Factors influencing the willingness of community service organisation staff to provide smoking cessation support: a qualitative study

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Abstract

Objective: This study aimed to explore factors influencing community service organisation (CSO) staff members' willingness to provide tobacco cessation support to clients experiencing disadvantage.

Methods: Face-to-face semi-structured interviews were conducted with 29 staff members from seven services in the alcohol and other drugs, homelessness, and mental health sectors in Western Australia.

Results: The primary barriers to providing cessation support were believing that addressing smoking was not a priority relative to other issues, being a current smoker, and the lack of a formal tobacco cessation program within the organisation. Factors that appeared to be most influential in enabling the delivery of cessation support were organisational processes requiring staff to routinely ask clients about tobacco use, confidence to provide support, and being a past smoker.

Conclusions: The introduction of organisational procedures that include routine cessation care should be of high priority in CSOs to help reduce smoking rates among clients. Staff may also benefit from receiving training in the provision of cessation support and education about the importance and feasibility of addressing smoking concurrently with other issues.

Implications for public health: The results may inform future efforts to increase the delivery of cessation care to groups of people experiencing disadvantage and comorbidity.

Key words: community service organisations, staff, cessation support, disadvantage, smoking

Rates of tobacco use among people experiencing disadvantage are considerably higher than among the general population. While the population prevalence of smoking is relatively low in many high-income countries (e.g. Australia 12%, UK 16%, US 14%, and Canada 13%),[1–4] smoking rates are often much higher among vulnerable segments of the population. Examples include people affected by alcohol and other drug dependence (77%–88%),[5–7] experiencing homelessness (75%–81%)[8–11] or living with a mental illness (29%–70%).[12–15]

In Australia, community service organisations (CSOs) are not-for-profit organisations that support vulnerable groups by providing services such as short-term accommodation, counselling, outpatient drug and alcohol withdrawal services, food provision and rehabilitation.[16] These organisations have been suggested as viable settings for addressing tobacco use among people experiencing disadvantage due to established relationships between CSO staff and clients and a demonstrated willingness among clients to accept cessation support from CSO staff.[17–19] Cessation support in CSOs may be delivered in various formats, including emotional support, provision of resources, and referral to quit services or general practitioners.[20] However, the provision of smoking cessation programs within CSOs is likely to be dependent on the willingness of CSO staff to provide this support,[21] yet little is known about their receptiveness to incorporating this function into their work roles.

The limited prior work investigating CSO staff members' attitudes to the provision of cessation support in both Australia and internationally has found that some staff consider it to be compatible with their roles while others do not.[17,21–24] The possible factors influencing staff members' provision of quit support have been identified as their confidence and perceived ability to deliver effective support and their own smoking status.[22–24] However, it is likely that staff members working in different CSO sectors experience different barriers and enablers when attempting to provide cessation support, resulting in calls for research to be conducted across a broader range of CSOs.[17,22]

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Submitted: August 2019; Revisions requested: November 2019; Accepted: December 2019
The authors have stated they have no conflict of interest.

Aust NZ J Public Health. 2020; 44:116-20; doi: 10.1111/1753-6405.12967

As most smoking cessation research conducted with CSO staff thus far has been quantitative, the present study aimed to extend the scope of previous studies by using qualitative methods to develop a deeper understanding of the factors influencing CSO staff in their decisions relating to the provision of cessation support to clients. A secondary aim was to identify any variations in these factors between staff working at different types of CSOs. The results provide insights into potential means of increasing support for CSO staff working across different sectors.

Methods

Semi-structured individual interviews were conducted with staff members from CSOs from the alcohol and other drug, homelessness, and mental health sectors in Western Australia. The study was granted ethics approval from a University Research Ethics Committee (approval number HR226/2015).

Recruitment

Interviewees were recruited from seven CSOs in metropolitan and regional Western Australia (Table 1). Sampling initially commenced by nominating three categories of CSOs that would provide access to a broad range of smokers experiencing disadvantage. These categories were CSOs addressing alcohol and other drugs, homelessness and mental health. Interviews were progressively conducted across multiple CSOs in each of these categories, including in regional areas where possible. Data collection continued until saturation was achieved both within and across the CSO categories. Saturation was determined to have occurred where no new concepts were emerging from the data from the various categories of sources.[25] Two data collectors spent approximately one week at each CSO, during which time staff members were informed about the study and advised they could approach the data collectors if they were interested in being interviewed. To be eligible to participate in the study, individuals were required to be working at the CSO in a paid or voluntary position, aged 18 years or above and English-speaking. Staff members were able to participate regardless of their smoking status.

Data collection

Two data collectors were present during each of the interviews. Both data collectors were tertiary-qualified female non-smokers who worked in the field of tobacco control. Neither had any pre-existing relationship with any of the interviewees. General topics of conversation during the interviews included the criteria used (if any) to determine whether discussions about quitting are instigated with a client, the availability and nature of cessation assistance within the CSO, and personal tobacco use. Interviews lasted for an average of 31 minutes (range 17–56 minutes). All interviews were audio-recorded and transcribed by a professional transcription service, with the exception of one interview in which the participant did not consent to being recorded. In this case, one of the data collectors conducted the interview while the other took detailed notes.

Data analysis

Interview transcripts and notes were imported into NVivo 12 and coded inductively to an emergent coding framework to facilitate thematic analysis. Reflecting the use of an emergent coding process, initial coding of the data was completed by one author (AP). The transcripts and the notes that were taken during the interview that was not recorded were read through multiple times and coded by line unit to facilitate the identification of themes. Matrix searches were conducted in NVivo to explore relationships between variables. The matrix searches facilitated the comparison of coding outcomes between the different types of CSOs to assess whether some issues were more relevant for certain sectors. The coder and another researcher (SP) discussed the findings to conceptualise a framework that incorporated the factors that influenced interviewees' provision of cessation support to clients. The factors that were categorised as being most consequential were those that were raised most often by the interviewees and appeared to have the greatest bearing on their readiness to assist clients to quit smoking. The rest of the research team reviewed the framework and assisted in refining the findings.

Table 1: Sample composition by community service organisation (CSO) type and location.

CSO type	Number of CSOs visited	Location	Number of staff members interviewed (n = 29)
Alcohol and other drugs	2	1 metropolitan	4
		1 regional	3
Homeless	3	2 metropolitan	8
		1 regional	4
Mental health	2	2 metropolitan	10
Total	7	5 metropolitan	22
		2 regional	7

Results

Sample

Twenty-nine CSO staff members were interviewed across the seven CSOs (an average of 4 per CSO, range 3–6). A majority of the sample was female (62%) and a relatively high proportion (28%) reported being current smokers (Table 2).

Factors influencing willingness to provide cessation support

The factors described by interviewees as influencing their willingness to provide their clients with cessation support fell into three main categories: staff-related, client-related and organisation-related. They were then categorised as being either barriers or enablers to the provision of cessation support (Table 3). Very few of the interviewees reported providing cessation support to their clients, and most of the relevant discussions in the interviews focused on the factors that discourage staff members from providing such support. Thus, overall the identified barriers appeared to be more consequential than the corresponding enablers. Illustrative quotes are provided throughout the analysis below, with descriptors given for each quote as follows: gender (F=female, M=male), type of CSO (AOD=alcohol and other drugs, H=homeless, MH=mental health), CSO location (metropolitan, regional), and smoking status (non-smoker, past smoker, smoker). Unless otherwise noted, the factors discussed below were found to be consistent across interviews with staff members from the different types of CSOs.

Staff-related factors

Barriers

A primary barrier was found to be staff members' beliefs that it was inappropriate to expect clients to address their tobacco use at the same time as they were dealing with other issues that the staff members regarded as being more urgent. Many interviewees reported that undergoing treatment for alcohol and other drug use or mental illness was difficult enough for clients without the added stress of attempting to quit smoking.

> *If they're using a hard drug and cannabis, I'm less likely to ask if they are using tobacco … So, the reasoning is bigger fish to fry basically.* (M, AOD, regional, non-smoker)

> *[Smoking] is a coping strategy for them … They probably need to be watched for what sort of circumstances and situations they're in before they give up because if you're coming into it very highly stressful … it's probably not the best time.* (F, MH, metropolitan, past smoker)

Compared to ex-smokers, interviewees who were current smokers or non-smokers generally took a more passive approach to providing cessation support to clients. They appeared unsure of how to best provide support, and some noted that they did not feel as qualified to offer advice as someone who had experienced quitting.

> *Interviewer: Do you know where you can refer people so they can get support if they do want to quit or cut down?*
>
> *Interviewee: I don't actually. No, I don't, no.*
>
> *Interviewer: What about for yourself? If you wanted support to quit, where would you go?*
>
> *Interviewee: I wouldn't go anywhere. Yeah, I guess when I think about quitting smoking, I don't think about having that support.* (F, MH, metropolitan, smoker)
>
> *Get the people that have gone through it to talk to the people that would like to give up smoking … Because they've been through it, so they can empathise because they know exactly what that person is going through. I would be the wrong person.* (F, H, metropolitan, non-smoker)

Enablers

Confidence in being able to approach clients to provide cessation advice appeared to be the primary determinant of whether staff members offered cessation support. Interviewees working at AOD services appeared to be more confident than those from other types of CSOs in their ability to discuss tobacco use and to support clients during their cessation attempts. They attributed this confidence to their training and experience in helping clients address other forms of drug dependence.

> *We're drug and alcohol counsellors, so it's not different to speaking to somebody about their meth addiction … We're trained and we've got degrees, we've got experience. We would be able to have those conversations, no problems.* (M, AOD, metropolitan, smoker)

As the counterpoint to the barriers perceived by staff members who were current and non-smokers, interviewees who classified themselves as past smokers reported that they felt equipped to offer cessation advice to clients because of their personal experiences with tobacco use and quitting. They demonstrated greater knowledge of the help and resources that are available to clients who are trying to quit smoking and reported being able to provide information about the benefits they personally experienced from quitting.

> *Interviewer: If you had a visitor, or maybe you have in the past, that wanted information or help to quit smoking – where would you send them?*
>
> *Interviewee: Now, I'd send them to your doctor. So, when you go to your GP, talk about this product (varenicline). It's amazing … I'd say, 'Listen, I've smoked for 40 or 30 years and this is what I did'.* (M, H, metropolitan, past smoker)
>
> *Interviewer: Do you ever have conversations with people about tobacco use at all? Does that come up?*
>
> *Interviewee: I do. Some people I do, and a lot of the conversations go, "You should quit smoking." And then they sort of go along the line of, "How do you know anything about it?" "Well, actually I do … trust me, you'll be better off."* (M, H, regional, past smoker)

Table 2: Sample demographics (n = 29)

Attribute	n	%
Age (years)		
18-24	1	3
25-34	8	28
35-44	5	17
45-54	8	28
55+	7	24
Sex		
Female	18	62
Male	11	38
Employment type		
Paid	26	90
Volunteer	3	10
Smoker status		
Non-smoker	14	48
Current smoker	8	28
Past smoker	7	24

Client-related factors

Barrier

Many interviewees mentioned that they would be more comfortable discussing tobacco use with clients if they had voluntarily raised the issue, rather than having to bring it up. However, interviewees from all three sectors noted that this was a rare occurrence.

> *Interviewer: Do you think it's something that should be raised in just a general discussion you have with clients?*
>
> *Interviewee: They've got to make the first step to say, "I want to quit".* (M, H, regional, smoker)

Enabler

Some interviewees discussed being more willing to talk to a client about their tobacco use if they had an established relationship. This seemed to be especially relevant for those working at homelessness services, who were particularly mindful of taking the time to build relationships to build trust and avoid deterring clients from accessing the service again in the future by raising difficult issues.

> *The hard part here is getting to know them and getting them to trust you … So, once they start – we'll often talk about some of their behaviours, smoking included … You've got to get their trust because they don't do trust very easily. You tread the path carefully, otherwise, you just lose them.* (M, H, metropolitan, past smoker)

Table 3: Factors described as influencing provision of cessation support.

Level	Influencing factors
Staff-related	Belief that addressing tobacco use is not a priority relative to other issues (-)
	Smoking status
	Current or non-smoker (-)
	Former smoker (+)
	Confidence (+)
Client-related	No expressed interest in cessation (-)
	Established relationship with staff member (+)
Organisation-related	Unsustainable programs/lack of programs (-)
	Instituted processes (+)

Note: factors within categories presented in order of apparent importance
(-) = barrier
(+) = enabler

Organisation-related factors

Barrier

A lack of sustainable tobacco-related programs and the unavailability of quit resources at CSOs appeared to discourage the provision of cessation support. Most interviewees noted that there were not currently any tobacco cessation programs or resources available in their services. Without these tools to assist them, many interviewees were unsure of how to help their clients to quit smoking. Some interviewees mentioned that there had previously been tobacco-related programs that had operated in their CSOs that had ended due to funding being cut or the departure of trained staff.

> *We had a staff member a couple of years ago, she ran the Quit group. It had some success, but she moved on and we couldn't access the training again … It's not just that we're ignoring the problem, but we have not got a conscious program to tackle the issue.* (F, AOD, metropolitan, non-smoker)

> *When I started here, I think there was a tail-end of a quit program that they had here … I don't know why it disappeared. I think we need something like that here … But we don't have the quit packs … But that's something that we seriously need here.* (M, AOD, metropolitan, smoker)

> *The quit smoking program that we had before, it's something I think that needs to be consistent … When you only get funding for it to run a couple of times, it's not going to work, I don't think.* (F, MH, metropolitan, smoker)

Enabler

Interviewees employed at two of the CSOs (1 AOD, 1 MH) described processes that were currently in place at their services to assess client tobacco use upon entry to the service. These processes appeared to encourage staff to not only routinely broach the topic of smoking, but also to instigate conversations about clients' level of tobacco use and the amount of money they were regularly spending on cigarettes. These conversations were reported to lead to the referral of interested clients to quit services.

> *One of the tools that we have is a general health prompt … Smoking is part of that, and seeing if this is an area the consumer would want to engage in. (If) it's identified, they'll have a one-on-one meeting with the registered nurse, and we'll start a program from there.* (M, MH, metropolitan, non-smoker)

> *We ask them how much they spend on smoking. Some will tell us $100 a week. Some will say $40. We get that sort of measure of what's going on.* (F, AOD, metropolitan, non-smoker)

Discussion

This study explored factors influencing CSO staff members' willingness to provide tobacco cessation support to their clients. The identified contributing factors related to staff members themselves, their clients, or the organisations for which they worked. Overall, the most consequential factors appeared to be staff- and organisation-related, especially existing beliefs about the appropriateness of addressing clients' tobacco use while they are attending CSOs to seek assistance for other issues and a lack of smoking cessation programs and/or resources at their services.

Interviewees' concerns about addressing clients' smoking at the same time as other issues (e.g. mental illness and substance use) present as an important intervention opportunity given prior research has shown that quitting smoking is generally not harmful to the psychological wellbeing of people living with mental illness and can improve outcomes for people being treated for substance use.[26,27] CSO staff may thus benefit from education about the importance of providing people with the opportunity to access cessation assistance, as well as being provided with appropriate cessation support resources and training.

The unsustainability of cessation programs in terms of both funding and staffing was raised by interviewees from all three types of CSOs. It has been proposed that due to the difficulty of acquiring sustainable funding and resources for programs, it can be more effective in the long-term to modify organisational policies.[28] For example, the introduction of smoke-free policies supports tobacco cessation among both clients and staff.[29,30] Simple, sustainable processes that support people to quit smoking may also be implemented, such as recording clients' smoking status and providing Quitline contact information.[31]

It is a promising finding that staff who reported that there were processes in place at their services to routinely ask clients about their smoking status and interest in cessation were more likely to report doing so than those without such a policy. This outcome suggests that the inclusion of routine questions about tobacco use into CSO admission processes is likely to be a positive step in encouraging the provision of quit support by staff. This could help to ensure that clients who are interested in quitting are identified and address staff members' concerns about discussing tobacco cessation with clients with whom they do not have an established relationship. Routinely asking clients about their interest in quitting is especially important given that this and previous studies have found that CSO staff perceive a lack of client interest in tobacco cessation as a barrier to providing support,[32] and the tendency to underestimate clients' interest in quitting smoking has also been documented.[33] In addition, brief tobacco interventions (such as the '5-As for smoking cessation' (Ask, Advise, Assess, Assist and Arrange) program that is currently regarded as best practice for general practitioners in Australia) could be introduced as part of normal care.[34]

For most factors, results were consistent across the three types of services. Partial exceptions related to confidence and relationships; interviewees from AOD services were more confident in offering cessation support to clients and interviewees from homelessness services were more concerned about the need to build relationships with clients before discussing tobacco use. The higher levels of confidence to discuss tobacco use with clients expressed by interviewees from the AOD sector suggests that these services may be the ideal sector in which to pilot CSO smoking cessation programs. Once process and evaluation research demonstrated program effectiveness in these contexts, roll-out could occur across other sectors.

The reluctance of interviewees who were current smokers to proactively offer cessation advice and support to clients is in accordance with prior research that has identified staff smoking as a potential barrier to tobacco cessation among clients.[35–37] This outcome suggests that addressing staff smoking is imperative not only for their own wellbeing, but also to improve the likelihood of them offering cessation care to their clients.[38,39] Providing staff support to quit smoking is especially important, given that a higher proportion of CSO staff smoke compared to the general population.[5,22]

The findings from the present study provide a deeper understanding of the factors

influencing CSO staff in their decisions to provide quit support to their clients. Importantly, the results demonstrate that there are common areas of assistance required across different CSO types, which should simplify the process of developing and implementing interventions designed to encourage and support CSO staff to provide smoking cessation guidance. A particular strength of this study is its focus on staff working at organisations servicing three high-priority smoking groups. There has been limited previous research conducted among staff working with these groups, and calls have been made to carry out further research in different types of community service organisations.[17,22] Study limitations include the modest sample size and data collection being restricted to one Australian state. Future research could employ quantitative methods and extend to other types of CSOs and those in other geographical locations to assess the broader applicability of the results.

Conclusion

The present study examined factors influencing the provision of smoking cessation support among CSO staff servicing three high smoking prevalence groups. The results may inform future efforts to increase the delivery of tobacco cessation care to groups of people experiencing disadvantage. In particular, the findings suggest that addressing staff members' personal beliefs about the appropriateness of clients quitting smoking while dealing with other issues and the introduction of organisational procedures that include routine cessation care should be a high priority to encourage CSO staff to support their clients to quit.

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