

Tobacco and the over 65's: A needs assessment based on smokers' and carers' views.

— Final Project report —

NHS BORDERS



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'The views expressed in this report are those of the project/research team and do not necessarily reflect the views of the funding body'.

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Executive Summary

Introduction

While tobacco is a major risk for all people, Older Adults have been identified as having high tobacco use, high rates of tobacco related ill health or inequalities in accessing services. Life expectancy is increasing with more people living longer than before. This trend is set to continue and as a consequence there will be more 'older' older adults.

The health of older adults is at significant risk from tobacco use and the hazards from smoking, in this age group, are well documented. There is much evidence to show that stopping smoking can provide an increase quality and quantity of life in older adults by adding both 'years to life' and 'life to years'. Increasing evidence demonstrates that mortality is reduced among those who stop between 65-75 years and that the benefits of stopping smoking are almost immediate for some conditions.

Smoking cessation in older adults can be challenging. Many smokers in this age group have smoked for several years and are strongly addicted to both nicotine and the habit. Smokers of this age often fail to see the point of stopping and have many misconceptions regarding smoking and health. Coming from the time where smoking was very much socially acceptable and often encouraged it can be hard to break down barriers built up.

Health professionals often fail to target this generation when it comes to advising on smoking cessation and as a result many older adults are left uninformed and unmotivated. Health professionals or carers working with this group of people also can have misconceptions regarding smoking cessation in this age group and therefore also need to be informed and encouraged.

As it has been shown smokers of this age group can benefit from stopping smoking and many do wish to quit smoking. Despite this older adults are often neglected and more needs to be done to ensure they receive the encouragement and appropriate advice they need to help them succeed in quitting.

Aim

The aim of the project is to establish the views and needs (including perceived barriers) regarding tobacco awareness and smoking cessation of people aged 65 and over and their carers living in a supported setting either residential or at home, within the Eyemouth area.

Methodology

The research approach was qualitative. A sample selection of four smokers aged 65 and over living within the Eyemouth area was recruited. Six carers who work with clients who smoke and are aged 65 years and over were also recruited. Data was gathered using individual interviews and focus group material, which was analysed.

Results

Smokers Key Findings:

Reason for tobacco initiation	<ul style="list-style-type: none"> ▪ Social norms and or social pressures were the main reason for tobacco initiation
Reason for continued tobacco use	<ul style="list-style-type: none"> ▪ Several positive factors associated with smoking were identified. ▪ Older smokers identified the main reasons for currently smoking were boredom, loneliness, pleasure and habit.
Health Benefits of smoking cessation	<ul style="list-style-type: none"> ▪ Most smokers were aware there could be some health benefits to stopping smoking in relation to improving symptoms, improved breathing was the main symptom identified. ▪ Many were suspicious of current advice and felt health risks were exaggerated or even wrong. ▪ Many smokers believed the damage would be already done and there would be no benefit to future health if they stopped.
Other Benefits for smoking cessation	<ul style="list-style-type: none"> ▪ Few benefits were seen to stopping smoking, however some recognised they might have more money.
Barrier to smoking cessation	<ul style="list-style-type: none"> ▪ Many older smokers believe that the damage is already done and therefore do not see the point in stopping smoking. ▪ Most smokers expressed the concern they would put on weight if they stopped smoking. ▪ Few smokers had been advised to give up smoking, received update information or offered support.
Previous smoking cessation attempt	<ul style="list-style-type: none"> ▪ All smokers had tried to give up at some point. ▪ Smoking attempts were viewed negatively ▪ Reasons for restarting were physiological, psychological and habitual.
Future smoking cessation	<ul style="list-style-type: none"> ▪ None of the smokers were keen to give up smoking in the future. ▪ The main reason being they 'were happy to smoke' and 'there was no point'. ▪ Smokers did not see themselves using the smoking cessation service in the future.
Knowledge of smoking cessation services	<ul style="list-style-type: none"> ▪ Smokers were unclear of services provided. ▪ Many had not heard of any services in the area. ▪ Those who had heard of services were unsure of what was involved.
NRT	<ul style="list-style-type: none"> ▪ The view of NRT was generally negative, mainly due to friends and families negative experiences. ▪ Knowledge of products available was poor. ▪ There were many misconceptions regarding NRT.
Group therapy and 1:1 sessions	<ul style="list-style-type: none"> ▪ There was uncertainty around this type of support. ▪ Many saw the benefits if individuals wished to take part, however not for them

Carers Key Findings:

View of tobacco use in clients over 65 years of age	<ul style="list-style-type: none"> ▪ Carers generally accepted smokers of this age. ▪ Most felt that it was to late for someone of this age to give up smoking ▪ Many felt it was not a priority to encourage elderly smokers to give up
Current advice/support	<ul style="list-style-type: none"> ▪ Few carers ever spoke to smokers about their smoking. ▪ Few carers advised smokers to give up. ▪ Many carers felt it was not their place to advise clients to give up.
View of smoking cessation in later life	<ul style="list-style-type: none"> ▪ Views were divided with equal numbers feeling smoking cessation was worthwhile or worthless ▪ Of those who thought it worthwhile they would not advise a client to give up, but would be willing to help if a client asked them.
Awareness and views of Health Benefits of smoking cessation in later life	<ul style="list-style-type: none"> ▪ Most carers were aware there could be some health benefits to stopping smoking in relation to improving symptoms ▪ Some were suspicious of current advice regarding health risks. ▪ Most carers believed the damage to be already done, but acknowledged there may be small benefits to future health if they stopped.
Perceived Barriers to smoking cessation in later life	<ul style="list-style-type: none"> ▪ Carers thought the main barrier to smokers not giving up would be the belief that the damage is already done and therefore no point in stopping smoking. ▪ Other perceived barriers included weight gain, social pressure and habit.
Knowledge of smoking cessation services in the area	<ul style="list-style-type: none"> ▪ Carers were unclear of services provided. ▪ Many had not heard of any services in the area. ▪ Those who had heard of services were unsure of what was involved.
NRT	<ul style="list-style-type: none"> ▪ The view of NRT was generally negative, mainly due to concerns of safety, addiction and side effects. ▪ Knowledge of products available was generally poor. ▪ There were misconceptions regarding NRT.
Group therapy and 1:1 sessions	<ul style="list-style-type: none"> ▪ There was uncertainty around this type of support. ▪ Many saw the benefits if individuals wished to take part.
Training needs	<ul style="list-style-type: none"> ▪ None of the carers had been on any tobacco training. ▪ Most thought they would benefit from some update training. ▪ None were aware of current guidelines. ▪ Carers require training on most aspects of tobacco and smoking cessation to ensure clear and correct advice is given.

Conclusion

Although this project managed to abstract only a small amount of smokers to participate it nevertheless was successful in eliciting the views and needs of a group of smokers who had rich information to share.

The key findings of the project have helped to develop an understanding of what issues need to be tackled by smoking cessation services, policy makers and health professionals when considering ways forward to improve their services.

Using the key findings recommendations for future work can be made.

Recommendations

From the key findings a number of actions and recommendations for future work have been identified

Awareness raising

- The Smoking Cessation Service should advertise their services widely ensuring smokers, health professionals, carers, volunteers and community workers both within an NHS and non NHS setting are aware of the current services available.
- The Smoking Cessation Service should engage with local voluntary and community groups to ensure a wider range of smokers of this age group are reached and ensuring group leaders/volunteers are informed on smoking cessation issues.
- Information about the Smoking Cessation Service should be distributed to local groups, community centres, residential homes and day centres to provide contact details of services.
- The Smoking Cessation Guidelines should be made readily available to all health professionals, volunteer and community workers to reinforce the importance of smoking cessation.
- Identified smokers wishing to give up should have access to information on local groups, classes and social events to help provide a supportive setting.
- Dissemination of positive experiences from former smokers accessing the smoking cessation service with or with out using NRT. This would help raise awareness of the benefits of local services and help counteract negative experiences and misconceptions regarding NRT.

Training

Training is required to increase staff knowledge and ensure appropriate information is given to smokers. There is also a need to increase staff confidence in order to show the importance of approaching someone who smokes, regardless of age.

- All health professionals including all carers who work with clients aged 65 and over should receive training (tailored to this age group's needs) on the following:

- Brief advice for smoking cessation.
 - Barriers and motivators of smoking cessation.
 - The benefits of giving up smoking in this age group.
 - The benefits of NRT with an update on product uses and availability.
 - Smoking cessation services available.
 - Current guidelines on smoking cessation.
- The possibilities of incorporating Smoking training into the training received by all carers should be explored.
 - Volunteer workers and community workers should be able to access basic education on tobacco issues and be aware of current smoking cessation services. Emphasis should be given to the benefits of quitting and the help smokers can receive.
 - Initial training should be followed up with regular updates to ensure compliance with current practice and knowledge.

Guidelines

- Guidelines should acknowledge the valuable contribution that carers can make to aiding and advising older adult to stop smoking. Carers whether NHS or Non NHS should be incorporated into guidelines with careful wording to ensure they are aware of their potential role and responsibilities.

Smoking Cessation Support Interventions

- Further work needed to explore the use of complementary activities that support quit attempts whilst addressing some of the factors identified that are barriers to quitting e.g. boredom and loneliness associated with quitting through more joined up working with local health promotion departments, volunteer groups and healthy living networks and local authorities.

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1. Introduction.

It has long been established that tobacco smoking is the major cause of preventable illness and premature death in Scotland.

Tobacco use is now a key public concern and there are now several policies, recommendations and initiatives introduced to tackle the problem.

As a result there has been a rapid increase in the development of smoking cessation service provision throughout Scotland. The updated Smoking Cessation Guidelines for Scotland (NHS Health Scotland & ASH Scotland) gives recommendations for the implementation of interventions to promote smoking cessation.

1.1 Smoking in the older adult.

While tobacco is a major risk for all people, Older Adults have been identified as having high tobacco use, high rates of tobacco related ill health and inequalities in accessing services. (ASH Scotland 2005a and ASH Scotland 2005b).

In Scotland the population is currently stable, but growing. People over the age of 65 now represent nearly 16% of the population. Life expectancy is increasing with more people living longer than before. This trend is set to continue and as a consequence there will be more 'older' older adults. At the last census around 358,900 people were aged over 75 in Scotland (ASH Scotland 2004).

Overall smoking declines after the age of 65 either because smokers are more likely to die young, leaving a high proportion of non-smokers in older age groups or because smokers quit smoking (HEA 1999).

However older smokers are an increasingly significant group and as the older population continues to rise the number of older smokers is also proportionally increasing. Estimates of the number of older smokers varies, but one estimate is that around a quarter of Scots aged 65-75 smoke regularly (NHS Scotland 2001) with more than 158,000 smokers aged 65 and over (ASH Scotland 2004).

The health of older adults is at significant risk from tobacco use and the hazards from smoking are well documented (DOH 1998). In Scotland around 13,000 people die every year from tobacco related diseases (Scottish Executive 2004).

Tobacco use in later life is not only responsible for a large number of premature deaths from smoking related diseases, but is also associated with an increased risk of illness, such as cancer, heart disease, chronic obstructive pulmonary disease, circulatory problems and stroke (Callum 1998, HEA 1999). It is also associated with a reduction in quality of life.

Tobacco use can also reduce the effectiveness of many medications often used in age related illnesses such as arthritis, diabetes and hypertension. It can also make rehabilitation after an illness prolonged.

1.2 Smoking cessation in the older adult.

There is evidence to show that stopping smoking can provide an increase in quality and quantity of life in older adults by adding both 'years to life' and 'life to years'. Increasing evidence demonstrates that mortality is reduced among those who stop between 65-75 years and that the benefits of stopping smoking are almost immediate for conditions such as heart disease and stroke (Kerr et al 2004).

Stopping smoking is important for older smokers who may already be experiencing smoking related diseases. It has been shown that giving up smoking even after the age of 60 will reduce the risk of smoking related diseases and decrease the time needed to recover from many illnesses (Health Scotland 2004)

Smoking cessation in older adults can be challenging. Many smokers in this age group have smoked for a large proportion of their lives and are strongly addicted to both nicotine and the habit. Smokers of this age often fail to see the point of stopping and have many misconceptions regarding smoking and health. Having lived through a period of time where smoking was very much socially acceptable and often encouraged it can be hard to break down barriers that have been built up.

Health professionals can often fail to target this generation when it comes to advising on smoking cessation and as a result many older adults are left uninformed and unmotivated. Health professionals or carers working with this group of people may also have misconceptions regarding smoking cessation in this age group and therefore also need to be informed and encouraged.

It has been shown that smokers of this age group can benefit from stopping smoking and many do wish to quit smoking. Despite this older adults are often neglected and more needs to be done to ensure they receive the encouragement and appropriate advice they need to help them succeed in quitting.

1.3 Aims and objectives.

Aims

The aim of the project is to establish the views and needs (including perceived barriers) regarding tobacco awareness and smoking cessation of people aged 65 and over and their carers living in a supported setting, either residential or at home, within the Eyemouth area.

Objectives

- To assess and explore the needs, views and attitudes of older smokers in relation to smoking issues, smoking cessation, smoking information and services.
- To assess and explore the practice, knowledge, views and attitudes of staff members/carers, who have contact with the above client group; in relation to smoking in this age group, smoking cessation interventions and knowledge of services available.
- To analyse the results of the needs assessment, record and document perceived needs and views.
- To identify priorities and possibilities for a future model of good cessation practice and service development that can be sustained and implemented in other areas.

1.4 Target Audience.

The target audience for this project includes the following:

- ❖ Smoking Cessation Team to help in the development of their service.
- ❖ Members of Primary Care team who work with older adults who smoke.
- ❖ Commissioners of smoking cessation training.
- ❖ Older adult smokers.

1.5 Project team.

Jenny Reid - Project Researcher and Author.

Fiona Doig – Project Lead.

1.6 Steering group.

Catherine Young - Health Promotion Manager.

Jo Hight - HLN Project Worker – Eyemouth.

Tom Trotter - Health Improvement Officer – Scottish Borders Council.

Alison McCormick - Senior Practice Pharmacist, Eyemouth.

Helen Dickson – Practice Nurse, Eyemouth Health Centre.

Gillian Adams – BIAS (Borders Independent Advocacy Service).

Tania Ferguson – Smoking Awareness Co-ordinator, NHS Borders.

Fiona Doig – Deputy Health Promotion Manager.

1.7 Funding sources.

This project was funded through Phase Three of the Tobacco and Inequalities (T&I) Small Grants Fund, managed by ASH Scotland, and Scottish Borders Council.

ASH Scotland is the leading voluntary organisation in Scotland tackling tobacco use. The Tobacco and Inequalities Project is a national community development project that aims to develop capacity and sustainability, as well as challenging and changing practice and policy. Based on the recommendations of previous work in the area, the current T & I project focuses on three target areas one of which is Older Adults

The initial amount of funding received was £9700 (£8700 from ASH Scotland and £1000 from Scottish Borders Council), and the project was given a twelve-month time limit (from August 2005). However, through long-term staff sickness, the project's original researcher was unable to take forward the project. A new researcher was assigned and the aims and objectives were revamped to meet the time limit and amended budget. A revised total budget of £4600 was funded and the project was given a six-month time limit running from February – July 2006.

2. Methodology

2.1 The research approach.

The research approach was qualitative. This approach was used, as the aim was to explore the views and experiences of current smokers and their carers in an effort to understand and describe these views.

In order to meet the needs assessment aims and objectives a range of research methods were used:

- ❖ Literature review
- ❖ Location, service and resource mapping
- ❖ One to one interviews with volunteer participants
- ❖ Focus group with community representatives

All of the above inter-linked with each other and provided essential data for the project.

2.2 Location Selection.

In the Scottish Borders there is a higher than Scottish average population aged 65 and over. The Scottish Borders consists of several rural areas with some recognised areas of deprivation.

The Eyemouth area was targeted for the location of this project as it has a higher than average over 65 population, is a rural area and is a recognised area of deprivation.

Another main reason for Eyemouth being chosen for the project were the close links between the smoking cessation service in the Eyemouth Health Centre and in the community via the Healthy Living Network.

To find out more about the chosen area and to confirm it was a suitable setting the Scottish Borders Social Atlas was used.

The Scottish Borders Social Atlas (Edition 1, 2005) shows a range of health and lifestyle related information for the Scottish Borders. The information in the atlas is extracted from larger projects on 'community health and well being profiles' (NHS Health Scotland, 2004) with population figures taken from the 2001 census.

With reference to the Atlas some important information regarding the chosen area can be seen. These include the following-

2.2.1 Smoking Status

- The estimated number of smokers in the Roxburgh and Berwickshire area, which includes Eyemouth, is 13,300 (31.6%). Smoking Attributable mortality (35 years and over), average and rates is recorded as 123 per year. (NHS Health Scotland 2004)
- The estimated number of smokers as a percent of 16 – 75 year olds in the Eyemouth area is 31 – 33%.

- Therefore the estimated smokers in the Borders as a whole is below the Scottish average (34.7%), but within the Borders itself Eyemouth has an increased percent of smokers.

It should be emphasised that the numbers/percentages do not include smokers aged 75 and over and this age group within the Borders requires further investigation.

2.2.2 Income

Within the Scottish Borders the lowest average incomes are found in the southern part of the local authority area. Another pocket is seen in Eyemouth.

2.2.3 Pensioner population

The proportion of lone pensioner households in the Scottish Borders is generally high, with Eyemouth being higher than Scottish average.

2.2.4 Social grade

Within the Scottish Borders a conspicuous cluster of lower rates are found in Teviot, Liddesdale, Coldstream and Eyemouth. Eyemouth has below the Scottish average number of people in social grade AB and higher than average % of population in social grade E (lowest grade).

2.3 Sample selection and recruitment methods.

Two main groups of volunteer participants were identified as being valuable to the projects aims and objectives. These were

- ❖ Current smokers, aged 65 or over, living in either a residential or home setting within Eyemouth.
- ❖ Carers who work with the above client group. Either smokers or non-smokers.

The project needed to recruit volunteers from both groups. The aim was to recruit as many people as possible, but it was hoped to recruit at least 10 – 15 volunteer participants. The following methods of recruitment took place.

2.3.1 Current smoker recruitment

Clients who currently smoke were recruited by a variety of means and from various settings within Eyemouth.

Unfortunately recruitment was a slow process and many prospective volunteers declined to take part. Also due to the projects aims and objectives and timescales the available time for recruitment was limited.

Health centre

Originally contact was made with Eyemouth Health Centre to ask permission to receive a mailing list of all know smokers who fitted the project criteria. The aim was to send out a standard letter informing clients of the project and inviting them to

participate. Unfortunately the Health Centre was not in the position to give such information due to concerns over confidentiality.

Residential homes

Eyemouth currently has two residential homes (one privately owned and one local authority owned). Contact with these homes was made (with permission from The Scottish Borders Council Social Work department, through the Acting Service Manager) by phone to establish the numbers of smokers in each residential home.

The private residential home was now non-smoking therefore no prospective clients or carers were able to take part in the project.

The local authority home had only one residential smoker. This lady was eligible to take part however she declined to do so. The reason she gave was that she was 'happy to smoke and didn't wish to give up'. She declined to discuss the subject any further.

Day centre, within residential home

The local authority home has a day centre within it where elderly clients can attend on a regular basis. With approval from The Scottish Borders Council Social Work department, the Residential Home Manager and Day Centre Manager, prospective clients were established and approached.

Visiting the day centre there were 6 smokers identified. A standard information sheet (Appendix 1) and consent form (Appendix 2) was given to each eligible client with an explanation of the project (given by the duty manager and by myself).

Of those eligible 3 agreed to take part however only 1 was interviewed as the other two pulled out. The reasons for pulling out were ill health and change of mind.

The general reasons for the others not wanting to take part were not wanting to discuss their smoking as 'happy to smoke and not wishing to give up'. It was made clear to participant that they would be in no way asked to give up, however clients were still very reluctant to participate.

The Healthy Living Network

The Healthy Living Network Project Worker who has strong links within the community setting was contacted. She was given the projects details and agreed to approach several community groups, including chest/heart/stroke club and gentle exercise group. As a result 3 smokers agreed to take part in a small focus group held at the local community centre.

Home care

To reach prospective volunteers who were resident at home and receiving home help, the Home Care team was involved in recruitment. With permission from The Scottish Borders Council Social Work department (through the Acting Service Manager, Service Manager for Care at Home and Assistant Home Care Manager) it was agreed information sheets and consent forms would be handed out to staff/carers to give to clients who were suitable to take part in the project.

Through a recent data collection it was stated that there were very few known smokers, although exact numbers were not given, it was estimated by the Home Care team to be less than 20.

Unfortunately no volunteers came forth from this recruitment method.

Community groups

Contact was made by phone with a local independent charity to see if they would be able to identify ways in which to recruit clients. This charity aims to promote a positive view of ageing, recognising the considerable contribution that older people can make to their communities.

Their Chairperson stated they were not in a position, due to internal developments they were unable to help with recruitment, however, they did agree to try and include the projects details in the next member's newsletter.

2.3.2 Carer recruitment

Carers who work with clients who smoke were recruited by two main sources: through the local authority residential home/day centre and through the home care system.

Carers did not have to be smokers to take part.

Residential homes/day centre

With approval from The Scottish Borders Council Social Work department, the Residential Home Manager and Day Centre Manager, carers who had previously or currently looked after residents who smoke were recruited.

In the residential home 3 carers agreed to participate. Within the day centre another 3 carers agreed to participate.

Again reluctance to take part was apparent, the main reasons given was that the carers approached did not wish to discuss issues around smoking.

Home care team

The other main source to find volunteers was through the Home Care Team. Permission and approval was sought from The Scottish Borders Council Social Work department (through the Acting Service Manager, Service Manager for Care at Home and Assistant Home Care Manager).

It was agreed that the Assistant Home Care Manager would approach staff/carers at their staff/carers meetings. A brief explanation of the project was given along with project information sheets and consent forms informing carers of the projects aims.

Carers who wished to take part or who required further information were asked to either contact myself directly or inform the Home Care Manager of their intention to volunteer.

Unfortunately no prospective volunteers came forth from this recruitment method.

2.3.3 Response rates

Table 1: The total number of participants recruited was as follows:

Places of recruitment	Carers	Smokers
Day centre	3	1
Residential home	3	0
Community groups	0	3
Care at home	0	0
Total	6	4

The original aim was to recruit at least 10 – 15 participants.

2.4 Data Collection.

2.4.1 Current smokers

It was decided that the most appropriate methods of consulting with clients and carers, to establish their views and needs, was to take part in one to one interview or to take part in a focus group, depending on individual requirements and circumstances. Phone interviews could be offered, but were not necessary. An information sheet was produced by the smoking cessation team to aid the interviewer (Appendix 3).

With permission from the volunteers the interviews were audio taped. All data was anonymised; tapes were not made available to anyone other than the project worker. Names were replaced with a participant numbers, S1 – S4 for the smokers and C1 – C6 for the carers, and it is not possible to identify individuals in any reporting of the data gathered.

The volunteers were informed they could withdraw at anytime and would not have to give a reason.

Interviews and focus group aims were to establish and encourage discussions around various themes including:

Current smokers

- ❖ Tobacco use (current smoking status, reasons for starting and continuing to smoke and patterns of smoking)
- ❖ Health beliefs, views, attitudes and knowledge (including knowledge of benefits and barriers to stopping smoking)
- ❖ Experiences and attitudes to Smoking Cessation (including previous experiences and approaches to stopping smoking, reasons for restarting and barriers and motivators of stopping smoking)
- ❖ Experience of local smoking cessation service (including experiences of use and knowledge of existing service)
- ❖ Views, attitudes and experiences of Group sessions, 1:1 support and Nicotine replacement therapy (NRT) (including health beliefs of use, previous experiences of use, benefits and barriers of use)
- ❖ Needs and ideas for future service development.

One smoker took part in a one to one interview while the other three participated in a small focus group held at a local community centre.
An interview guide for smokers can be seen in Appendix 4.

Carers

- ❖ Attitudes and views of tobacco use in clients over 65 years of age (include current advise/support given)
- ❖ Health beliefs, views, attitudes and knowledge (including knowledge and views of benefits and barriers to stopping smoking in clients over 65 years of age)
- ❖ Attitudes to Smoking Cessation (including views of a client aged 65 years and over stopping smoking, approaches to helping a client stop smoking, perceived barriers and motivators of stopping smoking)
- ❖ Knowledge and experiences of local smoking cessation service (including experiences of use and knowledge of existing service)
- ❖ Views, attitudes and experiences of Group sessions, 1:1 support and Nicotine replacement therapy (NRT) (including health beliefs, benefits and barriers of use of these treatments in clients of this age group)
- ❖ Training needs and ideas for future service development.

All carers took part in a one to one interview.
An interview guide for carers can be seen in Appendix 5.

2.5 Data Analysis

Interview and focus group material were reviewed and transcribed. Transcription was checked for accuracy. Themes were then identified and after listening to audio tapes and referring to transcription the views and needs of carers and smokers were summarised in categories i.e. tobacco use, health benefits etc.

3. Findings

The following findings have been separated into the two groups: the smokers and the carers.

3.1 Current smokers

3.1.1 Tobacco use (current smoking status, reasons for starting and continuing to smoke and patterns of smoking)

Current smoking status

All 4 smokers (S1 – S4) interviewed started smoking as teenagers. Table 2 below shows their current smoking status, current age and age of starting smoking.

Table 2: Current Smoking Status

	Current age (years)	Age started smoking (years)	Total Years smoked	Present smoking status (per day)
Smoker 1 (S1)	72	18	54	20
Smoker 2 (S2)	84	17	67	7-8
Smoker 3 (S3)	68	14	54	15
Smoker 4 (S4)	85	16	69	15-20

One lady when hearing how many the others smoked asked if she could change her amount to less.

All smoke cigarettes with the exception of one who usually smokes 15 cigarettes per day, but sometimes instead smokes 10-12 rolling tobacco, the reason given for this was rolling tobacco was cheaper to buy, lasted longer and less waste.

Tobacco use initiation

Social norms and or social pressure were the main reasons identified for starting to smoke. Some common reasons mentioned were the fact that cigarettes were readily available and very cheap. All reported having their first cigarette with friends or at work and enjoying the experience, which led them to continued use. All reported enjoying smoking and feeling smoking was a very normal and a socially acceptable thing to do.

All reported close family members including parents and siblings also smoking regularly so confirming the acceptability of smoking. Almost all of their friends smoked on a regular basis and smoking was seen as a way of life.

However two ladies did state that they would never have told their mothers they smoked at the time they started 'for fear of a telling off'.

*Started smoking when I was 18 I was at a dinner and dance for the factory and my friends were nagging me to have a fag so I took one and from then I smoked cause fags were not dear in them days packet for 2 shillings.
Used to smoke more but smoking less cause got a bad leg so cut down.
Used to smoke 40 but now got a packet this morning and that will last me till tomorrow. Now about 20 is better than smoking 40. (S1)*

It was the done thing to smoke everybody smoked especially in the Army. (S2)

It was the done thing, just the done thing. (S4)

A common theme was that smoking was acceptable and encouraged, especially in situations of social gatherings and at work. It was seen as a pleasurable experience. Many agreed that there was no mention of smoking being bad for your health and that there was no reason or incentive to give up.

Back then you never got anything said to you that it was going to damage you or anything. (S3)

All agreed smoking was never seen as a health risk with no health warnings or advice to give up was given.

Another common theme was that smoking was a cheap habit that everyone could afford. One lady stated she often got given free cigarettes at work as an incentive.

Current patterns of smoking and main reasons for tobacco use.

The pattern of smoking was individual, however most participants smoked more when on their own.

If I'm in the house I smoke if I'm outside I don't. (S4)

Smoke more when I'm sitting in bingo. (S2)

Smoke more in the morning when I'm on my own. (S4)

I'm on my own at night until my daughter comes in then I'm on my own so I watch telly and have a cig. (S1)

Three out of the four expressed that they never smoke in front of children or their young relatives for fear that they may want to start.

One lady expressed that she does not inhale when she smokes and could stop tomorrow if she wished.

The participants were asked what they would consider to be the main reasons for why they smoked now. Although reasons for continuing to smoke were individual there were many common themes.

The main reason for three of the participants for current tobacco use was boredom and being on their own: the other participant's main reason given was habit with boredom being her second reason.

After discussion the main reason for currently smoking were as follows:

- Boredom
- Habit
- Loneliness
- Pleasure

Certain triggers for smoking were noted these included watching TV, bingo, when on their own, doing a crossword or to help with concentration. All appeared to have certain habitual smoking patterns for example first thing upon rising or last thing at night.

Alternatively triggers for not smoking included when in the company of young children, when outside and when busy with chores.

A common feeling was that smoking helped with nerves or stress and that tobacco use was increased during times of stress. None of the participants stated that addiction to nicotine was a reason for their tobacco use.

3.1.2 Health beliefs, views, attitudes and knowledge of tobacco use (including knowledge of benefits and barriers to stopping smoking)

Throughout the interview, attitudes and knowledge regarding tobacco use and health were explored. When asked if they knew any benefits to stopping smoking most at first stated no, but with further discussion some knowledge and views regarding tobacco and health issues were revealed.

All participants acknowledged that they were aware that smoking could worsen or cause certain conditions. The main conditions mentioned were breathing difficulties, including bronchitis and cancer in general (not a specific one mentioned).

Two participants had experienced some symptoms of smoking related illness such as shortness of breath. One had cut down her cigarette intake in order to help current symptoms, therefore inadvertently showing that she was aware that smoking was contributing to her symptoms. Another who also had breathing difficulties knew that she should stop smoking and acknowledged the fact that she would benefit a reduction in symptoms if she were to stop smoking, but was reluctant to do so. One lady stated if she had any symptoms of a smoking related illness especially shortness of breath then she would stop smoking immediately.

In general although the participants were aware that tobacco had some health risks, the majority were suspicious of current advice and felt that health risks were exaggerated and even wrong.

I can't believe how years ago people used to smoke but you never heard anything bad about it. If you smoke you get this and that, and now it's every time you pick up the papers or watch telly, it's if you smoke you get cancer but years ago you never heard anything. (S4)

They say cancer kills, but so do lots of things. (S2)

The whole thing is just a farce. (S4 & S2)

A common reason for this was due to the fact they could recall several friends who had died of cancers and other smoking related diseases, but had never smoked.

Another common view expressed was that they could recall many family members and friends who had smoked, but had lived to a 'ripe old age' with no smoking related illnesses seen.

A lack of trust from advice was shown and the majority were unsure what to believe.

You don't know what to believe, I mean people who have never ever smoked have died of cancer. (S4)

You know my dad he smoked a pipe with baccy and if he couldn't get a pipe he would take a bit of baccy and chew it. Now my dad lived till he was 92 years old so going by that smoking can't be that bad. (S3)

Well I had 4 brothers and they all smoked and they all lived till their 80's and 90's, all smoked all their life and all lived a good life. (S2)

Another common issue was the belief that they were too old to stop now and that any benefits 'would be a waste of time as the damage was already done'. All felt it was too late to stop.

A major common concern and barrier to quitting was the issue of weight gain. Three of the four participants expressed concerns about the health risks of putting on weight and stated they would rather smoke than put on weight. One lady with breathing difficulties felt if she was to stop smoking she would put weight on which would be even worse for her breathing.

There is the chance of putting on extra weight and I can't afford to put on weight. If I stopped smoking I would put extra weight on and no way am I putting extra weight on. (S4)

When you stop you put on weight. (S4)

I'm 10 stone, don't need more weight, so keep smoking. (S2)

If I stop I'll put on weight and that won't help, the weight won't do my chest any good either. (S3)

If you stop smoking you eat more. (S3)

When talking about the benefits of stopping smoking the issue of money was raised several times. Generally they acknowledge a benefit to stopping was saving money and they expressed concern that the cost of cigarettes was rising too rapidly. However this was not a deterrent as they all stated that this would not deter them from smoking and that they would continue to buy them regardless of cost. One lady stated even if cigarettes reached £10 she still would buy them, while another stated if she were short of cash she would change to rolling tobacco.

Even with the view that they were unsure as to what extent tobacco was a health risk, many expressed concerns for the 'younger generation'. Nearly all felt that the 'Young ones' should be targeted instead of them. They showed a disapproval of younger people starting smoking, avoided smoking in young persons presence and even went as far as advising youngsters not to smoke. It was felt that education was the key to stopping the children from starting and it was expressed that money would be better spent working with younger people than with their generation.

3.1.3 Experiences and attitudes to Smoking Cessation (including previous experiences, approaches to stopping smoking, reasons for restarting and barriers and motivators of stopping smoking).

The participants were asked about their views regarding stopping smoking now and if they had ever attempted to quit in the past. In the cases where there had been an attempt to quit smoking discussion around why they had quit, experiences of quitting, reasons for failed attempts and their thoughts on what stops them quitting now. Responses were individual although many agreed on several things.

Quitting experiences

Most of the participants except one had tried to give up smoking at some point.

One lady had stated that she had never tried to give up and she will never give up, she had however cut down from 40 a day to 20 a day to help with her bad leg hence

linking reduced smoking with improvement in conditions. While she was trying to cut down a nurse had given her nicotine gum, but she disliked the taste tremendously and never tried it again.

One lady had tried to give up on a few occasions, but restarted each time as after a few days found she was suffering from headaches, as soon as she recommenced smoking the headaches went away.

One lady gave up smoking for 9 months while pregnant with her first child as she felt sick at the sight or smell of smoke, she restarted smoking soon after the birth for no specific reason other than she no longer felt sick with the smoke and therefore restarted the habit.

One lady stated she has tried to give up 'umpteen' times. Her longest period of smoking cessation was three weeks while she was admitted to hospital and not allowed to smoke. She reports she tried to abstain from restarting but reports boredom as being the main reason for recommencing smoking.

With each attempt of giving up boredom was given as a reason as well as habit and needing to do something with their hands.

Most of the ladies who had tried to give up had not been given any help or advice. Only one had tried NRT in the form of gum but had disliked its taste. Few had any medical support, been advised to give up, offered NRT or told about services available to help them quit.

All the Dr say's to me is 'how many do you smoke a day' he doesn't tell me to stop just asks how many I smoke. (S2)

Well I asked the nurse if I could get patches and I'm still waiting. (S3)

Only one participant had been advised by her doctor and nurse to stop smoking and is on the waiting list for group therapy. However when discussed further she felt that she had been forced to go on the list and stated that she was unsure if she would attend should a place come up. She also stated she has been waiting for a very long time and not sure if she is still on the list.

Current quitting status

When asked if they think about giving up now all participants stated that they had no intentions of giving up. Responses were similar in theme; all felt it was too late to give up at their stage in life, as they could not see any real benefit.

What's the use, as I say I've smoked since I was 17 now what's the use of me giving up cigarettes now at my time of life. (S2)

I couldn't give up now, don't want to put weight on. (S4)

I've tried in the past just couldn't do it. (S3)

No, no way never going to stop smoking. (S1)

I think it's too late to stop. (S2)

No I'm keeping my fags it's the first thing I think of when I get up in the morning. (S1)

No don't want to stop smoking. It's the only thing I've got. (S1)

When asked what puts them off stopping, similar themes were also seen. The main reasons for not wishing to give up were boredom, loneliness, weight gain, nerves, tension and headaches. All participants stressed that they enjoy smoking and look forward to their daily cigarettes.

3.1.4 Experience of local smoking cessation services (including Views, attitudes, experiences of Group sessions, 1:1 support and Nicotine replacement therapy (NRT)).

Smoking cessation services

When asked if they knew of any services in the area to help stop smoking the participants were unclear.

One participant knew of the services available at her GP's in the form of group sessions, she was unaware of the 1:1 sessions and pharmacy support.

One participant had seen an advert in her pharmacy but was unsure of what it was for, she had not heard of any other services.

Oh I've seen notices up in the chemist, but not sure what they do or anything. I suppose it's just an advert to buy patches. (S4)

The other two participants were unaware of any services available to them.

A few commented that they felt the services were not advertised enough.

When you don't know they are there (services) you can't use them. (S4)

Services should be advertised more. (S2)

None knew that they were able to get a free prescription for NRT products with or without using the services.

Only one participant had been advised formally to give up smoking. No other participant had been told the benefits of giving up or had been advised to stop smoking.

Nicotine Replacement Therapy (NRT)

A discussion took place around the topic of NRT.

All participants had heard of NRT in the form of patches and gum, one had heard and tried nicotine gum but disliked it. None had heard of any other NRT products such as lozenges, nasal spray, inhalator and micro tab.

The general opinion of the NRT was negative, mainly through family and friends experiences. They did not feel that these products would help them to give up as they recalled friends and family disliking the products and having failed attempts at using them.

The other misconception was that they would be expected to pay for the products and did not want to waste money on them. None felt they would benefit from trying the products.

Oh tried one of those gum things at the hospital and I spat it out it was horrible so I said no thank you. Aye tried it, but it was horrible, oh horrible, oh Yuk. My sister tried patches they didn't work tried for a while but no help. (S1)

Well I've never tried any so no opinion, but my friend tried them they had gum and she smoked the next day. (S4)

I knew someone who had the gum, but she smoked at the same time so that wasn't any use. (S2)

Group therapy and 1:1 sessions.

No participants had received any support in the form of group sessions or 1:1 sessions.

Participants were asked for their views regarding group therapy and 1:1 sessions. Many were unsure and discussion around the topic was limited.

One lady was awaiting a place on a group session. She had been made aware of this when admitted to hospital and through her practice nurse and was on a waiting list. She was unsure whether or not she would attend and stated she was told to go rather than asked if she would like to go after a 'lecture' in hospital. She felt that she would keep medical staff happy if she stayed on the list, but was unsure if she would in fact attend if a place did come up.

All the others felt that they would not wish to go to either a group session or a 1:1 mainly due to the fact they did not wish to give up smoking. They did comment that these sessions might benefit others who were in fact wishing to give up. They liked the idea of the social support, but again not for them at present.

I think group therapy would probably help, I mean I used to go to slimming group sessions and I did lose weight. It did help so probably it would help with smoking, she'd ask if you have smoked and if you had it would show you up a bit in front of the class and you'd feel a bit embarrassed then. I think that's how it works, might help with smoking but I don't know, I don't think I would go as I don't want to stop smoking. (S4)

Needs and ideas for future service development.

A discussion took place regarding what participants felt would help them in the future should they wish to give up. As all participants did not wish to give up this was based on theory. A few suggestions were made including:

- More clear advertising of services available- including putting in local paper and Border TV.
- They all agreed having someone to talk to would help to give support.
- Having an informal group within a community setting to give a social aspect.
- All made it clear they felt these services should be targeting a younger population and not someone of their age group.

I think something like this should be devoted to young people who are starting to smoke not to someone elderly like us. (S1)

Not for us, look how long I've been smoking should target the young people. (S2)

Devote these services to the young people. (S4)

It was made clear at this point in their lives none of the smokers interviewed were contemplating giving up smoking now or in the future.

3.2 Carers

All 6 participants were interviewed separately (C1 – C6).

3.2.1 Attitudes and views of tobacco use in clients over 65 years of age (include current advice/support given)

The participants were asked what their views were of someone aged 65 or over smoking. The responses were very similar with carers generally accepting people of this age smoking status. Many felt it was entirely up to the individual as long as they adhere to the designated smoking areas.

Many expressed a view that it was too late for smokers of this age to stop smoking now and that it should be acceptable for someone of their age to smoke. It was expressed that smoking in their age should be respected as they didn't know any better in those days and they have been smoking for many years.

Fine I mean they have been used to smoking for so long why would we stop them. (C6).

I think it's too late for them to stop. (C1)

As far as I'm concerned it's a democratic country and if they want to smoke then that's fair enough, especially as some of these people might have been in World War 2 or what have you, or might have known someone who've fought for their country as far as I'm concerned we wouldn't have been here today. (C2)

Few felt that actively encouraging an elderly person to give up smoking was a priority and many mentioned that younger people would benefit more if they gave up.

Looking at a ban for under 21's, I'm more concerned about that than someone elderly smoking. (C2)

Current advice/support

Participants were then asked if they had ever spoken to a client about their smoking or advised a client to stop smoking.

Three had not discussed smoking with any client, two had discussed fire safety issues with clients and one had 'joked' with a client regarding his smoking 'stunting his growth'.

On advising a client to stop smoking only two participants had broached the subject. One had suggested the client give up 'to help save money to buy nicer things'; the other had advised a client to stop 'as they were only having two cigarettes a day'.

Yes I must admit I have. I have just said if you only have two why don't you just stop all together, but I get I've done it all my life sort of thing. (C3)

All the other participants had not advised any client to stop. The reasons given as to why they hadn't were similar, mainly due to the belief it was up to them if they smoked and not the carers place to say otherwise.

'No not even when they are coughing absolutely coughing 'its not the fags son' and you laugh and say' no its not the fags' you get that quite a bit'. (C2)

3.2.2 Health beliefs (views, attitudes and knowledge of smoking in clients over 65 years of age)

Awareness of Benefits of smoking cessation

Participants were asked if they thought there would be any benefit to a person aged 65 or over giving up, if so they were asked to discuss what the benefits would be.

One participant thought there would be no health benefits. Another thought there would be only financial benefit to the person giving up, but no health benefits. They then went on to express the view that they felt there would be no benefits as the damage was done.

Find it hard to believe there is benefits; I think it will depend on the length of time they've been smoking. If they've been smoking since about 20 years old you know I find it hard to believe they'd benefit. (C6)

The main consensus was that most of the damage would have been done, however most viewed the opinion that there would be a benefit no matter how small. Two identified improved breathing with smoking cessation; one identified an improvement in general well being by feeling fitter.

I think it would help with their breathing I would imagine if they smoked all their life the damage would be done by then but I still think it would be beneficial for them to stop you know. (C3)

Yeah I mean probably think the real benefits would be they would feel a lot fitter. Sometimes folks are puffing away and spluttering away and they might feel better in themselves if they quit. (C2)

Only one participant was able to give more than one example of the benefits of smoking cessation, however they were unable to give specific health benefits in relation to health improvements.

It has to save the NHS hundreds of thousands of pounds of money for a start it has to save my health, has to save their health and has to save money in their pockets. (C1)

3.2.3 Attitudes to Smoking Cessation (including views of a client aged 65 years and over stopping smoking, approaches to helping a client stop smoking, perceived barriers and motivators of stopping smoking)

Views of smoking cessation in client aged 65 and over.

Participants were asked what they thought about someone of this age giving up. Their views were divided.

Half of the participants felt there had to be a benefit to giving up and that client's should be encouraged to give up. However it should be noted most felt they should be actively encouraged only if the client asked for help.

My thoughts I think as soon as anybody gives up it means a better quality of life even if its just the last 5 years or what ever. (C1)

I still think I suppose the damage is done, but I mean thinking about other health problems and seeing people ending up on oxygen and things I still think it would be better if they stopped. (C3)

Think they should get all the encouragement they need definitely (C5)

The other half felt that it was up to the person if they smoked or not. One was of the view that many elderly people can live long happy lives regardless of if they smoke.

Giving up if they want to give up then that's entirely up to themselves you know folk who are still in their 80 and 90's and still have a fag and are quite happy with that. (C2)

Up to them don't really know up to them if they want to keep going or stop. (C4)

One participant was unsure if a person of that age should give up as they felt that this may in fact cause further health problems and may lead to worse ill health.

Well in one way I think its worthless if they have been smoking for such a long time. I feel they become more ill. I remember what my mum said, my mum said 'you know I've smoked all these years, whilst I'm smoking whatever eats the smoke does just that if I give up it will start eating me'. (C6)

Approaches to helping a client stop smoking

Carers were asked to imagine a client that did wish to quit smoking and to describe how they would help them.

As none of the carers had been involved with helping a client give up smoking their answers were based on theory rather than actual practice.

One participant thought they would help by keeping them busy and taking their mind off things.

I'd probably get them interested in something else, something to occupy their hands occupy their mind and when its cig time get them to do something different to stop them thinking about cigs. (C1)

All other participants mentioned the use of NRT mainly in the form of patches as a way to help clients who wished to give up smoking. The way in which they would advise them varied, with some advising about the products themselves while the others would advise contact with another health profession including GP, Nurse, and Chemist to get the NRT products. Two participants also thought that they would advise group therapy as a method of helping clients to quit.

Would probably advise them about products in the chemists and what have you and I would think that would probably do. (C2)

Well I would ask if they wanted help from the Dr as you can get patches and different things and if they wanted to stop I think you should encourage them to get some help, if they are really serious about it. (C3)

Well I'd give them all the possible info available for them to stop smoking there's a lot of things like patches, chewing gum, help groups, which can maybe provide that. (C4)

Well I'd put them in touch with people who are more qualified and they could get patches and things. (C5)

Well I would see if I could get them to a group thing and see if the nurse from the health centre could come down and have a word, that sort of thing. (C6)

Perceived Barriers and motivators

When asked what barriers there may be to someone of this age group quitting smoking many were unsure. The main opinion was that a person of this age would have more than likely smoked all their life and have no reason to stop.

One participant felt that maybe ill health would prevent them stopping, but was unable to expand on this further.

I think their attitude is they have done it all their life so they just continue sort of thing. (C6)

Maybe ill health would prevent them. (C4)

I think they think I've done it all this time why should I bother now. (C5)

My mother in law smoked she came in the door gasping and as soon as she had got her breath back she lit up again did she know the benefits oh definitely but she was brought up in that era where it was the in thing wasn't it. (C1)

On further discussion other perceived barriers included:

- Weight gain if they quit
- Pressure from friends
- Habit

When asked about motivators to stop very few thought that a person of this age would have many motivators. Some viewed an increase in their spending money a motivator.

3.2.4 Knowledge and experiences of local smoking cessation service (including experiences of use and knowledge of existing service)

Discussion took place around local services in relation to smoking cessation of clients in this age group. Participants were asked if they knew of any services in the Eyemouth area to help clients if they wanted to stop smoking.

The following services were identified:

- No smoking clinic at day hospital (one participant)
- No smoking clinic at health centre, 1:1 sessions (one participant identified this as their sister attends)

The other participants were unsure. However, one did say they thought they had seen a poster in the health centre advertising 'something' but they were unable to recall what it was. Another identified the NHS Smokeline as a source of help and another thought the nurse at the health centre may help as in another region the nurse gave smoking cessation support.

Two of the participants knew of services available in another region due to family members attending, both of these were through the health centre.

Two participants mentioned getting patches to help support clients, but were not sure where they would obtain these.

None of the participants were able to identify pharmacy support or group therapy support, with the majority not familiar with any local service available.

Participants were then asked if they thought there were enough services for people of this age group.

Two participants were unsure, two participants felt there were enough services and two felt there weren't enough services.

One participant who felt there was enough services had not identified any local services but had identified the NHS Smokeline, their general view was that local services were not needed.

There is info, yeah; I think there is enough info without putting it in their faces all the time. (C2)

3.2.5 Views, attitudes and experiences of Group sessions, 1:1 support and Nicotine replacement therapy (NRT) (including health beliefs, benefits and barriers of use of these treatments in clients of this age group)

NRT

Participants were asked if they had heard of NRT and which ones they had heard of. All participants had heard of some form of NRT. All identified patches with one participant recalling they gave her friend nightmares.

One participant identified the nicotine inhalator as another staff member had previously used one, but they were unsure as to what its function was.

Another participant identified patches; gum and nasal spray as family members had used them, but their feeling regarding the products in general were negative.

None of the participants could name all of the NRT products and knowledge around the function of NRT was generally poor.

The participants were asked what they felt about clients of age 65 and over using NRT products and views were varied, but the general feeling was negative. The main concerns were around addiction to the products, product safety and side effects. None of the participants were fully aware of the function of NRT and how NRT works in relation to smoking cessation. Many participants had negative views of NRT and had misconceptions about the product, due to family and friend experiences. One participant felt that clients of any age should not receive NRT for reasons that clients should not get any help with withdrawal, but should be seen as part of the process of giving up. They were unaware of exactly how NRT worked.

Well its like someone giving up sugar and going on to saccharine I think if you want to give it up you just give it up I don't think they should get any what ever is in the patches to take off withdrawals symptoms I think they should just have to go through that. (C1)

One concern was how NRT would react with medications and for that reason this participant would not recommend its use in clients of this age. One other participant was also worried about the safety of NRT, but felt that it would have been tested before being licensed and prescribable and therefore safe. They then went on to say they would advise the client to see the pharmacist regarding which products they could take as they were unsure if there were different products safe for different age groups.

I think I would be wary especially if they were on other medications. (C5)

Another view and concern was that the use of NRT would lead to addiction for the product and cause undesirable side effects. This participant would not recommend it, but would not stop someone using NRT if they so wished.

My brother was on one form of it and I believe he became addicted to that. He was on the spray and he was on it for so long, he was on it for 3 years and he ended up having an operation on his face and everything. If they want to try it let them try it. (C6)

One other view was the disbelief that NRT works as one participant recalled a friend who had tried NRT and failed

I know people who have NRT patches and take them off to have a fag so it's not working. (C3)

Positive views were not common one participant felt that NRT would be beneficial with their reasons being:

I think if it's going to stop you and give you a bit of help then its bound to be beneficial isn't it? (C4)

Overall little was known around NRT and conflicting messages were apparent. Feelings of uncertainty and negativity around the use of NRT were often described. However when previously asked how they would help a client give up smoking all but one mentioned NRT, in particular patches, as a way of helping clients to quit.

Group sessions & 1:1 sessions

Discussion took place around what participants thought of both group sessions and 1:1 sessions in helping a client to give up smoking. Due to the fact that many were unaware of these services or that they had no direct experience of these services views were limited.

One participant did not think any of these services should be available their reasons being

I think its moddle coddling and money should be better spent. (C1)

All other participants felt that it would be up to the individual involved as some individuals do well in a group setting while others are better suited to a 1:1 approach. In general the feeling was positive with the social aspect of group sessions rating highly. The view expressed was that clients should want to go themselves to benefit fully and not be 'forced' to go.

When asked how easy they thought it would be for a client to use these services all agreed it would be very easy. Many suggested appointments could be made through them and if transport was needed they could provide it.

3.2.6 Training needs and ideas for future service development.

Need for training on smoking cessation topics.

Participants were asked if they felt they needed or would like any training regarding smoking issues. On first discussion the majority of participants were unsure. Many asked for an example of what could be included therefore some examples were given such as an update on NRT, update on services/policies, the risks of smoking and the benefits of quitting smoking in particular looking at people age 65 and over. Table 3 below indicates which of the examples the participants were interested in.

Table 3: Perceived Training Needs of Carers

Training requested	Participant (Carer)					
	C1	C2	C3	C4	C5	C6
Services available						
Policies/legislation		Yes				
Risks/effects of smoking		Yes		Yes	Yes	
Benefits of stopping smoking						
NRT update		Yes				
Barriers quit				Yes		
Other		General Update	General Update			Written Information

One participant was not sure, but felt it '*might be interesting to be updated on everything*'.

One participant stated they did not wish any training and felt training would not be a benefit to staff, the reasons being:

If they don't know it now they'll never know, don't think it would help. (C1)

One participant felt that formal training would be 'pointless'. This participant did not think training was necessary as they were very suspicious of NRT products and felt that they knew most of the information regarding smoking issues. They did however state that if there was training made available they 'would go anyway' and thought they would benefit from some written information, informing them as to where clients could get advice.

The other four participants did feel that they would benefit from some form of training; many mentioned that they felt they would benefit from an update of NRT products.

The effects of smoking etc think it's always nice to get updates what new products come out. (C2)

Probably maybe a good idea non-smokers may not be as aware with regards to what the risks are maybe a good idea. (C3)

I think it would help people not aware of all the things that can prevent or cut back on the smoking think it would be a good idea. (C4)

Well I think it would be an advantage. I suppose it would benefit us so we could give advice on where to get help, it might benefit us to have leaflets and things with all the information on. (C5)

None of the participants felt they required any training on the benefits of quitting smoking despite many not being aware of the benefits to this age group if they were to cease smoking.

None of the participant felt they would benefit from training regarding information on the smoking cessation service and the services currently available in Eyemouth, even though none were aware of all the services available and many were unable to identify any services in the area.

The one participant who wished to have training on policies and legislation was interested in the Legislation changes looking at ban for under 21's and not any smoking policy with regard to persons over 65 of age.

When asked how easy it would be for them to attend any training all felt it would be easy. The main concerns arising from discussion was that training should be local as one had no means of transport and the others felt it would be more time saving and more people would attend. The other concern was staff cover, as the carers are often short staffed, the general feeling was that in house training would be more practical and preferable.

Need for additional support

The participants all felt that they work in a supportive setting and could seek further support from other members of staff or their line manager. One participant felt that training would help her to improve her knowledge when talking to clients.

When asked if they would like any additional support with regards to client smoking cessation all stated no they did not feel they need any further support.

3.3 Summary and key findings.

From the gathered data key findings and messages have been identified for health professionals to consider when addressing tobacco issues.

Table 4 shows the key findings gathered from the current smokers aged 65 or over.

Table 5 shows the key findings gathered from the carers.

Table 4: Key findings (current smokers) for health professionals.

Reason for tobacco initiation	<ul style="list-style-type: none"> ▪ Social norms and or social pressures were the main reason for tobacco initiation
Reason for continued tobacco use	<ul style="list-style-type: none"> ▪ Several positive factors associated with smoking were identified. ▪ Older smokers identified the main reasons for currently smoking were boredom, loneliness, pleasure and habit.
Health Benefits of smoking cessation	<ul style="list-style-type: none"> ▪ Most smokers were aware there could be some health benefits to stopping smoking in relation to improving symptoms, improved breathing was the main symptom identified. ▪ Many were suspicious of current advice and felt health risks were exaggerated or even wrong. ▪ Many smokers believed the damage would be already done and there would be no benefit to future health if they stopped.
Other Benefits for smoking cessation	<ul style="list-style-type: none"> ▪ Few benefits were seen to stopping smoking, however some recognised they might have more money.
Barrier to smoking cessation	<ul style="list-style-type: none"> ▪ Many older smokers believe that the damage is already done and therefore do not see the point in stopping smoking. ▪ Most smokers expressed the concern they would put on weight if they stopped smoking. ▪ Few smokers had been advised to give up smoking, received update information or offered support.
Previous smoking cessation attempt	<ul style="list-style-type: none"> ▪ All smokers had tried to give up at some point. ▪ Smoking attempts were viewed negatively ▪ Reasons for restarting were physiological, psychological and habitual.
Future smoking cessation	<ul style="list-style-type: none"> ▪ None of the smokers were keen to give up smoking in the future. ▪ The main reason being they 'were happy to smoke' and 'there was no point'. ▪ Smokers did not see themselves using the smoking cessation service in the future.
Knowledge of smoking cessation services	<ul style="list-style-type: none"> ▪ Smokers were unclear of services provided. ▪ Many had not heard of any services in the area. ▪ Those who had heard of services were unsure of what was involved.
NRT	<ul style="list-style-type: none"> ▪ The view of NRT was generally negative, mainly due to friends and families negative experiences. ▪ Knowledge of products available was poor. ▪ There were many misconceptions regarding NRT.
Group therapy and 1:1 sessions	<ul style="list-style-type: none"> ▪ There was uncertainty around this type of support. ▪ Many saw the benefits if individuals wished to take part, however not for them

Table5: Key findings (Carers) for health professionals.

View of tobacco use in clients over 65 years of age	<ul style="list-style-type: none"> ▪ Carers generally accepted smokers of this age. ▪ Most felt that it was to late for someone of this age to give up smoking ▪ Many felt it was not a priority to encourage elderly smokers to give up
Current advice/support	<ul style="list-style-type: none"> ▪ Few carers ever spoke to smokers about their smoking. ▪ Few carers advised smokers to give up. ▪ Many carers felt it was not their place to advise clients to give up.
View of smoking cessation in later life	<ul style="list-style-type: none"> ▪ Views were divided with equal numbers feeling smoking cessation was worthwhile or worthless ▪ Of those who thought it worthwhile they would not advise a client to give up, but would be willing to help if a client asked them.
Awareness and views of Health Benefits of smoking cessation in later life	<ul style="list-style-type: none"> ▪ Most carers were aware there could be some health benefits to stopping smoking in relation to improving symptoms ▪ Some were suspicious of current advice regarding health risks. ▪ Most carers believed the damage to be already done, but acknowledged there may be small benefits to future health if they stopped.
Perceived Barriers to smoking cessation in later life	<ul style="list-style-type: none"> ▪ Carers thought the main barrier to smokers not giving up would be the belief that the damage is already done and therefore no point in stopping smoking. ▪ Other perceived barriers included weight gain, social pressure and habit.
Knowledge of smoking cessation services in the area	<ul style="list-style-type: none"> ▪ Carers were unclear of services provided. ▪ Many had not heard of any services in the area. ▪ Those who had heard of services were unsure of what was involved.
NRT	<ul style="list-style-type: none"> ▪ The view of NRT was generally negative, mainly due to concerns of safety, addiction and side effects. ▪ Knowledge of products available was generally poor. ▪ There were misconceptions regarding NRT.
Group therapy and 1:1 sessions	<ul style="list-style-type: none"> ▪ There was uncertainty around this type of support. ▪ Many saw the benefits if individuals wished to take part.
Training needs	<ul style="list-style-type: none"> ▪ None of the carers had been on any tobacco training. ▪ Most thought they would benefit from some update training. ▪ None were aware of current guidelines. ▪ Carers require training on most aspects of tobacco and smoking cessation to ensure clear and correct advice is given.

4. Discussion

The aim of the project was to establish the views and needs (including perceived barriers) regarding tobacco awareness and smoking cessation of people aged 65 and over and their carers living in a supported setting either residential or at home, within the Eyemouth area.

The intention of the project was to use the findings to help identify priorities and possibilities for a future model of good cessation practice and service development that can be sustained and implemented in other areas.

4.1 Limitations of project

First it is useful to recognise the limitations of the project.

The project had two subject groups, smokers over the age of 65 and their carers. Despite best efforts to recruit both groups of subjects recruitment proved to be hard. In both cases when approached prospective volunteers were reluctant to take part in the study. Many expressed that they were reluctant to discuss smoking issues. From the smokers point of view many felt that they did not wish to discuss their tobacco use, that they were reluctant to discuss ideas around smoking cessation and the general feeling was that they were happy smoking and did not wish to give up. From the carers point of view many declined to take part as they were not interested in smoking issues either because they felt it did not affect them or because they were reluctant to discuss tobacco issues for this age group. Even when it was reinforced to both smokers and carers that there would be no influence to give up many were still reluctant leading to several declining to take part.

Another reason recruitment of smokers was limited was due to the low numbers of smokers in the settings approached. Out of the two residential homes only one smoker was identified and the local day centre identified six smokers. The care at home team stated that they had very few known smokers on their books now, a recent count showed there to be approximately twenty.

It had been expected within these settings that the smoking rate for this age group would have been higher, but in reality numbers were few and this could have been for a few reasons. Firstly the small numbers of smokers identified in this age group could have been that the persons who do smoke were not reached. It is likely that many smokers do not attend residential settings, day centres or in fact any social group and therefore were missed out. The difficulties recruiting might also reflect the theory that over all smoking declines after the age of 65, either because smokers are more likely to die young, leaving a high proportion of non-smokers in older age groups or because smokers have quit smoking.

The other limitation of the project was that there are very few male participants, one male carer and no male smokers. Therefore opinions and views given were mainly female.

Never the less, despite these recognised limitations and slow recruitment the project did manage to reach the lower limited of the original aim to recruit at least 10 volunteers.

4.2 Tobacco use and Smoking Cessation

The findings from the research agreed with current thinking that smoking cessation in older adults can be challenging. Smokers are strongly addicted to both nicotine and habit. In this case all viewed smoking in a positive light and were reluctant to give up in the future.

As shown in this project, and others, smokers of this age group often start smoking at an early age due to social norms and social pressures. At the time that they started smoking cigarettes were readily available, cheap and actively encouraged. None of the participants can recall any health warnings or health risks being highlighted.

The main reasons for the smokers in this study continuing to smoke were physiological, psychological and habitual. Common reasons included boredom and loneliness with many reporting smoking being a positive part of their lives. Certain triggers for smoking were identified such as watching TV or social events, which lead to increase smoking. On the other hand certain triggers such as being outside, the presence of children seemed to reduce their smoking.

With the main reasons for smoking identified for this group of smokers it would be useful if these triggers could be addressed. As boredom was one of the main reasons for smoking, smoking may be higher in groups of people who do not attend social events or settings (as they may be even more bored). This leads back to the problems of recruiting and the relatively low number of smokers who attend day centres, groups etc, perhaps there are a high number of more isolated smokers who are not routinely reached.

For the identified smokers finding ways to alleviate their boredom would help to address the reasons for smoking. Perhaps this is something the local Health Promotion Departments, Volunteer groups, Health Living Network groups could look into further. If a smoker wishes to give up smoking then information regarding local groups and events should also be given along side smoking cessation advice.

Although most of the smokers had tried to give up and had reported negative experiences, none identified nicotine dependence as a reason for continued use of tobacco. Many felt that smoking helped in stressful situations, however nicotine is not known to help with stress, but in fact anxiety is a withdrawal symptom. The lack of awareness of nicotine dependence might be addressed by information/education.

Generally the misconception of 'it was too late to stop' and 'the damage was done' was supported by both smokers and reinforced by carers, many could name a few benefits of stopping, but were unsure of the real benefits or were even sceptical of the benefits.

As shown in this report, and others, health professionals can fail to target older adults when it comes to smoking cessation. This leads to the smoker being uninformed on current services and unmotivated.

In the case of this report only one smoker recalled receiving formal advice from their GP and hospital consultant to stop smoking and had been offered support from the smoking cessation service. All of the others, despite health professionals being aware of their smoking status had received no advice, support or services, which may help them to quit smoking. Many of the smokers were, as a result, unaware or confused about the existing smoking cessation services in their area, had

misconceptions regarding NRT products, and were unaware of the real benefits of giving up smoking.

None had been advised to stop by their carer or volunteer workers at local groups, and of the carers interviewed very few would routinely advise an older client to stop smoking. Many felt it was not their place to advise clients to quit, while others felt that it was the smokers choice and right to smoke, did not see the point in someone of this age group stopping and as a result were reluctant to discuss smoking issues with this age group.

As shown in 'The Smoking Cessation Guidelines for Scotland' (2004) this conflicts with two of the main recommendations:

- Recommendation 1:
'Healthcare professionals should have ready access to information on the current smoking status of their patient and should ensure that smokers have been advised to stop at appropriate opportunities and have been offered treatment to help them do so'.

- Recommendation 2:
'All smokers making an attempt to stop should have ready access to, and be strongly encouraged to use, dedicated smoking cessation services involving structural behavioural support and nicotine replacement therapy or Bupropion'.

It has been shown that even brief advice to stop smoking given to smokers can lead to an increased chance of a person quitting it should be recognised that brief intervention in this age group could benefit them hugely. According to guidelines GP's should ensure that they discuss smoking with known smokers (regardless of age) at least once a year and advise smokers to quit and offer treatments. All other health professionals should advise patients/clients to stop on initially determining their smoking status and offer treatments to help do so. The findings from the carers, however highlights some concerns and points for consideration. Firstly many of the carers themselves are unclear as to the services available. Many, like the smokers, are unaware or confused regarding services in their area and are therefore unable to offer appropriate advice.

Another influence is the fact that many carers were unaware of the real benefits to a person of this age group quitting smoking and agreed with the smoker's view that 'it is too late to stop as the damage has been done'. Carers can be seen to have the same misconceptions and negative feelings regarding NRT and as a result are unable to advise clients appropriately.

Secondly, guidelines refer to 'healthcare professionals' and give examples such as GP's, Health Visitors etc. this does not make it clear as to whether carers are included or not and many carers may or may not count themselves as health professionals, contributing to the fact many feel it is not their responsibility.

As carers play a valuable role in the day to day care of many smokers, are often more aware of clients smoking status and have regular access to smokers compared to other health professionals, it would be beneficial for guidelines to ensure this group of health care workers are included. This may also help give carers the confidence to approach older people about their smoking and emphasise their roles importance when it comes to helping an older individual quit smoking.

4.3 Addressing the misconceptions of tobacco use in older adults

As can be seen from the finding of this report both the smokers and carers had many misconceptions regarding several issues of tobacco use in the older adult, which would need to be addressed.

There were many misconceptions regarding the health benefits of an older adult quitting smoking generally the misconception of: 'it is too late to stop' and 'the damage is done' was supported by both smokers and carers alike.

Most of the smokers and carers did acknowledge that smoking can contribute to certain illnesses and conditions and that stopping smoking could help with some improvement in symptoms. However when asked about the benefits of quitting few were able to identify any real benefits, many showed that they were sceptical of current advice and many were confused about what to believe.

Many smokers and some carers focused on the disbelief that smoking causes ill health as they recalled family and friends who had smoked but led a happy long life. They also recalled a number of peers who had died or suffered ill health but had not smoked

With regards to NRT smokers and carers views were generally negative, mainly through peers experiences, misconceptions and lack of product knowledge. There were many misconceptions around NRT; knowledge of all the products available and products function was poor. Many were unaware where they could access NRT and that NRT was available on prescription.

As stated before despite there currently being several smoking cessation services in Eyemouth, smokers and carers alike were generally very unclear of services available to them and many had never heard of any services in their local area. Carers were therefore unable to pass the appropriate information regarding these services to anyone wishing to get help giving up.

Smokers and carers knowledge about the health risks of continued tobacco use, the benefits of giving up smoking and the services available to help them quit was therefore generally very poor. This leads to question whether smokers of this age, who are reluctant to quit smoking, are making an informed choice to keep on smoking. Also in the case of carers if they are unaware of the benefits, not receiving update information regarding products and services and are unaware of the importance of people of this age group quitting they can not be expected to give correct and appropriate advice.

None of the carers interviewed had received any form of training with regards to tobacco use in the older adults and none were aware of current guidelines. Carers have an important role in advising clients who smoke to quit and should be able to help address the many misconceptions that older adults may have regarding tobacco use and cessation.

From this study it has been shown that carers are reluctant to advise clients to quit and can have as many misconceptions as their clients. The need for initial and ongoing training should be therefore recognised as a key issue to take forward to help ensure carers are able to give the most up to date and appropriate advice.

As recommended in the 'The Smoking Cessation Guidelines for Scotland' staff training has been identified as an important issue for the success of a smoking cessation service:

- Recommendation 7:
'Relevant NHS staff and health and related professionals in local authorities and the voluntary sector should be provided with training. This should be in line with the Standards for Smoking Cessation Training in Scotland and appropriate to their role in cessation, whether it be the provision of brief advice or specialist cessation support'.

The carers interviewed in this study agreed that they would benefit from training although on what topic of training they felt they needed differed. From the findings it is clear that the carers interviewed would benefit from most aspects of tobacco and smoking cessation training to ensure they are aware of up to date advice and ensure the most clear and correct advice is passed on to smokers.

Carers would also benefit from training to raise their confidence and reinforce the importance of their roles when it comes to aiding and advising smokers to quit. Carers should also be aware of current guidelines and research in particular 'The Smoking Cessation Guidelines for Scotland' and 'A Guide for Health Professionals: Encouraging Smokers to Stop – What You Can Do'.

In conclusion the project has been successful in completing aims to find the views and needs of smokers aged 65 and over and their carers, on various issues of tobacco use and cessation.

The key findings of the project have helped to develop an understanding of what issues need to be tackled by smoking cessation services, service users, service providers, policy makers and health professionals when considering ways forward to improve their services.

Using the key findings, recommendations for future work can be made.

5. Recommendations for future work.

From the key findings a number of actions and recommendations for future work have been identified.

5.1 Awareness raising

- The Smoking Cessation Service should advertise their services widely ensuring smokers, health professionals, carers, volunteers and community workers both within an NHS and non NHS setting are aware of the current services available.
- The Smoking Cessation Service should engage with local voluntary and community groups to ensure a wider range of smokers of this age group are reached and ensuring group leaders/volunteers are informed on smoking cessation issues.
- Information about the Smoking Cessation Service should be distributed to local groups, community centres, residential homes and day centres to provide contact details of services.
- The Smoking Cessation Guidelines should be made readily available to all health professionals, volunteer and community workers to reinforce the importance of smoking cessation.
- Identified smokers wishing to give up should have access to information on local groups, classes and social event to help provide a supportive setting.
- Dissemination of positive experiences from former smokers accessing the smoking cessation service with or with out using NRT. This would help raise awareness of the benefits of local services and help counteract negative experiences and misconceptions regarding NRT.

5.2 Training

Training is required to increase staff knowledge and ensure appropriate information is given to smokers. There is also a need to increase staff confidence in order to show the importance of approaching someone who smokes, regardless of age.

- All health professionals including all carers who work with clients aged 65 and over should receive training (tailored to this age group's needs) on the following:
 - Brief advice for smoking cessation.
 - Barriers and motivators of smoking cessation.
 - The benefits of giving up smoking in this age group.
 - The benefits of NRT with an update on product uses and availability.
 - Smoking cessation services available.
 - Current guidelines on smoking cessation.
- The possibilities of incorporating Smoking training into the training received by all carers should be explored.

- Volunteer workers and community workers should be able to access basic education on tobacco issues and be aware of current smoking cessation services. Emphasis should be given to the benefits of quitting and the help they can receive.
- Initial training should be followed up with regular updates to ensure compliance with current practice and knowledge.

5.3 Guidelines

Guidelines should acknowledge the valuable contribution that carers can make to aiding and advising older adult to stop smoking. Carers whether NHS or Non NHS should be incorporated into guidelines with careful wording to ensure they are aware of their potential role and responsibilities.

5.4 Smoking Cessation Support Interventions

Further work needed to explore the use of complimentary activities that support quit attempts whilst addressing some of the factors identified that are barriers to quitting e.g. boredom and loneliness associated with quitting through more joined up working with local health promotion departments, volunteer groups and healthy living networks and local authorities.

6. Dissemination

All members of the steering group will receive a copy of the executive summary and a meeting is planned to discuss the key findings and recommendations of the report.

Copies of the report and executive summary will be disseminated to all appropriate parties including:

ASH Scotland.

Borders Community Health Partnership Adult Tactical Health Improvement Group.

Smoking Cessation Team, NHS Borders.

NHS Borders Smoking Awareness Group.

Health Promotion Department, NHS Borders.

Steering Group.

Homecare Managers, Scottish Borders Council.

All primary settings and key staff involved in the report will receive a copy of the executive summary.

The final project report will be disseminated through the STCA and ASHS bulletin, and through the ASH Scotland Board and T&I steering group members.

7. References

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8.1 Appendices

Appendix 1: Information Sheet

Tobacco and the over 65's: A needs assessment based on smokers' and carers' views.

Information Sheet

My name is Jenny Reid and I am a Project Researcher within the Health Promotion Department, NHS Borders, working on the above project.

ASH Scotland and Scottish Borders Council have funded this project. ASH Scotland is the leading voluntary organisation in Scotland tackling tobacco use. The tobacco and Inequalities project is a national community development project that aims to develop capacity and sustainability, as well as challenging and changing practice and policy.

The project aims to establish the views and needs (including perceived barriers) regarding tobacco awareness and smoking cessation of people aged 65 and over and their carers living in a supported setting, residential or at home, within the Eyemouth area.

The findings of this project will be valuable in helping design a model of good practice in smoking cessation for this age group.

- ❖ I am looking for volunteers to take part in this project. Volunteers should be current smokers, aged 65 or over, living in either a residential or home setting within Eyemouth.
- ❖ I am also looking for volunteer carers who work with the above client group. Either smokers or non-smokers.

If you agree to take part in this project you will be asked to take part in either a one to one interview with me or take part in a focus group. With your permission I will record the interview with audiotape. The interview will take no longer than 60 minutes. You will be free to withdraw from the project at any time and you would not have to give a reason.

All data will be anonymised; tapes will not be made available to anyone other than myself. Your name will be replaced with a participant number, and it will not be possible for you to be identified in any reporting of data gathered.

If you would like to contact the Smoking Awareness Co-ordinator about this project, you are welcome to contact Fiona Doig; her contact details are given overleaf.

If you have read and understood this information sheet, and would like to participate in the project, please now see the consent form.

If you would like any further information please do not hesitate in contacting me. My contact details are overleaf.

Contact details of project worker

Name of project worker: Jenny Reid
Address: Health Promotion Department
NHS Borders
West Grove
Waverley Road
Melrose
TD6 9SJ

Tel/Fax 01896 824500
Email: jenny.reid@borders.scot.nhs.uk

Contact details of the independent advisor

Name of adviser: Fiona Doig, Smoking Awareness Co-ordinator

Address: Health Promotion Department
NHS Borders
West Grove
Waverley Road
Melrose
TD6 9SJ

Tel/Fax 01896 824485
Email: Fiona.doig@borders.scot.nhs.uk

Appendix 2: Consent Form

Tobacco and the over 65's: A needs assessment based on smokers' and carers' views.

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from the study at any stage without giving a reason.

I agree to participate in this study.

Name of participant: _____

Signature of participant: _____

Signature of project worker: _____

Date: _____

Contact details of project worker

Name of project worker:	Jenny Reid
Address:	Health Promotion Department NHS Borders West Grove Waverley Road Melrose TD6 9SJ
Tel/Fax	01896 824500
Email:	jenny.reid@borders.scot.nhs.uk

Appendix 3: Information sheet for interviews

NRT –

NRT (nicotine replacement therapy) comes in different formulations (patch, gum, lozenge, nasal spray, microtab (sub-lingual tablet) and inhalator (plastic tube through which nicotine capsules are inhaled.)

People with a nicotine addiction (i.e. long-term smokers) experience withdrawal symptoms when they stop using nicotine. In other words, when they smoke a cigarette the nicotine levels in their blood go up and they feel comfortable. Over time, the nicotine level starts to drop and they experience withdrawal symptoms (i.e. anxiety, restlessness, difficulty concentrating, urge for another cigarette). In order to relieve these withdrawal symptoms people then reach for another cigarette and this cycle continues throughout the day.

The rationale for using NRT is that, by providing a lower dose of nicotine at steadier blood levels people can avoid the acute withdrawal symptoms. This makes withdrawal from nicotine less uncomfortable and also gives people the chance to tackle the behavioural, habitual and psychological components of their addiction.

NRT can double your chances of success in quitting. It is most effective when used properly, in a structured quit attempt and while receiving support from a trained advisor.

Group/1:1 support-

Evidence shows that support from a trained advisor, following a structured -----can double chances of success. This means that if someone attends for support and uses NRT they increase their chances of success by 4 times.

There is no clear evidence about what works best i.e. group or 1:1 but there seems to be some emerging evidence that groups are more effective. However, groups can be difficult to establish in areas with smaller populations.

Local services-

In Eyemouth 2 groups run regularly on Monday from 1-2 (Ailsa) and 4-5 (Practice Nurse). 1:1 appointments are also available with Ailsa and Helen, the nurse. Following an initial assessment people is offered a 6-appointment group/individual programme.

The following pharmacy in Eyemouth also offers support programmes and access to NRT: Romanes

Age groups-

About a third of people using our services are aged over 60 years.

Appendix 4: Client Interview Guide:

Discussion topics/questions.

Can you tell me a bit about when you started smoking and what your smoking is like now?

Try to include:

- ❖ When did you start?
- ❖ Why did you start?
- ❖ What do they smoke?
- ❖ How many do they smoke?

What are your main reasons for smoking?

Have you ever tried to stop smoking?

If yes can you tell me a bit about that?

- ❖ When tried to stop? How many times?
- ❖ Did they use anything to help them?
- ❖ How long did they stop for?
- ❖ Reason the started again?

Do you ever think about stopping now?

Discuss motivators and barriers to smoking versus quitting?

Do you think there are any benefits to stopping?

- ❖ List benefits

If you were to stop smoking tomorrow what help would you like?

Do you know if any help is available in the area to help people stop smoking?

Yes list benefits

If yes have they ever used these services?

- ❖ List experiences positive and negative.
- ❖ If they know of services but haven't used them why
- ❖ If used them would they use them again

Have you ever heard of NRT?

- ❖ If yes which ones, have they tried it, what do think were the benefits, negatives, would they consider it?
- ❖ If no explain what it is then ask would they think they could ever use these

What do you think of group or 1:1 sessions?

Discuss help available in Eyemouth such as:

- ❖ NRT & or
- ❖ Group sessions & 1:1 sessions at the GP after initial assessment people are offered 6 appointments/group sessions.
- ❖ Pharmacy support programmes.

Discuss views on each, would any of these be something would try?

- ❖ Which ones
- ❖ Why not
- ❖ Why

Currently about a third of people using these services are 65 or over how do you feel about that?

If you wanted to how easy is it for you to get to the GP?

Any changes to services they would like to see?

Any ideas for the future development of services?

Any other topic around tobacco use and the older adult they would like to discuss?

Appendix 5: Staff Interview Guide:

Discussion topics/questions

Some of your clients smoke? What do you think about that?

Have you ever spoken to a client about their smoking?

Have you ever advised a client to stop smoking?

Imagine a clients wants to stop smoking how would you help them?

What are your thoughts about someone of this age giving up?

Do you know of any benefits of stopping smoking in a person aged 65 or over?

What do you think may stop someone of this age stopping?

Services-

Do you know of any services in this area to help this client group if they want to stop smoking?

Do you think there are enough services available?

What help do you think would help a client to stop smoking?

Have you heard of NRT?

What do you think of the use of NRT in this client group?

- ❖ Benefits
- ❖ Negatives
- ❖ Would they recommend it

How would you feel if I told you that clients are twice as likely to give up with NRT?

What do you think of the use of GP group sessions?

What do you think of the use of 1:1 sessions?

Discuss the services available -

- ❖ NRT & or-
- ❖ Group sessions & 1:1 sessions at the GP after initial assessment people are offered 6 appointments/group sessions.
- ❖ Pharmacy support programmes.

If a person wishes to attend a GP session how easy is it for them to get there?

Currently about a third of people using these services are 65 or over how do you feel about that?

Training-

Do you think you need any training with regards to smoking issues?

Ideas:

- ❖ NRT
- ❖ Services
- ❖ Policies
- ❖ Benefits of stopping smoking
- ❖ Other

How easy would it be for you to attend training?

- ❖ Any restraints etc

Do you feel you can get support if helping a client?

Is there any further support you would like?

Any ideas for future development of service?

Any other topic around tobacco issues and the older adult they wish to discuss?