The Application of Health Psychology to Smoking Cessation within a Deprived London Borough

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SECTION A

PREFACE

PREFACE

The DPsych Health Psychology thesis illustrates a health psychologist in training's contribution towards developments in the field of smoking cessation in a deprived area of London. The process of undertaking competencies of research, consultancy, teaching and training, behaviour change interventions and clinical supervision are evident in the portfolio through case studies, a systematic review and a research study. The overall aim of the work has been to promote health and reduce illness by tackling issues related to health inequalities and smoking among groups with high smoking prevalence rates in the borough of Camden.

The UK government White Paper "Smoking Kills" published in 1998 outlined a national target of reducing smoking prevalence rates to 26% by 2005 and 21% by 2010 and to narrow the gap between smoking rates and social classes (Department of Health, 1998). National Health Service (NHS) stop smoking services were established throughout the country to help smokers change their behaviour through cost effective smoking cessation programmes (Department of Health, 2007; West, McNeill & Raw, 2000). Smoking prevalence rates have successfully decreased in the UK as the proportion of smokers had fallen to 21% in 2007 (Office for National Statistics, 2009). However, reducing smoking rates further remains challenging due to the complex components of the behaviour (Lawrence and Haslam, 2007), yet vital as half of smokers die prematurely as a result of their habit (Peto et al., 1994). Individuals from lower socio-economic groups are still more likely to smoke than those from more affluent backgrounds (Office for National Statistics, 2009). Despite the wide diversity of the population in Camden, the borough has been ranked the 19th most deprived in England (Office of the Deputy

Prime Minister, 2004) and its smoking prevalence rate higher than the national average (Camden Primary Care Trust, 2006; Health Survey for England, 1999).

In an attempt to reduce smoking rates and consequently narrow the health inequality gap, the work has entailed increasing accessibility and effectiveness of stop smoking services for the residents of Camden. As interventions including more intensive individual support appear more effective than less intensive smoking cessation programmes (Lancaster & Stead, 2006), health professional were trained in providing one to one interventions to help smokers make behaviour changes (West et al., 2000). The level II training days in smoking cessation were implemented with the aim to provide health professionals capable of reaching a diverse range of clients due to their various work settings across the borough, with the necessary knowledge, skills and confidence to offer effective individual stop smoking support. Smoking rates among people living with HIV and AIDS are higher than in the general population (Smith et al., 2004) and both HIV and smoking are more prevalent in lower socio-economic groups (Niaura, Shadel, Morrow, Flanigan & Abrams, 1999). Therefore, a teaching session on smoking and HIV/AIDS specifically tailored for staff at an HIV/AIDS clinic based in the borough was delivered. The objectives of the presentation were to enhance knowledge of the health risks of smoking among people living with HIV/AIDS, raise awareness of referral pathways to stop smoking services and increase levels of confidence in offering brief stop smoking advice to patients.

The trend of higher smoking rates among socially disadvantage groups is also reflected in pregnant women (Dolan-Mullen, 1999; Lindsay, 2001; Lumley, Oliver & Oakley, 2004). Tobacco use during pregnancy is a preventable cause of various adverse health outcomes on the fetus, developing child and mother (DiFranze &

Lew; Klerman & Rooks, 1999). Decreasing smoking among pregnant women is therefore a public health concern (Coleman et al., 2004). The research, systematic review and consultancy focused on the area of smoking and pregnancy. The pieces of work aimed to decrease smoking prevalence rates among this population by identifying effective methods of targeting pregnant smokers and supporting pregnant women in their quit attempts. The analysis of the systematic review presented modest results for the effectiveness of stop smoking interventions for pregnant women and indicated that women need to be targeted throughout their pregnancy regardless of cigarette consumption. However, a clear understanding of effective interventions enabling pregnant women to stop smoking is lacking.

The research which explored pregnant smokers' perceptions of NHS stop smoking services and midwives' perceptions of promoting smoking cessation to pregnant women identified various barriers as well as facilitators to approaching stop smoking services and offering stop smoking advice. The conclusions from the research resulted in numerous recommendations including providing clearer information to pregnant smokers about the stop smoking support available through the NHS and implementing training for midwives to encourage them to consistently offer effective stop smoking advice.

The aim of the consultancy was to increase referrals of pregnant smokers to the stop smoking service in Camden by outlining recommendations in a report based on the analysis of the systematic review, the results from the research and the findings from investigations of how other stop smoking services target and work with pregnant women.

The remit of decreasing smoking rates during pregnancy has also extended to clinical work. Health behaviour change interventions have been offered to clients in

one to one and group settings alike and included complex clients from deprived populations with higher smoking rates, hence requiring intense support and expertise advice. Encouraging behaviour change is likely to be more challenging among these clients who have mainly constituted pregnant women (Stotts, DiClemente & Dolan-Mullen, 2002) but also clients from certain ethnic minority groups with high smoking rates (Coleman, 2004), housebound individuals with medical illnesses (Steinberg et al., 2009), heavily addicted smokers (Coleman, 2004; Office for National Statistics, 2009), young people (Coleman, 2004) and clients with mental health problems (Coultard, Farrell, Singleton & Meltzer, 2000; Williams & Foulds, 2007). The case study included in the portfolio illustrates the implementation of interventions to change health-related behaviour through the facilitation of a stop smoking group in one of the most deprived areas of the borough.

In addition to providing health behaviour change interventions to clients from more deprived groups, the role has included supervising the work of health trainers in delivering interventions on smoking cessation, healthy eating and exercise and signposting clients to appropriate services (Department of Health, 2004). The NHS accredited health trainers had been recruited from the local community to reach the most socially disadvantaged population within the borough. The clinical supervision included assistance in understanding and employing health psychology practice, appraisal of the application of appropriate models and support in working and communicating effectively with a diverse range of clients.

By following appropriate guidelines such as the British Psychological Society's (2006) Code of Ethics and Conduct, the Data Protection Act (1998) and the National Patient Safety Agency (2007), the competencies that form the foundation of the doctorate course in health psychology have been undertaken to

high legal, ethical and professional standards. The DPsych thesis verifies that through the addition of elements of health psychology to the discipline of smoking cessation, the work of a health psychologist in training can serve a valuable attribution to promoting health and preventing illness by tackling health inequalities in a deprived area of the country.

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SECTION B

Unit 2 RESEARCH

Improving the Uptake of Stop Smoking Services by Pregnant Smokers: A Qualitative Study Identifying the Perceptions of Pregnant Smokers and Midwives

ABSTRACT

The objectives of the study were to identify how midwives perceive providing stop smoking advice to pregnant smokers and how pregnant women who smoke perceive stop smoking services. The overall aim was to find methods to improve the uptake of stop smoking services by pregnant women. Three focus groups with midwives and ten semi-structured interviews with pregnant smokers were undertaken. The qualitative data was analysed using Grounded Theory. The perceptions of midwives regarding provision of advice were identified as barriers as well as facilitators and related to outcome of advice, the relationship with clients, personal experiences, attributes, perception of role, the impact of external factors and aspects related to pregnant smokers and pregnancy. Pregnant smokers' perceived barriers and facilitators to approaching stop smoking services were categorised into areas of smoking behaviour, advice from health professionals, stop smoking services and negative perceptions of pregnant women who smoke. Midwives perceive a greater number of barriers than facilitators to providing stop smoking advice. Although many of these could be overcome by implementing effective mandatory training, other issues such as lack of time have major impacts on midwives' abilities to promote health. Pregnant smokers tend to have negative expectations of stop smoking services but the experiences of those who have attended the service are positive. Raising awareness of stop smoking support for pregnant women is crucial in improving uptake of the service.

CHAPTER 1

INTRODUCTION

1.1 Health Effects of Smoking

Imperative societal aims include reducing smoking during pregnancy and fetal tobacco exposure, curtailing second hand smoke exposure of infants and children, encouraging parents to stay healthy and creating completely smokefree homes (DiClemente, Dolan-Mullen & Windsor, 2000). Despite the challenges that these aspirations face, continuing to strive towards accomplishing them is crucial due to the devastating consequences of smoking. The staggering proportion of smokers dying prematurely as a result of their habit is one in two (Peto, Lopez, Boreham, Thun & Heath Jr., 1994). Woodby, Windsor, Snyder, Kohler and DiClemente (1999) proposed that exploring the behaviour change process for pregnant women who smoke is vital considering the detrimental health risks related to smoking during pregnancy for both the woman and baby. Smoking during pregnancy represents an essential health problem in the United Kingdom (Lindsay, 2001). It is a public health problem and identifying methods of reducing smoking amongst pregnant women is thus a necessity (Coleman et al., 2004). Even a slight decrease in smoking prevalence rates would lead to improved national health outcomes (Lindsay, 2001). Indeed, quitting smoking is the best thing that a pregnant woman can do for her own as well as her baby's health (McRobbie & Hajek, 2003). Studies suggest that smoking harms every phase of reproduction (U.S. Department of Health and Human Services, 2004).

1.1.1 Risks Prior to Pregnancy

Fertility in both men and women is negatively affected by smoking. Smoking reduces sperm count and increases the proportion of malformed sperm in men

(Merino, Carranza & Martinez-Chequer, 1998). Women who smoke take longer to conceive (Curtis, Savitz & Arbuckle, 1997) and are at greater risk of infertility (U.S. Department of Health and Human Services, 2001).

1.1.2 Risks during Pregnancy

Smoking during pregnancy increases the risk of complications for women and it is the most significant preventable cause of fetal and infant morbidity and mortality (Royal College of Physicians of London, 2000). It has been estimated that miscarriage is 25 percent more likely to occur for women who smoke during pregnancy (Royal College of Physicians of London, 1992) and a link between smoking and the risk of ectopic pregnancy has been established (Castles, Adams, Melvin, Kelsch & Boulton, 1999). Smoking is a preventable cause of perinatal disorders (DiFranza & Lew, 1995; Wisborg, Kesmodel, Henriksen, Olsen & Secher, 2001). In the UK, smoking is the cause of about a third of all perinatal deaths (Royal College of Physicians of London, 2000) which includes stillbirth and neonatal death (British Medical Association, 2004). Smoking increases the risk of placental complications (Castles et al., 1999; Naeye, 1990). Placental abruption, which refers to premature separation of the placenta from the wall of the uterus, is increased by 1.4 to 2.4 times for women who smoke during pregnancy. The risk of the placenta obstructing the opening of the uterus, or placenta praevia, is 1.5 to 3.0 times more likely to occur in smokers (Naeye, 1980). Smoking during pregnancy also increases the incidence of preterm premature rupture of the membrane (pPROM) which is associated with premature births and adverse outcomes such as infections in infants and mothers and neonatal problems (Castles et al., 1999; Merenstein & Weisman, 1996). Smoking during pregnancy increases the risk of preterm birth (Windham et al., 2000) with level of risk being related to cigarette consumption (Nabet, Lelong,

Ancel, Saurel-Cubizolles & Kaminski, 2007). Evidence indicates that the risk of having a premature birth is 1.5 to 2.0 times more likely for pregnant smokers compared to non-smoking pregnant women (U.S. Department of Health and Human Services, 2001).

Fetal development can be negatively affected as a consequence of maternal smoking (Heinonen, Ryynänen & Kirkinen, 1999) and low birth weight is strongly associated with smoking during pregnancy (Bernstein et al., 2005; DiFranza & Lew, 1995; Royal College of Physicians of London, 1992; Wilcox, 1993; Windham, Hopkins, Fenster & Swan, 2000). Babies delivered by mothers who smoke whilst pregnant are on average 200-250g lighter compared to babies of non-smoking mothers. A direct link has been identified between number of cigarettes smoked during pregnancy and reduced growth and development of the fetus (British Medical Association, 2004). Potential health consequences of low birth weight include subnormal growth, neurodevelopmental problems and infancy-specific as well as long-term illnesses (British Medical Association, 2004; Hack, Klein & Taylor, 1995; Reyes & Mañalich, 2005). Babies born to mothers who have been exposed to second hand smoke whilst pregnant are 40-50g lighter compared to other babies (U.S. Department of Health and Human Services, 2001). Although the earlier pregnant women stop smoking the greater the benefits, smoking cessation is associated with numerous favourable pregnancy outcomes at any stage of pregnancy (British Medical Association, 2004).

1.1.3 Risks Post Pregnancy

Smoking during and following pregnancy is also linked to various adverse post partum health outcomes. Sudden infant death syndrome (SIDS) has been found to be attributable to maternal smoking (DiFranza & Lew, 1995; Haglund &

Cnattingius, 1990; Malloy, Kleinman, Land & Schramm, 1988; Pollack, 2001; Wisborg, Kesmodel, Henriksen, Olsen & Secher, 2000a) with the risk of SIDS increasing three fold if the mother smokes during pregnancy and the level of risk escalating with the number of cigarettes smoked per day (Wisborg et al., 2000a). Mothers who smoke are less likely to start breastfeeding (Yeung, Pennell, Leung & Hall, 1981) and those who do tend to breastfeed for a shorter period of time compared to non-smoking mothers (Lyon, 1983). Both production (Vio, Salazar & Infante, 1992) and quality of milk (Hopkinson, Schanler, Fraley & Garza, 1992) is negatively affected if the mother smokes. Poorer lung function during infancy and childhood has been linked to smoking during pregnancy (Cunningham, Dockery & Speizer, 1994; Hanrahan et al., 1992) and second hand smoke has been found to increase the risk of respiratory illnesses (Malloy et al., 1988; Mannino, Siegel, Husten, Rose & Etzel, 1996). Maternal smoking as well as exposure of second hand smoke during pregnancy have been identified as contributing factors to asthma in children (Barber, Mussein & Taylor, 1996; Hu et al., 1997). Second hand smoke increases the risk of middle ear disease in children (Strachan & Cook, 1998; World Health Organisation, 1999) and children who are exposed to environmental smoke have a higher number of days of restricted activity, bed confinement and school absence per year compared to other children (Mannino et al., 1996). In addition, some studies have indicated that poorer performance at school and behaviour problems have been linked to second hand smoke exposure (World Health Organisation, 1999).

1.1.4 Cost

Maternal smoking during pregnancy has a significant impact on societal finances (Miller, Villa, Hogue & Sivapathasundaram, 2001). The extensive costs

associated with adverse health outcomes during pregnancy are preventable as the effects are short term and could be avoided even by short term smoking abstinence (Adams et al., 2002). The related hospital inpatient costs in childhood produced by smoking during pregnancy in the UK are substantial (Petrou, Hockley, Mehta & Goldacre, 2005). Considerable financial savings could be made if a higher proportion of women stopped smoking prior to the end of the first trimester and thus reduced the prevalence of low birth weight infants (Lightwood, Phibbs & Glantz, 1999). Bearing in mind the substantial evidence of the health risks associated with smoking during pregnancy, one could expect smoking prevalence rates among pregnant women to be low. One of the most frequently stated reasons for stopping smoking during pregnancy is the negative impact the behaviour has on health (Owen & Penn, 1999).

1.2 Smoking Prevalence Rates among Pregnant Women

Reported smoking prevalence rates among pregnant women have decreased in recent years. However, measurement of smoking and smoking cessation is generally based on self-reports, which might underestimate the rates (Linsday, 2002). As negative attitudes towards smoking during pregnancy have become more common over recent years, the accuracy of self-reported smoking status of pregnant women might have become more questionable (Cnattingius, 2004). Therefore, the apparent reduction might partly be attributable to underreporting of tobacco use due to social pressures. The stigma associated with smoking during pregnancy is still so strong that some smokers will not admit to their habit even when support is offered (Owen & McNeill, 2001; Pollak et al., 2006a) or underestimate the heaviness of their smoking behaviour (Coleman et al., 2004). Studies comparing self-reports to smoking status validated by biomarkers have found that pregnant women tend to

underreport their habit (Lindqvist, Lendahls, Tollbom, Åberg & Håkansson, 2002; Russell, Crawford & Woody, 2004; Webb, Boyd, Messina & Windsor, 2003). A study in New Zealand revealed that nearly a quarter of pregnant smokers did not report their smoking status accurately (Ford, Tappin, Schluter & Wild 1997). Although it is difficult to obtain precise smoking prevalence rates for pregnant women, the rates during and following pregnancy are sufficiently high to remain a concern, particularly among low income, low education and socially disadvantaged women (Dolan-Mullen, 1999; Lindsay, 2001; Lumley, Oliver & Oakley, 2004).

Defining smoking cessation rates is also problematic. Although it is typically defined as the percentage of women who quit smoking between conceiving and giving birth, there are marked differences between stopping smoking in the first and the third trimester both with regards to health outcomes (British Medical Association, 2003) and number of women quitting (Owen & Penn, 1999; Lumley et al., 2004). In addition, if complete abstinence is not achievable perhaps a reduction should be regarded as a successful outcome (Lindsay, 2001).

1.2.1 Smoking during Pregnancy in the UK

The Infant Feeding Survey in 2005 found that a third of mothers in the UK smoked at some stage 12 months prior to or during pregnancy and approximately half of the women quit before giving birth. However, 17% continued to smoke throughout their pregnancy. Women were more likely to smoke in Scotland and Wales whereas smoking rates immediately before and during pregnancy had decreased in England and Northern Ireland between 2000 and 2005. The prevalence rates had declined for women of all ages with the exception of those who were 20 years or younger. The survey found that women under the age of 21 and those in routine and manual occupations were not only most likely to smoke immediately

before or during pregnancy but also least likely to quit. The proportion of women who quit before or during pregnancy was 63% in managerial and professional jobs compared to 39% among women in routine and manual occupations. Women in the lower occupational groups were four times more likely to smoke throughout pregnancy than those belonging to the higher occupational categories (29% and 7% respectively) (Bolling, Grant, Hamlyn & Thornton, 2007). Ebrahim, Merritt and Floyd (2000) reported that the decline of smoking rates during pregnancy in the United States was a reflection of the overall reduction of smoking prevalence in the general population rather than specifically for pregnant women. However, the results from a British survey undertaken in the 1980s indicated that smoking prevalence rates among pregnant women decreased at a greater rate than for the general population (Fingerhut, Kleinman & Kendrick, 1990).

1.2.2 Women who Continue to Smoke during Pregnancy

Even though a large proportion of women stop smoking prior to or during pregnancy, many find it difficult to change their habit. Pregnant women who manage to stop smoking are most likely to do so during the first trimester (Lumley et al., 2004; Owen & Penn, 1999). Women who continue to smoke throughout their pregnancy constitute a complex population as working with this group of smokers has often proved challenging and rather ineffective (Stotts, DiClemente & Dolan-Mullen, 2002). There might be many reasons why a relatively large proportion of women fail to stop smoking during pregnancy including external as well as internal motivators (Curry, McBride, Grothaus, Lando & Pirie 2001). Various factors have been identified as predictors of continuing to smoke during pregnancy including social environmental aspects, demographic characteristics, behaviour and

psychological issues (Ershoff, Solomon & Dolan-Mullen, 2000a; Park, Tudiver, Schiltz & Campbell, 2004).

a. Social Environmental Factors

Women from lower socio-economic groups are more likely to continue to smoke throughout their pregnancy and relapse post partum (Albrecht, Rosella & Patrick, 1994; Haslam, Draper & Goyder, 1997; Lu, Tong & Oldernburg, 2001; Ludman et al., 2000; Madeley, Gillies, Power & Symonds, 1989; Olsen, 1993). Penn and Owen (2002) found that smoking prevalence rates were nearly ten times higher for those in deprived groups compared to the least deprived categories and women living in rented accommodation were nearly twice as likely to smoke compared to those owning a home. Lower income and unemployment have also been associated with smoking throughout pregnancy (Dolan-Mullen, 1999; Penn & Owen, 2002; Secker-Walker et al.; 1996 Solomon & Quinn, 2004). An extensive amount of research has indicated that less educated pregnant women are more likely to smoke and to return to smoking post partum (Albrecht et al., 1994; Dejin-Karlsson et al., 1996; De Vries, Bakker, Dolan Mullen & Van Breukelen, 2006; Ershoff et al., 2000a; Haslam et al., 1997; Lu et al., 2001; Madeley et al., 1989; Olsen, 1993; Paterson, Neimanis & Bain, 2003; Penn & Owen, 2002; Secker-Walker et al., 1996; Severson, Andrews, Lichtenstein, Wall & Zoref, 1995; Solomon & Quinn, 2004; Walsh, Redman, Brinsmead, & Fryer, 1997a; Wisborg, Henriksen, Hedegaard & Secher, 1996).

Pregnant smokers are less likely to quit if their partner is a smoker (De Vries et al., 2006; Lu et al., 2001; Ma, Goins, Pbert & Ockene, 2005; McBride et al., 1998; Ludman et al., 2000; Olsen, 1993; Penn & Owen, 2002; Severson et al., 1995; Severson, Andrews, Lichtenstein, Wall & Akers, 1997; Wisborg et al., 1996) or if

their friends and family smoke (Ershoff et al., 2000a; Haslam et al., 1997; Haslam & Draper, 2001; Solomon & Quinn, 2004). Living with smokers and being exposed to secondhand smoke have also been identified as predictors for smoking during pregnancy (Cnattingius, Lindmark & Meirik, 1992; Hegaard, Kjærgaards, Møller, Wachmann & Ottesen, 2003; Lu et al., 2001; Madeley et al., 1989; Paterson et al., 2003; Severson et al., 1995; Woodby et al., 1999) as have being unmarried or not living with the father of the baby (Cnattingius et al., 1992; Dejin-Karlsson et al., 1996; Haslam et al., 1997; Haug, Aarö & Fugelli, 1992; Penn & Owen, 2002; Solomon & Quinn, 2004; Walsh et al., 1997a). Pregnant women are more likely to smoke if partner and social support is perceived as inadequate (Dejin-Karlsson et al., 1996; McBride et al., 1998; Secker-Walker et al., 1996). Haug et al.'s (1992) study found that actual reduction of cigarette smoking, negative perception of smoking and determination to quit were significantly higher among smokers whose partners were encouraging or willing to cut down.

b. Demographic Characteristics

There are conflicting findings regarding age as a predictor of smoking in pregnancy. Some studies claim that younger women are more likely to smoke whilst pregnant (Dejin-Karlsson et al., 1996; Madeley et al., 1989; Solomon & Quinn, 2004; Walsh et al., 1997a whereas other results imply that older age predicts smoking in pregnancy (Ludman et al., 2000; Ma et al., 2005; Severson et al., 1995). Hawkin, Lamb, Cole and Law's (2008) study revealed that women from ethnic minority groups in the UK are less likely to smoke during pregnancy compared to white British and Irish women. Nonetheless, maternal health behaviours, such as tobacco use, worsen with length of residency in the country and the authors hence

stressed the importance for health professionals not to underestimate smoking prevalence rates among pregnant women from certain ethnic groups.

c. Behaviour

Pregnant women who smoke are more likely to experience stronger cravings (Ruggiero, Tsoh, Everett, Fava & Guise, 2000). A high level of addiction has been identified as one of the strongest predictors of continued smoking during early as well as late pregnancy (Cnattingius et al., 1992; Curry et al., 2001; De Vries et al., 2006; Ershoff et al., 2000a;) Haslam & Draper, 2001; Lu et al., 2001; Ludman et al., 2000; Ma et al., 2005; Olsen, 1993; Owen & Penn, 1999; Solomon & Quinn, 2004; Wisborg et al., 1996; Woodby et al., 1999). Duration and start of smoking habit can also affect pregnant women's smoking status and cessation (Lu et al., 2001; Woodby et al., 1999).

Studies have indicated that having an unwanted or unplanned pregnancy could be a determinant of smoking during pregnancy (Dejin-Karlsson et al., 1996; Ludman et al., 2000; Solomon & Quinn, 2004). In addition, a high parity number and being multigravida have been linked to poor smoking cessation rates among pregnant women (Cnattingius et al., 1992; Lu et al., 2001; Olsen, 1993; Solomon & Quinn, 2004; Walsh et al., 1997a; Wisborg et al., 1996).

d. Psychological Issues

Ruggiero et al. (2000) found that pregnant smokers are less likely to possess a negative approach towards their habit. Intention to quit in the next month and staying abstinent have been significantly associated with knowledge of health effects of smoking, motivation to quit and confidence in quitting (Ershoff et al., 2000a; Secker-Walker et al., 1996; Solomon & Quinn, 2004; Woodby et al., 1999). Haslam

and Lawrence (2004) claimed that pregnant women are less likely to feel personally responsible for the health of the fetus if they are smokers.

Wakschlag et al. (2003) examined psychosocial risk and health compromising behaviours among women who continued to smoke during pregnancy and concluded that weaker adaptive functioning, problematic relationships and an increased risk to engage in problematic health behaviours were predictive factors. A qualitative study that investigated the psychosocial factors that influence smoking during pregnancy detected lack of will-power and negative affect as barriers to smoking cessation (Haslam & Draper, 2001). Stress has been identified as one of the weightiest reasons for smoking among pregnant women (Owen & Penn, 1999). Ludman et al. (2000) found that lower levels of perceived stress was associated with smoking cessation in early pregnancy but not in the later stages.

Although a number of factors have been identified as predictors of smoking during pregnancy, it still remains unclear how pregnancy specific physiological and endocrinological changes affect smoking cessation such as withdrawal symptoms and temptations to smoke (Solomon & Quin, 2004).

1.3 Smoking Cessation Interventions for Pregnant Women

There are numerous psychological models and theories which have been developed to predict health behaviour change including the Theory of Planned Behaviour (TPB) (Ajzen, 1991), the Health Belief Model (HBM) (Rosenstock, 1974), the Health Action Process Approach (HAPA) (Schwarzer, 1992) and the Protection Motivation Theory (PMT) (Rogers, 1983). These models have attempted to explore the processes and attitudes that trigger actions of health-promoting and health-compromising nature. However, health professionals and researchers are still battling with the task of initiating health behaviour change in individuals.

Some research evidence into behaviour change interventions has proved effective but the challenge lies in identifying which components of the treatments are responsible for the promising results. The different aspects of interventions, e.g. delivery, intensity and duration, are frequently interwoven with each other as well as with other features of the psychological interventions (Lawrence & Haslam, 2007; Michie & Abraham, 2004). A behaviour such as smoking that is detrimental to ones health is intricate due to its addictive, automatic and yet pleasurable facets (Lawrence & Haslam, 2007).

A vast number of smoking cessation interventions for pregnant women have been developed and tested. Systematic reviews evaluating the effectiveness of interventions for promoting smoking cessation during pregnancy have concluded that stop smoking interventions for pregnant women can be effective and that they reduce prevalence of low birth weight and preterm birth (Dolan-Mullen, Ramírez & Groff, 1994; Lumley et al., 2004). Nevertheless, although many interventions appear to be effective, the successful results are usually modest and variable (Stotts, DeLaune, Schmitz & Grabowski, 2004). Stop smoking programmes targeted at pregnant women employ varying degrees of intensity but evidence is lacking regarding the link between intensity and impact (Lindsay, 2001).

1.3.1 Type of Intervention

Brief stop smoking interventions delivered by midwives have been found to have limited or no effect on outcome (Hajek et al., 2001; Wakefield and Jones, 1998; Walsh, Redman, Brinsmead, Byrne & Melmeth, 1997b; Wisborg, Henriksen & Secher, 2005). Hajek et al. (2001) recommended that other methods might be more effective and should be tested such as specialist treatments, telephone counselling and tailored self-help materials. However, Rigotti et al.'s (2006) randomised

controlled trial implied that proactive pregnancy tailored telephone counselling was only effective for light smokers and for women who had attempted to quit earlier during their pregnancy. Lillington, Royce, Novak, Ruvalcaba and Chlebowski (1995) examined the effectiveness of smoking cessation materials that were developed to meet cultural, linguistic and literacy needs of low-income ethnic minority pregnant smokers. The intervention was significantly associated with smoking cessation during pregnancy and abstinence post partum.

Studies investigating the effectiveness of stage of change oriented smoking cessation interventions in reducing smoking prevalence rates among pregnant women, as predicted by the Transtheoretical Model (TTM), have revealed insignificant or modest results (Aveyard et al., 2006; Hughes et al., 2000; Lawrence, Aveyard, Evans & Cheng, 2003). Although some TTM based smoking cessation interventions might be effective for short term outcomes during pregnancy, they do not seem to differ in effectiveness compared to standard care in the longer-term (Lawrence et al., 2005). However, the findings from Aveyard et al.'s (2006) study indicated that more intense interventions encourage pregnant smokers to further consider changing their behaviour even though it might not lead to smoking cessation.

Various research studies have concluded that multi-modal or more intense interventions are more effective in reducing smoking prevalence among pregnant women. The elements that these interventions have comprised of include counselling, telephone follow ups, advice from various health professionals, Nicotine Replacement Therapy (NRT) use, feedback of biomarker results, self-help manuals, video tapes and multi-component motivational smoking cessation programmes (Cope, Nayyar & Holdre, 2003; Dornelas et al., 2006; Glasgow, Whitlock, Eakin &

Lichtenstein, 2000; Hegaard et al., 2003; Manfredi et al., 1999; Walsh et al., 1997b). However, despite some encouraging results, more intense interventions do not automatically result in higher success rates. Some studies have not found the outcomes of more regular or intensive smoking cessation support to pregnant women to be very promising (Campbell, Walsh, Sanson-Fisher, Burrows & Stojanovski, 2006; Ershoff et al., 2000b; Stotts et al., 2002; Tappin et al., 2000; Tappin et al., 2005).

1.3.2 Socio-Economic Status

Spontaneous quitters are significantly less likely to relapse within 6 months of the intervention compared to women who stop smoking at a later stage of pregnancy (Ma et al., 2005). Ma et al. (2005) stressed that this finding highlighted the importance of educational messages and social norms in terms of encouraging women to quit spontaneously as well as promoting cessation later in pregnancy. In order to achieve the government's target of reducing the prevalence rates of smoking in the UK, women at reproductive age from lower socio-economic status groups need to be targeted through appropriate settings such as community based organisations. Pregnant smokers are more likely to come from lower socio-economic backgrounds and face challenging life circumstances as well as have poorer psychological resources and use their habit as a means of coping with stress (Ludman et al., 2000). Coping strategies and life skills are therefore imperative ingredients in interventions for this population and stop smoking programmes should encompass people in pregnant women's social network as well as other aspect of their lives (Dejin-Karlsson et al., 1996; Haslam, 2000; Haslam & Draper, 2001; Ludman et al., 2000; Scheibmeir & O'Connell, 1997; Wakschlag et al., 2003). Identifying the at risk women and developing effective interventions which consider

these factors remains a fundamental challenge in improving the health of mother and baby (Ludman et al., 2000).

1.3.3 Social Support

Bolstered social support have been found to positively affect the quit attempt of pregnant women (Donatelle, Prows, Champeau & Hudson, 2000). A peer counselling smoking cessation intervention was found to have a positive impact on reduction of cigarette consumption among pregnant women (Malchodi et al., 2003) while Albrecht, Payne, Stone and Reynolds (1998) indicated that peer support might be successful for pregnant adolescents. DiClemente et al. (2000) recommended that partners should be included in smoking cessation interventions for pregnant women as they have a great impact on the woman's quit attempt. A meta-analysis conducted by Park et al. (2004) concluded that partner support, in particular live-in partners or spouses, combined with the absence of partner criticism may positively affect success rates of stop smoking programmes for pregnant women. Nonetheless, these behaviours might be difficult to change. Only about 50% of pregnant women whose partner smoked reported that the partner had made any change to their smoking habit since the beginning of pregnancy (Owen & Penn, 1999).

Pollak, Baucom, Peterson, Stanton and McBride's (2006b) study which examined rated helpfulness and partner-reported smoking cessation support among pregnant and post partum women, found that partners who smoked were less likely to offer support. The provision of positive support, such as complimenting the woman for not smoking and expressing confidence in her ability to quit, depended on the partner's smoking status and the provision of negative support, e.g. commenting on smoking as a dirty habit and refusing to offer cigarettes, depended on the woman's smoking. Based on their findings, Pollak et al. (2006b) recommended that

interventions involving partner support should entail raising awareness to partners that support might not result in immediate outcomes and that support might be helpful even when women continue to smoke. Pregnant women also need to communicate to their partners that support is appreciated. Engaging partners in quit attempts is challenging, especially if they are smokers. This might be due to the fact that they feel hypocritical about helping others to stop while continuing to smoke themselves. The relationship between pregnant smokers and their partners can be complex (Ludman et al., 2000). McBride et al. (2004) reported some indication that partners of pregnant smokers find it difficult to consider how their behaviour might impact the relationship and that it is hard to engage men to assist their partners in their quit attempt. These men are likely to be young and involved in a fairly new relationship. Thus, developing relational thinking skills might be an important aspect of smoking cessation interventions for pregnant women and their partners. In addition, leaflets should be developed to target partners specifically (Haslam & Draper, 2001).

1.3.4 Pharmacology

The results of studies investigating the effectiveness of NRT use among pregnant women have not been convincing although the pharmacotherapy might be useful for some of the more addicted women (Kapur, Hackman, Selby, Klein & Koren, 2001; Wisborg, Henriksen, Jespersen & Secher, 2000b). Hotham, Gilbert and Atkinson (2006) proposed that nicotine patches might not be effective in reducing smoking prevalence rates among pregnant women. Instead, tobacco control measures and tailored smoking cessation support for women and their partners might be more effective tools in reducing smoking rates in this population.

1.3.5 Relapse Prevention

Reducing the relapse rate among pregnant women and identifying those most at risk of relapse remains challenging (Röske et al., 2006). Partners' smoking status, social support, self-efficacy and smoking abstinence coping strategies have been found to predict postpartum relapse in pregnant women (McBride, Pirie & Curry, 1992). Intention to resume smoking was identified as the main factor that predicted relapse within a year of post partum. This confirms the need for relapse prevention interventions for pregnant women and for all health professionals working with this population to address the issue (Röske et al., 2006). Johnson, Ratner, Bottorff, Hall and Dahinten (2000) proposed that smoking cessation interventions should be provided postpartum as well as during the prenatal stage in an attempt to increase smoking abstinence following birth. According to McBride et al. (1992), early postpartum interventions might be effective in preventing relapse as it appears to occur rather gradually. Based on an evaluation of relapse prevention interventions for pregnant women who quit smoking, McBride et al. (1999) revealed that pregnant smokers who receive postpartum interventions are significantly less likely to smoke at eight weeks and six months postpartum compared to women receiving only prepartum support. However, a year after delivery the differences were insignificant. The authors concluded that the duration and effectiveness of relapse prevention interventions for pregnant women need to be intensified.

A smoking cessation and relapse prevention intervention consisting of individual skill instruction and counselling with the help of self-help materials and regular reinforcement delivered by peer health counsellors was found to be ineffective for pregnant smokers (Gielen et al., 1997). Hotham, Atkinson and Gilbert (2002) proposed that health promotion for pregnant smokers should convey the

benefits of life time smoking abstinence for the woman, her partner and children. A recommendation based on Lumley et al.'s (2004) systematic review was that effective stop smoking interventions need to account for the perceptions of the women.

1.4 The Perceptions of Pregnant Smokers

Hotham et al. (2002) conducted focus groups with pregnant smokers to identify perceptions of nicotine patch use, approaches to cessation counselling by care providers and barriers to cessation. Although usage of nicotine patches was accepted among most of the women, some were concerned about safety of treatment and perceived smoking to be a preferable option. The pregnant women disclosed that care providers generally differ in their approach to smoking and reporting cutting down on number of cigarettes smoked per day halted further questions about smoking. This had a tendency to give the ambiguous message that cutting down was acceptable. The barriers to smoking cessation were identified as both general and pregnancy specific. Those relating specifically to pregnancy included uncertainty and stress regarding the harmful effects of smoking, as well as societal attitudes. The more general barriers were identified as; nicotine addiction, smoking behaviour as a means of coping with stress, lack of willpower, fear of weight gain, low self-efficacy on maintaining abstinence and smoking behaviour of others in their social network. Despite awareness of the risks related to smoking for the women and fetus as well as social pressures to stop smoking during pregnancy, some women continue to smoke due to feelings of depression and stress. The emotional well being of women might be impacted by physical health concerns, anxiety, financial worries and changes in hormone levels.

Ludman et al. (2000) stated that higher levels of stress among smokers might be due to the fact that stopping smoking can reduce stress e.g. through reduced health concerns. A qualitative study undertaken in Sweden explored how pregnant and postpartum women who either quit during or smoked throughout pregnancy perceived their smoking habit. Five different rationales were identified for smoking and quitting; justifying smoking, plans to stop at a later date, stopping smoking only for the duration of pregnancy, smoking as a health risk to the baby and smoking as an addiction that must be controlled (Abrahamsson, Springer, Karlsson & Ottosson, 2005).

1.4.1 Preferred Support

Ussher, West and Hibbs (2004) conducted telephone interviews with pregnant smokers to investigate their interest in types of smoking cessation support. A vast majority of the women, 86%, expressed that they wanted to stop smoking and 69% of these reported that they were interested in receiving support. Heavier smokers and those from managerial or professional occupations were most likely to require help. Individual face to face support as opposed to group interventions, behavioural support and self-help material were mainly mentioned as the preferred types of support. Women from lower socio-economic groups were significantly more likely to prefer 'buddying' as part of the intervention compared to women in professional or managerial occupations. In addition, participants from ethnic minorities mentioned behavioural support as a preferred method significantly more frequently than Caucasians. About half of the women interviewed stated that they were interested in undertaking exercise as part of the intervention. Ussher et al. (2004) concluded that pregnant smokers generally show a high level of interest in quitting smoking and receiving support. However, stop smoking services ought to

take into consideration ethnic and occupational differences and offer a variety of interventions for pregnant women who smoke. Individual support appears to be favoured and these flexible and private interventions must be offered to pregnant women who might feel embarrassed about their smoking status. The authors hypothesised that women from higher socio-economic backgrounds might have been more likely to report higher levels of interest in receiving smoking cessation support due to the fact that they face fewer barriers in attending clinics such as lack of child care. Additionally, women from more deprived socio-economic groups might have expressed higher levels of interest in quitting with a 'buddy' because of a weaker social support network.

1.4.2 Barriers to Attending Stop Smoking Services

Due to the low uptake of smoking cessation interventions during pregnancy (Taylor & Hajek, 2001), Ussher, Etter and West (2006) conducted research into perceived barriers by pregnant smokers to participate in stop smoking programmes by posting an internet based questionnaire on a smoking cessation website. This was the first study that aimed to identify pregnant smokers' perceived barriers and benefits in attending stop smoking programmes. The findings indicated that even though pregnant women who smoke believe that smoking cessation programmes can be very beneficial, they perceived various barriers to approaching services. The most frequently reported benefits of receiving support were advice about cravings and praise and encouragement in quitting. Factors that significantly contributed to an interest in receiving help from a counsellor were older age, lower socio-economic status, partner's encouragement and poorer self-efficacy. A mere 5-6% of the participants had received smoking cessation support during this or any previous pregnancy and many women felt that courses were ineffective and that they would

be unable to access one. A worrying proportion of the pregnant women stated that they had not received any stop smoking advice from their midwife or physician. The most frequently reported barriers were related to not wanting to get disappointed if the quit attempt was unsuccessful and not usually seeking help for issues such as smoking cessation. Ussher et al. (2006) concluded that further research is needed to investigate interventions that address and overcome these barriers. Additionally, stop smoking services must take these barriers into consideration when targeting and supporting pregnant smokers and information regarding the benefits of perceiving support for stopping smoking needs to be delivered during pregnancy. Stop smoking support should be an integrated part of antenatal care and health professionals need to promote smoking cessation routinely.

Translating smoking cessation interventions for pregnant women found effective in randomised controlled trials into equally effective in-service programmes is challenging (Lawrence et al., 2005). Primarily, smoking cessation interventions for pregnant women should be provided to improve outcomes of pregnancy for the infant and woman alike (Lindsay, 2001; Lumely et al., 2004). In addition, Lindsay (2001) proposed that for smoking cessation interventions for pregnant women to be implemented, utilised, supported and effective, they must be acceptable to the clients, providers as well as the strategic management of the programmes. The numerous studies which have investigated the effectiveness of smoking cessation interventions for pregnant women who smoke are futile unless they continue to be implemented and employed regularly by health professionals (Cooke, Mattick & Walsh, 2001). Hegaard et al. (2003) concluded that effective stop smoking regimens can only be successful if they are administered by trained midwives and form an integral part of standard prenatal care. Pregnant women

consider their midwife to be a crucial part of their pregnancy and the support and encouragement received from midwives are valued (Pullon et al., 2003).

1.5 The Role of Health Professionals

Prenatal care, involving frequent and repeated visits, offers ideal opportunities to identify smoking status and promote smoking cessation to pregnant women (Morgan, Thorndike, Armstrong & Rigotti, 2003). Recommendations have been outlined for all health professionals regarding the provision of smoking cessation advice to pregnant women. These include; assess smoking status at every opportunity, advise smokers to quit, assist clients in quitting, refer to specialist services, provide information and advice on NRT and recommend use if appropriate. Pregnant smokers should receive clear and firm stop smoking advice throughout pregnancy and training should be provided to health professionals (Raw, McNeill & West, 1999). A brief stop smoking intervention lasting between five and 15 minutes and consisting of the five components and self-help materials has been found to be a modest yet significant tool in increasing quit rates among pregnant smokers when provided by trained health care professionals. The interventions should therefore be implemented systematically by all prenatal care providers (Melvin, Dolan-Mullen, Windsor, Whiteside & Goldenberg, 2000; Secker-Walker et al., 1992).

GPs, obstetricians and midwives regularly meet pregnant women on a one to one basis and are thus ideally suited to provide smoking cessation advice (Department of Health, 1998; McRobbie & Hajek, 2003). Guidelines outlined by the National Institute of Health and Clinical Excellence (NICE) recommend that women with uncomplicated pregnancies should have a booking session and nine or six subsequent antenatal checks depending on whether the woman is a primagravida or

not respectively (NICE, 2008). A woman's main carer during pregnancy is her midwife who inherits the unique position of being able to contribute to the health of the woman, her baby and family (Lawrence & Haslam, 2007; Page, 1995). The relationship between midwives and pregnant women tend to be valued by the health care professionals and clients alike (Fraser, 1999; McCrea & Crute, 1991; Tinkler & Quinney, 1998). Beldon and Crozier (2005) stated that health promotion is a vital aspect of midwifery as the role of midwives involves promoting health rather than treating illness. Another responsibility of midwives is to contribute to reducing social inequalities, which is closely associated with smoking during pregnancy (Lumley et al., 2004). The key group of health care practitioners to provide smoking cessation advice to pregnant women is midwives (Lawrence et al., 2003). Dolan-Mullen (1999) stated that although the assess and advise aspects of the five A's have generally become part of standard care, midwives assist and arrange follow-ups less frequently.

1.5.1 Provision of Smoking Cessation Advice

Lindsay (2001) claimed that health professionals appear to comprehend the dangers of smoking during pregnancy and be enthused to decrease smoking rates. Nevertheless, the applied smoking cessation strategies are likely to be inconsistent and practical resources necessary to implement the strategies are lacking. Evidence also indicates that some health professionals fail to provide the most basic smoking cessation advice. The results from a large UK survey showed that half of pregnant smokers had not received information about the adverse effects of smoking during pregnancy or advice on quitting from their family practitioner and even a lower proportion of the participants claimed that their hospital doctor or midwife had provided any advice (Madeley et al. 1989). Approximately a quarter of pregnant

smokers participating in a more recent study claimed that they had not received any stop smoking advice whilst pregnant (Halsam et al., 1997). When provided, smoking cessation appears to be discussed only during the initial consultation with a midwife and not at every opportunity (Hotham et al., 2002; McCurry, Thompson, Parahoo, O'Doherty & Doherty, 2002).

Cooke, Mattick and Barclay (1996) found that midwives assessed the smoking status of pregnant women but they did not probe level of motivation or scope of social support. Additionally, brief smoking cessation interventions were delivered infrequently and the advice was often ambiguous. In a study conducted by Cope et al. (2003), the majority of pregnant smokers recalled that a general comment about the fact that they ought to quit was the only piece of advice that they had received during pregnancy. This statement did not lead to behaviour change and no information was provided regarding how to stop smoking. About 50% of pregnant smokers taking part in Haslam's and Draper's (2001) qualitative study expressed that they had expected smoking cessation to be discussed to a greater extent during their antenatal consultations. A survey in the USA implied that physicians identified the smoking status of pregnant women at 81% of visits. However, counselling was only provided at 23% of visits. The smoking status of pregnant women was identified more frequently at return visits compared to initial visits. Although unexpected, this finding might have reflected the attempt to establish a sound relationship with the women during the first visit and thus avoiding the subject of smoking. Smoking cessation counselling during pregnancy by physicians appears to be insufficiently implemented and in need of development (Morgan et al., 2003).

1.5.2 Perceptions of Health Professionals

A postal survey of self-reported delivery of smoking cessation interventions to pregnant smokers by maternity staff in London and their attitudes towards smoking during pregnancy suggested that over two thirds of the health care professionals had not provided any stop smoking advice during the previous week. This was despite that fact that the majority of the respondents expressed that; women should not be left alone to decide whether or not to smoke during pregnancy, many women would like to quit during pregnancy and they need support and advice on how to succeed. In addition, helping a pregnant woman stop smoking was perceived as one of the most important aspects of a midwife's role. Thus, the positive approach towards the role of providing smoking cessation advice that midwives held was not reflected in actual actions (Condliffe, McEwen & West, 2005). Some evidence suggests that midwives are more likely to provide self-help smoking cessation material and refer pregnant smokers to relevant services compared to doctors. However, they appear more reluctant to recommend complete abstinence preferring instead to encourage cutting down (Cooke et al., 2001; Walsh, Redman, Brinsmead & Arnold, 1995).

a. The Relationship

Aveyard, Lawrence, Croughan, Evans and Cheng (2005) reported that midwives might feel concerned about delivering more intense smoking cessation advice to pregnant smokers, as they believe that it might have a negative impact on their relationship by clients perceiving the process as hassling rather than helpful. The majority of midwives reported that they only bring up the topic of smoking at booking unless the woman raises the subject at subsequent meetings. The authors found that intensive advice to stop smoking delivered to pregnant women who

smoke was not associated with increased levels of stress. Smoking cessation advice could thus be provided to pregnant women without the worry that it will cause stress, in particular if the situation offers an opportunity to discuss fears and other issues. McLeod et al. (2003) also established a link between barriers to providing stop smoking advice and the fear of damaging the relationship between the midwife and the pregnant women. Although the results showed that stop smoking interventions delivered by midwives were significantly more effective than standard care, a number of midwives found it very difficult to ask women to participate in the study and consequently did not carry out the intervention. The midwives recognised that part of their role was to enquire about a woman's smoking status, yet many perceived knowing how to ask, identifying who might be receptive to the advice and providing appropriate support as challenging. Additionally, the midwives did not want to make their clients feel guilty or jeopardise their relationship. However, pregnant women expected to be asked about their smoking status by the midwife and those who expressed an interest in quitting experienced the midwife as providing helpful support and information (McLeod et al., 2003; McLeod et al., 2004).

Other circumstances that the pregnant women might experience could hinder some health professionals from bringing up the topic of smoking cessation (Aquilino, Goody & Lowe, 2003). However, Pullon et al. (2003) found that pregnant women perceive the attitude that midwives exhibit towards smoking cessation to be vital and reinforcement beneficial. Clear information and continuous support were appreciated and even when the advice became repetitive it was accepted that discussing smoking cessation was part of midwives' role. Some women expressed that they only studied smoking related material when the midwife had spent time introducing it.

b. Ability and Self-Efficacy

Research has identified that lacking necessary skills and knowledge as well as poor self-efficacy can prevent health professionals from promoting smoking cessation (Bishop, Panjari, Astbury & Bell, 1998; Condliffe et al., 2005; Cooke et al., 1996; Lindsay 2001; Mullen & Holcomb, 1990; Pullon et al., 2003). Clasper and White (1995) found that the majority of midwives, general practitioners and obstetricians in the UK perceived providing stop smoking counselling as a difficult and disagreeable task. About half of the practitioners reported feeling insufficiently trained and less than a third felt they possessed the necessary skills to provide advice. Implementing training could potentially improve ability and self-efficacy levels among midwives. However, lack of staff training has also been identified as a barrier to providing smoking cessation advice (Aquilino et al., 2003; Lowe, Balanda, Stanton, Del Mar & O'Connor, 2002).

c. Work Environment and Resources

Clinic priorities, staff shortages, hectic work schedules, insufficient time, large case loads and lack of continuity of care have been quoted as issues negatively influencing the provision of stop smoking advice to pregnant women (Aquilino et al., 2003; Bishop et al., 1998; Cooke et al., 1996; Lowe et al., 2002). Studies have also implied that staff approaches to clients and perceived clinical administration support might impact the delivery of health promotion information (Aquilino et al., 2003; Bishop et al., 1998). Ambiguous health messages, lack of relevant politics and a comprehensive hospital policy could be barriers to promoting smoking cessation with pregnant women (Bishop et al., 1998; Cooke et al., 1996). Likewise, Cooke et al. (1996) suggested that the existence of relevant politics and support from colleagues predicted delivery of smoking cessation advice. Some health

professionals perceive insufficient appropriate resources and educational materials as contributing factors to the difficulty of giving advice (Aquilino et al., 2003; Cooke et al., 1996; Lowe et al., 2002). Resources which have been specifically tailored for pregnant women who smoke have been found to be a beneficial tool in enabling midwives to more effectively provide appropriate advice (Pullon et al., 2003).

d. Outcome of Advice

Mullen and Holcomb (1990) found that factors that predicted allied health professionals' attitudes, beliefs and practice regarding health promotion and disease prevention included professionals' expectations of adherence and health outcomes. Condliffe et al. (2005) hypothesised that a reason why midwives do not systematically discuss smoking cessation might be unrealistic expectations of the outcome of the messages which can cause disillusion regarding the task. Negative perceptions of the effectiveness of interventions have also been identified as potential barriers (Aquilino et al., 2003; Bishop et al., 1998; Lowe et al., 2002). Bakker, de Vries, Mullen and Kok (2005) explored perceptions of providing smoking cessation counselling and the results revealed that midwives were generally motivated to provide advice but not to deliver interventions. Due to the barriers encountered by midwives in providing stop smoking interventions, the task of referring pregnant smokers to specialist stop smoking services is a vital element of their role in reducing smoking prevalence rates among pregnant women (Owen & Penn, 1999). In the UK, midwives are requested to refer pregnant women who smoke to specialist advisors at local National Health Service (NHS) stop smoking services (Department of Health, 2001).

1.6 UK Targets and NHS Stop Smoking Services

Reducing the proportion of pregnant smokers in the UK would lead to health gains for baby and mother as well as immediate financial savings to the NHS. Thus, the Department of Health (DH) outlined an aim in the *Health of the Nation* stating that at least a third of all pregnant women should stop smoking at the start of their pregnancy by the year 2000 (Department of Health, 1992). In the White Paper *Smoking Kills* (Department of Health, 1998), the government set a target for decreasing the percentage of pregnant women who smoke in the UK from 23% to 15% by the year 2010 with a fall to 18% by 2005. This would mean a reduction of around 55,000 pregnant smokers in England (Department of Health, 1998). In an effort to reach the set target, an NHS Pregnancy Smoking Helpline was set up for women to call and receive information about giving up and local Stop Smoking Services were established throughout the country where pregnant women can receive free support in their quit attempt. The NHS stop smoking programme is comprised of a combination of weekly behavioural support received on a one to one or group basis by a trained advisor four weeks post the quit date and the option to use pharmacotherapies (Department of Health, 2001). NICE guidance outlines that NRT can be supplied to pregnant women who have not managed to stop smoking (NICE, 2008). The NHS smoking cessation programmes have been identified as extremely cost effective interventions (West, McNeill & Raw, 2000). However, only approximately 5% of pregnant women who smoke attend stop smoking programmes in the UK (Taylor & Hayek, 2001).

1.7 Recommendations for Research

The NHS in the UK as well as many other health services worldwide strive to identify pregnant women who smoke and engage them with stop smoking services in

an attempt to reduce smoking rates during pregnancy (Condliffe et al., 2005). There is a need for research to examine the perspectives of women as well as health professionals to develop and improve smoking cessation interventions for pregnant smokers (Lindsay, 2001).

1.7.1 Pregnant Women who Smoke

The British Medication Association (2004) recommended that future research should investigate factors that contribute to successful recruitment, participation, success rates, relapse and outcome in real-life settings particularly with regards to reaching women from lower socio-economic groups. Pollak et al. (2006a) and Ershoff et al. (2000b) stressed that there is a need for improvements in smoking cessation interventions for pregnant women. Lawrence et al. (2005) proposed that an exploration into the complex and unique intentions that pregnant smokers experience and interventions developed accordingly is required. Women's perceptions of smoking and stop smoking support should be taken into consideration (Hotham et al., 2002). Further evidence of the factors associated with stopping smoking during pregnancy is needed (Woodby et al. 1999). Although evidence suggests that most pregnant smokers wish to quit, there is a lack of research into how pregnant women perceive smoking cessation services. Therefore, it is unclear how satisfactory pregnant women find the available stop smoking support as well as the type of support they require including NRT use (Lindsay, 2001; Ussher et al., 2004).

Ussher et al. (2004) recommended that future research is required to identify barriers perceived by pregnant smokers to attend stop smoking services and to design effective interventions. The results from Ussher et al.'s (2004) study investigating pregnant smokers' perceptions of stop smoking support were based on one brief telephone interview. The authors therefore proposed that profound face to face

interviews with pregnant women who smoke are needed to explore this area further. Additionally, research exploring barriers to and benefits of attending stop smoking services needs to be conducted with a more representative sample of pregnant smokers including those from lower socio-economic and Black and Minority Ethnic (BME) groups. Consequently, stop smoking services need to address the perceived barriers, inform pregnant smokers of the benefits of services and target women who require support in stopping smoking during pregnancy to tackle the low uptake of smoking cessation programmes by pregnant women who smoke (Ussher et al., 2006). Ruggiero, Webster, Peipert and Wood (2003) advised that in order to reduce smoking prevalence among pregnant women and relapse rates for postpartum women, not only must smoking cessation interventions that help pregnant women quit and stay abstinent be developed but more effective methods of reaching pregnant smokers should also be identified.

1.7.2 Midwives

Battersby, Fendall and Pougher (2002) recommended that midwives need to be trained in delivering stop smoking advice as well as in referring clients to appropriate stop smoking services. There is need for improvement in providing smoking cessation advice among health professionals working with pregnant women (Halsam et al., 1997). Lawrence and Haslam (2007) stressed the importance of enhancing the communication process between health professionals and pregnant women as midwives tend to acknowledge their role of providing stop smoking advice but might be disinclined to do so due to their concerns regarding the reactions of their clients. McEwen, West, Mitchell and Ussher (2003) detected that the number of pregnant women who are identified as being smokers by health care professionals do not reflect the true proportion of pregnant smokers. They presumed that this

problem was both due to underreporting by pregnant women as well as busy health care staff not routinely questioning the smoking status of their clients. Further research is needed to explore the barriers that midwives face in providing smoking cessation messages to their clients (Condliffe et al., 2005). Very few studies have investigated issues related to how health professionals perceive providing advice and the actual delivery of smoking cessation schemes to pregnant smokers. Practicalities as well as perceptions are commonly overlooked in research studies. Additionally, attempts to investigate how personal characteristics of health professionals, such as smoking experience, influence the likelihood to provide stop smoking advice is lacking (Lindsay, 2001). Lowe et al. (2002) suggested that professional and social interactions might feature as potential barriers for promoting smoking cessation and that significant factors relating to the probability of health professionals addressing the topic of stopping smoking with pregnant women have not been identified.

1.8 The Present Study

In order to help a greater number of pregnant smokers change their habit and consequently reduce smoking prevalence rates among pregnant women, increasing uptake of stop smoking services is essential. Due to the imperative role of midwives in antenatal care and health promotion (Beldon & Crozier, 2005; Lawrence et al., 2003; Lawrence & Haslam, 2007) the perspectives of midwives as well as pregnant smokers are significant factors in the process. A comprehensive understanding of the barriers midwives face in promoting smoking cessation to pregnant women and what prevents uptake of NHS stop smoking services by pregnant smokers appears to be lacking. As smoking rates are considerably higher among socially disadvantaged pregnant women (Penn & Owen, 2002), the research aimed to identify how midwives perceive providing stop smoking advice to their clients and pregnant

smokers' perceptions of stop smoking services in a deprived area of London. The research was undertaken in the borough of Camden which despite its wide disparities between the richest and poorest wards, was ranked the 19th most deprived borough in England in 2004 (Office of the Deputy Prime Minister, 2004). Smoking rates in Camden have been reported as higher than then the national average (Camden Primary Care Trust, 2006).

Qualitative research allows for the discovery of psychological processes that predicate behaviours impacting on health and illness (Payne, 2004). Conducting research absent of preceding assumptions of the perceptions of the participants is feasible through the application of a qualitative approach (McCrea & Crute, 1991). A qualitative design was thus employed in an attempt to in depth expose perceptions of midwives and pregnant smokers. Focus groups were carried out with midwives and semi-structured interviews were undertaken with pregnant women who smoke to permit the participants to expound their perceptions and the researcher to further explore the topics and gather rich and valuable data.

CHAPTER 2

METHODOLOGY

2.1 Rationale

Smokefree Camden offers pregnant women who smoke support in their quit attempt. Anyone who wishes can access the service regardless of whether they are residents of the borough or live elsewhere. The stop smoking programme is based on the recommended guidelines outlined by the Department of Health (2001) and consists of weekly behavioural support and the option to use pharmacotherapy. However, the support offered to pregnant women is more intense and extensive as frequent contact is established and maintained throughout pregnancy as well as post partum. The stop smoking sessions can take place in the woman's home if they are residents of the borough or in the location of the advisors' workplace. Midwives based in the borough are required to identify the smoking status of all pregnant women, provide advice and refer women to appropriate services (NICE, 2006; Raw et al., 1999).

The aims of the study were to identify how midwives perceive providing stop smoking advice to pregnant women and how pregnant smokers perceive the stop smoking services. Grounded Theory enables the researcher to conceptualise the topic that is being explored by forming a theory. As the research method involves investigating the consequences of actions and social interactions and the instigation of social processes, Grounded Theory was identified as a suitable methodology to be used in conducting the research (Willig, 2008).

2.2 Participants

2.2.1 Midwives

Three focus groups were undertaken with midwives. The aim was to include between six and eight midwives in each focus group to get the ideal number of participants (Krueger & Casey, 2000). However, due to time and staff restraints, 15 midwives in total took part in the study with two focus groups consisting of four midwives and one group including seven midwives. The participants comprised 11 community midwives, a specialist midwife, a consultant midwife, a rotational midwife and a manager of community midwifery. The midwives are numbered 1 to 15 in the findings section to represent the quotations of the participants (group one: 1-4, group two: 5-11 and group three: 12-15).

2.2.2 Pregnant Smokers

The initial research proposal sought to undertake focus groups with pregnant smokers. However, due to the challenges in identifying pregnant women who smoke to participate in the research, it proved unfeasible to recruit between six and eight participants simultaneously and to find a convenient location for all to attend. Therefore, ethical approval was sought to undertake semi-structured interviews with pregnant women who smoke. A total of 10 interviews were carried out and each woman was given an assumed name for purposes of anonymity. All of the participants were self-reported pregnant smokers at the time of their interviews. Of the 10 participants six categorised themselves as white British, one as black African, one as black Caribbean and two as mixed white and black Caribbean. The age of the women ranged between 18 and 39 years and five participants were primigravidas. Five of the pregnant women were in the process of trying to quit or cut down with the help of a stop smoking advisor, one woman who had not attended the service and

was at a very late stage of her pregnancy now requested support from the service, one participant had attended the service but was unsure if the time was right for her to change her habit, one woman had recently attended smoking cessation sessions but been unsuccessful in her quit attempt, one of the women wanted to stop smoking but had not attempted to do so or sought help from stop smoking services and one participant did not want to stop smoking. Table 2.2.3 summarises the information collected from the pregnant smokers.

Table 2.2.3 Summary of information collected from the participants.

Assumed Name	Age	Ethnicity	Pregnancy	Use of Stop Smoking Service during Pregnancy
Amy	29	Black/Black British Caribbean	2nd trimester	Attended the service
Sarah	19	White British	3rd trimester Primagravida	Did not attend service as did not want to quit
Emily	19	White British	2nd trimester Primagravida	Attended the service
Anna	29	Mixed White and Black Caribbean	1st trimester	Attended the service
Maria	30	Mixed White and Black Caribbean	2nd trimester	Had previously attended the service but unable to quit
Susan	39	White British	2nd trimester Primagravida	Attended the service
Jane	25	White British	2nd trimester	Attended the service but unsure of quitting
Clare	28	White British	2nd trimester	Attended the service
Kate	36	White British	3rd trimester	Had not attended the service but wanted to quit
Tracy	18	Black/Black British African	3rd trimester Primagravida	Attended the service at a very late stage in pregnancy

2.3 Materials

2.3.1 Midwives

A questioning route consisting of opening, introductory, transition, key and ending questions was developed. The purpose of the opening question was to make participants feel more comfortable and it required a brief and easily answered response. The introductory questions encouraged the focus group to start reflecting on the research subject by introducing the topic whereas the transition questions focused on the discussion topic in more depth and were thus the final link to the key questions. The main part of the focus group was centred on the key questions as they were designed to gather the bulk of the data relating to the research question. “How do you feel about talking to pregnant women about smoking cessation” is an example of a key question asked. Ending questions enabled the participants to reflect on the comments and thoughts that had been imparted and brought closure to the discussions (Krueger & Casey, 2000). Probing questions were added to further explore the responses of the participants.

2.3.2 Pregnant Smokers

An interview agenda was developed to create flexible semi-structured interviews. That is, the participants were encouraged to expand upon the topic yet the interview was lead in the relevant direction (Willig, 2008). A small number of open-ended questions were prepared including “How do you feel about the stop smoking service” and “What could stop you from approaching/make you approach the stop smoking service”. However, the questioning route and the probing questions used depended on the participant and the areas that needed further elaborating during the interview.

2.4 Procedure

2.4.1 Midwives

The midwives were recruited from two acute trusts within the borough of Camden. Two focus groups were carried out in hospitals and one was run in a Children's Centre in the borough. Participant information sheets were provided and written consent obtained prior to the focus groups taking place. The focus groups lasted approximately an hour and the main researcher facilitated the groups. Debriefing followed the discussions which were recorded.

2.4.2 Pregnant Smokers

The women were identified and recruited through midwives and the specialist stop smoking service. Three semi-structured interviews took place in the participants' homes, six women were interviewed at the hospital where the stop smoking service was based and one interview was conducted in a Children's Centre in the borough. The women received participant information sheets and written consent was obtained prior to the start of the interviews. The semi-structured interviews lasted between half an hour and an hour and the main investigator carried out all of the interviews which were recorded. The participants received £10 vouchers for retail stores as incentives to take part and a debriefing session took place after each interview.

2.5 Data Analysis

The tapes from the focus groups and the semi-structured interviews were transcribed and the constructs of Grounded Theory (Corbin & Strauss, 1990; Glaser & Strauss, 1967) were used to analyse the qualitative data. The data was subjected to the full version of Grounded Theory as open coding and exploration of the data were undertaken throughout and further data was gathered until saturation was reached

(Willig, 2008). A social constructionist approach was employed as it was assumed that codes and categories did not emerge from the data but were constructed by the researcher (Charmaz, 2006). The theory was presumed to be a reading of the data shaped by the researcher's personal background, method of questioning and usage of data, and thus not perceived as the only truth (Willig, 2008). As social processes as well as participants' experiences were focused upon, the research used a combination of the objectivist and subjectivist perspective to gain a more conclusive perception of the data (Willig, 2008). Data collection and analysis were undertaken concurrently to guide the direction of the subsequent focus group and interview. The initial phases of the analysis involved open coding and axial coding (Strauss & Corbin, 1990).

2.5.1 Coding

Initial open coding of the data was carried out by using line-by-line coding to select, separate and sort data (Charmaz, 2006) in order to identify descriptive low-level categories and codes grounded in the data (Willig, 2008). The process of axial coding was used as a coding paradigm by documenting and interconnecting the identified categories and codes in order for higher-level analytic and abstract sub-categories to emerge (Strauss & Cobin, 1990; Willig, 2008). Constant comparison analysis ensured that similarities and differences between the codes were explored and that sub-categories within categories emerged. Cases that did not fit within the categories were identified through negative case analysis (Willing, 2008). The constructs of theoretical sensitivity and theoretical sampling were utilised to reach theoretical saturation. That is, the researcher interacted with the data and progressed from a descriptive to an analytic level. Based on the identified categories, further data was collected until no more categories transpired and saturation was achieved (Willig, 2008). During the process of analysis, memos, diagrams and questions were

documented (Chamberlain, Camic & Yardley, 2004; Willig, 2008). Core categories were developed from the established categories by using selective coding (Chamberlain et al., 2004).

2.5.3 Reflexivity

As the social constructionist approach was used to analyse the data, it was necessary to incorporate reflexivity on the part of the researcher in the study. The researcher, who both conducted the focus groups and the semi-structured interviews as well as undertook the analysis of the data, worked at the NHS Stop Smoking Service in the borough. The remit of the job role of the researcher changed during the course of the research to support pregnant women stop smoking and therefore, some of the pregnant smokers taking part in the interviews were supported by the researcher in their quit attempts. The role as an advisor working for a stop smoking service could have impacted the participants' responses as they may have assumed that discussing negative aspects of the stop smoking service would affect any future support they expected to receive from the researcher. One of the focus groups consisted of midwives whose referrals of pregnant smokers might have been forwarded to the researcher. This might have limited their likelihood to openly discuss their actions and perceptions of providing stop smoking advice. Indeed, the researcher's own experiences and beliefs might also have affected the interpretations of the findings. Although Grounded Theory was employed as a method that was not likely to be influenced by the researcher, the results must be regarded as an interpretation of the data rather than as conclusive facts.

2.5.4 Ethical Considerations

The research was approved by the Central Office for Research Ethics Committees (COREC) (National Research Ethics Service (NRES)) and relevant

Research and Development departments. The amendments made to the research were approved by the research ethics committee.

CHAPTER 3

FINDINGS STUDY 1

MIDWIVES' PERCEIVED BARRIERS AND FACILITATORS TO PROVIDING STOP SMOKING ADVICE TO PREGNANT WOMEN

Midwives are required to assess the smoking status of pregnant women, provide advice on smoking cessation and refer clients to stop smoking services (Raw et al., 1999). However, the provision of stop smoking advice by midwives tends to be inconsistent and inadequate and hence in need of improvement (e.g. Cope et al., 2003; Haslam et al., 1997; Lindsay, 2001). The factors that have been identified as potential barriers to providing stop smoking advice among midwives include a concern that the advice might have a negative impact on the relationship with their clients (e.g. Aveyard et al., 2005; McLeod et al., 2003), lack of ability and low self-efficacy (e.g. Bishop et al., 1998; Condliffe et al., 2005), the work environment (e.g. Aquilino et al., 2003; Lowe et al., 2002), lack of resources (e.g. Aquilino et al., 2003; Lowe et al., 2002) and negative expectations of the outcome of the advice (e.g. Aquilino et al., 2003; Lowe et al., 2002). There is a need for further in depth research exploring how midwives regard providing stop smoking advice focusing on perceptions and practicalities as well as personal characteristics (Condliffe et al., 2005; Lindsay, 2001).

The aim of the present study was to identify how midwives perceive providing stop smoking advice to pregnant women. In order to obtain a profound understanding of the perceptions of midwives, a qualitative approach was applied and focus groups with midwives were conducted. The qualitative data from the focus groups was analysed within the constructs of Grounded Theory (Corbin & Strauss, 1990; Glaser & Strauss, 1967) and data collection and analysis were conducted until

theoretical saturation was achieved. Three focus groups with midwives were undertaken.

Two core categories emerged from the transcribed and analysed data from the focus groups:

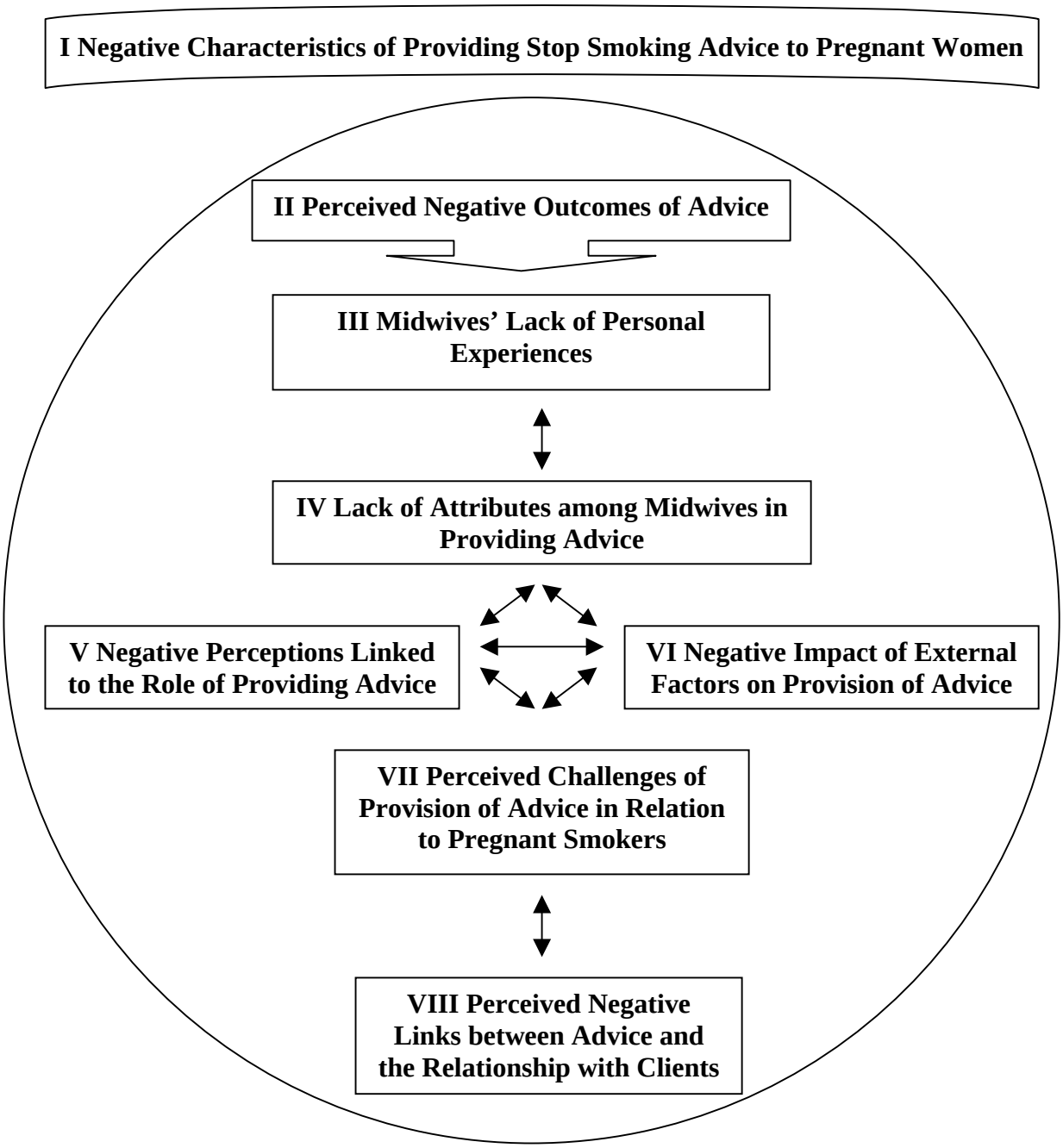
1. Perceived barriers to providing stop smoking advice to pregnant women
2. Perceived facilitators to providing stop smoking advice to pregnant women

The analysis indicated that the midwives mainly perceive barriers to providing smoking cessation advice. However, themes also emerged relating to what the midwives felt could facilitate the process. Therefore, the core categories were identified as perceived barriers and facilitators to providing stop smoking advice to pregnant women. Although the barriers outweighed the facilitators, many of the categories identified within the two core categories were interlinked. The first core category, the perceived barriers to providing stop smoking advice to pregnant women, is initially discussed. The extracts in the sections represent comments made by midwives during the focus groups. The instances when the quotations illustrate a conversation rather than comments from separate groups or instances are noted in the text.

3.1 Core Category 1 – Barriers to Providing Stop Smoking Advice to Pregnant Women

There were several categories that emerged from the analysis that were linked to the midwives' perceptions of barriers to giving smoking cessation advice. Diagram 3.1.1 illustrates the identified categories of the barriers to giving advice and the links between them.

Diagram 3.1.1 The links between the categories identified as perceived barriers to providing stop smoking advice by midwives.

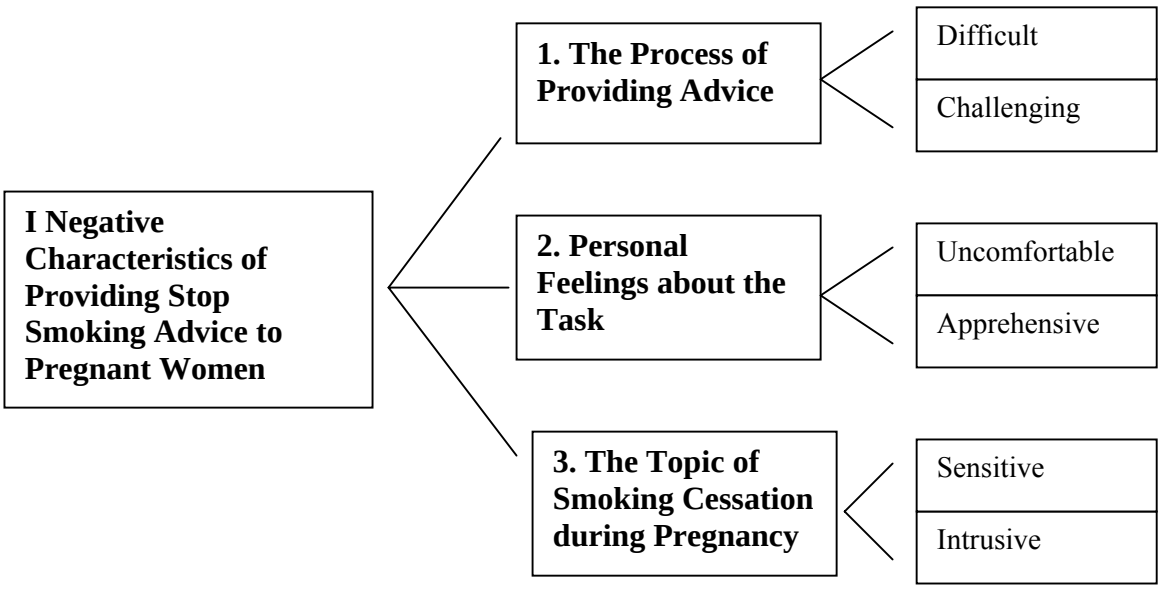


Each category identified as a theme relating to barriers to providing stop smoking advice and their sub-categories are discussed. The end of the section outlines the relationships between the categories.

I Negative Characteristics of Providing Stop Smoking Advice to Pregnant Women

The midwives used a variety of descriptions regarding their feelings about providing stop smoking advice to pregnant women. The majority of these expressions were negative. The midwives' perceived characteristics of the task of providing stop smoking advice could be divided into sub-categories of how they found '**the process**' of giving advice, what their '**personal feelings**' about the task were and how they perceived smoking cessation during pregnancy as a '**topic**'. Diagram 3.1.2 illustrates the category 'negative characteristics of providing stop smoking advice to pregnant women', its sub-categories and examples of these.

Diagram 3.1.2 'Negative characteristics of providing stop smoking advice to pregnant women' and its sub-categories.



Examples of some of the comments made with regards to the midwives' perceptions of providing stop smoking advice to pregnant women were the following:

12 I find it difficult.

4 …my first thought was that it's just an ongoing challenge…

1	*It's such a huge challenge.*
2	*I usually feel a bit apprehensive before discussing it with them.*
14	*It's a sensitive issue.*
9	*…they don't expect such intrusive questions.*

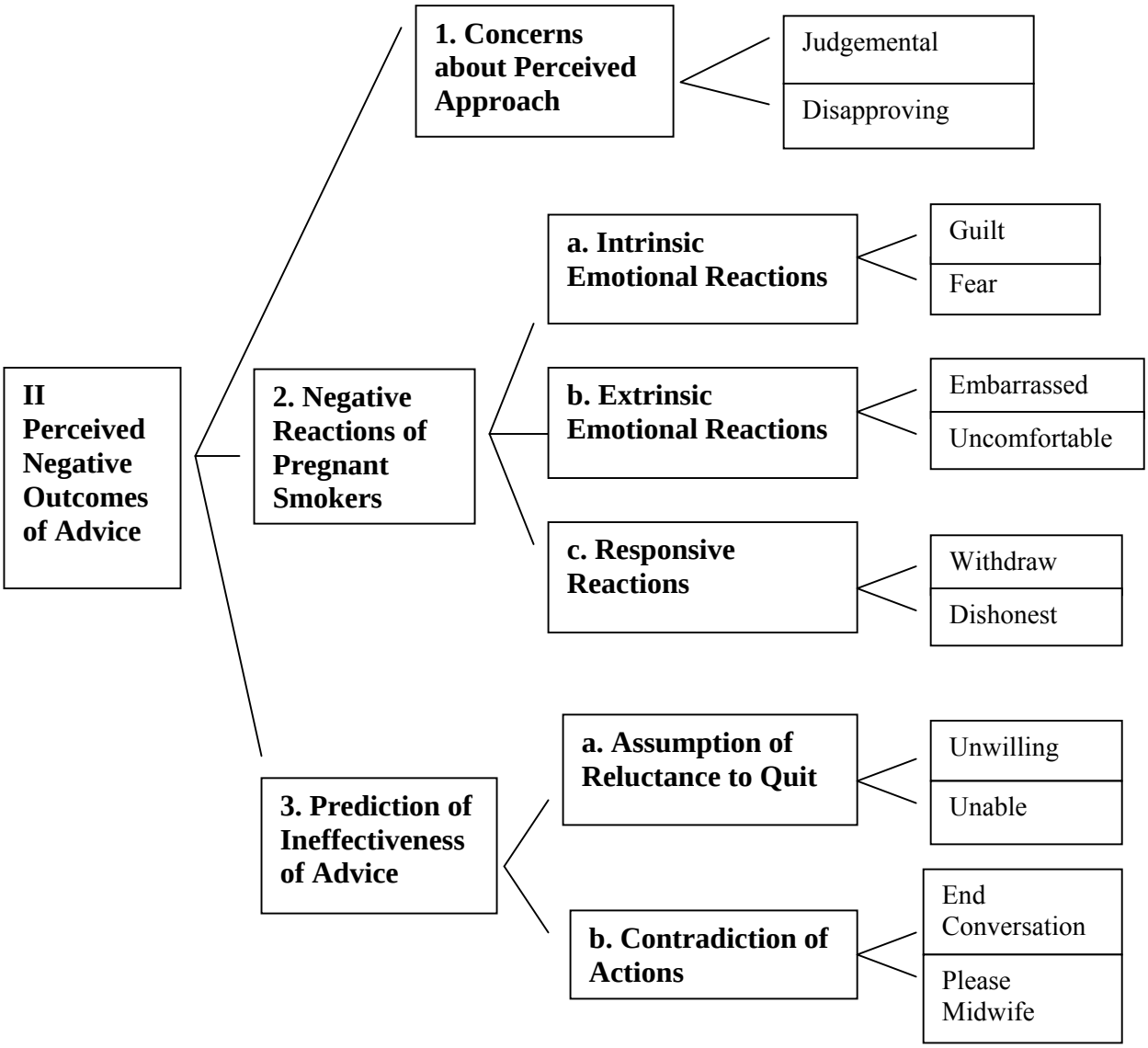
Although the midwives were asked '*What could make it difficult to give stop smoking advice to pregnant women*', this question was raised at a later stage during the focus groups after the midwives had explained that they felt the process was difficult. Therefore, the negative expressions of the subject were not a result of a leading question. The most frequently used word to describe how midwives felt about giving stop smoking advice was *difficult*. The process of providing advice was experienced by some of the midwives as negative and they thus used negative words such as difficult and challenging when reflecting on promoting smoking cessation to clients. Some of the participants referred to their personal emotions when describing their perceptions of the task. That is, they explained feeling uncomfortable or apprehensive about providing advice. Many of the midwives perceived the topic of smoking cessation during pregnancy negatively in that it was a sensitive or intrusive issue. The reasons midwives used these negative characteristics to describe the process of providing stop smoking advice, their personal feelings about the task and the topic of smoking cessation during pregnancy were explored during the focus groups. These reasons were identified as themes relating to '**perceived negative outcomes of advice**', '**midwives' lack of personal experiences**', '**lack of attributes among midwives in providing advice**', '**negative perceptions linked to the role of providing advice**', '**negative impacts of external factors in provision of advice**', '**perceived challenges of provision of advice in relation to pregnant**

smokers' and '**perceived negative links between advice and the relationship with clients**'. Therefore, 'negative characteristics of providing stop smoking advice to pregnant women' was identified as the overarching category linking in with the other categories and providing an explanation as to why the midwives mostly perceived providing advice in a negative light.

II Perceived Negative Outcomes of Advice

Midwives' perceptions of the outcome of providing stop smoking advice to pregnant women formed a substantial category as a potential barrier to promoting smoking cessation. That is, some participants expected the advice to have negative consequences and were therefore more reluctant to discussing smoking cessation. These expectations were based on the midwives' actual experiences of providing stop smoking advice as well as the assumed outcomes of the advice. The midwives' perceived negative outcomes of the advice were related to their '**concerns about how clients perceive their approach**', the '**negative reactions of pregnant smokers**' and their '**predictions that the advice would be ineffective**'. The negative reactions of the pregnant women that the midwives feared the advice would lead to could be split into '**intrinsic emotional reactions**', '**extrinsic emotional reactions**' and '**responsive reactions**'. The midwives' negative predictions of the outcome of the advice were associated with their '**assumption of reluctance to quit**' as well as the '**contradiction of actions**' in clients. The categories and examples of the sub-categories are outlined in diagram 3.1.3.

Diagram 3.1.3 The category 'perceived negative outcomes of advice' split into sub-categories.



1. Concerns about Perceived Approach

When asked about the first thing that comes to mind when thinking about giving stop smoking advice, one midwife responded:

> *2 Not to be judgemental probably. Not to come across as being judgemental.*

Many of the participants worried about how they come across when providing stop smoking advice and that pregnant women perceive their approach as

negative. The midwives explained that in reality they did not feel judgemental towards or disapproving of pregnant women who smoke. However, they were worried that their clients' perceptions of the provision of advice would not reflect their real attitude towards pregnant women who smoke. Fearing to be perceived as acting in a judgemental way and trying to avoid appearing as a judging health care professional seemed to be very common phenomena amongst the midwives. Not wanting their clients to perceive them as judgemental or disapproving and expecting the outcome of the advice to lead to these negative perceptions were thus identified as potential barriers to giving smoking cessation advice. Providing information of the risks associated with smoking during pregnancy and simultaneously avoiding being perceived as judgemental was considered a difficult task:

> 1 *You might come across as, um, disapproving.*
>
> 4 *…trying to communicate, um, that they could make a big difference for their health and saying it in a way that doesn't come across as judgemental but comes across as factual…*

Some of the midwives expected their clients to perceive receiving the advice in a negative way if the wrong things were said and they therefore strived to phrase the advice well. However, this task was considered challenging. How the midwives were perceived by the pregnant women was expected to influence their clients' reactions to the advice:

> 4 *…not wanting to say the wrong thing and trying to phrase it in a way that might elicit a good response…*

2. Negative Reactions of Pregnant Smokers

Thus, another perceived negative outcome of promoting smoking cessation to pregnant women was the clients' reactions to the advice. Some midwives expected or presumed that the pregnant smokers would react negatively to receiving advice. A number of midwives discussed that they had experienced negative reactions in pregnant smokers following the provision of stop smoking advice. The negative reactions of pregnant women could be split into sub-categories of '**intrinsic emotional reactions**', '**extrinsic emotional reactions**' and '**responsive reactions**'. There was, however, a general conception that both emotional and responsive reactions of the advice varied between pregnant women and that the negative reactions described did not apply to all clients. Nonetheless, the negative reactions that midwives expect or fear that the advice will lead to was a commonly emerging theme during the focus groups and was therefore identified as a barrier to providing stop smoking advice.

a. Intrinsic emotional reactions. Midwives talked about the intrinsic negative emotions that pregnant women who smoke might experience both prior to receiving stop smoking advice and as a result of the advice. The negative emotions were labelled intrinsic as they were directed towards the pregnant women themselves and their smoking habit and they included feelings of guilt, blame and fear. Guilt was the most commonly mentioned negative emotion that midwives believed many pregnant smokers carry or could be triggered by receiving advice. One of the reasons that midwives perceive promoting smoking cessation as a difficult task thus seemed to be due to the assumption that the advice could cause negative intrinsic emotions in their clients:

> *11 I think it's one of the hardest things to talk about, especially if they do* [smoke] *and then you can see that they're feeling really guilty and you just feel a bit like, like a bit torn.*
>
> *1 …a part of our jobs that I think we find difficult. Because I'd say there's such a mine field of not wanting to make people feel guilty…*

It was believed that both pregnant women who wish to change their behaviour as well as women who do not intend to quit experience feelings of guilt. Midwives assumed that the guilty emotions are related to the fact that the women are still smoking during pregnancy and that some feel unable to stop. The guilt was described as rather excessive in some circumstances:

> *7 Some of them are already so riddled with guilt that they want a bit of reassurance just to get an improvement*.

Midwives' attempts to avoid causing or adding negative intrinsic feelings in pregnant smokers was thus identified as a potential barrier to providing stop smoking advice. One midwife explained:

> *14 …you cannot talk a lot about it. Because you make them feel like guilty. I think you cannot really discuss it further if they don't want to.*

Avoiding causing fear was mainly mentioned with regards to scaring women of the health risks of smoking during pregnancy. As identified with regards to coming across as judgemental, some midwives acknowledged the need to inform their clients of the potential detrimental health effects of smoking during pregnancy

but simultaneously they did not want the information to lead to feelings of fear. This process was perceived as a difficult task:

3	*…sort of try and bring up that it does cause cot death, it can cause you to have a small baby but make it in such a way so that you don't scare the woman.*
1	*…you don't want to add to their stress but equally you have to inform them of the serious effects of smoking, so trying to balance the two, saying these quite stark facts which can be quite frightening….*

It thus appears that midwives perceive providing stop smoking advice to pregnant women as a difficult process due to concerns about the way they come across and the negative emotions the advice can result in. However, it was also discussed that causing some negative emotions might in fact be beneficial. This phenomenon was identified as a deviant case as although the desire to avoid behaving in certain ways and causing negative perceptions in their clients existed, it was recognised that this aspect of providing advice could have a positive influence on the outcome and encourage behaviour change in smokers. The extract below illustrates a conversation among some of the midwives regarding the difficulty experienced in achieving this:

1	*Yeah but that's the whole what makes it so difficult about the discussion. You don't want to make them feel terrible but to a certain extent you do. You do want them to feel 'oh my god, this is horrendous I shouldn't do it' ... you want them to take it on board enough.*
2	*Yeah, but you don't want the woman whose baby died of cot death to go away and think 'oh my god, I killed my baby', do you?*

1	*No but you want to say something that she can do to prevent it this time…*
2	*Yeah, of course. You just have to be really careful that it doesn't look like you're…*
4	*Blaming her.*
1	*Yeah, it's a fine line.*

The category 'concerns about perceived approach' and the sub-category 'intrinsic emotional reactions' included some challenging aspects with regards to provision of stop smoking advice to pregnant women. The midwives attempted to avoid appearing judgemental and causing negative emotions within their clients and they feared that promoting smoking cessation and particularly discussing the health risks might lead to these unwanted outcomes. However, the midwives also acknowledged the need to inform their clients of the detrimental effects of smoking during pregnancy and that covering these issues might be necessary in order for pregnant smokers to change their behaviour. It appeared that some midwives felt they had to choose between not providing sufficient information about smoking to their clients or being responsible for these negative outcomes. The chosen option depended on the midwife.

b. Extrinsic emotional reactions. Some midwives explained that pregnant women who smoke are likely to portray or experience negative extrinsic emotional reactions as a result of being offered smoking cessation advice. That is, a perceived outcome of promoting smoking cessation was that pregnant women show or feel negative emotions either towards the need to discuss smoking cessation or towards the midwife providing advice. An assumption among some of the participants was that receiving stop smoking advice is an unpleasant experience. Women could

experience numerous extrinsic emotional reactions as some of these emotions such as feeling ashamed of their habit could lead to other extrinsic reactions like feeling uncomfortable or victimised:

1	*… they might be uncomfortable talking to a health professional about it. They may be embarrassed or feel a bit ashamed that they're still doing something, or just annoyed by the thought that they have to talk to somebody else again about it, you know, what's it to you.*
12	*Even those who have no intention to stop smoking they feel like victims most probably. You know it's not nice to be asked by a midwife that you smoke.*

The last comment alludes that the midwife does not expect pregnant smokers to take responsibility for their behaviour but that they interpret the advice as unfair criticism. This perception could thus be linked to the concern of appearing judgemental. As the midwives wanted to avoid causing negative extrinsic emotions in their clients, the fear of being responsible for creating these feelings could be a barrier for the provision of smoking cessation advice to pregnant smokers.

c. Responsive reactions. The responsive reactions portrayed by pregnant smokers as a result of receiving stop smoking advice were also perceived as challenging and thus a barrier to discussing smoking cessation:

6	*But sometimes women's responses and attitudes can also make it difficult to give advice.*

The sub-category 'responsive reactions of clients' refers to the observed reactions that midwives felt that pregnant women display as a consequence of receiving stop smoking advice. These reactions were perceived as negative in

particular among the clients who do not want to stop smoking. The statement below is taken from a discussion on how pregnant women usually respond when being given stop smoking advice.

> 2 *I think it depends on how they feel about it themselves. It's negative if they are smoking and they're telling you that they're giving up or really that they don't want to give up then their reaction would be, um, to take a kind of step back and kind of just be really dismissive and say oh yeah, blah blah blah.*

Thus, the midwives described some women's reactions as withdrawal and acting dismissively. They experienced a change in the pregnant women's approach towards them as a result of being given advice and consequently, midwives did not feel that the women were equally open or trusting. The desire among midwives to avoid causing negative reactions in clients was therefore identified as a barrier to providing stop smoking advice. As discussed previously, midwives wished to avoid being perceived as judgemental by pregnant women. However, some of the participants felt that the negative responsive reactions of their clients could not always be avoided even when the advice was perceived as non-judgemental:

> 1 *I think sometimes even if your phrase it really well and you, you do it in a nice non-judgemental way I think people… if, if you're smoking and you don't want to be or you think you know it's the wrong thing to do then however somebody's approaching it you are then sat there thinking…you might be talking about eating the right thing or looking after your pregnancies all being positive and exciting and then suddenly you're saying but I am actually still smoking and you're aware it's the wrong thing, you do sometimes see a change in women. I think even if you've had a good*

> *conversation I think sometimes that they sometimes still withdraw a little bit and feel that they've changed in your eyes. Now I might be putting words into their mouth but they do sometimes seem to withdraw a little after it and you can see that they're a little quieter sometimes.*

Some of the midwives thus felt that they were unable to affect the reactions of the pregnant women regardless of how positively the conversation had been or how they had phrased the advice. Feeling unable to impact the outcome of the advice was perceived as a difficult aspect of providing stop smoking advice. In addition, the quotation above indicates that midwives might prefer their clients to perceive them as light-hearted and befriending rather than authoritative health care professionals. There was also a perception among some midwives that it was common for pregnant smokers not to reveal the truth about their habit and that those who did admit to being smokers tended to underestimate their cigarette consumption. The expectation that clients would not reveal their true smoking status could lead to a sense of disillusion about the point of giving advice and thus be a barrier to undertaking the task:

> 9 *There's also this perception that they're not actually telling you the truth, they probably smoke 40 a day…*

Previous research has also found that midwives are concerned that smoking cessation advice will cause negative emotional reactions in clients, such as guilt (McLeod et al., 2003). However, the negative perceptions of the specific outcomes of the advice do not appear to be equally established. The perceptions of the outcomes might be interlinked as midwives' concerns regarding causing negative

reactions in their clients could be related to how they fear they are perceived by pregnant women. That is, midwives might believe that the negative emotions and responses from pregnant smokers might be a direct result of the midwife coming across as judgemental or disapproving.

3. Prediction of Ineffectiveness of Advice

Another negative perception of the outcome of providing advice was that midwives doubted whether the advice would have a positive impact on the women's smoking behaviour. Those who predicted that the advice would be ineffective questioned the actual meaning of discussing smoking cessation with their clients. The 'prediction of ineffectiveness of advice' category could be split into sub-categories of '**assumption of reluctance to quit**' and '**contradiction of actions**'. 'Assumption of reluctance to quit' comprises the outcome of the advice with regards to women declining support in their quit attempt and the 'contradiction of actions' theme relates to the contradiction between women's responses and their behaviour.

a. Assumption of reluctance to quit. Some midwives admitted to feeling sceptical about the purpose of promoting smoking cessation as they did not expect women to stop smoking as a result of the advice. There was a sense that their part alone could not have a great impact on a woman's desire to change her behaviour. Not being able to contribute towards a behaviour change in their clients could also have a negative impact on how midwives felt they carried out their job. One midwife explained the inability to encourage pregnant smokers to quit as a sense of failure:

4	*I'm gonna ask them this question but, but I don't think that they're gonna want to give up and that might feel like I've failed on my part because I've not been this super midwife who's said the right thing at the right time and*

they're gonna quit and, I think that, that probably makes us feel as well uncomfortable about asking.

An assumption that pregnant smokers were unlikely to want to give up existed among some of the midwives and consequently, the potential influence of the advice was perceived as limited. One midwife compared smoking cessation advice for pregnant women to health advice that the midwife had received in their personal life, describing that one simply switches off if the will to change is absent. A number of midwives felt that regardless of how the advice was provided, they were unable to influence some women's decisions to continue to smoke throughout pregnancy and hence access stop smoking services. These perceptions could be both based on assumptions and on their real experiences of providing stop smoking advice. The fact that a woman has not stopped smoking despite being pregnant was perceived by some midwives as a sign that they were unwilling or unable to change their habit. The comments below are examples of two midwives' expectations and experiences regarding the outcome of the advice:

5 *I normally assume they don't want to. If they said I'm a smoker, then that itself sort of statement implies that they intend to continue to be a smoker, do you know what I mean?...they come to us, they, it's not as if we're giving them information that they don't already have, and, I mean if someone intends to give up smoking they would have sought help prior to booking. You know, they would have sought help prior to us seeing them but it's very rare that you, that I would see an individual who is actually, who would be willing to talk about wanting to give up, wanting to access services cause she would*

have accessed them already if they intend to and if they don't intend to then there is just a brick wall against it.

3 I rarely come across women who wanna give up and want the service to give up.

It thus appeared that some midwives assume that all women who want to stop smoking do so upon becoming pregnant and that the ones they identify as smokers are not prepared to change their behaviour. This idea negatively affected the midwives' perceptions of providing stop smoking advice. In addition, this concept could have reflected a tendency to shift the responsibility on to the women. That is, midwives might justify not promoting smoking cessation as they rationalise that pregnant smokers who want support in quitting would request it. The belief that most pregnant women are aware of the risks of smoking during pregnancy prior to seeing the midwife and yet have not given up added to the pessimistic view of the outcome of the advice.

Most midwives appeared, however, to comprehend the difficulty in giving up smoking and they regarded smoking as a strong addiction and a habit which is part of ones lifestyle and hard to break. These midwives acknowledged the importance of wanting to give up a complex behaviour as smoking in order to succeed but this could also be perceived as yet another factor contributing to the unlikely successful outcome of giving advice. The midwives who felt that most clients do not wish to stop smoking found it hard to predict a positive outcome of providing advice as they felt that unless a desire to stop smoking is present, the quit attempt cannot be successful. Cutting down on cigarette consumption was perceived as a more achievable and common outcome than actual abstinence:

15 *They either give up as soon as they find out they're pregnant or they cut right down but, trying to get those to quit completely, that's, that's difficult because in their eyes they think that that's a good thing but it's just a matter of trying to delve in deeper and the just talking a bit more to them about it really.*

A number of midwives had come across pregnant women who had managed to quit during pregnancy but had relapsed soon after delivery. There was a sense that encouraging women to remain abstinent post partum and for their own health was not achieved and therefore health promotion for pregnant women was seen as a difficult area with limited results.

b. Contradiction of actions. Some of the midwives explained that it was not unusual for pregnant women's replies to contradict their behaviour. This concept was mainly discussed in one of the focus groups in which the midwives felt that pregnant smokers frequently convey their wishes to quit or even be referred to stop smoking services but still do not change their smoking behaviour or attend a stop smoking programme. The extract below, illustrating a conversation between two of the participants, indicates that midwives perceive this inconsistency as a result of trying to please the midwife or simply wanting to end the conversation about smoking cessation:

1 *Yeah, they've said what you've wanted, yeah, I'm gonna stop…*

4 *But that's not what they've want to do…*

1 *So the conversation will be over.*

4 *Yeah, well the midwife might be feeling good cause she's got a referral out of it and she's done that so she feels like she's ticked a box but the woman's no*

nearer to changing her health…her lifestyle and her, you know, her smoking habit.

Thus, some midwives did not perceive the contradiction between what their clients say and how they behave as a result of being unable to stop smoking but as a consequence of not wanting to discuss smoking cessation. The midwives had experienced that pregnant smokers often try to end conversations about smoking by stating they have cut down and are not smoking as much as prior to the pregnancy. However, many pregnant women are still smoking later on during pregnancy although they have previously communicated that they are in the process of quitting:

2 *So that happens quite a lot I think. Um, maybe the, the whole, you know, I did smoke this much and now I'm cutting down is a bit of a standard response from people to stop you asking any more questions.*

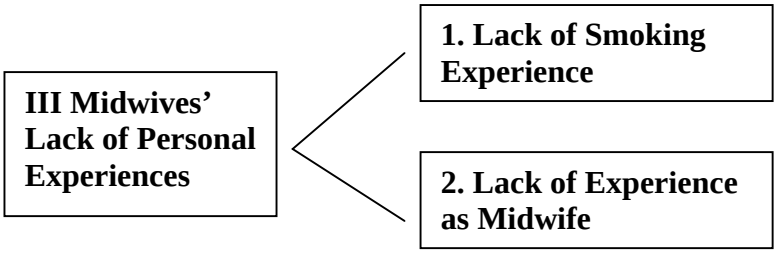
3 *A lot of them would say that they do want to stop but then a few months down the line they still haven't stopped*.

Scepticism regarding the effectiveness of stop smoking advice has previously been identified as a barrier to promoting smoking cessation by midwives (e.g. Aquilino et al., 2003; Bishop et al., 1998; Lowe et al., 2002). The perceived negative outcome of providing stop smoking advice emerged as a robust barrier to discussing smoking cessation among the midwives in the present study. Believing that a task will either not lead to the desired outcome or have detrimental results could prevent health professionals from promoting smoking cessation among their clients.

III Midwives' Lack of Personal Experiences

Some of the negative characteristics that were mentioned with regards to giving stop smoking advice were linked to lack of personal experiences. Both midwives' limited smoking experiences as well as midwifery experiences could negatively influence the perceived process of providing stop smoking advice. This category that emerged as a potential barrier to providing stop smoking advice could therefore be split into sub-categories of '**lack of smoking experience**' and '**lack of experience as midwife**' (diagram 3.1.4).

Diagram 3.1.4 The category 'midwives' lack of personal experiences' and its sub-categories.



1. Lack of Smoking Experience

Most of the midwives were not current smokers and had not previously smoked. Being able to empathise with clients was regarded by many participants as an important element in promoting smoking cessation and their perceived inability to comprehend the behaviour of smoking and the challenges in quitting was therefore seen as a barrier to providing effective advice. By not feeling that they could appreciate their clients' experiences, providing stop smoking advice was seen as a difficult task:

> *2 I feel quite uncomfortable actually because I don't smoke and I've never smoked*

> *13 I think it's harder if you don't smoke, talking to them about it.*
>
> *12 Maybe I should take up smoking, then I would understand.*

Interestingly, although many of the midwives discussed their perceived inability to empathise with their clients with regards to their lack of smoking experience, none of the midwives mentioned their personal experiences in relation to the actual pregnancy. That is, whether or not the midwives had been pregnant or given birth did not appear to have equally much impact on their understanding of their clients' situation and their perceptions of promoting smoking cessation as their smoking experience had. One midwife who was a smoker mentioned that although they did not perceive their smoking status as a barrier, they had reflected on their habit when giving advice and did not appear to think highly of their ability to promote smoking cessation. This was blamed partly on their smoking behaviour:

> *5 I do, I mean I do feel hypocritical sometimes although I'm not pregnant.*
>
> *5 I wouldn't take health promotion advice from me, except that I'm a crap smoker, but you know, who am I to say to someone how to improve their lives. I mean it's ridiculous, it is, it's bizarre.*

The midwives' personal experiences of smoking could therefore act as barriers and this applied mainly to those who were neither smokers nor ex-smokers. Although it is possible that being a smoker could also be a barrier to providing stop smoking advice, it was hard to determine as only two of the midwives were smokers. Additionally, even though the smokers mentioned that due to their behaviour they might not be the best advocated for smoking cessation, they insisted that their habit would not prevent them from discussing smoking cessation with their clients.

2. Lack of Experience as Midwife

A common opinion among the midwives was that a barrier to providing advice about stopping smoking was lack of experience in the job. Some midwives said that they had not spoken about smoking cessation as much in the earlier stages of their career in comparison to when they had gained more experience. One midwife explained that it was harder **not** to talk about smoking at this point in their career compared to earlier on:

> 1 *I think it almost gets harder the longer you're in the job because as you were saying, the smoking, you probably talk to people more about smoking now than when you were newly qualified…*

Midwives' attempts to avoid coming across as judgemental and triggering negative emotions in women were previously mentioned as a difficult aspect of providing stop smoking advice. However, this was perceived as even more challenging for those who had recently started their midwifery career. Some of the participants sympathized with newly qualified midwives who might ignore certain demanding features of their role such as giving stop smoking advice:

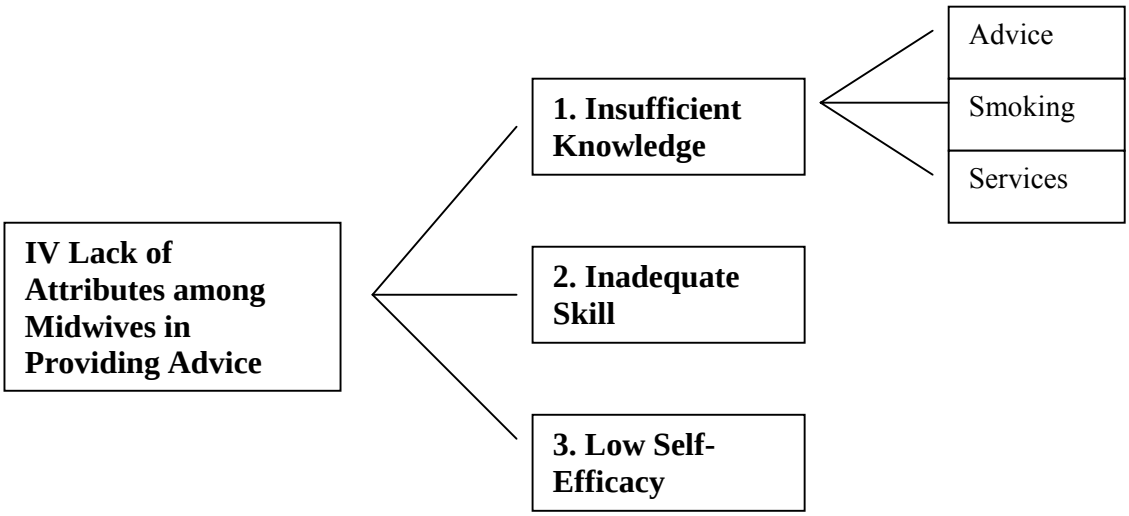
> 7 *There's this standard amount of information that we know women need, that we have a duty of care to provide and then we end up with all of the problems that that might generate with regard to support and trying not to make women feel judged and feel guilty. It's a huge tightrope to walk really. And you could actually forgive perhaps inexperienced practitioners for thinking, I'm not really gonna sort of…*

The duration of a midwife's career could thus be a significant barrier to giving stop smoking advice as it appeared that the whole process of discussing smoking risked being excluded if experience was lacking. Although Bishop et al. (1998) concluded that midwives prefer to discuss their own smoking experience when providing stop smoking advice to clients, Lindsay (2001) recommended that personal characteristics of health professionals such as smoking experience should be further investigated in relation to promoting smoking cessation. The identified theme relating to midwives' personal experiences in providing advice was thus relatively unexplored. In the present study this area was raised by the participants and not introduced by the researcher. It is an important finding as this barrier can only be tackled by influencing midwives' perceptions as changing their circumstances is unfeasible.

IV Lack of Attributes among Midwives in Providing Advice

The perceived difficulty of promoting smoking cessation to pregnant women could be linked to lacking certain attributes. Midwives mentioned a number of attributes that they perceived as necessary in being able to provide stop smoking advice. Lacking these attributes was seen as a potential barrier to giving advice. The attributes that were mentioned as influencing midwives' abilities to promote smoking cessation included '**knowledge**', '**skill**' and '**self-efficacy**'. These and the examples of the sub-category 'lack of knowledge' can be seen in diagram 3.1.5.

Diagram 3.1.5 The category 'lack of attributes among midwives in providing advice' and its sub-categories.



1. Insufficient Knowledge

Lack of knowledge was a commonly mentioned barrier to giving stop smoking advice and many midwives said that they felt limited in their ability to undertake the task as a consequence of the inadequate knowledge they possessed:

9	*Lack of knowledge.* [could make it hard to give advice]
12	*I don't feel I have enough knowledge about it.*
6	*I feel very limited. I have very little information.*

Many of the midwives believed that they did not possess enough knowledge about smoking and smoking cessation and even the midwives who said that their level of knowledge was adequate recognised that this could be a barrier for colleagues who had not acquired the same amount of awareness. The lack of knowledge was associated with various smoking related issues including awareness of what the advice should entail as well as factual aspects of smoking cessation, e.g. how to respond to women who decline support, what advice to give to those who

request help in quitting, facts on NRT use during pregnancy and information about stop smoking services. Any uncertainly regarding how to respond to any raised queries could prevent midwives from introducing the topic:

> 2 *Um, can I just ask, when… sometimes when you ask people at booking about smoking, they'd say…and you ask about cutting down and stopping and everything and some people say, I'm not going to, I know I won't give up, I didn't give up for any of my previous pregnancies, everything was fine um, I'm not going to give up. What do you do? What do you say? I mean do you, I'm asking seriously. Do you...if that was the first answer do you leave it or…?*
>
> 1 *And I think that stops people discussing that. I don't know, it's probably for smoking as well, is that people aren't sure exactly what they're going say to people who say yes or I don't want to. And it could stop you wanting to approach the subject in the first place.*
>
> 12 *If we don't know what kind of services are available, we can't really say it.*

It appeared that some of the participants had rather high demands of the level of knowledge that was required to effectively provide stop smoking advice to pregnant smokers. Possessing this level of expertise with regards to smoking related issues was perceived as lacking among most midwives. Even the midwives who perceived the provision of smoking cessation advice as an important part of their role explained that not feeling as an 'expert' in the field could prevent them from prioritising the topic:

> 9 *Like everyone's said, it is important, I think. But because we're not experts at giving advice we might put down like the last thing that we actually mention*

when we're going through health promotion but it is important just like everything else.

It thus appeared that the level of knowledge that the participants felt was necessary in order to provide advice varied between the midwives. Some mentioned possessing sufficient knowledge of the basic issues of smoking and stop smoking services as sufficient in promoting smoking cessation whereas others tended to require a large amount of information in order to feel comfortable undertaking the task. The reason for these varied perceptions is unclear. It might have been a reflection of how differently midwives perceive their role in encouraging behaviour change in pregnant smokers, it could have been due to individual differences between the participants or alternatively the reason might have been linked to the fact that midwives have varied expectations of their potential influence on the outcome of the advice.

2. Inadequate Skill

Awareness of relevant issues related to providing smoking cessation advice was thus believed to be an important factor in offering advice. However, in order to give advice effectively and achieve a positive outcome, midwives recognised that knowledge needs to be combined with a degree of skill:

4 *So I think, yeah, that it demands more, another level of skill I think to know the right questions to ask ...because addressing stop smoking in pregnancy, apart from just asking a woman does she smoke or does she not, which is quite, anyone can do that, but then do you get a person to think about what do they want to achieve, you know, that they want or give up or moving them*

on to the next step towards making that change, I think demands some degree of skill on the part of the midwife…

You need to be good at engaging.

The skills that midwives discussed as necessary in providing effective stop smoking advice were related to being able to communicate effectively with clients, being aware of which questions to ask and being able to encourage behaviour change in pregnant smokers. Perceiving that a fundamental attribute such as skill in carrying out the task of providing effective stop smoking advice was lacking could thus be an essential barrier to giving advice. As with level of knowledge, the midwives' perceptions of the degree of skill that is necessary in promoting smoking cessation varied. This discrepancy appeared to be linked to the midwives' expectations of the outcome of the advice and the actual task they were expected to undertake. That is, merely identifying a client's smoking status was not regarded as requiring a vast amount of skill whereas encouraging behaviour change was thought to be more demanding.

3. Low Self-Efficacy

Perceptions of possessing insufficient knowledge could lead to low levels of confidence in providing stop smoking advice. Consequently, some midwives felt that inadequate levels of self-efficacy could negatively affect the provision of advice. When discussing what could make it hard to give advice, one midwife explained:

I suppose midwives' knowledge. You know, do you know, do you feel confident, do you feel that you've been updated recently because when you don't, you do pull back a little bit. You think, oh, I don't know where I'm gonna go with this if it develops and that goes for all sorts of subjects, you

know… If you don't feel as if you know what you would say, you're confident of the advice, that can be a barrier for you.

Lack of confidence in providing advice was therefore identified as a barrier to undertaking the task. Although being knowledgeable of relevant issues could positively impact self-efficacy, some of the participants felt that this was not sufficient in feeling confident about the process of offering smoking cessation advice:

9 *I mean you read stuff but actually hearing yourself saying it and being confident saying it is not gonna be easy.*

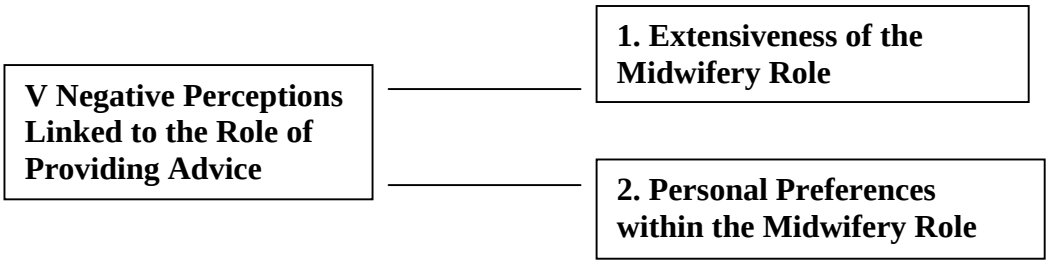
Feeling confident about the ability to promote smoking cessation was perceived as an important factor in giving stop smoking advice among most of the midwives. However, very few said that they possessed adequate levels of confidence regarding their ability to do so. Perceptions of possessing insufficient knowledge, inadequate levels of skill and poor self-efficacy among midwives have previously been identified as barriers to offering stop smoking advice to pregnant women as (e.g. Bishop et al., 1998; Condliffe et al., 2005; Cooke et al., 1996; Mullen & Holcomb, 1990; Pullon et al., 2003). The findings from the present study as well as a previous research confirm the importance of increasing perceived levels of attributes in midwives in order to overcome some of the barriers they face in promoting smoking cessation.

V Negative Perceptions Linked to the Role of Providing Advice

The midwives appeared to have different perceptions of their role of providing stop smoking advice and how it related to other parts of their job. Despite

acknowledging the provision of smoking cessation as an aspect of midwifery care, many viewed it as a difficult part of the job. The '**extensiveness of the midwifery role**' and '**personal preferences within the midwifery role**', impacted on the participants' perceptions of their role in promoting smoking cessation (diagram 3.1.6). These sub-categories were identified as potential barriers to providing stop smoking advice to pregnant women.

Diagram 3.1.6 The category 'negative perceptions linked to the role of providing advice' and its sub-categories.



1. Extensiveness of the Midwifery Role

A recurrent topic during the focus groups was the extensiveness of midwives' role. Smoking cessation is a subject that should be discussed in the initial booking session with pregnant women (Women's and Children's Health, 2008). However, the midwives explained that the allocated time for a booking session is one hour and during this time they are requested to discuss numerous other issues. The comments outlined in the box below are examples of the variety of issues that midwives are required to cover with either all clients or in certain circumstances:

1	*… mental health issues, you know if they're saying yes to depression,*
1	*…sexually transmitted diseases…*
1	*… their housing situation…*
2	*… screening…*

4	*If they've had three or four babies, you know, you've got to get all that history down.*
4	*Consenting for blood test…*
5	*…talking about alcohol…*
5	*… the psychological changes in pregnancy.*
6	*Downs syndrome*
7	*…breast feeding…*
12	*…the domestic violence issue.*
13	*… consenting to and HIV test or talking about a previous termination.*

Some midwives felt that they have to prioritise which topics are the most important as they are unable to cover all of them in depth. Despite being aware of the benefits of stopping smoking during pregnancy, some of the midwives felt that issues, for instance those that demand continuous care, should be prioritised as opposed to a topic such as smoking cessation:

1	*It's a small part of our role* [providing stop smoking advice] *in fairness. You know when you're talking about it and obviously it's serious and we give it its time but you know it's that... a question we ask at the beginning of the pregnancy and it's in an hour session and that conversation is... will often be done within a couple of minutes among other things and at the end of that there might be other things that we weren't sure about like, er, medical history or where you'll be referring to and they're the sorts of things, the things that may need more ongoing care. You're probably more likely to talk to people about that type of advice than that.*

> 11 *We do discuss it cause it's in the notes but it's a small, it is a small part to discuss, especially if there's a lot of problems as well.*

The first quotation in the box above indicates that midwives only tend to discuss smoking cessation during the booking session and that they do not follow up the issue in subsequent meetings. One midwife admitted that due to their wide role, it could be tempting to completely ignore giving stop smoking advice with the belief that someone else will discuss smoking cessation with the pregnant women, thus shifting the responsibility away from the midwives:

> 10 *Our job is so broad as well so obviously we have so many things to cover and then when smoking cessation comes in, it's kind of well, let's leave it to the other people to cover.*

The various areas that midwives are requested to discuss and be aware of were perceived as a big challenge within their work. The extensiveness of their role therefore does not only appear to influence the amount of time they are able to spend covering the different aspects but also perceptions of possessing insufficient knowledge of the topics. This in turn could affect their self-efficacy in carrying out the different tasks. Even the midwives who regarded providing stop smoking advice as a vital aspect of their role found it difficult to fit smoking cessation into the booking session and to feel confident in their ability to discuss the topic due to the numerous other areas they are required to be knowledgeable in:

> 4 *There's only so much you can do and only so much you can be interested in… I don't think there's such a midwife who can be up to date on everything and feel confident about every aspect of her job.*

One of the midwives acknowledged the significance of encouraging smokers to quit during pregnancy. However, the midwife did not feel that the detrimental health impacts of smoking were reflected in how midwives perceive the importance of providing advice:

> *4 I think statistically it's the most important thing we should be talking about because it has, I think the biggest effect on, on… we know that, that a significant minority of pregnant women smoke and we know that that will bring about lots of health issues for their children, may result in prem births and low birth rate babies which take up a lot of resources, lots of time... I read some information recently that said that if we got women to stop smoking we would, it would have the biggest effect on improving infant mortality and morbidity, um. But that's not reflected in, I don't think, in real life that's how we view it. I don't think…*

2. Personal Preferences within the Midwifery Role

Due to the extensiveness of the midwifery role, a theme that emerged from all focus groups was that midwives might specialise in various aspects of midwifery or have different interests in their jobs. These areas of expertise and interest might affect how midwives perceive the diverse parts of their role and how important they view the different elements. When discussing the perceived importance of smoking cessation compared the other aspects of midwifery, one of the participants said:

> *1 It is such a personal midwife thing cause we've all got our own little interests, you know.*

Therefore, in particular the specialist midwives appeared to focus mainly on their specific area and regard this as the most important part of their job. This could result in spending a big proportion of the sessions with clients discussing their field of expertise:

5	*I mean every specialist midwife wants to spend the majority of the time talking about their particular area in booking, you know.*

Not perceiving smoking as an equally important or interesting part of their role compared to other aspects of midwifery could hence be a barrier to giving advice or at least prevent some midwives from discussing it in more detail which would require more time:

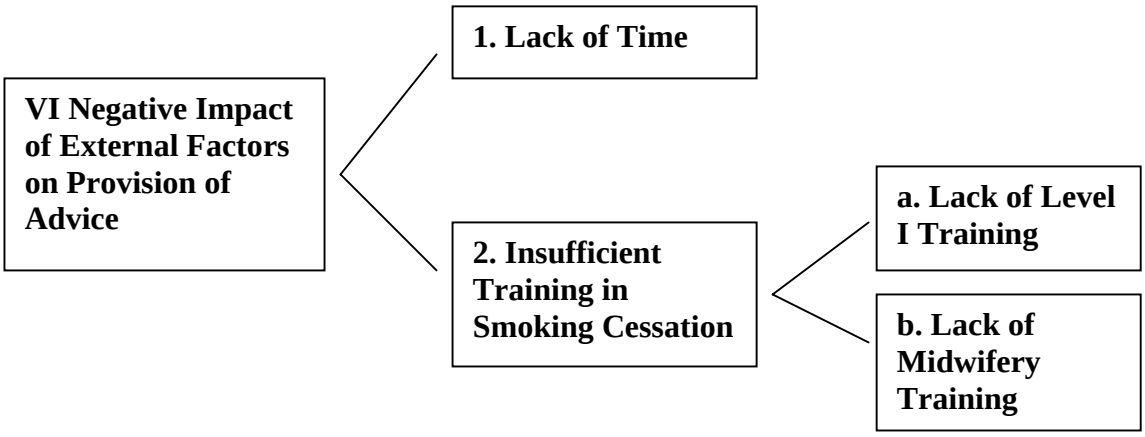
2	*…and I spend more time talking about screening tests because that's my job as well than I would about smoking.*

Although previous research has investigated how midwives regard their role of providing stop smoking advice (e.g. McLeod et al., 2003; McLeod et al., 2004) and some evidence indicates that midwives feel unable to cover all areas of their remit (Aveyard et al., 2005), their perceptions of promoting smoking cessation in relation to other aspects of their role have not been previously reported. It appeared that the midwives do not necessarily perceive provision of stop smoking advice per se as a negative part of their role but that due to the extensiveness of their job, they are compelled to prioritise certain areas. As a result of the broad role of midwifery, the participants explained that they need to spend a vast amount of time with each client; a request which was not met within their work.

VI Negative Impact of External Factors on Provision of Advice

The negative characteristics and perceptions of providing stop smoking advice that midwives mentioned frequently related to external factors. Therefore, the category 'negative impact of external factors on provision of advice' was one of the most predominant areas identified as a barrier to giving stop smoking advice. This category comprises issues that are not related directly to either midwives or pregnant women but were controlled by external factors. '**Lack of time**' and '**insufficient training**' were identified as sub-categories that emerged from external factors. Training could be further split into '**lack of level I training**' and '**lack of midwifery training**' (diagram 3.1.7).

Diagram 3.1.7 'Negative impact of external factors on provision of advice' split into 'lack of time' and 'insufficient training' and its sub-categories.



1. Lack of Time

The midwives' perceptions of providing stop smoking advice to pregnant women were influenced by the work structure. Having insufficient time to undertake all the areas of their job was one of the most frequently mentioned issues that negatively affected the provision of stop smoking advice. Many of the midwives felt that lack of time was the main barrier to promoting smoking cessation effectively:

2 *I think that time issue is the biggest issue.*

11 *It's just hard finding the time.*

7 *…it's time, cause there's a lot that we've got to discuss in an hour.*

13 *I think time constraints* [makes it difficult to discuss smoking cessation].

14 *The midwife is pressurised by time*

The perception of not having enough time related especially to the booking session when midwives are requested to assess the smoking status of clients, provide advice and refer to appropriate services (Raw et al., 1999; Women's and Children's Health, 2008). However, as discussed earlier, various other topics also need to be covered during the hour long allocated booking session. The participants described often feeling rushed and under pressure when undertaking booking sessions. One midwife even described that lack of time is the only factor that could prevent the provision of smoking cessation:

4 *And I think unfortunately, there's so much that we have to cram in like particularly thinking about the booking appointment, so much you have to cram in. If you're going to do a proper, proper assessment of a woman and her needs, and her... and look at her pregnancy holistically. Gosh, you could spend the whole afternoon doing it properly.*

2 *I think an hour plus the discussion about the other stuff you know, may be, you know, but we need more time and you know that's, that's the biggest thing. It's the only thing that would stop me from discussing things fully with people, definitely.*

Midwives were often under the impression that undertaking proper assessments of pregnant women and their needs would require a minimum of double the time of the currently hour long booking session. Some of the midwives were under the impression that although they were expected to complete a booking session in one hour, this was not the recommended time according to National Institute of Clinical Excellence (NICE) whose guidelines they believed indicated that the initial booking session should last between one and a half to two hours.

The restricted amount of time that midwives experienced that they had was seen as a problem to the extent that it prevented them from carrying out their jobs satisfactorily:

1 *You'd be quite happy to if you had the time, that's the thing isn't it. You don't do what you wanna do in your job because of time. I can't believe that anyone can do it in an hour. It is so difficult to discuss everything in that time.*

One of the comments made by a midwife represents the phenomenon 'choice'. This differed to the sub-category 'lack of time' as it was perceived that midwives were able to carry out all their tasks if they sacrificed their own free time. Thus, although not viewed as a positive dimension to their role, undertaking the required aspects of midwifery was possible if one chose to work additional hours:

1 *It feels like you have the choice of doing everything you want to do in your job, doing it well and meeting the standards or going home on time and…it shouldn't be like that but it certainly is a choice for most people.*

Some of the midwives discussed the provision of smoking cessation advice with regards to mainly asking their clients about their smoking status whereas other participants appeared to view the task of offering advice as a more intense process including encouraging identified smokers to quit and attend stop smoking services. Therefore, although most midwives mentioned that they had restricted time with their clients, the participants who tended to spend more time promoting smoking cessation regarded this as a bigger problem.

Large case loads contributed to the perceptions of restricted time. Thus, caring for a significant number of pregnant women added to the insufficient time that midwives could spend with each client. Additionally, midwives explained that there are usually women waiting to be seen outside the booking room while initial booking sessions are being undertaken. This added to feelings of stress during the sessions:

8	*The venue's a problem as well sometimes. Like here, we're talking about clinics and masses of people waiting.*

Lack of time is an area of great importance as it appears to affect and be affected by various other aspects of antenatal care such as case loads, the setting and the extensiveness of the midwifery role. Previous studies have identified insufficient time (e.g. Bishop et al., 1998) and lack of training (e.g. Aquilino et al., 2003; Lowe et al., 2002) as two of the main barriers to providing stop smoking advice among midwives.

2. Insufficient Training in Smoking Cessation

Lack of essential training was also mentioned as a potential barrier to giving stop smoking advice to pregnant women. Midwives spoke of training with regards to

level I training in smoking cessation as well as their midwifery training that they had undergone.

a. Lack of level I training. Level I training in smoking cessation aims to enable health professionals to provide effective brief stop smoking advice and to refer clients to stop smoking services (Health Development Agency, 2003). The majority of the midwives said that they had perceived the task of promoting smoking cessation as more challenging prior to undergoing level I training:

> *15 I found it harder before I had training.*

One midwife even described that before attending level I training, her '*heart would sink'* when she realised that a client was a smoker. A common perception was that training in smoking cessation was essential and without it, it was tempting to ignore this aspect of their role. Level I training was not only perceived as a method of teaching midwives how to provide stop smoking advice but also as a means of encouraging health professionals to do so:

> *10 …the thing we need is more training. We need more encouragement….*

However, a number of the midwives had not undergone a level I training course and they recognised that they would benefit from attending a training session. These participants appeared to feel less confident, knowledgeable and skilful with regards to promoting stopping smoking and this could thus potentially prevent them from discussing smoking cessation with their clients.

b. Lack of midwifery training. Another form of training that was not mentioned as frequently as level I training, but yet recognised by some as a barrier to providing smoking cessation advice, was the midwifery education. It was mentioned

that the midwives' training focused mainly on the more traditional parts of midwifery and not public health issues such as giving effective stop smoking advice:

> 4 *I think that when we train as midwives the emphasis is very much on the standard antenatal care, the standard postnatal care, or whatever that we provide and so we feel comfortable doing the more traditional parts of our jobs and I wonder whether, um, because addressing stop smoking in pregnancy, apart from just asking a women does she smoke or does she not, which is quite, anyone can do that, but then do you get a person to think about what do they want to achieve you know that they want or give up or moving them on to the next step towards making that change, I think demands some degree of skill on the part of the midwife and maybe that isn't really addressed in our training cause I can't remember, I can't remember addressing, um, much about public health issues when I trained as a midwife or at least if I did I probably dismissed it as not the exciting part of midwifery.*

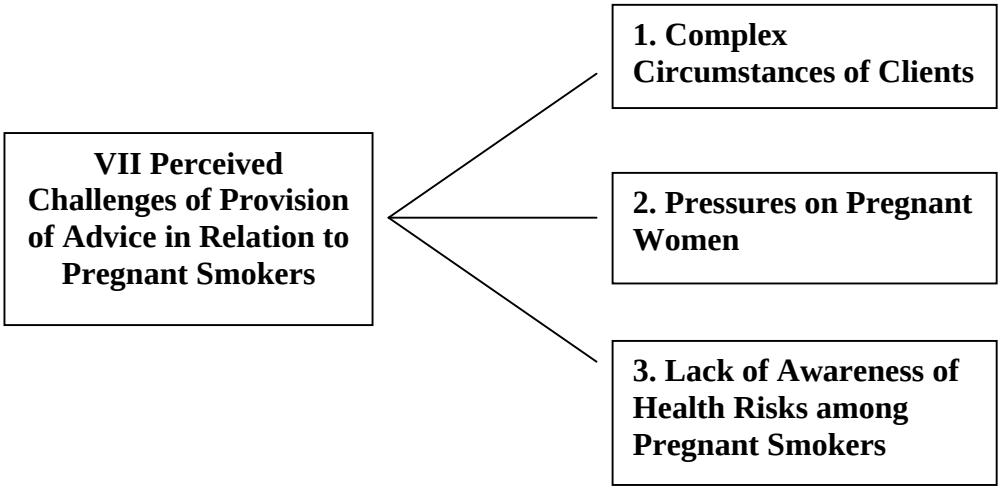
The perception among many midwives that they had not received satisfactory training with regards to smoking cessation was thus identified as a barrier to providing stop smoking advice. Midwives felt that appropriate training had the potential to address some of the issues which they perceived could prevent them from undertaking the task, such as lack of necessary attributes. Therefore, the implementation of smoking cessation training for midwives could be vital in improving provision of stop smoking advice as it has the potential to address various barriers that midwives face in undertaking the task. In addition, as inexperienced midwives might find it harder to promote smoking cessation compared to those with

a longer career, including stop smoking training at an earlier stage in their midwifery career could help newly qualified midwives to undertake the task.

VII Perceived Challenges of Provision of Advice in Relation to Pregnant Smokers

The negative characteristics that midwives used to describe their perceptions of giving stop smoking advice were also linked to their clients. That is, many midwives felt that the pregnant smokers who were offered advice had an impact on how they perceived the process of promoting smoking cessation. '**Complex circumstances of clients**, the '**pressures on pregnant women**' and '**lack of awareness of health risks among pregnant smokers**' were identified as potentially influencing midwives' perceptions of providing stop smoking advice (diagram 3.1.8). 'Perceived challenges of provision of advice in relation to pregnant smokers' was thus identified as a category which could act as a barrier to providing stop smoking advice.

Diagram 3.1.8 The category 'perceived challenges of provision of advice in relation to pregnant smokers' and its sub-categories.



1. Complex Circumstances of Clients

The clients of the midwives could influence their perceptions of providing stop smoking advice. The participants explained that although they tend to cover some aspects of smoking cessation during booking sessions with all clients, the extent to which they discuss stopping smoking and how important they view it varied according to the circumstances of the pregnant women. If it is necessary to cover other challenging topics in more depth such as mental health issues, domestic violence and housing problems, the midwives did not regard giving stop smoking advice as a priority:

> 4 *My heart would sink when somebody walked in who I knew was a smoker, knew, you know was overweight, knew, I, you know, you'd see those people walking in and you think ah gosh you've got so many issues going on in your life I don't think I can cope, I don't think I can deal with them all.*
>
> 1 *If you're meeting someone who's smoking and they also have, you know, really complex social problems or they're in a domestic violent situation that they're just fleeing…at that time, you'd probably be rating it lower with those sorts of concerns…*

The midwives felt that a substantial proportion of pregnant smokers have complex lives, come from deprived backgrounds and are dealing with other difficulties and stresses. Because of these circumstances, pregnant smokers were believed to be more likely to prioritise other issues to stopping smoking during pregnancy. Some of the midwives thought that these women regard quitting smoking as an issue that they cannot tackle at this point in their lives and the advice would

therefore have a limited impact. The discussion shown below illustrates this phenomenon:

1 *…so as well women's other circumstances are, um, as we were talking about earlier, sometimes smoking is not the main thing for people like when they're going through a really difficult time…*

3 *Exactly.*

1 *…having to stop smoking on top of that it's just too much for them and it's the least of their worries really sometimes.*

The various circumstances that the midwives had experienced pregnant smokers going through included housing situations, domestic problems, unplanned pregnancies and financial worries. One midwife explained how discussing smoking cessation becomes more challenging when clients are living under complex and deprived circumstances and she questioned the purpose of introducing the topic to these women:

1 *But then it does seem a bit ridiculous saying 'but you really should stop smoking'. You can see it and hear it come out and you think, you can understand why they wouldn't in those circumstances cause if you had to prioritise all your problems then it would probably not be high or on the top in their circumstances.*

The midwives did not appear to expect smoking to be very high on the hierarchy of problems that pregnant smokers might face. In fact, when discussing the challenging circumstances that some pregnant smokers are dealing with, smoking

was often not even described as a problem but as a strategy for coping with these challenging situations:

7	*Women know about pregnancy and smoking and we, what we know about smoking is that for some people it's really a coping mechanism for perhaps other stressful components of their lives.*

The participants tended to empathise with their clients and the stress they face. It appeared that some midwives did not only expect their clients to be unwilling or unable to change their behaviour due to stressful situations but the midwives themselves also viewed smoking as a coping strategy and stopping smoking as a task too challenging to undertake during difficult times. If midwives perceive smoking as a method for dealing with difficult life events and cessation potentially causing increased levels of stress, this could act as a barrier to promoting smoking cessation among clients with more complex circumstances.

Aquilino et al. (2003) also found that other circumstances of pregnant women might prevent midwives from promoting smoking cessation. As the midwives worked in a borough with some very deprived areas (Office of the Deputy Prime Minister, 2004) and smoking is more prevalent among pregnant women from low socio-economic groups (e.g. Haslam et al., 1997; Lu et al., 2001; Ludman et al., 2000), the midwives in this study might have been more likely encounter clients from socially disadvantaged background and complex circumstances. Therefore, the needs of clients might have been perceived as an even greater barrier for midwives in the present research.

2. Pressures on Pregnant Women

The midwives also discussed the fact that pregnancy is a stressful time in itself and that pregnant women are restricted in what they are advised to do during this time. Encouraging a behaviour change that was initiated many years ago and that many perceive as an enjoyment during a time of pressure was regarded as a difficult task:

5	*No, but being pregnant is really, really stressful. It's a time of huge change and we're already saying what they can and can't eat and how to live their lives in lots of ways, you know, that's what the whole booking is all about and to then say you need, something that you get great enjoyment from since, I dunno, you were 16, 14 years old for some, you need to stop that. That's a huge ask, you know, and I think that, that's the issue and any form of reduction is a huge achievement, especially during a time of great stress.*

All the information that pregnant women receive during their pregnancy and in particular in the initial booking session was thought to be rather overwhelming for many clients. As so many topics are covered during the booking sessions, some midwives felt that the pregnant women are unable to register and remember all the issues that are discussed. Some of the participants perceived promoting smoking cessation as adding to the bulk of information provided to pregnant women during the booking:

7	*There's quite a lot of information for them to take in as well. They go home and they have quite a lot of ideas and appointments and things and… I bet they can't remember everything.*

There was an appreciation among the midwives that society puts a vast amount of pressure and expectations on pregnant women which also contributes to the stress that women might experience. Discussing smoking cessation was perceived by some midwives as adding to the pressure that pregnant women already face. As midwives attempt to avoid causing further negative emotions in their clients, this could potentially prevent provision of smoking cessation to occur:

> 7 *Because of all the stuff that's in the press at the moment so to some extent you can appreciate how some people feel about this, they're being targeted.*
>
> 1 *There's a lot of expectation on women in their pregnancies now as well, that they will have this perfect health. They will do the yoga classes and eat the right things and not, you know, there's so many things now that they should and shouldn't do, you know. A lot of women are aware of that pressure you know, and whether they're smoking or not that goes for many other things so you don't, you don't want to make people feel worse.*

It has been recommended that midwives should not add to the potential pressure that women face during pregnancy (Department of Health, 2001). The midwives in the study were aware of the pressure that pregnant women might be under and they clearly did not want to contribute to this. However, it was previously discussed that midwives find it difficult to balance providing advice and avoiding causing negative emotions in clients. Promoting smoking cessation without pressurising women was also regarded as a challenge and yet again, midwives appeared to feel coerced into choosing between excluding certain requirements of their jobs or creating negative outcomes. It appears that midwives are requested to cover a variety of challenging topics with pregnant women and simultaneously they

are cautioned about adding further pressure on to clients. Achieving both could be perceived as a difficult task.

3. Lack of Awareness of Health Risks among Pregnant Smokers

Midwives' perceptions of pregnant women's awareness regarding the risks of smoking during pregnancy emerged as a barrier to providing advice. It was believed that pregnant women know that smoking during pregnancy is harmful for the baby as a lot of information exists in the public domain. Some midwives doubted the impact of the advice due to believing that pregnant smokers already possess knowledge of the health risks related to smoking during pregnancy.

> 1 *It's such a huge challenge and you wonder how you can make any difference if people are still continuing to with that, knowing the risks.*

However, although most midwives agreed that pregnant women are usually aware of the risks, they also sensed that some do not know the more specific details or extent of the risks:

> 12 *Maybe they don't know till death how bad it is and why it's bad, what can it do but they do know that it's bad.*

Although the midwives generally believed that their clients were aware of the health risks associated with smoking during pregnancy, they recognised that many women find it difficult to relate these risks to their own pregnancy. A fairly common response from pregnant women when being given advice about stopping smoking was that they had smoked during previous pregnancies and the baby had been unharmed. Similarly, some women communicated that their friends or mothers had smoked whilst pregnant and their habit had not had any detrimental effects on the

baby. Responses of this nature contributed to the challenges related to providing stop smoking advice. Midwives felt that these women required more information about the actual health risks of smoking but highlighting that the women's perceptions of a 'healthy baby' might be incorrect was perceived as difficult:

> 10 *Some women I've met have also said they're smoking because they've noticed nothing's happening to the baby. So, you know, they know the risk involved with the baby and everything but nothing's happened in previous pregnancies so they don't want to do it the whole way. You know they just try to cut down.*
>
> 4 *You know 'I had my last baby and I smoked and it was ok' and it's ha…you know then it's harder to work with, you know because they may have had a baby and it may be ok as they would say it and you don't wanna start saying well actually your baby is very unhealthy and it may not have had this or the other if you hadn't smoked so it's hard to make it clear that there are risks.*

The midwives mentioned that an alarming number of pregnant smokers say that they prefer to have a small baby and thus might as well continue to smoke. As these women lack full awareness of the health risks that are associated with low birth weigh, more information would have to be provided to those clients and this was perceived as a difficult message to deliver:

> 2 *For some women as well the idea of a low birth weight of a baby because of smoking, it doesn't bother them at all. They don't, they don't see that as linking in with the health problems that we describe. Having small babies is actually a good thing for some people, and not, it's not something that they*

think is a serious concern and it's actually quite difficult to, um, get that across.

The phenomenon of not feeling that the baby is real was also raised during the focus groups. This perception was thought to exist mainly among women who have unplanned or unwanted pregnancies and during the early stages of pregnancy. Discussing smoking cessation and the benefits of quitting during pregnancy could be more difficult with these clients as relating the messages to the baby might not have an impact and the clients might be less motivated to quit:

8 *To a lot of pregnant women, especially women who perhaps didn't want to get pregnant or aren't bothered, one way or another didn't plan their pregnancies, their babies aren't real.*

4 *…and they're kind of, I don't know, maybe it's in the beginning of their pregnancy, they don't see those issues as, oh yeah well, oh, that's nine months away.*

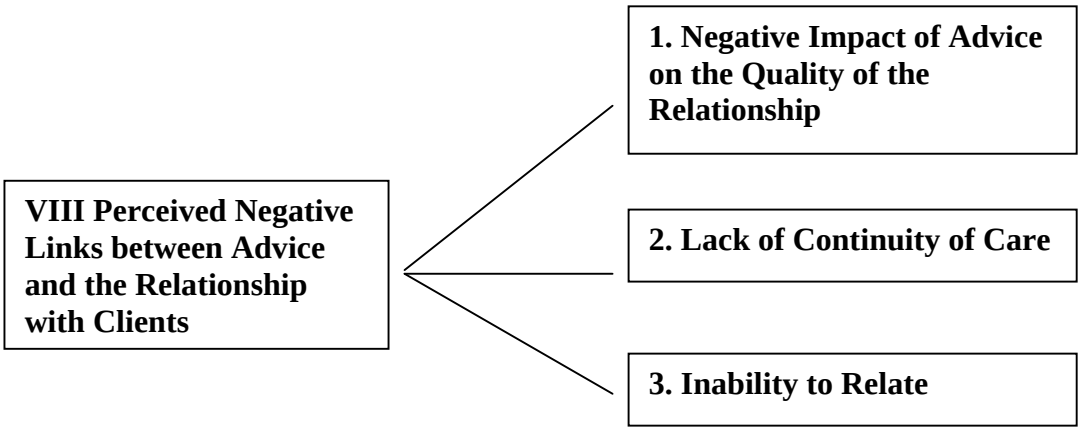
Previous studies have confirmed that pregnant smokers possess insufficient knowledge regarding the health risks related to smoking during pregnancy (e.g. Owen & Penn, 1999) and pregnant women who have unplanned or unwanted pregnancies are more likely to smoke (e.g. Solomon & Quinn, 2004). However, research exploring how these concepts influence midwives' perceptions of providing stop smoking advice appears to have been lacking. This finding therefore implies that not only are women with insufficient awareness of smoking and unplanned pregnancies more likely to smoke but midwives face stronger barriers in promoting advice to these women. Although most midwives felt that pregnant smokers lack

sufficient knowledge of the health risks related to smoking during pregnancy, they believed that pregnant smokers possess some awareness. A few of the participants were consequently perplexed about their clients' reasons for smoking and concluded that the advice could not have a positive impact on their behaviour. The findings thus imply that midwives' perceptions of the awareness that their clients hold regarding smoking during pregnancy could be a barrier to providing advice regardless of whether the knowledge is perceived as lacking or adequate.

VIII Perceived Negative Links between Advice and the Relationship with Clients

The perceptions of providing stop smoking advice among midwives were influenced by the relationship between midwives and pregnant women. Therefore, the final category that was identified as a potential barrier to giving stop smoking advice was the relationship. The fear of damaging the relationship with their clients have previously been identified as a barrier to providing stop smoking advice among midwives (e.g. Aveyard et al., 2005; McLeod et al., 2003). Aspects of the relationship which could influence perceptions of promoting smoking cessation were identified as '**negative impact on the quality of the relationship**', '**lack of continuity of care**' and '**the inability to relate**' (diagram 3.1.9).

Diagram 3.1.9 The category 'perceived negative links between advice and the relationship with clients' and its sub-categories.



1. Negative Impact of Advice on the Quality of the Relationship

Midwives were keen to establish and maintain a good relationship with their clients and if they felt that providing stop smoking advice had a negative impact on the quality of the relationship, it could be a barrier to carrying out the task. As discussed, some midwives were worried that clients would perceive the midwives as judgemental health professionals as a result of receiving stop smoking advice. If pregnant women responded to the advice in a negative manner, midwives would consider this to have a negative effect on the relationship:

> *2 It can put up a barrier between you and the woman if she feels that you're judging her.*

Some midwives were also under the impression that pregnant women might not be happy discussing smoking cessation advice with their midwife:

> *1 They might be uncomfortable talking to a health professional about it.*

The midwives who expected pregnant smokers to feel uncomfortable or unhappy discussing their habit with a midwife perceived that promoting smoking cessation could negatively impact the quality of the relationship that they were keen to establish and maintain. Morgan et al. (2003) found that midwives in the US were more likely to address smoking related issues with their clients in subsequent meetings than during initial booking sessions. They hypothesised that this was due to an attempt to establish a quality relationship with pregnant women and the midwives thus felt that promoting smoking cessation could have negative consequences. However, the majority of the midwives in the present were unlikely to see the same

women again during their pregnancies and they did not appear to discuss smoking cessation during other meetings than the booking session.

2. Lack of Continuity of Care

Most of the midwives taking part in the focus groups were not able to offer continuity of care to their clients. Therefore, all the topics that these midwives were required to discuss with pregnant women had to be covered during the initial booking session. The fact that a personal topic such as smoking cessation is promoted in the initial booking session when a relationship has not yet been established was perceived as a challenging aspect of the midwives' job:

> *You're just meeting the woman, and to approach all these issues cold… It's hard to start one of these conversations about smoking if you've never met them before, approaching personal subjects with people you've never met.*
>
> *…to build a relationship with them as well. You need to see them for several months.*

Midwives mentioned the negative aspect of not continuing to see clients during their pregnancies and how this could be a barrier to providing smoking cessation advice. One of the midwives discussed how providing stop smoking advice could be influenced by whether midwives could offer continuity of care:

> *…having talked to them a couple of times before your conversation inevitable goes a little bit further each time, whereas if you're meeting them, you've got to do the whole, hi how are you, isn't it cold outside, build up a little bit of a relationship so they're smiling and you're relaxed and do your standard things and then you're almost over and done and then it's hard to start one of*

> *these conversations about smoking if you've never met them before…so. You kind of always have that continuity.*

The lack of continuity of care could thus explain why the midwives appear unlikely to promote smoking cessation in follow up meetings with pregnant women. The perception of lack of continuity of care as a barrier to providing stop smoking advice confirms some previous findings (e.g. Bishop et al., 1998). However, previous research does not seem to have identified a link between midwives' perceived inability to relate to their clients and promoting smoking cessation.

3. Inability to Relate

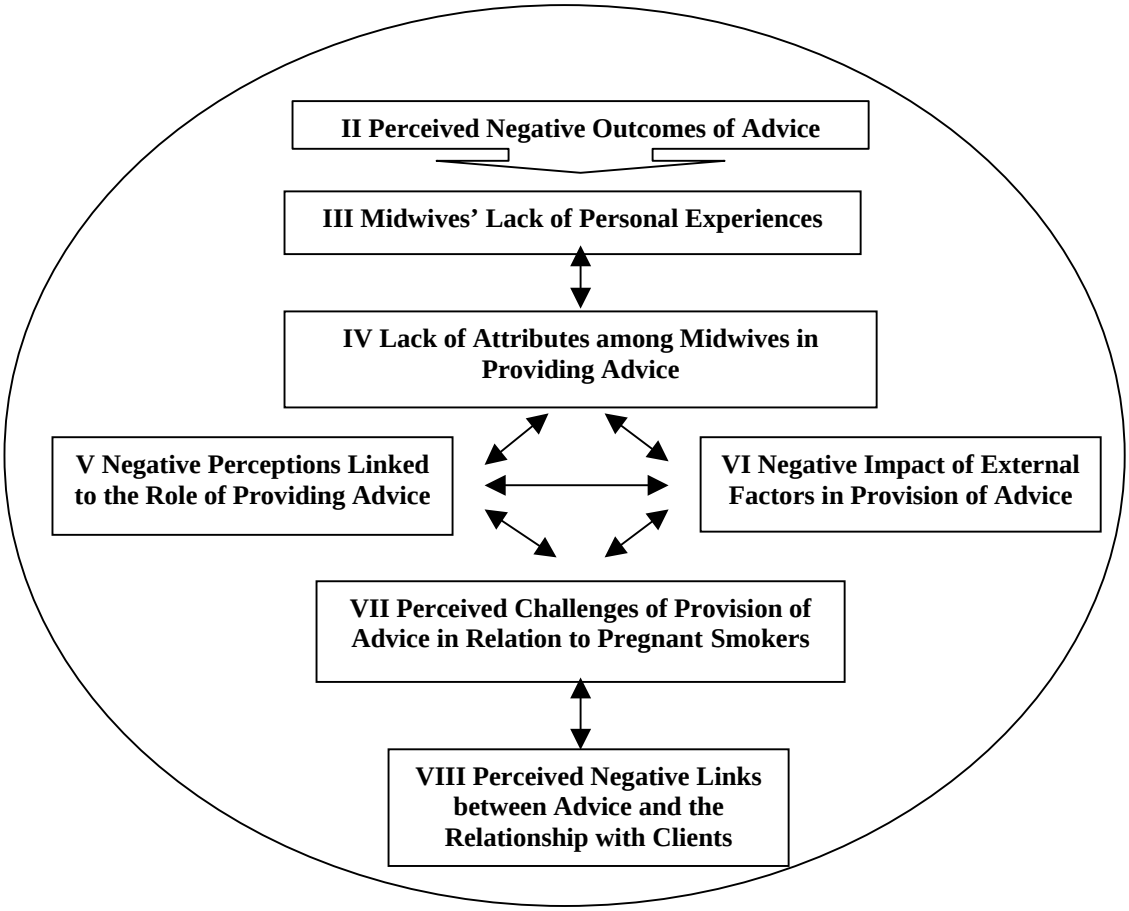
The final sub-category of the theme 'perceived negative link between advice and the relationship with clients' was labelled 'inability to relate'. This category refers both to the midwives' inability to relate to their clients as well as their perceptions of pregnant women's perspectives of the '*distance*' between them and their midwife. When midwives were not able to relate to a client and her circumstances they found it harder to discuss issues such as smoking cessation. The inability to relate to pregnant smokers affected the perceptions of midwives in that they could not empathise with their smoking behaviour and thus experienced difficulties in promoting smoking cessation. The participants also experienced that some pregnant smokers considered their and their midwives' backgrounds and circumstances to differ to the extent that it affected the openness and honesty of pregnant women. Consequently, they might be more reluctant to report their smoking status. This also contributed to the perceived challenge of providing stop smoking advice:

12	*I'm not from here, I'm not a local woman but a typical, you know, woman who smokes heavily. Maybe she started smoking when she was a teenager, keeps smoking after having three kids. I really can't understand it, the background… It is difficult to associate with them.*
2	*And that's kind of that they've, that, the barrier thing again, isn't it, that they see such a difference between you and them that they um, they're just gonna, they're not willing to tell you really what's going on for them and they're not going to um, they're not really open and honest cause they just see the distance between….it's just too big.*

The midwives' perceived inability to relate to their clients applied particularly to pregnant women who come from deprived areas. This might explain why the apparently newly discovered phenomenon was identified in the current study which was carried out in a borough with high levels of deprivation. The perceived inability to relate to clients was also identified as a barrier to providing advice with regards to the midwives' smoking history. That is, they felt incapable of understanding pregnant smokers if they had no experience of smoking and consequently regarded the provision of advice as more challenging. It thus appears that some midwives believe that is necessary to have similar experiences as pregnant women to be able to empathise with their clients and provide effective care.

IX Links between the Perceived Barriers to Providing Stop Smoking Advice

The different categories that emerged from the data with regards to perceived barriers to providing stop smoking advice were interrelated. The links between these are illustrated in the diagram below.



'**Perceived negative outcomes of advice**' was the only category that had a relationship with all the other identified categories. The perceived negative outcomes of providing stop smoking advice could be affected by various other factors. '**Midwives' lack of personal experiences**' was linked to the outcome of the task as attempting to avoid causing negative emotions such as guilt in pregnant women was seen as harder for inexperienced midwives who might as a consequence not even carry out the task. '**Lack of attributes among midwives in providing advice**' was thought to have a potential negative impact on the behaviour change of women as possessing inadequate levels of necessary attributes could decrease the chances of moving women towards the goal of stopping smoking. The midwives showed a great desire to be good at their jobs and became dissatisfied if they felt that they had not accomplished a target. '**Negative perceptions linked to the role of providing advice**' was thus identified as linking with outcome as not managing to help women

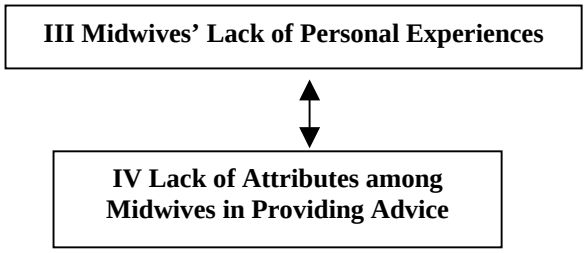
quit smoking could result in feelings of being unsuccessful as midwives. '**Negative impacts of external factors in provision of advice**' was also linked to the outcome of the advice. For instance, the limited booking time was seen as such as barrier that it could prevent midwives from giving effective advice and consequently have a negative impact on the outcome of the advice:

> *4 …if they say they, you know, I'm not interested in quitting, you know, on a good day when I've got time I'd then explore it, if I, if I've already got three people waiting for me out in the clinic and I'm running late or you know my phone's ringing or you know if you've got all those pressures, actually the temptation to say ok, where here's a leaflet take it away. You know she's not gonna read it but you've done your job, you've ticked the box.*

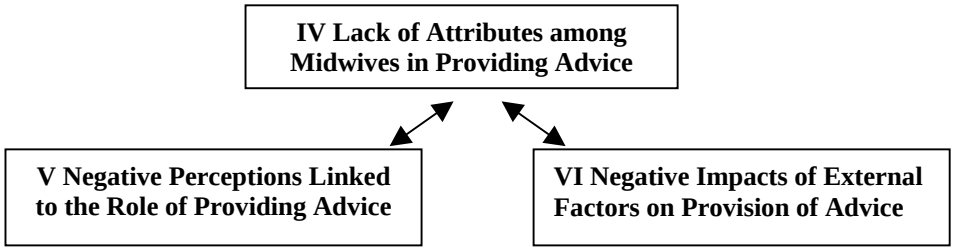
Even for those pregnant women who manage to quit, it was thought to be challenging to remain abstinent if other members in the household continue to smoke. In addition, pregnant smokers who had other complex needs were perceived as less likely to change their behaviour. Thus, the outcome of the advice was linked to '**perceived challenges in provision of advice in relation to pregnant smokers**'. If midwives did not consider that they provided continuity of care as part of their work they were also more likely to feel limited in their ability to help women make behaviour changes:

> *12 I don't follow up the woman enough to make their lifestyle change or anything.*

'**Perceived negative links between advice and the relationship with clients**' was therefore identified as having a link with outcome as it could potentially have a negative impact on the effectiveness of smoking cessation advice.



One of the reasons that midwives felt that the task of providing stop smoking advice was harder for inexperienced practitioners was that necessary attributes in providing advice, such as knowledge, increased with more experience. Hence, '**midwives' lack of personal experiences**' and '**lack of attributes among midwives in providing advice**' were related categories.

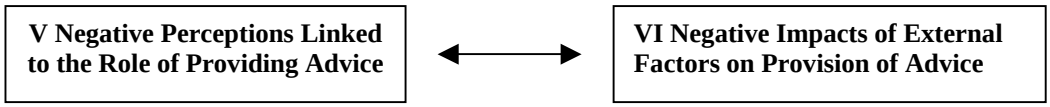


Recognising the role of midwives in helping women change their behaviour was perceived as a necessary skill in giving advice:

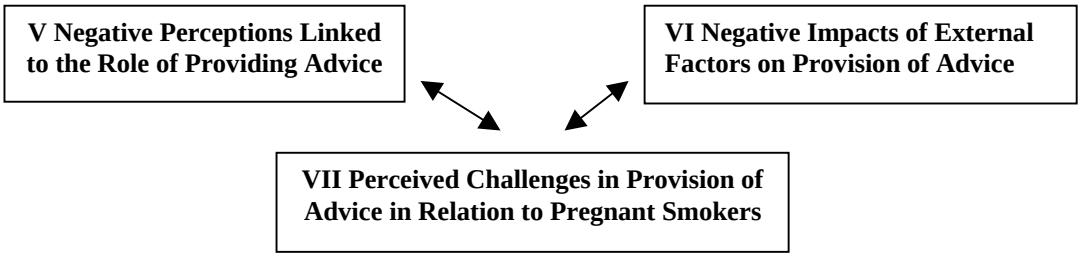
> 4 *Trying to see our role, not in trying to get them to quit but to get them to think about the next step that they can take to get them closer to that goal.*

'**Negative perceptions linked to the role of providing advice**' was hence associated with the category '**lack of attributes among midwives in providing advice**'. As a sufficient level of skill was believed to be a vital characteristic in giving stop smoking advice and improving the ability to provide effective health

promotion messages was not being addressed in the midwifery education, '**negative impacts of external factors on provision of advice**' was also linked to '**lack of attributes among midwives in providing advice**'.

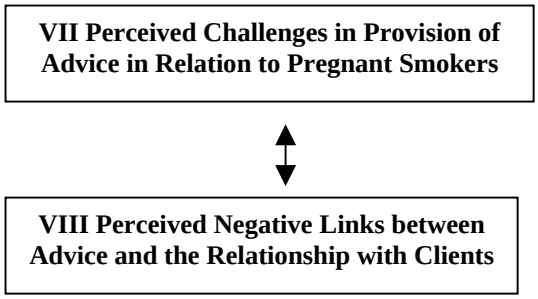


As a result of undergoing level I training in smoking cessation, some midwives explained that they understood their role better as they accepted that they were not expected to make all women quit smoking but encourage them to move close to changing their behaviour. '**Negative perceptions linked to the role of providing advice**' was therefore identified as linking with '**negative impacts of external factors on provision of advice**'.



The '**negative perceptions linked to the role of providing advice**' category was associated with the category **'perceived challenges in provision of advice in relation to pregnant smokers'** as the circumstances of pregnant women appeared to influence how midwives perceive the provision of stop smoking advice as part of their role. Promoting smoking cessation was regarded as less important for clients who face complex circumstances. A booking session with a pregnant woman who experiences various other difficulties during her pregnancy was described as demanding more time than a session with a client who is not dealing with the same amount of stressful situations. As midwives explained that pregnant smokers are more likely to have complex lives, more time is needed for their booking and this

adds to the pressure of covering all the topics required. '**Negative impacts of external factors on provision of advice**' were therefore also linked with the category '**perceived challenges in provision of advice in relation to pregnant smokers**'.



Since some pregnant smokers were regarded as quite complex clients and a number of the midwives could not offer continuity of care, it became even more challenging to provide stop smoking advice as the midwives could not follow up the issues discussed during the booking sessions at later stages in their pregnancy. '**Perceived challenges in provision of advice in relation to pregnant smokers**' could therefore have an impact on '**perceived negative links between advice and the relationship with clients**' and these two categories were thus related. Additionally, the perceived distance between midwives and their clients was likely to broaden if the women had various challenging needs and came from difficult or deprived backgrounds.

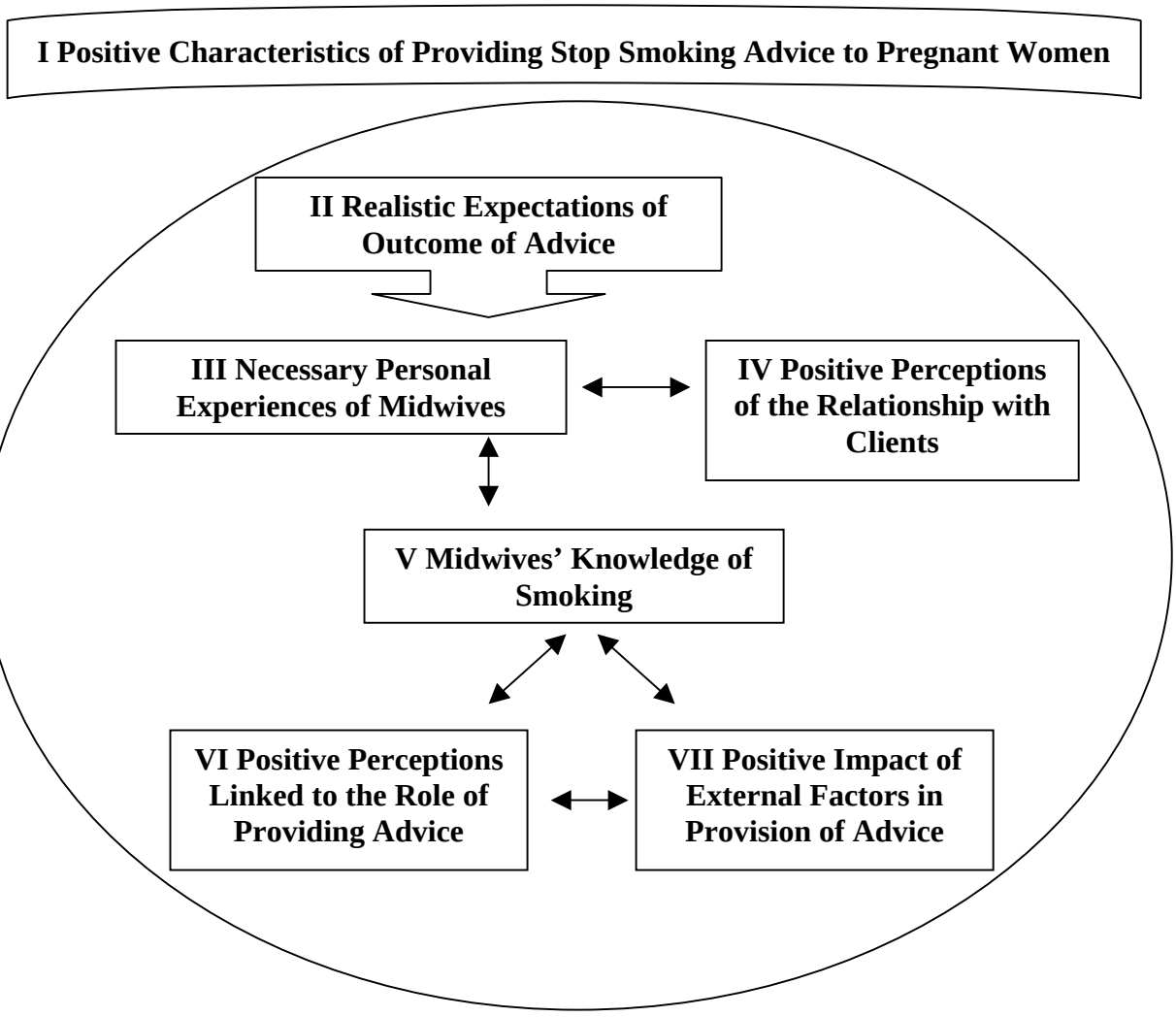
In addition to discussing perceived barriers to providing stop smoking advice, the midwives reflected on what could make it easier to promote smoking cessation to pregnant women and these issues were therefore explored further.

3.2 Core Category 2 – Perceived Facilitators to Providing Stop Smoking Advice to Pregnant Women

The second core category, 'perceived facilitators to providing stop smoking advice to pregnant women', was not as weighty as the first core category and most of

the topics were related to the perceived barriers. When the midwives discussed their perceptions of providing stop smoking advice, they talked about issues which already enabled them to carry out the task as well as factors which could assist them in doing so. Therefore, this core category comprises both perceived existing and potential facilitators. The categories that were identified as facilitators to giving smoking cessation advice and the relationships between these are outlined in diagram 3.2.1.

Diagram 3.2.1 The links between the categories identified as facilitators to providing stop smoking advice.

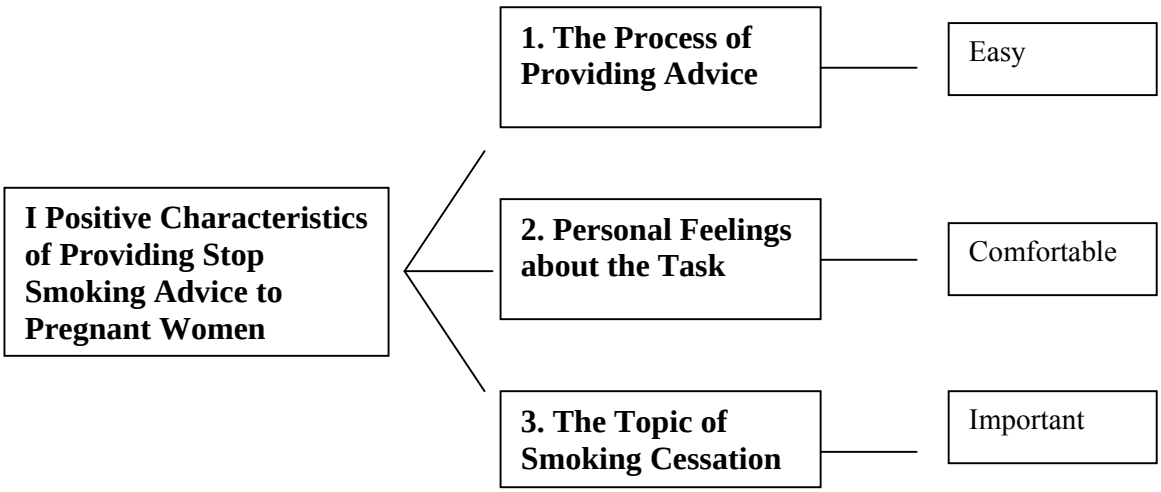


The identified categories relating to perceived facilitators, their sub-categories and how the links between them emerged are discussed.

I Positive Characteristics of Providing Stop Smoking Advice to Pregnant Women

The positive descriptions of the task of providing smoking cessation advice were not as numerous as the negative characteristics and they were mentioned less frequently. The characteristics perceived as positive were divided into sub-categories of how midwives found '**the process**' of giving advice, what their '**personal feelings**' about the task were and how they viewed '**the topic**'. An illustration of the category referring to positive characteristics of providing advice, their sub-categories and examples of these can be seen in diagram 3.2.2.

Diagram 3.2.2 'Positive characteristics of providing stop smoking advice to pregnant women' and its sub-categories.



Some of the positive descriptions that midwives used to explain the process of promoting smoking cessation to their clients are illustrated in the box below:

1	*…I do use my experience and I find that's an easy way for me…*
5	*I like giving smoking advice.*
4	*…and I probably feel a lot more comfortable talking about it…*
9	*I don't mind, I don't mind.* [giving stop smoking advice]

2	*Obviously giving up for the pregnancy is great and not smoking around the baby is really important and they're things we always discuss with women.*

Although it was much more common to perceive discussing smoking cessation with pregnant women as difficult, some of the midwives described the process as easy or not difficult. The midwives' positive personal feelings associated with providing stop smoking advice were also discussed as about a quarter of the participants explained that they felt comfortable carrying out the task, liked or did not mind it. Other positive perceptions of providing advice were related to how the midwives perceived the topic as many of the participants regarded smoking cessation during pregnancy as an important subject. Lindsay (2001) found that health professionals are aware of the health risks of smoking during pregnancy and are keen to promote smoking cessation. Although studies investigating midwives' perceptions of providing stop smoking advice have been conducted, these have mainly focused on the perceived barriers. Existing research exploring factors which could facilitate the task is more limited. Identifying what could enable midwives to promote smoking cessation to pregnant women is, however, also essential in improving the consistency and standard of provision of advice.

Regardless of whether the midwives portrayed providing smoking cessation advice in a negative or positive manner, they accepted that they had to ask all women about their smoking status as it was part of the booking session and a question on the relevant form. However, some midwives made a clear distinction between the task of simply identifying the smoking status of clients and actually providing advice and encouraging women to quit:

12 Smoking… talking is easier but making them quit is hard.

Some of the positive characteristics mentioned were related to merely asking whether the pregnant women smoked rather than providing brief advice about stopping and making referrals to stop smoking services. The midwives' explanations as to why they described giving advice with positive phrases were linked to having '**realistic expectations of the outcome of the advice**', '**having necessary personal experiences**', possessing a sufficient level of '**knowledge of smoking**', '**positive perceptions linked to the role of providing advice**', '**positive impacts of external factors in provision of advice**' and '**positive perceptions of the relationship with clients**'. 'Positive characteristics of providing stop smoking advice to pregnant women' was labelled as the encircling category that was associated with all other identified facilitating categories.

II Realistic Expectations of Outcome of Advice

The perceived negative outcomes of providing smoking cessation advice were categorised as potentially weighty barriers to carrying out the task. Although not all participants perceived the outcome as a barrier, four midwives explained that this was not due to expecting all women to quit smoking but rather accepted that they might not. The realistic expectations that these midwives held were therefore categorised as potential facilitators to providing advice (diagram 3.2.3).

Diagram 3.2.3 The category 'realistic expectations of outcome of advice' as a facilitator to providing advice.

II Realistic Expectations of Outcome of Advice

The participants who did not expect all pregnant smokers to change their behaviour purely as a result of receiving stop smoking advice from their midwife explained that they felt more relaxed or comfortable about the task of providing advice. They also acknowledged that pregnant smokers need willpower in order to quit smoking:

> 1 *But somehow this, I can, I feel more relaxed about it because it's something you know, I've gone through and it's something I think, they probably will walk out of there and won't give up the second I've spoken to them but I'm ok with that as well now.*
>
> 11 *…you can't really change anything but you can just keep talking about smoking and, um, even cutting back, they're gonna have to, want the need to do that.*

The midwives who had realistic expectations of the outcome of stop smoking advice appeared to simultaneously acknowledge the challenges in giving up an addiction such as smoking. Therefore, they believed that their advice might only be one contribution amongst others towards behaviour change in pregnant smokers:

> 1 *That if they speak to lots of people, eventually they'll get to the stage when they want to give up smoking. You know, you'll just be a small part of their path to get them to when they want to stop smoking.*

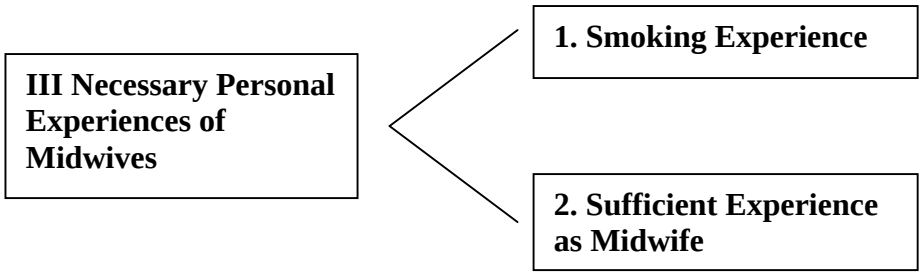
Abrahamsson et al. (2005) found that midwives who had realistic expectations of the effectiveness of stop smoking advice appeared more positive about promoting smoking cessation. Thus, it appears that comprehending the complexity of changing a behaviour such as smoking and accepting ones limitations

in enabling smokers to achieve this, could facilitate the provision of stop smoking advice. However, as discussed previously, perceiving smoking as an addictive behaviour could also be a barrier to providing advice as some midwives held pessimistic perceptions of the likelihood of stopping smoking as a result of receiving advice. The findings therefore indicated that midwives need to possess an awareness of the challenges related to smoking cessation yet appreciate the significance in offering stop smoking advice. Achieving this balance might be difficult but necessary to improve the provision of stop smoking advice to pregnant women.

III Necessary Personal Experiences of Midwives

Some of the positive characteristics associated with giving stop smoking advice were linked to the midwives' personal experiences. The midwives' '**smoking experiences**' as well as their '**experiences as a midwife**' were perceived as potential facilitators in the process of providing stop smoking advice. The category 'necessary personal experiences of midwives' and its sub-categories are shown in diagram 3.2.4.

Diagram 3.2.4 The category 'necessary personal experiences of midwives' and its sub-categories.



1. Smoking Experience

As discussed previously, some of the midwives who had never smoked felt that their lack of understanding of smoking was a barrier to giving stop smoking

advice. Respectively, the midwives who had previously smoked identified their experience as a facilitator. Only three of the midwives said that they had previously been smokers or ex-smokers and relapsed but all of them spoke about how they used their experience in a positive way to empathise and communicate with pregnant smokers. The current smokers did not appear to use their smoking experience as a method of discussing smoking cessation, though the number of smokers taking part in the focus groups was only two. Having previously smoked was perceived as an aid in promoting smoking cessation due to various reasons. The midwives spoke of using their experience as a means of discussing the topic, they felt more able to understand the experiences of their clients and they perceived their awareness of the subject to be greater:

11 *…because I, I do use my experience and I find that's an easy way for me…*[Ex- smoker]

1 *It's saying well, I've been in your situation and this is what worked for me. There are other things you know, and so it doesn't feel quite so stressful. I'm not saying, but you really shouldn't bottle feed because it's really bad. I don't feel, I find that harder because I've not had a baby, I've not breast-fed or bottle-fed.*

5 *I feel sometimes, it's weird, but I'm a smoker and, um, I remember I gave up for 18 months and during that 18 months I was like smoking cessation expert and, I, I, would really talk about it a lot in bookings because I felt I had information to impart because I had given up myself.*

A study exploring the perceptions of pregnant smokers with regards to receiving advice confirmed that heath professionals tend to mention their smoking

experience when discussing smoking cessation with their clients (Hotham et al., 2002).

2. Sufficient Experience as Midwife

Similarly as inexperienced midwives were thought to find it harder to discuss smoking cessation with pregnant women, more experienced practitioners recognised that they did not perceive the task as equally difficult as they had done in the beginning of their career:

1	*I don't mind it to be honest and probably that's just with years as well.*
8	*With good experience… I probably wouldn't find it the easiest thing to talk about but it's not the worst thing.*

Gaining experience of working as a midwife was thus perceived as facilitating the task of providing stop smoking advice. Participants with a longer midwifery history explained that their perceptions of providing stop smoking advice were more positive as a result of feeling more comfortable about the task due to gaining more professional experience. This concept seems to be a valuable addition to the research field exploring midwives' perceptions of providing stop smoking advice and it signifies the importance of delivering smoking cessation training to newly trained practitioners. In addition, as being able to empathise with clients emerged as an important factor in promoting smoking cessation, the effectiveness of level I training might improve by focusing its content on helping midwives with no smoking experience to gain a more comprehensive awareness of smoking related issues.

IV Positive Perceptions of the Relationship with Clients

Some of the positive perceptions of the task of providing stop smoking advice were related to the relationship between the participants and their clients. The relationship between midwives and pregnant women could thus act as a potential facilitator to promoting smoking cessation (diagram 3.2.5).

Diagram 3.2.5 The category 'positive perceptions of the relationship with clients' as a facilitator to promoting smoking cessation.

IV Positive Perceptions of the Relationship with Clients

Some of midwives felt that pregnant women tend to value the relationship with their midwife whom they like and trust:

> *15 But I think they really do, you know, they do trust us, don't they, you know, they like midwives.*

Having established and maintained a relationship of high quality with their clients was perceived as potentially enabling midwives to promote smoking cessation:

> *14 If the woman has a good relationship with you, it might help, it might not.*

As having a good rapport with clients was seen as an important factor in midwifery work, a quality relationship could contribute to making the task of providing advice easier and this was therefore categorised as a potential facilitator to giving advice. However, midwives' concerns regarding the impact of the advice on their relationship with pregnant women were identified as barriers to promoting

smoking cessation. Thus, although having a sound relationship could enable midwives to discuss smoking cessation, they also worried that the advice could damage the relationship. In addition, establishing a good relationship prior to discussing smoking cessation was only feasible for midwives who were able to provide continuity of care to pregnant women. The midwives who had continuity in their work commonly said that they appreciated this aspect of their role. An opening question for the focus groups was *'What do you like most about your work?'.* A number of the responses related to the continuity of the relationships they had with their clients:

15 *The best thing I like is, in my job, it's lovely to have the continuity, a beginning to end, and that's what I love. The relationships with the women and their families.*

5 *I like the continuity that my job gives me. As I get to know my clients better and look after them throughout their pregnancy.*

11 *I like everything to do with midwifery and the continuity and having my women seen all the time.*

This continuity of care was seen as a facilitator to giving stop smoking advice in that it enabled midwives to establish and maintain a good relationship with their clients and they were more able to return to previously discussed topics or discuss any uncovered areas. Even the midwives who did not offer continuity of care to clients attempted to re-address issues with women if they saw them again during their pregnancy. The extract below is taken from a discussion around continuity of care:

12 *think that, XXX, you have a continuity of care but we don't. I probably see them at booking and then now and then. Sometimes I come back to the same question if I see the same woman.*

15 *That's the benefit from that continuity of care, isn't' it?*

V Midwives' Knowledge of Smoking

Some of the positive characteristics used to describe providing smoking cessation advice were associated with possessing relevant knowledge. That is, midwives perceived that provision of stop smoking advice could be easier if they possessed a sufficient amount of awareness of smoking related issues (diagram 3.2.6).

Diagram 3.2.6 The category 'midwives' knowledge of smoking' as a facilitator to providing stop smoking advice.

V Midwives' Knowledge of Smoking

Lacking knowledge of smoking and smoking cessation was categorised as a barrier to providing advice. Equally, gaining more knowledge of the topics that midwives were requested to cover with pregnant women was thought to facilitate the task of discussing the issue:

4 *I probably wouldn't find it the easiest thing to talk about but it's not the worst thing. I think, probably, um, my awareness of public health issues and psychosocial issues is a lot greater.*

The knowledge that midwives perceived as helpful in providing stop smoking advice related mainly to the health risks associated with smoking during

pregnancy. One participant mentioned the need to gain sufficient knowledge in order to be convinced of the detrimental health effects that pregnant smokers are likely to encounter, as a basic awareness might be insufficient:

> 4 *I think, possibly, knowing, knowing how to…if you're convinced yourself about the risks that they're, that they're taking on their health and, you know, if you're, if you're convinced that smoking is gonna make kind of a major effect, it's gonna have a major effect on their baby or on their own health, if you're convinced of that, then it's kind of finding a way of actually communicating it to them…*

As previously discussed, although the midwives believed that pregnant smokers are aware of the fact that smoking during pregnancy is harmful, they do not possess sufficient knowledge of the risks. The midwife who made the above comment appears to allude to the same concept with regards to midwives as their knowledge of the seriousness of the specific risks might be insufficient. Although not mentioned specifically during the focus groups, skill and confidence were also embedded in some of the discussions on what could facilitate promoting smoking cessation. Knowledge, conviction, skill and confidence were related as midwives felt that possessing adequate knowledge and conviction of the effects of smoking can impact on communication skills and confidence in giving advice.

VI Positive Perceptions Linked to the Role of Providing Advice

Some of the positive characteristics that were described when discussing providing smoking cessation advice related to the midwives' perceptions of their role. Accepting that promoting smoking cessation was part of the midwifery role and

regarding it as an important aspect of their work could facilitate the task of providing advice (diagram 3.2.7).

Diagram 3.2.7 The category 'positive perceptions linked to the role of providing advice'.

VI Positive Perception Linked to the Role of Providing Advice

There was a desire to do a good job among the midwives and if this did not occur, it had a negative impact on their perception of their work. Therefore, an aspiration to perform well appeared to encourage midwives to carry out the various aspects of their job including promoting smoking cessation:

4 …*we all need to take it on as a role* [providing stop smoking advice]. *We want to do a good job as midwives. We want to give a good service and I do feel really dissatisfied when I know I've let someone walk out the room and I haven't addressed something I wanted with them.*

Midwives who felt comfortable with their role were more likely to deem the pregnant women's decision to continue to smoke as not necessarily linked to the actual advice. They tended to acknowledge and accept that although they were responsible for the provision of advice, their role did not encompass being solely responsible for the women's health behaviour. This insight appeared to lessen the perception of promoting smoking cessation as a difficult chore:

5 *I don't think it's any harder than talking about anything else. I think that, you know, my role is to give them the information and what they do with that information is up to them.*

However, one participant said that midwives are indeed capable of having a positive impact on pregnant women's lives and health behaviour. Despite acknowledging that some women regard smoking as a coping mechanism, the midwife felt that health care professionals are able to help women. Realising their capabilities in supporting pregnant smokers in their quit attempt and having a constructive impact on their lives can positively influence midwives' perceptions of promoting smoking cessation:

7 *Women know about pregnancy and smoking and we, what we know about smoking is that for some people it's a really coping mechanism for perhaps other stressful components of their lives and maybe as practitioners we can then help to manage their part of their lives that actually contributes to their need to smoke.*

8 *…and as midwives we've got a massive input to changing the way people think, if we give them the right support to do it.*

One of the midwives talked about their experience of level I training as undergoing the training had a positive effect on their perception of their role. The training had enabled the midwife to appreciate that providing stop smoking advice could not lead to a behaviour change in all pregnant smokers and that this was an unrealistic expectation of the role of midwives. As a result of this insight, the midwife had a more positive perception of their role in promoting smoking cessation:

4 *And that, that kind of approach seems to be… I've found that really helpful. It almost lifted a burden off me when I realised that my job isn't about getting them all to quit, it's about getting them to move on because to some people*

that will be to move on to quit but for some people it will be moving on to think oh yeah my children aren't the healthiest kids and maybe I could do something to change that or yeah, it's getting more expensive and I don't like the way my breath smells.

As discussed previously, the participants recognised that midwives vary according to what they perceive as important aspects of midwifery as they have different interests and they specialise in various areas. Therefore, perceived facilitators as well as barriers to giving advice could depend on the midwife. Although the broad role of midwives was identified as a barrier to providing stop smoking advice, some midwives preferred discussing smoking cessation in comparison to other topics. The reasons that some midwives perceived promoting smoking cessation as a preferable task compared to other aspects of their role included that the evidence regarding the health risks of smoking during pregnancy was less unambiguous in comparison to other behaviours and that the topic was considered less sensitive than some other areas they were required to cover:

5 *I like giving smoking advice, smoking cessation advice more than say, talking about alcohol because the evidence is clear cut. You know, you know that if you smoke in pregnancy it's gonna damage the baby whereas the alcohol consumption, there is no, you know, one study will say one thing and another study will say another. You know you're giving accurate advice when you're talking about smoking as opposed to the other things that we talk about in health promotion service.*

2 *I think it's maybe different for me because I work in foetal medicine as well so often things I have to talk about, telling people that their baby's gonna die*

or um, that there's an abnormality with their baby so smoking would be right probably near the bottom of the list of difficult things to talk about in that situation definitely um. Yeah, I don't, I do think it's, it, it does make me uncomfortable discussing it with women, um, sometimes but I don't, I wouldn't s...yeah, it's not really the in any way the most difficult thing or even very difficult probably um, yeah.

Many midwives had accepted the fact that their work involves discussing sensitive issues with their clients and this was something that was part of their role. As this was a fundamental aspect of their profession, the midwives felt that they should feel comfortable talking about challenging topics with their clients and if they were not, they were required to change. This recognition appeared to positively affect the perception of providing stop smoking advice as it was accepted as part of their duty due to its importance even when the topic was seen as difficult:

3 *Oh it's I obviously, I discuss lots of things that make me feel uncomfortable in my job but it's part of my job. I have to discuss worse things in my job you know so it's part of the role we have, it's important, it's an important part of what we do.*

1 *We've all been used to kind of doing things we feel uncomfortable with, aren't you… You have to learn to live with that uncomfortableness you now, approaching personal subjects with people you've never met, cause if you can't do that on a daily basis, you really are in the wrong job.*

Although some of the midwives accepted that discussing sensitive and uncomfortable issues with pregnant women is an inevitable aspect of their work, this

might not apply to all midwives. As discussed previously, some of the participants mentioned that they feel uncomfortable about certain topics they are required to cover. Therefore, this feature of midwifery could be easier for some midwives to become accustomed to while others might struggle. The smoking behaviour of pregnant women, such as cigarette consumption, also had an impact on how vital midwives perceived the task:

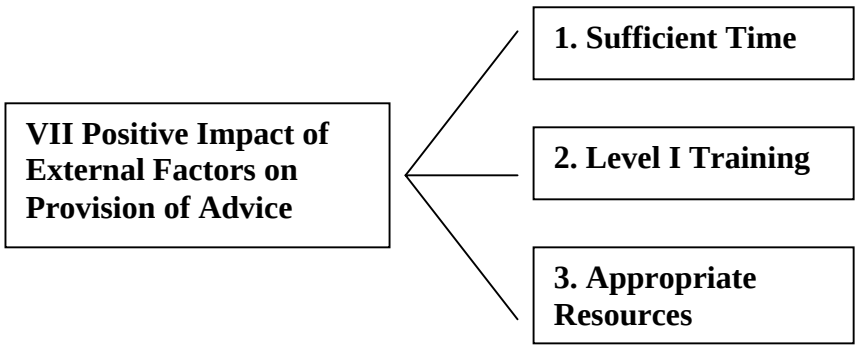
1	*If everything else was ok then it would pump up for me.*
5	*And it depends on the individual, if someone's smoking 40 day, then I'm gonna spend more time talking about it than someone who doesn't smoke at all, obviously, so it depends.*

Condliffe et al. (2005) found that midwives perceived providing stop smoking advice as a vital part of their role. However, the positive attitude towards the task did not result in the midwives actually promoting smoking cessation. Thus, while holding a positive approach towards provision of stop smoking advice can positively influence carrying out the task, it might not be sufficient by itself to encourage midwives to promote smoking cessation. Perhaps it needs to be combined with other factors in order to have an ultimate impact.

VII Positive Impact of External Factors on Provision of Advice

External factors were identified as possible facilitators to giving stop smoking advice as some of the positive characteristics used to describe the task of giving advice related to this category. The category 'positive impact of external factors on provision of advice' could be divided into sub-categories of '**sufficient time**', '**level I training**' and '**appropriate resources**' (diagram 3.2.8).

Diagram 3.2.8 'Positive impact of external factors on provision of advice' split into 'sufficient time', 'level I training' and 'appropriate resources'.



1. Sufficient Time

Lack of time was identified as a major barrier to providing stop smoking advice. Thus, having more time particularly during booking sessions was perceived as a facilitator to giving advice. None of the midwives felt that they currently had enough time to discuss all topics to the extent they wished with their clients and this category was thus perceived as a potential rather than an actual facilitator. During a discussion around what could make it easier to give advice, one of the midwives said:

> 2 *I think if we had an hour and a half that we would do… I think there would be more time given to each of the things that needed to be… I don't think an hour and a half is enough time actually anyway but it's better, um. So yeah, I do think it would have more… there would be more discussion…*

A smaller case load was believed to allow more time to be spent with clients and some midwives felt that this could therefore also help them to provide advice more effectively. Midwives perceived that working with a smaller number of

pregnant women would enable them to discuss issues to a greater extent and explore topics in more depth as they would be able to spend more time with each client:

> 5 *Ideally we'd have a caseload of 10 and we can spend all the time in the world discussing every element of health promotion for them.*

One midwife mentioned a midwifery team which looked after a smaller number of pregnant women and was therefore more able to discuss health promotion issues with their clients:

> 4 *The fact that you get a smaller case load of women and you're able to give, you're actually able to explore a lot more of these issues with women. And, almost your midwife bit becomes less important and the kind of more holistic social stuff and public health issues becomes, you've got the time to it you know…I think that that model gives a lot more scope for addressing these issues.*

2. Level I Training

The category 'level I training' was identified as a potential facilitator to providing stop smoking advice. Training in smoking cessation was described as one of the main elements that could impact positively on how midwives perceived the process of giving advice. It was apparent that the majority of midwives who had undergone level I training in smoking cessation had found it useful and that it had had a positive influence on their perception of giving advice. The feedback of level I training had also been mainly positive:

> 4 *I've had training now and I probably feel a lot more comfortable talking about it.*

> *11 I've been on a good course at the trust.*

The participants who had not completed level I training believed that it could have a positive impact on their ability to promote smoking cessation. The midwives felt they were in need of clearer information regarding stop smoking services, how to phrase the advice and a greater awareness of NRT products. The following extract shows a discussion on what effective training should comprise of:

> *14 Ways maybe, make it a little bit more clear how they can help with stopping smoking.*
>
> *13 Referral pathways which is clear for us to…People who we can call. Or how to encourage more and how they do stop smoking.*
>
> *12 And what not to say.*
>
> *13 And like other options. Like people want to know what they can use. Some people think that nicotine patches are bad during pregnancy.*

Level I training in smoking cessation thus served both as an actual and potential facilitator to providing advice. The midwives who had been trained said that regular update sessions would also be beneficial to help them keep up to date with issues related to smoking as well as motivated and confident in providing stop smoking advice. Studies have concluded that effective training sessions can increase midwives' levels of self-efficacy and improve the standard of stop smoking advice (e.g. Aquilino et al., 2003; Lawrence & Haslam, 2007). In addition, resources have been identified as helpful elements in the provision of advice (e.g. Pullon et al., 2003).

3. Appropriate Resources

Using appropriate resources was described as a potential facilitator to giving advice as it was believed that they could assist midwives in promoting smoking cessation to their clients. The midwives did not feel that they had been provided with sufficient and appropriate resources to help them and this category was therefore not identified as an existing but a potential facilitator. The participants mentioned mainly visual resources both as an aid in raising the topic and as a method of enabling pregnant women to comprehend the risks associated with smoking during pregnancy. They felt that visual information could potentially increase the likelihood of pregnant smokers changing their habit:

> 7 *Well, there is that piece of evidence that you can change women's minds about these things if you can give them visual aids too, for them. This is why the smoking cessation, you know, the baby in the bottle with a cigarette and so on, all of that stuff really, really, has an impact on some women.*
>
> 8 *I think that's what the aids are about, it's bringing the focus to the baby that they haven't really recognised for themselves.*

As the extract from a discussion below illustrates, visual cards or posters were perceived as potential useful tools in providing advice with regards to making the conversation about smoking more interactive:

> 12 *We put it in a card or something, don't we, like domestic violence. Maybe a little card like this.*
>
> 13 *…or maybe we could put, we can have one poster about smoking and…*
>
> 12 *With the baby with smoke coming from its mouth.*

13 *Yeah. Do you smoke?* [Points at poster] *Not just verbally but visual… Pictures just look better.*

12 *…hard hitting. I think booking can be just, it's you and me and the book. And a bit too boring. If we could just…*

13 *Make it a bit more interactive.*

12 *Yeah. That's the word. So they keep the advertisement of the baby smoking*.

VIII Other Issues Related to Smoking during Pregnancy

The midwives discussed factors related to governmental issues and other health professionals with regards to smoking during pregnancy. These themes were not directly associated with their perceptions of providing stop smoking advice and they were therefore not identified as a category within the core category 'facilitators to providing stop smoking advice'. However, as the participants felt that these issues had the potential to generally ease their task of giving stop smoking advice, they are also discussed.

Some participants recognised that there was a need to inform women about smoking and stopping smoking prior to becoming pregnant. The midwives agreed that the pre-education needed to start at schools so young people would be targeted prior to starting smoking or becoming too addicted:

8 *I think some pre-education as well would be useful before they actually come to us as well… I don't know who would do that although it's more government…*

7 *…need to do things like going to schools and get it started there so we get all the young people.*

These issues was not directly linked to the process of providing of stop smoking advice to pregnant women but rather to a reduction of smoking prevalence rates among pregnant women. Thus, if the proportion of pregnant women who smoked was smaller, midwives would not have to discuss smoking cessation as frequently.

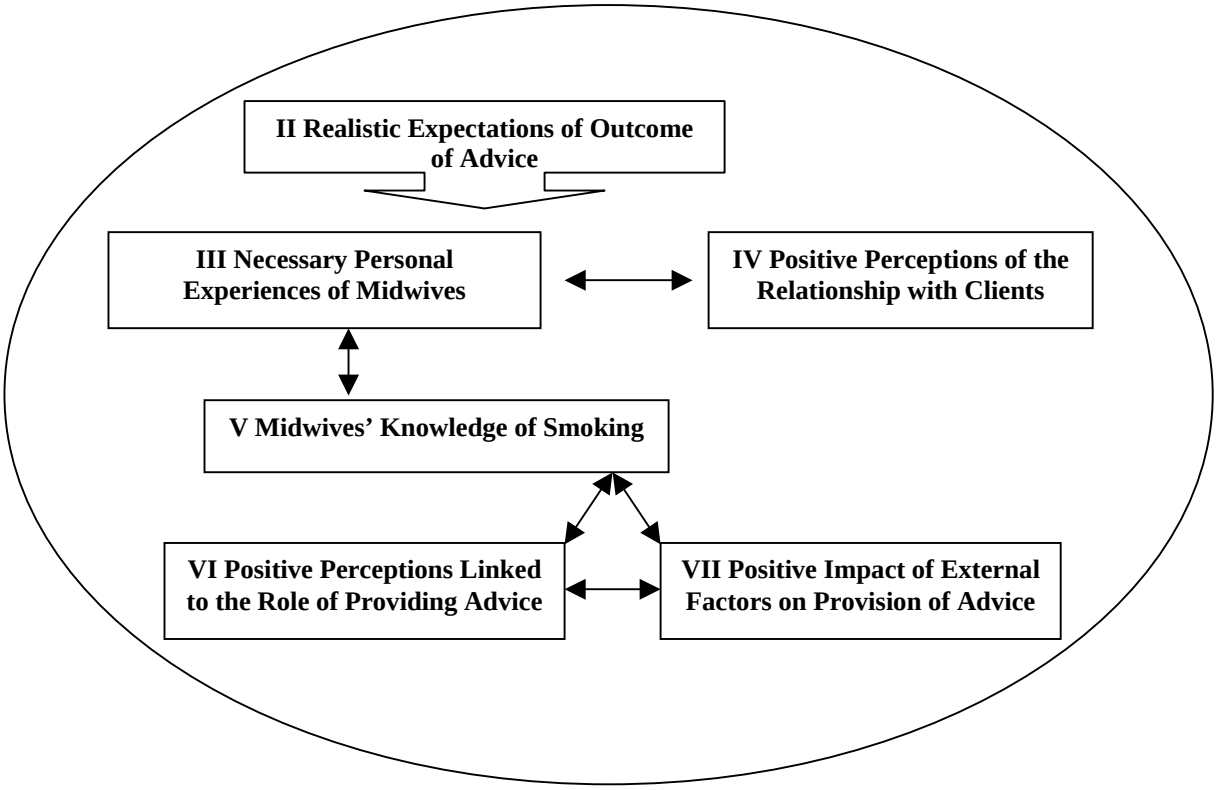
Some midwives seemed unsure of the advice that pregnant women and parents receive from other health professionals such as GPs. However, they believed that pregnant women are likely to respond well to smoking cessation advice provided by a doctor:

> 15 *What do GPs do though at the first appointment? Do they do anything with the women?*
>
> 14 *And if the GP can mention that smoking is not good for you and the baby…sometimes a woman likes the midwife but there is a chance… but they listen to the doctor more.*

The midwives felt that having a greater awareness of the role of other health professionals with regards to providing stop smoking advice to pregnant women and families and trusting that others are also offering advice would be beneficial. If a higher number of health care professionals regularly provided stop smoking advice to pregnant women, midwives believed that it could increase the number of women successfully stopping smoking during pregnancy.

IX Links between the Perceived Facilitators to Providing Advice

Some of the categories that were identified as potential facilitators to providing stop smoking advice were interlinked. The diagram below illustrates the identified relationships between the categories:

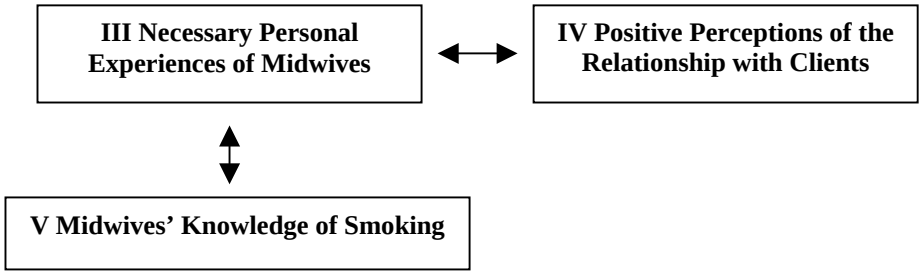


The '**realistic expectations of outcome**' category was linked to all categories identified as facilitators apart from '**positive perceptions of the relationship with clients**'. '**Necessary personal experiences of midwives**' was linked with realistic expectations as ex-smokers appeared less likely to have unrealistic expectations of the impact of their advice:

> 1 *And it does take, I mean it took me about two or three year for me to stop so I know that there are things along that way that accelerated things…*

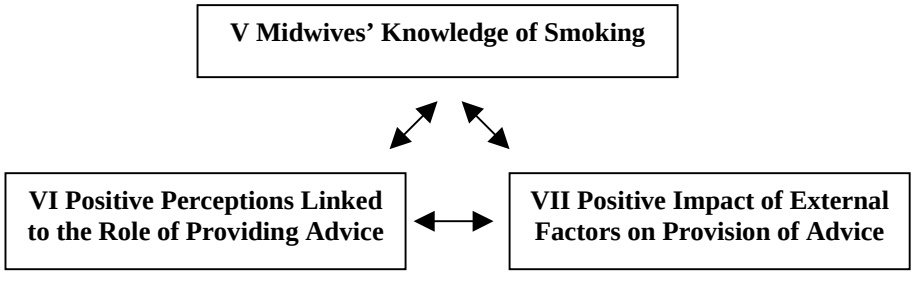
The midwives felt that possessing an adequate amount of awareness of smoking related issues could lead to more realistic beliefs of the outcome of the advice and '**midwives' knowledge of smoking**' was therefore associated with realistic expectations. '**Positive perceptions linked to the role of providing advice**' was linked to realistic expectations as midwives were more likely to feel comfortable discussing smoking cessation as part of their role when they acknowledged that

women who do not stop smoking as a consequence of receiving the advice is not due to the failures of the midwife. Some of the midwives mentioned that following their level I training, they realised that their job was not to make every pregnant woman quit smoking and that such an outcome was unrealistic. '**Positive impact of external factors in provision of advice**' was therefore also linked to realistic expectations.



The participants who used their smoking experience as an aid in providing effective stop smoking advice seemed to be of the opinion that this had a positive influence on the rapport between the midwife and their clients. The fact that they were ex-smokers appeared to provide midwives with knowledge regarding smoking and smoking cessation issues. '**Necessary personal experiences of midwives**' was thus identified as being linked to '**positive perceptions of the relationship with clients**' and '**midwives' knowledge of smoking**':

1	*I mean I gave up smoking myself and that's part of… I use that when I'm talking to women as for that kind of thing. To make it not sound like it's, I'm the health professional telling them that they're doing something bad. I say that I used to smoke and I gave up and I know how hard it is. That's how I try and get people engaged when I talk about it.*



'**Midwives' knowledge of smoking**' was linked to '**positive perceptions linked to the role of providing advice**' as gaining a clear understanding of the risks associated with smoking during pregnancy was thought to increase midwives' perceptions of smoking as an important topic and part of their role. As most midwives felt that their awareness and knowledge of smoking and giving advice had increased as a result of attending level I training, '**positive impact of external factors on provision of advice**' was linked with '**midwives' knowledge of smoking**'. In addition, '**positive impact of external factors on provision of advice**' was associated with '**positive perceptions linked to the role of providing advice**'. Level I training was described as an event which highlighted that their role entails providing advice and not necessarily persuading all pregnant smokers to quit. As a result of attending level I training, some midwives described that they felt more comfortable with the smoking cessation aspect as part of their role as a midwife.

Conclusion

The core categories that were identified from the qualitative data gathered from the focus groups with midwives were perceived barriers and facilitators to providing stop smoking advice. However, midwives tended to discuss perceived barriers to providing smoking cessation advice more extensively than potential facilitators and this category thus appeared much weightier. This indicates that midwives' perceptions of the task of discussing smoking cessation with pregnant women are more likely to be negative than positive. Indeed, negative characteristics of the task of providing advice were more frequently mentioned compared to positive characteristics.

The negative characteristics of providing smoking cessation advice were related to the perceived negative outcome of the advice, lack of personal

experiences, lack of necessary attributes, negative perceptions linked to the role of providing advice, negative impacts of external factors, perceived challenges in provision of advice in relation to pregnant smokers, and the perceived links between the advice and the relationship with clients. The positive characteristics of the task of giving stop smoking advice were related to realistic expectations of the outcome of the advice, necessary personal experiences, positive perceptions of the relationship with clients, knowledge of smoking, positive perceptions linked to the role of providing advice and of the midwifery role and positive impacts of external factors.

Some of the overlap between the perceived barriers and facilitators to providing stop smoking advice was due to a direct reverse between the categories. This applied to personal experiences of midwives, necessary or lack of attributes in providing advice and the impact of external factors. That is, these issues could be either barriers or facilitators depending on whether they were absent or present. Midwives who perceived they had relevant experiences and attributes were more likely to perceive the task of promoting smoking cessation as positive and the participants who felt they were lacking these aspects described providing advice more negatively. Similarly, insufficient training and time could prevent the provision of advice whereas sufficient time and appropriate training could facilitate the task. It was perceived as more challenging to give stop smoking advice to pregnant smokers with complex circumstances than it was to clients who did not have other demanding needs. Some of the categories were interlinked due to individual differences and perceptions among midwives as well as their clients. The midwives' perceptions of the outcome of the advice, their role in providing advice and the relationship with their clients varied between the participants and depending on how they viewed these

aspects they could act as barriers or facilitators. The pregnant women themselves could also have an impact on these categories.

The identified facilitators indicate that many of the barriers that midwives perceive with regards to promoting smoking cessation could be overcome. For instance, implementing effective training for midwives could address issues such as increasing levels of knowledge, confidence and skill, enabling midwives to understand smoking and empathise with smokers, informing midwives of the importance of smoking cessation as part of their role and creating realistic expectations of provision of advice. However, certain external factors which might not be possible to address through training were also identified as barriers, such as lack of time.

CHAPTER 4

FINDINGS STUDY 2

PREGNANT SMOKERS' PERCEIVED BARRIERS AND FACILITATORS TO APPROACHING THE STOP SMOKING SERVICE

The findings from study 1 illustrated how midwives perceive providing stop smoking advice to pregnant women. Study 2 explored how pregnant smokers perceive the stop smoking service. Although stop smoking programmes for pregnant women have often resulted in modest outcomes (Stotts et al., 2002), there is a lack of research investigating pregnant smokers' perceptions of stop smoking services (Ussher et al., 2004). The internet based study by Ussher et al. (2006) was the first to investigate the perceived barriers and benefits to attending stop smoking programmes by pregnant women. Despite high levels of interest in stopping smoking, the authors found that very few women had approached the service. The main barriers identified were concerns about feeling disappointed if the quit attempt was unsuccessful, not usually seeking help for issues such as smoking cessation, a disbelief in the effectiveness of the programme and not being able to access one. Receiving encouragement and advice about cravings were identified as the main benefits of attending a stop smoking course.

The present qualitative study conducted in depth semi-structured interviews to further investigate the insufficiently explored area of pregnant smokers' perceptions of the NHS stop smoking services in the UK. Ten interviews with pregnant smokers were undertaken before theoretical saturation was reached. Grounded Theory (Corbin & Strauss, 1990; Glaser & Strauss, 1967) was used to analyse the qualitative data. The participants consisted of women with various experiences of stop smoking services and perceptions of smoking. Although all

participants were smokers at the time of the interviews, the women varied with regards to whether or not they had attempted or wanted to quit during pregnancy. Additionally, the participants had different experiences of the stop smoking service as some had approached the service during the pregnancy or at a previous time in their life whereas others had never attended a stop smoking programme. Due to the mix of perceptions of smoking cessation and stop smoking services, numerous categories emerged from the data both with regards to reasons for approaching and not approaching the service. Two core categories were identified from the qualitative data:

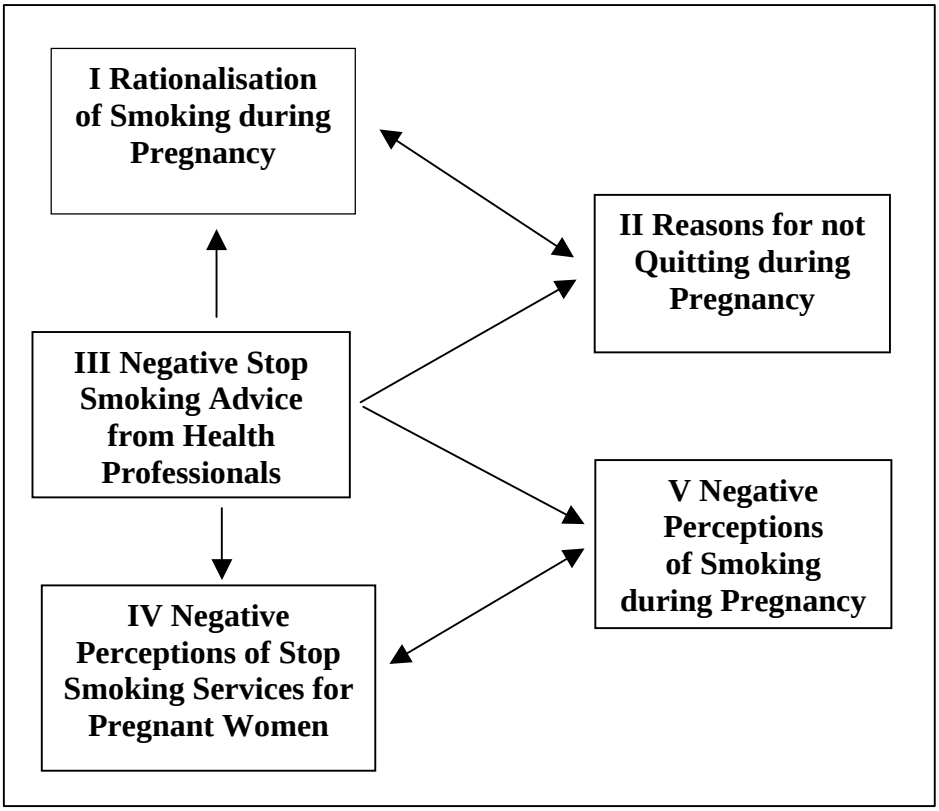
1. Pregnant smokers' perceived barriers to approaching stop smoking services
2. Pregnant smokers' perceived facilitators to approaching stop smoking services

4.1 Core Category 1 – Pregnant Smokers' Perceived Barriers to Approaching Stop Smoking Services

The pregnant women discussed their own reasons for not approaching the stop smoking service either during the present pregnancy or during previous pregnancies. Additionally, other women's potential reasons for not approaching the service for stop smoking support during their pregnancies were reflected upon. Diagram 4.1.1 illustrates the main categories that were identified as potential barriers to approaching the stop smoking service for pregnant smokers and how these categories could be linked. The categories were '**rationalisation of smoking during pregnancy**', '**reasons for not quitting during pregnancy**', '**negative stop smoking advice from health professionals**' '**negative perceptions of stop**

smoking services for pregnant women' and '**negative perceptions of smoking during pregnancy**'.

Diagram 4.1.1 The relationships between the main categories identified as barriers to approaching the stop smoking service by pregnant smokers.



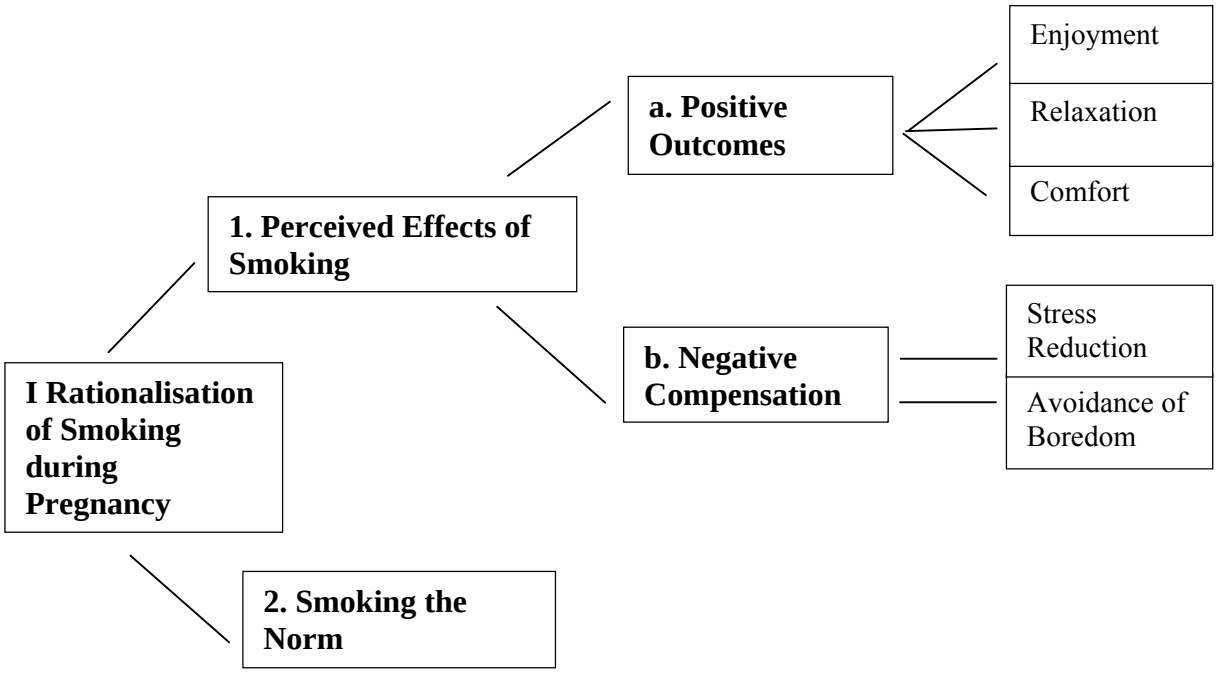
All of the themes are discussed and the relationships between the identified categories are outlined in the end of the chapter.

I Rationalisation of Smoking during Pregnancy

A theme that emerged as a strong reason for not approaching the stop smoking service was 'rationalisation of smoking during pregnancy'. This category indicated that pregnant women might not attend a stop smoking programme due to their rationalisations of their smoking behaviour. The pregnant smokers rationalised smoking during pregnancy with regards to '**perceived effects of smoking**' and '**smoking being the norm**'. 'Perceived effects of smoking' could be further split

into '**positive outcomes**' and '**negative compensation**'. The categories and examples of these are illustrated in diagram 4.1.2.

Diagram 4.1.2. The main category 'rationalisation of smoking during pregnancy' and its sub-categories.



1. Perceived Effects of Smoking

The participants described that some of the reasons for smoking during pregnancy were due to the perceived effects of smoking relating to both positive outcomes and compensation for negative experiences. Although these perceived effects of smoking were not directly associated with smoking whilst pregnant, some of them were described as more substantial during pregnancy.

a. Positive outcomes. Smoking was associated with a number of positive sensations. That is, the women expected or experienced that smoking resulted in positive feelings such as enjoyment, relaxation and comfort. Many women said that that they liked smoking in particular in certain circumstances such as following a

meal. The fact that smoking was perceived as an enjoyment could make it more difficult to change their behaviour:

Sarah	*I do enjoy it. I do like after I've had something to eat I think oh, I do have a nice cigarette I think oh, you know what, that's really, you know when you can really taste it, it makes me breathe my food out more. That was really nice, I enjoyed it.*
Emily	*…not many people would give up something that they enjoy.*
Kate	*But also I do enjoy smoking to a certain extent, you know if I've had something to eat…*

The participants also related smoking to a relaxing sensation and some quality time for themselves:

Sarah	*…it made me more relaxed.*
Kate	*…it's just that little bit of time, it just maybe takes up just 10-15 minutes of your time, just sat down, you're just sat there, you just relax and you're just smoking so that little bit of time there is just for yourself, just, you know?*

The positive outcomes of smoking such as enjoyment and relaxation can be attributable to the effects of nicotine in dependent smokers (Rose et al., 2007). Hence, these factors do not appear to be a unique aspect of smoking during pregnancy but are likely to be related to the addictive nature of smoking. Although the positive outcomes of smoking were not discussed in relation to the women's pregnancies, they were frequently mentioned and thus appeared as a justification for smoking. Two of the youngest women, aged 18 and 19, described smoking and

cigarettes as their comfort. None of the other participants mentioned smoking to be comforting. However, the teenagers illustrated the comforting aspect of their habit on several occasions. One of the women perceived cigarettes as her 'toy' and the other woman viewed them as her 'friend'. The reasons why the participants related smoking to their comfort included the fact that women are more restricted with other aspects of their lives such as drinking and eating whilst pregnant and that smoking serves as a comfort when they are alone. Although both women explained that cigarettes had been perceived as their comfort prior to becoming pregnant, the comforting aspect of smoking appeared more significant during pregnancy and one of the participants predicted that stopping smoking will be easier after giving birth as her baby will replace cigarettes as the source of comfort:

Sarah	*I'm a kid and that's my toy. I'm not giving it back to you, my comfort I'd say. That's what it is. I'd say that's why I'm not giving it up at the moment or I don't have any time cause that's my comfort.*
Sarah	*I've always, that has always been basically my comfort even when I weren't restricted or before I got pregnant.*
Tracy	*I'm nearly due, and the only thing I've got there really is cigarettes to comfort me and that's it.*
Tracy	*Yeah it's my comfort, it's like, I don't know, it's just become like a friend, but, it's just a comfort like if I'm not, I'm not really the type of person that's...I'm not always with people, apart from family, I'm not always, even if I'm now in my house, I'd be upstairs in my room, it's just my comfort kind of and there's just something to turn to because I don't feel like I have anything yet, but I'm going to have my baby soon and that's going to be my comfort.*

The association between cigarettes and comfort does not appear to have been identified in previous research. Could the comment '*something to turn to*' and the association between cigarettes and comfort be linked to a perception of lack of support? Perhaps women who do not regard cigarettes as their comfort have stronger support networks. This would explain why the women described the comforting aspect of smoking as one of the strongest reasons for smoking prior to but particularly during pregnancy which could be perceived as a scary time for the young women. One of the participants mentioned that she was frightened by the thought of giving birth. The rather childish description of cigarettes as a '*toy*' also indicated that the comforting aspect of smoking could either purely or partly be linked to the young age of the participants.

b. Negative compensation. Although the participants associated smoking with positive outcomes, they also rationalised their smoking with regards to negative compensation. Some of the women related smoking to negative experiences:

Tracy	*I think smoking is associated with bad things. I don't know like bad experiences and stuff like that. It makes you just want to turn to cigarettes and stuff like that.*

A perception of smoking was that it compensated for negative aspects of the participants' lives such as stress and boredom. Although negative compensation was not only associated with smoking during pregnancy, some of the aspects were more relevant at this point in their lives. For instance, as some of the women had more time on their hands due to being pregnant, they experienced feelings of boredom more frequently. Smoking was perceived as compensating for the negative

experience of being bored or having a mundane life. It appeared that smoking was regarded as the main or one of the few stimulations in some of the women's lives:

Amy	*It's usually boredom… Sometimes I will leave my cigarettes at home when I go out and I don't smoke and I come home and I don't really need to or want to it's just something to do.*
Sarah	*The more time you've got on your hands, the more the more bored you feel, the more you feel you need to smoke.*
Kate	*What to do otherwise, you know.*
Clare	*…and when you're at home, you get up in the morning you take the kids to school, you come home, you do dinner, you clean and you go to bed it can be quite boring really, and I know that sounds selfish but it can be and once you've got smoking in with that, it's our little bit of joy, have a fag on the balcony, so it's weird.*

Smoking due to boredom has previously been identified among pregnant women (Gillies, Madeley & Power, 1989). Associating smoking with stress also appeared as a common perception even for the women who stated that they were aware of the fact that smoking does not actually relieve stress. Smoking as a method of calming down following arguments was also mentioned as a rationale for smoking:

Kate	*…if I had you know a stressful or whatever day you know sometimes a cigarette would be like, aah.*
Sarah	*…oh if you're stressed, you have a cigarette, it calms your nerves. In fact, it don't but that's just what you think, how it makes you feel.*

Amy	*I got to remember that being stressed don't mean go and have a fag. I have to have, I really, as soon as I have an argument with my partner or after or when I'm a bit stressed the first thing that comes to my mind is having a cigarette. First thing, straight away…*

The comment by Sarah indicates that although she does not **think** that smoking relieves stress, she **feels** that it does. Evidently, the sensation of smoking as a stress reliever was stronger than her cognition that cigarettes do not reduce stress. Previous research has implied that one of the strongest reasons for smoking among pregnant women is that the behaviour is perceived as a means of handing stress (Owen & Penn, 1999). It has been suggested that it is vital to inform smokers of the evidence which shows that smoking does not alleviate stress but stress can in fact be exacerbated by smoking (Parrott, 1999). However, raising awareness might have limited outcomes if individuals continue to smoke if their association of cigarettes as a stress reliever is weightier than their knowledge of the actual effects of smoking. As previously recommended, teaching coping strategies to deal with stress might thus be a more effective method of helping pregnant women quit smoking (e.g. Dejin-Karlsson et al., 1996; Ludman et al., 2000). The association of smoking following an argument has been previously reported (e.g. Shiffman et al., 1996). Amy's description of smoking as a result of an argument almost compares to a sense of compulsion or lack of control. She could not explain the reasons for these immediate thoughts of smoking following an argument apart from the strong association between cigarettes and feeling stressed.

There were various other extrinsic stressful factors that the women associated with smoking. These varied greatly depending on the participants' personal

circumstances. Some of the responses to the question '*What (else) could make it difficult to stop smoking?*' were the following:

Maria	*Yeah I think like at the moment I'm a bit peed off with my living environment so that doesn't help.*
Susan	*The worry of various things, um. Preparing for things for when it comes, organising houses and I'm decorating at the moment. Getting all the smoke out of the house. Thinking about work, how long do I have to take off, when do I come back. Lots of thoughts, lots to think about. Yeah, cause normally I sit down and have a cup of coffee and a cigarette to think about it.*
Tracy	*I got court with social services, well might have court with social services and that's another thing that's going to, I don't know if I'm going to smoke or not.*

A couple of the quotations mentioned above were linked to being pregnant. Susan's main worries revolved around the pregnancy with regards to arranging her maternity leave and preparing for the baby and Tracy's encounter with social services was due to issues regarding her unborn child. The pregnant women might therefore rationalise their behaviour due to pregnancy specific as well as pregnancy non-specific stressful circumstances.

2. Smoking the Norm

The majority of the pregnant women perceived smoking as the norm in their own life, in their social network as well as in society as a whole. This was despite the fact that a minority of the general population (Office for National Statistics, 2009) and pregnant women (Bolling et al., 2007) in the UK smoke. This perception might

therefore be a reflection of the backgrounds of the participants as smoking rates are considerably higher among socially disadvantaged populations (Office for National Statistics, 2009; Penn & Owen, 2002). The perception of smoking as the norm emerged as a common rationale for the participants' behaviour and although many of the women explained that they perceived smoking during pregnancy as an undesirably habit, the perceived normality of the behaviour appeared as a weightier reason for continuing to smoke than pregnancy was for quitting. Perceiving the pregnancy itself as a sufficient reason for stopping smoking might therefore be harder for the women who normalise their behaviour due to their familiarity of smoking. Many of the women had started smoking at an early age and smoking was described as a routine and as a normal part of their lives:

Jane	*I've been smoking since I was about twelve years old.*
Emily	*...they've got a fag in their hand it feels normal to them. That's what it is, it's just normality it's just routine. It's just routine.*
Clare	*… fags, it's not as if they mean the world to me but it just becomes part of your life smoking…*

Another familiar rationale for smoking among the participants was that they had not considered quitting prior to their pregnancy:

Amy	*I didn't even want to stop. So I've never tried to even seek any information about it.*
Emily	*It was me being selfish really. Me just thinking about myself, thinking I'm still young. I was very young and I wanna enjoy myself with my friends and because like all friends like all get together and like laugh and joke and stuff and socialise….*

Emily was only 19 and yet she justified her former reasons for smoking with regards to her young age. Although she described her behaviour as selfish, she associated smoking with socialising and enjoying herself. As discussed, an identified reason for smoking was the outcome of enjoyment. Parents, peers and friends have previously been given as reasons for smoking among adolescent girls (French & Perry, 1996). Two of the youngest women in the current research associated smoking with their social network as they explained that the majority of their friends were smokers. This was perceived as a rationale for starting smoking in the first place as well as maintaining their habit despite being pregnant:

Tracy	*…there's a lot of things actually associated to why people smoke, um, like people around them, friends, that's probably, that's my experience anyway.*
Emily	*…it would be much more difficult for me to actually stop smoking because there's so many people around me like friends and people that smoke…*

One of the youngest participants perceived smoking as a common behaviour in society and that cigarettes and smoking are constantly present in her environment. Although the woman did not describe smoking during pregnancy as a usual or accepted habit in society, the fact that smoking in the general population was so widespread and that one is constantly reminded of cigarettes added to her rationalisation for continuing to smoke whilst pregnant:

Emily	*Do you know what yeah, it's always telly time, always telly time because every person on telly has always got a cigarette always*

sparking up a cigarette… That's what makes you wanna smoke more because they're advertising it in such a good way yeah… there's just smoking everywhere, all around your face wherever you look wherever you turn there's something to do with smoking something related to it…

Emily's quotation above illustrates her perception of smoking as a dominating aspect of the world. She described cigarettes and smoking in her environment as overbearing and rationalised her smoking habit in relation to this phenomenon as she thought it would have been harder for her to start smoking and easier to remain abstinent after a quit attempt if she was not constantly reminded of smoking. This perception could also have been a reflection of a shift of responsibility to society of her habit. This phenomenon of shifting responsibility could also explain another young participant's perceptions of her habit. Tracy felt that continuing to smoke was easier due to the fact that her mother had accepted her behaviour and she stated that she might have stopped smoking if it had not been for other family members:

Tracy *…but she'd actually accepted it, the fact that I smoke, that's made things easier. For like for example if she didn't accept it I probably wouldn't be smoking now. If she had said no to it or I was too scared to tell her it the, I think that would have helped. But because everyone in my family knows that I smoke it's not really helped me it's just made it so they know anyway so, that's partly the reason why I think.*

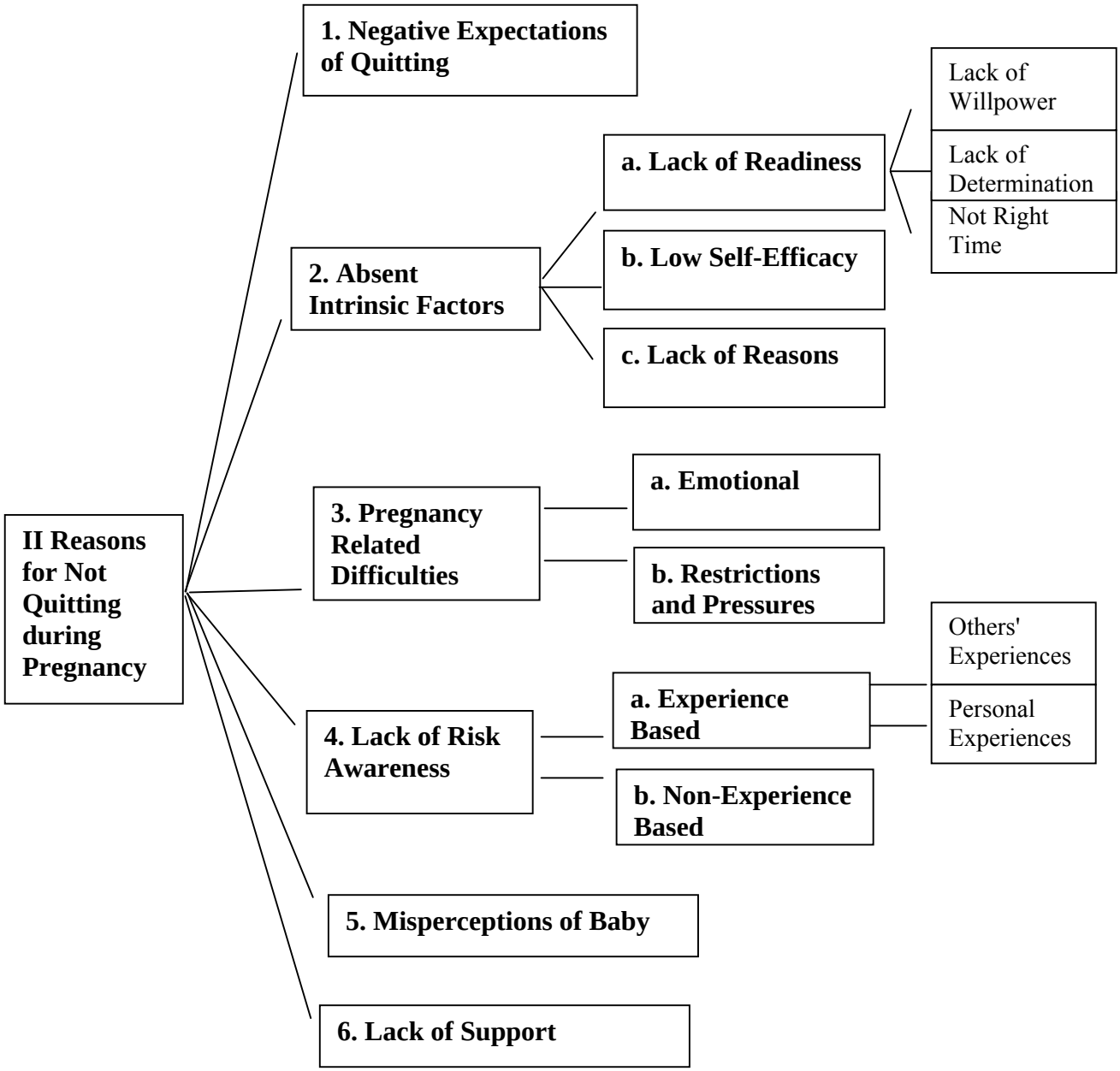
The participants' rationalisations for smoking during pregnancy were mentioned by women who did not want to nor had attempted to change their habit as

well as by those who wanted to and tried to stop smoking. Therefore, the category reflected reasons for continuing to smoke among a variety of participants. Although some of the identified categories related to the pregnant smokers' rationalisations for smoking could be more prominent during pregnancy, these themes did not differ from reasons the general population give for smoking, such as associating smoking with stress and enjoyment as well as smokers in their social network (Taylor, Lader, Bryant, Keyse & Joloza, 2006). Thus, the data indicated that women might not differ from other smokers simply because they are pregnant and the rationalisation processes of smoking do not appear to change as a result of becoming pregnant.

II Reasons for not Quitting during Pregnancy

Another category that was linked to the smoking behaviour of the participants and identified as a barrier to approaching the stop smoking service was 'reasons for not quitting during pregnancy'. That is, pregnant women might perceive the reasons for not stopping smoking as more substantial than reasons for quitting. The rationales for not changing ones smoking behaviour during pregnancy were related to '**negative expectations of quitting**', '**absent intrinsic factors**', '**pregnancy related difficulties**', '**lack of risk awareness**', '**misperceptions of baby**' and '**lack of support**'. Some of the sub-categories could be further split into '**lack of readiness**', '**low self-efficacy**' and '**lack of reasons**' (absent intrinsic factors), '**emotional**' and '**restrictions and pressures**' (pregnancy) and '**experience based**' and '**non-experience based**' (lack of risk awareness). The category, its sub-categories and examples of some of these are shown in diagram 4.1.3.

Diagram 4.1.3 The category 'reasons for not quitting during pregnancy' and its sub-categories.



1. Negative Expectations of Quitting

Analysis of the data indicated that a reason why some pregnant women do not stop smoking upon becoming pregnant could be because they have negative expectations of changing their behaviour. The participants predicted the process of quitting to be hard and to result in withdrawal symptoms due to its addictive nature.

The cravings, being short tempered and moody as well as putting on weight were some of the withdrawal symptoms that the participants mentioned could prevent a pregnant woman from stopping smoking. Four of the pregnant smokers had experienced more severe withdrawal symptoms as s result of being pregnant. Kate and Tracy explained why they expected stopping smoking to be hard:

Kate	*…getting a bit snappy and, and angry you know if, saying that my partner XXX, you know, was to say something I don't want to be short tempered you know, just because I stopped smoking. …I don't want to snap at people. Yeah. I'm not a moody sort of person anyway but I'm just thinking I don't want to become that.*
Tracy	*Probably because I'm pregnant now and I get cravings...*

A common description regarding the participants' expectations of stopping smoking was 'hard' or 'difficult'. One woman, Clare, even predicted that the process of quitting would be the most difficult tasks ever undertaken and Maria clearly wished that the process could be easier:

Clare	*Because that is one of the most hardest things in the world I think to stop smoking.*
Maria	*…why the hell am I smoking, it makes me think I wish it was easier… having to challenge parts of you I suppose you haven't had to is what I find difficult...or what makes me give up all the time. Cause you've got to stick with it all the time there's no escaping yourself.*

When discussing stopping smoking, some of the participants said that they feared the thought of not smoking again. Having cravings and relapsing were the

most common reasons that were given for feeling frightened which was also described as scary, worrying, daunting and even as sense of panic. One participant described this sense of fear to be present despite wanting to change her behaviour:

Clare	*It is frightening; when you're a smoker the thought of not smoking again it is scary, even for a pregnant woman, even though you want it so much. I said that I wanted it so much but it still scared me.*
Kate	*… stopping smoking, it was a bit daunting.*
Anna	*I'm just worried that I'll just stop and then start again.*

The negative expectations of quitting were based on assumptions of what the quit attempt would be like rather than on real experiences. Therefore, the perceived negative outcomes of stopping smoking appeared to be a justification of the habit for some of the pregnant women. However, the addictive part of smoking has been identified as one of the strongest predictors of smoking during pregnancy (e.g. Cnattingius et al., 1992; Lu et al., 2001; Ma et al., 2005; Olsen, 1993; Woodby et al., 1999). This could be explained by the fact that nicotine is metabolised at a faster rate during pregnancy and the withdrawal symptoms can thus be stronger for pregnant women (Dempsey, Jacob & Benowitz, 2002). Although the addictive part of cigarettes is likely to have an impact on the smoking behaviour of all individuals, this element of smoking might be more prominent among pregnant women.

2. Absent Intrinsic Factors

A number of intrinsic factors were mentioned as necessary in giving up smoking and lacking these was identified as a barrier to stopping smoking and consequently approaching the stop smoking service. The intrinsic factors included lack of readiness, low self-efficacy and lack of reasons.

a. Lack of readiness. The participants conveyed that pregnant smokers who do not feel ready to give up their habit are less likely to do so. Not having the willpower to stop smoking as well as wanting to continue to smoke were described as factors that prevented people from attempting to and succeeding in stopping smoking. The quotations below are taken from discussions around the participants' and other pregnant women's reasons for not stopping smoking. Emily's comment reflected her reluctance to quit smoking prior to becoming pregnant:

Emily	*…the main reason is because I won't go through with something yeah, a hundred percent if I don't want to do it.*
Anna	*I suppose that if you want to, which is the hard thing because not everyone wants to.*
Maria	*…they might not want to give up at all even though they might think sod it, I can't be bothered or they're quite happy smoking*
Sarah	*I'm quite happy and content at the moment to carry on smoking while I am pregnant.*

Although willpower was frequently described as a necessary factor in stopping smoking, some of the women also pointed out that simply wanting to quit has not been enough for them to change their smoking behaviour despite being pregnant:

Maria	*I do want to do it but I can't see what it is…*
Kate	*…if I did want to stop then I would just stop but sometimes it's not as easy as that and you do need a little help somewhere.*

Although one could expect that Kate's willpower combined with an unsuccessful quit attempt without help would result in uptake of a stop smoking programme, she had not attended the stop smoking service for support. This indicates that possessing willpower might neither be enough to quit smoking nor to approach stop smoking services. Smoking during pregnancy was also identified as a consequence of lack of determination. The participants believed that lack of motivation, the wrong attitude, not having the thought of stopping smoking in ones head or putting ones heart into the quit attempt negatively affected the likelihood of stopping smoking and approaching stop smoking services:

Clare	*You can't do it, you can come to these meeting every week... It has to be in your head as well.*
Maria	*My motivation, my attitude towards it. I think that's what's different more than anything else* [why not managing to stop on this occasion]…*I'd need to put my heart into it more for it to work.*

Not feeling that it is the right time to give up smoking was also identified as an intrinsic factor that could affect whether a pregnant smoker would give up her habit. Experiencing that one is mentally ready to quit as well as believing that the time is right were thought to be important aspects of a person's quit attempt and if these perceptions were absent it could hinder a behaviour change from occurring. Even if a woman tried to give up and attended the stop smoking service for support, the quit attempt was thought to fail if the person was not mentally ready to change her behaviour:

Sarah	*I just don't personally feel ready enough to stop smoking.*
Anna	*…not everyone feels it's the time to.*

Clare	*…you have to be ready. You can't come to these meetings and not be ready.*

Lack of commitment in quitting and perceiving that the time is not right have been mentioned as two of the main reasons for not stopping smoking among the general population (Lader & Goddard, 2004; Taylor et al., 2006). The pregnant women did therefore not differ from other smokers with regards to their perceived lack of readiness. Being pregnant did not appear to be sufficient to increase all pregnant smokers' sense of readiness to change their behaviour.

b. Low self-efficacy. The pregnant women described that lacking confidence in their ability to change their smoking behaviour could be a barrier to stopping smoking as well as approaching the stop smoking service. Low self-efficacy was both mentioned in relation to their own quit attempt and with regards to other smokers:

Emily	*I was worried that I wouldn't actually be able to set a date to stop smoking cause I've never done it yet….*
Anna	*…because when I first come I was nervous and I didn't think I'll do.*
Tracy	*I can't stop. You know I just can't, before it was just easier, but now I just can't stop.*

Although previous research has also confirmed the negative impact of lack of self-efficacy on pregnant smokers' quit attempts (e.g. Hotham et al., 2002), Ussher et al. (2006) found that low self-efficacy predicted an interest in the uptake of stop smoking services among pregnant women. The three participants who made the comments above with regards to their perceived lack of confidence all explained that

they wanted support in their quit attempt. However, Tracy had not attended a stop smoking programme despite being in the very end stages of her pregnancy. Poor levels of self-efficacy could thus add to the interest in attending stop smoking sessions but it does not automatically result in uptake of the service.

c. Lack of reasons. Not having weighty reasons for stopping smoking was also seen as a potential barrier to quitting for pregnant women. It was recognised that pregnant smokers could find it harder to stop smoking if they did not want to give up for themselves but purely because of the pregnancy:

Emily	*I don't think that there's any more that you could do really because it's up to the person, it is completely up to the person, you can't give up for a person, it's the person that's got to give up for themselves.*
Maria	*…that decision I made it myself in the sense that I'd planned it before. I'd put more into it, I was willing to have more risks. I promised to my daughter that I'd try and I got all things associated with it whereas this time I kind of thought, oh I'm pregnant, oh I better stop, so it's not the same. Yeah I suppose not the mental support behind it part from myself...haven't put myself in it I suppose the way I could.*

According to McLeod et al. (2003), the pregnancy itself might not be a sufficient motivator for all pregnant smokers to change their behaviour. The pregnant smokers in the present study appeared to use similar rationalisation thought processes regarding their habit as the general smoking population. This would explain why a pregnant woman might continue to smoke if her rationales for smoking and reasons for not quitting outweigh her reason for stopping due to

pregnancy. The pregnancy itself was also identified as a direct barrier to quitting smoking and approaching the stop smoking service.

3. Pregnancy Related Difficulties

The pregnant women explained that stopping smoking might be harder due to the emotional feelings experienced during pregnancy, the restrictions that pregnant women face as well as the pressure that pregnant women are exposed to. The concept of pregnancy as a specific reason for not stopping smoking appears to be relatively unexplored.

a. Emotional. The fact that women are more likely to feel emotional during pregnancy was perceived as a barrier to stopping smoking. Dealing with these emotions as well as stopping smoking could make the quit attempt more challenging for pregnant smokers. Hotham et al. (2002) suggested that pregnant women's mental well being which is a predictor of smoking during pregnancy could be linked to changes in hormone levels The participants discussed being hormonal during a time of pregnancy and therefore less able to deal with potential stressful situations such as stopping smoking:

Amy	*…it's harder cause your hormones are a bit crazy and you feel stressed more easily.*
Anna	*I think it's just your emotions and I think when you are pregnant you're very emotional so it's just trying to find a way to come across it, deal with it in a better way or maybe occupy yourself in a better way and try not to think about it as much which can be hard, yeah.*

As discussed, the analysis of the data indicated that some pregnant women smoke as a way of compensating for negative feelings like stress and that the

negative expectations of quitting and not feeling that the time is right can hinder a quit attempt from occurring. Feeling more emotional and hormonal during pregnancy could therefore be a major barrier to stopping smoking if women sense that their stress levels are higher and the negative outcome of quitting would be stronger. However, women might also use their hormonal levels as a justification for continuing to smoke during pregnancy and as an explanation for the challenges they expect to face if they chose to change their behaviour. Being more restricted and under pressure due to the pregnancy could also be perceived as justifications for continuing to smoke.

b. Restrictions and pressures. Feel more restricted during pregnancy due to not being allowed to behave similarly to how they had prior to becoming pregnant was a concept that was mentioned among the pregnant women. One woman perceived that the pregnancy itself brought restrictions as she was not physically able to engage in the activities she had previously been involved in. These feelings of restrictions could also hinder pregnant smokers from quitting. One of the participants, Sarah, mentioned the restrictions as one of the weightiest reasons for her decision to continue to smoke during pregnancy:

Sarah	*While I've been pregnant I've felt that a lot of other things have been restricted and this, and I feel that this, I'm not letting no one take, at the moment take this away from me. That's how I feel like cause I'm not allowed to drink, I'm not allowed to do certain things now because you are pregnant.*
Tracy	*I'm not as constructive as before, I'm not really doing things all the time so I'm just lazing around, because of the fact that I'm pregnant. I'm nearly due, and the only thing I've got there really is cigarettes…*

The perception of feeling restricted appeared to be more common among the younger participants and those who had not previously been pregnant. As well as feeling restricted, one of the participants felt that pregnant women are pressured to behave in certain ways. These pressures could result in a desire to rebel and ignore the advice that they are given regarding how to live. This phenomenon was only discussed by one participant but she felt very strongly about the perceived pressure and she mentioned it on various occasions. Sarah was the only participant who openly explained that she did not want to give up smoking during her pregnancy:

Sarah	*Yeah, I think when you're pregnant a lot of people are trying to not tell you their views, but telling you what you should do and what you shouldn't do and I think if you're pregnant, the more somebody tells you the more you going to rebel.*
Sarah	*But I think as soon as you find out you are pregnant there's a lot of pressure on all different things but the smoking comes on the most, I think. I'd say that's the most thing, because that's your health, that's the most thing they kind of try and drum into you but that's about it yeah.*

Although previous research has suggested that underreporting of smoking among pregnant women might be a result of the social pressures of quitting during pregnancy (e.g. Cnattingius, 2004), not changing ones smoking behaviour due to feelings of restrictions and pressures appears to be a newly discovered aspect of smoking during pregnancy. This concept was more apparent among the young participants who were primagravidas which indicates that the perceptions might be

stronger for women whose lives are more likely to change as a result of the pregnancy.

4. Lack of Risk Awareness

Another category that was identified as a rationale for not quitting smoking during pregnancy was 'lack of risk awareness'. That is, many of the pregnant women who smoked explained that they or other pregnant smokers are not fully aware of the risks related to smoking during pregnancy. The insufficient knowledge regarding the risks could be both non-experience and experience based.

a. Experience based. The experience based lack of risk awareness among pregnant smokers related to others' as well as their own experiences of smoking during pregnancy. Some of the women explained that it was difficult to fully believe the risks related to smoking during pregnancy due to the fact that they were aware of other women who had given birth to healthy babies even though they had smoked during their pregnancies. The participants mentioned their own mothers as well as friends and other women in their social network as people who had healthy babies despite smoking throughout their pregnancies:

Maria	*…my mum smoked, why don't I smoke…* [Maria spoke of the reasons given by some pregnant smokers for not quitting]
Clare	*But like I said it's weird when so many friends have had babies and smoked all the way through it and nothings happened you can't help but think you're going to be all right… I mean you hear that it makes your baby small and things like that but that to me, I don't believe that because I know people who have smoked and had 10 pound babies…*
Tracy	*I talked to one woman and she said she smoked throughout her whole pregnancy and in fact for all of her kids and nothing happened to any*

of them, so I think people like that, like actually, they give other women that kind of boost to carry on smoking.

A number of the participants had smoked during their previous pregnancies and they had not noticed any negative health outcomes in their children. This also appeared to be a barrier to stopping smoking during the current pregnancy:

Clare *I feel bad saying that cause you know it's bad if you smoke through your pregnancy and I did with my first boy but that's what makes it harder as well because you know I've had him and he's fine…*

Jane *And when I've had healthy children, and I did smoke through my younger…daughter's thingy and she come out fine…*

One woman explained that a scan late in her pregnancy had indicated that the baby was healthy despite the fact that she had continued to smoke whilst pregnant. This information had made it more difficult to get motivated to quit at this stage of her pregnancy:

Kate *…have scans and everything, oh your baby's growing fine, your baby's not going to be premature now because I'm almost full term you know, the only thing they can't say is if the baby is going to have asthma or anything like that due to smoking but um. You know I'm thinking ok, so my baby's not going to be premature, it's not going to be low birth weight because when you have scans now they tell you the weight of your baby, you know. So I'm thinking it hasn't done, it hasn't done any damage you know…*

Although Kate was aware of the fact that her child might suffer the consequences of her habit later on in life, she found it difficult to stop smoking at this point as she did not think that the baby was currently affected. This appears to be related to a misconception about the baby. This phenomenon was identified as a reason for not quitting during pregnancy and will be discussed later. Haslam and Draper (2001) also reported that pregnant smokers who are aware of the risks related to their behaviour might find it difficult to quit due to perceptions of pregnancies resulting in healthy babies despite the mother's smoking habit.

b. Non-experience based. Lack of awareness of the risks related to smoking during pregnancy could also be non-experience based and due to perceptions that information was lacking. One of the women, Sarah, mentioned that knowing that she was harming the baby would stop her from smoking and the fact that she did not consider this to be occurring at the moment prevented her from quitting. Although Tracy wanted to stop smoking, she found it difficult to comprehend the harmful effects of smoking during pregnancy:

Sarah	*If I felt at a certain point that what I was doing was harming too much of the baby …then I would consider giving up but to that point, it hasn't come to that so I'm still quite content with smoking.*
Tracy	*I've heard that it's because there's no actual evidence, what was it, there's no actual evidence that… no strong evidence actually that says smoking is harmful...I never actually heard like the proper truth to why, to why smoking will affect the baby and why it's bad.*

This apparent lack of awareness of the health risks was more prevalent among the young participants. However, even when pregnant women know that

smoking can have detrimental health effects, the participants believed that many women are not aware of the specific risks or their severity. They applied this conception to themselves as well as to other pregnant smokers:

Maria	*I think people who smoke underestimate the effects it has.*
Clare	*I mean everybody knows that you shouldn't smoke while you're pregnant but I wouldn't actually know, I could not sit here and tell you now what effects it does on the baby.*
Amy	*Cause I don't actually really know what it does to babies.*

Previous research has also found that pregnant smokers possess insufficient knowledge of the risks related to smoking during pregnancy (e.g. Walsh et al., 1997b). The fact that some pregnant women prefer to have a low birth weight babies was mentioned during one of the interviews:

Amy	*I think you see all those things, oh yeah, it does that but they're not really, I know it says low birth weight. But some people don't want big babies too so…*

A few of the women who had attended stop smoking sessions for support in their quit attempt mentioned that they had not been aware of how much carbon monoxide (CO) the fetus was exposed prior to having their levels monitored as part of the programme. Realising that their baby was affected by the poisonous gas was perceived as a positive aspect of the intervention:

Anna	*I don't think people realise that as much cause I didn't realise that until I had that test done… knowing how much carbon monoxide stuff is in your body that was quite an eye opener…*

Secondhand smoke was also discussed during the interviews and a number of the women explained that they find it difficult to consider or believe the risks linked to exposure of secondhand smoke:

Anna	*…you don't think about what you're actually doing when you're actually smoking around kids.*
Clare	*I know it's not good smoking in a room with kids but you don't think it does that, I mean there are people that can actually die of passive smoking and I think it's hard to believe I really do. So it's weird, someone who never picked up a fag in their life can die of someone else smoking is just crazy to me, I don't understand.*

These women had children and although they wanted to stop smoking because of them, they found it difficult due to the difficulties in understanding the health risks of passive smoking. Clare spoke of this on a few occasions and explained that she had been informed of the risks related to second hand smoke, yet she struggled to comprehend this concept. In a sense it appeared that she mistrusted the health promotion delivered. Insufficient knowledge of the risks of passive smoking among pregnant women has also previously been confirmed (e.g. Fingerhut, Kleinman & Kendrick, 1990; Owen & Penn, 1999).

Although the participants said that the existing information of smoking during pregnancy portrays it as a harmful behaviour, the messages were perceived as ambiguous. Explaining the health risks related to smoking during pregnancy with visual material might raise awareness of the effects of smoking. The women described that no visual information existed and this perceived lack of evidence of the health risks could prevent women from stopping smoking during pregnancy and

consequently approaching the stop smoking service. A common view was that potentially effective adverts on TV were lacking:

Sarah	*Yeah, there's not enough of just showing people, what actually happens, yeah you're telling us but there's no good telling us if you can't, if you're not gonna show us. I think that's why people don't take no notice.*
Jane	*… you've seen a lot of adverts about drinking and how that harms babies and like when you see the scan pictures and when you have a drink it starts jumping up and down and things like that which is quite a shocker but there's nothing really about smoking. Maybe in leaflets and things like that but not for like people that are like, general people like just sit in their front rooms watching telly or something so I don't think there is.*

When asked what kind of information pregnant smokers would benefit from receiving, the pregnant women found it difficult to make suggestions. Although they thought that it would be beneficial to show pregnant smokers the health effects of smoking with visual aids, they simultaneously stressed that using shock tactics or pressure might not be very beneficial in targeting this population:

Amy	*Maybe you could do shock tactics to show them like what actual, like, when you do speak to them say oh, you know this is, it's hard though because you don't want to really, maybe you would be pressuring them if you did say this is the type of damage…*
Maria	*But then I don't know what would work because I think...if you had people just being all, I think people who smoke underestimate the*

	effects it has so those things kind of things shock you into reality don't they. But I don't think they work to make you stop.

Haslam et al. (1997) found that awareness of the health effects did not predict smoking cessation among pregnant women. Some of the women in the present study also explained that being aware of the health risks related to smoking during pregnancy does not stop people from smoking whilst pregnant. This sub-category was therefore identified as a deviant case as awareness of smoking was discussed but not perceived as a predictive factor in quitting during pregnancy:

Jane	*Well, you know like what you hear it's bad for the baby and can it cause like...can stunt its growth and obviously if you're smoking so is the baby, so you do know that it's harmful but it just don't stop you I suppose.*
Susan	*…it's bad for you. You know that.*
Anna	*I've been told to stop smoking around my kids because my kids have had some asthma problems but it doesn't make, didn't make me stop.*

One of the participants, Maria, was crying during the interview while she was considering the health risks associated with smoking during pregnancy. Amy disclosed that she was so worried about the fact that she was smoking so she feared that her scan would reveal that the fetus was not alive:

Amy	*I'm literally going tomorrow to the scan, and I've kind of half prepared myself that, you know, it might not be alive.*

These pregnant smokers were very aware of the risks, yet they had not been able to change their behaviour. A couple of the women also admitted their tendency to ignore or block out any information about smoking related to the risks of smoking during pregnancy:

Maria	*Um, I don't know because I read a lot of pregnancy magazines, and even it's got stuff on what it does to your baby and things like that and I don't know if anyone is like me but sometimes you feel like you kind of skip that page so it's like a feeling, you're mentally trying to block it out anyway*
Anna	*I didn't necessarily go home and read all the leaflets.*

Another pregnant woman, Susan, explained that she did not want to receive any further information regarding the health effects of smoking during pregnancy. She felt that being aware of the fact that smoking is harmful during pregnancy is sufficient and receiving more specific facts would not motivate her to quit or seek help from the stop smoking service:

Susan	*I don't really wanna know a great deal because I'd get really paranoid. I mean everyone with a bit of common sense knows it's not good for you if you're pregnant, it's not good for the baby. But I don't think you need to be told any more unless you really want to be scared or, depends on what sort of person you are. If you need all the facts and the figures to make you, like what's in a beef hamburger… you don't need the nitty gritty facts about where the meat comes from, some people like to know all that but I don't.*

The pregnant women gave rather conflicting messages. On one hand, they felt that they needed more information regarding the health risks of smoking during pregnancy and on the other hand, they admitted to ignoring or feeling sceptical about the facts of the information available. Additionally, although they explained that more detailed and visual health promotion would be beneficial, they acknowledged that the information should not be too shocking. This discrepancy occurred both between participants but also within the pregnant women as some gave rather conflicting statements. This highlights the challenges encountered with regards to informing pregnant women of the health risks of smoking during pregnancy with the aim of encouraging behaviour change rather than preventing it.

4. Misperceptions of Baby

Pregnant women's perceptions of the fetus were also mentioned as a potential factor that could hinder women from stopping smoking during pregnancy. Women who did not care for the baby or did not perceive that it was real were thought to be less likely to stop smoking during their pregnancy:

Clare	*I just didn't care back then obviously, it was nothing to me. I didn't even feel I was pregnant for nine months it just went like that, that's how much it didn't mean nothing…*
Emily	*Either too selfish… but some people could be just too selfish and they probably won't proper care for their child because they won't probably feel that it's real just yet until the baby's in their arms until they see the child.*
Kate	*… you don't think about much of the baby you know because like when the baby's born you wouldn't smoke around the baby or the newborn or the child so why do you, when the baby's inside you and I think it's just,*

	at the moment it's like out of sight out of mind, you know because you can't see the baby, that's the only way I can explain it.

Previous studies have found that women are more likely to smoke if their pregnancy is unwanted or unplanned (e.g. Dejin-Karlsson et al., 1996; Ludman et al., 2000; Solomon & Quinn, 2004). The quotations mentioned by the participants in the present study indicated that the misperceptions of the baby by some pregnant women might be due to a lack of connection with the baby, not considering the baby, simply not caring, an inability or avoidance to think ahead and living in the moment. Encouraging uptake of stop smoking services among pregnant smokers whose perceptions of the baby might prevent them from even considering changing their behaviour represents a challenging task.

5. Lack of Support

A couple of the pregnant women predicted that they would not receive a lot of support from their social network during their quit attempt. The participants even anticipated being subjected to negative comments and expectations that they would not succeed. These predictions of lack of support could be a barrier to attempting to stop smoking and approaching the service for smoking cessation support:

Anna	*…cause some people don't support you or don't give you the credit you think you should have from these people. I think some people just wait to see if you're gonna relapse which is tough.*
Maria	*I'm the only one in my whole family who smokes and they've always got this kind of way of either feeling sorry for you, feeling disappointed, wishing you could be somebody else. I'm not gonna say anything but*

	you should stop having that cigarette. Those kind of unhelpful comments so leave me alone would be what I prefer from other people.
Maria	*…friends or people around you in general are always the first to say, oh I thought you give up or I knew you wouldn't give up. They've always got that thing about them, so that annoys me so if I was giving up I never think oh I'm gonna go and tell everyone and not because of anything other than if you don't, you don't want to have everyone going on about it, compounding your sense of failure… That's just not helpful. And it's surprising how many people feel the need to say that.*

Two of the participants explained that they would prefer people in their surroundings not to make any comments about their smoking behaviour or quit attempt as they expected these to be unhelpful or annoying:

Maria	*… if someone's constantly, I don't know how they can do it, because if they're constantly on you that's annoying, because it'd be like leave me alone let me do it. It would be a fine line or balance between them being helpful and them being annoying.*
Susan	*…some people work with nagging and some people don't. I find I do it, I do it to spite people.*

The link between smoking during pregnancy and inadequate social support has been identified in previous research (e.g. Dejin-Karlsson et al., 1996; McBride et al., 1998). However, Ussher et al. (2004) found that perceived lack of support did not predict interest in stop smoking services. Out of the three participants in the present study who most frequently mentioned their perceived lack of support, two women

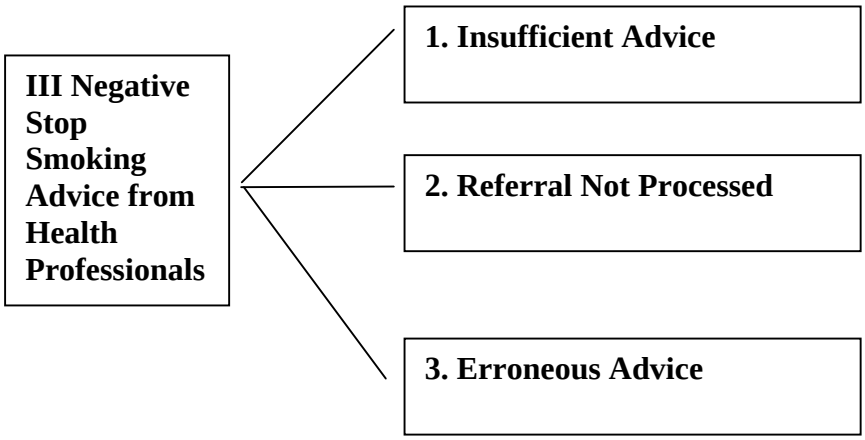
did not give this as a reason for attending the stop smoking programme whereas one woman did. Thus, lack of support could prevent a quit attempt from occurring but it could also potentially encourage uptake of the stop smoking service.

As with the categories identified under the theme 'rationalisation of smoking during pregnancy', some of the categories which emerged as 'reasons for not quitting during pregnancy' were not specifically relevant to stopping smoking during pregnancy. 'Negative expectations of quitting', 'absent intrinsic factors' and 'lack of support' could be equally relevant to smokers who are not pregnant. It appeared that pregnant women might continue to smoke due to these reasons **despite** being pregnant rather than **because** they are pregnant. Although 'lack of risk awareness' was mainly discussed with regards to the baby, not possessing sufficient knowledge of detrimental health outcomes of smoking also applies to other smokers (Cummings et al., 2003). The reasons mentioned for not quitting that were categorised under 'pregnancy related difficulties' and 'misperceptions of baby' were specifically associated with smoking during pregnancy. Thus, a direct link to the actual pregnancy were more so identified with regards to 'reasons for not quitting during pregnancy' than for 'rationalisation of smoking during pregnancy'.

III Negative Stop Smoking Advice from Health Professionals

The third main category that was identified as a barrier to approaching the stop smoking service was 'negative stop smoking advice from health professionals'. This category relates to health professionals' advice regarding stopping smoking to pregnant women. Diagram 4.1.6 indicates that the sub-categories of this category were identified as '**insufficient advice**', '**referral not processed**' and '**erroneous advice**'.

Diagram 4.1.6 The category 'negative stop smoking advice from health professionals' and its sub-categories.



1. Insufficient Advice

About half of the pregnant women expressed that they had not received sufficient advice from health professionals during their pregnancy regarding smoking cessation and stop smoking services. This perception of insufficient advice related to not receiving any advice, not being offered sufficient information, the midwives not providing advice unless the pregnant women initiated the conversation, not being given any follow up advice during subsequent meetings with midwives and not receiving any written material. Not being offered sufficient information regarding the stop smoking service from health professionals during pregnancy could be a major barrier to approaching the service:

Tracy	*Probably because no one offered it to them* [why a friend didn't approach the service during pregnancy]. *Because that's my reason. That's what I think anyway. Midwives do talk about smoking but they don't actually ask until you say.*
Clare	*The midwife didn't really say much.*
Jane	*No leaflets no nothing.*

Although the pregnant women did not tend to criticise the advice that they had been given about stopping smoking during their pregnancy, they discussed how they would prefer to receive advice. This was mainly related to being offered more information as well as leaflets and the advice being provided more consistently by midwives:

Jane	*... they need to be a bit more consistent and say look it's gonna happen, a bit more information about it I think yeah. I didn't really know what it was about it was just like do you want to talk to someone about not smoking?*
Jane	*Um, well if they come round, maybe some of the leaflets that we received from you like cause you give us lot of information when we come in. Maybe if you get them leaflets when the midwife come around they'd give you that information and to see what you're getting yourself into sort of thing and then I think you can make a better decision as well and at least you know what you're going to try to do cause like you come here basically like not knowing anything what's gonna happen or what you're about or nothing, yeah so maybe some leaflets.*
Clare	*… the main person that influences you through your pregnancy and the main person that you see so I think the midwife, if they had a bit more information to give you and like was consistent with it like if you did make appointments or did want to whatever, to make sure that they see them through...*
Tracy	*Just that more advice needs to be given to pregnant women.*

As Clare's comment demonstrates, pregnant women perceived the role of the midwife as an important aspect of their antenatal care. However, this also resulted in high expectations of the midwife. The pregnant women expected to be asked about their smoking status and to receive advice by their midwife and some pregnant women required additional information than what had been provided. Nonetheless, as discussed previously, the women had conflicting opinions regarding health promotion messages of the risks of smoking during pregnancy in that some admitted to ignoring the information provided or felt that they already had sufficient knowledge. This, however, referred to information about the health effects of smoking rather than the stop smoking support available for pregnant women. The provision of information to pregnant women needs to improve as previous research has also found that many women do not receive any or insufficient stop smoking advice during their pregnancy (Haslam & Draper, 2001; Ussher et al., 2006) but would prefer additional information (e.g. McCurry et al., 2002).

2. Referral Not Processed

A couple of the women had agreed for their midwife to refer them to the stop smoking service but the referral did not appear to have gone through as nobody from the service had contacted them. The reasons why this occurred were unclear but although one woman hypothesised that her midwife might have forgotten about the referral, she explained that she could sympathise with the midwife as she was aware of how busy she was. Obviously asking to be referred but not contacted by the stop smoking service was a barrier to receiving help from the service:

Jane	*I did get asked, I do remember that I did get asked if I did want to be referred and I did say that I did want to be referred but nothing come*

	of it... I actually contacted you and in the end because my friend come along so. I didn't like even like get a call.
Kate	*Well, yeah I was quite, I think in, I suppose something as serious as smoking, is smoking cigarettes when you're pregnant, it's not just you it's your baby but, but you know I, thinking maybe she's just too busy or she's meant to refer me and she hasn't or she has referred me thinking that whoever is going to be dealing with me has contacted me, you know.*

3. Erroneous Advice

Some of the advice that pregnant women had received from health professionals during their pregnancy regarding stopping smoking had been incorrect. A few of the pregnant women had been told by health professionals that they could not use NRT products whilst pregnant. The health professionals who had provided this erroneous advice to the participants included doctors and a pharmacist. None of the women had received inaccurate advice regarding NRT use from their midwives. However, it was identified that this piece of false information could prevent some pregnant women from approaching the service as NRT use during pregnancy could be an incentive to attending a stop smoking programme. All of the participants regarded the option to use NRT during their quit attempt as a positive aspect of the service:

Clare	*I went to a chemist once and I thought I might be pregnant but I wasn't so I said to him can I go on the patches if I'm pregnant? He went no, no, no, no you know that's so dangerous you just have to do it on your own.*

Susan	*At my doctors, the first time asked she didn't have much knowledge about NRT and that. It probably would have been better if she did.*
Kate	*I did ask my doctor, well not my doctor, a doctor. They didn't really recommend, they recommended me stopping, but nothing sort of like Nicorette patches, I don't know why. I didn't really go into it with him. He just said that if I wanted to stop then I would just stop, so.*

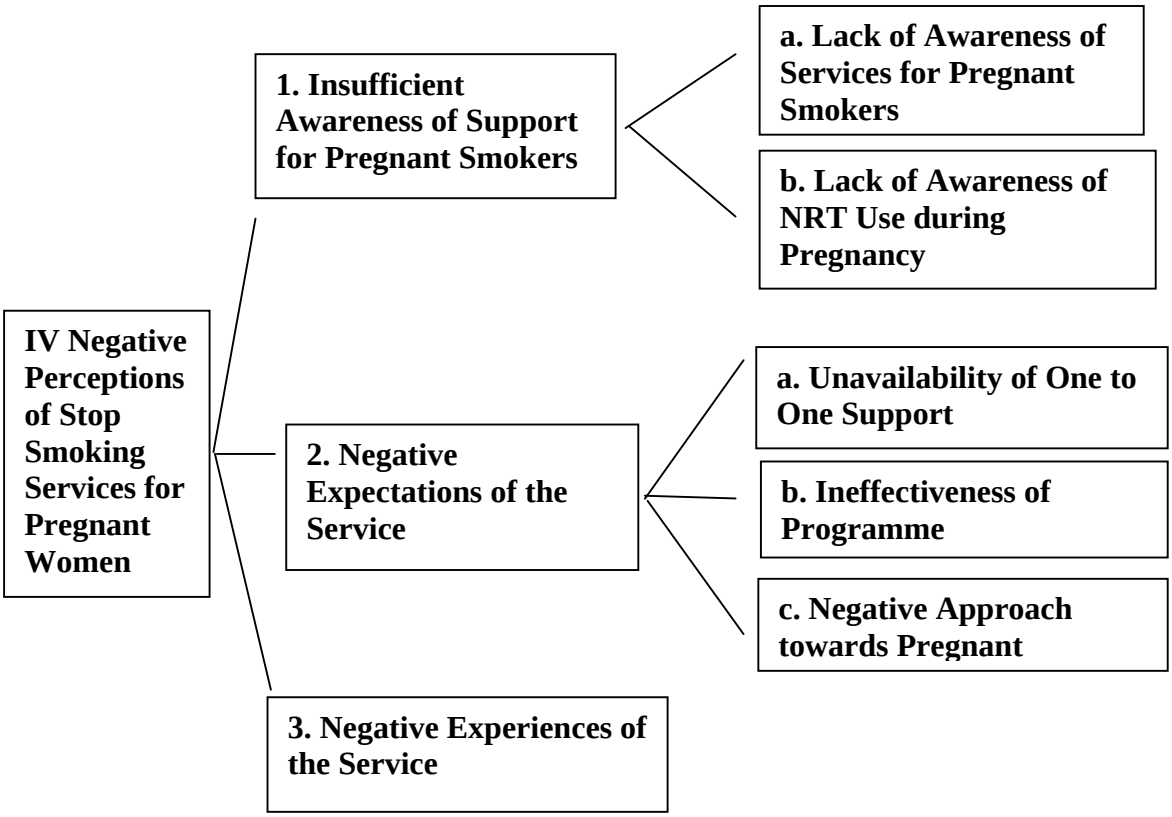
The last comment was made by Kate who had been told by a doctor that if she wanted to quit smoking she should simply be able to stop without help. This type of advice provided by health professionals could be major barriers to attending the stop smoking service as pregnant women might feel that they should be able to change their behaviour without support or medication. Additionally, they might expect the advisors of the service to hold similar opinions and not to regard their attendance as necessary.

IV Negative Perceptions of Stop Smoking Services for Pregnant Women

'Negative perceptions of stop smoking services for pregnant women' was identified as a category that could explain why pregnant smokers might not approach the service for stop smoking support. This category encompassed factors that were directly linked with stop smoking services such as '**insufficient awareness of support for pregnant smokers**', '**negative expectations of the service**' and '**negative experiences of the service**'. Insufficient awareness could be divided into '**lack of awareness of services for pregnant smokers**' and '**lack of awareness of Nicotine Replacement Therapy (NRT) use during pregnancy**' and negative expectations of the service could be split into sub-categories of '**unavailability of**

one to one support, '**ineffectiveness of programme**' and '**negative approach towards pregnant smokers**' (diagram 4.1.4)**.**

Diagram 4.1.4 The category 'stop smoking services for pregnant women' and its sub-categories.



1. Insufficient Awareness of Support for Pregnant Smokers

The 'insufficient awareness of support for pregnant smokers' category that was identified as a barrier to attending the service related to lack of awareness of services for pregnant women as well as misconceptions regarding NRT use during pregnancy.

a. Lack of awareness of services for pregnant smokers. The vast majority of the pregnant smokers had not been aware of the fact that stop smoking services have advisors who work particularly with pregnant women. In addition, the participants

had very little awareness of the stop smoking support that is offered both to pregnant women and smokers in general. Not being aware of the smoking cessation support specifically offered for pregnant women through the NHS was identified as one of the main barriers to approaching the service as some of the women explained that this alone could prevent women from attending stop smoking sessions. All of the women felt that programmes especially offered for pregnant women were beneficial and that women are more likely to approach stop smoking services if they are aware of the support that is on offer:

Susan	*I never knew it existed.* [The stop smoking service for pregnant women]
Tracy	*I didn't even know there was a service for pregnant women to stop smoking, didn't know there was because if I did I would have called it way earlier, which is bad.*

A couple of the participants explained that lacking awareness of the support available for pregnant smokers had in fact prevented them from approaching the stop smoking service whilst pregnant. Tracy felt strongly about this as it was her only reason for not approaching the stop smoking service earlier during her pregnancy. She therefore explained that information and advertising regarding the stop smoking service for pregnant women is lacking:

Tracy	*They don't really promote it as much, that's probably why pregnant women still are smoking. It's just not promoted at all.*
Tracy	*Because all the stop smoking adverts for example, none of them are for actual pregnant women, they're all for general smokers and I haven't seen no promotion of preg... I haven't seen no promotion at all actually*

of pregnant women stop smoking. I've just seen posters that say pregnant women are harming the baby by smoking and stuff like that, that's it, not actual pregnancy, like stop smoking service for pregnant women, never.

One woman who had not noticed any advertising regarding the stop smoking service aimed at pregnant women thought that pregnancy should be a sufficient motivator in giving up smoking and therefore advertising targeted at this population might not even be necessary:

Kate *Do you know what? I haven't seen any, really you know I think it's more, I mean you shouldn't smoke anyway while you're pregnant, that should be enough for you. It should be, it should be enough for you to stop you know so I haven't really seen any, no I haven't.*

If other pregnant women have similar beliefs to Kate in that the reason for the lack of information is due to pregnant women being expected to quit on their own, it might add to their perceptions of a judgemental attitude towards them by health professionals. Consequently, they might be less likely to approach the service. Although the women felt that more information and advertisements regarding the stop smoking service is needed, it was also recognised that it is ultimately the women's choice if they want to attend a stop smoking programme. Therefore, some of the participants found it difficult to recommend methods of targeting pregnant smokers and they acknowledge that services are limited in increasing uptake of stop smoking programmes by pregnant smokers. In addition, some of the pregnant women felt that it would be useful for health professionals to speak directly to

pregnant smokers more frequently about their habit. However, they recognised that smoking is a very personal issue that women might be reluctant to discuss:

Amy	*I don't know if they could probably do like, talk to people in doctor's surgeries or the doctor could ask them if they want to see someone at that time but it's quite difficult to kind of …especially people's privacy too, so…*
Clare	*You can only tell people and put your posters up it depends if people want to do it or not. There isn't, so I don't think there's any more you can do.*
Maria	*I suppose I haven't got that answer for how I think they should do it* [target pregnant smokers] *or then I wouldn't still smoke so I don't have an answer for that.*

This lack of awareness of stop smoking services for pregnant women is a new finding due to the limited research available of pregnant smokers' perceptions of the service. It highlights a potentially weighty reason for the low uptake of stop smoking services by pregnant smokers and it is vital that this is taken into consideration both on a national and a local level when promoting smoking cessation among pregnant women.

b. Lack of awareness of NRT use during pregnancy. A common erroneous assumption regarding the stop smoking support offered to pregnant smokers was that NRT use is prohibited during pregnancy. Even the participants who believed that some products could be used by pregnant women did not know that several NRT options are available. The realisation that pregnant women can use NRT as an aid in stopping smoking and that a number of products are available was met with relief.

Although an unawareness of NRT use during pregnancy might not have served as a direct barrier to approaching the service, realising that NRT was provided as part of the programme could have been a motivator for uptake of the service:

Tracy	*I didn't know that the patches and as well the stuff that were provided by NHS were allowed to be taken by pregnant women.*
Sarah	*Well I weren't aware that at first that you was allowed to use anything. I thought you might be able to use the chewing gum cause I thought that couldn't be harmful but I didn't know you was allowed to use patches or anything like that.*
Anna	*I didn't know there was other stuff you can get to stop smoking. I just thought it was just patches and I have seen the inhalers but then I've never seen the tablet and stuff like that.*

The positive perceptions of NRT use during pregnancy is a valuable finding as research into pregnant smokers' preferences regarding stop smoking support including medication has been limited (Lindsay, 2001; Ussher et al., 2004).

2. Negative Expectations of the Service

Several negative expectations of the stop smoking service were identified. These perceptions were either currently or had been previously held by the participants. Although the women who had used the service had realised that these former expectations were incorrect, the expectations of the service were identified as potentially weighty barriers to attending a stop smoking programme. The negative expectations included believing that only group support was offered, that the programme would be ineffective and that the advisor would hold a negative approach towards pregnant smokers.

a. Unavailability of one to one support. All of the participants described that they would prefer receiving one to one support as opposed to group support. However, about two thirds of the women currently or previously believed that only group support was on offer and they predicted that this could prevent women from approaching the service:

Clare	*I don't know, I just think like loads of meetings really and at first I thought it would be like loads of people just sitting round talking and that's what was up. I thought I don't want to go to one of those meetings where you've loads of people sitting in circles, talking about smoking.*
Jane	*Yeah that was enough to put me off but I think where there weren't no information about how you go about it, what happens in the meetings, is it group meetings she gets? I think that's what daunts people sometimes yeah It's a bit like daunting I think a lot of people worry about like do I have to sit in a group or is it a one on one session…*
Susan	*I just knew I didn't want to be with a group of smokers sitting round and things like that. I didn't like all that and sort of one has to be in there though you don't want to be.*

Ussher et al. (2004) also found that pregnant women are more likely to prefer individual support as opposed to groups support. This could be linked to pregnant smokers' negative emotions of guilt and embarrassment as well as their expectations of other people's negative approach towards pregnant smokers. Therefore, it is crucial that pregnant smokers are made aware of the individual support on offer

through the NHS stop smoking service as this misconception could prevent women from attending a smoking cessation programme.

b. Ineffectiveness of programme. Half of the women did not expect the stop smoking service to be effective. One of the participants based her disbelief in the service on the fact that she was aware of a few people whose quit attempts with the service had not been successful. As these negative expectations had directly prevented some of the participants from approaching the stop smoking service, they were identified as potentially strong barriers to attending the service:

Emily	*…don't want any help don't want to take any help cause they think it's not gonna help them.* [Emily discussing why some pregnant smokers do not attend the stop smoking service]
Jane	*I just didn't believe that it could help.*
Sarah	*I know a few friends have tried it, but not a lot of them have succeeded.*

Pregnant smokers' perceptions of the ineffectiveness of stop smoking programmes were also identified as preventing uptake of the service by Ussher et al. (2006). However, both Jane and Emily had attended the service despite their doubts regarding the outcome of the interventions. Susan, who also had sought help from the service, described her previous perception of the service as 'rubbish' due to her belief that the stop smoking programme would not be beneficial:

Susan	*Well I didn't know much about them and I just thought, oh I don't know, a load of rubbish.*

A sceptical view of the effectiveness of the stop smoking programme thus appeared as a barrier to attending the service. Yet, interestingly it had not prevented some of the women from attending a programme. The reasons for this are unclear. However, one of the participants said that the fact that she could attend with a friend outweighed the negative expectations of the outcome of the programme. Thus, it appeared that some of the women felt that they had 'nothing to lose' as they had not managed to quit on their own. However, this negative expectation of the service is likely to prevent pregnant women from attending stop smoking sessions. The participants also explained that some pregnant women believe that they are able to quit without help from the service. Thus, although they might not perceive the service as ineffective, they did not expect attending a stop smoking programme to be more effective than quitting without support. One participant thought that those who try to stop with willpower alone without success might not approach the service at a later stage as they justify their decision to smoke by the fact that they have indeed tried to stop but been unable to do so:

Sarah	*Um, probably a lot of women are stubborn, I think, we are. I'd say a lot of women are stubborn so they think, oh well, I'll go and try by myself and once I've tried by myself, oh I can't do it. Because I've tried and at least I've tried but I can't do it and they'll think them, that's it. At least to them that's acceptable. Whereas everyone else is like well, that's not because you've tried but you said you wanna give up but you're still smoking. So, I would, that's what I'd basically say, a lot of women are stubborn, they think, yeah, I can do this by myself, I can do that. And if it doesn't work out then they go straight back onto the fags..*

Sarah's notion highlights the importance of promoting smoking cessation and stop smoking services to pregnant women throughout their pregnancies as some might smoke as a result of not managing to quit in the earlier stages.

c. Negative approach towards pregnant smokers. Some of the women believed that it is not uncommon for pregnant smokers to lie about their habit to health professionals. This could be due to expecting the health professional to give a disapproving response or make the woman feel uncomfortable if they admit to smoking whilst pregnant:

Amy	*…some people lie and say they don't smoke when they do so.*
Sarah	*Cause if I went to some, probably a GP and he went are you still smoking and like no. I'd feel a bit wary about saying that because of the reaction I'd get back… Certain, certain, I'd say certain ones I can and certain ones I'd lie to because I'd feel intimidated. I don't know if it's just natural the way they are but that's the way they come across to me so I'm gonna back of and just, yeah, yeah, and lie. If I feel uncomfortable then I just tell them no.*

The perception that health professionals hold a negative approach towards smoking during pregnancy also extended to the stop smoking service and its advisors. That is, pregnant smokers might fear that the service will judge them for still smoking whilst pregnant. This worry was so profound that about two thirds of the participants described this as a likely barrier for pregnant women to approaching the service. Some of the women who had used the service explained that they had been concerned about this aspect of the service prior to attending the first session:

Amy	*Just that initial thing of thinking that someone's gonna to be judgemental towards you. I know that small fear but it's not really it's not correct you just have that in your head. Some people allow for that to stop them from seeking help… it made me, it made me quite wary to go and seek help, so, kind of, I was put off and didn't really want to go and do it because I had that kind of, um, kind of worry that I'd be judged because I'm smoking…*
Susan	*Thinking it will be too judgemental…*
Kate	*I think that's what kind of holds a lot of people back maybe. A lot of women who are pregnant feel like they're getting judged and thinking, you know oh my God, I can't let this person know I smoke.*

The women thought that their behaviour is viewed negatively and they thus anticipated a confrontation with regards to their habit. Trying to avoid this confrontation prevented them from seeking help to change their behaviour. Although Susan and Amy had attended the stop smoking service and in a sense overcome these concerns, they both mentioned that they would have ended the programme if their worries had been verified and the advisor had been judgemental. Some of the pregnant women mentioned that they were nervous about attending the stop smoking service due to the expectation that they would feel pressurised into stopping immediately or face the possibility of being reprimanded by an advisor. The women who had attended the service mentioned that the attitude of the advisor had not been condemning as expected but they predicted that these initial feelings of anxiety could prevent pregnant women from approaching the service in the first place:

Amy	*I just thought it'd be like I'd be put under pressure to stop smoking straight away.*
Susan	*It's just not so daunting as I thought it would be. I was a bit nervous the first day.* [Because] *…probably that you'd tell me off. That's about it really.*

Sarah explained that one of her reasons for not approaching the stop smoking service was that she had expected people working for the service to come from high social status backgrounds and portray negative attitudes towards clients. Although she did not hold this belief any more, this perception had prevented her from approaching the service in the past and contributed to her negative perception of the service:

Sarah	*So if you see someone that's working for the stop smoking service, and they look nice, and they can, some of them have good, how would you say, um, good verbal speaking basically. And you'd think, oh no, I don't want to go and see them.*
Sarah	*I think just the way when it first came, do you want to stop smoking, and they had a lot of people in high-power or really high in society, saying, oh I think you should give up smoking. Putting their opinions, you was a bit like okay, so it just seemed like at the moment in time all them people.*

Sarah's perceptions of the service had changed mainly due to the stop smoking advice provide by her midwife. She now regarded her midwife as being part of the stop smoking service and she had appreciated her approach in discussing

smoking cessation as it had been non-judgmental and non-pressurising. In addition, she did not perceive her midwife as a high-power health professional.

As none of the women had negative experiences of stop smoking advisors, these perceptions appeared to be a result of the image portrayed by the stop smoking service. This finding does not seem to have been identified previously and services are likely to benefit from taking these negative perceptions into consideration with regards to advertising and information aimed at pregnant women.

3. Negative Experiences of the Service

Two of the pregnant women who had used the stop smoking service had experienced some negative aspects of the programme. These included a delay in getting an appointment, being referred to another advisor and not being certain that a room would be available for the stop smoking sessions that took place in a hospital:

Amy	*I felt disappointed when she said that she was gonna refer me anyway cause I had builded up myself to stop so I felt a bit disappointed...I just wanted to do it quickly while I had that in my mind that I'm in the mood*
Maria	*Would have been helpful if it started quicker, because one of the things with it is that you get this burst and then it wanes off if it's not caught I think that would make a difference, the timing at the beginning.*
Maria	*…but this is like a red herring because they wouldn't normally be like this they've moved the hospital so this women hasn't always got a room, a guaranteed room, and I think that's not got I think it should be more respected than what it is in their environment…*

One woman explained that due to the advisor not being able to prescribe NRT, she had to make an appointment to visit her GP in order to get a prescription and consequently her quit date was postponed:

Maria	*…what happened though, they gave me a prescription or I'm supposed to...she has to refer me cause I'm doing it through the hospital and they had to refer it through my doctor to get a prescription because they can't give it to pregnant women. I set a date of when to give up and they didn't give me the prescription and it set my date all wrong and it made me just give up to some degree so I got it about two weeks after which kind of removed my enthusiasm I suppose.*

Although none of the women felt that the negative experiences would hinder them from approaching the service in the future, it might have had a negative outcome on their quit attempts as their experiences had dampened their enthusiasm to quit. One of the participants who mentioned some negative experiences of the service had not managed to stop smoking. However, she did not blame this on the service as her rational for not being successful was that she had not used the service as well as she ought to have done. Therefore, this was recognised as a deviant case as the negative experiences were not perceived as errors of the service but due to the woman's own faults:

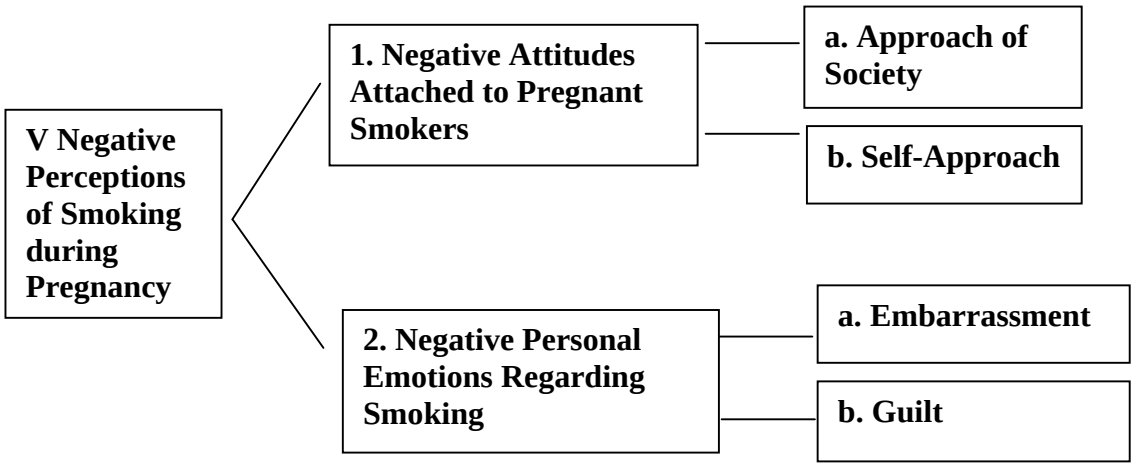
Maria	*I'm not giving up so there was no point in going if I'm continuously going to go and go and not do it so, she said I can contact her again if I decide to change my mind but it's, she knows I know what I'm supposed to do there's not really much she can tell me so... I don't use it too well.*

Maria's statement illustrated the need for a commitment from clients in stopping smoking. She acknowledged that stop smoking advisors are limited in their ability to support pregnant smokers in changing their habit unless the women are willing to take responsibility as well. However, as a delay in getting appointments and receiving NRT prescriptions could have a negative impact on a quit attempt, stop smoking services should consider these aspects when offering support for pregnant women.

V Negative Perceptions of Smoking during Pregnancy

The category 'negative perceptions of smoking during pregnancy' was also identified as a barrier to approaching the stop smoking service. These perceptions related to the '**negative attitudes attached to pregnant smokers**' with regards the '**the approach by society**' as well as the '**self-approach by pregnant smokers**' and the pregnant women's '**negative personal emotions regarding smoking**', such as '**embarrassment**' and '**guilt**' (see diagram 4.1.5).

Diagram 4.1.5 The category 'negative perceptions of smoking during pregnancy' and its sub-categories.



1. Negative Attitudes Attached to Pregnant Smokers

It was generally believed that the perceptions of pregnant smokers are negative. This belief was based on the participants' own as well as other women's experiences and the attitude of society as well as their own reflections on their habit.

a. Approach of society. The participants spoke of the negative attitude that society and other people hold towards pregnant smokers. These perceptions affirmed the participants' expectations that the stop smoking service and its advisors would judge women for continuing to smoke during pregnancy and could thus be a barrier for approaching the service:

Amy	*Our friend who smoked right through her pregnancy and she remembers people giving her dirty looks and things like that cause she was pregnant.*
Maria	*… because they probably feel themselves that it isn't right and also society tells them that it's not right...*

It emerged during the interviews that some of the pregnant women agreed to these negative perceptions that they sensed society possesses of pregnant smokers and that they had indeed held similar views prior to becoming pregnant or even during their own pregnancies.

b. Self-approach. Some of the women believed that smoking whilst pregnancy is a rare and unacceptable behaviour and two of the women admitted that they hide their habit due to the negative attitudes towards pregnant smokers:

Amy	*And the thing is before I was ever pregnant. I used to kind of, I did look down on them in a way and I thought oh, you're out of order. That's*

	why it's down to me now cause I'm thinking it's bad, it's not really fair on the baby.
Maria	*I remember the first time before I was pregnant. I though it was absolutely disgusting to see a women who was pregnant smoking I can't tell you how, it made me think what hell is she doing.*
Kate	*You know to see a pregnant woman because I know I was, if I was to walk down the street and see a pregnant women smoking I would look at her and think, you know I would judge them straight away. You know, because I know what I would do, that's why if I had a cigarette outside I would try, you know, I would stop, sit down or something so that if someone's walking past they wouldn't be able to kind of see that I'm pregnant…*
Tracy	*…because I'm pregnant and I'm smoking it's just not, not common. Personally I just saw it as bad so I didn't call.* [the stop smoking service]

The negative approach that the pregnant smokers held of their habit reflected an internal conflict between their beliefs and their behaviour. More than half of the participants explained that due to their negative attitude towards smoking during pregnancy they had been confident that they would quit immediately upon becoming pregnant. Being unable to do so was seen as a failure on their part and acted as a barrier to approaching the service as they expected advisors to be judgemental due to their own and society's perceptions of smoking during pregnancy. Although research suggests that women might be reluctant to reveal their true smoking habit to health professionals due to the stigma attached to smoking during pregnancy (Cnattingius,

2004), a direct link between the perceived negative attitudes towards pregnant smokers and their decision not to attend stop smoking services has not previously been established. However, none of the participants had experienced any health professionals or the stop smoking service as being judgemental towards their habit. Yet, these negative perceptions towards smoking during pregnancy had the potential to cause negative emotions within pregnant smokers. These negative emotions could also prevent pregnant women from attending a stop smoking programme.

2. Negative Personal Emotions Regarding Smoking

The participants discussed the negative feelings that they experience due to smoking whilst pregnant. These negative emotions involved feeling embarrassed and guilty and they could be experienced as a consequence of society's as well as their own negative attitude towards smoking during pregnancy.

a. Embarrassment. It was acknowledged that some pregnant women might feel too embarrassed or ashamed about their habit to seek help from the stop smoking service:

Emily	*They might like, in a way be ashamed because they might have been smoking through the whole of the pregnancy so they're ashamed of going to someone at such a late time in their pregnancy.*
Kate	*…probably a lot of women who are pregnant and they smoke are probably a bit too embarrassed or ashamed thinking, I can't go, you know, say this, because I felt like that as well, going to the pharmacy and that, well you shouldn't smoke anyway.*
Tracy	*I was embarrassed because I'm pregnant and I'm smoking.*

Thus, feelings of embarrassment could be a direct barrier to uptake of stop smoking services even among pregnant women who want to stop smoking but find it hard to do so without support.

b. Guilt. Another negative emotion that could stop pregnant women from approaching the stop smoking service was identified as guilt. Six of the women expressed that they felt very guilty about smoking during pregnancy and that this sensation was not useful in helping them to quit:

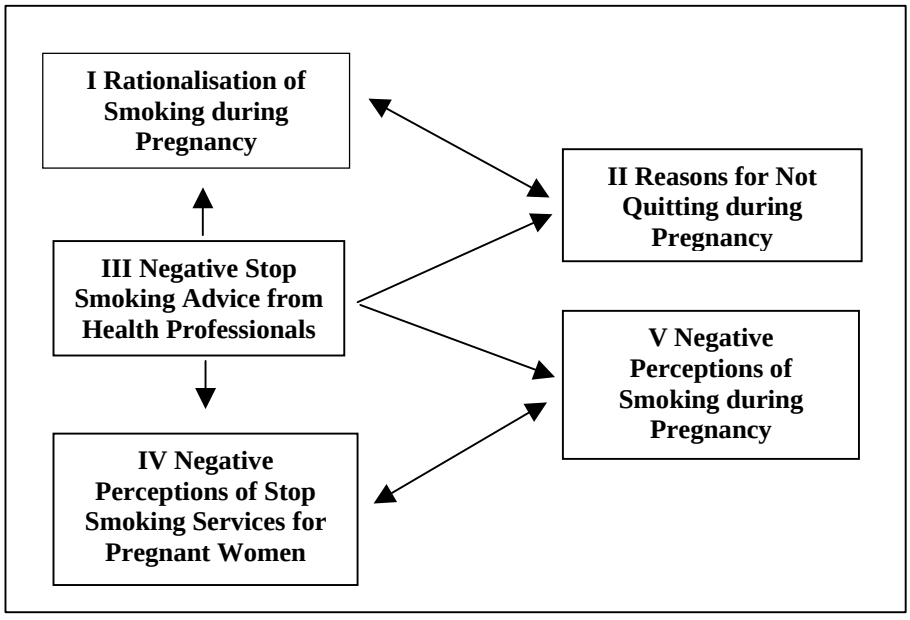
Maria	*For me, I think, guilt is not a useful feeling so I think for me it doesn't necessarily help when guilt makes it... I suppose it depends how you deal with your feelings I suppose for me, guilt makes me be more destructive than less so it's not necessarily a useful thing.*
Tracy	*I feel bad as well because my partner keeps saying things like how could you smoke, do you know what you're doing to the baby? And it does, it makes me feel guilty, it makes me feel like I am actually, like literally killing the child, that's how bad, that's how deep it goes.*

Neither Maria nor Tracy perceived the feeling of guilt as an aid in their quit attempt. They both explained that they wanted to stop smoking but Maria had been unable to do so and Tracy had not attended a stop smoking programme. Thus, feeling guilty might have added to the women's interest in quitting but not to their likelihood of being successful or approaching the stop smoking service. Interestingly, the participants who spoke of their own and other pregnant smokers' feelings of guilt did not mention being ashamed or embarrassed due to the habit. Thus, it did not appear that these feelings were necessarily linked but that pregnant smokers might feel guilty about their behaviour without necessarily being ashamed.

Yet, both emotions could prevent women from attending the stop smoking service. Ussher et al. (2004) proposed that stop smoking interventions for pregnant women must be private and flexible due women's perceptions of embarrassment regarding their behaviour. However, as previously discussed, pregnant women appear unaware of the stop smoking services provided by the NHS and the fact that they offer private and individual support sessions. Therefore, these types of interventions are unlikely to lead to an increase of the uptake of the service unless women are informed of this aspect of the programme.

VI Links between Categories Identified as Barriers to Approaching Stop Smoking Services

Although the categories that were identified as potentially preventing uptake of stop smoking services by pregnant women were separated by different themes, they were also interrelated. The links between the categories that were identified as potential barriers to approaching the stop smoking service are illustrated below.



The link between the themes '**rationalisation of smoking during pregnancy**' and '**reasons for not quitting during pregnancy**' was mainly based on

the fact that both referred to pregnant women's smoking behaviour. The categories provided some explanations as to why some women continue to smoke throughout their pregnancy with regards to their rationalisation of smoking and reasons for not changing their behaviour. The women's own perceptions of smoking and quitting as well as other factors in their environment that could affect their habit were discussed during the interviews. Although both of these categories could directly influence smoking behaviour during pregnancy, they might not necessarily be directly linked to approaching the stop smoking service as women who do not face these barriers in quitting might still not attend the service. However, in order for pregnant women to use the NHS stop smoking programme, it might be necessary to initially overcome the barriers to actually stopping smoking or wanting to do so. In addition, these categories highlighted that although the pregnancy might influence a woman's smoking behaviour, pregnant smokers might not differ from other smokers with regards to their habit and their perceptions of it.

Relationships between the category consisting of aspects related to '**negative stop smoking advice from health professionals**' and the categories '**rationalisation of smoking during pregnancy**', '**reasons for not quitting during pregnancy**', '**negative perceptions of stop smoking services for pregnant women**' and '**negative perceptions of smoking during pregnancy**' were identified. The data suggested that the stop smoking advice provided by health professionals could potentially have an impact on all of these categories. Insufficient or incorrect stop smoking advice from health professionals could prevent pregnant smokers from reflecting on their smoking habit and factors related to their decision not to quit. Some of the participants expressed that health professionals did not provide sufficient information on smoking related issues such as the health risks and NRT

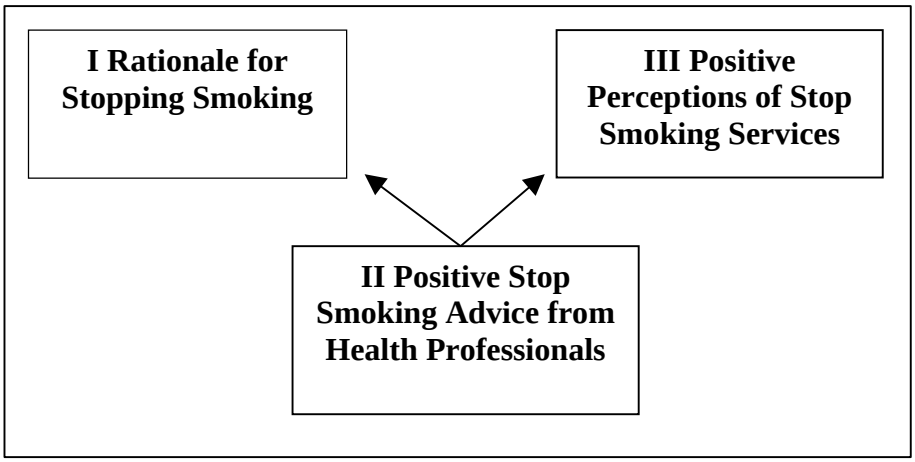
use. This could potentially be a barrier to stopping smoking. A number of the pregnant smokers also felt that they received inadequate information regarding stop smoking services for pregnant women from health professionals. This lack of or erroneous awareness of stop smoking services as well as the perception that services were judgemental towards pregnant smokers could hinder pregnant smokers from attending the service.

The categories '**negative perceptions of stop smoking services for pregnant women**' and '**negative perceptions of smoking during pregnancy**' also appeared to be strongly associated. A major barrier to approaching the stop smoking service was identified as both the negative perceptions that pregnant smokers experience that they are subjected to as well as the negative emotions that these perceptions create. Believing that the stop smoking service hold a judgemental approach towards pregnant smokers and feeling too ashamed to admit their habit could hinder some pregnant women from approaching the service.

4.2. Core Category 2 – Pregnant Smokers' Perceived Facilitators to Approaching Stop Smoking Services

Various categories that related to the barriers to attending stop smoking services were identified. However, eight of the women who took part in the interviews showed an interest in attending the NHS stop smoking programme during their pregnancy. The participants talked about what had and could have encouraged them as well as other pregnant smokers to approach the stop smoking service. The categories that were identified as facilitators to approaching the service were '**rationale for stopping smoking**', '**positive stop smoking advice from health professionals**' and '**positive perceptions of stop smoking services**'. These categories and how these could be interlinked are shown in diagram 4.2.1.

Diagram 4.2.1 The link between the categories that were identified as facilitators to approaching the stop smoking service during pregnancy.

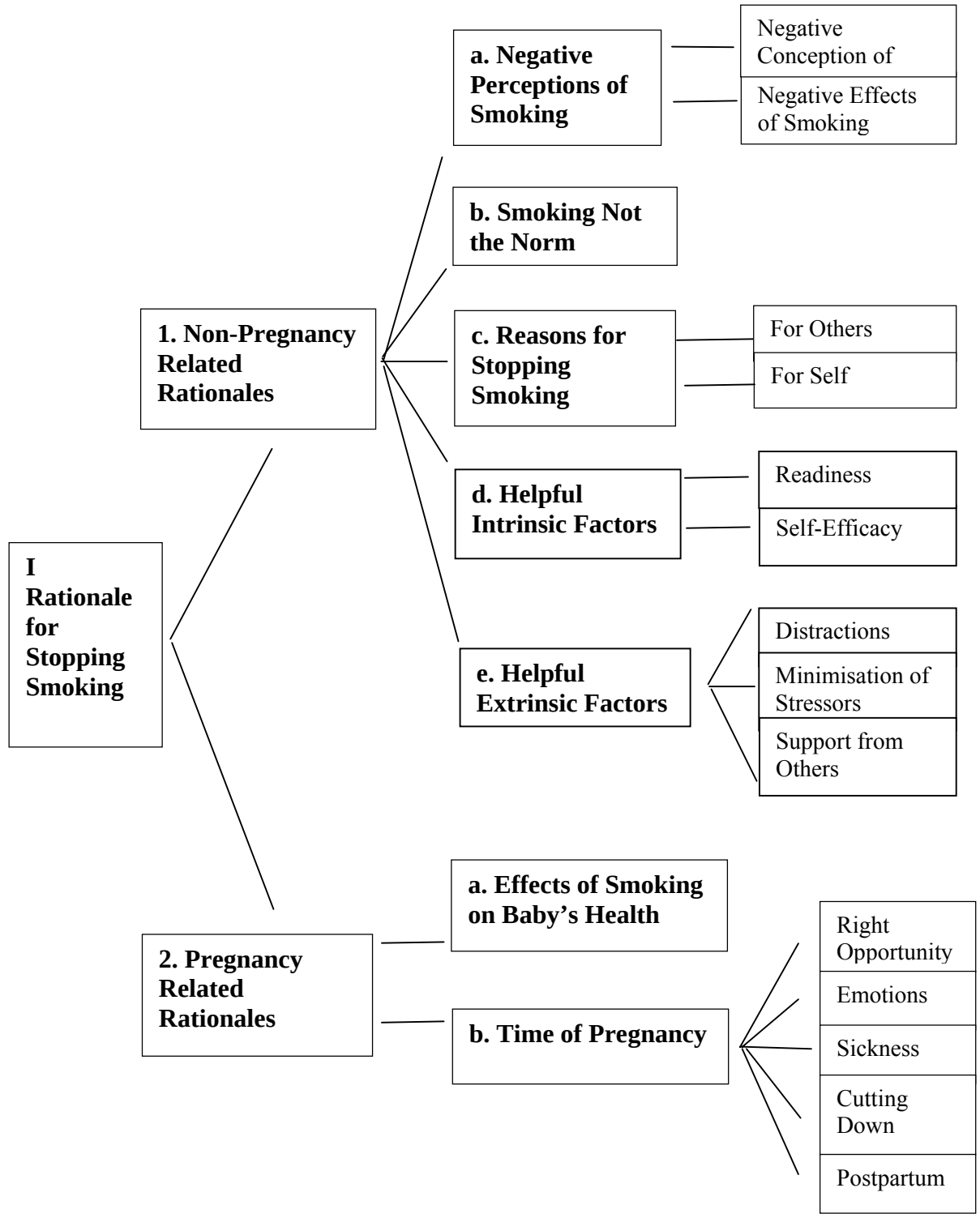


Each category and their sub-categories are outlined and discussed. The relationships between the categories are discussed in the end of section 4.2.

I Rationale for Stopping Smoking

The interviews indicated that in order to approach the stop smoking service for support, pregnant women who smoke must have a rationale for stopping smoking. Possessing a rationale could facilitate an attempt to stop smoking and a decision to use the stop smoking service. The participants discussed both '**non-pregnancy related rationales**' and '**pregnancy related rationales**'. These sub-categories could be further divided into '**negative perceptions of smoking**', '**smoking not the norm**', '**reasons for stopping smoking**', '**helpful intrinsic factors**' and '**helpful extrinsic factors**' (non-pregnancy related) and '**time of pregnancy**' and '**effects of smoking on baby's health**' (pregnancy related). The categories, sub-categories and examples of these can be seen in diagram 4.2.2.

Diagram 4.2.2 The category 'rationale for stopping smoking' and its sub-categories.



1. Non-Pregnancy Related Rationales

Some of the rationales that the pregnant women mentioned for stopping smoking were not related to their pregnancy. These included negative perceptions of smoking, smoking not being perceived as the norm, reasons for stopping smoking and helpful intrinsic and extrinsic factors in quitting.

a Negative perceptions of smoking. Some of the participants held negative perceptions of their smoking habit. A negative conception of smoking and perceiving the habit to result in negative outcomes could facilitate a woman's decision to stop smoking during pregnancy. The participants who wished to stop smoking often regarded smoking as a negative habit that they would prefer not to be addicted to:

Anna	*I felt I was getting too addicted*
Emily	*I haven't got a big habit as a lot of people have, you know they do smoke quite a lot you know, they probably would need a lot more support than I would need but it is an addiction.*
Maria	*Everything you can imagine there's noting useful about it... It's just not a nice habit…*

Emily explained that due to the addictive components of cigarettes, support in quitting is necessary in particular for those who are highly addicted. However, she appeared to focus on other smokers rather than on herself as she described that she is unlikely to need as much support as a more addicted person would require. She therefore equated the amount of required support with level of addiction. If pregnant smokers cut down on cigarette consumption upon becoming pregnant and feel less addicted, this could affect their perceived need for support and consequently their decision regarding uptake of the service. Various perceived negative effects of

smoking were also identified from the data. That is, a rationale for stopping smoking might be due to the perceived negative outcomes of smoking. The negative effects were perceived as facilitators to stopping smoking in an attempt to avoid them. The fact that smoking has an effect on ones appearance, the expensive habit of smoking, the smell of cigarettes and the detrimental effects on ones health were mentioned among the participants:

Kate	*…the other day I found out that it can age your skin more. With tobacco, sometimes, I've noticed that I've got yellow here and I've never had that before and I didn't know what it was and I was like ok, then I realised it was smoke, it was nicotine or whatever and oh, it was so disgusting so I'm really, really conscious…*
Clare	*I spent a fiver a day sometimes you know on fags.*
Emily	*Cigarettes stink anyways, it does really bad I can't stand the smell of like cigarettes….*

Another rationale that pregnant women gave for changing their smoking behaviour was the health effects of smoking. The participants who did not wish to continue smoking usually explained that they wanted to avoid becoming ill or jeopardising their health due to smoking. Two of the participants mentioned that they had lost relatives as a result of smoking related diseases and some of the pregnant smokers were already experiencing negative health effects due to their habit:

Maria	*Because it's awful for your health.*
Jane	*…mainly for my health really because I do worry about that because I've got a family history of cancer and a lot of my family died of cancer*

	and lung cancer and breast cancer and all this through smoking so basically it's just mainly health reasons.
Tracy	*…because my iron level is low already there's something in my blood that I don't have and because I smoke there's less of it...*
Anna	*Me waking up every morning, phlegmy throat because I smoked cannabis more than fags.*
Kate	*…just feeling more healthy and more sort of active. Well I'm active anyway but even more active yeah.*

Both the participants who already felt relatively healthy and those who did not looked forward to becoming healthier as a result of stopping smoking. Some of the negative health effects of smoking were thus mentioned with regards to their own health and not pregnancy

related. However, Tracy's comment about her low iron level was a concern due to her pregnancy and one of the participants acknowledged that it will be beneficial to quit now so she will have more energy when the baby is born. This acted as an incentive for her to change her behaviour:

Emily	*About my health, my health comes into it a lot. Hopefully I could be fitter, then when my child does come along I won't be wheezing or choking I could just go run with this baby, yeah, just fitness really.*

Other smokers have given similar rationales for changing their behaviour such as health and financial reasons (Taylor et al., 2006). Again, this finding suggests that pregnant smokers' rationales for smoking and stopping do not necessarily differ from the general population's.

a. Smoking not the norm. Although the majority of the pregnant women felt that smoking was the norm in their surroundings, a few of the participants had different experiences. A couple of the women explained that none of their family members were smokers. For both women, this was perceived as a potential facilitator to stopping smoking, mainly due to wanting to avoid being the only smoker in their social network:

Kate	*Yeah, I mean none of them smoke so you know it's not nice to sort of be the only person who smokes and say, oh, I'm just popping out for a cigarette, then I'll come back in and I'll just stink the place out, that's not nice…That would make it easier to stop yeah.*
Tracy	*I'm the only person that smokes in my whole family, out of my whole family from my Granddad to etc. I'm the only person, so that too* [could help in quit attempt].

Interestingly, Tracy had previously mentioned that she had both started and maintained her smoking behaviour due to the fact that the majority of her friends were smokers and that her family had accepted her habit. Simultaneously, the members of her family being non-smokers attributed to her rationale for stopping smoking. A woman's social network could therefore concurrently act as a barrier and facilitator to quitting. About half of the participants perceived that smoking had become less part of society mainly due to the smokefree legislation. Smoking was also regarded as a less accepted habit and some women felt that this could encourage a quit attempt:

Anna	*No, I think it's good that it's stopped in most places because it's more outside now so it's, you've got it outside rather than in pubs and bars*

	and restaurants, just stuff like that so I think that does help because it means it's not around you that much. It's not in your face as much as it used to be, but yeah..
Kate	*Once upon a time it used to be not cool to smoke but it used to be all right to smoke but these days I'm thinking it's the opposite now..*

The majority of smokers in the general population agree that most places should be smokefree (Taylor et al., 2006). Perceiving that smoking was not the norm was regarded as a potential facilitator to quitting among the pregnant women. Although this was not directly linked to smoking during pregnancy, the perception might be more dominant for pregnant smokers who appear concerned about the attitude of others towards their behaviour. Conversely, an identified barrier to stopping smoking and attending stop smoking sessions was the negative approach that pregnant smokers perceive that society holds towards them. This finding could indicate that participants differed with regards to their perceived barriers and facilitators to changing their behaviour. Alternatively, a behaviour not being perceived as the norm might not be regarded as equivalent to being perceived as a negative activity. Thus, whilst smoking not being perceived as the norm in society could be a facilitator to changing ones behaviour, a negative perception of smoking during pregnancy could be a barrier.

c. Reasons for stopping smoking. The importance of stopping smoking for oneself was also discussed during several of the interviews as the participants acknowledged that this could be a vital aspect of a successful quit attempt:

Clare	*You've got to do it haven't you, you've got to stop for yourself…*
Emily	*… it's the person that's got to give up for themselves.*

A number of the pregnant smokers who wanted to change their habit mentioned that their reasons for quitting included stopping for other people, mainly their mothers and children. Other people in their social network wanting the quit attempt to be successful was perceived as a facilitator to stopping smoking:

Clare	*…my mum hates it so much that's why I want to do it for her as well because she thinks it's terrible so… really for my son I've got to stop for cause he hates it, he hates me when I smoke so.*
Maria	*I promised to my daughter that I'd try.*
Jane	*…everyone wants you to give up which makes you want to do it yourself.*

Stopping smoking for the sake of others has also been reported by other smokers (Taylor et al., 2006) as a reason for changing their habit. One of the participants explained that she wanted to stop smoking for the stop smoking advisor who was supporting her in her quit attempt:

Clare	*….but you also want to do it for you as well like we want to come and sort of show you that we can do it.*

d. Intrinsic factors. Intrinsic factors relate to aspects within individuals that the participants felt could facilitate a person's attempt to stop smoking. A person's readiness to change and their level of self-efficacy were thought to affect a pregnant woman's decision to stop smoking. Both readiness to change (Prochaska & DiClemente, 1984) and level of self-efficacy (Bandura, 1977) have previously been found to predict the likelihood of changing a health related behaviour in individuals other than pregnant women. Lack of readiness was perceived as a potential barrier to

stopping smoking during pregnancy. Similarly, level of readiness could be categorised as a facilitator to changing ones smoking behaviour and attending stop smoking services. Readiness was associated with willpower and determination as well as the right time to quit. Wanting to stop smoking and having the willpower to do so were regarded as vital factors in stopping smoking as well as approaching the service:

Emily	*They've got to want it and if they want it that badly then they'll do.*
Anna	*I think deep down you have to want to do it before going ahead and ringing a number and wanting to stop and wanting to be helped in the first place.*
Susan	*…you've got to want to do it first to come to the first appointment anyway.*

A person's determination was described as another intrinsic factor that could affect an individual's decision to stop smoking. A high level of determination including feeling motivated to quit was believed to facilitate stopping smoking and attending stop smoking services:

Anna	*But I think that if you stick to it, and you're determined then it does help …if you're determined to stop smoking then you should do it and get all the support you need .*
Maria	*…it needs to be your own motivation to want to...*

The final aspect relating to readiness was considering that it is the right time to stop smoking. Clare felt that the time to quit was right for her and she acknowledged the importance of feeling ready:

Clare	*I'm nearly thirty now even though I still don't feel that I've grown up in my head I must have values, and issues, me morals so… I just knew it was time I had to give up, and I thought it's now or never.*
Clare	*I think if you're ready to do it you're ready to do it really…*

The first statement from Clare indicates that her sense of readiness was linked to her age rather than her pregnancy. Although she wanted to stop smoking due the fact that she was pregnant, she discussed that she had not quit smoking during her previous teenage pregnancy as she did not feel ready to do so. Believing in one's ability to stop smoking was considered to positively affect a person's decision to stop smoking and approach the stop smoking service. Previous successful quit attempts and attending a stop smoking session had boosted some of the women's self-efficacy. Tracy explained that her level of confidence had increased as a result of her midwife describing her own successful quit attempt and Maria mentioned the importance in believing in the effectiveness of NRT:

Emily	*…it's what they feel that they can do really if they feel that they can put 100% into giving up smoking then they'll do it…*
Clare	*Once you come here I think you realise that you can do it, yeah and that's it.*
Tracy	*So if she* [the midwife] *can do it I can do it too.*
Maria	*I think that they do help but you have to believe in them also.* [NRT products]

A number of non-pregnancy specific intrinsic factors were thus identified as facilitators in pregnant women's quit attempts. The pregnant women also discussed extrinsic factors as potentially facilitating stopping smoking.

e. Extrinsic factors. The extrinsic factors that were identified as facilitators to stopping smoking and approaching stop smoking services included keeping distracted, being exposed to low levels of stress and receiving support from others. Keeping distracted has previously been identified as a helpful factor in stopping smoking in the general population (Jorenby, 2001). Women who were in the process of attempting to stop smoking as well as those who did not try to quit believed that keeping distracted and occupied and making changes to ones routine could positively affect the outcome of the quit attempt. Some based this assumption on their own experiences and others on speculation:

Sarah	*So the more things you've got, you're basically doing, the more you don't think about fags. The more things to keep you occupied with I reckon that would help as well. So like trying new hobbies and things like that.*
Anna	*…it's just you've got to be aware of just occupying yourself or distracting yourself.*
Susan	*Slight change in routine, things you like to do when you have a cigarette. Sort of work your way round it.*

Having a stressful life was perceived as a barrier to stopping smoking and minimising the number of stressors in ones environment was believed to facilitate quitting. However, it was recognised that accomplishing this could be challenging if not impossible:

Maria	*I think, preferably you want to be in an optimum place you don't wanna be stressed about other things or big things because I think that we make better choices when we're not stressed already.*
Maria	*…but I think the less stresses you have in your environment the easier it would be. Easier said than done, obviously but I think yeah that would make it better.*
Clare	*So maybe, if you maybe, if you had a nice happy go lucky life it would be a lot easier.*

The women who made the comments above were referring to the stresses they experience in their lives and if these were non-existent, they would find it easier to stop smoking. However, the phrases '*happy go lucky life*' and an '*optimum place*' seem to reflect an unrealistic aspiration or a delusion of how a person's life needs to become in order to make behaviour changes. Thus, the stressful components of their lives could also act as a justification for continuing to smoke.

Positive social support has been identified as a predictor in stopping smoking among smokers other than pregnant women (Rice et al., 1996). Receiving support from individuals in the pregnant women's social network was frequently mentioned as an aid in stopping smoking. The participants perceived that the support from family, friends and partners could facilitate the process of stopping smoking. Haug et al. (1992) suggested that a partner's willingness to reduce their cigarette consumption can have a positive impact on a pregnant smoker's quit attempt. One women described that her partner's decision to stop smoking with her had a huge impact on her determination to quit and two friends who attended the service

together stressed the positive effects this had on their quit attempt as well as their decision to attend stop smoking meetings:

Sarah	*I think your friends and family really would, you need their emotional support as much as the NHS, the stop smoking service.*
Emily	*…it's me talking to my boyfriend and that he was agreeing and he said that if I stop he'll do it with me and that was like wow, because not many people would give up something that they enjoy and they like for somebody else really. When I see other people putting in a lot of effort yeah, makes me wanna put in a lot of effort, makes me determined, makes me want to strive for my goal and achieve it.*
Jane	[reason for coming to service] *Cause I could come with a friend actually. Yeah so that give me a bit more extra like support where I think if you do it with someone like with someone that you know it's a lot easier as well.*

The participants varied with regards to their required amount of support from their social network. One of the pregnant smokers pointed out that she did not wish to discuss her quit attempt with others but that brief praises from a family member was sufficient as means of encouragement:

Susan	*I talked to my sister yesterday, she helped me decorate and she went outside to smoke and another sister who's a non-smoker said you're doing really good and she just left it like that. She didn't go on and on. She just said that's really good, well done. That was enough. Discussing it would have bothered me.*

As with the intrinsic factors, the extrinsic factors identified as potential facilitators to stopping smoking during pregnancy were not pregnancy specific. However, some could have a more profound effect during pregnancy as the data revealed that pregnant women might be more prone to experiencing stress or feeling bored. Therefore, minimisation of stressors and distractions could be more important during a pregnant woman's quit attempt. In addition, although readiness could impact all smokers' likelihood of quitting, this aspect could be perceived as more urgent for pregnant women if they attempt to quit whilst pregnant.

2. Pregnancy Related Rationales

The participants also mentioned pregnancy related aspects when discussing their rationales for stopping smoking. Owen and Penn (1999) identified the impact on health as one of the most substantial reasons for stopping smoking during pregnancy.

a. Effects of smoking on baby's health. All of the women who wanted to stop smoking mentioned the health risks of the baby as one of their main reasons:

Emily	*Main reason cause I don't want my child to suffer anything.*
Maria	*…you've got a child with you, you should be doing everything you can to not harm it…*
Tracy	*Because smoking, like I know I'm affecting the child in some way.*

An identified barrier to stopping smoking during pregnancy was experience based lack of awareness as some women who had smoked during previous pregnancies had given birth to healthy babies and they were also aware of other women who had similar experiences. However, possessing adequate levels of awareness of health risks could also be experience based. Amy described that her

awareness of the heath risks of smoking during pregnancy was a consequence of having a previously low birth weight baby and being aware of other smokers who have had small children:

Amy	*Because of all the risks of miscarriages and low birth weight and, I've noticed that when he was born he was slightly smaller than I expected him to be and I think that because I did smoke partly through the pregnancy, not right through but I did smoke at some point.*
Amy	*…like my neighbour both of her kids, she smoked, both of them, and her daughter's still very small and her daughter's five so.*

Amy was, however, the only participant whose awareness of the health risks of smoking was experience based. Some of the pregnant women explained that they had noticed an increased amount of information available regarding the health risks of smoking:

Kate	*...there's more warnings on packets of tobacco, cigarettes, you know so I'm thinking, there never used to be that many warnings and now there is you know.*

However, this increase applied mainly to smoking in general. As discussed previously, the majority of the participants perceived the information regarding the health effects of smoking during pregnancy as insufficient. Nonetheless, two of the women felt that the amount of information available was adequate:

Maria	*I read a lot of pregnancy magazines, and even it's got stuff on what it does your baby and things like that.*

Susan	*I got the big bounty pack from the hospital that's got all… It's got all sorts of information. Actually I think there is something about smoking in there, how it affects the baby. And all the books, the baby books have something on what smoking does.*

Most of the participants suggested that an increase in the amount of information regarding the risks could encourage more pregnant women to quit smoking and approach the service. Visually portrayed messages delivered by midwives were described as potentially encouraging pregnant women go change their behaviour:

Maria	*…if people were more aware of the shock things then I think they might think twice...*
Sarah	*I think, we have it, it would be good to have it at the midwives, cause you go to see them quite often. And maybe like a poster on the wall or something, but also like when the midwife's explaining to them that if you do smoke, let me just show you that this is the effect that it can have.*
Tracy	*I think they should do it with the baby, like have like a scan or something that shows like what you're doing to your child, maybe that would help. And I think it would open up women's eyes more because if they're constantly seeing it then it would help them.*

Research has identified a link between knowledge of the health risks of smoking during pregnancy and smoking cessation among pregnant smokers (e.g.

Ershoff et al., 2000a; Secker-Walker et al., 1996). Increasing awareness could thus be a potential facilitator to stopping smoking.

b. Time of pregnancy. Although a number of non-pregnancy specific reasons were discussed with regards to quitting among the participants, the weightiest category mentioned as a reason for stopping smoking related to the actual pregnancy. This impact of pregnancy on a woman's quit attempt has been reported in previous studies (e.g. Owen & Penn, 1999). Thus, it appeared that although pregnant women possess similar rationales for quitting as other smokers, the pregnancy itself can indeed act as an additional reason and motivator for changing ones smoking behaviour. Pregnancy was identified as a potential barrier to stopping smoking but it was also described as a good time to quit. Various aspects of pregnancy could facilitate a quit attempt including a good opportunity to stop smoking, the emotions that can develop as a result of smoking during pregnancy, feeling sick during pregnancy, cutting down due to the pregnancy and wanting to stay abstinent following the birth of the baby. Nearly all of the participants had attempted to quit or cut down upon finding out about their pregnancy. Some explained that being pregnant provides women with the perfect opportunity to stop smoking:

Jane	*I think that like there is no like better reason to give up than when you're pregnant cause you've got an actual reason to give up for.*
Maria	*I think that if any time you're going to give up I suppose as a smoker that should probably be the time…*
Emily	*Well really as soon as I done the test and I found out and I was like oh god, and I thought I've got to stop.*

The reasons that the participants described pregnancy as the perfect time to quit was mainly related to the health outcomes affecting the baby which could provide pregnant smokers with a vital reason for changing their behaviour. It appeared that some of the women automatically associated pregnancy with quitting in particular if they had considered stopping smoking previously. One participant even predicted that stopping smoking is easier for pregnant women compared to the general population due to their weighty reason for changing their behaviour:

Amy	*Cause it's easier in a way cause there's a real good reason to stop…*

Two of the women stated that they would neither have attended the service nor tried to stop smoking unless they were pregnant:

Maria	*I thought inclined to go but then that might be because of the fact that I'm pregnant I think.*
Jane	*Cause it's related to pregnancy innit, because the midwife referred me. I know that you must deal with pregnant women so like, I want to know what I can use when I'm pregnant, and you know basically, I don't know because I've just associated it with the baby.*

The negative emotions that pregnant women can feel as a result of smoking during pregnancy were identified as potential barriers to stopping smoking and approaching the stop smoking service. However, Maria who regarded guilt as a destructive emotion, also recognised that it could simultaneously encourage some pregnant smokers to quit:

Maria	*…maybe contradict myself by saying there is a little sense of guilt that keeps you thinking about it or rather in the forefront of your thinking rather than just completely ignore it.*
Maria	*…much more motivated to give up when they're pregnant because they feel a sense of guilt I think and so I think that...*

The enjoyment of smoking was identified as a potential barrier to quitting but being pregnant could also stop some women from enjoying cigarettes. Three of the women had been experiencing sickness during this or a previous pregnancy which had resulted in a lack of enjoyment of smoking and an attempt to change their behaviour:

Anna	*…sometimes you get sick and don't want to smoke.*
Tracy	*Yeah, I didn't know I was pregnant then, but I was put off cigarettes, I had like a...whenever I smoked a cigarette I wanted to vomit. So I stopped smoking, not knowing that it was because I was pregnant. I thought it was just me, and then I only found out when I was four months pregnant. So that was the reason I stopped.*
Amy	*I think it was because I just, the thought even, straight away the morning sickness kicked in after six weeks, and it wasn't even enough time to kind think about it. I think just the smell of it. I didn't really enjoy it at all.*

Nearly all of the women taking part in the interviews had cut down on the number of cigarettes they smoked per day as a result of becoming pregnant. This was mainly due to a conscious attempt to reduce cigarette consumption but also

mentioned as an automatic reduction during pregnancy. Cutting down was described as a positive behaviour change that could facilitate stopping smoking completely:

Emily	*… being pregnant has boosted me a lot. I cut down a lot.*
Kate	*I moved from cigarettes to tobacco which made me cut down a lot more... you know there have been days when I haven't smoked for that whole day, not because of thinking, right I'm just not going to smoke today but for the fact that I didn't, I don't feel like one, you know or I just haven't had one. Sometimes you know when you get that headachy feeling or something and you know if you smoke it's going to make you feel worse, you know, so sometimes I do go a whole day and night without a cigarette, yeah, but it's not for the fact that, oh I think to myself oh you've done really well you haven't smoked today you know, you look at it like you know, I didn't need one.*

Another identified reason for stopping smoking during pregnancy was the wish to stay abstinent postpartum. This was because of health reasons as well as believing that it would be harder to smoke and easier not to smoke following the birth. One woman who already had a child and one participant who was primagravida described that it would be harder to smoke with a newborn baby. However, Kate rationalised her current smoking behaviour due to this belief as she was planning on quitting after the birth of her baby:

Tracy	*Because I don't want to have to smoke after I've given birth... And on top of that I can't be running out for a cigarette, and this is my first child, I can't be running out for a cigarette and try and balance taking care of her as well, it's hard and I don't think it's necessary.*

Kate	*Well, I just know that after the baby is born it'll just be so much more different. That would give me a really big incentive to you know and it would be a lot easier to stop when I've had him because with two children I wouldn't have time to do anything. I can't just, I don't know it'll just be easier when he's born for me. I know it will be.*

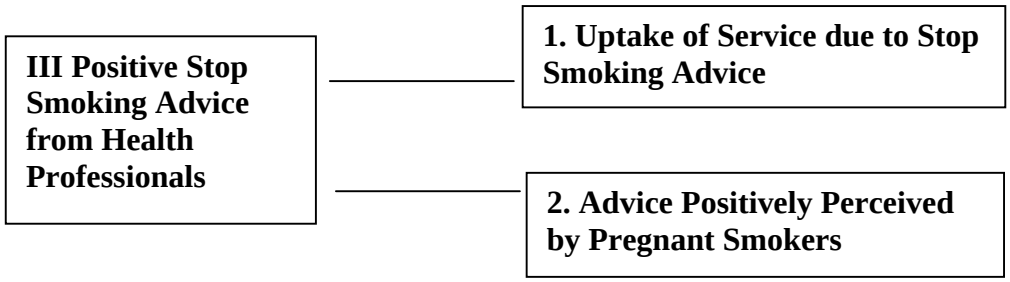
The analysis of the data revealed some new and interesting perspectives of smoking during pregnancy. There were conflicting findings regarding the perception of pregnancy and the rationales for smoking and quitting. Although the pregnancy itself was not regarded as an adequate reason for stopping smoking, it was also perceived as the perfect opportunity to quit. The negative emotions experienced by pregnant smokers, such as guilt was perceived as a potential barrier as well as facilitator for stopping smoking during pregnancy. In addition, suffering from stronger withdrawal symptoms and levels of stress as a result of being pregnant could prevent women from stopping smoking, yet the sickness that women might experience during pregnancy could encourage a quit attempt. These findings indicate that pregnant smokers are likely to encounter ambivalence regarding changing their behaviour and perceive the reasons for stopping smoking and continuing to do so as conflicting. This could explain some aspects of the difficulties that pregnant women face in quitting smoking as well as the challenges in encouraging pregnant smokers to approach stop smoking services and developing effective smoking cessation interventions.

III Positive Stop Smoking Advice from Health Professionals

The second category that was identified as a facilitator to approaching the stop smoking service was 'positive stop smoking advice from health professionals'.

This category could be split into the sub-categories '**uptake of service due to stop smoking advice**' and '**advice positively perceived by pregnant smokers**' (diagram 4.2.5).

Diagram 4.2.5 The category 'positive stop smoking advice from health professionals' and its sub-categories.



1. Uptake of Service due to Stop Smoking Advice

Five of the participants who had approached the stop smoking service for support had been referred through their midwife and one woman through her GP. The referrals had resulted in uptake of stop smoking sessions. Three women explained that they had attended the service purely because of the advice they had received from their midwife. If they had not been given stop smoking advice, they predicted that they would not have attended the service during their pregnancy:

Clare	*Yeah, my midwife informed me she was like yeah, would you like to go on the stop smoking regime thing. I was like yeah ok, she was like there's one for pregnant women de de de and she was explaining some of it... I need a push, I need a kick and that's what I got. But I wouldn't have, so because I got referred here, I made it. I would have been ready to do it, but I just haven't gone to the next step. I was ready to quit but I just didn't do nothing about it. So now, I was ready so the*

	lady sent me here and that was it so it's good, good job it's in my head because I wouldn't have, yeah
Maria	*She just said was I interested in going to a smoking sector...I dunno what word they used, smoking person to give up, or get help with giving up but I said yes so there wasn't much more that she needed to say.*
Susan	*Well if she hadn't have directed it, done it, organised it and you hadn't contacted me I probably wouldn't have done it off my own back. I would have left it until after the birth and then I probably wouldn't have done it then anyway.*

The advice received from the midwives had been a major facilitator to attending the stop smoking service for a number of the participants. Although this highlights the need for midwives to promote smoking cessation to their clients, it also draws attention to the rather substantial expectations that midwives are subjected to. Some of the comments above imply that the pregnant women rely on the midwife and their role in referring them to a stop smoking programme and thus taking some of the responsibility away from themselves. The fact that pregnant women expect and appreciate receiving smoking cessation advice from their midwife has been previously reported (McLeod et al., 2003; McLeod et al., 2004).

2. Advice Positively Perceived by Pregnant Smokers

Another facilitator to approaching the stop smoking services was related to how the advice provided by health professionals was perceived. Three of the pregnant women described that they had perceived the advice in a positive way and that the midwife had made them feel very comfortable in the process:

Susan	*…and the midwife suggested it here so that's it really, which I appreciated, her not going on at me about it cause I knew, everyone knows that smoke isn't good for you, you don't need it... She didn't judge me. She just suggested would I like to go to it and I said yes I'll give it a go and she said great, and she contacted you and that was that.*
Tracy	*I really felt happy because she actually, um, she didn't, she talked about herself cause she said she used to smoke and that she stopped with NHS help so that's why, that's how it started, because she said that she smoked, and she stopped and she's stopped for two years now or something like that, it was the NHS that helped her...*

Sarah appreciated the fact that her midwife had informed her of the possibility to use NRT during pregnancy. She found this piece of information useful despite her choice not to stop smoking:

Sarah	*I didn't know you was allowed to use patches or anything like that until she explained it to me about it so. But once she did I was like oh, okay I didn't know you could use that. That was quite nice of you to tell me. Nice bit of information there.*

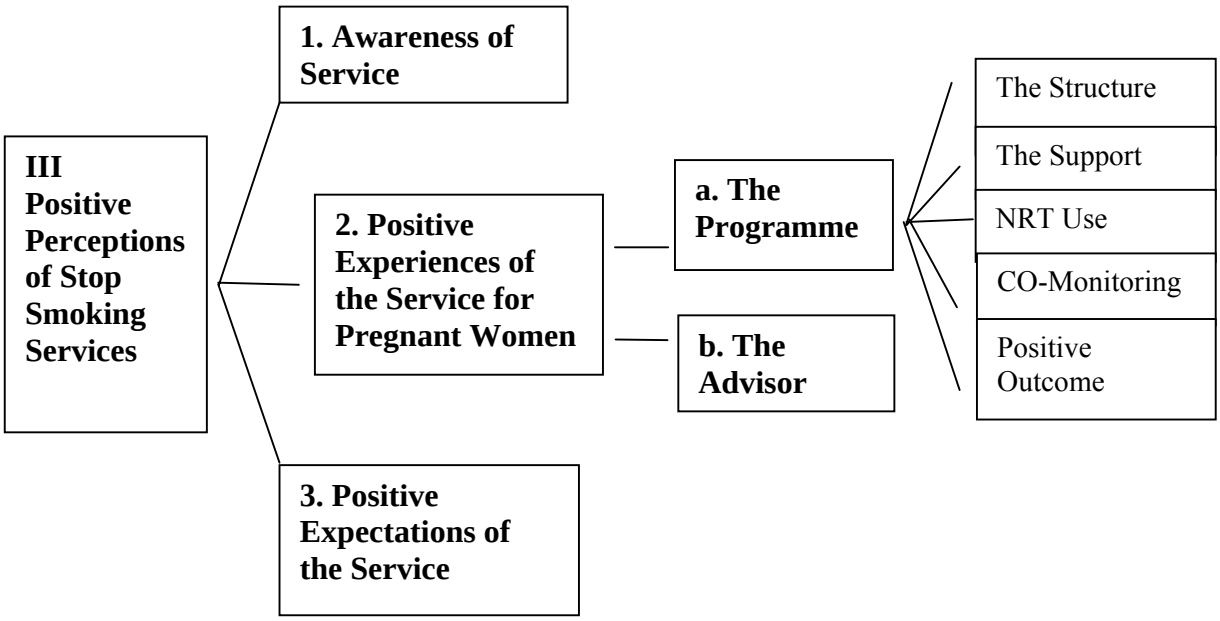
Although Sarah, Susan and Tracy all appreciated the information they had received from their midwife, they valued different elements of the advice. Susan was grateful that her midwife had a non-judgemental approach and had given brief advice, Tracy commented on the fact that her midwife talked about her own quit attempt and Sarah found the information on NRT use useful. Again, this finding

illustrates the complexity of working with pregnant women with regards to their various needs. It also highlights the challenges that midwives might face in providing stop smoking advice according to the clients' preferences.

III Positive Perceptions of Stop Smoking Services

'Positive perceptions of stop smoking services' was identified as a category that could act as a facilitator to approaching the service. Pregnant women's '**awareness of the service**', their '**positive experiences of the service for pregnant women**' and their '**positive expectations of the service**' were identified as sub-categories that could encourage pregnant smokers to attend a smoking cessation programme. 'Awareness of the service' could be split into sub-categories of '**the programme**' and '**the advisor**'. The categories and examples of these can been seen in diagram 4.2.4.

Diagram 4.2.4 The category 'positive perceptions of stop smoking services' and its sub-categories identified as facilitators to approaching the service.



1. Awareness of Service

The women who had previously used the service, those who were aware of its existence through other acquaintances and the women who had gathered information from advertisements appeared more likely to approach the service for smoking cessation support during their pregnancies. The awareness of stop smoking services did, however, relate to the support that is offered to the general population rather than the support provided specifically for pregnant women. Although it would be beneficial to raise awareness of the support offered to pregnant women, simply being aware of the fact that a stop smoking service exists and is on offer to all smokers could also encourage uptake of the service:

Maria	*Um, I've used them before anyway, without being pregnant so I did know that they existed I went and saw them…I'm plenty aware and I have been for some time that you can get it.*
Kate	*I know from on the TV and that I've seen you can have like one to one, counselling or a group thing, um.*
Sarah	*Cause that's what my friend done what she was like 15. I think she went to the doctors said she smoked asked about help and they given her patches.*
Clare	*...there's a lot more advertising for it and a lot more information and you do see it everywhere you go, NHS stop smoking blah blah blah. Yeah, it's like you're doubling your chances to quit so yeah, so that information is a lot better.*

Two of the participants discussed the benefits of raising awareness of the service in the streets of the borough. One woman who was heavily pregnant had

been referred to the stop smoking service as a result of being approached in the street by a member of a street team who distributed information about the local stop smoking service and made referrals for those interested. The woman was very happy with how she had been approached and the speed of which the referral was processed. She wished that this method of raising awareness of the service had occurred earlier during her pregnancy. The other participants had no experience of street campaigns yet suggested promoting the service through these means as useful:

Kate	*If I had got approached like by the man the other day earlier on in my pregnancy I think it would have been different... it was all in the timescale that the guy said and I had quite a bit of confidence in like the service I suppose, because you know it was, people got back to me quickly.*
Sarah	*I think talking, obviously talking to people and going around and saying fair enough. That's just giving you options and just telling you information basically.*

The participants seemed to prefer receiving information from 'real people' in a face to face environment. Sarah's comment shows that she was opposed to being lectured but felt that the information should be provided in a positive but non-pressurising manner. Some of the pregnant women mentioned that the vast amount of advertising and information regarding stop smoking services had increased during recent years. However, this applied to NHS stop smoking services in general rather than services specifically targeted at pregnant women. A common perception among the participants was therefore that there was a need for more information regarding stop smoking support for pregnant women. Apart from generally increasing

awareness, the participants felt that the adverts and information should include real quitters, be shown on TV, convey that there are other pregnant women who smoke, that NRT use during pregnancy is an option and that the service is non-judgemental:

Jane	*Yeah, maybe more things with people that it actually has helped cause you do see a lot of things and leaflets about statistics and things like that maybe a few things with actually people's own experiences like even in your leaflets and that like people's own stories about not smoking and um yeah, things like that I think. Just make it a bit more personal.*
Jane	*Well advertisements I think, on the telly, so more adverts definitely because they are the ones that get to you.*
Kate	*…a bit more advertising you know like um, exactly how they do it for you know, normal everyday people, but to do that but with pregnant women …and maybe to say you know you're not, you are not the only pregnant woman to smoke, you know you don't have to feel like this. You know just something like that, you know you can come to these agencies or whatever and they can help you to it without having to be um, involved with anyone else too much, yeah.*
Susan	*I think maybe more information about, like an advert or some sort of, not too in your face but an advert to say that some women find it hard to give up when they become pregnant and you can use patches and things.*
Kate	*… you know sort of advertising saying about you know, smoking while you're pregnant, you know, don't try to not make people feel like they're on their own you know you can come forward and get help no one will*

sort of, professional would kind of judge you, I think that that would, that, that, that, that would help.

One participant suggested that increasing awareness among the general population of the health risks of smoking during pregnancy as well as stop smoking services for pregnant women could lead to women quitting sooner or approaching the service earlier during their pregnancy rather than waiting for their midwife to refer them:

Tracy *And another thing, if there were adverts, I know it would prevent women from smoking like for example as soon as they found out they were pregnant they would stop automatically, and I think that would help. But there's some women that don't even know if they're pregnant or not and they're smoking. I just think it would help because it would be there in advance kind of, and if they do see it later on in the pregnancy they can still have something.*

The participants were asked what they requested from the stop smoking service and they outlined a number of factors which are already included as part of the service such as regular meetings, encouragement, NRT use, sessions taking place in convenient locations such as home visits and an option to receive one to one or group support. The women were not aware that these requirements already exist as part of the programme and this thus reinforced the need to provide information of the service available for pregnant smokers:

Kate *…just sort of encouragement, maybe you know you have, you, I'm not sure how long any process or how long it takes or whatever but maybe*

even like a little phone call or a text after a week saying like how you doing do you have, how has it been, you haven't smoked this week or whatever or have you had a little smoke the other day…

Tracy *For example the stop smoking packets and things like that…*[referring to NRT]

Jane *...a bit more home visits because obviously it's difficult for pregnant people to get out or if they've got kids and things like that.*

Sarah *Personally for me I prefer one-to-one because I don't, I'm sometimes like, I'm very shy so I don't like going into, if I was in a group I won't express myself or my opinions, I'd kind of sit back in the corner and watch everyone else so for me I prefer one-to-one. But some people might find it easier if they can see other people like in a group, encouraging more than like yeah, don't forget about it…*

Encouragement during quitting, one to one behavioural support and interventions taking place in private locations have previously been identified as preferred aspects of smoking cessation interventions by pregnant smokers (Ussher et al., 2004; Ussher et al., 2006). However, previous research investigating the requirements as well as experiences of pregnant women with regards to stop smoking support and NRT use is limited (Lindsay, 2001; Ussher et al., 2004). The participants in the study mentioned the benefits of tailoring support for pregnant women such as offering home visits, individual stop smoking sessions and additional encouragement. All of the pregnant women participating in the current study held positive perceptions of NRT use during pregnancy and although some had received conflicting information about the safety of the products, all women explained that

they had used or could consider using a product. The participants who had not used NRT felt that it could help women stop smoking and those who had been prescribed a product during their pregnancy explained that it was a useful tool in quitting smoking. The women who had attended the service for stop smoking support during pregnancy also discussed other positive experiences of the programme.

2. Positive Experiences of the Service for Pregnant Women

The women who had used the stop smoking service either prior to or during their pregnancy were very keen to describe the positive experiences of the service. There were hardly any negative experiences mentioned and all of the users claimed that they were happy with their decision to attend the programme and they would not hesitate to approach the service in the future. Thus, positive experiences of the service could be an influential facilitator to using the service. The women mentioned the programme and the stop smoking advisor as helpful factors in their quit attempt.

a. The programme. The stop smoking programme was perceived as a positive aspect of the stop smoking service. The structure of the programme, the support received, using NRT, CO-monitoring and positive outcomes of the programme all contributed to these positive perceptions. The pregnant women explained that the structure of the programme consisting of regular contact with an advisor had been a useful element of the service:

Anna	*…this way was different they gave me a number to ring up and when I rang up the number it was different and then they told me what type of things were involved to have meetings to have the actual people to talk to, to see how you're getting on to what support you need and if you need a chat if you're feeling down or you need a fag and I dunno it's a*

	different approach from what I normally have. I think it's a good approach.
Clare	*I like it it's been alright so far. We've come three times nearly in two weeks that's good for us… Yeah no it is good... meant as well we come back and that's saying something because I wouldn't normally probably come back and I've been back three times so that's good so there is something drawing me back.*
Susan	*I would recommend it, yeah. You've got to explain to someone or account for why you've started or why you've stopped or, it's not sort of an interrogation, it's quiet sort of you know quick in and out.*

Susan explained that she preferred brief sessions that did not entail too many questions whereas Anna liked the aspect of discussing things in more depth. Thus, although the women appeared to have different preferences with regards to the length of the sessions and the depth of conversation, they were happy with the support that they had received and the regular meetings with the advisor. This highlights the need to tailor the content of stop smoking sessions according to the needs and preferences of pregnant smokers. One woman who preferred informal chats as part of the interventions described that the main reason for attending sessions was because she could attend with a friend. Jane explained that it is unlikely that she would have agreed to attend sessions on her own:

Jane	*Cause I could come with a friend actually. Yeah so that give me a bit more extra like support where I think if you do it with someone like with someone that you know it's a lot easier as well. Like if you can come to the meeting together it doesn't feel as intrusive sort of thing*

and there's more friendly chats and sort of thing like that. Yeah, so I think, think that's why.

All of the pregnant smokers who had used the service appreciated the amount of support that the stop smoking advisor had provided. They regarded this as an important facilitator in their quit attempt:

Anna	*I think it's good and then also when they ring you up to check and to give you support as well to check to see how you are and I think that cause they tell you well done as well and not a lot of people said that so it helps to know that there's support behind you.*
Maria	*I think it's welcoming, I think it's supportive.*
Clare	*I'm just really pleased with like the experience that I've had really I mean me and my friend we've both been like pleasantly surprised with the amount of support you get considering how many people you obviously you must look after and things like that and you do feel that there's a lot of one to one support and I just think that I'm pleased I done it really.*

However, one woman acknowledged that the support provided was more effective due to her own response and ways of dealing with her quit attempt. She therefore recognised that although the support is a vital aspect of the programme, its effect is limited unless the client is receptive to help:

Maria	*…like I said quite supported and I was much more open to dealing with how I felt about smoking so I found it useful.*

Only a couple of the participants had been aware of the fact that NRT use during pregnancy is an option. The realisation that pregnant women could indeed use NRT during their quit attempt was perceived as an aid in managing to successfully stop smoking both among those who wanted to stop and the participant who was not in the process of quitting:

Jane	*I'm getting all this help like with the patches and with the inhalator.*
Sarah	*…you don't have to do it all by yourself just because you're pregnant.*
Clare	*They're very helpful you know it's nice how you give us the patches and the inhalers and things.*

Monitoring the pregnant smokers' CO levels as well as showing the clients' their baby's exposure to the gas were regarded as useful parts of the stop smoking programme. Both realising that the fetus is subjected to CO when the woman smokes and noticing the drop in CO level when tobacco consumption is reduced were viewed as incentives to stopping smoking and attending subsequent sessions:

Susan	*There's someone that can see you. You monitor how I'm doing. I know that if I slip back again, it's someone to report it to. In the nicest sort of way. Someone to write down the next sort of breath test or whatever it is. Also, you wanna know how you're doing and how much the baby's getting.*
Clare	*…and I think the best thing is when you've got to breath into that as well because you don't want your reading to go up you want to keep it the way it is so that helps, that really does help.*

Anna	*…that carbon monoxide, the measurements you have when you smoke… so that was like an eye opener. So it just think it makes you more aware of what your unborn child is actually getting.*

Although none of the participants taking part in the research had completely stopped smoking at the time of the interviews, two women mentioned the positive outcome of attending the service as a facilitator to continuing the programme. The women perceived a reduced CO reading and a decrease in cigarette consumption as an indicator of the effectiveness of the service as they described it as the most successful quit attempt they had accomplished. This positive sensation boosted their motivation to continue the stop smoking programme and to strive for complete abstinence:

Clare	*I think they're brilliant cause this is the best I've done it... I mean I know I've had the occasional one but I still look at myself now as I have stopped smoking.*
Clare	*I just like to say I like these meetings and they've helped me very much and yeah, that's probably about it. I can't really say no more. I mean I'm very happy…I'm very pleased.*
Susan	*Well at the moment my level has dropped so I would have to say yes it's very successful.*

b. The advisor. As a potential barrier to approaching the service was identified as pregnant smokers' expectations of feeling judged, the positive experiences of the programme and the advisor could be vital facilitators to attending the service. Two women mentioned that if they had perceived the advisor's approach

as negative they would not have continued with the programme. Thus, the role of the advisor was identified as an important element of a stop smoking programme. The participants felt that seeing an advisor whose remit is smoking during pregnancy could encourage pregnant women to approach the service. Some women had felt inclined to attend stop smoking sessions as a result of their midwife informing them that there is a stop smoking advisor who works with pregnant women. Three women explained that receiving expertise advice regarding issues related to smoking during pregnancy had or could positively influence their decision to approach the service:

Sarah	*I would because I'd ask them what they think in how what they think which ways are better in giving up smoking, whether they think it's that people find it easier with patches or gum up, based on their experiences, what they think, in their experiences what's worked.*
Clare	*…that is why I wanted to come here cause when you're pregnant, you specialise and that so you can tell us what we can use that was very helpful, cause I didn't know if you could wear patches.*
Tracy	*Because smoking, like I know I'm affecting the child in some way and I don't exactly know how that's why I want to talk to the NHS and find out how to get help to stop.*

The comments above signify yet again that pregnant women request support that is particularly tailored for smoking during pregnancy and that this aspect of the programme could facilitate uptake of the service. The pregnant smokers who had accessed a programme also mentioned the advisor as a great aid in their quit attempts. They found that their stop smoking advisor had been supportive and helpful and held a positive approach towards them and their behaviour. One of the

participants stressed that she liked the fact that her advisor was an ex-smokers and thus was better able to empathise with her clients:

Maria	*I like the fact that you get to talk to someone, and this particular women had smoked herself before so that was a comfort to know that there's someone else who's actually done it what you're up against. ..so I found that was helpful. Yeah I think overall I've had a good experience of it myself, other than not achieving my goal, but I mean, I don't think she could have changed that.*
Amy	*The way that your manner is like the way that you come across, very helpful, don't put, I don't feel under pressure in any way, really supportive and kind.*

Again it was acknowledged by one of the participants that her own approach as well as the advisor's has the potential to have a positive effect on the quit attempt:

Maria	*Yeah, I think I'm more open to talking about it seeing what I get out of it more so maybe than I was before so it's probably a bit of both me and her... I just maybe that I relate to her better and maybe I'm more susceptible and open to it now than but also she's more personable so she makes me feel more inclined to communicate what I feel about it...*

As research into how pregnant smokers perceive stop smoking services has been lacking (Ussher et al., 2004), the findings from the present study are valuable contributions to reaching a comprehensive understanding pregnant women's perceptions of stop smoking services. The data indicates that the pregnant women have positive experiences of the service which prevailed over the negative

experiences. However, the positive expectations of the service were less frequently mentioned in comparison to the negative expectations.

3. Positive Expectations of the Service

The pregnant smokers who had not approached the stop smoking service discussed their positive expectations of the programme. Additionally, the participants who had attended smoking cessation sessions talked about the positive perceptions they held of the service prior to using it. Thus, the category 'positive expectations of the service' refers to non-experience based perceptions of the stop smoking service. As the participants had not been aware of the stop smoking support offered for pregnant women, they referred to the service available for all smokers when discussing their expectations The only positive expectations that were mentioned were that the service attempts to help people change their behaviour and that the programme would be more effective than quitting alone:

Emily	*Um, suppose like I assume there's a lot of like talking and like with me, talking does help with everything, talking... I don't see any bad points at all about the stop smoking agency because they're there to help…*
Tracy	*I just, they help people and I think they're doing a good job really and there's a lot of people that dying from cigarettes and stuff like that. And NHS, the people seem to actually care.*
Kate	*I think what they do is really good and really positive you know because even you know with like anything I suppose addictive and that I mean if you've got ten people, you know one of them stops smoking, you know, then you are doing something right if you can get one person to stop, you know.*

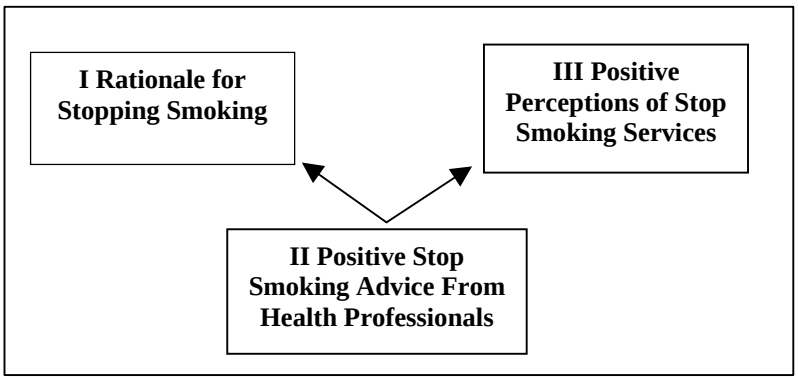
Ussher et al. (2004) found that one of the main benefits reported by pregnant women of stop smoking services was their effectiveness. A common reason for approaching the service among the participants in the present study was that the women did not believe that they would be able to stop smoking on their own and that they would be more successful with the help of the stop smoking service. However, analysis also identified that a negative expectation of the stop smoking service was that it would be ineffective. The proportions of women who expected the programme to be effective and ineffective were equal. One of the participants who did not want to stop smoking, Sarah, gave rather conflicting messages. Although, as previously discussed, she did not believe that the programme would lead to positive outcomes, she also explained that she would be more likely to succeed with the help of the service. This could be a reflection of the uncertainty that some of the pregnant women experience with regards to the stop smoking service:

Sarah	*Um, because I know on my own I'd be, I'd need some encouragement, I'd need some backup. Cause I know by myself I'd just think, oh forget about it, yeah, whatever, I had a fag, let's have another one. By myself, I'd like to do it with someone guiding me what ways they think is best for me to stop smoking, the way that's best for me.*
Emily	*Cause I know that I'll fail if I done it by myself. I know that I would.*
Tracy	*I can't do it on my own, I just wouldn't have the backbone to do it on my own, and as well even if I do, do it on my own there's nothing to like, I don't know. I just think it would help more if I came to the stop smoking service that's what I think. I don't think it would last if it was just me on my own.*

The positive expectations of the service were true reflection of women's real experiences. That is, the women who had used the service perceived the programme as helpful and effective and their positive expectations had thus been confirmed. In addition, the pregnant women's requests of the service are already part of the stop smoking programme. This indicates that the support that is offered to pregnant women as part of the NHS stop smoking programme meets the requirements of pregnant women. However, the fact that the positive experiences of the stop smoking service were much weightier than the positive expectations emphasises the need to inform pregnant women of the stop smoking services available specifically for them.

IV Links between the Perceived Facilitators to Approaching the Stop Smoking Service

The relationships that were identified between the categories representing the perceived facilitators to attending the stop smoking service are shown in the diagram below.



The category '**positive stop smoking advice from health professionals**' could potentially influence the women's '**rationales for stopping smoking**'. The 'rationale for stopping smoking' encompassed the women's perceptions of smoking and quitting and included both pregnancy related and non-pregnancy related factors that could influence a person's decision and ability to quit. The data suggested that

health professionals could have a positive impact on a woman's decision to stop smoking. For instance, one participant expressed that her level of self-efficacy had increased as a consequence of being given stop smoking advice by her midwife who had explained how she had managed to successfully give up with the help of the NHS stop smoking service. In addition, the pregnant women felt that provision of information regarding the health effects of smoking during pregnancy by midwives could encourage pregnant smokers to change their habit.

'**Positive perceptions of stop smoking services**' could also be influenced by '**positive stop smoking advice from health professionals**' as awareness of stop smoking services among pregnant women was partly due to receiving information from health professionals (particularly midwives). In addition, the majority of the pregnant women who had attended a stop smoking programme had done so as a result of being referred by their midwives. Sufficient and positive messages regarding stop smoking services with emphasis on the support provided to pregnant smokers could be a strong facilitator in pregnant women's decision to approach the service.

Conclusion

The analysis of the semi-structured interviews conducted with pregnant smokers identified two core categories; barriers and facilitators to approaching the stop smoking service. As the experiences of both smoking and use of the service varied greatly between the participants, several categories relating to both barriers and facilitators emerged from the data. Many of the identified categories of the two core categories were similar in that they could potentially act as both barriers and facilitators to approaching the stop smoking service during pregnancy.

Some of the main categories that were identified related to smoking in terms of continuing to smoke and stopping smoking. Barriers to stopping smoking and attending stop smoking services were categorises as ‘rationale for smoking during pregnancy’ and ‘reasons for not quitting during pregnancy’. ‘Rationale for stopping smoking’ was identified as a category which could facilitate stopping smoking and approaching stop smoking services. The categories that were related to the advice provided by health professionals could potentially both hinder and encourage pregnant smokers to stop smoking and attend stop smoking sessions. Issues related to stop smoking services could prevent as well as facilitate use of the service. Finally, the categories related to ‘negative perceptions of pregnant smokers’ were identified as barriers to changing ones smoking behaviour and approaching NHS services for smoking cessation support.

The findings revealed that the pregnancy itself could both encourage quit attempts from occurring and prevent women from changing their habit. However, pregnant smokers’ perceptions of smoking and quitting do not appear to differ greatly from the perceptions of other smokers. Nonetheless, the women still perceived stop smoking programmes specifically offered for pregnant women as beneficial and potential predictors of use of the service. The existing NHS stop smoking programme for pregnant smokers appear to meet the requirements of pregnant women but the low uptake of the service might be due to a lack of awareness of its existence. Pregnant women regard midwives as useful sources of information but many would prefer more information on the health effects of smoking during pregnancy and stop smoking programmes for pregnant women. Some of the data was rather conflicting both within and between the participants.

This highlights the challenges that pregnant smokers might experience with regards to stopping smoking as well as approaching stop smoking services.

CHAPTER 5

DISCUSSION

A reduction in smoking rates among pregnant women would lead to beneficial health outcomes for women, unborn babies and children (McRobbie & Hajek, 2003; U.S. Department of Health and Human Services, 2004). Albeit midwives are required to provide stop smoking advice to pregnant women and refer smokers to stop smoking services (Raw et al., 1999), the consistency and standard of the advice is in need of improvement (e.g. Cope et al., 2003; Haslam et al., 1997; Lindsay, 2001). In depth investigations into how midwives perceive promoting smoking cessation are limited (Condliffe et al., 2005; Lindsay, 2001). Uptake of stop smoking services by pregnant women in the UK is low (Taylor & Hajek, 2001; Ussher et al., 2006) and pregnant smokers' perceptions of services is a deficiently explored area (Ussher et al., 2004). The present research aimed to identify how midwives perceive providing stop smoking advice to pregnant women and how pregnant smokers perceive the stop smoking service. The analysis of the study exploring midwives' perceptions of providing stop smoking advice confirmed some findings from previous research. However, the qualitative approach of the study allowed for a thorough exploration of the topic and hence identified further detailed perceptions of the barriers and facilitators which could affect the provision of advice. The findings from the second study provided a profound insight into pregnant smokers' perceptions of NHS stop smoking services. Although the smoking behaviour of pregnant women has been previously researched, many of the perceived barriers and facilitators to actually attending services had hitherto been unexplored. The perceived barriers and facilitators that were identified with regards to providing advice as well as approaching the service are discussed.

Even though the angles of the two studied differed vis-à-vis the participants included and the perceptions explored, they were interrelated as they both investigated what could prevent and encourage pregnant smokers approaching the stop smoking service. The findings from the studies have therefore been integrated to encapsulate an inclusive discussion.

5.1 Emotions and Perceptions of Smoking during Pregnancy

The midwives' perceptions of providing stop smoking advice to pregnant women were mainly negative. The reasons that many midwives regarded the task as difficult related to various reasons including the perceived outcome of offering advice. One of the concerns was that the advice would cause negative emotions or reactions in pregnant smokers and that the midwives would appear critical of the women's behaviour. Other research has also revealed that midwives are concerned that pregnant women will feel guilty as a result of receiving stop smoking advice (e.g. McLeod et al., 2003). Informing pregnant smokers of the negative health risks related to smoking during pregnancy and simultaneously not appearing judgemental or causing feelings of guilt was perceived as a difficult task.

Abrahamsson et al. (2005) found that women experience feelings of embarrassment, failure and guilt as a consequence of not being able to stop smoking during pregnancy. In line with Abrahamsson et al.'s study, the pregnant women taking part in this research communicated that many pregnant smokers are embarrassed and feel guilty about their smoking behaviour. Additionally, they fear that health professionals will judge them due to their habit. However, the women also explained that they had not experienced feeling judged by health professionals and that their negative emotions were a product of their own perceptions of pregnant women who smoke or the negative attitude they perceive that society holds towards

smoking during pregnancy. Thus, the findings indicated that midwives do not tend to come across as condemnable although a concern among both midwives and pregnant smokers is that they will. Nonetheless, the pregnant smokers' concerns about feeling judged as well as their negative emotions regarding their habit were identified as potential barriers to approaching the stop smoking service. Smoking prevalence rates among pregnant smokers are likely to be underreported due to the negative perceptions attached to the behaviour (Cnattingius, 2004; Coleman et al., 2004; Owen & McNeill, 2001; Pollak et al., 2006). However, a direct association between the perceived negative approach towards pregnant smokers as well as their negative emotions regarding their habit and uptake of stop smoking services has not previously been reported. Pregnant smokers' expectations of being judged by services and individuals whose remits specifically involve helping people to stop smoking reflect a deeply rooted perception of smoking during pregnancy as an iniquitous behaviour.

Although the participants mainly regarded feelings of guilt as detrimental aspects of discussing smoking cessation and stopping smoking, some of the midwives and pregnant smokers alike acknowledged that negative emotions could also contribute towards a behaviour change. That is, feelings of guilt or embarrassment regarding smoking during pregnancy and fearing the detrimental health risks of smoking could be incentives for stopping smoking. Thus, these negative emotions could either result in constructive or destructive actions and achieving the desirable outcome was regarded as difficult.

Another concern among midwives was that feelings of embarrassment could lead to other negative emotions in pregnant smokers, such as feeling uncomfortable or annoyed about being given advice. However, as revealed in previous studies (e.g.

McCurry et al., 2002; McLeod et al., 2003), the pregnant smokers expected to be asked about their smoking status and they perceived the advice provided by their midwife as helpful. Being dishonest by claiming to be a non-smoker or underestimating cigarette consumption was another adverse yet not uncommon experienced reaction from pregnant smokers. The interviews with the pregnant women confirmed this perception as they also acknowledged that some pregnant smokers deny their smoking status. Research has verified this phenomenon as disclosure of smoking among pregnant women in antenatal care settings has been found to be lower than actual smoking rates (Pollak et al., 2006a). The pregnant women's behavioural reactions to the advice were also identified as a barrier to promoting smoking cessation. Some midwives explained that pregnant smokers might change after receiving advice by becoming more introverted, hence having a negative impact on their relationship.

5.2 The Relationship between Midwives and Pregnant Smokers

Establishing and maintaining a sound relationship with clients was accentuated as an important aspect of midwifery care. The concern that the provision of stop smoking advice could negatively affect the quality of the relationship was identified as a barrier to providing stop smoking advice. While a good relationship was thought to facilitate promoting smoking cessation, providing advice was simultaneously perceived as a potential barrier as midwives felt it could have a detrimental impact on the relationship. Previous evidence has also indicated that midwives predict provision of stop smoking advice to impact the relationship with pregnant women (e.g. Aveyard et al., 2005; Lawrence & Haslam, 2007). The quality of the relationship between midwives and pregnant women has been linked to satisfaction of care (Tinkler & Quinney, 1998). The pregnant smokers taking part in

the interviews also commented on the important part that midwives play in their antenatal care. However, regardless of whether the women had received any stop smoking advice from their midwife, they rarely made any negative comments regarding midwives. On the contrary, the women were very defensive of their midwife even in a couple of instances when they had agreed to be referred to the service but the referral had not been processed. Although it was recognised that this might have been because of the midwife not sending the referral to the appropriate service, the pregnant women empathised with the stress midwives are under and consequently appreciated that they might overlook certain aspects of their work. Thus, the women tended to like their midwives, they were reluctant to bestow them with any blame and they appreciated their support and advice as they found them a useful source of information.

5.2.1 Continuity of Care

Women in the UK are unlikely to see the same midwife during their pregnancy (Women's and Children's Health, 2008). The midwives taking part in the research who were able to provide continuity of care appreciated this aspect of their role and many of the midwives who could not see the same women throughout their pregnancies perceived this as a barrier to providing stop smoking advice. Many felt that working under the model of continuity of care could enable them to explore issues in more depth with their clients and readdress topics on several occasions. Some evidence has indicated that pregnant women perceive continuity of care as beneficial (e.g. Hodnett, 2000). However, Morgan, Fenwick McKenzie and Wolfe (1998) found that pregnant women prioritise other aspects of care such as participation in decision making, relations with the midwives and communication, to personal continuity of carer. The content was thus perceived as of greater importance

than the structure of midwifery care. Although many of the pregnant smokers in the present study had seen several midwives during their pregnancy, they did not complain about the care they had received. However, the women had not been provided any follow up stop smoking advice and this might have been a result of not being offered continuity of care.

5.2.2 Inability to Relate to Clients

Although midwives' concerns about the effects of stop smoking advice on the relationship with their clients is hence not a newly identified phenomenon, the perceived inability to relate to pregnant women emerged as a new concept. Some of the midwives explained that they were incapable of relating to their clients and they believed that this feeling was shared among many pregnant women. This could make it more difficult to provide stop smoking advice. A number of the midwives explained that their own and their clients' conjoint inability to relate to each other was due to the fact that they are from different backgrounds and their life circumstances are incompatible. Some of the midwives appeared to regard the ability to relate to their clients as a prerequisite for being able to empathise. Having different backgrounds and life circumstances prevented the health professionals from comprehending the experiences of pregnant women. As the research was undertaken in a borough with high levels of deprivation (Office of the Deputy Prime Minister, 2004) and pregnant smokers are more likely to come from socially disadvantaged groups (Lindsay, 2001; Lumley, Oliver & Oakley, 2004), the midwives in the present study might have encountered these difficulties to a greater extent than midwives in other areas. One of the pregnant women conveyed that she had previously possessed negative perceptions of the stop smoking service due to believing that it consisted of individuals from superior social classes. However, this

perception did not apply to midwives. Perhaps the dissimilarity between some pregnant women and midwives is not perceived as equally substantial among pregnant smokers as it is for midwives or alternatively pregnant women might not regard this difference as negatively affecting their relationship. They might not feel that midwives need to have similar life circumstances in order to empathise or provide satisfactory care. In line with previous research, the pregnant women tended to accept that asking about smoking status is part of the care that midwives provide (e.g. Pullon et al., 2003).

5.3 Midwives' Perceptions of their Role

The midwives also acknowledges that providing stop smoking advice is part of their role, confirming previous findings (e.g. Condliffe et al., 2005; Lawrence & Haslam, 2007). However, they felt that provision of smoking cessation advice should not only be the responsibility of midwives but also other health professionals. If the advice was provided consistently by all health professionals that pregnant women come into contact with during their antenatal care, a higher number of people would be able to positively influence women's chances of successfully stopping smoking. In addition, there were discrepancies between the midwives regarding how they viewed their role in relation to providing stop smoking advice. Those who perceived discussing smoking cessation as an important aspect of their work appeared more compliant about undertaking the task compared to those who did not regard it as essential as other parts of midwifery. However, according to Condliffe et al. (2005), positive perceptions of smoking cessation as part of the role of midwives do not automatically manifest in provision of advice. Therefore, accepting and appreciating that providing stop smoking advice is part of the midwifery role might not be sufficient to promote smoking cessation to pregnant women.

The role of midwives was described as very extensive in that they are expected to cover a variety of issues with their clients. The participants spoke of the fact that midwives tend to have specific areas of expertise or personal interests within their profession, such as breastfeeding, antenatal screening or mental health issues. Midwives were more likely to prioritise their area of expertise during the booking sessions with pregnant women. Thus, it was acknowledged that the extent to which midwives discuss smoking cessation with their clients vary according to the midwives' personal and professional interests. The extensiveness of the role was also perceived as a barrier to providing advice. Midwives' perceptions of promoting smoking cessation as part of their role has been previously investigated (e.g. McLeod et al., 2003; McLeod et al., 2004) and Aveyard et al. (2005) found that midwives feel they had to sacrifice other parts of the sessions when they offer smoking cessation advice to pregnant women. However, research exploring how provision of stop smoking advice compares to other areas of the midwifery role appears to be limited. The findings indicate that the negative perceptions that some midwives hold towards discussing smoking cessation might be partly due to the extensiveness of their role rather than the actual topic of smoking during pregnancy. In order to effectively undertake all the aspects of their broad role, the midwives felt that a large amount of knowledge and time were required.

5.4 The Work Structure of Midwives

The structure that midwives work under was identified as potentially affecting the provision of stop smoking advice. One of the most substantial barriers identified in offering advice was having insufficient time during the booking sessions. This finding supports conclusions from previous research (e.g. Bishop et al., 1998). Midwives are required to discuss numerous issues during booking

sessions with pregnant women (Women's and Children's Health, 2008) and many of the participants felt unable to cover all the topics effectively during the hour long session. Although NICE (2008) guidance outlines the frequency of antenatal appointments and recommends that initial sessions should be longer than subsequent sessions, it does not specify the time that should be assigned to the primary appointment. The limited amount of time allocated to each booking session affected other perceived barriers to providing stop smoking advice among the midwives such as the extensiveness of their role which was harder to manage due to lack of time. In addition, it was acknowledged that having a smaller case load of women could result in having more time with each client which would allow for further exploration of issues such as smoking cessation. Bishop et al. (1998) identified the clinical setting as a potential barrier to offering pregnant women stop smoking advice. This was also mentioned by the midwives in the present study. The main reason was, however, related to the fact that the midwives feel rushed during the bookings as other women are waiting outside for their delayed sessions. Therefore, the problems associated with the setting were linked to lack of time rather than the actual environment in which the bookings take place.

Although insufficient time was perceived as a barrier among the majority of the midwives, those who appeared to discuss smoking cessation in more detail regarded the problem as more significant. Midwives are not simply required to identify the smoking status of pregnant women but also to provide advice about and assist smokers in quitting, refer interested clients to stop smoking services and offer information on NRT (Raw et al., 1999). The recommended duration of a brief stop smoking intervention is between 5 and 10 minutes (NICE, 2006). The midwives might not have been aware of the time they are required to spend discussing smoking

cessation with pregnant smokers as some are likely to have underestimated and others overestimated the length of a brief intervention. Informing midwives of the actual requirements regarding provision of stop smoking advice could assist them in undertaking the task. In addition, raising awareness of the evidence based effectiveness of brief stop smoking interventions (NICE, 2006) could encourage midwives to promote smoking cessation among their clients.

5.5 Effectiveness of Advice

A common assumption among midwives was that provision of smoking cessation advice would not lead to the desired outcome, namely a successful quit attempt. Other research has also demonstrated that the reasons why maternity care providers do not regularly assist pregnant smoker in quitting smoking include their scepticism regarding the effectiveness of the advice (e.g. Bishop et al., 1998; Klerman & Rooks, 1999). Particularly midwives who focus on cessation rather than change tend to presume low levels of motivation to quit in pregnant smokers and underestimate the effect of the advice (Cooke et al., 2001; McLeod et al., 2003). This might result in midwives being less likely to provide stop smoking advice to their clients (Condliffe et al., 2005). As also reported in McLeod et al.'s (2003) study, some of the midwives were disillusioned about providing advice as they had encountered women who communicated that they were in the process of quitting but still continued to smoke throughout their pregnancy. Another impression among some midwives that emerged from the present study is that pregnant women who smoke do so because they are unable or unwilling to change their behaviour and providing stop smoking advice was therefore seen as a futile task. Abrahamsson et al. (2005) stated that many pregnant smokers have planned to stop smoking prior to becoming pregnant but are unable to do so. Nine out of the ten pregnant smokers in

the present study explained that they had not been able to change their behaviour despite wanting to do so. This demonstrates the complexity of a behaviour such as smoking as the desire to quit had not been a sufficient tool in achieving the aspired outcome. Research indicates that only 4% of smokers who quit without support stay abstinent for six months (Hughes, Keely & Naud, 2004). However, some of the midwives did not appear to perceive the lack of behaviour change as a result of the challenges in stopping smoking but as a verification of their clients' unwillingness to change and the ineffectiveness of the advice. The pregnant smokers also revealed that some women expect to stop smoking upon becoming pregnant but realise that they are unable to do so.

Research has found that positive perceptions of promoting smoking cessation among midwives are linked with realistic outlooks on the effects the advice (Abrahamsson et al., 2005). The present study revealed that midwives who have more realistic expectations of the outcome of the advice, i.e. they realise that not all pregnant smokers will change their behaviour and they focus more on behaviour change rather than immediate abstinence, appear more positive regarding promotion of smoking cessation. The majority of the pregnant smokers in the research who were attending the stop smoking service for support had been referred by their midwife. Most of these women predicted that they would not have approached the service unless their midwife had provided advice and completed a referral form. Thus, the advice provided by the midwives had already had a profound impact on these women's quit attempts. Some of the midwives felt that pregnant women who want to stop smoking and require help in doing so would seek help. Conversely, the pregnant smokers appeared to expect midwives to introduce the topic of smoking cessation and make referrals and without their input uptake of the service might not

occur. This phenomenon could have been linked to the women's health locus of control (Wallston & Wallston, 1982) as their external locus of control might have been stronger than their internal locus of control, thus not regarding events as being within their control but determined by external factors. Many pregnant smokers were also embarrassed of their habit and feared being judged and this could prevent them from raising the issue. A tendency to shift responsibilities thus seemed to occur among both midwives and pregnant smokers. If both parties detach themselves from the responsibility of discussing smoking related issues, a positive outcome resulting in behaviour change is unlikely to occur.

The findings underline the need to portray stop smoking services for pregnant smokers as the norm to encourage pregnant smokers to request help. Additionally, in order to gain realistic expectations of the outcome of advice, midwives need to possess some awareness of the behaviour of smoking and the intricacy involved in achieving abstinence. It is, nonetheless, crucial that these expectations do not become pessimistic but that midwives remain confident of the potential impact of their advice. However, as the midwives had noted, evidently not all pregnant women stop smoking during pregnancy and the analysis of the interviews identified various reasons for this.

5.6 Smoking Behaviour of Pregnant Women

Non-pregnancy and pregnancy specific factors related to the smoking behaviour of pregnant women were identified. Curry et al. (2001) claimed that both pregnancy related and general motivation is necessary in order for pregnant women to quit smoking. In line with previous research, intrinsic as well as extrinsic factors were detected as barriers to stopping smoking among pregnant women (e.g. Hotham et al., 2002).

5.6.1 Intrinsic Factors

The pregnant smokers and midwives alike acknowledged that certain intrinsic factors are necessary in order to stop smoking and that it varies greatly between individuals whether these are present or lacking. Previous research has suggested that women tend to doubt their ability to stop smoking during pregnancy (e.g. Hotham et al., 2002). Self-efficacy has been found to be an important element in changing pregnant women's smoking behaviour (De Vries & Backbier, 1994; Siero, van Diem, Voorrips & Willemsen, 2004; Woodby et al., 1999). Feeling confident about being able to change their smoking behaviour was viewed as an important factor in stopping smoking among the pregnant participants, many of whom tended to lack this vital feature. Other individuals' successful behaviour changes can also improve a person's self-efficacy (Bandura, 1998). One of the women explained that her level of confidence in quitting had increased as a result of her midwife describing her own successful quit attempt with the help of the stop smoking service. This increased sense of confidence in her ability to quit had positively affected her decision to approach the service. However, low levels of self-efficacy among pregnant women have been found to be associated with an interest in attending stop smoking sessions (Ussher et al., 2006). Not all of the pregnant smokers in the present study who displayed poor levels of self-efficacy had accessed the stop smoking service even though an inadequate belief in the ability to stop smoking without help was perceived as a reason to attend stop smoking sessions among some women. Although low self-efficacy might positively affect an interest in receiving help as the belief that one can quit without support is weak, it might not be sufficient in itself to predict uptake of the service. The findings suggest that both

high and low self-efficacy can affect a woman's decision to stop smoking and approach stop smoking services.

Lacking a sense of readiness to stop in terms of not feeling that the time is right and having low levels of determination and willpower was identified as potentially hindering pregnant women from stopping smoking. Haslam and Draper (2001) and Hotham et al. (2002) also ascertained that lack of willpower can be a barrier to smoking cessation among pregnant women. Self-efficacy (Bandura, 1977), readiness to change (Prochaska & DiClemente, 1984), a sense of commitment in stopping smoking and perceiving that the time is right (Lader & Goddard, 2004; Taylor et al., 2006) have been identified as intrinsic factors linked with smoking cessation in the general population. Therefore, the pregnant women's rationales for smoking did not appear to differ from other smokers' and their perceptions had not changed as a result of becoming pregnant. The smoking behaviour of pregnant women thus seemed to be affected by similar intrinsic factors which influence other smokers. The present study indicated that the intrinsic factors linked with smoking could be affected by extrinsic factors such as high smoking rates in the immediate environment.

5.6.2 Extrinsic Factors

a. Smoking as the Norm

The midwives as well as the pregnant smokers recognised that smoking tends to be perceived as the norm among pregnant women who smoke and this was identified as a barrier to stopping smoking. Many pregnant smokers are likely to have smoked from an early age and the habit has become a routine and integral part of their lives. Not attempting to or wanting to stop smoking previously could make it more challenging to change their smoking behaviour upon becoming pregnant.

Although only approximately a fifth of the general population in the UK are smokers (Office for National Statistics, 2009) and reports indicate that a minority of pregnant women smoke (17%) (Bolling et al., 2007), the majority of the pregnant women felt that smoking was a big part of their social network and a common behaviour in society. They regarded this phenomenon as decreasing their chances of achieving smoking abstinence. This could be explained by the fact that smoking prevalence rates are higher among pregnant women from lower socio-economic status groups (Office for National Statistics, 2009; Penn & Owen, 2002) and the study was carried out in a borough with high levels of deprivation (Office of the Deputy Prime Minister, 2004).

However, half of the women appreciated the fact that the smokefree legislation played a significant role in the reduction of smoking in society. They regarded this as an aid in stopping smoking. As discussed previously, an identified barrier to stopping smoking and approaching stop smoking services was the negative approach of society towards pregnant women who smoke. These ostensibly conflicting findings could have been a reflection of a discrepancy between the perceptions of the women. Alternatively, the women might have distinguished between a negative approach towards smoking during pregnancy and the behaviour not being regarded as the social norm. If the findings were a result of the latter option, smoking not being perceived as the norm could be a facilitator to quitting while smoking during pregnancy being perceived as a negative behaviour could be a barrier to smoking cessation. Although the majority of smokers in the general population approve of the smokefree legislation (Taylor et al., 2006), it could be a more important factor in pregnant women's quit attempts as they might be more

likely to consider other people's perceptions of their behaviour and they may be unable to disguise the physical aspects of their pregnancy.

As revealed in previous research, the social network of pregnant smokers is likely to involve a large number of smokers (e.g. Haslam et al., 1997) and this might negatively influence women's likelihood of stopping smoking (Haslam & Draper, 2001; Hotham et al., 2002). Some of the women in the study explained that they had started smoking and maintained their habit due to the commonness of smoking among their friends and family. Particularly the young participants appeared to shift the blame or responsibility of their smoking habit onto other people. However, it was also identified that the women's social network could facilitate a behaviour change if they consisted of non-smokers or offered constructive support in the women's quit attempts.

b. Social Support

Social support has previously been identified as a contributing factor to smoking cessation during pregnancy (e.g. De Vries & Backbier, 1994; McLeod et al., 2003) and lack of support has been found to negatively predict smoking cessation (e.g. Dejin-Karlsson et al., 1996; McBride et al., 1998). The findings from Ussher et al.'s (2004) study implied that pregnant women from lower socio-economic groups show a greater interest in the 'buddying' aspect of stop smoking interventions. That is, receiving support from another pregnant smoker during their quit attempt. The authors speculated that this might be due to the fact that women from more deprived backgrounds have lower levels of social support. However, they also found that women with higher socio-economic status have a greater interest in participating in a stop smoking programme. This might have been a result of facing fewer barriers in actually attending, such as having access to child care. A couple of the women in the

present study had attended the service partly due to their perceived lack of support. Thus, it appears that a desire to receive support in quitting among women who perceive current support as lacking could contribute to uptake of stop smoking services.

Previous studies have found that social support as well as a partner's decision to stop smoking can positively influence smoking cessation among pregnant women (e.g. Haug et al, 1992; McBride et al., 1998; Rice et al., 1996). Two friends who attended the service together emphasised the positive impact this had on their decision to stop smoking and approach the service. One of the pregnant women described that her partner's decision to stop smoking was beneficial in her own quit attempt. The support of friends and family was also perceived as a valuable factor when stopping smoking. The participants who had encountered criticism as opposed to encouragement from their social network portrayed this as negatively affecting the process of stopping smoking. Another negative extrinsic factor that appeared to influence the smoking behaviour of pregnant women was stress.

c. Stress

A common theme that was discussed both among the midwives and the pregnant smokers was the association between smoking and coping with stress. This link has been established in previous research (e.g. Dejin-Karlsson et al., 1996; Haslam & Draper, 2001; Hotham et al., 2002; McLeod et al., 2003). The women in the present study depicted smoking as a means of handling stress and the association between cigarettes and stress reduction was resilient even among those who deemed smoking to be a genuine stress reliever as implausible. Smokers might benefit from learning that smoking does not reduce stress but might in fact have the opposite effects (Parrott, 1999). However, as this realisation might not prevent women from

smoking, introducing stress management exercises into interventions could be a more effective method of helping pregnant smokers change their behaviour (e.g. Dejin-Karlsson et al., 1996; Ludman et al., 2000).

Some of the midwives also described smoking during pregnancy as helping women cope with stress. The fact that many pregnant smokers have complex needs and face challenging circumstances was perceived as a barrier to providing stop smoking advice. The midwives felt that many women are forced to deal with other issues which they prioritise over smoking cessation. Lindsay (2001) claimed that midwives tend to balance the perception that smoking can help pregnant women to reduce stress levels with the dangers related to smoking during pregnancy. If midwives hold misconceptions and believe that smoking can be used as an aid in dealing with stressful situations and do not consider the health risks as more severe than the stress of stopping smoking, they are unlikely to challenge these presumptions in pregnant smokers. The pregnant women discussed various stressful factors and circumstances which could negatively influence a person's decision to stop smoking as well as their likelihood of attending the service. Due to the deprived area in which the research took place, the complex circumstances of the women in the study might have been more extensive. Although the perception of smoking as a stress reliever could prevent smoking cessation from occurring, pregnant smokers' perceptions of smoking could also facilitate a quit attempt.

5.6.3 Perceptions of Smoking

Pregnant women's perceptions of smoking could act as a facilitator as well as a barrier to stopping smoking. Negative perceptions of smoking such as considering it to be a bad and smelly habit and a strong addiction that has detrimental effects on both appearance and finances motivated some of the women to change their

behaviour. However, it was also revealed that a reason for not abstaining from smoking during pregnancy is the perceived positive effects of smoking. The two youngest women mentioned the concept of comfort as a reason for smoking. The comforting aspect of smoking appeared more dominant during this time of their lives as one of the teenagers explained that she felt more restricted due to being pregnant and the other woman described feeling scared about the thought of giving birth. The comforting aspect could also have been linked to a sense of lack of support or to the young age of the participants. The perception of cigarettes as a comforting aspect of the women's lives does not appear to have been identified previously. The women in the study also mentioned smoking as an enjoyment and as a relaxing activity. Pregnant women's perception of smoking as a means of relaxing has previously been reported (e.g. Haslam & Draper, 2001). Perceiving smoking as an enjoyment and a relaxing behaviour might not be linked specifically to smoking during pregnancy but as a result of the effects of nicotine (Rose et al., 2007). In line with previous research, smoking was also perceived as compensating for negative aspects of the women's lives such avoidance of boredom (e.g. Gillies et al., 1989; Haslam & Draper, 2001).

Another barrier that was identified as potentially preventing cessation among pregnant smokers was the fact that they hold negative perceptions of quitting. Both the pregnant women as well as the midwives expected stopping smoking to be difficult mainly due to the addictive nature of the behaviour. A number of the pregnant women even described the thought of stopping as frightening. Nicotine dependence and withdrawal symptoms have previously been identified as strong barriers to smoking cessation during pregnancy (e.g. Haslam &Draper, 2001; Hotham et al., 2002; Woodby et al., 1999). As nicotine is metabolised at a faster rate

among pregnant women they might be more likely to experience withdrawal symptoms (Dempsey et al., 2002). Therefore, the addictive nature of cigarettes could have a greater impact on a woman's quit attempt during her pregnancy.

The pregnant women's perceptions of smoking and the factors which could influence stopping smoking during pregnancy did not appear to be directly linked to the pregnancy. For instance, the association between smoking and stress, enjoyment and social networks also exist among the general population (Taylor et al., 2006). However, some factors could have a stronger impact during pregnancy as the women explained that they are more likely to feel bored or stressed than prior the becoming pregnant. The pregnancy itself was also identified as a potential barrier as well as facilitator to quitting smoking and approaching stop smoking services.

5.6.4 Pregnancy

The fact that pregnant women rationalise their smoking habit similarly to other smokers could explain why the pregnancy is not a sufficient motivator to stop smoking among all women. On the contrary, some women felt that the pregnancy itself could make it harder to change their behaviour.

a. Pregnancy as a Barrier to Quitting

The relatively unexplored area of perceiving the pregnancy as a direct barrier to quitting was linked to experiencing stronger cravings and feeling more emotional during pregnancy. In addition, the pregnant women talked about the pressure and restrictions that they experience which could dampen their motivation to stop smoking. The pressure that is put on women during their pregnancy was perceived as a barrier to providing stop smoking advice by midwives as well as a barrier to quitting among pregnant smokers. The fact that women might be confronted with pressures to live perfectly healthy lives during their pregnancy and take full

responsibility for the health of their unborn baby was discussed amongst the midwives. Many felt that there was too much pressure on pregnant women from society and they were reluctant to add to this pressure by discussing smoking cessation. This perceived pressure was also mentioned by one of the pregnant smokers who felt that pregnant women are under an additional amount of pressure compared to the rest of the population. Perceived pressure to stop smoking from other people as well as society as a whole has been linked with continuing to smoke during pregnancy (e.g. Hotham et al., 2002; McCurry et al., 2002). Additionally, many women are required to make numerous behaviour changes during their pregnancy and to abstain from several pleasures (Pirie, 2000). Dame Karlene Davis DBE, RCM general secretary, recognised that although stopping smoking is one of the most crucial things a pregnant woman can do for the health of her baby, pregnant women are lumbered with advice and restrictions regarding how to live their lives. This pressure can lead to self-criticism and perceived blame by society and midwives should not add to this pressure (Department of Health, 2001). However, the midwives felt that avoiding appearing as a judgemental health professional and causing negative feelings in women was a difficult task with regards to promoting smoking cessation. They appeared very aware of the pressure that pregnant women face. The findings did not suggest that midwives are insensitive towards their clients' and their experiences. On the contrary, they were very concerned that they would add to their problems. In addition, some of the midwives discussed how various health recommendations regarding diet, alcohol, exercise and smoking, could potentially cause women to feel restricted regarding what they are allowed to do whilst pregnant. A small number of the pregnant women also mentioned the restrictions they face during pregnancy and one woman in particular felt that this was

one of her main reasons for continuing to smoke. Nonetheless, the participant in question still felt that pregnant women should receive smoking cessation advice from their midwife though in a non-pressurising manner.

Both the midwives and the pregnant participants discussed that pregnant women who do not perceive the fetus to be real are less likely to find motivation to stop smoking or to acknowledge the health risks associated with smoking during pregnancy. Previous evidence has also supported this suggestion (e.g. Dejin-Karlsson et al., 1996; Solomon & Quinn, 2004). The perception of the baby as non-existent could be due to various reasons including not being able to actually see or connect with the baby, the pregnancy being in the early stages, having an unplanned pregnancy, not considering or caring for the baby, not wanting to be pregnant or avoiding considering the future.

b. Pregnancy as a Facilitator to Quitting

On the other hand, many of the women expressed that pregnancies can facilitate quit attempts. It was acknowledged that the pregnancy can function as a weighty reason to stop smoking and can serve as an ideal time to change ones smoking behaviour. Most of the participants had cut down on cigarette consumption regardless of whether they wanted to be completely abstinent or not. As previously discussed, the guilt that pregnant smokers might experience due to their habit was perceived as a barrier as well as a facilitator to stopping smoking. Although feelings of guilt could be unhelpful and destructive in changing ones smoking behaviour, it was also recognised that a small amount of guilt could encourage pregnant smokers to quit. Additionally, as women might suffer from sickness during their pregnancy and some are repulsed by the smell and thought of cigarettes, this could also facilitate a quit attempt. A few of the women also mentioned that they wanted to stop

smoking during pregnancy in time for when the baby is born. Nonetheless, as McLeod et al. (2003) pointed out, it was appreciated that the pregnancy itself might not be enough to stop smoking for all.

The findings regarding the pregnancy itself as a facilitator as well as a barrier to quitting and approaching stop smoking services were at times conflicting. The varied perceptions seemed to differ between but also within the pregnant women. Even though pregnancy was descried as the perfect opportunity to quit, it was also perceived as a barrier to quitting. The findings illustrate the different perspectives of pregnant women but also the ambivalence they might face with regards to their habit and the complex nature of smoking as a behaviour. In addition to perceiving similar barriers to changing their behaviour as other smokers do, pregnant women might also be dealing with challenging issues related to the actual pregnancy. If the pregnant smokers themselves encounter these difficulties with regards to their behaviour, it is hardly surprising that midwives perceive barriers to providing advice, that uptake of stop smoking services among pregnant women is low and that smoking cessation interventions for pregnant women show modest results.

5.6.5 Health Effects of Smoking

The risks associated with smoking during pregnancy were given as a robust reason for stopping smoking among the pregnant women. This has been confirmed in previous studies (e.g. Owen & Penn, 1999). The health effects of the baby as well as the women's own wellbeing were perceived as facilitators to quitting during pregnancy. Some of the midwives felt sceptical about the point of providing advice as they felt that pregnant smokers are already aware of the fact that smoking during pregnancy is harmful and yet continue to smoke. This was therefore identified as a barrier to providing advice. However, a concept that emerged both during the focus

groups and in some of the interviews was that awareness of the adverse health effects related to smoking during pregnancy does not guarantee smoking cessation. Haslam et al. (1997) found that knowledge of risk was not a predictor of stopping smoking during pregnancy. However, in line with previous research (Walsh et al., 1997b), the present study revealed that midwives and pregnant women alike acknowledge that many pregnant smokers exhibit insufficient knowledge regarding the health risks associated with smoking during pregnancy. Although most pregnant smokers are aware of the fact that smoking can cause detrimental health outcomes, they do not appear to possess adequate knowledge or acceptance of the specific risks. In addition, the interviews implied that pregnant smokers are insufficiently knowledgeable of the health risks related to secondhand smoke which has also been noted in previous research (e.g. Fingerhut, Kleinman & Kendrick, 1990; Owen & Penn, 1999).

Haslam and Draper (2001) found that although the majority of pregnant smokers are aware of the health risks associated with smoking during pregnancy, the knowledge is not enough to trigger a quit attempt due their own and other smokers' previous uncomplicated pregnancies and healthy babies. Other research has also found that the disbelief or lack of awareness of the health risks can be a consequence of other pregnancies resulting in healthy babies despite the mother smoking throughout her pregnancy (e.g. Abrahamsson et al., 2005; Haslam & Draper, 2001; Hotham et al., 2002). Subsequently, some women might hold the belief that the health hazards will not affect them or their child (Haslam et al., 1997). The present study supports these findings as midwives frequently mentioned that pregnant smokers find it hard to appreciate the severity of the health risks due to their own or others' experiences of healthy babies despite smoking throughout pregnancy. This

was also discussed in the interviews as many of the pregnant smokers considered their experiences to contradict smoking cessation messages. The women's scepticism of the health outcomes of smoking could also have been associated with the concept of unrealistic optimism as smokers tend to underestimate the adverse effects of smoking in relation to their own health (Weinstein, Marcus & Moser, 2005). The insufficient awareness regarding the detrimental health risk of smoking during pregnancy was also perceived as relating to the lack of unambiguous information offered to pregnant women. Although there appears to be conflicting findings regarding level of knowledge as a predictor of smoking cessation among pregnant women, some studies have identified a link between lack of knowledge of health effects and smoking during pregnancy (e.g. Ershoff et al., 2000a; Secker-Walker et al., 1996). Therefore, increasing awareness might encourage pregnant women to stop smoking and consequently attend stop smoking services.

5.7 Information Regarding the Health Risks of Smoking during Pregnancy

A common opinion among the pregnant smokers was that there is insufficient information about the health risks related to smoking during pregnancy. One woman pointed out that if more information existed for the general population, a higher proportion of women would quit smoking prior to or in the early stages of pregnancy. Some of the women admitted that information or advertising of the negative effects of smoking might lead to undesirable outcomes such as choosing to ignore the information, not believing the content of the message or continuing to smoke. However, some of the adverts regarding smoking cessation also encouraged the pregnant women to reflect on their habit. Although it was recognised that it is difficult to find the balance between providing information about the adverse effects of smoking during pregnancy without scaring women, many conveyed that they

would prefer to receive more specific information as they possessed an inadequate amount of knowledge regarding the risks.

In line with previous research, a perceived barrier to providing stop smoking advice among midwives was lack of patient education aids (e.g. Bishop et al., 1998; Lindsay 2001). Using resources specifically tailored for pregnant smokers has been found to enable midwives to discuss smoking cessation with their clients (Pullon et al., 2003). The current study highlighted the potential benefits of using visual material. The midwives as well as the pregnant smokers explained that they would appreciate more visual aids in providing and receiving stop smoking advice respectively. Posters, leaflets and cards were mentioned as resources that could help midwives explain the effects of smoking during pregnancy and offer stop smoking advice.

5.8 Stop Smoking Advice from Health Professionals

Although the pregnant smokers mentioned different aspects of stop smoking advice as useful, all of the women who had received advice valued the information provided. The main criticism regarding smoking cessation advice centred on the insufficient amount of information provided. Other studies have confirmed that smoking is not covered to a great extent during a woman's antenatal care (e.g. Haslam & Draper, 2001) and that pregnant smokers are dissatisfied with the advice offered as they would prefer to receive more information consistently throughout their pregnancy (e.g. McCurry et al., 2002). Although the women in the present study were generally happy with the advice they had received, there was a lack of follow up and some would have preferred their midwife to elucidate the health risks of smoking in pregnancy. They also conveyed that the advice provided was

frequently short of information regarding the stop smoking support available for pregnant women.

5.9 Stop Smoking Services for Pregnant Women

Due to the lack of research into pregnant smokers' perceptions, experiences and preferences of stop smoking services and NRT use during pregnancy (Lindsay, 2001; Ussher et al., 2004), the findings from the current study add valuable insight into this area. Lack of awareness of services was identified as one of the main barriers to approaching the stop smoking service during pregnancy. Although all of the pregnant smokers were aware of the existence of stop smoking services, most of them had no previous knowledge of what smoking cessation programmes entail, nor had they realised that specific support for pregnant women is offered. Many of the women criticised the fact that information and advertising highlighting stop smoking support for pregnant women was lacking. Misconceptions regarding NRT use during pregnancy and negative expectations of the stop smoking service were identified as potentially preventing pregnant women from accessing the service.

5.9.1 Expectations of the Stop Smoking Service

Similar to the findings of Ussher et al.'s (2004) study, most of the pregnant women preferred face to face individual smoking cessation support and they would not have agreed to attend group counselling. However, a number of the women had been under the impression that only group support was offered. Another negative expectation of stop smoking programmes was linked to their perceived ineffectiveness. The women also revealed that many pregnant smokers believe that they will be able to stop smoking without any support and will hence not require any help from the stop smoking service. The fear of being judged or pressurised into quitting was identified as another major barrier to attending the stop smoking

service. Some of the women expected to be reproached by the advisor or met with disagreement due to their failure to quit smoking despite being pregnant. This was identified as one of the main barriers to attending the service as two thirds of the women presumed this worry to be common among pregnant smokers.

Although the negative expectations of the service tended to outweigh the positive expectations, some of the women viewed the stop smoking service as a useful facility prior to attending the programme. The main reason that the women held optimistic beliefs about the service was that they expected it to increase their chances of stopping smoking. These findings are in line with Ussher et al.'s (2004) study, which indicated that a perceived benefit to attending the stop smoking service among pregnant women is the belief that it is more effective than giving up alone. Thus, there were conflicting perceptions regarding the effectiveness of the service as some women expected it to have limited benefits. This inconsistency appeared to signal individual differences between the women as well as a lack of awareness of stop smoking services. Ussher et al. (2006) identified that advice regarding cravings, medications and health risks of smoking was a perceived benefit of attending the stop smoking service. A number of the pregnant smokers in the present study mentioned that they had approached the service due to the expertise of the advisor. In addition, perceiving that the stop smoking programme was part of antenatal care and related to pregnancy was also a reason for uptake of the service. The fact that the midwife had referred the women added to the positive impression that the support and programme were tailored for them and their situation. The findings indicate that although pregnant smokers might not differ from the general population with regards to their smoking habit, they show preferences towards stop smoking support specifically tailored for pregnant women and their needs. It appeared that this was

mainly due to their fear of being judged, their feelings of embarrassment with regards to their habit and receiving expertise advice explicitly for pregnant women.

Nearly all of the requests that the pregnant women described would be useful elements to include in the support offered to pregnant smokers already exist as part of the service. Regular meetings, provision of encouragement, NRT use, sessions occurring in convenient locations and the option to access one to one or group support were mentioned and all of these are currently structures of the stop smoking programme. Attending regular appointments, receiving encouragement and obtaining NRT have previously been identified as benefits of the stop smoking service among pregnant women who smoke (Ussher et al., 2006). A good relationship with the advisor was also mentioned as a desirable component of a stop smoking programme in the present study.

5.9.2 Experiences of the Stop Smoking Service

Although a small number of the participants who had attended the stop smoking programme had encountered some negative experiences of the service such as a delay in getting an appointment or having to visit their GP in order to get an NRT prescription, these incidents did not appear as significant so they would prevent the women from approaching the service in the future. The positive experiences of the women who had used the stop smoking programme were depicted much more frequently and included the structure of the weekly support sessions, the support that was offered, monitoring of their and their babies' CO levels, their faith in the effectiveness of the programme and the option to use NRT. The women also valued the advisors with regards to their skill and knowledge as well as the support and encouragement they had provided. Even though the participants differed in relation to the preferred content of the interventions, i.e. the length of sessions and depth of

conversations, they were all satisfied with the support they had received as they felt it met their personal requirements. This highlights the benefits of tailoring the sessions according to the needs and requirements of pregnant women. The findings thus indicate that the negative expectations of the service outweigh the positive expectations among pregnant smokers who have not accessed the stop smoking service. However, among the pregnant smokers who have attended a stop smoking programme, the positive experiences prevail over the negative experiences. Most of the women conveyed that there was insufficient information about the stop smoking service for pregnant smokers, which might have contributed to the negative expectations of the service.

5.10 Lack of Information of Stop Smoking Services for Pregnant Women

Although the participants had some awareness of the NHS stop smoking services, knowledge of support specifically offered to pregnant women was scarce. This was identified as a major barrier to attending the service and thus a vital finding that could affect uptake of stop smoking services among pregnant women. Some of the women claimed that their unawareness of the fact that services provide tailored support for pregnant women had prevented them as well as other pregnant smokers form approaching the service. It was suggested that adverts should be transmitted on television specifying that support is available for pregnant women. In addition, the adverts were believed to be more effective if they include stories of pregnant women who have stopped smoking with the help of the service and messages that make women realise that there are other pregnant women who smoke. Possessing incorrect information regarding the services, such as believing that only group support is offered could also prevent women from approaching the service. Some of the women asserted that if their midwife had possessed and provided more information of the

support available for pregnant smokers, this might have increased their chances of seeking help from the service. A reason why midwives might offer insufficient information to their clients might be their own lack of awareness of smoking related issues.

5.11 Attributes in Providing Stop Smoking Advice

Lacking necessary attributes such as knowledge, skill and self-efficacy in providing stop smoking advice to pregnant women has been identified as potential obstacles in promoting smoking cessation among health professionals working with pregnant women (e.g. Bishop et al., 1998; Condliffe et al., 2005; Cooke et al., 1996; Lindsay 2001; Mullen & Holcomb, 1990; Pullon et al., 2003). This concept was also a recurring subject of the focus groups. Many midwives felt that they did not possess adequate knowledge, skill or confidence to provide effective advice to pregnant smokers. Their awareness of the stop smoking service and support offered to pregnant women as well as smoking specific issues was often perceived as deficient. The limited amount of information that some pregnant women perceived was provided by their midwife could therefore have been linked to the inadequate awareness of smoking related issues that the midwives held. Perhaps midwives, like pregnant women, are aware of the fact that smoking during pregnancy is harmful but do not realise the severity of the risks or the details of the health effects. If midwives acquired more knowledge of smoking related issues they might become increasingly likely to provide advice and offer more detailed information as requested by pregnant smokers. However, the midwives seemed to vary with regards to the amount of knowledge they perceived was required. This might have due to an uncertainty of what the advice should consist of and what they are expected to cover. Some midwives seemed to discuss smoking cessation in more depth and others only

covered the basic aspects such as identifying the smoking status of clients. The midwives also had different perspectives of the level of skill that was needed in order to provide effective advice. The perception among midwives that they do not possess effective counselling skills was identified in the present study. Many of the midwives described that a certain level of skill is required in order to discuss smoking cessation effectively with pregnant women. Level of confidence in providing stop smoking advice also affected midwives' perceptions of the task. Feeling that their awareness of smoking related issues and level of skill in discussing the topic are satisfactory could increase the likelihood of midwives confidently promoting smoking cessation to pregnant women.

5.12 Training in Smoking Cessation for Midwives

Some of the midwives discussed that they had gained more knowledge, skill and confidence in providing stop smoking advice to pregnant women as a result of attending level I training in smoking cessation. Level I training aims to teach health professionals to provide brief effective stop smoking advice to clients and to refer smokers interested in receiving support to local stop smoking services (Health Development Agency, 2003). Not all midwives had been level I trained and many of the ones who had undergone training felt that they would benefit from attending an update session. Lack of training was identified as one of the main barriers to providing stop smoking advice and undertaking training a potential facilitator. Level I training could address various factors that might prevent midwives from discussing smoking cessation. Training delivered to a high standard has the potential to significantly improve the quality of interventions as well as midwives' self-efficacy in promoting smoking cessation (Aquilino et al., 2003; Cooke et al., 1996; Lawrence & Haslam, 2007). Mullen and Holcombe (1990) stressed the importance of skills

training to enhance current practice of promoting health among health professionals. In order to increase health professionals' motivation to provide smoking cessation advice when working with pregnant women, other authors have recommended that training should aim to increase awareness of the effects of smoking during pregnancy (e.g. Aquilino et al., 2003) as well as knowledge of local stop smoking services and referral pathways (Condliffe et al., 2005). The present study supports these recommendations as the pregnant smokers required more information on the health risks of smoking as well as stop smoking services and the midwives felt their knowledge regarding these issues was limited.

Previous research has acknowledged the need to deliver training in educational settings to students to focus on skills development at an earlier stage (e.g. Lawrence & Haslam, 2007). Promoting public health issues effectively was a topic that some of the midwives felt had been absent during their midwifery training. As lack of training was perceived as a barrier to providing stop smoking advice, an increase in training sessions from an earlier stage of midwives' careers could act as a facilitator to promoting smoking cessation to pregnant women.

5.13 Midwives' Personal Experiences

Including training sessions to midwifery students or early during the career of midwives that focus on providing brief health behaviour change interventions might encourage midwives with no or little experience to implement stop smoking advice more routinely. Inexperienced midwives were believed to be less likely to provide stop smoking advice to their patients compared to more experienced midwives. Lack of substantial clinical experience was thus perceived as a barrier to providing advice. There is little previous research that has explored the link between midwives' personal experiences and their perceptions of providing stop smoking advice

(Lindsay, 2001). The present study also found that midwives who have previously been smokers use their experience when providing stop smoking advice to pregnant smokers. These midwives felt more able to show empathy with their clients. In contrast, many midwives who had no smoking experience found themselves unable to relate or comprehend the addiction of smoking. Bishop et al. (1998) also found that antenatal staff tended to feel comfortable using their own smoking experience as a tool in providing smoking cessation advice to pregnant women. Pregnant smokers' experiences of receiving advice have implied that the approach of care providers reflect their own smoking status (Hotham et al., 2002). Although one of the women in the present study appreciated the fact that her midwife had mentioned her own smoking history when providing advice, none of the pregnant women indicated that midwives lacking smoking experience would negatively affect the provision of smoking cessation advice. As discussed previously, a barrier that was identified with regards to providing stop smoking advice among midwives was their perceived inability to relate to their clients. The fact that the midwives who had no experiences of smoking found it hard to empathise with clients and promote smoking cessation confirms this concept. Increasing awareness of smoking related issues through training sessions could enable midwives to better comprehend pregnant smokers and consequently feel more comfortable providing advice.

5.14 Recommendations

Many of the barriers and facilitators identified with regards to both providing stop smoking advice and approaching the stop smoking service overlapped. Encouraging all pregnant smokers to change their habit is an unlikely achievement (Hamilton, 2001). However, the results of the study indicated that it is possible to overcome many of these barriers and emphasise the facilitators in an attempt

promote smoking cessation and stop smoking services among pregnant smokers. Although practitioners are not capable of helping every pregnant woman who smokes to change her habit, midwives in particular are indeed able to contribute towards reducing smoking prevalence rates in this population (Klerman & Rooks, 1999). Therefore, it is vital that midwives continue to provide stop smoking advice to pregnant women (Dunkley, 1997). The recommendations outlined below are based on the findings from the present study as well as conclusions from previous research.

Training for Midwives

It has been recommended that training should be delivered to all health professionals in an attempt to provide more comprehensive and consistent smoking cessation advice to pregnant women (Dunkley, 1997; McCurry et al., 2002). The findings from the present study suggest that for level I training to be effective it should be mandatory for all midwives, focusing especially to include inexperienced midwives who might be less likely to provide stop smoking advice to their clients. Regular update sessions should be implemented to keep midwives up to date and motivated to continue promoting smoking cessation. The training should aim to create realistic expectations of the outcome of the advice but simultaneously stress the importance and effectiveness of providing brief advice. Information regarding both the health effects of smoking and stop smoking services for pregnant women including NRT use should also be delivered to increase midwives' level of knowledge. However, the role of the midwives with regards to providing advice should be described both in relation to their responsibilities and limitations. Midwives should also be informed of the expected duration of advice and effective methods of discussing smoking cessation with women who accept as well as decline

support. Implementing role plays might be a beneficial method of practicing promoting smoking cessation and increasing level of skill and confidence in providing advice. The midwives should be educated about the addictive components of cigarettes and the link between stress and smoking. The content of the training should also aim to improve level of comprehension with regards to the perceptions and expectations of pregnant smokers in order to improve midwives' abilities to empathise with their clients. Midwives should be informed that the advice is unlikely to have a damaging impact on the relationship with their clients and they should be reminded of the importance of offering advice at every opportunity and not just during the initial booking session.

As hospitals also have a responsibility to play their part in helping women stop smoking during pregnancy, Lowe et al. (2002) insisted that barriers such as lack of staff training, appropriate resources and time can be overcome by appropriate administrative support and a restructure of time spent with pregnant smokers. Therefore, a nationwide review of midwifery services with regards to workload, time issues and staff shortages is also recommended in an attempt to support midwives in their role and increase their ability to provide health promotion advice to their clients.

Resources

Providing midwives with appropriate training and resources to deliver stop smoking advice is crucial in targeting pregnant smokers (Owen & Penn, 1999). Hughes et al. (2000) proposed that an additional amount of resources for pregnant smokers is required. The recommendations based on the findings from the present study suggest that midwives should be provided with appropriate resources tailored specifically for pregnant smokers. Resources such as leaflets should be offered to all

pregnant smokers. The resources provided to pregnant smokers as well as other material such as posters should include visual messages and information. The resources should be developed with the aim to help midwives approach the topic of smoking cessation and engage pregnant smokers in discussions. In addition, they should aim to increase pregnant smokers' knowledge of the health effects of smoking during pregnancy, raise awareness of smoking support for pregnant women and improve levels of self-efficacy in stopping smoking.

Targeting Pregnant Smokers

One of the main barriers to approaching stop smoking services among pregnant smokers was their lack of awareness of the support available for pregnant women. The pregnant smokers also felt that their knowledge regarding the specific health risks of smoking during pregnancy was inadequate. Therefore, raising awareness of stop smoking services specifically for this population and the health effects linked to smoking during pregnancy is crucial. Implementing mandatory level I training to midwives as mentioned above could improve provision of advice to pregnant smokers. The use of visual resources should be used by midwives to increase pregnant smokers' understanding of the health risks of smoking. The approach of health professionals should be non-judgemental and non-pressurising. However, information should also be provide to pregnant smokers as well as the general population through advertisements on television including pregnant women who have managed to stop smoking with the help of the stop smoking service and portraying the service as non-judgemental and non-pressurising. In an attempt to increase levels of self-efficacy and reduce feelings of embarrassment and guilt, the adverts should inform women of the support available for pregnant smokers, the effectiveness of the programme, the availability of one to one support and home

visits and the option to use NRT. Adverts on TV should also provide visual messages about the specific risks of smoking during pregnancy without being overly graphic and with the aim to inform rather than shock.

Interventions for Pregnant Smokers

NHS stop smoking programmes for pregnant women should continue with their current structure, i.e. establish and maintain regular contact with clients, provide encouraging one to one or groups support, offer home visits, include NRT use as part of the programme and monitor the CO levels of women as well as the baby's exposure to the gas. Referrals should be processed quickly and stop smoking interventions offered to women without delay. If possible, women should be able to obtain NRT without having to visit their GP. Teaching coping strategies to deal with stress and cravings should be offered as part of the interventions. The type of support and sessions (i.e. length and content) provided to pregnant women should accommodate their requests and needs. Pregnant smokers should be informed of the possibility to access the service with partners, friends or family members who should be encouraged to quit and attend sessions with the pregnant women.

Limitations of the Study

Recruiting participants for the research proved incredibly challenging. Arrangement of focus groups with midwives who have hectic working schedules was very difficult and two of the focus groups therefore consisted of a lower number of participants than intended. In addition, as the research ethics committee only approved for pregnant smokers to be approached through health professionals working with pregnant women, recruitment for the interviews mainly relied on midwives. The process of conducting a sufficient number of interviews in order to reach theoretical saturation was very time consuming and it is believed that the

problems of recruiting pregnant smokers to participate in the research was a result of midwives forgetting the research due to their workload and the small number of pregnant women being identified as smokers. Therefore, some of the pregnant smokers who were interviewed for the study had attended the stop smoking service for support. It would have been beneficial to include a higher number of pregnant smokers who had not or did not intend to stop smoking nor approach the service in the research. Only one of the participants did not want to stop smoking during her pregnancy and seven of the women had attended a stop smoking session. Therefore, pregnant smokers who do not want to stop smoking or access the stop smoking service were underrepresented and additional barriers to approaching the service could have been identified if a higher number of women who had not agreed to be referred to the service had been included. One of the main limitations of the study was therefore that pregnant smokers who were harder to reach and include in the study, hence less likely to change their smoking behaviour and approach stop smoking services, were excluded from the research. Similar problems have been encountered by other studies with this population (McCurry et al., 2002). Nonetheless, the perceptions and experiences of the pregnant women taking part in the research varied greatly and this range added to the richness of the data. Additionally, the challenges in recruiting participants for this qualitative study highlighted some of the obstacles that midwives face in providing stop smoking advice, such as lack of time, as well as the difficulties of targeting and identifying pregnant women who smoke.

Another limitation of the study was that the researcher who conducted the focus groups as well as the semi-structured interviews had or was going to support some of the pregnant women in their quit attempts. This might have had a negative

impact on their honesty of their perceptions and experiences of the service. Although this did not apply to all women, as the investigator was working for the stop smoking service, the participants might have perceived the interviewer as representing the service which might have affected their responses. The perception of the researcher as a stop smoking advisor might also have influenced the openness of the midwives, particularly if their perceptions of providing smoking cessation advice or the stop smoking service were negative.

Future Research

If the recommendations above are implemented, it would be useful to conduct similar research in the future to explore the impact of the changes with regards to perceptions of stop smoking services and provision of smoking cessation advice among pregnant smokers and midwives in the borough. Uptake of stop smoking programmes by pregnant women as well as the effectiveness of interventions should also be investigated. Future research attempting to include a larger number of pregnant smokers who have not accessed the stop smoking service is needed. Additionally, exploring the views of pregnant smokers and midwives should be carried out in other areas of the country as the current study only included participants from one borough of London with high levels of deprivation. Methods of targeting and supporting pregnant smokers as well as issues related to midwives such as training might differ in other areas of the country. This sample is therefore unlikely to be representative of the nation as a whole.

Conclusion

The study adds valuable insight into how midwives perceive providing stop smoking advice to pregnant women and how pregnant smokers perceive the stop smoking service. Although midwives are more likely to perceive barriers than

facilitators to promoting smoking cessation, many of the barriers could be overcome by implementing effective training. Some of the perceptions that midwives hold towards provision of advice compare to the perceptions of pregnant smokers with regards to receiving advice. However, women expect and appreciate the advice offered by their midwife. Smoking during pregnancy is a complex behaviour due to the influences of pregnancy as well as non-pregnancy specific factors. Young women are likely to face additional challenges during pregnancy which could influence their smoking behaviour. Pregnant smokers' negative expectations of stop smoking services outweigh the positive expectations. However, the negative perceptions are mainly due to a lack of awareness of services as the experiences of stop smoking programmes tend to be positive. Uptake of stop smoking services among pregnant women could be increased by raising awareness of the support available for pregnant smokers.

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SECTION C

PROFESSIONAL PRACTICE

Unit 1 Generic Professional Competence

Working as a Health Psychologist in Training within an NHS Stop Smoking Service

WORKING AS A HEALTH PSYCHOLOGIST IN TRAINING WITHIN AN NHS STOP SMOKING SERVICE

I have been able to develop as a health psychologist in training through my work at a stop smoking service at a National Health Service (NHS) Primary Care Trust (PCT).

Implement and Maintain Systems for Legal, Ethical and Professional Standards in Applied Psychology

As a member of the British Psychological Society (BPS) and an employee of the NHS, implementing and maintaining high legal, ethical and professional standards in my work has served as a vital part of my role. I familiarised myself with the BPS Code of Conduct (2000) and my responsibilities at the PCT in the beginning of my employment and attended a mandatory induction at the trust which further clarified the legal and ethical requirements of the NHS. As part of my continuing professional development (CPD), I have kept abreast of new editions of relevant publications such as the BPS Code of Ethics and Conduct (2006) and abided by the four ethical principles; respect, competence, responsibility and integrity. I have followed the guidance by valuing the dignity of persons, aspiring for professional development yet acting within my professional boundaries, recognising my responsibilities and seeking to promote integrity (BPS, 2006). In addition, I have protected the confidentiality of clients and research participants alike and I have followed the appropriate personal conduct including valuing psychological evidence. I have processed personal data by adhering to the guidelines of the BPS as well as the Data Protection Act (1998). My work at the stop smoking service has been carried out at a password protected computer and I have ensured that all confidential records with client information, details of the participants of my research and audio

recordings have been securely locked away and that written consent has been obtained from clients and research participants. The Central Office for Research Ethics Committees (COREC) (renamed National Research Ethics Service (NRES) in April 2007) which aims to protect the safety, dignity and well-being of research participants (National Patient Safety Agency, 2007) approved my research and accompanying documents. In addition, relevant research and development departments provided favourable approvals of my research.

One imperative aspect of my role as a health psychology supervisor for two health trainers has been to ensure that the health trainers have undertaken their tasks in accordance with clinical governance (Scally & Donaldson, 1998). Thus, health psychology supervision meetings have been held on a monthly basis and I have observed the health trainers provide health behaviour change interventions. As the lead for level II training days in smoking cessation, I have made certain that the training has complied with the Health Development Agency (2003) standard requirements.

Reflection on Implementing and Maintaining Systems for Legal, Ethical and Professional Standards

Although various aspects of the implementation and maintenance of legal and ethical standards in applied psychology are palpable, one must ensure professional standards are followed by continuously reflecting on ones practice. The BPS (2006) encourages reflection of ethical dilemmas as it states that the Code of Ethics and Conduct cannot address every aspect of ethical challenges. The ability to reflect on ethical issues is a skill that I became increasingly accustomed to as I gained more professional experience. As abiding by legal, ethical and professional standards is such an integral part of the role of a health psychologist in training, in the beginning

of my employment I attempted to compensate for the lack of experience by seeking advice from supervisors and preparing for potential ethical dilemmas to arise. By gaining more experience, my level of knowledge and confidence regarding ethical issues simultaneously increased. However, as the consequences for making a misjudged unethical decision can be far more severe than other minor work related mistakes, I continued to seek regular advice from my supervisor throughout. It is crucial to appreciate the significance of the appropriate guidance as abiding by them might result in additional time consuming work and a delay of procedures. For instance, as a researcher I was required to document all changes to my research to the research ethics committee for approval, including minute amendments.

Although the BPS and the NHS are governed by similar ethical guidance, that is, they share the aim of protecting the best interest of clients and patients, they approach these goals from different standpoints. Compared to the BPS, the NHS is a massive organisation which is driven by targets and whose decisions, as a state run service, may be more greatly affected by the availability of finances. The two organisations might not have conflicting interests, but the NHS, alongside ensuring ethical procedures, also place great value on the volume of treatments and outcome. As an NHS employee and member of the BPS, I must be aware of this issue and continue to reflect on it constructively throughout my practice.

Contribute to the Continuing Development of Self as a Professional Applied Psychologist

The rich variety of tasks I have been assigned to undertake as a health psychologist in training at the stop smoking service have enabled me to continuously develop towards becoming a chartered health psychologist. My role has not been limited to working only as a specialist stop smoking advisor; indeed, my duties have

extended to being a trainer, researcher, consultant and health psychology supervisor. I have attended various health psychology and tobacco conferences and I have been encouraged to promote health psychology by adding elements of the field into events and projects I embark on, e.g. training sessions, health equity audits and evaluations. Through my numerous responsibilities, I have been able to develop in a variety of areas of knowledge and skills including; organisational cultures, time management and stress management, valuing diversity, problem solving, creativity, empathy and competence.

I have had the opportunity to work both as part of a team and individually and my communication skills have improved greatly through partnership work and in correspondence with individuals from various professional backgrounds. Working with others has been argued to be an essential component of both personal (Key Skills Support Programme, 2005) and professional development (Allin & Turnock, 2007). Allin and Turnock (2007) claimed that working in a team has the potential to improve efficiency, identify valuable areas of skill and knowledge, increase energy and creativity and enhance communication. Job related success has been associated with good communication skills, which can be developed through maturing self-awareness and self-knowledge as well as recognising and learning non-verbal cues. Those possessing high communication skills tend to demonstrate excellent self-monitoring skills and are able to adjust their own behaviour frequently according to the reactions of others (Dixon & O'Hara, no date). Unambiguous communication is a necessary ingredient of assertiveness which involves; communicating clearly, calmly, confidently and positively as well as establishing and maintaining boundaries, possessing negotiation and listening skills and being able to receive and provide feedback (BUPA, 2004). Effective listening can be consciously developed at

a workplace through telephone conversations, meetings, supervision sessions and even informal chats. This active, psychological process requires concentration and effort; however, it contributes to the process of identifying meaning to the communicated information (Dixon & O'Hara, no date).

Reflection can occur as part of a discussion or by keeping a reflective diary (Fade, 2005). By completing my practice and reflection logs, regularly meeting with my workplace supervisor and educational supervisor, attending both clinical and health psychology meetings and viewing recordings of presentations I have delivered, I have learned to continuously criticise and improve my skills and knowledge. Fade (2005) outlined reflection as a process involving describing, analysing and evaluating thoughts, assumptions, theories and actions, enabling practitioners to develop through learning experiences and improve practice. Self-awareness, which relates to the informative state of ones character, including beliefs and values as well as uncomfortable emotions and thoughts, and the ability to analyse critically and view a situation from a different angle form the framework for reflection (McClure, 2005).

Reflection on the Continuing Development of Self as a Professional Applied Psychologist

Gaining an accurate perception of my unusual position of being a full time student as well as an employee did not occur instantaneously. During the initial few months of my employment, both my educational and workplace supervisor recurrently reminded me of the linkage between the doctorate course and my job and that my identity should be as a health psychologist in training and not merely a stop smoking advisor. In due course, I became comfortable and clear with my position; however, the process was not as straightforward as I might have expected. I

continuously had to reflect on my role and make a conscious effort to distinguish health psychology within the tasks I performed. McClure (2005) stated that reflection is a critical aspect of learning and effective practice. However, developing the ability to reflect is not a haste process. Prior to beginning the DPsych Health Psychology studies, I had not been requested to reflect on my practice and although I did not find it very difficult to cognitively reflect, the challenge related to documenting my thoughts. This challenge was confronted by reflection on my practice through logbooks on a weekly basis as well as completion of case studies for the health psychology doctorate programme.

One of the most demanding aspects of my professional development as an applied psychologist has been to increase my level of confidence. I had not previously worked in the NHS and numerous tasks I have carried out during the two years at the PCT have been new assignments. Although rewarding, this has not only continuously compelled me to build upon my skills and knowledge, but also my level of confidence. At the stop smoking service, I was able to observe events prior to undertaking them, e.g. stop smoking interventions, level II training days and update sessions, and this was an enormous aid in my learning process. By observing and then doing, my level of confidence was slightly higher and as a consequence I felt more at ease and was less nervous than I would have been without the opportunity to observe.

While I have been able to develop all aspects of my communication skills at the service, I experienced that improving areas of active listening, self-awareness and the ability to comprehend and respond to non-verbal cues was fairly straightforward. The most problematic part of communication has been for me to become assertive. The aspects of assertiveness most in need of improvement have

been speaking confidently, establishing and maintaining boundaries and providing feedback. By holding presentations on several occasions, I have been able to develop the ability to speak confidently in front of a large number of people and through my role as a health psychology supervisor, I have improved my abilities to provide feedback and to establish and maintain boundaries. Despite the fact that I have learned a great deal through practice, I have also continued to reflect on my strengths and weaknesses to further develop these skills.

Provide Psychological Advice and Guidance to Others

Through my work at the stop smoking service, I have offered psychological advice and guidance to clients and health professionals alike. The stop smoking interventions I have provided include elements from motivational interviewing, which is based on encouraging people to make long-term behaviour changes (Miller & Johnson, 2001). The advice and guidance I have offered to clients have comprised of; weighing up the pros and cons of stopping smoking (Rosenstock, 1990), action planning (Sniehotta, Scholz & Schwarzer, 2005), rewards (Skinner, 1969), self-monitoring, developing coping strategies and boosting self-efficacy (Bandura, 1998). These elements were incorporated in order to increase motivation (Rosenstock, 1990), improve the chances of participating and adhering to behaviour change (Skinner, 1969) and enhance the chances of successfully stopping smoking (Bandura, 1998). During the intervention sessions, discussions were held regarding which methods the clients regarded as the most suitable and effective.

As a health psychology supervisor for two health trainers, I have regularly provided guidance and advice in the monthly one to one meetings. Allin and Turnock (2007) claimed that supervisors are responsible for facilitating the learning of their supervisees and that they need to possess a clear comprehension of how to

utilise power, influence and authority. Thus, in providing advice and guidance during the supervision meetings, rather than employing a didactic style, I focused on encouraging the health trainers to discuss and reflect upon their experiences and to review outcomes in subsequent meetings. McClure (2005) believed that the supervisory relationship is key in assisting supervisees in becoming reflective practitioners and that honesty and openness are pivotal for effective supervision and reflective practice.

My duties also included training various health professionals to become stop smoking advisors and supporting them in their role. The advice and guidance provided to the trainees during the training days was derived from effective evidence based methods for supporting clients in their quit attempt. By undertaking pieces of consultancy, such as analysing data from a counterfeit cigarette campaign and making future recommendations and improving the uptake of pregnant women who smoke to the stop smoking service, I provided psychological advice and guidance to my consultancy clients based on the findings from the pieces of work I undertook as well as evidence from psychological research and theories.

Reflection on Providing Psychological Advice and Guidance to Others

As a newly employed health psychologist in training at the stop smoking service I did not feel particularly confident in my ability to provide psychological advice and guidance to others. This applied especially to my role as a health psychology supervisor for health trainers who had more experience in providing interventions than I did. However, although I learned a significant amount through practical experience of both providing interventions and acting as a supervisor, I realised that my fundamental background and knowledge of health psychology

enabled me to employ skills and knowledge that were of immense value for the development of the health trainers and client care alike.

I found that a vital aspect of providing psychological advice and guidance was being aware of my responsibilities and limits and accepting these. Occasionally, clients receiving stop smoking support required help with various other issues, such as depression, physical illnesses or weight problems, and they expected my role, perhaps due to my job title, to extend to focusing on other areas like mental health. I did not offer any advice or guidance regarding areas that were not within my remit and I always attempted to be clear about what my role entailed and did not entail, e.g. I was not a clinical psychologist or a dietician. Rather, I advised these clients to seek support from, or I directly referred them, to appropriate health professionals. Informing clients that I was unable to provide the support that they expected could be daunting as some clients became quite reliant on the professional relationship that had been established. However, with experience I was able to describe my role more clearly to clients during the initial intervention session and I became more comfortable discussing boundaries.

Provide Feedback to Clients

The provision of feedback during processes of health behaviour change interventions can lead to rewarding outcomes such as; disclosure of valuable information, a caring and helping relationship and an increase in motivation and engagement. Feedback can range from simple advice relevant for the general population, to tailored messages for a certain group of people to personalised feedback (DiClemente, Marinilli, Singh & Lori, 2001). I have provided generic feedback in terms of advice to stop smoking on several occasions by; distributing smoking cessation leaflets and other promotional material during events such as No

Smoking Day, advertising the stop smoking service by taking a health bus to different locations in the borough, handing out leaflets with information about stop smoking clinics to the public and attending and holding presentations at various events. As a lead for HIV/AIDS and smoking I have held presentations for staff as well as patients at HIV clinics to provide more specific feedback on smoking and HIV and I have contributed to creating a leaflet tailored for the HIV positive population who smoke. During stop smoking interventions I have provided personalised feedback to clients relating to their individual quit attempt including aspects of changing their behaviour or personalised risk factors.

Feedback is a vital element of learning and development (Fade, 2005). Personal functioning is acquired through the regular provision of unambiguous feedback in a supportive and caring manner (Vasquez, 1992). Ende (1983) claimed that the process of providing feedback has the potential to improve performance through reinforcement of good practice, correction of mistakes and the facilitation of professional development. Effective and constructive feedback utilises various skills, such as active listening and communicating in an objective and precise language about a person's performance. (Dixon & O'Hara, no date). I have had the opportunity to provide both informal and formal feedback to individuals. Informal feedback can be provided without pre-arrangement and it forms a general part of practice development (McClure, 2005). The smoking cessation training days for health professionals consisted of various interactive activities such as role-plays and I provided trainees with informal feedback of their performances during these sessions. Additionally, I provided feedback to level II stop smoking advisors regarding their skills and knowledge of providing smoking cessation support during update sessions and visits at their workplace. The health psychology meetings with

health trainers were based on formal supervision, which refers to the provision of pre-arranged and regular feedback (McClure, 2005). The written and verbal feedback that was given to the health trainers was based on observations of interventions and their clinical performances.

McClure (2005) suggested that negative feedback should be; delivered in an accepting environment shortly after the problem has been identified, documented and include the establishment of objectives. Providing negative feedback is more likely to be problematic than giving positive feedback (Dixon & O'Hara, no date). This might be due to a fear of the reaction of the receiver of the feedback, as the provider of feedback might be concerned that any negative feedback will be taken personally and consequently damage the relationship or cause tension in the workplace. Additionally, the supervisor might feel that they do not possess sufficient evidence to back up their comments and they prefer to adopt a supportive rather than a judging role. Avoiding negative feedback might therefore result in feedback being offered in an ambiguous manner, leading to misunderstandings, or even complete avoidance of any negative aspects. Feedback given correctly is likely to motivate development and improvement and be appreciated by the receiver (Dixon & O'Hara, no date; Ende, 1983).

Reflection on Providing Feedback to Clients

Regardless of whether I have provided generic, population specific or personalised feedback, it has confirmed the benefits of the process. Generally, individuals have shown appreciation when receiving feedback and I have been able to use it as a tool in educating and increasing motivation in health behaviour change. This outcome was contrary to my initial expectations, which erroneously predicted that the majority of people would react negatively or defensively to feedback.

As part of my DPsych course and my work at the stop smoking service, I have received regular feedback regarding my own performance from both my educational and work supervisor. I believe that experiencing the process of receiving feedback has enabled me to develop the skills of providing feedback. However, I certainly noticed that as a new supervisor, I found it much harder to provide negative rather than positive feedback during the health psychology meetings with the health trainers. As a consequence of being excessively concerned about the reactions of the supervisees, I possibly provided rather ambiguous feedback of the observations of the health behaviour change interventions. Due to being very aware of this area in need of improvement, I focused on preparing for the feedback sessions, presenting objective and clear information and utilising both verbal and written feedback during the sessions. In addition, I ensured that the health trainers had the opportunity to comment on the feedback and that we discussed and agreed on future objectives.

Overall Reflection

I have constantly faced new challenges in my role as a health psychologist in training. I have developed immensely both professionally and personally through my employment at the stop smoking service and as a student at the DPsych Health Psychology course. Not only have I vastly increased the extent of my knowledge and skills during my two years as a health psychologist in training but I have also found that my level of confidence has been boosted significantly as a result. The route to becoming a chartered health psychologist has been and remains demanding. However, without its challenges, the accomplishments would not have been as richly rewarding.

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Unit 3 Consultancy

How a Stop Smoking Service Could More Effectively Target Pregnant Women Who Smoke

HOW A STOP SMOKING SERVICE COULD MORE EFFECTIVELY TARGET PREGNANT WOMEN WHO SMOKE

Assessment of Requests for Consultancy

The 1998 government White Paper "Smoking Kills" outlined the problems associated with smoking and the aims for reducing smoking prevalence rates. One of the national targets set was to reduce the percentage of women who smoke during pregnancy from 24% to 15% by 2010 (Department of Health, 1998). Each year, specific local targets are set for the proportion of women smoking at delivery. The percentage of pregnant women smoking at delivery in the borough where the consultancy took place had been higher than the set target during the previous financial year. Therefore, the National Health Service (NHS) Smokefree Service in the Primary Care Trust (PCT) of the borough aimed to increase referrals from pregnant women so smoking cessation support could be provided to a higher number of pregnant smokers early in pregnancy and consequently reduce the proportion of women smoking at time of delivery. The work for this consultancy Case Study follows the concepts and general approach described by Schein (1999).

I was approached by the Head of the Stop Smoking Service who enquired whether I would be interested in providing consultancy in a project aimed at increasing referrals from pregnant smokers. A meeting was consequently arranged and attended by myself, a specialist stop smoking advisor for pregnant women and families and the Head of the Smokefree Service. The objectives of the exploratory meeting were to identify what the problem was, to explore my role and involvement and to discuss potential actions. During the meeting, the specialist advisor, who was identified as the client, described the overall aim of the consultancy. As part of the

meeting a discussion was held regarding how to achieve the aim through objectives. It was decided that I would conduct a report with recommendations on how to increase uptake of the stop smoking service based on the work that the consultancy would entail. By the end of the meeting, we concluded that I would review appropriate literature and information and both the client and myself would consider further the tasks involved in the consultancy and the time frame required to complete the project. We discussed various possibilities including carrying out research with pregnant women and midwives, reviewing the effectiveness of smoking cessation interventions for pregnant smokers and investigating how other stop smoking services target pregnant women who smoke (see Appendix 1 for the minutes from the meeting).

Prior to the subsequent planning meeting, I investigated how the service was currently targeting pregnant women and the support that was offered to pregnant smokers approaching the service. In addition, I reviewed psychological research and evidence in the field of smoking among pregnant women and I considered the practicalities of undertaking the proposed tasks. In my assessment of the proposed consultancy, I concluded that it was a feasible project but that the work would be very time consuming. I realised the importance of discussing this with the client during our next meeting to clarify the complexity of the tasks.

Reflection on the Assessment of Requests for Consultancy

Organisations can require help from consultants to manage temporary work pressures and to utilise the skills of a consultant that are not available in the service (Boulton, 2003). The current stop smoking team was restricted in their capabilities to solve the problem the client faced due to limited time and resources. In addition, the client did not possess a psychology or research background and thus felt that she

would benefit from receiving help from a health psychologist. Schein (1999) recommended that exploratory meetings should be attended by a person who possesses the capability to influence the organisation, an individual who owns a problem and requires help and a person who is familiar with and recognises the value of consultancy work as well as comprehends the need for the client to be active in the consultancy project. The specialist advisor was identified as the person who perceived barriers in her work and the head of the stop smoking service held a high position in the organisation and possessed a vast amount of experience in consultancy work.

According to the process consultation model, although clients appreciate that there is need for improvement, they are unable to comprehend the fundamental problem and they are unaware of how consultants can be of assistance or how to improve the situation (Schein, 1999). The client was unable to explain the reason behind the low uptake of the stop smoking service by pregnant smokers. Although she possessed some thoughts around research ideas and evaluating the evidence from research studies, the proposition of conducting a systematic review and carrying out research with pregnant smokers to identify how they perceive the stop smoking service was received with interest as the client had not been aware of these options nor did she possess the skills to carry them out. However, in the beginning of the initial consultancy meeting, the client appeared to adopt the doctor-patient model (Schein, 1999). She seemed to expect my role to include diagnosing the problem, providing recommendations as well as delivering the action. In reflection, I also reinforced this relationship as I allowed the client to determine the process mode.

Prior to the meeting, I had ruminated on the consultancy tasks. However, I realised that I had not contemplated communication models between the client and

myself. As I was new in my role as a consultant, it would have been beneficial to reflect on these issues preceding the meeting and to assess the appropriate relationship. Schein (1999) argued that one of the first responsibilities of a consultant is to create an equal relationship. As the meeting progressed, and indeed as the project developed, I adopted the process consultation model as a base for the relationship and the consultancy project as a whole. My client's approach to the project, her position within the organisation, our previously established relationship, the nature of the consultancy as well as my own personal preferences towards the model all contributed towards the decision to employ the model in question. In future consultancy work, I will attempt to identify an appropriate model for establishing the client-consultant relationship at an earlier stage.

Plan Consultancy

During the planning meeting, attended by the client and myself, we clarified the consultancy tasks that had been discussed during our previous meeting: carrying out research, conducting a systematic review, contacting other services to identify how they target pregnant women who smoke and undertaking a review of health psychology evidence in targeting pregnant smokers. The work was agreed and I described the proposed time frame for completing the project. I specified that carrying out research and conducting systematic reviews are complex pieces of work that require time and dedication and that regular meetings with the client will be vital in undertaking the consultancy. The client agreed to the proposition and she recognised the importance of holding regular meetings. As she possessed a great amount of knowledge and experience of the stop smoking service as well as other departments of the NHS, her input would be invaluable in carrying out the consultancy work. Additionally, the client evidently comprehended the weighty

work that the project would involve (see Appendix 2 for the minutes from the meeting). Based on the meeting, I composed a contract in which I outlined the aim and objectives of the consultancy, the tasks that I would carry out, the time frame for the project and the projected cost (that the client was not required to pay on this occasion). The client was satisfied with the content and signed the contract (see Appendix 3).

Reflection on Planning Consultancy

The most vital elements of consultancy are the assessment and planning stages (Dryden, 2004). However, consultants as well as clients are influenced by psychological factors such as feelings, motives, intentions, attitudes, expectations, definitions and images of oneself, others and situations. Therefore, consultants are incapable of detecting the absolute truth and formulating a diagnosis on their own. A diagnosis is thus best made jointly by the consultant and the client (Schein, 1999) as a mutual agreement of the problems and potential solutions combined with a sound relationship form a vital basis for the planning stage (Earll & Bath, 2004). Consultancy has been defined as "a formal relationship where one party seeks help from another, the consultant's role being to facilitate the process whereby both the consultant and client arrive at a mutually acceptable solution" (Earll & Bath, 2004, pp. 230-1). Both the client and I seemed to have an impact in assessing and planning the consultancy work and we arrived at the action points collectively. I believe that a vital factor of the positive outcome of the planning stage was the sound relationship that had been established. Earll and Bath (2004, p. 234) pointed out that in consultancy, the objectives must be "specific, measurable, achievable, realistic and timely" and that the effectiveness of the outcome of a consultancy project is reliant on the transparency of the original objectives. In retrospect, certain aspects of the

consultancy project proved incredibly challenging to undertake, such as recruiting participants to take part in the research. A more specific diagnosis might have been the key in carrying out those tasks with less effort and in a shorter time frame.

Establish, Develop and Maintain Working Relationships with the Client

As the consultancy client and I worked in the same department of public health, we established contact early in my employment. However, the consultancy process encouraged the relationship to shift from a colleague-based partnership to a client and consultant relationship. The specialist stop smoking advisor was the intermediate client as well as the primary client in the consultancy project, as she attended all relevant meetings and generally owned the problem (Schein, 1999). The relationship with the client was maintained through effective communication and recurring meetings. Face to face meetings occurred on a regular basis, however, contact was also held through telephone calls and e-mails. The client was kept informed of the process of the consultancy as well as any challenges faced.

Reflection on Establishing, Developing and Maintaining Working Relationships with the Client

In order for the consultant and the client to be able to co-operatively assess aspects of the consultancy project and make improvements, an effective helping relationship has to be established. A sound relationship between the consultant and the client is therefore fundamental in the consultancy process (Schein, 1999). The relationship between the client and I had been respectful and supportive prior to the commencement of the consultancy project and this sound base was maintained throughout the process. In addition, a willingness to help each other was continuously apparent in the rapport. The challenges, though, lay in adopting our new roles as client and consultant. The client had to accept that I was the helper and I

needed to acknowledge that despite being part of the stop smoking service and possessing a strong desire to help, I did not own the problem. In addition, as Schein (1999, p. 95) elucidated, I had to "learn to access my ignorance" and avoid basing my expectations on past experience but remain objective throughout the process. This certainly applied to the project, as I knew my client beforehand and was already based in the organisation. Throughout the process, I learned that there were many aspects of the organisation as well as the client's situation that I was unaware of. Progressively I recognised the significance of bearing this in mind and ensuring that I explored various avenues throughout. Regular communication in combination with clearly defined objectives and directions enabled us to transform into and sustain a working relationship. Effective relationships are established, developed and maintained through receiving feedback and advice that the client provides and taking action following the appropriate suggestions (Earll & Bath, 2004).

Conduct Consultancy

One task within the consultancy was to conduct qualitative research with pregnant smokers to identify perceived barriers and attractiveness of stop smoking services and with midwives to identify their perceived barriers of providing stop smoking advice to pregnant women who smoke. Prior to commencing the research, ethics approval was sought from the appropriate research committees and trusts. The tapes of the focus groups with midwives were transcribed and the findings analysed. However, due to unforeseen challenges faced in recruiting pregnant smokers to take part in interviews, all interviews had not been undertaken and analysed by the consultancy deadline. A systematic review was conducted to evaluate the effectiveness of smoking cessation interventions for pregnant smokers. The review assessed whether time of pregnancy or type of smoker had an impact on the

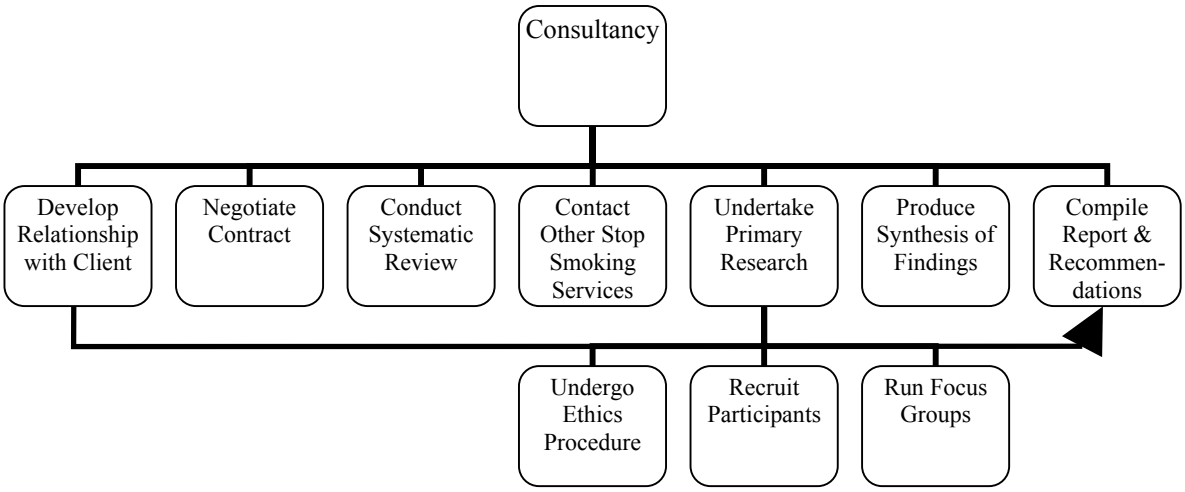
effectiveness of stop smoking programmes for pregnant smokers. Three stop smoking services in London were identified as suitable for the consultancy and meetings were arranged with advisors working with pregnant women. The services were selected through existing contacts and due to the fact that the client had no previous experience of working with the identified boroughs. The aim of the meetings was to identify alternative effective methods of targeting and working with pregnant women who smoke. Health psychology evidence into approaching pregnant smokers was also reviewed. In addition to the initial consultancy contract, an interim report was submitted to the client to outline in detail how the process was progressing (see Appendices 4 and 5 for the interim report and correspondence from client). Although the consultancy project was closed by the set deadline, the final report did not include the findings from the semi-structured interviews with pregnant smokers. It was agreed that once the results from the interviews were finalised, these would be provided to the client as an Appendix.

Reflection on Conducting Consultancy

A substantial component of the consultancy was to carry out research and undertake a systematic review. Therefore, whilst maintaining my role as a consultant, I was required to become a researcher. At times, these two roles could be interlinked and on other occasions they were separate. In the early stages of the consultancy I had to make a conscious effort to remind myself of my role at certain moments. However, as the project progressed I became accustomed to and confident with my various responsibilities. I realised that although I acted mainly as a researcher, for instance when I ran focus groups with participants, there was an overarching aim that I strove to accomplish by conducting the research. When analysing the qualitative data and the results from the studies included in the

systematic review, I used the skills and knowledge a researcher possesses. Yet, I increasingly started reflecting on how the findings could contribute to the recommendations I would provide to the client. I believe that the process of becoming more comfortable in my role and starting to regularly consider the impact the tasks had on the consultancy was a reflection on the developing relationship I had with the client as well as gaining more experience as a consultant. See Figure 1 for a tree diagram representing the organisation of my consultancy work.

Figure 1: Tree diagram of organisation of the consultancy



Monitor the Implementation of Consultancy

The greatest challenge faced with regards to carrying out the consultancy was to recruit participants for the research. In an attempt to overcome these problems, I met with the client on numerous occasions to discuss potential solutions to the setbacks. During the meetings with the client, we discussed the progress that had been made, future steps forward, any challenges that I had confronted and possible solutions to any problems. A number of amendments were made to the ethics application in an attempt to increase uptake of participation in the research. These modifications included the provision of incentives to pregnant smokers, running the

focus groups in more convenient localities and undertaking semi-structured interviews instead of focus groups with pregnant smokers. However, as the process of recruiting pregnant smokers for the research proved exceptionally challenging and lengthy, one final change to the initial contract was to exclude the findings from the interviews from the final report and to add these once completed at a later stage.

Reflection on Monitoring the Implementation of Consultancy

As the consultancy project developed as did the mode of communication between the client and myself. That is, discussions were converted into dialogues. According to Schein (1999), this process is a natural and valuable development in consultancy relationships as the client and consultant are able to express their views and understand each other more effectively. When I shared the challenges I faced with the client, I realised that the project itself as well as the individuals and the organisation involved would have benefited if I had involved the client earlier. The knowledge, experience and contacts that the client possessed proved pivotal in recruitment of participants and I should not have assumed that I had all the answers to the questions. In contrary, it was the client who owned the ultimate problem and whose circumstances I was involved in (Schein, 1999). Indeed, one of the reasons that the client had requested my help was to further her comprehension of how to effectively work with pregnant smokers who represent a very complex population. Therefore, it was not surprising that I faced challenges when attempting to recruit pregnant women who smoke for the research and I should have envisaged that the client was better placed than anyone to comprehend this. The decision to close the consultancy prior to undertaking all the interviews was arrived at by both the client and me (see Appendix 6 for minutes from the meeting). However, in retrospect I

could have shared this suggestion with the client earlier in the process as the difficulties experienced had not been predicted by either of us.

Evaluate the Impact of Consultancy

The aim of the consultancy was to increase referrals to the Smokefree Service from pregnant smokers. The recommendations delivered to the client were based on solid research into how midwives experience providing stop smoking advice and which smoking cessation interventions are the most effective for this population. In addition, literature reviews were undertaken to examine existing evidence and research and a number of other stop smoking services were contacted to discover other potential routes of targeting pregnant women who smoke. At a later stage the client would receive evidence into how pregnant women perceive the stop smoking service. The final consultancy report should enable the client to take forward some of the suggestions made and utilise the skills and knowledge conveyed in improving the service for pregnant smokers. As the overall aim was not an instant measurable outcome, further evaluation is required in the future to investigate if the number of referrals has increased. However, Earll and Bath (2004) pointed out that a method of evaluating a piece of consultancy is through client empowerment. If the client feels more confident in their ability to carry out the actions to solve the problem as a consequence of the consultancy work, the consultant has successfully met one of the objectives (see Appendix 8 for feedback assessment from client). Although I provided the client with written recommendations on how to improve the uptake of the stop smoking service by pregnant women (see Appendix 7), I also presented the recommendations in a meeting to clarify the findings and increase the chances of the client successfully carrying out the actions (Earll & Bath, 2004).

Reflection on Evaluating the Impact of Consultancy

An imperative objective of a piece of consultancy is to generate feasible solutions to problems faced by clients who will be able to carry out the recommendations (Earll & Bath, 2004). The process consultation philosophy encompasses that only the client can fully comprehend which recommendations are applicable and could be effective in the organisation. Therefore, the decision to actually implement changes rests with the client who owns the problem (Schein, 1999). Some of the recommendations drawn from the consultancy project were implemented relatively promptly. For instance, referral post cards were developed to encourage midwives to refer more clients into the service and plans were made to tailor these for the use of health visitors. This consultancy project fits well with the process consultation theory in that it aimed to help the client to improve the service in the future by providing them with the suitable tools rather than with concrete actions. Thus, the outcome was both remedial and preventative (Schein, 1999).

Overall Reflection

Earll and Bath (2004) proposed that essential skills that all consultants should acquire are time management capabilities, financial skills, effective listening abilities and communication skills. Consultants must be able to undertake outstanding projects that are delivered in the right time frame and covered by the agreed budget. As consultants are required to possess numerous different skills, carrying out consultancy work is a continuous learning experience. My experience in undertaking consultancy projects had initially been very limited and therefore I did not possess all the necessary skills, nor fully comprehended the magnitude of acquiring them, prior to starting the consultancy. Although I still have restricted practice in this line of work, carrying out the consultancy work provided me with a great opportunity to

develop in the field. Additionally, incorporating continuous reflection as part of the consultancy process added to my growth as a consultant and I will thus continue to include this aspect into future consultancy work.

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Appendix 1

Consultancy Meeting 4th September 2006

Present:
[redacted]
Carolina Herberts
[redacted]

Area	Topic	Actions
Aim and background of the proposed consultancy work	The number of referrals from pregnant women to the Smokefree Service is low. The client ([redacted]) is requesting help in increasing the number of referrals from pregnant smokers.	
Consultancy tasks that the final recommendations could be based on	Tasks that could be carried out for the consultancy were discussed: • Carrying out research with pregnant smokers and midwives • Undertaking a systematic review • Reviewing health psychology research into targeting and working with pregnant smokers • Contacting other stop smoking services to identify possible methods of targeting and working with pregnant women	• [redacted] and CH to reflect on the practicalities on conducting the consultancy work • CH to review how the service is currently targeting pregnant smokers • CH to undertake a brief review of current evidence into targeting pregnant women who smoke
Upcoming meeting	A meeting will be held between the consultant and the client to discuss the consultancy further	• A meeting to be held between CH & [redacted] on 17th September

Appendix 2

Consultancy Meeting 17th September 2006

Present:
[redacted]
Carolina Herberts

Area	Topic	Actions
The consultancy tasks that had been discussed during the previous meeting	The 4 main tasks that had been discussed during the previous meeting were discussed in more detail and agreed upon.	
The time frame of the proposed consultancy work	Due to the complexity and time consuming areas of the consultancy, CH proposed that the consultancy work would take 2 years and 3 months, starting in December 2006 and ending in February 2009. [redacted] agreed on the time frame.	
Meetings held between the client and the consultant	It was agreed that regular contact will be established and held between [redacted] and CH. Regular meetings will be held and the consultant and client will also communicate through e-mail and telephone contact.	
Consultancy contract	A consultancy contract outlining the aim and objectives of the consultancy, the tasks, the time frame of the project and what the consultancy would cost if the client was to pay will be completed.	• CH to provide [redacted] with a consultancy contract by the end of October 2006

Appendix 3

CONTRACT FOR CONSULTANCY WORK

TITLE OF WORK: **How the Stop Smoking Service Could Target Pregnant Women who Smoke More Effectively**

Contracting Client: [redacted]**, Stop Smoking Advisor, Families and Parents to Be**
Consultant: **Carolina Herberts, Health Psychologist in Training**

BACKGROUND

The consultant is undertaking a doctorate course in Health Psychology at City University and working at [redacted] Stop Smoking Service as a Health Psychologist in Training. The contracting client works at [redacted] Stop Smoking Service as a Stop Smoking Advisor for families and parents to be.

OBJECTIVES

The aim of the consultancy is to increase the number of referrals of pregnant smokers for support to quit smoking. The objectives are to; identify the barriers and facilitators for midwives and pregnant women in accessing stop smoking services, evaluate the effectiveness of smoking cessation interventions for pregnant smokers, explore alternative methods of targeting pregnant smokers and examine health psychology evidence in approaching pregnant smokers.

In order to achieve the above aim and objectives the following work will be undertaken:

1. Conducting research
   - The research will involve running three focus groups with pregnant smokers to identify perceived barriers and attractiveness of stop smoking services. The qualitative data will be analysed and the findings will suggest improvements for the service for pregnant smokers and effective promotion of the service.
   - The research will include running three focus groups with midwives to identify their perceived barriers of providing stop smoking advice to pregnant women who smoke. The qualitative data will be analysed and the findings could lead to changes in the provision of level I training for midwives.

2. Conducting a systematic review
   - The systematic review will be conducted by; writing a systematic review protocol, undertaking a search of studies, selecting appropriate studies from the search, awarding points for each study based on specific quality criteria, assessing the studies and writing up the review.
   - The systematic review will evaluate the effectiveness of psychological smoking cessation interventions for pregnant smokers.
   - The review will assess during what stage of pregnancy the intervention is most likely to be effective.
   - The review will also examine the effectiveness of interventions according to types of pregnant smokers (light or heavy).
   - The findings from the systematic review will suggest changes related to providing smoking cessation interventions for pregnant smokers.

3. Contacting other stop smoking services
   - The consultant will contact other stop smoking services in order to explore alternative and effective ways of targeting pregnant women who smoke.

4. Examine health psychology evidence in approaching pregnant women about smoking cessation.
   - The consultant will examine relevant research to ensure that any useful evidence is included in the final piece of consultancy.

Outcome of Consultancy:
The contracting client will be provided with written recommended strategies for promoting and adjusting stop smoking services to be more accessible to pregnant women.

CONSULTANT REQUIREMENTS

- The stop smoking advisor for family health will be the main point of contact for the consultancy work.
- Regular contact to be maintained with the contracting client.
- [redacted] PCT to liaise with relevant associated groups to secure support for the consultancy project.
- [redacted] PCT to act as the sponsor for the piece of research that will be undertaken.
- [redacted] PCT to assist in the provision of rooms suitable for the hosting of focus groups.
- The contracting client to assist the consultant in identifying suitable people to contact in other Stop Smoking Services.

TIMEFRAME

The total duration of the intervention is 2 years and 3 months.
Start of consultancy: December 2006
End of consultancy: February 2009

CODE OF CONDUCT

The consultant, a health psychologist in training, will carry out the service in accordance with the British Psychological Society Code of Conduct.

INTELLECTUAL PROPERTY

The consultant, a health psychologist in training, shall be named on any publications arising from her work. This has be discussed and agreed.

CONFIDENTIALITY

During the course of the services the consultant, a health psychologist in training, may have access to, gain knowledge of or be entrusted with information of a confidential nature. In signing this contract, the principal investigator agrees, unless expressly authorized by a senior authorized person to so, will not disclose to any unauthorized person or organization any such confidential information. The health psychologist in training agrees to store and process information in accordance with the Data Protection Act 1998.

COST

As this piece of consultancy form part of the consultant's job description, no extra fees will be requested. If a payment was required, the estimated fee for this work would be budgeted at a total cost of £29,785 (185 days).

Breakdown of cost

- Carrying out research 25 weeks (125 days)
- Conducting a systematic review 10 weeks (50 days)
- Contacting other stop smoking services 3 days
- Examining health psychology research 3 days
- Writing up piece of consultancy 4 days

£25,000 x 1.16 = £29,000 / 12 months / 15 working days = £161 / day

Cost per day £161

Signature…… Date……

Consultant name (Please Print)
Health Psychologist in Training
Smokefree [redacted], City University, London

Signature ……..……..….Date…..…..

Client name (Please Print)
Stop Smoking Advisor, Stop Smoking Advisor for Families and Parents To Be
Smokefree [redacted]

Appendix 4

Interim Report on the Project: "How the Stop Smoking Service Could Target Pregnant Women who Smoke More Effectively"

Prepared by the consultant:
Carolina Herberts, Health Psychologist in Training, Smokefree [redacted]
Prepared for the client:
[redacted], Stop Smoking Advisor for Families and Parents to Be, Smokefree [redacted]

Background

The consultant is undertaking a doctorate course in Health Psychology at City University and working at Smokefree [redacted] (formerly know as [redacted] Stop Smoking Service), [redacted] Primary Care Trust (PCT), as a Health Psychologist in Training. The contracting client works at Smokefree [redacted], [redacted] PCT as a Stop Smoking Advisor for families and parents to be.

Objectives

The objective of the consultancy project is to assess how Smokefree [redacted] at [redacted] PCT could target pregnant women who smoke more effectively. The aim of the consultancy is to increase the number of pregnancy referrals to the Smokefree Service.

Process

The timescale of the project is a total duration of 2 years and 3 months, starting in December 2006 and ending in February 2009. The consultant will carry out the project by:

1. Conducting research which will involve running focus groups with; pregnant smokers to identify perceived barriers and attractiveness of stop smoking services and with midwives to identify their perceived barriers of providing stop smoking advice to pregnant women who smoke.

2. Conducting a systematic review to evaluate the effectiveness of smoking cessation interventions for pregnant smokers including during what stage of pregnancy the intervention is most likely to be effective and the effectiveness of interventions according to types of pregnant smokers (light or heavy).
3. Contacting other stop smoking services to explore various alternative and potential effective ways of targeting pregnant women who smoke.
4. Examining health psychology evidence in approaching pregnant women about smoking cessation.

Progress

1. Conducting Research

The research was approved by the National Research Ethics Service (NRES) (formerly know as the Central Office for Research Ethics Committees (COREC)), [redacted] Community Local Research Ethics Committee in January 2007. The North Central London Research Consortium, Research and Development (R & D) department at [redacted] PCT provided approval of the research in February 2007 and the R & D department at [redacted] approved the research in September 2007. The appropriate individuals at the [redacted] were informed of the research and provided approval accordingly in March 2007. Since the research was approved, amendments have been made in an attempt to increase uptake of participation of focus groups. These modifications, which have received favorable approval from the research ethics committee, include the provision of incentives to pregnant women taking part in focus groups and running focus groups with midwives at acute trusts and with pregnant women at antenatal clinics, as an alternative to [redacted]. Sure Start donated 24 £10 vouchers to Marks & Spencers or John Lewis/Waitrose to be given to pregnant smokers participating in focus groups. Two focus groups with a total number of 11 midwives have taken place, one at the [redacted] in November 2007 and one at the [redacted] in January 2008. The tapes of the focus groups have been transcribed.

2. Conducting a Systematic Review

A systematic review has been carried out evaluating the effectiveness of smoking cessation interventions for pregnant smokers. The review assessed whether time of pregnancy or type of smoker had an impact on the effectiveness of stop smoking programmes for pregnant smokers. The systematic review protocol was completed and a data search of studies was undertaken in March 2007. Abstracts of studies were assessed for inclusion in the review, hand searches were undertaken in five journals and reference lists were examined. Nine studies met all the inclusion criteria and the studies were given quality points independently by two researchers in December 2007 and January 2008. A third researcher assessed any contradicted quality points. The results were analysed and the report was completed by the end of February 2008. The results indicated that the smoking cessation interventions for pregnant women were effective, however, when the criterion for significance was reduced, no significant results were revealed. The effectiveness of the interventions did not differ according to types of smokers included in the studies. The trials including women who were at a later stage of pregnancy in their second trimester were more effective compared to the studies that only included women who were at an earlier stage in the second trimester. See Appendix 1 for the full report.

3. Contacting Other Stop Smoking Services

Two other stop smoking services in London were contacted in March 2008 and meetings have been arranged with individuals working with pregnant women.

4. Examining Health Psychology Evidence

Health psychology evidence into approaching pregnant women who smoke will be reviewed in conjunction with writing up the research.

Challenges

The systematic review has been completed within the anticipated timescale.

However, the research has been slightly delayed due to a number of reasons:

- Neither the consultant nor the client was aware of the fact that ethics approval had to be sought from two acute trusts in the borough in addition to COREC. Although the consultant was informed of this some

time after submitting the COREC form, it took several months for one of the acute trust to process the ethics application.

- In an attempt to increase uptake of participation in focus groups by pregnant smokers, several companies were contacted and requested to contribute to the research with incentives. However, none of the companies agreed to provide contributions.
- Sure Start agreed to provide incentives in the form of vouchers to pregnant women taking part in the research. However, the decision as to which fund should be used for the purpose took several months to reach.
- Recruitment of midwives has been rather difficult due to their busy schedule. Contact was initially made with midwifery services in September 2007 and since then two focus groups have been undertaken, one in November 2007 and one in January 2008. Arranging a third focus group with midwives has proved challenging.
- Recruitment of pregnant smokers was planned to occur through midwives. However, no pregnant women have been recruited for the research. Ethics approval for the consultant to approach women in antenatal clinics was denied by the research ethics committee.

Future Progress

- A meeting was held with the Matron Maternity at the [redacted] in February 2008 as one more focus group with midwives still needs to be included in the research. The Matron Maternity agreed to arrange a suitable time and place and to recruit between six and eight participants to take part in a focus group. She will inform the consultant once this has been arranged.
- The research ethics committee approved the consultant's request to run focus groups with pregnant women who smoke in the antenatal clinics. The consultant will therefore meet with midwives at [redacted] in March 2008 to arrange the practicalities of running a focus group in the health centre and to ask the midwives to inform pregnant women of the research.

- Meetings with stop smoking advisors working with pregnant women at other stop smoking services in London will take place in March 2008.

Overall

Despite the delays and challenges faced in conducting the research for the project, the deadline for the piece of consultancy has not been postponed. Due to the beneficial input by the client, the consultant has been able to find alternative methods of attempting to recruit participants for the research.

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March 2008

Appendix 5

Dear Carolina

Many thanks for sending your systematic review and an interim report.This is most helpful
I am well aware of the challenges that you are likely to encounter with regard to co-ordinating arrangements with various departments and agencies. It's good to note that the project is on schedule at this stage.

With many thanks

[redacted]

[redacted]
Stop Smoking Adviser - Families and parents to be
Smokefree [redacted]
[redacted]
London [redacted]
Tel [redacted]

-----Original Message-----
From: Herberts, Carolina
Sent: 03 April 2008 09:36
To: [redacted]
Subject: Consultancy

Hi [redacted],

I have attached a consultancy interim report and my systematic review. However, my supervisor has not yet given me feedback for the review so bear in mind that it is not the final version.

Please let me know if you want any more information.

Thanks,
Carolina

Carolina Herberts
Health Psychologist in Training
[redacted]

Tel: 020 7530 6333
Fax: 020 7445 8556
E-mail: carolina.herberts@[redacted].nhs.uk

Appendix 6

Consultancy Meeting 22nd December 2008

Present:

[redacted]
Carolina Herberts

Area	Topic	Actions
Recruiting pregnant women who smoke for semi-structured interviews	CH had been in touch with a midwife who has recently trained to be a level II stop smoking advisor. The midwife had arranged for CH to visit a meeting with a midwifery team at an acute trust to inform them of the research and encourage them to recruit suitable participants. CH informed [redacted] that a voluntary MSc Health Psychology student will help out with transcribing interview tapes, conducting literature searches and contacting relevant services that could potentially help to recruit participants. CH informed [redacted] that an e-mail had been sent to people attending a Sure Start meeting asking them to circulate information about the research to their team members.	

	[redacted] had been informed through the head of the stop smoking service that social marketing people have been recruiting pregnant women who smoke for their research and that it might be possible to contact them regarding the problems faced in recruiting participants. [redacted] informed CH that adding the participant information sheet into booking packs for pregnant women might also generate some interest from pregnant smokers.	• CH to contact social marketing people to find out if it would be possible to recruit participants through them and if this would follow ethical guidelines. • CH to discuss this with the midwifery leads at two acute trusts
Changes to the consultancy contract	The deadline for the consultancy is the end of February 2009. However, due to the extreme challenges faced in recruiting pregnant smokers for the research that were unforeseen by both [redacted] and CH, it was recognised that completing the research by the deadline will not be possible. Therefore, the consultancy report will be submitted by the end of January and not include any results from the interviews. The results from the interviews will be provided to [redacted] as an Appendix once they have been undertaken and analysed.	• CH to submit the final consultancy report by 31st January 2009.

Appendix 7

Report on the Consultancy Project: "How the Stop Smoking Service Could More Effectively Target Pregnant Women who Smoke "

Prepared by the consultant:
Carolina Herberts, Health Psychologist in Training, Smokefree [redacted]
Prepared for the client:
[redacted], Senior Stop Smoking Specialist, Smokefree [redacted]

Background

The consultant is undertaking a doctorate course in Health Psychology at City University and working at Smokefree [redacted] (formerly know as [redacted] Stop Smoking Service), [redacted] Primary Care Trust (PCT), as a Health Psychologist in Training. The contracting client works at Smokefree [redacted], [redacted] PCT as a Senior Specialist Stop Smoking Advisor.

Objectives

The objective of the consultancy project was to assess how Smokefree [redacted] PCT could target pregnant women who smoke more effectively. The aim of the consultancy is to increase the number of pregnancy referrals to the Smokefree Service.

The Consultancy

The consultancy project started in December 2006 and the deadline was set for February 2009. The components of the consultancy were:

1. Conducting research involving running focus groups; with midwives to identify their perceived barriers of providing stop smoking advice to pregnant women who smoke and with pregnant smokers to identify perceived barriers and attractiveness of stop smoking services.
2. Conducting a systematic review to evaluate the effectiveness of smoking cessation interventions for pregnant smokers including during what stage of pregnancy the intervention is most likely to be effective and the effectiveness of interventions according to types of pregnant smokers (light or heavy).
3. Contacting other stop smoking services to explore alternative and potentially effective ways of targeting pregnant women who smoke.
4. Examining health psychology evidence in approaching and working with pregnant smokers.

Progress and Changes to the Consultancy

5. Conducting Research

The research was approved by the relevant ethics committees; the National Research Ethics Service (NRES) (formerly know as the Central Office for Research Ethics Committees (COREC)), [redacted] Community Local Research Ethics Committee, the North Central London Research Consortium, Research and Development (R & D) department at [redacted] PCT and the R & D departments at [redacted] and the [redacted]. Amendments were made in an attempt to increase uptake of participation in the research. These modifications included; the provision of incentives to pregnant women taking part in the research, undertaking semi-structured interviews with pregnant smokers instead of focus groups and running focus groups and interviews at alternative convenient locations. Three focus groups with midwives were undertaken. However, due to the challenges faced in recruiting pregnant women who smoke to take part in the research, only five out of between ten to twelve interviews were conducted at the time the report was submitted. Therefore, the client and the consultant agreed that the final consultancy report would not include the results from the interviews. Once all interviews have been undertaken and the data analysed, the consultant will provide the client with the results as an Appendix. The final research project will thus also be completed at a later stage.

6. Conducting a Systematic Review

A systematic review was carried out evaluating the effectiveness of smoking cessation interventions for pregnant smokers. The review assessed whether time of pregnancy or type of smoker had an impact on the effectiveness of stop smoking programmes for pregnant smokers.

7. Contacting Other Stop Smoking Services

Three other stop smoking services in London were contacted and meetings arranged with specialist stop smoking advisors working with pregnant women to assess how they work with and target pregnant smokers.

8. Examining Health Psychology Evidence

Health psychology evidence into approaching pregnant women who smoke was reviewed in conjunction with conducting the systematic review and the research.

Findings

1. The Research

The qualitative data from the focus groups with midwives was analysed using the Grounded Theory. The two core themes that emerged from the data were perceived barriers and facilitators to providing stop smoking advice to pregnant women. The categories identified as perceived barriers and facilitators are discussed below.

Core Category 1 - Barriers to Providing Stop Smoking Advice

I Characteristics of Task

The midwives used a variety of descriptions regarding their feelings about providing stop smoking advice to pregnant women. The majority of theses expressions were negative. The midwives' perceived characteristics of the task of providing stop smoking advice were divided into sub-categories of; how they found *the process* of giving advice (e.g. difficult, challenging), what their *personal feelings* about the task were (e.g. uncomfortable, apprehensive) and how they perceived *the topic* (e.g. sensitive, intrusive).

The reasons why midwives used these characteristics to describe the task of providing stop smoking advice were categories into areas of; *outcome, personal experience, lack of attributes, perception of role, external factors, pregnant women* and *the relationship*.

II Outcome

Midwives' perceptions of the outcome of giving stop smoking advice to pregnant women formed a substantial category as a barrier to providing advice. Sub-categories of outcome were identified as *avoidance*, *behaviour change* and *reactions*. These categories were further split into; *causing* and *acting avoidance*, *emotional* and *responsive reactions* and *actions* and *conflict behaviour change*.

The midwives attempted to avoid causing certain feelings in pregnant women such as guilt, blame and fear and they strived to avoid being perceived as acting in a judgemental or disapproving way as well as saying the wrong thing or providing information without causing any negative emotions in the women.

The reactions of pregnant women could also act as a barrier to giving advice. Midwives often expected or presumed that the pregnant smokers would perceive the advice in a negative manner. Responsive reactions constituted observed reactions of pregnant women as a consequence of receiving stop smoking advice. The midwives described some women's reactions as withdrawal and acting dismissive. The pregnant women's approach towards the midwife changed as a result of being given advice and consequently, they were not regarded as equally open or not trusting the midwife as much. There was also a perception among the midwives that it was common for pregnant smokers not to reveal the truth about their habit and that many who did report that they were smokers underestimated the number of cigarettes they smoked per day. Additionally, midwives expressed that that pregnant women who smoke are likely to portray or experience negative emotional reactions as a result of being given smoking cessation advice such as feeling uncomfortable or guilty.

Another outcome of providing advice that was a concern for midwives was the fact that they doubted whether the advice would impact on changing the woman's smoking behaviour. Some midwives admitted feeling sceptical about the purpose of asking as they did not expect women to stop smoking as a result of the advice. There was a sense that their part alone could not have a great impact on a woman's desire to change her behaviour. An assumption that pregnant smokers were unlikely to want to give up existed among some of the midwives and consequently, the potential influence of the advice was perceived as limited. The belief that most pregnant

women are aware of the risks of smoking during pregnancy prior to seeing the midwife and yet have not given up added to the pessimistic view of the outcome of the advice. Most midwives appeared, however, to comprehend the difficulty of giving up smoking and they regarded smoking as a strong addiction and a habit which is part of ones lifestyle and hard to break. The midwives thus acknowledged the importance of wanting to give up smoking in order to succeed and this was perceived as yet another factor contributing to the unlikely successful outcome of giving advice. Furthermore, it was not unusual that pregnant women's replies contradicted their actions. That is, women expressed that they wanted to quit or even be referred to stop smoking services but did still not change their behaviour. Midwives perceived this inconsistency as a result of trying to please the midwife or simply wanting to end the conversation. The midwives had experienced that pregnant women often tried to end the conversation by stating that they had cut down and were not smoking as much as they had done prior to their pregnancy. However, many pregnant women appeared to still be smoking later on during pregnancy although they had expressed that they were in the process of quitting.

III Personal Experience

Another category that was identified as a potential barrier to providing stop smoking advice was midwives' personal experience. Their personal experience was split into *smoking experience* and their *experience of working as a midwife.*

Most of the midwives taking part in the focus groups were not smokers and had not previously smoked. Many of the midwives perceived this as a barrier to giving smoking cessation advice as they felt unable to empathise with the experience of smoking and quitting. A common opinion amongst the midwives was that a barrier to providing advice about quitting was lack of experience in the job. Many midwives had not spoken about smoking cessation as much in the earlier stages of their career in comparison to when they had gained more experience.

IV Lack of Attributes

Midwives mentioned a number of attributes that they perceived as necessary in being able to provide stop smoking advice. Lacking these attributes was seen as a barrier to giving advice. The category lack of attributes was divided into sub-categories of *knowledge, skill* and *confidence.*

Lack of knowledge was a commonly mentioned barrier to giving stop smoking advice and midwives expressed that they felt limited as a consequence of the inadequate knowledge they possessed. Many of the midwives expressed that they personally did not feel that they possessed enough knowledge and even those midwives who felt that their level of knowledge was adequate recognised that this could be a barrier for other colleagues. The lack of knowledge was related to how to respond to women who decline support as well as those who request it, issues around stopping (e.g. Nicotine Replacement Therapy (NRT)) and stop smoking services.

In order to give advice effectively, midwives acknowledged that it needed to be combined with a degree of communication skill. Lack of confidence in providing advice was also identified as a barrier to undertaking the task. Low levels of confidence among some of the midwives were thought to be a potential cause of insufficient knowledge.

V Perception of Role

Midwives appeared to have different perceptions of the role of providing stop smoking advice and how it related to other parts of their job. How midwives viewed the aspect of giving smoking cessation advice as part of their role as a midwife was identified as a potential barrier to carrying out the task. The sub-categories of the perception of role category were identified as *midwives*, *the client*, and *other parts of role*.

The midwives showed a great desire to be good at their jobs and became dissatisfied if they felt that they had not accomplished a set goal. A rather common theme that emerged from all of the focus groups was that midwives might specialise in various aspects of midwifery and have different interests in their jobs that affect how important they perceive the diverse parts of their role. Therefore, in particular the specialist midwives tend to focus mainly on their specific area and regard it as the most important.

The client also had an impact on how midwives viewed providing stop smoking advice. Midwives were more likely to spend more time on the issue if the pregnant women did not have many other complex needs. If, however, there was a need to discuss other complex areas such as mental health issues, domestic violence and housing problems, the midwives did not regard giving stop smoking advice as a priority.

The role that midwives hold was described as very broad and this was a recurrent topic. Smoking cessation is a subject that should be discussed in the initial booking session with pregnant women. However, during booking sessions midwives are requested to discuss and be knowledgeable of numerous issues with giving stop smoking advice only being one part of the various areas that need to be covered. This was frequently described as a barrier to providing stop smoking advice.

VI External Factors

One of the most predominant categories identified as a barrier to giving stop smoking advice was external factors. This category comprised of issues that were not related directly to midwives or pregnant women but were controlled by external factors. *Work structure* and *training* were sub-categories that emerged from external factors. These sub-categories were further split into *time* and *setting* and *level I* and *midwifery training*.

Of all the categories and sub-categories that were identified as barriers to providing stop smoking advice to pregnant women, lack of time was the most frequently mentioned issue and many of the midwives felt that it was the main barrier. Midwives described that they often feel rushed and under pressure particularly when running initial booking sessions. The stress that they face did not only relate to providing stop smoking advice but to all aspects of the booking. The restricted amount of time that midwives experience they have was seen as such a problem that it prevented them from carrying out their jobs satisfactorily. Some midwives felt that the booking sessions were more stressful due to the setting in which they take place. As a result of lack of time and large case loads, midwives explained that booking usually run late. The fact that other women are waiting for their appointments while

they are undertaking a booking session with a pregnant smoker contributed to the feeling of stress and was thus a barrier to giving advice. However, some midwives claimed that undertaking bookings at home can also be a barrier as there are different pressures such as the woman being in a rush and children distracting the conversation.

The majority of the midwives expressed that they found it harder to discuss smoking cessation with pregnant women prior to undergoing level I training. A common perception was that training in smoking cessation advice was essential and if it was missing, it was tempting to ignore this aspect of their role. However, a number of the midwives had not undertaken a level I training course and these midwives recognised that they would benefit from attending a training session. The participants were under the impression that all midwives ought to be level I trained but accomplishing this could be another challenge due to them being required to attend various training events and update sessions and the amount of time needed to run and undergo training. Another form of training that was recognised by some midwives as barrier to providing smoking cessation advice was the midwifery education. It was mentioned that the midwifery training focused mainly on the more traditional parts of midwifery and not public health issues such as giving effective stop smoking advice.

VII Pregnant Women

'Pregnant women' was identified as a potential barrier to providing stop smoking advice. *Other circumstances* in pregnant women's lives, the *pressure* that pregnant women are under and their *awareness* of smoking were branded as sub-categories of pregnant women.

Other circumstances in pregnant women's lives constituted a barrier to providing smoking cessation advice. The midwives felt that a substantial proportion of pregnant smokers have complex lives and are often dealing with other difficulties and stresses. Because of these circumstances, pregnant smokers were believed to be more likely to prioritise other issues than stopping smoking. The various circumstances that pregnant smokers might go through included; housing situations, problems with their partner, unplanned pregnancies, financial worries and concerns regarding work. Smoking was perceived as serving as a strategy for coping with these challenging situations. Additionally, as smoking was often a generational habit among the pregnant smokers, this was perceived as a contributing factor to the difficulties of giving up.

The midwives also discussed the fact that pregnancy is a stressful time in itself and that pregnant women are already restricted in what they can do during this time. All the information that pregnant women receive during their pregnancy and in particular in the initial booking session was thought to be rather overwhelming for many clients. As so many topics are covered, some midwives felt that the pregnant women are unable to register and remember all the issues that are discussed. There was an appreciation among the midwives that society puts a vast amount of pressure and expectations on pregnant women that also contribute to the stress that women might experience during their pregnancies.

Midwives' perceptions of pregnant women's awareness regarding the risks of smoking during pregnancy were also identified as potential barriers to providing advice. It was believed that pregnant women know that smoking during pregnancy is harmful for the baby as a lot of information exists in the public domain. However, most midwives agreed that it is not rare for pregnant women to be unaware of the extent of the risks and the reasons it is dangerous. Many pregnant women were under the impression that cutting down was almost as beneficial as quitting completely. A fairly common response from pregnant women when being given advice about stopping smoking was that they had smoked during previous pregnancies and the baby had been unharmed. Similarly, women commented that their friends' or the mothers had smoked whilst pregnant and it had not had any detrimental health effects on the baby. The midwives also discussed that an alarming number of pregnant smokers express that they prefer to have a small baby and are not aware of the health risks that are associated with low birth weight. The phenomenon of not feeling that the baby is real was also brought up during the focus groups. This perception was mostly described to be revealed by those women who might have unplanned pregnancies, clients who were not happy about being pregnant or those in the early stages of their pregnancy.

VII The Relationship

The final category that was identified as a barrier to giving stop smoking advice was the relationship between the midwife and the pregnant woman. Midwives were keen to establish and maintain a good relationship with their clients. The relationship was divided into sub-categories of the *quality of the relationship*, *continuity* of care and the *ability to relate* to their clients.

If pregnant women responded to the advice in a negative manner, midwives would consider this to have a negative effect on the relationship. Some midwives were also under the impression that pregnant women might not be happy discussing smoking cessation advice with their midwife.

The fact that smoking cessation was discussed during the initial booking session and that this was the first time that the midwife and the pregnant woman met was perceived as a challenge to giving advice. Most of the midwives taking part in the focus groups were not able to offer continuity of care to their clients. Therefore, all the topics that the midwives were required to discuss with their clients had to be covered during the initial booking session and this was perceived as a negative aspect of not continuing to see their clients during their pregnancies. Midwives did not only feel that the lack of continuity was perceived as a hindrance for the midwife but also that pregnant women would benefit and prefer to see the same midwife throughout their pregnancies.

This 'relate' category refers both to the midwives' perceived incapability to relate to their clients as well as the pregnant women's perception of the distance between her and her midwife. The fact that both the midwife and the client felt that they were very different and unable to associate with each other was believed to affect the openness and honesty of the pregnant women.

Core Category 2 - Facilitators to Providing Stop Smoking Advice

During the focus groups, the midwives discussed what could make it easier to provide smoking cessation advice to pregnant women and this was therefore explored further. This area was not as weighty as the barriers to providing advice and most of the topics were related to the barriers.

I Characteristics of Task

The positive descriptions of the task of providing smoking cessation advice were not as numerous as the negative characteristics and they were mentioned less frequently. The positive perceived characteristics of the task were divided into sub-categories of; how they found *the process* of giving advice (e.g. easy, like it), what their *personal feelings* about the task were (e.g. comfortable, do not mind) and how they perceived *the topic* (e.g. important).

Midwives clarified that regardless of whether they portrayed the task of providing smoking cessation advice in a negative or positive manner, they accepted that they had to ask all women as it was part of the booking and a questions on the form. However, some midwives made a clear distinction between the task of asking the pregnant women about their smoking status and actually giving them advice and encouraging them to quit. Some of the characteristics mentioned were related to actually asking whether the pregnant women smoked rather than providing brief advice about stopping and making referrals. The midwives' explanations as to why they described giving advice with the positive phrases could be arranged into the categories; *outcome, personal experience, necessary attributes, perception of role, external factors* and *the relationship.*

II Outcome

The outcome of smoking cessation advice that midwives provide was categorised as a facilitator as well as a barrier. However, some midwives explained that the reason they felt comfortable with the outcome of their advice was not that they expected the women to quit smoking but that they accepted that they might not. The midwives who expressed realistic expectations of the outcome of their advice appeared to simultaneously acknowledge the challenges in giving up an addiction such as smoking and that their advice might have a positive impact but that it will only be one contribution amongst many others towards behaviour change.

III Personal Experience

Personal experience was identified as a potential facilitator to giving advice and this category was sub-categorised into *smoking experience* and *experience as a midwife*.

As discussed previously, some of the midwives who had never smoked felt that this was a barrier to giving stop smoking advice. Respectively, the midwives who had previously smoked identified their experience as a facilitator. Only a small number of the midwives were ex-smokers but all of them spoke about how they used their experience in a positive way to emphasise and communicate with pregnant smokers.

Similarly as inexperienced midwives were thought to find it harder to discuss smoking cessation with pregnant women, more experienced practitioners recognised that they did not perceive the task to be as difficult as they had done previously.

IV The Relationship
The relationship between the midwives and their clients could act as a facilitator. The relationship was divided into sub-categories of the *quality of the relationship* and *continuity* of care.

Some midwives expressed that pregnant women tend to have a positive approach to their midwives. Having a good relationship was perceived as a potential facilitator to providing stop smoking advice. Establishing and maintaining a good rapport with their clients was an important factor in midwifery work and feeling that a good relationship is present can contribute to making the task of providing advice easier.

The midwives who had continuity in their work commonly expressed that they appreciated this aspect of their role. This continuity was seen as a facilitator to giving stop smoking advice as they were more likely to return to previously discussed topics and thus more able to influence women's likelihood to change their behaviour.

V Necessary Attributes
Lack of attributes was identified as a barrier to giving stop smoking advice. Midwives therefore perceived that possessing the attributes, *knowledge, skill* and *confidence* could facilitate their task of giving advice.

Although knowledge was the only attribute that was literally mentioned as necessary in giving advice on smoking cessation, skill and confidence were also embedded in the discussions. Knowledge, skill and confidence were related as midwives felt that possessing adequate knowledge can impact on communication skills and confidence in giving advice.

VI Perception of Role
Perception of role was identified as a category which included potential facilitators to giving stop smoking advice. Midwives' perception of their role was sub-categorised into *midwives*, *clients* and *other parts of role*.

Many of the midwives regarded providing stop smoking advice as an important aspect of their role. There was also a desire to do a good job among the midwives and that if this did not occur, it had a negative impact on their perception of their work. As discussed previously, it was recognised that midwives vary according to what they perceive as important as they have different interests and they specialise in different areas. Therefore, facilitators as well as barriers to giving advice could depend on the midwife.

Midwives expressed that how important they perceived providing stop smoking advice was also related to the clients. If pregnant women do not face other complex needs and there is not a need to focus on other problems, providing stop smoking advice was viewed as more important. Additionally, the smoking status of pregnant women also had an impact on how vital midwives perceived it.

The broad role that midwives take on was identified as a barrier to providing stop smoking advice. However, smoking cessation was not regarded as very difficult

compared to some other issues due to the fact that they have to cover so many areas and at times very challenging subjects. Many midwives had accepted the fact that their role involves discussing sensitive issues with their clients and this was something that was part of the work load. How important the midwives perceived giving advice also varied greatly according to the midwife. However, it was often regarded as neither the most important nor the least important subject.

VI External Factors

External factors were identified as possible facilitators to giving stop smoking advice. This category was divided into sub-categories of *work structure, training, practical issues and the bigger picture.* These sub-categories were further split into *time, case load* and *setting*, *level I training*, *specialist in service, NRT* and *resources* and *other health professionals* and *governmental issues.*

A general perception was that being given more time particularly for booking sessions could make the task of giving stop smoking advice much easier. Some participants even attempted to think of alternative methods of running bookings and discussing issues with pregnant women to enable them to fit everything in. One midwife presented the idea of doing speed bookings. A smaller case load was believed to allow more time to be spent with clients and was this identified as a potential facilitator to giving stop smoking advice. Midwives felt that they would be able to discuss issues to a greater extent if they worked with a smaller number of pregnant women.

The setting could be seen as both a potential barrier and a facilitator. Some midwives felt that the home was the ideal venue to interact with pregnant women. However, as discussed previously, not all midwives felt that discussions were undisturbed in the women's homes either.

Training was identified as a major facilitator to providing stop smoking advice. It was apparent that the majority of midwives who had undergone level I training in smoking cessation had found it useful and that it had had a positive influence on their perception of giving advice. The feedback of level I training had also been mainly positive. It appeared that midwives felt they were in need of; clearer information regarding stop smoking services, how to phrase the advice and a greater awareness of NRT products. The midwives who had been trained expressed that regular update sessions would also be beneficial.

One topic regarding what could make it easier to give stop smoking advice was having a specialist in the service. Midwives discussed whether it would be beneficial to have a midwife who could specialise in smoking cessation issues and have dedicated time to support women in their quit attempts. However, not all agreed as some were aware of a similar scheme which had not been effective due to pregnant smokers not turning up for their appointments. One of the participants expressed that all midwives need to take responsibility and inform pregnant women of smoking related issues. Another suggestion was to identify a midwife to lead on the issue and to take responsibility for keeping midwives up to date and trained. Some midwives mentioned that it would be useful to be familiar with the specialist stop smoking advisor working for the stop smoking service so they would be aware of whom they were referring their clients to.

Resources were also discussed as a potential facilitator to giving advice. Midwives mentioned mainly visual resources both as an aid during the discussion and as a means to enable pregnant women to comprehend the risks association with smoking during pregnancy. Visual cards or posters were thought to be useful tools in providing advice.

Some participants recognised that there was a need to inform people about smoking and stopping smoking at an earlier age and prior to actually becoming pregnant. The midwives agreed that the pre-education needs to start at schools so young people would be targeted prior to becoming pregnant. Midwives seemed unsure of the advice that pregnant women and parents received from other health professionals such as GPs. Some midwives thought that pregnant women are likely to respond positively to smoking cessation advice provided by a doctor. It seemed that having a greater awareness of the role of other health professionals with regards to providing stop smoking advice to pregnant women and families and trusting that others are also offering advice could make giving smoking cessation advice an easier task for midwives.

See Appendix 1 for the complete analysis including extracts from the focus groups and explanations of the relationships between the categories.

2. Systematic Review

Following a thorough data search, nine studies were identified as meeting all the inclusion criteria and were thus included in the systematic review. Quality points were given to the studies independently by three researchers. The results were analysed and the report completed.
There was a discrepancy between intensity, duration and nature of the interventions in the trials included in the systematic review. Although analysis initially indicated that smoking cessation interventions for pregnant smokers are effective, the results proved non-significant when the criterion for significance was reduced.

Type of Smoker
One objective of the systematic review was to investigate whether the effectiveness of the interventions differed according to types of smokers participating in the trials. However, only two studies set an inclusion criterion regarding number of cigarettes smoked per day. Analysis showed that the effectiveness of the interventions did not differ according to type of smoker.

Time of Pregnancy
The inclusion criterion set for time of pregnancy of participants did not vary greatly in the trials as all studies set the cut-off point for a time in the second trimester. However, the studies which included pregnant women who were at a later stage in their second trimester compared to trials which set the inclusion criteria for earlier in the second trimester were significantly more effective.

Nature of Intervention
The trials that included NRT as part of the treatment were not more effective than the other smoking cessation programmes for pregnant women. In addition, more intensive interventions were not more effective than less intensive stop smoking programmes in the review. In the majority of the trials included in the review, midwives led the intervention. Analysis showed, however, that the outcome was more effective when the interventions were run by other health professionals, i.e. a counsellor or trained research staff.

See Appendix 2 for the full report of the review.

3. Other Stop Smoking Services

Three separate meetings were held with specialist stop smoking advisors working with pregnant women in different boroughs in London. As all stop smoking services follow the guidelines of the NHS, the different trusts appeared to use similar methods and programs to target and work with pregnant smokers. However, differences did exist and it was revealed that some services had identified methods that appeared effective in their work with pregnant smokers. All services reported that they receive a greater number of referrals than Smokefree [redacted]. Some of the points discussed are mentioned below;

Meeting 1.
- The specialist advisor is based in a hospital.
- Level I training is carried out once a month. Between 20 and 25 midwives attend the training that lasts approximately one hour. Despite the brief duration of the training session, it is very interactive and addresses mainly how to speak to pregnant women.
- A referral postcard has been developed for the midwives to make the referral process easier. Referrals have increased since the new postcard has been put in place.
- Pregnant women can self-refer by sending a text message to a mobile number.
- The image on the postcard and the advisor's contact details are displayed on posters and leaflets. The postcards and posters were promoted though a launch in the hospital.
- The advisor has regular contact with the midwives through a consultant midwife who passes the information on, including number of referrals and names of midwives who have referred.

Meeting 2.
- A close relationship established with neighbouring borough's pregnancy advisors.
- Level I training for midwives is mandatory, 1 per month is held and about 24 midwives attend.
- Level I training was half a day but has been reduced. A quiz is sent to midwives before the training.

- Level I training includes asking the midwives;
  - *How do they feel when they see pregnant women smoke, how do the women then feel, what is the consequence of this and why do they not quit.*
- During level II training, there is a 20 min presentation on how to raise the issue for pregnant smokers.
- Wristbands are given to pregnant women saying "*For my baby*" on the outside and "*Giving up for my baby*" on the inside.
- If a client quits they receive a baby t-shirt, bib and certificate.
- Leaflets, posters and handouts have been developed for targeting pregnant women.
- On the appointment card, there is a space to fill in CO-recordings and NRT choice.
- The advisor finds it very important to mention to the pregnant woman that they care about the baby but they are mainly there for the woman.

Meeting 3.

- The advisor does mainly home visits but is based in a Children's Centre which she finds very beneficial as she works with other agencies and can help the women with various issues.
- There are 4 stop smoking advisors who work with pregnant women in the borough, 2 specialist midwives and 2 specialist stop smoking advisors. Each advisor is responsible for an area of the borough and all are based in Children's Centres.
- All midwives receive level I training which take place over two half days.
- The number of referrals has increased since [redacted] took over the training.
- In the midwifery team, a consultant midwife feeds back to midwives how referrals are going and contacts those who do not refer.
- If the client quits she gets an incentive, 20% off beauty products and a certificate "*For the love of my baby*".
- Clients also get a gift when they have their baby; a bib and a voucher for Boots or Mothercare. They are also thinking about giving dads who quit something.

4. Health Psychology Evidence

As part of the systematic review and the research, various literature searches were conducted. The results from these searches are encompassed in the systematic review and the research dissertation which both provide a rich assessment of the evidence.

Ruggiero et al. (2003) advised that recruiting pregnant smokers into cessation programme is the first opportunity to improve smoking rates among this population. Pregnant women need to be approached during all the stages of change and recruitment needs to be tailored according to the women's needs. Pollak et al. (2006) stressed that there is a need for improvements in smoking cessation interventions for pregnant women. They identified that recruiting pregnant smokers to take part in interventions is a huge challenge. According to Pollak et al. (2006), the stigma associated with smoking during pregnancy is still so strong so some smokers will not admit to their habit even when support is offered.

Encouraging health behaviour change for women who maintain their smoking behaviour throughout their pregnancy is a tremendous challenge (Stotts, DiClemente and Dolan-Mullen, 2002), in particular among high risk, socially disadvantaged and low-income women (Donatelle et al., 2000; Lumley et al., 2004). Battersby, Fendall and Pougher (2003) stated that midwives delivering stop smoking messages and referring pregnant women to specialist services need to be highly trained.

Evaluations of Smoking Cessation Interventions for Pregnant Women

Windsor, Boyd and Orleans (1998) carried out a meta-evaluation of smoking cessation research among pregnant smokers and they found that self help cessation interventions for pregnant women can be effective. A quantitative review of interventions for pregnant smokers was undertaken by Dolan-Mullen, Ramirez and Groff (1994). The review implied that pre-natal stop smoking interventions increase smoking cessation rates and reduce the occurrence of low birth weight. Kelley, Bond and Abraham (2001) conducted a meta-analysis to assess whether the overall effectiveness observed in Dolan-Mullen et al.'s study would subsist when a greater number of interventions were included. Kelley et al. concluded that stop smoking interventions, in particular those based on self-help leaflets or manuals targeted for pregnant smokers, are effective. Kelley et al. also assessed whether the time of intervention in pregnancy was related to effectiveness but they found no significant association. In 2004, Lumley et al. conducted a meta-analysis, which assessed the effectiveness of smoking cessation interventions for pregnant smokers and the health of the fetus, mother, infant and family. They concluded that smoking cessation programs can help pregnant smokers to become successful quitters.

Future Recommendations

Based on the findings from the consultancy, the following recommendations are outlined;

Referral Pathways

- Develop a referral post card to be used by midwives. (This has already been introduced at one of the acute trusts where the referral cards are added into booking packs.)
- Develop a similar referral card for the other acute trust.
- Develop a poster and leaflets with the same image to be displayed in antenatal clinics. The resources to include contact details for the stop smoking advisor and Smokefree [redacted]. Women to be able to self-refer by sending a text message; "mum" to a mobile number.
- Develop a referral post card for other health care professionals who are likely to come into contact with pregnant women, e.g. health visitors.

Training

- Run regular mandatory level I training for all midwives.
- Run update sessions for those midwives who have not been recently trained.

- If it is challenging to find time for the training events, combine the update sessions with the training sessions and shorten the length of the training.
- Focus on the following issues during the training;
    - How to provide stop smoking advice in an effective and positive way. Aim to improve the midwives' skills and confidence in giving smoking cessation advice.
    - Increase awareness and knowledge of the stop smoking service, NRT, smoking, smoking cessation and risks related to smoking during pregnancy. Aim to increase general knowledge and understanding of the importance of the topic.
    - Provide information regarding the effectiveness of brief advice and interventions run by specialist advisors to create realistic expectations of the advice as well as to inform midwives of the benefits of the task.
    - Mention that all pregnant women benefit from receiving advice and interventions regardless of type of smoker, time of pregnancy and perceived readiness to change.
    - Stress importance of giving advice at every opportunity – not just during booking. The booking sessions are likely to be busy and all midwives are not able to provide continuity of care.
    - The training to be either run by the specialist advisor who is likely to support the pregnant women who are referred or the advisor to be introduced to the midwives during the training.

Working with Pregnant Women Who Smoke

- Continue to work with pregnant women regardless of stage of pregnancy and type of smoker as interventions for women who are at a later stage of pregnancy and heavier smokers appear to be equally effective.
- Provide incentive for successful quitters.
- As the interventions led by midwives appear less effective, trained level II advisors should continue to provide support to pregnant women with midwives being the main referrals.
- Stress to pregnant women that the advisor cares about the baby but is there mainly for the woman.
- Increase number of level II trained stop smoking advisors who are based in Children's Centres.

Other

- Identify a person within the midwifery teams at the acute trusts who already have a good relationship with the midwives to feed back number of referrals and contact the midwives who do not tend to refer.

January 2009

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Appendix 8

Smokefree [redacted]
Ground Floor
[redacted]
London
[redacted]

Feb 18 2009

Dear Carolina

Report on the Consultancy Project: "How the Stop Smoking Service Could More Effectively Target Pregnant Women Who Smoke"

Thank you for your report. It is an extremely well researched project which confirms many of the problems in working with this complex client group and makes invaluable recommendations.
It highlights the immense challenges in recruiting pregnant women to the study and shows that running focus groups with them is not feasible. You also reflect the difficulties midwives face in prioritizing the diverse range of topics they cover in a booking consultation. Lack of time, confidence and expertise to discuss client's smoking habits and fear of damaging the client - midwife relationship are recurring themes. However, the report gives valuable insight into midwives' perceptions of themselves as practitioners and aspects they feel positive about in helping pregnant smokers to quit. This will help when designing future training programmes. It is also useful to hear how other stop smoking services have increased referrals.

Recommendations.
Some examples of how your recommendations will be implemented:-

- Target women before they become pregnant. Work with the Contraceptive and Sexual Health Services to design a referral pathway.
- Review the content and length of Level 1 training in line with new DH guidance. Run L1 training during mandatory midwife training sessions, where possible. Provide regular updates.
- Present project findings to the Heads of the Maternity Services and Sure Start Children's Centre Stop Smoking Steering Group. Provide regular feedback on referral data and individual client progress to referring midwives.
- Design posters based on the referral post card (already implemented) to display in all antenatal settings and Children's Centres with a telephone number to call or text to self-refer.

We may take further action when the results of the client interviews are available.

Yours sincerely,

[redacted]

Senior Stop Smoking Specialist, Smokefree [redacted]

Unit 4 Teaching and Training

Level II Training in Smoking Cessation

CASE STUDY 1 - LEVEL II TRAINING IN SMOKING CESSATION

As individual stop smoking interventions increase success rates compared to less intensive support (Lancaster & Stead, 2006), the Thorax guidelines recommend that health professionals should be trained in providing interventions in smoking cessation (West, McNeill & Raw, 2000). Therefore, stop smoking services regularly hold training days to provide trainees with the necessary skills and knowledge to become level II advisors capable of providing one to one smoking cessation support. To reduce the number of inactive and ineffective trained advisors in the borough, the Smokefree service decided to revamp both the application process and the content of the level II training days.

Plan and Design a Training Programme that Enables Students to Learn about Psychological Knowledge, Skills, and Practices

Superior stop smoking advisors possess vital interpersonal characteristics (Sinclair, Bond & Stead, 2006). The application process therefore attempted to identify applicants holding effective communication skills and organisational abilities by asking both the applicants and their managers to rate the characteristics of each applicant (see Appendix 1 for the application form). In addition, prior to the training day, applicants were provided with a pre learning pack and requested to successfully complete a quiz including questions on addiction, pharmacotherapies and stop smoking interventions (see Appendix 2 for the quiz). Sinclair et al. (2006) identified that lack of counselling skills was a barrier for pharmacists in supporting clients in smoking cessation and by encouraging trainees to gain knowledge of smoking before the training, more focus could be directed towards teaching counselling skills during the training day. Evaluation forms from previous training

days indicated that trainees found role-play sessions the most useful part of the day and many expressed a wish that more time should be spent on interactive activities.

Honey and Mumford (1992) identified four types of learners; the activist who prefers learning by doing and experiencing, the reflector who favours learning by observing and reflecting, the theorist who wishes to comprehend underlying reasons, concepts and relationships and the pragmatic who learns effectively by actually trying out how things work. When planning the training day, types of learners were taken into consideration. As part of the training day, trainees would be able to observe and practice role-plays as well as reflect and learn underlying concepts of tasks.

Reflection on Planning and Designing a Training Programme

The trainees appeared to possess a clearer perception of their training needs than during previous training days. This might have been due to the fact that the application process was lengthier and applicants received clearer information about what is expected from level II trained advisors. However, as a number of applicants were unsure of some elements of the application process, the cover letter may be more informative if a flow chart was included. The training day began with trainees stating expected learning outcomes and these anticipations were written down on a flip chart (see Appendix 3 for a needs assessment of the audience). Even though a concluding session was dedicated to discussing any issues which had been ignored and most of the trainees' learning outcomes had been covered during the day, I felt that a more structured session of assessing whether their needs had been met should be incorporated in future training days.

Deliver the Training Programme

The audience consisted of 18 health professionals including pharmacists, practice nurses and mental health workers. During the introduction, members of the Smokefree team were presented and the trainees were asked to introduce themselves. The aim and objective of the training were highlighted and I provided the audience with an overview of the day (see appendix 4 for a session plan). This was followed by a presentation of the Smokefree service and a session, which aimed to inform trainees of the advisor pack they were given to help them provide stop smoking interventions. PowerPoint was used for these presentations. The other sessions I was involved in during the training included interactive activities in which trainees were asked to reflect on various scenarios in smaller groups and feed back to the rest of the audience, a carbon monoxide practice session and role-plays.

Reflection on Delivering the Training Programme

Overall, the training day went smoothly and the presentations and activities all progressed according to plan. The aim of revamping the training was to spend more time on practical sessions and this was definitely achieved. The trainees had completed a quiz prior to the day and they therefore possessed a greater knowledge about smoking compared to previous training days. This allowed for more time to be spent on practical sessions and teaching effective counselling styles. However, due to time pressure caused by various sessions lasting longer than expected, an assessment needs to be undertaken with regard to which sections should be included, excluded or shortened for the next training day. In addition, even though the audience possessed a greater level of knowledge of pharmacotherapies prior to the day compared to previous training events, some trainees did not appear to have assimilated the expected amount of information. This might have been due to

motivational factors, time restraints or a misjudgement of the importance of reading the literature they were sent. Therefore, future training days might benefit from the inclusion of presentations on Nicotine Replacement Therapy (NRT) and Zyban in addition to practical sessions. For those participants who had digested the material sent to them, such presentations would serve to refresh rather than educate. Although this part of the training may be repeating what some of the trainees already know, providing information on pharmacotherapies remains essential because of the implications for clients' health and safety.

Sinclair et al. (1998) examined the effectiveness of educational programmes in teaching medical students smoking cessation skills. They found that traditional didactic teaching was not as effective as audio feedback through the use of audio taped role-plays, role-plays with peer feedback and video feedback. Thus, another recommendation for future training days would be to pre-record role-play sessions. This would also ensure that each session covered all the necessary elements of providing effective stop smoking support and the trainers would have one less task to perform in an otherwise demanding and hectic day.

Although a change in the teaching schedule may have elicited an onset of nerves and insecurity in earlier presentations, I found that my level of subject knowledge was such that I was able to adapt and remain confident that I could deliver these sessions effectively. In addition, as I had liased with many of the participants prior to the day of training, I felt more at ease teaching on the day. Despite feeling confident in my delivery of the session, I may have acted within a certain comfort zone. That is, only delivering material I had thoroughly prepared and allowing little if any room for improvisation. Acting outside of this realm of certainty may in fact make me more comfortable dealing with situations that are off

protocol. Hence, future presentations may benefit from me being able to take greater risks with methods of delivery and give a little more of myself as the trainer.

Plan and Implement Assessment Procedures for the Training Programme

According to Hall, James and Roberts (1997), training can be assessed at different levels. One method of appraising the knowledge and skills a training session aims to enhance is through written forms of evaluation (see Appendix 5 for the assessment form, Appendix 6 for graphs of the responses and Appendix 7 for a summary of the feedback). Assessment forms were completed by the trainees who expressed the level of confidence, skills and knowledge they had acquired in providing stop smoking interventions. The highest level of assessing the effectiveness of training is by measuring health care outcomes (Hall, et al., 1997). This will be undertaken six months after the training day by investigating how many clients the advisors have supported, how soon after the training they provided the first intervention and the success rates of clients seen, compared to advisors trained in previous training events.

Reflection on Planning and Implementing Assessment Procedures for the Training Programme

The majority of the trainees reported that they felt "very confident" or "confident" in providing stop smoking sessions in the future and that they had very much or quite a lot knowledge and skills in providing effective level II smoking cessation support. The open-ended questions revealed that role-play and interactive sessions, which aimed to increase levels of confidence, knowledge and skills, were perceived as the most useful parts of the training. However, whether the advisors actually will provide more effective interventions and be able to support more clients remains to be assessed. The trainees appeared to possess the right knowledge and

confidence when practicing providing interventions and responding to questions commonly asked by smokers. However, as the audience had more opportunities to engage in interactive activities than during previous training days, the abilities of the trainees were more observable.

Evaluate the Training Programme

Evaluation forms were distributed to trainees in the end of the training day. As well as including five point scales to evaluate how useful trainees perceived different parts of the presentation, five open-ended questions were added to gain more reflective responses (Race & Smith, 1996) (see Appendix 5 for the evaluation form, Appendix 6 for graphs of the responses and Appendix 8 for summary of the feedback).

Reflection on Evaluating the Training Programme

The evaluation forms that trainees completed in the end of the training day mirrored very positive responses. Every part of the training was generally considered as "useful" or "very useful" by the trained advisors. One trainee responded that more strategies for working with mental health patients should have been included as part of the training day. As the mental health trust requires a vast number of mental health workers to attend level II training, a training day designed only for this professional group will be held. As mental health patients represent a complex group and there was not sufficient time to incorporate an extra session into the training, perhaps the mental health workers attending the training day would have benefited from attending the event specifically tailored for them.

Overall Reflection

Changing both the application procedure and the schedule of the level II training day in smoking cessation was a time consuming but rewarding process. Although each element of the training event unfolded as it had been designed to, only through the practical application of these processes could positive amendments be made for future training days to make the application process smoother and the training day more effective. The experience helped me to hone the necessary personal skills, knowledge and confidence in planning, delivering, assessing and evaluating a training event. It also allowed me to reflect on the elements of the process, which may require greater attention in the future.

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Appendix 1

5th April 2007

RE: Level 2 Training 2007

Dear Colleague,

Please find enclosed information regarding the Level 2 training planned for 2007.

Level 2 Training

This intensive all-day training will provide applicants with the skills required to actively support smokers in a 5-week stop smoking program. The training will be very practical consisting of hands-on activities including role-play sessions and interactive question and answer sessions.

What is expected of newly trained advisors?

- Trained advisors are expected to start supporting clients within a month of training and to support a minimum of four clients per quarter.
- Trained advisors are expected to follow the correct procedural process including adhering to the weekly session protocol as outlined in the level 2 advisor training pack and returning monitoring forms by the set deadlines.
- All level 2 advisors are also expected to attend at least one update session held by [redacted] every year.

What is the application process?

[redacted] is currently piloting a new application process for the level 2 training days in smoking cessation.

Why are we doing this?

There are a limited number of training places available and this application process has two aims:

- To target [redacted] resources more effectively.
- To identify applicants who are most able and likely to support people in smoking cessation over a 5 week period.
- To provide applicants with a clearer understanding of the intervention they will be implementing.
- To increase the proportion of people who become active advisors.

There are two stages to the application:

Stage 1

- The applicant completes an application form.
- The applicant provides their manager with this letter, their application form, the managerial reference request form and a copy of the Terms and Conditions.
- The manager completes the reference request form and sends the managerial reference request and the applicant's application form to [redacted].

The applicant's overall suitability to progress to stage 2 will then be assessed by [redacted].

Stage 2

- Applicants proceeding to stage 2 will be sent a pre-training learning pack and a quiz to measure the applicant's learning will be sent out. The aim of the quiz is to ensure that the applicant gains a required level of background knowledge regarding smoking cessation prior to attending the training day.
- The applicant will be asked to read the pre-training learning pack and return a completed quiz.

The successful applicants will then receive a written confirmation of their place on the level 2 training four weeks prior to the training date.

Stage 3

- Applicants who successfully complete the 1 day training will automatically be booked onto the next scheduled update session**. This is to ensure that they have an opportunity to feedback on their first clients and get support from Specialist staff and other advisors.

What are the Dates?

Level 2 Training Days:	**Monday 18th June 2007 and Tuesday 13th November 2007 9.30-16.30** [redacted]
PGD Training for Pharmacists*:	**Monday 18th June 2007 and Tuesday 13th November 2007 16.30 – 17.30** [redacted]
Level 2 Update Sessions**:	**Monday 29th October 2007 and February 2008 (Date to be confirmed)** **10.00-12.00 and 19.00-21.00**

*All Pharmacists attending the level II training day will automatically be booked a place on the corresponding PGD training. This training will be run by [redacted].

Please send all completed forms to our freepost address:

Freepost Licence No. [redacted]
[redacted] Stop Smoking Service
[redacted]
London NW1 0PE

(please ensure you copy the address exactly as it appears here)

Alternatively, you can fax the forms to us on [redacted]

We look forward to hearing from you.

Yours Sincerely

Carolina Herberts
Health Psychologist in Training
[redacted]

Application Form for Level 2 Training

Please tick training date:

Monday 18th June, 2007 ☐
(return this form by the 20th April)

Tuesday 13th November, 2007 ☐
(return this form by the 14th September)

1. Name _____

2. Job Title _____

3. Workplace _____

4. Address _____

5. Tel: _____ **Fax:** _____ **E-mail:** _____

6. To the best of your knowledge do you intend to be in this post for at least the next 6 months?

Yes ☐ **No** ☐

7. How many level 2 trained stop smoking advisors are there at your workplace? ____

8. Non-pharmacists only:

Would you be able to provide Nicotine Replacement Therapy (NRT) and/or Zyban prescriptions at your workplace?

Yes, both NRT and Zyban ☐ **Yes, but only NRT** ☐ **No, neither** ☐

If yes, who would prescribe the products? _____

9. To what extent are you in control of your workload?

1	2	3	4	5	6	7	8	9	10
Not at all				Moderately				Completely	

10. Would you be able to see clients for smoking cessation support within a month of training? **Yes** ☐ **No** ☐

11. What specific things do you need to put / are in place to ensure you are able to deliver smoking cessation support within a month of training?

_____

_____

12. Would you be able to provide stop smoking support to at least four clients per quarter? **Yes** ☐ **No** ☐

13. How will you ensure that you can recruit and provide stop smoking support to at least four clients per quarter?

_____

14. Who will be your main target client group(s) for the level 2 intervention?

(e.g. specific ethnic groups, age groups, mental health)

_____

15. Do you have any registered disabilities that impact on your ability to complete this application process?

Yes ☐ **No** ☐

If 'Yes' do you require further assistance from our service to help you complete the application process?

Yes ☐ **No** ☐

If 'Yes', please indicate how? _____

_____

I have read the enclosed Terms and Conditions and agree to abide by it, subject to me being accepted on the training program.

Signature: _____ Date: _____

Managerial Reference Request

Private & Confidential

1. Applicant's Name _____

2. Applicant's Job Title _____

3. How long is the applicant contracted to this post? _____

4. How long has the applicant been in post? _____

5. To what extent can the applicant manage their workload?

1	2	3	4	5	6	7	8	9	10
Not at all				Moderately					Completely

6. Please refer to the enclosed level 2 training letter and the applicant's application form and rate the applicant's ability on the following:

To give complicated instructions and information:

1	2	3	4	5	6	7	8	9	10
Poor				Moderate					Good

To communicate coherently:

1	2	3	4	5	6	7	8	9	10
Poor				Moderate					Good

To listen effectively:

1	2	3	4	5	6	7	8	9	10
Poor				Moderate					Good

To prioritise effectively:

1	2	3	4	5	6	7	8	9	10
Poor				Moderate					Good

To complete paperwork reliably:

1	2	3	4	5	6	7	8	9	10
Poor				Moderate					Good

To meet deadlines:

1	2	3	4	5	6	7	8	9	10
Poor				Moderate					Good

7. Please refer to the enclosed level 2 training letter and the applicant's application form and comment on the applicant's ability to undergo and implement the training:

8. Would the applicant be supported to attend yearly update sessions?
Yes ☐ No ☐

9. Would the applicant be able to see clients for stop smoking support within a month of training?

Job Title: _____ Organisation: _____

Address: _____

Tel: _____ Fax: _____ E-mail: _____

I have read a copy of the Terms and Conditions and support the applicant in abiding to it, subject to the applicant being accepted on the training program.

Name: _____ Signature: _____ Date: _____

(please print)

Level 2 - Community Stop Smoking Advisors

Terms and Conditions *Updated April 2007*

Your Commitment is to:

1. Provide 5 sessions per quitter of one to one evidence-based stop smoking treatment and behavioural support as outlined in the training.
2. **Fully** complete and return monitoring forms by the deadlines to the Stop Smoking Service.
3. Follow the treatment protocol outlined in the level 2 training session (and any new changes to the protocol that are implemented following the training).
4. Maintain the carbon monoxide monitor provided to you in accordance with the manufacturers instructions and the service requirements *(to be provided once you have registered).*
5. Should your service be permanently closed to clients, return the carbon monoxide monitor and other resources to the service.

Maintaining your skills:

6. In order to maintain your clinical skills you should aim to provide regular support to quitters throughout the year (we suggest a minimum of 5 clients per quarter).
7. Attend a minimum of one update, seminar or event each year aimed at level 2 advisors that has been organised by the Stop Smoking Service.
8. Attend an update session if you are inactive for a period of 6 months or more to ensure that you are up to date and fully equipped to offer support before seeing new clients.

Communication with the Specialist Stop Smoking Service:

9. Keep in regular contact with your locality Stop Smoking Advisor and discuss any problems in service delivery.
10. Inform the service giving 1 month's notice if you are moving premises or offering services from additional premises.
11. Inform the service giving 1 month's notice if the service needs to be temporarily or permanently closed to clients.

Our Commitment is to:

1. Provide regular update training, which will be offered at a variety of locations and times.
2. Re-calibrate CO monitors as recommended by the manufacturers.
3. Provide paperwork and materials (i.e. mouthpieces) necessary to provide level 2 services.
4. Provide a named Specialist Stop Smoking Advisor for your locality who will provide you with regular support and advice.
5. Arrange payment for return of fully completed monitoring forms.
6. Provide ongoing feedback and evaluation of your performance, this may include contacting some of your clients.
7. Provide support to advisors who are experiencing problems within any aspect of the service.
8. Give you 1 month's notice if we intend to end your agreement to provide Level 2 services.

Appendix 2

SMOKING QUIZ

Please answer each question and circle the correct answer(s)

Name_____

General Information

1. When will/did all enclosed public places and workplaces in England become smokefree?

a) July 2007 b) September 200 c) November 2007 d) January 2008

2. What percentage of adults smoke in England?

a) 15% b) 20% c) 25% d) 30%

3. What percentage of smokers would like to quit smoking?

a) 34% b) 60% c) 74% d) 90%

Effects of Smoking

4. What percentage of smokers will die early due to their habit?

a) 10% b) 20% c) 35% d) 50%

5. What percentage of lung cancer deaths are caused by smoking?

a) 10% b) 40% c) 60% d) 90%

6. The health effects of smoking in pregnancy are:

a) Miscarriage b) Low Birth Weight c) Diabetes d) All of them

7. What proportion of children in the UK are exposed to secondhand smoke at home?

a) A quarter b) A third c) Half d) Three quarters

Effects of Nicotine

8. Dopamine is associated with:

a) Improved alertness b) Improved concentration c) Improved memory d) Pleasure

9. Smoking relieves stress

a) True b) False

10. Which of the following is a withdrawal symptom of stopping smoking?

a) Lightheadedness b) Hair Loss c) Ear ache d) Bruising

11. The key message to note regarding nicotine withdrawal is that withdrawal symptoms are?

a) Permanent and abnormal b) Temporary and normal
c) Temporary and abnormal d) Permanent and normal

12. Nicotine is the substance in cigarettes that causes cancer.

a) True b) False

NRT and Zyban

13. In general how often during the day should quitters use their NRT (excluding patches)?

_____

14. An advantage of using the microtab is:

a) Its strong dosage b) Its nice taste
c) It simulates hand to mouth activity of smoking d) It is discrete

15. Describe the technique for using the NRT gum

_____

_____

16. Which NRT product is the most effective?

a) Patch b) Inhalator c) Nasal spray d) They are all equally effective

17. Which NRT product delivers nicotine fastest?

a) Patch b) Inhalator c) Nasal spray d) Lozenge

18. What are some of the side effects of NRT?

_____

_____

19. Pregnant women should not use NRT

a) True b) False

20. What is the only contraindication for NRT?

a) Breastfeeding mothers b) Under 18 year olds
c) Under 12 year olds d) People taking anti-depressants

21. What should someone with diabetes mellitus do whilst taking NRT?

a) Increase sugar levels b) Monitor blood pressure regularly

c) Check thyroxin levels d) Monitor blood sugar levels more closely

22. Why do people not tend to get addicted to NRT?

a) NRT delivers nicotine in a lower steady dose than cigarettes b) Nicotine is not addictive c) Because the taste is so bad d) NRT should only be used for 4 weeks

23. How can a client obtain Zyban?

a) Over the counter b) Through the specialist stop smoking service
c) On prescription from their GP d) Zyban is not yet available in Camden

24. Can a person with epilepsy take Zyban?

a) Yes, but they need to inform their GP b) Yes, they can
c) No, it is a contraindication d) Yes, but they can only take 1 tablet a day

25. A caution of Zyban is:

a) Previous adverse reactions to Zyban b) Alcohol abuse
c) Previous use of Zyban d) Pregnant women

26. How long is the Zyban treatment course?

a) 4 weeks b) 8 weeks c) 12 weeks d) 16 weeks

27. One of the most common side-effects of Zyban is:

a) Irritability b) Weight loss c) Weight gain d) Insomnia

28. How long before quitting should clients start using:

a. NRT _____
b. Zyban _____

Stop Smoking Sessions

29. Carbon monoxide replaces what in the body?

a) Oxygen b) Water c) White blood cells d) Glucose

30. The NHS Stop Smoking Service is based on which approach?

a) Abstinence b) Acupuncture c) Hypnotherapy d) Cut down to quit

31. Who is able to provide group support?

a) Level II advisors b) Level III specialist stop smoking advisors
c) Any health professional d) The general public

32. In the preparation session it is important to:

a) Discuss client's motivation to quit
b) Recommend follow-up prescription for Zyban
c) Encourage client to cut down their cigarettes d) Pressurise client into quitting

33. What is a necessary part of each stop smoking session?

a) Measure the client's CO reading b) Provide an NRT prescription
c) Set a quit date d) Provide the client with a quit certificate

34. Which of the following is a coping strategy for giving up smoking?

a) Identifying ways to avoid or handle trigger points b) Cutting down on NRT
c) Keeping cigarettes at home as a safety blanket d) Increasing alcohol intake

35. In which session would the advisor discuss relapse prevention?

a) First session b) Second session c) Third or fourth session d) Fifth session

36. In which session would the client start using NRT?

a) First session b) Second session c) Third or fourth session d) Fifth session

37. In which session would the advisor help the client prepare for quitting?

a) First session b) Second session c) Third or fourth session d) Fifth session

Please send the completed quiz to:

Freepost Licence No. [redacted]
[redacted] Stop Smoking Service
[redacted]

Alternatively, you can fax the quiz to us on:

[redacted]

Thank you!

Appendix 3

Needs Assessment

Presenter: Carolina Herberts
Audience: Health professionals with no previous training in smoking cessation
Date: 18th June 2007

Subject: Level II Training in Smoking Cessation
Venue: [redacted]
Time: 9.30– 16.30

Date	Assessment undertaken through	Details of the assessment	Suggestions/Recommendations made
05/01/07	A meeting with the Head of the Stop Smoking Service Service (a Consultant Health Psychologist)	The meeting was arranged to discuss changes to the level II training day including assessing the most suitable applicants for the training and the training needs of the trainees	As a number of trained advisors remain inactive or ineffective in supporting clients in stopping smoking, the Head of the Service requested changes to be made to the; 1) application process to assess the candidates most suitable to become advisors and 2) the content of the training to increase confidence in providing interventions. The head of the service suggested that the application process should be extended with questions around e.g. organisational skills, communication skills, ability to prescribe NRT, necessary procedures undertaken to supporting clients. The applicants' managers will also be requested to complete an assessment form for the applicant. In addition, applicants will be requested to pass a quiz on smoking to increase knowledge so more time can be spent on interactive activities during the actual training day.
02/04/07	A meeting with three stop smoking advisors from another borough	We changed ideas regarding the application process and content of our level II training days	The advisors in the other borough run an interactive activity in the beginning of each training day on "What makes a good advisor". This makes the trainees reflect on necessary characteristics of advisors and what constitutes effective interventions. In addition, they recommended running an interactive session on pharmacotherapies rather than only giving trainees a presentation on smoking cessation aids.
18/06/07	The audience attending the training	In the beginning of the training, the audience was asked to give information about what their learning expectations were. These issues were addressed during and in the end of the training day.	The expectations the audience gave included the following points: To become level II trained advisors To help mental health patients stop smoking To support people with drug and alcohol problems stop smoking As a manager to support mental health workers provide smoking cessation support To help people stop smoking in preparation for the Smokefree legislation To help people from BMEs stop smoking How the support services compare to other alternative therapies How to give effective smoking cessation support to clients

Appendix 4

Session Plan

Module: Core Unit: 4 Teaching & Training Competence
Subject: Level II Training in Smoking Cessation
Presenter: Carolina Herberts
Date: 18th June 2007 **Time:** 9.30 – 16.30
Venue: [redacted]

Topic/Aim(s) of Session:

For trainees to become level II advisors, able to provide effective stop smoking support

Learning Outcomes: By the end of the session participants will be able to -

Implement level II stop smoking support by possessing the right knowledge, skills and confidence

Time:	Outline Plan:	Participant activity
9.30	Coffee & Tea	
9.45	Introduction of team and trainees Aims and objectives outlined	Trainees to comment on their expectations of the day
10.00	Introduction to Smokefree [redacted]	
10.05	Level II advisor pack	
10.15	What Makes a Good Advisor?	Trainees to reflect on what makes a good advisor in groups of 5
10.30	Facilitating Behaviour Change	
10.40	CO-Monitoring	Trainees to practice talking about CO and taking readings
11.10	Tea/coffee break	
11.20	Champix	
11.30	Practical session on NRT & Zyban	Trainees to be given scenarios of various clients and discuss which pharmacotherapy to recommend and what advice to give
12.00	NRT & Zyban questions and answers	Trainees to practice answering questions about NRT & Zyban
12.10	Overview of 1st session and advisors to do role play	
12.40	Role play on 1st session	Trainees to do role play on the 1st session in groups of 5
13.00	Lunch	
13.40	Overview of 2nd session	Trainees to be given scenarios of various clients and in small groups and discuss what advice to give.
14.00	Advisors to do role play of 2nd session	
14.10	Role play on 2nd session	Trainees to do role play on the 2nd session in groups of 5
14.25	Overview of 3rd/4th session	Trainees to be given scenarios of various clients and in small groups and discuss what advice to give.
14.45	Advisors to do role play of 3rd/4th session	
14.55	Role play on 3rd/4th session	Trainees to do role play on the 3rd/4th session in groups of 5
15.10	Tea/coffee break	
15.20	Overview of 5th session and advisors to do role play	
15.30	Role play on 5th session	Trainees to do role play on the 5th session in groups of 5
15.45	Other issues	Trainees can ask questions about what has been covered so far
15.55	Questions & answers	Trainees to practice answering some common questions clients ask in smaller groups
16.05	What Happens Next?	Trainees to complete an action plan and book onto an update session
16.10	Questions	A final opportunity to ask questions for participants
16.15	Evaluation	Trainees to complete assessment/evaluation form
16.20	Distribution of certificates, CO-monitors, mouthpieces & advisor packs	Trainees to collect necessary material

Appendix 5 **Evaluation form - Level II Training** 18th June -07

Please complete both pages of the evaluation form

What is your job title? _____

1. How useful did you find the following parts of the training? (please circle)

a) Introduction to [redacted]

Very Useful Useful Neutral Not very useful Not at all useful

b) Level II Advisor Pack

Very Useful Useful Neutral Not very useful Not at all useful

c) What Makes a Good Level II Advisor? - Interactive session

Very Useful Useful Neutral Not very useful Not at all useful

d) Facilitating Behaviour Change

Very Useful Useful Neutral Not very useful Not at all useful

e) CO Monitoring

Very Useful Useful Neutral Not very useful Not at all useful

f) Champix

Very Useful Useful Neutral Not very useful Not at all useful

g) Practical Sessions

Very Useful Useful Neutral Not very useful Not at all useful

h) Questions & Answers Sessions

Very Useful Useful Neutral Not very useful Not at all useful

i) Role Plays

Very Useful Useful Neutral Not very useful Not at all useful

2. What were the most useful parts of the training day?

3. What were the least useful parts of the training?

4. Was there anything else you would have liked included in the training?

5. How confident do you feel in delivering level II stop smoking support to clients?
(please circle)

Very confident Confident Unsure Slightly confident Not at all confident

6. Do you feel you have sufficient knowledge to deliver effective level II stop smoking support? (please circle)

Very much so Quite a lot Unsure Not much Not at all

7. Do you feel you have the necessary skills to deliver effective level II stop smoking support? (please circle)

Very much so Quite a lot Unsure Not much Not at all

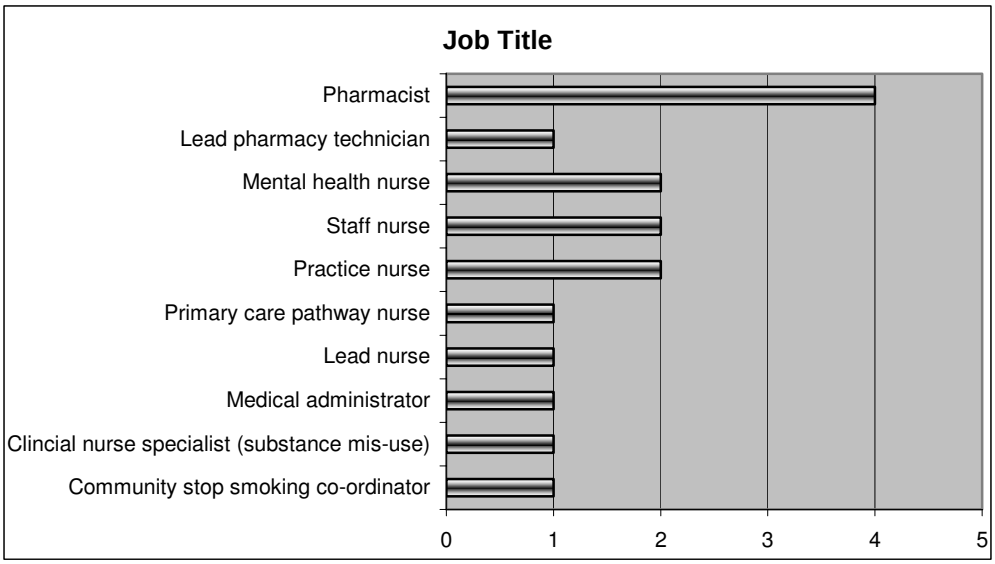
8. What further help and support do you think you will need to put what you have learnt today into practice?

9. Any other comments

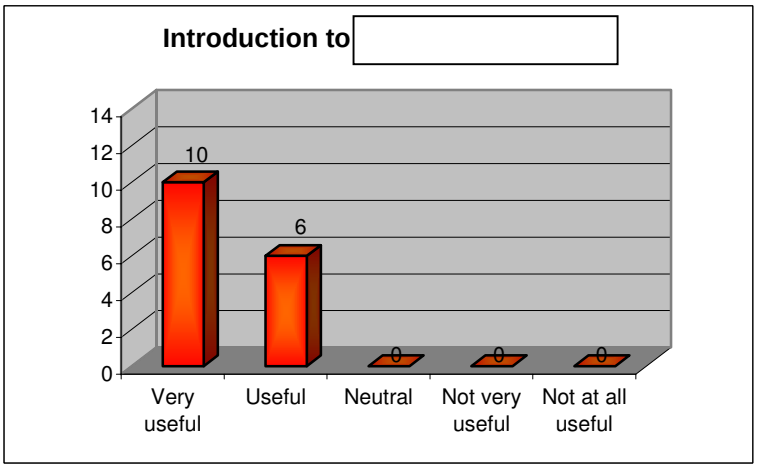
Thank You!

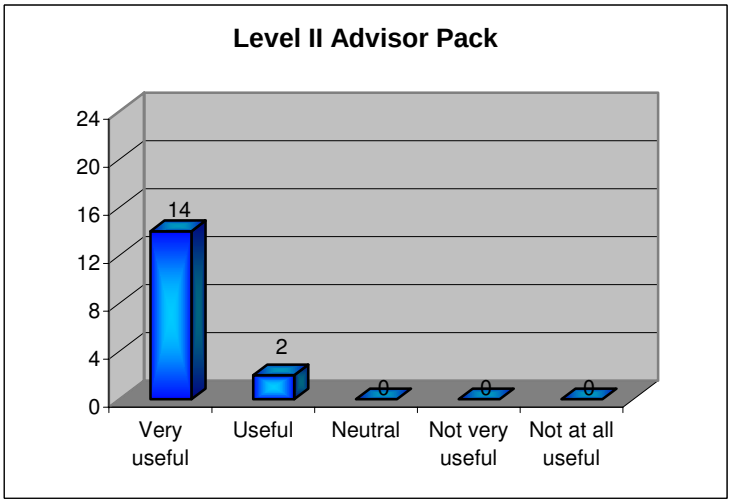
Appendix 6

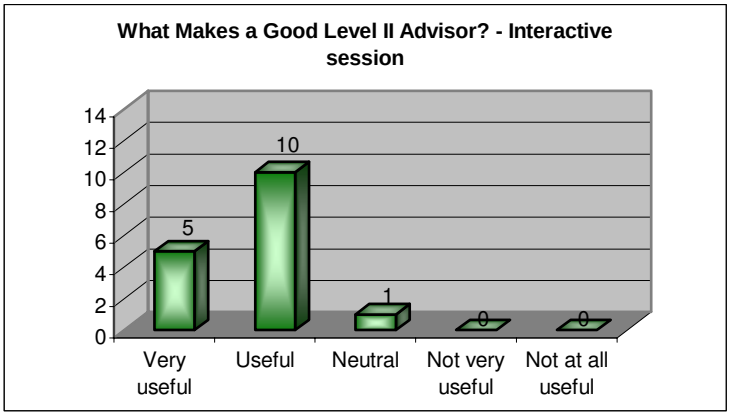
Assessment and Evaluation – Level II Training 18th June 2007



1. How useful did you find the following parts of the presentation?






What Makes a Good Level II Advisor? - Interactive session
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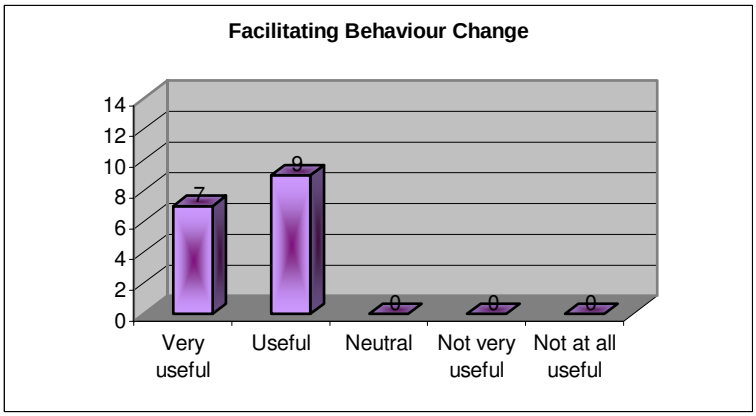
Not very useful
Not at all useful


Facilitating Behaviour Change
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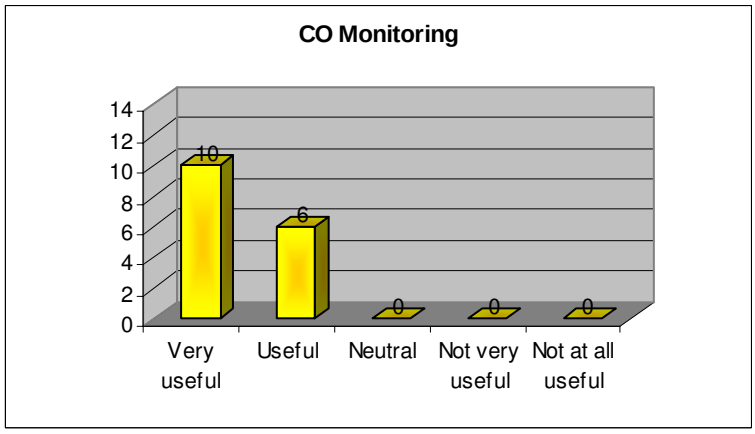
CO Monitoring
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Very useful
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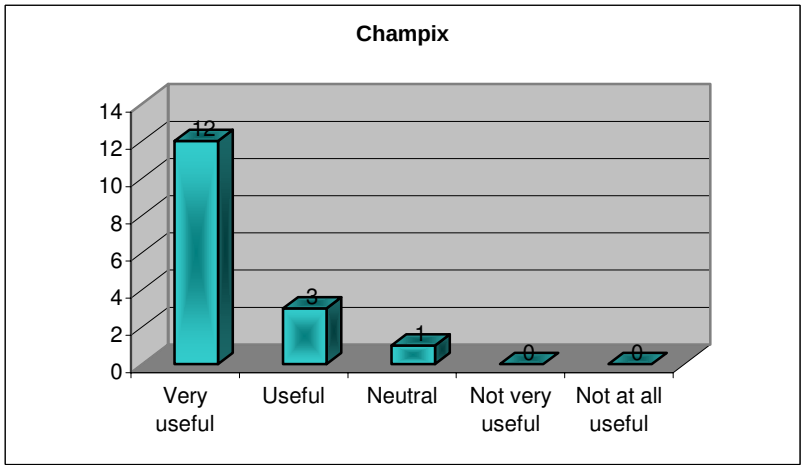
Champix
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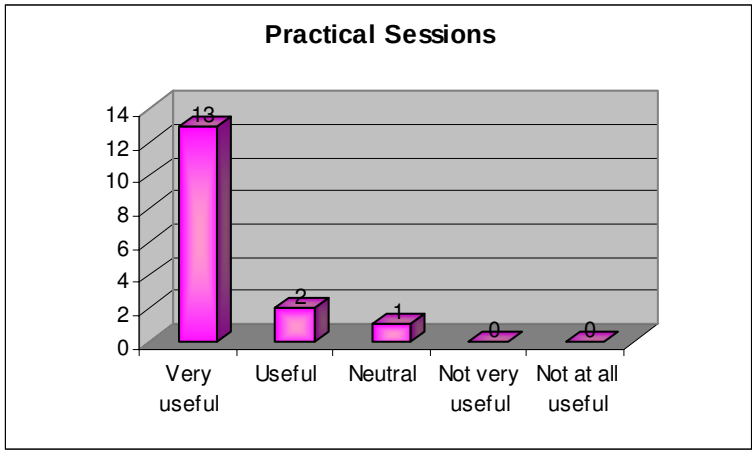
Practical Sessions
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Useful
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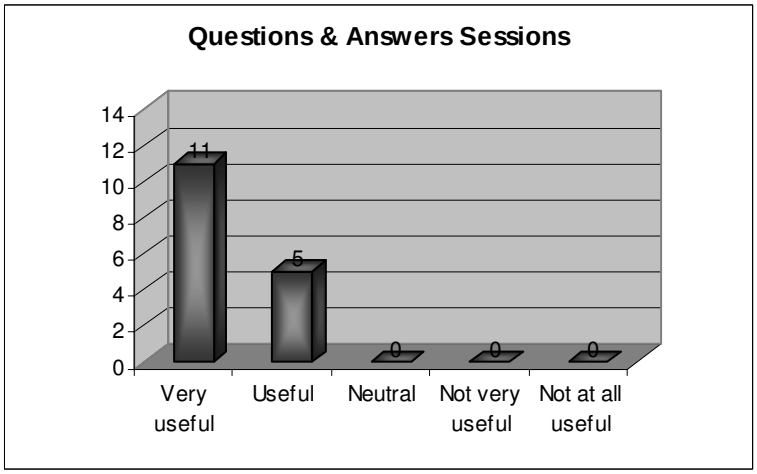
Not very useful
Not at all useful


Questions & Answers Sessions
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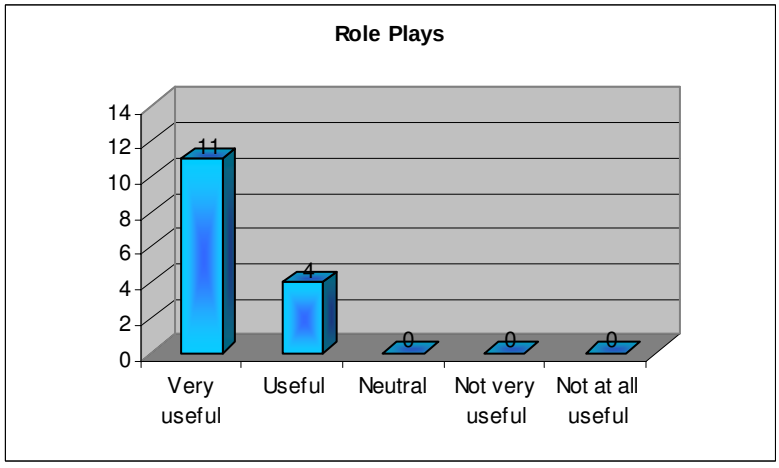
Very useful
Useful
Neutral
Not very useful
Not at all useful


Role Plays
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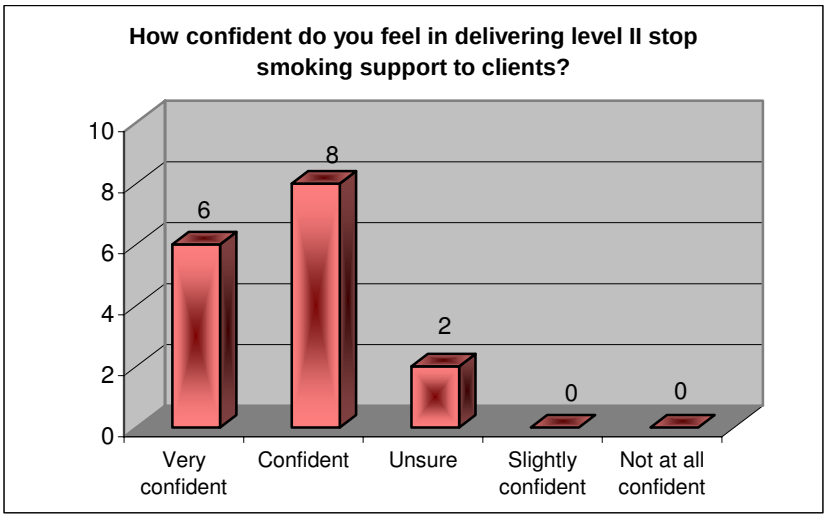
Not very useful
Not at all useful


How confident do you feel in delivering level II stop smoking support to clients?
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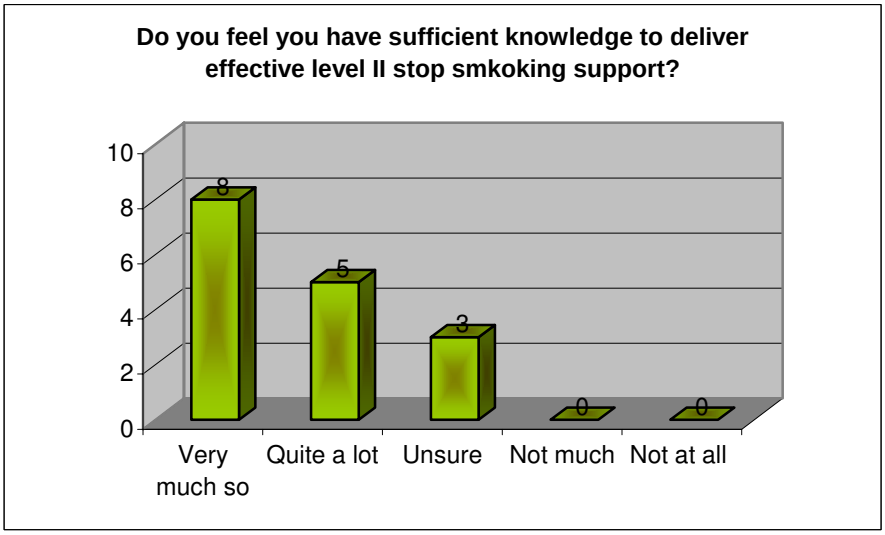
Very confident
Confident
Unsure
Slightly confident
Not at all confident


Do you feel you have sufficient knowledge to deliver effective level II stop smkoking support?
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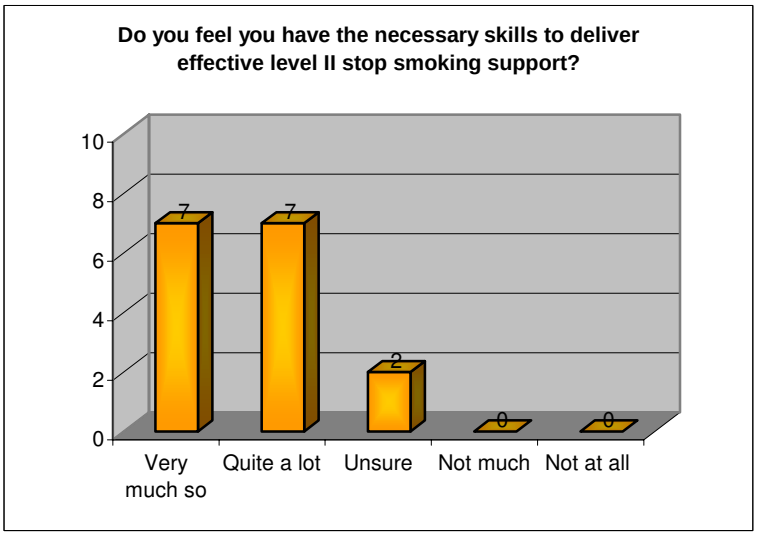
Very much so
Quite a lot
Unsure
Not much
Not at all


Do you feel you have the necessary skills to deliver effective level II stop smoking support?
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2
0
0
Very much so
Quite a lot
Unsure
Not much
Not at all

2. What were the most useful parts of the training?

- Role playing
- Going through 5 sessions by steps
- Q + A sessions + role play
- All relevant
- Everything covered was very relevant
- Role play / practical sessions
- The role play + questions and answers
- I found the Q & A sessions most useful
- How to carry out every session
- Practical sessions
- Being interactive – role playing
- Practical sessions and exemplar role plays
- Role play
- Watching the role play
- Role play for 1st session (skills etc)
- Practical session, questions & answers were the most useful parts of the training

3. What were the least useful parts of the training?

- CO^2 machine information

4. Was there anything else you would have liked included in the training?

- Already too much in a day!
- More strategies for working with mental health patients + ethnic minorities
- No
- No

8. What further help and support do you think you will need to put what you have learnt today into practice?

- See question 4. (More strategies for working with mental health patients + ethnic minorities)
- Support from existing smoking cessation officers
- Keeping updated and will try to start immediately
- Just need to get some practice before I'm fully confident
- Probably a few sit ins with an advisor + patient – will be organising this soon
- Working more closely with other level 2 advisors in the unit
- Networking, I will be suing networks to fill gaps

9. Any other comments

- It's been a fruitful day, thanks
- Name badge system very effective in getting whole group to interact
- No
- Very organised and productive learning day. Thank you!
- A well structured day with very knowledgeable and friendly trainers
- Thank you…
- Very interesting
- No

Appendix 7

Summary of Assessment and Recommendations for Future Training Days

The objectives of the training were to provide trainees with sufficient confidence and the right knowledge and skills to provide effective stop smoking interventions. The majority of the participants indicated that they felt very confident or confident in supporting clients giving up smoking and that they possessed very much or quite a lot of knowledge and skills in providing level II smoking cessation interventions. The open-ended questions revealed that role-play and interactive sessions, which aimed to increase levels of confidence, knowledge and skills, were perceived as the most useful parts of the training. The trainees appeared to possess the right knowledge and confidence when practicing providing interventions and responding to questions commonly asked by smokers.

Although a small proportion, a few of the trainees were unsure of whether the levels of confidence, skills and knowledge acquired were adequate to support smokers in their quit attempt. The replies to the open ended answers indicated that trainees expected their confidence levels to increase as they get experience but that support from the specialist service might help trainees to get into their roles as advisors. Perhaps ensuring that participants are aware of and receive ongoing support from experienced advisors might make them feel more comfortable in supporting clients. In addition, even though the audience possessed a greater level of knowledge of pharmacotherapies prior to the day compared to previous training events, some trainees did not appear to have assimilated the expected amount of information. Therefore, future training days might benefit from the inclusion of presentations on Nicotine Replacement Therapy (NRT) and Zyban in addition to practical sessions.

Whether the advisors actually will provide more effective interventions and be able to support more clients could be assessed six months after the training by investigating how many clients the advisors have supported, how soon after the training they provided the first intervention and the success rates of clients seen, compared to advisors trained in previous training events.

Appendix 8

Summary of Evaluation and Recommendations for Future Training Days

All parts of the training were perceived as useful or very useful. However, as the training was unduly affected by the constraints of time, some sessions will have to be excluded or shortened in the future. The part of the training day which was least frequently perceived as very useful was the interactive session on "What makes a good level II advisor" and therefore, this part of the training might have to be excluded in the future. In addition, the session was followed by a presentation on "Facilitating behaviour change" which included necessary characteristics of stop smoking advisors. Future training days could also be extended to starting 30 minutes earlier and finishing 30 minutes later. As the schedule was rather tight and the training day hectic and demanding for the advisors, the role play sessions demonstrated by the trainers could be filmed prior to the day. This could also ensure that the sessions would cover every necessary aspect of the interventions.

A change from previous training days was the inclusion of more interactive activities and role plays. Judging from both the trainees' ratings of the usefulness on these sessions and their responses to the open-ended questions, these parts of the training should certainly still be included in future level II training events.

Unit 4 Teaching and Training

Smoking and HIV

CASE STUDY 2 - SMOKING AND HIV

Due to significant improvements in mortality and morbidity, People Living With HIV/AIDS (PLWHA) are living longer, healthier and more productive lives (Palella et al., 2004). Improving the health status and quality of life of HIV positive individuals should be a treatment priority. However, PLWHA are increasingly becoming ill or dying of non HIV-related illnesses and cigarette smoking is in many cases an independent risk factor (Niaura et al., 2000). Arrangements were thus made for a teaching session to be delivered to the staff working at an HIV/AIDS clinic in the borough.

Plan and Design a Training Programme that Enables Students to Learn about Psychological Knowledge, Skills, and Practices

Winefield (2004) stated that the initial phase of preparing for a teaching session involves identifying the objectives and determining the learning goals. The objectives of the presentation were to; review the association between smoking and HIV, highlight raising awareness of smoking cessation to PLWHA and outline referral pathways to stop smoking services. The learning outcomes included gained knowledge of smoking and HIV/AIDS, increased confidence in providing stop smoking advice and raised awareness of referral pathways (see Appendix 1 for a session plan).

In assessing the needs of the audience, it is vital to know who the learners are, what knowledge they possess and the size of the audience (Winefield, 2004). I got in touch with the main point of contact at the clinic, a senior nurse, who communicated that a range of professionals attend the meetings and approximated that the audience would consist of 50 members of staff. He also underlined the need for basic knowledge areas to be covered in the presentation. As part of planning and designing

the teaching session, a project officer for sexual health was contacted as she had previously delivered a presentation for the same audience. Due to the variety of professionals attending the session, she advised that I should reflect on how the training could be relevant to all who attend. I called a specialist stop smoking advisor who is the HIV/AIDS lead in another borough to ask for advice regarding the content of the training. The advisor had conducted many similar presentations in another borough and advised that I link in evidence from research into mental health and specific statistics for the borough to make it more relevant and interesting. He also suggested that I should include research related to drugs and alcohol and gay and lesbian issues. Finally, I got in touch with a psychologist working at the HIV clinic who regularly attends these meeting. The psychologist suggested that I approach the subject from both a biological and a psychosocial perspective and that the presentation should be practical as opposed to theoretical so that the audience would feel empowered to employ the methods that are discussed. The psychologist also pre warned me that I would face detailed and daunting questions but that these questions would be asked not as a means of parading their knowledge but to enable them to apply their knowledge effectively (see Appendix 2 for a needs assessment of the audience).

Reflection on Planning and Designing a Training Programme

I developed the presentation with the main focus on the objectives and learning outcomes of the teaching session and I took into consideration the assessed needs of the audience. However, I felt that some recommendations of the specialist stop smoking advisor were based on his own areas of expertise and interest rather than on the needs of the groups. Although I raised issues related to drug and alcohol and homosexuality, due to the constraints of time, I prioritised other areas in greater detail.

I found it quite difficult to prepare for the session as HIV/AIDS is such a complex area and I do not have specialist medical training. Even though I could not be expected to be an expert in the field, I still needed to possess a working knowledge of the areas I addressed.

Deliver the Training Programme

I provided the audience with handouts of the PowerPoint slides used for the presentation so notes could be taken during the session (see Appendix 3 for PowerPoint slides). The handouts specified the objectives and a reference list was included so trainees could research information further (Race & Smith, 1996). Following an outline of the objectives of the teaching session, I provided the staff with an overview of the presentation. During my talk on the health effects of smoking, raising awareness of smoking cessation and referral pathways, the audience's interest was reflected in their body language, various queries that were raised and responses to the questions I posed. The session ended with an opportunity to ask questions and the audience was invited to complete assessment and evaluation forms.

Reflection on Delivering the Training Programme

As I had not previously delivered a teaching session on HIV/AIDS and smoking, I felt nervous prior to the presentation. However, I attempted to project an impression of calmness and confidence by maintaining eye contact with various members of the audience, maintaining a good body posture and speaking with a clear and well projected voice (Race & Smith, 1996). As a result of these techniques my own levels of comfort and enthusiasm increased. I was prepared for unexpected questions and differing views (Race & Smith, 1996) and as HIV/AIDS is a complex topic, I was ready to welcome these queries and admit not to possess all the answers.

However, I felt capable of answering all questions raised both during and following the presentation and through this process I realised that the audience's requirements surrounding my knowledge of HIV/AIDS were lower than the expectations I had of myself. Consequently, it became clear that the staff at the HIV/AIDS clinic shared a more accurate view of my role as a health psychologist in training than I had anticipated. I will continue to prepare extensively to feel confident in the teaching material I deliver. However, I could become more comfortable about how others may perceive my professional role.

Plan and Implement Assessment Procedures for the Training Programme

To evaluate the knowledge and skills that the trainees had acquired, written forms of evaluation were utilised (Hall, James & Roberts, 1997) (see Appendix 4 for the assessment form, Appendix 5 for graphs of the responses and Appendix 6 for a summary of the feedback). The assessment forms included questions on levels of confidence in providing brief stop smoking advice prior to and post the presentation and the usefulness of the teaching session relating to referral pathways and the impact of smoking. In addition, the presentation ended with a questions and answers section, which helped me to discover whether the learning outcomes had been met.

Reflection on Planning and Implementing Assessment Procedures for the Training Programme

The assessment forms indicated that the trainees experienced an increase in their level of confidence in providing stop smoking advice as a result of the teaching session. Nearly all participants had expressed that they perceived both the effects of smoking and referral pathways as being very useful or useful parts of the presentation. The audience asked various questions including issues related to the risks of smoking, pharmacotherapies, providing smoking cessation advice and their

personal smoking behaviour. Topics of discussion also involved the possibility to provide more intensive stop smoking support to patients at the clinic. Following the presentation, various members of the audience expressed an interest in improving the level of care for HIV positive smokers by becoming trained stop smoking advisors, assessing the smoking status of all patients or informing patients of the impact of smoking and support services available. These questions and the discussions indicated that the learning objectives were met. However, despite people's enthusiasm, it may be pertinent to remain in contact with the clinic to monitor any progress. An assessment tool that could be employed to monitor progress would be the examination of referrals made from the clinic to the Smokefree Service.

Evaluate the Training Programme

The evaluation forms completed by the audience examined the perceived content of the presentation (Morrison, 2003). Questions probed the usefulness of different parts of the presentation as well as open-ended questions on how the training could be improved by including, changing or excluding elements of the session (see Appendix 4 for the evaluation form, Appendix 5 for graphs of the responses and Appendix 7 for a summary of the feedback).

Reflection on Evaluating the Training Programme

The members of the audience perceived all parts of the presentation as either very useful or useful. This was a great relief as the audience consisted of a wide variety of professionals including a consultant, clinical psychologists, nurses and health advisors. The diversity of the attendees was reflected in their responses to the open–ended questions. These varied greatly with regards to what participants experienced as the most and the least useful part of the session and what the audience would have liked to have been included. A number of individuals

approached me following the presentation to convey how useful they found the session. I believe that the positive feedback was a result of having thoroughly assessed the needs of the audience prior to delivering the teaching session and ensuring that the delivery of the session was well structured.

Overall Reflection

Having to deliver this particular teaching session had raised some feelings of concern, as I had no previous experience of hosting a teaching session with an audience of this size, to a group that represented such a variety of professionals or on the subject of smoking and HIV/AIDS. However, the feelings of insecurity led me to more effectively and thoroughly plan the content of the session, prepare for delivering the presentation and design assessment and evaluation methods. Although I would feel comfortable presenting under similar circumstances in the future, I realise that the need for thorough preparation need not dissipate along with feelings of anxiety.

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Appendix 1

Session Plan

Module: Core Unit: 4 Teaching & Training Competence

Subject: Smoking and HIV/AIDS

Presenter: Carolina Herberts

Date: 20th June 2007 **Time:** 10.05 – 11.00

Venue: [redacted]

Topic/Aim(s) of Session:
Review the association between smoking and HIV Highlight raising awareness of tobacco use among People Living With HIV or AIDS (PLWHA) Outline referral pathways to stop smoking services
Learning Outcomes: By the end of the session participants will be able to -
Have an increase in their knowledge of smoking and HIV/AIDS Be more confident in providing stop smoking advice Refer clients to stop smoking services

Time:	Outline Plan:	Participant activity
10.05	Introduction, outline objectives and give an overview of the session	
10.10	The health effects of smoking Smoking and HIV/AIDS Smoking and sexual health	
10.20	Stopping smoking Pharmacotherapies Stop smoking services	
10.30	Giving stop smoking advice	
10.45	Referral pathways	
10.50	Questions	Opportunity for the audience to ask questions
10.55	Evaluation	Participants to complete assessment/evaluation forms

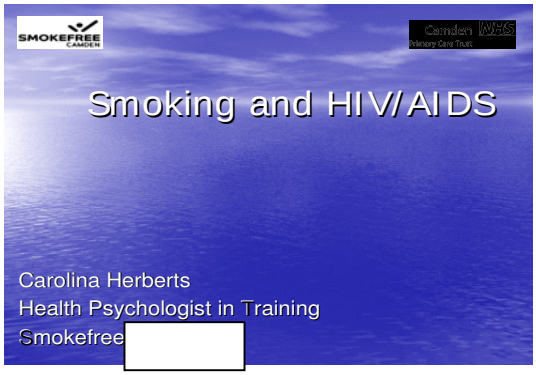
Appendix 2

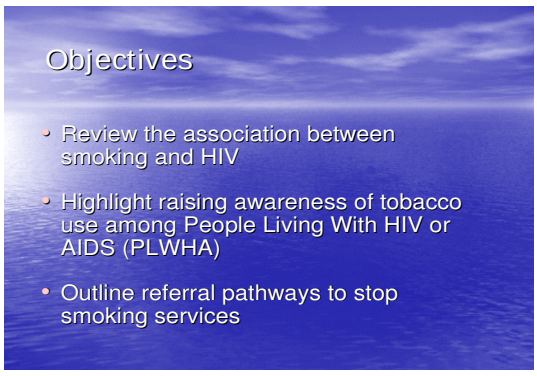
Needs Assessment

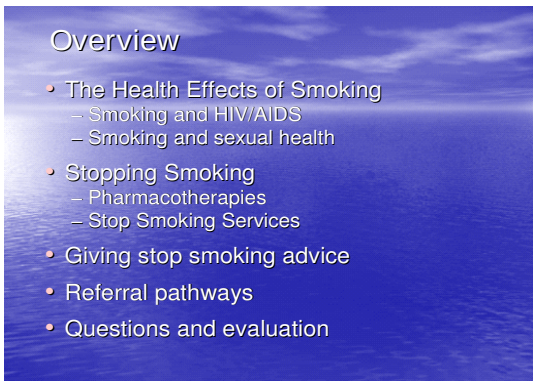
Audience: Staff working at an HIV/AIDS clinic **Subject:** Smoking and HIV/AIDS **Venue:** [redacted]
Presenter: Carolina Herberts **Date:** 20th June 2007 **Time:** 10.05 – 11.00

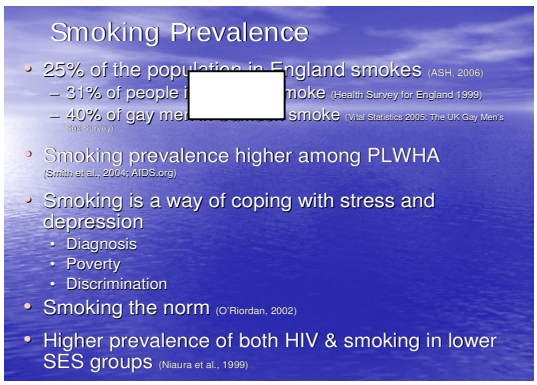
Date	Job Title of Person Contacted	Reason for Contact	Recommendations
25/04/07	Project Officer for Sexual Health	Had previously presented for the same audience	- As there are a variety of professionals in the audience (biggest group nurses) – keep it simple, do not talk to doctors/consultants only! - Talk about how to move forward. What can they do? - Make the presentation relevant for the audience - Nice group of people but be prepared for a lot of questions
30/04/07	Specialist Stop Smoking Advisors, HIV/AIDS lead in another borough	Had conducted many similar presentations for this kind of audience in another borough	- Link in evidence to mental health, cannabis, BME groups, drug & alcohol - Make it into a level I training with an interactive activity like a quiz (I informed the advisor that I have not been allocated enough time to do this) - Include specific facts for the borough - Give tips on raising awareness - Stress that they do not have to be experts to signpost patients and give advice - Give fact sheet
03/05/07	Senior Nurse HIV/GUM Outpatients	Main point of contact at clinic, able to give information about the audience	- Meetings consist of approximately 50 members of staff - A wide range of professionals will attend (clerical staff, health advisors, psychologists, counsellors, doctors, nurses etc) - Some of the members of the audience work in the sexual health clinic - Difficult to make presentation relevant for all but bear in mind the variety of professionals - Basic knowledge areas need to be covered - Mention that the service is for staff and those who do not work in the borough as well - Give resources - Mention whether HIV+ patients can take Zyban - How can one approach the subject of smoking to patients? - Leave some time for questions in the end - Contact a psychologist from the clinic who would help me further assess the needs of the audience
03/05/07	Clinical Psychologist at the HIV Clinic	Senior nurse recommended him and because he regularly attends these meetings	- Approach the subject from both a biological and psychological perspective - Try to make the presentation relevant fro the audience - A practical rather than a theoretical session - Outline referral pathways - Mention statistics on gay / African men - Remember: audience is very varied with regard to giving stop smoking advice - Bear in mind that the audience is very psychologically minded - Audience will ask some tough questions but asked simply because they are interested and want to learn

Appendix 3

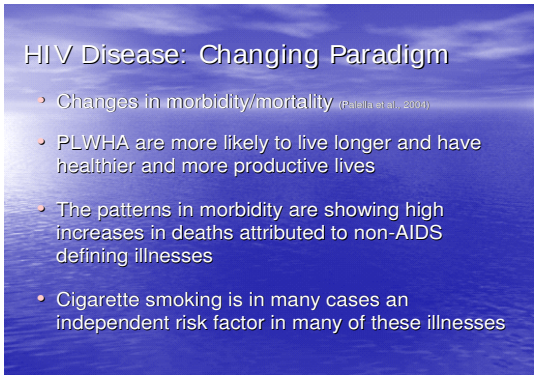

SMOKEFREE CAMDEN
Camden NHS
Primary Care Trust
Smoking and HIV/AIDS
Carolina Herberts
Health Psychologist in Training
Smokefree

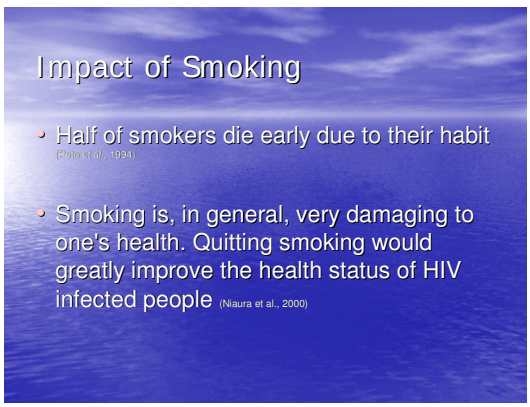

Objectives
• Review the association between smoking and HIV
• Highlight raising awareness of tobacco use among People Living With HIV or AIDS (PLWHA)
• Outline referral pathways to stop smoking services

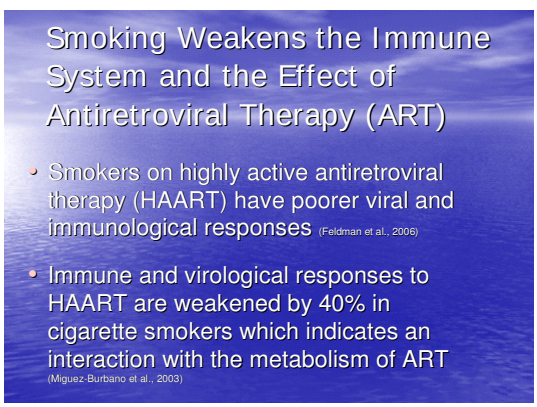

Overview
• The Health Effects of Smoking
– Smoking and HIV/AIDS
– Smoking and sexual health
• Stopping Smoking
– Pharmacotherapies
– Stop Smoking Services
• Giving stop smoking advice
• Referral pathways
• Questions and evaluation


Smoking Prevalence
• 25% of the population in England smokes (ASH, 2006)
– 31% of people i moke (Health Survey for England 1999)
– 40% of gay me smoke (Vital Statistics 2005: The UK Gay Men's Sex Survey)
• Smoking prevalence higher among PLWHA (Smith et al., 2004; AIDS.org)
• Smoking is a way of coping with stress and depression
• Diagnosis
• Poverty
• Discrimination
• Smoking the norm (O'Riordan, 2002)
• Higher prevalence of both HIV & smoking in lower SES groups (Niaura et al., 1999)


The Health Effects of Smoking


HIV Disease: Changing Paradigm
• Changes in morbidity/mortality (Palella et al., 2004)
• PLWHA are more likely to live longer and have healthier and more productive lives
• The patterns in morbidity are showing high increases in deaths attributed to non-AIDS defining illnesses
• Cigarette smoking is in many cases an independent risk factor in many of these illnesses


Impact of Smoking
• Half of smokers die early due to their habit (Peto et al., 1994)
• Smoking is, in general, very damaging to one's health. Quitting smoking would greatly improve the health status of HIV infected people (Niaura et al., 2000)


Smoking Weakens the Immune System and the Effect of Antiretroviral Therapy (ART)
• Smokers on highly active antiretroviral therapy (HAART) have poorer viral and immunological responses (Feldman et al., 2006)
• Immune and virological responses to HAART are weakened by 40% in cigarette smokers which indicates an interaction with the metabolism of ART (Miguez-Burbano et al., 2003)

Smoking Increases the Risk of Comorbid Disease and Infection

- Pulmonary disease (Miguez-Burbano et al., 2003; Crothers et al., 2005)
  - Bacterial pneumonia, tuberculosis (TB), chronic obstructive pulmonary disease (COPD)
- Cardiovascular disease (Saves et al., 2003; Thiebaut et al., 2005)
  - Heart attacks and stroke
- Cervical disease (Minkoff et al., 2004)
  - Human papilloma virus (HPV)
- Oral disease (Beck and Slade, 1996; Palacio et al., 1997; Conley et al., 1996; Shiboski et al., 1999; Sroussi et al., 2007)
  - Peridontal disease, oral candidiasis, oral hairy leukoplakia, oral warts

Other Impacts of Smoking

- Smoking has a negative impact on quality of life (Crothers et al., 2005)
- Smokers on HAART experience significantly higher morbidity and mortality rates (Feldman et al., 2006, Crothers et al., 2005)

Smoking and Sexual Health

- Fertility
  - Smoking affects both male and female fertility (Curtis et al., 1997; Sofikitis et al, 2000)

Men

- Smoking increases the risk of impotence by around 50% for men in their 30s and 40s (ASH and the BMA, 1999)

Women

- Women who smoke and use combined oral contraceptives have increased risk of heart disease (WHO, 1996)
- Smoking is a cause of cervical cancer (IARC, 2002)
- Smoking is related to problems in pregnancy

The Benefits of Giving Up Smoking

- Boosts the immune system
- Lower risk of non-AIDS related disease
- Better breathing
- Stronger resistance to respiratory infections
- Lowered toxic response to HIV medications
- Improved blood pressure and circulation
- Decreased Cardiovascular risk (Thiebaut et al., 2005)
- Financial savings
- Smokefree legislation 1st July 2007

(Gay Men & Smoking Project, Gay Men's Health, AIDS)

Stopping Smoking

Why Is It So Hard to Stop Smoking?

- It is addictive, smokers may want to quit but find it very difficult
- Nicotine is as powerfully addictive as heroin or cocaine (Royal College of Physicians, 2000)
- Withdrawal symptoms during abstinence
- 74% of smokers would like to quit but only 4% manage to do so without help (Lader and Goddard, 2004)
- 70% of gay men who smoke in Camden would like to stop smoking (Vital Statistics 2005: The UK Gay Men's Sex Survey)

Nicotine Replacement Therapy (NRT)

- Delivers low dose nicotine and reduces withdrawal symptoms
- Available to everyone on prescription
- Six products; skin patch, lozenge, gum, microtab, nasal spray and inhalator
- There is no evidence that these interact with anti-HIV medication

Zyban (bupropion)

- Relieves withdrawal symptoms
- Prescription-only medication
- Need to consult doctor to get Zyban
- Zyban interacts with anti-HIV drugs, with the protease inhibitor and NNRTI classes, possibly requiring a dose alteration. Should not be taken with ritonavir (Norvir) (Aidsmap)

Champix (varenicline)

Smoking - a Biopsychosocial Behaviour

- Physical behaviour
  - Nicotine very addictive
  - Withdrawal main reason for relapse
  - Nicotine Replacement Therapy or Zyban doubles the chances of quitting
- Psychological and social behaviour
  - Smoking associated with feelings and situations
  - Prepare for stopping
  - Motivation and barriers
  - Action plan and coping strategies

Stop Smoking Services

Individual Support

- Provided by around 200 community-based health professionals across [redacted]
- 5 sessions 20-30mins
- Services available in different languages and at convenient times i.e. days, evenings & weekends

Group Support

- Groups provided across [redacted] (day & evening)
- 7 sessions 1 – 1½ hours
- Particularly good for people who want to quit with others and more highly dependent smokers

- 1 to 1 support for complex clients

Evidence Based Interventions

One year sustained success rates

Willpower alone	2-3%
Brief HCP advice	3-5%
Brief HCP advice + NRT	6-9%
Smoker's clinic (no NRT)	10%
Smoker's clinic + NRT or Zyban	20%

- Combination of pharmacological aids and behavioural support most effective treatment

Giving Stop Smoking Advice

NICE Guidance

Everyone who smokes should be advised to quit…People who are not ready to quit should be asked to consider the possibility and encouraged to seek help in the future. If an individual who smokes presents with a smoking-related disease, the cessation advice may be linked to their medical condition.

People who smoke should be asked how interested they are in quitting. Advice to stop smoking should be sensitive to the individual's preferences, needs and circumstances…

(NICE, 2006)

Motivational Interviewing

"Motivational Interviewing is a directive, client-centred (approach to) elicit behaviour change by helping clients to explore and resolve ambivalence"

(Rollnick and Miller, 1995)

The Spirit of Motivational Interviewing

1. Motivation to change comes from the client
2. The client is responsible for choosing to change
3. Persuasion is not effective
4. The style is quiet and eliciting
5. The worker is directive in helping the client to make decisions
6. Readiness to change fluctuates
7. Characterised by a partnership

FRAMES – Elements of Brief Interventions (Miller and Sanchez, 1994)

- Feedback - of personal risk
- Responsibility – emphasis on personal responsibility for change
- Advice – give clear advice to change
- Menu – give a menu of alternative options
- Empathy – a warm, reflective, empathic and understanding approach
- Self-Efficacy – encourage self-efficacy for change

Stages of Change (Prochaska and DiClemente, 1984)

- According to the Transtheoretical Model of Change, people can be in different stages depending on their readiness for change

• Precontemplation	- Not ready to quit
• Contemplation	- Thinking about quitting
• Preparation	- Ready to quit
• Action	- Stopping smoking
• Maintenance	- Non-smoker
• Relapse	- Needs more help to start over

Stage 1: Not Ready

- Goal: Raise Awareness
- Major Tasks:
  - Inform and encourage
  - Ask key open ended questions
  - Respectfully acknowledge their decision
  - Give advice

Stage 2: Unsure

- Goal: Build motivation and confidence
- Major Tasks:
  - Explore ambivalence
  - Look into the future
  - Explore confidence and motivation
  - Ask about next steps

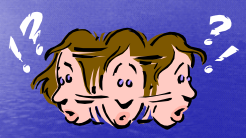
Stage 3: Ready

- Goal: Negotiate a plan
- Major tasks:
  - Facilitate decision-making
  - Identify change options
  - Give advice
  - Goal setting
  - Develop an action plan
  - Summarise the plan
  - Agree a reward for achieving the actions

How Can You Refer Clients?

- Smokefre[redacted]
  - Call us or [redacted]
  - E-mail us at stopsmoking@[redacted]uk
  - Fax us on 020 7445 8556
- NHS Smoking Helpline 0800 169 0 169
- Drug services
  - [redacted] Drug Service 020 7941 1700
  - [redacted] Drug Service 020 7530 3086

Questions



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Appendix 4

Evaluation Form - HIV and Smoking [redacted]

What is your job title? _____

1. How confident were you about giving stop smoking advice before the presentation? (please circle)

Very confident Not at all confident

1 2 3 4 5

How useful did you find the following parts of the presentation? (please circle)

2. The health effects of smoking

Very Useful Useful Neutral Not very useful Not at all useful

3. Stopping smoking

Very Useful Useful Neutral Not very useful Not at all useful

4. Giving stop smoking advice

Very Useful Useful Neutral Not very useful Not at all useful

5. Referral pathways

Very Useful Useful Neutral Not very useful Not at all useful

6. What were the most useful parts of the presentation?

7. Was there anything else you would have liked included in the training?

8. What were the least useful parts of the presentation?

9. How confident do you now feel about giving stop smoking advice? (please circle)

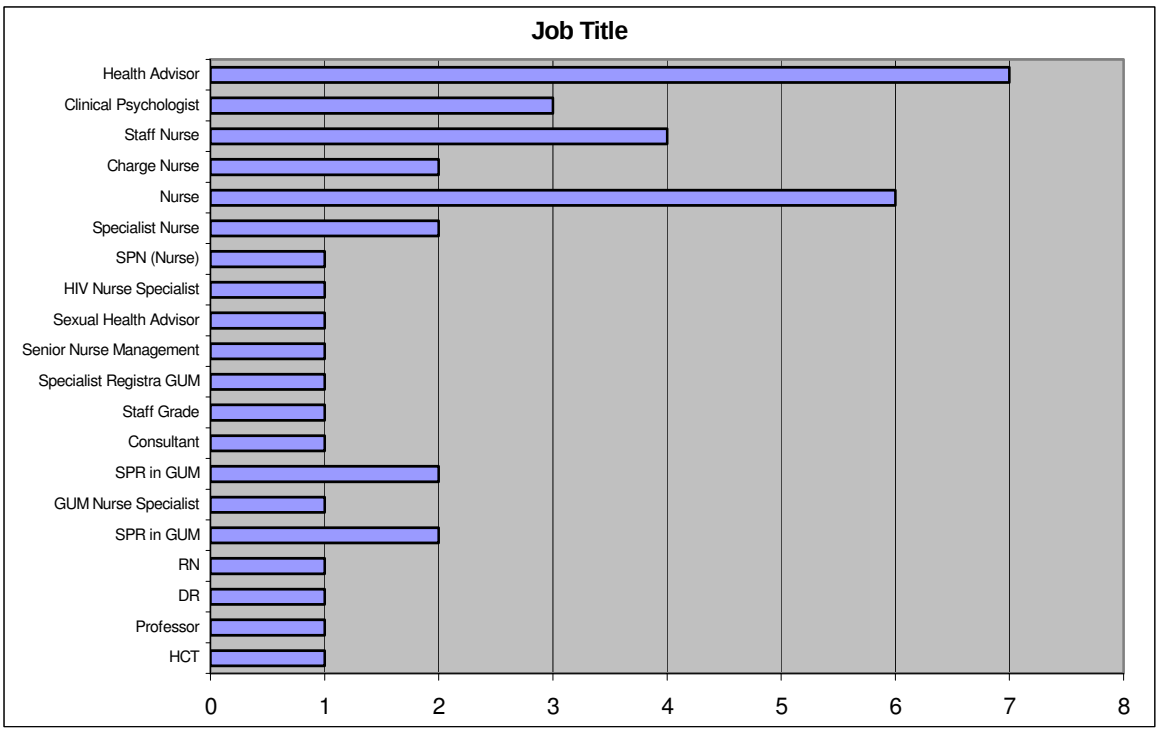
Very confident Not at all confident

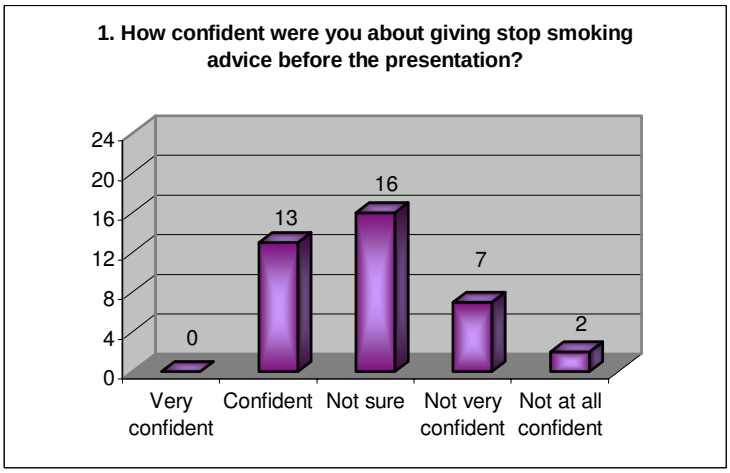
1 2 3 4 5

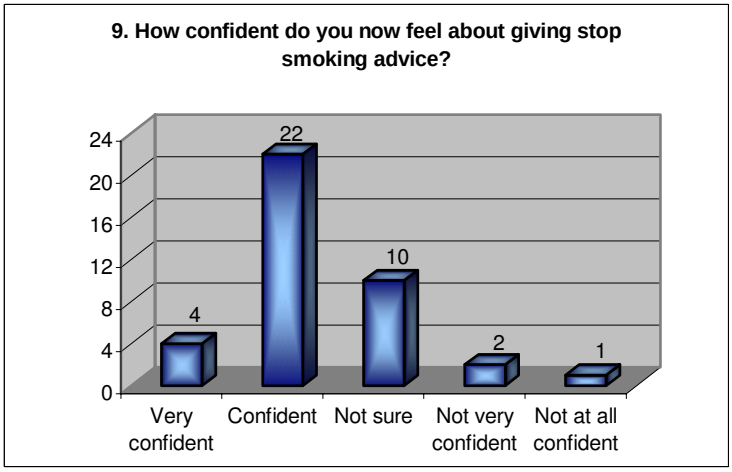
Thank You!

Appendix 5

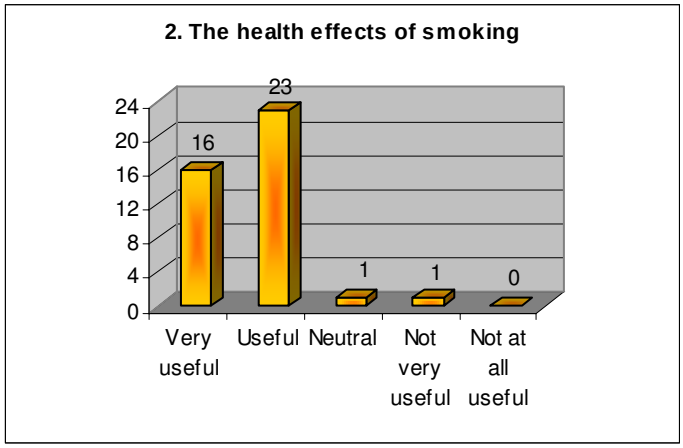
Smoking & HIV/AIDS Assessment & Evaluation Form

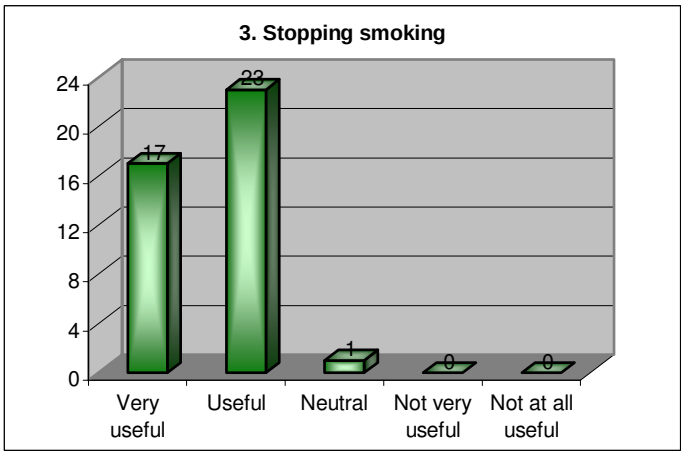


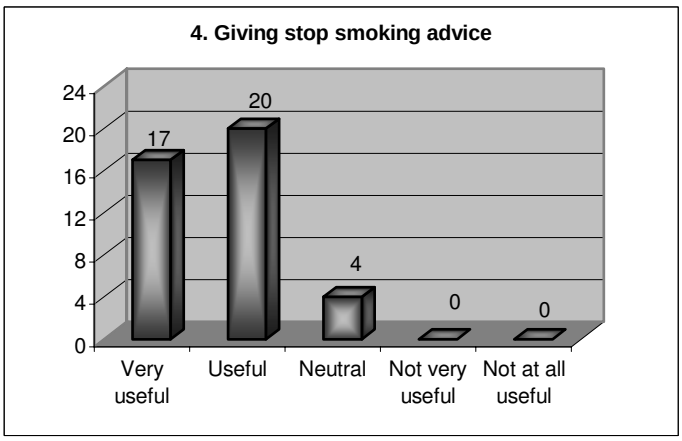


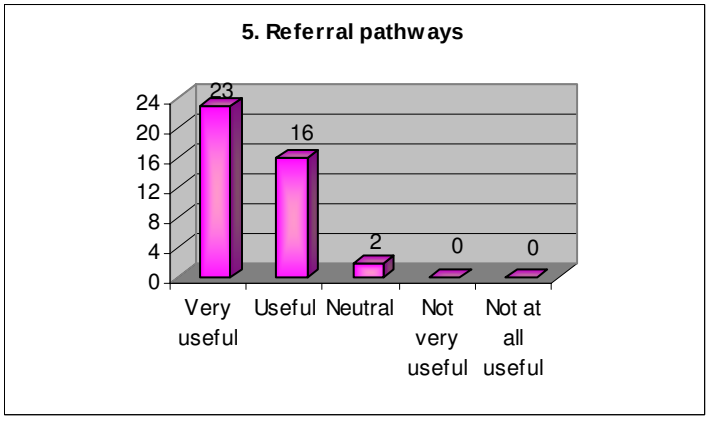


How useful did you find the following parts of the presentation?









6. What were the most useful parts of the presentation?

- Information about risks and options for cessation.
- To increase awareness of service available.
- Clarifying how to make conversations about stopping smoking useful for patients' stage of change.
- The slide on brief interventions. I'll adopt it for "everything".
- Specific reference to HIV & gay men.
- Evidence based approach.
- I enjoyed the stages of change – I'd like now to approach not ready, unsure and ready.
- Clear information.
- Effect of smoking on HIV.
- The relative chances of quitting with different c? and strategies.
- Finding out more about new therapies.
- Outline of HIV consequences.
- Motivational interviewing.
- Questions at end. Also very good to have handout given.
- Info about new treatments + phone no's.
- Difficulty in stopping smoking.
- Info on HIV, sexual health + smoking.
- Advice as to where to go for help.
- The parts about what is available to stop – locally.
- Very well presented. Referral pathways + info on impact of smoking + HIV.
- All (x 2)
- Referral pathways.
- Different ways to stop smoking, about groups… All!!
- Knowing services available (x 2)
- Overall very good overview.
- Discussing different methods – NRT/Zyban/Champix.
- Steps to stopping. Understanding impact for HIV + people.
- Effects of smoking on women.
- Information on the smokefree service.
- Be aware of the service + connection with HIV.
- Information about smoking + HAART.
- The explanation of the effects on people living with HIV.

7. Was there anything else you would have liked included in the training?

- Could you please include relapse and how to approach people who have relapsed. Cost of NRT.
- More discussion of the new drug.
- More about staff quitting.
- More specific detail on how health improves with smoking cessation. E.g week 1 benefits, week 2 benefits.
- To understand that there are non smokers + smokers in the audience.
- 1) Explaining to patients "side effects" like "difficult breathing". 2) What is involved in support groups same as one to one? Often patients say they don't want "AA" style.
- Role play situations – what are giving stop smoking advice or support.
- More about relapse.
- More explanation as to how smoking cervical ca / more marijuana smoking adverse effects.

8. What were the least useful parts of the presentation?

- Giving stop smoking advice.
- All good and useful (x 4)
- All very relevant.
- Any information on alternative therapies people have used.
- Discussion of ill effects of smoking. I know this already.
- Although handout very useful, better to distribute after presentation – too much reading + flicking about of papers at start of presentation.
- Health effects of smoking.
- Discussing health effects of smoking.

Appendix 6

Assessment

The assessment forms indicated that the audience experienced an increase in their level of confidence in providing stop smoking advice as a result of the teaching session. In addition, the majority of the trainees perceived the sections on the impact of smoking and referral pathways as very useful or useful parts of the presentation. Also, in the end of the session, various questions were asked, including the risks of smoking, pharmacotherapies, providing smoking cessation advice and personal smoking behaviour. The audience also discussed issues relating to the possibility to provide more intensive stop smoking support to patients at the clinic. Following the presentation, a couple of the members of staff expressed an interest in improving the level of care for HIV positive smokers by becoming trained stop smoking advisors, assessing the smoking status of all patients or informing patients of the impact of smoking and support services available. As the learning objectives of the presentation were to increase the knowledge of smoking and HIV/AIDS, improve confidence in providing stop smoking advice and raise awareness of referral pathways, the forms and the questions raised indicated that these objectives had been met. However, despite people's enthusiasm, it is pertinent to remain in contact with the clinic to monitor any progress.

Approximately a week after the teaching session, I received an e-mail from the lead nurse at the HIV/AIDS clinic. He requested that the clinic should consider, on the strength of my presentation, increasing the level of support provided to HIV/AIDS patients who smoke. This e-mail signalled that the overall aim of the presentation was met. That is, to improve the possibilities for HIV/AIDS patients to successfully stop smoking. The role of the Smokefree Service is to offer advice and support to enable the HIV/AIDS clinic to proceed with their plans.

Appendix 7

Evaluation

Nearly all of the participants perceived each part of the presentation as either useful or very useful. In addition, a number of individuals approached me following the presentation to convey how useful they found the session. The audience consisted of a wide variety of professionals including a consultant, clinical psychologists, nurses and health advisors. The diversity of the attendees was reflected in their responses to the open–ended questions as they responded very differently to what they felt was the most useful part of the presentation, including the health effects of smoking, giving stop smoking advice and referral pathways. The replies as to what should have been included in the session also varied including more information on staff quitting, the new drug and relapse prevention. Not many participants had given an answer to what they felt was the least useful part of the presentation and no theme appeared to emerge.

Future presentations should take the variety of professionals into account and if a presentation is given to a specific professional group, their answers could be examined in more detail. Information on relapse and relapse prevention might also be a useful addition to the presentation.

Throughout the session I conveyed myself as a confident and positive trainer by smiling and establishing eye contact with the audience. This use of body language appeared to be effective throughout in projecting a positive professional but approachable image. I believe that one of my main strengths lay in appearing more confident than I felt at the time and remaining positive throughout the session. Although I mainly looked at the audience when I was speaking, during some presentations I tended to turn around and look at the PowerPoint slides slightly too frequently. This checking behaviour may have given the audience the impression that I was not fully familiar with the material I was referring to. Although I was in fact secure in my subject knowledge, I could have more effectively conveyed this outwardly had I used the PowerPoint slides purely as a reference point for the trainees. In future sessions it would prove beneficial to make a specific effort to focus on developing this technique.

I found that the most successful means of summarising the trainees' expectations of the day was to transcribe these using a flipchart. This process could, however, be more efficient still if a colleague were able to transcribe comments whilst I maintained eye contact. This action would have maintained the pace of the session without diminishing the value attached to each trainee's comments. By verbally summarising the overall responses and linking these with the aims and objectives of the training day, ownership of the learning experience was promoted and served to provide a positive platform from which to launch the training proper.

I was able to promote active participation by encouraging trainees to ask questions throughout the day and by ensuring them that they should feel comfortable contacting the service for future help and support. This appeared to enable trainees to

interact in a less inhibited and more open manner. In addition, rather than merely providing basic information during the session, I included explanations and reasons in my communication with the participants. For instance, when providing the participants with an overview of the training session, I explained the rationale behind the inclusion of mainly interactive activities and role-plays. However, when stressing the importance and necessity of completing monitoring forms thoroughly, I could have explained in more detail why, and under which circumstances, advisors can make telephone appointments. I could also have described the purpose of the message on the appointment cards in more detail. When giving explanations, my face was rather expressive and I am unsure of whether this was perceived as positive or negative. Perhaps these perceptions depend very much on the individual.

Although I generally appeared confident and comfortable in my training role, I feel that I should still further develop aspects of my verbal communication as I occasionally stumbled and my speech did not always sound perfectly fluent. I hope that by gaining more experience in teaching and training I will be well placed to develop these skills further whilst continuing to nurture the strengths I have demonstrated thus far.

The video recording was submitted with the teaching and training log book. The recording was edited to portray those parts of the session that were reflected upon.

Unit 5.1 Implement Interventions to Change Health-Related Behaviour

Facilitating a Stop Smoking Group

FACILITATING A STOP SMOKING GROUP

Group interventions for smoking cessation have proved to be a successful tool in changing health-related behaviour (Bennett & Murphy, 1997). Prior to facilitating a stop smoking group, I attended level III training in smoking cessation. Level III training teaches the principals required in setting up and running stop smoking groups. The training was based on the withdrawal oriented model which is the treatment approach used by the Maudsley Hospital Smokers Clinic in London. The therapy is based on the theory that smokers are dependent on nicotine and that the withdrawal symptoms experienced when giving up smoking is a common cause for unsuccessful quit attempts. Therefore, an important part of running stop smoking groups is to help the clients deal with nicotine deprivation (Hajek, 1989). The course also included training in coping skills and facilitating the group as a social support network.

Session 1: Information Session

The clients were asked to complete a questionnaire and sign a consent form. This questionnaire would be completed in stages at the start of each session (see Appendix 1). Their efforts on taking the first step towards stopping smoking were acknowledged to encourage a sense of mastery. I explained that the participants had showed motivation for quitting by joining the group and that stopping smoking is the best thing a person can do for their health. I also mentioned that many people find quitting with the support of a group very powerful and beneficial. The structure of the seven week programme was then outlined to convey a sense of orientation.

Pros and Cons of Quitting

The importance of weighing up the pros and cons of stopping smoking was elucidated as it may increase motivation and enable participants to realistically

predict their quit experiences (Rosenstock, 1990). The clients were encouraged to share their motives for quitting and their reasons for wanting to continue smoking.

Nicotine Replacement Therapy (NRT) and Bupropion

I asserted that people are more likely to quit smoking with some pharmacological aid (Silagy, Lancaster, Stead, Mant & Fowler, 2006) and I provided information about NRT and bupropion. However, I emphasised that pharmacotherapies can reduce withdrawal symptoms but do not represent a miracle cure and motivation and determination are vital for a successful quit attempt. It is pertinent that participants are aware that smoking behaviour and cessation are influenced by psychological and social aspects as well as physiological factors (Marks, Murray, Evans & Willig, 2000).

Preparation

Monitoring ones actions increases the chances of successfully modifying a behaviour (Bandura, 1998). As the behaviour of smoking can be a deeply rooted habit with a number of associated situations and trigger points, I encouraged the participants to attempt to identify these. By reflecting on these associations, they could develop strategies to avoid or deal with situations in which they might normally smoke. Lastly, I provided the participants with a handout on preparing to stop smoking (see Appendix 2).

Reflection on Session 1

Bennett and Murphy (1997) claimed that group interventions benefit from the facilitator being able to directly address individuals' understanding of smoking, provide appropriate information specific for the group and identify and tackle any resistance or reluctance discerned from the participants. In addition, the group has the advantage of receiving instant and relevant help and support in behaviour change

and obtaining training for relevant skills. The participants had several queries related to resistance, knowledge and understanding of smoking which were answered and discussed. The majority of the clients appeared to have thought about these questions (e.g. smoking and stress, the power of addiction and smoking as a means of taking breaks) before attending the session. I noted that even though a large proportion of the group had been smoking for the majority of their lives, there were still many issues they were unsure of and keen to discuss. Had the participants not previously been in a situation where they felt comfortable about discussing their habit? Alternatively, perhaps only people who are preparing to change are keen to examine aspects of their behaviour.

Motivational Interviewing

The intervention was carried out in accordance with motivational interviewing which is based on encouraging people to make long-term behaviour changes. The relationship between the therapist and the clients is one of partnership and the focus of the intervention is to support the client in identifying risky situations and develop coping strategies (Miller & Johnson, 2001). Brown et al. (2003) found that motivational interviewing increased intentions to quit smoking and levels of self-efficacy. At the start of the sessions, some of the clients appeared unsure of my role and the level of interaction expected from them. However, they soon became accustomed to the procedure and adjusted well to active participation.

Self-Efficacy

An individual's belief in their own abilities in overcoming an addiction is associated to the likelihood of success (West, 2006). Bandura (1977) believed that self-efficacy does not only influence people's goals and how much effort they put into achieving them but also how likely they are to overcome difficult situations and

actually achieve their goals. By bringing up; the advantages of joining a stop smoking group and using pharmacotherapy, the motivation exhibited by attending the session and previous successful quit attempts, I endeavoured to increase the participants' self-efficacy. Bandura (1998) proposed that self-efficacy can be influenced through four various approaches, one being through the identification of previous profitable health behaviour changes. However, not all of the participants had previously managed to stop smoking and reflecting on the past successes of some might have negatively affected the self-efficacy of those clients. Also, it would be difficult to determine whether the participants believed that the advantages pointed out would be of any assistance to their personal quit attempt.

Perceived Advantages and Disadvantages of Quitting

The Theory of Planned Behaviour (TPB) states that people's attitudes towards a behaviour affect the probability of them actually performing the behaviour (Conner & Norman, 1995). As the group discussed the pros and cons of stopping smoking, one of the participants expressed that he was unsure of whether he was motivated enough to quit. According to the level III course I had attended, one of the facilitator's tasks is to assess the participants' motivation and those clients who are not motivated enough should be encouraged to postpone their quit attempt. However, given little time to reflect, I opted to maintain an optimistic and non-judgemental climate within the group. Consequently, I commended the participant for his honesty and encouraged him to reflect on his decision during the week. I was uncertain of whether I had conducted the situation according to the group's best interest but at the end of the seven weeks, the client had successfully managed to stop smoking and he felt incredibly grateful and positive about the group intervention. The participant claimed that he had expressed less motivation than the others due to misgivings

concerning his ability to stop smoking. Thus, the degree of motivation exhibited by an individual may be a reflection of other emotions and beliefs, such as levels of self-efficacy. This might have implications for the assessment of people's readiness to quit. Perhaps assessing motivation to quit through conversation in a stop smoking group could be considered too blunt a tool for determining levels of motivation in individuals.

The process of identifying reasons to quit can be a great motivation booster. If people have realistic expectations of the behaviour change, they are less likely to get disappointed and suffer set-backs. Rosenstock (1990) argued that an individual's knowledge, attitudes and intentions towards a behaviour can be modified if the risks and benefits of the action are discussed. In addition, participants expressed immense relief following the discussion that lead to the realisation that other smokers have similar experiences and feelings.

Self-Monitoring

I encouraged the participants to use the following week to pay attention to when and why they smoke. By identifying these trigger points, situations and emotions they could begin to prepare and consider any changes they could make to ease their urges to smoke in those circumstances. Bandura (1998) stated that unless people evaluate their own behaviour they will be unable to alter their performance and motivation to change. In addition, self-monitoring has been shown to trigger small but immediate effects which in turn can have a powerful impact on behaviour change (Korotitsch & Nelson-Gray, 1999). The participants will most likely be very different in their attempt to monitor their behaviour and it is probably not necessary to carry out identical preparation methods. However, it was difficult to ascertain whether clients actually related to the benefits of self-monitoring their behaviour.

Pharmacotherapy in Smoking Cessation

NRT and bupropion are used as pharmacological aids in smoking cessation. By using NRT, the withdrawal symptoms associated with stopping smoking can be reduced and thus, so can the likelihood of a lapse. Studies have shown that all six forms of NRT can significantly increase the chances of successfully quitting by 1.5 to 2 fold (Silagy et al., 2006). Trials of bupropion have indicated that the drug is an effective tool in quitting and can double the chances of stopping smoking (Johnstone et al., 2004). Bupropion is an atypical antidepressant which has been shown to block the effects of nicotine and relieve withdrawal symptoms (Cryan, Bruijnweel, Skjei & Markou, 2003). A few of the group members had made previous quit attempts without NRT and they alleged that these quit attempts were disrupted by unpleasant withdrawal symptoms. Their self-efficacy appeared to increase with the thought of not experiencing equally unbearable withdrawal symptoms.

The withdrawal oriented model stresses the importance of reducing withdrawal symptoms (Hajek, 1989) but all quit attempts are different and all smokers have different habits. Might the constant encouragement of using NRT or bupropion act as an excuse for not considering the psychological or social aspect of the behaviour? Additionally, as both myself and the majority of the group felt affirmative about the usage of pharmacotherapy, might some clients have felt pressurised into using it? Irrespective of whether the pharmacological aids actually help people to stop, clients need to feel that their decision to use it is based upon their own judgement.

Session 2: Preparation

I asked the group to share their thoughts on quitting and to discuss trigger points, difficult situations and ways to cope with them.

. *Using the Carbon Monoxide (CO) Monitor to Provide Bio-Feedback*

Following the group discussion I explained what Carbon Monoxide (CO) is and how it affects the body. In each session the clients' CO levels would be measured with a breathalyser. I stressed that initially high CO readings would soon recede to that of a non-smoker. As well as confirming abstinence, the CO monitor can increase motivation by enabling clients to identify measurable and improving health benefits (Raw, McNeill & West, 1998).

Quiz

The clients completed a quiz including questions on numbers of smokers and ex-smokers in the UK, annual cost of smoking and nicotine (see Appendix 3) and lastly they received a handout on the final preparation for stopping smoking (see Appendix 4).

Reflection on Session 2

Goal Setting and Action Planning

The importance of setting goals and planning for the behaviour change was stressed. The thought of never having another cigarette again was for most an appealing yet daunting prospect and making short-term plans appeared more manageable. Thus, the group was encouraged to set mini-goals as well as or instead of a long-term goal.

By self-monitoring a behaviour, one can reflect on performance and undertake action planning pertaining to dealing with situations in the future. Sniehotta, Scholz and Schwarzer (2005) claimed that the "intention-behaviour gap", which refers to the incongruity of intending to change a behaviour but not being able to accomplish this, is less likely to occur when detailed action planning, perceived self-efficacy and action control are present in the process. I found that even though

all of the participants had thought about making small changes and preparing for stopping, they varied greatly in the extent of preparation. This might have been a reflection of how beneficial each participant perceived the process of preparation.

Self-Efficacy

Attempts to increase participants' self-efficacy were again implemented throughout the session. Bandura (1998) argued that two effective techniques of increasing self-efficacy are social persuasion and enhancing positive mood. The participants were persuaded by myself and the rest of the group of their abilities to succeed in their quit attempts and their mood noticeably improved through others disputing any negative perceptions. In addition, the quiz included a question which highlighted the large number of ex-smokers there are in the UK. Learning of others' successes is a way of influencing a person's self-efficacy level (Bandura, 1998). However, the participants might have related more to a former group member attending the session to discuss their successful quit attempt rather than being presented with statistics.

Increasing Knowledge

I had contemplated whether to include the quiz in the session as I assumed it might appear rather childish and the questions too simplistic. However, the participants possessed a very modest level of knowledge regarding smoking and they seemed to enjoy completing the quiz. Cummings et al. (2003) stressed the importance of educating smokers about the health risks relating to smoking cigarettes. Findings from their study implied that smokers are misinformed about various aspects of cigarette smoking and pharmacological aids available during a quit attempt. The quiz helped to reinforce knowledge acquisition and correct any mis-understandings.

Rewards

Skinner (1969) claimed that rewards have been shown to affect how likely people are to participate and adhere to behaviour change. As stopping smoking can cause a number of withdrawal symptoms and be a major life changing experience, it is important to bring in positive aspects in the process. Providing long term or short term rewards can be an effective way of achieving this. People might, however, have varied possibilities of giving themselves rewards due to financial circumstances and limited free time. The discussion might have benefited from attempting to identify some feasible rewards for people in these situations.

Session 3 – Quit Day

There was an additional member to the group as a client who I had initially seen in a one to one session had decided to attend the stop smoking group. I congratulated the clients for deciding to have their last cigarette and the participants were encouraged to discuss their feelings about quitting.

Fitness Referral

I informed the group of a scheme in which people living in the borough who successfully quit smoking are entitled to; a free initial consultation with a member of the active health team, a number of free sessions in a local authority fitness centre and a reduced annual membership fee to the fitness centres.

Commitment to the Group

Handouts on the first week without smoking (see Appendix 5) were provided to the group members. Lastly, the participants took turns to throw away any remaining cigarettes and lighters and make a commitment to the group.

Reflection on Session 3

I had been slightly concerned about the new participant attending the group. The group dynamic had been very positive and I felt concerned about how new people joining would affect it. Also, the client believed that the health risks of smoking cigarettes were not as severe as society alleges. However, I was pleasantly surprised to see how well he bonded with the group and his talkative character encouraged the others to join discussions. When he mentioned his beliefs regarding the dangers of smoking, I clarified the existence of indisputable evidence of the adverse health effects of smoking. A number of the participants expressed that even though they want to stop smoking they commonly ignore the associated health risks.

A substantial proportion of smokers do not possess adequate knowledge of the health effects of tobacco use with many underestimating the health risks. Even those who are aware of the health risks tend to play down the severity and magnitude of the potential dangers. It is essential for smokers to gain an understanding of both risk and severity of smoking in order to become motivated to quit (The Framework Convention Alliance for Tobacco Control, 2005). Weinstein, Marcus and Moser (2005) investigated unrealistic optimism related to smoking and found that smokers tend to underestimate their risks of lung cancer both in comparison to non-smokers and other smokers and they commonly misunderstand other health risks of smoking. The group member who appeared cynical about the adverse health effects of smoking might have denied the dangers due to his worry of the health consequences. Even though his opinion developed into a positive and open discussion, I could have drawn on the views of the group before immediately reciting the evidence.

Smoking and Fitness

Marcus et al. (1995) found that short-term smoking quit rates are improved by exercise and that long-term smoking cessation maintenance can be influenced by exercise training. However, Ussher, Taylor, West and McEwen's (2005) systematic review discovered that there is not enough evidence to suggest that exercise can be an aid in smoking cessation even though it can reduce withdrawal symptoms and cravings. A number of the participants were concerned about putting on weight as they quit smoking and realising that they can join a fitness scheme a few weeks after stopping was a great relief for them. Furthermore, only those who remain abstinent for four weeks would be eligible to join the scheme. This would therefore act as a reward and a long-term goal. However, some clients mentioned that they would have appreciated the opportunity to undertake exercise from the start of their quit date.

Sessions 4 - 6 – Support

The group members were encouraged to discuss how they had experienced the week and handouts were provided in each session. In session four the handout revolved around the second and third week after stopping, in week five it touched on coping with a lapse or a relapse and the topic in session six was staying off cigarettes (see Appendices 6, 7 and 8).

Session 4

A group member who had not managed to stay abstinent described how he was suffering from schizophrenia and had only stopped using class A drugs a few weeks previously. The group was extremely supportive as they praised him for showing motivation by attending and managing to quit for a few days. But as he mentioned that he felt concerned about going back to using drugs, they suggested that the best time for quitting might not be at this point. Following the session I

spoke with the participant and he decided to re-consider his initial decision. However, after reflecting on the situation for a few days he determined that it was not the right time for him to stop smoking.

Reflection on Session 4

The participants attempted to increase self-efficacy in the group member who had relapsed. Even though he decided against continuing with his quit attempt, his confidence level seemed to improve as he was reminded of his achievements in ceasing to use hard drugs. Smoking rates among people with dual diagnosis are at least two to three times higher than in the general population. Furthermore, smoking cessation rates are lower for people with psychiatric illnesses (Kelly & McCreadie, 2000). However, Addington, el-Guebaly, Campbell, Hodgins and Addington (1998) claimed that it is possible for individuals with schizophrenia to stop smoking. The participant had a poor attendance rate and perhaps this combined with the fact that he had recently stopped using drugs made his attempt to quit smoking too difficult at this point in his life. More complex clients, like people suffering from mental illnesses, would be likely to benefit from tailored smoking cessation intervention programmes.

Session 5

One of the participants had lapsed and a large proportion of the discussion centred on how to deal with and avoid lapses. The participants also mentioned a variety of benefits they were experiencing as a result of stopping. One of the group members planned to attend a party at the weekend and coping with difficult situations was discussed.

Reflection on Session 5

Shiffman et al. (2000) found that prior to a person's first lapse, self-efficacy remains at high and stable levels but after a lapse, self-efficacy decreases and becomes more erratic. Consequently, low self-efficacy is a predictor for relapse. The session was thus to a great extent focused on the person who had lapsed and on increasing their self-efficacy. Yet again, this was met with encouragement and praise from both myself and the other participants. I found it difficult to achieve the balance between increasing self-efficacy whilst stressing the importance of striving to remain abstinent. It is possible to successfully quit following a lapse, however, I did not want the participants' determination to diminish through the belief that they could smoke occasionally without returning to being regular smokers.

Session 6

One of the participants had not smoked any cigarettes since quit day but had continued to smoke cannabis. He was very pleased of what he had accomplished so far and became defensive after the group asserted that him smoking cannabis might result in a return to smoking cigarettes. I stressed that he had indeed achieved something amazing and should be proud, but that smoking cannabis is no less dangerous than smoking cigarettes. He seemed to appreciate this recognition and mentioned that he would try to avoid smoking both cigarettes and cannabis in the future.

Reflection on Session 6

The session underlined the importance of increasing self-efficacy as opposed to criticising actions. Yet, it appeared vital to inform the client of the health risks related to smoking cannabis with tobacco. A report from the British Lung Foundation concluded that smoking cannabis is at least as harmful to the lungs as

smoking cigarettes. In fact, it can be more dangerous as the amount of smoke inhaled when smoking cannabis is two thirds greater than when smoking cigarettes. Furthermore, smoke is taken approximately a third deeper into the lungs and held four times longer before being exhaled (Young, 2002).

Session 7 – Last Session

The group discussed how they felt about sessions drawing to a close and a number of the participants were concerned about how it would impact their quit attempt. I suggested that they could continue to meet up as a group and they responded well to this suggestion, exchanged numbers and arranged a gathering. The participants who had successfully stopped smoking were handed certificates and a handout on relapse prevention was provided (see Appendix 9).

Reflection on Session 7

The stop smoking group proved effective as 70% of the participants managed to quit smoking (see Appendix 10 for information about setting up, implementing and evaluating the intervention). Although it is not certain that all quitters will still be abstinent in a year to come, a four week quit period represents a great achievement for a smoker who is likely to have made several previous unsuccessful quit attempts. Stead and Lancaster (2005) claimed that smoking cessation programmes do help smokers to quit. Group courses are particularly effective as they double the chances of quitting compared to less intensive interventions and self-help materials. But what aspects of the stop smoking groups make them effective smoking cessation interventions? As Michie and Abraham (2004) put forward, even though research shows that psychological interventions are valuable in changing health behaviours such as smoking, it is difficult to identify which techniques make the interventions effective as they are confounded with each other and other aspects

of the interventions such as delivery, intensity and duration. Stead and Lancaster (2005) also concluded that there is not enough evidence to identify the most effective psychological components in supportive smoking cessation programmes.

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Appendix 1

Stop Smoking Clinic

Group Name: ……

Client Name: ……

Personal Details	
Client Number:	
First Name:	Surname:
Address:	
Postcode:	Date of Birth:
Home Tel: Work Tel: Mobile:	
Sex M □ F □	Pregnant Y □ N □ E.D.D. / /

Please choose the ethnic group which best describes you.

☐ 1. White British
☐ 2. White Irish
☐ 3. White Other
☐ 4. Mixed White & Black Caribbean
☐ 5. Mixed White & Black African
☐ 6. Mixed White & Asian
☐ 7. Mixed Other
☐ 8. Asian/Asian Brit – Indian
☐ 9.Asian/Asian Brit – Pakistani
☐ 10. Asian/Asian Brit - Bangladeshi
☐ 11. Asian/Asian Brit - Other
☐ 12. Black/Black Brit - Caribbean
☐ 13. Black/Black Brit - African
☐ 14. Black/Black Brit - Other
☐ 15. Chinese
☐ 16. Turkish
☐ 17. Any other ethnic group
☐ 18. Not stated

GPs Name and Address

Name ……

Address ……

Consent

The Department of Health require that we collect certain information for service evaluation.

I understand the reasons for collecting this personal information and agree to the information that I have provided, being used for evaluation purposes. I agree to be contacted again for follow up.

Signature:_____ Date:_____

How did you hear about the service?

☐ GP
☐ Practice Nurse
☐ Pharmacist
☐ Other Professional
☐ NHS Quitline
☐ Other (please specity)
☐ Tube/Bus shelter
☐ Sure Start (member no)
☐ Family/Friends
☐ From a previous user of the service
☐ Newpaper/Magazine

1) How soon after waking do you smoke your first cigarette of the day?

☐ Less than 5 mins ☐ 5-15 mins ☐ 15-30 mins

☐ 30-60 mins ☐ 1-2 hours ☐ More than 2 hours

2) How many cigarettes do you smoke per day? ☐

3) Health Screening Questionnaire

This questionnaire will help figure out the best treatment options for you and help us keep track of health improvements after you stop smoking.	Please Tick	
	YES	**NO**
Have you ever had an eating disorder? (anorexia or bulimia?)		
Are you pregnant/breast-feeding?		
Do you have liver disease (cirrhosis)?		
Do you suffer from manic-depressive illness?		
Do you have epilepsy?		
Have you ever had seizures following head injury?		
Are you under 18?		
Have you had heart attack, angina or heart surgery in the past 6 months?		
Do you have any other problems with your heart?		
Are you diabetic?		
Do you have high blood pressure?		
Do you have kidney problems?		
Do you suffer from depression (now or in the past)?		
Do you suffer with anxiety, severe worry, or panic attacks?		
Do you suffer from any mental illness not mentioned above?		

Please give any details you think may be important for us to know if you said yes to any of the above items:

Are you currently using any prescription medications? Please list them below

Medication **For What?**

1_____
2_____
3_____
4_____
5_____

Carbon Monoxide (CO)

Carbon Monoxide (CO) is a gas that you inhale when you smoke. It is very toxic and takes the place of oxygen in your red blood cells. The result is that you do not get the oxygen supply you deserve. In addition your blood compensates by producing more red blood cells, so you blood becomes thicker. This means that your heart has to work harder to pump the blood around your body.

The good news however, is that very soon after you stop smoking your CO levels fall and your body is then able to get the oxygen it so badly needs for a healthy life. In addition the blood becomes less thick so the workload on your heart is decreased, thereby reducing the chances of a heart attack.

The levels of CO can very easily be measured using a simple machine that you blow into. You will be asked to take a breath and hold it for 15 seconds (if you can) and then blow into the machine.

OFFICIAL USE ONLY: Record of Medication

We will measure this before and after you have stopped smoking. When you have stopped the levels will fall and stay down. This will indicate that you REALLY are doing something positive for your health.

Week	No of weeks supplied	Product 1	Product 2	GP/PGD	Comments
1					
2					
3					
4					
5					
6					
7					

Session 2

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

2) Please tick each of the items below to show to what extent you have had these feelings or experiences <u>in the last week</u>.

	1	*2*	*3*	*4*	*5*	*6*
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

3) Carbon Monoxide Reading ☐

Session 3

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

2) Please tick each of the items below to show to what extent you have had these feelings or experiences in the last week.

	1	2	3	4	5	6
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

3) Please circle a number to show how confident you are that you will manage not to smoke for the next week:

Not at all Confident — Extremely Confident

0 1 2 3 4 5 6 7 8 9 10

4) What treatment aid are you using?

Patch	□	Gum	□
Lozenge	□	Inhalator	□
Microtab	□	Nasal Spray	□
Zyban	□		

5) Carbon Monoxide Reading

6) Any Side effects?……

Session 4

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

4) Please tick each of the items below to show to what extent you have had these feelings or experiences in the last week.

	1	2	3	4	5	6
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

5) Please circle a number to show how confident you are that you will manage not to smoke for the next week:

Not at all Confident — Extremely Confident

0 1 2 3 4 5 6 7 8 9 10

4) What treatment aid are you using?

Patch □ Gum □
Lozenge □ Inhalator □
Microtab □ Nasal Spray □
Zyban □

5) Carbon Monoxide Reading

6) Any Side effects?……

Session 5

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

6) Please tick each of the items below to show to what extent you have had these feelings or experiences in the last week.

	1	2	3	4	5	6
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

7) Please circle a number to show how confident you are that you will manage not to smoke for the next week:

Not at all Confident — Extremely Confident

0 1 2 3 4 5 6 7 8 9 10

4) What treatment aid are you using?

Patch	□	Gum	□
Lozenge	□	Inhalator	□
Microtab	□	Nasal Spray	□
Zyban	□		

5) Carbon Monoxide Reading

6) Any Side effects?……

Session 6

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

8) Please tick each of the items below to show to what extent you have had these feelings or experiences in the last week.

	1	2	3	4	5	6
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

9) Please circle a number to show how confident you are that you will manage not to smoke for the next week:

Not at all Confident — Extremely Confident

0 1 2 3 4 5 6 7 8 9 10

4) What treatment aid are you using?

Patch □ Gum □
Lozenge □ Inhalator □
Microtab □ Nasal Spray □
Zyban □

5) Carbon Monoxide Reading

6) Any Side effects?……

Session 7

1) How many cigarettes have you smoked per day in the last week? Please fill in the table below.

Tues After group	Wed	Thurs	Fri	Sat	Sun	Mon	Tues Before group

10) Please tick each of the items below to show to what extent you have had these feelings or experiences in the last week.

	1	2	3	4	5	6
Felt or Experienced:-	**Not at all**	**Slightly**	**Moderately**	**Quite a bit**	**Very Much**	**Extremely**
Craving for sweet foods						
Irritable						
Hungry between meals						
Depressed						
Absent minded						
Tired						
Eating when not hungry						
Disturbed sleep						
Tense						
Craving to smoke						
Difficulty concentrating						
At a loose end						
Dry mouth						

11) Please circle a number to show how confident you are that you will manage not to smoke for the next week:

Not at all Confident — Extremely Confident

0 1 2 3 4 5 6 7 8 9 10

4) What treatment aid are you using?

Patch	□	Gum	□
Lozenge	□	Inhalator	□
Microtab	□	Nasal Spray	□
Zyban	□		

5) Carbon Monoxide Reading

6) Any Side effects?……

OFFICIAL USE ONLY: Four Week Follow Up

Has individual smoked in the last 2 weeks? Yes ☐ No ☐ Lost to follow up ☐

Advisor: _____ Registration Number:_____

FEEDBACK: PLEASE TELL US WHAT YOU THINK!

We'd like to know what you think of the course we offer so we can improve it. Do tell us what you found useful, and what you didn't, on the form below.

1. **The group started two weeks before the quit date. Did you find this preparation period….. (circle one below)**

   a) too long? *b) about right?* *c) too short?*

2. **In the information session (first session), did you feel you received enough information about Nicotine Replacement Therapy and Zyban to make a good choice? (circle one below**)

   a) not enough *b) about right* *c) too much*

3. **The course lasted for 7 weeks. Did you feel this was…. (circle one below)**

   a) too short *b) about right* *c) too long*

   If you felt the course was too short or too long, how many weeks would you realistically like to have attended, in total? _____(write here)

4. **Are there any suggestions you have for other people trying to give up smoking?**

---

5. **What did you think of the Smoker's Clinic groups overall? What did you find the most useful? How could we improve?**

---

6. **We sometimes like to feature successful quitters in material about the clinic. Tick the boxes below if you are happy to help with this.**

☐ Yes, I would be happy for my comments to be used for the Smoker's Clinic newsletter/website.

☐ Yes, I would be happy to be contacted in the future to tell the story of my quit attempt in more detail possibly in the local press

☐ Yes, I would be happy for any photographs to be used for the Smoker's Clinic newsletter/website.

Appendix 2

PREPARING TO STOP SMOKING

Your decision to stop smoking is an excellent one as stopping smoking **is the most important thing that you can do for your health** both in the short and long term. When you stop you will quickly notice the benefits and this will motivate you to stay stopped.

You may find it helpful to view giving up smoking like a job that you've been putting off for a long time and have finally got round to. Now that you are ready to tackle it, make succeeding a priority in your life and give everything else second place for a while. Make this attempt a really serious attempt.

Making a good choice

When you stop smoking it is essential that you feel you have made a **really good choice** to stop. If you feel you have made a bad choice or no choice at all e.g. "I have to stop" "I can't stop" "I don't have a choice" then you will have less chance of success. To enable you to make this choice explore reasons why you want to stop smoking and also reasons why you **don't** want to stop smoking.

Reasons for giving up	**Reasons for not giving up**
……	……
……..	……
……..	……
……..	……
……..	……

When the reasons for giving up outweigh the reasons for not giving up, then you are well on the road to success. You will be able to make this choice to give up and although acknowledging that there may well be a sense of loss on quitting, the overall gains will be far higher.

Nicotine Replacement Therapy (NRT) and Zyban (bupropion)

Both these products can double your chances of successfully stopping. If you are taking Zyban, make an appointment with your doctor who can prescribe it to you. Zyban has to be taken at least a week before the quit date. Hang on to your NRT and bring it to the third session (your quit day) where you will start using it.

Appendix 3

QUIZ: WEEK TWO

Decide on your answers together!

1 What proportion of the adult UK population smoke?

15% 25% 35% 45%

2. How many ex-smokers are there in Britain?

2 million 6 million 12 million 16 million

3. Smoking 20 a day can cost you……..per year?

£350 £800 £1,400 £1,700

4. What kills more people?

Cigarettes Road accidents Drugs Alcohol

5. Which of these causes cancer?

Nicotine Tar Nicotine and tar

6. Identify one situation where all of you would find it difficult to refrain from smoking.

Appendix 4

The final preparation

By now you will have thought about the pros and cons of giving up smoking and will have made the choice that you do want to give up.

Giving up smoking represents a (very positive) change in lifestyle. Discussions in the group today will have generated some ideas about changes that can be used to live a smoke–free life.

Changes in lifestyle

- **Have breakfast.** How about making this change instead of reaching for the cigarettes? You might find it very enjoyable.

- **Change your routine.** Over the years, your smoking has become associated with many cues in your environment. Changing your routine first thing, for example, by switching from coffee to orange juice, or having a shower immediately on waking, will help to break these patterns.

- **Get rid of your smoking bits and pieces.** Bring them along next week, and we'll throw them away together.

- **Make some positive changes.** Stopping smoking can be a golden opportunity to revamp your life. Good strategies include taking up a hobby or activity (such as exercise), visiting no-smoking places (such as cinemas) and seeing more of supportive friends and family. These will help distract you and make giving up a more positive experience.

For next week: These are some suggestions of lifestyle changes you could make. I'm sure you will think of plenty more yourself that will suit you and your lifestyle. Bring along your ideas next week to share with the group.

Appendix 5

Your First Week Without Smoking

A lot of the difficulties people have when they stop smoking are due to giving up the drug nicotine. This is why you are using nicotine replacement therapy: it will ease some of the withdrawal symptoms. Although NRT does not remove the symptoms completely, it will make them less severe.

Symptoms that you may experience in the first few days:

Irritable: You may be short tempered at times.

Concentration: You may find it harder than usual to concentrate.

Changes in mood: You may feel more depressed than usual.

Appetite: You may feel more hungry than usual.

Restlessness: You may feel unsettled or "at a loose end".

Sleep disturbance: Your normal pattern may change. You may experience improved or longer sleep or insomnia.

Other changes: Some people complain of headaches, constipation, lethargy, disorientation, stomach cramps.

Coping with withdrawal symptoms and urges to smoke: There is no foolproof way of dealing with them but keeping as busy as you can and altering your daily routine will help. For example, avoid the pub if you think you will be strongly tempted to smoke there. Wash up and go for a walk after meals rather than sit in front of the TV.

The good news is that the symptoms will go away. After about three weeks of not smoking you will start feeling more like your old self. The urge to smoke will be strong at first and come back from time to time, but you will be able to resist this urge more easily as time goes on.

Coping with daily stress: Besides having withdrawal symptoms you will still experience every day stressors that you used to cope with by smoking.

You may find it helpful to view giving up smoking like a job that you‘ve been putting off for a long time and have finally got round to. Now that you are ready to tackle it, make succeeding a priority in your life and give everything else second place for a while.

Appendix 6

Your Second and Third Weeks Without Smoking

The second and third week can seem harder than the first!

This is because the ***novelty*** of doing something new is beginning to wear off. Stick at it, and remember to ***live one day at a time***. Just aim to go to bed each night without smoking.

- Cheer yourself up by buying something with the money saved from your first week without cigarettes.

- You may develop a sore mouth with small ulcers. These are not serious and will go away.

- Some people develop a cough after stopping smoking. This is harmless and will go away in due course.

- Your health really does ***improve*** from the time when you put out your last cigarette. Your carbon monoxide level is now the same as any other non-smoker.

- Your lungs will be working much more efficiently and you will be less breathless.

- Your heart rate will have decreased and you will have a healthier blood supply to your hands and feet.

- Be wary of pubs and parties. Too much alcohol will increase ***craving*** and reduce your ability to handle it sensibly.

By the end of the third week you may find that the worst of the withdrawal symptoms are over. These may be replaced by some rather confusing emotions. On the one hand you may feel glad to be rid of cigarettes but at the same time have very definite feelings of loss - 'like losing a friend' - is the way people often put it.

Be patient as over time you will become used to coping without cigarettes

Appendix 7

Coping with a Lapse and Preventing a Relapse

After stopping smoking, it is not too unusual to have a slip or lapse--whether it be a few puffs or a few cigarettes. It does not mean that you've failed or that you will inevitably relapse to regular smoking as before. Rather, it means that you have come across a situation or mood that is very risky for you, and that you need to plan a better way to handle these circumstances in the future. In short, try to look at a lapse as a learning experience rather than a failure.

If you expect to be perfect after your quit date, you may feel guilty or bad about yourself for temporarily losing control. You may say things to yourself like "I have no willpower." These feelings and thoughts are common, but they are not rational or justified, and definitely not helpful. They can lead you to give up your efforts and say "I might as well continue to smoke." *However you don't have to give into these feelings and thoughts – you can still be successful at stopping smoking.*

After a lapse, the most important thing to do is get back to your routine of non-smoking as soon as possible. Don't wait for tomorrow or the beginning of next week or next month. Throw away any cigarettes you might have purchased and start fresh right away. If you don't respond quickly and actively to your lapse, you face a serious risk of relapse. But if you act quickly, and evaluate what happened, you can turn your lapse into learning experience that improves your chances of success.

Specifically, think about the situation and circumstances that led you to smoke. Ask yourself "What could I have done to cope instead of smoking?" or "Is this a situation I should avoid for a while?" If you are prepared for risky situations, you are less likely to lapse when they arises again. In this way, a lapse can be turned into a positive learning experience to protect against a full-blown relapse.

Appendix 8

Staying off Cigarettes

Congratulations! Stopping smoking is a great achievement and so far you're doing well. The important thing now is to make sure that you ***stay off*** cigarettes. These are some situations that might take you by surprise, and put everything that you've gained at risk.

(1) **Irrational thoughts:** Such as "I could just have one", "one wouldn't matter", or "I'll just have one puff". Recognise that these thoughts will lead you down the path towards relapse, and undo all your hard work.

(2) **Trips away from home:** Usually holidays where you are more likely to be relaxed or conferences where you are likely to be anxious, but any sort of travel. Expect to be tempted, but expect to beat it. Come back a non-smoker.

(3) **At parties and celebrations:** There's always alcohol and always people offering cigarettes. Say "I'm going to enjoy myself but I'm going home tonight as a non-smoker". Be aware of the power of alcohol – it will weaken your resolve. If you are drinking alcohol perhaps choose a drink that you don't associate with smoking.

(4) **Feeling depressed, angry and frustrated:** Cigarettes promise support and comfort during difficult times. It's not easy to manage your feelings when you feel like this but try reminding yourself that your anger / frustration / depression will still be there to deal with if you have a cigarette. If you start again you will have to tackle giving-up smoking from scratch.

One of the most common mistakes that people make is to stop using their nicotine replacement therapy treatment too soon, thinking that the worst of the withdrawal symptoms are over. Use your nicotine replacement as advised by following the manufacturer's instructions. It is sensible to use these treatments for a minimum of 8 weeks after your quit date or for longer if you feel the need to.

Appendix 9

Relapse prevention

Giving up smoking and maintaining abstinence are very different problems. In order to remain abstinent in the long term, it is helpful to make changes in three different aspects of your life.

1. **Your behaviour**
2. **Your thoughts**
3. **Your awareness of feelings and how to cope with them**

1) Changing your behaviour - To change your behaviour you will need to think of 'people, places and things' that you associate with smoking. For example, it could be that you crave for a cigarette after a meal, when you are bored or hungry, in social situations, when drinking alcohol, when feeling energetic or sad etc.
At first, it might be helpful to avoid the people, places and things that make you want to smoke, but there are certain situations that you may not be able to avoid forever. Try to identify what makes you want to smoke in this situation and think about alternatives that you could do. Remind yourself that smoking does come as a package with lots of negative effects!

2) Changing your thoughts - Try to recognise thoughts that may lead you to relapse. For example, common thoughts that lead to relapse include:

- **Romanticising thoughts about smoking,**
- **Trying to test the strength of your abstinence**
- **Attributing a lapse to lack of willpower**

If you should lapse, thoughts such as 'I am no good' or 'I have no willpower' are not helpful and will only lower your self-esteem. It is more important to identify what went wrong in this particular situation and learn from this experience.

3) Changing your awareness of emotions and how to cope with them – Many smokers use smoking as a tool to deal with intense feelings like stress, frustration or sadness. You might feel that stopping smoking has taken this 'tool' away from you, but this loss might also help you to become more aware of your emotional household. It is important to bear in mind that putting your feelings into words and addressing them is more healthy and effective in the long-term as a method of coping with overwhelming emotions.

The most common situational factors associated with relapse are 1: ***Lack of support*** *during the giving up process and 2:* ***Weight gain****.*

When the support group meetings have stopped we would like to encourage you to find a new source of support in your everyday life. Maybe you can contact a person from the group, or you know somebody in your life that is able and willing to support you to remain a non-smoker. There is always the opportunity to arrange a booster session with us as well. Please call us on [redacted].

Excessive weight gain can bring down your self-esteem and make you feel extremely uncomfortable. If you are concerned about your weight, rather than using cigarettes to control your weight you could try a more healthier option: a) speed up your metabolism by being more active and/or b) cut down on fatty foods in your diet. Keep reminding yourself that you are doing more for your health by giving up smoking than you could ever do by being slim!

Appendix 10

Setting Up, Implementing and Evaluating the Intervention

In 1998 the Government published a White Paper called "Smoking Kills" which outlined the problems associated with smoking and set a target to cut the percentage of adult smokers from 28% to 24% by 2010 (Department of Health, 1998). Following this paper, NHS Stop Smoking Services were established to offer one to one or group support to smokers wanting to quit. Smoking cessation aids were also offered as part of the programme and in 2000 and 2001, bupropion (Zyban) and Nicotine Replacement Therapy (NRT) became available on NHS prescription (Department of Health, 2007). The National Institute for Clinical Excellence (NICE) issued guidance on the use of NRT and Zyban in 2002. An evaluation of the Stop Smoking Services programme was carried out in 2005 and the findings demonstrated that smokers quitting with the NHS Stop Smoking Service and using NRT or Zyban were up to four times more likely to succeed than by stopping with willpower alone (Raw, McNeill & Coleman, 2005).

Stop smoking groups are held at a variety of times during the week and in various areas of the borough. The smoking cessation group I facilitated was run in a Medical Centre and people contacting the Stop Smoking Service were informed of the group as an intervention option. The length of the course was seven weeks to allow for two weeks of preparation in case any clients opted to use Zyban and would consequently need one to two weeks of treatment prior to the quit date. The third session was the participants' quit date and the following four weeks were used as support sessions. New clients were allowed to join the group up to the third week.

The clients' smoking status were recoded by self-reports as well as Carbon Monoxide (CO) readings. By the end of the programme, 70% of clients were successful quitters. The participants were asked to complete an evaluation form following the seventh session to reveal their perceptions of the course. Their responses indicated that the majority of the group found that the length of the programme was appropriate and that the group intervention had been an extremely helpful tool in their quit attempt.

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Unit 5.2 Direct the Implementation of Interventions

Health Psychology Supervision for Health Trainers

HEALTH PSYCHOLOGY SUPERVISION FOR HEALTH TRAINERS

Whilst healthcare work has long been considered one of the most stressful and personally costly areas of work (Hawkins & Shohet, 1989), Cottrell (2002) argued that clinical supervision for healthcare workers has the potential to compassionately but significantly enhance the provision of care.

Background of the Health Trainer Scheme

In the Public Health White Paper "Choosing Health" (2004), the Department of Health (DH) described the scheme of incorporating National Health Service (NHS) health trainers as a new health resource for patients aiming to develop their health guides. The outlined main duties of the NHS-accredited health trainers entailed defining the changes clients wished to make, providing advice, motivation and support in making and sustaining the health behaviour change (e.g. stopping smoking, healthy eating or increasing exercise) and encouraging uptake of and signposting to other services in the community. (See Appendix 1 for needs assessment of interventions provided by health trainers.)

Clinical Supervision

All NHS organisations have a responsibility to continuously enhance the quality of clinical services and standards of care through clinical governance (Scally & Donaldson, 1998). In order to establish, maintain and promote standards and innovations in clinical practice in the interest of patients and clients, clinical supervision was advocated by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (now the Nursing and Midwifery Council (NMC)) in 1995. In 2003, the NMC described clinical supervision as a practice focused professional relationship in which the support of a skilled supervisor enables supervisees to reflect on their practice in order to further develop their skills,

knowledge and understanding of their practice (Nursing and Midwifery Council, 2003). Winstanley and White (2003) proposed that although there are a variety of definitions of clinical supervision, they all encompass similar essential ingredients to facilitate the improvement of therapeutic skills. Through a process consisting of empathetic support, transmission of knowledge and facilitation of reflective practice, practitioners have the opportunity to develop, reflect and evaluate their own clinical practice.

According to Bernard and Goodyear (1998) (as cited in Ellis, Krengel & Beck, 2002) the adaptation of the various roles of observer, teacher, colleague and evaluator by the supervisor creates a complex relationship between the supervisee and their supervisor. In order to adopt consistent and successful supervision, the fundamental issues of roles, responsibilities and expectations by both supervisor and supervisee should be addressed (Cottrell, 2002) and the content of the sessions outlined (Winstanley & White, 2003).

Health Psychology Supervisor

As a health psychologist in training, I was allocated the role of health psychology supervisor for two health trainers. My duties as a health psychology supervisor involved assisting the health trainers in comprehending and utilising general health psychology practices as well as auditing the use of and providing updates on these techniques. In addition, the responsibility comprised of supporting the health trainers in working and interacting effectively with different people and discussing individual cases and approaches in dealing with various types of clients. (See Appendix 2 for a supervision plan).

Reflection on My Role as Health Psychology Supervisor

During the initial supervision sessions, I outlined the general structure of the monthly meetings and clarified my role and duties. A significant amount of time was spent covering these issues as the health trainers were supervised by a number of people and I intended to ensure that there was no confusion regarding my role as their health psychology supervisor. However, in retrospect I realised that I should have investigated what their expectations of the supervision were. Although they appeared certain of my duties and expected as well as appreciated the advice and guidance they received, it would have been useful to identify what they were hoping to acquire from the sessions. Instead, as the supervisees were not confident enough to vocalise their expectations during the initial meeting, these were explored in subsequent sessions.

I empathetically provided continuous support by forming sound relationships with the health trainers. This was accomplished by retaining a non-judgemental approach, demonstrating an understanding of the difficulties of their job and endeavouring to assist in their clinical work. Transmission of knowledge was undertaken both during the meetings between the health trainers and me and between the meetings as the health trainers were encouraged to contact me or other relevant services if they had any questions or concerns. In addition, the health trainers were requested to attend various training events and update sessions to keep abreast of relevant areas, gain further knowledge and improve their skills. During the supervision meetings, the health trainers were invited to reflect on the interventions they had provided and occasionally to bring a case study of a client to be discussed more closely. (See Appendices 3 and 4 for tables listing the meetings held during the year).

I sensed that I managed to establish a trusting and supportive relationship with the health trainers. However, as they possessed very different personalities, levels of confidence and amounts of work enthusiasm, I needed to adjust my approach to the supervision according to the supervisee. One of the health trainers exhibited a great deal of confidence and job satisfaction and was keen to develop their skills and knowledge further. The other health trainer was lacking in confidence and this affected their enthusiasm for work and ability to develop their clinical practice. I therefore focused more on the area of empathic support with the health trainer whose confidence levels needed improving and more time on increasing knowledge with the health trainer who felt confident in their abilities and keen to become more knowledgeable. Thus, although there are guidelines and definitions of what clinical supervision should comprise of, supervisees are individuals with various needs and one must adjust the focus of the supervision in accordance with the supervisee in the interest of practitioners and their clients alike. (See Appendix 5 for a reflective analysis of potential problems in implementing the intervention and supervising its implementation).

Ethical Responsibilities

Vasquez (1992) asserted that supervisors have several ethical responsibilities. As supervision provides health workers with an opportunity to professionally develop and further their skills, clinical supervisors are obliged to promote ethical practice. Supervisors are ethically responsible for the training of three broad areas of the supervisee's professional functioning: ethical knowledge and behaviour, competency and personal functioning (Lamb, Cochran & Jackson, 1991). Supervisees are obliged to provide ethical services and supervisors are responsible for enhancing their ability to do so by promoting ethical knowledge and behaviour.

The supervisor also holds the responsibility of assuring the welfare of the clients seen by the supervisee by addressing competency and personal functioning. Vital aspects of competency do not only relate to possessing the necessary knowledge and skills but also to avoiding prejudice and valuing diversity. Developing personal functioning is promoted by regular provision of unambiguous feedback in a supportive and caring manner (Vasquez, 1992).

Reflection on My Ethical Responsibilities

Promoting ethical knowledge and behaviour as a health psychology supervisor related to various issues including; assuring that the advice provided to clients was correct, ensuring that client consent was obtained and holding discussions around confidentiality. Although I attempted to advise and guide the ethical aspects of the activities of the health trainers as effectively as possible, they worked independently and this made it impossible to monitor their behaviour at all times. Requesting the health trainers to bring a case study of a client with reference to ethical issues might have presented me with more awareness of their ethical knowledge. The competency of the health trainers was addressed by encouraging professional development by attending training and update events. Avoiding prejudice and valuing diversity are particularly fundamental aspects of the role of the health trainers as they work with clients from various minority groups. Both health trainers appeared highly aware of the importance of this and they appreciated the diversity of the clients they supported. By providing regular feedback, the health trainers' personal functioning was promoted. During the initial months of supervision, I found it difficult to offer negative feedback. However, I became accustomed to this process and discovered that criticism can be provided in a supportive manner regardless of whether it is positive or negative. As supervisors are

not in constant contact with supervisees, they can never know with absolute certainty how a supervisee operates. Therefore, it is essential for the supervisor to strive for an open and trusting relationship, to observe interventions frequently and to hold regular meetings where pertinent issues can be discussed. This would provide the most effective means of ensuring that quality care is provided.

Effectiveness of Supervision

Clinical supervision sessions can either be held on a one-to-one basis between the supervisor and the supervisee, or as a group meeting where a supervisor facilitates the supervision sessions with several supervisees attending. The latter has been perceived as the favourable alternative, in particular among community nurses and health visitors (Winstanley & White, 2003). A study which aimed to identify factors influencing the effectiveness of clinical supervision among community mental health nurses in Wales, found that the duration of the sessions most positively perceived was more than one hour and were held on a minimum occurrence of once a month. Another factor that increased the perceived quality of supervision was the sessions taking place away from the workplace (Edwards et al., 2005).

Reflection on the Effectiveness of Supervision

The five health trainers in the borough attended regular group meetings as well as one-to-one supervision meetings with their health psychology supervisor. Both the group and the individual meetings were held monthly with the group meetings lasting for approximately three hours and the duration of the one-to-one supervision meetings being one hour. However, on some rare occasions, the monthly individual meeting was postponed or cancelled due to annual leave or sick leave. Although attempts were made to re-schedule the meetings, it was not always possible to find a convenient time shortly after the arranged session. According to

Edwards et al. (2005), the usefulness of short or infrequent sessions is limited. Perhaps more effort should have been made to have regular meetings by arranging an alternative time in the event of cancellations.

All of the supervision sessions were conducted at locations away from the health trainers' work places. Edwards et al. (2005) found that the overall effectiveness of supervision was superior when sessions were not held at the practitioner's work place. The relationship with the supervisor improved and as the level of trust increased, supervisees were more likely to discuss sensitive and confidential issues. The benefits of conducting supervision sessions away form the workplace even extended to the supervisees reporting that the strengthened sense of support had a positive effect on the development of their skills and delivery of care. The location of the meetings might therefore have contributed to the open relationships I had established with the health trainers. Kilminster and Jolly (2000) consider the relationship between the supervisor and supervisee to be the most significant feature of effective supervision. As valid as the above recommendations are in the quest to improve the effectiveness of supervision, is it not possible to implement them in all clinical environments. This is not to say that these points should not be seriously considered as they may lead the way to best practice.

Training for Health Trainers

In line with the recommendations from the DH (2004), for health trainers to reach the most deprived groups and be able to empathise with the concerns and experiences of this population, they were recruited from the local community. The health trainers were trained in psychology-based methods to gain the appropriate skills to support people in behaviour change, including motivational interviewing techniques (Rollnick & Miller, 1995), active listening (Rollnick, Mason & Butler,

1999), goal setting (Carver & Scheider, 1998), action planning (Sniehotta, Scholz & Schwarzer, 2005) self-monitoring and boosting confidence (Bandura, 1998) (as cited in Michie et al., 2007). (The health trainer handbook detailing these techniques by Michie et al. (2007) can be retrieved from: http://www.abdn.ac.uk/healthpsychology/publications/Health_Trainer_Manual.pdf). The training also incorporated specific health promotion topics and information around other services.

I utilised some of the techniques mentioned above during the supervision sessions as a means of mirroring and revising the methods the health trainers had previously learned. As part of each supervision meeting, the health trainers were encouraged to reflect on client issues. We discussed how interventions were carried out, any difficulties or complex issues arising from the sessions, behaviour change techniques or health psychology models used, positive aspect of interventions and areas in need of improvement. Apart from enabling the health trainers to professionally develop, this reflective part of the supervision meeting allowed me to get an insight into how the health trainers carried out a behaviour change intervention and how they perceived the process. I also questioned the health trainers on which techniques and health psychology models they perceived that they were using during interventions. Additionally, both health trainers were observed providing interventions and received feedback from the sessions.

Refection on the Training for Health Trainers

One health trainer expressed that they had incorporated what they had learned during their training into the health behaviour change intervention sessions with clients. The supervisee was able to describe the techniques used and they confirmed an understanding into the usefulness of the health psychology methods.

Conversely, the other health trainer demonstrated an insecurity about which health psychology techniques they used and an inability to explain the methods. However, during the observations I discovered that the health trainer was in fact employing the techniques that the training encompassed. I realised that health professionals with no background in psychology might incorporate various elements from health psychology models without being aware of their terms or capable of describing them. The demands on the health trainers were high when bearing in mind the limited amount of training they had received and the fact that they were not previously qualified in a health or psychology related field. Yet, they were expected to possess the knowledge and use similar techniques to those applied by chartered health psychologists with years of training. As a supervisor of the health trainers, it was vital for me to take both their implicit and explicit memory skills into consideration when assessing their ability to conduct and monitor interventions by communicating verbally with the supervisees as well as observing an implementation of an intervention.

Setting Barriers in Clinical Practice

Adelman and Graybill (2005) evaluated the effectiveness of a pilot behaviour change programme in a primary care setting. They found that interventions provided by a lay health coach trained to support clients in modifying their health behaviours had the potential to be a successful tool in behaviour change projects and that patients perceived the interventions as positive and supportive. However, due to the various complex psychosocial factors that impact behaviour change, health coaches would benefit from guidelines on caseload management and setting barriers in their clinical practice.

To ensure that the health trainers received technical support for the interventions they provided, information regarding the health professionals and services to contact if they needed assistance were covered in the sessions. One of the health trainers supported pregnant smokers as part of their remit and they were requested to contact the specialist advisor who works with pregnant women and families to discuss these clients. This was to ensure not only that the health trainer received appropriate support but also that the clients obtained the optimal interventions and that the health trainer acted according to the protocol with this vulnerable group. The health trainers were provided with structured screening guidelines of clients in relation to smoking, healthy eating and exercise and they were requested to refer those clients who they were not authorized to support to appropriate services. (See Appendices 6–8 for the screening guidelines).

Reflection on Setting Barriers in Clinical Practice

One of the health trainers followed the guidance rigorously whilst the other health trainer did not act within the boundaries of the guidance on all occasions. I felt that the supervisee's performance was not directly linked with their lack of knowledge regarding the set boundaries but rather with a fundamental disagreement with them. The health trainer appeared at times to possess an excessive abundance of confidence in their own abilities and did not appreciate their ethical responsibility towards both themselves and the Primary Care Trust (PCT). Rather, they felt that the clients became disillusioned as a consequence of being referred. The health trainer also appeared to find it difficult to appropriately end the treatment course for certain clients. I dealt with the lack of comprehension by explaining the rationale behind the boundaries with regards to the clients, the health trainers and the PCT. In addition, we discussed methods of speaking to clients to provide them with the correct

information in an encouraging manner. The issue was also brought to the attention of the clinical supervisor who warned the health trainer of the consequences of breaching the directions and the importance of following them. As a result, the health trainer appeared less reluctant to strictly adhere to the protocol.

Following the screening guidelines was not, however, as straightforward as could be expected. The health trainer who firmly followed the guidance faced incomprehension from some of the GPs who did not understand why some of the patients referred to health trainers could not be supported. As the health trainer found it difficult to approach other health professionals to explain their role, the supervision sessions were adapted to incorporate discussions concerning effective and appropriate methods of communication. Although the health trainers appeared to come to terms with the difficulties surrounding the screening guidelines, this issue highlighted the complexity of helping the health trainers to understand their role and its boundaries as well as enabling other health professionals to do so.

Observation and Feedback of Interventions

Observing interventions and providing feedback of the observations are vital elements in improving interventions. This process comprises of reinforcing good performance, correcting mistakes and enabling the supervisee to develop professionally in clinical practice. Feedback has been argued to be a crucial component in the process of furthering ones clinical skills. It relates to the provision of information regarding a person's performance and has the potential to influence the improvement of performance. Effective feedback takes place in a relaxed atmosphere and the supervisor uses objective and precise language. A commonly occurring error, however, is that the provider of feedback is concerned that any negative feedback will be taken personally and consequently damage the relationship

between the supervisor and supervisee. In their attempt to avoid such an incidence, supervisors may either discuss the observation in an ambiguous manner, leading to misunderstanding of the feedback, or the supervisor might even avoid mentioning any negative aspects of the intervention. A consequence of poor feedback may be feelings of anger, embarrassment or defensiveness in the supervisee. The supervisor needs to explain the meaning of feedback and stress that it is not a reflection of the supervisee's self-worth. However, receiving feedback effectively also requires the supervisee to possess maturity, honesty and a sense of responsibility in improving their practice (Ende, 1983).

I observed both initial and follow up interventions provided by the health trainers and the sessions focused on smoking cessation and healthy eating. In the subsequent supervision meeting following an observed session, I provided oral and written feedback and we discussed both my own and the health trainers' evaluations of the session.

Reflection on the Observation and Feedback Provided

One of the key areas in which I perceived that I had to improve was similar to what Ende (1983) had outlined, namely the provision of negative feedback. I was overly concerned about the reactions of the health trainers and during the initial feedback sessions, I might have been too obscure regarding the negative feedback of the observations. This might have limited the value of the feedback. However, I recognised this need for improvement in my ability to supervise and I made a conscious effort to objectively and clearly present the information. I also realised that the health trainers perceived the process of a supervisor overseeing and directing an intervention quite differently and that they were not accustomed to the process. Although one of the health trainers eventually appreciated the benefit of feedback,

their reaction was quite defensive during the initial feedback sessions. I believe that the health trainer's reactions were linked to their levels of confidence, comfort and trust. These levels gradually increased during the period of supervision and consequently the health trainer became more receptive to feedback. The other health trainer was more open to both negative and positive feedback and generally held a more optimistic approach to the process of observations as well as to their professional development. This outlook appeared yet again to mirror the supervisee's high levels of confidence in their ability to carry out effective interventions as well as their ability to self-reflect.

Overall Reflection

Spouse and Redfern (2000) pointed out that learning how to supervise is a complex task and time and practice are vital components in the process of becoming a proficient supervisor. As a health psychology supervisor for two health trainers, I certainly experienced that although knowledge and education aided the development of becoming a supervisor, experience still formed the most fundamental part of the learning curve. Developing an open and trustworthy relationship with a supervisee and simultaneously remaining the authoritative person in the relationship is not a straightforward and effortless process and patience and practice are required in order to achieve this imperative balance.

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Appendix 1

Needs Assessment of Health Behaviour Change Interventions Provided by Health Trainers

Individuals are capable of enhancing their health by adopting healthy behaviours and avoiding health-compromising behaviours (Conner & Norman, 1995). A vast amount of people in England desire to change their behaviours, however, adopting and sustaining a healthier life style is a difficult process for many (Department of Health, 2004).

Research has indicated that socio-economic status is associated with health. In general, morbidity and mortality rates are higher among people from lower socio-economic backgrounds and individuals from more affluent social classes tend to be healthier (Adler & Ostrove, 1999; Smith, 1999). Whilst socio-economic status, employment, income and education constitute the broader determinants of health, other more specific factors such as smoking, diet and physical inactivity are crucial contributors of poor health. In addition, access to health care and quality of treatment is inferior amongst the most disadvantaged in society (Wanless, 2003).

The Department of Health (DH) (2004) outlined a scheme that would support individuals who desire to change their behaviour. In order to be able to empathise with clients who are less likely to benefit from health care and more likely to be affected by factors contributing to poor health, the new health resource identified as health trainers, would be lay people recruited from the local community. The duties of the NHS accredited health trainers would entail defining the changes clients wished to make, providing advice, motivation and support in making and sustaining

the health behaviour change (e.g. stopping smoking, healthy eating or increasing exercise) and encouraging uptake of and signposting to other services in the community. The aim of the heath trainer scheme was to improve access to health services and availability of support for patients to reduce health inequalities in England.

To support the development and auditing of the health trainer's skills and knowledge across the areas of health psychology and cognitive/behaviour change, I was allocated the role of health psychology supervisor for two health trainers.

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Appendix 2

Plan of Supervision for Intervention

In planning the supervision for interventions provided by the health trainers, I learned about what their training entailed and what the content of their previous health psychology meetings had been. Although I did not facilitate the group meetings, by communicating with both the supervisors who ran the sessions as well as with the health trainers themselves, I discovered what the objectives and subjects of the meetings were. I also enquired about any training the health trainers attended in order to gain an awareness of their development and capabilities. I met monthly with the health trainers on a one to one basis. During these meetings we covered the topics outlined in table 1. Some of theses issues were discussed continuously in each supervision session and others were covered either only once or on a few occasions.

Table 1. Topics discussed and rationale

Topic	**Rationale**
The health trainers' roles and responsibilities	Ensure that the health trainers have an understanding of their role and responsibilities
The health psychology supervisor's roles and responsibilities	Ensure that the health trainers have an understanding of the supervisor's role and responsibilities
The health trainers' expectations from the supervision	Discover the expectations of the health trainers to improve the value of supervision
Previous training and upcoming training sessions	Gain an insight into the health trainers' knowledge and need for future training

Reflection	Encourage reflection to improve clinical practice
Providing correct information	Ensure that correct information is provided to clients in accordance with clinical governance
Client issues	Discuss client issues to enhance clinical practice and professional development
Use of health psychology techniques	Ensure an understanding and use of relevant health psychology techniques
Use of forms	Ensure correct use of forms during interventions
Obtaining written consent	Ensure written consent is obtained
Time management	Improve time management skills
Communication	Improve communication skills
Referral to other health services	Ensure knowledge of other services for referral purposes
Ethical responsibilities	Ensure that health trainers act in an ethically responsible manner
Valuing diversity and avoiding prejudice	Ensure that health trainers value diversity and avoid prejudice
Feedback	Provision of feedback for the benefit of clinical care and professional development
Case studies	Reflect on case studies for professional development and improvement of clinical practice

Appendix 3

Health Psychology Meetings June –06 to July –07 Present: Health Trainer (HT) "X" and CH			
Date	**Area discussed**	**Topics discussed**	**Action points**
09/06/06	▪ X's work in general and the roles of Public Health Assistants ▪ X's opinions on X' work and role ▪ Time management ▪ The intervention sessions ▪ CH's role as a Health Psychology Supervisor	▪ The localities where X is based and when X is where ▪ Communication and referrals at practices ▪ Positive and negative aspects of work ▪ Discussion around how X manages the time at work ▪ How confident X feels about delivering interventions ▪ Using psychological theories and techniques in sessions ▪ CH coming to observe sessions	▪ X to call CH to arrange a date for her to come and observe sessions ▪ CH to observe sessions ▪ Next supervision meeting: 7th July 10am ▪ CH to e-mail X summary of meeting
07/07/06	▪ X's expectations from the supervision sessions ▪ The sessions CH had observed ▪ Observing some initial consultations ▪ Difficult clients ▪ Language barriers ▪ Points discussed in the group supervision meeting ▪ Training	▪ What would X like to get out of the health psychology supervision sessions ▪ More feedback of the sessions observed was provided – very positive in general ▪ CH coming to observe interventions given to new clients ▪ Discussed issues related to clients with mental health problems and people with learning difficulties ▪ Steps taken when language barriers are experienced, e.g. getting a translator ▪ Discussed any points brought up in the groups supervision and any requirements for the next group meeting ▪ Discussed the training X has undergone and any training X thought would be useful in the future	▪ CH to observe initial consultations ▪ CH to let X know if 17th August is a good day for observing these sessions ▪ Next supervision meeting: 8th September 10am ▪ CH to e-mail X minutes of meeting

	▪ Services to refer to and screening guidelines ▪ Annual leave	▪ Discussed services to refer complex or inappropriate referrals to and the screening guidelines HTs must follow. As X had not followed all of the guidelines so rigorously, there was a discussion about the importance of adhering to them ▪ X will be on annual leave between 24th July and 14th August. X will not have any new clients until after X's holiday and X can arrange for a health care assistant to cover some of the follow-up sessions	
08/09/06	▪ Any changes to X's work ▪ Consent forms ▪ The whole group meeting ▪ New weekly diaries that will be introduced in October ▪ Client issues ▪ CH observing an initial session	▪ X has started working on the health bus in [redacted] every second Wednesday afternoon ▪ Ensuring that clients fill in their consent form and reporting to [redacted] if any clients do not want to give consent ▪ Issues discussed in the meeting held 7th September ▪ How these diaries can be used to improve the service and reflect the work the Health Trainers undertake ▪ X is supporting some clients with mild mental health problems ▪ Discussed reasons why some clients do not return for follow-up sessions and how to deal with this ▪ CH was supposed to observe initial sessions 17th August. However, this had to be cancelled and a new date needs to be set	▪ CH to observe some initial sessions ▪ X to inform CH of a new possible date to observe sessions ▪ Next supervision meeting: 24th October 10am ▪ CH to e-mail X summary of meeting
24/10/06	▪ Being pro-active in the community ▪ Working on the health bus vs. providing interventions ▪ Client issues ▪ Clinics	▪ X is still working on the health bus in [redacted] every second week. X has also been working on the health bus for the diabetes week and flu promotion ▪ Discussed how ways of providing health advice and referring people when working on the health bus relate to the health psychology theories and methods used when providing interventions ▪ X had seen a client who was a chef and wanted support with changing her diet. X had been a bit worried about the fact that she had such a great amount of knowledge regarding food but the sessions were going really well. Discussed that the level of knowledge is not the most important skill for a HT but the ability to support a behaviour change ▪ X is busy at most clinics, but does not experience it to be too hectic ▪ DNAs at [redacted]. X will visit the Medical Centre behind the [redacted] sport centre, might set up a clinic there. Waiting for line manager to get back with available dates	▪ CH to observe some initial sessions ▪ X to inform CH of a new possible date to observe sessions ▪ CH to inform X of a suitable time for the next supervision meeting ▪ CH to e-mail X summary of meeting

	▪ The new weekly diaries ▪ Setting two goals	▪ X found the new diaries take a lot of time to fill in but X thought that this will get better as X gets used to them ▪ The guidelines for seeing clients state that setting two goals at the same time does not appear to be the most effective way of changing a behaviour – discussed how this affects X's work	
01/12/06	▪ Progress of work ▪ The weekly diaries ▪ Client issues ▪ Ethical responsibilities ▪ CH to observe some initial sessions	▪ X is being very pro-active and working a lot out in the community. X is involved in "Sensible Drinking Campaigns", a "Smoke Free Homes Project" with Sure Start, "Men's Health Promotion Week" with Sure Start and the "Sexual Health Bus" ▪ X has got used to the diaries and does not find them very time consuming anymore ▪ X is seeing a few clients with mental health issues at the moment and we discussed working with this group of people. Even if the clients are more complex, X does not have a problem working with this patient group ▪ Discussed the benefits and disadvantages of supporting couples or two people at a time as opposed to people on a one to one basis ▪ Discussed what constituted ethical responsibilities in the role of the health trainers ▪ CH observing sessions has been postponed as there is not time for this in 2006	▪ CH will e-mail X the minutes from the meeting ▪ Next supervision meeting: Friday 12th January 10am ▪ CH will let X know when she will be able to come and observe sessions
12/01/07	▪ LORs ▪ Supporting pregnant smokers ▪ Communication ▪ Work in the community	▪ X had been using LORs with some clients who he had seen at their homes. However, as HTs are not supposed to use these we discussed alternative methods of providing NRT prescriptions ▪ X is supporting three pregnant smokers. We discussed the importance of logging the NRT discussions with these clients and keeping [redacted] informed of the sessions. X will also ask the clients for their post natal notes so X could include information about smoking cessation ▪ Discussed the importance of communicating with various health professionals and the most effective way of doing this ▪ X is still involved in various campaigns: "Sensible Drinking Campaigns", a "Smoke Free Homes Project" with Sure Start, "Men's Health Promotion Week" with Sure Start and the "Sexual Health Bus". X has signed up 15 mums for the smoke free homes project and X will get in touch with these clients soon	▪ CH to e-mail X summary of meeting ▪ X to get in touch with [redacted] and provide her with an update of the pregnant clients ▪ X to start adding information in the postnatal notes ▪ X to reply to [redacted]s e-mail regarding the forms ▪ X will liaise with [redacted] about diet client ▪ CH to ask [redacted] and let X know

	▪ New MOT, HAPA and follow-up forms ▪ Client issues ▪ Attending a course ▪ CH to observe initial sessions	▪ There has been some confusion about which forms to use among some HTs. However, X prefers the new forms and was clear about which ones to use ▪ X is supporting four clients with mental health issues and X feels that it is going well. A GP has referred a client who might be underweight and he wants X to go through her diet with her. X might have to refer this client to appropriate services if she is under a certain BMI or has an eating disorder ▪ X had some questions about clients who are using NRT for more than 12 weeks. We discussed continuing to prescribe NRT for a while but helping the client to come off NRT while supporting them and referring the to the specialist services if necessary ▪ X would like to attend a course about communicating with deaf people. X had asked [redacted] who had referred him to [redacted] who had referred him to CH ▪ CH might be able to observe sessions either on 16th or 17th January	if it is ok to attend the course ▪ CH to let X know when she can come and observe sessions ▪ CH to e-mail X minutes of meeting ▪ Next supervision meeting: 16th February 10am
16/02/07	▪ Supporting pregnant smokers ▪ Work in the community ▪ MOT, HAPA and follow-up forms ▪ Client issues ▪ Courses	▪ X is supporting two pregnant smokers. X has got two new smoking cessation referrals from women who have recently given birth. 14 mums have signed up for the Smoke Free Homes Project ▪ The "Sensible Drinking Campaigns" is finished. The "Smoke Free Homes Project" with Sure Start and the "Sexual Health Bus" are ongoing. The "Men's Health Promotion Week" was postponed. A "Bowels Cancer campaign" is coming up soon ▪ The MOT forms to be completed at follow-up sessions, not just at the initial session. X has asked clients to fill them in at home and return them for the following sessions as clients are not keen to complete the MOT on several occasions and it is quite a time consuming process. [redacted] is developing questionnaires for the HTs to send to clients they have seen in the past to evaluate the service ▪ X is supporting three clients with mental health issues. A GP had referred a client who was underweight. X discussed with [redacted] and referred her back to the GP. X got two inappropriate referrals. X has discussed this with the GPs ▪ X is going to find out if X can attend the course about communicating	▪ CH to e-mail X summary of meeting ▪ X has not yet got in touch with [redacted] to provide her with an update of the pregnant clients. X will do so ▪ When [redacted]s questionnaires are ready, X will send the questionnaires out to clients ▪ CH to e-mail X copy of the feedback form ▪ X to find out if has a copy of the feedback he received after being observed in July –06. CH has lost the document as her computer crashed ▪ X to forward CH a copy of the

	▪ Evaluation of work	with deaf people in March ▪ CH gave feedback of session she had observed – very positive ▪ [redacted] has written evaluation of X's work	evaluation ▪ Next supervision meeting 16th March, 10am
16/03/07	▪ Supporting pregnant smokers ▪ Work in the community ▪ MOT, HAPA and follow-up forms ▪ Client issues ▪ Courses	▪ X is supporting one pregnant smoker and two women who have recently given birth. A midwife has given X three new smoking referrals from pregnant women. X has sent [redacted] an e-mail about his clients but X has had some problems with X's e-mail lately. 14 mums have signed up for the Smoke Free Homes Project and 3 more signed up on No Smoking Day ▪ The "Smoke Free Homes Project" with Sure Start and the "Sexual Health Bus" are ongoing. A date will be set for the "Men's Health Promotion Week" which was postponed. X received training for the "Bowels Cancer campaign". A screening programme will be introduced in the end of the month ▪ [redacted] has developed a questionnaire to evaluate the service. She will send these to clients that HTs have seen in the past ▪ X is supporting three clients with mental health issues. Two are depressed and one client has got mental health issues as a result of her drug addiction ▪ X is very busy at the clinics at the moment ▪ X attended a course in March about communicating with deaf people. X found it very useful	▪ CH to e-mail X summary of meeting ▪ X will call [redacted] to ensure that she received the e-mail ▪ X to forward CH a copy of the evaluation form ▪ X to find out if X has a copy of the feedback X received after being observed in July –06. CH has lost the document as her computer crashed ▪ Next supervision meeting 20th April, 10am
08/06/07	▪ Supporting pregnant smokers ▪ Work in the community ▪ MOT, HAPA and follow-up forms	▪ [redacted] had been asking about three pregnant clients who had been referred to X. X informed CH of the progress for each client. X was reminded of the importance of providing [redacted] with information about pregnant clients even if X cannot get hold of the clients ▪ The "Smoke Free Homes Project" with Sure Start and the "Sexual Health Bus" are ongoing and have been put on hold until X is feeling better. X did some Smokefree promotion for young teenagers, mums and mums to be. The "Men's Health Promotion Week" is set for 19th June or 3rd July. The "Bowels Cancer campaign" a screening programme has been introduced, flyers and cards set up in surgeries ▪ [redacted] had fed back to X that X needs to remember to get written consent from clients	▪ CH to e-mail X summary of meeting ▪ X will provide [redacted] with information about the pregnant clients X is supporting or has been supporting ▪ Next supervision meeting 6th July, 10am

	▪ Client issues ▪ Courses/training ▪ Other issues	▪ X has been on sick leave for approximately 2 months but was able to refer all stop smoking clients to other level II trained advisors before going on sick leave and inform all healthy eating/exercise clients that X will be away for some time ▪ CH asked X about a letter which had been given to a client. The letter, which included an action plan, had a few points giving advice about healthy eating. X explained that the reason that the action plan included so many points was that the client had incorporated some of these changes already as she had been on the programme for quite some time. However, we discussed that the HTs' role is to support clients in making small changes rather than to give advice as dieticians would and letters to clients should reflect this ▪ X had been on several training sessions: an update session on contraception and reproduction at the [redacted] centre, a 2 day training course on basic exercised for people with arthritis and training on Foetal Alcohol Spectrum Disorder ▪ CH asked if X could consider helping [redacted] with a presentation on chewing paan. X has not had any experience with clients who chew paan but X would be willing to help out ▪ Before X has an appraisal, X's line manager will go on a course on how to undertake one ▪ X is not on sick leave but is not seeing clients yet. Therefore, X is going a variety of training sessions and courses and catching up with paper work	
06/07/07	▪ Supporting pregnant smokers ▪ Work in the community ▪ MOT, HAPA and follow-up forms ▪ Client issues	▪ X is not supporting any pregnant clients at the moment. X has informed [redacted] of the pregnant smokers X had been supporting ▪ The "Smoke Free Homes Project" with Sure Start and the "Sexual Health Bus" are ongoing. X and his line manager will set a new date for the "Men's Health Promotion Week". The "Bowels Cancer campaign" is ongoing ▪ X is making sure that all clients are asked for written consent ▪ X started seeing clients again 2 weeks ago and X feels that many of them are very motivated. X is mainly getting referrals for healthy eating as the level II trained advisors in the practices might be supporting the smokers ▪ X has had some queries about Champix from GPs and from a client	▪ CH to e-mail X summary of meeting ▪ X will provide [redacted] with information when X supports a pregnant client in the future ▪ X will attend the [redacted] fun day with Sure Start next Tuesday ▪ X might be working on the "Sexual Health Bus" next Wednesday

	▪ Courses/training ▪ Other issues	▪ X has asked X's line manager whether X could attend a course on "Understanding health and social care". X is now waiting for [redacted] to give an answer ▪ Before X has an appraisal, X's line manager will go on a course on how to undertake one ▪ X is going on annual leave for 3 weeks from 25th July ▪ CH showed X how to use PowerPoint as the HTs are preparing presentations for the team supervision meeting	▪ X to attend an update session in smoking cessation on 29th October ▪ Next supervision meeting 7th September

Appendix 4

Health Psychology Meetings June –06 to July –07 Present: Health Trainer (HT) "Y" and CH			
Date	**Area discussed**	**Issues discussed**	**Action points**
07/06/06	▪ Y's work in general and the roles of Public Health Assistants ▪ Y's view on Y's work ▪ Time management ▪ Applying psychological theories in sessions ▪ CH's role as a Health Psychology Supervisor	▪ The localities where Y is based and which days Y is where ▪ Communication and referrals at practices ▪ Positive and negative aspects of work ▪ Discussion around how Y manages the time at work ▪ How confident Y feels about applying psychological theories in practice and delivering interventions ▪ CH coming to observe sessions	▪ CH to e-mail Y minutes of meeting ▪ Y to let CH know if Thursday 15th or Friday 16th is a suitable day for CH to observe sessions ▪ CH to observe sessions ▪ Next supervision meeting: 13th July, 2pm ▪ CH to send Y instructions on remote access to e-mail
13/07/06	▪ Y's expectations of the supervision meetings ▪ The session CH had observed ▪ Observing some follow-up session ▪ Difficult clients ▪ Language barriers ▪ Practices ▪ The group supervision meeting ▪ Services to refer to and screening guidelines	▪ Discussion around what Y would like to get out the health psychology supervision meetings ▪ More feedback of the session observed was provided ▪ CH coming to observe some follow-up sessions as well ▪ Discussed issues related to clients with mental health problems and people with learning difficulties and how to adjust the sessions according to their needs ▪ Discussion around difficulties related to behaviour change and clients not returning to follow-up sessions ▪ What to do if there are language barriers with clients. HTs can get interpreters for the sessions ▪ Discussed if Y has got any busier in certain practices and how to promote the service ▪ Discussed if there were any specific requirements for the future group supervision meetings that Y had not mentioned or had thought of since ▪ Discussed which services to refer to if Y feels that clients are	▪ CH to observe follow-up sessions ▪ CH to let Y know if 19th August is a good day for observing these sessions ▪ Y to let CH know when a good day for the next supervision meeting is ▪ CH to e-mail Y summary of meeting ▪ Y to call [redacted] to book a place for an update session ▪ CH to check with [redacted] about filling in questionnaires with complex clients

		complex or need more support and who approach if Y has questions ▪ Screening guidelines	
20/09/06	▪ Changes in practices ▪ Situations at other practices ▪ Promoting the service and being more pro-active ▪ Developing intervention skills ▪ New weekly diaries that will be introduced in October ▪ Training ▪ CH to observe some follow-up sessions ▪ A referral	▪ Y is not at the [redacted] practice or [redacted] surgery anymore. As both [redacted] and [redacted] medical centre have expressed an interest in a smoking clinic being set up at their premises, we will try to arrange meetings to discuss the possibility of Y working there instead ▪ Discussed ways to increase referrals at other practices where Y is finding Y has a lot of extra time (See below) ▪ Y had a few ideas regarding how Y could promote the service. I.e. organising health walks, approaching patients in waiting rooms, talking to other health professionals (GPs, nurses) about referring and delivering group talks ▪ Discussed the benefits of observing other people deliver interventions in order to get ideas give each other feedback. One method would be to observe another HT provide an interventions ▪ How these diaries can be used to improve the service and reflect the work the Health Trainers do ▪ Discussed the training Y has undertaken and training that Y feels would be beneficial for Y's continuing professional development ▪ Y might have some follow-up sessions CH can observe in a couple of weeks time ▪ A 16 year old boy was referred to Y for smoking cessation	▪ CH to e-mail Y minutes of meeting ▪ CH to call [redacted] medical centre and [redacted] to arrange meetings with the GP/practice manager, CH and [redacted]. CH to let Y know as soon as this has been done ▪ Y to get in touch with [redacted] and see if Y can observe her during some sessions ▪ Y to let CH know when she can come and observe some follow-up sessions ▪ Y to give CH the referral from the young person ▪ Next supervision meeting: 25th October, 2pm
25/10/06	▪ Changes in practices ▪ Being pro-active and promoting the service ▪ Observing another HT provide interventions	▪ Y has set up clinics in [redacted] Medical Centre and [redacted] Medical Centre. Has got a couple of referrals from both practices ▪ Y is still interested in doing health walks in the [redacted] area ▪ Discussed observing [redacted] deliver interventions	▪ CH to e-mail Y minutes of meeting ▪ Y to e-mail [redacted] and [redacted] to find out how to arrange this and contact [redacted] regarding training ▪ When [redacted] is back from sick leave, Y will get in touch with her to see if Y can observe a session on Wednesday afternoon

	▪ CH to observe some follow-up sessions ▪ The new diaries ▪ A referral ▪ Communication	▪ Y let CH know of a time when she can observe follow-up sessions ▪ Discussed the new diaries that the HTs have to complete. Y found them quite time consuming but not impossible to fit into the time schedule ▪ Y had not yet referred the 16 year old boy who Y saw a while ago for smoking cessation ▪ Discussed the importance of communicating with both myself and Y's line manager and the most effective methods of doing this	▪ CH to observe some sessions at [redacted] Rd on 1st November ▪ Y to refer young person to Stop Smoking Service ▪ Next supervision meeting: 29th November, 2pm
29/11/06	▪ Practices ▪ Doing health walks ▪ Observing sessions ▪ CH to observe some follow-up sessions ▪ Client issues	▪ Things are going well in all four practices. Y is settling in well in [redacted] Medical Centre and [redacted]. Y is quite busy and Y is getting mainly smoking cessation patients in three practices and mainly diet patients in one practice ▪ Y has got the forms for the health walk. Still considering whether Y should go ahead with them ▪ Y still keen on the idea of observing [redacted] deliver sessions. Y has not approached her regarding this yet as she is quite busy at the moment ▪ CH observing sessions has been postponed as there is not time for this in 2006 ▪ Y is seeing two couples at the moment. Discussed the benefits and disadvantages of supporting couples as opposed to people on a one to one basis	▪ Y will wait until Y finds out more about a project involving helping older people before Y decides to go ahead with the health walk ▪ Y will ask [redacted] if Y can observe a session if Y has any time off in the future ▪ CH will let Y know when she will be able to come and observe sessions ▪ CH will e-mail Y the minutes of the meetings ▪ The next supervision meeting will be held on Wednesday 10th January, 2pm
01/02/07	▪ Explaining the role of health trainers ▪ Practices	▪ Y experienced that some health professionals were unclear of Y's role. Discussed ways of communicating their role in an effective way ▪ [redacted] - very busy. Y will find out if Y can have another session there during the week. [redacted] – rather quiet. A receptionist who sees clients (takes blood pressure) will start referring clients to Y. [redacted] – quite busy. Y might find out if Y can have another session there during the week. [redacted] – Y will not work there anymore as the only nurse who refers clients only works one day a week	▪ CH to e-mail Y minutes of meeting ▪ As Y has two afternoons free Y will find out if Y can do extra sessions at [redacted] and [redacted] ▪ Y to find out about the Health Walks ▪ CH to call Y to find out if she can come and observe sessions on 13th

	▪ Activities ▪ Valuing diversity and avoiding prejudice ▪ Ethical responsibilities ▪ CH to observe some sessions ▪ Client issues	▪ Y will attend a National Women's Day event and be engaged in various activities for No Smoking Day ▪ Y has not heard anything about the older peoples project so Y might be able to do the health walks ▪ Discussed the importance of valuing diversity and avoiding prejudice and what one needs to consider when working in a clinical setting ▪ Discussed what constituted ethical responsibilities in the role of the health trainers ▪ CH has still not observed Y give follow-up sessions. Might be arranged for next month ▪ Discussion around some of Y's clients. ▪ Y was supporting some clients who did not speak English very well ▪ Y was supporting a client who was reluctant to discussing her smoking habit or history ▪ Y had been supporting a client who had trouble hearing	February ▪ Y to find out about getting a translator at the surgery ▪ CH to e-mail Y to let [redacted] know if 13th March is a good time for the next supervision meeting
26/04/07	▪ Practices ▪ Training ▪ CH to observe some sessions ▪ Y to bring case study to the next meeting ▪ Client issues	▪ Y has not got any free sessions as Y will set up a clinic again at [redacted] Surgery and [redacted] Surgery ▪ Y has another session at [redacted] Medical Centre ▪ Y will go on a refresher health and safety course ▪ Y has attended bowel cancer training and smoke free homes training for Sure Start ▪ CH will observe some of Y's healthy eating sessions and Y feels that Y finds these interventions harder than smoking cessation ▪ In the next supervision meeting, Y will bring a case study of one of Y's healthy eating clients to discuss ▪ Y was supporting some clients who did not speak English very well. As the surgery has not go a translator Y needs to find out how to get a translator if necessary in the future ▪ One of Y's smoking cessation clients keeps on having lapses and Y reflected on when it is time to end the course	▪ CH to e-mail Y minutes of meeting ▪ Y to let CH know when Y has a client for healthy eating so CH can come and observe ▪ Y to prepare a case study for the next supervision meeting ▪ Y to talk to another HT to find out how to get a translator ▪ Y to get more information about chewing paan ▪ CH to find out about how to complete monitoring forms for clients who do not speak English very well ▪ Next supervision meeting 24th May

	▪ Appraisal ▪ Feedback from observing clients ▪ Paan chewing	▪ Discussion around how Y felt that the appraisal went and the outcome of the appraisal ▪ CH gave feedback from observing Y provide follow up sessions for two clients ▪ Y reflected on the progress Y has made with regard to providing interventions and how Y now uses the health psychology theories within the clinical work very naturally and that Y feels a lot more comfortable ▪ Y will support people wanting to stop chewing Paan at [redacted] Surgery	(after meeting with [redacted])
14/06/07	▪ Practices ▪ Training ▪ CH to observe some sessions ▪ Y brought a case study to the meeting ▪ Client issues ▪ Paan chewing ▪ Other issues	▪ All sessions are up and running. Y is finding that they are not particularly busy but Y sees clients in each surgery ▪ Y has been on a refresher health and safety course, load handling course and KSF training course ▪ CH will observe some of Y's healthy eating sessions. Y has not let CH know of any new healthy eating clients ▪ Y discussed two healthy eating clients and reflected on the process and outcome of the sessions. The clients had very different goals and were in different situations but both were pleased with the changes they had made. We discussed the process of changing ones diet and exercising and how this can appear like a very lengthy process for some clients ▪ Y had not yet found out from other HTs how to get translators ▪ Y had not yet got any referrals from people wanting to stop chewing Paan at [redacted] Surgery ▪ As part of Y's action plan from the appraisal, Y will provide a presentation on chewing paan. [redacted] is willing to help out if Y wants him to although he has not supported any of these clients. This presentation will probably take place when Y is back from leave ▪ Y will go on maternity leave 24/7. Discussed people who need to be informed and practical issues to be resolved prior to going on the leave	▪ CH to e-mail Y minutes of meeting ▪ Y to talk to another HT to find out how to get a translator ▪ Next supervision meeting 12th July ▪ If Y gets a healthy eating client before Y goes on maternity leave, Y will inform CH so she can come and observe. If not, this will be postponed until Y returns

12/07/07	▪ Y had forgotten about the supervision meeting, a few things were discussed over the phone ▪ Practices and client issues ▪ Other issues	▪ Y had informed all the practices that Y is going on maternity leave and where to refer patients for smoking cessation. Y stopped seeing new clients a while back so Y was able to support all clients through the whole course ▪ Y had left Y's CO-monitor and phone with [redacted] ▪ This was Y's last day. Y is going on maternity leave from 13th July	

Appendix 5

Reflective Analysis of the Problems that Could be Encountered in Implementing the Intervention and Supervising Its Implementation

The Relationship between the Supervisor and the Supervisee

As supervisees cannot be monitored at all times, it is vital that the relationship between the supervisor and the supervisee is open and trusting. However, the supervisor needs to simultaneously remain the authoritative individual and it may be difficult to achieve this balance in the relationship. Other factors might also have an impact on whether supervisors are regarded as authoritative and respectable in their role. For instance, if the supervisee is older or the supervisor new to their position, it might be a challenging process to establish the appropriate relationship.

The Role of Supervisors

A number of people were involved in the health trainer project and the health trainers had been allocated to various managers during their time at the Primary Care Trust (PCT). Besides, they had been supervised by various people who had left the trust. The large number of people involved and the changes occurring regularly are likely to have had an impact on the health trainers. They certainly appeared confused about what the role of some people was and they were at times directed in conflicting directions. Supervisors adapt various roles such as observer, teacher, colleague and evaluator and this system creates a complex relationship between the supervisee and their supervisor (Bernard & Goodyear, 1998 as cited in Ellis, Krengel & Beck, 2002). It is therefore vital to address the roles and responsibilities of all

those who manage and supervise individuals in order to adopt consistent and successful supervision (Cottrell, 2002).

The Discrepancy between Expectations and Training

It was essential to consider the expectations of the work the health trainers carried out in relation to the training they had received. The demands on the health trainers were high when bearing in mind the limited amount of training they had undergone and the fact that they were not previously qualified in a health or psychology related field. Yet, they were expected to possess a vast amount of knowledge and employ similar techniques to those applied by chartered health psychologists with years of education. Without the awareness of any potential discrepancy between expectations and training for supervisees, it may be difficult for the supervisor to support supervisees in the development of skills, knowledge and understanding of their practice.

Observation of Interventions

A problem related to observing sessions is that supervisees might act differently when they are being observed. Some individuals become nervous and do not provide an intervention as effectively as they would do under normal circumstances. Others might be able to put more effort into delivering an effective intervention under observation by ensuring that they cover all necessary aspects and perform a comparatively superior intervention. Therefore, it is vital to observe a number of sessions on a regular basis so the supervisees become accustomed to the process. Supervisors must also take into consideration the different personalities and needs that supervisees possess and adjust the supervision accordingly. The ability to describe an intervention and to actually carry out an intervention might vary greatly

between supervisees. This might be due to the different skills in explicit and implicit memory or the capability to verbally describe the implementation of interventions.

The Provision of Feedback

Supervisors could feel concerned that providing negative feedback of an intervention might lead to feelings of embarrassment, defensiveness or anger and consequently damage the relationship. The provision of ambiguous feedback and lack of negative feedback might occur a result of these fears. The supervisor must therefore explain the meaning of feedback and stress that it is not a reflection of the supervisee's self-worth. However, receiving feedback effectively also requires the supervisee to possess maturity, honesty and a sense of responsibility in improving their practice (Ende, 1983). How effective the process of delivering and receiving feedback is therefore depends on both the supervisee and the supervisor. Moreover, the ability to practically transfer feedback into changes in ones practice might not be a process as straightforward for supervisees as the supervisor might expect. Depending on various factors such as the experience and training, some supervisees may never have previously undertaken this task.

There are a variety of problems that might be encountered in implementing and supervising interventions. Reflecting on these issues prior to and during supervision is therefore a fundamental component of effective supervision.

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SECTION D

Unit 2 SYSTEMATIC REVIEW

Evaluation of the Effectiveness of Smoking Cessation Interventions for Pregnant Women

EVALUATION OF THE EFFECTIVENESS OF SMOKING CESSATION INTERVENTIONS FOR PREGNANT WOMEN

Abstract

Background. As smoking during pregnancy has been linked to numerous negative health outcomes, reducing smoking prevalence rates among pregnant women is a public health priority. However, encouraging smoking cessation and abstinence maintenance for this population remains a challenge.

Objectives. The objectives of the systematic review were to explore the effectiveness of smoking cessation interventions for pregnant smokers, to evaluate during what stage of pregnancy the intervention is most likely to be effective and to assess the effectiveness of interventions according to types of pregnant smokers.

Search strategy. The databases that were searched included the PsychINFO, EMBASE, Medline, CINAHL and EBM Reviews (Cochrane Central Register of Controlled Trials (CCTR), ACP Journal Club (ACP), Database of Abstracts of Reviews of Effectiveness (DARE) and Cochrane Database of Systematic Reviews (CDSR)). Hand searches were carried out in key journals (British Journal of Health Psychology, Health Psychology, Journal of Health Psychology, Addiction and Nicotine and Tobacco Research) and reference lists were examined.

Selection criteria. Randomised, quasi-randomised and cluster randomised controlled trials of smoking cessation interventions for pregnant smokers with self-reported and validated smoking cessation in late pregnancy (34^{th} week of pregnancy – 48 hours within delivery) were included in the review.

Data collection and analysis. Two reviewers undertook quality assessment of the included studies and a third reviewer assessed any contradictory quality points. The author of the review analysed the data.

Main results. Analysis found that the smoking cessation interventions for pregnant women were effective. However, when the criterion for significance was reduced, no significant results were revealed. The effectiveness of the interventions did not differ according to types of smokers included in the studies. The trials including women who were at a later stage of pregnancy in their second trimester were more effective compared to the studies that only included women who were at an earlier stage in the second trimester.

Conclusions. Smoking cessation interventions for pregnant women who smoke can be effective. However, the results were not convincingly significant. Although the results of the systematic review indicated that there were no differences between the effectiveness of the interventions according to type of smoker and that interventions might be more effective for pregnant women at a later stage of pregnancy, the results should be considered with a degree of caution, as further investigation is needed to explore these areas further.

Background

Health Effects of Smoking during Pregnancy

Reducing the prevalence rate of smoking during pregnancy is a public health concern (Coleman et al., 2004) due to its numerous adverse effects on the fetus, developing child and mother (Klerman & Rooks, 1999). Smoking cessation during pregnancy significantly reduces the hazardous outcomes associated with smoking including bleeding during pregnancy, placenta previa, placental abruption, premature rupture of membranes and low birthweight due to retarded fetal growth. Nicotine in cigarettes may cause constrictions in the blood vessels of the umbilical cord and uterus, and can consequently decrease the amount of oxygen available to the fetus. Nicotine may also reduce the amount of blood in the fetal cardiovascular system. (U.S. Department of Health and Human Services (USDHHS), 2004). Smoking during pregnancy has been linked to ectopic pregnancies (Cnattingius, 2004) and spontaneous abortion occurs more frequently among women who smoke (Walsh, 1994).

Tobacco smoking during pregnancy reduces babies' lung function (USDHHS, 2004) and the child may consequently suffer from complications of the pulmonary function throughout their life (Cunningham, Dockery & Speizer, 1994). Infants whose mothers smoked both during pregnancy and following birth are more likely to suffer from sudden infant death syndrome (SIDS) (USDHHS, 2004). Children are more likely to develop neurobehavioural disturbances, attention-deficit hyperactivity disorder, behavioural problems and conduct disorder if their mothers smoked when pregnant (Olds, 1997). Additionally, female smokers are more likely to experience difficulties getting pregnant and have a higher risk of infertility

compared to non-smoking women. Studies suggest that smoking harms every phase of reproduction (USDHHS, 2004).

Smoking Prevalence and Cessation Rates among Pregnant Women

Although some women stop smoking as a result of becoming pregnant (Woodby, Windsor, Snyder, Kohler & DiClemente, 1999), many continue to smoke throughout pregnancy and a large proportion of those who manage to quit, resume smoking pre or postnatally (Ruggiero, Webster, Peipert & Wood, 2003). Thus, it appears that pregnancy itself is not a sufficient motivational tool to quit for all women (Lawrence & Haslam, 2007). It is difficult to estimate smoking prevalence rates amongst pregnant women. Even if pregnant smokers are offered smoking cessation support, they might not admit that they smoke due to the stigma associated with smoking during pregnancy (Pollak et al., 2006; Mullen, 1999). The Infant Feeding Survey in 2005 (Department of Health, 2005) revealed that pregnant women in routine or manual groups were significantly less likely to stop smoking during pregnancy compared to women in managerial or professional occupations and quit rates were the lowest among women who have never worked. In addition, young mothers, those aged 20 and under, had higher smoking levels before and during pregnancy compared to older women. The study indicated that a third of women in the UK had smoked at some point 12 months prior to or during pregnancy. Approximately half of these women reported that they had stopped smoking before the birth of their baby. The percentage of mothers who continued to smoke throughout their pregnancy was 17%, that is, one in six women.

Changing Health Behaviour

Many psychological health behaviour change models have been developed, including the Theory of Planned Behaviour (TPB) (Ajzen, 1991), the Health Belief

Model (Rosenstock, 1974), the Health Action Process Approach (HAPA) (Schwarzer, 1992) and the Protection Motivation Theory (PMT) (Rogers, 1983). Although the theories have explored the processes and attitudes involved in health-promoting and health-compromising actions, triggering behaviour change in individuals remains challenging. Certain unhealthy behaviours, such as smoking, are complex phenomena consisting of pleasurable, automatic and addictive constituents, which can consequently cause resistance to change in individuals (Lawrence & Haslam, 2007). According to Michie and Abraham (2004), although research shows that psychological interventions are valuable in changing health behaviours such as smoking, it is difficult to identify which techniques make the interventions effective, as they confound each other as well as other aspects of the interventions such as delivery, intensity and duration.

Stop Smoking Interventions for Pregnant Smokers

Pregnancy is a pertinent opportunity to encourage health behaviour change for women (Lawrence & Haslam, 2007). To identify and support pregnant women in stopping smoking is a clinical necessity and a pubic health priority for the National Health Service (NHS) in the UK as well as for other health services in the world (Condliffe, McEwen & West, 2005; Hotham, Gilbert & Atkinson, 2006). In the White Paper "Smoking Kills", the government set a target for decreasing the percentage of pregnant women who smoke in the UK from 23% to 15% by the year 2010 (Department of Health, 1998). However, encouraging health behaviour change for women who maintain their smoking behaviour throughout their pregnancy is a tremendous challenge (Stotts, DiClemente & Dolan-Mullen, 2002), in particular among high risk, socially disadvantaged and low-income women (Donatelle, Prows, Champeau & Hudson, 2000; Lumley, Oliver, Chamberlain & Oakley, 2004).

Effective stop smoking programmes are essential to help pregnant smokers quit and remain abstinent (Ruggiero et al., 2003) and identifying the fundamental elements of effective interventions is imperative (Lawrence & Haslam, 2007). A range of smoking cessation interventions for pregnant smokers can be found throughout the research literature. These interventions include; varying levels of intensity, behavioural and bio-chemical elements and those aimed at broad populations as well as tailored strategies (Lindsay, 2001). Nonetheless, Pollak et al. (2006) argued that smoking cessation interventions for pregnant women are in need of improvement. In addition, more information is required regarding the factors associated with successful quitting during pregnancy (Woodby et al., 1999). Intervention strategies and techniques for pregnant smokers must be developed and evaluated (Stotts et al., 2002) as smoking during pregnancy represents a problem devoid of a solution (Lawrence, Aveyard, Evans & Cheng, 2003).

Type of Smoker and Time of Pregnancy

Although research has indicated that brief smoking cessation advice can be an effective tool in reducing smoking during pregnancy, this type of counselling does not appear as successful for more dependent smokers (Mullen, 1999). Ershoff, Quinn, Stern, Gregory and Wirtschafter (2000) recommended that future smoking cessation interventions for pregnant women should take into consideration the needs of heavier smokers. Ludman et al. (2000) found that women who were more highly addicted smokers prior to becoming pregnant were more likely to continue to smoke during both early and late pregnancy. Those who continued to smoke in the later stages of pregnancy were older, appeared to have been smoking for a greater number of years and their confidence levels in quitting were lower. Ma, Goins, Pbert and Ockene (2005) reported that older age, smoking later in pregnancy and a higher

dependency negatively predicted successful quitting. Ruggerio et al. (2003) found that quitting smoking soon after finding out about the pregnancy was linked to a higher likelihood of enrolment into a smoking cessation programme as well as higher success rates. However, a study evaluating a peer counselling smoking cessation and reduction intervention revealed that reduction, while not cessation, was the greatest amongst those participants who smoked the highest number of cigarettes at baseline (Malchodi et al., 2003). Rigotti et al. (2006) suggested that pregnant women might benefit from receiving interventions which have been shown to be effective for light smokers as a large proportion of women tend to reduce their smoking in the early stages of pregnancy.

Evaluations of Smoking Cessation Interventions for Pregnant Women

Windsor, Boyd and Orleans (1998) carried out a meta-evaluation of smoking cessation research among pregnant smokers which indicated that self help cessation interventions for pregnant women can be effective. However, nearly all of the studies included in their evaluation were efficacy studies with trained counselors or health educators delivering interventions under ideal conditions. Therefore, Windsor et al. recommended that future reviews should include studies examining the effectiveness of methods in public health practice with a range of health professionals delivering interventions with various levels of intensity under not necessarily optimal circumstances. A quantitative review of interventions for pregnant smokers was undertaken by Dolan-Mullen, Ramirez and Groff (1994). The review implied that pre-natal stop smoking interventions increase smoking cessation rates and reduce the occurrence of low birth weight. Kelley, Bond and Abraham (2001) conducted a meta-analysis to assess whether the overall effectiveness observed in Dolan-Mullen et al.'s study would subsist when a greater number of interventions were included.

Kelley et al. concluded that stop smoking interventions, in particular those based on self-help leaflets or manuals targeted for pregnant smokers, are effective. Kelley et al. also assessed whether the time of intervention in pregnancy was related to effectiveness but they found no significant association. However, the majority of interventions began in the second trimester and this limited the power of the analysis. The authors recommended that future research should evaluate the effectiveness of smoking cessation interventions for pregnant women in relation to different types of smokers as the effectiveness of interventions may vary depending on whether the participants are light or heavy smokers. In 2004, Lumley et al. conducted a meta-analysis, which assessed the effectiveness of smoking cessation interventions for pregnant smokers and the health of the fetus, mother, infant and family. They concluded that smoking cessation programs can help pregnant smokers to become successful quitters. Lumley et al. reviewed numerous studies ranging from the years 1976 to 2003. However, the inclusion criteria in the review were not very stringent.

Objectives

The purpose of this systematic review was to explore the effectiveness of smoking cessation interventions for pregnant women who smoke. The review also assessed the effectiveness of stop smoking programmes according to types of pregnant smokers. In addition, an evaluation into whether time of pregnancy was associated with the effectiveness of smoking cessation interventions was carried out with the aim that there would be a greater variation in gestational weeks of participants than in Kelley et al.'s (2001) study and thus the power of the analysis would not be limited. The review included studies published from 1999 to provide an extension of the studies included in Kelley et al's meta-analysis, which evaluated

studies from 1981 to 1998. Additionally, the inclusion criteria set were more rigorous in comparison to Lumley et al.'s (2004) systematic review.

Method

Criteria for Considering Studies for the Review

Type of Studies

Randomised, quasi-randomised and cluster randomised controlled trials were considered for inclusion.

Type of Participants

All trials included participants who were pregnant smokers and the review excluded studies with spontaneous quitters, i.e. participants who had quit smoking when learning of pregnancy. Studies that specifically targeted young pregnant women were also excluded as a recent systematic review found that there is insufficient evidence to test the effectiveness of interventions for young smokers (Grimshaw & Stanton, 2006).

Type of Intervention

The studies in the systematic review investigated the effectiveness of smoking cessation interventions for pregnant smokers.

Type of Outcome Measure

The outcome measure in the studies was smoking cessation in late pregnancy (between the 34th week of pregnancy to 48 hours within delivery), self-reported and validated (biomarker used for at least 50% of participants).

Search Methods for Identification of Studies

The electronic databases that were searched for studies published between 1999 and 2006 were: The PsychINFO, EMBASE, Medline, CINAHL and EBM Reviews (Cochrane Central Register of Controlled Trials (CCTR) ACP Journal Club

(ACP), Database of Abstracts of Reviews of Effectiveness (DARE) and Cochrane Database of Systematic Reviews (CDSR)).

The search terms were: smok$ OR tobacco OR cigarette$ AND pregnan$ AND quit$ OR stop$ OR cessation AND behavio$ OR intervention$ OR therap$ OR treatment$ OR counsel$ OR support$ OR advice OR psycho$ OR motivational interview$ OR health promoti$ AND randomised controlled trial$ OR randomized controlled trial$ OR randomised control trial$ OR randomized control trial$ OR RCT OR RCTs.

Hand searches were undertaken in the journals; *British Journal of Health Psychology, Health Psychology, Journal of Health Psychology, Addiction* and *Nicotine and Tobacco Research*. Reference lists were also examined.

Methods of the Review

Data Extraction

The author of the systematic review extracted data from published reports and documented the following information:

1. The nature of the intervention (including who led the intervention)
2. Country of origin
3. Study design (including method of allocation, validation of smoking cessation, sample size justification)
4. Study population
5. Inclusion and exclusion criteria
6. Average consumption of cigarettes
7. Average gestational age of participants
8. Participant rate of eligible study population
9. Withdrawals

10. Follow-up points
11. Outcome measures
12. Potential findings regarding time of pregnancy and type of smoker

Quality Assessment

The quality assessment tool examined:

1) Selection bias: Description of the randomised allocation of the trial
2) Detection bias: Biomarkers used to validate self-report
3) Description of intervention
4) Description of time of intervention in pregnancy
5) Description of type of smoker (light/heavy)
6) Time range of follow up points
7) Sample size justification
8) Drop out rate at end of pregnancy
9) Intention to treat analysis / use of lost to follow-up data

The studies were assessed and quality points were provided independently by two reviewers (C. Herberts and G. Guy). A third reviewer (G. Absalom) examined any contradictions and determined the correct quality point. The following quality assessment criteria were followed:

1) Selection bias: 2 = computer randomised, 1 = other randomisation, 0 = no explanation
2) Detection bias: 1 = used at >1 follow-up point, 0 = used at 1 follow-up point/not clear
3) Description of intervention: 2 = step-by-step, 1 = some description, 0 = barely any description. 1 extra point was given if any psychological element was included

4) Description of time of pregnancy: 2 = information given, 0 = no information given
5) Description of type of smoker: 2 = information given, 0 = no information given
6) Time range of follow up points: 5 = 1 year postpartum, 4 = 9 months postpartum, 3 = 6 months postpartum, 2 = 3 months postpartum, 1 = end of pregnancy, 0 = before end of pregnancy
7) Sample size justification – (100 + participants in each group or sample size established by power analysis): 2 = yes – and followed, 1= yes – but did not get enough participants, 0 = not mentioned
8) Drop out rate at end of pregnancy: 2 = drop out rate ≤25%, 1 = drop out rate >25 %, 0 = not known
9) Intention to treat analysis / drop outs assumed smokers: 2 = yes, 0= no/not know

Studies categorised as receiving between 16 to 20 points were defined as high intensity, 11 to 15 point as medium intensity, 6 to 10 points as low intensity and studies receiving a quality score of 5 or below would have been excluded from the review.

Description of Studies

The studies included in the review were carried out in the UK (Cope, Nayyar & Holder, 2001, Tappin et al., 2000 and Tappin et al., 2005), the USA (Donatelle et al., 2000 and Dornelas et al., 2006), Australia (Hotham et al., 2006 and Panjari et al., 1999) and Denmark (Hegaard, Kjærgaards, Møller, Wachmann & Ottesen, 2003 and Wisborg, Henriksen, Jespersen & Secher, 2000). Most of the RCTs were undertaken at hospitals (Cope et al., 2001, Dornelas et al., 2006, Hegaard et al., 2003, Hotham et

al., 2006, Panjari et al., 1999 and Wisborg et al., 2000), two of the trials carried out home-based interventions (Tappin et al., 2000 and Tappin et al., 2005) and one study was run in conjunction with a Women, Infants, and Children (WIC) program (Donatelle et al., 2000). One study investigated how effective a point-of-care urine test from smoking was with regards to providing feedback and improving awareness about the effects of smoking (Cope et al., 2001). The impact of bolstered social support and financial incentives on smoking behaviour was measured in one of the trials (Donatelle et al., 2000) and one study measured the effectiveness of a psychotherapy session and telephone follow-ups (Dornelas et al., 2006). Three studies examined the effectiveness of Nicotine Replacement Therapy (NRT); one of the studies carried out a cognitive behaviour modification program including an option to use NRT (Hegaard et al., 2003) and two of the RCTs examined the effectiveness of free nicotine patches with counselling (Hotham et al., 2006 and Wisborg et al., 2000). A personalised smoking cessation intervention program was provided in one of the trials (Panjari et al., 1999) and home-based motivational interviewing was employed in two studies (Tappin et al., 2000 and Tappin et al., 2005). All of the RCTs included some psychological element as part of the intervention.

The reviewers concluded that six trials provided step-by-step information of the intervention (Donatelle et al., 2000, Dornelas et al., 2006, Hegaard et al., 2003, Hotham et al., 2006, Panjari et al., 1999 and Wisborg et al., 2000) and three studies described the intervention in some detail (Cope et al., 2001, Tappin et al., 2000 and Tappin et al., 2005). The control groups received some form of intervention in all of the trials, six of which provided standard care (Cope et al., 2001, Dornelas et al., 2006, Hegaard et al., 2003, Panjari et al., 1999, Tappin et al., 2000 and Tappin et al.,

2005). Midwives led the interventions in five studies (Hegaard et al., 2003, Panjari et al., 1999, Tappin et al., 2000, Tappin et al., 2005 and Wisborg et al., 2000), the researcher or research officers (trained midwives) provided the intervention in one study (Hotham et al., 2006) and master prepared mental health counsellors ran the intervention in one of the trials (Dornelas et al., 2006). Trained research staff provided interventions in one study (Donatelle et al., 2000) and one research article did not specify who led the intervention (Cope et al., 2001).

Only one trial did not provide information regarding the average number of cigarettes that the pregnant women smoked per day (Donatelle et al., 2000). The average number of cigarettes smoked per day ranged from 10 to 20 in the remaining eight RCTs. Two studies excluded women who smoked fewer cigarettes than a certain cut-off point (Wisborg et al., 2000 and Hotham et al., 2006). All studies apart from one (Cope et al., 2001) provided some information regarding the time of pregnancy when the intervention occurred or the mean or median for weeks gestation of the participants. The trials varied with regards to inclusion criteria and gestational week, ranging from 30 weeks or below to less than 20 weeks. Six studies stated a cut-off point for gestational age as part of the inclusion criteria (Donatelle et al., 2000, Dornelas et al., 2006, Hegaard et al., 2003, Panjari et al., 1999, Tappin et al., 2005 and Wisborg et al., 2000). Two studies excluded women who were still in their first trimester (Hotham et al., 2006 and Wisborg et al., 2000). The average gestational week for participants varied from 12 to 23 weeks. For more information, see ‘Characteristics of Included Studies’.

Methodological Quality

An inclusion criterion for the review was that the studies were randomised controlled trials (RCTs). With reference to selection bias, three of the research

articles did not provide information regarding how the participants were randomly allocated to the intervention and the control group (Donatelle et al., 2000, Dornelas et al., 2006 and Panjari et al., 1999) and only one of the studies allocated the participants using computer-generated numbers (Hotham et al., 2006). The other five studies allocated the participants based on other criteria, e.g. birth date, hospital unit number and balanced stratification such as deprivation (Cope et al., 2001, Hegaard et al., 2003, Tappin et al., 2000, Tappin et al., 2005 and Wisborg et al., 2000).

Three articles incorporated sample size justifications (Hegaard et al., 2003, Panjari et al., 1999 and Tappin et al., 2005) and six of the trials included over 100 participants in both the intervention and the control group at enrolment (Cope et al., 2001, Donatelle et al., 2000, Hegaard et al., 2003, Panjari et al., 1999, Tappin et al., 2005 and Wisborg et al., 2000). Less than 100 participants were allocated to each group in three studies (Dornelas et al., 2006, Hotham et al., 2006 and Tappin et al., 2000). The drop out rate was 25% or less in four studies (Dornelas et al., 2006, Hegaard et al., 2003, Tappin et al., 2000 and Wisborg et al., 2000).

An inclusion criterion for the systematic review was validated smoking cessation status including self-report and a biomarker confirming abstinence for 50% or more of the participants. A biomarker was used on more than one occasion in five of the trials (Donatelle et al., 2000, Dornelas et al., 2006, Hotham et al., 2006, Tappin et al., 2005 and Wisborg et al., 2000). Two studies used carbon monoxide monitoring (cut-off <8ppm) to validate smoking cessation (Dornelas et al., 2006 and Hotham et al., 2006) and the other studies measured cotinine. Cotinine in saliva was sampled in five studies (cut-offs ≤30ng/mL, <14.2ng/mL and <26ng/mL) (Donatelle et al., 2000, Hegaard et al., 2003, Hotham et al., 2006, Tappin et al., 2005 and Wisborg et al., 2000), urinary cotinine concentration was used as a biomarker in two

studies (cut-off <115ng/mL and cut-off not mentioned) (Panjari et al., 1999 and Cope et al., 2001) and two trials measured cotinine level in blood (cut-off <15ng/mL and <13.7ng/mL) (Tappin et al., 2000 and Tappin et al., 2005). In one study, an additional saliva specimen was analysed for thiocyanate (cut-off 100µg/mL) for self-reported quitters (Donatelle et al., 2000). Five of the research articles specified that the results were analysed on an intention to treat basis (Donatelle et al., 2000, Hotham et al., 2006, Tappin et al., 2000, Tappin et al., 2005 and Wisborg et al., 2000) and in two additional trials dropouts were assumed smokers (Dornelas et al., 2006 and Hegaard et al., 2003). Two studies excluded lost to follow up data in the analysis (Cope et al., 2001 and Panjari et al., 1999).

All studies measured smoking status at the end of pregnancy. One trial measured outcome between the 34th and 36th week of gestation (Panjari et al., 1999), three studies at week 36 of pregnancy (one study reported a median of 36 weeks) (Cope et al., 2001, Dornelas et al., 2006 and Tappin et al., 2000) and two trials at week 37 (one study reported a median of 37 weeks) (Hegaard et al., 2003 and Tappin et al., 2005). The other studies measured outcome at; 8 months gestation (Donatelle et al., 2000), 4 weeks prior to delivery (Wisborg et al., 2000) and 48 hour within birth (Hotham et al., 2006). Smoking cessation was defined as seven days point prevalence quit in three studies (Donatelle et al., 2000, Dornelas et al., 2006 and Wisborg et al., 2000) and six articles did not provide clear information about the definition of smoking status (Cope et al., 2001, Hegaard et al., 2003, Hotham et al., 2006, Panjari et al., 1999, Tappin et al., 2000 and Tappin et al., 2005). It was assumed that these studies defined smoking cessation as point prevalence quit. The final follow-up occurred at; the end of pregnancy (Cope et al., 2001, Hegaard et al., 2003, Tappin et al., 2000 and Tappin et al., 2005), two months post-partum

(Donatelle et al., 2000), three months after birth (Hotham et al., 2006), six months after delivery (Dornelas et al., 2006 and Panjari et al., 1999) and one year post delivery (Wisborg et al., 2000).

Three studies examined whether the intervention was more effective for lighter or heavier smokers (Cope et al., 2001, Dornelas et al., 2006 and Hegaard et al., 2003). However, all three trials concluded that number of cigarettes smoked at baseline was not a predictor of changes to smoking. One study found that although the quitters included both heavier and lighter smokers, women who displayed high levels of nicotine in the beginning of the study tended to reduce their nicotine intake whereas those who had already reduced their cigarette consumption had a tendency to increase nicotine intake (Cope et al., 2001). One study revealed that the intervention was more effective for women in early gestation (weeks 1-17) compared to the participants who received counselling in later pregnancy (weeks 18-30) (Dornelas et al., 2006). For more information, see 'Characteristics of Included Studies'.

Results

A total of 149 studies were found using the search strategy at electronic databases. Nine studies, conducted between 1999 and 2006, met all the inclusion criteria and were included in the review with a total of 2936 participants. The quality scores ranged from 8 to 20. Table 1 shows the outcome of the nine studies included in the review.

Table 1. The outcomes and the inclusion criteria of the trials included in the review.

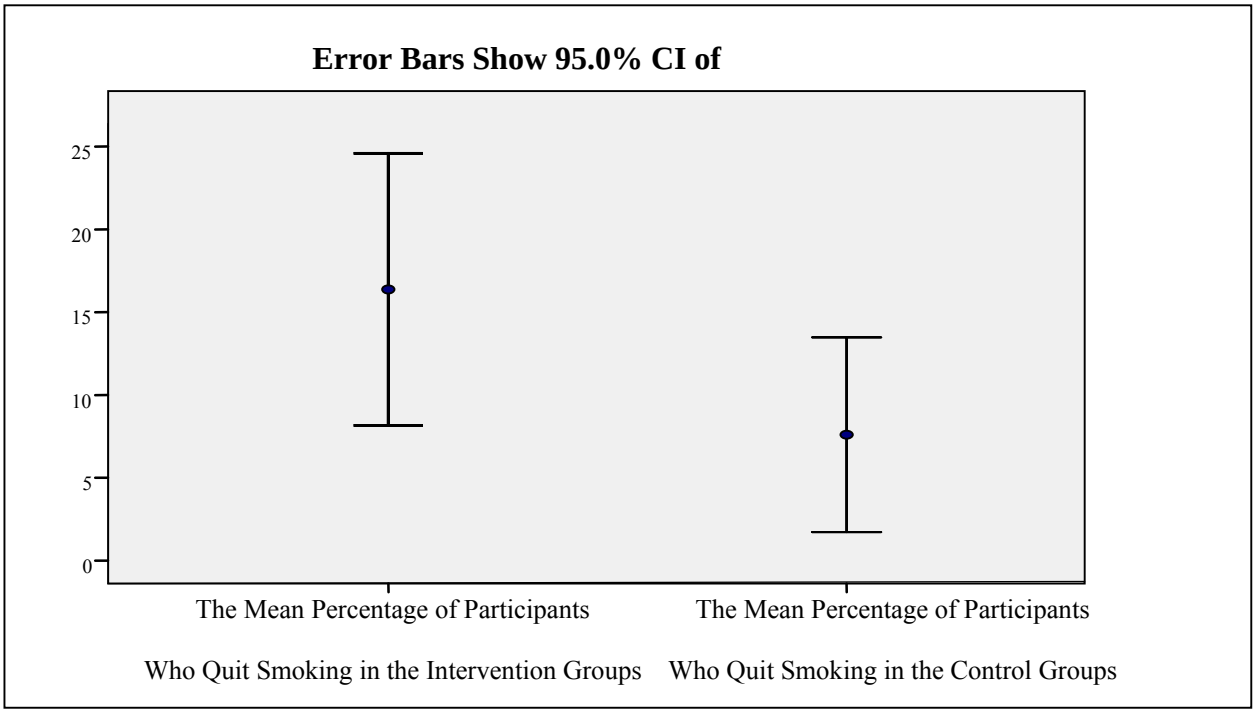
Trial		Intervention Group (IG)		Control Group (CG)		Difference	Type of Smoker	Time of Pregnancy
Authors/ Year	Quality Rating	Quitters	%	Quitters	%	%	Inclusion Criteria (IC)	Inclusion Criteria (IC)
Cope et al. (2001)	8	16/99	16.2%	0/63	0%	16.2%	No IC	No IC
Donatelle et al. (2000)	12	34/105	32%	9/102	9%	23%	No IC	≤28 weeks gestation
Dornelas et al. (2006)	15	15/53	28.3%	5/52	9.6%	18.7%	No IC	≤30 weeks gestation
Hegaard et al. (2003)	15	23/327	7%	7/320	2.2%	4.8%	No IC	≤22 weeks gestation
Hotham et al. (2006)*	14	3/20	15%	0/20	0%	15%	≥15 cigarettes/day	>12, < 28 weeks gestation
Panjari et al. (1999)	12	38/318	11.9%	35/356	9.8%	2.1%	No IC	< 20 weeks gestation
Tappin et al. (2000)	12	2/48	4.2%	4/49	8.2%	-4%	No IC	No IC
Tappin et al. (2005)	13	17/351	4.8%	19/411	4.6%	0.2%	No IC	≤24 weeks gestation
Wisborg et al. (2000)	20	34/120	28%	31/122	25%	3%	≥10 cigarettes/day	>12, <22 weeks gestation
Overall		182/1441	12.6%[1]	110/1495	7.4%[1]	5.2%[1]		
95% CI			8.16-24.59		1.72-13.48	1.46-16.10		

Outcome measure for all studies was point prevalence quit or abstinence for the previous 7 days. Follow-up occurred between the 34th week of pregnancy until end of pregnancy for all studies apart from * where follow-up was undertaken within 48 hours of delivery.

[1] The overall means are weighed by sample sizes for each condition in the nine studies.

The overall difference between the effectiveness of smoking cessation programmes for pregnant smokers in the intervention groups compared to the control groups was 5.2% [1.46 to 16.10, 95% CI]. The overall percentage of quitters in the intervention group was 12.6 [8.16 to 24.59, 95% CI] and in the control group 7.4 [1.72 to 13.48, 95% CI] (the overall means were weighed by sample sizes for each condition in the nine studies). The participants in the intervention groups (M = 16.38, SE = 3.56) were significantly more likely to be quitters in the end of pregnancy compared to the women in the control groups (M = 7.60, SE = 2.55) and a large effect size was revealed ($t(8) = 2.77$, $p < 0.05$, 1.46 to 16.10, CI 95%, $r = 0.70$). However, as six t-tests in total were conducted in the systematic review, the Bonferroni correction was undertaken to reduce the risk of Type I error and an α of 0.01 was used as the criterion for significance. This resulted in a non-significant difference between the outcomes of the intervention and the control groups ($t(8) = 2.77$, $p > 0.01$). See Figure 1 for an error bar graph of the results in the intervention and the control groups.

Figure 1. Error bar graph of the average percentage of pregnant women who quit smoking by the end of pregnancy in the intervention and the control groups.



Pooled comparisons were made of two or more studies using similar inclusion criteria or type of intervention.

Pooled Intervention Group 1

When the studies were pooled according to type of smoker, Hotham et al. (2006) and Wisborg et al. (2000) formed one group as the trials only included smokers who smoked a minimum of 15 or 10 cigarettes a day respectively. The results of the two studies were compared to the outcomes of the other studies, which had not set inclusion criteria with regards to type of smoker. On average, the intervention was more effective in the studies which excluded lighter smokers (M = 9.00, SE = 6.00) compared to the trials including all types of smokers (M = 8.71, SE = 3.94). However, no significant differences were found between the two groups ($t(7) = 0.035$, $p > 0.01$, -19.01 to 19.58, 95% CI) and the difference represented a trivial effect size $r = 0.01$.

Pooled Intervention Group 2

As all of the studies mainly carried out the intervention in the second trimester, analysis could not be undertaken comparing time of intervention in different trimesters. However, six of the studies had set exclusion criteria with regards to gestational week. Three trials; Donatelle et al. (2000), Dornelas et al. (2006) and Hotham et al. (2006), excluded participants who were in the 28th gestational week or more (≤28 weeks and ≤30 weeks) and four studies, Hegaard et al. (2003), Panjari et al. (1999), Tappin et al. (2005) and Wisborg et al. (2000), set the inclusion criterion for the 24th gestational week or under (≤20, ≤22 and ≤24 weeks). Trials were pooled according to whether the inclusion criterion set was less than the 28th or the 24th gestational week. The interventions that included participants who were in a later gestational week were on average more effective (M = 18.90, SE = 2.31) in comparison to the studies, which set the inclusion criteria for earlier in pregnancy (M = 2.53, SE = 0.96). Analysis showed that the difference was significant ($t(5) = 7.31$, $p \leq 0.001$, 10.61 to 22.13, 95% CI) and represented a large effect size $r = 0.96$.

Pooled Intervention Group 3

Pregnant women in the intervention groups used Nicotine Replacement Therapy (NRT) in three of the studies; Hegaard et al. (2003), Hotham et al. (2006) and Wisborg et al. (2000). These trials were combined and the results of the studies were compared to the other six studies, which did not use any pharmacotherapy as part of the treatment. The interventions that had not included NRT in the stop smoking programme were on average more effective (M = 9.37, SE = 4.60) than those that had used NRT in the intervention (M = 7.60, SE = 3.74). Levene's test for equality of variance revealed that heterogeneity of variance could not be assumed

and there were no statistically significant differences between the studies that included pharmacotherapy as part of the treatment and those that did not ($t(6.6) = 0.30$, $p > 0.01$, -12.42 to 15.96, 95% CI). The effect size in the analysis was small $r = 0.12$.

Pooled Intervention Group 4

When the studies were grouped according to who provided the intervention, five studies were pooled together as the interventions were led by midwives; Hegaard et al. (2003), Panjari et al. (1999), Tappin et al. (2000), Tappin et al. (2005) and Wisborg et al. (2000), and two studies were grouped together as counsellors or trained research staff provided the intervention; Donatelle et al. (2000) and Dornelas et al. (2006). Analysis excluded Hotham et al.'s (2006) trial as the intervention was led by both a researcher and midwives and Cope et al.'s (2001) study, as they did not specify who provided the intervention. The interventions that were led by midwives were on average less effective ($M = 1.22$, $SE = 1.50$) than those provided by other health professionals ($M = 20.85$, $SE = 2.15$) and analysis indicated that this difference was statistically significant ($t(5) = 7.12$, $p \leq 0.001$, 12.54 to 26.72, 95% CI), representing a large effect size $r = 0.95$.

Pooled Intervention Group 5

The studies were pooled according to intensity of intervention. Cope et al. (2001) and Hotham et al. (2006) were grouped as delivering less intensive interventions compared to Donatelle et al. (2000), Dornelas et al. (2006), Hegaard et al. (2003), Tappin et al. (2000), Tappin et al. (2005) and Wisborg et al. (2000). Panjari et al.'s (1999) study was excluded as the level of intensity fell between the two groups. The trials including more intensive smoking cessation programmes were on average less effective ($M = 7.62$, $SE = 4.39$) than the less intensive interventions

(M = 15.60, SE = 0.60). However, analysis did not find a significant difference between the groups ($t(6) = 1.00$, p > 0.01, -11.65 to 27.62, 95% CI) and revealed a moderate effect size $r = 0.38$.

Discussion

There was a discrepancy between intensity, duration and nature of the interventions in the trials included in the systematic review. Although analysis initially indicated that smoking cessation interventions for pregnant smokers are effective, the results proved non-significant when the criterion for significance was reduced. All of the trials included studies that had delivered some form of intervention to the control group. Due to the hazards of smoking during pregnancy, it might be unethical not to provide any stop smoking support or advice to pregnant smokers and therefore, trials generally examine whether intensive support is more effective than standard care (Aveyard, Lawrence, Croghan, Evans & Cheng, 2005). Even though delivering effective stop smoking programs for pregnant smokers is notoriously challenging, this might have contributed to the weak findings. However, pregnant women who agree to participate in research are more likely to be motivated than those refusing to take part (Panjari et al., 1999) and obviously those participants included in the analysis of the trials had given consent to be included in the intervention.

Type of Smoker

One objective of the systematic review was to investigate whether the effectiveness of the interventions differed according to types of smokers participating in the trials. However, only two studies set an inclusion criteria regarding number of cigarettes smoked per day; 10 cigarettes or more per day or a minimum of 15 cigarettes a day. Although the cut off points were not extreme and

the studies might not appear to include only heavier smokers, pregnant women are more likely to be lighter smokers as many cut down upon becoming pregnant (Rigotti et al., 2006). Analysis showed that the effectiveness of the interventions did not differ according to type of smoker. Although this result failed to reveal whether specific treatments better would suit lighter or heavier smokers, it indicated that interventions can be effective for all pregnant smokers, regardless of number of cigarettes smoked per day.

Time of Pregnancy

The inclusion criteria set for time of pregnancy of participants did not vary greatly in the trials as all studies set the cut-off point for a time in the second trimester. However, the studies which included pregnant women who were at a later stage in their second trimester compared to trials which set the inclusion criteria for earlier in the second trimester were significantly more effective. As stopping smoking has great health benefits both for the expecting woman and the fetus, cessation should be promoted as early in pregnancy as possible. However, the results are encouraging as they suggest that smoking cessation interventions can be effective for pregnant women in later pregnancy who do not manage to stop in the earlier gestational weeks. The studies included in the review indicated that the majority of trials exclude pregnant smokers who are in their third trimester and thus, there appears to be a lack of research investigating the effects of smoking cessation programmes for women at late pregnancy. Indeed, Pollak et al. (2005) recommended that research evaluating the effectiveness of stop smoking programmes aimed at pregnant women should incorporate participants who are at a later stage of pregnancy in trials.

Nature of Intervention

Similarly to the results of Lumley et al.'s (2004) review, the trials including NRT as part of the treatment were not more effective than the other smoking cessation programmes for pregnant women. Dempsey, Jacob and Benowitz (2002) reported that higher doses of nicotine might be necessary to increase effectiveness as nicotine is metabolised faster in pregnant women. More intensive interventions were not more effective than less intensive stop smoking programmes in the review. This finding implies that effective smoking cessation programmes do not have to be very extensive and could be led by midwives who might not have a great deal of time allocated to help women in their quit attempt. In the majority of the trials included in the review, midwives led the intervention. Analysis showed, however, that the outcome was more effective when the interventions were run by other health professionals i.e. a counsellor or trained research staff. Perhaps this finding was not unexpected as midwives are less likely to have undergone suitable training compared to health professionals specifically designated to the task. Yet, smoking cessation interventions for pregnant women would certainly be more cost-effective and practical if they were implemented by midwives. Battersby, Fendall and Pougher (2003) stated that midwives delivering stop smoking messages and referring pregnant women to specialist services need to be highly trained. In addition, the smoking cessation interventions offered to pregnant smokers need to be tailored specifically to the needs of this population.

Limitations and Future Recommendations

The inclusion criteria set in the systematic review was rather rigorous. This meant that although the review had the potential to gain face validity, important studies might have been omitted. Including a larger number of studies would have

been beneficial in the analysis to increase power. This could have provided more sound evidence of the effectiveness of interventions in terms of type of smoker, time of pregnancy and nature of intervention. Additional investigation is necessary to explore these areas in more detail. Further clarification of whether certain interventions are more effective for different types of smokers and if providing interventions during different trimesters have an impact on outcome, would be beneficial in order to tailor stop smoking support and increase its effectiveness among pregnant smokers. The systematic review is also likely to have suffered from publication bias, as research with statistically significant results is more likely to have been published compared to those trials reporting non-significant findings.

Although identifying effective smoking cessation interventions for pregnant smokers should remain a priority, Cooke, Mattick and Walsh (2001) pointed out that stop smoking programmes will not be effective unless they are adopted and utilised by health professionals. The process of translating effective behaviour change programmes into functioning in-service interventions remains problematic (Lawrence et al., 2005). Naturally, the ideal would be to increase smoking cessation rates before the start of pregnancy. Ma et al. (2005) stressed the importance of implementing interventions prior to conception to create a culture where smoking cessation during pregnancy is an encouraged norm. The health of unborn babies, infants and women would benefit greatly from future research exploring this field.

Characteristics of Included Studies

Authors	Cope, Nayyar & Holder (2001)
Methods	The aim of the study was to investigate a point-of-care urine test from smoking, to provide feedback to women, to improve awareness about the effects of smoking during pregnancy and to relate the test results to pregnancy outcome. The study was a cross-sectional randomised controlled trial with pregnant women. New referrals to three large inner-city hospital antenatal clinics in Birmingham were randomised based on their allocated hospital unit number. No sample size justification was given.
Participants	Pregnant women who were current smokers. The participants were recruited on their initial visit to the clinic. The average consumption of cigarettes was 11.8 per day.
Sample	New referrals to antenatal clinics were randomized. The initial recruitment of women in the intervention group was 447. Of these, 164 reported being current smokers. In the control group, 409 women were recruited of which 116 were smokers. During the course of the investigation, 109 smokers in the intervention group and 83 smokers in the control group were followed through to delivery.
Intervention	All intervention patients were interviewed at their initial visit and tested for smoking. The six-min test provided visual and numerical feedback. Smokers were followed up and retested at subsequent visits. The control group received anti-smoking counselling as part of routine care, but they did not see the test or its results. Both groups were interviewed and retested at 36 weeks gestation.
Follow Up Points	Initial visit and 36 weeks gestation.
Outcomes	Self-reported cigarette consumption and a smoking test device for nicotine metabolites in urine. 55 participants were lost to follow up in the

	intervention group and 33 participants in the control group. This data was excluded from the analysis.
Difference	15.4%
Quality Score	8
Notes	Self-reported cigarette consumption at recruitment was no predictor of changes to smoking. However, the smoking test results showed trends in which women with high results reduced their nicotine intake, while some with a low initial result, because they had previously reduced their cigarette consumption, tended to increase their nicotine intake. Women who quit included both those with low results who were long-term light smokers and women with high results who were shocked by the result and took a decision to stop.

Authors	Donatelle, Prows, Champeau, & Hudson (2000)
Methods	The aim of the study was to determine whether the combination of bolstered social support and financial incentives had an effect in reducing smoking behaviour among low income, high risk, pregnant and postpartum women who participated in Oregon's Women, Infants, and Children (WIC), USA, program. The program was a randomised, experimentally designed study. No explanation of the randomisation was given and no sample size justification was provided.
Participants	Criteria for entry into the study included the following: age 15 years or older, self reported smoker, English speaker/reader, WIC eligible and 28 weeks gestation or less. The mean gestation weeks in the intervention group was 16.6 and in the control group 16.4.
Sample	Recruitment resulted in 220 pregnant smokers taking part in the study out of 309 eligible participants. 112 of the women were in the treatment group and 108 in the control group. The overall participation rate was 71%.
Intervention	The strategy utilised a theory based "three pronged" approach to facilitate smoking cessation among pregnant and postpartum women; positive incentives, "bolstered" social support and community participation. All participants received $5 voucher at each assessment. At baseline, all women were given verbal and written information on the importance of cessation and received a self-help kit. Trained WIC program or SOS (Significant Other Support) program research staff delivered the brief educational intervention. The treatment participants were asked to designate a social worker and they were informed that they would get an incentive ($50 voucher) if they were confirmed as quit. All participants were telephoned monthly.
Follow Up Points	Baseline, eight months gestation and two months postpartum.
Outcomes	Participants completed written surveys and salivary specimen was collected and analysed for cotinine regardless of smoking status (cut-off 30 ng/ml), at each of the three assessments. An additional saliva specimen

	was also collected and stored and analysed for thiocyanated (salivary thiocyanate cut-off 100 μg/ml) if the participants were self-reported smokers. Participants were identified as quitters if they had not smoked in the previous seven days. The participation rate was 71%: a) treatment lost to follow up; 32% at eight months gestation and 36% at two months postpartum and b) control loss to follow up; 51.5% at eight months gestation and 52% at two months postpartum. Quit rates were analysed based on intention-to-treat, where all those lost to follow up were considered to be smokers and all enrolled women who successfully carried their babies to term were included.
Difference	23%
Quality Score	12
Notes	

Authors	Dornelas, Magnavita, Beazoglou, Fischer, Oncken, Lando, Greene, Barbagallo, Stepnowski & Gregonis (2006)
Methods	The study was a randomised trial of pregnant women receiving either usual care or an intervention conducted in the prenatal clinic consisting of counselling plus telephone follow-up delivered by a masters prepared mental health counsellor. The study was carried out in a hospital in Hartford, USA. No details of randomisation or sample size justification were provided.
Participants	The participants consisted of low income, predominantly Hispanic pregnant patients in an urban prenatal clinic. They were current smokers, 18 years and above and 30 weeks gestation or below. The mean for weeks of gestation at baseline was 18.68. Exclusion criteria were; recent history (previous six months) of abuse or dependence on alcohol or other non-nicotine substance, major psychiatric illness or lack of telephone. The average number of cigarettes smoked at baseline was 10.93.
Sample	140 patients were recruited of which 105 met the inclusion criteria. 53 participants were randomised to the counselling intervention group and 52 were randomised to usual care.
Intervention	All subjects received usual care. The health care provider implemented standard smoking cessation treatment guidelines. The intervention group received a counselling session followed by the patient's prenatal clinic visit. The session lasted 90 min and the main goals of the intervention were to 1) assess readiness to quit smoking, 2) quickly engage the participants in treatment, 3) identify potential psychological or social problems that might pose as barriers to quitting and 4) set a quit date. The psychotherapy session was provided at the clinic and followed by bi-monthly prenatal telephone calls from the therapist during pregnancy, and monthly telephone calls after delivery.
Follow Up Points	Baseline, end of pregnancy (36 weeks ±2) and 6 months postpartum.

Outcomes	The primary endpoints were point prevalence abstinence defined as self-report of smoking abstinence for the previous seven days, confirmed with a carbon monoxide reading and measured at end of pregnancy and six months postpartum (cut-off <8ppm). Smoking status was obtained for 100% of the sample at end of pregnancy and 82% at six months postpartum. If smoking status was not obtained, participants were assumed to be smokers.
Difference	18.7%
Quality Score	15
Notes	The intervention was effective for both the lighter and the heavier smokers. Counselling was more effective for those in early gestation (weeks 1-17).

Authors	Hegaard, Kjærgaards, Møller, Wachmann & Ottesen (2003)
Methods	The study was a quasi-randomised trial aiming to evaluate the effect of a multimodal smoking cessation intervention regiment on pregnant smokers at a university hospital in Denmark. Initial counselling was supplemented by an invitation to join a smoking cessation programme with nicotine replacement therapy as a voluntary option. Participants were allocated to intervention or control based on their birth date. Sample size justification was given.
Participants	The participants were identified as daily smokers. Exclusion criteria were; inability to speak Danish, age below 18 years, gestation of more than 22 weeks, verified psychiatric diseases and alcohol or drug abuse. Among participants, the average number of cigarettes smoked per day was 11 and the average gestational week at the first antenatal clinic visit was 16.
Sample	Pregnant women were invited to join the Smoke-Free Newborn Study at their first prenatal visit to the Midwifery Centre**.** The invitation was accepted by 696 of the 905 smokers eligible for participation. 348 women were allocated to the intervention group and 347 to the control group. 48 women were excluded and at the 37th week of pregnancy, the study group counted 647 women of whom 327 were in the intervention group and 320 in the control group.
Intervention	The control group received usual care, which included routine information about the risk of smoking in pregnancy and general advice on smoking cessation or smoking reduction. The intervention group received: 1) Individual counselling on smoking cessation by a specially trained midwife at the prenatal visit raning from 30 min to 40 min. 2) An invitation to join, individually or in a group, a smoking cessation program run by specially trained midwives. The program was based on a cognitive behaviour modification program comprising self-reporting, stimulus control and reinforcement control and maintenance strategies. The programme was established with nine appointments over a period of 14 weeks. The group

	was chaired by midwives and each meeting lasted 90 min. Individual sessions were chaired by one midwife and each meeting lasted 15-30 min. These midwives had received training prior to supporting the pregnant smoker. 3) An offer of nicotine replacement therapy as part of the program (the patch or the gum or the patch and the gum). NRT was maintained for a maximum of 11 weeks.
Follow Up Points	Baseline and 37th week of pregnancy.
Outcomes	The outcome measures were self-reported smoking cessation and a saliva cotinine (cut-off ≤30ng/mL) in the 37th week of pregnancy. The drop out rate was 49 out of from 696 participants. If no information on self-reported smoking status was available, no cotinine value obtained, or cotinine value was >30ng/mL, the woman was categorised as a smoker.
Difference	4.8%
Quality Score	15
Notes	Number of cigarettes smoked per day was not associated with smoking cessation.

Authors	Hotham, Gilbert & Atkinson (2006)
Methods	The randomised controlled study examined feasibility issues in offering free nicotine patches with counselling to pregnant women at the Women's and Children's Hospital in Adelaide, Australia, in terms of acceptability and effects on cessation, and to quantify levels of nicotine metabolites during use and at the end of pregnancy. Randomisation was undertaken by employing a sealed envelope system, using computer-generated numbers. No sample size justification was given.
Participants	Eligibility criteria were assessed at the second antenatal visit and included; self-report of smoking at least 15 cigarettes per day, gestation greater than 12 weeks (avoiding the first trimester) but less than 28 weeks and interest in quitting. The mean gestational age in weeks was 19.4 in the treatment group and 22.8 in the control group. The average number of cigarettes smoked per day was 19.9 in the treatment group and 19.6 in the control group.
Sample	1462 women were screened over a period of six months. Of these, 40 participants met the inclusion criteria and were enrolled in the study, 20 in the control and 20 in the intervention group. 26 participants completed the study.
Intervention	All participants were counselled for approximately five min by the researcher (EH) or by one of the part-time researcher officers who were midwives who had undergone training with QUIT. Counselling consisted of: an affirmation of the decision to stop smoking with QUIT brochures offered, negotiation of a quit date and discussion of what times and in what situations the women usually smoked and proposal of supportive options for avoidance of smoking. Women in the treatment arm were offered nicotine patches with use instructions for a maximum of 12 weeks. Further supportive counselling was given at all visits by either the researcher or a research officer for approximately two min.

Follow Up Points	Baseline (second antenatal visit), at least monthly from remainder of the participants' pregnancies and the primary end point was the last antenatal visit. Three further contacts were made; the secondary end points were within 48 hours of delivery and telephone contact at six weeks and three months.
Outcomes	At enrolment and all subsequent visits, smoking status was measured by self-report, carbon monoxide monitoring (cut-off <8 ppm) and salivary cotinine. Telephone contact was made at six weeks and three months post-delivery to enquire about smoking status but biological testing was not preformed on these occasions. The drop out rate was seven from the control and seven from the intervention group. Analysis of the data was on an intention to treat basis.
Difference	15%
Quality Score	14
Notes	

Authors	Panjari, Bell, Bishop, Astbury, Rice & Doery (1999)
Methods	The randomized controlled trial was carried out at the Royal Women's Hospital in Melbourne, Australia. The study evaluated the effectiveness of a personalized smoking cessation intervention provided to pregnant smokers during their antenatal care. No explanation was given regarding how the pregnant smokers were randomly allocated. The requested sample size was calculated.
Participants	The participants were current smokers and other inclusion criteria included gestation less than 20 weeks, singleton pregnancy, the ability to speak and read English and no drug dependency. The participants smoked on average 11 cigarettes per day at the time of the first antenatal visit. Average gestation at recruitment was 12 weeks.
Sample	The aim was to recruit 1,260 pregnant smokers. Of the 1,942 women who were identified as current smokers at their first visit, 1,013 were initially recruited with the remaining number of eligible participants being 951; 439 in the intervention group and 502 in the control group. Data from 339 women in the intervention group and 393 women in the control group could be evaluated. 240 participants completed the intervention.
Intervention	Women in the control group received standard antenatal care, which included the distribution of a pamphlet during a group information session. The intervention group was counselled on four occasions by the same midwife who had been trained in smoking cessation techniques. The session consisted of distribution of literature, viewing a video, delivery of messages about the risks of smoking and advice to quit. The counselling component included concepts such as identification of smoking cues, discussion of the costs and benefits of quitting and goal setting. Subsequent sessions, usually lasting 5-10 min, consisted of personalized counselling and distribution of literature. Follow-up sessions were offered at around 16-20, 24 and 28 weeks gestation.

Follow Up Points	Baseline, mid pregnancy (24-28 weeks) and late pregnancy (34-36 weeks). Study participants were telephoned at six weeks and six months post-delivery to assess self-declared smoking status.
Outcomes	The quit rate was determined on the basis of self-reported cessation combined with a first visit and late pregnancy urinary cotinine concentration (cut-off <115ng/mL). 77% (n=339) of the eligible participants in the intervention group were evaluable of which 71% (n=240) completed the intervention. 78% (n=393) of the women in the control group were evaluable. Only evaluable women were included in the analysis, excluding those lost to follow-up and others excluded.
Difference	2.1%
Quality Score	12
Notes	

Authors	Tappin, Lumsden, McIntyre, McKay, Gilmour, Webber, Cowan, Crawford & Currie (2000)
Methods	The study formed part of a programme to establish if proactive opportunistic home-based motivational interviewing, which has strategies for every 'Stage of Change', delivered by specially trained midwives, would help pregnant smokers reduce their habit. The study was undertaken at clinics in Glasgow, UK, and participants were randomised into the control and the intervention group. The research midwife phoned W.H.G who allocated to two equal groups using random numbers with stratification into six frames by telephone (yes or no) and deprivation (categories 1 & 2, 3-5 or 6 or 7). No sample size justification was given, however, the study was a pilot study.
Participants	The participants were pregnant women who were smokers at booking. The median of gestation at booking was 14 weeks. The average number of cigarettes smoked the day prior to booking was 14.8 in the intervention group and 13.2 in the control group.
Sample	133 pregnant smokers were identified at the clinic and 100 of these were eligible for the study and gave consent to participate. 50 women were allocated to the intervention group and 50 to the control group. Three clients were lost to follow up.
Intervention	The control group received normal care, which should consist of information about smoking at maternity booking. The intervention group received motivational interviewing at home with one research midwife using the five principles; expression of empathy, development of discrepancy, avoiding argumentation, rolling with resistance and supporting self-efficacy. The strategy was matched with 'Stage of Change'. Clients received a median of four sessions. Midwife training of motivational interviewing took place during three weeks.
Follow Up Points	Booking and late pregnancy (median 36 weeks gestation).

Outcomes	The outcomes were self-reported change in smoking habit and cotinine level in blood (cut-off <15ng/ml). 97 clients completed the study and analysis was performed on intention to treat basis.
Difference	-4%
Quality Score	12
Notes	

Authors	Tappin, Lumsden, Gilmour, Crawford, McIntyre, Stone, Webber, Macindoe & Mohammed (2005)
Methods	The study was a randomised controlled trial to determine whether the quit rate for pregnant smokers increased with motivational interviewing provided at home by specially trained midwives in Glasgow, UK. An administrator provided random allocation using sealed envelopes after entering details on a database. Random allocation used balanced stratification for three levels of smoking before pregnancy and cutting down. A third party made up envelopes in batches. The requested sample size was calculated but not achieved.
Participants	The pregnant women were participants who were regular smokers at antenatal booking and 24 weeks gestation or less. The mean for gestation weeks in the intervention group was 13.3 and in the control group 13.5 at enrolment (the median was 13 weeks). The average number of cigarettes smoked on the day previous to enrolment was 11.7 in the intervention group and 11.3 in the control group.
Sample	Women at two hospitals were recruited. The aim was to recruit 930 women; however, this was not achieved. 1684 pregnant smokers were identified of which 762 consented to take part. 351 women were recruited in the intervention group and 411 in the control group. All participants completed the study.
Intervention	Midwives provided standard health promotion information including information on smoking and pregnancy. Women in the intervention group were offered two to five additional home visits of about 30 min duration from the same midwives. Midwives made six attempts to contact women, including the home visit arranged at enrolment, two to three telephone calls, one or two “cold” calls to the house, and sending a letter asking them to telephone a free number. A consultant provided five days training in motivational interviewing followed by one day a month throughout the study.

Follow Up Points	Enrolment or baseline (obtained either at enrolment or at next antenatal visit), at 25-31 weeks and in late pregnancy (median 37 weeks gestation).
Outcomes	Self reported smoking cessation plus cotinine concentrations serum (cut-off <13.7 ng/ml) or saliva (cut-off <14.2 ng/ml). Cutting down was self-report of smoking half that at booking plus cotinine concentrations half the previous measurement. The number of lost to follow-ups was 29. The main analysis was performed on an intention to treat basis.
Difference	0.2%
Quality Score	13
Notes	

Authors	Wisborg, Henriksen, Jespersen & Secher (2000)
Methods	The objective of the study was to assess the effectiveness of nicotine patches on smoking cessation in pregnant women and the effect of nicotine on birth weight and preterm delivery. Participants at a University Hospital in Aarhus, Denmark, were randomly allocated in balanced blocks of six, to nicotine or placebo. A randomisation list was generated and patches supplied with randomisation numbers and the code was kept between the patch number and the specific treatment until data collection was finished. As the women entered the study, they were assigned consecutive numbers on the randomisation list that corresponded to specific patches. No sample size justification was given.
Participants	Healthy pregnant women who smoked 10 or more cigarettes per day after the first trimester and were less than 22 weeks pregnant were invited to participate. The average number of cigarettes smoked per day was 13.4 in the nicotine group and 14.2 in the placebo group.
Sample	611 women were invited to participate and 250 participants agreed to take part. 124 women were allocated to the intervention group and 126 to the control group. Data from 87% of the participants was obtained at the final visit.
Intervention	Smoking cessation counselling was done with a midwife. At the first visit, which lasted 45-60 min, participants were interviewed about their smoking habits and previous quit attempts and given information about smoking and quitting. A pamphlet was also provided. Treatment with patches was planned for 11 weeks, the 15mg patch for eight weeks and 10mg patch for three weeks. The participants in the control group received placebo patches. The second and third visits were scheduled eight and 11 weeks after the first visit and the fourth visit was four weeks before the expected delivery date. The visits lasted 15-20 min and if women did not attend visits they were telephoned.

Follow Up Points	Baseline and three prenatal visits. Participants were interviewed by telephone three months and one year post delivery.
Outcomes	Self-reported abstinence of at least seven days at second, third and fourth prenatal visits. Cotinine in saliva was sampled at each prenatal visit (cut-off <26ng/mL). Information about smoking habits at the second, third and fourth visits was missing for 23 (9%), 33 (13%) and 33 (13%) respectively. Those women were categorised as smokers. The principle of intention to treat analysis was used. Participants were interviewed by telephone three months and one year after delivery.
Difference	3%
Quality Score	20
Notes	

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