ASH Scotland
Tobacco and Inequalities Project

An investigation of attitudes towards tobacco use and quitting among three groups facing inequalities

(Needs Assessment Report 2)

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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[1]; nearly 50% of Bangladeshi men[2] and around 70% of patients in psychiatric hospitals[3] 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. Both desk-based and primary research methods were used, including literature reviews; rapid mapping of services and resources; in-depth interviews with service providers and focus groups with community representatives. This report concentrates on the focus groups with people from the three target groups (also referred to as service users). Three literature reviews, a service and resource directory and report on interviews with service providers are also available from ASH Scotland.

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[1] Scottish Executive (2000) *The Scottish Health Survey 1998*
[2] Health Education Authority (2000) *Black and Minority Ethnic Groups in England: The Second Health and Lifestyle Survey*
[3] Meltzer *et al* (1996) *Economic activity and social functioning of residents with psychiatric disorders (OPCS Surveys of Psychiatric Morbidity in Great Britain, Report 6)*

Eleven focus groups were undertaken with representatives from the three target groups, with between two and nine people per group. There were three groups with people from minority ethnic communities, four groups of users of mental health services and four groups of older adults. In total 62 individuals participated.

A semi-structured interview schedule was used to guide the interviews, although participants were free to raise other issues that they felt were important. Vignettes (short stories about a fictional smoker) were used to facilitate discussion. Topics included: reasons for starting and continuing to smoke; attitudes towards quitting and experiences of trying to stop; barriers and motivators to cessation; and opinions on real-life services and resources. The interviews lasted approximately one hour and 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 focus groups.

Findings

The key findings are as follows:

- Most people started smoking out of curiosity or due to social pressures. Early experiences of tobacco use were shaped by the social and historic circumstances in which the participants were living. In particular, older adults and first generation ethnic minorities started to smoke in a cultural climate where smoking was more socially acceptable and there was less incentive to quit.

- Participants associated smoking with their daily routine, and with stress relief and relaxation. Few people acknowledged that they might be addicted to tobacco. The mental health groups focused more on smoking as a coping mechanism to deal with difficulties, while the minority ethnic groups spoke more of smoking as a way to relax and socialise.

- There was a general awareness that smoking was bad for health, but knowledge and acceptance of the risks varied greatly. This depended on personal experience of tobacco-related illness, information from medical or smoking cessation professionals and personal or cultural beliefs about health.

- Experiences of quitting were a normal part of the participants' tobacco use history. Health was the primary motivation to quit. Family, the social acceptability of smoking, finances and appearance were popular secondary motivations. Most people had tried to stop smoking at some point in their lives, often for extended periods of time or on multiple occasions. Relapse was common and was usually associated with stressful events, habitual triggers and side-effects of quitting. The minority ethnic participants had fewer experiences of successful quitting.

- Approaches to quitting varied. A number of recent quitters had sought support from smoking cessation services or had used pharmaceutical cessation aids (NRT or Zyban), while others preferred to go 'cold turkey'. There was widespread belief that determination and will-power were essential, and that the decision to stop has to come from within. Older men and minority ethnic men were most vocal about quitting on their own.

- Awareness of smoking cessation services was low amongst participants who had not already received specialist support to quit. However, there was a general interest in smoking cessation services when these were described to participants. People who had used smoking cessation services spoke favourably about the professional support, the group support and the education value of the sessions they attended.

- Attitudes and experiences of NRT and Zyban varied. Awareness of the availability of patches and gum was high, but negative attitudes about the efficacy or safety of smoking cessation products were common. The older males generally spoke less favourably about pharmaceutical cessation aids than the females.

- Mass media campaigns and other health promotion resources (e.g. leaflets) were valued for drawing attention to issues, but it was recognised that there are limits in their effectiveness and reach. It was felt that the media could be used to better publicise support that is available to help people quit.

- Some people feel pressurised by changing social attitudes towards smoking, including the forthcoming legislation on smoking in public places, and were concerned about potentially negative social and personal impacts. There was also some confusion about the scope of the legislation and the motivations for this. Participants in the mental health groups were most vocal on this matter. Others felt that the legislation sent a clear message about the risks of tobacco smoke and would be beneficial to people who were trying to stop.

Further details are provided in the full report.

Conclusions

The focus groups with representatives from the three community groups identified that while existing approaches to tobacco control are valuable, work still needs to be done to provide appropriate support to those most in need – the groups who smoked the most, who are least likely to stop and who need the most support when trying to quit. Awareness of the dangers of tobacco and the support available needs to be raised; and preconceptions about smoking and quitting challenged. This is true both for the general public and for staff workers in health and other sectors.

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

- Smoking cessation services need adequate and sustained funding to enable them to further develop work with target groups.
- National media campaigns are needed to raise awareness of tobacco related health issues, second hand smoke and smoking cessation services at national level; including positive testimonials of real quitters.
- Tobacco control approaches should involve a wide range of community and voluntary organisations, to encourage more people to think about the relevance of tobacco issues.
- All health professionals should be trained in brief advice for smoking cessation and should be aware of smoking cessation guidelines. Basic tobacco education should be offered to professionals outside health care settings. Specialised tobacco training, focusing on issues and needs relating

to particular groups, should be developed (in line with Smoking Cessation Training Standards).

- Additional support is required to prevent relapse. Options include longer term or more intensive smoking cessation support, support post-NRT, drop in/on-call support, telephone support, peer support/buddying.
- Further investigation is needed of ways to work with people who do not want to use NRT or Zyban (preferring to rely on 'will-power').
- Further investigation into pre-quit initiatives (e.g. information and education sessions, discussion groups) and harm reduction approaches (e.g. cutting down, changing times and places of smoking) are required for people who are not yet ready to stop smoking.
- Information is needed on the extent to which different groups are accessing smoking cessation services and on outcome measures.
- There should be a review of quit line services in Scotland to investigate (a) who is using them (b) what they are being used for (e.g. for further information and advise or for back-up support post-quit) and (c) the availability of non-English language support.
- Greater publicity and distribution of health promotion information in languages other than English is required.
- Pre-work is needed to people prepare for the introduction of new smoking in public places legislation. This includes public awareness raising information and ground-level support from organisations working with marginalised groups.
- Research into the availability and use of non-smoked tobacco products in Scotland, and into product labelling (e.g. health warnings) is needed.
- Further research is needed on tobacco use and cessation with communities who were not adequately represented in this, or other, recent studies (e.g. older men; people in psychiatric hospitals; and young, female and new or hidden minority ethnic populations – Gypsy Travellers, refugees and asylum seekers, migrants from Eastern Europe)
- Evaluated pilot projects should be established to try out new approaches to working with particular inequalities groups and the learning used to develop appropriate future services.

Further recommendations and more detail are given in the full report.

In short, 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. 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 update 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 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 inacceptable, 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 exit 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 for the next process. The research was undertaken throughout 2004. This report concentrates on focus groups with representatives from the three target communities. Further details on the other three stages of the research are given in separate reports by ASH Scotland. See Section 5 for information on how to access these documents.

To ensure that the needs assessment was robust and fully linked to the perceptions and needs of service users, a crucial stage in the research was consulting with actual members of the three target populations. Involving people from minority ethnic communities, older adults and people with experience of mental illness provided a more detailed understanding of the issues relating to tobacco use and approaches to tackling this, and uncovered issues not raised in consultations with service providers.

Focus groups

A number of factors were taken into account when deciding on the most appropriate methods to use to consult with the client groups. Issues such as English language ability, literacy and functional impairments were considered, as was the Scotland-wide scope of the research and diversity in each of the three groups. A further consideration was how to recruit potential participants - to involve current and ex-smokers, existing smoking cessation service users and potential clients, and people from a range of socio-demographic backgrounds from across the country.

Focus groups were chosen as the primary research method. This method allows for a detailed exploration of views based around key themes, whilst giving participants the opportunity to bring up issues that they wish to talk about. The interaction between individuals in the group also brings to light differences in individual opinion and areas of apparent consensus. The aim of the focus groups was to encourage discussion on the following themes:

- Tobacco use (including reasons for starting and continuing to smoke, level of tobacco use and patterns of smoking)
- Health knowledge, and beliefs about tobacco and second-hand smoke
- Attitudes to and experiences of cessation (including barriers and motivators to quitting, knowledge and experience of different approaches to cessation)
- Opinions on smoke-free legislation and policies
- Experience of service provision (including knowledge and use of smoking cessation services)
- Opinions of existing health promotion materials (including leaflets and media campaigns)
- Needs and ideas for service development

An interview schedule was designed and piloted to guide the focus groups. At the beginning of each group the facilitators introduced themselves and gave participants clear verbal information about the project and what would be involved. They explained that participants could withdraw at any time, assured them that their views will remain confidential and that names or other identifying information would not be divulged when reporting the results of the study. This was intended to allay any concerns or misconceptions about the research and to gain consent from participants, in line with ethical guidelines (Social Research Organisation, 2003).

This was followed by some general questions about why people smoke or why people might start in the first place. These introductory questions served the dual purpose of relaxing the participants and providing context for the remainder of the discussion. The remaining questions focused more specifically on tobacco use, quitting, and about tobacco services, resources and policies. An example interview schedule is attached as Appendix 1 in Section 8 of this report.

Vignettes (short stories) were used to facilitate discussion. These described a hypothetical person's 'smoking journey', describing when they began smoking, their decision to stop smoking and their experience of attending a smoking cessation group. The vignettes could be adapted so that the person being discussed matched the characteristics of the group (e.g. their age, ethnicity etc). The vignettes provided a focus of discussion, and allowed people to reflect on a specific situation and to compare this to their own experiences. The facilitator stopped at various points in this story to ask participants their thoughts and to ask questions. In some focus groups, the vignette provided a necessary structure, but in others the use of the vignette was

not required to facilitate discussion. An example vignette is attached as Appendix 2 in Section 8 of this report.

2.3 Sampling

Eleven focus groups were undertaken with representatives from the three target groups. There were three minority ethnic groups (Pakistani, Bangladeshi and Chinese), four groups of mental health service users and four groups of older adults. Groups varied in size, with between two and nine participants in each. In total 62 individuals took part in the group interviews. The interviews lasted between 45 minutes and one and a half hours.

There was overlap between the characteristics of participants in some groups. For example, a number of people in the minority ethnic and mental health groups were also older adults, while some of the older adults had characteristics that would have fitted with the other groups. Most groups were mixed gender, although the three minority ethnic groups were all male and two of the older adult groups were all female. The group interviews took place in Edinburgh, Glasgow and Aberdeen. Most participants therefore lived in urban areas and were predominantly from the central belt of Scotland.

The groups included current smokers, recent ex-smokers (those who had quit in the last five years) and long-term non-smokers (e.g. those who had quit over five years ago)[4]. Among the current smokers, there were some participants who were more receptive to changing their behaviour and others who were resistant to quitting. The participants who had tried to quit had used a variety of approaches and included people who had attended NHS smoking cessation services or had used pharmaceutical smoking cessation aids such as NRT or Zyban.

Participants were recruited through service providers who been interviewed in an earlier phase of the needs assessment. They were provided verbal and written information about the study (including an information sheet for potential participants describing the study) and the kind of people we were looking for. Participants were offered reimbursement of travel expenses and were given refreshments and a 'thank you' gift voucher. Interpreters were organised for the three minority ethnic groups to help with facilitation. These factors were in line with ethical guidance that potential participants should not be excluded for reasons of communication, disability, comprehension or expense. (Social Research Organisation, 2003).

A table summarising information on the focus group participants is included as Appendix 3 in Section 8 of this report.

[4] It should be noted that the five-year threshold is not a usual designation for 'recent ex-smoker' within smoking cessation research. Most studies measure short-term outcomes in the first few months after quitting, with a longer-term measure at one-year (Hughes *et al*, 2003). The five-year period was selected in this study because it corresponds approximately to the time when smoking cessation services came into existence in all Health Boards in Scotland. It also reflects the fact that a high proportion of smokers relapse in the first year of a quit attempt.

2.4 Analysis

Two researchers were present at each focus group. One was primarily responsible for asking questions and facilitating discussion, while the other tape recorded the session (with permission from the participants) and took detailed field notes to record observations and ideas.

Tape recordings 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 techniques and sample size means that the analysis is qualitative in nature. The findings are based on discussions with representatives from the three target groups, with quotes given to illustrate opinions. In focus group research there are essentially two units of analysis – the group and the individual. The group dynamics means that it can be difficult to gauge what each individual thinks, therefore it is not always appropriate to count the number of participants giving a certain opinion. Instead, the research focuses on key themes emerging from the group discussions and the range of opinions discussed. The frequency and fervour with which particular views were expressed was taken into account in the reporting.

2.5 Strengths and limitations

The strengths of this research were that it investigated the knowledge, beliefs and experience of a wide range of people in relation to smoking and quitting. Participants in the groups came from diverse backgrounds – males and females, people from different age groups and ethnic backgrounds, and people with a range of physical and mental health diagnoses. The participants had different patterns of tobacco use. At one end of the spectrum were heavy smokers with no intention of stopping, and at the other were long-term non-smokers. The research uncovered information about tobacco issues and barriers to tackling smoking within certain communities, and highlighted actions that might help to address these shortcomings.

Although efforts were made to invite participants from a range of backgrounds, there were nonetheless some limitations in the actual sample. Within the mental health groups, the participants were people living in the community who were in contact with mental health services. The research did not include people who were in hospital because of their illness or those who were not in touch with mental health services. The minority ethnic sample involved only men from three communities (Chinese, Bangladeshi and Pakistani). There were no women or representatives from other minority ethnic groups. In the interests of client confidentiality, information was not gathered on the client's medical history or diagnosis, or their age, which presents limitations on the analysis. The research also had an unintentional urban bias, as many of the agencies that helped with recruitment were from the central belt and large cities.

The sampling decisions were partly due to practical constraints, such as accessing willing participants, and time and resources available for the research. However, it was also acknowledged that other research has recently been undertaken which did

not need to be duplicated. For example, ASH Scotland recently funded work to undertake research about tobacco with older adults (Kerr *et al*, 2004) and with participants from minority ethnic communities in Glasgow (Asghar, 2000). Research was also undertaken as part of this needs assessment with service providers working in smoking cessation, health and with the three target communities, which supplements the findings outlined in this report (ASH Scotland, 2005a). These studies should be read in conjunction with this report. The recommendations in this report highlight further work that is needed to fill any gaps not yet addressed within this, or other, studies.

3. FINDINGS

3.1 TOBACCO USE AND HEALTH BELIEFS

In the initial stage of the focus groups, participants were told the first part of a story about a hypothetical smoker. This story described when the person started smoking and how much they currently smoked (see Appendix 2). The group were then asked about their own tobacco use history, for example how old they were when they started to smoke, why they started smoking and about their current patterns of tobacco use.

3.1.1 Current tobacco use

There was great variation in current tobacco use among the 62 people participating in the focus groups. 33 were current smokers, 17 were recent ex-smokers (quitting in the last five years) and 12 were non-smokers (quitting more than five years ago). Of the 26 participants in the mental health groups, 16 were current smokers, 7 had quit in the last five years and 3 classified themselves as non-smokers. Of the 20 people in the older adults groups, 6 were still smoking, 7 had quit recently and 7 were non-smokers. In the minority ethnic groups, 11 out of 16 were current smokers, with 3 recent ex-smokers and 2 non-smokers. This information is presented a table in Appendix 3.

There were differences in the levels of tobacco use among those who were still smoking. Although participants were not questioned directly about how much they smoked, this information was revealed in the course of many discussions. Some people were heavy smokers and were highly addicted to nicotine. For example, one woman said she got through two packs of cigarettes a day and often got up during the night to smoke. Two of the men reported smoking between 40 and 60 roll-ups and up to 80 cigarettes a day.

Although participants were not asked explicitly about the type of tobacco they used, many people mentioned this in the interviews. Cigarettes were most common, followed by roll-ups (loose tobacco hand rolled in cigarette papers). In addition, one older man said he only smoked a pipe, one Chinese man reported smoking cigars regularly and one Bangladeshi man said he chewed tobacco. Other forms of tobacco were discussed, although not necessarily used by participants themselves. For example, the South Asian groups mentioned that people in their communities used water pipes (hooka) and chewing tobacco (paan), while others said that cannabis (hash) was an issue for young people.

3.1.2 Tobacco use initiation

The majority of participants started to smoke before the age of 18. The participants reported first trying a cigarette when they were children or young teenagers, with the

age of first experiment with smoking ranging from age 3 (taking a draw of mother's cigarette) to 'in my twenties'. A few people discussed how they moved from experimentation to regular usage, saying that after starting to smoke casually, they found themselves smoking larger amounts, more frequently. Generally, the participants indicated that they started to smoke regularly in their teens.

Social norms or social pressure were the most common reasons why the participants began smoking. A number said they tried smoking to be like their peers or other role models (such as family or celebrities), or because they saw it as 'cool', 'fashionable' or 'grown up'. Others mentioned that they tried smoking out of curiosity or rebellion. The Bangladeshi and Chinese groups noted that smoking was common among males in their communities, especially at social gatherings, and that they started smoking in order to be seen as men.

> *Your friends all smoked, so you joined in. That was like me at school.* (Tony, MH4)

> *When I was young I worked with 2 women and 25 men. Everybody 'come on Maria, start'. Everybody smoked, you know. I was 16 and I says 'oh, I don't like this smell' but everybody says 'oh, come on Maria, come on'. That's why I start smoke.* [Maria, OA3]

> *We started smoking with friends and in business or social gathering.* [Mr Chan, BME2]

The older participants spoke of different attitudes towards tobacco when they were younger, noting that smoking was previously more common and socially acceptable. They mentioned that there were fewer restrictions on where smoking was permitted in the past, that tobacco was advertised using glamorous images and how role models, such as film stars, sports personalities and other celebrities, were often smokers. They noted that less was known about health risks of smoking in the past, referring to a lack of health warnings on tobacco packaging and not receiving advice from doctors to give up smoking. Three people even recounted tales of medical professionals smoking in their presence in the past.

> *I started smoking when I was 15 year old. At that time the film stars and my parents smoked, my older brother smoked, older people smoked. It seemed the grown up thing to do.* (George, MH1)

> *Oh aye, you could smoke everywhere then. It didn't matter where you were, you smoked everywhere.* (Jean, OA3)

> *They didn't tell you the dangers 2 or 3 decades ago.* (Mr Ho, BME2)

> *I had a cigarette while I was in labour, with the doctor and the midwife. And then when the baby was born, we had another cigarette with the doctor, the midwife, the husband, I and the baby in the cot. That was…it was just something that was done…Nobody said anything.* (Mary, OA2)

Although stories about starting to smoke were personal and unique to the individual, common themes emerged across all groups. For example, most people started to smoke out of curiosity or the influence of social norms. Each individual's experiences of starting to smoke were shaped by the social and historic circumstances in which they were living. This is particularly true for the older and minority ethnic participants,

who began smoking in a different cultural climate, where smoking was more socially acceptable and there was less incentive to quit.

3.1.3 Reasons for tobacco use

The participants were asked about the reasons why they smoked and to describe times or places that they might smoke more than usual. Most commonly, smoking was described as a habit. Participants discussed triggers that prompted them to smoke. These varied from person to person, but were generally related to a particular behaviour or emotion. For example, participants mentioned times in their daily routine when they smoked more - in the morning when they got up, before going to bed, at meal times, or with a cup of tea or coffee. The mental health groups in particular commented on the ritualistic nature of smoking and how daily routines revolved around cigarettes.

> *At worst I smoked between 30 and 40 a day. Of these 30 and 40 a day I only enjoyed 5 of them. The rest of them was pure habit. The first two in the morning yes, after food yes, the rest of them was just go in your pocket for something to do – pure habit.* (Roger, MH4)

> *A lot of the problem is that it becomes right habit forming. You know, its all part of your routine.* (Eleanor, MH3)

> *- I would imagine a good 50% of the time, 50% of what you smoke, you don't really need it. But subconsciously it's 'fag time'.*
> *- Automatically you get a cigarette, as you say, cigarette in one hand; a cup of tea in one hand and a cigarette in another, the two of them go together.* (George and Fiona, MH1)

Next most common was the feeling that smoking helped people to cope with stress, anxiety, nerves or tension, or to calm them down. These reasons seemed to be particularly prominent in the mental health groups, although others also raised these issues. A number of participants mentioned that they smoked more if they felt stressed about something, or during a period of major change or upheaval in their life, such as a bereavement or family problems, or a period of severe mental illness.

> *Sometimes, you know, if you have something on your mind. If you're feeling stressed out, you will, you'll just smoke and smoke and smoke and smoke.* (Eleanor, MH3)

> *I've seen doctors make me go and have a cigarette, to calm me down, to quieten me down.* (Betty, MH2)

> *Sometimes you're getting some tensions and you're not getting relaxed, he actually start smokes. Because he get relief after smoking.* (Akbhar, BME3)

> *When I was feeling ill, really bad, I was smoking twenty times more than usual*. (Roger, MH4)

A number of individuals, particularly older adults and people with mental health difficulties, mentioned that that they smoked more when they were bored, or if they were at home alone or feeling isolated.

I won't have a problem for as long as we're in here about smoking because I'm doing things. There's no need for it. But then when we're finished the first thing I'll do is unconsciously roll a fag. (John, MH1)

See when you're on your own too, oh dear. A cigarette is your friend and only somebody that smokes knows that… Because when you're on your own, lighting up a cigarette you've got company there (Marlene, OA4)

Others focused on smoking as a way to socialise and relax. Four groups discussed the association between alcohol and smoking, with individuals saying that they smoked more when they were out in public, for example at the pub or bingo. The Chinese and Bangladeshi groups also stated that they smoked more on social occasions, or to take a break from work. Three of the mental health groups mentioned smoking more before going somewhere where smoking was restricted, to compensate for the fact that they would be unable to smoke for a certain period of time.

Playing Mahjong and gambling, dinner receptions, social occasions. Relaxing to smoke after a day's hard work (Mr Lee, BME2).

I think for men it was get together in company and enjoy in your leisure time. (Tariq, BME3)

You can't have a fag for two hours because you're going somewhere, so you have five while you can. (Eleanor, MH3)

In general, addiction was not one of the most common reasons given for smoking, with six of the eleven groups not raising this issue at all in their discussions. Although no-one explicitly stated that they were addicted to tobacco, a few people did mention that cigarettes were addictive, and some associated habit with addiction. These discussions suggest that addiction was regarded more as a psychological than physical issue. Pleasure and enjoyment were discussed less frequently, with only five people in three groups mentioning either of these as a reason why they smoked.

A lot of the smoking I do is habit – it's not the nicotine that's addictive – it's the habit. Opening up the tin and rolling one (Victor, MH4)

Know what I mean, it's an addiction. Drink's an addiction for alcoholics, and fags are an addiction for the smokers…It's like coffee, its addictive. (Craig, MH3)

To sum up, participants talked in detail about the reasons why they smoked. Stories varied according to an individual's circumstances, although key themes emerged from the discussions. In general, people associated smoking with their daily routine, as a way of dealing with stress or with socialising. Very few people acknowledged that they might be addicted to tobacco.

Although there were similarities between the discussions of each of the three target groups, there did appear to be some themes that were more common among some participants than others. For example, The men from minority ethnic backgrounds

tended to view smoking as a way to relax and socialise, while the mental health groups focused on smoking as a coping mechanism to help deal with difficulties.

3.1.4 Knowledge and beliefs about tobacco and health

Throughout the course of the interviews participants revealed information about their knowledge and beliefs in relation to tobacco and health. They talked of their awareness and experience of tobacco related illness, their assessment of the risks associated with tobacco, as well as other beliefs about addiction and the effects of nicotine.

The participants talked about conditions that were caused by or worsened by smoking. All of the groups talked about respiratory problems. Lung cancer was mentioned most frequently, although emphysema, asthma, coughs and general breathing difficulties were also discussed. There was some discussion about heart disease and angina, although not by all groups. There was limited mention of other circulatory disorders or other cancers, and of oral or vocal conditions.

All groups had participants who had experienced symptoms or diseases that they felt were related to smoking. The older participants were more likely to have experienced serious diseases (including heart disease, emphysema, stroke, angina and COPD) than the younger participants. There was also talk of family, friends or other people who had smoking related diseases.

There was great variation in the extent to which people acknowledged or accepted the health risks associated with smoking. Those who had direct experience of a smoking related illness, who had quit smoking or had received smoking cessation support, spoke more of the health risks of tobacco. Those who were not ready to stop smoking tended to deny or rationalise the risks of smoking.

Although there was a general awareness that smoking was bad for health, some people felt that the health risks were exaggerated. A few particularly vocal participants were reluctant to believe that smoking was associated with an increasingly large number of medical problems. A common reaction was to refer to people (e.g. friends, families or celebrities) whose individual experiences defied the statistics (for example people who smoked but lived a long and healthy life; or people who did not smoke but contracted a smoking-related disease).

> *Right, there's a packet of cigarettes. On the front it says 'Smoking Kills'. On the other side 'smoking causes fatal lung cancer'. What is should say is smoking* <u>*can*</u> *cause fatal lung cancer, because my grandmother died of lung cancer and never smoked a cigarette in her life*. (Margaret, MH2)

Another common response was to highlight other substances, such as alcohol or food; or atmospheric pollution from vehicles, industry or chemicals, which they felt might cause diseases attributed to smoking. Two others stated that genetics or 'the system of your body' were more significant factors than smoking.

> *Possibly there is some caused by cigarettes, but I really don't think there's as much illnesses caused by smoking as what we're told there is.* (Marlene, OA4)

> *Its not just smoking, its vehicles, its industry, its everything. Smoking is not the only pollution out there and it's not the be all and end all cause of everything*. (John, MH1)

Although most people were aware that smoking was detrimental to health, some people discussed what they saw as the benefits of smoking. For example, many felt that smoking helped them to relax and to calm the nerves, although two people questioned these beliefs, stating that smoking actually has the opposite effect.

Two of the mental health groups discussed how people with mental illness were more likely to smoke, and hinted at a causal relationship between smoking, the symptoms of mental illness and using medications such as anti-depressants.

> *Well it's twice as much mental health people smoke so much – they're on a load of drugs that cause them to smoke.* (Roger, MH4)

The minority ethnic focus groups revealed further beliefs about tobacco. For example, individuals in the Bangladeshi group discussed how tobacco aided digestion and helped them work better, while one of the Chinese men felt that smoking relieved tiredness. The Bangladeshi men also talked about the nature of addiction, which they described as something that was 'in the blood' and increased with age.

> *When you get pressure like job pressures, you have to faster to yourself, so you need nicotine in your body so you that they can make you faster…So I continue to smoke. So the brain can go fast*. (Mr Khan, BME1)

The focus groups also revealed beliefs about the contents of tobacco and cigarettes. Three people who had attended smoking cessation services talked about the harmful chemicals and additives in tobacco. Seven people discussed tobacco products that they felt were less harmful to health (e.g. finer tobacco, mild cigarettes, low tar, or types of tobacco that are no longer on the market), because they contained fewer additives, less nicotine or were not as addictive. One older man, who smoked a pipe and had never been advised to stop by his doctor, claimed that 'pipe smoking is better for you'. Another participant asserted that cannabis does not do as much damage as cigarettes. Beliefs about pharmaceutical aids for smoking cessation (e.g. Zyban and NRT) were also raised, which is discussed later in the section on quitting.

To sum up, acceptance of the risks of smoking varied from person to person. Factors impacting on their knowledge included personal experience of tobacco-related illness, information from health or smoking cessation professionals, personal understandings of risk and illness, and cultural or folk beliefs.

3.1.5 Discussion and recommendations

The focus group discussions revealed that tobacco was, or still is, very much a normal part of life for the participants. Detailed stories were shared about starting to smoke, about smoking habits, feelings about cigarettes, and about other people's tobacco use. Most participants started to smoke out of curiosity or the influence of social pressure, and found that tobacco took on an importance in their daily routines or as a coping mechanism. While there was a general awareness that smoking was bad for health, knowledge and acceptance of the risks varied. It was evident that the participants enjoyed the opportunity to talk about tobacco in an open and non-

threatening forum, and that the interviews encouraged them to think about tobacco issues.

The discussions suggest that more needs to be done to raise awareness of the health risks of smoking. In particular, work is needed to educate people of the widespread health problems caused by smoking, other than lung cancer. Work is also needed to debunk myths that persist about the benefits of smoking, about 'safer' forms of tobacco (e.g. low tar or menthol cigarettes) and other forms of tobacco (e.g. pipes, roll-ups, oral tobacco). People who have used tobacco for a long time, or are highly dependent on it, should be encouraged to take steps to tackle their tobacco use and should be reminded that there are tangible benefits to quitting no matter what their age or medical condition.

Gaps in knowledge about tobacco and health appear to be more pronounced among minority ethnic groups. Greater efforts are needed to raise awareness of tobacco issues among minority ethnic communities and challenging unique cultural health beliefs (e.g. that tobacco is an aid to digestion). Possible approaches include targeted health promotion campaigns and involvement of community members (with similar cultural and linguistic backgrounds) in peer education. Further research on tobacco use among minority ethnic populations in Scotland is also needed, including covert smoking practices, prevalence among women and hidden minorities, and use of chewing tobacco and hooka pipes.

The discussions on quitting indicated that person-centred approaches to cessation are appropriate. Given the detailed personal nature of an individual's smoking history and behaviours, smoking cessation clients should be encouraged to reflect on their own reasons for smoking, for quitting and triggers to smoking, and to devise plans to cope with situations where they feel tempted to smoke. Additional help is important for some clients, such provision of extra support at difficult periods and help with coping with stress.

The cultural context of tobacco use must be also taken into account when developing appropriate approaches for specific client groups. The historic and social circumstances in which a person begins to smoke, the length of time they have been smoking and their belief systems have an impact on their thoughts about quitting and approaches used. The subject of quitting is the focus of the following section.

3.2 EXPERIENCES OF QUITTING

The main thrust of the group interviews was about stopping smoking. Participants discussed a number of issues relating to quitting, including reasons for stopping smoking, experiences of quitting, relapse, successful quit attempts, approaches to quitting and opinions on smoking cessation services. Much of the discussions were spontaneous, although some followed on from the story about the hypothetical character's decision to stop smoking and approach to quitting. The following sections summarise discussions on a variety of topics relating to quitting.

3.2.1 Current quit status

The discussions revealed that most participants had tried to stop smoking at some point in their lives, with varying levels of success. Out of the 62 people who took part in the research, approximately half (33) were current smokers. Of the remainder, 17 were recent ex-smokers (had stopped smoking in the last five years) and 12 were non-smokers (those who were non-smokers for more than five years).

In the minority ethnic and mental health groups there were more current smokers, and in the older adults groups there were more former smokers. Indeed, two of the older adults groups were made up entirely of people who had recently given up smoking with support from local smoking cessation services. The minority ethnic groups appeared to have fewer experiences of successful quitting. This was certainly the case in the Bangladeshi group where all were still smoking.

The participants appeared to be at different stages of change (Prochaska and DiClemente, 1982). Some were pre-contemplative or contemplative (not currently considering stopping or ambivalent about it), others were in the preparation stage (trying to change) and others were in the action or maintenance stages (practicing or sustaining a new behaviour).

3.2.2 Motivations to quit

The groups were asked what things had ever made them think about stopping smoking. All groups mentioned health as a primary motivation to quit. Broadly speaking there were three sub-themes in these discussions: a general awareness that smoking was bad for health, personal experience of a condition that was related to smoking, or being advised to stop by a health professional. Social factors, financial incentives and cosmetic reasons were also given as reasons for quitting.

A number of individuals elaborated on specific health problems that had led them to a quit attempt, including undergoing surgery or being in hospital (5 people); asthma, chest or breathing difficulties (3 people); heart problems (3 people); stroke (2 people); angina (2 people); emphysema (2 people); throat problems (including surgery for polyps), colds or flu (2 people); a family member's smoking related illness (2 people); Chronic Obstructive Pulmonary Disease (1 person); coughs and wheeziness (1 person); and teeth and gum problems (1 person).

> *I stopped for medical reasons because I had 2 heart attacks and an operation and the surgeon told me if I went back to smoking again, he didn't want to know me because I couldn't survive another operation.* (Victor, MH4)

> *My health was horrendous and it was getting worse and worse. …You get fed up going in and out of hospital, so you can get oxygen to breathe. Then you're back in house and the first thing you do is light a cigarette. I thought, this cannot go on. This has to stop.* (Maureen, MH2)

> *Every year I take a chest infection because of my asthma and 2 years ago I had been, I got about 4 infections, one after the other and the year before was the same and I decided right, I have had enough.* (Fiona, MH1)

Advice from a health professional was a key motivation to stop smoking. In all of the mental health and older adult groups, individuals mentioned that they had been advised to stop smoking by health professionals, especially if they had an existing health complaint relating to smoking. Generally the minority ethnic participants talked less about advice from health professionals. While some respondent's GPs appeared to have good contacts with local smoking cessation services, others were not referring clients for specialist support.

The nature of advice and the extent to which it was acted upon varied. Three participants said that they had simply been told they should stop smoking, with little additional guidance or support to help them. Another two said that their doctor had advised them to cut down rather than to actually stop. Those who had quit recently tended to talk more positively about input from doctors and nurses. Five people spoke of their doctors' ongoing support and encouragement throughout their quit attempt. Those had been referred to smoking cessation services by their doctor were particularly positive about health professionals' advice.

The influence of family and other people was a secondary motivation to quit. Five people said their grandchildren were a reason for wanting to quit, either because they wanted to protect them from second-hand smoke or because their grandchildren objected when they smoked. Family also seemed to be an important motivator for minority ethnic participants. Indeed, these groups mentioned that decreasing social acceptability of smoking and increasing restrictions on places where smoking is permitted have made them consider quitting.

> *I have to say, it was my grandchildren. They just didn't like the idea… She [granddaughter] would go 'Tsk, that smells Nana, that smells!' You know, and you'd light up and she'd go 'That's dirty, don't do that.'* (Fiona, MH1)

> *And so many places you are not allowed to smoke…People do not like it, even bus stop you are standing, people are behind you and if you are smoking, smoke goes that way and everybody is looking at you like this* [makes face]. *It's not nice.* (Mr Aslam, BME1)

Many participants stated that money was an important consideration in their decision to quit. However, this tended to be an additional benefit rather than the primary reason. Only two older women explicitly said that they had stopped smoking because they could not afford it. Nonetheless, a number of people said they begrudged the money they spent on cigarettes and felt this was a good incentive to give up.

> *Your health first, then your wealth.* (Victor, MH4)

> *You can save a lot of money as well as improving your health in the process as well.* (Tariq, BME3)

There were also various 'cosmetic' and 'sensory' reasons for quitting. For example, four participants (three from minority ethnic groups) mentioned the smell of tobacco as off-putting. Others commented on the benefits of quitting on their appearance and to their house, even if this was not a primary motivation for stopping.

> *I'm going to embarrass myself now and tell you my reasons, one of my big reasons why I stopped, vanity. …I was smoking roll-ups and my teeth started to go brown. …My fingers were stained…*(Eleanor, MH3)

A final motivating factor, which is specific to the South Asian participants, was the Muslim holy month of Ramadan. The Bangladeshi and Pakistani groups mentioned that smoking was not permitted during the period of sunrise to sunset during Ramadan, which provided an impetus to continue with a quit attempt.

Although not strictly 'motivations', the successful quitters spoke of the benefits of quitting from their personal experience. The older adults in particular talked of

immediate health benefits, such as being less wheezy or breathless, and having fewer or less persistent coughs and colds. One woman with emphysema said she had been in hospital fewer times and for shorter periods since she had stopped smoking. The older adults also spoke of the money they saved and things they were able to buy after quitting. Others spoke of improvements in the cleanliness of their house and an improved sense of smell and taste. It was evident from the way that the ex-smokers talked that their self-esteem had also been boosted by quitting.

To sum up, although reasons for quitting are personal, there are common factors that motivate people to think about giving up smoking. The most common reasons are health related, particularly if someone has a condition related to, or exacerbated by, smoking. Secondary factors included money, family, the social acceptability of smoking, and personal appearance.

3.2.3 Relapse

Stories of relapse were common among the current smokers and recent ex-smokers. Many of the current smokers had tried to stop smoking in the past, while many of the recent ex-smokers had tried to give up a number of times before they were successful. Some people had even quit for prolonged periods before lapsing. For example, one person had quit for seven years, another for two, before starting again. More common was to stop for a few weeks or a few months before relapsing. Many of the recent quitters still spoke cautiously about being ex-smokers, suggesting they were still conscious of the possibility of later relapse.

> *I stopped it about 6 times. This time it's over a year now. I think that will be it now.* (George, MH1)

> *It was three years ago past May. But even yet, if there's any stress in the family or anything, you know, I think, 'Oh I could go a cigarette.'* (Janette, OA4)

> *When people asked me how long I've stopped I always say a year past December because I don't know if I'll make it till this December. You know what I mean? …Because every now and again I still crave it.* (Eleanor, MH3)

Generally, the longer-term non-smokers smoke less of the difficulties of stopping smoking or relapsing. In the past there was less support available for quitters, which meant that people needed to be quite determined in order to stop. In addition to a different social climate surrounding smoking in the past, it seems that there was also a different environment around quitting, which encouraged self-reliance. This attitude seemed to prevail among many of the older male participants in the group.

Although stories about relapse were unique to personal circumstance, overall there were three main reasons for relapse: stress, habitual triggers to smoking and side-effects of quitting. Most commonly, relapse was prompted by a period of stress, often related to a major life event. At least eight of the participants talked in detail about things that had happened that had caused them to smoke again after a period of abstinence. People spoke of bereavement, illness, mental breakdown, being assaulted, becoming unemployed and an industrial accident as reasons why they started smoking again. Others spoke more generally of 'personal difficulties', 'worry' and 'nerves'.

> *I stopped smoking for two year. Because of everything that happened in my life I went back on it again. I stopped for two year and I stopped for three months, so I did. When I stopped smoking, something happens then I'm back on the fags again. I said to myself, what's the point for me to stop smoking, when something's going to happen and I end up on the fags again.* (Craig, MH3)

> *But even then, I gave up the beginning of this month. I thought, I've had enough. But a week and a half later it was just a stressful time again. I lost my dad 3 months ago.* (John, MH1)

Strong cravings, or the desire for a cigarette at times or places habitually associated with smoking, were further common reason for relapse. Three people talked of the problems of going to the pub or drinking alcohol, and three spoke of friends encouraging them to smoke. Two participants mentioned that they had quit while they were in hospital, but had relapsed after discharge when smoking became an option again.

> *Your peers that do smoke 'you sure you want to give up, you sure you don't want a cigarette' and it's usually in the pub after a couple of beers when you're really at your weakest.* (John, MH1)

> *Another thing that annoyed me when I first stopped smoking, when you were in company 'do want a cigarette?' 'no' 'oh, go on'.* (Nan, OA3)

> *I was often in hospital with my lungs and that and I never missed a cigarette because it was a smoke free atmosphere. The minute I got outside the door to go out I lit up a cigarette* (Roger, MH4)

For others, side effects of quitting were a reason for starting to smoke again. Common side effects included weight gain, sleep problems, mood problems (e.g. depression, anxiety, grumpiness) and nausea. The South Asian groups also discussed digestion problems (e.g. acidity and bloating). Another man spoke of relapsing after changing anti-depressants. Three recent quitters described how the first three months were the most difficult in terms of side-effects and cravings, but that things got easier after that. Many people noted that they simply lacked the willpower to quit or that it was just too difficult.

> *You were asking about the symptoms. That's what I got, anxiety, panicky, a lot of nausea without smoking, but eventually it goes away, if you give it a chance. Like I says to this chap here, did you give the patches enough time? You only gave them 8 weeks.* (Victor, MH4)

In short, trying to quit was normal for most of the smokers, who talked of past quit attempts and the reasons why these were, or were not, successful. Approaches to quitting are detailed in the following section.

3.2.4 Approaches to quitting

The 12 people who had stopped smoking more than five years ago tended to say that they had 'just stopped' or had used will-power alone. A few pointed out that there was not the sort of help to quit in the past and they had no choice but to go it alone.

I stopped just like that. One day I says I'm not going to smoke again and I just stopped. (Doreen, OA1)

Among the 17 recent ex-smokers (quitting in the last five years), the majority (n=13) had quit with support from smoking cessation services and/or through using products such as NRT or Zyban. Of the remainder (n=4), three had quit alone ('cold turkey'), and one had undergone laser therapy.

Of the 33 current smokers, none who had unsuccessfully tried to quit recently had sought help from smoking cessation services, although two people mentioned being prescribed Zyban from their doctor and a number of others had tried NRT. In three cases where people had used NRT (patches and gum) it appears that they had either not really wanted to quit, or did not know how use the product properly. Many of the recent relapses were when people had tried to quit without any form of support.

People discussed using alternative therapies and harm reduction approaches when trying to stop smoking, generally with limited long-term success. For example, three people had tried acupuncture, one had hypnotherapy and another had laser therapy. All except the latter had started smoking again.

I've tried hypnotism, the counsellor, all sorts, the weird and wonderful – acupuncture, I tried acupuncture. (John, MH1)

Participants in three of the mental health groups discussed changes they had made to their smoking habits that they believed were beneficial. Three said they had cut down on the amount they smoked (two mentioned that doctors had advised them to cut down), three were no longer smoking inside their home, one was having their first cigarette of the morning later, and another said she was reducing the tar smoked (which related to her beliefs about 'safer' cigarettes). These people had generally relapsed before and were perhaps not ready to quit, but felt they should be doing something about their smoking.

I'm now, just now, beginning to wean myself back off… I'm starting cutting down the tar and the nicotine intake and going that way about stopping. Getting less and less. (Margaret, MH2)

I was on 40 a day, and I went on to roll-ups just to cut it down, that was 50g a week. Now I'm down to about 25g a week. But I'm keeping on cutting it down and down and down. (John, MH1)

Even if I said to myself, I'll wait another 20 minutes, half an hour and then go outside and have one, its still me taking one less. I'm still cutting it down. (Geoff, MH2)

The participants suggested a number of tips to help someone who wanted to stop smoking. These were related to their own experiences of quitting, to experiences of people they knew, or on popular folk theories. Ideas included having something to keep busy or break your routine; consuming something else in place of cigarettes; saving money that would be spent on tobacco; taking exercise and watching your diet to combat weight gain; quitting at the same time as a friend or relative, or having someone to talk to; and reminding yourself of the reasons and benefits to quitting.

> *I had her phone number* [relative who quit at same time]*, and she would have mine, and 'oh I really need a cigarette, I need to talk to somebody'. And you'd just sit and talk.* (Kate, MH2)

> *I decided right, I have to have something in place of that cigarette, so I was learning to work the computer …I find if I've got something in place, the times I would be having a cigarette if I have something in place then, it takes your mind off it*. (Fiona, MH1)

> *I chew mints. And I do exercises, you know like this…and that one* [demonstrates]. *You know I've got enough exercises to take my mind off the cigarettes as well as just sitting doing nothing.* (Sarah, OA4)

The recent quitters who had gone through smoking cessation services advocated seeking professional and social support and using NRT. Many of the recent quitters also felt that longer-term support, for about three months, was necessary.

> *Go to a smoking cessation clinic. That's what I would say. You'll get all the help you need.* (Janette, OA4)

A theme expressed in every group was that determination and willpower was the key to a successful quit. Regardless of their quit status, the majority of participants said that in order to stop smoking it has to be the 'right' time, it has to be your decision and you really have to want to do it. A number of the current smokers, particularly middle-aged or older males, said that will-power was the only thing that could help you stop. The recent quitters attributed their success in quitting this time to two things: one, that it was the right time and that they were really determined to stop, and two, that smoking cessation support was now available.

> *I knew my time. I knew then that I was ready to stop.* (Fiona, MH1)

> *I think when I comes to stopping smoking, it's something that you've got to want to do.* (Mary, OA2)

> *If you want to stop you have to do it yourself. Something has to get into your brain* (Stanley, MH4)

> *It's just a question of finding the willpower and the motive to be able to give up.* (Shabir, BME3)

> *I tried a couple of times, but see at this stage with hindsight, it was kind of half-hearted attempts. …But I think you can't stop for anyone else. It can't be for anyone, its got to be your decision and for you.* (Eleanor, MH3)

To summarise, there was great variation in the methods used by participants when trying to stop smoking. Those who had quit more than five years had tended to do so without any medical support, as this was not so readily available in the past. People who were still smoking but had tried to quit in the past had tended to rely on willpower, alternative therapies or using NRT without additional support. The majority of successful quitters in recent years had sought support from smoking cessation services and/or pharmaceutical products. The following sections will include more detailed discussion about these particular approaches to cessation.

3.2.5 Smoking cessation services

Six people had attended dedicated smoking cessation services (five at groups and one with individual support), while two other participants had received one-to-one support from their medical practice. All but one of the people who had received professional smoking cessation support were female, and all but two were over the age of sixty. Two were from mental health groups and none were from minority ethnic groups. All had been referred to the service by a doctor.

Among the rest of the participants, awareness of smoking cessation services and knowledge of how they operated appeared to be low. When asked what support was available to help people stop smoking, those who had not attended smoking cessation services mentioned quit-lines, doctors, pharmacies, alternative therapies (e.g. hypnotherapy or acupuncture) or NRT. A couple of participants commented that there should be some kind of counselling for smokers, as there is for other addictions, apparently unaware of free support services available.

When smoking cessation services were described in a story about an imaginary quitter to participants who had not used professional support, only two participants said they had heard of something similar services. Awareness of smoking cessation services appeared to be particularly low among minority ethnic participants and older men. However, when the workings of services were described in detail, there was a sense of interest in the approaches used and in the fact that they were free to access. This suggests that more is needed to publicise services to members of the public, to raise awareness of the type of support that is available.

> *There's no real help that way. It's all very well making new laws forbidding smoking in public places, well how about adding on to that and boosting it up a bit with a bit of help to stop smoking?* (Stanley, MH4)

> *Well, you see, people are forced to have to pay for these things* [laser-therapy and hypno-therapy]*. If the government is going to bark at people to give up smoking they should provide a free service.* (Graeme, MH4)

The participants who had sought professional smoking cessation assistance spoke in detail about their experiences. In particular they valued expert advice and support from staff, and spoke favourably about the knowledge and personalities of the advisors. They appreciated that smoking cessation professionals took an interest in them, especially in the longer term. Most talked of the educational value of sessions, learning about what was in cigarettes, the impact on health and benefits of quitting.

> *It was the help that you're getting that stopped me. They convince you.* (Janette, OA4)

> *We got of know a lot of information that we never knew nothing about.* (Mary, OA2)

> *I just know I came here, I could've walked in here any time and* [smoking cessation advisor] *welcomed me with open arms. And just let me talk, and listened. And I think that's the secret.* (Marlene, OA4)

Secondly, the participants who had attended a smoking cessation group valued the support they received from other members of the group. They felt it was useful to talk to people who were going through the same experience and to share stories.

Everyone who had gone through a group also enjoyed the social aspect and camaraderie.

> *If you've got other people there to support you as well, knowing that you're not the only one that's trying to give up. Definitely.* (Frances, MH4)
>
> *You can go along with other folk, other smokers, and you know, if they want to stop you're encouraging a group, so you're not just an individual, you're a whole group that's working together, to stop each other from smoking.* (Eddie, OA2)
>
> *And I thoroughly enjoyed it. I thought it was very supportive others being there. It's a wee bit isolated, you're on your own, you never meet anyone.* (Sarah, OA4)

A range of other benefits of professional smoking cessation support was mentioned. For example, three people found carbon monoxide monitoring to be a useful motivation and an incentive not to 'cheat'. One woman mentioned the accessibility of the service, which she had gone to because it was local and easy to get to. Another appreciated the speed with which she was seen by the specialist. Both of them highly valued the longer term and flexible approach offered, where they could call upon the specialist for support when they needed it. Two of the woman attending smoking cessation services had also received referrals from their GP to see a dietician to help with weight gain.

> *I went to my doctor and I said I've been told I need to give up smoking for surgery, and it's only a couple of weeks till the surgery and I don't know what to do. And she said I'll help you, and she lifted the phone and phoned* [smoking cessation advisor] *and I had an appointment the next day. It was as quick as that.* (Marlene, OA4)
>
> *I fell by the wayside because I'd forgotten to take the letter up to my doctor, I couldn't find it. I said to myself don't bother, so I just started smoking. Then I thought, no, I really am distraught, I'll phone up* [smoking cessation advisor] *and see if I could get into another one* [smoking cessation group]. *And I did, thanks very much!* (Sarah, OA4)

To sum up, those who had received smoking cessation support highly valued the professional advice and assistance, as well as encouragement from other group members. However, awareness of available support was low amongst other participants, suggesting that further publicity of services and better referral protocols are needed.

3.2.6 NRT and Zyban

Participants had varied knowledge, attitudes and experiences of pharmaceutical smoking cessation aids, such as NRT and Zyban. All but one group (the Bangladeshi men) discussed NRT, particularly patches and gum, and at least eleven participants had used some form of NRT. Three people spoke of trying the gum, five had used patches and three had used inhalators; (with two using both inhalators and patches). Most appeared to have been prescribed NRT by their doctor, although three people said they had bought products from pharmacies. Four people reported using Zyban.

Attitudes to NRT were mixed. Those who had used NRT in a successful quit attempt were more positive about these products and noted that they had helped them

through the early stages of their quit attempt. A couple even resorted to NRT occasionally for extra support. For example, one woman who had quit for over a year kept an inhalator for when she was feeling 'a bit weak'.

> *Oh, it tasted horrible* [inhalator]*…but at least it gave me something in my hand, that's what I needed. That's what I needed, I think that really helped. Even if I was outside I could use it. I still do.* (Marlene, OA4)

> *I swear by the patches. The best.* (Janette, OA4)

> *I stopped 2 years past in October. I did it through the patches but before that I tried 2 or 3 times but it was quite hard.* (Fiona, MH1)

Others were less positive or suspicious about medications. Their opinions seemed to be based on negative personal experience, on the experiences of acquaintances, on media coverage or on hearsay. People spoke of various problems with NRT, for example that the gum does not taste good; the patches do not stick; the spray causes nausea; or that it is too expensive. Five people explicitly stated that patches or gum do not work. One man, who advocated going 'cold turkey', felt that NRT could lead to dangerous levels of nicotine or a new addiction. In two instances it appears that people had been using NRT incorrectly or had been supplied it when they were not really motivated to quit.

> *The doctor didn't give me any advice, in Chinese or in English…I found that they* [patches] *are not helpful because I like smoking*. (Mr Lee, BME2)

> *I bought nicotine patches and I binned them. I put one there, right, two seconds later it comes off. It didn't stick.* (Craig, MH3)

> *That's the problem with the patches and the chewing gum, you've decided to give up cigarettes…then you've got to decide to give up the patches. You're giving up 2, possibly 3 things in a period of time which increases the hardship.* (John, MH1)

Issues to do with Zyban were also discussed. Two of the four people who had used Zyban felt that the product had been a help, while two had stopped taking it. Two of those who had used it mentioned the side effects (sleeping difficulties, skin reaction and headache). Four others, who had not used Zyban, expressed negative views on the product, because of the risks, contraindications, side effects, or because it is an anti-depressant.

> *The one thing I'm not so very keen on is Zyban, there's a risk there, it doesn't work or it can make somebody very ill by taking it. To me, if there's a risk, you don't take it.* (Mary, OA2)

> *You've got to watch that Zyban, Zyban can do certain things to you. A lot of people become ill with Zyban.* (Roger, MH4)

> *That's something I was frightened off, the tablet, because I had heard, somebody had told me, or I'd heard it on the television somewhere, that there was somebody dying.* (Marlene, OA4)

To sum up, most people, with the exception of the Bangladeshi men, were aware of the existence of NRT. There were mixed feelings and experiences about NRT and

Zyban. Some people had positive personal experiences of these products, but others were not convinced of their efficacy. In particular, the older males did not speak so favourably about pharmaceutical cessation aids as did the females.

3.2.7 Discussion and Recommendations

People talked at length about their own quit attempts, including approaches used, problems experienced, successes and relapse. For the majority of participants, thinking about quitting, trying to quit and starting to smoke again were normal parts of their personal tobacco use history. The most common motivations to quit were health related, followed by family, the social acceptability of smoking and finances. Reasons for relapse were varied, but were typically spurred on by a period of stress, habitual triggers, side effects of quitting or lack of will-power. Approaches to quitting varied, ranging from will-power alone, to using support from a smoking cessation specialist and pharmaceutical cessation aids.

The interviews elucidated a number of ideas for future development of tobacco control initiatives and smoking cessation services. For example, focus groups showed how some people continue to deny the health risks of smoking. This suggests that work is still needed to educate people about the dangers of smoking, for example through mass media public health campaigns and advice from health professionals. Additional efforts are required to motivate people who are not unwell, or who do not have symptoms associated with smoking, to consider quitting.

Interestingly, there was little discussion about age, mental health or ethnicity being particular barriers to quitting. The idea that it was ‘too late’ to stop smoking, or that it was a person’s ‘only pleasure’ did not emerge strongly in the discussions. (Indeed, two older adults said they actually thought it was harder for young people to quit.) This suggests that health professionals and others working with particular client groups might be making assumptions about people’s desire or ability to stop smoking that are perhaps not justified. Work is needed to challenge these preconceptions and to raise awareness of the importance of smoking as an issue.

More needs to be done to encourage doctors to promote non-smoking messages consistently. It seems that doctors are not always discussing tobacco use with all patients and are not always offering suitable advice on how to stop (e.g. referring people to a specialist smoking cessation service or prescribing NRT appropriately). This indicates that further work is needed to make GPs and other health professionals aware of current smoking cessation guidelines and their role in smoking cessation (Health Scotland and ASH Scotland, 2004). Work is also needed to develop appropriate referral protocols between with GP practices, hospitals and smoking cessation services.

It is apparent that many people are not aware of the existence of smoking cessation services, what they do or that they are provided free of charge. There are also fears and misconceptions about pharmaceutical products. This shows that much more needs to be done to publicise the free support that is available for people and the evidence base for what works. Targeted awareness raising should be considered for groups with lower experiences of quitting, for example minority ethnic communities, to encourage more people to think about quitting and to use evidence based approaches. Given the interest shown in services after these were described to groups, it seems that positive testimonials of real people who have gone through a smoking cessation service might be a good approach.

The interviews uncovered a number of ideas for the enhancement and development of smoking cessation services. In order to provide a more holistic approach to healthy lifestyles and behavioural change, smoking cessation service providers should investigate working in partnership with other agencies and professionals, such as substance misuse services, dieticians, exercise consultants and practitioners of relaxation techniques. This would be of particular significance for some client groups, such as people with mental health problems, who might need additional support to deal with stress relief and weight gain.

Relapse prevention work is particularly important when working with inequalities groups and people who are highly addicted to tobacco. Longer-term and more intensive cessation support, for a period of months, and flexible approaches are appropriate for some clients. Extra support seems to be especially important in the first three months of a quit attempt, when a person comes off NRT, after discharge from hospital and on occasions when an individual is finding it difficult for whatever reason. Another approach is to use three month and twelve month follow-ups as a chance to discuss a person's quit attempt and ongoing support needs. Services may also want to contemplate using peer support to reinforce professional support.

Ways of making services more accessible for groups with particular needs should be explored. For example, situating services in locations that are easily accessible by public transport, or within community settings. Providing support at different days and times would make them more accessible to a wider range of people. Services may wish to consider providing drop-in or on-call support as back-up to structured sessions. This might also increase accessibility for people who find it difficult to stick to appointments. Ways of providing quick responses to priority groups should also be investigated. Encouraging self-referrals from people who feel motivated to stop should be considered.

Services may also wish to investigate models of support that are most appropriate for people who do not want to use NRT or Zyban, or who are reluctant to attend groups. In particular it seems that older males and people from minority ethnic backgrounds might not be seeking help from conventional services and work needs to be done to redress this issue. Services should monitor the demographics of clients using their services, and compare this to the characteristics of their local population, to find out which groups are not seeking support. Outcomes should also be monitored routinely, using the Scottish smoking cessation minimum dataset and other outcome measures, to investigate where further work is needed.

Finally, new approaches to working with smokers who are resistant to changing their behaviour need to be explored. Although existing practice focuses on quitting, the interviews revealed that harm reduction approaches, such as cutting down, or altering the times and places when they smoke, are seen as positive changes for people who might not be ready to stop smoking but nonetheless want to do something about their tobacco use. Such approaches are particularly pertinent in light of new legislation and attitudes towards smoking in public places. Further research into harm reduction approaches and how these might be used effectively in practice warrants further attention.

Further ideas for service development are discussed in the following sections on media campaigns, health promotion resources and legislation on smoking in public places.

3.3. OTHER RESOURCES AND CAMPAIGNS

Other approaches to tobacco education and smoking cessation – including mass media public awareness campaigns, telephone quit lines and information leaflets – were discussed at different stages of the interviews. Some people mentioned these in relation to motivations to quit and experiences of quitting, while others raised these as ways of getting information or advice. The groups were also presented with examples of information leaflets and asked for their opinions on them.

3.3.1 Mass media

Individuals in all groups recalled advertisements they had seen on television about the effects of smoking and passive smoking, or for quit lines. The Bangladeshi and Pakistani groups mentioned that they had seen anti-tobacco commercials on both English language and Asian channels. Nobody talked about tobacco information campaigns in newspapers or on the radio.

Several people described specific campaigns in detail and said what they thought about them. There were mixed opinions about the approaches used in different campaigns and the effectiveness of advertisements in general. Some appreciated the honesty of campaigns that portrayed smoking related illness. Others did not think that shock tactics worked or preferred more humorous, light-hearted approaches. A few people stated that advertisements were a waste of time and money.

One of the mental health groups in particular felt strongly that it would be useful to have more positive campaigns, rather than negative campaigns focusing on death and disease. They believed it would be worthwhile to focus on the benefits of quitting, rather than the problems caused by smoking, and to give people confidence that they can stop. They suggested using positive testimonials of people who had quit and how this had impacted on their lives.

> *It would be nice if you could see an advert of people who've quit – we've done it, it's great, now we feel much better, we've got money…* (John, MH1)

The respondent's comments suggest that advertisements are valued for drawing attention to issues, although there are limits to their reach and effectiveness.

3.3.2 Telephone quit lines

There was little discussion about quit lines, with only two groups mentioning quit lines as a way to get help when stopping smoking. None of the participants explicitly stated that they had phoned a quit line. Nonetheless, the two men who mentioned quit lines said they could be useful to get help and encouragement, both before and during a quit attempt. Another participant in the Pakistani group welcomed the provision of information in other languages, particularly if it was free of charge.

> *If you need encouragement I think the phone line would be great, if you've given up smoking and you're just cracking, all you want is a little bit of help with it, that motivation is just to stay stopped. …Now, it might just be a 10 minute chat with somebody but that might just get you through the day*. (John, MH1)

This suggests that more could be done to raise awareness of the existence of quit lines and the actual support and assistance that they provide. This is true for both generic quit lines, but also those in languages other than English.

3.3.2 Leaflets and printed resources

The groups were shown copies of information leaflets about tobacco use and quitting and were asked if they had ever seen anything similar. For most groups these were generic leaflets from a variety of providers. However, the minority ethnic groups were also shown resources in Urdu, Bengali and Cantonese, and the older adults were given two examples of leaflets specifically targeted at their age group. The groups were asked for their opinions on such leaflets, for example whether they would be interested in them, what they liked or disliked about them, and how they could be improved.

Awareness of leaflets, booklets and other printed resources, and experience of using them, varied immensely. Those who had recently attended smoking cessation services were particularly aware of leaflets. Three three others said that they had seen similar leaflets at their doctor's practice, pharmacy and a mental health drop-in centre. Nobody mentioned seeing or using audio-visual information sources.

In all groups people asked if they could take the leaflets home. In particular, the minority ethnic groups appeared not to have seen resources in their language before and seemed interested in the leaflets they were presented. The older adults groups also had not seen resources targeted towards their age group and appeared interested in information that was specifically focused on the benefits of quitting in older age. This suggests that there is still a place for leaflets within health promotion, particularly for communicating targeted messages or for groups where awareness of tobacco issues is low.

> *This is a good thing here, it's telling you about the benefits of giving up…you're not thinking about 10 years, you're thinking about 2, 3 months from now.* (Mary, OA2)

> *- If there's a leaflet in Bengali, a Bengali person will pick it up and read it.*
> - *Also get bored in the restaurant at work so it would be a good time to pick up a leaflet.* (Participants, BME1)

A number of people who had given up smoking in the last five years, especially those who had used a smoking cessation service, discussed using printed resources when they were going through the process of stopping. Three people valued the practical advice and tips on quitting, while two others felt that the medical evidence was a useful as an incentive and encouragement.

> *One of the things you got off* [smoking cessation service]*. It's a book, you scratch off day one, day two, day three, and it gave you a different tip for every day.* (Kate, MH2)

> *One of the things that interested me, '20 minutes after you stop smoking, your blood pressure and your pulse rate fall', that sort of thing. I think I quite enjoyed reading these things.* (Mary, OA2)

There was also discussion about the shortcomings of leaflets. The time and effort to read a leaflet was mentioned as issues for people who have difficulty reading and for those who are not motivated to quit. When the leaflets were distributed in the groups

a couple of people did not bother to look at them. Indeed, one Pakistani man stated that he had never learned not read or write and one older woman mentioned that she was partially blind. Others said that leaflets were most useful for people who were serious about stopping, especially as a way of reinforcing information they had already been given.

> *There's nothing wrong with the leaflets, it's getting people to sit down and read them. I wouldn't say it's a waste of money but I think if you're bringing out a leaflet you've got to target somebody.* (Eddie, OA2)

> *I don't think many smokers are going to be particularly* [interested]*…not unless they've actually passed the point of saying 'I'm going to give up' and they need something to reinforce.* (Alex, MH1)

> *I think people who would only pick up these leaflets have the intention to give up.* (Shabir, BME3)

Finally, the groups suggested features that they thought made a good leaflet. The general characteristics were that it should be eye-catching, colourful and with pictures, and that it should not be too long or wordy. The minority ethnic groups commented on the worth of having leaflets in other languages, particularly for older generations.

In short, despite the limitations of printed health promotion resources, these are still valuable tools. Leaflets, brochures and posters are particularly useful for raising awareness of tobacco issues in communities where knowledge of health problems and experiences of quitting are more limited, for communicating targeted messages and for using as a resource in specialist support services.

3.3.3 Discussion

It appears that supplementary approaches to smoking cessation (e.g. media campaigns, quit lines and printed resources) are valuable for drawing attention to issues and making people think, although they may have limited appeal for people who are not motivated to stop smoking. The group discussions bring up a number of issues that should be taken into account in the future development of such resources.

For example, health promoters may wish to consider publicising smoking cessation services in the mass media and to raise awareness of the support available. Likewise, it might be worthwhile to publicise what kind of support and assistance telephone quit lines are able to provide, particularly for people who are going through a quit attempt. Another suggestion emerging from the interviews was to broadcast 'real life' testimonials of quitters as a way of raising awareness and motivating people to quit. Finally, to broaden the scope of any campaigns, the use of satellite television and Asian language channels, as well as local and national radio and press, should be investigated.

Suggestions for the future development of other information resources also came to light in the interviews. Generally, people felt that leaflets were useful to give additional information and motivation, but that they were best used as a supplement to other information or to facilitate discussion. There appeared to be gaps in awareness of leaflets that need to be addressed through more imaginative and

targeted distribution. In particular, more work needs to be done extend the reach of leaflets, particularly those in other languages, to minority ethnic communities. It seems that the three inequalities groups involved in this study would benefit from targeted information that addresses their particular situation. Developing and distributing audiovisual formats of information sources is another possibility that should be considered to disseminate key information. Involving representatives from different groups in the development and pre-testing of resources is essential to ensure that the format and the messages conveyed are appropriate.

3.4 SMOKE FREE POLICIES

The focus groups were conducted during the period when the Scottish Executive was consulting on legislation on smoking in public places, or when the Scottish Parliament had announced its intention to introduce laws to this effect. Although the interviews did not specifically focus on this topic, this issue was raised by a number of groups in the course of the discussions. It was debated at length by two of the mental health groups, with one respondent being particularly vocal on this matter.

3.4.1 Opinions on legislation

Overall, the groups recognised a change in popular attitudes towards tobacco use, to it now being less common and less socially acceptable. All groups appeared to be aware of concerns surrounding second-hand smoke (passive smoking). Indeed, changing attitudes towards smoking and a growing awareness of the affect of smoking on others, were influential factors in many people's thoughts about quitting.

There were mixed opinions about legislation on smoking in public places, with opponents to legislation being most vocal on the matter. While there was general approval for not smoking around children, in hospitals, on transport and in places where food is served, people expressed reservations about the extent of legislation, especially in pubs and clubs. Typically opponents advocated using ventilation systems and/or having separate smoking sections.

Three groups discussed the potential negative impact of no smoking policies on businesses and customers, such as loss of profits and redundancies; or increased drinking, smoking and passive smoking in the home. One group of older adults and one mental health group discussed the recent introduction of regulations on smoking at their local drop-in and community centres, and the impact this had had on members.

> *At least half the men that used to come in just don't come in now because there's no smoking. I hate coming in on Friday. Going outside in the pouring rain.* (Graeme, MH4)

> *Now, either the folk will stop coming along or if they want a cigarette they'll have to go out the door.* (Mary, OA2)

Some people apparently felt pressurised by changing social norms regarding the acceptability of smoking. They talked of being stigmatised, victimised, picked on, attacked, dictated to and brainwashed, and that proposals were 'not fair', 'over the top' and 'out of control'. Participants in the mental health groups expressed were more likely to express these negative emotions.

A smoker is getting attacked from everywhere, you know what I mean? From myself, from other people, from those in health, from everywhere, saying smoking is not good. (Mr Iqbal, BME1)

I mean it is a problem. I'm not disputing that fact. But we are to a certain degree victimised. (John, MH1)

Ok, I'll go along with that, but the point that I'm making is the way that everybody is being dictated to. That's all it is – it's all dictatorship. (Graeme, MH4)

Doubts were expressed over the government's motivations for introducing legislation. Two participants called into question the evidence on the health effects of smoking and passive smoking, and felt that policy makers manipulated figures in order to pursue their own agendas. Others stated that other major health issues, such as obesity and alcohol use, were not being addressed so vociferously. One group discussed the mixed messages that were conveyed by the government in reclassifying cannabis, whilst simultaneously trying to denormalise smoking. Others felt that the government did not really want to tackle tobacco use because they made too much money from tax on tobacco products.

But they're not being fair – they're using figures to justify having a go at smokers but the figures are much, much larger for other problems that they're not even tackling, so they're not being fair (John, MH1)

This is what it's all about, it's just brainwashing people because somebody doesn't like it so they spend fortunes and their entire life campaigning for it to stop. (Graeme, MH4)

- The government don't really want everybody to stop smoking.
- They'd lose far too much money on it. Far too much on tax and duty.
(Participants, MH2)

Finally, the groups revealed some misunderstandings and misgivings about the scope and implementation of the legislation. Two of the most outspoken critics were concerned that open public places and dwelling places would be included. One man postulated that the sale and use of tobacco would be outlawed and smokers would be criminalised in future.

Soon you won't be allowed to smoke in [the street] *because it's a public place. That's going too far.* (Graeme, MH4)

From what I've seen from the news and the radio and everything else is that they're going to ban smoking in public owned buildings. Fine. But does the government realise that council houses are public owned buildings? (John, MH1)

Although opponents of smoke free legislation were more outspoken than those in favour, the positive impacts of policies were also discussed. It was noted that legislation would raise awareness of the dangers of smoking and second-hand smoke, and might encourage people to think about stopping. Indeed, one man pointed out that introducing the legislation was the ideal time to promote smoking cessation services.

I think the government should not lose the momentum in providing information at the same time as banning…providing information for patches and other things as well. (Tariq, BME3)

Others felt that a smoking ban would benefit people who have a smoking related illness who find it difficult to be in places where there is smoke. Indeed, one man who had recently quit following a heart attack indicated that a smoking ban would be beneficial for his health and his relationship with fellow residents.

I live in sheltered housing. There's about 4 or 5 ladies that smoke. They walked in the common room, smoke like a mist, so I started coughing, they said 'Victor shut-up'. 'No, you shut up, put the bloody cigarette out!' (Victor, MH4)

A number of ex-smokers mentioned that they found it difficult not to smoke in pubs or when out socialising with friends. In this respect they felt that the legislation would be beneficial to quitters by helping them to 'resist temptation'. Indeed, one woman spoke of how helpful it was that her mental health drop-in centre had gone smoke free at the time she had quit, as she was able to socialise with others.

3.4.2 Discussion

Legislation on smoking in public places was high on the agenda at the time of the research. There was much discussion on this topic, even though it was not explicitly asked about. The depth of the debate, the strength of language used and the concerns and misconceptions discussed indicate that there is still much work to be done to educate people about second hand smoke, about the scope of the legislation and why it is needed. Mass media public awareness raising campaigns are needed as a first step to communicating these messages.

The fears expressed about the negative social and personal impact of an increasingly non-smoking society indicates that work is particularly necessary with groups where smoking prevalence is traditionally high, and with smokers who already feel marginalised or isolated. Work is also needed in places which will be exempt from the legislation, such as psychiatric hospitals, care homes and supported accommodation, to support clients with the changes happening in the outside environment. The government, smoking cessation specialists, health professionals and others working with particular communities all have a role to play in preparing people for the introduction and impact of the new legislation.

4. RECOMMENDATIONS

To summarise, the focus groups produced a great deal of data that was analysed to find out more about the issues relating to tobacco and cessation in the three target communities of the ASH Scotland's Tobacco and Inequalities Project (minority ethnic communities, older adults and mental health). The key finding was that many individuals from these groups would like to do something about their tobacco use, and would benefit from appropriate information and support. A number of actions have been identified to better meet the needs of these three groups. These are outlined below.

4.1 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.
- Smoking cessation services (SCS) will need adequate and sustained funding to enable them to further develop services to work with target groups.

4.2 Awareness Raising

- National media campaigns are needed to raise awareness of tobacco and cessation issues at national level (see section 4.7)
- SCS should publicise their services widely to raise awareness among the general public and key partner organisations at local level.
- SCS should engage with a wide range of community and voluntary organisations to encourage staff to think about the relevance of tobacco issues.
- 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, both within and outside the health service.

4.3 Development of Smoking Cessation Services

- SCS should be developed in accordance with current *Smoking Cessation Guidelines for Scotland* (Health Scotland and ASH Scotland, 2004), with awareness that alternative models of service delivery may be required to achieve success with some clients.
- Information is required on the extent to which SCS are being accessed by different client groups, and their outcome measures.
- SCS should consider ways in which they could be more accessible and relevant to different communities, and how priority groups could be targeted (e.g. outreach services or thematic groups)
- SCS should be encouraged to offer additional support for relapse prevention (e.g. longer term support, support post-NRT, drop-in support, telephone support, peer support/buddying).
- SCS should consider ways of working with people who do not want to use NRT or Zyban (who prefer to rely on ‘will-power’), but may still benefit from professional support.
- SCS should consider ways of providing more holistic approaches to cessation, potentially in partnership with other agencies or professionals (e.g. combining cessation with wider healthy lifestyle issues – exercise, diet, stress relief, tackling other substance misuse).
- SCS, or other service providers, should consider branching out into tobacco areas that are not strictly ‘cessation’ (e.g. wider tobacco issues education and training, prevention, pre-quit work, harm reduction)
- Further prevention and pre-quit initiatives should be developed for those who are not yet ready to stop smoking (e.g. information and education sessions, discussion groups, motivating healthy smokers)

- Further exploration of ways of working with people who wish to change their tobacco use, but are not ready to quit, are required (e.g. harm reduction approaches)
- 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.
- Where possible, client groups should be involved in the development and evaluation of services, to ensure their particular needs are met.

4.4 Training

- All health professionals, especially primary care and mental health practitioners, should be trained in brief advice for smoking cessation and be aware of recent smoking cessation guidelines.
- Basic tobacco issues education should be offered to a range of professionals working outside healthcare settings.
- Specialised training should be tailored for those working with particular client groups. This should meet *Standards for Smoking Cessation Training* (Partnership Action on Tobacco and Health, 2003) and address particular cultural issues or special needs relating to the client group.

4.5 Quit lines

- The potential for quit lines to be used as a primary way of providing longer-term, back-up support for recent quitters should be explored.
- 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.
- A review of the availability of non-English language quit line services in Scotland is required (e.g. Asian quit-lines provided by the NHS and Quit, the UK Chinese quit-line).
- Greater provision and publicity of non-English language quit line services is required.

4.6 Self Help Materials

- The language, graphics, design and font size used in developing printed information about tobacco use and cessation should ensure they are readable and represent different communities.
- Greater publicity and distribution of printed information in languages other than English is required.
- Leaflets should be distributed in a range of health and community organisations to improve access and reach.
- Audiovisual versions of information should be developed (e.g. DVDs, cassettes).
- Training for professionals in the facilitated use of health promotion information should be developed

- Information on other tobacco products and ways of smoking, and their associated risks, should be developed (e.g. pipes, cigars, roll-ups, cannabis, chewing tobacco, and low tar, menthol, and herbal cigarettes).
- A diverse range of people should be involved in developing and pre-testing resources, to ensure they are appropriate to special needs (e.g. language, literacy) and contain appropriate information.

4.7 Mass Media Campaigns

- To increase coverage to different groups in society, both national and local media (e.g. television, radio and newspapers), and specialist media (e.g. Asian channels and radio stations) should be used.
- Mass media should be used raise awareness of SCS and the approaches they use. A potential way to advertise SCS would be to use testimonies of people who have successfully stopped smoking with professional support.
- Media campaigns should continue to raise awareness of the diverse health risks associated with tobacco (in particular heart disease, circulatory disorders and other cancers) and passive smoking.
- The media should be used to raise awareness of the reasons for smoke-free legislation and the scope of new laws in Scotland.
- Any media campaigns should try to reflect diversity in the images presented.
- Positive campaigning should be used in addition to traditional approaches emphasising the dangers of smoking.
- SCS should be aware of new campaigns before they are launched to prepare for potential increases in demand.

4.8 Smoke Free Policies

- Awareness raising and publicity are required in advance of new Scottish legislation on smoking in public places, to educate people to the dangers of second-hand smoke, the extent of the legislation and the availability of SCS.
- Organisations working with older adults, mental health service users and other marginalised groups will need assistance preparing for the introduction of legislation, and to help clients with the transition to an increasingly no-smoking society.

4.9 Miscellaneous

- Research into the availability and use of non-smoked tobacco products in Scotland is required (e.g. paan, gutkha, tobacco toothpaste).
- Trading standards should be involved in ensuring that the sale of non-smoked tobacco products (e.g. paan, gutkha) is legitimate and that appropriate health warnings are included.
- Further research is needed with particular communities who were not adequately represented in this, or other recent, studies (e.g. older men, people in psychiatric hospitals, with particular sub-groups in the minority ethnic population - young people, women, new or hidden minorities such as Gypsy Travellers, refugees and asylum seekers, and migrants from Eastern Europe).

- A detailed exploration into harm reduction is required, looking at different approaches, potential benefits, communicating harm reduction messages and the relationship with cessation.

4.10 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 (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 service providers**

Or **contact ASH Scotland**:

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

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Fax: 0131 225 4759
Email: 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.

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

Chinese: residents of Scotland 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)

Gutkha: A form of commercially manufactured, flavoured and sweetened chewing tobacco products.

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 Board Areas 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 tobacoo.

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.

Passive smoking (see second hand smoking)

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.

Second hand smoking: Inhaling other people's tobacco smoke. Second hand smoke is made of two types of smoke - mainstream smoke (smoke breathed in and out by smokers) and sidestream smoke (from the end of a burning cigarette). Also known as passive smoking.

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 (SCS): 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 – Sample focus group structure

The following gives a guide to the structure of the focus group interviews. The questions noted are *examples* of the themes that were raised, although these were not necessarily asked word-for-word in the same way each time. Each session followed a similar pattern, although the actual questions asked and the order depended on the issues raised by the group.

PART 1 – WELCOME AND INTRODUCTION

Introduce ourselves and explain about ASH Scotland, our study and what we will do in the session. Go over confidentiality issues.

ASH Scotland:

- Aims to raise awareness about tobacco use and its harmful effects. We are not anti-smokers. The aim of our work is to improve health. We are not here today to lecture you about smoking or to try to get you to stop.

The study:

- We know that there are many reasons why people smoke and that the nicotine in cigarettes makes them addictive. We know that people often find it difficult to give up, especially if they have smoked for many years. We are also aware that people aren't always given the information and help that they need when they try to quit.
- The aim of this study is to find out more about people's views on smoking and people's experiences of trying to quit. We also want to find out about information or advice you may have been given about stopping smoking and to hear your thoughts on what helped or what would have helped when you were trying to stop.

The session:

- We've going to tell you a story about someone and their smoking, and we're going to stop at different stages of this story to ask your views and thoughts on it, and about your own experiences.

Confidentiality

- Anything we talk about today will be confidential and your name won't be used in any reports we write. If there's anything you don't feel happy talking about that's OK, you don't have to. If everybody agrees we'd like to record what people say to help us remember information later on. We might also make some notes as we go along. If you want to leave you are free to do so at any time. If you have any questions please ask us.

PART 2 – SMOKING HISTORY AND BEHAVIOURS

First of all, we'd like to tell you the first part of (name)'s story.
[Part 1 of vignette – see appendix 2]

Questions/Prompts

- Thinking about yourself, or people you know, why do you think people start smoking?
- Why do you/they continue to smoke?
- Do you/they smoke more in certain places or situations?

PART 3 – MOTIVATION TO CHANGE, HELPS AND HINDRANCES

Now we're going to tell you the second part of (name)'s story.
[Part 2 of vignette – see appendix 2]

Questions/Prompts

- What things have ever made you think about stopping smoking?
- What reasons do you think other people have for giving up?
- What about:
  - Health (what health problems are caused by smoking?)
  - Advice from doctor/health professional
  - Friends/family
  - Money
  - Adverts on TV
  - Smoking bans

If you were (name)'s friend…

- Where could they go for information or advice?
- What kind of help is there for people who want to stop smoking?
- What do you think would be most helpful?

We'd like to find out more about your experiences of stopping smoking…

- Have you ever tried to stop smoking?
- What did you do to help you give up?
- Where did you get information or advice?
- How did you get on?
- Why do you think you were successful / unsuccessful that time?
- What kind of problems might (name) face when they try to give up?
- What about:
  - Stop smoking services/groups
  - NRT/Zyban
  - Doctors
  - Pharmacies
  - Phone-lines
  - Friends/family
  - Will-power
  - Restrictions on smoking (bans/smoke free areas)

PART 4 – REAL LIFE SERVICES AND RESOURCES

Now we'll tell you the final part of (name)'s story.
[Part 3 of vignette – see appendix 2]

Questions/Prompts

We'd like to ask you your thoughts on this kind of clinic:

- Have you heard of this before?
- What is good about it?
- Is there anything that you don't like about it?
- Any thoughts on: time, locations, NRT, group?

We'd like to show you some examples of leaflets about smoking [pass round leaflets].

- Have you ever seen anything like this?
- Where / when / what were they?
- What do you think about these?
- What could make it better?

Ask about television adverts:

- Have you ever seen any?
- Where / when / what were they about?
- What do you think about these?
- What could make it better?

Thinking about everything we've discussed today, what would help you the most when you are trying to give up smoking?

Is there anything else you would like to add before we finish?

Thank you for taking part in this study. Your opinions are very useful and help us to see how things could be improved to help people who want to stop smoking. Once we have finished doing all the interviews we will write up the results in a report. We will make sure that you are sent a copy.

Appendix 2 – Sample vignettes

The following excerpts illustrate how vignettes were used as a hypothetical story to encourage discussion in the groups. The vignettes used each time followed a similar structure. Parts 1 and 2 contained some contextual information about the person, their smoking history and reasons for wanting to stop. In these sections, small details about the person could be adapted to suit the characteristics of the actual group (e.g. name, age, occupation, ethnicity). Part 3, which describes the service used to help the person to quit was exactly the same each time.

The example below was used in a focus group with Pakistani men.

Part 1 - Smoking history and behaviours

- Ashraf is 33 years old and works for a bank. He lives with his wife and son in Glasgow. His parents moved from Pakistan to Scotland before he was born. Ashraf started smoking at school when he was 16. He usually goes through a pack of ten a day, or a few more if it's been a particularly stressful day.

Part 2 - Motivation to change, helps and hindrances

- Recently Ashraf has been thinking about trying to stop smoking. He's seen adverts on the TV about the risks and knows its not good for him. His work has introduced a no smoking policy and he's fed up going outside to smoke. Ashraf's wife has also been on at him to quit and doesn't like him smoking around his son.

Part 3 - Real life services and resources

- Ashraf's friend told him about a stop smoking clinic where a trained specialist helps people who are trying to quit. Ashraf went to the clinic at a centre near his work at the same time as 10 other men and women of all different ages. The group was run for an hour on a Friday evening for 8 weeks.
- The group talked about their smoking and how they felt about stopping. The specialist gave them information about the effects of smoking on health, about what they might feel like when they gave up, and she answered any questions the group had. She helped them think of ways to cope with cravings and withdrawal symptoms and stress.
- Ashraf was encouraged to set a quit date and prepared himself to stop smoking on that day. The clinic supplied him with patches (called nicotine replacement therapy or NRT) to help him with his cravings when he gave up cigarettes. He wore these patches for three months. Although he found it hard sometimes, Ashraf has now been off cigarettes for a whole year and has put the money he saved towards a buying a new computer.

Appendix 3 – Focus group participant information

Group	Participants	Male	Female	Current Smokers	Recent ex-smokers	Non-smokers
BME 1	6	6	0	6	0	0
BME 2	6	6	0	3	2	1
BME 3	4	4	0	2	1	1
BME total	**16**	**16**	**0**	**11**	**3**	**2**
OA 1	9	1	8	4	2	3
OA 2	2	1	1	0	2	0
OA 3	6	0	6	2	0	4
OA 4	3	0	3	0	3	0
OA Total	**20**	**2**	**18**	**6**	**7**	**7**
MH 1	5	4	1	2	2	1
MH 2	7	1	6	4	2	1
MH 3	6	4	2	5	1	0
MH 4	8	5	3	5	2	1
MH total	**26**	**14**	**12**	**16**	**7**	**3**
TOTAL	**62**	**32**	**30**	**33**	**17**	**12**

Key
BME – Black and Minority Ethnic
OA – Older Adults
MH – Mental Health
Recent ex-smoker - quit in past 5 years
Non-smoker - quit over 5 years ago