3.1 TEN STEPS IN SETTING UP A NATIONAL QUIT-LINE SERVICE

Similar to an individual quitting smoking, the process of setting up and maintaining a quit-line service is seldom linear and logical. Politics, personalities, and funding fluctuation may rapidly create, remove or change opportunities. However, a number of steps should be kept in mind to help create and maximize opportunities. If a country already has an established quit line, it is still useful and important to periodically and systematically re-examine what is being done and why.

The following are a series of steps recommended when preparing to create and launch a quit line, or when performing a strategic review of an existing quit-line service. Some of the steps are dealt with in detail here, while others are dealt with in later sections (see also Appendix 10 which includes the Minimum Standards for Australian Quitline Services).

Step 1. **Identify a quit-line expert** for the country or concerned ministry. If responsibility for mastering the knowledge and issues relating to establishing a science-based quit line is too diffuse, there will be less accountability. Of course, there should also be an effort to widely disseminate knowledge about the quit line.

Step 2. **Assess the needs for quit-line services** in the population (World Bank, 2004), including specific characteristics that may impact the use of quit lines such as:
- prevalence of tobacco use, including types of tobacco use
- languages spoken
- access to a phone
- cultural acceptance of phone-based services
- the number of tobacco users interested in quitting and making quit attempts.

This assessment should include determining if different patterns exist in geographical, economical and cultural groups. Assessing these characteristics is not an exercise to determine whether a country needs a quit line: its purpose is to determine what form of quit line can best serve the needs of the country at its current stage of tobacco control development.

Step 3. **Determine the place and the role of quit-line services** in the national tobacco control and treatment strategy focusing on two key aspects.

1. The amount of cessation support resources currently available through health-care systems and community-based programmes. Some countries may have many programmes and services for quitters, but very little coordination. In this sort of situation, there may be need for a robust referral capacity within the quit-line service. This may be important for two reasons: it can help secure resources for callers, and ensure that, politically, other tobacco treatment services, which may be concerned that the quit line will supplant them, are not alienated. Other countries may have virtually no resources to help tobacco users quit. In this case, services must be developed with the understanding that callers must rely completely on quit-line services and their own resources.
2) Consider the current state of existing and planned tobacco control policies likely to increase quit attempts, the demand for treatment and potential funding. Examples include smoke-free legislation, mass media de-normalization campaigns, health-systems initiatives and tobacco taxes (Box 3). All of these activities have the potential to increase interest in quit attempts and calls to a quit line. In addition, the existence of a quit line can be used to help achieve these policy objectives. Quit lines can have the biggest impact on quitting and tobacco prevalence if their services and promotion are provided in a manner that complements other tobacco control activities.

**Box 3. Normalizing quitting**

A country has a very low rate of quit attempts and significant second-hand smoke exposure in public places. The tobacco control unit is planning a major public awareness campaign, including mass media advertisements and posters, about the dangers of tobacco use and second-hand smoke to help de-normalize smoking and normalize quitting.

However, there is concern on the part of some politicians (some of whom smoke and have the power to remove funding for the programme) that government funds should not be used to demonize smokers or make them feel guilty. Putting the quit-line phone number on advertisements used in the campaign can help diminish the sense that the government just wants to blame smokers.

**Step 4. Determine the goals of the quit line.** Depending on the specific circumstances, the reasons for creating or expanding a quit line can vary, and may impact on whatever services and promotional strategies are deployed (Ossip-Klein & McIntosh, 2003).

1) **High reach with minimal counselling.** This goal may be set because there are only a few other services available, quit attempt rates are low, and resources are limited. With this goal, triage processes need to be in place to determine which callers get limited live services, and to ensure that the non-live services, such as recorded messages and printed materials, are provided in a manner that provides callers with a good experience. Even if live calls are very brief, careful attention to call quality is important. If increasing quit attempts is a high priority, promotional campaigns that impact on large numbers of tobacco users are important, and the content of the promotion should encourage quit attempts. The South Africa Quitline is an example of this type of quit line (see Box 2 for details).

2) **High effectiveness (quit rates) with lower reach.** This goal may be set because the quit line is being used as a referral resource by community resources, such as medical clinics, where high-quality quit-line services will enhance the delivery of brief in-person services. With this goal, close attention to counsellor training and protocols will be especially important. An example of high effectiveness with low reach can be found in the case example in Box 4.

3) **High reach and high effectiveness (impact).** This ideal goal may be realistic where there is substantial funding for promotions and services (Box 5).
Step 5. Determine the range of services and desired/likely utilization rates (see Section 5. Range of services), including whether the quit line wants to increase counselling use alone, increase use of medication, or increase use of counselling and medication together.

Step 6. Determine strategies for creating demand for the quit line, keeping in mind how different strategies may affect its role and impact (see Section 6. Creating a demand for service for further details).

Step 7. Determine what sponsors could fund and oversee the quit line.
1) Develop an estimate of what funding level range is appropriate to the quit line’s intended role in the overall tobacco control programme.
2) Identify a reliable funding source (note: existing quit lines with insufficient funding to fully realize their objectives should periodically review the possibilities for additional funding sources that have not been tapped).
3) Create a start-up and ongoing budget.

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Box 4. Example: targeting health-care workers

In a large country with a limited budget for cessation and a high prevalence of tobacco use, most users do not plan on quitting. A majority of health-care workers (including doctors) smoke but have a higher interest in quitting than the general population. Tobacco control advocates view the high-smoking rate among health-care workers, especially doctors, as a barrier to moving other work on tobacco control forward, since the politicians look to the medical community for guidance regarding tobacco control initiatives.

Quit-line developers plan to start with limited promotion and service for most callers, including a menu of recorded calls with information on why they should quit and tips for how to quit successfully. However, the limited service will be augmented with full proactive counselling and aggressively targeted promotion specifically for health-care providers interested in quitting themselves. As the percentage of health-care workers using tobacco decreases, this strategy will be re-examined.

Box 5. Case example: New Zealand Quitline

The New Zealand Quitline is an example of a telephone cessation programme with high reach and high effectiveness, offering free telephone support, other resources and low cost NRT to all New Zealand residents, with a particular focus on Māori smokers. The Quitline is run by Quit Group, a charitable trust funded by the Ministry of Health. Their purpose is to reduce the number of New Zealanders who smoke by providing effective support nationally for more smokers to make more quit attempts. In addition to running the quit line, Quit Group develops and provides other innovative quit-smoking programmes, including television, radio and print campaigns, an interactive web site (with chat and blog functions), and a text messaging service to help smokers trying to quit (Quitline, 2011).

In this country, with a population of just over four million, the quit line was able to register about 44 000 people (5% of all smokers) to make a quit attempt either by telephone (67%) or via the web site (33%) in one year. Callers can request a quit pack containing practical quit smoking advice, talk to an adviser for individualized support, obtain quit cards for subsidized nicotine patches, gum and lozenges (AUD$ 5.00 for four weeks’ supply), and sign up for a text messaging service (Txt2Quit). See: [http://www.quit.org.nz/txt2quit/page/txt2quit_5.php](http://www.quit.org.nz/txt2quit/page/txt2quit_5.php).

Telephone advisers receive two weeks of classroom training followed by a one-on-one coaching period and advanced training of three to six months. From 30 to 45 advisers are available to take calls from 8:00 to 21:30 six days per week.
It is very important to understand how much quit-line services will cost to deliver, and how much money is potentially available through various sources to fund them (see Section 4. Funding). There may be potential sources of funding that are not immediately apparent. Look beyond the existing tobacco control budget, examining possibilities such as new tax revenue, health-care services reimbursement, and other public health and government programmes.

**Step 8.** Determine a project management plan for implementation. Setting up a robust quit line is a complex undertaking. Long-term success is more likely if a systematic approach is taken in coordinating the various elements required to launch the service. This includes the identification of minimal standards, the critical milestones, interrelationships between elements, clarification of the role of those working on the project, and a timeline. Managing the process of the creation, launch and growth of a quit line is as important to success as the specifics of the services that are planned to be delivered (see Appendix 2 for more information on how project management can be used to simplify quit-line set up and ensure success).

**Step 9.** Determine what organization will deliver services. Approach this creatively and systematically to be sure you have identified the best possible group to deliver the services. Regardless of whether the service operator could be one of several government agencies, NGOs or private companies, consider creating a competitive process to select a quit-line operator and a media/promotions contractor.

1) Consider a competitive bidding process (see Appendix 3 for a sample of the Request for Proposal form).
2) Write contracts with the selected providers for delivery of services.
3) Closely monitor the contracts to ensure adherence to standards and deadlines.

**Step 10.** Determine who is accountable for ensuring the success of the quit line, including both its operational and strategic success in fulfilling its role within larger tobacco control efforts (Box 4).

### 3.2 QUIT-LINE MODELS AND OPERATIONAL STRUCTURE

Several different approaches to setting up a quit line are explored here, including the advantages and disadvantages. Additional recommendations for quit-line management and operation are also provided.

#### 3.2.1 Models

Quit lines have been created and operated both as a part of a broader service (such as a health-related hotline) and as a single-issue tobacco-specific service.

##### 3.2.1.1 Quit lines as part of a broader service

Some quit lines are embedded in larger call centre environments that are performing other services, for example inside government-run call centres for broader health services or private call centres offering many different types of services to purchasers (Box 6). This model enables quit lines to take advantage of economies of scale and existing infrastructure.
Technical advice for establishing and operating quit-line services

Challenges to this model occur when quit lines are embedded in larger call centres or service organizations where they run some risk of playing a secondary role to the needs of the larger organization or the largest commissioning agency. There may be pressure for the quit line to conform to how business is conducted for other services. For example, if the quit line is embedded in an information and referral centre with very high volumes, very brief time on the phone, and no follow-up, there may be pressure to apply this type of call-handling model to quit-line calls. This risk can be mitigated by ensuring that the senior leadership of the larger organization clearly understand the unique needs and characteristics of quit-line service delivery.

3.2.1.2 Quit lines as a single-issue tobacco-specific service

Due to the challenges associated with embedding quit lines in broader services, some quit lines operate as separate services, focusing entirely on tobacco services. The biggest challenge to this approach, especially initially, is that the infrastructure costs of setting up and operating a call centre are significant (Box 7).

Box 6. Case example: Essentiagroup, the United Kingdom

The Essentiagroup, one of the organizations providing quit-line services in the United Kingdom, provides multiple services from a large call centre in Glasgow, Scotland. In addition to providing services to tobacco users, they also provide health and wellness assistance through contracts with the Central Office of Information, Department of Health and the Scottish Government, as well as non-health social services, such as the Home Heat Helpline, that helps those who are having problems paying their heating bills, and Skills Development Scotland, which puts people in touch with education and training opportunities.

They are able to train people across these different lines of service, making it easier to handle increases and decreases in volumes, and to develop robust training and quality assurance systems. Because of the large volumes of calls, such quit lines can afford larger, more sophisticated telephony and computer systems.

Box 7. Case example: Group Health Cooperative, the United States

Group Health Cooperative, a large integrated health system in the United States, operated a quit line for its members and some states. The quitline relied on other resources also used by other groups inside the health system, such as call centre technology serving a large nursing help line. The larger infrastructure was invaluable during the start-up and growth phase of the quit line. The unit providing quit-line services benefitted significantly from the existence of telephony systems, computer support, contracting and legal services, as well as the clinical personnel and management support and experience in the health system.

However, as the quit-line service grew, they found that it was very challenging to get some of their needs prioritized. For example, it was difficult to convince the larger call centre to change the rules that determined how calls from various numbers were routed, and the type of messages that were given, even though this was critical for the quit line. The other users of the system did not require rapid changes in these rules, and their needs were a higher priority. In addition, the accounting system set up to support health-care clinics did not work well for the types of contracts the quit line supported. These types of factors ultimately led to an amicable administrative separation from Group Health and the establishment of a separate call centre (Free & Clear).

Group Health Cooperative has been a valued customer of Free & Clear since this administrative separation. Both parties have maintained an active partnership in providing the best possible experience to members of Group Health’s tobacco cessation services.
3.2.1.3 Country versus state/provincial quit-line service
Most small- and medium-sized countries have created quit lines that function at national level. Others, such as Australia, Canada and the United States, rely on regional, state or provincial quit lines. Some have hybrid models.

The advantages of providing a national service include: (i) only having to create and maintain a single call centre infrastructure; (ii) ensured access to the same services throughout the country; and (iii) ease of coordinating and executing national promotional media campaigns referring to the quit line.

The advantages of providing services at the state/provincial level include: (i) increased ability to customize services to the needs of a specific geographical population; (ii) greater awareness of and relationships with local resources, such as health-care and other state-level programmes; and (iii) greater variation in services which may allow for experimentation.

Some countries, such as the United States, have created hybrid models where each state or province is responsible for its own quit-line services, but the national government assists with some of the costs, puts strong pressure on the states to offer quit-line services, provides a centralized call number, and encourages collaboration between states on quality and research.

The suitability of the model depends on the characteristics of the country considering a quit line.

3.2.2 Quit-line management
3.2.2.1 Outsourcing quit-line services
Government agencies (or other entities) sponsoring a quit line sometimes choose to outsource (subcontract) service provision to an outside service provider. Although this means that the sponsoring/funding agency loses some direct control, potential advantages to outsourcing quit-line services, include:

- sophisticated call centre expertise and infrastructure
- clinical counselling expertise
- service provider assumes some of the financial risk for variable call volumes
- start-up costs may have already been paid
- ease of expansion and contraction.

Situations where having the sponsoring agency operate the quit line directly (Box 8) include:

- if there is an existing call centre capacity within the sponsoring agency, for example, if the funder already runs a call centre for mental-health services;
- if there is existing tobacco treatment expertise within the sponsoring agency;
- if direct control of quit-line operations by the funding agency is an important political or cultural requirement.
Situations where outsourcing (Box 9) makes sense include:

- if a high volume of calls is anticipated;
- if considerable variability in call volume is anticipated (it is challenging to efficiently staff a quit line with wide fluctuations in call volume);
- if there is no in-agency expertise of operating a call centre, including both technical and human;
- if there is no in-agency expertise on how to deliver counselling;
- if the outsourcing of services is an important political or cultural requirement.

Box 8. Example: sponsoring agency operates a quit line

A government agency with a potential population of half a million smokers has received permission to start a quit line with a small start-up grant, but no real budget for ongoing operation. The director of the agency is strongly in support of trying to make it happen, “if we can run it with existing staff and resources.” She is hopeful that if they can show it is effective, there may be more funds in a year or two to expand. They already operate a countrywide crisis line for suicide, alcohol and HIV with 10 phone coaches. There is excess capacity in the crisis line, and several people in the agency have already carried out tobacco counselling in a clinic. In these circumstances, the agency decided it made sense to begin by providing the service “in house”. They made sure that the phone coaches that would provide quit-line counselling received a week’s training on tobacco coaching run by a quit line in a neighbouring country, and located protocols to support the coaching. As the service grows, their decision can be re-visited.

Box 9. Example: outsourcing in the United States

Each state in the United States has a separate state-sponsored and funded quit line. Many of the state quit lines handle dozens of calls a day and, during media campaigns, calls can spike into the hundreds. The quit lines are highly visible politically, and service and clinical quality are critical for their continued funding. Most state health departments now outsource the operation of their quit lines to service providers, which range from state universities to hospital call centres to private quit-line companies to other non-profit agencies. Some service providers serve a single state, and some serve multiple states (McAfee, 2007).

3.2.2.2 Who provides the service?

Quit lines can be operated by a wide variety of providers, including universities, health-care institutions, governmental and philanthropic organizations, as well as private companies. See Table 1 for some of the characteristics of these different providers

<table>
<thead>
<tr>
<th>Type of institution</th>
<th>For</th>
<th>Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universities</td>
<td>Strong research/evaluation capability, access to counselling expertise</td>
<td>Less incentive to expand service, complex bureaucracies</td>
</tr>
<tr>
<td>Health care</td>
<td>Expertise in clinical care, used to helping large numbers</td>
<td>“Medical” model rather than public health</td>
</tr>
<tr>
<td>Governmental</td>
<td>Funder directly oversees delivery</td>
<td>Less competition may diminish efficiency</td>
</tr>
<tr>
<td>Philanthropic</td>
<td>Fewer constraints on nature of service</td>
<td>Unlikely to have expertise in complex service delivery</td>
</tr>
<tr>
<td>Private companies</td>
<td>High service levels, incentive to increase use, flexible</td>
<td>Profit motive may get in the way of public health goals unless incentives are aligned</td>
</tr>
</tbody>
</table>
3.2.3 Operating challenges

There are a number of major challenges to the delivery of quit-line services that have been addressed successfully in very different settings around the world.

a. Enrolment protocols. How do callers sign up? What data should be collected to support the operation as well as any additional data to support evaluation or clinical research?

b. Counselling protocols. How do we decide what to do?

c. Quality of service. How do we ensure that what we want to happen is happening?

d. Hours of operation, office space, technology [telephony and computer requirements].

e. Staffing and planning. How do we make sure we have the right number of people at the right time with the right skills to handle normal call volumes, and how do we handle fluctuating demand efficiently?

f. Recruiting and training.

g. Managing workflow.

h. Reporting.

Each of these challenges are explored in some detail below.

3.2.3.1 Developing, testing and implementing new and revised protocols

Once you have decided to create a quit line, you have to decide what each participant will, ideally, experience: what sort of counselling will be provided; how will the programme be structured (timing, frequency and intensity of counselling); what is the expected outcome of each interaction; and what data should be recorded for each interaction?

Telephone counselling protocols are the expectations and guidelines that structure what will occur on each interaction. They also help structure training and quality assurance efforts.

3.2.3.1.1 What is a protocol?

Protocols spell out what is supposed to happen when a caller reaches the quit line. This can include many different aspects of the call experience.

• How the phone is to be answered?
• What initial questions should be asked?
• What data should be recorded?
• Triage rules around types of service to be offered.
• Counselling elements.
• Other call functions such as referrals, medication, materials, Internet, and study offering.
• How to close a call.
• Rules for follow-up, e.g. whether to offer future calls, timing of calls, method of future connection [appointment, quit-line calls, participant calls, etc.], content of future calls.

Some elements should be very specific, such as the type of data that should be recorded, whilst others should be more general such as the order of counselling elements.
How can a country that is just getting started with a quit line best develop quit-line protocols? The creation of detailed quit-line protocols can be very time consuming, take a great deal of effort, and will evolve over time with experience. The first decision is whether a country wants to develop structured counselling protocols from scratch, or locate and adapt existing standard protocols.

An example of a high-level protocol is included in Appendix 4, with information on how to obtain more detailed information. Many existing quit lines are willing to offer advice on protocol design.

3.2.3.1.2 How to test and revise protocols
Quit lines should establish explicit processes to identify and incorporate new counselling strategies. New ideas can come from: staff based on their experience; participation at scientific conferences; ongoing literature reviews; a rigorous review of internal experience; and consultations with outside experts. Increasingly, regional consortia of quit lines are cooperating by sharing expertise and experience. It is important to explore new ideas to determine whether they fit into the existing framework, and establish how they might improve quit-line operations and be incorporated into training programmes. There are specific criteria that can be used for testing and revising protocols.

- Is there evidence that the new approach will improve quit rates, satisfaction or reach of the quit line?
- Can the new approach be implemented without disrupting quit-line operations?
- Will the new approach make the quit line more costly to operate, or more efficient?
- How does this idea compare with other possible changes?

It is often a good idea to implement new approaches in a staged manner, rather than across the board. For example, a new approach to handling calls or counselling can be tried with a small group of counsellors rather than all of them, keeping close track of how the counsellors feel it is working and observing how it is impacting on the service.

Advisory board
Many quit lines establish an advisory board of experts to help review their protocols and evaluation data, provide suggestions regarding key issues and plans and, based on the evidence and their experience, make recommendations on the quit line’s focus in the future. An advisory board can be made up of academics who have worked in tobacco control and treatment or related fields, people with experience of quit lines from other countries, and policy experts (Box 10).

Box 10. Case example: the role of a quit line advisory board
An advisory board can be convened by various organizations. For example, in the United States, large service providers often have advisory boards, many state health departments have advisory boards for their tobacco programmes, and the North American Quitline Consortium (NAQC) has an advisory board.

In general, these advisory boards meet at least once a year for a day. Supplemental teleconferencing meetings are often held, and members may also be expected to provide some brief individual consultation involving, for example, reviewing documents. It is very important to set out clearly the amount of work that future board members will be expected to do. In some cases, board membership is entirely voluntary and, in some cases, board members are paid an honorarium.

Board meetings are most successful when the agenda is carefully planned and focuses on the most important elements that can be learned from the board members, rather than simply presenting what the quit line is doing. Ideally, some materials are sent to the board members for review ahead of time. Agendas should include some presentation of the quit-line’s activities, but plenty of time should be allocated for members’ opinions.
“Secret shopping”

One under-used method of identifying problems with quit-line services is “secret shopping”. This is a method often used by call centres, retail stores and social services.

A secret shopper (or shoppers) calls the quit line with a specific “story” and observes how their case is handled as it unfolds. They take careful notes regarding how the call is handled (sometimes they record the call). Generally, there will be a set of quality indicators that they will specifically watch for and grade, such as customer service experience, rapport building, specific elements of counselling, and appropriate referral and follow-up.

Generally, transparency when conducting secret shopping is advised to avoid ill feelings. This can include a funder of a quit-line service informing the service provider that they will be doing some secret shopping during the year, or a quit-line provider letting its staff know that part of the internal quality assurance monitoring includes secret shoppers.

3.2.3.2 Ensuring service quality

Having a great protocol is only the beginning. Translating a protocol into a fully functioning quit line requires many more steps (see Appendix 10 – Table 12. Minimum standards for Australian Quitline Services). One important element of the process is putting in place a plan for assuring and improving the quality of services. This plan should track key clinical and service performance metrics (important measurable processes and outcomes), including both what metrics the quit line will measure, and the setting of performance targets (Box 11).

Box 11. Example: key metrics for a quit line

- Provide quit-line service to at least 3% of smokers per year (note: this requires knowing how many smokers there are in your targeted population).
- At least 90% of calls to the quit line are answered within 30 seconds (requires a telephony system that can provide this report).
- Quit rate at six months of 30% among responders to a follow-up survey.

Consistent under-performance on any metric should trigger a root-cause analysis to identify why the target is not being reached.

Because metrics and statistics can be overwhelming to produce and interpret, it is helpful to identify a limited number of core metrics to monitor, attempt to make their updating as automatic as possible, and be sure that the people in the quit line (and its funding organization) receive and review the metrics on a regular basis (such as monthly or quarterly).

Quality of counselling calls is one of the most important quality components. Specific internal procedures for reviewing calls are included in Appendix 5.
3.2.3.3 Hours of operation, space needs and technology (telephony and computer requirements)

3.2.3.3.1 Hours of operation
There is broad variation in hours of operation of quit lines worldwide, ranging from a few hours a day on weekdays to 24 hours a day, seven days a week, 365 days a year. Most quit lines do not operate with 24 hours a day, seven days a week live access unless they are embedded in a larger call centre that already offers this level of service. There are very few tobacco users who want or need help at 3:00 in the morning. However, the more time counselling services are available, the more convenient it is for callers and the stronger the perception that the quit line is attempting to meet the needs of callers (although offering broader hours of operation also increases costs).

Recommendations
• Reasonable operating hours should be identified based on when tobacco users are most likely to call (typically morning and evening hours).
• Identify these hours of operation on printed materials.
• During periods when calls are not answered live, recorded message should be provided indicating when live counselling is available. Recorded messages should be available at all times. Consider allowing callers to leave their name and number for call back, but be sure your staff actually calls back in a timely manner.
• Once patterns of high call volume are clear, the quit line should be kept open during peak times.
• The quit line should be staffed for at least five days a week for at least eight hours a day; ideally more.
• Consideration should be given to staffing that overlaps with most common work/home times – i.e. from 8:00 to 19:00.

In Australia, the approach is the use of a call-trafficking service for most states. A national commercial call centre answers all calls, then forwards them to either the state-based provider for counselling, or sends out a quit kit. This has proven useful during periods of high call volume and for after-hours message taking.

3.2.3.3.2 Space needs
The service should operate in a safe and secure location, which meets relevant occupational health and safety standards.

The call centre environment should be set up to:
• ensure counsellors can talk and listen to callers without excess noise
• provide for confidentiality of written and computer records
• allow for growth in the number of staff.

3.2.3.3.3 Telephony requirements
Quit lines that are handling a significant volume of calls require different types of call- centre technology to function efficiently. The following functions are important.
• A private branch exchange (PBX). This includes a communications server that can be connected to hundreds of telephones simultaneously. Quit lines that are part of a large organization with an existing phone system can usually be integrated into the larger system (CDC, 2004).
• Call queuing and routing. The phone system has to be able to handle a large number of simultaneous calls, including following rules on how calls from different areas or different numbers will be prioritized and routed. Some of these and other similar functions are handled by an automatic call distributor, which can be programmed to follow complex rules on who receives which types of calls.
• Phone lines capable of handling high volumes of calls. There are different types of phone lines with different capabilities. For a quit line with large volumes, high-speed lines such as T1 lines may also enable much lower long-distance rates (Anderson & Zhu, 2000).
• Real-time monitoring. Software can display what is happening in the call centre, such as how many callers are on hold and how many counsellors are on the phone. This enables staffing decisions and routing determinations to ensure service quality.
• Reporting capability. Software can create reports that track important elements both at the level of the call centre and the individual counsellor. For example, productivity metrics for individual counsellors can be tracked, such as time on live calls and number of calls. Statistics, such as abandonment rates, can also be generated at the call centre.
• Call monitoring. The ability to monitor calls for quality review as well as to support counsellors in crisis situations.

3.2.3.4 Computer system requirements

Unless the quit line is very small, it will benefit from a computer system to assist with the intake and counselling process, as well as data collection and report generation. Many quit lines create a form of “user interface” where the intake and counselling staff are cued as to what questions to ask, and given some support for providing the counselling intervention. The computer system can then run analyses and generate automated reports using special reporting software. Unfortunately, there is no currently available “shareware” application available that performs these services specifically for new quit lines. Most quit lines use common basic software programs such as Microsoft SQL Server to create their systems, but have invested in programming to create custom solutions to their quit lines requirements.

Quit lines hold large amounts of information about individuals. As quit lines are set up, policies on the computerized storage of participants’ data and on staff training should be carefully developed to ensure that participants’ right to privacy is maintained.

3.3 STAFFING AND CONTRACT OVERSIGHT

3.3.1 Staffing

In many instances, the agency that is sponsoring and funding the quit line will outsource the delivery of services. In this case, details of operations, training and staffing may be the responsibility of the operator, with the sponsoring agency primarily responsible for setting goals, creating the contract, picking the operator, and monitoring processes and outcomes. However, even if you are the person in a government agency that is contracting out the services, it is important that you have some familiarity with how a high-quality quit-line service is staffed, in order to oversee the quality of the service provided. Staffing considerations are outlined below.
Technical advice for establishing and operating quit-line services

- Clearly defining and documenting duties, roles, rights and responsibilities of staff.
- Size of staff is dependent upon number of lines available, hours of operation, anticipated demand based on promotion and referrals, and size of smoking population: a new quit line can have as few as two staff members (intake-counsellors) when first created. Some quit lines serving larger countries or multiple regions employ hundreds of people. There are basic tools available that can be downloaded free from the Internet that help calculate staffing requirements based on certain basic assumptions (see Erlang C calculators at: http://www.erlang.com/calculator/erlc/).
- A developed quit line may need a variety of staff expertise (Anderson & Zhu, 2000).
  - A receptionist/administrative aid.
  - Intake staff. If tobacco quit-line services are part of a broader hotline, intake staff can be shared between the different lines. Some quit lines ask counsellors to perform the intake function, which can work well under certain circumstances, but is challenging because of the extra amount of time they must spend with each caller if volumes are high or variable.
  - Trained counsellors. Specific counsellors trained in smoking cessation skills.
  - Supervisory staff and a network manager to monitor and supervise counsellors.
  - A head of the quit line (operations manager).
- Larger quit lines or quit lines with ambitious agendas that aim to increase reach, quality or research may also have:
  - clinical advisers (i.e. psychologist/physicians) to train/enhance the skill base of the quit line;
  - an evaluation manager to oversee data management, analysis and report creation;
  - client services managers to work with the institutions that are contracted to provide services;
  - a call quality manager;
  - a training manager.
- Criteria for employment (recruitment). Selection and recruitment policies, and procedures for each category of staff should be developed. Close attention should be paid to the qualifications of the counsellors.
  - Current tobacco users should be excluded. It is too complicated for someone who is still smoking to counsel others reliably and consistently about how to quit. Most existing quit lines require counsellors to have been tobacco-free for at least six months to two years.
  - A history of counselling experience or natural counselling skills is an important asset. The employment interview can include a “mock” interview so that the person making the hiring decision has direct experience of the applicant’s skills.
  - A candidate’s capability to do the required data entry while counselling should be determined.

Some quit lines use volunteers or college interns who are paid a minimal stipend to help provide counselling or other services. College students who want to acquire counselling experience, retirees and successful quitters may volunteer. Incorporating some volunteer or intern assistance may help lower the cost of delivering the quit-line service. However, care should be exercised to ensure volunteers are committed to providing high-quality services. A minimum commitment of time per week or month, and a minimum length of service, such as six months or a year, should be required to justify the initial commitment the quit line must make to adequately train and supervise volunteers. They can also be assigned to less complex tasks, such as registering callers or making brief call backs.
3.3.2 Counsellor training
Training of counsellors is a critical component of quit-line operation. The structure and length of training is dependent upon the nature of the role of the counsellors, past experience, and how much support (such as online prompting) is available. Worldwide, training of new counsellors varies from one week to six weeks. Unless counsellors have significant prior analogous experience, or their role is going to be circumscribed (i.e. very brief supportive advice rather than true counselling), training should be at least two weeks. Counsellor training should be both informational and experiential. For example, trainees can listen to calls and role play with each other. Orientation to record-keeping requirements, caller confidentiality procedures and standards, and other operational aspects should be incorporated into the training.

New trainees should be closely supervised for a while after formal training. This should include doing initial calls with live supervision, followed by the review of recorded calls (if available) and record keeping.

At the highest level, training should address (CDC, 2004; World Bank, 2004):
- psychology, epidemiology and biology of tobacco use
- general principles of counselling
- effective counselling techniques for motivation and behaviour change
- quitting strategies
- challenging counselling scenarios
- multicultural counselling
- effective case management practices, including use of protocols
- health issues related to tobacco use and cessation
- knowledge of medication aids.

Detailed information about training approaches is included in Appendix 6, including a sample training course planner and outline as well as adult education principles.

3.4 MEDICATION
The third WHO recommendation on offering help to quit tobacco use is “access to low-cost pharmacological therapy”. Quit lines have the potential to assist with this recommendation and benefit from the incorporation of medications into their protocols. However, the use of medication should be weighed carefully with issues of cost, safety and policy.

Many quit lines in Europe and the United States, as well as in Australia and New Zealand, provide some level of medication support for quit-line callers. Most quit lines at least provide detailed information about how the medications work, the arguments for and against the various types of medications, potential side effects and how to manage them, as well as details on where they can be obtained. A few quit lines provide a full course of medication to all interested callers, with as many as 80% of callers receiving it. Because of cost concerns, many quit lines only provide shorter courses (i.e. two-week “starter kits”) of over-the-counter medications, encouraging users to purchase more medication (or obtain it from the health system, if covered). Medication is either sent directly to callers via the mail, or eligible callers are sent pharmacy vouchers that can then be exchanged for free medication at a local pharmacy.
Some quit lines only provide full courses of medication to populations of particular interest to public health, such as the poor or those without access to health insurance. Because of the expense and concerns over wastage, many quit lines only provide medication to those planning to quit in the next 30 days. Some also only provide medication during brief time-limited “campaigns”, i.e. for one to three months, primarily to increase quit attempts and calls (Box 12). For those quit lines who consider providing a full course of medication (e.g. eight weeks of nicotine patches), some thought should be given to whether to provide the full course of medication at once or to provide the first four weeks and then link the second four weeks to the completion of a later counselling call.

The use of medication associated with a quit line may be impractical or inappropriate, especially in some developing or transitional countries, for a number of reasons:

- medication may be more expensive compared to counselling, given the lower labour costs in developing/transitional countries
- medications may not be available in all countries
- even if available, regulations may prohibit any form of distribution linked to a quit line.
- medication use may be less appropriate culturally.

However, there are a number of additional benefits to the integration of medication use into the quit-line setting that are worth considering.

- Knowledge of the availability of free medication through a quit line, even in small quantities, has proven to be a dramatic promotional tool (see Section 6.2 Promotion of quit line services) and can be cost-effective.
- The availability of medication can increase a health-care provider’s interest in referring patients to a quit line.
- Strong evidence indicates that medication provided through a quit line, both over-the-counter and prescription, increase quit rates compared to counselling alone (Hollis et al., 2007; Swan et al., 2003; Cummings et al., 2006).
- Further strong evidence suggests that the provision of brief instruction in proper use, assistance with side-effect management, adherence encouragement, and concurrent behavioural support provided by quit-line counsellors increases quit rates compared to medication alone (Fiore et al., 2008). This could be important given that most cessation medication is used in settings with much less education and support than is provided in the trials proving their effectiveness.

Frequently Asked Questions (FAQs) about medication use in quit lines.

- Is it legal? Countries vary dramatically in terms of what is allowed regarding the provision of medication. Its feasibility will depend on the status of the stop-smoking medications (i.e. whether they require a prescription or not) and the laws and regulations regarding shipping through the mail, across geographical boundaries, etc.
- Is it safe? When used with carefully constructed protocols and with medical back up. Hundreds of thousands of people have received stop-smoking medications safely through quit lines.
• What are the dangers? Nicotine replacement therapy is widely accepted as being very safe and is available over-the-counter in many countries. However, protocols need to address areas of concern, such as pregnancy, recent heart attack, and history of severe allergic reaction. Prescription medications are more complex to administer. If offered, they must be provided with medical oversight consistent with a country’s regulatory requirements, and ongoing support is recommended to assess for infrequent but potentially serious side effects. There are various ways this can be accomplished, usually by requiring quit-line callers to obtain a prescription before receiving a voucher or medication.

• Will people really use it? What about wastage and resale? With proper decision support and guidance by well-trained phone counsellors, most people use the medication provided. Counsellors can be trained to review simple solutions in cases where callers discontinue medication due to minor side effects. There is no evidence of the widespread re-sale of the medications sent by quit lines. However, systems should be in place to guard against systematic re-sale (such as cross-checking for multiple orders sent to the same address).

3.4.1 Training implications for counsellors
All quit-line counsellors should receive training in evidence-based pharmacotherapy options. Counsellors should be able to provide basic decision support by describing how each medication available in a country works, the arguments for and against the use of each medication, how to use each medication correctly, and be able to solve minor side effects. Callers who have serious medical conditions can be referred back to their health-care providers to decide whether there are significant risks associated with using a particular medication (see Section 3.3.2 Counsellor training).

3.4.2 Counsellor support
Treatment protocols including decision support for cessation medications should be tightly scripted to ensure caller safety and to reduce risks to the quit line. The protocol can identify medical conditions and medications that may prevent the quit line from providing a particular medication. Instructions for use and potential side effects should be made available to counsellors for quality control.

Box 12. Case example: free nicotine replacement therapy campaign in the State of Oregon, the United States
In 2005, the State of Oregon in the United States ran a three-month campaign offering NRT (patches or gum) to any caller to the quit line. There was no paid media, but the local press covered the event. The quit line also encouraged word-of-mouth promotion by including “tell a friend” cards in the mailings to callers. Callers who had health insurance could receive two weeks’ free NRT, delivered via the mail. Callers without insurance were selected randomly and received either two weeks or eight weeks’ treatment. All callers receiving two weeks’ NRT were encouraged to purchase more (which included their being sent a paper bank to deposit their savings from not buying cigarettes). The results were impressive. There was a 15-fold increase in calls to the quit line during the three-month campaign, and call levels remained elevated for months afterwards. A significant improvement in quit rates was seen when pre-campaign quit rates were compared to campaign quit rates. A cost-effectiveness analysis found that the availability of NRT was a very cost-effective way to promote quit-line calls (Fellows et al., 2007). In the uninsured, those receiving eight weeks of NRT were more likely to quit than those receiving two weeks (McAfee et al., 2008).