ALLEN+CLARKE

QUIT GROUP ENVIRONMENTAL SCAN FINAL REPORT

November 2012

Commercial and in confidence

Contents

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1. Executive summary

In May 2012, *Allen + Clarke* was asked by the Quit Group to undertake an environmental scan to inform its future strategic direction. The Quit Group sought a report for presentation to its Board meeting in early September. This report was intended to inform a discussion by the Board on the future strategic direction for the Quit Group. In undertaking this piece of work *Allen + Clarke* committed to:

- assess the wider environment (for example, health priorities, funding pressures, political imperatives, cessation clients' needs, role of the new Health Promotion Agency (HPA) and how these may affect the Quit Group over the short to medium term (next five years);
- assess the incentives that drive the cessation sector and that either encourage or impede good collaboration, coordination, and health outcomes. For example, you are interested in whether a competitive approach to service delivery is a barrier to effective service delivery and good health outcomes, and whether a perception of double dipping (where a person may use a couple of different cessation service 'offerings') is seen by providers and/or the Ministry as positive or negative;
- assess the Quit Group's potential role in helping make the Smokefree Aotearoa/New Zealand 2025 target a reality, including any leadership, coordination, clearinghouse, collaboration facilitation or other functions that it could perhaps offer – or that others could;
- look at Quit Group performance and value for money and to the extent possible, compare with other providers and types of services that are offered, with a view to identifying effective directions for future service delivery - with an eye on the Smokefree 2025 target;
- review the current expectations on the Quit Group vis-a-vis targets for both quantity of clients supported, and the quality / intensity of engagement with different types of clients and quit outcomes (e.g. self-referred and District Health Board-referred; voluntary and motivated versus potentially unmotivated) and assess potential future options for targets and modes of operation on the part of the Quit Group. This includes assessing the likely scale of cost differences for different sub-groups that the Quit Group would or could work with, what should be the Quit Group's core target market and the range of engagements that Quit Group offers or could offer; and
- identify key proposals for discussion and negotiation with the Ministry of Health on setting future expectations for the Quit Group, with supporting rationale and where it exists, evidence (to support the Quit Group's contract negotiations which are expected to commence in early 2013).

Based on the environmental scan, the general consensus is that there is room for improvement across cessation services if New Zealand is to meet the Smokefree Aotearoa/New Zealand 2025 target. It was recognised that Quit Group is the 'biggest player' in the cessation services sector, and that it has an integral role to play in achieving the 2025 target of less than five percent smoking prevalence in New Zealand.

This Executive Summary outlines the seven key findings from the environmental scan and collates the recommendations that relate to these high level findings.

1.1. ABC Health Targets – How can Quit Group capitalise on these to improve referral numbers from primary and secondary health care?

In July 2009 the Ministry of Health (the Ministry) introduced a focus on providing "Better Help for Smokers to Quit". In 2012/2013 the following health target has been set for District Health Boards (DHBs) (Ministry of Health website, 2012):

> *95 percent of patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.*

The approach approved and promoted to DHBs is referred to as ABC. 'ABC' is a memory aid for health care workers to understand the key steps to helping people who smoke. These steps are as follows (Martin Jenkins, 2009):

A. **Ask** all people about their smoking status and document this.

B. Provide **Brief** advice to stop smoking to all people who smoke, regardless of their desire or motivation to quit.

C. Make an offer of, and refer to or provide, evidence based **Cessation** treatment.

Information available at the time of this research indicates that (Ministry of Health, 2012b):

> *The national result for the Better help for smokers to quit hospital target increased from 91.3 percent in quarter three to 93.6 percent of smokers being offered help and advice to quit nationally in quarter four 2011/12. Over 35,900 hospitalised smokers have been identified in quarter four and 33,631 have received* ***brief advice****.* (Our emphasis)

Therefore the data available for the 2011/2012 year shows that over 139,708 smokers were identified through a hospital based ABC check, and of these 126,567 or 90.6 percent were offered brief advice to quit.

Based on provisional data, performance for the primary care 'better help for smokers to quit' target has improved slightly in quarter four although it is still far short of the 90 percent target. The national average for the fourth quarter was approximately 34 percent in 2011/12. The results are markedly different across DHBs ranging between 20 percent and 56 percent.

Recent research which looked specifically at ABC smokefree outcomes from hospital-based intervention found that just under half of all survey participants said that hospital staff had told them about services or organisations that could assist them with stopping smoking (Wyllie, 2012). Quitline was the main service recalled (25 percent). Mention of Quitline was greater among those aged under 25 years (38 percent). If patients had been advised by three or more staff they were more likely to say they had been told about support services (65 percent) and to recall being told about the Quitline (36 percent). Those spoken to by doctors/specialists were more likely to mention the Quitline (36 percent). Of those that reported being told about Quitline, 17 percent had contact with this service.

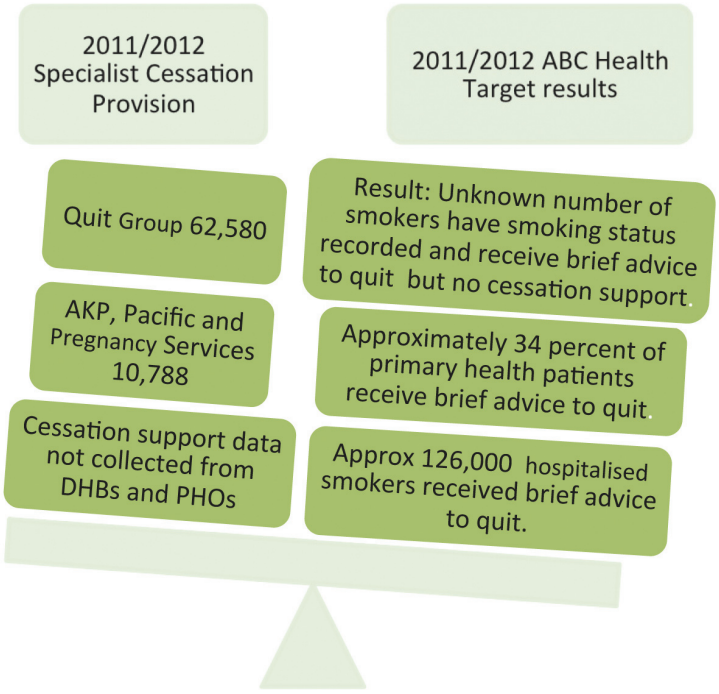
While this research goes some way to addressing Quit Group's concern at the lack of clarity of how DHBs define cessation, even when they do count the C of ABC, it does not provide an insight into ABC in the primary sector. It was felt that more needs to be done to identify whether C is seen as:

1. NRT prescription given, or
2. NRT prescription given and information provided about cessation services, or
3. NRT prescription given and practitioner led cessation support or practitioner driven referral to a specialist cessation service.

Without this level of understanding it is difficult to understand the extent to which smokers receiving ABC from their health professional are likely to access cessation services if they are willing to consider making a quit attempt.

Figure one illustrates the imbalance identified when you compare these figures with the figures available for those who have signed up for a quit attempt in 2011/2012 with Quitline (62,580), Aukati KaiPaipa (AKP) (7,260), Pacific Services (1,632) or Pregnancy Services (1,896) it is clear that there is no information available on the large numbers of smokers who receive the **AB** but are not receiving the **C** part of this approach through these specialist services. Unfortunately, data is not available for smoking cessation services provided by DHBs and/or Primary Health Organisations (PHOs).

Figure 1: Brief advice and cessation support out of balance



Key informants interviewed during the course of *Allen + Clarke*'s environmental scan recognised both benefits and concerns relating to the focus on the ABC health targets. These targets have 'demanded' buy in from health professionals who might otherwise not see smoking cessation as a part of their role. They also present an opportunity for Quit Group, and others, through increased referrals from DHBs. However, it was recognised by key informants that while the ABC approach can be the first step on the smoking cessation pathway it does not automatically lead to a motivated quit attempt. There is a need to recognise that clients referred by their health professional may not be 'motivated' quitters, and may need additional encouragement, information and support to set a quit date.

To date the primary health sector has not been a big referrer to Quit Group. Unfortunately data is not available to identify where primary health referrals are being made to, however there are reports of a number of PHOs setting up their own smoking cessation services, rather than referring to specialist services already available.

The recent introduction of an automatic referral from within the Medtech patient information system will hopefully lead to an increase of referrals as it is rolled out to all general practices. One key informant reported that there were issues with other aspects of the Medtech update that included the 'ManageMyHealth' Quitline Referral and felt that this may have resulted in a lower uptake of this version of Medtech. The possible impact of the automatic referral system is shown in the most recent monthly report from Quit Group where they reported 220 DHB referrals in the month of June 2012, and 136 MedTech referrals for the same period. This is particularly significant when you consider the relatively small numbers reported as receiving ABC in primary care (less than 35 percent of identified smokers).

Until the Quitline Referral within ManageMyHealth is utilised by all primary health providers that use Medtech there are a number of steps that Quit Group could take to increase their referrals from the primary health sector. It was also suggested that in order to increase referrals from the ABC health targets Quit Group would benefit from improving their referral system and strengthening their relationship with those working in regional smoking cessation programmes, particularly DHB Smokefree coordinators. These two issues are addressed in further detail in this report.

Other practical steps suggested by key informants included attending Royal New Zealand College of General Practitioners and College of Primary Health Care Nurses conferences, getting advertisements or articles in publications that are targeted at these groups and sending information to each General Practice/PHO regarding the services they offer and the outcomes they achieve for different demographic groups.

From July 2012 a new health target for cessation support during pregnancy has been introduced which is likely to lead to an increase in referrals for supporting pregnant women:

> *Progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.*

The Ministry is keen for all smoking cessation provider services to ensure they are prepared and able to support increasing numbers of pregnant women to quit smoking. In order to meet the specific needs of this target group, providers need to ensure they have appropriate systems and resources in place.

Recommendation: Promote Quitline services in primary health and DHB smokefree coordinators. Look for opportunities to raise awareness of Quitline services in primary health and with hospitals to increase referrals (section 4.1.1).

Recommendation: Ensure appropriate and targeted support is available for pregnant smokers: this may require additional training and/or the development of specific resources to meet the needs of this target group (section 4.1.4).

Ministry consideration: Undertake a stocktake of cessation services to identify whether there are gaps in quality provision: this should include those services provided by DHBs and PHOs (sections 4.2.3, 4.2.5 and 4.5.1).

1.2. Improved referral processes should lead to increased referral numbers

Quit Group is aware that there are improvements to be made in their referral processes and work is underway to instigate a number of changes. The findings below were generated from interviews undertaken with key informants who were not generally aware of any planned changes and therefore reflect their experience as at the end of July 2012.

Key informants suggested that Quit Group take steps to access the National Health Index (NHI) numbers to improve the linkages between the services that they provide and those provided as part of public health.

Quit Group reports aggregated data on the number of DHB referrals, including the number and percentage of successful contacts and the number and percentage of those contacted that have signed up for Quit Group services. This is demonstrated in **figure two**. However this level of information does not allow health professionals to follow up with the clients who were not able to be contacted by Quit Group to check their contact details next time they come into see their health professional. During the course of the environmental scan key informants from DHBs commented that some of the patients they refer to Quit Group report back that 'Quitline never contacted me'. While it was recognised that for some patients this may have been an excuse, the health professional has no way of knowing if they do not have information from Quit Group to respond with.

The Ministry is keen to see the Quit Group focus on the centre of the target as identified in **figure two** i.e. providing high quality, appropriately targeted services to those clients that have signed up to Quitline. The next focus should be on improving referral systems to increase referrals and successful contact rates through ABC health target outcomes. It was felt by the Ministry that this was the most appropriate way for Quit Group to meet and exceed their contract targets.

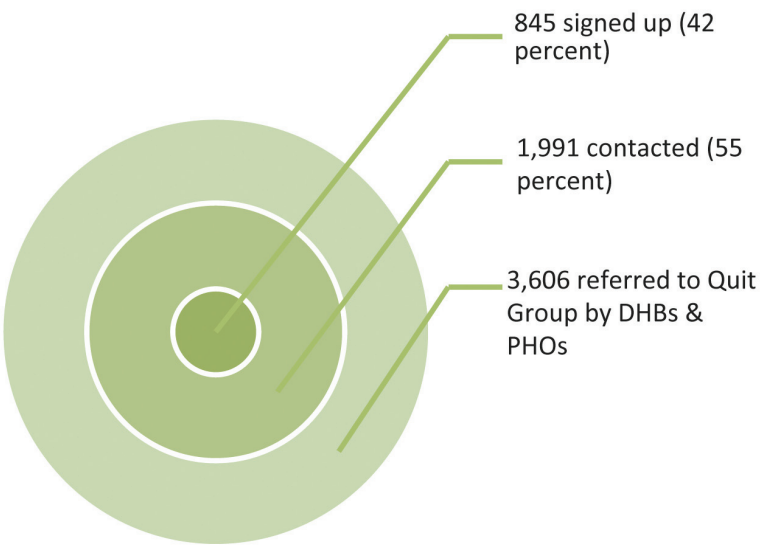


Figure 2: 2011/12 DHB/PHO referrals, contact and sign ups

Feedback to the referrer is a key part of a successful referral, as it provides the referrer with confidence in the service they are referring to. Not only does this encourage future referrals but it also aids follow-up at the point of referral. While providing DHBs with aggregate data on the number of referrals is useful these are not able to be followed up and it was widely thought by other organisations that it would be more useful to inform referrers which clients were not able to be contacted so that they could follow these up themselves. Accessing the NHI for clients should go some way to make it easier to feedback on individuals referred.

Another recommendation was to add the 'best time to contact' to the referral form. This could also prompt referrers to check best contact details at the time of referral. This was noted to be a particular issue when patients are being discharged from hospital as they often do not go home to their usual address.

It was also recognised by many that relationships between providers and others is vital to support appropriate referrals, to create a sense of 'if I refer to you then you will refer to me'. Obviously at all times the appropriateness of the service for the client is integral for successful referrals. There is a recognition across the sector that there is no 'one size fits all' when it comes to smoking cessation services and that all providers need to consider whether their service, or a combination of services, that are most appropriate for the client and where it is identified that they would be better served by another provider then the connections need to be made.

An issue raised by a number of key informants was a lack of awareness of the different services provided by Quit Group and others, and also the outcomes achieved for different groups. Organisations need to be both aware of the services, and the quality of those services, provided by others if they are to be confident that referring a client to a certain provider is likely to achieve the best possible outcome: one less smoker.

Recommendation: Establish a more effective referral system that includes providing feedback to the referrer including success in contacting the client and smoking status at three months (sections 4.1.1 and 4.2.3).

Ministry consideration: Establish a searchable register of quality smoking cessation services informed by tier one reporting to aid referrals. This could be created so the referrer enters basic information about the client to be referred: age, ethnicity, gender, location and any key health issues i.e. pregnancy, diabetes, and the database makes a suggestion of possible services for referral (section 4.2.3 and 4.2.4).

1.3. Improve engagement with regional networks

In many regions cessation providers meet regularly and refer amongst themselves, however Quit Group is not overly 'visible' to these organisations and therefore is not always considered to be part of the response to smoking cessation in their region. This has resulted in an uncoordinated response to smoking cessation across the sector, something that needs to be addressed urgently to achieve the Smokefree 2025 target.

Nearly all key informants suggested that Quit Group would benefit from strengthening their engagement with other organisations working in smoking cessation. One suggestion for how this could be achieved is by attending the smoking cessation network meetings which are held in most regions every 6-8 weeks. It was felt that it was not necessary to attend every meeting, and that once or twice a year would suffice. However, it could be useful to also investigate utilising phone and/or video conference services to support this relationship building.

In order to develop these relationships the first step would be to find out who leads these networks and make contact to discuss how Quit Group could fit within their programme. These contacts would also be useful when it comes to consultation for new initiatives, and it is vital that they are kept informed with what new initiatives Quit Group is planning. Regular contact with regional networks could also be useful for helping to ensure the data that Quit Group makes available is accessed more widely by other organisations. If regional cessation providers had a better understanding of the

numbers of smokers in their region who were using Quit Group's services this could help them to see Quitline as part of the regional response to smoking cessation.

It was felt that a key consideration for Quit Group engagement with regional networks was to listen. This was considered to be a priority in order to find out what provider networks are doing in the regions, where their successes are, and where they might benefit from further information or support from Quit Group. There was some concern from key informants that if Quit Group's attendance at these meetings was not carefully managed it could have a negative impact on these relationships. Key informants strongly emphasised that Quit Group representatives need to demonstrate an understanding that their services are part of the answer to regional smoking cessation, not the definitive answer to smoking cessation. Quit Group agrees that Quitline services are not the whole answer to smoking cessation and recognises that the perceived view of other providers is different.

Discussion regarding clients accessing a number of smoking cessation services from different providers during their quitting journey raised a number of possible suggestions for how engagement with regional networks could be strengthened. One informant felt that inviting people to visit the Quit Group offices if they were in Wellington to 'see their services in action' could help to build understanding amongst others of how Quitline could work alongside their own services to support smoking cessation. Another suggested demonstrating Quit Group's online resources and discussing with providers how they could use these as part of their work i.e. using the online Quit Stats tool and Quit Blogs to support face to face provision. This would help to build an understanding that smoking cessation providers can, and should, work together, rather than in competition to achieve the Smokefree Aotearoa/New Zealand 2025 target. This should also help to avoid duplication of resource development.

Recommendation: Add linkages with regional networks to the new Quit Group relationship manager role including regular attendance at regional network meetings (section 4.2.1 and 4.2.3).

Recommendation: Ensure the first step in any interaction with regional networks and other providers is to listen. This is crucial to ensure that it doesn't appear that Quitline is trying to take over regional initiatives (section 4.3.1).

Recommendation: Develop a communications strategy outlining the services offered by Quitline. Include information about the services offered, and how they link with other services (section 4.1.4).

Recommendation: Promote the availability of Quit Group data/information with regional networks: so regional providers can see the role that Quitline already plays in regional cessation (section 4.3.1).

Consideration for cessation sector: Investigate how DHB smokefree coordinators could be utilised for engagement across the sector and whether it is appropriate for them to represent the Quit Group at regional meetings they are not able to attend (section 4.2.2 and 4.3.3).

1.4. Smoking cessation would benefit from improved coordination of services

While the general consensus from key informants was that better coordination of services would aid smokers and make achieving the Smokefree 2025 target a reality, there was less agreement as to how this could be achieved. One aspect of this was the different thoughts on the extent to which the

Ministry should be involved in coordination; some felt that it was not their role whereas others felt that they had a part to play in organising the coordination, if not actually providing it.

Some felt that it makes sense for there to be one point of contact for smoking cessation services, which could then act as a 'triage' to different services. However others felt that this could add unnecessary delay in linking smokers with their service provider and getting a 'Quit Card' out to them so they can access nicotine replacement therapy (NRT). In the past the Ministry has discussed with Quit Group the role of Quitline as providing triage as appropriate to other smoking cessation services, yet it was felt by the Ministry that this was one aspect of the Quit Group's role that it has not fully embraced. Quit Group are not overly supportive of this for 'strategic and effectiveness' reasons, and are concerned that the set up would be 'just another cost'.

Improved relationships are seen as integral for effective coordination of services to meet the needs of smokers trying to quit. It was generally agreed that coordination needs to occur both horizontally – across cessation providers, and vertically – with primary and secondary health care. In order for this to occur there needs to be a better understanding of what services are available from whom, and which of these services work best for different client types i.e. not only age, gender and ethnicity but also intensity of addiction and possibly for other health issues. Also, where appropriate, how clients can use multiple services to support their cessation journey.

One approach could be for high level target for quit outcomes across all smoking cessation providers. This target could be aligned to achieving the Smokefree 2025 target, with a particular focus on target populations such as Māori, Pacific and maternity target populations. Providers would then be given targets for their own quit outcomes and their contracts could include some form of 'count' for the clients that they refer to different service types that successfully quit. Therefore, they would get recognition for the role they play in supporting a smoker to get on an appropriate quit programme.

Ministry consideration: Investigate how multiple service access can be encouraged: including issuing a formal communication from the Ministry contract team to providers that this doesn't affect recording of targets (section 4.2.4).

Ministry consideration: Clear and targeted discussion with Quit Group regarding trialling a 'collaborative triage' approach to their service and how this would work including potential for piloting (section 4.3.1).

Ministry consideration: Consider how to record and recognise collaboration between providers where it improves smoking cessation outcomes i.e. set up a reporting system that counts clients supported by two or more providers (section 4.2.2).

1.5. Current and potential roles for Quit Group

Quit Group is recognised as providing integral services for smoking cessation, particularly for those smokers who do not want, or do not have access to, face-to-face cessation services.

With the Government's ongoing focus on value for money, and reduced funding available to support a full range of services, all cessation providers need to ensure they focus on providing the best services available. The Ministry highlighted that just because an organisation had received funding for a particular service in the past was no guarantee that they will receive ongoing funding. The Ministry perspective is that it is 'about more than meeting targets, it is about providing a high quality service that represents value for money in achieving smoking cessation outcomes'.

Cessation services

It was widely agreed that there is a need for a Quitline in the suite of services available to smokers trying to quit and that Quit Group are best placed to provide that service in New Zealand. International evidence suggests that 'with renewed focus on healthcare reform and cost containment, cost effective services like quitlines will become more necessary and valuable' (NAQC, 2009).

A number of key informants felt that there is a sufficient range of Quitline services and that rather than develop new services, more work could be done to streamline and improve their existing services. Quitline is recognised as the sole national provider of 'remote' smoking cessation services and therefore they should focus on:

a) making sure these services are the best they can be; and

b) ensuring all health professionals and others that work with smokers are aware of Quitline's services and how they work so they can make appropriate referrals.

Recommendation: Build on the findings of this report to streamline and improve Quitline services particularly regarding issues of improving reach to target populations (sections 4.1.4 and 4.3.1).

Working for youth

Smoking cessation for youth is one area where some providers felt they were not currently providing services that are appropriately targeted to meet the needs of young smokers i.e. those under 25. It was recognised that more research needs to be done in this space. However, there is a feeling from some tobacco control researchers that this is not a group that should be targeted in smoking cessation, but rather focuses on health promotion initiatives to discourage them from taking up smoking in the first place.

Consideration for the cessation sector: Analyse cessation data on youth access to specialist cessation services to inform an evaluation of effectiveness of services for smokers under 25 and share learnings across all providers (section 4.3.1).

Partnering with face to face services

As mentioned above, Quit Group could benefit from thinking more about how they can support local services. This would help to present a 'united front' in the fight for a smokefree New Zealand. For example, at the moment the only information provided on the Quitline website about face-to-face services directs people to Aukati KaiPaipa services, and there is no mention of other initiatives i.e. those targeted at Pasifika and pregnant women. At the very least a link could be provided to the Smokefree contacts map.

Recommendation: Strengthen engagement with specialist face-to-face services. Suggested approaches include: attending regional network meetings; provide a link to the Smokefree contacts website from the Quit website; investigate establishing memoranda of understanding with other provider organisations regarding referrals and sharing of resources/data (see section 4.2.2 and 4.2.3).

Training for health professionals

There was some suggestion from those working in cessation training that there may be a place for Quit Group to be involved in smoking cessation training for health professionals, particularly in making the link between B and C in the ABC approach used in primary and secondary health. One key informant

commented that 'Quit Group should have been more involved in telling primary care how to get from B to C' but that they understood that 'they were not invited to be part of that conversation'. However, Quit Group expressed that while this would be valuable there are concerns around the resource requirements of extended involvement in this space. They felt this would require either additional funding or for resources to be taken away from other service provision or marketing.

The role of quitlines in this providing follow up cessation services has been recognised internationally (NAQC, 2009):

> *Many* [health care professionals] *accept responsibility for the first two As* [A&B in NZ] *but resist the other three As* [C in NZ] *because they are time consuming and many do not feel they have the counselling skills required. Quitlines can assist by taking responsibility for the follow up calls to the smoker.*

The Elephant in the Room online learning module for health professionals in the ABC approach includes some information about Quitline, including their contact details. However, the focus of information for referrals is to suggest that health professionals contact their DHB smokefree coordinator. In some ways this seems appropriate, considering that the people utilising this information are funded by their DHB, however it does provide impetus for Quit Group to ensure strong relationships with DHB smokefree coordinators to ensure Quitline is seen as part of the response to smoking cessation alongside the face to face services that are available in the DHB regions.

Recommendation: Investigate what training is already provided to health professionals: particularly in primary health, and identify opportunities to add Quitline information, including the services available and how they operate, to these programmes (sections 4.1.1 and 4.3.1).

Training for smoking cessation advisors

Near the end of the environmental scan *Allen + Clarke* became aware of a push to formalise training for cessation advisors across the range of specialist services. The Quit Group is considering how to provide recognition for the training they already provide their advisors and whether this training is something that can be shared with others.

The Ministry has been running training workshops for pregnancy services already. The Ministry has noted that the Quit Group was not invited to participate in these and that this was an oversight that should be corrected in the future.

Recommendation: Investigate the appropriateness of sharing Quitline cessation advisor training resources with other specialist providers. While recognising the need for different training approaches which are appropriate for groups targeted by specialist service providers (section 4.3.5).

Consideration for the Ministry: Ensure that Quitline advisors are included in future training workshops.

1.6. Quit Group is well placed to support other health promotion agencies with information and data to inform their work

Quit Group is seen to have a unique role in health promotion in that Quit Group staff talk with more smokers than any other organisation and are well placed to be the voice of quitters in a similar way to how tobacco companies at times promote themselves as the voice of smokers. One key informant highlighted the difference in their role to that of other organisations, "Quit Group is the 'smokers' friend' there to support them, Health Promotion Agency (HPA) is more aggressive against the tobacco industry and political push for tobacco control". ASH is recognised as having a key role in health promotion and advocacy as well for tobacco control.

The general feeling was that it was not Quit Group's role to lead health promotion, but that they did have a vital role in supporting the work of other health promotion/tobacco control agencies.

One way Quit Group could be involved is to make the best use of their 'everyday' data by providing the HPA with data that will allow it to demonstrate the success or otherwise of tobacco control health promotion initiatives. It is widely recognised that television and other promotion increases the number of calls to Quitline and other smoking cessation service providers (Wilson, 2003 & NAQC, 2009):

> *Television advertisements are effective in generating an increase in the number of new callers to Quitline, including Māori. Calls increased when an advertisement was screening and the proportion of Māori callers dropped when there was no television advertisement. Similar increases in call volume were observed in a study of US quitlines. Some US quitlines found using other forms of media, such as radio, newspaper and direct mail to be effective in increasing call volumes.*

This could be further extended to build relationships with regional networks by providing them with additional data in response to specific initiatives i.e. regional smokefree days. In the same way that advertisements for Quitline are likely to have a flow on effect for local services, regional smokefree promotions might result in increased calls to Quitline, and analysis of this should be undertaken.

Another way that Quit Group could get more involved in health promotion is by linking in with other public health promotions where there is a relationship with smoking i.e. asthma and diabetes. Again, rather than lead this work, it would be more appropriate for Quit Group to work with the national organisations for these health issues and support them with information and or providing links to their resources. This could be used for information that goes out to the general public, but would be just as important to link with messages given to health professionals.

Recommendation: Engage with other health promotion agencies including a formal agreement with the HPA including sharing insight gathered from Quitline data and to work together on communications plans to avoid duplication and ensure effective spending of communications funding (sections 4.1.5 and 4.3.2).

1.7. Make better use of 'everyday' data

Quit Group is seen to have a wealth of 'everyday' data on quitting behaviour that should be used initially to inform their own business planning, and secondly be made available to researchers for wider research and programme development purposes. The Ministry was keen to see Quit Group focus on the information they provide in their regular reports, recognising that it is this information that is analysed to record outcomes achieved and therefore informs the Ministry's analysis of the extent to which Quit Group is achieving their contract requirements. This 'everyday' data is recognised as essential to inform understandings of the effectiveness of their services.

In the past the Quit Group has undertaken additional service evaluations to identify the quit status of their clients. As Quit Group implements the Tier Level One Smoking Cessation Service data recording and reporting requirements these evaluations are no longer be required (once the Specification is fully implemented). Therefore, while these evaluations had an important role in the past, they are not required going forward as client quit status will be recorded and reported as part of the Tier Level One Service Specification.

The Ministry recognises that Quitline will lose clients through no fault of its own (i.e. those who ring and only want NRT and no additional support and those who avoid or do not respond to follow-up contact). The Ministry agrees that it is not always appropriate for Quitline advisors to spend time chasing clients that don't want additional support and is keen that Quit Group present data in a way that makes it quite clear the division of support provided and impact achieved.

There may be a need to reframe the contract between the Ministry and Quit Group to provide for better recognition of the type of service that Quitline provides depending on the needs of the client. One approach would be reporting level of engagement with, and outcomes, based on the following categories of people:

- People who called only wanting a Quit Card and not interested in follow up support. These people could be asked if they would be happy to respond to a text message in four weeks asking if they were quit or not.
- People who called, showed interest in receiving support but were lost to follow up (unknown result).
- People who called and had intense engagement and were able to be followed up at four weeks and three months.

This would allow the Quit Group to report the different levels of support they provide and the difficulty they have in achieving the necessary follow up with clients who are only interested in receiving minimal support, or who are not ready to make a full quit attempt. Quitline advisors time could therefore be better targeted at providing intensive support to those smokers that want it, and are ready to quit, rather than chasing people who essentially want to quit 'cold turkey' (with NRT) and those that are not ready to quit. The key for Quit Group reporting to the Ministry is transparency around the type of service that smokers are wanting to access and the place of Quitline as a national provider of this type of service.

Another aspect of data collection that could be improved to increase usability across broader health priorities/issues is accessing the NHI number of clients. It was felt that this would improve understandings of client behaviour including the impact of other health issues/interactions and also access to other services (cessation and other). It was also felt that this would make reporting back

to referrers easier because providers could be confident that they were reporting on the correct client.

Recommendation: Continue to use 'everyday data' to inform business planning (section 4.3.4).
Recommendation: The Quit Group should actively engage with the Ministry on the possibility of future outcomes reporting on the basis of different client groups / differing 'intensities' of service.

Recommendation: Access NHI and link to client data to improve usability of client data for cessation service analysis and wider health research (sections 4.1.1 and 4.2.3).

2. Context of the environmental scan

2.1. The Quit Group

The Quit Group is an incorporated charitable trust that operates Quitline. Quitline was established in 1999 and provides a range of services to support smokers trying to quit. Quitline is funded by the Ministry of Health (the Ministry) and its services are provided free to users.

Quitline services are accessed by telephone, text or online. These services are designed to address the three parts of smoking addiction: chemical (through subsidised nicotine replacement therapy (NRT)), emotional and habitual. Quit Group also assists employers to reduce workplace smoking rates through their Quit@work programme. This programme was not included in the environmental scan. Quitline also has responsibility for coordinating the Quitcard programme which enables health professionals working in the community to provide subsidised NRT products as part of their smoking cessation support services.

In the 2011/2012 year, Quit Group supported 62,580 quit attempts through their range of services.

2.2. The wider cessation sector

2.2.1. Aukati KaiPaipa

Aukati KaiPaipa is a face-to-face service that combines counselling with NRT and is promoted as a service for Māori by Māori, although anyone can access their services.

In 1998, Aukati KaiPaipa launched the 2000 pilot programme to test the viability of implementing a smoking cessation intervention in a Māori health setting, specifically targeting Māori women and their whānau. This pilot ran in seven Māori health providers from August 1999 – 2001.

The programme was successful in reducing smoking prevalence in Māori women, and the quit rate was found to be 29 per cent compared to the 12.5 per cent of women quitting not in the programme. The programme was extended and now has more than 30 sites throughout New Zealand.

Aukati KaiPaipa now runs as a free programme, funded by the Ministry of Health, which focuses on quitting smoking as a lifestyle change. The programme involves:

- an assessment by coaches on the client's readiness to quit,
- creating a reduction plan to identify smoking triggers and providing coping skills for this,
- an intensive programme in which clients become smokefree with the aid of NRT, and
- client follow-up to assess whether the programme is preventing relapses.

In the 2011/2012 year, Aukati KaiPaipa providers supported 7,260 quit attempts across the country.

2.2.2. Pacific smoking cessation programmes

The six services targeted at Pacific smoking cessation are generally free of charge. There is an emphasis placed on the use of personalised programmes and face-to-face support, with the option of speaking

to someone in the client's native Pacific language often being available. Some programmes stress the importance of cultural support. These services also offer NRT through patches, lozenges and gum for free or at a subsidised rate. Essentially, the different programmes offer the same services to Pacific peoples. However, where the services do differ is in the length of the programme, this can range between 8 weeks to 12 months.

Rather than one overarching organisation like Aukati KaiPaipa for services targeted to Māori, Pasifika services are provided through regional organisations. Smoking abstinence is usually assessed at the client's four week and three months follow up.

In the 2011/2012 year, Pacific smoking cessation providers supported 1,632 quit attempts across the country.

2.2.3. Pregnancy cessation services

There are six dedicated pregnancy smoking cessation service providers funded directly by the Ministry. The services are located in Auckland, Hawke's Bay, Christchurch and Invercargill.

These services are provided by PHO, DHB and specialist maternity service providers alongside other health services targeted at pregnant women. Some of these services are specifically targeted at high risk pregnancies, or Māori and Pacific women, and are based on these cultural ideologies.

In the 2011/2012 year, dedicated pregnancy smoking cessation providers supported 1,896 quit attempts across the country.

2.3. Smokefree Aotearoa/New Zealand 2025 goal and intervention logic

The Ministry of Health's *Smokefree New Zealand 2025: Next steps in tobacco control* provides an overview of the analysis and steps taken to date to inform the setting of a Smokefree Aotearoa/New Zealand 2025 goal (Ministry of Health, 2011a). The following information provides an overview of this goal and the steps required to achieve it.

The Māori Affairs Select Committee undertook a tobacco inquiry process over 2009-10 and in response the Government accepted most of the 42 recommendations, including:

- adopting the landmark Smokefree 2025 goal – the first country to set a date for achieving its smokefree vision, and
- committing to set specific mid-term outcome targets to drive and monitor progress towards the 2025 smokefree goal.

In setting this goal the Government has made it clear that it is an aspirational long term goal and does not commit to banning or prohibiting tobacco altogether by 2025. The goal is defined as 'reducing smoking prevalence and tobacco availability to such low levels that New Zealand would be essentially smokefree.'

Preliminary scenario modelling results suggest that:

- Achieving very low population wide smoking prevalence (<5 per cent) by 2025 is achievable but will require ambitious mid-term targets. This includes halving overall smoking prevalence to 10 per cent by 2018, and also halving smoking rates in very high prevalence population groups i.e. Māori, Pacific.
- Achieving these targets will require improvement and ramping up over time of all the main policy levers and interventions in the current tobacco control programme.
- The Smokefree 2025 goal is unattainable by stopping smoking initiation alone and requires significant increases in cessation rates among current smokers. That means building on the 'Better Help for Smokers' Health Target approach and the critical cessation services and other means to support it.

It is clear from these targets that a joint approach to increasing smoking cessation is essential and with the first target set for 2018, this requires immediate action from all parties involved in encouraging and supporting smokers to quit. The Next Steps 2011–2015 document released in December 2011 outlines a clear role for cessation service providers in achieving the 2025 goal (HPA, 2011):

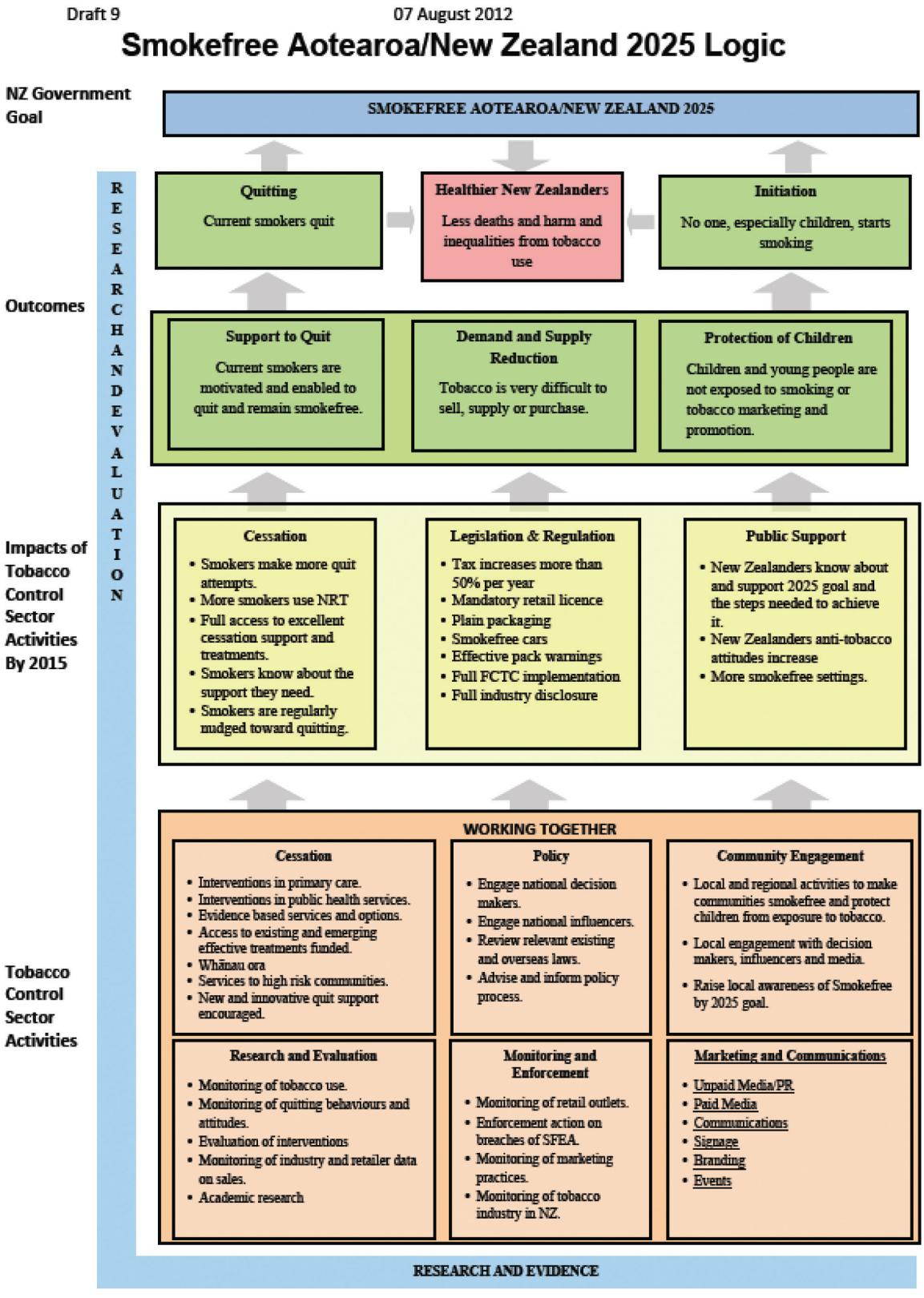
> *Proposed actions will contribute to increased quit attempts and smokers should have access to the best evidence based support when they quit. The range and quality of smoking cessation options for smokers in New Zealand has improved considerably with a health service target, engagement for primary care services and more efficient processes for obtaining NRT.*

The document recognises that there is room for improvement in different aspects of smoking cessation services including:

- all quit services targeting high needs communities need to be well resourced and offer high levels of competency;
- evaluation of services to ensure effectiveness and quality;
- better understanding of reasons for lapse and relapse into smoking;
- access to new and emerging evidence based cessation treatments; and
- integration of smoking cessation into Whānau Ora and other services.

Figure three illustrates the intervention logic released by the Health Promotion Agency and identifies the three tranches of work recommended to meet this goal; cessation, legislation and regulation, and public support. This is being regularly updated and is current as at the end of August 2012.

Figure 3: Smokefree 2025 Intervention Logic



NB: The impacts and activities are not listed in any particular order of priority.

2.4. Ministry of Health funding and tier level one service specifications

The Ministry of Health began rolling out new measurement outcomes for smoking cessation services in early 2011 with the release of the Smoking Cessation Services tier level one service specification (Ministry of Health, 2011b). The service specification is supported by a summary document providing background and clarification.

The Ministry had found that providers were using different ways of measuring smoking cessation outcomes and a consistent outcome measure across all cessation services was required to 'provide a true picture of effectiveness and cost efficiency'.

The tier level one service specification puts in place a standard outcome measure of smoking status at two time-points. The first is at four weeks following the target quit date, and the second is at three months after the target quit date.

The four week measure was chosen to allow for:

- smoking lapses within the first two weeks after the target quit date
- comparison with the outcomes of the UK's NHS Stop Smoking Service, which is the largest and most developed publicly funded cessation service in the world
- the estimation of one year quit rates.

Following discussions with some service providers a three month measure was also included as it was thought that only counting four week status would not demonstrate the achievement of some smokers who struggle to quit within the first four weeks. The three month measure allows these 'late quitters' to be measured.

The introduction of these measures required all services to establish a process for setting and documenting a target quit date for all service users, which is used as the nominal date that follow up dates are based upon.

Where possible it is recommended that self-reported quit status should be validated with a carbon monoxide reading; however, it is acknowledged that this is not possible for services like Quitline that do not provide face-to-face support.

Smoking cessation service providers are encouraged to measure continuous abstinence e.g. at six and twelve months where possible.

Due to the tier level one service specification being released within a contracting cycle, Quit Group is required to report to this service specification from July 2012. This allowed Quit Group some time to undertake necessary changes to ensure they would meet the specification requirements.

Due to the changing state of reporting and monitoring of outcomes resulting from the roll out of the tier level one service specifications, smoking cessation services are currently in a state of transition. The Ministry is keen to encourage all providers, including Quitline, to focus on service provision and ensure that they have the capacity and capability to meet the needs of their clients. This should be achieved by focusing on providing high quality services that meet clients needs, particularly those from the Māori, Pasifika and pregnancy target groups.

3. Introduction

3.1. Purpose of this Environmental Scan

This report presents the findings of an Environmental Scan undertaken by *Allen + Clarke* to inform the future strategic direction of the Quit Group. The focus of this work was on how to make the cessation arm of implementing the Smokefree 2025 vision most effective. As such, Quit Group sought an independent and objective look at cessation services, including the scope of the Quit Group's services.

The report will contribute to the Quit Group Board's thinking about their strategic direction, initially in the short to medium term (2-5 years) and looking ahead to the longer term vision of working to the 2025 Smokefree target. Quit Group and *Allen + Clarke* also hope it will be a useful resource for the Ministry of Health and the wider cessation sector as they collaborate to improve cessation services and the role they play in meeting the 2025 goal.

3.2. Research questions

In initiating this environmental scan *Allen + Clarke* developed a set of high level key research questions in consultation with the Quit Group. These were supported with a more detailed set of areas of inquiry, outlined in Appendix A.

Theme 1: *Wider environment - In what ways do wider environmental factors impact on the Quit Group and the wider cessation sector?*

Theme 2: *Collaboration and/or coordination - What are the incentives and barriers on the cessation sector with regards to collaboration and coordination of services?*

Theme 3: *Potential role - What is the potential role/s of the Quit Group looking ahead to achieving the Smokefree Aotearoa 2025 target?*

Theme 4: *Performance - What does Quit Group do well, and where are the main areas for improvement?*

Theme 5: *Expectations - What are current expectations of the Quit Group in terms of service to funders and clients and how is this likely to change in the future?*

3.3. Methods and data sources

Allen + Clarke used a mixed-method approach for the Environmental Scan, drawing on multiple sources of information including a review of the relevant literature, key informant interviews and data analysis. This ensured that the Environmental Scan was informed by both qualitative and quantitative data.

3.3.1. Key informant engagement

Key informant engagement was undertaken at two phases of the Environmental Scan. The initial phase was focused on stakeholder engagement and included interviews with key Quit Group personnel including two Board members for brainstorm and information sharing sessions. These discussions informed the design of the final research matrix. Also at this time, meetings were held with key Ministry

of Health personnel, from policy and contracting teams, to brief them on the proposed work, and seek their engagement and input into the research design.

These initial meetings collated information and insights that informed the development of a research matrix that expanded on the project's areas of inquiry and identified a comprehensive set of research questions for the second phase of engagement. Potential stakeholders to interview in the second phase were also identified in the initial meetings.

The second phase of key informant interviews were undertaken with a range of smoking cessation stakeholders including tobacco control peak body representatives, tobacco control researchers, DHB and PHO representatives, other specialist cessation provider representatives and key Ministry of Health informants that were not included in the first phase of engagement.

3.3.2. Literature evidence review

Throughout phase one, key informants were asked to recommend research literature to inform the environmental scan. Appendix B outlines the main learnings from key documents as they relate to the themes for the Environmental Scan. These are also cited throughout this report as appropriate. We did not undertake a full literature review.

Ministry of Health documents were widely used to inform understandings of contracting requirements and areas for focus in relation to smoking cessation provision. This is particularly the case for the DHB Health Targets for smoking cessation. Other key documents included those related to the proposed approach for tobacco control and smoking cessation to achieve the Smokefree Aotearoa/New Zealand 2025 target.

3.3.3. Data analysis

As outlined in the limitations section below, it was difficult to access the level of detailed data required to obtain a comprehensive insight into smoking cessation service provision across New Zealand. *Allen + Clarke* had hoped to be able to undertake this level of analysis in order to provide more detailed recommendations for future focus.

However, analysis of the available DHB data against the ABC health targets proved useful in identifying the possibility of high numbers of smokers who are receiving brief advice from their health professional, either during a visit to their local primary health provider, or due to a visit to hospital, who may or may not receive information about available Quitline services.

3.4. Limitations

The major limitation of this environmental scan is the lack of available data for other providers of cessation support. The Ministry was only able to provide *Allen + Clarke* with total numbers of quit attempts with Aukati KaiPaipa, Pacific Services and Pregnancy Services for 2011/2012. They were not able to break this data down by ethnicity, gender, age or DHB region or provide outcomes data. This reduces the ability to provide useful or detailed commentary on gaps in service provision, or means of improving referral and seamless support for smokers.

Information about the cessation support services provided by DHBs and PHOs is not collected by the

Ministry. This meant that while the 'How is my DHB performing' reporting provided an indication of the number of smokers that were **asked** about their smoking status and given **brief advice** by their health professional, we were unable to identify the numbers that actually received **cessation support**; that is data is only available for AB and not the C. Also, while actual numbers of those that are given brief advice is available for hospitalised patients, only percentage figures are published for primary health care (Ministry of Health, 2012c).

4. Environmental scan findings

4.1. Wider environment

4.1.1. Health priorities

Need to connect to other public health priorities.

Tobacco is linked to numerous public health priorities, including cardiovascular disease (CVD), diabetes, asthma and cancer. There are benefits for smoking cessation providers to ensure linkages are made with organisations working to raise awareness for CVD, diabetes, asthma and cancer. Many of these organisations run national, and regional, initiatives during the year and it is vital that these organisations are aware of both the relationship between smoking and their health issue, and also an overview of the services that are available and where/how to get more information.

Recommendation: Contact key organisations leading work in relevant public health priority areas to establish a relationship and look for ways to work together to highlight the impact of smoking on these health conditions and the role that Quitline services can play in this area.

Identify links to tobacco as a social indicator i.e. deprivation, other additions.

One key informant suggested that smoking provides an indicator to other community indicators:

> *When you dig into smoking communities you find Māori, Pacific and those with mental health issues, also vulnerable to other addictions, alcohol, gambling and drugs. Could smoking be an indicator to child vulnerability? Tobacco has been a social determinant from the start but it is only now being understood.*

The suggestion that smoking prevalence could be linked to these community indicators is not without its risks and would require sensitive research to substantiate it. Therefore this is not for the Quit Group, but for national level organisations involved in research. A key first step is linking smoking status to NHI numbers, which is currently being pursued in both primary and secondary health care. The next step is then looking at the relationship between these socioeconomic and health concerns on a broader basis than provided for in clinical research. This information could then be considered in policy development for supporting communities targeting smoking cessation, particularly as we get closer to the 'thin edge of the wedge' of the Smokefree 2025 target.

Recommendation: Link Quitline client data to the NHI to make it more useful across health research.

ABC targets have demanded buy-in from all health professionals; but they are focusing on the target rather than the quality of cessation support provided.

The Ministry's 'How is my DHB performing' reports the percentage of patients who are smokers and seen by a health practitioner in a public hospital that have their smoking status recorded, and the percentage that are offered brief advice and support to quit smoking by DHB. The available data (as at August 2012) indicates that approximately 124,000 smokers were given brief advice and support to quit smoking by their DHB (Ministry of Health, 2012b). However, the data available for those seen by Quit Group or one of the other specialist smoking cessation providers funded directly by the Ministry indicates that approximately 50,000 of these people were not seen by a specialist cessation service provider. This demonstrates a major gap in cessation support. Unfortunately the Ministry of Health does not collect data from DHBs and/or PHOs regarding the cessation services that they provide.

This represents a major gap in the information available to the Ministry and cessation service providers to plan or put in place systems to ensure support is available and targeted appropriately if we are to meet the Smokefree 2025 target.

Ministry consideration: Support the development of reporting that utilises NHI numbers of clients to aid analysis and evaluation of outcomes for individuals across all services.

ABC in primary care could be a big opportunity for Quit Group and other providers

While implementation of ABC in primary health was seen as a possible opportunity for Quit Group and other cessation service providers due to the increase in smokers being given advice to quit smoking, it was also recognised that there are a number of possible barriers to these people taking up cessation services. The first is the recognition that smokers prompted by their health provider may not be internally motivated to quit. Quit Group requires smokers to at least be 'thinking about quitting' before they will begin them on their quitting pathway. The second issue relates to the primary health practitioner's level of awareness of the services available and initiating a suitable referral. In both cases, more work needs to be done to develop information for primary health practitioners and referral systems to cessation service providers so that full advantage of this opportunity can be taken.

Recommendation: Promote Quitline services to primary health and DHB smokefree coordinators. Look for opportunities to raise awareness of Quitline services in primary health and hospitals to increase referrals.

Recommendation: Establish a more effective referral system that includes providing feedback to the referrer, regarding both success in contacting the client and smoking status at three months.

4.1.2. Funding pressures

Big jump in delivery requirements for less money.

Increased targets for the same amount of funding were instigated across all smoking cessation service providers and therefore have required a change of thinking/approach in order to meet the new targets. The development of additional online services was one development the Quit Group has made to meet new targets. While the Quit Group has had success with increased numbers it is still falling short of the targets set by Ministry contracts, particularly for target groups.

Providers across the board expressed concern about the lack of continuity of funding which has made it difficult to plan long term and to offer staff security in their roles. There was also a certain level of wariness to instigate new initiatives when they could not to be trialled without risking funding. For example one cessation provider we spoke to referred to the introduction of quit groups as one approach they had taken to support more smokers to quit. They were experiencing success with this approach; however continued funding for this initiative was not confirmed and this made planning for further quit groups difficult.

One key informant was concerned that the Ministry had 'cut people's funding and contract lengths' which they saw as a 'heavy handed rather than constructive approach that doesn't show a robust understanding of the realities'.

Ministry consideration: The impact of lack of continuity of funding on service planning and provision. Consider providing 'indicative funding' information for out-years at the time of contracting.

Providers need to be flexible about their services, but also be supported to evaluate programmes and demonstrate outcomes.

Key informants from national tobacco control agencies expressed some concern about the capability of smaller smoking cessation providers to evaluate their programmes and accurately demonstrate the outcomes they are achieving. By contrast, Quit Group were seen to have more capacity and capability in this space than other providers. It was also recognised that this was vital considering the large number of clients they support.

Recommendation: Retain a focus on monitoring and service evaluation to identify key factors for cost effectiveness, informed by understandings from international research. Quit Group could look to develop a set of key considerations that could be shared with other cessation providers to inform their service evaluation work.

4.1.3. Political imperatives

Strong political support for tobacco control.

Support for tobacco control comes from all political parties - but not necessarily all politicians. In addition to high level political support for tobacco control, there are a number of organisations that are well placed to undertake any necessary political advocacy role, i.e. Smokefree Coalition (SFC) and Action on Smoking and Health (ASH). It is important that the Quit Group act as a service provider focused on supporting smokers to quit, rather than engaging in any political advocacy or lobbying.

Recommendation: The Quit Group should not be involved in any activity that could be construed as lobbying.

ABC target a political decision – focused on outputs not outcomes.

The ABC health targets for DHBs are seen as a political decision by some which are 'easy' to record and report; although it is relatively easy to record the Ask and Brief Advice aspects at the point of initial contact. As DHB's hit the required targets for A and B and the focus shifts to the provision of cessation support it will be harder to demonstrate, particularly if effective referral and feedback systems are not in place.

However, there is an increasing need for smoking cessation service providers to demonstrate outcomes achieved to Ministers. Providers collect data that they report to the Ministry as part of their contract requirements, and should consider the appropriateness and possible approaches to use this data to demonstrate they are achieving good outcomes for their clients and communities. It is particularly important to demonstrate outcomes that are being achieved in supporting Māori, Pasifika and pregnant women to quit smoking. Not only for the services specifically targeted to these groups, but also organisations like Quit Group that provide smoking cessation support to the broad range of smokers.

Appropriate reporting for smoking cessation outcomes for target groups should be presented across all forms of provision, including DHBs and PHOs. This would require providers working together to present a united front for smoking cessation, or the Ministry collating and reporting the outcome data in this way. This would help to build an understanding of the role that smoking cessation is playing in meeting the Smokefree 2025 target.

Ministry consideration: Consider options for presenting outcomes for target groups across all forms

of provision, including DHBs and PHOs, i.e. separating reporting of referral to/provision of Cessation support, from the Ask and Brief advice.

By next election will have the evidence of initiatives and their impact e.g. Smokefree prisons, tobacco hidden in retail.

A key informant from a national organisation commented that evidence of the impact on tobacco use from recent initiatives implemented in recent years, particularly smokefree prisons, tax increases and tobacco hidden in retail will be available by the next election. For example, Quitline services were offered to smoking inmates to support them to quit while incarcerated. However, there was no follow up support arranged with Quitline upon their release. Quit Group has suggested that there could be a role to connect Probation Service with Quitline through the ClicktoQuit tool which could be used in the pre or post-release interview every prisoner has.

Other initiatives that have been instigated are the ABC health targets, although the impact of these on specialist smoking cessation services is difficult to track at the moment.

Recommendation: Quit Group should work with national advocacy and research organisations to consider how the data they collect can be used to provide evidence of the impact of initiatives such as smokefree prisons, tax increases and tobacco hidden in retail.

4.1.4. The needs of cessation clients

Number of smokers supported by Quit Group is impressive

Key informants interviewed as part of the environmental scan were impressed at the large number of smokers that Quit Group was able to support on their quitting journey. Other providers are not able to meet such large numbers, even when they do provide similar services (e.g.it was reported that some DHBs now provide phone and text support for patients in addition to face to face). However it is recognised that no other provider has quite as broad a range of services, which allow layering of support from a single provider.

Recommendation: Continue to provide a broad range of services and, where appropriate, consider new complementary services.

Everyone has different needs and Quit Group's services do meet a need; just not everyone's

The widely held perception is that Quit Group is well placed to meet the support needs of smokers who do not want, or feel they need, face to face support. It was recognised that Quit Group provides 'time effective therapy given as and when people need it', something that can be difficult to provide in a face to face approach.

A few key informants questioned how the Quit Group approach fitted within a Māori kaupapa. Some providers felt that Quit Group was not meeting the needs of Māori clients, despite the availability of Quit Group data to demonstrate they do engage with and support large numbers of Māori to quit. Those individuals who had confidence in Quit Group's ability to support Māori smokers try to promote their work amongst face to face providers, however there is still room for improvement in sharing these messages.

One specialist provider felt that smokers with 'chaotic lives', which could include mental health issues, no fixed abode or other addictions are unlikely to use a phone or online service because of difficulties accessing the necessary landline or internet connection. While Text2Quit support could be useful for some of these people, there was a lack of awareness regarding what sort of support was provided in this way including whether the texts were proactive or reactive.

Recommendation: Examine how text services can be used as a standalone service for those with limited access to a landline or the internet.

Recommendation: Share Quitline outcomes for Māori more widely particularly with Aukati KaiPaipa and others that target Māori.

Need to be prepared for increased referrals for pregnant women who smoke

From July 2012 a new health target for cessation support during pregnancy has been introduced which is likely to lead to an increase in referrals for supporting pregnant women:

Progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.

The Ministry is keen for all smoking cessation provider services to ensure they are prepared and able to support increasing numbers of pregnant women to quit smoking. In order to meet the specific needs of this target group, providers need to ensure they have appropriate systems and resources in place.

Recommendation: Ensure appropriate and targeted support is available for pregnant smokers; this may require additional training and/or the development of specific resources to meet the needs of this target group.

Too many questions up front, delay in getting NRT. Need to act while client motivated.

One concern about providing cessation support remotely is the inevitable delay in getting clients the necessary pharmacotherapy support (i.e. NRT) if they are ready to quit when they first make contact. One key informant suggested investigating the possibility of emailing or faxing a quit card directly to the client's closest pharmacy so the client can get access to the pharmacotherapy support while they are motivated to quit.

This comment was made prior to wider understanding of the new motivational interviewing approach being implemented by Quit Group in response to the Tier One service specification requirements. It could also reflect a limited understanding of the services provided by Quitline.

Recommendation: Quit Group should communicate the recent change of approach to their service model to other providers and possible referrers to address their concerns and raise their understanding of the support that Quit Group provides.

Concern - what if someone rings in then says they want face-to-face? What are they told?

A number of key informants interviewed were uncertain what smokers were told if they rang Quitline and told them they were interested in a face to face service. If they are given the information of local providers then this message needs to be shared with these providers so they have confidence that Quit Group is making 'referrals' where appropriate.

One cessation service provider was concerned that every time a client rang in they might talk to a different advisor and have to repeat their story each time, which they felt would lead to a lack of continuity of support. They also felt that Quitline wasn't able to provide behavioural support over the phone and that this would have a negative impact on the success of the client's quit attempt. Quit Group could think about how they can inform smoking cessation service providers and other stakeholders about the service that they provide, so they can have confidence that the approach taken will meet the needs of the client.

Recommendation: Develop a communications strategy outlining the services offered by Quitline. Include information about the services offered, and how they link with other services. This could then be trialled with other cessation providers and then rolled out nationally across primary health, DHBs and the broader cessation sector.

Doesn't meet needs of young people; but what provider does? Some feeling this is a real gap; but recognition not a lot of evidence about what works.

There was a recognition from key informants across the board that evidence suggests that the smoking cessation services currently available are not meeting the needs of young people i.e. those under 25. In part this is due to a lack of evidence of what does work for young people. However there was some feeling that rather than target this group for smoking cessation, it is more appropriate to focus on promoting the harmful nature of tobacco and discouraging young people from starting to smoke in the first place.

Due to the high numbers of Māori and Pacific youth that smoke (according to the 2009 Tobacco Use Survey 44.3 percent of Māori smokers are aged 15-24) any gaps in supporting youth to quit smoking are keenly felt by these target populations. One way to address the short fall in Māori and Pacific targets for quit attempts could develop initiatives that target those under 25.

Recommendation: Work with HPA to promote Goalpost through schools, tertiary education providers, Facebook, YouTube etc.

4.1.5. Role of the Health Promotion Agency

Tobacco control still on agenda for HPA. HPA and Quit Group need to get together and establish a high level agreement on their communications work.

The Ministry of Health confirmed that tobacco control will remain a key item on the government funded health promotion agenda for the short term at least, and expects that the role played by the HPA to be similar to that played by its predecessor the Health Sponsorship Council (HSC).

There was agreement from key informants that all tobacco control/smoking cessation health promotion work needs to be complementary and should be planned together to get the 'best bang for our buck'. In the past a similar approach had been implemented by Quit Group and the HSC, however it was felt that the recent changes to the lead health promotion organisation presented a good opportunity to formalise an agreement to ensure consistency in the face of increasing funding pressures. One informant expressed a concern that at times there appeared to be 'undue' focus on marketing awards, rather than the quit outcomes that should have been the target.

Those working with the smaller providers were keen to see further consideration given to how the advertising dollar could be spent to promote cessation support provided by all specialist providers rather than, what they see, a focus on the services provided Quitline.

Recommendation: Engage with health promotion agencies: including a formal agreement with the HPA including sharing insight gathered from Quitline data and to work together on communications plans to avoid duplication and ensure effective spending of communications funding.

HPA needs Quit Group's understanding of smokers.

There was an understanding that while the HPA may be the 'experts' when it comes to health promotion they did not have the same level of understanding of the experiences of smokers that Quit Group has. Therefore it was necessary for Quit Group to support the HPA by sharing insight gathered from their service delivery and research regarding the triggers for smoking etc. to inform health promotion initiatives.

Recommendation: Provide data of peaks in call volumes following health promotions to lead health promotion organisations i.e. World Smokefree Day.

4.2. Collaboration and/or coordination

Key informants expressed high level recognition that cessation service providers need to work together if we are to achieve the Smokefree 2025 target. Relationships, referrals and funding structures were seen as the key barriers to collaboration between service providers.

4.2.1. Incentives to collaborate

The incentive is more intervention = better quit outcome. So the incentive is getting people to stop smoking. We won't meet the 2025 goal if we don't work together.

Collaboration relies on a sense of the 'greater good' of people quitting smoking. The focus on supporting people to quit smoking and achieve better health outcomes is generally what encouraged them to get involved in public health. There is recognition from many that this is a shared vision that is best achieved by working together, even by those that acknowledge they are not currently working with other organisations to achieve this outcome.

Recommendation: Retain focus on 2025 target in all work. Work with the Ministry and other providers to look at how this can be achieved across cessation services.

Lots of collaboration/networking going on between providers regionally.

Regional networks in smoking cessation that met regularly (4-6 times per year) were widely reported and there was a feeling by many that collaboration was 'alive and well' in the regions. Where the Quit Group was not included in this it was thought this could have been due to a feeling that they were not part of the regional response to smoking.

In order to increase collaboration and referrals from regional providers, an urgent response to the lack of interaction with regional networks is required.

Recommendation: Add linkages with the regional networks to the roles of the new relationship managers.

4.2.2. Barriers to collaboration

Relationships across the sector need to improve before different providers would be open to collaboration.

The realisation that providers that did not meet the targets set by the Ministry would risk future funding cuts unfortunately meant that there was some unwillingness to collaborate. One informant commented that 'there is a sense from others that Quit Group is the big player, with the money, staff, research capacity and infrastructure. Others have low budgets and few FTEs.' This had lead to reports of animosity between providers resulting in 'patch protection' behaviours. It was seen as important that as a national organisation Quit Group weren't viewed as trying to 'usurp' the local providers. There was recognition from all key informants that this did not provide the ideal platform to achieve the Smokefree 2025 target.

One suggestion as to how this could be aided is by providing opportunities for Quit Coaches and Quitline advisors to meet and share their experiences and learnings from the frontline. It was recognised that managers and others get some opportunities to meet and talk at conferences etc, but that these

opportunities are not always shared by those working at the forefront of smoking cessation. One key informant commented that this recognises the 'need to look after the cessation workforce because they are the ones delivering the intervention'.

Another key approach is for the Quit group to be more open, and be seen to be more open, to referring clients to other cessation providers where the client indicates a preference for that type of service. Ministry recognition of shared successes in getting people to be smokefree at three months would also foster this sort of collaboration.

Recommendation: Provide opportunities for Quitline advisors to meet with advisors from other providers.

Ministry consideration: Options for recognising referrals between providers where appropriate.

Quit Group non-attendance at regional network meetings seen as an issue.

As discussed in **section 4.2.1** a number of key informants felt that it would be beneficial for Quit Group to attend regional network meetings to establish a presence in the regions. This would help put a face to the Quitline name and would allow organisations to build a better understanding of the service that Quit Group provides while also helping Quit Group to understand what is being achieved in the regions.

Allen + Clarke is aware that the Quit Group is in the process of employing a relationship manager and believes that an important part of their role should be building relationships with these regional networks. The attendance of Quitline advisors at events could help strengthen relationships with other providers.

Recommendation: Investigate how DHB smokefree coordinators could be utilised to strengthen relationships with the regions, and whether it would be appropriate for them to represent the Quit Group when they are not able to attend regional network meetings.

Lack of an effective referral system with feedback loop is a major issue. If there is no feedback then providers are unlikely to refer to the Quit Group in the future.

One issue raised by many was the lack of feedback by Quit Group regarding referrals. This meant that when patients/clients were next seen and told their health professional that they hadn't heard from Quit Group this was all the health professional had to go on. They were not to know whether this was because Quitline never received the referral information and therefore no attempt was made, or whether 1, 2, 5 or 10 attempts were made to contact the person. Referrers can only go on the information they are given, and if feedback is not received from Quit Group then the only option they have is to believe what the patient tells them, even when they recognise that it might not always be the 'whole truth'.

Even with the new Medtech referral system, one key informant commented that while you get a referral receipt that is the only feedback received, i.e. no information about whether they have been contacted and signed up for a quit programme. To increase referrals from primary health it was felt that 'Quit Group need to prove that they are a team player in this by reporting back to GPs'. Planned improvements in referral systems need to address this and other concerns. In each case it was recognised that privacy concerns can make giving feedback difficult to manage.

One informant who is heavily involved in their regional network commented that they have developed

a ‘pathway for referrals through their regional network, where the provider comes back and acknowledges receipt of the referral and later provides feedback on how successful the intervention was’. They felt that the lack of this sort of feedback from Quit Group for referrals did have an impact on the likelihood of future referrals.

Recommendation: Investigate options for improving referral feedback including talking with other providers, DHB smokefree coordinators and primary health professionals about the type of feedback wanted.

Contracts/service specs need to change to require more collaboration; providers blame each other for making the funding competitive.

As discussed in **section 4.1.4** some key informants mentioned patch protection, where local service providers were reluctant to share information with Quit Group. This was thought to be in some way due to jealousy over the amount of funding that Quit Group received from the Ministry, and suspicion that Quit Group might try to take over any initiatives and therefore put at risk their ability to meet their targets.

Even with a ‘perfect’ referral system in place, there is a need to address concerns about meeting Ministry funding contract target numbers. This was seen to be an issue both for the smaller providers, but also for Quit Group and one informant reported a sense that ‘the culture in Quit Group is one of retain and protect your client numbers’. Whether or not this impression is accurate, it is one that needs to be addressed if relationships and referrals are to improve.

It was felt that the Ministry needed to consider whether they want to encourage coordination of services. One key informant suggested that coordination was sometimes a ‘dirty word’ for funders. If the Ministry sees coordination of services as an appropriate way to achieve the Smokefree 2025 target then it would be beneficial to put steps in place to encourage/support organisations to do this.

Ministry consideration: Consider how to record and recognise collaboration between providers where it improves smoking cessation outcomes i.e. setting up a reporting system that counts clients supported by two or more providers.

4.2.3. Coordination of services

It was generally agreed by all key informants that smokers would benefit from better coordination of smoking cessation services.

Need to know who each other is, and what you’re doing, so can make informed referrals.

A key issue raised was the need to ensure the services that smokers were referred to were well suited to their situation and the type of support they wanted on their quitting journey. One difficulty in this area is the perceived lack of awareness of services available not only centrally i.e. in primary and secondary health care for referrals from ABC, but also within the cessation sector of the services available, and particularly the quality of those services. Key informants were wary about making referrals to other providers, when clients indicated they wanted a different type of support than that offered by their organisation, when they were not confident that a) spaces were available or b) the service provided was high quality. Both availability and quality were seen as integral to making ‘informed referrals’.

One informant commented that ‘9 out of 10 times the health professionals I talk to don’t know what

Quitline's services are. They don't promote themselves enough in primary care; lack of visibility is a real issue'. Unfortunately this lack of awareness means that smokers who may be well supported by their services are not referred by their health professional as part of the ABC health target.

Ministry consideration: Establish a searchable register of quality cessation services informed by tier one reporting to aid referrals. This could be created so the referrer enters basic information about the client; age, ethnicity, gender, location and any key health issues i.e. pregnancy, diabetes, and the database makes a suggestion of possible services for referral.

There is a responsibility for all providers to inform clients about the different service options available so they can decide which will work best for them.

There was recognition from key informants working with smokers that every provider had a responsibility to ensure their clients received the most appropriate support. There was concern that perhaps this did not currently occur as providers were scrambling to achieve their contract target numbers of signed up quit attempts, even when they were aware that their service may not be the best option for that client.

Specialist service providers like Aukati KaiPaipa, Pacific Services and Pregnancy Services were known to refer amongst themselves at the local level. One informant commented that 'nothing compels them to work together but there is some collaboration'. However these three organisations have different target populations and therefore it could be seen as less of a conflict to refer a client to other specialist providers rather than sign them up for a quit programme.

Quitline do not refer Māori clients to Aukati KaiPaipa and other specialist services as a matter of course, because they do have the capability to work with these client groups, and have targets set by the Ministry of Health to achieve with these priority groups. However, information about the Aukati KaiPaipa service is available on the Quitline website.

Ministry consideration: Establish a searchable register of quality smoking cessation services informed by tier one reporting to aid referrals. This could be created so the referrer enters basic information about the client to be referred: age, ethnicity, gender, location and any key health issues i.e. pregnancy, diabetes, and the database makes a suggestion of possible services for referral.

Key informants raised issues around sharing information. Quit Group accessing the NHI number would help.

There was an awareness that cessation services had been developed outside of the 'sphere of general clinical service' and that this needed to be remedied to improve coordination of services. One informant was interested in knowing whether the Medtech development had meant that GPs would now have access to a patient's Quitline history. Not necessarily the detail, but the number of times that a patient has made a quit attempt. It was recognised that 'most people who are trying to quit have already tried a number of services and this is useful information for those supporting them to make this lifestyle change'.

Recommendation: Access NHI and link to client data to improve usability of client data for cessation service analysis and wider health research.

Need to improve the 'lost to follow up.'

Alongside the concerns about 'closing the feedback loop' (see **section 4.2.2** above) it was felt that practical steps needed to be taken to improve the numbers lost to follow up. For example in 2011/2012

Quitline was unable to contact 46 percent of those clients referred by DHB hospitals which indicate a high number of 'lost opportunities' for quit attempts (The Quit Group, 2012). It was recognised that this in part could be due to the difficulties in contacting people and one recommendation was to reintroduce the 'best time to contact' on the referral form. This would also act as a prompt to the referrer to check that the number on file was up-to-date, particularly as it was recognised that many people do not go 'home' after being discharged from hospital.

Interestingly the successful contact rate for Medtech referrals is much higher, with 62 percent of those referred via Medtech in the first six months of the electronic referral's availability being contacted (ibid). This may in part be due better contact details for patients. The number of referrals via Medtech has increased each month since the introduction of the system and hopefully this increase will continue.

Recommendation: Reintroduce 'best time to contact' to the referrals form and add a prompt to check currency of contact details of client.

Different perspectives on the roles that the Ministry and Quit Group would/should play in coordination

The role of the Ministry in coordination of services was one area where there was a wide divergence of opinions. One informant commented that the Ministry is the only organisation that has all the information about providers and the capacity and quality of the services they provide. While the Ministry has this understanding it is not shared with the sector, something which had previously been raised as an issue.

However, another informant commented that 'there is no role for the Ministry in coordination, they should focus on their roles of policy, funding and monitoring'. Another key informant commented that the DHBs are doing 'more coordination than the Ministry'. One informant commented that the Ministry 'lacks understanding of the realities of smoking cessation and therefore there is no place for them in coordination'.

When asked whether there is a role for Quit Group in coordinating services, one informant felt that 'if Quit Group can't refer clients to more appropriate local services how could they be expected to play a bigger role in wider service coordination' They were also concerned that Quit Group would have a 'vested interest'.

Recommendation: Strengthen engagement with specialist face-to-face services. Investigate establishing memoranda of understandings with other provider organisations regarding referrals and sharing of resources/data.

Ministry consideration: Give active consideration to the findings of this review particularly regarding barriers to coordination. Consult with all providers as to how this could/should be achieved to avoid duplication of services and address concerns about the impact of a competitive funding environment.

4.2.4. Clients accessing a number of services

Clients should be encouraged to access multiple services if appropriate

One informant from a national tobacco control organisation was concerned that clients could be given conflicting advice and there was a need to 'ensure everyone has the same level of competency and understanding of the current thinking of approach', i.e. around NRT use by young people and pregnant women. There was also reference to research evidence that shows 'the more support the better'. One

informant who was involved in the AKP pilot noted that the 'most valuable learning from the pilot is the support, if they can pick up the phone in between face-to-face meetings and talk to someone, that's great'.

Quit Group's own research has also shown this for clients accessing multiple Quitline services. If this approach was pursued in the future, then research of outcomes would be a vital component. Access to NHI by all service providers would aid research in this area.

Recommendation: All cessation service providers to access NHI so use of multiple services can be recorded, tracked, and evaluated.

Ministry consideration: Support the development of reporting that utilises NHI numbers of clients to aid analysis and evaluation.

Clients accessing multiple services to be promoted amongst providers – not necessarily to the clients. Individual providers need to be confident that the other services are high quality.

A key informant who works with the full range of smoking cessation service providers emphasised the importance of promoting the multiple services philosophy to providers in the first instance rather than clients. They felt that there were bound to be cases where clients are aware of this and access multiple services anyway. They suggested that providers need to 'buy into the liaison with other providers – like Whānau Ora navigators', and that 'Quit Group should provide 'leadership about the philosophy of cessation, providing a blanket over the on the ground cessation services, supporting them, not in competition with them'.

Ministry consideration: Establish a searchable register of quality smoking cessation services informed by tier one reporting to aid referrals.

Providers need to be confident that clients accessing multiple services is 'okay' with the Ministry and won't have a negative impact on their contract deliverables.

This was something that all service providers agreed was an issue. On the whole they were willing to do whatever they could to support smokers to quit, and if that meant layering services to provide additional support they were happy to do so. However there was the recognition that they had contractual requirements to meet, and there was some concern that if a client used another service they might not 'count' towards their target numbers.

A clear message would need to be given by the Ministry, and emphasised to people working across all provider types, that funding was not at risk if clients utilised more than one of the services. It was emphasised that this message would 'need to come from the Ministry or trainers or they won't believe it'. If providers were confident the funding was secure, they would be more willing to tell clients about the services provided by other organisations (presuming they were aware of them) to aid them on their quit journey.

Ministry staff indicated to *Allen + Clarke* during this environmental scan that they are comfortable with multiple service use.

Ministry consideration: Investigate how multiple service access can be encouraged including issuing a formal communication from the Ministry contract team that this doesn't affect recording of targets.

Marketing needs to promote more than one option for quitting. Smokers don't understand more than one support option available.

It was felt by many that promoting Quit Group's services alongside those provided by AKP and Pacific and pregnancy services could increase the likelihood of smokers accessing the appropriate support for their quit journey. The next step would be discussion with the client on how services provided by others, including Quitline could be layered to provide additional support as required. It was felt that 'people should be aware of the different types of service available, it shouldn't matter what service they use as long as they quit'.

One informant felt that there should be a process for naming local, regional and nationally available services. This would be supported by advertising that provides logos, links and contact details of the different services that are available in the area.

Recommendation: Quit Group and HPA to consider adding contact details of specialist services in their promotions: for example by providing a link to the Smokefree Contacts website from the Quit website.

Recommendation for cessation sector: All cessation service providers to work with the HPA to develop a national campaign that focuses on quitting and provides information to smokers about all the different cessation services available.

Ministry consideration: Adding contact detail inclusion of other services to contract requirements for communications funding.

4.2.5. Competitive approach

Some providers lack capability to demonstrate they are achieving outcomes.

It was recognised that New Zealand spends quite a large amount of government money on smoking cessation and that there needs to be scrutiny to ensure we are getting the best value for our money. However, there was concern expressed that it was not an even playing field and that more need to be done to 'support providers to demonstrate their outcomes'.

One informant who works with a range of providers across PHOs and specialist services commented that 'there needs to be a clear outcomes measure rather than just outputs. Providers need to be able to evaluate outputs to report outcomes'. The tier one reporting requirements of quit status at four weeks and three months focuses on outcomes. Quit Group recognises the resource demands of meeting the tier one reporting requirements and has already undertaken a services evaluation which found the following quit status of clients at 4 weeks:

- 35.7 percent of Quitline clients had not smoked at all in the preceding week
- 29.1 percent had not smoked at all in the preceding 2 weeks

Ministry consideration: Actively support organisations as they implement tier one service specifications to ensure they have the capability and systems in place to achieve the reporting requirements.

Benefits: can't be complacent! Focus on core business.

There was recognition from smoking cessation service providers interviewed that having targets to aim for could be a positive thing as it forced them to focus on their core business of supporting smoking

cessation, and not get sidetracked by other issues. It was felt that while there were many 'cons' to competitive funding it does help to 'keep everyone on track'.

Ministry consideration: Link targets to the 2025 goal so that everyone has their eye on the progress they are making towards 'end goal' with a specific focus on the Māori and Pacific priority groups. One option could be to create a 2025 countdown tool which illustrates the progress towards the goal of 5 percent smoking prevalence, which could be something that the country could be proud of.

Negatives: short term contracts, no ability to plan, uncertainty for staff. Doesn't encourage innovation – no room for trialling. Doesn't encourage referral – want to keep the potential of an outcome. Has resulted in no trust between providers.

An issue raised by a number of informants was the lack of certainty regarding continuing funding and the importance of being able to plan for longer than 12 months at a time. This lack of certainty for staff was seen as a risk for the ongoing quality of service provision. One informant reported that DHBs choose whether or not to invest in ABC programmes in primary care on a yearly basis which is disruptive to services.

As discussed above, some providers are wary of Quit Group which they see as 'having lots of money and resources'. One informant expressed concern that there was no 'transparency to the funding which can cause angst amongst providers'. Tier one reporting should address some of the transparency issues.

Ministry consideration: Consider ways to provide data generated by tier one reporting back to providers to address concerns about quality of provision.

Ministry consideration: Provide 'indicative funding' information for out-years at the time of contracting.

It is often inappropriate to compare provider outcomes, given different providers reaching different smokers with varying motivations.

While it was seen as appropriate that those seeking cessation funding need to quote cessation costs there needed to be better linkages to understandings about the types of clients that providers are working with. One informant commented that 'motivated and supported smokers have higher quit rates'. Client initiated cessation service interactions have higher quit rates than those initiated by the cessation service because the client is usually more motivated.

Ministry consideration: Include ways to record the nature of the original contact in reports i.e. client initiated or service initiated. Particularly when considering distance to quit date and quit outcomes.

4.3. Potential role for Quit Group going forward

The Quit Group is recognised as providing integral services to smokers trying to quit. Its services are seen to meet the needs of many who do not want, do not need, or do not have access to face-to-face services.

4.3.1. Cessation support

Focus on core business - being the best supporting people with telephone and other remote services.

Key informants suggested that Quit Group focus on its core business, looking closely at the services it provides and whether there are changes, no matter how small, that it could make to streamline and improve services to better meet the needs of smokers. Informants from across the board suggested that Quit Group should focus its efforts on providing services that support clients that cannot, or don't want to, access face to face services, or that could be used alongside face to face services.

Essentially, key informants encouraged Quit Group to retain their core service of telephone support, and examine how the other services they provide can build on that, alongside providing layered support for smokers registered with more intensive face to face services. An approach that was seen as positive by all key informants we spoke to.

Recommendation: Focus on core role as a cessation service provider, streamlining and improving existing services (if necessary) before considering other roles.

Need to make Quit Group services more visible in the primary health sector for ABC referrals.

One key informant who regularly works with health professionals across the primary sector reported that 'nine times out of ten the health professionals I talk with don't actually know what [Quit Group's] services are'. They suggested that Quit Group think about how they can support primary sector health professionals to get from B to C for their patients. It was also suggested that it would be good to provide a link to Quitline training especially for practice nurses to increase knowledge of their services in primary health. The data available for ABC health targets in primary care indicate that there is a gap in primary health professionals' knowledge of suitable cessation services.

Recommendation: Investigate what training is already provided to health professionals, particularly in primary health and identify opportunities to add Quitline information, including the services available and how they operate, to these programmes.

Need to be prepared to learn from, and share learnings with, others in the cessation sector - what works, for whom?

All providers would benefit from hearing what and how everyone is doing.ABC referrers, Quit Clinics and AKP and other specialist providers need to understand how Quit Group supports their clients, either as a standalone service, or alongside their own services. Quit Group also needs to demonstrate a willingness to link to local services and make referrals where appropriate. Quit Group need to be more visible to build relationships and work with other providers, and one key informant suggested that interactions should follow the following format 'listen, ask, listen, plan and then consult'.

What can be done to ensure Quitline e-newsletters are more widely received by those working in the

cessation sector? These are well received by those that get them, but there are so many people that don't know about these e-newsletters and other information that Quit Group makes available. Tier one reporting should hopefully help with this, as everyone is collecting the same data. There is a need to recognise the differences in the people they support and also the different types of support they provide.

Recommendation: Smoking cessation service providers, including Quit Group, should look at ways to promote their way of working with clients to other organisations. Quit Group could run an 'open day' so other providers can better understand what they can provide. Also promote newsletters to other cessation providers so they have better awareness of the information that Quit Group already shares.

Develop resources to support youth to quit smoking?

Building on the findings of **section 4.1.4** around difficulty working with youth, one key informant noted that 'there is a lack of resources for working with youth, and this is a barrier to successful engagement with this group'. However, a researcher informant noted that 'they might not be meeting the needs of young people, but young people should not be their target'. The challenge of engaging with young people is something that is found across the cessation sector. Other informants suggested that more should be done to utilise technology to promote their services to young people. The Quit Group has created a mobile website for use on telephones, however commented that they were reluctant to develop a Smartphone application due to the requirement to regularly update them.

Any smoking cessation initiatives targeted at youth could benefit from demonstrating the rewards of not smoking in a way that speaks to youth. One approach could be for Quitline to provide a link to online games where points are earned for cigarettes not smoked which are then exchanged for game tokens. Other possibilities could be identified by Quit Group developing a relationship with a private company or organisation that works with youth to identify opportunities to provide rewards for stopping smoking that would be appealing for youth. However, there would need to be checks in place to ensure that a) they actually smoked to start with and b) that they have actually given up smoking. This could in part be achieved through a relationship with tertiary education providers.

Recommendation: Promote Goalpost application to other smoking cessation providers to use with their clients that have an affinity with social media.

Recommendation: Analyse cessation data on youth access to specialist cessation services to inform an evaluation of effectiveness of services for smokers under 25 and share learnings across all providers.

Need a portal to the range of cessation providers, a single point of access: 0800, website, etc, that then puts client to a local provider or Quitline.

The Ministry of Health informed us that they had discussed with Quit Group the importance of Quitline's role as a triage service which would help to ensure that smokers receive the most appropriate cessation support for their needs. A number of key informants were interested in how a 'collaborative triage' could be added to the cessation sector. However, Quit Group were not overly supportive of this for 'strategic and effectiveness reasons', and are concerned that the set up would be 'just another cost'.

One key informant reported that they felt if Quitline, for example, was to lead coordination it needed to involve 'genuine representation' from other providers during the development stages. This could be achieved through a workstream with sector representation to avoid appearing to impose a new approach on providers. The suggestion was made for 'a 0800 number that puts you through to an

advisor locally who then puts you on to a local AKP, or other provider, or to Quitline'. While Quit Group are seen to be best resourced to provide this it would need to be developed in collaboration with other providers to ensure everyone felt they were on an equal playing field.

The Ministry is keen for Quit Group to investigate how this could be achieved further, to ensure ongoing coordination of cessation services that are most appropriate to each client's needs.

Recommendation: Actively consider how a collaborative triage role can be added to the Quitline suite of services.

Ministry consideration: Engage with the Quitline on the suitability of Quitline implementing a 'collaborative triage' approach to their service and how this would work, including the potential for piloting.

4.3.2. Health promotion

Good to have a national campaign that provides information about ALL of the services available - focus on supporting the quitting journey, which ever path they take.

As mentioned in **section 4.1.5** a number of informants recommended that there should be more focus on promoting quitting – rather than separate services. This would be more cost effective spending, particularly if a portal to all services was to be developed. However, it was felt that something along these lines could be done immediately.

At the moment Quit Group is only funded to promote its own services, and other providers need to recognise that. However at least one key informant recognised that there is a flow on effect to other providers. If Quit Group was to run a campaign promoting other services then their contract would need to change to reflect this. However one key informant commented that the 'contract for mass media went to Quit Group, and they have used it for their own promotion rather than promoting cessation generally'. Whether or not this is the case, this has resulted in a negative response from some people towards Quit Group.

Recommendation: Quit Group and others specialist cessation service providers to work with the HPA to develop a national campaign that focuses on quitting and provides links/information to all the different approaches available.

It would be good to have a public health focus on quitting – for a healthier New Zealand. Encourage people to support smokers to quit in a positive way.

One key informant felt that better use could be made of the 'How is my DHB performing?' reporting, including promoting DHBs to think about 'how healthy can we be in getting our people smokefree'. This could be linked to other public health messaging, i.e. healthy hearts, diabetes, and cancer awareness.

Another area for consideration is looking at ways to encourage the public to support smokers to quit, rather than deride them for their habit which is the more common response at the moment. Something along the lines of the 'Like Minds, Like Mine' mental health initiative where they interview friends and colleagues and talked about how they provided support. This would be an area for another organisation, possibly the HPA; however Quitline would be one way to access 'stories' for such a campaign.

Recommendation: Ministry and Quit Group to work with HPA to look at how broader, and more positive, public health approaches to smoking cessation could be encouraged.

All providers have a role in health promotion; however their primary role is to support people who have already been prompted.

All cessation services have a role in prompting people to quit but their main role is to provide support for people once they make the decision to quit, or at least start thinking about quitting.

The current Quit Group contract is focused on the number of people signed up for quit attempts, however it may be better to focus on number of successful quit outcomes i.e. set target number, rather than target percentage of quit attempts. This would be so that providers have more focus on getting people signed up for the right programme, and supporting them once they've signed up, rather than trying to attract large numbers to their service. This could also improve referrals between providers and therefore relationships and sharing of information.

Ministry consideration: Consider whether closer focus on quit outcomes in conjunction with quit attempts could be an appropriate way of recognising cross sector progress towards the Smokefree 2025 target.

Provide health promotion agencies with data to demonstrate the success of initiatives, especially to Ministers who want to cut communications funding.

Quit Group should support others working in this space by 'giving feedback on the outcomes from health promotion work'. Quitline already plan for increased staff during times of television advertising for their services because they experience an increase in calls. Are there other initiatives, provided by other organisations, which also increase calls, for example the 'Smoking Not Our Future' promotion; does that impact on calls to Quitline? Also specific events targeted for World Smokefree Day on 31 May should be assessed.

Recommendation: Provide data of peaks in call volumes following health promotions to organisations like HPA, SFC and ASH i.e. World Smokefree Day.

Quit Group should capitalise on the media attention they get.

Quit Group is widely recognised as the main smoking cessation service provider in New Zealand and one key informant commented that they regularly get approached by the media when smoking cessation/ tobacco control is in the news. It would be good for Quit Group to capitalise on this attention, not just for their services, but also to promote quitting as a whole. One informant commented that Paula Snowdon makes a good spokesperson for smoking cessation and that the Quit Group should capitalise on the opportunities that it gets. However, this needs to be carefully managed as some smaller providers already feel that Quit Group doesn't do enough to promote quitting as a whole.

Recommendation: The Quit Group should continue to be available for media queries however, it is important to recognise the importance of promoting the availability of face-to-face services and the role of Quitline for those that don't want, or can't get to, these services, or who want a top up to these services.

4.3.3. Policy and regulation

Quit Group could promote themselves as the 'voice of smokers' in consultation.

Quitline advisors have more experience than anyone else in talking to the people that are directly impacted by the changes that are brought about by tobacco control policy and the impact the changes had on their decisions to quit smoking. Where consultation on changes is taking place it was suggested that Quit Group could somehow been involved in either canvassing opinions of smokers, or to provide them with information about where they can make these thoughts known. Quit Group wouldn't have to be proactive in this, because they need to be cognisant to keeping people focused on their own quit attempts.

Recommendation: Provide a link to policy consultation from the Quitline website particularly their blog page, could be a useful step.

Quit Group data is a good barometer of policy and regulation measures, and needs to be used to demonstrate effects.

As with health promotion, the data Quit Group gathers on smokers and their experiences is seen as vital to informing future tobacco control initiatives. Research needs to inform policy, however there was a concern that Quit Group no longer has the necessary research capacity in-house and it was felt that this had had a negative impact on their ability to make best use of this data.

Ministry consideration: Consider how data from Quitline and other providers could be used to inform policy and programme development.

Policy and regulation should not be a focus for Quit Group.

As with health promotion, many key informants felt that policy and regulation should not be a focus for Quit Group. Policy developments are seen as more cost effective than funding cessation services, yet they go hand in hand. Policy changes help to prompt people to quit i.e. smokefree environments and tax increases, and then cessation services are needed to support people once they make the decision to quit. It was suggested that while Quit Group needs to be cognisant of the policy landscape so it can plan for changes, and that they should get involved in consultations, essentially work in this area should be left to others.

Recommendation: Quit Group needs to continue to be aware of new initiatives so that they can plan for any increase in demand for their services, in the same way they do with health promotion initiatives.

Quit Group needs to retain their role on Tobacco Control Working Group.

Quit Group's role on the Tobacco Control Working Group (TCWG) was seen as positive by those working at the national level in health promotion and/or policy and regulation. It was felt that it was important for them to retain this role and to ensure the Working Group benefits from their experience, knowledge and data.

Ministry consideration: Ensure all providers are kept up to date with what is being undertaken by the TCWG and that different provider types are adequately represented.

4.3.4. Research and evaluation

Quit group should focus on using their everyday data to inform improvements, rather than funding big picture research.

Key informants felt that any data analysis undertaken by Quit Group should focus on their 'everyday data' and how it can be used to improve their services. Again the concern was raised that the Quit Group no longer has the research capacity in-house and it was felt that this had had a negative impact on its ability to make best use of this data.

Recommendation: Work with other groups to ensure the data is used appropriately to inform their work. Linking to the NHI could allow broader analysis of Quitline data.

A clearinghouse for research would be a useful addition to the cessation space.

There were mixed responses to the question whether there was a role for the Quit Group to act as a clearinghouse for research. It was generally agreed that there was a need for such a clearinghouse but less consensus as to whether a cessation service provider was the most appropriate place for this. A number of informants noted that the establishment of the Turanga provided a more appropriate place for this.

Ministry consideration: How can the Turanga can better utilise their role to get research findings distributed amongst the sector, including how tier level one data analysis finds can be shared.

Organisations want data – if it is available then they don't know about it. Help regional providers to see that QG is part of the solution to smoking cessation in their region.

Knowing the numbers supported in each DHB region is useful for DHB smokefree coordinators and regional providers. However, it would also be useful to provide information about the numbers who have quit at three months. This would help to build an understanding of not just the numbers supported but the success achieved, and therefore the changing face of smoking in the regions.

Rather than Quit Group distributing this information, there could be a role for the Ministry as it collected data from all funded providers and therefore could provide information across all specialist providers. At the moment there is no data collected from DHBs/PHOs about the services that they provide, and this would need to be done if a 'true' picture of smoking cessation support was to be achieved. One informant mentioned monthly phone conferences for the DHB smokefree coordinators, and it was thought that this could provide a useful network for the distribution of data.

Recommendation: Investigate how the DHB smokefree coordinators monthly phone conferences could be utilised to share data and utilisation trends either directly, or as an avenue to bring what is available to the attention of those working in local services.

Need for research and evaluation to be more centralised, and better coordinated.

One provider informant suggested that it would be good to have evaluation of cessation services centralised, which would need development of an effective method of evaluation to compare different services including consideration of client types and needs i.e. those with longer term nicotine addictions and/or multiple addictions. This would require funding and would probably need to be led by the Ministry.

Ministry consideration: Undertake a stocktake of what evaluation of cessation services has been done to date and build on that.

4.3.5. Other

Keep addiction services separate.

For the key informants that were asked about the concept of combining addiction services, there were strong feelings that this could have a negative effect on smoking cessation services. Informants were concerned that smokers would not want the 'stigma' linked to other addictions; it is seen as more socially acceptable to be giving up smoking. There was also concern that the advisors/counsellors on such a help line wouldn't have the expertise necessary to support such a wide range of issues and it could have a negative impact on the quality of service clients received.

It was felt that referral between services was okay, but only if managed very carefully and if raised by the client. It was felt that it was not appropriate to be provided by one organisation or even accessed through a single 0800 number.

Ministry consideration: Consult widely before moving to a combined approach to helpline/addiction services, with particular consideration of the impact of stigma issues presented by clients engaging with services, and the ability to ensure access to well informed and trained counsellors.

Could provide training for smoking cessation counsellors/Quit Coaches.

In addition to providing training for primary health professionals, as suggested in section 4.3.1 one provider informant suggested that Quit Group could sponsor webinars and workshops to help push the expertise out to the smoking cessation community. Individual providers should lead training for their staff; however, if providers are to suggest clients could also access Quitline, it would be appropriate for Quitline to provide training to the providers about their services.

Near the end of the environmental scan *Allen + Clarke* became aware of a push to formalise training for cessation advisors across the range of specialist services. The Quit Group is considering how to provide recognition for the training it already provide to its advisors and whether this training is something that can be shared with others.

The Ministry has noted that the Quit Group was not invited to participate in these and that this was an oversight that should be corrected in the future.

Recommendation: Quit Group could develop a videoed 'walk through' and explanation of their service that possible referrers could watch to learn more about the service they provide.

Recommendation: Investigate the appropriateness of sharing Quitline cessation advisor training resources with other specialist providers. While recognising the need for different training approaches which are appropriate for groups targeted by specialist service providers

Ministry consideration: Ensure that Quitline advisors are included in future training workshops.

Quit Group need to think about how it can work with other health services.

The Ministry currently focus data collection on the smokers supported by specialist cessation services i.e. Quitline, Aukati KaiPaipa, Pacific Services and Pregnancy Services, as well as what is being achieved by DHBs using the ABC Health Target as a barometer in this space. However one provider informant felt that most of the work being done in the regions is undertaken by PHOs and that until there was a better understanding of the services they provided it would be difficult to build a full picture from which the Ministry, Quitline and other services can plan.

One informant from a specialist service provider also commented that in the three years they had worked there they had never had any contact from Quitline. They also were concerned that they didn't have anyone within Quitline that they felt they could contact directly. It was felt that this made it difficult to build a good working relationship between the two organisations.

Recommendation: Quit Group to send the contact details for the new relationship manager to other providers so they feel they have someone they can contact. This would be likely to have a positive impact on interagency relationships and referrals.

4.4. Performance

4.4.1. Effectiveness

Reporting quit status of clients

The Ministry expressed concern at the effort that Quit Group had put into additional service evaluation in the past. However, the introduction of the Tier Level One Service Specification means this information will be collected as part of core service monitoring and additional evaluation is no longer required.

The Ministry recognises that clients have different needs that the Quit Group will lose some clients purely due to the type of cessation service they desire i.e. some clients ring to get NRT and do not want any further support.

Recommendation: The Quit Group should actively engage with the on the possibility of future outcomes reporting on the basis of different client groups / differing 'intensities' of service.

Very good service well received by those that want to quit with 'remote' support.

Quitline is recognised by those interviewed as providing a good remote support service which is well received by those people that want to quit in that way. The smokers that are successful using Quitline's services are usually motivated smokers who can, and do, utilise the range of services Quitline provides. This doesn't degrade the service provided, but rather recognises that they are usually dealing with a different type of client to those supported by the face to face services.

The following section outlines key performance and effectiveness learnings from the international and New Zealand research literature.

- **Impact of television advertising on call volumes**. Calls increased when a television advertisement was screening and the proportion of Māori callers dropped when there was no television advertisement. Television advertisements are effective in generating an increase the number of new callers to Quitline, including Māori (Wilson et al, 2005).

This finding was supported by information from Quit Group staff that highlighted the importance of having additional Quitline staff manning the phones when television advertisements are scheduled to be aired.

- **Phone support interventions.** 'Telephone counselling is an effective method of cessation support and multiple sessions are better. Telephone counselling should be provided in conjunction with patient cessation materials, educational approaches, NRT etc. At a minimum, materials should be provided along with the telephone support' (Stead, Perera & Lancaster, 2009).

The range of services and information provided by Quitline are seen by key informants as wide ranging and effective.

- **Mobile phone interventions (including texting)** 'A review found that there is a lack of evidence to determine whether mobile phone based cessation services (texting) are effective long term. There is evidence of a beneficial short term effect' (Whittaker et al, 2009).

Allen + Clarke is aware that Quit Group is currently considering how their Text2Quit service can be improved. Some key informants felt that there were opportunities for a text service to support those that are remotely based and do not have regular access to a landline.

- **Web-based interventions.** 'There is limited evidence on the long term effectiveness of internet based cessation services. Individually tailored services were found to be more effective than static websites' (Civljak et al, 2010).

The Quit website is recognised as being interactive providing services such as blogs and quit statistics calculators. Where clients utilise the online Quit Coach, this information is added to their Quitline file and the information can then be accessed by advisors that support them over the phone.

- **The role of pharmacotherapy with other cessation interventions.** 'A UK study found that NRT is linked to higher quit rates than no pharmacotherapy. Quit rates are further increased when NRT and varenicline are used in conjunction' (Brose et al, 2011).
- 'Access to low cost NRT supports access to cessation services' (Wilson, 2003).

Clients that utilise Quitline services are able to access low cost NRT. Quitline also has responsibility for coordinating the Quitcard programme which enables health professionals working in the community to provide subsidised NRT products as part of their smoking cessation support services.

- **Quit and Win interventions.** 'There is limited evidence of the effectiveness of cessation competitions. One contest in New Zealand did provide favourable results with 40 percent of participants remaining quit at 12 months. The study had a disproportionately high number of Māori participants' (Wilson, 2003).
- **Group therapy.** 'A UK study found that group supports were found to have higher quit rates than one to one services. However, other studies have not shown group therapy to be any more effective than one on one intervention. There could be merit in using group therapy given the potential for cost effectiveness' (Brose et al, 2011).

The findings above provide an introduction to some of the research that has been undertaken regarding different intervention approaches for smoking cessation. As the Quit Group looks to redevelop current services i.e. Text2Quit or introduce new services, these should be informed by international research findings.

4.4.2. Value for money

Telephone based support is good value for money.

Telephone support is widely seen as a cost effective approach to smoking cessation. However, despite a large number of published papers, no single methodology to evaluate the cost effectiveness of different programmes have been established (NAQC, 2010). This means that there will always be some questioning of reports identifying the cost effectiveness of smoking cessation services.

Could money be better spent on developing better online services?

As Quit Group has already achieved good results with their web based services and some key informants queried whether there might be a benefit to focusing future developments in this area. Research undertaken by the North American Quitline Consortium found:

> *The importance of value for money means that it is critical to demonstrate that new interventions are cost effective and present greater efficiencies than existing ones. It is through these ongoing analyses that new and effective programmes will be developed, implemented and reviewed (NAQC, 2010).*

Recommendation: Retain a focus on monitoring and service evaluation to identify key factors for cost effectiveness informed by understandings from international research. Quit Group could look to develop a set of key considerations that could be shared with other cessation organisations to inform their service evaluation work.

The following section outlines value for money learnings from the international and New Zealand research literature.

Although significant, the revenue generated from the sale of tobacco products is overshadowed by the costs associated with the health burden they create.

One argument used by smokers against tobacco control initiatives is that the government doesn't actually want them to stop smoking because of the revenue generated by tobacco taxes. The following quote is taken from the comments to an article on the Dominion Post section of the Stuff website about the Capital and Coast DHB initiative to call all registered primary care patients to record their smoking status (Torrie, 2012):

> *Don't fool yourself, the last thing government wants is for people to give up smoking. No smokers = less tax and more pensions to pay. Thats [sic] why they always endorse knee-jerk band-aid approaches that will never help (like plain packaging – a smoker cares about the packaging about as much as a heroin user cares about the brand of the needle... And putting the prices up – if tobacco is as addictive as heroin or P, and people are prepared to pay $1000 or $5000 per week for their heroin or P, whats [sic] the point other than revenue collection? Their own forecasts predict that people will still be smoking at $100 a packet.*

A number of commentators in the tobacco control sector domestically and internationally have indicated that if countries were to 'triple the cost and halve the consumption they would still double the tax take'. International agencies, including the World Health Organization, argue strongly for at least a portion of increased government revenue from increased tobacco taxation is dedicated to health promotion and cessation support services. This is considered a means of firstly building support for tax increases (the most effective population level tobacco control intervention), but also as a more equitable approach: supporting poorer smokers in particular to make the move to a smokefree lifestyle.

Recommendation for the cessation sector: Research findings on the revenue generated from tobacco sales, including how it should be used to support smoking cessation, would be good to include in a public health campaign.

Cost for Quitline per successful quit at 12 months $2,000.

These figures, taken from the Quit Group's 2011 Return on Investment report are the most recent available for cost per successful quit, however they are based on research which was completed in 2007. Quit Group expect that taking into account the recent changes to their services, including the increase in numbers reached and successful quit attempts, the current cost per successful quit is likely to be significantly lower.

4.5. Expectations

4.5.1. Targets

Targets not necessarily informed by science.

The current targets focus on outputs rather than outcomes. One key informant suggested that it might be more appropriate to look at how targets can be aligned to improved health outcomes rather than smoking prevalence. Not for individual organisations, but rather at the Ministry level. This is important to support ongoing funding for smoking cessation and tobacco control initiatives. However, it has been recognised in research literature that 'it is unclear when the tobacco control efforts of the recent past will have a substantial impact on reducing the mortality rate' (NAQC, 2010).

Ministry consideration: Ministry, with other tobacco control partners, to look at how targets informed by evidence of cessation outcomes can be achieved, through the Tobacco Use Survey and by linking cessation client data to NHI.

Generally more work required for less money.

The Ministry was clear that this is the nature of the current fiscal environment and all cessation providers need to be prepared to respond to external pressures such as the expectation to do more with less, and ongoing analysis of value for money considerations. There is also no guarantee that services that have been funded in the past will continue to be funded in the future and providers need to ensure they are able to demonstrate how they are achieving value for money outcomes.

Increased targets have caused 'casualties' at the front line with non-performing organisations losing funding. Hopefully this means that when get close to the 'thin edge of the wedge' and only the 'hardcore' smokers remain, then those providers still being funded will be best placed to support them to quit where possible. The long term target for those working in cessation is that they will do themselves out of a job. The shortened time for monitoring, from 12 months to 3 months, means that not only are providers expected quit results sooner, but it also means that providers are not able to report longer term quit results.

Recommendation: Quitline needs to focus on delivering high quality core services that meet the needs of their clients.

From the literature

- The publicly reported health targets have been highly effective. There is better provision of assistance to quit smoking (Ministry of Health, 2012a).

However, this does not acknowledge the comments made by some informants who were concerned that the ABC health targets had placed too much emphasis on the A & B aspects and resulted in less focus on the provision of cessation support.

Ministry consideration: Undertake a stocktake of what cessation support primary health professionals are providing patients or making referrals.

4.5.2. Target clients

Could do more for specific target health groups i.e. pregnant women, diabetes and asthma.

The findings of the recent review of pregnancy smoking cessation services should be shared with other specialist cessation service providers as the key informants we spoke with indicated they were keen to expand their knowledge in this space. At the moment Quit Group reports indicate that they are a long way from achieving the targets set by the Ministry in this area (which has been increased despite the fact they weren't achieving their original targets). Where targets have been increased in this way they need to be supported by research showing what works.

Ministry consideration: Look at broader public health work and how these linkages can be made and relationships between organisations supported.

Need to be prepared for increase in referrals from lead maternity carers.

The Ministry is currently focussing on pushing agencies to refer pregnant smokers to specialist cessation services, including Quitline. This is a new Health Target for 2012/13 and the Quit Group needs to ensure Quitline advisors are appropriately trained and confident to support these high priority clients.

Recommendation: Ensure appropriate and targeted support is available for pregnant smokers; this may require additional training and/or the development of specific resources to meet the needs of this target group.

5. Recommendations/areas for consideration

5.1. Recommendations for Quit Group

5.1.1. Core business – things for immediate action

Service provision

- **Focus on core role as a cessation service provider, streamlining and improving existing services (if necessary) before considering other roles** (section 4.3.1 and 4.5.1).
- **Build on the findings of this report to streamline and improve Quitline services** particularly regarding issues of improving reach to target populations (sections 4.1.4 and 4.3.1).
- **Continue to use 'everyday data' to inform business planning** (section 4.3.4).
- **Examine how text services can be used as a standalone service** for those with limited access to a reliable line for phone calls and/or the internet (section 4.1.4).
- **Ensure appropriate and targeted support is available for pregnant smokers;** this may require additional training and/or the development of specific resources to meet the needs of this target group (section 4.1.4).
- **Actively consider how a collaborative triage role can be added to the Quitline suite of services** (sections 4.3.1).
- **The Quit Group should actively engage with the Ministry on the possibility of future outcomes reporting on the basis of different client groups / differing 'intensities' of service** (sections 4.3.1 and 4.4.1).

Engagement with others to support coordination/collaboration

- **Strengthen engagement with specialist face-to-face services** Suggested approaches include: attending regional network meetings; provide a link to the Smokefree contacts website from the Quit website; investigate establishing memoranda of understanding with other provider organisations regarding referrals and sharing of resources/data (section 4.2.2 and 4.2.3).
- **Promote the availability of Quit Group data/information with regional networks** so regional providers can see the role that Quitline already plays in regional cessation (section 4.3.1).
- **Add linkages with regional networks to the new Quit Group relationship manager role** including regular attendance at regional network meetings (section 4.2.1 and 4.2.3).
- **Ensure the first step in any interaction with regional networks and other providers is to listen.** This is crucial to ensure it doesn't appear that Quitline are trying to take over regional initiatives (section 4.3.1).
- **Communicate the recent change of approach to their service model** to other providers and possible referrers to address their concerns and raise their understanding of the support that Quit Group provides (section 4.1.4).
- **Send the contact details for the new relationship manager to other providers** so they feel they have someone they can contact. This would be likely to have a positive impact on interagency relationships and referrals (section 4.3.5).

Linkages to DHBs and primary health targets

- **Promote Quitline services to primary health and DHB smokefree coordinators** look for opportunities to raise awareness of Quitline services in primary health and with hospitals to increase referrals (section 4.1.1).
- **Investigate how the DHB smokefree coordinators monthly phone conferences could be utilised** to share data and utilisation trends either directly, or as an avenue to bring what is available to the attention of those working in local services (section 4.3.4).

Data collection and analysis/research and evaluation

- **Access NHI and link to client data** to improve usability of client data for cessation service analysis and wider health research (sections 4.1.1, 4.2.3 and 4.2.4).

Referral

- **Investigate options for improving referral feedback** including talking with other providers, DHB smokefree coordinators and primary health professionals about the type of feedback wanted (section 4.2.2).
- **Establish a more effective referral system that includes providing feedback to the referrer** including success in contacting the client and smoking status at three months (sections 4.1.1 and 4.2.3).
- **Reintroduce the 'best time to contact' to the referral form** and possibly also a prompt to check currency of contact details on file (section 4.2.3).

Health promotion/advocacy

- **Engage with other health promotion agencies** including a formal agreement with the HPA including sharing insight gathered from Quitline data and to work together on communications plans to avoid duplication and ensure effective spending of communications funding (sections 4.1.5 and 4.3.2).
- **Work with HPA to promote Goalpost** through schools, tertiary education providers, Facebook, YouTube etc (section 4.1.5).

5.1.2. Aiming for Smokefree 2025 – new areas to improve how we're working

Engagement with others to support coordination/collaboration

- **Develop a communications strategy outlining the services offered by Quitline.** Include information about the services offered, and how they link with other services (section 4.1.4).
- **Retain focus on 2025 target in all work.** Work with the Ministry and other providers to look at how this can be achieved across cessation services (section 4.2.1).
- **Investigate the appropriateness of sharing Quitline cessation advisor training resources with other specialist providers.** While recognising the need for different training approaches which are appropriate for groups targeted by specialist service providers (section 4.3.5).

Getting the most out of DHBs and primary health targets

- **Investigate what training is already provided to health professionals** particularly in primary health, and identify opportunities to add Quitline information, including the services available and how they operate, to these programmes (sections 4.1.1 and 4.3.1).

Data collection and analysis/research and evaluation

- **Ensure Quit Group retains a focus on monitoring and service evaluation to identify key factors for cost effectiveness**, informed by understandings from international research. Quit Group could look to develop a set of key considerations that could be shared with other cessation organisations to inform their service evaluation work (section 4.1.2 and 4.4.2).

5.1.3. "Nice to dos" – future focus when other work has been achieved

Engagement with others to support coordination/collaboration

- **Quit Group could run an 'open day' (could be shared via webinar) so other providers can better understand what they can provide.** Also promote newsletters to other cessation providers so they have better awareness of the information that Quit Group already shares (section 4.3.1 and 4.3.5).
- **Provide opportunities for Quitline advisors to meet with Quit Coaches from other providers** (section 4.2.2).
- **Develop a videoed 'walk through'** and explanation of their service that possible referrers could watch to learn more about the service they provide (section 4.3.5).

Data collection and analysis/research and evaluation

- **Work with national advocacy and research organisations** to consider how the data they collect can be used to provide evidence of the impact of initiatives such as smokefree prisons, tax increases and tobacco hidden in retail (section 4.1.3).
- **Provide data of peaks in call volumes following health promotions** to lead health promotion organisations i.e. World Smokefree Day (sections 4.1.5 and 4.3.2).
- **Make Quitline data available for research purposes** this could include partnering with a research unit and provide them with the questions Quit Group would like to be explored to inform their service development (section 4.3.4).

Health promotion

- **Contact key organisations leading work in relevant public health priority areas** to establish a relationship and look for ways to work together to highlight the impact of smoking on these health conditions and the role that Quitline services can play in this area (section 4.1.1).

Policy and regulation

- **Provide a link to policy consultation pages on the Quitline website** particularly the blog pages (section 4.3.3).

5.2. Areas for consideration across the wider cessation/tobacco control sector

5.2.1. Aiming for Smokefree 2025 – new areas to improve how we're working

Service provision

- **Ensure appropriate and targeted support is available for pregnant smokers:** this may require additional training and/or the development of specific resources to meet the needs of this target group (section 4.1.4).
- **All cessation service providers to access NHI** so use of multiple services can be recorded, tracked and evaluated (section 4.2.4).

Engagement with others to support coordination/collaboration

- **Share Quitline outcomes for Māori more widely particularly with Aukati KaiPaipa and others that target Māori**, so they have more confidence regarding Quitline services success with Māori (section 4.1.4).
- **Investigate how DHB smokefree coordinators could be utilised to for engagement across the sector,** and whether it would be appropriate for them to represent the Quit Group when they are not able to attend regional network meetings (sections 4.2.2 and 4.3.3).

Training for smoking cessation advisors

- **Investigate the appropriateness of sharing Quitline cessation advisor training resources with other specialist providers,** while recognising the need for different training approaches which are appropriate for groups targeted by specialist service providers (section 4.3.5).

Data collection and analysis/research and evaluation

- **Ensure all providers retain a focus on service evaluation to identify key factors for cost effectiveness,** informed by understandings from international research. If appropriate service providers, including Quit Group, could look to develop a set of key considerations that could be shared with other cessation organisations to inform their service evaluation work (section 4.1.2 and 4.4.2).
- **Analyse cessation data on youth access to specialist cessation services** to inform an evaluation of effectiveness of services for smokers under 25 and share learnings across all providers (section 4.3.1).

Referral

- Report referrals to and from other specialist cessation providers **if not in monthly reports to the** Ministry then consider how to provide this to those services so they better understand referrals go both ways (section 4.2.2).

Health promotion/advocacy

- All cessation service providers work with the HPA to develop a national campaign that focuses on quitting and provides links and information to all the different services available (section 4.2.4).

5.3. Areas for consideration by the Ministry of Health

5.3.1. Aiming for Smokefree 2025 – new areas to improve how we're working

Engagement with others to support coordination/collaboration

- **Consider how to record and recognise collaboration between providers where it improves smoking cessation outcomes** i.e. set up a reporting system that counts clients supported by two or more providers (section 4.2.2).
- **Give active consideration the findings of this review particularly regarding barriers to coordination.** Consult with all providers as to how this could/should be achieved to avoid duplication of services and address concerns about the impact of a competitive funding environment (section 4.2.3).
- **Clear and targeted discussion with Quit Group regarding the trialling of a 'collaborative triage' approach to their service** and how this would work, including the potential for piloting (section 4.3.1).
- **Ensure that Quitline advisors are included in future training workshops** (section 4.3.5).

Data collection and analysis/research and evaluation

- **Investigate how specific data (as it relates to individual smokers)** can be collected and shared to inform provision of cessation support (section 4.1.1).
- **Actively support organisations as they implement tier one service specifications** to ensure they have the capability and systems in place to achieve the reporting requirements (section 4.2.5).

Improving understanding of quality in cessation service provision

- **Undertake a stocktake of cessation services to identify whether there are gaps in quality provision** this should include those services provided by DHBs and PHOs (section 4.2.3, 4.2.5 and 4.5.1).
- **Establish a searchable register of quality smoking cessation services informed by tier one reporting to aid referrals.** This could be created so the referrer enters basic information about the client: age, ethnicity, gender, location and any key health issues i.e. pregnancy, diabetes, and the database makes a suggestion of possible services for referral (section 4.2.3 and 4.2.4).
- **Support the development of reporting that utilises NHI numbers of clients to aid analysis and evaluation** of outcomes for individuals across all services (section 4.2.4).
- **Actively support organisations as they implement the tier level one service specification** to ensure they have the capability and systems in place to achieve the reporting requirements (section 4.2.5).

Smoking cessation policy

- **Ensure all providers are kept up to date with work of the Tobacco Control Working Group** and that different provider types are adequately represented (section 4.3.3).
- **Consider how data from Quitline and other providers could be used to inform policy and programme development** (section 4.3.3).
- **Consult widely before embarking on a combined approach to addiction/helpline services** with particular consideration of the impact of the stigma on clients' engagement with services, and

concerns about delays to accessing specialist services due to additional steps to go through (section 4.3.5).

- **Consider whether the current target focus on numbers of quit attempts** is the best approach, or whether a closer analysis of quit outcomes should be considered (section 4.3.2).

Contracting/target setting

- **Consider the impact of lack of continuity of funding,** consider providing 'indicative funding' information for out-years at the time of contracting (sections 4.1.2 and 4.2.5).
- **Investigate how multiple service access can be encouraged** including issuing a formal communication from the Ministry contract team to providers that this doesn't affect recording of targets (section 4.2.4).
- **Consider whether closer focus on quit outcomes in conjunction with quit attempts** could be an appropriate way of recognising cross sector progress towards the Smokefree 2025 target (section 4.3.2).
- Examine how targets informed by evidence of cessation outcomes could be developed and **implemented,** possibly through the Tobacco Use Survey. Linking cessation services client data to NHI would aid this (section 4.5.1).

5.3.2. "Nice to dos" – future focus when other work has been achieved

Service provision

- **Include ways to record the nature of the original contact in reports** i.e. client initiated or service initiated. Particularly when considering distance to quit date and quit outcomes (sections 4.2.5).
- **Consider options for recognising referrals between providers where appropriate** (section 4.2.2).

Engagement with others to support coordination/collaboration

- **Ministry and Quit Group to work with HPA to look at how broader, and more positive, public health approaches to smoking cessation could be encouraged** (section 4.3.2).

Smoking cessation policy

- **Look at broader public health and how linkages can be made** and relationships between smoking cessation and other organisations supported (section 4.5.2).

Data collection and analysis/research and evaluation

- **Consider how Turanga can better utilise their role to get research findings distributed amongst the sector,** including how tier one data analysis finds can be shared (section 4.3.4).
- **Undertake a stocktake of what evaluation of cessation services has been done to date** (section 4.3.4).
- **Identify research findings on the revenue generated from tobacco sales,** including how it should be

used to support smoking cessation, would be good to include in a public health campaign (section 4.4.2).

- **Investigate how specific data (as it relates to individual smokers)** can be collected and shared to inform provision of cessation support (section 4.1.1).

Contracting/target setting

- **Link targets to the 2025 goal so that everyone has their eye on the progress they are making towards 'end goal' with a specific focus on Māori and Pacific priority groups.** One option could be to create a 2025 countdown tool which illustrates the progress towards the goal of 5 percent smoking prevalence, which would be something that the country could be proud of (section 4.2.1, 4.2.5 and 4.5.1).

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Appendix A: Interview guide

The wider environment

In what ways do wider environmental factors impact on the Quit Group and the wider cessation sector?

Health priorities - Quit Group staff, MOH staff, Smokefree Coalition, ASH

1. In what ways can/do other health priorities impact on smoking cessation? (i.e. for clients, funders, providers)
2. How has the ABC approach affected the cessation providers and what are the implications over the next 5 years?

Funding pressures - Quit Group staff, MOH staff, Smokefree Coalition, ASH

3. How have funding pressures informed the MOH's expectations of the Quit Group and what is the likely implication of this in the future? (i.e. setting targets, change in outcomes)

Political imperatives - Quit Group staff, MOH staff, Smokefree Coalition, ASH

4. How is the smoking cessation sector informed by the political environment? (i.e. minor party support)

The needs of cessation clients - As above + other cessation providers

5. To what extent do the current Quit Group services meet the needs of cessation clients? (i.e. new online services, 1-to-1 telephone support)
6. What needs are not being met by the Quit Group?

Role of the HPA - As above + HPA

7. What role does the new HPA play in supporting the work of the Quit Group over and/or alongside other cessation providers?

Collaboration and/or coordination

What are the incentives and barriers on the cessation sector with regards to collaboration and coordination of services?

Incentives for collaboration - Quit Group staff, MOH staff, Smokefree Coalition, ASH, other cessation providers, other referring organisations

8. What incentives are there for providers (incl Quit Group) to collaborate and share information?
9. What incentives are there for organisations (incl Quit Group) to refer clients to other providers that offer a different service?

Barriers to collaboration - Quit Group staff, MOH staff, Smokefree Coalition, ASH, other cessation providers, other referring organisations

10. What barriers are there for organisations (incl Quit Group) to refer clients to other providers that offer a different service?
11. How can linkage and referral systems be improved?

Coordination of services - Quit Group staff, MOH staff, Smokefree Coalition, ASH, other cessation providers, other referring organisations

12. Is there a need for greater coordination of services? How would such coordination work and what role could/would individual providers play? What role would the MOH and others play?

Clients accessing a number of services - Quit Group staff, MOH staff, Smokefree Coalition, ASH, other cessation providers, other referring organisations

13. Is there a concern about clients using more than one service at any one time? If not, is this an appropriate approach and how can it be promoted?

Competitive approach - Quit Group staff, MOH staff, Smokefree Coalition, ASH, other cessation providers, other referring organisations

14. What impact (positive and negative) has a competitive approach had on the cessation sector? What are the benefits to changing this approach?

Potential role

What is the potential role/s of the Quit Group looking ahead to achieving the Smokefree Aotearoa 2025 target?

Cessation - Quit Group staff, MOH staff, Smokefree Coalition, ASH, other cessation providers, Smokefree researchers

15. What else could the Quit Group be doing in the cessation space to help achieve the 2025 goal?
16. How does it need to adapt in order to do this?

Health promotion - As above (but not other cessation providers) + HPA

17. What should the Quit Group be doing in the health promotion space that would support the 2025 goal?
18. Where does this potential role fit in relation to the expected functions of the new HPA?

Policy and regulation - As above (but not other cessation providers) + HPA

19. What should the Quit Group be doing to support policy and regulation aimed at the 2025 goal?
20. How does it need to adapt in order to be an effective player in this space?

Research and evaluation - Quit Group staff, MOH staff, Smokefree Coalition, ASH, other cessation providers, Smokefree researchers

21. What role is there for the Quit Group to feed its intelligence (i.e. data, knowledge and experience) into the sector, that is, to inform the planning and delivery of cessation services and health promotion services, and to inform policy and regulations?
22. Is there a role for the Quit Group in promoting greater coordination or a clearinghouse for research and evaluation of cessation services? Would this be a useful role for another organisation?

Other - Quit Group staff, MOH staff, Smokefree Coalition, ASH, other cessation providers, Smokefree researchers

23. What are the barriers and benefits for the Quit Group in getting involved in cessation roles outside of NZ? (incl planning and advisory roles, as well as service delivery roles)

24. Outside of the smoking cessation and tobacco control sector, what other potential roles are there for the Quit Group? (incl comment on consolidating service with other addiction services)
25. Would moving into these other potential areas (international or other sectors) support the Quit Group's contribution to the 2025 goal? How?

Performance

What does Quit Group do well, and where are the main areas for improvement?

Effectiveness - MOH staff, Quit Group staff, other cessation providers

26. What results does Quit Group achieve and for whom? (i.e. outcomes for different clients)
27. What is the comparative effectiveness of different QG modes?
28. How does Quit Group's effectiveness compare to other cessation providers?
29. What does Quit Group do well at, and where are the main areas for improvement? (e.g. population groups, or tailoring services to individuals)

Value for money - MOH staff, Quit Group staff, Smokefree researchers

30. In what areas does Quit Group provide strong value for money compared with other cessation providers, and where does it provide comparatively more value for money?

Expectations

What are current expectations of the Quit Group in terms of service to funders and clients and how is this likely to change in the future?

Targets – MOH staff, Quit Group staff

31. What are current expectations around number of Quit Group clients and quality of engagement, including for different types of client and for outcomes, and what is the evidential basis for these targets?

Target clients – MOH staff, Quit Group staff

32. What are the potential options for Quit Group's future target market, including likely cost differences for different options?

Modes of operation – Quit Group, other cessation providers, MOH staff, Smokefree Coalition, ASH

33. What are the potential options for Quit Group's future modes of operation, including the range of modes of engagement that it should offer?
34. What improvements could be made to Quit Group's existing modes?

Appendix B: Evidence review

Theme 1: Wider environment	
Wilson, 2003	Quitline experienced an increase in calls when NRT was subsided in 2000. Bupropion is a proven smoking cessation therapy that is not subsidised in New Zealand, although other countries such as UK and Australia fund it. New Zealand does have the antidepressant nortriptyline available for use in smoking cessation. It is understood that Pharmac supports its use for smoking cessation; however it is not registered for this purpose.
Wilson et al, 2012	There is strong evidence that increasing the price of tobacco decreased the rates of smoking among young people and adults, and that young people are more sensitive to price rises.
Wilson et al, 2012	There is some evidence to suggest that banning smoking in public places has some effect on smoking prevalence. Studies evaluating the effect of bans on cessation and initiation have reported mixed results. It is possible that the effectiveness of a smoking ban depends on the comprehensiveness of legislation, level of enforcement, public support and other relevant legislation.
Torrie, 2012	In an effort to meet Ministry of Health targets, four public health organisations funded by Capital & Coast District Health Board set up a call centre in an effort to contact known smokers on GPs' books. Noted that additional funding covered the cost of contacting people, but not for providing cessation support.
Theme 2: Collaboration and/or coordination	
Centres for Disease Control and Prevention, 2004	One potential way for quitlines to accomplish both population impact and cessation for individuals is by partnering more fully with the healthcare system. To dramatically increase healthcare initiated utilisation, quitline referrals must be instituted on a systems level. It would then increase its population impact not only by providing effective counselling services, but also by enhancing the use of other available cessation resources, including pharmacotherapies and community cessation programmes.
NAQC, 2009	Six states had great success with building referral programmes designed to refer smokers to the Quitline from 'natural' settings like their health professional's office, community organisations and schools etc.
Gravitas, 2012	17.6 per cent of survey respondents used other services i.e. pharmacy products, GP support, electronic cigarettes and NRT from sources other than the NZ Quitline.
Theme 3: Potential role	
Treasury, 2012	The Ministry is reviewing the number of 0800 lines currently in use and believes there are both efficiency gains through rationalisation and potential improvements in effectiveness.

Ministry of Health, 2012a	A focus on proven preventative measures and earlier intervention can result in significant health gains. More smoking reduction programmes will have significant benefits for New Zealanders.
Ministry of Health, 2012a	The Ministry will increase access to public health services and personal health interventions (including cessation and nicotine replacement therapies) to reduce smoking related harm.
Treasury, 2012	Further developing primary care as the accessible and affordable first point of contact for health services for all New Zealanders. Through work at primary care level also expect to see better help to quit provided to those that smoke.
Centres for Disease Control and Prevention, 2004	As evidence of effective interventions for target populations becomes available, Quitlines have expanded their capacity to provide culturally sensitive and language-effective services to more communities, therefore broadening the menu of evidence-based counselling services.
Centres for Disease Control and Prevention, 2004	Quitlines could support patient compliance with cessation treatments by helping them to access other support systems available locally (e.g. culturally specific cessation classes), either alone or in combination with Quitline counselling.
NAQC, 2009	Health system changes can be direct, such as regular training of clinicians in brief cessation interventions, which include educating heath care professionals about the availability of Quitline. Many [health care professionals] accept responsibility for the first two As (A&B in NZ) but resist the other three As (C in NZ) because they are time consuming and many do not feel they have the counselling skills required. Quitlines can assist by taking responsibility for the follow up calls to the smoker. Quitlines who partner early in the system change process see calls increase and can reduce resistance and cost as well.
Centres for Disease Control and Prevention, 2004	Quitlines must consolidate their achievements and establish their value as an effective population based approach to cessation. Continuing research and development are needed to provide more comprehensive scientific support.

Theme 4: Performance	
Wilson et al, 2005 ***Wilson, 2003*** ***NAQC, 2009***	Television advertisements are effective in generating an increase in the number of new callers to Quitline, including Māori. Calls increased when an advertisement was screened and the proportion of Māori callers dropped when there was no television advertisement. Similar increases in call volume were observed in a study of US quitlines. Some US Quitlines found using other forms of media (such as radio, newspaper and direct mail) to be effective in increasing call volumes.
Centres for Disease Control and Prevention, 2004	Evaluation and comprehensive reporting is an integral part of providing information that can help improve services, provide accountability to the contractor and provide information on the quantity, quality and value of services provided.
Tala Pasifika, 2010	In 2006, 4 per cent of all callers to Quitline were Pacific peoples.
Gravitas, 2012	The more Quitline services used, the better the quit outcome. Among those clients surveyed that used all five Quitline services, the quit rate is 54.4 percent.
NAQC, 2009	With renewed focus on healthcare reform and cost containment, cost effective services like Quitlines will become more necessary and valuable. If resources are limited, programmes need to balance reaching/serving more people with programmes that are potentially less effective versus serving fewer people but serving them more intensely and perhaps more effectively. Typically callers who do not reach a staff member the first time they call are unwilling to leave their information or to call back.
Quit Group, 2011	Cost for Quitline per successful quit at 12 months was $2,000.Tangible costs – decreased production from morbidity and mortality, resources diverted from consumption of cigarettes, cost of treating induced diseases. Intangible costs – costs resulting from death and illness.
NAQC, 2010	Although significant, the revenue generated from the sale of tobacco products is overshadowed by the costs associated with the health burden they create. Concern over the unknown impact of the following possible contributing factors on the slowing rate of decline in smoking prevalence in the United States: a reduction in available funds for cessation programmes, the ease of getting those who were ready to quit with early cessation efforts and leaving those more addicted to nicotine remaining, and the increased stress of economic hard times. Reference made to an evaluation of cost-effectiveness of interventions found the more intensive the intervention, the more cost-effective the result. Quitlines, particularly those offering more intensive counselling and pharmacotherapy, were highly cost-effective in this analysis. Cost-effectiveness increases when nicotine replacement therapy is added to counselling.

	Cost-effectiveness comparisons must be sure to evaluate similar products and have full knowledge of possible variables. Unfortunately, those making these comparisons often do not have the information about these programmes to make informed evaluations and decisions.
Intervention methods	
Whittaker et al, 2009	A review found that there is a lack of evidence to determine whether mobile phone based cessation services (texting) are effective long term. There is evidence of a beneficial short term effect.
Civljak et al, 2010	There is limited evidence on the long term effectiveness of internet based cessation services. Individually tailored internet services were found to be more effective than static websites.
Stead, Perera& Lancaster, 2009	Telephone counselling is an effective method of cessation support and multiple sessions are better. Telephone counselling should also be provided in conjunction with patient cessation materials, educational approaches, NRT etc. At a minimum, materials should be provided along with the telephone support.
Brose et al, 2011 ***Wilson, 2003***	A UK study found that NRT is linked to higher quit rates than no pharmacotherapy. Quit rates are further increased when NRT and varenicline are used in conjunction. Access to low cost NRT supports access to cessation services.
Brose et al, 2011 ***Wilson, 2003***	A UK study found that group support interventions were found to have higher quit rates than one on one services. However, other studies have not shown group therapy to be any more effective than one on one intervention. There could be merit in using group therapy given the potential cost-effectiveness.
Wilson, 2003	Advertising campaigns are only effective when combined with other interventions, including tax increases, education programmes and the provision of counselling.
Wilson, 2003	There is limited evidence in the effectiveness of cessation competitions. One contest in New Zealand did provide favourable results with 40 per cent of participants remaining quit at 12 months. The study had a disproportionately high number of Māori participants.
Murray et al, 2009	A UK study found that proactive contacting of smokers through primary care records increased the number of quit attempts but did not increase cessation rates.
Tala Pasifika, 2010	Two thirds of Pacific people who smoke reported having been asked about their smoking status by a health care worker in the previous 12 months. A third of Pacific people who smoke reported having been provided with advice or information about cessation services in the past 12 months.

Intervention settings	
Brose et al, 2011	A UK study found that specialist cessation services had higher quit rates than cessation services delivered in a primary care setting.
Murray et al, 2009	There is some evidence from the UK that suggests other health providers, such as pharmacists and dentists, may be able to provide cessation support as people are able to access them without a pre booked appointment.
Wilson, 2003	There is limited evidence on the effectiveness of church based cessation services to target particular ethnic groups. A New Zealand report suggests that given the importance of church in the daily lives of Pacific people there may be merit in considering church based cessation services to target Pacific people.
Other	
TalaPasifika, 2010	25 per cent of Pacific people who smoke believe that nicotine replacement therapies are more harmful than smoking cigarettes. 45 per cent of Pacific people who smoke believe that smokers should be able to quit without assistance.