TACKLING SMOKING IN GLASGOW: EXECUTIVE SUMMARY

UNIVERSITY
of
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LINDA BAULD, JANET FERGUSON,
LOUISE LAWSON, JOHN CHESTERMAN AND KEN JUDGE

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Smoking is the largest single preventable cause of death and disability in the UK. Smoking prevalence in Scotland is higher than in other parts of the country and the problem is particularly acute in Glasgow. In the Greater Glasgow Health Board area, smoking prevalence is over 33 per cent, rising to 37 per cent in Glasgow city. In some of the most deprived parts of Glasgow, smoking rates are as high as 63 per cent. This means that efforts to improve health and reduce health inequalities in the city must include strategies and services to tackle smoking.

The Glasgow Centre for Population Health (GCPH) funded this study in partnership with NHS Health Scotland and NHS Greater Glasgow. It took place between July 2004 and September 2005. The research involved three main components:

- A scoping study of the Glasgow tobacco strategy
- An evaluation of intensive group-based smoking cessation services in Glasgow
- An exploratory study of Starting Fresh, the pharmacy-based treatment for smokers in Glasgow

GLASGOW TOBACCO STRATEGY

The 1998 UK white paper, *Smoking Kills*, put forward a wide range of measures to reduce overall smoking prevalence and improve health. It emphasised that policies needed to focus on both prevention and treatment and that no single form of action was likely to be sufficient. The white paper outlined the key elements of a comprehensive tobacco control strategy and was followed by investment in a range of policies and programmes, including the establishment of NHS smoking cessation services across the country.

In Glasgow, the policies outlined in *Smoking Kills* built on a tradition of tobacco control work in the city, dating back to the Glasgow 2000 project, established in 1983. The new money that became available in the late 1990s highlighted the need for a strategy that would influence current investment decisions and guide future action. A new organisation, Smoking Concerns, was created within NHS Greater Glasgow to continue the work of Glasgow 2000 with a specific focus on developing and managing a wider network of smoking treatment services. At around the same time the Glasgow Healthy City Partnership formed a Tobacco Working Group. One of its first tasks was to develop a Tobacco Strategy for Glasgow.

As part of our work examining efforts to tackle smoking in Glasgow we set out to describe the origins and content of the strategy and sought to understand the contribution it has and could make to guiding relevant programmes and services. The strategy and related documents were reviewed and we conducted semi-structured interviews with thirteen professionals involved in the development or implementation of the strategy.

Strategy Development and Objectives

The development of the Glasgow Tobacco Strategy began with a programme of consultation with key organisations and individuals in 2000. Outcomes from the consultation led to development of an initial draft. A further version was completed in 2003 and disseminated to a wider range of groups and organisations. During this process a range of developments were taking place at national and local level that were to affect the content of the strategy. There was some delay in agreeing the final version, which was eventually published in February 2005.

Several interviewees were critical of the length of time it had taken to draft and launch the strategy. Given the range of developments in tobacco control that

occurred between 2000 and 2005, having a strategy in place earlier could have focussed attention on key areas for investment and development.

The strategy is perhaps most usefully seen as a document that describes three things: the extent of the ‘tobacco epidemic’ in Glasgow, including its role in contributing to inequalities in health; the general principles and objectives of tobacco control that have been agreed by key agencies and organisations in the city; and examples of the wide range of activities being undertaken to prevent or treat smoking in relation to key categories such as young people, the NHS and communities.

Implementation

At present, *formal* implementation of the strategy has not taken place. However, it would be inaccurate to argue that the Glasgow Tobacco Strategy has not been implemented in any form. The objectives and actions described in the strategy were being pursued by the relevant organisations during the process of its formation and publication. Important developments, such as a commitment from the City Council to invest considerable resources in tobacco control activities have taken place. The document serves as a useful focus for developing further activities to address smoking. Many interviewees emphasised the symbolic importance of the strategy to guide current and future actions.

Actions

All of the key stakeholders we interviewed expressed strong levels of commitment to the strategy in terms of senior management input, resources and policies within their organisations. All could cite examples of specific activities that related to one of the six themes for action. Some argued that more work needed to be done to engage voluntary and private sector organisations in particular, but that progress was being made. The strategy identifies several key strands for action and provides examples of action in relation to each theme. These themes are: leadership; young people; supportive environments; media; the NHS; and community.

Future Direction

Since 2000 a number of cities and regions across the UK have developed similar documents. What is perhaps unusual about Glasgow’s strategy is the multi-agency ownership of the document and its associated principles and objectives. It has emerged as the result of extensive consultation and refinement. The result is a useful statement of shared principles and objectives with agreed categories for action. The strategy does not, however, outline any specific future activities or programmes that can be monitored in terms of milestones, targets or timelines for implementation.

Given the extent of the challenge facing Glasgow in relation to tobacco, it is fair to ask if a strategy of this kind is sufficient. Is a statement of principles and shared goals enough? Where will the strategy be in five years time? Undoubtedly progress will have been made. However this progress is perhaps more likely to have arisen as a result of national policy (the Scottish smoking ban, increased resources for cessation services) and ongoing local programmes than as a result of the strategy itself.

INTENSIVE GROUP SERVICES

Since 1999 smoking cessation services have become available within the NHS. In Glasgow, one element of these services is treatment that, at the time of the study, was delivered by Local Health Care Co-operatives (LHCCs), co-ordinated by Smoking Concerns. The model of service provided is based on research evidence

regarding what is most effective in helping smokers to quit, and primarily involves group support.

Beginning in July 2004, we worked with colleagues at Smoking Concerns to design and conduct an evaluation of the group services. This component of our research aimed to address three main research questions:

- How is the group service structured and delivered?
- What are the characteristics of people who access the service?
- How successful is the service in helping people to quit, and what socio-demographic and service factors affect cessation rates?

We used qualitative and quantitative methods to address these questions. First we interviewed a wide range of professionals involved in managing and delivering the service. A total of 26 interviews were carried out between October 2004 and March 2005. Secondly data was collected and analysed from clients accessing the services from July 2004- May 2005.

Interview findings

Interviews covered a wide range of themes, with a focus on how group services were developed and are delivered in Glasgow.

Promoting Services

- As with any new service, publicity and promotion have been important issues in Glasgow. Interviewees described service promotion as a significant challenge.
- There was initial confusion about who was responsible for publicising services and many interviewees commented on a lack of time and resource to do so.
- A number of different techniques were used to recruit clients, some more successful than others.
- Once clients have indicated an interest it is another challenge to actually persuade them to turn up for sessions, and drop-out rates were high.
- Service promotion also took place with local health professionals. GPs are the main referrers and so promoting services to them was seen as important but also an ongoing challenge, requiring repeated reminders.

Referral Pathways

- Smokers can either self refer to the service or be referred by a health professional.
- GPs (or other health professionals) will usually offer brief smoking cessation advice to a smoker. If they wish to quit, the doctor or other health professional then refers them to group or pharmacy services.
- Some GPs were described as more willing to refer clients to the pharmacy service due to the promotion of Starting Fresh and other factors. This was described as having implications for the volume of referrals to the group service.
- In one LHCC, a GP practice had established an automated referral system and this was described as having increased referrals significantly.

Treatment

- At the time of the study, treatment offered by the LHCC services was predominantly group-based, although one to one support was delivered in a small number of cases.
- Groups follow the Maudsley model and run for a period of seven weeks, facilitated by trained advisors.

- The quit date corresponds to week 3 and 4 week smoking status is recorded at week 7.
- Behavioural support is combined with the use of either NRT or Bupropion (occasionally both products) for most clients.
- Clients attending the group service collect their prescription weekly (up to 12 weeks) from a pharmacy that is participating in Starting Fresh.

Interviewees were asked in detail about their experience of managing and facilitating groups. Key points included:
- LHCCs aim to make groups available during the day and in the evening, as stipulated by the service level agreement between Smoking Concerns and LHCCs.
- Evening groups were generally described as more popular, but there are advantages and disadvantages associated with running both day and evening groups.
- Because of the difficulty of in recruiting clients in some areas, some interviewees described long gaps between groups. Long waiting times can be a significant disincentive for smokers.
- The fact that the service level agreement stipulated the number of smokers required to initiate a group was perceived as too rigid by some interviewees.
- Interviewees from Smoking Concerns explained that the framework for group numbers were based on Maudsley guidelines, and that maintaining consistency across LHCCs was important.
- Whilst understanding the importance of running groups based on best available evidence, many interviewees felt that there should be more scope for adapting the rules to match local circumstances.

Targeting
There are subgroups of the population who are a priority for smoking cessation and wider tobacco control measures across the UK. These include pregnant women, young people, and economically disadvantaged smokers. Professionals providing group support in Glasgow were asked about their approach to targeting. The majority reported that, at the time of the study, their service was not specifically targeting priority groups and was open to all members of their community who want to quit smoking. Interviewees were however aware of the importance of reaching particular groups. Treating smokers living in deprived areas was described as a priority. Many LHCCs attempted to recruit more disadvantaged smokers through promoting the service and running groups in venues that were perceived as accessible and acceptable to these communities.

At the time of the study, group-based services were still at a relatively early stage of development and in some cases were struggling to attract any smokers, let alone those most in need of cessation support. More developed services may be required if successful and sustainable efforts at targeting are to be undertaken.

Future of Services
Although intensive group support cessation services have now existed within the Greater Glasgow area for several years, they are still being developed. It was not until 2003 that the majority of LHCCs have been able to run groups and at the time of our interviews the service was still treating relatively small numbers of smokers – less than 1,000 per year. In part this is due to the time and effort required to appoint staff, train advisers and promote services. It is also due to the limited amount of funding available for the services in the city. NHS Greater Glasgow has also invested in the

pharmacy service and wider tobacco control activities, leaving a relatively small amount of funding for intensive group support.

The level of resource available for smoking cessation in the Greater Glasgow area is increasing, however. In Scotland as a whole funding for smoking cessation services rose from £3 million in 2004/05 to £7 million in 2005/06, with further increases planned in the future. Interviewees were asked about their opinions regarding priorities for future service development, and three main themes emerged.

- Interviewees were largely positive regarding what their local service had achieved thus far and optimistic about scope for further development.
- They emphasised the need for more resources if services were to expand.
- They had very clear views about a role for services in addressing the needs of particular groups of smokers in the future.

Clients and Outcomes

In addition to exploring the delivery of group support services in Glasgow through interviews with staff, we analysed data from smokers accessing the service between July 2004 and May 2005. Data was collected in 14 LHCCs. When the study commenced, some routine client was data already collected by services, but this was fairly limited. A more detailed form was developed with colleagues from Smoking Concerns and advisers from LHCCs. This was based on the extended minimum dataset used in the English national evaluation of smoking treatment services and the Scottish minimum dataset, which was being developed at the time of the study.

Methods

All intensive group smoking treatment services collected data about each smoker who was in contact with the service and set a quit date. Data supplied to the research team were kept anonymous, while including information about the deprivation category of users' place of residence, which was derived from postcodes. In order to avoid a breach of confidentiality postcodes were not provided directly to the research team. The total number of records between July 2004 and May 2005 was 689. Of these some were excluded because no consent was given or because a quit date had not been recorded. The final sample available for analysis was 448.

From the routinely collected data a wide range of descriptive indicators were available about clients and services. Smoking status was classified into five possible outcomes: 'CO-validated quitters– CO reading of 1 - 9'; 'self-reported quit without validation; 'non-quitters'; and 'lost to follow up'. As there were only 12 smokers who were self-reported quitters, one primary outcome was derived for the purposes of this analysis: whether user was a CO-validated quitter (at four weeks) with a CO reading of 1 - 9.

Results

44 per cent of clients were CO validated quitters at four weeks, rising to 47 per cent when self-report quitters were included. A wide range of client and service characteristics was associated with cessation at the bi-variate level.

- Women were less likely to be successful in their attempts to quit (41 per cent) than men (53 per cent) although they made up over two thirds of clients accessing services.
- Older smokers were, on average, more likely to quit than younger clients although these results were not statistically significant.
- The majority of smokers accessing services (56 per cent) were living in areas classified as amongst the 20 per cent most deprived wards in Scotland.

- These smokers were less likely to quit (39 per cent) than those living in the most affluent areas (56 per cent).
- Those who were in employment (48 per cent) or retired (47 per cent) were more likely to quit than those who were unemployed (44 per cent) or permanently sick or disabled (33 per cent). Likewise owner-occupiers (56 per cent) were more successful in quitting than those who were tenants (37 per cent).
- Smoking history and behaviour also affected quit rates. Those smoking fewer than 10 cigarettes per day were much more likely to quit (61 per cent) than those smoking 31 or more (44 per cent).
- Those who began smoking within five minutes of waking were also more likely to fail in their quit attempt than those smoking later in the day.
- Several indicators of health status were found, and self-reported health in particular was associated with cessation. Clients who defined their health as 'not good' were less likely to quit (31 per cent) than those who defined their health as 'good' (49 per cent) or 'fairly good' (51 per cent).

Results of multi-variate analysis suggested that certain factors were positively associated with a successful quit attempt. These were:

- Smoking 10 or fewer cigarettes daily
- Having made at least 1 attempt to quit in previous year
- Socio-economic group score 1 (least deprived)
- Receiving services in two particular LHCCs

There were also several key characteristics negatively associated with quitting:

- Being female – women were more likely to attend smoking cessation sessions but were less likely to be successful in their quit attempt.
- Smoking 31 or more cigarettes daily
- Smoking the first cigarette within 5 minutes of waking
- Having poor self-reported health

Discussion

Intensive group support services in Glasgow are successfully helping smokers to quit. Results suggest that just under half of clients accessing services and setting a quit date will have stopped smoking at four weeks. These results are consistent with other studies.

It is possible to estimate the number of quitters a service will achieve at one year based on CO validated four week quit rates. Using the figure of smokers accessing the service during a ten month period as a baseline, we can estimate the number of smokers that are likely to access the service in a twelve month period - 827. With a 44 per cent CO validated four-week quit rate between 90 and 120 of these clients will be non-smokers at one year.

The characteristics of Glasgow clients do, however, have an impact on success rates. Two-thirds of smokers who participated in this study are living in the poorest 40 per cent of wards in Scotland. Less than half of participants were employed, most had low levels of education and a significant proportion were entitled to income support. A growing number of studies are examining the relationship between socio-economic status and smoking cessation and they all point to one consistent finding – that poorer smokers are less likely to quit. This study further supports this finding with lower cessation rates apparent across a range of socio-economic indicators.

Some indicators of smoking behaviour point to differences between Glasgow respondents and those participating in the English national evaluation that help to

shed some light on the nature of the client group accessing intensive group services in Glasgow. While the proportion of clients in both studies who could be defined as ‘heavy’ smokers (21 or more cigarettes per day) was similar, a higher proportion of the Glasgow sample (45 per cent) smoked a cigarette within five minutes of waking than those in the English study (34 per cent). A slightly higher proportion of the Glasgow sample had attempted to quit in the past year (61 per cent) than in England (55 per cent). In addition, a far higher proportion of Glasgow clients, when asked whether they smoked ‘mainly for pleasure’, ‘mainly to cope’ or ‘about equally’, responded that they smoked ‘mainly to cope’ (51 per cent) when compared with the English client group (21 per cent). These indicators of dependence, when combined with findings relating to socio-economic status, suggest that services in Glasgow are treating a group of smokers with complex needs who may require particularly intensive support to quit.

Service characteristics can also affect quit rates. Intensive group support services in Glasgow deliver a service based on the Maudsley model of smoking cessation. This means that the type of treatment provided to smokers in this study was fairly consistent. The one element that differed significantly was the location of treatment, in terms of which LHCC delivered group services attended by the smoker. Results from our multivariate analysis suggest that smokers receiving treatment delivered by two LHCCs in particular were more likely to quit at four weeks: W1 and W3. One of these areas had high rates of GP referral, which may contribute to differences in outcome. Other factors may also be relevant. Differences in outcomes between areas present challenges for those coordinating and commissioning services in terms of quality control, training and support.

PHARMACY SERVICE

In addition to group-based interventions, smokers in the city can access help to quit through the Glasgow pharmacy stop smoking project, Starting Fresh. It began in 2003. As of September 2005 there were 180 pharmacies participating in the scheme, representing 81 per cent of all pharmacies in the city.

The aim of this component of our research was to examine issues related to the development and delivery of the pharmacy service and to begin to look at client outcomes through secondary analysis of the client database. The study had four specific objectives, to:

- explore pharmacists’ views of the nature of treatment they are able to offer smokers through the Starting Fresh programme.
- examine current arrangements for monitoring Starting Fresh clients in a sample of pharmacies, and to explore their capacity to collect more detailed data.
- conduct secondary analysis of the existing database of smoking cessation clients to examine issues of service reach and effectiveness.
- explore the extent to which a more comprehensive, longer-term evaluation of the service would be possible.

Pharmacy Interviews

In order to explore pharmacist’s views of the service and examine current monitoring arrangements, 26 pharmacists in Greater Glasgow were interviewed. The sample comprised pharmacists working in a mix of more affluent and deprived areas representing all LHCCs, and from independent pharmacies, corporate chains and health centres. A further interview was undertaken with the Starting Fresh Project Officer and Public Health Pharmacist from Greater Glasgow Health Board.

Starting Fresh's aim is to offer an easily accessible smoking cessation service by means of weekly behavioural support and access to NRT. Only one form and brand of NRT, the Nicorette 16 hour patch, is provided (with some exceptions). All participating pharmacies receive a fee for their involvement with the service.

Training
A requirement of participation in Starting Fresh is that pharmacists must have attended a recognised training event run by the Health Board and/or completion of an authorised NRT training programme. Data provided by the Health Board (August 2005) indicate that 426 staff had been through the training programme, of which 217 were pharmacists. The vast majority of pharmacists interviewed had been trained. However the level and consistency of training varied. In some pharmacies all staff had undergone training whereas in others only a minority of staff had been trained or were waiting to attend the training.

Service Operation
A Starting Fresh protocol is available and distributed to all participating pharmacies. For each client the programme runs for a period of twelve weeks for successful completion. The protocol stipulates that a private counselling area is available. Only a minority in the study had no obvious counselling area apart from the shop counter. Many pharmacists reported that privacy was not a particular issue in delivering the service.

The majority of pharmacists were happy to prescribe Nicorette. However, some raised issues around the "unfairness" of not having a choice of product. This was said in the context of GPs and the LHCC groups being able to offer a range of other products without this same restriction.

Pharmacists were asked about links with other smoking cessation services in Glasgow. Generally interviewees had low levels of awareness of the LHCC groups and related services. Some were aware that the groups existed but had little idea as to how they connected with the pharmacy service.

Monitoring
Pharmacists are required to collect monitoring data from all clients using the service. The purposes of the monitoring forms are so that pharmacists can claim their payments and so that the service can be evaluated. Generally, pharmacists were able to cope with the monitoring procedures and were aware of the purpose of monitoring clients. Most felt that current monitoring systems were adequate and that they currently had little extra capacity to collect more detailed data from clients. This poses challenges for future evaluation.

Issues and Challenges
Starting Fresh is one of many public health initiatives taken on board by community pharmacists in the context of their changing role. Overall findings from our interviews suggest that most pharmacy staff found Starting Fresh a reasonably straightforward service to deliver. However, this aspect of our research raised a number of issues and challenges that warrant further exploration.

One issue is tackling smoking-related inequalities in health. Starting Fresh is a universal service that is available to all people who are motivated to quit and are registered with a GP. It does not have the explicit aim of reducing smoking-related inequalities and there are no specific strategies in place within the service to target particular smokers. Despite this, findings from our analysis of the client database suggest that the service is being effective in reaching a large number of smokers in

deprived parts of the city. The majority of interviewees were sympathetic with people's attempts to quit especially within the context of socio-economic deprivation. However, a minority of pharmacists questioned some clients' motives for accessing the service and queried key elements such as access to free NRT.

A further issue involved perceptions of effectiveness. Whilst success rates in individual pharmacies varied, the overall quit rates across Greater Glasgow are between 20-30% at four weeks. In general pharmacists were not aware of what type of success rates they should expect. This suggests that pharmacists could benefit from more information about the service overall, and its relationship with other forms of smoking cessation support in Glasgow to maintain and develop the service in the future.

Analysis of Client Database

In order to begin to examine the outcomes achieved by the pharmacy-based service, we conducted an analysis of the existing client database for 2004.

Methods

Basic information is collected by the pharmacist or pharmacy staff regarding each client. Because our research involved a limited exploratory study at this stage, we did not have the opportunity to collect more detailed data. Instead, we were provided with access to the client database (after personal identifiers had been removed) and the findings described here are a product of our analysis of these records.

Smoking cessation services were provided by 167 participating pharmacies in Greater Glasgow during 2004. Smokers were seen by pharmacists or pharmacy assistants for five sessions at weekly intervals, with the quit date corresponding to week 1 and the 4 week smoking status given at week 5. NRT was provided to smokers throughout the treatment period. Those smokers who remained in the programme beyond week 5 could continue receiving support up to week 12.

The initial sample of 13035 records represents the total number of records for service users with quit dates in 2004. The initial sample was reduced to 11297 after excluding cases with incomplete postcodes. Data about smoking behaviour and employment status of users was very poor. As a result, the only variables for which there were not a high proportion of missing values in the original sample overall were Scottish and Glasgow deprivation decile, gender, age, eligibility for free prescriptions and smoking status at four weeks.

Results

20 per cent of clients were recorded as CO validated quitters at four weeks, rising to 28 per cent when self-report quitters were included.

Almost 60 per cent of all Starting Fresh clients live in the most disadvantaged fifth of neighbourhoods in Scotland. In common with the group service, cessation rates for Starting Fresh clients were clearly associated with levels of deprivation. For both men and women the self-report cessation rates increased from about 25 per cent in the most disadvantaged quintile to about 38 per cent in the most advantaged quintile. There was compelling evidence that users are being drawn from the most disadvantaged parts of the Glasgow population, with 57 per cent residing in the bottom two-fifths of deprived neighbourhoods in the city.

In examining cessation rates by age category for all users, and for men and women separately, the results broadly confirmed what is known from other studies; older users tend to have higher quit rates. Women had slightly lower quit rates. Significant differences were also found in cessation rates between those users eligible for free prescriptions and under the age of 60 (a rough proxy for living on benefits) and all others. On this basis, those users who were most disadvantaged were substantially were likely to quit smoking in the short term (21 per cent self report and 15 per cent CO-validated) than others (35 and 25 per cent respectively for self-report and CO-validated).

Discussion
Although the amount of data collected about users of pharmacy services was rather limited compared to that available for the group support services, some important results were evident.

Cessation rates for the pharmacy services were lower than those reported for the intensive group service in Glasgow or for services in general in England. Short-term cessation rates of 20-30 per cent are what might be expected of a relatively "brief" intervention. These kind of cessation rates produce relatively small numbers of quitters in the longer term. Using the figure of 13,035 smokers (the total number of smokers setting a quit date in 2004) as a baseline, we can estimate that between 645 and 860 of these clients will be non-smokers at one year.

It is important, however, not to judge the success of the pharmacy service on these kinds of estimates. What is needed to make more comprehensive judgements about outcomes is more information about relative costs, models of service delivery and comparative client characteristics. Even though cessation rates appear to be quite low they could prove to be very cost-effective. What can be said for certain is that the pharmacy services have succeeded in providing a high volume of services. What is also significant, given the importance of reducing health inequalities, is that service users are to be found disproportionately in the most disadvantaged neighbourhoods.

Overall, the impression gained from these findings is that the pharmacy services have done an effective job in providing support to smokers across Glasgow and in particular in reaching smokers living in the most deprived areas. But it is almost certain that these services are not contributing to reducing inequalities in smoking because cessation rates are lower in the most disadvantaged neighbourhoods. To rectify this either more intensive support achieving higher cessation rates has to be offered to the most disadvantaged smokers or services need to be targeted – even more than they are already – towards smokers in the most deprived areas.

CONCLUSION

This study has attempted to evaluate key elements of current work to address smoking in Glasgow. The research has a number of limitations in terms of elements of research design, in particular what data were available to inform the study. Despite these limitations, a number of important themes emerge. These include the:

- Relationship between interventions and outcomes
- Challenge of addressing inequalities
- Role of NRT
- Relationship between services

Interventions and Outcomes

This study examined outcomes for clients receiving two different forms of treatment – group support plus NRT/bupropion, and one to one support plus NRT in a pharmacy setting. The study did not specifically set out to compare these two models of service. Some general comparative statements can be made but these should be treated with caution.

Our findings are consistent with a range of other research that suggests that intensive group services are more effective in supporting smokers to quit that briefer one-to-one interventions of the kind delivered by the pharmacy service. CO validated four-week cessation rates for those attending groups were 44 per cent compared with 20 per cent for the pharmacy service.

However, there are some caveats that need to be considered in relation to this comparison. One of the most important is that, for smokers accessing Starting Fresh in 2004, the quit date was recorded as their first visit to the pharmacy and receipt of NRT, whereas for those attending groups the quit date is from week 3. Initial drop out rates from services can be significant.

Secondly, we currently have no information about cost-effectiveness. This study did not set out to examine issues of cost but it is an important question for future research.

Thirdly, any comparison of outcomes should consider the overall impact of services in terms of the number of smokers treated and potential contribution to improving population health. The number of smokers accessing group support services in Glasgow is currently small, compared with the very extensive reach of the pharmacy services.

Finally, it is likely that different models of service will achieve different outcomes depending on the characteristics of smokers who access services. Intensive group support will work well for some smokers but may not be as appealing to others. Likewise the relatively brief advice provided in pharmacies may not be sufficient to help some, particularly more heavily addicted, smokers to quit.

Addressing Inequalities

As already outlined there are considerable differences in smoking rates depending on the deprivation level of difference communities in Glasgow. The qualitative components of our work suggest that professionals involved in managing and delivering smoking cessation in Glasgow are aware of the challenge involved in addressing inequalities in health. However, in relation to smoking treatment services specifically, there is very little evidence to suggest that specific targeting strategies currently exist. Efforts to target appear to be limited to attempts to locate and promote services in deprived communities.

Quit rates are significantly lower amongst more disadvantaged smokers. The difference is marked enough that current services are at risk of exacerbating inequalities in health caused by smoking rather than addressing them. In short, more needs to be done in Glasgow to help poorer smokers to quit. This is not just about increasing the volume of services in disadvantaged communities. We believe it is also about modifying and improving services so that they are more effective in supporting smokers. Although we have very little research evidence to guide us, we

do know that disadvantage is associated with higher levels of addiction, and what is required to help more heavily addicted smokers to stop is more intensive services.

The Role of NRT

The vast majority of smokers in this study used NRT to support their quit attempt, which has proven efficacy when used appropriately. What is slightly unusual about smoking treatment services in Glasgow, however, is that NRT can be supplied directly by the pharmacist on prescription without direct involvement of GPs. Smokers accessing group support services are also referred to pharmacists for the weekly supply of NRT. However, direct supply of NRT in Glasgow involves a single supplier and a first line product – the 16-hour patch.

Findings from our research suggest that preference for this single product is not without its problems. It limits the flexibility of trained advisers in terms of the advice they can provide to smokers about the wide range of products that could potentially help them to quit. There is a need for further research to determine whether current arrangements are in the best interests of smokers.

Relationship Between Services

Different models of smoking treatment are also available in Glasgow. Additional services – in the form of a specialist project ('breathe') for pregnant women and cessation support in secondary care are also available in the city. However, findings from this study suggest that some professionals involved in delivering smoking treatment, particularly pharmacists, have little or no awareness of the other services available. It should be possible for smokers accessing one service to be easily referred to the other and vice versa.

One of the current barriers to this transfer of clients between services is the limited availability of group services and the potential for smokers to become discouraged while waiting for a group to become available. Serious consideration needs to be to given to expanding the service, as they have been proven to be effective.

The final point we would like to emphasise is the relationship between smoking treatment services and wider tobacco control efforts in Glasgow. It is important to recognise that treatment services in themselves will not make a vast difference to levels of smoking in the city. What will make a difference is the combination of widely available, accessible smoking treatment tailored to the needs of different groups of smokers, combined with serious and concerted tobacco control measures.