

Vermont Tobacco Cessation: Needs Assessment Report

October 2019

Introduction

As part of their comprehensive multi-component program, the Vermont Tobacco Control Program (VTCP) implements a variety of best practice cessation strategies to encourage and help tobacco users quit. Cessation strategies work at multiple levels of care, and include administering the 802Quits Programs, collaborating with Vermont Medicaid to expand and promote use of the Medicaid cessation benefit, and promoting integration of tobacco treatment into systems of care. The VTCP targets cessation strategies and resources to priority populations with disparate tobacco burden in an effort to promote health equity. Furthermore, the VTCP uses multiple communication strategies to counter pro-tobacco messaging and to promote awareness and use of cessation resources.

Despite progress made in reducing tobacco burden in Vermont over past decades and recent years, the current smoking prevalence among adults in Vermont has remained unchanged at 17-18% from 2012 to 2017. The proportion of adult smokers in Vermont who made a quit attempt has fluctuated some during 2011 to 2017, however the current rate of 59% (2017) is unchanged from the rate in 2011.¹

The VTCP makes significant investments in administering, improving, and promoting their 802Quits Programs – quitline, quit online, quit in-person, and text support—per established best practice for comprehensive tobacco control programs.² Despite the evidence base for the relative effectiveness of these practices, the relatively low reach of these programs as demonstrated by annual registrants to the programs³ has spurred discussion among VTCP team members on the relevance of these cessation supports offered by the VTCP and need to rethink approaches to cessation to better support Vermonters in their cessation efforts.

The VTCP had particular interest in what would be most valuable to Vermont tobacco users from their perspective, and there is little published research on this topic to date. Placing tobacco users at the center of research to inform program improvements is distinct from the research informing current best practices, which is based largely on comparisons of relative effectiveness at a population-level. Research focusing on tobacco users' lived experiences and desires in relation to cessation support could yield new insights to inform a tobacco cessation program and strategies that would be more useful, usable, and appealing to Vermont tobacco users.

Toward this end, the VTCP contracted JSI Research & Training Institute, Inc. (JSI) to conduct a needs assessment to inform future efforts to identify, design, and provide relevant approaches to support cessation. The needs assessment examined the following research question:

¹ Vermont Behavioral Risk Factor Surveillance System.

² CDC. Best Practices for Comprehensive Tobacco Control Programs—2014.

³ Vermont Department of Health. 2017 Cessation Report. July 2018.

What are the perceptions, experiences, and needs of tobacco users in Vermont related to tobacco use and cessation?

The needs assessment included four research tasks:

- 1) A quantitative data review of VTCP surveillance data examining Vermont cessation strategy trends and combinations with “quit on my own”;
- 2) An environmental scan of research examining the factors that influence tobacco users to become former tobacco users;
- 3) Key informant interviews with a selection of programs that have conducted cessation research and evaluation; and
- 4) Focus groups with Vermont adults throughout the state who have experience using tobacco to gain understanding on the perceptions, experiences, and needs related to tobacco use and cessation.

Each of the research tasks focused on what would be most valuable to tobacco users. Additionally, JSI engaged Tobacco Advisors (adults living in Vermont with current or former experience using tobacco) in the research process to ensure relevance and accuracy of the focus group study. Each task and its findings are documented and described in individual reports, and available in the appendices. This needs assessment report summarizes the main research findings across the four tasks. The findings from the focus groups serve as the primary findings of this needs assessment, considering the user-centered approach to this study. Findings from the additional tasks supplement the primary findings from the focus groups. The overall needs assessment findings and recommendations are intended to inform and guide the VTCP in ideation and planning to define relevant cessation approaches to reach tobacco users in Vermont and engage and support them in cessation.

Methods

To inform how to provide useful, usable, and desirable forms of cessation support to Vermont tobacco users, the VTCP sponsored a needs assessment to examine the perceptions, experiences, and needs of tobacco users in Vermont related to tobacco use and cessation from tobacco users’ perspectives. JSI used a participatory approach to develop and conduct the needs assessment, working closely with the VTCP Cessation Team to inform the focus of the study, final research question, and the respective tasks and activities. Four tasks were conducted to address the research question—a quantitative data review, environmental scan, key informant interviews and focus groups. The quantitative data review, environmental scan and key informant interviews were conducted prior to the focus groups with the findings used in part to inform the focus of the focus groups, including the data collection tools (survey and semi-structured discussion guide).

1. **Quantitative Data Review on Cessation Strategies Among Vermont Adults.** This task was led and conducted by the VTCP analyst during December 2018 – January 2019. The analyst examined cessation-related data from the Vermont Adult Tobacco Surveys conducted from 2008-2016, with a focus on examining trends in cessation methods used among current and former smokers. The

analysis also examined the self-reported cessation strategy “quit on my own” and the combination of methods used with “quit on my own” to gain understanding of what this concept means. The data review, analysis and findings were published in a Vermont Department of Health data brief titled *Cessation Strategies Among Vermont Adults: Current & Recently Quit Former Smokers*.⁴ This task of the needs assessment helped to inform a population- and program-level understanding of cessation strategy trends, variation in methods used by demographic characteristics, and shed light on the cessation strategies used in combination with “quit on my own”. The data brief from this task is available in Appendix I.

2. **Environmental Scan on Tobacco Cessation.** This task was led by JSI and conducted during December 2018 – January 2019. JSI synthesized findings from a selection of peer-reviewed literature and unpublished Vermont-specific research to understand factors that influence smokers to become former smokers and tobacco user-centered approaches to promoting cessation. The environmental scan report is available in Appendix II.
3. **Key Informant Interviews.** This task was led by JSI and conducted during April – May 2019. The VTCP director identified experts from other programs that have conducted research or evaluation on cessation strategies relative to reach, appeal, and/or effectiveness. JSI contacted and conducted semi-structured interviews with leadership from three programs: (1) the director of the New York State Tobacco Control Program; (2) the vice president of Clearway Minnesota and the director of their tobacco treatment programs; and (3) the director of the Vermont Center for Behavior and Health. These interviews provided information on cessation strategies currently employed in the field to reach, engage, motivate, and support tobacco users, with a focus on approaches that are distinct from current best practice and/or tailored and/or targeted with the aim of improving acceptability and relevance to tobacco users. The key informant interview report is available in Appendix III.
4. **Focus Groups with Current Tobacco Users.** This task was led by JSI and conducted during May – August 2019. JSI conducted five focus groups throughout the state with 47 adults in Vermont who were current tobacco users (defined as using a tobacco product every day or some days, and have used tobacco regularly for the past 2 years or more). Two Tobacco Advisors were engaged individually at two points during this task. First, to provide input to the focus group tools (i.e., survey and discussion guide), the location of the focus groups, and recruitment strategies. Second, to provide input on the findings and their interpretation. The focus group data provides in-depth quantitative and qualitative information on tobacco users’ perceptions, experiences, and needs related to tobacco use and cessation. The focus group report is available in Appendix IV.

JSI then synthesized the findings across these four research activities to identify crosscutting themes for VTCP’s consideration in ideation and planning of future cessation support efforts.

⁴ Vermont Department of Health. *Cessation Strategies Among Vermont Adults: Current & Recently Quit Former Smokers*. June 2019.

Key Findings

A summary of the key findings and themes from the focus groups are provided, with key findings from the additional three tasks selected to supplement the focus group findings.

- 1. Primary reasons people use tobacco include stress relief followed by habit or addiction.** Stress is a predominant recurring reason for smoking per studies reviewed as part of the environmental scan. The focus group data endorse this. Stress and/or anxiety reduction, mood regulation and/or relaxation were primary reasons for smoking or tobacco use among focus group participants. Smoking or tobacco use is reported to be a valuable stress management strategy. Stress is also a common reason for returning to smoking or tobacco use after a quit attempt. In addition to stress, addiction and habit are indicated as motivations or reasons for smoking or tobacco use, both per the environmental scan and focus group findings. Other reported main reasons for smoking or tobacco use include boredom, the reward provided, and the opportunity to take a break. These reasons for using tobacco outweigh the dislikes and drawbacks of using tobacco and of quitting.
- 2. Primary reasons people do not like using tobacco include the smell, financial cost, judgment, and health implications.** The smell from smoking cigarettes was frequently one of the first things noted among focus group participants when asked what people do not like about using tobacco or smoking. Other dislikes included the cost associated with smoking or tobacco use; health implications, particularly respiratory and lung health issues; and perceived judgement and stigma associated with using tobacco or smoking.
- 3. Smoking-related judgment and stigma contribute to perceived discrimination and social rejection.** Feeling judged by former smokers, never smokers, and society in general is a prevailing theme in the focus group data. Participants remarked on the change in social norms on smoking over time and how it is now socially unacceptable to smoke or use tobacco. This along with laws and policies restricting tobacco use contribute to people feeling stigmatized, discriminated against, and outcast from society due to tobacco use.
- 4. Addiction to nicotine (i.e., smoking, tobacco use) and tobacco use disorder are perceived to be under-recognized and undervalued.** Participants of the focus groups recognize addiction is driving their tobacco use and some referred to themselves as an addict. They also shared the perception of tobacco addiction being undervalued and/or less prioritized compared to other substance use disorders, addictions, or health issues. There was also shared sentiment from focus group participants on need to give tobacco addiction equitable support and resources as other addictions such as opioid use disorder.
- 5. Primary motivations for quitting tobacco use include health implications, financial costs of tobacco use and current or future children. However, motivations for quitting are insufficient in and of themselves to lead to quit attempts.** Both the environmental scan and participants of focus groups identified common motivations for quitting tobacco use, primary among them are health implications or consequences, financial costs of tobacco use, and current or future children. The participants of the focus groups generally described the same motivations for past and future quit attempts. Furthermore, many participants shared that they have witnessed health consequences of smoking or using tobacco, either personally and/or among people close to them, and want to quit,

but have not been able to do so successfully. Therefore, other factors may be critical to influencing the decision to quit (e.g. fewer stressors, immediate health issue). This is supported by findings from the environmental scan, including reducing barriers to quit such as stress and lack of support from one's immediate network (e.g., partner, family).

- 6. Beyond motivation and intention, there is a desire to remove significant barriers to be “ready to quit”.** Survey data from the focus groups indicate a majority of participants want to quit using tobacco, but are at different stages of readiness. From the focus group discussions, participants recognize the need to be ‘ready to quit’; they need to feel prepared (e.g., have a plan, be organized, have fewer stressors present or have stressors managed). Additionally, participants find setting a quit date to be stressful and feel there should be more acceptance for approaching quitting by reducing use versus completely quitting all at once.
- 7. Various barriers make it difficult to quit tobacco use, with primary barriers including stress and lack of support from family or peers.** Findings from the environmental scan and focus groups indicate primary barriers to quitting include stress, lack of support from family or peers and/or being around family or peers that use tobacco, lack of self-efficacy, and cost of cessation supports. The focus group data also indicate smoking or tobacco-use triggers pose a barrier to quitting, for example, smoking after eating or when drinking coffee, and/or easy access to tobacco products and marketing. Furthermore, the focus group data suggests a lack of desirable cessation supports or accessibility of the supports at the time they are wanted.
- 8. Personal choice and having control over when and how to quit is important.** From the focus groups, participants expressed they do not want to feel like they are being coerced into quitting and that setting a quit date can be more stress-inducing and backfire. Some participants voiced need for personal choice in determining what is appropriate for them, rather than a one size fits all approach. Some participants indicated they feel an urge to smoke in response to people nagging them to quit and/or anti-smoking commercials. From the environmental scan, the literature suggests there is heterogeneity with regard to preferred approach to quitting, potentially by sociodemographic and number of quit attempts. From the quantitative data review, cessation methods used by current smokers varies by gender and age; females are more likely than males to talk with a healthcare provider and young adults are more likely to report quit on my own and less likely to talk with a health care provider compared to adults 45 years of age and older. ClearWay Minnesota’s research-informed quit plan services endorses an approach that provides participant choice by offering a suite of cessation supports to meet individual readiness and preferences. ClearWay Minnesota reported their cessation treatment program greatly increased their reach after introducing this tailored program.
- 9. The concept of “quit on my own” is a preferred approach to cessation, but varies in what it means.** Per the quantitative data review, “quit on my own” is the most commonly reported cessation strategy among former and current smokers. Half of current smokers (49%) and more than half of former smokers (61%) exclusively used “quit on my own” during their last quit attempt. Others used a combination of “quit on my own” plus either talking with a healthcare provider, using an e-cigarette, or using NRT. From the focus groups, about half of the participants preferred “quit on my own” as a cessation strategy versus quit with help. However, participants varied in their definition of “quit on my own” versus with help. Most often, “quit on my own” is associated with “cold turkey” or without counseling or assistance (i.e. no help). Some suggest obtaining NRT such as patches, gum,

lozenges, or getting support from family or friends is also quit on my own. Quit with help is most often associated with counseling support, group meetings, and/or help from a healthcare provider. Opinions varied on the use of NRT being quit on my own or quit with help. Some indicated it is not quit on my own because it involves the use of nicotine. Others indicated one could use NRT, but no other services such as the quitline. From the environmental scan, the majority of quit attempts are unassisted (without pharmacotherapy or behavioral assistance). Personal and societal views of independence, strength, autonomy and self-control were found to link to beliefs and decision-making about quitting unassisted.

Notably, the preference for “quit on my own: does not jibe with focus group participants’ expressed need for tobacco addiction support that is on par with support and resources offered for treating other addictions.

- 10. Desired forms of cessation support for future quit attempts varies and having lived experience is important for being a credible source of cessation support.** From the focus groups, participants have experience with a variety of cessation strategies and are open to different cessation strategies; preferences depend on personal characteristics, needs and tolerance. They indicated a suite of choices for cessation support is preferable to meet variation in readiness, preference, acceptability, need, etc. This is supported by the environmental scan as well as Minnesota’s participant research on cessation preferences.⁵ This also aligns with the importance of choice in one’s path to cessation. Focus group participants expressed that credible sources for cessation support include a healthcare provider and/or someone with experience using tobacco. Those who do not use tobacco are not credible sources of information or support for cessation because it is perceived that they do not understand tobacco use, the addiction and the “struggle” or challenge of quitting.

Interest in peer support for cessation was mixed among focus group participants. It was agreed that a person who provides peer support needs to have experience using tobacco to be credible. Those who liked the idea of peer support in a group setting expressed the need for encouragement from others, especially from those who share experience with tobacco. Some participants expressed interest in peer counseling or support but preferred a one-to-one context. Another suggested option for peer support involved an informal group without counseling and instead organized social events or connections for people who use tobacco and are considering quitting; for example, meetups coordinated by VTCP or its partners.

- 11. There is interest and value in quitting together, but variation with partner readiness and commitment may pose challenges.** Several participants attending the focus group came as a pair, either husband and wife or partners; parent and adult child; or friends. Some couples shared they had tried to quit together as a motivation to one another. Participants expressed that quitting together has its challenges, for example, stress levels during a quit attempt contributing to disputes. There were comments about both people being irritable at the same time due to not using tobacco. Pairs of people approaching a quit attempt together may be at different stages of readiness or commitment; one participant shared that a failed quit attempt of their partner affected their quit attempt, resulting in their failed quit attempt. Another example of quitting together was using a quit buddy. One pair of participants referred to themselves as quit buddies and expressed the

⁵ Dreher M., Schillo B.A., Hull M., Esqueda V., Mowery A. A case study for redesigning tobacco cessation services: gaining critical insights from current and former smokers. *Social Marketing Quarterly*. 2015. Vol. 21(4) 200-13.

importance of having this person readily available to reach out to as needed to talk to when challenged by quitting, and to offer motivation and support.

Discussion & Recommendations

The user-centered focus of the cessation needs assessment with engagement of people who currently use tobacco provides an important contribution of information to guide cessation supports and strategies that are useful, usable, and used. The findings of this study are limited in generalizability. For example, the environmental scan was not exhaustive, focus group participants and therefore the findings may not fully represent people who use tobacco and are not interested in quitting (e.g., the majority of focus group participants expressed interest in quitting), and the study did not capture insights from former tobacco users and therefore lacks information on what people have found to be helpful and/or supportive in their quit journey. There are many opportunities for additional research to expand on the findings of this needs assessment. Additional areas of research and/or research questions are included in the key informant interview report and focus group report.

The following recommendations are offered to the VTCP to inform ideation and identify opportunities and solutions to optimize cessation support. The recommendations are based on the key findings from within and across the needs assessment tasks. Recommendations are also informed by JSI knowledge and experience in public health, public health programs, and substance use disorders. Per the exploratory nature of this study, recommendations are elements to consider when developing or enhancing cessation support strategies. Additionally, a selection of models are recommended for VTCP consideration in guiding program approach to cessation.

- ❖ **Focus on alleviating quit barriers, addressing triggers, and promoting readiness to quit.**
 - Despite strong interest and motivators to quit, tobacco use often trumps quitting. In addition to addiction to tobacco, tobacco use is an important part of people’s lives for a variety of reasons, including: stress, mood and anxiety management; providing a “break”; instituted within daily activities and routines; and shared by, in many cases, the majority of people’s immediate network of family and friends.
 - Simply removing tobacco from one’s life is not a feasible nor sustainable option to quitting without attending to the causes of tobacco use, primarily stress and triggers (e.g., eating, being around others who use tobacco).
 - Consider opportunities to support people in planning to address or tend to their triggers and personal challenges; identify stress relief strategies and support strategies when stressors and triggers present.
 - Build support and awareness about how smoking is often a response to personal challenges (e.g., stress, trauma) and offer alternative strategies for growth, healing, and wellness. Support a range of outcomes other than cessation, including tobacco reduction and improvements to other aspects of health, such as nutrition, stress, and social support.

- Support people in progressing from being motivated to quit to being ready to quit. Assist in moving from beyond motivation to further along the spectrum of readiness. This includes managing stress or having a stress management plan, and having supports and support systems in place. Supports might include family and/or peer support, as well as support with basic needs (e.g., food, transportation) to mitigate stress.
 - Consider tobacco use treatment within the context of need for behavioral health support relative to anxiety, mental health, trauma, and stress.
- ❖ **Connect people to resources and supports to aid cessation.**
- Partner and/or family support is an influential factor in quitting, including approval and encouragement to quit, and/or reducing exposure to tobacco during a quit attempt.
 - Peer support is a desirable option for some people interested in quitting. Explore models of peer support that could be applied in VTCP cessation strategies.
 - Explore coordination of meetups for tobacco users interested in quitting as a strategy for connecting people with shared experience and community building.
 - Consider the importance of having lived experience with tobacco use when providing cessation counseling or support.
 - Explore opportunities to assist people interested in quitting tobacco use with support for basic needs, such as transportation, housing, and food with the intent of reducing stress and promoting stability and readiness to quit.
- ❖ **Provide choice in quitting and promote shared-decision making.**
- Support people in quitting *my own way* versus *on my own*. For example, consider offering a suite of approaches to quitting from which people could choose some or all, per their preferences, needs, and values.
 - Promote active-collaboration and shared decision-making between people who use tobacco and their providers to customize cessation supports and/or a cessation plan. Consider cessation timing, pace, and method, and ensure the values, needs, and preferences of individuals are honored.
 - Identify opportunities to assess the needs of individuals who present for cessation support and refer and tailor support accordingly per one’s preferences, values, needs, motivations, readiness, and goals.
- ❖ **Advance the narrative of tobacco use as an addiction and chronic condition, and promote *how to quit* instead of *why to quit*.**
- Promote communications and messaging on tobacco use as an addiction and substance use disorder like other substance use disorders such as opioid use disorder. Consider this framing in media campaigns and communications and training to providers.

- Promote tobacco use disorder as an endpoint or chronic condition versus a behavior or risk factor. Consider it as a recurring and remitting behavior.⁶ Consider then addressing risk and protective factors of tobacco use disorder (per a chronic disease model for tobacco use and as is done for substance use disorders).
- Re-evaluate messaging that uses a behavior change approach to ensure that it avoids a focus on individual weaknesses, which can be stigmatizing and potentially lead to victim blaming.
- Look to substance use (e.g., opioid use) media campaigns and messaging approaches to inform tobacco use campaigns and messaging.
- Instead of giving attention to the health consequences of tobacco use, explore promotion of the benefits of not using tobacco and how to quit. Consider messaging on helping individuals identify what they want to see changed in their lives and/or what they will gain as a result of quitting.
- Decouple communications and messaging on *how to quit* and *why to quit or not use*. While promoting why to quit or not use remains relevant (e.g., youth prevention, emerging products such as electronic nicotine delivery systems), it can also be perceived as unhelpful, condescending, and/or lacking credibility or relevance (e.g., extreme health consequences of smoking). This may have unintended consequences on the 802Quits brand (e.g., discredit the brand). Consider communications and messaging that promotes the 802Quits brand in conjunction with tactics on how to quit and resources to support quitting.

Considering the needs assessment findings and recommended elements for cessation strategies, the following are offered to guide the VTCP approaches to cessation treatment, support and resources.

- ❖ Consider existing **peer support models** used for other substance use disorder treatment to guide peer support for tobacco addiction. Select models include Alcoholics Anonymous and the [Vermont Recovery Network's Peer-to-Peer Support Services](#). Explore Vermont's [Kindred Connections](#), a volunteer network of cancer survivors that provide peer support to cancer patients and caregivers.
- ❖ Consider promoting a **patient-centered care model** for cessation treatment services to include active-collaboration, shared decision-making and customized cessation treatment plans that incorporate patient preferences, values and needs. The National Academy of Medicine defines patient-centered care as: "Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."
- ❖ Consider a **trauma-informed framework**. Trauma is a common experience among people who use tobacco. Research has documented the relationship between exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Explore existing strategies and elements of trauma-informed care for tobacco cessation; review the body of literature on trauma-

⁶ Bernstein SL. and Toll BA. Ask about smoking, not quitting: a chronic disease approach to assessing and treating tobacco use. *Addiction Science & Clinical Practice*. 2019. 14.29.

informed approach to tobacco use. This includes *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*⁷ and the recommendations from *Tobacco Free Register Nurses' Association of Ontario* on integrating trauma-informed care⁸. These are summarized below as a starting point:

- Emphasize physical and emotional safety, understanding that safety is defined by those being served.
- Prioritize developing trust and transparency in services and programs. Recognize that building trust takes time and is an essential first step.
- Create opportunities for people to build a sense of control and empowerment by maximizing choices, focusing on growth and skills-development, and assisting people with identifying their own strengths.
- Establish systems of collaboration and shared power, recognizing people as experts in their own lives.
- Recognize the importance of peer support and lived experience.
- Incorporate policies and processes that are responsive to the racial, ethnic, and cultural needs of the individuals served, and recognize and address historical trauma.

⁷ Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

⁸ www.tobaccofreeRNAO.ca

Appendices

1. Quantitative Data Review -- Cessation Strategies Among Vermont Adults Brief
2. Environmental Scan Report
3. Key Informant Interview Report
4. Focus Group Report

Appendix I

Cessation Strategies Among Vermont Adults: Current & Recently Quit Former Smokers

Background

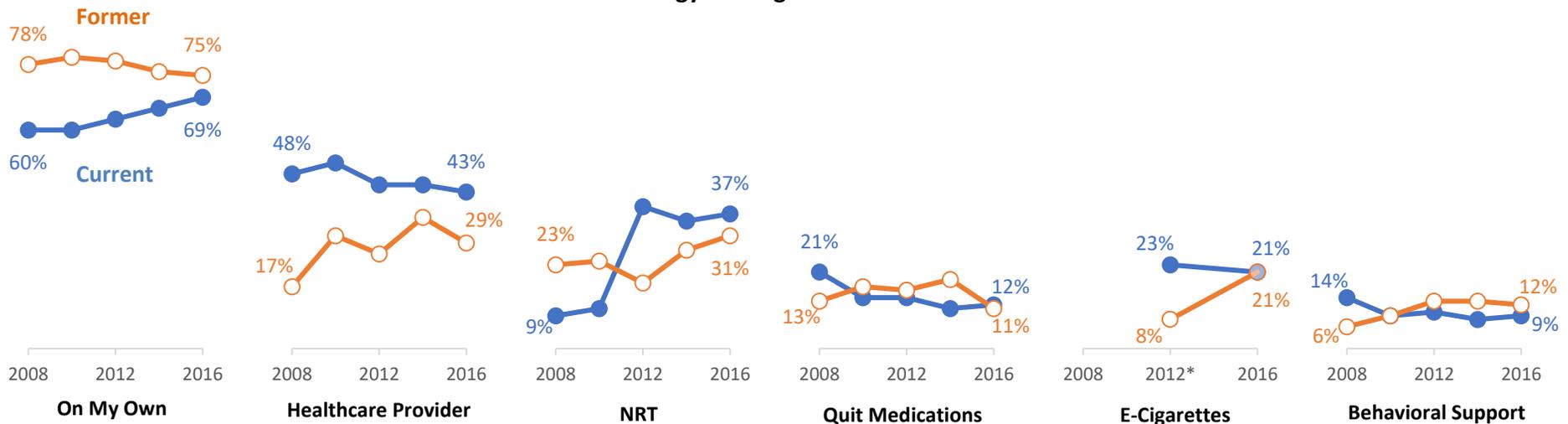
While smokers often report quitting on their own, research shows that smokers are using a variety of cessation strategies and many are using more than one method at a time.¹ In Vermont, current smokers report using an average of two cessation methods, with some using as many as eight methods during a single quit attempt. The vast majority of smokers report quitting, or trying to quit, on their own (75% and 70%, respectively). However, it is possible that some consider support such as using nicotine replacement therapy (NRT), “quitting on their own”.

Using VT Adult Tobacco Survey data from 2008 to 2016, we first assessed trends in cessation methods used among current and recently quit (≤ 5 years) former smokers. Next, we identified core cessation method combinations used among those who report quitting on their own. This data brief seeks to unpack the subjective meaning of “on my own” as a cessation method and extends our knowledge of smoking cessation as a more complex and multidimensional concept.

Cessation Strategy Trends

Since 2008, three-quarters of recently quit (≤ 5 years) former smokers reported quitting on their own as one of their cessation strategies. This was also the strategy reported most often among current smokers. Almost half reported talking with a healthcare provider (43%), which was significantly more than former smokers (29%). The only statistically significant change over time among current smokers was an increase in the use of NRT from 2010 to 2012. The use of electronic cigarettes significantly increased over time among former smokers only.

Trends in Each Cessation Strategy Among Current and Former Smokers: 2008 to 2016



Source: VT ATS, 2008-2016. Categories are *not mutually exclusive*. In other words, a respondent could choose more than one strategy.

* Data were first collected on e-cigarettes in 2012. Two years of data were combined (2012 and 2014) for e-cigarettes because of a small sample size.

¹ Caravallo RS, Shafer PR, Patel D, Davis KC, McAfee TA. Quit Methods Used by US Adult Cigarette Smokers, 2014-2016, *Prev Chronic Dis* 2017; 14:160600. DOI: <https://doi.org/10.5888/pcd14.160600>.

Cessation Strategy Combinations with “Quit on My Own”

The following section describes common cessation strategies that were utilized at the same time as quitting on their own. Results showed 23 unique, mutually exclusive cessation strategy combinations for former smokers who reported quitting on their own. Four core combinations comprised 82% of the patterns identified. The remaining combinations were too small to report. The four core combinations included:

- Exclusively unassisted (own only)
- Unassisted and discussed cessation with a healthcare provider
- Unassisted and used electronic cigarettes
- Unassisted and used NRT

Results showed 26 cessation strategy combinations for current smokers who reported quitting on their own. Five core methods comprised 85% of the patterns identified. The first four core combinations were the same as former smokers. Current smokers identified one additional combination:

- Unassisted, discussed cessation with a provider and used NRT

Utilizing cessation medications or behavioral support, such as the Quitline or in-person counseling, were not included in the core strategies of current or recently quit former smokers who said they quit on their own.

Demographic Differences in Cessation Among Current Smokers

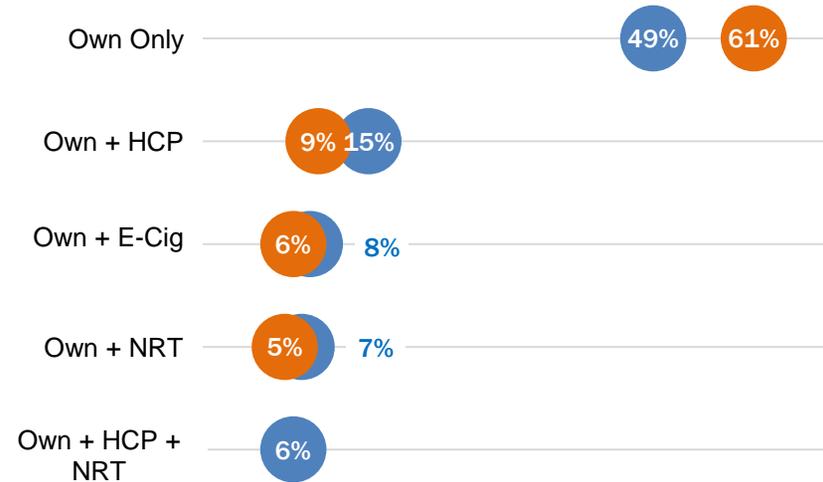
Males were significantly less likely than females to talk with their healthcare provider (38% vs 50%) (Table 1). Compared to those age 45 and older, adults 18 – 25 years old were significantly more likely to report quitting on their own (78% vs 61%) and less likely to discuss cessation with their healthcare provider (24% vs 55%). Two notable differences were found for core cessation combinations among current smokers (Table 2). Those with only one or two past-year quit attempts were significantly more likely to report their most recent quit attempt as exclusively unassisted compared to those with more than two past-year attempts (56% vs 35%). Those age 45 and older were significantly more likely to report a combination of talking with a healthcare provider and quitting on their own in their most recent attempt compared to those 18-44 years old (22% vs 9%). This data brief helps provide a picture of what the cessation experience looks like for Vermonters and suggests how we might assist current smokers in the quitting process.

For more information, please contact:

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For more information on the Vermont Tobacco Control Program: <http://healthvermont.gov/wellness/tobacco>

Former smokers were significantly more likely to report their last quit attempt exclusively unassisted compared to **current smokers**.



Note: These are mutually exclusive strategy combinations chosen among those who said they quit on their own. Former smokers = those who quit within the past 5 years. Own only=exclusively unassisted; HCP=healthcare provider; E-cig=electronic cigarette; NRT=Nicotine Replacement Therapy. Prevalence of own + HCP + NRT is too small to report for former smokers. Source=VT ATS, 2012, 2014 & 2016.

Table 1. Cessation Methods Used Among Current Smokers by Demographic Characteristics

	Own	HCP	NRT	Meds	E-Cigs	Service
	%(95% CI)					
Gender						
Male	69% (63.4-73.6)	38% (33.3-43.8)^a	34% (29.3-39.6)	11% (7.9-14.4)	20% (16.2-24.8)	7% (5.0-9.3)
Female	63% (57.8-68.2)	50% (44.2-55.5)^b	40% (34.8-45.6)	14% (10.4-18.3)	24% (19.8-28.9)	11% (8.5-15.0)
Race/Ethnicity						
People of Color	75% (63.7-84.1)	41% (30.0-53.4)	38% (26.9-50.2)	--	23% (14.7-33.9)	11% (5.9-18.2)
White, Non-Hispanic	65% (61.2-69.0)	44% (40.1-48.3)	37% (33.2-41.1)	12% (9.7-15.1)	22% (18.8-25.6)	9% (7.0-11.1)
Age						
18-25	78% (67.2-86.4)^a	24% (15.2-35.0)^a	28% (18.8-39.0)	--	16% (9.6-26.7)	--
26-44	68% (61.3-73.6)^{a,b}	38% (31.4-44.3)^a	38% (31.3-44.4)	12% (8.4-17.8)	25% (19.6-31.1)	7% (4.9-11.1)
45+	61% (56.2-66.3)^b	55% (49.0-59.9)^b	40% (34.9-45.0)	14% (10.7-17.5)	22% (18.3-26.6)	12% (9.5-15.6)
Household Income						
< \$25,000	65% (58.5-71.0)	50% (42.7-56.4)	44% (37.6-51.2)	12% (8.0-17.2)	22% (16.7-27.8)	11% (8.0-15.1)
\$25,000 - < \$50,000	63% (56.1-70.1)	43% (36.3-50.4)	34% (27.5-41.0)	14% (10.1-20.2)	25% (19.7-31.8)	11% (7.1-15.9)
\$50,000 - < \$75,000	71% (59.9-79.8)	44% (34.1-55.1)	32% (22.5-42.3)	14% (8.1-23.6)	22% (13.9-32.4)	--
\$75,000 +	67% (58.2-75.5)	37% (28.8-46.9)	42% (33.3-52.3)	--	20% (13.7-29.2)	--

NOTE: Total sums to greater than 100% because categories are not mutually exclusive. Own only=exclusively unassisted; HCP=healthcare provider; E-cig=electronic cigarette; NRT=Nicotine Replacement Therapy.

-- Sample too small to report.

^{A,B} Groups within demographic categories that share a common letter are statistically similar to each other. Groups not sharing a common letter are statistically different from one another. For example, talking with a HCP among males and females is significantly different while using NRT is statistically similar. Only categories that are bolded have estimates with significant differences.

Source=VT ATS, 2012, 2014 & 2016.

Table 2. Combinations of Cessation Methods Used with “Quit on My Own” in Most Recent Quit Attempt Among Current Smokers, by Individual Characteristics

	Own Only	Own + HCP	Own + E-Cig	Own + NRT	Own + HCP + NRT
	% (95% CI)				
Gender					
Male	51% (44.6-58.0)	14% (9.7-19.0)	8% (5.0-11.7)	7% (4.0-10.9)	6% (3.5-9.7)
Female	45% (37.9-53.3)	17% (12.3-21.8)	--	10% (6.0-15.4)	6% (3.7-9.6)
$\chi^2 (5, N = 794) = 0.48; p > .05$					
Race/Ethnicity					
People of Color	47% (32.8-61.5)	--	--	--	--
White, Non-Hispanic	49% (43.3-54.2)	16% (12.6-19.8)	7% (4.8-10.3)	8% (5.7-11.8)	6% (3.9-8.2)
$\chi^2 (5, N = 785) = 0.42; p > .05$					
Age					
18-44	54% (46.3-60.8)	9% (5.5-13.5)^a	9% (5.4-14.3)	11% (7.4-17.1)	--
45+	43% (35.4-50.1)	22% (17.1-27.9)^b	5% (3.4-8.3)	4% (2.6-7.6)	8% (5.5-12.8)
$\chi^2 (5, N = 783) = 5.54; p < .01$					
Household Income					
< \$50,000	45% (39.1-51.8)	15% (11.0-19.2)	8% (4.6-12.2)	10% (6.3-14.6)	6% (3.7-9.3)
\$50,000 - \$75,000 +	49% (40.1-58.1)	16% (10.4-23.7)	8% (4.7-13.6)	--	8% (4.3-13.0)
$\chi^2 (5, N = 705) = 0.56; p > .05$					
Number of Attempts in Past 12 months					
1-2 attempts	56% (48.9-61.9)^a	13% (10.0-17.9)	7% (3.9-11.0)	8% (4.9-12.3)	5% (2.7-7.5)
>2 attempts	35% (27.7-43.0)^b	19% (13.4-25.7)	9% (5.4-13.7)	8% (4.6-13.8)	9% (5.5-14.2)
$\chi^2 (5, N = 771) = 3.46; p < .01$					

NOTE: Own only=exclusively unassisted; HCP=healthcare provider; E-cig=electronic cigarette; NRT=Nicotine Replacement Therapy.

-- Sample too small to report.

^{A,B} Groups within demographic categories that share a common letter are statistically similar to each other. Groups not sharing a common letter are statistically different from one another. For example, talking with a HCP among males and females is significantly different while using NRT is statistically similar. Only categories that are bolded have estimates with significant differences.

Source=VT ATS, 2012, 2014 & 2016.

Appendix II

Vermont Tobacco Cessation: Environmental Scan

January 2019

Purpose

The purpose of this environmental scan is to provide an overview of research examining the factors that influence tobacco users to become former tobacco users. The Vermont tobacco Control Program is interested in the following questions:

- 1. What factors influence smokers to become former smokers?** (e.g., Stages of Change, social determinants of health)
 - Why do people smoke and why don't they quit?
 - *What is the benefit of smoking?*
 - How do people conceive/understand "quit on your own?"
 - What factors influence motivation (and/or readiness) for cessation?
 - How do social determinants of health influence cessation activity?

- 2. What are the current innovative methods to promote cessation?**

The information acquired in this environmental scan will be used to develop semi-structured interview guides with tobacco users in Vermont, and to inform the interpretation of findings and recommendations based on discussions with tobacco users.

Methods

John Snow Inc. Research & Training (JSI) conducted a search for peer-reviewed articles this environmental scan in January 2019. Peer-reviewed research articles published from 2009 to 2018 were identified by searching for the following terms on PubMed and Google Scholar:

- factors quit “smoking OR tobacco”
- motivations for “smoking OR tobacco”
- social determinants of health approach to “smoking OR tobacco”
- unassisted cessation
- human centered design smoking OR tobacco
- user centered design smoking OR tobacco

It should be noted that in initial searches, terms such as ‘innovative’ and ‘novel’ were used to find newer approaches to tobacco cessation, but resulted in highly specific aspects to cessation promotion (e.g. tailoring assistance in online communities) or unfeasible forms of assistance (e.g. new transdermal products to come to the market). These search terms were replaced by ones related to human or user centered design, given that this project is ultimately interested in designing cessation services that will be relevant, appropriate, and attractive to Vermont tobacco users, rather than simply new.

To maintain the focus of this environmental scan, certain articles were excluded, such as methodological validation studies; studies that did not include adults; studies focused on people with specific diagnoses (e.g. COPD, HIV, oral cancer); studies focused on light, intermittent, or social smoking; studies on smoking cues; studies on factors that lead to smoking initiation; genetic or biological factors related to tobacco use or cessation; factors for cessation within the context of an intervention (e.g. workplace program); and factors related to relapse. Most studies that failed to include U.S. research participants were excluded as well, although several were included given their high relevance to the scan. The vast majority articles examine smoking specifically rather than tobacco use in general. Literature shared by the Vermont Department of Health was also incorporated. A total of 37 articles were deemed relevant to this environmental scan.

Key Findings

Among the articles reviewed in the environmental scan, the most valuable for the Vermont Department of Health to review are the two studies of Vermont Smokers – 1) “Reducing Adult Tobacco Use in Vermont: Research Report” by Rescue Social Change Group, and 2) the results from the focus groups conducted by the Tobacco Action Group – and 3) “A Case Study for Redesigning Tobacco Cessation Services: Gaining Critical Insights From Current and Former Smokers” by Dreher et al., an in-depth qualitative study of current and former smokers’ perspectives and implications for the Minnesota tobacco cessation program.

The articles were grouped into four main topics, and the key findings are summarized here:

1. **Motivations for smoking.** Despite being aware of the health and financial costs of smoking, smokers continue to evaluate the benefits of smoking as more favorable than quitting. Smoking is a significant part of a smoker’s identity, daily routines, and social relationships. The weight and meaning of smoking for smokers, or tobacco users more broadly, can be informative for effective outreach and cessation programming.
2. **Factors related to quitting.** Current smokers are likely to feel that they ‘ought’ to quit, but commitment towards quitting varies greatly. The literature cited a variety of motivations for quitting tobacco use, including financial cost, current or future children, health concerns, and consideration of appearance. Barriers to quitting included lack of confidence in the success of future quit attempts (particularly due to discouragement by past failed quit attempts), stress, lack of social support from one’s immediate network, frequent smoking, drinking habits, smoking for self-confidence, and financial cost of cessation aids. Directly addressing some of these barriers, such as discouragement by past failed quit attempts, stress, and changes in one’s social networks may be worthy of further research as to their effectiveness in promoting cessation. Notably, former smokers tend to mention a tangible motivator for their cessation, such as a health diagnosis. Lower socioeconomic status is associated with lower quit rates (not necessarily quit attempts), and there may be some opportunity to assist lower socioeconomic groups with preventative health programs beyond smoking cessation.
3. **Unassisted cessation.** In recent years, there has been debate over whether and how tobacco cessation programs and policies should promote unassisted cessation. The majority of former smokers quit without formal assistance from medications or professionals, even though there is much research on the comparative effectiveness of quitting with assistance. The debate remains over the cost-effectiveness of promoting

unassisted cessation (both financially and in health outcomes), how assisted cessation should be framed, and how to most effectively assist disadvantaged populations.

4. **Perceived helpfulness of smoking cessation methods.** Generally, smokers prefer to have little to no barriers to their cessation method (e.g. no burdensome or confusing registration process). There is no clear approach that Vermont smokers prefer overall, though based on the Vermont focus group research, Vermonters seem to have little interest in the Quitline, and more interest in assistance from real persons (e.g. peers, cessation support groups, doctors). The literature suggests that there is heterogeneity with regard to preferred approach, potentially by sociodemographics and number of quit attempts. It may be worth considering approach like that of Minnesota's, which offers a suite of approaches to smokers along the continuum of readiness.

Motivations for smoking

Several qualitative studies have examined smoker's accounts of why they smoke. Two studies were of Vermonters, conducted for the Vermont Department of Health. Stress is the predominant recurring reason for smoking across these studies, followed by socialization.

In "Reducing Adult Tobacco Use in Vermont: Research Report" (hereafter referred to as the "Vermont Research Report"), smokers in Vermont often cited stress, in addition to addiction and habit, as a cause of continued smoking. Personal life events such as divorce or day-to-day stress would lead to using tobacco. In the Tobacco Action Group ("TAG") focus groups, stress was also cited as the primary reason for smoking. When TAG focus group participants were asked what would help them to quit, some suggestions were more jobs/opportunities, and access to mental health/therapists. These suggestions may be borne of the desire to reduce stress in their lives as a means to make quitting easier.

In the Vermont Research Report, most participants had a spouse, partner, parents, and/or friends who would smoke, and many participants associated tobacco use (and notably, relapse during a quit attempt) with alcohol use. Despite most participants having experienced negative health effects of smoking, some expressed criticism or outright disbelief of the probabilities that they would get a smoking-related disease.

In a survey of college students, non-daily smokers were more likely to smoke for social reasons, whereas daily smokers were more likely to smoke for self-confidence, boredom, and affect regulation.

In a focus group study of young smokers in the UK, the participants offered explanations to defend their choice to smoke despite the health risks, including: minimization of the risk (e.g. in comparison to other risky activities); perceived health benefits of smoking (e.g. stress relief); and construing it as a temporary phenomenon that would conclude upon entering responsible adulthood.

In interviews with the LGBTQ community in New York City, study participants described image, socializing, and stress as the main reasons for smoking.

Factors related to quitting

The literature cited a variety of motivations for quitting tobacco use, including financial cost, current or future children, health concerns, and consideration of appearance. Barriers to quitting included lack of confidence in the success of future quit attempts (particularly due to discouragement by past failed quit attempts), stress, lack of social support from one's immediate network, frequent smoking, drinking habits, smoking for self-confidence, and financial cost of cessation aids.

Smokers' given reasons

In the Vermont Research Report, smokers in Vermont described the financial cost of tobacco products and their current (or future) children as motivations for quitting. Some participants also described smoking-related health issues as a reason for trying to quit. Notably, many participants perceived quitting as an all or nothing process. Participants were discouraged by their previously unsuccessful quit attempts and expressed a lack of confidence in their future ability to quit. Other barriers to quitting included stress and lack of social support from their immediate network, who tended to use tobacco regularly.

A separate study found that consideration of appearance may be a motivation for quitting. Other barriers to quitting in the literature included perceiving it to be too difficult to quit, and concern about the financial cost of cessation aids.

Health concerns

A survey conducted in Florida found that having a history of a tobacco-related medical condition was significantly associated with recent and lifetime quit attempts. In this study, greater nicotine dependence and being advised by a healthcare provider to quit smoking was also positively associated with lifetime quit attempts.

Sociodemographics

In a 2011 systematic review of predictors of quit attempts and success of quit attempts, motivational factors were the main predictors of quit attempts, and cigarette dependence predicted success after an attempt had been made. Higher socioeconomic status was found to predict success in two studies, but gender, age, marital status, and educational level were not consistent prediction of quit attempts or success. An international study examining smokers in Canada, US, the UK, and Australia also found that smokers with higher education and income were more likely to intend to quit and abstain from smoking for at least one month.

Other studies using nationally representative U.S. data have found that Hispanics and Asians were less likely to attempt to quit, and that fewer African Americans reported long-term quitting. Racial/ethnic minorities were not less likely to receive healthcare provider advice to quit smoking, but were less likely to use nicotine replacement therapy.

Social determinants of health

Underlying explicit motivations for tobacco use is the broader socioeconomic context which can influence behavior. Differential vulnerability and exposure to tobacco use initiation, continuation, and cessation can affect tobacco use behavior; these different influences encompass a wide range of phenomena, including but not limited to availability of tobacco products, higher levels of stress, co-occurring health and other problems, working conditions, social norms permissive to smoking, and barriers to affordable cessation services. Given that education and income are both highly related to more positive health outcomes, it not surprising that smokers with financial stress are less likely to make quit attempts and achieve long-term abstinence. Elimination of tobacco-related disparities should consider how to address the particular barriers low-income populations face.

Suggesting a more holistic approach to treating health issues among smokers, the Vermont Research Report described that low-income tobacco users in Vermont, based on that study and a concurrent study on adult obesity in Vermont, often had co-occurring health problems. The participants in both the tobacco and obesity studies responded positively to the idea of visiting a local cessation counselor. The authors proposed that VDH could build a system of “preventative health upselling,” such that cessation counselors would be trained in a comprehensive set of health issues and how to work with individuals with comorbidities, be able to explain the value of other preventative health services and relation to quitting, and facilitate the participation in other programs while serving as the individual’s overall preventative health point of contact.

Specific populations

In a survey of college students, readiness to quit was negatively associated with having more friends who smoke, more frequent binge drinking, being a frequent smoker, and smoking for self-confidence.

In a study of mothers in California, Black women had significantly lower odds and Latina immigrants had significantly higher odds of being a former smoker compared to White women. Factors that decreased odds of being a former smoker included persons smoking in the home, having a majority of friends who smoke, perceptions of their neighborhood as unsafe, and experiencing food insecurity.

Several studies have examined factors related to smoking and quitting during pregnancy. Though women were aware of the health risks to the fetus, knowledge of potential health risks was not a sufficient motivator for quitting. Across the studies social reasons were the primary reasons for continuing to smoke: the importance of their relationships with other smokers and concerns about changes to these relationships, belonging to social networks with prominent smoking norms, and being tempted to smoke by members of their social networks. Other factors negatively associated with quitting included willpower, role, the meaning of smoking, a high rate of tobacco consumption, understanding of facts, changes in smell and taste, a smoking partner, a large number of children, issues with cessation provision, and deficiencies in prenatal care.

Using data from a national sample of homeless adults, factors associated with current smoking included out-of-home placement in childhood, victimization while homeless, past-year employment, and prior illicit drug use or problem alcohol use. Respondents with multiple homeless episodes were more likely to receive quit advice, but less likely to quit.

Unassisted cessation

From 2010 to 2015, Simon Chapman and colleagues published a series of articles about the “Global Research Neglect of Unassisted Smoking Cessation” and how health authorities should place greater emphasis on understanding and promoting unassisted smoking cessation (i.e., without formal assistance in the form of medication or professional assistance). A systematic review of population-based studies in nine countries, including the US, has demonstrated that the majority of quit attempts are unassisted.

In qualitative research with Australian former smokers who quit unassisted, Chapman et al. found that former smokers preferred to quit unassisted for a number of reasons: 1) prioritization of lay knowledge gained from personal experience and others over professional or theoretical knowledge; 2) perception that the costs and benefits of quitting unassisted were preferred over quitting with assisted; 3) the belief that quitting is their personal responsibility; 4) the perception that quitting unassisted is ‘right’ or ‘better’ in relation to their self-identity or self-image. Personal and societal values of independence, strength, autonomy, and self-control seemed to influence these smokers’ beliefs and decision-making about quitting. Morphett et al. found similar results in interviews with Australian smokers, and found a relationship between the perceived nature of the individual’s smoker’s addiction and the value of pharmacological cessation aids; there were frequent negative impressions of pharmacological cessation aids, particularly with regard to side effects.

Chapman et al. also found that three key concepts were identified as important to their having quit unassisted: motivation (reason for quitting), willpower (strategy to counteract cravings or urges, or personal quality or trait), and commitment (seriousness or resoluteness). Commitment was often the distinguishing factor between failed and successful quit attempts, and could be conceived as tentative or provisional, but also cumulative as the quit attempt progressed.

Chapman and colleagues criticize the dominant assumptions about successfully eliminating tobacco use, particularly that ideas that 1) as smoking rates decrease, the remaining smokers will be most deeply addicted and will need nicotine replacement in some form, and 2) that unassisted cessation is inefficient and inhumane. Chapman and other hypothesize that pharmaceutical marketing strategies may have reduced the expectations of the difficulty of quitting, and the overmedicalization of smoking cessation may have contributed to the international trend towards a lower prevalence of unassisted quit attempts, and unfortunate leveling off of successful quit rates. Chapman et al. recommend promoting the fact that most successful ex-smokers quit unassisted, that many do not plan their quitting in advance, and that

failed quit attempts are normal, natural, and rehearsals for eventual success. Chapman et al. also recommend tobacco cessation efforts that will reach the smoking population at large through taxes, graphic pack warnings, smokefree public places, and mass reach public awareness campaigns, with assisted cessation receiving less emphasis than it currently does.

This viewpoint has also met been met with criticism. Robert West et al. argue that the success rate of unassisted cessation is far lower than that of assisted cessation, and therefore it is inaccurate to say that unassisted cessation is more effective. West et al. raise the concern that ineffective quit attempts delay successful quitting, which harms smokers and those around them. West et al. also argue that it is morally indefensible to implement such tobacco control strategies as increased taxation and mass media marginalization of smokers, without providing assistance, when smoking is often more prevalent in disadvantaged groups. West and Chapman also disagree about the external generalizability of effectiveness studies.

As Raupuch et al. observe, “unaided quitting turns out to be the most effective and least effective quitting method at the same time.” That is, though most former smokers quit unassisted, unassisted quitting requires more attempts than assisted cessation. The debate remains over the cost-effectiveness of promoting unassisted cessation (both financially and in health outcomes), how assisted cessation should be framed, and how to most effectively assist disadvantaged populations.

Some more information about how smokers conceive of ‘quit on your own’ is included in the next section.

Perceived helpfulness of smoking cessation methods

Studies on smoker's preferences regarding cessation approaches have tended to examine relatively local populations and focus on assisted cessation methods. The search terms using 'human centered design' and 'user centered design' yielded articles that on formative research for specific mobile applications or websites, rather than tobacco or smoking cessation more broadly.

Both the Vermont Research Report and TAG focus groups offer rich insight into how smokers in Vermont perceive different smoking cessation methods. There is no clear approach that Vermont smokers prefer overall, though based on the Vermont studies, Vermonters seem to have little interest in the Quitline, and more interest in assistance from real persons (e.g. peers, cessation support groups, doctors). There was no data regarding Vermont smokers' perceptions of unassisted cessation. Results from several other non-Vermont studies are summarized as well.

In the Vermont Research Report, smokers in Vermont did not have a consistent positive impression on cessation approaches discussed, including cold turkey, hypnotism, alternative products (e.g. e-cigarettes), FDA regulated NRT, and the Vermont Quit Network's Quitline. Participants had a generally negative impression of the utility of the VT Quitline, both those who had called and those who had never called. In contrast, the few participants who were aware of local cessation support groups (e.g. at the hospital) had very positive opinions, and some other participants expressed interest.

In the TAG focus groups, participants described outreach through doctors or nurses, Facebook, radio, and personal outreach as most useful. Quitting with friends or peers was the preferred method of quitting for almost all participants, whereas there was little interest in group classes, quit coaches, or cold turkey. When asked where they would go for help with quitting, all participants said they would go to their doctor. For these focus group participants, less effective outreach methods included flyers, presentations, school communications, newspapers, the 802Quits campaign, and community centers. They were not interested in Quitline, Quit by Text, or the Patch. Focus group participants disliked educational materials on the harms of smoking, which assumed their ignorance of the information.

The Vermont studies did not examine relationships between sociodemographics and cessation method preferences, but there is certainly heterogeneity within the Vermont tobacco user population regarding preferences. Studies of non-Vermont populations may suggest some potential sociodemographic differences, particularly with regard to age. For instance, older

smokers (older than 40 years of age across the studies described here) in Northern Appalachia had greater interest in quitting assistance, and older smokers in lower-income neighborhood in Connecticut had greater concern regarding the cost of cessation products. Older smokers in Buffalo and Niagara Falls, New York were more interested in cessation products and resources, especially because they were more likely to have experienced health effects from tobacco use. Also in the Connecticut study, women and Black participants were more interested in a free quitline or quit website.

Both the Northern Appalachia and New York studies found general interest among smokers regarding social media and texting for promoting smoking cessation. Though younger smokers tended to use internet and text messaging more often, there was robust use of these technologies across age groups as well as socioeconomic groups.

The most in-depth, non-Vermont study of what smokers desire in terms of cessation approach was one of current and former smokers in Minnesota. This qualitative study described five major themes. The first major theme from their research was that smoking is a significant part of a smoker's identity. Smokers perceived that living as a nonsmoker would be very different from their own lives, and that quitting represented a farewell not just to addiction but an enjoyable way of life. Smoking facilitated bonds in their social networks, and smokers described being self-conscious about their smoking habits among non-smokers. Second, commitment to quitting varied – some smokers had clear goals, and some were not ready to set a quit date. Many smokers disliked the idea of setting a quit date at all, instead preferring for the 'moment' to arrive (e.g. threat to marriage, health scare), or quitting through cutting back. Smokers who said they preferred to 'quit on their own' used terms like 'cold turkey' and 'mind over matter,' suggesting a desire to rely on inner determination rather than outside resources, including emotional support, especially from nonsmokers. The third theme was that many smokers needed help to tip the scale towards quitting, and former smokers described experiences both subtle and great in causing them to quit. However, these events were tangible in nature (e.g. health diagnosis), in contrast to current smokers' motivations to quit. The fourth theme was that smokers had different preferences in assisted cessation approaches (e.g. free NRT without counseling, phone support, text messaging). The fifth and final theme was that smokers seek services that have low or no barriers (e.g. no burdensome or confusing registration process).

The findings from the Minnesota study were used to redesign Minnesota's cessation services. For instance, they developed a campaign that focused on understanding what it is like to be a smoker, and acknowledging smokers' difficulties on their website. Minnesota QUITPLAN Services stopped requiring smokers to set a quit date within 30 days and developed material to assist smokers who are thinking to quit, but not yet ready to quit. The redesigned QUITPLAN

Services also provided a variety of quitting tools (e.g. phone coaching, text and e-mail support) to meet the diverse needs and preferences of Minnesota smokers. Early results have been promising: more tobacco users signed up for QUITPLAN Services in the first six months of its redesign launch in spring 2014 than in all of 2013 (9,053 vs. 5,922). Several additional articles about Minnesota's cessation program have been published as well, including a smoking cessation contest and reengagement of cessation program participants; these were found outside of the context of the environmental scan search terms, but may be of interest to the Vermont Tobacco Control Program.

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Appendix III

Vermont Tobacco Cessation: Key Informant Interviews

July 2019

Purpose and Method

JSI conducted three semi-structured interviews with other tobacco programs conducting cessation research and evaluation. The purpose of these interviews was to provide information on cessation strategies currently employed in the field to reach, engage, motivate, and support tobacco users, with a focus on approaches that are distinct from current best practice and/or tailored/targeted with the aim of improving acceptability and relevance to tobacco users.

VTCP identified three key informants for JSI to engage:

- the New York State Tobacco Control Program,
- ClearWay Minnesota, and
- the Vermont Center on Behavior and Health.

VTCP and JSI contacted the key informants by email to schedule 30-45 minute phone interviews. JSI used a semi-structured guide to interview the key informants on the following topics:

- description of the organization's tobacco cessation work
- rationale and description of cessation strategies aimed to enhance reach and/or acceptability
- key design and implementation factors in their cessation strategy(ies)
- lessons learned during implementation
- considerations and insights for VTCP to guide their cessation approach

This document summarizes the findings from the key informant interviews – first individually, and then across the interviews.

New York State Tobacco Control Program

Background: VTCP selected the New York State Tobacco Control Program (NYS TCP) as a key informant to understand why and how it shifted away from emphasizing their state quitline as a part of its cessation efforts. Although the New York State Smokers' Quitline remains a part of its cessation program, its most recent focus has been promotion of "health systems for a tobacco-free New York." The NYS TCP also includes community programs, paid media campaigns, and research components.

Rationale for Change in Approach: Despite the Quitline reaching 3% of smokers in the state, one of the highest levels of reach in the nation, NYS TCP wanted to reach more smokers. Though they supported the quitline as a valuable service for highly motivated smokers who wanted to quit (and continue to fund their quitline), NYS TCP wanted to reach the other 97% of smokers not calling the quitline. They also considered that those using the quitline were likely the most motivated to quit while those not calling the quitline might be less motivated and therefore would need additional assistance. With 80% of smokers seeing a provider each year (according to their Adult Tobacco Survey), NYS TCP saw this relationship as opportunity to connect smokers with someone of influence.

Current Program: The NYS TCP largely follows the Clinical Practice Guidelines 2008 (Chapter 5) on tobacco cessation and promoting use of these guidelines within existing health systems. This includes focus on health system strategies such as providing training and resources to providers to deliver effective treatments, promoting hospital policies that support and provide tobacco dependence services, and including tobacco dependence treatments under different health insurance plans. Training emphasizes provision of tobacco treatment therapies adequately to maximize use and effectiveness (e.g., dual NRT). The program places particular efforts towards reaching lower-income, less-educated populations, which are more likely to smoke.

NYS TCP works with health and behavioral health care organizations/systems via contracts to implement health systems work. Like Vermont, NYS TCP has also collaborated with their state Office of Mental Health and their Medicaid agency to expand and promote their cessation benefit. NYS TCP started this initiative with the Office of Behavioral Health and expanding the benefit to behavioral health patients because they needed more help with cessation. Medicaid later agreed to roll out the expansion. Now, all health plans in the state provide the expanded cessation benefit.

NYS TCP cessation strategies includes tailored implements media campaigns to reach and engage populations with less education and/or lower income. They take into consideration whether diversity is reflected in ads selected as well as whether planned placement of ads will effectively reach target populations.

Key Informant Considerations for VTCP:

- Everyone has to re-learn the work of the quitline. Consider the quitline a clinician extender, not an outcome in and of itself.
- Primary care providers see cessation work as part of their role, but they have to do more work themselves to support smokers in tobacco treatment. That is, not only do they promote and/or refer to the quitline, they also ask, advise and assist with provision of effective treatments, provide motivation and encouragement to patients, and are supported by a system of care. This includes a tobacco user identification system (e.g., EHR), provider resources and training to ensure consistent delivery of effective treatments, and dedicated staff to provide tobacco treatment (i.e. Clinical Practice Guidelines 2008).
- There is a learning curve in understanding how to work with health system and their administrators (e.g. recording when an organization adopts a new policy or procedure).
- Changing health systems is much harder than providing and promoting a quitline.

Questions for VTCP Research:

- What is the reach of the health systems approach, especially when, in NYS TCP's experience, there is some reluctance from providers to encourage quitting because they do not want to be "pushy"?
- In the environmental scan, tobacco users said they would go to their doctor if they wanted assistance with quitting, but how do they feel about their doctor encouraging quitting? What kinds of support would they be more or less receptive to from their doctor?

ClearWay Minnesota

Background: In the environmental scan, the most in-depth research on what smokers desire in terms of cessation assistance was conducted in Minnesota, and that research formed the basis for Minnesota's tobacco control approach. In Minnesota, three key players work together on tobacco control: the Minnesota Department of Health Tobacco Prevention and Control (MN TPC), ClearWay Minnesota (a tobacco cessation nonprofit), and Blue Cross Blue Shield.

Rationale for Change in Approach: ClearWay Minnesota (Clearway MN) was established in 1998 and funded by 3% of the state's tobacco master settlement agreement funds. Their mission is to reduce the harm that tobacco causes Minnesotans by reducing tobacco use and exposure to secondhand smoke through research, action and collaboration. Throughout its time, ClearWay MN's tobacco treatment program has gone through different phases. It began with telephone counseling through a quitline, and later added NRT and face-to-face counseling (F2F) programs with a trained tobacco counselor through clinics and community based organizations. Additionally, they offered a quit plan at work program. They found that F2F programs were ineffective due to lack of smoker receptiveness and reach. They also found that there was an expectation in the health care setting that the trained tobacco counselor role would pay for itself and it did not. With these factors at play, ClearWay MN decided to discontinue their F2F programs.

In 2012, ClearWay saw a drop in quitline enrollment, and spearheaded a [research effort](#) to understand what participants wanted. They learned they needed to offer what participants want, when they want it and how they want it. They also learned that tobacco users could generally be categorized as either 1) wanting as much help as possible, or 2) wanting to quit on own (i.e. not talk to a coach) but open to using NRT and a tangible quit guide. These insights, among others, formed the basis for their current quit plan services program.

Current Program: There are two key components to their quit plan services. First, they offer the [quit plan helpline](#) -- a traditional telephone counseling model offering free NRT and complimentary texting, email and print materials. They enhance the effectiveness of the quitline by focusing on outreach to uninsured and underinsured populations, and collaborating with health plans to connect to people in the state who want telephone counseling. Second – and crucial to program's expanded reach from 5,900 to 16,000 – they offer [individual quit plan services](#), offered via phone, web, and mobile app enrollment with the absolute minimum number of questions asked to participants. They don't asking about insurance and learned in their formative research that participants are tired of being asked survey questions when trying to get services. The individual quit plan services is a tailored program in which registrants can choose any or all of the offer four services: starter kit of NRT, texting program, email program, and/or a printed quit guide. The program also has tailored outreach to African American and American Indian populations through community partners, and is supported through a paid media campaign emphasizing hope and promising “no judgment, just help” as well as quit plan ambassadors in the community. ClearWay MN also launched a separate quitline for the state's

American Indian population, which was co-designed with their quitline vendor and the American Indian Cancer Foundation.

Key Informant Recommendations for VTCP:

- Be clear about what will guide decision-making. For ClearWay MN, it was the participant experience, and this guiding principle influenced vendor selection, the media campaign, and web and phone service design, and all other aspects of the program. When facing program decisions, it was always brought back to the participant experience.
- It is valuable to talk to people who use the services to understand if anything is going wrong. ClearWay MN calls everyone who gets a start kit to check if they received the NRT, had any other questions, and could get connected to other services if interested.
- Even if the quit rate goes down like it has in their program, if you reach more people, you are still making a greater impact on a population level.

Question for VTCP Research:

- To what extent would the findings on ClearWay MN tobacco users also apply to VT tobacco users?

Vermont Center on Behavior and Health

Background: The Vermont Center on Behavior and Health (VCBH) at the College of Medicine at the University of Vermont is a NIH-supported interdisciplinary research center that focuses on the relationship between lifestyle behaviors and premature death. It is a unique NIH-funded center in that it applies the disciplines of behavioral economics and behavioral pharmacology (e.g. use of incentives) to support behavior change, especially among socioeconomically disadvantaged populations. VTCP included VCBH among the key informants because VCBH has conducted tobacco cessation research in Vermont.

Related Research: The Director of VCBH brought experience in developing an incentive-based program, in combination with other treatment, to address cocaine dependence, which was highly effective when other forms of treatment had failed. A criticism of the incentives-based approach is whether it can stop behaviors long-term, and therefore VCBH considered contexts in which a short-term incentive could provide long-term value. In Vermont, VCBH conducted a recent trial of an incentive intervention with pregnant women who smoke, and had a quit rate of 38% compared to the 9% VT quitline quit rate. The Director suggested that Vermonters would be open to an incentive-based program.

Key Informant Recommendations for VTCP:

- Consider focusing on smoking during pregnancy, because Vermont is ranked 4th from the bottom in the nation on this measure. Smoking during pregnancy is associated with unique and potentially devastating health consequences for the fetus and baby.
- Incentives are not a magic bullet, but it does have appeal for people who are interested in quitting.
- If Vermont were to implement an incentive-based approach at scale, it would need to be delivered as part of the quitline, and have either regional hospitals deliver the intervention or a remote method through smart phones. A vendor would need to be hired to provide the infrastructure to perform this work and protect against fraud.

Question for VTCP Research:

- To what extent would Vermonters be interested in incentives? Would the incentives increase motivation to quit, or only provide additional motivation for those who are already interested in quitting?

Conclusion

The three key informant interviews with the New York State Tobacco Control Program, ClearWay MN, and the Vermont Center on Behavior and Health offered insight into different potential avenues VTCP could pursue beyond the quitline. The tobacco control programs in New York and Minnesota were both concerned about the inadequacy of reach of their quitlines. Though they continued their quitlines, New York shifted to a health systems approach with an emphasis on providers, and Minnesota developed an approach to support tobacco users in their attempts to ‘quit on their own’ (i.e. without telephone or provider counseling) by offering choice in starter kits of NRT, a printed quit guide, and/or text and email support. The Vermont Center on Behavior and Health offered their insights into improving quit rates for smoking during pregnancy through an incentive-based program. Overall, these interviews demonstrate that there are different evidence-based approaches aside from the quitline that could further support cessation efforts and reduce tobacco use rates in Vermont.

Questions remain regarding:

1. What tobacco cessation services would be most desirable, usable, and useful to Vermont tobacco users? To what extent are the findings in Vermont similar to Minnesota’s?
2. For each of these potential approaches (health systems, supporting ‘quit on your own,’ and incentives for specific populations), what would the estimated impact on tobacco use rates be when considering population reach x quit rate effectiveness? How much would cost per quit be in each circumstance?
3. Which of these potential approaches would be most feasible given Vermont’s current infrastructure? What additional investments would be required?

The first of these questions will continue to be examined in the focus groups. The other questions can be considered through additional secondary research and discussion with VTCP. Addressing these questions will help to build on existing knowledge and practices in the field to enhance VTCP’s tobacco cessation approach.

Appendix IV

VERMONT TOBACCO CESSATION: FOCUS GROUP FINDINGS

August 2019

Purpose and Method

In May and June of 2019, JSI Research & Training, Inc. (JSI) conducted focus groups with Vermont adults who had experience using tobacco to gain understanding on the perceptions, experiences, and needs related to tobacco use and cessation. The focus groups were a part of a larger cessation needs assessment project conducted for the Vermont Tobacco Control Program (VTCP). The focus group study was reviewed by the Vermont Agency of Human Services' Institutional Review Board (IRB) as part of the application submitted for the cessation needs assessment project. The IRB deemed that the project, including the focus group study, does not meet the federal definition of human subjects research based on the primary purpose being to inform the program. Therefore, the study and needs assessment were deemed to be outside of IRB oversight.

The previously conducted components of the cessation need assessment—quantitative data review, environmental scan, and key informant interviews—provided input to the focus group component of the needs assessment. Additionally, JSI engaged tobacco advisors in the research process to ensure relevance and accuracy of the focus group study. People were eligible to be a tobacco advisor if they were:

- An adult, 18 years of age or older; and
- Living in Vermont; and
- A *current tobacco user*--defined as persons who uses a tobacco product every day or some days, and have used tobacco regularly over the past 2 years; **OR**
- A *former tobacco user*--defined as persons who previously used tobacco products regularly for at least 2 years, and have been quit for ≤ 5 years.

JSI recruited tobacco advisors to participate in the research process by conducting outreach through VTCP community partners (e.g., community-based prevention organization, free clinic) and posting on Front Porch Forum. As a result, two tobacco advisors were engaged in the process—one former cigarette smoker and one current cigarette smoker. JSI met with each tobacco advisor individually at two points in the focus group study. Each engagement was arranged for an in-person meeting 60-90 minutes long at a public meeting space in Vermont. Tobacco advisors were first engaged prior to focus groups to provide input on the instruments (e.g., questions and response options, language) and recruitment considerations for the upcoming focus groups (date, time, location, outreach). Tobacco advisors were engaged a second time, after the focus groups were conducted and preliminary findings were available, to provide input on the findings and their interpretation. Tobacco advisors were offered a \$50 Visa gift card for each engagement they participated in.

Focus group instruments included a survey and discussion guide (Appendix I). In addition to basic demographic questions, the survey included questions on tobacco use and cessation methods tried. Survey questions and response options were designed to align with questions from validated survey tools to the extent possible and relevant. These included questions from the Vermont Behavior Risk Factor Surveillance Survey, Vermont Adult Tobacco Survey, and the Motivation to Stop Scale. The discussion guide was designed to address tobacco use, perceptions of tobacco use and non-use, perceptions of and experience with quitting, and desired cessation support. The guide included open-ended and closed-ended question. The instruments were revised based on input from tobacco advisors.

The focus groups were conducted in five different regions of the state with current tobacco users. With assistance from the VTCP community partners and tobacco advisors, focus group participants were recruited indirectly through flyers, social media, and Front Porch Forum as well by direct outreach from community partners to their networks (e.g., clients served, co-workers). Participants that registered for the focus groups were prompted to invite other people in their networks that might be eligible to register for the focus group (snowball sampling). JSI screened potential focus group participants for eligibility, which were that they must be at least 18 years old, living in Vermont, and a current tobacco user.

The table below summarizes where the focus groups were conducted and the number of participants in each focus group. The total number of focus group participants was n = 47. Locations selected for the focus groups were based on input from VTCP (considering tobacco burden in that region, relationships with community partners in the location) and aiming to cover various geographic regions through the state (e.g., Northeast Kingdom, southern region of the state, central region of the state). Four of the focus groups were conducted at restaurants in semi-private spaces. JSI sought out restaurants within the communities identified for the focus groups that would accommodate a family style meal (e.g., pizza) and semi-private room to hold the focus group. The intention was to conduct the focus groups in settings that was perceived as acceptable and appealing for participants. The focus group held in Bennington was conducted in a private meeting space in a church due to inability to locate a restaurant in Bennington that could meet the focus group need. The church space was recommended by a VTCP community partner based on it being commonly used for convening groups and meetings in the community.

Location	Number of participants
Bennington, Vermont	5
Derby, Vermont	11
Plainfield, Vermont	7
Rutland, Vermont	12
St. Johnsbury, Vermont	12
Total	47

Each of the focus groups were 75 to 90 minutes in length. At the beginning of each focus group, participants completed the survey on demographic characteristics, tobacco use, and quit experiences. Two JSI staff co-facilitated the focus group discussion using the semi-structured focus group guide with one co-facilitator typing notes. The focus groups were audio recorded with permission granted by all focus group participants. Participants were provided food and refreshments during the focus groups and received a \$50 Visa gift card for their participation.

Given the exploratory nature of this study, JSI used a grounded theory¹ approach to analyzing the data. Focus group audio recordings were transcribed. Three JSI researchers reviewed the transcripts and focus group notes for *codes*, or conceptual units pertinent to the research questions. This coding process was iterative, such that each researcher examined the qualitative data and codes at multiple points, reflecting and building on the coding that had been logged previously in a codebook. The research team then collectively categorized the codes into a set of distinct *themes* that reflect broader patterns within the data. The research team also used facilitator notes on focus group dynamics and other observations not captured in the transcripts (e.g. tone and expressions of participants) to inform their interpretation of the data. Following analysis of the data to identify themes, JSI met with tobacco advisors in-person and facilitated discussion to gain their input on the themes (i.e., interpretation of the data). Tobacco advisors were asked for their reactions to the themes, the extent to which they resonated with them or disagreed, and considerations or thoughts that came to mind upon hearing the themes. Themes were refined based on tobacco advisor input.

Survey Results

Demographic Characteristics

Focus group participants varied in their demographics overall and by location to some extent (Table 1). Overall, slightly more participants identified themselves as women than men, although the focus group in Bennington had more males. The majority of participants identified their sexual orientation as straight. The focus group in Rutland had the highest proportion of those that identified as either bisexual or lesbian. A large majority of participants identified as white and none identified as Hispanic. There were a wide range of ages between 19 and 74; the average age of focus group participants was 44, and only 10% were less than 30 years old. About two-thirds of focus group participants had completed one year of college or more. Household income varied, ranging from less than \$10,000 to more than \$100,000. However, a little over half reported an annual household income of less than \$25,000. About two-thirds (63%) of participants were insured by a public insurance program, including Medicaid and Medicare. Over half of those in Rutland were insured by Medicaid. While a majority of participants smoked cigarettes, some also used e-cigarettes. Participants in St. Johnsbury used the most variety of tobacco products.

¹ Glaser, B. G. & Strauss, A. L. (1967). *The Discovery of Grounded Theory. Strategies for Qualitative Research*. Chicago: Aldine.

Table 1. Focus Group Participant Demographics by Location

	Total (n=47)	Bennington (n=5)	Newport (n=11)	Plainfield (n=7)	Rutland (n=12)	St. Johnsbury (n=12)
Gender						
Female	60%	20%	73%	57%	75%	50%
Male	38%	60%	27%	43%	25%	50%
Transgender	2%	20%	-	-	-	-
Sexual Orientation						
Straight	85%	80%	91%	86%	73%	92%
Bisexual/Lesbian	9%	-	-	14%	18%	8%
Prefer Not to Say/Another	6%	20%	9%	-	9%	-
Race/Ethnicity						
White, non-Hispanic	87%	60%	73%	100%	91%	100%
POC	13%	40%	27%	-	9%	-
Age						
18-24	7%	-	9%	-	-	20%
25-34	26%	-	27%	40%	27%	30%
35-44	21%	40%	27%	-	9%	30%
45-54	24%	-	9%	40%	46%	20%
>=55	21%	60%	27%	20%	18%	-
Education						
High School or Less	35%	20%	18%	43%	46%	42%
Some College	46%	60%	46%	43%	55%	33%
College or More	20%	20%	36%	14%	-	25%
Annual Household Income						
<\$25K	54%	100%	27%	-	73%	58%
\$25K - <\$50K	26%	-	46%	25%	9%	33%
\$50K - <\$75K	7%	-	9%	25%	9%	-
>\$75K	14%	-	18%	50%	9%	8%
Health Care Coverage						
Medicaid/State Program	37%	-	36%	29%	55%	42%
Medicare	15%	40%	9%	14%	18%	8%
Medicare and Medicaid	11%	60%	-	-	-	17%
Employer	20%	-	36%	14%	27%	8%
Uninsured	11%	-	18%	29%	-	8%
Another Type	7%	-	-	14%	-	17%
Tobacco Product						
Cigarettes	57%	60%	55%	100%	67%	25%
Cigarettes & E-Cigs*	21%	-	27%	-	25%	33%
E-Cigs	9%	40%	9%	-	-	8%
Other*	13%	-	9%	-	8%	33%

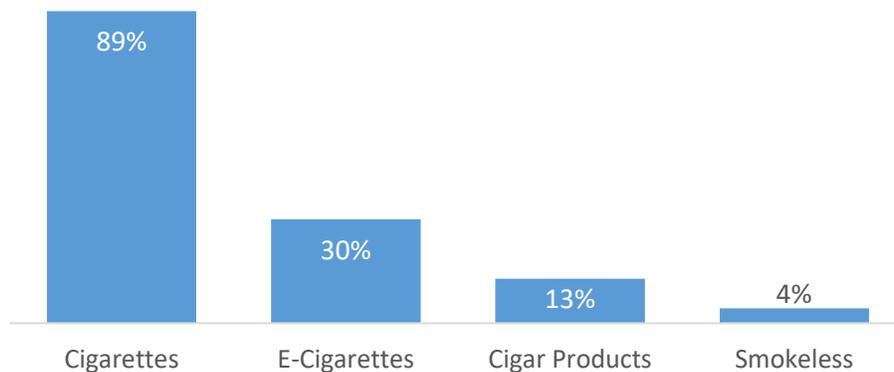
*Cigarettes & E-cigs includes those that use cigarettes, e-cigs, and cigar products (n=2)

**Other includes different combinations of cigarettes, cigar products, and smokeless.

Tobacco Use

From the survey, the great majority of focus group participants reported using tobacco every day (89%), while 11% reported using some days (data not shown). The most commonly used tobacco product was cigarettes (89%; Figure 1) followed by electronic cigarettes/electronic vapor products (30%). A few participants reported using cigars, cigarillos or little cigars (13%) and smokeless tobacco (4%). Participants were allowed to select any tobacco products they usually use, therefore the responses in Figure 1 include those who chose more than one type of product. Table 1 provides mutually exclusive categories of tobacco products used.

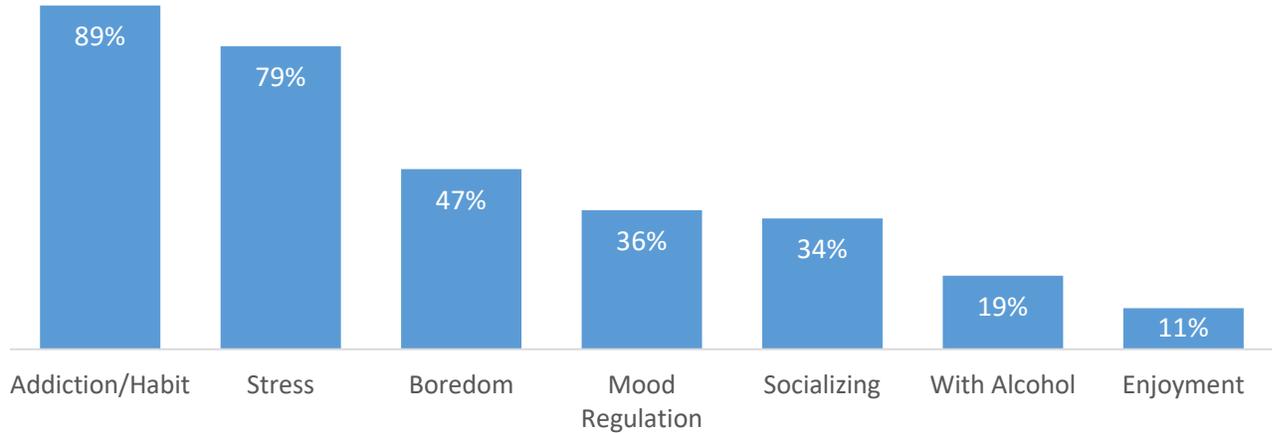
Figure 1. Types of Tobacco Products Used, including Multiple Products Selected (n=47)



**NOTE: Respondent could choose more than one tobacco product, therefore sum does not equal 100%*

The most commonly cited main reasons for tobacco use were addiction or habit, stress, boredom, mood regulation, and socializing (Figure 2).

Figure 2. Main Reasonse for Using Tobacco (n=47)

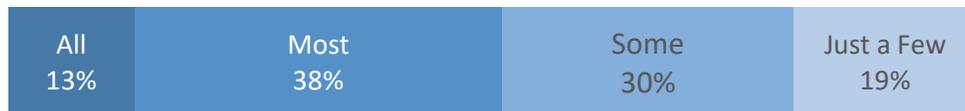


**Other responses include self-confidence, appearance, time to one's self/break, reward, family smoked, helps with nausea, and as replacement for smoking marijuana*

**NOTE: Respondent could choose more than one tobacco product, therefore sum does not equal 100%*

All the participants had family and/or friends who use tobacco. Half (49%) said *all* or *most* of their family and/or friends use tobacco. Close to another third (30%) said *some* of their family and/or friends use tobacco (Figure 3).

Figure 3. Number of Friends & Family that Use Tobacco (n=47)



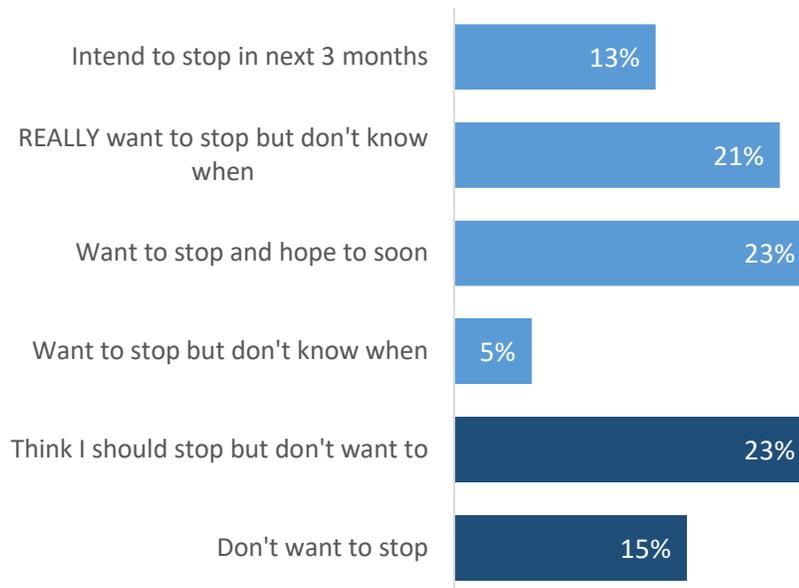
Desire to Quit

Participants were asked to describe their desire to quit using the Motivation to Stop Scale. This scale includes the following response options:

- I REALLY want to stop using tobacco and I intend to in the next month
- I REALLY want to stop using tobacco and intend to in the next three months
- I REALLY want to stop using tobacco but I don't know when I will
- I want to stop using tobacco and I hope to soon
- I want to stop using tobacco but I don't really know when
- I think I should stop using tobacco but I don't really want to
- I don't want to stop using tobacco.

No participants reported intentions to quit within the next month and 13% indicated they intend to stop in the next three months. A majority (62%) want to quit using tobacco, but responses varied across the spectrum of level of desire (Figure 4). Nine participants chose not to answer or chose more than one response and were, therefore, not included in the results.

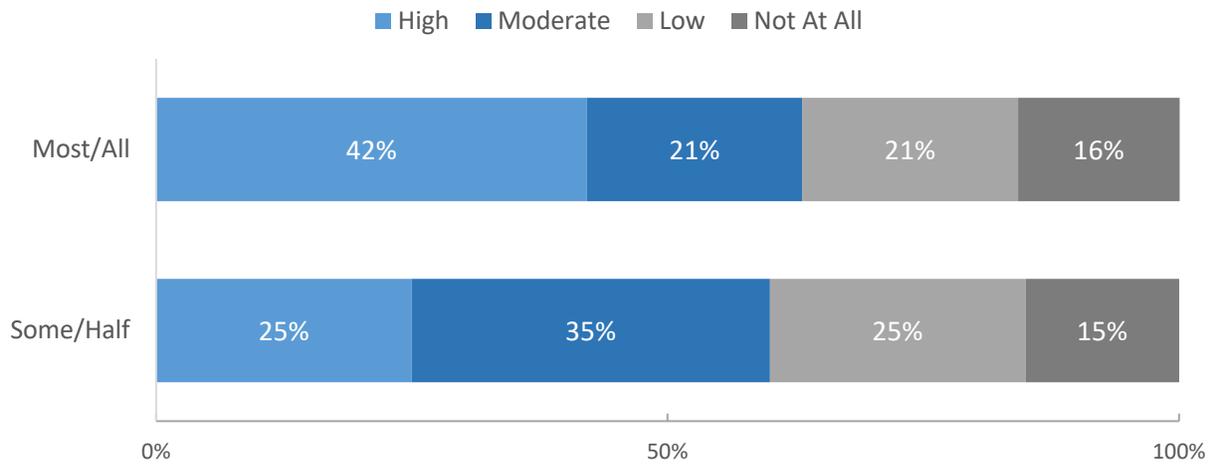
Figure 4. Readiness to Quit (n=39)



We further explored the data by examining the relationship between desire to quit and number of friends and family who use tobacco. Here, those with a “high” desire to quit were those that either intend to quit in the next three months or REALLY want to stop but didn’t know when. Those with a “moderate” desire to quit include those who want to stop and hope to soon or don’t know when. Those with a “low” desire to quit include those who think they should stop but don’t really want to, and those that only reported that they do not want to stop were categorized as “not at all”.

Figure 5 shows that those who have more friends and family that use tobacco have a higher desire to quit. More specifically, 42% of those that report most or all of their friends use tobacco have a high desire to quit compared to 25% of those with only some or half of their friends who use tobacco.

Figure 5. Desire to Quit by Number of Friends & Family Who Use Tobacco (n=39)



Attempts to Quit

The majority of participants reported they had not made a serious quit attempt in the last 12 months (42%), while close to a quarter had made one attempt (23%) and one quarter had made two attempts (26%). The remainder, 9% made between 3 to 6 attempts (Figure 6).

Figure 6. Number of Past-Year Quit Attempts (n=43)

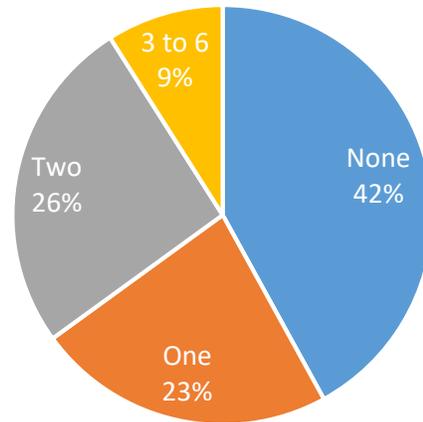
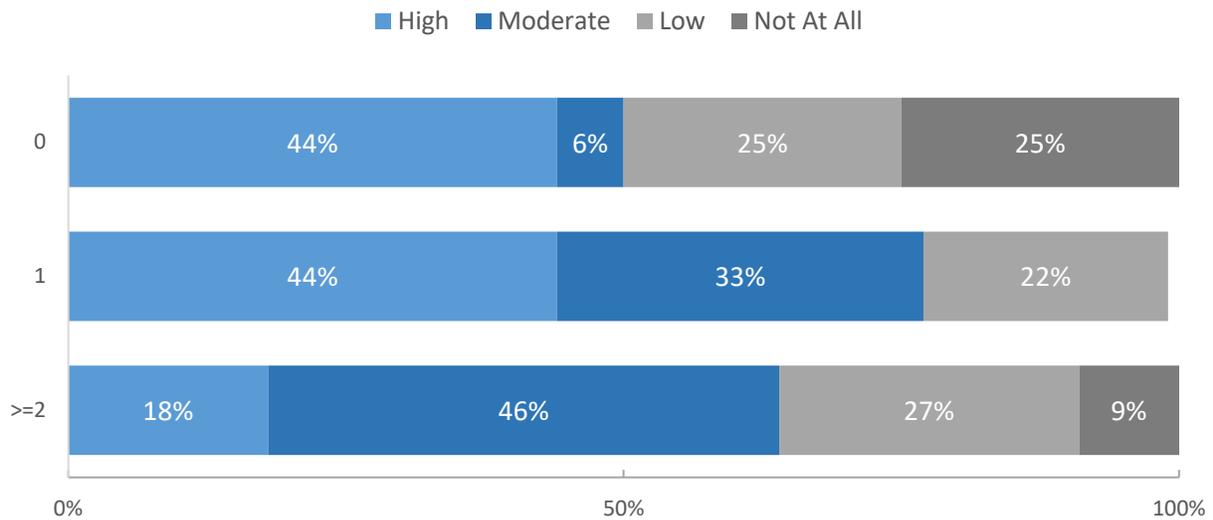


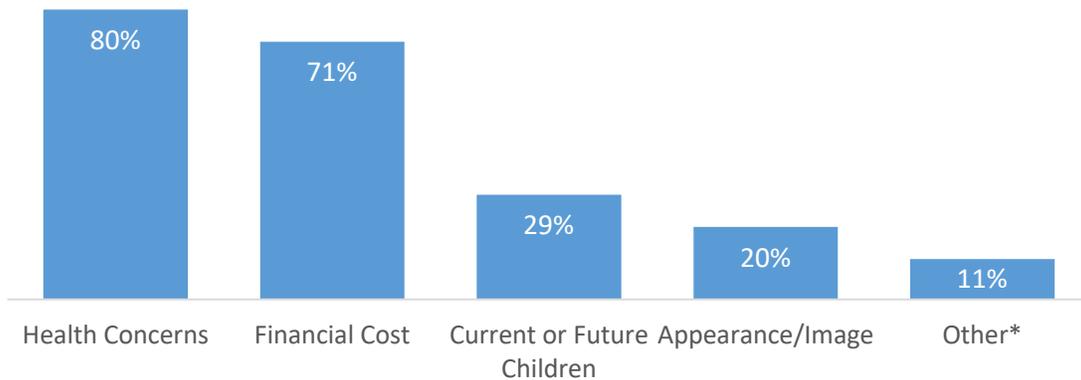
Figure 7 shows the relationship between desire to quit and number of past-year quit attempts. Those who made one quit attempt in the last year have the highest desire to quit – 77% have either a high or a moderate desire to quit. Only 18% of those that made two or more quit attempts in the past year report a high desire to quit using tobacco, less than those who have made no attempts (44%).

Figure 7. Desire to Quit by Number of Past-Year Quit Attempts (n=36)



The most common reason cited for a quit attempt was health concerns (80%; Figure 8). This was followed by financial cost (71%), current or future children (29%) and appearance or image (20%).

Figure 8. Main Reasons for Past-Year Quit Attempts (n=45)



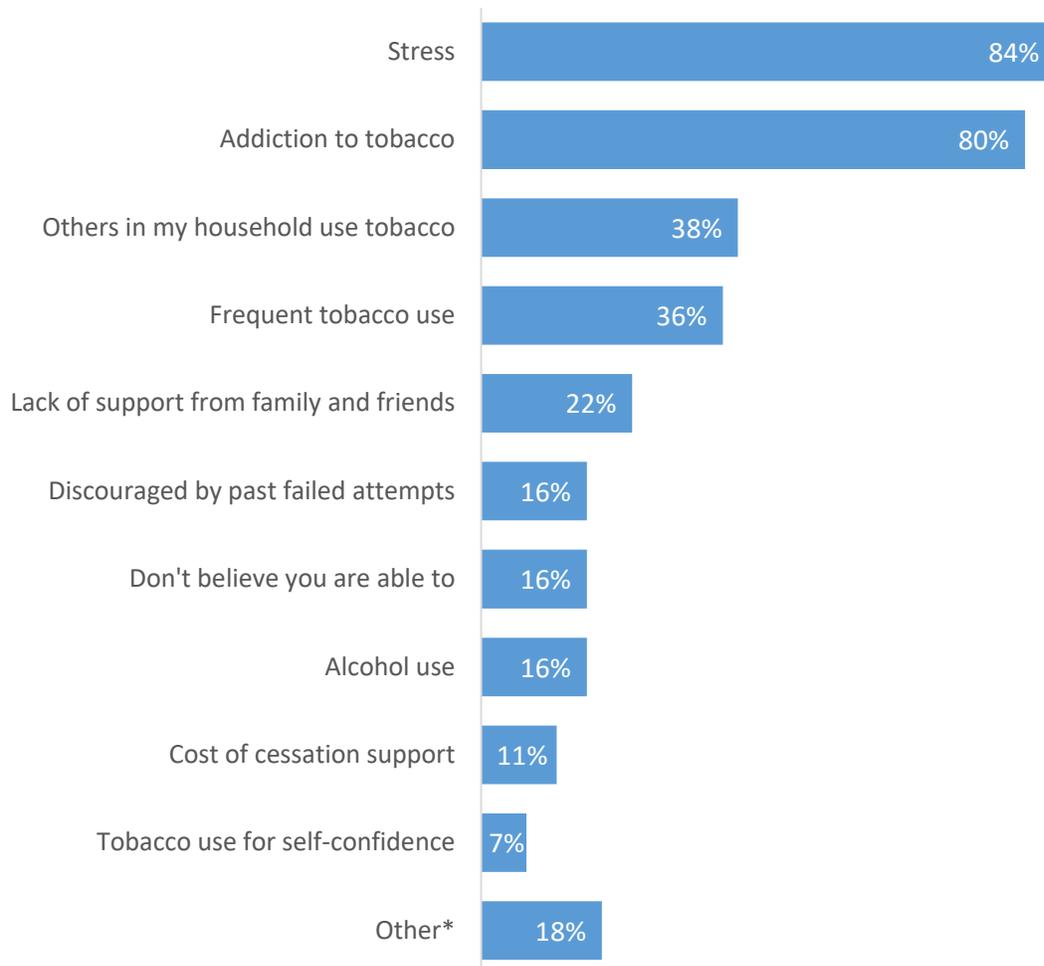
*Other includes grandkids, workplace, no desire to quit, husband diagnosed with asthma, and incarceration.

NOTE: Respondent could choose more than one tobacco product, therefore sum does not equal 100%

Based on the survey data, stress and addiction are overwhelmingly the most reported challenges that participants face when trying to quit using tobacco (Figure 9). A related factor commonly is their own frequent use of tobacco – about one-third of participants reported this

barrier (36%). Other shared challenges that about a quarter to one-third of participants reported relate to social relationships: having others in their household who use tobacco (38%) or a lack of support from family and friends (22%). Interestingly, while social relationships are a barrier, having more friends and family who use tobacco also seems to be a motivator to quit (shown in Figure 5).

Figure 9. Barriers & Challenges when Attempting to Quit (n=45)



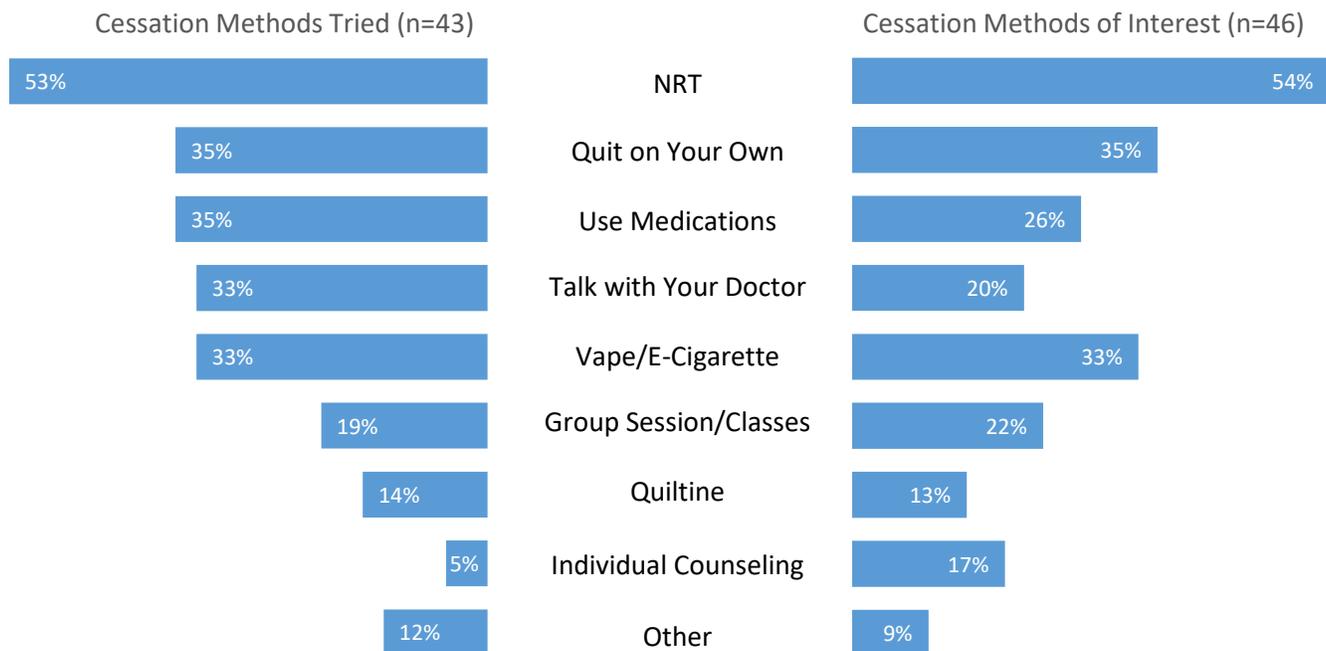
**Other includes haven't attempted, past difficulty quitting, medications increase desire to smoke, migraines, relaxation, delaying quit, feeling as if being forced to quit.*

NOTE: Respondent could choose more than one tobacco product, therefore sum does not equal 100%

Cessation Methods Tried and Of Interest

Among participants who reported on the method(s) used during their most recent quit attempt, more than half (53%) reported having tried NRT to help quit and a little over one-third reported quitting on their own (35%), using cessation medications (35%), having talked with their doctor or other healthcare professional (33%), or vaped/used e-cigarettes (33%) (Figure 10). Cessation methods of most interest among participants were similar to those that they have already used in previous quit attempts. The only differences are that less participants are interested in talking with a doctor or other healthcare professional (20%) and more are interested in individual counseling (17%).

Figure 10. Cessation Methods Used in Past-Year Quit Attempts and Methods of Most Interest



NOTE: Respondent could choose more than one tobacco product, therefore sum does not equal 100%

Focus Group Themes

Focus group discussions were analyzed within the context of the overarching cessation needs assessment research question -- *What are the perceptions, experiences, and needs of tobacco users in Vermont related to tobacco use and cessation?*; and considering the concepts probed on during the discussion (tobacco use, perceptions of tobacco use and non-use, perceptions of and experience with quitting, and desired cessation support). It is notable that participants expressed their appreciation for the opportunity to take part in a focus group on this topic. Many participants indicated they liked having the opportunity to share their experiences, and/or appreciated that the state is interested in learning about their experiences to inform future cessation resources. Some also expressed appreciation for having the focus group opportunity available in their community (versus Burlington).

Twelve main themes emerged from the focus group discussions. The main themes are listed in bold text. The bullets under each main theme are sub-themes linked the main theme.

1. Focus group participants were predominantly comprised of people who have smoked heavily for a long time and were well aware of their addiction to tobacco and the health consequences.

- Most participants smoked cigarettes and had been smoking for years or decades.
 - Several started smoking as a teenager, some as a very young teen or pre-teen.
 - Several indicated their family members smoked, influencing their decision to smoke and providing access to cigarettes.
 - Several shared that many of their peers smoked at the time they initiated smoking and it seemed the normal or “in” thing to do at the time.
 - Some participants noted when they started smoking it was more socially acceptable and not as stigmatizing as it is today.
- Many participants described themselves as heavy or regular smokers; some indicated they are a stress smoker, closet smoker, chain smoker, or light smoker.
- Participants were well aware of the addictive nature of tobacco or smoking and expressed their tobacco use/smoking as an addiction or referred to themselves as an addict.

2. There are many reasons people like to use tobacco, primary among them being stress relief.

- Many participants named tobacco use as a mechanism for stress and/or anxiety reduction, mood regulation, and/or relaxation.
 - Stress levels among people can be quite high, and smoking or tobacco use is a valuable stress management strategy that is more important than tobacco use drawbacks, dislikes or consequences.
 - Stress is a common reason for returning to smoking or tobacco use after a quit attempt.
 - Some participants see tobacco use or smoking as a way to treat their anxiety, PTSD and other mental health conditions.

- People often referenced the habit or addiction when asked what they liked about using tobacco. Some commented that it feeds their addiction.
 - Participants indicated both nicotine addiction and physical/habitual addiction (e.g. hand to mouth, after waking up, after eating, while drinking alcohol, while driving, with certain people, with coffee.)
 - Smoking or tobacco use becomes part of daily routine. There are also parts of daily routine that trigger or promote one to smoke or use tobacco (e.g., drinking coffee, driving, after a meal).
- Several people like that smoking or tobacco use provides an opportunity to take a “break”.
 - Smoking or vaping afford a reason and opportunity to take a break from work, family/social setting, life.
- Several people shared that smoking or tobacco use serves as a reward or provides something to look forward to.
- Smoking or tobacco use is a way for some to address boredom; it provides something to do.
- Some participants stated they simply enjoy it (e.g., smoking).

3. There are many reasons people do not like to use tobacco, primary among them being the smell, financial cost, judgment, and health implications.

- Smell was frequently one of the first things noted when asked what people do not like about using tobacco or smoking.
- The cost associated with smoking or tobacco use was voiced as a dislike.
- Judgement and stigma were called out as things people don’t like about smoking or tobacco use. Some referred to being embarrassed or feeling guilty. Some noted they don’t smoke in certain places or around certain people because they feel judged or stigmatized.
 - For example, some shared that they hold a cigarette discretely when passing children on the street.
 - Others feel frustrated, angry, stigmatized that they are looked upon by society as less than because they use tobacco or smoke.
- Several noted health implications of smoking or tobacco use as dislikes, particularly lung health issues such as breathing, coughing, or lung cancer.
- Some people called out addiction as a reason they do not like using tobacco or smoking, noting “*the control over me*”.

4. Tobacco users experience judgment and lack of understanding from former smokers and never smokers, and society in general.

- Many participants mentioned judgment from former smokers and non-smokers.
- There has been change over time in the social norm for tobacco use and smoking. Participants shared that more people used to smoke and now that fewer people do, smokers feel like outsiders.

- Many people remarked on limits on when and where they use tobacco, either self-imposed limits based on where they feel comfortable or perceive it acceptable to smoke or use tobacco, or imposed limits due to no-smoking/tobacco or secondhand smoke policies. The latter contributes to perceived discrimination.

“Annoyed because opioid users have a safe place to shoot but I can’t smoke where I live” (state elderly housing)
- Some feel government laws or policies on where smoking or tobacco use is allowable makes them an outcast in society; rejected, segregated, stigmatized, judged.

“...But one thing that really irritated me was when they come up with the brilliant idea they were gonna give heroin people a safe place to shoot...I went off the deep end, because I don't have a safe place to smoke a cigarette.”
- A few participants made comments that questioned how much the health department (“the system”) cares about them:

“I feel like if the health department really gave a shit they just wouldn’t let people sell cigarettes.”

 - They should consider vaping as a strategy as helpful to this population; not just worry about the effect on teenagers: *“Would help if health department didn’t slam vaping because teenagers are using. It is helpful to me.”*

5. Tobacco users feel that tobacco addiction is underestimated/appreciated by the public and the healthcare system.

- Participants recognize addiction is driving their tobacco use.
- Some indicated that tobacco should be addressed like other addictions, including opioid use disorder.

“... we have rehab centers for everything else. Why don’t we have rehab centers for nicotine?”
- Participants shared a common perception of tobacco addiction being considered less urgent and/or prioritized compared to other addictions or health issues.

“Yes!...we’ll move mountains for people who are drug addicted, but not for nicotine addiction...where is our help?” [tobacco advisor in response to this focus group finding]
- Participants feel tobacco addiction is not given same level of resources as other drugs.

“...if someone calls for opioid addiction, we get them in right away. I work in this field and we do that. But for tobacco we don’t have anything.”
- Failed quit attempts are common and demotivating; each failure chips away at self-efficacy, people may feel judged by former smokers, and they may avoid future quit attempt because they don’t want to feel like a failure again.

6. Health consequences and other motivations (e.g., children or future children) for quitting are insufficient in and of themselves to lead to quit attempts.

- The motivators described for past and future quit attempts are generally the same (particularly health consequences, children, and cost). Therefore, other factors may be

critical to influencing the decision to quit (e.g. fewer stressors at the time, immediate health issue).

- Many participants have witnessed health consequences of smoking or using tobacco, either personally and/or among family members, and want to quit, but have not been able to do so successfully.
 - Some people referenced health consequences due to smoking or using tobacco, but indicate they are willing to accept the risk. For example, “*...all going to die someday, so might as well enjoy...*”; “*Some smokers have lived to be 100 years old. Not everyone will get cancer.*”
- Common tobacco use dislikes - smell, cost, addictive nature - were often not primary motivators for quitting.
- Some participants mentioned intending to quit during pregnancy, or limiting use to reduce potential harm to the fetus. At least one participant did not believe there was harm in smoking during pregnancy given her own experience.

7. Personal choice and having control over when and how to quit is important.

- Participants expressed they do not want to feel like they are being coerced into quitting.
- Participants spoke to the need to be ‘ready to quit’ - i.e. circumstances need to line up before attempting to quit, there is need for fewer stressors.
- Participants remarked that a quit date can be more stress-inducing and backfire. This then may result in lower self-efficacy because of the feeling of defeat or failure.
- Some participants indicated they can feel an urge to smoke in response to people nagging them to quit and/or anti-smoking commercials.
- There is variation in how people interpret/define quit on your own versus with help. Roughly, about half prefer on your own and half prefer with help.
 - Most often, quit on your own is associated with “cold turkey” or without counseling or assistance (i.e. no help). Some suggest obtaining NRT such as patches, gum, lozenges, or getting support from family or friends is also quit on your own.
 - Quit with help is most often associated with counseling support, group meetings, and/or help from a healthcare provider.
 - Opinions varied on the use of NRT being quit on your own or quit with help. Some indicated it is not quit on your own because you are using nicotine. Others indicated one could use NRT, but no other services such as the quitline.

8. Tobacco users have often had experiences with different forms of cessation support, and vary in their desired forms of support for future attempts.

- Participants have experience with a variety of strategies and have been exposed to public health messaging on tobacco use and quitting.
- Participants seemed open to the different cessation strategies, but with some caveats on improvements that would make them work better for their needs (financial, allergies, side effects, accessibility, quality, format).

- Participants indicated individualized preferences on each of the cessation strategies depending on personal characteristics, needs and tolerance.
- A suite of choices is preferable to meet the variation in readiness, preference, acceptability, need, etc. (confirms literature). This also aligns with the importance of choice in one's path to cessation.
 - Some participants voiced need for personal choice in determining what is appropriate for them, rather than a one size fits all approach.
 - The spectrum of choices may allow response to different times of readiness.
- Participants feel non-smokers were not credible sources of information or support for cessation because they don't understand tobacco use, the addiction and the "struggle" or challenge of quitting.
- Many participants noted their healthcare provider or doctor would be a credible source for obtaining cessation support.

NRT

- Many participants had experience with pharmacotherapy, including NRT and/or medication.
- Many mentioned side effects from using pharmacotherapy for cessation (e.g., dreams from Chantix).
- Many participants have experienced cost/access barriers that made pharmacotherapy unsustainable or not feasible.
- While some participants liked the option of using pharmacotherapy, they disliked the steps needed to obtain pharmacotherapy, such as going to a provider and/or completing paperwork. They want easy access to pharmacotherapy.
- Some participants expressed dislike of NRT patches due to allergic reaction.

Vaping

- Some people used vaping to cut down on tobacco use. For some it didn't work, but others have used it to successfully cut down.
 - Some noted negative experiences with vaping, such as increased nicotine intake and nicotine poisoning, and becoming more addicted than with cigarettes alone.

Quitline

- Most comments on the quitline were not favorable. Some participants preferred to not speak with a stranger on the quitline or noted that when they tried to use the quitline they didn't get the support that they were looking for. For example, having to wait for a call back from the quitline was a problem considering their addiction and the need for immediate support when feeling ready to quit. Some participants shared they felt the quitline counseling was prescriptive, disingenuous, and/or not helpful.

Peer Support

- Some people were open to the idea of peer support (leader or peers needs to have smoking or tobacco experience to be credible). Some participants had no interest in this type of support.

- Those who liked the idea of peer support in a group setting expressed the need for encouragement from others, especially from those who share experience with tobacco.
"... when you quit you get that isolation feeling. There's no one. You kind of stay away from everyone, 'cause you don't want to see that cigarette. It's that much on your mind. Having a community when you're starting it and connections to.... It'd be nice to always have a buddy to quit with. Someone to share the story with, to know what you're going through, you know? Yeah, it's hard."
- Some participants expressed interest in peer counseling or support but preferred a one-to-one context. Some cited not doing well in social situations.
"I find that an accountability partner, someone who is also trying to quit, you know texting and calling, stuff like that"
- Among those with interest in peer support, some suggested an informal group without counseling and instead organizing social events or connections for people who use tobacco and are considering quitting.
- Some participants shared interest in peer support noting it is important that the counselor have experience using tobacco to be relatable and credible.
"Yeah, that's why the recovery network and recovery resources, in my opinion, is so helpful. 'Cause these people who are helping you have, in one way or another, been there before."

Alternative Wellness

- Several participants were open to alternative forms of cessation support such as hypnosis or acupuncture.
 - The mention of hypnosis sparked interest among some participants as something they would consider trying to help with quitting.
 - Some people said they tried hypnosis or knew of someone who tried hypnosis and it didn't work; others shared the contrary.

9. There is interest and value in quitting together, but variation with partner readiness and commitment may pose challenges to success.

- Several participants attending the focus group came as a pair, either husband and wife or partners; parent and adult child; or friends. This provided opportunity to inquire about thoughts on and experiences with quitting together.
 - For those participants that registered as a pair, either both in the group would attend, or neither would attend after registering.
 - It seemed to make sense for couples to try to quit together because they could motivate one another to quit and try to stay quit. Also, if one continues to use tobacco and one tries to quit, being around someone who is still smoking, for example, posed a quit barrier for the one trying to quit. *"I feel like on my own I would have given up sooner."*
- Quitting together has its challenges; stress and contributing to disputes. There were comments about both people being irritable at the same time due to not using tobacco.

- If one person was not successful in staying quit it may lend to the other being more likely to have a failed quit attempt, too.
 - Couples/partners may be at different stages of readiness or commitment when quitting together; one participant shared that a failed quit attempt of their partner affected their quit attempt, resulting in their failed quit attempt
- Quit buddies – one pair of participants referred to themselves as quit buddies and expressed the importance of having this person readily available to reach out to as needed to talk to when challenged by quitting, and to offer motivation and support.

10. There is an intention to stop using tobacco, but readiness and preparation to quit tobacco use is contingent upon various factors.

- Survey data indicates a majority of participants want to quit but are at different stages (see Figure 4).
- Participants recognized the need to be organized and have certain things in place in life before making a quit attempt. For example, reducing stress or not anticipating any upcoming stress, having a plan for quitting, being in a job setting where there is not a culture of using tobacco.

“And, I plan on quitting again, but I know me and if I don't get all of my ducks in a row first I fail. So, I'm just trying to get my life together just a little bit here before I [try]”
- Participants shared there should be more acceptance for approaching quitting with reducing use versus completely quitting all at once; taking small steps.
- The idea of a commitment to quit and/or setting a quit date is stressful. It sets up for feeling like a failure.
- Participants expressed they do not want to feel like they are being coerced into quitting.
- Building on the recognized role of stress in readiness to quit (more stress, less ready to quit), some participants were agreeable to the notion of support with basic needs such as housing, transportation, food, as being a relevant and useful aid in readiness to quit.
 - Some participants noted this type of support could alleviate some stress, which in turn would help one in their ability to quit.
 - Fewer participants quietly expressed disagreement with this type of support to aid cessation (e.g., shook head no).
 - Some shared concerns about needing to hold people accountable if they were to receive this type of support and/or this type of support being abused (i.e., obtaining support but not quitting) or that this was an entitlement approach that they were not supportive of.

11. Various barriers make it difficult to quit.

- Habit, triggers and associated activities with tobacco use make quitting seem challenging.
 - Some participants wondered what they would do on the long drives without a cigarette.

- Others associated waking up, coffee or eating with tobacco use; all activities they would need to continue but without tobacco if they quit.

“Habit. It's been such a part of your day for such and such amount of years. Then you just wake up and it's not supposed to be there anymore. So of course you're going to think about it all the time, you really want it. But you don't. But you do....”

- Being around family or peers who use tobacco makes it challenging to quit. Participants shared that quit attempts when they have been successful for some time are undermined when they are around tobacco users.

“I talked to my physician, my regular doctor about ... 1-800-quit's. I had a really good person that called me every day, and they did a lot. I did the lozenges, the patches. ...So I just quit doing that. Being around other smokers, and the stresses in life, just ended up building up and I just threw in the towel at that point.”

- Easy access to tobacco products and marketing are a barrier; they promote and/or trigger use.
- Lack of acceptable cessation supports or accessibility of the supports at the time they are wanted are a barrier to quitting.
- The cost and continuity of access to pharmacotherapy is a barrier to cessation.
- Some participants expressed usefulness of having help with meeting basic needs first in order to reduce their stress, which would then allow them to focus on quitting.

“But those are your needs and that's what's stressing you out and you eliminate major things that are stressing you out than I could say that could be helpful to put somebody in a place to quit smoking.”

12. Electronic nicotine delivery (vaping) was explored by some participants, with some having negative experiences, however two of the people who were positive about it used a very strategic approach.

- Some of those that tried vaping were surprised by the high nicotine level they received, which sometimes caused them to use cigarettes at a higher rate than before they vaped in order to obtain a similar level of nicotine that they had received when vaped.
- Those who were positive about vaping used it in a very controlled and step-wise approach to taper or manage nicotine dependence. They shared they are working to intentionally reduce the nicotine level being used as a way to “ween” from their nicotine addiction.

Study Limitations

- Most focus group participants had used tobacco for many years, and generally expressed interest in quitting (though a minority were not interested). The focus group participants and therefore the findings may not fully represent people who use tobacco and are not interested in quitting.
- We don't have information from former tobacco users and therefore lack information on what people have found to be helpful and/or supportive in their quit journey.

Summary of Findings

- Focus group participants were highly appreciative of the opportunity to participate, share their thoughts and experiences, and hear from others who use tobacco.
- Common reasons for tobacco use and smoking: stress management, addiction to nicotine, habit. This aligns with the literature on reasons for tobacco use.
- Common quit barriers include: stress management, addiction, habit, high prevalence and acceptability of smoking/tobacco use among family, peers, networks; and access to acceptable quit supports.
- Perceived stigma and judgement towards smokers and tobacco users is strong and may contribute to feelings of less than, unworthy, and outcast.
- Tobacco users identify significant motivators to quit (e.g., health consequences), but other factors stymie quit attempts (e.g., stress, lack of readiness, denial that health consequences will occur).
- Choice in when and how one approaches and/or proceeds with a quit attempt, quit plan, or quit journey is important. This is an important element in ensuring respect and dignity for other social and health supports, such as food assistance, family planning, other substance use treatment options.
- Peer support is appealing for some, and could be offered in a variety of formats to meet a variety of preferences (e.g., formal group counseling with counselor who has experience using tobacco; quit buddy network, semi-structured peer support gatherings).
- Pharmacotherapy support is appealing for some, and could be provided with minimal burden and barrier (e.g., similar to easily and freely accessing condoms from health centers, or other community resources, etc.).
- Credible supports include individuals with lived experience (i.e., current or former tobacco users) and healthcare providers.

Additional Research for Consideration

- Examine perceptions and experiences from former tobacco users, and what their use experience was, what worked for them in their quit journey, what they found helpful or not, etc. and how this compares to current tobacco users experiences and challenges.
 - One tobacco advisor suggested conducting interviews with people who are in quit classes to learn about the challenges they experience while trying to quit (and have established at that point motivation and commitment to quit). For example, what do they find to be most stressful during the initial phase of quitting and trying to stay quit? And, what have they found helpful during this time to stay quit?

- Explore perceptions and experiences of specific groups, such as ENDS/vaping; young adults; and/or vulnerable populations (e.g., other substance use conditions, mental health conditions) to identify similarities and differences with findings from this study, and inform tailored cessation strategies for specific groups.
- Explore models of peer support for tobacco as well as for substance use recovery to inform evidence-based or best practice strategies and elements for peer support. Include review of Alcoholics Anonymous, Narcotics Anonymous and Nicotine Anonymous. Consider other peer support models, such as Kindred Connections volunteer cancer survivor network (Vermont)
- Examine judgement or bias among healthcare providers and/or how tobacco users perceive feeling judged by healthcare providers and the implications on patient experience, support and/or treatment. This is based on one tobacco advisor sharing her experience with judgment from healthcare providers when identifying as a smoker and the perception of not being worthy of treatment, regardless of the ailment she is presenting for, because she is a smoker and “she is doing this to herself”. When exploring the concept of judgement during focus groups, the discussions did not get into judgement by healthcare providers.
- Examine evidence-based and best practice approaches to treating and/or messaging on substance use disorder, such as opioid use disorder, and role of trauma-informed approaches and empathy. Consider opportunities to inform approaches for tobacco cessation.
- Examine the evidence-base on tobacco prevention and control mass media campaigns that are fear-based versus non-judgmental and encouraging to understand which approach is more acceptable, appealing and useful for people who use tobacco. Some focus group participants and one tobacco advisor noted the fear-based commercials are not helpful in motivating a quit attempt, either because they are stressful or because they are not credible (e.g., person missing part of their jaw from smoking, person who received transplant from being a smoker). Commercials called out as favorable included the person sharing that quitting takes multiple times and the Chantix ‘Cold Turkey’ commercial.

Appendix I: Focus Group Instruments

Vermont Tobacco Control Program

Vermont Cessation Needs Assessment
Current Tobacco User Survey

Survey ID	Focus Group Location	Date

Survey administered to focus group participants at the beginning of the focus group and instructed to take time to read and complete as participants are settling in and before the discussion begins. If a focus group participant arrives late, they will be asked to complete the survey after the discussion has ended.

This survey asks questions about your tobacco use, attempts to quit using tobacco, and demographic information. Please complete this survey as you wait for the focus group to begin. You may choose to skip any or all of these questions. Please feel free to ask a facilitator if you have any questions about this survey.

1. Do you use tobacco every day, some days, or not at all?	<input type="radio"/> Every day <input type="radio"/> Some days <input type="radio"/> Not at all
2. Which types of tobacco products do you usually use? Select all that apply.	<input type="radio"/> Cigarettes <input type="radio"/> Electronic cigarettes or electronic vapor products such as JUUL, vape pens, e-cigars, e-hookahs, hookah pens, mods, etc. <input type="radio"/> Smokeless tobacco such as chewing tobacco, snuff, dip, snus, or dissolvable tobacco products <input type="radio"/> Cigars, cigarillos, or little cigars
3. What are the main reasons you use tobacco? Select all that apply.	<input type="radio"/> Stress <input type="radio"/> Socializing or part of social relationships <input type="radio"/> Addiction or habit <input type="radio"/> Use when drinking alcohol

	<ul style="list-style-type: none"> <input type="radio"/> Self-confidence <input type="radio"/> Boredom <input type="radio"/> Mood regulation <input type="radio"/> Appearance/Image <input type="radio"/> Other: _____
4. How many times in the past 12 months have you made a serious attempt to quit using tobacco?	
5. What are the main reasons you have attempted to quit using tobacco? Select all that apply.	<ul style="list-style-type: none"> <input type="radio"/> Financial cost <input type="radio"/> Health concerns <input type="radio"/> Current or future children <input type="radio"/> Appearance/Image <input type="radio"/> Other: _____
6. What are the main barriers or challenges you've experienced when attempting to quit using tobacco? Select all that apply.	<ul style="list-style-type: none"> <input type="radio"/> Stress <input type="radio"/> Addiction to tobacco <input type="radio"/> Discouraged by past failed attempts to quit <input type="radio"/> Don't believe you are able to quit <input type="radio"/> Lack of support from family or friends <input type="radio"/> Frequent tobacco use <input type="radio"/> Alcohol use (used tobacco when drinking alcohol) <input type="radio"/> Tobacco use for self-confidence <input type="radio"/> Cost of cessation support (e.g., NRT, medication, counseling) <input type="radio"/> Others in my household use tobacco <input type="radio"/> Other: _____
7. In your most recent attempt to quit using tobacco, did you... Select all that apply.	<ul style="list-style-type: none"> <input type="radio"/> Quit on your own with no help <input type="radio"/> Call a quit line for help <input type="radio"/> Talk with your doctor or other health professional <input type="radio"/> Attend group sessions or classes <input type="radio"/> Receive individual counseling <input type="radio"/> Use nicotine replacement therapy (e.g., patch, gum, lozenge, spray, etc.) <input type="radio"/> Use Zyban or Wellbutrin <input type="radio"/> Use Chantix or Varenicline

	<ul style="list-style-type: none"> <input type="radio"/> Use an e-cigarette <input type="radio"/> Use another method: _____
<p>8. Which of the cessation methods listed are of most interest to you? Select top 3 methods</p>	<ul style="list-style-type: none"> <input type="radio"/> Quit on your own with no help <input type="radio"/> Call a quit line for help <input type="radio"/> Talk with your doctor or other health professional <input type="radio"/> Attend group sessions or classes <input type="radio"/> Receive individual counseling <input type="radio"/> Use nicotine replacement therapy (e.g., patch, gum, lozenge, spray, etc.) <input type="radio"/> Use zyban or Wellbutrin <input type="radio"/> Use Chantix or Varenicline <input type="radio"/> Use an e-cigarette <input type="radio"/> Use a method not listed here
<p>9. Which of the following describes you?</p>	<ul style="list-style-type: none"> <input type="radio"/> I don't want to stop using tobacco <input type="radio"/> I think I should stop using tobacco but don't really want to <input type="radio"/> I want to stop using tobacco but haven't thought about when <input type="radio"/> I REALLY want to stop using tobacco but I don't know when I will <input type="radio"/> I want to stop using tobacco and hope to soon <input type="radio"/> I REALLY want to stop using tobacco and intend to in the next 3 months <input type="radio"/> 'I REALLY want to stop using tobacco and intend to in the next month
<p>10. How many of your close adult family and friends use tobacco?</p>	<ul style="list-style-type: none"> <input type="radio"/> All or nearly all (about 100%) <input type="radio"/> Most of them (about 75%) <input type="radio"/> Some of them (about 50%) <input type="radio"/> Just a few (about 25%) <input type="radio"/> None (about 0%)
<p>11. What is your age?</p>	

12. What sex were you assigned at birth, on your original birth certificate?	<input type="radio"/> Female <input type="radio"/> Male
13. How do you describe yourself? (check one)	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Transgender <input type="radio"/> Do not identify as female, male, or transgender <input type="radio"/> Prefer not to say
14. Do you consider yourself to be:	<input type="radio"/> Straight <input type="radio"/> Lesbian <input type="radio"/> Gay <input type="radio"/> Bisexual <input type="radio"/> Another <input type="radio"/> Prefer not to say
15. What is the primary source of your health care coverage?	<input type="radio"/> Medicaid/Other State Program <input type="radio"/> Medicare <input type="radio"/> Employer <input type="radio"/> Self-purchased <input type="radio"/> Military or Other Government <input type="radio"/> Uninsured <input type="radio"/> Another
16. Do you consider yourself...? Select all that apply.	<input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> Native Hawaiian or Other Pacific Islander <input type="radio"/> White <input type="radio"/> Another <input type="radio"/> Prefer not to say
17. Are you of Hispanic, Latino, or Spanish origin?	<input type="radio"/> Yes <input type="radio"/> No
18. What is the highest grade or year of school that you have completed?	<input type="radio"/> Grades 9-11 <input type="radio"/> Grade 12 or GED <input type="radio"/> College 1 year to 3 years <input type="radio"/> College 4 years or more <input type="radio"/> Don't Know

<p>19. Is your annual household income from all sources:</p>	<ul style="list-style-type: none"><input type="radio"/> Less than \$10,000<input type="radio"/> \$10,000 to less than \$15,000<input type="radio"/> \$15,000 to less than \$20,000<input type="radio"/> \$20,000 to less than \$25,000<input type="radio"/> \$25,000 to less than \$35,000<input type="radio"/> \$35,000 to less than \$50,000<input type="radio"/> \$50,000 to less than \$75,000<input type="radio"/> \$75,000 to less than \$100,000<input type="radio"/> \$100,000 or more
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Vermont Tobacco Control Program

Vermont Cessation Needs Assessment

Focus Group Guide – Current Tobacco Users

- **Conduct informed consent with each attendee as they arrive.**
- **Following signed consent, administer survey**
- **Initiate focus group discussion and introduction once all attendees have consented and completed the survey.**

Introduction

Good morning/afternoon/evening! Thank you for agreeing to participate in this focus group about your thoughts and experiences with using tobacco. My name is Fonda Ripley and I will be facilitating our focus group discussion today. My co-worker, Anna Ghosh, will be helping me. She may ask questions as well and will type notes during our discussion. In today's discussion, we will be asking questions about your thoughts, experiences, and interests when it comes to tobacco use and cessation.

During this discussion, we want to hear from everyone and want to hear your honest thoughts, opinions, and experiences. There are no wrong answers. Please be respectful of each other, and let us have just one person talking at a time so that we can hear what everyone has to share. We do have a lot to cover, so we will try not to spend too much time on any topic.

The information shared today will be summarized and shared with the Vermont Tobacco Control Program and program stakeholders who are trying to improve the program. Still, the information you share with us today will be anonymous. So that we can make sure what you share today is not identifiable, please do not share your real name during this discussion. I would also like to remind you that participation in this focus group is voluntary, and that you can decide to leave or choose not to respond to questions at any time.

As a reminder, we would like to audio record this discussion so that we do not miss anything that you say. The recording will be kept under password protection and deleted at the end of the study. Does anyone prefer that we don't record our discussion today?

[If OK to record, begin recording]

Before we begin with the discussion, does anyone have any questions?

[If OK to record, start recording]

Personal tobacco use

The Tobacco Control Program is interested in doing a better job hearing from all of you, who have personal experience with using tobacco. I have personal experience with tobacco as well. My job today is not to convince you to quit or to make you feel bad about tobacco use. My job today is to make sure the Tobacco Control Program can hear your honest thoughts and experiences – so that the services they offer can be more relevant, useful, and valuable to people who might want to quit. This is an opportunity to share the ups and downs of tobacco use so the Tobacco Control Program can really ‘get it’ from your perspective.

- 1. Let’s start by sharing our personal experiences with tobacco use. What kind(s) of tobacco do you use and how long have you used?**
 - a. Does everyone here smoke cigarettes? Does anyone here use other kinds of tobacco, like chewing tobacco, e-cigarettes, cigars, etc.?

- 2. People use different ways to describe the kind of smoker/tobacco user they are: light/heavy, social (maybe just when you drink), a stress smoker, a closet smoker, a tobacco enthusiast, etc. How would you describe yourself as a smoker/tobacco user?**

Perceptions of Tobacco Use

3. **What do you like about smoking/using (tobacco product)?**
 - **Prompts:** relieves stress, enjoy using with others, something to look forward to

4. **Is there anything you do not like about smoking/using (tobacco product)?**
 - **Prompts:** can only use in certain places, financial cost, feeling lectured or judged by others

5. **What does being a smoker, being a vaper, being a chewer, etc. mean to you?**
 - a. OR, What does it mean to be a tobacco user / identify as a tobacco user?
 - a. How is tobacco use a part of your daily routine? Your relationships? Who you are?
 - b. Is the role of tobacco use or importance of tobacco use different for cigarette smoking versus other tobacco product use?

Perceptions of Non-Use

6. **Can you imagine yourself as a non-smoker/non-user? How would your life be different? What would you miss about smoking/using tobacco?**

7. **Do you know anyone personally who's quit? Do you see them or relate to them differently now? How so?**

Perceptions of Quitting

8. **Have you ever thought about quitting? Why or why not?**

9. **What does it mean to “quit on your own” versus “quit with help”?**
 - a. Which do you prefer, why?
 - b. Does it count as “on your own” if you get support from other people? Use NRT? Reduce use gradually?
 - c. In what circumstances would you not want to quit on your own?

10. **What are your feelings on making a commitment to quit?**
 - **Prompts:** concerns, needs, motivations, timeline, methods, public expression

11. What would you say is the biggest barrier or challenge to quitting successfully?

Experiences with Quitting

12. Has anyone here tried to quit? Can you tell me about your experience?

- *Prompts: Why, when, how many times, how, use of different methods*

13. What encouraged or motivated you to make your last quit attempt? How did you know you were ready to try quitting?

14. How did you start smoking/using tobacco again?

- a. How do you feel about it?
- b. Does it make you feel any differently towards quitting (eventually)?

15. What might motivate you to make another quit attempt?

Desired Cessation Support

16. There are a lot of things out there that can help people quit: NRT, quitlines, support groups, etc. What makes them appealing or unappealing to use?

17. If you were determined to quit, what kind of support would you want?

- *Prompts (social support): peer support, family support, employer or work-based support, community support.*
- *Prompts (wellness): Counseling on substance use, stress reduction, healthy eating and weight gain anxiety or depression*
- *Prompts (channel): online, app, texting, healthcare provider, alternative therapies (e.g., acupuncture, hypnosis), etc.*

- a. What do you need to support you in quitting? Why?
- b. What appeals to you about that kind of support versus other kinds?

- c. We've discussed stress as one of the reasons people use tobacco. The VTCP is interested in whether getting people connected to resources for basic needs (like employment and housing) would be helpful to people trying to quit. What do you think?

18. Who would be a credible, reliable and/or trusted source for providing cessation support? Why?

- a. *Prompts: Healthcare provider, peer, etc.*

Closing

Thank you very much for all of the thoughts and experiences you have shared today. Before we finish with this focus group discussion, I'd like to ask if anyone has any thoughts they'd like to add on to the discussion – maybe something you didn't get a chance to say earlier, or thoughts about later? Any suggestions or parting thoughts you'd like to share with the Vermont Tobacco Control Program?

Thank you for your time and participation in this focus group. Your thoughts and experiences will be very helpful to improve tobacco cessation services in Vermont.