Potential sources of cessation support for high smoking prevalence groups: a qualitative study

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Abstract

Objective: This study aimed to: i) explore potential sources of cessation support as nominated by disadvantaged smokers; and ii) identify factors influencing decisions to use these sources.

Methods: Semi-structured interviews were conducted with 84 smokers accessing community service organisations from the alcohol and other drugs, homeless, and mental health sectors. Transcripts were coded and thematically analysed.

Results: Doctors emerged as the most commonly recognised source of cessation support, followed by Quitline, community service organisation staff; and online resources. The main factors contributing to the possible use of these sources of support were identified as awareness, perceived usefulness and anticipated emotional support.

Conclusions: The results suggest that doctors are an important group to consider when developing cessation interventions for disadvantaged smokers due to their recognised ability to provide practical and emotional support. However, efforts are needed to ensure doctors are aware of the benefits of cessation for these groups. Community service organisations appear to be another potentially effective source of cessation support for disadvantaged smokers.

Implications for public health: The results indicate that cessation interventions among high-priority groups should endeavour to provide personalised emotional and practical support. Doctors and community service organisation staff appear to be well-placed to deliver this support.

Key words: tobacco, smoking, cessation support, disadvantage, community service organisations

Australia has among the lowest rates of smoking in the world. The population prevalence of daily smoking is currently at 12%;[1] however, rates are significantly higher among specific population segments. These include people living with a mental illness (29%–70%), people experiencing alcohol and other drug dependence (77%–93%), and people experiencing homelessness (76%–84%).[1–6] Different forms of disadvantage often occur in combination (e.g. people experiencing homelessness can also be living with a mental illness and experiencing alcohol and other drug dependence).[7] Due to high smoking prevalence rates, these groups are disproportionately affected by tobacco-related illnesses.[8] A majority of people experiencing disadvantage have been found to express an interest in quitting smoking.[9] However, they often have lower levels of success when quitting than other people who smoke.[9]

The likelihood of quit attempts being successful can be improved when sources of cessation support are used.[10-12] Many services are available in Australia to provide support to people to quit, such as brief interventions from health professionals, the Quitline telephone counselling service, and online services such as the smartphone application My QuitBuddy.[13] Overall, the sources of cessation support most commonly accessed in Australia are doctors (10%), cessation literature (9%), internet resources (5%), smartphone applications (4%), and the Quitline (2%).[1] Sources of cessation support that have previously been identified as being acceptable among vulnerable populations (e.g. Indigenous peoples) include doctors and interventions delivered via mobile phones.[14,15]

Although utilisation rates of cessation support services by Australian smokers of lower socioeconomic status have improved over time to be relatively on par with smokers of higher socioeconomic status,[14] little is known about the cessation behaviours of people experiencing other forms of disadvantage such as homelessness, mental illness, and alcohol and other drug dependence. These smokers may face unique barriers to using cessation support. For example, health professionals have been found less likely to provide people living with a mental illness or alcohol and other drug dependence with cessation support due to the belief that: i) cessation can be detrimental to clients' mental health; ii) other aspects of treatment are prioritised; and/or iii) their clients do not want to quit.[16,17] These perceptions exist despite evidence that smoking cessation does not significantly affect substance use treatment outcomes or symptoms of mental illness and, in some

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cases, can improve both.[18,19] Other barriers to receiving cessation support among smokers experiencing disadvantage include limited access to healthcare due to a lack of transportation, being stigmatised due to living with a mental illness and/or alcohol and other drug dependence, and doubts about the usefulness of quit support.[20-22]

The limited previous research with high smoking prevalence groups has tended to focus on general barriers to quitting.[17,21] Prior work does not appear to have investigated the factors influencing the acceptability of various sources of cessation support, and this information is needed to develop strategies to increase the acceptability and attractiveness of support options. To address this knowledge deficit, the present study focused on attitudes to sources of cessation support among three priority groups: people experiencing homelessness; mental illness; and/or alcohol and other drug dependence. The study aims were to explore the potential sources of cessation support identified by smokers experiencing disadvantage and gain a greater understanding of the factors that influence their decisions to use these sources. The findings can inform future efforts to increase utilisation of evidence-based sources of cessation support among members of these groups.

Methods

Semi-structured individual interviews were conducted with clients accessing community service organisations (CSOs) located in metropolitan and regional Western Australia. CSOs are not-for-profit organisations that provide services to members of the community who are experiencing disadvantage. The interviews were conducted as a part of a larger study investigating tobacco-related attitudes and behaviours among clients in CSOs.[23] The researchers who conducted the interviews were experienced in the area of tobacco control.

Recruitment

Interviewee recruitment took place in seven non-profit CSOs (see Table 1). To be eligible to participate, CSO clients were required to be aged 18 years or older, a current smoker and English-speaking. Clients were informed about the study by CSO staff via announcements and signage located around the services and were able to approach the researchers if they wanted to participate.

No incentives were offered to clients in exchange for their participation in the study. Interviewees were asked to provide written and/or verbal consent to be interviewed and audio recorded. In the case that consent to being recorded was not given (n=4), a second researcher took detailed notes throughout the interview. On average, the interviews lasted 25 minutes (range 6–49 minutes).

Data collection

Interviews were conducted between March 2016 and March 2017. Two researchers spent approximately one week at each CSO location to allow clients time to become comfortable with their presence and to approach them if/when they were ready. Upon expressing their interest in participating in the study, interviewees answered preliminary questions relating to their age, gender and main source of income. An interview guide was used to direct a general discussion about interviewees' tobacco use. Topics relating to the larger study included clients' smoking history, what they like/dislike about smoking and their views on tobacco control regulations. The topics raised with interviewees that related to the present study were their experiences with and interest in quitting and where they could receive information/help if they ever wanted to quit (e.g. "Where would you go to get support if you were at the point of wanting to quit?"). This approach ensured that interviewees who did not express an interest in quitting were still asked if they knew where they could receive cessation support. If not mentioned spontaneously, interviewees were also asked about any quit support provided to them by the CSO staff (e.g. "Have you spoken to the staff here about your smoking?" or "How would you feel about staff offering you support to quit or cut down smoking?").

Table 1: Community service organisation categories.

CSO type	Number of CSOs	Location	Number of clients interviewed (n=84)
Mental health	2	2 metropolitan	19
Homeless	3	2 metropolitan	32
		1 regional	9
Alcohol and other drugs	2	1 metropolitan	21
		1 regional	3
Total	7	5 metropolitan	72
		2 regional	12

Data analysis

Interview recordings were transcribed verbatim. Transcripts and detailed notes were imported into the qualitative data analysis program NVivo 11. Interviews were coded by line unit and the coded data were then thematically analysed. Data were coded by a single coder (the first author) and an emergent coding process was used to allow novel findings to be identified. The sections of the transcripts that related to sources of cessation support were read by a second researcher and potential themes were discussed to reach a consensus on the findings. The other members of the research team were then consulted to refine the findings.

Results

Sample

Eighty-four CSO clients participated in the interviews. Table 2 shows the demographic characteristics of the sample. Most of the sample members were male (75%) and reported government payments as their main source of income.

Potential sources of cessation support

Most of the interviewees had previously attempted to quit smoking and reported an interest in trying again in the future. Lengths of sustained cessation in the past ranged from days to years. Most of the minority who did not wish to quit still nominated potential sources of cessation support should they decide to quit. Overall, whether discussing past or future quit attempts, the hierarchy of sources of support identified by interviewees remained the same. Doctors were the most commonly identified source of cessation support, followed by the Quitline, then CSO staff and finally online resources. Results were comparable across age groups.

Factors influencing intentions

Three factors were described as being the primary decision criteria used to assess cessation support options: i) awareness of the existence and availability of the source of quit support; ii) the perceived usefulness of the information provided by the source; and iii) the anticipated emotional support (e.g. encouragement and motivation) offered by the source. The matrix shown in Table 3 illustrates how each source was rated in terms of these criteria. The number

of ticks represents the extent to which the relationship between the source and the relevant decision criterion was evident in the interviewee discussions. The findings relevant to each source of support are outlined below and are accompanied by illustrative quotes from the interviewees. The following descriptors have been used: gender: F=female, M=male; type of CSO: AOD=alcohol and other drugs, H=homelessness, MH=mental health; and CSO location: metropolitan, regional.

Doctors

When asked about where they could access information and/or support to quit smoking, interviewees from all three types of CSOs most frequently mentioned doctors, although this was especially notable among those attending mental health services. Most who spoke about doctors referred to general practitioners (GPs), with doctors who work in hospitals and dentists also mentioned occasionally. The high unprompted awareness of doctors appeared to have been at least partly due to this form of assistance occurring in both active and passive modes: smokers can ask doctors for quit assistance and doctors can raise the topic of quitting with their patients.

> *(Quitting is) brought up constantly when you're a stroke sufferer. But then … you make the decision to say, 'I want to make sure I survive'. So, from there they just kept encouraging it and looking for ways (they) could help.* (M, H, metropolitan)

The interviewees generally described doctors as being able to provide useful information about quitting, especially in terms of cessation medications and nicotine replacement therapies (NRT).

> *I went to my doctor's just last week, actually. I said to her, 'My lungs are feeling like shit, I need the patches'. So, we're starting on the 21 milligrams … But hopefully within the first two weeks, I should not need the 21 milligrams anymore because 21 milligrams is prescribed for people who are smoking 20 a day … which I'm not. So, she's even suggested to cut the patch in half.* (F, H, metropolitan)

High levels of trust were expressed, although at times this was a double-edged sword due to the reported tendency for some doctors to advise against quitting and the acceptance of this advice by smokers. This situation appeared to be most prevalent among those accessing mental health services, with tobacco use apparently considered a secondary health priority for some of these patients, consequently negatively affecting their self-efficacy.

> *I've had (doctors) say to me, 'Don't give up smoking just yet, because you'll fail'. I had too much going on … Yeah, and they were right. I would have failed and just put myself through a bit of trauma for nothing.* (F, MH, metropolitan)

> *I'm trying to quit meth and I'm trying to quit marijuana and I miss my kids and all that sort of stuff. And to quit smoking at the same time, I got told by the GP not to do it.* (M, MH, metropolitan)

As well as being a valued source of advice, doctors were described by some interviewees as being willing and able to provide the emotional support needed to achieve successful cessation. In particular, some interviewees reported having seen the same doctor for an extended period of time, and thus having an established relationship that gave the doctor a firm understanding and appreciation of their circumstances.

> *I'd go straight to my GP. I've got an amazing doctor at home. She's wonderful. If I went to her and said, 'That's it, I want to quit smoking,' she'd be like, 'Yep, no worries, about time, let's go'. She'd be there for me.* (F, AOD, metropolitan)

Table 2: Sample demographics (n=84).

Attribute	n	%
Age (years)		
18-24	7	8
25-34	16	19
35-44	16	19
45-54	24	29
55+	19	23
Missing	2	2
Gender		
Male	63	75
Female	21	25
Main source of income		
Government payments	65	77
Employment	13	15
Other	3	4
Missing	3	4

Quitline

There were high apparent levels of unprompted awareness of the Quitline as a source of cessation support across the sample. This appeared to be primarily due to the regular promotion of the Quitline during tobacco control campaigns.

> Facilitator: *You said you're wanting to quit, would you know of anywhere to go to get information or support from anyone?*
>
> Interviewee: *No. Except the Quitline, like I've seen on TV.* (F, MH, metropolitan)

Although awareness of the service was high, perceptions of the utility of the information provided by the Quitline were mixed. Some interviewees, especially those who had previously accessed the service, reported that practical information is provided that can assist smokers to quit and stay quit. Others felt that the advice would not be new or would not relate to their particular circumstances, or that the recommended cessation techniques were inappropriate or ineffective.

> Facilitator: *Would you phone (the Quitline) again?*
>
> Interviewee: *No, because I know what they say … The 4 Ds, and the drink and the stuff like that – sip drinks and all that.* (M, H, metropolitan)

> *The guy on the Quitline just said reward yourself with lollies or chocolates or biscuits or something. I would put on too much weight if I did that.* (M, MH, metropolitan)

Perceptions of the emotional support provided by the Quitline were also variable. Some felt that the optional follow-up services offered by the Quitline could provide the support needed to sustain a quit attempt. Others did not like the idea of talking to strangers about their smoking habits, especially if it was necessary to speak to a different person each time.

> *I suppose if I get to the stage where I am quitting and I'm struggling, I would probably ring them then and have a chat with somebody who'll … give me some boost in confidence – definitely.* (M, AOD, regional)

Table 3: Identified sources of cessation support and applicable decision criteria.

Source of support	Decision criteria		
	Awareness of service	Perceived usefulness of information provided	Anticipated emotional support
Doctor	√ √ √ √	√ √ √ √	√ √ √
Quitline	√ √ √	√ √ √	√ √
CSO staff	√	√ √	√ √ √ √
Online resources	√ √	√	N/A

Note: number of ticks indicates extent of relevance.

Quitline is pretty good for some people. I gave them my number. Ringing me back encouraged me to give up and that. (M, MH, metropolitan)

You feel strange ringing a stranger, if it's someone different every time, because then you have to explain everything all over again. (F, H, regional)

Community service organisation staff

If CSOs were not mentioned spontaneously, interviewees were directly asked about their willingness to receive smoking cessation assistance from CSO staff members. Although it appeared to be a form of cessation support they had not previously considered, most were receptive to the idea. Especially among those attending AOD CSOs, addressing their tobacco use was seen as a logical step while they were focusing on their other drug dependence. Some interviewees had already been supplied with various forms of quit support by CSO staff, such as integrating goals to quit smoking into their care plans and the provision of cessation advice and literature. It was also noted that CSO staff could refer clients to other forms of cessation support such as the Quitline and healthcare providers.

I've only just started one-on-one counselling, so my care plan is in its infancy sort of thing … The first goal that I've put in my care plan is to work on my overall fitness and general health. So, sugar, caffeine, nicotine – all those sort of things – because they're all tied in with addiction. (M, AOD, metropolitan)

For instance, here, they provide a lot of things … If they can't do something, they'll refer you to somewhere else. There's hospitals, there's private health centres … there's a variety of networks. (M, H, regional)

In some cases, interviewees reported that they had formed trusting relationships with CSO staff, which enabled them to feel comfortable in seeking or receiving support from them. Similar to the case with doctors, these relationships were described as being conducive to high levels of understanding of the particular circumstances of the individual and hence were considered to be more likely to result in acceptable interactions and outcomes.

If I'm having a hard time of coping, they pick up on it, they're really good. They know – because I'm bipolar, I'm mostly manic most of the time, I don't get really low or something unless I'm triggered. If they see that I'm not coping or I'm not being sociable … then they ask what's wrong and I'm sort of like, 'I'm trying - struggling hard to quit smoking'. We have a little talk and it's a bit like that. (M, MH, metropolitan)

They're good here. They don't judge. They try and help as much as they can. If you are having a bad day and you want to have a cigarette, they'd say, 'You know you don't really want to, but if you must, you must'. But they won't judge you if you do. (F, H, regional)

Online resources

Among the various sources of cessation support discussed by the interviewees, awareness of online resources was relatively low. Of the few who perceived these resources to be a viable option, most indicated that they would either use generic search engines to locate relevant information or access the Quit website. Very few interviewees reported either using or planning to use smartphone applications, and there was no mention of available interactive quit assistance websites that can offer personalised information.

Facilitator: *So, if you were trying to seek some information about quitting – where would you go to find that information?*

Interviewee: *Internet … The search stream would be 'stop smoking' – simple. It's common sense.* (M, H, metropolitan)

Among those using online resources as a source of cessation support, the main types of information sought were facts about quitting and how to source cessation aids.

Me and another guy are jumping online today to look up on the Quit website to look at patches … because when we finish this pouch of tobacco, we are going to make a fairly concerted effort to stop. (M, AOD, metropolitan)

Discussion

This study explored where people from high smoking prevalence groups would seek support during a cessation attempt. The primary factors that appeared to influence interviewees' identification of particular sources of support were awareness of the source, perceived usefulness of the information provided and anticipated emotional support. When discussing quit attempts, most interviewees nominated doctors as the sources of support they could access, followed by Quitline, CSOs and online resources. Results were consistent across the three types of CSOs included in the study (alcohol and other drugs, homelessness and mental health services).

Doctors were the most commonly identified source of smoking cessation support for people experiencing these forms of disadvantage. This finding is in accordance with prior Australian research in which doctors have been found to be the most frequently accessed source of quit support for smokers in general.[1] This preference for doctors seemed to be due largely to the practical information interviewees perceived would be provided (especially regarding NRT and cessation medications), along with relatively high levels of anticipated emotional support. However, some interviewees, particularly those accessing mental health CSOs, had been advised by their doctors that they should not quit smoking because their other health conditions should be prioritised. This experience reflects findings previously reported in the literature that people living with a mental illness and/or affected by alcohol and other drug use are sometimes dissuaded from quitting.[16,17] To reduce health inequities, it is important to address tobacco use among populations with high smoking rates; the findings of the present study suggest that doctors could benefit from receiving additional support, education about current smoking cessation guidelines and training to enable them to better support these groups. People experiencing homelessness may have limited access to traditional healthcare settings and may be more likely to access doctors through street outreach services.[20] These services could also benefit from receiving additional training and support to encourage smoking cessation.

Community service organisations received low levels of awareness as a source of cessation support. However, interviewees were receptive to the idea of receiving information and support from the services they were accessing, especially due to the emotional support they anticipated they would receive from staff during a cessation attempt. Given the interviewees' current use of CSOs, these organisations represent a promising potential source of cessation assistance. Previous research has found that trials of smoking cessation programs offered in CSOs were considered acceptable and useful by clients[24] and that upskilling staff to provide quit support is effective in increasing the provision of cessation advice.[25] A recurring theme in the data was interviewees' desire for ongoing support, especially from

someone who had an understanding of their personal circumstances. For clients who have regular contact with a CSO, staff members could potentially offer this continued support. To address a lack of awareness of CSOs as a potential source of cessation support, organisations could implement policies that include offering brief intervention to all clients who smoke.

Interviewees had a relatively high awareness of the Quitline as a source of cessation support: however, it received mixed responses regarding perceived usefulness and emotional support. For smokers living with a mental illness, it has been found that using the Quitline in conjunction with support from a health practitioner may increase the likelihood of cessation attempts being successful.[26] Some interviewees were hesitant to contact the Quitline because of their preference to discuss the issue with someone who had an understanding of their personal circumstances. The findings indicate that uptake of the Quitline service among CSO clients may be improved by raising awareness of its call-back service and that counsellors can keep confidential case notes so that they will not have to repeat themselves each time they call.

Online resources had a low level of salience and appeared to be rarely used by interviewees. Given that tailored cessation support offered through internet-based resources has been found to improve the likelihood of successful quit attempts among the general population,[27] this option may represent an underused alternative that could be the focus of future interventions. Access to technology is not necessarily a major barrier, as Australians experiencing homelessness have high rates of mobile phone use and approximately three-quarters have access to a smartphone; however, data charges may be a possible barrier to use if public Wi-Fi hotspots are unavailable.[28] Given the lack of research on utilisation of online cessation resources by people experiencing disadvantage, future research could invite members of these groups to assist in the design of online resources to ensure they are acceptable and appropriate for addressing their specific needs. For example, in the present study, online resources were not identified by interviewees as providing emotional support during quit attempts, so future online interventions may include features to address this concern.

Strengths and limitations

The high number of participants for a qualitative study was a strength of the research; however, the sample was confined to people accessing CSOs in Western Australia, so the results may not be generalisable to other geographical locations. A larger sample size may have yielded more differences between clients recruited from different kinds of CSOs. Larger-scale studies may be needed to provide greater insights into these potential differences. In addition, since interviewees were required to opt-in to the study, clients who had a greater interest in quitting smoking may have been more likely to elect to participate in the research. The potential for bias arising from the data being coded by one researcher was minimised through the discussion of emerging interpretations with other members of the research team. The analysis of the interview data from the participants who did not consent to being recorded may not have been as in-depth as for those who were transcribed, given the restrictive nature of note taking. Furthermore, only three priority high smoking prevalence groups were included in the study. Possible areas for future research could be exploring the factors that influence the acceptability of sources of quit support among other high smoking prevalence populations in Australia such as Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people in prison.[13]

Conclusions

This study examined the cessation support options that were most commonly identified by people experiencing disadvantage and the factors that influenced their interest in accessing these services. The results may inform future efforts to provide cessation support to people experiencing disadvantage. In particular, the findings highlight the importance of personalised support and of individuals being able to access assistance from someone who has an understanding of their specific situation. While doctors were considered favourably due to their ability to offer both practical and emotional support, there appears to be a need to address misconceptions among some doctors regarding treating tobacco dependence simultaneously with mental illnesses and/or alcohol and other drug dependence. Future interventions could also focus on CSOs as a setting to provide quit support to high smoking prevalence groups as they already have a trusted relationship and may be able to provide practical and emotional support. Such interventions would ideally upskill staff and introduce organisational policies and strategies that support cessation. Regardless of the form of support provided, the results suggest that cessation interventions among these high priority groups should address the need for emotional support during quit attempts as well as providing relevant and practical information.

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