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### The motivators and barriers to a smoke-free home among disadvantaged caregivers

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DOI:

[10.1093/ntr/ntr030](https://doi.org/10.1093/ntr/ntr030)

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*Document Version*

Peer reviewed version

*Citation for published version (Harvard):*

Jones, LL, Atkinson, O, Longman, J, Coleman, T, McNeill, A & Lewis, SA 2011, 'The motivators and barriers to a smoke-free home among disadvantaged caregivers: identifying the positive levers for change', *Nicotine & Tobacco Research*, vol. 13, no. 6, pp. 479-86. <https://doi.org/10.1093/ntr/ntr030>

[Link to publication on Research at Birmingham portal](#)

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**The motivators and barriers to a smoke-free home among disadvantaged caregivers: identifying the positive levers for change**

Journal:	<i>Nicotine &amp; Tobacco Research</i>
Manuscript ID:	NTR-2010-455.R1
Manuscript Type:	Original Investigation
Date Submitted by the Author:	n/a
Complete List of Authors:	Jones, Laura; University of Nottingham, UK Centre for Tobacco Control Studies, Division of Epidemiology and Public Health Atkinson, Olesya; University of Nottingham, Division of Primary Care Longman, Jo; University of Sydney, Northern Rivers University Department of Rural Health Coleman, Tim; University of Nottingham, Division of Primary Care; university of nottingham england, Division of Primary Care McNeill, Ann; University of Nottingham, UK Centre for Tobacco Control Studies, Division of Epidemiology and Public Health lewis, sarah; university of nottingham, epi and public health
Keywords:	Smoking caregivers, Disadvantage, Smoke-free homes, Children, Second hand smoke

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**The motivators and barriers to a smoke-free home among disadvantaged caregivers:  
identifying the positive levers for change.**

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**Running head:** Smoke-free homes: identifying levers for change

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**Key Words:** Smoking caregivers; Disadvantage; Smoke-free homes; Children; Second-hand-smoke

**Total word count (excluding abstract, references, acknowledgments, figures & table etc):**

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4575

**Abstract****Introduction:**

The aims of this study were to explore home smoking behaviours and the motivators and barriers to smoke-free homes, among a group of disadvantaged caregivers for young children, and to identify the positive levers that healthcare professionals can utilise when supporting smoking behaviour change.

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**Methods:**

In-depth qualitative interviews were conducted between July and September 2009, with 22 disadvantaged smoking caregivers, accessing Children's Centre Services in Nottingham, UK. Interviews were audio-recorded and transcribed verbatim. Data were coded and analysed thematically to identify emergent main and sub themes.

**Results:**

Caregivers had some general understanding of the dangers of second hand smoke, but their knowledge appeared incomplete and confused. All interviewees described rules around smoking in the home, however, these tended to be transient and fluid and unlikely to be effective. Caregivers were often living in difficult and complex circumstances and experienced significant barriers to creating a smoke-free home. The motivators for change were more strongly linked to house decor and smell, than children's health suggesting that visible evidence of the harm done by second hand smoke to children might help promote smoke-free homes.

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**Conclusions:**

Findings suggest that further tailored information on the effect of second hand smoke is required, but to instigate caregiver behaviour change, providing demonstrable evidence of

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1  
2 the impact that their smoking is having on their children's health is more likely to be  
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4 effective.  
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## 6 7 8 **Introduction** 9

10 Globally, 40% of children are regularly exposed to second hand smoke (SHS) (Oberg 2011).

11  
12 In the UK, around two million children are regularly exposed to SHS and close to half of all  
13 children live in households with at least one smoker. Exposure to SHS has been causally  
14 linked with a number of childhood morbidities including upper and lower respiratory tract  
15 infections, middle ear infections, sudden infant death syndrome, asthma and wheeze  
16 symptoms and bacterial meningitis (Cook & Strachan, 1999; Jones et al., 2011; Royal College  
17 of Physicians, 2010). Children are at greater risk from exposure to SHS compared to adults  
18 given their higher respiration rate (Willers, Skarping, Dalene, & Skerfving, 1995) and less  
19 well developed airways, lungs and immune system. A recent report by the Royal College of  
20 Physicians (2010) estimates that childhood cases of disease, related specifically to SHS  
21 exposure generates an additional 300 000 UK general practice consultations and 9500  
22 hospital admissions each year. Caregiver smoking in the home is therefore a common but  
23 preventable source of childhood morbidity.  
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39 The home is the primary source of SHS exposure in children (Ashley & Ferrence, 1998; Wipfli  
40 et al., 2008), and although exposure in England has declined markedly over the previous  
41 decade (Sims et al., 2010), 63% of children who live with one parent who smokes and 79%  
42 of children who live with both parents who smoke, are still regularly exposed to SHS in the  
43 home (Jarvis, Mindell, Gilmore, Feyerabend, & West, 2009). Smoking by caregivers (parents  
44 and other carers such as grandparents) and whether smoking is allowed in the home are the  
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2 two main determinants of a child's level of exposure to SHS (Jarvis, et al., 2009; Sims, et al.,  
3  
4 2010). Exposure is highest for the most deprived children because their caregivers are more  
5  
6 likely to smoke and smoke more heavily (Jarvis & Wardle, 2005; Sims, et al., 2010). In  
7  
8 addition, disadvantaged smokers are more likely to perceive smoking as a normative social  
9  
10 behaviour (Wallace-Bell, 2003), smoke in the presence of children (Johansson, Halling, &  
11  
12 Hermansson, 2003) and smoke in domestic settings such as in homes and cars (Bolte &  
13  
14 Fromme, 2009). In addition, lone parents, in particular lone mothers living in social  
15  
16 disadvantage, are more likely to smoke (Rahkonen, Laaksonen, & Karvonen, 2005), smoke  
17  
18 around their children and expose their children to SHS.

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21  
22 Children's exposure to SHS is therefore an ongoing and significant public health burden.  
23  
24 However, any measure to reduce or prevent smoking in the home has social and political  
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26 implications, in that it is difficult to implement, monitor, and evaluate behaviour change  
27  
28 within private residential settings (Gehrman & Hovell, 2003), as well as being particularly  
29  
30 difficult to enforce. The most reliable way to reduce SHS exposure in children would be to  
31  
32 encourage caregivers to quit smoking altogether. However, for those caregivers who cannot  
33  
34 or will not quit, the next best option is to promote homes that are completely smoke-free.  
35  
36 Nevertheless, there is evidence to suggest that some caregivers, particularly those who are  
37  
38 disadvantaged, may face significant barriers when trying to implement and maintain a SFH  
39  
40 for their children, given the substantial behaviour change that may be required (Blackburn  
41  
42 et al., 2003; Phillips, Amos, Ritchie, Cunningham-Burley, & Martin, 2007; Robinson, 2008;  
43  
44 Robinson & Kirkcaldy, 2007a, 2007b). ~~For some caregivers, in particular women, the ability~~  
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47 to initiate and maintain a smoke-free environment for their children competes with their  
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49 other caring and life responsibilities, which is further restricted by the physical environment  
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2 in which they live (Robinson & Kirkcaldy, 2007a, 2007b). The process of implementing and  
3 maintaining a smoke-free home for some women can involve the need for forceful  
4 negotiation with other members of the household and visitors, and the success of these  
5 negotiations relies heavily upon the personality traits of the caregivers making the request  
6 and those who are receiving it (Robinson, Ritchie, Amos, Greaves, & Cunningham-Burley,  
7 2011).

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16 Whilst these studies have provided a useful insight into attitudes and behaviours around  
17 smoking in the home, they have not explored in great detail how embedded smoking  
18 behaviours within households influence a caregiver's ability to effect change. Therefore, this  
19 study, which forms part of a larger piece of work developing a health care professional  
20 (HCP) intervention on SFH, explores in greater detail the barriers and motivators around  
21 achieving a SFH, among a very disadvantaged group of caregivers and builds on previous  
22 work by aiming to identify the positive levers for change that HCPs can utilise when  
23 supporting caregivers and their families in changing their current smoking behaviours.  
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### 33 Methods

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35 Given the sensitivity of discussing smoking around children, qualitative one to one  
36 interviews were chosen as the appropriate method of research to provide an empathetic  
37 and supportive environment in which caregivers could openly discuss their smoking  
38 behaviour. Participants were recruited from four (of 16) randomly selected Sure Start  
39 Children's Centres (CCs) across Nottingham City. Children's Centres are free to join and offer  
40 a range of free or subsidised activities and support services for low-income caregivers with  
41 children under five years of age. We chose to recruit via CCs as the caregiver smoking rate is  
42 known to be high in the demographic groups who access these services. Given that we were  
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Deleted: of the 16 Sure Start Children's Centres across Nottingham City, which

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1  
2 trying to recruit socio-economically disadvantaged smoking caregivers, often with a number  
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4 of young children to care for, it was anticipated that recruitment may be particularly difficult  
5  
6 (Parry, Bancroft, Gnich, & Amos, 2001). To help aid recruitment, each participant was  
7  
8 offered an inconvenience allowance in the form of a £15 retail voucher as compensation for  
9  
10 the time taken to participate and for having to arrange child care. To be eligible for  
11  
12 interview, participants needed to be over 16 years of age, a smoker, have at least one child  
13  
14 under the age of five years living with them the majority of the time, and currently or have  
15  
16 recently smoked inside the home.  
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19  
20 Twenty-two semi-structured one to one interviews were conducted between July and  
21  
22 September 2009. Of the 22 interviews, 16 were with mothers, one with a grandmother and  
23  
24 five with fathers, Of the 16 mothers and one grandmother that participated, eight were  
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26 married or living with a partner, one was divorced and eight were single; two of the mothers  
27  
28 were employed, five were housewives, nine were unemployed and one was retired. Of the  
29  
30 five fathers interviewed, four were married or living with partners and one was single; one  
31  
32 was employed and the remainder were unemployed. On average, there were two children  
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34 living in each household interviewed (range, one through six) and in 62% of the households  
35  
36 there were two or more adults smokers living in the home.  
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40 An interview guide was initially developed from the literature and subsequently through  
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42 discussions with HCPs working with smoking caregivers in Nottingham and within the  
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44 research team. Interviews took place in a private room at the CC where the caregiver was  
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46 accessing services and explored topics including knowledge of the risks of SHS, attitudes and  
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48 behaviour to smoking in the home, and the hypothetical motivators and barriers to creating  
49  
50 a SFH. A questionnaire was administered to each participant at the end of the interview to  
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ascertain basic demographic and smoking information. Ethical approval for this study was sort and gained from the University of Nottingham Medical School Ethics Committee (ref: A/5/2009).

### Analysis

Data analysis was ongoing throughout the period of data collection and regular discussions were held between the two interviewers (LLJ and OA) and within the research team. The interview topic guide was reviewed and revised following discussion and reflection by both interviewers as the study progressed, to ensure that newly emerging topics were incorporated into future interviews and to improve the relevance and importance of original topics. With participants' written consent, each interview was digitally audio-recorded and transcribed verbatim by an external specialist transcription company. Each transcript was carefully checked by for transcription errors to ensure data quality. NVivo software version

8 (QSR International Pty Ltd, Australia) was used to facilitate the analysis of the transcripts.

Data were analysed thematically, generating an open coding framework, utilising the six phase process outlined by Braun and Clarke (2006). OA and LLJ independently reviewed each transcript and initial ideas were noted that identified preliminary codes. These codes were then grouped into potentially relevant themes and discussed between the two researchers conducting the analysis and with the wider research team. Further analysis clarified the specific nature of each theme leading to the development of names and descriptions. Following agreement of the themes identified, extracts were taken from the transcripts to exemplify each theme in order to reflect the experiences of each of the participants.

### Findings

#### *Knowledge, attitudes and beliefs*

**Deleted:** In this paper, where appropriate, the interviewer's voice will appear as "INT" throughout and the contribution of the interviewee will be identified in italics on a new line of text. Analysis of the transcripts was conducted using

**Deleted:** LLJ and OA independently developed an open coding framework, which was checked for agreement and refined as appropriate, before being discussed within the research team. All data were then coded and analysed thematically to identify emergent main and sub themes, and to explore data trends and patterns.¶

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2 Caregivers were asked to discuss their knowledge of the harms of SHS both to their own  
3 health and that of their children. All of the caregivers were aware, to some extent, of the  
4 risk of smoking, however, only a small number of caregivers could link SHS exposure to  
5 specific diseases or chronic conditions in children, the most commonly identified being  
6 asthma (Box 1, quote a). Several caregivers were confused and frustrated by their lack of  
7 knowledge and sought answers from the researcher in an attempt to clarify their own  
8 knowledge, and stated that external sources of information such as from HCPs and mass  
9 media campaigns lacked clarity and did not offer links between SHS exposure and specific  
10 childhood diseases (Box 1, quotes b-c). When probed, some caregivers appeared unwilling  
11 to acknowledge that SHS exposure is associated with poor health outcomes in children. In  
12 some cases, caregivers were reluctant to discuss the effects of SHS exposure and their  
13 uneasiness was demonstrated by avoiding eye contact with the interviewer and defensive  
14 body language. Several caregivers articulated views that the wider environment may be  
15 more of a threat, in comparison to the risk of tobacco and SHS, to their own health and that  
16 of their children and thus felt justified in continuing and maintaining their current smoking  
17 behaviours (Box 1, quote d). Caregivers justified their smoking behaviour by disregarding  
18 medical knowledge surrounding the risks of tobacco use and SHS exposure. This was  
19 rationalised by referring to the discrepancy between their own personal experiences, those  
20 of their family and peer network and the medical information presented in the media and  
21 by HCPs. It appears that a rejection of the pregnancy related smoking messages from HCPs'  
22 leads to a rejection of the SHS smoking and child health messages post delivery (Box 1,  
23 quote e). When probed to see if they would like more information about the dangers of SHS  
24 exposure there were mixed reactions, with some caregivers admitting that it may be helpful  
25 and may lead to changes in smoking behaviour, whilst other caregivers rationalised that

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2 they would feel even worse about smoking around the children if they fully understood the  
3 risks of SHS exposure and therefore they would prefer not to know (Box 1, quotes f-g).  
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#### 7 ***Fluidity and complexity of household smoking rules***

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9 All caregivers described rules around smoking in the home, typically restricting smoking to  
10 one or two rooms (Box 2, quote a-b). The caregivers tended to disclose more insights about  
11 the fluidity and complexity of their home smoking rules as the interview progressed,  
12 suggesting that they felt more comfortable with the researcher and increased in confidence  
13 over time. One mother initially stated that she only ever smoked in the kitchen (Box 2,  
14 quote c), however, she subsequently disclosed that on a Friday, because her daughter was  
15 at nursery, she smoked in the living room (Box 2, quote d). This fluidity in home smoking  
16 rules was justified by the opening of a window to ensure that the room was 'clear' prior to  
17 the child returning home, implying that because she could not smell smoke, she believed  
18 that the risk of harm to the child was significantly reduced or even removed.  
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#### 31 ***Positive behaviour change***

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33 There were some caregivers who had, over a period of time, made the association between  
34 their smoking and health issues with their own children and then implemented changes to  
35 their smoking behaviour (Box 2, quote e). In addition, several caregivers discussed the fact  
36 that they had been able to initiate a smoke-free environment for their newborn baby,  
37 believing that infants of this age were at most risk if exposed to SHS, however, the strictness  
38 of this changed and became more relaxed as the child got older and the family's perception  
39 of risk decreased (Box 2, quotes f-g).  
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### **Barriers to initiating a smoke-free home**

Table 1 provides an overview of the barriers for initiating and maintaining a SFH that emerged from the interview data. Within the interviews, there was significantly more discussion around the barriers to creating SFH compared to the motivators, and caregivers constructed detailed and often complex discourse about why they were unable to initiate and maintain a SFH for their children. The main barriers related to habits and stressors. Caregivers perceived that it would be very difficult to change their current smoking behaviour in order to smoke outside, as smoking was such an ingrained behaviour in their day to day routine. Several caregivers, both men and women, openly admitted that they were 'lazy' and were unwilling to make the effort to smoke outside as it was simply easier to smoke inside. In addition, there was the overriding desire to smoke in comfort, privacy and in a safe environment, none of which were facilitated when smoking outside for some caregivers (Box 3, quotes a-c). For the majority of participants there appeared to be a conflict between being a smoker and being a caregiver, in that, caregivers perceived that smoking around a child was less harmful than leaving the child unattended whilst going outside to smoke (Box 3, quote d).

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Nearly all of the caregivers, once probed, indicated that the fluidity of their home smoking rules was a consequence of dealing with day to day living such as the presence of children and/or visitors in the household, the influence on relationships with others who care for their children, the weather conditions, and in particular, stress levels. Caregivers found it harder to keep rigid rules when under increased stress and articulated that the act of smoking provided an opportunity to 'escape' from these issues for a few minutes and ultimately helped them to cope more effectively (Box 3, quote e). What was clear is that

1  
2 these caregivers lead complex and difficult lives and smoking, as well as exposure to SHS, is  
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4 very low on their priority list of things that they should actively do something about.

5  
6 Smoking and exposure to SHS were often perceived as the 'lesser evil' in comparison to the  
7  
8 other significant problems that these caregivers and their children face when living and  
9  
10 growing up in poverty. A number of caregivers expressed concern that if smoking was taken  
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12 away from them, they would not be able to cope with everyday life. (Box 3, quote f).

**Deleted:** Smoking allows these caregivers to cope with life and care for their children effectively, even in difficult circumstances

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16 There were a small number of caregivers who felt that they lacked autonomy in their  
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18 relationships with family and friends and so were unable to enforce rules about smoking in  
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20 the home. This was a particular problem for caregivers who received childcare help from  
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22 smoking family and friends, as they felt that by enforcing certain rules they may be seen as  
23  
24 hypocritical given that they were also smokers, and there was an underlying fear that these  
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26 carers may withdraw their childcare support if actively prevented from smoking within the  
27  
28 care giving environment (Box 3, quote g).

### 30 31 ***Motivators for initiating a smoke-free home***

32  
33 Table 1 provides an overview of the motivators for initiating and maintaining a SFH that  
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35 emerged from the interview data. The strongest emerging motivator was around house  
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37 decor and the fact that the caregivers did not like the smell of cigarette smoke (Box 3, quote  
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39 h). When probed, child health emerged as another reason for wanting to stop smoking in  
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41 the home, however, it appeared that this was of lower priority in contrast to house decor  
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43 (Box 3, quotes i-j). A number of caregivers discussed the fact that they wanted to quit  
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45 smoking and articulated that they thought that making their homes smoke-free could be a  
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47 manageable first step in the complex process of quitting. The potential self-reward and  
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49 positive reinforcement generated as a result of making this significant change in behaviour,  
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1  
2 may empower caregivers to attempt to quit smoking (Box 3, quotes k-l). Several caregivers  
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4 were concerned about being seen as a role model for being a smoker by their children, and  
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6 articulated that by taking smoking outside of the house, their children may not perceive  
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8 smoking to be such a normative behaviour, and may therefore be less likely to initiate  
9  
10 smoking in later life. Guilt was a predominant theme that was interwoven with several of  
11  
12 the other motivators, and was perceived to be one of the biggest influences when trying to  
13  
14 implement changes in smoking behaviour, particularly for female caregivers (Box 3, quotes  
15  
16 m-n).  
17

## 18 Discussion

19  
20 This research adds to the growing body of evidence that for many disadvantaged caregivers,  
21  
22 in spite of some awareness of the extensive health risks to children, and some rules around  
23  
24 where they themselves and visitors can smoke in their homes, initiating and maintaining a  
25  
26 SFH is particularly difficult. Although caregivers implement rules, these are often fluid and  
27  
28 modified in reaction to day to day living and so do not offer adequate protection to the  
29  
30 children living within the household. This study significantly increases our knowledge of the  
31  
32 barriers and motivators to smoking caregivers in creating and maintaining a SFH and  
33  
34 suggests promising avenues to promote SFH in the future.  
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40 This study confirms previous research showing the fluidity of household rules around  
41  
42 smoking (Phillips, et al., 2007; Robinson & Kirkcaldy, 2007a); all families described rules  
43  
44 around smoking in the home, typically restricting smoking to one or two rooms, but these  
45  
46 rules were violated with some regularity, as has been seen in other population groups. In  
47  
48 line with other research however, the majority of families interviewed articulated that they  
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50 had implemented strict home smoking rules around their newborn baby, typically smoking  
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**Deleted:** Caregivers often reported being confused about the health risks to their children when exposed to SHS and created resistant discourses in order to rationalise and justify their continued home smoking behaviours.

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**Deleted:** Caregivers appeared to believe that by restricting smoking to only one room, and by employing strategies such as using an air freshener and opening windows, the risk of harm to their children was greatly reduced or even eliminated. However, even

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**Deleted:** (Phillips, et al., 2007; Robinson & Kirkcaldy, 2007a). The evidence suggests that only complete smoking bans are effective and there is clearly a need to promote this message more consistently (Blackburn, et al., 2003).

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2 outside, but that these rules tended to be relaxed as the child got older and here appeared  
3  
4 to be two main reasons why home smoking rules became more fluid (Holdsworth &  
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6 Robinson, 2008; Robinson & Kirkcaldy, 2009). The first related to changing risk perceptions,  
7  
8 in that caregivers felt that newborn babies were at the greatest risk of harm from exposure  
9  
10 to SHS and thus should be protected, but that as children grew, they were perceived to  
11  
12 become more tolerant and so less in need of protection (Robinson & Kirkcaldy, 2009).

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15 Secondly, caregivers described a conflict between caring for the child and the desire to  
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17 smoke (Holdsworth & Robinson, 2008; Robinson & Kirkcaldy, 2007a). Additionally, in our  
18  
19 study, we showed that mothers perceived it to be easier to leave a newborn baby

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21 unsupervised for ten minutes to go outside to smoke in comparison to leaving a mobile and  
22  
23 inquisitive toddler. Caregivers made a conscious decision to smoke in the house, albeit away  
24  
25 from the child, but close enough to provide adequate supervision. In addition, whilst not  
26  
27 always openly articulated, there was an underlying tension around the need to continue to  
28  
29 smoke, which manifested itself in narratives of routine and the perceived difficulty of  
30  
31 changing current smoking and caring behaviours. This supports other studies which  
32  
33 explored why mothers continue to smoke in the home and suggested that smoking enables  
34  
35 mothers to 'cope' with caring in circumstances of poverty and hardship (Graham, 1993;  
36  
37 Robinson & Kirkcaldy, 2009) and that their ability to initiate and maintain a smoke-free  
38  
39 environment for their children competes with their caring responsibilities, which is further  
40  
41 restricted by the physical environment in which they live (Graham, 1984; Robinson &  
42  
43 Kirkcaldy, 2007a, 2007b). It is evident that health promotion messages need to highlight the  
44  
45 continuing risk from SHS throughout childhood and beyond. Nevertheless, that families are  
46  
47 able to initiate and maintain a SFH, even if only for a short period of time, could be used as a  
48  
49 positive lever by HCPs when trying to help families to make their homes smoke-free.  
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3 Initiating and maintaining a SFH for these families is often complicated by the transient  
4 lifestyles they lead, in that their family lives are complex and often unstable. The primary  
5 caregiver, typically the mother, and the children tend to stay in one place and partners and  
6 other adults regularly move in and out of the household. In addition, caregivers articulated  
7 that their daily lives involved many conflicting priorities, of which changing behaviour  
8 around tobacco use was not one. This instability and lesser priority intensifies the fluidity of  
9 their household smoking rules and creates further barriers to the initiation and maintenance  
10 of a SFH. As described in other populations, by restricting smoking within the home,  
11 caregivers were concerned that they may be seen as hypocritical by their family and peer  
12 networks, for whom smoking was seen as a normative behaviour (Phillips, et al., 2007) and  
13 that this would run the risk of negatively impacting on their relationships, particularly with  
14 other adults that reside within their household and with smoking family and friends who  
15 provide essential support, emotional and financial, to the caregiver and often free childcare  
16 for their children (Robinson, 2008). It is clear that HCPs must consider the composition of  
17 the household and the potential impact on relationships when attempting to help caregivers  
18 reduce children's exposure to SHS. By offering support to partners and other smoking adults  
19 who reside, or spend considerable time within the household the chances of success may be  
20 increased. The evidence suggests that only complete smoking bans are effective and there  
21 is clearly a need for HCPs to promote this message more consistently (Blackburn, et al.,  
22 2003).

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The strongest emerging motivator for stopping smoking in the home was house decor and  
smell, whilst few caregivers actively articulated children's health as a motivator when asked  
an open question; decor and smell have also been overriding concerns of smoking

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**Deleted:** It is evident that health promotion messages need to highlight the continuing risk from SHS through childhood and beyond. Nevertheless, that families are able to initiate and maintain a smoke-free home, even if only for a short period of time, could be used as a positive lever by health care professionals when trying to help families to make their homes smoke-free. In addition, it appears that health care professionals can increase the likelihood of caregivers being able to successfully initiate and maintain a smoke-free home, by providing support for all smoking adults within the household.¶

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3 caregivers in other studies (Holdsworth & Robinson, 2008; Phillips, et al., 2007). One  
4 interpretation of these findings is that caregivers are more strongly motivated by the sight  
5 or smell of the impact of SHS exposure, for example, the smell from smoke and the damage  
6 that smoke does to furnishings. That caregivers in our study appeared to believe that by  
7 restricting smoking to only one room, and by employing strategies such as using an air  
8 freshener and opening windows, the harm to their children was greatly reduced or even  
9 eliminated, was perhaps because there was no demonstrable evidence of the impact of SHS  
10 exposure. Unlike the immediate evidence of smell, the concept of a child who is currently  
11 outwardly well getting cancer in later life, while emotive, is an abstract concept, and an  
12 event that may occur in the distant future. Often, caregivers do not perceive these longer  
13 term outcomes to be as a direct result of their current smoking behaviours, and thus do not  
14 prompt the need for immediate action. One possible interpretation of these data is that  
15 providing caregivers with demonstrable evidence, such as biochemical markers of SHS  
16 exposure in their children, may be a more effective promoter of successful and sustained  
17 behaviour change.

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Caregivers' poor knowledge of the risks of harm from SHS has been linked with exposure in children (Lader, 2008), yet increased awareness of the risks has not resulted in increased measures to make homes smoke-free (Royal College of Physicians, 2010). Within the current study, smoking caregivers' knowledge of the risk of SHS exposure varied considerably. A number of caregivers appeared confused about the health risks of tobacco use and SHS exposure, similar to previous research which highlighted caregiver confusion around the health risks and also identified that caregivers construct alternative explanations for their children's illnesses based on personal knowledge and circumstances and create resistant

**Deleted:** and on several occasions sought clarification from the interviewer.

discourses to dominant scientific knowledge that may link these illnesses with their own smoking behaviours (Robinson & Kirkcaldy, 2007b). This apparent confusion around the risks, mixed with resistance to health messages, also suggests that some demonstrable evidence of the impact of smoking in the home on children’s health may be more effective for promoting behaviour change. Such a finding may well also override participants’ ‘laziness’ to change as it challenges their complacency around the relative risks of smoking around children and others.

Another important motivator was the desire to quit smoking, which is the most reliable way to reduce children’s exposure to SHS, and several caregivers articulated that they thought that stopping smoking in the home could be a manageable first step in the complex and difficult process of quitting smoking. Whilst HCPs should encourage and reward positive behaviour change, such as taking smoking outside of the home, it will be important that they also emphasise that cutting down can be an important first step towards quitting and that smokers should ultimately aim to stop smoking completely as this will be best for their own health and the health of their children.

**Deleted:** Finally, health care professionals must also consider the composition of the household and the potential impact on relationships when attempting to help caregivers reduce children’s exposure to SHS. By offering support to partners and other smoking adults who reside, or spend considerable time within the household the chances of success are significantly increased.

**Strengths and limitations**

We interviewed a relatively small number of very disadvantaged individuals, aiming not for generalisability, but rather to collect data that were rich and insightful. We actively chose to engage with this disadvantaged target group in order to identify positive levers for change and thus help to reduce health inequalities. The nature of the one to one interviews facilitated in depth discussion of household smoking behaviours and the motivators and barriers to initiating and maintaining a SFH and allowed saturation of themes. It is possible that, even in the one to one situation, caregivers may have felt inhibited in discussing their

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2 real feelings on some topics due to the moral issues surrounding SHS; for example, this may  
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4 have influenced some caregivers in their response to questions on whether they wanted  
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6 more information on SHS health risks. Nevertheless, our methods allowed critical and  
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8 objective comparisons between caregivers, from similar backgrounds but with very different  
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10 experiences and attitudes. We focussed our interviews on identifying those levers for  
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12 behaviour change that might lend themselves to HCP intervention, and our results are likely  
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14 to have utility beyond this target group, including policy makers, advocacy organizations and  
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16 educators.  
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## 20 Conclusions

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22 Whilst the best way to reduce children's exposure to SHS is to encourage their caregivers to  
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24 quit smoking all together, there are a group of caregivers who cannot or will not quit and so  
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26 the next best option is to encourage these families to make their homes completely smoke-  
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28 free. This study extends our knowledge of the attitudes, beliefs and behaviour of  
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30 disadvantaged caregivers, for whom smoking in the home is still common. Whilst some  
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32 attempts were being made to restrict smoking at home, the fluidity of these home smoking  
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34 rules appears unlikely to offer appropriate protection for smokers' children. The motivators  
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36 to introducing SFH were home decor and smell, children's health and the possibility that  
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38 making a successful change in home smoking behaviour might be a stepping stone to  
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40 quitting completely. Our findings suggest that tailored information to reduce children's SHS  
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42 exposure is necessary, but in order to instigate disadvantaged caregiver behaviour change,  
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44 providing demonstrable evidence of the impact of smoking on their children's' health is  
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46 more likely to be effective.  
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**Funding**

This study was supported by core funding to the UK Centre for Tobacco Control Studies ([www.ukctcs.org](http://www.ukctcs.org)) from the British Heart Foundation, Cancer Research UK, Economic and Social Research Council, Medical Research Council, and the Department of Health, under the auspices of the UK Clinical Research Collaboration.

**Declaration of interests**

There are no competing interests for any of the authors regarding this paper.

**Acknowledgements**

We would like to thank the Children's Centre staff: Nikki Cregg-Briggs, Caroline Koczalski, Pauline Wilkinson, Katie Brown, Ian Lunn and Hazel Begg for their help and support and the families who gave up their time to participate.

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## Tables

**Table 1.** Barriers and motivators to initiating and maintaining a smoke-free home for disadvantaged caregivers in Nottingham (the strongest emerging themes are highlighted in bold).

<i>Barriers</i>	<i>Motivators</i>
<b>Influence on relationships</b>	<b>House decor</b>
Space restrictions	<b>Children's health</b>
Conflict of being a smoking caregiver	Pet's health
<b>Conflict between coping and caring</b>	Improved health of caregiver
Stress	Increased life expectancy of caregiver
<b>Habit, addiction, boredom</b>	Ability to care for children as they get older
Abuse of other addictive substances	<b>Reduced risk of children becoming smokers</b>
<b>Desire to smoking in comfort, privacy, and in a safe environment</b>	Influence of partner, family & friends
Lazy, lack of will power	Guilt
Tobacco use low on priority list	<b>Desire to quit smoking</b>
Personal choice	Legal or rental restrictions
Social & peer pressure	
Lack of autonomy, culture, hospitality	

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**Quote a**

"...high instances of asthma and obviously cot death's higher if people are smoking in the house..." (single mother, 25-34 yrs)

**Quotes b & c**

"My friend's son's got asthma, I don't know if that's from [his] smoking or what? (single father, 16-24 yrs)

"I know passive smoking is supposed to be worse than smoking itself, int it? I dunno I think it is? I'm sure it is, oh I don't know" (single mother, 25-34 yrs)

**Quote d**

"I'd say you get more pollution in the air than you would from standing in front of someone who's got a cigarette on, do you know what I mean?" (single mother, 25-34 yrs)

**Quote e**

"Well the midwife said to me obviously your smoking doesn't help but it has been researched and proven that smokers tend to have smaller babies erm but I think having friends that had had babies and they'd smoked and their babies were like eight or nine pounds I was thinking oh it's a load of rubbish and I think you do kind of like just brush it off..." (cohabiting mother, 25-34 yrs)

**Quotes f & g**

"I think more, I think for me and for people that do smoke in the house, more information what it actually does to your children in the long run" (single mother, 25-34 yrs)

"Well I don't anyway, I don't know what other people are like, cos I know, I know some of the bad side of it....and if I hadn't probably, if I knew more then I'd hate myself if I couldn't stop, do you know what I mean? That's, that's probably why I wouldn't want to know" (single mother, 25-34 yrs)

**Box 1. Knowledge, attitudes and beliefs around second hand smoke**



**Quotes a & b**

"I only smoke in the living room, I don't smoke upstairs, er, I don't smoke in the kitchen. There's just the living room I smoke in" (*divorced grandmother, 45+ yrs*)

"See I do that, I only smoke in my kitchen but when she's gone to bed I'll smoke in the living room" (*single mother, 16-24 yrs*)

**Quote c**

"I've always smoked in the kitchen, that's the only place we all smoke, out the way from the children" (*married mother, 25-34 yrs*)

**Quote d**

"It was like now on a Friday because [daughter] is in nursery from 8 o'clock on Friday cos normally just afternoons but cos she's in all day Friday er sometimes I have a fag in the living room because no children are in the house but we make sure that like, before they actually come home that it's clear and we make sure we open a window and that so you can't smell it" (*married mother, 25-34 yrs*)

**Quote e**

"Even though I realised I was a smoker I didn't realise the damage it was doing to my eldest son. Erm he was asthmatic cos he lived in a home where there was always somebody smoking which was me erm but the time I realised that and stopped smoking out of the house, erm his asthma went but you know, he was about...eight. So for a fair number of years I'd actually caused him damage as well as myself. I never connected his asthma with my smoking" (*single mother, 25-34 yrs*)

**Quotes f & g**

"Well I don't smoke erm, when they was babies I never smoked in front of them at all. Er now that they're like running around and stuff like that I'll go in the kitchen and smoke in the kitchen and if, and they'll be in and out so I can't help em being round it but erm you see I can't smoke outside. I'd never smoke in front of em as tiny babies. I think the first time I smoked in front of any of my children they was over the age of one or two even" (*single mother, 25-34 yrs*)

"I mean, when he, when he was a baby, I stopped smoking and went outside and had fags outside but as he's got older, he's in the other room and I'm in the kitchen" (*single mother, 35-44 yrs*)

**Box 2.** Fluidity and complexity of household smoking rules (quotes a-d) and positive behaviour change (quotes e-g)

**Quotes a-c**

"...and a bit lazy sometimes I think, I can't be bothered to go outside so you'd light a fag up and say, well, here we go, you know" (*married father, 35-44 yrs*)

"Like I said if it's raining I end up smoking in the house, I know for a fact I'll won't go outside in the rain if I'm having a fag, fag will get wet" (*single mother, 16-24 yrs*)

"Cos I wouldn't go outside if I lived in [local area] because it is, it's not nice. It's like, I tried doing that smoking outside...I weren't on my doorstep I was sat on the kitchen table... but the only reason why I did that was because my garden, like, there's that...alleyway type thing and then my garden and then my door, so you don't know who's coming round and then for it to be dark as well it is scary to go outside..." (*single mother, 25-34 yrs*)

**Quote d**

"We just, just decided to but we wouldn't dare smoke in front of her, I don't know why. But that where she started crawling around and we're both outside, we didn't really want to leave her in, leave her by herself so...then we would smoke in the kitchen and then we just started smoking around her as well." (*single mother, 16-24 yrs*)

**Quote e**

"...and all you wanna do is scream at em and you can't do that so you end up going into the kitchen, having a fag and then you sort it..." (*single mother, 25-34 yrs*)

**Quote f**

"Errrr stress really, bringing up four kids and one with, you know, disabilities as well and plus cos I'm like here there and everywhere lately" (*single mother, 25-34 yrs*)

**Quote g**

"No. It's just, I don't know, it's his life. I mean, he's 12 years older than me, what right have I got to tell him what to do, do you know what I mean?... To be honest with you, when he's not there, I mean, like today, he's not going to be there, it's going to be smoke-free. He's not going to be back till half nine, 10 o'clock tonight, the kids will be in bed, it doesn't matter." (*married mother, 25-34 yrs*)

**Quote h**

"Cos I'm, I'm house-proud, it's the smell on your curtains, your clothes, the walls. I mean I'm lucky cos I've got all painted walls and I'll be washing my walls regular so I do see it" (*single mother, 34-44 yrs*)

**Quotes i & j**

"I just come in one day, I opened the door and my house smelt of cigarettes, I'm not one for these artificial air fresheners because they just give me headache, I hate them erm I thought well how, how do you get rid of this nasty awful smell, oh I know don't smoke no more. And then I took my eldest son for his asthma review and she said you know he doesn't need inhalers anymore and then it just clicked" (*single mother, 25-34 yrs*)

"...and [daughter's] health as well. So obviously yeah, I think that she', it wasn't coming near her in the flat but obviously it does cos it, it stays don't it and lingers" (*single mother, 16-24 yrs*)

**Quotes k & l**

"I think cos if I had to smoke outside and I hate going outside. So I just wanted to stop, and for my daughter as well. It's not very nice for her" (*single mother, 16-24 yrs*)

"Possibly to do it in like a two-step phase, to do that one first and then after a while stop altogether...Make the smoke-free house permanent, smoking outside but then, erm, after a while just give up totally" (*Married mother, 25-34 yrs*)

**Quotes m & n**

"...because of the health benefits to my kids. It breaks my heart to think that my son's asking me for a cigarette and saying he needs it" (*cohabiting mother, 35-44 yrs*)

"Erm, quite bad cos you feel guilty for – not for excluding them but for doing that because they shouldn't be seeing that" (*married mother, 25-34 yrs*)

**Box 3.** The barriers (quotes a-g) and motivators (quotes h-n) to initiating & maintaining a smoke-free home