A guide to smoking cessation in Scotland 2010

Helping smokers to stop

Brief interventions

Updated 2017

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Taking Action on Smoking and Health

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Professional endorsements
This Guide is endorsed by the Royal College of General Practitioners (RCGP) in Scotland.

Acknowledgements
NHS Health Scotland and ASH Scotland would like to thank colleagues within their respective organisations, ISD and NES for their advice and help in clarifying aspects of the contents of this guide; Professors Linda Bauld and Robert West in particular for clarifying aspects of the evidence during the preparation of this document; the Substance Misuse Advisory Group of RCGP (Scotland) and the UK Department of Health in providing comment; smoking cessation coordinators and practitioners in Scotland who provided case studies and feedback on the document during its development; and the Reference Group, involving representation from the Scottish Government, NHS Health Scotland, ASH Scotland and Smoking Cessation Coordinators, who provided feedback on the minor editorial update.

Statement of competing interests
Dr John Bery has received honoraria for chairing and speaking at meetings and consultancy work, and travel funds and hospitality, from manufacturers of smoking cessation products.

Published by NHS Health Scotland

Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

A minor editorial update has been undertaken in 2017 to retain the future-proof aspect of the Guide's components.

NHS Health Scotland is a WHO Collaborating Centre for Health Promotion and Public Health Development, www.healthscotland.scot

Action on Smoking and Health Scotland (ASH Scotland) is a registered Scottish charity (SC010412), www.ashscotland.org.uk

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Why read *Helping smokers to stop*?

Helping smokers to stop, and the *Brief interventions flowchart* which has been updated in 2017 to incorporate harm reduction and e-cigarettes, is a guide for everyone working in health and health-related (e.g. social care and other community and voluntary) settings and for people who work with smokers, to help them encourage smokers to stop through the provision of opportunistic advice, often referred to as 'brief interventions'.

It provides evidence-informed advice on using brief interventions to encourage smokers to think about quitting and to help them stop. The advice is based on the best evidence currently available, including National Institute for Health and Clinical Excellence (NICE) guidance which has been rigorously quality assured – such guidance provides the basis for the 'Recommendation' sections in this document. Other 'good practice' recommendations, which are not taken from NICE and similar highly quality assured evidence sources, are designated as such. This guide aims to make sure that everyone who has the opportunity to work with smokers to help them quit has access to up-to-date advice on how best to do so in one document with its accompanying flowchart.

Helping smokers to stop is aimed at a wide range of health and health-related practitioners, all of whom can help to reduce the number of people smoking by taking the opportunity to encourage any smokers they meet day-to-day to try to stop. ***All* health and health-related staff should raise the issue of stopping smoking in their day-to-day work with patients and clients and, where appropriate, refer them on to local services to help them stop.**

Many professional groups are well placed to help smokers to stop by targeting and delivering support to particular population groups, by offering brief interventions and referral on to services for intensive support, and potentially through the provision of pharmacotherapy, as appropriate, in line with local prescribing protocols, including:

- **Dentistry** (due to the large proportion of the population who visit a dentist for regular check-ups, including key groups such as teenagers and pregnant women).
- **Pharmacies** (due to their potential to offer an accessible and flexible option, thereby reaching large numbers of smokers). In addition to pharmacies which offer standard, brief intervention support, a national community pharmacy scheme offering intensive support has been in place since 2008; details are available in Appendix B.
- **Midwifery staff** (due to their ability to monitor smoking status at appointments, and offer non-judgemental smoking cessation advice and support throughout the pregnancy and at the postnatal appointment).
- **Primary and secondary care staff** (due to their potential to identify and record the tobacco use of their patients, remind smokers at every suitable opportunity of the health benefits of stopping, and ability to prescribe pharmacotherapies, although see pages 17–21 onwards for specific detail and guidance around this).

The first few pages of *Helping smokers to stop* (especially pages 7–10) give a brief summary of the key points contained in the document. This is intended to give practitioners an easy introduction to the best way to provide a brief intervention and a quick refresher guide for those already experienced in providing brief interventions.

However, before providing brief interventions, we recommend that most practitioners should take the time to read the whole document, particularly those pages which describe a brief intervention in more detail and give guidance on the prescription or provision and use of different pharmacotherapies.

Contents

Introduction

A guide to smoking cessation in Scotland 2010, lightly refreshed 2017, comprises this document (*Helping smokers to stop*), a *Brief interventions flowchart, Planning and providing specialist smoking cessation services, Tobacco harm reduction* and a *revised definition of smoking cessation services*. The guide is intended to steer NHS policy and practice around smoking cessation by bringing together up-to-date, evidence-informed advice on helping people to stop smoking.

The 2010 guide, lightly refreshed 2017, replaces the 2004[1] and 2007[2] *Updates* of the *Smoking Cessation Guidelines for Scotland*. It provides a summary of evidence and information on smoking cessation, for each of two groups of professionals:

- All health and health-related (e.g. social care, community, voluntary or private sector) practitioners who are not specialists in smoking cessation but who have regular opportunities to advise people to stop smoking through the provision of brief interventions (***Helping smokers to stop*** and the ***Brief interventions flowchart***).
- Smoking cessation specialists (also known as specialist smoking cessation advisers) and other providers of intensive smoking cessation support (e.g. pharmacists involved in the national pharmacy scheme) and smoking cessation coordinators and service planners in NHS Boards and/or health and social care joint integration boards, through the provision of specialist/intensive support or service planning (***Planning and providing specialist smoking cessation services, Tobacco harm reduction* and a *revised definition of smoking cessation services***).

Helping smokers to stop

Advice, normally called brief interventions, provided to smokers when they are in contact with health practitioners for another reason, can be an important part of a smoker's 'journey' to stopping smoking. *Helping smokers to stop*, and its accompanying *Brief interventions flowchart*, provides up-to-date, evidence-informed advice on helping people to stop smoking through brief interventions. The advice in this guide is generally derived from a few key source publications (overleaf), including NICE guidance. **It is not intended to provide new recommendations**. It aims to make sure that everyone who has the opportunity to work with smokers to help them quit, has access to up-to-date advice on how best to do so. *Helping smokers to stop* should be used by the following:

- GPs, pharmacy staff providing basic standard support (i.e. those who provide support outwith the National Pharmacy Smoking Cessation Service scheme standards – those involved in the national pharmacy scheme should instead use *Planning and providing specialist smoking cessation services*), dentistry staff, midwifery staff, hospital staff, primary care staff, nursing staff, health care assistants, support workers, and other health professionals.

- Any other group with a part to play in helping smokers to quit smoking (whether in the NHS, local authorities or the community/voluntary/private sector, with some of the latter groups having an increasing public health role through their first-line contact with smokers).

Terminology

Although the terms 'smoking' and 'smoker' are used throughout this text, the encouragement to stop also applies to other forms of tobacco use.

Key source material for *Helping smokers to stop*

All recommendations in *Helping smokers to stop* are drawn from (or adapted or inferred from) one or more of the following evidence-informed resources:

1. *Smoking Cessation Guidelines for Scotland: 2004 Update* (NHS Health Scotland and ASH Scotland, 2005)[1].
2. *Smoking Cessation Update 2007: Supplement to the 2004 Smoking Cessation Guidelines for Scotland* (NHS Health Scotland and ASH Scotland, 2007)[2].
3. *NHS Health Scotland Commentary on NICE Public Health Intervention Guidance no.1 – Brief interventions and referral for smoking cessation in primary care and other settings* (NHS Health Scotland, 2007)[3].
4. *NICE Public Health Guidance 10 – Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard-to-reach communities* (National Institute for Health and Clinical Excellence, 2008)[4].
5. *NICE Public Health Guidance 26 – How to stop smoking in pregnancy and following childbirth* (National Institute for Health and Clinical Excellence, 2010)[5].

The pieces of NICE guidance have been reviewed at regular intervals, usually every 2–3 years, and updated if/as required. Further details on these sources are available in Appendix A. In the minor editorial update, some recommendations from NICE public health guidance 48 have also been incorporated where appropriate, particularly in the section for hospital patients. NICE guidance on smoking cessation interventions and services is scheduled for completion in November 2017.

Case studies for *Helping smokers to stop*

Case studies illustrate how the evidence and recommendations have been implemented in practice, for example to make the prescribing process seamless and smoking cessation support in hospital integral to patient care. The examples are longstanding and, in some instances, have been superseded by and embedded into national developments as part of all Boards' services.

Why encourage smokers to stop?

The health impacts of smoking are well-established[6]. In addition, exposure to second-hand smoke (passive smoking) can affect non-smokers' health, for example through exacerbating respiratory symptoms and triggering asthma attacks, and increasing the risk of lung cancer, respiratory illnesses (such as asthma), heart disease and stroke[7–9]. Exposure to second-hand smoke during pregnancy can cause fetal growth impairment and increased risk of pre-term birth[10].

The evidence is strong and consistent on the health benefits of sustained smoking cessation[11], and both recent[12] and long-term[13] evidence is incorporated into the table below. Stopping smoking reduces the risk of many of the conditions associated with smoking. For some conditions, the risk drops soon after quitting towards the level of a never-smoker, but for others, elevated risk remains for more than 20 years. However, smoking cessation always carries some, often significant, health benefit. Risk depends on the previous duration and intensity of smoking, and varies between those with and without pre-existing evidence of disease, and therefore it is advisable to promote smoking cessation as soon as possible rather than after smoking-related disease has set in[11].

Benefits of smoking cessation within short-term of having quit[12, 14-16*]

Benefits within days:

- Heart rate drops.
- Carbon monoxide and oxygen levels in blood return to normal (similar to those of never-smokers).
- Senses of taste and smell sharpen.

Benefits within weeks:

- Risk of sudden death from cardiac event/heart attack begins to reduce.
- Decline in lung function slows down; lung function begins to improve.
- Reduced rates of post-operative complications.
- Reduced incidence of respiratory infections; coughing and shortness of breath decreases.
- Reduced severity of asthma attacks.
- Improved complexion.
- Reduced risk of complications during pregnancy.
- Reduced risk of low birthweight in infants; low birthweight baby risk drops to normal (if quit occurs before pregnancy or during first trimester).

* Evidence has been adapted from these sources.

Benefits within a few months:

- Symptoms of chronic bronchitis (cough, phlegm, wheezing, shortness of breath) improve.
- Ulcer risk drops (gastric and duodenal) – improved short-term healing and reduced recurrence.

Benefits within a year of having quit:

- Reduced risk of cardiovascular and respiratory disease, i.e. slows progression of heart or respiratory disease and reduces risk of it recurring (e.g. coronary heart disease (CHD) risk is cut by half one year after quitting).
- Mild/moderate chronic obstructive pulmonary disease (COPD) sufferers: improvement in lung function.

Benefits of smoking cessation over medium- and longer-term of having quit [12, 14-16*]

Benefits after several years (five years or less) of having quit:

- People without CHD: substantial reduction in CHD risk compared with persistent smokers (two–four years).
- People with CHD: approx. 35% reduction in risk of re-infarction or death (two–four years).
- Decline in lung function with age slows to that of never-smokers (within five years).
- Cervical cancer risk falls to that of never-smokers (five years).

Being quit in the longer-term reduces the risk of:

- Lung cancer.
- Other cancers (compared with continuing smokers): e.g. mouth, throat, oesophagus (squamous cell rather than adenocarcinoma) and oral cancer, bladder, kidney, pancreas, urinary tract, stomach, and larynx.
- COPD: risk of death is reduced after quitting.
- Cardiovascular disease including stroke/cerebrovascular disease, CHD and peripheral artery disease.

Further information: Information and literature – health education resources

- **Smokeline:** Telephone: 0800 848484
  LanguageLine facility is available through this service for clients whose first language is not English. Textphone number: 18001 0800 84 84 84
  BSL users contact SCOTLAND-BSL
- Further information on the Smokeline service and smoking cessation: www.nhsinform.scot/healthy-living/stopping-smoking
- Limited quantities of literature for clients, and a DVD providing further detail about smoking cessation services and what to expect from them, can be obtained from the local NHS Board area's health promotion and resource library.
- ASH Scotland Information Service's free enquiry service: enquiries@ashscotland.org.uk

* Evidence has been adapted from these sources.

Summary of key principles and recommendations

Brief interventions

All **smokers should be:**

- asked how interested they are in quitting (and advice should be sensitive to the individual's preferences, needs and circumstances)
- advised and encouraged to quit (*advice may be linked to the disease/medical condition), *reminded of the benefits of quitting, offered help to do so (unless there are exceptional circumstances), and encouraged to use services
- advised of the dangers (to themselves and others) of exposure to second-hand smoke
- *have smoking status reviewed and recorded, preferably electronically, and with smooth recording and referral systems in place for recording and maintaining smoking status records and prompting action and referral to smoking cessation services as required and enabling continuity of care between services.

Smokers who are *not* ready to quit:

- should be asked to consider quitting and be encouraged to come back to seek help in the future
- should be offered brief advice (including any relevant health promotion material).

Smokers who *are* ready to quit:

- should be offered a referral to an intensive smoking cessation service (e.g. an NHS smoking cessation service or pharmacy engaging in the national pharmacy scheme)
- *if a referral is not accepted, should be offered advice to stop smoking and advised to attend services, and offered access to pharmacotherapy if/as appropriate, plus additional support.

*These should be offered and available from healthcare professionals in particular.

In using the term 'brief intervention', this guide uses the following definition, drawn from two of the key sources[3,4] listed earlier:

Opportunistic advice, discussion, negotiation or encouragement, and referral to more intensive treatment where appropriate. These brief interventions are commonly used in many areas of health promotion and are delivered by a range of primary and community care professionals.

For smoking cessation, brief interventions typically take between five and ten minutes and may include the following:

- Simple opportunistic advice to stop.
- An assessment of the patient's commitment to quit.
- An offer of pharmacotherapy and/or behavioural support.
- Provision of self-help material.
- Referral to more intensive support such as the NHS smoking cessation (stop smoking) services.

Although in both practice and research, the terms 'brief advice' and 'brief intervention' can vary in terms of duration and content referred to, and additionally the terms are often used interchangeably, this guide adopts the term 'brief intervention' and its definition as described above, and recommends that practitioners deliver brief interventions in line with that definition. However, it recognises that some practitioners/staff (including ancillary staff, healthcare assistants, receptionists and administrative staff) will only ever be able to offer a shorter version of the intervention, and that sometimes other practitioners/staff who would normally offer a five to ten minute brief intervention will only be able to offer a shorter version due to time constraints. If time does not allow a brief intervention as described previously or in the *Brief interventions flowchart*, benefits will still be gained from asking a patient or client:

- if they smoke, and
- if they do:
  - have they ever thought about the impact of smoking on their health?
  - would they consider stopping smoking?
  - if they would like to stop, would they like to be put in touch with local services to help them or be given details of such services?

Definition of 'specialist smoking cessation services'

It may be helpful for practitioners who are not familiar with smoking cessation services to understand what those specialised services offer. A definition of these specialist/intensive services is provided in and signposted to from Appendix B.

This summary description of a brief intervention is provided so that practitioners have an easy reference to introduce them to brief interventions, and to provide a quick refresher for those already undertaking brief interventions. It is not a full description of the process, and practitioners are strongly recommended to refer to the fuller description of a brief intervention on page 12.

Using pharmacotherapy

In Scotland, pharmacotherapy for smoking cessation means the use of nicotine replacement therapy (NRT), bupropion (trade name Zyban®) or varenicline (trade name Champix®) to help reduce the severity of symptoms experienced by individuals stopping smoking.

Available evidence suggests that pharmacotherapy is most effective when combined with intensive smoking cessation support (for example from an NHS smoking cessation service).* That is why, in Scotland, a strong emphasis has been placed on NHS smoking cessation services and why it has generally been recommended to prescribe pharmacotherapy within the context of (i.e. within or in conjunction with) such services. However, should the patient/client be committed and motivated to stop but unwilling or unable to accept such a referral, it is still effective and cost-effective to prescribe pharmacotherapies to smokers who want to quit in conjunction with brief intervention support. Details are available on pages 17–19 of this document.

What are the pharmacotherapy products?

Nicotine replacement therapy (NRT) delivers nicotine to the body but in smaller quantities than involved in smoking and without the 4,000 other chemicals present in tobacco smoke. There are eight formats of NRT products and all have similar effectiveness. Thus the choice between them for the client/patient can often be one of personal and practical preference:

Patch – discreet and easiest to use.
Gum – allows good control of nicotine dose.
Sprays (nasal and oral) – reportedly good for very addicted smokers due to fast delivery of nicotine.
Sublingual tablet – discreet, flexible, good dose control.
Lozenge – discreet, flexible, good dose control.
Strips (oral) – discreet, flexible, good dose control.
Inhalator – good if smoker misses the ritual of smoking.

Combination/dual NRT – NRT formats can be used in combination, which enhances their effectiveness, with patch and another form the most common combination.

Regardless of the format used, normal practice is for the patient/client to start using it on the quit date and to continue use for approximately 12 weeks, although this varies according to manufacturer/brand, format and stage in the quitting process.

Bupropion (Zyban®) is a prescription-only medicine that comes as a tablet. It was originally developed as an anti-depressant but is licensed in the UK only for smoking cessation. It does not contain nicotine and the way it helps smokers stop is not fully understood. It is started one–two weeks before a person's target date for stopping smoking, and the dose is built up initially. A typical course lasts seven–eight weeks although it is prescribed in supplies of approximately four weeks, and in line with the recommendations on pages 17–18.

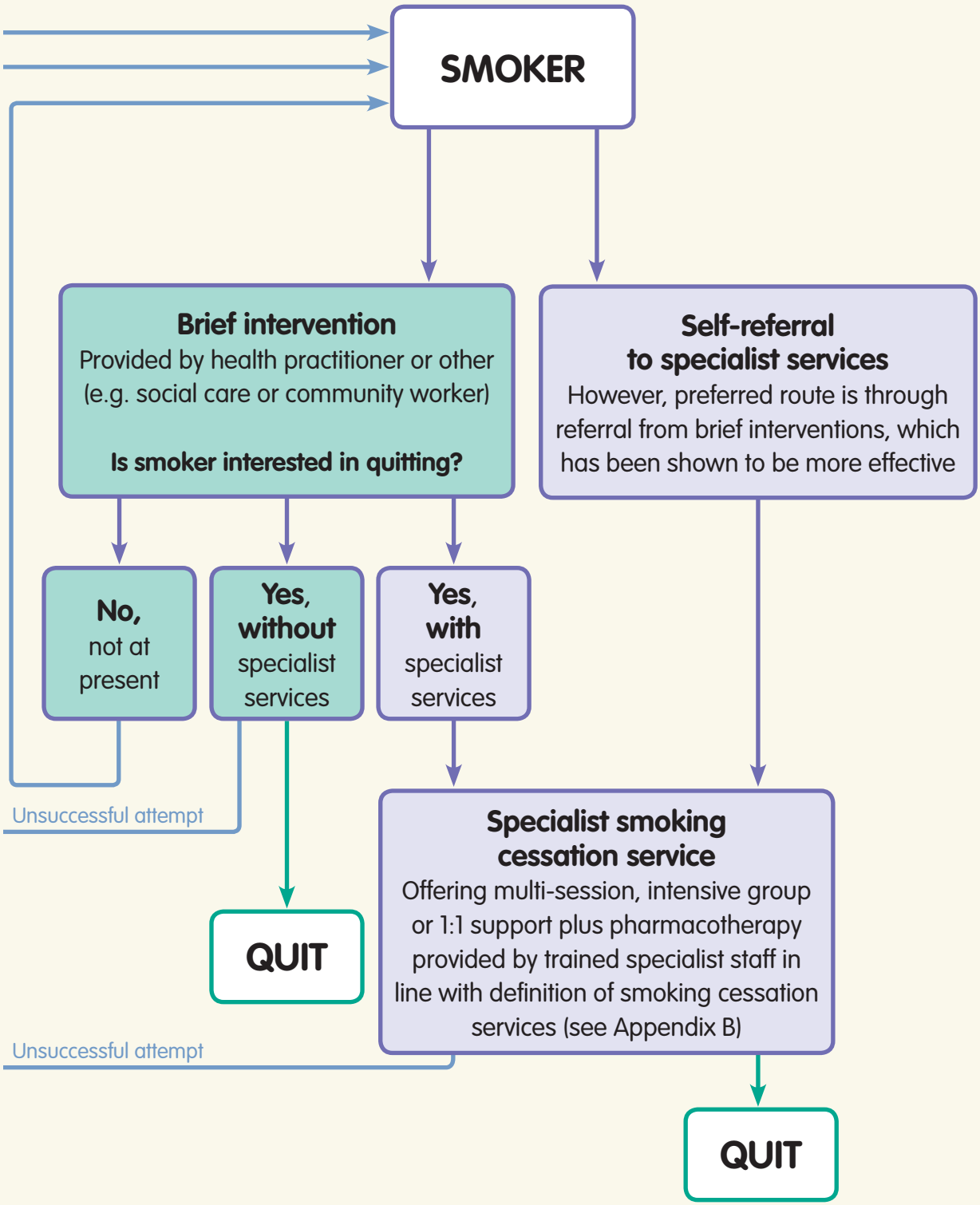
*Inferred from key source material, and additional expert advice.

Varenicline (Champix®) is a prescription-only medicine. It comes as a tablet and does not contain nicotine. It has been specifically developed to help people quit smoking. It is thought to work by reducing cravings and withdrawal symptoms. It is started one–two weeks before a person's target date for stopping smoking. The dose is built up over the first week and the usual course of treatment is 12 weeks. Treatment may be repeated in people who manage to stop smoking, to reduce the risk of relapse, although the benefits of extended/repeated treatment seem to be relatively small.

This description of the products is provided as an easy reference for practitioners to help them give information to patients or clients about the different products available to support a quit attempt. However, it is not a full description of the products or their use, and practitioners must refer to pages 17–20 before recommending or prescribing particular products.

As noted on page 1, the focus of the Guide is on robust, highly processed, quality assured evidence which provides the basis for the Recommendation sections. E-cigarettes, and other products or combinations of products which have not been included in NICE recommendations, are therefore not covered in this section or indeed in this component of the Guide. Additionally, e-cigarettes are not a licensed smoking cessation medication and cannot be prescribed on the NHS. See www.healthscotland.scot/publications/a-guide-to-smoking-cessation-in-scotland for the *Brief interventions flowchart* for practitioners, accompanying e-cigarettes and harm reduction brief intervention information, and the *Tobacco harm reduction* component.

Figure 1: A pathway for smokers quitting through NHSScotland smoking cessation services*



Developed by *A guide to smoking cessation in Scotland 2010* Working Group, 2009

*See Appendix B for definition of specialist/intensive services.
For those not interested in quitting (i.e. unable/unwilling to quit) but who may be interested in and offered harm reduction options, the same pathway applies – see also *Brief interventions flowchart* for practitioners.

Brief interventions: general principles and recommendations

Brief interventions can generate or trigger quit attempts and provide motivation to quit, or encourage more smokers to think about quitting over the long-term, by encouraging smokers to consider the risks of smoking and the benefits of stopping. Therefore, in such cases, brief interventions are an important part of a smoker's pathway to stopping smoking (as shown on page 11).

Available evidence continues to suggest that the most effective smoking cessation approach is a combination of intensive support and pharmacotherapy.* That has been the reason for placing a strong emphasis in Scotland on NHS smoking cessation services.

Brief interventions by non-specialist staff (who have not been trained to deliver specialist smoking cessation support and who are not employed for that purpose) are effective in triggering quit attempts and encouraging smokers to use the smoking cessation services **but are not a substitute for those services**[1].

What do brief interventions involve?

A brief intervention to stop smoking involves seizing opportunities that arise around other contact with patients and clients to advise smokers to stop and to recommend support to help them do so – normally this will be NHS specialist smoking cessation services. More specifically, it consists of a health professional (or other health or social care worker):

- raising the topic of smoking with a patient or client on a regular basis, for example through asking about and recording smoking status
- assessing their willingness and commitment to quit
- advising them regularly to stop smoking and of the benefits of doing so
- offering support, encouragement, information and follow-up and/or referral to more intensive support through the local NHS smoking cessation services.

Roles which can be played in smoking cessation, value of brief interventions, and integration of smoking cessation activity

Health practitioners can contribute to smoking cessation by providing brief interventions – they are, or have the potential to be, a vital source of referrals to smoking cessation services as well as of triggering quit attempts through their wider reach. As brief interventions are effective in triggering new quit attempts, they are an essential element in efforts to increase the number of people who quit smoking.

*Inferred from key source material, and additional expert advice.

Specialist smoking cessation services, which increase the rate at which quit attempts are made and improve the success rate of quit attempts, should not be seen in isolation from other smoking cessation activity such as the provision of brief interventions. A definition of a specialist/intensive smoking cessation service is available in Appendix B.

As far as possible, specialist services and wider smoking cessation activity should be closely integrated.

Recommendations for 'brief interventions'

As a general rule, anyone who could provide a brief intervention should:

- *ask at appropriate times about, and have ready access to information on, the patient's/client's current smoking status and tobacco use, and the most recent occasion on which advice to stop was given (and the nature of that advice and the response to it)
- advise and encourage all current smokers to quit *when they attend an appointment/ consultation, and offer them help to do so (unless there are exceptional circumstances, e.g. occasionally it might be judged inappropriate to do so because of a presenting medical condition or other personal circumstances)
- include advice on the dangers of exposure to second-hand smoke and a reminder at every suitable opportunity on the benefits of quitting
- offer advice to stop smoking that is sensitive to the individual's preferences, needs and circumstances (but note that there is no evidence that the 'stages of change' model is more effective than any other approach)
- *if a smoker presents with a smoking-related disease, the advice to stop smoking and the benefits of quitting may be linked to their medical condition
- for current smokers, find out how interested they are in quitting
- have contact with the intensive/specialist smoking cessation services to which they can refer smokers.

*These actions are targeted at health professionals in particular.

For smokers who are *not* ready to quit, healthcare professionals should:

- ask them to consider quitting and encourage them to seek help in the future
- provide any relevant health promotional material, including that which may be linked to a patient's/client's presenting condition
- record/document their smoking and tobacco use status where appropriate, and review with the individual once a year and/or when appropriate.

For smokers who *do* want to stop, healthcare professionals should:

- offer a referral to an intensive/specialist support service (for example, an NHS smoking cessation service, or support provided by the national pharmacy scheme); those who have had accredited training to provide intensive smoking cessation support may 'refer' to themselves, where appropriate
- if a referral is not accepted, offer:
  - advice, encouragement and support to stop smoking and to attend services
  - **access to pharmacotherapy if/as appropriate by practitioners with suitable training
  - additional support such as:
    - review or telephone contact by the GP
    - details of the Smokeline service (0800 848484 and www.nhsinform.scot/smoking) and further information on smoking cessation (www.nhsinform.scot/healthy-living/stopping-smoking)
    - available support materials
    - basic, standard pharmacy-based support (i.e. those who provide support outwith the National Pharmacy Smoking Cessation Service scheme, and therefore which is less intensive than the national pharmacy scheme).

**In line with the 'Good practice' section on page 19 of this resource.

Community workers/practitioners working outside the health sector who have a remit for smoking cessation (and which could include those working in addiction services, voluntary or community organisations, or social work) should:

- offer to refer people who smoke to an intensive support service (for example, an NHS smoking cessation service) – workers/practitioners who are trained to provide intensive smoking cessation support may 'refer' to themselves.

Evidence for brief interventions

Brief interventions to help patients stop smoking are very cost-effective and effective. Sustained and systematic brief intervention delivery produces a 'dripping tap' effect to each patient or client (gradually moving or 'nudging' them towards the point where they are ready to quit) and also produces a cumulative effect (promoting more quit attempts to be made in the population). While the effectiveness of brief interventions might appear small in percentage or absolute terms*, the *cumulative* public health effect can be significant due to the frequency with which individuals have contact with health or social care staff and therefore the associated potential for reaching large numbers of smokers in the population over time. In addition, those who are medically referred to smoking cessation services are more likely to be successful than self-referrals[17]. Brief interventions thereby have the potential to make a large contribution to reducing smoking rates.

* http://tobacco.cochrane.org/evidence

The terms 'brief advice' and 'brief intervention' have often been used interchangeably, and indeed the evidence for this level of support does not make a distinction between the definitions or between the length of support offered and the respective outcome success. Detailed information on the effectiveness of brief interventions is available from NICE[18]. The recommendations in this document apply to all smokers rather than specific recommendations for particular groups. This is because there are gaps in the evidence in terms of the effectiveness of brief interventions with particular population groups, in particular settings. However, in some cases more specific detail is available for particular population groups or settings where pharmacotherapy information is specific to that group or setting (e.g. clinical prescribing guidance for pregnant women) or because subsequent NICE guidance (www.nice.org.uk/PH10, www.nice.org.uk/PH48 and www.nice.org.uk/PH39) has up-to-date and specific evidence and recommendations for those groups or settings. Where this type of detail is available, it is described in this document.

Cost-effectiveness and numbers needed to treat (NNTs)

The numbers needed to treat (NNTs – a measure of the total number of patients who need to be treated to ensure at least one of those patients has a positive outcome) in order to achieve a long-term quitter compare very favourably with other interventions that are routinely delivered in primary care. Although the timescales for these NNTs are very different, smoking cessation interventions compare very well with other routine medical interventions, as indicated in Figure 2 below. Evidence-based smoking cessation interventions, and even a short brief intervention, also represent excellent value for money.

Figure 2: Comparison of effectiveness of a brief intervention versus other treatment[19*]

Intervention	Outcome	Numbers needed to treat
Statins	Prevent one death over 5 years	107
Antihypertensive therapy	Prevent one stroke, myocardial infarction, death over 1 year	700
Cervical cancer screening	Prevent one death over 10 years	1,140
GP brief advice to stop smoking (< 5 minutes)	Prevent one premature death	80
Add pharmacological support	Prevent one premature death	38–56
Add behavioural support	Prevent one premature death	16–40

* Evidence has been adapted from this source.

Figure 2 shows that brief advice, in this case provided by a GP, compares favourably with other preventative interventions in terms of number needed to prevent one undesirable health outcome. However, as much of the research was conducted before current smoking cessation services were created, it might be expected that more smokers can be encouraged to use services and therefore the effect of advice will be greater.

Specifically, in terms of cost-effectiveness, analyses undertaken to inform the NICE guidance[20] found brief interventions to be cost-effective and that they can generate quality-adjusted life years (QALYs) at a low cost. The cost per QALY tends to increase as the patient's age increases, but brief interventions delivered to a 60-year-old cohort are still cost-effective. Detailed information on cost-effectiveness of brief interventions (including by type of brief intervention, provider type and setting) is available from NICE (https://www.nice.org.uk/Guidance/PH1); however, there is insufficient evidence to compare types of brief intervention in different settings and for different population groups, or to assess the cost-effectiveness of brief interventions with referral[20, 21].

Cost effectiveness analyses, and associated sensitivity analyses, can vary depending upon quit rate assumptions, length of intervention, age of individual, and level of dependency[3].

Brief interventions conducted by GPs and nurses, in all settings, to all age-groups, and with all supplementary aids (e.g. self-help material, provision of quitline number and NRT) are cost-effective. Figure 3 shows the cost-effectiveness of brief intervention smoking cessation support for a cohort of 50-year-old males and females. The incremental cost-effectiveness ratios are well below NICE's lower £20,000 per QALY benchmark[22].

Figure 3: Summary of cost-effectiveness of brief interventions – Cost per QALY based on 50-year-old cohort (treatment cost perspective)[22]

Cost per QALY*		
Intervention	**Male**	**Female**
Brief, opportunistic advice from a GP (5mins)	£829	£845
Brief, opportunistic advice from a GP (5mins) and advice to use NRT	£2390	£2435
Brief advice from a practice nurse in a primary care setting (30mins) (0.5-3% above control)	£575–£3448	£586–£3514
Brief advice from a staff nurse in a hospital setting (30mins) (0.5-3% above control)	£258–£1548	£263–£1578

*Incremental cost/QALY over and above control.

Pharmacotherapy: general principles and recommendations

In Scotland, pharmacotherapy in the context of smoking cessation refers to the provision of nicotine replacement therapy (NRT), bupropion (trade name Zyban®) or varenicline (trade name Champix®) to help reduce the severity of physiological and psychological symptoms experienced by individuals quitting smoking.

This section is a guide for those who wish to know more about the pharmacotherapies provided through specialist smoking cessation support or who may be able to provide a prescription of pharmacotherapy alongside a brief intervention. (This may be because they are providing a brief intervention to a patient/client who is committed and motivated to stop but who specifies that they do not wish to attend or are unable to accept a referral for specialist smoking cessation services, or to a patient who is undergoing an enforced quit in hospital). For that reason, this section should be read in conjunction with the 'Good practice' section on page 19 and should also take into account the section on recommendations regarding pharmacotherapy for specific population groups.

This section provides an introduction to, and recommendations for, the general principles of pharmacotherapy in smoking cessation, not detailed individual product guidance or issues on safety. Links to detailed and up-to-date guidance on dosage, contra-indications, cautions, safety updates, and new products licensed for smoking cessation, can be found from the sources listed on page 20.

Available evidence suggests that pharmacotherapy is most effective when combined with intensive smoking cessation support (for example from an NHS smoking cessation service).[1–4*] That has been the reason for placing a strong emphasis in Scotland on NHS smoking cessation services and generally for encouraging prescribing only within the context of such services.

Recommendations for pharmacotherapy

- NRT, varenicline or bupropion should normally be prescribed at the setting of a quit date, and as part of an 'abstinent-contingent' treatment in which the smoker makes a commitment to stop smoking on or before their target quit date. If prescribed, it should be offered in conjunction with advice, encouragement and support, plus referral or strong encouragement to attend specialist smoking cessation services.
- Some types of NRT products are licensed for use in circumstances where smokers wish to 'cut down to quit'. This is one of several harm reduction approaches for those unable/unwilling to quit by conventional smoking cessation approaches – see *Brief interventions flowchart* for practitioners (accompanies this component) and also *Tobacco harm reduction* (accompanies *Planning and providing specialist smoking cessation services*) which provides detail of licensed smoking cessation products for this approach, for short-term or long-term temporary abstinence purposes, and for long-term use for former smokers to remain quit. In order to improve the evidence base, such an approach should be evaluated thoroughly. Further guidance and details are available in NICE guidance for tobacco harm reduction approaches at www.nice.org.uk/PH45

*Evidence has been inferred from these sources and additional expert advice.

- A prescription of NRT, varenicline or bupropion should be sufficient to last only until two weeks after the target quit date. Normally, this will mean two weeks of NRT and three–four weeks for varenicline or bupropion. Subsequent prescriptions should be given only to people who show on re-assessment that their quit attempt is continuing (abstinent-contingent).
- If a smoker's attempt to quit is unsuccessful using NRT, varenicline or bupropion, a repeat prescription should not be offered within six months unless specific circumstances have been identified that have hampered the person's initial attempt to stop smoking, in which case it may be reasonable to try again sooner. However, see *Good practice: Repeat prescribing* box below for further information on suitable items for discussion with a smoker to help them reach a suitable decision on when to try again.
- Bupropion is a prescription-only drug which was licensed for use in the UK for smoking cessation with motivational support, in those aged 18 years and over. Varenicline is another prescription-only medication which was accepted by the Scottish Medicines Consortium (SMC) for use within NHSScotland for smoking cessation in those over 18 years of age **only as a component of a smoking cessation programme**. Although NICE guidance does advise that these products, and NRT, can be prescribed with brief intervention support, the evidence is strongly in favour of their prescription in conjunction with intensive support, such as that offered through a specialist smoking cessation service.
- Varenicline or bupropion may be offered to people with unstable cardiovascular disorders (and by implication, those with stable cardiovascular disorders), subject to clinical judgement.
- **Neither varenicline nor bupropion should be used by young people under 18, or by pregnant or breastfeeding women.**
- If NRT is being considered for young people aged from 12 to 17; pregnant or breastfeeding women; or people who have unstable cardiovascular disorders, the risks and benefits should be explained. To maximise the benefits of NRT, people in these groups should also be strongly encouraged to use specialised behavioural support in their quit attempt.
- **Different types of NRT may be given in combination** (usually nicotine patches and another form, such as gum, inhalator, lozenge, sublingual tablet/microtab, oral or nasal spray, oral strips) to people who show a high level of dependence on nicotine or who have found single forms of NRT inadequate in the past. **However, only one single type of pharmacotherapy should be used at one time: NRT, bupropion or varenicline should not be used together in any combination**.
- Unless there are contraindications or cautions, one medication should not be favoured over another. When deciding which therapies to use and when, the options should be discussed with the client or patient before choosing the one that seems most likely to succeed, taking account of:
  - whether a first offer of referral to an NHS smoking cessation service has been made
  - contraindications and the potential for adverse effects (note: practitioners and prescribers need to maintain an up-to-date knowledge and awareness of any medical conditions and potential for drug interactions in connection with the pharmacotherapies, and refer to the GP if/as appropriate)
  - the client's personal preferences
  - the availability of appropriate behavioural support
  - the likelihood that the client will follow the course of treatment
  - the client's previous experience of smoking cessation aids.

Good practice: If prescribing outwith specialist smoking cessation services

As highlighted on the previous page, in order to give the patient/client the best possible chance of a successful quit outcome and to maximise the long-term success of the quit attempt, the evidence points towards pharmacotherapy prescribing generally only being encouraged in conjunction with intensive smoking cessation support provided through specialist smoking cessation support services. Prescribers are therefore encouraged not to prescribe unless the patient has already engaged, and set a quit date, with the services and therefore a protocol or dispensing procedure is in place in conjunction with the services for issuing and collection of prescriptions and repeat prescriptions.

However, in the course of providing a brief intervention, if a client is willing and motivated to quit* but is unwilling or unable to accept a referral to specialist smoking cessation services (including to pharmacies involved in the national pharmacy scheme), a decision to offer pharmacotherapy support outwith the intensive support service should take into account the following:

- Prescribing guidelines around smoking cessation (including suitability for the patient/client, and taking due account of any relevant contraindications and cautions) as outlined above and from the sources of further information cited.
- The likelihood of the patient/client following the course of treatment, bearing in mind the likelihood of compliance being maximised if attending specialist services where additional monitoring of the patient/client and their use of pharmacotherapy can take place (the latter is particularly important in the case of new drugs for smoking cessation).
- The effectiveness and cost-effectiveness evidence that the optimal form of support for a long-term successful quit is pharmacotherapy in conjunction with specialist smoking cessation support (but balancing this against the evidence, especially the quantity of evidence regarding NRT, that pharmacotherapy in conjunction with brief intervention support is more effective than either brief intervention support on its own or a quit attempt without brief intervention support, and additionally bearing in mind the benefits of minimising disease progression, e.g. among cardiovascular and respiratory patients and hospital patients).
- That prescriptions should only be issued contingent on a quit date being set, and repeat prescriptions contingent on a continuing quit attempt (with the smoker remaining quit), and therefore the need to review the patient's/client's progress face-to-face in advance of them reaching the end of their prescription supply.

Continuing smoking carries many health risks, both short-term and long-term. Pharmacotherapies have a variety of side effects in some subjects, but the prescriber should always balance the risks of continuing smoking against the potential benefits and risks of the pharmacotherapy being considered.

*One rationale for assessing a patient's/client's motivation and willingness to quit is to ensure that pharmacotherapy, if prescribed with brief intervention support only, is only supplied to those motivated to quit (to minimise the risk of a failed quit attempt which may impact on the smoker's future motivation and therefore outcome when undertaking a quit attempt); the exception to this would be in the case of hospital patients in which NRT may be prescribed for an enforced quit due to unplanned hospital admission irrespective of their desire to quit.

Good practice: Repeat prescribing

If a smoker's attempt to quit is unsuccessful using NRT, varenicline or bupropion, the following should be discussed with the smoker to help them reach a suitable decision on when to try again: pausing for several months, to renew motivation and determination to succeed before making another quit attempt, increases the likelihood of successfully quitting; if the smoker wishes to make another quit attempt before then, they should not be dissuaded but should make a concerted focus to address the specific issues that resulted in the failed quit attempt, and they may wish to consider a different formulation of NRT or a completely different medication.

Further information: Information sources for pharmacotherapy

The UK Medicines and Healthcare products Regulatory Agency (MHRA)
www.mhra.gov.uk
The MHRA provides information on pharmacotherapies licensed for use in the UK including that provided by the Committee on Safety of Medicines. It also monitors safety of new drugs and provides updates on new side effects, contraindications or drug interactions. Searching for 'stop smoking' through the website address above will yield information on smoking cessation treatments.

The British National Formulary (BNF)
www.bnf.org
The BNF, updated bi-annually, is intended to provide UK health practitioners with practical information on the selection and clinical use of medicines. A search for 'cigarette smoking' will produce the relevant sections.

The Electronic Medicines Compendium (eMC)
www.medicines.org.uk/emc
The eMC contains updated and accessible information about medicines licensed for use in the UK. It provides both summaries of products and patient information leaflets.

Scottish Medicines Consortium (SMC)
www.scottishmedicines.org.uk
The SMC considers new pharmacotherapies' potential for use in Scotland.

Local Area Drugs and Therapeutics Committees, local formularies and prescribing protocols
These should reflect the above recommendations, guidance and updates, including that from the other sources of information given here, and may be developed and adapted to enable innovative, flexible dispensing practices such as weekly dispensing and for the 'cut down to quit' approach where undertaken – see *Tobacco harm reduction* on the latter.

As smoking affects the metabolism of various medications, such as clozapine, olanzapine, theophylline and warfarin, drug dosages of such medications may require adjusted when smoking cessation takes place. The above sources provide further information.

As noted on page 1, the focus of the Guide is on robust, highly processed, quality assured evidence which provides the basis for the Recommendation sections. E-cigarettes, and other products or combinations of products which have not been included in NICE recommendations, are therefore not covered in this section or indeed in this component of the Guide. Additionally, e-cigarettes are not a licensed smoking cessation medication and cannot be prescribed on the NHS. See www.healthscotland.scot/publications/a-guide-to-smoking-cessation-in-scotland for the *Brief interventions flowchart* for practitioners, accompanying e-cigarettes and harm reduction brief intervention information, and the *Tobacco harm reduction* component aimed at specialist services and which focuses on a variety of harm reduction approaches involving NRT use as well as on unlicensed forms of nicotine such as e-cigarettes.

The following case studies have been included as examples of prescribing protocols in operation within smoking cessation services. These alternative routes of prescribing mean that patients or clients do not need to attend GPs to obtain prescriptions.

Case studies: Prescribing protocols

NHS Greater Glasgow and Clyde's service for hospital inpatients uses an inpatient protocol, designed for their acute sector smoking cessation advisers who are not nurses, which details how to request NRT for patients. A standard NRT request form is used internally for hospital pharmacists and another one externally through which additional supplies are accessed by patients on discharge from hospital via their local pharmacist. Housebound patients identified by intensive smoking cessation services are issued with an NRT request form, requesting that NRT be issued under the community pharmacy unscheduled care prescription form system (CPUS) given that patients cannot attend their local pharmacy. This policy of pharmacy supply of NRT is to reduce the need for patients to attend GPs to obtain NRT and ensures that CO monitoring is also undertaken.

NHS Grampian ensures that the smoking cessation service – known as the Smoking Advice Service – liaises with GPs for prescribing pharmacotherapies, in particular, varenicline.

NHS Lanarkshire has a Patient Group Direction (PGD) for the provision of nicotine replacement therapy products within community-based smoking cessation services. This PGD allows NRT to be offered free of charge within all smoking cessation service clinics. This 'one stop shop' approach means patients/clients can get both behavioural support and pharmacotherapy within the clinic setting from nurse advisers with no need to attend their GP or pharmacy.

Effectiveness evidence for pharmacotherapy

An overview and network meta-analysis of Cochrane systematic reviews examined how the three pharmacotherapies licensed for smoking cessation compared with placebo and with one another in achieving continuous or prolonged long-term abstinence of six months or longer[23]. The overview and network meta-analysis excluded reviews of smoking cessation for particular settings or populations (e.g. pregnant women or specific disease groups). The data in the table below is derived from this overview and meta-analysis unless supplemented with data from a separate Cochrane review on the specific pharmacotherapy where the data was not available in the overview.

Figure 4a: Effectiveness of pharmacotherapies at six months post-quit[23]

Based on 6+ month outcome data unless otherwise stated	Odds ratio .v. placebo unless otherwise stated	Credible Interval (CredI)
NRT	1.84 (patch 1.91; gum 1.68; other 2.04).	OR 1.84; CredI 1.71-1.99
Bupropion	1.82	OR 1.82; CredI 1.60-2.06
Varenicline	2.88	OR 2.88; CredI 2.40-3.47
Combination NRT	2.73	OR 2.73; CredI 2.07-3.65
Bupropion .v. NRT	0.99	OR 0.99; CredI 0.86-1.13
Varenicline .v. NRT	1.57	OR 1.57; CredI 1.29-1.91
Varenicline .v. Buproprion	1.59	OR 1.59; CredI 1.29-1.96
Combination NRT .v. NRT (single)*	1.34*	RR 1.34; CI 1.18 to 1.51*
Bupropion .v. Combination NRT	0.68	OR 0.68; CredI 0.50-0.91
Varenicline .v. Combination NRT	1.06	OR 1.06; CredI 0.75-1.48

* data and further details from http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000146.pub4/full

The overview and network meta-analysis found NRT and bupropion to be equally effective but combination NRT (use of dual products) and varenicline to be superior and as effective as one another – for example, varenicline was almost 3 times as effective as placebo, and just over 1.5 times as effective as single NRT or bupropion which in turn were each almost twice as effective as placebo by helping people 80% more people to quit than placebo. The overview also examined risks of serious adverse effects through the incidence of these associated with these pharmacotherapies and found neither of them to have evidence of harms that would mitigate their use.

Another systematic review examined the combination of behavioural support and pharmacotherapy, concluding that it increased smoking cessation at the six-month follow-up stage or beyond by 70–100% in comparison with usual care, brief advice or a minimal intervention[24]. Further details on the evidence for intensive/behavioural support and pharmacotherapy are available in the *Planning and providing specialist smoking cessation services* component, including the consistent findings from observational studies such as smoking cessation service reviews of this being the optimum form of smoking cessation support in terms of outcomes of quit attempts.

While the Cochrane individual pharmacotherapy systematic reviews are regularly reviewed and updated as required, the conclusions of such updates do not differ substantially given the wealth and quality of evidence supporting the conclusions, confidence intervals and estimates of effects.

Another review, by West et al (2015)[25], and which also updates the evidence published in the original Thorax (2000) Smoking Cessation Guidelines: An Update[26] and also focuses on comparing a range of pharmacotherapies side by side, is based on a combination of the following to estimate the likely effectiveness of each intervention in different settings:

- Cochrane systematic reviews of randomised trials. The effect of permanent cessation is expected to be half of these cited figures.
- Analysis and evidence from additional, 'real world' studies.

Figure 4b: Effectiveness of pharmacotherapies at 6–12 months post-quit[25]

The interventions below were delivered by health professionals[a] to smokers wanting help to quit and willing to set a quit date.

Intervention .v. comparsion (placebo)	%age point increase in 6–12-month abstinence (95% CI – confidence interval)	Projected %age point increase in 6–12-month abstinence .v. no intervention
Single NRT	6 (6–7)[b]	6
Combined NRT	11[c]	11
Bupropion	7 (6–9)[d]	7
Varenicline	15 (13–17)[d]	15

a = healthcare worker qualified to prescribe or provide the pharmacotherapy
b = no clear differences between products or interaction with intensity of behavioural support, but some evidence that higher-dose products are more effective than lower-dose ones
c = synthetic estimate based on incremental effect of dual-form nicotine replacement therapy (NRT) compared with single-form
d = studies were undertaken in the context of multi-session face-to-face behavioural support.

The results of this review also show the benefits of all three pharmacotherapies, with the superiority of combination NRT and varenicline, in this case with varenicline having the most favourable outcomes.

Brief interventions with particular population groups

The general principle and underlying assumption is that all healthcare professionals should advise and encourage all smokers to quit, and offer them help to do so, unless there are exceptional circumstances.

There have historically been three national target groups for tobacco control / smoking cessation and reducing smoking prevalence, and for which targets have been set:

- Socio-economically deprived groups
- Young people
- Pregnant women

These remain priority groups although, of these, prevalence and performance targets have only been set for those within deprived groups more recently – a focus on reducing inequities in prevalence (in the most recent tobacco control strategy) and on a specific proportion of successful smoking cessation quits to be from the most deprived areas (in recent HEAT targets and subsequently the Local Delivery Plan standard).

Additionally, there are other priority groups for smoking cessation such as those:

- for whom smoking prevalence is high (e.g. psychiatric patients who are more likely to die prematurely of smoking-related illnesses than the general population of smokers)[27,28]
- who are otherwise vulnerable (e.g. older adults, for whom it is never too late to quit smoking in order to enjoy the health benefits and who are actually more likely to quit successfully than younger people[29,30])
- with particular smoking-attributed or smoking-exacerbated medical conditions.

Specific recommendations and guidance in smoking cessation for these groups, where available from the key source material or subsequent NICE guidance as previously referred to, is summarised in this section.

Collectively, addressing tobacco use in these longstanding and additional priority groups should help contribute to a range of related targets and quality measures, performance targets for smoking cessation with their deprivation focus, national targets to achieve a tobacco-free generation and narrowed inequities/inequalities in smoking prevalence by 2034, and thus ultimately reduce inequities in smoking-attributable morbidity and mortality.

Socio-economically deprived groups

In 2014, 21% of deaths in the most deprived quintile of Scotland were attributed to smoking, compared with 15% in the least deprived quintile[31].

Specific guidance/recommendations:

- Socio-economically deprived/disadvantaged smokers should be especially encouraged to use services.

Young people

Specific guidance/recommendations:

- Young smokers, who express a serious intention to quit and a desire for support to do so, should be:
  - encouraged to use local smoking cessation services, and details on when, where and how to access them should be provided alongside a referral.
- Practitioners should be aware of, and actively consider the importance of, a range of school-based prevention alongside the cessation approaches for this age group, linking in with relevant organisations where appropriate; detailed recommendations are provided in the *Scottish Perspective on NICE Public Health Intervention Guidance 23 on School-based interventions to prevent smoking*, available at www.healthscotland.com/scotlands-health/evidence/NICE.aspx
- NRT:
  - Discuss with the young person and use professional judgement to decide whether or not to offer NRT to young people aged 12–17 who request it or who show clear evidence of nicotine dependence.
  - If NRT is prescribed, offer it as part of a supervised regime.
- Neither varenicline nor bupropion is licensed for, and therefore should not be used by, people under the age of 18 years.

Pregnant women, women planning a pregnancy or who have recently given birth, and their partners or family members

Smoking during pregnancy is: the 'single largest preventable cause of disease and death to the fetus and infants, and accounts for a third of peri-natal deaths'[32]; the single largest modifiable risk factor for pregnancy-related morbidity and mortality[1]; and a cause of a number of pregnancy (including labour) complications, as well as fetal and neonatal problems, e.g. ectopic pregnancy, bleeding during pregnancy, premature detachment of the placenta and premature rupture of the membranes, an increased risk of miscarriages, fetal growth restriction, pre-term delivery, low birthweight, stillbirth, reduced lung function in and beyond infancy, sudden infant death syndrome (SIDS, now increasingly referred to as 'sudden unexplained death in infancy – SUDI'), and an increased risk of neonatal death and orofacial clefts[4,6,10,33]. Maternal exposure to second-hand smoke during pregnancy is a cause of a small decrease in birthweight[6] and is associated with persistent adverse effects on lung function throughout childhood[11].

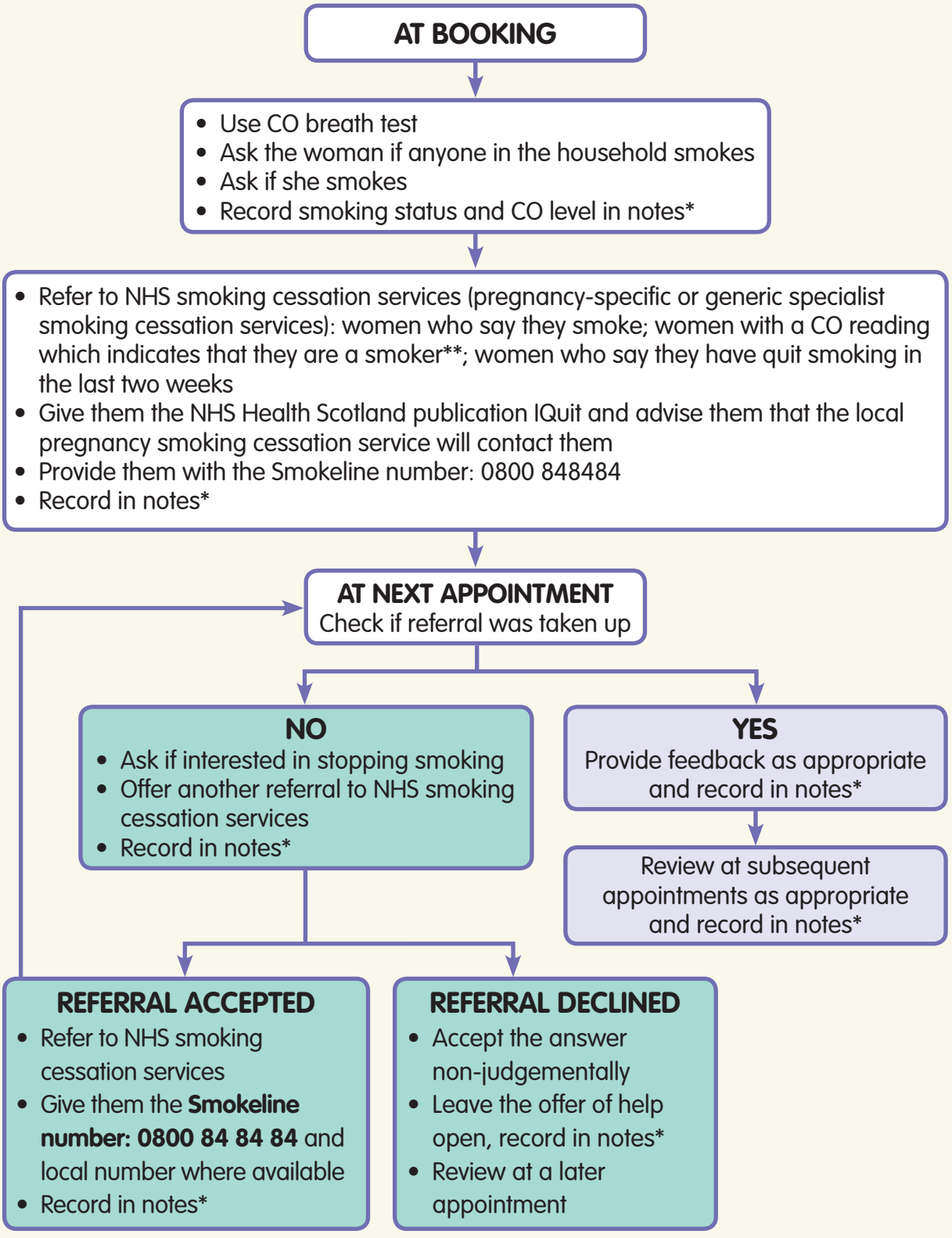
In addition to the benefits (of e.g. triggering a quit attempt and uptake of specialist smoking cessation services) outlined on pages 12–16, the contribution that midwives and other health and support staff can make to reducing the risks highlighted above through their contact with pregnant women can therefore be significant. As pregnant women

have relatively frequent contact with a range of health professionals, pregnancy presents an important opportunity to provide interventions that reduce the risks of the conditions above. Some women find it difficult to say that they smoke during pregnancy, because the pressure not to smoke is intense[5]. This can make it difficult to ensure that they are offered appropriate support.

Carbon Monoxide (CO) testing is a tool that can be used effectively – when combined with a non-judgemental supportive approach – to assess an individual's smoking status and, in turn, to direct them to appropriate support. Midwives (at first booking) are particularly well-positioned to automatically refer pregnant women who smoke (or have a CO reading which indicates that they are likely to be a smoker) to specialist cessation services, to review progress at subsequent appointments, and should follow the modified referral pathway diagram from maternity services to smoking cessation services on page 27.

Figure 5: Referral pathway for pregnant women from maternity services to NHSScotland smoking cessation services [5•]

Provide all women with information (for example, a leaflet) about the risks of smoking to her and the unborn child, including smoking by partners or family members. Address any concerns she, her partner or family may have about stopping smoking. Tell partners and family members about NHS smoking cessation (stop smoking) services.



*Preferably the patient handheld record.

**See www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/mcqic/Maternity-Care for updates on how this referral pathway is being implemented in Scotland – 4ppm level referral 'cut-off' point in lieu of NICE's recommendation of 7ppm.

• Evidence has been adapted from this source.

Further information: Validating smoking status during pregnancy

When using CO monitors, the exact cut off point which indicates whether a woman is a smoker or non-smoker is not clear cut, and those who smoke infrequently or inhale very little may be difficult to distinguish from those who are exposed to second-hand smoke (or other environmental factors)[5]. The purpose of the initial CO test is to act as an aid to discussion around smoking status, to potentially circumvent problems of under- and mis-reporting, as well as identifying other problems which may be contributing to high CO levels.

Regular biochemical validation via CO monitoring may encourage a pregnant woman to quit, as well as provide positive feedback once a quit attempt has been made5. Although no measure is 100% accurate, urine or saliva cotinine tests are more accurate than CO monitoring as they can detect exposure over the past few days rather than hours (although the adviser should remain mindful that cotinine levels may be raised among those using nicotine replacement therapy)[5]. All forms of biochemical validation reduce the likelihood that a smoker may miss out on the opportunity to get help to stop.

This modified referral system is recommended to ensure that pregnant women who smoke are provided with the best possible support. The specialist service accepting the referral (which may be specialist/intensive support specifically for pregnant women and their partners rather than generic specialist/intensive support) should conduct a follow-up telephone call prior to service attendance to any women referred in this way, in order to provide information about the service, and allow a woman to decline the offer at that point. All these recommendations should be carried out with a non-judgemental, client-centred approach to make clear that this is an opportunity for women referred in such a way to access information and specialist service support, not an obligation to attend services if, after information is provided, they do not wish to do so.

Many women relapse to smoking following the birth of the child. There can be a common misperception among partners and other family members that smoking away from (i.e. not in the proximity of, or else blowing smoke in the other direction from) the baby or once a baby has grown into a toddler is relatively safe. Health of children and the home environment are inextricably linked. Second-hand smoke exposure increases the risk of lower respiratory tract infections including bronchitis and pneumonia, and reduces lung function[10,33,34]. It increases the risk of sudden infant death syndrome (SIDS or cot death) – now increasingly referred to as 'sudden unexplained death in infancy' (SUDI) – as well as ear problems such as glue ear, severity of asthma (frequency of episodes, severity of attacks), and is a risk factor for new cases of asthma[10,11,33,34].

The recommendations contained within this section are based on *NICE Public Health Guidance 26 – How to stop smoking in pregnancy and following childbirth*, and contain guidance that enhances existing practice and which has implications for service design. It is recognised that, given the nature of the changes to practice that follow, these recommendations may take time to become embedded in service delivery, and that there are a number of key stakeholder groups involved in making this happen, e.g. service planners and commissioners, smoking cessation managers and staff, midwives and other health professionals. Given the serious consequences of smoking throughout and beyond pregnancy, however, all those who have a responsibility and opportunity to encourage and support pregnant smokers to stop should move towards meeting these recommendations.

Pregnant women, women planning a pregnancy or who have recently given birth

Specific guidance/recommendations:

- Pregnant women should, at **first maternity booking**, be offered the following **by a midwife:**
  - have their exposure to tobacco smoke discussed, and a CO test undertaken
  - have the purpose of the CO test explained (to allow them to see a physical measure of their smoking and exposure to other people's smoking), be asked if they or anyone else in the household smokes, and have their smoking habits discussed – e.g. if they are a light/infrequent smoker, how many cigarettes they typically smoke, and number of cigarettes smoked (and when) on the test day (as CO levels will fall overnight) – which should help to interpret the CO reading
  - be referred and fast-tracked to conveniently located and timed specialist smoking cessation services (which may be pregnancy-specific) using local arrangements if: they are a self-reported smoker; if they have a CO reading* higher than would be expected for a non-smoker); or if they have stopped smoking within the last two weeks – see referral pathway document for updates on how this referral pathway is being implemented in Scotland. (*Note that, on the basis of experience, and taking into account that light/infrequent smokers can register a CO reading of 3ppm, all smoking cessation services in Scotland opted to use a lower cut-off point for automatic referral of 4ppm in lieu of NICE's recommendation of 7ppm, and this was subsequently incorporated within the Maternity and Children Quality Improvement Collaborative – MCQIC.)
  - have explained that this referral is part of normal practice and that a specialist smoking cessation adviser/smoking cessation specialist midwife (as appropriate) will be in touch to offer support; have this recorded in the notes; and have the Smokeline 0800 84 84 84 number and local helpline number provided for interim advice
  - have the flexibility of the services emphasised, what they can offer and how they can help people to quit

- help for non-smokers with high CO to identify the source of the CO. Note: while 7ppm and above is the usual level indicating a smoker, a lower level (e.g. 3ppm) may apply for light/infrequent smokers; a higher reading may occur if prior exposure has taken place to other sources of pollution e.g. traffic fumes, leaky gas appliances
- be advised about possible CO poisoning if they have a high CO reading (more than 10ppm) but say that they do not smoke, and be asked to call the free Health and Safety Executive gas safety advice line on 0800 300 363
- as well as being advised, at the earliest opportunity, of the dangers of smoking and the hazards of second-hand smoke exposure to their unborn babies and themselves, be provided (especially by a trained health professional) with relevant supporting information (such as leaflets) in a suitable format
- have the health benefits of stopping for the woman and her baby explained, and advice to stop completely (not just cut down) provided
- be advised that their partners or others in the household contact NHS smoking cessation services, or positive feedback given if no one smokes.

- Pregnant women should, at the **next or subsequent appointments**, be offered the following **by a midwife**:
  - be asked if the referral was taken up; if it was not, be asked if they are interested in stopping smoking, offered another referral to the service using local arrangements and have the Smokeline and other local helpline numbers provided, and have this recorded in the notes. If the referral was taken up, provide and request feedback (e.g. through praise and enquiring about experiences) and review at subsequent appointments. If the referral is declined, have the answer accepted impartially, but the availability of flexible support (e.g. home visits) highlighted, the offer of help left open, and this reviewed at subsequent appointments
  - where appropriate (i.e. when undertaken), have smoking status, CO level, and response to referral and feedback recorded regularly in the notes (e.g. in the woman's hand-held record).
- All pregnant women (**in addition to the above recommendations**), and also those planning a pregnancy, and those with children under 12 months (including, in particular, breastfeeding women), should be offered the following **by those providing health and support services** (e.g. GPs, practice nurses, health visitors, family nurses, those working in contraceptive services, fertility clinics, and the wider maternity team – excluding midwives who should follow the recommendations above):
  - have their smoking status discussed as early as possible and monitored regularly through using any appointments/meetings as an opportunity, and be offered practical advice, and personalised information, encouragement, advice and support on how to stop smoking throughout the pregnancy and beyond (preferably via services or to supplement that offered by services)

- be advised of the dangers of smoking and the hazards of second-hand smoke exposure to unborn babies and themselves, including the risks to young children, (and the links with existing presenting medical conditions where relevant), at the earliest opportunity (and be provided by suitably trained health and support service staff with relevant supporting information such as leaflets in a suitable format on this second-hand smoke issue and on the benefits of stopping)
- be advised to stop and be encouraged to use, and where appropriate (i.e. those who want to stop) be fast-tracked to, conveniently located and timed specialist smoking cessation services to do so (or, if it is still not feasible for them to attend, consideration should be given to service delivery through home visits)
- have details provided on when, where and how to access specialist smoking cessation services alongside the referral to such services using local arrangements, emphasising their flexibility, what they can offer and how they can help people to quit, plus the Smokeline and other local helpline numbers provided in the interim (and this recorded in the notes e.g. the woman's hand-held record)
- have any concerns regarding stopping smoking addressed
- be provided with continued support should they successfully quit smoking prior to or during pregnancy, to encourage and help them to stay stopped beyond the duration of the pregnancy itself.

Many of the recommendations above (e.g. smoking status recorded, information on smoking cessation services referrals, recording of response to referral in order to have details of engagement with services and therefore which referrals are 'active', provision of information accounting for diverse literacy and cultural needs) are in line with the performance assessment measures outlined in CEL and CMO letters, available at www.knowledge.scot.nhs.uk/home/portals-and-topics/health-improvement/hphs.aspx, and NICE guidance on acute, maternity and mental health services at www.nice.org.uk/PH48

See also the following for useful information: *Evidence into Practice project on smoking cessation in pregnancy* which includes examples of how these recommendations have been implemented www.healthscotland.com/uploads/documents/19968-EIPPregnancyProjectReport.pdf; *pregnancy and smoking cessation effectiveness evidence briefing* www.healthscotland.com/documents/6103.aspx

Pharmacotherapy for pregnant women, women planning a pregnancy, and women who are breastfeeding

Specific guidance/recommendations:

- For pregnant women and women planning a pregnancy:
  - The risks and benefits of NRT should be discussed with pregnant women who smoke, particularly those who do not wish to accept other help from NHS smoking cessation services, and NRT should only be used if smoking cessation without NRT fails.
  - If a pregnant woman expresses a clear wish to receive NRT, professional judgement should be used to decide whether to prescribe or provide it, and in tandem with discussion with the specialist service to which the pregnant woman has been referred (which will have more specific details around how to prescribe). While it cannot guarantee complete safety, the risk to the fetus of the mother's continued smoking generally outweighs any potential adverse effects from NRT.
  - Intermittent forms of NRT, such as lozenges or gum, are preferable to continuous forms such as patches, although a patch may be more appropriate if suffering from nausea/vomiting. Pregnant women using nicotine patches should be advised to remove them before going to bed to avoid the administration of nicotine overnight.
  - Neither bupropion nor varenicline should be used by women who are pregnant or seeking to become pregnant.
- For breastfeeding women:
  - For breastfeeding mothers, NRT may be recommended to assist a quit attempt.
  - The risks and benefits of NRT should be discussed with breastfeeding women who smoke and who have been unable to stop smoking unaided. If a breastfeeding woman expresses a clear wish to receive NRT, professional judgement should be used to decide whether to prescribe or provide it. However, any risk is likely to be small in comparison with the amount of nicotine from cigarettes, and the smokefree environment will also outweigh any risk.
  - If NRT is used when breastfeeding, it should be used in line with the manufacturer's instructions, and it is preferable to use intermittent, oral forms every now and then, such as lozenges or gum, rather than continuous forms. This is because intermittent forms of NRT can be timed to allow the maximum time between their use and feeding of the baby, and so minimise the amount of nicotine in the milk. If breastfeeding women do use nicotine patches, advise them to remove them before going to bed to avoid the administration of nicotine overnight.
  - Neither bupropion nor varenicline should be used by women who are breastfeeding.

Partners of pregnant women, parents of young children, and other family or household members

Specific guidance/recommendations:

- Partners of pregnant women (or of women planning a pregnancy or with infants aged under 12 months, including breastfeeding women), parents of young children, and other family or household members, should:
  - have their smoking status discussed as early as possible (and monitored regularly)
  - be advised at the earliest opportunity of the dangers of smoking and hazards of second-hand smoke exposure to unborn babies, young children and pregnant mothers, and linked in with existing presenting medical conditions where relevant
  - be given practical and personalised information, and smoking cessation advice on how to stop smoking throughout and beyond the pregnancy (preferably via services or to supplement that offered by services)
  - be advised to stop and be encouraged to use local smoking cessation services, and details on when, where and how to access them should be provided alongside a referral (using local arrangements) for timely access to such services
  - have any concerns regarding stopping smoking addressed.

Hospital patients (including those preparing for hospital admission)

Specific guidance/recommendations:

- Patients should be reminded at every suitable opportunity of the short-term and long-term health benefits of stopping and the advice linked to their medical condition.
- Patients should be encouraged to stop smoking, for their own health benefits as well as due to NHS smoke-free premises (buildings and grounds), and:
  - reminded of the smoke-free status of NHSScotland hospital buildings and grounds, in order that they and their visitors/carers can prepare for this accordingly, for their own health and to avoid exposing others to second-hand smoke
  - be advised of the types of support and pharmacotherapy available to help smoking cessation or temporary abstinence for themselves and for their visitors, and offered timely access to an intensive support service (normally an NHS smoking cessation service – see also bullet 4 below).
- Patients referred for elective surgery or waiting to be admitted to hospital should be encouraged to stop smoking before the operation or pre-admission and should be offered timely access to an intensive support service (normally an NHS smoking cessation service).

- Hospital inpatients who use tobacco in any form should be offered:
  - advice and, if appropriate, NRT from a suitably trained health professional to help them to quit and/or to manage nicotine withdrawal symptoms through an enforced quit – all NHSScotland hospital buildings and grounds are smoke-free
  - a referral to/appointment with an intensive support service – intensive smoking cessation services and pharmacotherapy while in hospital, from an on-site service and within 24 hours of admission. (Due to the rural and remote nature of some services in Scotland, an on-site service may only be available in mainland hospitals; however, intensive support should be provided within or as close to 24 hours of admission such as within two working days.)
- Patients waiting to be discharged from hospital, particularly those who have tried to quit smoking in hospital, should be offered, and fast-tracked for, intensive support to stop smoking, including 1+ week's pharmacotherapy post-discharge or until contact with a smoking cessation service, and an appointment for such support booked prior to their discharge.
- Relatives/visitors/carers, as well as patients, should be reminded if/as appropriate that NHSScotland premises (including hospital buildings and grounds) are smoke-free, in order that they can prepare for appointments, visits and hospital stays accordingly. Additionally:
  - carers and household members should be reminded of the risks of second-hand smoke and not to smoke around the patient (including in the house and car)
  - all should be:
    - advised of the use of pharmacotherapies for smoking cessation or temporary abstinence, for their own health and to avoid exposing others to second-hand smoke
    - advised of the benefits of stopping smoking
    - offered a referral to smoking cessation services
    - where appropriate/applicable, directed to point-of-sale of licensed nicotine-containing products for temporary abstinence for those who wish to use them.

Additional information: Hospital patients

CEL and CMO letters, available at www.knowledge.scot.nhs.uk/home/portals-and-topics/health-improvement/hphs.aspx, the *mapping exercise/audit relating to smoking cessation support in secondary care* (www.healthscotland.com/documents/2664.aspx), the *Evidence into Practice project on smoking cessation* which includes examples of how these recommendations have been implemented (www.healthscotland.com/documents/5979.aspx), the *HPHS smoking cessation evidence briefing* and *secondary care evidence briefing* (www.healthscotland.com/documents/27133.aspx and www.healthscotland.com/documents/6039.aspx), the *NHSScotland smoke-free implementation guidance* (www.healthscotland.com/documents/24828.aspx), and *NICE guidance on smoking in acute, maternity and mental health services* at www.nice.org.uk/PH48 provide some recommendations and examples of action/implementation for smoking cessation services for this client group.

Note the considerations described in the Pharmacotherapy section with respect to use of pharmacotherapies by patients with certain conditions or being prescribed other medication, and in the information sources for pharmacotherapy section with respect to adjustment of other drug dosages when quitting smoking.

Case studies: Hospital patients

A variety of service models exist (e.g. in terms of access or referral pathways to services within and between primary and secondary care, and service locations/bases in primary and secondary care – including some hospital-based smoking cessation services in Scotland).

NHS Greater Glasgow and Clyde's service for hospital inpatients includes NRT and smoking cessation service information in the hospital prescribing formulary.

NHS Grampian, as part of the development of pre-operative smoking cessation in partnership with GPs and outpatient consultants, has smoking cessation included on the standard proforma in pre-assessment clinics.

People with heart disease or respiratory disease

Specific guidance/recommendations:

- It is important to:
  - ensure that people who have heart disease or respiratory disease, and those who live with them, are aware of the risks of smoking and second-hand smoke exposure (active and passive smoking) to people with such diseases
  - ensure that they are aware of the rapid and longer-term benefits to them of not being smokers and not being exposed to second-hand smoke even after being diagnosed with heart disease

- give them smoking cessation advice with pharmacotherapy if appropriate
- offer them timely access to smoking cessation support, including timely access to an intensive smoking cessation service, with fast tracking where clinically advisable.

In terms of pharmacotherapies, offer a prescription in conjunction with referral to an intensive smoking cessation service (and/or provide brief intervention support plus signposting to licensed nicotine-containing products for cessation/reduction such as temporary abstinence for those who are unwilling or unable to accept such a referral – see *Tobacco harm reduction* component):

- For smokers with stable heart disease:
  - the benefits of using NRT to stop smoking outweigh any risks there may be with NRT
  - varenicline or bupropion may be offered, subject to clinical judgement.
- For smokers with unstable cardiovascular disorders:
  - if prescription or provision of NRT is being considered, the risks and benefits should be explained
  - varenicline or bupropion may be offered, subject to clinical judgement.
- For smokers in hospital with severe heart disease:
  - NRT can be used if recommended and supervised by the doctor treating the patient.

Additional information: Patients with heart or respiratory disease

Allowing for the expanded range of available pharmacotherapies, recommendations in the Pharmacotherapy section of this document are compatible with references to smoking cessation in the following Scottish national clinical guidelines: for chest (coronary, cardiac) and respiratory conditions at www.sign.ac.uk/guidelines/published/index.html and www.sign.ac.uk/guidelines/development/index.html

People with diabetes

Smokers who have diabetes have a considerably increased risk of developing cardiovascular disease and complications from it, so it is very important that they quit smoking.

Specific guidance/recommendations:

- Blood sugar should be monitored more closely when someone with diabetes is trying to stop smoking, since both stopping smoking and the use of NRT affect insulin metabolism.

Additional information: Patients with diabetes

Allowing for the full range of pharmacotherapies, recommendations in the Pharmacotherapy section of this document are compatible with references to smoking cessation in the following Scottish national guidelines: for diabetes at www.sign.ac.uk/assets/sign116.pdf

Good practice: Diabetes patients

As both nicotine and the constituents of tobacco have numerous effects on blood sugar metabolism, and quitting smoking (with or without the aid of pharmacotherapy) can alter the body's insulin resistance, with the processes which take place being complex, diabetics should be encouraged to consult with and discuss any attempt to quit with their diabetic team, as adjustment of their ongoing diabetes treatment may be necessary.

Diabetic smokers should also consult with their doctor before using bupropion (as per guidance from MHRA and the other sources provided on page 20).

Case study: Diabetes patients

NHS Western Isles has a smoking cessation adviser who is a diabetes specialist nurse. This adviser promotes awareness of the link between smoking and diabetes and additionally provides training to support other staff working in diabetes.

People with mental health problems

Smokers with mental health problems have higher levels of dependence on smoking, with rates of cardiovascular, stroke and respiratory disease being higher among some mental health groups than the general population.

Specific guidance/recommendations:

- Offer those with mental health problems tailored smoking cessation advice, which includes developing a personal smoking cessation plan as part of a review of their health and wellbeing, with fast tracking where possible.
- The considerations described in the Pharmacotherapy section with respect to use of pharmacotherapies by patients with certain conditions or being prescribed other medication, and in the information sources for pharmacotherapy section with respect to adjustment of other drug dosages when quitting smoking, apply to people with mental health problems.

Black and minority ethnic groups

Smokeless oral tobacco products are widely used by some minority ethnic groups and are harmful to health, so tobacco cessation should be made available to those who want to quit this habit[3].

Other tobacco use besides smoking can include smokeless tobacco, shisha, snus and oral snuff. Smokeless tobacco is most commonly used by those from South Asian communities, and includes tobacco with or without flavourants (such as misri and qimam/kiman), with various alkaline modifiers (such as khaini, gul and naswar/niswar/nass), or with slaked lime as an alkaline modifier and areca nut (such as gutkha, zarda, mawa, manipuri and betel quid). Paan, shanmah and tombak are most commonly used by Asian, Saudi Arabian and African communities respectively.

Specific guidance/recommendations:

- Minority ethnic groups should be especially encouraged to use services.
- Patients or clients from minority ethnic groups should be asked about all forms of tobacco use, not just that which is smoked.
- For further information on these products and on quitting, see NICE guidance on smokeless tobacco at www.nice.org.uk/Guidance/PH39

Older adults

Specific guidance/recommendations:

- As giving up smoking still has benefits by reducing the risk of smoking-related diseases and decreasing the time needed to recover from many illnesses, older adults should be informed about the benefits of smoking cessation, and encouraged to give up smoking and referred on to smoking cessation services.

Users of NHS premises and patients' family and household members/visitors

Good practice: Users of NHS premises and relatives/visitors/carers/household members of patients

The recommendations for hospital patients, earlier in this section, are also applicable beyond hospital settings with respect to other patient groups and relatives/carers/household members of such patients, as follows:

- Patients and their relatives/carers should be reminded of the smoke-free status of all NHSScotland buildings and grounds, in order that they can prepare for such appointments or visits accordingly.
- Relatives, carers and household members should be reminded not to smoke around the patient (including in the house and car).
- Patients and their relatives/carers/household members (if/as applicable) should be advised of the use of pharmacotherapies for smoking cessation or temporary abstinence for their own health and the health of those around them, the benefits of stopping smoking, and offered a referral to smoking cessation services.

Brief interventions with particular population groups – additional information

Good practice: How to create a smoke-free environment

Smoking cessation is the gold standard, and a smoke-free environment is best achieved through quitting and thus smokers should be advised to quit. For those unable/unwilling to quit, a smoke-free environment is the next-best option, achievable through the use of licensed nicotine-containing products for harm reduction such as temporary abstinence and advice to avoid smoking in particular around pregnant mothers and unborn babies, young children, and those with heart or respiratory disease, especially in confined spaces such as the home and car – see *Brief interventions flowchart* for practitioners, accompanying e-cigarettes and harm reduction brief intervention information, *Tobacco harm reduction*, and NICE guidance on harm reduction available at www.nice.org.uk/PH45, for further detail.

Further information:

A smoking cessation services review, available at www.healthscotland.com/documents/23527.aspx, focused on national action to reduce variation in quit outcomes and improve consistency between Boards, and developed an action plan for national and local use.

Monitoring

Although brief interventions are not intended to be recorded in the Information Services Division (ISD) National Smoking Cessation Database (as this is designed for gathering data on quit attempts from specialist/intensive smoking cessation services only), the following type of monitoring should be useful to those who provide brief interventions:

Recommendations for monitoring

- Monitoring systems should be set up to ensure that health professionals have access to information (e.g. patient's case notes, all records held in General Practice and in hospitals) on current smoking status and the most recent occasion on which advice was given to quit smoking (or encouragement to stay stopped for ex-smokers), the nature of that advice, and the response to that advice.

Such monitoring (especially in GP practices, and in maternity and acute sector units) has been part of the requirement of the General Medical Services GP Contract/Quality and Outcomes Framework (QOF – www.isdscotland.org/health-Topics/General-Practice/Quality-And-Outcomes-Framework/) although new arrangements for quality under the Scottish GP contract have yet to be established (www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gp-contract-negotiations/contract-agreement-scotland), and is in line with performance assessment measures under the CEL and CMO letters (available at www.knowledge.scot.nhs.uk/home/portals-and-topics/health-improvement/hphs.aspx).

Training standards

Recommendations for training

- Training in the provision of brief interventions (including asking about all forms of tobacco use and advising on the dangers of second-hand smoke exposure in general, to infants and to pregnant women and unborn children; in what specialist services offer; in how to make referrals), and which complies with national training standards, should be taken up by all frontline staff (whether from the NHS, local authority, or community and voluntary sector) who could potentially provide brief interventions and make referrals, and/or who could advise on or prescribe pharmacotherapies.
- Students in the health and caring professions should be trained and updated via CPD in tobacco education and in how to help people to stop smoking.
- Telephone quitline staff should be trained to at least brief intervention level; telephone quitline staff who offer support should be trained to 'individual behavioural support' level.
- Additional, specialised training should be available for those working with specific groups, e.g. people with mental health problems, those who are hospitalised, and pregnant women, in line with particular specialism or sub-specialism.

- Training in relation to smoking and pregnancy should address the barriers some professionals may feel when they try to raise the issue of smoking during pregnancy (e.g. damaging the relationship between client and professional) and the important role that partners and 'significant others' can play in helping pregnant smokers (or women who have recently given birth) to quit.
- All midwives and others who could potentially work with women who are pregnant, planning a pregnancy or have an infant aged under 12 months (e.g. GPs, practice nurses, health visitors, family nurses, those who work in youth and teenage pregnancy services, children's centres, dental services, social services, and voluntary and community organisations), should be trained to deliver interventions to the target group commensurate with the recommendations on pages 29–30.

Good practice: Training standards

In addition to the training outlined above, telephone quitline staff who offer support within Boards' services or nationally should have undergone specific telephone skills training.

Healthcare students should be trained in generic and lifestyle/topic-based brief interventions.

Further information: National and local training

Training provided and undertaken should be of national standards which have been standardised and ensure consistency across Scotland. Details of brief intervention training are below. A national model of training for smoking cessation specialists will be available from 2017. The training builds on and supersedes the former quality standards for smoking cessation training in Scotland, which covered both brief intervention and intensive/behavioural support.

NHS Health Scotland hosts brief intervention e-learning in smoking cessation as part of its Health Behaviour Change training suite of online training materials (see www.healthscotland.scot/tools-and-resources/learning-and-development and https://elearning.healthscotland.com). Training in very brief advice and in other aspects of smoking cessation will also be available in Scotland from 2017.

Details of locally available training are available from NHS Board smoking cessation coordinators or from local NHS smoking cessation services.

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Appendix A: Key source material

Source 1: *Smoking Cessation Guidelines for Scotland 2004 Update* (NHS Health Scotland and ASH Scotland, 2005)

This document was commissioned by NHS Health Scotland and ASH Scotland to take account of the experience of the first few years of delivering these services, and the evidence base in smoking cessation. It replaced *Smoking Cessation Guidelines for Scotland* published in 2000. This updated document made recommendations for the organisation and implementation of clinical interventions to promote smoking cessation in Scotland. It was intended for use by health professionals and health planners at all levels. It provided a blueprint for the development of systems for ensuring that all health professionals were able to play an effective role.

Source 2: *Smoking Cessation Update 2007: Supplement to the 2004 Smoking Cessation Guidelines for Scotland* (NHS Health Scotland and ASH Scotland, 2007)

This paper updated the guidance and developments presented in the *Smoking Cessation Guidelines for Scotland: 2004 Update* (NHS Health Scotland and ASH Scotland, 2005) above.

Source 3: *NHS Health Scotland Commentary on NICE Public Health Implementation Guidance no.1 – (NICEPHIG1 – 'Brief interventions and referral for smoking cessation in primary care and other settings'*) (NHS Health Scotland, 2007)

As part of its role in promoting and supporting evidence-informed action for health improvement in Scotland, NHS Health Scotland produced *Commentaries on NICE Public Health Guidance* (now known as *Scottish Perspectives on NICE Public Health Guidance*). The process involves consideration of the evidence and recommendations presented in the NICE guidance, in the context of policy and practice in Scotland. This Commentary presents recommendations on brief interventions and referral for smoking cessation in primary care and other settings. The Commentary only considers whether brief smoking cessation interventions, rather than more intensive interventions, are effective at encouraging individuals to quit smoking; it presents recommendations on brief interventions and referral for smoking cessation in primary care and other settings.

Source 4: *NICE Public Health Guidance 10 – 'Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities'* (2008)

The Guidance is for NHS and other professionals who have a direct or indirect role in – and responsibility for – smoking cessation services. This includes those working in local authorities and the community, voluntary and private sectors. This Guidance superseded 'Guidance on the use of nicotine replacement therapy (NRT) and bupropion for smoking cessation' (*NICE technology appraisal guidance 39*).

Source 5: *NICE Public Health Guidance 26 – 'How to stop smoking in pregnancy and following childbirth'* (2010)

The Guidance is for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, helping women to stop smoking in pregnancy and following childbirth. It complements, but does not replace, other NICE guidance cited above.

The pieces of NICE guidance have been reviewed at regular intervals, usually every 2–3 years, and updated if/as required. NICE guidance on smoking cessation interventions and services is scheduled for completion in November 2017.

Appendix B: Definition of an intensive/ specialist smoking cessation service and the national pharmacy scheme

The term 'smoking cessation services' tends to be the more frequently used term in Scotland, and is the professionally recognised term among health practitioners and used within the field of smoking cessation and smoking cessation research. Therefore, this is the term adopted most frequently throughout this publication. The term 'stop smoking services' tends to be the commonly recognised term used among members of the public, and is therefore used by health professionals when discussing the services with the public in order to provide a clearer understanding of what they are.

This definition, originally developed in 2006 and updated in 2012, is included in order that those providing brief interventions have a clearer understanding of the services to which they are referring smokers. It is intended to reflect services as they are currently set up in Scotland. It is noted that this definition may change over time as services evolve and further evidence becomes available.

A specialist/intensive service is an NHS supported service with staff who have attended nationally recognised training and who have dedicated time to deliver group and 1:1 support for a series of planned/scheduled sessions in which: a target quit date is set; support provided throughout the quit attempt through multi-session, intensive, structured behavioural support and in conjunction with pharmacotherapy (as appropriate); and the client is followed up at one month, three months and one year post quit-date and outcomes recorded.

See www.healthscotland.scot/publications/a-guide-to-smoking-cessation-in-scotland for a current, full and detailed definition of an intensive/specialist smoking cessation service.

National Pharmacy Smoking Cessation Scheme

A national community pharmacy scheme was launched in 2008 in which up to 12 weeks of structured behavioural support (ordinarily 1:1) and NRT or, more recently, varenicline is offered in accordance with revised national service specifications. The aim is to 'provide extended access through the NHS to a smoking cessation support service, including the provision of advice and smoking cessation products, in order to help smokers successfully stop smoking…'. Pharmacists and their support staff are encouraged to seek out clients pro-actively, such as those with cardiac or respiratory disease, clients from disadvantaged neighbourhoods, pregnant women or young people. Further details are available from *Planning and providing specialist smoking cessation services*, Community Pharmacy Scotland or from the local NHS Board Consultant in Pharmaceutical Public Health.

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