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*"The lesser of two evils":* **A qualitative study of staff and client experiences and beliefs about addressing tobacco in addiction treatment settings.**

**Running title:** Tobacco and addiction treatment settings

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**ABSTRACT**

**Introduction and Aims**: To explore beliefs about tobacco dependence treatment from the perspective of staff and clients in addiction treatment settings.

**Design and Methods**: A qualitative study was conducted between August and November 2013 using grounded theory methodology.  Participants were recruited from four government-funded drug and alcohol services in a regional centre of New South Wales, Australia. Treatment centre staff (n=10) were interviewed using a semi-structured interview guide and two focus groups (n=5 and n=6) were held with clients of the same treatment centres.

**Results**: Both clients and staff wish to do more about tobacco use in addiction treatment services, but a number of barriers were identified.  Staff barriers included lack of time, tobacco-permissive organisational culture, lack of enforcement of smoke-free policies, beliefs that tobacco is not a treatment priority for clients and that clients need to smoke as a coping strategy, and perceptions that treatment was either ineffective or not used by clients. Clients reported smoking as a habit and for enjoyment or stress relief, seeing staff smoking, NRT unaffordability and perceptions that NRT may be addictive, and inability to relate to telephone cessation counselling as barriers to quitting smoking.

**Discussion and Conclusions:**. Client and staff perceptions and attitudes about the treatment of tobacco, particularly those relating  telephone support and NRT, provided information which will inform the design of smoking cessation programs for addiction treatment populations.

**Key words:** smoking, qualitative, substance-related disorders

**INTRODUCTION**

Compared to the general population, smoking is more prevalent in addiction treatment services, and these smokers are more heavily nicotine dependent and smoke more cigarettes (1-3). Reports suggest that many people start smoking for the first time while in treatment and ex-smokers resume smoking when returning to treatment (3). As a result, tobacco-related health burden such as cardiovascular disease is substantial among people with drug and alcohol addiction (4, 5).

Evidence-based tobacco treatment guidelines recommend that smokers with alcohol and drug dependence be offered assistance to quit smoking (6, 7). However, drug and alcohol services rarely address client tobacco use (8) and most have limited smoking policy implementation or enforcement (9). There is surprisingly scarce information about why tobacco is not addressed within the drug and alcohol sector. One Australian survey of 417 managers and other staff found that the barriers to delivering tobacco treatment were concern regarding its impact on clients' other treatment outcomes, a perceived lack of client interest and a lack of staff training (8). A more recent UK survey of 145 staff found negative attitudes amongst treatment staff towards addressing tobacco. For example, treatment for smoking was rated as significantly less important than treatment for other substances, and only 29% of staff felt that smoking should be addressed in a client's primary addiction treatment (10).

The high levels of social disadvantage, drug dependency and comorbidity among smokers in drug and alcohol treatment suggest they would have difficulty quitting without support (11, 12). Indeed, one study found a quit ratio of less than 10% amongst drug and alcohol treatment clients (12). The motivation and intention to quit smoking among clients of addiction treatment services is also not clear. Some surveys suggest high rates of motivation to quit smoking (1, 10, 13), but others indicate many clients have no such intention (12). Only one study has explored how clients feel about being offered support to quit smoking during drug and alcohol treatment and found that clients were positive and believed that addressing

smoking during treatment was appropriate (10). Understanding factors that influence the delivery and uptake of tobacco treatment in drug and alcohol treatment services is important for designing effective complex interventions. Qualitative research methods can help identify barriers and facilitators for change as perceived by clients and staff (14). This study aims to explore the experiences, attitudes and beliefs about smoking cessation care from the perspective of staff and clients in drug and alcohol treatment settings.

**METHODS**

**Design**

A qualitative study was conducted between August and November 2013 using grounded theory, an inductive general method of analysis in which theory is generated (15, 16). Drug and alcohol treatment centre staff was interviewed using a semi-structured interview guide while focus groups were held with clients of the same treatment centres. The research received approval from the University of Newcastle and Hunter New England human research ethics committees.

**Setting**

The study was conducted in four government funded drug and alcohol services in a regional centre of New South Wales (NSW), Australia. These included a community based opiate treatment program (OTP), an inpatient drug and alcohol service in a major teaching hospital, an outpatient hospital based drug and alcohol service and a detoxification (detox) unit. All services were smoke-free under the local Health Authority act. Four different addiction programs were used to gather data.

**Sample**

*Staff*

A range of staff (eg, counselling, management, nursing) who had face-to-face contact with clients were recruited and these included of smokers and non-smokers. Different staff had different roles within the service and the study aimed to capture how smoking is addressed in each role. Staff members were eligible to participate if they had direct client contact and spoke English. Purposive sampling was undertaken using a snowball process where possible participants were recommended by individual staff members. The director of each unit was asked to provide consent for their unit to take part in the study. A member of the research team presented the study at a staff meeting. Any staff interested in participating then contacted the research team via email. If they provided written informed consent, a time was made for a one-on-one interview in a private room at their place of work.

*Clients*

Clients who were current smokers, proficient in English and who did not have severe mental health issues as judged by clinical staff, were eligible to participate in the research. The staff provided these clients with information sheets and invited them to attend the focus group. Focus groups were held at the centres in private meeting rooms with light refreshments provided. Clients who attended were asked if they had read the information sheet, understood the content and whether they had questions. Participants were asked to provide written informed consent before the focus group commenced. Only one client (detox) declined to provide consent and left before the discussion commenced.

**Procedures**

*Staff*

All interviews were conducted by an experienced interviewer (AW), recorded and transcribed. Participants were given the opportunity to read and comment on the interview

transcript. Interviews ranged between 30 and 60 minutes in length. At the completion of the interview participants were offered a $15 shopping voucher to reimburse them for their time.

*Clients*

Two client focus groups were conducted in meeting rooms at the treatment centres. Centre staff (two with the OTP group and one with the detox group) were present during sessions for safety purposes but did not interact in any way with the group. They sat outside the discussion circle and undertook other work. Following each one-hour focus groups, participants were offered $20 grocery vouchers (excluded purchase of tobacco or alcohol) to cover any associated costs. All discussions were audio-recorded and transcribed.

**Study Instruments**

Staff interviews included a short written questionnaire on demographics, smoking status, and work. Clients also completed a brief smoking-related survey including items on demographics, smoking behaviours and quit attempts. The client focus groups were initially asked "What are you experiences regarding smoking?" and staff were asked "What are your experiences regarding clients smoking?" Prompts were used to help direct the topic back to smoking if it drifted too far into another domain and these included "What are your experiences in trying to quit?" (FGs) and "What are you experiences of clients trying to quit?" All participants were encouraged to talk freely about their thoughts and experiences. Questions also arose from the participant data spontaneously - including the concept of Quitline causing users to feel stressed. All questions were open ended and designed to deepen the level of understanding. **Coding and Analyses**

Survey data is summarised using descriptive statistics including proportions and numbers for categorical data and means and ranges for continuous data. All interview and focus group

data were analysed by two researchers (AW and BB) using qualitative methods. Transcripts were closely and repeatedly analysed to identify emerging themes and subthemes and were coded using NVivo 10 software (17). Data were transcribed and analysed using constant comparative analysis, an inductive method (15). Each transcription was coded and these codes were analysed. Codes were given titles suggested by the data and those with similar meanings were clustered into categories where themes and subthemes were identified. Data were gathered and analysed until saturation point where no new codes or categories arose. The contents of the main themes are summarised with relevant quotes in the results to illustrate findings.

## RESULTS

### Staff Interviews

Ten interviews were conducted with staff from the four treatment programs. Four were male, the average age was 52 years (range = 32 - 65years) and all were University-level qualified (one Nursing Unit Manager, six nurses, one pharmacist, one counsellor and one case-worker). Staff had worked in drug and alcohol settings for an average of 15 years (range = 1- 32years). Two staff were current smokers both of whom had previously attempted to quit. Table 1 summarises the themes and quotations extracted from the staff interviews.

### 1. Why Clients Smoke

Staff felt most of their clients smoked and a number of reasons for the high smoking rates were suggested.

#### Social disadvantage contributes to smoking

Staff agreed unanimously that the majority of their clients smoked and the main reason for this high rate related to their clients' socially disadvantaged status. It was one of the ways

their clients coped with difficulties in life. To illustrate this argument, staff gave graphic personal examples of the disadvantages their clients faced including abusive relationships, generational unemployment, extreme poverty, depression and deprivation.

*Smoking as a coping mechanism*

A common theme raised by staff was that clients smoked to deal with stress and this stress inhibited interest in quitting. One Nursing Unit Manager said this 'stress' was actually the physical process of tobacco addiction where short-term withdrawal symptoms were incorrectly interpreted by the smoker as stress-related. The smoker perceived they were stressed, they had a cigarette to 'cope' and the symptoms disappeared, reinforcing this belief. Most other staff felt their clients were legitimately stressed and smoking relieved this.

*The social context of smoking*

Staff described a range of social factors such as pro-smoking social norms, smoking as a social activity and the social acceptance and bonding nature of smoking among clients' peers and families which influenced client smoking and lack of success in quitting.

*Nicotine addiction*

Staff also believed clients were highly addicted to smoking, *"dependence – they're dependent on them"* and that they had difficulties addressing addictions in general, *"they have addiction issues"*.

Table 1 about here

**2. *Supporting clients to stop smoking***

There was some discussion about current provision of support to clients and staff reported to be aware that smoking was harmful for their clients and that it was an important issue that

should be addressed and followed-up as part of their role. Staff identified aspects of smoking cessation care currently provided to clients, however they also noted that not all clients received this, as smoking cessation support was not routine or systematically provided. Staff said would like to have "standards" for tobacco dependence treatment, as they do for treatments for other dependences. Often smoking was only pursued if the client reported it as their primary drug of concern.

### 3. *Barriers to the delivery of smoking cessation care*

Staff reported a number of factors that made it difficult for them to provide clients with support to stop their smoking.

#### *Not a treatment priority for staff*

The concept of tobacco smoking being the *"lesser of all evils"* was repeated by a number of staff. The belief that tobacco smoking is less harmful than clients' other drug addictions, meant tobacco was a low priority treatment target for staff.

#### *Perception that cessation is not a priority for clients*

Staff thought clients did not consider tobacco smoking as treatment priorities compared to their illicit or other drug use.

#### *Lack of time and increased burden*

Many participants said having to address tobacco addiction would increase their workload with little benefit as their clients are particularly difficult to treat.

#### *Attitudes and organisational culture*

Staff Felt the reason tobacco smoking was not routinely addressed in drug and alcohol settings was due to an organisational culture less focussed on providing optimal care. The reason for this culture was thought to be due to the nature of addiction and the stigma attached to the types of clients they care for. That if clients had physical ailments like cancer

or injuries, staff would take better care, but because clients are 'just addicts', some staff had more relaxed attitudes towards the standard of care they provided. Some staff expressed frustration at the attitudinal issues around tobacco in particular, but were unable to explain why they exist.

*Lack of compliance with nicotine dependence treatments*

Beliefs that clients do not use treatments appropriately, such as nicotine replacement therapy (NRT), were seen as a factor which discouraged staff in providing further offers of help.

*Lack of compliance with smoke-free policies*

In-patient drug and alcohol staff were unhappy with the numbers of staff and clients who disregarded the non-smoking policy and the fact that no-one enforced it.  Only the outpatient clinic (in a different hospital) actively addressed smoking on the premises by informing people who smoked (not necessarily drug and alcohol clients) about the policy. All staff interviewed felt that staff smoking was a poor role model for clients and staff who did smoke expressed feeling hypocritical.

*Perceptions that smoking cessation programs and treatments are not effective*

Some staff members had tried to quit smoking  but found it difficult and subsequently believed that tobacco treatments and programs did not work. Staff who smoked indicated they did not use the treatments and were less likely to recommend them.


**Client Focus Groups**

Two focus groups were conducted with a total of 11 participants (6 in one and 5 in the other), all of whom were current smokers. Basic characteristics of participating clients are summarised in Table 2. Participants were attending treatment for heroin, amphetamine or cannabis.

Table 2 about here

A summary of client statements and focus group themes are provided in table 3.

### 1. Desire to quit smoking

*Family-related motivation to quit*

Most clients said they intended to or would have liked to try to quit smoking. They discussed the social factors that provide motivation to quit smoking including family support, and encouragement when they did make attempts to quit or cut down on their smoking. Some participants said that *'no smoking'* policies at home assisted them to quit or cut down. Feelings of guilt about scaring family members with their continued smoking and pressure from family to stop smoking were common.

*Health-related motivation to quit*

Clients were well aware of the health impact of smoking and believed that smoking was doing them harm which motivated them to quit. Most believed they were more at risk of dying from tobacco-related diseases than from their other addictions. Knowing people who had experienced smoking-related health problems was another reason to quit smoking. Other motivations to quit involved how it made them feel, especially in regards to smell and physical appearance.

### 2. Barriers to quitting smoking

*Habit and enjoyment*

A primary reason clients said they continued smoking was because of habit, often linked to routine daily activities and enjoyment.

*Coping strategy*

Clients believed that smoking relieved their anxiety and stress. Treatment for clients' other drug use was strongly related to feelings of stress and anxiety and smoking was seen as a means of coping with interventions such as group therapy.

*Smoking is not like other addictions*

Although most clients understood the harms caused by smoking and the impact on their health, they didn't group it in the same category of harm as their other addictions which were perceived as more urgent.

*3. How smoking is addressed within drug and alcohol services*

*Variable access to cessation support*

Some clients said they received no help to quit tobacco at all, while others had received some assistance. Often assistance is very brief and consisted of either being given a Quitpack, the telephone number for the Quitline or offer of NRT. The detox unit was completely non-smoking and NRT was provided to all clients during their stay. However, there was no follow-up or encouragement to continue not smoking; NRT was not dispensed at discharge nor were prescriptions for NRT made available. The OTP Clinic was also a non-smoking environment however as clients were only there for a short period of time, they reported smoking outside the building on the footpath. Clients said they had occasionally been offered NRT free-of-charge by the clinic, but this was only when the clinic was participating in research trials and was therefore not consistently available, and none had been offered scripts for NRT from the clinic although a few had been recommended to see their own doctor for a NRT prescription. Most had never been asked whether they would like help with smoking cessation although all had been asked whether they were smokers.

*Acceptability of receiving assistance from staff*

Clients were open to receiving assistance from staff for their smoking and thought it would help them quit if staff were supportive and talked about smoking - *"might make you think more about it"*. However, clients said they saw staff smoking at the treatment centres and as a result it was difficult to view them as role models. This occurred in smoke-free services and clients acknowledged that most staff tried to be inconspicuous.

*Use of NRT*

Clients believed NRT could help them stop smoking, however, they either didn't receive a high enough dose for a long enough time, or NRT was too expensive if it wasn't provided by the service. The impact of NRT use was also reportedly undermined by exposure to other clients' smoking, making it less effective as a quitting aid. Some clients felt using NRT was not really quitting. This point was especially salient to clients within the OTP who compared NRT to methadone maintenance programs. They were also concerned NRT may be addictive.

*Difficulties with Quitline*

Most clients said they had not used the telephone smoking cessation support service, Quitline, and were not interested in trying it. Those who had used it found it unhelpful and contributed to their stress, leading to more smoking. Others preferred not to receive counselling via the telephone.

Table 3 about here.

**DISCUSSION**

This qualitative study highlights a number of themes around the use and treatment of tobacco smoking in addiction services. Some of the themes raised in the staff interviews concur with previous survey research (8-13) such as perceptions that smoking is a way for clients to cope with their stressful lives and that smoking cessation is not as high a priority as other drug use.

Novel findings include differences between client and staff perceptions about tobacco treatment, particularly in relation to telephone cessation support and NRT.

The study provides some valuable information regarding motivating factors to encourage clients to quit and which should be incorporated into cessation support interventions. Clients wanted to quit for various reasons including their health and gaining family approval, which is consistent with reasons identified by smokers more generally (18). Clients also said they would be receptive to receiving quit advice from staff in this setting. Both staff and clients perceived smoking as a major health issue and would like tobacco-based standards or systems that could be used in these settings.

In contrast to wanting to quit smoking due to the health harms caused by it, some clients felt their other drug use was a more 'urgent' concern, mostly due to the social problems caused to their lives by their illicit drug or alcohol use.  In contrast, tobacco was legal and could be used with no obvious immediate effect on a smoker's life. These results are similar to another recent study with methadone maintenance clients which have found some ambiguity around intentions to quit smoking (12). The findings suggest that while addictions clients are interested in quitting smoking, they may not have clear plans to do so until they have treatment for other drug use, which disrupts their ability to function on a daily basis. Education of staff and clients of the benefits of simultaneous treatment for tobacco and other drugs will improve understanding of the benefits in addressing both dependencies (19).

Situations unique to addiction treatment were identified as barriers to client quitting which need to be addressed in smoking cessation programs. For example, some clients expressed distress in group therapy and listening to other clients' addiction stories, leading them to

smoke as a way to cope. To counter this, stress management as part of therapy and smoking cessation can be emphasised. Similarly, clients reported that the smoking permissive environment of drug and alcohol services undermined quitting attempts. There is clear evidence of the benefits of smoke-free policies and environments however policy enforcement is the most important factor for their success (20). In the mental health setting a lack of consistency and a prevailing culture of acceptance of smoking have been identified as continuing problems for smoke-free policy implementation (21). It is important that staff in drug and alcohol treatment services feel confident to enforce smoke-free policies and have the support of management.

There is a need to implement evidence-based interventions that are acceptable to staff and clients, such as brief advice or posters reminding clients to ask for help. Free or highly subsidised NRT which is readily available at high doses was important for clients. Most clients were surprised at the effectiveness of NRT, however some felt it was potentially another addictive substance. Education of both staff and clients is needed to improve compliance and address misperceptions such as the concept that smoking alleviates stress and that NRT is addictive. Clients reported either disinterest in using telephone cessation services or negative experiences with the telephone cessation support service Quitline. This may be due to Quitline's main purpose as a universal population-level cessation service and it was not designed for helping people with multiple complex needs (22). For example, clients said that the Quitline counsellor 'stressed' them and they felt like having a cigarette following the telephone call. It is important that Quitline counsellors are trained to support smokers who may have mental health and addiction concerns, and to understand the type of language which may trigger smoking for these smokers. As the demographic of smokers shifts in many countries to those with lower socioeconomic status and physical and mental health

comorbidities (11), it is important that cessation services adapt. Specialist smoking cessation telephone services for smokers with other addictions may be required (23).

All the services in this study were 'smoke-free' sites. In the OTP and detoxification clinics, clients were not allowed to smoke on the grounds, but knew which staff members smoked and where they smoked, despite staff attempting to be inconspicuous. Clients reported that it would be difficult to receive cessation support from staff, while staff continued to smoke on-site. Similarly, patients of smoke-free psychiatric facilities report that it is easier to quit when no one else is smoking (24). In-patient drug and alcohol staff were dissatisfied with the numbers of both staff and patients who disregarded the non-smoking policy and lack of enforcement.  All staff interviewed felt that staff smoking was a poor role model for clients. Any smoking cessation intervention introduced into addiction treatment services also needs to address staff smoking and provide support to staff to quit or provide clear guidance on how to avoid smoking during work time (for example with the use of NRT).

**Limitations and strengths**

Selection bias is possible due to staff self-selecting to participate and client participants being selected by staff, rather than being randomly selected. All participants were offered a shopping voucher ($20 for clients, $15 for staff) as reimbursement for their time, travel and parking costs. It is possible this reimbursement influenced the choice of participant which may result in a biased sample. However staff were not aware of the reimbursement until the interview concluded and some chose not to accept the vouchers. Having service staff present at the focus group sessions may have impacted on what clients disclosed. The staff presence was required to fulfil Occupational Health and Safety requirements. However, in both sessions staff did not react to discussions and participants were aware that there would be no

reprisals for the information they provided. Finally, due to low numbers of participants in each type of treatment setting, differences were not highlighted. Further research is warranted given the different practices and cultural contexts to treatment provision across types of programs, and recent research which has found variation in mental health treatment settings (25).

**Conclusion**

The results of this exploratory study suggest that both clients and staff wish to do more about tobacco use in addiction treatment services, but a number of barriers to achieving this were identified.  Staff barriers included lack of time and tobacco-permissive organisational culture, lack of enforcement of smoke-free policies, beliefs that tobacco is not a treatment priority for clients and that clients need to smoke as a coping strategy, and perceptions that treatment was either ineffective or not used by clients. Clients reported smoking as a habit and for enjoyment or stress relief, seeing staff smoking, NRT unaffordability and perceptions that NRT may be addictive, and inability to relate to telephone cessation counselling as primary barriers to quitting smoking. Addressing these barriers requires a comprehensive approach. To help clients quit smoking, staff in addictions services need interventions that build their capacity and improve organisational culture. Staff require training and resources, services require management support and organisational policy enforcement, and the sector requires funding and resourcing to tackle tobacco. Although there have been calls for organisational change interventions that encourage the delivery of tobacco treatment in addiction settings, no trials have yet evaluated the effectiveness of these approaches. Further intervention research is required to identify the optimal strategies to increase tobacco dependence treatment delivery in addiction settings.

**Acknowledgements**

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**Table 1. Staff quotes and discussion themes arising from staff interviews.**

| Theme | Quote | Setting |
|---|---|---|
| **Why clients smoke** | "(M)ost of their family smokes, they probably are more likely to come from low socioeconomic backgrounds, they probably are less educated, dropped out of school earlier, probably are less confident about their abilities to do something positive." | OTP |
| | "(T)hese are people that are so disadvantaged to start off with, and they're addicted to cigarettes, and it's almost like it's the one thing you've got." | OTP |
| | "They've got so much else on their plate that smoking – that's their way of coping with things." | OTP |
| | "But if you're living in a really stressful environment, in a really terrible area, or lots and lots of dramas at home, and lots of other things going on, giving up smoking is probably going to be the last thing you're going to think about doing really." | OTP |
| | "Everyone around them smokes … in their community it's really acceptable and I think it's a bonding thing for a lot of them. Family. Their family smoke and it's just habit." | OTP |
| | "(D)ependence – they're dependent on them" | Inpatient |
| | "(T)hey have addiction issues". | Detox |
| **Supporting clients to stop smoking** | "A lot of people do perceive (tobacco) as the less of all the evils, but it's not … I see the results of smoking related illnesses. Yeah, it's probably one of the worst." | OTP |
| | "I think it would be great to introduce some sort of standard treatment option for drug and alcohol clients that smoke and give them a bit of encouragement that they can actually quit." | OTP |
| | "So they do get asked (about smoking) at assessment and we do discuss various techniques, the usual, you know set a date, goal setting, talk about getting NRTs. | Outpatient |
| | "We did a little while ago have some NRT to give out, and it was very popular, and people were taking it up. | OTP |
| | "Everyone gets asked what drugs they use and nicotine is part of that.  We do talk about NRT and again depending on why they're here, is it their prime, it's not often their prime reason to come.  Occasionally it is." | Outpatient |
| **Barriers to stopping smoking** | "And I think also that it's probably the lesser of two evils … you know that they're doing it, but at the same time you don't make any moves to take it any further than that." | OTP |
| | "(J)ust that perception that we won't worry about it. We're not going to hassle them out about something seemingly insignificant as smoking, compared to what else is going on in their life." | OTP |
| | "(W)e're usually dealing with multiple substances here and cigarettes is the last one that they want to give up." | Inpatient |
| | "I think there's a perception too as to how much time is it going to take, especially for clinicians who are extremely | Inpatient |

| | | |
|---|---|---|
| | busy dealing with difficult clients.  Like is this just going to be another burden?" | |
| | "I've always been surprised … in drug and alcohol is that it's (tobacco) the substance that's very rarely addressed." | OTP |
| | "(P)atient assessment … can be quite … poorly done for various reasons. And you might have a person who's a smoker who can go days without that being picked up." | Inpatient |
| | "you have disenfranchised clients .. where you don't necessarily have to give good treatment … because they're 'just drug addicts'." | Inpatient |
| | "Why are medical staff going 'OK, I'll prescribe the NRT', without any further follow up? Why does it stop there?  Why are our attitudes to it so poor?" | Inpatient |
| | "They'll have a go at it, but then two days later you'll see them smoking, and they prefer not to have the patch, or some of them actually smoke with the patches on." | Inpatient |
| | "Well my (own quitting) experience of NRT has been pretty disappointing.  I didn't really find that it helped at all.  But then again I've heard other people say that it has helped but, no, I don't think it was fantastic at all.  I wouldn't use that method again." | OTP |
| | "When you are prescribed Champix, the GP has to give you the Quitline number as part of the prescribing process.  So I know it's there but I didn't actually use it." | OTP |
| | "I haven't used it (Quitline).  If I ever got serious enough about it I probably should." | OTP |

**Table 2. Demographics of participating clients (n=11).**

| Characteristic | *n* | % |
|---|---|---|
| **Smoking status** | | |
| Current smoker | 11 | 100 |
| **Gender** | | |
| Male | 10 | 91 |
| Female | 1 | 9 |
| **Highest level of education** | | |
| Primary school | 0 | 0 |
| High school years 7-10 | 6 | 55 |
| High school years 11-12 | 1 | 9 |
| TAFE or other trade | 3 | 27 |
| University degree | 1 | 9 |
| **Aboriginal or Torres Strait Islander status** | 1 | 9 |
| Yes | 10 | 91 |
| No | | |
| **Ever tried to quit** | | |
| Yes | 9 | 82 |
| No | 2 | 18 |
| **Quit intentions** | | |
| Quit in the next month | 2 | 18 |
| Quit in the next 6 months | 5 | 46 |
| Quit, but not in next 6 months | 2 | 18 |
| Never quit | 0 | 0 |
| Don't know | 2 | 18 |

| | Mean | Range |
|---|---|---|
| **Age (years)** | 34 | 24 – 53 |
| **Age started smoking** | 15 | 11 – 21 |
| **Cigarettes/day** | 14 | 7 – 30 |
| **Weekly tobacco expenditure (AUD)** | 44 | 8 – 80 |

**Table 3. Client quotes and discussion themes arising from client focus groups.**

| Theme | Quote | Setting |
|---|---|---|
| **Attitudes to smoking** | "If (your family are) non-smokers like mine are, like my Mum and Dad and my brother … they are like 'Hey man, you're doing well', you know, if they see you're still not smoking. I had a lot of compliments (when I tried to quit smoking)." | OTP |
| | "Not allowed to smoke at me Mum's, no. So I've stopped smoking inside at home." | OTP |
| | I've got nieces and they watch television and see the anti-smoking ads and they go 'Uncle B_, I want you to stop smoking' and it makes me feel really guilty. | Detox |
| | "I want to give up smoking because of my health, you know." | OTP |
| | "My mum went cold turkey … I think being in hospital and nearly dying snapped her out of it, that's why I want to try to give up because it's generation after generation saying the same thing" | Detox |
| | "No-one escapes from it, you either quit it or it kills you, you know. And it still might when you quit. All it does is cost you heaps of money and make you smell like shit and makes you unfit." | OTP |
| **Barriers to quitting** | "Mine's very habitual like when I jump in the car I spark up a smoke and things like that, or after a meal." | OTP |
| | "It's just the things I do each day and then there's the in-between parts where I'll have a beer and I'll have a smoke or I have a shot and have a smoke. I like smokes." | Detox |
| | "(Smoking) takes the edge off when you're nervous and anxious – it just takes the edge off." | OTP |
| | "Anxiety, stressed out situations, that's when I usually smoke." | Detox |
| | Sometimes you go to NA (narcotics anonymous) and listen to heartfelt stories from people and you pick up on the similarities and you can relate to them and have empathy (but) just talking about it triggers, even something bad or negative, it still triggers the whole impulse.  It's a catalyst." | Detox |
| | "Yeah, you get really blasé so when you look at something like cigarettes ….when you're used to shooting up heroin and speed in … car parks you don't really look at it (tobacco) as a drug." | Detox |
| **Smoking in drug and alcohol services** | "The doctor does (ask about smoking) but the nurses don't really." | OTP |
| | "(I)t's all about the quit pack man, that's all you get." | OTP |
| | "I reckon some sort of notice to say that help is available, would get people thinking 'Ok, maybe'." | OTP |
| | "You usually see them hiding around the back there." | OTP |
| | "Yeah, you see them. They smoke out that side of the building | OTP |
| | "Seems to work, the patches, I haven't wanted a smoke since I've been here really." | Detox |
| | "I did ask for some more and (the nurse) said that she was out, there weren't any more there, they'd run out." | OTP |
| | "I don't even understand that (NRT), that's not even quitting you know." | OTP |
| | "It's just like taking methadone." | OTP |

| | | |
|---|---|---|
| | "I reckon they need to make the patches and everything cheaper than the cigarettes for people to get that incentive to give up smoking." | Detox |
| | "If we kept wearing these [nicotine patches], we'd get addicted to them eventually … It would be better than smoking anyway, the lesser of two evils." | Detox |
| | "I was wearing the patches for about a month and when I'd be sitting there with the patches on in the daytime talking to people I'd be fine but as soon as someone would pull out a cigarette I'd have to get a lozenge out because it'd make me feel like having a cigarette yeah." | OTP |
| | "I've used the Quitline and it stressed me out even more. … She was talking to me and it freaked me out. I'd light up a cigarette. It stressed me out to the point where, after I finished speaking to her, I went and had a cig." | Detox |
| | "I found it (Quitline) too stressful." | Detox |
| | "I don't like talking on the phone. I can talk to someone, but on the phone, no." | Detox |