

Smoke signals: An investigation of anti-smoking communication within marginalised communities within the health system. An outline research proposal

* Martin Williams, DBA. University of Technology, Sydney
Martin.williams@uts.edu.au
Associate Professor John Allan, Queensland Health Department.
john.allan@health.qld.gov.au

Abstract

Purpose: This paper outlines a case for investigation of why current anti-smoking advertising and promotional messaging is not having positive effects amongst smokers within the health system who are marginalised and experience mental illness.

Design/methodology/approach: It is proposed that a case study approach be adopted using qualitative research amongst respondents from within the Brisbane Health system, using a semi-structured questionnaire with appropriate communication stimuli.

Originality/value: Previous research demonstrates anti-smoking messaging is having effects on smoking cessation amongst the general population. However, smokers who are marginalised within the health system appear not to be responding to health warnings and anti-smoking advertising messaging. No research is available on why current anti-smoking messaging is having minimal resonance and effects amongst this group. This qualitative study will offer opportunities for leadership and application of best practice communication in helping people make a truly informed choice about tobacco.

Keywords: Anti smoking, tobacco, health services, marginalised communities

Track 6 Research

Smoking rates are dropping in many segments of the community, although members of marginalised communities seem to be more likely to resist campaigns to cease smoking. The purpose of this paper is to review the literature from the perspective of advertising effects to determine which factors may lead to greater success and to explore the data collection methods used in previous studies with the aim of suggesting which approach to data collection and analysis may be most effective in a study of smokers in the health system, including those with mental illness. The paper concludes by proposing research outlines for such a study.

Literature review

Evidence indicates that media campaigns can be effective tools for preventing smoking, particularly amongst youth (Wakefield et al., 2003). Noar and Kennedy, (2009) demonstrated health-prevention media campaigns have influence on actual behaviours, albeit in the short term. From the early 2000's, in the USA, longitudinal surveys of government-funded television campaigns conducted in Massachusetts amongst youth (Siegel & Biener, 2000), and in Florida (Sly et al., 2001) have reported significant reductions in smoking up-take as a function of reported exposure to counter advertising

campaigns. A massive anti-smoking 'truth' advertising campaign resulted in substantial declines in youth smoking (Farrelly et al., 2005). In fact, many states and countries, including Australia since the 1980's, have implemented anti-tobacco media campaigns, with beneficial effects (Borland, 1997; Borland & Hill, 1997; Wakefield et al., 2003). In the UK the Health Education Authority's anti-smoking TV campaign reduced smoking prevalence through encouraging smokers to stop and helped prevent relapse (McVey & Stapleton, 2000). The greatest influence on smoking rate reduction in Australia is evidenced by the 2013 National Drug Strategy Household Survey, following the plain packaging introduction. Substantial reduction to rates has occurred. The percentage of 18 to 24-year-olds who have never smoked increased to 77% from 72% in 2010, while the number of 12 to 17-year-olds who have never smoked held steady at a near universal 95%. The three-year survey shows just 12.8% of Australians over the age of 14 are now smoking on a daily basis. This is a significant decline from the 2010 survey when smoking rates were 15.1% (Freeman, 2014).

Advertising research carried out globally has tended to concentrate on groups biased towards youth, and though not exclusively, they are comparatively high in self-efficacy (Biener et al., 2004; Leshner et al., 2009; Schneider et al., 2001; Wong & McMurray, 2002) where this is seen as important to cessation. On the other hand, those who do not perceive that they are efficacious respond in a variety of ways, while those unable or unwilling to change their smoking behaviour represent a hard-core of smokers, may never be able to quit (Thompson et al., 2009). In these studies youth has developed a resistance to what they regard as authoritative messaging. Other research has given consideration to age, gender, and ethnicity (Farrelly et al., 2003). Studies of adults have included research in less advantaged communities and has demonstrated the importance of social context for the up-take and maintenance of smoking (Poland et al., 2006), especially among disadvantaged groups, where factors associated with low socioeconomic status (e.g. high unemployment, poor education, stress etc.) are implicated in high smoking and much lower quit rates (Baker et al., 2006; Harwood et al., 2007).

It is recognised that within marginalised communities, indigenous populations are consistently over-represented in smoking prevalence, particularly within developed countries throughout the world including Canada, New Zealand and the U.S. (Yusuf et al., 2001; Bramley et al., 2005) where associated morbidity and mortality statistics amongst marginalised communities are also high, (and also amongst schizophrenia patients: Lambert et al., 2003). Research in Australia and New Zealand amongst the marginalised or groups with less self-efficacy, has, for the most part, concerned epidemiological studies of the incidence and prevalence of smoking and the links between smoking and disease (Ivers, 2001). For example, Vos et al., (2007) established that 12% of the total disease burden among Indigenous Australians is attributable to tobacco use and while tobacco use is the single most important risk factor for excess mortality and morbidity amongst Indigenous Australians, tobacco use was responsible for as much as one-fifth of Indigenous deaths in 2003.

Thus analysis of smoking rates among the marginalised has demonstrated a resistance to advertising campaigns designed to reduce smoking incidence, which has implications for the health system as a whole (Allan, 2013). While there is debate within the health system about how much higher the rate is amongst folk with serious mental illness than the general population, there is little debate about its harmful effects (Ragg & Ahmed, 2008). Therefore further investigation amongst marginalised communities that includes Indigenous respondents across age groups is worthwhile.

Anti-smoking message content

Wakefield, Durrant, et al., (2003) compared the similarity in how youth in the United States, Britain and Australia appraise anti-smoking advertisements with different characteristics. Across these countries youth responded to anti-smoking advertisements in similar ways, such that a certain level of generalization is possible in reviewing anti-smoking research country to country. In fact, a major review of mass media to reduce smoking amongst youth underpins that there is no single recipe for anti-smoking advertising that leads to smoking cessation or reduction and no one single investigative method can be employed (Wakefield, Flay, et al., 2003).

Much of the research concerning anti-smoking messaging has used stimuli that have included advertising examples, predominantly from print advertisements, (and packaging) and from watching TV commercials, while experiments have investigated different aspects of the messaging, the target audiences and how these messages are being received. The results of Cohen et al.'s (2007) advertising review reveals that anti-smoking advertising relies overwhelmingly on appeals to attitudes, and that generally these anti-smoking campaigns have been effective. Intersecting with the advertising messaging is the cultural context in which smoking occurs. Arguably, while discovery about messaging in itself is valuable, the context of the culture and the environment may be as important to the way in which anti-smoking advertising content is made relevant, thus ultimately its effects. So while tobacco is a global phenomenon, consumed across many different and varied ethnic groups, it is 'culture [that] shapes the specific methods and patterns of its use' (Unger et al., 2003, p. S101). In fact, Unger et al. contest that the reasons people use tobacco, the meanings of tobacco use, and the implications of not smoking, are all determined - to a significant degree - by cultural context, which in this context may be being played out within our proposed research samples and therefore be an important factor in the resonance of the advertising message.

The social determinants of smoking amongst marginalised communities (Thomas et al., 2008; Johnson & Thomas 2008; Passey et al., 2012) using qualitative methods, may offer clues as to why advertising messaging is not having positive effects. Johnson and Thomas's (2008) investigation amongst marginalised Indigenous communities identifies a complex interplay of historical, social, cultural, psychological and physiological factors that influence the smoking behaviours of Indigenous adults in remote Australian communities; many of their findings being supported by previous researchers. Many of the determinants of smoking and barriers to quitting were similar to those that exist among smokers in disadvantaged settings elsewhere. For example, personal- substance abuse, emotional disorders, risk perceptions, family-parenting attitudes towards smoking-social -peer smoking, environmental- tobacco advertising and, cigarette pricing. Pampel (2006) also found lower socioeconomic status (SES) groups and those more marginalized from dominant groups (more self-determining) appear to differ in smoking norms. Based on current SES patterns of smoking, the habit may not carry the same stigma for lower SES groups as it does for higher SES groups—it might even signify risk taking, independence, and an anti-authoritarian attitude.

Social and economic contexts reinforce how an addictive behaviour is influenced by cultural norms and processes that could have significant effects on the resonance of anti-smoking campaigns is supported by New Zealand research by Hill et al. (2007). They advocated that public health programs, aimed at reducing tobacco use, should pay particular attention to disadvantaged, Indigenous and ethnic minority groups in order to

avoid widening relative inequalities in smoking and smoking-related health outcomes. Other SES factors of high importance that participants identified, included stress, overcrowding, boredom, and a low health priority as salient, which were prevalent within an experience of relapse after an attempt to quit (Johnson & Thomas, 2008). In addition, researchers determined, high nicotine dependence, characterised by withdrawal, the significant amount of time spent obtaining the tobacco and unsuccessful attempts to quit (Shadel et al., 2000), was also instrumental in maintaining their smoking behaviour, (Bancroft et al., 2003), while research amongst Australia's prison population cited cannabis attachment (Belcher et al., 2006).

Perhaps Johnson and Thomas's (2008) most enduring discovery lies in their determination that the most significant drivers of smoking related to the unique social and cultural context is explained through the inter-exchange and sharing of tobacco; sharing between family and friends may act as reinforcement. Thus the importance afforded by reciprocity in Australian Indigenous communities deserves special attention, which may be shared in wider marginalised communities. In fact, within previous research Brady (1993) underscores the role that social and kinship (friendship or exclusion) pressures play in relation not only to tobacco but to alcohol abuse and thus within marginalised populations these two factors may go hand in hand. Furthermore, external factors such as the health system itself, and the support mechanisms within it may be inadequate (Allan, 2013). Given this, it is imperative to understand the context in which marginalised people start to smoke, the reasons as to why they persist in smoking, in addition to their reasons for rejection or outright defiance (Wolburg, 2004) towards current anti-smoking messaging; the obstacles and drivers to quitting all need more thorough understanding. It is only when we understand these factors that policy and programs on tobacco control can start to make some headway in reducing the alarmingly prevalent incidence of smoking amongst the marginalised within the health system.

Therefore the study's aims are: 1. The identification of marginalised adult communities containing smokers. 2. Description of The reasons why these individuals started and under what circumstances these smokers continue to smoke. 3. The obstacles to, and the drivers of quitting smoking, and 4. The reasons why the current anti-smoking messaging is not having resonance within this target group.

Methodologies Previously Employed

Studies have included extended focus group research, experiments and some have employed large-scale telephone or in class surveys in longitudinal studies, mostly amongst youth, particularly in the USA, and heavily weighted towards quantitative methods. A review of campaigns by Wakefield, Flay, et al., (2003) covered empirical studies encompassing community trials, field experiments with studies both within natural and controlled settings. Other advertising investigation has migrated to interactive Internet communication (Miller et al., 2001) where increasingly tobacco advertising and promotion is occurring (Freeman, 2011). Some other researchers have explored the effects of message frame (positive versus negative), however, these findings have been mixed (Schneider et al. 2001; Wong & McMurray, 2002).

In an exhaustive review of health communication campaigns, Freimuth (1994) distinguished six types of effects advertising campaigns typically seek to achieve. Order on their hierarchy (of effects) on their persuasive impact, suggesting larger effects occur in the earlier stage (awareness, information seeking, knowledge gain) and more modest (attitude

change, behaviour intentions, behaviour change) in later stages. Highly emotional scare campaigns concerning TV messaging in New Zealand, concentrated on respondents watching ads (Leshner et al., 2009), however, overall media campaigns show marginal evidence of a direct link between media consumption, viewer attitude and behaviour change (Macnamara et al., 2013, p.20), but in examining fear and disgust content knowledge and awareness levels have heightened (Biener et al., 2004; Lesner et al., 2009). However, no links to attitude and behaviour have been established, thus consensus regarding the dynamics of fear appeals in advertising remains elusive.

Fear and disgust appeals go beyond advertising per se. Hammond's (2011, p.327) review states 'Health warnings on packages are among the most direct and are prominent means of communicating with smokers and health warnings promote long-term abstinence from smoking. In Australia, 62% of quitters reported in 2008 that the pictorial warnings had 'helped them to give up smoking,' while 75% reported the warnings 'had an effect on their behavior' a significant increase from the 25% who reported an effect from text warnings 8 years earlier; larger warnings with pictures being significantly more effective than smaller, text-only messages' (Shanahan & Elliott, 2008, p. 28). Strahan, et al. (2010), found highly emotional messaging is significantly more effective but concluded fear appeals are effective to the extent that they are accompanied on pack by messages that provide information about how to avoid the threat that is highlighted by the fear appeal. Despite this, Thompson et al., (2009), believe that fear appeals could be having a negative impact on certain sectors of the population. Thus the messaging may be having the opposite effect serving to reinforce the stigmatisation of 'hard-core' smokers (Aitken & Eadie, 2006), a significant number occurring amongst the marginalised.

Authors stress more research on message content is essential, (Hammond, 2011) and though Glock et al., (2012) determined that self-efficacy can determine cessation success, reframing warnings as questions on packs might reduce defensive effects, they concurred. Thus further research into why anti-smoking communications are having little or no effect amongst the marginalized within the health system requires urgent investigation.

Recommended Research Methodology and Limitations

It is suggested that due to the complexities, this study should employ qualitative methods to explore the reasons why marginalised people start to smoke, continue to smoke and may or may not quit. It is proposed that under a hierarchy of advertising effects model (Friemuth 1994; Keller 1989) through more fully understanding these processes effective anti-tobacco interventions for this population, discovery can be made. There may be some limitations to the study. Many of marginalized are less well educated. They are also vulnerable. They may be unwilling to discuss issues that are extremely personal to them and on the other hand a self-completion survey could be difficult to operate. Similarly, it may be less easy to engage younger adults to participate in the study, as many of the marginalized will include those in the health system suffering from schizophrenia and major forms of depression, thus with serious mental illness. Many of these folk will be relatively older. Thus, the narratives surrounding smoking initiation refer to participants' experiences, in some cases, will have occurred several decades ago and might not be fully representative of their actual experiences of taking up smoking. Nevertheless previous research findings suggest that there is a complex interplay of historical, social, cultural, psychological and physiological factors, which influence the smoking behaviours of marginalized adults that need explication.

Approximately 30 semi-structured interviews with marginalised community members, (from amongst those of low SES, Indigenous and with mental illness within the Queensland health system), will investigate their views and experiences of smoking, and include those who have not taken the habit up. Health staff working in the communities will include both government and non-government workers, and occur in two selected communities amongst both male and females. Advice on any significant cultural protocols will be carried out through informal discussions with health leaders, where appropriate community members can provide additional data. Sampling will utilise a mix of purposive and snowball techniques, aiming to be inclusive of the experiences of adult respondents, with a range of smoking histories and with an idea of finding out the vernacular used around smoking and the reinforcement processes occurring. To prompt response on messaging, anti-smoking advertising photographic stimuli will include the visceral imaging being used on tobacco packaging, outdoor advertising poster messaging, and will also include simple health warnings being employed locally.

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