

WE CAN QUIT



Findings from the Action Research Study **FULL REPORT**

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Responsibility for this report and the views expressed herein lies wholly with the authors.

Glossary and Abbreviations

BS	Behavioural Support
Bupropion/Zyban	Bupropion (Zyban) is a non-nicotine based pharmacotherapy that reduces the urge to smoke and the symptoms of nicotine withdrawal.
CBT	Cognitive Behavioural Therapy
CO	Carbon Monoxide
CO monitor	A machine that measures levels of toxic CO in the breath.
CSS	Client Satisfaction Survey
CVS	Community Voluntary Sector
GIUFB	Give it Up For Baby
HSE	Health Service Executive
ICS	Irish Cancer Society
IPHI	Institute of Public Health Ireland
LDPC	Local Development Partnership Companies
MABS	Money Advice and Budgeting Service
NAB	Neighbourhood Advisory Board
NAG	Neighbourhood Advisory Group
NCRI	National Cancer Research Institute
NGO	Non Government Organisation
NRT	Nicotine Replacement Therapy
NWCI	National Women's Council of Ireland
RAPID	Revitalising Areas by Planning, Investment and Development
SES	Socio-economic status
Varenicline	Varenicline (Champix) is a pharmacotherapy which alleviates symptoms of craving and withdrawal and also acts on the brain's dopamine receptors to reduce the pleasurable effects of smoking
WCQ	We Can Quit



CHAPTER 1

Introduction and Background

1.1 Introduction

Tobacco use is the leading cause of preventable death in Ireland with 5,500 smokers dying each year from tobacco related diseases (Dept of Health 2013a). In 2009 approximately €500 million of health expenditure in Ireland was directly due to smoking related diseases. Ireland ranks second highest for smoking related causes of death in the EU (Ferlay et al 2010 cited in Healthy Ireland Dept of Health 2013b). Current figures suggest that one in three people in Ireland will develop cancer during their lifetime, with an average of 30,000 new cases each year. This number is expected to rise to over 40,000 per year by 2020. One in four cases of cancer is preventable, and smoking remains the leading cause of preventable cancers, particularly lung cancer.

More women in Ireland are now dying from lung cancer than breast cancer (NCRI, 2011). Women in lower socioeconomic groups have the highest rate of smoking in Ireland (SLAN Burgha et al, 2009), with women aged 18 to 29 having a rate of smoking (56%) which is twice that of women from more affluent groups of the same age. These women are also less likely to quit smoking. Recent data highlight the differences in smoking across the different population groups, with the C2 (skilled manual workers) and DE group (semi-skilled, unskilled workers or unemployed) accounting for nearly two thirds of smokers (62.9%) (Hickey and Evans 2015).

Tobacco Free Ireland (Dept of Health 2013) recognises the importance of channelling smoking cessation to lower socio-economic groups.

'targeted and tailored smoking cessation interventions should be used where necessary, for example in socially disadvantaged areas' (Dept of Health 2013 pg 52).

The links between cancer and smoking amongst women in Ireland, and other developed countries, have been recognised by international organisations such as the World Health Organisation through the Framework Convention of Tobacco Control. The WHO has called for a gendered lens to be applied to tobacco control policies (WHO, 2010). Despite this,

few countries have attempted to tailor interventions to meet the needs of women. This is particularly the case in relation to the provision of services to help women stop smoking, where there is some evidence that existing services may not be meeting the needs of female smokers, particularly those living in more disadvantaged areas. Research has noted that women are less successful than men at quitting (Perkins, 2001, Perkins et al, 1999). In the UK, evaluations of NHS stop smoking services have consistently found that while more women access these services than men, their quit rates are lower (Ferguson et al, 2005, Bauld et al, 2009, Bauld et al, 2011, Bauld et al, 2012, Hiscock et al, 2011). This is also reflected in national routine data where four week quit rates for women have been slightly lower than men's over the past decade in both Scotland and England (ISD Scotland, 2013; The Information Centre, 2012).

1.2 The We Can Quit Action Research

In recognition of the context outlined above, and following the *Women and Smoking: Time to Face the Crisis Conference* in July 2012, the Irish Cancer Society (ICS) formed a partnership with the National Women's Council Ireland (NWC) and Institute of Public Health Ireland (IPHI) to develop an innovative community based approach to support smoking cessation among women from socially and economically disadvantaged communities, and established a national advisory group to lend support to the initiative. As part of this project ICS commissioned the action research to inform the development a community based smoking cessation model to support women to stop smoking, and established an external advisory group to support the project (See Appendix 1).

The project consisted of five phases. Phases 1-3 consisted of an evidence review and engagement with key stakeholders to identify potential approaches for the *We Can Quit* model. Phase 4 represented the development and delivery phase whereby the *We Can Quit* model was piloted in two disadvantaged communities in Dublin. The final phase involved the evaluation of the pilot implementation in two sites in Dublin, to assess the

acceptability and potential effectiveness of the *We Can Quit* model.

This report presents the key research findings from the 5 Phases.

- Phase 1: Evidence Review (conducted by the research team presented in Chapter 3)
- Phase 2: Engagement with stakeholders (conducted by the research team with ICS and partners organisations presented in Chapter 4)
- Phase 3: Model Identification (conducted by research team in with ICS and partner organisations presented in Chapter 5)
- Phase 4: Model Design and Delivery (ICS team and partner organisations presented in Chapter 6)
- Phase 5: Evaluation of Pilot Delivery (Research team and ICS presented in Chapter 7 and Chapter 8)

The report concludes with a summary of the key learning from the process of designing and delivery a community based smoking cessation service and provides some recommendations for policy, practice and research.

1.3 Background and Rationale for We Can Quit

1.3.1 Tobacco Use Among Women

Smoking is a health inequalities issue, demonstrated by the fact that women living in the most deprived circumstances have a higher rate of smoking of lung cancer than women in the least deprived circumstances (NCRI, 2011). One in three people in Ireland will develop cancer during their lifetime. In Ireland an average of 30,000 new cases of cancer are diagnosed each year. More women in Ireland are dying from lung cancer than breast cancer (NCRI, 2011). Women in lower socioeconomic groups have the highest rate of smoking in Ireland (SLAN 2007, Brugha et al 2009), and women aged 18 to 29 in this group have a rate of smoking (56%) which is twice that of women from more affluent groups in the same age group. These women are also less likely to quit smoking. While the evidence points to higher levels of smoking among low socio-economic

status (SES) women, higher SES women are more likely to be successful in a quit attempts (Harman et al 2006).

Research has also noted the cumulative effect of disadvantaged on women's smoking. Exposure to childhood disadvantage, early motherhood and financial hardship has been found to be associated with heavy smoking among young women (Graham et al., 2006). Patterns of smoking can also impact on the next generation. Children living in socioeconomically disadvantaged communities are more likely to have parents who smoke (Sims et al 2010), and their homes are more likely to have fewer smoking restrictions (Akhtar et al 2009). Parental smoking in the home increases the child's chances of become an adult smoking (via role modelling) and has direct and immediate impact on children's health (Coleman and Bauld 2011).

A number of authors have argued that smokers from lower SES groups should be targeted for greater efforts to support smoking cessation. Such efforts need to focus as much on the social conditions that affect women's lives as on the individual level interventions (Graham et al., 2006), including approaches to improve the life options of women (Kandel et al 2009).

1.3.2 Women and Smoking Cessation

Recent research in England (Beck, 2013, unpublished PhD thesis) found that women accessing cessation services appeared to experience more disadvantage and have more caring responsibilities than men using the services. Despite accessing the support services, women were less likely than men to quit smoking in the short term (i.e. at four weeks), and in the longer term (i.e. at 52 weeks). Interviews with women living in disadvantaged areas revealed that, as previous research has shown, smoking was perceived to be an integral part of the women's lives. It was used by women as a coping strategy for stressors in daily life. Reasons for accessing the cessation services included reduced social acceptability of smoking, as well as health issues. Women's suggested improvements for smoking cessation services centred on increasing accessibility of

venues and appointment times, as well as providing more tailored support including information on pharmacotherapy, and providing advice on changing smoking 'routines'.

In terms of developing cessation services, one key concern is whether women who smoke are motivated to quit or would even contemplate accessing support to stop. UK research estimates that up to 16% of smokers have no desire to quit (Jarvis et al, 2003). These smokers tend to be older, more dependent on nicotine, and from more socio-economically deprived backgrounds (whether they are women or men). It is acknowledged that progress in reaching this group will depend on delivering interventions that are targeted to the particular needs and perceptions of these smokers.

It is also worth noting that tobacco use among women in Ireland and in other countries is complex. Smoking is a cultural and social issue for many women, providing perceived opportunities for social bonding which often reinforce addiction to smoking. Many women describe their smoking as a means to relieve stress (this is discussed in greater detail in Chapter 3 below).



CHAPTER 2

Research Methods

The *We Can Quit* project had five objectives. These were to:

1. Develop a community-based smoking cessation programme which encourages women living in socially and economical disadvantaged areas to quit smoking
2. Foster environments which support women who want to quit smoking
3. Identify supports and barriers to quitting
4. Learn about the mechanisms which help women quit
5. Identify appropriate structures for the sustainability of the programme

Different research methods were employed for each phase of the research. Phases 1 and 3 relied on evidence from the national and international research literature. Phases 2 and 5 employed mixed methods approaches to consult with key stakeholders (women and service providers) to (a) identify the support needs of women smokers; (b) to gain their views of the *We Can Quit* Pilot; and (c) assess the effectiveness of the pilot.

2.1 Phase 1 and Phase 3: Evidence Review and Model Identification

A systematic review approach was employed to identify, screen and synthesise the international research evidence. Using these procedures three bodies of research were assembled and synthesised to provide the evidence base to underpin the development of the *We Can Quit* model.

1. **Barriers and Facilitators.** This included research exploring the barriers and facilitators experienced by women living in disadvantaged areas when considering stopping smoking, as well as research with service providers delivering such services.
2. **Effectiveness of Smoking Cessation Support.** This included review level evidence describing the effectiveness of approaches to support smoking cessation (e.g. behavioural support, stop smoking medication such as

Nicotine Replacement Therapy (NRT)), with a particular focus on women. This body of evidence consisted of findings from systematic reviews of effectiveness including Cochrane Reviews.

3. **Effective Means of Engagement.** Research describing different approaches/interventions to engage with low income women on the subject of smoking cessation in community settings. This body of evidence consisted of findings from both reviews and primary studies.

Reflecting the three bodies of literature, the search strategy used three sets of keywords summarised in Appendix 2. Searches were carried out for papers published between 2003 to 2013 using the following databases and websites: AMED (Allied and Complementary Medicine); ASSIA (Applied Social Science Index and Abstracts); British Nursing Index; CINAHL (Cumulative Index of Nursing and Allied Health Literature); Cochrane Central Register of Controlled Trials; Cochrane Database of Systematic Reviews; DARE Database; EMBASE; Medline; PsycINFO; Sociological Abstracts; SIGLE; SCOPUS, NHS Centre for Reviews and Dissemination; Social Science Citation Index and Google Scholar. Websites of relevant organisations were also included (e.g. Health Scotland, ASH, Roy Castle, Quit etc).

Following initial searching and screening, 466 references that were selected for abstract review. From the original 466, 348 were excluded at this stage because they did not meet the inclusion criteria i.e. (a) focus on women or low income communities or (b) located in community based settings. This generated a total of 118 papers that were selected for full review: 23 describing barriers and facilitators to smoking cessation; 77 on cessation effectiveness, and 18 describing research on effectiveness of different approaches to user engagement. Given the high number of systematic reviews on the subject of smoking cessation, evidence from the most recent reviews was included for full review. Particular attention was given to effectiveness reviews containing evidence on gender issues or community based approaches.

2.2 Phase 2: Stakeholder Consultation

Phase 2 was stakeholder consultation to inform the design of *We Can Quit*. Stakeholders in this instance included female smokers from disadvantaged areas, and a range of service providers with a role to play in supporting smoking cessation. This phase of the research had two objectives. Firstly, to gauge stakeholders' views on the need for a smoking cessation intervention designed for women living in disadvantaged communities; and secondly, to assess the suitability of different possible approaches or models. Service providers were consulted with by means of an on-line survey, and focus group interviews were used to consult with female smokers living in different areas.

The findings from the literature review informed the design of the stakeholder questionnaire which was hosted on-line using Survey Monkey. The survey link was cascaded to service providers identified by the Irish Cancer Society and the external multi-agency advisory group members.

This stage of the research also involved a consultation with female smokers living in disadvantaged area. Four focus groups consisting of a total of 24 women were convened with women in living in urban and rural locations in Ireland. The aim of the group was to consult with different age women to hear their experiences of quitting, what helped with and what hindered previous attempts, and to gain a greater insight into their support needs.

2.3 Phase 3: Model Identification and Development of We Can Quit Model

Phase 3 focused on identifying and reviewing models or approaches that aim to address the specific needs of women smokers and or smokers living in disadvantaged areas. From this process the research team suggested features from the different models that might be incorporated within for the *We Can Quit* programme.

Once a potential model was identified, the Irish Cancer Society commenced the process of

developing the *We Can Quit* programme to fit into the Irish context.

The core elements of the *We Can Quit* model included:

- An integrated partnership approach between a national health charity, local community sector organisations and the local health service: supported by a local advisory structure
- Proactive pooling of skills, expertise and resources from partners to deliver services to meet the common objectives of supporting smokers living in a disadvantaged area to quit
- Delivering a group smoking cessation support programme which:
 - follows the HSE recommended national standards for smoking cessation practice;
 - Is co-delivered by community and health workers in a 12 week workshop style programme;
 - provides access to free NRT (combined therapies); and
 - is confidence boosting and celebratory, achievements are shared with family, friends and community.

2.4 Phase 4: Evaluation of the Delivery of We Can Quit Model Pilot

The *We Can Quit* pilot, delivered in two areas in North Dublin, was evaluated using a prospective observational cohort study designed to follow all women who participated in the programme. Ethical approval for the study was granted by the Irish College of General Practitioners. Data were collected by four different approaches during this phase the study: CO validated monitoring data; an anonymous client satisfaction survey (CSS); telephone interviews with a sample of participants; and an anonymous survey of key stakeholders involved in the planning or delivery of the *We Can Quit* pilot. During registration all participations received written information about the research study and a consent sheet. Participation in the research was voluntary.

2.4.1 Validated Monitoring Data

Information from all women who consented to participate in the research was collected by the group facilitator at baseline, 4 weeks after quit date, and 12 weeks after the programme commenced. The baseline data gather information on demographic characteristics including socio-economic status (SES), smoking behaviour, and the smoking patterns of family members. At weeks 6 and 12 the monitoring data collected smoking status with (CO monitor); the range of interventions received including whether NRT was accessed and whether single or combination therapy, and quit attempt.

2.4.2 Client Satisfaction Survey and Qualitative Interviews with Participants

Client satisfaction was assessed using an anonymous self completion survey administered to all women at the end of the programme. The survey was combined with short follow-up interviews at after the end of the programme with a sample of participants from each site (n=8). The interviews asked how the participant learned about the programme, what her experience of the programme was, and her perceptions of the main benefits of programme. The interview also explored any perceived weaknesses of the *We Can Quit* approach, and sought suggestions for future improvements to the programme.

2.4.3 Survey of Partner Organisations and Follow-up Workshop

In order to explore how the programme was planned and delivered in each site, the final stage of the research involved self completion survey of partner organisations involved in either the planning or delivery of the *We Can Quit* in the two areas. The questionnaire asked the respondent about their role in the *We Can Quit* programme, explored their experiences of planning or delivering the programme, and sought their views on the different components of the *We Can Quit* model. As part of the survey, and during the follow-up workshop, the

added value of the community-based approach to supporting women to quit was examined.

The survey preceded a workshop with n=30 participants from the two areas. During this workshop, the key findings from the pilot were presented, and partners views on the on the sustainability of the programme was explored. Key areas for discussion included their experience of planning and/or delivering the *We Can Quit* programme, the infrastructure and support for the delivery of the project, key successes and achievements, challenges to the planning and delivery of the programme, and suggestions for future improvements or further support needs.



CHAPTER 3

Findings from Evidence Review (Phase 1)

This chapter presents the key findings from the rapid review of the literature. The review evidence is presented in three sections.

1. Barriers and facilitators to smoking cessations for women living in disadvantaged areas.
2. Evidence of the effectiveness of approaches to supporting smoking cessation (overview of evidence for general population)
3. Evidence of the effectiveness of different approaches to smoking cessation support for low smokers, with a particular focus on tailored community-based interventions directed to women.

3.1 Barriers and Facilitators to Smoking Cessation

Both primary studies and existing systematic reviews (McNeill et al 2012; Torchalla et al 2012; Gollust et al 2008; Bock et al 2009) describe a number of barriers to smoking cessation experienced by women from disadvantaged communities. These include:

- Addiction: nicotine dependence, psychological attachment to tobacco use; sometimes combined with other substance misuse problems.
- Dealing with social and economic factors: stress, childcare difficulties (parenting alone/young children), poverty, dealing with debt, unemployment/boredom.
- Cultural factors: difficulties in challenging a culture of smoking, intergenerational smoking, peer pressure.
- Individual factors: lack of skills or confidence to deal with stress/debt etc. (self-esteem/self-confidence), mental health problems/depression, fear of being judged, fear of failure.
- Access to services: availability of services, not engaged with services, limited transport to services, limited childcare to access services, limited reach of services to disadvantaged groups/hard to reach populations; and stigma and discrimination (e.g. Lesbian or bisexual women/women with mental illness).

- Lack of knowledge/awareness of different supports and services; lack of confidence and/or awareness of the effectiveness of different approaches (including pharmacotherapies) and their associated costs.

The literature also points to a number of barriers experienced by professionals when delivering smoking cessation interventions (Blumenthall et al 2007; Gollust et al 2008; Bryant et al 2011; McNeill et al 2012). These include:

- Organisational factors: time/resources constraints; lack of organisational commitment; staff turnover; smoking policies; concerns about costs associated with providing counselling and/or pharmacotherapy
- Situational and individual factors: staff lacking confidence and/or skills to deliver smoking cessation messages and work with disadvantaged groups; lack of awareness of local support (e.g. cessation clinics/quit lines etc); limited access and opportunity to engage with low income smokers
- Context of client relationships: can often be a crisis situation; staff perceptions of patient lack of readiness to quit; lack of trust in the relationship between worker and client.

3.2 Approaches to Smoking Cessation (General Population)

There is a considerable body of evidence from a number of countries, using a variety of study designs, exploring the effectiveness of approaches to smoking cessation. Evidence of the efficacy of different treatment approaches from Randomised Controlled Trials (RCTs) can be found in a number of systematic reviews, most notably in reviews undertaken by the Cochrane Collaboration (e.g. Cahill et al, 2008, Stead and Lancaster, 2005; Hughes, Stead et al 2014; Ussher, Taylor and Faulkner 2014). This evidence is summarised below, followed by a summary of the evidence on the effectiveness of these same types of treatment when they are tried in 'real world' settings with disadvantaged groups.

Overall, there is evidence to support the following:

- Behavioural Support (BS) involving:
 - brief advice from a health professional
 - one to one or group behavioural support
 - telephone quit lines (particularly proactive support)
- Stop smoking medication including:
 - Nicotine replacement therapy (single or dual product)
 - Bupropion (Zyban)
 - Varenicline (Champix)

Evidence is also now available regarding the efficacy of Cytisine (a further stop smoking medication) (Etter 2006) but this is not available or licensed as a medicine in many parts of Western Europe including Ireland.

3.2.1 Brief Advice and Behavioural Support

Brief advice from a health professional, particularly a GP, has been shown to have a positive effect on smoking cessation. However, as the *We Can Quit* programme was to involve more intensive support, the research concentrated on a longer duration of advice, usually referred to as 'Behavioural Support' (BS).

Evidence indicates that there are a range of approaches to behavioural support that can help people stop smoking. For example, face to face individual and group behavioural support are effective, as is proactive telephone support (Mottillo et al., 2009; Lancaster & Stead, 2005; Stead & Lancaster, 2005; Stead et al. (2008). Compared to self-help and other less intensive interventions, the chances of quitting are approximately doubled when good quality behavioural support is delivered. However, there is not enough evidence to evaluate whether group therapy is more effective or cost-effective than intensive individual counselling (Stead & Lancaster, 2005).

The best outcomes for smokers engaging with a treatment programme are achieved through a combination of behavioural support and medication. Figure 1 illustrates the number of times better than no treatment different types of intervention are. As it shows, the optimum available

treatment is a combination of behavioural support and varenicline (Champix), followed by behavioural support and more than one NRT product (patch plus gum, for example). However, even the delivery of behavioural support plus one NRT product is more than three times more likely to result in smoking cessation (usually measured at six months in the trials included in Cochrane reviews) than just brief advice or no treatment.

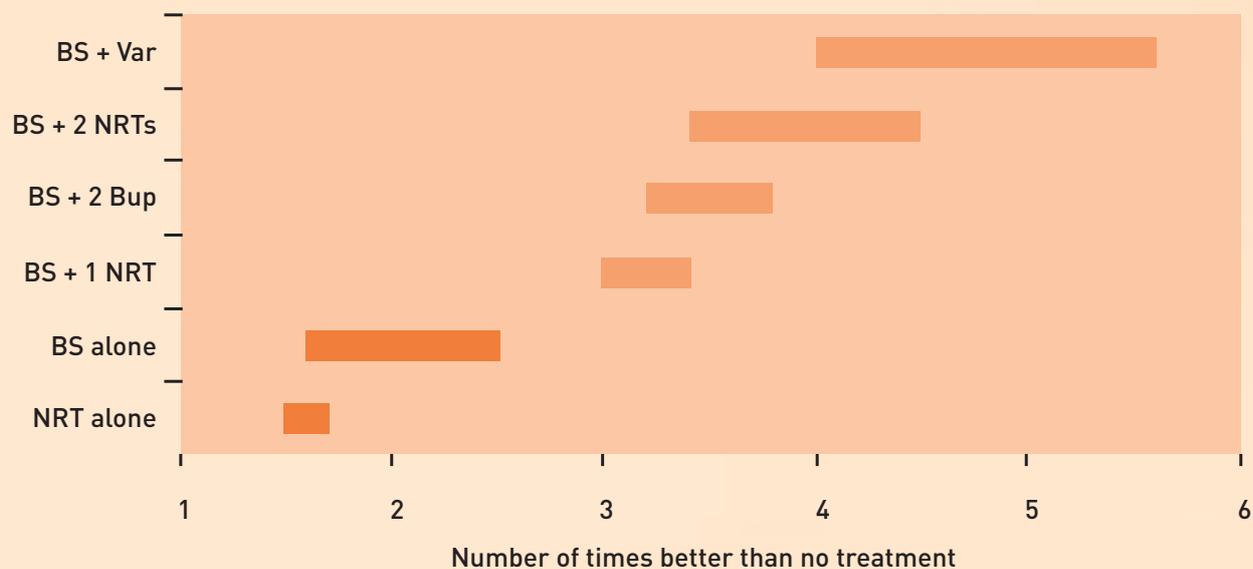
3.2.2 Nicotine Containing Products

There is now a variety of nicotine containing products available for smokers aiming to cut down or stop smoking. Some of these are available as medicines and are effective as smoking cessation aids, in particular NRT. Others are unlicensed and sold as consumer products in Ireland as elsewhere. The majority of these unlicensed products are electronic cigarettes (e-cigarettes), sometimes known as vapourisers. The evidence on the effectiveness of ecigarettes for smoking cessation is growing (Hajek, Etter et al. 2014). However, these products were not a focus of the *We Can Quit* study and were still not widely used in Ireland at the time the project commenced, although this changed during the course of the research.

In the *We Can Quit* programme, the stop smoking medication available was NRT. Thus, although good evidence exists regarding the efficacy of varenicline and bupropion for smoking cessation, we focus here on NRT.

Nicotine replacement therapy is available in Ireland in the form of transdermal patches, gum, lozenges, inhalers, nasal sprays, sublingual tablets and a newer product, an oral spray. Patches allow a slow release of nicotine throughout the day while other forms can be used as needed and are more rapidly acting. When used appropriately, NRT operates by decreasing nicotine withdrawal symptoms (Stead et al, 2008). It is rare for smokers to use too much NRT as higher than recommended dosing results in nausea, stomach pain, headache, diarrhoea and other symptoms. Contraindications for NRT use (Lavelle et al, 2003) are limited for adult women but do include those women who have had a recent cardiovascular or cerebrovascular event (but not

Figure 1: Efficacy of Behavioural Support and Medication



Source: West (2013), Data from Cochrane reviews; bars represent 95% CIs based on risk ratios versus placebo (for medications) or brief advice/no treatment (for Behavioural Support (BS)); figures for BS + NRT/Bup/Nor/Var involve multiplying effect of BS and effect of medication

those with stable heart disease), patch use for those with skin disorders, and importantly, the safety and efficacy of NRT use during pregnancy is still not firmly established (Coleman et al, 2012).

There is an additional body of evidence on the use of NRT to cut down to quit combined with behavioural support. Several recent systematic reviews have shown that cutting down using NRT over a relatively short period (such as 6 weeks) before quitting is just as successful as an abrupt quit attempt with NRT (Moore et al 2009; Wang et al. 2008).

3.2.3 Combination of Behavioural Support and Medication

A number of studies have examined whether services offering a combination of behavioural support and medication are able to reach disadvantaged smokers (women and men), and whether such approaches are successful in helping people quit (Hiscock et al, 2011, Fiore et al, 2008). Many of these have involved evaluations of programmes that commonly consist of between 6-12 weeks of one to one or group behavioural support, provided by a health professional or lay worker trained in smoking cessation combined with free or subsidised provision of stop smoking

medication. As carbon monoxide (CO) screening when setting a quit date and then at follow up has been shown to be an effective motivational instrument to maintain abstinence (i.e. Jarvis et al 1986), many of these programmes also include the measurement of CO in exhaled breath as part of the behavioural support offered. Findings from these studies have been included in recent systematic reviews that go beyond trials to include a number of other study designs (Bauld et al, 2010, Hiscock et al, 2010). Overall, these studies have shown that these types of services can reach these groups. Indeed, there is evidence that the NHS Stop Smoking Services (SSS) in England (which offer behavioural support and a prescription for smoking cessation medication) has been successful in increasing its reach in less affluent areas (Chesterman et al, 2005. West et al 2013). Smokers from disadvantaged communities are just as likely to be motivated to stop and just as likely to try stop as their more affluent neighbours, but studies show their quit rates tend to be lower (Kotz and West, 2009, Hiscock et al, 2011).

3.2.4 Relapse Prevention Interventions

Research from the English Stop Smoking Services estimate that approximately 75% of successful quitters at 4 week relapsed to smoking 6 months after their quit date (Coleman et al 2010). In their review of relapse prevention interventions Coleman et al (2010) found some evidence to suggest that extending pharmacotherapy treatment (such as NRT, bupropion or varenicline), is both effective and cost-effective for preventing relapse to smoking. However, in their review of relapse prevention approaches, Hajek et al (2013) found only limited evidence from rigorous studies to support the effectiveness of different relapse prevention strategies. They concluded that while there was insufficient evidence to support the use of any specific behavioural interventions the verdict is strongest for interventions focused on identifying and resolving tempting situations, as most studies included a focus on this. Hajek et al found some studies on the extended treatment with varenicline may help some smokers, and further studies of extended treatment with nicotine replacement are needed.

3.2.5 Other Approaches

Fear of weight gain is often identified as one of the barriers to cessation, particularly among women. One review examined the effectiveness of exercise for smoking cessation (Ussher et al. 2014). Exercise prescription and duration of follow-up varied extensively between the studies. Long-term impact on smoking cessation was found in one study. The authors conclude that while there is evidence to recommend exercise as an aid for reducing tobacco *withdrawal and cravings* there is insufficient evidence to recommend exercise as a specific aid in smoking cessation. More research based upon high quality trials is needed in this area to inform cessation practice.

A further review by Parsons et al., (2009 cited by Boland and Schwartz 2010) investigated the efficacy of interventions for preventing weight gain after smoking cessation. The researchers analyzed interventions designed specifically to aid smoking cessation and limit post-cessation weight gain and those interventions designed to aid smoking

cessation that may also have an effect on weight. While some interventions appeared promising, the authors found insufficient evidence to make strong clinical recommendations for effective programming.

3.3 Smoking Cessation Support for Women

The vast majority of trials and observational studies of cessation programmes have been involved both male and female participants. Only two of the reviews located examined smoking cessation among women (Tortilla et al 2012; Bock et al 2009). Bock et al (2009) examined the effectiveness of different treatments (e.g. Cognitive Behavioural Therapy (CBT), and pharmacotherapies (NRT, bupropion, and varenicline) delivered to women, while Torchalla et al (2012) summarised the characteristics of interventions delivered to women (Torchalla et al, 2012).

3.3.1 Cognitive Behaviour Therapy (CBT) for Women

The Bock et al (2009) review identified one study (Schmitz and colleagues 2007) that examined the efficacy of bupropion (Zypan), cognitive behavioural therapy, and supportive therapy (ST). Women under the age of 30, and who smoked more than 10 cigarettes a day were assigned to one of four conditions: CBT plus bupropion; ST plus bupropion; CBT plus placebo; or ST plus placebo. The CBT psychological interventions were 1-hour weekly group sessions. Participants who received bupropion combined with the CBT achieved higher smoking abstinence rates than participants receiving bupropion and supportive therapy. However, among participants receiving a placebo, ST was superior to CBT. Bock et al conclude that additional research is required to determine the efficacy of CBT alone with women smokers.

3.3.2 NRT for Women

NRT reduces nicotine withdrawal symptoms, the craving for cigarettes, and urges to smoke, and replaces some of the positive pharmacological effects of nicotine while the smoker quits (Bock et al 2009). As discussed above, all forms of NRT can effectively double quit rates compared with placebo,

although there are some variations between product types (Fiore et al 2008, Silagy et al 2004). Bock et al cite recent meta-analyses which found no gender differences in response to NRT (Munafò 2008). Bock et al also found some evidence that longer term use of some form of NRT (such as nicotine gum) may be especially helpful to women concerned about post cessation weight gain (Nordstrom et al 1999), but cautioned that the results of studies examining this have been mixed.

3.3.3 Bupropion and Varenicline for Women

Bock and colleagues' review identified one meta-analysis of 19 placebo-controlled trials that showed that bupropion (Zyban) approximately doubles cessation rates (Hughes et al 2004). Overall, placebo-controlled clinical trials show no differences in bupropion efficacy between men and women. Most placebo-controlled clinical trials have not examined gender differences in response to varenicline (Champix). Overall abstinence rates using varenicline have not shown any differences in cessation rates between the sexes (OR, 2.41 vs placebo and 1.7 vs nicotine replacement at 12 weeks) (Eisenberg et al 2008; Scharf et al 2008).

3.3.4 Exercise Programmes for Women

There is some evidence that physical activity interventions when delivered alongside smoking cessation services can assist cessation and help to address weight gain in some clients. To date most programmes using exercise to support smoking cessation have been delivered to both sexes, to women in general (rather than disadvantaged women) or to pregnant women (Ussher et al, 2012). Our searches identified one study exploring the effectiveness of exercise programmes with women suffering from depression that may have some relevance for the *We Can Quit*. Vickers et al (2009) reported on a RCT of 10 weekly individually tailored exercise counselling sessions designed to motivate increased regular physical activity and short bouts of exercise in response to urges to smoke. The control group received information on health topics including sleep hygiene, nutrition and health, screening tests for women.

3.3.5 Characteristics of Interventions Directed to Women

Torchalla and colleagues (2012) examined what types of smoking cessation services or interventions had been delivered to women, what their characteristics were and how successful they were. They identified 39 studies, 36 of these were conducted in the USA. They covered multiple study designs, and most focused on subgroups of women (for example women with cardiovascular disease), and reported outcomes for a particular topic of relevance to women in the programmes such as concerns around weight gain. The interventions delivered varied and they grouped these into 6 headings:

- Interventions to address exercise, weight gain concerns
- Mood/stress management
- Matching quit date to menstrual cycle
- Peer counselling
- Brief interventions in a health care setting
- Interventions with no face to face contact (e.g. telephone counselling)

Overall, the findings from the review were that while interventions tailored for women can be effective, no single model was recommended. Both the Bock et al. (2009) and Torchalla et al (2012) reviews conclude that while significant progress has been made in examining the process of smoking cessation among women, further attention is needed to elucidate the therapies and approaches that are most effective for women who are trying to quit smoking.

3.4 Approaches to Delivering Smoking Cessation Support for Low Income Women Smokers

Our searches only identified 2 descriptions of tailored smoking cessation programmes directed to low income women. Most smoking cessation programmes directed to women tend to focus on pregnant women. A small number have been directed to women of young children but these tend to be delivered within health care setting.

As already discussed there are relatively few studies of 'women only' cessation programmes, and only a small number have aimed to reach low income women in particular. Different approaches have been used. In the section below we present some of the examples of community based approaches to delivering smoking cessation work for low income women in the sections below. Additional information on specific programmes is available in the Appendix 3.

3.4.1 Working with Community and Voluntary Services (CVS)

Within the literature, there is emerging evidence pointing to the importance of working in partnership with the community and voluntary services (CVS) in order to deliver smoking cessation support to people living on socially and economically disadvantaged areas. Survey research with CVS in Australia indicated that community organisations are receptive to supporting smoking cessation, but require further support to integrate such support into usual care (Bonevski et al 2013; Bryant 2013).

One study in Australia (Bonevski et al 2011) delivered tailored smoking cessation interventions to smokers (males and females) from disadvantaged areas via a case worker within a Non-Government Organisation (NGO) community-based organisation. The organisation operated seven days a week, provided counselling services four days a week and a range of other services which included: financial and relationship counselling; life skills courses; and emergency relief. A baseline screening survey regarding nicotine dependence, previous quit attempts, depression, partner smoking status, and financial stress was used to produce an individualised checklist of the types of assistance each client may need. The intervention used motivational interviewing, pharmacotherapy, allocation of a support person and support pack, referral to specialist quit services as well as the centre-run life skills courses, and follow-up using unscheduled drop-in or phone-in sessions. The intervention was implemented over one or two face-to-face visits (each two weeks apart), which commenced immediately after baseline survey

completion, followed by at least two phone contacts (one week apart) (See Appendix 3 for fuller description).

In England, a recent pilot study in Nottingham with low income families found some merit in working with Children Centres (centres set up by government to provide services for low income families) (McEwen et al 2012a; McEwen et al 2012b). Referral Liaison Advisers (RLAs) were employed to attend the Children Centres to identify and engage with smoking parents, offer advice and refer to local stop smoking services using an opt-out referral system (i.e. consent to referral was assumed unless a the parent specifically stated that they were not interested) (see Appendix 3 for further detail). This approach did increase referrals to the specialist stop smoking services (SSSs) (Roy Castle Lung Cancer Foundation's Fag End service and the NHS New Leaf service in Nottingham). The study concluded that referring smokers to the Smoke-free Homes initiative can be a useful way of engaging clients into a discussion about stopping smoking; recruiting a 'champion' in the Children Centres, and having a dedicated worker from the Stop Smoking Service (i.e. the RLA) regularly available at the Children Centre was effective in raising the profile of SSSs and Smoke Free Homes initiatives. McEwen et al caution that smoking cessation support service should be timely in their response to referrals to maximise the impact and the likelihood of action by the family members; and highlights the need for imaginative ways of raising tobacco awareness to avoid any stigmatisation of tobacco users or resistance to messages, preferably embedding any advice with other issues that are routinely discussed.

Both the Australian and Nottingham studies demonstrate the potential of community based services (non-health) as a means to engage with smokers and offering a referral route to specialist services. In the USA, the best evidence of the effectiveness of such community based approaches to working with low income women emerges from the evaluation of the Sister to Sister programme (described in more detail later in the report) evaluated by Andrews et al (2005, 2012). With the Sister to Sister (StS) model a 7-member working group of local laypersons ("insiders") was

established to provide guidance on community preferences, contexts, and a comprehensive community assessment. Using this process the community partners developed an intervention with 4 major components: neighbourhood-level component (2 antismoking activities and 1 policy change), peer groups support (behavioural counselling), one to one coaching sessions by community health workers (CHW), and the provision of NRT. At six month follow-up the 7-day point prevalence abstinence was 39% in the treatment condition compared with 11.5% in the control condition. After several feasibility and pilot studies, this collaborative partnership is now engaged in a randomized controlled trial that is testing the effectiveness of a multilevel smoking cessation intervention in public housing neighbourhoods in 2 states in the USA.

Another model *There's a Way out for me* programme (Stewart et al 2010, 2011) used a community based approach to reach low income women living in the Edmonton, Winnipeg and Vancouver in Canada. The community based programme provided 14 weekly group support sessions delivered peers, professional facilitators and volunteer buddies. The study was small scale with 44 participants and was evaluated using a 13 item survey following intervention and 8 item survey 3 months later. The process evaluation indicated that the support group 'mobilised and reinforced' participants' intentions to quit, increased the women's life skills and self esteem. Support came in the form of emotional, informational, affirmation and practical support from women who face similar challenges, and the women were able to share. The authors concluded that a holistic approach tailored for the low income women is required to meet the smoking cessation support needs of women from low incomes. Community agencies played an important role in recruiting the women to the programme and research.

3.4.2 Interventions directed to Low Income Parents

Within the literature there are a range of examples of smoking cessation interventions that have been delivered to pregnant women in different settings. However, a small number of programmes have been

delivered to women at different stages of their lives. For example, a small number of studies evaluated the effectiveness of smoking cessation approaches delivered to mothers (and parents) of children attending paediatric clinics and welfare centres. For example, in the USA Curry et al (2003) report on an RCT of a smoking cessation intervention delivered to ethnically diverse low income women attended paediatric centres. The women, recruited using handouts and information sheets distributed by clinic receptionists, were offered a brief motivational message from the child's clinician, self-help guide to quitting, 10-minute motivational interview with nurse or research assistant and up to three outreach telephone calls. Clinicians received training on the interventions and followed a protocol including *Ask Advise Assist* and the women received a self-help guide to quitting *Make yours a fresh start family: A Magazine for Women who Smoke*. At follow-up the intervention group demonstrated slightly more successful verified quit rates than the control group (14% (I) versus 7% (C) at 12 months (adjusted OR = 2.77).

In general, the evidence base on the effectiveness of interventions directed to parents is very mixed. A recent Cochrane Review (Baxi et al 2014) was unable to determine whether interventions directed to parents influenced parental smoking or their children's exposure to second hand cigarette smoke, although the review did include a small number of studies that demonstrated some success by providing intensive counselling within clinician settings (such as those described above).

3.4.3 Smoke Free Homes Initiatives

There is also a growing literature on interventions to promote smokefree homes (see Wilson et al 2012 for description of the REFRESH Approach), but this was outside of the inclusion criteria for the review and not examined in detail. The *We Can Quit* National Advisory Committee may wish to consider the evidence on these types of approaches as an element of the *We Can Quit* programme once it is under active development. For example, recent qualitative research suggests that personalised biofeedback of children's exposure to second hand smoke may be a key motivator (Jones et al 2011 et al cited by Wilson et al 2012).

3.4.4 Financial Incentives

In recent years the role of incentives to promote the uptake of cessation services or help maintain abstinence has received growing attention the literature (Cahill and Perera 2011; Aveyard and Bauld 2011; Tappin et al 2014), particularly for low income and pregnant women (Lumley et al 2009). A recent evaluation of the Quit4U programme in Scotland (Ormston et al 2012), which offered financial incentives combined with NRT and behavioural support to encourage and support to smokers living in disadvantaged areas to quit, found higher quit rates at one, three and 12 months compared with the average quit rates of other NHS cessation services in Scotland (there was some loss to follow-up which made comparison with other studies difficult). The authors concluded the Quit4U programme represented a highly cost-effective use of NHS resources. Participants' accounts of the support received from pharmacies suggests that CO tests may have helped to provide an additional focus for encouragement and support, which may, in turn have improved engagement with pharmacy staff (see Appendix 3 for further information).

3.5 Key findings from Community-based Approaches and Approaches Directed to Women Living in Disadvantaged Area

The review level research provided some clear messages for the development of community based smoking cessation supports for women living in disadvantaged areas.

- The need for tailored services to make them more 'client-centred' by providing cessation support at accessible settings (Murray et al 2008 cited by Bonevski et al 2011; Stewart et al 2009, Andrews et al 2005, 2012).
- The importance of working with the community and voluntary sector. There is an emerging body of evidence pointing to the potential of partnerships with community and voluntary sector to deliver tailored smoking cessation messages and support to communities living in disadvantaged areas (see Bonevski et al 2011, McEwan et al 2012; Andrews et al, 2012).
- Some studies and recent commentaries have pointed to the potential benefits of adopting an assets-based approach with parents/communities to harness their motivation to protect their children from smoking (Amos et al 2008) but the evidence of the effectiveness of this approach alone is limited (Baxi et al 2014).
- There is good evidence from trials in the USA for the efficacy of financial incentives for smoking cessation in pregnancy (Lumley et al 2009) but less is known about the effectiveness of this approach with the general population. There is some emerging evidence from Scotland on the effectiveness of financial incentives combined with NRT and behavioural support (Ormston et al 2012).
- A social marketing element is viewed as key in a number of existing community-based smoking cessation interventions. For example, the *Give it up for Baby* initiative in Dundee (Radley et al 2013) developed the intervention and social marketing approach with a multi-disciplinary stakeholder group consisting of representatives from health, local authority and community development organisations. The process of social marketing began with via initial discussions with community development groups to explore their views on the intervention and to test their views on the publicity material.



CHAPTER 4

Findings from the Consultations with Stakeholders (Phase 2)

In this Chapter we present the findings from the survey of service providers and the focus groups with four groups of female smokers living in disadvantaged areas.

4.1 Key findings from the Survey of Service Providers

As described in Chapter 2, the e-survey was cascaded by the Irish Cancer Society to the key contacts identified by the national advisory group. This provided a profile of the contacts that included public, private and voluntarily sector organisations working in health and community development (see Appendix 4). A good number of responses (n=93) were received, of which n=88 were valid (i.e. complete/or non duplicate). A range of organisations participated in the survey including: HSE (Physiotherapy/Occupational Therapy, Primary care, Smoking Cessation Services, Health promotion, Hospital, etc), National Organisations (including charities/research), Youthreach, Family Resource Centres, Women's organisations, Private practices, Community Development/Traveller organisations, and homeless agencies.

It should be noted that the survey was not intended to be representative of all health and community service providers in Ireland, but was conducted to gain greater insight into service providers' views and experiences of the barriers facing women when trying to quit, and to learn about possible opportunities to address such barriers.

In the sections below the key findings from the survey are presented grouped by (a) perceptions of barriers facing women; (b) sources of support for smoking cessation; (c) service providers' views on support needs of women smokers and staff delivering smoking cessation services; and (d) examples of community based approaches to support.

Please note that the findings from the closed questions are presented in actual numbers of responses (not percentages) using tables and figures. The key messages from the open ended responses are categorised and presented in a narrative summary with supporting extracts from the responses.

4.1.1 Barriers to Smoking Cessation

Respondents were presented with a list identified from the literature review on the barriers women from low income communities face regarding smoking cessation. The findings from the survey echo the themes in the literature. For example, stress, addiction and an emotional attachment to cigarettes were viewed as being very important or important by the majority of respondents (n=81, n=82 and n=79 respectively) (Table 4.1). In addition unemployment (n=75), culture of smoking in community (n=74), and a fear of weight gain (n=70) were also viewed as very important or important barriers to smoking cessation.

Table 4.1: Barriers Women from Disadvantaged Areas Face Regarding Smoking Cessation

Barrier	Very important/ important	Unimportant/ Very unimportant	Neither important or unimportant
Addiction	82	0	2
Coping with high levels of stress	81	0	2
Emotional attachment to cigarettes	79	0	3
Unemployment	75	1	7
Culture of smoking in community	74	3	7
Fear of weight gain	70	4	10
Lack of awareness of support	68	7	8
Lack of community support	62	6	14
Information not available/accessible	52	12	16
Lack of childcare to attend support	51	12	18
Perception that health professional is not approachable/interested	49	11	20
Tobacco industry manipulation	40	17	23
Perceived cost of service	36	22	20
Fear of being judged	35	16	29
Transport to service	31	14	34
Other	21	2	12

Base 83

4.1.2 Importance of Sources of Smoking Cessation Support for Women living in Disadvantaged Areas

Respondents were asked their views on different types of smoking cessation support identified in the review of the literature (Table 4.2). Support from family and friends were clearly perceived as very important by nearly all respondents. In the main, findings are consistent with the literature, with most respondents viewing support (one to one of group) being important or very important. Brief advice from GPs and support from nurses were also considered important.

Table 4.2: Source of Smoking Cessation Support for Women Living in Disadvantaged Areas

Answer Options	Very important/important	Unimportant/ Very unimportant	Neither important nor unimportant
Support from friends	82	0	2
Support from family	80	1	3
Individual counselling (face to face)	79	0	4
Support from group	75	3	5
Brief advice from GP	73	4	6
Support from nurse	70	2	11
Pharmacotherapy (e.g. NRT, Zyban/Champix)	60	1	12
Financial Incentives (e.g. Shopping vouchers/rewards)	57	8	13
Self Help Material	54	11	17
Internet/Social Media	51	6	22
Support from telephone quit-line	50	7	20
Co monitors (biofeedback)	49	10	12
Other support	26	0	10

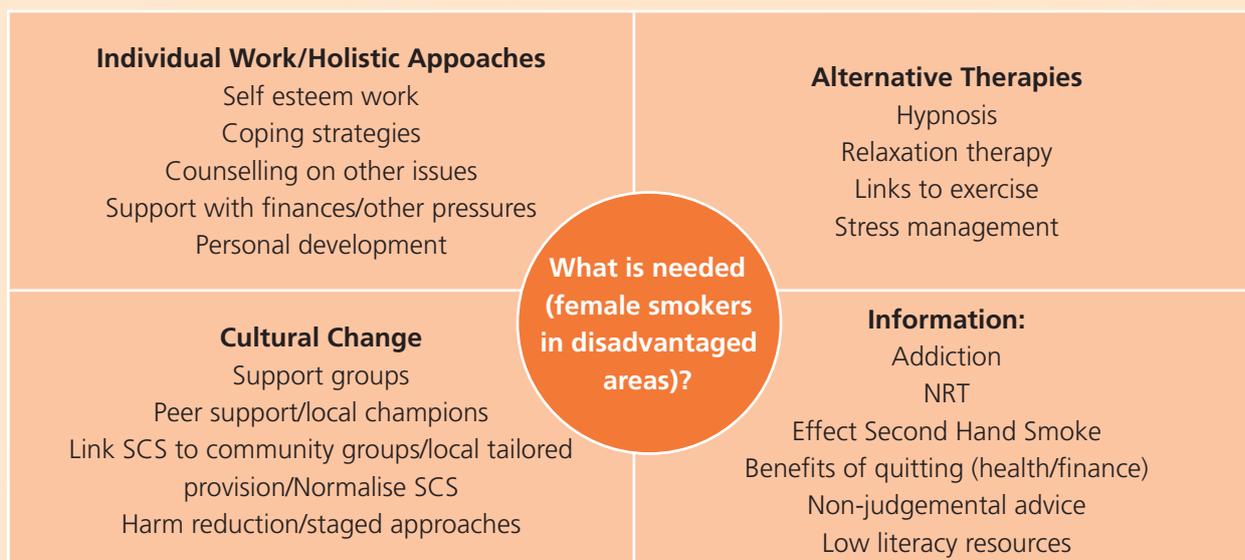
Base 85

Other support needs were identified as important included group support, help to manage stress, access to local services, access to NRT (low cost) and holistic approaches to address some of the wider social, psychological and financial pressures facing women living in disadvantaged areas (further details on these needs are presented in the section on the support needs of different groups of women below).

4.1.3 Views on the Support Needs of Sub-Groups of Women living in Disadvantaged Areas

Respondents were asked their views on the support needs of different groups of women living in socially and disadvantaged areas (rural and urban). Over half of respondents to this question felt that women in living in disadvantaged areas (n=46) and young women (n=47) had additional support needs, and approximately two fifths (n=38) felt that women in rural areas had additional support needs. A number of respondents expanded upon their views on the additional smoking cessation support needs of disadvantaged women which can be grouped within four broad inter-related themes summarised in Figure 2 and discussed below.

Figure 2: Summary of Service Providers' Open Ended Responses on the Needs of Female Smokers Living in Disadvantaged Areas.



Individual Work/Holistic Approaches

Addressing the specific support needs of women from disadvantaged was a common theme. Suggestions included personal development work, support with finances and help to build the skills to cope with other pressures which impact on their smoking behaviour (e.g. dealing with stress, parenting, domestic violence etc).

Alternative Therapies

This view centred on providing alternatives therapies to support smoking cessation, such as hypnosis, relaxation therapy, providing links to exercise programmes, and stress management.

Cultural Change

Cultural change towards smoke free homes and environments was seen as an importance element to support smoking cessation. Suggestions of ways to support this included working with local support

groups, peer support and local champions, linking smoking cessation services to local community groups, and tailoring support to local needs. Other suggestions included normalising smoking cessation support and services, supporting harm reduction (e.g. cutting down to quit), staged approaches to cessation and initiatives to encourage smoke free workplaces and homes.

Information

Providing women with information on the nature and effects of nicotine addiction, continued smoking and second hand smoking was a common theme. Linked to this was the importance of describing the benefits of stopping smoking for health and finances. Respondents pointed to the need to provide this information in a non-judgemental manner and using easy read low literacy resources.

4.1.4 Improving the Uptake of Available Services

To gauge respondents' views on possible ways to improve the uptake of smoking cessation services in Ireland, respondents were presented with a range of strategies and asked to rank each one using a scale of 1 to 10, with 1 representing the least important and 10 the most important. To assess the perceived importance of each strategy, an average score was calculated for each strategy (high score indicating high importance and low score indicating low importance). Overall n=84 service providers responded to the question with positive responses (average score more than 5) to each strategy (see Figure 3). The strategies receiving the highest scores included access to free NRT/medication, local support groups, the provision of information on different types of smoking cessation support, information on supports available locally, and flexible appointments.

Figure 3: Ways to Increase Uptake of Smoking Cessation Support for Women Living in Disadvantaged Areas

Average scores (1 least important-10 most important – Average scores)



4.1.5 Challenges and Opportunities to Smoking Cessation Provision - Service Providers

The questionnaire also included a section on the challenges experienced by staff when delivering smoking cessation services to women in disadvantaged areas. Consistent with the other research studies, survey respondents experienced a number of challenges to deliver smoking cessation when working with low income women. Despite several respondents saying they did not know (because they had no experience to draw on),

n=38 (45%) felt staff faced additional challenges, and n=30 (35%) felt they would require additional support to support women to quit. Encouragingly, half of the respondents (n=42 49%) felt there were opportunities for staff to deliver smoking cessation alongside their current role. Open ended text to supplement the responses are summarised below. These challenges can be grouped into three related themes: social and community factors; the relationship with the client; and organisational factors. Figure 4 below presents a summary of the three themes.

Figure 4: Barriers to Delivering Smoking Cessation Support Experienced by Staff



The type of barriers and challenges facing staff to support women living in disadvantaged areas to quit include: the lack of priority cessation has for some women with high number of stressors; a perceived fatalistic attitude of smokers; staffs' own smoking behaviour; the relationship between the smoker and the health professional; staff's fear of preaching; getting referrals; lack of interest; lack of resources or priority for staff to deal with smoking cessation; staff skill and confidence and their ability to deal with the wider issues impacting on smoking behaviour.

An additional challenge raised by one respondent was the expected outcome of the intervention. The effectiveness of the intervention is often judged on the successful quit rather than the journey to quitting.

A challenge is that support is expected to result in a quit outcome, whereas engaging with women in disadvantaged areas, and beginning the process of awareness raising, and perhaps protecting children from passive smoke in the home, can be a valid outcome in itself.

4.1.6 Current Community-based Approaches

To help inform model design respondents were asked if they were involved in the delivery, or offered training/support to support the delivery of, community based initiatives to women living in disadvantaged areas. Around half (n=41) of respondents did, however only 16 were evaluated. Of the 41 programmes described, n=13 focused on low income women (but did not have a focus on health), n=12 described smoking cessation approaches that reach women in low income areas (but not designed specifically to meet their needs); n=9 described a community based smoking cessation service; and n=4 described a training service to support community based smoking cessation, and 3 described other approaches. While many described providing support elements important for a smoking cessation service for women living in disadvantaged areas, none described a community based smoking cessation addressing all of the identified needs of such women within the context of delivery effective smoking cessation support (i.e. behavioural support plus access to 2 forms of NRT).

The approaches described reflect many of the suggestions already discussed and include:

- the provision of opportunistic advice within primary care and hospital care settings (e.g. brief advice from physiotherapist/Occupational therapist, Public Health Visitor) including asking smoking status at all appointments, providing brief intervention, and advising smoking to see GP);
- advice and support via lay health workers/CHW;
- personal development work;
- locating mainstream services in areas of high disadvantage;
- the active promotion of services;
- offering flexible appointments (and reduced costs); and
- initiatives to challenge the culture of smoking (e.g. smokefree home initiatives).

4.1.7 Key Points from Stakeholder Survey (Phase 2)

In general, the findings from the stakeholder survey were similar to those emerging from the international literature on the barriers facing women when thinking about quitting, and possible facilitators to supporting women to quit.

- Addiction/emotional attachment to cigarettes, stress, and unemployment were viewed to be key barriers facing women living in disadvantaged communities when quitting by nearly all respondents. The culture of smoking in community, and a fear of weight gain were also viewed as very important or important barriers to smoking cessation.
- Many of the service providers are aware of the specific support needs of smokers living in socially and economically disadvantaged areas, particularly women. These needs centred on four key areas:
 - individual work (e.g. self esteem work, coping strategies, personal development);
 - alternative therapies (e.g. hypnosis, stress management);
 - cultural change (e.g. local champions/peer led services, normalise smoking cessation services, community based support); and
 - providing information (e.g. addiction, NRT, SHS).
- Free NRT/medication and provision of local support groups were perceived very important to improve uptake of smoking cessation support
- Practitioners identified the need to find sustainable ways to access and work with socially disadvantaged groups as service providers were perceived to face a number of challenges to deliver smoking cessation when working with low income women. These focused on three themes:
 - social and community factors;
 - the relationship with the client; and
 - organisational factors.

Despite around half of respondents being involved in some way with community based initiatives delivered to women living in disadvantaged areas, no smoking cessation programme specifically tailored to the needs of women in disadvantaged areas was identified.

4.2 Findings from the Focus Groups (Development of Programme)

As previously described (Chapter 2) four focus groups were conducted with women in living in urban and rural locations in Ireland to explore their views on smoking cessation. The aim of the focus groups was to gain a range of views from different aged female smokers living in socially and economically disadvantaged rural and urban settings. The women were recruited through community based development organisations, community health workers, Youthreach, and training organisations. Within each group there was a mixture of smokers (light to moderate to heavily dependent). To commence each session, the researcher asked the individuals in the group to state what age they were when they started smoking and how many cigarettes they currently smoked. Smokers were also asked to describe previous quit attempts (see Appendix 6 for topic guide).

Most of the older women started to smoke at an early age (aged 11-14), and many of their friends and family are also described as smokers. A number of the participants in both the older and younger groups reported suffering from smoking related illnesses such as COPD and asthma. In the rural group many of the young women started smoking in their early teens (aged 11-14), but in the urban group the pattern was mixed with a number starting to smoke early in the teens but an equal number commencing later in the teens/early 20s. The group who started to use tobacco later did so after starting to use cannabis. Their continued cannabis use was also given by one young woman as a reason for relapse after previous quit attempts.

All four focus groups identified common barriers. These included:

- level of addiction/dependency;
- the culture of smoking within the community/peers;
- the social context of smoking (peers/family); and
- coping with stress.

Women in the older smoker groups (aged 30-55) were more likely to report having received advice from health professionals to quit and/or to describe previous quit attempts. Only a small number of the younger women reported previous quit attempts, and any smoking cessation advice received was given in context of a pregnancy or a chronic health condition (asthma).

When asked what type of approaches might help smokers consider quitting, in all groups the women reported that local champions, accurate information on NRT, and other stop smoking medication would help. It is important to note that in all groups there were discussions about the benefits and disadvantages of NRT as a support to cessation. It was clear that the women were not fully informed about the different NRTs or the other pharmacotherapies available as a support to cessation. Notably, not all were aware of the availability of NRT on prescription for medical card holders. A small number of women held very negative perceptions of the different therapies and feared side effects.

Younger smokers felt that programmes that integrate smoking within wider issues such as health, beauty, fitness, money management might appeal more than a programme focused on smoking alone. Older smokers believed it was important to include a focus on stress management/ self-esteem, and to provide social support. The importance of integrating messages on the health effects of second hand smoke on children was raised by the older women. One woman described how smoking cessation messages delivered via her son's primary school had already prompted her to consider quitting. Similarly, one of the young women with asthma described how her mother quit using NRT as an aid in order to support her cessation attempt. Her mother is still quit but the daughter relapsed. This highlights the importance of the wider family support for successful cessation, and how a quit attempt among one family member can prompt or facilitate quit attempts among other family members.

In one of the groups, the researcher raised the issue of financial incentives to promote and maintain cessation. This idea had mixed responses. Some felt that it might provide a motivation to quit but it would be difficult to implement and was open to abuse. One young woman felt that it would send the message to non-smokers that smokers were being rewarded, which she felt was wrong. Another young woman felt that despite the financial benefits of quitting, and even with an additional financial incentive to quit, no incentive would be great enough for her to quit, as she put it *"I just love my cigarettes and couldn't cope without them"*. This highlights the level of physical and psychological dependency on tobacco even among the younger smokers.

Traveller women highlighted the need for tailored information and support, ideally delivered from community health workers who understood the pressures experienced by travellers (e.g. unemployment, eviction, discrimination). Within the discussions there was a sense of powerlessness and hopelessness among some of the older smokers. This appeared to stem from the poor health status among the traveller community and feed into a lack of motivation to quit. One older woman stated when *"it's your time to go it's your time to go"*.

The women described the culture of tobacco use among the traveller community and highlighted the need to explore ways of discussing quitting that is non-threatening or non-judgemental. They described a lack of trust in health professionals and the need for information and support from their own community to address the culture of smoking. Suggestions included working on other issues and embedding smoking cessation within these approaches rather than delivering a standalone smoking cessation programme.

4.2.1 Focus Groups with Women - Key findings

Overall the barriers described by women smokers echoed those identified by the literature and by service providers. Across the four groups there were a number of common themes. For example, all women described a high level of addiction and dependency on tobacco. Many of the women, particularly the older women, were keen to quit but struggled to do so.

The culture of smoking within the family/peers and wider community emerged as a barrier for all groups. Older women with young children in the family home (children or grandchildren) felt that children were an important incentive to quit smoking or to cut down in the home.

The importance of support from community was felt to be important. Many felt that support from peers who understood their lives would be an asset. Within the traveller community the support of lay health workers was viewed to be particularly important.

Both young and older women had mixed views and understandings of the benefits of pharmacotherapies as a support to smoking cessation, and not all were aware that NRT is available free of charge on prescription for those on medical cards.

In terms of future support programmes, the younger women felt that smoking cessation could be integrated within beauty and fitness programmes, whereas the older women were more likely to suggest personal development, debt management, parenting or self esteem programmes. Both groups referred to the need for stress management.



CHAPTER 5

Identification of Potential Models for We Can Quit (Phase 3)

The report thus far has outlined findings from the literature, from a survey of professionals and from focus groups with women smokers in different parts of Ireland. There are common themes emerging from the first two phases of the research. These include the need:

- to tailor support for women which includes the provision of effective approaches to smoking cessation and removes the barriers to accessing such services
- for support from someone from own community who understands the contexts of women's lives
- to address the culture of smoking within the community and to encourage a cultural shift; and
- to address the wider factors that contribute to smoking e.g. stress, childcare, parenting alone, dealing with debt, low confidence/self esteem etc.

The aim of Phase 3 was to draw together the key messages from the stakeholder engagements (advisory group and esurvey), the focus groups with smokers from disadvantaged communities; and the findings from the rapid review of the international literature to *suggest* potential models/ approaches that might be incorporated within for the *We Can Quit* programme. Having reviewed the available evidence, and reflecting the findings from the fieldwork and literature review the research team identified one approach, which incorporated approaches to address many of the needs identified from Phase 1 and Phase 2. The Sister to Sister (StS) model was developed for women from disadvantaged communities and is currently being trialled in 2 the states in the USA. This model includes the delivery of effective smoking cessation support (e.g. behavioural support and two types of NRT) through a service tailor to women living in low income communities. Based on the findings to date¹, the Sister to Sister approach includes many of the elements described in other community based programmes emerges as the most promising and evidence based example and provides a *starting*

1 The Sister to Sister model is currently being evaluated in different states in the USA using RCT design to assess its effectiveness in different settings and with different profile of low income women.

point for a model that can be adapted to better fit the Irish context.

The Sister to Sister model is described in section 5.1 below. However, key messages from the other studies described in Chapter 3 were also considered when developing the *We Can Quit* model.

5.1 The Sister to Sister (StS) Model

The '*Sister to Sister: Women helping women to quit smoking*' programme has been trialled in African American urban, high poverty neighbourhoods (Andrews et al, 2005, Andrews et al, 2007, Andrews et al, 2012). The intervention has at its core the combination of behavioural support and stop smoking medication that has demonstrated efficacy in trials and effectiveness in observation studies of services, as outlined in Chapter 3. This combination was offered to women as part of a wider community-based that used social marketing approaches and involving a 24 week "multi-level intervention at the individual, interpersonal and neighbourhood level" (Andrews et al, 2012, 133).

The Sister to Sister model is:

- Community based;
- Involves local agencies and organisations;
- Delivers an evidence based smoking cessation support (Behavioural Support (group and individual) + trained counsellors + NRT) to women from disadvantaged communities;
- Provides support from community health workers based in the community;
- Includes relapse prevention element; and
- Employs social marketing to promote cultural change and promote cessation services;

The programme adopted a collaborative participatory approach to engage with the local community by establishing a Neighbourhood Advisory Board (NAB). The NAB included at least 5 local residents to work with those delivering the programme. This board is responsible for establishing other wider tobacco control activities within the local area and promoting the cessation programme by holding a 'kick off' (promotion)

event when it starts (Andrews et al, 2012). At its simplest, the NAB appears to provide local buy in/ support for the treatment elements. In terms of smoking cessation, this is delivered by Community Health Workers (CHWs) and trained counsellors. One to one behavioural support sessions are run by CHWs who are local women who are ex-smokers and who are trained (40 hours training) by health professionals to deliver individual behavioural support. They are referred to as 'coaches' in the programme. The CHWs make proactive contact with women motivated to stop smoking and then meet with them weekly for 12 weeks, with the expectation that a quit date will be set within the first two weeks of meetings. After 12 weeks women can continue to be seen less frequently up to 24 weeks.

Group sessions are delivered by a trained smoking cessation counsellor (with a nursing background in the case of the original Sister to Sister pilot). As with individual sessions, women were expected to set a quit date within two weeks of attending, and on average the groups met for 6 weeks. They consisted of 45 minutes of group discussion followed by individual support or information if required. Nicotine replacement therapy was provided free of charge by the nurse involved in the programme. Initial results from the pilot of the group-based elements of the programme were very promising with 24 hour point prevalence abstinence rates of 80% at 6 weeks and 73% at 12 weeks, with a sustained (continuous) abstinence rate of 60% at two months.

This Sister to Sister model has a number of other community-level components that are described in the papers that outline findings and describe the larger RCT that is now underway following pilot studies (Andrews et al, 2005, Andrews et al, 2007, Andrews et al, 2012).

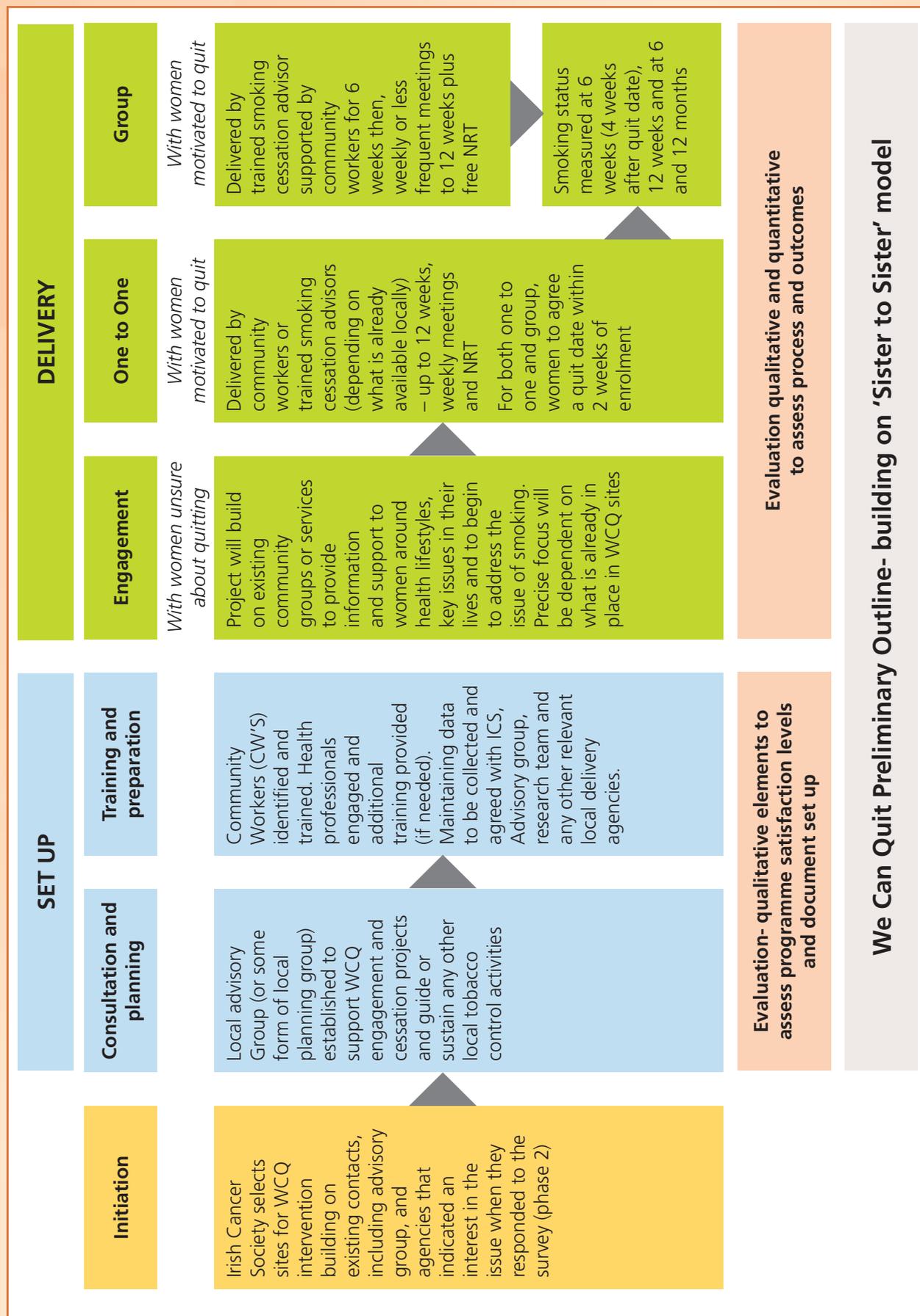
The research team outlined this StS model for the '*We Can Quit*' programme as it appeared to combine what is known to 'work' from efficacy and effectiveness studies with a community-based approach tailored to women living in disadvantaged areas. The elements of the StS model that appeared particularly important for the '*We Can Quit*' model were:

1. the development of a steering group/community oversight group in each community that the programme takes place in to secure buy-in from local community;
2. offering an option of a slightly delayed quit date – so women don't need to sign up and quit on week one, could attend for 2 or 3 weeks before quitting, and be encouraged to cut down during that period;
3. offering a one to one or group option (groups if feasible);
4. providers could be trained lay counsellors rather than health professionals (depending on what is already in place locally);
5. provision of free or subsidised NRT (supply routes to be determined based on what is available locally); and
6. the addition of a relapse prevention element – so women able to return after the weekly sessions have ended

The duration of treatment for groups (6 weeks) in Sister to Sister is similar to what NHS stop smoking services in the UK offer, while the one to one element at 12 weeks is longer. The *We Can Quit* model could be tailored to local resources, but the research team felt that the groups should meet for at least 6 weeks and based on the research team's experience across multiple studies and working with a range of cessation programmes, one to one meetings should also be for at least 6 weeks (ideally more) with less frequent relapse prevention follow up meetings after weekly contact has ended, either face to face or over the telephone. Figure 5 below presents an outline of key features of the suggested model.

This model could be further developed and tailored to meet the specific needs of the women using the service. For example, elements from Australian approach of working with community and voluntary services (Bonevski et al 2011), and the English pilot programme working with children's services to encourage referrals to stop smoking services and smoke free homes (McEwen et al 2012) might be incorporated.

Figure 5: The Proposed Key Elements of the *We Can Quit* Programme





CHAPTER 6

The Design and Delivery of the We Can Quit (Phase 4)

6.1 Introduction

Chapter 5 (figure 8) outlined the high level elements for the *We Can Quit* delivery model a community based smoking cessation programme for low-income women. Phase 4 of the *pilot study* was conducted as a participatory action research project. This chapter sets out how the Irish Cancer Society and local delivery partners developed and implemented the model in two north Dublin communities. It describes how local and national partners used available knowledge and resources to deliver a community based smoking cessation programme to meet the needs of women smokers. It provides a rationale of the principles underpinning *We Can Quit* and outlines the key features of the delivery model. The chapter also describes the processes involved in forming local partnerships to develop and deliver the model; and the steps involved in designing a training programme to support its delivery. Finally, the methods employed by local advisory committees to engage participants in this new partnership approach to health and social service delivery, are presented.

6.2 Rationale

Phase 2 of the study demonstrated that no tailored smoking cessation service provision for women existed at community level in Ireland. The purpose of the delivery phase was to explore how community led, partnership based approaches could be implemented to improve access to smoking cessation services at community level, for a specific population group. Low-income women smokers, living in areas where smoking rates are significantly higher than the national average, were identified as key study participants.

Phase 4 sought to harness the interest and experience of health professionals and community workers to design and develop a delivery model based on the shared values and evidence based disciplines of Health Promotion and Community Development. A participatory action research methodology was adopted to acknowledge the role that voluntary and statutory community practitioner's play in developing new knowledge to

address tobacco related health inequalities through community action².

Gender is a key determinant of health and has a significant bearing on the way women and men uptake and experience health and social services. The WCQ delivery model took account of both the current best practice standards of smoking cessation, and also the principles of gender mainstreaming. Service planners can use gender mainstreaming as a tool to introduce specific measures at local, regional or national level to address gender-related health inequalities, when evidence indicates a difference in outcomes. This provided flexibility within the model to meet the needs of woman smokers.

6.2.1 Core principles of the *We Can Quit* approach

The principles underpinning the *We Can Quit* delivery model are complimentary to current National Public Health, Local and Community Development policies.³

They can be summarised as follows:

- An integrated partnership approach: a proactive way of delivering services by pooling skills and expertise, supported by a local advisory structure
- Participatory evidence-informed action research to develop new knowledge for academic research, policy and practice in an Irish context
- Creating community based responses to high level policies by promoting equality and mutual respect between the community and statutory sector
- Co delivery of the model by community development staff and health professionals
- A non judgmental and empowering approach, based on equality between the service user and the service provider, to increase personal agency
- Integrates social justice issues like poverty, inequality, gender, caring roles and responsibilities into the understanding of the subject area.

2 Irish Cancer Society Strategy Statement; towards a future without cancer 2013-2017

3 Department of Health (2013) 'Health Ireland - A Framework for Improved Health and Wellbeing 2013-2025'. Dublin: Department of Health.

The *We Can Quit* delivery model also takes a women-centred approach to smoking cessation. It offers women a supportive group environment to understand smoking and addiction, where they learn and share from each other, develop skills and increase their confidence to quit. It values women's health for its own sake; aims to empower them to take control of their health; and accepts that women know most about their own smoking behaviour. Designed for women who definitely want to quit, but also for those who want to cut down and make a quit attempt by the end of the programme.

6.2.2 Developing the Delivery Model

To support this action research phase, a delivery model for the *We Can Quit* programme was established to take account of the principles and approaches described in section 6.2 above. It incorporated the findings from the evidence review study, which had recommended a combination of group based behavioural support, one-to-one support and access to combination or dual NRT. The Sister to Sister model presented in the Chapter 5 was highlighted as a good reference point for programme development and delivery.

One of the recommendations of the "Sister to Sister" pilot study was to extend the number of group based sessions from six to twelve. The *We Can Quit* local delivery team used this as their starting point and developed a programme to incorporate the perspectives of the women respondents from the participant focus groups in Phase 2.

The Sister to Sister model was co-delivered by one Nurse Practitioner with expertise in delivering smoking cessation support, and one Community Health Worker providing group facilitation and one-to-one social support. At an early stage, it was realised that this role distinction would not be feasible within the Irish context. However, local partners agreed that a co-delivery model based on joint facilitation between Local Health Professionals and Community Development Officers would provide the best use of the community and clinical resources available locally.

In consideration of the core principles described in the last section, the **key features of the Delivery Model** are presented in box one below:

- Establishment of a local advisory group to identify needs of target population and oversee programme planning and delivery
- Programme design follows the HSE recommended National Standards to Smoking cessation practice
- Co – facilitated weekly group-based support and activities over 12 weeks
- Flexible one to one smoking cessation support and motivational interviewing
- Free access to a 12 week supply of combination Nicotine Replacement Therapy and additional motivational support from Pharmacy
- Programmes explore the need to name and manage fear of failure and to establish what personal success is for participants
- Confidence boosting and celebratory, achievements are shared with family, friends and community, through local media
- Participant follow-up week 6, week 12, week 26 and at one year.

Based on these key features, the train the trainer's programme to support community facilitators in their programme delivery was developed (see section 6.5). The practicalities involved in bringing the delivery model to two selected pilot sites are presented in the next section.

6.3 Background to the Pilot Sites

The process of identifying suitable pilot sites commenced in March 2013. The *We Can Quit* National Advisory Committee (see appendix 1) informed the criteria for selecting sites, based on the principles outlined in section 6.3.2.

Ideally a combination of one rural and one urban setting was favoured. However based on the timescale set and the amount of staff resources available, it was agreed to conduct the pilot in two urban areas.

Irish Cancer Society staff contacted several *phase 2* respondents to discuss their expressed interest in developing smoking cessation programmes for women in their community. Follow up meetings with the Local Development Partnership Companies were held in the summer of 2013; their purpose was to establish a local partnership arrangement to implement the *We Can Quit* action research study.

Based on this feedback, the Irish Cancer Society selected two pilot sites in former RAPID areas of North Dublin to test the *We Can Quit*, model. Both local delivery partners have a strong track record in promoting social inclusion and delivering suitably targeted employment and early-years development programmes to address the needs of their respective populations. An initial target of recruiting 30 female smokers to the programme from each site was set.

6.3.1 Description of Area A

Area A is on the outskirts of northwest Dublin with a total population of over 100,000 inhabitants. It is a relatively young and growing population. 57% of the population is single. 23.5 % of its inhabitants come from minority ethnic communities, the majority of whom live in private rented accommodation. Area A had no community based Smoking Cessation Service, although there was a part-time service available through the local acute hospital. It did however have a strong Primary Care Social Work team, who had identified the need for training in smoking cessation, and a local area partnership with very experienced community workers. The study area mirrored the population of the local primary care centre (approximately 8,000 people). Public and community venues located close to local amenities and bus routes were selected.

6.3.2 Description of Area B

Area B is situated within Dublin City boundaries and has an ageing population. Unemployment, dependency and smoking prevalence rates would

be significantly higher than the National average. This pilot site was different in that it already had an established Stop Smoking Service. Managed by the Local Development partnership, delivered by HSE trained Lay Health Advocates and funded by the Local HSE. An extensive community consultation on the development of a WHO Healthy Communities initiative, had recently been completed. The expansion of the smoking cessation service into other communities within a wider catchment area had been identified as a priority. Based on the consultation exercise, a pilot area of approximately 7,000 residents was selected. This area was prioritised as having less access to local services and amenities, whilst experiencing higher than average levels of socio-economic disadvantage.

6.4 Establishing Local Partnerships

The Local Area Partnership Companies in each pilot study area took the lead role in establishing the local advisory structure. The process commenced in the summer of 2013 with a view to rolling out the first WCQ programme in early 2014. Each advisory group provided guidance on how the *We Can Quit* model could develop, in tandem with current local strategic development plans for community health and social inclusion. Partnership members invited representatives from local statutory and community agencies, to discuss and seek agreement with local delivery partners, on the best way to develop the WCQ model. In each area a number of 'virtual' advisory team members, who could not attend meetings, made themselves available to offer support and advice to their colleagues.

The key areas of responsibility for each local advisory committee were as follows:

- To agree the study area parameters for recruiting participants
- To agree and oversee a recruitment and selection strategy
- Marketing and information dissemination
- Work out time frame for the delivery phase
- Identifying suitable community facilitators to be trained in programme delivery

- To oversee the local resources required to deliver the model.
- Provide critical feedback on the planning and delivery process of the research study.

In September 2013 an advisory group was established in Area A, with representation from local HSE Health Promotion and Primary Care teams, local area Partnership, the Irish Cancer Society and local community organisations. The Advisory committee met 8 times over a 12 month period to inform all aspects of pilot programme delivery. Due to the tight timeframe set, members of the advisory committee were also actively involved in promoting the programme to potential study participants and in the delivery of the model.

In Area B it was agreed in principle that the delivery of the *We Can Quit* should feed into a sub group of the Local partnership's Healthy Communities initiative. However, as a interim measure, a planning group involving the Partnership representatives, the Stop Smoking Service, the Irish Cancer Society and local community based women's organisation was established to co-ordinate the delivery of the pilot programme.

6.4.1 Role of the Community Pharmacist in Providing NRT

The smooth provision of free NRT to programme participants was seen as crucial to the implementation of the *We Can Quit* model. Resource limitations in terms of time and staff meant that national approaches to accessing free or low cost NRT were not pursued. Instead a local arrangement was devised approximately 6-8 weeks before the programmes commenced. The Irish Cancer Society approached 4 community pharmacies located in the selected pilot areas. Community Pharmacists were invited to dispense combination NRT therapies to *We Can Quit* participants, who wanted to avail of it. Monitoring arrangements in terms of NRT selected and a system for billing and accepting GMS prescriptions were made. The NRT was made available in two ways:

- For medical card holders (with free access to GP care) - the woman was asked to make an appointment with GP for the free prescription of NRT

- For women without medical cards – the local pharmacist dispensed the NRT.

Pharmacy staff got behind the programme and played a crucial role in ensuring that the NRT was appropriately administered and monitored to Participants. They also provided further motivational support to *We Can Quit* Participants. In September 2014 two community pharmacies accepted a seat as partners on the local *We Can Quit* Advisory Structure.

6.5 Preparing for Delivery

This section describes the processes involved in developing a training and capacity building plan for programme delivery. Community Facilitators were selected by local partners, based on an agreed role description. The training components of the *We Can Quit* train the trainers programme, based on the 12 week plan, are shown below.

6.5.1 Recruiting the Community Facilitators

Both local area partnerships had a good supply of community development staff, all with a wealth of knowledge of the issues affecting women in their area. Some had direct lay health work experience; one had expertise in delivering smoking cessation interventions and others with strong group facilitation skills and or direct experience working with the target group. The community facilitators were also women who worked and/or lived in the two pilot communities. All except one was an ex-smoker.

The principle of equity in the partnership was employed with equal numbers of Health Professionals from the Primary Care Social work team (5), Community Development Officers (6) and Lay Health Advocates (4) being trained up to deliver the *We Can Quit* community programme. The programme design highlighted the value of all aspects of each smoking cessation programme being delivered by two facilitators, one from the community and one from the health service.⁴

4 In Area B Lay health advocates from HSE funded Healthy food made easy programme and the local Stop Smoking service co-facilitated the programmes.

6.5.2 Training the Community Facilitators

The *We Can Quit* train the trainers programme was developed by the Irish Cancer Society and Health Promotion and Improvement (HSE). The HSE has a training remit in tobacco and delivers the Brief Intervention for Smoking Cessation training, in line with best practice internationally.

Angela King, King Consultancy, equality and health promotion training specialist, was commissioned by the Irish Cancer Society to co-ordinate the training of trainers component of the pilot programme. She provided ongoing mentoring and support for community facilitators during the delivery phase of the programme.

The aim of the *We Can Quit* training the trainers programme was to increase the capacity of the Community Facilitators to engage and support low income women who smoke, to quit; and to provide them with the necessary knowledge and skills to deliver the WCQ 12 week group based smoking cessation programme to women in their local communities.

The training programme was adapted from the original Sister to Sister (StS) model⁵ incorporating group based behavioural support, one to one support and the provision of two types of NRT. The Training co-ordinator compiled suitable training materials incorporating the HSE smoking cessation standard, the HSE/NWCI Training guidelines for Gender mainstreaming and other relevant health education and promotion materials from the Irish Cancer Society.

The main components of the training programme were as follows:

1. The context and rationale for the programme, exploring the role that gender and the other determinants of health play in smoking and quitting

5 The Sister to Sister model, originally developed in the United States of America for low income African American women smokers in urban neighbourhoods, is currently being evaluated in the different states of the USA using a RCT design to assess its effectiveness in different settings and with different population groups of women.

2. Tailored smoking cessation training based on the HSE accredited Brief Intervention for Smoking Cessation (BISC) based on the needs of the trainers and intended beneficiaries.⁶
3. Building a holistic, women centred and empowering approach to health and wellbeing throughout the programme; and addressing how smoking relates to other lifestyle factors by exploring the benefits and barriers to living a healthy life.
4. Skills development through group facilitation skills, brief intervention techniques and motivational interviewing, confidence boosting activities, the Community Facilitator's role in record keeping, and supporting the ongoing monitoring and evaluation of the Programme.
5. Exploring other social supports and community resources available to women locally and agreeing ways to integrate them into the programme.

6.5 Supporting the Community Facilitators

A key element of the training component of *We Can Quit* included the training, mentoring and support of the Community Facilitators. The facilitators received two and a half days training to deliver the programme, with follow-up weekly phone calls or text messages to provide additional support. This was also an opportunity to reflect on issues that may have arisen.

The community facilitators also met during the programme delivery phase to plan and evaluate their sessions. At this stage they were asked to give feedback on the programme from the perspective of the training, recruitment, delivery etc. This allowed feedback on the individual components of the programme. The feedback from the training component was very positive with most trainers acknowledging the value and relevance of the training.

Their recommendations (see 8.2) shaped the revised procedures in the *We Can Quit* programme and were included in the Train the Trainers Guide,

6 Also included motivational interviewing approaches and techniques, health effects of smoking, tobacco addiction, the benefits of quitting and the evidence based aids to quitting including pharmacology.

the Community Facilitators' pack and the Participant pack. It is anticipated that the Train the Trainers Guide will be used as the basis for rolling out the *We Can Quit* programme by other HSE Trainers regionally or nationally.

6.6 Programme Delivery

The processes described in the previous sections indicate the level of commitment and energy from everyone involved in the partnership to make the programme happen. One of the most challenging aspects of the Delivery phase was finding women smokers to participate in each of the pilot sites within the time frame set. A description of the recruitment procedures and processes is presented below.

6.6.1 Recruiting the Women

The establishment of open and transparent recruitment, selection and referral processes was a key consideration for both the Local Advisory Committee and the Research Ethics Committee. The inclusion criteria required participants to be at least eighteen years of age and not pregnant, live in the designated catchment area and self-report as a current smoker. The programme was aimed at women who have either made an unsuccessful quit attempt or who express a clear intention to quit smoking. A system of referral to HSE smoking cessation services for women and men who did not meet the inclusion criteria was set up. Further selection criteria to give priority to the most disadvantaged smokers, such as those currently engaged in community employment schemes, early years development and young parenting programmes, were put in place. These were not implemented as none of the programmes were oversubscribed. The community outreach and social marketing methods used to engage a target of 60 low-income female smokers are described below:

6.6.2 Promoting We Can Quit

Social marketing was identified as a key element of the *We Can Quit* delivery model. Local delivery partners planned to build on the coverage given to the HSE National Quit campaign, which ran from mid January 2014. Promotion for the local programme commenced in January through the

local media and community newsletters. Women were invited to come to information sessions up to 4 weeks before the programme was due to commence. Participants were offered the choice of a morning or evening programme. Three main methods of social marketing were used to target women in both sites as follows:

6.6.3 Traditional Promotion Methods

The local delivery partners used their contact lists to announce the arrival of the programme by letter to key clinical and community stakeholders. The Partners asked them to support the initiative by spreading the word. A community flyer was circulated to 60-80 stakeholders and 15 relevant health care providers in Areas A and B. Flyers and posters were displayed in community centres, local health centres and GP surgeries. Advertisements were placed in community newsletters (circulation 10,000) local newspapers and local community radio. The Clinical community were contacted through emails sent by HSE Primary Care development co-ordinators. In Area A, all local schools were contacted through the Home school liaison teachers.

6.6.4 Active Methods

Community facilitators attracted women onto the programme using word of mouth or face-to-face conversations. A number of opportunities to engage directly with participants are highlighted below:

- Drop-ins to community groups and other community events
- Brief interventions with individual participants attending health and social services including GP and pharmacy
- "Taster" information sessions for women currently involved in community-based programmes to gauge their interest in the programme.
- Brief intervention stands at an annual adult education festival.

At the planning stage, briefing sessions were suggested for community development staff local primary care teams, particularly GP's and Public Health Nurses. Due to time constraints on the part of the WCQ team, only one GP practice was briefed about the programme in Area A.

6.6.5 Social Media

In Ireland (RoI) Social media usage rates are known for each of the occupational classes. Over 80% of people in categories AB, B-C1, C2 have access to least one type of Social media. For social groups D,E and F the usage rate is just under 50%. (*Safefood Ireland, 2014*) The Irish Cancer Society uses a variety of social media to communicate its awareness raising campaigns to its on-line community (over 135,000 Facebook fans). The *We Can Quit* pilot provided the opportunity to target low income women smokers, via this medium, for first time.

Area A

Two targeted Irish Cancer Society page posts went out in February to announce the programme. This reached a potential audience of 4,600 women. A further two Facebook advertisements were circulated to Facebook users in the Area A for 4 days between the 7th and the 11th of February. The frequency of this campaign was high, with each person in the target audience viewing the ad on average six times. As a result, 6 people registered on line, 3 out of the 4 on line participants who attended the programme completed the course. This was a cost of roughly €25 per online recruit.

Area B

Two targeted Irish Cancer Society page posts went out in February to announce the programme. This reached a potential audience of 2,290 women. Three Facebook ads were sent on St Valentine's Day, two aimed at women and one aimed at men (710), to encourage them to ask "the ladies in their life" about quitting. An ad was posted again on a local organisation's Facebook page in late March and early April. There was a low response rate to the ad. No one registered on line, although approximately 49 people clicked on to the site and 42 people shared or like the ad.

6.6.6 Selecting Suitable Venues

Each local advisory committee identified suitable community venues in their respective catchment areas for programme delivery. In advance of their social marketing activities, Area A selected a well-resourced community managed building that charged reasonable rates for room rental; and a newly built primary care centre, provided by the HSE in kind.

There was less choice of amenities available in Area B's selected catchment area. There were difficulties in terms of block booking space for a 12-week duration, due to the size of buildings and the level of existing community demand. This impacted on the social marketing activities of the advisory committee and affected the direct recruitment opportunities for the local staff on the ground. Once two best available venues had been agreed, a second round of traditional promotional activities took place. The schedule for programme delivery was delayed by 6 weeks.

6.6.7 Promoting the Partnership Approach to Smoking Cessation

The local delivery partners were keen to demonstrate that the community were behind the participants, supporting them in their quit attempt. During the programme participants received "freebies or goodies" such as stress balls, cash cans, branded mugs, cosmetics and pens. Although these gifts were not a necessity, they communicated the message that key community organisations were supporting their efforts to quit. It encouraged good attendance at key sessions particularly at weeks 6 and 12, when participant monitoring took place.

Finally, the celebration event at the end of week 12 provided a further opportunity to reinforce the continued commitment of the local delivery partners to support smoking cessation in communities where it is needed most. It acknowledged the improvements women had made to their health and the benefits they had brought to family and friends. Group photographs were sent to participants and the local newspapers to highlight their achievements and to encourage others to seek support to quit.

6.7 Summary

The target of recruiting 60 women onto the *We Can Quit* programme proved to be more challenging than anticipated. A total of 48 women expressed an interest in the programme during the recruitment process. This translated into 39 participants registering to take part in the study.

The working relationships between the organisations described in this chapter took time to build. Partners have demonstrated their willingness to work together in common purpose. The aim is to build healthy tobacco free communities, with full community support, to reduce the burden of ill health and normalise quitting. The experience of those directly involved in both the planning and delivery of the programme are captured in the next chapter.



CHAPTER 7

Findings from the Evaluation of the We Can Quit Pilot (Phase 5)

The purpose of this chapter is to present key findings from the evaluation of the service delivery component of the *We Can Quit* programme. As described in Chapter 6, the *We Can Quit* pilot was delivered in two areas in North Dublin. The service delivery elements of the pilot were evaluated using a prospective observational cohort study designed to follow up all women who participated in the programme.

Different data were collected from the participants and key stakeholders during course the research:

- Baseline measurements (key demographic data, smoking history, previous quit attempts, smoking status, which included a CO breath test);
- Routine monitoring data collection at each visit (which included smoking status validated by a CO breath rest);
- An anonymous client satisfaction survey (CSS) (n=29);
- Telephone interviews with a sample of participants (n=8); and
- An anonymous survey of key stakeholders (n=14) involved in the planning or delivery of the *We Can Quit* pilot followed by a stakeholder event with (n=29 participants) to discuss the findings

7.1 Analysis of Baseline and Monitoring Data

We start by presenting the key findings from the baseline and monitoring data and draw on findings from the client satisfaction survey where relevant. Information from all women who consented to participate in the research was collected by the group facilitator at baseline, 6 weeks (which was 4 weeks after they set a quit date), and 12 weeks after the programme commenced. The baseline data gathered information on socio-economic status (SES), smoking behaviour, and smoking patterns

of family. Smoking status was assessed at 6 and 12 weeks, involving biochemical validation with a carbon monoxide (CO) breath test. Data was also collected on the range of interventions received including NRT.

The findings from the analysis of monitoring data are presented in the sections below. However, before presenting the data it is important to describe some caveats around the interpretation of the findings.

7.1.1 Limitations of the Analysis of Monitoring Data

As previously discussed in chapter 6, one of the key challenges for this pilot study was to find female smokers living in disadvantaged areas of Ireland who might be interested in stopping smoking, recruit them to the programme and help them maintain adherence to the programme. Despite several innovative strategies to facilitate this (discussed in chapter 6) the number of women who signed up was not sufficient to allow analysis beyond simple frequencies and cross tabulations. This means that the analysis could not examine how the characteristics of participants or the type of support they received affected outcomes. For example, we know from the literature that factors such as determination to quit, nicotine dependence and age can affect who stops smoking and who does not, but due to the sample size in this study, any differences observed may have been due to chance. However, we are able to draw on findings from our recent research, particularly a national evaluation of Stop Smoking Services in England, to help contextualise the *We Can Quit* quit rates (see Box 2). It is also worth emphasising that despite the limited quantitative analysis possible of monitoring data, we do have a number of other data sources to draw on (such as the survey and qualitative work) which provide further evidence to inform future plans for *We Can Quit*.

Summary Box 2: Effectiveness of NHS Stop Smoking Services in England

NHS stop smoking services in England were established from 1998 and offer a combination of behavioural support (one to one or in groups) and stop smoking medication (NRT, varenicline and/or bupropion). The first national evaluation of the services (Ferguson et al, 2005) was conducted between 2000 and 2004 and found CO validated quit rates of 54.6% and 14.6% at 4 and 52 weeks respectively (n=2069).

Members of the research team have just completed a subsequent national study of services in England, following a period of substantial change for the services and an expansion to less intensive (i.e. pharmacy and general-practice based one to one support) behavioural support. Findings from this study, completed in November 2014 (Dobbie et al, 2014), were CO validated quit dates of 44.1% and 9.3% at 4 and 52 weeks (n= 3057).

Reporting the outcome of participant quit attempts was measured in two ways in *We Can Quit*: point prevalence and continuous abstinence. These measures are standard reporting measurements for smoking cessation programmes.

- **Point prevalence** means smoking status at the time the question was asked. It is a less robust measure as it allows for relapse between the time of starting the quit attempt and the follow up point.
- **Continuous abstinence**, on the other hand, means no smoking since a quit date was set. Both are presented in the findings.

The Russell Standard (West et al 2005) provides guidelines for evaluating smoking cessation

interventions and services. Based on definitions in the standard of short and longer term abstinence, at 4 week follow up clients are allowed to smoke in the first two weeks and at twelve months clients are allowed to smoke up to 5 cigarettes in the previous 50 weeks and still be counted as abstinent from smoking.

The *We Can Quit*, clients were asked at 6 weeks (which was 4 weeks after they set a quit date) and 12 weeks whether they had:

- quit and remained quit
- quit and relapsed and quit again

Thus the cessation rates for *We Can Quit* and the evaluations of the UK Stop Smoking Services are not strictly comparable.

7.1.2 Participant Characteristics

Thirty-nine women signed up to participate in *We Can Quit*, with a fairly even split across the two study sites of Area A (51%) and Area B (49%). The age range of participants was 24 – 66 years, with a mean age of 45. One fifth (21%) lived with a smoking spouse or partner and most participants self-reported one or more medical conditions⁷ (64%). Around two thirds (64%) had 1 or more indicators of low socio-economic status⁸ which suggests that the target demographic (women living in deprived areas) was reached (Table 7.1).

7 Medical conditions were high blood pressure, heart problems, diabetes, respiratory problems, stroke, ulcers, bad circulation, under/overactive thyroid, skin problems.

8 Indicators of low socioeconomic status were unemployed or unable to work due to sickness or disability, no educational qualifications or junior certificate, rental housing and lone parent household (client indicated that they were the sole adult in a household with children).

Table 7.1: Client Characteristics at Baseline (Week 1)

	n	%
<i>Socioeconomic status</i>		
0 indicators of low ses	14	35.9
1 indicator of low ses	12	30.8
2 or 3 indicators of low ses	13	33.3
Total	39	100.0
<i>Marital status</i>		
does not live with spouse or partner	16	41.0
lives with smoking spouse or partner	8	20.5
lives with non smoking spouse or partner	7	17.9
Unknown	8	20.5
Total	39	100.0
<i>Household</i>		
Lives with a smoker	18	48.6
Lives with only non smoker(s)	15	40.5
Lives alone	4	10.8
Total	37	100.0
<i>Support for quit attempt</i>		
Has support	32	84.2
No support	6	15.8
Total	38	100.0
<i>Determination to quit</i>		
Extremely determined	14	37.8
Quite or very determined	23	62.2
Total	37	100.0
<i>Serious quit attempt in the last year</i>		
Yes	15	40.5
No	22	59.5
Total	37	100.0

	n	%
<i>E-cigarettes</i>		
Yes in the past	17	51.5
Yes currently	5	15.2
No	11	33.3
Total	33	100.0
<i>Medical conditions</i>		
no conditions	14	35.9
1 condition	11	28.2
2 to 5 conditions	14	35.9
Total	39	100.0
<i>Site</i>		
Area A	19	48.7
Area B	20	51.3
Total	39	100.0

Attrition

Of the 39 women who initially signed up to *We Can Quit*, 27 (69%) were followed-up at week 4, and 26 (67%) were followed-up at week 12. Ten of the 39 participants who signed up and completed the baseline monitoring form but never engaged with the programme beyond this (i.e. did not return for further sessions). Thus, the main drop out happened early on in the programme, before the quit date, which was four weeks into the programme. However, once women got to four weeks post quit date, most remained in the programme to be followed up at 12 weeks. Participants who remained with the programme were more likely to: have higher socio-economic status; live with a non-smoking spouse or partner; have support to quit; be extremely determined to quit and to have made a serious quit attempt in the last year. Once again, the caveats around small sample size should be considered because the relationship between cessation outcomes and these characteristics are not significant.

7.1.3 Awareness of We Can Quit

The majority of participants signed up to *We Can Quit* because they wanted to stop smoking (82%), but there were a small number (24%) who were interested in learning more about quitting or to cut down. Awareness of *We Can Quit* came from a variety of sources (Table 7.2) with different forms of marketing (41%) and word of mouth (29%) being the most popular modes of communications. Table 3.2 shows that awareness from the health and community setting was lower in comparison to informal and marketing approaches. However, this should be treated with caution due to ambiguity

around the answer option 'word of mouth'. Feedback from the local stakeholder dissemination workshop (held in November 2014) highlighted that some women may have considered learning about the programme from a social worker or community worker 'word of mouth'. For example, one explained that she had encouraged one of the women in her area to sign up to '*We Can Quit*' when she met her as she was leaving the centre, this she argued could possibly be interpreted by the woman as word of mouth rather than a formal referral from a health worker.

Table 7.2: How Clients Heard About the Service

	n	%
Informal		
Word of Mouth/friend	11	29.0
Work	4	10.5
Marketing		
Leaflet	6	15.8
internet (3 from facebook)	4	10.5
Local Paper/Newsletter	4	10.5
Information session	2	5.3
Health Professionals		
Pharmacy	2	5.3
GP	3	5.9
Social/community		
Parenting Project	2	10.6
Community Group	1	2.6
Referred by community/social worker	1	2.6
Tobacco control		
Smoking Cessation Advisor (quitline) or group leader	1	2.6

Base=38

7.1.4 Type of Intervention Received

A variety of types of behavioural support was offered to participants with group support being the most common (89%)⁹. In addition, 82% used some form of NRT to help their quit attempt (discussed in more detail below).

Table 7.3: Interventions Received

	n	%
Attended a group	25	89.3
Attended one to one	10	35.7
Received text message	16	57.1
Received telephone support	13	46.4
Took NRT	24	85.7

Base N= 28 (Respondents were asked to tick as many as apply)

Similar results were found in the CSS with group support (86.2%), NRT (93.1%) and 'We Can Quit' (92.8%) being the most popular form of support that participants would engage with should they start to smoke again. This is in contrast to telephone (40%) and one to one supports (52%) which were viewed less favourably (Table 7.4)

Table 7.4: Source of Support Should Participants Start to Smoke Again (CSS)

	n	%
Telephone support through Quitline		
Yes	10	40
No/unsure	15	60
Total	25	100
Group support		
Yes	25	86.2
No/unsure	4	13.7
Total	29	100

⁹ Given that all the women attended the WCQ group at some point.

	n	%
One to one		
Yes	13	52
No/unsure	12	48
Total	25	100
NRT		
Yes	27	93.1
No/unsure	2	6.9
Total	29	100
We Can Quit		
Yes	26	92.8
No/unsure	2	7.1
Total	28	100

Nicotine Replacement Therapy

As discussed in Chapter 6 *We Can Quit* provided access to free NRT. Single and combination NRT products were used by participants (46% used a single NRT product and 54% used more than one). The most common form of NRT was a patch 61%, followed by an inhalator (43%) (Table 7.5). Nearly all (93%) of the participants who completed the client satisfaction survey found NRT to be very helpful or helpful.

Table 7.5: Type of NRT Used

	n	%
Type of NRT		
Patch	17	61
Inhalator	12	43
Gum	3	18
Nasal spray	4	14

Base = 28

7.1.5 Cessation Outcomes

A key question for the pilot evaluation of *We Can Quit* was to capture any change in quit rates which were measured using self-report and validated via a Carbon Monoxide (CO) breath test at baseline, 4 and 12 weeks. As discussed in section 7.1.1 quit rates are presented in two ways: point prevalence and continuous abstinence. Results are presented in Table 7.6.

The CO validated quit rates at 6 weeks (4 weeks after quit date was set) were: 41% point prevalence and 20.5% continuous abstinence. At 12 weeks point prevalence was 46% and continuous abstinence 20.5%. A key point to note is that quit rates do not change between 4 and

12 weeks, which is unusual as we would normally expect to see a substantial decline in quit status at the 12 week follow-up period. We have outlined above (in Box 2) 4 and 52 week quit rates from two large prospective studies, conducted a decade apart, in England. Routine monitoring data from UK services is also available. This has some caveats but data from stop smoking services in Scotland is particularly useful as there both 4 and 12 week outcomes are recorded (in England only 4 week follow up is mandatory, hence why the two research studies previously mentioned were conducted). For example quit rates (self-report) at 4 and 12 weeks for Stop Smoking Services in Scotland in 2012 were 38% and 5.5% respectively (ISD, 2013).

Table 7.6: Quit Rates

	'Self' report		CO validated	
	N	%	N	%
Total in sample	39	100	39	100
point prevalence at 6 weeks	20/39	51.3	16	41.0
point prevalence at 12 weeks	18/30	46.2	18	46.2
continuous abstinence at 6 weeks	8/39	20.5	8	20.5
continuous abstinence at 12 weeks	8/39	20.5	8	20.5
continuous abstinence at 6 & 12 weeks*	6/39	15.4	6	15.4

* There were 2 clients who said they had stopped smoking without relapse at 12 weeks but whose answers at 6 weeks contradicted this. Note that the client with no data at 6 weeks was assumed to have been continuously abstinent. 6 week follow up occurred 4 weeks after the quit date

Table 7.7 present quit rates excluding those who dropped out after baseline, this improved the quit rate. At 6 weeks the CO validated point prevalence was 55.2% and 20.5% continuous abstinence. At 12 weeks CO validated point prevalence was 62.1% and continuous abstinence 27.6%.

Table 7.7: Quit Rates (Excluding Drop Outs)

	'Self' report		CO validated	
	n	%	N	%
Total excluding drop outs	29	100	29	100
point prevalence at 6 weeks	20/29	69.0	16	55.2
point prevalence at 12 weeks	18/29	62.1	18	62.1
continuous abstinence at 6 weeks	8/29	27.6	8	27.6
continuous abstinence at 12 weeks	8/29	27.6	8	27.6
continuous abstinence at 6 & 12 weeks	6/29	20.7	6	20.7

6 week follow up occurred 4 weeks after the quit date

As noted above the base numbers are too small to tease out the factors that influence cessation outcomes for the *We Can Quit* sample. However, the recent evaluation of English Stop Smoking Services identified several factors that influenced longer term quitting which are listed below (Dobbie et al, 2014). It is worth emphasising that these factors are the same as those identified in a number of other previous studies. The ones listed were also found to be predictors of quitting for *We Can Quit* participants (albeit not significant) which means that we can have a greater level of confidence in interpreting the results.

- Being older
- Having a higher wellbeing score
- Having a higher socio-economic status
- Having a lower dependence on tobacco
- having fewer smokers among friends and family
- Attending group support.

Summary Box 3: Quit rates at 6 weeks and 12 weeks

The overall numbers of those signing up to the *We Can Quit* were relatively small, with a quarter of the group dropping out before week 4. However, for the 29 women who remained with the programme, the longer term outcomes were good. **At 6 weeks the CO validated quit rates were 41% point prevalence, and at 12 weeks point prevalence was 46%.** Women who had stopped by four weeks after their quit date maintained abstinence at the 12 week recording point. This is important, and **feedback from the women indicates that the quality of the behavioural support delivered by staff, combined with the access to free NRT played an important role in the programme's support.**

7.2 Findings from the Client Satisfaction Survey and Feedback Interviews

Feedback from participants was an important part of the process evaluation of the *We Can Quit* programme. Through the client satisfaction survey (CSS) and semi-structured interviews with women after the programme had ended, the research aimed to identify the features of the programme that (a) contributed to successful quitting or (b) did not work well. Client satisfaction was assessed using an anonymous self completion survey administered to all women at the end of the programme. Overall 29 of the initial 39 participants completed the client satisfaction survey providing a response rate of 74%.

The client satisfaction survey had six sections.

1. Type of support received
2. Type of support they would seek if needed it in future
3. Satisfaction with different elements of the programme
4. Type of NRT offered and what used
5. Views on the NRT
6. Overall views on the *We Can Quit*

Relevant findings from the client satisfaction survey were combined with the findings from the follow-up interviews with a sample (n=8) of participants after the programme ended. A semi-structured interview guide was used during the interviews, and covered similar themes as the self-completion questionnaire. However, the interview also focused on exploring the aspects of the *We Can Quit* Programme that worked well, and if there was anything that did not work or could be improved. Women were selected at random from the list of participants who, at registration, had given their consent for an independent researcher to contact them at the end of the programme. A purposive sampling strategy was used to ensure the sample represented participants from the two pilot areas, and included women who had not completed the programme as well as those who had remained to the end. Of those interviewed, 6 had quit at the end of the programme, 1 had quit during the programme but relapsed, and one had cut down to

stop smoking. The woman who cut down to stop smoking dropped out before week 4 but reported she has still cut down and is preparing to make her quit attempt.

One of the women who quit at end of the programme was interviewed five months after the start of the programme, this participant was quit at the end of the programme and remained quit for four months but circumstances led to her and her young family being made homeless, which resulted in her smoking again. This participant was adamant that when her housing situation was sorted she would make a further quit attempt.

The data from both the interviews and the client satisfaction survey were combined, and analysed using a thematic content approach.

7.2.1 Reasons for Attending

To begin each of the interviews, women were asked how they heard about the *We Can Quit* programme and their reasons for, and their expectations when joining the group. As would be expected from the monitoring data gathered at week 1, the main source of information about the programme was via local media and word of mouth.

As the monitoring data indicated that approximately two thirds of participants reported having one or more health conditions, it is not surprising to learn that most of women interviewed wanted to stop smoking for health reasons.

I was worried about my health I couldn't walk a block to the shops, I'd be out of breath and would be really gasping and I decided that was it (Individual interview, quit at end of programme)

I needed to give up for health reasons. I am waiting for an operation on my lung not cancer like but a large lump....before Christmas I started to get ready to quit, I had cut down so the time was right for me to join the group. (Individual interview, quit at end of programme)

My health was starting to fail, and I said to myself it was time to stop smoking. I joined the group, it was the best thing I did for myself in a long long time. (Individual interview, quit at end of programme)

However, the interviews suggest that group support was also an important driver to join *We Can Quit*.

I joined the group because I needed help, and from the group I made new friends. (Individual interview, quit at end of programme)

In both the client satisfaction survey and the interviews, participants were asked to recall how they felt about joining the group, and if they felt anxious at all. Only a small number of women (4/26 16%) reported they felt anxious most of the time or some of the time, but all (26/26) reported that they felt comfortable being part of the group.

Nervous – I wasn't nervous I knew everyone was there for the same reason (Individual interview, quit at end of programme)

One woman described being dubious about the course at the beginning, but decided to give it a try.

I went to the group very sceptical thinking 'how can talking help me quit' but once I was there I knew I kinda liked this. (Individual interview, quit at end of programme)

Summary Box 4: Drivers for Attending the *We Can Quit* Programme

The main reasons for attending the *We Can Quit* programme were:

- Group support
- Health concerns
- Support to quit

7.2.2 Support Received

The client satisfaction survey focused on the smoking cessation support received during the *We Can Quit* programme, asking participants which support they had received, how often they availed of the group support and the one to one support, and if they wanted to stop smoking in the future (if relapsed) which supports they would seek. Tables 7.8 and 7.9 below provides the responses to these questions.

Table 7.8: Support or Help Used During Programme

	'Self' report	
	n	%
Base:	29	100
NRT	27/29	93
Group support	29/29	100
One to one support	9/29	31
Text support	14/29	48

Table 7.9: Support or Help Participant Would Use in Future if Needed

	'Self' report	
	n	%
Base:	29	100
NRT	20/29	69
Group support	25/29	86
One to One support	14/29	48
Call free quit-line	10/29	34
Go back to <i>We Can Quit</i>	27/29	93

Please note the bases can differ due to not relevant responses or missing responses.

All the women reported using the group support, with most attending all or nearly all of the sessions (only 2 of the respondents indicated that they had attended only 1 or 2 sessions). All but two of the women reported using the NRT as an aid to quitting. Almost half (14 48%) of the women had received text support, but a smaller proportion of women reported receiving one to one support (9 31%). However, during the interview it emerged that one to one support was provided before or at the end of the group sessions, and some received additional telephone support.

The group support approach appeared to be an important support for women, with nearly all indicating that if they needed support to stop smoking again they would attend group

support (25/86%) or go back to the *We Can Quit* programme (27.93%). Seven in ten (20.69%) would use NRT, half (14.48%) would seek one to one support, but only a third (10.34%) would seek support from the Quitline.

It was evident from the CSS responses and from the interviews that the women felt the group provided an extremely important support for the women.

Very good course, great support to be able to talk face to face with like minded smokers who wanted to quit then quit. XXX were excellent. Good information and advice plus easy to speak to. Plus the fact they were ex smokers helped. (CSS)

The group were great, they provided genuine support, all ages 60s, 50s, 40s to 30s and 20s, a good spread married divorced single. (Individual Interview, quit at end of programme)

Group support was an important and popular form of support, with all participants reporting attending all or nearly all of the group sessions.

In the group everyone is giving up their time. You want to give it your best shot. (Individual Interview, quit at end of programme)

From the interviews it was evident that the women supported each other in other ways, helping them deal with hardships they encountered along the way.

I hadn't expected as much support as we got from the group. Our group was great. One of the women had an aunt, who had lung cancer, and she had a couple of family bereavements, but the group supported her. It was like a group therapy. We would tell each other things we wouldn't tell anyone else (Individual Interview, quit at end of programme)

It took us a couple of weeks to gel, but when we got on we were telling each other things we wouldn't have told other people. You got support that was genuine. (Individual, Interview quit at end of programme but relapsed at interview)

A number of the women commented that the combined group support and access to NRT had made the difference for them.

I had tried the group support before – but for me it made a difference having access to the two NRT. (Individual Interview, quit at end of programme)

This is the second time I went to a group for support. But this time with the patch and the gum it made all the difference (CSS)

As might be expected, the facilitators were viewed as playing an important role in the success of the programme. In all but one of the interviews, the women were glowing in their feedback on support provided by the facilitators. This was echoed in the CSS responses.

The co-ordinators were two super people (Individual interview, quit at end of programme)

The extra supports, they knew all the tricks etc. (Individual interview, quit at end of programme but relapsed at interview)

I hadn't expected as much help as we got from the two girls. One was like your mammy, a bit strict and the other was like your sister. They worked well together. Some of the women thought one was a bit stern but they realised afterwards she needed to be. (Individual interview, quit at end of programme).

One woman, who was cascading the advice from the group to support her partner who quit on the same day, commented how much the facilitators supported the both of them to stop smoking.

The two facilitators were great. They complemented each other...the mammy one was brilliant, she was strict, and that helped. They really supported me and my partner. (Individual interview, quit at end of programme).

The importance of having an ex-smoker facilitate the group was raised by a number of the women in both the CSS and the interviews.

The advisors, if one is a non-smoker that would be OK but two non-smokers wouldn't work. You need to understand the longing for the cigarette. They have to know what you are going through. (Individual interview, quit at end of programme but relapsed)

In the CSS, less than a third (9/29) indicated they had received one to one support. However, during the interviews it was evident that different understandings of one to one support may have contributed to this low proportion. It would appear that most understood the one to one support to be the quitline or separate advice sessions.

One to one, if you need help you can get the advice from the mentor or the quitline. I spoke to the facilitator to explain what happened about losing my job – she was great and said I could contact her anytime. I am thinking of giving up again, now I have sorted out work. (Individual interview, quit but relapsed at time of interview)

I didn't use the helpline but was good to know that it was there. A few of the other ladies who didn't have support used it and found it really good (Individual interview, quit at end of programme)

Many described receiving one to one support during the group sessions, before it commenced or at the end.

... listened to you, if you were feeling down she talked to you. (Individual interview, quit at end of programme)

When I would come out from the group, I'd think to myself that was a laugh. But you knew why you were there, and you knew you had their numbers {facilitators mobile} if you felt that you needed a cigarette. It was a good backup. (Individual interview, quit at end of programme)

At all group contacts, the ladies checked our CO and asked us to write how we were feeling...the facilitator gave me her number so I could ring her if I needed anything (Individual interview, quit but relapsed at time of interview)

In the CSS the respondents indicated that the CO monitor was used during all or nearly all visits, and all but two (26/28 93%) of the respondents felt this to be helpful or very helpful.

Found CO test helpful. I thought it was great motivational test in keeping you on track. (CSS)

When you did quit it was brilliant especially when you went over to the CO monitor seeing the levels going down. When I first did it I was very nervous but seeing them go down made a difference. It was like going to weight watchers and seeing the scales go down. The others in the group are encouraging; you don't want to go in smoking and letting the group down. (Interview quit, at end of programme but relapsed).

Two women were unsure about the monitor. It emerged during the interviews a small number of women were not consistently positive about the monitors as they experienced an element of frustration when not getting a low reading they expected due to pollution and second hand smoke.

Not sure how good the CO monitor was, well how accurate it was, especially if you have been exposed to fumes or second hand smoke. Some weeks it went up when you know you hadn't smoked. It is a little bit like going to weight watchers and the scales going up when you know you've been good. It is really important the scales work and everyone understands them. (Individual interview, quit at end of programme)

During the course of the interviews, a number of women commented on the usefulness of the different tools provided by the programme that helped them outside the group setting.

The tape recording {CD} was good. The other girls didn't like the man's voice but I did. I'd have it on as I was going about the house, listening when I was doing things. You needed to take the time to listen because it gave good tips. Advice with food, but it would be better if this was visual, you'd be able to see the recipes. (Individual interview, quit at the end of programme).

Others mentioned the stress-ball, stress management advice, savings book and the mood boards. The tips and advice for managing cravings (e.g. drinking water and yoga) were also recalled as being helpful. The quit date was mentioned by two of the women.

I didn't like the idea of setting a date to give up but once the group settled in I thought to myself OK

lets go for it. So I set the 1st of April, April fool's Day to quit. I told my partner and that was that. By the time April first came along we both gave up (Individual Interview, quit at end of programme)

Summary Box 5: Type of Support Received

In the CSS participants reported receiving:

- Group support (100%)
- One to one support (31%)
- Text support (48%)

From the CSS and interviews the elements of the programme the women found useful included:

- The group support – women in the same situation
- The facilitators (community based and ex smoker)
- Access to NRT
- Support from pharmacy staff
- The biofeedback from the CO monitor
- The tips and tools to support quitting (stress management advice, healthy eating, drinking water to manage cravings, exercise etc)

7.2.3 Access to Nicotine Replacement Therapy (NRT)

The monitoring data indicated that 27 of the participants accessed NRT. From the client satisfaction survey and telephone interviews it was evident that access to NRT was an important component in the programme. The client satisfaction survey indicated among the NRT users, while many combined more than one method, most (92% 23/25) used patches, over half used the inhalator (spray) (56% 14/25) and/or the gum (52% 13/25), and a small number (3/25) used lozenges. All those who used the NRT found it helpful or very helpful (27/27). Most (20/27 74%) accessed it directly from the pharmacists with the letter from *We Can Quit*. When asked if they would have used the NRT if they had not been offered it free of charge, the women were less sure in their response. A third (32%) indicated they definitely would or probably would have used NRT, a fifth (6/28) stated they maybe would have used it, but 28% (8/28)

would not have used it. From the interviews, it was evident that some women found attending their GP for the prescription to add an additional layer or barrier for them to access the NRT.

It was obvious that the access to free NRT made a difference to women, particularly to those who had tried NRT before.

Could not have quit without this course and getting the NRT aids for free was fantastic. I would not have paid for them. I know that sounds crazy but it's true, I will spend all that money on smokes but wouldn't consider paying that much for patches and gum. Thanks a million to XXX and XXX and all the cancer research team from myself, husband and my 4 proud and happy children. (CSS)

I did try before, but when I went back on them I couldn't last without them. At the time I tried patches. Most of the time I forgot the patch – I had to go to the chemist and buy them – 30 euro a week – I know I was spending more on cigarettes but when I added it all up, I couldn't justify spending the money on the patches. (Individual interview, quit at end of programme)

Excellent course that was easily accessible. The facilitator was extremely understanding and fun in their approach. The access to NRT, with the letter, was a big benefit of the course. The text messages were also helpful. XXX and XXX did a really great job. I very much appreciate the past 12 evenings they have had to work (CSS)

The NRT was great. I used to patches to manage the cravings, and had the inhaler when I needed a hit (Individual interview, quit at end of programme but relapsed)

One of the unexpected successes from the *We Can Quit* was the role that pharmacies played in the delivery of both the NRT, and additional support and encouragement. It was evident from the feedback, that women had initially mixed views on the support they received. While most of the respondents to this question on the CSS were very satisfied or satisfied (20/24 83%), a small proportion (4/24 17%) were less satisfied with the services. From the follow-up interviews, the reason behind this satisfaction was

identified as a 'teething' problem whereby a small number of the pharmacies were not aware of the *We Can Quit* programme until after the first letters had been issued.

At the beginning it was a wee bit embarrassing as they {the pharmacy staff} didn't know what I was talking about. They thought I was a bit weird and I felt uncomfortable...but the next time I went for my patch they were really encouraging and knew all about it. (Individual interview, quit at end of programme but relapsed at time of interview)

The pharmacy staff emerged from the interviews as provided an additional valuable layer of support and encouragement.

Pharmacy was great I had a meeting with them and asked how you were getting on. (Individual Interview, quit at end of programme).

The local pharmacy gave me advice. They were always at me to give up, and were really pleased when I gave up (Individual Interview, quit at end of programme).

When I went to the chemist, they knew what I was talking about and what was going on. They gave you advice and support, and you got encouragement from all the staff. (Individual Interview, quit at end of programme).

A small number of women described receiving support from other professionals such as GP and staff at the diabetic clinic.

My GP was really pleased when she heard I gave up. She was over the moon, really pleased with me. It was great not to smoke for the operation. And when she heard himself had given up she jumped with joy.....The staff at the diabetic clinic were delighted with me as well. They were thrilled with my bloods and my cholesterol especially with the risk of eating more when you give up (Individual interview, quit at end of programme)

Summary Box 6: Importance of support

- Access to NRT emerged as an important aspect of the programme
- Access to free NRT for non-medical card holders
- Access to combined therapies
- Additional support from pharmacy staff
- Encouragement and support from other health care professionals

7.2.4 Benefits of the *We Can Quit* Programme

From the client satisfaction it was evident that participating in the programme helped women in a number of ways.

This programme gave me the confidence to quit smoking. XX and XX were very helpful. The group were lovely. I learned quite a lot on how to change my routine and this helped a lot. (CSS)

From the individual interviews it was evident that participating in the programme helped women in a number of ways as well as quitting or cutting down. The increased level of energy was described by a number of the women.

Once we gave up, I started to notice the brown stains everywhere, so I did a big clean up, bought some paint with the money I would have spent on the smokes. I painted the house. It gave me something to do, kept my mind off them. The house is gleaming now. (Individual interview, quit at end of programme)

The energy. I use the pedometer to keep me on track; I do 10000 steps a day and am chuffed with myself (Individual interview, quit at end of programme)

I distracted myself, got lots done in the house. It is amazing when you stop you realised how much

time you spend smoking (Individual interview, quit at end of programme)

In some of the interviews the financial benefits of quitting were described.

..the extra money makes a big difference. We are OAPs and are both on disability. Now we have given up the cigarettes we have more money to spend we can go places. Before we gave up we had to pay the car tax, the insurance and NCT so money was tight. Now we are not spending money on the smokes we have the car, it gets us out (Individual interview, quit at end of the programme)

I have got used to the extra money in my pocket. I bought table and chairs for the back garden and some plants. I bought the paint to revamp the house. I also bought a pair of the Sketchers Go Walk {shoes}. Before I gave up smoking there is no way I would have done that that would have been 3 packets of cigarettes. (Individual interview, quit at end of the programme)

During the course we had a pamper day, and had our nails done and had a hand massage. I would never have done something like that. Before I quit all my spare money was going on the smokes, I'd feel guilty about doing something like that, but not now. (Individual interviews, quit at end of programme)

One of the women with a chronic health problem described some benefits to her health but because of the hot summer was still experiencing respiratory problems.

I still find it hard to go shop, before I might stop twice maybe three times. I am now able to get the shops now without stopping as much (Individual interview, quit at end of programme)

With all of the interviews, the importance of the bond with the group and sense of connection was a strong theme. All of the women came away from the groups with new connections and contacts within their communities. Many of the women expressed a sense of sadness when the group ended, wanting the group to continue for longer.

I would describe the WCQ as a support group and in each session we would learn something different e.g. mood board about are plans for the future. People I met at the group, they were ordinary people no different to me, a wee bit younger, lovely people to meet and to be with...very honest and open. I actually made friends with some of them. (Individual interview, quit at end of programme)

For one or two of the older women there was a sense that attending the group gave them a sense of purpose, and became a social event as well as a support group.

We all got tea and coffee, and on our last day we had a wee celebration, a wee cake with We Can Quit. It was great to get out of the house. (Individual interview, quit at end of programme)

One woman in particular was anxious that when the winter draws in she would have fewer reasons for going out, and thought this might be a time where she could start smoking again. This highlights the need to consider different strategies to provide the women with opportunities to meet with the group after the end of the facilitated group sessions.

From the literature review and research with stakeholders (described in chapters 3 and 4) the importance of local champions and cultural change was a strong message. From the interviews, one of the unexpected outcomes from the programme was the ripple effect of the *We Can Quit*, whereby women attending the programme became an advocate for quitting, and supported others outside the programme to stop smoking, and in a small way became local champions. For example, one woman, who gave up smoking while attending the programme, supported her niece who could not attend because of work commitments.

"I used to explain to my younger niece (age 22) about what was said at this course and she would say 'oh I never thought of it like that". I am pleased to say she also has given up". (CSS and individual interview)

During the follow-up interview she described in more detail how she supported her.

I tried to get my sister and my niece to attend the group. My niece wanted to come along with me but couldn't make it because of her work. I talked her through the approach and the tips. She stopped when I stopped 2 weeks into the programmeI used to bring her back all the information and the like. She loved the stress ball and the savings book. She thought they were fantastic I advised her about the NRT, she didn't know you could use more than one. When I had some spare I'd give her mine. (Individual interview, quit during programme but relapsed)

Another described how her partner had always promised if she gave up he would. So, when she set her quit date, he also quit. She recounted how she passed on the tips and advice from the group to him. She also shared the NRT with him (which meant she would not have been able to take it as directed), as she felt she was getting along fine without it, and felt it was important for her quit attempt to support her partner to give up, as she would not be able to stop smoking with a smoker living in the house.

I started with the NRT but was getting along fine so I gave them to my partner cos he is like a bitch without them. But with him off it was easier for me to keep at it. I'd never have been able to do it without him giving up (and him on the patches)... he was a really heavy smoker so I am really delighted with him (Individual interview, quit at end of programme)

This ripple support emerged during another interview as a woman described how she relayed the support from *We Can Quit* to a male friend who was trying to stop smoking. He was moving in with his girlfriend who is a non-smoker. He had previously attended weightwatchers, and knew the group support worked for him. The interviewee passed out all the tips and advice, and sought out a group for him (Men's Sheds).

Another woman talked about her friends who were smokers, and how she was encouraging them to stop smoking.

I have friends who smoke. A lot of them of not ready to quit but one of them wants to sign up to

the next We Can Quit. She saw if I can go from 40 a day to being a non-smoker, she could do it. I am her inspiration so I am. (Individual interview, quit at end of programme)

Summary Box 7: Benefits of the *We Can Quit* Programme

In the CSS and interviews participants reported a number of benefits of the programme:

- Setting quit date
- Cutting down cigarettes
- Quitting
- Increased energy levels
- Access to local support network
- Financial savings, more money to spend on home improvements etc
- Increased self confidence
- Encouraging family and friends to quit.

7.2.5 Improvements to the *We Can Quit* and Future Directions

Most of the participants (from survey and interviews) were very positive in their assessment of the programme.

The programme should be rolled out all over the country as I don't think I would have done so well without the support of XXX, XXX and the group (CSS)

It should keep running. It will help plenty of women to stop and be healthier. The programme has helped me so much. I have cut down a huge amount and I will stop in the next few weeks. (CSS)

Very happy there is finally a support group for smokers (CSS)

A small number made suggestions about the timing of different elements of the course. All of the women interviewed really enjoyed the healthy eating sessions but a few suggested that it would be useful to have some input on this at an earlier stage to help women prepare for quitting and to alleviate concerns (and risks) about gaining weight.

One woman suggested

Move the input on healthy eating routines etc before the set to quit date. In our group a lot of the girls had replaced cigarettes with sweet stuff, chocolate and the like, and were piling on the weight. They can be supported by learning how to deal with the cravings, eating carrots or doing yoga and the like. It was good to have the healthy eating session but you need them early on as well. (Individual Interview, quit at end of the programme)

Later in the interview she suggested

it would be good to have the tape {CD} as a DVD, that way you could see how the food looks and you might be more inclined to make the recipes (Individual Interview, quit at end of programme)

The suggestion for more preparation for managing stress was offered in both the interviews and the survey.

Mix it up for the first 6 weeks as it is very stressful. Week 6 was very enjoyable. (CSS)

Exercise and relaxation techniques early on would be good as well. These take a while to learn. I learned my coping skills from another course. When I wanted a cigarette I just used these. (Individual Interview, quit at end of programme)

I found the course very helpful however the time of day caused a few people problems. XXX was great, very encouraging and made the group fun! The healthy eating advice at start. Stress ball at start. Day 1 of course to be quit date, NRT from day 1. (CSS)

Improvements to the how the NRT is accessed was raised by one of the women.

NRT letter given on day 1 because you build yourself up the day you start as it is the day you give up. (CSS)

During the interviews, one of the women felt the NRT should be made available to all women (GMS and non-GMS) in the same way (i.e. via letter to pharmacist). She had cut down to stop smoking, set her quit date but encountered problems getting an appointment with her GP to get the NRT leading up

to her quit date. The other women in the group had accessed the NRT from the pharmacy and had quit. Prior to this happening she was unhappy with the quality of the facilitation, so when she encountered the problem accessing the NRT she dropped out.

Have it so everyone gets the NRT in the same way or have the letter for the GP on the first day so women have the NRT when they are ready to quit. (Individual interview, cut down to quit but dropped out before week 4)

Problems with the facilitation of the group were identified in one of the groups. In this group, the interviewee described the two facilitators as inexperienced and lacking in confidence in their delivery of the programme. The fact that one of the facilitators was a current smoker was viewed to impact on the quality, as she was perceived by the group to be both a facilitator and a participant.

One was a current smoker which wasn't ideal. Definitely future programmes should be delivered by an ex smoker or non-smoker, but preferably an ex smoker as they will know what you are experiencing. (Individual interview, cut down to quit but dropped out before week 4)

This interviewee dropped out from the *We Can Quit* before week 4 but said she had heard from others from the group (who had gone on to stop smoking) that new facilitators were appointed after she left and the course had improved. It is not unexpected that one of the recommendations for improvement emerging from this interview was improved recruitment procedures.

The facilitators should be well vetted at the beginning, and maybe have the chance to have a test review to make sure they know the programme well and are able to meet the needs of the women. (Individual interview, cut down to quit but dropped out before week 4)

In both the CSS responses and during the interviews, a number of the women suggested that the programme be expanded in some way.

Would love if the programme went on a bit longer (CSS)

Expanding the length of time by phasing out the last meetings to every second week was suggested by one of the interviewees. This would allow women a longer period of contact, and continued opportunities to meet.

I thoroughly enjoyed the course but definitely it would be good to have a follow-up meeting after the course. (Individual interview, quit at end of programme but relapsed)

It would be good to meet with the women to see how they are getting on, and to get support if you start again. Maybe set up a facebook group. (Individual interview, quit at end of programme)

Offer the programme again, evening group would be good. Offer over 6 months starting with weekly until women quit, then offer every 2nd week for support over 6 months. That would help women get over the 3 month period. (Individual interview, quit but relapsed)

Overall, most of the participants were happy with how the programme with the facilitation and delivery of the course.

Everything was great and the staff were lovely too. I wouldn't change anything about the group (CSS)

Everything was covered. Great help always (CSS)

Summary Box 8: Recommendations for improvement

Most women were very positive in their feedback of the programme. A small number made recommendations for improvement. These included:

- providing some advice on healthy eating and stress management;
- improving GMS patients' access to the NRT;
- greater promotion of the WCQ programme; and
- targeted approaches to reach younger women, particularly young mothers. Suggestions for reaching this group included the use of social media, as well as active promotion through parenting groups and schools

7.3 Survey and Follow-up Workshop with Local Partners and Stakeholders

In order to explore how the programme was planned and delivered in each site, the final stage of the research involved self completion survey of local partner organisations (n=14) involved in either the planning or delivery of the *We Can Quit* in the two areas. The survey asked respondents to describe their role in the *We Can Quit* programme in terms of planning or delivery, and explored the partner organisations' views and experience of the *We Can Quit* programme.

This was followed up by a feedback event with 30 participants from the two pilot areas. The function of the event was to feed back the main findings from the pilot study, and to explore partners' views on the on the sustainability of the model. Key areas for discussion included: Their experience of planning and/or delivering the *We Can Quit* programme, infrastructure and support for the delivery of the project, key successes and achievements, any challenges in the planning and delivery, and suggestions for future improvements or further support needs.

7.3.1 Views on the *We Can Quit* programme

In order to identify the perceived value of the different components of the *We Can Quit* programme, respondents were asked their views on the importance (on a 5 point scale from very important to not at all important) of the different components of the *We Can Quit* programme (Table 7.10). None of the respondents viewed any of the components to be unimportant. However, most viewed the weekly support; community based; access to free NRT; and trained staff from the local community to be very important.

Table 7.10: Stakeholders' Views on the Importance of the Different Components of the *We Can Quit* Programme

Component	Very Important n (%)	Important n (%)	Neither import unimportant n (%)	Not Important	Total N
Community based	13 (92.9)	1 (7.1)			14
Weekly group support	13 (92.9)	1 (7.1)			14
Access to free NRT	12 (85.7)	2 (14.3)			14
Trained staff from local community	12 (85.7)	1 (7.1)	1 (7.1)		14
CO monitor	10 (71.4)	3 (21.4)	1 (7.1)		14
Setting Quit date	10 (71.4)	4 (28.6)			14
12 week programme	9 (64.3)	4 (28.6)	1 (7.1)		14
One to one advice	9 (64.3)	5 (35.7)			14
Follow-up support via Quitline	5 (35.7)	9 (64.3)			14

Respondents were asked for their opinion on the *We Can Quit* programme through a series of closed and open questions. The first of these questioned respondents' views on how successful the programme had been in reaching females from disadvantaged communities (see Table 7.11 below). All responded to the question, with over half (n=8 57%) considering it to be very successful, and the remaining viewing it to be successful. Following this question, respondents were asked if there was any way the *We Can Quit* programme could reach more women from disadvantaged areas. The importance of a good lead time was noted, and other suggestions included targeted recruitment using a range of channels, greater use of all media (local newspapers/newsletters and radio, involving schools (posters directed to mothers, notes in school bags), encourage greater word of mouth especially involving women who have attended the *We Can Quit* programme

It's challenging to get women to engage but I think over time that word of mouth will be very important.

The next question asked respondents whether the *We Can Quit* programme added value to other

smoking cessation supports in the local area. Nearly all respondents (10/12 83%) felt it did add value, 1 was unsure and the other did not believe it added value. Eight respondents provided additional comments on how the programme added value. Some viewed this added value to be achieved by providing tailored support within community settings it succeeded to support women to quit, and the potential for participants to tell others about other available supports in the area (the ripple effect described in section 7.2 above).

Important. Women quitting and telling others how they did it!

It successfully surpasses any other models.

..because the women who quit can tell their partners that although this was for women there are other services available.

The feedback from the women using the WCQ support group said that although they had tried other methods - none targeted the issue's as good as this. They felt supported within the group, and the 12 weeks meant they felt fully confident in the quit.

Yes - the fact that women in these areas were actively targeted and recruited to the group, that this is a gender based programme which acknowledges that women's needs differ from men, I think the length of the programme would encourage bonding and cement relationships which would further support women, I think the free NRT was very helpful. I think the fact that it was based in the community rather than a healthcare facility was probably more attractive and women were more likely to attend.

Later in the survey, respondents were asked if they felt the programme helped women quit. Most felt that it had helped women quit (yes all women 6/13 46%; yes some women 6/13 48%) and one did not know. Respondents were also asked if the programme helped women in other ways. Three quarters (9/12 75%) felt it did, and the others

did not know. Most described improvement in confidence and skills.

Gave them confidence, it empowered them to take charge of their own health.

A small number commented on the benefit of establishing a network in the community.

It allowed them to develop new networks. It provided an outlet and introduction to other healthcare education initiatives

Some women have learned the skills to make other changes to the life like dealing with panic and stress. Some have joined other programmes for fitness and interests.

Socially, it was a great way to get people together.

Table 7.11: Stakeholders' views on the reach, added value, and future roll out of We Can Quit

In your opinion...	does the We Can Quit programme reach women from disadvantaged communities?	does it add value to other local smoking support services?	should it be rolled out to other areas?
Response	n (%)	n (%)	n (%)
Yes	8 (57.1)	10 (83.3)	11 (91.7)
No	6 (42.9)	1 (8.3)	1 (8.3)
Don't know		1 (8.3)	
BASE	14 (100)	12 (100)	12 (100)

Particular components of the programme were raised as important in adding value to other services.

Participants in the group have tried the one to one support or quitting alone unsuccessfully so the group adds another level of support for the women.

Some described the important elements that added value to the service without reference to other services.

..the free NRT and the length of time for support 12 weeks

A number of the pharmacists felt they offered the We Can Quit programme an important additional layer of counselling and support within the community.

I also was able to provide Joanne with useful learning from these previous schemes, such as the "rule of 3" When a participant presented in the pharmacy, we would take them into the consultation room for a brief 'interview', to get all of their details, including the frequency and type of smoker they were. The health counsellors would already have recommended suitable NRT products to the ladies, but we would ensure that these choices were the most applicable for the individuals. We would then counsel on the appropriate use of each product and reiterate the best progression over the 3 months in terms of dose reduction. The participants would then attend the pharmacy at weeks 0, 2, and 6 for supplies of NRT and at each supply we would make a further brief intervention, offering support, guidance and reinforcement of the positive steps that they were making for their health.

The absence of a smoking cessation service outside primary care in one of the areas meant that the We Can Quit was viewed to add considerable value to the local services.

There are no smoking supports available outside of general practice in this area.

It encourages women to give up smoking. GP's may not have the time to spend with patients. If these ladies have no health issues at present then there is no need to visit the GP. If financially they think

it's too expensive then this will help them make the change. No excuses.

The previous experience of some of the partner organisations and individuals was viewed by some as adding value to the We Can Quit programme (via community based programme or via Pharmacist advice) was considered to add to the success of the delivery.

...involvement of all local services e.g. pharmacies doctors etc. was great

I felt that an experienced group facilitator really helped with an in-depth knowledge of the challenges and materials

Previous experience of running smoking cessation clinics in other jurisdictions and bringing these learnings to the practice

In response to the question on the roll out of the model, all but one (11/12 92.7%) felt it should be rolled out to other women. When probed on how this might be achieved, the responses included re-running the courses/keeping the programme going, offering taster sessions in other areas, by providing resources to deliver the programme in disadvantaged areas.

7.3.2 Experience of Planning or Delivering the We Can Quit Programme

The experience of planning and delivering the We Can Quit programme was explored through the survey and during the stakeholder event. Responses to the question on what helped in the planning phase included the regular meetings and emails, personal contact, a knowledge and awareness of the local services (which helped to promote the service), and the training to deliver the programme.

We knew recruitment of women was going to be difficult enough, so it was good to explore this at the advisory meetings to ensure all links/avenues were covered.

A number described challenges to planning, which included time to plan delivery and recruit women to the programme.

Very tight time frames which led to insufficient time for recruitment.

Recruitment was hard and quite rushed. I think allowing longer for recruitment would help in the future.

During the survey and feedback workshops the community facilitators indicated they had experienced a small number of challenges when delivering the programme. Examples of challenges included lack of time to plan, having ready access to information about other services to direct women to on their specific concerns.

Having information and contacts for linked in services i.e. addiction services, local nurse, MABS. The women in the group asked many questions on health, money worries, smoking cannabis in connection with giving up etc. When health checks came we were unable to source community nurse, but the pharmacy very kindly stepped in for health overview.

More time would have meant more targeted area, and possibly a greater attendance. It seemed rushed and so location etc. were picked quickly, and possible not the right one's for the job.

As might be expected, recruiting women to the programme was one of the main challenges facing the programme.

Very tight time frames which led to insufficient time for recruitment and planning, and a lot of meetings.

Time frame too tight, lack of clarity re recruitment process, too many people involved in taking names & having contact with applicants/participants.

Two respondents noted the challenge, but identified how by working with the advisory group they overcame this challenge.

We knew recruiting women to the programme would be difficult enough, so it was good to explore this at the advisory meetings to ensure all possible links/avenues were covered. Everybody had access to different groups and I think this was important in getting the information out.

Recruitment was very challenging there was time restrictions more time may have helped. These challenges were overcome by using contacts and colleagues for support and getting stuck in with the support from others involved.

Others noted how they addressed some of the challenges in promoting the service and recruiting women to the programme.

{We}...had a lot of networking and development the relationships built up before the programme started, and were already working in the stop smoking services which helped me look at what was best way to promote the services

I linked in with any contacts I had in the area, HSE and others to raise awareness and promote the WCQ, phoned key individuals and sent on posters etc. I sent on the info to HSE Stop Smoking support services in the area but I think the key organisations are those who have a footfall of women so community groups and the partnerships were paramount

Uncertainty of times and locations was also a challenge for one of the groups.

Short time-frame, uncertainty of dates.

Pharmacy staff reported experiencing a number of challenges, having to make time to provide one to one support and advice to the women.

Time. We were not funded to provide the advice to each of the participants and therefore had to fit participants into our busy practice, attempting to offer them the best opportunities to make very success of the service, whilst at the same time trying not to undermine, reduce the service level of our primary business and revenue creation

One pharmacist felt that ad-hoc way in which women presented was a challenge,

The ad hoc manner in which participants presented to the pharmacy.... There was quite a lot of confusion around the end-point for various participants.

In terms of delivering the programme, apart from the time issues described above, most respondents appear to be happy with the training and the content of the programme. Respondents described aspects of the approach that helped in the delivery. These included the pack and resources, the involvement of other partner organisations, trained facilitators, and the availability and flexibility of a budget to run the course.

The pack was a great resource and used for planning the sessions. The freedom in the last few weeks was good for the women to feel they were getting the most out of the programme.

Involvement of local services e.g. GP, pharmacies etc was great

Availability of budget to run the programme

One of the respondents highlighted the importance for the facilitators to have the full pack in advance and to all the equipment and support materials for the groups.

Having the full pack in advance and ensuring facilitators' pack contents match contents; facilitators to have enough disposable covers for CO machine to last for the duration of the group, in advance of the group starting; facilitators to be aware of the funding available for the running of the course

Some identified challenges in addressing some specific questions raised during the sessions.

Answering the women on cannabis link - though Angela researched and provided me with info. The worry from the women re weight gain - and reassuring them of health options/nutrition and activity.

The process of accessing the NRT via the GP was recalled as a challenge as one woman did not have access to NRT when they wanted to quit.

Access to NRT was not available for one lady as doctor was on holidays so she didn't come back.

7.3.3 Improvements to the Planning and Delivery Process

Respondents from both the planning groups and operational staff commented that the *We Can Quit* model addressed many of the support needs of women living in disadvantaged areas, but some felt the model reach and success could be improved. Bearing in mind the pilot status of the *We Can Quit*, the partner organisations made a number of recommendations for improvement described in the sections below.

Suggestions for improvements to the planning phase included additional time to secure buy in from all key stakeholders, playing particular attention to primary care and local community pharmacies, as well as key support organisations (e.g. MABs, parenting programmes, addiction services, social work etc). Time was also required to plan the detail of the delivery e.g. where and when the programme will be delivered, who will deliver the programme, how it will be promoted and who will be recruited.

Establish better links with organisations in the community that could help us with planning and delivery.

Avoiding duplication of the services was raised by one respondent.

XX already has a quit smoking programme in the XX centre. Yet the evening one was also based here.

However, one of the women interviewed had previously attended the group support but found that with the WCQ model which was tailored to the needs of women and provided access to NRT she was more successful in giving up and staying quit.

Getting the right location for the groups to meet was also raised as an important consideration by both the service providers and during the interviews. It was evident that while most of the settings were suitable, one respondent in the stakeholder survey noted that the facilities in one of the venues were limited. This was also mentioned in the feedback interviews with one of the participants.

The recreation centre in XXX was ok, though facilities e.g. toilet location, and access to kitchen were not good. So women had no water, and had a long trip to the loo.

The importance of appointing and training suitable community facilitators was viewed to be of paramount importance. Similar to the feedback from women, the importance of having at least one ex-smoker in the team was raised.

Respondents felt that some of the recruitment and communication problems experienced in some areas could be addressed by appointing a local co-ordinator in each area to take responsibility to contact women expressing an interest in adding and to feedback to the key referral organisations. This combined with the proactive recruitment of women to maximise uptake and retention.

Confusion and overlap in the keeping of names and contacting interested participants. This can be avoided by having one point of contact for initial information

More planning time for recruitment, one named person/agency to hold master list of applicants, group facilitators to make contact with the participants to explain programme and offer/confirm places & provide details on time & locations

Suggestions for the proactive recruitment included each area planning a marketing strategy relevant to the local community to reach the client group including health fairs, talks at schools and parenting programmes etc.

I would probably target relevant agencies to put out information to target their clients, staff and networks. Support from Doras Bui was very helpful

Active promotion of the programme from key health service providers was also suggested.

...proactive contacting of clients. As far as I know they did get contacted after they opted in with reminders. I would go as far as suggesting that if a health professional gets their agreement and consent, they could refer to WCQ who then could contact the client and do so regularly until the group starts, 20 years of working with this

population has taught me that they are very disempowered about helping themselves and really respond to a lot of support

The involvement of 'graduates' from the *We Can Quit* in the promotion of service and recruitment strategies was suggested.

....some previous participants could do a video saying what it meant to them to be viewed online by the public

Specific suggestions for the promotion of the service and recruitment of women included leaflets, posters, social media, and importantly, face to face contact with women to describe the programme.

7.3.4 Improvement to the delivery of *We Can Quit*

In terms of the delivery of the *We Can Quit* programme, most survey respondents were happy with the approach and content of the *We Can Quit* programme, but offered suggestions for improvement. Time to plan and reflect emerged as important in the survey response and was the dominant theme discussed during the stakeholder workshop.

The importance of having paired facilitation, where a less experienced facilitator is matched with a more experienced facilitator was also viewed to be important by a small number of respondents. Similar to the participant feedback, having trained ex-smokers to deliver the programme was recommended in both the survey, and during the stakeholder feedback workshop.

The importance of clear protocols for dispensing the NRT was raised by the Pharmacists.

If the programme was rolled out to further trials we must be cognisant that the scheme could be open to abuse by participants if more clear guidelines are not determined as to quantities of NRT that they are entitled to under the scheme.

During the follow-up workshops, two of the pharmacists provided suggestions on how the process might be improved to record the uptake of the NRT, and more importantly to link the service

provided by pharmacies back to the *We Can Quit* team and the primary care team. Suggestions for improvement included use of guidelines and protocols for information sharing, and one of the pharmacists drafted a version that might be used. Another suggestion was the *We Can Quit* participant nominating a pharmacy (from a list of participating pharmacies) to dispense the NRT. During a short registration with the pharmacy, the pharmacist will seek permission to share information with the women's GP. The nominated pharmacy approach would mean the women have one central point to access the NRT, have an opportunity to build up a supportive relationship with the pharmacists, and would facilitate information sharing to provide a more joined up approach.

7.3.5 Future Direction – Key messages from the Stakeholder Event

During the stakeholder event, the key messages from the participant feedback and the local stakeholder survey were presented to the group. These were followed-up by a two workshops to tease out the messages and recommendations for the future direction of the *We Can Quit*. Detailed below are the key messages emerging from this workshop

One of the first observations of the group was the unexpected added value of working in partnership with pharmacies to prescribe NRT and provide women with an additional layer of support and encouragement. Participants recommended that the Irish Cancer Society:

- Engage with NRT suppliers to reduce the cost of NRT or get sponsorship for NRT for the next phase of the development;
- Consider strategies for the cascading of NRT to other family members, possibly identify routes whereby individuals can access the NRT legitimately outside the group setting, and research the effectiveness (and extra value) improving access to NRT from pharmacy (without group support); and
- Develop clear protocols for pharmacies for the prescription of NRT.

In the follow-up workshops, participants were asked to consider if the *We Can Quit* approach is sustainable at local and national levels, and if so, what improvements are required.

The feedback from the group indicated that participants felt there was a place for *We Can Quit*, as it provided group support, tailored to the needs of women and delivered by local facilitators. A particular strength was the opportunity to engage with community organisations to plan, promote and deliver smoking cessation support, particularly organisations that had not previously been involved in smoking cessation support.

The group identified opportunities at national and local levels to integrate community based approaches to smoking cessation.

Opportunities at a National Level

- The target of 5% smoking in 2025 means smoking cessation is a priority for everyone.
- For community based approaches to work, leadership is required at national level to support such approaches. Key agencies identified here were the Health Service Executive, and the Irish Cancer Society. It was acknowledged that both organisations had demonstrated initial commitment with the *We Can Quit* pilot study; further action would be needed to roll out the approach and to demonstrate the effectiveness of wider implementation of the approach.
- The approach would require funding (and a cost-benefit analysis would help inform this)
- Consider opportunities to integrate the *We Can Quit* approach within the local health service plans in line with the Tobacco Free Ireland
- Also at a national level participants felt that there would be a need for capacity building and community health training. Again the HSE could play a role here to deliver the *We Can Quit* Train the Training to new community facilitators in their areas. Such training should include training/briefing for partner pharmacies and GP/ PCTs.

Opportunities at a Local Level

At a local level the group felt there some areas have structures to support the *We Can Quit* model

- Resources and co-ordination is required to establish local advisory groups and for delivery set up to make sure it is delivered well, but once established less resources may be required.
- Organisations working with disadvantaged groups are well placed to identify and encourage readiness to quit. The smoking cessation support is more effective with smokers who are ready to quit. Building this readiness can take time and organisations working with women (such as lone parent projects) have a potential role encouraging women to think about giving up, and referring them to the support service.
- The local area partnerships and engagement from the stakeholders provide possible structures for the governance of the *We Can Quit* model.
- It is important to have established referral and feedback protocols for the local primary care team to integrate the *We Can Quit* model and to provide more holistic approach.
- As the programmes roll out, past participants are potential role models and local champions for change.

The *We Can Quit* model was viewed as providing an important opportunity for partnership working to deliver health work with local communities in local communities.

- For individual groups the *We Can Quit* provided individual projects in the pilot study with opportunities to build community based connections with local smoking cessation services and pharmacies. The process was viewed as strengthening good links and building relationships.

- Stakeholders commented that there was potential to build further relationships with smoking cessation services located in local acute settings (Beaumont Hospitals, Connolly Hospital). This would provide opportunities for referral to *We Can Quit* and from *We Can Quit* after the end of the group programme.
- The community based approach to promoting smoking cessation provides more 'foot soldiers' for all cessation services. The more people working on the ground (community, health, and other services) – the more opportunities for referrals. All add value to each other's services.
- Further links with primary care might be achieved through presentations/information to clinical teams/networks; this might secure buy-in and open opportunity for referral pathways. The development of a referral protocol might help in this regard to ensure there is a feedback loop to provide outcomes on the programme for the client/patient.
- The *We Can Quit* approach was considered by one of the groups to have potential to be applied to other high prevalence groups of smokers including men's groups.



CHAPTER 8

Conclusions and Recommendations

This action research project aimed to develop and test a tailored smoking cessation programme for women in Ireland. The research was initiated to address the specific needs of women living in socially and economically deprived communities. The *We Can Quit* model was informed by a range of evidence assembled in the different phases of the research. From Phases 1 to 3 there are clear messages on (a) what works in supporting smokers to stop (e.g. behavioural support combined with access to free stop smoking medication, in WCQ case 2 forms of NRT), (b) the needs of women in disadvantaged areas (e.g. stress, living in poverty, low self esteem etc.), and (c) the barriers they face when quitting. Thus the research pointed to the value of delivering community-based approaches to providing women with effective smoking cessation support. What also emerged from the literature were potential models of support that might be tailored to an Irish context, such as the Sister to Sister model.

In the section below the key findings from the pilot study are summarised before outlining recommendations for future delivery of the *We Can Quit* programme. These recommendations have been informed by the research findings, as well as feedback from partner organisations that attended a one day event to reflect on findings and explore future directions.

8.1 Key Findings from the Pilot Study

The numbers of participants who signed up to *We Can Quit* was relatively small, with a quarter of the group dropping out before week 4. However, for those women who remained with the programme, the longer term outcomes were good. Women who had stopped by four weeks after their quit date maintained abstinence at the 12 week recording point.

- The available data suggests that the *We Can Quit* model offers an effective model for engaging and supporting smokers in deprived areas to quit. While there was some drop-out after the first weeks, attrition between 4 and 12 weeks was extremely low. Also, quit rates remained stable between 4 and 12 weeks,

which is unusual for a cessation programme, where some dropout in this period would be expected.

- Women reported that their main reasons for joining *We Can Quit* were to improve their health and the appeal of group support.
- The group support was popular, with participants reporting attending all or nearly all of the group sessions. The support women offered each other went beyond smoking cessation, with some participants drawing on the group support for other types of help and advice (e.g. support with bereavement etc.).
- Feedback from the women indicates that the quality of the behavioural support delivered by staff, combined with the access to free NRT played an important role in the success of the programme.
- Overall, the feedback from participants was extremely positive. The women reported feeling enthusiastic and engaged by the different components of the programme. Particular aspects included:
 - The group support;
 - Facilitation by local women including ex-smokers;
 - Access to free NRT and support from Pharmacy staff; and
 - Activities to address the barriers to quitting (e.g. advice on healthy eating, stress management).
- Access to free NRT was an important aid to smoking cessation for participants. However, some participants found the process of obtaining free NRT (i.e. via their GP) was a barrier to NRT use.
- The benefits of being part of *We Can Quit* extended beyond stopping smoking. For example, participants reported improved physical fitness, self-confidence, wider social networks and financial gain. There was also an appetite for the group to meet beyond the intervention period to continue to offer, and receive, mutual support.
- An added reported outcome was the 'ripple effect' where participants shared their experience of being part of the programme

with friends and family which, in turn, had an influence on their smoking behaviour and potentially play an important role in challenging the culture of smoking within the wider community.

- Only a small number of participants felt the programme could be improved, suggestions included providing some advice on healthy eating and stress management. Improving GMS patients' access to the NRT was suggested. Regarding the promotion of the programme, a number of older participants highlighted the importance of a targeted approach to younger women, particularly young parents. Suggestions for reaching this group included the use of social media, as well as active promotion through parenting groups and schools.
- The feedback from the local stakeholders was also very positive, confirming a high level of commitment from the partner organisations in both areas. However, recruitment of women to the programme in the early stage of development was a significant (and anticipated) challenge for *We Can Quit*.
- All but two of respondents to the survey considered the *We Can Quit* model to add value to local services.
- A number of stakeholders felt the strength of *We Can Quit* was the group support located in community venues, and delivered by local facilitators. The access to free NRT and the links to community pharmacies that provide a further layer of support were also considered to be important.
- Reflecting the 'newness' of the *We Can Quit* model, some of the partners reported experiencing a small number of initial challenges which arose from the partnership approach to delivering smoking cessation service within a community setting, the most important being time to plan. Many of these 'teething' problems resolved as the programme embedded within the community. Useful messages from the stakeholder group were generated during the workshop, centred on the future set-up and planning of *We Can Quit*, which are included in the recommendations below.

8.2 Recommendations for Improvements to Planning and Delivery

From the feedback with the participants and service provider a number of recommendations emerged for improvements to the planning and delivery phase of the *We Can Quit*

- Securing 'buy-in' from all relevant stakeholders, and extend the planning and delivery partnerships to other relevant local organisations such as primary care teams, MABS, etc.
- Ensuring there is sufficient time to plan the service, paying attention to the locations of venues (and the venue facilities); the timing of the programme (day/evening); the recruitment and training of community facilitators
- Exploring strategies and opportunities to get commitment to *We Can Quit* included in business planning of the local partners (e.g. social work, smoking cessation service, pharmacies, local development partners etc.)
- Developing a social marketing strategy with the local advisory groups to promote programme to include a range of activities including distribution of promotion material to relevant organisation, health fairs, attending service providers meetings, giving talks to parenting programmes etc.
- Recommendations to **improve recruitment** include:
 - Appointing a local co-ordinator with responsibility for gathering all the referral forms/interest forms, and to keep everyone updated on the start and location of programme etc.
 - Providing all key local organisations (e.g. hospital departments, primary care, community pharmacy, parent groups, local development groups, social work departments, MABs, etc.) with information packs about the programme (including times and locations of next group), with referral sheets and the name of a local co-ordinator;

- Agreeing a communication channel whereby the local co-ordinator provides feedback to referral organisations, as well as the women referred to the programme;
- Considering ways of involving *We Can Quit* 'graduates' in the promotion of future courses; and
- Inviting local organisations, and participant's family and friends to the celebrating the success event.

■ Recommendations for the improvement of the **delivery** of the programme include;

- Inviting all key partner organisations with a central role in either providing referrals or delivering the programme to an information session at the beginning of the community facilitator training to provide opportunities for everyone to meet and become more familiar with the programme.

■ Recommendations to **minimise drop out** include:

- Following-up participants between sessions, particularly if they have missed a couple of sessions;
- Providing participants with option to call into pharmacy to have CO levels monitored (if unable to attend group) and having levels recorded on record book to be shared with group the next week (and have monitoring data updated); and streamlining data monitoring systems to ensure quality data are collected without interfering with the support process.

8.3 Recommendations for the Future Development of the *We Can Quit* model

The promising early results from this pilot suggest that delivering an intensive, tailored face to face smoking cessation intervention is feasible in the Irish context. The ambitious national targets to reduce overall population prevalence of smoking by 1% per annum and to reduce smoking rates to 5% by 2025 require action at a number of levels, and this pilot study suggests that a programme like *We Can Quit* could have an important contribution to make to provide women with effective support to stop smoking.

If the *We Can Quit* model is to be rolled out, consideration should be given to:

- Establishing a protocol for the model planning and delivery to allow replication in other areas, outlining the mandatory components of the programme, and providing a menu of optional activities to tailor support to the needs of participants;
- In order to maximise partnership working, exploring mechanisms and opportunities to translate the commitment and goodwill of individuals and partner organisations into strategic planning at an organisational and area level;
- Further identifying and removing barriers to accessing stop smoking medication (combination NRT);
- Considering approaches to maximise the 'ripple effect' of the programme whereby participants cascade support to others not attending the groups support thus promoting smoking cessation within the community, and how family and friends can be supported to quit;
- Exploring how younger smokers might be encouraged to think about cessation, and recruited to the *We Can Quit* programme;
- Supporting women beyond the end of the programme to maximise the benefits of the group as a source of encouragement to remain quit and/or to help prevent relapse;
- Investigating the level of resources required (and available) to implement the *We Can Quit* programme, with particular focus on access to free or subsidised NRT;
- Exploring how *We Can Quit* might be 'branded' to encourage wider awareness within the communities, and become integrated within other relevant health and social initiatives; providing support to prevent relapse after the end of the programme e.g. integrating relapse prevention messages and skill development during the delivery of the programme, exploring opportunities for group participants to meet or keep in contact via social media;
- Ensuring access to stop smoking medication is as straightforward as possible for GMS clients,

which means reducing the number of 'stages' in the system that is required to obtain NRT. Careful consideration of the appropriate role for GPs should be given, alongside the potential of pharmacists to directly prescribe and supply NRT; and

- Exploring the options whereby participants can continue to access to free or low cost NRT and the associated support from Pharmacy staff after the programme as ended as part of a relapse prevention.

8.4 Policy Recommendations

The Irish Cancer Society has recognised that in order to help to achieve the Department of Health's goal outlined in Tobacco Free Ireland (TFI) of a smoking rate of 5% by 2025 new and innovative ways to tackle smoking have to be developed. If more innovative approaches are to be implemented, specific action is required at a policy level.

- Ring fence tobacco taxation for smoking cessation services. Smoking cessation services, such as *We Can Quit*, are a key part of tobacco control and health inequalities policies both at local and national level and therefore need to be developed and maintained. Treating tobacco addiction as a care issue is a critical principle underpinning the tobacco free policy and it is necessary to provide effective smoking cessation services to the 81% of smokers who want to quit.¹⁰
- Draw on local skills and assets to embed smoking cessation within local communities. Phases 1 to 3 of the study highlighted the potential of using existing community structures to target harder to reach smokers, and the pilot evaluation has demonstrated the potential of community facilitators working along health professionals to support smoking cessation:
 - Consider supporting community based smoking cessation services facilitated by local people who have been trained as cessation advisers. These could target to specific population groups with smoking rates higher than the national average (e.g. the homeless, travellers, women in lower socioeconomic groups etc.)
- Make Nicotine Replacement Therapy (NRT) free and simplify its provision.
 - A key success to the *We Can Quit* pilot phase was the provision of free NRT to the participants. 82% of the successful quitters used some form of NRT and 93% said they found it to be very helpful or helpful.
 - At present NRT has to be paid for by the user, unless they have a medical card. This is a barrier to potential quitters trying to access it. 28% of the *We Can Quit* participants said they would not have used NRT if they had to pay for it.
- Consideration should be given to removing VAT of NRT to reduce the cost for smokers trying to quit.
- The Dept. of Health/HSE should consider exploring the possibility of making NRT available to all those who sign up for smoking cessation programmes such as *We Can Quit*.
- The Dept. of Health/HSE should consider exploring the possibility of allowing any member of the primary care team (e.g. GP, Dentist, Pharmacist, Nurse Practitioner) to prescribe NRT.
- Develop and disseminate clear guidelines for the prescribing of NRT by GPs and Pharmacies
 - Currently, there are no guidelines or protocols for the prescribing of NRT by pharmacists or doctors. For the second phase of WCQ the Irish Cancer Society has devised some guidelines modelled on the ones being developed by the HSE, but with the addition of more structured behavioural support delivered by a pharmacist.
 - The guidelines and protocols should be in line with best practice.

10 Ipsos MRBI for the Irish Cancer Society; January 2014

8.5 Research Recommendations

- Further research is required to explore the effectiveness of the programme. Ideally future research would also examine efficacy i.e. would have a controlled element including a comparison group.
- A larger sample of women should be recruited to participate in order to be able to examine the factors associated with successful abstinence from smoking.
- As randomised control trials of a community-based approach to supporting smoking cessation may be challenging to implement, future research might include waitlist control or could compare outcomes achieved by improving access to NRT (dispensed through pharmacies providing one to one support) with the full group support programme.
- In future work, data collection should be carefully handled in order to not act as a potential deterrent to women (e.g. fewer questions asked on week 1). If WCQ programme is part of a further research study then informed consent could be sought after an initial visit, i.e. at week 2. This would minimise the risk of over-burdening facilitators with paperwork at week 1 at a time when they need to get to know the needs and expectations of the women who have signed up to the programme.
- Where possible, future research involving the programme should measure abstinence from smoking according to the Russell Standard, which is the gold standard for outcomes in cessation studies.
- As electronic cigarettes become more popular, careful monitoring of their use should be part of any future programme.
- Where possible future research should include an economic evaluation.

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Appendices

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Appendix 1: List of 'We Can Quit' National Advisory Group Members

Name	Organisation
Norma Cronin	ASH Ireland
Alison Begas	Dublin Well Woman
Peggy Maguire	European Institute of Women's Health
Brigid Quirke	Health Sciences UCD/Pavee Point
Eddie Ward	HSE Health Inequalities Unit
Kate Cassidy	HSE Health Promotion Officer
Martina Blake	HSE Tobacco Control Framework
Noelle Cotter	Institute of Public Health
Kevin O Hagan	Irish Cancer Society
Joanne Vance	Irish Cancer Society
Rachel Wright	Irish Cancer Society
Miriam Daly	Irish Collage General Practitioners
Cliona McCormack	Irish Heart Foundation
Marie Laffoy	National Cancer Control Programme
Rhona Mahony	National Maternity Hospital
Jacqueline Healy	National Women's Council of Ireland
Frances Byrne	OPEN

Appendix 2: Key terms used in literature review

Focus	Primary Keywords	Secondary Keywords	Population	Type of paper
Barriers and Facilitators	Smoking Cessation Smoking	Facilitators Barriers Blocks Challenges Ireland	Women OR female AND disadvantaged groups OR inequalities OR social class OR single parent OR lone parent, homeless OR low income OR low SES OR deprived OR deprivation, OR disadvantaged	Review OR Systematic Review OR Survey OR Qualitative study
Cessation Effectiveness	Smoking cessation Quit Giving up	Advice, group support, one to one counselling, booklets, helpline, text, internet, behavioural therapy, pharmacotherapy, behavioural support, nicotine replacement therapy, Ireland, interventions, effectiveness	All populations OR Women OR Females	Systematic Review
Engagement Effectiveness	Smoking cessation Approaches Giving Up	Community based community setting, health visitor, women's groups, training centres, primary care, Ireland	Women OR female AND disadvantaged groups OR inequalities OR social class OR single parent OR lone parent, homeless OR low income OR low SES OR deprived OR deprivation, OR disadvantaged	Review OR Systematic Review OR Survey OR Qualitative Study OR mixed methods

Appendix 3: Summary of other Approaches with Low Income Smokers

Quit4U (Ormston et al 2011)

'Quit4U' offers stop smoking support and incentives to stay stopped to those eligible to join the scheme. 'Quit4U' can be accessed within community pharmacies (chemists) or stop smoking groups throughout Tayside. As well as offering support, they can also discuss the use of Nicotine Replacement Therapy (NRT). Those who are eligible to join will receive £12.50 credit per week which can then be used towards food and groceries. Participants will need to make weekly visits to their community pharmacy/stop smoking group where they will be asked to breathe into a carbon monoxide testing machine which can tell whether they have been smoking or not. For every week that participants stay smoke free they will receive a £12.50 credit up to a maximum of 12 week.

Nottingham Children Centres (CC) and Stop Smoking Service (SS) (McEwen et al 2012)

Referral Liaison Advisers (RLAs) were employed in each area to attend the CCs to update records, intervene with clients, and support staff to use an opt-out referral system. At the point of a new contact being made with the CC, clients who smoked, or who had a family member who smoked, were routinely identified and informed that it was standard procedure to refer them for stop smoking support and to the local smoke free homes/families service. The client had to refuse the referral (opt-out) if it was not desired. The referral was then passed on by paper referral (Liverpool) or by electronic database link up (Nottingham). The project period of data collection in both areas was seven months.

Description of the content of the case-worker smoking Intervention (Bonevski et al 2011)

Case-worker session 1 At the client's first visit during an intervention week, staff will receive the survey print-out and checklist alerting them to client smoking status, nicotine dependence, previous quit attempts, and other issues such as depression or financial stress which may require additional support. All clients will be advised to quit. At that initial visit, clients will be asked to sign a behavioural contract outlining the support they will be given by staff to help quit smoking and their role in compliance with use of support strategies and making quit attempts.

Use of effective cessation support strategies A major component of the intervention is the provision of pharmacotherapy. Clients will be offered a choice of medication at no cost. Local pharmacists will also be provided with the algorithm for NRT and suggested as a source of advice and monitoring.

Social Support The case worker will ask the client to nominate a 'support' person for their quit journey and provide a support pack to give to their support person. The support pack will contain advice on support strategies (e.g. advice on supportive behaviour, committing to an attempt to quit together until successful, not smoking near them, an NRT discount voucher if a smoker, and the Quitline number). If a client does not have a potential support person, the caseworker will locate a volunteer at the Centre who will take on the role of the support person via telephone contact.

Support for other potential relapse-related factors As relevant, clients will be provided with information about courses and support options offered by the centre and other local agencies for issues such as depression and financial stress.

Description of the content of the case-worker smoking Intervention (Bonevski et al 2011)

Case-worker sessions 2 At the next visit, smokers who have attempted to quit will be asked about their progress and motivational interviewing will be used to encourage additional quit attempts among those who have tried and failed; and to encourage either an immediate or pre-planned quit attempt prior to the next session (within the next two weeks).

Use of NRT will be encouraged. Clients will be advised about other medications available on prescription to maximise their chances of successful quitting including bupropion SR, and varenicline. They will also be provided with written materials to take to their doctor. Those who need further assistance such as referral to specialised services will be offered a fax or email referral to Quitline, whereby the Quitline will call them.

Support for other potentially relapse-related factors Clients experiencing stressful situations (mental health, financial or relationship concerns), as recorded at the survey print-out will be offered enrolment into Life Skills courses provided by the Centre. Other support options in the local area will be discussed. There is evidence that individuals from lower socioeconomic positions tend to have greater needs for a variety of life stressors including housing needs, financial stress, employment concerns and physical and mental health concerns which affect relapse. They will also be offered the opportunity to schedule a visit together with their support person. At the final scheduled face to face meeting, clients will be asked to drop-in or phone-in when they require assistance. They will be told that their counsellor will make further phone contact to monitor progress and address relapse.

Phone contacts (x 2) Maintenance and follow-up are important components of this intervention. When face to face visits finish, staff will phone clients and check on progress, address difficulties, identify needs and provide advice. If practical aids are required, the client will be asked to return to the clinic to collect them. The invitation of un-scheduled drop-in or phone-in sessions will be reinforced

Appendix 4: Summary profile of organisations sent survey link

A cascade approach was used to reach a cross section of service providers via local managers and services through email. This included:

- Primary care staff including:
 - PHNs assigned to PCTs
 - RGNs assigned to PCTs
 - Occupational Therapists
 - Physiotherapists
 - Speech and Language Therapists
 - Dieticians
 - Therapy staff assigned to PCTs
 - Community nurses through the Institute of Community Health Nurses
- Addiction counsellors
- Local and community development organisations
 - Community health projects
 - Traveller organisations
 - Local Area Partnerships
 - Women's groups and networks
- Youth services
 - Youthreach
 - Youth groups
- Family Resource Centres
- Health Promotion staff
 - HSE Health promotion officers
 - Smoking cessation officers
 - National health promotion organisations
- National organisations
 - Partner charities
 - Health and social issue charities
 - Research organisations

Appendix 5: Esurvey respondent Profile

Type of organisation	N
Community Development Organisations	2
National Charities (Health)	3
National Organisation (Other)	5
Education	1
Youth Reach/Youth Organisations	9
Traveller organisations	3
Family Resource Centre	9
Homeless Organisations	2
HSE (Physio/OT, Primary care, SCS, Health promotion, hospital, etc)	36
Private Organisations	9
Women's Organisations	5
Other	4

Notes

Notes

the 1990s, the number of people in the UK who are employed in the public sector has increased from 10.5 million to 12.5 million, and the number of people in the public sector who are employed in health care has increased from 1.5 million to 2.5 million (Department of Health 2000).

There are a number of reasons for the increase in the number of people employed in the public sector. One reason is that the public sector has become a more important part of the economy. Another reason is that the public sector has become a more attractive place to work. A third reason is that the public sector has become a more important part of the welfare state.

The increase in the number of people employed in the public sector has led to a number of changes in the way that the public sector is organized. One change is that the public sector has become more decentralized. Another change is that the public sector has become more market-oriented. A third change is that the public sector has become more customer-oriented.

The increase in the number of people employed in the public sector has also led to a number of changes in the way that the public sector is funded. One change is that the public sector has become more dependent on government funding. Another change is that the public sector has become more dependent on private funding. A third change is that the public sector has become more dependent on user fees.

The increase in the number of people employed in the public sector has also led to a number of changes in the way that the public sector is managed. One change is that the public sector has become more professionalized. Another change is that the public sector has become more bureaucratic. A third change is that the public sector has become more hierarchical.

The increase in the number of people employed in the public sector has also led to a number of changes in the way that the public sector is evaluated. One change is that the public sector has become more subject to external evaluation. Another change is that the public sector has become more subject to internal evaluation. A third change is that the public sector has become more subject to self-evaluation.

The increase in the number of people employed in the public sector has also led to a number of changes in the way that the public sector is perceived. One change is that the public sector has become more respected. Another change is that the public sector has become more valued. A third change is that the public sector has become more trusted.

The increase in the number of people employed in the public sector has also led to a number of changes in the way that the public sector is viewed. One change is that the public sector has become more visible. Another change is that the public sector has become more accessible. A third change is that the public sector has become more transparent.