Addictive Behaviors 84 (2018) 193–200

Contents lists available at ScienceDirect

Addictive Behaviors

journal homepage: www.elsevier.com/locate/addictbeh

Integrating smoking cessation care into routine service delivery in a medically supervised injecting facility: An acceptability study

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HIGHLIGHTS

- The smoking prevalence among people who inject drugs is high.
- Smoking cessation care was integrated at a supervised injecting facility (SIF).
- An organizational change intervention was piloted to ensure change in practices.
- Staff and clients reported significant increases for nearly all care strategies.
- Treating smoking at the SIF was deemed highly acceptable by staff and clients.

ARTICLE INFO

Keywords:
People who inject drugs
Organizational change
Supervised injecting facility
Drug consumption room
Smoking cessation care
Tobacco smoking

ABSTRACT

Background: Among people who inject drugs (PWIDs) the prevalence of tobacco smoking exceeds 80%; making smoking cessation intervention a priority for this population. This study aims to examine staff and client perspectives from a supervised injecting facility regarding: i) whether an organizational change intervention increased rates of smoking cessation care delivery (pre- to post-intervention); and ii) acceptability of the intervention.

Methods: A pre-and-post intervention pilot study in a supervised injecting facility was conducted in Sydney, Australia between July 2014–December 2015. The intervention employed an organizational change approach and included six components. Cross-sectional samples of staff (pre $n = 27$, post $n = 22$) and clients (pre $n = 202$, post n = 202) completed online surveys pre and post intervention.

Results: From pre to post-intervention staff reported smoking cessation practices significantly increased for the provision of verbal advice (30% to 82%; $p < 0.001$), offer of free or subsidized nicotine replacement therapy (30% to 91%; $p < 0.001$), referral to a general practitioner (19% to 64%; $p = 0.001$), and follow-up to check on quit smoking progress (18.5% to 64%; $p = 0.001$). Significantly more clients reported receiving all smoking cessation strategies post-intervention. Over 85% of staff agreed that it was acceptable to address client smoking as part of usual care and 95% of clients agreed that it was acceptable to be asked by staff about their tobacco smoking.

Conclusions: Increasing the provision of smoking cessation care using an organizational change approach is both feasible for staff and acceptable to staff and clients of supervised injecting facilities.

1. Introduction

The tobacco smoking rate among people who inject drugs exceeds 80%.(Bowman et al., 2012; Shin et al., 2013) Chronic tobacco-related conditions account for a growing proportion of morbidity and mortality for people who inject drugs.(Marshall, Kirk, Caporaso, et al., 2011)

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https://doi.org/10.1016/j.addbeh.2018.04.001
Received 3 November 2017; Received in revised form 27 March 2018; Accepted 2 April 2018
Available online 05 April 2018

Studies examining quit attempts and quitting interest among people who inject drugs suggest that those seeking treatment are willing to engage with smoking cessation strategies.(Clarke, Stein, McGarry, & Gogineni, 2001; Shin et al., 2013) Further there is considerable data suggesting that quitting smoking contributes to improved drug outcomes.(Friend & Pagano, 2005a; Friend & Pagano, 2005b; Moore & Budney, 2001) Given their focus on harm reduction, supervised injecting facilities have the potential to be supportive environments to assist people who inject drugs to quit smoking.

Studies are yet to explore whether supervised injecting facilities are addressing client smoking. Research with similar harm reduction services such as methadone maintenance programs report varying levels of smoking cessation care provision by staff, ranging from: 73% providing brief advice to quit,(Richter, Choi, McCool, Harris, & Ahluwalia, 2004) 18%–97% offering individual or group smoking cessation counselling, (Olsen, Alford, Horton, & Saitz, 2005; Richter et al., 2004) and 12% prescribing nicotine replacement therapy (NRT).(Olsen et al., 2005; Richter et al., 2004) Barriers to the provision of smoking cessation care include AOD staff beliefs and attitudes such that: tobacco smoking is a low priority for their clients given the number of other acute health problems(Hall & Prochaska, 2009; Hurt, Croghan, Offord, Eberman, & Morse, 1995) and fear that smoking cessation will negatively impact upon other treatment outcomes.(Bobo, Slade, & Hoffman, 1995)

Organizational change interventions such as the Addressing Tobacco Through Organizational Change (ATTOC)(Guydish, Ziedonis, Tajima, et al., 2012; Ziedonis, Zammarelli, Seward, et al., 2007) and Systems Change Approach(Fiore, Keller, & Curry, 2007) have been developed specifically for increasing smoking cessation care delivery in the alcohol and other drug setting. Preliminary evidence suggests organizational change interventions have been successful at changing staff and client attitudes and practices to smoking treatment.(Guydish et al., 2012; Hoffman, Kantor, Leech, et al., 1997; Sharp, Schwartz, & Novak, 2003; Ziedonis et al., 2007) Few studies, some with relatively small samples, have addressed client cessation rates and produced mixed results.(Campbell, Krumenacker, & Stark, 1998; Deal, Newcombe, Walker, & Galea, 2014; Guydish et al., 2012; Patten, Martin, & Owen, 1996; Poole, Greaves, & Cormier, 2003; Vest, Kane, DeMarce, et al., 2014) An organizational change approach is likely to achieve sustained integration of smoking cessation care into the routine practices of health services.(Guydish et al., 2012; Jessup, 2007; Knudsen, Studts, Boyd, & Roman, 2010) Further, such interventions are found to be both acceptable to staff and clients in the alcohol and other drug setting.(Christiansen, Brooks, Keller, Theobald, & Fiore, 2010; Deal et al., 2014)

The acceptability of an organizational change intervention that implements smoking cessation care into supervised injecting facilities remains unexplored. Acceptability is a key consideration for successful implementation and maintenance of interventions in any healthcare setting.(Nahhas, Wilson, Talbot, et al., 2016) In the context of this study, acceptability refers to the suitability of assessing smoking status and providing smoking cessation care. If an intervention is suitable, staff and clients are more likely to benefit however if the intervention is considered to have low acceptability it may not be delivered as intended and therefore not have the desired outcomes. This study examined staff and client perspectives from a supervised injecting facility regarding: i) whether an organizational change intervention increased rates of smoking cessation care delivery (pre- to post-intervention); and ii) the acceptability of the intervention.

2. Methods

2.1. Setting

Participants were recruited from a non-government managed medically supervised injecting facility which operates daily in Sydney, New South Wales (NSW), Australia. It is the only such facility in the Southern Hemisphere and in 2015–2016 supervised an average 4100 injections a month by approximately 600 clients (Jauncey, *unpublished data*). Persons registering and utilizing the service can do so without providing any personal information (e.g. name, address, and, contact details). On initial consultation at the facility, each person is provided with a unique identifying number which they use when accessing the facility. The facility has a three-stage client visit: stage 1 is the waiting room and assessment area; stage 2 is the injecting room; and stage 3 is the aftercare, drug referral, and health promotion area. This intervention was conducted primarily in stages 1 and 3.

2.2. Design

A pre and post intervention pilot study was conducted in July 2014–October 2016. Staff were asked to complete an online survey prior to intervention implementation (pre-intervention phase) and after implementation of all organizational change strategies (post-intervention phase). A cross-sectional sample of clients were informed about the study in stage 1 and asked to complete a computer administered survey in the aftercare room (stage 3) at pre-intervention and post-intervention (Fig. 1). Given that personal details are not collected at the service to ensure privacy, clients could not be followed up by researchers, and two cross-sectional samples were recruited instead (pre and post).

2.3. Participants

2.3.1. Staff

Eligible staff were: current employees who worked at least one shift every two weeks at the supervised injecting facility during the study period, had therapeutic client contact (e.g. doctor, nurse, counsellor, health education officer), and, were in a role where treatment was part of their normal duty (i.e. staff members employed in administrative and other/unspecified roles were excluded).

2.3.2. Clients

Eligible clients were adult current tobacco smokers currently engaged with the supervised injecting facility. For the post-intervention survey only, recent quitters who ceased smoking in the last 12 months were also included.

2.4. Procedures

Prior to study commencement, written organizational consent was obtained from the facility director. Ethical approval was obtained from the University of Newcastle Human Research Ethics Committee (Approval No H-2013-0082).

2.4.1. Pre-intervention phase

2.4.1.1. Staff. The site contact to the research team was sent an invitation email containing the participant information statement and hyperlink to the online survey for distribution to eligible employees. Weekly e-mail reminders were sent for three weeks.

2.4.1.2. Clients. During the study period, when clients presented to stage 1 at the facility, staff members notified all individuals that they would be approached by a research assistant for informed consent to complete a survey in stage 3 (after care). Stage three was selected as the recruitment site following consultation with the management team who indicated that clients were agitated prior to their injection (stage 1), the injection room is not a safe setting for conducting research (stage 2), and that clients are calmer in stage 3. On entry to stage three, clients are fully conscious following their injection. Ability to give informed consent was an eligibility criterion and if clients were judged unable to do so by service staff the research assistant did not approach them. All participants were provided with participant information statements. Survey completion constituted consent. The survey was administered to