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ARTICLE

Opinions of women from deprived communities on the NHS stop smoking service in England - person-centered perspectives

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Abstract

Background: In most European countries, women are relatively more susceptible to smoking-related diseases, find it more difficult to quit and are more likely to relapse than men. With the aim of improving the understanding of women's needs from smoking cessation services, this qualitative study examines perceptions of women from deprived communities on the National Health Service stop smoking service in England, UK.

Methods: A qualitative study of 11 women, smokers and ex-smokers, who had used the stop smoking service located in disadvantaged communities in East Sussex, England, UK. Data were collected through focus group and semi-structured interviews and were subjected to thematic analysis.

Results: Women felt that services tailored to their needs would improve cessation rates. They expect smoking cessation facilitators to be non-judgemental and to offer psychological insight into addiction. However, women's opinions differed on the importance for facilitators to be female or ex-smokers and on the preference of group or one-to-one services, some women expressed a preference for women only groups. The women praised the continuity of care, capacity for peer support, flexibility of time and location and free cessation aids offered. Conversely, the women felt that services were poorly advertised, that access was not universally good and that services at the work place and drop-in groups would improve access for working women and women with young children.

Conclusion: Flexible, person-centered services that are tailored towards the needs of individual smokers and better dissemination of information regarding the range of services available could facilitate greater uptake of smoking cessation services for women in deprived communities.

Keywords

Individualized services, interviews, person-centered healthcare, psychological insight, socioeconomic deprivation, smoking, tobacco, women

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Introduction

In most European populations, women from deprived communities have a higher prevalence of smoking than

women in other socioeconomic classes [1]. The Opinions and Lifestyle Survey reported an increase in smoking prevalence among UK women in routine and manual occupations from 26% to 32% between 2011 and 2012 [2].

This compares to a prevalence of 19% among all UK women in 2012 and a prevalence of 24% among women in Europe in 2012 [1,3]. In a study of 19 European countries, women aged 25 to 39 years from lower socioeconomic groups were more likely to be ever smokers than women from high socioeconomic groups [4]. This is concerning considering that women are relatively more susceptible than men to develop certain smoking-related diseases, including lung cancer, coronary heart disease and stroke as well as the range of morbidity associated with smoking that only affects women, such as cervical cancer, miscarriage and premature rupture of membranes [5-9]. UK research has shown that two-thirds of deaths in women smokers over the age of 50 are caused by smoking. While the benefits of quitting smoking are greater at a younger age, women who stop smoking by the age of 40 years avoid 90% of the excess mortality caused by continuing smoking [10].

The majority of current smokers who understand the health risks of tobacco use want to give it up [11]. Research has indicated that smoking cessation is more difficult to achieve for women than men [12,13]. As many as two-thirds of smokers accessing National Health Service (NHS) stop smoking services are women; however, women are overall less likely to successfully achieve short term cessation through the NHS stop smoking service than men [14]. There is considerable evidence that smokers who try to quit with support are up to four times more likely to succeed than those who attempt it alone [14]. Despite this, population-based studies show that most smoking cessation attempts are made without formal assistance [15]. Therefore, it is important to provide stop smoking services that are accessible and targeted towards the needs of women smokers who are trying to quit.

In the UK, a large proportion of public health resource is dedicated to smoking cessation services. Although it is well established that women are more susceptible to smoking-related disease and find it harder to quit smoking than men, little research has been undertaken to understand the perception and expectations of women regarding stop smoking services. This highlights the importance of understanding women's needs and expectations from the stop smoking services to develop interventions that specifically assist female smokers [16,17]. A review of smoking cessation programs targeted at women found that women-specific services could attract women from hard-to-reach subgroups and pointed to the need for attention to interventions for women from disadvantaged groups [17]. At a local level, public health teams in local authorities and clinical commissioning groups are encouraged to determine the demographics of their communities in order to tailor smoking cessation services to best meet their population's needs [18]. The aim of this qualitative study was to ascertain the needs and service expectations of women from deprived communities, including current and ex-smokers, who had used the NHS Stop Smoking Service.

Methods

Sample

The participants were 11 adult women living in disadvantaged neighbourhoods (as defined by the Index of Multiple Deprivation [19]) who had accessed the East Sussex NHS Stop Smoking Service in the 2-year period between February 2009 and March 2011. Participants were aged between 18 and 79 years; 4 were current smokers and 7 were ex-smokers, 6 lived with a smoker and 4 were currently employed.

Recruitment

The study was approved by the NHS Brighton East Research Ethics Committee. Eligible participants were identified through records of the stop smoking service and initially contacted by telephone and invited to take part in the study by a staff member from the stop smoking service. Those interested in taking part in the study were posted an information sheet outlining the study. Participants were reimbursed for their travel costs and received a £10 shopping voucher.

Data Collection

Data collection was undertaken using one focus group (comprised of 3 women, FG a-b) and 8 semi-structured interviews (Participants 1-8). This approach was chosen because it was felt that group dynamics may have inhibited participants' discussion on some of the topics due to the sensitive nature of the subject. All interviews lasted about 60 minutes. Prior to commencing the focus group/interviews the facilitators reiterated the aims of the research and obtained written informed consent. Interview topic guides were developed to elicit information on women's perceptions of smoking cessation services and included questions on attitudes to the current service, areas that could be improved and attitudes to services specifically for women. Interview questions were designed by researchers to cover key topics and were formulated so they could be refined in real-time as themes arose and developed.

Data Analysis

The focus group discussion and interviews were audio recorded and transcribed *verbatim*, with the exception of any references to participant names or identifiable information to protect participant anonymity. Data were subjected to thematic analysis [20], both manually and using the NVIVO software package, to identify relevant or recurrent themes. To minimise bias, the data were integrated by a second researcher on a separate occasion to examine codes for consistency and validation. All emergent topics were categorised and organised into themes and sub-themes which evolved throughout the

process. Anonymised quotes from the participants have been used to illustrate overarching themes.

Results

The process of analysis identified 3 overarching themes related to the facilitator characteristics, strengths of the service and areas of improvement, each of which is described and illustrated with *verbatim* quotes below.

Facilitator Characteristics

Many participants felt that it was important for their stop smoking facilitator to be an ex-smoker; however, this view was not shared by all participants as some felt that a more general understanding of addiction was sufficient:

“Obviously it helps if the person is an ex-smoker themselves because in that way they know the pitfalls they know the problems because they may have gone through them themselves. People that have never smoked don't always understand some of the problems that you have in here [points to head].” (Participant 6)

“[It's] not necessarily important [for the facilitator to be an ex-smoker] but they need to understand addiction in general.” (Participant 1)

Opinion was also divided on whether the participants would prefer to have a female facilitator:

“a lot of the girls or ladies that I know that have been through the service are the older ladies like myself sort of 55 plus, so we're going through a lot of things in our life like 'the change' [i.e., menopause] ... a bloke doesn't always understand that, whereas a woman would.” (Participant 6)

“No I got on well with the guy actually. I don't think it would have made a difference [if the facilitator was female] for me.” (Participant 7)

Women clearly valued a facilitator who was non-judgemental and who would address the psychology of their addiction:

“I think it was because they didn't judge people, they definitely didn't judge people because people were a bit nervous about saying if they'd had a relapse but you didn't feel like you were being told off after that. They were just 'Well what can we do to overcome that if it happens again?' Let's talk it through.” (Participant 8)

Special reference was made to some of the techniques facilitators employed to help quitters to think positively and prepare psychologically for times of craving:

“... M's been really good I mean he doesn't go into huge detail or delve into your mind too much but personally more of a focus on that [psychology] aspect of it would definitely increase the success rate. Because it's [smoking] a mental thing.” (Participant 3)

“... it's fine that they [facilitator] understand the physical implications of smoking but I think a greater understanding of the psychological reasons for smoking would be more useful.” (Participant 2)

Strengths of the Service

Participants generally spoke positively of the service they had received, citing the ability to build a relationship with the same stop smoking facilitator and the peer support they felt in groups as assets in their quit attempt:

“... they [facilitators] know an awful lot about my personal life ... so they know when I'm stressed and I can talk to them.” (Participant 4)

“... just meeting that once a week and hearing everyone's experiences and knowing that you weren't the only one doing it and wanting to get through the next week and be there and tell everyone else that you'd done it for another week was all good incentive.” (Participant 8)

Participants also praised the convenience of the location of the service in their neighbourhood:

“It's just knowing that I don't have to travel by bus to go see somebody, it's in my area. It's the convenience of it ... my mobility rules my life so it's very frustrating if the support wasn't in the area I'd find it very difficult to try and do it.” (Participant 6)

“... location is the most important thing because personally I don't think I would go down the town to a smoking clinic.” (Participant 4)

Interviewees also noted the importance of flexibility of appointments:

“The out of hours [was helpful] ... my husband doesn't get home till quarter to 7 so seeing him [facilitator] at 7 o'clock was ideal for us.” (Participant 2)

Those who were working also appreciated the service's workplace initiative (free stop smoking clinics held at quitters' workplace provide nicotine replacement and trained facilitator support):

“It was convenient, I don't know if I'd have gone to a group situation outside of work really just because of time, there's always something else to do you can make an excuse almost.” (Participant 7)

Many found the free non-smoking aids very helpful and appealing:

“Obviously I think the replacements [are helpful] ... and it's free, if you go to Boots it costs a fortune.” (FGb)

Areas for Improvement

Participants had a number of suggestions on how the service could be improved. These focused on better advertising:

"I found it hard to find the service to start with ... I went to my doctor's and he just goes "go on the internet." It was a struggle for about a year trying to find [the service]." (FGc)

"The one thing that you could improve is getting the message out there that they will come into your workplace because it's only because I picked up the phone that I knew that." (Participant 8)

Another area for improvement related to the access to the service:

"To make sure that the services in all the areas [are] like it is here All [disadvantaged] areas ... should have the same sort of facilities because in all those areas you've got people with mobility problems but also with financial problems." (Participant 6)

Participants agreed that female only groups would be beneficial in encouraging more women to engage with the service:

"If I was going into an outside [smoking cessation] group I'd probably feel more comfortable in an all-female group." (Participant 8)

Many of the women indicated that the services that were designed to fit around their lifestyle would motivate them to access the smoking cessation services and that greater service flexibility was required to meet the needs of women with difficult childcare arrangements and to accommodate working hours:

"I think probably drop in groups ... I would have thought that women with young children are more housebound or have fairly difficult childcare arrangements would need something more flexible." (Participant 1)

"I probably wouldn't have gone to one of these services had it not come here. Because people work so much more these days and with family and whatever." (Participant 7)

Participants felt support through social networking would be of value to young smokers who wanted to quit although not all the participants felt they would necessarily use it themselves:

"... people are using social networking sites a lot and it would cut out the time issue because time is very tight for a lot of people. It can be very supportive [if] you can just log on." (Participant 3)

"... if there had been a really good social network from it [the group] like texting people saying 'I'm really desperate' you know just like a support group would work where if you got to a critical point you could sort of either ring someone, email or text them or something like that. That would have been better." (Participant 1)

"... [a buddy system] for me it wouldn't, I'd have been too embarrassed to phone." (Participant 2)

Discussion

The National Institute for Clinical Excellence (NICE) UK guidelines recommend regular review of local smoking cessation services in order to learn from and document strategies that have been successful and highlight areas for improvement [18]. In this study of women from deprived communities in South East England, attitudes towards the NHS stop smoking service were generally positive. There was no common consensus between the women on what format an ideal smoking cessation service should consist of, which indicates the importance of tailoring the services to meet the women's individual preferences [17,21].

Particular emphasis was given to the positive impact of building a relationship with a non-judgemental stop smoking facilitator. This is consistent with previous research which has shown that fear of health professional judgement can act as a barrier for disadvantaged smokers to access smoking cessation services [22,23]. Several women felt that group sessions were highly valuable, notably in the support, advice and shared experiences provided from attending the groups. Groups provided a platform for forming supportive relationships between individuals who could continue to encourage abstinence between sessions. Previous studies have found that smokers who engage in group rather than one-to-one interventions are more likely to be abstinent at 4-week follow-up [24-27]. However, some participants expressed a preference for the one-to-one approach due to feeling intimidated or embarrassed about talking in front of a group. One-to-one interventions have also been shown to be effective and are an important option for those who do not feel able to access group support services and for services in rural areas where group sessions may not be feasible [14].

The women were largely in consensus that it did not matter to them whether a man or woman facilitated the group, but some women expressed a preference for a female facilitator and felt that female only groups would encourage more women to engage with the service. These findings reiterate the importance of providing a range of options to smokers who are trying to quit, in order to extend the reach of the service. Providing gender specific as well as mixed gender groups and an option for a male or female facilitator for one-to-one interventions may be helpful for persuading smokers to engage with the service.

Convenience of location was reported as an important attribute of the local service by most participants and especially by those who attended focus groups held in premises on a local authority housing estate and those who had accessed services through their workplace. Studies suggest that this level of care towards disadvantaged smokers has resulted in greater uptake of smoking cessation services among smokers of low socioeconomic status [24]. Unfortunately, these smokers are more likely to relapse so these measures have only contributed to a modest reduction in smoking in this group [28,29]. Despite this, service flexibility in terms of location and time were also identified as areas where the service could be improved. Drop-in groups were suggested as a means to

improve access to smoking cessation services especially for women with young children. The local service already provides drop-in facilities at three different locations across Brighton and Hove; this is consistent with previous research which suggested smokers were unaware that the facilities they were proposing as improvements to the service were already available to them [22]. Some participants also expressed views that services were poorly advertised, thus emphasising the need for improved information dissemination and advertising.

Participants cited the provision of free pharmacological quit aids as a strength of the service. Meta-analysis of randomised control trials shows quit attempts are more successful when a smoking cessation facilitator is combined with nicotine replacement therapy (NRT) or other cessation therapies [30]. The cost of smoking cessation aids has also been shown to be a deterrent for people from deprived communities [23]. Evidence suggests that utility of NRTs is particularly important for women. Research from the International Tobacco Control Four Country Surveys showed that women who do not use any medication are less likely to be successful in their cessation attempt and the difference in successful cessation between men and women is removed when medications are used [12].

Participants felt that social networking sites could be utilised as a further support while quitting, particularly for younger women. The internet holds huge potential for assistance as it is widely available and can offer 'round the clock' support, which could be harnessed by the smoking cessation service in the provision of a private social network site for service users. Studies of internet-based interventions for smoking cessation show that interventions which utilise an interactive element and particularly those that are tailored to individuals, can be an effective means to increase the quit rate amongst smokers [31,32]. However, one review of web-assisted tobacco interventions found that most internet-based interventions did not provide an interactive component, but that those that did provide chat rooms and email support had the highest reported satisfaction rates [33].

Conclusion

This study examined the attitudes of women from deprived communities towards their local NHS stop smoking service and included perceptions of the current service, areas that could be improved and attitudes to services specifically for women. A small sample of smokers and ex-smokers were recruited, which limits generalizability. However, this is a first step towards examining attitudes among a hard-to-reach group of treatment seekers and provides important insights into the needs and attitudes of these women.

The women in this study held generally positive attitudes towards their local smoking cessation services. The group of women were divided in what format they felt would be most accessible and beneficial to their individual cessation attempt. By providing a variety of options of different types of sessions the women are able to choose

the options that they feel most comfortable with. The women praised the convenience of the meeting locations, however, they also suggested ways in which the accessibility could be improved; namely that the services were not well advertised and that having additional platforms in which to access the services would be beneficial.

Suggestions for more flexible services included drop-in groups to accommodate women with difficult childcare arrangements and continued use of workplace interventions. Flexible person-centered services that are tailored towards the needs of individual smokers and better dissemination of information regarding the range of services available to smokers are key areas for improvement and could facilitate greater uptake of smoking cessation services for women in deprived communities.

Funding and Conflicts of Interest

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