Irish Cancer Society

WE CAN QUIT

Development & Evaluation of an Action Research Project

SUMMARY

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Finally, we would like to acknowledge the HSE Department of Health Promotion & Improvement, particularly Miriam Gunning and Jean Molloy who provided their expertise and support to the training and implementation phase.

Celebrate Success

Organisations that provide programmes for disadvantaged smokers need to recognise that, just as programmes aimed at other challenging issues, success may be hard to measure, especially in the short term. While successful quitting may be the ultimate goal, smoking less, knowing more about the health risks, or being more open to quitting are good indicators of change in the right direction.

Cancer Council New South Wales (2008) Clearing the Smoke - Best practice smoking cessation strategies.


Congratulations
This certificate confirms that
has been Smoke Free for 4 weeks
Well done and keep up the good work
John McCormack
Chief Executive
touchstone

Foreword

Following the startling revelation in 2011 that for the first time, more women in Ireland were dying from lung cancer than breast cancer, the Irish Cancer Society decided we needed to act to tackle this crisis. Women were dying from a cancer that in 90% of cases is preventable, as it's caused by smoking. In some communities the rate of women smoking, can far exceed the national average.

We realised that we needed to develop new and creative ways to tackle the smoking crisis amongst women, and that it was something that we could not do alone. Communities needed to be supported and resourced to become smoke free using evidence based, collaborative and targeted programmes. *We Can Quit* was created as a community based approach to support smoking cessation among women from socially and economically disadvantaged communities. Developed by the Irish Cancer Society, in partnership with the National Women's Council of Ireland, the Institute of Public Health Ireland, the HSE and local stakeholders, the programme was delivered in January 2014. Based on HSE national standards in smoking cessation, *We Can Quit* is the first evaluation of a tailored community based model, to address the quitting needs of women.

The *We Can Quit* model, which is explained in detail in this report, has the potential to become a crucial element of smoking cessation services in Ireland. The partnership approach utilised during the 12 week programme serves to highlight the potential *We Can Quit* can have in delivering the objectives of the governments' Healthy Ireland framework and specifically their Tobacco Free Ireland policy.

Foreword

A wealth of evidence shows that smokers need a combination of behavioural support and medication to help them quit. With this in mind, *We Can Quit*, provides participants with behavioural support through group based and one to one smoking cessation support from trained community facilitators as well as access to free NRT, through the local pharmacy. The encouraging results following the evaluation of *We Can Quit* reinforces this evidence.

Tremendous credit must go to all those who were involved in bringing *We Can Quit* from an idea to the successful project we have seen delivered in two communities in Dublin. Most importantly, I offer congratulations to the women who have successfully quit smoking as participants of the group. Quitting is tough. The women who have successfully completed *We Can Quit* are role models who can inspire change within their families and communities. They are healthier and have managed to reduce their risk of developing cancer and other smoking related diseases in the future.

After four weeks, the validated quit rate was **41%** among members of the group and after 12 weeks, the validated quit rate was **46%.** This compares favourably with other models of cessation programmes.

Feedback from the women indicates that the quality of the behavioural support delivered by staff, combined with the access to free NRT played an important role in the programme's support.

The fact that community facilitators implemented the programme and participants engaged in the study has meant that we now know more about the barriers to quitting for women, not only personal barriers, but how the system can be improved to support them by providing more responsive services. *We Can Quit* has the potential to help hundreds of women in Ireland stop smoking and for Ireland to be one step closer to being tobacco free.

The researchers that have collated this study should be safe in the knowledge that not only have they contributed to smoking cessation services in Ireland, but also to the global fight against tobacco.

As a result of the pilot study, a number of recommendations have been made in the areas of policy; planning, recruitment and delivery; research and future development. These reflect the need for novel and inventive ways of addressing the shortfall in smoking cessation services in Ireland. They include:

- Ring fence tobacco taxation for smoking cessation services
- Modify the way Nicotine Replacement Therapies are provided, including:
  - Making NRT free
  - Removing VAT of NRT to reduce the cost for smokers trying to quit
  - Making NRT available to all those who sign up for smoking cessation programmes such as *We Can Quit*
  - Allowing a wider range of health professionals to prescribe NRTs
- Allow for replication of the model in other areas
- Explore how younger smokers might be encouraged to think about cessation
- Support women beyond the end of the programme.

We Can Quit forms one part of the Irish Cancer Society's strategy to tackle Health Inequalities as part of our strategic plan entitled *'Towards a future without cancer'* published in 2013. We want to help make positive changes and that's why we are committed to establishing Cancer Action Communities – collaborative projects designed for communities identified as being at high risk of cancer – in localities across Ireland between now and 2017.

We won't give up until cancer does.

John McCormack
Chief Executive
Irish Cancer Society

Summary

This action research project aimed to develop and test evidence informed smoking cessation support programme tailored to meet the specific needs of women in socially and economically disadvantaged areas Ireland. The *We Can Quit* programme was informed by extensive consultations with women and service providers. The evaluation of the pilot implementation in two disadvantaged areas found promising findings and indicated that a programme of this type may have a valuable role to play in helping women stop smoking. Importantly, the research identified recommendations for practice, policy and further research. These are now being considered by the Irish Cancer Society and its partners in order to inform future work. This summary report presents the key messages from the project.

Fuller details and all references are available in the full report.
http://www.cancer.ie/we-can-quit

Background to the Study

Tobacco use is the leading cause of preventable death in Ireland with 5,500 smokers dying each year from tobacco related diseases. More women in Ireland are now dying from lung cancer than breast cancer. Women in lower socioeconomic groups have the highest rate of smoking in Ireland, with women aged 18 to 29 having a rate of smoking (56%) which is twice that of women from more affluent groups of the same age.

These women are also less likely to quit smoking. Following the *Women and Smoking: Time to Face the Crisis Conference* in July 2012, the Irish Cancer Society (ICS) formed a partnership with the National Women's Council Ireland (NWCI) and Institute of Public Health Ireland (IPHI) to develop an innovative community based approach to support smoking cessation among women from socially and economically disadvantaged communities.

A national advisory group was established to support to the initiative, and an action research study was commissioned to inform the development the smoking cessation model and to evaluate the implementation of the pilot programme.

The action research project consisted of five phases involving different levels of engagement with and participation from key stakeholders including women living in disadvantaged areas, combined with a review of the national and international research literature to identify potential approaches to deliver evidence informed model of support. The *We Can Quit* model was developed and piloted in two disadvantaged communities in Dublin in partnership with the HSE and community and local development organisations. The final phase involved the evaluation of the pilot implementation of the *We Can Quit*.

Research Objectives

The *We Can Quit* project had five objectives. These were to:

1. Develop a community based smoking cessation programme which encourages women living in socially and economical disadvantaged areas to quit smoking
2. Foster environments which support women who want to quit smoking
3. Identify supports and barriers to quitting
4. Learn about the mechanisms which help women quit
5. Identify appropriate structures for the sustainability of the programme.

Different research methods were employed for each phase of the project. The research commenced with two rapid evidence reviews to assemble the research evidence to inform the development of the model. Mixed methods approaches were employed to consult with key stakeholders (women and service providers) to (a) identify the support needs of women smokers; (b) to gain their views of the *We Can Quit* Pilot; and (c) assess the effectiveness of the pilot. Fuller details of the research methods are presented in Chapter 2 of the full report. http://www.cancer.ie/we-can-quit

Developing the *We Can Quit* Model

The evidence review and consultations with stakeholders identified key elements important for the delivery of smoking cessation support for women living in socially and economically disadvantaged areas. The key features of the model are described in Box 1. The principles underpinning the model are complementary to National Public Health and Local Community Development policies. The principles include:

- An integrated partnership approach between a national charity, local community sector organisations and local health services
- Participatory evidence informed action research to develop new knowledge and bridge the gap between academic research, policy and practice in an Irish context
- Creating and promoting equality and mutual respect between the community and statutory sector in the development of community based responses to high level policies

- Co-delivery of programme by training community development staff and health professionals
- A non-judgemental and empowering approach integrating social justice issues such as poverty, inequality, gender, and caring roles and responsibilities.

Evidence Reviews

A systematic review approach was employed to identify, screen and synthesise the international research to assemble and synthesis the evidence base to underpin the development of the *We Can Quit* model. This evidence was grouped into three categories (1) women and tobacco use; and (2) the barriers and facilitators to quitting; and (3) effectiveness of different smoking cessation approaches. Detailed findings are outlined in the full report.

In terms of 'what works' in smoking cessation, an extensive body of literature exists. The best outcomes for smokers engaging with a treatment programme are achieved through a combination of behavioural support and medication. The optimum available treatment is a combination of behavioural support and Varenicline, a stop smoking medication available on prescription. This is followed by behavioural support and more than one Nicotine Replacement (NRT) product (patch plus gum, for example). However, even the delivery of behavioural support plus one NRT product is more than 3 times more likely to result in smoking cessation than just brief advice or no treatment

There is also now good evidence that cutting down to quit over a relatively short period while using NRT is a promising way to quit smoking and can be integrated into programmes where participants are hesitant about making an 'abrupt' quit attempt.

Our evidence review also looked at existing examples of community based smoking cessation support for women living in disadvantaged areas. The review identified two models that looked particularly promising and appropriate for the *We Can Quit* programme: *There's a Way Out for Me* (Stewart et al 2010, 2011) in Canada and the *Sister to Sister* (Andrews et al., 2007, Andrews et al., 2012) programme in the USA.

Box 1: Key Features of *We Can Quit* model

The *We Can Quit* model takes a woman-centred approach to smoking cessation. It aims to empower women to take control of her smoking by offering them supportive space to understand their smoking addiction. The group approach aims to provide participants the opportunity to develop skills, build confidence to quit, and to share experiences from each other. It is aimed at women who want to quit but also for those who want to cut down with a view to quitting by the end of the programme.

Core elements of the *We Can Quit* model

- Supported by a local advisory group who identify the needs of the target population and oversee the programme planning and delivery
- Delivered by trained community facilitators following the HSE recommended national standards for smoking cessation practice, with in-built flexibility
- Co-facilitated weekly group based support and activities over 12 weeks
- Flexible one to one smoking cessation support and motivational interviewing
- Access to 12 week supply of combination NRT and additional support from pharmacy staff
- Programmes explore the need to name and manage fear of failure and to establish what personal success is for participants
- Confidence boosting and celebratory, achievements are shared with family, friends and community via local media
- Participant follow-up at week 6, week 12, week 26 and at one year.

Stakeholder Consultation

Stakeholder consultation was an important element of this action research project. Consultations were conducted using an online survey (with service providers with a role to play in supporting smoking cessation) and focus groups (with female smokers living in disadvantaged areas).

Views of Service Providers

The themes from the consultation with service providers reflected messages from the literature on the professionals' views on the barriers facing women when thinking about quitting.

- Addiction and/or emotional attachment to cigarettes
- Stress and unemployment
- The culture of smoking in the community
- Fear of weight gain.

Many of the service providers are aware of the specific support needs of smokers living in socially and economically disadvantaged areas, particularly women. These needs centred on four key areas.

- Individual work (e.g. self-esteem work, coping strategies, personal development)
- Alternative therapies (e.g. hypnosis, stress management
- Cultural change (e.g. local champions/ peer led services, normalise smoking cessation services, community based support
- Providing information (e.g. addiction, NRT, SHS).

Service suggested strategies to improve the uptake of current provision. This included:

- Provision of free or lower cost NRT/ medication
- Offering local support groups
- Identifying sustainable ways to access and work with socially disadvantaged groups.

Views of Female Smokers

Overall, the barriers described by women smokers echoed those identified in the literature and by service providers. Across the four focus groups there were a number of common themes.

- All the women described a high level of addiction and dependency on tobacco
- Many, particularly the older women, were keen to quit but struggled to do so
- The culture of smoking within the family/ peers and wider community emerged as a key barrier for all groups. Older women with young children in the family home (children or grandchildren) felt that children were an important incentive to quit smoking or to cut down in the home
- The importance of support from within their local community was also important. Many felt that support from peers who understood their lives and had experience of giving up cigarettes would be an asset. Within the Traveller community the support of lay health workers was viewed to be particularly important
- Both younger and older women had mixed views and understandings of the benefits of pharmacotherapies as a support to smoking cessation, and not all were aware that NRT is available free of charge on prescription for those on medical cards
- Younger women felt that smoking cessation could be integrated within beauty and fitness programmes, whereas the older women were more likely to suggest personal development, debt management, parenting or self-esteem programmes. Both groups referred to the need for support and advice with stress management.

Model Identification

Four common themes emerged from the first two phases of the research. These included the need to:

- tailor support for women to remove the potential barriers to access effective smoking cessation support services
- include a level of support from community members who understand the contexts of women's lives

- address the culture of smoking within the community and to encourage a cultural shift; and
- address the wider factors that contribute to smoking e.g. stress, childcare, parenting alone, dealing with debt, low confidence/ self-esteem etc.

The third phase of the research focused on identifying potential models of support that might be delivered as part of the *We Can Quit* action research. This involved a further review of the literature to narrow down options for how the programme would be developed and delivered.

Model Development and Delivery

The earlier stages of the study made it clear that a number of key elements needed to be included in the development and delivery of the *We Can Quit* programme, including:

1) Development of a steering group/ community oversight group in each community
2) Offering an option of a slightly delayed quit date, so women do not need to sign up and quit on week one (thus can attend for 2 or 3 weeks before quitting), and be encouraged to cut down during that period
3) Offering the option of one to one or group support
4) A co-delivery model between trained community development staff and health professionals
5) Provision of free or subsidised NRT
6) Addition of a relapse prevention element to provide women with support after the cessation support sessions have ended.

The pilot programme was then introduced into two former Rapid (Revitalising Areas by Planning, Investment and Development) areas of North Dublin. Area A is in the outskirts of north-west Dublin and has a relatively young and growing population, with a quarter of its inhabitants coming from a minority ethnic community. Area B is situated within Dublin City boundaries and has an ageing population.


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Partnership Approach

The local partners agreed that a co-facilitation model between local health professionals and community development officers was an important aspect of the model at delivery level; harnessing community and clinical knowledge and practice. However, where no health service professionals were available, health service trained community lay health facilitators were hired to co-deliver the pilot programme.

The Irish Cancer Society worked in partnership with the HSE Health Promotion and Improvement Directorate to ensure that the training content for the *We Can Quit* programme was in line with current best practice in smoking cessation, nationally and internationally. The community facilitators were trained to deliver the programme, with follow-up weekly phone calls to provide additional support.

Evaluation of the *We Can Quit* Model Pilot

The *We Can Quit* Pilot was evaluated using a prospective observational cohort study designed to follow up all women who participated in the programme.

Baseline data gathered information on socio-economic status (SES), smoking behaviour, and smoking patterns of family. Smoking status was assessed at 4 and 12 weeks involving biochemical validation with a carbon monoxide (CO) test. Data were also collected on the range of interventions received including NRT. The outcome of participant quit attempts was measured in two ways in the evaluation: point prevalence and continuous abstinence.

- **Point prevalence** is a measure of smoking status at the time the question was asked. It allows for relapse between the time of starting the quit attempt and the follow up point
- **Continuous abstinence** is a measure of no smoking since a quit date was set.

The views and experiences of key stakeholders involved in the delivery of the programme were sought through: a survey of key stakeholders (N=14); a stakeholder event with (N=29 participants) to gain further feedback and to discuss the sustainability of the *We Can Quit* approach.

Results

Thirty-nine women signed up to participate in *We Can Quit*, with a fairly even split across the two study sites. The age range of participants was 24 – 66 years, with a mean age of 45. One fifth (21%) lived with a smoking spouse or partner and most participants self-reported one or more medical conditions (64%). Around two thirds (64%) had 1 or more indicators of low socio-economic status which suggests that the target demographic (women living in deprived areas) was reached.

Women were also asked their views on the programme through a client satisfaction survey which 74% (n=29) completed. More detailed interviews were conducted with eight women to explore responses further.

Feedback from the women indicated that the quality of the behavioural support delivered by staff, combined with the access to free NRT played an important role in the programme's support. The main drivers for women to join *We Can Quit* were to improve their health and the appeal of group support

Overall, the feedback from participants was extremely positive. The women reported feeling enthusiastic and engaged by the different components of the programme. Particular aspects highlighted by the participants are summarised below.

- The group support was an important and popular form of support, with all participants reporting attending all or nearly all of the group sessions
- The support the participants' offered each other went beyond smoking cessation, with some participants drawing on the group support for other types of support; bereavement for example

Box 2 - Quit Rates

The overall numbers of those signing up to the *We Can Quit* were relatively small, with a quarter of the group dropping out before week 4. However, for the 29 women who remained with the programme, the longer term outcomes were good.

At 4 weeks the CO validated quit rates were 41% point prevalence, and at 12 weeks point prevalence was 46%. Women who had stopped by four weeks after their quit date maintained abstinence at the 12 week recording point. This is important, and **feedback from the women indicates that the quality of the behavioural support delivered by staff, combined with the access to free NRT played an important role in the programme's support.**

- Facilitators were highly regarded and praised for the level of support they offered, which for one participant extended to her partner who also quit during the programme period. Facilitators who are ex-smokers were considered to build an important rapport with participants
- Access to free NRT was an important aid to smoking cessation for participants. However, some participants found the process to obtain free NRT (i.e. via their GP) problematic, which could act as a barrier to NRT use
- There was high degree of support from participants to roll out the programme.

Some unexpected findings from the study were that the benefits of being part of *We Can Quit* extended beyond the health benefits of stopping smoking. For example, participants reported improved physical fitness, self-confidence, wider social networks and financial gain. There was also an appetite for the group to meet beyond the intervention period to continue to offer, and receive, mutual support.

An added benefit of *We Can Quit* was the 'ripple' effect' where participants shared their experience of being part of the programme with friends and family which, in turn, had an influence on their smoking behaviour.

Views of Partner Organisations and Service Providers

In order to explore how the programme was planned and delivered in each site, the final stage of the research involved a self-completion survey of local partner organisations (N=14) who had been involved in either the planning or delivery of the *We Can Quit* in the two areas. This was followed up by a feedback event with partner organisations from the two pilot areas. Partner organisation and service provider views were detailed and informative, and directly influenced the recommendations arising from the study that are set out below.

Recommendations

Based on the findings of the study, recommendations for future work focused on four main areas. These include recommendations for improvement of the *We Can Quit* model planning, recruitment and delivery, recommendations for the model development, recommendations for policy and practice, and future research.

Planning, recruitment and delivery

Recommendations to improve the **planning** of the *We Can Quit* included:

1. Securing 'buy-in' from all relevant stakeholders, and extend the planning and delivery partnerships to other relevant local organisations such as primary care teams, Money Advice and Budgeting Service (MABS), etc.
2. Ensuring there is sufficient time to plan the service, paying attention to the locations of venues (and the venue facilities); the timing of the programme (day/evening); the recruitment and training of community facilitators
3. Exploring strategies and opportunities to ensure commitment to *We Can Quit* is included in business planning of the local partners (e.g. primary care, social work, smoking cessation service, pharmacies, local development partners etc.)
4. Developing a social marketing strategy with the local advisory groups to promote the programme which could include a range of activities, such as: distribution of promotional materials to relevant organisation, health fairs, attending service providers meetings, giving talks to parenting programmes etc.

Recommendations

Specific recommendations to improve **recruitment** and retention of smokers include:

5. Appointing a local co-ordinator with responsibility for gathering all the referral forms/interest forms, and to keep everyone updated on the start and location of programme etc.;
    - providing all key local organisations (e.g. hospital departments, primary care, community pharmacy, parent groups, local development groups, social work departments, MABs, etc) with information packs about the programme (including times and locations of next group), with referral sheets and the name of a local co-ordinator
    - agreeing a communication channel whereby the local co-ordinator provides feedback to referral organisations, as well as the women referred to the programme
    - considering ways of involving *We Can Quit* 'graduates' in the promotion of future courses; and
    - inviting local organisations, and participants family and friends to the celebrating the success event.

Specific recommendations to **minimise drop out** include:

6. Following-up participants between sessions, particularly if they have missed a couple of sessions;
    - providing participants with option to call into pharmacy to have CO levels monitored (if unable to attend group) and having levels recorded on record book to be shared with group the next week (and have monitoring data updated); and streamlining data monitoring systems to ensure quality data are collected without interfering with the support process.

Recommendations for the improvement of the **delivery** of the programme include;

7. Inviting all key partner organisations with a central role in either providing referrals or delivering the programme to an information session at the beginning of the community facilitator training to provide opportunities for everyone to meet and become more familiar with the programme.

Future development of *We Can Quit*

The promising results from this pilot suggest that delivering an intensive, tailored face to face smoking cessation intervention is feasible in the Irish context. The ambitious national targets to reduce overall population prevalence of smoking to 5% by 2025 require action at a number of levels, and this pilot study suggests that a programme like *We Can Quit* could have an important contribution to make to provide women with effective support to stop smoking.

If the *We Can Quit* model is to be rolled out, consideration should be given to:

1. establishing a protocol for the model planning and delivery to allow replication in other areas, outlining the mandatory components of the programme and providing a menu of optional activities to tailor support to the needs of participants
2. in order to maximise partnership working, exploring mechanisms and opportunities to translate the commitment and goodwill of individuals and partner organisations into strategic planning at an organisational and area level
3. further identifying and removing barriers to accessing stop smoking medication (combination NRT)
4. exploring how younger smokers might be encouraged to think about cessation, and be recruited to the *We Can Quit* programme;

5. supporting women beyond the end of the programme to maximise the benefits of the group as a source of encouragement to remain quit and/or to help prevent relapse
6. exploring how *We Can Quit* might be 'branded' to encourage wider awareness within the communities, and become integrated within other relevant health and social initiatives; providing support to prevent relapse after the end of the programme e.g. integrating relapse prevention messages and skill development during the delivery of the programme, exploring opportunities for group participants to meet or keep in contact via social media; and
7. exploring the options whereby participants can continue to access to free or low cost NRT and the associated support from Pharmacy staff after the programme as ended as part of relapse prevention.

Policy Recommendations

The Irish Cancer Society recognises that in order to achieve the Department of Health's goal in Tobacco Free Ireland (TFI) of a smoking rate of 5% by 2025, new and innovative ways to tackle smoking have to be developed. This requires specific action at policy level.

The experience of *We Can Quit* brings into focus the need for novel and inventive ways of addressing the shortfall in smoking cessation services in Ireland. Our policy recommendations can be broken into two categories: the provision of services and Nicotine Replacement Therapy (NRT).

The provision of services

1. Ring fence tobacco taxation for smoking cessation services
    - Smoking cessation services, such as *We Can Quit*, are a key part of tobacco control and health inequalities polices both at local and national level and therefore need to be developed and maintained


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Recommendations

- Investment in smoking cessation services is one of the most cost-effective healthcare treatments, according to the US Surgeon General. There is an urgent need to commit further funding to such services and we believe that using a percentage of excise from tobacco can build up community-based services. Such intervention requires a more than tenfold increase in the health spending on cessation services currently
- Ring fencing funding from tobacco excise will signal a serious commitment to ensuring a reduction in the number of people smoking in order to achieve the goal of a tobacco-free Ireland by 2025
- Treating tobacco addiction as a care issue is a critical principle underpinning the tobacco free policy, and it is necessary to provide effective smoking cessation services to the 81% of smokers who want to quit.

2. Draw on local skills and assets to embed smoking cessation within local communities
    - Phases 1 to 3 of the study highlighted the potential of using existing community structures to target harder to reach smokers, and the pilot evaluation has demonstrated the potential of community facilitators working alongside health professionals to support smoking cessation
    - Consideration should be given to supporting community based smoking cessation services facilitated by local people who have been trained as cessation advisers. Advisors could target to specific population groups with smoking rates higher than the national average e.g. homeless people, Travellers, women in lower socioeconomic groups etc.

Nicotine Replacement Therapies (NRT)

One of the key reasons for the success of *We Can Quit* was the availability of NRT to the group. All the women (n=27) who used the NRT found it helpful or very helpful.

It is obvious that the access to free NRT made a difference to women, particularly to those who had tried NRT before. The policy on NRTs requires significant change.

3. Make NRT free and simplify its provision
    - At present NRT has to be paid for by the user, unless they have a medical card. This is a barrier to potential quitters trying to access it. 28% of the *We Can Quit* participants said they would not have used NRT if they had to pay for it.

A number of considerations should also be given to policies governing NRT:

4. Consideration should be given to removing VAT on NRT to reduce the cost for smokers trying to quit
5. The Dept of Health/HSE should consider exploring the possibility of making NRT available to all those who sign up for smoking cessation programmes such as *We Can Quit*
6. The Dept of Health/HSE should consider exploring the possibility of allowing any member of the primary care team (e.g. GP, Dentist, Pharmacist, Nurse Practitioner) to prescribe NRT
7. Develop and disseminate clear guidelines for the prescribing of NRT by GPs and Pharmacies
    - Currently, there are no guidelines or protocols for the prescribing of NRT by pharmacists or doctors. For the second phase of WCQ the Irish Cancer Society has devised some guidelines modelled on the ones being developed by the HSE, but with the addition of more structured behavioural support delivered by a pharmacist
    - The guidelines and protocols should be in line with best practice.

Recommendations

Research recommendations

The study raises a number of issues for further research which are described in more detail in the full report.

In particular, it will be important to build on this relatively small pilot if the programme is further developed. A larger sample of women should be recruited, ideally from a range of venues offering the programme. This would allow more in-depth analysis of the factors associated with successfully stopping smoking in this group. Where possible the monitoring data might be revised to allow for comparisons with quit rate data from HSE or international studies (e.g. Sister to Sister evaluations). New developments including electronic cigarette use should be factored into future studies. The inclusion of a cost-benefit analysis in an economic evaluation of the next feasibility study, is recommended.


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