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Stuck in the catch 22: attitudes towards smoking cessation among populations vulnerable to social disadvantage.


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Stuck in the catch 22: attitudes towards smoking cessation among populations vulnerable to social disadvantage

Pateman K1*, Ford P1, Fitzgerald L2, Mutch A2, Yuke K2,3, Bonevski B4, Gartner C2,5.

1School of Dentistry, The University of Queensland, Herston Australia, 2School of Public Health, The University of Queensland, Herston Australia, 3The Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care, Inala Australia, 4School of Medicine and Public Health, The University of Newcastle, Australia, 5UQ Centre for Clinical Research, The University of Queensland, Herston Australia.

*Corresponding author details:

Email: k.pateman@uq.edu.au
Post: C/-Oral Health Centre, University of Queensland
Cnr Bramston Terrace and Herston Road
Herston, QLD
Australia 4006
Phone: +61 7 336 58149

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Abstract

Aim: To explore how smoking and smoking cessation is perceived within the context of disadvantage, across a broad cross section of defined populations vulnerable to social disadvantage.

Design: Qualitative focus groups with participants recruited through community service organisations (CSO).

Setting: Metropolitan and regional settings in Queensland, Australia. Focus groups were held at the respective CSO facilities.

Participants: Fifty-six participants across nine focus groups, including people living with mental illness, people experiencing or at risk of homelessness (adult and youth populations), people living with HIV, people living in a low income area and Indigenous Australians.

Measurements: Thematic, in-depth analysis of focus group discussions. Participant demographic information and smoking history was recorded.

Findings: Smoking behaviour, smoking identity and feelings about smoking were reflective of individual circumstances and social and environmental context. Participants felt ‘trapped’ in smoking because they felt unable to control the stressful life circumstances that triggered and sustained their smoking. Smoking cessation was viewed as an individual’s responsibility, which was at odds with participants’ statements about the broader factors outside of their own control that were responsible for their smoking.

Conclusion: Populations vulnerable to social disadvantage experience many shared and unique barriers to smoking cessation that are closely tied to their experiences of disadvantage. Tobacco control programs aiming to reduce smoking among disadvantaged groups are unlikely to be successful unless the complex interplay of social factors are carefully considered.
Introduction

In Australia, the proportion of the population aged 14 and over who smoke is now below 13% (1), yet smoking remains disproportionately high among certain sub-populations, including people experiencing homelessness, substance use issues, unemployment, mental health issues, sole parenting, incarceration and stigmatisation (1-3). The disparity in smoking prevalence occurs along a social gradient whereby people most at risk of social and economic disadvantage are more likely to smoke and experience poorer health outcomes (3, 4). The substantial contribution of tobacco smoking to the adverse financial and health outcomes these populations experience is now recognised (5-7).

Tobacco consumption is high in disadvantaged areas due to a number of social and environmental factors. Living in a disadvantaged community increases the likelihood of smoking due to an ‘area effect’ caused by highly stressful environments, limited resources and options for recreation, normalisation of smoking, increased availability of tobacco and isolation from the wider community (8-10). At an individual level, issues of nicotine addiction, competing priorities, life stress, negative attitudes towards cessation and limited access to or engagement with quit support services also influence smoking prevalence (4, 11-14).

Previous research has described the barriers to smoking cessation experienced by individuals living in disadvantaged areas (8, 11, 15-17) and clients of community service organisations (18-20). Among the broader sphere of groups at risk of social and economic disadvantage, specific sub-populations report unique barriers to quitting (4). These issues stem from diverse issues tied to racism, cultural and historical ties to tobacco (Indigenous Australians); social marginalisation (lesbian, gay, bisexual and transgender populations, people living with HIV, people with severe and persistent mental illness); and crises relating to housing instability and risk of homelessness (4, 21, 22). These specific sub-populations represent the ‘hard to reach’ or ‘hard to treat’ and report a higher prevalence of smoking and additional barriers to cessation than the general population (1, 23, 24).

In order to understand the perceived resistance to smoking cessation strategies reported among populations vulnerable to social disadvantage, the social context and meaning of smoking must be understood (25). Analysis of the ‘upstream’ causal factors of disadvantage that are associated with smoking is required (26), in addition to individual perceptions of the social context that triggers smoking. Social context may be conceptualised as the relationship between social structure (rules of society and resources); practices (activities that transform the world we live in) and agency (ability for people to deploy a range of causal powers) (27, 28). Among the qualitative literature, the use of cigarettes to fill a number of meanings related to living in disadvantage are described. Smoking may fill a functional and pleasurable role associated with reward and self-care that, seemingly, contradict public health representations of smoking as a risky, anti-social and health damaging behaviour (5, 7, 29, 30). As noted by McKie et al. (29), “smoking can shift from being an unremarkable daily activity to being loaded with symbolic significance” and is woven into everyday life. Smoking is used to enable socialising and form bonds with other smokers or may form a solitary practice in response to inactivity or boredom relating to circumstances of deprivation or unemployment (5, 29).

Given the complexity of the many meanings of smoking and its association with lower socioeconomic status and disadvantage, a deeper exploration of these issues in the context of the ‘hard to reach’ or ‘hard to treat’ populations is required (6, 25). The present study aims to explore how smoking and smoking cessation is perceived within the context of disadvantage, across a broad cross section of defined populations vulnerable to social disadvantage.

Methods

Nine focus groups were held at a range of community service organisations (CSO) in metropolitan and regional Queensland, Australia. Focus groups were held with participants living in a disadvantaged area, people identifying as Aboriginal or Torres Strait Islander, people living with HIV,
people living with mental illness and substance use disorders and people experiencing, or at risk of, homelessness, including young people. Focus group descriptions are provided in Table 1.

Inclusivity of the CSOs was a central element of the research design. Organisations were approached through new and existing relationships built by members of the research team. CSO staff were involved in the organisation and advertisement of the focus groups. This approach enhanced researcher engagement with potentially hard to reach populations and provided reciprocal benefits to CSOs targeting smoking cessation as a health priority for their clients (23, 31).

Setting

Focus groups were held at the facilities of the respective CSOs. Eight focus groups were conducted in an urban setting (mixture of inner and outer city) and one was conducted in a regional setting. The focus groups held at the Indigenous organisation were separated into male and female groups. This segregation is a common practice due to the gender roles embedded throughout urban Australian Aboriginal society. Mixed gender groups are acknowledged as less appropriate in some circumstances as participants may feel restricted in the range of topics they are comfortable discussing openly.

Participant eligibility

Participant eligibility criteria included self-identification as a daily tobacco smoker, including those currently attempting to quit, and sufficient English to provide informed consent and participate. Eligibility age was 18 years or over; however the eligibility age was 16 years for the young people at risk of homelessness group, providing the person could demonstrate competence to consent (32).

Focus group procedures

Group discussions were facilitated by one or two members (PF, CG, LF, AM, KY) of the research team who were trained in qualitative research methods and had prior experience in working with groups vulnerable to social disadvantage. Each focus group followed a semi-structured format engaging participants in discussion about smoking behaviours, experiences with quit attempts and views on the current support available for people to quit smoking. Participants also completed a brief demographic survey at the end of each focus group with additional questions about smoking history. Focus groups were audio recorded and transcribed for analysis.

Data analysis

Transcriptions were imported into qualitative data analysis software Nvivo 10 (© QSR international). Thematic data analysis was performed as outlined by Braun and Clarke (33). This involved an initial reading of the data for accuracy and overview, followed by the development and application of descriptive codes based on patterns observed in the data, and the critical analysis of codes to collate them into themes. The initial coding and data analysis was performed by author KP. At each stage of data analysis authors KP and PF met to discuss emerging themes prior to discussion at team research meetings. Disagreement in coding or data categorisation was resolved by discussion. Descriptive analysis of demographic data was performed using IBM SPSS Statistics (Version 22).

Ethical considerations

This study was reviewed and approved by the University of Queensland Behavioural and Social Sciences Ethical Review Committee (project no. 22014000093). Focus groups held at the Indigenous Health Service were also approved by the Inala Community Jury (a committee made up of local
Indigenous community members) and the Queensland Health Princess Alexandra Hospital Human Research Ethics Committee (Approval number HREC/14/QPAH/393 - SSA/14/QPAH/408). Participants were required to complete a consent form prior to participation and were reimbursed for their time and travel with an AUD $40 supermarket gift card.

Results

Sample

Fifty-six participants took part in the nine focus group discussions. Across all groups, comparable numbers of men and women participated (27 men and 29 women); 46% (n=26) had made a quit attempt in the past 12 months and participants smoked an average of 20 cigarettes per day (see Table 2).

Thematic analysis

Across the focus groups, the practice of smoking differed based on individual circumstance and social context. Smoking was described as a behavior that was influenced by socioeconomic and environmental context, however was an individualized responsibility to quit. The decision to continue smoking, cut down or stop completely was aligned with the internal motivations, inner strength values and socioeconomic and environmental circumstances of the individual. Motivations to quit smoking included improvement to current and future health and fitness; financial incentives and improved relationships with non-smokers. Despite identifying reasons to quit, participants described the influence of life stress that stemmed from the socioeconomic determinants of disadvantage as preventing a tangible cessation attempt.

Smoking cessation: Waiting for the right time

Importance was placed on waiting until the ‘right time’ to make a quit attempt. The ‘right time’ represented a change in circumstance that triggered smoking behaviour, and was associated with improved chance of success. Conceptualisations of the ‘right time’ varied by individual context and were reflective of perceived sources of stress and structural determinants of smoking tied to disadvantage.

Across focus groups, life stress was described in relation to relationships and conflict, living in an area with low employment opportunities, unemployment generally, homelessness, mental distress (anxiety and depression), social isolation, loneliness and in response to racial stereotypes and historical use of tobacco. Smoking was used across the sub-populations to provide comfort, relaxation and to counter negative moods or feelings. Stress was a commonly cited reason for relapse during a quit attempt.

R1: It relieves the stress.
Facilitator: It relieves the stress
R1: Unless you’re going to put out another product over the counter, people are going to keep smoking.
R2: Pretty much.
R1 & R2 Indigenous (female).

As summarized by one participant, the reward afforded by smoking was the momentary distraction from the present environment.

R3: It’s a distraction...it takes you away from what you’re doing for a moment...that’s more what it is rather than the actual act of smoking [Laughter]
R4: It stops the thought processes.
R3 & R4 male, person living with HIV.

In addition to stress relief, smoking was used to cope with symptoms of mental illness, to mediate anxiety and depression and to counteract the sedative effect of medications. The physical act of inhaling deeply and exhaling was useful in managing nervous conditions and preventing panic attacks.

Participants smoked in response to feelings of social isolation and stress stemming from stigma associated with living with HIV or identifying as lesbian, gay, bisexual or transgender (LGBT). The impact of marginalisation and stigma on the mental health of the LGBT community was identified as a contributor to continued smoking.

R1: I actually receive a lot more stigma for being gay than I do for having HIV, particularly from my family. And smoking de-stresses that factor, you know?
R1 male, person living with HIV.

Participants who associated their smoking with a single source of stress (e.g. stress from family conflict), described an increased sense of control and increased self-efficacy towards discussing a future quit attempt. This was contrasted by participants who experienced multiple and competing social, financial and health stressors (i.e. mental illness, homelessness and social isolation).

Consequently, for these participants, the ‘right time’ to quit was distant due to concurrently dealing with multiple stressors such as unstable housing and mental illness. Quitting smoking was seen as something that ideally should be done, but was not able to be prioritised due to current circumstances.

R1: The missus [wife], if she gave up smoking I could go with her
Facilitator: Family support, what about other support?
R1: No just family support I reckon.
R1 Indigenous (male).

Boredom was an issue across focus groups for participants not engaged in paid work. Smoking to alleviate boredom was particularly magnified for the young and mature people at risk of homelessness, and participants from other subpopulations who had experienced homelessness.

Smoking provided an activity and a way to occupy the hands when there was nothing else to do. Gaining employment was cited as a reason to stop smoking.

R2: I gave up pretty good for a while there …But yes, I ended up on the streets in Brisbane and went back on the smokes again, I tried [quitting] again this year, but I just found the boredom too much to bear.
R2 male, person experiencing mental illness (regional).

R2: most of this area is people that aren’t working or they’re studying and most of us are on welfare here.
So we’ve got all this spare time.
R2: male, person living in a low income area.

Existing on a limited income narrowed the choice of alternative hobbies or activities available to cope with stress, which meant that smoking was used to provide that relief. This caused a feeling of being trapped into a smoking lifestyle with little choice but to continue smoking.

*R1: When you're quitting smoking ...you're actually wanting to embark on a new lifestyle and that's where there's no finances, that's where there's no money to do it and that's why it continually fails for people.*

R1 female, person experiencing a mental illness (urban).

*R6: The people who can give it [smoking] up have support, they're 9 to 5ers...they have good friends, a good place to live, they're not homeless, they don’t have to go to the 139 club for a rotten meal.*

R6 male, mature person at risk of homelessness.

A limited income further altered how participants perceived and engaged with quit support services. Participants were able to access subsidised smoking cessation medications if included as part of a quit plan prescribed by a medical practitioner. However, this limited the choice of cessation products to those listed on the Pharmaceutical Benefits Scheme (bupropion, varenicline and nicotine patches). Consequently, non-listed nicotine replacement products were viewed as an expensive gamble and contributed to the belief that quitting was more expensive than smoking, despite the rising cost of tobacco.

*Smoking cessation: A battle of willpower and matter of individual agency*

Quitting smoking was framed as an internal battle in which the positive aspects of smoking (tied to its multiple meanings and role in stress relief) were constantly measured against the negative impact on finances and health. A strong mindset was regarded as the key to moving past ambivalence about the positive and negative aspects of smoking.

Participants who intended to quit described the importance of quitting for the ‘right reasons’ (i.e. oneself), as opposed to conforming to social pressure or expectations to quit from non-smoking society. Quitting for the ‘wrong reasons’, such as pressure from friends, family or government restrictions, were viewed as an explanation for why previous quit attempts had ended in failure. Quitting without the use of nicotine replacement products, or ‘cold turkey’ was valued as an honourable way to quit and signified inner strength, commitment and a strong mindset.

Previous experiences with failed quit attempts were aligned with beliefs of poor willpower, low self-efficacy and having a strong addiction to nicotine. Nicotine addiction was viewed as an enabler of smoking and contributed to a lack of willpower and an inability to control smoking behaviour.

*R4: Well I’m addicted...just yesterday my friend bought me two packets of cigarettes. I finished the [first packet] yesterday and last night I finished the rest. I’m just purely addicted...if I don’t have one I go into a panic.*

*Facilitator: Is there anything you enjoy about smoking?*

*R4: Not really.*
A smaller subset of participants described smoking as a way of representing personal freedom and autonomy over their own health. Despite articulating the negative impact of smoking on health, finances and relationships, a resistance to pressure from health messages and tobacco control policies was described.

*R8: We’ve got to such a point where you are so sick of seeing this and being told what to do, that you actually want to be in control of your own destiny.*

R8 female, person experiencing mental illness (regional).

**Discussion**

The results of this study highlight the complexities surrounding smoking and cessation across a number of sub-populations vulnerable to social disadvantage. Smoking serves a number of functional roles in the lives of these populations. It is also embedded in the structural aspects of disadvantage. Our findings illustrate how the social and economic outcomes of disadvantage influence an individual’s perceived capacity to quit smoking (21, 25).

The study was strengthened by the inclusion of a broad cross section of subpopulations vulnerable to social disadvantage. Our findings highlighted the varied perceptions of structural outcomes of disadvantage and the influence on individual behaviours. Experiences of mental illness, social isolation, homelessness, unstable housing, unemployment and financial stress were shared across focus groups. This highlights that while specific groups may report unique barriers to cessation (4), there is a complex interaction between health, social and economic issues that overlap between populations vulnerable to social disadvantage. Importantly, participants who perceived more issues to do with stressful life circumstances as well as greater addiction to nicotine described less confidence in their ability to quit. Competing priorities mean that dealing with more immediate threats to health, such as poor housing, environmental hazards and mental health issues are more pressing than smoking cessation (34).

The use of smoking to cope with life-stress was commonly cited across focus groups. Smoking provided comfort and self-care through a means to achieve stress relief and relaxation. Tan (35) described how smoking can provide a means to preserve an individual’s mental wellbeing in times of emotional turbulence, or as a temporary escape from reality. In the present study, turbulent and stressful lives were a pivotal trigger to smoke and clearly influenced participants’ capacity to quit. Among people living with severe mental illness, smoking has been described as a means to exert personal freedom, autonomy and a sense of control (36). The use of cigarettes to manage medication side effects and mental illness symptoms are also reported (36, 37). Emerging literature suggests choice and agency are essential in crafting wellbeing into daily life when living with limiting chronic physical and mental illness (38). While it is beyond the scope of this study to draw further conclusions about the role of agency and smoking in the lives of groups vulnerable to social disadvantage, our results clearly highlight an area in need of deeper investigation.

Connecting with other smokers provided a means to overcome social isolation that resulted from marginalisation and stigmatisation for people living with HIV and people living with severe mental
illness (37, 39). Our results confirm that smoking is embedded in social structures and place for people living with disadvantage (15, 40, 41). Smoking to cope with boredom and loneliness has previously been identified as a barrier to cessation among people experiencing homelessness (40) severe mental illness (42) and is particularly pronounced among people living with HIV (39, 43). Stigmatisation and denormalisation of smoking as a public health tool may have unintended negative consequences on groups that already experience marginalisation and stigmatisation. There is concern that policies that take such an approach make leave disadvantaged smokers ‘vulnerable to dual stigmatisation’ (7, 44). A critical view of future tobacco control and government polies is required and must involve an evaluation that includes the impact on further stigmatisation of at risk groups (44).

Statements made about the structural determinants of smoking were seemingly contradicted by participant’s views of the individualised responsibility for quitting. Participants emphasised the importance of willpower and quitting smoking as part of a holistic change in lifestyle that must be driven by the individual. The individualised nature of quitting has been reported in shaping cessation strategies used among the general Australian population (45). In Smith et al’s (45) study of ex-smokers, quitting without assistance was believed to be a morally superior method of cessation as it aligned with personal values of independence, strength, autonomy, self-control and self-reliance. Similarly, Morphett et al’s study (46) of smokers’ attitudes toward assisted and unassisted quitting found smokers identified quitting unassisted as the ‘best’ way to quit and one they valued for the sense of achievement that it would bring, while using cessation aids was seen as ‘cheating’. Possessing sufficient willpower, a strong desire to quit, and being ‘ready’ were seen as necessary, and generally, sufficient, for a quit attempt to be successful.

Our results suggest that disadvantaged populations share similar views about the individual role, responsibility and value associated with quitting ‘cold turkey’ with the general population of smokers, but perceive additional challenges in quitting due to structural influences and a perceived lack of appropriate options for cessation support. A lack of financial capital and associated stress was a structural issue that narrowed the options for choice in nicotine replacement therapies (NRT) and willingness to attempt using novel or higher cost pharmacological quit aids. A reluctance to use NRT among socially disadvantaged populations is reported elsewhere and is linked to beliefs about product unpleasantness, experiences with previous failed quit attempts, concerns about replacing one addiction with another and prohibitive cost (11, 19, 40).

Our results support the development of tobacco control policies and cessation strategies that address the social determinants of smoking at a policy level and also implement community based and individualised approaches to cessation. Government policy that addresses equitable employment opportunities for people at risk of discrimination and marginalisation is required (47). Public health strategies that move away from the shame-stigmatisation approach by acknowledging the multiple meanings of smoking and sense of loss that may occur when quitting, may help to reengage smokers who do not respond to conventional public health messages concerning tobacco use (29).

At a community level, promoting support for quitting smoking as a shared community responsibility rather than solely a problem for individuals to face alone could encourage more smokers to access the supports available. In this regard, strategies using peer support or influence to encourage
seeking help with a quit attempt may be appropriate, particularly if delivered through CSO networks (19, 20, 48, 49). Finally, harm reduction approaches are required for individuals who are unwilling or unable to quit (50). As part of this approach, there is a need to dispel myths and negative connotations around the use of NRT. As part of a holistic approach, harm reduction policies that explore alternative products such as electronic cigarettes that mimic the pleasures associated with smoking is also required. A cross-sectional survey among CSO clients in New South Wales, Australia reported similar rates of awareness and use of electronic cigarettes compared to those observed in the general Australian population, suggesting these devices may be a viable harm reduction option for this population group (51). This will require a policy shift in the Australian context, which currently does not allow non-therapeutic clean nicotine products to be sold or used (52, 53).

**Study strengths and limitations**

To our knowledge, this was the first study to include a cross section of multiple, defined sub-populations who were vulnerable to social disadvantage. A range of views, including those of people identifying with ‘hidden’ or difficult to reach populations are presented in our findings. This demonstrates the appropriateness of an inclusive research design involving CSOs, especially in engaging Indigenous Australians, people at risk or experiencing homelessness, people living with HIV and people with severe mental illness. However, this method of recruitment limited our sampling frame to those individuals who accessed services through CSOs. Conclusions cannot be drawn about the generalisability of our findings to the broader sub-populations vulnerable to social disadvantage, particularly those people who do not access support services, who include those who are coping well independently (and not in need of CSO assistance) or alternatively, those who are most isolated and disadvantaged or too unwell to participate. Discrepancies in the number of participants in respective sub-populations may have also limited the breadth of our results. Further research with particular subgroups, particularly with Indigenous males may be applied for further exploration of the issues presented here.

Social acceptability bias may have also influenced statements about smoking and intentions to quit made by participants. The researchers who conducted the focus groups were from a public health background, with an interest in smoking cessation. Allowances and efforts were made to facilitate discussions around smoking in a non-judgemental manner; however it is possible that some participants may have veiled their statements about intention to quit in light of the dominant anti-smoking public health discourse in Australia (54). This may have also explained some of the seemingly conflicting statements about intention to quit and functional role that smoking played in participants present situations. Contradicting statements about intentions to quit are reported elsewhere in qualitative studies of smoking among disadvantaged populations (15).

**Conclusion**

Sub-populations vulnerable to social disadvantage experience common and unique barriers to smoking cessation that are heavily influenced by structural limitations of disadvantage. Participants provided conflicting descriptions about smoking as a socially and structurally embedded behaviour that was an individual responsibility to quit. Limited ability to control stressful aspects of life shaped by disadvantage led to feelings of an inability to quit smoking under the current circumstances. Public health and tobacco control programs aiming to reduce smoking among disadvantaged groups may risk limited success unless they take into consideration the complex issues supporting smoking
and sabotaging quitting uniquely expressed by these groups of smokers. This would involve reorienting tobacco control messages to ensure they resonate with these smokers, offering more intensive cessation support and harm reduction alternatives. Wider social policy addressing the multiple and entrenched barriers to quitting is also required.
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Table 1: Focus group descriptions and abbreviations

<table>
<thead>
<tr>
<th>Focus group</th>
<th>Description</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger persons at risk of homelessness</td>
<td>Youth service that provides holistic community services to disadvantaged and homeless young people (aged 12-25 years)</td>
<td>Urban – inner city (1)</td>
</tr>
<tr>
<td>Mature persons at risk of homelessness</td>
<td>Provider of accommodation and support for persons suffering long-term homelessness.</td>
<td>Urban – inner city (1)</td>
</tr>
<tr>
<td>People living with HIV</td>
<td>Peer based advocacy organisation representing people diagnosed with Human Immunodeficiency Virus (HIV).</td>
<td>Urban (1)</td>
</tr>
<tr>
<td>People accessing health clinic in low income area</td>
<td>Organisation that provides general practice services as well as specialised services for complex and chronic health issues for high-need groups (including homeless and supported parole program) in low income area.</td>
<td>Urban – outer city (1)</td>
</tr>
<tr>
<td>Indigenous health service</td>
<td>Government health service for Aboriginal and Torres Strait Islander people.</td>
<td>Urban – outer city (2)</td>
</tr>
<tr>
<td>People experiencing mental illness</td>
<td>Provider of community based services and programs for people living with mental illness and experiencing social and financial disadvantage.</td>
<td>Urban (2) Regional (1)</td>
</tr>
</tbody>
</table>
Table 2: Sample demographics (n=56)

<table>
<thead>
<tr>
<th></th>
<th>Homeless (mature) n=8</th>
<th>Homeless (young) n=8</th>
<th>HIV n=5</th>
<th>Low SES n=5</th>
<th>Indigenous n=9</th>
<th>Mental illness n=21</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td><strong>Age</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td>36 (22-62)</td>
<td>21 (17-24)</td>
<td>40 (36-45)</td>
<td>40 (21-68)</td>
<td>39 (26-59)</td>
<td>46 (27-67)</td>
<td>39 (17-68)</td>
</tr>
<tr>
<td><strong>Gender</strong> (n, %)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Male</td>
<td>4 50.0%</td>
<td>3 37.5%</td>
<td>5 100.0%</td>
<td>2 40.0%</td>
<td>2 22.2%</td>
<td>11 52.4%</td>
<td>27 48.2%</td>
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<tr>
<td>Female</td>
<td>4 50.0%</td>
<td>5 62.5%</td>
<td>0 0.0%</td>
<td>3 60.0%</td>
<td>7 77.8%</td>
<td>10 47.6%</td>
<td>29 51.8%</td>
</tr>
<tr>
<td><strong>Indigenous status</strong>&lt;sup&gt;*&lt;/sup&gt; (n, %)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal &amp;/or Torres &amp; Strait Islander</td>
<td>1 25.0%</td>
<td>1 14.3%</td>
<td>0 0.0%</td>
<td>0 0.0%</td>
<td>7 77.8%</td>
<td>2 12.5%</td>
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<td>Other</td>
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<td>5 100.0%</td>
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<td>2 22.2%</td>
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<td><strong>Quit attempt in previous 12 months</strong> (n, %)</td>
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<td></td>
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<td>5 55.6%</td>
<td>10 47.6%</td>
<td>26 46.4%</td>
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<tr>
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<td>6 75.0%</td>
<td>5 62.5%</td>
<td>1 20.0%</td>
<td>3 60.0%</td>
<td>4 44.4%</td>
<td>11 52.4%</td>
<td>30 53.6%</td>
</tr>
<tr>
<td><strong>Cigarettes/day (mean)</strong></td>
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<td>17</td>
<td>27</td>
<td>20</td>
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<td>20</td>
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