



**REVIEW OF SMOKING CESSATION SERVICES  
IN THE CAPITAL AND COAST  
DISTRICT HEALTH BOARD**

*Prepared by*

**Service Planning and Funding  
Capital and Coast District Health Board**

*November 2003*

# REVIEW OF SMOKING CESSATION SERVICES IN THE CAPITAL AND COAST DISTRICT HEALTH BOARD

November 2003

## TABLE OF CONTENTS

EXECUTIVE SUMMARY _____	2
INTRODUCTION _____	4
BACKGROUND AND CONTEXT _____	4
<i>PART ONE: COMMUNITY SMOKING CESSATION SERVICES</i> _____	<i>6</i>
SMOKING CESSATION SERVICES _____	7
TRAIN-THE-TRAINER SMOKING CESSATION PROGRAMMES _____	8
BY MAORI FOR MAORI SMOKING CESSATION SERVICES _____	8
SMOKING CESSATION FOR PACIFIC PEOPLE _____	10
PHO's _____	10
GENERAL PRACTICE _____	10
PRIVATE SMOKING CESSATION SERVICES _____	11
SMOKING CESSATION AND YOUTH _____	12
SMOKING CESSATION IN PREGNANCY _____	12
DISCUSSION _____	13
<i>PART TWO: HOSPITAL SMOKING CESSATION SERVICES</i> _____	<i>16</i>
INTRODUCTION _____	16
BACKGROUND _____	16
THE REFERRAL PROCESS _____	16
PROGRAMME DATA _____	17
PACIFIC SERVICES _____	20
DISCUSSION _____	20

# **REVIEW OF SMOKING CESSATION SERVICES IN THE CAPITAL AND COAST DISTRICT HEALTH BOARD**

*November 2003*

## **EXECUTIVE SUMMARY**

This report provides a review of smoking cessation services in the Capital and Coast District Health Board. The main conclusion is that there is significant potential to improve smoking cessation services by service coordination and provider development. A summary of key points is outlined below:-

## **COMMUNITY SMOKING CESSATION PROGRAMMES**

- From 1 January 2004 the new Smoke-free Environments Amendment Bill 2003 will mean that all schools, workplaces and hospitality venues will be required by law to be completely smokefree indoors and outdoors. The challenge for health providers is to ensure that smoking cessation services are available to support smokers who are motivated to quit as a result of this legislation.
- A range of smoking cessation services are available in the community, including Quit Line, services in general practice and services by Maori providers.
- The capacity of local Maori and Pacific providers could be further developed for smoking cessation.
- Locally, a service gap exists for youth. C&CDHB could consider funding smoking cessation services for this client group. The effectiveness of programmes for youth is still being evaluated.
- The National Guidelines on Smoking Cessation are not clear on the use of nicotine replacement therapy in women who are pregnant. These guidelines are due for review in 2004, and workforce provider development with midwives could be considered after this.
- The cost of smoking cessation services in general practice may prevent low income people from accessing this service. Discussion could be held with providers and PHOs on ways in which costs may be reduced.
- The aim of attending smoking cessation training is not only to be able to issue vouchers for nicotine replacement therapy. Staff who have attended training are more able to provide appropriate assessment, motivation and referral. Short education sessions could be offered to a range of staff working in community health agencies.
- Maori and Pacific clients may be more at ease with a smoking cessation provider of their own ethnicity. Information on Maori and Pacific smoking cessation providers should be distributed to health providers to assist decision-making on service options.
- Staff working in the Aukati Kai Paipa programme have significant experience in smoking cessation that could be shared with others. Discussions could be held to identify willingness to be involved in workforce provider development with GPs and Quit Coaches in the region.

## **QUIT FOR OUR KIDS HOSPITAL SMOKING CESSATION PROGRAMME**

- C&CDHB is working towards the majority of buildings and grounds being completely smokefree by 1 January 2005. This provides a “window of opportunity” to promote smoking cessation for staff and patients. Consideration could be given to developing a dedicated smoking cessation programme for staff.
- Hospitalisation provides a useful opportunity to quit. This relates to advice to reduce smoking prior to an anaesthetic, advice to quit for medical reasons, and temporary incapacity while in hospital.
- Referrals to the programme could be improved by more information being given to clients about the programme when the admission form is being completed.
- Staff who are informed of smoking cessation issues will “champion” the programme. As a way to maintain high awareness of the programme it is recommended that regular in-service education on smoking cessation be offered to staff. Information on the service should be routinely factored into the corporate orientation of new medical and nursing staff.
- Senior management staff of C&CDHB should continue to actively support the programme. Communications staff could also assist with publicity.
- The potential exists for developing or enhancing services for a range of client groups for example mental health clients, pre-operative clients, women who are pregnant, and clients within community health services.
- Geographical distance makes it difficult to provide hospital smoking cessation services to Kenepuru Hospital and Kapiti. Further consideration should be given management of services in these areas.
- Funding could be identified for a Pacific Quit Coach to work within the Hospital and Health Service. Alternately, Pacific clients are supported by existing staff, but are referred to a Pacific provider on discharge.
- Possible funding changes coupled with increased coordination and capacity of community smoking cessation services could facilitate redesign of the present service. Given the short length of time many surgical patients now spend in hospital the role of the Quit Coach as a broker of care could be considered as a future option, with clients referred to other providers on discharge.
- Staff in general practice could be made more aware of the QFOK programme. This may facilitate client preparation to quit smoking and the early referral of patients on the waiting list for surgery.

# REVIEW OF SMOKING CESSATION SERVICES IN THE CAPITAL AND COAST DISTRICT HEALTH BOARD

*November 2003*

## INTRODUCTION

Reducing smoking is one of the 13 population health objectives in The New Zealand Health Strategy<sup>1</sup>. Consistent with this, an objective in both the Capital and Coast District Strategic Plan 2002-7 and the District Annual Plan for 2003-4 is to reduce the rate of smoking. Two activities identified in this year's District Annual Plan which will assist to achieve this objective are:-

- (1) To review the coverage and uptake of smoking cessation services
- (2) To review the effectiveness of hospital-based smoking cessation services

This report aims to achieve these two activities by reviewing smoking cessation services in the Capital and Coast District Health Board (C&CDHB) region. Part One reviews community smoking cessation programmes and Part Two reviews the hospital service.

## BACKGROUND AND CONTEXT

Tobacco smoking contributes to a range of diseases and premature death and is a major contributor to socio-economic inequalities in health<sup>2</sup>. There is evidence that smoking can cause about 40 different diseases, for example asthma, chronic obstructive respiratory disease, stroke and lung cancer<sup>3</sup>. Related conditions from "second-hand" smoke include glue ear, asthma, croup, bronchiolitis and pneumonia. The burden of these diseases results in high cost to the government and affected individuals. Smoking cessation is an important way of reducing the burden of these diseases.

From 1 January 2004 the new Smoke-free Environments Amendment Bill 2003 will mean that all schools, workplaces and hospitality venues will be required by law to be completely smokefree indoors and outdoors. This new legislation provides a "window of opportunity" for smoking cessation. The challenge for health planners is to ensure that sufficient smoking cessation services are available to support smokers who are motivated to quit as a result.

Nationally, 25.2% of males and 23.9% of females over 15 years of age smoke. Within C&CDHB this rate is a little lower with 21% of males and 19.2% of females over 15 identifying as smokers.

---

<sup>1</sup> Minister of Health. 2000. *The New Zealand health strategy*. Wellington: Ministry of Health.

<sup>2</sup> Ministry of Health. 2001. *Inhaling inequality – tobacco's contribution to health inequalities in New Zealand. Public Health Intelligence Occasional Bulletin 7*. Wellington: Ministry of Health.

<sup>3</sup> Doll, R., Peto, R., Wheatley, K., & Gray, R. 1994. Mortality in relation to smoking: 40 years' observations on male British doctors. *BMJ*, 309: 901-11.

However, smoking is socio-economically patterned with higher rates in lower socio-economic groups. Data identifies significant ethnic disparities with 49.4% of Maori and 35.2% of Pacific people over 15 smoking. In the age group from 25-54 over 60% of Maori women smoke<sup>4</sup>. Reducing smoking will contribute significantly to reducing inequalities in the health status of Maori.

*He Korowai Oranga Maori Health Strategy*<sup>5</sup> expands on the principles and objectives identified in the New Zealand Health Strategy providing more detail on how Maori health objectives will be achieved. The strategy recognises the need and desire for Maori to have *tino rangatiratanga* or self-determination over services. Maori are strongly motivated to seek their own solutions to health issues and manage their own services. The overall aim of the Maori Health Strategy is *whanau ora*/family health. Key ways in which *whanau ora* may be achieved are by involving Maori in decision-making, developing partnerships with iwi and Maori at governance and operational levels, ensuring all Maori populations have access to a choice of a Maori provider for a range of community-based services, and improving integration between providers.

A *National Maori Tobacco Control Strategy*<sup>6</sup> has recently been published. This report confirms the need for Maori smokers to have equitable access to an appropriate cessation method. Groups with special needs include pregnant women, *rangatahi*/youth and *tangata whaiora*/mental health clients. When working with Maori both traditional and contemporary cessation methods should be considered.

Overall 35.2% of Pacific people over 15 years of age smoke<sup>7</sup>. Priority goals identified within *The Pacific Health and Disability Action Plan*<sup>8</sup> are to encourage and support healthy lifestyles by way of minimising harm from tobacco and creating healthy environments. Key actions with respect to these priorities are:-

- to ensure that health services are responsive to the needs of Pacific peoples
- to ensure that services provided to Pacific peoples are holistic and encompass a culturally-competent approach
- to explore the development of Pacific Quit Line and smoking cessation programmes
- to improve the availability and delivery of services in the area of smoking
- to improve linkages between Pacific communities and statutory and non-statutory agencies to ensure coordinated and integrated planning

---

<sup>4</sup> Source ACNielsen (NZ) Ltd. Ministry of Health. 2003. *Tobacco facts 2003: Public health intelligence occasional report No 20*. Wellington: Ministry of Health.

<sup>5</sup> Minister of Health & Associate Minister of Health. 2002. *He korowai oranga – Maori health strategy*. Wellington: Ministry of Health.

<sup>6</sup> Aparangi Tautoko Auahi Kore - Maori Smokefree Coalition. 2003. *National Maori tobacco control strategy 2003 to 2007*. Wellington: Aparangi Tautoko Auahi Kore.

<sup>7</sup> Source ACNielsen (NZ) Ltd. Ministry of Health. 2003. *Tobacco facts 2003: Public health intelligence occasional report No 20*. Wellington: Ministry of Health.

<sup>8</sup> Minister of Health. 2002. *The Pacific health and disability action plan*. Wellington: Ministry of Health.

## PART ONE: COMMUNITY SMOKING CESSATION SERVICES

A framework for smoking cessation adopted by New Zealand<sup>9</sup> consists of the Five A's. It is recommended that all primary care providers utilise this framework:-

*Ask* – identify and document smoking status

*Assess* – assess a person's willingness to quit. This involves identifying the stages of change<sup>10</sup> with respect to quitting, namely being not ready to quit, contemplating quitting, ready to quit soon and/or in a maintenance or relapse stage

*Advise* – offer cessation advice on a regular basis, over an extended period, to all smokers

*Assist* – offer appropriate treatment and assistance to smokers or recent quitters; offer nicotine replacement therapy

*Arrange* – arrange follow-up for smokers

Key factors relating to successful smoking cessation include the following<sup>11</sup>:-

- Smoking cessation represents a dynamic process that occurs over time. On average smokers work through a cycle of pre-contemplation, contemplating quitting, quitting and relapsing three to four times.
- Personalised empathetic smoking cessation advice to smokers increases the likelihood of success.
- A supportive, ongoing relationship with a health professional is often an essential precursor to successful quitting.
- Repeating advice to quit in different forms from several sources over a long period increases success.

Maori are a high priority group for smoking cessation. The following groups of smokers<sup>12</sup> require special consideration:-

- parents or care givers of children
- pre-adolescents and adolescents
- pregnant and breast-feeding women
- people with smoking-related organ damage and people who are hospitalised
- people with mental health problems or other chemical dependencies
- people with heart conditions

Hospitalisation provides a powerful opportunity to quit as patients are often forced to cut down or quit. Medical advice to quit can also provide important motivation.

---

<sup>9</sup> National Advisory Committee on Health and Disability. 2002. *Guidelines for smoking cessation*, 2<sup>nd</sup> edition. Wellington: National Advisory Committee on Health and Disability.

<sup>10</sup> Prochaska, J, Diclemente, C. Transtheoretical therapy. 1982. Towards a more integrative model of change. *Psychotherapy Theory Res Prac*, 19: 276-88.

<sup>11</sup> National Advisory Committee on Health and Disability. 2002. *Guidelines for smoking cessation*, 2<sup>nd</sup> edition. Wellington: National Advisory Committee on Health and Disability.

<sup>12</sup> National Advisory Committee on Health and Disability. 2002. *Guidelines for smoking cessation*, 2<sup>nd</sup> edition. Wellington: National Advisory Committee on Health and Disability.

## **SMOKING CESSATION SERVICES**

### ***Quit Group***

The Quit Group is a charitable trust formed by the Cancer Society, Te Hotu Manawa Maori and the Health Sponsorship Council managing three smoking cessation Programmes – Quit Line, Quit Cards (the exchange provider programme) and the Quit for our Kids Programme. These programmes are funded by the Ministry of Health.

### ***Quit Line***

The national Quit Line provides free and confidential support and information to callers who want to quit smoking. Callers assessed as suitable for nicotine patches or gum and are sent a voucher that can be exchanged at a pharmacy. The first four-weeks' supply costs \$5, and the second months' supply \$10. Smokers can be directed to a culturally-appropriate counsellor.

Using data from the last three years approximately 10% of callers to Quit Line have been from the Wellington area (04 STD code). Of these 15.5% have been Maori, 76.3% have been NZ European/Other European and 4.6% have been Pacific callers.

In terms of effectiveness of the programme approximately 34% of callers who register with Quit Line report that they are smokefree at six months.

### ***Quit Cards (formerly known as the Exchange Card Programme)***

The Quit Card Programme allows health providers with an interest in smoking cessation to distribute exchange cards for NRT to smokers wanting to quit. In order to provide this service health workers need to show evidence of having attended a smoking cessation training programme. It is expected that clients are followed up and supported after receiving NRT (for example 2-3 visits) but this is not monitored by the Quit Group.

It would appear that a number of general practices charge for this service. One rationale for charging is that the client is saving from not buying tobacco. A large IPA in Christchurch has identified a way of reducing this cost for clients (see below – services in general practice).

A range of health providers in the C&CDHB area are registered with Quit Group to provide exchange cards. This includes 8 general practices, Wellington Prison, Salvation Army, the Wellington Division of the Cancer Society, Victoria University, and one Maori health provider.

### ***Quit for our Kids Programme***

Wellington Hospital is currently funded by the Quit Group to provide a smoking cessation programme, 'Quit for our Kids'. The programme is for patients who smoke, adults who have children in hospital, and smokers who are hospital patients themselves and/or who care for children. This programme is further discussed in Part Two.

## **TRAIN-THE-TRAINER SMOKING CESSATION PROGRAMMES**

Health workers who wish to issue vouchers for subsidised NRT need to have attended a smoking cessation programme. Options include the Cancer Society Can Quit Practice Programme (targeted more at general practice), or one of three National Heart Foundation programmes.

### ***National Heart Foundation***

The National Heart Foundation is contracted by the Ministry of Health to provide three train-the-trainer smoking cessation programmes:-

- a generic programme
- a programme delivered by Te Hotu Manawa Maori developed for Maori a priority group
- a programme delivered by the Pacific Islands Heartbeat Programme developed for Pacific people as a priority group

The programme provided by Te Hotu Manawa Maori is an extensive programme taking 11 days to complete; the others are 2-4 days duration.

### ***Cancer Society – Can Quit Practice Programme***

The Can Quit Practice Programme is an evidence-based smoking cessation programme designed by the Wellington Division of the Cancer Society and the Department of General Practice of the University of Otago in Wellington. This programme has been developed for practice nurses, GPs and other health professionals working in primary care. The programme provides the following:-

- a) Two full days training on smoking cessation, the exchange card programme and motivational interviewing. During the programme participants are given a number of prompts, guides and aids.
- b) Following the training, staff are available to provide advice, support and continuing education.
- c) Site visits are undertaken aimed at reviewing patient records and other systems which support smoking cessation.

Quit rates from the programme are identified as 20% at 9 months.

## **BY MAORI FOR MAORI SMOKING CESSATION SERVICES**

### ***Te Hotu Manawa Maori***

Te Hotu Manawa Maori is a national provider of smoking cessation train-the-trainer programmes affiliated to the National Heart Foundation. The agency also provides workshops on the National Guidelines for Smoking Cessation. It is understood that locally there has been low interest in these workshops (personal communication, Sue Taylor, Te Hotu Manawa Maori).

### ***Aukati Kai Paipa***

Aukati Kai Paipa is a 'by Maori for Maori' smoking cessation programme for women as a priority group. However, because environment is crucial to the success of the programme whanau living in the household are also encouraged to be involved in the programme. In this programme NRT is free to the client.

An evaluation of the pilot programme undertaken in 2000 has been published<sup>13</sup>. In this programme clients are given NRT for an 8-10 week period, but continue to be supported for 8 months or longer. Acceptability of the programme is enhanced by Maori delivery in a Maori setting.

Using data from the pilot 23% had quit at 12 months. These figures are likely to be an underestimate of the quit rate as data was not able to be utilised from two providers in the study and a stringent definition of "quitting" was used.

### ***Kokiri Marae Hauora***

Kokiri Marae Hauora in Lower Hutt is one of 37 Aukati Kai Paipa sites in New Zealand. They were also one of 7 original pilot programmes and accordingly call themselves a "tuakana" site. The Kokiri Marae service covers the Hutt Valley and greater Wellington region except Kapiti. The reason Kapiti is not included is that it is difficult to service due to distance.

The contracted service commences when NRT is given to a client. However, in essence, the service begins at least a month prior when the client makes the initial contact with the service. If low motivation is identified the client is deemed not ready for the programme. Quit coaches have weekly face-to-face contact with clients for 3-4 months, followed by monthly phone or face-to-face contact for a further 9 months.

The programme uses minimal advertising relating to budget constraints and current workforce capacity. Referrals tend to be by word-of-mouth and people who know about the programme. Several general practices consistently refer to the service. Others who refer include whanau/family, Maori health providers, Wellington and Kenepuru Hospital, and workplaces.

The Kokiri Marae programme reports a very high quit rate. In the last two years the 12 month quit rate has been 57% (2002) and 73% (2003).

### ***Hora Te Pai Health Services, Paraparaumu***

Hora Te Pai Health Services provide Whanau Ora, Tamariki Ora, and Maori Well Women's services to Maori, Pacific and high need families residing between Paekakariki and Peka Peka. Smoking cessation support is provided by one worker able to issue vouchers for NRT. This service is provided as part of an existing service and is not separately funded.

---

<sup>13</sup> Ministry of Health. 2003. *Evaluation of culturally appropriate smoking cessation programme for Maori women and their whanau: Aukati Kai Paipa 2000*. Wellington: Ministry of Health.

### ***Maraeroa Marae Health Clinic, Porirua***

Maraeroa Marae Health Clinic is a Maori health service in Porirua. Services include whanau ora, tamariki ora, well women's health promotion, maternity support, outreach immunisation, injury prevention and asthma services. One community health worker at Maraeroa Health Clinic is able to support clients wanting to quit smoking and issue vouchers for NRT. This service is provided as part of an existing role and is not funded. The Manager would like to extend this service.

### ***Ora Toa Health, Porirua***

Ora Toa Health is an iwi health service in Porirua with three medical centres (enrolled population 10,000) and a health unit providing a range of community services. Services include tamariki ora, whanau ora, maternity support services and management of people with diabetes, cardiovascular and respiratory disorders. A kaupapa Maori Drug and Alcohol service is also provided. Three staff within Ora Toa Health are trained in smoking cessation (one practice nurse, one community health worker and a worker in the Drug and Alcohol service). The service is currently seeking a contract with Quit Group to issue vouchers for NRT.

## **SMOKING CESSATION FOR PACIFIC PEOPLE**

Five workers from Pacific Health Service Porirua have been trained in smoking cessation and are hoping to be able to issue NRT in the near future. Training is planned for workers at the Pacific Health Service Wellington. An identified service issue is the need for additional funding to ensure that this service is able to be given appropriate priority.

### **PHO's**

PHO's have funding dedicated to services to improve access. This funding is used in many different ways but it is possible that access to a free or low cost smoking cessation service could be funded from this.

## **GENERAL PRACTICE**

### ***Wellington Independent Practice Association (WIPA)***

WIPA employs a respiratory coordinator who manages the smoking cessation and other respiratory programmes. The WIPA smoking cessation programme grew out of work on a joint C&CDHB - WIPA Models of Care project which aimed to reduce the impact of chronic obstructive pulmonary disease (COPD) on the health services. As a result of involvement in this project many practice staff belonging to WIPA have attended smoking cessation training and are registered to issue NRT vouchers. The quit rate of clients at WIPA practices is 23% at six months. A proportion of WIPA practices charge for smoking cessation.

### ***Porirua Union Community Health Service***

Two nurses at Porirua Union Community Health Service have attended smoking cessation training and issue vouchers for NRT. The agency is a part of the Cancer Society Can Quit Practice programme and provides services free-of-charge.

### ***Newtown Union Health Service***

Due to time constraints the Newtown Union Health Service has chosen not to have a dedicated smoking cessation service. Staff refer patients to Quit Line or to the Kokiri Marae Aukati Kai Paipa Programme.

### ***Pegasus IPA***

Pegasus IPA in Christchurch has developed a smoking cessation programme for patients which is essentially free-of-charge to the patient apart from the cost of subsidised NRT. Information on this programme is included with this review as it provides a possible model that could be adapted in the Wellington region.

Many GPs and practice nurses within the IPA have been trained in smoking cessation. Pegasus buys the NRT from the pharmacy and then claims back the cost of subsidised NRT retrospectively. For each week clients are on NRT they are asked to return to the practice to collect their next supply and pay \$2.50 (a four week subsidised supply is normally \$10). This mandatory contact with the practice enables the client to have weekly follow-up by a practice nurse.

In order to compensate for staff time Pegasus pays practices \$20 for each enrolment on to the Quit Card Programme. An additional \$10 is paid at six months when clients are contacted to obtain their quit status. External evaluation of the programme in 2000 identified a 23% success rate at 6 months which has remained stable over time.

## **PRIVATE SMOKING CESSATION SERVICES**

### ***Dr Simon Ryder-Lewis Breathe Easy Clinic***

Dr Ryder-Lewis is a medical practitioner who provides smoking cessation programmes to individuals or group sessions in workplaces. The cost is \$300 per person, with substantial reductions for groups with over 10 participants. In addition to the smoking cessation programme he provides dietary advice to avoid weight gain, NRT if needed to reduce withdrawal symptoms, and follow-up during the months after quitting. Data on the quit rate from this programme was unavailable.

## SMOKING CESSATION AND YOUTH

A national survey of fourth form students<sup>14</sup> identified females as being more likely to smoke than males. The reverse is true for Asian fourth formers where smoking among males is more common, but numbers are small compared to other ethnic groups.

Maori females in the fourth form have a high rate of smoking<sup>14</sup>. National data indicates that over 40% (41.8%) report at least weekly smoking and 34.3% report daily smoking. The level of smoking by secondary school students is inversely associated with school socioeconomic status. Male and female students at schools with a low socioeconomic quintile have 2.5 and 4.2 times the daily smoking rate compared to students at schools with the highest quintile<sup>15</sup>.

The numbers of young people who smoke contributes to the stable overall prevalence of adult smoking – this group takes the place of adults who have stopped smoking. From 1 January 2004 the new Smoke-free Environments Amendment Bill 2003 will mean that all schools will be required by law to be completely smokefree indoors and outdoors. Role modelling of smokefree behaviour and promotion of positive attitudes about smoking in this environment may motivate youth to be smokefree.

The smokefree workforce in the Wellington/Wairarapa area has been concerned for some time about the lack of smoking cessation services for youth and is currently looking at strategies to respond to this need. One problem has been the lack evidence-based models on which to base programmes for this group. Internationally there is a strong move towards youth smoking cessation initiatives that are “youth led but adult-guided”. Further consideration will need to be given to smoking cessation services for this group.

## SMOKING CESSATION IN PREGNANCY

Women who smoke in pregnancy are an important high risk group. Quitting at any point in the pregnancy yields benefits, although the earlier the abstinence the greater the benefit<sup>16</sup>. There is a high relapse rate in the post-natal period<sup>17</sup>.

---

<sup>14</sup> ASH national fourth-form survey. 2002.

<sup>15</sup> Ministry of Health. 2003. *Tobacco facts 2003: Public health intelligence occasional report No 20*. Wellington: Ministry of Health.

<sup>16</sup> National Advisory Committee on Health and Disability. 2002. *Guidelines for smoking cessation*, 2<sup>nd</sup> edition. Wellington: National Advisory Committee on Health and Disability.

<sup>17</sup> National Advisory Committee on Health and Disability. 2002. *Guidelines for smoking cessation*, 2<sup>nd</sup> edition. Wellington: National Advisory Committee on Health and Disability.

Nicotine passes freely to the newborn in breast milk, therefore smoking while breast feeding is not recommended. However, the New Zealand Cessation Guidelines<sup>18</sup> provide unclear advice for women who are pregnant. On the one hand, it is identified that the risks for the mother and foetus associated with continued smoking are greater than those associated with NRT (p 22). Yet it is also stated that NRT should be “considered when a pregnant or breastfeeding woman is unable to quit, or when the likelihood of quitting with it’s potential benefits outweighs the risks of NRT and potential continued smoking” (p16). It is understood these guidelines will be reviewed in 2004, after which time seminars to midwives would be helpful.

Research has been undertaken by the Wellington School of Medicine and Health Science on the midwife’s role in smoking cessation and the use of NRT. Findings are yet to be published. Results able to be communicated at this time are that while most midwives question women on their smoking status only a little over half (55%) give smoking cessation advice (personal communication, Dr Deborah McLeod, Research Director, Department of General Practice, Wellington School of Medicine and Health Sciences). Thus, there would appear to be potential to improve the smoking cessation advice given by midwives.

## **DISCUSSION**

Quit rates of various programmes should be interpreted with caution as the time intervals at which quit rates are reported are variable and smoking cessation programmes do not have a standard definition for quitting. Success within programmes may also relate to instrumental factors such as the amount of funding to deliver the programme and aspects of service delivery, for example the rigor with which clients are chosen.

A range of smoking cessation programmes are available for people residing in the C&CDHB area. The Quit Group funds a range of programmes namely Quit Line, the Quit Card Programme and Quit For our Kids. Any member of the public can self-refer to Quit Line, however a telephone is required to access this service. The Ministry of Health also funds Kokiri Marae Hauora to provide a Maori-specific smoking cessation programme in the greater Wellington region. Health workers can choose to attend a range of smoking cessation workshops and be registered to issue vouchers for NRT.

Following a review of smoking cessation services in the community key issues are identified below: -

### *Services for Maori*

All Maori providers consulted advocated that the more personal services provided by Maori providers have the capability of reaching a client group that would not normally access Quit Line. Kokiri Marae Hauora in Lower Hutt provides a very successful Maori-specific smoking cessation programme for the greater Wellington region. Services could be enhanced by developing the capacity of Maori providers in Wellington City and Kapiti Coast to provide this service.

---

<sup>18</sup> National Advisory Committee on Health and Disability. 2002. *Guidelines for smoking cessation*, 2<sup>nd</sup> edition. Wellington: National Advisory Committee on Health and Disability.

### *Services for Pacific people*

Pacific Health Services Porirua have staff trained in smoking cessation and staff at Pacific Health Services Wellington will attend training in the near future. This will hopefully lead to authorisation to issue vouchers for NRT. However, despite the will to manage this service staff are fully engaged in other health activities. Consideration could be given to funding to assist these two providers.

### *Services for pre-and post-natal women*

Lead Maternity Carers (LMCs) are understandably inhibited giving NRT when the national guidelines<sup>19</sup> are unclear on the management of women who are pregnant. Workforce provider development with LMCs could be considered following review of the guidelines in 2004.

### *Smoking cessation and youth*

Youth smoking cessation services are under-developed in the region and C&CDHB could consider funding cessation services for this client group. As there are no local or international models on which to base services, programmes should be developed as pilots.

### *Smoking cessation training*

A range of health professionals and community workers have attended smoking cessation training and are registered to issue vouchers in exchange for NRT. However, smoking cessation training alone increases awareness of health promotion opportunities that are presented on a daily basis and the need to motivate clients along the "cycle of change". The more health workers that have received this training, the more intensive and coordinated will be the approach. Short education sessions may facilitate staff being released to attend sessions.

### *Services in general practice*

The cost of smoking cessation services in general practice may prevent low income people from accessing this service. A large IPA in Christchurch has a system of enabling this service to be free. This model should be shared with practices and PHOs as it may have merit locally.

Maori and Pacific clients may be more at ease with a smoking cessation provider of their own ethnicity. Information on Maori and Pacific smoking cessation providers should be available to general practice to assist when service options are discussed.

### *Service coordination*

Smoking cessation services may be improved by increased service coordination, and liaison and referral between providers. As part of their health promotion role Regional Public Health could be asked to distribute information to providers on the range of smoking cessation services in the community and the names of Quit Coaches.

---

<sup>19</sup> National Advisory Committee on Health and Disability. 2002. *Guidelines for smoking cessation*, 2<sup>nd</sup> edition. Wellington: National Advisory Committee on Health and Disability.

### *Workforce Provider Development*

Since the establishment of the Aukati Kai Paipa programme staff have gained considerable experience in smoking cessation that could be shared with others. It is recommended that discussions be held with Te Hotu Manawa Maori and Kokiri Marae Hauora to identify willingness to be involved in workforce provider development with GPs and Quit Coaches in C&CDHB.

## **PART TWO: HOSPITAL SMOKING CESSATION SERVICES**

### **INTRODUCTION**

C&CDHB is currently funded by the Quit Group to provide a smoking cessation programme. Nine other sites in New Zealand are funded to deliver the programme, with C&CDHB the largest urban site.

The Quit for our Kids Programme (QFOK) programme is described as a brief smoking intervention programme with follow-up discontinued at three months. The programme has been designed specifically for patients who smoke, adults who have children in hospital, and smokers who are hospital patients themselves and/or who care for children. Staff can self-refer to the programme if they meet the criteria, provided they do not constitute more than 10% of the site's total programme clients.

### **BACKGROUND**

The QFOK Programme has officially been in operation since June 2001. Two Quit Coaches have been employed full-time since the inception of the programme. Staff are employed by the Medical-Surgical Services Group and have a dual reporting role to this service and the Quit Group. The female coordinator manages the women's services and children's wards, while the other coordinator, a male, manages the other wards. Referrals from Wellington Hospital occupy most of their time, however staff will travel to Kenepuru Hospital if more than five clients require assessment and support. NRT is provided is free-of-charge to clients.

### **THE REFERRAL PROCESS**

#### *Referral*

In the first eighteen months of the programme referrals were by word-of-mouth. Early efforts were made to include smoking questions on the admitting form and this was achieved after eighteen months. A daily list from the admission office is now available detailing all patients' answers to these questions. The number of those who are uncertain about quitting is very high. One issue raised by Programme staff was this rate could be improved if clients are given more information about the programme when this form is being completed. The Quit Coaches continue to meet with staff to provide information and gain support for the programme but are aware that efforts to reach relevant staff could continue to be improved.

As well as receiving information from the Admissions Office, staff also receive referrals direct from wards and departments. Staff regularly walk through the hospital and it is not uncommon to receive referrals as they do this. When time permits the Quit Coaches also take the opportunity to talk to nursing staff at team meetings.

## *Assessment*

Staff visit most clients while they are hospital; if discharged early they are followed up at home. As part of the programme the assessment protocol lists a large number of medical contraindications for NRT (Table 1). Medical clearance is required for acceptance on the programme. If referred by a medical practitioner it is assumed the client has approval to be on the programme.

**Table 1: Contraindications for NRT [QFOK Assessment Tool]**

- Pregnancy
- Breast feeding
- Cardiovascular disease
- Asthma
- High blood pressure
- Stroke
- Gastric diseases/ulcers
- Diabetes requiring insulin
- Using antidepressant
- Generalised skin disorder
- Kidney/liver disease
- Thyroid condition

Some patients are initially prescribed NRT by resident medical staff rather than Programme staff. Clients from out of the district are given initial support and referred to other smoking cessation programmes on discharge.

## *Follow-up and support*

The database supplied by QFOK which stores statistical information also acts as a recall register. Staff receive daily reports of clients who need to be contacted.

## *Discharge*

Clients are discharged from the service at three months. Some clients are referred earlier to a community smoking cessation programme, for example Aukati Kai Paipa. Depending on need clients may be supported for a longer period of time.

## **PROGRAMME DATA**

### ***National data***

An evaluation of the national QFOK Programme was undertaken from May 2001 to May 2003<sup>20</sup>. Over one third (39%) of programme clients had no formal educational qualifications and 36% were Maori. This compares to 2001 Census data<sup>21</sup> in which 24% of the population were identified as having no qualifications and 16% were Maori. Two thirds (64%) of programme clients were female. In this evaluation the quit rate at 12 months was 15%. However, of those that had relapsed a significant

---

<sup>20</sup> BRC Marketing & Social Research. 2003. *Quit for our Kids Programme: Summary of the final report of the evaluation.*

<sup>21</sup> *New Zealand census of population and dwellings.* 2001.

number (74%) had made changes in their attitude and behaviour in relation to smoking, and 30% were planning to quit in the next 30 days.

In the national evaluation clients interviewed were positive about the programme. Three quarters (73%) of those surveyed felt that being in hospital was a good time to stop smoking. A majority rated their Quit Coach as friendly (87%), supportive (77%) and understanding (76%).

### **Local data**

#### *Referrals*

In the first year there were approximately 70 referrals to the programme, with numbers increasing three-fold in the second year as hospital staff became familiar with the programme.

Data has been obtained for four months of the programme from July to October 2003. In this four month period 116 new clients were accepted on to the programme, an average of 29 per month. Within this group 56.4% were NZ European/other European, 33.3% were Maori, 8.5% were Pacific and 1.7% were from other groups. This compares to the hospital admission rate of Maori at 13.6% and Pacific at 9.1%<sup>22</sup>.

Consistent with national data, in the three month period from August to October 2003 60.8% of new clients were female and 39.2% were male (July excluded from the analysis due to a database error).

Programme staff report a good success rate with clients in the cardiac and respiratory departments. One reason for high motivation in these wards is that clients have been given a medical reason for quitting. Dr Peter Martin, a respiratory physician in the Department of Respiratory Medicine (also on the Board of the Quit Group) is very supportive of the programme. Physicians, surgeons, registrars, house surgeons and nurses are becoming more supportive as the programme continues.

The four main areas of referral to the programme are Surgical, Medical, Cardiac and Other wards (Table 2). Given that the cardiac area is a specialty area, a rate of 19.8% of all clients coming from this department is indicative of good support of the programme. A smaller number (6.8%) are from the Department of Respiratory Medicine, but this rate is significant when compared to larger medical and surgical units that have been grouped for analysis.

A small number of clients are referred from paediatric wards, which is consistent with other QFOK sites. This may relate to misunderstanding by parents that the question on smoking relates to them when they are completing admission details for their child, or reduced motivation to quit.

---

<sup>22</sup> Admissions to Wellington Hospital June 2002 – July 2003.

**Table 2: Referrals from Ward or Department  
QFOK Programme – July – October 2003**

Medical	21	18.1%
Surgical	27	23.3%
Cardiac	23	19.8%
Respiratory	8	6.8%
Other	24	20.6%
Outpatients	3	1.4%
Maternity/Obstetric	6	5.1%
Orthopaedics	2	0.6%
Paediatrics	1	0.5%
Neonatal	1	0.5%
	116	100%

Specific data on the quit rate for the QFOK programme in C&CDHB is not available. However, between December 2001 and August 2002 a random sample of 15 C&CDHB clients were assessed at three months on their quit status. In this sample a large majority (80%) had not smoked in the last two days (Table 3).

**Table 3: Quit Status at Three Months  
Random sample of C&CDHB clients on the QFOK Programme  
December 2001- August 2002**

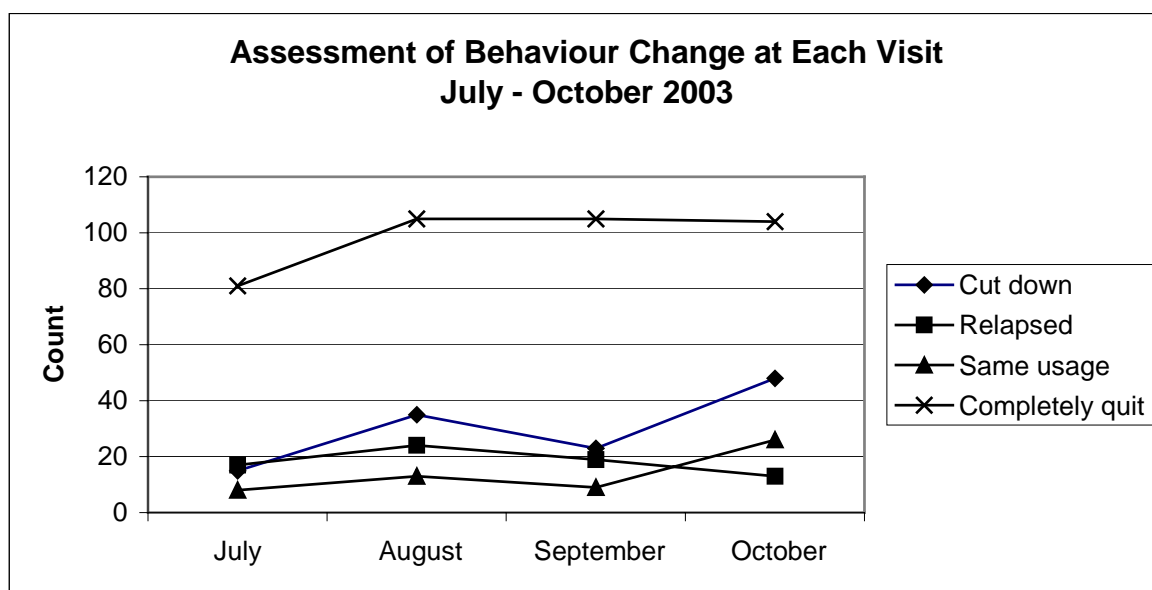
Q3. Are you still stopped? Or have you started smoking again?

	% n=15	Number of clients
· Still stopped (not smoked in last 2 days)	80	12
· Started smoking again	20	3
<b>Total</b>	<b>100</b>	<b>15</b>

### *Behaviour change*

At each follow-up contact clients are asked about behaviour change. In the four month period from in July to October 2003 61.2% of clients had quit completely (no tobacco in two days), 11.3% had relapsed, 18.8% had cut down, and 8.7% were smoking at the same rate (Graph One).

**Graph One: QFOK: Assessment of Behaviour Change at each Visit**



## **PACIFIC SERVICES**

In the last year a Pacific Support Service has been set up within the hospital. Case managers follow-up and support Pacific patients who are hospitalised or attend outpatient or community health services. Smoking cessation is not provided by this service at the present time.

## **DISCUSSION**

Hospitalisation provides a useful opportunity to quit. This relates to advice to reduce smoking prior to an anaesthetic, advice to quit for medical reasons, and temporary incapacity while in hospital. In 2005 there will be increasing pressure on staff and patients to quit smoking when the new C&CDHB Smokefree Policy is implemented.

In the last two years the hospital has been funded to provide a smoking cessation programme through the Quit Group. Data obtained in a random sample of 15 clients and on behaviour change over a four month period are very favourable.

In the four months from July to October 2003 the highest number of referrals were received from medical, surgical, cardiac and "other" wards. Compared to the known rate of Maori and Pacific people who smoke the programme appears to be supporting an appropriate number of Maori clients, but a reduced number of Pacific clients.

As with any new programme the service may be further developed. These areas are summarised below:-

### *Referrals to the programme*

A high number of people admitted to Wellington Hospital identify that they are uncertain about quitting. One issue raised by Programme staff was this rate could be improved if clients were given more information about the programme when this form is being completed. Continued discussion with Admissions Department staff could improve information given to clients.

### *Marketing the programme*

The Quit Group Training Coordinator and local staff have worked hard to market the programme. The employment of new medical and nursing staff provides an excellent opportunity to market the programme and gain support. QFOK staff regularly talk to 4<sup>th</sup> and 5<sup>th</sup> year medical students and to new medical and nursing staff at their corporate orientation. Role plays demonstrating the ease with which assessment for smoking cessation can be made are well received.

Quit Coaches are employed to support patients but may be reticent marketing the programme at management level (personal communication, Training Coordinator, The Quit Group). It is important that senior management staff of C&CDHB continue to actively support the programme. Communications staff could also be invited to assist with publicity.

### *Staff smoking cessation programmes/in-service education programmes*

Staff who are informed of smoking cessation will “champion” the programme. As a way to maintain high awareness of the programme it is recommended that short in-service education sessions be offered regularly to all nursing staff and “front line” health workers. A quit smoking programme could also be developed for staff.

### *Information to health providers*

It is important to keep staff in general practice updated on the QFOK programme and services offered to encourage referral. Similarly, a database of Quit Coaches employed in the community would be useful for all providers in order to facilitate service coordination, liaison and referral.

### *Contraindications for involvement in programme*

Pregnancy and cardiovascular disease are identified as contraindications for involvement in the programme. Despite this contraindication it is gratifying to note that a high number of referrals are received from the cardiac department.

Small numbers of pregnant or post-natal clients are referred. The Quit Coaches reported that the pregnant women referred will commonly volunteer that their midwife has advised that they should not use NRT. The two workers felt that clients do not necessarily agree and may offer this information as if seeking a second opinion. Recommendations on the management of this client group have been discussed in Part A of this report.

*Service gap: Services for Maori*

Kokiri Marae Hauora provides a very successful smoking cessation programme in the greater Wellington region. Additional local services could be further developed within existing Maori providers.

*Service gap: Services for Pacific people*

Quit Coaches who are Pacific may be better able to motivate and support Pacific clients. At the present time staff within the Pacific Support Service at Wellington Hospital are not trained in smoking cessation. However, given the multiple responsibilities of staff within this unit it may be best if existing Quit Coaches support Pacific clients while in hospital, but clients are referred to a Pacific provider on discharge.

*Service gap: Kenepuru Hospital and Kapiti*

Discussion with the two Quit Coaches identified that it is not cost-effective travelling to Kenepuru Hospital and Kapiti to see clients. Further consideration needs to be given to the way in which clients are best supported in these areas.

*Service gap: Acute and community mental health*

Clients with mental illness have a high rate of smoking, however the number of referrals from this area have not been identified. It may not be appropriate for clients to be encouraged to quit in the acute phase of their illness, but consideration could be given to developing a programme for clients in recovery. The ability to identify referrals from this group in programme data would be useful.

*Service gap: Pre-operative assessment clinics, and community services*

Clients advised to quit for medical reasons are highly motivated. The two Quit Coaches have a good working relationship with staff in the pre-operative assessment clinics and a number of clients are referred to the programme. If GPs were more aware of the programme clients booked for surgery could be referred earlier. Patients attending community services could also be referred.

*Funding*

At the time of writing it is not known if the Quit Group will be able to continue to fund the programme. It is hoped that funding will continue as the local programme is very successful. The potential exists for further developing services for a range of client groups for example mental health clients, pre-operative clients, women who are pregnant, and clients within community health services. The programme could be also further strengthened by increasing staff training on smoking cessation.

Possible funding changes coupled with increased coordination and capacity of community smoking cessation services could provide the opportunity for service redesign. Given the short length of time many surgical patients now spend in hospital the role of the Quit Coach as a broker of care could be utilised, with clients referred to other providers on discharge. Consideration could also be given to funding a dedicated quit smoking programme for staff.

The relatively small cost of the programme must be weighed up against the potential health gains of reduced admissions to hospital.