstinence.

PHOs

13. Support integrated smoking cessation pathways within mental health and addiction services.
14. Support longer-term smoking cessation engagement models, including interventions extending beyond standard short-term treatment periods.
15. Support equitable access to pharmacotherapy and behavioural interventions for people with serious mental illness.
16. Address misconceptions within health services that smoking cessation worsens mental health outcomes.
17. Support development of digital and innovative smoking cessation approaches to improve reach and engagement.

Good Practice Statements

Clinicians

- Address misconceptions that smoking cessation worsens mental health or psychiatric stability.
- Use culturally safe, non-judgemental, person-centred, and recovery-oriented communication approaches.
- Recognise the substantial inequities in smoking-related harm experienced by people living with mental health conditions.

Practices and Services

- Provide follow-up and relapse prevention support over extended periods where feasible.
- Consider involving family, whānau, peer support, or wider support networks where appropriate.
- Recognise that people with serious mental illness may benefit from more intensive and flexible smoking cessation support.

PHOs / Health Systems

- Support integration of smoking cessation into routine mental health and addiction service delivery.
- Support workforce capability in smoking cessation treatment for people with mental health conditions.
- Recognise tobacco dependence as a major contributor to reduced life expectancy and health inequities in people with serious mental illness.

Evidence Summary

- People living with serious mental illness experience substantially higher smoking prevalence and greater nicotine dependence than the general population.
- Smoking cessation is associated with improvements in anxiety, depression, stress, wellbeing, and quality of life, with no evidence of worsening mental health outcomes.
- Person-centred behavioural interventions improve smoking cessation outcomes in people with serious mental illness.
- Extended-duration interventions combining behavioural support and pharmacotherapy improve long-term abstinence outcomes.
- Varenicline, bupropion, and nicotine replacement therapy significantly improve smoking cessation outcomes and are generally well tolerated in people with and without mental health conditions.
- Effective interventions commonly include pharmacotherapy, motivational enhancement, cessation education, skills training, and relapse prevention approaches.

- Smoking cessation support can be successfully integrated into routine mental health and addiction services but often requires more intensive support and longer-term engagement.
- Digital interventions show emerging promise for improving reach and engagement.
- Financial incentives may further improve engagement and cessation outcomes in some settings.

Smoking Cessation and Chronic Pain

Audience

- General practice teams
- Pain services
- Prescribers
- Stop smoking services
- Mental health and addiction services

Evidence-Based Recommendations

Clinicians

1. Recognise that smoking and nicotine use may function as short-term self-management for pain symptoms.
2. Explain that nicotine may produce transient analgesic effects but does not improve underlying pain mechanisms and reinforces ongoing nicotine dependence.
3. Use standard smoking cessation approaches including behavioural support and evidence-based pharmacotherapy.
4. Discuss the relationship between smoking, nicotine dependence, chronic pain, mood, sleep, physical activity, and opioid use because this may improve motivation to quit and engagement with treatment.
5. Recognise that smoking cessation is associated with improvements in long-term pain outcomes and reductions in opioid use.
6. Consider more intensive or tailored smoking cessation support for people with chronic or persistent pain where appropriate.

Practices and Services

7. Incorporate smoking cessation support into chronic pain assessment and management approaches.
8. Use person-centred and supportive approaches that acknowledge the interaction between pain and nicotine dependence.
9. Consider pain-focused psychoeducation approaches because these may improve motivation to quit and engagement with cessation support.

10. Support ongoing follow-up and relapse prevention where feasible.

PHOs

11. Support integrated smoking cessation and chronic pain management approaches.
12. Support workforce capability regarding the interaction between smoking, nicotine dependence, pain, mood, sleep, and opioid use.
13. Support equitable access to smoking cessation support for people living with chronic pain.
14. Support development and evaluation of tailored interventions for people with chronic pain because evidence for pain-focused smoking cessation interventions remains limited.

Good Practice Statements

Clinicians

- Recognise the complex interaction between smoking, chronic pain, insomnia, mood disorders, sedentary behaviour, and opioid use.
- Use non-judgemental and person-centred communication approaches when discussing smoking and pain.
- Acknowledge that some people may perceive smoking or vaping as helping manage pain symptoms in the short term.

Practices and Services

- Integrate smoking cessation discussions into broader chronic pain management and wellbeing conversations.
- Use pain-focused education approaches where feasible to support engagement with cessation treatment.
- Recognise that people living with chronic pain may require longer-term support and follow-up.

PHOs

- Support integrated and multidisciplinary approaches for chronic pain and nicotine dependence.
- Recognise the overlap between chronic pain, mental health conditions, opioid use, and smoking-related harm.

Evidence Summary

- Nicotine has transient analgesic effects that may temporarily increase pain tolerance and reduce pain sensitivity, potentially reinforcing ongoing nicotine use and dependence.
- Smoking is associated with a higher burden of chronic pain and chronic musculoskeletal pain.
- Smoking is more prevalent among people using opioids, highlighting overlap between tobacco use, chronic pain, and opioid dependence.
- Smoking may contribute to chronic pain through pathways involving depression, insomnia, and sedentary behaviour.
- Smoking cessation is associated with improvements in pain outcomes and reductions in opioid use.
- Pain-focused psychoeducation interventions improve knowledge, motivation to quit, and engagement with smoking cessation support.
- Evidence that pain-focused smoking cessation interventions improve long-term abstinence outcomes remains limited.
- Current evidence supports standard smoking cessation approaches for people with chronic pain, including pharmacotherapy combined with behavioural support, with some individuals potentially benefiting from more intensive or tailored interventions.

Smoking Cessation in LGBTQIA+ Populations

Audience

- All health workers
- General practice teams
- Stop smoking services
- Mental health and addiction services
- Community and peer support organisations
- PHOs

Evidence-Based Recommendations

Clinicians

1. Provide smoking cessation support using affirming, culturally safe, non-judgemental, and person-centred approaches that respect sexual orientation, gender identity, and gender expression.
2. Routinely offer smoking cessation support to LGBTQIA+ people, recognising the higher prevalence of smoking and nicotine use in many LGBTQIA+ populations.
3. Recognise that smoking may be influenced by minority stress, discrimination, stigma, social exclusion, trauma, and mental health challenges.
4. Offer evidence-based smoking cessation interventions, including behavioural support and pharmacotherapy, as these are effective for LGBTQIA+ populations.
5. Use inclusive communication and avoid assumptions regarding relationships, identities, bodies, or health experiences.
6. Recognise the importance of social support, peer networks, and community connection when supporting smoking cessation.

Practices and Services

7. Ensure smoking cessation services are inclusive, welcoming, and affirming for LGBTQIA+ people.
8. Provide staff training in culturally safe and inclusive care for LGBTQIA+ populations.
9. Incorporate flexible models of support that recognise differing experiences and barriers within LGBTQIA+ communities.

10. Integrate smoking cessation support with mental health, wellbeing, and other services commonly accessed by LGBTQIA+ people where appropriate.
11. Use proactive outreach approaches to improve engagement with populations experiencing barriers to care.

PHOs

12. Support inclusive and equity-focused smoking cessation services for LGBTQIA+ people.
13. Support workforce development in LGBTQIA+ affirming care and communication.
14. Support partnerships with LGBTQIA+ organisations and communities to improve service design, accessibility, and engagement.
15. Support monitoring and quality improvement approaches that identify and address inequities experienced by LGBTQIA+ populations.

Good Practice Statements

Clinicians

- Use inclusive, affirming, non-judgemental, and person-centred communication approaches.
- Avoid assumptions regarding sexual orientation, gender identity, relationships, or family structures.
- Recognise the impact of minority stress, discrimination, stigma, and social exclusion on smoking behaviour and cessation attempts.
- Where appropriate, acknowledge the importance of peer support, chosen family, and community connections.

Practices and Services

- Ensure services are visibly inclusive and welcoming for LGBTQIA+ people.
- Use intake forms, systems, and communication approaches that support inclusive and respectful engagement.
- Recognise that experiences and needs differ across LGBTQIA+ populations and avoid treating LGBTQIA+ communities as a single homogenous group.

PHOs

- Support co-design and engagement with local LGBTQIA+ communities and organisations.

- Use equity-focused approaches to service planning, monitoring, and quality improvement.
- Recognise the intersection of LGBTQIA+ identities with ethnicities, disability, socioeconomic disadvantage, mental health conditions, and other determinants of health.

Evidence Summary

- Smoking prevalence is higher among many LGBTQIA+ populations than in the general population.
- LGBTQIA+ people experience higher levels of minority stress, discrimination, stigma, social exclusion, and mental health challenges, all of which may contribute to tobacco and nicotine use.
- Evidence indicates that standard evidence-based smoking interventions, including behavioural support and pharmacotherapy, are effective for LGBTQIA+ populations.
- Tailored and affirming interventions may improve engagement, acceptability, and treatment uptake.
- Inclusive healthcare environments and affirming clinician communication improve healthcare engagement and trust.
- Community connection, peer support, and social networks may play an important role in smoking cessation for some LGBTQIA+ people.
- Evidence specific to LGBTQIA+ smoking cessation interventions remains relatively limited, but available evidence supports culturally safe, affirming, person-centred, and equity-focused approaches to care.

Supporting Smokefree Pregnancies and Whānau

Audience

- Midwives
- General practice teams
- Maternity services
- Stop smoking services
- PHOs
- Obstetric and neonatal services

Evidence-Based Recommendations

Clinicians

1. Routinely ask about smoking and nicotine use during pregnancy using supportive, culturally safe, mana-enhancing, and non-judgemental approaches.
2. Recognise that smoking disclosure during pregnancy may be affected by stigma, shame, fear of judgement, and previous experiences with health services.
3. Offer behavioural smoking cessation support to all pregnant people who smoke because this improves smoking cessation outcomes during pregnancy.
4. Offer nicotine replacement therapy (NRT) in pregnancy to people who are unable to stop smoking with behavioural support alone as this reduces risk compared to continuing smoking and current evidence does not indicate harm.
5. Continue smoking cessation support throughout pregnancy and the postpartum period because relapse after birth is common.
6. Use relationship-based, whānau-centred communication approaches because these improve trust, engagement, disclosure, and retention in care.
7. Discuss the risks of smoking and vaping during pregnancy using clear, supportive, evidence-based communication that avoids blame or fear-based messaging.
8. Recognise that smoking cessation support during pregnancy may require repeated offers of support, flexibility, and ongoing follow-up over time.

9. Recognise that stop smoking services may provide more intensive behavioural support, follow-up, relapse prevention, and culturally tailored support than is feasible within routine maternity consultations.

Practices and Services

10. Use supportive system approaches to identify smoking and nicotine use during pregnancy and connect whānau with support early.
11. Offer timely access to culturally responsive stop smoking support services, including kaupapa Māori and whānau-centred services where available.
12. Use proactive follow-up and relapse prevention approaches because relapse after birth is common.
13. Use culturally safe, flexible, trauma-informed, and whānau-centred approaches to smoking cessation support during pregnancy.
14. Consider opt-out referral pathways because these improve engagement with smoking cessation support.
15. Consider carbon monoxide (CO) screening as part of supportive engagement and identification approaches where available and appropriate.
16. Integrate smoking cessation support into routine maternity, early parenting, and whānau wellbeing pathways.

PHOs

17. Support proactive, equity-focused, system-based smoking cessation pathways within maternity services.
18. Support integrated approaches combining behavioural support, pharmacotherapy, follow-up, and referral pathways.
19. Support culturally safe, whānau-centred, equity-focused, and Kaupapa Māori approaches to smoking cessation support during pregnancy.
20. Support workforce capability in pregnancy smoking cessation support, including culturally responsive communication, trauma-informed care, and referral pathways.
21. Support implementation of system approaches including routine identification, opt-out referral pathways, structured follow-up, and service integration.

22. Consider financial incentive approaches where feasible because evidence suggests these may improve smoking cessation outcomes during pregnancy.

Good Practice Statements

Clinicians

- Avoid judgemental, punitive, or fear-based communication approaches.
- Recognise that smoking and nicotine dependence may occur within broader social, financial, intergenerational, and relationship contexts.
- Recognise that many wāhine and whānau may have experienced stigma, blame, or judgement when discussing smoking during pregnancy.
- Use supportive, person-centred, culturally responsive, and mana-enhancing communication approaches.

Practices and Services

- Integrate smoking cessation support within maternity, early parenting, and whānau wellbeing pathways.
- Use proactive engagement and repeated offers of support throughout pregnancy and the postpartum period.
- Ensure referral pathways are timely, accessible, flexible, and responsive to whānau needs.
- Support continuity of care and whakawhanaungatanga across services wherever possible.

PHOs

- Support equity-focused maternity smoking cessation services.
- Support partnership approaches between maternity services, stop smoking services, primary care, iwi, Māori providers, and community organisations.
- Recognise that system-level approaches are likely to achieve greater impact than clinician-only interventions.

Evidence Summary

- Smoking during pregnancy remains a major modifiable risk factor for adverse maternal and infant outcomes including Sudden Unexpected Death in Infancy (SUDI).
- Self-report alone may under-identify smoking during pregnancy, partly due to stigma, shame, and concerns about judgement.
- Supportive, non-judgemental, culturally safe care environments improve smoking disclosure and engagement with support.
- Behavioural smoking cessation interventions delivered by nurses, midwives, and stop smoking practitioners improve cessation outcomes during pregnancy.
- Evidence for pharmacotherapy effectiveness during pregnancy is mixed, although longer-duration NRT may improve cessation outcomes.
- Current evidence does not demonstrate increased risk of major congenital malformations associated with NRT, varenicline, or bupropion exposure during pregnancy, although evidence remains limited for some treatments.
- Do not recommend vaping as a first-line smoking cessation approach during pregnancy. Vaping during pregnancy has been associated with increased risks of adverse infant outcomes including low birth weight, preterm birth, and small-for-gestational-age infants. Where a pregnant person is already using vaping to remain smokefree, support continued abstinence, use supportive and non-judgemental communication, and offer behavioural support with nicotine replacement therapy as the preferred pharmacological option.
- Psychosocial interventions, counselling, financial incentives, and opt-out referral pathways improve smoking cessation outcomes and may improve perinatal outcomes.
- Carbon monoxide monitoring combined with opt-out referral pathways increases engagement with smoking cessation support.
- System-based approaches combining routine identification, behavioural support, referral pathways, pharmacotherapy, and structured follow-up are likely to provide the most effective support for smoking cessation during pregnancy.

Supporting Smoking Cessation for Children and Young People

Audience

- General practice teams
- School-based health services
- Stop smoking services
- PHOs
- Paediatric services
- Child and adolescent mental health and addiction services

Evidence-Based Recommendations

Clinicians

1. Offer behavioural smoking cessation support to children and young people who smoke because behavioural interventions may improve long-term smoking cessation.
2. Tailor smoking cessation support to the young person's developmental stage, nicotine dependence, preferences, and social context.
3. Consider nicotine replacement therapy (NRT) on an individual basis for nicotine-dependent young people receiving behavioural support, recognising that evidence of effectiveness is limited although NRT appears generally well tolerated. Noting that NRT is contraindicated in children under 12 years of age.
4. The safety and effectiveness of varenicline, bupropion and cytisine have not been established in people under 18 years and these are not recommended for routine use in this age group.
5. Involve the young person in the decision-making process and seek specialist advice where nicotine dependence is severe.
6. Ask routinely about vaping as well as smoking.
7. Do not recommend vaping as a smoking cessation approach for children and young people.
8. Recognise that smoking cessation support for children and young people may require repeated offers of support, flexibility, and ongoing follow-up.

9. Where appropriate and with the agreement of the young person, involve parents, caregivers, or whānau as part of smoking cessation support.

Practices and Services

10. Ensure smoking cessation services are developmentally appropriate, youth-friendly, accessible, and responsive to the needs of children and young people.
11. Offer timely access to behavioural smoking cessation support and provide proactive follow-up to support engagement and relapse prevention.
12. Integrate smoking cessation support with youth health, primary care, school-based health, mental health, and other services where appropriate.

PHOs

13. Support equitable access to youth-friendly smoking cessation services.
14. Support workforce capability in youth smoking cessation, including developmentally appropriate communication and behavioural support approaches.
15. Support further research and evaluation to strengthen the evidence base for smoking cessation interventions for children and young people.

Good Practice Statements

Clinicians

- Use culturally safe, supportive, non-judgemental, person-centred communication that respects the young person's autonomy and confidentiality.
- Recognise that smoking behaviour in children and young people is influenced by peers, whānau, schools, and the wider social environment.
- Encourage repeated quit attempts where needed, recognising that relapse is common during smoking cessation.
- Consider involving parents, caregivers, or whānau where appropriate and acceptable to the young person.

Practices and Services

- Ensure services are flexible, youth-friendly, and easy to access.
- Promote continuity of care and follow-up to support sustained smoking cessation.

PHOs

- Support equity-focused approaches that improve access to smoking cessation support for children and young people.
- Encourage collaboration between primary care, youth health services, schools, community organisations, and stop smoking services.

Evidence Summary

- Daily smoking among children and young people in New Zealand has declined substantially over the past two decades, although supporting those who continue to smoke remains important because nicotine dependence established during adolescence may persist into adulthood.
- Behavioural interventions may improve long-term smoking cessation among children and young people, although the certainty of evidence remains low.
- Current evidence does not demonstrate consistent long-term benefit from individual counselling or pharmacotherapy alone.
- Available evidence suggests NRT is generally well tolerated in young people, but evidence of effectiveness remains limited.
- Smoking cessation interventions should be developmentally appropriate, youth-friendly, and recognise the influence of peers, whānau, schools, and the wider social environment.
- Involving parents, caregivers, or whānau, where appropriate and with the young person’s agreement, may strengthen smoking cessation support.
- Further high-quality research is needed to determine the most effective smoking cessation interventions for children and young people.

Smoking Cessation in Secondary Care

Audience

- Hospitals
- Inpatient teams
- Outpatient services
- Emergency departments
- Pre-operative services
- Discharge teams
- Mental health and allied health services
- PHOs

Evidence-Based Recommendations

Clinicians

1. Routinely identify and record smoking status in all secondary care settings.
2. Offer smoking cessation support before, during, and after admission, outpatient care, emergency department attendance, or surgery.
3. Inform patients about available smoking cessation support at all relevant points of care.
4. Provide pharmacotherapy for nicotine withdrawal management and smoking cessation where appropriate.
5. Use brief opportunistic smoking cessation interventions in emergency department and outpatient settings where feasible.

Hospital and Secondary Care Services

6. Initiate behavioural smoking cessation support during admission and ensure support continues after discharge for at least one month, and preferably longer where appropriate.
7. Combine behavioural support with pharmacotherapy because this improves smoking cessation outcomes.
8. Use systematic, opt-out smoking cessation models including routine identification, pharmacotherapy, behavioural support, automatic referral to cessation services where available, and structured post-discharge follow-up.

9. Use integrated tobacco dependence treatment “bundle” approaches rather than isolated or ad hoc interventions.
10. Offer pre-operative smoking cessation interventions as early as possible before surgery because these improve smoking cessation outcomes before and after surgery.
11. Use multidisciplinary approaches involving medical, nursing, allied health, and specialist tobacco treatment staff where possible, and tailor interventions to patient needs, preferences, and clinical context.
12. Ensure smoking cessation support is integrated across inpatient, outpatient, emergency department, mental health, and pre-operative pathways.
13. Before a person stops smoking, review their other medicines for interactions with tobacco smoke. Doses of clozapine, olanzapine, chlorpromazine, haloperidol, theophylline, and other affected medicines may need to be lowered, and doses of warfarin adjusted according to INR. Additional monitoring of medication levels and symptoms may be necessary. This effect is caused by tobacco smoke rather than nicotine, and therefore applies whether or not the person is using NRT, varenicline, or a vaping product.

PHOs

13. Support integrated hospital-to-community smoking cessation pathways.
14. Support active referral and structured post-discharge follow-up systems, including access to ongoing community or telephone support where feasible.
15. Support system-level approaches that embed smoking cessation into routine secondary care delivery.
16. Support workforce training and organisational systems that reduce reliance on individual clinician initiative alone.
17. Address implementation barriers including time pressure, competing clinical priorities, uncertainty regarding role responsibility, and limited staff capability.

Good Practice Statements

Clinicians

- Smoking management should be included in care planning for planned admissions and surgery.
- Use culturally safe, supportive, non-judgemental, and person-centred communication approaches.
- Recognise that hospital admission may increase motivation to quit and create opportunities for engagement with cessation support.

Hospital and Secondary Care Services

- Hospitals should ensure nicotine replacement therapy and other smoking cessation pharmacotherapies are readily available.
- Secondary care smoking cessation models should include multidisciplinary support, active referral pathways, and structured follow-up after discharge.
- Emergency department interventions should prioritise immediate treatment initiation and active referral rather than deferred advice alone.

PHOs / Health Systems

- Support coordinated pathways across hospital, primary care, stop smoking services, and community providers.
- Recognise that system-based approaches are more effective than relying solely on opportunistic clinician-delivered interventions.
- Support sustainable implementation through staff training, service integration, monitoring, and ongoing quality improvement.

Evidence Summary

- Secondary care settings provide important opportunities to support smoking cessation because hospital contact may increase motivation to quit and create temporary abstinence periods.
- Hospital-initiated behavioural counselling continued after discharge improves smoking cessation outcomes.
- Combining counselling with pharmacotherapy after discharge further improves quit rates.

- Effective international secondary care models use systematic identification, opt-out referral, pharmacotherapy, behavioural support, and structured post-discharge follow-up.
- NHS inpatient tobacco dependence treatment “bundle” models and the Ottawa Model of Smoking Cessation demonstrate improved smoking cessation outcomes and reductions in readmissions and emergency department presentations.
- Pre-operative smoking cessation interventions improve smoking abstinence before surgery and may improve longer-term abstinence outcomes.
- Emergency department smoking cessation interventions are effective, particularly when they include pharmacotherapy initiation and active referral to follow-up services.
- Smoking cessation support in secondary care often requires multidisciplinary approaches and adaptation to different patient groups and clinical settings.
- Smoking cessation support remains inconsistently delivered in secondary care settings due to barriers including time pressure, competing priorities, uncertainty regarding role responsibility, and system constraints.
- Overall evidence supports systematic, opt-out, multicomponent smoking cessation models embedded within secondary care systems and continued after discharge.

Tailoring Smoking Cessation Support

Audience

- All health workers
- General practice teams
- Stop smoking services
- Secondary care services
- Mental health and addiction services
- PHOs

Evidence-Based Recommendations

Clinicians

1. Deliver smoking cessation support using individualised, adaptive, and person-centred approaches rather than one-off or fixed interventions.
2. Regularly review and adjust smoking cessation treatment based on effectiveness, patient preferences, tolerability, engagement, and changing circumstances.
3. Optimise pharmacotherapy where appropriate, including dose adjustment, extending duration, switching agents, or combining therapies.
4. Tailor behavioural support to individual needs, including intensity, format, communication style, and follow-up approaches.
5. Use multicomponent interventions combining behavioural support, pharmacotherapy, relapse prevention, and ongoing follow-up because these improve smoking cessation outcomes.
6. Recognise that people experiencing socioeconomic disadvantage, disability, severe mental illness, or complex health needs may require more intensive, multidisciplinary, and longer-duration support.
7. Use culturally responsive approaches that take account of language, beliefs, social context, community influences, and lived experience.

Practices and Services

8. Support systematic and adaptive tailoring of smoking cessation support through routine review and follow-up.

9. Use flexible delivery models including digital interventions, text messaging, outreach approaches, peer or lay support, and personalised communication where appropriate.
10. Provide coordinated and multidisciplinary smoking cessation support for people with complex health or social needs.
11. Ensure smoking cessation interventions are adapted to local population needs and barriers to engagement.
12. Use proactive and sustained follow-up approaches rather than short-term intervention alone.

PHOs

13. Support system-enabled tailoring through routine data capture, clinical pathways, prompts, digital tools, and integrated follow-up systems.
14. Support coordinated smoking cessation pathways across primary care, secondary care, stop smoking services, mental health services, and community providers.
15. Support culturally responsive and equity-focused smoking cessation service design.
16. Support implementation quality, including consistency of delivery, workforce capability, service integration, and adaptation to local context.
17. Support more intensive and comprehensive smoking cessation support for populations experiencing disproportionately high smoking-related harm and nicotine dependence.

Tailoring Support for Tobacco and Cannabis Co-Use

Clinicians

18. Recognise that concurrent tobacco and cannabis use may reduce smoking cessation success for some people.
19. Offer integrated treatment approaches addressing both tobacco and cannabis use simultaneously where appropriate.
20. Use behavioural interventions such as motivational interviewing, cognitive behavioural therapy, and contingency management when supporting people with tobacco and cannabis co-use.

21. Offer evidence-based smoking cessation pharmacotherapy including nicotine replacement therapy, varenicline, or bupropion for tobacco cessation where appropriate.

22. Recognise that behavioural interventions remain the primary treatment approach for cannabis use disorder because there are currently no approved pharmacotherapies for cannabis use disorder.

Practices and Services

23. Integrate smoking cessation support with broader addiction and behavioural health services where appropriate.

24. Use coordinated and non-judgemental approaches for people who use both tobacco and cannabis.

PHOs / Health Systems

25. Support development of integrated tobacco and cannabis treatment pathways.

26. Recognise the limited evidence base and support further research regarding tobacco–cannabis co-use treatment approaches.

Good Practice Statements

Clinicians

- Recognise that smoking behaviour is influenced by individual, social, cultural, environmental, and structural factors.
- Avoid relying solely on brief advice approaches for people with high nicotine dependence or complex needs.
- Use collaborative and person-centred decision-making when tailoring treatment plans.

Practices and Services

- Ensure smoking cessation support remains flexible, adaptive, and responsive over time.
- Use proactive engagement and continuity of care approaches.
- Recognise the importance of peer support, social context, and community influences for some populations.

PHOs / Health Systems

- Support system-level approaches that enable tailored care rather than relying solely on individual clinician initiative.
- Ensure smoking cessation systems are adaptable to different populations and local contexts.
- Recognise that effective tailoring requires high-quality implementation and sustained service support.

Evidence Summary

- Tailored smoking cessation support involves adaptive and individualised approaches that adjust pharmacotherapy, behavioural support, and follow-up over time.
- Tailored interventions improve smoking cessation outcomes across a range of populations and settings.
- Digital interventions, personalised care plans, and tailored messaging may improve engagement and support more equitable access to smoking cessation support.
- Populations experiencing socioeconomic disadvantage, disability, severe mental illness, and complex health needs often require more intensive, multidisciplinary, and longer-duration interventions.
- Culturally tailored interventions may improve smoking cessation outcomes by addressing language, beliefs, social context, and cultural relevance.
- Effective smoking cessation support for people with complex needs often requires coordinated, team-based, and multicomponent approaches across primary care, secondary care, and specialist services.
- Concurrent tobacco and cannabis use may adversely affect smoking cessation outcomes for some people.
- Evidence supports integrated treatment approaches for tobacco and cannabis co-use, combining behavioural interventions with evidence-based smoking cessation pharmacotherapy for tobacco dependence.
- Behavioural interventions remain the primary treatment approach for cannabis use disorder because approved pharmacotherapies are not currently available.
- Overall evidence supports system-enabled, culturally responsive, intensive, and adaptive smoking cessation models of care.

Stop Smoking Services

Audience

- Stop smoking services
- General practice teams
- PHOs
- Hospitals and secondary care services
- Mental health and addiction services
- Community and outreach services

Evidence-Based Recommendations

Clinicians and Stop Smoking Practitioners

1. Offer evidence-based smoking cessation support combining behavioural support with pharmacotherapy or other approved cessation aids.
2. Use multicomponent behavioural interventions including motivational interviewing, cognitive behavioural approaches, relapse prevention, and goal setting.
3. Aim to minimise delays between identification of smoking status, enrolment, initiation of treatment, and establishment of a quit date.
4. Use person-centred, culturally safe, culturally responsive, and adaptive approaches tailored to individual needs and circumstances.
5. Recognise that some populations experiencing higher smoking-related harm or barriers to care may require more intensive and flexible support.

Stop Smoking Services and Healthcare Services

6. Use proactive, system-enabled approaches to identify and engage people who smoke rather than relying solely on opportunistic referral.
7. Use streamlined referral pathways including electronic referral and opt-out approaches where appropriate to improve engagement and access.
8. Use proactive outreach approaches including text messaging, outreach clinics, digital engagement, wānanga, whānau and community-based approaches, and trusted local providers where appropriate.
9. Provide timely and accessible follow-up because delays in treatment initiation are associated with lower quit rates.

10. Use flexible and tailored delivery models, including outreach, home-based support, wānanga, kaupapa Māori, Pacific, peer-supported, or multidisciplinary approaches for people with complex health or social needs where appropriate.
11. Integrate smoking cessation services with primary care, secondary care, maternity, mental health, and community services.
12. Routinely monitor engagement, timeliness, quit outcomes, and equity of access as part of continuous quality improvement.

PHOs

13. Support integrated, system-enabled smoking cessation pathways across healthcare settings and community services.
14. Support electronic referral systems and proactive engagement approaches that reduce barriers to accessing support.
15. Support equitable access to smoking cessation services for populations experiencing disproportionate smoking-related harm.
16. Support workforce capability in behavioural support, motivational interviewing, pharmacotherapy management, and culturally responsive care.
17. Support flexible and adaptive smoking cessation service models responsive to local population needs and context.
18. Consider financial incentive approaches where feasible because these improve smoking cessation outcomes when combined with evidence-based support.

Good Practice Statements

Clinicians and Stop Smoking Practitioners

- Use supportive, non-judgemental, and person-centred communication approaches.
- Recognise that engagement and retention are critical determinants of smoking cessation outcomes.
- Recognise that repeated quit attempts and ongoing engagement are common components of successful cessation.

Stop Smoking Services and Healthcare Services

- Ensure services are accessible, timely, and responsive to diverse population needs.

- Use flexible engagement approaches to improve access for populations less well served by traditional healthcare models.
- Integrate relapse prevention and ongoing follow-up into routine smoking cessation care.

PHOs

- Support coordinated pathways between healthcare services, stop smoking services, and community providers.
- Use equity-focused monitoring and quality improvement approaches.
- Recognise that proactive and system-level approaches are more effective than relying solely on individual clinician referral behaviour.

Evidence Summary

Structured Stop Smoking Services are effective, particularly when behavioural support is combined with pharmacotherapy.

Stop Smoking Services currently engage approximately 6.5% of people who smoke each year, with higher reach among Māori and Pacific peoples, providing a strong foundation for further expansion through systematic referral and outreach approaches.

- Multi-session behavioural support delivered by trained practitioners improves quit outcomes compared with brief advice alone.
- Proactive outreach approaches improve recruitment, engagement, and smoking cessation outcomes.
- Electronic referral and opt-out systems improve referral rates and access to support.
- Delays between identifying smoking status and initiating treatment are associated with substantially lower quit rates.
- Tailored and adaptive interventions may improve engagement and outcomes for populations experiencing complex health or social needs.
- More intensive and flexible models of support may be required for populations experiencing disproportionately high smoking-related harm.
- Financial incentives improve smoking cessation outcomes and may support long-term abstinence.

- Effective Stop Smoking Services are proactive, timely, accessible, integrated within health systems, and responsive to population and community needs.

Note on financial incentives: Financial incentives are not presented as a standalone guideline chapter because they are considered one component of broader smoking cessation support. The evidence for incentives has been reviewed and incorporated into the recommendations within the Cessation Support, Pregnancy, and Stop Smoking Services sections, where they are considered alongside behavioural support, pharmacotherapy, and service delivery approaches. Services may consider incentives as part of a comprehensive smoking cessation programme where appropriate.

Group-Based Behavioural Support

Audience

- Stop smoking services
- General practice teams
- Community providers
- PHOs
- Public health and outreach services

Evidence-Based Recommendations

Clinicians and Stop Smoking Practitioners

1. Offer group-based behavioural support as an effective smoking cessation intervention option.
2. Combine group-based behavioural support with pharmacotherapy because combined approaches improve smoking cessation outcomes.
3. Use structured behavioural programmes incorporating problem solving, coping strategies, motivational support, relapse prevention, and behavioural change techniques.
4. Use culturally safe, supportive, non-judgemental, and person-centred facilitation approaches.
5. Recognise that group-based support may achieve smoking cessation outcomes comparable to individual counselling while providing an efficient service delivery model.

Stop Smoking Services and Healthcare Services

5. Use proactive recruitment and engagement approaches rather than relying solely on voluntary self-referral.
6. Use personalised invitations, clinician referral, text messaging, and repeated outreach approaches to improve recruitment and attendance.
7. Use flexible delivery models including in-person, digital, hybrid, rolling-entry, or open-enrolment formats where appropriate.
8. Deliver programmes in accessible community settings where feasible to improve engagement and retention.

9. Incorporate culturally appropriate facilitation, peer support, and equity-focused approaches to improve accessibility and acceptability.
10. Address practical barriers to participation including transport, timing, childcare, digital access, and competing commitments where possible.
11. Integrate group-based cessation support into routine referral pathways across primary care, hospital, and community services.

PHOs

12. Support system-enabled recruitment pathways including SMS outreach, electronic referral, and opt-out referral approaches.
13. Support flexible and accessible models of group-based cessation support.
14. Support equity-focused programme design for populations experiencing disproportionate smoking-related harm or barriers to accessing cessation support.
15. Prioritise service reach, recruitment, engagement, and retention as key measures of programme effectiveness.
16. Support integration of group-based behavioural support within broader smoking cessation systems and pathways.

Good Practice Statements

Clinicians and Stop Smoking Practitioners

- Use supportive, non-judgemental, and person-centred facilitation approaches.
- Recognise that peer support and social connection may improve engagement and motivation for some people.
- Encourage repeated engagement opportunities for people who do not initially attend or complete programmes.

Stop Smoking Services and Healthcare Services

- Use flexible and responsive programme designs to reduce participation barriers.
- Recognise that programme availability alone is insufficient without effective recruitment and engagement systems.
- Ensure programmes are culturally responsive and accessible to diverse communities.

PHOs / Health Systems

- Recognise that recruitment and retention are major determinants of population-level impact.
- Support integration of group-based cessation support with proactive outreach and referral systems.
- Use continuous quality improvement approaches to monitor engagement, attendance, completion, and quit outcomes.

Evidence Summary

- Group-based behavioural support improves smoking cessation outcomes compared with minimal intervention, self-help approaches, and brief advice alone.
- Smoking cessation outcomes from group-based support appear broadly comparable to individual counselling approaches.
- Effective group programmes commonly combine structured behavioural support with pharmacotherapy across multiple sessions.
- Behavioural change techniques associated with effectiveness include problem solving, coping strategies, motivational support, reinforcement, and social framing approaches.
- Recruitment, engagement, and retention remain major limitations to population-level impact.
- Passive recruitment approaches such as advertising alone are generally insufficient to achieve high participation.
- Proactive and personalised recruitment approaches improve engagement with cessation programmes.
- Common barriers to participation include low awareness, preference for unaided quitting, stigma, transport, time constraints, competing commitments, and poor integration into healthcare pathways.
- Flexible programme designs, rolling-entry formats, community-based delivery, and culturally appropriate facilitation may improve accessibility and retention.
- Overall evidence supports group-based behavioural support as an effective and efficient smoking cessation intervention when embedded within proactive, system-enabled, and equity-focused cessation systems.

Bespoke Behavioural Smoking Cessation Approaches

Audience

- Stop smoking services
- General practice teams
- Community smoking cessation providers
- PHOs

Evidence-Based Recommendations

Clinicians and Stop Smoking Practitioners

1. Recognise that some people who smoke may prefer non-pharmacological or group-based behavioural smoking cessation approaches.
2. Offer evidence-based behavioural support options that align with individual preferences and readiness to engage.
3. Inform people who smoke that approaches such as Allen Carr's Easyway may support smoking cessation for some individuals, although the evidence base is more limited than for established multicomponent smoking cessation interventions.
4. Continue to offer established evidence-based smoking cessation approaches, particularly behavioural support combined with pharmacotherapy, because these have the strongest evidence for effectiveness.
5. Use person-centred and non-judgemental approaches when discussing different smoking cessation options.

Stop Smoking Services and Healthcare Services

6. Consider incorporating or referring to a range of behavioural smoking cessation approaches to improve engagement with people who smoke who may not access conventional services.
7. Ensure people who smoke are informed about the relative evidence base, potential benefits, and limitations of different cessation approaches.
8. Integrate behavioural-only approaches within broader smoking cessation systems and referral pathways where appropriate.

PHOs / Localities / Health Systems

9. Support flexible and accessible behavioural smoking cessation options that may improve engagement for some populations.
10. Recognise that evidence for bespoke behavioural approaches remains less certain than for established evidence-based cessation interventions.
11. Support ongoing evaluation and research regarding behavioural-only smoking cessation approaches.

Good Practice Statements

Clinicians and Stop Smoking Practitioners

- Respect individual preferences regarding pharmacological and non-pharmacological smoking cessation approaches.
- Recognise that some people who smoke may be more willing to engage with alternative or group-based behavioural approaches than with traditional stop smoking services.
- Encourage ongoing engagement with smoking cessation support regardless of the specific intervention selected.

Stop Smoking Services and Healthcare Services

- Ensure behavioural-only approaches are not presented as superior to established evidence-based multicomponent interventions where evidence is insufficient.
- Use behavioural approaches as part of a broader, flexible smoking cessation support system.

PHOs / Health Systems

- Support access to a range of evidence-informed smoking cessation interventions while maintaining emphasis on established evidence-based care.
- Recognise the importance of engagement and acceptability in smoking cessation service design.

Evidence Summary

- Allen Carr's Easyway is a structured behavioural smoking cessation approach that aims to alter beliefs, motivations, and emotional responses associated with smoking.

- Randomised trials have reported smoking cessation rates of approximately 19–22% at 6–12 months.
- Evidence suggests Allen Carr's Easyway may achieve smoking cessation outcomes broadly comparable to some specialist smoking cessation services in selected participants.
- Some studies suggest higher quit rates compared with low-intensity digital cessation support.
- Evidence quality remains limited due to small study numbers, methodological limitations, recruitment challenges, and heterogeneity between studies.
- Current evidence is insufficient to conclude that Allen Carr's Easyway is superior to established evidence-based smoking cessation programmes.
- Behavioural-only approaches such as Allen Carr's Easyway may appeal to people who smoke seeking non-pharmacological or group-based cessation support.
- Overall evidence supports Allen Carr's Easyway as a potential additional behavioural support option rather than a replacement for established multicomponent smoking cessation services.

Part 3: Pharmacotherapy for Smoking Cessation in Adults

Part 3: Pharmacotherapy for Smoking Cessation in Adults

Pharmacotherapy for Smoking Cessation

Audience

- Prescribers
- General practice teams
- Stop smoking services
- Pharmacists
- Mental health and addiction services
- PHOs

Evidence-Based Recommendations

Clinicians

1. Offer evidence-based pharmacotherapy to people who smoke because pharmacological treatments increase smoking cessation rates.
2. Combine pharmacotherapy with behavioural support wherever possible because combined approaches improve smoking cessation outcomes.
3. Tailor pharmacotherapy choice based on nicotine dependence, patient preference, previous quit attempts, tolerability, comorbidities, contraindications, access, and treatment goals.
4. Consider combination nicotine replacement therapy (NRT), typically a nicotine patch plus a fast-acting nicotine product, because this is more effective than single-form NRT.
5. Consider higher-intensity or combination pharmacotherapy approaches for people with higher nicotine dependence or repeated relapse.
6. Before prescribing, consult the New Zealand Formulary or product information for current dosing, contraindications, cautions, and interactions.

7. Discuss expected benefits, common adverse effects, and appropriate use of smoking cessation medications.
8. Recognise that serious adverse events associated with smoking cessation pharmacotherapies are uncommon.
8. Offer NRT because it increases smoking cessation rates compared with placebo or no pharmacotherapy.
9. Use combination NRT where appropriate because this improves smoking cessation outcomes compared with single-form NRT.
10. Tailor the type of NRT to patient preference, nicotine dependence, convenience, and tolerability.
11. Consider higher-dose fast-acting NRT products for people with greater nicotine dependence where appropriate.
12. Consider preloading NRT prior to the quit date because this may improve quit outcomes.
13. Offer varenicline where appropriate because it is among the most effective smoking cessation pharmacotherapies.
14. Offer cytisine where it is accessible and appropriate because evidence suggests effectiveness broadly comparable to varenicline and combination NRT. Prescribers should confirm current registration, funding, and supply status, as availability of cytisine in New Zealand may change; where cytisine is supplied as an unapproved medicine, the usual requirements for prescribing unapproved medicines apply.
15. Offer bupropion where appropriate because it improves smoking cessation outcomes compared with placebo.
16. Consider nortriptyline where first-line therapies are unsuitable or unavailable, recognising evidence certainty is lower than for first-line treatments.

Practices and Services

17. Ensure smoking cessation pharmacotherapies are readily accessible within smoking cessation pathways.

18. Support medication adherence through education, follow-up, dose adjustment, and management of adverse effects.
19. Integrate pharmacotherapy management within broader behavioural support and relapse prevention approaches.

PHOs

20. Support equitable access to evidence-based smoking cessation pharmacotherapies.
21. Support workforce capability in smoking cessation pharmacotherapy prescribing and management.
22. Support system-enabled approaches that integrate pharmacotherapy with behavioural support and follow-up pathways.

Good Practice Statements

Clinicians

- Use shared decision-making when selecting smoking cessation pharmacotherapy.
- Explain that repeated quit attempts and changes in pharmacotherapy are common and may improve long-term success.
- Encourage continued engagement with behavioural support alongside medication use.

Practices and Services

- Ensure people who smoke receive clear guidance regarding correct medication use and expectations.
- Use proactive follow-up to support adherence, troubleshoot adverse effects, and optimise treatment.
- Recognise that some people may require extended-duration or combination pharmacotherapy approaches.
- Be aware of current funding criteria when selecting smoking cessation pharmacotherapy. For example, in New Zealand varenicline is funded by Special Authority at 1 mg twice daily for 12 weeks; extended-duration treatment beyond this period improves relapse prevention but is not currently funded. Discuss cost with the person before starting extended treatment, and consider funded alternatives where cost is a barrier.

PHOs / Health Systems

- Support consistent access to smoking cessation medications across healthcare settings.
- Recognise that pharmacotherapy is most effective when embedded within broader smoking cessation systems and behavioural support pathways.
- Support ongoing review and adaptation of pharmacotherapy access and prescribing pathways.

Evidence Summary

- High-certainty evidence demonstrates that several pharmacotherapies increase smoking cessation rates compared with placebo or minimal intervention.
- Nicotine e-cigarettes, varenicline, cytisine, and combination nicotine replacement therapy demonstrate the highest quit rates in meta-analyses.
- Combination NRT is more effective than single-form NRT.
- Single-form NRT, fast-acting NRT, and bupropion also significantly improve smoking cessation outcomes.
- Varenicline and cytisine demonstrate quit rates broadly comparable to or greater than combination NRT in some analyses.
- Serious adverse events associated with smoking cessation pharmacotherapies are uncommon.
- NRT is generally well tolerated, with adverse effects usually related to the mode of nicotine delivery.
- There is no clear evidence that one form of NRT is superior to another, and product choice should be individualised.
- Preloading NRT before the quit date may modestly improve smoking cessation outcomes.
- Evidence supporting snus or nicotine pouches for smoking cessation is weak compared with established cessation treatments.
- Heated tobacco products have not demonstrated effectiveness for smoking cessation and continue to expose users to toxicants and carcinogens.

Use of E-Cigarettes to Stop Smoking (Vaping to Quit Smoking)

Audience

- Prescribers
- General practice teams
- Stop smoking services
- Pharmacists
- Mental health and addiction services
- PHOs

Evidence-Based Recommendations

Clinicians

1. Inform people who smoke that vaping to quit smoking can increase smoking cessation rates compared with nicotine replacement therapy (NRT), non-nicotine e-cigarettes, behavioural support alone, or no support.
2. Use vape to quit smoking approaches within a broader smoking cessation framework that includes behavioural support, follow-up, and relapse prevention.
3. Discuss both the potential benefits and potential harms of vaping using balanced, evidence-based, and non-judgemental communication.
4. Explain that vaping products are not risk-free, but current evidence indicates combustible tobacco smoking carries substantially greater health risk than nicotine vaping products. This comparison applies to regulated nicotine vaping products used as a cessation aid and should not be extended to heated tobacco products, snus, or nicotine pouches, for which effectiveness as cessation aids has not been demonstrated.
5. Encourage complete transition away from combustible tobacco smoking for people using vaping as a smoking cessation aid and avoid long-term dual use where possible.
6. Tailor smoking cessation approaches according to patient preferences, nicotine dependence, previous quit attempts, treatment goals, and tolerability.
7. Recognise that behavioural support substantially improves smoking cessation outcomes when combined with vaping-to-quit approaches.

8. Discuss uncertainties regarding long-term health effects of vaping and support informed decision-making including vaping cessation when possible.
9. Do not recommend vaping to people who do not currently smoke, to young people, or as a first-line approach during pregnancy.

Practices and Services

10. Integrate vape to quit smoking approaches within evidence-based smoking cessation services and referral pathways.
11. Provide clear guidance regarding appropriate use of vaping products for smoking cessation, including strategies to minimise dual use and support eventual nicotine cessation where appropriate.
12. Use supportive follow-up and relapse prevention approaches for people using vaping to quit smoking.
13. Ensure smoking cessation discussions include consideration of poisoning risk, device safety, dependence, environmental exposure, and safe storage away from children.
14. Ensure vaping advice is integrated with behavioural support and broader smoking cessation care planning.

PHOs

15. Support balanced, evidence-based communication regarding vaping for smoking cessation.
16. Support integration of vape to quit smoking approaches within broader smoking cessation systems and behavioural support pathways.
17. Support ongoing surveillance, monitoring, and research regarding long-term health effects, cessation outcomes, and population-level impacts of vaping.
18. Recognise that evidence regarding long-term harms and comparative risks of vaping continues to evolve.
19. Support workforce capability in evidence-based vaping-to-quit counselling and risk communication.

Good Practice Statements

Clinicians

- Use balanced, non-stigmatising, and person-centred communication when discussing vaping with people who smoke.
- Avoid presenting vaping as either harmless or equivalent in risk to combustible tobacco smoking.
- Recognise that some people who smoke may prefer vaping as a smoking cessation approach, particularly after unsuccessful quit attempts using other methods.
- Recognise that complete smoking and vaping cessation remains the preferred long-term outcome where achievable.
- Recognise that some people who choose vaping to quit smoking will continue to vape in the medium to longer term.

Practices and Services

- Support informed decision-making by discussing both smoking cessation effectiveness and uncertainties regarding long-term harms.
- Encourage complete smoking cessation and avoidance of ongoing dual use where possible.
- Ensure advice regarding vaping is consistent, evidence-based, and integrated with behavioural support and relapse prevention.

PHOs

- Support public health messaging that clearly distinguishes combustible tobacco products from regulated nicotine vaping products when used as a smoking cessation aid, while acknowledging that vaping is not risk-free.
- Recognise the evolving nature of the evidence base and the need for ongoing review of recommendations.
- Support consistent clinical messaging regarding relative risk, smoking cessation effectiveness, and ongoing uncertainties.

Evidence Summary

- High-certainty evidence demonstrates that nicotine e-cigarette use in adults increases smoking cessation rates compared with nicotine replacement therapy.

- Moderate-certainty evidence suggests nicotine e-cigarettes also improve quit rates compared with non-nicotine e-cigarettes and behavioural support alone or no support.
- Behavioural support substantially improves smoking cessation outcomes when combined with vaping-to-quit approaches.
- Serious adverse events associated with vaping interventions in smoking cessation trials appear uncommon, although evidence certainty remains limited.
- Evidence regarding long-term harms of vaping remains incomplete and continues to evolve.
- Reported harms associated with vaping include nicotine poisoning, burns and explosion injuries, dependence, respiratory symptoms, and e-cigarette or vaping product use-associated lung injury (EVALI), particularly involving THC-containing products.
- Observational evidence has raised concerns regarding respiratory, cardiovascular, and mental health effects associated with vaping, although much of this evidence is low certainty and subject to confounding.
- Comparative risk frameworks consistently conclude that combustible tobacco products carry substantially greater health risks than non-combustible nicotine products including vaping products.
- Nicotine replacement therapy remains among the lowest-risk nicotine delivery systems.
- Comparative risk analyses and toxicant exposure modelling consistently suggest that exposure to carcinogens and toxicants from vaping is substantially lower than from combustible tobacco smoking, although not risk-free.
- Long-term epidemiological evidence regarding vaping-related health effects remains limited, and some comparative risk analyses have methodological limitations and uncertainties.
- Overall evidence supports vaping to quit smoking as a potentially effective smoking cessation aid for adults who smoke, while recognising uncertainty regarding long-term health effects and the importance of balanced risk communication.

Non-Nicotine Pharmacotherapy for Smoking Cessation

Audience

- Prescribers
- General practice teams
- Stop smoking services
- Pharmacists
- Mental health and addiction services
- PHOs

Evidence-Based Recommendations

Clinicians

1. Offer varenicline, cytisine, bupropion, or nortriptyline where appropriate because these medications improve smoking cessation outcomes compared with placebo.
2. Use non-nicotine pharmacotherapy as part of a broader smoking cessation approach that includes behavioural support and follow-up.
3. Tailor medication choice according to nicotine dependence, patient preference, comorbidities, previous quit attempts, tolerability, contraindications, and treatment goals.
4. Discuss expected benefits, common adverse effects, treatment duration, and appropriate medication use with patients.
5. Monitor for adverse effects and treatment tolerability during therapy.
6. Consider extended-duration pharmacotherapy where appropriate because this may improve relapse prevention and maintenance of long-term abstinence.

Varenicline

7. Offer varenicline where appropriate because it is among the most effective smoking cessation pharmacotherapies.
8. Start varenicline prior to the planned quit date using standard dose titration.
9. Consider combining varenicline with nicotine replacement therapy (NRT) for people who do not achieve cessation with varenicline alone, recognising evidence for additional benefit is mixed and this combination does not meet special authority criteria for varenicline subsidy.

10. Monitor for neuropsychiatric symptoms, and suicidal behaviour during treatment, particularly in people with pre-existing mental health conditions, although absolute risk appears low.

11. Use caution in people with a history of seizures or other relevant risk factors.

Bupropion

12. Offer bupropion where appropriate because it improves smoking cessation rates compared with placebo.

13. Consider combining bupropion with NRT or varenicline in selected situations, recognising evidence for long-term additional benefit remains uncertain.

14. Use with caution in people with seizure risk or other contraindications to bupropion.

Nortriptyline

15. Offer nortriptyline where appropriate because it improves smoking cessation outcomes compared with placebo, although the evidence is less certain than for some other pharmacotherapies.

16. Start nortriptyline before the planned quit date and increase the dose gradually in accordance with current prescribing information. Taper the dose when discontinuing treatment to reduce the risk of withdrawal symptoms.

17. Assess contraindications, medicine interactions, cardiovascular risk, and seizure risk before prescribing, and monitor for adverse effects and treatment tolerability during therapy.

Cytisine

18. Offer cytisine where available and appropriate because it improves smoking cessation outcomes compared with placebo.

19. Be aware that cytisine effectiveness appears broadly comparable to varenicline in some analyses and may be greater than NRT in some studies.

20. Discuss common adverse effects including gastrointestinal symptoms and sleep disturbance, which are generally mild to moderate.

21. At the time of writing, no cytisine products are approved for marketing in NZ, and cytisine is not routinely available as a smoking cessation treatment. Clinicians should confirm current regulatory and supply status before considering its use.

Practices and Services

22. Ensure access to evidence-based pharmacotherapy within smoking cessation pathways.
23. Support medication adherence through follow-up, education, dose optimisation, and management of adverse effects.
24. Integrate pharmacotherapy prescribing with behavioural support and relapse prevention approaches.

PHOs

25. Support equitable access to funded and evidence-based smoking cessation pharmacotherapies.
26. Support workforce capability in prescribing and monitoring smoking cessation medications.
27. Support integration of pharmacotherapy with behavioural support and system-enabled smoking cessation pathways.

Good Practice Statements

Clinicians

- Use shared decision-making when selecting smoking cessation pharmacotherapy.
- Recognise that repeated quit attempts and medication changes are common and may improve long-term success.
- Encourage ongoing engagement with behavioural support alongside medication use.
- Discuss potential neuropsychiatric symptoms and advise patients to seek review if significant mood or behavioural changes occur.

Practices and Services

- Ensure people using smoking cessation medications receive clear guidance regarding correct use, expected effects, and duration of treatment.
- Use proactive follow-up to optimise adherence and treatment effectiveness.

- Recognise that some people may benefit from extended-duration or combination pharmacotherapy approaches.

PHOs

- Support consistent access to smoking cessation medications across healthcare settings.
- Recognise that pharmacotherapy is most effective when embedded within broader behavioural support systems.
- Support ongoing review of funding, access, and prescribing pathways for smoking cessation medications.

Evidence Summary

Varenicline

- Varenicline more than doubles smoking cessation rates compared with placebo and is among the most effective smoking cessation pharmacotherapies.
- Varenicline demonstrates smoking cessation outcomes broadly comparable to cytisine and nicotine e-cigarettes and greater effectiveness than single-form NRT and bupropion.
- Combining varenicline with NRT may modestly improve smoking cessation outcomes, although evidence certainty is low and findings are inconsistent.
- Extended-duration varenicline may improve relapse prevention and maintenance of long-term abstinence.
- Common adverse effects include nausea, insomnia, abnormal dreams, headache, and fatigue, which are usually mild.
- Current evidence does not demonstrate a clear increase in neuropsychiatric adverse events compared with placebo, although monitoring for psychiatric symptoms is recommended.
- Cardiovascular safety data remain uncertain but major trials have not demonstrated clear increased cardiovascular risk.

Bupropion

- Bupropion significantly improves smoking cessation outcomes compared with placebo.
- Combination therapy with NRT or varenicline may improve short-term outcomes, although long-term benefit remains uncertain.

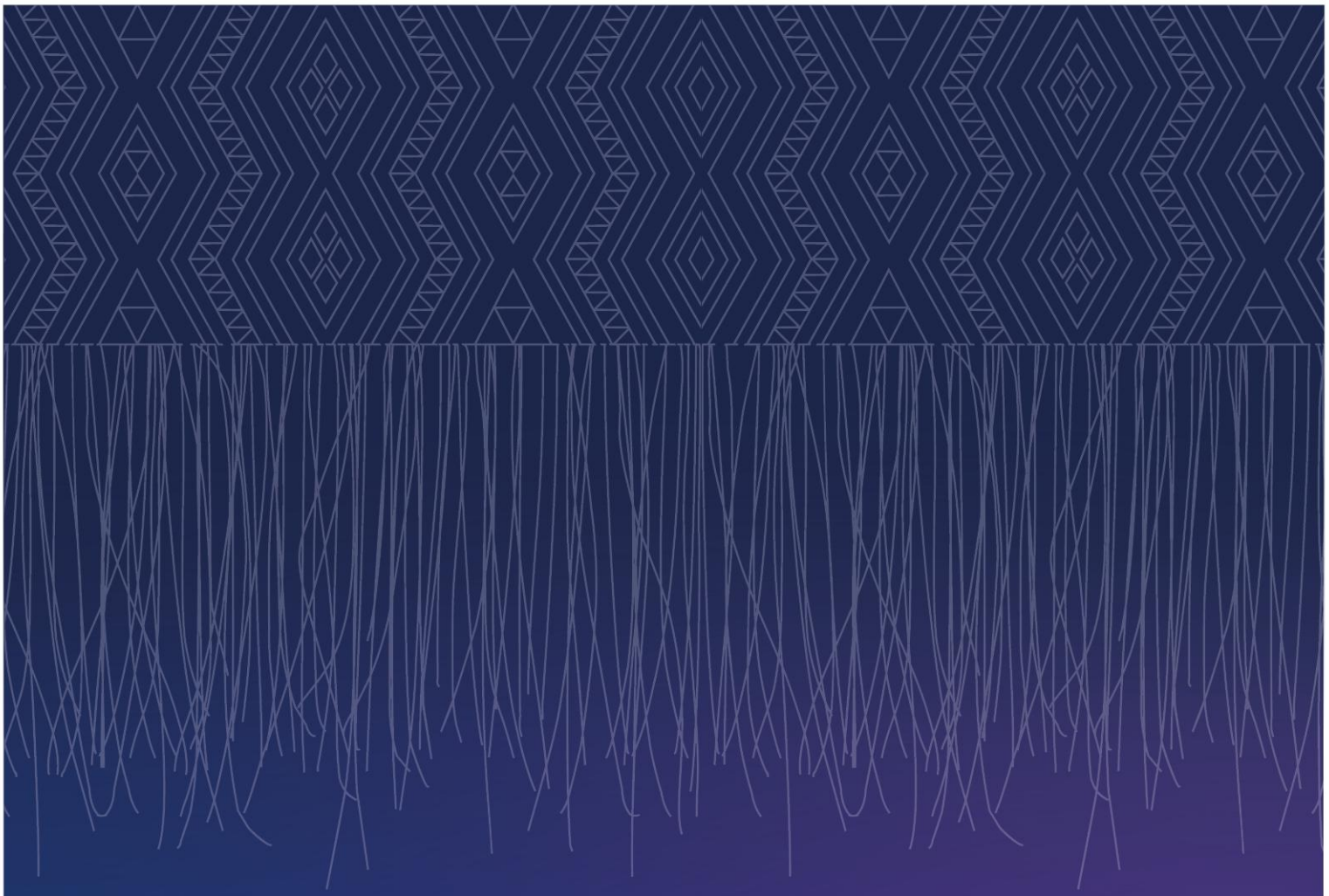
- Bupropion is generally well tolerated, although there may be a small increase in serious adverse events compared with placebo.

Nortriptyline

- Moderate-certainty evidence indicates that nortriptyline probably improves smoking cessation outcomes compared with placebo.
- The estimated benefit is modest, and the evidence is less certain than for several other established smoking cessation pharmacotherapies.

Cytisine

- Moderate-certainty evidence demonstrates that cytisine improves smoking cessation outcomes compared with placebo.
- Cytisine quit rates are typically higher than placebo and may be greater than NRT in some analyses.
- Comparative analyses suggest cytisine effectiveness may be broadly similar to varenicline.
- Cytisine appears to be associated with fewer serious adverse events than varenicline.
- Adverse effects are generally mild and commonly include gastrointestinal symptoms and sleep disturbance.
- Combine behavioural support with pharmacotherapy.



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