NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Tobacco: preventing uptake, promoting quitting and treating dependence

Draft for consultation, November 2024

Overview

This guideline has been updated to include cytisinicline, a medicinally licensed product, as a stop-smoking intervention.

This will update NICE guideline NG209 (last updated January 2023).

Who is it for?

- Commissioners and providers of stop-smoking interventions and support, including those in the voluntary and community sectors
- Commissioners and providers of interventions and support for preventing uptake of smoking
- Health and social care professionals, including clinical leads in secondary care services and managers of clinical services
- People working in local authorities, education and the wider public, private, voluntary and community sectors
- Those commissioning, planning and delivering mass-media campaigns
- People with a remit to improve the health and wellbeing of children and young people aged 24 and under; this includes those working in the NHS, local authorities and tobacco control alliances
- Retailers of tobacco products
- Employers, estate managers and other managers

- Employee and trade union representatives

It may also be relevant for:

- Researchers and policy makers
- Manufacturers and retailers of medicinally licensed nicotine-containing products and nicotine-containing e-cigarettes
- Members of the public, including:
  - children, young people, their parents and carers
  - people using health and social care services, and their families and carers
  - women, and trans men and non-binary people, who are pregnant or planning a pregnancy, or who have a child aged up to 12 months, and their families and carers
  - people over 16 who smoke and are in paid or voluntary employment

What does it include?

- the updated recommendations
- rationale and impact sections that explain why the committee updated the recommendations in 2025 and how they might affect practice
- the guideline context.

Information about how the guideline was developed is on the guideline's webpage. This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

New and updated recommendations

We have reviewed the evidence on stop smoking interventions. You are invited to comment on the changes to the recommendations that are highlighted (in yellow) and marked as **[2025]**.

We have not reviewed the evidence for the recommendations shaded in grey and marked **[2010, amended 2025]**, **[2013, amended 2025]**, **[2018]**, **[2021]**, **[2021,**

amended 2022], or parts of recommendations marked **[2018]** or **[2021]** that are not shaded in grey, and cannot accept comments on them. In some cases, we have made minor wording changes for consistency, clarification or to bring the language up to date. See update information for a full explanation of what is being updated.

Full details of the evidence and the committee's discussion on the 2025 recommendations are in the evidence review. Evidence for the 2021 recommendations is in the full version of the 2021 guideline.

Contents

1 Recommendations on treating tobacco dependence

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

This guideline should be read alongside NICE's guidelines on patient experience in adult NHS services and babies, children and young people's experience of healthcare, which have guidance on giving information to people and discussing their views and preferences.

In this guideline, we use the following terms for age groups:

- children: aged 5 to 11
- young people: aged 12 to 17
- young adults: aged 18 to 24
- adults: aged 18 and over.

Unless otherwise stated, the recommendations on treating tobacco dependence are for people over the age of 12 who want to stop smoking or reduce harm from smoking.

At the time of publication (February 2025), no nicotine-containing e-cigarettes were licensed as a medicine for stopping smoking by the Medicines and Healthcare products Regulatory Agency (MHRA) and commercially available in the UK market. All nicotine-containing e-cigarettes in the UK that are not licensed as a medicine by the MHRA are regulated by the Tobacco and Related Products

Regulations (2016), and cannot be marketed by the manufacturer for use for stopping smoking.

These recommendations aim to help people aged 12 or over (unless otherwise stated) to stop smoking or, if they do not want or are not ready to stop in one go, to reduce their harm from smoking. They cover interventions and services delivered in a range of settings, including NHS primary and secondary care, and emphasise the importance of targeting vulnerable groups who find giving up smoking hard or who smoke a lot. Pregnant women are mainly covered in the section in the complete guideline on treating tobacco dependence in pregnant women.

1.12 Stop-smoking interventions

These recommendations are for people providing stop-smoking support or advice. For training requirements see the National Centre for Smoking Cessation and Training (NCSCT) standard for training in smoking cessation treatments.

For recommendations on digital and mobile health interventions for stopping smoking, see NICE's guideline on behaviour change: digital and mobile health interventions.

See recommendation 1.14.23 in the complete guideline for advice on people's use of prescribed medicines that are affected by smoking (or stopping smoking).

1.12.1 Tell people who smoke that a range of interventions is available to help them stop smoking. Explain how to access them and refer people to stop-smoking support if appropriate. **[2021]**

1.12.2 Ensure the following are accessible to adults who smoke: **[2021]**

- behavioural interventions:
  - behavioural support (individual and group)
  - very brief advice **[2021]**
- medicinally licensed products:

  - bupropion **[2021]**
  - cytisinicline **[2025]**
  - nicotine replacement therapy (NRT) – short and long acting **[2021]**
  - varenicline **[2021]**
- nicotine-containing e-cigarettes **[2021]**
- Allen Carr's Easyway in-person group seminar. **[2021]**

1.12.3 Consider NRT for young people aged 12 and over who are smoking and dependent on tobacco. If this is prescribed, offer it with behavioural support. **[2018]**

1.12.4 Do not offer cytisinicline, varenicline or bupropion to people under 18. **[2013, amended 2025]**

1.12.5 Do not offer cytisinicline to people aged 66 and over. **[2025]**

1.12.6 Offer behavioural support to people who smoke regardless of which option they choose to help them stop smoking, unless they have chosen the Allen Carr Easyway in-person group seminar. Explain how to access this support. **[2021, amended 2022]**

1.12.7 Discuss with people which options to use to stop smoking, taking into account:

- their preferences, health and social circumstances
- any medicines they are taking
- any contraindications and the potential for adverse effects
- their previous experience of stop-smoking aids.

Also see the advice in the recommendations on medicinally licensed products, and on nicotine-containing e-cigarettes in the complete guideline **[2021]**

1.12.8 Advise people (as appropriate for their age) that the following options, when combined with behavioural support, are more likely to result in them successfully stopping smoking **[2021]**:

- cytisinicline **[2025]**
- a combination of short-acting and long-acting NRT **[2021]**
- varenicline **[2021]**
- nicotine-containing e-cigarettes. **[2021]**

1.12.9 Advise people (as appropriate for their age) that the options that are less likely to result in them successfully stopping smoking, when combined with behavioural support, are:

- bupropion
- short-acting NRT used without long-acting NRT
- long-acting NRT used without short-acting NRT. **[2021]**

1.12.10 For adults, prescribe or provide bupropion, cytisinicline, varenicline or NRT before they stop smoking, and for **[2018]**:

- bupropion, agree a quit date set within the first 2 weeks of treatment and reassess the person shortly before the prescription ends **[2018]**
- cytisinicline, agree a quit date set within the first 5 days of treatment and reassess the person shortly before the prescription ends **[2025]**
- NRT, agree a quit date and ensure the person has NRT ready to start the day before the quit date **[2018]**
- varenicline, agree a quit date and start the treatment 1 to 2 weeks before this date, reassess the person shortly before the prescription ends. **[2018]**

For a short explanation of why the committee made the 2021, 2022 and 2025 recommendations and how they might affect practice, see the rationale and impact section on stop-smoking interventions.

Full details of the evidence and the committee's discussion are in:

- evidence review K: cessation and harm-reduction treatments
- evidence review L: barriers and facilitators to using e-cigarettes for cessation or harm reduction
- evidence review M: long-term health effects of e-cigarettes
- evidence review P: effectiveness and cost-effectiveness of Allen Carr's Easyway.

- evidence review A: effectiveness and cost-effectiveness of cytisinicline for smoking cessation

Recommendations on treating tobacco dependence during pregnancy

1.20 Nicotine replacement therapy and other pharmacological support

1.20.11 Do not offer cytisinicline, varenicline or bupropion to women, trans men or non-binary people who are pregnant or breastfeeding. **[2010, amended 2025]**

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions, see the NICE glossary or, for public health and social care terms, the Think Local Act Personal Care and Support Jargon Buster.

Allen Carr's in-person group seminar

A session lasting between 4.5 and 6 hours with elements of cognitive behavioural therapy and a brief relaxation exercise. Participants are encouraged to carry on smoking as normal until they attend the session and to smoke as normal during scheduled smoking breaks (around every 45 to 60 minutes) until a final ritual

cigarette at the end. After the session, regular texts remind participants that they can contact the provider if they have further questions. The price includes up to 2 shorter (around 3.5 hours) follow-up sessions if wanted.

Behavioural support

Scheduled meetings (face to face or virtual) between someone who smokes and a counsellor trained to provide stop-smoking support. Behavioural support can be provided either individually or in a group. Discussions may include information, practical advice about goal setting, self-monitoring and dealing with the barriers to stopping smoking as well as encouragement. The support also includes anticipating and dealing with the challenges of stopping (see NICE's guideline on behaviour change: general approaches and the National Centre for Smoking Cessation and Training [NCSCT] Training Standard). Support is typically offered weekly for at least the first 4 weeks of a quit attempt (that is, for 4 weeks after the quit date) or 4 weeks after discharge from hospital (where a quit attempt may have started before discharge), and normally given with stop-smoking pharmacotherapies. Behavioural support does not include Allen Carr's Easyway in-person group seminar.

Cessation

Stopping the use of tobacco, smoked or smokeless. This includes stopping use of tobacco and moving on to pharmacotherapies (including nicotine replacement therapy) or nicotine-containing e-cigarettes.

Closed institutions

Environments where people are detained or stay for a long time and where smoking is not permitted. These include secure mental health units, immigration removal centres and custodial sites, as well as places like long-stay mental health units and military establishments.

Compensatory smoking

Inhaling more deeply or smoking more of each cigarette to compensate for smoking fewer cigarettes.

E-cigarettes

Also called electronic cigarettes or vaping devices. A product that can be used for the inhalation of vapour through a mouthpiece. E-cigarettes can be disposable or refillable by means of a refill container and a tank, or can be rechargeable with single-use cartridges. Products may be used to consume nicotine or used without nicotine (see nicotine-containing e-cigarettes).

Products that contain or could contain nicotine in the form of e-liquid are covered under the European Union's 2014 Tobacco Products Directive and need to be notified to the Medicines and Healthcare products Regulatory Agency (MHRA). Other devices such as disposable e-cigarettes that do not contain nicotine, and 0% nicotine e-liquids, are regulated under the General Product Safety Regulations (2005; definition informed by the MHRA's e-cigarettes regulations for consumer products). E-cigarettes are not currently (February 2025) licensed medicines but are regulated by the Tobacco and Related Products Regulations (2016).

Harm reduction

Measures to reduce the illnesses and deaths caused by smoking tobacco among people who smoke and those around them. Some measures or products may reduce harm more than others. People who smoke and currently do not want, or are not ready, to stop in one go can reduce their harm by smoking less and abstaining from smoking temporarily. The benefits of harm reduction itself are uncertain, but it may mean people are more likely to stop smoking altogether in the future.

Medicinally licensed nicotine-containing products

Nicotine-containing products that have been given marketing authorisation by the MHRA. At the time of publication (February 2025), nicotine replacement therapy

products were the only type of medicinally licensed nicotine-containing product on the market. If any nicotine-containing e-cigarette were licensed by the MHRA and made commercially available, it would be included in this definition.

Nicotine-containing products

Products that contain nicotine but do not contain tobacco and so deliver nicotine without the harmful toxins found in tobacco. This currently includes nicotine replacement therapy, which has been medicinally licensed for smoking cessation by the MHRA (see nicotine replacement therapy), and nicotine-containing e-cigarettes. Currently there are no licensed nicotine-containing e-cigarettes on the market. Nicotine-containing e-cigarettes on general sale are regulated under the Tobacco and Related Products Regulations (2016) by the MHRA. For further details, see the MHRA website.

Nicotine-containing e-cigarettes

Nicotine-containing e-cigarettes are vaping devices filled with nicotine-containing e-liquid. These devices must be notified to the MHRA and must meet the requirements of the European Union (2014) Tobacco Products Directive (definition informed by the MHRA's e-cigarettes regulations for consumer products).

Nicotine replacement therapy

Products medicinally licensed for use as a stop smoking aid and for harm reduction, as outlined in the BNF. They include transdermal patches, gum, inhalation cartridges, sublingual tablets, lozenges, mouth spray and nasal spray.

Pharmacotherapies

This covers medication licensed for smoking cessation such as cytisinicline, varenicline or bupropion, as well as nicotine replacement therapy.

Safety

This refers to the incidence of minor and major side effects associated with nicotine-containing products.

Schools

'Schools' is used to refer to:

- maintained and independent primary, secondary and special schools
- city technology colleges and academies
- pupil referral units, secure training and local authority secure units
- further education colleges
- ‘extended schools’ where childcare or informal education is provided outside school hours.

Secondary care

All publicly funded secondary and tertiary care facilities, including buildings, grounds and vehicles. It covers drug and alcohol services in secondary care; emergency care; inpatient, residential and long-term care for severe mental illness in hospitals, psychiatric and specialist units and secure hospitals; and planned specialist medical care or surgery. It also includes maternity care in hospitals, maternity units, outpatient clinics and in the community.

Self-help materials

Any manual or structured programme, in written or digital format, that someone can use to try to stop smoking or reduce the amount they smoke. These can be used without the help of healthcare professionals, stop-smoking advisers or group support. They can be aimed at anyone who smokes, particular populations (for example, certain ages or ethnic groups), or may be tailored to individual need.

Smokefree

Air that is free of tobacco smoke. E-cigarettes are not covered by smokefree legislation.

Smokeless tobacco

Any product containing tobacco that is placed in the mouth or nose and not burned and which is typically used in England by people of South Asian family origin. It does not include products that are sucked, like 'snus' or similar oral snuff products (as defined in the European Union 2014 Tobacco Products Directive).

The types used vary across the country but they can be divided into 3 main categories, based on their ingredients (Stanfill et al. 2010):

- Tobacco with or without flavourants: misri India tobacco (powdered) and qimam (kiman).
- Tobacco with various alkaline modifiers: khaini, naswar (niswar, nass) and gul.
- Tobacco with slaked lime as an alkaline modifier and areca nut: gutkha, zarda, mawa, manipuri and betel quid (with tobacco).

South Asian family origin

People with ancestral links to countries in southern Asia, including Bangladesh, India, Nepal, Pakistan or Sri Lanka.

Specialist tobacco cessation services

Evidence-based services that offer support to help people stop smoking or using smokeless tobacco. In England, these are generally referred to as 'stop-smoking support or services' or 'smoking cessation services' because they normally focus on people who smoke tobacco. But a service might brand itself as a generic tobacco cessation or tobacco dependence service, to emphasise a focus on more than 1 form of tobacco.

Stop in one go

The standard approach in most stop-smoking support. The person makes a commitment to stop smoking on or before a particular date (the quit date). This may or may not involve the use of pharmacotherapies or nicotine-containing e-cigarettes before the quit date and for some time afterwards, depending on the person's needs.

Stop-smoking support

Interventions and support to stop smoking, regardless of how services are commissioned or set up.

Telephone quitlines

These provide proactive or reactive advice, encouragement, counselling and support by phone to anyone who smokes who wants to quit, or who has recently quit.

Temporary abstinence

Stopping smoking with or without medication for a particular event or series of events, in a particular location, for specific time periods (for example, while at work, during long-haul flights or during a hospital stay), or for the foreseeable future. (The latter might include, for example, abstinence while serving a prison sentence or while detained in a secure mental health unit.)

Under-served groups

Groups who may be less likely to benefit from an intervention because they have specific needs that the intervention does not address, or because they may face additional challenges in engaging with the intervention.

Rationale and impact

This section briefly explains why the committee made the 2021, 2022 and 2025 recommendations, and how they might affect practice and services. They link to details of the evidence and a full description of the committee's discussion.

Stop-smoking interventions

Recommendations 1.12.1 to 1.12.9

Why the committee made the recommendations

The committee for the 2021 version of the guideline looked at a large amount of evidence assessing the relative effectiveness of several interventions, including medicinally licensed products (varenicline, bupropion and nicotine replacement therapy [NRT]) and nicotine-containing e-cigarettes. They also looked at these interventions combined with each other. Most of the interventions or combinations of interventions were delivered with behavioural support. Most evidence investigated medicinally licensed products, with fewer studies about e-cigarettes.

The evidence found that these interventions were effective, and that some were likely to be more effective than others, especially in combination with behavioural support. The committee also agreed with the evidence that a combination of short- and long-acting NRT was effective as well.

Based on the evidence of relative effectiveness and their expertise, the committee agreed that several individual products, as well as short-acting and long-acting NRT in combination, were likely to lead to people successfully stopping smoking when used alongside behavioural support.

The committee for the 2025 update to this guideline agreed to include cytisinicline, a medicinally licensed product, in the recommendations. Although the evidence base for cytisinicline ranged from moderate to very low quality, it was found to be effective in in helping people to stop smoking when combined with behavioural support. It was found to be more effective than placebo or NRT, and there was no difference identified for the effectiveness of cytisinicline compared with varenicline. When compared to placebo or no medication, and NRT, those taking cytisinicline were at higher risk of nausea and insomnia. But when varenicline was compared to cytisinicline, those taking varenicline were at greater risk of experiencing nausea. However, the absolute numbers for these differences were small and the committee

noted that side effects like nausea and headache can also be symptoms of nicotine withdrawal.

The available cost-effectiveness evidence, although limited, showed that cytisinicline, as with other stop smoking interventions, is likely to be cost-effective. The committee also acknowledged that, because of the high costs and severe consequences of smoking-related diseases, most interventions that are clinically effective in smoking cessation, are cost-effective. When recommending cytisinicline the committee acknowledged the limited evidence in various population subgroups, particularly groups affected by health inequalities. The committee discussed adding a research recommendation on this area but agreed that the 2 existing research recommendations in the guideline on

stopsmoking interventions for under-served groups and support for people with mental health conditions to stop smoking covered key gaps in the evidence.

The committee for the 2021 version of the guideline agreed that people should first be told about all the available options so they can make their own choice. If people do want more information about which options are likely to work best, it is important that people providing stop-smoking support or advice can make this clear. The committee discussed very brief advice and using opportunities to tell people who smoke about the range of interventions available, along with having longer discussions about these options and providing more detailed advice. They agreed these align well with the principles of NHS England's making every contact count.

The committee for the 2022 version of this guideline looked at the evidence for Allen Carr's Easyway to stop smoking in-person group seminars. This is an approach that uses cognitive behavioural therapy and relaxation methods without pharmacotherapy. It also includes a final ritual cigarette at the end of the seminar, regular follow-ups and optional shorter follow-up sessions.

The evidence considered by the committee compared Allen Carr's Easyway in-person group seminar with 1-to-1 support provided by an NHS stop smoking service

(which includes behavioural support and the use of medicinally licensed products) and with a remote stop smoking service (which included behavioural support and information about how to access medicinally licensed products). The committee agreed the evidence showed it was as good as other methods such as 1-to-1 support provided by local stop-smoking services, but there was not enough evidence to position Allen Carr's Easyway in-person group seminar within the hierarchy of effectiveness of interventions in recommendations 1.12.7 or 1.12.8.

The committee noted that evidence suggests Allen Carr's Easyway in-person group seminar is cost effective and represents good value for money from an NHS and public sector perspective. They agreed that making it available through the NHS and local authorities alongside other interventions would broaden people's choice, and that the more choice people have, the more likely they are to find the right intervention for them. They also agreed that some people are reluctant to use pharmacotherapy, and Allen Carr's Easyway would potentially increase the number of people attempting to stop smoking by offering an alternative to interventions that include pharmacotherapy.

The committee discussed various ways of providing the seminar, including online, but noted that the evidence they saw was only for the in-person group seminar (although in 1 study an online follow up was offered). Therefore, they were unable to generalise from this evidence to formats other than the in-person group seminar.

The committee discussed the funding of studies of the intervention. One was funded by Allen Carr's Easyway, but the committee agreed that the methods used to conduct the study minimised any risk of bias associated with this.

The committee discussed the potential effect of Allen Carr's Easyway on inequalities in health. They noted that the length of the seminar (4.5 to 6 hours) and any travel costs to attend the seminar might be difficult for some people, and that people who are housebound would not be able to attend an in-person group seminar at all. They also noted that the evidence did not include any analysis by age, ethnicity, or pregnancy and so it was not clear whether its effectiveness differed in these groups.

The committee were unaware whether the in-person group seminars were available in languages other than English, and agreed this was a potential barrier for some people. The evidence also showed that the quit rate was greater in people with higher education in the Allen Carr Easyway in-person group seminar arm. The committee discussed that commissioners would need to know and understand the needs of their local populations to be able to commission Allen Carr's Easyway in a way that would maximise access and use of the service.

The committee agreed that more research on the effects of Allen Carr's Easyway in different population groups, and on the effectiveness of other ways to deliver the programme (for example the online and book versions) would be useful (see the research recommendations on Allen Carr's Easyway).

The committee decided not to recommend some combinations of interventions even though they were as effective as individual options. This was because, based on their experience, they had concerns over adherence rates, the difficulty of obtaining prescriptions for multiple interventions at once and a lack of information on contraindications that made these combinations less feasible than other options.

In most of the evidence, the stop-smoking product (medicinally licensed products or nicotine-containing e-cigarettes) was combined with some form of behavioural support. This meant that the results of the evidence depended on behavioural support being given alongside. The committee agreed that people providing stop-smoking support should offer behavioural support alongside any nicotine-containing products the person is using, irrespective of whether they are providing the product. This is to give people a better chance of stopping smoking. They also agreed that offering behavioural support to people using nicotine-containing e-cigarettes would increase their chances of stopping smoking.

In addition, the committee recognised the need for more evidence about what factors may prevent those who smoke from using other forms of nicotine, particularly among population groups with higher smoking prevalence. (See the research

recommendation in the complete guideline on factors that may influence the use of nicotine replacement therapy and e-cigarettes.)

How the recommendations might affect practice

Conversations guided by each person's preference are good practice and should already be taking place. However, extra time may be needed for people providing stop-smoking support or advice to discuss the intervention options with people who want to stop smoking, especially for the additional advice on e-cigarettes and, potentially, for the addition of cytisinicline which has a complex treatment regimen. If these recommendations lead people to quit successfully with fewer unsuccessful attempts, this may mean fewer appointments per person.

Commissioning Allen Carr's Easyway in-person group seminar through the NHS or local authority would have resource implications for stop smoking services. But the intervention is cost effective and although the initial cost was higher than the comparator (Quit.ie or local stop smoking services group) this would be quickly offset (within 5 to 7 years) by the reduction in comorbidities and associated healthcare costs. The committee were also advised that the NHS or local authority is likely to be able to negotiate a discount for the intervention if enough people take up the offer.

The committee noted that some people living in rural areas may need help with travel costs if they need to travel long distances to attend the in-person seminar.

Return to recommendations

Context

In 2018, 14.7% of adults in the UK smoked cigarettes. Rates were higher than average for some groups, including those in routine and manual occupations, and those with mental health conditions. Although this is a decline of more than 5 percentage points since 2011, smoking is still the main cause of preventable illness and premature death in England (Office for National Statistics [2018] Adult smoking habits in the UK). In 2017/2018, an estimated 4% (489,300) of NHS hospital

admissions in England, and an estimated 16% (77,800) of all deaths, were attributed to smoking (NHS Digital 2019 Statistics on smoking, England).

Treating smoking-related illness is estimated to cost the NHS £2.6 billion a year and the wider cost to society is around £11 billion a year (NHS England Health matters: tobacco and alcohol CQUIN).

In 1 in 5 local authorities, the specialist service has been replaced by an integrated lifestyle service (Action on Smoking and Health and Cancer Research UK's Stepping up: the response of stop smoking services in England to the COVID-19 pandemic).

This guideline forms a single source for tobacco guidance that updates and replaces NICE's guidelines on:

- smoking: workplace interventions (PH5, 2007)
- smoking: preventing uptake in children and young people (PH14, 2008)
- smoking prevention in schools (PH23, 2010)
- smoking: stopping in pregnancy and after childbirth (PH26, 2010)
- smokeless tobacco: South Asian communities (PH39, 2012)
- smoking: harm reduction (PH45, 2013)
- smoking: acute, maternity and mental health services (PH48, 2013)
- stop-smoking interventions and services (NG92, 2018).

This guideline includes recommendations on harm reduction, which was previously covered by PH45. In PH45, harm reduction included cutting down before stopping smoking, cutting down longer term, temporary abstinence, or stopping smoking altogether by switching to a medicinally licensed nicotine-containing product. In the current guideline, switching completely from smoking to any nicotine-containing product is considered to be stopping smoking rather than harm reduction.

The approaches for harm reduction in this guideline should not detract from providing the highly cost-effective interventions to help people stop smoking altogether. Instead, recommendations on harm reduction are intended to support

and extend the reach and impact of existing stop-smoking support. Although existing evidence is not clear about the health benefits of smoking reduction, people who reduce the amount they smoke are more likely to stop smoking eventually.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE webpage on smoking and tobacco.

For details of the guideline committee see the committee member list.

Update information

February 2025

We have reviewed the evidence for cytisinicline as a medicinally licensed product. Changes made following this review are marked **[2025]**.

Recommendations that have been deleted, or changed without an evidence review

For recommendations shaded in grey and ending **[2010, amended 2025]**, **[2013, amended 2025]** and **[2021, amended 2025]**, we have made changes that could affect the intent without reviewing the evidence. Yellow shading is used to highlight these changes, and reasons for the changes are given in table 1.

Table 1 Amended recommendation wording (change to intent) without an evidence review

Recommendation in 2021 version of this guideline	Recommendation in current guideline	Reason for change
1.12.4 Do not offer varenicline or bupropion to people under 18.	1.12.4 Do not offer cytisinicline, varenicline or bupropion to people under 18.	Recommendation amended for consistency with new recommendations on cytisinicline.
1.20.11 Do not offer varenicline or bupropion to pregnant or breastfeeding women	1.20.11 Do not offer cytisinicline, varenicline or buproprion to pregnant or breastfeeding women, trans men or non-binary people.	Recommendation amended for consistency with new recommendations on cytisinicline. The language in this recommendation has also been updated to include trans men and non-binary people who are pregnant or breastfeeding.

Previous updates

August 2022: We have reviewed the evidence on Allen Carr's Easyway seminar to stop smoking for people who smoke.

Recommendations updated as a result of this review are marked **[2021, amended 2022]**.

November 2021: This guideline updates and replaces NICE's guidelines on:

- smoking: workplace interventions (PH5, 2007)
- smoking: preventing uptake in children and young people (PH14, 2008)
- smoking prevention in schools (PH23, 2010)
- smoking: stopping in pregnancy and after childbirth (PH26, 2010)
- smokeless tobacco: South Asian communities (PH39, 2012)
- smoking: harm reduction (PH45, 2013)
- smoking: acute, maternity and mental health services (PH48, 2013)

- stop-smoking interventions and services (NG92, 2018).

We have reviewed the evidence and made new recommendations, if relevant, on:

- digital and mass-media stop-smoking campaigns for preventing uptake
- proxy purchasing and supply of illicit tobacco
- impact of e-cigarettes on future smoking behaviour
- Smokefree Class Competitions for preventing uptake (no recommendations made)
- opt-out referral to stop-smoking support in pregnancy
- incentives for stopping smoking in pregnancy
- effectiveness, safety and acceptability of nicotine replacement therapy and e-cigarettes for stopping smoking in pregnancy
- effectiveness of treatments for stopping smoking
- barriers and facilitators to using e-cigarettes for stopping smoking
- long-term health effects of using e-cigarettes
- relapse prevention.

These recommendations are marked **[2021]**.

We have also made some changes without an evidence review (marked as **amended 2021**) to:

- avoid duplicating other NICE guidance, and remove duplication or improve alignment between recommendations from different guidelines
- remove any recommendations about providing information or tailoring support and treatment that overlap with the general principles in NICE's guideline on patient experience in adult NHS services
- remove prevention strategies that are no longer standard practice or considered appropriate, particularly fear-based messaging for children and young people
- change the emphasis of prevention campaigns to support policy rather than enforcement

- remove mention of the ASSIST (A Stop Smoking in Schools Trial) intervention, because current evidence has not been evaluated
- clarify who should be taking action
- clarify where mention of health problems relates specifically to smoking-related problems
- reflect uncertainty about the impact of long-term use of licensed nicotine-containing products
- clarify expected minor side effects from stopping smoking, so these are not mistaken for effects of licensed nicotine-containing products or other interventions
- clarify what interventions were intended to be used in recommendations that previously talked about 'pharmacotherapies'
- clarify reasons for monitoring prescribed medicines in people who are stopping or trying to stop smoking
- remove mention of people in custodial settings, because these are now all smokefree.

For more information about how the original guidelines were amalgamated and any changes that were made to the recommendations, see the summary of deleted and amended recommendations.

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