

Drug and alcohol counsellors in community health settings reaching smokers from a low socio-economic community

Andi Andronicos^A and Helen Achat^{A,B}

^AWestern Sydney Local Health District, Centre for Population Health, Cumberland Hospital Campus,
Locked Bag 7118, Parramatta BC, NSW 2124, Australia.

^BCorresponding author. Email: helen.achat@swahs.nsw.gov.au

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Australia experienced a significant decrease in smoking prevalence^{1,2} in the 1980s and 1990s, from 35 to 23%, which continued into the 21st century, as did other developed countries.^{2–4} Despite this decrease, there are still significantly higher rates of smoking among those with less formal education, those in blue collar occupations and the unemployed.^{5,6} Smokers from disadvantaged communities are just as likely as smokers from high socioeconomic status communities to try aids such as Nicotine Replacement Therapy (NRT) and prescribed medications⁷ and can succeed in quitting. However, they are more vulnerable to relapsing⁸ and need to be encouraged to access existing services and treatments⁹ across diverse settings.¹⁰

This study was conducted to test the viability of utilising Drug and Alcohol (D&A) counsellors to deliver ‘quit clinics’, offering NRT in conjunction with behavioural support in three New South Wales Community Health Centres (CHC) to reach smokers from low socioeconomic backgrounds. A Medline search yielded no studies of D&A counsellors in Australian CHC settings offering behavioural support and/or subsidised or no-cost NRT. The Sydney West Area Health Service Human Research Ethics Committee approved this study.

Four counsellors attended a 3-day course on Nicotine Addiction and Smoking Cessation. From July 2007 to August 2009, counsellors offered nicotine-dependent clients aged 18 years or older 2 weeks of no-cost NRT via a community-based pharmacy voucher system, a plan for extended use of NRT, individually tailored face-to-face and telephone counselling sessions, and supporting materials.

Recruitment relied on referrals from GPs, wide dissemination of a program brochure, and publicity via articles, advertisements and community diary entries in local newspapers. The pilot service was promoted to GPs and community-based pharmacies via guest appearances at their professional functions and through advertisements and articles in their newsletters.

Information collected included clients’ demographic data, medical history and assessment, treatment and discharge details. The

Fagerström Test for Nicotine Dependence¹¹ was used to measure the degree to which smokers would experience nicotine withdrawal. The score determined the appropriate treatment to reduce the severity of withdrawal symptoms. For consenting clients who were followed up at 3 and 6 months by telephone, additional information was collected about smoking status together with feedback about the service. One-on-one interviews were conducted with the four counsellors.

The 117 clients (57 females, 60 males) ranged in age from 18 to 69 years, with a mean age of 46 years. The majority were pension or benefits recipients (66%), lived in public (38%) or private (23%) rental accommodation and, if employed, were labourers (28%) or tradespersons (14%). Most clients were nicotine dependent only (80%) and had high to very high dependence (80%), which warranted higher dosages of nicotine replacement. Out of those who commenced, 67% completed treatment (Table 1).

Of the 80 clients who agreed to follow up, 72 participants were interviewed at 3 months and 66 at 6 months. The percentage of clients who reported having quit smoking was 29% at 3 months and 17% at 6 months, consistent with the literature.¹² Those who had relapsed cited stress, family issues and being exposed to other smokers as reasons for not being able to quit or stay quit.

Three aspects of the service that clients considered important/very important were the counselling sessions (86%), the first week’s free NRT (91%) and ease of access to the CHC (97%). The clients’ overwhelming satisfaction largely reflected their recognition that ‘the biggest strength of the service was its counsellors’ and is indicative of the skills of the counsellors. The open-ended question, ‘What was the best thing about the service?’ elicited responses such as: ‘The actual counsellor I had sympathetic, never felt pressured, good common sense and a lot of knowledge. Appointment schedule was very flexible.’ and ‘The counsellor rang back and followed up. Made sure I made it to follow-up appointments; the support and counselling’.

From the counsellors’ perspective, the strengths were the actual face-to-face interactions, the no-cost NRT and the experience of being part of successful quit attempts. Working with nicotine-

Table 1. Program clients' demographics, smoking and health profile, and participation (n = 117)

Characteristic	Description	n	%
Sex	Female	57	48.7
	Male	60	51.3
Age	Mean age	46	
Income	Full-time employment	28	23.9
	Temporary benefit	22	18.8
	Pension (e.g. aged, disability)	55	47
	Other	12	10.5
Accommodation ^A	Private residence – owned or purchasing	44	37.9
	Private residence – private rental	27	23.3
	Private residence – public rental	44	37.9
	Other	1	0.9
Occupation	Professionals	5	4.3
	Tradespersons and related workers	16	13.7
	Clerical, sales and transport workers	18	15.4
	Other	45	38.5
	Pension/retired	21	17.9
	Other employment	8	6.8
	Not working	8	6.8
	Other (not stated)	7	5.9
Drug	Nicotine dependent only	94	80.3
	Co-dependent (nicotine with alcohol and/or other substance)	23	19.7
Fagerström Test for Nicotine Dependence ^A	Very low to low dependence	11	9.5
	Medium dependence	12	10.3
	High to very high dependence	93	80.2
Contact sessions	Face-to-face (mean average)	2.7 sessions	–
	Telephone (mean average)	1.5 sessions	–
	Total mean average	4.2 sessions	–
Reason for cessation of treatment	Treatment completed	78	66.7
	Left without notice	18	15.4
	Other	21	17.9

^An = 116 because of missing data.

dependent clients offered a change of clientele for some counsellors.

Strategic efforts by D&A counsellors at CHC can successfully reach and provide local 'quit services' to clients from low socioeconomic communities. The 2011 Federal Government initiative to provide subsidised nicotine patches on the Pharmaceutical Benefits Scheme addresses the clients' main concern of access to affordable NRT. This Pharmaceutical Benefits Scheme listing, in conjunction with accessible local D&A counsellors, optimises NRT access and counselling support for quit attempts. These initiatives begin to address the increased risk of relapse experienced by vulnerable groups. Replication of the provision of quit services incorporating access to D&A counsellors at local CHC will ascertain its value among competing priorities for disadvantaged communities.

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