Complete Summary

GUIDELINE TITLE

Brief interventions and referral for smoking cessation in primary care and other settings.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Brief interventions and referral for smoking cessation in primary care and other settings. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Mar. 36 p. (Public health intervention; no. 1).

GUIDELINE STATUS

This is the current release of the guideline.

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SCOPE

DISEASE/CONDITION(S)

Smoking

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Counseling
Evaluation
Prevention

CLINICAL SPECIALTY

Dentistry
Family Practice
Internal Medicine
Nursing
Pediatrics
Preventive Medicine
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dentists
Hospitals
Nurses
Patients
Pharmacists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Social Workers

GUIDELINE OBJECTIVE(S)

To help local health and social care services as well as the community and voluntary sectors plan and deliver the most effective and most cost-effective services to encourage people who smoke to quit

TARGET POPULATION

People in England who smoke

INTERVENTIONS AND PRACTICES CONSIDERED

1. Brief interventions in health and community care, involving opportunistic advice, discussion, negotiation, or encouragement
    - Simple opportunistic advice to stop
    - An assessment of the patient's commitment to quit
    - An offer of pharmacotherapy and/or behavioural support
    - Provision of self-help material and referral to more intensive support such as the National Health Service Stop Smoking Services
2. Review of smoking cessation policies and practices by policy makers, commissioners, and managers
3. Availability of smoking cessation advice and support in community, primary, and secondary care settings (with special emphasis on efforts targeting hard to reach and deprived communities)
4. Monitoring systems to inform health professionals on the current smoking status of their patients

MAJOR OUTCOMES CONSIDERED

- Non-validated and validated smoking status, such as self-reported smoking abstinence and biochemically validated smoking abstinence such as saliva cotinine
- Cost effectiveness

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): Key questions were established as part of the scope. They formed the starting point for the review of evidence and facilitated the development of recommendations by the Public Health Interventions Advisory Committee (PHIAC). Refer to appendix D in the original guideline document for a list of the key questions.

Evidence of Effectiveness

One review of effectiveness was conducted.

Identifying the Evidence

The following databases were searched for recent systematic reviews (2000 to August 2005) and for trials (1985 to August 2005): MEDLINE, Cochrane Database of Systematic Reviews, Cochrane Controlled Trials Register (CENTRAL), Cochrane Tobacco Addiction Group Specialised Register, Reference Manager, DARE, ASSIA, British Nursing Index, Embase, Cinahl, PsycINFO Sociological Abstracts.

Additional searches using the same databases were conducted for information on barriers to implementation and for the question on referrals to the National Health Service (NHS) smoking services. In addition, a call for information on referrals was put out on Globalink UK, an international network of over 1000 tobacco control activists, smoking cessation workers, and researchers. (This includes most smoking cessation coordinators in England.) Regional stop smoking service managers were also asked for referral data. Full details of the databases and search strategies can be found in the full effectiveness review.

Details of the search terms and strategies are included in the rapid review report. (See the "Availability of Companion Documents" field.)

Selection Criteria

Reviews were excluded by two reviewers if:

- The title or abstract did not primarily address smoking cessation.

- The study was clearly not conducted systematically.
- The study did not address any of the scope questions (in such cases lower level evidence was sought).

A similar process was used to exclude trials and other types of research studies. For these studies one reviewer judged the potential relevance of the evidence. Consistency of coding was assessed in a subset of 80 papers and a kappa of >0.6 obtained for inclusion versus exclusion. Papers where there was uncertainty about the intervention's classification were retained.

Economic Appraisal

The economic appraisal consisted of a review of economic evaluations and a cost-effectiveness analysis.

Review of Economic Evaluations

A systematic search was carried out on 9 databases from January 1985 to August 2005: CINAHL, Cochrane Library, DARE, EMBASE, NHS HEED, NEED, HMIC, MEDLINE and PSYCINFO.

Where available, abstracts were used to identify papers that might be relevant to the review as appraised by two reviewers. Papers which included, or potentially included, cost-effectiveness results were identified and full copies obtained.

Studies were excluded if they:

- Did not contain any original evidence
- Did not report the costs (or cost effectiveness) of interventions
- Reported on interventions comprising more than one session (other than brief follow-up contacts)

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Study Type

1 Meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs (including cluster RCTs)

2 Systematic reviews of, or individual, non-randomised controlled trials, case-control studies, cohort studies, controlled before-and-after (CBA) studies, interrupted time series (ITS) studies, correlation studies

3 Non-analytical studies (for example, case reports, case series).

4 Expert opinion, formal consensus

Study Quality

++ All or most criteria have been fulfilled. Where they have not been fulfilled the conclusions are thought very unlikely to alter

+ Some criteria have been fulfilled. Those that have not been fulfilled or not adequately described are thought unlikely to alter the conclusions

- Few or no criteria have been fulfilled. The conclusions of the study are thought likely or very likely to alter

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Evidence of Effectiveness

Quality Appraisal

Included papers were assessed for methodological rigour and quality using predetermined National Institute for Health and Clinical Excellence (NICE) methodology checklists. Each study was described by study type (categorised as types 1-4) and graded (++, +, -) to reflect the risk of potential bias arising from its design and execution (see the "Rating Scheme for the Strength of the Evidence" field above).

Study type and quality were described together, for example, as (1++) or (2-). The studies were also assessed for their applicability to the UK.

Summarising the Evidence and Making Evidence Statements

The review data was summarised in evidence tables (see full reviews and the synopsis [see the "Availability of Companion Documents" field]). Outcomes of interest included non-validated and validated smoking status (such as, self-reported smoking abstinence and biochemically validated smoking abstinence such as saliva cotinine).

Trials that included follow-ups of six months or more were the primary focus. Trials of shorter duration were included where necessary.

The findings from the review were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements reflect the strength (quantity, type, and quality) of evidence and its applicability to the populations and settings in the scope.

Economic Appraisal

Included studies were assessed for quality using a checklist based on pre-determined criteria. Inclusion of quality of life years (QALYs) as an outcome measure was essential at this stage. As with the review of effectiveness, studies were then given a score (++, +, -) to reflect the risk of potential bias arising from its design and execution. The evidence tables for the cost-effectiveness review are included in the review (see appendix E of the original guideline document).

Cost-effectiveness Analysis

A cost-effectiveness analysis was carried out for brief interventions in primary care.

An economic model was constructed to incorporate data from the reviews of effectiveness and cost effectiveness. The aim was to estimate the average QALYS gained over the simulation time period. The estimates were based on the estimated 12 month quit rates taken from the review of effectiveness. The estimates were calculated for different ages and gender of the population cohort. Because of the limited nature of the evidence a wide range of sensitivity analyses were performed.

A number of assumptions were made which could underestimate or overestimate the cost per QALY (see modelling report for further details [see "Availability of Companion Documents" field]).

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Informal Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

How Public Health Interventions Advisory Committee (PHIAC) Formulated the Recommendations

At its meeting in January 2006, PHIAC considered the evidence of effectiveness and cost effectiveness and comments from stakeholders to determine:

- Whether there was sufficient evidence (in terms of quantity, quality, and applicability) to form a judgement
- Whether, on balance, the evidence demonstrates that the intervention is effective or ineffective, or whether it is equivocal
- Where there is an effect, the typical size of effect

PHIAC developed draft recommendations through informal consensus, based on the following criteria.

- Strength (quality and quantity) of evidence of effectiveness and its applicability to the populations/settings referred to in the scope
- Effect size and potential impact on population health and/or reducing inequalities in health
- Cost effectiveness (for the National Health Service [NHS] and other public sector organisations)
- Balance of risks and benefits
- Ease of implementation and the anticipated extent of change in practice that would be required

PHIAC noted that the effectiveness of some interventions could vary according to the context in which they were delivered. For example, the social acceptability of smoking in a particular community might affect the way an intervention was received.

PHIAC also considered whether research should be a condition for a recommendation where evidence was lacking.

Where possible, recommendations were linked to an evidence statement(s)—see appendix A of the original Guideline Document for details. Where a recommendation was inferred from the evidence, this was indicated by the reference "IDE" (inference derived from the evidence).

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

Overall, brief interventions were found to be cost effective, and would support the recommendations.

The cost-effectiveness analysis demonstrated that brief interventions conducted by general practitioners (GPs) and nurses, in all settings, to all age groups included in the model, and with all adjuncts (nicotine replacement therapy [NRT], self-help, telephone helpline) can generate quality-adjusted life year (QALY) gains at a low cost. The cost per QALY tends to increase as the patient's age increases, but brief interventions delivered to a 60-year-old cohort are still cost effective.

When only comparing the costs of an intervention with no intervention, the estimated incremental cost per QALY gained varied from around 221 to around 9515 pounds sterling, depending on the assumptions used (see appendix E—the economic analysis modelling report—in the original guideline document for further details).

When the healthcare savings are included (as smokers quit smoking and avoid preventable disease), these are offset by the cost of the intervention. Using this

method, the incremental costs per QALY gained vary from 135 pounds sterling to 6472 pounds sterling, depending on the assumptions used.

These variations reflect the results from the sensitivity analysis (regarding the assumptions made on background quit rates, length of intervention, age of the individual and their level of dependency).

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The draft guidance, including the recommendations, was released for consultation in January/February 2006. The Public Health Interventions Advisory Committee met in February 2006 to consider stakeholder comments and to revise the recommendations accordingly. The guidance was signed off by the National Institute for Health and Clinical Excellence (NICE) Guidance Executive in March 2006.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

1.1 Brief Interventions in Health and Community Care

Brief interventions involve opportunistic advice, discussion, negotiation, or encouragement. They are commonly used in many areas of health promotion and are delivered by a range of primary and community care professionals.

For smoking cessation, brief interventions typically take between 5 and 10 minutes and may include one or more of the following:

- Simple opportunistic advice to stop
- An assessment of the patient's commitment to quit
- An offer of pharmacotherapy and/or behavioural support
- Provision of self-help material and referral to more intensive support such as the National Health Service (NHS) Stop Smoking Services.

The particular package that is provided will depend on a number of factors, including the individual's willingness to quit, how acceptable they find the intervention on offer and the previous ways they have tried to quit. See Diagram 1 in the original Guideline Document for a summary of this care pathway.

1.1.1 Practice Recommendations

Who Should Receive Advice?

Recommendation 1: Everyone who smokes should be advised to quit, unless there are exceptional circumstances*. People who are not ready to quit should be asked to consider the possibility and encouraged to seek help in the future. If an individual who smokes presents with a smoking-related disease, the cessation advice may be linked to their medical condition.

Recommendation 2: People who smoke should be asked how interested they are in quitting*. Advice to stop smoking should be sensitive to the individual's preferences, needs and circumstances: there is no evidence that the "stages of change" model** is more effective than any other approach.

Who should advise smokers and how?

Recommendation 3: General practitioners (GPs) should take the opportunity to advise all patients* who smoke to quit when they attend a consultation. Those who want to stop should be offered a referral to an intensive support service (for example, NHS Stop Smoking Services). If they are unwilling or unable to accept this referral they should be offered pharmacotherapy in line with National Institute for Health and Clinical Excellence (NICE) technology appraisal guidance no. 39 (available from: www.nice.org.uk/TA039) and additional support. The smoking status of those who are not ready to stop should be recorded and reviewed with the individual once a year, where possible.

Recommendation 4: Nurses in primary and community care should advise everyone who smokes* to stop and refer them to an intensive support service (for example, NHS Stop Smoking Services). If they are unwilling or unable to accept this referral they should be offered pharmacotherapy by practitioners with suitable training, in line with NICE technology appraisal guidance no. 39 (available from: www.nice.org.uk/TA039), and additional support. Nurses who are trained NHS stop smoking counsellors may "refer" to themselves where appropriate. The smoking status of those who are not ready to stop should be recorded and reviewed with the individual once a year, where possible.

Recommendation 5: All other health professionals, such as hospital clinicians, pharmacists, and dentists, should refer people who smoke* to an intensive support service (for example, NHS Stop Smoking Services). If the individual is unwilling or unable to accept this referral, practitioners with suitable training should offer a prescription of pharmacotherapy in line with NICE technology appraisal guidance no. 39 (available from: www.nice.org.uk/TA039), and additional support. Those who are trained NHS stop smoking counsellors may "refer" to themselves. Where possible, the smoking status of those who are not ready to stop should be recorded in clinical records and reviewed with the individual once a year, where possible.

Recommendation 6: Community workers*** should refer people who smoke* to an intensive support service (for example, NHS Stop Smoking Services). Those who are trained NHS stop smoking counsellors may "refer" to themselves.

*Occasionally it might be inappropriate to advise a patient to quit: for example, because of their presenting condition or personal circumstances.

**DiCLemente CC, Prochaska J, et al. (1991) The process of smoking cessation: an analysis of precontemplation, contemplation, and preparation stages of change. *Journal of Consulting and Clinical Psychology*. Vol 59(2) 295-304.

***Community workers are practitioners working outside the health sector who have a remit for smoking cessation.

1.2.2 Strategic Recommendations for Policy Makers, Commissioners and Managers

Recommendation 7: Strategic health authorities, NHS hospital trusts, primary care trusts (PCTs), community pharmacies, local authorities, and local community groups should review smoking cessation policies and practices to take account of the recommendations in this guidance.

Recommendation 8: Smoking cessation advice and support should be available in community, primary, and secondary care settings for everyone who smokes. Local policy makers and commissioners should target hard to reach and deprived communities including minority ethnic groups, paying particular attention to their needs.

Recommendation 9: Monitoring systems should be set up to ensure health professionals have access to information on the current smoking status of their patients. This should include information on: a) the most recent occasion on which advice to stop was given, b) the nature of advice offered, and c) the response to that advice.

CLINICAL ALGORITHM(S)

A clinical algorithm on brief intervention for smokers is available in the original guideline document.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type and quality of supporting evidence is identified and graded for each recommendation (see appendix A of the original guideline document).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate use of brief interventions and referral to promote smoking cessation

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The Healthcare Commission assesses the performance of National Health Service (NHS) organisations in meeting core and developmental standards set by the Department of Health (DH) in "Standards for Better Health," issued in July 2004. The implementation of National Institute for Health and Clinical Excellence (NICE) public health guidance will help organisations meet the standards in the public health domain. In addition, it will help meet the health inequalities target as set out in "The NHS in England: the operating framework for 2006/7."

NICE has developed tools to help organisations implement the guidance (see "Availability of Companion Documents" field).

- Costing tools
    - Costing report to estimate the national savings and costs associated with implementation
    - Costing template to estimate the local costs and savings involved
- Implementation advice on how to put the guidance into practice and national initiatives which support this locally
- Audit criteria to monitor local practice

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Chart Documentation/Checklists/Forms
Clinical Algorithm
Quick Reference Guides/Physician Guides
Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Institute for Health and Clinical Excellence (NICE). Brief interventions and referral for smoking cessation in primary care and other settings. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Mar. 36 p. (Public health intervention; no. 1).

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Mar

GUIDELINE DEVELOPER(S)

National Institute for Health and Clinical Excellence (NICE) - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

GUIDELINE COMMITTEE

NICE Project Team

Public Health Interventions Advisory Committee (PHIAC)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

NICE Project Team Members: Mike Kelly, CPHE Director; Antony Morgan, Associate Director; Lesley Owen, Analyst; Patti White, Analyst; Bhash Naidoo, Health Economics Adviser

Public Health Interventions Advisory Committee (PHIAC) Members: Mrs Cheryll Adams, Professional Officer for Research and Practice, Development with the Community Practitioners' and Health Visitors' Association (CPHVA); Professor Ron Akehurst, Professor of Health Economics and Dean of the School of Health and Related Research (ScHARR), University of Sheffield; Professor Sue Atkinson, Regional Director of Public Health for London, Health Adviser to Mayor and Greater London Authority; Professor Michael Bury, Emeritus Professor of Sociology at the University of London and Honorary Professor of Sociology at the University of Kent; Professor Simon Capewell, Chair of Clinical Epidemiology, University of Liverpool; Professor K K Cheng, Professor of Epidemiology, University of Birmingham; Mr Philip Cutler, Forums Support Manager, Bradford Alliance on Community Care; Professor Brian Ferguson, Director of the Yorkshire and Humber Public Health Observatory; Dr Ruth Hall, Director of Public Health for Avon, Gloucestershire and Wiltshire Strategic Health Authority; Ms Amanda Hoey, Director, Consumer Health Consulting Limited; Mr Andrew Hopkin, Senior Assistant Director for Derby City Council; Dr Ann Hoskins, Director of Public Health for Cumbria and Lancashire Strategic Health Authority; Professor David R

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Public Health Interventions Advisory Committee are required to make an oral declaration all potential conflicts of interest at the start of the consideration of each public health intervention appraisal. These declarations will be minuted and published on the National Institute for Health and Clinical Excellence (NICE) website.

Members are required to provide in writing an annual statement of current conflicts of interests, in accordance with the Institute's policy and procedures.

Potential members of the Public Health Programme Development Groups (PDG), and any individuals having direct input into the guidance (including expert peer reviewers), are required to provide a formal written declaration of personal interests. A standard form has been developed for this purpose which also includes the Institute's standard policy for declaring interests. This declaration of interest form should be completed before any decision about the involvement of an individual is taken.

Any changes to a Group member's declared conflicts of interests should also be recorded at the start of each PDG meeting. The PDG Chair should determine whether these interests are significant. If a member of the PDG has a possible conflict of interest with only a limited part of the guidance development or recommendations, that member may continue to be involved in the overall process but should withdraw from involvement in the area of possible conflict. This action should be documented and be open to external review. If it is considered that an interest is significant in that it could impair the individual's objectivity throughout the development of public health guidance, he or she should not be invited to join the group.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Brief interventions and referral for smoking cessation in primary care and other settings. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Mar. 4 p. (Public Health Intervention Guidance 1). Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Costing report: brief interventions and referral for smoking cessation in primary care and other settings. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 May. 23 p. (Public Health Intervention Guidance 2). Available in Portable Document Format (PDF) from the NICE Web site.
- Costing template: brief interventions and referral for smoking cessation in primary care and other settings. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 May. Variable p. (Public Health Intervention Guidance 2). Available from the NICE Web site.
- Implementation advice: brief interventions and referral for smoking cessation in primary care and other settings. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 May. 18 p. (Public Health Intervention Guidance 2). Available in Portable Document Format (PDF) from the NICE Web site.
- Audit criteria: brief interventions and referral for smoking cessation in primary care and other settings. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 May. Variable p. (Public Health Intervention Guidance 2). Available from the NICE Web site.
- Cost-effectiveness of brief intervention and referral for smoking cessation. Economics modelling report. York (UK): The University of York, Centre for Health Economics on behalf of PHRC; 2006 Jan 20. 25 p. Available in Portable Document Format (PDF) from the NICE Web site.
- Rapid review of brief interventions and referral for smoking cessation. London (UK): Academic & Public Health Consortium; 2005 Nov. 310 p. Available in Portable Document Format (PDF) from the NICE Web site.
- Methods for development of NICE public health guidance. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Mar. 131 p. Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- The public health guidance development process. An overview for stakeholders including public health practitioners, policy makers and the public. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Mar. 46 p. Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1014. 11 Strand, London, WC2N 5HR.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on October 23, 2006. The information was verified by the guideline developer on February 6, 2007.

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