3.2

Implementing a Stop Smoking Service

Designing a Service Strategy

Key Decisions

Before implementing a Stop Smoking Service a number of important decisions need to be made. The decisions made will inevitably determine whether the service succeeds in achieving its aims and is maintained over time. The issues that need to be addressed include what the service aims actually are, and which levels of treatment are to be delivered in which circumstances. A number of recommendations relating to these decisions are presented below.

Service Aims

It is important to establish exactly what a service is intended to achieve. This, in turn, will depend on the context within which a service is being delivered. For example, some mental healthcare services that only see patients for a very short period of time may take the decision to restrict their smoking cessation related aims to brief intervention and referral. However, if at all possible, mental health services should take the opportunity to deliver a full and consistent pathway from brief intervention through to intensive stop smoking support. This full service will incorporate at least three key aims (McNally, 2006):

Aim 1: Conduct Widespread Staff Training in Smoking Cessation Support: This aim is fundamental in implementing a smoking cessation service and should serve to ensure that the mental health trust has sufficient ownership over the service (rather than leaving it to the local stop smoking services). They key word in this aim is 'widespread'. That is, if a service is to be effectively promoted during routine care then a large proportion of trust staff will need to have been trained in at least brief (level one) interventions (see section 3.3).

Aim 2: Make Brief Smoking Cessation Intervention a Part of Routine Clinical Care: In many cases, this aim will be the most difficult to achieve. Yet it is an essential aim if real differences are to be made to the prevalence of smoking among mental health service users. Routinely raising the issue of patients' smoking (maybe on admission or discharge) is by far the best tool for promoting a smoking cessation service, as well as a way of fundamentally addressing the place of smoking within the culture of the mental healthcare system. The value of and implementation of routine, brief intervention is discussed in Section 3.4.

Aim 3: Provide a System of Accessible and Effective Smoking Cessation Support. By far the most important word in this aim is 'accessible' since it is service accessibility rather than service effectiveness that is likely to be the greatest challenge in a mental health setting. A 'Four Dimensional' Treatment Framework for delivering stop smoking support is presented in Section 3.5, while the individual elements that treatment should address are discussed in Sections 4.1 to 7.2.

Levels of Intervention

In mental healthcare, one size rarely fits all, and the level of intervention should always reflect the needs of the patient at any particular time. For example, a patient who is only considering stopping

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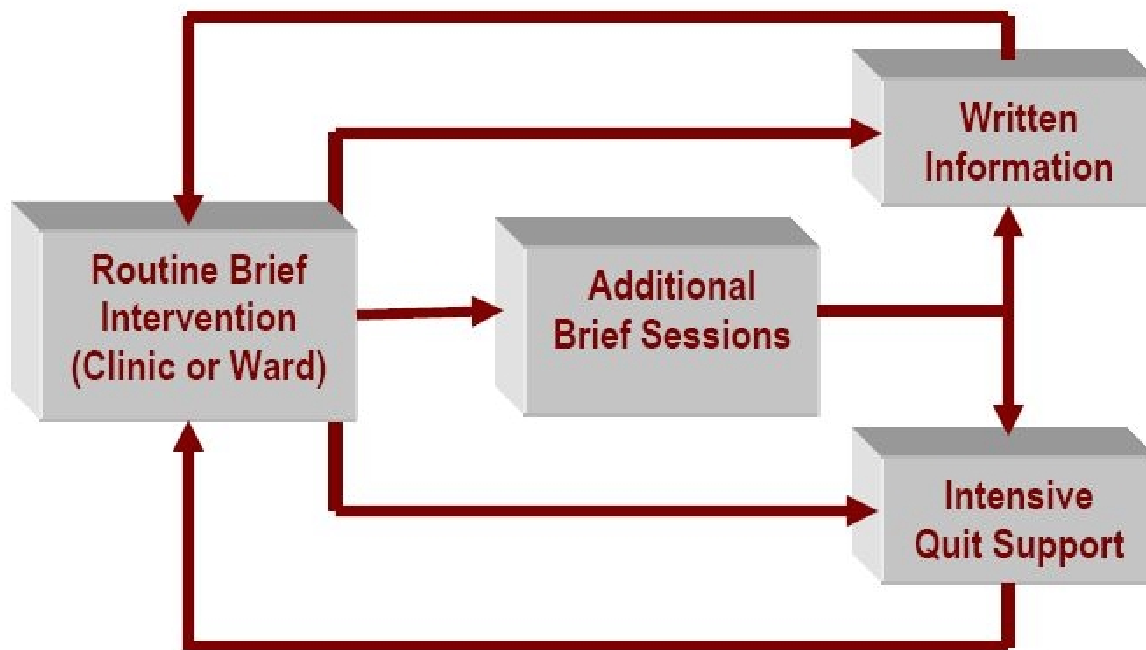
smoking and not fully committed to a quit attempt may find a full-blown, intensive intervention incorporating several weeks of support too much and rather overwhelming.

Therefore, the structure of a smoking cessation system should adopt a ‘stepped’ approach, in which patients may (or may not) progress through levels of intervention that best suit their needs. This not only avoids an inappropriate level of intrusion into the patient’s life, but also ensures a more efficient use of human and financial resources. One example of a stepped approach first outlined by McNally (2006) is illustrated below.

A Stepped Approach to Service Delivery



For each patient, a brief intervention should be delivered routinely (see section 3.4). The point at which a brief intervention is delivered will of course depend on the care setting and the condition of the patient. On wards, for example, brief interventions may be worked into the routine around admission (if the patient is well enough), at a care-plan review or upon discharge. For community-based patients, brief interventions may be carried out as part of a regular clinical appointment with the care coordinator.

As illustrated above, a brief intervention may have one of at least three outcomes. First, and maybe most commonly, the patient will express a lack of motivation to quit and little interest in further intervention. In these cases, written information about smoking and details of local available support can be given. The intervention should be entered into the patient’s notes along with a recommendation that the intervention be delivered again after a few months.

Second, it is also quite common that the patient may express an interest in quitting, but also an unwillingness to commit immediately to further intervention. The aim here is to avoid ‘pushing’ the patient into a quit attempt, which would be entirely inconsistent with the ‘person-centred’ approach described in the previous chapter. Rather, the clinician should suggest some ‘breathing space’ and time for the patient to make a decision. In these cases, written information can be given as before, but in addition, another brief session should be arranged for within a few days (additional brief sessions should preferably be delivered by the same clinician but may, in cases of discharge for example, be passed on to a colleague in the community or the stop smoking service). After further, brief sessions

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the client may be referred onto intensive quit support or, if still unwilling to quit, given written information as in outcome one.

Finally, a third possible (although less common) outcome of a brief intervention is that the patient expresses an immediate keenness to quit and the desire to find help in doing so. In these cases, the decision has usually been made some time before and the intervention has acted as a 'trigger'. A straight referral to intensive quit support is therefore appropriate in these cases.

It is important to note, however, that a referral to intensive quit support does not negate the need to recommend another brief intervention in, say, a few months time. Depending on the outcome of the intensive support, a future brief intervention may well serve to reverse or prevent relapse, and remains an essential part of the patient's ongoing support.

Pharmacotherapy

A potential barrier in the delivery of Stop Smoking Services can be access to pharmacotherapy. The various pharmacological treatments are discussed in Section 4.1. However, the mechanism for the prescription and delivery of these treatments needs to be discussed and agreed from the outset. One option is that all requests for pharmacotherapy are directed to a member of medical staff who can write a prescription. While this route is simple to establish, it can lead to delays if a smoking cessation service is attempting to treat several service users at one time.

Another option that can save both time and enhance the continuity of care is the establishment of a Patient Group Direction (PGD). A PGD is a document that is agreed and signed by a senior member of medical or pharmacy staff. It acts as a direction to a nurse to supply and/or administer certain medicines to patients using their own assessment of patient need. It therefore takes away the need for a medical staff member to write an individual prescription in every case.

A Patient Group Direction in mental health settings is likely, at this point in time, to relate only to Nicotine Replacement Therapy. Bupropion is a fairly complex drug to prescribe due to the numerous known interactions with other medicines and its potential to lower the seizure threshold. Varenicline is a new drug that has not been extensively examined in mental health settings (although this situation will change in the near future), and at least for the moment, it is best delivered to mental health service users via individual medical prescriptions.

The drawing up of a Patient Group Direction is a relatively simple process if the appropriate people are involved (eg – senior medical doctor, senior pharmacist and a service manager). Issues to be decided upon are the range of products that can be supplied, the source of funding, and the staff that may operate under the PGD. Guidance on implementing PGD's is widely available (eg: RCN, 2004) and templates of PGD's are available for downloading (eg – PHLink, 2009).

References

- McNally (2006). Smoking & Mental Health. Helping Smokers Quit in Mental Health Settings. Bristol: Gasp
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