1

Key local data (Sunderland):

- Much higher mortality and hospital admission rates (per 100,000 of the local population) caused by diseases directly related to smoking (compared to England data and in the 'top 3')
- Lower socioeconomic (SES) groups seek cessation services MORE - but are MUCH LESS likely to succeed
- Local and national services do not understand *WHY*

2

Lower SES and smoking: Lower SES groups smoke more. E.g. workers - 28.5% lower SES vs 10.2% higher SES

3

Covid-19 and smoking: 13 of 14 participants had smoked MUCH MORE - equal strength themes of stress AND 'boredom'

4

Public health and health services:

- Lower SES group-focused research in the 'smoking' literature is SPARSE
- WHO and 'PHE' do not differentiate lower SES-specific groups from other groups within strategic planning or 'social marketing' – despite lower and middle income countries appearing to mirror the trajectories seen in the UK (1970s onwards)
- Behaviour change cessation models were mostly developed 20+ years ago - some leading researchers suggest re-evaluating models
- ALL participants described examples of healthcare worker attitudes, inc. cessation workers, as negative and punitive towards 'smokers'. ALL described accessing AND maintaining engagement with smoking cessation services as futile experiences

5

FACILITATORS TO SUCCESSFUL CESSATION AS IDENTIFIED BY THE SAMPLE:

1. There is **NO** *'right time'* to quit – but cessation support must be easily and directly accessible
2. Public health - ALL fully accepted tobacco control policies (and most wanted stricter controls); ALL wanted to quit; ALL wished they had never started citing adolescent education as key
3. 'Future-self' health – key knowledge requested: strong cognitive dissonance with currently held smoker identity, impacting on motivation to quit and/or remaining in 'pre-contemplation' stage (Transtheoretical Model); ALL understood the health consequences; MOST had experienced deaths of loved ones 'due to smoking'
4. Healthcare worker interactions – MOST preferred their GP or GP practice as an access point (perceptions of increased emotional support and individualized care); ALL had experienced negative and/or judgmental attitudes by a wide range of healthcare workers, inc. at cessation services, which acted as STRONG BARRIERS to seeking and/or maintaining cessation engagement
5. Stress - key knowledge requested: impact of relapse on individual agency, coping mechanisms and behavioural regulation; psychobiological knowledge of nicotine and addiction; relapse prevention strategies; strategies to combat negative automatic thoughts of capability and individual agency as related to smoker identity and smoking triggers
6. Boredom - key knowledge requested: strategies to mitigate cumulative life stressors as related to lower SES status; ALL had realized during Covid-19 lockdown that 'boredom' was a stronger than previously appreciated smoking trigger – ALL wanted to know about this mechanism as it related to behavioural regulation
7. Seeking family/friend/co-worker support is key