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Use and Outcomes of a State-Funded In-Person Counseling Program

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Many tobacco control programs include cessation services; however, few include free in-person counseling. We could locate only three descriptions of use and outcomes of free in-person counseling in a real-world setting ¹⁻³; thus, we describe our experience with in-person counseling in Vermont (VT).

Vermont intensified its tobacco control program in 2001 using Master Settlement Agreement funds (<http://humanservices.vermont.gov/tobacco>). In the last few years, cessation components include a) access to a quit-line run by the American Cancer Society (www.cancer.org/docroot/PED/content/PED_10_5_1x_Quitline_Partnerships.aspx), b) a cessation website (www.quitnet.com), c) free or reduced-cost nicotine replacement therapy (NRT) and d) an in-person counseling program based at local hospitals (www.healthvermont.gov/prevent/tobacco/index.asp). Media spots refer smokers to the quitline or to their local hospital. The in-person program includes group programs based on the American Cancer Fresh Start (www.acsworkplacesolutions.com/freshstart.asp) or the American Lung Association Freedom From Smoking Programs (www.ffsonline.org) and individual counseling by Tobacco Treatment Specialists (TTSs). The program has trained 30 TTSs and almost all completed the University of Massachusetts TTS training ⁴. In 2008 there were 9.0 FTE TTSs based at the 13 VT hospitals.

The outcomes reported below are from the 2008 VT Adult Tobacco Survey (ATS) and the 2009 VT Cessation Services reports prepared by RTI International (for the State of Vermont (<http://humanservices.vermont.gov/tobacco>)). The VT ATS surveys, by random digit dialing, Vermont adult (18+) residents during the fall of each year. The survey target is 1,000 current smokers and recent quitters plus 1,000 never smokers and former smokers (> 1 yr abstinent). In 2008, 1609 smokers (1.9% of VT smokers) used the in-person program whereas 1083 (2.8%) used the quitline and 663 (1.2%) the internet program. Over half (62%) of VT smokers made at least one attempt to quit in the last 12 mo and 76% of smokers were aware of the in-person program. Thus, among those who were aware and made an attempt to quit in 2008, about 4% used the in-person program. In comparison, 3–6% of English recent quitters used in-person counseling ⁵ (www.smokinginengland.info/Ref/smokinginenglandoverview%281%29.pdf). Over the life of the program (since 2001), about 14,000 VT smokers (or about 13% of VT smokers) have attended in-person counseling.

Compared to the quitline and internet programs, the in person program had older, heavier and more dependent smokers; e.g., 48% of Quit in Person clients smoked their first cigarette immediately upon arising vs. 34% of quitline clients. Most clients (82%) of the in-person program returned for a second visit compared to 56% of the phone counseled and 26% of the internet clients. Depending on assumptions about missing data, between 54%–81% of those in the in person program used medication with their quit attempt.

Participants in the in-person program were called by an independent evaluation firm (www.macrointernational.com) at 3, 6 and 12 mo to report smoking status. No biochemical verification was attempted (nb- biochemically verified results are usually < 5% lower than self-reports⁶.) In 2008, the response rate at 12 mo was 45%. If only those who were reached are included in the abstinence rate, the 7 day point prevalence quit rate was 39%. If all those who were not reached were assumed to be smokers, the quit rate was 18%. In comparison, the abstinence rates in UK, US, and Spanish programs were 15%², 22%¹, and 55%³ using similar abstinence criteria. Also, in the 2000 USPHS meta-analyses of studies of intensive counseling and of nicotine products using similar outcomes, the long term point prevalence rates were typically 25–30%⁷.

We conclude a state-funded, free, in-person counseling program a) is as popular as quitline or internet programs but is still used by only a small minority of smokers trying to quit, b) attracts heavier, more dependent smokers and retains them for multiple sessions, and c) produces quit rates similar to other real-world programs and to that produced in research efficacy studies. Thus, we believe a) an in person program will not generate excessive demand and overwhelm resources, b) serves smokers who probably need more intensive treatment, and c) produces outcomes similar to those obtained by specialists in research clinics.

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