Received: 7 December 2023 | Accepted: 17 April 2024

DOI: 10.1111/add.16533

REVIEW

ADDICTION SSA

Opportunistic smoking cessation interventions for people accessing financial support settings: A scoping review

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Funding information
Action on Smoking and Health (ASH) UK; NIHR Applied Research Collaboration (ARC) for Oxford and Thames Valley (P.D., M.G., S. H., and PA); and National Institute of Health Research (NIHR) Oxford Biomedical Research Centre (BRC) (P.A).

Abstract

Aim: The aim of this work was to systematically scope the evidence on opportunistic tobacco smoking cessation interventions for people accessing financial support settings.

Methods: We searched MEDLINE, Embase, PsycINFO and the Cochrane Tobacco Addiction Group specialized register to 21 March 2023. We duplicate screened 20% of titles/abstracts and all full texts. We included primary studies investigating smoking cessation interventions delivered opportunistically to people who smoked tobacco, within settings offering support for problems caused by financial hardship, for example homeless support services, social housing and food banks. Data were charted by one reviewer, checked by another and narratively synthesized.

Results: We included 25 studies conducted in a range of financial support settings using qualitative (e.g. interviews and focus groups) and quantitative (e.g. randomized controlled trials, surveys and single arm intervention studies) methodologies. Evidence on the acceptability and feasibility of opportunistic smoking cessation advice was investigated among both clients and providers. Approximately 90% of service providers supported such interventions; however, lack of resources, staff training and a belief that tobacco smoking reduced illicit substance use were perceived barriers. Clients welcomed being asked about smoking and offered assistance to quit and expressed interest in interventions including the provision of nicotine replacement therapy, e-cigarettes and incentives to quit smoking. Six studies investigated the comparative effectiveness of opportunistic smoking cessation interventions on quitting success, with five comparing more to less intensive interventions, with mixed results.

Conclusions: Most studies investigating opportunistic smoking cessation interventions in financial support settings have not measured their effectiveness. Where they have, settings, populations, interventions and findings have varied. There is more evidence investigating acceptability, with promising results.

KEYWORDS
behavior change, cessation, disadvantaged, financial support, nicotine replacement therapy, opportunistic, smoking

Tobacco use remains a leading risk factor for premature morbidity and mortality worldwide [1–3]. People experiencing socio-economic disadvantage have a higher prevalence of tobacco use, and consequently a greater burden of tobacco-attributed morbidity compared to their non-disadvantaged peers [3]. Systematic reviews and meta-analyses have shown that opportunistic smoking cessation interventions in healthcare settings are effective [4], and that behavioral support, both in-person [5, 6], and technology-based [7], may increase the success of quit attempts among disadvantaged adults. However, it is unclear whether providing opportunistic interventions to promote smoking cessation in services aimed at alleviating financial disadvantage (e.g. food banks, social housing and financial advice services), is acceptable, feasible, effective and cost-effective.

Given the nature of these settings and the frequency of their use, they may represent promising new venues for opportunistic smoking cessation interventions. Moreover, cigarettes and tobacco have become increasingly expensive, and there is evidence that the financial burden of smoking can motivate people's decision to quit [8]. Providing smoking cessation support within services targeted at alleviating financial stress may provide an opportunity to use this potential lever for behavior change.

To our knowledge no scoping or systematic review has investigated opportunistic smoking cessation interventions in financial support settings. Therefore, we set out to scope the existing evidence on research carried out to date and its resulting findings, identify gaps and provide future directions for research in this area.

METHODS

Our aim was to systematically scope the evidence on opportunistic tobacco smoking cessation interventions for people accessing financial support settings; particularly regarding acceptability, feasibility, effectiveness, cost effectiveness and components focusing on the financial implications of tobacco smoking and cessation. We designed, conducted and reported this review in accordance with methodological guidance on the conduct of scoping reviews [9], and the preferred reporting items for systematic reviews and meta-analysis extension for scoping reviews (PRISMA-ScR) checklist [10]. We registered the review protocol prior to commencement [11].

Data sources and searches

We conducted searches using Ovid (incorporating the databases of Medline [Ovid MEDLINE Epub Ahead of Print, In-Process and Other Non-Indexed Citations, Ovid MEDLINE Daily and Ovid MEDLINE], EMBASE and PyscINFO), and the Cochrane Tobacco Addiction Group specialist study register, encompassing literature published prior to 21/03/2023 (Data S1). We supplemented this with manual reference searches of all included articles.

Study selection and charting

Our inclusion criteria required studies to have investigated a smoking cessation intervention delivered opportunistically to people who smoked tobacco within settings that offered financial support or assistance regarding problems caused by financial hardship, for example, services for people experiencing homelessness, social housing, food banks and financial advice services. Within the context of this review an intervention was regarded as opportunistic if it occurred in the natural course of people accessing financial support, without specific forewarning, and regardless of intervention intensity, that is, the intervention could include intensive behavioral support, or very brief advice and/or simply referral to external services. Tobacco smoking cessation included any form of tobacco smoking, including, but not limited to, conventional cigarettes, cigars, shisha and water pipes. Vaping cessation was not within the remit of our review, although vaping as a risk reduction method for tobacco smoking was. Studies were eligible regardless of study design (e.g. experimental, observational or qualitative), outcomes investigated, whether participants were clients or service providers, whether the intervention was implemented or hypothetical (i.e. people being asked about a service that could exist in the future), whether the provision of financial support was a primary or secondary function of the service, or the opportunistic tobacco smoking intervention part of a broader multi-component health intervention with other components delivered in, and/or referred out to, other financial or non-financial support settings. We excluded studies whose full text was not available in English as this was the sole shared language between reviewers.

We uploaded search results to Covidence systematic review software (Veritas Health Innovation, Melbourne, Australia; available at www.covidence.org), which removed duplicates. We screened search results against eligibility criteria in two stages: (1) title and abstract; and (2) full text. The first 20% of all titles and abstracts were independently screened by two reviewers (P.D., N.L. or T.P.). After each 50 citations that were dual screened, reviewers met to discuss any disagreements, contacting a third reviewer (P.D., N.L. or T.P.) where necessary. This was to ensure all reviewers agreed on the interpretation of the eligibility criteria. The remaining 80% of citations were single screened, with reviewers discussing uncertainties with other reviewers and erring on the side of inclusion if in doubt. Full-text screening was performed in duplicate by two reviewers (P.D., N.L. or T.P.) independently. During full-text screening the reasons for exclusion were recorded, and any disagreements resolved with the assistance of a third reviewer.

One reviewer (P.D., N.L., T.P., M.G. or SH) charted data on study characteristics, study methods and outcomes (Data S2). Charted data were checked by a second reviewer (P.D., N.L., T.P., M.G. or S.H.), and any disagreement resolved with the assistance of a third reviewer. The charted data were reviewed and synthesized narratively by two reviewers (P.D. and N.L.).

RESULTS

Included studies

Our searches yielded 8629 results, of which 2591 were removed as duplicates. We identified five additional non-peer reviewed reports through searching reference lists of included articles. We screened the titles and abstracts of the remaining 6043 articles, resulting in 376 articles for full-text screening. Full-text screening resulted in 30 included articles, reporting on 25 studies (Figure 1). Eleven of these studies were conducted in homelessness support services [12–22]; five in organizations offering mixed social services, for example, the Salvation Army [23–27]; four in women, infants and children (WIC) programs (which provide nutritional and health support to low-income mothers) [28–31]; two in social housing [32, 33]; two in food banks [34, 35]; and one in a cheque cashing setting [36].

Eleven studies examined attitudes toward potential smoking cessation interventions, or whether smoking cessation services were currently being offered in a relevant setting [12, 13, 15, 17, 18, 21, 22, 24, 25, 28, 32]. Five of these were qualitative investigations that collected data through interviews or focus groups [15, 17, 18, 25, 28]; four combined surveys with interviews or focus groups [12, 21, 22, 32]; and two were surveys only [13, 24]. The remaining 14 studies examined the effectiveness and/or acceptability of new programs offering opportunistic cessation support [14, 16, 19, 20, 23, 26, 27, 29–31, 33–36]. Of these, six were RCTs [23, 26, 27, 30, 31, 35]; three evaluated an intervention using surveys [19, 20, 34]; two evaluated an intervention using interviews [14, 16]; one using retrospective observational data [29]; one using interviews, focus groups and

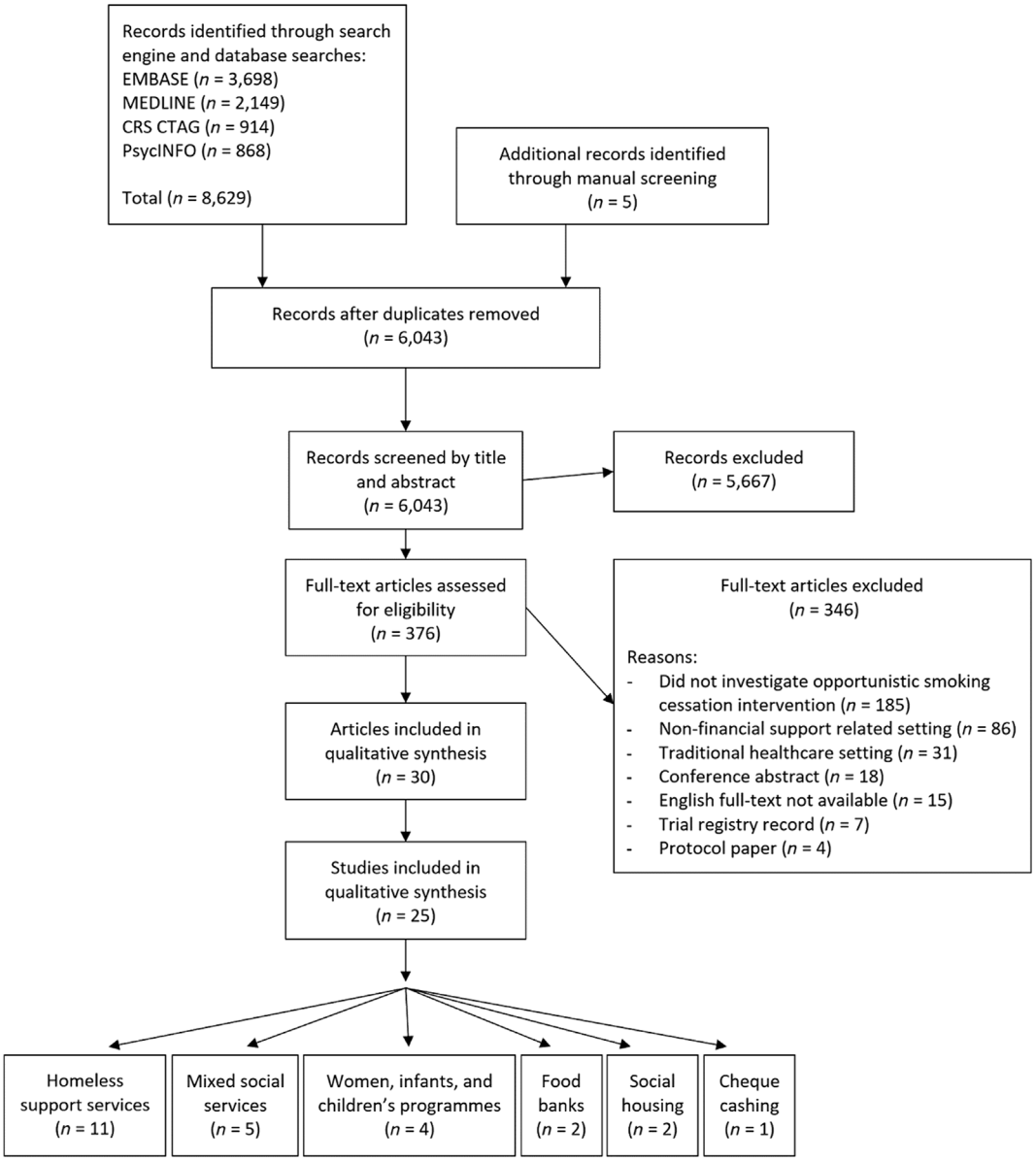

FIGURE 1 PRISMA-ScR flow diagram.

TABLE 1 Selected characteristics of the 25 included studies.

Study ID (lead author/year)	Study design	Participants	Setting	Country	Sample size (*n*)	Intervention/service being assessed (if applicable)	Comparator (if applicable)	Funder
Alizaga 2020 [32]	Survey, interviews	Service providers	Social housing	USA	53 providers	Not applicable	Not applicable	Tobacco-Related Disease Research Program and National Cancer Institute
Aquilino 2003 [28]	Focus groups	Service providers	Women, infants and children program	USA	25 providers	Not applicable	Not applicable	Iowa Department of Public Health
Bonevski 2011 [12]	Interviews, focus group, survey	Service providers and clients	Homeless support services	Australia	43 providers; 32 clients	Not applicable	Not applicable	Cancer Council New South Wales and Cancer Institute New South Wales
Bonevski 2018 [23]	RCT	Clients	Social services	Australia	431 clients	Comparator intervention plus free of clients cost NRT and 5 counselling sessions (3 face-to-face; 2 phone)	On-screen advice to quit smoking, the state Quitline telephone number and 'Call it Quits' branded gifts.	NHMRC of Australia
Brodsky 2009 [29]	Retrospective observational	Clients	Women, infants and children program	USA	4497 clients	Not applicable	Not applicable	Not reported
Bryant 2011 [24]	Survey	Clients (smoking and non-smoking)	Social services	Australia	383 (235 smoking) clients	Not applicable	Not applicable	Cancer Council New South Wales and Cancer Institute New South Wales
Christiansen 2010 [26]	RCT	Service providers and clients	Social services (Salvation Army)	USA	295 clients; providers *n* not disclosed	Brief 30 s 'ALSO' intervention (Ask, Link, Share, Offer). Clients were asked if they smoked; smoking was linked to the service's mission; tobacco use health information was shared; and self-help material offered on how to quit and associated services.	Printed information on how to quit, using cessation medications, a smoking Quitline, and benefits of quitting.	Wisconsin Tobacco Prevention and Control Program

TABLE 1 (Continued)

Study ID (lead author/year)	Study design	Participants	Setting	Country	Sample size (*n*)	Intervention/service being assessed (if applicable)	Comparator (if applicable)	Funder
Collins 2022 [30]	RCT	Clients	Women, infants and children program	USA	396 clients	Brief smoking advice (Ask, Advise, Refer), with clients referred to telephone cognitive behavioral therapy counselling for smoking cessation, with NRT, a smoking cessation app and multimedia health education and skills training materials related to smoking.	Brief smoking advice (Ask, Advise, Refer), with clients referred to 12 weeks of nutrition counselling, a nutrition app; and a multimedia tool kit called 'Food for Thought: Eating Well on a Budget' (attention matched to intervention).	National Cancer Institute and National Institutes of Health
Cox 2022 [13]	Survey	Service providers	Homelessness support services	UK	99 providers	Not applicable	Not applicable	Cancer Research UK
Donatelle 2000 [31]	RCT	Clients	Women, infants and children program	USA	240 pregnant clients	Comparator intervention, plus participants were asked to select a social supporter (someone with a regular, close, positive association) and received financial incentives for biochemically confirmed quitting (until 2 months postpartum)–$50 vouchers for participants and $25 for social supporters monthly.	Verbal and written information on the importance of smoking cessation and a self-help kit.	Robert Wood Johnson Foundation Smoke-Free Families Program, Albany General Hospital Foundation, Blue Cross/Blue Shield/ HMO Oregon, Collins Medical Trust, Epitope, Fred Meyer, Good Samaritan Hospital, March of Dimes Emerald Chapter, Oregon State University Research Office, Peace Health, The Corvallis Clinic Foundation
Fernandez 2022 [27]	RCT	Clients	Social services [2-1-1]	USA	111 smoking (relevant) clients (more participants in overall trial)	Comparator intervention, plus telephone navigation from a	Assess cancer control needs of callers to 2-1-1 helpline and if caller identified as	Cancer Prevention Research Institute of Texas; Cancer Prevention and

(Continues)

TABLE 1 (Continued)

Study ID (lead author/year)	Study design	Participants	Setting	Country	Sample size (*n*)	Intervention/service being assessed (if applicable)	Comparator (if applicable)	Funder
						trained cancer control navigator. Navigators provided logistical support (e.g. scheduling appointments, arranging transportation to care) and aimed to address psychosocial and structural barriers to quitting.	smoking then referral to stop smoking services.	Control Research Training and Career Development Program; Department of Health Promotion and Behavioral Sciences and the Center for Health Promotion and Prevention Research at UTHealth School of Public Health
Franco 2011 [25]	Focus groups	Clients	Social services	Australia	53 clients	Not applicable	Not applicable	Not reported
Neale 2022 [14]	Interviews	Clients (smoking and formerly smoking)	Homelessness support services	UK	34 (18 smoking; 16 formerly smoking)	E-cigarette or NRT	Not applicable	NIHR Maudsley BRC, Maudsley NHS Foundation Trust, King's College London
Paisi 2023 [33]	Interviews, focus groups, surveys	Service providers and clients	Social housing	UK	226 clients; 13 providers	Program offered to residents by housing officers when signing up for tenancy. Residents completed well-being questionnaire and then officer explored whether resident would like to improve behavior in relation to smoking, diet, physical activity, alcohol consumption, and/or mental well-being. If so, officer suggested ways to change relevant	Not applicable	Not reported

TABLE 1 (Continued)

Study ID (lead author/year)	Study design	Participants	Setting	Country	Sample size (*n*)	Intervention/service being assessed (if applicable)	Comparator (if applicable)	Funder
						behavior and sign posted appropriate organizations. Welcome pack provided that included e-cigarette vouchers. Catch-ups with officers provided at 1-, 6- and 12-month follow-ups.		
Parnell 2020 [15]	Interviews	Service providers	Homelessness support services	Australia	12 providers	Not applicable	Not applicable	Not reported
Perkett 2017 [34]	Surveys	Clients	Food bank	USA	144 clients	10–12-min educational intervention (delivered via PowerPoint by trained researcher) to increase knowledge about harmful effects of smoking and second-hand smoke, mechanisms of nicotine dependence, strategies for quitting, and the local quit line. A state quit line handout was provided.	Not applicable	The American Lung Association and the National Institute of General Medical Sciences of the National Institutes of Health
Robson 2021 [16]	Interviews	Service providers and clients	Homelessness support services	UK	9 providers; 5 clients	E-cigarette or NRT	Not applicable	NIHR Maudsley BRC, Maudsley NHS Foundation Trust, King's College London
Shadel 2014 [17]	Interviews	Service providers	Homelessness support services	USA	19 providers	Not applicable	Not applicable	The California Tobacco-Related Disease Research Grants

(Continues)

TABLE 1 (Continued)

Study ID (lead author/year)	Study design	Participants	Setting	Country	Sample size (*n*)	Intervention/service being assessed (if applicable)	Comparator (if applicable)	Funder
								Program Office of the University of California
Sindelar 2014 [36]	Randomized field experiment	Clients	Cheque cashing (one of three settings, the other two were healthcare and grocery)	USA	Not reported	Brochure titled 'Quit Smoking and Save Money' displayed with visual and written gain-framed, finance-orientated messages around quitting smoking, information on a quitline and a 'Quit and Win' contest. Specific information on financial gains achievable over a day, week and year.	Brochure titled 'Quit Smoking and Get Healthy' displayed with visual and written gain-framed, health-orientated messages around quitting smoking, information on a quitline and a 'Quit and Win' contest. Specific information on heath gains achievable over a day, week and year.	CARE Research Partnership Program - Yale Center for Clinical Investigation, National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, the State of Connecticut Department of Mental Health and Addiction Services
Steinberg 2020 [35]	RCT	Clients	Food bank	USA	58 clients	(1) Comparison intervention, plus one brief motivational interviewing (MI) session including reasons to quit, and increasing confidence, provided by a clinical psychology student. (2) Comparison intervention, plus NRT sampling – 10-min description of nicotine patches and lozenges and a free of client cost 2-week supply of both.	Referral-Only intervention - written information on state Quitline and the location and telephone number of a local tobacco dependence clinic.	Rutgers University Office of Community Relations, Community-University Research Partnership
Sung 2017 [18]	Interviews			USA	9 providers	Not applicable	Not applicable	

TABLE 1 (Continued)

Study ID (lead author/year)	Study design	Participants	Setting	Country	Sample size (*n*)	Intervention/service being assessed (if applicable)	Comparator (if applicable)	Funder
		Service providers	Homelessness support services					National Institutes of Health and UCSF School of Pharmacy Vince Isnardi Opportunity Fund
Taing 2020 [19]	Surveys	Service providers	Homelessness support services	USA	53 providers	Modified Taking Texas Tobacco Free program implemented over 12–15 months; including training for providers tailored to settings serving people experiencing homelessness on tobacco control and cessation; some providers were also trained to be specialist smoking cessation providers; motivation interviewing training offered; agencies provided with print materials to display and distribute to clients; agencies also offered NRT supplies and carbon monoxide monitors.	Not applicable	Cancer Prevention and Research Institute of Texas and National Cancer Institute
Vijayaraghavan 2015 [22]	Survey, focus groups	Clients (smoking and formerly smoking)	Homelessness support services	USA	66 clients (62 smoking; 4 formerly smoking)	Not applicable	Not applicable	California Tobacco-Related Disease Research Program
Vijayaraghavan 2016 [20]	Surveys		Homelessness support services	USA	12 providers; 46 clients	3.5-h provider training on smoking	Not applicable	

(Continues)

TABLE 1 (Continued)

Study ID (lead author/year)	Study design	Participants	Setting	Country	Sample size (*n*)	Intervention/service being assessed (if applicable)	Comparator (if applicable)	Funder
		Service providers and clients				cessation counselling including smoking cessation resources, and strategies to incorporate smoking cessation counselling into workflows.		California Tobacco Related Disease Research Program
Vijayaraghavan 2016 [21]	Survey, interviews	Service providers	Homelessness support services	USA	48 providers	Not applicable	Not applicable	California Tobacco Related Disease Research Program

Abbreviations: ALSO, Ask, Link, Share, Offer; BRC, Biomedical Research Centre; CARE, Community Alliance Research and Engagement; HMO, Health Maintenance Organization; MI, motivational interviewing; NHMRC, National Health and Medical Research Council; NIHR, National Institute for Health Research; NHS, National Health Service; NRT, nicotine replacement therapy; RCT, randomised controlled trial; UCSF, University of California, San Francisco; UK, United Kingdom; USA, United States of America.

surveys [33]; and one a randomized field experiment [36]. Twelve of the 25 included studies were conducted among clients [14, 22–25, 27, 29–31, 34–36]; eight among providers [13, 15, 17–19, 21, 28, 32]; and five among a combination of clients and providers [12, 16, 20, 26, 33]. Sixteen studies were conducted in the United States [17–22, 26–32, 34–36]; five in Australia [12, 15, 23–25]; and four in the United Kingdom (UK) [13, 14, 16, 33]. Of the 21 studies that reported their funder, none received funding from the tobacco, e-cigarette or pharmaceutical industries (Table 1).

Acceptability and feasibility

Service providers

Five studies reported on what staff working in financial support settings would think and feel about introducing opportunistic smoking cessation support. All of these studies reported majority support from directors and staff in offering such support, with ~90% of providers across all studies consistently stating smoking cessation support would be appropriate and desired in their services [16–18, 21, 32]. Some providers also recognized the role of tobacco in adding to financial strain and that discussing tobacco use in the context of financial stability would be feasible [32]. However, some providers did express concerns; in two studies providers noted a perceived lack of organizational support and resources to action smoking cessation assistance [17, 32], and another two studies reported that most directors and staff felt they did not presently have the appropriate skills or expertise to offer smoking cessation services [21, 32]. Staff in one of the aforementioned studies, as well as in two additional qualitative studies, reported that they would welcome training to provide this form of intervention [16, 21, 28]. Some providers also reported that their current lack of confidence meant they did not offer opportunistic advice on smoking cessation, which was most evident among staff who were never or current smokers [15]. Moreover, some staff regarded smoking as a lower priority issue, suggesting that smoking diverted clients from more harmful behaviors (e.g. other addictions) or concerns (familial, financial or employment related) [15, 26, 28, 32, 33]. Staff in several studies reported that a strong relationship was an important base on which to deliver opportunistic intervention, and that they would not feel confident in intervening without this unless the client raised the issue themselves, which staff reported rarely occurred [17, 21, 32].

Two studies asked staff about what cessation support was currently offered, or might be offered, in services for people experiencing financial difficulties [12, 13]. One study specifically asked providers about the smoking cessation interventions they thought would be feasible in services offering support for people experiencing homelessness [12]. Providers reported individual counselling; hypnosis; acupuncture; non-financial incentives to quit, for example, football tickets; and free of client cost or subsidized nicotine replacement therapy (NRT) as the five least desirable and feasible of 17 possible options. Strategies perceived to be the most desirable and feasible

were not reported. Another study asked staff in homelessness support services about their current actions on promoting tobacco smoking cessation, where staff reported encouraging clients to switch to vaping [13].

Three studies reported the experiences of service providers who had intervened on smoking as part of an intervention taking place in the setting [26, 28, 33]. Two studies reported that staff had positive reactions to providing opportunistic support for cessation. They reported that clients were keen to discuss smoking, reacted positively to offers of support and that staff felt positive afterwards about the support that they had offered [26, 33]. Providers in the third study, which took place in the WIC program (who provide supplemental foods, nutritional education and health care referrals to low-income pregnant and postpartum women and their children), reported experiencing a range of reactions from clients in response to asking about their smoking status and advising them to quit. These ranged from receptiveness to defensiveness and embarrassment [28].

Clients

Eight studies investigated the acceptability of offering smoking cessation support to clients [12, 14, 16, 22, 24–26, 33]. There were high levels of support for the provision of assistance in homelessness and social services settings [22, 24–26]. One study reported that smoking cessation was not currently discussed enough by providers [22], and in another, clients in a Salvation Army setting reported that they were pleased to be asked about their smoking, because it made them feel the service cared about them [26].

Some studies also reported on the types of support that clients of financial support settings would like to see. One study reported that clients believed multiple approaches to helping people quit should be implemented, and that there would be interest in services that addressed other addiction issues in parallel [22]. The provision of free of client cost or reduced cost NRT (some clients were otherwise discouraged by the cost) and incentives to quit were deemed the most popular quitting aids among clients [12, 22, 24]. However, there was also a potential concern that cash incentives might be used to buy cigarettes (it was unclear whether participants were concerned about others, themselves or both, using cash incentives in this manner) [12]. One study also investigated the least popular approaches to quitting support, which were referral to a telephone Quitline and text message support [24].

In three of the eight studies examining the acceptability of opportunistic smoking cessation interventions to clients, the intervention was already being provided [14, 16, 33]. Two were providing clients with e-cigarettes in homelessness support settings [14, 16], with one study reporting that the offer of e-cigarettes was deemed a 'great' idea [14] and the other that four of the five (80%) clients interviewed accepted an offer of an e-cigarette [16]. A study conducted in UK social housing provided a health-related behavioral intervention focused on exercise, alcohol consumption, eating behavior and smoking. Only 226 (22.2%) of 1016 invited social housing tenants took part in the study. Those who smoked and were interviewed reported they did not use the smoking cessation services offered by their social housing provider, although quantitative analysis found a significant reduction in smoking at 12-month follow up [33].

Effectiveness

Comparative evidence from RCTs

Of the six included RCTs all but one [26] examined more versus less intensive opportunistic smoking cessation interventions [23, 27, 30, 31, 35] (Table 1). The comparator for all five of these studies was minimal support to quit smoking (i.e. self-help materials, signposting and/or referral to local smoking cessation services and/or brief advice on why and how to quit). Four studies investigated added behavioral support, NRT or both in their intervention arms [23, 27, 30, 35]. Bonevski *et al*. [23] (n = 431) offered their 187 intervention participants an intensive five-session counselling regime and free of client cost NRT. There were no clear differences in quit rates between study arms at 6-month follow-up (validated continuous rates: intervention: 1% vs comparator: 1.4%; OR = 0.77 (95% CI = 0.1–8.5). However, intervention participants did report lower adjusted mean cigarettes smoked per day (cpd) than those in the comparator group at follow-up (7.8 vs 12.8), as well as more mean quit attempts (3.6 vs 1.6) [23]. Collins *et al*. [30] asked WIC clients in their intervention arm whether they smoked, advised about quitting and referred to smoking cessation treatment, including telephone counselling and NRT. The intervention resulted in a twofold increase in 12-month biochemically validated quit rates compared to the comparator group (15/199, 7.5% and 7/197, 3.6%, respectively) [30]. Fernandez *et al*. (n = 111) provided its 61 intervention participants, callers to a mixed social support service (the 2-1-1 helpline), with referral to stop smoking services and enhanced navigation through the referral (logistical support to overcome potential barriers to treatment seeking such as scheduling appointments and arranging transportation). The intervention resulted in an increase in participants completing smoking cessation counselling compared to referral-only comparator participants (31% vs 16%). Smoking cessation rates were not reported [27]. Steinberg *et al*. [35] (n = 57) investigated two interventions. In the first, food bank clients received a single motivational interviewing session before being referred to stop smoking services, and in the second, clients were provided with a 2-week supply of NRT. Across all three study arms only one person, in the referral-only comparator group, was biochemically confirmed abstinent at 1-month follow-up. The motivational interviewing arm self-reported reducing their cpd by four, the NRT group by two and the referral comparator by <1 cpd [35]. Donatelle *et al*. [31] (n = 240 pregnant women) provided 112 intervention participants, attending WIC clinics, with financial incentives for quitting, in addition to the minimal intervention provided to comparator participants. The intervention group had higher quit rates than the comparator group at both the 8-month gestation (intervention: 34/105, 32% vs comparator:

9/102, 9%) and 2-months postpartum follow-up points (intervention: 22/103, 21%; comparator: 6/102, 6%) [31].

In the only RCT that compared a smoking cessation intervention to no intervention (n = 295), 148 intervention participants in the Salvation Army social support service were provided with very brief (30-second) smoking cessation advice. Clients were asked if they smoked, smoking was linked to the Salvation Army's mission, and tobacco use health information, self-help materials and information on associated services were shared. The intervention increased the likelihood that participants would 'probably' or 'definitely' seek help when they decided to quit compared to no intervention (61% vs 44%), but there was no clear difference in the proportions of participants who reported that they 'probably' or 'definitely' intended to quit in the next 6-months (49% vs 45%). Smoking cessation rates were not reported [26].

Additional evidence from single-armed studies

Five single-arm studies collected additional effectiveness data. Two studies investigated the impact of training service providers in homelessness support services on knowledge and delivery of smoking cessation support [19, 22]. Both found an increase in knowledge on the provision of smoking cessation support. The training also led to substantial increases in the number of clients being provided with smoking cessation support. In one study, there were increases in the provision of treatment and referrals in comparison to the previous month (46% vs 74%), arranging follow up with clients to assess progress (39% vs 74%), providing non-nicotine smoking cessation medications (9% vs 30%), providing NRT (17% vs 41%) and advising smokers to quit (54% vs 64%). There was only a small increase in the provision of behavioral counselling (43% vs 48%) [19]. The second study found the proportion of clients being asked about tobacco increased from 21% to 65% [22].

In one study where n = 144 food bank clients received a 10- to 12-minute smoking cessation education intervention, including information on smoking harms, nicotine addiction mechanisms, ways to quit and the local Quitline, knowledge and intention to quit increased slightly (+0.86; on a 0–7 scale, and +0.9; on a 0–10 scale, respectively). At 6-week follow-up 7.4% of smokers reported calling the Quitline in the previous month [34].

Two single-arm intervention studies investigated the impact of smoking cessation support on actual smoking behavior. The first was a retrospective observational evaluation of the WIC program in the United States, who were providing referrals to stop smoking services. Clients entering the program during the first trimester of pregnancy were less likely to have increased their smoking (OR = 0.64; 95% CI = 0.52–0.79) and more likely to have decreased or quit smoking (OR = 1.51; 95% CI = 1.17–1.96) compared to those who entered during the second or third trimester [29]. Finally, one study evaluated a health-related behavioral intervention focused on exercise, alcohol consumption, eating behavior and smoking. If residents wanted to change their smoking behavior, they were provided with support through goal setting, motivational interviewing, signposting to relevant services and e-cigarette vouchers. A significant reduction in self-reported smoking in the smoking component of the 'How Are You' (HAY) quiz was observed at 12-month follow up [33].

Cost-effectiveness

None of the included studies investigated cost-effectiveness as an outcome.

Components focusing on the financial implications of smoking and cessation

Few studies reported intervention components focused on the financial gains associated with quitting smoking. However, one survey of 99 UK homelessness services, found that two services self-reported discussing smoking in the context of barriers to monetary management with their clients [13]. Additionally, the counselling manual used in one interventional study stated: '*If applicable talk with the client about how much money is spent on cigarettes per week*' [23]. A third study provided some participants with financial incentives to quit, so it is possible that the financial aspects of smoking were discussed; however, this was not explicitly stated [31].

Most notably, a randomized field experiment conducted in cheque cashing, grocery and healthcare settings in the United States, investigated the potential effect of the financial cost-saving element of quitting smoking as an intervention strategy. Smoking cessation brochures with financial messaging (e.g. financial gains achievable over a day, week and year from quitting smoking) were displayed and rotated, in randomized order weekly, with smoking cessation brochures displaying health messages (e.g. health gains achievable over a day, week and year). More of the financial messaging brochures were taken by clients in all settings, with the largest difference in the cheque cashing setting (124 financial vs 74 health brochures). Subsequent smoking cessation was not assessed [36].

DISCUSSION

We found 25 studies that investigated an opportunistic smoking cessation service within financial support settings. Approximately half investigated the opinions of service providers and/or clients on the provision of these services. A large majority of both service providers and clients supported provision of opportunistic smoking cessation interventions in financial support settings. A small minority of service providers believed that smoking cessation was not a feasible goal for clients, with barriers including a lack of resources and skills to provide the support needed, perceived negative client response to being asked about their smoking, clients having more urgent priorities and tobacco use as a harm reduction strategy to prevent more illicit substance use and as a stress reliever. Clients welcomed being asked

about their smoking and being offered assistance to quit. Some clients had concerns about the costs of treatments, for example NRT, but were interested in being offered free of client cost or cheap nicotine-based quitting aids and cash or non-financial incentives for quitting. Few studies investigated current smoking cessation support practices in financial support settings; however, current provision of e-cigarettes was reported in a small number of settings and viewed positively.

Evidence on effectiveness was sparse. Only six of the 25 included studies were RCTs and the majority compared more to less intensive interventions, with mixed results. The follow-up length was generally short (i.e. less than 6 months) and smoking cessation was only assessed in four RCTs. However, the one study that investigated the use of financial incentives for pregnant women using the WIC program had promising cessation results, in-line with the wider evidence on financial incentives for quitting smoking in pregnant women [37]. None of the included studies assessed the cost effectiveness of opportunistic smoking cessation interventions.

All included studies took place in the United States, Australia or the United Kingdom, and many in services offering support for homelessness. Most studies did not report on discussion of the potential financial benefits of quitting smoking. Therefore, no studies have drawn clear conclusions on the acceptability and effectiveness of this as an intervention component. However, one study did look at the uptake of smoking cessation materials that highlighted the financial benefits versus the health benefits of quitting smoking and found more uptake of the former [36]. Both service providers and clients also acknowledged the financial impact of smoking and the potential cost savings of quitting as a motivator for change. Prior evidence suggests that focusing on the financial benefits of quitting smoking can be more salient than health-focused campaigns when targeted at people experiencing homelessness [38], and broader research from a health perspective suggests focusing on financial gain rather than loss is more persuasive [39].

Strengths and limitations of this study

We carried out this scoping review using systematic methods and reporting, guided by the Joanna Briggs Institute updated methodological guidance for the conduct of scoping reviews and the PRISMA-ScR extension checklist [9, 10]. A potential limitation may be the ability of our search strategy to identify all appropriate financial support settings. We worked with a search strategy specialist (J.L.B.) and kept our search terms broad to minimize the chances of missing relevant literature, but it is possible that we failed to identify some terms used to identify relevant settings. For reasons of pragmatism, we did not carry out dual screening of all records at title/abstract stage; however, we did spend time ensuring that all reviewers were interpreting the eligibility criteria in the same way, and where in doubt put records through to full-text screening where we dual screened all records. We did not screen and include studies where the full text was not available in the English language, which may have caused bias. However, we have no reason to believe that the relevant studies would be more prevalent in countries that do not publish or translate as commonly in the English language and based on the overall lack of evidence in this area it is unlikely that much was missed for this reason.

Implications for Research and Practice

Very brief interventions to support behavior change are delivered within 30 seconds to 2 minutes, and often adopt a variation of the 3A's approach (ask, advise and act) [4, 40]. This involves tactfully initiating a short discussion regarding an individual's health behavior, for example, smoking, weight management, physical activity (ask), advising on the best form of support available for the issue (advise) and making an offer to arrange access to this support (act). Such interventions are well suited to opportunistic delivery and have traditionally occurred in primary care settings, capitalizing on a trusted environment and pre-existing relationship [4]. However, this approach could be implemented opportunistically in any setting, which sufficiently links the behaviors to a related outcome. This includes, for example, intervening opportunistically on smoking in financial support settings where, rather than health, the focus is more implicitly on the financial benefits of quitting. Based on the lack of resources and skills allocated to smoking cessation in financial support settings, the provision of very brief advice with referral to existing evidence-based services (i.e. combined behavioral support and medications or e-cigarettes) appears a promising approach that should be thoroughly evaluated.

The financial benefits of stopping smoking are often highlighted as potential motivators for quitting across the general population. For example, Scotland's national health information service, NHS Inform, is one of several organizations whose website hosts a tool that can be used to calculate the money that could be saved through quitting smoking [41]. However, providing information on the financial benefits of quitting and/or the use of financial incentives for quitting smoking as core components of smoking cessation support for those experiencing financial difficulty requires further examination; in particular because of the intuitive nature of the approaches in this setting and promising preliminary findings.

Additional relevance to intervention content were findings from one study that the most desired support options among clients, that is, free of client cost or subsided NRT and incentives to quit, were those perceived as the least desirable and feasible by service providers [12]. This warrants further investigation to establish whether this discrepancy is consistently observed across different financial support settings, why it exists (e.g. providers perceive that funding for this support would need to come from their own overstretched budgets) and whether it may be possible to mediate on any persisting differences between clients and providers to reach a consensus on desirable and feasible intervention components.

Future evaluations of opportunistic smoking cessation support should take place in a wider range of financial support settings; in countries outside of the United States, and financial support settings outside of homelessness support services, where the majority of

primary research has been conducted to date. More research is needed to assess what opportunistic smoking cessation support is currently being offered and how the financial aspects of smoking are dealt with in financial support services in different countries and settings. Studies investigating the feasibility and effectiveness of smoking cessation support should compare interventions to the current standard of care. They should also ensure they measure smoking cessation, and that they do this in the long term, because populations who find it harder to quit may take longer to achieve abstinence. As well as clinical effectiveness, studies should investigate cost-effectiveness and consider the financial stability and wellbeing of clients.

AUTHOR CONTRIBUTIONS

Paul Doody: Conceptualization; data curation; formal analysis; investigation; methodology; project administration; writing—original draft; writing—review and editing. **Thomas Parkhouse:** Data curation; investigation; writing—review and editing. **Min Gao:** Data curation; investigation; writing—review and editing. **Simona Haasova:** Data curation; investigation; writing—review and editing. **Jonathan Livingstone-Banks:** Data curation; investigation; methodology; writing—review and editing. **Hazel Cheeseman:** Conceptualization; funding acquisition; writing—review and editing. **Paul Aveyard:** Conceptualization; funding acquisition; writing—review and editing. **Nicola Lindson:** Conceptualization; data curation; formal analysis; investigation; methodology; project administration; writing—original draft; writing—review and editing.

ACKNOWLEDGEMENTS

This review was funded by Action on Smoking and Health (ASH) UK. P.D., M.G. and S.H. receive funding from the NIHR Applied Research Collaboration (ARC) for Oxford and Thames Valley. P.A. is funded by the National Institute of Health Research (NIHR) Oxford Biomedical Research Centre (BRC).

DECLARATION OF INTERESTS

None.

DATA AVAILABILITY STATEMENT

Any data which exists further to that within the manuscript and supplementary files is available on request from authors.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Doody P, Parkhouse T, Gao M, Haasova S, Livingstone-Banks J, Cheeseman H, et al. Opportunistic smoking cessation interventions for people accessing financial support settings: A scoping review. Addiction. 2024. https://doi.org/10.1111/add.16533