Author’s response to reviews

Title: A qualitative exploration of smokers’ views regarding aspects of a community-based mobile stop smoking service in the United Kingdom

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10 October 2011  
Dr Linda L Pederson  
Editorial Office  
BMC Public Health  

Dear Dr Pederson,

**MS:** 1745954143578687  

**Title:** A qualitative exploration of smokers' views regarding a community-based mobile stop smoking service.

**Revised Title:** A qualitative exploration of smokers’ views regarding aspects of a community-based mobile stop smoking service in the United Kingdom

Thank you for the opportunity to resubmit the above manuscript. Please find the revised manuscript attached. We have revised the manuscript according to the reviewer’s comments and have provided authors’ responses to each of these below. We have highlighted the changes in the manuscript by underlining the relevant text and this text is also included following our response to each comment.

We look forward to hearing from you soon.

Yours Sincerely

Dr Manpreet Bains
Reviewer 1 comments

Major Compulsory Revisions

1. The Discussion and Conclusions are the sections that need some clarification in my opinion. It is not at all clear to me how the information will be used in the development of the program, in recruitment or in evaluation. In other words, what has been learned from this research that can be applied to programs to assist smokers in this subpopulation?

Authors’ Response: Whilst the findings have been used to inform the development of the main trial, the aim of this paper was to explore smokers’ views of the mobile service which would then be fed back to refine the delivery of the service. Regarding the latter part of the comment, there are certainly points that can be taken from this research to inform future initiatives. Some more discussion has been included throughout the Discussion and Conclusion sections to clarify these. For example, our findings indicate that perceived accessibility is important when attempting to engage smokers; this could be achieved by offering a drop-in format rather than an appointment-based system. Furthermore, utilising techniques that go beyond traditional settings (e.g. clinics held in health centres) may be pivotal in terms of reaching specific sub-populations (Text added to the Conclusions section, page 13: ‘Importantly, SSS which offer flexibility (e.g. drop-in) and go beyond more traditional settings may result in the service being perceived as more accessible by smokers, who may be more likely to engage as a result.’

However, it has been emphasised that further research is required to unpick the reasons for traditional settings being perceived as less accessible (Text added to Discussion section, page 10:__)
'Great appeal was associated with the drop-in format over making an appointment, suggesting that future programs should be designed so that smokers perceive them as being flexible and accessible; although the precise details regarding what it is that makes one SSS seem more accessible than another needs to be studied further.'

2. In addition, it seems to me that statements to the effect that MSSS may be an effective means to trigger quit attempts goes considerably beyond the information that was collected. This may be true for some smokers and it would seem to me that additional information could be collected to help to identify the groups.

Authors’ Response: We agree that some of our statements might have gone beyond the information collected and have amended these accordingly; for instance, the opening sentence of the Discussion (Text amended in Discussion, first sentence, page 10: ‘This study demonstrates that MSSS may be an effective way to reach smokers who may not normally engage with SSS.’) Additionally, we have included a statement suggesting that further research is required to improve our understanding about whether a MSSS appeals to certain groups over others, such as spontaneous quitters or those from socially disadvantaged groups; perhaps because such a format may offer a more transparent service that is flexible, resulting in more favourable perceptions of accessibility compared with more traditional settings held in health centres (Text added to Discussion, page 12, second paragraph: ‘However, further research is required to explore whether specific groups of smokers may find a mobile service more appealing than others, such as those from socially disadvantaged groups or spontaneous quitters; perhaps because this format may offer a more transparent service that is flexible resulting in more favourable perceptions of accessibility compared with more traditional settings held in health centres.’). Indeed, this is also a matter the main study will investigate further (Text added to
Discussion section, page 11: ‘Further exploration of this issue will be possible during the main MSSS study period.’

3. I think that the title should be modified. In the first place, the authors should indicate that the information is being collected in the UK, since the reader initially has no idea for the site of the data collection. Second, the focus is not on the service itself, but some very specific aspects of it and this could be stated in the title.

Authors’ Response: The title has been amended to clarify the focus and to indicate that the study was carried out in the UK (page 1).

‘A qualitative exploration of smokers’ views regarding aspects of a community-based mobile stop smoking service in the United Kingdom’

4. The manuscript is very well written, with a few minor exceptions. In the Background, it would have been helpful to have some information about the extent of the decline in prevalence and what period of time was referenced.

Authors’ Response: We have included more specific prevalence data from 1980 to 2008/09 and we have emphasised that the rate of decline has been less marked in recent years (Background, page 3, first paragraph now reads: ‘Smoking prevalence has declined between 1980 and 1996 in the general population from 39% [2] to 28% respectively [3]. In recent years however, the decline has slowed down and prevalence was reported as being 22% in 2008/09 [3].’).

5. There is mention of the fact that smoking remains a significant contributor to health inequalities; some description of the inequalities would be helpful.

Authors’ Response: Further description of the inequalities has been included, as suggested (Background, page 3, first paragraph):
‘Smoking therefore remains a significant contributor to health inequalities; for example, it is the main factor associated with higher death rates in the manual as compared with the non-manual occupation group [5]. Therefore, smoking is an important factor when attempting to understand reasons for those from less affluent groups experiencing poorer health outcomes and decreased life expectancy when compared with those from more affluent groups [6].’

6. There is a reference to 8% of smokers utilizing stop smoking services. It is not stated whether this is 8% of all smokers or some select subgroup of smokers.

Authors’ Response: Apologies for this confusion. This reference is reflective of all smokers and has now been clarified by adding in the word ‘all’ before smokers (Background, page 3, second paragraph, line 2). The sentence now reads:

‘Whilst the provision and uptake of National Health Service (NHS) stop smoking services (SSS) has improved in recent years [9], only 8% of all smokers utilise them [3].’

7. It is not clear what the authors mean exactly by demographic data (referenced in the Limitations section). What specific demographic data are they referring to? Employment status, gender and age are included and these are typically considered to be demographic variables. Are they specifically referring to income?

Authors’ Response: Thank you for pointing this out. Although we have data regarding employment (i.e. employed, unemployed, home carer, full-time student), we lack more specific details such as type of work (manual/non-manual), income or housing information, which may be more accurate indicators of socio-economic status. This information would have allowed us to decipher, perhaps more reliably, whether the service reached those from socially disadvantaged groups. The Limitations section has been amended to reflect this more appropriately (Limitations, page 13) and now reads:
‘Thirdly, whether the MSSS reached smokers from disadvantaged groups is difficult to ascertain because precise data regarding type of employment (manual/non manual), income and housing for those interviewed were unavailable.’

8. Also, it is not stated, or at least I could not find, whether the smokers were daily smokers, irregular smokers, heavy or light smokers and how long they had smoked.

Authors’ Response: Whilst we recognise that it would have been useful to include this information, these data were not collected as part of the interview.

Reviewer 2 Comments

1. Page 3: Is the last sentence referring to the annual average of 57% abstinent at 4 weeks in 2001 or 2005? This sentence might be rephrased to clarify the point.

Authors’ Response: This sentence refers to 57% being the average for each year over the four year period (2001 to 2005). This sentence has been clarified (Background, page 4, first paragraph):

‘In addition, 57% of clients were abstinent from smoking at four weeks (annual average over the period 2001 to 2005 [23]).’

2. Page 4: I recommend further elaboration on the methods of the MSSS. Given that the MSSS seems to be a novel and somewhat successful approach at promoting quit attempts, it would be helpful for the authors to give the readers more details regarding the details of the approach. The authors might also consider including a figure with a photo of the actual service trailer.
3. Some questions that I had as I read through the methods include: how long was 1 appointment? Were there wait times between clients? Did clients have to make appointments to see the counselors? Did everyone receive all 3 forms of follow-up (face-to-face, reactive and proactive telephone support) or just one? How long was the actual period between initial visit and follow-up (“few days”)? How many follow-up contacts were there and at what intervals? How long did the follow-up appointment last? Was any incentive given to complete follow-up?

Authors’ Response to comments 2 and 3: Firstly, we have included a figure with a photo of the MSSS (Figure 1). Secondly, we have elaborated on the methods of the MSSS and by doing so have addressed both of these points (Methods, page 5, second paragraph). The reader is now informed that the initial consultation lasts approximately 30 minutes and subsequent consultations 15 minutes. We have made the format of follow-up offered clearer, and that if the client was attending follow-up at the MSSS, this was on a drop-in basis, whereas fixed clinic locations can offer appointments or drop-in sessions. Text to say that clients were encouraged to return for consultations weekly for up to 12 weeks has been added. The incentives to attend follow-up consultations were primarily to collect NRT and obtain a CO reading. The following text has been added to the Methods section, page 5, second paragraph:

‘The advisors followed the same protocols as New Leaf, where clients received an initial consultation lasting approximately 30 minutes during which behavioural support and pharmacotherapy treatment (by delegated prescribing) were provided and clients were supported to either quit now or on an agreed date. The client was then encouraged to attend weekly follow-up consultations with an advisor for up to 12 weeks following their quit date, either at the MSSS (drop-in basis) or a fixed clinic location (appointment/drop-in; varies according to clinic so clients may have to wait if advisor busy with another client). During these sessions lasting approximately 15 minutes, the advisor provided further behavioural support, monitored carbon monoxide levels and arranged
pharmacotherapy treatment (nicotine replacement therapy [NRT] given direct to the client), according to the needs of the client. Clients were informed that they could contact an advisor if support was required between follow-up (reactive telephone support). If clients failed to attend follow-up the advisors would attempt to contact the client via telephone on up to three occasions, and then a letter was sent via post.’

4. Page 5: Were the demographic or SES differences between the 40 individuals contacted and the 30 individuals that were not attempted to be contacted?

Authors’ Response: The mean age of those interviewed and those not interviewed were similar (42 and 41 years). Regarding gender and employment status, the two groups were also similar in terms of their composition (male = 45% and 48%; employment = 63% and 70%); this has been included in the manuscript (Methods, Study Design and Participants, page 6).

‘The age, gender and employment status distribution of those not interviewed was similar to the interviewed participants (mean age = 41 years and 42 years; male = 48% and 45%; employed = 70% and 63%).’

5. Page 9: While I found the results interesting in that many participants found this type of service to be “more accessible” and they were more likely to approach it and make that the day they were going to quit smoking, there is a great deal of evidence to suggest that spontaneous quit attempts are not as successful and have a high rate of relapse compared to quit attempts that smokers are prepared for and have planned out. The authors should consider adding a paragraph in the discussion regarding these different quit attempts and whether this type of service is ultimately successful comparing costs of the service (also not included in manuscript) and benefits in the short and long term.
Authors’ Response: A section regarding the success of spontaneous quit attempts has been included in the Discussion (page 11, first paragraph). To the authors’ knowledge, the literature on this matter is mixed. There are a number of studies that suggest that spontaneous quit attempts yield more successful outcomes [e.g. Larabie, 2005; West and Sohal, 2006]. However, more recent research failed to support this and found no difference between spontaneous and planned attempts ([e.g. Cooper et al., 2010]

Discussion, page 11, first paragraph). When considering the latter part of the reviewer’s comment, given the aims of the current study, we are unable to consider different quit attempts in relation to the costs/benefits of such a service. Moreover, this is a matter that the main study will seek to examine and report, in due course (Discussion, page 11, first paragraph). It is important to mention that spontaneous quit attempts are often unsupported due to their nature; however, in this case we are providing support to the spontaneous attempt so would hope it would improve success rates. The following text has been added on page 11:

‘It is also important to consider the success of spontaneous quit attempts compared with more planned attempts, particularly when evaluating services such as a MSSS. Early research indicates that spontaneous quit attempts yield more successful outcomes than planned attempts [24, 25]; however these studies have been argued to be flawed methodologically, due to their cross-sectional designs and failure to control for confounding factors such as recall bias. More recent research that adopts a longitudinal approach suggests that prior planning was unrelated to outcomes [31]. The advantage of the MSSS triggering spontaneous quit attempts is that support is available at the point the quit attempt is initiated; spontaneous quit attempts are often, by their very nature, unsupported [29, 30], hence increasing the likelihood of failure. Further exploration of this issue will be possible during the main MSSS study period.’
6. Page 9: The first sentence of the discussion states that this type of service may be effective to engage those from socially disadvantaged groups. However, a stated limitation of the paper is the inability to ascertain if disadvantaged groups were reached by this intervention. Please explain.

Authors’ Response: We have amended this sentence and removed the part referring to socially disadvantaged groups (Discussion, page 10, first sentence). The sentence now reads: ‘This study demonstrates that MSSS may be an effective way to reach smokers who may not normally engage with SSS.’

Minor Essential Revisions
7. Page 10: Rephrase “…for others, it built on pre-existing thoughts about quitting which had not been acted upon, a finding that is supported in the literature.”

Authors’ Response: As suggested, this sentence has been rephrased and the words ‘a finding that is ’ added (Discussion, page 10, third paragraph).

8. Page 10: Rephrase “…particularly conducive for attracting this group of smokers, mainly because their quit…”

Authors’ Response: As suggested, the above sentence has been rephrased and the word ‘mainly’ added (Discussion, page 11, first paragraph).

9. Page 10: Punctuation: add “;“ after “put them at ease; for”

Authors’ Response: A semi-colon has been added as suggested (Discussion, page 11, second paragraph).
Discretionary Revisions

10. Page 3: Consider adding an additional sentence explaining why “when considering breast cancer screening, services located at non-health facilities were perceived as more accessible than those at health facilities [12].”

Authors’ Response: Reasons for screening services held at non-health facilities being perceived as more accessible than those held at health facilities are not known and is pointed out as a matter for further research by the authors of the cited study. We have included some text to state this (Background, page 4, first paragraph). The sentence now reads: ‘For example, when considering breast cancer screening, services located at non-health facilities were perceived as more accessible than those at health facilities; however, reasons for this requires further research [14].’

11. Page 3: Consider adding another sentence explaining why the Roy Castle Fag Ends SSS in Liverpool is an example of a client-led approach is successful and what it means that it is “flexible”.

Authors’ Response: Another sentence has been added providing more information about the nature of the Fag Ends SSS that makes it a flexible service (Background, page 4, first paragraph).

‘The Roy Castle Fag Ends SSS in Liverpool (UK) is an example of a client-led approach that is flexible offering both one-to-one or group support where there is no waiting list, clients choose whether to make an appointment or drop-in, and they decide when to stop attending.’

12. Page 5: When were the interviews conducted, at what time point? How long did they take?
Authors’ Response: In response to the first question, we have now added to the methods section the sentence ‘The interviewer aimed to conduct the interviews within a week of the initial consultation between September and November 2010; however, this varied between one and ten days’ (Study design and participants section, page 6, second paragraph). In response to the second question, interviews lasted between 10 and 55 minutes, and on average lasted 16 minutes and this information has been included in the Methods section (Methods, Interviews, page 7, first paragraph): ‘Interviews were conducted in a private room at Nottingham City Hospital (by M.B.) via telephone, lasted 16 minutes on average (ranged between 10 and 55 minutes) and were digitally audio-recorded.’

Additional comments

1. Please remove your Authors Qualification from the System.

Authors’ Response: Author qualifications have been removed from the system.

2. For reporting Qualitative Studies, please adhere to RATS Guidelines (http://www.biomedcentral.com/info/ifora/rats)

Authors’ Response: We have ensured that the RATS Guidelines have been adhered to, and based on this we have included some text regarding Ethics, namely anonymity and confidentiality (Text added to Interviews, page 7): ‘Participants were informed that data would be anonymised, treated confidentially and that they were free to withdraw at any point during the interview, if they so wished.’