THE BELFAST SMOKING WITHDRAWAL CENTRE:  
A PRELIMINARY REPORT

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MANY methods of assisting smokers to give up tobacco have been described, such as the use of pamphlets, posters, hypnosis, aversion therapy, individual counselling and group clinics (Delarue, 1973; Russell et al, 1976; and West et al, 1977). In 1974 a survey revealed that in Northern Ireland no medically supervised organisation existed to cater for individuals seeking help to stop smoking (Scott, Nabney and McCullough, 1974). The results obtained by smoking withdrawal clinics in the U.K. and U.S.A. varied considerably, and on the whole were rather discouraging (Ejrup, 1964; Ball et al, 1965; and Conrad, 1971). Nevertheless, it was felt worthwhile to carry out a two-year study of the value of a Belfast-based smoking withdrawal centre, in which a variety of methods would be used to help smokers to stop smoking (Wood, 1977). This preliminary communication presents the results of the centre’s first year of operation.

ORGANISATION AND METHODS

The smoking withdrawal centre operates in the premises of and with the financial support of the Ulster Cancer Foundation. By means of leaflets circulated to doctors and dentists and by publicity in the media, the attention of the medical and lay public was drawn to the existence of the centre. The sessions are held weekly and no charge is made for attendance. At the initial visit each client is interviewed by one of the authors and relevant social and medical details such as age, sex, cigarette consumption and symptoms related to tobacco are recorded. Clients with symptoms suggesting the need for further investigation are referred to their general practitioner. Height and weight are measured, and respiratory function is assessed by means of a vitalograph.

Having taken time to establish rapport with the new client, the doctor gives him several booklets setting out the hazards of smoking and suggesting several alternative modes of stopping. Each client is given a “smoking chart” in which each day of the week is divided into compartments, and he is asked to record with a mark in the appropriate compartment of the sheet every cigarette smoked. It has been shown that this activity focuses the smoker’s attention on the magnitude of his problem and enables advice to be concentrated on periods of peak consumption (Ball, Kirby and Bogen, 1965; Scott, 1977).
Following this short session of individual counselling, all the clients see a film from the centre's film library. These films seek in different ways to present the facts about the serious damage to health caused by cigarette smoking. Afterwards a one-hour group therapy session is held, with the film acting as a stimulus to discussion. Members of the group recount their own smoking problems and help each other by describing how they overcame them. The group leader simply prevents discussion from wandering from the subject, and the doctor provides factual information. Clients who have already stopped smoking discuss how they overcame the difficulties experienced after stopping smoking, and those who have stopped smoking longest encourage those who have just stopped.

Clients are asked to attend six consecutive weekly evening sessions. At second and subsequent visits clients chat informally amongst themselves before the film and group discussion. They are urged to have stopped smoking completely by the third or fourth visit. Having completed the six-week cycle, clients are welcome to attend periodically, both to strengthen their resolve to remain non-smokers and to encourage new clients. Clients requiring support during the week can telephone the centre and either speak to one of the staff or listen to a pre-recorded message on tape. Clients are being reviewed after six months and thereafter will be followed up at yearly intervals.

RESULTS

One hundred and sixty-four clients (69 men and 95 women) attended at least one full session at the centre. Ninety-seven (59 per cent) had heard of the centre through publicity in the press and on television, and 17 through finding leaflets about the centre in doctors' and dentists' waiting-rooms. Nine were referred by doctors and 41 came on the recommendation of clients who had already attended the centre. One hundred and thirty-four clients (82 per cent) cited concern for their health as the principal reason for deciding to stop smoking. Eighteen (11 per cent) said that their principal reason was financial, and 12 (7 per cent) gave other reasons, usually related to their family. Cough was the commonest symptom reported by clients.

The ages at which clients had started to smoke regularly are indicated in the figure. The mean age of commencing regular smoking was 17.5 years. The mean cigarette consumption recorded at the first visit was 29.8 daily. Forty-three per cent smoked 30 cigarettes or more daily.

The short-term success rate, defined as complete abstinence from smoking for one week or more at the time of the last visit to the centre, was related to the number of attendances (Table 1). Twenty-six of the 40 clients (65 per cent) who attended at least five of the six sessions in the withdrawal programme were successful. Information concerning the success rate among the 69 clients who attended only once is lacking, but for purposes of judging the overall success rate they were all assumed to have failed to stop smoking. This gives an overall success rate of 21 per cent.
Overall 29 per cent of men stopped smoking and 16 per cent of women (Table 2). Clients who initially smoked 30 cigarettes or more daily had a success rate of 23 per cent compared with 20 per cent among those who smoked less heavily (Table 3).

### Table 1

| Number of attendances | Corresponding number of clients | Number stopped at last visit | Short-term success rate per cent |
|-----------------------|---------------------------------|-----------------------------|---------------------------------|
| 1                     | 69                              | ?                           | ?                               |
| 2–4                   | 55                              | 9                           | 16                              |
| 5 or more             | 40                              | 26                          | 65                              |
| Total                 | 164                             | 35                          | 21                              |

### Table 2: Short-term success rate analysed by age

| 164 clients attending | Sub-group | Number | Successful (Short-term) |
|-----------------------|-----------|--------|-------------------------|
|                       | Men       | 69 (42%) | 20 (29%)                |
|                       | Women     | 95 (58%) | 15 (16%)                |
|                       | Total     | 164 (100%) | 35 (21%)                |

### Table 3: Short-term success rate analysed by initial cigarette consumption

| 164 clients attending | Cigarette consumption | Number | Successful (Short-term) |
|-----------------------|------------------------|--------|-------------------------|
|                       | <30/day                | 93 (57%) | 19 (20%)                |
|                       | >30/day                | 71 (43%) | 16 (23%)                |
|                       | Total                  | 164 (100%) | 35 (21%)                |

### DISCUSSION

Several important facts emerged from this preliminary analysis of the clientele attending the Belfast smoking withdrawal centre, and of the short-term results achieved. First, there exists a large number of people in the community who desire help in stopping smoking. The profile of our clientele was similar to that described by other authors. Like West and his colleagues (1977), our clients began smoking young and smoked heavily. As other authors have found (Williams, 1972), the drop-out rate after the first visit was high, 42 per cent of our clients and 40.7 per cent of Williams' failing to attend further sessions. The actual numbers attending, averaging just over three new clients each week, was close to the optimum, as with the high drop-out rate the actual number in the group was usually in the range 8-16.

The great majority of our clients had not been referred by doctors and their overriding desire was to avoid developing smoking-related diseases rather than to
arrest their progress. This contrasts with the clientele attending clinics such as that of Ball, Kirby and Bogen (1965), who were all referred by doctors and of whom 78 per cent already had developed smoking-related diseases.

The tendency for the habit of regular smoking to develop at around the school-leaving age is demonstrated (Figure). The high mean daily cigarette consumption of 29.9 is similar to that reported in other studies (Ball, Kirby and Bogen, 1965; West et al, 1977). Though the average client’s annual expenditure on cigarettes was calculated at approximately £270, it is noteworthy that only 11 per cent regarded the high cost of their habit as being a more important reason for stopping than the health hazard.

The problem of how to analyse the results of a group in which different members attended differing numbers of sessions has been encountered by other workers. Ball and his colleagues (1965) analysed only those who indicated a serious attempt to stop smoking by attending three or more sessions (mean 6) out of the seven in their programme. Orr (1971) excluded those who “lost interest before giving the treatment a chance to be effective”. Williams (1972) eventually stopped registering clients who did not return after the first visit. Our short-term success rate of 65 per cent for those attending five or more sessions is similar to the figures of 60 to 88 per cent quoted by Ejrup (1964). The real problem on which attention is being concentrated now is how to persuade those who attend once to keep on attending.
Compared with the important influence exerted by the number of attendances, other factors such as the sex of the clients and the initial daily cigarette consumption had less effect on short-term success rate. A slightly higher success rate in men has also been found by other workers (Williams, 1972; Delarue, 1973; West et al, 1977). Our finding that the number of cigarettes smoked formerly did not influence short-term success rate coincides with that of West et al (1977). However, these authors found that after five years follow-up there was a higher long-term success rate among formerly light smokers.

The results achieved by the Belfast smoking withdrawal centre in its first year of operation could well be described as disappointing. However, other workers with longer experience have reported that it may take several years for this type of clinic to achieve its full potential (Williams, 1972). We have learned many useful lessons and believe that the effectiveness of the centre in helping people to stop smoking is improving. The second role of the centre is to help those who stop smoking to remain non-smokers. Indeed, some would argue that only the long-term results are really important (Delarue, 1973). We are attempting to follow up clients who have attended the centre, and will report the long-term results later. Only then will it be possible to assess the cost-effectiveness of the centre's work and to advise regarding the setting up of similar centres in other areas.

SUMMARY

The organisation and methods used in Northern Ireland's first medically-supervised smoking withdrawal centre are described. Individual and group counselling, leaflets and films are all employed. In its first year of operation 164 clients sought the centre's help in stopping smoking, 82 per cent because of concern for their health. Their average tobacco consumption was initially 30 cigarettes daily. Women clients outnumbered men but had a lower success rate in stopping smoking. Short-term success in stopping was closely related to the number of sessions attended. Sixty-five per cent of those attending at least five of the six sessions stopped smoking.

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