Delivering smoking cessation support to disadvantaged groups: a qualitative study of the potential of community welfare organizations

Jamie Bryant1*, Billie Bonevski1, Christine Paul1, Jon O’Brien2 and Wendy Oakes2

1Centre for Health Research and Psycho-oncology, The Cancer Council New South Wales and University of Newcastle, Room 230A, Level 2, David Maddison Building, Callaghan, New South Wales 2308, Australia and 2Cancer Council New South Wales, Woolloomooloo, New South Wales 2011, Australia

*Correspondence to: J. Bryant. E-mail: jamie.bryant@newcastle.edu.au

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Abstract

Reaching disadvantaged groups for smoking cessation represents a significant challenge. Not-for-profit community service organizations (CSOs) represent a promising setting for the delivery of quit smoking support to disadvantaged smokers. However, their potential has not yet been explored. This qualitative study examined the acceptability of community service-delivered smoking cessation care. In-depth interviews and focus groups were conducted with 8 managers, 35 staff and 32 clients of CSOs between December 2008 and March 2009 in New South Wales, Australia. Discussions were audiotaped, transcribed and analysed using thematic analysis techniques. Quantitative surveys were also conducted to explore preferences for cessation support. Results showed that the acceptability of providing and receiving cessation support in the community service setting was high. Staff perceived the provision of quit support to be compatible with their role but reported barriers to providing care including competing priorities, insufficient resources and inadequate staff training. Brief intervention approaches were preferred by managers and staff, while financial incentives and access to free or subsidized nicotine replacement therapy (NRT) were desired by clients. The community service setting represents a promising access point for engaging disadvantaged smokers for cessation and further research exploring the effectiveness of support delivered in this setting is clearly warranted.

Introduction

Tobacco smoking is the single greatest preventable cause of death and disease worldwide and is currently responsible for more than 5 million deaths each year [1]. Despite significant reductions in smoking prevalence in western developed countries over the past several decades [2–4], smoking remains highly prevalent among some subgroups of the population. Severely disadvantaged and marginalized groups such as the homeless, prisoners, the indigenous, individuals with a low income and individuals with a mental illness are consistently found to have significantly higher rates of tobacco use. For example, compared with current smoking prevalence of 16–20% in western developed countries, cross sectional and national health surveys have found rates between 26 and 30% among individuals with the lowest socioeconomic status or living at or below the poverty level, between 32 and 50% for indigenous groups [6, 7], between 69 and 70% for individuals who are homeless [8, 9], between 35 and 90% for individuals with a mental illness [10–12] and between 72 and 79% among prisoner...
populations [13–15]. As a result of these significantly higher smoking rates, disadvantaged groups suffer disproportionally from tobacco-related death and disease.

Accessing and engaging disadvantaged groups for smoking cessation represents a significant challenge [16]. Despite the fact that disadvantaged groups have some of the highest rates of smoking, they are less likely to access preventative health care services such as smoking cessation programmes, are less likely to receive advice and support to quit smoking from primary care providers [17] and are less likely to access telephone Quit-lines even during mass media campaigns [18]. Innovative approaches to engage these smokers with cessation services are needed and one emerging approach is the integration of quit smoking support into existing networks of disadvantaged smokers [19, 20]. England’s National Health Service Stop Smoking Services, which are dedicated cessation clinics set up in response to English health policy targets to reduce tobacco-related health inequalities [21], have recently reported success in targeting low income, pregnant and young smokers in intensive cessation services by delivering care in easily accessible local community settings such as community centres and libraries [22]. As a result of this targeted approach, 32.3% of all smokers accessing cessation services lived in the most disadvantaged areas compared with 9.6% of smokers who lived in the most advantaged areas [23]. This approach is novel and represents a significant change from support traditionally delivered by physicians and other health care workers in primary care settings. Within Australia, community service organizations (CSOs) represent a similarly innovative community-based setting for the delivery of smoking cessation care to hard-to-reach smokers.

CSOs are non-government, not-for-profit organizations that provide welfare services in the communities in which they are based. They provide a range of services including financial and family counselling, temporary accommodation, food and material aid and child and family support to individuals in need. Within Australia, the CSO sector is large, with recent reports estimating a throughput of more than 3 million people each year [24]. CSOs have a number of characteristics which suggest they are well placed to provide smoking cessation support to disadvantaged smokers; they have existing established contact with a large number of disadvantaged smokers, are uniquely placed to address smoking in a holistic way alongside other issues faced by their clients and are in the position to provide personalized and ongoing support. The potential for integrating cessation care into existing community welfare services also means that CSOs represent a potentially sustainable and cost-effective access point. Despite the difficulty of accessing and engaging with disadvantaged smokers and the potential of CSO’s to effectively target disadvantaged smokers for cessation, little research has examined the use of the CSO setting as an access point for delivering cessation support. One study has provided some evidence of potential effectiveness, with a recent pilot study reporting a verified 6-month quit rate of 7.5% among clients following a group quit programme delivered by a CSO. While a quit rate of this size might seem low, and the study had a number of limitations including a small sample size, this rate is comparable to cessation rates found with other hard-to-treat disadvantaged smokers [25, 26], providing evidence of the potential population impact of smoking cessation care delivered in this setting.

Despite this potential, little is known about the current provision of smoking cessation care by CSOs or their openness to routinely delivering such support in a community-based welfare setting. This qualitative study aimed to explore the perceptions of community welfare service managers, staff and clients about (i) the acceptability of providing and receiving cessation support, (ii) organizational barriers to providing support and (iii) the types of support considered appropriate and feasible.

### Methods

#### Design

This study used a qualitative research design. A purposive maximum variation sampling approach
was used to ensure representation from the widest possible range of service types, staff and clients. Separate focus groups were conducted with clients and with staff of CSOs. In-depth interviews were conducted with managers. All participants also completed a brief pen and paper exit survey at the conclusion of the focus group or interview.

Setting
Eleven social services offered by six non-government community welfare organizations operating in New South Wales, Australia, participated. The types of services included child, youth and family early intervention services, community care centres, residential drug and alcohol services and outreach services for homeless young people. Some services were ‘drop-in’ services and some provided ongoing casework and counselling support. There was also considerable range in the size and types of support the services provided; some of the more intensive early intervention services had capacity for 15 clients, while some community care centres which provided material aid and referral assisted over 1000 clients per year.

Recruitment
According to the Australian Council of Social Service Australian community sector survey [27], there are over 5800 not-for-profit social services in Australia. Seven of the largest CSO’s in terms of the range, number and types of services they provide that operate in New South Wales, Australia, were invited to an information meeting to discuss involvement in the research. Representatives from five organizations attended this meeting and all expressed interest in being involved in the research. A top-down approach to recruitment was then used; the chief executive officer (CEO) of each organization was contacted by telephone and invited to participate in the research. All provided consent. CEO’s were then asked to provide the details of area managers who could nominate services within the organization for participation. The manager’s of the nominated services were then contacted and given the opportunity for their service to be involved in client focus groups, staff focus groups and/or telephone interviews with service managers dependent on availability of staff and clients and the number of hours they were able to commit to the research. One additional organization was recruited after hearing about the research from another organization and expressing an interest in being involved. Table I shows the range of focus groups and interviews selected by services. Purposeful sampling was used to ensure inclusion of a diverse range of service and client types [28].

Procedure
Client focus groups
Clients who smoked tobacco and were aged over 16 years were eligible to participate. Clients were identified by service staff and invited by letter to participate in a 1-hour group discussion. Client focus groups were conducted in a private room by two facilitators. Clients were provided with reimbursement for participation.

Staff focus groups
Staff who had contact at least weekly with clients at the service were eligible to participate. All eligible staff employed at each participating service were invited to participate in a 1-hour focus group via a letter from the research team that was distributed by the service manager. Staff focus groups were conducted in a private room by two facilitators.

Manager interviews
Managers who were involved in the day-to-day running of their service were eligible to participate. All eligible managers employed at the services contacted were invited to participate in a telephone interview. Manager telephone interviews were conducted by one interviewer.

For all focus groups and interviews, sampling continued until saturation of the data was reached [where facilitators agreed that no new themes were emerging from the discussions (29)]. All participants were informed that discussions would be audiotaped and that de-identified comments may be used for reporting purposes. This study had
ethics approval from the University of Newcastle Human Research Ethics Committee and each organization provided approval for participation.

Discussion guide

Semi-structured interview protocols were used to guide discussions. For clients, this involved discussion of current smoking behaviour, past quit attempts, motivation to quit and attitudes and preferences for different types of cessation strategies. For managers and staff, this involved discussion of attitudes and service policies around smoking, the types of cessation care currently offered and attitudes and preferences for developing and implementing cessation strategies into routine care.

Quantitative exit survey

At the conclusion of each focus group or interview, participants were asked to complete a brief exit survey assessing their attitudes towards a range of smoking cessation interventions. Managers and staff were asked to rate the desirability (‘desirable’, ‘not desirable’ or ‘unsure’) and the feasibility (‘feasible’, ‘not feasible’ or ‘unsure’) of 17 possible smoking cessation strategies that could be offered to clients. Clients were asked to rate the acceptability (‘would like’, ‘wouldn’t like’ or ‘don’t care’) of 16 similar smoking cessation strategies that could be offered by CSOs. Cessation strategies included in the survey were derived from strategies identified by the Cochrane Collaboration Tobacco Addiction Group that the authors identified as having the potential to be implemented in a community service environment [30].

Analysis

Qualitative data analysis

Discussions were audi-taped, transcribed verbatim and the transcripts checked for errors. Data collection and analysis were conducted between December 2008 and March 2009. Data were analysed qualitatively using thematic analysis by one facilitator (J.B.) using NVivo version 8.0 [31]. To establish inter-rater reliability, a proportion of transcripts were independently analysed by the second facilitator (J.O.) and emergent themes were compared and reconciled where necessary.

Quantitative exit survey analysis

For manager and staff surveys, proportions were calculated for each variable. Client survey ratings

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Manager interview</th>
<th>Staff focus group</th>
<th>Client focus group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service A: child, youth and family early intervention</td>
<td>1</td>
<td>F</td>
<td>4</td>
</tr>
<tr>
<td>Service B: community care centre</td>
<td>1</td>
<td>M</td>
<td>6</td>
</tr>
<tr>
<td>Service C: community care centre</td>
<td>1</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>Service D: infant and child service</td>
<td>2</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Service E: residential drug and alcohol programme</td>
<td>2</td>
<td>M and F</td>
<td>7</td>
</tr>
<tr>
<td>Service G: infants and child services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service H: family support service</td>
<td>1</td>
<td>F</td>
<td>5</td>
</tr>
<tr>
<td>Service I: family support service</td>
<td>1</td>
<td>F</td>
<td>6</td>
</tr>
<tr>
<td>Service J: family support service</td>
<td>1</td>
<td>F</td>
<td>7</td>
</tr>
<tr>
<td>Service K: outreach service for homeless youth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total participants</td>
<td>8</td>
<td>35</td>
<td>30</td>
</tr>
</tbody>
</table>

aAs this service had recently undergone a policy change where they had banned smoking, manager interviews were conducted with both the current coordinator of the service, as well as the coordinator who was in charge at the time the ban was introduced.
bStaff from these services were combined to form one staff group.
of would like and don’t care were combined to represent an openness to receiving the type of quit smoking support from the CSO and proportions calculated.

Results

Qualitative results

Sample

Eight telephone interviews lasting an average of 30 min were conducted with managers from seven services. Thirty-five staff members participated in six staff focus groups which lasted an average of 54 min. Thirty-two clients participated in six client focus groups which lasted an average of 50 min. Twenty-two clients and 35 staff and managers were females. Four staff members and one manager identified themselves as smokers. Two staff members identified themselves as ex-smokers.

Manager and staff results

Manager and staff attitudes towards smoking.

Smoking was reported to be highly prevalent among clients, with estimates of smoking prevalence varying between 25 and 99%. Managers and staff were highly aware of the health consequences and financial impacts of smoking, especially for clients who were on limited incomes; yet, smoking was accepted, considered ‘pretty normal’ and staff often reported turning a blind eye to smoking.

Manager and staff attitudes towards smoking (quotes):

Well I think we just turn a blind eye …. It’s a shame they do, but we accommodate it I suppose. We’re conscious if we’re having a group they need a break. (Female staff member, child and family early intervention service).

None of us kind of thinks smoking’s a good idea, it’s just that we kind of need to accommodate our clients. (Female staff member, child and family early intervention service).

I think a lot of staff accept it due to the young people coming off harder drugs …. A lot of staff, including myself, don’t really frown upon it. (Male staff member, residential adolescent life management service).

Current provision of cessation support. Most services did not provide quit smoking support to clients. For most, smoking had ‘just not been on our radar’. Two services reported routinely asking about and documenting new client smoking status. One residential youth drug and alcohol service offered subsidized courses of nicotine replacement therapy (NRT) to clients who expressed an interest in quitting smoking but reported low uptake. Informal discussions about the benefits of quitting smoking and referral to telephone support such as Quitline or a General Practitioner was sometimes provided opportunistically in response to a client’s request for help or support, but otherwise the provision of smoking care was largely not seen as part of the staff members’ role. In some instances, managers and staff reported discouraging clients from giving up smoking as it was perceived as the only effective coping mechanism available to clients who were stressed and in crisis.

Current provision of cessation support (quotes):

If they asked for and wanted help with smoking then yes we would do that … but we don’t go in there and say oh gee, you should stop smoking. (Female manager, family support service).

I’ve encouraged people but it’s probably not really in my job description. If they talk about it, I will highlight the benefits of it and praise them and encourage them and stuff but yeah, it’s not something that I would say ‘let’s talk about your smoking. (Female staff member, family support service).

There would be time when we would actually discourage families from giving up smoking at
that particular point in time, because of the high stress they’re under. And it’s actually one of the only coping strategies that they have got. (Female manager, family support service).

Manager and staff attitudes towards the acceptability of providing quit support. Despite currently providing little quit smoking support to clients, there was strong agreement from staff and managers that CSOs were an appropriate setting for the delivery of quit smoking care. Providing cessation support was considered highly relevant and a good fit with the organizations’ focus on improving the health and well-being of clients. Trusting relationships between staff and clients and client familiarity in receiving support from the organization were identified as the primary reasons the community service setting was well suited to providing quit smoking care. A minority of staff members were concerned that providing quit smoking support would negatively impact on the ability of the organization to provide welfare support. While these staff members saw the CSO as a good place to identify clients who wanted to quit smoking, they believed support was more appropriately provided through external specialized services.

Manager and staff acceptability of providing quit support (quotes):

I think it would be interesting to ask our clients about whether they smoke and if they wanted to talk about it and look at ways to manage it …. Because I don’t think we know enough about it. (Female staff member, family support service).

If [the client] is willing to make that [quitting smoking] part of their goals, then we would help them work towards that. (Female manager, child and family early intervention service).

Yeah, because smoking is not our core business. We are a welfare agency and we support families through crisis but smoking is never a crisis. (Female staff member, family support service).

Why the CSO is well placed to provide cessation support (quotes):

We see them for a long time and we get to know them quite intimately, so the barriers are let down after establishing a rapport. (Female staff member, residential adolescent life management service).

I think we are well placed because we have access to families and we’ve created our relationship with families and so there’s that trust there. (Male staff member, family service).

I think it would be a good thing because it provides an access point for them and a place where they feel comfortable and safe to go, rather than having to go somewhere strange with different people. (Female staff member, family support service).

Perceived barriers of providing smoking cessation support to clients. Despite the high perceived benefit of providing cessation support to clients, several barriers to providing support were identified. The most frequently reported barrier was low perceived priority. Clients were often in crisis when first in contact with the community service and had immediate needs such as homelessness or domestic violence that needed to be addressed. Another barrier to the provision of quit smoking support was inadequate staff time. Services were often already working at capacity and reported to be ‘overloaded’ and ‘burdened’ with their current caseloads. Staff reported that they had inadequate training, skills and knowledge about how to address the issue of tobacco with their clients. There was also a reluctance to pro-actively raise the issue of smoking with clients. Smoking was viewed as a personal choice, and there was concern among managers and staff that clients may perceive advice to quit smoking as judgemental, intrusive or ‘nagging’ and that the provision of this type of support might make clients hesitant to continue contact with the service.
Perceived barriers of providing smoking cessation support to clients (quotes):

I guess we move in largely when there is a crisis in the household and quite possibly .... The crisis is not about smoking at that time. It’s about another issue. (Female manager, family support service).

Not with the current resources we have, no .... The staff has way too much to do already. (Female manager, family support service).

I don’t know how well skilled I am, confident I would feel, giving advice about stopping smoking. (Female staff member, family support service).

If they feel like we’re trying to make them give up smoking, we’re potentially going to lose them. If they feel like we’re judging them, we’re going to lose them. (Male manager, community care centre).

Types of cessation support considered appropriate to offer clients in the CSO setting. There was variability between services in the types of support considered appropriate to offer clients; offering group quit smoking programmes or integrating smoking care into existing programmes was considered feasible by some services but was considered resource heavy and unrealistic by others. Offering vouchers for free or heavily subsidized NRT that could be redeemed at a nearby pharmacy was perceived to be of enormous benefit to clients who could not afford to access such support. Flexibility with the provision of services and being able to offer repeated opportunities for quitting following relapse were considered important. Staff and managers reported strong preferences for support that was tailored to the particular client groups they were working with and wanted clear guidance about the types of support they could provide that would be relevant to the unique needs of their clients.

Types of cessation support considered appropriate to offer clients in the CSO setting (quotes):

I think we need more than just general education … we’re working with high-risk, a targeted group. It’s not the mainstream, you know who respond well to public education, public health stuff. They’re a hard to reach target group—so how can we get a custom-made sort of program or strategies and guidelines for how we can implement them. Yeah. So something more than just you know, a general public health program. (Female staff member, child and family early intervention service).

Client results

Client acceptability of receiving cessation support from the CSO. Most clients reported a desire to quit smoking and had made multiple failed attempts to quit in the past. Clients reported a strong desire for support and encouragement to quit smoking but reported being unable to receive this from partners, family or friends who were often also smokers. The opportunity to receive support, encouragement and praise to quit smoking from staff at the CSO alongside the support already provided was viewed positively.

Client acceptability of receiving cessation support from the CSO (quotes):

If I ever felt like quitting yeah …. Because then I’d know it would be good encouragement. I like speaking to the workers when I’m stressing, so I think it would be good. (Male client, residential adolescent life management service).

I reckon it would be alright as long as we weren’t feeling like we were getting pestered. (Female client, young mothers service).

Yeah it would be alright, they could ask. (Male client, community service).

Types of cessation support wanted by client:

Again, there was variability in client preferences for support. Some wanted to attend quit smoking groups where they could meet and receive support from others who were also trying to quit smoking, while some preferred informal or one-on-one support. Clients acknowledged that quitting was likely to take multiple attempts and
reported a strong preference for personalized quit support that could be offered by a familiar person over an extended period of time. Telephone support like Quitline was viewed with scepticism and was perceived to be ineffective, despite the fact that the majority of clients acknowledged never having accessed this service.

**Types of cessation support wanted by clients (quotes):**

Support … I don’t know, just a social worker to come around and you know, just have a bit of a chat … meet them at the park or something. *(Female client, child and family early intervention service)*.

I’d like to go to someone for some serious advice, you know, someone who actually cares and will support you … I would prefer to get useful advice from a person—not over the phone. *(Male client, residential adolescent life management service)*.

If you were keen to give up, smoking groups would be great because then you would meet people doing the same thing. *(Female client, child and family early intervention service)*.

Maybe subsidise the quit smoking products. Maybe someone could subsidise these products so they’re affordable. *(Female client, residential drug and alcohol program)*.

**Quantitative exit survey results**

**Sample**

Exit surveys were completed and returned by all participants (*N* = 75).

**Manager and staff exit survey results**

Manager and staff ratings of the desirability and feasibility of cessation strategies are reported in Table II. Strategies rated most desirable and feasible were brief intervention and referral approaches. Strategies that were considered undesirable included offering clients individual quit smoking counselling (35.7%), providing non-financial incentives like shop vouchers (33.3%) or government sponsored financial incentives (26.2%) and providing alternative therapies like acupuncture (28.6%) and hypnosis (23.8%).

**Client exit survey results**

Client ratings of the type of cessation support they would be open to receive are presented in Table III. The strategies clients were most open to included being asked if they smoke cigarettes by staff at the CSO (100%), being asked if they are interested in quitting (94%), being given cash rewards (94%) or non-cash rewards for quitting (94%) and having access to free or subsidized NRT (88%).

**Discussion**

**Main findings**

This qualitative study provides insight into the attitudes of managers, staff and clients of CSOs in providing and receiving cessation support.

Overall, managers and staff reported strong support for providing cessation care to clients: they acknowledged that smoking was detrimental to their clients’ well-being and considered smoking care an appropriate component of their role as carers. They expressed a willingness to provide certain types of support to clients which primarily consisted of low-intensity strategies such as asking about and recording client smoking status and providing information, brief advice, general support and referral. Perceived barriers to providing support were similar across all services and included smoking cessation being seen as a lower priority than the provision of other types of welfare support and lack of resources, time and training to provide quit smoking services. Staff and managers were also concerned that raising the issue of smoking may appear judgemental or harm rapport with their clients. Providing training and education for staff about the importance of addressing smoking as a long-term health and financial issue and how to approach clients and provide support in a non-judgemental way is likely to aid significantly in addressing these concerns.
Clients were also enthusiastic about receiving support from staff at the CSO. Clients spoke positively about the help and support they already received from CSOs, including the provision of accommodation, life skills training and counselling and reported that receiving support and encouragement would be of great benefit during quit attempts. Manager and staff perceptions that clients would find questions and advice about smoking intrusive and judgemental appeared largely unfounded.

**Opportunities for intervention**

Agreements in the types of cessation strategies managers and staff were willing to provide and the types of cessation support clients were open to represent encouraging opportunities for intervention. Strategies considered acceptable to at least half of all managers, staff and clients included asking about smoking status, providing pamphlets and information about quitting, providing videos or DVDs about quitting, providing individual quit smoking counselling and providing group quit smoking counselling. The provision of brief advice (asking about smoking status and providing pamphlets and information), group counselling and individual quit counselling all align with evidence-based practice for adult smoking cessation, so are likely to be good starting points for incorporating into routine care in the CSO environment. Also strongly endorsed by a number of clients, staff and managers was the provision of free or subsidized NRT. NRT has been repeatedly shown to be cost effective and to increase the success of quit attempts [32, 33]; however, the cost is frequently prohibitive to smokers on a low income. The willingness of CSOs to facilitate access to free or subsidized NRT

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**Table II. Manager and staff ratings of 10 most desirable and 10 most feasible cessation strategies (N = 43)**

<table>
<thead>
<tr>
<th>Cessation strategy</th>
<th>Desirable (%)</th>
<th>Not desirable (%)</th>
<th>Unsure (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing quit smoking pamphlets and information to clients</td>
<td>92.9</td>
<td>0</td>
<td>7.1</td>
</tr>
<tr>
<td>Referring clients to quit smoking services that provide telephone support (e.g. Quitline)</td>
<td>88.4</td>
<td>2.3</td>
<td>9.3</td>
</tr>
<tr>
<td>Developing policies about smoking at the organization</td>
<td>88.1</td>
<td>0</td>
<td>11.9</td>
</tr>
<tr>
<td>Providing support and encouragement for clients who make quit smoking attempts</td>
<td>86.0</td>
<td>0</td>
<td>14.0</td>
</tr>
<tr>
<td>Providing brief verbal advice to clients about the negative effects of smoking and the benefits of quitting</td>
<td>78.6</td>
<td>4.8</td>
<td>16.6</td>
</tr>
<tr>
<td>Asking clients about their smoking status</td>
<td>74.4</td>
<td>14.0</td>
<td>11.6</td>
</tr>
<tr>
<td>Giving clients a video or DVD about quitting smoking</td>
<td>72.1</td>
<td>9.3</td>
<td>18.6</td>
</tr>
<tr>
<td>Recording smoking status in client records</td>
<td>62.8</td>
<td>20.9</td>
<td>16.3</td>
</tr>
<tr>
<td>Running a group quit smoking counselling programme</td>
<td>60.5</td>
<td>20.9</td>
<td>18.6</td>
</tr>
<tr>
<td>Offering individual quit smoking counselling</td>
<td>54.8</td>
<td>35.7</td>
<td>9.5</td>
</tr>
<tr>
<td>Feasible (%) Not feasible (%) Unsure (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing quit smoking pamphlets and information to clients</td>
<td>85.4</td>
<td>2.4</td>
<td>12.2</td>
</tr>
<tr>
<td>Referring clients to quit smoking services that provide telephone support (e.g. Quitline)</td>
<td>83.3</td>
<td>4.8</td>
<td>11.9</td>
</tr>
<tr>
<td>Providing support and encouragement for clients who make quit smoking attempts</td>
<td>81.0</td>
<td>2.4</td>
<td>16.6</td>
</tr>
<tr>
<td>Developing policies about smoking at the organization</td>
<td>76.7</td>
<td>4.7</td>
<td>18.6</td>
</tr>
<tr>
<td>Asking clients about their smoking status</td>
<td>73.8</td>
<td>9.5</td>
<td>16.7</td>
</tr>
<tr>
<td>Providing brief verbal advice to clients about the negative effects of smoking and the benefits of quitting</td>
<td>67.4</td>
<td>7.0</td>
<td>25.6</td>
</tr>
<tr>
<td>Giving clients a video or DVD about quitting smoking</td>
<td>66.7</td>
<td>7.1</td>
<td>26.2</td>
</tr>
<tr>
<td>Recording smoking status in client records</td>
<td>61.9</td>
<td>11.9</td>
<td>26.2</td>
</tr>
<tr>
<td>Organizing a quit smoking counsellor to make home visits to clients</td>
<td>39.5</td>
<td>16.3</td>
<td>44.2</td>
</tr>
<tr>
<td>Running a group quit smoking counselling programme</td>
<td>38.1</td>
<td>23.8</td>
<td>38.1</td>
</tr>
</tbody>
</table>
deserves further exploration and may be a particularly important factor in effectively engaging disadvantaged smokers in smoking cessation programmes [34] and increasing the success of quit attempts.

Further research
Russell’s landmark 1979 study [35] suggested that smoking cessation was possible and efficacious in the general practice setting. However, research which followed showed that many organizational, provider and patient, barriers to the provision of cessation assistance in this setting existed including time constraints [36–39], lack of resources [36], lack of training [36–39] and perceived lack of client motivation [36, 38]. Among health professionals serving disadvantaged communities, additional cited barriers include the fact that patients often present in crisis and are often unable to pay for cessation treatment [36]. Similar barriers were identified by CSO staff in this study. Research has helped identify strategies to overcome these barriers and improve rates of practitioner delivery of smoking cessation advice [40]. Similar research into ways to overcome the barriers identified by staff and clients and improve the effectiveness of CSO-delivered support for highly addicted disadvantaged smokers is needed. It was noteworthy that managers and staff indicated an openness and willingness to work through identified barriers. Given the demonstrated acceptability of implementing cessation support in this setting, further research should develop and examine the effectiveness of interventions likely to be cost effective and successful within the community service setting. In particular, examination of strategies with high ratings of acceptability among managers, staff and clients are clearly warranted.

Implications for service providers and policy makers
This research shows that CSOs show significant promise in encouraging and supporting quit attempts among disadvantaged smokers. Importantly, they provide an access point to a large number of disadvantaged smokers desiring help to quit and are open to providing support if provided with the time, training and guidance to do so. Clients also appear motivated to quit smoking and are open to receiving personalized support from CSOs. The fact that managers and staff often expressed different opinions about the type of delivery or intensity of support that they would like to provide is indicative of the large variability in the types of support services provide, the expertise of staff and the specific needs of clients who are receiving care. Tailoring cessation strategies for each organization or offering a menu of evidence-based cessation strategies may be necessary for widespread uptake in this setting.

Study limitations and strengths
This study used qualitative methods to illustrate the views of disadvantaged welfare clients and their

<table>
<thead>
<tr>
<th>Table III. Client ratings of cessation strategies (N = 32)</th>
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<tbody>
<tr>
<td>How would you feel if staff at [organization] …</td>
</tr>
<tr>
<td>Asked you if you smoke cigarettes</td>
</tr>
<tr>
<td>Asked you if you were interested in quitting</td>
</tr>
<tr>
<td>Offered you cash rewards if you quit</td>
</tr>
<tr>
<td>Provided non-cash rewards like footy tickets or shop vouchers if you quit</td>
</tr>
<tr>
<td>Offered you free or cheap nicotine patches or gum</td>
</tr>
<tr>
<td>Offered you an alternative therapy like hypnosis</td>
</tr>
<tr>
<td>Told you about ways to stop smoking</td>
</tr>
<tr>
<td>Ran a counselling group for smokers to help you quit</td>
</tr>
<tr>
<td>Offered you an alternative therapy like acupuncture</td>
</tr>
<tr>
<td>Gave you a video or DVD about quitting smoking</td>
</tr>
<tr>
<td>Offered you quit smoking pamphlets</td>
</tr>
<tr>
<td>Gave you a computer or internet-based programme to help you quit</td>
</tr>
<tr>
<td>Offered you individual counselling to help you quit</td>
</tr>
<tr>
<td>Had a quit smoking counsellor who could visit you at home</td>
</tr>
<tr>
<td>Put you in touch with telephone quit help like Quitline</td>
</tr>
<tr>
<td>Did not allow any smoking at the service</td>
</tr>
</tbody>
</table>
carers about assistance to quit smoking. Health services research tends to be dominated by quantitative approaches and qualitative methods are often criticized for not being reliable, valid and objective [41]. However, within the context of understanding underlying issues, the appropriateness of an intervention and gaining a sense of the match between an intervention, a system and the user, qualitative methods are critical [41–43]. Given the qualitative nature of the study and the purposive sampling used, the results cannot be considered representative or highly generalizable. The study sample was drawn only from non-government CSOs operating in New South Wales, Australia, and therefore, the results should be interpreted only in this context. Further research is required to generalize these findings to other types of community organizations operating in other areas. Further, we did not collect detailed demographic information from clients who participated in focus groups and this lack of specific participant information limits the extent the findings can be generalized to disadvantaged subgroups. In terms of analysis, thematic analysis has the potential to result in the de-contextualization of the speakers’ words; however, great care was taken to analyse the participants’ words in their broader context. Finally, we have used some numerical counting from exit surveys to help describe the prevalence of particular preferences and views within the samples interviewed. These should not be taken to imply statistical representation of the population under consideration but are used to represent the diversity of views.

Conclusion

CSOs are providers of a range of welfare services to a diverse range of disadvantaged individuals in the Australian community. They are uniquely placed to tackle the high prevalence of smoking among their client population, are considered appropriate for the delivery of cessation care by service providers and service users and represent an innovative and promising point for accessing disadvantaged smokers. Further research which examines the effectiveness of support delivered in this setting is clearly warranted.

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Conflict of interest statement

None declared.

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