Report on Smoking Cessation Review - Tasmania

Smoking Cessation Review Team – Tasmania

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Commissioned by the Department of Human and Health Services, Tasmania, Australia

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Executive Summary

Assisting people who smoke and reducing the burden of tobacco related death and disease for disadvantaged groups are key policy objectives in the Tasmanian Tobacco Action Plan 2006-2010. It is now 2007 and whilst some progress has been made towards these objectives, many of the recommended actions have not occurred.

This report, as part of a review on smoking cessation interventions in Tasmania on future service provision, is based on international best practice and provides an opportunity for the Department of Health & Human Services (DHHS) to progress towards achieving the objectives of the Tasmanian Tobacco Action Plan.

Our preferred and recommended option in the development of a comprehensive smoking cessation program in Tasmania is to immediately commence the implementation of our recommendations. However, we also recognise that the resources to do this are currently limited. We have, therefore, suggested that the following individual components be introduced gradually:

Short Term - 2007/2008 Financial Year

1. Invest in media campaigns to promote quitting. These campaigns should encourage people to use effective methods to help them quit (e.g. give Quitline number, see their GP to talk about options such as NRT, buproprion and varenicline).

2. Optimise opportunity for media exposure surrounding the launch of varenicline.

3. Appoint a smoking cessation coordinator within DHHS to manage and co-ordinate smoking cessation activity, including smoking cessation training across Tasmania, and manage the Quit Tasmania service agreement.

4. Assess specific Quitline counseling support requirements to respond to anticipated increases in demand consequent upon the appointment of a smoking cessation coordinator, improved NRT access and possible subsidy of varenicline.

5. Commence work at a national level, initially through the Inter Governmental Committee on Drugs through to the Ministerial Council on Drug Strategy, to promote improved community access to NRT.

6. Investigate opportunities for collaboration at the state or national level with pharmacies to deliver smoking cessation programs.

Medium Term - 1 to 3 years

7. Ensure adequate Quitline counseling resources are available to respond to demand, particularly once subsidized NRT is available.

8. Implement subsidized NRT through the Quitline.

9. Provide access to hospital-based smoking cessation co-ordinators at the Royal Hobart Hospital, Launceston General Hospital and North West Regional Hospitals and associated district hospitals.

10. Any underspend from subsidized NRT should be directed to public education campaigns (if funded from Tasmania health budget).
Long Term - 3 to 5 years

11. Increase funding for public education campaigns to a level commensurate with other Australian jurisdictions.

12. Re-evaluate Tasmania’s approach to cessation service provision.

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**Prompt more Quit Attempts**

Smoking Cessation Co-ordinator – 1 FTE – *coordinates* the Tasmania smoking cessation and *smoking cessation training program*

Undergraduate medical, dental, nursing and allied health students

Hospitals

3FTE hospital smoking cessation coordinators

QUIT Tasmania - Quitline + subsidised nicotine replacement therapy

General practitioners, health, appropriate non-health and community workers

Aboriginal Health Services (Face-to-face service or refer to QUIT)

Mental Health and Alcohol & Drug Services (Face-to-face service or refer to QUIT)

Mass Media and unpaid media

Non-governmental organisations

Triage out to existing face-to-face services if required e.g. Alcohol & Drug Services, Aboriginal Health Services

*Smoking cessation training – Brief advice to stop smoking, smoking cessation support, specialist, Fresh Start (mainstream and Aboriginal, to be conducted by QUIT) and within undergraduate health curriculum of medical, dental, nursing and allied health students.*
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*Prompting quit attempts is the aim of the program*  
Paid and unpaid media  
Part of the smoking cessation program to be coordinated  
Refer to the Quitline  
Report back to referrer  
Triage to face-to-face services
Introduction

This report sets out recommendations to the Steering Committee for an appropriate model for the delivery of smoking cessation interventions in Tasmania. The recommendations are the focus of the Review of Smoking Cessation Interventions in Tasmania (review) recently commissioned by DHHS. They outline the most effective, efficient and accessible way to provide smoking cessation services in Tasmania including where, how and by whom. The review has been undertaken in parallel with the Alcohol, Tobacco and Other Drug Services Review and the Future Health Services Plan (including the Primary Health Services Plan and the Clinical Services Plan).

The report recommendations take into account:

- The needs of high risk target groups such as people of low socio-economic status, those with mental illness, young people, pregnant women and Aboriginal people; and
- How to improve the utilisation of pharmaceutical interventions and provide Cessation advice to those with more complex needs.

This report is the culmination of a number of activities: a stocktake of smoking cessation services, analysis of current smoking cessation interventions, interviews and surveys conducted, consultation with the Steering Committee, background reports, analysis of service gaps, assessment of feedback from consultation with key stakeholders, and recommendations to the Steering Committee for future smoking cessation service provision in Tasmania based on international best practice with subsequent feedback from the Tobacco Coalition.

Background

Tobacco control strategies are essential in reducing smoking prevalence. Interventions such as price increases and mass media campaigns are effective in both preventing uptake and prompting people who smoke to make quit attempts. Whilst smoking cessation treatments on their own do not have a large effect on smoking prevalence, they make up a key component of any tobacco control program. Evidence-based smoking cessation treatments are effective and more cost effective than many other treatments provided by health care services.

The National Tobacco Strategy 2004-2009 and a number of Tasmanian strategic and evidence-based documents are relevant to the review and were evaluated to provide a framework for the recommendations. The National Tobacco Strategy 2004-2009 is a statement of the resolve of federal, state and territory governments ‘to work together and in collaboration with non-government agencies on a long-term, comprehensive, evidence-based and coordinated national plan to reduce the often hidden but nevertheless very real misery and wasted human potential caused by tobacco smoking in Australia’.

A key objective of the Strategy is to ‘encourage and assist as many smokers as possible to quit as soon as possible. An objective outcome of the Strategy is increased cessation with five outcome indicators including:

- Fewer adults smoking regularly
- Substantially more adult smokers attempting to quit
- Substantially fewer quitters relapsing
- A lower average number of years that users smoke prior to quitting
- Fewer longer term ex-smokers resuming smoking.
In looking at the tools that could be used to encourage and assist smokers to quit, the Strategy provides the rationale and evidence for promoting Quit and smokefree messages and providing smoking cessation services and treatment.

The Tasmanian Tobacco Action Plan 2006-2010 provides a detailed and comprehensive strategy aimed at reducing smoking in Tasmania. Six strategy areas are outlined in the Action plan. Two strategy areas are relevant to this review. Strategy area 3: Cessation services and treatments, and Strategy area 5: Tailoring initiatives for Disadvantaged groups.

**Strategy Area 3: Cessation Services and Treatment**

Appropriate services and treatment for smokers are essential to ensure all smokers have access to support and affordable pharmacotherapies if they decide to quit. The implementation of interlinking policies and programs is also needed to ensure all smokers in contact with the health care system are identified and advised to quit, particularly pregnant women and new parents, chronic disease sufferers, people living in institutions and other high risk groups. The policy objective is to improve promotion and accessibility of resources and services to assist smokers to quit. To achieve this, the plan outlines a number of recommended actions:

- Continued commitment to the funding of Quit Tasmania to operate the Quitline telephone counseling service.
- Evaluate the Quitline and other Cessation services provided by Quit Tasmania to determine effectiveness, efficiency and level of resourcing required.
- Conduct a review to determine the most effective, efficient and accessible way to provide cessation services, particularly high-risk target groups in clinical, community and regional settings.
- Promote evidence-based cessation programs in workplaces and community settings.
- Promote national accredited training programs to equip health professionals and allied workers plan and deliver smoking cessation programs.
- Encourage general practitioners to deliver interventions on smoking cessation with patients.

**Strategy Area 5: Tailoring Initiatives for Disadvantaged Groups**

Several social groups in Tasmania suffer a particularly high burden of tobacco disease. These include Aboriginal peoples, people with mental illness and in custodial settings, parents and carers in disadvantaged/low socioeconomic areas, smokers in rural and remote regions and people from certain cultural backgrounds. By ensuring access to information, treatment and services for people in such groups the burden can be reduced. The policy objective for Strategy Area 5 is; to reduce the burden of tobacco related death and disease for disadvantaged groups by ensuring access to information, treatment and services.

The following recommended actions to achieve this objective are outlined in the Action plan:

- Collaborate with Aboriginal health groups to identify solutions to the high use of tobacco in the Aboriginal community and train and increase the skills of Aboriginal health workers to plan and deliver effective cessation programs.
- Provide and promote cessation services for smokers with mental illness.
- Provide and promote cessation services for people in institutionalized care such as custodial settings, aged care facilities and group homes.
- Provide and promote cessation services for smokers in rural and remote regions and low socio-economic areas.
- Ensure information and strategies to address the cultural and ethnic diversity of Tasmanian society and identify and target high risk groups.
The *Smoking Cessation Review Scan of DHHS Services* identified smoking cessation services in Tasmania including QUIT Tasmania (QUIT), Alcohol & Drug Services (ADS) in the South and North-West, the Brighton Community and Health Centre (if/when required) and Aboriginal Health Service (provision of subsidised nicotine patches).

The background report for the review identified new evidence emerging about the effectiveness of various smoking cessation interventions and new interventions that are being developed.

This report therefore takes account of these key documents and aligns their findings with the recommendations. Our analysis suggests that existing service arrangements are not meeting the needs of people who smoke in terms of the range and type of services provided and equity of service coverage.

**Methods**

We reviewed the key documents, analysed current smoking cessation interventions, consulted with key stakeholders and the Steering Committee, analysed service gaps, assessed feedback from consultation with key stakeholders and made recommendations to the Steering Committee to inform this report.

Key documents accessed to guide the recommendations were the following:

- National Tobacco Strategy 2004-2009;
- Tasmanian Tobacco Action Plan (Tobacco Coalition, 2006);
- Smoking Cessation Review Scan of Department of Health and Human Services (DHHS);
- Background Report for the Tasmanian Smoking Cessation Review.

A stocktake of current cessation services was undertaken and analysed.

As part of the consultation process, a total of 58 organisations were entered into a database consisting of governmental, non-governmental and educational stakeholders. Stakeholders from the list were sent a questionnaire to complete and return, and face-to-face, telephone and voice over internet protocol (Skype) interviews were also conducted. These interviews used semi-structured questions to elicit information from the stakeholders. All data thus collected was analysed looking for common themes and issues.

There was a limited stakeholder response to invitations to submit using the provided questionnaire. A total of 13 questionnaires (Appendix 3) were returned and 18 interviews/meetings/written submissions took place. Other data were obtained from face to face interviews, telephone interviews and email. Smoking cessation service gaps were identified and analysed by comparing requirements and recommendations from key documents with current smoking cessation services.

One face-to-face meeting was held with the Steering Committee. Further contact was maintained via email. The Steering Committee offered guidance and direction to the review team. Recommendations were made to the Steering Committee. These were sent to the Tobacco Coalition for comment, which will inform this report.
Findings

There are smoking cessation services provided in Tasmania but they are limited in terms of efficiency and accessibility. They do not systematically meet the needs of high-risk target groups and smoking cessation medicines are largely inaccessible to those with more complex needs.

Many of the key stakeholders expressed frustration at the lack of smoking cessation services in Tasmania and the need for the DHHS to make a commitment to smoking cessation services that are effective and accessible. There is good evidence for effectiveness of interventions for smoking cessation presented in Table 1.

Table 1: Evidence for effective interventions for smoking cessation

| Brief advice by doctors to stop smoking. |
| Proactive telephone support, adding telephone support to pharmacotherapy increases abstinence rates over that of pharmacotherapy alone. |
| Face-to-face support delivered individually or in a group. There is correlational evidence that high intensity interventions are better than low intensity interventions. |
| Nicotine replacement therapy (NRT) (including combination or two NRT products). |
| Bupropion (Zyban) |
| Nortriptyline |
| Varenicline (Champix) |
| Multi-session behavioural interventions for pregnant women particularly using cognitive behavioural therapy. |
| Hospital-based cessation services that include follow-up for at least one month post-discharge |
| Pre-operative cessation |

Source: Background report

Analysis of key documents, smoking cessation services and identified gaps

In conducting an analysis of smoking cessation interventions and service gaps, we found that there were considerable gaps in relation to recommendations in the Tasmanian Tobacco Action Plan and the evidence provided in the background report for the review. The evidence base and recommended smoking cessation strategies and analysis of service gaps are presented in Table 2.

Table 2: Evidence-base and recommended smoking cessation strategies found in key documents and analysis of the current smoking cessation services and identified gaps

<table>
<thead>
<tr>
<th>Smoking cessation interventions, systems and related activity found in key documents</th>
<th>Current smoking cessation interventions and the identified gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief advice to stop smoking from all health care professionals.</td>
<td>Brief advice is not routine in general practice and hospital settings.</td>
</tr>
<tr>
<td>Tailoring initiatives for disadvantaged groups.</td>
<td>There are limited dedicated smoking cessation services for Aboriginal people, mental health and alcohol and drug service users, young people and women of child bearing age.</td>
</tr>
<tr>
<td>Research, evaluation, monitoring and surveillance.</td>
<td>Limited evaluation data only for all smoking cessation services. Some reporting of smoking cessation outcomes but no use of standard outcome measures to allow comparison or benchmarking.</td>
</tr>
<tr>
<td>Strategies for improving smoking cessation services and treatment for smokers.</td>
<td>Plans and strategies in national documents but little progress against smoking cessation plans/aims.</td>
</tr>
<tr>
<td>Objectives of services and treatment for smokers.</td>
<td>Need to be aligned with current evidence-base.</td>
</tr>
<tr>
<td>Institutionalized treatment of tobacco dependence throughout the health care system.</td>
<td>Alcohol and drug and mental health services are taking a lead in smoking cessation but services are not generalized or institutionalized dependence is not viewed as a priority</td>
</tr>
</tbody>
</table>
Include tobacco and smoking cessation treatment in undergraduate and graduate training programs for all relevant health professionals.

Some evidence of training but needs development to increase reach into allied health professionals.

Market national treatment services to health professionals and provide workable referral mechanisms.

Some marketing and some health professionals refer patients to QUIT, systems in place for referrals to QUIT, who have good referral systems (based on 5As) but not used by all health professionals.

Develop and implement system and facility guidelines and protocols to ensure that treatment of tobacco dependence becomes a standard and routine aspect of health care.

There are national smoking cessation guidelines but general practitioners use of them appears to be inconsistent. There is disparity within and between service sectors regarding systems and protocols for smoking cessation support. Treatment of tobacco dependence is not standard practice.

Ensure access to appropriate smoking cessation support for any smoker in the country.

Limited access to smoking cessation services, particularly in the North and North-West and there are limited hospital based services.

National Quit Campaign materials.

Good but need updating.

Disease-specific Quit materials.

None.

Other self-help materials.

Some available but generally out-of-date.

Ensure client satisfaction with services.

No ongoing monitoring. QUIT annual report 2005/2006 gives some information. Mental health and alcohol and drug service evaluations are anecdotal and do not use consistent and standardized measures.

Ensure quality of service.

No national program for ensuring quality or benchmarking.

Publish and distribute high-quality quitting resources.

Good information available from pharmacy groups and QUIT, other services have minimal resources.

Improve access to more intensive face-to-face smoking cessation support for highly dependent smokers.

Limited intensive services in some areas are available for users of mental health and alcohol and drug services but services are stretched and not able to provide general coverage to other people who smoke.

Primary care smoking cessation service.

A lack of community and practice nurse-lead services and smoking cessation workforce.

Interested and skilled health and other professionals

Smoking cessation is not a priority in mental and alcohol and drug services. A lack of training for the existing smoking cessation workforce.

Increase the quality of use of evidence-based pharmacotherapies.

Limited offering of NRT and other evidence-based pharmacotherapies (except for bupropion mainly through general practitioners) in smoking cessation services.

Educate consumers and the public.

Some pamphlets and information is available to the public in district hospital and community centres but the availability is inconsistent.

Advertising in mass media.

QUIT does some mass media advertising but low funding limits the campaigns.

Subsidy scheme for NRT.

No national subsidy in place, some subsidy on a health card but cost is still high for disadvantaged groups.

Summary and assessment of feedback from consultation with key stakeholders
Feedback from the questionnaires has been assessed by the review team with the information gathered from face-to-face meetings, telephone and skype calls and email contact. This is summarised in Appendix 1.

Comments on draft recommendations from the Tobacco Coalition
The Tobacco Coalition provided comments on the draft recommendations proposed by the review team which are summarised in Appendix 2. Comments were received from Smoke-Free Tasmania, Kathy Barnsley, Acute Health Services DHHS (Divisional Support Unit), Pharmaceutical Society, Heart Foundation, General Practice Tasmania, QUIT, Aboriginal Health Service and ASH Australia.
Recommendations

The following recommendations are based on our assessment of the key documents, the current mix of DHHS-funded smoking cessation services, evidence-based/best practice smoking cessation services and consultation with key stakeholders and the broader community. We recognise that some of the recommendations are already being implemented.

We propose that a standardised approach to funding and monitoring is established for all DHHS smoking cessation support and training contracts to ensure that there is greater equity, than at present, in the provision of evidence-based high quality smoking cessation services across geographical regions, for Aboriginal people, mental health and ADS clients, and low socio-economic groups.

ADS clients, hospital patients, workers (particularly health workers with an emphasis on mental health workers) and repeat quitters should be included as target groups and pregnant women should be extended to women of child bearing age.

We have removed youth as a target group and replaced them with parents, as the evidence is very weak for smoking cessation interventions with young people but they are strongly influenced by parental smoking. We would, therefore, identify Aboriginal people, users of mental health and ADS, women of childbearing age, hospital patients, parents, health workers, repeat quitters and people with low socio-economic status as high risk target populations.

It is essential that a comprehensive statewide smoking cessation program is effective, efficient, accessible and affordable, particularly for the high risk target populations. The model we are proposing for Tasmania will meet these criteria and can be added to as required.

Our preferred and recommended option is to immediately commence the implementation of a comprehensive smoking cessation program across Tasmania. However, we also recognise that the resources to do this are currently limited. We have, therefore, suggested individual components be introduced gradually and that over time it will lead to the desired program. Nevertheless, it is vital that planning for full implementation begins immediately.

The key recommendations are:

1. All people who smoke should be able to access or be referred to a proactive\(^1\) telephone or face-to-face multi-session behavioural smoking cessation support with the offer of subsidised NRT.

2. Standardised smoking cessation training (with specific components on mental health, other addictions, pregnancy and Aboriginal health) should be provided for all health, other appropriate non-health and community workers on the provision of brief advice to stop smoking. Where possible brief advice training should fit in with other training events (such as continuing professional development). Smoking cessation training should also be provided to health workers offering smoking cessation support as part of their role and those providing smoking cessation support as their sole focus.

3. All hospitals (including district hospitals), healthcare facilities for inpatients, primary health care services, appropriate community-based and custodial services should have smokefree policies including the grounds and preferably computerized systems to identify and record the smoking status of patients/clients. Patients/clients who smoke

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\(^1\) Patients/clients who smoke can be referred to Quitline by health professionals and other appropriate non-health or community workers, quit advisers then contact the patient/client and offer cessation support and at the conclusion of the cessation treatment, report back to the referrer.
should be advised to stop smoking and referred to the Quitline if appropriate. When appropriate, users of mental health and alcohol and drug services, and Aboriginal people who smoke may be triaged from the Quitline or referred directly to specific face-to-face cessation services. Subsidised NRT should be available for all inpatients for temporary abstinence or smoking cessation.

To facilitate this, it is recommended that resources be made available to implement the following:

1. **Media**
   1.1 Mass media - current funding for mass media campaigns should continue but be reoriented to promote options for quitting. This should focus on personalizing the health risks of smoking, to increase people’s sense of urgency about quitting and their awareness of effective therapies and contact details for services. Any media campaign should include coverage of Aboriginal and other disadvantaged groups.
   1.2 Unpaid media – Non-governmental organisations (NGOs) should make use of unpaid media to support media campaigns in encouraging people who smoke to quit and access cessation services. This can be achieved through television and radio interviews, print media and the internet.

2. **Expanding the smoking cessation workforce**
   2.1 A 1.0 full-time equivalent (FTE) smoking cessation co-ordinator should be appointed to manage the implementation of the Tasmania-wide smoking cessation and training program. This position should be within DHHS.
   2.2 Quitline advisers – At least 4FTE quitline advisers should be employed to manage Quitline calls as a result of the proposed extended Quitline hours.
   2.3 Hospital cessation coordinator – 3FTE should be recruited/appointed, one smoking cessation co-ordinator in each of the major hospitals with coverage extending to the closest district hospitals. The hospital smoking cessation co-ordinators should lead the hospital (acute and district) smokefree project teams to ensure the development and implementation of smokefree policies, systems and referral or provision of smoking cessation support. Patients who smoke should be offered NRT in hospital and referred to Quitline or appropriate face-to-face services within or outside the hospitals. The referral system should link to the patient’s GP. The hospital smoking cessation co-ordinators would work in close liaison with the smoking cessation co-ordinator and trainer.
   2.4 Fresh Start cessation leaders – part-time to run quarterly Fresh Start courses in the North and North-West.

3. **Smoking cessation services**
   3.1 Quitline – A telephone quit support service that smokers can contact themselves for smoking cessation support or can be referred to by health professionals from hospitals (acute or district), primary health care and community services should be established. NRT should be offered to all people who ring the Quitline for smoking cessation support. The hours of the service should be extended to approximately 70 hours per week including weekends.
   3.2 Individual smoking cessation support - Face-to-face multi-session behavioural smoking cessation support with the offer of NRT should continue to be offered through ADS, mental health services and Aboriginal Health Services at the current level. These services should review the accessibility of the smoking cessation services for their target audience and make the necessary changes to improve accessibility.
   3.3 Fresh Start courses – These group smoking cessation support courses should be provided statewide. They should be free of charge and NRT should be offered to the attendees. Courses should be run quarterly. The appointment of additional Quitline advisers should enable the existing Health Promotion Officer to run more courses in the South. Smoking cessation leaders will need to be appointed to run courses in the North and North-West.
The Aboriginal Health project leader (0.3FTE) could run courses quarterly, specifically for Aboriginal people who smoke, in Launceston and Burnie (or run ‘train the trainer’ courses for Aboriginal Fresh Start leaders).

4. **Subsidised pharmacotherapy**
   4.1 Zyban – Currently accessed through the Pharmaceutical Benefits Scheme (PBS).
   4.2 Varenicline – Being considered for the PBS.
   4.3 NRT should be subsidized and offered to all people who smoke and access smoking cessation services. Opportunities to work with the Commonwealth Government to secure improved access to subsidized NRT should be investigated but it could also be provided through a quit card program specifically for NRT through QUIT Tasmania. GPs could prescribe NRT but all other quit card providers would need to be registered (would need evidence of smoking cessation support training) and access quit cards for their patients/clients from QUIT. Subsidised NRT should also be available for repeat quitters. There is no evidence to suggest that repeat quitters should not use NRT for repeated quit attempts.

5. **Health care and other appropriate settings**
   All health care professionals in all health care settings, particularly doctors, should offer brief advice to stop smoking routinely to all smokers. The importance of this intervention cannot be underestimated. The evidence clearly shows that what doctors say and do about smoking in consultations makes a huge difference to their patients. Advice from other health professionals is also acceptable to patients and likely to be effective.
   5.1 Acute and district hospitals - The hospital smoking cessation co-ordinators should manage the smokefree policies, develop and implement systems and co-ordinate smoking cessation support for the Royal Hobart Hospital (RHH), Launceston General Hospital (LGH) and the North-West Regional Hospital (NWRH) and associated district hospitals.
   5.2 Primary health care and appropriate community settings – The smoking cessation co-ordinator should liaise with Divisions of General Practice to advise and assist primary health care services to develop smokefree policies, systems and referral or provision of smoking cessation services.
   5.3 Custodial settings – As many Aboriginal and others from disadvantaged groups are in custodial settings with no access to smoking cessation support, appropriate workers in custodial settings could be trained in brief advice to stop smoking and/or smoking cessation support. Access to telephones could be made available to make or receive calls from Quitline advisers. NRT should be available free-of-charge for this setting.

6. **Standardised training**
   6.1 Brief advice to stop smoking training - For health professionals and appropriate non-health (e.g. social/prison workers etc) or community workers.
   6.2 Smoking cessation support for health professionals and appropriate non-health or community workers.
   6.3 Specific training for specific professional groups working with: pregnant women; users of mental health; ADS; and Aboriginal people. There may also be specific training developed for other identified requirements e.g. implementing systems in hospitals and primary health care services.

7. **Pharmacies**
   7.1 Opportunities to develop a model for structured smoking cessation programs delivered by pharmacies should be investigated e.g. the Diabetes project could be remodeled for the provision of smoking cessation support.

8. **Evaluation**
   8.1 Current and future smoking cessation interventions should be evaluated.
It is vital that planning for full implementation begins immediately as follows:

**Short Term - 2007/2008 Financial Year:**

1. Invest in media campaigns to promote quitting. These campaigns should encourage people to use effective methods to help them quit (e.g. give Quitline number, see their GP to talk about options such as NRT, bupropion and varenicline).

2. Optimise opportunity for media exposure surrounding the launch of varenicline.

3. Appoint a smoking cessation coordinator within DHHS to manage and co-ordinate smoking cessation activity across Tasmania, and manage the Quit Tasmania service agreement.

4. Assess specific Quitline counseling support requirements to respond to anticipated increases in demand consequent upon the appointment of a smoking cessation coordinator and improved NRT access.

5. Invest in smoking cessation training from brief advice to stop smoking to specialist cessation support for health professionals, appropriate non-health and community workers.

6. Commence work at a national level, initially through the Inter Governmental Committee on Drugs through to the Ministerial Council on Drug Strategy, to promote improved community access to NRT.

7. Investigate opportunities for collaboration at the state or national level with pharmacies to deliver smoking cessation programs.

**Medium Term - 1 to 3 years:**

8. Ensure adequate Quitline counseling resources are available to respond to demand, particularly once subsidized NRT is available.

9. Implement subsidized NRT through the Quitline.

10. Provide access to hospital-based smoking cessation co-ordinators at the RHH, LGH and NWRH and associated district hospitals.

11. Any underspend from subsidized NRT should be directed to public education campaigns (if funded from Tasmania health budget).

**Long Term - 3 to 5 years:**

12. Increase funding for public education campaigns to a level commensurate with other Australian jurisdictions.

13. Re-evaluate Tasmania’s approach to cessation service provision.

There is an opportunity now to develop a moderately comprehensive smoking cessation program that incorporates evidence-based smoking cessation services, accessible subsidised NRT and training of health professionals, appropriate non-health and community workers in hospitals, primary health, community settings, mental health and ADS. We recommend that this program be added to in the future to ensure a fully comprehensive smoking cessation program exists across Tasmania.
The recommended smoking cessation model for Tasmania

**Prompt more Quit Attempts**

Smoking Cessation Co-ordinator – 1 FTE – coordinates the Tasmania smoking cessation and *smoking cessation training program*

- Undergraduate medical, dental, nursing and allied health students
- Hospitals
  - 3FTE hospital smoking cessation co-ordinators
- General practitioners, health, appropriate non-health and community workers
- Aboriginal Health Services
  - (Face-to-face service or refer to QUIT)
- Mental Health and Alcohol & Drug Services
  - (Face-to-face service or refer to QUIT)
- Mass Media and unpaid media
- Non-governmental organisations
- Quitline - Quitline + subsidised nicotine replacement therapy
- Triage out to existing face-to-face services if required e.g. Alcohol & Drug Services, Aboriginal Health Services

*Smoking cessation training – Brief advice to stop smoking, smoking cessation support, specialist, Fresh Start (mainstream and Aboriginal) and within undergraduate health curriculum of medical, dental, nursing and allied health students.*

**Flowchart:**
- Prompting quit attempts is the aim of the program
- Paid and unpaid media
- Part of the smoking cessation program to be co-ordinated
- Refer to the Quitline
- Report to referrer
- Triage to face-to-face services

A smoking cessation co-ordinator (Appendix 4) should be appointed for Tasmania to ensure that there are effective, accessible smoking cessation services and training services available; approx. 4FTE quit advisers; and 3FTE hospital smoking cessation co-ordinators for acute and district hospitals. Smoking cessation services should be centred around the Quitline. The Quitline should be the provider of subsidised NRT. Quitline hours should be extended to include weekend coverage. Quitline should triage clients to specialist services when required. Mass media and unpaid media are an integral part of prompting quit attempts. This should be the responsibility of the Quitline and NGOs.
Conclusions

This report draws together data from a range of documents, including a review of the literature on evidence for effectiveness, broad consultation across the health and tobacco control sectors, analysis of current cessation services and discussion with the Review Steering Committee to formulate recommendations for a comprehensive smoking cessation program for Tasmania, based on our findings from the review process and best practice comprehensive smoking cessation program (Appendix 5). There is considerable scope for improvement in the current smoking cessation support systems, service provision and training: gaps exist in service coverage for high-risk target groups and across geographical areas, training is very limited as is alignment of service delivery with current best practice.

We have not discussed the current funding stream and service delivery model as there is no evidence to recommend the best practice model for funding and service delivery. Currently cessation services are funded by ADS in collaboration with Environmental Health.

Current smoking cessation services do not appear to have been evaluated and we noted the inclusion of some interventions for which there is insufficient evidence of their efficacy e.g. acupuncture, hypnotherapy and Allen Carr. Whilst there is some prescribing of bupropion, mainly within general practice, there is extremely limited use of pharmacotherapy and it is very costly for the patient/client.

High risk target groups are not well covered. Only a handful of smoking cessation services exist, provided by ADS for mental health and alcohol and drug clients. Some provision of subsidised NRT is provided to Aboriginal clients but often without behavioural support. The Quitline is available for the general population and although it provides a very good proactive referral service, it does not provide NRT to its clients and there is no provision of a report back to the referrer.

As a general principal all people who smoke in Tasmania should have access to proactive telephone and/or face-to-face smoking cessation support with the offer of subsidized pharmacotherapy. All the high risk target groups of people of low socio-economic status, those with mental illness, other addictions, parents, pregnant women, Aboriginal people, workers and repeat quitters need to be assured of accessibility to services. This includes a proactive Quitline service, transparent referral systems from hospitals and the primary health care sector to the Quitline and other specific smoking cessation services, Aboriginal (including family members, whether Aboriginal or not) cessation services and increased GP/practice nurse pregnancy smoking specific knowledge in the primary health care setting. Pregnant women generally see their GP several months before they see their midwife and therefore need to be offered cessation support at the first point of contact with their GP.

Smoking cessation training is an integral part of increasing smoking cessation support in hospitals and the primary health care sector. Health professionals, appropriate non-health and community workers should be able to access training for the provision of: brief advice to stop smoking, smoking cessation support and specialised smoking cessation support. Health organisations should support and encourage staff training as part of their continuing professional development and as a priority to treat all patients/clients who smoke.

Policies and systems should be implemented in all health care facilities to prompt and support health workers to ask patients/clients about their smoking, record the information, give them brief advice to stop smoking, and refer to smoking cessation services or provide smoking cessation support. Smoking cessation services or referrals to smoking cessation services should be an integral part of hospital and primary health care services including mental health
and ADS. If patients/clients are referred to smoking cessation services, the referrers should be provided with a report on patient/client progress.

We believe that the DHHS should invest in mass media to prompt people who smoke to make quit attempts. The media should act as a driver to increase people’s sense of urgency about quitting and their awareness of effective therapies and contact details for services.

There is an opportunity now to develop a moderately comprehensive smoking cessation program that incorporates evidence-based cessation services, accessible pharmacotherapy and training of health professionals, appropriate non-health and community workers in hospitals, primary health care and community settings, mental health and ADS. This can be added to over time. It will require a competent workforce using the most cost-effective, evidence-based methodologies to provide smoking cessation support. The appointment of a smoking cessation co-ordinator is a key step to ensuring an effective, efficient and accessible smoking cessation programs are established in Tasmania.
References


Smoking Cessation Review Scan of Department of Health & Human Services. Prepared 2006

Review of Smoking Cessation Interventions. Background report for the Department of Health & Human Services, Tasmania. Dr Hayden McRobbie, CTRU, University of Auckland (lead author).


### Appendix 1

#### Summary and Assessment of feedback from key stakeholders

| Mental health and alcohol and drug services | The culture of smoking in mental health and alcohol and drug services limits smoking cessation interventions and addressing of smoking by staff. There is a need to focus on staff and patients who are smoking in ADS and mental health services. An addiction specialist identified smoking cessation services for this group as almost non existent and those that do exist are antiquated and moralistic. From an addictions view point smoking cessation practice in Tasmania is limited and not evidence-based. Smoking cessation is not a priority in the ADS. NRT is not routinely used to support cessation. There is a need to address nicotine addiction and address it with appropriate interventions that are based on effective behavioural support and current evidence-based pharmacotherapy. The level of smoking cessation training among mental health and ADS practitioners is considered outdated and inappropriate. It is not sufficient to support smoking cessation practice as a core role or service. ADS is providing cessation interventions to some clients but not directly to general hospital patients or community clients. |
| Hospital services | There was considerable frustration voiced by those who made submissions from hospital services. There is evidence for the provision of accessible smoking cessation in the hospital and the community. Many people want to stop smoking when they are in hospital. The hospital intervenes with NRT and then there is no support on discharge. There was dismay at the Royal Hobart Hospital when the Smoking Cessation Clinic was closed. What is needed is expert counsellors and pharmacological support. Smoking cessation support is a reasonably specialised skill. It will take time and resource to develop the skill in the community. There is a need for an expert centre. The Smoking Cessation Clinic was that expert centre. It provided pharmacological and counselling support. |
| General practice and community Cessation support | In one general practice division, general practitioners routinely ask patients about smoking and record smoking status in the medical notes. However, the provision of brief advice to stop is not routine, and one submission described the approach of general practitioners to smoking cessation as being ‘ad hoc’. They often refer patients to QUIT for ongoing support. More community support is needed and more practice nurses could provide smoking cessation support. There is a large cohort of people with social and mental health issues, who find it difficult to stop smoking and to access general practitioners’ services. There is a need for a graded approach with widespread interventions in the community. This could involve ADS, general practitioners, practice nurses, community pharmacists promoting the use of NRT and cessation. Many pharmacists are already providing smoking cessation support and people who smoke and wish to quit should be referred to these pharmacists. |
Appendix 2

The following is a summary of comments received from the Tobacco Coalition on the draft recommendations proposed by the review team. Comments were made specifically by: Smoke-Free Tasmania, Kathy Barnsley, Acute Health Services (Divisional Support Unit), Pharmaceutical Society, Heart Foundation, General Practice Tasmania, QUIT, Aboriginal Health Service and ASH Australia.

<table>
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<tr>
<th>Summary of feedback from Tobacco Coalition</th>
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<tr>
<td><strong>Support for the review</strong></td>
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<td>The draft recommendations were generally well supported. It was noted that there needed to be a full commitment from all stakeholders for this to be a success. There was some concern from one group that the consultants were not from Australia and, in particular, were not familiar with Tasmania. Another group thought that there were some areas that impacted significantly on Aboriginal people and the review team did not determine the most effective, efficient and accessible way to provide smoking cessation services, particularly for high-risk groups in clinical, community and regional settings.</td>
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<tr>
<td><strong>Media</strong></td>
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<td>The lack of a sustained mass media campaign was highlighted by most groups. It was suggested by one that it should be rolled out over at least 12 months. There was acknowledgement that media was part of the recommendations but it was considered too late for some. The review authors were directed to the resources 'Increasing promotion of Quit and Smokefree messages: Ideas and Resources and ‘Improving services and treatment for smokers: Ideas and Resources’ (Australian National Tobacco Strategy 2004-2009). One organisation suggested that if it was a funding choice between subsidising NRT and a properly funded media campaign the priority should be a media campaign. It was also suggested that media activity needed to include Aboriginal and other disadvantaged groups.</td>
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<tr>
<td><strong>Subsidised NRT</strong></td>
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<td>Most groups were very supportive of subsidised NRT with one citing the need for a mix of options for smokers. There was particular support in hospitals and custodial settings. However, one group cautioned against over reliance on the use of NRT and suggests money earmarked for smokers for whom NRT has failed be used for specialist counselling services instead. Another was concerned that providing subsidised NRT could soak up any new resources made available to tobacco control. Two groups pointed out that NRT was cheaper than cigarettes with one suggesting that subsidising it could act as a disincentive to continue to buy cigarettes. There was a concern that there was no indication on how the subsidised NRT would work. A question was posed as to the whether it would be available to all or just high-risk and low income groups.</td>
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<td><strong>Hospital services</strong></td>
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<td>There was support for the three cessation co-ordinators in the major hospitals but it was suggested that they should be linked to district hospitals and community based services and one hospital identified the need for additional resources for education and publicity. One group was unsure what the role of the smoking cessation practitioners would be. There was support for brief advice to stop smoking for patients who smoke in hospitals and fax referrals to Quitline but it was pointed out that there needed to be specialist smoking cessation services with well trained staff for heavy smokers.</td>
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<tr>
<td><strong>Primary healthcare</strong></td>
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<td>It was suggested that routine provision of brief advice during patient consultation with general practitioners was problematic and advised that it should be when it is appropriate.</td>
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<tr>
<td><strong>Smoking cessation services</strong></td>
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| One group asked where the smoking cessation services would be provided and how the access and referral system would work and how this would link into local general practitioners and other health services and suggested that this needed to be spelt out. There was a suggestion that there should be more emphasis on telephone support to youth, support for health workers and a question as to whether Quit calls back mobile phones? There was disappointment expressed by one group that there was no service delivery model recommended and a question around how/when that would happen and a
<table>
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<tr>
<th>Suggestion</th>
<th>Details</th>
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<tr>
<td>Cost benefit analysis</td>
<td>Suggestion that the review should undertake a cost benefit analysis on the recommendations. One person suggested that the distribution of smoking cessation services should be statewide. One group was very supportive of Quitline extending its hours. One group wanted smoking cessation services to be provided in custodial settings.</td>
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<tr>
<td>Extra staff</td>
<td>Extra staff including a smoking cessation co-ordinator was strongly endorsed but it was suggested that the co-ordinator should not be located within ADS. It was considered that the Quitline would require 5FTE. The appointment of a smoking and pregnancy officer and to be located at Quit was supported. The review team was informed that a 0.3FTE Project Officer for Aboriginal Health had recently been employed and this needed to be included.</td>
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<tr>
<td>Fresh Start</td>
<td>It was suggested that courses be run statewide and although providing NRT free of charge would increase participation, it could be the motivation for doing the course. One group would like to see QUIT have sufficient resources to provide Fresh Start groups specifically for Aboriginal groups at least quarterly, in Launceston and Burnie.</td>
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<tr>
<td>Smoking cessation training</td>
<td>Smoking cessation training was supported for health professionals particularly in hospital settings. GPs should not have to be trained but it should be offered to them. One group would have liked to have seen motivational interviewing included in the review.</td>
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<tr>
<td>Funding</td>
<td>Increased resources were suggested for QUIT, including quarterly Fresh Start groups in the north and north-west. Significant funding is needed to improve smoking cessation services. There was concern that the current level of funding for mass media campaigns is inadequate.</td>
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<tr>
<td>National policy</td>
<td>Two groups recommended including a reference to the National Policy in the review.</td>
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<tr>
<td>Other comments</td>
<td>Pharmacies could offer smoking cessation but there are conflicts if NRT is subsidised. Evaluation of future smoking cessation interventions were supported by one group but a suggestion was made that if they were evidence-based then they would not need to be evaluated.</td>
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Appendix 3:
Questionnaire for the Review of Smoking Cessation Interventions in Tasmania

April 2007

Objectives:
1. To identify and analyse smoking cessation services, particularly those provided for people of low socio-economic status and mental illness, young people, pregnant women and Aboriginal people.
2. To seek input into future options for a model of best practice for smoking cessation interventions within Tasmania.

Name:             Position:
Organisation:
Type of organisation:
Size of organisation (number of employees):
Location (South, North or North West):
Date of interview:
Interview method: email

Please tick the boxes that apply to your organisation. Please feel free to return the questionnaire electronically or by fax: +64 (or 001164) 3 442 9236.

1. Does your organisation/service have systems in place to:

☐ Identify patients/clients who smoke?
Record the smoking status of patients/clients?

Provide brief advice on stopping smoking to patients/clients who smoke?

Provide a smoking cessation service for patients/clients who smoke and wish to quit smoking?

Refer patients/clients who smoke and wish to quit smoking to a smoking cessation service?

Comments/Barriers:

2. If your organisation/service does provide or refer patients/clients, who smoke and wish to quit smoking, to a smoking cessation service, does that cessation service offer:

- Pharmacology treatment?
- Behavioural support?

Comments:

3. Does your organisation provide training to staff on the:

- Management of the organisation’s smokefree policy?
- Implementation of systems to support a smokefree policy and smokers who wish to quit smoking?
- Provision of brief advice on stopping smoking?
- Provision of smoking cessation treatment for smokers who wish to quit smoking?
- Referral of smokers, who wish to quit smoking, to a smoking cessation service?

Comments/Barriers:

4. If your organisation/service does not provide or refer patients/clients to a smoking cessation service, what do you think the barriers are?

5. Do you have any suggestions on how existing smoking cessation services could be improved or new smoking cessations services could be established that would be accessible to your patients?

6. Please provide any further information that you think may be useful.
Appendix 4:
Role of the Smoking Cessation Co-ordinator

**Purpose:**
To increase the number of quit attempts made by people who smoke in Tasmania and to reduce the harm caused by smoking.

**Objectives:**
1. Take a leadership and advisory role in the promotion of smoking cessation services and systems.
2. Assist in the development of effective evidence-based smoking cessation services available for people, who smoke particularly the high risk target groups.
3. Assist and oversee the development of a continuum of smoking cessation training that is accessible to health professionals, appropriate non-health and community workers
4. Assist in the development and implementation of smokefree policies and systems in hospitals, the primary healthcare and other appropriate sectors.

**Key stakeholders:**
QUIT Tasmania
Royal Hobart Hospital
Launceston General Hospital
North West Regional Hospital
Aboriginal Health Services
Mental Health and Alcohol and Drug Services
SmokeFree Tasmania
Tobacco Coalition
Primary health care sector
Tertiary education sector

**Key Tasks:**
- Establish a smoking cessation network.
- Work collaboratively and in consultation with key stakeholders in the development of a plan to ensure the broad coverage of evidence-based effective smoking cessation services with the availability of subsidised NRT.
- Develop a smoking cessation training plan for health professionals, appropriate non-health and community workers and to provide oversight and support for the implementation of the plan.
- Work towards ensuring the provision of strong structured smokefree policies and the systems in hospitals and the primary health care sector.
- Liaise closely with hospital and GP division staff, hospital smoking cessation co-ordinators and QUIT Tasmania in the development of systems and provision of an accessible, effective smoking cessation service.
- Link in with the broader smokefree networks in Tasmania to ensure a synchronised strategy in smoking cessation and smokefree.
- Link with undergraduate health and allied health courses to ensure the provision of brief advice and smoking cessation training in the curricula.
- Keep up-to-date with the latest evidence in smoking cessation support and pharmacotherapy.
- Feed information and latest evidence to NGOs to speak out in the media whenever possible.
Appendix 5:
A best practice comprehensive smoking cessation program

A best practice comprehensive smoking cessation program should include major interventions of proven effectiveness, access to proven pharmacotherapy, smoking cessation services for general and specific populations and additional interventions that would support cessation.

Major interventions of proven effectiveness

(1) A national Quitline service – a proactive service with formalised referral system including feedback to the referrer.

(2) Mass media campaigns to promote quitting, a Quitline and subsidised evidence-based pharmacotherapy should be continuous.

(3) Smokefree health care settings and systems for smoking cessation support – All health care settings should: have a smokefree policy that includes the grounds; have systems to ask and record the smoking status of all patients; provide training of all staff on the policy, systems and provision of brief advice to stop smoking; ensure all frontline staff offer brief advice to stop smoking to patients and refer to the health care cessation clinic or onto a smoking cessation service (if referring on, there must be follow up of patients), which may be an individual or group face-to-face or telephone cessation service.

Access to proven pharmacotherapy

(1) Subsidising all evidence-based pharmacotherapy including nicotine replacement therapy (NRT), bupropion, and varenicline for at least twelve weeks for each quit attempt.

(2) Diminishing or removing contra-indications from the outside of NRT packages – A directive should be sent to pharmaceutical companies to standardise key messages and dosing particularly for pregnancy and adolescents, as is underway in the United Kingdom.

Smoking cessation for general and specific populations

(1) General population
  • Individual and group-based multi-session behavioural support and subsidised pharmacotherapy for all people who smoke.

(2) Specific populations
  • Indigenous people – Individual or group-based multi-session behavioural support and subsidised pharmacotherapies that are acceptable to indigenous people who smoke.
  • Women of childbearing age –
    (i) For pregnant women the use of NRT may be considered but it is recommended that a risk benefit assessment be undertaken. Individual and group multi-session behavioural (may consider cognitive behavioural therapy) support.
    (ii) For women of childbearing age who are not pregnant individual or group multi-session behavioural support and subsidised pharmacotherapy.
  • People with mental illness – Intensive individual or group multi-session behavioural support and subsidised pharmacotherapy.
- People with other addictions – Individual or group multi-session behavioural support and subsidised pharmacotherapy.
- People of low socio-economic status – Individual or group multi-session behavioural support and subsidised pharmacotherapy.
- Hospitalised patients - Individual or group based multi-session behavioural support and subsidised pharmacotherapy on discharge, with one month follow up after discharge.
- Workers - Targeting health workers and mental health workers in particular – Individual or group multi-session behavioural support and subsidised pharmacotherapy.
- Repeat quitters – Individual or group multi-session behavioural support and subsidised pharmacotherapy. Time to next quit attempt should not be restricted. May need intensive multi-session behavioural support as they are often highly dependent.

Smoking cessation related services

(1) Train health professionals, appropriate non-health and community workers
- All health professional, appropriate non-health and community workers should be trained in giving brief advice to stop smoking to all patients/clients who smoke, regardless of their expressed readiness to change. The priority should be GPs, nurses, dentists, midwives, mental health, addiction, pharmacists and health workers.
- Whilst different training is required for different groups e.g. primary, secondary, community and specific populations e.g. pregnant women, users of mental health and addiction services etc., core elements and frameworks must be consistent and include pharmacotherapy.
- There should be standardisation around training methods and content, whilst allowing for culturally appropriate training methods and content to be used by indigenous peoples’ training programs.

(2) Undergraduate training on tobacco control and smoking cessation for all medical, nursing, dental, midwifery and other allied health students – There should be a minimum of brief advice to stop smoking training for all undergraduate medical, nursing, dental, midwifery and other allied health students.