A qualitative study about smoking cessation with clients of community service organisations that work with disadvantaged families

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Introduction

There is a strong relationship between cigarette smoking and social disadvantage. The greater an individual's level of disadvantage, the more likely they are to start smoking cigarettes and the less likely they are to succeed in quitting.[1,2] Low quit rates among disadvantaged people have been suggested to be related to factors such as: smoking is considered 'normal'; smoking is used as a relief in difficult situations; people lack self-efficacy in quitting; and the lack of affordable and appropriate treatments.[3-6]

To decrease smoking among disadvantaged people, interventions should consist of a combination of measures to address nicotine addiction as well as assistance in dealing with the routines and stresses that are enmeshed with daily smoking patterns.[6] Reaching disadvantaged people for smoking cessation is difficult, however, a recent approach is the integration of quit smoking support into existing networks such as community service organisations (CSOs).[7,10,11] A US study reported that the provision of a very brief (30 second) smoking intervention by a CSO was well received by clients. However, the intervention did not affect participants' intention to quit smoking and highlighted the need for more intensive interventions that address the barriers to quit smoking.[8]

Research with clients from a range of welfare organisations found that clients have a desire to quit smoking and express a need for support to do this.[10] A recent study found that when organisations are offered training, resources and support, there is a positive change in staff members' confidence to address smoking with their clients.[9]

The aim of this study was to determine whether clients of CSOs that work with disadvantaged families consider the organisation to be a suitable avenue for the delivery of smoking cessation assistance, and to explore clients' knowledge and attitudes on smoking, and barriers to quitting.

Methods

Seven focus groups were conducted in the Illawarra region of New South Wales in 2009. Participants were current smokers over 18 years of age. They were recruited via non-government CSOs that provide assistance to disadvantaged families such as child and family early intervention services, and financial and social support. The first author of the study contacted CSOs to discuss options for addressing smoking cessation with their clients. Staff of the organisation invited clients to participate in this study. Participants were offered an incentive of a $40 gift card if they decided to participate.

A series of open-ended questions were used to prompt discussion on smoking and the assistance required to quit smoking (Table 1). The groups were facilitated by the first author and the duration of

Abstract

Issue addressed: To determine whether clients of community service organisations (CSOs) that work with disadvantaged families consider the organisation to be a suitable avenue for the delivery of smoking cessation assistance, and to explore clients' knowledge and attitudes on smoking, and barriers to quitting.

Methods: Seven focus groups were undertaken with clients from CSOs that work with disadvantaged families. Participants were asked questions on effects of smoking on health, barriers to quitting smoking and whether CSOs could provide smoking cessation support. Note-based analysis was undertaken to identify issues.

Results: Participants view CSOs as an acceptable avenue to provide support to quit smoking. Participants had misconceptions about the effects of smoking on health and the desire to quit smoking was not a priority among many participants.

Conclusions: There is a need for smoking cessation support to be integrated into CSOs for disadvantaged families as clients are unlikely to seek support elsewhere.

Key words: Community service organisations, disadvantaged people, smoking cessation

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So what?

As community service organisations have regular contact with disadvantaged people, the integration of smoking-cessation assistance in their programs may contribute to a decrease in smoking among this group of people.

each group was 45 to 60 minutes. The second author took detailed notes which included quotes, discussions, and observations on body language as suggested by Kruger (1998).[11] After the first group, minor modifications were made to the order of questions to improve the flow of discussions. Following each group, the first two authors independently wrote summary comments. Note-based analysis was conducted by the first two authors to identify the main issues, and on the most appropriate quotes to illustrate findings. Data saturation was reached by the seventh focus group.

This research was approved by the University of Wollongong/South Eastern Sydney and Illawarra Area Health Service Human Research Ethics Committee.

Results

There was a total of fifty-three participants. An average of eight participants attended each focus group, with a range of four to 15. There were more female (n=44) than male (n=9) participants.

Knowledge and attitudes

All groups knew that smoking affects the respiratory system such as causing lung cancer, however, in two groups, positive benefits of smoking were the initial responses. "It motivates me" and "… gives me something to look forward to." There appeared to be a general acceptance that people need a drug or vice to get through the day, "Smoking is the worst thing I do – so that's okay."

Barriers on quitting

The smoking ritual gives structure to life and is used as a reward in achieving daily chores. "Wash-up then have a smoke, then clean bedroom have a smoke, vacuum have a smoke. Keeps you on track." Several participants recognised that smoking filled up their day. "Don't know what to do instead of smoking!", "It's like being naked if you go out without them" (i.e. your cigarettes) and so "quitting throws out your whole way of life!"

Smoking and its perceived ability to alleviate stress was a barrier to smoking cessation. "I reckon, when I feel heaps stressed, it could be something really minor… but it seems really out of proportion to me, then I sit down and have a smoke and can rationalise it."

A strong message from all groups was the difficulty in accessing affordable treatment, particularly nicotine replacement therapy (NRT). "I would never pay for patches that might not even work, but would always buy cigarettes in preference because I know I enjoy them."

Support to quit

The majority of participants have tried to quit smoking at some point, however, a small number had never tried to quit nor even considered quitting. The majority of participants did not want more information on the effects of smoking and health, however, all groups overwhelmingly expressed the need for support. "Have lots of info but actually doing something is the problem." In most groups there was a strong request for informal type of support that could be provided by CSOs. "Smoking is a drug, but there is no detox service to quit."

The acceptability of CSOs in providing smoking cessation support

Participants considered it acceptable that CSOs address smoking cessation as they are familiar with the venue and people, and the organisation offers personalised information and support. "You can already ring Quitline or go on the internet for information but need more support, and support from someone who knows what you are going through." The Quitline was often mentioned and when the group was asked whether they would phone the Quitline, the response was: "No, it's not for me," or "I would rather face-to-face."

Participants thought it was advantageous to incorporate smoking information into existing CSOs' programs as clients are: "Not going to be looking for it – [I'm] too busy". It was also recognised that the information needs to be promoted: "I don't think I would approach coordinator to talk about smoking, as I wouldn't relate the two." However, if the information is raised it can be well received. "It [quitting smoking] was mentioned at playgroup and that was okay."

Discussion

Our findings support other studies that suggest that CSOs are an acceptable avenue for providing smoking cessation support for disadvantaged people.[8-10] It has been reported that people need social pressure and to have concerns about their health to quit smoking,[4] however, these factors were not strongly articulated by the participants in our study, with many participants perceiving smoking as an acceptable vice. CSOs are well placed to influence the social norms of their client groups and potentially change people's smoking behaviours.

A study in the UK investigating the design of smoking-cessation services to attract disadvantaged people found there is a need for personalised, non-judgemental and flexible support.[3] This was

Table 1: Focus group questions.

1. What do you think are some of the effects of smoking on your health?
2. What do you think are some of the effects of passive smoking?
3. Do you think you would like more information on the effects of smoking?
4. We intend working with organisations (insert organisation's name) to help people to quit smoking. How would you feel about getting information and support about smoking from staff from (insert organisations name)?
5. Is quitting something you've thought of before?
6. What has made it difficult to stop?
7. What are some things that might help you overcome these barriers?

reflected in our study but, importantly, we found that this group of people were not likely to seek this support elsewhere. The findings from the present study suggest that clients are reluctant to try new smoking cessation treatments if they are expensive and with no guarantee of success, however, there was interest in the provision of affordable quit smoking treatment. This supports other research which found that clients expressed a desire to quit smoking but the cost of NRT was a barrier.[12]

As smoking is deeply embedded in their lives, provides structure and rewards in daily routines, and is perceived as a way of coping with stress,[3,6] these issues need to be addressed in order for people to quit smoking. CSOs may be in an ideal position to assist clients to learn new techniques to replace the role that smoking fulfils in their life.

The limitations to this study are that the participants were predominately female, and from organisations in one region of New South Wales. The results should be interpreted in this context. This study confirms the findings of other studies that suggest that CSOs are an ideal avenue to provide disadvantaged smokers with smoking cessation support.[9,10] Further research is required to determine the impact of smoking cessation support delivered by CSOs on the smoking rates of clients.

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