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Framing Cessation Care

Message Guide

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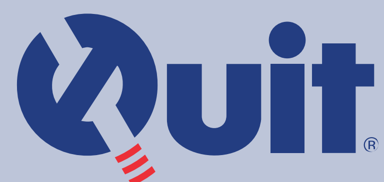


Introduction

General practitioners (GPs) and pharmacists play an important role in supporting their patients to quit smoking and vaping. est practice cessation care (brief advice to quit plus pharmacotherapy, as appropriate, and behavioural intervention) significantly increases the number of people who quit smoking[1]. Despite this, not all GPs[2] and pharmacists[3] provide best practice cessation care for example follow the Ask, Advise, Help [AAH] model) either consistently or in full.

This message guide contains evidence-based recommendations for how to motivate GPs and pharmacists to implement best practice cessation care with patients who smoke. It is intended for use by anyone engaging with GPs and pharmacists on this topic and is based on extensive research and message testing conducted by Common Cause Australia on behalf of Quit in 2021-22.

In what follows, we outline the research methodology and key findings before detailing our key recommendations. For further information about this research or recommendations contact Quit.

Methodology

The Common Cause approach to developing and testing persuasive messaging is based on decades of research from the fields of social psychology, cognitive linguistics, and behavioural economics. A key finding of this body of research is that most people think about health and other social issues from multiple and often conflicting perspectives. In cognitive linguistics, these different perspectives are known as cognitive frames.

Cognitive frames operate mostly at a subconscious level, which means people's attitudes and behaviours are often driven by factors beyond their conscious awareness. Importantly, subconscious decision-making has been found to apply even among people working in high-stakes professions in which evidence-based practice is a core guiding principle[4].

In the case of our research, we sought to identify cognitive frames which make GPs and pharmacists feel, at a gut level, that the AAH model should be implemented in full with every patient who smokes. We also sought to understand which frames moved these healthcare practitioners into a more hesitant mindset, in which deviating from the AAH model felt acceptable, if not preferable.

We began by reviewing previous research into the attitudes and behaviours of healthcare practitioners in relation to cessation care. This was followed by a workshop with Quit and the Victorian Department of Health to clarify and refine our research brief.

To further explore existing knowledge, assumptions and motivations around cessation care among healthcare professionals, we conducted 10 focus groups over Zoom with GPs and pharmacists currently working in patient-facing roles. Five groups were conducted with GPs and five with pharmacists. Each group included a mix of genders and ages from across Australia

with a fifth of participants practicing in rural or regional areas. Through these focus groups we identified a number of potential framing elements, including key concepts and metaphors, that could be enablers of, and barriers to, delivering best practice cessation care.

To explore how messaging can be used to overcome these barriers and tap into the enablers of best practice, we conducted a 15-minute online survey with 1,007 health professionals working across Australia. The sample was split evenly between GPs (n=502) and pharmacists (n=505).

The survey deployed a range of question formats, including forced choice[5] and split sample[6] questions. We also tested four 30-second audio-recorded messages in which participants moved a dial up and down on their screens as they listened to the messages to indicate their level of agreement with what they were hearing in each moment. This provided us with a word-by-word view of the persuasive effect of the messages we tested and allowed us to isolate specific words and phrases that most resonated with our audiences.

Among other variables, the full results of the survey were analysed by profession, gender, metro-rural location of practice, and patient-population to identify how health professionals operating in different contexts responded to our messaging.

Finally, we scored the answers of each respondent to key questions throughout the survey to classify them into the following three attitudinal segments:

Supporter: Supporters believe the full AAH model should be followed with every person who smokes, regardless of their motivation. They also believe people who smoke struggle to quit because of lack of support, rather than lack of personal motivation. Supporters believe most strongly that the support health professionals provide to patients makes a significant difference to cessation outcomes.

Persuadable: Persuadable health professionals mostly support the application of the AAH model, but have mixed views about whether it is always appropriate – especially if a patient is not 'ready'. They believe best practice cessation care can make a difference to cessation outcomes, but less strongly than Supporters.

Reluctant: Reluctant health professionals are on the fence or less accepting of the importance of following the AAH model. They are more likely to see patient motivation as the key barrier to quitting, as opposed to lack of support, and that offering support to patients before they are 'ready' risks pushing them away. They are the least likely to believe that cessation care makes a significant difference to cessation outcomes.

Overall, among participants in our survey, we classified 23% as Supporters, 62% as Persuadable, and 15% as Reluctant. A breakdown of these attitudinal segments by profession revealed GPs were more likely to be Supporters than pharmacists. Meanwhile, pharmacists were more likely to be Persuadable than GPs, with no significant difference between the two groups in the Reluctant segment.

	Supporters	Persuadable	Reluctant
GPs	28%	59%	14%
Pharmacists	18%	65%	17%

By analysing the full results of the survey based on the responses of these three attitudinal segments to each of the questions and messages we were able to identify more and less helpful messages. Messages that appealed strongly to Supporters and also shifted Persuadables were identified as most useful for future messaging as they toggle Persuadables into a Supporter mindset. On the flip side, messages that appealed strongly to both Reluctant and Persuadable respondents were identified as harmful messages because they move Persuadables into a Reluctant frame of mind.

Summary of findings

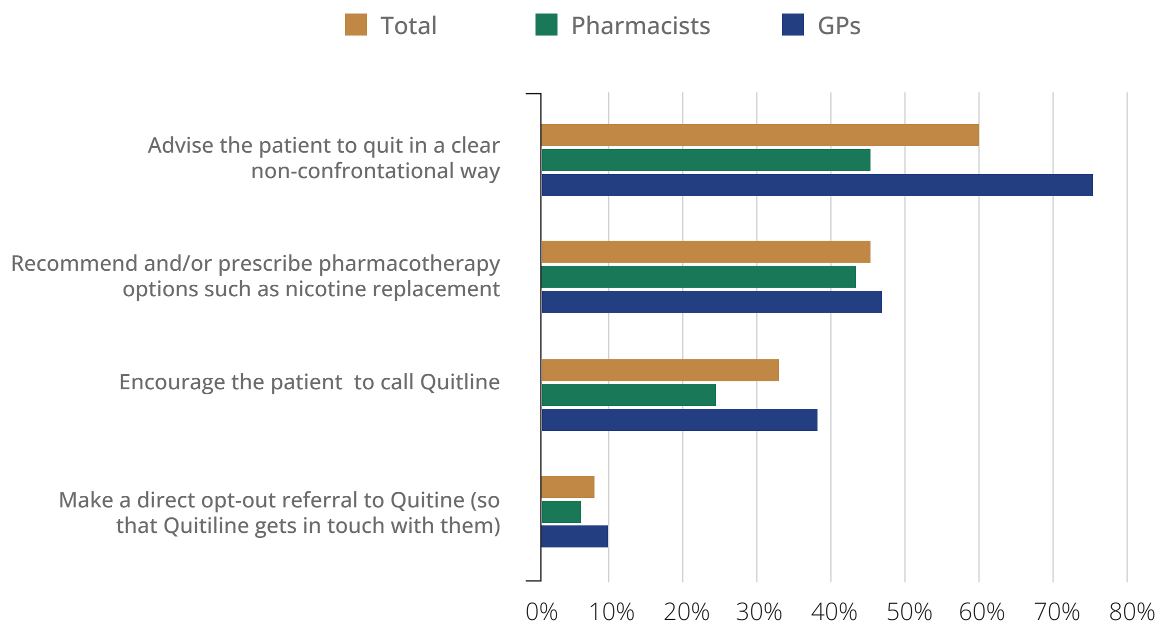
Most GPs and pharmacists who completed our survey either agreed or strongly agreed smoking should be addressed as a clinical priority (89%). However, this did not translate into full implementation of best practice cessation care. In fact, most respondents did not implement the AAH model in full most of the time.

In line with findings from previous research[7], our survey found GPs and pharmacists were more likely to ask a patient if they smoked and advise them to quit, than they were to follow through with practical advice and support with quitting.

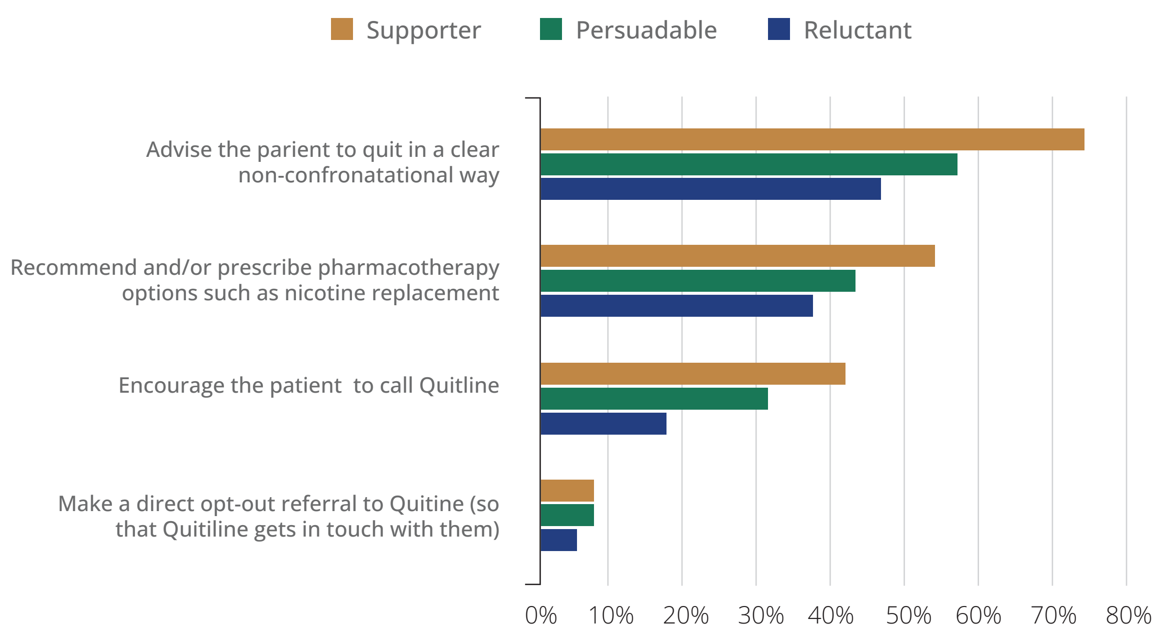
When it comes to the cessation care provided by healthcare professionals 'most of the time':

- 60% reported advising smoking patients to quit in a clear, non-confrontational way
- less than half (45%) recommended and/or prescribed pharmacotherapy options such as nicotine replacement therapies or prescription stop smoking medications
- 31% encouraged their patients to call Quitline
- just 8% made a direct opt-out referral to Quitline.

As the graph below illustrates, GPs were more likely to engage in all forms of cessation care than pharmacists, although the level of difference varied by type of care.



Clear differences also emerged in the care provided by the Supporter, Persuadable and Reluctant attitudinal segments, with Supporters more likely to follow the AAH model in almost all cases than both Persuadable and Reluctant respondents as illustrated in the graph below. The only exception was making direct opt-out referrals to Quitline, in which Supporters were just as unlikely as Persuadables to provide this best-practice care, with only 9% of both groups doing so 'most of the time'.



To identity what attitudes and beliefs might be driving the overall higher quality of cessation care provided by Supporters compared to other segments, we compared the responses of these segments across the survey and identified a number of core cognitive frames that appear to act as barriers and enablers of best practice care.

Motivation vs Support

While the vast majority of health professionals in our survey agreed they have knowledge about quitting that patients can benefit from (GPs 98%; pharmacists 96%) and that they play an important role in helping patients to quit (GPs 99%; pharmacists 94%), many struggled to believe their efforts would make a difference to cessation outcomes if the patient was not already motivated to quit.

When presented with a series of statements either framing patient motivation as the key to quitting or the need for external support, including from GPs and pharmacists, a clear pattern emerged. Supporters overwhelmingly agreed with statements that centred on the need for external support as vital to quitting, while Reluctant respondents chose statements focussed on patient motivation. Persuadable respondents were split roughly evenly between support and motivation focussed statements on each occasion.

For example, when asked whether most people struggle to quit smoking because: (a) "they lack motivation"; or (b) "they don't have the tools and support they need";

- **77%** of Reluctant respondents chose the motivation statement (a),
- **81%** of Supporters chose the support statement (b),
- while Persuadables were split **43% to 57%** between the two statements respectively.

Meanwhile, when asked whether patients have the best chance of quitting when (a) "they are motivated and adopt an approach that suits them"; or (b) "they have the support of the GP or pharmacists combined with pharmacotherapy and behavioural counselling through Quitline";

- **84%** of Reluctant respondents chose the motivation statement (a),
- **86%** of Supporters chose the support statement (b),
- and Persuadables were again split down the middle **49% to 51%**.

This suggests that focussing on the need for external support is an important framing element for our communications, while messaging that emphasises patient motivation is likely to be unhelpful and activate higher levels of reluctance towards implementing the AAH model.

In addition, our research found that focussing on the positive impact of providing support was more important than emphasising the need for that support in the first place. In one split sample question, the number of respondents who agreed "GPs and pharmacists should always provide patients with proactive advice and support to quit no matter their level of motivation", was significantly higher when respondents had first been shown an impact-focussed statement compared to a need-focussed statement. When they had first been shown the impact-focussed statement: "1 in 5 unmotivated patients will take steps towards quitting when advised to by a health professional", 80% agreed with the proactive advice statement above. This support dropped to 60% among those shown a need-focussed statement about tobacco killing "nearly four times as many people as alcohol and illicit drugs combined".

In other words, showing GPs and pharmacists that their advice and support can make a difference is a more powerful way of boosting their motivation to engage in best practice cessation care than framing it as a clinical priority.

Right Time vs Every Attempt Helps

Another key difference between Supporters and Reluctant GPs and pharmacists is the way they think about quit attempts.

Reluctant GPs and pharmacists overwhelmingly believe conversations about quitting and embarking on quit attempts are best left until the 'time is right' and patients have the greatest chance of quitting for good. Supporters, on the other hand, tend to see every quit attempt as a useful step in the right direction and, therefore, it is always the right time to try.

For example, while the vast majority of Reluctant GPs and pharmacists (92%) agreed "people shouldn't attempt to quit smoking until they are ready", only a minority of Supporters (28%) agreed. Persuadables, meanwhile, were in majority agreement (64%), though far below the level of agreement among Reluctant respondents.

Similarly, while 85% of Reluctant GPs and pharmacists agreed "when people have a lot going on and are feeling stressed, it's not the right time to quit", only a quarter (24%) of Supporters agreed. Once again, a small majority of Persuadables (59%) agreed with the 'right time' statement.
These results suggest that the 'right time' frame is a key concept underlying the reluctance of many GPs and pharmacists to provide consistent cessation care.

One way of countering the 'right time' frame may be to focus instead on the value and importance of multiple quit attempts – where the outcome of each attempt is less important than what is learned in the process of trying.

Encouragingly, there was overwhelming agreement among respondents that "it often takes people many attempts to quit smoking" (92%) and that "it is always worth providing advice to patients about effective ways to quit smoking" (94%). However, the strength of that agreement varied considerably. For example, while 65% of Supporters strongly agreed it is always worth providing advice to patients about effective ways to quit smoking; this strong agreement dropped to 38% among Persuadables and just 17% among Reluctant respondents.

This suggests that one of the key cognitive frames among GPs and pharmacists who more consistently apply the AAH model in full, is their strong belief that every quit attempt is a step in the right direction. Strengthening this narrative is likely, therefore, to be an important element of motivating more GPs and pharmacists to apply the AAH model more often, with more patients.

Values orientation

In our focus groups, GPs and pharmacists emphasised the importance of being presented with facts and evidence to influence their decisions around cessation care.

Indeed, in our survey, we tested identical messages that either included or excluded facts and references and found the inclusion of numbers and references significantly boosted the persuasiveness of our messages. Ensuring facts and evidence takes centre-stage in our messaging is, therefore, vital.

However, despite this conscious focus on facts among health professionals, our research found the personal values orientation of respondents also influenced their attitudes and behaviours in their professional life.

For example, when respondents were asked to select which set of guiding principles most appealed to them personally, Reluctant GPs and pharmacists were twice as likely as Supporters to select a list of values that included ambition, success, authority, social power and wealth. Among social psychologists who study values and their influence on decision-making, these are known as Self-Enhancing values[8]. A variety of studies from around the world have found Self-Enhancing values to be associated with more individualistic, antagonistic, and discriminatory attitudes and behaviours[9].

In the case of smoking cessation care, this may explain why Reluctant respondents were more likely to blame individuals and their lack of motivation for their failure to quit rather than external factors such as lack of support from healthcare professionals.
In any case, it is a useful reminder that even highly trained professionals who consciously seek out evidence to guide their practice, are also affected by sub-conscious drivers that influence their beliefs and behaviours.

Our messaging, therefore, needs to not only provide healthcare professionals with the facts about cessation care, but also to embed these in a narrative that engage helpful values that encourage GPs and pharmacists to accept those facts.

Journey and practice metaphors

Conceptual metaphors play an important role in language and cognition by helping people talk about and conceptualise complex or abstract concepts by reference to more tangible objects and experiences with which they are more familiar[10]. Conceptual metaphors operate at a subconscious level in communications, in that they are typically deployed without the communicator being aware of their use and interpreted by the audience without them noticing the metaphor. As a result, conceptual metaphors are a powerful tool for influencing persuadable people's thinking and conclusions about important issues.

Through our research we identified two important conceptual metaphors that help GPs and pharmacists think and talk about their role in the process of smoking cessation.
The first is Quitting as a Journey. This metaphor was used unprompted by several focus group participants and frames quit attempts as steps forward in the journey towards a life free from tobacco and vaping products. Used well, this metaphor helps frame quitting as the outcome of multiple steps, with each step bringing patients closer to their destination. Within the journey metaphor, the role of GPs and pharmacists is to act as guides – outlining the best path to take and equipping patients with what they'll need along the way. The central role is still that of patients, who need to undertake the journey, but their ability to reach their destination is significantly boosted by the support they receive along the way.

When embedded in our messaging, this metaphor tested well in our survey. For example, 9 in 10 respondents agreed "every attempt at quitting brings someone closer to quitting for good" and that "unmotivated people need help taking that first step to quitting." In addition, a 30-second message we tested using the Journey metaphor throughout was rated as convincing by 95% of both GPs and pharmacists.

The second metaphor we explored was Quitting as a Skill. This metaphor frames quit attempts as practice that helps them strengthen their quitting skills. As with the journey metaphor, framing quitting as a skill is useful in that it implies more quit

attempts are better than less. With each attempt, patients learn something new about their triggers and strategies they can use to overcome them. The role of healthcare professionals is to act as coaches – helping their patients develop a plan, leverage their strengths, and keep up the practice.

While this metaphor also tested well as a 30-second audio message, with over 95% of GPs and 97% of pharmacists rating it as convincing, it was not a metaphor that emerged unprompted from healthcare professionals in our research. This makes it is less likely to be a metaphor GPs and pharmacists will proactively use themselves when thinking and talking about smoking cessation unless prompted to by our messaging.

Familiarity with Quitline

Another noteworthy finding from our survey was the lack of in-depth understanding among GPs and pharmacists of the Quitline service. Almost all respondents (99%) had heard of Quitline and reported, at least, a general understanding of what it does. However, only 21% said they were “very familiar with Quitline” or had a “thorough understanding” of it.

This thorough understanding rose to 28% among Supporters – almost twice the proportion of Reluctant respondents (15%). There was a similar level of difference between GPs and pharmacists in their depth of understanding of Quitline with 27% of GPs reporting a thorough understanding compared with 15% among pharmacists.

Given that referrals to Quitline and other specialist counselling services are an integral part of the AAH model of cessation care, this shallow understanding of the organisation and its work suggests the need for more engagement with GPs and pharmacists. Importantly, as the results discussed below illustrate, additional engagement using a well-framed message is likely to yield significant improvements in both understanding and behaviours.

Potential for change

After listening to and rating the four audio messages, respondents were asked a number of questions repeated from earlier in the survey. These repeat questions were used to identify any shifts in attitudes or behavioural intentions as a result of the audio messages.

Encouragingly, significant positive changes were recorded across a range of attitudes and beliefs among both GPs and pharmacists. These positive shifts in support were recorded for all attitudinal segments – including the Reluctant segment.

For example, the percentage of respondents who strongly agreed they had an important role to play in helping patients quit smoking rose from 59% to 73% among GPs and from 47% to 61% among pharmacists.
Meanwhile, the percentage of respondents who chose the option "Sharing proactive advice about the benefits of pharmacotherapy and behavioural counselling through Quitline is worth doing every time you talk to a patient who smokes", rose from 45% to 80% among Persuadables and from 13% to 52% among Reluctant GPs and pharmacists.

Finally, the proportion of respondents who felt confident that referring patients to the Quitline clinical service would improve their chances of quitting rose from 75% to 95%.

Recommendations

Based on the research insights summarised above, we have developed four key recommendations for how to persuade GPs and pharmacists to adopt AAH cessation care in their daily practice.

Recommendation #1
Frame quitting as a journey

The journey metaphor provides a powerful mental shortcut for communicating the key messages GPs and pharmacists need to hear to motivate more consistent application of the AAH model.

By framing quitting as a journey that requires multiple steps, with each step bringing patients closer to quitting, the journey metaphor helps overcome the competing urge of healthcare professionals to wait for the 'right time' or adequate patient motivation before providing proactive advice and support. Instead, it makes each step, no matter how big or small, feel like the right thing to do.

The journey metaphor also provides a clear role for healthcare professionals as trusted guides who can:

- motivate patients to take the first or next step in their journey;
- show them the best path forward (pharmacotherapy combined with behavioural counselling through Quitline); and
- equip them with what they need (prescriptions, if appropriate, and a referral to Quitline).

To illustrate what the journey metaphor might look like in practice, the following is the message we tested using the journey metaphor that was rated as convincing by 95% of GPs and pharmacists.

"The journey to a life free from tobacco addiction has ups and downs.

Studies show that patients who have the support of their GP or pharmacist, who use pharmacotherapy for smoking cessation and who use the Quitline clinical service, which has trained behavioural counsellors and psychologists, are the most likely to stay the course.

Quitline's evidence-based counselling service proactively gets in touch with patients to support and guide them along the way. Your patients are 13 times more likely to engage with treatment if you refer them directly to Quit.

As a GP or pharmacist, you can give your patients the guidance they need by referring them to Quitline."

Recommendation #2
Remind them quitting takes practice

GPs and pharmacists already know it takes most people many attempts to quit smoking. They also readily accept that every attempt brings people who smoke closer to quitting for good.

But they also worry that their time and effort will be wasted if it's 'not the right time' for their patients, or if their patient motivation levels are not high enough to sustain the attempt.

Describing quitting as a skill that improves with practice reframes quit attempts as beneficial no matter the duration or ultimate outcome. Seen from this perspective, the time health professionals invest in cessation care feels more worthwhile to healthcare professionals.

Indeed, this proved a highly convincing message in our testing. The below example was rated as convincing by 95% of GPs and 97% of pharmacists in our survey.

"Practice makes perfect. When it comes to quitting smoking, a little change each day can add up to a lifetime of difference.

As GPs and pharmacists, we can give our patients the tools they need to strengthen their quitting skills over time.

This includes pharmacotherapy for smoking cessation as well as support from the specialist counsellors at Quitline. They keep in touch with our patients and coach them through the tough times to strengthen their motivation and keep their new routines going.

Together with Quitline, we can help more of our patients improve their health over time."

Recommendation #3
Tell them it works!

Nothing is more motivating than knowing that your work will make a difference. This is as true for healthcare professionals as it is for anyone else.

Unfortunately, most GPs and pharmacists are not convinced that cessation care makes a difference unless patients are already motivated. Tobacco may well be the leading preventable cause of death and disease in Australia, but if providing advice and offering support falls on deaf ears, it only makes sense for healthcare professionals to focus their limited time with patients on more productive matters.

Therefore, one of the most important things you can do to motivate GPs and pharmacists to provide AAH cessation care, is to show them it actually works. Instead of wasting time telling healthcare professionals what they already know – that smoking is a clinical priority – show them research and examples that prove AAH cessation care leads to better patient outcomes.

Make sure to provide tangible and specific outcome measures from credible research sources. When we provide clear figures and reference our sources, GPs and pharmacists will be more persuaded by the information presented.

Some examples of helpful outcome measures we tested are provided below.

"1 in 5 people who report being unmotivated to quit, will make a quit attempt in the next six months. Therefore, clinicians should not stop offering support to smokers even if they have recently reported that they do not want to quit."

"The advice of a GP or pharmacist, together with pharmacotherapy, is 1.61 times more effective than when people try to quit without any aids. And when you add behavioural support, such as the specialist counselling offered by Quitline, this combined approach is 3.25 times more effective."

"Your patients are 13 times more likely to engage with treatment if you refer them directly to the Quitline program."

"Research shows a conversation with a health professional is a major trigger in prompting people to make a quit attempt. One in every 33 conversations will result in patients quitting for good."

Recommendation #4
Chose your words wisely

The words we choose to use can have a substantial effect on how healthcare workers interpret our message by acting as shortcuts to competing cognitive frames. Based on our research, we recommend the following words to lose and use when communicating with GPs and pharmacists.

From	To	Why
Cessation intervention	Cessation care	The term 'intervention' implies GPs and pharmacists do not have a natural role to play in smoking cessation. The term 'cessation care', however, frames the interaction as a natural part of healthcare.
Brief advice	Ask-Advise-Help model of cessation care	Many GPs and pharmacists equate 'brief advice' with simply advising patients to quit without further information or support. Therefore, reference the Ask Advise Help model specifically.
Quitline	Quitline program/ clinical service	Many GPs and pharmacists think of Quitline as a hotline, rather than a service that provides ongoing care for smokers seeking to quit. Therefore, never mention Quitline without providing at least some broader context for what it does.
Referral to Quitline	Referral to Quitline, so they can contact your patient directly.	Many GPs and pharmacists think making a 'referral' to Quitline simply means advising patients to call Quitline. Therefore, when encouraging healthcare professionals to make direct opt-out referrals, provide greater context that clarifies what this means.
Failed/ successful quit attempts	Every quit attempt is an opportunity to learn new skills / a step in the right direction	There is no such thing as a successful or failed quit attempt, as they are all essential parts of the quitting journey. Therefore, avoid framing quit attempts in terms of the outcomes of each.
Customers (in a pharmacy context)	Patients	Referring to people who smoke as patients, rather than customers frames the interaction as one of healthcare instead of keeping customers happy.
Smokers	People who smoke	By Using person-first language helps build empathy and avoid stereotypes.
Motivated / Unmotivated	More/less motivated	Avoid talking about motivation where possible but, when necessary, refer to people by levels of motivation rather than the presence or absence of it.
Choice	People dependent on nicotine	Never refer to people's choice to smoke. This primes the motivation frame that undermines best practice cessation care.

1. Kotz D, Brown J, West R. 'Real-world' effectiveness of smoking cessation treatments: a population study. Addiction. 2014;109(3):491-499
   https://pubmed.ncbi.nlm.nih.gov/24372901/

2. Reference for GPs (note not AAH specific):
   Keto, J., Jokelainen, J, Timonen, M., et al. Physicians discuss the risks of smoking with their patients, but seldom offer practical cessation support. Substance Abuse Treatment, Prevention, and Policy. 2015;10(43):1-7 https://pubmed.ncbi.nlm.nih.gov/26525302/

3. [Quit unpublished data]

4. Danziger, Levav, J., & Avnaim-Pesso, L. (2011). Extraneous factors in judicial decisions. Proceedings of the National Academy of Sciences - PNAS, 108(17), 6889–6892. https://doi.org/10.1073/pnas.1018033108

   i. Forced choice questions force respondents to choose between one of two statements with no option to skip or opt out of the question. This allows us to assess the strength of opposing frames relative to each other.

   ii. Split sample questions split the sample into two even groups and present each with different versions of the question. These questions are used to assess the impact of using different words or frames on responses.

5. [Quit unpublished data]

6. Crompton, Tom (2010) Common Cause: The Case for Working With Our Cultural Values.
   https://www.researchgate.net/publication/277002308_Common_Cause_The_Case_for_Working_With_Our_Cultural_Values

7. Ibid

8. Lakoff, George & Johnson, Mark (1980) Metaphors we life by. Chicago University Press

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