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**Implementing a smoking cessation program in
social and community service organisations:
A feasibility and acceptability trial**

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Abstract

Background: Novel ways of accessing and engaging smokers who are socially and economically disadvantaged may help reduce socio-economic disparities in smoking rates. This study assessed the feasibility and acceptability of integrating smoking cessation support into usual care at a social and community service organisation.

Methods: One social and community service organisation providing a Personal Helpers and Mentors program participated. Support workers were provided with training in 5 As (Assess, Advise, Agree, Assist, Arrange), brief motivational interviewing and use of nicotine replacement therapy, and then recruited clients into a six-month smoking program. Acceptability and feasibility were assessed prior to receiving training and at three and six month follow-up for support workers, and at enrolment into the program and at four and six month follow-up for clients.

Results: Six support workers (67%) and 20 of their clients (65%) participated. Overall acceptability of the program was high, particularly among clients. The amount of time spent talking about smoking increased from 3.8 minutes per visit at baseline to 15.5 minutes at six month follow-up. There was a significant reduction in the number of cigarettes smoked, from 20.5 cigarettes per day at baseline to 15 cigarettes per day at six month follow-up ($p = 0.04$).

Conclusions: Social and community service organisations are both interested in and capable of providing smoking care, and the majority of clients found the smoking cessation intervention acceptable and helpful. Given the demonstrated acceptability and feasibility of this approach, further research to determine its effectiveness is warranted.

Introduction

The socio-economic gradient in smoking prevalence is well-documented, with significantly higher smoking rates found among those of lower socio-economic position ^{1,2}. While individuals experiencing multiple forms of social and economic disadvantage, including low income, low educational attainment, unemployment, homelessness, social isolation and mental illness (hereafter referred to as disadvantaged smokers), attempt to quit at rates similar to those of other smokers, they are less likely to succeed ³⁻⁵. Factors which appear likely to contribute to poor success rates include smoking for a longer period of time ⁴, higher rates of nicotine dependence ^{6,7}, lower self-efficacy to quit ⁷ and being less likely to receive assistance to quit ⁸. Given that these factors may operate synergistically, there are strong grounds for providing cessation programs that specifically target disadvantaged smokers.

One potential access point for supporting disadvantaged smokers may be social and community service organisations ^{9,10}. These organisations are non-government, not-for-profit organisations that provide welfare services, such as financial and material support, personal and social support, and general information and advice, to individuals in need. These organisations are well-placed to deliver smoking care to highly disadvantaged smokers, as they have regular contact with a high proportion of marginalised groups, are able to address smoking alongside other issues faced by their clients, and are in a position to provide tailored support. The sector is also large, with approximately 5,769 not-for-profit social services organisations operating in Australia ¹¹.

Several recent studies have identified support for the provision of smoking care in the social and community service organisation setting ^{9,10,12}. Clients attending a Salvation Army service for emergency assistance in the United States found it acceptable to have their smoking

addressed with a very brief thirty- second intervention ¹⁰, and the provision of training has been found to increase staff knowledge, skills and confidence in addressing tobacco-related issues ¹². While these studies suggest the social and community service setting holds potential for addressing smoking, a number of barriers to providing support have been identified ⁹. These include perceived client disinterest, lack of resources, and competing priorities such as homelessness and poverty ⁹. Currently, there is a lack of sound evidence about whether these barriers can be overcome and smoking care integrated into the routine work of social and community service organisations.

This study aimed to determine the feasibility and acceptability of integrating the delivery of smoking cessation support into usual care at a social and community service organisation serving highly disadvantaged smokers, as well as to assess the impact of the program on client smoking.

Method

Setting

One social and community service organisation providing an Australian government-funded Personal Helpers and Mentors program (PHaMs) participated. These programs operate across Australia, providing support to individuals living in the community who are recovering from mental illness and need help managing daily activities. To be eligible for participation, clients must score ≥ 3 on the PHaMs Eligibility Screening Tool ¹³ (indicating impaired functioning with regard to personal capacity activities, community participation and independent living), must be willing to address any dual-diagnosed co-morbid drug and alcohol issues, and reside in a defined postcode area ¹⁴. The PHaMs program adopts a strengths-based recovery approach. Clients generally engage with the service for 6-12 months.

Smoking care program

The smoking care program was developed on the basis of formative qualitative research⁹ and published evidence of the effectiveness of behavioural interventions with disadvantaged groups¹⁵. PRIME theory was used as the guiding theoretical framework to inform the development of an intervention that emphasised repeated brief intervention and motivational interviewing¹⁶. Aspects of Diffusion of Innovation theory (relative advantage, compatibility and complexity) were also incorporated to ensure the program was compatible with the organisation's systems and to facilitate uptake¹⁷. Support workers were involved in determining the structure and content of the program, which was designed to be flexible and easily integrated into usual care with minimal burden.

Support worker training

A one-day training workshop was delivered by an experienced tobacco educator. Training provided a rationale for incorporating smoking cessation into usual care, as well as instruction on assessing nicotine dependence using the heaviness of smoking index (HSI)¹⁸, training in the use of the 5 As (Assess, Advise, Agree, Assist, Arrange) brief intervention¹⁹, brief motivational interviewing²⁰ and the use of nicotine replacement therapy (NRT). A booster training session was conducted three months after the initial session to answer questions and review skills.

Counselling, information and support

Support workers were encouraged to use the 5 As at each visit with their clients during the intervention period. This included 1) asking about and recording smoking status in case notes, 2) assessing willingness to quit, 3) providing advice to quit, 4) providing support and encouragement to quit and 5) arranging follow-up. Support workers were provided with

resources including a tailored quit plan, referral forms to the telephone Quitline, informational pamphlets and self-help resources.

Free nicotine replacement therapy

Free NRT could be accessed by clients directly from support workers or from local participating pharmacies for the duration of the study. The use of NRT was optional but strongly encouraged. All types and strengths of NRT were available (i.e. gum, inhaler, patch, lozenge and microtab). Support workers determined NRT type and strength based on client preferences and manufacturer recommendations. Clients were encouraged to use multiple forms of NRT if they were heavily nicotine-dependent (defined as HSI $\geq$ 5).

Procedure

Support workers

Support workers at the participating service were invited to attend a one-day training workshop. Support workers completed a pen-and-paper survey prior to the commencement of training and follow-up surveys three and six months later [Appendices 6.2, 6.3, 6.4 and 6.5].

Clients

Eligible clients were invited by their support workers to enrol in a quit smoking program [Appendices 6.6 and 6.7]. Eligible clients were adults currently engaged with the PHaMs program who reported daily smoking and were willing to talk about their smoking with their support workers. Clients completed a baseline survey at enrolment [Appendix 6.8], and follow-up surveys four and six months later [Appendix 6.9].

Measures

Support worker surveys

Demographic and work characteristics, including gender, age, smoking status, highest level of education, time in current position and client caseload, were collected at baseline. At each follow-up point, support workers were asked to indicate how often they provided quit support to clients (e.g. asking and recording smoking status, assessing motivation to quit, advising clients to stop smoking and assisting clients to quit by providing support, encouragement and free NRT) and how much time (in minutes) they spent at each visit discussing tobacco use. Usefulness of training was assessed using five items at three month follow-up. Program acceptability was assessed using seven items at six month follow-up.

Client surveys

Demographic information was collected at baseline. The short version Patient Health Questionnaire (PHQ-2) was used to screen for depression²¹. Smoking status was assessed by asking, "Do you currently use tobacco products?" with response options, "Yes, daily", "Yes, at least once per week", "Yes, at least once per month" and "No, not at all". Smoking cessation was assessed at follow-up by asking, "Have you smoked a cigarette, even a puff, in the past 7 days?" with response items "Yes" and "No". Clients were asked if they had tried to reduce the number of cigarettes they smoked in order to quit, how interested they were in quitting smoking, their intention to quit smoking in the future, the amount spent on tobacco each week, and the number of cigarettes smoked on average each day. At four and six month follow-up, clients were asked about the types of cessation support they had received from their support workers and whether the clients had initiated NRT use (including the type and length of use), their perceptions of the service¹⁰ and the acceptability of the program.

Analysis

Descriptive statistics (frequencies and proportions) were used to describe demographic and smoking characteristics. Due to the small number of participants, response categories using a five-point Likert scale were collapsed into a three-point Likert scale: “Strongly agree or agree”, “Neither agree nor disagree” and “Strongly disagree or disagree”. Paired t-tests were used to examine changes from baseline to follow-up where appropriate. The study was approved by the University of Newcastle Human Research Ethics Committee [Appendix 6.10].

Results

Client demographics and smoking status

Thirty-one smokers were approached to participate by nine support workers. Twenty provided consent and completed a baseline survey (consent rate 64.5%). One client died between baseline and the first follow-up. Seventeen clients completed the follow-up survey at four months (89%), and 13 clients (68%) completed the follow-up survey at six months.

Demographic and smoking characteristics are reported in Table 7.1.

Support worker outcomes

Nine support workers participated in training and completed the initial survey. Six support workers had clients who enrolled in the program and thus were included in the study. All support workers completed the three month follow-up survey. One support worker left the service between the three and six month follow-up points. The remaining five workers completed the six month follow-up survey. At baseline, 50% of participating support workers were male, and participants had an average age of 26.5 years ($SD=3.78$). All but one support worker had a university degree. None was a current smoker. Support workers had an average caseload of 9.5 clients, and all had been in their current positions for less than 12 months.

Table7.1: Demographic characteristics of participating clients at baseline (N=20)

	M	SD
Age	39.84	14.22
Average number of years smoked	23	13.3
	N	%
Gender		
Male	10	50
Female	10	50
Education		
Secondary school years 7-10	9	45
	4	20
Secondary school years 11-12	4	20
TAFE	3	15
University degree		
Income		
\$100-\$200	4	20
	5	25
\$200-\$300	6	30
\$300-\$400	3	15
>\$500	2	10
Prefer not to answer		
Aboriginal or Torres Strait Islander		
Yes	2	10
	18	90
No		
Employment		
Currently unable to work	12	60
	4	20
Unemployed	1	5
	1	5
Part-time or casual employment	1	5
Student	1	5
Retired		
Home duties		
PHQ-2		
Depressed mood - yes	18	90
	12	60
Anhedonia - yes		

Smoking status		
Daily	20	100
Attempted to quit smoking previously		
Yes	17	85
No	3	15
Intention to quit		
Next 30 days	7	35
	9	45
Next 6 months	1	5
Sometime, but not in next 6 months	3	15
Don't know		

Usefulness of training and program acceptability

Support worker ratings of the usefulness of training and program acceptability are reported in Table 7.2. Most components of the training were rated as somewhat or very useful, with all caseworkers rating access to free NRT as somewhat or very useful. Program acceptability was generally high. All support workers agreed that providing quit support did not have a negative effect on their relationships with clients and were happy to attend extra training. Two support workers thought that providing support was difficult, and more than half either agreed or were undecided about whether providing support to clients took too much time. Most agreed it would be better to refer clients to external programs than provide support within the PHaMs program.

Table 7.2: Support worker ratings of the usefulness of cessation training and resources at 3 month follow-up (n=6), and program acceptability at six month follow-up (n=5)

Usefulness of training	Not at all useful	Somewhat useful	Very useful
How to approach the issue of smoking	0	3	3
Appropriate use of nicotine replacement therapy	0	3	3
Use of motivational interviewing	1	3	2
Quit kits, Quit plans and Quitline referral forms	0	4	2
Access to free nicotine replacement therapy*	0	0	5
Program acceptability	Strongly agree or agree	Neither agree nor disagree	Strongly disagree or disagree
Providing quit support is not too difficult	3	0	2
Providing quit support does not take up too much time	2	1	2
Providing quit support has had a negative effect on my relationships with clients	0	0	5
The majority of my clients were receptive to talking about their smoking	4	0	1
It would be better to refer clients to external quit programs than provide support within PHaMs	4	1	0
I would be happy to attend further training to revise or improve my quit smoking skills	5	0	0
I would recommend training to other support workers working with disadvantaged clients	5	0	0

* Note: one participant answered "Not applicable" to this question

Provision of support

Assessing willingness to quit, providing advice to quit smoking and providing access to NRT increased from baseline to three month follow-up, and then decreased at six month follow-up (Table 7.3). The average amount of time spent discussing tobacco use increased from 3.8 minutes per visit at baseline (SD=2.6, range 0-7.5 minutes) to 33.3 minutes at three month

follow-up (SD= 43.3, range 5-120 minutes), and then decreased to 15.5 minutes per visit at six month follow-up (SD=8.7, range 7.5-30 minutes).

Table 7.3: Support worker provision of support at baseline (n=9), three month follow-up (n=6) and six month follow-up (n=5)

		Never or rarely	Some-times	Often or almost always
Ask about smoking status?	<i>Baseline</i>	3	3	3
	<i>3 months</i>	0	1	5
	<i>6 months</i>	1	1	3
Assess willingness to quit?	<i>Baseline</i>	3	5	1
	<i>3 months</i>	0	2	4
	<i>6 months</i>	1	2	2
Advise to stop smoking?	<i>Baseline</i>	6	3	0
	<i>3 months</i>	2	1	3
	<i>6 months</i>	2	1	2
Provide support and encouragement?	<i>Baseline</i>	5	1	3
	<i>3 months</i>	0	0	6
	<i>6 months</i>	0	1	4
Provide access to nicotine replacement therapy?	<i>Baseline</i>	9	0	0
	<i>3 months</i>	1	2	4
	<i>6 months</i>	0	3	2

Client outcomes

Program acceptability

Client ratings of program acceptability are reported in Tables 7.4 and 7.5. The majority of clients agreed that it was probably or definitely acceptable to be asked about their smoking by their support worker, and all but one agreed that they would return to the service in the future.

Support received

Client reports of support received during the program are shown in Table 7.6. The majority of clients (70%) initiated NRT use during the program. However, few reported using NRT consistently.

Table 7.4: *Client acceptability of the smoking care program at four month (n=17) and six month follow-up (n=13)*

		Strongly agree or agree	Neither agree nor disagree	Strongly disagree or disagree
Talking to my support worker about my smoking was helpful	4 months	14	0	2
	6 months	12	1	0
Talking to my support worker about my smoking made me think about quitting	4 months	14	1	0
	6 months	9	4	0
I did not like being asked about my smoking by my support worker	4 months	2	3	10
	6 months	0	4	9

Table 7.5: Client acceptability of the smoking care program at four month (n=17) and six month follow-up (n=13)

		Definitely not	Probably not	Probably yes	Definitely yes
Was it OK to be asked about your smoking by your support worker?	4 months	0	1	5	10
	6 months	0	1	3	9
Would it be OK to be asked about your smoking at your next visit?	4 months	0	3	4	9
	6 months	0	1	3	9
Would you return to [organisation] to use other services?	4 months	1	0	7	8
	6 months	0	0	5	8

Table 7.6: Client reports of support received at four month (n=17*) and six month (n=13) follow-up

		Yes	No
Asked about smoking	4 months	13	2
	6 months	8	5
Asked if interested in quitting	4 months	13	2
	6 months	6	7
Advised to quit	4 months	9	6
	6 months	4	9
Received support and encouragement	4 months	12	3
	6 months	5	8
Received free nicotine replacement therapy	4 months	12	3
	6 months	5	8
Referred to Quitline	4 months	6	9
	6 months	2	11
Referred to general practitioner	4 months	3	12
	6 months	1	12

* Data from two participants missing at four month follow-up.

Smoking characteristics at six month follow-up

At six month follow-up, no participants reported seven-day point prevalence abstinence.

However, all participants (100%) reported that they had reduced the number of cigarettes they smoked in order to quit. There was a significant reduction in the number of cigarettes smoked by participants, from 20.5 cigarettes per day (SD=9.9, range 8-45) at baseline to 15 cigarettes per day (SD=9.3, range 4-40) at six month follow-up ($t=2.26$, $p=0.04$). There was a non-significant reduction in money spent on tobacco per week, from an average of AUD\$70.95 at baseline (SD=35.9, range \$25-\$140) to \$60.69 (SD=42.3, range \$12-\$145) at six month follow-up ($t=1.13$, $p=0.28$).

Discussion

Our findings support evidence that training social and community service organisation staff to provide cessation support is feasible and acceptable^{10,12}. All components of training were rated as somewhat or very useful by the majority of support workers, and all support workers reported that they would recommend training to others. Recently, Cancer Council New South Wales has provided smoking care training to more than forty social and community service organisations across New South Wales, further demonstrating acceptability and interest in this type of program across a range of services. The finding that two-thirds of eligible clients enrolled in the program and 68% were retained at six month follow-up provides further evidence of the feasibility of this approach for a traditionally hard-to-reach group, and supports earlier work showing strong client support for receiving cessation assistance in this setting^{9,10}.

While support worker attitudes towards the program were positive overall, feedback at six month follow-up suggested that many believed that providing support took too much time,

and that referral to external programs would be preferable. Evidence of the relative effectiveness of integrating support into the social and community service setting *versus* using social and community service organisations as a referral point to existing services is needed to enable organisations to consider the relative costs and benefits of providing in-house cessation support. Despite these concerns, the amount of time spent addressing smoking during routine visits increased following training. Provision of the 5 As at three month follow-up was similar to levels reported in a similar larger trial¹².

While NRT increases the success of quit attempts, the cost is often prohibitive to smokers on a low income²². Although development of the intervention drew heavily on formative research which identified strong support for the provision of free NRT^{9, 22}, overall uptake and use were inconsistent. Poor adherence to NRT has been found for a number of highly disadvantaged groups, including in community-based trials with adolescents²³ and homeless smokers²⁴. Heavily subsidised NRT patches became available *via* prescription in Australia in February 2011 for individuals receiving government welfare benefits. Rates of uptake are yet to be determined.

No participants reported seven-day point prevalence abstinence. However, there was a significant reduction in the number of cigarettes smoked, and at six month follow-up all participants reported reducing the number of cigarettes smoked in order to quit. This is a positive finding, although complete abstinence remains the ultimate goal²⁵.

Limitations

Difficulties obtaining data from clients meant that the first follow-up occurred four months post-baseline, rather than three months post-baseline as planned. The small sample size limits

the generalisability of conclusions and resulted in wide standard deviations. An adequately powered, randomised controlled trial which will provide rigorous evidence of the effectiveness of providing cessation support in this novel setting is currently underway²⁶. Client diagnosis was not assessed. This means it is likely that the study population comprised a heterogeneous mix of mental illness of varying types and severity.

Conclusions

Innovative methods for accessing and engaging disadvantaged smokers may help reduce the burden of smoking-related morbidity and mortality that falls disproportionately on individuals of lower socio-economic position. This study adds to the emerging literature demonstrating the potential of a novel setting in providing cessation support to highly disadvantaged smokers. Given the size and potential reach of the sector, further well-controlled trials to evaluate the effectiveness of this approach in reducing smoking rates among this disadvantaged group are needed.

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