

Non-cigarette tobacco cessation support in England: current provision, confidence, and barriers identified in a cross-sectional survey of healthcare professionals involved in smoking cessation support

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Abstract

Introduction: While cigarette smoking remains the dominant form of tobacco use in England, a range of other tobacco products are also used. Evidence on demand for non-cigarette tobacco cessation support—and on providers' preparedness and barriers to offering such support—remains limited.

Methods: We conducted a cross-sectional online survey of professionals involved in smoking cessation support in England ($n = 96$). For each specific non-cigarette tobacco product (cigars, cigarillos, shisha, pipes, bidis, chewing tobacco, dry snuff, moist snuff/dip, and heated tobacco), the survey assessed awareness, perceived harms, demand for cessation support, interventions offered, training and confidence, and perceived barriers to providing support.

Results: Awareness was universal for cigars, pipes, and shisha; high for chewing tobacco (87.5%), heated tobacco (77.1%), and cigarillos (71.9%); and lower for dry snuff (56.3%), bidis (33.3%), and moist snuff/dip (26.0%). Client demand for cessation support was low: 20.8% of participants reported requests at least monthly for cigars and $\leq 13.5\%$ for other products. Support was mainly behavioral and nicotine replacement therapy-based, with few ($<25\%$) offering other pharmacotherapies. Most participants who offered support used the same approach as for cigarettes ($>90\%$ across products), with few having received product-specific training (2.1%–19.8% of all participants). The main barriers included perceived lack of demand (46.9%), training (44.8%), and knowledge (43.8%); open-ended responses also emphasized that commissioning constraints excluded non-cigarette products.

Conclusions: Healthcare professionals in England report limited demand for cessation support for non-cigarette tobacco products, which may partly reflect service reach and commissioning constraints rather than lack of need. Few report receiving product-specific training; most apply standard cigarette cessation approaches or are not commissioned to provide support.

Implications: Healthcare professionals involved in smoking cessation support in England often lack the training, knowledge, and funding to support people to quit non-cigarette tobacco. Including these products in service plans and commissioning would enable them to give proper support.

Keywords non-cigarette tobacco, cigars, shisha, chewing tobacco, smokeless tobacco, heated tobacco, cessation support, stop smoking services, harm perceptions

Received: December 9, 2025. Revised: February 13, 2026. Accepted: March 17, 2026

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Introduction

While cigarette smoking remains the most common form of tobacco use in England,¹ a range of other smoked and smokeless tobacco products are also used.² These products differ substantially in form, consumption patterns, nicotine delivery, and health risks—ranging from combustible products with high toxicant exposure to non-combustible options with lower but still significant risks.^{3–7} Importantly, all non-cigarette tobacco products remain more harmful than abstaining from tobacco use entirely.^{3–7} Yet evidence on the demand for cessation support for these products—and on healthcare professionals' preparedness and perceived barriers to offering such support—remains limited. Existing tobacco-dependence treatment systems, including local-authority funded stop smoking services which are widely available in England and free at the point of access, were developed primarily to support cigarette cessation, raising questions about their capacity to meet changing patterns of tobacco use and dependence.

Recent evidence suggests that non-cigarette tobacco use is an important and evolving component of England's tobacco landscape. Approximately 3.7% of adults—around 1.7 million people—report currently using at least one non-cigarette tobacco product, with cigars and shisha currently the most commonly used.² Use is socially patterned and often shaped by cultural norms: for example, shisha is more frequently used within Middle Eastern communities,^{8–10} and bidis and chewing tobacco have established use among South Asian populations.^{11–15} Recent population data show that cigar, cigarillo, and pipe use is more common among men and those who also smoke cigarettes, whereas shisha use is concentrated among younger adults, minority ethnic communities, and people who vape.² While smokeless tobacco is disproportionately used by people who also smoke tobacco, some people only use smokeless products.²

Evidence suggests non-cigarette tobacco use in England has grown in recent years. According to the Smoking Toolkit Study, the proportion of adults who do not smoke cigarettes at all but smoke some other form of tobacco increased from 0.36% in 2013 to 1.8% in 2023 (~772 800 people), with the steepest increases occurring among young adults since 2020.¹⁶ Similar patterns are evident among youth. According to the ITC Youth Tobacco and Vaping Survey, the prevalence of any non-cigarette tobacco use among 16–19-year-olds in England increased from 7.4% in 2017 to 11.6% in 2024, in contrast to declining use in Canada and the United States over the same period.¹⁷ Much of this rise was driven by increasing cigarillo, cigar, and smokeless tobacco use.¹⁷ These trends are consistent with HM Revenue and Customs data showing that UK cigar sales increased from £73 million in 2019 to £165 million in 2024, with clearances figures following a similar pattern.¹⁸

Together, these findings show that non-cigarette tobacco is now used by substantial numbers of adults and youth in England, yet current cessation support systems were designed for cigarettes.¹⁹ Guidelines recommend that healthcare professionals routinely assess smokeless tobacco use, advise users on health risks, and offer or refer for cessation support.¹⁴ However, in practice, these recommendations may not be consistently implemented, and some healthcare professionals who provide smoking cessation support may have limited training, confidence, or resources to support users of smokeless or other non-cigarette tobacco products. It therefore remains unclear whether existing services

can adequately meet the needs of people using alternative tobacco products. This study addresses these gaps by examining healthcare professionals' awareness, confidence, training, and current practices related to non-cigarette tobacco cessation across England. Specifically, the study aimed to address the following research questions:

1. Which non-cigarette tobacco products do healthcare professionals involved in smoking cessation support encounter people seeking support to quit?
2. How confident are they in supporting people to stop using these products?
3. Have they received any training in this?
4. What support do they currently offer?
5. What are the main barriers to offering support?

Methods

Design and sample

Data were collected via a cross-sectional online survey using the REDCap online survey platform between June 25 and August 7, 2024. Eligible participants were healthcare professionals aged ≥18 years, based in England, and involved in providing cessation support (eg, stop smoking service practitioners and advisors in primary care and local authority-commissioned services). Recruitment occurred via emails targeting stop smoking services (distributed by research team members, the National Centre for Smoking Cessation and Training [NCSCT], and other tobacco control contacts) and social media advertisements (LinkedIn). Participants could optionally provide contact details to enter a prize draw for one of six £50 vouchers.

A total of 132 people responded, of whom 96 (72.2%) were eligible for inclusion and completed the survey, forming the analytic sample (of those excluded, one was not based in England and the remainder did not complete the survey, with most dropping out before completing the initial section assessing participant characteristics). All participants were screened for implausibly fast response times and duplicate email addresses to identify potential automated responses; no evidence of such issues was found. Ethical approval was obtained from the UCL Research Ethics Committee (ID 0780); all participants provided written informed consent before completing the survey.

Measures

Data were collected using a structured questionnaire co-developed with patient and public involvement representatives and tobacco cessation experts. The questionnaire items are provided in full in [Supplementary File 1](#). The questionnaire captured four main domains:

1. Participant characteristics, including job role, workplace setting, region, years of experience, and service focus.
2. Awareness and perceptions of non-cigarette tobacco products. Participants were asked about nine products—cigars, cigarillos, pipes, shisha, heated tobacco, chewing tobacco, bidis, dry snuff, and moist snuff/dip. Visual examples and brief descriptions accompanied each product to facilitate

accurate identification. For each product participants were aware of, they were asked how harmful they perceived the product to be relative to cigarettes and whether the product causes cancer.

3. Confidence, training, and support provision. For each product participants were aware of, the questionnaire assessed whether they had received product-specific training, their confidence in providing cessation support, whether their service offered support for that product, and perceived service demand. Participants also indicated the types of interventions provided, including behavioral support, nicotine replacement therapy (NRT), varenicline, cytisine, bupropion, e-cigarettes, nicotine pouches, referral to other support, or other interventions. Open-text responses captured types of training received and ways in which they made adaptations relative to cigarette cessation support.
4. Barriers and resource needs. All participants were asked to select from a list of potential barriers to providing support for non-cigarette tobacco cessation. Open-text responses captured other barriers to supporting cessation and desired resources to improve support provision.

Statistical analysis

All analyses were conducted using SPSS version 29. The analyses were not pre-registered and should be considered exploratory.

Participant characteristics were summarized using frequencies and percentages for categorical variables and medians and interquartile ranges for continuous variables. Responses related to non-cigarette tobacco cessation service demand, beliefs about harms and health risks, training, confidence, provision of support, and differences between smoking and non-cigarette tobacco cessation approaches were summarized using frequencies and proportions. Open-ended responses regarding training received, types of support offered, differences in support, barriers, and resources were coded inductively using descriptive content analysis to identify recurring ideas, which were summarized narratively. Raw open-ended responses are provided in [Supplementary File 2](#).

Results

Sample characteristics

We analyzed responses from 96 participants involved in providing smoking cessation support, representing all regions of England ([Table 1](#)). The majority (88.5%; $n = 85$) were specialist stop smoking or tobacco dependence advisors, with the remainder including a general practitioner and professionals in management, coordination, clinical, or pharmacy roles. Over half of participants (56.3%) worked in community settings, and 42.7% delivered services targeting specific populations, most commonly pregnant individuals, people with mental health conditions, ethnic minority groups, young people, and those living in deprived areas. Additional groups supported included individuals with learning disabilities, autism, and people with substance dependencies and people experiencing homelessness. Most services (61.5%) had eligibility criteria for access, such as being a current smoker (rather than exclusively vaping), meeting minimum age thresholds (usually 12 or 18 years), residing, working, or being registered with a general practitioner (GP) in the service area, or belonging to a

priority group (eg, pregnant or postnatal clients, inpatients, or people with mental health conditions). Participants reported a median of 4 years' experience in smoking cessation support (range <1–26 years). Most (76.0%) indicated that clients sought support for smoking cessation at least daily, and for the majority (67.7%), the typical duration of smoking cessation support offered to clients was between 9 and 12 weeks.

Non-cigarette tobacco product awareness, perceived harm, and health risks

[Table 2](#) summarizes awareness and perceptions of non-cigarette tobacco products. Awareness was universal for cigars, shisha, and pipes (all 100%), and remained high for chewing tobacco (87.5%), heated tobacco (77.1%), and cigarillos (71.9%). In contrast, awareness was lower for dry snuff (56.3%), with fewer than half of participants aware of bidis (33.3%) or moist snuff/dip (26.0%).

Among participants who were aware of each product, perceived harm compared with cigarettes varied across products. Of the smoked products, most participants viewed cigars, cigarillos, pipes, and bidis as about as harmful as cigarettes (54.2%–67.7%). Perceptions of shisha were more uncertain, with a smaller proportion (41.7%) rating it as about as harmful as cigarettes. For the smokeless products, perceived harm was generally lower than for smoked products, with fewer participants perceiving them as equally harmful: chewing tobacco (36.9%), dry snuff (27.8%), moist snuff/dip (40.0%), and heated tobacco (36.5%). Very few participants considered any product to be not harmful at all.

Beliefs about cancer risk followed a similar pattern. For smoked products, almost all participants believed cigars (100%), cigarillos (98.6%), bidis (96.9%), and pipes (96.9%) cause cancer, with a slightly lower proportion for shisha (84.4%). For smokeless products, endorsement was generally lower: while almost all participants believed chewing tobacco (92.9%) causes cancer, fewer believed this for heated tobacco (75.7%), dry snuff (66.7%) or moist snuff/dip (72.0%). Uncertainty about cancer risk was common for these latter two products (29.6% and 16.0%, respectively).

Demand for and provision of non-cigarette tobacco cessation support

[Table 3](#) presents findings on demand for and provision of cessation support, among all participants surveyed (those not aware of the product were treated as neither seeing clients seeking support, nor offering support, for product cessation). Across all products, few participants reported clients seeking cessation support frequently. Requests were most common for cigars (at least monthly: 20.8%; at least yearly: 50.0%), heated tobacco (13.5%; 31.1%), and shisha (11.5%; 34.4%) and least common for moist snuff/dip (1.0%; 2.1%) and dry snuff (0%; 2.1%).

Provision of support for each product generally reflected patterns of demand, with participants more likely to offer support for smoked than smokeless products. Most participants reported offering cessation support for cigars (82.3%), with moderate levels for pipes (68.8%), cigarillos (55.2%), and shisha (54.2%). Support was less common for chewing tobacco (40.6%) and heated tobacco (37.5%), and rare for bidis (22.9%), dry snuff (11.5%), and moist snuff/dip (9.4%).

Behavioral support and NRT were the most commonly reported interventions across all products, with particularly high rates of

Table 1 Sample characteristics.

Characteristic	% (n) ^a
Professional role	
Stop smoking/tobacco dependency advisor	88.5 (85)
Service manager/lead	5.2 (5)
Coordinator/advisor in local authority public health team	2.1 (2)
Clinical staff	2.1 (2)
General practitioner	1.0 (1)
Pharmacy support staff	1.0 (1)
Primary workplace setting	
Community	56.3 (54)
Hospital—inpatient	20.8 (20)
Hospital—outpatient	4.2 (4)
Primary care	2.1 (2)
Remote (eg, online, app, telephone)	15.6 (15)
Other (eg, multiple settings)	3.1 (3)
Service focuses on a specific population	42.7 (41)
Service has eligibility criteria for cessation support	61.5 (59)
How often clients approach service for smoking cessation support	
Daily	76.0 (73)
Less than daily but at least weekly	17.7 (17)
Less than weekly but at least monthly	6.3 (6)
Typical duration of support provided	
4–8 weeks	6.3 (6)
9–12 weeks	67.7 (65)
>12 weeks	26.0 (25)
Region of England	
North East	9.4 (9)
North West	7.3 (7)
Yorkshire and the Humber	5.2 (5)
West Midlands	17.7 (17)
East Midlands	25.0 (24)
East of England	3.1 (3)
London	8.3 (8)
South East	11.5 (11)
South West	2.1 (2)
All of England	10.4 (10)
Ethnic group	
White	79.2 (76)
Asian	16.7 (16)
Black	4.2 (4)
How long provided smoking cessation support (years), median (IQR); min-max	4 (8); <1–26

^aUnless otherwise specified. IQR, interquartile range. Min, minimum. Max, maximum.

provision for cigars (78.1% and 82.3%, respectively) and pipes (66.7% for both). Advice or provision of e-cigarettes was also reported by some (eg, 52.1% and 51.0% for cigars, respectively). Pharmacotherapies such as varenicline, cytisine, and bupropion

were much less frequently offered (<25% across all products). Very few participants offered advice on nicotine pouches (3.1%–11.5% across products) or referrals to other support (3.1%–14.6%).

Table 2 Non-cigarette tobacco product awareness, perceived harm, and health risks.

Measure	% (n)								
	Cigars	Cigarillos	Shisha	Pipes	Bidis	Chewing tobacco	Dry snuff	Moist snuff/dip	Heated tobacco
Aware of product^a									
Yes	100 (96)	71.9 (69)	100 (96)	100 (96)	33.3 (32)	87.5 (84)	56.3 (54)	26.0 (25)	77.1 (74)
No	0 (0)	25.0 (24)	0 (0)	0 (0)	65.6 (63)	12.5 (12)	42.7 (41)	70.8 (68)	20.8 (20)
Don't know	0 (0)	3.1 (3)	0 (0)	0 (0)	1.0 (1)	0 (0)	1.0 (1)	3.1 (3)	2.1 (2)
Perceived harm compared with cigarettes^b									
Not harmful at all	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	1.4 (1)
A lot less harmful	0 (0)	0 (0)	3.1 (3)	0 (0)	0 (0)	4.8 (4)	5.6 (3)	4.0 (1)	4.1 (3)
A little less harmful	2.1 (2)	4.3 (3)	12.5 (12)	4.2 (4)	6.3 (2)	15.5 (13)	35.2 (19)	32.0 (8)	48.6 (36)
About the same	54.2 (52)	59.4 (41)	41.7 (40)	67.7 (65)	62.5 (20)	36.9 (31)	27.8 (15)	40.0 (10)	36.5 (27)
A little more harmful	18.8 (18)	21.7 (15)	11.5 (11)	18.8 (18)	6.3 (2)	17.9 (15)	9.3 (5)	8.0 (2)	5.4 (4)
A lot more harmful	25.0 (24)	8.7 (6)	25.0 (24)	8.3 (8)	25.0 (8)	19.0 (16)	3.7 (2)	4.0 (1)	0 (0)
Don't know	0 (0)	5.8 (4)	6.3 (6)	1.0 (1)	0 (0)	6.0 (5)	18.5 (10)	12.0 (3)	4.1 (3)
Believe that product causes cancer^b									
Yes	100 (96)	98.6 (68)	84.4 (81)	96.9 (93)	96.9 (31)	92.9 (78)	66.7 (36)	72.0 (18)	75.7 (56)
No	0 (0)	0 (0)	2.1 (2)	0 (0)	0 (0)	1.2 (1)	3.7 (2)	12.0 (3)	4.1 (3)
Don't know	0 (0)	1.4 (1)	13.5 (13)	3.1 (3)	3.1 (1)	6.0 (5)	29.6 (16)	16.0 (4)	20.3 (15)

^a Among all participants ($n = 96$). ^b Among participants aware of the product.

Differentiated approaches to non-cigarette tobacco cessation support

Most participants who provided support indicated that their approach to non-cigarette product cessation did not differ from support for stopping smoking cigarettes, particularly for cigars, cigarillos, pipes, and bidis (all >90%; Table 3). However, open-ended responses highlighted several ways in which support was tailored to specific products (Supplementary File 2).

Adaptations to behavioral support were the most commonly cited modifications in the open-ended responses. Participants emphasized the importance of understanding unique usage patterns and product-specific barriers, including social or cultural factors. One participant noted: "We'd discuss how and why they use cigars and the barriers to quitting. The association with cigars and it not being tobacco and the use in celebrations etc." Similar considerations were reported for cigarillos, pipes, and shisha, with attention to frequency, context, and social patterns: "Normally these people are not doing it every day but occasionally and socially," and "we would talk about when, how and how often. Whether there is a social aspect, e.g., at shisha café, etc."

Treatment limitations were also frequently noted, reflecting service restrictions and commissioning frameworks. For smokeless products such as chewing tobacco, dry snuff, and moist snuff/dip, many participants reported that support was restricted to behavioral approaches, with limited access to pharmacotherapy. One participant explained: "We as a stop smoking service are NOT commissioned to provide support for chewing tobacco users, only combustible tobacco. However, due to the population demand, we do offer behavioral support and NRT for these service users. The NRT gum is the most preferred product of service user choice

as it replicates the chewing tobacco sensation." Restrictions on treatments for shisha were also reported: "We do not offer NRT/Vapes for shisha use. We would offer behavioural support for users."

Product-specific harm and risk considerations were incorporated into discussions with clients. Participants highlighted differences in carbon monoxide (CO) exposure, tar, and oral versus respiratory cancers. For example, one participant described providing "relevant info on dangers of shisha," while another noted that support for cigarillos was "similar but [had] more emphasis on CO gas and tar."

Training and confidence in providing non-cigarette tobacco cessation support

Table 4 summarizes training and confidence among all participants. Overall, relatively few participants reported having received product-specific cessation training. Training was most common for shisha (19.8%), followed by cigars (17.7%), pipes (16.7%), heated tobacco (14.6%), and chewing tobacco (13.5%). For all other products, receipt of training was less common (<10%).

Among those who had received training, the NCST was the most frequently cited source in open-ended responses, followed by local or service-specific programs (Supplementary File 2). For cigars and cigarillos, participants often reported that the training they received was the same as for cigarettes, indicating a largely generic rather than product-specific focus. One participant explained: "I apply the same training as I received to help people quit cigarettes. I don't make a distinction between cigarettes and cigars; they both contain tobacco and cause nicotine addiction." For less commonly used products—such as heated tobacco,

Table 3 Demand for and provision of non-cigarette tobacco cessation support.

Measure	% (n)								
	Cigars	Cigarillos	Shisha	Pipes	Bidis	Chewing tobacco	Dry snuff	Moist snuff/dip	Heated tobacco
Frequency of clients seeking support for product cessation^a									
At least weekly	6.3 (6)	2.1 (2)	3.1 (3)	0 (0)	1.0 (1)	0 (0)	0 (0)	0 (0)	0 (0)
At least monthly	20.8 (20)	9.4 (9)	11.5 (11)	4.2 (4)	5.2 (5)	6.3 (6)	0 (0)	1.0 (1)	13.5 (13)
At least yearly	50.0 (48)	29.2 (28)	34.4 (33)	25.0 (24)	9.4 (9)	19.8 (19)	2.1 (2)	2.1 (2)	31.3 (30)
Offer support for product cessation^a									
Yes	82.3 (79)	55.2 (53)	54.2 (52)	68.8 (66)	22.9 (22)	40.6 (39)	11.5 (11)	9.4 (9)	37.5 (36)
No	11.5 (11)	36.5 (35)	25.0 (24)	16.7 (16)	75.0 (72)	37.5 (36)	63.5 (61)	84.4 (81)	46.9 (45)
Don't know	6.3 (6)	8.3 (8)	20.8 (20)	14.6 (14)	2.1 (2)	21.9 (21)	25.0 (24)	6.3 (6)	15.6 (15)
Types of support offered for product cessation^{a,b}									
Behavioral support	78.1 (75)	52.1 (50)	50.0 (48)	66.7 (64)	22.9 (22)	39.6 (38)	11.5 (11)	9.4 (9)	37.5 (36)
Nicotine replacement therapy	82.3 (79)	55.2 (53)	52.1 (50)	66.7 (64)	20.8 (20)	38.5 (37)	9.4 (9)	7.3 (7)	35.4 (34)
Varenicline	25.0 (24)	14.6 (14)	14.6 (14)	17.7 (17)	6.3 (6)	9.4 (9)	3.1 (3)	1.0 (1)	10.4 (10)
Cytisine	19.8 (19)	12.5 (12)	9.4 (9)	12.5 (12)	5.2 (5)	8.3 (8)	3.1 (3)	1.0 (1)	10.4 (10)
Bupropion	19.8 (19)	15.6 (15)	8.3 (8)	16.7 (16)	6.3 (6)	7.3 (7)	4.2 (4)	2.1 (2)	9.4 (9)
Provision of e-cigarettes	51.0 (49)	38.5 (37)	33.3 (32)	43.8 (42)	15.6 (15)	25.0 (24)	8.3 (8)	4.2 (4)	27.1 (26)
Advice on e-cigarettes	52.1 (50)	35.4 (34)	31.3 (30)	45.8 (44)	14.6 (14)	21.9 (21)	8.3 (8)	5.2 (5)	26.0 (25)
Advice on nicotine pouches	11.5 (11)	9.4 (9)	9.4 (9)	11.5 (11)	5.2 (5)	9.4 (9)	4.2 (4)	3.1 (3)	7.3 (7)
Referral to other support	14.6 (14)	7.3 (7)	5.2 (5)	10.4 (10)	6.3 (6)	6.3 (6)	3.1 (3)	3.1 (3)	6.3 (6)
Other	2.1 (2)	1.0 (1)	0 (0)	1.0 (1)	1.0 (1)	0 (0)	0 (0)	0 (0)	0 (0)
None of these	17.7 (17)	44.8 (43)	45.8 (44)	31.3 (30)	77.1 (74)	59.4 (57)	88.5 (85)	90.6 (87)	62.5 (60)
Support differs from cigarette cessation^c									
Yes	2.5 (2)	3.8 (2)	5.8 (3)	3.0 (2)	0 (0)	12.8 (5)	18.2 (2)	11.1 (1)	5.6 (2)
No	93.7 (74)	96.2 (51)	84.6 (44)	93.9 (62)	90.9 (20)	76.9 (30)	81.8 (9)	88.9 (8)	94.4 (34)
Don't know	3.8 (3)	0 (0)	9.6 (5)	3.0 (2)	9.1 (2)	10.3 (4)	0 (0)	0 (0)	0 (0)

^a Among all participants ($n = 96$). Those not aware of the product were treated as neither seeing clients seeking support, nor offering support, for product cessation.

^b Not mutually exclusive; participants were asked to select all that applied. ^c Among participants who reported providing support for product cessation; valid percentages shown.

bidis, and dry snuff—some participants described receiving only basic information on what the products are and how they work. In contrast, training for culturally specific products, including shisha, bidis, and chewing tobacco, sometimes incorporated a demographic or cultural focus, reflecting their higher prevalence within certain communities. One participant highlighted this approach, stating: “we had a workshop on different smoking habits and products that were more common in some Asian communities,” while another described shisha training as including “information on use amongst different demographic groups, how it's used and [its] impact.”

Among participants who were aware of each product, confidence in providing cessation support varied substantially. Overall, participants reported higher confidence for smoked products than for smokeless products. Confidence was highest for cigars, cigarillos, and bidis (around 44% very or extremely confident) but lower for pipes (26.0%) and shisha (19.8%). Among smokeless products, confidence was highest for heated tobacco (25.7%), followed by chewing tobacco (15.5%), moist snuff/dip (8.0%), and dry snuff (3.7%).

Barriers to providing non-cigarette tobacco cessation support

Table 5 summarizes reported barriers. The most frequently endorsed barriers to providing cessation support were lack of demand (46.9%), lack of training (44.8%), and lack of knowledge (43.8%). Other barriers cited by a notable minority of participants included lack of confidence (20.8%), language barriers (19.8%), and lack of evidence-based treatment (18.8%). Fewer participants identified lack of motivation or low priority (15.6%) and time constraints (14.6%), accessibility barriers (8.3%) or other reasons (15.6%), while 10.4% reported no barriers.

Open-ended responses provided further insight into structural and systemic challenges represented within the “other” category (Supplementary File 2). Funding and commissioning limitations emerged as the most prominent issue, mentioned by nine of the 15 participants who reported “other” barriers, with many noting that their services were not resourced or authorized to provide support for non-cigarette tobacco products. Some explicitly stated that “it's not part of the funded programme” or “not in the

Table 4 Training and confidence.

Measure	% (n)								
	Cigars	Cigarillos	Shisha	Pipes	Bidis	Chewing tobacco	Dry snuff	Moist snuff/dip	Heated tobacco
Received training in product cessation^a									
Yes	17.7 (17)	9.4 (9)	19.8 (19)	16.7 (16)	8.3 (8)	13.5 (13)	4.2 (4)	2.1 (2)	14.6 (14)
No	74.0 (71)	84.4 (81)	75.0 (72)	75.0 (72)	89.6 (86)	77.1 (74)	92.7 (89)	94.8 (91)	83.3 (80)
Don't know	8.3 (8)	6.3 (6)	5.2 (5)	8.3 (8)	2.1 (2)	9.4 (9)	3.1 (3)	3.1 (3)	2.1 (2)
Confidence in providing support for product cessation^b									
Not at all confident	1.0 (1)	1.4 (1)	8.3 (8)	1.0 (1)	0 (0)	14.3 (12)	33.3 (18)	24.0 (6)	4.1 (3)
Not very confident	8.3 (8)	5.8 (4)	30.2 (29)	22.9 (22)	28.1 (9)	34.5 (29)	35.2 (19)	32.0 (8)	23.0 (17)
Somewhat confident	46.9 (45)	47.8 (33)	40.6 (39)	50.0 (48)	28.1 (9)	32.1 (27)	25.9 (14)	36.0 (9)	41.9 (31)
Very confident	38.5 (37)	37.7 (26)	17.7 (17)	22.9 (22)	37.5 (12)	13.1 (11)	3.7 (2)	8.0 (2)	23.0 (17)
Extremely confident	5.2 (5)	7.2 (5)	2.1 (2)	3.1 (3)	6.3 (2)	2.4 (2)	0 (0)	0 (0)	2.7 (2)
Don't know	0 (0)	0 (0)	1.0 (1)	0 (0)	0 (0)	3.6 (3)	1.9 (1)	0 (0)	5.4 (4)

^aAmong all participants ($n=96$). Those not aware of the product treated as not having received training. ^bAmong participants aware of the product (n per product shown in Table 1).

Table 5 Barriers to providing non-cigarette tobacco cessation support.

Barrier	% (n)
Lack of demand	46.9 (45)
Lack of training	44.8 (43)
Lack of knowledge	43.8 (42)
Lack of confidence	20.8 (20)
Language barriers	19.8 (19)
Lack of evidence-based treatment	18.8 (18)
Lack of motivation/low priority	15.6 (15)
Lack of time	14.6 (14)
Accessibility barriers	8.3 (8)
Other	15.6 (15)
None	10.4 (10)

Among all participants ($n=96$); participants were asked to select all that applied.

stop smoking service specification.” A few participants also highlighted equity and access challenges, including low literacy among clients and difficulties reaching specific demographic groups—particularly older South Asian men—due to perceived cultural or language barriers.

Training and resource needs

When asked about helpful training and resources, participants provided detailed open-ended feedback (Supplementary File 2). Training and education needs dominated responses, with many calling for bespoke, product-specific training on non-cigarette tobacco products—covering their composition, health risks, and cessation strategies. Participants repeatedly described gaps in existing NCSCT materials and requested additional or dedicated NCSCT modules focused on non-cigarette tobacco products, noting the need for “training and understanding of the product

and how it is used” and asking whether “NRT and medication can be used to help quit” these products. Product knowledge gaps—such as unfamiliarity with how products were used, nicotine content, and harm profiles of heated tobacco, snuff, and chewing tobacco—were frequently highlighted, alongside uncertainty about how cessation approaches might differ from conventional cigarette support.

Participants also stressed the importance of accessible formats and delivery methods, with most favoring online modules, e-learning, and webinars for flexibility, while a smaller number preferred interactive face-to-face workshops, case studies, and peer reflection sessions. Practical, evidence-based resources were requested, including downloadable patient information leaflets, visual aids, and QR code-linked materials explaining product risks and available cessation options. One participant suggested “specific downloadable leaflets explaining risks of using, and examples of support options.”

Finally, several participants highlighted cultural and demographic considerations, particularly the need for multilingual materials and culturally competent services to reach groups where non-cigarette tobacco use is more prevalent. One comment noted the importance of “more multilingual specialists within the team.”

Discussion

This survey of healthcare professionals involved in providing smoking cessation support in England examined awareness, confidence, training, and current practices regarding cessation support for non-cigarette tobacco products. Overall, our findings indicate that current service provision remains predominantly cigarette-focused, with limited preparedness to support users of alternative tobacco products. Awareness of more visible combustible products, such as cigars and shisha, was high; however, professional confidence and training lagged considerably, particularly for culturally specific and less visible products such as

bidis and smokeless tobacco. Notably, shisha was often perceived by participants as less harmful than other combustible products, reflecting broader misconceptions about its risks despite evidence of significant toxicant exposure.²⁰ These gaps signal a need for targeted workforce development, commissioning reform, and improved guidance to ensure cessation systems remain responsive to changing patterns of tobacco use.

A striking pattern was the disconnect between awareness, training, and confidence. While cigars, pipes, and shisha were almost universally recognized, fewer than one in five respondents reported receiving product-specific training, and training rates for bidis and moist snuff/dip were minimal. Despite this, over 40% felt very or extremely confident in supporting cigar cessation, with qualitative responses suggesting confidence often stemmed from the assumption that cigarette-based strategies generalize to all tobacco products rather than from specialist expertise. Qualitative responses described some attempts at product-specific adjustments (eg, emphasizing oral cancer risk for smokeless tobacco, addressing social aspects of shisha), but also highlighted uncertainty—particularly for emerging products such as heated tobacco (as has been documented in other countries²¹). Advisors also noted that some non-cigarette products are used non-daily and in social or cultural contexts. Although not explicitly stated, these patterns may present additional challenges for cessation support, as standard training tends to focus on daily cigarette use and framing tobacco use as inherently negative, rather than navigating situations in which use is culturally significant or socially normative.

These findings reflect the historical orientation of England's tobacco control infrastructure. Stop smoking services were developed primarily to support cigarette cessation, offering behavioral support alongside pharmacotherapies such as NRT, varenicline, and bupropion.²² While this model is effective for cigarettes,²³ and there is some evidence that certain treatments can help people to quit smokeless tobacco,²⁴ the support offered by services may not adequately address the distinct use patterns and nicotine delivery profiles seen with non-cigarette products. For example, shisha and some smokeless tobacco products are often embedded in social or cultural contexts,^{8–15} while cigars and pipes involve different nicotine delivery profiles and patterns of use compared with cigarettes.²⁵ Reliance on cigarette-based approaches in the absence of tailored evidence risks suboptimal outcomes and underscores the need for product-specific cessation strategies.

Equity considerations are central. Products disproportionately used by South Asian communities—such as bidis and certain smokeless tobacco products—had the lowest awareness, training, and reported support. In contrast, shisha, which is more prevalent,² highly visible, and more strongly associated with Middle Eastern communities in England,^{8–10} was more familiar to participants but still lacked consistent tailored support. Without tailored guidance and proactive outreach, the current system risks widening tobacco-related disparities for groups with higher use of culturally specific products.

Training needs were repeatedly emphasized. Participants requested product-specific education and practical resources, including modules on composition, health risks, patterns of dependence, and effective cessation strategies. Digital and modular delivery formats were preferred, aligned with workforce needs and NCSCT delivery models.²⁶ The emphasis on multilingual

materials reflects wider evidence that culturally tailored cessation resources can improve engagement among minority ethnic groups and users of culturally specific tobacco products.²⁷ Co-design with affected communities could help ensure that training resources and interventions are culturally appropriate, accepted by users, and aligned with their lived experiences.

Structural factors also constrained provision. Commissioning restrictions were widely reported, with services in some areas funded only for cigarette cessation, and in certain cases pharmacotherapies available only to cigarette smokers. In this context, limited practitioner knowledge of treatment options for non-cigarette tobacco products may reflect the absence of commissioned pathways, training opportunities, and clinical incentives, rather than individual knowledge deficits. These are barriers that are also reflected in qualitative work among health care professionals with experience in providing support for non-cigarette tobacco.²⁸

Nearly half of respondents cited low demand as a barrier, yet this may reflect limited awareness of services or trust among affected communities to use services rather than lack of need. Practitioner-reported demand may also partly reflect the relative prevalence of different non-cigarette products in the population. For example, products used by only a small proportion of tobacco users, such as bidis or certain smokeless tobacco types,² may generate fewer requests for support, even if individual users would benefit from intervention. Low observed demand should therefore not be interpreted as indicating a lack of population-level need. Explicit inclusion of non-cigarette products in commissioning frameworks, guidelines, and performance metrics will be essential to enable cessation service practitioners to apply new skills and resources in practice.

Inclusive and precise terminology is also important for both public health messaging and cessation service provision. Messaging that focuses only on “smoking” or “cigarettes” may not resonate with users of non-cigarette tobacco—particularly smokeless tobacco or waterpipe—leading to underreporting of tobacco use behaviors, misunderstanding of harms, and perceived or actual lack of cessation support. Likewise, practitioners may miss opportunities to provide support if routine assessments do not explicitly ask about non-cigarette tobacco products. Ensuring campaigns and service protocols explicitly encompass all forms of tobacco can help address gaps in awareness, perceived harms, and engagement with cessation support.²⁹

Findings should be interpreted in light of the practitioner-level nature of the sample. Most respondents were individual health-care professionals involved in smoking cessation support, rather than service managers or commissioners, and many had relatively limited time in role. This may have influenced reported awareness, confidence, and preparedness to support cessation for less commonly encountered non-cigarette tobacco products, particularly where services were not commissioned to provide such support. Importantly, practitioner-reported demand reflects what is observed within routine practice and may not fully capture service-level or population-level need. In particular, triage processes, commissioning arrangements, and organizational structures may shape which clients are seen by individual practitioners and which tobacco products are prioritized within services.

This study had several limitations. The convenience sample may over-represent healthcare professionals with greater interest in tobacco treatment. GPs (~1%) and pharmacists (0%) were

substantially under-represented, limiting generalizability to primary-care and pharmacy settings. Survey respondents do not represent services across the United Kingdom and were disproportionately based in the South East of England. We did not capture or compare the ethnicity or demographic profiles of local populations, which may influence demand for cessation support for products more commonly used in specific communities. Awareness was low for some products, so sample sizes were small for analyses limited to those aware of these products. The cross-sectional design captures a single time-point and self-report measures may be subject to recall or social desirability bias and reflects perceived rather than actual service provision. Nonetheless, the study highlights systemic gaps in training, commissioning, and readiness to support non-cigarette tobacco users.

In conclusion, non-cigarette tobacco use in England is diverse and evolving, yet cessation support remains largely modeled on cigarette smoking. High confidence in the absence of product-specific training, coupled with low preparedness for culturally prevalent products, risks compromising support quality, and exacerbating inequalities. Strengthening provision will require coordinated action: commissioning reforms, product-specific clinical guidance, training aligned with national guidelines, and co-designed resources reflecting diverse use patterns and dependence profiles.

Supplementary material

Supplementary material is available at *Nicotine & Tobacco Research* online.

Funding

This work was supported by Cancer Research UK (PICCTR-2024/100001). JB and SC are members of the Behavioral Research UK Leadership Hub which is supported by the Economic and Social Research Council (ES/Y001044/1). For the purpose of Open Access, the author has applied a CC BY public copyright license to any Author Accepted Manuscript version arising from this submission.

Declaration of interests

LS has received honoraria for talks, unrestricted research grants, and travel expenses to attend meetings and workshops from manufacturers of smoking cessation medications (Pfizer; J&J), and has acted as paid reviewer for grant awarding bodies and as a paid consultant for health care companies. All authors declare no financial links with tobacco companies, e-cigarette manufacturers, or their representatives.

Author contributions

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editing [equal]), Jamie Brown (Conceptualization [equal], Funding acquisition [supporting], Investigation [equal], Methodology [equal], Writing—review & editing [equal]), Harry Tattan-Birch (Conceptualization [equal], Funding acquisition [supporting], Investigation [equal], Methodology [equal], Writing—review & editing [equal]), Sharon Cox (Conceptualization [equal], Funding acquisition [supporting], Investigation [equal], Methodology [equal], Writing—review & editing [equal]), Masuma Mishu (Funding acquisition [supporting], Investigation [equal], Methodology [equal], Writing—review & editing [supporting]), David Hammond (Funding acquisition [supporting], Investigation [equal], Methodology [equal], Writing—review & editing [supporting]), and Sarah E. Jackson (Conceptualization [equal], Data curation [supporting], Formal analysis [equal], Funding acquisition [lead], Investigation [equal], Methodology [equal], Supervision [lead], Writing—original draft [equal], Writing—review & editing [equal])

Data availability

Data are available from the corresponding author on request.

Ethics approval

Ethical approval was granted by the UCL Research Ethics Committee (Approval No. 0780). Participants provided written informed consent.

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