

# **Dumfries & Galloway**

# **Smoking Cessation Strategy**

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# **DUMFRIES & GALLOWAY**

## **SMOKING CESSATION STRATEGY**

### **EXECUTIVE SUMMARY**

This Smoking Cessation Strategy has been developed to build upon existing work on smoking cessation and set it within a strategic framework. Its purposes are to define and develop the role that a range of partners has to play in smoking cessation and to identify and prioritise future developments to offer improved cessation support to smokers in Dumfries & Galloway. Smoking cessation forms a major strand of a wider tobacco control programme, which also includes helping young people to avoid starting to smoke and increasing access to smoke free environments.

#### **1. Context**

Smoking is both addictive and has a social context, and the health service has a clear role in helping people to stop.

A number of national documents give guidance on the development of smoking cessation. There is therefore a need for a coordinated strategy on smoking cessation that takes account of national imperatives but is sensitive to the local situation in Dumfries & Galloway.

#### **2. Opportunities and Challenges for Smoking Cessation in Dumfries & Galloway**

Smoking is estimated to cause around 350 deaths a year in Dumfries & Galloway. Thirty percent of men and 25% of women in Dumfries & Galloway are current smokers. Smoking prevalence is highest in our poorest communities.

Much work to help people stop smoking already occurs in the region and this strategy seeks to build on that. Local targets for reducing the prevalence of smoking have been set. The targets selected for Dumfries & Galloway are:

- Adults – from an average of 27% in 2000 to 25% by 2005 and to an average of 23% by 2010.
- Women who smoke during pregnancy – from 27% in 2000 to 23% by 2005 and to 20% by 2010.

#### **3. Key Principles of Smoking Cessation**

The approach to smoking cessation needs to take account of wider determinants of health such as deprivation. There are many factors that make it difficult for smokers to stop and it is particularly important to adopt a non-victim blaming approach. The Stages of Change model offers a widely accepted explanation of how people stop smoking, and is included in this strategy.

Though a number of different organisations have roles to play in smoking cessation, the largest role is played by the NHS. Smoking cessation needs to be integrated into routine NHS care, and this requires the entire NHS to raise the priority given to smoking cessation activities.

#### **4. What Works in Smoking Cessation?**

There is a body of evidence around the effectiveness of interventions in smoking cessation. This is summarised in the Smoking Cessation Guidelines for Scotland.

#### **5. Estimated Demand for Smoking Cessation Services in Dumfries & Galloway**

There are an estimated 31,400 people aged 18 or over in Dumfries & Galloway who smoke regularly. It is likely that the number of smokers who wish support from the NHS in smoking cessation will be very substantial.

#### **6. The Framework for the Strategy**

The framework details the key building blocks of the strategy:

- People who have a role to play
- Settings
- Target population
- Interventions
- Evidence base
- Staff involvement in planning and monitoring
- Volunteer/target population involvement in planning and monitoring
- Training
- Role of the Smoking Matters Service
- Co-ordination and communication about the implementation of the strategy
- Monitoring and evaluating the smoking cessation strategy in Dumfries & Galloway and disseminating the results at both local and national levels

#### **7 - 11 Agendas for Action**

Sections 7 to 11 of the strategy cover the agendas for action, which set out recommendations for how smoking can be tackled within a range of settings including **primary care (section 7)**, **secondary care (section 8)**, **maternity services (section 9)**, **workplaces (section 10)** and **schools (section 11)**. These are covered in each Agenda for Action under the following headings:

- Setting
- Staff
- Target population
- Intervention
- Evidence base
- Implementing the strategy
- Training

#### **12. Current Model and Future Developments in Smoking Cessation Services in Dumfries & Galloway**

The Smoking Cessation Guidance for Scotland makes a number of recommendations for the provision of cessation services. Some smokers may need only brief advice with pharmacological support whereas others may benefit from more intensive support. This is reflected in the stepped care approach to cessation. The guidance recommends that all smokers should be encouraged and supported to stop, but that there should also be a focus on smokers in priority groups.

Guidance from the National Institute for Clinical Excellence gives details of the role of nicotine replacement therapy and bupropion in smoking cessation. The likelihood that a smoker will be successful in stopping depends on four factors:

- the smoker's motivation
- the extent of nicotine dependence
- the intensity and quality of support offered
- the use of pharmacological aids

A high degree of motivation is required for successful cessation.

The model of smoking cessation that exists in Dumfries & Galloway divides smokers into those seen by Smoking Matters and those seen within primary care and the community. Currently Smoking Matters provides support to smokers in five priority groups only:

- People on a low income
- Pregnant women
- Young people aged between 18 and 24
- People with coronary heart disease, cerebrovascular disease, peripheral vascular disease, diabetes or respiratory disease
- NHS staff/independent professional groups contracted to the NHS

All other smokers currently need to be managed within primary care and the community.

The current annual expenditure (2002/03) on smoking cessation in Dumfries & Galloway amounts to £109,290 for the Smoking Matters service and approximately £180,000 prescribing costs for nicotine replacement therapy and bupropion.

To meet the national guidance, there is a need to further develop and add to the current model of services in Dumfries & Galloway. It has to be recognised that all the elements of an ideal strategy cannot necessarily be implemented immediately. The Smoking Cessation Policy Group have therefore identified and prioritised a list of future developments to offer improved cessation support for smokers. These developments are in order of priority:

1. Develop the Smoking Matters Service to increase capacity and meet local needs
2. Expand the groups of smokers who can be referred to Smoking Matters
3. Raise the profile of smoking cessation across Dumfries & Galloway
4. Provide direct smoking cessation support within secondary care
5. Support workplaces to provide smoking cessation
6. Provide additional resources to primary care to further support smoking cessation
7. Increase the number of cessation attempts funded by the NHS from one attempt to two attempts per year
8. Provide funding to community pharmacists to further enhance their input to smoking cessation
9. Provide smoking cessation support for young people aged 12-18
10. Work with communities in a community development approach to encourage smoking cessation

## 1. CONTEXT

- 1.1 Smoking is an addiction, with a similar potential for dependence to that of heroin or cocaine<sup>1</sup>. Smokers know that the habit is harmful to their health and many wish to give up. However only around 1% of smokers each year manage to give up smoking on their own. The low success rate is attributed both to the addictive nature and the social context of tobacco use. The rate of successful cessation can be increased by a number of effective interventions.
- 1.2 Stopping smoking can give rapid benefits. These include better health for individuals, improved public health, and economic benefits both to the individual and for organisations including the NHS<sup>2</sup>.
- 1.3 This strategy has been developed by the Smoking Cessation Policy Group for a number of reasons. First, the profile of smoking cessation has increased considerably in recent years. A number of national documents have set the context. These include: *Smoking Kills*<sup>3</sup>, *Towards a Healthier Scotland*<sup>4</sup>, *Smoking Cessation Guidelines for Scotland*<sup>5</sup>, *NHS Smoking Cessation Services*<sup>6</sup> and *Helping smokers to stop and stay stopped: a guide for health professionals*<sup>7</sup>. Second, nicotine replacement therapy (NRT) and bupropion (zyban) are both available on NHS prescription as aids to smoking cessation. Third, though there is much opportunistic advice and support for smoking cessation in Dumfries & Galloway, it is important to ensure that there is a coordinated approach to smoking cessation to reduce differences in services across the region. Fourth, demand for smoking cessation has risen but the specialist smoking cessation service, Smoking Matters, has been working within a limited resource.
- 1.4 There is therefore a need for a coordinated policy on smoking cessation that takes account of national imperatives but is sensitive to the local situation in Dumfries & Galloway. The strategy attempts to address this. It is recognised that there are a number of unknown quantities in developing such a strategy at a time of considerable change in the profile of smoking cessation. It is likely that there will need to be refinements to the strategy in the years ahead and the Smoking Cessation Policy Group will continue to keep the situation under review.

It has to be recognised that all the elements of an ideal strategy cannot necessarily be implemented immediately. The strategy therefore includes a list of prioritised future actions in addition to those currently in place.

- 1.5 Smoking cessation forms a major strand of a wider tobacco control programme. Other tobacco control issues include helping young people to avoid starting to smoke and increasing access to smoke free environments. Again, there is much existing work in these areas within Dumfries & Galloway. A strategic context to support wider tobacco control work will be developed, which will have close links to this Smoking Cessation Strategy.

## **2. OPPORTUNITIES AND CHALLENGES FOR SMOKING CESSATION IN DUMFRIES & GALLOWAY**

### **2.1 The National Perspective**

- 2.1.1 Smoking is the single largest cause of preventable ill health and premature death in Scotland. It causes more than 13,000 deaths each year<sup>4</sup>. The 1998 Scottish Health Survey found that 34% of men and 32% of women were current cigarette smokers, with a further 4% of men smoking only pipes or cigars<sup>8</sup>.
- 2.1.2 There has been a significant fall in adult tobacco smoking since the 1970s but the General Household Survey showed that smoking rates in the UK rose between 1994 and 1996 for the first time in recent years from 27% to 28%, though this later fell back to 27%<sup>9</sup>.
- 2.1.3 While there has been a reduction in adult smoking over the last ten years, in contrast there has been an increase in smoking rates among young people. The proportion of 15 year old young women who are daily smokers doubled from 12% in 1990 to 24% in 1998<sup>10</sup>. Daily smoking rates in 15 year old young men rose from 12% to 19% in the same time period.
- 2.1.4 There is a clear relationship between deprivation and smoking. While overall smoking rates have fallen over recent decades, for the least advantaged they have barely fallen at all. The disadvantage, inequality and hardship experienced by people on low incomes mean that they are much more likely to smoke than those who are better off. An increase in income inequalities, particularly amongst families, combined with a rapid growth in lone parenthood has created a closer association between tobacco use and poverty. In 1996, 12% of men in professional jobs smoked compared with 40% of men in unskilled manual jobs<sup>3</sup>.

### **2.2 What about Dumfries & Galloway?**

- 2.2.1 As in Scotland, smoking is the largest cause of preventable ill health in Dumfries & Galloway. It is estimated to cause one in every five deaths, which represents around 350 deaths a year locally caused by smoking. Coronary heart disease, respiratory disease and a variety of types of cancer are the main causes of death related to smoking. In addition, passive exposure to cigarette smoke increases the risk of developing lung cancer, asthma and heart disease in those who have chosen not to smoke themselves.
- 2.2.2 Smoking rates in Dumfries & Galloway are lower than those in Scotland overall. The Dumfries & Galloway Health and Lifestyle Survey 2000 found that 30% of men and 25% of women were current smokers<sup>11</sup>. Smoking rates are higher in younger age groups: in the 18-24 year age group 43% of men and 36% of women smoked. Rates are also higher in those with less education: 33% of those with standard grade educational qualifications smoked compared with 19% of people with a diploma, degree or professional qualification. In 2000, 27% of pregnant women smoked during pregnancy.
- 2.2.3 Much work, both opportunistic and planned, to help people stop smoking in Dumfries & Galloway already occurs in day-to-day practice by general practitioners, practice nurses, midwives, pharmacists, dentists, health visitors, health professionals in secondary care and by others within the community. In addition to this, the specialist smoking cessation service, Smoking Matters, has an extremely important role. The service offers one-to-one and group support for certain smokers as well as the training of staff and volunteers on brief interventions and motivational interviewing. This service is pivotal to the implementation of the strategy.

## **2.3 Strategic Context**

2.3.1 The recent national strategies *Smoking Kills*<sup>3</sup> and *Towards a Healthier Scotland*<sup>4</sup> set out a range of tobacco control measures including:

- taxation
- tackling cigarette smuggling
- enforcing the law against selling tobacco to children
- advertising restrictions
- public information
- health promotion
- cessation support

2.3.2 National targets set out in *Towards a Healthier Scotland* for the reduction in smoking include:

- Adults – from the 1995 level of 35% to 33% by 2005 and to an average of 31% by 2010.
- Young people (12-15 year olds) – from the 1995 level of 14% to 12% by 2005 and to 11% by 2010.
- Women who smoke during pregnancy – from the 1995 level of 29% to 23% by 2005 and to 20% by 2010.

The national targets are likely to be difficult to achieve in Scotland, since smoking rates have substantially increased among young people in the 1990s, as noted previously.

## **2.4 Local Targets**

2.4.1 The overall smoking rate in Dumfries & Galloway is currently 27%<sup>11</sup>, which is already below the target rate for adults in Scotland of 31% by 2010. It would therefore be inappropriate to adopt the national target for adults in Dumfries & Galloway. In 2000, 27% of pregnant women in Dumfries & Galloway smoked during pregnancy. This is below the 1995 Scottish level, but above the national target for 2005. There are no overall data currently available in Dumfries & Galloway on smoking rates in young people aged under 18.

2.4.2 There are potential difficulties in aiming to reduce further a smoking rate in adults that is already below the national average. However, a local target for the rate of smoking in adults should be sufficiently challenging to motivate work around smoking cessation. The national target for pregnant women is applicable to Dumfries & Galloway without modification. A target for young people will be not be set until further work has identified smoking rates in this age group. The targets selected for Dumfries & Galloway are:

- Adults – from an average of 27% in 2000 to 25% by 2005 and to an average of 23% by 2010.
- Women who smoke during pregnancy – from 27% in 2000 to 23% by 2005 and to 20% by 2010.

### 3. KEY PRINCIPLES OF SMOKING CESSATION

- 3.1 Any action to help people stop smoking should adopt a “non-victim blaming” approach<sup>12</sup>. The highest prevalence of smoking is amongst our poorest communities. This strategy needs to be set within the context of taking action on the wider determinants of health, such as addressing issues related to poverty, improving housing, creating greater employment opportunities and developing active, supportive communities. Locally this work is being taken forward through the Community Planning process, and this strategy forms a building block of the Community Plan.
- 3.2 Smokers often find it difficult to stop due to a range of complex reasons. Some of these, such as the influence of people smoking on television or films or in other forms of media, cannot be effectively modified at a local level. The smoking habits of members of the family or social circle and the effect of peer pressure may have considerable influence.
- 3.3 To maximise success, measures to promote smoking cessation need to be complemented by more general tobacco control measures. These include smoke-free policies in workplaces, public and social settings such as pubs and restaurants, consistent public information about the harms of smoking and the benefits of giving up and national action to stop the advertising and promotion of tobacco.
- 3.4 The process for a smoker of stopping smoking is described by the Stages of Change model<sup>13</sup>. Descriptions of the five stages of change are shown in the Table:

Stage of Change	Individual Characteristics
Pre-contemplation	The individual is still a smoker and is not convinced that the negative aspects of smoking outweigh the positive.
Contemplation	The individual is still smoking, but considering the benefits of stopping.
Preparation	The individual is still smoking but prepared to stop in the near future.
Action	The individual is in the process of stopping smoking or has stopped very recently.
Maintenance	The individual is an ex-smoker.

The model indicates that stopping smoking is a gradual process rather than a single event that happens spontaneously. There is therefore a very important role in helping smokers to move from pre-contemplation to contemplation and preparation. This role applies to all who are concerned with supporting smoking cessation, and goes much wider than, though it certainly includes, health professionals.

- 3.5 Though a number of different organisations have roles to play in smoking cessation, the largest role is played by the NHS. Smoking cessation needs to be integrated into routine NHS care, and this requires the entire NHS to raise the priority given to smoking cessation activities<sup>5</sup>.
- 3.6 Tobacco dependence is a potentially fatal health condition. It is therefore a particular responsibility of health professionals to recognise and treat tobacco dependence, just as it is, for example, to detect and treat hypertension<sup>14</sup>.

#### 4. WHAT WORKS IN SMOKING CESSATION?

- 4.1 Wherever possible, interventions and services should be based on evidence of effectiveness from research. The evidence base for reducing the harm due to tobacco is substantial. The Cochrane Tobacco Addiction Review Group in the UK and the Agency for Health Care Policy and Research in the US have conducted systematic reviews on tackling smoking.
- 4.2 The research led to the development of evidence-based smoking cessation guidelines for health professionals from the Health Education Authority<sup>15</sup>, which were updated in 2000<sup>16</sup>, and, more recently, smoking cessation guidelines for Scotland prepared by Action on Smoking and Health Scotland and the Health Education Board for Scotland<sup>5</sup>. This strategy draws heavily on the evidence set out in these documents.
- 4.3 The Table shows the smoking cessation interventions where there is clear evidence of effectiveness<sup>5</sup>. It shows the improvement in cessation rate over that in controls who did not receive the intervention. Broadly speaking, the effects of individual interventions may be added together. For example, treatment that combines intensive support with NRT can increase long-term abstinence rates by around 16% (8% intensive support + 8% NRT) compared with those who receive neither intervention. As yet, there are not enough studies on bupropion in smoking cessation to be sure of its effectiveness, but the available results suggest that its success rate is probably similar to that for NRT.

Intervention	Increase in % of smokers abstinent for 6 months or more
Very brief advice to stop (3 min) by clinician versus no advice	2%
Brief advice to stop (up to 10 min) by clinician versus no advice	3%
Adding NRT to brief advice versus brief advice alone or brief advice + placebo	6%
Intensive support (e.g. smokers' clinic) versus no intervention	8%
Adding NRT to intensive support versus intensive support or intensive support + placebo	8%
Cessation advice and support for smoking hospital patients versus usual care	5%
Cessation advice and support for pregnant smokers versus usual care or no intervention	7%

- 4.4 Experience in the Smoking Matters service and elsewhere suggests that even higher rates of cessation may be achieved in people who are sufficiently motivated.
- 4.5 A number of alternative therapies are popularly reported to aid smoking cessation. The Smoking Cessation Guidelines for Scotland point out that for hypnosis there is insufficient evidence of effectiveness and for acupuncture there is evidence of placebo effect only<sup>5</sup>. The NHS and other public organisations have an obligation to use public money effectively and that means basing services on clear evidence of effectiveness. It would therefore be inappropriate to include these therapies in this strategy.

4.6 The Smoking Cessation Guidelines for Scotland<sup>5</sup> should be referred to alongside this strategy. They give clear advice on how the NHS and others can help people to stop smoking and are based on published research and expert clinical experience. The guidelines make recommendations for evidence-based interventions from a range of professionals in a variety of settings. This strategy draws on those recommendations and adds to them to suit local circumstances.

## 5. ESTIMATED DEMAND FOR SMOKING CESSATION SERVICES IN DUMFRIES & GALLOWAY

- 5.1 There are an estimated 31,400 people aged 18 or over in Dumfries & Galloway who smoke regularly.
- 5.2 When smokers were asked whether they would like to stop smoking, 73% said that they would<sup>11</sup>. However the level of motivation of many of these smokers is likely to be insufficient for a successful attempt at stopping. The proportion of smokers who are adequately motivated to stop smoking and who wish to access NHS services to help them do so is not known. The experience of local general practitioners suggests that between 10% and 33% of smokers may be sufficiently motivated and wish support from the NHS in smoking cessation each year.
- 5.3 The table below shows approximate numbers of smokers who might wish to access NHS cessation support each year for a range of proportions who are adequately motivated. It is clear that the number of smokers who wish support from the NHS in smoking cessation is likely to be very substantial. No single organisation can support so many smokers who wish to stop. This therefore indicates the necessity for the entire NHS, as well as other agencies, to raise the priority of smoking cessation activities.

% of smokers who are motivated and wish to access NHS cessation support each year	Number of motivated smokers wishing NHS cessation support
10%	3,140
15%	4,710
25%	7,850
33%	10,360

- 5.4 Using 2001 General Register Office population estimates, there were 116,327 people aged 18 and over in Dumfries & Galloway. Currently, an estimated 31,400 people aged 18 and over smoke. The local target of 2% reduction in adult smoking prevalence by 2005 and a further 2% reduction by 2010 requires that 2,300 fewer adults smoke by 2005 with an additional 2,300 fewer smokers by 2010.
- 5.5 Reducing the prevalence of smoking may be tackled in two main ways: by reducing the number of young people who start smoking or by increasing the number of people who stop smoking. There is strong evidence about the effectiveness of interventions to help people stop smoking (**Section 4.3**). The national increase in smoking prevalence among 15 year olds (**Section 2.1.3**) indicates the magnitude of the challenge in finding effective ways of stopping young people from starting to smoke.

## **6. THE FRAMEWORK FOR THE STRATEGY**

### **6.1 Aim**

The aim of this strategy is to build on what is already happening locally and set it within a strategic framework. This is so that all who have a key role to play in helping people stop smoking know what it is they have to do and possess the skills to do it effectively.

### **6.2 Objectives**

- To promote a multi-disciplinary and multi-agency approach to smoking cessation within Dumfries & Galloway.
- To provide a framework to define the elements of the strategy.
- To provide coordinated guidance for smoking cessation in Dumfries & Galloway while keeping local flexibility where there are clear benefits.
- To have a particular focus on the groups identified in the Smoking Cessation Guidelines for Scotland and NHS Smoking Cessation Services as having a defined need for support in stopping smoking, including those who live in deprived circumstances, pregnant women and young people.
- To define clearly the role provided by the specialist cessation service Smoking Matters.
- To provide appropriate training to those with a role in smoking cessation to enable them to support smokers in stopping.
- To prioritise future developments in smoking cessation in Dumfries & Galloway.

### **6.3 Framework**

The following framework sets out the key building blocks of the strategy:

6.4 People who have a role to play

6.5 Settings

6.6 Target population

6.7 Interventions

6.8 Evidence base for the intervention

6.9 Staff involvement in planning and monitoring

6.10 Volunteer/target population involvement in planning and monitoring

6.11 Training

6.12 Role of Smoking Matters Service

6.13 Co-ordination and communication about the implementation of the strategy

6.14 Monitoring and evaluating the smoking cessation strategy in Dumfries & Galloway and disseminating the results at both local and national levels

### **6.4 People Who Have a Role to Play**

- 6.4.1 A number of groups and individuals play a key role in supporting others to stop smoking. The most obvious are the range of health professionals who come into contact with a large number of our local population on a day to day basis but this role is not exclusive to them. Those who play a key role and form an important part of this strategy are:

- All health professionals
- Smoking cessation specialists
- Pharmacists and pharmacy assistants
- Staff in workplaces and businesses
- Teachers and other professionals within the school setting

6.4.2 Other groups also have a role to play in raising awareness of healthy lifestyles including the importance of stopping smoking:

- Community workers
- Social care staff
- Sport and leisure staff
- Volunteers in a range of settings
- Young people as peer educators

## **6.5 Settings**

There are a range of settings where smokers can be supported to stop, including:

- Primary care
- Hospitals
- Maternity services
- Workplaces
- Schools
- Leisure and recreation settings
- In the community

## **6.6 Target Population**

6.6.1 All smokers should have access to support within the overarching principle of motivation. The Smoking Cessation Guidelines for Scotland set out priority groups for smoking cessation support and this strategy will adopt them. The priority groups include those living in deprived circumstances, pregnant women and young people. This strategy includes two additional priority groups: smokers with certain diseases and NHS staff/independent professional groups who are contracted to the NHS. The defined diseases include vascular disease (coronary heart, cerebrovascular or peripheral vascular disease), respiratory disease or diabetes as there is evidence that smokers may be more receptive to advice to stop when it is linked with an existing medical condition<sup>16</sup>. NHS staff and independent professional staff contracted to the NHS are included because they have a key exemplar role.

6.6.2 The priority groups therefore include:

- Smokers on a low income – *defined for the purposes of this strategy as people entitled to free prescriptions*
- Pregnant women who smoke
- Young people – *aged between 18 – 24*
- People with one or more of the following illnesses, vascular disease (coronary heart, cerebrovascular or peripheral vascular disease), diabetes or respiratory disease
- NHS staff/independent professional groups contracted to the NHS

## **6.7 Interventions**

- 6.7.1 The Stages of Change model (**Section 3.4**) indicates that much can be done to help smokers move to a position where they are ready to stop. Interventions that can help include asking about smoking behaviour, reminding about the risks of continuing to smoke and pointing out the health, social and financial rewards of stopping. Health professionals should advise in a clear, consistent and unequivocal way that patients stop smoking.
- 6.7.2 Provision of supportive materials can be helpful, such as the *Aspire to Stop Smoking Guide*<sup>17</sup>. Other possible sources of information are a number of websites including Action on Smoking and Health ([www.ash.org.uk](http://www.ash.org.uk)), the Health Education Board for Scotland ([www.hebs.scot.nhs.uk/topics/smoking/index.htm](http://www.hebs.scot.nhs.uk/topics/smoking/index.htm)), or UK NHS Smoking cessation webpage ([www.givingupsmoking.co.uk](http://www.givingupsmoking.co.uk)). HEBS also provide a Smokeline telephone number (0800 848484) and an email facility for questions about stopping smoking (e-smokeline@essentiagroup.com).
- 6.7.3 Encouraging a supportive environment, e.g. enlisting help from partner, family, friends or work colleagues.
- 6.7.4 When the smoker is at the stage of taking action to stop smoking, a number of interventions are effective (**Section 4.3**). These include provision of brief intervention advice, more intensive or regular support, advice and support for pregnant women or hospital patients who smoke, and arranging for access to NRT or bupropion, if appropriate. NRT and bupropion in smoking cessation have been the subject of a report by the National Institute for Clinical Excellence in England<sup>18</sup>, which has been adopted by the Health Technology Board for Scotland as equally valid for Scotland.
- 6.7.5 When a smoker has succeeded in stopping smoking, maintenance to prevent relapse is often important. Interventions to help maintain smoking cessation include focussing on the benefits of having stopped, identifying threats to staying stopped and dealing with specific problems such as withdrawal symptoms or weight gain.

## **6.8 Evidence Base**

The evidence base for interventions on smoking cessation is covered in **Section 4** of the strategy and, in more detail, in the *Smoking Cessation Guidelines for Scotland*<sup>5</sup>. The evidence around intervening in key settings is noted in the *Agendas for Action* (**Sections 7-11**).

## **6.9 Staff Involvement in Planning and Monitoring**

The policy agenda within the NHS sets out the clear need and rationale for staff involvement in planning and service delivery. The development and implementation of this strategy is no different. While there are common targets and elements, each organisation will have its own circumstances and each staff grouping may have different roles. These differences need to be recognised. Staff representatives make up part of the Smoking Cessation Policy Group. More widely, staff are involved in implementing and delivering services in their organisations. By communicating with or participating in the Policy Group, they are also involved in monitoring the strategy to ensure that we learn from their experiences of services.

## **6.10 Volunteer/Target Population Involvement in Planning and Monitoring**

The NHS works to a policy directive that determines public and patient involvement in the planning of services and interventions. In smoking cessation, this is best achieved through

volunteers and members of community and voluntary organisations. Through participation in the Smoking Cessation Policy Group, they are also involved in monitoring the smoking cessation strategy to ensure that what we learn from their experiences of services informs future development.

### **6.11 Training**

- 6.11.1 Health professionals who have received training are significantly more likely to intervene with smokers than those who have not received specific training<sup>5</sup>. There is also some evidence that smokers are more likely to stop if seen by health professionals trained in smoking cessation<sup>5</sup>. Therefore, there is a clear need for training health professionals both to give effective smoking cessation interventions and to increase their inclination to intervene.
- 6.11.2 Based on the recommendations, training will be made available for primary care teams, pharmacists, pharmacy assistants, dentists, dental nurses and hygienists. It will also include secondary care staff and maternity services. This can contribute to continuing professional development for these groups of professionals.
- 6.11.3 The priority for this strand of the strategy is to ensure that all health professionals have access to effective and appropriate training and receive training support and follow-up from the Smoking Matters Service. Training is also important for other professionals and volunteer groupings, teachers, youth workers, social care workers and volunteer lay health workers in the Building Healthy Communities programme areas. This will be established in tandem with health care professional training where possible.

### **6.12 The Role of the Smoking Matters Service**

- 6.12.1 The Smoking Matters Service currently has three main responsibilities: to offer direct smoking cessation support to people in the priority groups, to support the development of the infrastructure detailed in this strategy through training and networking and to raise the profile of smoking cessation across the region.
- 6.12.2 Smoking Matters is a finite resource that has to be utilised in the most efficient way. It plays a key role within this strategy to deliver training in smoking cessation to the range of people described above. This acknowledges the fact that in order to achieve the development of a comprehensive infrastructure there is a need for flexibility, both from the Smoking Matters Service and from health professionals. However, the Service will work to create opportunities to bring together staff from other agencies and volunteers with NHS professionals within local areas. The Agendas for Action (**Sections 7-11**) set out the broad framework for the training. Smoking Matters will also support workplaces by providing training to organisations that require it as part of the implementation of a workplace smoking policy or who are registered for the Scotland's Health at Work Award Scheme (SHAW).
- 6.12.3 Smoking Matters also has an ongoing role in direct smoking cessation support. This will be offered through a secondary referral mechanism.
- 6.12.4 Smoking Matters aims to develop partnership work with community health projects in disadvantaged areas such as the Building Healthy Communities in Dumfries & Galloway Programme (BHC) to actively involve smokers and support the most disadvantaged to give up. There is an opportunity to train volunteers within the BHC to deliver smoking cessation support.

### **6.13 Co-ordination and Communication**

- 6.13.1 Coordination and communication in developing the strategy and keeping it updated is the role of the Smoking Cessation Policy Group. The group will communicate with and take account of feedback from groups and individuals with a role in smoking cessation in so doing.
- 6.13.2 There is also a need for coordination and communication within and between settings where it will be implemented. Organisations that are responsible for or have a clear role in the settings listed in **section 6.5** are asked to plan how the strategy may be best implemented within the organisation and identify implications for the way in which services are delivered. This may require taking account of existing policies on smoking so that they are consistent with the smoking cessation strategy.

### **6.14 Monitoring and Evaluation**

- 6.14.1 The Smoking Cessation Policy Group will monitor the overall impact of the strategy. This will cover issues such as:
- *The effectiveness of communication*
  - *How and when staff were involved in planning and review*
  - *How and when volunteers/target population were involved in planning and review*
  - *The effectiveness of training*
  - *Levels of demand for NHS smoking cessation support*
  - *Funding issues, including the need for future development*
  - *Is the strategy being followed?*
  - *Rates of smoking cessation*
- 6.14.2 The Smoking Matters Service has a key role to play in monitoring and evaluation of activity. The Scottish Executive have provided the framework for this<sup>6</sup>, which includes:
- *Number of smokers using the service per thousand population*
  - *Percentage of smokers successfully completing a course of treatment*
  - *Percentage who have received NRT and for how long*
  - *Initial one month cessation rate and later 3 and 12 month cessation rates*
  - *Users feedback on the quality of service*
- 6.14.3 Some monitoring of the effectiveness of smoking cessation activity in other settings as well as Smoking Matters would be most helpful. This is not generally feasible at present, however individuals and organisations concerned with smoking cessation are encouraged to try to identify the difference they are making.

## **7. AGENDA FOR ACTION – PRIMARY CARE**

### **7.1 Setting**

All primary care settings.

### **7.2 Staff**

Staff who play a key role in smoking cessation include general practitioners, practice nurses, nurse practitioners, community pharmacists, health visitors, district nurses, midwives, dentists.

### **7.3 Target Population**

All smokers in the practice population, with a focus on those in the priority groups:

- Smokers on a low income - *entitled to free prescriptions*
- Pregnant women who smoke
- Young people - *aged between 18 – 24*
- People with one or more of the following illnesses, vascular disease (coronary heart, cerebrovascular or peripheral vascular disease), diabetes or respiratory disease
- NHS staff/independent professional groups contracted to the NHS

### **7.4 Intervention**

Primary care is a setting where smoking cessation advice and support should be routine and focussed. Brief advice, assessment and follow-up, should be provided for the smoker whenever appropriate, including pharmacological support if indicated. Recommendations based on those set out in *Helping Smokers to Stop and Stay Stopped: a guide for health professionals* are:

*Ask* - about smoking behaviour routinely and record using relevant READ codes

*Advise* - when appropriate, advise smokers to stop

*Assess* - willingness to stop

*Assist* - if adequately motivated, assist in developing a plan to stop

- if not adequately motivated, encourage motivation to stop.

*Arrange* - for the patient to receive follow up if in process of stopping smoking

### **7.5 Evidence Base**

About 90% of all patient contact with the NHS takes place in primary care<sup>19</sup> with approximately 80% of the population consulting their general practitioner at least once a year<sup>20</sup>. Consultation rates are higher for smokers<sup>21</sup>. Sixty-eight percent of the population visit a pharmacist at least monthly<sup>22</sup>. Dentists also see a large number of patients, many of whom have smoking related conditions<sup>3</sup>. This gives a clear rationale for smoking cessation work in the primary care setting.

### **7.6 Implementing the Strategy in Primary Care**

Primary care services already provide a huge amount of advice and support to patients attempting to stop smoking, in addition to prescribing pharmacological aids. The evidence shows that this input is extremely valuable in helping smokers to stop. It is desirable to give

further support to smoking cessation in primary care, and this is identified in the list of priorities for future development (**Section 12.4**).

The circumstances of each primary care team are unique. Each team will have its own mix and experience of staff. Some teams work in close proximity to other services while others practise in relatively isolated locations. Practice populations can differ considerably in age structure, prevalence of smoking and levels of social deprivation. There is also variation between LHCC areas. These differences need to be recognised.

It is recommended therefore that each LHCC develops a plan for how smoking cessation will be tackled within its area, taking account of the principles in this strategy as well as local priorities and constraints. It is also recommended that each practice plans for how smoking will be tackled in the practice population, taking account of the principles in this strategy as well as priorities, constraints and the unique practice situation. This will mean identifying implications for the way in which services are delivered. It may be necessary to take account of existing policies on smoking so that they are consistent with the smoking cessation strategy.

Community pharmacists have an important role in helping smokers to stop. This role includes supporting people prescribed pharmacological support by their general practitioner, those referred by the Smoking Matters service and also members of the public who choose to buy NRT over the counter. In some areas of Scotland, services have developed in which community pharmacists are funded to offer advice and support as well as dispensing pharmacological aids. It may be appropriate to develop similar services in Dumfries & Galloway, though there needs to be coordination to ensure consistency and avoid unnecessary duplication of services.

There is a need also to develop lines of communication between different settings implementing the strategy, for example between secondary care, maternity services, community pharmacies and primary care.

## **7.7 Training**

Representatives from the Smoking Matters Service will provide a programme of brief intervention training, which will be offered to primary care staff who have a role to play in smoking cessation. This training will also be extended to community and voluntary organisations that can equally benefit from working with a similar approach.

## 8. AGENDA FOR ACTION – SECONDARY CARE

### **8.1 Setting**

Inpatient, day patient and outpatient settings.

### **8.2 Staff**

Staff who play a key role in smoking cessation include medical staff, nursing staff and those in allied health professions.

### **8.3 Target Population**

All inpatients, day patients and outpatients who smoke with a focus on those in the priority groups:

- Smokers on a low income - *entitled to free prescriptions*
- Pregnant women who smoke
- Young people – *aged between 18-24*
- People with one or more of the following illnesses, vascular disease (coronary heart, cerebrovascular or peripheral vascular disease), diabetes or respiratory disease
- NHS staff/independent professional groups contracted to the NHS

### **8.4 Intervention**

A hospital stay or encounter needs to be seen as an opportunity to help smokers stop. All hospital premises should have up to date smoking policies and supportive environments for patients to stop smoking. The same basic approach is recommended for hospital staff as for other health professionals (as set out in *Helping Smokers to Stop and Stay Stopped: a guide for health professionals*):

*Ask* - *record the smoking status of patients on admission*

*Advise* - *when appropriate, advise smokers to stop*

*Assess* - *willingness to stop*

*Assist* - *if adequately motivated, assist in developing a plan to stop*

- *if not adequately motivated, encourage motivation to stop*

*Arrange* - *follow up to primary care or Smoking Matters if in process of stopping smoking on discharge*

When hospital admission is planned for elective surgery, pre-surgery assessment clinics should be used to assess the smoking status and where appropriate give advice on stopping before coming into hospital.

When a patient is discharged from hospital, information about cessation attempts and advice given should be included in the discharge letter so that the primary care team can follow up smoking cessation.

### **8.5 Evidence Base**

There is consistent evidence that many health care professions can deliver effective smoking cessation interventions. Smoking cessation advice and support for hospital inpatients who smoke helps about 5% more smokers to stop compared with usual care<sup>5</sup>. There is also an increase in success when a variety of health professionals co-operate in giving advice<sup>23</sup>.

This evidence supports the concept of patients being given continuous care from hospital to community in what should be a standardised approach to smoking cessation.

Many patients in hospital settings will have coronary heart disease, cerebrovascular disease, peripheral vascular disease, diabetes or respiratory disease and will therefore fall into one of the priority groups. If they smoke, the hospital visit may be a good opportunity for them to assess the benefits of stopping smoking, particularly if it is linked with an existing clinical condition<sup>16</sup>.

## **8.6 Implementing the Strategy in Secondary Care**

The circumstances of each hospital are different. It is recommended that each hospital develops a plan for how smoking cessation will be tackled within the hospital, covering inpatients, day patients and outpatients as appropriate. This will mean identifying implications for the way in which services are delivered. It may be necessary to take account of existing policies on smoking so that they are consistent with the smoking cessation strategy.

It is important to consider whether smoking should be permitted at all within each hospital environment. This issue relates more to wider tobacco control but can also help to support smoking cessation in patients and staff.

Each hospital should develop communication lines on how the strategy is to be implemented within its settings. There should also be clear lines of communication between different settings implementing the strategy, for example between primary and secondary care.

## **8.7 Training**

Representatives from the Smoking Matters Service will provide a programme of brief intervention training, which will be offered to secondary care staff who have a role to play in smoking cessation.

## 9. AGENDA FOR ACTION – MATERNITY SERVICES

### **9.1 Setting**

Community, primary care, outpatient and inpatient settings for antenatal and postnatal women.

### **9.2 Staff**

All midwives, primary care staff, and hospital clinical staff who come into contact with pregnant women who smoke.

### **9.3 Target Population**

Women who smoke both ante-natally and post-natally.

### **9.4 Intervention**

Pregnancy is a time when women are in regular contact with a number of health professionals and all those who share the care should play a part in raising the matter of smoking and offering advice and support. It is important that the message is consistent.

While most women are motivated to protect the health of their unborn child, the benefits to their own health from stopping smoking should also be highlighted. Continued cessation support after delivery is important as it helps to prevent relapse after delivery and to protect children in the home from environmental tobacco smoke, which has been associated with an increased risk of Sudden Infant Death Syndrome, respiratory disease and chronic middle ear disease.

The same basic approach is recommended for maternity service staff as for other health professionals (as set out in *Helping Smokers to Stop and Stay Stopped: a guide for health professionals*):

*Ask* - record the smoking status of pregnant women

*Advise* -those who smoke to stop

*Assess* - willingness to stop

*Assist* - if adequately motivated, assist in developing a plan to stop  
- if not adequately motivated, encourage motivation to stop

*Arrange* - follow up to *Smoking Matters* if required during pregnancy

Midwives should ensure that information about the smoking status and cessation attempts of women in their care is routinely passed on to health visitors.

The benefits of NRT seem to outweigh the risks for pregnant smokers, though NRT products are not currently licensed for use in pregnancy. However, it is suggested that NRT is offered to pregnant smokers only if they cannot stop smoking without it<sup>5</sup>. The NRT sublingual tablet and lozenge are options for pregnant smokers who are unable to stop without nicotine substitutes<sup>5</sup>.

### **9.5 Evidence Base**

Smoking cessation interventions during pregnancy are effective and should be used routinely. Although most pregnant women who smoke are aware of the health risks to their unborn baby, only 10-25% attempt to stop during their pregnancy and most of those who do

stop relapse after delivery<sup>5</sup>. Smoking cessation advice and support for pregnant women who smoke helps about 7% more smokers to stop compared with usual care<sup>5</sup>. During pregnancy women have regular contact with health care professionals and this contact can be used consistently in smoking cessation.

## **9.6 Implementing the Strategy in Maternity Services**

It is recommended that maternity services develop a plan for how smoking cessation will be addressed within each maternity setting. This will mean identifying implications for the way in which services are delivered. As many different professionals are involved in care for pregnant women who smoke, this needs to clarify the roles in smoking cessation of different groups and ensure that a consistent message is given. It may be necessary to take account of existing policies on smoking so that they are consistent with the smoking cessation strategy.

Maternity services need to develop communication lines on how the strategy is to be implemented within its settings. There should also be clear lines of communication between different settings implementing the strategy, for example between primary care or secondary care and maternity services.

## **9.7 Training**

Representatives from the Smoking Matters Service will provide a programme of brief intervention training, which will be offered to staff in maternity services who have a role to play in smoking cessation.

## **10. AGENDA FOR ACTION – WORKPLACES**

### **10.1 Settings**

Workplaces.

### **10.2 People with a Role to Play**

Occupational Health Departments, staff and management in workplaces in Dumfries & Galloway.

### **10.3 Target Population**

Staff within workplaces in Dumfries & Galloway who smoke.

### **10.4 Interventions**

There are a range of workplaces in Dumfries & Galloway that have policies on smoking in place and it is hoped to increase this through the workplace health programme, which is included in the Safe and Healthy Communities Theme of the Community Plan. Alongside the implementation of smoking policies, smoking cessation support should be provided.

It is important to provide a supportive environment to enable smoking cessation support to be offered and accepted. NHS Dumfries & Galloway is in the process of developing a comprehensive multi-agency workplace health programme which will include SHAW as a key component. This strategy will form a plank of the work focus for this programme.

Smoking Matters will provide direct support to staff in the NHS or independent professional groups contracted to the NHS who wish to give up smoking. The NHS and associated professional groups must act as exemplar organisations in relation to smoking policy and smoking cessation support.

### **10.5 Evidence Base**

There is good evidence to support the role of smoking policy development in aiding smoking cessation and in preventing environmental exposure to tobacco smoke.

### **10.6 Implementing the Strategy in Workplaces**

The circumstances of each workplace are different. It is recommended that each workplace develops its own particular and culturally appropriate plan to tackle smoking cessation in its workforce.

Good practice in health policy development has established that all parties who may be affected by policy should have the opportunity to contribute to its development. They should also be involved in a process of implementation.

Each workplace should develop clear communication lines on how their policies are being implemented and develop opportunities for ongoing feedback. There is an opportunity for workplaces to network with each other and share good practice and resources.

### **10.7 Training**

Representatives from the Smoking Matters Service will provide a programme of brief intervention training, which will be offered to occupational health staff. This training will also be extended to community and voluntary organisations that can equally benefit from working in a similar approach to the Smoking Matters Service.

## **11. AGENDA FOR ACTION – SCHOOLS**

### **11.1 Settings**

Secondary schools.

### **11.2 People with a Role to Play**

Teachers, school nurses and other professionals within the school setting. Also young people as peer helpers.

### **11.3 Target Population**

Students and staff within secondary schools in Dumfries & Galloway who smoke.

### **11.4 Interventions**

Secondary schools already have policies on smoking in place. In view of the increase in smoking in young people (see **section 3.1.3**), and considerable evidence that young people want help in stopping<sup>5</sup>, it is important also to be able to offer support in smoking cessation.

It is particularly important to provide a supportive environment for young people to enable smoking cessation support to be offered and accepted. Young people seem more likely to seek support from friends and family than from authority figures such as teachers and nurses. Other young people as peer helpers may have a particular role.

The teenage years are the time when most young smokers start smoking. However experience in primary care suggests that a number begin smoking at an earlier age of less than 12 years. Though there is some expressed desire for smoking cessation support in the under 12 age group, there is currently no evidence of effectiveness for any interventions at this age. The main need for this age group is for education about the harm and addictive nature of smoking rather than cessation support.

Many young smokers may be experimenting with tobacco rather than nicotine dependent. This means that their main need is for advice and support rather than pharmacological aids to smoking cessation. At present, NRT is not recommended for use by young smokers<sup>5</sup>.

### **11.5 Evidence Base**

There is currently a paucity of evidence to support the role of policy development as a vehicle to encourage smoking cessation and prevention in schools. Available research suggests that smoking cessation services are perceived negatively by young people and of little value to them<sup>24</sup>. There is therefore an important place for evaluating the success of any interventions introduced in Dumfries & Galloway schools.

### **11.6 Implementing the Strategy in Schools**

The circumstances and culture of each secondary school are different. Smoking policy development in secondary schools that involves the whole school will provide the platform to raise the issue of smoking with the whole school community.

There exists already a programme of health promoting schools within Dumfries & Galloway supported by a multi-agency strategic group, the Health Promotion Steering Group. The Steering Group will provide direction and support to schools in developing policies on smoking. From there, each school community can determine how they should offer cessation support both to pupils and staff.

It is good practice that young people themselves should have the opportunity to contribute to the development of smoking cessation support as well as being involved in its implementation. Programmes encouraging young people to train as peer helpers, offering brief interventions should be developed. The school nurse also has a key role to play.

Each school should develop clear communication lines on how their policies are being implemented and develop opportunities for ongoing feedback. There is an opportunity for schools to network with each other and share good practice and resources.

### **11.7 Training**

Representatives from the Smoking Matters Service will provide a programme of brief intervention training which will be offered to school nurses, teachers, other professionals and young people who have a role to play in smoking cessation within the secondary school setting.

## 12. CURRENT MODEL AND FUTURE DEVELOPMENTS IN SMOKING CESSATION SERVICES IN DUMFRIES & GALLOWAY

### 12.1 Smoking Cessation Guidance

- 12.1.1 The Smoking Cessation Guidelines recommend a stepped care approach to smoking cessation. This consists of brief advice, augmented if appropriate with NRT or bupropion, from a health professional together with follow up. Patients for whom brief advice combined with NRT or bupropion is proving insufficient (perhaps because motivation is lacking or level of dependence is higher) may benefit from more intensive support, either from practice-run smoking cessation clinics or the specialist smoking cessation service<sup>5</sup>.
- 12.1.2 All smokers should be encouraged and helped to stop. However, there should also be a focus on smokers in priority groups, including pregnant women, those on a low income, young people, older people, those with mental health problems and those with chronic illness such as diabetes, heart disease and respiratory disease<sup>7</sup>.
- 12.1.3 The NICE/HTBS guidance details the role of NRT and bupropion in smoking cessation<sup>18</sup>. It points out that the likelihood that a smoker will be successful in stopping depends on four factors:
- the smoker's motivation
  - the extent of nicotine dependence
  - the intensity and quality of support offered
  - the use of pharmacological aids
- 12.1.4 The level of motivation is difficult to assess. Some questions that may help assess motivation are:
- Does the person want to stop smoking?
  - How important is it for the person to stop smoking?
  - How confident is the person about stopping smoking?
  - Would the person be prepared to stop smoking within the month?
  - Has the person had a previous quit attempt?
- 12.1.5 The level of advice and support that should be provided to the smoker during a cessation attempt is of major importance, but it is difficult to specify exactly how much should be provided<sup>18</sup>.
- 12.1.6 The NICE/HTBS guidance recommends that smokers aged under 18, who are pregnant or breastfeeding, or who have certain conditions (cardiovascular disease, hyperthyroidism, diabetes, severe renal or liver impairment and peptic ulcer) should discuss the use of NRT with a relevant health care professional before it is prescribed. However, significant harm is associated with continuing to smoke and it can be expected that NRT will deliver less nicotine, and none of the other potentially disease-causing agents, than would be obtained from cigarettes<sup>18</sup>.
- 12.1.7 Bupropion has a number of possible adverse effects, with seizures being the most clinically important (occur in about 1 in 1,000 patients). In addition, it should not be used in women who are pregnant or breastfeeding and smokers aged under 18<sup>18</sup>.
- 12.1.8 The NICE/HTBS guidance or other prescribing guidance should be consulted for questions about prescribing of NRT or bupropion.
- 12.1.9 The NICE/HTBS guidance recommends that if a smoking cessation attempt using NRT or bupropion is unsuccessful, the NHS should normally fund no further attempts within 6 months.

## **12.2 Current Model of Smoking Cessation in Dumfries & Galloway**

The model of smoking cessation that currently exists in Dumfries & Galloway includes the following key points:

- Assessment of motivation is crucial in identifying those smokers who are likely to be successful in stopping.
- Brief advice from a health professional backed up if appropriate with NRT or bupropion and some form of follow up is the central aspect of smoking cessation. Due to the contraindications and possible adverse effects associated with bupropion, NRT is the more commonly used form of pharmacological support.
- There is a focus on smokers who fall into one of five priority groups:
  - People on a low income
  - Pregnant women
  - Young people aged between 18 and 24
  - People with coronary heart disease, cerebrovascular disease, peripheral vascular disease, diabetes or respiratory disease
  - NHS staff/independent professional groups contracted to the NHS
- Smokers in priority groups can be referred to the Smoking Matters Service for advice, support and prescription of NRT.
- Smokers not in the priority groups need to be managed within primary care and the community.
- If a cessation attempt is unsuccessful, there should normally be no further prescribing of pharmacological aids in a 12 month period.

## **12.3 Current Expenditure on Smoking Cessation in Dumfries & Galloway**

This falls into two categories: costs of the Smoking Matters service and prescribing costs.

### **12.3.1 Smoking Matters Service**

The 2002/03 budget for the Smoking Matters Service is £109,290, funded partly from general revenue allocation and partly from HIF. There are currently 4.29 wte staff, which includes four smoking cessation advisers (two full-time A&C Grade 6 and two part-time A&C Grade 5 posts) and a part-time administrator (A&C Grade 3). One of the Grade 6 postholders has been on long term sick leave. In addition, the budget covers administration, travel and resource costs.

### **12.3.2 Prescribing Costs**

Prescribing costs relate to NRT (which may be prescribed in primary care or by Smoking Matters) and bupropion (primary care only). Total prescribing costs for 2001/02 were approximately £130,000 for NRT plus £10,000 for bupropion prescribed in primary care, making a total of £140,000. In addition, the estimated annual cost of NRT prescribed by Smoking Matters is £40,000. This makes a total of £180,000. Prescribing costs have risen as more smokers seek cessation support from the NHS.

## **12.4 Future Developments**

- 12.4.1 Further action is needed in a number of areas in smoking cessation in Dumfries & Galloway. The Smoking Cessation Policy Group therefore identified future developments that would enhance the current model of services and offer improved support to smokers trying to stop. These developments require additional resources. Smoking is such a potent cause of ill health and death that the Policy Group believe that additional investment in smoking cessation services would be among the most cost effective ways of improving both individual and population health in Dumfries & Galloway.
- 12.4.2 It is likely that any additional developments will be introduced and funded one at a time. The future developments have therefore been ranked by the Smoking Cessation Policy Group in order of priority.
- 12.4.3 The prioritised list of future developments, with the highest priority actions being listed first, is as follows. Where numbers and costs are included in this section it must be understood that these are best estimates rather than exact figures. In most cases, data to enable accurate and detailed calculation of costs and benefits are simply unavailable.

### **1) Develop the Smoking Matters Service**

**This is seen as the top priority for future development and many of the other possible developments rely on extra capacity being created within the Smoking Matters Service. An increase in staff capacity enabling more smokers to be seen would mean a shift in NRT prescribing costs from primary care to the Smoking Matters Service as well as some additional NRT prescribing costs.**

There are two requirements in developing the Smoking Matters Service. These are to increase the number of smokers who can be seen within the service and to adapt the current structure to ensure that local needs are met. Both requirements could be achieved by increasing the staffing level to provide one whole time equivalent smoking cessation adviser based in each locality. In addition, there is a need for a designated smoking cessation coordinator in Dumfries & Galloway, as noted in NHS HDL (2001) 64. This role is currently filled on an ad hoc part-time basis by a smoking cessation adviser. There would also be a need for increased administrative capacity to support the increase in referrals. The table below shows staffing data relating to the current and proposed models.

	<b>Current Staffing (wte)</b>	<b>Proposed staffing (wte)</b>
Smoking cessation coordinator	0.81 (ad hoc basis)	1.0 (defined role)
Smoking cessation advisers	2.81	4.0
Smoking Matters administrator	0.67	1.3
<b>Total staff</b>	<b>4.29</b>	<b>6.3</b>

The primary function of the smoking cessation advisers' role is to deliver a specialist cessation service within the NHS. The proposed model for the Smoking Matters Service

also gives the opportunity for each adviser to take on an additional role of working in partnership with other organisations to develop smoking cessation within the wider community.

Smokers are seen and supported over approximately a three-month period. Up to 120 smokers are newly referred to the service each month. Smokers can be seen on a one-to-one basis or in a group setting. Currently one of the 2.81 wte smoking cessation advisers is off on long term sick leave. This means that the service is delivered at present by 1.81 wte advisers.

Increasing the number of smoking cessation advisers from 2.81 wte (effectively 1.81 wte taking account of the 1 wte on long term sick leave) to 4 wte would mean that the service could cope with approximately 265 referrals per month compared to the 120 per month currently referred. This equates to the service taking 3,180 referrals of smokers per year, which is approximately 10% of the 31,400 estimated number of smokers in Dumfries & Galloway (**Section 5**). That might not meet all the demand for NHS smoking cessation support in Dumfries & Galloway, but gives a pragmatic starting point.

In addition, an estimate of the benefits in terms of reduction in smoking prevalence can be made. The prevalence of smoking in adults in Dumfries & Galloway was 27% in both 1995 and 2000<sup>11</sup>. This lack of change implies that over the past few years the number of people who began smoking was fairly similar to the number who stopped smoking or died. That time period predates the availability of NRT on NHS prescription.

Published evidence suggests that 16% of motivated smokers who receive intensive support and NRT will successfully stop and be non-smokers at six month follow up (**Section 4.3**). This figure is over and above the cessation rate in people who do not receive intensive support or NRT. The proposed model with 3,180 referrals per year therefore implies that around 510 additional smokers per year would become non-smokers at six months, and that this is in addition to those who would stop smoking on their own or with assistance in primary care. As indicated in **Section 5.4**, the local target of 2% reduction in adult smoking prevalence by 2005 would equate to approximately 2,300 fewer adult smokers. The target of a further 2% reduction by 2010 would require an additional 2,300 fewer adult smokers by 2010. The proposed model would suggest that over the seven years to 2010 approximately 3,570 fewer adults would smoke. The stepped care approach, recommended by the Smoking Cessation Guidelines means that a number of other smokers will be assisted to stop with support from primary care or in other settings. The evidence indicates that 6% of smokers given brief intervention from a healthcare professional and NRT will successfully stop (**section 4.3**). It is likely that the 2010 target will be met by reductions in smoking among people seen in all of these settings.

Based on current NRT prescribing costs, It is estimated that 265 referrals per month will generate approximately £135,000 per year of NRT cost. The majority of this will be a transfer of NRT prescribing costs from primary care but there is likely to be some additional NRT prescribing too. There is no accurate way to calculate the additional costs of NRT prescribing; these costs have been estimated at approximately £35,000.

<b>Costs:</b>	
Additional 0.19 wte A&C 6 Smoking Cessation Coordinator	£4,750
Additional 1.19 wte A&C 5 Smoking Cessation Advisers	£26,200
Additional 0.67 wte A&C 3 Administrator	£9,500

Additional travel and supplies	£6,000
Extra NRT costs	£35,000
<b>Total</b>	<b>£81,450 recurring</b>

## 2) Expand eligibility

**Expand the groups of smokers who can be referred to the Smoking Matters Service. This depends on increased capacity within Smoking Matters (Point 1). Additional groups of motivated smokers who could benefit from referral to Smoking Matters include:**

- a) Smoking partners or family members of people referred. The rationale for this is that stopping smoking is more difficult if people in the home continue to smoke.**

The numbers of additional referrals from this group to Smoking Matters is difficult to quantify. Smokers may be living alone, may live with a non-smoking partner or a smoking partner who is not motivated to stop. In addition, there may be other family members who smoke. Service experience suggests that including motivated partners/family members of smokers referred might increase the total number of referrals by approximately 25%. This would amount to an additional 30-65 referrals to Smoking Matters per month.

**Costs:**

The cost of including this group in possible referrals to Smoking Matters would be zero, but requires that Smoking Matters capacity is increased as in Point 1 above.

- b) Women who managed to stop smoking ante-natally, but relapse after birth.**

Pregnancy is a prime opportunity for women to stop smoking. They have good contact with health professionals during this time and many women manage to stop. However a number of women who stop successfully during pregnancy start smoking again postnatally. Stopping smoking is important for the mother and baby after birth as well as for the unborn child. The numbers in this group are small and it is estimated that this would amount to an additional 1-2 women per month.

**Costs:**

The cost of including this group in possible referrals to Smoking Matters would be zero, but requires that Smoking Matters capacity is increased as in Point 1 above.

- c) Older people (65 years and over)**

Stopping smoking can improve the quality of life at all ages, especially when patients have multiple health problems. Older smokers consistently underestimate the risks smoking poses to their health and also believe that the effects of smoking are irreversible.

Many older people fall into an existing priority group. It is important to enable all older people to be referred to Smoking Matters if appropriate. Based on service experience, it is estimated that if all older smokers who were motivated to stop were referred to Smoking Matters, this might amount to an additional 15-30 referrals per month.

**Costs:**

The cost of including this group in possible referrals to Smoking Matters would be zero, but requires that Smoking Matters capacity is increased as in Point 1 above.

**d) People with mental health problems.**

Smoking prevalence is significantly higher among people with mental health problems, from approximately 50%-80%. However, studies have shown that people with mental health problems recognise that smoking is a problem, are interested in attending smoking cessation groups and appear to be appropriately motivated<sup>25</sup>. Smokers with mental health problems tend to have high levels of cigarette consumption and greater dependence than other smokers. Specialist treatment is not routinely offered to people with mental health problems despite evidence of effectiveness<sup>25</sup>.

It is important not to offer treatment when the mental health illness is very active, but to wait till the patient's condition stabilises. As with planning any intervention with a vulnerable group smoking cessation should be planned sensitively, and should be considered within a broader context of that individual's health needs. Mental health workers already possess many of the skills to do this, though they may benefit from specific training on the social, pharmacological and physiological consequences of tobacco use. Smoking Matters would have a role in supporting mental health workers to provide cessation support to the individual. People with mental health problems could also be referred to Smoking Matters working within set guidelines for referral. This could amount to an additional 15-20 referrals per month.

**Costs:**

The cost of including this group in possible referrals to Smoking Matters would be zero, but requires that Smoking Matters capacity is increased as in Point 1 above.

**e) Other motivated individuals who do not fall into an already defined group**

It is very difficult to estimate the numbers in this group. They are likely to be substantial since the prevalence of smoking is high among people in their 20s and 30s who are unlikely to fall into the groups already defined. It is estimated that allowing all motivated smokers to be referred to Smoking Matters would increase referrals by between 60-100 per month.

**Costs:**

It is likely that the cost of allowing all motivated smokers to be referred to Smoking Matters would be zero, provided that the Smoking Matters capacity is increased as in Point 1 above.

**3) Raise profile of smoking cessation**

**Raise the profile of smoking cessation with health professionals and the wider community. The extra demand that would follow this means that again it is largely dependent on increased capacity in Smoking Matters. Consideration would need to be given to the most appropriate means of raising the profile, such as working in partnership with existing health and community programmes, by campaigns or through the media.**

The service already has as one of its functions the raising of awareness around smoking cessation among public and professionals. There is a need to raise the profile further both to

make an impact on overall smoking prevalence in the region and to attract specific groups of smokers. This requires a small budget to plan an ongoing programme of awareness raising. The Smoking Cessation Coordinator would have responsibility for developing this programme and holding the budget.

**Costs:**

**in D&G      £5,000 recurring**

(to include working with existing health and community programmes, campaigns and through the media)

**4) Smoking cessation in secondary care**

**Provide direct smoking cessation support within secondary care settings. Currently, there is no formal cessation support within secondary care, yet this is outlined in national guidance. In addition, secondary care staff should be able to refer smokers directly to Smoking Matters. The feasibility of this again depends on increasing the capacity of Smoking Matters as in point 1 above.**

Based on a pilot scheme in DGRI which ran from Jan-Mar 2001, the aim of this project would be to establish links between the Smoking Matters Service to patients and staff within the acute setting. This would be achieved by introducing a part-time post within the acute setting that would support patients/staff to stop smoking and also liaise with the Smoking Matters Service and/or primary care services.

The objectives include:

- Helping patients and staff to stop smoking with adequate in-house or organised community support.
- Ensuring that, where appropriate, pharmacological support for a planned smoking cessation attempt is available.
- Raising the profile of the Smoking Matters Service with other staff.
- Developing links for patients and staff between hospital and community setting.

On discharge, NRT prescribing and follow up will be available either through the Smoking Matters Service or primary care.

<b><u>Costs:</u></b>	
Part-time staff (Grade 5/E Grade – 8 hours per week)	£5,700
Travel	£500
Resources & Admin	£1,000
<b>Total</b>	<b>£7,200 recurring</b>

**5) Support workplaces**

**Support workplaces to promote smoking cessation. There would be an opportunity to link smoking cessation with broader tobacco control measures in helping workplaces to develop smoking policies. Again this depends on an increased capacity within the Smoking Matters Service.**

The aim here is to encourage workplaces to provide in-house support to employees wishing to stop smoking. It is hoped that this initiative would attract small as well as large employers. This would be achieved by working in partnership with the Occupational Health Department in the first instance. The role of Smoking Matters would be to provide training and resources to enable this to happen rather than to offer direct cessation support. The costs therefore include providing workplace training and resources.

<b><u>Costs:</u></b>	
Staff time/travel	£3,000
Participants' resources	£1,400
<b>Total</b>	<b>£4,400 recurring for a number of years</b>

#### 6) Additional support to primary care

**Provide additional resources to primary care to further support smoking cessation. Staff in primary care have an extremely important role in encouraging and supporting their patients to stop smoking, but due to competing priorities there may be difficulty within current resources in maximising the support that can be given to patients trying to stop.**

The additional resources proposed for Smoking Matters in Point 1 above would substantially increase capacity to see smokers within the specialist service. However, there will also be a need for some smokers to be seen within primary care, either as the first point of contact in the stepped care model or for reasons of accessibility. The NICE Guidance estimates that ongoing support in primary care would involve one group session per week for the average practice, with each session comprising between 3 and 8 patients and costing £50<sup>18</sup>. Realistically, however, it cannot be expected that this proposed model would meet the needs of every practice in Dumfries & Galloway. Given the geographical variations across the region, it seems appropriate to allocate funds for smoking cessation support to the localities for them to use in the most effective way.

It is not known what the likely demand would be for ongoing support in primary care in Dumfries & Galloway. It seems most appropriate to provide funding for a pilot project to clarify the level of demand and to monitor and evaluate outcomes of the intervention. Six weeks of group sessions would cost £300, at a cost of £50 per session. This could be provided in eight blocks over a year, costing £2,400. This amount would be allocated to each locality to identify those practices in the locality who are interested in taking this work forward. There might be a small increase in NRT prescribing costs if more patients were inclined to attempt stopping smoking as a result of the project. It is likely, however, that the large majority of patients seen would attempt to stop in any case.

Smoking Matters would have a role in working with participating practices to provide training and establish monitoring and evaluation systems. Future allocation of funds in primary care would depend on the results of the pilot project.

**Costs:**

**6 weeks of group sessions x 8 blocks for each locality      £9,600 initially as 1 year pilot.**

**Recurring funding would depend on evaluation of pilot.**

## 7) Increase number of attempts

**Increase the number of cessation attempts funded by the NHS from one attempt to two attempts per year. As noted above, the NICE/HTBS guidance recommended up to two attempts per motivated smoker per year.**

There are good arguments to support further attempts at stopping smoking even if the first has been unsuccessful. Service experience suggests that approximately 25% of smokers who have made one cessation attempt funded by the NHS will be unsuccessful and may seek a second NHS-funded attempt within a year. A second attempt is less demanding of staff time than an initial attempt, though the prescribing costs will be similar. If the above measures have already been funded, it is likely that the increase in staff time could be absorbed within the system (Smoking Matters, Primary Care or the workplace). The overall costs of prescribing NRT or bupropion are likely to increase by 25% to reflect the additional cessation attempts.

### Costs:

**25% increase in prescribing costs for smoking cessation                      £53,750 recurring**

## 8) Support community pharmacies

**Provide funding to community pharmacies to enhance the level of input by community pharmacists to support smoking cessation.**

Each community pharmacist would be offered a professional fee of £15 per session to support an agreed number of customers over their cessation attempt. Each smoker seen six times for 15 minutes per session would imply a cost of £90 for support plus £120 for NRT, prescribed under a Patient Group Direction, making a total of £210 for a supported cessation attempt.

The involvement of community pharmacies in smoking cessation builds on the work they already achieve in supporting smoking cessation in Dumfries & Galloway. An additional advantage is that the model can increase accessibility, particularly for smokers in rurally isolated areas. It is most important that smoking cessation services are co-ordinated to ensure consistency and avoid unnecessary duplication of services. The best way to achieve this would be for each LHCC to agree the needs for smoking cessation support in their local population and the balance between services provided by community pharmacies and primary care services.

### Costs:

It is difficult to know how many smokers would be supported by community pharmacies. As an example, if every Community Pharmacy in Dumfries & Galloway was funded to provide a cessation support service to five smokers a year, the cost would be £32,550 (31 x £210 x 5)

**Total cost per five smokers per pharmacy per year                      £32,550 recurring**

## 9) Support young people

**Provide smoking cessation support for young people aged 12-18.**

There is evidence that smoking rates with young people have increased sharply in recent years, especially among girls<sup>10</sup>. There is also evidence that young people become addicted to tobacco very quickly, and many express a desire to stop smoking<sup>5</sup>. However there is little evidence regarding either the most appropriate setting for the delivery of smoking cessation programmes for young people or their effectiveness<sup>5</sup>. Available research suggests that

young smokers are more likely to take part in cessation activities which are of short duration and involve participation. Young people are also more likely to seek support from friends and family than from nurses or teachers.

Due to the paucity of evidence in this area, it is recommended that a variety of interventions are tested to determine what works best. The health service needs to work in partnership with schools, youth workers and youth organisations to develop and evaluate interventions in a range of different settings. Services should be taken to young people rather than provided through health settings. Young people themselves should be involved in the design and provision of appropriate services including peer support. At present NRT is not recommended for use by young smokers. The main need is for advice and support. Introducing and evaluating interventions with young smokers is a major piece of work. The expanded Smoking Matters service (point 1) could have some input, but to make a significant difference with this group requires a dedicated member of staff with a particular remit to work with children and young people. Part of the remit could also include the health promotion aspects of tobacco control as well as smoking cessation support. It is proposed that the post would be initially for three years with continuation depending on an evaluation of effectiveness.

**Costs:**

**1 wte A&C 5 Young People's Smoking Cessation adviser            £22,040 annually for three years.**

**Recurring funding would depend on evaluation.**

## **10) Community development**

**Work with communities in a community development approach to raise the profile of smoking cessation and encourage it, particularly in deprived communities.**

A pilot community smoking cessation project has been funded by the NHS Board for up to three years through the Health Improvement Fund. This is planned for the Machars area of Dumfries & Galloway. The pilot project is based on research indicating that a defined community model can lead to a significant decrease in prevalence of smoking in a deprived area. It is not clear whether the research model, which was carried out in a deprived inner city population in the United States, would translate successfully to a rural area like Dumfries & Galloway. This means that evaluation of the pilot project will be crucial in determining whether the model should be used more widely in Dumfries & Galloway.

**Costs:**

At this stage there is no need for additional funding. If the pilot is successful however, it would then be appropriate to adopt similar methods in other deprived areas of Dumfries & Galloway, which would have cost implications.

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