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Implementing a Stop Smoking Service Brief Intervention & Referral

Are Brief Interventions Effective?

The aim of a brief intervention should not primarily be seen as smoking abstinence. Rather, the intended outcome in most cases will be a referral for intensive stop smoking support. Despite this, brief advice does have an independent effect on cessation rates. A systematic review has identified 41 trials, conducted between 1972 and 2007, including over 31,000 smokers (Lancaster & Stead, 2008). Pooled data from 17 trials of brief advice versus no advice (or usual care) detected a significant increase in the rate of quitting (relative risk (RR) 1.66).

Who Should Receive a Brief Intervention?

In short, brief interventions should routinely be delivered with everyone that smokes. By working towards this aim in a mental health setting we are reducing an important inequality in service access and providing an opportunity for service users to utilise something that is widely available to the general population.

In some cases, however, mental health service users will not be in a position to respond to a brief, smoking cessation intervention. Examples may include the time soon after admission to an acute care ward, when a service user may be upset, angry or confused. Therefore, mental health service staff need to examine the usual pathway service users follow through their service and determine the most appropriate time to deliver routine brief interventions.

Once this appropriate time has been identified a service should incorporate brief interventions into its regular routine. This may include making the intervention part of routine assessment schedules or as part of care planning meetings.

How to Deliver a Brief Intervention?

The delivery of a brief intervention should not be too 'scripted'. That is, the professional should attempt, as far as possible, to allow the service user to give their opinions on the issues being discussed and pose their own questions and concerns. Some form of pre-set structure is useful however, and previous work has highlighted the usefulness of a "Four A's" approach: Ask, Advise, Assist, Arrange (West et al., 2000).

Ask: The intervention should begin with the professional asking about the service user's smoking. Here, it is crucial that the tone is conversational and not conducted like an interview from behind a clipboard. Most patients will have some previous experience of being 'hassled' or 'told off' about their smoking by a health professionals, so the aim is to put the patient at ease and avoid any sense that this will be another such occasion. One useful question in the Ask stage is "What do you like about smoking". This question can often serve to open up a dialogue, as well as allow the service user to reflect on what function smoking serves for them.

Advise: The Ask stage is followed by the offer of brief advice. However, before the professional delivers a 'lecture' on the dangers of smoking it may be useful to invite the service user to contribute to this advice from his or her own knowledge and experience. The aim here is actually to get patients to 'advise' themselves, by asking a questions such as "What is that you don't like about smoking?" or "What do you know about the dangers of smoking?" This approach again allows the service user to more in control of the intervention and less 'preached at'.

Advise: While the advice stage is about 'why' one should quit, the 'Assist' stage should be concerned with 'how' one could quit. A good starting point here is to ask the service user about any previous quit attempts, or what they know about how other people have stopped smoking. The professional can then fill in any gaps in the service user's knowledge about what support is available, including both pharmacotherapy and individual or group support.

Arrange: At then end of the intervention some appropriate action should be taken (and recorded in the notes). In cases where a service user is suitably motivated, an immediate referral to quit support may be acceptable, in which case the appropriate contacts should be made. If the brief intervention has created an 'impulse' to quit smoking then this should be acted upon swiftly and delays in referral should be avoided.

In cases, where it is evident that a service user is undecided about whether now is the right time to quit then it may be beneficial to offer 'breathing space'. Here, the professional and service user may arrange to talk again about the issue in a few days, possibly after the service user has gone through some written information on what stop smoking support involves.

Finally, in many circumstances, a referral to stop smoking support may be refused by the service user. This should not be viewed as a 'failure'. Rather the professional has done his or her job by giving back an opportunity to the service user relating to quitting smoking, and the service user has made an informed choice. In these cases, written information on smoking and contact details should be given, and the 'door left open' to future enquiries and discussion.

References

Lancaster T, Stead LF. (2008) Physician advice for smoking cessation. The Cochrane Database of Systematic Reviews 2008, <http://www.cochrane.org/reviews/en/ab000165.html>

West R, McNeill A, Raw M (2000) National smoking cessation guidelines for health professionals: an update. *Thorax*, 55, 987-999