

**ASH Scotland**  
Tobacco and Inequalities Project



# **Service providers' views on tobacco work with three inequalities groups**

## **(Needs Assessment Report 1)**

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## Contents

ACKNOWLEDGEMENTS .....	3
EXECUTIVE SUMMARY .....	4
1. INTRODUCTION.....	8
1.1 ASH Scotland Tobacco and Inequalities Project.....	8
1.2 Tobacco and health.....	9
1.3 Minority Ethnic Communities.....	10
1.4 Older Adults .....	11
1.5 Mental Health .....	12
2. NEEDS ASSESSMENT RESEARCH .....	14
2.1 Aims and objectives .....	14
2.2 Methods .....	14
2.3 Sampling .....	15
2.4 Analysis.....	16
2.5 Strengths and limitations.....	16
3. FINDINGS.....	17
3.1 ORGANISATIONAL ISSUES .....	17
3.1.1 Funding, staffing and resources .....	17
3.1.2 Partnership working .....	18
3.1.3 Summary .....	19
3.2 TOBACCO USE: PREVALENCE AND EXPLANATIONS.....	19
3.2.1 Minority Ethnic Communities.....	19
3.2.2 Older Adults .....	21
3.2.3 Mental Health .....	21
3.2.4 Summary.....	23
3.3 SMOKING CESSATION: MOTIVATORS AND BARRIERS.....	23
3.3.1 Motivators for quitting.....	23
3.3.2 Barriers to quitting .....	24
3.3.3 Summary .....	26
3.4 SMOKING CESSATION SERVICES .....	26
3.4.1 Knowledge and experience of tobacco work.....	27
3.4.2 Smoking cessation service issues.....	27
3.4.3 Ideas for service development .....	29
3.4.6 Summary .....	33
3.5 WIDER TOBACCO STRATEGIES AND ISSUES.....	34
3.5.1 Second hand smoke and smoking policies .....	34
3.5.2 Cannabis and oral tobacco .....	36
3.5.3 Summary .....	37
3.6 EDUCATION AND TRAINING .....	37
3.6.1 Knowledge and experience of training .....	38
3.6.2 Barriers and shortcomings of training.....	38
3.6.3 Ideas for training development.....	39
3.6.4 Summary .....	42

3.7 RESOURCES AND MEDIA .....	42
3.7.1 Features of leaflets.....	43
3.7.2 Information gaps .....	44
3.7.3 Using and accessing resources .....	45
3.7.4 Other media .....	47
3.7.5 Summary .....	49
3.8 RESEARCH, EVALUATION AND MONITORING .....	49
3.8.1 Knowledge and experience .....	50
3.8.2 Gaps and priorities .....	50
3.8.3 Summary .....	53
4. RECOMMENDATIONS .....	53
5. FURTHER INFORMATION.....	60
6. BIBLIOGRAPHY .....	61
7. GLOSSARY .....	66
8. APPENDICES .....	69
Appendix 1 – Example Interview Schedule.....	69
Appendix 2 – Interview participant information .....	74

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## **EXECUTIVE SUMMARY**

### **Background**

ASH Scotland is the leading voluntary organisation in Scotland tackling tobacco use and plays a key role in raising awareness about tobacco and its harmful effects. A key area of ASH Scotland's work is the *Tobacco and Inequalities Project*, which is now in its third phase (2003-2007). Based on the conclusions and recommendations of previous work in the area, the current project focuses on three target areas:

- Minority Ethnic Communities
- Older Adults
- Mental Health and Well-being

While tobacco is a major health risk for all people, members of these three groups have been identified as having particularly high tobacco use prevalence or inequalities in accessing services. For example, studies indicate that 25% of women aged over-65<sup>1</sup>; nearly 50% of Bangladeshi men<sup>2</sup> and around 70% of patients in psychiatric hospitals<sup>3</sup> are current smokers. However, these groups may not get adequate advice or support to address their tobacco use.

### ***Needs assessment aims and objectives***

The primary aim of the needs assessment research was to find out more about knowledge, attitudes and behaviours relating to tobacco use and quitting among people from the three target groups and among service providers working with these communities. The findings from the research would then be used to identify actions for future development and delivery of smoking cessation services and other tobacco control measures.

Early objectives were to build a socio-demographic profile of the three target groups in Scotland; to describe the key issues in relation to tobacco use for each of the three target groups and to map existing tobacco-related resources and services for the target groups. The successive objectives were to consult with smoking cessation specialists and other service providers about tobacco issues and working with the three target communities; and to consult with the target populations about their perceptions and requirements regarding tobacco use and cessation.

### ***Research methodology***

The needs assessment involved four distinct phases, which overlapped and fed into the each other, using a range of desk-based and primary research methods: literature reviews; service and resource mapping; in-depth interviews with service providers and focus groups with community representatives. This report focuses on interviews with service providers, although three literature reviews, a service and resource directory and a report on focus groups with community members are also available from ASH Scotland.

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<sup>1</sup> Scottish Executive (2000) *The Scottish Health Survey 1998*

<sup>2</sup> Health Education Authority (2000) *Black and Minority Ethnic Groups in England: The Second Health and Lifestyle Survey*

<sup>3</sup> Meltzer *et al* (1996) *Economic activity and social functioning of residents with psychiatric disorders (OPCS Surveys of Psychiatric Morbidity in Great Britain, Report 6)*

In total, 33 service providers, with wide-ranging positions and responsibilities, from a variety of health, academic and voluntary organisations from across Scotland were interviewed. A semi-structured interview schedule was used to guide the interviews, although participants were free to raise other issues that they felt were important. Themes covered included organisational issues and partnership working; knowledge and experience of tobacco work and working with specific client groups; service delivery and development issues; education and training needs; resource requirements and research priorities. Most interviews were on a one-to-one basis and lasted approximately one hour. Interviews were taped and transcribed to help with the analytical process. The transcripts were coded and indexed by researchers to look for key themes emerging from the interviews.

## ***Findings***

The key findings are as follows:

- Most service participants expressed an interest in developing tobacco work with the three target groups and in partnership working, but were constrained by practical matters such as shortfalls in funding, time, staff, experience and other resources.
- Awareness of tobacco use among the three target groups varied, depending on the respondent's background and current job. The participants discussed patterns of tobacco use and suggested explanations for it, based mostly on anecdotal evidence, and identified particular issues for each of the target client groups. A lack of research into tobacco use issues among certain communities was identified.
- The service providers identified a number of factors that they felt would motivate someone to quit, as well as barriers to cessation. These included 'internal barriers' from the service users' perspectives, but also 'external barriers' such as a lack of information or support.
- Knowledge about cessation services varied. Some service providers had little awareness of service available, while others worked in the smoking cessation field. The participants discussed a number of issues relating to existing smoking cessation services and working with the three groups. Raising awareness about the dangers of tobacco and availability of NHS smoking cessation services, and flexibility in service delivery, were identified as key ways of making services more accessible and appropriate to the target groups.
- Experience of tobacco training varied. Some participants had never undertaken any tobacco education courses, whilst others were experienced trainers in this area. The participants identified a number of barriers to delivering or receiving training. They also suggested ideas for tobacco issues training relevant for those working with the three target groups.
- The participants debated the use of printed and audio-visual health promotion resources, and the mass media for informing the public. They felt that it was important to provide information about tobacco and cessation in a variety of formats to raise awareness and improve access to services, but noted that it was important that these were provided in conjunction with support from professionals.

- Some wider tobacco control issues were discussed, particularly smoking policies and the impact that these would have on some client groups. Generally there was support for introducing smoke-free areas, but there were some concerns about prohibiting smoking in psychiatric hospitals and care homes. The use of oral tobacco and cannabis were also identified as other areas that required further work.

## **Conclusions**

The interviews with service providers identified that existing smoking cessation services were perhaps not providing to those most in need – the groups who smoked the most, who were the least likely to stop and who needed the most support in their quit attempts. They also acknowledged that the introduction of smoking policies would have an impact on particular client groups.

The major recommendations resulting from this phase of the research are as follows:

- Smoking cessation services should receive sustained ring-fenced funding and staff should be employed on long-term contracts.
- Local services should be visible, accessible and appropriate to clients from different communities.
- Services should be developed in accordance with Scottish Smoking Cessation Guidelines<sup>4</sup>, but with an awareness that some client groups may need longer or more intensive support.
- Tobacco control networks should engage with a wide range of organisations and professionals.
- Evaluated pilot projects should be established to test out new and innovative approaches working with particular inequalities groups, and the learning from these used to develop appropriate services in future.
- Service users should be involved in the development and evaluation of services.
- Public awareness campaigns are required to alert people to the dangers of second-hand smoke, to raise awareness of smoking cessation services and to provide information about the extent of the new smoking in public places legislation.
- Different levels of education and training are required to ensure that service providers are aware of the importance of addressing tobacco use and are confident to provide appropriate advice and support. (This includes brief advice training for all health professionals and tobacco training in undergraduate and post-graduate/post-registration degrees; tobacco issues training for a wider range of professionals; and training on race awareness and mental health etc for smoking cessation specialists).
- Any training developed should be in-line with Scottish Standards for Smoking Cessation Training<sup>5</sup>, but additional information relevant to particular client groups may be added.

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<sup>4</sup> NHS Health Scotland and ASH Scotland (2004) *Smoking Cessation Guidelines for Scotland: 2004 Update* Edinburgh: Health Scotland

<sup>5</sup> Partnership Action on Tobacco and Health (2003) *Standards for Smoking Cessation*

- There is a need for better co-ordination of health promotion materials and it would be useful to investigate if resources developed in England (e.g. leaflets and telephone quit-lines in other languages) could be adapted for Scotland.
- There is a need for further research into tobacco use prevalence amongst certain groups and about what works best to help different communities to stop smoking.
- There is a need for an audit of the availability of non-smoked tobacco products (e.g. paan, gutkha) in Scotland and a national drive to include health warnings with these goods.

A range of actions is required to tackle tobacco use amongst groups facing inequalities and a range of partner agencies needs to be involved in their implementation. Awareness needs to be raised and preconceptions challenged, both among the public and staff. Strategies for change include awareness-raising campaigns in the mass media; providing education and training for service providers; providing appropriate and accessible smoking cessation services; providing appropriate health promotion resources; implementing and supporting smoke-free policies; and undertaking further research. It is hoped that the above recommendations will be taken forward over the coming years by ASH Scotland, policy makers, health providers and tobacco control partners in order to improve the health of Scotland's people.

## 1. INTRODUCTION

### 1.1 ASH Scotland Tobacco and Inequalities Project

ASH Scotland is the leading voluntary organisation in Scotland tackling tobacco use. Established in 1973, the organisation holds a wealth of experience and knowledge on tobacco issues. We play a key role in raising awareness about tobacco use and its harmful effects. Our main activities are an expert information service, parliamentary lobbying, campaigning, action-based projects and taking forward tobacco control alliances and coalitions.

ASH Scotland campaigns for the implementation of effective tobacco prevention and cessation strategies, to raise awareness of nicotine as an addictive substance and to regulate the activities and products of the tobacco industry. One of our main aims is to ensure that effective support services are in place to help smokers who want to quit. We believe that the most effective way to take forward the tobacco control agenda in Scotland is to work in partnership with other public health agencies, voluntary organisations and statutory bodies.

A key area of ASH Scotland's work is the *Tobacco and Inequalities Project*, which is now in its third phase. Between 2003 and 2007 the organisation is coordinating this national community development project that aims to:

- Raise awareness of the issues and the inequalities that some communities across Scotland face in relation to tobacco and health
- To establish good practice that can be disseminated and implemented across Scotland
- To fund pilot tobacco and cessation initiatives with specific communities where inequalities are evident
- To form partnerships that will increase capacity, maximise sustainability and keep tobacco and inequalities issues high on local and national agendas
- To stimulate positive change in policy and practice

The three initial target areas of the project are:

- Minority Ethnic Communities
- Older Adults
- Mental Health and Well-being

The focus of ASH Scotland's current tobacco and inequalities project grew from the conclusions and recommendations of previous work in the area. The first phase was the Women, Low Income and Smoking Project (WLISP), which operated between 1996 and 1999 and aimed to explore new ways of working to address smoking reduction among women living on low income. The second phase of inequalities work ran from 1999 to 2002 and built on the recommendations of the WLSIP. Both projects stimulated significant interest in developing new approaches to tackling smoking and raised positive expectations and aspirations in the community about future work. Reports on the previous tobacco and inequalities projects are available from ASH Scotland, both in hard copy and on-line. Details are given at the end of this report.

## 1.2 Tobacco and health

Tobacco use is the single biggest preventable cause of ill-health and premature death in Scotland. Scotland has an estimated 1.4 million smokers, representing more than one third of the adult population (Scottish Executive, 2000a). Around 13,000 people in Scotland die every year from tobacco-related diseases, including heart disease and many cancers (Callum, 1998). There are also serious health risks associated with passive smoking (ASH Scotland, 2004a).

While smoking is a major health risk for all people, certain groups within society experience poorer health or inequalities in accessing services. There is a strong correlation between smoking and deprivation, with people on low income being more likely to smoke and more likely to smoke more cigarettes on average. (Scottish Executive, 2000a). Smoking rates are also high among socially excluded groups (NHS Health Scotland and ASH Scotland, 2004). Tobacco use is a major factor in perpetuating inequalities in health.

Tobacco use is a key public health concern and several policies and initiatives have been introduced to tackle the problem. The *1998 UK White Paper on Tobacco* and the *1999 Scottish Public Health White Paper* emphasised the major health risks of smoking and set targets to reduce smoking rates among young people and pregnant women, and to provide more support for adult smokers who want to quit (Department of Health, 1998; Scottish Office, 1999). Subsequent documents reiterated the need to take action on tobacco in order to improve the health of Scotland's population, including the *2003 Scottish White Paper on health* (Scottish Executive, 2003), the recent Scottish Executive *Tobacco Action Plan* (Scottish Executive, 2004b).

As a result there has been a rapid development of smoking cessation ('stop smoking') services in Scotland in recent years. There are now dedicated services helping smokers to quit in all fifteen Health Board Areas. Smoking cessation treatment includes behavioural and pharmaceutical interventions (alone or in combination) that contribute to reducing or overcoming tobacco dependence in individuals and in the population as a whole. Behavioural interventions include brief advice to quit, intensive support for individuals or groups, counselling and cognitive behavioural therapy. Licensed pharmaceutical interventions for smoking cessation in the UK include Nicotine Replacement Therapy (NRT), which comes in many forms including patches, gum, tablets, inhalers and nasal spray, and Bupropion (trade name Zyban), a non-nicotine medication.

The recently updated *Smoking Cessation Guidelines for Scotland* (Health Scotland and ASH Scotland, 2004) gives recommendations for the organisation and implementation of interventions to promote stopping smoking. They advise that specific populations should be offered smoking cessation treatment appropriate to their circumstances. The groups mentioned include original targets such as smokers on low income, young people and pregnant women, although people with particular medical conditions and psychiatric patients are also mentioned.

Meanwhile, the recent *Tobacco Action Plan* recommends that smoking cessation services should address the needs of groups who may be difficult to engage in services and not necessarily catered for by traditional health or workplace settings, such as people with mental health problems and members of ethnic minorities (Scottish Executive, 2004b).

Smoking services are a core element of a comprehensive approach to tobacco control to improve the health of Scotland's population. Other elements of tobacco control include fiscal and legislative interventions, prevention of smoking uptake and wider health promotion initiatives. Another key contribution to tobacco control in Scotland is the new legislation to end smoking in enclosed public places, which will be introduced in March 2006 (Scottish Parliament, Bill 33, 2005).

### **1.3 Minority Ethnic Communities**

Scotland's minority ethnic population is small but growing. At the 2001 census 2% of residents identified themselves as from minority ethnic backgrounds, with the largest group being of Asian origin (General Register Office for Scotland, 2001). The largest minority ethnic populations are in Greater Glasgow and Lothian areas, with concentrations in other major towns and cities.

Minority ethnic groups have a greater risk of developing certain smoking related diseases than the white population. For example, there are higher rates of coronary heart disease, some cancers, hypertension, stroke and diabetes among Britain's minority ethnic population (Balarajan and Raleigh, 1993). Minority populations experience further inequalities in accessing services, due to lack of information, communication difficulties, discrimination or inappropriate service provision (Race Equality Advisory Forum, 2001).

Although there have been no national surveys on tobacco use within Scotland's minority ethnic population, studies from England show that tobacco use varies both within and between different ethnic groups (Eaton, 2004; HDA, 2000a; Sproston, 1999). Overall smoking rates among ethnic minorities appear to be the same, or lower, than those found in the wider population, with minority ethnic groups smoking fewer cigarettes per day.

However, there are notable variations in certain ethnic sub-groups. High rates of tobacco use (over 50%) are found among Bangladeshi men. Heavy smoking (more than 20 cigarettes per day) were also observed for older Indian men and Pakistani men aged 30-49 (HDA, 2000a). Although there are marked gender differences in smoking among certain minority groups, with low rates among South Asian women, there is evidence that smoking prevalence is escalating among young women (ASH Scotland, 2000; WHO, 1999). Indeed, a study on perceptions and experiences of tobacco use among 85 black and minority ethnic adults living in Glasgow in the late 1990s suggest that the overall prevalence of tobacco use may be higher than previously recognised. (ASH Scotland, 2000).

Oral tobacco, such as paan and gutkha, is also common in some South Asian communities. English research found that chewing tobacco products was particularly prevalent among Bangladeshi women (HDA 2000a). Chewed tobacco products are associated with an increased risk of mouth and throat cancers among users (Critchley and Unal, 2003, WHO, 2003). Other forms of tobacco used in ethnic communities include hookah pipes (used to smoke tobacco filtered through water) and bidis (unfiltered, often flavoured, cigarettes wrapped in leaves).

Research has looked at knowledge, attitudes and experiences of tobacco use and cessation within minority ethnic groups. The reasons why people from minority ethnic backgrounds start and continue to smoke are largely comparable to the reasons commonly cited by the White majority population, including peer pressure, family influence, socialising, managing stress and relaxation (ASH

Scotland, 2000; HDA, 2000b). In some communities, smoking is treated as socially unacceptable, particularly smoking among women and younger people (ASH Scotland, 2000; Bush *et al*, 2003). These attitudes could impact on levels of covert smoking.

While most people are aware that smoking is bad for health, one study found that South Asians are less likely to acknowledge the addictive nature of smoking (HDA, 2000b). Knowledge of the links between smoking and respiratory diseases (other than lung cancer), heart disease and oral cancer are also poor (HDA 2000a). Stopping smoking appears to be a more recent phenomenon in minority groups than in the wider population (HDA, 2000a). Studies have found that smokers from minority ethnic backgrounds are more likely to attempt to give up unaided, or to seek advice from within their own social circles, and that there is a low level of awareness of anti-tobacco agencies, pharmacological aids and prevention materials (ASH Scotland, 2000; Rudat, 1994).

In conclusion, there are specific issues relating to tobacco use and access to services in ethnic minority communities that should be taken into account when devising appropriate strategies and services. Service providers should be aware of the minority ethnic population within their area, differences in tobacco use in ethnic groups and should be sensitive to cultural, linguistic and religious factors. It is important not to assume that a 'one size fits all' approach is appropriate for everyone, yet it is equally important not to stereotype and make assumptions about the needs of individuals because of their background. Differences exist between men and women, between generations, between people born in the UK and other countries, and between those with different education levels and language abilities.

For further information on the issues discussed above, see *Tobacco and Ethnicity: A Literature Review* (ASH Scotland, 2004b).

#### **1.4 Older Adults**

Life expectancy is increasing and consequently there is a growing number of older adults in Scotland. At the 2001 census nearly 16% of the population were aged over 65 (General Register Office for Scotland, 2001), with increasing numbers of people living into their seventies and beyond. A rise in both absolute and relative numbers of older people is projected over the next thirty years (NHS Scotland, 2001).

The number of older smokers is increasing steadily as the proportion of older adults in the population rises (Kerr, Watson and Tolson, 2002). In Scotland it has been estimated that around a quarter of the 65-74 age group smokes regularly (NHS Scotland, 2001), and around 11% of those aged over-75 still smoke (Dudleston *et al*, 2001). Older men are more likely to smoke cigars or pipes than those in younger generations (Scottish Executive, 2000a).

Smoking is associated with all major causes of death among older adults, and increased years of illness, disability and reduced quality of life. Research suggests that one in three smokers die prematurely, losing on average 12-15 years of life (Cataldo, 2003). Tobacco use is also associated with many other health complaints and with conditions associated with ageing (Cataldo, 2003; HEA, 1999). Smoking is known to increase the time needed to recover from many illnesses and major surgery (Appel and Aldrich, 2003), while tobacco interacts with many medications commonly prescribed to older adults (Molander

*et al*, 2001). There is also some evidence to suggest that smoking may speed up mental decline (Ott *et al*, 2004; Juan *et al*, 2004).

Giving up smoking has immediate and long-term benefits for adults of all ages. There is increasing evidence to demonstrate that mortality is reduced even among those who stop smoking later in life or who have already developed diseases associated with tobacco use (Maguire *et al*, 2000; Taylor *et al*, 2002; Victor and Howse, 2000; Critchley and Capewell, 2004). The benefits of stopping smoking before surgery and radiotherapy have been demonstrated (Raw *et al*, 1998). Quitting improves general health and well-being, reduces disability caused by chronic illness and protects against loss of physical function. In short, stopping smoking adds both *years to life* and *life to years*.

However, smoking cessation in older adults can be challenging. Older smokers may have smoked for years and are therefore strongly addicted to nicotine and habituated to the act of smoking. Many older smokers underestimate the risks of smoking and overestimate the benefits, believing that it is too late or pointless to stop (Appel and Aldrich, 2003; Kerr *et al*, 2004; Kerr, Watson and Tolson, 2002; Jarvis *et al*, 2003; Fee *et al*, 1999). Other older smokers use smoking as a strategy to cope with life circumstances, particularly boredom, stress or isolation, and may be reluctant to give up (Parry, Thomson and Fowkes, 2002).

Awareness of support available is a potential barrier to smoking cessation in older people (Kerr *et al*, 2004). Evidence suggests that health professionals often fail to target older smokers or refer them for specialist support, either because they are reluctant to broach the subject of stopping in the first place, or because they believe that few older adults are actually able to stop successfully (Kerr *et al*, 2004; Kerr, Watson and Tolson, 2002). The advice given to patients appears to be influenced by their health and chronological age (Maguire *et al*, 2000). Other barriers include physical access to services by adults who have functional impairments.

Nonetheless, many older smokers do want to quit and manage to do so. Indeed, a recent evaluation of smoking cessation services in England found that older users were more likely to be successful in their attempts to quit (McNeill, Raw, Bauld and Coleman, 2005). The challenge to those working in health and related services is to ensure that older smokers are encouraged to quit and that they receive appropriate help in doing so.

For further information on the subjects mentioned here, refer to *Tobacco and Older Adults: A Literature Review* (ASH Scotland, 2004c).

## **1.5 Mental Health**

Tobacco use prevalence is significantly higher among people with mental health problems than among the general population (McNeill, 2001). In general, a greater severity of mental illness is associated with higher rates of smoking. Surveys reveal consistently high smoking rates among people with all categories of mental health problems, with highest rates in people with a diagnosis of psychosis (Meltzer *et al*, 1995). Over 70% of patients in British psychiatric institutions are current smokers (Meltzer *et al*, 1996). People with severe mental illness also tend to smoke more heavily compared to the general population (McNeill, 2001; Meltzer *et al*, 1996).

A number of explanations have forwarded to account for these high rates of tobacco use. Smoking is used as a coping mechanism to deal with stress and anxiety, or as form of self-medication (McNeill, 2001; McCloughen, 2003, Patkar, 2002). The environment and culture of mental health services has traditionally condoned smoking. Factors such as boredom and lack of recreational activities; peer pressure or smoking as a social activity; using cigarettes as currency, rewards or punishments; staff smoking and lack of smoking policies in institutions; have all been given as explanations why so many patients in psychiatric hospitals smoke (McNeill, 2001; HDA, 2001; McCloughen, 2003). In addition, there is often a lack of support to encourage quitting amongst people experiencing mental illness.

Tobacco use affects the health and well-being of people experiencing mental health difficulties. People with chronic mental health problems have a higher risk of premature death than the general population (Seymour, 2003). Studies show that smoking related diseases, particularly respiratory disorders and heart disease, are more common in people with severe mental illness than among the general population (Seymour, 2003; McCloughen, 2003). In addition, smoking can intensify symptoms of both neurotic and psychotic conditions and can affect the workings of prescribed medications (Zvolensky, Schmidt and McCreary, 2003; Goff, Henderson and Amico, 1992).

Surveys indicate that approximately half of smokers with mental health problems in Britain express an interest in quitting (Meltzer *et al*, 1995 and 1996). However, professionals working with people who have mental health problems often overlook smoking and often do not give advice or support to quit. This may be because of low expectations of clients' desires or abilities to quit, or because staff working in this field perceive the mental health of their patients as the priority, or are concerned about the effect of stopping smoking on mental health symptoms. Challenging preconceptions and encouraging staff and carers working in the mental health field to address the issue of tobacco is paramount.

People with mental health problems begin to and continue to smoke for many of the same reasons as other smokers, and like most smokers, they can find it difficult to quit. Nicotine is an addictive drug and cigarettes become an integral part of many smokers' daily routines. Those experiencing mental health difficulties have many of the same concerns as other smokers when it comes to quitting, as well as more specific concerns relating to the effects of stopping smoking on medications or symptoms of mental illness (Mentality, date unknown). Although having mental health problems may undermine attempts at quitting, it does not necessarily affect the actual ability to stop (McNeill, 2001).

Given high levels of tobacco use among mental health service users, second hand smoke (passive smoking) is a particular concern, particularly in residential centres and psychiatric hospitals. These are places where people live and work, and where anyone spending time might inhale other people's tobacco smoke. Policies to restrict areas where smoking is permitted are therefore an important consideration (HDA, 2001).

Given the mental health spectrum (ranging from minor depression to chronic, long-term psychotic disorders); the different circumstances in which people live with mental illness (those with short term difficulties who sustain 'normal' lives, to those living long-term in psychiatric hospitals); and the number of people whom mental illness affects (including staff and carers); a number of approaches are needed to address smoking in the area of mental health.

For further information on the topics examined above, read *Tobacco and Mental Health: A Literature Review* (ASH Scotland, 2004d).

## **2. NEEDS ASSESSMENT RESEARCH**

### **2.1 Aims and objectives**

Needs assessment is a research approach that provides background information to inform the planning process and assist in the development of future services. It involves consultation with various stakeholders to ascertain different needs, identify inequalities and assess priorities. Undertaking a needs assessment was important in the early stages of the *Tobacco and Inequalities Project* to uncover important issues and identify areas for action.

The aim of the needs assessment was to investigate the development and delivery of tobacco services appropriate to minority ethnic communities, older adults and people with mental health difficulties. Particular objectives to address were as follows:

1. To build a socio-demographic profile of the three target groups in Scotland.
2. To describe the key issues in relation to tobacco use for each of the three target groups.
3. To map existing tobacco-related resources and services, specifically those aimed at each of the target groups.
4. To consult with staff working with the three target groups.
5. To consult with smoking cessation and other health professionals.
6. To consult with the target populations about their perceptions and requirements regarding tobacco use, cessation and prevention.
7. To uncover the pertinent education and training issues (e.g. existing opportunities and future requirements).
8. To identify priorities and possibilities for future resource and service development.

### **2.2 Methods**

In order to meet the needs assessment aims and objectives, the needs assessment involved four distinct phases, using a range of research methods:

1. Literature reviews
2. Service and resource mapping
3. In-depth interviews with service providers
4. Focus groups with community representatives

The stages overlapped and fed into each other, with each sequential phase providing information essential for the next process. The research was undertaken throughout 2004. This report focuses on the in-depth interviews with service providers. Further details on the other three stages of the research are given in separate reports by ASH Scotland. See Section 6 for information on how to access these documents.

In order to gain a better understanding of the issues surrounding tobacco work with the three target groups it was important to consult with professionals working in the relevant fields. Areas of particular interest included professional's views on

tobacco issues, working with specific client groups, service delivery and development, education and training needs, and resource requirements.

Semi-structured interviews were deemed to be the most appropriate research method, as this approach enables a full and detailed discussion of pre-identified issues, allows for any misunderstandings to be clarified and permits the respondent to raise other matters that they feel are important. The interviews also gave the opportunity to gather further information about existing services and resources and helped the research team in identifying possible participants for focus groups with representatives from client groups.

A detailed questionnaire was designed and piloted to guide the interviews and included questions on key themes (an example interview schedule is attached as Appendix 1 in Section 8 of this report):

- The participant's job, the organisation they work for, their experience of tobacco work
- Funding, staffing and resources
- Partnership working
- Monitoring and evaluation
- Tobacco use prevalence and reasons for this
- Tobacco cessation: barriers and motivators
- Tobacco services: knowledge of, contact with, relevance to target groups
- Tobacco information and resources: knowledge of print, audiovisual and internet resources, comments on such materials
- Education and training: knowledge and experience of tobacco issues training, barriers, education needs
- Research: knowledge of tobacco research or reports, research priorities
- Attitudes to key recommendations
- Suggestions for engaging client groups in the research

The interviews began with some general questions about the main aspects of the participant's job and about participants the work of their organisation. These introductory questions served the dual purpose of relaxing the respondent and providing context for the remainder of the interview. The remaining questions focused more specifically on tobacco use and cessation issues, and working with the client groups.

The majority of participants were interviewed on a one-to-one basis, although there was one paired interview and one group interview involving three colleagues. Most interviews were conducted in person, although three were undertaken over the telephone. The interviews lasted approximately one hour. The interviewer completed a questionnaire and took detailed field notes during and after each interview to record significant observations and ideas. The interviews were also tape recorded for later transcription and analysis.

### **2.3 Sampling**

In total, 33 service providers from a variety of health, academic and voluntary organisations were interviewed. They had wide-ranging positions and organisational responsibilities, including smoking cessation co-ordinators and specialists, other health professionals and those with experience of working with minority ethnic communities, individuals with mental health problems and/or older adults, in various capacities.

To get a sense of issues arising in different parts of the country, efforts were made to interview staff from across Scotland, from both urban and rural areas, including the Islands. Nonetheless, the majority of participants (20 out of 33) were from Glasgow and Edinburgh. This was in part due to practical constraints (time and financial) but also because a number of relevant organisations and willing participants were identified from these areas. A table summarising information about the participants' jobs, organisations, location and involvement in tobacco work is included as Appendix 2 in Section 8 of this report.

## **2.4 Analysis**

Tapes from the interviews were transcribed and entered into a word processing package. Two researchers read through the transcripts to identify themes, and then coded and indexed the texts. The first stage of coding involved identifying key themes and marking these out on the transcripts. The process of indexing involved bringing all data on a particular theme together, starting with broad categories and narrowing these into a larger number of subcategories. This was done by copying the original transcripts and using the cut and paste feature. Details of each theme were then extracted, responses compared and contrasted, and the key issues summarised.

The methodology and sample size used in the research meant that the analysis was largely qualitative in nature. The findings discussed below are based on conversations with the service providers and quotes are given to illustrate the opinions expressed. For information the number of participants expressing a certain opinion are given in brackets for contextual information. Due to the nature of the research, there is no quantitative, statistical analysis.

## **2.5 Strengths and limitations**

The strengths of this research were that it investigated the knowledge, beliefs and experience of a wide-range of professionals in relation to tobacco and cessation issues. Interviews were undertaken with people who did not work in the health field and had no prior background in tobacco work, including some who smoked themselves, as well as health professionals. Participants were from across Scotland and there were representatives from different demographic groups (e.g. both males and females, different age groups, different ethnic backgrounds). The research uncovered detailed data about a range of tobacco issues and barriers that might prevent tobacco from being addressed within certain communities, and highlighted actions that might help to address these shortcomings.

One limitation of the study was that it did not include many representatives working in primary care or secondary care, or from psychiatric hospitals (e.g. doctors and nurses). The majority of participants were also from central Scotland, with few from rural or isolated areas. There were also less people working with older adults than the other client groups. The sample was based partly on practical constraints, such as accessing willing participants, but also because other research has been undertaken which can be read in conjunction with this report. For example, ASH Scotland recently funded work to undertake research with members of the primary care team working with older adults (Kerr *et al*, 2004) and with health professionals working with minority ethnic communities (Asghar, 2000).

It should be noted that a further report has been produced on the service user perspectives, based on focus group interviews with representatives from the three target communities (ASH Scotland, 2005a). The information from this phase of the research supplements the findings from the service provider interviews outlined in this report.

### **3. FINDINGS**

#### **3.1 ORGANISATIONAL ISSUES**

In the initial stages of the interview participants were asked about the organisation they worked for and the main aspects of their job. They were also asked to comment on issues relating to funding, staffing, resources and partnership working, and how these impacted on their ability to undertake tobacco issues work with the three target groups.

##### **3.1.1 Funding, staffing and resources**

As the interviewees came from a wide range of different organisations - including health services, voluntary organisations and academic institutions - funding came from many sources. Some receive statutory funding, while others worked for time limited projects.

Almost everyone commented that insufficient or unsustainable funding placed limitations on their work. Resulting problems included staff recruitment and retention, the capacity for partnership working, the ability to train staff and to purchase equipment. Short-term funding for time limited initiatives was also regarded as a problem. Although people felt pilot projects could be worthwhile for trying out new approaches, there was concern about developing services that were then discontinued and the impact this could have on clients. The capability of affecting any major health behavioural changes within a short time scale was a further shortcoming of short-term project funding.

*You're never going to say no to more resources. I think that the work that we do is really quite innovative and the only thing holding us back is obviously a lack of core funding and this is an issue across the voluntary sector, so I'm sure nothing I'm saying is at all surprising. [BME10]*

*[Tobacco work] is not a priority of ours at the moment, I would say that's due to a lack of resources rather than anything else. It's not because we're not interested, we just don't have the capacity. [OA04]*

*The government seems to be really tied on this idea that throwing money at a problem by way of an initiative for a few years is an appropriate political thing to do. I think most of us who have been in the field for a while argue that this is a complete waste of money. [BME11]*

The smoking cessation specialists were particularly vocal about the perceived lack of funding to support their work. Only one of the five smoking cessation professionals felt that their budget was adequate. For the other four, a lack of funding was a serious concern, particularly in relation to staffing. Three of the smoking cessation specialists were employed on temporary contracts and commented that other staff were often on part-time or sessional contracts. This

made it difficult to recruit and retain staff, and to plan or develop services in the longer term.

*I don't think it's rolling money, so there's no guarantee that that will become a permanent job. Which is a concern when they say, "we must push forward smoking cessation". [SC02]*

*Wherever I go funding is always an issue...especially for tobacco work. ...What would improve it is if there was a flood of money that we all had to be accountable for, not just money that we can squander, it has to be money that could be used to set up things that make it sustainable. [SC03]*

Continued, ring-fenced funding for smoking cessation was regarded as a necessity to enable services to develop and expand. The participants working in community and voluntary organisations also welcomed additional funding as a way of increasing capacity to undertake tobacco work with the target groups.

### **3.1.2 Partnership working**

There was a great deal of enthusiasm for partnership working and participants gave many examples of good multidisciplinary working relationships. Nonetheless, challenges in partnership working were identified. Funding, staff and time were practical constraints that limited organisations' ability to work together. Other barriers were organisational priorities, individual personalities and interests. Internal structural issues, such as staff changes and reorganisation, also impacted on partnerships.

*It's difficult because everybody is so busy and it may not be as high on their agenda as it is on the health promotion agenda. [SC03]*

*When things start to change, in terms of organisation, restructuring, then it can become quite difficult in terms of finding out who is responsible for what. [BME07]*

Participants had a number of ideas on how to build capacity for tobacco control work through partnership working. Networks such as the Scottish Tobacco Control Alliance were valued, although the scope for greater information sharing was identified. Some felt that people in different areas of Scotland were working too much in isolation, while others thought that there was much to be learned from tobacco experts further afield, particularly from elsewhere in the UK.

Increased working with people outside of the smoking cessation field was also advocated. For example, it was suggested that smoking cessation specialists could work with experts in other areas in the actual delivery of smoking cessation, to increase the range of skills and to join-up expertise. It was also proposed that there should be more joint working with addictions and substance misuse services, as there were many common issues and approaches. As a starting point, it was suggested that smoking cessation services should provide information about their work to key organisations working with target client groups. Other areas where participants felt that better partnerships could be developed included prisons, educational establishments and even fire services.

*I think we need to kind of raise our profile, we need to get a bit modern, a bit sharper, we need to make ourselves more accessible to wider range [of people]...We should really be putting together information packs or being prepared to go out to speak to anyone and everyone who asks us. [SC04]*

*We are the smoking cessation specialists, we are not the specialists in maternity, youth or anything. And the aim there is to allow these specialists, all these professionals from the other agencies, to take smoking cessation to their clients, to their particular clients. [SC01]*

In short, participants were enthusiastic about partnership working as a way of diversifying and developing services, but there were real practical constraints that affected their ability to develop partnerships. To an extent, additional funds and staff could have a positive impact on partnership work. However, other issues, such as organisational priorities, internal changes and finding someone to champion a cause, were less easy to influence.

### **3.1.3 Summary**

A number of organisational issues act as barriers to the provision of tobacco services and work with target groups. Similar issues affect professionals working across different fields. Funding is a key issue, with many services constrained in what they are able to do by shortages of money or staff. Time is also an issue, with organisations facing large workloads and conflicting demands on their time. Appropriate funding for smoking cessation is essential to help services develop and expand.

## **3.2 TOBACCO USE: PREVALENCE AND EXPLANATIONS**

The interviewees were asked, based on their experience or perceptions, what they saw as the prevalence of tobacco use amongst minority ethnic communities, people with mental health problems and/or older adults. They were asked if there were any variations by age or gender, and if tobacco was consumed in any form other than cigarettes. They were also asked why they thought there might be such a prevalence of tobacco use.

The service providers had varying levels of knowledge about tobacco use issues. Approximately half of the participants (n=16) had received tobacco issues training or had undertaken cessation work, while the remainder (n=17) had little experience in this area. Some participants referred to research in their responses, although the majority relied on anecdotal evidence from their experience of working with certain clients or perceptions.

### **3.2.1 Minority Ethnic Communities**

Participants identified high smoking rates among certain minority ethnic sub-communities. Smoking was seen as particularly common among Bangladeshi men, but also among Pakistani and Chinese men. High rates of smoking was also identified amongst 'newer' and more 'invisible' minority ethnic groups, including Arabic communities (including Middle Eastern and Turkish), Eastern Europeans, Refugees and Asylum seekers, and Gypsy Travellers.

Overall, there was thought to be a higher smoking prevalence amongst minority ethnic men than women, and among older generations. Nonetheless, there was a perception that smoking might be increasing within second generation Asians. There was also anecdotal evidence that smoking may be more common among Asian women than surveys suggest. It was noted that women and younger Muslims and Sikhs might hide their tobacco use through fear of disapproval or stigma.

*Anecdotally I've noticed smoking being high particularly in men, especially Bangladeshi men. There's also high prevalence in Chinese community. [BME08]*

*It's very prevalent [among Gypsy/Travellers]. Both sexes and for the youngsters too from quite an early age...It's hard to put a percentage on the number of people who smoke but I would have thought it's at least 70% and the majority of them are heavy smokers. [BME11]*

*When I went to college, other than myself and one of my friends, every other Asian girl in that college smoked. It was surprising to see that practically every Asian girl smoked. [BME04]*

In addition to cigarette smoking, other forms of tobacco use were mentioned. It was noted that chewing tobacco (paan and betel nut) was popular in some South Asian communities, particularly for Bangladeshi women; while hooka pipes were used in some South Asian and Arabic communities. One respondent mentioned cannabis and khat as particular issues in Caribbean and Somali communities respectively.

The reasons suggested for such a prevalence of tobacco use among minority ethnic communities were similar to those that would explain tobacco use in the general population. Enjoyment, sociability, habit, addiction, relaxation, coping with stress, deprivation, unemployment, discrimination, isolation and difficult work or personal situations were all given as reasons why people smoked. More culturally specific reasons were discussed, such as a greater acceptability of smoking and chewing tobacco in some communities. Smoking was seen as a sociable and masculine pursuit in certain cultures; and the glamorisation of smoking in the media in Asian countries was also mentioned.

*I don't know if the reasons would be that different, from the wider community. People smoke because of stress, anxious, or financial worries, or whatever. Whatever reasons people smoke, I still think it would be applicable to any of the kinds of people from minority ethnic groups. [BME07]*

*Whereas for Muslims, Pakistanis, it's not forbidden, it's part of the social culture, so it is higher. ...If you smoke you are into the adulthood. [BME03]*

In short, there appears to be high tobacco use among certain minority ethnic sub-groups. However, several participants indicated that their opinions were based on anecdote and observation, rather than research evidence. Knowledge about tobacco use among certain sub-sectors of the minority ethnic population is sparse. This indicates a need for more reliable data on minority ethnic tobacco issues in the Scottish context.

### 3.2.2 Older Adults

Participants working with older adults had less to say about prevalence of tobacco use among older adults than the service providers working with the other two client groups. Only one respondent, who had undertaken research on tobacco with older adults, quoted actual figures on smoking prevalence. The remaining participants offered conjectures based on the clients they worked with. It was noted that some older men smoked pipes and cigars. One respondent mentioned the popularity of roll-ups among the older adults she had worked with, because it was cheaper to buy tobacco that way.

Again the reasons given for why older adults smoked were broadly comparable to those expected for the general population. Addiction, routine and the pleasures of smoking were seen as key reasons. Issues such as social isolation, boredom and coping with personal difficulties were noted as pertinent explanations for older people's tobacco use. Some participants focused on the length of time that older adults had been smoking and the difficulties of giving up a life-long habit. It was pointed out that the social climate in which older people started smoking was different in the past, when smoking was more common and acceptable, and when less was known about the risks. A lack of professional support to help older people to quit was also discussed.

*It's men I've spoken to and they say, 'I've smoked all my life... I've smoked since I was 14 and there's nobody telling me not to smoke now'...It's something that they've done for years. [OA01]*

*We simply found that some older people are maybe not getting enough support that they need from health professionals. [OA05]*

*If you had a habit that you'd done for 50 or 60 years, trying to break the habit is very, very difficult. [OA05]*

To sum up, the participants working with older adults were able to describe patterns of smoking among older people based on anecdotal evidence. Few differences were distinguished between older and other smokers. However, issues that were felt to affect older people's tobacco use were the length of time that they had smoked, their ability to change and the level of support they were offered.

### 3.2.3 Mental Health

The mental health service providers indicated that smoking was widespread among people with mental health problems and that heavy smoking was common. A number of interviewees commented that roll-ups were quite popular, as these were cheaper than packet cigarettes. Three interviewees said that some of their clients used cannabis, although others had not encountered this issue. The participants did not report any marked differences in tobacco use according to gender or age. However, it was suggested that older clients who had been in psychiatric hospital were almost certain to have smoked.

*Probably 75% of them are smokers, if not more than that... And then you have those who smoke dope etc...It's actually very prevalent, much more prevalent than I had realised. [MH03]*

*I think there might be a few that don't use it, but in general I'd say the vast majority of service users do use tobacco...They do tend to smoke an awful lot, it seems to be when they put one out, one's lit up. [MH05]*

A number of reasons were forwarded to explain the high rates of smoking among people with mental health problems. Once again, many of the suggestions were comparable to general explanations as to why people smoke. The mental health workers stated that their clients smoked to relax or calm down; to cope with stress and anxiety; or if they were bored, particularly if they lived in deprived circumstances or were experiencing social isolation. It was suggested that smoking was used as a form of self-medication, to counteract the symptoms associated with mental illness or as a 'crutch' to help people cope with life's difficulties. There was some debate over whether tobacco really did help to calm people or alleviate other symptoms of mental illness.

*I think it's a coping mechanism, honestly. I've talked recently with some of my clients about their smoking and that, and they say to me, 'it's all I've got and it keeps me going'...I had one lady trying to give up smoking and when I went in to see her, what a state she was in, and I had to end up saying to her, after talking to her, 'go and have a cigarette'. [MH02]*

*They think it calms them down. They think that it helps them to cope. You'll hear them saying, 'if I don't have a cigarette I won't be able to cope'. Basically it's a crutch for a lot of them. [MH03]*

*And then there's also the proven fact that cigarette smoke can sometimes aid people with depression and schizophrenia, in that it may well lift their mood and that it may well lower the incidence of voices. [MH08]*

*If they're smoking they're nice and calm, if they're not smoking, you'll hear a lot of them talking about delusions and they'll be hearing noises or seeing things, whereas when they're smoking, it seems to bring them down, calm them down. [MH05]*

Some participants associated high smoking rates to the culture of mental health services. Those who had a background in psychiatric nursing or medicine mentioned that cigarettes were used as rewards in the past and that smoking was common among mental health staff. One respondent discussed at length the significance of the smoking room in psychiatric hospitals as a social area at length. Five of the mental health participants noted that *choosing* to smoke had particular resonance for clients with more severe mental illness who may have less control over other aspects of their life, particularly their medication and treatment. They felt this made it difficult to advise people to stop smoking.

*We have spoke to a lot of our clients about trying to give up smoking, but it's a case of, 'no no, I like smoking'. And it's their choice, and they do let you know it's their choice. [MH05]*

*The smoking room can be a more desirable environment to be in. In the non-smoking room there is more to 'cope with' – a strange place, strange people and the chance to dwell or experience symptoms more. The smoking room can be more sociable. [MH10]*

To summarise, the participants who worked with people with mental health problems indicated that tobacco use was high amongst their clients. It appears

that there are strong associations between the culture of mental health services and smoking.

### **3.2.4 Summary**

The participants had varying knowledge about tobacco use issues within the three target areas (minority ethnic communities, older adults and mental health). They described patterns of tobacco use among particular groups, suggested reasons for this prevalence and identified particular issues for specific communities. Much of what was discussed was based on anecdotal evidence, indicating a need for greater awareness of the pertinent tobacco issues among staff working with particular client groups. More reliable data is also needed on ethnic minority tobacco use prevalence.

## **3.3 SMOKING CESSATION: MOTIVATORS AND BARRIERS**

The service providers were asked what they thought were the main motivators and barriers to stopping smoking (or stopping other tobacco use) amongst the target groups.

### **3.3.1 Motivators for quitting**

Participants working across all fields identified health as the most common reason why a person would be likely to quit. This was felt to be a particularly strong motivation if a person was experiencing a health problem that could be attributed to or exacerbated by smoking. One respondent working with older adults mentioned that advice from health professionals could be an important factor. The impact of second-hand smoke on the health of significant others, such as partners, children or grandchildren, was given as a further reason why people might consider stopping smoking.

*I think if they saw that their health was compromised in some sort of significant kind of way. [BME10]*

*If they had say, an attack of angina or some heart attack or had a bypass or they had recurrent chest infections, things like that tended to encourage them to stop. [OA05]*

*One of the chaps from the first group that I did, has a very severe mental health problem. He did stop and we asked him why. He said 'I went to the doctor and the doctor told me I'd the chest of a 90-year-old and I didn't want to be like that'. [MH03]*

Financial reasons were the second most commonly cited reason for quitting, particularly for people on low incomes or those receiving benefits or pensions. Some participants doubted that money was a primary motivator and pointed out that even those on a tight budget would still find money for tobacco. They felt that saving money was usually an additional benefit rather than the prime motivation.

*Cost was an issue. It didn't seem to almost stand out on it's own, but it was a factor that in addition to other things may help to tip the balance in encouraging them to stop. [OA05]*

*I was going to say cost, but nah, it wouldn't even be the cost...maybe depending on some of their situations but...I don't know. [MH02]*

Family and social pressures were further common reasons suggested for why people might think about quitting. In particular, a growing awareness of the affects of secondhand smoke was suggested as a particular potential motivator for those with children or grandchildren. A few mentioned changing attitudes to smoking and felt that proposed legislation to limit smoking in public places could be influential in encouraging some people to quit. Community and religious pressures were identified as possible motivating factors for some minority ethnic populations.

*I think when you introduce smoking bans or smoking restrictions, smokers can then realise that they can go for longer periods than they thought themselves, that they're able to do it and that can spur them on into thinking, 'gosh I can maybe try and quit here or just smoke at a certain time'. [SC04]*

In short, the participants felt that the main factor that would motivate people to quit would be health related. Supplementary reasons included money, changing attitudes to smoking and restrictions on smoking in public places. In general, similar reasons were given for all three target groups.

### **3.3.2 Barriers to quitting**

The participants recognised that quitting was a difficult thing to do, particularly for people who were very heavy smokers or had smoked for most of their lives. Addiction to nicotine, the habitual nature of smoking and coping with stress were identified as common difficulties in quitting. Insufficient motivation, determination and willpower were also seen as general barriers.

A lack of awareness of the health impact of tobacco was seen as a further barrier to quitting. It was noted that despite health warnings and health promotion campaigns, many smokers continued to deny the affects of smoking and were therefore unlikely to try to stop. A lack of knowledge about available support for quitters (e.g. smoking cessation services, NRT and Zyban) was identified as a further barrier. In particular, it was felt that people who did not engage with health professionals (particularly GPs) would be less likely to be informed about support available.

*[People] don't know the various services that are out there, the support that's out there, and probably because of that aren't able to get the appropriate advice that they should be getting. [BME04]*

*We had a few people that weren't necessarily convinced that smoking had damaged their health despite the fact they were exhibiting signs that it had. [OA05]*

*I think it's maybe people out in the community...who are not aware of the services that are provided, that may not get the same level of service. It's not everybody that goes into their health centre for checkups. [OA02]*

The accessibility of services was mentioned as another barrier. Two different concepts of accessibility were discussed - physical and psychological. Physical

accessibility refers to the times or locations that services are provided, while psychological accessibility refers to an individual's own desires or ability to engage with a service. Physical access was identified as a potential problem for people with disabilities, those who are geographically isolated or reliant on public transport, for those who have childcare or other caring responsibilities, or those whose working hours conflict with service times. It was also noted that conventional smoking cessation services were not always suitable for people lacking confidence and social skills, or those with special needs or language difficulties.

*If you look at generally the ethnic minority population, men are probably are working all hours of the day and night, so they're not able to attend groups. [BME04]*

*Quite a high percentage [of smoking cessation groups] run in the evening and older people generally, in particular older women in the winter, don't go out in the dark... A lot of older people don't have cars, so they're relying on public transport, they want something that's local, easy to get to. [OA05]*

Language, literacy and the format of information were seen as issues preventing some people from accessing support, particularly those whose first language is not English, or those with functional impairments. The set up of conventional smoking cessation services, such as group work and the frequency or duration of support were acknowledged as further potential barriers to accessing quit services. These issues are discussed in detail in sections 3.4 and 3.7.

Other issues were discussed in relation particular groups. The interviewees felt that individuals might not regard quitting as a priority if they are dealing with deprivation, stressful circumstances or social isolation. Smoking was described as a coping mechanism, 'one of life's pleasures', and a lifestyle choice, and therefore as something that older adults or people with mental health problems might be reluctant to give up. It was suggested that older adults or people experiencing mental illness might not recognise the benefits to quitting, either because they felt it was 'too late' to stop any damage, or because quitting might have a detrimental effect on the symptoms of mental illness.

*For older people, I suppose it's an attitude thing, it's really, 'why should I give up smoking now when I've smoked so long? Is my health actually going to improve because I've smoked for 50 years?' Those kinds of things. [SC05]*

*The fear, the fear I would say of becoming more unwell. They think that if they stop that they would become more anxious I would say, it would bring on anxiety attacks. [MH06]*

It seemed that some health professionals shared these attitudes, which creates a significant barrier to cessation if they are not offering advice about quitting to some of their patients due to their own preconceptions. It seems that some mental health workers are reluctant to address tobacco use among their clients if they do not see it as a treatment priority, if they believe it could impact negatively on a client's condition or behaviour, or if they were smokers themselves. Others said they lacked confidence or skills to raise the issue of smoking, or that it was futile any way. In short, the historical and cultural acceptance of smoking within mental health services was a significant barrier.

*Thinking of nurses, as I come from a nursing background, its one in a million things to do and why would that come before the other things you do as part of your job? It's way down the priority list. [OA03]*

*I'm very aware of reports that have been done that highlight that when people with mental health problems raise the issue of smoking with their GP or health professionals they're quite often told not to worry about their smoking. Their mental illness, their medication, them complying with the medication is seen as much more important. [SC04]*

Finally, covert smoking was noted as a barrier to quitting. Three participants working with minority ethnic communities felt that the stigma of smoking makes it difficult for people to seek help. Another respondent working in mental health felt that people who smoke cannabis might not seek help to quit smoking because they did not want to cut down on their cannabis use.

To sum up, there were both internal and external barriers to quitting. Internal barriers relate to a person's motivation, beliefs and behaviours, while external barriers relate to service provision. Many of the barriers might be faced by anyone who is trying to stop smoking, while others are more of an issue for certain client groups. Challenging beliefs about people's ability to quit and professionals' confidence in raising the issue of smoking are paramount. Improved awareness of the dangers of tobacco and about support available to quit, and improved education and training for staff are key actions required to reduce these barriers.

### **3.3.3 Summary**

The participants identified a number of factors that they felt would motivate a person to attempt to give up tobacco and a number of factors that might act as a barrier to actually undertaking a quit attempt. The main motivators were health related, although there were also a number of supplementary factors. It was recognised that motivators were very personal and individual. A number of general difficulties that smokers face when trying to quit were forwarded, particularly the problems of overcoming an addiction and behavioural change. External barriers, such as a lack of information about the dangers of tobacco or support available for quitters were further issues. Overall, the barriers and motivators were similar for all three target groups, although some 'culturally specific' issues were identified.

## **3.4 SMOKING CESSATION SERVICES**

Participants were asked about their own experience of tobacco work and their knowledge of organisations providing tobacco information or cessation support. They were invited to comment on the appropriateness of current models of smoking cessation delivery for the three target groups and to suggest how services could be further developed.

Some of the participants had a great deal of knowledge about tobacco issues and cessation services, and talked about specific issues concerning the three target groups. Others had less specialised tobacco knowledge, but provided important information about working with individuals from the specific client communities.

### **3.4.1 Knowledge and experience of tobacco work**

Given the different occupational backgrounds of the participants, there was great variation in knowledge and experience of tobacco issues and cessation work (summarised in table form in Appendix 2). Five participants were smoking cessation specialists. These individuals were involved in various aspects of smoking cessation work, including developing and managing services, giving training and providing support to clients, and had a detailed knowledge of tobacco issues. Many reported that their work covered a wider remit, including education and prevention, policy development and alliances work.

Eleven of the other service providers had undertaken some kind of tobacco work. For example, among the mental health staff, two did cessation as a part of their job and four had undertaken brief interventions training. Of the participants working in minority ethnic health, one had a special interest in minority ethnic tobacco use, one had undertaken education work on paan with Bangladeshi women, and another had been actively involved in stop smoking campaigns on local radio. Among the interviewees working with older adults, one participant had been involved in research on older adults and tobacco, while another had undertaken some tobacco work as part of an older adults healthy living scheme. The remaining seventeen participants had little or no knowledge or experience in the field of tobacco education or cessation.

All participants (smoking cessation specialists and staff working in other fields) were asked if they knew of any tobacco services doing work with any of the three client groups. Those with no background in the area exhibited a low awareness of specialist smoking cessation services and spoke more of telephone quit-lines or GPs when asked where people could go for advice about tobacco use. Others described work they had been involved in or mentioned other time limited or small-scale initiatives. There appeared to be some work happening on an ad-hoc basis throughout the country, but few well established services.

Further information on existing services and resources for the three client groups can be found in ASH Scotland's *Tobacco and Inequalities Project Service and Resource Directory* (see Section 6, Further Information for details).

### **3.4.2 Smoking cessation service issues**

The smoking cessation specialists reported that their services were developed in line with evidence based guidelines for smoking cessation, and offered structured group-based and one-to-one support for quitters. Both the smoking cessation professionals and experts in other fields identified a number of shortcomings with existing smoking cessation provision.

Conventional models of service delivery were seen as inappropriate for some clients. Others felt that the traditional appointment system, whereby clients are expected to turn up for a number of sessions at a structured time and place, might not be suitable for their certain clients. For example, some workers with minority ethnic groups said that the concepts of group work and appointments were culturally unfamiliar to some communities. They felt it could be difficult to engage some people from ethnic minority backgrounds in groups. Mixed sex groups were deemed inappropriate for many South Asian women. One mental health worker mentioned that group work was not suitable for people with

attention difficulties or disruptive behaviours, and another mentioned that clients with chaotic lifestyles were prone to missing allocated appointments.

The frequency and duration of support offered in conventional smoking cessation programmes was identified as a further issue. It was noted that some people would need longer term and more intensive support than is traditionally offered (e.g. one hour a week for six weeks). It was agreed that additional support would be more appropriate for clients who were strongly dependent on tobacco, who were experiencing deprivation and social isolation, or who faced difficulties in everyday life. Clients who it was thought would benefit from longer, more intensive support included people with mental health problems, older heavy smokers and pregnant women.

A further key challenge was competing priorities. The smoking cessation specialists were well aware of the reasons why tobacco work with minority ethnic communities, older adults and people with mental health problems was important, and some had already developed or were planning work with one or more of these groups. However, there were reasons why it was not always possible to concentrate on these groups.

Other groups were often afforded higher priority within national or local tobacco strategies. For example, people on low incomes, pregnant woman and young people were highlighted as priority groups in the UK Tobacco White Paper (Department of Health, 1998). Other groups experiencing high tobacco use or difficulties in accessing services were also identified as key communities to work with in local areas:

- People with functional impairments
- People with learning disabilities
- The homeless
- The housebound or isolated
- People with other substance misuse problems (alcohol or drugs)
- Particular occupational groups or people working unsocial hours
- People with particular medical conditions (smoking related diseases or pre-surgery)

One respondent stated that the minority ethnic population in their area was too small and scattered to justify targeting them. Another felt that older adults did not require a sufficiently different approach to other clients. All of the specialists commented that their service is open to everyone and does not necessarily focus on any particular need group within the adult population.

The smoking cessation specialists talked in detail about other constraints that restricted their ability to develop services. Limited budgets and staff shortages placed real restraints on the capacity to develop services. Staff knowledge and skills were a further issue. Other challenges, such as referrals, waiting lists, accessing resources and the relationship with other health and social care services also impacted on the way smoking services operated and their ability to work with groups such as minority ethnic communities, older adults and people with mental health problems.

### **3.4.3 Ideas for service development**

Following from the discussions about the limitations of existing smoking cessation services, the participants were asked to comment on recommendations for future service development and to suggest how services could better meet the needs of the three target groups.

#### ***Improving awareness***

The participants thought that an important first step in improving take up of services was to raise greater awareness of the risks of smoking and of support available to help people quit. This includes providing information in a range of languages and formats to improve the reach of messages. Encouraging 'gatekeepers' to smoking cessation services (e.g. GPs and other health professionals) to inform patients about support available and to refer them on was another key action. Others felt that more work needed to be developed with people who are not yet motivated to stop smoking, such as pre-cessation education and awareness raising sessions.

#### ***Service times and locations***

The interviewees suggested a number of ideas as to where services could be located and promoted to improve accessibility. While it was recognised that there was a place for cessation services in traditional health settings and delivered by health professionals, it was argued that locating cessation in community locations - where members of the target groups live, work or congregate - might help to improve reach. Getting to know the local community, identifying existing networks and liaising with influential people or organisations in the community was an important step in the process.

Suggested locations for targeting minority ethnic communities included community organisations (such as religious buildings, social or support groups, local shops and restaurants) and events (such as Melas for Asian communities or horse fairs for Gypsy Travellers), where people feel safe, secure and supported. Some participants suggested that Mosques and Islamic religious leaders could be involved in educating people about tobacco and recruiting them to services

Ways of improving physical access to services for older adults included providing home based support, transport to clinics, or providing services in locations frequented by older adults (such as community centres, social clubs, bingo halls and nursing homes). Similar suggestions were given to improve access for people with mental health problems, for example by providing support in psychiatric hospitals or in day centres. Providing cessation services on different days of the week and at different times was mentioned as a simple way of improving reach.

#### ***Alternative models of delivery***

It was felt that services could be more flexible and that programmes should be adapted to meet the needs of people who required longer and more intensive support. The importance of keeping people engaged with services was discussed. Suggestions included offering one-to-one support; daily support;

providing drop-in sessions whereby people could talk to a specialist about their tobacco use on a less structured basis; offering support by telephone or email; offering quick interventions and fast-tracking particular clients.

Relapse prevention was another key area where it was felt that further work was needed. Ideas for relapse prevention also included more intensive and longer-term support, for example over a period of three months rather than the traditional seven week programme; and using drop in or telephone support for when people needed extra help. The participants identified stress management, providing alternative activities to smoking and offering additional support on weight gain were key areas of work that should be developed for clients with mental health problems.

Several workers noted that traditional success rates might not be as high when working with groups who required extra encouragement and motivation, which had implications for service monitoring. It was also noted that in reality they may need to work against current service provision protocols to keep inequalities groups engaged with the service. For example, one worker described that her experience of working with mental health clients meant allowing people to return for another quit attempt sooner than was recommended in service provision protocols.

### ***Medication Issues***

Service providers felt they could benefit from more information about the medication issues, such appropriate dosage of NRT and interactions with prescription medications commonly prescribed to particular client groups (e.g. for mental health diagnoses or to older people).

Two workers who had provided cessation support to people with mental health difficulties suggested that information on diagnosis and medication should be gathered at initial assessment and the quit attempt carefully monitored to assess the impact of cessation on the patient (e.g. mental state, affects of change in medication, side effects). This was felt to be particularly important as nicotine affects the metabolism of many medications. Therefore any change in level of nicotine, either due to smoking less or using NRT, could mean that the dose of medications might need to be altered. One worker advocated liaising with pharmacists to get expert advice, or identifying support staff to work with.

### ***Specialised or targeted services***

The idea of offering specialised or targeted services generated a great deal of debate, and opinions on this were mixed. Some participants felt there was a place for special services targeted at certain sub-sections of the community. For example, having special groups based on nationality or language for those whose first language is not English. Having single sex groups led by a specialist of the same gender was another idea. Another worker felt that targeted services for clients with mental health problems could be useful to address specific issues, such as medication and symptoms of mental illness. Nonetheless, it was recognised that practical issues (e.g. resources, conflicting priorities, training, providing specialist staff) were a barrier to development of specialist services.

Others were more reticent about segregating services and expressed concerns about labelling people and treating them differently because of their background or specific medical condition. In particular, those working in the mental health

field felt that that providing targeted services could be stigmatising and discriminatory. Choice and flexibility were seen as the best solution. It was felt that tobacco information and services should be open and accessible to everybody, but with a recognition that there may be circumstances when methods need to be modified to reflect individual requirements (e.g. providing one-to-one support, or interpretation, or specific information). Having a range of mainstream and culturally specific services that worked co-operatively was seen as the ideal.

### ***Holistic lifestyle approaches***

There was a general acceptance amongst all groups of service providers that integrated approaches, which tackled smoking alongside other healthy lifestyle initiatives (e.g. diet and exercise, or alongside other addictions), were worthwhile. The importance of understanding the role that tobacco plays in an individual's life and of improving people's knowledge and encouraging self-confidence was also accepted.

Holistic health improvement approaches were seen as particularly important for groups where health promotion campaigns may traditionally have been neglected (e.g. older adults or mental health patients) or for people who are contemplating change. The mental health service providers in particular recognised the value of holistic healthy lifestyle approaches. They noted that the traditional division between mental health and physical health services meant that mental health patients' physical health was often neglected. It was recognised that mental and physical health impacted on each other and there was enthusiasm to treat mind and body more holistically. It was noted that providing alternatives to smoking and addressing weight gain were particular issues for mental health patients.

Some participants had already been involved in healthy lifestyle initiatives, including a 'one stop clinic' to encourage minority ethnic men to have a comprehensive health check. Others had tried to link smoking cessation into other services, for example fitness classes or dieticians. One respondent felt that there should be a greater role for approaches which raised self-awareness and empowerment, such as cognitive behavioural therapy. Two of the participants felt that smoking cessation has become medically oriented and that too much importance was attached to NRT. While they recognised the value of pharmaceuticals, they thought that supporting individuals and developing their capacity to change was of equal importance.

Partnership working was recognised as important in developing more holistic approaches. In addition to working with exercise consultants and dieticians, it was also argued that smoking cessation services should look towards other addictions services for ideas. They advocated more joint working and partnership between smoking cessation and other addictions services, as there were many commonalities in the approaches needed.

### ***Harm reduction approaches***

The participants commented on the need to investigate harm reduction strategies (e.g. cutting down, changing the times or places when a person smokes) and their impact. Most people agreed that total cessation was the ideal and views on harm reduction were mixed.

Some argued that the evidence against harm reduction was clear - that people tend to cut down then gradually build back up to the same level again, or they tend to smoke in a different pattern, trying to get the same level of nicotine as they had before - and that there was no point in doing further research. There was recognition that smoking reduction was contrary to existing guidelines for smoking cessation service development and this had implications for the feasibility of introducing this kind of work.

Others acknowledged that in reality there were individuals who were unlikely to quit completely. They felt in these circumstances it would be useful to know more the benefits of cutting down. It was felt that harm reduction approaches could be appropriate for heavy or long-term smokers, or those who were not motivated to stop smoking. In particular, tobacco reduction was discussed as a possible approach in the mental health field, but also with older adults. Others felt that harm reduction approaches might have a role to play in helping people adjust to legislation to restrict smoking in public places. One person also mentioned harm reduction in relation to cannabis use.

*But you might be working with a client group who, if they go from 40 cigarettes to 5 that's actually quite a good success for them. [SC02]*

*Again, from working in the addiction field I think there are great merits in harm reduction. ...I feel that if people can begin to reduce their tobacco intake, the number of cigarettes they smoke, that in itself sends a powerful message to that individual. A lot of people think, 'gosh I went 2 hours there and I didn't have a cigarette, I never thought I'd be able to do that'. [SC04]*

There was also a recognition that there were other measurements of success than just quit rates, for example, positive changes to a client's tobacco use (less frequent smoking, not smoking in particular locations, confidence to attempt to quit) that should be taken into account in service monitoring.

### **Peer support and community involvement**

The participants debated the merits of training peer group members to communicate tobacco education and cessation advice. Most were in favour of the concept of social support for quitters and felt that extra support and encouragement was beneficial. Some had already used a buddying approach in smoking cessation and noted that in addition to the supportive element, buddying can give a person sense of value as they are helping someone else.

Participants working with all three of the client groups had examples of peer-mentoring and peer-education work which they felt had evaluated well. It was noted that people informally pass on information to family and friends any way, making this a 'natural' approach. Others felt that messages could be more effective when delivered by someone who has first hand experience of what a person is going through, or if they were delivered by someone from a similar background. In particular, some staff working with minority ethnic clients felt that a recognised member of the community could be more effective in delivering messages than staff who are not always seen as 'one of them'. People in the mental health field were also enthusiastic about the buddying approach.

However, there was concern about misinformation being passed on, and there was an awareness of issues of confidentiality in tight knit communities or in

groups where tobacco use was taboo. Some felt there was a lack of evaluated evidence to suggest that peer education was actually effective. It was felt that peer support approaches needed to be handled sensitively to ensure that the information and assistance provided was appropriate, and that they would have to work in tandem with specialist support.

Another type of community involvement – involving actual or potential service users in designing and developing services – was discussed by a number of participants. It was recognised that there may well be particular reasons that things have to be done differently for particular groups. In order to ensure that services are delivered appropriately it was deemed important to involve communities in needs assessment, consultation, piloting or evaluation work. It was argued that engaging with communities would not only help to develop quality and effective services and resources, but could also be educative and empowering for the community members.

### ***Improving skills and capacity***

A final importance step in making services more accessible and appropriate for the three inequalities groups was improving staff skills and increasing capacity. A major challenge in service development is overcoming staff preconceptions and encouraging them to raise the issue of tobacco use with their clients. Improved inter-agency and partnership work was identified as an important development. Participants also felt that raising staff awareness and improving skills, through education and training, was a key way to address this issue.

Three types of education and training were discussed – for smoking cessation specialists, for health professionals and for people working with the three client groups. It was felt that all health professionals, including practice and hospital doctors, dentists, nurses, allied health professionals and mental health staff, should have at least basic training in smoking cessation; while other professions could benefit from introductory information about tobacco issues. It was also suggested that health professionals and smoking cessation specialists could benefit from information about the specifics of working with the three client groups. Training issues are discussed in more detail in section 3.6.

### **3.4.6 Summary**

To summarise, it was recognised that existing smoking cessation services were perhaps not providing to those most in need – the groups who smoked the most, were the least likely to stop and who needed the most support in their quit attempts. A number of shortcomings with existing services were identified and suggestions given as to how they could develop to be come more accessible and appropriate.

The paradox between improving access to marginalised groups without treating them differently was recognised. It was felt that people are individuals, with their own cultures and beliefs, and should be treated as such. There was caution about stereotyping and stigmatising. Nonetheless, it was recognised that different people need a different approach and that flexibility and choice are vital.

The participants identified a number of ways that services could be developed to make them more appropriate for different client groups and to increase uptake. A combination of factors is needed to raise awareness and improve access to services, including improved education and information; providing smoking

cessation services in a range of health and social settings; and providing alternative models of support.

It was reiterated that adequate resources and support are essential for new approaches to be implemented. Providing alternative models of service provision would require additional funding, staffing and expertise. It was also acknowledged that dealing with inequalities might involve work that does not meet with existing guidelines for service delivery and that alternative approaches to monitoring and evaluation would be required.

### **3.5 WIDER TOBACCO STRATEGIES AND ISSUES**

Smoking cessation services are only one aspect of a wider tobacco control strategy that includes education and awareness raising, prevention, extending smoke free areas, increased taxation and fiscal measures. While not all of these issues were discussed during the interviews, smoking policies and reducing exposure to second hand smoke were key areas of discussion. Other tobacco use issues, notably cannabis and oral tobacco, were also raised.

#### **3.5.1 Second hand smoke and smoking policies**

A number of interviewees raised the issue of second hand smoke, particularly that was a lack of awareness of the risks among their client groups. Those working with minority ethnic groups felt that there was a low level of understanding about this issue, or that many people in these communities might be exposed to second hand smoke at home or at work (particularly in the restaurant trade).

*I think there's a very much little knowledge of passive smoking, and a lot of work needs to be done around that as well. I mean I've gone into ethnic minority homes where the father's sitting there and there's a baby lying there in the same room and he's just smoking away without even realising the effects that it has on other people, let alone babies. [BME04]*

*There are some paradoxes here because Travellers are very family-orientated and they're very supportive, protective even, of their children but they don't make the associations that perhaps you and I might make between their own behaviour and the effect it might have on their children. [BME11]*

These discussions indicate that more needs to be done in terms of public education campaigns to inform people about the risks of second hand smoke and about increasing the provision of smoke free areas.

The interviews took place before the Scottish government launched its consultation on smoking in public places or announced its plans to legislate on this matter (Scottish Parliament Bill 33). The topic of smoking policies was not covered explicitly in all interviews, although participants working with mental health service users and older adults were asked for their thoughts on the need for smoke free areas in places where their clients live and/or socialise. Other participants also raised the issue of smoke free areas independently; particularly those who had a remit for tobacco control or who had been involved in discussions about developing smoking policies for their organisation.

None of the participants disagreed with the principle of extending smoke free areas. However, some had reservations about the extent of policies to restrict smoking and the affect that this would have on their clients. The shift towards a society where smoking was increasingly unacceptable was seen as a cause of potential anxiety and isolation for some smokers. It was commented that existing no smoking legislation had already had an impact on some people with more severe mental illness. One respondent noted that the aim of her organisation was to get people out of their houses and to reduce social isolation, and she felt that introducing smoking policies might drive people away.

*Sometimes getting them out shopping can be hard because there are problems where there are no smoking policies, we have go straight in and out because they know they can't smoke in there. [MH06]*

*I'm thinking of one lady in particular, who is so, so anxious about this smoking ban in Ireland and she said to me 'There'll be deaths because of this. People rely on their cigarettes and they'll die if they don't get a cigarette.' And she looks on that as part of her life and the whole thought of not being able to have her cigarette. [MH11]*

*A lot of them have said... 'I'm not coming back, if they stop smoking in here'. [OA01]*

Many of the participants felt there should be special considerations for psychiatric hospitals and care homes. There were concerns about prohibiting people from smoking in places that were essentially their home. The participants were generally supportive of having smoke free areas and protecting people from passive smoking, providing there were designated smoking areas. In general, the medically trained professionals (psychiatrist, former psychiatric nurse and occupational therapists) appeared to be more in favour of restrictions than the support workers.

*It can be bad enough for people when you've got nowhere to smoke when...you've not got any mental health problems. I hate to say it, but some people get really anxious, it's not good for them and I definitely think it [a designated smoking area] should always be available. [MH02]*

*I think there's big issues for older people in care homes not having places to smoke...Now I think it would largely be welcomed that there are smoke free areas, but I think there's also an issue of allowing older smokers to smoke, and it pains me to say that. [OA04]*

One mental health professional supported provision of smoke free areas, but questioned the feasibility of this, due to building design, space and cost. He also noted with some reticence that a smoking room had been included as part of the development of a new young peoples' day unit, as it was felt people probably would not come if they were not able to smoke. Three participants felt that smoking rooms were an important health and safety consideration. One argued that they would help staff control where people smoked, thus reducing the risk of fires. Another two felt it was dangerous to have frail older people leaving the premises to smoke.

*If they weren't allowed to smoke they would sneak into somewhere that they could have a cigarette. They would break the rules. You know what its like, fly smokers put other people at risk because they tend to go into*

*places like linen cupboards or where rubbish is stored, where they're endanger of setting the whole place alight. So if there's a designated area they can have some control over that. [MH11]*

*I think it's great, don't get me wrong, to have it, but I think it's quite dangerous for older people to be going outside onto the street in the cold [to smoke]... they're still going outside with their walking sticks and zimmers. To me that is far more dangerous for older people, health-wise as well...I far rather there was a wee room, a segregated area for older people [to smoke] and maybe that's somewhere they could go. [OA01]*

However, even some of those who advocated separate smoking areas struggled to reconcile two conflicting viewpoints. On the one hand, they accepted the client's need to smoke, but on the other did not think that mental health patients should be treated differently from wider society.

Despite the challenges, some participants spoke optimistically about the implementation of no-smoking policies. It was noted that the introduction of smoking policies could have a positive impact on the level of people's tobacco use and might encourage them to think more about their smoking. One respondent, a worker of a mental health drop-in centre, discussed at length her experiences of setting up a smoke free day at their premises. She noted that initial resistance actually subsided quickly and that people's perceptions that they would struggle were unfounded.

*So the entire day is no smoking in the building and it's very interesting because some of the people who were totally against it, depending on which of their friends are in, they will go the entire two hour drop-in without even wanting to go out for a cigarette...whereas before they would be chain smoking. [MH01]*

The importance of getting both service users staff 'on board' with any legislation, by educating them about the need for smoking policies, involving them in discussions and development, and supporting them to deal with the introduction of any change was noted.

*You're always going to get resistance from workers who are your worst nightmare because they will have a fag with people and it's about that thing 'right you've got a responsibility to these folk to help them. This is damaging their health.' So it's about getting the policy makers on-side and also getting the workers that are actually doing the face to face work with them on-side and change that culture – it's about cultural change. [MH09]*

These comments suggest a need for a wider public awareness campaign about the dangers of passive smoking and about the impact of smoking policies.

### **3.5.2 Cannabis and oral tobacco**

The mental health service providers were asked if they thought more information was needed on the implications of smoking cannabis on mental and physical health. Everyone who was asked this question agreed that this would be useful (n=9). While some knew little about cannabis, others knew of existing studies or noted that the available information was not consistent. Three participants explicitly stated that they thought there was a causal link between cannabis and

mental health problems, particularly depression. The need to have accurate information to present to clients was seen as an important step.

*Cannabis definitely causes great depression. A lot of the dual diagnosis we have is all cannabis related, they start off smoking that then they become really depressed, that's when we get them on board because of the depression. [MH06]*

*On the internet you get people saying that it doesn't actually do anything to you, but there's quite a lot of information out there informing us that it can exacerbate people with psychosis and stuff like that. [MH09]*

One of the participants, who had undertaken smoking cessation and drugs work, mentioned that more training on cannabis was needed for health professionals and for smoking cessation specialists. He also felt that harm reduction approaches might need to be considered in relation to cannabis use, rather than focusing on cessation.

Service providers working with South Asian communities were asked to comment on the recommendation that packaging of paan and other chewing tobacco products should include health warnings. Everyone agreed that all tobacco products should be clearly labelled. Three participants said that they felt that knowledge about the risks of smokeless tobacco was low, both among users and health service providers. Incorporating health information was seen as an important step in raising awareness of the health risks.

However, two participants noted the difficulty in giving health warnings given that many people who used such products (particularly older Bangladeshi women) might not be able to read, either in English or in their mother tongue. Other strategies to raise awareness and tackle smokeless tobacco use would therefore also be required.

### **3.5.3 Summary**

The participants identified that there were a number of issues that had to be taken into account as part of a wider tobacco control strategy. They recognised the need for awareness raising around second hand smoke and strategies to tackle this. In particular there was support for legislation on smoke free areas, but a recognition that there were issues that would have to be considered in relation to exemptions. A need to raise awareness about other tobacco related products, such as cannabis smoking and oral tobacco, and for fiscal and legislative measures to control their usage were also recognised. Getting the public and policy makers involved in wider tobacco control initiatives was the key to making an effective impact.

## **3.6 EDUCATION AND TRAINING**

Participants were asked if they knew of, had ever taken, or had ever provided, tobacco issues training, and for further details where appropriate. They were also asked more generally about any other training they had been involved in related to their work with the specific client groups. They were then asked what they felt would be the main education and training needs for staff wanting to offer tobacco interventions to the three client groups, and about barriers to providing tobacco issues training to staff in their line of work. Finally, the participants were invited to

comment on a recommendation that specialised training should be developed on tobacco use and cessation issues specific to the three client groups.

### **3.6.1 Knowledge and experience of training**

Given the variety of the participants' roles and remits, there was great variation in their knowledge and experience of tobacco education and training. Fifteen of the 33 participants had never taken any tobacco training. Eleven of them did not know of any training sessions or providers, while four knew of training that was available, but had not attended any courses. Twelve had some level of training in tobacco issues (ranging from a two-hour course on brief interventions to a two-day course on smoking cessation) and four mentioned that they had undertaken training on addictions or substance misuse.

All of the smoking cessation specialists were involved in providing training to a range of professionals. One had even developed training specifically for members of the local mental health team. Three other participants did some kind of tobacco issues training as part of their current job. For example, two of the mental health workers regularly provided tobacco issues and/or cessation training, while one of the minority ethnic workers ran a course on ethnicity and tobacco. A number of the participants had provided or organised training in other areas specific to their fields.

### **3.6.2 Barriers and shortcomings of training**

The participants identified a number of barriers to providing education and training to improve staff knowledge and skills about tobacco issues. Some felt that tobacco was simply not regarded as a priority issue for many organisations working with older adults, minority ethnic communities or in mental health. The participants noted that training needs to be seen as relevant to a person's work and that often there would be more pressing demands on staff professional development. Staff interest and motivation, and accredited training, were identified as key issues.

*If they're not interested in that area they won't attend... There's time and accreditation, which is so important for nurses. Unfortunately nurses don't just do courses just for personal development. And it has to be relevant to people, to make a difference to their practice. [OA03]*

*It's perhaps something that's not very high on our priorities and if we had the funding perhaps we would certainly look at it. [MH08]*

Funding and time were further key issues for most participants. Many said there was a lack of money to send staff on training. Training courses provided by private companies were identified as being particularly costly. The location of courses, particularly for those living in more rural or isolated areas, was a further issue, with travel and accommodation costs sometimes needing to be factored in. Another issue was staff taking time out of work. Covering absence was a particular concern within health and care work.

*There's constraints on staff, staff find it's very difficult to get time, even if they want to do training, they've got to get time off to do the training. [OA05]*

*It's probably down to time and funding, everybody's so overloaded with the work there is anyway and getting time away to do this training needs covered, so it'll be cost mainly and staff motivation. [MH01]*

A lack of awareness of tobacco training that was available and a lack of appropriate training were further barriers. The smoking cessation specialists spoke in detail of the shortcomings of some smoking cessation courses, which were expensive and not always of high quality. One respondent talked in detail about training she had attended that missed out what she felt was vital information, for example about working with groups, health behaviour change and addiction theory, and that some of the information was not applicable to the Scottish context. She also mentioned a dearth of higher-level training for trainers, to equip them with the skills for designing and delivering smoking cessation training. Another respondent working with minority ethnic communities commented that while there was a lot of training available around smoking and the general population, there was little in the way of culturally specific expertise.

An additional problem was that training was often very theoretical and passive, without much practical experience for attendees. Three of the smoking cessation specialists commented that training courses did not always fully equip people to actually facilitate smoking cessation work and that training often goes unused if people do not get the chance to put their learning into practice.

### **3.6.3 Ideas for training development**

It was accepted that education and training were key requirements in order to raise awareness of tobacco issues and to provide staff with the skills to address tobacco use in the communities they worked with. Participants were asked to think about the relevant education and training needs for staff working in their respective fields in relation to tobacco issues. They acknowledged three broad categories of recipients with different training needs – smoking cessation specialists, health professionals and other professionals working with the client groups. Different types of education and training were identified, depending on the person's occupation and background knowledge, from basic awareness raising to detailed training in specialist support.

At an elementary level, the participants identified a need for education for different types of professionals to help them better understand the risks associated with tobacco and the importance of smoking cessation. Increased awareness about services that are available to help people to quit was also identified as being important, both within the health care sector and beyond. The need for tobacco awareness training was thought to be particularly important prior to the introduction of smoking policies.

*...Anyone working with people, especially in the care field, let's build in tobacco awareness right in there, whether it's a nursery nurse, teaching, in care of the elderly or whatever, let's build it in a little bit, even if it's just an optional part, of tobacco awareness. [SC03]*

*They've got to have an understanding, they've also got to have knowledge, be clearly aware themselves of the benefits of stopping smoking and be able to discuss that...They then need to have knowledge of services and understanding of services that are out there to refer on. [OA05]*

Three of the participants explicitly mentioned the importance of ensuring that *all* health professionals - particularly doctors and nurses, but also pharmacists, dentists and allied health professionals - have at least basic training in smoking cessation. One respondent who had recently carried out research with members of the primary care team found out that knowledge about the work of smoking cessation services and their success was limited, which may have had an impact on referrals. Another respondent mentioned the importance of widening training to whole staff teams, for example in psychiatric hospitals, so that a number of people are able to provide support, rather than just one individual.

*I had one GP that said to me, he was aware that nicotine replacement therapy had a better success rate than going cold turkey, but he actually thought it would be better for people to go cold turkey, and he carried on explaining to me why that was. So there are interesting issues in terms of things like that, where knowledge and attitudes need to be addressed. [OA05]*

*Smoking has gained huge priority but I suppose I'm still quite amazed at how little nurses get in training and GPs get in training [SC04]*

*And perhaps getting people like GPs onboard and practice nurses...and having it a core part of their training, when they're studying at university, having brief interventions and how to deal with tobacco. [SC03]*

The participants identified a number of general issues that they felt would need to be covered in generic training courses on tobacco and cessation. These included:

- Information on the affects of tobacco
- Information on the benefits of quitting
- Different approaches to cessation and the evidence base
- The work of a cessation service
- Medication issues (e.g. NRT and Zyban)
- Working with individual clients (building motivation and offering support)
- Working with groups
- Theories of behavioural change
- Theories of addiction
- Dealing with withdrawal symptoms

One smoking cessation specialist noted that Partnership Action on Tobacco and Health (PATH) had already identified standards for smoking cessation training in Scotland, which detailed the items that should be covered in three levels of smoking cessation training – brief advice, specialist cessation support and specialist cessation support for groups (Partnership Action on Tobacco and Health, 2003).

A further issue raised by the smoking cessation specialists relates to following-up on training. As aforementioned, many courses were identified as being quite theoretical without much in the way of practical experience for trainees in working with clients. Therefore it was recommended that trainees should be paired with experienced smoking cessation mentors, for example to shadow their work and co-facilitate groups. Offering follow-up sessions to consolidate and build upon

learning was noted as another way to improve the quality and applicability of training.

There was an acknowledgement that people would need to relate any general tobacco or cessation knowledge to the specific circumstances of individuals or client groups. In addition to the aforementioned types of general information on tobacco and cessation, the participants identified a number of themes that they felt it would be useful to include in tobacco training that related specifically to a particular population.

- Awareness of the key demographic and socio-economic features of the client group, and differences within it
- Awareness of tobacco prevalence and profiles specific to the client group (including other forms of tobacco use, hidden tobacco use)
- An understanding of specific cultural issues, lifestyles and health beliefs of the client groups
- Common medical conditions and medications (including the mental health spectrum)
- Awareness of discrimination and inequalities faced by the population
- Challenging stereotypes and attitudes
- Special needs and requirements (e.g. disabilities, functional impairments, language and literacy issues)
- Practical ways of engaging with the client group and working with clients with special requirements
- Evidence base for tailored interventions

A number of additional issues were raised specifically in relation to working with the three target communities. For example, cultural competency, race awareness, language issues and practicalities such as working with an interpreter were key themes for minority ethnic communities.

*If you have the knowledge of the people, their habits, the behaviour, the prevalence and everything, you are aware of the community, you are aware of the sub groupings then you will devise specialised training. [BME03]*

*I think people think that's somehow more difficult working with the BME community, it isn't... But I think people really need to have an understanding of, and an appreciation of, the context of people and their lives, it's about racism, it's about discrimination and how they have unequal access to health services in general. Those kinds of things, those need to be covered. [BME10]*

Participants from the mental health field added that information about mental health (e.g. diagnoses, symptoms and treatments of different illnesses); the relationship between tobacco and stress, anxiety and depression; about medication interactions and dosages (e.g. antidepressants, anti-psychotics and NRT); about the length and intensity of support that might be required would also need to be covered in a specialised course.

*Basically how mental health affects people, information on the different aspects of mental health, the different types, how it can affect people, some of the impacts of medication... More awareness of the side effects of stopping smoking, the stresses that it causes and how that interacts with people's medication... [MH01]*

*There would have to be attitudinal stuff done about mental health, basic facts about that. There should be information about potential drug interactions. There would need to be a lot about listening, and the pace/length of the support that would be needed. [MH07]*

In relation to older adults, it was noted that a specialised course should cover something on the social history of tobacco (e.g. prevalence and attitudes in the past, the acknowledgement of the health impact); on health beliefs; information on working with clients with special needs (e.g. visual, hearing or mobility impairments); age discriminations; and specific information about working with clients who already have a tobacco related disease.

The pros and cons of developing specialised training on tobacco use and cessation issues specific to the three client groups were discussed. In general, people felt it would be a good idea to have training that covered the areas mentioned above, but there were some reservations. Questions were raised about how specialised tobacco training would fit with existing generic training, while some were concerned about taking on areas outside of their expertise. Others felt that developing specific training could be discriminatory in itself.

The consensus was that specialised training could be a useful addition to general tobacco training, but that care would be needed to ensure the information being delivered was appropriate. Partnership between different agencies and areas of expertise was identified as an important way forward. One respondent also noted that it was important to evaluate the impact of training, and was planning to undertake research to investigate the differences in the work of primary care practitioners who had received specialised training, and a control group who had not.

#### **3.6.4 Summary**

To sum up, while most participants accepted that tobacco work was a worthwhile area, there were a number of practical reasons that limited the provision of appropriate education and training in tobacco issues. A number of suggestions were given about topics that could be covered in awareness raising and training sessions, depending on the target audience. On one level, issues specific to inequalities groups could be incorporated into generic tobacco training as required. On another level, professionals working within a particular area of expertise could be offered basic tobacco training that relates to their client group. An important objective was to provide staff working in different fields with at least a foundation in tobacco and cessation issues, making sure they are aware of the importance of tobacco as an issue and of the support available to people who want to quit.

### **3.7 RESOURCES AND MEDIA**

The service providers were asked if they knew of any information resources (e.g. leaflets, posters, audio-visual and web-based media) about tobacco, cessation or related issues, and for details where possible. They were shown examples of existing leaflets and asked for their opinions on the style and content, and their thoughts on using these with the client groups they worked with. They were also asked to comment on recommendations relating to the development and dissemination of leaflets.

Knowledge of available tobacco resources varied greatly, depending on the individual's remit and involvement in tobacco work. Those who had been involved in smoking cessation or health promotion had a greater awareness of available resources. However, some people working in the smoking cessation were not aware of the range of resources that were available, suggesting a need for greater publicity of the information available.

### 3.7.1 Features of leaflets

Regardless of their knowledge of available resources, all participants had opinions on the leaflets shown to them during the interview and identified features that they thought made for a useful, user-friendly leaflet. For example, font size, spacing of text and paper quality were important factors in readability. Others mentioned that the language used within should be simple, with non-technical vocabulary and short sentences, to ensure that leaflets are easy to read. It was noted that there needed to be a balance between having enough information in leaflets, but not so much that people get bored reading it. This was identified as particularly important for people who have concentration or literacy issues. The availability of translated information was identified as a need for people whose first language was not English.

*I think people don't tend to read things that are more than just a few pages. I don't think there's any difference between older people and younger people in terms of the volume, I think it's just a general issue of what people will read. [OA05]*

*Not too much text because for a lot of people who are highly medicated, reading's very difficult because they just can't focus their eyes properly or they can't concentrate. So the sharper, short messages are the better. [MH01]*

The visual appeal of leaflets also rated highly. Participants noted that leaflets should be eye-catching, bright and well laid out. The need for culturally appropriate images (e.g. pictures of older adults, or of non-white people) was also discussed as a way of encouraging people to pick up and identify with leaflets. Others thought that pictorial messages (e.g. how different organs are affected by smoking) would be a useful approach. One respondent felt strongly that high production quality was important.

Some participants commented on the tone or style of leaflets. The use of 'shock tactics' was discussed, but nobody felt that this was appropriate as a stand-alone approach. There was a tendency to favour a non-judgemental approach whereby facts were imparted without 'nagging'. Many service providers valued the use of personal testimonies and positive stories about people who had successfully quit. A few advocated a more light-hearted approach or the use of humour. One person suggested incorporating information from religious texts into leaflets for Islamic communities.

*It would be quite good for them to see a video or a leaflet that we could give out. 'Yeah, I suffered depression, I suffered schizophrenia, it was really hard for me but this is how I did it and it was worth it'. You need a wee role model scenario. Where they could say 'Oh right, people like me do give up smoking then'. [MH11]*

Although many of the issues raised were applicable to leaflets in general, some themes emerged which the participants felt were particularly pertinent for the client groups they worked with. For example, visual impairment was mentioned in relation to older adults, concentration was an issue for people with mental illness, while the availability of culturally appropriate, translated information was a noteworthy issue for minority ethnic communities.

### **3.7.2 Information gaps**

The content of leaflets was discussed and areas where information was lacking were identified. The participants suggested additional items that they thought should be incorporated, particularly in relation to the client groups they worked with.

For example, staff working with minority ethnic communities identified a lack of translated information in certain languages. While information was readily available in the main South Asian languages (e.g. Urdu, Punjabi and Bengali), there were thought to be fewer resources available in other languages, particularly those common in newer immigrant communities (e.g. Chinese, Arabic, Turkish, Eastern European languages). The diversity in languages was recognised as a challenge - one respondent noted that there were over ninety languages spoken in Glasgow alone and that it would be problematic to produce and store resources for all of these. Three participants mentioned having English translations alongside the other language, which would be beneficial for professionals wanting to facilitate usage.

Another gap identified was the need for more information about different forms of tobacco use common in some minority ethnic communities (e.g. oral tobacco and hooka pipes). One respondent also identified a low awareness of pharmacotherapy (e.g. NRT and Zyban) as an issue among South Asians. It was also noted that people calling foreign language telephone quit-lines provided by the NHS in England were rerouted to the generic Scottish quit-line, which only provides information in English.

Participants working in the mental health field also had suggestions about additional information that it might be useful to incorporate into health promotion leaflets. For example, some felt it would be useful to have information about the impact on tobacco on particular conditions or symptoms (e.g. schizophrenia, anxiety, depression) or about cannabis and mental health. However, as is discussed below, not everyone agreed on the appropriateness of this kind of information.

Suggestions were also given in relation to information that would be useful for older adults. For example, it was felt that information on pipes and cigars could be useful, and that information should go beyond primary prevention messages to include more tertiary prevention, looking at the benefits of stopping smoking even for people who already have a smoking related disease (e.g. cancer or heart disease).

Opinions on the need for targeted information varied. While some felt that tailored information resources would be useful, others felt that the messages about tobacco should be the same for everyone. Some, particularly within the mental health field, felt more strongly and noted that it was potentially

stigmatising to treat people differently. Generally, it was accepted that tailored leaflets could be worthwhile in specific circumstances, but that they would need to be developed with sensitivity.

*That's assuming that the information for older adults is different. Obviously the harmful effects would be the same and I suppose the 'it's never too late' message would be specific to them but I have reservations about the presentation of specific material. [OA03]*

Some of the participants noted that they make their own leaflets when they cannot find suitable information. For example, one had worked with a group of Bangladeshi women to develop a leaflet on paan (oral tobacco). Another smoking cessation professional described how she had produced a leaflet describing the content of group programme to distribute to potential quitters, as well as a summary of the information covered in each groupwork session for clients to take away for reference.

Another smoking cessation specialist commented that leaflets in circulation were sometimes outdated and did not reflect the current situation in smoking cessation.

*I feel disappointed in [their] leaflets...I had a look at their catalogue the other week and the most recent leaflet is 7 or 8 years old and some of the leaflets that they're still producing are 10 years old and I'm very disappointed in that because they really should be producing things that meet the needs of people now. I'm not saying it's not good, but the look has to change, the content maybe has to be formatted slightly differently. [SC03]*

It should be noted that while the above discussions focus on written information, particularly leaflets, the participants also commented on non-written materials, which is discussed in section 3.7.4.

### **3.7.3 Using and accessing resources**

The service providers had a great deal to say about the use and effectiveness of leaflets. While some accepted that leaflets had a worthwhile place in health promotion, many felt that their impact was limited or that they were not particularly cost-effective. Participants noted that leaflets were a passive way of informing people and that it was not simply enough to hand out leaflets without providing further support and information. They also questioned if people actually pick up and read leaflets, particularly if they have literacy difficulties or if they are not actually motivated to stop smoking. The appeal of written resources was noted as being particularly limited for many minority ethnic communities, who were thought to prefer oral information.

*My understanding is that although leaflets can look great and we might think they're wonderful, the evidence has shown that the actual impact on the people they're targeted at is quite low. [OA05]*

*Ok, I use leaflets, we all use leaflets, but we need to be aware of their limited appeal to people. Again, we need to come up with more creative ways of letting people know what's on offer, where to go get it. [SC04]*

A number of participants commented that leaflets could be effective when their use was facilitated by a health professional or used to reinforce information that a patient has been given. For example, many of the smoking cessation specialists used leaflets as part of group or one-to-one interventions or gave them to clients to take away for their own reference. Although a number of participants were critical of leaflets, only one person specifically identified a need for training in the use of leaflets.

*I am in favour of giving something to people like this [booklet] to fall back on if they want to read more about it, but first it is to get them to think about it. [BME03]*

*I think we need training in how to use leaflets, how to work through something like this with someone, to be able to direct them to the most relevant bits for them. [MH07]*

Accessing appropriate written resources was a further issue raised by the service providers. A number of participants felt that co-ordination of resources was a problem and that it could be difficult to find out what resources were actually available. Three participants mentioned specifically the difficulties in accessing resources developed by the NHS in England (both translated leaflets and foreign language telephone quit-lines). This potentially leads to situations where time, effort and money are wasted producing new information when similar resources already exist.

It was noted that availability of resources to download and print on the internet improved access, but often meant reduced quality. The cost of obtaining, producing and storing resources were further barriers to access, particularly when organisations had limited budgets or conflicting priorities.

*Certainly, there needs to be a coordination, you see there's so many leaflets that are published now, there are so many types, there will be a 90% overlap of information within these. [BME03]*

*That's the thing - if you've got some money you can buy leaflets. If you haven't got any money, then that's a bit harder. So you can download stuff from the internet, ...There may well be stuff, it doesn't mean that it's not there, I just haven't found it...so we did our own! [SC02]*

Participants were asked their opinions on having centrally prepared resources. In theory, most agreed that this would be beneficial, although there were some caveats. For example, there were questions as to how this would be managed on a practical level and who would co-ordinate it. A couple of participants commented that it would be better to adapt existing quality resources (e.g. from the NHS in England) for use in Scotland rather than redesigning entirely new ones. However, the issue of meeting local needs was raised. One person noted that centrally prepared resources were acceptable on the proviso that local contact details or additional information could be added. Other respondent felt that locally developed resources, to match the needs of distinct communities, were more appropriate.

*Centrally produced materials – yeah, I don't see why that's not a good thing, it makes for economies of scale, makes our life easier...The thing is being able to put your local service provider on there. So as long you can, at the same time, signpost people to a local provider. [BME09]*

The issue of clients accessing materials was also discussed. It was noted that traditionally health promotion leaflets were distributed in health settings, particularly GP practices, hospitals and pharmacies, which means that certain people (e.g. those who are housebound or those who have limited contact with health professionals) are unlikely to access this information. To improve access it was suggested that leaflets could be circulated more effectively by distributing them in places other than medical settings, in particular in places where the client groups might congregate. A number of ideas for targeted distribution were suggested, such as social clubs, care homes, drop-in centres, relevant hospital wards, religious settings, community centres and even ethnic shops.

*We find with a lot of leaflets, people put them in places where the communities don't go to get information, they assume we all use the same places and we don't, and therefore the leaflets can just sit there and not be used. [BME08]*

*Maybe it's spreading the deposits for all these leaflets, pharmacies, sport centres, lunch clubs where older people gather, where do people with a mental health problem go for their self help groups, for their interest groups? [SC04]*

A number of participants noted the importance of involving potential service users in the development and evaluation of resources. Three of the interviewees working with minority ethnic communities in particular had much to say about engaging with different communities or client groups in needs assessments, to find out what would work best for them. The importance of involving community members was mentioned particularly in relation to the production of translated materials. One respondent commented that involving users in the creation of materials can also be educational and motivational.

*Get them involved. Don't sit there and develop it and then hand it out to folk. That's not the way to do it. Go out and meet people, go and get focus groups, see what they think of resources and develop it very much from the bottom up. [MH09]*

*I would be interested to know if any of these [various leaflets] were developed with minority ethnic communities because I know from our own experience when we've translated materials there's always been a thing about quality assurance [BME08]*

To summarise, leaflets were generally viewed as worthwhile if they were used in a facilitated manner, but that it was not enough to simply provide leaflets and assume that these alone would help people to address their tobacco use.

### **3.7.4 Other media**

In addition to discussions about leaflets, the participants also had a great deal to say about other resources that could be used to impart information. They talked about a number of ways of disseminating health promotion messages, including using audio-visual resources, other print media, the internet and broadcast media.

Some of the participants felt that it was important to develop audio versions of leaflets – audio cassette, video or DVD – particularly for important for people who have difficulty reading, for example due to visual impairment or literacy problems. A number of the participants working with minority ethnic communities also felt that audio resources might be appropriate for certain communities (including Chinese, South Asian and Gypsy Travellers) that have an oral tradition.

*Well in relation to the Chinese community, I'm not absolutely sure that just relying on the written word is sufficient. There's lots of commentaries to suggest that, for example, videos and other multimedia, are actually more important and more effective. [BME09]*

*In that context for Travellers we need to think about whether there's visual stuff that people can pick on, and it may well be an audio-visual equivalent, whether it be a CD or tape or short video that releases the key messages [BME11]*

The use of other print media, such as newspapers and magazines, to disseminate information about tobacco and services to help people quit was only mentioned by a couple of participants. In particular those working with minority ethnic community thought that newspapers or magazines in community languages could be used to target information at particular groups. One respondent talked in detail about his plans to use this approach in the coming year to raise awareness:

*This year I have plans to have, in terms of media campaigns...two or three articles in minority ethnic magazines, widely-read magazines, on smoking issues, so we'll see how that pans out. This is something new; it is part of the wider accessibility and communication of services and raising people's awareness. [BME03]*

Interestingly, few participants talked about the potential for using the internet as a way of distributing health promotion information.

The use of broadcast media – television and radio – was mentioned by more people. Television was regarded as an important method of communicating messages about tobacco and quitting because of its visual impact. In particular, the potential for using television to advertise the availability of stop smoking services was noted. One participant commented that workers should be informed about new campaigns before they are launched, to prepare themselves for the impact, and that any investment in media campaigns had to be matched with investment in services to meet public demand.

Others questioned the effectiveness and cost of television health promotion campaigns. Indeed, one worker in a rural area commented that national campaign drives might not reach more isolated areas, which she felt in itself was an inequality issue.

*TV will have more of a physical impact. But I don't know, having said that, the adverts that HEBS and all these other agencies do, do they have an impact? Are people not smoking as much because of these? What does research show? [BME04]*

*Possibly something in the media, something on the television, that tells people that the service is available to everybody, and specify everybody -*

*the general public, pregnant mums, ethnic minorities, mental health, the lot...I think one big media awareness advert would be quite the thing because a lot of people actually listen to the smoking adverts on the television. [SC01]*

Some participants pointed towards the importance of including satellite television stations and ethnic media for widening the reach of health promotion advertisements.

*Obviously national and local media, but also black and minority ethnic media as well, because I think that's too often left out...of those sort of campaigns. It's obviously important to use the sources that people use in getting that message across. [BME10]*

There was debate around the appropriateness of targeting messages to particular communities. There was consensus that using the media needs to be handled sensitively and that messages on television should be broad rather than focused. This was for reasons of cost, and to avoid singling out and stigmatising particular groups. An inclusive approach, including representation of people from different backgrounds was the preferred option.

Radio was another audio media that it was suggested could be used to broadcast messages about smoking and quitting, and to advertise services. Some of the participants already had experience in using local radio. For example, one smoking cessation specialist commented that she already used local radio to advertise the service, while another had run a week-long anti-tobacco campaign on an a local Asian station, with information about the affects of smoking, people's personal experiences of quitting, expert advice and listener interaction, which he said had been well received. Three participants working in minority ethnic health in the Glasgow area mentioned that the local Asian radio station was an effective way of targeting the Asian community there.

### **3.7.5 Summary**

In summary, participants felt that it was important to provide information about tobacco and cessation in a variety of formats, in order to raise awareness and improve access to services. Leaflets were seen as worthwhile if they were used in conjunction with support, but their limitations were recognised. A range of other methods to impart health promotion information was recommended, including audio-visual resources and broadcast media. Concerns were expressed about the duplication of information and difficulties in accessing resources. A more co-ordinated approach to the dissemination of information and involving service users in the development of resources were noted as key actions. Any mass media campaign needs to be met by an investment in services in order to meet expectation and demand by the public.

## **3.8 RESEARCH, EVALUATION AND MONITORING**

Service providers were asked if they knew of any research relating to tobacco issues within the relevant client group(s) and for further details where appropriate. They were asked if their organisation was required to evaluate its performance and if they had any further comments about monitoring and evaluation that they wished to raise. Finally, were asked what they felt were the

priorities for future research and were asked to comment on some recommendations for research.

### **3.8.1 Knowledge and experience**

Knowledge about existing research on tobacco and cessation issues relating to minority ethnic communities, older adults and mental health varied, depending on the respondent's interests and job remit. Those who had experience of tobacco work appeared to be aware of the key research issues, and some of the other participants also exhibited a sound awareness of key research. One of the participants had undertaken research with older adults about smoking and had a thorough knowledge of existing research in this field.

However, in general, there was low awareness about key research findings related to tobacco use and quitting among the health professionals working with the three target groups. Some commented that there might be published research available, but that it was time consuming to search for it. Raising awareness of existing literature among professionals working with the client groups was recommended and having easily accessible literature reviews was identified as a positive step.

The majority of the participants were involved in evaluating their work in some way. They appeared to be accustomed to keeping records for the purposes of evaluation and monitoring, with most commenting that their organisation built evaluations into overall work-plans, with information being collected continuously to feed into performance assessment.

*If it's done in real time, if all the information is gathered real time, and not just at the end of a project, then it can be somewhat easier.*  
[BME07]

*I certainly find it useful in terms of quality assurance and knowing exactly what we're doing, or not doing as the case may be, and it enables us to plan that little bit better.* [MH08]

In general evaluation was recognised as being valuable, with few participants commenting that this aspect of their work was difficult or problematic.

### **3.8.2 Gaps and priorities**

A number of gaps in the knowledge base were identified and participants suggested what they felt were priorities for future research, monitoring and evaluation.

#### ***Tobacco use prevalence***

The need for further evidence about tobacco use prevalence within certain sub-sectors of the community was identified. Section 3.2 discussed that there was anecdotal evidence about prevalence, but no reliable up-to-date statistics in the Scottish context. A few participants advocated better information on prevalence of smoking among older adults, broken down into different age brackets and by gender. The majority of participants working with minority ethnic communities agreed with a recommendation that there is a need for better research on

tobacco use prevalence among minority ethnic communities in Scotland, particularly figures broken down into age and gender.

Two participants working with minority ethnic communities noted that stronger evidence about tobacco prevalence would help people realise that this was an important issue, and that without the evidence base it was easier to ignore the problem. Two participants also commented that it would be useful to collect data on ethnic origin in wider health services monitoring, for example to find out about the prevalence of different types of cancers and other smoking related diseases in different ethnic groups.

*We live in an evidence based society now and because there's very little evidence about the prevalence it's very easy for people to say 'well, it's not really an issue'. And unfortunately that's the conclusion that a lot of people come to. So that's why it's absolutely key for the researchers out there to actually show people about prevalence rates so actual services can be provided. [BME10]*

*A lot of our energies have one into things like diabetes, which we've had information about in the South Asian community. ...We have looked at smoking and tobacco use, and I think the thing that really holds us back is lack of scientific, quantitative data, and that's really sort of prevented us from taking things forward. ...We simply don't have the data, the information that would help us form a strategy around it. [BME07]*

While there were no calls for more studies on the prevalence of smoking among people with mental health problems, (perhaps because the mental health workers were well aware of the scale of tobacco use among their clients from experience), a couple felt that studies on tobacco use prevalence among staff and carers working in the mental health field would provide interesting background information as to why smoking might not be addressed within the mental health field. Indeed, research into the reasons why health professionals working with older adults and in mental health do not raise the issue of tobacco use with their clients was identified as another area for further research.

Others felt that there was enough information on tobacco use prevalence and attitudes:

*I can reiterate that the research papers are there, prevalence-wise we are aware... Draw the action plans rather than keep doing [research]... start working on the recommendations. Just now there is a stop, they do the research and it stops there. [BME03]*

These participants argued that using existing information to develop strategies and action plans was more important than doing further research.

### **Smoking cessation data**

In addition to better information about smoking rates, a number of participants were interested in data on quitting rates. People felt that both local and national level statistics about people using smoking cessation services, broken down into different demographic groups, would be useful. Monitoring the uptake of services by priority groups was also seen as important. Surprisingly, none of the five smoking cessation professionals talked in detail about monitoring requirements

for smoking cessation services or expressed any major concerns about this aspect of their work.

The need for a wider evaluation of smoking cessation services in Scotland, to find out who is accessing services, why people might not be attending services and what kind of interventions are effective was identified. One participant noted that a national evaluation study from England shows that what is being done down south is effective, but that the findings are not necessarily transferable to the Scottish context. The importance of disseminating information about the effectiveness of smoking cessation services to health professionals was also noted as important.

It was noted that a different monitoring framework might be needed when looking at inequalities groups. One participant discussed at length that qualitative evaluation should be granted a higher profile than just collecting statistics.

*The only real difficulty I have with a lot of evaluation, is the 'bums on seats', it's quantitative. Well, I'm afraid the way we work, it's qualitative, there's got to be a balance. The story, to a certain extent is more important than the results. [MH09]*

A number of participants argued that traditional outcome measures, such as quit rates, may be lower for some groups and that other ways of evaluating success (such as harm reduction outcomes, awareness and confidence) should be incorporated into monitoring and evaluation frameworks.

### **Service effectiveness**

A number of participants identified a need for further evaluation of the evidence base on the effectiveness of approaches to tackling smoking with certain client groups. A general theme that emerged was the need for an appraisal of different smoking cessation strategies and examples of stop smoking initiatives that had worked with particular communities. People accepted that there was a need to work with inequalities groups and wanted examples of good practice to help in developing appropriate services.

*I suppose examples of good practice, what's worked elsewhere really and we could develop there. [SC05]*

*We need to try to work out what to do with older people, it has to be evaluated, so we can actually say 'yes, A, B and C is effective, and D is not', so that needs to come in the future I think. [OA05]*

*I think it would be nice to see some way of knowing about best practice and some way of knowing what works well and why it worked. [MH08]*

Other suggestions for further research were also proposed. For example, many people felt that studies looking at people's motivation to quit (particularly among older adults and people with mental health problems) and research with smokers who were resistant to quitting would provide useful learning. An investigation of the effectiveness of harm reduction approaches within particular communities was a common area of interest (which was discussed in section 3.4.5).

*I think if we research why people give up then we can maybe get better at helping more give up and sustaining long term abstinence. Or it could be*

*does harm reduction work, is it a useful alternative to smoking cessation?*  
[SC04]

*What about the people who don't want to go to along to groups? What can you best do with these people? And the people that are not motivated, how do you help to motivate them?* [OA05]

Many participants felt that more information and guidance was needed in relation to medications. In particular there were calls for studies on appropriate dosage of NRT for severely addicted smokers and in relation to mental health. Others wanted more information about the impact smoking and quitting on the dosage of medications prescribed for mental health problems (e.g. anti-psychotics and anti-depressants). The impact of cannabis on mental health was regarded as an important area for further study.

*We've already touched on it, medication, definitely, we need to look at their meds and how that affects them.* [MH02]

*More awareness of the side effects of stopping smoking, the stresses that it causes and how that interacts with people's medication.* [MH01]

A number of the participants noted that it was important it to involve service users in research and service delivery. Using community development approaches and action-based research was felt to be empowering for service users, and their involvement helped to ensure that models of service delivery were appropriate and accessible.

### **3.8.3 Summary**

The participants felt that increasing the knowledge base would enable them to better target appropriate health promotion strategies. They identified shortcomings with existing research and audit strategies, and priorities for action to address these. Some commented that acting on research and implementing recommendations was more important than undertaking new studies.

## **4. RECOMMENDATIONS**

The data from the interviews was analysed to look for key themes and to find out what were the needs of different professionals who work, or may work, with the target communities, in relation to tobacco and cessation issues. The findings from the research have identified a number of actions that are needed to address these needs, which are discussed below under a number of themes.

### **4.1 Funding and resources**

- Smoking cessation services should receive sustained, ring-fenced funding in order to provide adequate generic services and to enable them to further develop services to work with target groups. Long-term contracts for smoking cessation co-ordinators and practitioners would also help services to develop more sustainable and appropriate services.
- Other voluntary and statutory sector organisations need appropriate funding, resources and expertise in order to undertake tobacco and cessation work with their clients. Professionals who undertake tobacco

and cessation work as part of their job (i.e. non-specialists) should be allocated ring-fenced time to undertake this work.

#### **4.2 Networks and partnerships**

- Smoking cessation services should be encouraged to publicise their services widely and engage with a wide range of partner organisations, to raise awareness among quitters and organisations working with target groups (who may wish to refer clients on).
- Information and advice about tobacco issues, cessation services and tobacco policies should be communicated to a wide range of community and voluntary organisations, especially outside the health and statutory sector, to encourage people to think about the importance and relevance of tobacco.
- Information about the *Smoking Cessation Guidelines for Scotland* (Health Scotland and ASH Scotland, 2004) should be disseminated to a wide range of professionals and organisations. In particular members of the primary care team should be aware of the guidelines and their role.
- A range of partner organisations should be involved in the development and implementation of tobacco strategies (both local and national). A wider range of organisations (including voluntary, community and non-statutory organisations) should be invited to join the Scottish Tobacco Control Alliance (STCA). Local tobacco control alliances should encourage the involvement of organisations working with target groups.
- Where possible, client groups should be involved in developing, piloting and evaluating services, to ensure that their particular needs are met.

#### **4.3 Tobacco strategies**

- Tobacco strategies should include a range of approaches to tackling tobacco, including but not limited to cessation, and should involve participation of different partners.
- Health Boards should be encouraged to develop local tobacco strategies that take into account national targets, but also acknowledge local populations and identify priorities accordingly.
- Health service staff at all levels (including planners, policy makers, managers and practitioners) should be aware of the need to address tobacco and of their role in the process.
- Research into the availability and use of non-smoked tobacco products (e.g. paan, gutkha, tobacco 'toothpaste') in Scotland is required and trading standards should be involved in ensuring that the sale of such products is properly licensed and that appropriate health warnings are included.

#### **4.4 Smoking Cessation Service Development**

- Smoking cessation services should receive sustained, ring-fenced funding and staff should be offered long-term contracts. Capacity and expertise can be increased by working in partnership with trained workers from other relevant organisations.

- Smoking cessation services should raise awareness of their service within local communities and among a range of organisations. Local services should be visible, accessible and appropriate to clients from different communities.
- Service providers should consider ways in which they could be made more accessible and relevant to different groups, and how high risk groups could be targeted. As part of this process, smoking cessation professionals should be aware of prejudices and stereotypes (e.g. racism, ageism, disability discrimination). Where possible, service users (actual or potential) should be involved in the development and evaluation of services.
- Smoking cessation work should be developed in accordance with current guidelines for smoking cessation (Health Scotland and ASH Scotland, 2004); however, there needs to be an awareness that more flexible approaches and alternative models of service delivery may be required to achieve success with some clients.
- Evaluated pilot projects should be established to test out new and innovative approaches working with particular inequalities groups, and the learning from these used to develop appropriate services in future. Alternatives to group work, longer and more intensive support, and addressing relapse are likely to be needed for some clients (e.g. those with severe and enduring mental health problems, those who are highly addicted to tobacco).
- Services should investigate alternative ways of reaching particular client groups, including the isolated, housebound and hospitalised. They may want to consider providing outreach or specialist services within a range of venues – including community settings, religious venues, hospitals, care homes, drop-in centres and workplaces. Providing drop-in services or tying smoking cessation into other activities may be appropriate for some client groups.
- In addition to cessation, initiatives are required for people who are not yet ready to address their tobacco use or for people for whom smoking has not become a health issue. Prevention and pre-quit initiatives might include information and education sessions for particular client groups or harm reduction strategies.
- Awareness raising and cessation support should also be provided for staff, carers and families of some client groups (particularly mental health and older adults)
- There should be a review of quit-line services in Scotland to ensure they are meeting the needs of different client groups, particularly those for whom English is not their first language. It would be useful to investigate if services developed in England (e.g. Asian quit-lines provided by the NHS and Quit, the UK Chinese quit-line) could be adopted in Scotland.

#### **4.5 Second hand smoke and smoking policies**

- Awareness raising and publicity campaigns are required in advance of the new legislation to educate people to the dangers of second-hand smoke, the extent of the legislation and about smoking cessation services. This should take the form of national media campaigns, easy to read leaflets

and posters, and direct engagement to raise awareness among particular staff and client groups.

- Tobacco policies should be appropriately signed and a named contact given in event of enquiries. Tobacco policies should be about health and safety and should not be moral statements.
- Voluntary and statutory organisation should be given information and advice on implementing tobacco policies to protect the health and safety of the public and staff.
- The implementation and impact of smoke-free policies in different settings should be monitored and evaluated, looking at staff and user views, compliance and environmental impact. Where exemptions are granted there should be appropriate environmental controls to minimise the effects of second-hand smoke in areas where smoking permitted; regular environmental audits to assess levels of smoke pollution; and risk assessments for staff and others exposed to second-hand smoke.
- Smoking cessation services will need appropriate investment and support in order to meet any increased demand placed on them as a result of any new legislation.

#### **4.6 Education and training**

- All health professionals should be trained in brief advice for smoking cessation, in accordance with Smoking Cessation Guidelines (Health Scotland and ASH Scotland, 2004), and Standards for Smoking Cessation Training (Partnership Action on Tobacco and Health, 2003). This would include all members of primary care, secondary care and psychiatric teams, as well as dentists, pharmacists and allied health professionals. Learning networks may be adapted for this purpose.
- Tobacco and smoking cessation should be included into undergraduate courses and should be offered as part of post-registration and post-graduate training.
- Specialised training should be tailored for those working with particular client groups, which would meet the Standards for Smoking Cessation Training and would address particular cultural issues or special needs relating to the client group.
- Smoking cessation specialists should be provided with anti-discriminatory training and have at least a basic awareness of mental health issues.
- Basic tobacco and cessation education should be developed and offered to a wider range of professionals working outside healthcare settings, to raise awareness of the importance of the issue. Learning networks may be adapted for this purpose.
- It would be useful to evaluate the impact of training on staff knowledge, attitudes and practice.

#### **4.7 Health promotion materials**

- Information on tobacco use and cessation should be provided in a variety of formats (printed and audio-visual) and in a variety of languages. Attention should be paid to the language used, graphics, design and font size to ensure they are readable and represent different communities.

Leaflets should be distributed in a range of health and community organisations to improve access and reach.

- Where possible a diverse range of service users should be involved in developing and pre-testing resources. At local level this can be particularly educative and empowering. Leaflets should also be evaluated and reviewed regularly to ensure the information contained within is correct, to assess any gaps in information provided, and to check that the language and presentation is user-friendly.
- It would be useful to have further printed information on other smoking materials (e.g. pipes, cigars, roll-ups), cannabis and chewing tobacco; and information targeted towards certain client groups that addresses specific issues.
- There is a need for better co-ordination of health promotion materials. It should be investigated whether printed materials in a range of languages developed by the NHS in England could be rebadged/adapted for Scotland.

#### **4.8 Mass media**

- Television (terrestrial and satellite), radio and the press should be employed to raise awareness of the dangers of smoking, the impact of second-hand smoke, the extent of new smoking legislation and the availability of NHS smoking cessation services. Both national and local media, and specialist media (e.g. Asian channels and radio stations) should be used.
- Smoking cessation services need appropriate investment and support in order to meet any increased demand placed on them as a result of media campaigns. Smoking cessation professionals should be informed about any new national campaigns in advance.
- Any media campaigns should try to reflect diversity in the images presented.
- Positive campaigning, e.g. using testimonies of people who have successfully stopped smoking, should be used in addition to traditional campaigns emphasising the dangers of smoking.

#### **4.9 Monitoring and evaluation**

- Information is required on the extent to which services are being accessed by different client groups and their outcome measures.
- The Scottish Executive should seek to include the over-65s in smoking cessation targets.
- Smoking cessation specialists and others who provide smoking cessation support as part of their work should understand and know how to implement local and national guidelines on monitoring and evaluation (Partnership Action on Tobacco and Health, 2004).
- There should be an awareness that quit rates may be lower for some client groups and that alternative outcome measures will need to be considered (e.g. a wider picture of behavioural change, harm reduction measures).

- The smoking status of all patients should be regularly recorded by health professionals, as per the Smoking Cessation Guidelines (Health Scotland and ASH Scotland, 2004). In addition, the smoking status of mental health patients should be recorded on admission to hospital and monitored thereafter by primary care and mental health services.

#### **4.10 Further research**

- There is a need for baseline statistics on smoking prevalence and patterns of tobacco use among minority ethnic communities in Scotland, including 'traditional' minority communities (e.g. South Asian and Chinese) and 'newer' or more 'invisible' minority ethnic groups (e.g. Arabic communities, Eastern Europeans, Refugees and Asylum seekers, Gypsy Travellers). This should include an investigation of age and gender distinction and covert tobacco use. Studies could make use of questionnaires recently developed in Urdu, Punjabi, Sylheti and Cantonese to measure tobacco use (Hanna, Hunt and Bhopal, 2004).
- Research into the availability and use of non-smoked tobacco products (e.g. paan, gutkha, tobacco 'toothpaste') in Scotland is required.
- There is a need for information on how tobacco use changes over time among those with mental illness, to identify particular smoking risk factors (e.g. the relationship between tobacco use and quitting, with periods of mental ill-health, stress, activity etc). Research on tobacco use prevalence among psychiatric nurses and carers would also be valuable.
- There is a need for further research on the effectiveness of different approaches to cessation (including harm reduction approaches) to find out what works best helping people from different client groups to stop smoking.
- Services should be encouraged to undertake local needs assessments and community based action research, in different settings and with different populations, to find out about the people in their area and their distinct tobacco needs.
- Service providers would benefit from more information about the implications of cannabis on mental health.

#### **Summary and conclusion**

A range of actions is required to address tobacco use amongst groups facing inequalities and to keep tobacco as a high profile issue. Awareness needs to be raised and assumptions challenged, both among the public and professionals. Strategies for change include awareness-raising campaigns in the mass media; providing education and training for service providers; providing appropriate and accessible smoking cessation services; providing appropriate health promotion resources; implementing and supporting smoke-free policies; and undertaking further research.

Continued support from policy makers and health service managers is vital to keep tobacco and inequalities issues high on the agenda. These recommendations need to be met with adequate investment in smoking cessation services and other tobacco control measures, and a range of partner agencies need to be involved in their implementation.

It is anticipated that some of the recommendations outlined above will be taken forward by projects funded by ASH Scotland's Tobacco and Inequalities small grants fund. Other recommendations will need to be addressed by policy makers, health providers and tobacco control partners. Working with communities such as minority ethnic groups, older adults and people with mental health difficulties can be challenging, but it can make a real impact on the health of Scotland's people.

## 5. FURTHER INFORMATION

For more information on ASH Scotland's **Tobacco and Inequalities Project** please see our website:

[www.ashscotland.org.uk](http://www.ashscotland.org.uk) (follow the link: initiatives/inequalities).

The following documents are available on-line:

Copies of the three **literature reviews**

- Tobacco and ethnicity
- Tobacco and older adults
- Tobacco and mental health

A tobacco and inequalities **service and resource directory**

A copy of the full **needs assessment summary report**

A report on **interviews with community groups**

Or **contact ASH Scotland:**

Action on Smoking and Health (ASH) Scotland  
Tobacco and Inequalities Project  
8 Frederick Street  
Edinburgh  
EH2 2HB

Tel: 0131 225 4725

Fax: 0131 225 4759

Email: [ashscotland@ashscotland.org.uk](mailto:ashscotland@ashscotland.org.uk)

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## 7. GLOSSARY

**Anxiety disorders:** severe and long lasting feelings of unease and discomfort that interfere with a person's everyday life, work or relationships. Specific anxiety disorders include panic disorders, post-traumatic stress disorder, obsessive compulsive disorder and phobias.

**Asylum seeker:** a person living in a country other than his or her own, in search of protection. This describes those who may not fulfil the criteria laid down by the 1951 Geneva Convention to be granted refugee status, or those who have applied for protection as a refugee but are awaiting the determination of their status.

**Bipolar disorder:** a condition in which people experience extreme mood swings, experiencing depression on some occasions, mania on others and normal mood in between. Also known as manic depression.

**Black:** an ethnic description based on skin colour, usually for those with African-Caribbean ancestry. Collectively used for those describing themselves as Black, Black Scottish, Black British, Black Caribbean, Black African and Black Other.

**Brief advice or Brief intervention:** opportunist advice to smokers to stop and recommendation to use treatment (e.g. an NHS smoking cessation service) to help them to do so. This advice does not in itself involve help with smoking cessation.

**Bupropion (Zyban®):** a non-nicotine based medicine licensed for prescription to help with stopping smoking, by helping to reduce cravings and withdrawal symptoms.

**Chinese:** Those who were born in, or whose ancestry is from, China (including Hong Kong).

**Community:** a group of people who share a common interest, sense of identity or common geography, or are perceived by others as sharing common interests or identities.

**Depression:** 'clinical' depression is defined as a low mood which affects all aspects of life (home, work, family, social activity) and lasts for more than two weeks, influencing a person's ability to carry out their work or conduct normal personal relationships.

**Ethnic group:** a social group characterised by a common sense of identity based on a number of features, such as language, religion, country of origin, customs.

**GP (General Practitioner):** a doctor/physician who is not a specialist but treats all illnesses and who provides care outside a hospital (e.g. at a GP practice or health centre, or in a patient's home)

**Gypsy Traveller:** communities with a long tradition of a nomadic lifestyle, whatever their race or origin, excluding organised groups of travelling show-people. Also known as gypsies.

**Health Board:** NHS Health Boards are responsible for all NHS services in their area. There are fifteen regional Health Boards in Scotland.

**HEBS (Health Education Board for Scotland):** the national agency for health information, health promotion, health advice and health education in Scotland. Now known as NHS Health Scotland.

**Hooka:** a hooka is a pipe used to smoke tobacco filtered through water. Also known as argila or hubbly bubbly.

**Minority Ethnic Community:** people whose ethnicity is different from the majority of the population in a specific area. Also referred to as ethnic minorities and Black and Minority Ethnic (BME) communities. The term minority ethnic is the preferred designation used by the Race Equality Advisory Forum in its 2001 report on a race equality strategy for Scotland.

**NHS (National Health Service):** health care in the UK is delivered free at point of access.

**NRT (Nicotine Replacement Therapy):** pharmaceutical products that help people to give up smoking by reducing their withdrawal symptoms. Comes in a range of forms including skin patches, chewing gum, tablets, lozenges, inhalators and nasal spray.

**Non-smoked tobacco:** tobacco consumed by other means, such as chewing or sniffing. Includes paan and betel, which are popular forms of chewing tobacco in South Asian communities. Also known as smokeless tobacco.

**Neurosis:** mental states rooted in the normal emotional responses of a person's culture, but the responses are much more severe than normal. Common neuroses include depression and anxiety disorders.

**Paan:** a smokeless form of tobacco. Paan is a green leaf filled with a paste made of areca nuts, lime condiment, sweeteners and tobacco, which is chewed.

**Partnership Action on Tobacco and Health (PATH):** an initiative, managed by ASH Scotland and funded by the Scottish Executive, which leads developments in good practice for Smoking Cessation services, including training and data collection.

**Psychosis:** describes the distortion of a person's perception of reality, often accompanied by delusions and/or hallucinations. Examples include schizophrenia and bipolar disorder.

**Refugee:** a person who is outside the country of their nationality due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, and who is unwilling to avail themselves of the protection of the host country.

**Schizophrenia:** a disorder where thoughts and perceptions become distorted, with symptoms including delusions, hallucination and blunted emotions.

**Scottish Tobacco Control Alliance (STCA):** a multi-disciplinary, multi-sectoral body of over 120 organisations concerned with the impact of tobacco on Scotland and its people.

**Smoking Cessation Co-ordinator:** have a co-ordinating role for the smoking cessation services across a particular Health Board Area.

**Smoking Cessation Practitioner:** a generic term for those who offer specialist cessation support, regardless of whether it is as part or all of their remit.

**Smoking Cessation Service:** services set up to help people stop smoking, run by trained smoking cessation specialists. SCS offer both structured behavioural support and NRT or Zyban to smokers intending to stop, by specially trained staff. This support can be offered in groups or individually and follows a structured protocol.

**Smoking Cessation Specialist:** someone whose role is exclusively to provide specialist cessation support (i.e. the work does not form part of a wider remit).

**South Asian:** residents of Britain who were born in, or whose ancestry is from, the Indian sub-continent. Those people born in Bangladesh, India and Pakistan, and their descendants.

**Traveller:** a number of groups are covered by this term, including Gypsies, Fairground and Circus people, Bargees and New Age Travellers.

**Zyban:** see Bupropion.

## 8. APPENDICES

### Appendix 1 – Example Interview Schedule

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#### ASH Scotland Tobacco and Inequalities Project Needs Assessment Questionnaire (Minority Ethnic Groups)

##### Part 1: Information about the respondent and their work

*Thank you for taking part in our needs assessment research. The information you provide will be used to inform our recommendations. Information will be used in anonymised form only.*

- 1 Name of participant
- 2 Job title
- 3 Organisation
- 4 Address
- 5 Phone number
- 6 Email
- 7 Website
- 8 Geographic area of operation
- 9 Employed full-time or part-time?
- 10 Hours worked per week?
- 11 Length of time in post?

*First of all, I'd like to ask you some questions about you and your work...*

- 12 What are the main aspects of your job?  
(Prompt: What do you do in a typical week?)  
(Prompt: What is the main work of your organisation?)

*And now about your organisation...*

- 13 Approximately how many people work in your team or for your organisation?  
(Details)
- 14 Can you tell me about how your organisation is funded?  
(Prompt: Source(s) of funding)  
(Prompt: Duration of funding, short term or permanent)
- 15 What key organisations or individuals do you work with?
- 16 How could your partnerships/networks be improved?
- 17 Are there any further comments you would like to make in relation to staffing, funding, resources, networks or partnerships?
- 18 Are you required to evaluate any aspects of your service provision?  
(Yes – go to question 19, No – go to part 2)
- 19 If yes, please provide details on what you evaluate and how you evaluate it.  
(Details)

## Part 2: Experience of tobacco work

*I'm now going to ask some question about your own tobacco work (if any) and any tobacco work within your organisation...*

- 1 Have you ever done any tobacco work?  
(Yes – go to questions 2 & 3, No – go to question 4)
  
- 2 If yes, what kind of work was it?  
Education/prevention    Tobacco cessation  
Policy Development    Developing resources  
Providing training    Research  
Other (please specify)
  
- 3 Please provide further details:  
(Prompts: Type? Target audience? Funding? Duration?)
  
- 4 Does anyone else in the organisation do any tobacco work?  
(Yes – go to question 5, No – go to question 6)
  
- 5 If yes, please provide details:  
(Prompts: Type? Target audience? Funding? Duration?)

*And now a few questions on tobacco issues training?*

- 6 Do you know of any tobacco issues training courses?
  
- 7 Have you ever taken any tobacco issues training courses?
  
- 8 Have you ever provided any tobacco issues training?
  
- 9 Have you ever provided any training relating to working with minority ethnic communities?
  
- 10 If yes to any of the above, please provide details:  
What training was it?  
Who provided it/who was it for?  
What was covered in the course/how long was it?  
What did you/the trainees think of it?

### **Part 3: Tobacco use in minority ethnic communities**

*I'd now like to ask a few questions about tobacco use in minority ethnic communities...*

- 1 Based on your experience, or your perceptions, how prevalent is tobacco use among the minority ethnic communities you work with?  
(Prompt: Are there any variations in tobacco use between different groups e.g. age, gender)  
(Prompt: Is tobacco consumed in any form other than cigarettes?)
- 2 Why do you think there is such a prevalence of tobacco use?

*I'd now like to ask a couple of questions about tobacco cessation in minority ethnic communities*

- 3 What do you think are the main motivators for people from minority ethnic backgrounds to stop smoking?
- 4 What do you think are the main barriers that might prevent people from minority ethnic backgrounds from stopping smoking?
- 5 What do you think are the reasons why service providers might not be providing appropriate services to tackle tobacco use among minority ethnic communities?

### **Part 4: Tobacco services and resources**

*I'm now going to ask you some questions about organisations and professionals who provide tobacco-related information and support....*

- 1 Do you know of any organisation or individuals who provide tobacco related services? (Yes – provide details, No – go to question 2)
- 2 Have you had any contact with any such organisations or individuals?  
(Yes – provide details, No – go to question 3)
- 3 Do you know of any services that provide tobacco-related information or support targeted at minority ethnic communities?  
(Yes – provide details, No – go to question 4)
- 4 How could tobacco services be more relevant to minority ethnic communities?

*The next few questions will focus on health information resources...*

- 5 Do you know of the following kinds of information on tobacco use?

Leaflets	Posters
TV/Radio campaigns	Print media campaigns
Web-based resources	Audio visual resources
Other	

For each one please provide details:

Who produced them?  
Have you ever used them?  
What did you think of them?  
What do your clients think of them?  
Do they address issues specific to minority ethnic communities?

- 6 I have some examples here of existing tobacco information resources. What do you think of these?  
(Prompts: content/layout/visual representation)
- 7 Thinking of the service users you work with, what features do you think make for good health promotion material?
- 8 One recommendation relating to tobacco and minority ethnic communities is that: 'There is a need for free, centrally prepared information which specifically addresses minority ethnic communities and are provided in a range of languages'. What are your thoughts on this recommendation?
- 9 Another recommendation is that: 'Information and advice on smoking cessation and tobacco policies should be made available for professionals and organisations working with minority ethnic communities.' What are your thoughts on this recommendation?
- 10 Another recommendation is that 'The media should be used to disseminate targeted messages to minority ethnic communities about tobacco use and cessation.' What are your thoughts on this recommendation?
- 11 Do you have any other comments in relation to tobacco services or resources?

## **Part 5: Training and Education**

*I'm now going to move onto some questions about education and training...*

- 1 What would you say are the main education/training needs for staff wanting to offer tobacco interventions to minority ethnic communities?  
(Prompts: What particular issues should be covered in a tobacco cessation training course relating to minority ethnic communities?)
- 2 In your line of work, what are the main barriers to providing tobacco issues training to staff?
- 3 One recommendation relating to tobacco and minority ethnic communities is that: 'Specialised training should be developed on tobacco use and cessation issues specific to minority ethnic communities'. What are your thoughts on this recommendation?
- 4 Another recommendation is that: 'Members of minority ethnic communities should be trained to communicate tobacco education and advice about cessation'. What are your thoughts on this recommendation?
- 5 Do you have any other comments relating to education and training for staff working with minority ethnic communities?

## **Part 6: Further research**

*I now have a couple of questions relating to research...*

- 1 Do you know of any research or reports relating to tobacco use and minority ethnic communities? (Yes – provide details, No – go to question 2)
- 2 What would you say are the research priorities relating to tobacco use among minority ethnic communities?
- 3 One recommendation relating to tobacco and minority ethnic communities is that: 'There is a need for better research on tobacco use prevalence among minority ethnic communities in Scotland.' What are your thoughts on this recommendation?

## **Part 7: Actions and recommendations**

*I'm now going to ask your opinion on some recommendations relating to tobacco services and minority ethnic communities...*

- 1 Stop smoking services should provide services that are appropriate and accessible for people from minority ethnic backgrounds.
- 2 There is a need for specialised tobacco services, which are targeted at people from minority ethnic backgrounds and aim to address their specific needs.
- 3 Information on tobacco use and cessation support should be provided in a variety of community settings.
- 4 Packaging of paan (and other chewing tobacco products) should include health warnings
- 5 Are there any other key actions to address tobacco use among minority ethnic communities that you feel are important which have not been noted?

## **Part 8: Final comments**

*As part of the needs assessment we want to engage with different minority ethnic communities about their own needs in relation to tobacco education, prevention and cessation.*

- 1 Do you know of any individuals, organisations or networks who might be willing to help us with our research?
- 2 Do you have any ideas for engaging with service users in order to under research with them?
- 3 Finally, do you have any other comments to make in relation to the general themes discussed today?

*Thanks you for your assistance with our needs assessment.*

*We shall keep you informed of our research progress and will let you know when the findings are published.*

*In the meantime, if you have any further questions please don't hesitate to get in touch.*

## Appendix 2 – Interview participant information

Theme	Type of Job	Organisation Type	Area	Tobacco work
SC	Coordinator/SC Practitioner	Health Service	Lanarkshire	Yes
SC	Coordinator/SC Practitioner	Health Service	Edinburgh	Yes
SC	Coordinator/SC Practitioner	Health Service	Shetland	Yes
SC	Health Promotion Officer	Health Service	Glasgow	Yes
SC	SC Practitioner	Health Service	Borders	Yes
BME	Director of Health Inequalities	National Charity	UK	Yes
BME	Link-worker	Health Service	Lothian	Yes
BME	Health Promotion Officer	Health Service	Glasgow	Yes
BME	Public Health Practitioner	Health Service	Glasgow	No
BME	Public Health Practitioner	Health Service	Glasgow	No
BME	Nurse	Health Service	Glasgow	No
BME	Community Development Officer	Health Service	Glasgow	No
BME	Manager	Voluntary Sector	Lothian	No
BME	Manager	Voluntary Sector	Glasgow	No
BME	Information and Research Officer	Voluntary Sector	Glasgow	No
BME	Development Officer	Voluntary Sector	Highland	No
OA	Development Worker	Voluntary Sector	Edinburgh	No
OA	Project Coordinator	Health Service	Falkirk	Yes
OA	Development and Research Manager	University	Edinburgh	No
OA	Policy Officer	National Charity	Scotland	No
OA	Research Fellow	University	Glasgow	Yes
MH	Project Worker	Voluntary Sector	Aberdeen	Yes
MH	Support Worker	Voluntary Sector	Glasgow	No
MH	Mental Health Practitioner	Health Service	Glasgow	Yes
MH	Support Worker	Voluntary Sector	Glasgow	No
MH	Support Worker	Voluntary Sector	Glasgow	No
MH	Support Worker	Voluntary Sector	Glasgow	No
MH	Project worker (substance misuse)	Voluntary Sector	West Lothian	Yes
MH	Manager	Voluntary Sector	Glasgow	No
MH	Project worker (substance misuse)	Voluntary Sector	West Lothian	Yes
MH	Psychiatrist	Health Service	Edinburgh	No
MH	Occupational therapist	Health Service	Lanarkshire	Yes
MH	Occupational therapist	Health Service	Lanarkshire	Yes

### **Key**

SC – Smoking Cessation  
 BME – Black and Minority Ethnic  
 OA – Older Adults  
 MH – Mental Health